Psychologically informed services for homeless people

Good Practice Guide

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Introduction

The purpose of this paper is to help providers and commissioners develop or remodel services in order to address identified emotional and psychological issues amongst rough sleepers and young homeless people.

These services include
- hostels
- foyers
- supported accommodation
- rolling shelters
- night centres
- severe weather emergency provision
- winter shelters
- floating support services
- day centres
- assessment centres/Hubs
- street outreach.

There is growing evidence of the extent and range of psychological and mental health problems amongst homeless people and rough sleepers. Up to 60% of adults living in hostels in England will have diagnosable personality disorder compared with about 10% in the general population and all other mental health disorders are significantly over-represented. (Maguire et al, in prep; Cockersell, 2011; Rees, 2009). Also over-represented are histories of neglect, abuse and traumatic life events dating back to childhood and continuing through adult life (http://www.jrf.org.uk/publications/tackling-homelessness-and-exclusion). The behaviour observed in people with personality disorder can often be seen as a way of coping with the traumatic experience of difficult childhoods and the cumulative effect of adverse life events. It is better described as 'complex trauma', in other words, as a reaction to an ongoing and sustained traumatic experience.

People with a history of complex trauma, including the chronically homeless, , may behave in a range of ways that suggest underlying difficulties with trusting relationships, and with managing their own emotions in the face of perceived adversity.

Introduction

Many of the people that homelessness and rough sleeper services work with may for example:

- seem to have difficulty managing their emotions
- self-harm or have an uncontrolled drug and/or alcohol problem
- appear impulsive and not consider the consequences of their actions
- appear withdrawn or socially isolated and reluctant to engage with help which is offered
- exhibit anti-social or aggressive behaviour
- lack any structure or regular daily routine
- not have been in work or education for significant periods of time
- have come to the attention of the criminal justice system due to offending.

There are particular issues to consider around 16-17 year-olds who may have had traumatic and abusive childhoods. On top of the challenges of adolescence which all young people go through, they may also exhibit emotional and behavioural problems often associated with antisocial behaviour, which can lead to homelessness.

Psychologically informed environments are intended to help staff and services understand where these behaviours are coming from, and so to be able to work more creatively and constructively with people with so-called challenging behaviours. Evidence shows that people affected by trauma, even lifelong experiences of compound or complex trauma, can and do recover. They have already demonstrated great resilience and strength in surviving on the streets and seeking help from homelessness services (many clients have sought help from a whole range of services to no avail before they even become homeless). Psychologically informed environments are intended to use the latest insights and evidence from the psychological disciplines to give rough sleepers and homeless people the best chance of sustainably escaping the cycle of poor wellbeing and chronic homelessness.

One key outcome of a psychologically informed environment is to reduce rates of eviction and abandonment in order to reduce the number of vulnerable people sleeping rough. Research by Homeless Link showed that 47% of former rough sleepers who were evicted from or abandoned hostel places in London were subsequently found rough sleeping again www.homeless.org.uk/evictions-project

References
Cockersell, P. (2011) Journal of Public Mental Health, July 2011, 10:2
Maguire N (in submission)
Rees, S (2009). "Mental Health in the Adult Single Homeless Population" PHRU/Crisis, at: http://www.crisis.org.uk/publications-search.php?fullitem=235

Psychologically Informed Environments

The concept of a PIE was originally developed by Robin Johnson and Rex Haigh (http://www.rjaconsultancy.org.uk/PIEconcept.html), as part of the Royal College of Psychiatrists' Enabling Environments initiative. http://www.rcpsych.ac.uk/quality/qualityandaccreditation/enablingenvironments.aspx. It closely is linked to the current development of 'PIPEs' (Psychologically Informed Planned Environments) for more high secure services in the criminal justice system.

In their original paper, Johnson and Haigh suggested that "for the moment, at least, the definitive marker of a PIE is simply that, if asked why the unit is run in such and such a way, the staff would give an answer couched in terms of the emotional and psychological needs of the service users, rather than giving some more logistical or practical rationale, such as convenience, costs, or Health And Safety regulations" In that sense, "psychology" is an aspect of emotional intelligence and empathy, and should not be seen as the preserve of any one discipline or school of thought.

The purpose of a psychologically informed environment is to enable clients to make changes in their lives. This can be expressed in different ways but will usually be changes in behaviours and / or emotions for example an ability to establish and maintain relationships, reduce drug or alcohol use, feel less depressed or fearful. It is important that these changes are measurable so

that services can review their efforts, demonstrate to clients themselves that change is being made, and learn and adjust their response (see also reflective practice, below). It will also be important that services can demonstrate to commissioners what difference the therapeutic service made, through for example reductions in chaotic behaviour, evictions or hospital admissions or increased engagement with staff.

People who are homeless or insecurely housed are among those most in need of psychologically informed help, but are also among those least able to access mainstream psychological therapy services. Psychologically aware housing services cannot be a replacement for clinical services. Health commissioners must be involved in the development of PIEs to ensure that services have the support they need. It is also important to ensure that there are referral routes into appropriately designed and accessible clinical services, including those for people with dual diagnosis.

Services for rough sleepers and young homeless people currently use a range of techniques and approaches to manage clients whose behaviour puts them at risk of eviction or abandonment.

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Those services that have developed a psychologically aware approach will recognise that clients with challenging behaviour have particular support needs, often arising from earlier trauma and abuse. As part of this approach, they will be working within a broadly therapeutic framework, enabling them to develop clear and suitably consistent responses to clients who may be chaotic and distressed and who have learned not to trust.

The term "therapeutic framework" describes the thinking underpinning an approach to psychological needs. There are a number of frameworks to choose from, including humanistic, psychodynamic, CBT and DBT (see complex trauma guidance for more information) There is no single right approach to addressing someone's emotional and psychological needs and organisations may decide to use more than one framework.

An explicitly psychological framework can legitimise and informs the different approaches staff can use and gives them additional insight into how people may behave. Training all staff within an agreed framework or combination of frameworks will help them work more effectively with clients with complex trauma. This approach will help clients who often behave chaotically to gain an understanding of their behaviour, take

responsibility for themselves and develop negotiated, positive relationships. This in turn will help them move away from a street lifestyle and rough sleeping.

Psychologically aware services will aim to risk manage clients as well as risk assessing them, so that vulnerable and chaotic people with for example, multi drug use and mental and physical health needs are not excluded from services. That means they will work with the challenging behaviour of clients rather than restricting access until behaviour changes. They may, for example, operate what is sometimes called "elastic tolerance" so that behaviour that might normally result in eviction and a return to rough sleeping can be tackled creatively and with flexibility, addressing the behaviour without rejecting the individual.

A key element of a psychologically informed environment is reflective practice (www.infed.org/thinkers/et-schon.htm). This term describes the process of recapturing and analysing actions and processes in order to learn from incidents and improve the responsiveness of the service. It enables clients to feel that their problems are recognised and that they are being heard. It gives staff a perspective on the emotional challenges of their work and also helps to develop learning cycles and skills development. It encourages a

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climate that enables clients to feel that their problems are recognised and that they are being heard. Where staff work in teams – as they typically do – reflective practice should be a shared approach, aiming to learn from and support each other in learning. Shared, group learning, especially in reflective mode, is particularly suited to effect changes in a group culture.

Staff coaching, training and recruitment should explicitly acknowledge the need for a psychologically informed approach and dispel myths and fears some may have around psychological approaches. Staff will not be acting as therapists, but may be adapting, developing and refining formally therapeutic approaches in their work with sometimes challenging clients. Effective staff supervision, both individual and group, is an essential component of a psychologically informed environment.

There are five key areas to consider when developing PIEs

- Developing a psychological framework
- The physical environment and social spaces
- Staff training and support
- Managing relationships
- Evaluation of outcomes

For more information on psychologically informed environments or PIEs see www.nmhdu.org.uk/complextrauma

Homeless Link has produced a useful tool on mental health and wellbeing which can be found at http://homeless.org.uk/mental-health-guide

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References
Johnson, R & Haigh, R (2010) "Social Psychiatry and Social Policy for the 21st Century – new concepts for new needs: the psychologically informed environment" in J. Mental Health & Social Inclusion, 14:4

Five key areas

Developing a psychological framework

To be effective, there needs to be corporate commitment to the introduction of a psychological informed approach, which ideally should then become part of an organisation's service commissioning or business plan. Developing into a psychologically aware service means transforming the way a service operates, rather than being just an add-on to an existing way of working. The positive effects will be seen in both staff and clients and can be effective in both street based and accommodation based services.

As a result, it is essential that any formal psychological framework used within the service - any particular school of thought on human development and personal change- is made explicit to all staff. They should be clear about what changes each approach is designed to enable in the individual, how they themselves will need to work and what support the organisation can offer during this process. They should be free to question how suitable, coherent or consistently applied any particular framework may be.

There are a number of frameworks or paradigms which describe the prevailing view or patterns of thought between the different approaches to psychological therapies. For example, the behavioural, humanistic and psychodynamic paradigms provide three different sets of assumptions, concepts, values and practices that make up the different disciplines they inform.

The Psychodynamic Paradigm

All psychodynamic therapy is based on the idea that how and who we are is shaped by dynamic processes. 'Dynamic processes' here means that we can and do change, and that we change through our relationships with the people and circumstances around us. Relationships affect everybody involved, and changes in one part of any system will affect the other parts. In the case of human beings, there are four key dynamics of relationships – between one person and another/others (interpersonal), between a person's own physiological, emotional, and rational/cognitive selves (intrapersonal), between a person and their environment, and between a person's past, their present and, potentially, their future.

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One of the most important relationships is that between the baby/child and his/her mother/primary care giver. The experience we have as a baby/child affects how we see and respond to all other relationships. Not only does it affect how we think, feel and behave, there is solid evidence that experience shapes the very physiology of the brain (Schore, 1994). These early experiences continue to colour how we experience other relationships and ourselves. Positive, thoughtful relationships help foment changes in brain physiology that underpin sustainable change: we can, and do, literally change our minds.

Evidence from neurobiology shows that these processes continue to be dynamic – that is, open and responsive to change – throughout our lives (Siegel 2011). This is essentially a hopeful approach, based both on the idea that what we think, feel and do makes sense (or, often, once made sense in a particular context), and also that we can and do change how we think, feel and behave. However, we may need help to change deeply unconscious patterns of thinking and behaviour. In psychotherapy, change is effected primarily through talking and feeling in a safe and holding (or "containing") environment, and through the relationship between therapist and client. Psychodynamic psychotherapy uses what the client

brings and the relationship between therapist and client to make links between, and understand, the client's past and present, internal and external, experience. Thinking about and understanding this experience within a safe relationship/set of relationships enables the client to work through it, and to manage and (re)mediate its effects on their lives.

Psychodynamic psychotherapy has a very strong evidence base as effective with people with characteristics of any personality disorder, diagnosed or otherwise, has a greater effect size with personality disorders than other therapies, and has a longer term impact; psychodynamic psychotherapy has been shown to continue working long after formal therapy ends as it enables people to develop themselves (Shedler, 2010). It therefore supports sustainable recovery.

Psychodynamic thinking is not confined solely to one-to-one therapeutic work between therapist and client. The same perspective and values can also be employed in e.g. group work, peer-to-peer support, etc, and can inform service models and organisational culture. When the impact of psychodynamic processes in a particular service context or relationship is consciously understood and explicit, we can talk of a "psychologically informed environment". Even when

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such awareness is simply implicit, it is nevertheless strongly influential. This is because psychodynamic processes happen regardless of whether the participants in any social situation are overtly conscious of them or not: they are the natural processes of human relationships and human 'being'.

