

# Mental health

## Good practice guide

May 2010

# Meeting the psychological and emotional needs of homeless people


**Non-statutory guidance on dealing with complex psychological and emotional needs from the National Mental Health Development Unit and the Department for Communities and Local Government**




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### Acknowledgments

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# Introduction

## The purpose of the guide

This guide describes effective ways of recognising and meeting the psychological and emotional needs of people who have experienced homelessness, are sleeping rough or living in insecure accommodation, in particular young people and rough sleepers with histories of complex trauma (see below for a definition of **complex trauma**). The guide outlines the national policy context, the research evidence which informs developing practice, and explores the issues for service providers and commissioners.

The guide describes the common psychological problems associated with complex trauma and offers examples of treatment models available. The case studies describe a variety of existing services for rough sleepers and young people which address emotional and psychological problems. These illustrate the wide range of techniques and approaches that are commissioned across the country, with contact details. For further information on any aspect of the guide please contact: [helen.keats@communities.gsi.gov.uk](mailto:helen.keats@communities.gsi.gov.uk)

## Who is this guide for?

The good practice guide is designed to assist:

- Supported accommodation key workers and managers
- Local authority housing options teams and managers
- Supported accommodation providers
- Day centre staff
- NHS homelessness healthcare services
- Social workers
- Drug and alcohol workers
- Prison and probation housing advice staff
- Offender managers
- Assertive outreach teams
- Health staff in A+E departments
- Hospital discharge coordinators
- Psychiatrists and psychologists
- GPs and practice managers
- Health visitors
- Community Psychiatric Nurses (CPNs)
- Local commissioners of housing, health or support services
- Local councillors

**We hope you find it useful.**

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### How to use the guide

The guide is divided into six sections:

#### Section 1: An outline of the key issues

- The national policy context
- Importance of agencies working together
- New research and practice from pilot projects
- Issues for accommodation and support providers
- Importance of well-trained frontline staff
- The Psychologically Informed Environment approach (PIE)
- Drugs and alcohol

#### Section 2: Case studies

There are four groups of wide-ranging case studies showing good practice in action that cover:

- Clinical assessment tools
- Schemes for young people
- High support schemes for adults
- Staff capacity building and support

#### Section 3: Definitions and weblinks

- A look at some of the key definitions of different psychological disorders which can predict homelessness
- Some useful weblinks to give you more information on psychological techniques and approaches

#### Section 4: Guidance and good practice

Some very helpful papers that outline more on The Psychologically Informed Environment (PIE) and reflective practice – as well as some strong stories about individual clients and good practice around the UK.

- The psychologically informed environment (PIE)
- Reflective practice
- Personalisation pilots and invest to save
- CBT Project at Derby Road, Southampton
- The use of medication
- Childhood experiences

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### Section 5: Research

Some key papers (presented in their original form) that offer top-level research to help commissioners explore a wide range of issues surrounding complex trauma.

- Collaboration models for complex trauma and severe social exclusion
- Cognitive and behavioural therapeutic interventions to tackle homelessness – research synopsis
- How psychological factors related to traumatic experience and personality disorder are associated with chronic homelessness – a paper
- Bio-psychosocial influences in complex trauma and repeat homelessness: the evidence base and the implications for future research and practice – a synopsis

### Section 6: Glossary

Acronyms spelled out.

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## Section 1: An outline of the key issues

The causes of homelessness can be complex. For some people it may result from social or mental health difficulties, often undiagnosed. Tackling homelessness effectively for these groups will require agencies integrating accommodation with psychologically informed health and support services.

Recent research suggests that behaviour which can increase the likelihood of homelessness may be associated with mental health problems such as:

- personality disorder
- post-traumatic stress disorder
- complex trauma; or
- conduct disorders in children.

### What is complex trauma?

The behaviour observed in people with personality disorder can be described as reactions to and ways of coping with the traumatic experience of difficult childhoods. It may, therefore, be more useful to describe personality disorder as 'complex trauma', in other words, a reaction to an ongoing and sustained traumatic experience. This description will be used in the guide. Please note there are more detailed **definitions** of personality disorders later in this section.

The prevalence of personality disorders in the general population varies according to the way it is measured, but it is generally acknowledged that around 10 per cent may reach diagnostic levels.<sup>1</sup> However, it is estimated that this rate rises to 60 per cent of adults living in hostels in England.<sup>2</sup>

Rough sleepers and young people who have experienced homelessness generally experience higher rates of mental health problems than the general population. These are people who, with a few exceptions, will not be accessing mainstream mental health services and they can present challenges to which conventional mental health services have not on the whole responded well. In some cases, primary health care may be engaged, though good practice here is far from universal.

The term 'complex trauma' does not seek to convey a medical diagnosis, but rather a set of experiences which may underpin emotional, cognitive and behavioural patterns seen in adulthood. This guide deliberately tries to avoid the polarised argument about homelessness being either the fault of the individual or the fault of society, but rather sees homelessness as resulting from an interaction of the two in some vulnerable groups.

<sup>1</sup> For example, Eksellius et al, 2001.

<sup>2</sup> Maguire et al, in prep.

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## Section 1: An outline of the key issues

### The national policy context

It is important to emphasise that not all people who have experienced homelessness will have suffered traumatic childhood experiences or would be diagnosed as experiencing complex trauma. However, there is growing evidence that a significant proportion – particularly of those with very complex needs such as entrenched rough sleepers or young people who have endured sustained traumatic experiences before facing homelessness – may suffer from complex trauma.

Developing services that acknowledge the psychological and emotional needs of people with complex trauma issues is likely to produce positive outcomes for those people who may have been adversely affected by the experience of homelessness but who may not have such complex and entrenched problems. Adopting a psychologically skilled approach will not only provide positive outcomes with those who have received a medical diagnosis, but also with those clients who may have learnt ineffective and destructive coping strategies which affect their ability to maintain healthy relationships or accommodation.

Experiencing a traumatic childhood may mean people develop problems in later life, particularly with attachment, emotion regulation and interpersonal skills (see definitions section for more on personality disorders). These may underpin many of the emotional and behavioural issues which cause and perpetuate homelessness and lead to further mental health problems, drug and alcohol misuse. These problems can also be compounded by further trauma in adult life, thus perpetuating the cycle of homelessness. Without addressing the trauma it can prove difficult to help people stabilise their lives and find and keep accommodation.

In recognising the psychological and emotional needs of people who are homeless or living in insecure accommodation, there are clear implications for the commissioning of services and for the training and support of key working and resettlement staff.

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is a need for joined up input and support from primary care services, including support to general practitioners, emergency health services and specialist mental health services engaging with this client group, to enhance the capacity within accommodation services to meet these needs. It is important that we appreciate the complexity of the challenge for service provision, the support that homelessness and health services need when working with people experiencing complex trauma; and the need for partnership working between agencies.

