Social Psychiatry and Social Policy for the 21st Century - new concepts for new needs:

The 'Psychologically Informed Environment'

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This article first appears in "Mental Health and Social Inclusion", Nov 2010, as the first part of a series of papers introducing new concepts in social psychiatry. The second paper, on the "enabling environments" initiative, is in currently in press; and the third, on social psychiatry and public health, is in preparation.

Abstract:
Although the idea of a therapeutic community has lost none of its dynamism, there are many modern-day environments in which the original TC model has been unable to make headway.
In recent years, new ideas have been emerging for the development of institutions and services, which can be adapted to a wider range of psychological needs and settings, such as homelessness hostels and refuges.
The "psychologically informed environment" arises from the scope for reflective practice, leading to changes in day-to-day working – including a more planned variant for high secure services. The PIE approach seems now to offer greater flexibility in scope than the TC model.
Nevertheless, such new approaches may yet need a clear values base; and the next article in this series will explore new ideas for the creation of "enabling environments" in a still wider range of settings.

Social psychiatry and the recognition of emotional intelligence

The idea of a therapeutic community – of a place of which people could say that living here IS the therapy – has a long and honourable history, stretching back to the early Quaker community, the York Retreat (Stewart 1992), and beyond. In the immediate post war years, the ideas and ideals of the 'TC' seemed to many to embody the hopes for a new form of social psychiatry, more appreciative of the importance of relationships to individual mental health and recovery, and also to community mental health (Jones 1968a). But the early promise and early growth of therapeutic communities in the UK and elsewhere has not been sustained, at least within mainstream healthcare, and some have always questioned whether there can be a single, 'pure' model (Clark, 1965: Jones 1968b: Vaglum 1982: Johnson 2006) for a community, especially granted the increasingly complex psychological demands of the new century (Mulgan et al 2009).

Yet at the same time, many of the values and principles that the early TC pioneers espoused – such as greater user involvement and empowerment, flexibility and responsiveness in services, transparency and accountability of the professionals – have passed into the mainstream of UK social policy; and social inclusion policies (Social Exclusion Unit, 2004: National Social Inclusion Programme, 2009) now encourage all services in the broader community to be more conscious of the mental health and emotional needs of those at risk of marginalisation. Clearly the extra-ordinary dynamism and transformative power of the original TC model has not gone away; but it may no longer need to be the only yardstick for positive engagement with a psycho-social or community dimension.

In this extended paper, we set out to describe some of the new thinking which is attempting to convey, within the UK, a growing recognition of the significance of the social context for any efforts to enhance mental health and promote individual and community well-being. These new concepts aim both to embody current new thinking and to encourage new practice, in the introduction of enlightened management for enhanced well-being in hospitals and prisons, schools and workplaces, housing projects and places of faith.

Part One describes one such approach, the 'psychologically informed environment', focussed primarily on institutions and services which need to recognise with clarity and sensitivity the psychological and emotional aspects of their work, and to adapt their ways of working accordingly. Its aim is to encourage more enlightened work in hostels, refuges etc to support them in managing the more marginalised more effectively.

Part Two will take the same issues further, to outline the development of the UK Royal College of Psychiatrists' 'enabling environment' initiative, which embraces a still wider scope in the broader health and well-being arena.

The 'psychologically informed environment'

In July 2010, the UK Department of Communities and Local Government (CLG), in conjunction with the National Mental Health Development Unit (NMHDU), published new guidance for frontline services – and for those who commission such services – on better ways of meeting the psychological and emotional needs of people who are homeless (CLG 2010). The guidance stresses the need for services to recognise that many of their clientele will have suffered some degree of emotional trauma, whether in the short term, or perhaps over an extended period, and in some cases, long-standing difficulties stemming from neglect and abuse going back to childhood.

The point is not just that services – health and social care services, as well as homelessness resettlement services – will need to be attentive to these needs. It is also that to fail to work with such issues, in such a crisis situation, is a waste of an opportunity. In then promoting a string of examples of innovative practice, the guidance introduces a new term to the vocabulary of services – that of the 'psychologically informed environment', or 'PIE'.

Wherever any agency has effective control over many aspects of the day-to-day lives of the individuals living there, as for example in a hostel, a hospital or a prison, we have in effect, it is suggested, a highly managed environment. When in addition the primary task or ethos of the service is the treatment, rehabilitation or other management of problematic behaviour, we therefore have an environment that is - or can be - to some degree consciously planned for the purpose, despite whatever inevitable practical constraints there may be.

The concept of a 'psychologically informed environment' then describes the outcome of an attempt to identify, adapt and consciously use those features of the managed environment in such a way as to allow the resources and the day-to-day functioning of the service to be focussed on addressing the psychological needs and emotional issues thrown up by the residents.

