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What, How and Why of a Psychologically Informed Environment (PIE) Within Youth Refuge

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Abstract
Being homeless is broadly understood to be traumagenic. Thus, support services for individuals experiencing homelessness (such as youth refugees) are encouraged to use trauma-informed models of care. However, there is a dearth of research that (1) focuses on youth refuge specifically, despite refuges being the most common response for youth homelessness worldwide, and (2) explains trauma-informed care models in detail so that they may be evaluated in practice. This paper outlines a trauma-aware framework used for nearly a decade within a youth refuge located in Melbourne, Australia: a psychologically informed environment (PIE). The paper provides: (1) an overview of trauma-informed care before describing what a PIE entails; (2) the how of a PIE, including core principles, their theoretical underpinnings, and how these principles are practically applied; and (3) the why of a PIE, focusing on implications for practice. A PIE is underpinned by key theoretical approaches such as attachment theory, the core emotional needs model, psychodynamic theory and formulation, social cognitive theory, and the transtheoretical model of change. A PIE encompasses five core principles of (1) relationships, rules, responsiveness, and roles; (2) physical and social spaces; (3) learning and enquiry; (4) staff support and training; and (5) psychological awareness. Overall, PIEs have been found to increase consumer engagement and decrease evictions, instill confidence and improve empathy within the staff, and decrease the risk for organizations, as seen by low incident rates. It is hoped that by providing this detailed outline of a PIE, more research can be undertaken into youth refuge care models, and more psychologically informed frameworks that address the multi-directional relationship between trauma and homelessness can be employed.

Keywords
Emergency shelters, homelessness, homeless youth, practice frameworks, psychologically informed environment, trauma, trauma-informed care

Introduction

Youth homelessness is a serious global health and humanitarian issue associated with a myriad of health, economic, and psychosocial problems. Common concerns for youth experiencing homelessness include poor physical and mental health, increased substance use, decreased income, limited academic achievement, and social exclusion (Timms & Drife, 2021). Due to the deleterious impacts of homelessness on developmental trajectories, those who experience homelessness during adolescence tend to have more and longer episodes of homelessness during adulthood (Taylor & Sharpe, 2008). Biological regulatory systems and attachment to others are disrupted, leading to a lack of self-regulation and the inability to form healthy relationships (van der Kolk, 2014). Prolonged and repeated episodes of homelessness increase and

compound trauma symptomology, resulting in entrenchment within helping/support sectors (Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri [FEANTSA], 2017) from a lack of development of a range of important life skills (Krabbenborg et al., 2017). As such, youth homelessness deserves attention so that significant health, economic, and societal costs can be prevented.

The most common international response to youth homelessness is the provision of crisis accommodation, i.e., short-term residential services with various health, hygiene, support, and vocational services attached. These accommodation services (also known as hostels and emergency shelters - henceforth "youth refuge") purport to teach adolescents the necessary skills to become autonomous, functional adults. In reality, support services are predominately focused on enrolling youth in employment to obtain income so they may fund an independent housing option and 'solve' their homelessness. Substantiating this, Jaman et al. (under review) found that trauma-informed models were neglected within these settings in favour of strengths-based models that championed self-sufficiency and independence, and which align more with neo-liberal policies currently in favour internationally. This review concluded that further research was needed to understand whether youth refuge produced positive outcomes, but whether it also: (1) met the developmental and support needs of adolescents, (2) addressed the experience of trauma, and (3) prioritised the creation of sustainable pathways to permanently exit homelessness (Jaman et al., under review).

Jaman et al. (under review) also found scarce detailed explanations of refuge practice models. Others have similarly identified the need for clarification of trauma-informed care models (Hanson & Lang, 2016; Krause et al., 2018). Research on psychologically informed environments specifically remains scarce, and the framework has been described as "nebulous and devoid of evidence-based foundations" (Schneider et al., 2022, p. 9). To begin to address some of these criticisms, this paper provides a descriptive overview of a refuge practice framework in use for approximately ten years within a youth refuge in metropolitan Melbourne, Australia: a psychologically informed environment (PIE). The youth refuge is a purpose-built site encompassing 13 individual units (each with a private kitchen and bathroom) that can accommodate nine single young people and four families at a time (Jaman, 2018). According to statutory data reported to the Department of Families, Fairness and Housing (DFFH), it housed 192 young people in 2022-2023.

This paper is presented in three parts: (1) an overview of trauma-informed care before describing *what* a PIE entails; (2) the *how* of a PIE, including core principles, their theoretical underpinnings, and how these principles are practically applied; and (3) the *why* of a PIE focussing on implications for practice.

What is a PIE?

