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ACP UK ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Practice-based guidelines:

Clinical Psychologists working with and in Homelessness

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Introduction

These guidelines are the result of a recognition that a growing number of clinical psychologists are working within services for people facing homelessness and severe multiple disadvantage (SMD), who have often been excluded from mainstream statutory services. Due to this exclusion, people facing homelessness have often not had contact with clinical psychology services, and clinical psychologists have often had no contact with them or the services that support them. It is for this reason that these guidelines were developed: to learn from the small minority of clinical psychologists working in this area and share their expertise with others.

Twelve experienced clinical psychologists anonymously contributed to the development of these guidelines through a structured and rigorous Delphi method research process that developed a consensus about good practice in the field. The guidelines may be helpful for both clinical psychologists already working in this field and those in mainstream services working to increase the inclusion of individuals facing homelessness and SMD. The guidelines may also support the understanding of the growing number of commissioners and services seeking to employ clinical psychologists in this field. The guidelines provide crucial information regarding where the profession's efforts should be placed to best support this population and the staff working with them. They provide the foundations to guide future policies at both an organisational and wider systemic level across the sector, creating the foundations for the accountability of the provision of appropriate, high quality support to be measured against. They promote the provision of support and training to staff, with a view to promoting the wellbeing of staff as well as those using services. Furthermore, they highlight to services and commissioners the need for research and service development to be incorporated into clinical psychology posts to generate further evidence and guide the provision and quality of psychologically informed support to those traditionally excluded.

The guidelines are divided into those relating to 'direct' work with people using services and those focused on 'indirect' work: supporting others to do their direct work and making broader contributions to the sector through working with systems and engaging in research. Some guidelines may be applicable to both direct and indirect work but they are generally organised into these two categories. Anonymised vignettes are provided for each guideline to illustrate different ways in which the ideas might be implemented. These are all based on real examples provided by clinical psychologists involved in developing the guidelines. We hope this brings them to life and offers inspirational examples of what can be achieved when clinical psychologists work flexibly and collaboratively to promote the rights and meet the needs of those facing homelessness.

Acknowledgements

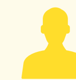
We would particularly like to thank the 12 Clinical Psychologists who took the time to contribute to these guidelines so that psychologically informed ways of working in homelessness services can be both recognised and advanced. We would also like to thank the many people they have worked with, who have taught them what works. Finally, thanks to Dr Ché Rosebert for her contributions and support in relation to these guidelines.

Direct working guidelines

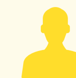
Approach

1. Be flexible in your approach, holding the person at the centre of your work, encouraging all opportunities to engage.

For example, flexibly implementing protocols, moving your working hours to facilitate appointments, and considering how and where you engage people. Use outreach and in-reach approaches, taking psychological interventions to the point of need, going out to where homeless people find themselves so you are visible to the homeless community and their support networks (e.g., hostels, day centres, streets). This may mean meeting outside of the clinic or office base, meeting where service users feel comfortable e.g., meeting in public spaces providing confidentiality can be maintained.



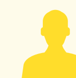
Oliver's service is open access with no exclusion criteria to encourage engagement, going to the service user, meeting where they feel comfortable. In Oliver's experience, this often means meeting outside of the clinic environment including visiting hostels, day centres and local GP practices. Being flexible in working hours also helps to facilitate early morning outreach providing the opportunity to engage with rough sleepers. If a person experiencing homelessness would like to talk to Oliver during this outreach, he will do this in situ, whilst respecting confidentiality and environment they are in, using this as an initial contact to build on.



Neil casts the referrals net 'far and wide' including local Accident and Emergency Departments who see certain faces on a regular basis and other organisations such as housing, mental and physical health services, the police, and social services. Initial engagement means going out to meet the person where they are at rather than expecting them to come to you. If Neil does not get a response from them initially, he will keep working to get into contact with them and is often creative in the way that he does this e.g., contacting their social worker to find out where they last saw them and to provide an update on the individuals circumstances or visiting a local day centre the person is known to visit. Though flexible in taking their services to the point of need, Neil also ensures that they have implemented good, clear risk protocols for all staff operating outside of standard protocols (e.g., meeting on a canal tow path bench rather than at a clinic) which helps them and other staff members to feel safe in their role.

2. Prioritise relationship building as it can take time to build trust and engagement.

Do not expect the work to follow a pre-determined or 'manualised therapy' route. Life events will get in the way (i.e., moving accommodation, becoming street homeless, physical health concerns), so it is important to journey alongside someone.



Working with this population has led Elaine to recognise the importance of adapting the way you engage with an individual to build the therapeutic relationship. One of Elaine's most successful therapy appointments was using what Elaine refers to as 'rap therapy'. The service user found it too difficult to talk to Elaine, but they would rap about their life and how they were feeling. Using a less traditional

method and being open to being creative, using the service user's preferred way of communicating helped build the relationship. Being able to have humour and 'rap back' helped reduce the power imbalance as Elaine was not going in from a point of 'expertise' and could communicate in a way the service user found helpful.

Michael was living on the streets when he was referred to Andrew. During their work, Michael moved from the streets to a friend's house, to emergency accommodation and then was admitted to hospital before being discharged and supported into an appropriate hostel setting. Andrew worked with Michael throughout this time and remained involved in his care, meeting with him on a regular basis including on the ward, completing cognitive screenings and additional assessments. Journeying alongside Michael and continuing to be involved in his care irrespective of Michael's circumstances helped Michael to build trust with Andrew and the wider professionals and services, resulting in him being placed in appropriate supported accommodation.

3. Attend to the therapeutic relationship, being mindful of the interaction between trust and attachment.

Use supervision to discuss and reflect on how best to manage the relational and power dynamics between yourself and the service user. DNA's and re-referrals may be part of the engagement process - reflecting on these with service users can help build understanding and trust with staff and services.

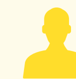
Naomi had been referred to psychology twice before. She had left each time after a couple of sessions when she thought the psychologists were telling her to let go of the past by forgiving the people who had abused her. She did not attend the first session but responded to a telephone call and had a lengthy conversation with the psychologist Thandie. Having discussed in supervision concern that Naomi would disengage early again, the need for Naomi to be confident that she could lead her therapy was highlighted. Thandie summarised the conversation in a letter both to check they had a shared understanding and to give Naomi something tangible to hold onto. Naomi felt understood and after a few telephone consultations attend sessions reliably in person.

Jeanne found that reaching women in a high support mixed-gender hostel seemed particularly difficult. Perhaps due to histories of complex and long-running (often ongoing) traumas, difficulties building trust, perceived differences in social class and status, shame and an expectation of being judged and let down by professionals. Jeanne drew on research and input from the women themselves to devise a female centred approach. This included offering female-only groups, women from the hostel acting as co-facilitators and being creative and flexible with engagement approaches (chats over cups of tea,therapy whilst out walking). Jeanne found supervision essential for understanding engagement patterns and relational dynamics, where often a period of engagement would be followed by multiple DNAs and it was tricky to find a balance between encouraging continued therapeutic contact vs the woman having enough control over the relationship. Jeanne found the book 'Streetalk' by Pippa Hockton really helpful for understanding the relational patterns that can occur in therapy with very traumatised women.

4. Consider the likely trauma histories of service users you are working with, appreciating engagement can be a long process, as it is likely trust has been violated multiple times.

Re-building this will take time and will require flexibility regarding DNAs etc.

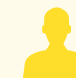
Tim arranged to meet Craig multiple times over several months to complete a neuropsychological assessment, however, Craig was not there when Tim visited at the agreed times. After several months of arranging to meet, Craig did attend the appointment, explaining he now felt ready to engage with the service. Tim explained that, by making sure he turned up at the time and place that had been agreed even if though Craig had consistently not attended showed that Tim was consistent, reliable, and did not deprioritise him over other tasks. Tim recognised that it is likely persons experiencing homelessness, including Craig, have been let down multiple times in the past in relationships, and during contact with other services, professionals, and providers. Working through this, by being reliable is likely to help build trust and increase the likelihood that a person experiencing homelessness will engage with services.



Owen had worked with Heather for over a year after she moved into a hostel for women escaping domestic violence. Heather had experienced multiple traumas in her family home as a child and into her adult life with her long-term partner. Whilst working with Owen, Heather had to be rehoused several times as her ex-partner managed to locate her, and also assaulted her on one occasion. Owen had to be mindful that he was not just managing historic trauma, but live trauma. Therefore, it was important that Owen was flexible and provided a safe space for Heather to engage over a long period of time, at her pace.

5. Many people who are homeless may have lost touch with hope, so it is important to actively maintain it.

Communicating hope to the service user and others in their system can be a radical force for change. Use supervision to nurture hope and support you to avoid problem saturated stories about service users. Avoid individualising the problems of the person who is homeless by accounting for the sociopolitical context and social/relational history of the person. Individualising and pathologising discourses can counteract hope and agency.



Oliver uses narrative formulation to help decentre away from one way of thinking. In both direct therapy and indirect working with staff, he considers what has been influential in a person's a life, incorporating the wider social context. Oliver believes this is particularly pertinent with people experiencing homelessness. Telling a story and helping the individual to develop other stories can help the person identify and understand what their values, hopes, dreams and wishes are in relation to their own moral code. This can help to foster engagement and increase motivation for them make the changes that they want to.

Annabelle maintains active hope by providing service users with an element of choice and control in whether they attend appointments or not, and openly

discussing with them what she is thinking of offering. Providing service users with choice, control and collaboration can be a valuable asset as many will not have experienced this before. If a service user chooses not to take up the space offered, Annabelle reiterates that the space will be available to them in the hope that they will take it up when they are ready to use it.

6. Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.

Ryan had experienced many traumas from his early years into adulthood. He had been a victim of violence and a perpetrator and had been imprisoned for dealing drugs. He was going through lengthy court actions to regain contact with his children who barely remembered him. In therapy Psychologist Olatunde helped Ryan explore the kind of father he wanted to be even if he did not have direct contact with his children and signposted Ryan to both legal services and services that could support him to be the best Dad he could be directly or indirectly. By the end of the work Ryan had been allowed to write a letter to his children and was hopeful about future contact.

