# Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services

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## ABSTRACT

**Aims**: Psychologically informed environments (PIE) is a broad and flexible framework developed in UK homelessness services. PIE integrates psychologically informed ideas and approaches into service design to consider the psychological and emotional needs of service-users and staff. This study aimed to explore how psychological professionals interpret and implement PIE and what this looks like in practice.

**Methodology**: Semi-structured interviews were conducted with 11 practitioner psychologists who use a PIE approach in homelessness services or organisations. Reflexive thematic analysis was used to explore how PIE is applied in practice.

**Results**: Five themes were identified through the thematic analysis: (1) 'PIE is a journey, not a destination' which describes how practitioner psychologists deciphered and implemented PIE over time. (2) 'Building trusting relationships' which describes the importance and process of building trust with people experiencing homelessness and with colleagues. (3) 'Systemic barriers to PIE' which describes systemic, structural, and societal barriers to the implementation of PIE. (4) 'Reluctance from staff teams' which describes some staff teams' discomfort with reflective practice sessions and the judgemental attitudes held towards service-users, and (5) 'The enormity of PIE' which describes PIE as a vast framework which can be utilised by professionals and services irrespective of formal psychological training and is challenging for a single staff member to hold and manage in their day-to-day workload.

**Conclusions**: This research explored the accounts of practitioner psychologists using PIE in homelessness services. The time required to decipher and implement PIE should be acknowledged by senior leaders, commissioners, and psychological professionals. Building trusting relationships with both service-users and other staff is a cornerstone of PIE and should be emphasised. Consideration should be given to policies and initiatives to reduce systemic limitations, engage staff teams, and share the responsibility of implementing PIE.

**List of Abbreviations**

| | |
|---|---|
| ACEs | Adverse Childhood Experiences |
| CBT | Cognitive Behavioural Therapy |
| LGBTQ+ | Lesbian, gay, bisexual, transgender, queer, questioning, + indicates acceptance of any other terms used by individuals to describe their gender and/or sexual identity |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| PIE | Psychologically Informed Environments |
| TIC | Trauma Informed Care |

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# CHAPTER ONE: INTRODUCTION

Homelessness is a complex social phenomenon which has increased substantially in England since 2010 (Wilson & Barton, 2022) resulting in calls to expand the provision of services and initiatives to support people experiencing homelessness (Crisis, 2018; NICE, 2022). Consequently, increasing focus has been placed on Psychologically Informed Environments (PIE), a framework developed in homelessness services to meet the psychological and emotional needs of service-users and staff.

This chapter will provide an introduction to the topic of homelessness. Homelessness is comprised of a multitude of interweaving threads and readers will be encouraged to consider each factor discussed in the wider context presented in this chapter, as no single factor takes priority or is more crucial than others (Fitzpatrick et al., 2017). Consideration will initially be given to many of the potential causes of homelessness, such as socio-political factors and individual and psychological factors. An exploration of the impact of homelessness on a person's mental health and wellbeing will then be undertaken. Relevant policies and frameworks concerning homelessness will be outlined, followed by a summary of homelessness services in the UK. The role of applied psychologists and psychotherapists in homelessness settings will be highlighted. PIE will then be introduced, with the information provided throughout this chapter so far serving as a rationale for psychological approaches in homelessness services. A scoping review of relevant literature pertaining to PIE in homelessness services will be conducted. In the context of this PIE literature review, the chapter will conclude with an outline of the research rationale and research questions.

## 1.1. Defining Homelessness

### 1.1.1. The Legal Definition

The Housing Act (1996) outlines the circumstances where one may be legally defined as homeless. These include, but are not limited to, when an individual is not entitled to occupy accommodation, when they have accommodation but cannot

secure access to it or have no location to legally situate it (for example, for movable structures, vehicles, or vessels), or when it is unreasonable for them to continue residing in their accommodation (for example, due to risk of domestic violence). Threatened homelessness is defined as when an individual or household is likely to become homeless within 56 days (Homelessness Reduction Act, 2017), including if they have been served notice of termination of tenancy.

Homelessness therefore manifests in various forms, including people who are 'street homeless' or 'rough sleepers', people seeking refuge from domestic violence, people unable to live with family due to relationship breakdown, and people living in hostels or shelters. The definition of homelessness also includes 'hidden homelessness' where people reside informally with friends or family, or 'sofa surf'. Hidden homelessness, estimated to comprise 13 times the number of people visibly sleeping rough, is concealed from official statistics and does not receive appropriate support from services (Hidden Homelessness in London, 2017).

### **1.1.2.** Critique of Legal Definition

The legal definition of homelessness can be critiqued for not acknowledging the various interconnecting factors which contribute to its cause, maintenance, and personal and social impact (Somerville, 2013). Minimising the nuanced underlying factors present in homelessness impedes the development and efficacy of initiatives designed to address homelessness (Mago et al., 2013). Also, 'hidden homelessness' receives an insufficient acknowledgement in the legal definition, permitting its continuing absence from official statistics and further contributing to confusion among services and the wider public (Pleace & Hermans, 2020).

### **1.1.3.** Definitions for this Project

This chapter will provide the backdrop for the subsequent research study, by summarising and reviewing relevant literature on homelessness and on the provision of services for people experiencing homelessness. It is acknowledged therefore that different conceptualisations of homelessness will be present across different research papers and operate between different homelessness services. Consequently, a broad definition of homelessness will be employed with consideration of publications and studies which identify 'homelessness' as a focus. It

is hoped this will represent the wider spectrum of homelessness in its many forms. It is acknowledged, however, that publications often focus on more 'severe' forms of homelessness, such as street homelessness, which should be held in mind whenever reviewing or interpreting the literature on homelessness.

## 1.2. Understanding Homelessness – Social, Political, and Structural Factors

Structural factors (such as housing shortages), public policies (such as austerity and funding cuts), poverty, and systemic discrimination are inextricably entwined with homelessness and are fundamental to understanding how it is caused and how it manifests. This section will briefly consider each of these structural factors in turn.

### 1.2.1. The Housing Crisis

The housing crisis in the UK refers to the shortage of affordable, good quality housing to rent or buy. Social housing has become increasingly scarce as properties sold through the right-to-buy policy have not been replaced, leading to a 20% reduction between 2004 and 2016, contributing to increasing waiting lists for housing with local authorities (London Housing Strategy, 2018). The lack of affordable housing increases the chances that someone may become homeless, as there are fewer options available to them to secure stable accommodation. Consequently, initiatives to tackle homelessness typically include commitments to increase the number of affordable homes (e.g. London Housing Strategy, 2018), although efforts to rectify this have yet to fully materialise due to various factors, such as insufficient investment and complexities in planning law (Barton et al., 2023).

### 1.2.2. Public Policy and Austerity

The introduction of austerity policies in 2010 resulted in steep cuts to welfare benefits and Local Authority budgets, which have been associated with an increase in homelessness in the UK (Loopstra et al., 2014). Welfare benefits constitute a safety net against homelessness, with cuts increasing the likelihood that someone may become homeless when combined with other factors. Denmark, which has a robust welfare system, has substantially lower levels of shelter use than the USA, though people in Denmark who are transitionally homeless were observed to have greater levels of mental health difficulties (Benjaminsen & Andrade, 2015). This

supports the assertion that welfare benefits provide a safety net against homelessness, with other contributing factors seemingly needing to be greater in scope or intensity to increase the likelihood of homelessness in the context of a stronger welfare system.

Cuts to welfare benefits reduce the money available to an individual and a household to spend on core necessities, such as rent payments, and have been observed to increase mental health difficulties amongst those impacted (Mattheys, 2015). In addition, as this level of need was increasing, public spending cuts reduced the resources available to NHS mental health services, depriving potential service-users of timely support (O'Hara, 2014). As mental health difficulties have been observed to contribute to homelessness (Piat et al., 2015), this suggests that austerity policies may have impacted and increased homelessness rates through various means.

### **1.2.3.** Poverty and Childhood Poverty

Homelessness and poverty are often discussed in conjunction, understandably as people experiencing homelessness are typically materially poor (Mabhala et al., 2021). As discussed in the previous section, reduced incomes, due to welfare benefit cuts for example, increase the likelihood of homelessness as housing costs become unaffordable.

Bramley and Fitzpatrick (2018) highlighted results from the British Cohort Study, a longitudinal study which collected data about British adults for between 10-15 years from 1970. Their analysis of the data indicated poverty was the central factor for predicting homelessness, and that childhood poverty in particular predicted adult homelessness. This indicates that poverty is a causative factor in the development of homelessness. Bramley and Fitzpatrick (2018) did observe a complex interplay of factors however, suggesting that homelessness cannot be simplified to explanations around childhood poverty. For example, they identified that the primary protective factor was access to social support networks, such as living with an adult partner or being able to live as an adult in the family home, which serves as a 'buffer' to homelessness.

Mabhala et al. (2021) examined childhood poverty and socioeconomic status of people experiencing homelessness and their parents in relation to adverse life experiences. They argued that in addition to depriving a person of material resources, poverty produces social conditions which increase the probability of homelessness, for example, by increasing the likelihood that someone may experience traumatic or adverse life experiences. Thus, poverty can trigger a sequence of events that ultimately results in homelessness. This provides further evidence that the causes of homelessness are complex and multifaceted. For further discussion on adverse life experiences, see Section 1.3.1.

### **1.2.4.** Discrimination, Oppression, and Power

Discrimination, marginalisation, and the operation of power over minoritized communities can also contribute to the causes and manifestation of homelessness. While poverty was discussed above, other areas of difference and identity are considered below. This is not an exhaustive list, and there are other forms of discrimination that are not discussed here in depth, for example, towards people with mental health difficulties, physical health difficulties, or who have neurodevelopmental differences. As has been emphasised throughout this chapter, complexity is prominent when understanding homelessness. Encouragement is therefore given for an intersectional stance to be held while reading the following paragraphs to consider how different identities may interweave with poverty and with one another.

#### **1.2.4.1.** *Women and Domestic Violence*

Much of the homelessness literature initially focused on the experiences of lone adult men, and continuing criticisms have been levelled at the European research community for failing to explore the experiences of homeless women (Bretherton, 2017).

Bretherton (2017) described how women's experiences of, and pathways into, homelessness are different to men. Domestic violence, which women are more likely to experience, is a major contributory factor to homelessness, although research has often treated this as a separate social problem to homelessness rather than considering how they connect (Mayock et al., 2016). For many homeless women,

domestic violence represents a pathway to homelessness not experienced as frequently by men, characterised by violent relationship breakdown and the need to escape a threatening environment that was supposed to be a safe and secure home (Bretherton, 2017).

Homeless women are also subject to sexist attitudes from services, including homelessness, health, and welfare services, often for not adhering to stereotypical gender roles, such as the ‘mother’, ‘wife’, or ‘carer’ (Mayock et al., 2016).

#### **1.2.4.2.** *Ethnicity and Racism*

Black and Minority Ethnic people are 2.5 times more likely to experience poverty than White people (Emiston et al., 2022) and experience disproportionate levels of homelessness in the UK. A report by Heriot-Watt University (Bramley et al., 2022) found that Black people are three times more likely to be homeless than White people when considering all forms of homelessness, while Pakistani and Bangladeshi people are overrepresented when examining hidden homelessness statistics (such as overcrowded accommodation and sofa surfing). In addition, 32% of homeless Black people had reported experiencing discrimination from landlords (including private landlords and local authority / social landlords), implying that discrimination may increase the risk of becoming homeless and/or maintain homelessness.

#### **1.2.4.3.** *LGBTQ+ Youth*

LGBTQ+ young people also experience disproportionately high levels of homelessness, with 24% of homeless youth in the UK belonging to an LGBTQ+ community (akt, 2015). Transgender people appear to be at particular risk, with 25% experiencing homelessness at some point in their lives (Bachmann & Gooch, 2018). These high rates of homelessness appear to be the result of family breakdowns, with 77% of LGBTQ+ homeless young people reporting that coming out to their parents was the primary factor which precipitated their homelessness (akt, 2015). This aligns with other research which shows that social support networks, such as family, are a key protective factor against homelessness (Bramley & Fitzpatrick, 2018).

Once homeless, LGBTQ+ young people are at greater risk of experiencing violence and discrimination than other young people and are more likely to develop substance use issues and experience sexual exploitation (Bhandal & Horwood, 2021). This indicates that homeless LGBTQ+ people have a greater likelihood of experiences which entrench and maintain their homelessness over time.

## 1.3. Understanding Homelessness – Individual and Psychological Factors

Various individual and psychological factors have been observed to coincide with homelessness, such as adverse childhood experiences and traumatic brain injury. As has been discussed previously in this chapter, the interaction between different factors in homelessness is complex and so consideration should be given to how different individual factors interweave, both with one another and with the social and political contexts described above.

The large number of variables that have been examined, both as potential factors in the development of homelessness and as potential consequences of homelessness, is extensive. It is beyond the scope of this chapter to explore all these factors in depth, though interested readers may wish to explore other published writings on the varied relationships between homelessness and learning and neurodevelopmental difficulties (Stone et al., 2019), substance use (McVicar et al., 2015), and the criminal justice system (Mabhala et al., 2017), among others.

### 1.3.1. Adverse Childhood Experiences

Adverse childhood experiences (ACEs) refer to the categorisation of negative experiences that can occur during childhood, such as physical and sexual abuse, physical and emotional neglect, and dysfunctional experiences at home (e.g. domestic violence between parents, or losing contact with a parent following parental divorce or due to them being incarcerated) (McEwen & Gregerson, 2019). It is not unusual for a person to have experienced one or more ACEs during their childhood, though exposure to a greater number of ACEs has been strongly correlated with increased mental health and physical health difficulties in adulthood (Finkelhor et al., 2015). Attachment difficulties, which have been described as a product of ACEs involving caregivers (Murphy et al., 2014), have also been associated with greater

mental health difficulties and dysfunctional relationships in adulthood (Van Dijke et al., 2018).

People experiencing homelessness have experienced a significantly higher number of ACEs when compared to the general population, suggesting this may underlie the mental health difficulties that frequently present in homelessness (Liu et al., 2021). In addition, attachment difficulties are also exhibited to a greater degree by people experiencing homelessness (Anderson & Rayens, 2004, Seager, 2011), providing further evidence of the adverse experiences prevalent in homeless communities.

### 1.3.2. Traumatic Brain Injury

Reported rates of traumatic brain injury (TBI) are high among people experiencing homelessness. Percentage rates of TBI vary considerably between different research studies, possibly reflecting the experiences associated with different types of homelessness, though approximate averages for TBIs of any severity are around 50% (Stubbs et al., 2020). While an individual may be at greater risk of sustaining a TBI while homeless, the majority of TBIs appear to be sustained prior to becoming homeless (Oddy et al., 2012). There is extensive variation in the impact a TBI may have, though common areas of impairment include executive function, emotion regulation, communication, and concentration (Barman et al., 2016). Cognitive impairments of this nature can contribute to the causes of homelessness by compounding other areas of difficulty and making it harder to sustain employment, manage tenancies, or communicate effectively with others.

## 1.4. The Impact of Homelessness on Mental Health

Mental health difficulties are prevalent among people experiencing homelessness with homelessness described as both a cause and a consequence of mental distress (Perry & Craig, 2015). As individuals spend a considerable amount of their lives in their homes, it is reasonable that their housing, or lack thereof, has a substantial impact on their wellbeing (Singh et al., 2019).

Various mental health presentations have been associated with homelessness. Substance and alcohol use is prevalent (Fazel et al., 2008) and rates of depression

and psychosis are high amongst people experiencing homelessness, more so than both prisoners (Fazel & Danesh, 2002) and refugees (Fazel et al., 2005). Street homelessness has been associated with more severe mental health difficulties, such as psychosis and personality disorder diagnoses (Rees, 2009; Perry & Craig, 2015). The high rates of adverse and traumatic life experiences in early life amongst people experiencing homelessness may also be contributing to the high levels of mental health difficulties observed (Seager, 2011; Sundin & Baguley, 2015).

This section will move beyond the potential causes of homelessness and summarise how the experience of homelessness itself can impact mental health and wellbeing, including by contravening a person's core needs and subjecting them to stigma and discrimination. In addition, responses and patterns of behaviour often associated with people experiencing homelessness will be considered and conceptualised in the context of their life experiences, both those that happened prior to and during their becoming homeless.

### **1.4.1.** Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs (1943) provides a framework for understanding how experiencing homelessness impacts on a person's mental health. The first level of Maslow's Hierarchy of Needs, the core physiological needs of a person, are often contravened when homeless. People experiencing homelessness, and rough sleepers in particular, may not have consistent access to shelter, sufficient sleep, or warmth. In addition, poverty and lack of a secure base may limit consistent access to food and water.

Feelings of threat and discomfort and the operation of harm towards people experiencing homelessness conflicts with the second level of Maslow's Hierarchy of Needs: the need to feel safe and secure, including in their surroundings and with others (such as with family, friends, and acquaintances). Living in poor quality and unaffordable housing has been associated with high stress levels and reduced perceptions of control over one's life (Gibson et al., 2011). Threats of housing loss, which for people experiencing homelessness may involve eviction from hostels or temporary accommodation, or the breakdown of a 'sofa surfing' arrangement can also impact a person's mental wellbeing, by generating feelings of fear and anxiety

(Vasquez-Vera et al., 2017). In addition, people experience high rates of victimisation from others while homeless, including physical violence, theft, discrimination, and sexual exploitation (Bonugli et al., 2013; Heerde et al., 2015).

The third level of Maslow's Hierarchy of Needs, the need for love and belonging, is constrained by the contraventions of the previous two levels, providing potential context for research findings of interpersonal difficulties amongst people experiencing homelessness (De Espíndola et al., 2020). In addition, many people experiencing homelessness do not have a supportive social network of family or friends (Bramley & Fitzpatrick, 2018).

The observations in the previous paragraphs suggest people experiencing homelessness will struggle to access the fourth and fifth levels of Maslow's Hierarchy of Needs, esteem and self-actualisation respectively. This may correspond with the high levels of mental distress experienced by people experiencing homelessness (Irwin et al., 2008).

### **1.4.2.** Stigma and Discrimination Towards Homelessness

People experiencing homelessness are often subject to stigmatising and discriminatory perceptions from the general public (Reilly et al., 2022) constituting another element of homelessness which impacts one's mental health and wellbeing. To illustrate, when research participants were given clinical vignettes to read, the term 'homelessness' was seen to produce accusations of blame towards the person for their circumstances (Phelan et al., 1997). UK and US citizens were also observed to hold less compassion towards people experiencing homelessness than the German, Belgian, or Italian public (Toro et al., 2007). Curiously, in a research study with US adults, Tsai et al. (2019) recorded high levels of compassion towards people experiencing homelessness alongside beliefs that the government should provide additional funding. This possibly suggests that views towards people experiencing homelessness may be highly polarised, that the context in which homelessness is discussed is crucial, or that attitudes in the US have changed over time.

Belcher and DeForge (2012) argue that stigma towards people experiencing homelessness stems from capitalist ideologies in society. Individualist values are

accentuated, generating a tendency to blame the individual for their circumstances rather than larger social and economic forces. In addition, social stigma occurs in conditions where social, economic, and political power is unequal. As a group which can be characterised as not 'contributing' or 'useful' to a functioning capitalist society, people experiencing homelessness can therefore become a target for discrimination from others.

#### **1.4.2.1.** *Internalised Stigma*

People experiencing homelessness are aware of the negative attitudes that are held about them by others which can lead to these beliefs being internalised by the individual, contributing to feelings of distress. In a study with US and Canadian homeless youth, Kidd (2007) reported that greater perceived stigma from others was associated with greater feelings of self-blame for their homeless status, lower self-esteem, and increased feelings of suicidal ideation. This indicates that stigma towards people experiencing homelessness is directly contributing to the mental distress present in these communities.

In a systematic literature review on the effects of stigma on people experiencing homelessness, Reilly et al. (2022) reported that people were aware of the discriminatory views held about them by healthcare providers and staff. They identified a series of themes summarising the beliefs of people experiencing homelessness when attending healthcare settings, including that they felt dehumanised, that they feared the power healthcare professionals could wield over them, and that stigma was anticipated. This resulted in greater avoidance of care and poorer engagement with services, indicating that stigma towards people experiencing homelessness impacts not just the quality of the care they receive but also the degree to which they access it. It should be noted that Reilly et al. (2022) observed that positive attitudes and relationships were also present in healthcare settings and were greatly valued by people experiencing homelessness.