There are a number of national policy developments that underpin the development of new approaches to tackling emotional and psychological issues and homelessness, as part of tackling health inequality and improving public health.

### **New and increased flexibility for commissioners and providers**

The removal of the ringfence around Supporting People funding creates new and increased flexibility for commissioners and providers. It enables them to extend their range into areas of need where they are often the first to engage with and the best placed to work with people experiencing complex trauma.  
[www.communities.gov.uk/news/corporate/1075788](http://www.communities.gov.uk/news/corporate/1075788)

### **Cross-government working with New Horizons**

The approach taken in this guide to meeting the emotional and psychological needs of people who have experienced complex trauma and who are homeless or living in insecure accommodation is intended to support the vision of New Horizons the cross-government programme for improving mental health and well being.  
[www.newhorizons.dh.gov.uk/index.aspx](http://www.newhorizons.dh.gov.uk/index.aspx)

New Horizons sets out a twin-track approach to improving population mental health and enhancing the quality and accessibility of mental health care. Both elements of this approach can be applicable to people who are socially excluded, where the range of risk factors leading to social exclusion can also leave people at greater risk of mental ill-health and needing to access mental health care. Addressing these issues can include intervening early to prevent people needing to access services at a stage of crisis: through proactive employment or housing support, for example; and also through changing service specifications across multi-agency service pathways to ensure that all services in social care, acute and primary health care, housing; leisure and employment are responsive to the needs of people who use them.

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### Importance of agencies working together

There is an increasing recognition in the UK about the importance and cost benefits of preventive services.

#### Joint Strategic Needs Assessment

Responsibility for the assessment of health needs fits within the remit of the local primary care trust (PCT) working in partnership with other agencies, most notably local authorities. The statutory framework for needs assessment within a local area is the Joint Strategic Needs Assessment (JSNA) which is led by local authorities with input from primary care trusts. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081097](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097)

The JSNA in turn feeds into the local planning system through the mechanism of Local Area Agreements (LAAs). In an area of commissioning such as complex trauma it would be good practice for agencies to work together in the needs assessment phase and in taking forward commissioning plans for new services to meet the identified needs. Equally, existing services could be refocused to reflect the recognition of complex trauma as an issue for clients. [www.dh.gov.uk/en/SocialCare/Socialcarereform/Localareaagreements/index.htm](http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Localareaagreements/index.htm)

These local commissioning arrangements to meet the newly-identified needs will enhance the capacity and the potential for innovative approaches such as:

- practice-based commissioning and social prescribing
- to be able to intervene earlier
- greater needs-led flexibility.

The impetus of World Class Commissioning in the NHS, the outcomes of JSNAs across local authorities and primary care trusts and the transformation programme for adult social care have also helped to sharpen the commissioning focus on a range of socially excluded groups, including people who are homeless or living in insecure accommodation or individuals who may have experienced difficulty accessing services by virtue of diagnoses such as personality disorder or complex trauma.

*Inclusion Health – Improving Primary Care for Socially Excluded People* is a practical guide aimed at supporting PCTs to commission improved access to high quality primary care services for socially excluded people. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114067](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067)

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Frequently, the complex challenges socially excluded people face can mean that many lead chaotic lives. The challenge facing commissioners and providers is how to work with excluded people to ensure that all opportunities are optimised to help stabilise their care needs, and to support them into pathways to recovery wherever possible. Traditional services tend to engage poorly with socially excluded people and vice versa. They frequently experience barriers to accessing primary care and maintaining the relationships with providers that lead to continuity of care. By addressing these issues there is potential to secure not only better health outcomes for those who need our help the most, but also to deliver better value.

*Inclusion Health* is the latest in a series of best practice guides which have been produced by the Department of Health, primary care team in support of the implementation of the primary care and community services strategy, *Our vision for primary and community care*. This guidance is also linked with the Cabinet Office, Social Exclusion Task Force and Department of Health new short study **Inclusion Health**. This study outlines how improvements in health care for the most excluded groups in society can be accelerated to ensure high quality services are available to all, and sets out a series of actions to drive these changes at a national level. This guide can be found at

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114067](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067)

A key factor in improving outcomes for people with a personality disorder is the response they receive from staff. There has been a great deal of stigma attached to a diagnosis of personality disorder and this often translates to discrimination and exclusion. Staff, especially those in non-specialist settings, working with people with such a diagnosis can often lack awareness, skills and training to cope effectively with what can be perceived to be challenging and risky behaviour. Specialist practitioners often work in isolation, lacking the support networks to deal effectively with high-need clients.

### Dispelling myths and stereotypes

There is a need to dispel myths and stereotypical beliefs about untreatable, unsuitable, undeserving or hard-to-reach clients, and this paper outlines new research on underlying needs and examples of effective practice to correct the negative terminology. In order to address the problem the Department of Health and the Ministry of Justice commissioned a comprehensive training and development programme for personality disorder, the Knowledge and Understanding Framework.

[www.personalitydisorder.org.uk/training/kuf/awareness](http://www.personalitydisorder.org.uk/training/kuf/awareness)

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### New research and practice from pilot projects

In the past, it was thought that problems associated with personality disorder were untreatable. Evidence from a number of pilot projects funded by the Department of Health and two sets of guidelines from the National Institute for Clinical Excellence (NICE) issued in 2009 is changing that. <http://guidance.nice.org.uk/CG78>

Ground-breaking therapeutic programmes are making real and lasting improvements to families, prisoners, 'untreatable' psychiatric patients and others who experience extreme social exclusion. This guide outlines many examples of effective practice emerging within housing services (see [Section 2: Case studies and CBT project, Derby Road, Southampton](#)).

#### Applying the learning from the pilots

The challenge now is for commissioners to apply the learning from the pilots and the developing evidence base to ensure that people experiencing complex trauma are treated by skilled and specialist staff working together across agencies. *Recognising Complexity, commissioning guidance for personality disorder services* from the Department of Health,

provides guidance for commissioners by reviewing what is known about personality disorder, government policy, clinical approaches and learning from the pilots, and sets out a series of recommendations. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_101788](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101788)

#### Making public money work harder through 'health check' pilots

There are strong spend-to-save arguments for health, the criminal justice system and the homelessness sector in favour of tackling complex trauma, particularly in excluded and vulnerable groups. This can be achieved by partnership working through the LAA process and by looking at ways of joining up individual local funding streams to achieve better outcomes.