Peter was working in an outreach team. The multidisciplinary team (MDT) identified an entrenched rough sleeping man, Jerry, who avoided contact with others. Jerry had an opiate dependency, was not engaging with addictions services, had a chaotic lifestyle and the MDT suspected he had underlying psychosis and possibly a learning disability. Despite Jerry's avoidance, the MDT persisted with offers of support such as help finding accommodation and physical health checks alongside flexible offers of psychology input from Peter over a lengthy period of time, which was characterised by frequent DNA's. Following a hospital admission, Peter was able to visit Jerry which provided the opportunity for him to build a relationship with Jerry. Once Peter had formed a good relationship with Jerry, Jerry agreed to further assessment alongside a transfer from hospital in rehabilitation, and then on to supported accommodation. Whilst Jerry continued his substance use, he engaged in this in a less risky way, and continued to engage with mainstream services.

7. Encourage curiosity in both staff and service users and their wider support network (e.g., family members and staff).

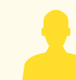
Approaching clients with curiosity can help validate their experiences and support them to reflect on factors impacting their lives and explore how they are responding to these. This in turn can encourage them to become curious about psychological approaches and how they may help. Encouraging curiosity can help staff, including Clinical Psychologists, avoid assumptions and falling into dominant narratives relating to homelessness and consider what happened to the person and why they are working with them at this time.

Once Hannah catches herself as a professional thinking that she knows something in a concrete way, she takes this as an indication that she has stopped being curious and has closed down other narratives. To manage this, Hannah engages in supervision, peer support, continues to read and learn, and is part of a wider community within the field of homelessness.

When reflecting with services users, carers or staff Halle uses a framework she calls 'thinking in spheres'. This means visualising the multiple contexts people are in within concentric circles that spin, change, ebb and flow over time. So, reflecting on individuals, groups, teams, services, organisations, communities, education, work, leisure, money, local and national politics, spirituality and religion. Halle encourages the person or people she is working with to imagine being in varying positions and view the world from multiple perspectives, sometimes using the 'miracle question'.

8. Have strong self-awareness and reflective practice, for example through journaling and/or supervision.

Acknowledging difficulties and frustrations in this work is crucial to help manage any issues that arise. Neil highlights the need to have good relationships within the team to feel able to discuss any frustration or issues you may be facing, and, where applicable, raise these with the wider system and agencies involved. For example, he described instances where he may be frustrated working with someone because he does not perceive them to be very receptive or very grateful, or because they may agree to do one thing and then do the opposite. Openly discussing and reflecting on these issues with colleagues, and where applicable, other agencies, can help you explore how best to move forwards. Neil emphasises that this is particularly important for less experienced members of the team and when your team may be only one discipline.



Considering and reflecting on the boundaries you are working within, particularly as there are no guidelines for what is and is not ok, is critical. At times, Andrew knows that he may be moving the boundaries too much. He acknowledges that maintaining appropriate boundaries can be hard, as you can be drawn into powerful attachments with the service user. To manage this, Andrew draws on reflective practice and having 'critical friends' to hold him to account. He highlights that Trainee Clinical Psychologists are vital within the team, as they can provide a different perspective and are more likely to raise issues, providing they are given the support to feel safe enough to do so.

9. Think carefully about what your role should be with this person.

Consider the network of professionals, whose role is what, boundaries, who is best placed, who has the best relationship with the service user and how you can help.

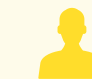
Aleksandr had recently moved to the UK, had no consistent work history, had been charged with a public order offence and had recently been assaulted, resulting in a brain injury. He was referred to Neil for a neuropsychological assessment to determine the impact of his brain injury. On meeting Aleksandr, it became clear that one of the primary difficulties was that Aleksandr could not speak English; a major barrier to Aleksandr accessing services as much of the basic information, education and advice was not available to him. Neil contacted an interpreter with experience of working in mental health services. The interpreter supported Neil to complete a thorough assessment of Aleksandr's head injury and provided Aleksandr with some initial signposting information in his language. Neil also consulted with Social Care to assign a Social Worker who could speak Polish to support him in pursuing housing, and Aleksandr has since successfully been placed in a local hostel. The neuropsychological assessment results helped Aleksandr obtain appropriate legal representation as he was recognised as someone who had social issues and the potential psychological implications of this. Neil recognised what his role could be in supporting Aleksandr by providing a neuropsychological assessment and considered who else could be best placed to optimise support for Aleksandr.

Using psychological formulation, Matilda hypothesised with staff that Kay may find the environment of a hostel too anxiety provoking as she had been living on the streets for several years. Rather than offering psychological therapy or another service to support Kay, Matilda and the wider staff team felt it would be most beneficial for Kay's outreach worker to build a relationship with her where she was living at that time. As Kay and her outreach worker built up a relationship, her outreach worker would offer to bring Kay to the hostel for a cup of tea and speak to staff informally. Kay began to accept this offer, would visit the hostel for a cup of tea, and then return to where she was staying. Slowly Kay started to visit the hotel without her outreach worker present, as she began to build trust in the hostel staff and surrounding environment. Throughout this work, Matilda and other Clinical Psychologists in the service supported staff, including the outreach worker, to remain consistent. Being consistent in their approach allowed Kay to feel safe enough over time to begin to stay in the hostel and she has since moved to another hostel full time. Carefully considering who would be best placed to build a relationship with Kay to help her feel safe in engaging with the hostel environment was key to helping her to work towards engaging with the service.

10. Clear communication, within the boundaries of consent, is key with everybody.

Be clear with everyone - the service user and others (e.g., those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing.

Tim was asked to complete a capacity assessment to explore Jane's decision for her discharge destination from hospital. After attending a case conference, Tim spent several appointments with Jane to explain to her what his role was and what he was going to offer, and to understand and appreciate her history and consider what her needs may be regarding a possible assessment. From taking the time to speak in depth with Jane about her past and choices, it became clear to Tim that Jane did not need an assessment regarding her discharge decision, but instead needed one regarding her treatment and end of life care. Tim feels being impartial in this situation was crucial, considering what he had been asked to do whilst critically considering what Jane was telling him throughout their conversations to determine the outcome. Communicating this to third parties in their role meant Tim had to be clear with what he had been asked to do and provide evidence to support his decision, communicating the findings assertively to others whom may not agree with the decision at the time. Considering this, the focus of the work changed, as did the outcome regarding Jane's care.



Oliver explained the importance of exploring with the person what they might need whilst making sure that he does not promise anything other than what he can emotionally and/or physically deliver. He uses formulation and engagement to discover what he can offer the service user.

11. Promote good multi-agency working across professionals especially when working with complexity and risk.

Coming together regularly, including with the client, is vital.

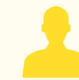
Angela was behaving in ways that hostel staff were experiencing as challenging. Having left a domestically violent relationship, Angela struggled with authority and would drink alcohol to help her cope. Angela also used to get in to fights with other residents frequently and was close to being evicted due to the increasing risk to others. Erin, the clinical psychologist in the hostel, arranged a meeting with Angela and the hostel manager to think about the situation. Erin explained that they started this meeting by using a strengths-based approach, highlighting things that staff appreciated about Angela, and that they wanted her to stay in the hostel but it was getting to a point where staff and residents did not feel safe. Therefore, they offered Angela the opportunity to think about what she and staff could do to help her to feel less distressed, reduced her risk to others and enable her to stay in the hostel. Coming alongside Angela and jointly discussing risk with her helped her engage. This resulted in Angela and the staff team creating a shared agreement about how she would try to manage her distress in future, and what staff could to do help her. Following this, Angela's risk reduced, she began to engage with her alcohol worker and was able to remain in the hostel.

Terry was referred to Andrew's team from the local A&E department, as he was a frequent attender, and they began to suspect underlying mental health issues. He was jointly assessed by Andrew and the Consultant Psychiatrist who were able to identify during the initial assessment the extent of his contact with other services, and recognised that he was at relatively high risk, as he was vulnerable to exploitation from others. The team, including social workers, continued to work closely with Terry to support him to obtain emergency accommodation, and Terry has formed a good relationship with his key worker. As a result of this contact with Terry and his placement, which provided him with stability and reduced his risk, he was able to form good relationships with Andrew and completed a cognitive assessment, which indicated impairments. The assessment supported exploration into looking at appointeeship for Terry's finances to avoid him being exploited, reducing his risk. Crucially, throughout this working with other professionals and agencies from the initial assessment stage, Andrew valued the input and different perspectives of other professionals to determine the best route forwards for Terry.

12. Where possible, be co-located and embedded within the multidisciplinary team.

If this is unavailable, think of how you can access the network of services working with these groups that do offer multiple disciplines. If a care co-ordinator or someone in a similar role is not involved, consider working in ways that ensure all of a person's needs are met.

Noting a high prevalence of Autism within the homeless population, a local homelessness team, supported by Liam, actively sought out and made arrangements with a local Autism service to provide consultation for staff working with people experiencing homelessness who may be autistic. Having access to this support meant that they could further their understanding about service users they suspected may have autism and consult with the specialist about how best to engage with those service users.



In Andrew's role in outreach, he takes on roles Clinical Psychologists in mainstream services may not, depending on the service user's needs and needs of the service and partnership organisations. He works flexibly within their multidisciplinary team comprised of Social Workers, Occupational Therapists, Consultant Psychiatrist, Community Mental Health Nurse and Psychology, often writing supporting letters or helping staff members to deliver items to people if other staff are not available. Working in an integrated team helps Andrew to work closely with other professionals in resolving issues around social care, such as an individual struggling to access benefits.

Individual therapy

13. Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse).

Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g., motivational interventions) that can help people work towards their goals e.g., make changes to substance use and engaging with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g., NICE guidance for dual diagnosis and substance misuse) that can support this work.