When working with homeless people, achieving an initial engagement is crucial, and building and sustaining a relationship of trust is central to successful work. Psychodynamic approaches, which prioritise the quality of relationships, have a lot to offer here. However, one of the main reasons why the psychodynamic approach is popular with the clients themselves (apart from effectiveness) is that it does not shy away from the actual experience clients have lived, or the emotional impact of that experience, and respects the reasons why individuals made and make the life choices they do. In line with the recovery approach, it recognises the often awful impact of the past and the effects others and the environment have had and continue to have on people and the validity of coping strategies developed to deal with these stresses, while at the same time working with them to picture a better future in their own terms.

Cognitive and Behavioural Approaches

There are a number of interventions based on the expression of the relationship between thoughts, feelings and behaviours (between 40 and 50 at the last count). Five of the major forms of this group of psychological therapies are Cognitive Behaviour Therapy (CBT), Schema Focussed Cognitive Therapy (SFCT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT) and Mindfulness Based Cognitive Therapy (MBCT). To a greater or lesser extent, all of these therapies are based on theories which have received empirical attention to demonstrate their validity. These therapies fall into two basic groups, sometimes referred to as 'second' and 'third wave' cognitive therapies. CBT and SFCT are examples of the former, the other three examples of the latter.

CBT: The original form of CBT as described by Aaron Beck and colleagues (Beck et al, 1979) considered the content of thoughts important, together with how they led to particular emotions and behaviours, and described typical 'thinking errors' which lead to distressing experience. According to the theory these ways of thinking are due to fundamental (core) beliefs which are formed in interaction with childhood

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experience. These core beliefs colour the way the individual interprets their world and drive emotions and behavioural attempts to cope with it. Typical therapeutic interventions involve identifying these ways of thinking in terms of content and testing them, using techniques such as behavioural experiments, or setting up new activities in a graded way, so as to set individuals up for success. CBT is delivered in individual and group formats. CBT is highlighted by the National Institute of Clinical and Health Excellence (NICE) as treatment of choice for the treatment of anxiety, depression, first episode psychosis and antisocial personality disorder (in group form, with people in prison). CBT can be particularly useful with people who struggle to think about abstract concepts, as it is designed to be easily communicated and is therefore based around simple, concrete models and techniques. Hostel staff have also reported finding the models useful in thinking about their own reactions to client behaviours, and making choices about how they behave in response.

SFCT: Jeff Young developed SFCT in response to the need to treat deep seated interpersonal difficulties and deal explicitly with fundamental 'schema', i.e. clusters of beliefs about the self which drive maladaptive behaviours. Eighteen specific 'schema' were empirically identified, together with modes of operating and three broad ways of attempting to cope

the distress associated with them; schema avoidance, overcompensation and surrender.

DBT: Developed by Marsha Linehan, DBT focuses on reducing maladaptive behaviours (particularly self-harming behaviours) and increasing functioning for people suffering complex trauma issues (perhaps diagnosed as borderline personality disorder). The premise of the therapy is that clients are doing the best that they can in life, but have not acquired certain skills, e.g. manage emotions; establish and maintain relationships (perhaps due to attachment disruption and / or inconsistent, punishing or neglectful parenting); or consider the consequences of behaviours (leading to impulsivity). Emotion dysregulation is a key issue, and interventions are often based around teaching skills to manage anger and anxiety. Recent evidence has indicated that emotion dysregulation is an important factor in the relationship between childhood abuse and antisocial behaviours, and that it may be useful to consider not only under-control of emotions, but also over-control. The former may lead to outbursts of negative emotions, the latter suppression of all emotional experience, both of which may be problematic for the individual and lead to ways of coping which have negative consequences.

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The therapeutic relationship is an intrinsic aspect of DBT treatment, not only as a model of a healthy relationship, but also to reinforce behaviours which are less harmful to the individual. DBT also makes use of 'mindfulness' techniques to enable clients to notice the negative judgements that they make about themselves and others. This form of cognitive intervention, based around the process of thinking rather than the content, is one of the factors distinguishing 'third wave' forms of cognitive therapy.

Of particular use in homelessness is the concept that many problem behaviours are associated with difficult emotions and ways of coping with them, and that skills can be taught to enable clients to deal more effectively with distress, thereby reducing behaviours which result in negative consequences (e.g. arrest, eviction). This can result in hope that things may be different. DBT is delivered in individual and group formats, often in tandem. DBT is recommended by NICE as treatment of choice for self-harming behaviours in the context of borderline personality disorder.

ACT: Steve Hayes developed therapeutic processes around acceptance of difficult life events, based on a robust, empirically defined theory associating language (internal dialogue) with distress. Some of the processes

of change are similar to those used in CBT, particularly those designed to enable 'cognitive flexibility', i.e. the ability to reflect on internal dialogue and moderate the experiences associated with it. Of particular use is 'values' work, which enables individuals to articulate what they value about themselves and the behaviours that they may engage in which are in the service of those values. This is particularly useful in engaging people in change.

MBCT: John Teasdale and colleagues developed MBCT to treat recurrent and severe depression. The practice of mindfulness (purposefully paying attention to experience, including thoughts) has been found to be particularly useful in reducing the intensity of depression experienced, and the lengths and frequency of depressive episodes.

Cognitive and behavioural therapies and Psychologically Informed Environments (PIE)

There are a number of concepts and practices which may be of particular use in PIEs. Easily accessible cognitive models have been shown to be useful in enabling staff to be able to reflect on internal experiences. By teaching staff groups to notice and articulate beliefs about situations, others' motives and their own behavioural urges, it may be possible to

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increase the amount of considered interventions and reduce the number of 'knee-jerk' reactions to clients' more challenging behaviour. Staff may also start to 'catch' thoughts about their own lack of efficacy with clients, which may lead to hopelessness, burn-out and absence or resignation. Generally, being able to catch or notice thoughts enables choices to be made. If a particular thought about another tends to lead to a particular way of dealing with them, noticing that this is just a thought enables the individual to make a more informed choice about what they do. This is particularly important when those thoughts are negative evaluations of another. So the cognitive models are a simple way of enabling reflection on internal experience.

Staff can also be equipped with skills to enable clients to develop cognitive skills which may then underpin those challenging behaviours and distressing experience. Clinical experience indicates that some clients will work better with more concrete 'thought challenging' interventions based on content, whereas others may make more use of more abstract mindfulness techniques to notice thought processes. Either way, cognitive flexibility is facilitated.

All new activities set up for clients may make use of 'graded hierarchies' (i.e. breaking all tasks down into manageable chunks) in order to ensure success and not feed into existing beliefs about failure. Beliefs about what is going to happen may be articulated, and all associated activities set up as 'experiments' to test those beliefs.

The concept of 'skills' can be a useful one. Most will be familiar with developing practical, tenancy sustainment skills, and it is only a short step to consider 'emotion regulation' and 'interpersonal' skills as things that can be learned.

Motivation to change is an important issue. Staff may be taught to articulate their own expectations for change. The 'Cycle of Change' published by Prochaska and DiClemente in 1982 is a very useful tool to describe what is realistic in terms of change at any stage. So for those who are in the 'precontemplative' stage, i.e. don't see the need to engage in whatever change is deemed useful, the changes that staff should expect are only cognitive ones, i.e. change in the client's beliefs about the need to change. Behavioural change should not be expected. Behavioural change will only

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be possible when the person is in the 'contemplative' stage, so interventions should be designed accordingly. A common mistake that we all make is to try to engage a client in behavioural change when they do not see the need to make it, or the costs of engaging in the change outweigh any perceived benefits. The result of this may be beliefs about failure for staff and client alike. Articulating beliefs about change, and values work are complimentary to Motivational Interviewing techniques in engaging clients in the process of change.

The behavioural paradigm

The behavioural paradigm is a useful framework for describing the way that people behave in terms of the reactions of their environment. However, the strength of a behavioural understanding (fairly simple explanations relying on a theoretically strong, observation-based approach) is also its weakness, in that it takes little or no account of thoughts or internal narrative.

This approach can however enable staff to identify and predict negative responses to their behaviours and develop appropriate responses which are psychologically informed and which will enable them to work more positively with clients with a range of issues.

This approach also has strengths in accounting for substance abuse and self-harm in terms of physiological factors such as cravings and urges. There are two main ways of expressing the way that people learn to behave: 1) classical and 2) operant conditioning.

Some clients in detox settings can display cravings when confronted with drug paraphernalia as this is associated with the drug itself. This type of conditioning is classical conditioning, in which two or more stimuli are repeatedly paired together (i.e. drugs works or the environment in which they use are repeatedly presented with the drug and the physical response), resulting in a physical response to the works or environment alone. This has in the past been treated using repeated exposure to the stimulus (paraphernalia and environment) in the absence of the drug. The cravings reduce as the physiological response to the stimuli reduces due to the repeated presentation.

Some clients learn that shouting at staff results in the staff leaving them alone, which means he doesn't have to actively deal with the presenting issue. This is described as operant conditioning through 'trial and error' in which certain behaviours are reinforced and

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therefore repeated. For example the staff member may withdraw and stops 'bothering' the client. In order to reduce the problematic behaviours, staff, as a whole group, have to develop a common behavioural response, usually being clear about why the behaviour is problematic for the individual in the long-term (despite solving a problem in the short-term) and teaching the individual to make their needs known in more useful ways. If the whole staff group does not respond in this way, splits can develop, where one subgroup of staff reinforces the behaviours by responding as the client intends and another tries to behave differently, by e.g. not responding. This can be confusing for client, and may actually make the problem worse through intermittent reinforcement, i.e. sometimes being reinforced and sometimes not. This intermittent reinforcement is a very powerful way of ensuring behaviours don't change.

Staff may be familiar with the following technical terms which describe of some of the ways that clients can behave:

Positive reinforcement: A client's behaviour is more likely to occur if it is suitably rewarded. This reward is described as a 'positive reinforcer'. If the reinforcer has a consequence which the individual finds desirable it may mean that the modified behaviour is repeated.

Negative reinforcement: Clients may self-harm, which temporarily removes unpleasant emotions, or use drugs, which remove symptoms of withdrawal. This is a 'negative reinforcer', where the behaviour removes negative feelings. Negative reinforcement is also often used to refer to strategies that (usually unintentionally) reinforce negative perceptions or behaviours. For example, if staff give the highest levels of attention to clients when they create a disturbance it creates a negative reinforcement for disturbing behaviours.

Punishment: Clients may repeatedly behave in a way that results in something unpleasant for example, pain, emotional dysregulation, stress or eviction. This consequence is described as a 'punisher', leading to consequences which are explicitly undesirable but which are familiar to the client. However the behaviour may not lessen despite the consequence being punishing, which is where a more cognitive understanding may be more useful.

Humanistic psychology

Humanistic psychology is sometimes described as 'the third force' in psychology, coming as it did after the establishment of psycho-analytic and behavioural approaches. Humanistic psychology is not a specific technique or school, but rather a perspective in psychology that focuses on and sets most store by the

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aspects of our existence that are uniquely human, such as potential, meaning, value, personal responsibility, choice, individuality and self-expression. More humanistic approaches in therapy or treatment tend to work to support and endorse these features and capacities in the lives of those coming for assistance.

Work to engage marginalised and excluded individuals, those with entrenched difficulties, and/or those who are especially wary of authority or care services, may often need to start with such issues, to achieve the engagement with support that may even need to precede the offer of shelter. This may, for example, mean that the therapist gives at least equal weight to the person's strength and goals – their assets. Humanistic psychology, like behaviourism, tends to keep at arm's length the medical model of psychiatry, and typically aims for a less-pathology-focused view of the person.

A key ingredient in this approach is the encounter between therapist and client and the possibilities for dialogue. Humanistic psychology practitioners tend, therefore, to allow their own personalities and concerns to become part of the engagement process, rather than attempting to remain neutral, as simply technique providers, as behaviourist approaches imply, or to become a blank screen on which clients may project their own concerns, as psycho-analytic theory typically proposes.