Total Place is a new approach to local public service delivery, encouraging local partners to put the citizen at the heart of service design in delivering service improvements and savings. The Total place report, published alongside the 2010 Budget, draws on the

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findings of 13 pilots that worked closely with central government to map the totality of public spending in their area, identify national-level changes to support local collaboration and discern opportunities for genuine, cross-organisational service transformation in chosen themes. These themes included housing, tackling alcohol and drug use, children's health and well being, mental health services and reducing reoffending. A report of the findings of the pilot stage is available at [www.hm-treasury.gov.uk/psr\\_total\\_place.htm](http://www.hm-treasury.gov.uk/psr_total_place.htm)

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### Issues for accommodation and support providers

#### Ongoing difficulties for people who have experienced complex trauma

The evidence from practitioners and recent research suggests that people with a history of complex trauma are likely to have ongoing difficulties related to issues such as attachment and loss, emotional dysregulation and impulsivity, dependence, avoidance, rejection, mistrust or hostility. A better awareness of these issues can help services to recognise these vulnerabilities early on, and take steps to engage the individual through some sensitivity to likely problems.

With those for whom complex trauma has become entrenched – those who might, for example, be given a diagnosis of personality disorder – it may be helpful to be aware of the advice currently given by mental health services on working with those with personality disorder. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009546](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009546)

#### Additional problems of those experiencing complex trauma

Many people experiencing complex trauma will have additional problems, for example: learning difficulties, physical or other mental health problems or re-offending. They may not be in regular contact with a GP or mental health services or have any formal psychiatric assessment of diagnosis established. They may use emergency departments for the majority of their healthcare needs. For example, new research by the Social Exclusion Task Force and Department of Health found that homeless people are 40 times more likely to be unregistered with a GP and five times more likely to use A&E when they could not speak to a doctor than the general public. [www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf](http://www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf)

Current advice suggests that supportive and collaborative relations with the client are more effective than technical or coercive interventions. This supports the experiences of many housing resettlement staff that user-defined outcomes are the strongest basis on which to build. Use of person-centred approaches such as the 'Outcomes Star' can give this a specific focus. (See case study on [Homeless Link Outcomes Programme](#)).

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People with complex trauma who have experienced homelessness may behave in a range of ways that suggest underlying difficulties with relationships, or with managing their own emotions. Some people may for example:

- self-harm or have an uncontrolled drug and/or alcohol problem
- appear impulsive and not consider the consequences of their actions
- appear withdrawn or socially isolated and reluctant to engage with help which is offered
- exhibit anti-social or aggressive behaviour
- lack any structure or regular daily routine
- not have been in work or education for significant periods of time
- have come to the attention of the criminal justice system due to offending.

Some people may have had unsatisfactory experiences of housing, health or care and support services in the past; and some may now be wary of all forms of authority or bureaucratic systems, despite the good intentions of the service provider. Some may be reluctant to reveal the full extent of their problems until they are reassured that their trust will not be betrayed, others may need to challenge services to test the

response, until they are sure that trust is well placed. It is estimated that 55-60 per cent of adults in supported accommodation have a diagnosable personality disorder, in many cases resulting from neglectful and abusive early experiences. This can result in anti-social and violent or disruptive behaviour which is hard for frontline staff to manage and which, in some cases, can lead to exclusion or eviction.

Such outwardly disruptive behaviour is only one possible manifestation of an underlying difficulty in managing relationships. Equally problematic can be high dependency or avoidant behaviour, or very erratic and inconsistent responses to stressful situations and demands, with irresponsible and sometimes melodramatic behaviour. There are many possible presentations of dysfunctional and self-defeating attitudes (reactions and ways of thinking) that can give a clue to underlying and deep-seated emotional and psychological difficulties which need to be addressed.

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### Particular issues for 16-17 year-olds

There are particular issues to consider around 16-17 year-olds who have experienced homelessness and who may have had traumatic and abusive childhoods. On top of the problems of adolescence which affect young people generally, they may also exhibit behavioural problems, of lesser (oppositional) or higher severity (conduct disorder), with the latter usually being associated with antisocial behaviour. (Please also see the definitions section.) In some cases the behaviour may not get diagnosed at all, but labelled as anti-social or just 'being difficult'.

These problems can lead to and compound the experience of homelessness for these young people. It can make it much more difficult for them to:

- achieve a successful transition into adult life
- hold down a tenancy
- remain in education
- make healthy relationships; or
- find a job.

Their behaviour may also increase their chances of losing their accommodation and becoming homeless again. Not recognising or working with their experiences of trauma means there is a risk of those young people disengaging from services, resulting in a potential lifetime of homelessness and exclusion.

### Emotional and social maturity younger than chronological age

An additional difficulty for staff working with young people is that the young person's emotional and social maturity may be much younger than their adulthood chronological age. This developmental discrepancy is particularly prominent among young people who have experienced complex trauma, and can be compounded by the additional problems faced by adolescents in transition to adulthood.

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People who have experienced homelessness and who experience complex trauma can prove:

- difficult to engage with
- demonstrate volatile, irresponsible, risky or antisocial behaviour; and
- use drugs and alcohol.

They may behave and think in particular ways which perpetuate their problems. This makes key working very hard and at times frustrating for both client and worker.

Without effective, psychologically informed input by staff and/or therapists as an integral part of case management or key working with clients, there is unlikely to be any resolution of their problems. Accommodation on its own, even coupled with support, will very rarely enable people experiencing complex trauma to deal with negative self-belief or emotional dysregulation and change how they behave.

The high prevalence of personality disorder and complex trauma among clients of some homelessness services means that hostel staff and resettlement workers can often find themselves engaged in quite psychologically sophisticated and demanding work, for which they should be properly recognised, trained and supported. It is important for staff and commissioners to understand that this approach complements but does not replace access to mainstream clinical psychology services by clients.

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### Importance of well-trained frontline staff

People who are homeless or insecurely housed are among those most in need of psychologically informed help, but are also among those least able to access mainstream clinical psychology services. The skills and awareness of frontline health and support staff to this issue are central here, and staff training and staff support are equally important, in order to develop individual resilience and address burn out and high staff turnover. The capacity and the opportunity to reflect upon experience and for staff to support each other in learning to manage challenging behaviour, can also make a significant difference to the resilience of the organisation in coping with the emotional impact of such demanding work.

#### Psychological training and awareness training

There are now a number of well-evidenced models of psychological training and awareness raising that can be offered to frontline staff in a variety of non-specialist settings in order to improve awareness of the issues around complex trauma. There are also tools for self-help with proven effectiveness that can assist non-specialist staff. Where accessible psychological

services, such as those outlined in the **Case studies** are provided, they generally have a high level of take up, good attendance and strong positive outcomes.

#### More effective services at relatively low cost through staff training

Managers and commissioners alike need to consider how far staff development, training and supervision may, in the long run, produce more effective services at a relatively small cost. Resilient services need to provide a careful mixture of flexibility and consistency, and the use of **reflective practice** is generally acknowledged to lead to constructive changes in daily routines and the best use of facilities.