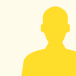
Roger began meeting with Matilda for support with anxiety. When he initially attended appointments, he would often turn up intoxicated. Unlike other services, Matilda did not turn Roger away – instead Matilda would speak with Roger, agree a shorter session length and discuss whether he could attend the next appointment slightly less intoxicated or alternatively, whether they could schedule the appointment slightly earlier in the day when he may have consumed less alcohol. Taking the practical step of changing the time Matilda and Roger met helped to reduce his alcohol intake, meaning he was more able to explore some of his anxieties during the appointment. This helped him to recognise that he was drinking before appointments to help to reduce his anxiety as he was scared of what may come up in appointments. Over time, Roger's alcohol intake reduced, and he was slowly able to come into contact with his own feelings and early life experiences without feeling the need to overcompensate as frequently.

When Erin first met with Megan, Megan was drunk all the time. Initially, Erin did not put many boundaries in place, as she felt that Megan would not engage with Psychology if she did. Instead, she offered a space for her to think about how she was coping. After meeting a few times, Erin spoke with Megan about how she was coping with their distress. Erin began to reinforce times Megan drank less, highlighting the improvement in the sessions. Highlighting this to Megan meant Megan began to recognise the value of the appointments and continued to decrease her alcohol intake. Erin emphasised the importance of considering the approach taken on an individual basis, as some coping mechanisms can be dangerous, e.g., using drugs with the potential risk of overdose. To manage this, Erin adapted therapy with Megan to focus more on stabilising her mood, thinking about what could help her to become more stable in both a practical and emotional way.

14. Working with the pre-contemplation stage is critical - you have to work with where the person is at regarding their sense of self, motivation, and values.

It is important that Maslow's hierarchy of needs does not influence whether you offer psychological interventions. Service users may also need time to understand how this support can be helpful for them, as they may have had limited experience of these approaches.

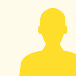
Neil has found demonstrating to service users how your contribution can be helpful is often important in encouraging engagement. He explains that, if a service user does not have a roof over their head, the fact they may have some difficulties with memory may be of interest to you as a professional but exploring this may not be a priority for them. However, if you translate some of their difficulties into something that is meaningful to them – for example, if they may struggle to remember where they put the application form for something or where they put the number for a housing organisation, this can help them to see why you might be helpful to them. Making your contribution into something meaningful which someone can understand the impact of can help to bridge the goal-discrepancy you may find yourself in.



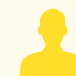
Owen visits somebody straight after they have been released from prison homeless, using an assertive outreach model. Doing so helps them to become a familiar face. He considers this to be part of the 'pre-treatment' and 'pre-engagement' phase.

15. Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies.

It is important to recognise that you may retraumatise them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.



Elaine has experienced the engagement process taking months or years before a service user feels safe to engage. Adrian had been street homeless for 25 years before moving into the hostel Elaine worked in. Throughout his time living on the streets, he had refused to engage formally with Psychology. However, he was happy for Elaine to make him a cup of tea every week and have a brief informal conversation with him. Slowly, over a period of months, moving at Adrian's pace, they moved from the canteen area with their cup of tea to the courtyard, and then into a room to have their cup of tea. Though Elaine's conversations with Adrian never lasted longer than 20 minutes, by the end of their work together they had shared around 95 cups of tea and have completed work around Adrian's voice hearing and delusional beliefs. This example highlights the importance of moving at the service user's pace, using creative non-traditional means, in a way they feel comfortable to allow them to come into contact with Psychology at a pace they feel comfortable with.



Providing a space for Judith to feel safe in beginning to think psychologically was a key consideration for Matilda. The hostel was running a group which staff felt it might be helpful for Judith to attend. However, Judith found this quite anxiety provoking, as she had been used to providing care for others and may struggle to be in a care-receiving role as the member of a group. Therefore, Matilda asked if Judith would co-facilitate the group with them so that she could maintain a more comfortable care-giving role, whilst also being present in the room to start to learn about these tools herself. By attending this group, Judith recognised that some aspects of what the group were learning may be useful for her to put into practice. Offering Judith this role in co-production meant she could keep the power and control what she wanted to discuss, feel valued and engage at her own pace, helping to avoid retraumatising Judith.

16. Consider screening for cognitive and neurological problems.

Assessments should consider asking clients about learning problems, previous head injury and other trauma. Including cognitive difficulties such as brain injury and intellectual disability in formulations can support understanding, as these can contribute to the breakdown of placements, and impact on social and day to day functioning. Consider how therapy may need to be adapted in relation to difficulties identified.

Steve was living in a hostel and had been aggressive towards staff members. He also had a number of physical health difficulties and had a history of non-engagement with services. Hannah reviewed Steve's history and case notes and saw that he had completed a memory screening assessment at a local hospital. The outcome of the assessment summarised that he was cognitively intact – however, Hannah reviewed the assessment scores and identified that he was quite impaired, with scores indicating that he may have dementia. Exploring this resulted in a greater understanding of Steve's behaviour and previous difficulties engaging with services. Though it took two years to obtain the support required for Steve, Hannah and staff at the hotel were able to understand what may be contributing to some of his behavioural difficulties, meaning they were able to adapt their practice to Steve e.g., by recognising that he may not remember information that they tell him. Future cases benefitted from this learning with Steve as they were able to contact the local authority for support as they had for Steve, which in one case resulted in an individual receiving support relating to their brain injury within two weeks.

Throughout his adult life Jim had lived in various residential settings, he was found to struggle with self-care and independent living tasks. The team from the hostel in which he was currently living, found that he struggled to express himself and communication was a real issue. Jim would easily become frustrated or retreated and hide in his room. He was also vulnerable to exploitation from others. The hostel team had attempted to refer Jim to learning disability services for additional support, consideration over appropriate accommodation and for specialist mental health input, but these had continually been declined. The in-house Psychologist in his latest placement was slowly able to build trust and support Jim in completing some initial screening and assessment to explore his intellectual functioning, social functioning and current needs. He was felt to have learning disability or developmental disorder prior more in-depth formal neuropsychological assessment being completed as he had a history of attending a special needs school, had no formal qualifications, has observable intellectual and social impairment, expression and communication difficulties and difficulties with basic activities of daily living (e.g. unprompted self-care, ability to cook, clean or use a washing machine, struggles to pick up tasks when supported to completed them, unable to complete complex or multi-staged tasks). He had very basic reading skills, poor written skills but was able to tell the time. As a result of this initial screening Jim was accepted by the Mental Health Learning Disability team for some further assessment and specialist input around his complex trauma. This then subsequently led to an Adult Social Care assessment and referral to more suitable sheltered housing for people with intellectual disability outside the rough sleeper pathway.

17. It is important that goal setting is done collaboratively.

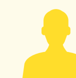
Oliver explained that when working with Sam, though they initially developed goals together, as they built trust and began to explore more of Sam's past, they built more of an understanding of what had led Sam to this point. Supporting Sam to re-address the balance of power and his value system in relation to his current difficulties resulted in Oliver and Sam reviewing and amending the goals of their work in line with Sam's new aims of wanting to re-connect with his family.

Nathan started working with Martin during a hospital admission following a period of rough sleeping following significant losses, substance use alongside a presentation of psychosis. As Martin began to make a positive recovery, he started discussing returning to work in a responsible and stressful position. Martin always wanted to move into independent accommodation and take on a therapeutic role to others. Whilst Nathan recognised that this man was intelligent and achieved a lot in his past, he (and wider team) were concerned that he was rushing into roles and that some expectations may be unrealistic or risk a relapse in his mental health. Nathan continued to meet with Martin weekly in supported accommodation and tried to be flexible to meet his needs, however they began to experience frustrations and new issues in the therapeutic relationship. To resolve this, Nathan began to be more service user led in working towards goals. Martin went on to move into independent accommodation, return to an influential working role, and remains an advocate for mental health and supporting others.

18. Formulation is key and sometimes the most basic are the best.

Sharing a formulation collaboratively is essential, helping the individual to feel valued, making them more than just a 'label'.

Hannah carefully considers whether to share the formulation directly with service users. Though Hannah acknowledges completing a good assessment and formulation to produce goals is critical, sharing this can be overwhelming. Therefore, she applies caution when putting things in writing and/or drawing things out, as she has found it can impact service users in unexpected ways. Consequently, she uses clinical judgement and/or where possible, is led by conversations with the service users about whether to formally share their formulation.

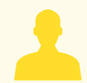


Erin found that a lot of the people within this population at been given a label of 'Emotionally Unstable Personality Disorder' but with little understanding of what this meant. Erin would use formulation to develop a shared understanding of what this label actually means in terms of the service user's experience – contextualising the symptoms and how these can also be understood in relation to other models (trauma, attachment, social inequalities, gender etc.). Making meaning of the person's experience and decontextualizing shame was often key.

19. Trauma is highly prevalent in this population (both historic and current/ repeated patterns of trauma).

Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.

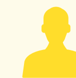
Creating a setting where someone feels safe to talk to you is important in facilitating engagement and trust and, for Elaine, that is rarely in a traditional therapy room. Elaine explained that in direct work she uses a lot of what she terms ‘walking therapy’. She has found this to be particularly effective if someone has experienced significant and possibly repetitive traumas, meaning they find it too distressing to engage in direct face to face therapy. Going for a walk with someone side by side changes the power dynamic, making the appointment less threatening, encouraging a conversation.



Peeling back the layers can take a long time to explore the impact of trauma on a service user’s presentation. Bill had been sofa surfing for several was referred to Elaine for support with psychosis and anger management. Elaine said staff working with Bill felt his psychosis was his primary difficulty. However, Elaine began to consider the Power Threat Meaning Framework, resulting in her reflecting on Bill’s presentation being a possible trauma response. This prompted Elaine to ask Bill about his early life. As Elaine had taken the time to build up a safe and trusting relationship, Bill disclosed that that he had been sexually abused by his father’s employer when he was a child. This changed Elaine’s approach and intervention away from exploring anger management and psychosis, to using Eye Movement Desensitization and Reprocessing for his trauma, resulting in his psychotic symptoms disappearing. Elaine re-formulated that Bill had experienced a Complex Post-Traumatic Stress response. She attributes this reformulation to thinking beyond the initial reason for referral, alongside keeping up with new developments in the field. Importantly, she also waited until the appropriate time in the relationship, after enough safety and trust had been established to explore this with Bill.

