



School of Psychology



Cognitive and behavioural therapeutic interventions to tackle homelessness

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Introduction

Homelessness is a social problem that has a major impact, both on society as a whole and the individuals concerned. While a common perception of a homeless person is of someone sleeping rough, there are a number of other situations in which people can be described as insecurely housed and/or at risk of homelessness, such as living in a hostel, 'sofa surfing' and staying with friends or family, usually for short periods of time.

Although the government and its stakeholders achieved the target to reduce rough sleeping by two thirds by April 2002, there remains an insecurely housed population, many of whom have drug, alcohol or mental health problems and who are at risk of rough sleeping. There is also evidence of some people having difficulty maintaining tenancies because of anti social behaviour, which is being tackled through the Government's Respect Task Force.

This discussion paper attempts to highlight the links between mental health problems and homelessness, and describes a pattern of cognitive, emotional and behavioural difficulties which leads to repeated tenancy breakdown and homelessness. It offers some solutions to tackling homelessness, which can be incorporated into work on homelessness resolution and prevention. It attempts to offer suggestions for pathways out of homelessness, detailing the implicated cognitive, emotional and behavioural factors and ties this to individual developmental experience. As such it is presented within frameworks associated with Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT), with reference to attachment processes.

Two categories of serious and enduring mental health problems will be discussed in detail. First, the psychotic disorders (i.e. those associated with the diagnosis of schizophrenia), and second, the personality disorders (PD) will be considered. For the purposes of this discussion, PD will be considered as a mental health problem, despite the 'treatability clause' associated with the 1983 Mental Health Act (this is discussed in more detail below).

Current policy

Current government policy focuses on tackling and preventing homelessness as early as possible, through a combination of housing advice, tools such as mediation or rent deposits and housing related support funded through the Supporting People (SP) programme. However SP excludes financial support for therapeutic services, such as psychotherapeutic input.

The £90 million Hostels Capital Improvement Programme (HCIP) currently in place aims to make hostels places of change rather than containment. It focuses on ensuring that homeless people are given the opportunity to change their expectations and their lives, through access to a range of services, which could include psychotherapeutic interventions where available and appropriate.

There is evidence that unless the underlying causes of homelessness, such as drug or alcohol misuse, anti social or violent behaviour or mental health problems are tackled, some people will continue to be at risk of rough sleeping or of repeatedly losing their accommodation. There is also evidence of a link between mental health problems and substance misuse, with some people using drugs and alcohol to 'self medicate'.

Mental health and homelessness

A significant factor contributing to someone becoming homeless is mental health problems, many of which remain undiagnosed. The prevalence of psychotic disorders in the homeless population (i.e. those associated with diagnoses such as schizophrenia) varies between 4 and 40 per cent, depending on assessment methods and populations investigated. There is no published literature describing the prevalence of personality disorders, although an unpublished doctoral thesis found that 59 per cent of a hostel population reached diagnostic levels. The lack of research data may be partly due to the difficulties in diagnosis and treatment, but may also be due to the 'treatability' clause still in operation due to the 1983 Mental Health Act. This states that any patients to be 'sectioned' under the Act must be 'treatable', meaning that individuals diagnosed with a PD could not be sectioned as an inpatient solely due to their diagnosis as PD was not deemed

treatable when the Act was published. It is useful to consider PD as a serious and enduring mental health problem, which can have long-term negative effects on the way in which a person interacts with their environment.

Other mental health problems that may be implicated are Post Traumatic Stress Disorder (PTSD), anxiety and depression, in addition to drug and alcohol problems. PD is characterised by a number of emotional, cognitive and behavioural factors which can be seen to contribute to repeated tenancy breakdown.

The diagnostic criteria for Borderline Personality Disorder (BPD) are particularly useful when considering such factors. The following are the diagnostic criteria associated with BPD set out by the North American Diagnostic and Statistical Manual (DSM):

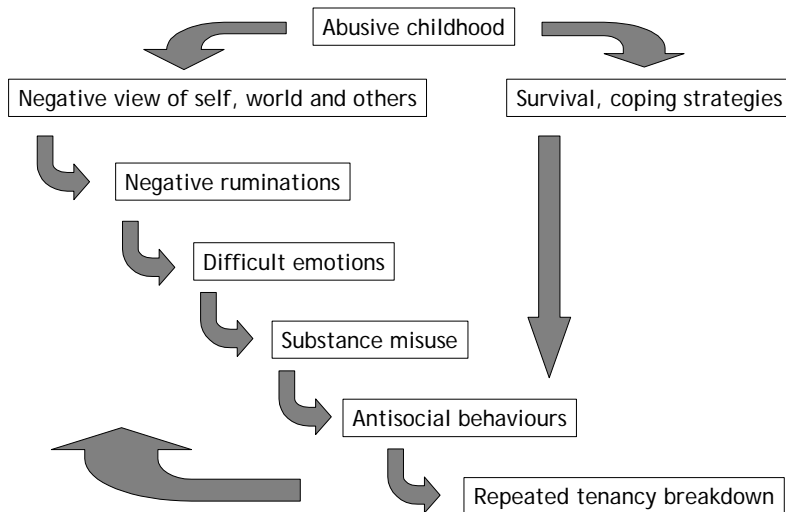
1. A pattern of intense and unstable interpersonal relationships
2. Frantic efforts to avoid real or imagined abandonment
3. Identity disturbance or problems with sense of self
4. Impulsive behaviour that is potentially self-damaging
5. Recurrent suicidal or parasuicidal behaviours
6. Affective (emotional) instability
7. Chronic feelings of emptiness
8. Inappropriate or uncontrollable anger
9. Transient stress-related paranoid ideation or severe dissociative symptoms (i.e. paranoia induced by stress, and 'dissociation' - a process of 'removing' oneself from reality typically learned during episodes of early abuse)