In some respects, therefore, humanistic approaches offer an alternative approach, but humanistic practitioners are typically holistic in approach, and aim to integrate a wide (or 'eclectic') range of insights and specific techniques, as appropriate to each individuals' needs and circumstances. It may be just as accurate and helpful to see humanistic approaches, not as a distinct third force, but rather as the fertile meeting ground between the other two. In fact, of course, all these different schools and approaches draw from each other hugely, and more skilled and confident practitioners may draw on techniques and insights that underlie them all. However, crucially, all schools recognise that learning and un-learning are both most effectively achieved in some kind of helpful relationship, and especially in a group.

References
The description of humanistic psychology here is an extract from "Psychology in the environment", in Johnson R and Haigh R (Eds) (2012) "Complex trauma and its effects: perspectives on creating an environment for recovery". Brighton: Pavilion, and used here by permission of the publishers

Five key areas

The physical environment and social spaces

Designing and managing the social environment is central to developing a psychologically informed service. Thoughtful design, preferably one with service user input, based on thinking through the intentions behind a service, can result in useful changes in the way a building is used, and how it is valued by staff and clients.

The Housing LIN published a useful paper on how to develop healthy hostels. The 5 outcomes to be achieved are similar to those needed within a psychologically aware service:

- Creating a healthy environment
- Reinforcing positive relationships
- Developing opportunities for meaningful occupation
- Offering specific health related services
- Access to healthcare

http://www.housinglin.org.uk/Topics/type/resource/?cid=2423

Developing a psychologically informed service doesn't have to involve large capital works-small and inexpensive changes can work equally well. Whether a building is redeveloped or redecorated, it can signal that there is a changed approach to the service, which is the key message for staff and clients.

Ideally the building should reflect the different levels of engagement required by individuals. Some will be comfortable with a structured approach while others, for example, chaotic drug users, may find a more informal approach less threatening. The flexible use of space, possibly incorporating drop-in facilities next to more formal services, could offer clients a safe and private environment, reinforcing appropriate social boundaries without creating no-go areas that could result in conflict.

Some services have found that improving kitchen and dining facilities has had a positive effect on the behaviour of clients and also improving their diets and health. For example, Look Ahead HA spent around £60k on new kitchens and decorating and furnishing common parts at Hopkinson House, a hostel for people

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with alcohol problems. Residents were able to eat hot food prepared for them, or cook for themselves, with help. The new dining area gave people the option to eat together or alone, and small communal areas on each floor offered quiet spaces where people could read or watch TV. These relatively minor changes have transformed the way residents interact with each other and with staff.

Other providers have replaced notices in reception areas about rules and sanctions with information about available services and how to access them. This has switched the emphasis away from what will happen if someone breaks the rules to one which offers support and encouragement to change, and has helped to develop congruence (Carl Rogers, 1951)or rapport with staff.

Brighter Futures takes this thinking one step further. They argue that people with complex needs are often systematically denied the right to feel proudly and powerfully themselves. They are stereotyped as members of a particular group, they lose their identity and are oppressed. This oppression is usually, but not exclusively, perpetrated by groups which are seen as being more powerful than their target. Therefore any interaction which creates or could be perceived to create a "them and us" or makes an assumption about

someone's behaviour based on a stereotype reinforces their oppression and prevents the establishment of good working relationships and rapport.

The safety of staff and clients is crucial, and providers should aim to achieve this through good design and lighting in common areas and without the need for intrusive surveillance.

The principles behind the Hostel Capital Programme, now the Homelessness Change Programme, fit very well within a psychologically informed environment. The programme emphasised the need for welcoming, well decorated and well lit buildings, providing a safe environment within which vulnerable and often isolated people could turn their lives around and move away from the streets. Key outcomes of the programme included a reduction in evictions, clients moving into independent or more appropriate supported accommodation and people getting onto training schemes or into employment. It is strongly recommended that the principles behind Places of Change and the Homelessness Change Programme are incorporated into any remodelling of services to make them psychologically aware.
http://www.homesandcommunities.co.uk/ourwork/homelessness-change

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Evidence-based design

'Evidence-based design' is a concept which may be useful when considering how to create a psychologically informed environment. This stresses the importance of the environment on the individual, and empirically evaluates environmental interventions on such outcomes as perceived wellbeing, negative emotions etc. The Centre for Health Design links to a range of resources which may aid the design of hostels (www.healthdesign.org/).

Codinhoto and colleagues (2008) define a set of four factors which found to influence health outcomes:

- Ergonomics, including dimensions, shape and layout of the environment
- Fabrics and ambient factors, including material, lighting, acoustics, temperature and humidity;
- Art and aesthetics, including colour, design and art;
- Services, including maintenance, cleanliness and decontamination (where necessary).

These factors have been found to impact on psychological, emotional and physiological factors which contribute to or impede health. There are a number of points to draw out from this approach.

1. Noise and acoustics can have a significant impact on mood, which makes the consideration of materials used in public areas important, those which dampen noise being favoured. Noise is also cited as a significant problem in sleep disturbance in large environments.

2. Light, whether natural or artificial appears to be an important factor which may be beneficial in a number of health areas, both generally and in specific situations (e.g. seasonal affective disorder being positively affected by broad spectrum light at 10,000 lux plus.). However, it is possible to get light levels wrong in both directions, either too little or too much.

3. Open, green areas can promote a lower arousal and the opportunity to socialise, although the evidence is mixed.

4. Art and aesthetics can be an important contribution to health, both in terms of the activity and the appreciation. However some evidence indicates that 'inappropriate' art can have detrimental effects on mental health. The form of art should therefore be carefully considered and piloted.

Five key areas: The physical environment and social spaces

5. Colours have been found to have effects on mental health. For example greys, purples and reds have been found to be associated with depression and tend not to be used in therapeutic environments. Reds and yellows have been found to promote more anxiety than blues and greens.

These are just a few of the factors which may affect mood and behaviour within hostel or other environments. Others, such as the use of ventilation systems, furniture, use of televisions and temperature levels could also be considered in the light of evidence. Given the large amount of work done in this area, it would seem useful for the concept of evidence-based design to be considered when physical environments are being commissioned or improved.

Five key areas

Staff training and support

Services for rough sleepers have traditionally been shaped by the need to provide a crisis response. While that remains an important role, particularly with severe weather shelters and night shelters, psychologically aware services require a different approach to key working and this will affect how organisations recruit, train and manage staff. Staff training and support is therefore central to the transition into psychologically aware services.

All services working with your clients should be included in discussions about the development of psychologically informed services. Supporting People teams, PCTs, GP practices, adult social care, drug and alcohol services, mental health teams, Probation and education and learning services are part of the process and should be included in discussions about the development of psychologically aware services. Changes to the ways in which key workers interact with clients will affect their work as well, and they may find it useful to develop a psychologically consistent approach, to maximise positive outcomes. Pathways and transitions between services also need to be thought through and carefully crafted.

A key element to psychologically informed services is the introduction of reflective practice. This term describes the process of continuous learning from professional experiences, which encourages problem solving and critical thinking skills. Key working clients with complex trauma can be challenging and exhausting, but adopting a reflective approach, especially after difficult incidents, can enable staff to learn from experiences and thereby improve the way they respond when something similar happens again. Reflective practice serves to enable the staff member to make their internal experiences (thoughts and emotions) explicit, thereby facilitating the possibility of reducing the intensity of difficult emotions and possibly altering behaviours. It also serves to enable a 'learning cycle', whereby the staff member practices newly acquired skills and has an opportunity to reflect on the experience. This is essential if psychological skills are to be effectively acquired.

Reflective practice can be developed within personal development planning through self or peer assessment or group work, and can significantly reduce staff burn out.

Five key areas: Staff training and support

For example, Thames Reach's casework management approach ensures that teams discuss cases regularly and establish what approaches are working well. Staff have regular supervision sessions which include talking through all cases. There are good practice workshops organised and action learning sets to encourage reflective practice so that teams learn what works well, and can aim to improve services further. There has also been clinical supervision for some teams - where an external professional will participate in the discussion of cases at the team meeting - for example the Graham House hostel.

St Mungo's has developed a four-module training package for the staff and management of its psychologically informed environments. The theme of the training is 'Managing Relationships' Staff do three modules – one on psychologically-informed understandings, including attachment, behaviour, development, change processes; one on psychologically-informed interventions, such as motivational interviewing, empathic listening etc; and one on client involvement and empowerment, developed using Groundswell's 'Escape Plan' (available via http://www.groundswell.org.uk/the-escape-plan.html). Managers also do a module on 'enabling management', including leadership and change management, and performance management.

These trainings are reinforced and supported through clinician-led clinical supervision, and through reflective practice groups, including a reflective practice group for PIE Managers. The trainings were developed with and co-delivered by clients.

The approach by all staff to clients, developed through the theoretical framework, should be assertive and consistent where appropriate, and staff should be confident in managing conflict. The development of a consistent reward and sanctions framework that is adopted by all staff will help promote ownership of behaviour by individuals and recognition of the impact of anti social behaviour. However there needs to be some discussion of when consistency is right, and when flexibility and person-centred-ness is, and variations in responses should be explained in terms of the values used to make them. Every service needs to consider this issue, in context – and keep it under constant review.

There should be ongoing evaluation, by staff and clients, to develop a robust evidence base of outcomes. This means that all staff must have a reasonable understanding of the ultimate purpose of any data collection, as a form of feedback on what is working, so that any future changes in practice are informed by the evidence that the service itself has generated.

Five key areas: Staff training and support

Brighter Futures' bespoke training offers a "box of tools" which staff and customers can use creatively and flexibly depending on the customers needs and goals. The cornerstone of their support is motivational interviewing combined with use of the Outcome Star (http://www.homelessoutcomes.org.uk/The_Outcomes_Star.aspx).

All staff, regardless of their role undertake elements of the training. Courses last between two and three days. Observations of practice and assignments are completed in addition to classroom sessions. Many staff are ex-customers or people with a lived experience and raising self-awareness is a key component of the training.

This describes the way people learn to make choices based on thinking rather than feelings. It is this thinking which empowers them to become more independent. This model is applied to support work with customers and casework supervision with staff.

Reflective casework supervision sessions are undertaken by senior practitioners who are "expert" team members. Their role is being developed to ensure that staff are effectively supported and learning from the classroom is translated into practice and experiential learning is captured in the learning cycle.

Brighter Futures describes support as

"… someone from outside my cycle of stresses, offering me their thinking so that I get back in touch with my ability to do what I need to be able to".

Five key areas

Managing relationships

A focus on managing relationships is perhaps at the heart of what makes a psychologically informed environment different. In this model, relationships are seen as a principal tool for change, and every interaction between staff and clients is an opportunity for development and learning. Rather than seeing the management or staff role as simply trying to contain, control or even manage behaviours, their main role is to encourage the capacity to self-manage. In terms of management, this means delegating more responsibility and creativity to the staff team, and in staff terms it means encouraging the development of responsibility and autonomy in the client group.

The development of an explicit service philosophy and practice that is discussed with and adopted by all staff will help promote ownership of behaviour by individuals and recognition of the impact of anti social behaviour. If this is developed with the clients, then it will have even greater ownership and will help shift the power balance. This approach also results in a more predictable set of outcomes for specific behaviours, enabling individuals to make more informed choices about their actions.

Organisations should review their evictions protocol, ideally with user involvement, to allow opportunities for clients to modify behaviour through graded sanctions, consistently employed. Psychologically informed services need to think creatively about sanctions, avoiding the usual warning letter – eviction route and actively looking at examples of good practice.

Homeless Link has published research on eviction and abandonment (http://homeless.org.uk/evictions-abandonment-toolkit-why) and also produced a toolkit identifying best practice (http://homeless.org.uk/evictions-abandonment-research).

