

**"Living here has changed me": Resident and staff perceptions of  
Psychologically Informed Environments for homeless people**

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**Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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## Overview

Homeless people have often had significant early adverse experiences and are at risk of consequent mental health difficulties. This thesis examines psychological interventions designed for meeting the needs of this group.

Part 1 is a literature review of the outcomes of psychological interventions for homeless people with mental health problems. Twenty studies met the inclusion criteria. Interventions were grouped into four types: traditional psychological interventions, supported housing with a talking-based component, therapeutic communities and peer support interventions. Design quality was variable. All studies reported positive outcomes on at least one measure. However, the variability in outcomes and rationales for intervention suggest that there is scarce evidence about which models are appropriate to the needs of homeless people and that there is a lack of agreement about how to measure success.

Part 2 is a qualitative study exploring the experiences of living and working in a 'Psychologically Informed Environment' (PIE), a new model of hostel provision which aims to meet the psychological and emotional needs of homeless people. Semi-structured interviews were carried out with residents, staff and therapists in two PIE hostels. Interview transcripts were analysed using thematic analysis and 18 themes were organised into five domains: what makes a home, resident needs, managing relationships, reflective practice and theory vs practice of PIEs.

Part 3 is a critical reflection on carrying out the research. Methodological issues and choices made in the design of the study are discussed. Limitations arising from these choices and future directions for research are then considered followed by reflection on the role of the psychologist in relation to PIEs.

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## **Part 1: Literature Review**

### **Outcomes of psychological interventions for homeless adults with mental health problems**



## Abstract

**Aims:** Homeless people often struggle to access mental health care. Despite high levels of mental health difficulties in this group, their needs often remain neglected. Psychological interventions can potentially address these difficulties. This review aimed to critically evaluate the literature on psychological interventions for homeless people over the last 20 years and examine the outcomes of talking-based or psychosocial interventions with this group.

**Method:** A systematic search of the databases *PsycINFO*, *CINAHL* and *MEDLINE* identified 20 papers which met inclusion criteria. The methodological quality of studies were assessed using an adapted version of the Downs and Black checklist (1998).

**Results:** Interventions were grouped into four types: traditional psychological interventions, supported housing with a talking-based component, therapeutic communities and peer support interventions. All studies reported positive outcomes on at least one measure. The strength of designs was variable.

**Conclusions:** Whilst the studies demonstrated that homeless people engage in talking-based interventions, the variability in outcomes and rationales for intervention suggest that there is scarce evidence about which models are appropriate to the needs of this group. There is little agreement about which outcomes should be used to measure success.

## **Introduction**

An extensive body of literature shows that mental health difficulties are much more common in homeless people than in the housed population, with higher rates of psychosis, depression and post-traumatic stress (Fazel, Geddes, & Kushel, 2014; Fazel, Khosla, Doll, & Geddes, 2008). There has been a particular focus in recent years on the prevalence of people who meet criteria for a diagnosis of personality disorder but remain unrecognised by services (Fazel et al., 2008; Johnson & Haigh, 2012a). Estimates of undiagnosed personality disorder are as high as 70% for hostel residents who are arguably in better circumstances than those sleeping rough. Homeless adults also have high rates of substance use, physical health problems and other needs (Farrell et al., 1998; Lehman & Cordray, 1993). Despite this, there has been little systematic examination of which psychological interventions are effective for this client group.

The homeless population is not a homogenous group. It ranges from people who are unstably housed or going through transient periods of being without accommodation to people who live in hostels and those who are chronically homeless or 'entrenched' rough sleepers. Official statistics on homelessness suggest over 7,500 people were seen rough sleeping in London alone in 2014-2015, a figure that has been rising year on year (Greater London Authority, 2015).

High levels of early adversity and abuse or neglect are reported in the homeless population (Christensen et al., 2005; Fitzpatrick, Bramley, & Johnsen, 2012; Sundin & Baguley, 2015). Difficulties in early attachment relationships are known to impact on later ability to manage emotions and relationships (Bowlby, 1973, 1977; British Psychological Society, 2007). Hence early abuse, neglect and trauma have been consistently associated with increased rates of mental health problems (Macmillan et al., 2001; Weich, Patterson, Shaw, & Stewart-Brown, 2009) personality difficulties (Herman, Perry, & Van der Kolk, 1989) and substance use (Dube et al., 2003). There is also evidence of the presence of 'complex trauma' in the homeless population which results from prolonged exposure to early adversity (Maguire, Johnson, Vostanis, Keats, & Remington, 2009). It is therefore likely that

psychological difficulties in many homeless people are largely developmental in origin. However influences on wellbeing are also bidirectional with reports of the hardship of street homelessness and hostel living impacting on mental health (Goodman, Saxe, & Harvey, 1991; Newburn & Rock, 2005).

### ***Mental Health Services for Homeless People***

The majority of services for homeless people are provided by the voluntary sector and their emphasis has traditionally been on providing shelter, housing and meeting basic needs. However, given the evidence about mental health in this population, it is clear that any effective intervention requires more than simply putting a roof over someone's head (Seager, 2011). Whilst mainstream mental health services do provide for people with complex difficulties, homeless people are often excluded structurally - for example by not being registered with a GP or having a lifestyle that makes it difficult to attend scheduled appointments (Elliott & Taylor, 2012; Jarrett, 2010). The prevailing assumption of the UK National Health Service is that people in need will be able to ask for help or be assisted by friends and relatives; there is little capacity to assertively seek out those who are socially excluded and unable to attend services. Homeless adults therefore often slip through the net of services and are unable to access mental health interventions with the ease of the general population (Bramley et al., 2015). It is also often assumed that people need to reach a state of 'insight' or readiness to access psychology services and before this point may be rejected or turned away (Elliot, 2015).

The NHS has a duty to provide equal access to healthcare for all groups regardless of their status (NHS, 2013) and therefore there is an argument to be made for mental health services specifically tailored to the needs of homeless people. Clinical Psychologists could be one group of clinicians well placed to contribute to this work, being trained to formulate and work with multiple layers of need for people with complex presentations. In reality, however, there are very few such specialist services (Maguire, 2015a) and few Clinical Psychologists both in the UK (Brown, 2015) and the US (Rogers et al., 2012) report working with homeless people.

In addition to service-level and structural deficits, there is very little evidence about the outcomes of specific psychological therapies that meet the needs of homeless people with mental health problems. A UK Government report recommends that psychological interventions be provided in collaboration with good quality housing services (Department of Health, 2011) and NICE Guidelines on working with personality disorder have been published in recent years (NICE, 2009a, 2009b). However, Maguire (2015a) points out that whilst many practitioners use models derived from other settings, these may or may not be appropriate to the difficulties that homeless people describe. With very little evidence about outcomes of specific psychological therapies in homeless settings, it is difficult to know which, if any, interventions might be most appropriate for this population.

### ***Previous reviews***

Existing reviews have focused on related subjects including service user satisfaction with mental health services for homeless people (Bhui, 2006), the prevalence of mental health difficulties (Fazel et al., 2014, 2008) physical health interventions (Wright & Tompkins, 2006), interventions for women (Speirs, 2013) and housing and policy-level strategies to end homelessness (Pauly, Carlson, & Perkin, 2012). Low-intensity permanent supported housing such as the Housing First model has been subject to numerous evaluations (Leff et al., 2009). However this model provides housing which is not contingent upon receipt of any treatment. Whilst some argue that Housing First draws upon psychological principles of self-efficacy and empowerment, it does not include formal psychological intervention. Case-management strategies such as Critical Time Intervention and Assertive Community Treatment have also been subject to reviews and evaluation (de Vet et al., 2013; Hwang & Burns, 2014). However, these are not clinical interventions but focus instead upon practical strategies such as outreach, care-planning, advocacy or provision of crisis care. There is no known review of psychological interventions for this client group.

### ***The current review***

The current review therefore aims to examine studies of psychological interventions for homeless people with mental health problems. It is limited to talking based interventions

either embedded in supported housing or provided in outpatient settings and excludes case-management or low-intensity Housing First approaches.

The central question the review aims to answer is what psychological interventions have been developed for homeless people with mental health problems and what is the evidence for their effectiveness?

## **Method**

### ***Inclusion and exclusion criteria***

The inclusion criteria were:

1. *Population*: homeless adults (18 and over) with mental health problems. Homelessness was defined broadly as people rough sleeping, 'roofless' or living in hostel accommodation. Mental health difficulties were also defined broadly as any difficulties in psychosocial functioning or wellbeing as well as formal psychiatric diagnoses.
2. *Intervention*: psychological interventions, defined as group or individual talking-based approaches.
3. *Design/Comparator*: randomised controlled trials (RCTs), uncontrolled trials or quasi-experimental designs producing quantitative results.
4. *Outcome*: interventions aimed at improving the mental health, psychological or psychosocial functioning, substance use or housing status of recipients.
5. *Setting*: outpatient clinics, interventions embedded in supported housing or other residential settings.

The exclusion criteria were:

1. Interventions for homeless families
2. Pharmacological interventions
3. Interventions that exclusively aimed for cessation of substance use

### ***Search strategy***

The electronic databases PsychInfo, CINAHL and MEDLINE were used. The search used the following terms: *(Homeless\* NOT (adolescen\* OR youth)) AND (Psychol\* OR Therap\* OR Intervention OR Counsel\* OR Support\* NOT medication) AND (Mental Health OR Substance\* OR Drug\* OR Psych\* disorder OR symptom OR personality)*.

The search was filtered to include only papers from peer reviewed journals in English, published between 2000 and 2015.

### ***Study selection***

A total of 3345 studies were returned: 973 from PsychInfo, 1419 from MedLine and 953 from CINAHL. Once duplicates were removed, there were 2338 studies in total.

Studies were screened by title and abstract to create a shortlist of 250 potentially relevant papers. The shortlisted papers were examined more fully and 19 studies met the inclusion criteria. 231 papers were rejected from the shortlist for the following reasons: 44 were not psychological interventions; 49 were qualitative studies; 24 were service evaluations or descriptive studies of services; 15 contained no original quantitative data and 15 were not for homeless people.

One study contained duplicate data: Gale et al. (2008) was almost identical to a study published in 2006. Therefore the earlier study was excluded.

Forty six studies were removed because they evaluated supported housing interventions with minimal or no reference to talking-based components, including the Housing First model which places homeless people straight into accommodation that is not contingent on receiving any psychological support.

There were 17 studies evaluating case-management strategies such as Access to Community Care and Effective Services and Supports (ACCESS), Critical Time Intervention (CTI) or Assertive Community Treatment (ACT) models. These are not clinical interventions and were therefore excluded unless there was explicit reference to talking-based components integrated within in these.

A further 20 studies were removed because they evaluated substance use interventions. Interventions which focused primarily on cessation of substance use were excluded, as were substance use interventions which were not exclusively for homeless people. Studies targeted primarily at mental health which included substance use as an outcome variable were included in the final review.

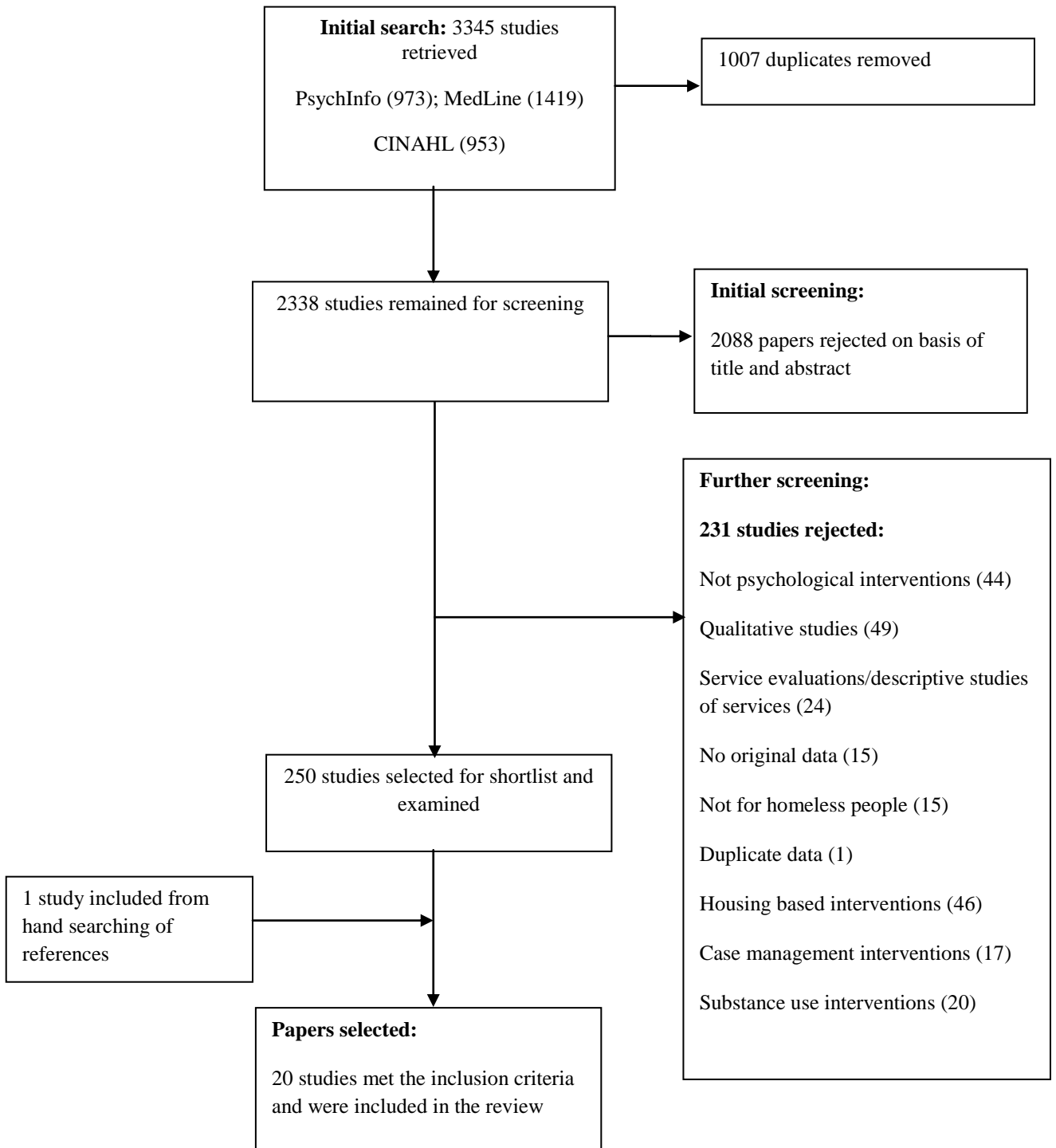
A hand search of references was carried out and one additional study was included, bringing the total number of studies included to 20. Figure 1 summarises the study selection process.

### ***Quality Ratings***

A rating tool was used to evaluate the quality of each study. Since a variety of designs were used and few were large-scale randomised controlled trials, an adapted version of Downs and Black (1998) was used which is more appropriate for practice-based research in routine settings (Cahill, Barkham, & Stiles, 2010).

This provides a 28-item checklist covering four different areas: reporting, external validity or clinical representativeness, internal reliability and internal validity or selection bias. Each item is rated 1 (yes) or 0 (no or unable to determine) with a maximum possible score of 32. Table 3 summarises the quality ratings assigned to each study.

*Figure 1: Study selection process*





## Results

The 20 studies were organised into the following categories. Since most studies used multiple outcome measures for a broad population of homeless people and all demonstrated at least some positive effects, studies were grouped according to type of intervention:

1) *Traditional psychological interventions*: (n=5): these were 1:1 or group interventions delivered in the community or outpatient settings by clinical psychologists or therapists.

2) *Supported housing settings incorporating psychological components*: (n=7): these studies evaluated supported housing projects that explicitly included psychological or talking-based interventions for residents.

3) *Therapeutic communities* (n=5): these papers described interventions based either wholly on a Therapeutic Community (TC) model or a variant adapted for this client group.

4) *Peer support* (n=3): these studies described talking-based interventions delivered by peer support workers with a history of homelessness.

Studies are summarised in Table 1. Effect sizes are reported where given. Due to the large number of different outcome measures used, the constructs measured are reported rather than the actual instrument.

Table 2 illustrates the different outcome measures used (not including measures of frequency such as hospital admissions, number of drugs used or nights spent homeless). Desai et al. (2008) and Harpaz-Rotem et al. (2011) used a "measure of self-esteem" without stating the name.

**Table 1: Descriptions of individual studies**

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
<b>Traditional psychological interventions</b>							
Ball et al. (2005)  USA	24 sessions of individual weekly therapy focused on personality disorder and substance use relapse prevention.	Dual-focus schema therapy (DFST) (Ball, 1998)	Therapist trained in DFST	RCT comparing DFST with standard group substance use counselling (SAC). Assessment at baseline, end of therapy and three month follow up.	52 homeless clients receiving services at a drop-in centre with substance use in last 30 days and screened for features of personality disorder.	Therapy retention and utilisation	Clients used DFST better than SAC (despite weekly sessions vs multiple weekly group sessions). No evidence supporting better retention for DFST with worst retention for greater Cluster C severity. Impossible to measure other outcomes because of high attrition.
Cockersell (2011)  UK	Up to 25 sessions of individual psychotherapy.	Psychodynamic therapy; Cycle of Change (Prochaska & DiClemente, 1982)	UKCP-registered psychodynamic psychotherapists	Uncontrolled trial (pilot study): Compared group of clients who received psychotherapy with those who did not. Assessment at baseline and end of therapy.	274 therapy attendees referred by hostel staff and other agencies with a range of presenting difficulties including relationship difficulties, low mood, anger and anxiety.	Wellbeing, social inclusion and progress on Cycle of Change measured using Outcomes Star	Therapy clients "three times more likely to move from pre-contemplation to action on cycle of change" than those not receiving therapy. Therapy clients "showed greatest improvement across all domains of Outcome Star". Greatest domain of improvement was meaningful occupation (42% employed or in education compared to 21% who did not attend therapy).
Desai et al. (2008)  USA	CBT intervention ('Safety Seeking') for people with comorbid trauma and substance use difficulties. Up to 25 sessions of group and individual manualised treatment.	Cognitive behaviour therapy; Safety-seeking (Najavits, 2002)	Case managers trained in model and basic counselling skills	Uncontrolled trial comparing two groups. Phase I: case management and substance use counselling; Phase II: Seeking Safety treatment. Assessment every three months for a year.	450 (359 in Phase I; 91 in Phase II) homeless female veterans with a history of trauma and substance use across 11 medical centres.	Health status including substance use, self-esteem, physical and mental wellbeing; PTSD symptoms, housing status; social support	Significant improvement over time on every outcome, regardless of phase. Phase II had better outcomes than phase I on work, social support, health status, PTSD symptoms and addiction severity. Greater overall improvement than Phase I. At follow-up, greater rates of improvement for Phase II clients in PTSD symptoms and social support.

*Table 1 Continued*

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
LePage & Garcia-Rea (2012)  USA	'Lifestyle coaching': individual sessions with psychologist to monitor behaviour recording logs and review mood. Opportunities for healthy behaviours assessed. Social reinforcement provided.	Behavioural activation, contingency management	Clinical psychologists	RCT comparing treatment as usual and non-coached alternative to coaching intervention. Assessment at start of treatment and six month follow up.	56 recently homeless veterans with diagnoses of substance dependence in early remission discharged from rehabilitation programme.	Relapse during follow-up; increase in "positive lifestyle behaviours"	Coached group spent more time abstinent than control groups. Rate of relapse significantly different between conditions with moderate effect size ( $\phi=0.41$ ) and lower in coached than non-coached group ( $\phi=0.36$ ). Coaching did not increase "healthy lifestyle behaviours" but may have reduced their decline.
Washington, et al. (2009)  USA	12 sessions of twice weekly manualised group CBT ('Life Management Enhancement') "to reduce the effects of psychological trauma attributable to homelessness."	Comprehensive Health Seeking and Coping Paradigm (CHSCP; Nyamathi, 1989)	Researcher	RCT comparing treatment group with non-LME group. Assessment at start and end of treatment and three month follow up.	76 homeless African-American women over the age of 50.	Beliefs about personal control; perceptions of benefits of social relationships; self-efficacy, self-confidence	Women in intervention group had more 'appropriate' levels of beliefs about personal control than non-LME group. Women in experimental group had higher levels of self confidence but no differences in reliance on others or ability to assert autonomy.
<b>Supported housing settings incorporating psychological components</b>							
Bradford et al. (2005)  USA	Seen in residential setting by the same psychiatrist for "supportive psychotherapy and pharmacotherapy as clinically indicated"; collaboration with social worker for goal setting and assertive follow-up.	None stated	Psychiatrist and social worker	RCT comparing consistent appointments with same clinician vs client initiative to make appointments with no systematic follow-up. Assessment at baseline and end of treatment.	102 homeless people referred to psychiatry clinic at shelter.	Mental health appointments and length of attendance; attendance at substance use treatment; housing status, employment	Intervention group more likely to attend at least one follow up appointment at secondary mental health clinic than control group particularly those with substance use problems. No significant between-group differences in attending two or three appointments but study underpowered to detect these. Non-significant improvements in housing and employment.