### **1.4.3.** Patterns of Relationships and Interpersonal Difficulties

People experiencing homelessness have been characterised by healthcare professionals and services as exhibiting interpersonal or relational difficulties or patterns of behaviour that may be considered 'challenging' (Balda, 2016).

People experiencing homelessness have been characterised as having interpersonal difficulties (De Espíndola et al., 2020) and often have poor engagement with services (Darbyshire et al., 2006). Social isolation is common (Saunders & Brown, 2015), including the absence of close family or friends, as is agitated or aggressive behaviour (Balda, 2016). Distrust of others has been described as a common response following both experiences of childhood trauma (Hepp et al., 2021) and experiences of discrimination (Armstrong et al., 2013; Thrasher et al., 2008), suggesting these patterns of behaviour may be survival strategies developed by some people experiencing homelessness in the context of their life experiences. Nonetheless, distrust of social interactions can prolong homelessness, by limiting the access someone has to support services (Kryda & Compton, 2008). Relationship and interpersonal difficulties can therefore be considered in the context of homelessness and its impact on mental health and wellbeing.

## 1.5. Relevant Policies and Frameworks

The impact of homelessness on mental health and wellbeing and the consequences of this for the individual have ramification for local services, such as those provided by the NHS and local authorities, who frequently fail to meet the complex needs of people experiencing homelessness. Consequently, various initiatives, policies, and strategies have been introduced to develop services, better support people experiencing homelessness, and to prevent homelessness.

### 1.5.1. NICE (2022) Guidelines: Integrated Health and Social Care for People Experiencing Homelessness

NICE (2022) published guidelines to inform the development and provision of health and social care services for people experiencing homelessness. Various recommendations for services and service delivery are provided, such as increasing involvement of people with lived experience of homelessness in the planning and delivery of services, improving and sustaining engagement with potential service-users through various means (including by introducing PIE or trauma-informed care approaches), and enhancing communication with people experiencing homelessness (including by considering communication styles and the information

that is being communicated). Recommendations for research for services for people experiencing homelessness include examining the effectiveness and acceptability of PIE and psychological approaches, exploring structural and systems variables in the commissioning and delivery of health and social care services integrated with housing, and the effectiveness and cost effectiveness of longer health and social care contacts.

### **1.5.2.** Homelessness Reduction Act (2017)

This Act was developed to enhance early intervention for people at risk of homelessness, for example by increasing the time within which someone is considered 'threatened with homelessness' (from 28 to 56 days), thereby increasing the timeframe for intervention. In addition, staff in specified public authorities, such as Jobcentre Plus, social services, prisons, probation services, inpatient wards, and emergency services, became legally obligated to identify the housing status of service-users and to make appropriate referrals (subject to consent) if they are found to be experiencing homelessness or at risk of homelessness.

### **1.5.3.** NHS Long Term Plan

The NHS Long Term Plan (2019a) highlights the high rates of mental health difficulties encountered by people experiencing street homelessness. As access to mainstream mental health services is restricted, often due to perceived complexity of needs, and as there are few specialist mental health services across the country, additional investment was confirmed to rectify this. Areas of development include the creation of specialist homelessness mental health pathways and better integration between services.

The NHS Long Term Plan also includes a commitment to ensure all services, including those relevant to people experiencing homelessness, become trauma informed. This is noteworthy because, as described previously in this chapter, there are high rates of adverse life experiences among people experiencing homelessness.

### 1.5.4. Rough Sleeping Initiative: 2022 to 2025 Funding Allocations

The Rough Sleeping Initiative (Department for Levelling Up, Housing and Communities, 2022) allocates funds provided by the government to local authorities, charities, and other organisations to support people experiencing or at risk of rough sleeping. Up to £500 million has been made available to services in 303 areas, an expansion of the 2020 to 2021 funding allocations which provided £112 million to around 270 areas (Ministry of Housing, Communities & Local Government, 2020). Funds can be used by recipients to develop services, provide housing, and employ staff in reference to their local contexts and alongside existing support available in their area.

## 1.6. Homelessness Services

Homelessness is characterised by complex needs and has been described as 'tri-morbidity', where physical health difficulties, mental health difficulties, and addictions converge (Stringfellow et al., 2015). This presents challenges for services seeking to meet the needs of this population, with NHS services typically being structured to meet specific needs rather than deliver a holistic service (Wade, 2021), despite evidence that a holistic approach is more effective when working with people experiencing homelessness (Cornes et al., 2018, Stergiopoulos et al., 2017). In addition, this NHS service structure underlies a tendency for potential service-users to be discharged or their referrals rejected if they do not meet precise criteria, leading some people experiencing homelessness to be frequently passed between mental health, social care, and addictions services (Gunner et al., 2019).
People experiencing homelessness have higher rates of admission to mental health inpatient services. Services and service-users often face a dilemma, where prompt discharge from a mental health hospital may result in returning to the street or to inappropriate housing, with the alternative being prolonged stays in hospital, which can be unnecessary and distressing (Jenkinson et al., 2020).

Specialist NHS services are not common for people experiencing homelessness in the UK (Cornes et al., 2011). Some exceptions exist across the country, however, such as the development of rough sleeping mental health services following commitments in the NHS Long Term Plan (NHS England, 2019b). In addition,

Pathway teams have been introduced to provide support and care co-ordination for people experiencing homelessness who are admitted to physical and mental health hospitals (Dorney-Smith et al., 2016). Despite these exceptions, there are few NHS specialist services for people experiencing homelessness and, as existing services are often not designed to effectively meet their needs, they are frequently excluded from receiving appropriate help and support.

The majority of homelessness services in the UK are provided by third sector organisations with various national charities such as Crisis, Shelter, Centrepoint, St Mungo's, and akt, alongside local charities. Different third sector organisations provide different services, including offering help and advice, offering housing and legal advice, managing temporary accommodation and hostels, providing street outreach services, support with welfare benefits, assistance accessing employment or education, support for drug and alcohol issues, or simply providing a safe space. Third sector homelessness organisations also lobby and advocate for the needs of people experiencing homelessness to the government and policy makers (Lobb et al., 2022).

While third sector homeless organisations vary substantially from one another, they can offer more holistic services for people experiencing homelessness than traditional NHS mental health services (Swindley, 2015). They are not without limitations, however, which can restrict their reach. For example, no service can meet all of the needs of their client base alone, with poor communication and collaboration between third sector homeless organisations and other services (including other third sector organisations, NHS services, and social care services) often hampering the provision of genuinely holistic services (Dutton et al., 2023).

Reductions in funding in recent years from national and local governments and commissioners limit the services and initiatives third sector organisations can provide to people experiencing homelessness (Buckingham, 2011). In addition, the training provided to staff varies substantially between third sector homeless organisations, with many relying on inexperienced and poorly trained workforces (Crane & Warnes, 2005). This is compounded by the poor pay often afforded to staff (Crane & Warnes, 2005) resulting in high staff turnover across the sector.

Another limitation impacting both third sector and NHS services for people experiencing homelessness is that only a minority receive the support offered by these providers, with the majority of potential service-users either not being identified or opting not to engage with services (Gunner et al., 2019). This raises questions regarding the efficacy of homelessness services, given they fail to contact or support so much of their target audience.

### 1.6.1. Stigma Within Homelessness Services

As in the general population (see Section 1.4.2.), staff members in NHS and third sector services have been shown to hold negative and stigmatising attitudes towards people experiencing homelessness. General practitioners in the UK have shown considerable variation in attitudes towards people experiencing homelessness, with negatively disposed staff members perceiving them as 'difficult, untrustworthy timewasters', identifying some as being undeserving of care, and resenting the expectation that they should adapt their provision to meet the needs of people experiencing homelessness (Lester & Bradley, 2001). In addition, people experiencing homelessness have reported feeling stereotyped by healthcare staff and being perceived as untrustworthy (Reilly et al., 2022). Prejudicial and discriminatory views are also reportedly held by hostel staff (Bhui et al., 2006), with hostel residents feeling the actions of staff to be disrespectful, unsympathetic, and rude (Stevenson, 2014). Schneller (2012) posits that staff members may hold negative attitudes towards people experiencing homelessness if they have experienced behaviours that challenge from this client group without access to training on appropriate management. These discriminatory beliefs, and the awareness of them by people experiencing homelessness, poses challenges for specialist services to adequately engage and meet the needs of their client base.

## 1.7. The Role of Applied Psychologists

There is considerable potential for applied psychologists, such as clinical, counselling, and forensic psychologists, to work in homelessness settings across NHS and voluntary sectors, reflecting their wide-ranging role. This might include direct contact with people experiencing homelessness via psychological

assessments and interventions, or could consist of indirect interventions, including consultation, staff support, and service development. In addition, applied psychologists are increasingly supporting the implementation trauma-informed care (TIC) within services, in line with the NHS Long Term Plan. Due to the multifaceted nature of homelessness, there are opportunities to utilise psychological formulation to increase awareness of people experiencing homelessness and their needs, and to conceptualise the various factors in their lives into a coherent narrative. This process can be used to provide support and validation when working directly with a person experiencing homelessness, and when working with other staff members in the homelessness sector to provide guidance and combat stigmatising beliefs.

### 1.7.1. Psychological Assessment and Intervention

Psychological assessments can be used to explore and demystify the complex experiences a homeless person may have had in their life and identify primary areas of support. Such assessments may validate the service-user's experiences and support them to reflect on their circumstances while also providing guidance for other professionals supporting them. Psychological assessments, and the corresponding formulations that may be developed, can be used to advocate for the service-user's needs when liaising with other organisations, for example, when making referrals to other services and for welfare benefits and housing.

Psychological interventions and therapy can also be offered to homeless service-users to provide support for mental health difficulties. Research studies examining the efficacy of psychological interventions for people experiencing homelessness have presented a mixed picture, with one literature review suggesting cognitive behavioural therapy (CBT) provided significant improvements in anxiety but not in the areas of depression, post-traumatic stress disorder, psychological distress, self-efficacy, or quality of life (Hyun et al., 2020). A separate literature review examining interventions for homeless women found CBT and motivational interviewing were effective in reducing substance use and increasing healthcare use (Speirs et al., 2013). Saunders (2018) provided evidence for the effectiveness of psychodynamic psychotherapy for homeless women offered by St Mungo's in the UK, delivered within a gender- and trauma-informed framework. These varied findings in the literature suggests psychological interventions may be effective for people

experiencing homelessness in some circumstances, particularly if they are adapted to incorporate and centre a person's lived experiences.

### 1.7.2. Indirect Interventions and Leadership

Yousefzadeh and Farquharson (2022) reported that when considering homelessness prevention, many clinical psychologists described how they would work indirectly. For example, to support other professionals in their understanding, skills in formulation could be used to develop a narrative of the service-user within the systemic context. Other highlighted opportunities for clinical psychologists included utilising their leadership and influence within services, working with commissioners and stakeholders, and becoming politically active. Practitioner psychologists are increasingly entering leadership roles in the UK, utilising their skills to inform service development (Channer et al., 2018). Low levels of staff wellbeing and high levels of burnout are prevalent in homelessness services (Schneider et al., 2021), suggesting that another area of indirect intervention could be staff support, such as facilitating supervision, staff training, and reflective practice.

## 1.8. Psychologically Informed Environments

### 1.8.1. Development of PIE

Many of the opportunities for applied psychologists working in homelessness, described in the previous section, can be encapsulated within a PIE approach. Developed from the enabling environments approach, PIE was outlined by Johnson and Haigh (2010) as a broad framework for integrating psychological concepts into the service structures to meet the psychological and emotional needs of service-users. While it was developed in homelessness hostels, PIE is now applied across homelessness services more widely.

While PIE was developed separately from TIC approaches, they share similarities, such as developing a greater awareness of service-users' lives. PIE, however, expands the focus beyond trauma/adversity, by emphasising the relationships between staff and service-users, and providing staff support and training (Keats et al., 2012).

The original version of PIE consisted of five elements (see Table 1.). The encouragement was for these to be applied flexibly, as required by the service context and service needs (Keats et al., 2012). For example, a service could utilise whichever psychological framework they felt most appropriate (e.g. CBT, attachment theory) as long as a greater understanding of their service users and their needs was developed.

PIE 2.0 (PIElink.net, n.d.-a) was presented as an updated framework, expanding and restructuring some of the elements (see Table 1). For example, 'spaces of opportunity' includes an acknowledgement of the systems and pathways around the service, in addition to creating a welcoming physical environment (as outlined in the original PIE framework). Also, 'relationships' was removed from the original line-up and repositioned as a core principle that ran through every element. Reflective practice has been described both as a second core principle in PIE 2.0 (Boag, 2020) and as a sub-component of 'learning and enquiry' (PIElink.net, n.d.-a).

**Table 1.**

*The five key elements of the original PIE framework and PIE 2.0*

| **Original PIE Framework** | **PIE 2.0**<br>*Core Principles: Relationships*<br>*Reflective Practice* |
|---|---|
| Developing a psychological framework | Psychological awareness |
| Staff training and support | Staff training and support |
| The environment and social spaces | Spaces of opportunity |
| Evidence of outcomes | Learning and enquiry |
| Managing relationships | The three Rs: rules, roles, and responsiveness |

Services using a PIE framework are often referred to, both informally and in published literature, as ‘a PIE’. Different services continue to use both frameworks of PIE, including in combination with one another or with their own adjustments (Boag 2020). For example, Cockersell (2018) presented the original PIE framework with two new elements, client participation and access to psychological therapy. An emphasis has been placed on PIE as a flexible framework, where everything can be customised according to the presenting circumstances (Johnson, 2017). In an early account of PIE, Johnson and Haigh (2010) considered the ‘definitive marker’ of being PIE as when “if asked why the unit is run in such and such a way, the staff would give an answer in terms of the emotional and psychological needs of service-users, rather than giving some more logistical or practical rationale” (p.32). Nonetheless, its versatile applications indicate that exactly what constitutes a PIE could still be contested as its principles can be interpreted very differently in practice (Schneider et al., 2021).

To provide familiarity with a PIE framework, the following sections will summarise each element of PIE 2.0, beginning with relationships and reflective practice as core themes which run through each of the following elements. The headers are structured using the PIE 2.0 framework as this expanded on the original PIE framework. Overlap can and does occur between the different elements in PIE and are not to be considered distinct entities.

#### **1.8.1.1.** *Relationships and Reflective Practice*

A focus on relationships has been described as integral to PIE, with relationships pronounced as the principal tool for change (Keats et al., 2012) and around which all other elements coalesce (Boag, 2020). While it flows through every element, the written literature has emphasised the relationships between staff members and service-users (e.g. Boag, 2020), with every interaction considered an opportunity to learn and develop (Keats et al., 2012).

Reflective practice can be defined as demonstrating self-awareness and thinking critically and evaluatively to learn from past and present experiences (Lilienfeld & Basterfield, 2020). Reflective practice is conducted both as an individual or group endeavour and can be utilised in many respects across the different domains of PIE.

In PIE settings, facilitated reflective practice group sessions are often conducted to rehearse and embed the skills of reflective practice to promote a reflective atmosphere and a ‘culture of enquiry’ within a staff team (PIElink.net, n.d.-b).

#### 1.8.1.2. *Psychological Awareness*

This element of PIE comprises the psychological concepts and theories which inform the actions taken within a service as they implement PIE (Keats et al., 2012). Any number of approaches can be taken in any combination according to the needs of the service, such as CBT (Keats et al., 2012) or attachment theory (Seager, 2011). These psychological frameworks can be used in a variety of ways, for example, to inform staff training on the psychological needs of people experiencing homelessness, in team formulation sessions to facilitate understanding of individual service-users, or to promote staff wellbeing initiatives (Tickle, 2022).

#### 1.8.1.3. *Staff Training and Support*

This element consists of interventions offered to staff teams to increase their knowledge and improve wellbeing in acknowledgement of the challenges faced by staff members working in homelessness services. Examples of staff training and support include mandatory staff training, group reflective practice sessions, and staff wellbeing initiatives (Keats et al., 2012).

#### 1.8.1.4. *Spaces of Opportunity*

This element originally referred to the built environment and how physical spaces (such as in hostels or drop-in centres) can be adapted to reduce re-traumatisation and promote feelings of safety and security among service-users (Keats et al., 2012).

PIE 2.0 expanded this element from the original version so that it also encapsulates surrounding systems, such as other services in the vicinity that clients may access and the referral pathways between them. Developing spaces of opportunity therefore encourages a focus on relationship-building with other systems to improve coordination and reduce barriers present between them (Tickle, 2022).

#### 1.8.1.5. *Learning and Enquiry*

This element comprises different aspects of the learning process. A focus on the continuing development of services and of the implementation of PIE within them is encouraged. Capturing outcome data is encouraged to provide evidence of the impact of PIE on a service and its service-users. This data can be used to inform service developments and be shared with commissioners, funders, or policy leads to demonstrate the impact of PIE (Cockersell, 2016).

Specific tools are available to facilitate the learning process, such as the Pizazz self-assessment form (Buckley & Tickle, 2023), to examine which PIE elements in a service are more or less developed than others. The Pizazz provides a framework for evaluating and reflecting on one and one's service's adherence to PIE 2.0 using various steps, such as providing a rating for each of the five elements of PIE 2.0 (i.e. 'poor', 'early', 'progressing', 'advanced'), providing evidence for why this rating is warranted, considering what helps or hinders the implementation of each element, and then developing an action plan for moving forward. A peer review with someone sufficiently removed from one's service is then encouraged, which may lead to re-evaluation of previous steps. The Pizazz does not have established norms or benchmarks and is therefore designed as a self-assessment tool to promote reflection on the implementation of PIE, rather than as a measurement of outcomes. In addition, the Pizazz is designed with PIE 2.0 in mind and may therefore not be applicable to a service using the original or an adapted PIE framework, unless the Pizazz is itself adapted first.

Learning and enquiry is also promoted within staff teams via reflective practice, for example, to support staff to reflect and learn from their experiences and adapt their practice moving forward (PIElink.net, n.d.-b).

#### 1.8.1.6. *The Three Rs – Rules, Roles, and Responsiveness*

A new element introduced in PIE 2.0, the three Rs reflects a focus on the day-to-day running and practices within a service or organisation. For example, consideration could be given to 'rules', both those formally written into policies/procedures and those unwritten, which influence practice in unhelpful or contradictory ways, such as certain eviction policies in homelessness hostels. Such rules can also reflect the

various and competing roles held by services, staff members, and the service-users themselves (Tickle, 2022).

## 1.9. PIE – Research and Literature

The PIE literature has steadily developed since its conception. Initial publications largely consisted of commentaries which discussed many of the underlying features of PIE (e.g. Walton & Walton, 2012; Whelan, 2012). More recently, outcome studies have begun to emerge, alongside published accounts of PIE and how it has been implemented. Nevertheless, due to the flexibility of the framework, confusion can persist as to what PIE looks like in practice, presenting barriers to services and organisations implementing the framework for the first time.

### 1.9.1. Literature Review Strategy

The literature search was conducted using the EBSCO and PsychINFO databases. Research terms used in the searches were 'psychologically informed environment*' and 'homeless*'. From the results generated, article titles and abstracts were reviewed, and articles were selected based on their relevance to the topic. Grey literature was excluded, except for when disseminated in a published journal article (e.g. Ritchie, 2015, Cockersell, 2016). See Appendix A for a summary of the literature review strategy.

### 1.9.2. Literature Review

This section will explore the published literature on PIE, broadly separated into three areas. Firstly, accounts of the implementation of PIE within the literature will be examined. Secondly, consideration will be given to studies which explore perceptions and perspectives of PIE. Thirdly, studies which include service-level outcome data on PIE will be reviewed. The studies examined in the second two areas, containing perceptions of and service-level data on PIE, also provide helpful insights about the implementation of PIE in practice. All of the research studies included below take place in the UK or Ireland.

Implementing PIE involves adapting various elements of a service or organisation in line with multiple streams of practice, dependent on both the context of the

organisation in question and the version of PIE that is being employed. This can understandably present challenges when seeking formal outcome data of the PIE approach in its entirety. No frameworks, measures, or tools have been specified for evaluating the outcomes of PIE, with encouragement given to organisations to develop their own measures or to creatively utilise data that they are already collecting (e.g. number of hostel evictions).

### **1.9.3.** Implementing PIE

Three papers are presented which consider how PIE has been or will be implemented within different organisations, for example, looking at how psychological awareness has been cultivated, the different initiatives promoted, and which methods of evaluation have been considered. The summaries presented below offer a snapshot of the available information on PIE in practice and therefore will not capture every detail contained in each publication.