20. Make use of integrated models of psychology, paying attention to attachment and theories of motivation.

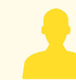
Working integratively, drawing together multiple models and formulating each person based on what they need is central to Elaine’s approach. Elaine has found Cognitive Analytical Therapy can be helpful for reflective practice with the service user at the start, Cognitive Behavioural Therapy can be useful to support understanding and interventions, and attachment theory is often key. For example, one young person was initially offered Cognitive Behaviour Therapy for anger management, however exploration with the service user resulted in identifying that much of their anger originated from issues relating to attachment. Elaine changed her approach to focus more on attachment, which led to uncovering a significant level of trauma, leading to using Eye Movement Desensitization and Reprocessing therapy. They then completed the work using Acceptance and Commitment Therapy, working towards the service user’s goals by identifying their values.



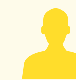
David has found the value in formulating Psychodynamically, recognising and respecting psychological defences, what might be split off and utilising the meaning within the transference and countertransference to make sense of someone’s experience. David has found that this can be integrated into a variety of treatment approaches such as mentalization or attachment-informed models, motivational interviewing, Cognitive Behavioural Therapy and Compassion Focused Therapy, where things such as trauma responses, interpersonal patterns of relating, self-destructive behaviours, ‘stuckness’ or de-motivated can be explored.

21. Consider what model fits the person, and how to adapt it based on their current circumstances.

For example,briefer sessions over longer periods of time, more warming up and cooling down/ containment time in sessions, more stabilisation work.



Using clinical judgement and thinking to review and evaluate what she is doing is crucial in Hannah’s work in homelessness services, including considering the number and pace of sessions. Hannah recognises that the number of sessions a Clinical Psychologist can offer can be an area of difficulty, as services are commissioned based on the number of sessions. However, considering individual differences within this population is critical – when working in a GP practice, Hannah said one service user received 16 sessions with good outcomes, whilst another had three years-worth of contact. Hannah feels it is important to have a strong rationale from the beginning of the work for decision making, to be able to justify the work. Support from the wider team from the start can also help.



Adapting models and materials to fit the service user’s needs is an everyday consideration for Elaine. Alongside working flexibly with the number of appointments, she explains that many service users do not have a high level of literacy or English as a first language, meaning you may not be able to use lots of the materials and resources you normally would. Each needs to be adapted to fit the person and to make them accessible. She highlights the importance of also being mindful of translations and the cultural context of psychological models, as many models are predicated on Western ideas of mental illness. For example, the individual may have no concept of mental illness and instead may think that they are possessed by spirits.

22. Approaches to direct work should seek to apply the frameworks of Trauma-Informed practice and Psychologically Informed Environments (PIEs) where possible, encompassing all elements that come with this.

For example, building relationships, helping people connect and feel empowered, value-based, recognise the impact of trauma on an individual and avoiding re-traumatisation.

Oliver approaches his initial assessments using a trauma-informed approach. His aim is for the person to come out of the assessment and want to see

him again if they want to and if it is appropriate for them to. Instead of screening for information like other services, Oliver sees the assessments as creating a dialogue to explore what the person may find helpful.

Tim formulates right from the start of the work the possible traumas an individual may have experienced during their life and possible impact of psychological work on retraumatising them. For example, if he meets a woman who he knows has been engaging in street working and may have been abused by men, then Tim considers the potential impact of his gender on the individual. Tim highlights the need for Clinical Psychologists to consider and hold in mind a range of issues prior to meeting a service user and be mindful of how these may impact the service user, as trauma may still be active. Doing so can help you to build trust with the individual and form a strong attachment with them, which may enable you to explore any trauma(s) they may have experienced and mitigate the risk of re-traumatising them.

23. Endings are just as important as beginnings.

Actively paying attention to and working jointly with staff and service users e.g., by devising care plans at the beginning of the work for the end of the work, can help work through feelings of rejection and service withdrawal users may experience.

Within Matilda's service, a Clinical Psychologist will attend a pre-admission meeting prior to a person moving into the hostel. The service user, their key worker and the manager attend these appointments. Matilda finds the meeting helpful as she can complete a mini assessment of the person's needs and explore whether they may want to engage in Psychology. During this meeting, they consider the move in as well as the move on process, discussing where an appropriate referral onwards may be once their stay at the hostel ends.

The duration of work with homeless service users can vary depending on the setting, but generally flexibility around this and the ability to offer slower longer pieces of work is of real value. Nonetheless, Lucy recognises that it is vital to attend to the ending from the start of the work and has seen how this can get avoided due to feelings of guilt, abandonment, there always being more work to be done or feeling you are the main stable attachment figure for someone. She has found that it can be the service users with the greatest dependency needs or with repeated losses and abandonments, that clinicians and staff teams may feel it is hardest to end the work with and this can be avoided or unconsciously acted out (e.g. somehow forgetting to give extended notice and count down towards breaks, leave, endings; finding reasons to continue the work; repeated crises which mean it never feels the right time to end, but which could also inadvertently reinforce crises for people). This all needs careful formulation, reflection around boundaries, self-monitoring and supervision. Sometimes breaking work down into bitesize chunks, prioritising with the service user, considering the next steps and any onwards referrals you may be working towards from the start, regular reviews and re-contraction as needed.

Indirect working guidelines

Relationships with and support for staff

1. The foundation has to be based on spending time to build relationships.

Consider what safety means for different staff groups and take the time to get to know them.

Providing emotional and psychological safety is crucial to how Oliver views his role in hostels. Oliver does this by finding a space where staff feel they are able to express their opinions, attitudes, frustration, anger, and sadness, in a way which is helpful for them, the wider team and residents. In Oliver's experience this can be through a range of support mechanisms including training, team, and individual reflective practice or through interventions at a management level. Oliver finds that creating this safety often leads to increased creativity within staff teams.

When Hannah began working in a local hostel, she recognised there was a significant amount of suspicion from staff members. Time was limited in the hostel, as Hannah was only able to work one day per week across three separate hostels. To manage this, Hannah was flexible in what she offered the staff, making suggestions to the team regarding teaching and training based on what had come up in her conversations with them. Working with the staff group, listening to their needs and being flexible helped Hannah tailor the support she offered to the team.

2. Build relationships and partnerships with staff who are key to much of what we do.

Emphasise good practice, consider evolution not revolution.

Following a critical incident, staff were offered a debrief session with Elaine, which developed into ongoing reflective practice group for staff members to discuss learning taken from the incident and the team bringing other cases to discuss. Allowing this group to evolve into something the staff found helpful increased its acceptability as is indicated by the fact it has never been cancelled.

When Matilda was recruited by local commissioners, one aspect of her work was to implement a Psychologically Informed Environment in a local hostel. Matilda approached this enthusiastically, but, after starting, recognised that the staff may feel implicitly and explicitly criticised, feeling that they had been told by commissioners that they 'needed a psychologist to improve practice'. This experienced highlighted to Matilda the importance of sensitivity when considering how any change in a service starts. Clinical Psychologists should pay close attention to the change management process right from the start. Actively working with the staff team, service and organisation from the beginning can help them own the work, as they will be less likely to experience the work as something that is forced upon them. If this is not completed, there can be resistance within the staff team, service and/or organisation, with people feeling disempowered or encroached upon, feeling criticised or undermined.

3. Think about your language and how you explain things to staff in a way that is accessible, interesting, and more than just common sense.

Doing so will help to prevent staff feeling disempowered.

Erin has found applying psychological frameworks staff are familiar with, such as attachment theory, can help staff to understand why their service users are responding in a certain way e.g., if they have an insecure attachment, they may be quite avoidant or dependent on staff. Using this framework has been helpful and easy for staff to understand, as many have nursing or social work backgrounds and therefore have some knowledge and understanding of attachment theory. Using a familiar model means staff do not feel that they are learning something new, which helps them to feel more competent in their role.

Bessie routinely asks staff first what their understanding of a situation is to honour and learn from their knowledge, skill and experience. Where appropriate Bessie relates what she has heard from staff to psychological theory and models and / or adds to what has been said to share her understandings with staff. Staff then consider what actions they may take on the basis of the shared understandings.

4. Be mindful of the stress and pressures that staff (e.g., outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be.

Meet staff where they are at considering what they would find helpful, as staff may not have the supervision and training that we would like them to have.

Oliver acknowledges that many individuals are ‘running on empty’ from both a staff and organisational perspective. Within the voluntary sector, they may be chasing contracts to stay afloat and keep the service going. Consequently, Clinical Psychologists may seek to sell what they think is best practice, but this could be perceived as an expert ‘lecturing’ staff on what they should do, which is likely to damage relationships. Acknowledging that many services are just trying to survive is important, alongside managing your own and the staff members’ expectations and anxieties about what you can provide and what a service user needs.

Erin is mindful in her role that staff working with people experiencing homelessness want to do well and are often eager to learn and develop psychological knowledge to support their work. However, Erin carefully considers the support she can offer as she is conscious that she may appear to be adding to staff members’ workload through additional meetings.

5. Clinical Psychologists should provide a space for validating workers’ emotional reactions/toll of the work and understanding behaviour.

Erin is flexible in the way she creates space for staff, as she acknowledges that staff deal with a lot of emotion and trauma on a daily basis, but often have little support for this. Being present in their environment and offering informal chats can help provide a space for workers to think about the work and understand why someone is doing something. Erin also uses this space to signpost to other agencies if needed or help the staff member think about what they are struggling with and provide them with some tools to help manage these difficulties.

Tim provides therapeutic support for managers and staff from local hostel organisations if they have been identified or identify themselves as struggling. Staff feedback has been positive, and it is being accessed increasingly by the staff teams, with staff absences reducing across the services.