Relationships being key, group work and other shared activity should be supported where appropriate and the 'Escape Plan' has an excellent section on this. Group work should also be encouraged for the staff team, with attendance at reflective practice and (if present) group supervision strongly promoted, or obligatory. To keep a group healthy, the 'difficult conversations' should not be avoided, but discussed openly, with a facilitator if necessary/available. Honesty is a crucial

Five key areas: Managing relationships

part of any sustaining and therapeutic relationship, and in all honest relationships there will sometimes be disagreements: these should be aired, and a negotiated position achieved. The more staff and management do this, the more natural it will become for this to happen in staff/client interactions, and indeed in client/client ones too.

The development of positive pathways within support planning, which emphasise what clients can do rather than what they can't, will help staff promote a change in aspiration and motivate change. For example, Thames Reach has developed a person centred approach called Planning Alternative Tomorrow with Hope, which asks clients to identify the kind of life they want, and what they will contribute and how they will stay strong, so that the emphasis is on how resilient they are. Other tools include "gifts and qualities" reminding clients what they bring to support planning so that it becomes a two way process.

The risk management approach they have developed ensures that clients are encouraged to make informed choices about behaviour, and develop the ability to

assess and take some risks in their lives. The purpose of risk management is to ensure that clients have a physically and emotionally safe enough space in which to develop, not to protect the organisation from litigation: it should be enabling, not limiting.

Many clients will have a history of abusive relationships, in other words relationships involving an abuse of power: many clients are therefore acutely aware of power dynamics and of potential, actual or perceived abuses of power. Power should be discussed openly, and should be taken into consideration when conceiving client interactions and client pathways. Change, as in moving on, often require a person to re-evaluate their own relationship to people with power over aspects of their lives. This can be a difficult process, and some boundary challenges can be seen in this light. If staff and management are aware of the impact of unequal power structures, it will be easier for them to manage creative relationships.

Five key areas

Evaluation of outcomes

Evaluation of outcomes is crucial in the development of psychologically informed services. Evaluations are crucial because they are a cornerstone of reflective practice, which in turn is a cornerstone of psychologically informed environments. If you do not know what impact what you do or say is having, how can you know whether it is positive and how can you improve it?

There is not a great mystique about evaluation: it is the opportunity to know which things you do or say are effective, in what situations and with whom. It is an opportunity for staff and clients to learn. It also enables funding to be drawn down, and better services for homeless people to be developed, but in its most simple form it enables recovery-oriented work to take place. You cannot claim to deliver effective client-focused services if you do not know what effect they have on clients. This principle of knowing whether something that we as staff are doing is positive or not is just as applicable at the service level as with the individual.

There are three levels of evaluation that can be applied

1. Policy level measures, whether defined by government or local commissioners . These may be fairly broad, and more sophisticated than mere 'targets'. Examples may be reduction in overall antisocial behaviours, reduction in rough sleeping; or shared outcomes across multiple departments e.g. reduction in police time, reduction in emergency care use.

2. Service level measures, defined by the services themselves. These should map on to what the service believes that their interventions may deliver, e.g. quality of personal relationships, reduction in antisocial behaviours, reduction in distress, increase in cognitive flexibility etc.

3. Individual measures, defined by the staff member in collaboration with the service user. These should be meaningful for the service user, realistic and – usually – behaviourally defined (although relationships and emotions as well as other factors may of course feature). These measures may result from the question 'what do you want to change in your life?'

Five key areas: Evaluation of outcomes

Evaluation and monitoring, particularly at the individual level can also enable staff and clients to see progress that is potentially significant but might otherwise be hidden. For example, it can be easy to see the last set of negative behaviours such as the last drinking binge or arrest but if processes don't monitor such incidents over the longer term people may not spot that the number of such incidences may have dropped. Another example might be someone using a sharps box for the first time, meaning that they have recognised the impact that discarding sharps unsafely could have on staff and other residents, a potentially significant behavioural change but one which could be overlooked if not specifically identified and monitored.

Case studies

The following case studies demonstrate the different ways in which organisations working with rough sleepers and young homeless people are transforming their services into ones that are psychologically aware.

Psychologically Informed Environments (PIE) at St Mungo's

Background

St Mungo's recognised some years ago that there was a significant contingent of our clients who had undisclosed and undiagnosed mental health, psychological and/or emotional disorders. This underpinned what are known as 'challenging behaviours', substance dependency and chronic homelessness, including long term rough sleeping.

Seven years ago, we embraced the recovery approach as our guiding ethos, and have since developed our recovery practice through training and greatly enhanced client participation, including founding and developing an autonomous client-led organisation, Outside In.

In the absence of much statutory provision, four years ago we developed our own psychological therapy service, Lifeworks, initially funded through the Adults Facing Chronic Exclusion programme led by the Cabinet Office. We also then developed a model of working with people with dual diagnosis – severe and enduring mental illness and co morbid substance dependency – which incorporated a psychotherapist into the support team.

When the concept of 'psychologically informed environments' (PIEs) emerged, we saw it as a development which fitted well with our other initiatives, including access to psychotherapy, personalisation, increased client co-production, and the deepening and widening of our recovery orientation.

We are currently piloting PIEs at seven different sites.

Case study: PIEs at St Mungo's

St Mungo's PIEs

St Mungo's pilots include:

- 3 projects for people with diagnosed severe and enduring mental health problems
- Rolling shelter for rough sleepers coming directly from the streets
- Female sex workers' project
- Project for people with dual diagnosis
- First stage rough sleepers hostel

They are situated in London and the South West.

The core elements of a psychologically informed environment, as outlined in this paper, are:

- Psychological framework
- The physical environment and social spaces
- Staff training and support
- Managing relationships
- Evaluation of outcomes

We will therefore describe the pilots in terms of these headings, rather than project by project. We have placed 'Managing Relationships' first because of its primary importance.

Managing relationships

Managing relationships is the most important point of all, and in fact it could be said that a psychologically informed environment is one in which relationships are consciously managed with the intention of generating positive experiences that lead to personal growth and positive change. This is as true for staff (and managers) as clients. It could also reasonably be said to describe the recovery approach.

The common denominator of the experiences of our clients, what has led them to become homeless, is damaged relationships. Clients themselves cite relationship problems as the cause of homelessness more than any other single factor, and when we hear the stories of our clients, they contain often multiple relationship breaks; many of our clients come from relationships that, from infancy onwards, were very hostile, neglectful or damaging.

Positive relationships have the potential to repair much of the damage from these negative relationships. Positive relationships are 'therapeutic' in the broad sense, meaning healing and enabling, whether they are formally therapeutic as in our psychotherapy sessions or informally therapeutic as in the relationship between key staff and clients.

Case study: PIEs at St Mungo's

Just as clients cite relationship breakdown as one of the principle causes of homelessness, they also cite a positive relationship, often with someone involved in their support, as crucial to their recovery. This is very empowering for staff too: as individuals, and through their own actions and behaviours, they really can make the difference. We see psychologically informed environments as a way to provide the best conditions we can for as many staff as possible to do just that.

Finally, two points that we have found are worth emphasising. Firstly, relationships aren't just between clients and key staff. There needs to be a framework of positive relationships – with management, with partner agencies such as social services or primary care, with commissioners, and with senior staff. And secondly, relationships require work and attention if they are to thrive, and this again doesn't just mean between key staff and clients, but between all those involved in keeping the project happening.

Making PIEs a reality, therefore, becomes a whole system project requiring the recognition that managing relationships needs to be something that everybody does. This again aligns with recovery, which is a whole system approach. How do staff do it if their managers, or senior managers, or HR, don't? St Mungo's have therefore adopted an organisational change programme

incorporating the concepts of PIEs, personalisation and recovery, and applied it across all our services and central teams. We are changing recruitment, training, appraisal, performance management, and a host of other systems.

Psychological framework

We use a psychodynamic framework, for two reasons mainly: the evidence base, and the fit with the recovery approach.

The evidence for the effectiveness of a psychodynamic approach both in formal therapy and in informing staff interactions when working with homeless people and rough sleepers is very strong. There is widespread agreement that levels of (mostly undiagnosed) personality disorder are around 60% or more in the rough sleeping and hostel population (Maguire, 2009; Cockersell, 2011). There is strong evidence from meta-analyses that the effect size for psychodynamic interventions with personality disorder is greater than for other therapies such as CBT or DBT, and that it goes on working after the formal interventions have ceased (Shedler, 2010): in other words, it enables people to develop internal resources they can continue to apply and learn from after they move on. This fits neatly with the recovery approach.

Case study: PIEs at St Mungo's

The evidence of our own experience is also that psychodynamic approaches are effective in enabling this client group to progress recovery further and more deeply: our own psychodynamic psychotherapy service, Lifeworks, demonstrated improved positive outcomes across 100% domains of the Outcome Star, with >40% of clients in employment or training placements, within 25 sessions (Cockersell, 2011). Other psychodynamic therapy services (e.g. Westminster PCT's Homeless Health Team Counselling Service, Providence Row's Just Ask) for rough sleepers have also achieved impressive results, and attendance rates of over 70% are common: that is rough sleepers literally voting with their feet.

Secondly, the psychodynamic approach fits well with the recovery approach. It emphasises relationships, the potential for sustainable change within each of us, the dynamic and changing nature of who we are, and how that is impacted on by our interaction with our environments, human and physical, and it emphasises that everything we do and all that we feel is meaningful, not just arbitrary. It values individuals over categories: psychodynamic approaches work with the client's perspective and meanings, and on the topics the client wants to work with, rather than imposing a structured model on them, or channelling them into categories

and conditions, and then treating the category/condition. Our own psychodynamic work is constantly evolving, developing new ways of working in response to interactions with clients.

We provide access to individual psychodynamic psychotherapy with a fully qualified and highly experienced psychotherapist to all clients of our PIEs, and the psychotherapists also provide clinical supervision to the staff teams.

We see PIEs as principally supporting a process of recovery through positive relationships: psychodynamics provides an evidence-based explanatory framework for understanding, developing and describing this process.

What doesn't necessarily sit well with rough sleepers (or many of our staff for that matter) is the technical language of psychology or psychoanalysis: we have therefore, with the help of our clients, reinterpreted psychodynamic concepts through and in the language of the Escape Plan (Groundswell, 2011). We use the concepts of the Escape Plan, adapted and developed though various training modules, to promote both recovery and psychodynamic awareness.

Case study: PIEs at St Mungo's

The Physical Environment and Social Spaces

The nature of the environment is that it is not always, and certainly never totally, under our control: this is and has been particularly true for most homeless people and rough sleepers. We therefore try to return as much control as possible to the clients in developing projects and in their ongoing existence. Even this is not always very possible: funding decisions taken by commissioners can drastically alter a project with no input from, and no possibility of appeal by, clients. This reflects the wider world, and repeats the experience many rough sleepers have had, that their views are not considered important at all. This has happened to a couple of our pilots, where recent funding decisions have detrimentally altered their environments.

Within this caveat, we work with our clients to create the best environment possible. This means somewhere that they can feel reasonably comfortable in, that has the basic facilities they need, that isn't too institutional, and so on – but particularly it means somewhere they can feel safe. To embark on a process of change, as we hope that people will when they come to a PIE, requires a feeling of being safe, and that means safe psychologically as well as safe physically. Both are important.

It is therefore not so much the quality of the building, though undoubtedly a good quality building does give people a sense of wellbeing, but the quality of interactive space – is there somewhere private to have conversations about important things? Is there a social space not dominated by a TV or by a particular group of individuals? Is there a sense of 'my space' in parts of the project? Is there a feeling of ownership, even pride, in the project from the clients? Is that shared with the staff?

This sense of 'quality space' is not (necessarily) determined by the structural space. It has been achieved in some of our PIE projects, despite being severely constrained by the age of the building and the funding available, through cooperative working, client involvement, and making the best of what there is: reducing the number of notices and notice boards, breaking large areas up into more intimate spaces, changing reception layouts, changing colours, and encouraging client-led activities, and other client groups, to use spaces in a varied and engaging way.