Woodcock and Gill (2014) presented their ambitions for PIE and its impact in a housing project for 16–25-year-olds who had experienced homelessness, were care leavers, and/or had been involved with the criminal justice system. Their aspirations included all project workers having a basic understanding of the role of a ‘secure base’ (Bowlby, 1988), and of the impact of disrupted attachments and trauma. Reflective practice groups and individual supervision were cited as ways for project workers to learn more about themselves, with similar initiatives to be implemented within the organisational leadership structure. Reference was also made to the development of pathways and activities for their young people, to provide opportunities for leisure and skills-development. Therapeutic support, in the form of individual and group interventions, was also emphasised. Consideration was also being given to how the PIE may be evaluated, such as with the Outcome Star measure (MacKeith, 2011) and through gathering quantitative data on range of topics, including the number of administered sanctions and evictions, and the degree of engagement with groups and leisure pursuits. As this report details their ambitions for the implementation of PIE, however, it could be critiqued as speculative as many of their proposed initiatives or desired outcomes were not yet observable.

Schneider et al. (2021) presented a phased approach to the implementation of PIE, which they illustrated in a homelessness prevention third-sector organisation not yet utilising PIE. Various validated measures were administered with staff and clients to identify which needs were present within the organisation and establish a baseline. This information could then be used to inform the implementation of PIE, such as where initiatives should be targeted, while establishing a framework to evaluate these initiatives. Staff and service-users completed the Warwick-Edinburgh Mental Wellbeing Scale and the Essen Climate Evaluation Schema, while staff additionally completed the Professional Quality of Life Scale and Attitudes related to Trauma-informed Care Scale. Key findings included high rates of secondary traumatic stress (STS) observed amongst staff, with this being a predictor for burnout. Support staff and team leaders had less enthusiasm for trauma-informed values and reflective practice than senior managers, as did staff with higher rates of STS and burnout. This presented a challenge, as these were the groups that were felt to have the highest need for reflective practice interventions. The authors reported that they intended to pilot intensive reflective practice and team formulation sessions with the staff most vulnerable to STS, while seeking to dismantle engagement barriers.

Tickle (2022) provides a comprehensive account of PIE 2.0, illustrated with case examples from Opportunity Nottingham. In reference to previous findings, efforts were being made to complement the shortcomings of training on PIE and TIC (Burge et al., 2021, see below) with ongoing psychological consultations and team formulation meetings. In addition, possibly relating to the findings of Buckley et al. (2020, see below) that team formulations can increase feelings of powerlessness, social spaces were being developed, not just to make physical environments more comfortable but also to cultivate public and political spaces to advocate for systemic change. This demonstrates how PIE is continuing to evolve in line with new research. The principle of learning and enquiry was discussed, including how evaluation is embedded into specific programmes and performed by external, independent evaluators. While Tickle (2022) does not provide detailed accounts of these evaluations, reference is made to a series of reports on various topics produced by their organisation and available online.

### **1.9.4.** Perceptions of PIE Amongst Staff and Service-Users

Benson and Brennan (2018) interviewed keyworkers in various homeless projects in an organisation in Ireland on their experiences of being trained in and using psychological approaches and counselling skills. Participants spoke positively of PIE and the training they received, expressing hopes that more training would be provided across the organisation and in more depth. They reported they felt more able to engage service-users in keyworker sessions and felt more confident in their work. In addition, participants observed that policies and procedures had changed since the introduction of PIE, becoming less rigid and punitive. Benson and Brennan's (2018) study can be critiqued, however, for its use of purposeful sampling to identify potential participants. Consequently, the participants may not be representative of the wider views in their organisation towards PIE and psychological approaches.

Buckley et al. (2020) interviewed staff members in two homelessness hostels before and after a series of team formulation sessions were conducted as part of the implementation of PIE. Team formulation is defined in the study as when teams are supported by clinical psychologists to incorporate psychological thinking, collaboratively and reflexively, into the support provided to service-users (Geach et al., 2018). Buckley et al. (2020) described how the team formulation sessions contributed to three elements from PIE 2.0: psychological awareness, staff support and training, and enquiry and learning. Participants reported that their understanding of service-users and of the impact of trauma increased, resulting in greater empathy and better understanding of service-users' patterns of behaviour. Participants described taking more time to reflect, leading to different approaches being taken in their work, suggesting the team formulation sessions also promoted reflective practice. However, participants reported increased feelings of hopelessness and powerlessness due to greater consideration of service constraints and their inability to consistently meet service-user needs. Buckley et al. (2020) discussed how this might be ameliorated by acknowledging systemic limitations and power differentials during team formulation sessions, alongside broader developments to discuss commissioning arrangements and improve service delivery.

Phipps et al. (2017) conducted semi-structured interviews with residents, staff, and psychotherapists at two London hostels which had introduced PIE. The data were

qualitatively analysed using thematic analysis, with the themes representing the combined experiences of the three groups interviewed. Participants observed that the PIE hostels were preferable to and less chaotic than previous hostels they had experienced and that efforts had been made to make the physical environment more welcoming. Physical adaptations were particularly impactful when led by service-users, with these changes perceived as better reflecting their identities. Building and managing relationships between staff and service-users was highlighted, with trust described as a key component, albeit one requiring time to cultivate and remaining vulnerable to potential ruptures. Reflective practice was described as valuable by many staff members for managing the emotional toll of their work, though some participants critiqued the perceived luxury of 'thinking' in reflective practice, rather than 'doing' as they were accustomed in their role. Some staff questioned the distinctness of PIE from previous initiatives in the homelessness sector. In addition, similarly to Buckley et al (2020), staff reported frustrations with service constraints, such as limited resources and unreasonable service targets for resident move-on. As highlighted by Phipps et al. (2017) themselves, the single-service focus of their study is a limitation. In addition, compiling the interview data from residents, staff, and psychotherapists into a single dataset for the thematic analysis limits the ability to explore distinctions in views between these groups.

### **1.9.5.** Service-Level Data on PIE

Ritchie (2015) reported data from a two-year review of the Waterloo Project, a homelessness hostel situated in the London Borough of Lambeth, following the introduction of PIE facilitated by a clinical psychologist and an assistant psychologist. The data suggested the introduction of PIE had a positive impact on residents. Findings indicated most residents engaged with individual and group psychological interventions, showing positive outcomes on the Outcome Star (MacKeith, 2011) and self-report CORE-10 (Barkham et al., 2013) measures. Increased engagement was observed with drug and alcohol services and GP services, while contact with the criminal justice system reduced. An independent evaluation of residents' perspectives of psychologists working in the service was universally positive, although, as it was not reported what this evaluation consisted of, care should be taken when interpreting these findings.

Ritchie (2015) also examined the impact of PIE for staff at the Waterloo Project, with an independent evaluation concluding that reflective practice groups were valued as a source of support. The Maslach-Burnout Inventory (Maslach et al., 1997) was administered with staff, with interesting results. *Personal accomplishment* increased amongst staff following the introduction of PIE, while *depersonalisation* remained low throughout the data gathering periods. However, a low/medium increase was observed in *emotional exhaustion*. Ritchie (2015), however, does not speculate on what the mixed results might represent in relation to the experiences of staff members and to PIE.

Cockersell (2016) shared data relating to the same London hostel project as Ritchie (2015), with additional updated details, alongside findings from other organisations, such as St Mungo's. Regarding the former, a reduction was observed in the number of 'incidents' (for example, untoward events including violence, ambulance callouts, etc). Regarding St Mungo's, an analysis took place comparing services which had introduced PIE and those which had not. It was reported that residents of PIE hostels were 2.5 times less likely to be evicted than residents from non-PIE hostels of a similar profile. In addition, PIE hostels reported 20% fewer incidents than non-PIE hostels.

Burge et al. (2021) explored the effect of 4-days of training on PIE and TIC approaches to staff working in homelessness services. Quantitative analysis of staff TICOMETER scores, an organisational measure of TIC, provided mixed results. Following training, moderate statistically significant improvements were observed in three TICOMETER domains, (knowledge and skills, relationships, and policies and procedures) when compared to pre-training scores. The remaining two TICOMETER domains (service delivery and respect) did not improve. There was considerable individual variation, with some participants scores decreasing following the training, indicating future research could examine how staff perceived the training they received. The authors debate whether TIC training may not be sufficient to enact change on its own, and that it may have greater impact when delivered concurrently with wider system and cultural change. Burge et al. (2021) did not appear to formally assess the impact and retention of the PIE training amongst participants, focusing more so on the TIC training. While PIE and TIC have many similarities, and these

research findings are likely generalisable to PIE training, they are not identical. Caution is therefore warranted in extrapolating these findings to PIE training.

## 1.10. Summary of Literature Review

The literature on PIE has been steadily expanding since its conception, being researched and discussed in various contexts. There is a lack of uniformity in what PIE looks like in practice, however, with no single approach taken regarding its implementation and evaluation. Staff and service-user perceptions of PIE appear to be broadly positive, with some caveats. For example, systemic and service-related limitations were highlighted (Phipps et al., 2017) and found to produce feelings of powerlessness among staff (Buckley et al., 2020), while the introduction of PIE was also associated with a low-medium increase in emotional exhaustion for unclear reasons (Ritchie, 2015). Findings on the outcomes of PIE are encouraging, with reductions observed in the number of reported incidents (Cockersell, 2016) and increased engagement with external services (Ritchie, 2015).

The studies examining the perceptions and experiences of PIE, did so within a single organisation each, producing challenges when seeking to draw wider conclusions from the findings. Also, the majority of qualitative research into PIE has so far examined the experiences of frontline staff and service-users, but not those of psychological professionals. So far, it appears only one study (Phipps et al., 2017) interviewed psychotherapists, doing so alongside frontline staff and service-users and compiling the information into a single dataset.

## 1.11. Research Rationale

Various interweaving factors contribute to and entrench homelessness, including socio-political, and individual and psychological factors. People experiencing homelessness often experience prejudice regarding their homeless status, both from the public and from staff members with whom they access support, reducing the efficacy of support and impairing engagement. In addition, services and organisations which offer support to people experiencing homelessness face

prominent challenges, such as low staff wellbeing, due to reductionist processes, increasing demand for their services, and reduced funding.

PIE offers a framework for psychological professionals working in homelessness settings to consider and contend with the issues described above. PIE provides an opportunity to raise awareness of the psychological needs of people experiencing homelessness, enhancing interventions and combating stigma amongst staff, whilst simultaneously supporting staff wellbeing. The flexibility of PIE is a strength of this approach, enabling its application across a range of contexts and service structures. However, this can generate confusion when interpreting how PIE is applied in practice and what exactly constitutes a 'PIE'. The review of the literature highlighted an emerging and encouraging source of practice-based evidence and reiterated the versatile applications of PIE. Once again, however, the flexibility of the approach also poses a challenge for researchers seeking to evaluate it in a uniform approach.

Further clarity on the application of PIE in practice and across contexts, focusing on the experiences of psychological professionals, will provide guidance for those tasked with implementing PIE. This includes those already working in PIE settings and contributing to service development, staff joining a PIE service for the first time, and those seeking to apply PIE in a service which has not used the framework before. Further clarity would also provide guidance for service leads and commissioners in understanding what is meant by PIE and how it might appear in practice, while reducing potential misconceptions (for example, that PIE is a rigid framework or must be delivered in a particular manner).

### 1.12. Research Aims

This study will address the lack of clarity over what PIE looks like in practice, by interviewing psychological professionals (e.g. clinical psychologists, counselling psychologists) working in a variety of settings to explore the manifestation of PIE between different services/organisations and consider how they have been influenced by individual service contexts. The research questions are as follows:

1. How is PIE interpreted and implemented in practice?

2. What are the similarities and differences between PIE services?
3. What are the barriers and facilitators to implementing a PIE framework?
4. What examples of innovative practice have emerged from implementing a PIE framework?

# CHAPTER TWO: METHODOLOGY

## 2.1. Chapter Overview

This chapter begins by outlining the epistemological stance within which the study has operated, before detailing the ethical considerations. The research design is described, as is the analytic strategy which was employed. The chapter concludes with a section on researcher reflexivity.

## 2.2. Epistemological Position

Epistemology is defined as the theory of knowledge and regards what we as individuals 'know' to be 'true'. In research, epistemological debates centre around whether research findings reflect or mirror reality, with these discussions particularly prominent when considering qualitative data (Harper & Thompson, 2012). Epistemological positions range from realism / positivism (the assumption that there is one objective reality that can be studied) to relativism / social constructionism (the assumption that there are multiple realities co-constructed by individuals and groups of people) (Harper & Thompson, 2012).

It has been recommended that researchers, particularly when using qualitative methods, define which epistemologies inform their approach, as this discloses how meaning is being conceptualised (Braun & Clark, 2006). This study is underpinned by a pragmatist paradigm, which diverges from the conventional epistemological spectrum. A pragmatist stance eschews debates on what constitutes 'truth', in contrast to other epistemological positions, and instead emphasises practical considerations of what might be most useful in particular contexts or for particular purposes (Rorty, 1982). Pragmatism goes beyond considering merely what is practical, however, by stating that knowledge or an action are fundamentally indivisible from the *consequences* of the corresponding knowledge or action (Denzin, 2012). It is deemed impossible for a researcher to prove or disprove what constitutes reality, and it is therefore unhelpful to debate this along epistemological lines

(Pharies, 1985). Instead, it is the practical consequences of knowledge that are considered to be of principal value.

Pragmatist positions have been described as ‘anti-positivist’ due to their critique of the notion of an objective reality (Denzin, 2012), implying similarities with a social constructionist interpretation. However, pragmatist perspectives also critique social constructionist and relativist stances because, by proposing that multiple equally valid realities exist, there is the implication that any action is permissible in its corresponding context (Cornish & Gillespie, 2009)

For this study, a pragmatist stance is appropriate because the aim is not to compare the outcomes of different PIE services or for an ‘idealised’ or ‘true’ version of PIE to be extrapolated from the data. Instead, the aim is to explore how the PIE framework is flexibly applied in a range of contexts for maximum benefit. By examining PIE in practice, including the similarities and differences between how the framework has been utilised and examples of innovative practice, one can offer guidance for services both in how to apply PIE and in how to adapt it to their specific service contexts.

## 2.3. Design

The research questions were exploratory in nature, concerning how the PIE framework has been interpreted, adapted, and applied in a range of different service contexts, and of the common areas of similarity and difference between PIE services. In line with a pragmatist position, there is no one ‘true’ application of PIE to be found. Consequently, each of the participants represented examples of good practice and each of them apply PIE in unique ways that are ‘true’ to their individual contexts.

A qualitative design was selected to address the research questions. Descriptive data regarding participants and their organisations was also collected to further explore how PIE is utilised in practice and the similarities and differences between PIE services. A position of pragmatism affords a degree of flexibility in identifying a research design, using qualitative, quantitative, or mixed methods, so long as it

adequately applies to the research aims (Feilzer, 2010). To explore how participants have utilised the PIE framework, interviews were employed to access and explore the information in-depth. Reflexive thematic analysis (Braun & Clark, 2021a; Braun & Clark, 2021b) was selected due to its ability to attend to the research questions, regarding the nature of the participants' services and how PIE has been applied. In addition, reflexive thematic analysis can acknowledge and analyse participants unique perspectives of PIE, a multifaceted framework, and its utilisation in the complex area of homelessness. Thematic analysis has been characterised as epistemologically flexible (Braun & Clark, 2006), allowing it to align with the pragmatist position of this study.

## 2.4. Participants

The sample consisted of 11 participants who worked in a variety of homelessness settings and held a range of roles and levels of seniority within their organisations. Some participants were broadly embedded within a specific service (sometimes offering consultation to neighbouring services), while others held senior positions which involved liaising and contributing to multiple services in an organisation. Eight participants identified as women and three as men. Eight participants identified as White British, one as White Irish, one as 'any other mixed background', and one did not disclose. Eight participants were clinical psychologists, two were counselling psychologists, and one was a forensic psychologist.

### 2.4.1. Inclusion Criteria

The criteria for participation were psychological professionals (e.g. practitioner psychologists or psychotherapists) based in the UK or the Republic of Ireland and who were currently working in a service/organisation for people experiencing homelessness. They were to have worked in the service/organisation for a minimum of 6 months and it must define itself as using a PIE framework.

## 2.5. Procedure

### 2.5.1. Consultation and Development

For the development of the study and the procedure, various specialists in the PIE field were contacted to request advice and input, with three meetings arranged to discuss PIE and PIE research. These conversations informed the development of the research questions, study design, and interview materials.

### 2.5.2. Developing the Interview Schedule

A semi-structured interview schedule (Appendix B) was developed to explore the elements which have frequently been situated within a PIE framework, while allowing for discussion regarding participants' unique applications of PIE. A review of previous literature, including grey and white literature, was used to develop the questions. For example, because PIE 2.0 reorganised and expanded on some of the elements of the original version of PIE (Boag, 2020), questions were incorporated which reflected both iterations. In addition, increased emphasis on client participation and access to psychotherapy have also been suggested (Cockersell, 2018), so questions were incorporated to reflect these elements. As different services use different iterations of PIE, and have adapted PIE to suit their contexts, it was anticipated that not all questions would necessarily apply to every participant, though it was hoped they would still serve as reflective prompts for discussion.

### 2.5.3. Recruitment

Participants were recruited via a mailing list for psychological professionals (including clinical psychologists, counselling psychologists, and psychotherapists) working in homelessness services. At the time of advertisement, this mailing list contained 123 email addresses and included professionals working in services and organisations across the UK. An email including an attached poster advertising the study was circulated (Appendix C), with prospective participants encouraged to contact the researcher. Prior to the interview, participants were given a participant information sheet (Appendix D) and asked to complete a consent form (Appendix E). Following the interview, participants were emailed a debrief sheet (Appendix F).

### 2.5.4. Pre-Interview Questionnaire

A pre-interview questionnaire (Appendix G) was developed to gather additional data about participants and their respective services prior to interview.

### 2.5.5. Semi-Structured Interviews

Participants who offered to be interviewed were liaised with over email and provided with the participant information sheet, consent form, and pre-interview questionnaire. Interviews were conducted and recorded using Microsoft Teams. Interviews lasted between 50 and 100 minutes, with an average interview time of around 68 minutes.

### 2.5.6. Transcription

Microsoft Teams transcription software was used to generate transcripts, which were downloaded into Microsoft Word following each interview. Each interview recording was replayed alongside the corresponding transcript, to correct errors and formatting issues and to anonymise the information. Banister et al.'s (1994) conventions were used to inform the transcript editing process and improve clarity (Appendix H). See Appendix I for an extract from an interview transcript.

## 2.6. Ethical Considerations

### 2.6.1. Ethical Approval

Ethical approval for this study was granted by the University of East London School of Psychology Ethics Committee (Appendices J & K). No other ethical approval was required, as participants were not recruited directly through NHS services.

### 2.6.2. Informed Consent and Confidentiality

Prior to arranging or conducting interviews, participants were presented with a participant information sheet and a consent form they could return electronically. The participant information sheet detailed the nature of the study, what to expect from participation, how data will be stored, and the right to withdraw. Participants could contact the researcher with questions before providing their consent, and also prior to the interviews taking place.

No identifiable information was stored, whether regarding the participants themselves or the services they work for. Names of people and services were

removed to ensure anonymity. All data was stored on password protected files and was accessible only to the researcher.

### 2.6.3. Potential Distress

Participating in the study and discussing the topic of PIE was not anticipated to be distressing for participants. Nonetheless, there was a possibility that asking about one's experiences at work could evoke feelings of distress. Research into job satisfaction amongst health and social care professionals indicates high rates of stress and burnout (Tamminga et al., 2023), and additional research into the experiences of clinical psychologists (who made up the majority of participants) suggests widespread feelings of doubt over their professional skill and ability (Hannigan et al., 2004). If distress of this nature, or due to other unanticipated factors, were to occur, it was agreed that it would be discussed and managed within the interview itself, with opportunities to have a break or step back offered as appropriate.

A debrief sheet, including the researcher and supervisor contact details and outlining the withdrawal process, was emailed to participants following their interview.

## 2.7. Data Analysis

### 2.7.1. Analysis

Reflexive thematic analysis was selected as the most appropriate qualitative approach to identify and analyse themes and patterns from the interview data. Braun and Clark's (2006) six-phase protocol for thematic analysis was employed as follows:

1. *Familiarisation with the Data*

This step was initiated when the interview transcripts were reviewed alongside the corresponding recording to correct errors and formatting issues and to be anonymised. This process of transcribing is valuable in the familiarisation and interpretation of the data (Byrne, 2021). Following this initial review phase of the transcripts, re-reads continued to familiarise oneself with the content

2. *Generating Initial Codes*

The transcripts were reviewed to generate as many codes as possible. These initial codes were then reviewed, edited, and reorganised manually.