The organisation of the frontline service over and above the skills, resilience and activities of individual staff, can have a significant impact on the extent to which the service can manage challenging or frustrating behaviour. Equally, the physical design of a building can have a significant impact on behaviour and influence positive relationships, as has been well demonstrated by the Homes and Communities Agency's Places of Change Programme. [www.homesandcommunities.co.uk/places\\_of\\_change](http://www.homesandcommunities.co.uk/places_of_change)

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### The Psychologically Informed Environment approach

People who have been homeless often come to expect rejection and, therefore, find it difficult to trust those who are there to help them and talk openly about important issues in their lives. The psychologically informed environment (PIE) can be created in a service such as a hostel or day centre where the social environment makes people feel emotionally safe. A PIE is an approach rather than a place, and an example of what the Royal College of Psychiatrists terms an 'enabling environment'. PIEs can be developed within existing commissioned services, wherever appropriate training and development enables staff to respond effectively to people with psychological needs and longstanding emotional problems. This includes trying to understand people's behaviour, helping them to be involved with others in a genuine way, and to take as much responsibility for themselves as possible.

A PIE 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, or engagement with treatment and therapy.

It is striking that many of the case studies describe opportunities for tiered or staged involvement, so that the warier client can develop trust and eventually engagement more fully, but on their own terms. This will require careful and appropriate pacing of interventions, and can be a slow process. Many services make good use of peer support, and aim to work with the informal social networks that supported accommodation will inevitably produce. We need to be aware that for some people, this may offer the only sense of community they have. User-led services that work to encourage engagement but not reproduce dependency will be more effective than those that overlook the social dimension of person-centred services.

Tackling complex trauma requires a combination of approaches and therapies. Both the physical environment and the approach to clients by staff can have a significant effect. Engagement and consistency of approach are central to this, as is appropriate staff training and support.

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### Drugs and alcohol

It is crucial that access to services is not conditional on abstinence from drugs or alcohol. This is particularly important with people who experience complex trauma and who also use drugs or alcohol as self-medication, sometimes described as dual diagnosis. Until the underlying causes of the complex trauma are diagnosed and treated, the substance misuse is highly likely to continue. Denying access to either accommodation or mental health services because of continued substance misuse is likely to result in rough sleeping and ill health. However this has to be balanced with the need for services to ensure the safety of staff and residents.

[www.dualdiagnosis.co.uk](http://www.dualdiagnosis.co.uk)  
[www.dh.gov.uk/en/Publicationsandstatistics/  
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DH\\_062649](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649)

It is important to distinguish between those who use drugs and alcohol as way of coping with complex trauma and those whose drug and alcohol use may largely be recreational though still problematic. Robust assessment, joint working and communication between professionals will assist with identification of underlying complex trauma and referral to appropriate services.

It is also important that working relationships between staff from different services are good, in order to help ensure that the difficult relationships that some vulnerable individuals may experience do not become rerun as repeated patterns of conflict between agencies and services. Joint training events, link-workers, colocation, information-sharing meetings, case conferencing and other such bridging mechanisms can be helpful in building and maintaining better working relationships that work more seamlessly to meet complex needs.

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### Best practice tips

#### Getting started

Some best practice tips to help service providers and commissioners adapt existing services or develop new ones which address the issues surrounding complex trauma in an often chaotic client group whose behaviour can be perceived as very challenging.

Build requirements into service specifications for providers of direct services and relevant assessment team functions to:

- 1 Train and support staff to recognise and work with the behavioural, emotional and cognitive issues that are problematic for people with complex trauma.
- 2 Make sure that multi-agency risk management follows risk assessment, to ensure that homeless people with complex trauma are not excluded from accommodation or support services.
- 3 Work with homeless people with complex trauma with their presenting behaviour rather than restricting access to appropriate services until behaviours change.
- 4 Develop, and include in contractual arrangements, clear care pathways and a consistent, psychologically informed approach from all agencies, statutory and non-statutory, working locally with people who are homeless or in insecure accommodation.

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These case studies offer examples of how psychologists diagnose personality disorder and how service providers can assess the emotional and psychological needs of their clients. There are also case studies that look in more depth at how services can support young people – and adults with high-support needs.

The findings and recommendations in these case studies are those of the authors and do not necessarily represent the views or proposed policies of CLG or NMHDU.

### Clinical assessment tools

- Millon Clinical Multi-axial Inventory; Personality Diagnostic Questionnaire
- The Leeds Holistic Framework
- New Directions Assessment – South West London Mental Health NHS Trust
- Homeless Link Outcomes Programme

### Schemes for young people

- Intensive fostering – the Youth Justice Board
- Family Liaison pilots – the Youth Justice Board
- High support hostels – Depaul UK
- Kids Company, London
- The Zone, Plymouth

### High-support schemes for adults

- 90 Lancaster Street, Multiple Needs Unit, Birmingham

- Home Base, Community Housing and Therapy
- St George's Crypt, Leeds
- Leeds NFA Health Centre
- Lifeworks, St Mungo's psychotherapy service
- Leicester Homeless Mental Health Service
- The Old Theatre Broadway London

### Staff capacity building and support

- Coaching Skills training course – Foyer Foundation
- Westminster Cognitive Behaviour Therapy project
- Knowledge and Understanding Framework, Department of Health
- Behaviour support service, Brighton and Hove
- Art of defusing training, Bedford
- Novas Scarman psychological skills training
- Framework Housing Association, Nottingham

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### Clinical assessment tools

In clinical assessments, the prevalence rates of personality disorder (PD) can vary greatly depending on the form of assessment used.

The broad spread of signs and symptoms mean that diagnosis is often difficult and unreliable. There is evidence that studies which rely on formal psychiatric diagnosis produce highly-variable results. There are, however, a number of clinically-developed self-report measures which give an indication of the presence/absence of PD and its severity, two of which are covered below.

#### Millon Clinical Multiaxial Inventory (MCMI-III)

- This is a 175-item true/false questionnaire that is extensively used in clinical and research settings.
- It has subscales which identify the presence of specific types of PD according to an 85th percentile cut-off.
- It also has subscales to identify depression, anxiety, drug and alcohol problems and post-traumatic stress disorder (PTSD).

- The PD diagnoses are based on the Diagnostic and Statistical Manual (DSM-IV) published by the American Psychiatric Association. The MCMI has been criticised for being over-inclusive in its diagnosis of PD. [www.psychcorp.co.uk/product.aspx?n=1316&skey=4364](http://www.psychcorp.co.uk/product.aspx?n=1316&skey=4364)

#### Personality Diagnostic Questionnaire (PDQ-4)

- This is a 99-item true/false questionnaire extensively used in clinical practice to screen people suffering from PD. It is also extensively used in research. The PDQ is also based on the Diagnostic Statistical Manual (DSM-IV) categories of PD.
- The newest version has a clinical significance scale which attempts to address the problem of false positive diagnosis.