Case study: PIEs at St Mungo's

Staff training and support

Fundamental to PIEs is reflective practice. We have encouraged the development of local reflective practice models in each of the pilots, recognising that the very different services are not well served by a single, centrally determined reflective practice model. However, as mentioned above, we also provide clinical supervision groups facilitated by psychodynamic psychotherapists. In addition, the managers of the pilots also have a reflective practice group of their own, facilitated by another psychotherapist.

We have developed a set of core training modules which collectively can be seen as providing some basic training in various approaches to managing relationships. The training is, of course, psychologically informed; it is also informed by client experience, the recovery approach, and management theory.

The training modules we offer are:
Managing relationships 1: how behaviours and interactions can be understood through the concepts of attachment, the processes of change (including Cycle of Change), transference and counter transference, power dynamics, respect, and the impact of expectations and aspirations.

Managing relationships 2: techniques to help what we do to impact positively on others, including motivational interviewing, active listening, group facilitation, open questioning, honesty, prosocial modelling, coaching.

Supporting change: using client developed methods such as the Escape Plan or 10XBetter (http://www.mungos.org/about/clients/outside_in), and the recovery approach to foster transformative actions and activities, including co production.

Managing relationships 3, for managers: situational leadership, empowering and enabling staff, managing client-focused performance, managing co production relationships with clients and commissioners.

Case study: PIEs at St Mungo's

There is also access to a much wider training programme both in house and externally, and we are working towards personalised employment experiences and individualised development as part of the programme to ensure the recovery approach is real for all our staff as well as our clients. Our training programme also includes placements and formal apprenticeships for clients who want to become project staff (or to work in other aspects of the organisation's work such as central services), and support for client volunteers who take on an aspect of service delivery (for example, inducting other clients, staffing reception, preparing food etc) for relatively short periods.

Finally, another important aspect of staff support is that senior management support the development of psychologically informed environments and understand the implications, such as treating the staff with respect, encouraging a thoughtful and creative environment, and engaging in creative dialogues about aspects of working practice that affect the staff (for example, potential changes to working terms and conditions).

Evaluation of outcomes

Again like recovery work, psychologically informed environments require measurement and evaluation of outcomes. This is for two straightforward reasons: it isn't possible to be reflective if you don't know what you're achieving (or failing to achieve), and because if PIEs are to flourish they need to demonstrate their impact.

We use the Outcome Star because it (or a variation) is widely used and known, and we have mapped it against the Cycle of Change and various other indicators (e.g. Treatment Outcomes Profile TOPS www.homelessnessoutcomes.org.uk). We are also measuring staff turnover and absences, and using qualitative feedback from staff and clients and other stakeholders.

We are in the process of agreeing the use of more clinical evaluation tools, working with psychologists and psychiatrists to measure the clinical impact.

Case study: PIEs at St Mungo's

As it is early days for most of the pilots so far we only have indicative results. Outcomes include:

- Reduction in hospitalisations and emergency care
- Increase in positive moves, and increase in sustainment of moves
- Greater engagement in all sorts of activities, from informal groups to accredited trainings and employment placements
- Positive staff and client experience
- Reduction in staff sickness rates
- Reduction in serious incidents

Conclusion

We feel that, though there is undoubtedly still much to be done, we have already achieved much to be proud of. We will be publishing a preliminary report early in 2012, and a fuller one in September 2012, when we will have a more comprehensive dataset, including preliminary clinical material.Until then, we leave you with a comment from one of our clients:

I was drinking and using drugs for a long time. I used to work in the music business but lost it and ended up sleeping rough. I had a lot of family problems and for a long time, thought it was all my fault…I now know it wasn't just me, it was all of us, none of us are perfect. May be if my parents had used this service things may have turned out different. I think it could have helped them. I now realise that the drink, the drugs, [losing] the flat, the family, it's all linked… If it wasn't for them I'd be dead by now, no word of a lie.

For more information contact Peter Cockersell at Peter.cockersell@mungos.org

Case studies

Stamford St Complex Needs Unit – London Borough of Lambeth

The Stamford Street PIE is at an early stage of development in terms of the psychological framework and interventions. The models of intervention used will be influenced by an initial comprehensive psychological assessment of client need, and will develop in collaboration and partnership with hostel staff. It is likely to include elements such as psychological individual and group interventions, staff training, supervision and consultation/reflective practice, following the best practice evidence in this guideline and others, as well as relevant NICE guidelines.

Stamford St will be a purpose built, 19 bed, high support accommodation service for entrenched rough sleepers with multiple and complex needs. The project will have skilled, 24 hour staffing who will work assertively and responsively to individual needs and behaviours. Support is aimed at assisting residents to maintain their accommodation and to address the issues and behaviours that have caused the breakdown of multiple accommodation placements in the past. There will be a high staff/service user ratio and staff will be expected to work with the presenting behaviour of service users

rather than restricting access to services until their behaviour changes.

The service will integrate accommodation with psychologically informed health and support services. It will support clients with the most complex needs, for example personality disorder and complex trauma coupled with substance misuse issues and anti-social behaviour, self-harm, an offending history and exclusions from other projects. Previous exclusions show that normal hostel systems have not worked for this client group. Stamford St will take a more flexible, creative and personalised approach.

To support the service function it will host a clinical psychologist and an assistant psychologist who will provide:

- Clinical interventions with clients
- Clinical (group) supervision to staff
- Support to create a Psychologically Informed Environment (PIE)
- Support and training to staff to recognise and work with service users with complex needs

Case study: Stamford St Complex Needs Unit

Stamford St will operate on a principle of 'elastic tolerance' that can confront inappropriate behaviour, but will never reject the individual. Service users may be barred for a specific period but will always have the option of returning and negotiating, through, for example, changes to their behaviour, why they should be allowed to try again. Support is both responsive and assertive to needs and behaviours; behaviour that in other settings might lead to eviction is challenged and change is sought through consultation and realistic goal-setting with the individual.

Co-operation and collaboration between agencies will be vital to facilitate effective routes into and between services and to enhance service capacity to work with sensitivity and awareness. Project staff will build up strong relationships with health, social services, probation, drug and alcohol services, education services, learning disabilities, local GPs and mental health teams to ensure there is a multi-agency approach to meeting service users' needs. Working in this way will enable us to address the housing needs of one of the most excluded groups in Lambeth. There will be a team approach: each worker having an in-depth knowledge of the service users and can provide support when it is needed, but each client also has a lead key worker to co-ordinate support and provide consistency.

There will be a focus on health and daily living skills – money management, attending appointments, cleaning and food preparation – alongside substance misuse and mental health specialist support. In addition, through the use of therapy and motivational interviewing techniques, service users will be given the opportunity to take responsibility for their actions and change their behaviour. There will be on-site sessions from local specialist services and service users will be supported to take part in activities outside the project such as basic skills classes, gardening, music, art, job club, training/education, leisure activities and day trips.

Expected length of stay at the project is 12-18 months with service users moving on once engaging with services and ready to move on within the accommodation pathway.

Evaluation of outcomes

The overarching aim of the project is to support:

- Those facing multiple disadvantage work towards becoming self-reliant (e.g. to have jobs, stable homes and to participate in their communities)
- Rough sleepers with a history of eviction and or abandonment to sustain accommodation and move on/through the pathway

Case study: Stamford St Complex Needs Unit

- Rough sleepers with a history of non-engagement with services and treatment to engage with services and sustain that engagement

In addition, the following outcomes are expected:

- A reduction in anti-social and chaotic behaviour
- An increase in the number of service users accessing clinical therapy
- A reduction in negative outcomes for service users such as hospital admissions and spells in prison
- Improved physical, emotional and mental health
- Improved personal motivation and taking of responsibility
- Improved social networks and relationships
- Improved self-care and living skills

Further details from critchie@lambeth.gov.uk
or Clinical Psychologist emma.williamson@slam.nhs.uk

Case studies

Waterview Personality Disorder Case Discussion Pilot Evaluation – June 2011

Summary

This paper describes the evaluation of the personality disorder case discussion pilot that took place from January to July 2011, aimed at providing new ways to help workers engage with long term rough sleepers to help them off the street. The paper goes on to outline the pilot extension from Sep 2011 to March 2012.

The Waterview Centre

The Central and North West London NHS Foundation Trust Waterview Centre offers an evidence-based treatment programme designed to treat clients with personality difficulties/disorder, in the boroughs of Westminster and Kensington and Chelsea. The multi-disciplinary team maintains a therapeutic environment, providing safe and consistent boundaries within a psychoanalytically informed framework. The programme is for those with a primary diagnosis of personality disorder or other mental health problems where a personality disturbance complicates their treatment. Their primary objective is to help people develop better ways of coping and avoid the unplanned use of inpatient and emergency services. They provide group based psychological interventions based on Mentalization Based Treatment and Dialectical Behavioural Therapy. The aim of this treatment is to enable people to reduce maladaptive ways of coping and better manage affect, to establish a more stable sense of self, to help people engage in more constructive interpersonal relationships and behaviours, and to enhance their level of involvement in the community.

Because the Waterview Centre is targeted at non substance using patients, only a handful of rough sleepers had ever utilised this service and there were few links between the Waterview and rough sleeping services. As a first step, a discussion pilot was developed to offer teams the opportunity to present and discuss clients with personality disorders with the Waterview Service Manager.

Psychologically informed services for homeless people
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Case study: Waterview

The pilot design

In November 2010 funding was agreed for the Waterview to provide two hours clinical supervision/action learning sets for staff working across the rough sleeping outreach and hostel teams. The sessions were facilitated by the Waterview Manager (and Deputy when available).

The outreach and hostel teams were invited to propose clients with suspected or diagnosed personality disorder who they thought it would be useful to discuss in this forum and suggest workers interested in attending.

The sessions included two 45 minute presentations and discussion of individual clients.

For each client a basic information sheet was prepared to assist the staff in presenting cases, and included the following:
- Basic information: age, DOB, gender
- Length of time working with client.
- Vignette to include: presenting difficulties/problems/risks.
- Specific concerns or questions

Attendees and nominated clients were coordinated by the WCC Rough Sleeping Team, prioritising '205' clients (a priority group of the most long term rough sleepers). In total 16 of the 24 clients presented were long term entrenched rough sleepers in London, known as '205' clients. The discussion group could have up to 10 people attending.

Initially funding was for six sessions over three months from January to March 11. Due to the initial success this was extended for a further six sessions between March and July 11. In total of 12 sessions were delivered over the 6 month period, with 24 clients discussed. Each two hour session cost £100 and the pilot to date has been funded from an under spend in the PCT mental health commissioning budget.

Psychologically informed services for homeless people
Good Practice Guide

Case study: Waterview

Evaluation form feedback

Feedback was obtained through evaluation forms completed at the end of each session, from nine out of ten sessions (one session's evaluations forms were unobtainable). Attendance numbers are listed below

Session	Attendance Numbers
1	8
2	9
3	Rescheduled due to facilitator sickness
4	5
5	6
6	6
7	8
8	8
9	4
Total Feedback Sheets	**54**

Findings – The relevance of the supervision

Scored as Excellent – 47
There were no scores of Not Good or Poor.
Scored as Good – 17
Total – 54

Key points learnt from the supervision experience

Some responses had one or two key points. Responses listed participants increased knowledge on:

Boundary management and limit settings	12 responses
Increased knowledge on practical interventions relevant to the client group.	12 responses
Discussion in relation to planning interventions for clients (including managing risk and behaviour)	12 responses
No comment	9 responses
Increased awareness on different perspective relevant to client group.	6 responses
Importance of understanding impact this work has on worker.	5 responses
Importance of supervision	3 responses
Understanding use of empathy	2 responses
Reinforced existing skills	2 responses

Case study: Waterview

Least beneficial aspects of supervision

There were 8 responses, stating:

"Diagnosis mentioned but left unexplained"

"Sometimes there is no better way to work with these clients"

"Lack of background information presented about a client brought back for discussion"

"Lack of preparation in presentation of client" x 2 responses.

"Not knowing the service user".

"I was late".

"Too much information and not enough time".