3. *Searching for Themes*

Themes and subthemes were categorised based on the content of the initial codes and how they related to the research questions. Care was taken to acknowledge the different service contexts participants operated within.

4. *Reviewing Themes*

Themes, and how the codes were situated within them, were reviewed for coherence, consistency, and usefulness. Diagrams were developed to illustrate the different themes and subthemes and where they sat in relation to one another. Discussions took place with the research supervisor to review the themes and prompt reflections.

5. *Defining and Naming Themes*

Themes and subthemes were organised into hierarchies and finalised, constructing the findings from the analysis into a coherent narrative.

6. *Producing the Report*

A narrative account of the thematic analysis was composed for the written report, with select extracts incorporated to illustrate each theme.

## 2.8. Reviewing the Quality of the Research

Braun and Clark (2021a) provided an evaluation tool to assess the quality of thematic analysis. 20 questions are provided for researchers to consider, broadly separated into two categories; those which focus on the selection and explanation of the methods and the methodology, and those which focus on the quality of the analysis. The first category will be considered here, with each question attended to in turn. See Section 4.2.2. for discussion of the second category.

Reflexive thematic analysis is detailed in this section and the rationale provided for its selection, in line with the research questions and aims of this study. Pragmatism is presented as the theoretical underpinning of this study, providing methodological flexibility and alignment with reflexive thematic analysis. In this study, data is collected via interviews, providing a good 'fit' for reflexive thematic analysis. The protocol for reflexive thematic analysis is adhered to throughout this study, without interference from other types of thematic analysis.

Problematic assumptions pertaining to thematic analysis are not evidenced in this study, such as incorporating concepts from other qualitative approaches or from incompatible philosophical traditions, or by assuming thematic analysis is atheoretical in nature. The process of completing the reflexive thematic analysis is provided, demonstrating a coherent understanding of this approach. While the collection of descriptive statistics was used as a supplementary research method, a rationale for this is provided. The researcher takes a position of reflexivity, considering their own position and perspective (see below).

The notion of credibility is described by various guidelines for assessing qualitative research (e.g. Elliott et al., 1999; Lincoln & Guba, 1985; Northcote, 2012) and is therefore considered in this study. Credibility refers to whether the views of participants corresponds with how these views are represented by the researcher (Tobin & Begley, 2004).

## 2.9. Reflexivity

A valuable characteristic of qualitative research is reflexivity; consideration of the researcher's subjective positions, within which the study is situated, and how these may influence the nature of the research that is produced (Braun & Clark, 2021b). This, therefore, acknowledges the instrumental role I have held in this research project, by determining the methodology, conducting the analysis, and constructing meaning through my conclusions.

I am a white British cisgender man in my late-20s working in a profession that has been characterised as middle class (Ahsan, 2020), and so therefore inhabit a

number of privileged identities. Throughout my life, I have been influenced by left-wing political views and debates, particularly regarding socioeconomic status, social class, and poverty. In recent years, I have become increasingly influenced by intersectional approaches and, through my clinical psychology training at the University of East London, have become more familiar with contextualist perspectives, with their emphasis on social context in understanding distress.

The topic of homelessness initially appealed to me as a research topic for a number of reasons. The stigma I had previously witnessed from peers towards people experiencing homelessness was something which had always stood out to me. I noticed the role of the political context in homelessness and am of the view that different political philosophies, such as neoliberalism and austerity, are fundamentally implicated in its foundation. Alongside this political context however, I was also curious about the role of numerous interweaving adversities which frequently coincided with homelessness, including poverty, domestic violence, racism, homophobia, transphobia, substance misuse, traumatic brain injury, and forensic histories (plus many more), and how clinical psychologists could use formulation to better understand these factors. When developing my ideas for a thesis study, I initially explored trauma-informed care approaches in homelessness services as an avenue to acknowledge these wide-ranging adversities, which ultimately led me to the topic of PIE.

This has led to a nuanced and sometimes seemingly contradictory position on my part as to the causes of homelessness. That is, I both conceptualise homelessness as a social issue predicated by political and economic factors, and as a potential consequence of adverse and traumatic experiences on an individual level. Further nuances arise through my conceptualisation of psychological trauma and how I situate the impact of discrimination and oppression (including racism, misogyny, and transphobia) within a trauma frame (Williams et al., 2023), while simultaneously perceiving them as socio-political issues in nature.

# CHAPTER THREE: RESULTS

This chapter will outline the research findings. Descriptive data regarding the participants and their respective services and organisations will be presented first. Subsequently, the thematic analysis of the interview data will be presented with each theme described in turn.

## 3.1. Descriptive Data

Descriptive data were collected via the pre-interview questionnaire and from questions in the interview. See Table 2 for a summary of the descriptive data.

Participants have been categorised depending on whether they held a strategic leadership role, were based in a single service, or providing consultation or other services to other organisations / teams. Each category reflected the main role of a participant, though there was some overlap between them, with participants conducting elements of all three roles to some degree. Two participants were the only psychologists in their respective organisations, while other organisations employed multiple psychological staff, each embedded in a different service or team. As detailed in Table 2, no participants reported that their organisation employed between five and nine psychological professionals. In addition, while the version of PIE that participants reported as their primary framework is included in Table 2, most participants avoided fixed positions, often saying how they were 'informed' by a particular version of PIE. Furthermore, flexibility and versatility were demonstrated by participants as they applied PIE in their respective services and organisations and integrated it into their own practice. Every participant described using multiple psychological models and/or frameworks, including but not limited to trauma-informed care, attachment theory, CBT, psychodynamic approaches, and compassion focused therapy.

Formal outcome measures were used by some participants' services to evaluate psychological (or non-psychological) interventions with service-users, such as the CORE-10 (Barkham et al., 2013), the HoNOS (James et al., 2018), and the Outcome

Star (MacKeith, 2011). Measures for assessing trauma-informed practice within an organisation were also utilised by three participants to evaluate organisational change. Some participants gathered feedback on PIE and/or psychology in the service from staff teams by using surveys and feedback forms they had developed. The Pizazz, or its online counterpart the PIE Abacus, were highlighted by at least six participants to assess how 'PIE' their service was. Some participants described the Pizazz as particularly useful while they were still relatively new to their service, for familiarising themselves with the PIE framework and what this might look like in the context of their service. Two participants did not find the Pizazz as useful as they wanted, opting to develop or use different measures. Two participants reported that as they were relatively new to their organisations, they had not yet prioritised evaluation. Some participants referred to trainee psychologists on placement in their organisations who had completed research projects evaluating PIE.

Service-user involvement varied between participants, though the majority reported that this was minimal or superficial in nature and everyone said service-user involvement was something that could be improved upon.

**Table 2**

*Overview of descriptive data*

| Descriptive data | N of participants |
|---|---|
| **Service Sector** | |
| NHS | 4 |
| Third sector | 5 |
| Private | 2 |
| **Service & Role Context** | |
| Strategic leadership / policy | 4 |
| Based in a single service | 5 |
| Consulting and providing services to other organisations | 2 |
| **Version of PIE** | |
| Original version | 1 |
| Version 2.0 | 8 |
| Unsure | 2 |
| **Length of time organisation has been using PIE** | |
| Less than 5 years | 6 |
| Between 5 and 12 years | 5 |
| **Number of psychological staff involved in the implementation of PIE** | |
| One | 2 |
| Between two and four | 4 |
| 10 or more | 5 |

Five themes, with 12 subthemes, were identified from the analysis of the interview data. This chapter will describe each theme in turn, illustrated with selected quotes from the interviews. See Table 3 for a summary of the themes and subthemes.

**Table 3**

*Overview of themes and subthemes*

| Themes | Subthemes |
|---|---|
| **1.** PIE is a Journey, not a Destination | Deciphering and Implementing PIE |
| | PIE as an Ongoing Process |
| **2.** Building Trusting Relationships | Informal Interactions |
| | Overcoming Distrust and Suspicion |
| | Providing a Foundation for Intervention |
| **3.** Systemic Barriers to PIE | Ambivalent Relationships with Other Systems |
| | Lack of Investment in Staff |
| | Structural Limitations |
| **4.** Reluctance from Staff Teams | Discomfort with Reflective Practice |
| | Judgemental Attitudes Towards Service-Users |
| **5.** The Enormity of PIE | You Don't Have to be a Psychologist to do PIE |
| | Holding and Managing PIE |

## 3.2. Theme One: PIE is a Journey, not a Destination

Two participants used the phrase *"PIE is a journey, not a destination"* (Participants 2 & 9), encapsulating the view held by many participants of PIE as an ongoing

process. This theme captures both the personal journey of participants as they deciphered what PIE is for them, and that PIE and its various elements can only be implemented in a service or organisation as an ongoing process over time.

### 3.2.1. Subtheme One: Deciphering and Implementing PIE

Participants described a personal journey as they deciphered what PIE is for them and how it could be applied in their organisation.

> *I did write up a document around, you know, what is the psychology service for this organisation going to be… and introducing the PIE model, the PIE framework… So I suppose I wrote quite a lengthy document as much for myself in a way as for them, my managers, to kind of orientate myself.*
>
> Participant 5

Different methods were described by participants as they sought to understand PIE, including writing reports on PIE, as in the quote above, and by using the Pizazz PIE self-assessment tool.

> *I think the, the Pizazz has got some really nice questions in it and that's been a starting point to help us think about defining each of the, each of the parts of PIE [for our service].*
>
> Participant 6

While the process of deciphering PIE was more present in interviews with psychologists with relatively less experience of homelessness services, it was also referenced by participants in more established and/or strategic leadership roles in their organisations.

> *"So what would be my hopes and plans? So, um, to know what it [PIE] is." [laughs]*
>
> Participant 8

### 3.2.2. Subtheme Two: PIE as an Ongoing Process

While the previous subtheme addressed the personal journey of the psychological professional, this subtheme illustrates the journey of the organisation as PIE is implemented.

PIE was described as a long-term endeavour, with change incremental in nature. Participants spoke to navigating resistance as they sought to implement PIE, including from pre-existing systemic processes and ways-of-working that were embedded in the organisation.

> *[on giving advice to others looking at PIE for the first time] Don't think you're going to be able to achieve it even in the first year. You know, you need to think long-term. Um, and, you know, maybe, maybe you start off small, you know.*
>
> Participant 5

> *I kind of always think about 'evolution' rather than 'revolution'. You know, I'd love to come in and have the PIE revolution, but it's not gonna happen for all sorts of complex systems reasons. And so it's a slow, steady plod, sometimes with a big leap in it.*
>
> Participant 1

PIE was described as a fluid process which did not necessarily progress in an upwards trajectory, and that day-to-day variations within the service and how it is implemented by professionals were to be expected and should be normalised.

> *And I think sometimes I have days where [I'm] more 'PIE', the hostel has days where it's more 'PIE' or less 'PIE', and that's, you know, that's OK, that's part of being PIE is to reflect on that and to think about why that might be and what we can kind of learn.*
>
> Participant 2

As part of the ongoing process of PIE, participants discussed the 'culture' of their workplaces and how PIE can guide their efforts to change embedded ways-of-working.

> *It [PIE] is instead a framework to guide you to ensure that your services are designed around emotional needs of people that need it… I do think… what my predecessor's [previous psychologist] done well, is establish a culture around PIE.*
>
> Participant 8

PIE, and particularly reflective practice, was also seen as an avenue to encourage change in the culture, language, and attitudes of staff teams. An example given was that of frontline staff becoming more reflective towards, and curious of, the emotions and actions at play, both for themselves and for service-users.

> *I have started to, to, kind of, observe the colleagues that I do reflective practice with start to use language that I would consider to be psychological language. So I've heard people talking about, you know, slowing down, starting to kind of think about how I feel, what's going on for the other person.*
>
> Participant 6

> *For me, it's [reflective practice] about protecting time to be reflective with the idea being that we are reflective more of the time, and I do think that that's happening. I've had some really nice feedback in [location] around, like, people just observing their colleagues really taking the time to try and think about "what's going on for this person", "how's my response impacting on that" and "what should I do".*
>
> Participant 8

### 3.3. Theme Two: Building Trusting Relationships

The importance of building trusting relationships was highlighted by participants. Informal interactions maintained over time were defined as a means of overcoming distrust and suspicion, developing a foundation for meaningful change. Participants

spoke to three main examples of relationships: relationships between frontline staff and service-users, relationships between participants and staff teams (including frontline staff and managers), and relationships between participants and service-users in psychological interventions. Interestingly, the subthemes and most of the codes within were present throughout all three examples of relationships. Therefore, while the selected quotes speak to relationships in different contexts, they illustrate recurrent processes in the development of trusting relationships in PIE settings.

### **3.3.1.** Subtheme One: Informal Interactions

Formal appointments, whether team formulation sessions with staff, staff key-working sessions with service-users, or traditional therapy sessions with service-users, were often considered uncomfortable or intimidating. Participants therefore pivoted to alternative means of conducting the work that were considered more acceptable.

> *I've had to do formulation in a slightly, umm, ad hoc way, that they don't know I'm doing it. You know, just, like, the general chit-chat and you're just dropping in little seeds here and there. And, and I think that seems to be the best approach with some of the staff. There's, there's sometimes a bit of an uncomfortability (sic) if things become too formal.*
>
> Participant 7

To facilitate relationship-building while engaging service-users in key-working sessions and psychological interventions, an emphasis was placed on being 'with' the person and sharing in their activities and interests.

> *[In key-work sessions] It's kind of just spending a bit of time playing a game with them, or even watching TV or reading the newspaper together, and so doing, you know, something just really basic and informal, but sort of, how important that is in terms of building that relationship with their clients.*
>
> Participant 3

The importance of maintaining and persisting with these informal contacts with service-users was also emphasised, as opposed to being treated as isolated interactions in time.

> *[regarding a therapy client] Sometimes we make great headway, other times it's just sitting alongside him, chatting about him playing his guitar or, you know, whatever we need just to kind of keep the, the contact going. And then when we get a moment of of dropping something in about a coping strategy or a bit of psycho-ed work around, you know, something he's talking about.*
>
> Participant 11

### **3.3.2.** Subtheme Two: Overcoming Distrust and Suspicion

Building trusting relationships, via the methods described in the previous subtheme, was emphasised by participants for overcoming feelings of distrust and suspicion which may be held by others, often for reportedly good reason. For example, it was noted that for service-users experiencing homelessness, their trust had been broken historically many times by others and by services.

> *[With] the vulnerable population that we work with, a big dilemma is 'trust'. So trust has been broken so many times.*
>
> Participant 7

As with the previous subtheme, substantial time, sometimes in the region of years, was highlighted as needed to overcome feelings of distrust and suspicion. See the below quote for an illustration of this in the context of a participant who provided consultation on PIE to other services.

> *It has taken years to build a relationship with them enough for them to be trusted to let us in [and] know that we're not spies for the Council. And, you know, that we genuinely want to support them to be the best that they can in, in terms of delivering PIE.*
>
> Participant 11

Also observed in the quote above was feelings of wariness towards the psychologist introducing PIE, from the service they were providing consultation to. Similar

wariness of the perceptions of psychologists was commented on by another participant when discussing psychological interventions.

> *In the beginning was, kind of, allowing them just to familiarise themselves with me and to kind of build a bit of trust and see that I'm not this, kind of, scary doctor that's, you know, gonna tell them they're crazy or whatever.*
>
> Participant 3

### 3.3.3. Providing a Foundation for Intervention

The process of building trusting relationships was considered valuable to develop foundations for further work and meaningful intervention, such as supporting service-users to attend formal psychological therapy.

> *There was a lot of that [informal work and trust-building] and then, you know, over time I've been able to build some clients [into] a more stable phase where they can attend therapy every week.*
>
> Participant 3

Trusting relationships between participants or frontline staff and service-users also provided a foundation to make wider changes in their life, such as engaging with other support services.

> *We have just been present with him. We've validated him. We've sat with him through every crisis that he's had. We've shown that we care about him, we've helped him, you know, attend appointments with the substance misuse service. We've helped him start to develop a social network.*
>
> Participant 6

## 3.4. Theme Three: Systemic Barriers to PIE

Participants spoke about facing various barriers while attempting to introduce and implement PIE, including systemic hurdles. For example, tensions with other services, such as mental health and social care teams, were highlighted, including barriers to accessibility for people experiencing homelessness and the difficulties

which arose when other systems conceptualised a service-user from a 'non-PIE' perspective. Such tensions required careful navigation from participants. In addition, participants described the pressure of working under broader systemic and structural limitations, such as insufficient resources and societal narratives.

### **3.4.1.** Subtheme One: Ambivalent Relationships with Other Systems

Participants described the challenge of liaising with external services which were not informed by a PIE approach and whose staff consequently tended to prioritise different narratives or conceptualise service-users differently.

> *Often the other systems around the, the PIE system are not 'PIE-compliant', which makes it then very difficult. You know, how do you, how are you PIE-congruent when your colleague from another organisation is not seeing things in that particular framework?*
>
> Participant 4

> *It's very hard to get social workers to be psychologically and trauma-informed with the women… I've been in some really appalling child protection meetings where chairs have spoken horrendously to the women and it's just, you know, you try and challenge that and you're shot down.*
>
> Participant 11

Participants reported that colleagues within their own services sometimes felt similarly frustrated with external services, often in relation to referral and discharge pathways.

> *And that does come up quite often in conversations with hostel staff, often they're quite angry at, at like services for discharging someone from hospital, say, or like not accepting them at the mental health team.*
>
> Participant 2

On other occasions, participants spoke about how they had successfully developed positive relationships with external services, including when there may have been histories of tension or barriers to referral. Often these relationships were developed

by building personal connections with staff members in the other team, to facilitate communication and provide a point of contact.

> *But I do think our relationship with services has improved quite a lot in the year that I've been there. And interestingly what I think has helped with that again is just the [personal] relationships that we've formed. I'm just thinking, like, [with the] mental health liaison teams in hospitals.*
>
> Participant 2

One participant spoke to tensions with senior leadership in their organisation and commissioners while another referred to organisational barriers which can impede PIE.

> *But as I said to you earlier on to some degree, having to fight commissioners and people in positions of power who, for whatever reason don't really want me to do this.*
>
> Participant 6

### **3.4.2.** Subtheme Two: Lack of Investment in Staff

Several participants discussed a historical lack of investment in, or a neglect of, frontline staff members in their organisations. Different participants described this in different terms, though most prominent was an acknowledgment that frontline staff often experience and/or witness events that could be distressing or traumatic in nature, and the subsequent impact this has on staff wellbeing. Introducing staff wellbeing measures was therefore described as a priority for PIE.

> *Staff aren't aware of the agenda around burnout, like the impact of secondary trauma. So a big part of the intervention which, which we're still working on and it will go on for some time, which is how can we create a better staff wellbeing across the organisation.*
>
> Participant 7

At other times, focus was placed on more material under-investment in staff, for example, insufficient training in mental health and relationship-building for frontline

staff, and low wages for staff and managers in homelessness services. PIE was promoted to rectify the former example, through staff training initiatives. Issues around poor pay was considered trickier to challenge using the PIE framework, however.

> *The only word that comes to mind is not very nice, but there's been a lot of neglect in terms of skilling their staff up… What, what we're trying to help them to do is try and marry [staff practical experience] up actually with the knowledge-base, so that they feel skilled but they also have the knowledge.*
>
> Participant 7

> *The wages for people working as support staff has just dropped, dropped. I think people earn almost the same as I was earning doing the same job in 2002. You know the real wages just have not gone up.*
>
> Participant 4

### **3.4.3.** Subtheme Three: Structural Limitations

Some participants highlighted broader structural limitations in society and how these impacted on service delivery and on people experiencing homelessness. Structural limitations included underfunding of services, housing shortages, and unhelpful narratives in society towards people experiencing homelessness. Participants subsequently discussed PIE in different ways, such as considering how to implement it within these contexts, or sharing hopes that PIE may one day provide a means to challenge some of these structural limitations.

One participant shared hesitations about whether PIE should be fully implemented in the face of structural limitations and speculated on whether it would even be appropriate to attempt this in the systemic context.