Not yet formally researched, but proven effective in practice, the PDQ is the assessment framework used for the personality disorder Managed Network, and NIMHE/DH PD pilot. [www.pdq4.com](http://www.pdq4.com)

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### Leeds Holistic Framework

Not yet formally researched, but proven effective in practice, the Leeds Holistic Framework is the assessment framework developed by Ray Middleton from Community Links for the Leeds personality disorder Managed Network – one of the NIMHE/DH PD pilots.

[www.commlinks.co.uk](http://www.commlinks.co.uk)

This assessment tool is used by key workers at Community Links in Leeds and enables them to identify and understand the emotional and psychological needs of their residents. It is completed as part of the process of agreeing a support package and regularly reviewed.

Its strength is that it does not use technical language, but asks questions in a way that is readily understood by individuals with such difficulties. It also helps to identify problems without any suggestion that these problems are a matter for healthcare, social care or support services.

It is particularly useful for services that may be commissioned and funded by diverse funding streams.

The questions in the Leeds Holistic Framework are outlined in more detail opposite.

### Leeds Holistic Framework for Understanding Complex Needs

Consider and discuss the following with the client:

#### 1 Environment

##### Where they LIVE

- Describe what it is like where the client lives. How would they describe it?
- How safe and secure is it where they live?

##### What they DO with their lives

- a **Living skills:** can/do they cook/shop/clean/manage money?
- b **Meaningful use of time:** study/voluntary work/paid work/hobbies?

##### Who do they MEET? (social networks)

- Describe the people the client meets regularly?
- How do they view these people?
- What influence do others have on the client?

#### 2 Beliefs and thoughts about:

##### Themselves (their identify)

- How would the client describe himself or herself?
- How do they think and feel about themselves?
- How does the client think other people see them?

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### Other people

- How would the client describe the other people they meet?

### The 'way the world works'

- How does the client think their 'world works'? (e.g. is it dangerous/unfair etc – this is a hard question so you can say you 'do not know'!)

### Motivation to change and take responsibility

- How motivated to change are they in order for their life to get better?
- To what extent do they see themselves as responsible for their own problems?

### 3 Problem-solving strategies:

#### Assessing a problem

- List some of the problems the client has at the moment.
- Does the client tend to exaggerate or minimise their problems?
- How do they tend to react to their problems?

#### Planning a solution

- Does the client plan solutions to problems?
- Are their plans realistic and achievable?
- Does the client avoid solving problems?

#### Taking risks

- What risks are they vulnerable to?

- Self-harm?
- Physical health?
- What risks are there of them harming someone else or offending?

### Reviewing/reflecting on the outcomes of plans and actions

- How much does the client reflect on their actions and consider how effective their plans have been?
- How much do they learn from experiences? (Do they adjust their plans based on past experiences?)

### 4 Building relationships:

#### Co-operating

- What is the client like at asking for, and co-operating with, help?
- In what ways does the client help others?

#### Conflict


- What conflicts crop up for the client? (What does the client get cross about?)

#### Ways of communicating


- What is the client like at listening to and understanding others? What are they like at communicating?
- Does the client think other people listen to and understand them?


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### 5 Managing emotions:

#### Anger

- What does the client get angry or cross about?
- How does the client react when they get angry?

#### Anxiety/fears

- What does the client get anxious, fearful or worry about?
- How does the client react when anxious?

#### Low mood/enjoying life activities

- What causes the client to get low in mood or fed up?
- What activities does the client enjoy doing?

#### Other emotions (e.g. guilt, loneliness, shame, grief, emptiness, excitement, envy, stress...)

- What other emotions does the client experience?

#### Addictions and impulsive acts

- Does the client use any of the following to cope with thoughts, feelings or lack of feelings? (i.e. do they misuse any of these mood-altering activities?)
- Over- or under-eating alcohol/drugs/gambling/misusing sex/work addiction/
- Exercise/self-neglect/self-harm/cutting/burning/overdosing others
- Do these activities cause the client any problems?
- Does the client want to stop or reduce these activities? [Y/N]

### 6 Reflections and connections:

- Discuss what connections you or they can make between the five areas.
- How **you** think and feel about this client?
- What your **role and limits** are in relation to the client?

Contact: [ray.middleton@commlinks.co.uk](mailto:ray.middleton@commlinks.co.uk)

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### New Directions Assessment – South West London Mental Health NHS Trust

#### Snapshot summary

The New Directions Team aims to provide an early intervention for residents from the London Borough of Merton who are not engaging with frontline services, resulting in multiple exclusion, chaotic lifestyles and negative social outcomes for themselves, their families and communities. The team reports to a multi-agency partnership group.

#### Background

During the development phase a local 'Chaos Index' was agreed to help identify individuals or groups that the New Directions Team (NDT) could target.

It was important from the start to understand the different perspectives of the multi-agency partnership which included social services, primary care, mental health services, housing, youth inclusion services, the police, drug and alcohol services, Jobcentre Plus, the Learning and Skills Council and the volunteer centre and find out who they considered the new team would

actually be serving based on real case studies. At initial meetings it was clear that while all members could identify potential clients for the new team there was a range of perspectives.

Early discussions and a review of the relevant research showed that a high proportion of people with multiple needs tended to have mental health problems, often in combination with substance use or personality disorder. While local case studies were being developed, a brief review of the literature about people who did not engage, or were rejected by mental health services, was also carried out to identify key individual characteristics.

#### What we do and how we do it

##### Development of the Chaos Index

The multi-agency partnership was keen for the Chaos Index to focus on behaviours. The local case studies were analysed to ascertain consistent behaviours and to understand the level of impact of these behaviours. Standardised assessments were drawn on to support the development of the Chaos Index but the essential element was ensuring that the index reflected the range of behaviours identified through the local case studies thus reflecting the local population of Merton.

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To ensure reliability and consistency in assessment, it was agreed the team manager would carry out all the Chaos Index assessments of referrals to the NDT team.

### Piloting the Chaos Index

The Chaos Index was piloted across several of the agencies from the multi-agency partnership including the police, mental health services, alcohol/drug services and the youth inclusion services. A key aim of the pilot was to establish an eligibility threshold on the index for referral to the NDT.

Each agency carried out the piloting as a desktop exercise based on existing knowledge of clients in Merton. They also considered clients they thought should be eligible for the NDT and those people they thought would not. Agencies were also asked to comment on the index including:

- how easy it was to use
- how understandable it was
- whether there were criteria that were missing
- whether the anchor points on the index were correct; and
- whether the distance between the anchor points were sensible and understandable.

The pilot showed that the Chaos Index was easy to use and understandable. However, there were concerns about people who were potentially marginal especially when services considered the scoring of a person could change within a short period of time. For example, a person might be leading a chaotic lifestyle resulting in current negative social outcomes, but because they were engaged with frontline services they were scoring '2' on the 'engagement with frontline services' criterion which would not make them eligible to continue the assessment – or, therefore, the NDT. However, agencies thought that this situation could change and the person could score 3 or 4 within a short period of time thus making that person potentially eligible for the NDT service. This concern has been addressed through ways of working between the NDT and other agencies.