Most beneficial aspects of supervision

There were 35 responses that varied in range:

"Opportunity to share knowledge" x 13 responses

"All aspects of the supervision was most beneficial" x 6 responses

"Hands on approach to supervision" x 6 responses

"Clarity of supervisor" x 5 responses

Other comments were individual and included:

"Understanding the importance of boundaries".

"JHT involvement"
(The mental health team for rough sleepers)

"Supportive and safe place".

"Opportunity to follow up on a client".

Case study: Waterview

Qualitative feedback on the pilot design from key stakeholders

In addition to the evaluation forms, which related to each session, qualitative feedback on the pilot design (along with its evaluation and future design) was requested from three key stakeholders who attended the majority of sessions - managers from the mental health team for rough sleepers and two outreach teams. Their responses are listed below:

I think these sessions are invaluable. The facilitator has a way of making the sessions very safe and asking just the right questions and she has amazing expertise and understanding of the issues of the clients and how they affect the staff. It tends to be the same people who attend and that makes it a solid group who can bounce ideas about and who can report back developments about clients. On the other hand it would be good to have other people from the teams attending as I think everyone would benefit from the shared experience and knowledge imparted there. I know it's not everyone's thing but having an understanding of how clients may be feeling and developing different approaches should be in everyone's toolkit. Be good to embed it within the teams. Perhaps we could have some of the

sessions to hear about progress made with people as a result of the discussions at these groups. Tracey has a knack of unpacking diagnoses and assumptions and opening up ideas and possibilities for clients. Thank you for arranging these sessions as they are invaluable.

I have really enjoyed and benefited from attending the groups. I'm sure the group over a longer period of time will help to reduce "burn out", so I don't know if sickness levels, concerns about staff performance or retention of staff could be measured.

I think that one of the best ways to assess the benefits of the pilot would be to speak to the people who have presented, and to document the advice given which would then input into clients' action plans, and to assess whether that has helped workers to engage more positively with their clients, towards accessing services (including those peripheral to accommodation) and/or maintaining engagement with services and accommodation. I could provide you with a couple of examples, myself, and am sure that there are others, too.

Case study: Waterview

I know that I have also used advice and techniques gained in the sessions when doing client supervision with members of my team, so there will also be a trickle down effect. Again, I could probably come up with some examples here, too, although not necessarily any that have borne any fruit, yet.

Additionally, given the number of 'emotionally disturbed' (if not psychiatrically unwell) clients that we work with, having this space inevitably will reduce burn out, and help retain more experienced workers, but again, I don't know how you would document this, especially in the short term.

I think one way to improve the sessions would be to clarify who should be attending (e.g. even where a team does not have a specific client being discussed, there is benefit in being part of the group) to somehow create more accountability with attendance, e.g. my impression is that attendance from specific teams has dropped off more recently, while JHT have started coming (and this has been incredibly good for our joint working!)

I also think some sort of written record of the sessions would be really helpful, for reference, but am unsure of whether this would be appropriate or not, give it is meant to be a confidential space…

In my opinion, this is the most valuable resource we've had access to, and I think it will definitely help our teams to work better, all around. And we've definitely got more clients we would like to discuss.

Proposed pilot extension
September 11 – March 2012

Given the positive feedback, it has been agreed that the pilot will be extended to March 2012, with modifications to the pilot design to respond to key feedback points. Funding will be identified from the WCC Rough Sleeping budget.

Case study: Waterview

Proposed new pilot design

The new style pilot will commence again in September 2011. The pilot will operate on a 3 month cycle, opening with a two hour presentation on personality and personality disorders, then using the next 5 fortnightly sessions for case presentations and discussion. Each cycle will have 10 places and workers will book and commit to all 6 sessions, with each person having one slot to discuss a case. The Waterview will provide a certificate to all those completing the sessions.

Pilot audit

As before, for each client presented, a basic anonomised information sheet will be prepared to include the following:

- Basic information - age, DOB, gender
- Length of time working with the client.
- Vignette to include: presenting difficulties/problems/risks
- Specific concerns or questions

At the end of the session the worker will add on a summary of the recommendations and plan discussed at the session, along with a date for review and this will be collated centrally by the WCC Rough Sleeping Team. This will create a record of the pilot and over time, a dossier on working with rough sleepers with personality disorder. An audit cycle will be created revisiting the recommendations and whether they made a difference. This audit process will take place in Jan 12 to contribute to the final evaluation of the pilot in Feb 2012.

Victoria Aseervatham
Deputy Head of Rough Sleeping
Commissioning Strategy
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Case studies

Look Ahead Housing Association

Look Ahead currently provides over 400 units of hostel accommodation and a further (approx) 800 units of floating support/ tenancy sustainment services to rough sleepers and single homeless people. In addition to this we provide a range of services (approx 250 units of support) to young people across London and the South East. Our services for rough sleepers include a large hostel service for rough sleepers leaving the streets and a range of smaller specialist services for individuals with complex needs. This includes our 35-bed drinker's hostel as well as our 28 –bed high support unit for rough sleepers with offending histories. We also provide a female –only hostel for vulnerable, homeless women.

Over the last 8 months we have begun to develop our service, Hopkinson House into a psychologically aware service. Hopkinson House is a 24/7 staffed service for rough sleepers with alcohol dependency in South Westminster. Typically users of this service will have a long history of rough sleeping with repeat admissions and tenancy failures within hostels in the borough.

In order to try and address this we therefore decided to implement a number of the psychologically related activities which would the organisation create a new more psychologically aware service.

One of the key successes was the introduction of John Conolly, our PCT funded psychologist. John provided dedicated one-to-one counselling for residents in a way that was tailored around their particular needs and circumstances and the results have been extremely positive.

Over the last 9 months we have introduced a number of key principles of the psychologically aware environment into both the physical design and operational delivery of this service. Examples of measures taken so far include:

Weekly group counselling services provided to all residents by PCT funded psychologist.

Case study: Look Ahead Housing Association

Substantive redecoration and refurbishment of all communal areas in the hostel, to provide an environment more conducive to our 'recovery model'. Colour schemes and physical design were agreed between residents and a qualified consultant to ensure that this was achieved.

Memory Project. This project was facilitated by Look Ahead's Art's Co-ordinator to work particularly with residents around cognitive impairment. Residents worked with a photographer to take photographs of locations and sites across London that had a particular resonance with them. This work was a pre-requisite to individual therapeutic interventions by Westminster's Memory Project, who intend to provide 'reminiscence therapy (currently being reviewed alongside PCT commissioning priorities).

Introduced new protocols around Case Management and Observational Practice. This protocol, places an emphasis on Look Ahead's Person Centred Planning Approach and ensures that all staff use an 'eliciting approach to keyworking residents. Staff will receive training in basic counselling skills to support Look Ahead's person centred and revised case management approach.

Introduced weekly group work sessions facilitated by drug and alcohol practitioner from Turning Point, to improve take up of therapeutic and clinical health services by residents and accelerate access to treatment and other interventions.

Involvement of Groundswell Peer Mentors. Mentors are trained ex-service users of rough sleeping services who work closely with our residents to provide moral and emotional support to them around addressing their primary health needs. This also includes providing encouragement for residents to engage with mainstream health services where appropriate

At the outset of Look Ahead taking over this service, staff were involved in the redesign of the service through business planning activities. Staff were briefed of our intention to develop a more therapeutic service based on the recovery model and principles of personalisation.

The change of approach has been challenging for some staff. We have experienced some challenges in effecting a cultural change within the service, particularly amongst longer-serving staff, who have not grasped the PIE concepts easily. A main barrier to achieving this has

Case study: Look Ahead Housing Association

been staff aversion to risk taking. We are addressing this issue through case management and individual staff supervision. We expect that all staff within the service will have completed CBT training, by the end of the year and to also have a firmer grasp of case work management and how it supports our recovery approach.

It is our aspiration to engage more of our residents into a wider programme of therapeutic interventions provided on site and within the local community. As of yet we have not experienced a discernable improvement in treatment outcomes for residents, however the service has experienced an unprecedented level of positive move –on and consequently a reduction in negative departures from the service.

There have been some difficulties in evaluating the success of individual initiatives, as these have not always been as consistent as we would have hoped, with some services provided by externals (psychologist, therapeutic casework) often experiencing interruptions.

This is likely to continue over the next year as Westminster PCT experiences cuts to front-line services and unprecedented change to the commissioning arrangements for these services and resources.

We will carry out a contemporaneous evaluation of the efficacy of our new out Case Work Management approach and how this improves outcomes around recovery. This is an internal measure of our psychologically informed approach and we will conclude this by the end of summer 2012.

Approximately £60K was spent on the refurbishment of the hostel. The ongoing costs for training will fluctuate between £2-4k per annum to re-enforce CBT approaches both for new staff and refreshers for existing staff.

We have worked closely with local PCT funded homeless services (Cardinal Hulme General Practitioners) NCWL Trust (Psychologist and Memory Project) and local DAT funded treatment services (Turning Point).

Case study: Look Ahead Housing Association

It is worth acknowledging the potential impact that changes within the Health Reforms may have on our efforts to achieve true PIE services. Most of the psychological therapies and services that are accessed by (not 'available to', which is a very separate discussion) rough sleepers are funded specifically for this purpose. We know that the take up of therapies within Hopkinson House has been improved by the regular attendance of the psychologist within the service. Vital services such as these may be missed under GP commissioning consortia, as they may be considered to niche and/or fall between those localities within the remit of new GP consortia.

Further details available from
paulperkin@lookahead.org.uk

Case studies

Developing St Basils as a Psychologically Informed Environment

Needs

St Basils, works with young people, aged 16-25 who are homeless or at risk of homelessness. We provide a range of prevention, early intervention, accommodation and support services in the West Midlands.

Young people who come to us have multiple needs underpinning their homelessness. Each year around 4000 young people approach us for assistance and we will accommodate over 1000. Whilst 16 and 17 year olds make up around 29% of referrals, a much greater proportion of this age group are being accommodated directly by St Basils as there are fewer Landlords able and willing to accommodate this age group. 67% of young people accommodated by us are 19 or under. Over 25% of all young people identify mental health, drugs or alcohol as an issue for them at the point of referral. By far the greatest reported reason for homelessness is relationship breakdown with family or friends. 78% of young people are NEET or have become NEET as a result of their accommodation situation.

Our Response

Following in depth consultation with young people, staff and stakeholders, we have restructured our services to ensure that every young person has continuity of relationship with a support worker who will stay with them throughout their time at St Basils and continue to support them when they move on into the community. In addition, in many schemes, we have night/weekend support workers who do not have an individual case load but who work with young people to embed learning and development and ensure the collective are safe and meaningfully occupied. We have a Family Mediation team and Time Out bed spaces to provide short term respite and breathing space for young people where assessment can take place and a support plan developed to support them in their preferred option. Housing management and our landlord function is separate.

Case study: St Basils

A Whole organisation approach to developing St Basils as a Psychologically Informed Environment

In recognition of the complex needs of an increasing proportion of the young people we accommodate and support, we are investing heavily in developing St Basils as a PIE (Psychologically Informed Environment) organisation. We are working with one of the Country's leading Clinical Psychologists, Dr Nick Maguire from Southampton University to develop and implement this programme over a three year period. Having followed closely Nick's work on complex trauma we found significant resonance with the presenting needs of young people, the challenges facing staff and the difficulty in accessing appropriate mainstream mental health services.

Programme aims:

1. To improve positive outcomes for young people, build resilience and capability and enable them to move on and sustain their independence in an increasingly challenging environment;
2. To ensure staff have skills, attitudes, behaviours and resilience to cope and support positive outcomes for young people.

3. To influence commissioning policy and practice and deliver our Commissioners' outcomes; and maintain our position as a high quality provider.