Action learning and service evolution

As to how any service may approach the task, however, at this stage the field is entirely open. There is as yet, at least, no single or particular school of thought or of human understanding that necessarily underpins or informs the thinking in fostering a PIE. There is no one set of beliefs that the staff of a PIE need to sign up to, no overall view of the nature of human

nature, or even of the underlying problems of the 'membership'. So it might be any form of psychological theory that might inform the work of the staff, from psychodynamics to behaviourism, from Gestalt to evolutionary psychology, Transactional Analysis, Dialectical Behavioural Therapy, Neuro-Linguistic Programming to existential humanism, and all points between and beyond. It is perhaps arguable that a meditation space or retreat founded on the more psychologically oriented faiths, such as Buddhism, might qualify. Certainly the York Retreat, that original template for compassionate care, has a good claim to the name.

But wherever that more psychological thinking can then be translated meaningfully into a carefully considered approach to re-designing and managing the social environment, then we have a PIE. It is these changes in day-to-day running, derived from reflective practice, that mark the development of the PIE. But for the moment, at least, the definitive marker of a PIE is simply that, if asked why the unit is run in such and such a way, the staff would give an answer couched in terms of the emotional and psychological needs of the service users, rather than giving some more logistical or practical rationale, such as convenience, costs, or Health And Safety regulations.

Although training may well help, the key to psychological thinking here is not received wisdom, or even acquiring new skills, but reflective practice. The guidance stresses the central role of shared and thoughtful learning from experience, suggesting:

" [R]eflective practice is advantageous in three distinct ways –

- Firstly, by aiming to recognise and understand service users' difficulties, it helps to generate amongst clients a sense of being understood and "heard". It enables keyworkers to identify and defuse potential conflicts, and so to ensure safe practice.

- Secondly, it enables staff to get some perspective on the emotional challenges in their work, thereby enabling some distance from it and the possibility of working out the emotional content of the work being done. In this way anxieties may be reduced and burnout may also go down.

- Thirdly, it enables shared learning cycles to be set up which enhance the acquisition of skills. Staff attending such groups have the opportunity to discuss the models and techniques employed to facilitate change in detail, and corrective feedback may be offered."

The guidance goes on to note "Recent evidence has indicated that negative beliefs about the population reduced and perceptions of effective working increased, in addition to burnout falling, when a programme of reflective practice group work was added to a training course."

This also requires a management of the service which is prepared to allow the time and this scope for frontline staff to think, discuss and argue over how things could perhaps be done differently, and make whatever suitable changes they can. The guidance observes that "there are obvious time and cost commitments involved in enabling front-line staff to attend regular supervision, typically for an hour and a half every two weeks. It is vital therefore that managers 'buy in' to the concept and are able to perceive the benefits in order that a long-term commitment can be made."

High risk or secure environments

The possibility of a more thoughtfully designed environment in residential resettlement settings, such as in homeless persons hostels, women's refuges and foyers for homeless

youth, is therefore currently being actively explored (CLG 2006, 2010). But similarly, in the context of the prison service, the concept of a psychologically informed and carefully planned environment may also in many situations be more useful than the earlier notion of a therapeutic community, at least as commonly defined. There certainly are and have been many valuable initiatives to create specialist TC units within the prison system; but they remain at the margins, going against the tide.

And yet there clearly are other successful and constructive prison and youth offender institutions (Owers, 2010); which are not TCs as such but which, in some perhaps less clearly articulated way, do manage to create and use positive relationships very effectively. Here, too, we may now need to find another vocabulary, and another set of key principles, to describe what is most effective in the most constructive prison regimes, and also for example in approved premises (formerly known as 'probation hostels'). It is likely that such factors are 'highly distilled' in existing TCs, but could also be developed in another fashion, as with PIEs. In homelessness resettlement, such changes may come about gradually and incrementally. In a more controlled environment such as a prison, where all changes in the daily routine must be thoroughly managed in great detail, introduction of a PIE may need to be more tightly planned.

Here, it is suggested, we need to think more in terms of planned change – a psychologically informed planned environment, or 'PIPE' – and there are currently discussions within the National Offender Management Service over the nature of the changes that might be introduced in several pilots over then next year or more. But the common thread is that these changes come about through the conscious application of careful thinking about the psychological and emotional needs - and potential - of the residents.

