

Psychologically Informed Environments for Homeless People: Resident and Staff Experiences

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Abstract

Purpose: Many homeless people have significant levels of early adverse experiences and consequent mental health difficulties. This study examines the experiences of residents and staff living and working in a Psychologically Informed Environment (PIE), a new model of hostel for homeless people which aims to update and make more flexible the principles of the therapeutic community, thereby meeting the psychological and emotional needs of residents.

Design and approach: Semi-structured interviews were carried out with nine residents, ten staff and five psychotherapists at two PIE hostels in London, UK. The data were analysed using thematic analysis with a phenomenological epistemological approach.

Findings: Analysis generated 18 themes for residents and staff combined, organised into five domains: what makes a home, resident needs, managing relationships, reflective practice and theory vs practice of PIEs. The study suggests that PIEs broadly meet their aim in providing a different type of environment from standard hostels. Efforts to build relationships with residents are particularly prioritised. This work can be challenging for staff and reflective practice groups provide a supportive forum. There are limits to the extent to which the theoretical PIE can be put into practice in the current political and economic climate.

Originality/Value: This is one of the first qualitative studies of PIEs. It provides perspectives on their theoretical background as well as how they operate and are experienced in practice. It may be informative to services intending to establish a PIE and to commissioners in assessing appropriate resources.

Keywords: Homelessness, Hostels, Psychologically Informed Environments, Reflective Practice

Article Classification: Research Paper

Introduction

Hostel accommodation is one of the oldest forms of institution for homeless people (Busch-Geertsema and Sahlin, 2007). Hostels have developed from places which meet only basic needs of physical shelter to environments which support people with a variety of difficulties (Warnes *et al.*, 2005).

Levels of mental, physical health and substance use needs are much higher in the homeless than housed population (Fazel *et al.*, 2014, 2008). The prevalence of early adverse experiences and consequent attachment difficulties have been linked to a range of mental health problems, particularly personality disorder (Bramley *et al.*, 2015; Campbell, 2006). Seager (2011a) argues that many homeless people lack any concept of home as a safe place. Being 'psychologically unhoused' (Scanlon and Adlam, 2006 p.10) is often expressed through alienation, self-neglect, and an inability to transition to and sustain a housed state. This can contribute to frequent eviction and abandonment of housing (Teixeira, 2010). 'Multiple exclusion' homelessness, where people are not only homeless but also experiencing 'deep social exclusion' (Fitzpatrick, Bramley & Johnsen, 2011, p.149), is therefore more than a social or economic issue and interventions need to consist of more than just housing (Cockersell, 2012).

'Psychologically Informed Environments' (PIEs) (Johnson and Haigh, 2010, 2011a, 2011b) have been proposed as such an intervention. They are neither solely a therapeutic technique nor the provision of physical shelter alone. Instead, they are an attempt to meet the fundamental needs of residents by providing psychological safety and rebuilding damaged attachment relationships through the provision of a professional home and family. PIEs borrow values from therapeutic communities in providing a structured environment where participating in a shared social context is 'treatment' for mental health problems (Kennard, 2004). A PIE is conceptualised as an 'updated' therapeutic community (Haigh *et al.*, 2012) which has a more flexible, less intense approach but retains core principles of the value of social processes in a day-to-day living environment and the power of good quality relationships to facilitate change. This can be created in "any setting where the social environment makes people feel emotionally safe" (Maguire *et al.*, 2010, p.19). A "broadly therapeutic framework" should underpin this (Keats *et al.*, 2012 p.6). No particular psychological model is prescribed, provided a coherent approach is chosen and there is a fit between environment, approach and resident needs. Staff are expected to understand and use therapeutic principles in their work. Seager (2011b) interprets a PIE in terms of attachment theory. He argues that a PIE should facilitate secure and consistent attachment relationships by, for example, the environment not containing more

residents than can be held in mind by staff and not being so large that it feels like an institution rather than a home. In summary, the document endorsing PIEs as an appropriate intervention for homeless people (Keats *et al.*, 2012) states that PIEs should have five components:

1. A psychological framework, explicitly committed to as the therapeutic approach underlying the project.
2. The physical environment managed in a way which promotes psychological safety.
3. Staff supported to make consistent changes to approaches to clients by means of reflective practice groups, which also provide ongoing learning and reflection.
4. Managing relationships should be considered the principal tool for therapeutic change, rather than controlling behaviour.
5. Outcomes should be evaluated at service and individual levels

Hostels use a 'keyworking' system where one staff member has a caseload of residents who they support. Previous studies suggest that keyworking is a demanding, sometimes poorly defined task (McGrath and Pistrang, 2007) carried out in challenging environments (Maguire, 2012). Core elements of the therapeutic alliance are central to helping relationships, both in formal psychotherapeutic or informal relationships (Barker and Pistrang, 2002). However, establishing therapeutic relationships can be exceptionally demanding for keyworkers due to difficulties in interpersonal relationships often presented by homeless people (Arslan, 2013). Keyworkers often do not receive as much supervision as other helping professionals. Team splits and problematic dynamics can also occur when working with people with diagnoses of personality disorder (Campling, 2004) and studies from client perspectives have shown how unhelpful patterns of communication can arise within hostels (Stevenson, 2014).

Reflective practice groups, derived from Schon, (1983), are central to PIEs and aim to support staff with these challenges. These involve an active process of reflection and learning, rather than being simply support groups. Groups help staff reflect on interactions with residents and each other, explore the context of behaviour and consider alternative perspectives.