6. To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential.

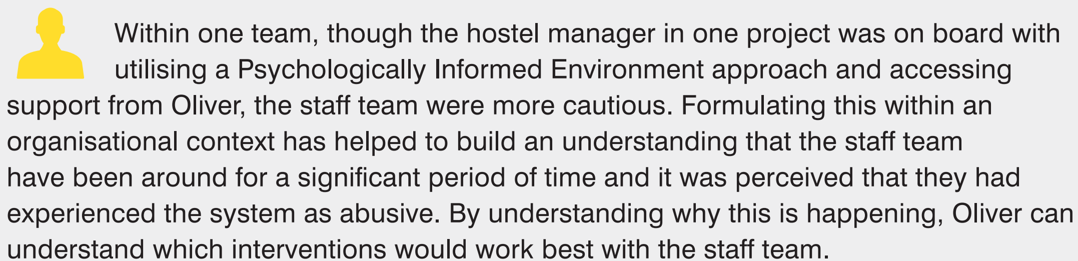
Clinical Psychologists should provide training, reflective practice, consultation, consistent team approaches and debriefs.

Tim runs reflective groups for all hostel workers and managers from a local housing organisation. He provides monthly group reflective sessions which are organised using a specific structure – they start with a grounding exercise such as mindfulness, move on to a mini training session on a range of topics from brain injury, to the purpose of reflective groups or culture and safety in the work environment. Each reflective group finishes with a practical exercise for staff to complete.

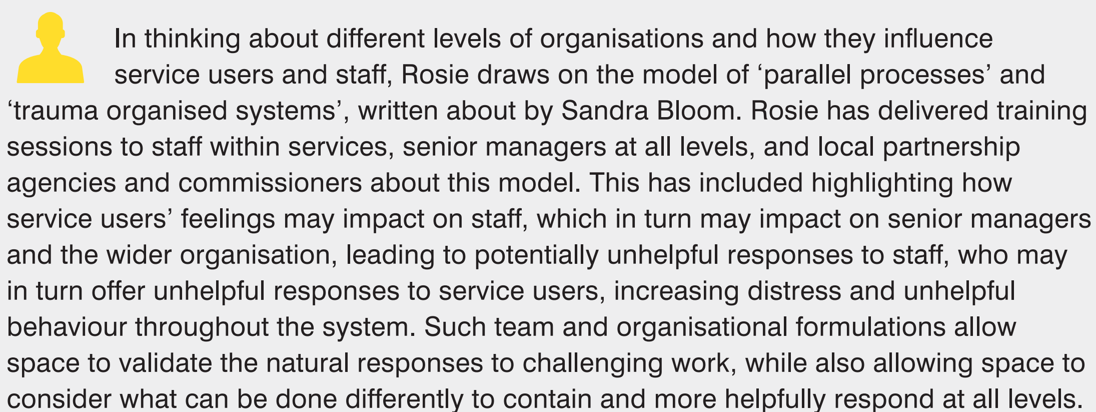
Shortly after Elaine joined a new service, there was a death in the service. This had a big impact on the staff, particularly the staff member who found the service user. To help staff to manage the possible impact of this event, Elaine offered an initial debriefing session to all staff, and this later evolved into ongoing reflective practice for the staff members. She also provided some additional support to the staff member as they were beginning to experience flashbacks. Finally, to support staff in future situations, Elaine also amended the risk assessment and process, and delivered training to all staff on this to support their future practice. Staff feedback indicated that they had found this helpful, and the individual staff member who received additional support had minimal time off work for the incident, indicating they felt supported at work.

7. Develop psychological formulations and understanding of what is happening within teams or organisations and share with organisations in order for organisations to understand how they are influencing the service users and the different levels within the service.

This offers space for the organisation to think about what they do.



Within one team, though the hostel manager in one project was on board with utilising a Psychologically Informed Environment approach and accessing support from Oliver, the staff team were more cautious. Formulating this within an organisational context has helped to build an understanding that the staff team have been around for a significant period of time and it was perceived that they had experienced the system as abusive. By understanding why this is happening, Oliver can understand which interventions would work best with the staff team.

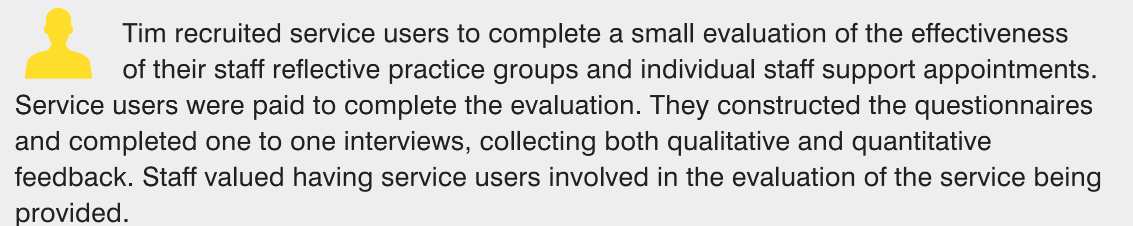


In thinking about different levels of organisations and how they influence service users and staff, Rosie draws on the model of 'parallel processes' and 'trauma organised systems', written about by Sandra Bloom. Rosie has delivered training sessions to staff within services, senior managers at all levels, and local partnership agencies and commissioners about this model. This has included highlighting how service users' feelings may impact on staff, which in turn may impact on senior managers and the wider organisation, leading to potentially unhelpful responses to staff, who may in turn offer unhelpful responses to service users, increasing distress and unhelpful behaviour throughout the system. Such team and organisational formulations allow space to validate the natural responses to challenging work, while also allowing space to consider what can be done differently to contain and more helpfully respond at all levels.

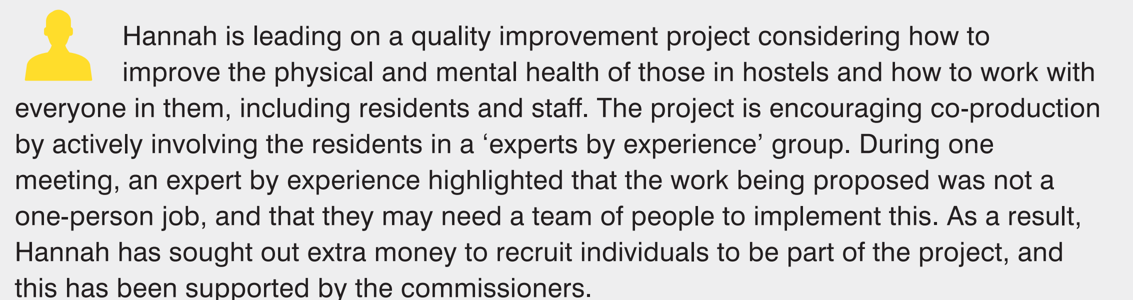
Supporting staff to support service users, including building therapeutic skills

8. Where possible and appropriate, work should be led by service user involvement and feedback.

Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g., through focus groups, surveys, informal verbal feedback.

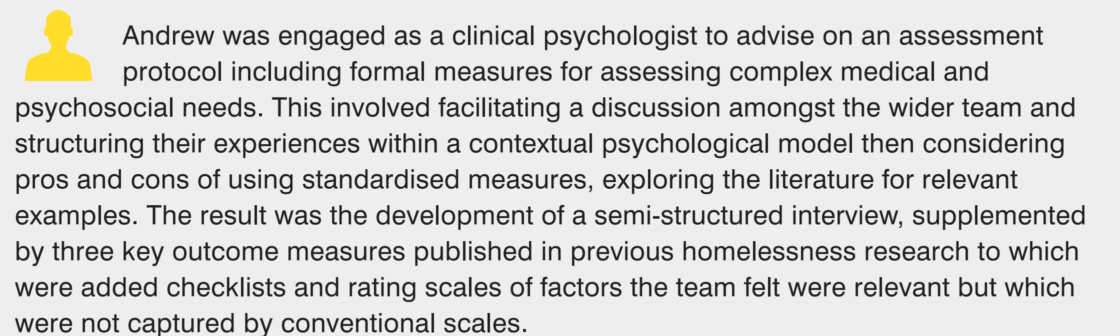


Tim recruited service users to complete a small evaluation of the effectiveness of their staff reflective practice groups and individual staff support appointments. Service users were paid to complete the evaluation. They constructed the questionnaires and completed one to one interviews, collecting both qualitative and quantitative feedback. Staff valued having service users involved in the evaluation of the service being provided.

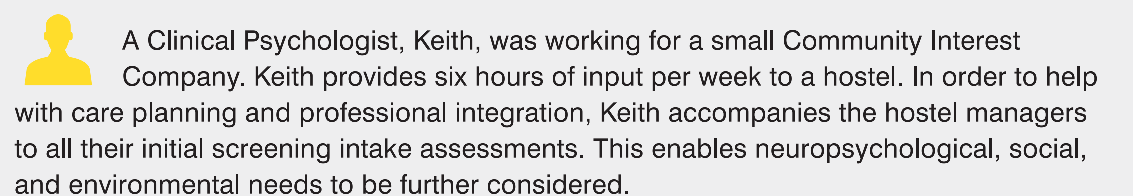


Hannah is leading on a quality improvement project considering how to improve the physical and mental health of those in hostels and how to work with everyone in them, including residents and staff. The project is encouraging co-production by actively involving the residents in a 'experts by experience' group. During one meeting, an expert by experience highlighted that the work being proposed was not a one-person job, and that they may need a team of people to implement this. As a result, Hannah has sought out extra money to recruit individuals to be part of the project, and this has been supported by the commissioners.

9. Clinical Psychologists should be involved in ensuring that team screenings and initial needs assessments consider relevant psychosocial factors.



Andrew was engaged as a clinical psychologist to advise on an assessment protocol including formal measures for assessing complex medical and psychosocial needs. This involved facilitating a discussion amongst the wider team and structuring their experiences within a contextual psychological model then considering pros and cons of using standardised measures, exploring the literature for relevant examples. The result was the development of a semi-structured interview, supplemented by three key outcome measures published in previous homelessness research to which were added checklists and rating scales of factors the team felt were relevant but which were not captured by conventional scales.