Variety and ecological 'fit'

Note however that with the notion of a PIE, there is no assumption at all that structured group work, democratic decision-making, communalism, permissive self-expression, 'reality confrontation', or any of the features commonly associated with the archetypal TC model (Rappoport 1960: Clark 1974: Hinshelwood & Manning 1979), need necessarily apply. They may well do so; but if so, a reason must be given as to why they are appropriate in this setting, and suited to the social and emotional needs of this particular clientele (Johnson 2006). There is no prior assumption of a need for 'therapy', nor is a community focus necessarily central. If a sense of belonging, security and affinity, even of common purpose, is developed, we may well see this as a good thing; but it need not and usually should not be segregating and exclusive.

One thing, however, that we can say with confidence is that, whether in a prison, a night shelter, or even an acute ward, or wherever safety and management of risk is a key concern, a genuinely constructive environment always aims to do more than simple containment of challenging behaviour. A PIE or PIPE will aim to use the potential for change that resides in all human beings in the pursuit of some wider or future goal, whether it be the reduction of re-offending, a positive attitude to learning, developing better interpersonal relationships, or engagement with formal treatment and therapy.

The PIE approach can therefore perhaps best be thought of not as a new model in itself, but rather as a tool or framework to encourage creative and responsive thinking on the part of the staff team. This not to say that service users, carers, volunteers and graduates will not be involved in such reflection; only that there is no prescribed way, such as the 'community meeting' in a TC, by which that should happen. But it seems that the concept of a PIE may help take us into territory where the older TC concept was unable to go. We might even speculate that, over time, various distinct schools of PIE and PIPES may emerge, each clear

as to why it is suited to particular circumstances and each with its own evidence for effectiveness in context.

Finally, whilst it is important to stress the role of the staff team in thinking afresh over the needs of the client group, we should not overlook the impact of the built environment itself. A number of studies (e.g.: Cooper Marcus, 2007: Malenbaum, 2009) have demonstrated for example that a pleasant view of greenery in a central courtyard can delay the deterioration of mental functioning of those inflicted with dementia. Even the positioning of a reception area and security lights in a hostel can completely change the institutional atmosphere - from something alienating to something welcoming (Intelligent Space, 2003). A planned environment can be planned on many levels (Lawlor & Webb, 2009).

The PIE in wider social context

This raises nevertheless two further questions. Firstly, is being 'psychologically informed' in itself enough to guarantee the more humane treatment that we wish to see? As one cautious critic has suggested, brainwashing is psychologically informed. If that may seem an absurd extreme, we need to recall that in the 1940s and 50s, 'operant conditioning' and token economies were promoted, based on a very crudely reductionist but fully "psychological" interpretation of human learning and motivation. 'Post-Fordism' – the atomistic production line approach to maximising efficiency – is also based on psychological studies – though their application to health and social care these days is shunned in relation to service users, and its application is confined solely to the actions of the staff.(Chakrobortty, 2010).

So it may well be that, in addition to psychological insights, we need to include some form of values statement. In homelessness services, such values are already embedded in the service model by the Quality Assurance Framework for Supporting People funding (House of Commons, 2010). Is there a need for something comparable in other areas where the PIE or PIPE might go?

Secondly, are there nevertheless still limits to the applicability of the PIE concept? Indeed there are. One key aspect of a PIE, and an essential requirement for a PIPE – one half, indeed, of the defining features - is that there should be a coherent, defined environment which is managed, and so can be planned, in order for that planning to be psychologically informed.

What are we then to say of those many social environments where the members of the community themselves have the largest say in how they run their own lives, not as planned by any other group, but self-directing, as individuals living their own lives? This, after all, is the community at large, where most of us live most of our lives. And what of all those environments where people come together to follow some other primary purpose, such as economic productivity, education and training, recreation, or the expression of their faith?

With increasing recognition of the wider social determinants of health, mental health and well-being (Wilkinson & Marmot, 2003; Dept of Health, 2009: Milton, 2010) it becomes, we suggest, both necessary and possible to explore a wider range of issues that impact upon individual and community well-being. But for this, we must go beyond the notion of a planned environment, and we will need to introduce a second, new and considerably broader concept – the 'enabling environment'.

Conclusion

In this paper, we have proposed that, where the concept of a Therapeutic Community was unable to go, the more flexible and adaptable concept of a Psychologically Informed

Environment, or 'PIE', can be applied. With its stress on reflective practice in frontline services, the PIE approach, along with its counterpart the PIPE, for high risk or secure settings, aims to revitalise discussion over how best to manage the psychological and emotional needs of some of those most excluded from the mainstream of society, and to support them into recovery.

But to address the wider social determinants of public health, mental health and well-being, we also need concepts that can recognise and promote positive social relationships and social capital on a broader canvas. Here, the concept of an 'enabling environment' attempts to transcend the distinction between treatment agencies and the wider world. This will be the subject of Part Two.

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