Observations indicate that a proportion of homeless people, particularly rough sleepers or those living in hostels or night shelters, exhibit behaviours which frequently result in eviction. Typically, this is behaviour which contravenes the rules of the establishment, e.g. consuming alcohol on the premises or returning obviously intoxicated, owning, obtaining, or consuming illegal substances and violent or aggressive behaviours. These latter behaviours can be functionally related to forms of substance abuse, e.g. to obtain substances or as a result of ingesting them.

These behaviours can be seen to be similar to a number of behavioural factors associated with personality disorders. It is argued that most of these can be traced to abusive experiences in critical developmental stages, i.e. childhood and adolescence. There is evidence of an association between having been brought up in care and later homelessness. Additionally clinical observations indicate a high prevalence of early neglect and abuse in the homeless population.

It is being proposed here that repeated tenancy breakdown and eviction can be formulated, taking into account a number of individual historical, cognitive, emotional and behavioural factors. These are described in the diagram below, drawn up by the first author.

Possible pathway to homelessness



Early abusive experiences can result in difficult thought processes and rumination and concomitant intolerable emotions. The easiest method of altering these in the short-term at least is to take some form of substance, i.e. drugs or alcohol. This is more likely to happen when skills in regulating emotion have not been learnt in childhood. These, in combination with aggressive behaviours learnt in childhood and adolescence, result in antisocial behaviours and repeated tenancy breakdown. Where more adaptive interpersonal skills have not been learnt, more destructive ones which have previously been successful to some extent (e.g. aggression) are used.

Therapeutic interventions

In the last twenty years a great deal of progress has been made in terms of the treatment of severe mental health problems, particularly those associated with Cognitive Behaviour Therapy (CBT) and its variants. The research examining cognitive models and treatment of psychosis in particular have progressed to such an extent that the National Institute of Clinical Excellence (NICE) recommends that CBT should be a treatment option for those with suffering schizophrenia along with medication.

The research literature examining models and treatment of personality disorders has not been so fruitful. The evidence so far is mixed in terms of its findings regarding personality disorders generally. Methodological, design, population and research setting problems mean that definitive conclusions can not yet be made. There is however some evidence that a variant of behavioural therapy, Dialectical Behavioural Therapy (DBT) is effective in reducing self-harming behaviours of those suffering borderline personality disorder (NICE now recommends DBT as a psychological treatment for borderline personality disorder).

Supervision

The problems that people within the homelessness population suffer are complex and often of an interpersonal nature. This means that interpersonal interactions can be difficult due to inherent ambiguities in human communication and sensitivities of clients associated with childhood neglect and abuse. Some may interpret others' attitudes as rejecting and neglectful easily, and become depressive or angry, behaving accordingly.

Frontline workers are expected to deal first hand with such difficult interactions, without the aid of taught psychological skills and frameworks to work with. Frameworks and methods of working with interpersonal difficulties are best learnt through case discussion in a group format. There should be ongoing clinical supervision, provided regularly (e.g. once every fortnight) and facilitated by a qualified practitioner.

In addition, supervision within a Cognitive Behavioural framework focuses on facilitating workers to enable cognitive, emotional and behavioural change, and deal with the difficult interactions which are inevitably experienced. These are described in terms of the beliefs about the interactions, and associated emotions. For example many staff have thoughts about not being effective when clients relapse in terms of a particular behaviour that has been worked on. These beliefs are made explicit and alternative thoughts about what is happening developed. One possible outcome of regularly attending to staff clinical practice and emotions is fewer staff experiencing burnout and less staff turnover. This may save money in the long term.

The Southampton experience

Single men's homelessness CBT project

In Southampton between 2001 and 2004 a project to deal with clients who had proved most difficult to maintain in tenancies was commissioned, funded through

the then Homelessness Directorate. This was a four bed house (leased from a local housing association) with dedicated support workers provided by a local homelessness charity (Society of St James), and psychologist time bought from the local NHS trust. In addition to the Society of St James and NHS Trust, Southampton City Council and Rough Sleepers Initiative (now Southampton Street Homeless Prevention Team) were involved in the collaboration. The arrangement of tenancies meant that clients with greater difficulties could be taken on, and typical referrals were people who had been evicted from all or most other projects in the city, had poly-drug and alcohol abuse issues, some having prison records.