Historically, many hostels have been in poor physical condition, sometimes occupying the same buildings as dormitory-based buildings that preceded them (Busch-Geertsema and Sahlin, 2007), contributing to a perceived sense of threat and lack of control over the environment for potential residents. Despite a drive to transform hostels into more pleasant environments (Department of Communities and Local Government, 2006), ambivalence about safety or desirability of hostel

accommodation persists, especially amongst multiply excluded homeless people or when hostels have high levels of substance use (Chandler and Cresdee, 2008). Conversely PIEs are intended to establish a social environment that promotes safety through thoughtful design of the physical space. Evidence-based design suggests factors such as light, open or closed spaces and noise levels impact on psychological wellbeing (Mazuch and Stephen, 2008). Design of the physical environment is intended to send a message about valuing shared space and those living within it (Keats *et al.*, 2012).

Aims of study

Much has been written about theory of PIEs and the rationale for their need. Several homeless services have been established as PIEs recently (Blackburn, 2012; Edwards, 2012; Williamson and Taylor, 2015). However, there has not yet been a formal in-depth exploration of how PIEs operate and how they are experienced by residents and staff. Moos (1997) describes how treatment environments operate on many levels, with the institutional context, architecture, organisational policies and the client group interacting and influencing the social climate or 'personality' of a project. The social environment is complex, and in the case of PIEs, somewhat idiosyncratic. Pauly *et al.* (2014) argue that to evaluate such interventions a method should be used that goes beyond quantitative measures of individual change. A qualitative method was therefore used to capture this wider context. Since this is a relatively novel topic, an exploratory approach focusing on participant experience was chosen. Staff and residents are both integral to PIEs. Therefore, semi-structured interviews were carried out with three groups of participants: staff, residents and psychotherapists.

The study focused on the following questions:

- 1) What are the experiences and perspectives of residents and staff living and working in a PIE?
- 2) Are there any perceived differences between PIEs and standard hostels?

Method

Setting

The study was carried out in two supported housing projects run by a voluntary sector organisation in London, UK. The organisation's PIEs were structured according to the five characteristics outlined above. They were underpinned by the psychodynamic model and promoted the recovery approach. The organisation's therapy service provided therapists across each project who facilitated reflective practice and provided optional individual psychotherapy to residents. The projects specialised in working with people with long-term mental health problems. Each had a system of keyworking where residents were matched with a staff member to assist with support needs.

Ethical approval was gained from the UCL Research Ethics Committee.

Participants

Three groups were invited to take part, using a purposive sampling method which aimed to recruit participants according to their ability to provide first-hand information on the topic:

1. *Residents* who had lived in the hostel for at least one month, spoke English with sufficient fluency to participate in an interview and were neither floridly psychotic nor highly intoxicated. Ten residents were invited to participate and nine took part. All but one were male. Most residents fell into the 46-55 age category and had lived at the project for between two and five years. Seven were White British or Irish; one was Black British and another Asian British.

2. *Staff* who had been working in the hostel for at least three months, attended a minimum of two reflective practice sessions and either had keyworking relationships or regular contact with residents. Twelve staff were invited to take part and ten agreed; all but two were male. Staff were evenly spread between the 26-46 age groups; six were White British and four were Black British or African.

3. *Psychotherapists* from the therapy service who had facilitated reflective practice sessions and provided either therapy or supervision for at least six months. Five therapists were approached and all agreed to take part. All were White British or European. Participants were spread between 36-45 and over-55 age groups.

Interview

The interview schedule was developed based on the first four areas of the PIE (a psychological framework, management of the physical environment, reflective practice and managing relationships). A service user was recruited from the organisation's service user forum to advise on the proposed schedule and interview process. Interviews used a semi-structured format, allowing the researcher flexibility to ask follow-up questions or further explore pertinent themes. All interviews were carried out by the first author and were audio-recorded.

A phenomenological epistemological approach was adopted in which the researcher attempted to understand from first-hand accounts participants' lived experiences in the context in which they occur (Giorgi & Giorgi, 2008). A phenomenological approach is particularly appropriate in researching experiences of service delivery (Biggerstaff, 2012).

Analysis

Verbatim transcripts of recorded interviews were analysed using Thematic Analysis (Braun and Clarke, 2006). This method entailed repeated reading of transcripts, generating initial codes, sorting codes into themes, identifying and defining themes and considering how they fitted together into broader domains. Analysis was undertaken in parallel with ongoing interviews, allowing the schedule to be adapted in line with emerging themes and domains to be revised as data were collected. Staff, therapist and resident data were analysed separately until it became clear that the groups had many themes in common. The coding structures were amalgamated to create a single framework which presents the three groups together.

In accordance with guidelines for avoiding bias in qualitative research, testimonial validity checks were offered to all participants (Elliott, Fischer & Rennie, 1999; Stiles, 1999). Coding of transcripts was carried out by the first author and the coding structure independently checked by the fourth author to ensure credibility.

Results

The analysis generated 18 themes organised into five domains. Each domain is described below with illustrative quotes provided in Table 1.

Domain 1: What makes a home?

Most participants spoke about making the hostel a 'home'. Almost without exception, participants recalled hostels from the past or others which were chaotic and less thoughtful of resident needs. Staff spoke of efforts to make the environment 'homely' and some residents concurred that this was the case. However the issue was raised of what 'home' really meant beyond a comfortable environment. Co-production of the environment was spoken of as key, to construct a space that was both valued by residents and reflected their identity. A risk was identified in efforts to improve environments so much that they became clinical and corporate. Feeling safe was spoken of as an important part of being at home, both in terms of physical security and, by some, through keyworker relationships.

Domain 2: Impact of client needs

Most staff were aware that residents often had a history of severe and chronic trauma and some made links between this and current mental health difficulties. Most residents were diagnosis-focused, but also spoke of shared experience of mental health problems with others. Some staff reported distress

at thinking about client trauma but also particular reward when residents were doing well, sometimes against the odds. There was acknowledgement that in light of these needs, flexibility was necessary both in rules and provision of therapy, as rigid application of sanctions was counterproductive.