Some members of the steering group and several of the agencies who piloted the index suggested the name should be changed to a less pejorative term. Nobody wanted an individual who had been assessed under the Chaos Index to see this as a 'badge of honour'!

The name of the assessment was changed to the New Directions Team assessment.

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### Outcomes from the pilot – and further review

Following the piloting a threshold for eligibility to the NDT was set at a score of 22 or above. It was agreed that the threshold and the NDT assessment (the former Chaos Index) would be reviewed after six months. The aim of the review would be to check whether:

- the NDT assessment worked in practice and had face validity

- the eligibility threshold was set at the right level; and
- the team was targeting people who were not engaging with frontline services.

### Review of NDT assessment after six months

Thirty referrals were made during the six-month operational period. The highest number of referrals came from the police.

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**Table 1: Referral sources and numbers, accepted referrals, gender and ethnicity**

Referral source	Total referrals	Gender (% male)	Ethnicity (% white)	Accepted referrals	Gender (% male)	Ethnicity (% white)
Police	13	38	85	9	33	100
Probation	1	100	100	1	100	100
General hospital	1	100	100	0	-	-
Adult mental health	3	67	33	2	50	50
Older people team	1	100	100	0	-	-
Housing	2	100	50	2	100	50
Drug services	4	75	75	2	50	50
YMCA	2	50	50	1	100	100
Faithin Action	1	100	100	1	100	100
Physical disability team	1	0	Not stated	1	0	Not stated
A relative	1	0	100	1	0	100
<b>TOTAL</b>	<b>30</b>	<b>57</b>	<b>82</b>	<b>20</b>	<b>50</b>	<b>89</b>

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Of the referrals not taken on by the team a total of seven were not appropriate: four did not score above '2' on the initial question of 'engagement with frontline services' which ended the assessment process and three people were not residents of the London Borough of Merton. Only four people did not meet the eligibility threshold of 22 points. It had been agreed that borderline scores would be discussed. One assessment scored '21' and it was decided, based on the person's circumstances, to take them onto the caseload of the team.

The NDT assessment does not appear to discriminate in terms of gender (57% referred and 50% of the accepted caseload are male) or ethnicity (82% referred and 89% of the accepted caseload were white). The high referral and acceptance rate for white people is consistent with agencies that support homeless and vulnerably housed people across London<sup>3</sup>.

### Does the NDT assessment work and have face validity?

We also looked at how the NDT assessment works in operation and whether it has face validity by looking at:

- the assessments scores for the six-month period
- the feedback from the NDT team manager in terms of whether:
  - the criteria and anchor points in the assessment reflected the behaviours of the referrals made to the NDT team; and
  - local agencies had provided feedback that the criteria and anchor points were not reflective of local circumstances or key behaviours had been omitted.
- The feedback received at the multi-agency partnership meetings.

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<sup>3</sup> Broadway (2008) Street to Home: Annual report for London 1 April 2007 – 31 March 2008. London: Broadway

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### The assessment scores

Of the 20 clients taken onto the caseload, all met the threshold of the first question (scoring 3 or 4) on the engagement with frontline services which was the first step in the eligibility to the team. Table 2 shows the breakdown scores by criteria for all 20 assessments accepted by the team and shows that in terms of each criterion there was a wide range in the behavioural anchor points scored within the assessment process (as one would expect).

The average scores and ranking provide a sense of the 'typical client' the team is serving. The ranking highlights that 'risk to others' was the highest scoring criterion for all the clients followed by 'risk from others'. The lowest scoring criterion was 'intention to self-harm'.

**Table 2: Scores for the total caseload of the team (n=20)**

Criterion	Range	Average	Rank
Engagement with frontline services	3 – 4	3	N/A*
Intention to self-harm	0 – 2	1	9
Unintentional self-harm	0 – 4	3	6
Risk to others	2 – 6	4	2
Risk from others	0 – 8	6	1
Stress and anxiety	2 – 4	3	3
Social effectiveness	1 – 4	2	8
Alcohol / drugs abuse	0 – 4	3	5
Impulse control	1 – 4	2	7
Housing	1 – 4	3	4

\* Engagement with frontline services is not ranked as all clients have to achieve a score of 3 or more to be eligible to continue the assessment.

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### Feedback from the NDT team manager

The ongoing feedback from the NDT team manager is that the criteria and anchor points work and appear correct. In addition, there has not been any feedback from local agencies to contradict this.

### Feedback from the multi-agency partnership group

The multi-agency partnership concluded (at the steering group in August 2008) that the assessment appeared to be identifying the target group of people and that the assessment seemed to work effectively within the context of Merton.

### Looking at the eligibility threshold

Excluding the 7 inappropriate referrals, only 4 people did not meet the eligibility threshold for the NDT assessment. One person was a borderline score and was taken on by the team based on the person's circumstances. The remaining three total scores for the assessment were 18, 15 and 20.

Based on this review it would seem that the original eligibility threshold set at 22 points, with the caveat that there will be a discussion on borderline cases, was the correct threshold.

### Checking that the NDT assessment targets the right group of people

The average and ranking scores from Table 2 provides a behavioural profile of an average or 'typical' client who was referred and accepted onto the NDT team caseload in the first six months of operation. Box 1 illustrates the behavioural profile of a 'typical' client on the caseload.

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### Box 1: Behavioural profile of a 'typical' NDT client

An individual who is non-compliant with routine activities or reasonable requests, does not follow a daily routine though may keep some appointments.

They are subject to the probable occurrence of abuse or exploitation from others and pose a risk to the property of others and/or pose a minor risk to the physical safety of others. In response to stress the person has very limited problem-solving skills and becomes hostile and aggressive to others.

They have high housing support needs and are either at immediate risk of losing their accommodation or living in short-term/temporary accommodation.

They regularly use alcohol or abuse drugs which causes significant effect on functioning resulting in aggressive behaviour to others. The individual has a high risk to their physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment.

They have temper outbursts and/or aggressive behaviour of moderate severity and have had at least one episode of behaviour that is dangerous or threatening. They have marginal social skills that sometimes create interpersonal friction or appear inappropriate. They pose minor concerns about the risk of deliberate self-harm or a suicide attempt.

Based on this review it would appear that the NDT assessment is targeting the group of people whom the multi-agency partnership were aiming to reach out to when originally bidding for the pilot project.

The NDT assessment in operational use is achieving the original aim in being able to target residents from the London Borough of Merton who are not engaging with frontline services, resulting in multiple exclusion, chaotic lifestyles and negative social outcomes for themselves, families and communities. The NDT assessment works, has face validity and the original threshold set for eligibility to the team seems to be correct.