Trauma-Informed Care

Current discourse defines being homeless as traumagenic and encourages services to utilise trauma-informed responses to intervene effectively (Hopper et al., 2010; McKenzie-Mohr et al., 2012). Generally, trauma is defined as events that are extraordinary in terms of their overwhelming nature (FEANTSA, 2017). Trauma can be caused by: (1) a singular event (e.g., sexual assault or loss of a parent); or (2) events that begin in childhood, occur repeatedly, within the context of family and relationships (e.g., neglect, emotional abuse, and/or repeated physical/sexual abuse). Experiencing these events results in feelings like shock, terror, shame, and powerlessness which then negatively impact upon self-perception, world views and neurobiological makeup (Bransford & Cole, 2019). Trauma also impacts individuals' capacity for emotion regulation, leading to maladaptive coping mechanisms (e.g., substance use, violence). A trauma-informed service formulates these behaviours and emotional reactions as normative responses to traumatic experiences rather than as evidence of disorders, deviance, or individual failures (Bransford & Cole, 2019; Hopper et al., 2010). Trauma-informed approaches thus allow for intervention at the root cause of distress rather than focussing only on symptomology (Conradi & Wilson, 2010). For example, a trauma-informed intervention understands substance use as a potential coping mechanism for traumatic memories; hence, if the

memories are reduced, the need for substance use decreases too. Research has shown that support services who do not understand or consider the critical relationship between trauma and homelessness are less effective than those who do (FEANTSA, 2017; Hopper et al., 2010; McCarthy et al., 2020).

Psychologically Informed Environments (PIEs)

PIEs originated within adult homelessness services in the United Kingdom (UK). A PIE framework resulted from policymakers and practitioners recognizing that individuals experiencing homelessness presented with many complex emotional, psychological, and social needs; however, services lacked training, resources, and strategies to work with these needs effectively (Breedvelt, 2016). Resultingly, many individuals were excluded or evicted from homelessness services. To improve service delivery, a 'good practice guidance' document was created (Keats et al., 2012), which outlined key principles needed for effective service. Keats et al. (2012, p.4) summarised that "psychologically informed environments are intended to use the latest insights and evidence from the psychological disciplines to give…homeless people the best chance of sustainably escaping the cycle of poor well-being and chronic homelessness". The use of the word 'psychology' refers to emotional intelligence and empathy versus a specific discipline or theoretical basis (Keats et al., 2012).

A PIE is informed by therapeutic community principles – "a place of which people could say that living here is the therapy" (Johnson & Haigh, 2010, p. 30). Specifically, a relational, community focus is central as PIEs theorise that disrupted attachment bonds shape future interpersonal behaviour and contribute significantly to wide-ranging psychological problems. PIEs are, therefore, particularly relevant in the context of youth homelessness, which has been shown to predominately result from relationship breakdown or family violence. These disrupted relationships then lead to: (1) limited emotion regulation abilities; (2) unhealthy substance use or other unhelpful coping strategies as emotional self-regulation; (3) a lack of interpersonal skills, resulting in mistrust, a reluctance to engage in support, and social withdrawal; (4) limited impulse control; and potentially (5) destructive anti-social behaviours such as aggression or criminal involvement. A PIE encourages those who use its framework to view such behaviours of concern as the result of unmet psychological and socioemotional needs (Cockersell, 2011). This is consistent with trauma-informed approaches utilised with a range of vulnerable populations that focus on understanding pain-based behaviour (Anglin, 2013) as a way of meeting fundamental human needs (see for example, Brendtro et al., 2005; Deci & Ryan, 2000).

However, a PIE differs from trauma-informed care with its focus on relationships as the key tool for change. Under a PIE framework, disrupted attachment bonds are viewed as primary drivers for maladaptive behaviour and the basis for psychological issues; consequently, healthy relationships are the vehicle through which said behaviours can be modified and symptomology reduced (Cockersell, 2011; Williamson, 2018a; Seager, 2011a). It is primarily through providing psychological safety and developing relational bonds that earlier attachment injuries may be addressed (Phipps et al., 2017) as individuals have their needs met in healthier, prosocial ways (Seager, 2011a). A PIE is also a constructive environment, meaning it attempts to do more than just contain behaviours. Johnson and Haigh (2010) explain that a PIE uses the innate potential to change inherent in all humans in pursuit of wider goals. For example, within the youth refuge, staff role-model appropriate behaviour, help youth tolerate boundaries, and demonstrate how to self-manage in times of distress to achieve the broader goal of teaching interdependence so that positive outcomes, including permanent housing, can be sustained.

Via supportive relationships with staff and the provision of a 'professional family' (Phipps et al., 2017), youth are encouraged to understand and examine their personal history and collaboratively determine the unique function of their specific behaviours of concern. Once the underlying need/s that drive their maladaptive behaviours are understood and agreed upon, a tailored, empathic response is developed to facilitate engagement, provide psychoeducation, and reduce further harm or isolation. For example, for youth who self-harm, these behaviours are seen as an attempt to express

emotions like anger, sadness, or pain. Workers reflect this formulation to the young person, agree on the function of said behaviour (self-expression, connection seeking), and then create a plan to develop emotion regulation and help-seeking skills so that more prosocial, constructive ways of expression can be implemented in future (e.g., asking for help, expressing emotions clearly). Ultimately, through these actions, a PIE attempts to offer a familial type setting where typically developing teenagers are usually offered such skills (Phipps et al., 2017; Seager, 2011a). This is the 'therapeutic community' aspect of the model and why relationships are the key ingredient of a PIE's success.