*Table 1 Continued*

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
Harpaz-Rotem et al. (2011)  USA	Residential treatment to address psychosocial needs of women. Provision at different sites "varied in the array of clinical and rehabilitation services available."	Not stated, although some clients received 'Safety Seeking' intervention: CBT for substance use and trauma (Najavits, 2002)	'Professional staff and peer counsellors'	Observational study comparing clinical outcomes of those who spent >30 days (RT group) to < 30 days in treatment. Assessment at baseline and three, six, nine and 12 months.	451 homeless female veterans with mental health and substance use difficulties.	Employment, use of health services, substance use, mental health, self-esteem, physical functioning, PTSD symptoms, housing, social support	RT group had more days worked at six and nine months and fewer nights homeless at three and six months; higher social support throughout; decreasing symptoms of poor mental health and (non-significant) but lower PTSD symptoms over time. However RT group had higher rates of substance use on average; alcohol use declined over time but drug use did not.
Harrison et al. (2008)  USA	Residential programme of: case management, individual counselling, group therapy, recreational therapy, vocational/ training, and medication management.	Comprehensive, Continuous Integrated Care (CCIC): integrating Seeking Safety (Najavits, 2002), 'SPARC' Co-occurring disorders manual (Moore, Matthews, Hunt & Peters, 2004), Motivation enhancement (Miller & Rollnick, 1991) ; CBT, 12-Steps, relapse prevention	Not stated	Uncontrolled observational study Assessment at baseline and six month follow-up.	76 homeless people with co-occurring mental health and substance use problems.	Substance use, housing status, mental health, treatment satisfaction	Significant improvement in housing status and employment between baseline and follow-up. Significant improvement on all mental health domains except hostility with either moderate or small effect sizes. Significant reduction in drug use from baseline to follow-up, and non-significant reduction in alcohol use. Overall reduction in number of people abstinent.

*Table 1 continued*

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
Lester et al. (2007)  USA	"Contingency management +": behavioural day programme: Phase I (two months): individual goal setting and reinforcement, counselling. Phase II (three months): weekly aftercare group sessions. Abstinent contingent housing and vocational training.	Contingency management	Not stated	Randomised controlled trial comparing CM + with standard CM (abstinence contingent housing and training only). Assessment at baseline and six month follow up.	118 Homeless clients with cocaine dependence/polysubstance use disorder (DSM defined), coexisting mental health problems and symptoms of PTSD.	Improved approach coping and lower levels of avoidance coping associated with fewer symptoms of PTSD	CM+ group reported fewer PTSD symptoms with less severity than CM group at six months. Significant reduction in avoidance over time for CM+ group with greater gains for male clients. CM+ group reported higher levels of overall coping.
Maguire (2006)  UK	Staff training in CBT; individual formulation and weekly treatment sessions with clients. Supervision and reflective practice for staff.	Cognitive behavioural therapy	Clinical psychologist	Uncontrolled trial. Assessment at entry into program and 10 week follow up	Four homeless men who had completed alcohol detoxification, were sleeping rough and had difficulty accessing hostel accommodation. All with "higher than average scores" on CORE.	Self-efficacy, alcohol dependence, functioning/risk subscales of CORE, anxiety depression. Self-efficacy and hopefulness of staff	Indicated risk reduced for all. Mixed results on functioning, self-efficacy, anxiety and depression and alcohol dependence. Incidents of theft, violence, sleeping rough reduced to zero for all except one. Significant differences in self-efficacy and hopefulness of staff between start and end.
Quinney and Richardson (2014)  UK	Pilot project of staff training and reflection in AI: Non-problem focused conversation; journaling; workshops, peer mentoring and strengths-based individual work. Rolled out and integrated into hostel delivery.	Appreciative Inquiry (Cooperrider & Whitney, 2005)	Facilitator not stated; Hostel staff	Uncontrolled observational/pilot study. Assessment at end of pilot study.	Eight residents of high support needs hostel who had been "in the homeless system for a very long time, were well known to a number of hostels and staff, and had not significantly responded to services previously."	Substance use, engagement in education or training, housing, 'future focus and emotional maturity'; 'social benefits' (cost savings)	87% reported decreased drug use; 62% engagement in education; 87% moved to lower support accommodation. 100% reported greater future focus and emotional maturity. Outcomes 'confirmed with support workers'. Reported cost saving of £14,960 from one client from reduced prison stays, arrests, curfew monitoring and unsuccessful detoxes.

*Table 1 continued*

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
Smelson et al. (2013)  USA	'MISSION': 12 month manualised intervention: mental health and substance use treatment, Critical Time Intervention case management, peer support and vocational support.	Dual Recovery Therapy (Ziedonis & Stern, 2001), assertive community treatment using Critical Time Intervention; (Susser et al., 1997).	Case managers and peer specialist team	Quasi-experimental design comparing MISSION with treatment as usual (housing and general psychosocial support). Assessment at baseline, six months and 12 months.	333 homeless veterans with a DSM diagnosis of substance abuse disorder and co-occurring mental health problems (excluding diagnoses of schizophrenia and bipolar disorder).	Treatment engagement, hospitalisation, substance use and addiction severity	MISSION group had greater reduction in number of days hospitalised and more contact with services at 12 months compared to no change in TAU group. Significant reductions in the employment, alcohol, drug, legal and psychiatric domains from baseline to 12-month follow-up in both groups but no other significant differences between groups.
<b>Therapeutic Communities</b>							
De Leon et al. (2000)  USA	Comparison of two 12 month therapeutic community programmes (low intensity TC2, moderate intensity TC1) and treatment as usual.	Modified Therapeutic Community. Adaptations included: "greater flexibility, less intensity, greater individualisation".	"A not-for-profit agency specialising in the residential rehabilitation of severely and persistently mentally ill clients"	Controlled trial with sequential allocation. Assessment at baseline, 12 months and last follow-up contact available for each client.	342 homeless clients with Axis I diagnosis and additional substance use or dependency diagnosis.	Substance use, levels of criminal activity, HIV risk behaviour, psychological functioning, prosocial behaviour	Two TC groups had significant findings on greater number of outcomes than TAU group (although some may be explained by larger sizes of two TC groups). All groups showed improvements at final follow up but TC2 had largest and most consistent changes. Those who completed TC programme had better outcomes than those who dropped out and TAU clients who received other services of similar intensity.
Egelko et al. (2002)  USA	Abstinence-based six month therapeutic community programme in a "half-way house" after hospital treatment.	Modified Therapeutic Community model (see above)	"Mental health professionals and para-professionals with special training"	Longitudinal observational study. Assessment at baseline, three months and a subset at six months.	131 Homeless men with substance dependence and mental health problems.	Psychological functioning and symptoms	Significant improvements from baseline to three months on depression, anxiety, self-concept and symptoms of psychological distress. 34 of 52 clients evaluated at T1 and T2 still in treatment at six months and showed significant improvement on majority of dimensions of psychological functioning.

*Table 1 continued*

<b>Author, date and country</b>	<b>Intervention</b>	<b>Theoretical underpinnings</b>	<b>Therapist</b>	<b>Design</b>	<b>Sample</b>	<b>Outcome variables</b>	<b>Main findings</b>
Gale et al. (2008)  UK	"Home Base": dispersed therapeutic community for military veterans. Weekly individual and group psychotherapy sessions; employment and training activities; horticultural therapy.	Therapeutic Community (Kennard, 2004); mutual self-help. "Psychoanalytic perspective in the treatment of homelessness"; also integrating CBT.	Psychologists and psychotherapists	Uncontrolled trial: case study of development of the project and outcomes over three years.	20 clients started treatment over the three years with a range of mental health and substance use problems.	Successful treatment completion, training and employment	During 12 month period, 16 clients successfully moved on and 13 were "successful endings" moving to permanent accommodation. Over three years 74% of clients entered employment.
McCracken and Black. (2005)  USA	Therapeutic community including multiple elements: group interventions and community tasks plus adaptations (health care services, relapse prevention and 12-step groups).	Therapeutic Community based on Haigh (1999)	Social worker, vocational coordinator, 'chemical dependency counsellor' psychology interns, psychiatrist, clinical consultants	Naturalistic outcomes study. Assessment at baseline, six weeks, three months and six months.	37 residents	Psychiatric symptomatology, substance use, interpersonal and social functioning	Significant improvement between baseline and six weeks on measures of general distress but gains lost at follow up. Decrease in substance use from baseline to six weeks but none subsequently. Alcohol use decreased over longer-term. Improvement in interpersonal and social functioning overall from baseline to six months.
Sacks et al. (2003)  USA	12 month "TC-orientated" aftercare program to facilitate transition to independent living: including therapeutic and psychoeducation classes and groups, vocational training.	Modified Therapeutic Community model (see above)	Counsellors and mental health professionals	Non-randomised trial: Comparison of those taking part in TC aftercare to those moving straight into community. Assessment at baseline, 12 months and 24 month follow up.	115 "mentally ill" homeless people with substance use problems who had completed a TC programme.	Substance use, criminal activity, HIV risk behaviour, psychological functioning, prosocial behaviour	Significant overall positive gains for TC group on 13/14 outcomes across all time points (compared to four for control group). Gains made at baseline to 12 months and then stabilisation to 24 months in 'antisocial behaviour' and drug use. Psychological functioning and prosocial behaviour gain were linear. Symptoms of psychological distress showed no change over time.

*Table 1 continued*

Author, date and country	Intervention	Theoretical underpinnings	Therapist	Design	Sample	Outcome variables	Main findings
<b>Peer Support Interventions</b>							
Eisen et al. (2015)  USA	Therapeutic benefits of providing peer support. Comparison of 'Vocational rehabilitation (VR) specialists' and 'peer specialist' roles.	Peer support; "helper therapy principle" (Riessman, 1965)	Peer support specialists working under supervision	Uncontrolled observational study: comparing job roles and outcomes for VR and peer support specialists.	152 peer specialists and 222 vocational rehabilitation specialists across 138 veteran health care sites "with a history or risk of homelessness". Internet administered survey.	Overall mental health, general self-efficacy, work-related quality of life and helping-related quality of life.	Both roles had high levels of job satisfaction, mental health and both work-related and helping-related quality of life with few differences between groups. Peer support specialists more likely to share stories of recovery, mentor and advocate. Satisfaction with supervision related to work and helping related quality of life.
Tsai and Rosenheck (2012)  USA	Group Intensive Peer Support (GIPS) in supported housing. Weekly meetings with peer supporters: clients at different stages of housing acquisition and recovery advice, inform, and provide emotional support to each other.	GIPS: peer support and active client participation	Case manager as facilitator and clients as peer supporters	Pre-post non-equivalent groups: Comparing outcomes for clients before and after GIPs implemented at demonstration site and nationally. Assessment over two years pre-GIPs and one year afterwards.	269 homeless people with mental health and substance use problems (at GIPS demonstration site) compared to 30,977 (data obtained nationally)	Housing status, employment, mental health/clinical outcomes including quality of life, substance use and functioning, contact with case managers.	Clients in GIPS showed greater increase in quality of life scores than clients at other sites. No differences related to housing, employment or clinical outcomes. After GIPS implementation, case manager activities greater at demonstration site. Clients at GIPS demonstration site took longer to be admitted to the programme than other sites, but obtained housing more quickly.
Weissman, et al. (2005)  USA	12 month peer support intervention: peers acting as 1:1 mentors, encouraging socialisation and taking part in self-help groups.	None stated	Peer advisors who had received training and supervision	Randomised trial. Comparison of peer support intervention to usual case management. Assessment at baseline, four, eight and 12 months.	32 homeless male veterans with mental health and substance use problems	Employment, housing status, quality of life, social inclusion and acceptance	High attrition in control group - only data from study group analysed. Three (23%) employed at baseline and nine (69%) employed follow-up. No individuals lived independently at baseline, six (46%) did so at follow-up. Clients with peer advisors had 'modest improvement' in quality of life. No change for social inclusion or acceptance.



**Table 2: Summary of measures used**

<b>Name of Measure</b>	<b>Type</b>	<b>Construct Measured</b>	<b>Number of uses</b>
Addiction Severity Index (ASI)	Structured interview	Addiction-related impairment	5
Alcohol Use Scale (AUS)	Clinician observed	Scale based on <i>DSM-III-R</i> criteria for severity of disorder	1
Beck Depression Inventory (BDI)	Self-report	Depression	3
Behaviour and Symptom Identification Scale (Basis-24)	Self-report	Multidimensional mental health assessment	1
Belief in Personal Control Scale (BPC)	Self-report	Locus of control	1
Brief Symptom Inventory (BSI)	Self-report	Inventory of psychological problems	2
COPE (Brief version)	Self-report	Coping processes	1
Clinical Outcomes in Routine Evaluation (CORE)	Self-report	Subjective wellbeing, symptoms, functioning, risk	1
Drug Use Scale (DUS)	Clinician observed	Scale based on <i>DSM-III-R</i> criteria for severity of disorder	1
Early Maladaptive Schema Questionnaire-Research (EMSQ-R)	Self-report	Early maladaptive schemas	1
Generalised Self-efficacy Scale (GSE)	Self-report	Perceived self-efficacy	2
Global Assessment of Functioning (GAF)	Clinician report	Continuum measure of psychological, social, and occupational functioning	1
Heinrichs Carpenter Quality of Life Scale	Semi-structured interview	'Deficit symptoms in schizophrenia'	1
Hopkins Symptom Checklist (HSCL-25)	Self-report	Anxiety and depression	1
Housing Stability and Satisfaction Scale	Self-report	Housing satisfaction	1

*Table 2 continued*

<b>Name of Measure</b>	<b>Type</b>	<b>Construct Measured</b>	<b>Number of uses</b>
PTSD Checklist (PCL-5)	Self-report	PTSD symptoms and severity	2
Post-traumatic Diagnostic Scale (PDS)	Self-report	PTSD symptoms and severity	1
Quality of Life Interview (QoLI)	Self-report	Subjective and objective quality of life for people with mental health problems	1
Quality of Life Inventory (QOLI)	Self-report	Importance and satisfaction in 16 life domains	1
Short Alcohol Dependence Data (SADD)	Self-report	Measure of alcohol dependence	1
Short-Form Survey (SF-12)	Self-report	Physical and mental functioning	2
Shortened Manifest Anxiety Scale (SMAS)	Self-report	Anxiety	3
Stigmatization Scale	Self-report	Personal experience of stigma	1
Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (SCID)	Structured interview	DSM-IV psychiatric diagnoses including substance use disorder	3
Substance Abuse Subtle Screening Inventory, Third Edition (SASSI-3)	Self-report	Identifies individuals who have a high probability of having a substance dependence disorder	1
Symptom Checklist Revised short version (SCL-30-R) or full version (SCL-90-R)	Self-report	Psychological difficulties	5
Tennessee Self-Concept Sub-Scale (TSCS)	Self-report	Self-esteem	2
Wellbeing Impact Assessment Measure	Assessment 'toolkit'	Social determinants of mental health	1
Work Limitations Questionnaire (WLQ)	Self-report	Extent of health impact on job performance	1

*Table 3: Quality ratings for studies*

<b>Study</b>	<b>Reporting (Maximum m = 11)</b>	<b>External validity (Maximum m = 11)</b>	<b>Internal reliability (Maximum = 5)</b>	<b>Internal validity (Maximum = 5)</b>	<b>Total score (Maximum 32)</b>
<b>Traditional Interventions</b>					
Ball et al. (2005)	11	9	4	3	<b>27</b>
Cockersell, (2011)	3	9	1	0	<b>13</b>
Desai et al. (2008)	9	8	4	3	<b>24</b>
LePage & Garcia-Rea (2012)	8	9	5	4	<b>26</b>
Washington et al. (2009)	10	5	4	5	<b>24</b>
<b>Interventions embedded in supported housing</b>					
Bradford et al. (2005)	9	9	3	4	<b>25</b>
Maguire, (2006)	4	7	2	1	<b>14</b>
Harpaz-Rotem et al. (2009)	10	7	4	5	<b>26</b>
Harrison et al. (2008)	7	9	3	1	<b>20</b>
Lester et al. (2007)	9	6	4	5	<b>24</b>
Quinney and Richardson (2014)	3	4	2	0	<b>9</b>
Smelson et al. (2013)	9	6	3	5	<b>23</b>
<b>Therapeutic Communities</b>					
De Leon, Sacks, Staines, & McKendrick, (2000)	10	8	4	5	<b>27</b>
Egelko et al. (2002)	8	9	3	3	<b>23</b>
Gale et al. (2008)	6	8	0	0	<b>14</b>
McCracken and Black (2005)	3	6	3	1	<b>13</b>
Sacks et al. (2003)	10	8	4	5	<b>27</b>
<b>Peer support Interventions</b>					
Eisen et al.(2015)	10	10	3	5	<b>28</b>
Tsai & Rosenheck (2012)	9	9	4	3	<b>25</b>
Weissman et al. (2005)	6	9	3	2	<b>20</b>
<b>Mean Score (range)</b>	<b>7.7 (3-11)</b>	<b>7.8 (4-10)</b>	<b>3.2 (0-5)</b>	<b>3.0 (0-5)</b>	<b>21.6 (9-28)</b>

The overall quality of studies was moderate. Eight out of the 20 studies scored 25 points or over and five scored 15 or under. Studies which scored poorly tended to do so more because of lack of necessary detail (or reporting of such) than methodological errors.

### ***Reporting***

The majority of studies scored most highly in the domain of reporting. However, no studies reported measures of clinical significance as opposed to statistical significance, making it difficult to judge whether the outcomes were clinically meaningful. Very few studies reported effect sizes except Harrison et al. (2008) and LePage & Garcia-Rea (2012), making it difficult to ascertain the magnitude of reported significant differences. Most studies reported the specifics of their interventions in detail and some reported the rationale for their model (e.g. Cockersell, 2011; Gale et al., 2008; Washington et al., 2009). However some provided only very sketchy details (e.g. Bradford et al., 2005) making them virtually impossible to replicate. Some studies also described the outcomes in very little detail (e.g. Mccracken & Black, 2005). Characteristics of clients lost to follow up were also poorly reported.

### ***External validity***

Criteria for clinical representativeness of samples were generally met, with all studies carried out in non-university settings and facilities representative of treatment received by the majority of clients. Groups of clients were highly heterogeneous in terms of personal characteristics and presenting problems as would be expected in practice-based settings. Whilst most studies reported their sampling strategies, many did not state how many people chose to take part and therefore potentially how representative their sample was. Some studies targeted specific groups, in particular veterans, again having an impact on representativeness. There are also three specialist interventions for women who make up only a small proportion of the homeless population.

### ***Internal reliability***

The majority of statistical tests used were appropriate. However, some studies carried out several tests and did not report adjustment for multiple comparisons (e.g.

Harrison et al., 2008) and some studies with very small sample sizes carried out little or no statistical testing and presented only descriptive statistics. All of the studies used well validated measures (with the exception of one novel measure in Maguire (2006)) and most reported on the reliability and validity of measures used. However some studies were not able to report on aspects of mental wellbeing as a primary measure and only reported on service uptake or use of treatment. There was a tendency towards using self-report measures with surprisingly little consideration of participants' literacy or other potential biases of relying on self-report. A number of studies (e.g. Desai et al., 2008; Harpaz-Rotem et al., 2011) evaluated interventions across varying sites with significant variability in the programmes being provided which is likely to have had an effect on the consistency of application of the intervention.

### ***Internal validity***

Only De Leon et al. (2000) and Bradford et al. (2005) reported carrying out a power calculation prior to statistical analysis. Several studies reported the possibility of being underpowered in the discussion. Post-hoc power calculations were carried out on studies that gave sufficient data to do so (estimating a medium effect size and 80% power). Four studies did not carry out any statistical analysis. Of the remaining 16, five were underpowered. Some studies which started with large samples had significantly reduced follow-up rates - for example the completion rate in the programme described by Egelko et al. (2002) was only 35% and Desai et al. (2008) report follow-up rates at 12 months as 27-53%. Such a large reduction in sample size in longitudinal designs means they were unlikely to be sufficiently powered beyond baseline or the first time comparison to detect significant differences between groups.

### ***Traditional Psychological Interventions***

Five of the studies evaluated traditional psychological interventions: group or individual therapeutic approaches in outpatient or non-residential settings.

A significant range of interventions were used. Four studies evaluated individual psychotherapy, one used a group approach and one had a flexible group or individual

approach across different settings. Most studies used different theoretical orientations: 'Lifestyle coaching', psychodynamic therapy, dual-focused schema therapy and two different manualised CBT interventions. Multiple different outcome measures were used, ranging from measurement of symptoms to more concrete outcomes such as entry into employment or occupation, making meaningful comparison between the studies difficult. The variability in approaches and differing given rationales for their use supports the idea that there does not seem to be a coherent or unified view on what might work best for this client group in terms of individual therapeutic approaches.

Three studies were randomised controlled trials and two were uncontrolled observational studies. All studies demonstrated some improvement on at least one measure. Some interventions were targeted at specific groups, such as older African-American women (Washington et al., 2009) or female veterans (Desai et al., 2008), so their generalisability to other populations is debateable. With the exception of Cockersell (2011) which was a pilot study, all the studies had moderate to high quality ratings.

The experience, training and supervision of therapists delivering each intervention was variable across the groups. For example the psychotherapists in Cockersell (2011) are described as registered UKCP psychotherapists with "considerable post qualification experience" (p.93) supported by two supervisors. The therapist delivering DFST in Ball et al. (2005) received advanced training, ongoing supervision and already worked part-time delivering schema therapy and those delivering Le Page et al.'s intervention were qualified clinical psychologists. Desai et al. (2008), on the other hand, described the group facilitators as case managers with no prior experience of delivering CBT interventions and discuss the time and challenges involved in training workers to deliver the intervention.