Domain 3: Managing relationships

Both staff and residents spoke about the importance of building relationships, both in theoretical terms of meeting psychological needs and in practical terms of conversations with residents showing genuine interest in their backgrounds and needs. Trust was spoken of as the mark of a good keyworker-resident relationship, but it was acknowledged that this could be exceptionally difficult to build up, given that residents' history of relationships often included serious breaches of trust, leaving them suspicious. Both staff and residents described benefits of communicating with each other as equals. Residents spoke of relationships with their keyworker or therapist as 'make or break': whilst some spoke of feeling cared for by their keyworker and turning to them first for help, there were also indications that for some these relationships could be tenuous and break down quickly.

Domain 4: Reflective Practice

As well as the emotional impact of knowing about trauma explored in Domain 2, the toll of everyday working with a complex client group who could be challenging in their behaviour was noted by staff, including feelings of disappointment, rejection or the need to retreat despite a wish for 'open doors'. A link was made between potential for burn-out and the need for a space to reflect. Reflective practice sessions were described as a safe space to take a step back from everyday tasks and think in detail about what might underlie resident difficulties, allowing staff to see the 'bigger picture' of client lives and appreciating multiple perspectives. There was evidence that sessions allowed staff to make changes in interactions with resident and reflect on their own actions and motivations, which in turn had an impact on client behaviour. However, reflective practice was not universally appreciated: some considered it an unnecessary luxury in a culture where the staff role is considered 'doing' rather than 'thinking'; others were unwilling to be seen talking negatively about clients.

Domain 5: Theory vs Practice

Some participants expressed scepticism about whether PIEs were anything beyond a new label for general good practice or a watered-down therapeutic community. 'Psychology' was interpreted as a broad humanistic approach rather than a technical model-specific approach. Staff spoke of scarce resources alongside unrealistic externally imposed goals and targets which did not match the complexity of the task and could dehumanise their role as carer. This was particularly illustrated in the expectation of moving clients on in 24 months which, whilst potentially rooted in fear of making

residents 'dependent', many found unsettling and staff found difficult to reconcile with promoting safety. Despite positive aspects of the recovery model, it also created ambivalence between staff wanting to push residents towards 'taking responsibility' but also protecting and caring for them.

[Insert Table 1 here]

Discussion

This study provided a qualitative exploration of resident, staff and therapist experiences of PIEs. The data suggest PIEs are broadly meeting their aims by supporting staff to promote positive experiences of relationships in an environment valued by residents. Nevertheless, this is a challenging task and translating the model into practice is not straightforward.

What makes a home?

Almost all participants described other hostels which contrasted with their current environment, chiming with reports of hostels being perceived as dangerous and chaotic (Hall, 2006). Whether participating hostels were actually PIEs (Domain 5), it was universally agreed they were different and better than the past.

Most participants described efforts to make the physical environment homely, leading to the question of how to construct an environment which allowed people to *feel* 'at home'. Campbell (2006) states if homelessness is communication of the distress of an internal state of "unhousedness", a 'home' needs to be more than something provided unthinkingly by benevolent agencies. The danger of prescribing what a typical home should be rather than involving residents in co-creating a space that reflected their preferences and character was noted. Davis (2004, p.21) describes providing choice in design for homeless people as the "cornerstone of dignity" and the importance of signalling "someone cares about them and that they are worthy of this concern". These findings accord with quantitative research of treatment environments suggesting resident participation strengthens resident-staff relationships and is correlated strongly with a supportive environment (Moos, 1997). Interestingly, projects which aimed to be aesthetically pleasing and architecturally innovative could fail to be experienced as a 'home', being instead too corporate and clinical, and inadvertently lacking the containment and psychological safety provided by more manageable spaces.

PIEs aim to facilitate psychological safety; having a limited concept of a safe home may explain why some residents described safety in physical terms (room checks, locked doors). However, others endorsed feeling safe through relationships, indicating basic conditions of psychological security were being addressed - being held in mind by someone who is responsive to one's needs, providing the 'secure base' for an attachment to develop (Seager, 2006).

Resident needs and histories

Whilst residents spoke of having shared difficulties with others, staff spoke more explicitly about their awareness of the impact of trauma and linked this to current mental health. The strong emotional reaction to this echoes experiences of "compassion fatigue" or cumulative vicarious trauma, documented in helping professions and homelessness staff specifically (Arslan, 2013; Seager, 2013). Nevertheless, there was evidence of "compassion satisfaction" (Stamm, 2010) with staff feeling particularly rewarded by positive relationships.

A flexible approach to rules, described as "elastic tolerance" (Keats *et al.*, 2012, p.6) in PIE guidance, was discussed in relation to resident needs. 'Revolving door homelessness' is exacerbated by frequent eviction from hostels where residents are unable to adhere to rules (Homeless Link, 2010). Thoughtless application of rules was described as counterproductive since the ultimate sanction of eviction did not hold much fear. Flexibility was also expressed through emphasis on engagement as a precursor to therapy and as therapy itself. Brown *et al.* (2011) note that homeless people were once considered too "chaotic" to benefit from therapy and therefore that the work needs to go beyond "conventional spaces and domains of psychotherapy" (p.310). Phipps (2016) suggests homeless people can and will engage in psychological interventions and therefore it would be a mistake to buy into a culture of judging people as unsuitable for psychotherapy because of a perceived "deficiency in their psychological mindedness" (Seager, 2006, p.275).

Managing relationships

Without exception, participants spoke about relationships and either an implicit or explicit grasp of their necessity. Relationship building has been described as the "bread and butter" of work with homeless people (Cockersell, 2012, p.179) and trust was described as the key component of such relationships. Writers on complex trauma emphasise that recovery can only occur in a relational context, through which disempowerment and disconnection from others are mended and the capacity for trust re-built (Herman, 1997; Van der Kolk, 2014). Damaging infantilisation or abuse of power is not uncommon in relationships between homeless people and institutions (Hoffman and Coffey,

2008). However, staff and residents indicated benefits of relating to each other as equals, echoing the 'flattened hierarchy' of a therapeutic community.