> *I think the, you know, the complexity of, of, I suppose, the level of influence that you have on certain structural problems, you know, like macroeconomic problems, like a massive housing crisis, you know, and, and being humble within that because maybe it's not appropriate for us to, you know, do certain things whilst the stressors in the system are that huge.*

Participant 5

Two other participants shared future hopes that PIE could be used to enact structural change, such as by advocating for more resources and the restructuring of services, or by fostering change in societal narratives towards homelessness.

> *So if there was more input, maybe a bit more resources, a bit more funding, I know that's always the main issue is just lack of resources. But if somehow PIE could contribute to that and to kind of motivate for that and show how that sort of systems change is needed.*
>
> Participant 3

> *So I just hope that, you know, laypeople could be more 'PIE' when they walked past [people experiencing homelessness]… One thing that I love is, you know, obviously I think about PIE services where people have paid to maybe embed a model. But just as a community or more socially if we could be more PIE.*
>
> Participant 2

### 3.5. Theme Four: Reluctance from Staff Teams

Participants shared a range of responses from staff teams towards PIE and psychologically informed approaches. For example, while some participants reported that staff engaged well with reflective practice, others described staff discomfort with being in a formal reflective space. In addition, some participants said staff teams had appeared naturally therapeutic, while others had observed comments and actions from staff towards service-users which did not align with traditional PIE values.

#### 3.5.1. Subtheme One: Discomfort with Reflective Practice

Some participants reported that frontline staff felt discomfort in reflective practice sessions when formally asked to slow down and place a focus on their emotional state. Participants considered the reason for this being because staff spent so much of their roles dealing with crisis situations which encourage them to maintain a 'doing' or problem-solving position.

*I think in the homelessness sector, because so much of the work is 'doing' and responding to crises and acting quickly, when you get people into reflective practice spaces, I think it's quite jarring sometimes for them and they're thinking like "what, what are we doing?" "we've got so much to do".*

Participant 9

Other participants felt that managers struggled more with reflective practice than frontline staff, albeit for similar reasons such as feeling compelled to problem solve.

*[In reflective practice groups] Managers often seem to want to rescue or to problem solve or, or to, you know, be quite solution-focused rather than being, kind of, reflective and curious and "oh that's interesting".*

Participant 10

In response to this discomfort, participants spoke about taking a tentative stance and avoiding a rigid approach to reflective practice. This included offering flexibility with how sessions are structured and providing an alternative focus where appropriate, such as conducting team formulation sessions instead of reflective practice.

*So I kind of just ask them what they want or what they can, sort of, tolerate as a, as a group. And not trying to kind of say, "well this is reflective practice, this is what it's meant to look like" and just sort of meeting the group where they're at really. And just pushing a bit sometimes in terms of how they're coping or trying to, kind of, talk to difficult team dynamics.*

Participant 9

*Some service managers have said to me: "instead of calling it 'reflective practice', can we have formulation meetings because they'll get together around a service-user and they'll talk about a service-user and there'll be a lot of reflective practice. But if we call it 'reflective practice', they won't show up".*

Participant 1

As seen in the above two quotes, even when traditional reflective practice sessions are not facilitated and an alternative is offered, such as team formulation, participants continued to tentatively weave in elements of reflective practice.

> *But we do kind of then sneakily get some reflection in when, while we're thinking about, about the person [in team formulation] and how you know, how it makes people feel and those kinds of things.*
>
> Participant 11

### **3.5.2.** Subtheme Two: Judgmental Attitudes Towards Service-Users

There were observations that staff teams would sometimes promote unhelpful narratives of service-users experiencing homelessness, such as placing personal responsibility on them without seeking to understand the underlying factors behind behaviour, as is advocated by a PIE approach.

> *[There are] some sort of unhelpful narratives where they 'just need to learn a lesson' or, you know, "that behaviour is inappropriate". That kind of narrative, rather than trying to understand where the behaviour came from.*
>
> Participant 4

It was also noted that some staff teams would distinguish between different service-users, where those who do not present as 'nice' or 'good', or who display behaviours that challenge, are not considered suitable for the service.

> *So somehow we're attracting 'nice' homeless people, and I think every now and then when we get someone who comes in who isn't 'nice', who are, quite understandably through all sorts of really good reasons, is a bit rough around the edges or a bit more challenging, we really struggle with that.*
>
> Participant 10

Challenging service-users who are considered unsuitable for the service may then be referred elsewhere, such as to mental health services, for specific interventions to resolve the behaviours that challenge.

> [There's this] Kind of desire to kind of pass them off to another service. You know "oh the problem is their mental health, once their mental health is sorted we, we can, we can work with them"… Yeah, there's something around not being the right service if someone presents in a challenging kind of a way.
>
> Participant 10

Two participants described physical barriers that hostel staff erected between themselves and service-users, such as conversing through the office window or door instead of face-to-face. In these instances, participants advised staff that removing physical barriers could reduce behaviour that challenges.

> *There's a bit of a culture of staying in the office and talking to people through this, kind of, Perspex glass… And actually that's a very physical barrier in interactions and the person is standing in the reception so there's no privacy.*
>
> Participant 9

> *Very soon after they made themselves more visible, a lot of that [challenging] behaviour just started to drop off. Because I think it was around needing connection with people and they offered that in a more kind of proactive way.*
>
> Participant 11

## 3.6. Theme Five: The Enormity of PIE

Participants shared various comments which portrayed PIE as a vast approach which stretched beyond them as individuals. Participants defined PIE as an approach which should not be restricted to the domains of practitioner psychologists, but as one which can be and is implemented by professionals and services irrespective of formal psychological training. In addition, participants described the pressure of overseeing all the elements of PIE and managing their day-to-day workloads.

### 3.6.1. Subtheme One: You Don't Have to be a Psychologist to do PIE

Some participants said that prior to their arrival, and therefore prior to the formal introduction of PIE, their organisation had already been implementing policies and

encouraging working practices which aligned with a PIE approach. Participants appeared keen to highlight instances when practices had been pre-existing or implemented by others, so as not to take credit for others' work.

Two participants emphasised a strong relational ethos in their organisation and how this had pre-existed, and provided a foundation for, PIE interventions around relationships between staff and service-users.

> *I think that ethos of, you know, having a kind of equality in relationships is in the organisation, that has been part of the value system of the organisation since its inception. So that's nothing to do with me.*
>
> Participant 5

> *So I think the organisation has a very good and a very strong grasp of the relevance of a relationship in a PIE, like they don't theoretically know that, but they, just from their practice, like, it's been there, it's been there for years… It's almost like I'm able to go in and say what you're doing is already PIE.*
>
> Participant 7

One participant described a focus on the built environment as a PIE element already understood within their organisation

> *They've been very, very good at making their environments psychologically informed. So from an architectural structural point of view… the access hubs where anybody can go in off the street basically, are all PIE-informed environments.*
>
> Participant 7

Participants also described colleagues as potential allies and supporters in the implementation of PIE, such as managers facilitating top-down changes by encouraging frontline staff to participate in PIE initiatives or by making changes to the physical environment.

*One of our new service managers recently – nothing to do, I can't take any credit for this – but she's come in very tuned into PIE and she has completely transformed the physical environment of our biggest hostel.*

Participant 1

*Work on that relationship with the hostel managers because again, if we're wanting the whole staff team to be PIE-informed… then we need to have that buy-in again, like, you know, that being followed up in their line management or their supervision.*

Participant 2

One participant reported having conversations with colleagues about each member of the team taking on responsibility for a different pillar of a PIE 2.0 approach (e.g. 'psychological awareness', 'spaces of opportunity').

*Because we're a small team… what we're doing is we're, we are identifying a PIE champion for each pillar. So I as the psychologist, I'm going to do the, the psychological awareness bit… You [PIE champions] don't have to be an expert in this area. It's just an opportunity for us to ask questions of each other*

Participant 6

### **3.6.2.** Subtheme Two: Holding and Managing PIE

Most participants, across different working contexts (i.e. strategic leadership roles, hostel-based roles, and consultation roles), described difficulties managing their workload, both in terms of commencing and completing PIE-related projects, and on a day-to-day basis.

*[I] Think that there's, like, endless opportunities to do things, and that's not something you should complain about. But it is quite stressful… And I'm really bad at saying 'no' because I find it all interesting.*

Participant 8

*I'm also based over four hostels at the moment, it should be three… because we haven't filled all the posts at the moment. I'm juggling a lot and it's [hard] trying to find the time for all of these things and trying to plan interventions.*

Participant 3

This led to reflections around how change can be achieved and what is manageable in the circumstances.

*I think the biggest challenge is really keeping it manageable, being realistic about organisational change and how that happens. And being realistic about what change you can influence and to what extent you can influence things.*

Participant 1

Some elements of PIE were emphasised by almost every participant, such as relationships, psychological awareness, staff training and support, and reflective practice.

*So I think the relationships aspect of PIE is very much at the core for me.*

Participant 9

*The focus on reflective practice and I guess the the, maybe, the the validation, if that's the right word to you know say "this is important".*

Participant 5

In contrast, other elements of PIE appeared to have received less attention by some participants, such as the systems around their organisation and the built environment, potentially due to workload pressures and service constraints (such as high staff turnover).

*So I think we're quite bad at [working with other services] at various levels, but we're recognising that, um, I think we're quite inward focused… Everyone's very busy… I just think we're in silos and actually would work better if we were together more.*

Participant 8

*I think some of the more kind of service level stuff, such as buildings and you know the the, the three Rs and that kind of stuff, I think probably at least at this centre we're not quite there yet or if it's happening, it's happening, kind of, under the radar.*

Participant 10

# CHAPTER FOUR: DISCUSSION

The varied applications of PIE reflect unique 'recipes' that are tailored and adapted to whichever setting PIE is applied. This study sought to examine how PIE is implemented in practice and across settings, from the perspectives of psychological professionals working in homelessness settings, expanding and complementing the literature on this multifaceted framework.

This chapter will consider the key findings of this study in the context of the theoretical and empirical literature, including that which focuses on PIE and homelessness. The research questions will be addressed in relation to the findings, with connections drawn between different research questions as appropriate due to the wide-ranging questions that were developed and the nature of the qualitative findings. A critical review will then explore this project and its quality, via a section on reflexivity and considerations of the study strengths and limitations. Finally, implications and recommendations will be described for the continuing development of PIE for services and service development, in clinical settings, in research, and for policy.

## 4.1. Research Questions: The Findings in the Context of the Literature

Themes were developed spanning the interviews as outlined in the Results chapter. Connections can also be observed between themes, illustrating how the themes often inform and underlie one another. Consequently, connections will be drawn between the themes and subthemes in this section as appropriate as the research questions are addressed.

### 4.1.1. Considering the Interpretation and Implementation of PIE

#### 4.1.1.1. *PIE is a Journey, not a Destination*

The need for time and patience was highlighted when using PIE and working in homelessness services. The first theme presented was '*PIE is a journey, not a destination*', through which participants highlighted that implementing PIE is a

gradual, incremental process. This aligns with and reinforces previous literature which has described PIE as an ongoing process of learning and development, rather than a list of achievements which can be 'ticked off'. The name of this theme, '*PIE is a journey, not a destination*', was chosen after two participants used the term, though it is also present in literature discussing PIE (Atkins & Syed-Sabir, 2022, p. 10, Johnson, 2017 p. 21) suggesting it may have become a narrative in some PIE services. The ubiquity of this theme across interviews and between services indicates it does indeed reflect the experiences of practitioner psychologists implementing PIE.

This theme also encapsulated the journey travelled by participants as they sought to identify what PIE was or what it would look like in their service. While participants inferred they had a sufficiently coherent understanding of PIE to begin implementing it, this was nonetheless a continuing process. Participants described different methods for deciphering PIE. For some, writing reports for colleagues provided clarity on PIE and how it could be applied in their organisation. Completing the Pizazz self-assessment tool shortly after joining a service was also described as a method for practitioner psychologists and services to decipher PIE, identify a baseline, and produce targets for intervention. The Pizazz is a self-development and reflective tool for services and organisations to review their implementation of the five elements of PIE 2.0, while also serving as a potential research tool (Buckley & Tickle, 2023). The findings of this study demonstrate that the Pizazz can also be a useful for practitioners and services as they decipher and familiarise themselves with PIE. The process of deciphering PIE can also be inferred from the PIE literature. For example, there are accounts of PIE being applied in the context of different psychological approaches, inferring that psychological professionals have deciphered and conceptualised PIE differently depending on their context and specialisms (e.g. Keats et al., 2012; Middleton, 2017; Quinney, 2017).

#### **4.1.1.2.** *Building Trusting Relationships*

Relationships were described by most participants as an important aspect in the implementation of PIE, in line with its emphasis in the PIE literature (e.g. Boag, 2020). 'Trust', whether explicitly named or implicitly referenced by participants, characterised discussions on relationships. Consistent comments across interviews

inferred a process where informal interactions sustained over time could overcome distrust and suspicion and provide a foundation for meaningful intervention. Notably, this process spanned the formation of relationships in three different contexts: between frontline staff and service-users, between psychological professionals and frontline staff, and between psychological professionals and service-users in individual therapy. Phipps et al. (2017) too reported that building and maintaining trusting relationships were integral following interviews with frontline staff, service-users, and psychotherapists in a homelessness PIE organisation. The focus on trusting relationships is therefore not limited to psychological professionals and is held by staff and service-users also. While Phipps et al. (2017) suggested that the single-service nature of their study was a limitation, the findings of this report demonstrate an emphasis on trusting relationships occurs in the implementation of PIE across homelessness organisations.

Keats et al. (2012) discusses how people experiencing homelessness may have histories of complex trauma and have consequently learnt not to trust. They highlight the importance of building trust when working with people experiencing homelessness. This also aligns with discussions of trustworthiness as one of the key ingredients of trauma-informed care (TIC) (Menschner & Maul, 2016). For people experiencing homelessness, increased feelings of distrust can be caused by various factors. For example, high rates of attachment difficulties are observed among people experiencing homelessness (Anderson & Rayens, 2004, Seager, 2011), which have been related to interpersonal difficulties and distrust of others (Sandberg et al., 2010; Wang & Scalise, 2010). Power and stigma could also be implicated in feelings of distrust among homeless people. People experiencing homelessness are typically aware of prejudiced attitudes held towards them by professionals, having experienced them first-hand (Stevenson, 2014). Prejudice may also be experienced in relation to social identities which are overrepresented in and intersect with homelessness communities, such as misogyny and domestic violence towards women (Bretherton, 2017), racism towards people of colour (Bramley et al., 2022), and discrimination towards LGBTQ+ people (akt, 2015). Experiencing discrimination has been associated with higher levels of distrust towards health and social care providers (Armstrong et al., 2013; Thrasher et al., 2008), suggesting this may also influence relationship formation with services and staff members amongst people

experiencing homelessness. Research has highlighted the role of the therapeutic alliance in psychological therapy indicating that this influences outcomes more so than other factors, such as the choice of therapy model (Ardito & Rabellino, 2011). Higher feelings of distrust and the subsequent difficulties for psychological therapists to develop therapeutic relationships may therefore explain the inconsistent findings in the literature regarding the efficacy of psychological therapy for people experiencing homelessness (Hyun et al., 2020; Saunders, 2018; Speirs et al., 2013).

The importance of building trusting relationships with staff members was also emphasised by participants. Previous studies have also highlighted the importance of mutual trust for improving teamwork and collaboration in healthcare services (Jones & Jones, 2011; Morley & Cashell, 2017). Participants reported that while some staff members and managers readily engaged with psychological input, others appeared distrustful or dismissive of psychology, hindering efforts to increase psychological awareness and promote reflective practice. As psychologists have not traditionally been represented in homelessness settings until relatively recently (Maguire, 2011), staff may be less familiar with psychological approaches and perspectives. Consequently, these staff members may perceive the work of psychological professionals as unnecessary if staff prioritise action and problem-solving over reflexivity. Additionally, it may be perceived as threatening when psychological professionals seek to discuss painful or uncomfortable emotions (Ferguson, 2018). High levels of staff burnout and secondary traumatic stress in the homelessness sector may also increase feelings of distrust among staff teams. Schneider et al. (2021) found that these two factors were associated with less enthusiasm towards trauma-informed values and reflective practice, which are central elements of PIE in many settings. The findings of this study therefore suggest that cultivating trusting relationships with staff teams is fundamental in the implementation of PIE, as otherwise efforts to facilitate psychological awareness and provide staff support are likely to fail.

The focus on building trusting relationships with colleagues to facilitate psychological awareness and provide staff support aligns with PIE 2.0, within which ‘relationships’ was moved from being its own element to becoming a core principle of PIE that ran through every element (PIElink.net, n.d.-a).

#### 4.1.1.3. *Implementing the Enormity of PIE*

Some elements of PIE appeared to receive greater focus (e.g. relationships, psychological awareness, staff training and support, and reflective practice) from participants, while others appeared to receive relatively less focus (e.g. the systems around their organisation and the built environment). The vastness of the PIE framework appeared to contribute to this, constraining the initiatives participants were able to pursue in their day-to-day work. In addition, as the breadth of the PIE framework undoubtedly contributes to the difficulties some psychological practitioners have interpreting PIE, this may also make it more difficult to develop sufficient familiarity with every element of the approach. The relative priorities given to some of the principles of PIE may reflect the 'journey' organisations go on as the framework is implemented, as elements will inevitably be introduced or developed in an unequal manner. This relates to a reported strength of PIE, as the flexibility of the approach encourages services to tailor it to their own circumstances (Johnson, 2017). This suggests that one should be careful when interpreting the uneven implementation of PIE as a barrier or limitation, as this may be appropriate within the service context and/or the length of time a service has been utilising PIE.

The built environment appeared to receive less relative focus by some participants compared to other elements of PIE. It was not immediately clear why this element was deprioritised over others, though this may relate to this element potentially being the most removed from conventional psychological theories and approaches, and consequently receiving minimal focus in psychological and psychotherapeutic training programs.

The introduction of the PIE 2.0. framework placed an increased emphasis on the systems surrounding a service or organisation (Boag, 2020). This provides a potential explanation for why this element also received relatively less focus by some participants as, while most participants described using PIE 2.0, they may still be more familiar with the original PIE framework. Additionally, this element will have inevitably been subject to less discussion in the PIE literature due to its later incorporation into PIE.

### 4.1.2. Considering Similarities and Differences between PIE Services

Various similarities and differences between the participants' services and organisations were observed, though it was interesting how even in the context of differences, themes and trends were still present between services.

PIE is being utilised in a range of sectors, with participants representing NHS and third sector organisations. Private organisations were also represented, who provide consultation and PIE-related services (such as reflective practice sessions or psychological therapy) to providers who lacked their own integrated staff to oversee PIE. In addition, participants held different roles within their respective organisations, such as being based within a single service or holding a strategic leadership role which spanned multiple services and involved input into organisational policy. Most participants used PIE 2.0, perhaps because of its more recent publication (PIElink.net, n.d.-a), though one used the original version of PIE and two others said they were unsure but thought they were informed by both frameworks. Boag (2020) also discusses the merits of combining elements of both the original PIE framework and PIE 2.0, if appropriate to the service context. While some participants spoke confidently and with certainty regarding which version of PIE they used, most were less committal, speaking about how they were 'informed' by a particular PIE framework. It is notable that regardless of the service sector, level of seniority, and version of PIE that was used, the themes in the thematic analysis were present throughout the interviews. Participants that provided consultation or input to multiple teams, either within their organisation or with external services with which they were contracted, also reported the same codes that ultimately constituted the thematic analysis. This suggests that practitioner psychologists' experiences and use of PIE are relatively uniform across these different contexts.

Participants reported a wide range of theoretical approaches that they applied within PIE, including attachment theory, TIC, CBT, and third-wave CBT, within a wide range of initiatives typical to PIE, including reflective practice, team formulation, staff training, and individual therapy. This reflects comments by Johnson (2017) who encouraged flexibility in the interpretation of PIE. In addition, published accounts of PIE services also suggest that various psychological approaches are used in practice, such as the examples of PIEs in the Good Practice Guide (Keats et al, 2012), alongside accounts of PIE integrated with appreciative inquiry (Quinney &

Richardson, 2014; Quinney, 2017) and open dialogue (Middleton, 2017). Within this study, the most cited models or frameworks by participants were trauma-informed approaches and attachment theory. Trauma-informed approaches and TIC have been growing in popularity in recent years, being utilised for service development, policy initiatives, and research, initially in the USA (Becker-Blease, 2017) and subsequently in the UK, illustrated by the commitment for NHS services to become trauma-informed (NHS Long Term Plan, 2019). Understanding how service-users may have faced traumatic experiences and be re-traumatised through contact with services aligns with elements of PIE, such as developing psychological awareness. This indicates that practitioner psychologists in UK homelessness services are often utilising both PIE and TIC when contributing to service development and organisational change. Attachment theory may have been referenced by several participants due to its ability to conceptualise how adverse life experiences might impact a person's later relationships and generate relational difficulties (Fletcher et al., 2015). This might be useful within a PIE framework to develop psychological awareness while maintaining consideration of relationships.