Fidelity to model and the quality of the intervention in manualised interventions may also vary. Studies such as Washington et al. (2009) did not give details about the experience of their group therapist and merely state that they followed the group plan and manual for the intervention without any monitoring of quality.

Whilst retention in treatment was reported to be good in Cockersell (2011) and Washington et al. (2009), both Ball et al. (2005) and Desai et al. (2008) described high levels of participant attrition. Due to the transient nature of the client group, it is difficult to follow up those who dropped out of treatment. Nevertheless, having more information about the characteristics of those failing to complete treatment and their reasons for disengaging would allow better judgements to be made about whether the effects are generalisable and whether the treatments are acceptable to those at whom they are aimed.

Cycle of Change theory (Prochanska and DiClemente, 1983), a transtheoretical model of behaviour change, was used by Cockersell (2011) as part of the outcome measures in terms of client movement from one stage to another. Whilst this is an intuitive and popular model which is widely used in addiction settings, the strength of the evidence underlying it has been questioned (Whitelaw, 2000).

#### ***Supported housing settings integrating psychological components***

Seven studies evaluated psychological interventions integrated into supported housing or treatment settings. Again these used a wide range of interventions of varying intensity and different outcome measurements. All studies reported positive change on at least one outcome. Bradford et al. (2005) compared the effect of consistent and intensive appointments with helping professionals in a shelter environment to a client-led approach to seeking help. Harpaz-Rotem et al. (2011) described residential treatment to address the needs of homeless women. Harrison et al. (2008) and Smelson et al. (2013) described similar residential programmes including case management, peer support, vocational training and both group and individual therapy in the former. Lester et al. (2007) used a contingency management intervention specifically targeted at clients with substance use and post-traumatic stress disorder. Maguire (2006) evaluated an integration of staff training and reflection and individual therapy sessions within a small hostel. Quinney and Richardson (2014) described piloting a new model of "appreciative inquiry" through a number of modes in a hostel setting.

With the exception of two randomised controlled trials (Bradford et al., 2005 and Lester et al., 2007) and one quasi-experimental design (Smelson et al., 2013), all of the papers reported uncontrolled observational studies. Maguire (2006) and Quinney and Richardson (2014) both described small-scale pilot projects with four and eight participants respectively, with the intention of rolling these out to larger scale and more in-depth research at a later date.

Both Maguire (2006) and Quinney and Richardson (2014) reported the role of training, support and reflection provided to staff as part of the implementation of the intervention. Although Quinney provides minimal detail about how this was done, it highlights the potential role for psychologists in terms of consultation and systemic intervention in organisations as well as the provision of 1:1 therapy (also discussed in Maguire, 2012).

Despite the practical benefits of having psychological therapy components integrated into supported housing, for the purposes of evaluation it is difficult to pick apart the outcomes of the intervention from other potentially confounding factors in the environment such as the general quality of staff support, supportive relationships between clients or the quality of the environment, all of which may contribute to recovery in different ways (Moos, 1997). This is particularly the case with the four studies which were uncontrolled and therefore unable to demonstrate that change was not due to extraneous factors.

### ***Therapeutic Communities***

Five studies evaluated interventions based on the Therapeutic Community (TC) model: that is, a group-based residential intervention in which living in the community is considered a therapeutic intervention in itself. Group and individual psychotherapeutic treatment is usually integrated into the stay (Kennard, 2004).

Whilst adhering to the general philosophy and principles of the TC, four of the five studies adapted the TC model to meet the needs of this client group. McCracken and Black (2005) adhered most closely to the original TC model as described by Haigh (1999). Gale et



al. (2008) described a 'dispersed' TC made up of individual flats rather than group living specifically designed for the needs of ex-services personnel, in particular integrating vocational training as well as psychotherapy. De Leon et al. (2000), Egelko et al., (2002) and Sacks et al., (2003) all use similar adaptations (The 'modified MICA TC approach') designed during the 1990s. This operates more flexibly and at a lower intensity, which is better suited to the needs and ability to participate of clients with complex needs and substance use problems.

Two of the studies (Gale et al., (2008) and McCracken and Black, (2005)) were naturalistic observational studies which reported progress of residents from baseline over time. As well as the limitations of a single-group design, both were of noticeably lower quality to other studies, failing to report in detail any outcome data. Both also failed to report in any detail negative findings or those who did not complete the programme.

Egelko et al. (2002) also used a longitudinal design but with a more robust framework and set of outcome measures. Sacks et al. (2003) and De Leon et al. (2000) were the only two studies that used comparison or treatment as usual control groups, with both showing significant change over time for those taking part in the TC programme on a number of measures of psychological functioning.

Gale et al. (2008) gave some detail about what constituted "successful outcomes" for community residents, such as "ability to maintain a functional civilian life; consolidated social skills and social networks" (p.124) but did not report fully on which residents met all of these criteria. The other studies reported outcomes in more detail. Both Sacks et al. (2003) and McCracken and Black (2005). demonstrated significant changes from baseline to Time 1 on a variety of measures but no subsequent gains or stabilisation suggesting an initial 'flight to health' effect with potentially fewer long-term effects. The only controlled trial (De Leon et al., 2000) suggested that the greater the modification of the TC intensity, the more successful the outcomes, suggesting a less intensive TC model than standard would be appropriate for this client group.

As with evaluating psychological components embedded into supported housing, there are again inherent difficulties in being able to evaluate the TC model. Whilst it is possible to measure outcomes in various domains, the very nature of the TC being complex and multi-faceted with a heterogenous client and staff group means that it is difficult to tease apart the different elements and know which are most helpful or effective. The nature of TCs may also mean there is an element of self-selection in those taking part in treatment. Lees, Manning, & Rawlings (2004) point out that an emphasis on robust research and evaluation has only been adopted relatively recently by TCs in a climate where it is now necessary to prove the effectiveness of a treatment model in order to secure funding.

### ***Peer Support Interventions***

Three studies evaluated talking-based peer support interventions. These were either groups of peers supporting each other or people with a history of homelessness formally employed as peer support specialists. Tsai and Rosenheck (2012) evaluated the Group Intensive Peer Support (GIPS) programme consisting of weekly meetings with clients at different stages of housing acquisition and recovery advising and supporting each other. Weissman et al. (2005) and Eisen et al. (2015) described programmes where peer supporters are employed. Whilst the former two studies evaluated the effects of peer support on recipients, the latter evaluates the effects of being employed in this role on the peer supporters themselves.

Whilst Weissman et al. (2005) employed the strongest design using a randomised controlled trial, the high attrition rate in their control group left only a very small sample available at follow up. The final study lacked power and the researchers were only able to analyse the data from the intervention group. Both Eisen et al. (2015) and Tsai and Rosenheck (2012) used large data-sets collected nationally, giving them sufficient power. However in both cases their participants were spread over multiple sites and regions, making it unlikely that there was consistency across the interventions and therefore a meaningful set of comparisons. Tsai and Rosenheck (2012) used a pre-post implementation design comparing the GIPS demonstration site to national administrative data collected at other

sites making the groups non-equivalent. Although they controlled for differences between groups using regression analysis, using such a large amount of data meant that some factors, such as staff changes were beyond their control.

Eisen et al. (2015) was the only study which used the 'helper' therapy principle: the idea that helping others can equally, if not to a greater extent, benefit the helper's psychological wellbeing as well as that of the person receiving help. They reported both peer specialists and vocational rehabilitation specialists had low levels of mental health problems compared to other veteran samples and that quality of life scores were substantially higher than comparable clinical samples. There were significant weaknesses in the study design since it was uncontrolled and did not capture change over time in improvement of participants' mental health difficulties. However, the idea implicit in all three studies that mutual help can benefit both the giver and recipient of help has already been established with other client groups and in other settings, such as mutual self-help substance use groups and peer-led mental health services (Solomon, 2004). The service-user led group Groundswell identified peer support as one of the critical factors in exiting homelessness (Groundswell, 2007) and this principle merits further study within this population. Both Weissman et al. (2015) and Eisen et al. (2005) note that peer support is a complex task for the helper and benefits can be contingent upon sufficient and good quality supervision.

## **Discussion**

The 20 studies in this review evaluated a range of interventions with a wide array of outcomes, based on different theoretical positions. Studies were grouped into four categories based on the context of the intervention: traditional 1:1 or group interventions in outpatient settings, psychological interventions embedded in a supported housing setting, therapeutic communities (or adaptations thereof) and peer support interventions. All of the studies were carried out in representative clinical settings using heterogenous samples representative of the homeless population. All of the studies reported a positive outcome on at least one

measure. No studies reported any overall negative effects. However the weaknesses of several studies, in particular the high attrition rate and subsequent impact on statistical power mean that many of these results should be viewed with caution.

The plethora of models and outcome measures used in the different interventions, as well as the different rationales for providing these, emphasise the point made by Maguire (2015a) and Elliot and Taylor (2012) that there is both little available evidence about which models, if any, are particularly appropriate to the needs of homeless people and little agreement about which outcomes should be used to measure success or otherwise of such interventions. Peer-led research also demonstrates how what is measured by researchers or professionals may be at odds with what is considered 'success' by homeless people themselves (Groundswell, 2007; Terry, 2015). With the exception of Quinney (2014) there was little evidence that consideration had been given to client perspectives of meaningful outcomes. Therefore identifying both what construct to measure and how to quantify or compare change across interventions is particularly problematic. Pauly et al. (2012) found a similarly large number of outcome indicators in their review of policy-level strategies addressing homelessness and this confused and fragmented picture was similar to the experience of Brown et al. (2011) when searching for literature prior to piloting a psychotherapy project for homeless people.

Few studies, with the exception of Cockersell (2011), McCracken and Black (2005) and Ball et al. (2005) discussed the impact of early trauma on the attachment needs of homeless people and how this influenced their chosen intervention. The majority of studies moved straight to testing a therapy 'brand'. Seager (2013) argues that therapy brands and dose-response measurements are meaningless without considering people's fundamental psychological needs such as secure, trusting relationships, safety and belonging. Similarly, Silverman (1996) argues that therapy techniques are 'painting by numbers' when the bulk of change can be accounted for by the therapeutic relationship. This reflects Rogerian theory that psychological growth occurs in the context of a relationship characterised by empathy, genuineness and unconditional positive regard (Rogers, 1957). Few studies gave

consideration to the therapeutic relationship or these 'non-specific factors' as the primary means through which psychological and attachment needs could be met (Asay & Lambert, 1999).

Several studies were small scale feasibility or pilot studies (Cockersell, 2011; Maguire, 2006; Quinney & Richardson, 2014) which produced promising results. However these were not set up as full-scale research projects and the authors hoped to collect additional data at a later stage. As Maguire (2015a) and Gaetz (2014) suggest, there has been a gap between homeless services in the voluntary sector set up to meet the needs of clients and organisations that are better resourced and equipped for outcome-driven evaluation and larger-scale research. This issue of quality in homelessness research has been recognised for some time (Fitzpatrick, Kemp, & Klinker, 2000). Having independent researchers carry out such studies in partnership with the voluntary sector would reduce the risk of accusations of bias, since staff evaluating their own service may have a vested interest in successful outcomes. This is a service that is now being explored in Canada (Gaetz, 2014) and UK-based organisations are also beginning to offer resources on evidence based research (Breckon, 2016). The 'Housing First' model was excluded from this review because it does not have mandatory talking-based components. Nevertheless it was established as a community psychology intervention and has been subject to numerous evaluations and randomised trials (e.g. Goering et al., 2011; Kirst, Zerger, Misir, Hwang, & Stergiopoulos, 2015), demonstrating that outcome research can be carried out and followed up with this client group if a culture of research is established.

The 'Modified Therapeutic Community' model (De Leon et al., 2000; Egelko et al., 2002; Sacks et al., 2003) is the only intervention which has received sustained attention and replication (e.g. Sacks, McKendrick, Sacks, & McClelland, 2010). Whilst there is evidence in the 'grey literature' that further work and replications are being carried out on other interventions (e.g. Maguire, 2015b), these have not yet been published in peer-reviewed form which would lend greater credibility.

The context of services in the UK and the US, where the majority of studies were carried out, is very different. Whilst in the UK all residents are entitled to free healthcare at the point of access, making entry at least in theory more equitable, services in the US rely on health insurance or subsidies. The ability to engage with services is therefore likely to differ between the two contexts. In addition, the bulk of US research is focused on homeless veterans, largely because of the overrepresentation of veterans in the US homeless population, the increase in funding in recent years to end homelessness in this group and the more comprehensive veteran-specific services provided by the Veterans' Administration (Perl, 2014). In contrast, only a small proportion of the homeless population in the UK are reported to be military veterans (9% in total with 3% in the British Armed Forces (Greater London Authority, 2015)). The generalisability of these studies is therefore questionable both in terms of health service context and client group.

Most studies reported inevitably large drop-out rates, given that it can be challenging to follow up participants with transient or chaotic lifestyles. The studies which were aimed at the most challenging groups in this respect (e.g. Ball et al., 2005) suffered the most from attrition and difficulty in follow up, making their final samples less viable than would otherwise be expected and the researchers unable to measure more outcomes than use of therapy and retention rates. The inability to follow up those people who dropped out of treatment means that we have very little information about what factors contributed to this and to make a judgement about the acceptability of treatment to participants. It is therefore difficult to know what, if anything, could be adapted to make the various interventions more effective in this respect. In addition to this, long-term follow up after treatment completion was very limited or not possible in most studies, making it impossible to know if any gains made during treatment were sustained or to assume that those who dropped out made no gains at all. Johnson (2013) points out that therapy gains may not be linear since many people with complex needs go through several cycles of lapse and relapse as well as repeated attempts to form trusting relationships with therapists before reaching long-term change. Similarly, the transition from homelessness to 'housed' is often neither

straightforward nor linear and successful long-term outcomes are not always guaranteed even when housing status, used as an outcome measure, objectively improves (Busch-Geertsema, 2005). This suggests further complicating factors in being able to make reliable measurements of outcomes with this population.

A noticeable lack of studies apart from LePage & Garcia-Rea (2012) and Maguire (2006) were implemented by clinical psychologists. Gale et al. (2008) and Cockersell (2011) were delivered by psychotherapists. The majority of studies relied on the training of staff to deliver manualised interventions. Whilst clinical psychologists are well placed to act in a consultative role to train and reflect with staff on their interventions (e.g. Maguire, 2006), there was little evidence of individually tailored formulation-based approaches which may be appropriate for clients with this level of complexity. On the other hand, however, the need to deliver interventions 'at scale' is also relevant, providing that staff have the sufficient level of training and ongoing support which was reported to be difficult in some cases (e.g. Harpaz-Rotem et al., 2011).

Pauly, Wallace, & Perkin (2014) point out the complexities of evaluating interventions for homeless people and the risks of only using outcome measures focused on individual change. They suggest using methodological approaches which are better able to capture the context in which the intervention is being delivered. For example, the social and economic context and its influence on the availability and affordability of housing should be considered where housing status is a relevant outcome. This may impact both on how successes are measured but also the transferability of interventions to other settings. It also avoids blaming programmes or individuals for what might be wider systemic or social and political issues (Brown et al., 2011). They suggest instead 'realist' pragmatic approaches to collecting evidence such as multiple case-study designs. Whilst these are subject to their own limitations such as small sample sizes, they may add further to the evidence base.

### ***Limitations of review***

The current review only analysed studies with quantitative results. A large number of papers were excluded because they were qualitative studies, although these also described

promising interventions with this client group. Similarly, some promising interventions in non-peer reviewed literature were excluded. A more extensive review such as a narrative synthesis of qualitative results could further enrich the available evidence and as suggested above provide greater detail into the context of the delivery of interventions.

Whilst the quality ratings scale used gave some indication of the relative strengths and weaknesses in study quality, it is a somewhat blunt tool without an agreed cut-off point for what constitutes 'good enough' research. There is therefore a risk that the results of promising studies which may not have been sufficiently well-resourced to implement a more sound methodology could be neglected.

### ***Research implications***

Research carried out in the most naturalistic settings, particularly in the voluntary sector, appeared to be the least well resourced to provide a robust methodology and good quality outcomes, which is readily acknowledged by some authors. This is unfortunate given the promising nature of some of the interventions described. Enabling such organisations to have support or consultation from external organisations could make this research much more robust and potentially strengthen the evidence base further, lending more credibility to the possibility of mental health services tailored specifically for homeless people. This could include building on and replicating studies described as pilots (Cockersell, 2011; Maguire, 2006; Quinney and Richardson, 2014) with stronger designs including the use of control groups and sufficiently powered samples. In addition, consistent follow-up studies on the use of different models (e.g. the CBT interventions in supported housing) would help ascertain whether there is a greater long-term benefit of one particular model and aid comparison between services and approaches.

There is little evidence of any consultation with clients about personally meaningful outcomes. Instead there has been a plethora of different interventions with multiple different outcomes. Making sure that future research measures outcomes which are meaningful to recipients would be beneficial.



### *Clinical implications*

The review provided evidence that psychological interventions for homeless people with mental health problems may have a range of benefits over different outcomes. There was no evidence reported of any harm or adverse effects related to such interventions. However some studies were subject to issues of poor quality and should be treated with caution.

The literature provides evidence that despite drop-out rates, homeless people can and will engage with the provision of psychological therapies despite being excluded from many mainstream services. Psychological interventions can be provided in a variety of formats including traditional 1:1 or group psychotherapy, being embedded within housing or being delivered by peer specialists. Nevertheless, there is little evidence of the strength of one approach or model over another with little follow-up evidence available to replicate or further explore this.

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## **Part 2: Empirical Paper**

### **"Living here has changed me": Resident and staff perceptions of Psychologically Informed Environments for homeless people**

*"Living here has definitely changed me. I'm actually starting to be glad that I'm here, not wanting to be dead" (Resident)*

## **Abstract**

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

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

**Results:** The analysis generated 18 themes which were organised into five domains: what makes a home, resident needs, managing relationships, reflective practice and theory vs practice of PIEs.

**Conclusions:** The study suggests that PIEs are broadly meeting their aim in providing a different type of environment from standard hostels. Efforts to build relationships with residents are particularly prioritised. This work can be challenging for staff and reflective practice groups provide a supportive forum. There are limits to the extent to which the theoretical PIE can be put into practice in the current political and economic climate.

## Introduction

Hostel accommodation is one of the oldest forms of institution for homeless people. As industrialisation and migration to urban areas increased in the 19th century, the need grew for accommodation to replace the workhouse (Busch-Geertsema & Sahlin, 2007). The nature and purpose of hostels developed in the latter part of the last century from places designed to meet only the most basic needs of physical shelter to improved environments which now support people with difficulties such as mental health and substance use problems and help people move on into independent accommodation (Warnes, Crane, & Foley, 2005).

Levels of need are much higher in the homeless than housed population in mental health, physical health and substance use (Fazel et al., 2014, 2008). The prevalence of early adverse experiences and consequent attachment difficulties have been linked to a range of mental health problems and particularly to people meeting criteria for a diagnosis of personality disorder (Bramley et al., 2015; Campbell, 2006). Chronic homelessness is therefore more than a social or economic issue and any proposed intervention needs to consist of more than just the provision of housing (Cockersell, 2012); hence drives to 'end homelessness' have usually proved futile (BBC, 2008; Taylor, 2016).

Seager (2011a) and Scanlon and Adlam (2006, 2012) have discussed the 'unhoused mind': how many homeless people lack any concept of home as a safe place, something usually developed through early attachment and family relationships. This often results in a 'psychological homelessness' expressed through alienation, exclusion, self-neglect, lacking a sense of self-value and mistrust of others. With these issues unaddressed, homeless people can find it difficult to transition to and sustain a housed state both physically and psychologically. This can lead to frequent patterns of eviction and abandonment, or despite frequent offers being made, rejection of housing altogether (Teixeira, 2010).

As discussed in Part 1, whilst homeless people can and will engage in psychological interventions, there are often structural barriers to their ability to do so, such as requirements to attend regular appointments at a fixed location. There is also little agreement about which

psychological interventions might be most appropriate and acceptable for this group of people, with a large range of therapies tried but few applied and evaluated consistently.

### ***Psychologically Informed Environments***

'Psychologically Informed Environments' (PIEs) have been proposed as an additional method of intervention. They are neither a therapeutic technique nor the provision of physical shelter alone. Instead they are an attempt to meet the fundamental needs of residents by providing psychological safety and security and rebuilding damaged attachment relationships through the provision of a professional home and family.

Johnson and Haigh first proposed the concept in a series of papers (Johnson & Haigh, 2010, 2011a, 2011b). PIEs for homeless services were endorsed in non-statutory guidance by the Department of Communities and Local Government and National Mental Health Development Unit (Maguire, Johnson, & Vostanis, 2010) and refined into operational guidelines (Keats, Maguire, Johnson, & Cockerell, 2012). The Royal College of Psychiatrists 'Enabling Environments' initiative has been drawn upon (Haigh, Harrison, Johnson, Paget, & Williams, 2012; Royal College of Psychiatrists Centre for Quality Improvement, 2014) as have 'PIPES', PIEs applied to secure environments (Turley, Payne, & Webster, 2013).