Residents spoke of positive effects of keyworker relationships, such as feeling cared for and having honest communication, mirroring research which established effective therapeutic relationships are characterised by warmth, trust and acceptance (Asay & Lambert, 1999) and suggests that these processes are key regardless of setting. There was evidence of residents using their keyworker as a 'secure base', being the person they would seek out above others. It is now acknowledged that insecure attachment styles can be modified to 'earned secure' style in response to positive relationships in adulthood (Saunders *et al.*, 2011) supported by evidence of neuroplasticity throughout the lifespan (Siegel, 2012). Despite this good groundwork, there was also a sense of 'make or break', reflecting the inescapable fact that patterns of unstable interpersonal relationships were not easy or quick to change.

Reflective Practice

Many staff spoke of aspects of day-to-day work being challenging and frustrating. From an attachment perspective, it is likely that residents lack the ability to self-soothe and struggle to both elicit and use professional care in fruitful ways (Adshead, 2001) leaving staff having to tolerate well-intentioned care being rejected. The toll of working in such an environment was linked to the need for space to reflect. Staff described reflective practice as an opportunity to step back from everyday work, gain greater awareness of their clients and hypothesise about reasons for behaviour. Developing reflective capacity and the ability to mentalise are key skills in therapeutic relationships (Dallos and Stedmon, 2009) potentially adding to the quality of keyworker relationships. Staff reported experimenting with interactions with residents and noting their outcomes, suggesting they were using an experiential learning cycle (Kolb, 1984). This supports findings by Maguire (2006) that formulation groups can increase staff self-efficacy.

However, reflective practice was not straightforward. Voluntary sector culture was described as privileging 'doing' things for others; thinking about one's own feelings was regarded by some as an unnecessary luxury. Expressing negative feelings about residents was sometimes felt to be incongruent with staff self-perception and values as carers. These findings suggest keyworking remains a "taken for granted model of practice" (Holt and Kirwan, 2012, p.389) which lacks clarity in relation to integrating the active helper role with that of a more reflective therapeutic practitioner.

Theory vs Practice

The homelessness sector has been subject to numerous initiatives (Wilson and Barton, 2016). Whilst most staff felt that PIEs brought something new and valuable, a minority questioned whether PIEs were a jargonistic label for long-standing good practice. This led to the question of what psychology's contribution should be, if a PIE was to be meaningful. Some participants suggested that this should be defined as "psychology with a small p", "psychosocial" relationally-focused interventions (Johnson and Haigh, 2012, p. 240).

Despite guidance stating PIEs should not require large amounts of resources, funding constraints in the current economic climate was an ongoing theme. Services are contracted-out and unrealistic expectations from commissioners which failed to take into account the complexity of the task or needs of residents contributed to anxiety about outcomes, staff role in delivering them and by inference, services being re-commissioned (Davies, 2008). Nowhere were these issues more prominent than in the area of moving on. Some residents were looking forward to this, but others described the process as something they were not ready for. Short-term contracts and consequently fragmented service provision in an increasingly marketised social care system conflicts with the long-term process of "re-homing" (Seager, 2011a, p.187) and rebuilding damaged attachments. A marketised system constructs recipients of care as consumers making rational choices; however homeless people are, in reality, among the most disenfranchised in decision making (Brennan, Cass, Himmelweit, and Szebehely, 2012), making "informed consumer choice" a false promise.

Some suggested fear of encouraging 'dependence' with its resonances of outdated long-term institutionalisation lay behind the need to move people on, with dependence being mistaken for genuine attachment (Bucci *et al.*, 2015). Campbell (2006) notes that disruption caused by enforced moves can represent a rupture in newly established attachment relationships, prompting feelings of rejection and abandonment, further reinforcing the cycle of exclusion where people become increasingly less trusting. Staff are therefore placed in a double bind whereby they need to nurture residents but also move them on. Similar ambivalence was expressed by staff being anxious that residents might become *too* safe and comfortable and that the recovery model entailed "taking responsibility". Some questioned the usefulness of this model, Seager (2011a, p.186) arguing that the first healthy attachment relationship must precede any attempts at 'rehabilitation'. This is supported by research on 'enforced recovery' of 'problem' drug users which was least likely to be effective for those without any experience of stability to aspire to (Johnsen and Fitzpatrick, 2007).

Limitations

These findings should be considered in the light of a number of limitations. Because PIEs are flexible and customised to create a fit between environment and client group, they are by definition idiosyncratic. The generalisability of these findings across settings is therefore limited. Secondly, there are limitations in relation to the sample. Whilst the sample achieved a mix of ages and ethnicities (with a bias towards men reflective of the client group), many staff were self-selected as those with interest in the model. Residents were to an extent selected, although there was no evidence of bias towards positive report. A larger sample of residents would have been preferable; however challenges in recruiting residents to participate precluded this. Lastly, a phenomenological epistemological approach meant relying solely on participant report of subjective experience. Whilst there is no reason to believe this is not valid, there was no means of verifying experiences through triangulation with other sources.

Implications for Practice

A number of suggestions for both professional practice and further research arose from this study:

When creating a hostel environment, consultation with residents and active coproduction of the space is more likely to contribute to a valued space. Imposing solutions or preconceived aesthetic ideas may not make a 'home'.

Staff who engaged with reflective practice reported it being a valuable process which influenced their practice positively, including promoting greater awareness and ability to engage differently with their clients. Staff working in supported accommodation could benefit from groups to reflect on their work and to support the complex task of building relationships (formulation groups, reflective practice or similar). Further research could investigate whether engagement in such groups has an effect on staff burn-out, perceptions of self-efficacy or team coherence, as suggested by Maguire (2006). Keyworkers could also benefit from greater clarity of their professional role and updating or defining their skill set and theoretical base. This could retain their role as active helpers, harnessing existing skills and implicit understanding of client needs, whilst also giving consideration to their role as reflective practitioners.