The How of a PIE

Core Principles of a PIE

From inception, the definition of a PIE was never specific so that it could be adapted and localised to suit any setting or context (Johnson, 2017). Rather than being a manualised or prescriptive program, a PIE framework asks service providers to view situations through a psychologically informed lens to inform their practice choices (Johnson & Haigh, 2010). It is dynamic, needs-based, and individualised, resulting in its application being unique for each participant. This flexibility can result in the perception that the framework is ambiguous and/or inconsistent. Such a view can be reinforced by a common trap for those who use a PIE, whereby the policies of the organisation are prioritised over the needs of the individual. This can be seen in situations where a young person must abide by the rules which are applied consistently versus consistently adapting rules to flex for the needs of specific individuals. Hence, staff recruitment and training are important as users of the framework must be highly adaptable and needs-focused versus rigid, methodical, and rules-based.

A PIE's principles apply to youth, staff, and visitors of the refuge, meaning all individuals within the community are afforded the same psychologically informed, needs-based responses. For example, a staff member who is observed to be punitive with youth which results in negative outcomes will be offered the same opportunity to formulate about the reasons for their response in the context of their working life, leading to the opportunity to reshape their behaviour through psychoeducation and reflection. This process is no different to that afforded to youth with behaviours of concern. The overall social climate of a PIE can thus be defined as a 'learning environment' where all individuals are continually reflecting on and reshaping their behaviours in the pursuit of better connections and increased ability to meet their socioemotional needs more productively.

A 'needs-based' framework means a PIE prioritises meeting individuals' immediate physical and socioemotional needs so that they can meaningfully engage in support, regardless of diagnosis or background. Every human has needs at any given time, even if those needs could be labelled maladaptive, e.g., avoiding relationships from fear. As such, a PIE does not rely on diagnostic labels as they can be reductive and provide little practical assistance for multi-disciplinary teams which may include a range of training modalities, expertise, and experience, such as occupational therapists, psychologists, social workers, and support workers. Moving away from diagnostic labels (which require specific training and therapeutic knowledge) to focus on immediate needs gives staff from these varied backgrounds a common language and frame with which to upskill young people and help educate them to find other ways of meeting their needs that are less maladaptive and more likely to achieve their self-identified goals. Staff working within a PIE are thus encouraged to see behaviour as communication, and to ask others directly what their needs are rather than assuming a diagnosis will provide this context.

The application of a PIE within youth refuge is case management combined with informal social support. As the primary function of a PIE is not therapeutic treatment, staff focus only on 'changing' behaviours as needed to achieve goals. For example, increasing an individual's ability to speak with real estate agents to obtain housing, not to change any underlying psychological disorder. Young people are asked to reflect on their unique processes, e.g., what barriers prevent them from achieving their goal and how might we prevent these barriers, rather than focusing on the aetiology of their disorder and how they might change it more broadly as occurs in psychological treatment.

'Psychologically informed' within a PIE does not mean psychological therapy or focus, but rather using emotional intelligence and empathy as connection tools (Keats et al., 2012). Moreover, 'therapeutic' in this context is not about clinical intervention but about the environment and the relationships that are built and sustained within this environment that can support young people to meet their individualised needs. For some young people, this may involve more clinical approaches. If that is the case, they are supported to engage with the relevant professionals. Overall, however, the therapeutic elements of a PIE exist within the way staff approach their work with young people, the way they relate to each other and the young people, and the way that young people are supported to identify and meet their needs to increase their wellbeing.

Within this relational, needs-based, learning environment, the five key principles of a PIE are: (1) *relationships, rules, responsiveness, and roles; (2) physical and social spaces; (3) learning and enquiry; (4) staff support and training;* and *(5) psychological awareness.* These principles are embedded within all policies, procedures, physical spaces, and interactions between peers, workers and residents, and individuals and the organisation.

Building Trusting, Responsive, and Supportive Relationships.

> "Rather than seeing the management or staff role as simply trying to contain, control or even manage behaviours, their main role is to encourage the capacity to self-manage" (Keats et al., 2012, p.24).

Relationships are fundamental change agents within a PIE as it is through relationships that maladaptive behaviours and responses can be relearned and reshaped – all behaviours, whether helpful or unhelpful, are viewed as learnt behaviours that have been reinforced by individuals' circumstances and socialisation (Cockersell, 2011; Williamson, 2018a; Williamson & Taylor, 2015). 'Elastic tolerance' is employed whereby individuals are offered understanding and the opportunity to change rather than exclusion and rejection through service withdrawal. This 'empathic discipline' is used to meet the needs of the young person rather than to decrease staff frustration and/or promote organisational ideals (Seager, 201b). For instance, a young person who swears at staff each time they are told they cannot access the kitchen is understood to have been denied the opportunity to learn distress tolerance through firm boundary setting within their developmental history. Within the safety of trusting and caring relationships with staff, this young person can have their behaviour of concern explained, clarified, and understood without judgement, punishment, or harm. New, more constructive, prosocial behaviours can be explored, modelled, and tested. Ownership of behaviour is promoted, and the unequal power dynamics between staff and youth are considered and named as appropriate (Breedvelt, 2016). Praise and positive reinforcement of new behaviours is frequently given to promote change which has been shown to be effective when working with youth (Krabbenborg et al., 2017). Using a developmental approach, it is also understood that it takes time to change learned behaviour (Seager, 2011b), thus staff are gentle and offer reminders and further support where needed for as long as needed. The purpose of change is reinforced, and the reward for change is learning how to have one's needs met successfully and more easily than before, which in turn increases competence and autonomy, both known buffers against psychological distress (Krabbenborg et al., 2017).