A PIE borrows the principles and values of therapeutic communities (TCs) developed at military hospitals during the Second World War, post-war institutions such as the Henderson and Cassell Hospitals and later expanded to a wide range of settings (Whiteley, 2004). Whilst institutions developed differently, the central concept is that a TC provides a structured environment where participating in a shared social context is the 'treatment' for mental health problems. Whilst group and individual therapy is provided, a TC creates a "living-learning" situation (Kennard, 2004 p.296) where everything that happens between staff and residents is used as an opportunity to learn, try out new ways of dealing with difficulties and later apply these in the outside world.

Whilst the underlying principles of creating a managed environment which focuses on the psychological needs of residents are the same, a PIE is conceptualised as an "updated"

TC "for the 21st century" (Haigh et al., 2012 p.35) with a more flexible, less intense therapeutic approach but one that retains the core principles of the value of social processes in a day-to-day living environment and the power of good quality relationships to facilitate change.

A PIE "can be created in a service such as a hostel or day centre where the social environment makes people feel emotionally safe" (Maguire et al., 2010, p.19). A "broadly therapeutic framework" should underpin this (Keats et al., 2012 p.6). There is no prescription for which model this should be, provided a coherent and consistently applied approach is chosen and there is a 'fit' between the environment, approach and resident needs. Staff are expected to be able to understand and use therapeutic principles in their work. Therefore a PIE is neither a place nor a model in itself but "a tool or framework to encourage creative and responsive thinking on the part of the staff team"(Johnson & Haigh, 2010 p. 33):

*"Wherever...psychological thinking can be translated meaningfully into a carefully considered approach to redesigning and managing the social environment, we have a PIE...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." (Johnson & Haigh, 2010, p31-32)*

Seager (2011b) interprets a PIE for homeless people in terms of attachment theory. A PIE should facilitate secure and consistent attachment relationships by, for example, the environment not containing more residents than can be held in mind by staff and not being so large and impersonal that it feels like an institution rather than a family home. In summary, Keats et al., (2012) state PIEs should have five main components:

1. A psychological framework explicitly committed to as the therapeutic approach underlying the project.
2. Physical environment and social spaces managed in a way that is conducive to psychological safety and security.

3. Staff being trained in the therapeutic approach and supported to make consistent changes to interactions with and approaches to clients. Reflective Practice groups are provided to maintain this and provide ongoing learning and reflection.
4. Managing relationships should be considered the principal tool for change, rather than staff only controlling behaviour.
5. Evaluation and monitoring of outcomes at service and individual levels should take place.

### ***Keyworking and Reflective Practice***

Hostels use a system of 'keyworking' where one member of staff is assigned a caseload of residents with whom they meet regularly to provide practical and emotional support. Previous studies have shown that keyworking is a complex and demanding task which is not always well defined (McGrath & Pistrang, 2007), and hostels can be chaotic and difficult environments in which to carry it out (Maguire, 2012). The core elements of the therapeutic alliance are likely to be central to helping relationships, both in formal psychotherapeutic or informal relationships (Barker & Pistrang, 2002). However establishing therapeutic relationships can be exceptionally challenging for keyworkers to achieve due to difficulties in interpersonal relationships often presented by homeless people (Arslan, 2013). Keyworkers often do not receive as much clinical supervision as other helping professions to support their work (Maguire, 2012). Splits and problematic dynamics can occur, particularly in teams working with people with diagnoses of personality disorder (Campling, 2004). Studies from client perspectives have also shown how unhelpful patterns of communication can arise within a challenging hostel environment (Stevenson, 2014).

Reflective practice groups are a central feature of PIEs. These differ from training in that they involve an active process of reflection and learning rather than passing down "received wisdom" (Johnson & Haigh, 2010 p.32). Reflective practice is originally derived from Schon (1983) and aims to support staff in their task of helping residents. Groups should enable staff to reflect on their actions and interactions with residents and each other, explore

the context and reasons behind behaviour and consider alternative perspectives. This should be part of a cycle of action, reflection and continuous learning, rather than simply being a support group.

### ***Physical environment***

Many hostels have historically been very large or in poor physical condition, sometimes occupying the same buildings as Victorian-era workhouses or formerly dormitory-based buildings that preceded them, such as Rowton Houses or lodging houses (Busch-Geertsema & Sahlin, 2007). This has contributed to a sense of threat and perceived lack of control over the environment by some residents, often leading to a rejection of hostels as a safe place to stay altogether (Hutson, 1999; Neale, 2001), even if they are perceived as caring by staff (Johnsen, Cloke, & May, 2005). Despite a drive ten years ago to make hostels into more welcoming and pleasant environments (DCLG, 2006), ambivalence about the safety or desirability of hostel accommodation persists, especially amongst chronically homeless people or when hostels have high levels of substance use (Homeless Link, 2010; Chandler and Cresdee, 2008).

Conversely PIEs are intended to establish a social environment that is not just in good condition but promotes safety through thoughtful design of the physical space, which is based on the needs of the client group and facilitates positive relationships. Evidence-based design suggests factors such as light, open or closed spaces and levels of noise impact on health and psychological wellbeing (Codinhoto & Tzortzopoulos, 2009; Evans, 2003; Mazuch & Stephen, 2008). Design of the physical environment is intended to send a message about valuing the shared space and by extension the people living within it (Keats et al., 2012).

### ***Aims of the study***

Much has been written about the theory of PIEs and the rationale for their need. Several homeless services have been established as PIEs within the last five years (Blackburn, 2012; Edwards, 2012; Williamson & Taylor, 2015). However, there has not yet

been a formal in-depth exploration of how PIEs operate in practice and how they are experienced by staff and residents.

Moos (1997) describes how treatment environments operate on many levels. The institutional context, physical and architectural features, organisational policies and nature of the client group interact and influence the social climate or 'personality' of a project. The social environment is complex and multifaceted (and in the case of PIEs, flexible and somewhat idiosyncratic). In evaluating homelessness interventions there is also a need to use a method which goes beyond quantitative measures of individual change and consider the wider context in which they are being implemented (Pauly et al., 2014). A qualitative method was an appropriate way to capture these different features and since this is a relatively novel topic, an exploratory approach focusing on participant experience was suitable. A phenomenological approach using thematic analysis (Braun & Clarke, 2006) was therefore chosen. As both staff and residents are integral to the PIE, semi-structured interviews were carried out with three groups of participants at PIE hostels: staff, residents and psychotherapists.

The study focuses on the following questions:

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

## **Method**

### ***Setting***

The study was carried out in a voluntary sector organisation providing services for homeless people in London. Two supported housing projects designated as PIEs were selected for the research in consultation with management. One project consisted of a single hostel and the other of three affiliated hostels with different levels of support sharing the same staff team.



The organisation's PIEs were structured according to the five key characteristics outlined above (an underlying psychological framework, a planned physical and social environment, provision of reflective practice groups, a focus on managing relationships and evaluation of outcomes). They were underpinned by the psychodynamic model and promoted the recovery approach. Each hostel had a part-time psychotherapist who facilitated reflective practice and provided optional individual psychotherapy to residents. The participating projects specialised in working with people with long-term mental health difficulties. Both were second stage hostels which accepted clients moved on from other accommodation.

Each hostel had a system of keyworking where residents were matched with a named staff member. Keyworking involved regular meetings to identify and assist with support needs, provide practical and emotional support and make plans for a resident's care.

#### ***Service user consultation***

A service user was recruited from the organisation's service user forum to act as a consultant to the project. Advice was provided on the suitability of the interview schedule, recruitment of participants and the interview process. These were adjusted in accordance with feedback provided.

#### ***Ethical approval***

Permission for the study to take place was given by senior management (Appendix A). Ethical approval was granted by University College London Research Ethics Committee (Appendix B).

#### ***Participants***

Three groups of participants were interviewed:

- 1) Hostel staff
- 2) Hostel residents
- 3) Therapists from the organisation's psychotherapy service

Eligibility criteria were:

- 1) Residents who had lived in the hostel for at least one month and were between 18 and 75 years of age. Residents were required to speak English with sufficient fluency to be able to participate in an interview. Residents were excluded if they were floridly psychotic, highly intoxicated at the time of interview or posed a risk of violence.
- 2) Staff who had been working in the hostel for at least three months and had attended a minimum of two reflective practice sessions. Staff either had keyworking relationships or regular contact with residents. Management, part time and locum staff were also included.
- 3) Psychotherapists who had been attached to the hostels for over six months, had facilitated reflective practice sessions and provided psychotherapy or supervision during this time.

### ***Recruitment***

The study used a purposive sampling method which targeted recruitment of participants according to their ability to provide first hand information-rich data on the topic. The researcher met with hostel management and identified eligible staff. Information sheets (Appendix C) were circulated by hostel managers. Staff were approached in person or by email to discuss participation. Staff who participated were asked to identify residents who met the eligibility criteria and distribute information sheets to invite participation. The manager of the psychotherapy service was approached to recruit psychotherapists and interviews were arranged by email.

Interviews took place in a private room at the hostel or at the organisation's offices at a time of the participants' choice. Resident interviews lasted between 20 and 40 minutes and staff interviews between 40 minutes and 90 minutes. Signed consent was obtained on the day of the interview (Appendix D). Residents were offered a £10 voucher to reward their participation.

Recruitment ended when a sufficiently rich data set had been achieved and saturation was evident. The data appeared to capture both common themes and variability

between participants over a range of topics; however, no new significant information emerged in repeated interviews.

***Participant characteristics***

Out of 12 staff approached, ten agreed to take part (reasons given for not participating were lack of time). Out of ten residents approached, nine took part. Five psychotherapists were approached and all agreed to take part. Participant characteristics are summarised in Table 1. To preserve participant confidentiality, individual demographic information has been suppressed.

***Table 1: Summary of participant characteristics***

<b>Participant Group</b>	<b>Participant ID</b>	<b>Sample size</b>	<b>Age Group (n)</b>	<b>Ethnicity (n)</b>	<b>Gender (n)</b>
Residents	R1-R9	9	26-35 (3) 36-45 (1) 46-55 (4) 66-76 (1)	White British or other White background (7) Black African/Caribbean/British (1) Asian/Asian British (1)	Female (1) Male (8)
Staff	S1-S10	10	26-35 (4) 36-45 (4) 46-55 (2)	White British or other White background (5) Black African/Caribbean/British (4) Not disclosed (1)	Female (2) Male (8)
Psychotherapists	P1-P5	5	36-45 (2) 46-55 (1) 56-65 (1) Not disclosed (1)	White British or other White background (4) Not disclosed (1)	Female (2) Male (3)

Two staff were educated to degree level and five held a diploma in Health and Social Care. Two staff held graduate diplomas, one held a counselling skills qualification and one referred to in-house training. Three psychotherapists who reported their training held masters level qualifications. Eight staff and psychotherapists had worked with homeless people for more than five years, four for between one and five years and one less than six months.

Most residents had spent between two and five years living in the hostel. As the participating projects were second-stage rather than direct-access hostels, most had moved directly to the hostel from hospital or other accommodation.

### ***Interview schedule***

The interview schedule was developed (Appendix E) taking into account the first four areas of a PIE (the psychological framework, physical environment, managing relationships and reflective practice). These were interpreted as the key components of putting PIEs into practice. Less emphasis was given to area five (evaluation of outcomes) as the aim of the study was to focus on psychological processes. The interviews followed a semi-structured format allowing the researcher flexibility to ask follow-up questions, adapt the order of questioning or explore further any pertinent themes (Smith, 2005). Over time the interview schedule was adapted and refined to avoid duplication of questions and incorporate themes which arose. At the end of the interview, participants were given the opportunity to reflect on the process and add any additional comments.

### ***Epistemological Approach***

A phenomenological epistemological approach was adopted: that of trying to understand from first-hand accounts participants' lived experiences in the context in which they occur (Giorgi & Giorgi, 2008). A phenomenological approach is useful for exploring how people feel about issues, events or experiences and was particularly appropriate in understanding participants' experiences of a service delivered to them (Biggerstaff, 2012).

## *Analysis*

Interviews were audio recorded and transcribed by the researcher and research assistants.

Thematic analysis (Braun & Clarke, 2006) was used to analyse the data, aided by NVivo software (QSR International, Version 11, 2015). This was selected as an appropriate method as it can be used to explore individual experiences in depth and describe central ideas in rich and complex data. However, it is also a flexible method which is freer of theoretical and epistemological assumptions than other thematic brands, making it suitable for a critically realist phenomenological approach which assumes that participants' language generally reflects 'real' constructs in the world and aims to fully describe rather than interpret their experiences (Giorgi, 2009).

This method involved repeated reading of transcripts, generating initial codes, sorting codes into themes, identifying and defining themes and considering how themes fitted together into broader domains. Analysis was undertaken in parallel with the interview process, allowing the interview schedule to be adapted in line with emerging themes and domains to be defined and reordered as the data was collected. An example of text-level analysis is provided in Appendix F.

Staff, psychotherapist and resident data were initially analysed separately until it became clear that many of the themes produced were common across all three groups. The three coding structures were amalgamated to create a common framework which presents all three groups together.

Braun and Clarke (2006) specify a difference between data and theory-driven analysis. For the purposes of this study it was difficult to use a purely data-driven approach without prior reference to theory, since PIEs exist within a theoretical framework. The data was therefore approached with an emphasis on participant experience.

## *Credibility checks*

In accordance with guidelines for avoiding bias in qualitative research, testimonial validity checks were carried out (Elliott, Fischer, & Rennie, 1999; Stiles, 1999). Participants

were given the opportunity to have a summary of themes from their transcript returned to them by post or email (Appendix G). Two out of ten staff, four out of five psychotherapists and four out of nine residents opted for this. Two therapists responded to the checks, one to confirm the information was accurate and another to provide further clarification. The thematic structure was checked by an independent researcher to ensure its credibility.

### ***Researcher Perspective***

Disclosure of researcher perspective also contributes to the validity of qualitative research (Caelli, Ray, & Mill, 2003; Finlay, 2002). I am a white British woman in my mid-30s carrying out the research as part of the doctorate in Clinical Psychology. I do not have personal experience of street homelessness. I have several years' experience working with homeless people in day centres, as a street outreach worker and manager of a cold weather shelter. My motivation to carry out this research stems first from my belief that homelessness is often neglected by clinical psychologists and that homeless people's voices are rarely heard in psychological research. Secondly, my own struggles to help homeless people access and maintain housing led me to investigate a potential solution for 'revolving door' homelessness.

Attempts were made to 'bracket' my personal perspectives by making them transparent and being aware of them throughout the research process (Fischer, 2009). This allowed engagement with the material which genuinely attended to participant views, without making a wholly idiosyncratic interpretation of the data whilst still allowing the process to be informed by relevant knowledge and experiences. This is discussed further in Part 3 of the thesis.

## **Results**

The analysis generated 18 themes organised into five domains (Table 2). The structure of data from staff, therapist and resident interviews was comparable and therefore all three are presented together.

*Table 2: Summary of Themes*

<b>Domains</b>	<b>Themes</b>
1. What makes a home?	1.1 Memories of other hostels 1.2 Constructing a home 1.3 Creating a valued space 1.4 Feeling safe
2. Resident needs	2.1 Awareness of trauma history and mental health needs 2.2 Emotional reactions to resident backgrounds 2.3 Flexibility and engagement
3. Managing Relationships	3.1 Building trusting relationships 3.2 Being on the same level 3.3 Client perspectives of relationships: make or break
4. Reflective Practice	4.1 Working with distress: the need for reflective practice 4.2 A "thinking space": gaining greater awareness 4.3 Doing things differently 4.4 The staff role: thinking or doing?
5. Theory vs practice	5.1 What's in a name? 5.2 Resources and expectations 5.3 Safety or moving on? 5.4 Recovery and "taking responsibility"

### **Domain 1: What makes a home?**

This domain focused on the construction of 'home' within the physical and social environment.

#### ***1.1 Memories of other hostels***

Almost all staff and residents spoke in detail about hostels which had not been thoughtful about resident needs. Many were described as "*horrible*" (R6), "*chaotic*" (S10) places which "*were awful...[and]...felt sad*" (S3):

S10: *"In a normal project without PIE you're firefighting...that's what happened in [hostel name]...someone actually called it "Helmand Province" it was that bad..."*

S7: *"This is going to sound brutal...but there's no other way to put it. It's almost like a farm: get them in, process them, get them to where they need to be...that kind of revolving door system. They come out and they come back in again. And that's because I don't think anybody is...trying to understand the client."*

Most participants compared this with the current environment as generally "calm"

(S5, R6) and *"relaxed... I don't think we've had the police here for a very long time"*

*[whereas] "it does happen a lot in other places"*(S6).

Residents often commented on this being the result of the behaviour of others being experienced as less challenging:

R5: *"It's the people I was living with...knocking on the door and asking me for cigarettes or sugar, something ridiculous like that and bringing their guests out and walking up and down the kitchen throwing rubbish everywhere. Here it's not like that, we've got a living room and we've got a kitchen separate so if your guests come in, they sit down there. To look after it there's a cleaner here...I've never seen it dirty actually..."*

Others spoke about hostels in the past being places where *"you are just there to get the housing benefit off them.... [now] we are here to help people"* (S7):

R9: *"In the 70s it was get them sober, get them washed, get them fed, get them de-loused and kick them out again. That was basically it."*

S7: *"There's one hostel in [location] that's primarily a bail hostel initially - they were just taking homeless people in...it was a very tough hostel, a lot of violence by the clients towards staff...police were always there, riot police sometimes, ambulances were always there, people trying to take their own lives and clients who were very, sort of not happy with their lives, people you know, using anything as drugs...that was a very tough experience....."*

## ***1.2 Constructing a home***

Many staff spoke about making the hostel a 'home' or "surrogate home" (P3). Both staff and residents pointed out *"we don't even use the word 'hostel' anymore"* (S9) because it had *"negative connotations"* (S8):

S8: *"Rather than calling them hostels I suppose we would call them supported accommodation projects...hostels suggest somewhere that's possibly temporary or trapped....quite a chaotic place and we would hope [name] is much calmer and much more therapeutic."*



Despite open acknowledgement the environment was far from perfect, staff and residents described efforts *"to show that this is not an institution, it's just it's a nice place [which] feel[s] homely with all these pictures [of] taking clients on holidays, buying a TV..."*(S9).

R1:*"It's friendly.. it's homely... it used to look like a hospital before...The paint on the walls, it used to be pink and green, now they changed the decoration and they put in new furniture, new book shelves...so it's more homely now, it's like home you know. It's not like a hospital environment ...where you've got medication, drugs and that kind of thing."*

The key standard described by staff was that a *"project should be nice enough so that staff feel we would live there"* (S1).

### ***1.3. Creating a valued space***

Going beyond a general sense of 'home' being comfortable, consideration was given to its form. Some took inspiration from their own home: *"I think about like what I do at home, or what other people do that I know or what family do, like have a nice table that everyone sits round for dinner"* (S8).

However, the need to coproduce the environment to create a space with value for residents was also considered important. Whilst the design of the building could not be changed, residents could have *"control over their environment"* (S10) by determining things from furnishing and paint colours to whether a project had a pet: *"To me that's an example of a PIE...they're involved in the process, because it is their home"* (S1).

This did not always result in a typical hostel environment:

S7: *One lady wanted fuchsia pink on her walls. . what's interesting is that it is not a kind of [hostel name] colour. 'Oh no you can't have that, you've got to pick this pastel range'. We thought, hold on, I'm not living there, she's living there, that's what she wants."*

In the past, the dominant view was *"if you just make it nice, they'll ruin it"* (P1). Now it was recognised without producing the environment together *"ok there might be some initial aesthetic, this is a bit nicer...[but] if people aren't involved, what value do they hold for the thing?"* (P1). One staff member spoke about the positive effect coproducing the communal space had on residents:

S4: *"...Some of the individuals that's taken part you would never think would be interested...but since we've done that we've had so much interaction: "[name] when*

*are the sofas coming?". This is an individual that [is] not really engaging...and all of a sudden, here he is, he's talking, he's interacting, he's asking about timelines "when's this going to be done?"*

Whilst some buildings were considered aesthetically pleasing or architecturally innovative, this did not necessarily translate into something either valued or appropriate, instead being "corporate" or "clinical", lacking "much identity of the people that live here, found in this place, in the fabric of this place" (P1):

P4: *"There was a building...that got some kind of architectural award for homelessness that's got transparent walls, glass walls and...you think, well that might be an architecturally inspired thing but what's that like for a homeless person to look at a transparent wall, transparent house with no visible boundaries,...that seems to a complete misunderstanding of what a nice environment would be for this purpose."*

#### **1.4 Feeling safe**

The final theme in this domain was a place that was safe. Residents and staff both spoke of physical security:

R6: *"I felt secure there, I felt safe believe it or not because it was one, two, three doors you had to get through before you got to me. With what's happened with me, I feel vulnerable all the time..."*

However some residents experienced attempts by staff to ensure their physical safety through room checks as "a bit much" (R2).

Other staff conceptualised safety as meeting residents' basic psychological needs: "It's important for our clients that they actually feel safe and they feel someone cares for them and they belong somewhere" (S8). Residents also commented on a sense of relational safety:

Interviewer: *"Is there anything else that helped you feel safe there?"*

R6: *The staff. To be honest with you, I've had a few iffy staff in my time...but there has been a couple that I've taken to and believe it or not, one I did take to, it was a bit hard but I took to him...I got on with him like a house on fire, you know. If I had a problem, he would sort it."*

This could be both formal keyworking relationships or just "to be there with them and feel a level of safety perhaps that they don't often experience"(P3).