The psychologist provided CBT input for two and a half days a week, comprising individual sessions with residents and group supervision with support workers. Attempts were also made to engage clients in the running of the house through house meetings.

Between Sept 2001 and April 2004, 23 people were resident in the project. Fourteen of these had previously been street homeless, two came straight from prison, two were street homeless and referred via the local detox unit, and five came from direct access hostels, having been evicted.

The average stay for all clients was 17.5 weeks (range 2 - 62 weeks). In terms of move-on, nine went to their own residence, three went to residences out of area, two were referred back to direct access hostels, three went back to prison, two moved away and lost contact, and two returned to street homelessness. Two clients were murdered, one after having left the project and one shortly after having moved in.

The project and psychological therapy was effective in terms of enabling 14 out of the 23 clients to find and sustain accommodation, despite their previous history of repeat homelessness. The rest were either difficult to engage and / or their continued antisocial behaviours resulted in eviction.

DBT and domestic violence project

A joint project between Hampshire Partnership NHS Trust and Women's Aid was funded by the Homelessness Directorate to find ways of preventing repeat homelessness in women who have experienced domestic violence.

The project tested the idea that if the women involved could feel more in control of their lives they would be more able to solve day to day problems and hence be more able to maintain their tenancies. The project used a short-term group based

on DBT. DBT is a therapeutic intervention which focuses on teaching skills such as managing emotions, problem solving, distress tolerance and assertiveness.

The project comprised a 12 week group for the women and training for the staff at Women's Aid so that they could continue to support the women both between sessions and after the group had finished.

Results from the group showed improvements in self-esteem, mood and feelings of control. Comments from the women themselves suggested that the group was well received, and that they found they could deal with problems and negotiate with professionals and systems more effectively. Almost half of the group members moved out from the hostel during the course of the group and were able to establish themselves independently. There was no evidence that any of the women went back into their abusive situations.

Developing ways in which such groups could become more readily available is the challenge of the future. Training the staff of the hostel to provide the intervention is one way forward, but requires time and ongoing supervision if it is to be successful. However, such therapeutic approaches have wide ranging benefits for those who go through them and could in the long term be very cost effective in preventing the cycles of behaviour which keep people stuck and dependent on services.

Implications

Both CBT and DBT have been successfully used alongside Supporting People and other services within some hostels to enable highly chaotic people to find and keep accommodation. This has led to greater access to other services such as detox and has also led to reduced numbers of people rough sleeping.

However the schemes have identified a number of key issues which need to be addressed by agencies wishing to commission similar services:

- Thought must be given to the type of property and tenancy agreement made available to clients of the service.
- Because of the chaotic nature of many of the clients, services should be provided within the accommodation rather than through traditional out patient services.
- Levels of engagement can vary considerably and services must be flexible enough to manage this.

- Hostel staff must be offered training in the CBT/DBT approach (as opposed to delivery of the therapy) so that they have an understanding of the models and can reinforce key messages consistently. This may be difficult to sustain, given the traditionally high staff turn-over rates in the sector.
- This is a challenging client group to work with, and staff can feel frustrated and demoralised on occasions. Support must be made available to ensure that staff avoid 'burn out' and maintain motivation.
- Additional funding has to be identified for psychotherapeutic services, and this can be difficult. It is particularly important as access to local mental health provision (e.g. community mental health teams) is extremely limited, partly due to limited access to primary care and therefore referral but also because of a shortage of therapists. Even those who do access secondary and tertiary care are unlikely to be offered psychological therapies if they are currently using substances or alcohol. It could be that this would be a fruitful area for investment in primary care psychology for Primary Care Trusts to consider.
- Identifying shared outcomes such as a reduction in the use of A&E and mental health crisis services / admissions, reduced re-offending, reduction in anti social behaviour, reduction in evictions, reduced numbers rough sleeping, harm minimisation etc can be an effective way of encouraging multi agency buy-in.

Conclusions

- Undiagnosed and / or untreated severe and enduring mental health problems can contribute to repeated tenancy breakdown and therefore homelessness.
- Psychological therapies have proved an effective intervention for chaotic and challenging clients and have reduced time spent homeless.
- Psychological therapies should be specifically funded and delivered within accommodation rather than through out patient services, to maximise take up and engagement.
- Schemes need to have multi agency involvement, to have clear outcome measures and to be properly evaluated

Useful references

NICE Guidelines, Mental Health: <http://www.nice.org.uk/page.aspx?o=mental>

Many thanks to Angela Jones, DCLG and Oily Alcock, Bristol City for comments on drafts of this paper

December 2006