As trust in relationships is paramount, young people are reminded where appropriate that staff share information about them, and that the reason for this is to offer the highest level of care, support, and safety possible. Thus, the entire 24/7 staffing group support each young person and are invested in their development, not just one 'key worker'. While each individual does have one case manager who coordinates their care, referrals and develops a case plan, relevant information is also shared throughout the team in weekly meetings, via formal case notes, and within a 'continuity log' which logs entries and exits to the refuge, casual reminders (e.g., X needs to be at school by 8am) and informal interactions that are not suitable for more formal case notes (e.g., X asked for milk). The 'continuity log' allows for the 'therapeutic community' - a sense of connectedness and safety as each member shares their observations, interactions, as well as promises made to the residents to ensure these

are delivered. By remaining connected, open, and inclusive in this way, the team can work as one rather than as separate components unaware of what the other is doing. A flat working hierarchy is also created as every viewpoint counts, further reinforcing that the entire staffing team supports each young person. All these elements work together to build consistency and predictability of approach for residents which increases physical and psychological safety for all (Benson & Brennan, 2008; Conradi & Wilson, 2010).

Elastic tolerance does not mean there are no consequences for behaviour. Behaviours that breach community responsibilities (alcohol or drug use on-site) or that harm or endanger others (physical or sexual assault) may lead to service 'timeouts'. Self-care planning for how to manage during the timeout is offered (e.g., what to do if distressed) and accommodation is provided locally for the prescribed timeout period. It is important that the *behaviour* is rejected and not the *person*. As such, at no point is support withdrawn – the individual cannot reside on-site but is welcome to contact the service or to seek support from their case manager where they will be greeted warmly and helped as before.

Responsiveness is also a key element of these relationships' success, and that of the organisation. Aligned with trauma-informed principles, the organisation tries to deliberately notice the ways policies, procedures, guidelines, and practice may inadvertently oppress, disempower, or recreate maladaptive relational patterns and then changes these (Krause et al., 2018). For example, referral pathways are scrutinised, with advocacy to remove exclusionary criteria or lengthy referral requirements. Where possible, collaboration between services is sought and services provided in-house to remove hurdles for engagement. This includes 'drop-in' visits whereby a specialised staff member from another service (e.g., a registered nurse) bases themselves within the refuge to expediate support and increase connection. Rules and processes are challenged by staff and residents, with the former having the added responsibility of understanding the reasoning behind each expectation placed on a resident. Team meetings are utilised to question and assess staff motivation for practice choices, and to highlight relational patterns or organisational requirements that may be driving support decisions as opposed to the needs of young people. As Johnson and Haigh (2010, p. 32) explain, "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."

Creating Safe and Welcoming Physical Spaces that Facilitate Social Connection

Physical spaces should allow for differing levels of social interaction that can be independently chosen (Breedvelt, 2016). This means spaces where individuals can choose to interact formally or informally with others but that can also be easily exited to facilitate safety and privacy. This requirement extends to staff who need uninterrupted workspaces to not only uphold confidentiality but to also allow for breaks and places where they can recharge or seek peer consultation separate from those they support. Service user input into design, decoration and improvements is sought and applied where practical, and space is given for individual expression. When assessing any space, individuals are encouraged to ask, "Would I want to live here?" then make improvements as necessary. Colours are muted and soothing, and trauma-informed design principles are adhered to as much as possible (Owen & Crane, 2022).

Staff Training and Support.

Staff are provided with training to enable a deep understanding of young peoples' presentations as unmet psychological and socioemotional needs. Consistency in these formulations is critical (Seager, 2011b). Staff are also offered training in soft skills (e.g., emotional intelligence, active listening) and various basic psychological techniques so that they can offer creative and individualised responses to behaviours of concern. The type of training is locally chosen – there is no prescription for certain psychological techniques to be applied, hence training can be as dynamic and needs-based as the support offered within a PIE. Training is also provided to develop self-

awareness of the impact of staff's own assumptions, theories, and beliefs on their practice, and regular reflective practice plays a key role in developing this understanding. As all individuals within a PIE are offered needs-based, trauma-informed care, staff support through supervision and peer consultations are central to the model. The ways that staff are supported can be tailored to suit local conditions and staff choice, promoting the needs of safety, autonomy, and nurturance.

Cultivating Psychological Awareness

Psychological awareness is demonstrated through appropriate psychologically informed approaches. These approaches are not limited to a particular theoretical model, and multiple approaches can be used simultaneously. Various approaches have been incorporated into PIEs including psychodynamic, humanistic, and cognitive-behavioural therapy approaches (Breedvelt, 2016). As mentioned previously, the main purpose of psychological awareness is to support trauma-informed, socio-ecological formulations of behaviours that discourage the use of simplistic diagnostic labels and instead view individuals holistically, asking 'what has this young person *experienced* that may lead to them acting and feeling this way?' rather than 'what is wrong with them?' (Bransford & Cole, 2019; Krause et al., 2018). Regardless of the applied theoretical approach, responses to youth need to be consistent, dynamic, and creative (Cockersell, 2011). Moreover, psychological approaches should be constructive, user-friendly and facilitate skill-building such that individuals can grow and or/heal (Johnson & Haigh, 2011).