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### New Directions Team Assessment

#### Instructions

The New Directions Team assessment is used in assessing whether someone referred to the New Directions Team is appropriate for the service.

The assessment will not be the only criterion to be used in determining service eligibility, and certain vulnerable groups of people will be given priority:

- care leavers, particularly those with multiple risk factors e.g. school exclusion
- young offenders
- prisoners facing release from HMP Wandsworth
- repeat offenders or former prisoners with drug/alcohol problems
- people with particularly pronounced housing difficulties

The items in the assessment are rated on a 5-point response format with 0 being a low score and 4 being the highest score, There are two criteria where 0 is the lowest score and 8 is the highest. There are 10 criteria in total each with 5 anchor points.

Criterion 1, engagement with frontline services, tests the basic eligibility for New Direction team, if a score of 0 – 2 is achieved then the person is not eligible to complete the assessment or be considered for the team.

Client Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home telephone \_\_\_\_\_

Mobile \_\_\_\_\_

Referrers name, organisation and contact details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person carrying out assessment \_\_\_\_\_

Date \_\_\_\_\_

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Select **ONE** statement that best applies to the person being assessed. Base all scores on the past **one month**

### 1 Engagement with frontline services

- 0 = Rarely misses appointments or routine activities; always complies with reasonable requests; actively engaged in tenancy/treatment
- 1 = Usually keeps appointments and routine activities; usually complies with reasonable requests; involved in tenancy/treatment
- 2 = Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment
- 3 = Non-compliant with routine activities or reasonable requests; does not follow daily routine, though may keep some appointments.
- 4 = Does not engage at all or keep appointments

**If score for 'Engagement with frontline services' is 0 – 2 please stop, end of assessment**

**If score is 3 or 4 please continue →**

### 2 Intentional self-harm

- 0 = No concerns about risk of deliberate self-harm or suicide attempt
- 1 = Minor concerns about risk of deliberate self-harm or suicide attempt
- 2 = Definite indicators of risk of deliberate self-harm or suicide attempt
- 3 = High risk to physical safety as a result of deliberate self-harm or suicide attempt
- 4 = Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt

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### 3 Unintentional self-harm

- 0 = No concerns about unintentional risk to physical safety
- 1 = Minor concerns about unintentional risk to physical safety
- 2 = Definite indicators of unintentional risk to physical safety
- 3 = High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment
- 4 = Immediate risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment

#### Notes

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### 4 Risk to others

- 0 = No concerns about risk to physical safety or property of others
- 1 = Minor antisocial behaviour
- 2 = Risk to property and/or minor risk to physical safety of others
- 3 = High risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour
- 4 = Immediate risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour

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### 5 Risk from others

- 0 = No concerns about risk of abuse or exploitation from other individuals or society
- 1 = Minor concerns about risk of abuse or exploitation from other individuals or society
- 2 = Definite risk of abuse or exploitation from other individuals or society
- 3 = Probably occurrence of abuse or exploitation from other individuals or society
- 4 = Evidence of abuse or exploitation from other individuals or society

#### Notes

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### 6 Stress and anxiety

- 0 = Normal response to stressors
- 1 = Somewhat reactive to stress, has some coping skills, responsive to limited intervention
- 2 = Moderately reactive to stress; needs support in order to cope
- 3 = Obvious reactivity; very limited problem solving in response to stress; becomes hostile and aggressive to others
- 4 = Severe reactivity to stressors, self-destructive, antisocial, or have other outward manifestations

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### 7 Social effectiveness

- 0 = Social skills are within the normal range
- 1 = Is generally able to carry out social interactions with minor deficits, can generally engage in give-and-take conversation with only minor disruption
- 2 = Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate
- 3 = Uses only minimal social skills, cannot engage in give-and-take of instrumental or social conversations; limited response to social cues; inappropriate
- 4 = Lacking in almost any social skills; inappropriate response to social cues; aggressive

**Notes**

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### 8 Alcohol / drug abuse<sup>4</sup>

- 0 = Abstinence; no use of alcohol or drugs during rating period
- 1 = Occasional use of alcohol or abuse of drugs without impairment
- 2 = Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others
- 3 = Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others
- 4 = Drug/alcohol dependence; daily abuse of alcohol or drugs which causes severe impairment of functioning; inability to function in community secondary to alcohol/drug abuse; aggressive behaviour to others; criminal activity to support alcohol or drug use

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<sup>4</sup> Drugs include illegal street drugs as well as abuse of over-the-counter and prescribed medications.

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### 9 Impulse control

- 0 = No noteworthy incidents
- 1 = Maybe one or two lapses of impulse control; minor temper outbursts/aggressive actions, such as attention-seeking behaviour which is not threatening or dangerous
- 2 = Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening
- 3 = Impulsive acts which are fairly often and/or of moderate severity
- 4 = Frequent and/or severe outbursts/aggressive behaviour, e.g. behaviours which could lead to criminal charges / Anti Social Behaviour Orders / risk to or from others / property

**Notes**

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### 10 Housing

- 0 = Settled accommodation; very low housing support needs
- 1 = Settled accommodation; low to medium housing support needs
- 2 = Living in short-term/temporary accommodation; medium to high housing support needs
- 3 = Immediate risk of loss of accommodation; living in short-term / temporary accommodation; high housing support needs
- 4 = Rough sleeping / "sofa surfing"

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### Scoring

Please insert the assessed score against each criterion point and add up the total score.

#### Criterion

#### Score

- 1 Engagement with frontline services
- 2 Intentional self-harm
- 3 Unintentional self-harm
- 4 Risk to others
- 5 Risk from others
- 6 Stress and anxiety
- 7 Social effectiveness
- 8 Alcohol / drug abuse
- 9 Impulse control
- 10 Housing

### Outcome

Referral accepted:  YES  NO

If not accepted what advice guidance has been given to referrer?

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© South West London & St George's Mental Health NHS Trust

**TOTAL SCORE**

**/ 48**

Contact: [Miles.Rinaldi@swlstg-tr.nhs.uk](mailto:Miles.Rinaldi@swlstg-tr.nhs.uk)

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### Homeless Link Outcomes Programme

#### Snapshot summary

The aim of the Homeless Link Outcomes Programme is to support organisations to improve their services to end homelessness.

We see the programme as a major opportunity to promote the value of an outcomes approach in helping services to focus on the needs, potential and development of each individual person.

#### Background

Homeless Link has run the Outcomes Programme which includes the Outcomes Star tool and the online Outcomes Star System since June 2008.

The Outcomes Star is widely recognised as an example of good practice.

Through our outcomes programme we aim to:

- encourage organisations to have a shared philosophy of an outcomes approach
- enable homelessness agencies to access and use outcomes measurement tools that meet their needs

- increase awareness of good practice in outcomes approaches
- improve services for vulnerable people who may be at risk of homelessness within other sectors; and
- enable the sector to improve its services through good outcomes data.