A Clinical Psychologist, Keith, was working for a small Community Interest Company. Keith provides six hours of input per week to a hostel. In order to help with care planning and professional integration, Keith accompanies the hostel managers to all their initial screening intake assessments. This enables neuropsychological, social, and environmental needs to be further considered.

10. Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes which are evaluated.

Ensure that consultation is useful to care planning, not only theoretical.

With permission, Roisin has adapted Hollingsworth & Johnstone's (2014) Team formulation questionnaire to routinely evaluate the reflective practice she offers. Based on the evaluation, reflective practice is refined.

Lucy found that it was valuable to think about how the wide range of needs the service user had could benefit from psychologically-informed input, rather than just the mental health or psychological needs. This included for example - contributing to thinking about what might support someone taking up a bed space for a first time and how to sustain that placement; the experience of someone with a history of sexual abuse being 'physical touched' or being asked to de-robe in a physical health appointment; or recognising that a hostel manager had a responsibility to the wellbeing of all the residents of a property and the need to balance this.

11. Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these.

Work from a position of building capacity by offering what is meaningful and practical for the staff and service, developing existing strengths in staff teams. This may be by sharing knowledge and discussing ideas through reflective groups, providing additional training, formulation, case discussions and consultations. Mentoring for frontline staff should also be considered.

Due to minimal Clinical Psychology provision, Elaine has adopted a strengths based, upskilling approach, seeking to empower staff in their role to use psychological knowledge where appropriate, building capacity within the staff team. She does this predominantly through consultancy and open discussion with hostel staff to help them to consider why a service user may be presenting in a certain way. For example, one service user was identified as having difficulties with anger. Elaine helped to normalise this as an understandable reaction to their situation and helped staff to think of times they have been angry and how they have managed this. Encouraging staff to consider how they respond to these feelings themselves helps this become more accessible to staff in moments when psychology is not available and reduces the number of referrals to Psychology from staff. By supporting and upskilling staff, they can often complete much of the work providing appropriate support mechanisms are in place.

By providing training, formulation sessions and access to a Clinical Psychologist, over time a local hostel team is now able to formulate using psychological knowledge and understanding without needing a Clinical Psychologist present for the duration. Being able to formulate as a team has helped staff in the hostel Matilda supports to understand and contain the distress of several service users within the service without needing to consult a Clinical Psychologist, helping to build understand and capacity within the team.

12. Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically and Trauma-Informed environments.

Using case-based sessions has helped Matilda to develop guidelines for ways of working consistently with individual service users. This has helped to develop a consistent team approach across all staff, including those on night shifts. Matilda noted this has worked particularly well with service users who have been self-harming significantly in public areas when staff have been unsure how to respond, resulting in inconsistency of approach, with some staff members reinforcing behaviour without meaning to e.g., providing extra care giving at certain moments may escalate behaviour. Therefore, they think as a team about the individual and consider what they may want to pay attention to, when they should give praise and when they should not.

Developing a coherent psychological framework for the services with a training programme developing the tools and therapeutic approaches that all staff can be trained and feel confident in. This has been done using Mentalization-Based approaches in some PIE organisations; others have used Cognitive Behavioural Therapy and Dialectical Behavioural Therapy or narrative and strength-based approaches to great effect.

13. Model and reinforce the skills that you want to develop within systems and staff groups.

In Hannah's supervision with staff, she uses a model of Appreciative Inquiry, asking staff to think about something they have done really well. Hannah noted that though staff may find this hard, when she provides them with the rationale that change can sometimes be really small, they are often able to find something to discuss. Hannah will then link this to instances with residents where staff members are often really trying to get service users to identify something positive that has happened recently, and highlights that practicing it themselves may make it easier to do this with residents. Modelling this during support sessions helps staff to identify these more easily, which then helps them to apply this learning with service users.

Matilda seeks to impress upon all staff the importance of maintaining self-care and a good work-life balance. She models this to staff by taking regular breaks, going on holidays, and going home on time, believing it is important to 'practice what you preach'. Matilda also encourages regular supervision for Clinical Psychologists working in the hostels, alongside other staff members, and has supported the implementation of regular reflective practice groups and regular team meetings.

14. Remember to tell stories for both direct and indirect work as these can motivate people to work together.

People often remember these and will help to draw in multiple agencies.

Claire was living in a hostel and had been referred to Annabelle for support with behaviour that staff were experiencing as challenging. After several appointments with Claire and with her consent, Annabelle met with staff separately and shared some of what had been discussed. Doing this helped to provide staff with an understanding and story behind Claire about what had contributed to her current situation and presentation. Following this, Annabelle reported a visible shift in staff members' responses to Claire, as they began to feel more compassionate and connected with Claire. As a result, they began to adapt and change their interactions with Claire in subtle ways.

Staff at the local hostel had had contact with Guy, who had been placed into emergency accommodation due to a snow alert. During this visit, he assaulted a member of staff and as a result had been excluded onto the streets. The team were concerned about him coming back into the hostel; they were worried that, as he had been unable to contain himself for this short period, it was likely that this may happen again. To explore Guy's background, Matilda asked his key worker to contact someone who had known him a lot longer who may be able to provide some insight into Guy. They were able to provide additional information about Guy's background, establishing that Guy had experienced significant levels of violence when he was younger. This led the team to reframe Guy from being 'aggressive', to hypothesising that Guy's background may mean that he felt continually threatened. Considering Guy's story helped staff and the wider services recognise that Guy may be scared, which reduced their anxieties around engaging with Guy. Reducing their anxieties helped staff to change their approach to Guy, implementing a caring and compassionate approach rather than being firm with the boundaries, which helped Guy begin to engage with staff and services.

15. In relevant contexts, when there is consent from service users, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.

Vanya was living in hostel accommodation and had been expressing behaviour staff were finding challenging, which was creating feelings of frustration in the staff team. Annabelle worked with Vanya to explore a safe space where she could express herself outside of the hostel and explore their thoughts and feelings in a safe space with Annabelle in the hostel. It was agreed with Vanya that these discussions could then be transferred into the wider staff support system around them. Using a narrative formulation, staff were then able to understand the reasons behind some of Vanya's behaviours and consider how staff may be perpetuating some of Vanya's behaviour, enabling them to reduce some of the triggers in Vanya's environment. Working collaboratively with Vanya and the staff team, with her consent, encouraged consistency of approach, which helped to reduce Vanya's distress and prevent her from being evicted.

Ben had lived in many hostels in the past, but the placements had often ended with his eviction after reports of violence or targeting staff. He fought against rules and boundaries that were experienced as meaningless, controlling, or rejecting. Ben was particularly sensitive to hostel staff being busy and not immediately available to support him such as when in team meetings, with other residents, on the phone or taking leave. This would be a trigger for outbursts and continually banging on locked doors or meeting rooms. In group reflective practice the team shared experiences of what was working well with Ben and based on their psychological formulation, the team developed staff team approach detailing how to work most effectively. This incorporated an understanding of Ben's outbursts stemming from fears of rejection and abandonment, underpinned by experience of childhood neglect and growing-up in care. Staff were able to understand Ben's desperation at times when he felt more excluded or neglected and made additional provision to provide reassurance and structure when it was known staff would be unavailable (e.g. lots of warning of keyworker annual leave and who would be his named keyworker cover; offering dedicated time to meet before and after team meetings; praising attempts to wait; being transparent when things could not be completed immediately and agreeing a time when this need could realistically be met). This was very effective, and the team quickly became able to reassure and de-escalate Ben, helping him to settle into the hostel, sustain his accommodation and begin to trust in the staff to a greater and greater extent alongside a growing ability to regulate his emotions and manage frustration.

16. Contract work as transparently as you can.

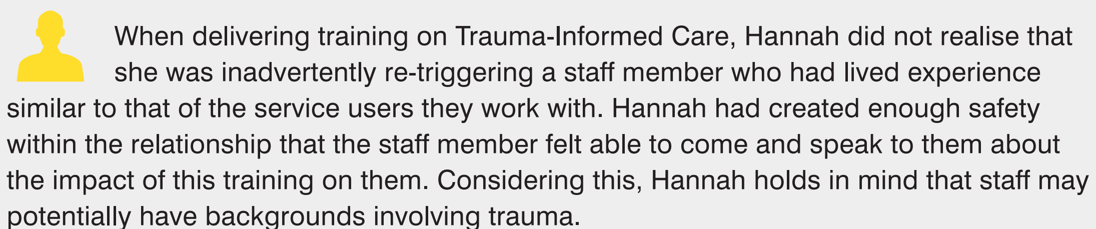
Ensure all including senior managers are involved, have authorised, and support the work.

Sharon was struggling to move into the local hostel accommodation, as staff hypothesised that she may find the environment threatening. Matilda and staff recognised that the move would need to go at Sharon's pace, meaning a hostel space would need to be held for her. Matilda shared the rationale behind this decision with local commissioners to help them to recognise and support the need for the bed to be held for Sharon, meaning it would be vacant for a period of time. Doing so meant the bed remained open until Sharon felt able to stay in the hostel.