#### **Domain 2: Impact of Client Needs**

The second domain focuses on client needs and their impact on staff and practice

within the hostel.

### **2.1 Awareness of trauma history and mental health needs**

Most participants spoke about the need for residents to live in a supported environment because of long-standing mental health problems and subsequent difficulties coping independently: "*clients who in the majority have been in the mental health system for twenty, thirty years*" (P6). The severity of this was also referenced: "*trauma doesn't even begin to describe what some of these clients have gone through*"(P3).

Some residents referenced their diagnosis: "*My diagnosis was I'm a borderline personality disorder with suicidal tendencies...and I self harm as well*"(R6) and awareness of the difficulties of others: "*people with a mental illness or...a hostel for mental people... everyone here has got problems, everyone here is on medication*" (R5).

Whilst staff were also often diagnosis-focused, most made links between current mental health difficulties of residents and past trauma:

S10: "*Most [residents] have a traumatic background. I think sixty percent of those who end up homeless go through care services, care homes and all that. I think for me they would have suffered a lot of trauma when they were young.*"

S7: "*One of my clients, she has a lot of problems, she has a personality disorder, extremely heavy alcoholic and...suffered domestic abuse from her father, has been sexually abused through childhood, has then since been in very violent relationships consistently.*"

### **2.2 Emotional reactions to resident backgrounds**

Staff spoke about how knowing about these histories brought up a range of reactions, could "*provoke some very intense emotions...*" (P2) or be distressing:

S9: "*It used to affect me, because when I first read a [referral form] and it was a lot of abuse...I can almost live it do you know what I mean? It did affect me in a way where for the first month, I couldn't see the person because I felt so bad...every time I saw the client I had tears in my eyes.*"

However, it was also noted that staff felt rewarded when residents were doing well because of the awareness that things had been very different in the past:

S6: "*The best thing [is] when they say thank you, when they're smiling and enjoying themselves. Because they've spent most of their life being afraid or taken advantage of or being abused in some form or another.*"

One staff member in particular described working through their own distress to providing containment:

*S9: "It's like one of my clients here...she would come to my office and cry non-stop for like half an hour, chat and cry, chat and cry, but I felt like I was more prepared...I suppose because she was a bit worried about her past and that we didn't know much and I was like, look we know everything before you came here ...there's nothing you can tell me that's going to make me run away."*

### **2.3 Flexibility and engagement**

Most staff linked their knowledge of resident difficulties to being flexible, particularly when applying sanctions: *"we have a much more flexible [approach]"* (S8) because *"rules work for those who will comply...and most of the client group we have don't really comply with rules"* (S10).

Some staff spoke about how rigidly applying rules was counterproductive because either *"they'll just go the opposite way and sometimes it gets people's backs up"* (S8) or the ultimate sanction (eviction) did not hold any fear:

*S10: "The one thing service users are not afraid of is being put back on the streets... they've been there, they've survived, so you threaten them with an eviction and they'll take the piece of paper from you, so how effective is it anyway?"*

Some residents spoke of being appreciative of flexibility:

*R9: "The staff were good about it. I was drinking for three years. I continued drinking and I was in no state to start my recovery, so they gave me time."*

Provision of psychotherapy was also flexible, focusing on engagement and containment over a traditional psychodynamic approach: *"it's not so much about interpretation"* (P3):

*P1: We have been known to be delivering sessions sitting at the bedside of somebody ...who is bedridden. We have a great picture of one therapist who is sitting there with a Staffordshire bull terrier on their knee and the client's sitting in bed with an ash tray that looks like something from the Royle Family, [laughter] so I think there's something about that...engagement work and that therapy is much more blurred in a sense. You're sort of moving in and out of these things sometimes and sometimes you're in the room and sometimes you are not in the room, the therapy room."*

### **Domain 3: Managing Relationships**

This domain highlights themes around relationships within the hostel.

### **3.1 Building relationships and trust**

Both staff and residents spoke of the importance of building relationships. For some this was meeting a basic psychological need:

P1: *"I think of this as a strand that goes through all of the work...I think of it as....trying to create an opportunity for a positive experience of relationship. So I tend to think of it in broadly psychological ways and for... universal psychological needs really, and all of those are relational."*

Others conceptualised it more practically in terms of conversations between staff and residents:

S8: *"I...try and get to know them and build relationships with them and try and understand where they are coming from - who they are, and what they like to do and what they don't like to do. What interests them and what doesn't interest them and how many friends they've got and where their family are or who their family are and how much contact they have with them and whether they would like to have more contact or less contact."*

"Trust" (R9) was spoken of by both as the mark of a good keyworker relationship. One resident spoke of realising *"they're doing the best for you. There's no ulterior motive. Once you get over that, you can start progressing"* (R9). This could be particularly difficult because *"most of the clients have had histories of trauma in the past, with relationships based on abusive circumstances...where trust has been seriously damaged"* (P3) and *"they have been hurt, they're very sensitive and very defensive - a lot of barriers are up and they are very suspicious of people"* (S5). However once trust was gained, *"the barriers get drawn up you know, you get good relationships"* (S5).

### **3.2 Being on the same level**

Creating relationships with a sense of equality between staff and residents was regarded as important: *"it is not a 'them and us', it is kind of an 'us and us'"* (S10). Staff tried to promote informal interaction because *"[it's] better spending lots of time with them informally you know, not sat down across a desk with a load of papers.....go for a coffee or go to the park or just sit in the garden and talk to someone"* (S8).

Tasks such as keyworking and providing meals were opportunities for informal contact:

S1: "I never, ever carry paper when I go to see them. Sometimes I'll have an impromptu chat with them at the dinner table....If staff come in and eat with them, that's a really good equaliser. When we're all sat round the table together it's almost like, we're all just people having a chat and our roles don't really exist."

Breaking down "us and them" was also referenced by staff who had personal experience of homelessness and could relate to residents in a unique way:

S1: "Even though I'm the employee and they're the client, and we can't really get away from that... I try and always see that I'm on the same level as them. I don't see that I'm in any way superior. Because in my particular case I have been where they are."

Residents also spoke of the importance of staff treating them as equals and adults:

R6: "Why I like certain staff is because they talk to me the way a normal person would talk to me, not down at me or not to me like a child ...[keyworker] is more to my level - if he thinks I've done something wrong he'll tell me straight."

### **3.3 Client perspectives of relationships: make or break**

Resident perceptions of relationships, especially with their keyworker or therapist, were crucial. Some spoke about how their keyworker was the first person they turned to:

R4: "She's up front...she tells you how it is and that....and she's straight with you, she's honest, she helps you".

Interviewer: So if you needed help with anything, who would you go to first?

R4: I would go to [keyworker name], yeah, yeah, I would go to [her].

Interviewer: Ok, and if she wasn't here, what would you do?

R4: Well I could ask for her, to phone her, because they'll let me use the phone and phone her."

Others spoke of feeling cared for by their keyworker:

R5: "If you have a problem, I had [keyworker] yesterday, and I had a nice conversation with her...someone who gives you advice and tells you "don't do that,"...someone cares for you...that's how it is in here."

Some regarded the keyworker relationship as "more like a friend. I know there's boundaries..but I need interaction, so we talk about football...and things what's happening in the world. And it helps my isolation"(R9).

One resident spoke of the relationship with their therapist as "a godsend... I can unload everything that's going on in my head" and made a powerful statement that "living here has definitely changed me. I'm actually starting to be glad that I'm here, not wanting to be dead, thanks to [organisation] and the staff here" (R6).

Despite this, some spoke of negative interactions with staff which could undermine the benefits described above:

R6: *"Talk to me like a person...there's a couple of women who [don't do that] and you get up and they say, ok I'll sort it out but I would never, ever talk to her again."*

R5: *"I just go upstairs and see what staff are up there exactly because sometimes there's a new staff, I never seen him before. I only know [name], and [name] and [name] my support worker.... if they're not there then I just go and wait for them and ask them when they are coming back, because the others I don't know much about them...especially at night times, night staff, security - when I ask them some questions or something, how can I get my medications and they say we are not allowed to do that....that's what I find unhelpful...they make it negative."*

#### **Domain 4: Reflective Practice**

The fourth domain focuses on the processes of reflective practice: how it is experienced and the effects on residents and staff.

##### ***4.1 Working with distress: the need for reflective practice***

The emotional impact of knowing about client trauma has been explored in theme 2.1. However, general stressors of working with a complex client group were reported. Some staff spoke of *"find[ing] some clients very difficult in their behaviour"* (S6) or struggling to engage with others:

S2: *"There's one lady...[diagnosed with] personality disorder...you can't engage with her ... she won't turn up to sessions, won't come out of her room...he [the manager] can't do it, I can't do it, I don't know who can do it..."*

Others talked of battling personal disappointment or rejection *"when you've worked with a client throughout a number of years and you feel that you have a good relationship and they really press the self destruction button"*(S4).

Psychotherapists made links between these stressors and staff reactions. Despite having an 'open doors' policy (S6, S6, S8), staff needed to *"protect themselves in different ways"* (P3):

P2: *"I think the staff often feel overwhelmed...there is a comfort in retreating to that kind of space [the office] because to be exposed to that level of distress or madness is too much."*

The link was made between this work and reflective practice:

S10: *"What we quickly discovered was if we don't have an environment to reflect on what we do, you have a burnt-out staff team....I remember one of them describing a couple of clients to me - he said they were a whirlwind blowing everything in their sight."*

P5: *"Anyone who is working with human distress and pain - it has a toll, it has an effect on you. And people act as if it doesn't - as if 'this is what we've got to do, it's ok.'... so for me I would want everybody who is working in social care, irrespective of what level, to have some form of reflective practice so they can at least talk about the effect of what's happening on them as a team."*

#### **4.2 A "thinking space": gaining greater awareness**

Most staff stated that an important part of reflective practice was provision of a "safe space" (S1) or "thinking space" (S10) and taking a step back from everyday tasks: *"it isn't about solutions, it isn't about action or business, it's about sharing and thinking"* (P1). This provides a setting to think in more detail about what could underlie resident difficulties:

S8: *"Sometimes it may be just a better appreciation that actually someone is doing this because this is happening, and maybe they're upset about that.... just that you have a better appreciation of why that person is behaving as they are."*

This could also be the case for understanding ongoing problems:

S6: *"the sort of things that happen continuously with certain clients - we can talk to somebody who understands about that and their diagnosis and can understand why certain behaviours might be happening and how we can support them."*

One participant commented that becoming more aware of such material *"really helps me to be a better worker. Because [name] our psychotherapist, sometimes she will have an angle that I haven't even considered"* (S1).

Gaining the "bigger picture" of residents' lives could put these difficulties into a wider context:

P3: *"When I started working in this team I was surprised by how little thought was given to the clients, the resident's background history, and it almost felt foreign as if, 'Why are you asking us?' ...that has changed over time... so now I ask, 'So what do we know of this person?'. They [the staff] don't say 'Oh well I don't know', they don't concentrate just on the practical side of where this person might be at but they do think about the bigger picture, a more realistic picture of this person's needs and where they come from and what the original trauma might have been, how this might ... take shape in their current relationships."*

Appreciating the validity of multiple perspectives, *"allowing different ways of thinking to emerge in one single room"* (P3) and *"thinking in different ways"* (S4) was



spoken of, once it was established that the space was safe enough not to “get into trouble”

(S3) for having different opinions:

*S3: "She won't give you the answer but she'll...give you something to think about...obviously people have different opinions so they all come out and if you say something, it will prompt somebody else to say something so then it opens up discussion..."*

#### **4.3 Doing things differently**

The next phase of reflective practice was differences made to staff practice:

*P2: "I'm thinking about a particular client where I think the staff team developed quite a punitive response to her, which I think was born out of anxiety, but also helplessness in a way and I guess to be able to sort of reflect on that, you know, and think about how to...maybe interact in a different way or to understand-firstly to make the connection in terms of why is this happening and then to why everyone is kind of ganging up on her...and I guess highlighting the negative impact that may have on her because the staff team became caught up in something."*

Some staff spoke of changes directly influenced by reflective sessions and noticing consequent changes in resident behaviour. For example:

*S5: "We stopped talking to her about her alcoholism and stopped kind of telling her the things that she had done badly and kind of worked on being positive about certain things that she did....she started to be more aware of what she was doing and kind of how things like her bedroom being a mess - she uses that as a way to reflect how she's thinking...and actually build[ing] her self-confidence...it's kind of she's seeing more about herself and understanding more."*

Others spoke about reflecting on their own motivations and making changes as a result - in this example, needing to “fix” a resident to prove their own worth:

*Interviewer: "When you realised that maybe you were trying to do it for yourself...rather than the client, what did you change as a result of that and what happened?"*

*S9: To start with, I felt better ...the relationship got back to normal with the client basically. I did give the client a lot more space and a lot more time to come up with what they wanted rather than what I wanted them to do....so they took charge in a way rather than me being in charge."*

#### **4.4 The staff role: thinking or doing?**

Despite these benefits, sessions were not without challenges, particularly when first introduced. The most prominent of these was to the staff sense of role, traditionally considered to be doing things for residents. Taking time to reflect was considered by some a “talking shop” (P5) or an unnecessary luxury. As a result some people “outwardly hated” it (P1):

P1: *"...It goes against the third sector tradition [and] culture in which you do rather than think. You don't procrastinate, you get in and do and further than that, you do more than you're paid to do and that's valued, you go the extra mile."*

S4: *"There's been a view that what is this space going to change? The arena that we are sitting in speaking, how is that going to change the service? How is that going to change the clients?"*

Others struggled with reflection being interpreted as criticism of their decision

making:

S2: *"It is uncomfortable to question your own decisions...and it's uncomfortable to have somebody really critically analyse the decisions that you make...unless you're used to it or open to it."*

Willingness to talk about one's feelings was thought by some as "unprofessional" or "negative" (P1). Some longer-serving staff thought *"they've seen the client, been there done that. So there's a pretence that the behaviour of the client doesn't affect them, they know what to do"* (S10).

Aspects of reflection were difficult for some to reconcile with the caring role, in particular, acknowledging negative feelings towards residents:

P4: *"You work in this environment, you get angry, you feel tired, you get full of grief and hate and all sorts of feelings...[but] very few say for instance, 'I hate that patient for what he did' ...so people can only talk in positive terms about some of the most damaged people in the country. Where's the conversations about how difficult it is, how hard it is, how infuriating it is, how angry-making it is? The other things will follow, what a joy, what a pleasure, I love working with you this is great, you know, these things follow from having conversations that are more difficult."*

## **Domain 5: Theory vs practice**

The final domain focuses on challenges involved in putting the theoretical PIE into practice in the real world.

### **5.1: What's in a name?**

Some participants expressed scepticism about whether a PIE was anything more than just good practice: *"I have my own type of way of working that works, and I think...you would want to work in that way whether you were working in a PIE or if you weren't"* (S4).

Others questioned whether a new label was meaningful:

S8: *"PIEs is like a loose...term to try and capture what has possibly been going on for years... I would naturally try and get to know someone that I am trying to*

*support and I would try and understand where that person is coming from and...how that informs how they behave at the moment."*

Others spoke about how "*the psychological bit*" (P1) was a broad humanistic rather than model-specific approach to:

*"...only really to support human empathy...because you don't want to push the psychology with a big P if you like because clients tend to run a mile from that....you're almost trying not to do too much, you're trying to create the context..."*

Some felt a PIE was a watered-down, less valuable therapeutic community:

P4: *"What's wrong with therapeutic milieu or therapeutic community? Why do we need psychologically informed environments, why do we need these new words...?"*

### **5.2 Resources and expectations**

Most staff spoke about scarce resources alongside a growth in expectations and pressures which created "*a bit of a kind of mismatch between the idea and what we're actually physically able to do*" (P2). Others reported how externally imposed goals and targets were simplistic and did not fit the complexity of the task:

S10: *"Funders and commissioners seem to think it's like a factory where you come in as a rough sleeper, go through the process, you engage with the service and at the end of it you come out ready for independent accommodation. Now it doesn't quite work like that."*

Some staff spoke about how being "*pushed to hit targets*"(S9) conflicted with their perceived role because "*in here it shouldn't be like that*" (S9). This could dehumanise the task of caring:

S9: *"You think, "Oh god I have to do this and that" but your client is not ready and you're pushing the client and...that breaks the relationship and your client is seeing you as a worker not a human being."*

The ability of staff to engage in reflection whilst being "*under massive pressure from above*" was also restricted because "*it goes against what they actually intend to do - you know, you've got a job, you're here to care, you're here to do something, but the reality is that you can't do it ...adequately*" (P5).

### **5.3 Safety or Moving on?**

Moving on from the hostel was a very prominent theme. Whilst PIEs promote attachment and time to build consistent relationships, "*it's short term accommodation with*

*specific outcomes attached to it, and it's expected that at the end of 24 months you can.....move people on.....there is a pressure, no questions about that."*(S10)

Whilst some residents were keen to move on, many recalled an unsettling experience and how they were concerned about *"going back in circles again and again and again"* (R6).

R5: *"Once you live in a place for five years you get used to everything... it feels like a home to you and you know the staff, you know everyone..., moving out from there, all your stuff's packing, [it's] quite difficult."*

R6: *"Stressful, it was horrible. I was excited but at the same time I really didn't want to do it."*

Moving people through accommodation pathways was acknowledged as part of the utilitarian nature of the homelessness system: *"you might want to turn the room around quickly"* (S6) or *"because there are other people sleeping on the street...."*(S10), but the effect could be detrimental:

P2: *"Even if you are relatively well functioning, if you had to move...every year or every two years, I don't think that would be particularly stabilising for any of us."*

P5: *"If you've been there for three years and you feel quite comfortable and then you're moved on somewhere else, that's a massive transition...particularly if their experience in childhood has been one of abandonment and neglect, then of course it's going to re-traumatise them and bring all that up again."*

Others discussed systemic confusion between the concepts of dependence and attachment which proved *"a real shame for the staff and clients"*(P1):

P4: *I think what's happening...is a muddling up of dependency and attachment issues - for someone to become dependent on a place is a 'thoroughly bad thing' so we keep them moving, moving, moving, moving, whereas the way of understanding attachment is for someone to become attached to something in order that they can build a secure base... I think that the moving on problem is rooted in anxiety about dependency."*

#### **5.4 "Recovery" and "taking responsibility"**

Staff on the whole saw the recovery model which underpins the organisational approach as a positive concept: *"It's about creating an environment in which people can recover, it's where people are given the ability to do that"* (S7), and residents likewise: *"Instead of just a hostel putting you there, they use the recovery process...in [organisation name] it's all about recovery"* (R9).

However, putting this into practice created ambivalence and confusion: staff spoke about encouraging residents to "*take responsibility*" (S6) for themselves, "*motivate and empower them*" (S6) and move them on from a position of perceived passivity into a more active, independent role. They fluctuated between providing safety and "*protecting them*" (S6) from the outside world but also "*pushing*" people "*on their way*" (S2):

S3: "*I suppose the person isn't ready..., they may never be ready to sort of take some responsibility and they've created a safe haven here, it's almost like you know, your time here is up, you need to move on.*"

S5: "*We all have to move forward in life, to progress, you know.....because a lot of them do not want to leave here, they want to stay but we have to say to them, this is not a hotel, it's a project and you have to progress and move forward.*"

There was recognition from psychotherapists that "*there's been some tension with the recovery model...there is a lot of pressure [to] get better*" (P2) and this was often not realistic or appropriate for this client group:

P5: "*These people don't know what that [recovery] means. It's not about recovery, it's more like discovery...they're not recovering from anything because they've never been anywhere in the first place...recovery is obviously important. You want someone to recover. But really I think there's a mistake...it's as if you could somehow magically be ok. I don't think you can be. ..And the issue...is not about curing as if one were to recover - it would be about helping people to deal with the problems that they have.*"

## **Discussion**

This study provided a qualitative exploration of resident, staff and therapist experiences of PIE hostels. Themes were organised into five domains: what makes a home, the impact of resident needs and backgrounds, managing relationships, reflective practice and the tensions inherent in making a PIE reality. The data suggest that in broad terms PIEs are meeting their aims by supporting staff to promote positive experiences of relationships in an environment that is valued by residents. Nevertheless this is a challenging task and translating the model into practice is particularly difficult in the current economic and political context.

### **What makes a home?**

Almost all participants gave accounts of hostels from the past or other places they had experience of which contrasted with their current environment. This chimes with reports

of hostels being perceived as dangerous and chaotic places (Busch-Geertsema & Sahlin, 2007; Hall, 2006; Teixeira, 2010). Therefore whether the hostels in question actually were PIEs (see Domain 5) and despite deficits in some areas, it was universally agreed that the current setting was extremely different and better than the past.

Most participants described efforts to make the physical environment different to these negative memories by creating a more homely, welcoming and less institutional environment and abandoning the word 'hostel' altogether. This raised the question of how to construct an environment which went further than comfortable furnishings and allowed people to feel 'at home'. It was suggested there was a danger of either simply prescribing what a typical home is assumed to be and unintentionally arriving at a superficial solution or creating an environment that was aesthetically pleasing but ultimately quite corporate or clinical. Campbell (2006) states that if homelessness is considered a communication of distress in the form of an internal state of "unhousedness", a home is "not something that can simply be given to a person by benevolent agencies" (p.164). This was reflected by the participant citing an example of a hostel whose physical environment had been modernised using glass and large open spaces but had inadvertently paid less attention to the containment and psychological safety provided by a smaller, more manageable space with greater privacy. This experience of once innovative architecture failing to meet psychological needs or take into account resident preferences in planning is one that has been replicated more widely in urban environments (Galan-Diaz & Martens, 2015).