Social care has been 'marketised' in recent years with short-term contracts awarded on the basis of cost and outcomes, often leading to fragmentation of services, unrealistic goals and pressure placed on staff (Seager, 2011a, 2013, Moriarty and Manthorpe, 2014). Funding for supported housing has also been affected by the current economic climate (Homeless Link, 2013; Hastings *et al.* 2015). These factors are at odds with the task of modifying insecure attachment relationships, which requires active

long-term emotional support (Saunders *et al.* 2011) provided by staff who feel secure and well supported themselves. Services need sufficient time, resources and structures to be able to provide this. This includes appropriately paced and 'stepped' move-on so that the continuity of attachment relationships are maintained rather than suddenly ruptured and keyworkers remain a secure base for residents to return to whilst their independence develops.

Despite the evidence of the quality of hostels being vastly improved in recent years, this research does not provide any 'hard' evidence of superiority of PIEs over non-PIEs. Further research using a quantitative methodology would be necessary to investigate this. In particular, a longitudinal study of attachment styles could evaluate whether clients make substantial gains in their ability to relate to others.

Conclusions

Hostels in the 21st century have come a long way from large-scale institutions meeting only the most basic of needs. Evidence from this study suggests that whilst providing accommodation and support for homeless people will remain a challenging task for professionals, PIEs can provide a context of a valued environment which supports the core processes of managing attachment relationships between staff and residents. Staff who engage in reflective practice can benefit from a space for processing the emotions created by this work. In this respect, PIEs appear to be meeting their aims by conceptualising homelessness more broadly than a physical state and attending to the needs of their residents, including psychological needs, in a more holistic manner than has been the case historically. However, transforming theory into practice is not always possible, particularly in relation to availability of resources and length of stay, often determined by trends in social care in the current economic and political environment. PIEs must be sufficiently resourced to ensure that gains to both resident and staff wellbeing are maintained and they have the best possible chance to meet the psychological and emotional needs of their residents in the future.

References

- Adshead, G. (2001). "Attachment in mental health institutions: a commentary". *Attachment and Human Development*, Vol. 3 No. 3, pp. 324–329.
- Arslan, S. (2013). "The experiences of professionals working with homeless people in a clinical setting: a qualitative study". *Housing, Care and Support*, Vol.16 No.3/4, pp. 145–153.
- Asay, T. I., & Lambert, M. J. (1999). "The empirical case for the common factor". In Duncan B., Miller, S. and Hubble, M. (Eds.), *The heart and soul of change: What works in therapy*. American Psychological Association, Washington DC, pp. 23–55.
- Barker, C., & Pistrang, N. (2002). "Psychotherapy and social support: integrating research on psychological helping". *Clinical Psychology Review*, Vol. 22 No.3, pp. 363–81.

- Biggerstaff, D. (2012). "Qualitative research methods in psychology". In Rossi, G. (Ed.), *Psychology - Selected Papers*, InTech, Rijeka, pp. 175-206.
- Blackburn, P. J. (2012). "Developing a psychological approach: the Wellbeing Service for homeless and vulnerably housed people in Bristol". *Housing, Care and Support*, Vol.15 No.2, pp 66–70.
- Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard Edges: Mapping severe and multiple disadvantage*. Lankelly Chase, London.
- Braun, V., & Clarke, V. (2006). "Using thematic analysis in psychology". *Qualitative Research in Psychology*, Vol.3 No. 2, pp. 77–101.
- Brennan, D., Cass, B., Himmelweit, S., & Szebehely, M. (2012). "The marketisation of care: rationales and consequences in nordic and liberal care regimes". *Journal of European Social Policy*, Vol.22 No.4, pp. 377–391.
- Brown, G., Kainth, K., Matheson, C., Osborne, J., Trenkle, A., & Adlam, J. (2011). "An hospitable engagement? Open-door psychotherapy with the socially excluded". *Psychodynamic Practice*, Vol. 17 No.3, pp. 307–324.
- Bucci, S., Roberts, N. H., Danquah, A. N., & Berry, K. (2015). "Using attachment theory to inform the design and delivery of mental health services: a systematic review of the literature". *Psychology and Psychotherapy*, Vol.88, pp. 1–20.
- Busch-Geertsema, V., & Sahlin, I. (2007). "The role of hostels and temporary accommodation". *European Journal of Homelessness*, Vol 1, pp. 67–93.
- Campbell, J. (2006). "Homelessness and containment: a psychotherapy project with homeless people and workers in the homeless field". *Psychoanalytic Psychotherapy*, Vol. 20 No. 3, pp 157–174.
- Campling, P. (2004). "A psychoanalytical understanding of what goes wrong: the importance of projection". In Campling, P., Davies, S., and Farquharson, G.(Eds.), *From toxic institutions to therapeutic environments: Residential settings in mental health services*. Royal College of Psychiatrists, London, pp. 33–44.
- Chandler, T., & Cresdee, S. (2008). "The revolving door research project: 'Climbing Everest naked'". Health and Social Policy Research Centre, Brighton.
- Cockersell, P. (2012). "Homelessness, complex trauma and recovery". In Johnson, R. and Haigh, R. (Eds.), *Complex trauma and its effects*. Pavilion, Hove, pp. 169-180.
- Dallos, R., & Stedmon, J. (2009). "Reflective practice in psychotherapy and counselling". Open University, Maidenhead.
- Davis, S. (2004) *Designing for the Homeless: Architecture that works*. University of California Press, Berkeley.
- Davies, S. (2008). "Contracting out employment services to the third and private sectors: a critique". *Critical Social Policy*, Vol. 28 No.2, pp. 136–164.
- Department of Communities and Local Government (2006). "Places of Change: Tackling homelessness through the Hostels Capital Improvement Programme". DCLG, London.
- Edwards, A. (2012). "Developing a psychological approach: learning from a housing association pilot". *Housing, Care and Support*, Vol. 15 No. 2, pp. 63–65.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999)." Evolving guidelines for publication of qualitative research studies in psychology and related fields". *The British Journal of Clinical Psychology*, Vol 38 No. 3, pp. 215–29.
- Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008)." The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis." *PLoS Medicine*, Vol.5 No. 12, e225.
- Fazel, S., Geddes, J. R., & Kushel, M. (2014). "The health of homeless people in high-income countries: descriptive epidemiology, health consequences and clinical and policy recommendations". *The Lancet*, Vol. 38 No. 9953, pp. 1529–1540.
- Fitzpatrick, S., Bramley, G., & Johnsen, S. (2011). "Pathways into multiple exclusion in seven UK cities". *Urban Studies*, Vol 50 No.1, pp.148-168.