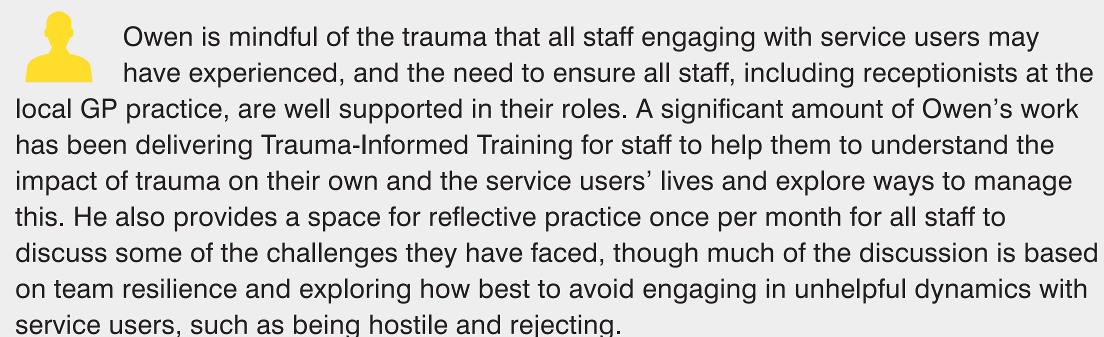
Bridget was always keen to be involved in her support and very capable of involvement. However, she found meetings overwhelming. Felicity sought her consent to bring together members of the hostel, substance misuse service, and community navigator for a formulation meeting. Before the meeting, Bridget and Felicity went through the formulation model together and filled in all the information that Bridget wanted people to know about her and how best to support her. This was added to by staff in the formulation meeting with observations made by those supporting Bridget. This was talked through with Bridget after the meeting and she appreciated strengths-focused observations from staff and was involved in refining the support plan, which was signed off by senior managers.

17. Demonstrate that services are Trauma-Informed e.g., through staff training, awareness of processes and procedures being Trauma-Informed, providing a space for reflective practice and offering trauma therapy to service users if needed.

Attending to the emotional impact of the work on colleagues is an important starting point. The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences. Where necessary, Clinical Psychologists can provide sign posting to staff to support services to manage this impact.

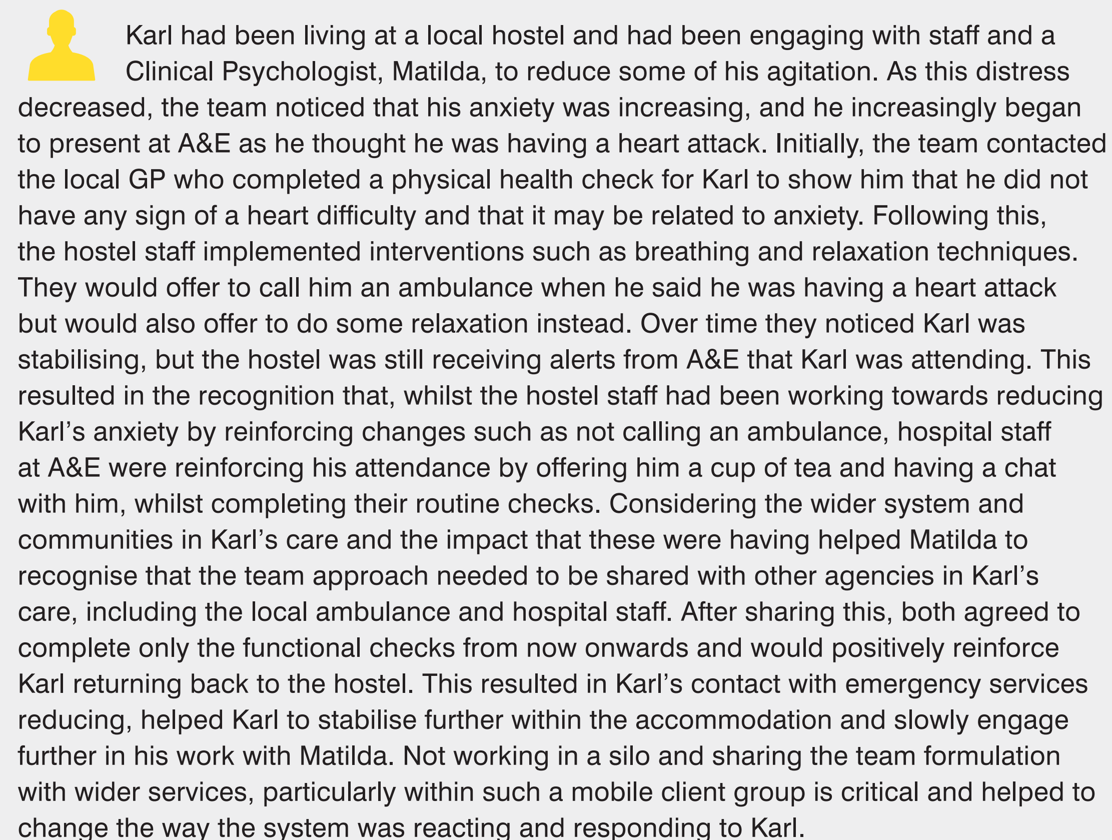


When delivering training on Trauma-Informed Care, Hannah did not realise that she was inadvertently re-triggering a staff member who had lived experience similar to that of the service users they work with. Hannah had created enough safety within the relationship that the staff member felt able to come and speak to them about the impact of this training on them. Considering this, Hannah holds in mind that staff may potentially have backgrounds involving trauma.

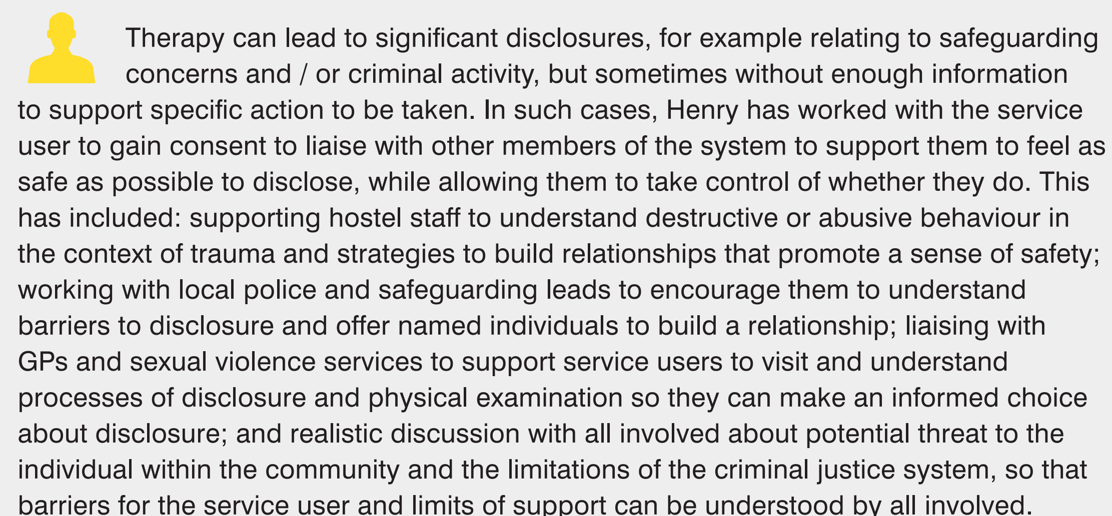


Owen is mindful of the trauma that all staff engaging with service users may have experienced, and the need to ensure all staff, including receptionists at the local GP practice, are well supported in their roles. A significant amount of Owen's work has been delivering Trauma-Informed Training for staff to help them to understand the impact of trauma on their own and the service users' lives and explore ways to manage this. He also provides a space for reflective practice once per month for all staff to discuss some of the challenges they have faced, though much of the discussion is based on team resilience and exploring how best to avoid engaging in unhelpful dynamics with service users, such as being hostile and rejecting.

18. Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.



Karl had been living at a local hostel and had been engaging with staff and a Clinical Psychologist, Matilda, to reduce some of his agitation. As this distress decreased, the team noticed that his anxiety was increasing, and he increasingly began to present at A&E as he thought he was having a heart attack. Initially, the team contacted the local GP who completed a physical health check for Karl to show him that he did not have any sign of a heart difficulty and that it may be related to anxiety. Following this, the hostel staff implemented interventions such as breathing and relaxation techniques. They would offer to call him an ambulance when he said he was having a heart attack but would also offer to do some relaxation instead. Over time they noticed Karl was stabilising, but the hostel was still receiving alerts from A&E that Karl was attending. This resulted in the recognition that, whilst the hostel staff had been working towards reducing Karl's anxiety by reinforcing changes such as not calling an ambulance, hospital staff at A&E were reinforcing his attendance by offering him a cup of tea and having a chat with him, whilst completing their routine checks. Considering the wider system and communities in Karl's care and the impact that these were having helped Matilda to recognise that the team approach needed to be shared with other agencies in Karl's care, including the local ambulance and hospital staff. After sharing this, both agreed to complete only the functional checks from now onwards and would positively reinforce Karl returning back to the hostel. This resulted in Karl's contact with emergency services reducing, helped Karl to stabilise further within the accommodation and slowly engage further in his work with Matilda. Not working in a silo and sharing the team formulation with wider services, particularly within such a mobile client group is critical and helped to change the way the system was reacting and responding to Karl.



Therapy can lead to significant disclosures, for example relating to safeguarding concerns and / or criminal activity, but sometimes without enough information to support specific action to be taken. In such cases, Henry has worked with the service user to gain consent to liaise with other members of the system to support them to feel as safe as possible to disclose, while allowing them to take control of whether they do. This has included: supporting hostel staff to understand destructive or abusive behaviour in the context of trauma and strategies to build relationships that promote a sense of safety; working with local police and safeguarding leads to encourage them to understand barriers to disclosure and offer named individuals to build a relationship; liaising with GPs and sexual violence services to support service users to visit and understand processes of disclosure and physical examination so they can make an informed choice about disclosure; and realistic discussion with all involved about potential threat to the individual within the community and the limitations of the criminal justice system, so that barriers for the service user and limits of support can be understood by all involved.

19. Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival.

Doing and planning with people and organisations rather than doing to.

Matilda works into several different hostels and has found each staff team's reflective practice needs vary. To support uptake within each team, Matilda delivers training on the value of reflective practice and provides the team with examples of what reflective practice may look like. She then co-produces this with the staff so that it fits with the team's needs and wider system. This helps staff to feel empowered and take ownership of the reflective practice group, feeling that they have 'done with' rather than been 'done to'. Consequently, reflective practice groups vary in their focus across different hostels, with some more focused on staff support, wellbeing, and the impact on the work, whilst others focus more on formulating service users and how best to work with them. Matilda acknowledges that a balance of both aspects may be best, but it is important to be mindful of what the team's needs and wants are at the time.