Key Service Outcomes

1. To improve positive outcomes for young people:
- Building resilience and capability, i.e.:
  - the ability to overcome hurdles and barriers which are not in the service of their values;
  - the skills, confidence and behaviours which will assist them to make informed decisions about their lives
  - The skills to make progress towards their own defined goals, in the service of their personally defined values.
- Enabling them to move on and sustain their independence in an increasingly challenging environment
2. To work with staff:
- To ensure staff have the skills, attitudes and behaviours which not only increase their own resilience thereby reducing anger, anxiety and hopelessness around challenging situations, but also to more effectively support positive outcomes for young people.
- Embedding practice which builds resilience and capabilities rather than dependencies

Case study: St Basils

Elements of Programme

1. Core training in psychological skills for all relevant employees (estimate 180)
2. Specialist training for application of these skills in specific areas (support staff and managers)
3. Development of our evaluation framework and infrastructure and review and analyse data for agreed period (over 3 years initially)
4. Set up and run Reflective Practice Groups in collaboration with NHS partners, Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)
5. Review tools and working methods to ensure they support an approach consistent with Psychologically Informed Environments

Key Service Outputs

✓ Establish baseline in year 1 (2011) – established

✓ Carry out training for all staff in partnership with Southampton University September/October 2011 - Completed

✓ Establish partnership with BSMHFT and contribute to training – Aug 2011 – established

✓ Commence reflective Practice sessions with BSMHFT following completion of training – commenced November 2011

✓ Work with researcher from Southampton University to establish KPIs, baseline and monitoring arrangements – if possible extend over 3 years – researcher appointed and baseline Indicators identified

• Share learning, research outcomes and publish reports – ongoing

• Embed learning and good practice

Case study: St Basils

Partners

The following partners are currently committed to the work:

- Department of Communities and Local Government have contributed funding to this work as this is the first of its kind working with young people.
- Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) have committed to the partnership providing Clinical Psychologists' time to carry out training for all staff alongside Dr Maguire and to provide resources for reflective practice sessions on an ongoing basis with Support staff. They have also created a direct referral route for young people who need clinical support into their YouthSpace mental health service. We have offered free use of our buildings for non-institutional clinics and drop in facilities for young people with mental health needs across the City and we are working towards their engagement in our multi-agency YouthHub services. They have offered their time on a pro bono basis whilst we will pay for the supervision costs for their psychologists engaged in reflective practice.
- London Housing Foundation has contributed funding towards the supervision of Clinical staff over the three year period

- Birmingham City Council have ring fenced the funding from DCLG and are supporting the approach
- Dr Nick Maguire from Southampton University is working alongside us in developing the programme and delivering it over the initial three years
- St Basils Board, staff and young people have committed significant resources to the programme

Collaboration and shared learning

This is a collaborative approach. The relationships formed to develop and deliver the programme are based less on a conventional purchaser/provider contract and more on the contributions each partner can make which will help deliver better outcomes for young people. St Basils' Youth Advisory Board has been involved in shaping the approach and will be closely involved in the monitoring of outcomes. The learning from this work will be shared and will hopefully contribute to shaping future housing related support services for young people. All partners will have the rights to use the reports to distribute to their stakeholders. St Basils will provide 3 days specifically dedicated to sharing the learning from the programme with London based housing organisations.

Psychologically informed services for homeless people

Good Practice Guide

Case study: St Basils

Progress to Date and Next Steps

Phase 1 - Training

The programme was launched in June followed by implementation of phase 1 involving training for all staff during Aug/Sept. Housing Management and Business Support Staff received one day's training; Support Staff received 3 days and Managers an additional half day. Training will be embedded in our annual programme and will be part of induction and refreshers over the life of the programme.

Phase 2 - Reflective Practice

Birmingham and Solihull Mental Health Foundation Trust began reflective practice sessions in November 2011.This is an absolutely critical element of the programme in order to embed good practice and ensure the work is informed from a clinical perspective. We have converted space in our Edmonds Court foyer to provide a reflective practice and health suite.

Clinical Psychologists will provide reflective practice sessions every Friday morning from 9.00 – 12.30 at St Basils commencing 25th November 2011. This provides 3 x 1 hour sessions accommodating a maximum of 6 staff per session = 18 each Friday. All support staff are able to have a monthly session. Additional sessions

are provided for our Solihull staff locally. and BSMHFT Family Clinical Practitioner provides a monthly session specifically for our family mediation team.

The sessions take a case based approach and provide the opportunity for support workers to discuss appropriate approaches based on a psychologically informed approach. These will support learning and good practice but will not replace line management.

In this way BSMHF will increase reach to their high risk client groups. Each support worker has an average case load of 12 young people.

Whilst clearly this is not the same as one to one clinical sessions, the intention is to have a consistent approach to prevention and supporting positive mental health which in turn contributes to positive move to independence and transition to adulthood.

Phase 3 – Data Collection and Analysis

The following key outcomes have been identified for both staff and young people. Our aim is to avoid extra or unnecessary work. We will establish the baseline before the start of the programme and monitor regularly throughout the three year period with 6 monthly review and analysis by Southampton University.

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Document Map

Introduction

Psychologically informed Environments (PIE)

Five key areas

Case studies

Appendix

Case study: St Basils

Young People

1. Reduction in serious incidents.
   Baseline: 2011 Qrtr 1& 2
   Target: 20% reduction in year 1
2. Reduction in Notice to Quit served
   for behavioural issues
   Baseline: NSPs served for behavioural issues
   currently represent 26.5% of all Notices.
   2011 Qrtr 1& 2
   Target: 25% reduction in year 1
3. Reduction in unplanned departures
   Baseline: 2011 Qrtr 1&2
   (14% of total departures)
   Target: 25% reduction in year 1
4. Reduction in anti-social behaviours/increase
   in pro-social behaviours
   Self–Report Data to complement hard data.
   Will include case studies; Incident reports; feedback
   from Reflective Practice and individual outcomes;

Staff

1. Reduction in sickness absence
   Baseline: 2011 Q1&2
   Target: 25% reduction in year 1
2. Reduction in Grievances and disciplinary action
   Baseline: 2011 Q1& 2
   Target: 50% reduction in year 1
3. Improvement in positive mental Health
   as self assessed. Questionnaires completed
   during Programme
   Baseline: established during training at Phase 1
   Target: Review each six months

Phase 4 – Review and Alignment of working models to PIE approach

This stage is yet to be developed and will be reviewed following 6 months of reflective practice and reflection on Outcomes Star Pilot.

Further details from jean.templeton@stbasils.org.uk

Case studies

Simple solutions for complex needs – an analytical social care approach – Brighter Futures

We have a strongly analytical approach in developing our work. First we seek to understand how people developed complex needs. Secondly we then try to understand the behaviour that arise including the self- help treatments people adopt to cope with their "dis-ease."Our resulting social care model has been developed based on our 25 years of experience and learning.

We are now working with Keele University Department of Psychology, Masters in psychology course offering research apprenticeships and opportunities to do dissertations.

Our customers arrive with a wide range of presenting problems including involvement in sex work (male and female), drug and alcohol addiction, street homeless, tenants under threat of losing their tenancy, older people unable to sustain independent living, people with learning disabilities and in need of support to live independently, people with mental illnesses and people convicted of crimes.

Our understanding of complex needs is that they arise as a result of complex causes. No two people will have exactly the same set of needs, but the genesis of these needs will be rooted in an exposure to some of a group of circumstances. People with complex needs will have experienced some of the following "predisposing factors":

- Physical ill health.
- Mental ill health.
- Bereavement or loss of important relationship.
- Poor support or social networks.
- Psychological trauma.
- Learning disability (particularly if it is undiagnosed).
- Financial poverty, poor housing, diet etc.
- Uncertainty of financial or housing affairs.
- Other major uncertainties (e.g. risk of deportation, unstable relationship, gender uncertainty).
- Periods of institutionalisation and their aftermath (being in Local Authority care, the armed services or prison for instance).
- Sexual abuse or exploitation.
- Physical or psychological abuse.

Case study: Brighter Futures

Those who suffer from one or more of the above often try to retain a sense of well being or cover up the pain by engaging in ill advised but well intentioned activities. These activities can be seen as self medication for someone who knows that their life is unsatisfactory (that is they are dis-eased). These self-help treatments are generally pursued with an addictive fervour because this is what displaces the pain. They often involve substances which are actually addictive. It can easily be seen that using a variety of these self-help treatments will, over a period of time create a series of complex overlaying problems. The longer a situation is endured, the more complex will the overlay become. For the external observer it becomes increasingly difficult to identify cause, effect and cure as a mass of symptoms of dysfunction appear. Self-help treatments include:

- Using alcohol or illegal drugs.
- Using religion or other calming world views.
- Joining gangs, institutions or extremist organisations.
- Pursuit of money, power or sex.
- Offending, offensive or anti-social behaviour.
- Self doubt, self harm or self punishment.
- Seeking social isolation.
- Becoming over dependent on services or institutions.

It is easy to see how a mixture of, predisposing factors with one or more of the self-help treatments is a path to disaster for an individual.

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Document Map

Introduction

Psychologically informed Environments (PIE)

Five key areas

Case studies

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Case study: Brighter Futures

BRIGHTER FUTURES recognises that the paths into these situations of complex need are many and confusing. However, we believe that the pathway out of them is essentially simple. We design individual journeys for our customers to help them back to fulfilled engagement which are all:

- Individually designed to deal with the symptoms of the predisposing conditions.
- Able to provide an appropriate alternative mode of coping with the underlying pain which does not involve the use of self-help treatments.
- Individually designed to remove the underlying causes of the predisposing conditions where possible.
- Designed in discussion, negotiation and with the agreement of the customer.
- Holistic: they address all the needs, physical and psychological of the customer.
- Multi dimensional: they use all the many services of BRIGHTER FUTURES itself and also refer customers to our many partners.
- SMART, that is, specific (activities or targets), measurable (we include and measure frequency of attendance etc), achievable (they are suited to the customer, not us), realistic (challenging, but possible) and timely (they are offered in the right sequence).

- Simple: these are understandable and legible pathways. They are human in conception and deliver care that is customer centred and has no unnecessary boundaries.

It should be noted that this approach ensures that our engagement is not conditional upon a person having already abandoned their self-help treatments. We will help people to live without, for instance, drink, or offending, but recognise that this must be a product of our support and involvement rather than a precondition of it.

This approach works. We end the downward spiral of ever more complex needs that tend to occur with other piecemeal approaches. We put individuals back in touch with where they really want to be. We remove the enormous cost to the public purse of people whose lives are out of control and who therefore cause enormous disruption and cost to others.

Further details from gill.brown@brighter-futures.org.uk
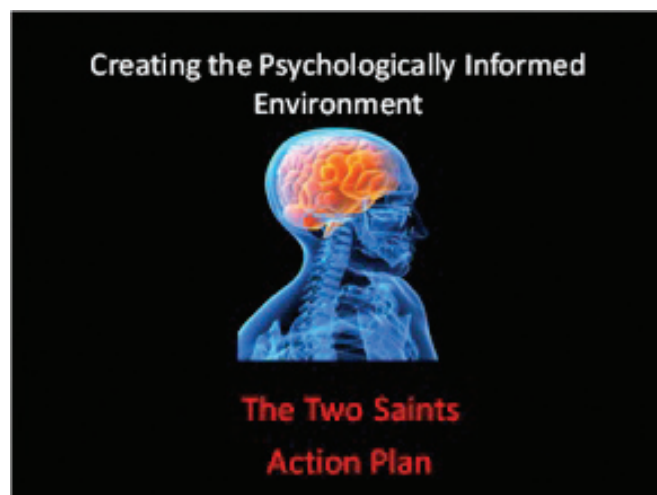
Case studies

Two Saints Housing Association

Intranet article to staff of about developing psychologically aware environments

Dear All,

Many of you will have been hearing much talk about PIE. I appreciate this has been a popular subject on the terraces for years but this is a PIE with a difference- it's healthy! The Psychologically Informed Environment is one which 'seeks to understand people's reactions and to, and ways of coping with traumatic experiences' . The Department for Communities and Local Government and the National Mental Health Development Unit commissioned some research, pilots and ultimately a good practice guide in May 2010 (from which I quote throughout this update)

The research and, in some cases, overdue common sense suggests that 'Adopting a more psychologically skilled approach will help to provide more positive outcomes for clients; particularly for those who may have learnt ineffective and destructive coping strategies which affect their ability to maintain relationships or accommodation' ; and furthermore 'Accommodation on its own, even coupled with support, will very rarely

Case study: Two Saints Housing Association

enable people experiencing complex trauma to deal with negative self-belief or emotional disregulation and change how they behave.' In short 'Without addressing the trauma it can be difficult to support people to stabilise their lives and find and keep accommodation, Maintain Relationship's and engage in positive meaningful activities'

The report also suggests some clients 'may behave and think in particular ways which perpetuate their problems. This makes key working very hard and at times frustrating for both client and worker' but firmly asserts 'A key factor in improving outcomes for people with Complex trauma (or personality disorder) is the response they receive from staff.'