Differences existed between participants regarding the evaluation of PIE and the evaluation of the impact of PIE. A combination of formal outcome measures for psychological interventions, measures to evaluate trauma-informed practice, staff feedback forms, reviewing routine service data, and the Pizazz were described by participants. The complexities of homelessness services present challenges for clinicians and researchers seeking to formally evaluate PIE (Buckley & Tickle, 2023). The range of evaluation methods used by participants reflected the range of approaches observed in the PIE literature (e.g. Cockersell, 2016; Schneider et al, 2021). In addition, participants who used the Pizazz also reported it to be useful in deciphering PIE, connecting to literature which has qualitatively analysed Pizazz scores to reflect on the implementation of PIE (Buckley & Tickle, 2023)

Similar responses were given when participants were asked about service-user involvement. While some participants reported elements of service-user involvement or co-production taking place, this had often been organised separately from PIE and psychology. Everyone described this as something they, their organisation, or their clients (for participants working in the private sector) could improve upon. Some

participants did not appear to have considered service-user involvement in relation to PIE previously, perhaps because it was not explicitly named in the original version of PIE or in PIE 2.0. Client participation has been suggested as a new element of PIE (Cockersell, 2018), increasing the emphasis on shared ownership of services and valuing the voices of service-users, which would align with service-user involvement initiatives. Nonetheless, it is demonstrated that while PIE has been positively integrated with TIC in some settings, the same might not be true for co-production initiatives.

### **4.1.3.** Considering and Navigating Barriers to PIE

Systemic and structural barriers to PIE, negative attitudes from staff teams, and the enormity of the PIE framework were discussed by participants, shedding light on the barriers they faced as they sought to implement PIE. In this section, these barriers to PIE will each be considered in turn.

#### **4.1.3.1.** *Systemic Barriers to PIE*

Participants described various barriers and restrictions which they navigated as they sought to implement PIE. For example, poor investment in staff by their organisations. This included limited acknowledgement of, and support regarding, the distressing aspects of their roles and the impact this has on wellbeing, alongside insufficient training and poor pay. These factors have been found to contribute to lower staff satisfaction and increased burnout (Bimpong et al., 2020; Johnson et al., 2018). This presents numerous barriers to PIE, such as potentially increasing feelings of distrust towards psychological contributions, increasing staff turnover (requiring more training and inductions on PIE to be facilitated), and limiting staff knowledge and confidence. Participants described the training and staff support they provided as beginning to address some of these under-investments, though this was considered an ongoing and difficult process.

Some participants also described the impact of broader structural limitations in society, such as underfunding of services, housing shortages, and unhelpful narratives in society towards homeless people. Participants were tentative as they considered how to utilise PIE in these circumstances, without clearly formulated plans to navigate these structural barriers. While thoughtful reflections were offered

on the importance of being humble and acknowledging the limitations of PIE, hopes were also shared that PIE-informed values could influence structural limitations in future by reducing prejudiced attitudes towards people experiencing homelessness.

The above two paragraphs suggest that psychological professionals face a challenge in navigating systemic and structural barriers, though the positive hopes of the future that were shared potentially reflect one avenue for navigation. This indicates that psychological professionals face similar quandaries to other staff members working in homelessness settings, such as feelings of frustration (Phipps et al., 2017) and powerlessness (Buckley et al., 2020) regarding service limitations, with the latter increasing following the introduction of psychological formulation sessions.

#### **4.1.3.2.** *Reluctance from Staff Teams*

As previously discussed, participants described navigating staff resistance to psychological approaches as they sought to implement PIE. In particular, some staff members and staff teams exhibited discomfort with reflective practice groups or voiced negative attitudes towards service-users, represented in the theme '*reluctance from staff teams*'.

It was reportedly difficult for some staff members to slow down and engage in reflective discussions in reflective practice group sessions, though participants were divided over whether this manifested more within frontline staff or managers. Regardless, it was felt that many staff struggled to exit a problem-solving or 'doing' stance, either because their work was so focused on crisis management or because of their managerial responsibilities. In response, participants described taking a flexible approach, for example by not placing undue pressure on attendees within the sessions or by offering team formulation sessions as alternatives. Participants emphasised how they would tentatively weave in and encourage elements of reflective practice. This flexible stance with reflective practice has parallels with research on psychological formulation, where clinical psychologists have reported taking implicit approaches where they 'chip in' in informal conversations, when providing clinical supervision, and in multidisciplinary team meetings (Christofides et al., 2012).

The tendency for staff to be ‘doing’, and therefore find reflective practice sessions difficult, was also present in the findings of Phipps et al. (2017) who speculated about the culture of voluntary organisations of privileging the needs of others over one’s own. Another potential explanation is that as staff in homelessness settings have typically not received further training (such as in social work or nursing) they may have received less exposure to psychological approaches or reflective practice. In addition, and as already discussed, high levels of burnout and secondary traumatic stress in homelessness settings appears to contribute to reduced enthusiasm for reflective practice sessions (Schneider et al., 2021). It is not clear why enthusiasm for reflective practice sessions is influenced or reduced in this way, though it may be connected to the increased feelings of powerlessness and hopelessness at service constraints produced by team formulation sessions in homelessness hostels (Buckley et al., 2020). This might suggest that building psychological awareness through an approach such as PIE is not always helpful for every staff member. Consequently, the findings of this study, that there was sometimes resistance to reflective practice sessions, may be a result of staff members seeking to protect themselves from additional distress. Alternatively, Buus et al. (2011) found that high workloads, and the associated high levels of stress, caused nurses to deprioritise attending clinical supervision groups, even when they held positive perceptions of these spaces. This presents an unfortunate paradox, potentially being mirrored in homelessness services, where high workloads prevent staff from attending initiatives which may reduce or support them to manage the corresponding stress they experience.

Participants reported that while some staff held positive attitudes towards service-users, others sometimes voiced negative attitudes and beliefs, such as promoting judgemental narratives without seeking to understand the underlying factors behind behaviour or wanting to exclude ‘challenging’ service-users from the service and refer them elsewhere. It is concerning that such beliefs are held by some staff in homelessness services, albeit not surprising as this reflects previous findings that staff often hold prejudiced attitudes towards people experiencing homelessness (e.g. Bhui et al., 2006, Stevenson, 2014). It should be noted, however, that some staff were also reported to hold positive beliefs, particularly by two participants who

described a strong relational ethos in their respective organisations. This suggests a range of perspectives are present in the homelessness sector, potentially mediated by a service's culture. Nonetheless, it appears that judgemental attitudes can pose a barrier to PIE, by inhibiting the development of psychological awareness within staff teams and the development of relationships between staff and service-users.

#### **4.1.3.3.** *The Enormity of PIE as a Barrier*

PIE was described as a vast framework, as participants sought to incorporate the various elements and components of PIE in their work, summarised in the theme '*the enormity of PIE*'.

High workloads were widely reported by participants as they attempted to juggle the competing demands of their services and organisations, including the various initiatives which had stemmed from the introduction of PIE. This led to some participants reflecting openly about achievable change and how to manage their priorities. This suggests that, similarly to other staff working in homelessness settings (Schneider et al., 2021), psychological professionals are also susceptible to high workloads, putting them at increased risk of burnout. This corresponds to previous research which has identified high rates of burnout and chronic stress among practitioner psychologists (McCormack et al., 2018), suggesting these findings are not restricted to psychological professionals working in PIE settings. Nonetheless, the prevalence of this within the interviews indicates this is an important factor to hold in mind when considering barriers to PIE.

The enormity of PIE appears to contribute to an uneven implementation, where some elements are prioritised over others (see Section 4.1.1.3.). As this may also reflect the 'journey' of deciphering and implementing PIE, care should be taken when interpreting the uneven implementation of PIE as a limitation as this may be appropriate within the service context and/or the length of time a service has been utilising PIE.

### **4.1.4.** Considering Innovative Practice and Facilitators for PIE

Various examples of innovative practice and facilitators were described by participants as they implemented PIE and navigated or responded to the obstacles they faced.

Sufficient time was required for psychological professionals and their organisations to commence and travel their PIE 'journey', as they identified what PIE was, what it would look like for the organisation, and as they implemented it over time. Consequently, a facilitator for PIE is the availability and acknowledgement of the time and space required, by senior figures in one's organisation or commissioners. In addition, the variability and changeable nature of PIE, within and across different contexts, alongside the range of applications stemming from the enormity of the framework indicates that another facilitator is when a degree of flexibility is provided by senior figures in one's organisation or commissioners, rather than holding a rigid perception of PIE or of the role of an applied psychologist.

In the face of resistance or distrust from staff, participants described taking a flexible approach to build relationships and engagement over time. This often included developing a presence in a service to allow informal interactions to take place and to make themselves available for ad-hoc conversations. Through this process, participants sought to subtly promote psychological awareness and reflexivity within teams at a pace that was tolerable for the system, while also providing staff support. Participants found that formalised psychological meetings, such as reflective practice sessions, could sometimes feel uncomfortable or intimidating for colleagues initially but that many of the principles could be utilised informally, or after adapting the sessions, to make them more tolerable to staff and appropriate to their needs. Other participants spoke to the dynamics that arose in reflective practice and how they would encourage those present to move from a solution-focused position into a reflective position. In addition, the content and structure of psychological meetings, such as reflective practice and team formulation sessions, inevitably varied depending on the service context. This was particularly notable for participants working in private settings who might work with a range of services, including hostels and outreach providers. It can be inferred that identifying the appropriate course of action in each instance required psychological professionals to conduct assessments of the systems within which they were working to respond and meet staff needs

optimally. Schneider et al. (2021) also identified the need to assess the service context before developing targets for PIE initiatives, formalising this in their study with a phased approach and the administration of various measures with staff and service-users. Furthermore, in the current study, participants reported that substantial time was required to embed themselves within staff teams suggesting that another skill required by psychological professionals is the ability to tolerate uncertainty as they develop their role within a system.

Participants took a similarly flexible approach regarding service-users, whether providing consultation or training to frontline staff on their interactions with service-users, or when providing psychological therapy. Tentative stances, where trusting relationships can be developed with service-users, was emphasised, representing the innovative practice developed from the experiences of psychological professionals, frontline staff, and homelessness organisations working with this client group. This may also align with writings on elastic tolerance, another example of innovative practice within the PIE literature where consideration is given to how 'challenging behaviour' can be understood and responded to in ways which are not punitive (e.g. inappropriate evictions or sanctions) (Keats et al., 2012) and minimise disruptions in the developing relationships that a service-user may have with a service or staff (Boag, 2020).

The subtheme '*you don't have to be a psychologist to do PIE*' also contains examples of facilitators and innovative practice. Some organisations had already established a foundation of good practice that facilitated the implementation of PIE before the employment or introduction of a psychological professional, such as developing a strong relational ethos among their staff or designing the built environments in psychologically informed ways. This both reduced the number of areas requiring initial focus from the psychological professional and provided a foundation for beginning discussions with colleagues about the rationale and opportunities of PIE. This reflects the assertion that the original development of PIE was partially informed by examples of good practice that were already occurring in homelessness services (Johnson & Haigh, 2010).

Some participants described locating and encouraging ‘allies’ within their organisations to support the implementation of PIE. This included fostering relationships with managers to encourage discussions about PIE, and conversations informed by PIE values, in service meetings and in staff supervisions. In addition, one participant encouraged their colleagues to become ‘PIE champions’ for different pillars of the PIE framework, allowing different staff members to take some responsibility for facilitating discussions on different topics. Babiker et al. (2014) discusses the importance of developing teamwork in healthcare services to enhance outcomes for service-users, rather than depending on a single healthcare professional. They highlight the need to provide staff teams with motivation and develop strategies to enhance service provision. The actions by psychological professionals correspond with Babiker et al. (2014) and demonstrate how they have innovatively developed PIE in their organisations, by promoting co-ownership of PIE with colleagues and encouraging others to become involved in its implementation.

## 4.2. Critical Review and Reflections

### 4.2.1. Reflexivity

Reflexivity in research describes the process of reflecting on a study at every stage and from various vantage points. Research cannot be extricated from the researcher and is inevitably influenced by various factors, such as the researcher’s personal perspectives and values, their social and cultural contexts, and their theoretical and epistemological positions (Barrett et al., 2020). While reflexivity does involve identifying and challenging areas of potential bias (Verdonk, 2015), it is also an opportunity to develop a fuller account of the research by exploring how it may have been shaped by the researcher’s positions and values (Braun & Clarke, 2021a). The researcher is therefore encouraged to ‘own’ their position in relation to the study, using this as a space from which additional insights may spring (Braun & Clarke, 2021a).

#### 4.2.1.1. *Personal Reflexivity*

I have endeavoured to maintain a reflexive stance throughout this research project, through personal reflections, learning and reflective opportunities afforded to me during my clinical training, and through discussions with my supervisor.

As a white British cisgender man in my late-20s working in a profession that has been characterised as middle class (Ahsan, 2020), I inhabit multiple privileged identities which may have influenced this study. This includes how the research questions were defined, the interview schedule developed, the interviews conducted, and the data analysed. Indeed, while I believe there is immense value in conducting research on psychology and homelessness, it is important to note that I am not representative of most people who experience homelessness in the UK. In addition, as most participants were also from white backgrounds and all participants were practitioner psychologists (and hence in a middle-class profession), this privilege may also be reflected in the interview data. I wonder how the privileged parts of my and my participants' identities influenced what was named in the interviews and how the topic was attended to, alongside our perceptions of the 'problem' and of the 'correct' way of working within homelessness. Also, because of the focus PIE places on supporting staff teams, I note the disparities between myself and my participants with frontline staff working in homelessness settings, who likely receive less pay and may therefore belong to lower socioeconomic backgrounds. As this study focused on the perspectives of participants implementing PIE, the interviews necessarily involved conversations about the perceptions and responses from other staff and colleagues towards PIE and psychological input. I wonder if frontline staff would have shared or agreed with the conclusions of participants or the findings of this study or if there would be areas of disagreement or debate, and what this would tell us about the implementation of PIE. In addition, as PIE has been found to increase feelings of powerlessness amongst staff teams (Buckley et al., 2020), I wonder whether I could have better explored this or other potential negative impacts of PIE, such as through the inclusion of questions in the interview schedule explicitly enquiring about negative impacts of PIE.

Even if working from a psychologists' or psychological perspective, I am curious how a different researcher might have reached different conclusions from the dataset or have conducted an entirely different study in the first place. Topics such as this warrant ongoing reflection, for clinical psychology, for homelessness services, and for PIE frameworks moving forward.

#### **4.2.1.2.** *Epistemological Reflexivity*

Epistemological reflexivity includes considerations of the factors which informed and influenced the conceptualisation of a research study, how the research questions were developed, and which methodologies were selected. Reflections also focus on how each of these elements shape the outcomes and conclusions of the research study (Willig, 2013).

The onto-epistemological position used in this project is a pragmatist paradigm, diverging from conventional debates of 'realism-vs-relativism' and instead emphasising the practical applications of knowledge. 'Knowledge' and the consequences of that knowledge are therefore conceptualised as being indivisible from one another (Denzin, 2012). In line with this position, I have sought not to extrapolate or idealise a 'true' version of PIE from the data, but instead to explore how it has been implemented in practice. Consequently, even as I conducted the analysis and interpreted the results, I have endeavoured to hold in mind the versatility of PIE across contexts and between practitioners. However, I wonder if the guidance this project may offer for practitioners, services, and commissioners looking at PIE could nonetheless still be (mis)interpreted rigidly, without seeing it as an opportunity to consider insights from the application of PIE in practice from the perspective of psychological professionals. I have hoped that using a qualitative framework enabled a fuller discussion of the nuances in the findings and in the data.

### **4.2.2.** Quality of the Research

As described in the *Methodology* chapter, Braun and Clark's (2021a) evaluation tool was used to assess the quality of thematic analysis and the current research. They provide 20 questions for researchers to consider, broadly separated into two categories; those which focus on the selection and explanation of the methods and the methodology, and those which focus on the quality of the analysis. The second category will be discussed in this section, with each question considered in turn. See Section 2.8. for the consideration of the first category.

The themes and subthemes in this report are clearly summarised and detailed, both in a table of themes and subsequently in the body of text itself, illustrated with relevant quotes (see Chapter 3.0.). The themes are considered to represent patterns of shared meaning underpinned by central concepts. They are not named after or

structured according to interview schedule questions or the research questions for this study. The themes are therefore considered ‘fully realised’ indicating further analysis, or the use of coding reliability or codebook approaches to thematic analysis, would not be necessary at this stage. In addition, no themes represent contextualising information that would benefit from being separated from the analysis or presented elsewhere.

The themes provide a foundation for actionable outcomes, either through guidance for service developments and the applications of PIE, or for reflecting on and navigating potential obstacles and pitfalls that may present. This aligns with the pragmatist paradigm of this study, which centres the actionable consequences of knowledge. Thematic analysis has been described as epistemologically flexible (Braun & Clark, 2021b) while pragmatism is considered methodologically flexible (Kelly & Cordeiro, 2020), suggesting these two positions are compatible with one another. In addition, efforts have been made to remain conceptually consistent and coherent throughout this thesis, avoiding contradictory statements or philosophical confusion.

Braun and Clark (2021a) describe some of the potential indicators of a weak or unconvincing analysis, which will be considered in this paragraph. While Braun and Clark (2021a) do not dictate how many or how few themes should be present, the five themes developed in this project sits within their broad guidance of between two and six (Braun & Clark, 2021b). Within the themes are situated 12 subthemes, providing a straightforward data hierarchy. Efforts have been made to ensure the themes, subthemes, and codes are distinct from one another, that the analysis reflects the data extracts (participant quotes), and to provide a suitable number of data extracts.

Various guidelines for assessing qualitative research place a focus on ascertaining credibility (e.g. Elliott et al., 1999; Lincoln & Guba, 1985; Northcote, 2012), which refers to whether the views of participants reflect how they are represented by the researcher (Tobin & Begley, 2004). To achieve sufficient credibility, reflections on the analysis and the themes were conducted over a prolonged period, alongside discussions with the thesis supervisor for further refinement.

The final question proposed by Braun and Clark (2021a) queries the presence of problematic statements about the generalisability, or lack thereof, of the results. This report is keen to highlight the value of the results for services using or considering a PIE (or similar) approach. While it is acknowledged and emphasised that different organisations will interpret, apply, and value PIE differently from one another, the results are still argued to offer guidance and insight to any settings or practitioners.

### **4.2.3.** Strengths of the Study

This study contributes to the expanding understanding of PIE from a unique perspective. To the best of one's knowledge, it is the first study to centre the views and experiences of practitioner psychologists tasked with implementing PIE in homelessness settings. The study was developed following consultation with specialists in the PIE field and benefited from a strong level of engagement in terms of participants.

The breadth of PIE homelessness contexts represented, including hostel, outreach, statutory, voluntary, and private sectors in various combinations, is a strength of this study. Participants also represented varying levels of seniority within their organisations. The thematic analysis of the data provides a coherent and consistent account of PIE across these contexts, increasing the applicability of the findings to various settings working with PIE approaches or with similar frameworks. The contribution of the findings should also be highlighted as it provides a basis for a range of recommendations (see Section 4.3. below).

### **4.2.4.** Limitations of the Study

Participants consisted of 11 practitioner psychologists recruited via an advertisement circulated on a mailing list for psychological professionals working in homelessness services. It is possible that those who volunteered to participate in the study did so because they held particularly strong or unique views about PIE and may therefore not be representative of psychological professionals working in the field more generally. Participants may have also been influenced by the need to evidence the impact of psychology and of PIE in their respective organisations (for example, if

liaising with commissioners for continuing or additional funding, or if employed on fixed-term contracts with renewal dependent on positive outcomes), potentially impacting how they talked about and communicated PIE when participating in their interviews.

In addition, while recruitment was open to psychotherapists working in PIE settings, none chose to participate meaning their views may not be reflected in this study. The participant sample was predominately from White backgrounds, presenting a risk that this may have influenced the perceptions and accounts of PIE and the priorities in its implementation.