Actively involving residents in coproducing the environment was conceived as a way to create a place both valued by and cared for by residents and one that reflected their character and identity. Von Sommaruga-Howard (2004) notes that involving all stakeholders in creating a therapeutic space gives a message that "the [patient] is worth it" (p.77). Similarly, Davis (2004) explains the importance of providing choice in design for homeless people since "choice and self-determination are the cornerstones of dignity and a homeless person has few options...a place that makes people feel welcome, comfortable and safe signals that someone cares about them and that they are worthy of this concern" (p.21). This

contrasts powerfully with the statement about hostels deliberately failing to provide pleasant surroundings "because they'll just ruin it". These findings also accord with quantitative research of treatment environments suggesting that resident participation strengthens resident-staff relationships and is correlated strongly with a supportive environment that encourages skills development; small units (by definition more like a 'home') were also strongly associated with greater staff-resident support (Moos, 1997).

One of the aims of a PIE is to facilitate psychological safety in a client group that have a limited template of a safe home. This limited concept may explain why some participants spoke of safety as room checks and physical barriers to the outside world. Others endorsed feeling safe through their relationship with staff, indicating that basic conditions of psychological safety were being addressed - being held in mind by someone who is responsive to one's needs and having a meaningful social connection affording a sense of belonging (Seager, 2006). By extension this provides the 'secure base' for a secure attachment to develop (discussed further in Theme 3.1).

### **Resident needs and histories**

Awareness of a history of trauma was present in all staff interviews. For ethical reasons, residents were not asked about early experiences and whilst they were aware that the accommodation was for people with mental health problems, it is not fully known how they conceptualised their own difficulties. Some staff made explicit links between early adversity and current mental health, whilst others had a more general understanding of this. There was evidence that staff not only had strong emotional reactions to this knowledge but some found it distressing. Vicarious trauma is often linked to burn-out or "compassion fatigue" and has been documented both in the helping professions generally (Herman, 1997; McCann & Pearlman, 1990) and homelessness staff specifically (Arslan, 2013; Seager, 2013). Nevertheless, there was also evidence of "compassion satisfaction" (Stamm, 2010) or staff being rewarded by positive relationships precisely because of the knowledge that others had abused and let residents down in the past. One staff member in particular demonstrated

providing containment for their client by showing they had the capacity to bear the knowledge of this and "hold" their distress.

In light of resident needs, a flexible approach to rules was discussed. "Elastic tolerance" (Keats et al., 2012, p.6) is proposed in PIE guidance where sanctions and evictions are applied in such a way to meet resident needs rather than to punish. Client-led research has shown that flexibility is often lacking in services and this can be a barrier to engagement with staff (Terry, 2015). Frequent eviction, where residents are unable to adhere to rules and are constantly passed between hostels, is recognised as one of the causes of 'revolving door' homelessness (Homeless Link, 2010). There was recognition that thoughtless application of rules was counterproductive since the ultimate sanction of eviction and return to the streets did not hold much fear.

Part of this process of flexibility was emphasis on engagement as a precursor to therapy and indeed as the therapy itself, rather than insistence that a fifty minute session must be attended. As Brown et al. (2011) note, psychotherapy with this client group provides something beyond the "conventional spaces and domains of psychotherapy" to people once considered too "chaotic" or "unwell" to benefit from conventional work (p.310). Nevertheless, those who did build a therapeutic relationship with therapists or staff spoke of its benefits (explored further in Domain 3). This supports the conclusion of Part 1 that homeless people can and will engage in psychological interventions (albeit in a suitably adapted form), rather than having a culture of judging people "not suitable for psychotherapy" or having a "deficiency in their psychological mindedness" rendering them outside the realms of talking therapy (Seager, 2006, p.275).

### **Managing relationships**

Without exception participants spoke about experiences of building relationships both positive and negative. Staff either explicitly recognised the role of relationships or demonstrated a more implicit grasp of their necessity. The skill of relationship building has been described as the "bread and butter" of staff work with homeless people (Cockersell, 2012, p.179) rather than an added extra or something confined to a therapy context. Writers



on complex trauma emphasise that recovery can only take place in the context of a formal or informal relationship rather than in isolation (Van der Kolk, 2014). Herman (1997) describes how the core experience of psychological trauma is disempowerment and disconnection from others, hence recovery must involve new connections. Trust was described as a key element of a resident-staff relationship. Herman also describes how through connections with others a person who has experienced trauma can learn (or re-learn) the capacity for trust as well as identity, autonomy and intimacy. Therefore, whilst the physical trappings of home described in Domain 1 support these processes, the experience of relationship is considered to be at the centre of a PIE. Without such relationships, there is no "mental and relational sense of home" (Cockersell, 2012, p.177).

Residents spoke of positive effects of a good keyworker relationship, in particular, a sense of being cared for and for honest communication. This mirrors research on the therapeutic relationship where an effective bond between therapist and client is characterised by warmth, trust and acceptance (Asay & Lambert, 1999), suggesting that the same processes feature in this less formal setting. Insecure attachment styles can change to an 'earned' secure style in response to later life circumstances (Saunders, Jacobvitz, Zaccagnino, Beverung, & Hazen, 2011) and it is now recognised that early trauma does not inevitably lead to later 'disorder' should alternative supportive relationships intervene (Johnson & Haigh, 2012a). This is supported by evidence of neuroplasticity throughout the lifespan (Siegel, 2012). Having a good quality therapeutic relationship provides scope for modification of insecure attachment styles (Blackburn, Berry, & Cohen, 2010) and there was some evidence of residents using their keyworker as a 'secure base', being the person they would seek out despite other staff being present. Despite this, there was also a sense of 'make or break', with relationships which floundered being difficult to salvage. Rowe (1999) describes trust between worker and homeless client as "a thread that is stretched and loosened and wound through the many moments of a relationship and it can break at various points...trust is tied to an investment in the relationship...when plans fall through, the relationship can hold up or fall apart and much depends on how each party regards the other"

(p.83). This reflects the inescapable fact that despite good groundwork achieved through relationships, many residents had significant interpersonal difficulties and remained quickly rejecting of others.

Staff and residents indicated they benefitted from a structure where efforts are made to relate to each other as equals. Staff spoke of ways they tried to make official tasks such as keyworking less formal to avoid putting barriers in the way of the helping relationship. Studies of interactions between homeless people and staff or institutions have highlighted the damaging effects of infantilisation (Hoffman & Coffey, 2008; Stevenson, 2014) or abuse of power through the “veil of bureaucratic justice” (Rowe, 1999p. 37). Many staff had given considerable thought to issues of power imbalance. This has echoes of the ‘flattened hierarchy’ in a therapeutic community where there is less demarcation between staff and residents than other settings (Campling, 2001). Staff with lived experience of homelessness also reflected on how this contributed to a levelling of the relationship, reflecting the positive findings from peer support interventions outlined in Part 1.

### **Reflective Practice**

PIE guidance suggests reflective practice groups should be used to help staff process emotional responses to client work and support learning. This domain largely explores staff experience of reflective practice and its effects; whilst most residents were aware that staff met regularly to discuss their needs and support them, ‘reflective practice’ was not a shared term. Despite unwillingness to express negative feelings about residents (see Theme 4.3) some staff made reference to finding aspects of the work frustrating and emotionally challenging. Adshead (2001) notes that from an attachment perspective, many residents in institutional settings lack the ability to self-soothe due to early trauma and that "there is a failure to be able to elicit care (or soothing) from professional caregivers in fruitful ways...so often we see people who are longing for a secure attachment that would reduce their distress, but have no idea either how to elicit care productively, or how to use it when it is offered by a competent caregiver"(p. 327-328). This offering of care from staff and perceived rejection by residents was noted as particularly difficult to understand or tolerate.

The need to retreat and protect oneself from resident distress was referenced by psychotherapists, contrasting with the aim of projects to have 'open doors' - a phenomenon noted in care settings since early observations of nursing staff (Menzies-Lyth, 1960). Witnessing burn-out (emotional exhaustion, lack of work satisfaction and 'depersonalisation' from clients) and the toll of working with distress were spoken of and clearly linked to the need for a space to reflect and be supported (Carson & Dennison, 2008).

As a way to address these difficulties, staff almost universally described reflective practice as a safe, containing space to take a step back and think about their clients. Whilst this was not without challenges (theme 3.4), staff spoke of it as a valuable opportunity to gain greater awareness of residents as "whole people" and how this could impact on what might lie behind behaviour. Learning to appreciate different perspectives without feeling attacked also emerged as an important element (Hatton & Smith, 1995). Developing reflective capacity and the ability to mentalise thoughts and feelings of others are key qualities in developing positive therapeutic relationships (Dallos & Stedmon, 2009) potentially adding to the quality of keyworker relationships described in Theme 3.1.

There was evidence that reflective practice went beyond provision of support and allowed staff to make changes in the way they interacted with residents, ranging from more active listening to changing behavioural interactions. This suggests staff were able to put an experiential learning cycle (Kolb, 1984) into place which involves reflection on action and experimentation with different responses, or according to Schon's model (Schon, 1983) to use both 'reflection in' and 'reflection on' action. This supports findings by Maguire (2006) that staff formulation groups can have an impact on feelings of self-efficacy and perceived ability to facilitate change.

Despite these benefits, the process was also difficult and revealed ambiguities about the staff role. Psychotherapists indicated the culture of the voluntary sector is one where 'doing' was privileged and going the extra mile particularly valued. Rowe (1999) discusses a working culture in homelessness which is highly value-driven but particularly action-oriented or "hyperactive" (Hoggett, 2010, p.203). Having time to think about one's own

feelings was regarded as an unnecessary luxury by some (Haigh, 2008). On the other hand, being able to express negative feelings about residents, whilst regarded as essential to the process by facilitators, was felt to be incongruent with staff self-perception and values as a carer. Some staff felt less safe, at least initially, in the reflective environment, perceiving themselves as being scrutinised and criticised. These tensions around staff role suggest that keyworking or caregiving in the residential setting remains a "taken for granted model of practice" (Holt & Kirwan, 2012 p.389) with staff struggling to reconcile the active helper role with perceptions of a more reflective, therapeutic practitioner (Bland, 1997).

### **Theory vs Practice**

The majority of staff felt the concept of PIE brought something new. However, a minority questioned whether PIE was a meaningful label. Longer-serving staff members were more likely to suggest that PIE was new jargon for good practice that had been going on for many years. Since the 1990s the homelessness sector has been subject to many new initiatives (Wilson and Barton, 2016) and there was a sense a PIE could be yet another. This raises the question if a PIE is to be a meaningful and lasting model, besides the facilitation of reflective practice, what role should psychology play? It was suggested that this may be "psychology with a small p", "psychosocial" relationally-focused interventions or a broader sense of "mind mindedness" (Johnson & Haigh, 2012b, p. 240). Rather than getting stuck on a particular model, these should be services that pay attention in a general sense to fundamental human needs for wellbeing (Seager, 2013).

Whilst PIE guidance states large amounts of money are not needed to create a psychologically informed service, the issue of resources in the current economic and political climate was an ongoing theme. This was described as creating an atmosphere which was not conducive to reflection. Services are contracted-out and unrealistic targets and expectations from commissioners which failed to take into account the complexity of the task or the psychological needs of residents contributed to frustration and anxiety about what needed to be achieved, staff role in delivering this and by extension, services being re-commissioned (Cunningham & James, 2014; Davies, 2008; Moriarty & Manthorpe, 2014).

Nowhere was the issue of unrealistic targets more prominent than in the theme of moving on. Whilst some residents were looking forward to moving into independent accommodation, for others the process was extremely anxiety provoking. Staff too were happy to see residents move on if they were ready. Whilst efforts were made to extend residents' stays if possible, they were inevitably time-limited. Short-term contracts and fragmented service provision in an increasingly marketised social care system is wholly at odds with the long-term process of "rehomeing" and the time needed to rebuild damaged attachment relationships (Seager, 2011a, p.187). A marketised system constructs recipients of care as consumers making rational choices. However, in reality homeless people and other vulnerable groups such as people with learning disabilities are often the most disenfranchised in decision making about their accommodation (Brennan, Cass, Himmelweit, & Szebehely, 2012), thus making "informed consumer choice" an "ineffective countervailing force" to the practice of "housing [patients] as cheaply as possible" (Moos, 1997 p.159).

It was suggested that anxiety about encouraging dependence with its resonances of outdated long-term institutionalisation lay behind the need to move people through the system. However the argument was made that dependence was falsely pathologised and mistaken for a need for genuine attachment and connection with others (Bucci, Roberts, Danquah, & Berry, 2015). Campbell (2006) notes that disruption caused by enforced moves can represent a rupture in newly established attachment relationships, prompting feelings of rejection and abandonment. This may further reinforce a cycle of exclusion where people become less trusting of allowing relationships to be built again. Staff are therefore placed in a double bind: on one hand they need to nurture residents and help them feel safe whereas on the other they must achieve outcomes and move people on.

This ambivalence was further reflected in views about recovery. Whilst staff recognised the need for relational and physical safety, they spoke of the need to help residents 'take responsibility' for themselves and anxiety that residents might become too safe and comfortable. Whiteford (2010) discusses the 'responsibilisation' of homeless people

and argues that it is misplaced in the context of profound social exclusion, reducing homelessness to a “deficit model of citizenship” (p.11). "Taking responsibility" was often framed by the recovery model. Whilst many staff and residents embraced recovery as a means of providing hope and aspiration, others questioned its usefulness. Seager (2011a, p.186) notes that "for people who have never functioned or enjoyed a healthy personality in the first place it is impossible to 'recover' or be 'rehabilitated'. Such people are still looking to get started in life": the formation of the first healthy attachment relationship and work to undo the damage done by past relationships must come first. This is supported by research on 'enforced recovery' of 'problem' drug users which was least likely to be effective for those without any experience of stability to aspire to recover to (Johnsen & Fitzpatrick, 2007). Service user groups have criticised the corporatisation of the recovery model (Recovery in the Bin, 2016; Scanlon & Adlam, 2010) arguing that what began as a user-led concept has been hijacked by neo-liberal forces, becoming coercive and lacking the relevance of its original form.

### ***Limitations***

There are a number of limitations to this research. The first concerns transferability. The need for a fit between environment and client group means that a PIE is flexible and idiosyncratic in its set-up. There will therefore always be limits on the extent to which these findings can be transferred to other settings with different client and staff groups.

Secondly, whilst the sample achieved a mix of ages and ethnicities (with a bias towards men which is reflective of the client group), many staff were self-selected as those who were interested in the model. Those who were hostile to reflective practice were more difficult to access. Residents were also to a certain extent selected although there was no particular evidence of bias towards those giving a positive report.

Lastly, the epistemological approach meant that the study relied solely on participant report of subjective experience. Whilst there is no reason to believe this is not valid, there was no means of verifying experiences through, for example, checking against notes or other sources of information.

### ***Clinical recommendations***

A number of suggestions for clinical practice emerged out of the study:

When creating a hostel environment, residents should be consulted about what constitutes a valued space rather than imposing solutions from above. Simply having an aesthetically pleasing building may not make a home.

Staff who engaged with reflective practice reported it being a valuable process which influenced their practice positively. The study provides evidence, albeit in qualitative form, that staff in supported accommodation could benefit from a group setting to reflect on their work and to support the complex task of building relationships (formulation groups, reflective practice or similar). However, keyworkers could also benefit from greater clarity of their professional role and updating or defining their skill set and theoretical base. This could retain their role as active helpers, harnessing existing skills and implicit understanding of client needs whilst also giving consideration to their role as reflective practitioners.

Services need sufficient time to be able to achieve the complex task of 'rehomeing' and building attachments and reconsideration of the meaning of dependence is needed. In the absence of more time, a carefully stepped move-on could be adopted (including aftercare groups) so that relationships are not suddenly ruptured and the hostel and keyworkers remain a secure base to return to. Psychologists are in a position to act at policy or commissioning level to influence realistic targets and goals for services and exercise a voice about the damaging effects of short-term contracts and marketisation on social care.

### ***Research recommendations***

As an initial exploratory study, the remit of this research is limited. Despite the evidence of hostels being vastly improved since the past, this research does not give any solid evidence of the superiority of PIEs over non-PIEs. This would require comparison to a hostel with no PIE features whatsoever. Such a place is unlikely to exist as even hostels with the most basic resources have some emphasis on forming relationships. Further research using a quantitative methodology which could control for such variables and quantify degrees of 'PIE-ness' would be necessary. Measures such as the Community Oriented

Programs Environment Scale (COPES; Moos, 1997), which measures dimensions of social climate, and the Service Attachment Questionnaire (SAQ; Goodwin, Holmes, Cochrane, & Mason, 2003) which measures client attachment to services, could aid this.

The study illustrates broadly the value of building relationships both from staff and resident perspectives. A longitudinal study of attachment styles could evaluate whether substantial gains in the ability to relate to others are developed.

Staff who engage in reflective practice report benefits in greater awareness and ability to engage differently with their clients. A further study investigating whether engagement in reflective practice has an effect on staff burn-out, perceptions of self-efficacy or team coherence could add to the evidence collected by Maguire (2006).

### **Conclusions**

Hostels in the 21st century have come a long way from their roots as large-scale institutions providing only the most basic needs. Evidence from this study suggests that whilst providing accommodation and support for homeless people will remain a challenging task for professionals, PIEs provide a context for focusing on the core processes of managing attachment relationships between staff and residents and creating a home as a valued space. Reflective practice provides a forum for staff to be supported and creates a space for necessary processing of emotions created by this work. In this respect, PIEs appear to be broadly meeting their aims by conceptualising homelessness as a psychological rather than physical state. However, transforming theory into practice is not always compatible with trends in social care determined by the current economic and political environment. PIEs must be suitably resourced to ensure that gains to both resident and staff wellbeing are maintained and they have the best possible chance to meet the psychological and emotional needs of their residents in the future.

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## **Part 3: Critical Appraisal**



## **Introduction**

This part of the thesis is a reflection on the process of carrying out the research reported in part 2. Methodological choices made in the design of the study and possible limitations due to these choices are discussed, followed by reflections on the process of carrying out the research. I will then discuss the role of psychologists in respect to PIEs. The final section will concern issues around self-reflexivity, in particular my dual role as trainee psychologist and former employee in the homelessness sector and how this relates to my interpretation of the data.

## **Background to the study**

As stated in Part 2, my motivation for wanting to do this research was around my pre-training professional experience with homeless people. Having spent several years working with chronically homeless people, finding suitable accommodation and supporting clients to maintain it was a constant struggle. Initially, I could not understand why people would abandon or refuse to take up accommodation that I had spent so long organising for them, before coming to realise that the hostels I had referred them to did not feel safe. On top of this, the deep sense of alienation and psychological homelessness I witnessed and the inability of some people to tolerate being indoors even for short periods of time made helping clients even to get through the door of a hostel feel like an impossible task. I very much wanted to find out what could work for this client group and if anything could be more acceptable than continuing to sleep on the street.

## **Methodological Issues**

### ***Choice of method***

The choice of design was a methodological issue from the outset. A quantitative evaluation of a PIE vs a non-PIE environment using a measure such as the Community Oriented Programs Environment Scale (COPEs; (Moos & Otto, 1972) to compare the quality of environments on different scales was an attractive idea given that it could potentially show using 'hard' data that a PIE environment was superior to a non-PIE on a range of scales. However, a quantitative methodology was rejected for a number of reasons.

First, as discussed in part 2, it was difficult to find a hostel which had no 'PIE' features whatsoever, even if this was simply some effort to think about staff-resident relationships or improve the physical environment. Other confounding issues may have also been present such as non-specific therapeutic factors. This made a meaningful comparison between hostels difficult.

Second, my own experience suggested residents may not be willing and able to complete a set of quantitative measures. The use of lengthy measures has been found to be an unhelpful process which puts up barriers with this client group (Elliott & Taylor, 2012). A significant number of residents had literacy difficulties and struggled to read the information sheet and consent form, which I summarised for them. I felt that this justified a talking-based rather than reading and writing method. At the planning stages I intended to use the Service Attachment Questionnaire (SAQ; Goodwin et al., 2003) to collect preliminary data about resident attachment to the hostel. This 25 item questionnaire was developed to measure client attachment to mental health services, rather than specific caregivers. However, whilst some participants were able to complete this questionnaire, others struggled so significantly with literacy that I decided to stop using it.

I therefore decided to use a qualitative method with the intention of capturing the complexity and richness of the subject matter. It also seemed an appropriate fit for an exploratory study on a novel topic. Carrying out the analysis on several levels over two sites (staff, residents and psychotherapists including managers and supervisors) did produce a very rich and complex set of data. PIEs are an attempt to make the therapeutic community model more flexible and applicable to a number of different settings. Because of this their implementation is always somewhat idiosyncratic and nuanced, making a qualitative method a better fit. As the purpose of a PIE is to be flexible and customised to different settings (Johnson & Haigh, 2011) for a client group that often go through cycles of change before achieving stability, a 'one size fits all' approach is warned against (Johnson, 2013).