Learning and Enquiry

A key question within a PIE is "What do you need?" and readily applies to staff, the organisation, and the individuals they support. The answer to this question informs all worker and organisation responses. More formal evaluation also occurs at three levels: (1) policy level measures defined by government or funding organisations; (2) service level measures; and (3) individual measures. How formal evaluations are conducted will differ across services based on funder requirements, service outcomes, and service knowledge and resources, however key performance indicators should be measured to ensure that the service is achieving its aims. Youth participation is vital here: youth are the experts in their care, thus obtaining feedback from residents is crucial to ensure the organisation continues to do what works and stops what doesn't.

All five principles are sustained using 'reflective practice' which are dedicated moments of time where workers pause and reflect on their practice and the organisation, the needs of youth and any potential function of the behaviours they utilise, and what, in terms of service delivery and response, can be offered and/or improved to meet these needs. This reflection can occur in structured supervision (either with peers or individually) however staff are also encouraged to incorporate reflection in conversations with peers, within management, and in personal moments of self-reflection. Ingrained reflection is modelled within team meetings whereby staff ask each other to consider the histories, experiences and motivations of youth when determining how best to provide support.

In summary, a PIE service aims to not only provide material aid and housing, but to offer youth the opportunity to strengthen their self-worth, develop emotional intelligence, embrace their identity, and feel a sense of connection to their peers and chosen community. Staff accept and promote this enhanced purpose (Seager, 2011b). Through the development of collaborative, caring and trusting relationships which model unconditional positive regard and non-judgemental problem-solving, staff guide young people to achieve their personal goals and simultaneously develop into autonomous, skilful, self-regulated adults.

Theoretical frameworks

Whilst a PIE is theoretically flexible, this paper argues there are certain fundamental theories that define a PIE regardless of context. Whilst services may choose to use different psychological techniques to influence change (mindfulness, mentalisation), the underlying ideas that inform a PIE remain unchanged. Relationships are always seen as the vehicle of change; thus, attachment theory informs all

services that claim to use a PIE. A PIE is always a living-learning environment; hence a social learning theory will always be relevant. A PIE always aims to holistically understand an individuals' behaviour; hence a psychodynamic approach is relevant. *What* is a PIE remains consistent; *how* a PIE is delivered is what differs. This paper proposes the following theories as the *what* of a PIE which are then expanded with different techniques and approaches to explain *how* a service practices a PIE. For example, a PIE always highlights that physical spaces are important. What decor one service chooses to use versus another does not make a PIE. The decor functions in the same way – to fulfill the principle of physical spaces, which is informed by Social Cognitive Theory (SCT; Bandura 1999) whereby social environments impact individuals and behaviour. The theory does not vary; the expression of it does.

Attachment Theory

Attachment styles have been found to influence therapeutic processes and outcomes (Bucci et al., 2015) and overall health is founded upon nurturing relationships and community (Seager, 2012). Attachment theory posits that healthy psychosocial functioning requires a secure attachment to a key caregiver. Secure attachment is developed through the caregiver: (1) providing a safe base from which to explore; (2) being available and flexible; (3) being sensitive and responsive to psychosocial and physical needs; and (4) intervening when needed (Bowlby, 1977). The principles of attachment therefore offer organisations a template from which to shape their role – just like infants use the primary caregiver as a secure base and safe haven from which to explore the world, and return to them in times of hurt, distress or need (Ainsworth & Bowlby, 1991), so too can an organisation and its staff provide a secure attachment. Separation from primary attachment figures – which occurs when adolescents are expelled from home, regardless of reason – promotes the need for new attachments (Reid, 2018; Schuengel & Ijzendoorn, 2001). To successfully engage and become a new secure base, services must first understand differing attachment styles and how to offer sensitive and responsive care to individuals who often find relationships and accepting care difficult. Attachment styles can then be altered in response to this alternative, secure support (Reid, 2018).

Secure attachment to the service is desired as it has also been shown that individuals have a natural disposition to comply with the wishes of a primary attachment figure: if an individual receives sensitive and responsive care, this natural disposition is strengthened. If punitive discipline or training is given, these measures decrease this natural cooperation (Ainsworth & Bowlby, 1991). Thus, services who offer responsive, sensitive care will foster a desire to engage and collaborate in their consumers (and management can foster this within a staffing group). Youth within refuge with better caregiver relationships respond quicker to intervention, engage in more help-seeking behaviour (Heinze, 2013) and are better able to reintegrate into society (Stefanidis et al., 1992). Understanding attachment processes can assist youth to 'attach' to new supports and engage in help, and the positive relationships that then ensue can lead to many protective benefits (Reid, 2018).