Kathryn works with a large provider of temporary accommodation, street outreach, and substance misuse services. Through regular connections with senior management, she has worked to embed psychologically informed approaches through organisational initiatives that are already happening, such as work with the Staff Council, revision of supervision documents to embed more reflective approaches, reviews of policies and procedures, and the promotion of staff well-being initiatives. Supporting changes that the organisation was already seeking to make through collaborative consultation has offered a way of contributing to a shift in organisational culture towards more psychologically informed approaches, rather than trying to introduce completely new approaches to systems with limited capacity for change.

20. Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible.

People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the

Working collaboratively with other agencies is critical to Matilda's work in this area, though she notes that the client group can prefer for services and people within these services to function in silos. Despite often having multiple needs, service users may struggle to want professionals to share information and work collaboratively with others. It can be challenging to empower the individual to have trust and feel safe that their information is protected, whilst encouraging them to share openly and think about issues of consent and collaboration. Being transparent with all aspects of the system, including the service user, and respecting differences in needs can help to navigate these challenges.

James was a man in his early 30s with a history of deliberate self-harm and regular suicide attempts. He agreed to engage with Lucy in weekly psychology sessions where they initially focused on risk management, emotion regulation and his alcohol use which increased risk and impulsivity. At their request a workshop was also conducted with the hostel and outreach team on *'understanding and managing deliberate self-harm'*. After a serious suicide attempt the psychologist ensured James was referred and accepted under the care of a CMHT and called a multi-agency case conference (Including James, hostel management, keyworker, the PIE Clinical Psychologist, CMHT, probation, and substance misuse services) to develop an integrated care plan managed by the hostel key worker and PIE psychologist. This was a turning point for James and the start of more effective coordinated MDT care.

21. Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector.

Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care (TIC) can be really useful to help guide the work, for example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change. Clinical Psychologists should explore structures such as PIEs and TIC and consider whether the structure or elements of them would be beneficial in guiding work the context they are working in.

After winning a contract for a new service, Elaine began thinking about how the service could be psychologically informed right from the start of the project. Consideration was given to what would be needed in terms of staff, training, reflective support, how the building physically looked and a separate research and evaluation component. This also included considerations for the frequency of staff supervision alongside the policies and procedures across the service. Amending the evictions and sanctions policy is a key component of this work, as service users used to receive three letters under their door prior to their eviction. Thus, Elaine is working collaboratively with the service and housing leads to consider different way to make this process more psychologically informed.

Matilda has supported the implementation of PIEs in several services and this is her key strategy in creating a sense of coherence within and across the projects. The PIE framework has been implemented in several ways, some of which are described below:

- Developing a specific psychological model training framework for all staff who work in the hostels irrespective of role to attend. Providing training in these areas can help staff to use these in both their personal and professional life, which can help them to regulate their own emotions supporting their work with service users alongside their own wellbeing.
- Implementing reflective practice as part of the ongoing supportive practice, including having a staff development and wellbeing function.
- By thinking about how the environment can be empowering and safe, creating spaces of safety and connection.
- By creating operational groups comprised of senior management to consider different aspects of the PIE project (e.g., the physical environment) and how this could be modified.
- Supporting the evaluation of projects through considering how best to collect data, how to analyse and evaluate what the services are going on an ongoing basis.

22. Setting up specialist services for homeless people is not sufficient.

Inclusivity needs to be promoted within the wider system (e.g., local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.

Jimmy a 54-year-old man was referred for support from a third sector neuropsychology service, due to concerns about his cognitive abilities. Liaison with a range of services and a review of his medical records enabled the development or a neuropsychological formulation which drew attention to his psychosocial context. Jimmy had attended a school for children with special educational needs and had lived in his parental home until the age of 42. Leaving the parental home led to a deterioration into self-neglect, addiction, criminal behaviour, and rough sleeping. Strong relationships between the third sector agency and statutory services led to a more compassionate and contextual understanding of his difficulties, with a neuropsychological formulation shared across homeless provisions, healthcare, social services, and probation.

Work with James offered a specific case to highlight that coordinated multi-agency multidisciplinary care was vital. For this to happen in other cases, work was completed on the network and referral pathways. Matilda, as the psychologist in contact with the services, worked hard to develop relationships with the network of local services including through establishing a joint referral pathways meeting structure, attending Single Point of Access meetings, offering training to Community Mental Health Team (CMHT) or Primary Care services on the needs of homeless people, lobbying locally and influencing stakeholders on barriers around issues such as dual diagnosis. This was a turning point for James and the start of more effective coordinated care when, through perseverance and the establishment of joint meeting structure, James' mainstream CMHT referral was finally accepted, after his use of alcohol had proven a barrier for so long.

23. Working to bring different services together and to proactively support the needs of people with multiple complex needs, bridging the gaps between services that service users can fall between, helping to address service exclusion.

Being part of a multi-agency task group seeking to help people who are experiencing long term street homelessness into accommodation has provided Oliver with the opportunity to share a psychological understanding of why a service may be struggling. Bringing agencies together can help prevent service users fall between the gaps and prevent exclusion from services and promote understanding of the individual's circumstances and needs from a psychological perspective.

Collaboration and encouraging partnership working with multiple agencies is a major part of Matilda's role. Gaps have been identified between homeless and services and health services, as service users are often excluded from these statutory services due to service design. Therefore, Matilda has been working to support services engage in a piece of work by embedding psychology at the point of need within hostels, supporting access to these services, reducing service exclusion.

24. Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.

When beginning work in this field Jason noted the absence of psychologist groups he could turn to for advice but found by contacting homelessness charities directly that a number had connections to various psychological practitioners. Upon further research he joined the Faculty for Homelessness and Inclusion Health which led in turn to a focus group, conference presentation and email professionals group. By being willing to discuss and offer advice on research this provided a means of enhancing his own service provision and contributing to initiatives nationwide.

Sarah has worked hard to develop a network of local and national psychologist doing similar work, finds time to attend specialist training and networking events and joins in with regular opportunities to connect such as twitter chats (#HomelessPsychology). Her team have also set-up networking meetings with other psychologists in the region to share the work and find ways to work together on national agendas. Sarah finds this supportive in work that can at times feel isolating and challenging.

Contributing to the evidence base

25. Clinical Psychologists should allocate time to research and evaluation.

As well as seeking out opportunities to promote and complete research, they should be a source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible, highlighting its value to senior management.

Richard worked collaboratively with a local charity in order to offer pro bono advice and training to their staff, and explore how they could better evaluate, promote and improve upon their current service. This led to suggestions for joint working and ultimately to setting up a small scale evaluation project which would be presented to staff and Trustees and used locally to promote their work.

Small scale research and service evaluation is as important as larger pieces of research and wider dissemination of the work through articles and conference presentations. The evidence-base is still relatively young and there is great value in sharing evidence-based practice. Continue to measure what you are doing and share that to influence commissioning, service sustainability and expansion.

26. Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community.

Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.

The psychologists on the team were instrumental in writing up a service evaluation which was published through the BPS, reported at a BPS conference and posted on Researchgate as open access in order to reach a wider readership. The emphasis of the paper was on the rationale, process and learning outcomes for the team in order that it might be useful for colleagues engaged in similar work, improve service quality and help break down barriers to inclusion.

Having opportunities to share learning with major national bodies such as NHS England, Public Health England, and the Department for Levelling Up, Housing and Communities has enabled us to grow the work, develop a national reputation, and support others in using our evidence-base to gaining funding and developing service provision for PIEs that incorporate embedded clinical psychologists.

Further Resources

Online communities of those interested in homelessness services:

Homeless Link, the national membership charity for organisations working directly with people who become homeless in England: https://www.homeless.org.uk/our-work/resources. The Homeless Link briefing on PIE and TIC can be found at: https://homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments

Pathway, the UK's leading homeless healthcare charity, which includes the active Faculty for Homeless and Inclusion Health: https://www.pathway.org.uk/about-us/

PIElink, which has a wealth of PIE-focused resources and opportunities to connect with others in the sector: http://pielink.net/

The Nottingham Practice Development Unit, which hosts free e-learning modules, webinars, and Communities of Practice, PIE and TIC: http://pdunottingham.org

Aneemo, which offers a wide range of courses for organisations, groups, and individuals to support the delivery of PIE and TIC: https://www.aneemo.com/

Books and clinical guidelines:

Brown, G. (Ed.) (2019). *Psychoanalytic thinking on the unhoused mind.* Oxon, UK: Routledge.

Cockersell, P. (Ed). 2018). *Social exclusion, compound trauma and recovery: Applying Psychology, Psychotherapy and PIE to homelessness and complex needs.* London: Jessica Kingsley Publishers.

Cooper, A. & Preston-Shoot, M. (2022). Adult safeguarding and homelessness: *Understanding good practice.* London: Jessica Kingsley Publishers.

Hockton, P. (2019). *Street Talk: Not angry but hurting. A model for therapy developed through work with women in street prostitution.* Free Association Books.

Johnson, R. (Ed.). (2012). *Complex trauma and its effects. Perspectives on creating an environment for recovery.* Brighton, UK: Pavilion Publishing.

Levy, J.S. (2021). *Pretreatment in action. Interactive exploration from homelessness to housing stabilisation.* Ann Arbor, MI, US: Loving Healing Press.

Levy, J.S. & Johnson, R. (2018). *Cross-cultural dialogues on homelessness. From pretreatment strategies to Psychologically Informed Environments.* Ann Arbor, MI, US: Loving Healing Press.

National Institute for Health and Care Excellence (NICE), (2022). *Integrated health and social care for people experiencing homelessness.* NICE guideline [NG214]. Available at: https://www.nice.org.uk/guidance/ng214

Twitter:

There is an active community of psychologists and others interested in PIE, who connect via #homelesspsychology and @PathwayUK

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