However if this model does stand the test of time and continues to be used, quantitative evaluation or evidence-based practice may be necessary to secure funding. As

discussed in Part 2, this could provide evidence that if a psychologically informed service is better able to meet resident needs, more resources should be available, for example for allowing residents a longer length of stay to avoid the re-traumatising effects of moving on. Pleace (2011) discusses the complexities of gathering rigorous evidence about the effectiveness of supported housing, concluding that measures over multiple domains are needed. With a longer timescale and more resources it may be possible to carry out a larger-scale quantitative study using the COPEs or SAQ, as well as measures of staff wellbeing to investigate evidence of the benefits of PIEs. From a purely economic point of view, if this can reduce the volume of revolving-door homelessness, there are also financial implications.

### ***Implicit vs Explicit understanding***

A further methodological issue at the forefront of the study design was whether residents would have an explicit understanding that the hostel was a PIE and what this meant. As the interviews progressed, most did not recognise the technical terminology of 'PIE', although many were aware that staff had regular meetings in order to support them and that psychotherapy was offered which was not the case in other hostels they had known. Many residents explained that this was a particular environment to help people with mental health problems and had an awareness that their fellow residents had similar difficulties. I felt confident that the questions about the quality of relationships and the environment tapped into an implicit understanding of the differences between a PIE and a non-PIE hostel. Most, if not all, participants strongly endorsed positive comparisons between their current accommodation and other hostels they had stayed in or visited, illustrated in Theme 1.1 ('memories of other hostels').

Nevertheless this does raise the question on a service level of whether PIEs could be more explicit with their residents about trying to create a different type of environment and how this takes place. As indicated in Domain 1 ('what makes a home?'), staff were particularly thoughtful about resident involvement and co-production of the environment, but this did not translate into making the rationale behind this explicit to residents themselves. This may be linked to some of the ambivalence noted around whether a PIE was

simply a new trend or a label for good practice which some staff felt had been carried out for years. It may also have been because staff felt a lack of confidence explaining the rationale to residents.

### *Sampling strategy and gatekeeping of residents*

Weiss (1993) notes that any evaluation of programmes always takes place in a political context and that researchers should not ignore different interests and motivations of actors within the system and both the obstacles and opportunities these provide. This proved to be the case in gaining access to participants. The sampling strategy was to access staff through the hostel management and psychotherapy service, then to interview staff and ask them to nominate suitable residents. Hostel managers were, on the whole, keen to help find staff participants. There was a risk that management would only allow me to interview staff with an enthusiasm for the model or likely to present the hostel in a positive light, despite my explanation that this was an exploratory study rather than a service evaluation. Whilst it was helpful to speak to staff who had a good understanding of PIEs, it was clear that some staff did not like reflective practice in particular. However I was only able to gain this knowledge second-hand from others and it would have been useful to explore the reasons for this from those who actively disliked the process.

Resident recruitment proved to be more difficult. Residents on the whole were keen to take part but difficulties arose from being allowed access to them. This could have been for a number of reasons: staff may have been worried about residents offering critical views of them; therapists may have also been concerned that by asking residents what brought them to live at the hostel, I would be unnecessarily bringing up traumatic experiences and were trying to protect them from this. The issue of concern about blurred boundaries between therapist and recruiter for research was also possible. However I felt that the foremost reasons were likely to be those reflected in the research – that staff were under significant pressure in terms of time and resources to do anything on top of their normal job role and, as detected in the literature review, a culture of research may still be less strong in the voluntary sector.

### *Experiences of carrying out interviews*

As a novice in qualitative interviewing, I initially stuck quite rigidly to the interview schedule. I soon found that this led to repetition and in line with qualitative guidelines, modified the initial schedule to capture the main themes that were emerging. I was aware of the risk of putting words into participants' mouths and so found myself being less directive than I would have otherwise been, particularly when I felt a participant was about to make a point that I felt fitted with emerging themes. However, guiding participants less sometimes had the unintended consequence of people getting lost in their answer and when analysing the material produced large blocks of text which could occasionally lack focus.

I was in the position of having a dual role: as a former staff member myself with several years of experience working with homeless people I was able to understand the common language and the context of the system (for example pressures around resources and move-ons). It was only after research assistants who helped with transcribing brought to my attention they did not understand some terms (such as NTQ – Notice to Quit, PRF – Pathways Referral Form or names of services) that I realised I had taken these terms for granted. Berger (2013) discusses how being an 'insider' on a topic and having a shared language, background and frame of reference can give a researcher greater capital and in this context, to be taken more seriously by some staff. Despite this, I found myself often moving across the boundary from 'insider' to 'outsider' as described by Berger and also by Rowe (1999) in his study of outreach workers and homeless people. My 'outsider' position was particularly reinforced when I was viewed with some suspicion by other staff, some of whom expressed anxiety after the interview (usually off tape) that I had been going to test them on their understanding of psychological principles.

My concern that residents might be passive or acquiescent in the process proved unfounded as most were able to offer their views of the physical environment and feelings about relationships with their keyworker. However some more abstract questions such as how the environment 'felt' were more difficult to answer with some residents (and staff) struggling to find the emotional vocabulary to describe this, falling back on descriptions of

the literal physical environment. Some participants explained that they were struggling with the side effects of medication which made it difficult to think clearly, whilst others were mildly intoxicated (heavy intoxication being an exclusion criterion). Having a service user representative carrying out resident interviews might have added a further level of context to the interviews due again to a shared language and experience. Unfortunately the service user advisor who was recruited for the project was unable to work with me long-term due to other commitments.

### *Analysis and presentation of data*

As explained in Part 2, whilst I initially analysed staff, resident and therapist data separately, it became clear that the themes produced by the three groups were broadly similar, even if they contained contrasting perspectives (for example, views on recovery). I therefore decided to amalgamate the data from the three groups and present it together rather than create three separate units of analysis. The risk in this approach is that resident voices could get lost and just be used to back up points made by staff. Having been a staff member myself I was aware of aligning myself with staff over and above residents. Some themes by necessity only contained staff views (such as reflective practice). This also raised the question of whether this method privileges the more articulate who are better able to express their views and opinions through talking (discussed by Ashby (2011)) more literally in relation to people with disabilities). Whilst staff members were often able to express themselves at greater length, residents were on the whole, but not without exception, able to make succinct and often powerful comments about their experience of care.

I found myself faced with difficult decisions about what to include when presenting the data. So many quotations illustrated the domains I had chosen in diverse and interesting ways that I struggled to choose which to include, partly because excluding certain quotes felt like denying participants their voice and partly because of a need for myself to 'prove' what I had found, given the criticism of qualitative analysis as subjective and lacking rigour (Stiles, 1993). Using a composite narrative was one way to include more material but this could have failed to capture the tensions and contrasting views present.

## **The role of psychology**

The issue that continually arose during the research process (and justified its inclusion as a topic from the outset) was, beyond the provision of individual therapy - what is the role of psychology and psychologists in creating and working with psychologically informed environments? One might assume given the terminology that a psychologist would be central to such a task, but what emerged was a different picture that provided interesting reflections on the role of the profession and the blurred lines between formal therapy and a what is more broadly 'therapeutic'.

Whilst on one hand staff interviewees could have been anxious about being tested on their knowledge of psychological principles that informed their work, I wondered whether this was due more to psychologists being poor at communicating both their role and basic psychological principles in an understandable way. Psychologists have a reputation for being overly 'wordy', difficult to understand and protective of knowledge as somehow special or unique (Connolly & Williams, 2011; Osborne-Davies, 1996). Whilst residents were able to speak about the benefits of individual therapy, staff gave the impression that the process took place behind closed doors and was somewhat mysterious. Most staff had a strong implicit grasp of what their clients needed, but were not always able to label or fully articulate this in psychological language. Johnson and Haigh (2012) critique 'psychology with a big P' and suggest that what is needed in relation to a PIE is not detailed psychological techniques (or indeed a psychologist) but a basic understanding of concepts such as relationships, containment and attachment and training on how to put these into practice (Woodcock & Gill, 2014).

Given that much of the benefits of the relationships between staff and keyworkers came from their relationship being on the same level (Theme 3.2), this suggests that part of the psychologist's task could be to communicate these principles to workers and allow them to be embedded in their existing skills and practice without excessively formalising their role. The Royal College of Psychiatrists' response to an analysis of homeless mental health suggested that the challenge of meeting psychological needs partly depends on how

"therapeutic" and "professionalised" agencies are prepared to become (Royal College of Psychiatrists, 2009, p.6). However, this is often resisted: as one participant replied in their respondent validity check "we don't want staff to become any kind of 'ologist". In this respect the role of the psychologist in a PIE is more as a consultant and facilitator than direct practitioner, a direction in which the profession is becoming more active (British Psychological Society, 2007). As discussed in the next section this is something that needs to be done collaboratively within the values and culture of homelessness organisations.

### **Self reflexivity**

Debate is ongoing about to what extent researchers can 'bracket' their experiences (Fischer, 2009): on one hand, subjective experiences could be too influential in the treatment of the data (Tufford & Newman, 2012). On the other, it is recognised that these can provide a useful perspective on the material by allowing the researcher to be alert to relevant issues (such as the shared language and context already discussed). Ahern (1999) argues that attempts to eliminate the effects of personal experience are futile and the ability to be reflexive is more important - having an honest exploration of personal values and interests and understanding their effect on the object being studied, thus balancing the "tension between involvement and detachment" (Berger, 2013 p. 221). Finlay (2002) states that qualitative research should not be about "detached scrutiny" or reporting "facts and truths" (p. 532.) but recognition that knowledge is actively constructed and that the world and our experience of the world cannot be separated. The task therefore, is to "identify the lived experience that resides in the space between subject and object. The researcher strives to capture some of the connections by which subject and object influence and constitute each other" (p533).

The most important question in this respect throughout the research was whether my enthusiasm for finding a model that works, particularly one relevant to my chosen career of clinical psychologist, could cause me to interpret the data in an overly positive light. Johnsen, Cloke, and May (2005, p.787) warn against staff over-romanticising "spaces of care" for homeless people in this respect.



In addition to this, my dual experience was especially interesting in terms of reflexivity as I had experienced both the role of staff member and of (pre-qualified) psychologist and researcher. Reflective practice was a particular case in point, as I had experienced this from both sides. During training I co-facilitated reflective practice groups on an inpatient ward and struggled to encourage busy staff to sit down and think for an hour and justify why this might be necessary or even helpful. However as an outreach worker in a homelessness team, I also took part in reflective practice and despite valuing the process, I too had the experience of being a "doer" rather than a "thinker" (Theme 4.4), sometimes feeling that I was too busy to have the luxury of time to sit down and think when clients needed attention. Other colleagues questioned whether what we were doing was a psychological task at all and whether our time would not be more usefully spent "doing". It was often frustrating that what emerged as a psychologically healthy solution for a client was not practically possible within the constraints of the system (for example helping clients to access self-contained accommodation without negotiating benefits applications) - also reflected in Themes 5.2 and 5.3 of this research ('resources and expectations' and 'safety or moving on?'). On the other hand, as a trainee psychologist, I have also found myself rather angrily defending the homeless system that I had been a part of, or felt attacked when my current colleagues struggled to negotiate it or commented how detrimental some processes, such as the practice of verifying people sleeping rough, could be to psychological wellbeing (Department for Communities and Local Government, 2011). I would argue that being on both sides of the fence did enable me to use my experiences to enrich my understanding of the data whilst being careful to use reflexive abilities to recognise when I might be taking one position over another-often by recognising and monitoring emotions triggered during the research process (Ahern, 1999).

Finally I was struck by the answers staff gave to what was intended to be a warm up question about what motivated them to work in the homelessness sector. Staff took a highly value-driven approach to their work and spoke of being motivated by the desire to promote social justice or a recognition of structural inequalities. Some staff reflected that they had not

had the opportunity to talk about these motivations for a long time. There was a sense of working with some of the most damaged, in need and vulnerable people who other services and indeed the wider population do not want to acknowledge the presence of (Rowe, 1999) Whilst this can contribute to a culture of "hyperactivity" (Hoggett, 2010 p.203), having a workforce motivated by such values should be regarded as an asset rather than an obstacle. Creating an environment which balances staff being able to both 'do' and 'think' or reflect should underpin this.

### **Taking the idea forward**

Tackling the whole topic of PIEs in one research project turned out to produce a hugely rich amount of data on a range of different topics from reflective practice, to attachment relationships, to the relationship between behaviour and the physical environment that it was difficult to do justice to each of these areas. I was only able to give very cursory attention to some areas such as peer support from staff with personal history of homelessness and other areas such as resident mutual support were similarly given less consideration. Further work on each of these areas would help us understand in greater detail the processes involved.

PIEs are a potential way of approaching hostel provision for people who can live in shared, supported accommodation. However there are still a substantial number of people who are chronically homeless and cannot tolerate coming indoors at all, however supportive the environment (Teixeira, 2010). This raises the question of whether the principles and values of a PIE can be applied to broader settings such as outreach work. The "Pre-treatment" approach translates some of the principles of safety (including basic physical safety if not actual shelter) and relationship formation (engagement in a manner that promotes trust, safety and autonomy) into outreach work as a necessary process before trying to facilitate change (Levy, 2015).

Evidence gained around resources, move-ons from the hostel and the ambiguities around the recovery approach raised questions about whether a psychologically informed model is consistent or even possible within the current context of social care. Homeless

services have been contracted out to voluntary sector and other providers by local authorities for some time. However in the current economic and political climate resources have been greatly reduced whilst targets and goals have shortened and become more unrealistic. The increased marketization of both health and social care threatens to make this situation worse with the risk of short-term contracts being awarded at least partly on the basis of reduced cost or the ability to meet (unrealistic) targets. This is in addition to prominent media and political narratives about vulnerable groups including welfare claimants being duplicitous and undeserving (McGrath, Griffin, & Mundy, 2015), making homeless people an unattractive group in the eyes of many.

The solution to this needs to take place on a political level and depends on the ability and willingness of psychologists not only to have a voice on such matters but a loud and persuasive enough voice to influence policy.

### **Conclusions**

Carrying out this research into a relatively novel topic involved addressing challenges at methodological and practical levels at every step of the process. It also put me in the interesting and privileged position of researching something both close to my heart personally and formative in my professional experience. I hope that it will lay some foundations for the future research directions discussed and that the model will survive, grow and be something that psychologists play an active role in.

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## Appendices

## **Appendix A - Management Approval Letter**



14.01.15

Catriona Phipps  
University College London  
1-19 Torrington Place  
London  
WC1E 7HB.

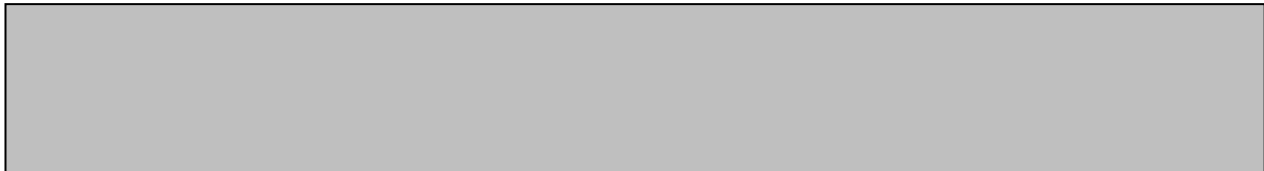
Dear Catriona

Many thanks for your enquiry and submission to conduct a qualitative research study at [redacted]. [redacted] I have considered your request and am happy to grant permission for you to progress.

On review of your proposal and in discussion with you and your supervisor Chris Barker, I understand that the project will not require NHS ethics clearance and that no major ethical concerns are likely to be identified in academic committee at UCL.

I look forward to working closely with you in the further preparation and implementation of the project including identifying and managing any risks that may emerge from the process of client semi-structured interviews with the support of the team at [redacted] and the local PIE project teams.

Best Regards





## **Appendix B - UCL ethical approval**



Professor Chis Barker  
Research Department of Clinical, Educational and Health Psychology  
UCL

24 February 2015

Dear Professor Barker

**Notification of Ethical Approval**

**Project ID: 6350/001: Staff and resident experiences of psychologically informed environments for homeless people**

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been approved by the UCL REC for the duration of the project i.e. until October 2016.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.
2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

**Reporting Non-Serious Adverse Events**

For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator [redacted] within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

**Reporting Serious Adverse Events**

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely



Professor John Foreman  
Chair of the UCL Research Ethics Committee

Cc:  
Catriona Phipps, Applicant  
Dr John King

## **Appendix C - Resident and Staff/Therapist Information Sheets**

**Staff and Resident Experiences of Psychologically Informed Environments for  
Homeless People  
Information Sheet for Residents**

My name is Catriona Phipps and I am a trainee Clinical Psychologist at UCL. I would like to invite you to take part in a research interview about the hostel that you are living in. Before you decide whether or not to take part, please read the following information about what it will involve.

This project has been approved by the UCL Research Ethics Committee (Project ID number 6350/001)

**What are you trying to find out?**

You may possibly know that this hostel is run in a particular way that is 'psychologically informed'. I am interested in your experience of living in this hostel: whether it is similar or different to other hostels you may have lived in, how you get on with staff and other residents and how you find the environment. Hearing about your experiences will help us understand more about this type of hostel and whether or not residents find it helpful. It will also help with planning and developing services in the future.

**Why have I been asked to take part?**

I am asking everyone who has lived in this hostel for more than one month to take part. I will also be talking to members of staff about their experiences of working here.

**Do I have to take part?**

The decision to take part in the project is entirely up to you. If you decide to take part and then change your mind, you can tell me at any time without having to give a reason. This will not affect any of the support you receive at the hostel.

**What will happen if I decide to take part?**

I would like to talk to you for up to an hour and ask you some questions about your experience of the hostel. This will take place at the hostel at a convenient time for you. There are no right or wrong answers: I would like to understand your experiences and views. I will audio record our conversation so that I make sure I remember everything you tell me. I will also ask you to complete a short questionnaire.

When we have completed the questions, you will be offered a £10 voucher to thank you for your time.

If you find answering any of the questions upsetting, you are free to stop our conversation at any time. You are also free to take a break and return when you feel ready.

The information you give me during our conversation will be kept confidential. The only exception to this is if you suggested that you or someone else is at serious risk of harm. In this case I would need to follow this up with staff at the hostel and other professionals.

**What will happen to my information?**

I will use the recording of our conversation to write down everything you have said. When I do this, your name and any identifying details will be removed so that all the information you give me is anonymous. The recording will then be deleted.

The written records will be stored securely. Only researchers involved in this study will be able to access this information. All of your information will be collected and stored in accordance with the Data Protection Act 1998.

I will put together the views of all the different people I speak to about their experiences of the hostel. These findings will make up a report that will be submitted to UCL and shared with management at [organisation name]. The report may also be published. I may use quotes of your exact words when I write up my report, but no-one will be able to identify you from these.

If you agree, I will send you a summary of what we talked about in our conversation and you will have the opportunity to feed back to me whether you think it is accurate. You can also chose to receive a copy of the final report.

**Who should I contact if I have any questions?**

Please discuss the information above with others if you wish. If there is anything that is not clear or if you have any further questions, please contact me or my supervisor Chris Barker.

**Thank you for taking the time to read this. If you decide that you would like to take part in the project, I will ask you to complete a consent form.**

**Researcher contact details:**

**Catriona Phipps**

[phone number]

[email address]

**Chris Barker**

[phone number]

[email address]

Research Department of Clinical, Educational and Health Psychology  
University College London, Gower Street, London WC1E 6BT

**If you have any comments or complaints you may also contact**

**[Manager name]**

[telephone number]

[email]

[address]

**Staff and Resident Experiences of Psychologically Informed Environments for  
Homeless People  
Information Sheet for Staff and Therapists**

My name is Catriona Phipps and I am a trainee Clinical Psychologist at UCL. I would like to invite you to take part in a research interview about the hostel that you work in. Before you decide whether or not to take part, please read the following information about what it will involve.

This project has been approved by the UCL Research Ethics Committee (Project ID number 6350/001)

**What are you trying to find out?**

I am interested in the experiences of people living and working in a 'psychologically informed environment' (PIE): how it compares to other hostels you may have worked in, how you relate to the residents in this environment and how you find reflective practice sessions. Hearing about your experiences will help us understand more about this type of hostel and how it could be a possible model for meeting the psychological and emotional needs of homeless people. This may contribute to the planning and development of services in the future.

**Why have I been asked to take part?**

I am asking all staff who have been working in the hostel for at least three months and who have taken part in reflective practice sessions about their experiences. I will also be talking to residents about their experience of living here.

**Do I have to take part?**

The decision to take part in the project is entirely up to you. If you decide to take part and then change your mind, you can tell me at any time without having to give a reason and without any penalty to you.

**What will happen if I decide to take part?**

I would like to talk to you for up to an hour and ask you some questions about your experience of working at the hostel. This will take place at the hostel at a convenient time for you. There are no right or wrong answers: I would like to understand your experiences and views. I will record our conversation so that I make sure I remember everything you tell me.

If you find answering any of the questions upsetting, you are free to stop our conversation at any time. You are also free to take a break and return when you feel ready.

The information you give me during our conversation will be kept confidential. The only exception to this is if you suggested that you or someone else is at serious risk of harm. In this case I would need to follow this up with the hostel manager and other professionals.

