PIEs at St Mungo’s

**Background**

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

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

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

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

We are currently piloting PIEs at seven different sites.

**St Mungo’s PIEs**

St Mungo’s pilots include:

- three projects for people with diagnosed severe and enduring mental health problems
- Rolling shelter for rough sleepers coming directly from the streets
- Women’s project
- Project for people with dual diagnosis
- First stage rough sleepers hostel

They are situated in London and the South West.

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

- Psychological framework
- The physical environment and social spaces
- Staff training and support
- Managing relationships
- Evaluation of outcomes
We will therefore describe the pilots in terms of these headings, rather than project by project. We have placed ‘Managing Relationships’ first because of its primary importance.

**Managing relationships**

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

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

Positive relationships can repair (much of) the damage from these negative relationships. Positive relationships are ‘therapeutic’ in the broad sense, meaning healing and enabling, whether they are formally therapeutic as in our psychotherapy sessions or informally therapeutic as in the relationship between key staff and clients. Just as clients cite relationship breakdown as one of the principle causes of homelessness, they also cite a positive relationship, often with someone involved in their support, as crucial to their recovery. This is very empowering for staff too: as individuals, and through their own actions and behaviours, they really can make the difference. We see psychologically informed environments as a way to provide the best conditions we can for as many staff as possible to do just that.

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

Making PIEs a reality, therefore, becomes a whole system project requiring the recognition that managing relationships needs to be something that everybody does. This again aligns with recovery, which is a whole system approach. How do staff do it if their managers, or senior managers, or HR, don’t? St Mungo’s have therefore adopted an organisational change programme incorporating the concepts of PIEs, personalisation and recovery, and applied it across all our services and central teams. We are changing recruitment, training, appraisal, performance management, and a host of other systems.

**Psychological framework**

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

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

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

Secondly, the psychodynamic approach fits well with the recovery approach. It emphasises relationships, the potential for sustainable change within each of us, the dynamic and changing nature of who we are, and how that is impacted on by our interaction with our environments, human and physical, and it emphasises that everything we do and all that we feel is meaningful, not just arbitrary. It values individuals over categories: psychodynamic approaches work with the client’s perspective and meanings, and on the topics the client wants to work with, rather than imposing a structured model on them, or channelling them into categories and conditions, and then treating the category/condition. Our own psychodynamic work is constantly evolving, developing new ways of working in response to interactions with clients.

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

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

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

The Physical Environment and Social Spaces

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

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

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

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

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

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

The training modules we offer are:

- **Managing relationships 1:** how behaviours and interactions can be understood through the concepts of attachment, the processes of change (including Cycle of Change), transference and countertransference, power dynamics, respect, and the impact of expectations and aspirations.

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

- **Supporting change:** using client developed methods such as the Escape Plan or 10XBetter, and the recovery approach to foster transformative actions and activities, including coproduction.

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

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

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

**Evaluation of outcomes**

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

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

We are in the process of agreeing the use of more clinical evaluation tools, working with psychologists and psychiatrists to measure the clinical impact.
As it is early days for most of the pilots so far we only have indicative results. Outcomes include:

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

**Conclusion**

We feel that, though there is undoubtedly still much to be done, we have already achieved much to be proud of. We will be publishing a preliminary report early in 2012, and a fuller one in September 2012, when we will have a more comprehensive dataset, including preliminary clinical material.

Until then, we leave you with a comment from one of our clients:

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

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