- Giorgi, A., & Giorgi, B. (2008). "Phenomenology". In Smith, J. (Ed.), *Qualitative psychology: A practical guide to research methods*. Sage, London, pp. 26-52.
- Haigh, R., Harrison, T., Johnson, R., Paget, S., & Williams, S. (2012). "Psychologically informed environments and the "Enabling Environments" initiative". *Housing, Care and Support*, Vol. 15 no. 1, pp. 34–42.
- Hall, T. (2006). "Out of work and house and home: contested youth in an english homeless hostel". *Ethnos*, Vol. 71 No. 2, pp. 143–163.
- Hastings, A., Bailey, N., Bramley, G., Gannon, M. & Watkins, D. (2015) The cost of the cuts: the impact on local government and poorer communities. Joseph Rowntree Foundation, York.
- Herman, J. (1997). *Trauma and Recovery* (2nd Edition). Basic Books, New York.
- Hoffman, L., & Coffey, B. (2008). "Dignity and indignation: how people experiencing homelessness view services and providers". *Social Science Journal*, Vol 45 No. 2, pp. 207–222.
- Holt, S., & Kirwan, G. (2012). "The "key" to successful transitions for young people leaving residential child care: the role of the keyworker". *Child Care in Practice*, Vol. 18 No. 4, pp. 371–392.
- Homeless Link (2010). *Staying in: Understanding evictions and abandonments from London's hostels*. Homeless Link, London.
- Homeless Link (2013). *Who is supporting people now?* Homeless Link, London.
- Johnsen, S., & Fitzpatrick, S. (2007). "The impact of enforcement on street users in England". Joseph Rowntree Foundation, York.
- Johnson, R., & Haigh, R. (2010). "Social psychiatry and social policy for the 21st century – new concepts for new needs: the "psychologically informed environment". *Mental Health and Social Inclusion*, Vol. 14 No. 4, pp. 30–35.
- Johnson, R., & Haigh, R. (2011a). "Social psychiatry and social policy for the 21st century- new concepts for new needs: the " Enabling Environments" initiative". *Mental Health and Social Inclusion*, Vol. 15 No. 1, pp. 17–23.
- Johnson, R., & Haigh, R. (2011b). "Social psychiatry and social policy for the twenty-first century- new concepts for new needs: relational health". *Mental Health and Social Inclusion*, Vol 15 No.2, pp. 57–65.
- Johnson, R., & Haigh, R. (2012). "Psychology in the environment". In Johnson, R and Haigh, R (Eds.), *Complex Trauma and Its Effects*. Pavilion, Hove, pp. 231–240.
- Keats, H., Maguire, N., Johnson, R., & Cockersell, P. (2012). *Psychologically informed services for homeless people: Good practice guide*. DCLG, London.
- Kennard, D. (2004). "The therapeutic community as an adaptable treatment modality across different settings". *The Psychiatric Quarterly*, Vol.75 No. 3, pp. 295–307.
- Kolb, D. (1984). *Experiential Learning: Experience as the Source of Learning and Development*". Prentice Hall, Englewood Cliffs, NJ.
- Maguire, N. (2006). "Cognitive behavioural therapy and homelessness: a case series pilot study". *Behavioural and Cognitive Psychotherapy*, Vol. 34 No. 1, pp. 107.
- Maguire, N., Johnson, R., & Vostanis, P. (2010). *Meeting the psychological and emotional needs of homeless people*. DCLG, London.
- Maguire, N. (2012). "Training for front-line homeless workers: practicalities and ethics of teaching cognitive behavioural and dialectical behavioural psychological therapeutic techniques". *Housing, Care and Support*, Vol. 15 No. 4, pp. 177–185.
- Mazuch, R., & Stephen, R. (2008). "Creating healing environments: humanistic architecture and therapeutic design". *Journal of Public Mental Health*, Vol. 4 No. 4, pp. 48–52.
- McGrath, L., & Pistrang, N. (2007). "Policeman or Friend? Dilemmas in working with homeless young people in the United Kingdom". *Journal of Social Issues*, Vol.63 No.3, pp. 589–606.
- Moos, R. (1997). *Evaluating treatment environments: The quality of psychiatric and substance misuse programmes*. Transaction Publishers, New Brunswick.
- Moriarty, J & Manthorpe, J. "Fragmentation and competition: voluntary organisations' experiences of support for family carers". *Voluntary Sector Review*, Vol. 5 No.2, pp.249-257.