Importantly it recognises support workers role and contribution going on to say 'The high prevalence of personality disorder and complex trauma among clients of some homelessness services means that hostel staff and resettlement workers can often find themselves engaged in quite psychologically sophisticated and demanding work, for which they should be properly recognised, trained and supported. It is important for staff and commissioners to understand that this approach complements but does not replace access to mainstream clinical psychology services by clients.'

I am sure that many of you will recognise this as the simple truth as I do. We can also see that by becoming more psychologically aware in our practices we will benefit ourselves as staff and all clients, not just those with Complex Trauma (estimated at 60% in hostels). The Psychologically Informed Environment is an approach and not a place. So how do we embed this new approach?? Service and Senior Managers met on the 21st of September and formulated an action plan to move us forward. This focussed actions on five key areas:

1. Practice – Embedding reflective and other practices into the fabric of what we do. The report suggests 'It is the changes in day-to-day running, derived from reflective practice and discussion that mark the development of the PIE.' And 'Reflective practice is an essential component of effective, safe work with people who suffer complex trauma.'This will afford staff much more forum to gain management and peer support for the work they do.

2. Policy and Procedure – looking at how we need to review our P & P's to embrace the PIE approach.

3. Staff Training – how do we ensure our staff have appropriate training , supervision and support in this area. We also need to understand the boundaries and keep all safe and clear about where support workers role ends and that of professional services begins.

Case study: Two Saints Housing Association

4. Physical (Buildings) – how we maintain, select, design and modify our buildings as the opportunity comes along to create the best physical environment possible to engender engagement and positive outcomes.

5. Communication - How do we communicate this approach and the changes it entails to staff, clients and stakeholders.

The last thing to say is that this is not another thing to do, far from it, is the obvious bedfellow to our other advancements with respect to personalisation and person centred planning and is simply a different, not additional, way of doing things. We are confident this approach will give staff more support, training and forum to enhance the already exemplary job that they do.

Further details from Jon.Cox@twosaints.org.uk

Case studies

The Bristol Wellbeing Service for people who are homeless or vulnerably housed

Second Step has taken measures to equip its staff with a greater awareness of psychological therapies and how these can help service users to change. As part of its strategy and in the creation of operational deliverables the strategy emphasises the importance of creating psychologically informed environments. This has been supported through a combination of the delivery of a 4 day course which encompasses the main principles of CBT, and also explains the workings of DBT, which can lead to an appreciation of the ways in which service users with complex trauma/PD present. How staff members can respond more effectively. is examined, both from an individual, but importantly also from a team-based and systemic perspective. A description of attachment theory was also delivered which has helped staff to understand and empathise with the lived experience of service users with PD/complex trauma. Motivational interviewing for substance misuse has also been examined with delivery of group work for service users planned for 2012.

A further critical development backed by the Second Step Board has been the funding and therefore provision of on-going reflective practice (RP) to all teams attempting to create PIE and implement basic psychological principles. In this way, psychological training is effectively extended with recourse to an experienced consultant clinical psychologist. In terms of psychologically informed environments, RP is thought to represent THE critical component in terms of enhancing delivery of care, "because it allows practitioners and frontline staff to think, discuss and debate over how interventions may have been conducted differently, and make changes that are both positive and iterative in nature" (Mental Health Good Practice Guide, 2010).

The Bristol Wellbeing Service for Homeless People

Running since 2010 and working with 100+ homeless people each week, this service is run by Second Step and St Mungos in partnership. All staff and volunteers are psychologically trained. A phased model of intervention is used; firstly establishing safety and trust and supporting stabilisation of mental health

Case study: The Bristol Wellbeing Service

and symptoms, then moving towards planned clinical interventions and finally moving on. Many people coming to the service are deeply mistrustful of services and stuck in repetitive cycles of addiction/homelessness. Evidence emerging from the Wellbeing Service is that people require engagement interventions that move them towards psychological readiness before they can take part in more structured and evidenced based therapy that will lead to enhanced probability of long-term successful outcomes By providing low threshold engagement options that reflect where people are in the cycle of change (usually pre-contemplative / contemplative) we build trusting relationships and increase numbers actively participating in planned therapeutic interventions.

More than 50% of the current cases open for psychological planned treatment are people with histories of complex trauma – numbers accessing open sessions are higher. The service:

- Offers a low threshold approach with initial contact being informal 1:1 in open access settings
- Strong focus on engagement, non-clinical activities to build trust.
- Close/joint working with agencies close to communities, such as those working with female sex workers.

- Non-assessment activities that promote inclusion and positive contact
- Peer volunteers model recovery
- Use of psychologically informed and recovery based approaches and tools that develop self-empowerment and self-management e.g. Recovery Star

Recovery Education

Developed and run at Second Step, Recovery Education is an innovative programme that works with groups of service users to develop a strong understanding of recovery philosophy through practical based sessions, which encourage the development of wellness toolkits and recovery resources to use in everyday life. Staff with lived experience of mental health issues and service users developed this work and deliver the programme.

The course is delivered on a modular basis and includes creative activities and discussion time which has been very successful within our Wellbeing Service (as above).

Further details from chris.kinston@second-step.co.uk

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Appendix

Publications that may be interesting

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Appendix

What is reflective practice?

Reflective practice is the process of reflecting on actions and interactions, either during or after they have occurred.

Reflective practice can be an individual activity (e.g. keeping a log) or a group process. As part of the Recovery and Personalisation Transformation Plan, St. Mungo's projects will be supported to implement reflective practice.

The purpose of reflective practice is to allow you (as individuals and as a team) to step back and reflect on behaviours and actions taken, thus allowing you to learn, build on successes and make improvements going forward. It is a tool that facilitators can use to bring about a process of self awareness, learning and change.

One of the aims of reflective practice is to explore perspectives of services users and develop a more multi dimensional perspective of clients (rather than focusing on/dealing only with the issues the client is presenting with).

What are the origins of reflective practice?

Reflective practice draws on the work of Donald Schon, a philosopher, who first coined the phrase in 1983. He argued that the ability to reflect on action was part of the process of continuous learning. Today reflective practice is used in both the private and public sectors for a range of activities.

Schon's approach is closely linked to the theories on how people learn. The act of reflecting on what we have done or are doing allows us to explore why we act like we do and what was/is happening in the context in which we work.

It takes into account that people learn through peaks and troughs, rather than a smooth curve. Schon felt that reflecting on ones actions helped the process of learning. Reflective practice helps people move through the cycle of learning.

Since then, reflective practice has come to be seen as one of the cornerstones of recovery-oriented and person-centred ways of working, as well as a key activity for professionals involved in care and support for vulnerable individuals.

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How does a team reflective practice session work?

There are several models that can be used; at a minimum each session will usually require a facilitator, one or more staff as presenters and other staff as group members who will feed back to the presenter.

Roles

Presenter/s - presents an issue/s for discussion. This may be directly focused on their client work or it may be a team or organisational issue that is impacting on the work. The focus is to increase understanding of an issue and, from the increased understanding, to devise new ways of approaching it.

The Facilitator-is responsible for supporting the presenter to get what they want out of the session by asking prompting questions.

Time Keeper - can be the facilitator or a group participant.

Process

If the Presenter/s (the suggested maximum number is two presenters for a one hour session) has not been chosen in advance they can be chosen at the start of the session by the group once they have heard what each person plans to present.

- Contracting with the group about what they hope to achieve from the reflective practice.
- Clarifying the role of the facilitator and the group participants.
- The presenter describes their aim/s in bringing the case to the group. For example, feedback on supports they could offer a client. They describe the case, including the client's background, their supports, their ambitions and what is holding them back in their recovery journey.
- Group participants help the presenter analyse what has worked well and what needs to improve, stop or change. The group works together to try to understand why the situation is as it is, and what factors they could change to enable client change to occur; the factors/actions should usually be changes the presenter or team can effect themselves, rather than along the lines of `get someone to do something'.

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- The presenter committing to a set of change actions and/or behaviours
- The effectiveness of these actions can be reviewed at a later session.

What are the skills needed for reflective practice?

Reflective practice encourages individuals to question what, why and how we do things and what, why and how people with whom we interact also do things. It is a process that seeks to understand the underlying mechanisms and rationale behind behaviour. It recognises that behaviours do not occur in isolation or without reason: they are part of social relationships and are influenced by interpersonal and group interactions, and by environamental pressures. Reflective practice encourages the individual to view their own activities and their outputs from different perspectives. The purpose is to create greater awareness and understanding of the reasons for and impact of one's actions. It is a process of questioning assumptions, keeping an open mind, and asking 'what if'?

The resulting conclusions that can be drawn from this analysis are designed to generate alternatives, facilitate choices and challenge assumptions.

The skills needed therefore for the facilitator (and which the participants will also develop) to be effective in reflective practice revolve around support : listening, encouraging reflection, recognising achievements, offering help, providing motivational feedback and challenge: questioning, promoting different ways of doing things, providing developmental feedback, seeking improvement. Reflective practice is best undertaken by a facilitator or coach who can support and challenge the learning. This could be a practitioner experienced in psychological approaches. Managers can also be supported and trained to move into the role of facilitator.

Creating a reflective environment

It is necessary to create an atmosphere in which group members are open to talk about individual and interpersonal problems and difficulties. Mutual trust is a key condition for group reflective practice and should not be affected by interpersonal tension. This does not mean ignoring interpersonal tension: on the contrary, it is important that interpersonal tension(s) is at least acknowledged openly by the group and, if possible, dealt with within and by the reflective practice group.

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Group participants should reach an agreement on several conditions concerning basic attitudes and cooperation, in order to create a productive and trustful group atmosphere for the sessions.

The key `ingredients' that promote the success of a reflective practice group are:

Trust: participants who trust each other will speak more openly

Confidence: information about cases and the group process should remain confidential within the group (with an exception where there is a risk of harm to a client/staff member)

Support: participants should endeavour to support each other

Appreciation: mutual esteem promotes openness

Challenges: challenges should be directed at practice and attitudes rather than people and personalities, and should be carefully constructed and dealt with; it is worth spending some time at the beginning talking about how the group will enable members to make constructive challenges of each others' practice

Each project must develop a local Policy for their reflective practice process. The following areas should be covered:

1. Frequency-this should be a minimum of every x weeks
2. 2 Attendance. All staff on duty should attend and there should be a minimum required attendance level (i.e each staff member must attend at least six sessions per year). Managers should attend but not manage - they are there for their experience, not their authority.
3. Length of session
4. Venue
5. Confidentiality
6. Evidence of sessions- the minimum requirement is a record of the date and list of topics discussed along with any comments. This should be signed off by the facilitator and participants.
7. Review - a periodic review should be carried out to gauge the usefulness of the sessions and to provide an option for a change of facilitator.

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Document Map

Introduction

Psychologically informed Environments (PIE)

Five key areas

Case studies

Appendix