Core Emotional Needs Model (CNM)

Attachment theory proposes that, to build a secure attachment, an individuals' physical and psychosocial needs must be met, so understanding what these needs are is integral. The core needs model (CNM) within Schema Therapy posits that psychological, emotional, and interpersonal difficulties arise when universal needs are unmet (Young et al., 2006). These universal needs are defined as: (1) fostering connection through the provision of safety, stability, nurturance, and acceptance; (2) autonomy, competence, and a sense of identity; (3) freedom to express valid needs and emotions; (4) spontaneity and play; and (5) realistic limits and self-control. For example, growing up within a family where the need for realistic limits was not met as no limits were enforced can result in entitlement, inability to tolerate boundaries, and a lack of consideration of others, which then, if not corrected, becomes a pervasive emotional and behavioural pattern. Similarly, if too many limits are imposed, the individual may rebel which results in insufficient self-control from a lack of self-discipline (Lockwood & Perris, 2012). Positive changes within individuals are enacted

and strong working alliances formed when therapists meet these core needs for clients, and in turn help them see the importance of meeting these needs for themselves through more prosocial, constructive behaviour (Dadomo et al., 2016; Young et al., 2006). The entitled individual is taught to consider the needs of others, resulting in better attachments, leading to less desire to engage in entitled behaviours. The CNM has strong empirical support when working with individuals with attachment-based concerns, especially borderline personality disorder (Lockwood & Perris, 2012; Young et al., 2006). Considering most, if not all, youth experiencing homelessness have some type of attachment injury, the CNM suits the refuge cohort. Moreover, maladaptive schemas resulting from unmet needs mirrors findings that demonstrate that entrenched behaviours of concern result in chronic homelessness (Cockersell, 2011); changing these entrenched behaviours by modelling other ways to meet core needs may therefore prevent repeated homelessness.

The CNM is also straightforward and universal, thus easy to apply for workers with differing backgrounds. The inclusion of 'realistic limits' differentiates this model from others, such as the Self-Determination Model (Deci & Ryan, 2008), which focuses on the role of motivation as a driving force in need attainment (see for example, Deci & Ryan, 2000) versus skill development to *constructively* meet needs. All humans will strive to meet needs that are important to them; what is missing for youth with disrupted attachment, traumatic histories, and multiple social deprivation is an understanding of: (1) what their needs are; and (2) how to meet these needs productively. The CNM offers information not only on motivation for behaviour but also how to reshape maladaptive strategies. Once the need is understood, creative and personal strategies can be developed to meet it better. For example, a youth who uses anger and intimidation to meet their need for autonomy can be taught to express themselves assertively instead. Just as attachment representations can be strengthened, so too can maladaptive patterns be rewritten so that future behaviour better serves the individual (and society).

Psychodynamic Theory and Formulation (PF)

Understanding the needs which drive behaviour is important, but so too is understanding what led to the development of the behaviour individuals currently use (or not use) to meet these needs. Psychodynamic theory is suited for this purpose as it is a theory that "addresses the entirety of a person's lived experience" (The Psychodynamic Formulation Collective [PFC], 2022) which aligns with trauma-informed principles. Genetics, attachment style, temperament, family circumstances, discrimination, trauma, inequity, and poverty can all be included in psychodynamic formulation (PF) in conjunction with the CNM to explain why someone currently acts the way they do. Using such a broad range of factors when formulating individuals' behaviour aligns with socioecological models which show that interactions between factors at microsystem, mesosystem, and macrosystem levels all contribute to development of concerns (Brofenbrenner, 1977), including homelessness. Moreover, social work, which is the activity of a PIE, has been explained as a practical profession that "seeks to resolve problems at the individual, relational and society level" (Rasmussen & Salhani, 2010, p. 209) hence gathering knowledge and affecting change at all levels is inherent.

Other ways of formulation, for example cognitive-behavioural theory, focus on microlevel characteristics as the reason for difficulties and situate the need for change at this level only, which research shows is not as effective when working with individuals with complex needs and histories, such as youth experiencing homelessness (FEANTSA, 2017). Moreover, PF sees people as innately capable of change and positions this change within relationships and between people and environments (Cockersell, 2011) – each of these ideas is contained within a core principle of PIE. PF also considers the role of normative adolescent developmental milestones (Sanders, 2013) ensuring that typical teenage milestones are not recorrected at detriment of growth.

Social Cognitive Theory (SCT)

Social Cognitive theory (SCT) explains the influence of individual experiences, the actions of others, and environmental factors on individual behaviour. SCT adds to CNM and PF by focusing on how to change behaviours, which it posits is achieved through instilling expectations, self-efficacy, and using observational learning and other reinforcers. SCT aligns with the previous theories as it states that "human adaptation and change are rooted in social systems", once more acknowledging the importance of quality social interactions for positive change (Bandura, 1999, p.23). SCT sees human behaviour as involving reciprocal interactions between three sets of influences: (1) personal, (e.g., thoughts, beliefs, values); (2) behavioural; and (3) social/environment factors.

Bandura (1999) proposes that individuals are both an agent for change and a responder to change. Individuals exist in imposed physical and sociostructural environments, however, do have some agency over how they interpret and react to these (Bandura, 1999). Punishing or rewarding aspects of environments are activated based on how people behave, and individuals therefore construct social environments and their level of involvement with institutional systems based on their actions. These situations then affect the individual personally, which in turn affects their behaviour, which in turn impacts the environment, and so on, in a cyclical and mutually reinforcing loop. SCT is therefore suited to a PIE as it enhances understanding of why an individual may choose to act as they do, what the environment may be promoting, and what can be done to change behaviour. This type of reflection is also trauma informed as it: (1) encourages empowerment of individuals by highlighting what they can do to enact change, both in themselves and their environments; and (2) requires reflection by the organisation on itself and the actions of those within it and how these factors contribute to interactions with youth rather than focusing solely on microlevel factors.