- Pauly, B., Wallace, B., & Perkin, K. (2014). "Approaches to evaluation of homelessness interventions". *Housing, Care and Support*, Vol. 17 No. 4, pp. 177–187.
- Phipps, C. (2016). "Living here has changed me: Resident and staff perceptions of Psychologically Informed Environments for homeless people" (Unpublished doctoral thesis).
- Saunders, R., Jacobvitz, D., Zaccagnino, M., Beverung, L. M., & Hazen, N. (2011). "Pathways to earned-security: the role of alternative support figures". *Attachment & Human Development*, Vol. 13 No. 4, pp. 403–20.
- Scanlon, C. & Adlam, J. (2006). "Housing "unhoused minds": inter-personality disorder in the organisation?" *Housing, Care and Support*, Vol. 9 No. 3, pp. 9–14.
- Schon, D. (1983). *The Reflective Practitioner*. Basic Books, New York.
- Seager, M. (2006). "The concept of "psychological safety": a psychoanalytically informed contribution towards "safe, sound & supportive" mental health services". *Psychoanalytic Psychotherapy*, Vol 20 No. 4, pp. 266–280.
- Seager, M. (2011a). "Homelessness is more than houselessness: a psychologically-minded approach to inclusion and rough sleeping". *Mental Health and Social Inclusion*, Vol. 15 No. 4, pp. 183–189.
- Seager, M. (2011b). "Ten universal and defining features of PIES". Unpublished.
- Seager, M. (2013). "Using attachment theory to inform psychologically-minded care services, systems and environments". In A. Danquah, N. and Berry, K. (Eds.), *Attachment Theory in Adult Mental Health*. Routledge, New York, pp. 213-224.
- Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. Guilford, New York.
- Stamm, B.H. (2010). The Concise ProQOL Manual, 2nd Ed. Available at http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf, accessed 28th September 2016.
- Stevenson, C. (2014). "A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation". *Journal of Substance Use*, Vol 19 No. 1-2, pp. 134–140.
- Stiles, W. (1999). "Evaluating qualitative research". *Evidence Based Mental Health*, Vol. 2, pp. 99–102.
- Teixeira, L. (2010). *Still left out? The rough sleepers "205" initiative one year on*. Crisis, London.
- Van der Kolk, B. (2014). *The body keeps the core: Mind, brain and body in the transformation of trauma*. Penguin, St Ives.
- Warnes, T., Crane, M., & Foley, P. (2005). *London's Hostels for Homeless People in the 21st Century*. Pan-London Providers Group, London.
- Williamson, E., & Taylor, K. (2015). "Minding the margins: an innovation to integrate psychology in a homeless hostel environment". *Clinical Psychology Forum*, December 2015 (Special Issue), pp. 3–8.
- Wilson, W & Barton, C (2016). *Rough Sleeping (England)*. Briefing Paper Number 02007. House of Commons Library, London.

Table 1: Domains and Themes¹

Domains and Themes	Quotes
1. What makes a home?	
1.1 Memories of other hostels	<p>R9: "In the 70s, it was get them sober, get them washed, get them fed, get them de-loused and kick them out again. That was basically it."</p> <p>S10: "In a normal project without PIE you're firefighting...that's what happened in [hostel name]...someone actually called it 'Helmand Province' it was that bad..."</p>
1.2 Constructing a home	<p>R1: "It's friendly...it's homely, you know...first thing it wasn't very homely because it used to look like a hospital before. The paint colours...it used to be pink and green, now they changed the decoration and they put in new furniture, new book shelves, new books in there so it's more homely now, it's like home you know."</p> <p>S9: "This is not an institution, it's just it's a nice place [which] feel[s] homely with all these pictures [of] taking clients on holidays, buying a TV..."</p>
1.3 Creating a valued space	<p>P1: "The reason that nothing had happened previously was because the view was that if you make it nice, they'll just ruin it... [whereas now]... if people aren't involved, what value do they hold for the thing?"</p> <p>P4: "There was a building...that got some kind of architectural award for homelessness that's got transparent walls...and...you think, well that might be an architecturally inspired thing but what's that like for a homeless person to look at a transparent wall?"</p>
1.4 Feeling safe	<p>Interviewer: "Is there anything else that helped you feel safe there?"</p> <p>R6: The staff. To be honest with you, I've had a few iffy staff in my time...but there has been a couple that I've taken to and believe it or not, one I did take to, it was a bit hard but I took to him..."</p> <p>S8: "It's important for our clients that they actually feel safe and they feel someone cares for them and they belong somewhere."</p>
2. Impact of client needs	
2.1 Awareness of trauma history and mental health needs	<p>R2: "People that have ...complicated problems are usually complicated people... This is what I found in the hospital ...the people that you were with made up for it because they were also going through the same thing."</p> <p>P3: "Trauma doesn't even begin to describe what some of these clients have gone through".</p>
2.2 Emotional reactions to resident backgrounds	<p>S9: "It used to affect me, because when I first read a [referral form] and it was a lot of abuse...I can almost live it do you know what I mean? It did affect me in a way where for the first month, I couldn't see the person because I felt so bad...every time I saw the client I had tears in my eyes."</p> <p>S6: "The best thing [is] when they say thank you, when they're smiling and enjoying themselves. Because they've spent most of their life being afraid or taken advantage of or being abused in some form or another."</p>
2.3 Flexibility and engagement	<p>R9: "The staff were good about it. I was drinking for three years. I continued drinking and I was in no state to start my recovery, so they gave me time."</p>

¹ R denotes a resident, S a staff member and P a psychotherapist with their identification number