Extensive work went into the development of the interview schedule and the pre-interview questionnaire, such as referring to the PIE literature, considering the initial consultation that took place with PIE specialists, and reflecting with the research supervisor. Nonetheless, there are inevitably other questions that could have been asked which might have provided further insights into the application of PIE. For example, a question could have probed for negative impacts of PIE for a service, staff team, or service-users, informed by research suggesting PIE can increase feelings of powerlessness amongst staff (Buckley et al., 2020). In addition, as different identities intersect with homelessness, people can experience marginalisation from society and from services. Other questions could have therefore focused on the appropriateness of the psychological frameworks used and whether they are relevant to the diverse communities represented within homelessness, or explored if and how anti-racist practice is utilised.

## 4.3. Implications and Recommendations

The study's findings provide guidance and advice for psychological professionals considering or using PIE. In addition, the findings have implications and recommendations for the development of policy, for services and organisations, and for future research on PIE.

### 4.3.1. Implications for Policy

Clinical psychologists and psychological professionals can use their training and skills to develop and inform policy decisions (Channer et al., 2018). This can include developing commissioning or funding arrangements to ensure homelessness services and organisations have the resources and the backing to introduce PIE. The findings of this study emphasise the need for policies and commissioning arrangements to acknowledge the time needed to implement all elements of PIE and of the importance of avoiding unrealistic timeframes. As there is no single 'recipe' for PIE, its versatility and broad scope should be recognised as opportunities to tailor a unique 'recipe' to the presenting context with various avenues for application. Consequently, a careful balance is recommended where rigid perceptions of what PIE 'should' look like in practice are avoided, while guidance is simultaneously provided to support psychological professionals to familiarise themselves with PIE. Additional funding for the employment of sufficient staff will alleviate the pressures of managing the enormity of PIE and maximise the potential of the framework. Attention should also be placed upon the systemic barriers to PIE, such as the lack of investment in staff in homelessness services, and how rectifying this would enhance the application of PIE. In addition, PIE should not be perceived as an antidote to pressures stemming from societal and structural limitations, as these factors might mitigate the effectiveness of PIE. Policy initiatives focusing on wider societal and structural inequalities would therefore enhance the provision of both PIE and homelessness services more generally. Clinical psychologists could contribute to the development of psychologically informed policies, informed by PIE principles, facilitating psychological awareness of the impact of policies on services and the public.

### **4.3.2.** Implications for Services and Organisations

As with commissioners and policy makers, senior leaders in services and organisations must acknowledge the time required to implement PIE and the contextual nature of this approach, providing space and support throughout this process. When providing support, senior leaders could consider the phased approach presented by Schneider et al. (2021) where PIE is introduced incrementally following an initial data gathering phase, with time also dedicated to evaluating PIE subsequently. To maximise the efficacy of PIE, senior leadership should also support the development of trusting relationships between psychological

professionals and other staff, while still validating feelings of discomfort within themselves or others as they arise. Additionally, consideration should be given to how staff and colleagues can themselves support the implementation of PIE, in acknowledgement of the enormity of the framework, to support the psychological professionals and provide staff teams ownership of the approach. Improving and incorporating service-user involvement in relation to PIE would also present a number of opportunities for services and organisations, such as enhancing trust with people experiencing homelessness through authentic representation (Barker & Maguire, 2017) and providing additional colleagues with whom to share the enormity of PIE. Organisations without psychologically trained staff should also hold in mind the vastness of PIE and explore whether there are elements that they could consider tentatively implementing.

### **4.3.3.** Implications for Clinical Practice

Clinical psychologists and other psychological professionals working with PIE or similar approaches will be able to access this study to inform their work in this area. This may be particularly useful for practitioners who are not familiar with PIE as they decipher what PIE is for them and their organisation. Acknowledging that deciphering and implementing PIE is an extended process, and that PIE is broad in scope, may offer reassurance and/or validation for professionals examining it for the first time. Cultivating trusting relationships appears to be a cornerstone of PIE, indicating this could be a priority for psychological professionals as they consider how they introduce PIE to their colleagues and how they and their service engage service-users. Adapting PIE to the service and staff-team context is common practice, providing encouragement for psychological professionals to utilise the framework flexibly and in collaboration with other frameworks as appropriate. It may be useful for psychological professionals to reflect on the potential obstacles to PIE, such as systemic limitations and discomfort from colleagues, to consider how and whether these would manifest in their own service and how they might navigate or mitigate them. Psychological professionals may also benefit from considering the enormity of PIE and how they might engage with this in practice, such as introducing it incrementally, fostering realistic expectations from themselves and others, and identifying colleagues to support them in the implementation of PIE. In addition,

consideration should be given to the elements of PIE that might be overlooked, such as a focus on neighbouring systems and on the built environment.

### 4.3.4. Implications for Research

Additional research on the effectiveness and acceptability of PIE is recommended by NICE (2022) to improve health and social care services for people experiencing homelessness. The enormity of PIE however, as perceived by participants in this study, might pose challenges to researchers seeking to examine discrete outcomes or aspects of PIE in practice. Consequently, it is recommended that future research on PIE is conducted from various methodological positions, including both qualitative and quantitative approaches. Quantitative outcome research could consist of analyses of service-wide outcomes conducted before and after the introduction of PIE to a service or organisation. These studies could be informed by previous quantitative research, such as utilising data that services are already recording (such as eviction rates and number of reported 'incidents') (Cockersell, 2016), or re-evaluating data that was initially collected to inform the introduction of PIE (Schneider et al., 2021). If following the latter approach, care should be taken when selecting which measures are used to inform the implementation of PIE as there is a risk that details may be inadvertently overlooked or emphasised if administering narrow tools or measures. Attitudes and feelings of trust among staff teams towards psychological professionals and PIE could also be explored. For example, routine data could be examined (such as the number of attendees at reflective practice or team formulation sessions) while also inviting qualitative feedback, such as through feedback questionnaires, interviews, or focus groups. Regardless of the methodological stances taken in future research, it is imperative that publications detail what PIE means and how it has been implemented in each context, given its variability in practice.

NICE (2022) also recommend that future research on PIE considers inequalities and the impact of PIE for different groups. The role of power and how this has been wielded in the lives of people experiencing homelessness was alluded to, in greater or lesser extents, by participants in this study, and the focus placed on trusting relationships suggests an acknowledgement of the negative experiences people may have had when accessing homelessness services. Nonetheless, this could have

been explored in more depth and in relation to communities more likely to experience homelessness, or whose experiences of homelessness differ from one another. Future research exploring the experiences of marginalised and oppressed communities could be used to develop PIE approaches and to consider how this framework can be utilised to best meet their needs. Such research must be conducted with an intersectional stance, to consider how different forms of adversity intersect with one another, with homelessness, and with socioeconomic status.
To support practitioner psychologists with the task of evaluation and research, additional placements in PIE settings could be offered to trainee clinical psychologists because, as part of their clinical training, they routinely complete service evaluation projects.

Future research could replicate this study in different contexts or with different participants. For example, the views of psychotherapists and other non-psychologist staff involved in the implementation PIE could be centred and examined to see how they compare with the perceptions of practitioner psychologists.

Additional qualitative research could further explore the themes found in this study. For example, the nature of trust and distrust towards services felt by people experiencing homelessness could be examined using interpretive phenomenological analysis. Feelings of distrust amongst staff teams towards psychological professionals and discomfort with reflective practice could also be explored in interviews using interpretative phenomenological analysis. Alternatively, Foucauldian discourse analysis could be used to explore these themes through dialogues between psychological staff and non-psychological staff, or between psychological and/or non-psychological staff and people experiencing homelessness. Using Foucauldian discourse analysis would also enable an examination of inequalities and power, as discussed previously in this section and in line with NICE (2022) research recommendations.

The importance placed on trust in the development of relationships with service-users and colleagues indicates that future research could look more closely at how trust can and is cultivated through interactions. In addition, research could examine the effectiveness of current training for psychological professionals on how to work

with staff teams, build trusting relationships, and navigate discomfort or resistance from colleagues.

Given the reported impact of structural limitations, such as housing shortages and underfunding for homelessness services, on the effectiveness of PIE, future research could assess these impacts more formally. This might provide a rationale for wider policy changes to reduce structural limitations and facilitate and maximise the effectiveness of PIE and homelessness services more widely.

### 4.4. Conclusions

This is the first study to explore the experiences of practitioner psychologists using PIE approaches in UK homelessness services. This study explores the application and implementation of PIE in practice with consideration given to how PIE is conceptualised across contexts, the barriers faced in its application, and examples of innovative practice. This research characterised PIE as a 'journey' with participants reporting that time was needed both to decipher what the framework meant for them and their service and to then implement it incrementally. Trust was highlighted by participants as crucial to the development of meaningful relationships. Notably, trusting relationships were a necessary foundation for intervention, both when supporting service-users and when engaging staff teams and colleagues in PIE and psychological initiatives. Participants described barriers and impediments to PIE, such as systemic and structural limitations and tensions with other services. In addition, discomfort with reflective practice and judgemental attitudes within staff teams hindered the progress of PIE, requiring careful consideration and navigation by participants. Participants also commented on the enormity of PIE, discussing a vast framework which stretched beyond them as individuals. The vastness of PIE provided opportunities for colleagues and services to introduce PIE initiatives irrespective of formal psychological training, though also presented a challenge for participants to oversee the implementation of the entirety of PIE within their day-to-day work.

Policy makers, commissioners, senior leaders in organisations and services, and practitioner psychologists must acknowledge the time required to decipher and implement PIE effectively. As trusting relationships are integral to PIE, psychological

professionals and organisations are encouraged to prioritise building trust both with service-users and between psychological professionals and staff teams. Systemic and structural barriers to PIE should be contended with, such as the lack of investment in staff in homelessness services, insufficient funding of homelessness services, and negative societal narratives towards people experiencing homelessness. Increased collaboration and teamwork within services and organisations, such as through whole-team approaches or by developing service-user involvement, will share the enormity of PIE and enhance the application of PIE approaches in homelessness services.

PIE is a broad and versatile framework, constituting both a strength and a limitation in terms of its implementation. While underpinned by this broad framework, PIE remains fundamentally unique to each practitioner and each service context, presenting unlimited ‘recipes’ for what PIE looks like in practice. Consideration of the findings and recommendations presented in this report will support and facilitate the effective introduction and implementation of PIE and PIE-informed approaches across a variety of settings.

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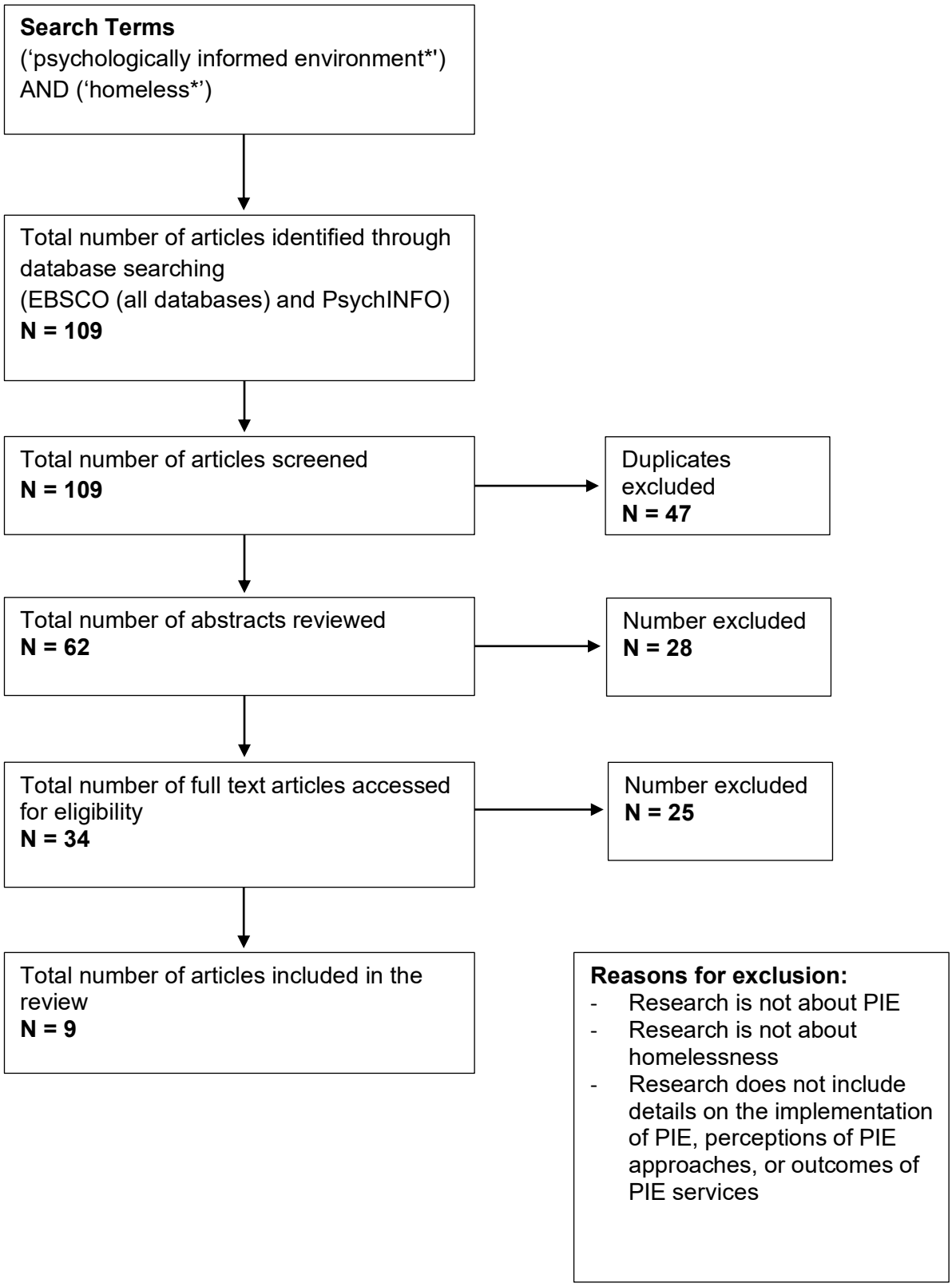
## APPENDIX A: Literature Review Strategy



## APPENDIX B: Interview Schedule

*Introduction*

1. Can you tell me a bit about PIE at [name of service]?
   - *(Prompts: What does it look like? Is it unique or different from other PIEs? How long has your service been using PIE and how has this developed over time?)*

*Communication*

2. How have you communicated the PIE framework to staff (at all levels of the organisation), commissioners and external professionals, and service users?
   - *(Prompts: What has the response to PIE been from staff, external professionals, and service users?)*

*Staff support and training*

3. What staff support and training do you offer?
   - *(Prompts: What does mandatory / optional training, reflective practice, and/or team case formulation look like? What does reflective practice look like? Is team case formulation provided in your service and, if so, what does it look like?)*

*Relationships*

4. What do 'relationships' mean in your service?
   - *(Prompts: When drawing on a PIE framework, some services emphasise 'relationships' (for example, between service users and staff) more or less than other services might do. What do 'relationships' mean in your service?)*

*Models and frameworks*

5. Which psychological framework(s) do you predominately draw on? How is it applied in your service?
   - *(Prompts: How did you decide which psychological framework(s) to use?)*
6. Are psychological, or other MDT, interventions offered to service users? If so, what are they?

7. Which version of PIE do you use? Are there any particular principles or other elements which you are influenced by or you have incorporated into your PIE(s)?

*Service-user involvement*

8. Is there service-user involvement in your service? If so, what does this look like?

*Physical spaces and the surrounding systems*

9. What changes/adaptations have you made, or are planning to make, to the physical environment and social spaces?
    - *(Prompts: How did you identify which changes to the physical environment to focus on?)*
10. Are there any 'unwritten' rules or procedures within the day-to-day running of your service that you have given consideration or worked with?
11. What focus is there on the networks, systems, and pathways around your PIE(s)?
    - *(Prompts: For example, other services in the local area and the referral & move-on pathways for service-users. How did you identify which areas to focus on? How is that understood as part of your PIE? What role (if any) does PIE play in this within your service?)*

*Evaluation and learning*

12. Are you evaluating your PIE(s), or have you done so previously?
    - *(Prompts: Are you collecting outcome data? What outcome data are you collecting? How did you decide which outcome data etc to collect? Was this data that was already being recorded or did you bring in new measures? Have you disseminated, reported, or published any of your outcome data?)*
13. Tell me about the biggest challenges for you in your work?
    - *(Prompts: How have you tried to overcome these challenges?)*

*Miscellaneous and looking to the future*

14. What advice would you give to a service looking at PIE for the first time?
15. What are your future plans for your service and PIE? What are your hopes for the future of the PIE field?
16. Is there anything else that you think it would be useful for me to know, or any big questions I haven't asked?

**APPENDIX C: Recruitment Materials**

University of East London

## Psychological professionals working in Psychologically Informed Environments (PIE) needed for a research study

PIE is being increasingly utilised in the development of homelessness services. This study will examine how PIE frameworks have been interpreted, adapted, and implemented in practice.

The findings from this project hope to inform guidance for services and future research.

**Who can take part?**
Psychological professionals (clinical and counselling psychologists, psychotherapists, etc) who have been working in a PIE setting for a minimum of six months.

**What will taking part involve?**
An interview, lasting around 1-1.5 hours, online via Microsoft Teams. You will also be asked to complete a pre-interview questionnaire.

**For more information or to take part please contact:**
**Jed Nash at u2075222@uel.ac.uk**

## APPENDIX D: Participant Information Sheet

Version: 1
Date: 27/05/2022

**PARTICIPANT INFORMATION SHEET**

**Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services**

**Contact person: Jed Nash (trainee clinical psychologist)**
**Email: u2075222@uel.ac.uk**

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., colleagues, friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

**Who am I?**
My name is Jed Nash. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology (DClinPsych). As part of my studies, I am conducting the research that you are being invited to participate in.

**What is the purpose of the research?**
I am conducting research into Psychologically Informed Environments (PIE) and their application in homelessness services. The study will examine how PIE frameworks have been interpreted, adapted, and implemented in practice. The findings from this project will shed new light on the varied applications of PIE in practice which could inform guidance for services and future research.

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

To address the study aims, I am inviting psychological professionals (clinical psychologists, counselling psychologists, psychotherapists, etc) who work in a PIE setting to take part in my research. If you are a psychological professional who is currently working (for a minimum of 6 months) in a service which identifies itself as using a PIE framework, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

**What will I be asked to do if I agree to take part?**
If you agree to take part, you will be asked to complete a pre-interview questionnaire, followed by a qualitative interview with the researcher. The interviews will take place remotely via Microsoft Teams, will take approximately 1-1.5 hours, and will be recorded and transcribed. During the interviews I will ask you questions about different elements of the PIE framework, how they are used in your service, and how they have been applied to your service's specific circumstances.

Your participation is voluntary, so you will not have to answer all of the questions and you can stop your participation at any time.

**Can I change my mind?**
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by letting the interviewer know at any time. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

**What are the risks and benefits of taking part?**
The research is designed to minimise any potential risks. However, it is possible that talking about aspects of your work with homeless people and in homelessness services may be distressing. Please be aware that you do not have to share anything you do not feel comfortable with. You do not have to answer all of the questions and you are free to pause or stop the interview at any time.

Benefits of participation include contributing to the development of knowledge on the application of PIE in homelessness services. The aim is to publish the results of the study in an academic journal which may contribute to the developing body of knowledge regarding PIE and its application in practice.

**How will the information I provide be kept secure and confidential?**

The interview will be recorded and auto-transcribed using Microsoft Teams and stored securely on a password protected computer. Transcripts of the conversations will be reviewed and anonymised, with all identifying information removed. After I have transcribed your interview the recording of your interview will be deleted. Transcripts will be stored for a maximum of three years.

Your anonymised data may be seen by my supervisor and those who mark my thesis. Anonymised extracts of the interviews will be used within the thesis and within publications sharing research findings, such as reports or presentations. The thesis will be publicly accessible via UEL's institutional repository.

Broad demographic information and organisation-level data may appear in the thesis, but you and your service will not be identified on any written material resulting from the data collected, or in any write-up of the research.

**What will happen to the results of the research?**

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, and/or short reports. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally or identify the service for which you work. Any identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of three years, following which all data will be deleted.