**What will happen to my information?**

I will use the recording of our conversation to write down everything you have said. When I do this, your name and any identifying details will be removed so that all the information you give me is anonymous. The recording will then be deleted.

The written records will be stored securely. Only researchers involved in this study will be able to access this information. All of your information will be collected and stored in accordance with the Data Protection Act 1998.

I will put together the views of all the different people I speak to about their experiences of the hostel. These findings will make up a report that will be submitted to UCL and shared with management at [organisation name]. The report may also be published. I may use quotes of your exact words when I write up my report, but no-one will be able to identify you from these.

If you agree, I will send you a summary of what we talked about in our conversation and you will have the opportunity to feed back to me whether you think it is accurate. You can also chose to receive a copy of the final report.

**Who should I contact if I have any questions?**

Please discuss the information above with others if you wish. If there is anything that is not clear or if you have any further questions, please contact me or my supervisor Chris Barker.

**Thank you for taking the time to read this. If you decide that you would like to take part in the project, I will ask you to complete a consent form.**

**Researcher contact details:**

**Catriona Phipps**

[phone number]

[email address]

**Chris Barker**

[phone number]

[email address]

Research Department of Clinical, Educational and Health Psychology  
University College London, Gower Street, London WC1E 6BT

**If you have any comments or complaints you may also contact**

**[Manager name]**

[telephone number]

[email]

[address]

## **Appendix D - Consent Form**



**Staff and Resident Experiences of Psychologically Informed Environments for  
Homeless People  
Consent Form**

This project has been approved by the UCL Research Ethics Committee (Project ID number  
6350/001)

**Please complete this form after you have read the Information Sheet**

*Please tick if you agree:*

I have read the information sheet and understand what the study involves. I have been given the chance to ask any further questions:

I understand that my participation will be recorded and I consent to the use of this material as part of the project:

I agree that my words can be used in a written report which may be published, but that they will not include my name or any identifying details:

I understand that if I no longer wish to take part, I can stop my conversation with the researcher or withdraw my information from the project at any time without giving a reason:

I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with the provisions of the Data Protection Act 1998:

I agree that the research project has been explained to me to my satisfaction and I agree to take part:

Participant name (BLOCK CAPITALS): \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Researcher name: (BLOCK CAPITALS): \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

I would like to receive a written summary of my conversation with the researcher and have the opportunity to feed back whether I think it is accurate.

I would like to receive a summary of the finished report

***If you have ticked this box, please indicate how we can contact you:***

***I would like to receive the summary by post to the hostel address:***

***I would like to receive the summary by email (please provide an email address below):***

.....

## **Appendix E - Resident, Staff and Therapist Interview schedules**

**Staff and Resident Experiences of Psychologically Informed Environments**  
**Resident Interview Schedule**

*Thank you for agreeing to being interviewed for this research project. It will take up to an hour. I need to run through a few details with you before we start and check that you are still happy to take part.*

- *I'll be asking you some questions about yourself and how you find living in this hostel.*
- *Taking part is entirely voluntary, so if at any stage you want to stop, please tell me.*
- *I'll be recording our conversation on this dictaphone*
- *Afterwards I will type up our conversation. Your personal details will be kept anonymous. This means I may use your words to show a particular point, but your name will not be used. Please feel free to speak openly and tell me your opinions.*

*Do you have any questions before we begin?*

*I'm going to ask you to sign this form to say that you agree to take part:  
**Give consent form and obtain signature.***

*I'm also going to ask you to complete this form with some questions about you:  
**Give demographic information form***

*And before we start, I'm going to ask you to complete these questions about how well you feel the hostel meets your needs.*

***Give the questionnaire: Experiences of living in the hostel (Amended SAQ).***

*Now I'm going to start the recording.*

**1) Setting/Background:**

**Briefly, could you tell me what brought you to live in this hostel?**

Prompts: Can you tell me a little about what life was like before you came to live here?  
How long have you lived here?  
Who arranged for you to live here?  
When you knew you were coming to live here, how did you feel about it?  
Have you lived in any other hostels?

**2) Understanding of PIEs:**

**How does this hostel compare to others you've lived in?**

Prompts: Are there any particular similarities to other hostels?  
Do you notice any particular differences?  
What do you know about the way this hostel is run?  
If you were describing this hostel to someone who didn't know anything about it, what would you say?

**3) Experience of living in the PIE**

**How do you find living in this hostel?**

Prompts: What are the best things about living here? The less good things?  
Have you been offered the chance to speak to the therapist from  since you've lived here? If so, how have you found it?  
If not, why did you decide not to speak to them?  
How do you feel about moving on from the hostel?

### **3.1) Atmosphere and environment:**

#### **How do you find the atmosphere of the hostel?**

- Prompts:
- How would you describe the atmosphere of the hostel?
  - If you could change anything about the atmosphere, what would it be like?
  - How do you find the physical space of the hostel?
  - If you could change it, what would it be like?
  - What are the hostel rules? What happens if you break them?
  - Do you get consulted about the way the hostel is run? If so, how?

### **3.2) Relationships within the hostel:**

#### **How do you get on with other people here?**

- Prompts:
- How do you get on with staff here?
  - Which members of staff work with you? Do you have a keyworker? How long have you known them?
  - What kind of things do you do with your keyworker?
  - If you need to ask for help, who would you do? What happens?
  - What are the most/least helpful things about the way staff work with you you/talk to you?
  - Is there anything else that staff provide that helps?
  - Is there anything else you would like staff to do or do differently?
  - How do you get on with the other residents here?
  - How do residents support one another?

### **4) Understanding of PIEs (follow up):**

**This hostel sees itself as a 'psychologically informed environment'. I wonder if you've ever heard staff using this term? (check).**

**In terms of the things we've discussed, do you have any ideas why they describe the hostel in this way?**

- Prompts:
- Do you have any thoughts or ideas about what PIE might be?
  - If so, what does it mean to you?
  - Do you have any thoughts or ideas about why such an environment was put in place here?
  - From your perspective, what advice might you offer to someone else setting up a similar service?

*That's all the questions that I have to ask you. Do you have any final comments or questions about anything we've talked about?*

*Thank you for taking part. How did you find the interview? Did the interview raise any concerns which it would be helpful for us to discuss?*

*I'm going to stop the recording now.*

***Give voucher and ask participant to sign voucher receipt form.***

**Staff and Resident Experiences of Psychologically Informed Environments for Homeless People**

**Staff Interview Schedule**

*Thank you for agreeing to being interviewed for this research project. It will take up to an hour. I need to run through a few details with you before we start and check that you are still happy to take part.*

- *I'll be asking you some questions about yourself and how you find working in this hostel.*
- *Taking part is entirely voluntary, so if at any stage you want to stop, please tell me.*
- *I'll be recording our conversation on this dictaphone*
- *Afterwards I will type up our conversation. Your personal details will be kept anonymous. This means I may use your words to show a particular point, but your name will not be used. Please feel free to speak openly and tell me your opinions.*

*Do you have any questions before we begin?*

*I'm going to ask you to sign this form to say that you agree to take part:  
**Give consent form and obtain signature.***

*I'm also going to ask you to complete this form with some questions about you:  
**Give demographic information form***

*Now I'm going to start recording.*

**1) Setting/Background:**

**Can you tell me about your job and how you find working at this hostel?**

Prompts:       How long have you worked here?  
                  How many residents do you keywork?  
                  What led you to want to work in this role?  
                  Have you any prior experience of working with homeless people? Do you have any other training or qualifications and how do they help with your work?

**2) Understanding of PIEs:**

**This hostel is a PIE. How do you understand the concept of a PIE?**

Prompts:       If you had to describe a PIE to someone who didn't know what it was, what would you say?  
                  Are there any differences or similarities between this hostel and others you have worked in that aren't PIEs?  
                  How do external agencies or other people understand what happens here?

**3) Experience of working in the PIE:**

**What's your experience of working in or delivering the PIE?**

Prompts:       What role do you play within the PIE?  
                  How do you find the reflective practice sessions? How do you find the other training provided?  
                  How do you think they have influenced your professional practice?  
                  Apart from reflective practice, how else are you supported to do your job?  
                  How do you find moving residents on from the hostel?

**3.1) Atmosphere and environment:**

**How would you describe the atmosphere in this hostel?**

- Prompts:        If you could change anything about the atmosphere, what would it be like?  
                    How do you find the physical space of the hostel?  
                    If you could change it, what would it be like?  
                    What are the hostel rules? What happens if someone breaks them?

**3.2) Relationships within the hostel:**

**How do you find working with residents at this hostel?**

- Prompts:        What things do you do with the residents you keywork?  
                    What do you find most rewarding or easiest about working with this client group?  
                    What things do you find most challenging?  
                    Are there any things that make it difficult/easier to support residents here?  
                    Does working in a PIE change anything about the relationship you have with your residents?  
                    Could you give me any examples of a success or a difficulty working with specific residents here?  
                    How do the residents get on with each other in the hostel?

*That's all the questions that I have to ask you. Do you have any final comments or questions about anything we've talked about?*

*Thank you for taking part. How did you find the interview? Did the interview raise any concerns which it would be helpful for us to discuss?*

*I'm going to stop the recording now.*

**Staff and Resident Experiences of Psychologically Informed Environments for Homeless People**

**Therapist Interview Schedule**

*Thank you for agreeing to being interviewed for this research project. It will take up to an hour. I need to run through a few details with you before we start and check that you are still happy to take part.*

- *I'll be asking you some questions about yourself and how you find working in this hostel.*
- *Taking part is entirely voluntary, so if at any stage you want to stop, please tell me.*
- *I'll be recording our conversation on this dictaphone*
- *Afterwards I will type up our conversation. Your personal details will be kept anonymous. This means I may use your words to show a particular point, but your name will not be used. Please feel free to speak openly and tell me your opinions.*

*Do you have any questions before we begin?*

*I'm going to ask you to sign this form to say that you agree to take part:  
**Give consent form and obtain signature.***

*I'm also going to ask you to complete this form with some questions about you:  
**Give demographic information form***

*Now I'm going to start recording.*

**1) Setting/Background:**

**Can you tell me about your job and your work at the hostel?**

Prompts:        Could you tell me about the main parts of your role here?  
                     How long have you worked in this role?  
                     What was it that led you to want to work in this setting/with homeless clients?

**2) Understanding of PIEs:**

**This hostel is a PIE. How do you understand what a PIE is?**

Prompts:        If you had to describe a PIE to someone who didn't know what it was, what would you say?  
                     Are there any differences or similarities between this hostel and others you have worked in or been to that aren't PIEs?  
                     Why might PIEs be particularly relevant to this client group? (if you agree that they are?)  
                     Do you think clients have an understanding that this is a PIE/similar or different to other places?

**3) Experience of working in the PIE:**

**What's your experience of working in or delivering the PIE?**

Prompts:        What role would you say you play within the PIE?  
                     How do you find facilitating the reflective practice sessions? How are they received by staff? Are there any challenges in helping staff reflect on their work?  
                     What changes, if any, do you think the sessions make to the staff team? And to clients?  
                     Could you give me an example of any of these changes?



How do you find delivering individual therapy to the clients in this hostel? How is it similar or different to working with other client groups?  
What would you say are the main challenges about the role? And the best things?  
Are there any differences between how you would ideally imagine a PIE and the realities of how things are set up here?

**3.1) Atmosphere and environment:**

**How would you describe the atmosphere in this hostel?**

Prompts:           How do you find the physical space of the hostel?  
                      How do you find the atmosphere of the hostel?/how it feels to be here?  
                      If you could change either of these things, what would it be and why?  
                      Does the fact that the hostel is a PIE influence these things?

*That's all the questions that I have to ask you.*

*Do you have any final comments or questions about anything we've talked about?*

*Is there anything you think I should have asked which I missed out?*

*Thank you for taking part.*

*How did you find the interview?*

*Did the interview raise any concerns which it would be helpful for us to discuss?*

*I'm going to stop the recording now.*

## **Appendix F - Examples of analysis**

Figure 1 illustrates the analysis applied to two original transcripts, one from a resident interview and another from a staff interview.

Table 2 and illustrates how each code was organised into the final themes in Domain 4. Some codes were dropped, some were amalgamated and others moved into a different domain. Some themes were named after the initial codes and others were given labels to capture the meaning of an amalgamated group of codes.

Figure 1: Example of coded transcript

	Initial notes	Coding	Final theme and domain
<p><b>Resident Transcript:</b></p> <p>Interviewer: And are there any differences or similarities between the atmosphere at your other hostels and here, how it sort of feels to be living in the different places do you think?</p> <p>Participant: Yeah, <u>the atmosphere's different actually yeah.</u></p> <p>I: Can you tell me what it is that's different?</p> <p>P: Well, [sigh] the only one I can remember is <u>the last one actually, it's the people I was living with, I was sharing with, I wasn't getting along with them, I was having a lot of argument with them, the toilets specially when they use or I use and they complain in the showers, knocking on the door and asking me cigarettes or sugar, something ridiculous like that and bringing their guests out and walking up and down the kitchen throwing everywhere rubbish. Here it's not like that actually, we've got a living room and we've got a kitchen separate so living room if your guests come in, they sit down there, yeah. To look after it there's a cleaner here so they clean all the time, I've never seen it dirty actually even how many people I share with six people because my old house there were only two people had to share with, I was the third one, but here it is six and that doesn't happen here.</u></p>	<p>Atmosphere different to last hostel</p> <p>Not getting on with others at last hostel</p> <p>Lots of arguments</p> <p>More chaotic</p> <p>Here it's not like that</p> <p>More space</p> <p>Cleaner environment</p> <p>Sharing with more people but environment better</p>	<p>Negative comparisons to other hostels</p> <p>Negative comparisons to other hostels</p> <p>Physical environment: positive</p>	<p>1.1 Memories of other hostels</p> <p>1.2 Constructing a home</p>

<p>I: That's interesting. Ok, and if you had to describe this hostel to somebody that didn't know where you lived, so a friend for example, what would you tell them, what would you tell them that it's like, what would you tell them about the place that you live?</p> <p>P: Um, I would tell them that <u>you get a lot of support actually</u>. Because I've got friends and I told them, he lives at [...]. <u>I used to live there beforehand</u>. He's got his own room, kitchen, toilet and everything he has, there's twenty four hours security as well but <u>he doesn't...they don't have people at college, study</u> or..he's got a problem with drugs, and drug anonymous, alcohol anonymous, <u>they don't help him like the way here has helped</u>. <u>If you have a problem, I had [keyworker] yesterday, and I had a nice conversation with her</u>, something like that, <u>someone who gives you advice</u> and tells you don't do that, don't do that, <u>someone cares for you</u> I mean that's how it is in here, that's why I <u>feel everyone in here, all attention is for your care</u>, your health, your interest in everything <u>they support you with it</u>.</p>	<p>Getting support</p> <p>Comparison to a place lived in before</p> <p>Other hostels not providing same help, opportunities</p> <p>Getting help</p> <p>Talking with keyworker</p> <p>Getting advice from keyworker</p> <p>Feeling cared about by keyworker</p>	<p>Support and help</p> <p>Negative comparisons to other hostels</p> <p>Support and help</p> <p>Keyworker relationship</p> <p>Caring</p>	<p>1.1 Memories of other hostels</p> <p>3.3 Client perspectives of relationships</p>
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<p><b>Staff transcript:</b></p> <p>P: It's a <u>very relaxed project...we have, I don't think we've had the police here for a very long time, ambulances don't come here very often...</u></p> <p>I: Is that something's that happened a lot in other places?</p> <p>P: <u>It does happen in a lot of other places.</u> It may be because we don't have a high level of drug use here, but , no we don't tend to have a lot of incident reports done, usually the safeguarding reports are generally for things that have happened outside with clients. <u>The clients are quite relaxed, we have a very open-door policy in the office which at times can cause problems cause they won't knock on the door, they'll just walk in when it's closed...</u> but I think it's a <u>very relaxed place.</u></p> <p>And I think <u>part of that is driven by the PIE</u> cause it's, you know, <u>they need to feel safe and secure.</u> It's <u>not all about sort of targets and goals and things like that, we kind of try and protect them from that in some ways.</u></p> <p>We kind of make it clear that...we understand why the service is here and <u>the pressures involved</u> , but we will kind of say you know, <u>asking somebody to move within three days when they've been here for three years is not like, for them psychologically, it's not a good thing, and we will say that, you know you might want to</u></p>	<p>Calm, relaxed Ambulances and police haven't been here for a long time</p> <p>Other hostels more chaotic Low level of drug use</p> <p>Client needs - safeguarding</p> <p>Relaxed Open doors Flexibility/tolerance Relaxed</p> <p>They need to feel safe and secure Targets and goals Protection (but also from 'taking responsibility' later?)</p> <p>Targets/pressures</p> <p>Negative effects of moving on</p> <p>Expectations: turning the room</p>	<p>Relaxed/calm Negative comparison to other hostels</p> <p>Negative comparison to other hostels</p> <p>Relaxed/calm Flexibility Relaxed/calm</p> <p>Safety Targets and goals</p> <p>Pressure Effects of moving on</p>	<p>1.1 Memories of other hostels</p> <p>2.3 Flexibility and engagement</p> <p>1.4 Feeling safe</p> <p>5.3 Safety or Moving on?</p> <p>5.2 Resources and expectations</p>
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<p><u>turn the room around quickly</u> but this person needs a bit of time to think about what's going on and I think that helps.</p> <p>It's definitely <u>supported by things</u> like just offering if they want to have a coffee and cake and stuff before they go with other people, do they want other people to know, <u>that all comes from us talking about what's going on in reflective practice, and some of those small things that you would miss necessarily.</u></p>	<p>round quickly</p> <p>Individual/personal support</p> <p>Reflective practice: getting a better picture of someone's needs</p> <p>Noticing things that would be missed</p>	<p>Resources</p> <p>Flexibility</p> <p>Seeing someone as a whole</p> <p>Gaining awareness and understanding;; doing things differently</p>	<p>2.2 Flexibility and engagement</p> <p>4.2 Gaining awareness and understanding</p> <p>4.3 Doing things differently</p>
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Table2: Examples of codes making up the final themes in the domain 'Reflective Practice'

<p><b>Reflective Practice</b></p>	<p>4.1 Working with distress: the need for reflective practice</p> <ul style="list-style-type: none"> <li>• Emotional reactions and challenges</li> <li>• Stress and pressure</li> <li>• Challenges with client behaviour</li> </ul> <p>4.2 A "thinking space": gaining greater awareness</p> <ul style="list-style-type: none"> <li>• Protected space</li> <li>• Seeing someone as a whole</li> <li>• Gaining awareness and understanding</li> <li>• Understanding behaviour</li> </ul> <p>4.3 Doing things differently</p> <ul style="list-style-type: none"> <li>• Doing things differently</li> <li>• Learning</li> <li>• Seeing changes</li> </ul> <p>4.4 The staff role: thinking or doing?</p> <ul style="list-style-type: none"> <li>• Talking about feelings</li> <li>• Challenges to reflection</li> <li>• Thinking vs doing</li> </ul>
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## **Appendix G - Example of Testimonial Validity letter**

[Name]

[Role]

[email address]

19th December 2015

Dear [Name],

**Re: Research into Psychologically Informed Environments**

Thank you for taking part in a research interview with me about [name of hostel] being a Psychologically Informed Environment (PIE).

Before the interview, you said that you would like to receive a summary of the themes that arose from our conversation. This is so you can let me know whether or not you think what I have taken from the conversation is accurate.

I have enclosed a summary document with this letter and some space for your comments.

Please feel free to contact me either by replying to this email [email address], or contacting me by phone on [number].

When the study is finished, I will send you a copy of the final report.

Best wishes and thank you again for your participation,

**Catriona Phipps**

**Trainee Clinical Psychologist**

**UCL**

### **Summary of themes from your interview:**

You told me that:

- 1) Peer support: there are elements of peer support in your role [REDACTED] and because of your own background. This gives you a special perspective on your work.
- 2) Being on a level: it's important to you to be on the same level and be equal with residents, for example your informal style of keyworking and being able to sit round the table with residents and chat.
- 3) Being positive and considerate in your communication: you told me that an important part of PIEs was to think about how you communicate with residents, for example how you word posters, when you manage client expectations about having to wait to see you when you are lone working and when you ask residents not to smoke indoors.
- 4) Co-production: you told me that at the hostel residents are encouraged to co-produce the environment, such as helping with decoration. This gives a feeling of being more democratic and is important because the hostel is the residents' home.
- 5) Protected time and safe space: you told me that reflective practice provides a safe space to talk about clients or issues within the team. It helps you have greater awareness of issues and means you can appreciate multiple different points of view about a problem or issue.
- 6) Team issues and relationships: you told me that sometimes there were difficulties in the team such as communication.
- 7) Physical environment: you told me that there were some negative things about the physical environment such as how the buildings are maintained. This can be confusing to residents about how their space is valued. However you also described positive things in PIE environments such as having animals.
- 8) You described some flexibility rather than being punitive in enforcing the rules of the hostel, such as asking people politely not to smoke.
- 9) Relationships with residents: you told me that you are aware that residents may have had difficult lives and therefore it is important to spend time with people and allow them to trust you.
- 10) You told me that there can be tensions between what you think is important in the PIE, such as spending more time with people and what you can actually achieve because of the pressures of lone working and having to complete admin tasks.

How accurate is this summary?

Is there anything else you would like to add?

Is there anything you think is wrong with the summary?

Do you have any other comments on the interview or the study in general?