	<p><i>S10: "Rules work for those who will comply...and most of the client group we have don't really comply with rules...the one thing service users are not afraid of is being put back on the streets... they've been there, they've survived, so you threaten them with an eviction and they'll take the piece of paper from you, so how effective is it anyway?"</i></p> <p><i>P1: "We have been known to be delivering sessions sitting at the bedside of somebody... who is bedridden. We have a great picture of one therapist who is sitting there with a Staffordshire bull terrier on their knee and the client's sitting in bed with an ash tray that looks like something from the Royle Family...so I think there's something about that...engagement work and that therapy is much more blurred in a sense."</i></p>
<p>3. Managing Relationships</p>	
<p>3.1 Building trusting relationships</p>	<p><i>R9: "They're doing the best for you. There's no ulterior motive. Once you get over that, you can start progressing"</i></p> <p><i>S8: "I...try and get to know them and build relationships with them and try and understand where they are coming from."</i></p>
<p>3.2 Being on the same level</p>	<p><i>R6:"Why I like certain staff is because they talk to me the way a normal person would talk to me, not down at me or not like a child."</i></p> <p><i>S10: "It's not a 'them and us', it is kind of an 'us and us.'"</i></p>
<p>3.3 Client perspectives of relationships: make or break</p>	<p><i>R5: "If you have a problem, I had [keyworker] yesterday, and I had a nice conversation with her...someone who gives you advice and tells you "don't do that"...someone cares for you...that's how it is in here."</i></p> <p><i>R6: "Talk to me like a person...there's a couple of women who [don't do that] and you get up and they say, ok I'll sort it out but I would never, ever talk to her again."</i></p>
<p>4. Reflective Practice</p>	
<p>4.1 Working with distress: the need for reflective practice</p>	<p><i>S10: "What we quickly discovered was if we don't have an environment to reflect on what we do, you have a burnt-out staff team...I remember one of them describing a couple of clients to me - he said they were a whirlwind blowing everything in their sight."</i></p> <p><i>P5: "Anyone who is working with human distress and pain - it has a toll, it has an effect on you. And people act as if it doesn't - as if 'this is what we've got to do, it's ok.'... so for me I would want everybody who is working in social care, irrespective of what level, to have some form of reflective practice so they can at least talk about the effect of what's happening on them as a team."</i></p>
<p>4.2 A "thinking space": gaining greater awareness</p>	<p><i>S8: "Sometimes it may be just a better appreciation that actually someone is doing this because this is happening, and maybe they're upset about that.... just that you have a better appreciation of why that person is behaving as they are."</i></p> <p><i>P3: "When I started working in this team I was surprised by how little thought was given to the ... resident's background history, and it almost felt foreign as if, 'Why are you asking us?' ...that has changed over time... so now I ask, 'So what do we know of this person?'. They [the staff] don't say 'Oh well I don't know', they don't concentrate just on the practical side of where this person might be at but they do think about the bigger picture, a more realistic picture of this person's needs and where they come from and what the original trauma might have been, how this might ... take shape in their current relationships."</i></p>

<p>4.3 Doing things differently</p>	<p>S5: "We stopped talking to her about her alcoholism and stopped kind of telling her the things that she had done badly and worked on being positive about certain things that she did....she started to be more aware of what she was doing and kind of how things like her bedroom being a mess - she uses that as a way to reflect how she's thinking...and actually build[ing] her self-confidence...it's kind of she's seeing more about herself and understanding more."</p> <p>S9: "I thought, I'm going to fix this client. It took a year and it wasn't going anywhere. I felt so frustrated to the point where I didn't know what to do. I talked about it and I was asked...."why?" ... "Why are you doing what you are doing?" I thought I was doing it for the client, but I think I was doing it for me...I didn't realise that....</p> <p>Interviewer: When you realised [that], what did you change and what happened?</p> <p>S9: To start with, I felt betterthe relationship got back to normal with the client basically. I did give the client a lot more space and a lot more time to come up with what they wanted, rather than what I wanted them to do. ...so they took charge in a way rather than me being in charge"</p>
<p>4.4 The staff role: thinking or doing?</p>	<p>S4: "There's been a view that what is this space going to change? The arena that we are sitting in speaking, how is that going to change the service? How is that going to change the clients?"</p> <p>P1: "...It goes against the third sector tradition [and] culture in which you do rather than think. You don't procrastinate, you get in and do and further than that, you do more than you're paid to do and that's valued, you go the extra mile."</p>
<p>5. Theory vs practice</p>	
<p>5.1 What's in a name?</p>	<p>S8: "PIEs is like a loose...term to try and capture what has possibly been going on for years...."</p> <p>P4: "What's wrong with therapeutic milieu or therapeutic community? Why do we need psychologically informed environments, why do we need these new words...?"</p>
<p>5.2 Resources and expectations</p>	<p>S10: "Funders and commissioners seem to think it's like a factory where you come in as a rough sleeper, go through the process, you engage with the service and at the end of it you come out ready for independent accommodation. Now it doesn't quite work like that."</p> <p>S9: "You think, "Oh god, I have to do this and that" but your client is not ready and you're pushing the client and...that breaks the relationship. Your client is seeing you as a worker, not a human being."</p>
<p>5.3 Safety or moving on?</p>	<p>R5: "Once you live in a place for five years you get used to everything... it feels like a home to you and you know the staff, you know everyone... moving out from there...[it's] quite difficult."</p> <p>P4: I think what's happening...is a muddling up of dependency and attachment issues - for someone to become dependent on a place is a 'thoroughly bad thing' so we keep them moving, moving, moving, moving, whereas the way of understanding attachment is for someone to become attached to something in order that they can build a secure base... I think the moving on problem is rooted in anxiety about dependency."</p>

<p>5.4 Recovery and "taking responsibility"</p>	<p><i>R1: "I'm not really very happy but you know, I've got no choice, I've been here a long time.....I've over- stayed my welcome..."</i></p> <p><i>S5: "We all have to move forward in life, to progress, you know.....because a lot of them do not want to leave here, they want to stay but we have to say to them, this is not a hotel, it's a project and you have to progress and move forward."</i></p> <p><i>P5: "It's not about recovery, it's more like discovery...they're not recovering from anything because they've never been anywhere in the first place...recovery is obviously important. You want someone to recover. But really I think there's a mistake...it's as if you could somehow magically be ok. I don't think you can be. And the issue...is not about curing as if one were to recover - it would be about helping people to deal with the problems that they have."</i></p>
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