**Who has reviewed the research?**

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

**Who can I contact if I have any questions/concerns?**

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Jed Nash
Email: u2075222@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: L.Farquharson@uel.ac.uk

**or**

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

**Thank you for taking the time to read this information sheet**

## APPENDIX E: Consent Form


**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services**

**Contact person: Jed Nash (trainee clinical psychologist)**
**Email: u2075222@uel.ac.uk**

| | **Please initial** |
|---|---|
| I confirm that I have read the participant information sheet dated 27/05/2022 (version 1) for the above study and that I have been given a copy to keep. | |
| I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage. | |
| I understand that if I withdraw during the study, my data will not be used. | |
| I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. | |
| I understand that the interview will be recorded using Microsoft Teams. | |
| I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission. | |
| It has been explained to me what will happen to the data once the research has been completed. | |
| I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me. | |
| I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. | |
| I agree to take part in the above study. | |

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……

Researcher's Name (BLOCK CAPITALS)

……

Researcher's Signature

……

Date

……

## APPENDIX F: Debrief Form

**PARTICIPANT DEBRIEF SHEET**

**Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services**

Thank you for participating in my research study on psychologically informed environments. This document offers information that may be relevant in light of you having now taken part.

**How will my data be managed?**
The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

**What will happen to the results of the research?**
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, and short reports. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally or identify the service for which you work. Any identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

**What if I been adversely affected by taking part?**

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, if you have been affected please do contact me or my supervisor if you have specific questions or concerns.

You can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

**Contact details**

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Jed Nash
Email: u2075222@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: L.Farquharson@uel.ac.uk

**or**

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

**Thank you for taking part in my study**

## APPENDIX G: Pre-Interview Questionnaire

**Pre-Interview Questionnaire –** Thank you for your participation. Answering these questions will help save time during the interview.

If you have any queries, please contact Jed Nash at u2075222@uel.ac.uk.

1. **Name:**
2. **Job title:**
3. **Professional background (e.g. clinical psychologist, counselling psychologist etc):**
4. **Number of years qualified:**
5. **Service and/or organisation name:**
6. **Are you working in the statutory or voluntary sector?**
7. **What is your service context? i.e. Are you based in a specific service, or do you work at an organisational level across multiple services?**
8. **How many psychological staff are involved in implementing PIE in your service/organisation?**
9. **How long have you worked for your service/organisation?**
10. **How long has your service/organisation been applying PIE?**

11. **Is your service using any outcome measures to evaluate its use of the PIE framework?**

The following questions are on demographics. **This section is optional; you do not have to answer any of these questions if you do not want to.**

1. **How old are you?**
   ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+

2. **Which of the following best describes your Gender?**
   ☐ Man ☐ Woman ☐ Non-Binary ☐ Own Description:

3. **Please highlight your ethnic background(s):**

| **WHITE** | |
|---|---|
| A | White British |
| B | Irish |
| C | Any other White background: |
| **ASIAN** | |
| D | Asian British |
| E | Indian |
| F | Pakistani |
| G | Bangladeshi |
| H | Chinese |
| I | Any other Asian Background: |
| **OTHER ETHNIC GROUPS** | |
| J | Arab |
| K | Any other ethnic group: |

| **MIXED** | |
|---|---|
| L | White and Black Caribbean |
| M | White and Black African |
| N | White and Asian |
| O | Any other mixed background: |
| **BLACK** | |
| P | Black British |
| Q | Caribbean |
| R | African |
| S | Any other Black background: |

## APPENDIX H: Transcription Convention

Minor changes were made to the transcripts to clarify quotes and enable the quotes used in the analysis to be read easily.

Excess repetitive or filler words (e.g. ‘you know’, ‘kind of’) were removed.

Conventions informed by Banister et al. (1994) were added within the transcripts:

… omitted words or sections

[text] addition of content for clarity

[X] to replace identifying names or locations to preserve anonymity

**APPENDIX I: Extract from Interview Transcript**

| Transcript Extract | Initial Codes |
|---|---|
| Interviewer<br>And how have you communicated this framework to to staff and and other professionals?<br><br>Participant<br>So so staff in the services, you mean?<br><br>Interviewer<br>Yeah. Yes, yeah, at any level, I guess. So this could be on the frontline or it could be more senior people or or the commissioners or or whoever it might be.<br><br>Participant<br>So with the staff, when we first start working with the service, we would meet with the staff just to kind of do a bit of consultation and collaboration, collaborative working really around who we are and what we kind of offer, but also what they feel they need. And that also gives us a sense of what the appetite is. So we've had some that have been so receptive and you know can't get enough of it. And then others who probably you know would rather shut the door.<br><br>Interviewer<br>Yeah.<br><br>Participant<br>Perhaps I'm being a bit dramatic. But, you know, kind of there's not quite that receptiveness there as as | Wariness of psychology<br><br>Wariness of psychology |

| | |
|---|---|
| there are with others. Not many I have to say, but but just a couple. So we kind of worked hard to build relationships and I think for those in that latter category who are less willing, you know it has taken years to build a relationship with them enough for them to be trusted to let us in [and] know that we're not spies for the Council. And you know that we genuinely want support them to be the best that they can in in terms of delivering PIE. And for some, I think there were still kind of organisational barriers and cultures that prevent that being fully implemented, but we're just doing the best we can and kind of chip it away at some of that slowly. So, yeah, in terms of staff and managers that we would start probably initially with a a meeting with the managers and explain what we do, what we can offer. Then meet with the staff team and then obviously those relationships would be maintained throughout the the reflective practice process. And then, we've had regular communication with the commissioners, so they've been very keen to learn from this process as well. | Relationship building<br><br>Time is needed to win trust<br>Overcoming distrust<br><br><br><br>Systemic barriers<br><br>PIE as a prolonged process<br><br><br><br><br><br>Contacts maintained over time |

**APPENDIX J: Application for Research Ethics**

University of East London

# UNIVERSITY OF EAST LONDON
## School of Psychology

## APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS (Updated October 2021)

**FOR BSc RESEARCH;**
**MSc/MA RESEARCH;**
**PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY**

| **Section 1 – Guidance on Completing the Application Form** (please read carefully) | |
|---|---|
| 1.1 | Before completing this application, please familiarise yourself with:<br>▪ British Psychological Society's Code of Ethics and Conduct<br>▪ UEL's Code of Practice for Research Ethics<br>▪ UEL's Research Data Management Policy<br>▪ UEL's Data Backup Policy |
| 1.2 | Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback. |
| 1.3 | When your application demonstrates a sound ethical protocol, your supervisor will submit it for review. |
| 1.4 | Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7). |
| 1.5 | Research in the NHS:<br>▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance.<br>▪ Useful websites: |

| | |
|---|---|
| | https://www.myresearchproject.org.uk/Signin.aspx<br>https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/<br>▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required.<br>▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example.<br>▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process. |
| 1.6 | If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website:<br>https://fadv.onlinedisclosures.co.uk/Authentication/Login<br>You may also find the following website to be a useful resource:<br>https://www.gov.uk/government/organisations/disclosure-and-barring-service |
| 1.7 | Checklist, the following attachments should be included if appropriate:<br>▪ Study advertisement<br>▪ Participant Information Sheet (PIS)<br>▪ Participant Consent Form<br>▪ Participant Debrief Sheet<br>▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5)<br>▪ Permission from an external organisation (see section 7)<br>▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use<br>▪ Interview guide for qualitative studies<br>▪ Visual material(s) you intend showing participants |

| **Section 2 – Your Details** | | |
|---|---|---|
| 2.1 | **Your name:** | **Jed Nash** |
| 2.2 | **Your supervisor's name:** | **Dr Lorna Farquharson** |
| 2.3 | **Name(s) of additional UEL supervisors:** | **Dr Matthew Jones Chesters** |
| | | 3rd supervisor (if applicable) |

| | | |
|---|---|---|
| 2.4 | **Title of your programme:** | **Professional Doctorate in Clinical Psychology (DClinPsych)** |
| 2.5 | **UEL assignment submission date:** | **01/05/2023** |
| | | **22/05/2022** |

| **Section 3 – Project Details** | | |
|---|---|---|
| Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research. | | |
| 3.1 | **Study title:**<br>Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager | **Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services** |
| 3.2 | **Summary of study background and aims (using lay language):** | **The proposed study will explore psychologically informed environments (PIE) and their application in homelessness services. The study will examine how PIE frameworks have been interpreted, adapted, and implemented in practice** |
| 3.3 | **Research question(s):** | **- What influences the interpretation and implementation of PIE?**<br>**- What are the similarities and differences between PIE services?**<br>**- What are the barriers and facilitators to implementing a PIE framework?**<br>**- What examples of innovative practice have emerged from implementing a PIE framework?** |
| 3.4 | **Research design:** | **Qualitative design. Semi-structured interviews will be completed with participants and analysed using thematic analysis. Organisation-level data and demographic data will be recorded and presented.** |
| 3.5 | **Participants:**<br>Include all relevant information including inclusion and exclusion criteria | **Interviews will be conducted with 8-12 psychological professionals (e.g. Clinical Psychologists, Counselling Psychologists, Psychotherapists) working in PIE settings. Participants must have worked in their organisation for a minimum of 6 months. Participants can work in any service which supports individuals experiencing homelessness and identifies as using a PIE framework (such as homeless hostels or homeless outreach services** |

| | | | |
|---|---|---|---|
| | | **and including both voluntary and statutory organisations).** | |
| 3.6 | **Recruitment strategy:**<br>Provide as much detail as possible and include a backup plan if relevant | **Recruitment ads will be circulated via mailing lists linked to national homelessness psychology groups/networks. An alternative plan for the project, if recruitment proves challenging, will be to review and analyse published literature on different PIE services.** | |
| 3.7 | **Measures, materials or equipment:**<br>Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc. | **Laptop and the Microsoft Teams application.** | |
| 3.8 | **Data collection:**<br>Provide information on how data will be collected from the point of consent to debrief | **A pre-interview questionnaire will gather additional data about each participant and their respective services. Interviews will be conducted with participants using Microsoft Teams, and will be recorded and auto-transcribed. The auto-transcriptions will be reviewed and edited by the researcher.** | |
| 3.9 | **Will you be engaging in deception?** | **YES**<br>☐ | **NO**<br>☒ |
| | If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature? | If you selected yes, please provide more information here | |
| 3.10 | **Will participants be reimbursed?** | **YES**<br>☐ | **NO**<br>☒ |
| | If yes, please detail why it is necessary. | If you selected yes, please provide more information here | |
| | How much will you offer?<br>Please note - This must be in the form of vouchers, not cash. | Please state the value of vouchers | |
| 3.11 | **Data analysis:** | **The interview transcripts will be analysed using thematic analysis, as per the protocol outlined by Braun & Clarke (2006). Organisation-level data and demographic data will be recorded in the pre-interview questionnaire and will be presented in the final report.** | |

| Section 4 – Confidentiality, Security and Data Retention | | | |
|---|---|---|---|
| It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.<br><br>If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here. | | | |
| 4.1 | **Will the participants be anonymised at source?** | **YES**<br>☐ | **NO**<br>☒ |
| | If yes, please provide details of how the data will be anonymised. | Please detail how data will be anonymised | |
| 4.2 | **Are participants' responses anonymised or are an anonymised sample?** | **YES**<br>☒ | **NO**<br>☐ |
| | If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.). | **The researcher will review and edit each transcription (removing identifiable information in the process) before downloading into a word doc. This transcription will then be stored in a password protected file on both the researcher and supervisor's secure accounts.** | |
| 4.3 | **How will you ensure participant details will be kept confidential?** | **Interview recordings will be deleted once the transcriptions have been downloaded and reviewed. The transcriptions will be stored in a password protected file on both the researcher and supervisor's secure accounts. Only the researcher, supervisor, and examiners will have access to anonymised transcripts. Video files will be saved in the UEL OneDrive for Business titled: 'Participant number, participant initials: Date of interview'. Consent forms will be completed electronically and stored in UEL OneDrive for Business.** | |
| 4.4 | **How will data be securely stored and backed up during the research?**<br>Please include details of how you will manage access, sharing and security | **The transcriptions will be stored in a password protected file on both the researcher and supervisor's secure accounts. Audio and video files will be saved in the UEL OneDrive for Business titled: 'Participant number, participant initials: Date of interview'.** | |
| 4.5 | **Who will have access to the data and in what form?**<br>(e.g., raw data, anonymised data) | **Myself and my project supervisor will have access to the interview transcripts and the pre-interview questionnaire summary data.** | |

| | | | |
|---|---|---|---|
| 4.6 | **Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases) | **Anonymised interview transcripts and anonymised pre-interview questionnaires.** | |
| 4.7 | **What is the long-term retention plan for this data?** | **Anonymised interview transcripts will be kept for three years on UEL's OneDrive for business by the research supervisor, after which they will be deleted.** | |
| 4.8 | **Will anonymised data be made available for use in future research by other researchers?** | **YES** ☐ | **NO** ☒ |
| | If yes, have participants been informed of this? | **YES** ☐ | **NO** ☐ |
| 4.9 | **Will personal contact details be retained to contact participants in the future for other research studies?** | **YES** ☐ | **NO** ☒ |
| | If yes, have participants been informed of this? | **YES** ☐ | **NO** ☐ |

| **Section 5 – Risk Assessment** | | | |
|---|---|---|---|
| If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible. | | | |
| 5.1 | **Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.) | **YES** ☐ | **NO** ☒ |
| | If yes, what are these, and how will they be minimised? | Please detail the potential risks and include measures you will take to minimise these for your participants | |
| 5.2 | **Are there any potential physical or psychological risks to you as a researcher?** | **YES** ☐ | **NO** ☒ |
| | If yes, what are these, and how will they be minimised? | Please detail the potential risks and include measures you will take to minimise these for yourself as the researcher | |

| | | | | |
|---|---|---|---|---|
| 5.3 | **If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:** | **YES** ☐ | | |
| 5.4 | **If necessary, have appropriate support services been identified in material provided to participants?** | **YES** ☐ | **NO** ☐ | **N/A** ☒ |
| 5.5 | **Does the research take place outside the UEL campus?** | **YES** ☒ | **NO** ☐ | |
| | If yes, where? | **Interviews will be conducted remotely using Microsoft Teams.** | | |
| 5.6 | **Does the research take place outside the UK?** | **YES** ☐ | **NO** ☒ | |
| | If yes, where? | Please state the country and other relevant details | | |
| | If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard).<br>Please confirm a Country-Specific Risk Assessment form has been attached as an appendix.<br>Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants. | **YES** ☐ | | |
| 5.7 | **Additional guidance:**<br>▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.<br>▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the | | | |

| | |
|---|---|
| | Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor).<br>▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).<br>▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree. |

| **Section 6 – Disclosure and Barring Service (DBS) Clearance** | | | |
|---|---|---|---|
| 6.1 | **Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?**<br>If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project | **YES**<br>☐ | **NO**<br>☒ |
| | * You are required to have DBS or equivalent clearance if your participant group involves:<br>(1) Children and young people who are 16 years of age or under, or<br>(2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. | | |
| 6.2 | **Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?** | **YES**<br>☒ | **NO**<br>☐ |
| 6.3 | **Is your DBS or equivalent (for those residing in countries outside** | **YES**<br>☒ | **NO**<br>☐ |

| | | | |
|---|---|---|---|
| | **of the UK) clearance valid for the duration of the research project?** | | |
| 6.4 | **If you have current DBS clearance, please provide your DBS certificate number:** | **001703367124** | |
| | If residing outside of the UK, please detail the type of clearance and/or provide certificate number. | Please provide details of the type of clearance, including any identification information such as a certificate number | |
| 6.5 | **Additional guidance:**<br>▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian).<br>▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language. | | |

| **Section 7 – Other Permissions** | | | |
|---|---|---|---|
| 7.1 | **Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?** | **YES**<br>☐ | **NO**<br>☒ |
| | If yes, please provide their details. | Please provide details of organisation | |
| | If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix. | **YES**<br>☐ | |
| 7.2 | **Additional guidance:**<br>▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. | | |

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| | ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s. |

| **Section 8 – Declarations** | | |
|---|---|---|
| 8.1 | **Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:** | **YES**<br>☒ |
| 8.2 | **Student's name:**<br>(Typed name acts as a signature) | **Jed Nash** |
| 8.3 | **Student's number:** | **u2075222** |
| 8.4 | **Date:** | **25/04/2022** |
| ***Supervisor's declaration of support is given upon their electronic submission of the application*** | | |

## APPENDIX K: School of Psychology Research Ethics Committee Approval

University of East London

# School of Psychology Ethics Committee

## NOTICE OF ETHICS REVIEW DECISION LETTER

**For research involving human participants**

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**Reviewer:** Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

| Details | |
|---|---|
| **Reviewer:** | **Fevronia Christodoulidi** |
| **Supervisor:** | **Lorna Farquharson** |
| **Student:** | **Jed Nash** |
| **Course:** | **Prof Doc Clinical Psychology** |
| **Title of proposed study:** | **Recipes for PIE: An Exploration of Psychologically Informed Environments (PIE) in Homelessness Services** |

**Checklist**
(Optional)

| | YES | NO | N/A |
|---|---|---|---|
| Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.) | ☐ | ☐ | ☐ |
| Detailed account of participants, including inclusion and exclusion criteria | ☐ | ☐ | ☐ |
| Concerns regarding participants/target sample | ☐ | ☐ | ☐ |
| Detailed account of recruitment strategy | ☐ | ☐ | ☐ |
| Concerns regarding recruitment strategy | ☐ | ☐ | ☐ |
| All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.) | ☐ | ☐ | ☐ |
| Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| Clear and detailed outline of data collection | ☐ | ☐ | ☐ |
| Data collection appropriate for target sample | ☐ | ☐ | ☐ |
| If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point | ☐ | ☐ | ☐ |
| If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation | ☐ | ☐ | ☐ |
| Concerns regarding data storage (e.g., location, type of data, etc.) | ☐ | ☐ | ☐ |
| Concerns regarding data sharing (e.g., who will have access and how) | ☐ | ☐ | ☐ |
| Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored) | ☐ | ☐ | ☐ |
| If required, General Risk Assessment form attached | ☐ | ☐ | ☐ |
| Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise | ☐ | ☐ | ☐ |
| Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise | ☐ | ☐ | ☐ |
| If required, Country-Specific Risk Assessment form attached | ☐ | ☐ | ☐ |
| If required, a DBS or equivalent certificate number/information provided | ☐ | ☐ | ☐ |
| If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.) | ☐ | ☐ | ☐ |
| All relevant information included in the participant information sheet (PIS) | ☐ | ☐ | ☐ |
| Information in the PIS is study specific | ☐ | ☐ | ☐ |
| Language used in the PIS is appropriate for the target audience | ☐ | ☐ | ☐ |
| All issues specific to the study are covered in the consent form | ☐ | ☐ | ☐ |
| Language used in the consent form is appropriate for the target audience | ☐ | ☐ | ☐ |
| All necessary information included in the participant debrief sheet | ☐ | ☐ | ☐ |
| Language used in the debrief sheet is appropriate for the target audience | ☐ | ☐ | ☐ |
| Study advertisement included | ☐ | ☐ | ☐ |
| Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.) | ☐ | ☐ | ☐ |

| **Decision options** | |
|---|---|
| **APPROVED** | Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment. |
| **APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** | In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. |

| | |
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| | **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials. |
| **NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** | In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.<br><br>**Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study. |

## Decision on the above-named proposed research study

| | |
|---|---|
| **Please indicate the decision:** | **APPROVED** |

## Minor amendments

| Please clearly detail the amendments the student is required to make |
|---|
| |

## Major amendments

| Please clearly detail the amendments the student is required to make |
|---|
| |

## Assessment of risk to researcher

| | | |
|---|---|---|
| **Has an adequate risk assessment been offered in the application form?** | **YES** ☒ | **NO** ☐ |
| | If no, please request resubmission with an **adequate risk assessment.** | |
| **If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:** | | |
| **HIGH** | Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics. | ☐ |
| **MEDIUM** | Approve but include appropriate recommendations in the below box. | ☐ |
| **LOW** | Approve and if necessary, include any recommendations in the below box. | ☒ |
| **Reviewer recommendations in relation to risk (if any):** | Please insert any recommendations | |

| **Reviewer's signature** | |
|---|---|
| **Reviewer:** (Typed name to act as signature) | **Dr. Fevronia Christodoulidi** |
| **Date:** | **14/06/2022** |
| ***This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee*** | |
| **RESEARCHER PLEASE NOTE**<br>For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. | |

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

| **Confirmation of minor amendments**<br>(Student to complete) | |
|---|---|
| **I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data** | |
| **Student name:**<br>(Typed name to act as signature) | Please type your full name |
| **Student number:** | Please type your student number |
| **Date:** | Click or tap to enter a date |
| ***Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required*** | |