Individuals wanting to affect change in behaviour need to consider not only what the environment promotes, but what the individual may think about the behaviour desired. 'Personal agency' is the capacity to control thought processes, motivation, emotion, and action for specific intentions (Bandura, 1999). People think about where their actions are likely to lead (or need to think in this way) to produce intended results. For example, if an individual thinks that their behaviour will get them what they desire, they will continue the behaviour, even if punished. However, punishment will be a deterrent when the individual thinks their behaviour won't produce what they need (Bandura, 1999). Within the context of a PIE, timeouts from the refuge for unacceptable behaviour cannot be negotiated or the message to the individual is 'the behaviour does not really matter' therefore the environment will not affect the desired change. Other ways to enact change within SCT include examples from role models and reinforcements, both of which are elements of caring, trusting relationships with staff. Furthermore, Bandura (1999) believed that individuals attempting to realise a goal guide and motivate their efforts through: (1) appraisal of personal capability; (2) choosing an overall goal that is achieved through subgoals; (3) positive and negative outcome expectations; (4) the value placed on the outcome; and (5) perceived environmental constraints and opportunities. Change is created by interacting with each of these mechanisms to increase an individual's overall self-efficacy, which mirrors case management practice which is the application of a PIE.

Transtheoretical Model of Change (TMC)

TMC builds on SCT by examining *when* people will make behaviour changes. TMC explains that individuals progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska & Velicer, 1997). Each stage requires stage-matched intervention, and change is seen as a process through which individuals may proceed in a non-linear way versus one discrete step. The TMC suits the developmental stage of adolescence where milestones for typical development include experimentation and frequent changes in self-identity and goals (Sanders, 2013). TMC reminds workers that adolescents may flip between stages on some behaviours whilst improving overall.

Why a PIE: Implications for Practice

Consumer Impact

Cockersell (2016) highlights that the first 'outcome' of any service that works with individuals with compound trauma, attachment injuries, and multiple social deprivation is to help people want to engage with services at all. Before any other outcome can be achieved, engagement and containment in support is necessary, as individuals can frequently display a high level of urgent need coupled with a reluctance to engage with support (Williamson, 2018a). PIE recipients were found to use help and services better than non-PIE receivers, with increased rates of therapeutic participation (Cockersell, 2016). Williamson and Taylor (2015) successfully used a PIE to engage 70% of residents in a hostel in mental health treatment, with many then attending mainstream physical and mental health services for the first time. Cockersell (2016) also noted increased positive engagement with other health services, suggesting a change in help-seeking attitude within PIE recipients themselves.

Moreover, PIEs decreased the rate of evictions and increased positive exit outcomes (Cockersell, 2016) meaning individuals tolerated help for longer. Similarly, Williamson (2018a) noted that when support was tailored and informed by a relational understanding, individuals previously thought of as 'treatment resistant' would engage. These increased rates of help-seeking resulted in positive mental health outcomes, decreased aggression, reduction in criminal justice and emergency services contact, reduced alcohol and substance use, and sustained housing placements meaning reduced homelessness episodes (Cockersell, 2016; Williamson, 2018a; Williamson & Taylor, 2015). Furthermore, individuals within a PIE described the environment as "different and better" than other non-PIE hostels (Phipps et al., 2017, p.77).

Staff Impact

Staff working with individuals experiencing homelessness witness a high occurrence of mental health issues, negative self-perceptions, and rates of trauma in the individuals they serve (Benson & Brennan, 2018). High rates of burnout and vicarious trauma for staff are therefore common (Peters et al., 2020; Reid, 2018). Despite working within these demanding conditions (see Peters et al., 2020), researchers have found that staff working within a PIE framework reported increased confidence in their abilities, a more empathic understanding of their consumers (Benson & Brennan, 2018; Reid, 2018), and a strengthened capacity to manage safe, positive, and developmental relationships (Cockersell, 2016). Staff felt PIEs improved staff/management relations as well as client/staff ones (Cockersell, 2016). Staff reported increased engagement between workers and service users (Williamson, 2018b) and increased motivation within service users (Benson & Brennan, 2018). "A PIE works" was the consensus amongst staff; the framework was perceived as addressing underlying issues for consumers which enhanced positive outcomes leading to increased acceptability and enthusiasm from staff to apply it (Benson & Brennan, 2018, p. 57).

Organisation Impact

A decrease in 'incidents' (i.e., events including violence, ambulance callouts, crisis admissions to hospital) has been demonstrated within PIEs compared to incidents involving consumers in non-PIE provision (Cockersell, 2016; Williamson, 2018a). Youth experiencing homelessness typically have increased mental health concerns, more substance use, and more frequent suicidal ideation than the general population (Benson & Brennan, 2018) yet a PIE environment has been shown to contain these behaviours. Table 1 below provides resident numbers, incident types and rates from a youth refuge that uses a PIE framework in Melbourne, Australia[1]. This data was extracted by the Program Manager (Edmanson, 2023, personal communication) from mandatory incident reporting data that is provided to the funding body (DFFH) as per funding obligations. Despite working with youth with complex and multiple needs, extremely low rates of incidents have

[2] The first author has worked at this youth refuge for 8 years as a clinical psychologist and PIE practice lead. Data have been provided to the first author in a fully de-identified format, with permission from the youth refuge for use in the first author's PhD.

occurred. While further research is needed to understand the mechanisms which create these organisational benefits (and for whom exactly these benefits occur), the data in Table 1 highlight the potential benefits that can be achieved through PIEs.

Table. 1

Resident Numbers, Incident Types and Rates During 2018 – 2022

Year	Residents (*n*)	Incident Type and Number									
		Suicidal ideation reported – no emergency services attendance	Suicide attempt requiring ambulance	Admission to psychiatric hospital	Self-harm requiring medical attention from staff	AOD overdose	Aggression requiring police attendance	Mental health crisis requiring emergency services	Physical assault of staff	Physical assault between residents	Property damage
2018	261	4	1	3	1	4	4	6	0	0	5
2019	245	0	4	4	6	0	2	11	0	0	4
2020	220	1	1	2	1	4	4	6	0	1	2
2021	198	2	2	0	0	4	2	4	1	1	0
2022	186	3	1	4	3	4	1	8	0	0	1
Total	**1110**	**10**	**9**	**13**	**11**	**16**	**13**	**35**	**1**	**2**	**12**

Discussion

There is a lack of theoretical and conceptual explanations of service models for youth refuge and rigorous research of PIEs more broadly. To our knowledge, this is the first paper which has aimed to describe conceptual and theoretical foundations of a PIE framework for youth refuge. As can be seen, PIEs represent a holistic framework for service delivery that operates at the organisational, practice, and interpersonal level, and one which encourages positive changes for all within its environment - consumers, staff and their practice, and the organisation. It is not a prescriptive program nor a theory but is an approach to service provision that is fundamentally grounded in trauma-aware principles. This is an important consideration, given that trauma informed approaches are disappointingly absent from current refuge practice (Jaman et al., under review) despite strong evidence for the need to support youth experiencing homelessness in this way (McCarthy et al., 2020) and widespread recognition that homelessness itself is a trauma (Hopper et al., 2010).

Complex needs can be compounded and exacerbated when young people encounter support services that do not adequately account for the impacts of trauma, leaving individuals feeling powerless and/or controlled (FEANTSA, 2017). These needs can also be deepened by services who do not provide needs-based care and who lack the ability to accommodate different experiences, as this can lead to an 'inverse care law' whereby those who need the most care receive the least support (Rosengard et al., 2007) and/or care received is inappropriate or insufficiently holistic to be effective (Cornes et al., 2011). People facing multiple disadvantage (i.e., homelessness, drug and alcohol misuse, poor mental health) often have the lowest rates of contact with mental health and primary care services (Bramley et al., 2020; Dobson, 2019), repeatedly 'falling through the cracks' as services are ill-equipped to address trauma and multiple needs (McCarthy et al., 2020). Hence, tailored, holistic, dynamic, and needs-responsive services which view trauma in the landscape of an individual's life whilst also considering socio-ecological reasons for their homelessness are urgently needed. Such services have the potential

to meaningfully reduce and potentially eliminate youth homelessness, however they require well elucidated practice models tested with robust research before evidence-based practice and understanding can increase. Currently, whilst there is recognition that there needs to be more robust literature on 'what works for whom', this research remains scarce (Bramley et al., 2020). This paper argues that the first step in increasing this knowledge base is understanding and explaining the frameworks that can underpin it.

Further, it is important to understand the core theories that underpin a PIE as these theories provide the framework for understanding young peoples' behavioural, emotional, and psychological patterns and which responses can guide services to effectively intervene. Two key factors appear to unite each of the theories discussed: (1) relationships are central to trauma and healing from trauma; and (2) 'maladaptive behaviour' is best understood as an attempt to fulfill unmet, universal needs. When viewed in these ways, the theoretical frameworks that inform PIEs provide insights not only into the presenting difficulties for youth that impact on sustainable, positive outcomes, but also the most appropriate and effective ways to intervene to address these challenges, and to create short- and long-term change. Service provision needs to move away from 'quick fix', unidimensional, pathologizing interventions, which have been shown to exclude those most in need (Rosengard et al., 2007) and move towards interventions that can offer parallel psychological and practice service provision (such as PIEs [Williamson, 2018a]) and which can address the multi-directional relationship between homelessness and trauma (Hopper et al., 2010). As Williamson (2018a, p. 150) explains, "interventions can often be in danger of targeting symptoms…when what needs to be addressed is a developmental and relational problem".

Conclusion

PIEs provide a conceptually rich and theoretically informed framework for youth refuge that moves beyond one-size-fits-all models and a focus on psychopathology. Understanding the pervasive impacts of interpersonal trauma – particularly during adolescence – on psychological and psychosocial adjustment necessitates a complete shift from dominant practice. Providing youth with safe, stable, nurturing relationships within supportive environments is a necessary first step in helping to eliminate youth homelessness. Without such relationships, the impacts of trauma will continue to express in 'maladaptive' or harmful behaviours that further entrench homelessness and perpetuate cycles of disadvantage and despair. When youth refuge is genuinely trauma-aware – through the implementation of PIEs for example – young people experiencing homelessness become empowered to meet their fundamental and universal needs in ways that are less likely to perpetuate and compound their trauma, leading to many protective benefits.

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