#### The Outcomes Star System

The Homeless Outcomes website has comprehensive guides for staff and clients in how to use the star. Organisations can create and then store stars online. The website content is all free.

The website also allows the reporting of outcomes for individuals, projects or for the organisation as a whole. It also allows you to:

- show service users a picture of their progress at the touch of a button
- summarise your outcomes in a simple visual format; and
- benchmark your performance with other similar organisations.

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The Outcomes Star was developed by Triangle Consulting, originally for St Mungo's, and was subsequently widely tested and revised for the London Housing Foundation.

All the information about the Outcomes Star System is at: [www.homeless.org.uk/outcomes-star-system](http://www.homeless.org.uk/outcomes-star-system)

Contact: [joanne.crellen@homelesslink.org.uk](mailto:joanne.crellen@homelesslink.org.uk)

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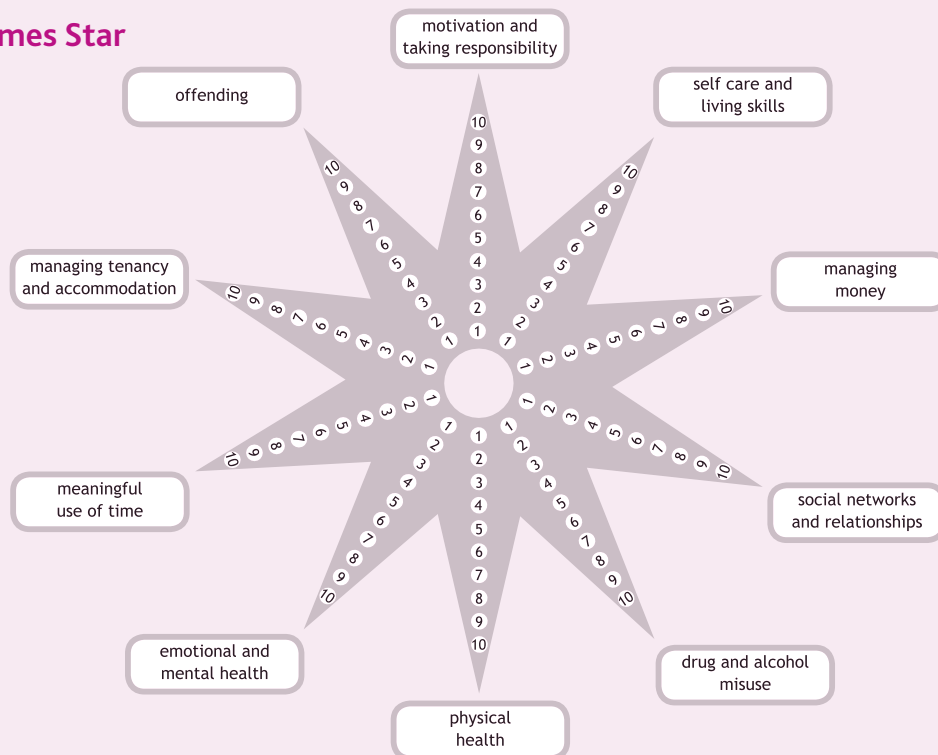
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### The Outcomes Star



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### Schemes for young people

These case studies offer examples of schemes designed to meet the emotional and psychological needs of young people who are homeless or at risk of homelessness, including those in contact with the criminal justice system.

#### Intensive Fostering – Youth Justice Board

##### Snapshot summary

The Intensive Fostering programme, funded by the Youth Justice Board, is an alternative to custody for children and young people whose home life is felt to have contributed significantly to their offending behaviour.

##### Background

Intensive Fostering ensures young people get the support they need within their community to address those factors that may have contributed to their offending behaviour. The programme, like other community penalties, also aims to hold a young person to account for their offences.

##### What we do and how we do it

The programme offers intensive care for up to 12 months for each individual, as well as a comprehensive programme of support for their family. The scheme is based on the Multi-dimensional Treatment Foster Care (MTFC) model which has been used successfully with offenders in Oregon since the 1980s. This model is based on a system of points and levels which reward appropriate behaviour.

A support team is employed to work with:

- the child or the young person in developing their social skills and changing their behaviours and attitudes
- the birth family by offering a range of support, including family therapy, counselling and parenting skills
- the foster carer by providing daily contact with a supervisor to discuss the young person's behaviour patterns and ensure that any potential problems are identified before they become critical.

All Intensive Fostering carers are assessed, registered and trained by the local authority. Carers are also required

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to have in-depth training in the MTFC model as well as knowledge of offending behaviour, the legal framework and the work of youth offending teams (YOTs).

Carers should also receive training on:

- understanding child/adolescent development
- methods of communicating with young people
- dealing with challenging behaviour
- risk management
- drug misuse.

The Intensive Fostering scheme is currently being piloted with foster care providers in Hampshire, Staffordshire, London, and Trafford and in 2010 Cambridgeshire and Peterborough. Placements of young people in homes began in early 2005. The pilot started in 2005 and we are waiting for the evaluation to be published in summer 2010.

Intensive Fostering emerged following the Anti-social Behaviour Act 2003, which makes a provision to include foster care as a requirement of a Supervision Order.

Contact: [Howard.Jasper@yjb.gov.uk](mailto:Howard.Jasper@yjb.gov.uk)

### Family liaison pilots – Youth Justice Board

#### Snapshot summary

Work has started in six pilot sites to ensure children and young people with mental health, learning disabilities and other issues such as family conflict, homelessness or drug and alcohol misuse get the help they need as soon as they come into contact with the police.

#### Background

The aim of the six Youth Justice Liaison and Diversion schemes is to prevent further offending and avoid future harm to victims by tackling, at the earliest possible opportunity, the problems that have led young people to get into trouble. The scheme does not aim to replace sanctions for serious crimes.

The scheme is supported by the Department of Health, the Youth Justice Board, the Department for Children, Schools and Families, the Ministry of Justice and the Sainsbury Centre for Mental Health.

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### What we do and how we do it

Scheme workers liaise closely with the police and the Crown Prosecution Service in police custody suites to identify those young people who need additional help. In cases where mental health, learning disabilities or drug and alcohol difficulties are suspected, workers will help these young people and their families get speedy specialist assessments. They will also work hard to get young people and their families into the full range of services they need.

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### High support hostels – Depaul UK

#### Snapshot summary

Depaul UK, in partnership with two local authorities, has set up two hostel projects in Rochdale and Oldham to deal with young people who have multiple and complex needs and to assist the authorities in meeting the requirements of the Public Service Agreements 12 and 16.

The projects are high-support – with staff present at all times – in purpose-built, self-contained flats for eight to nine young people.

Each young person has a personal support plan and external support from the funding authority, social services, the youth offending team or a worker from Child and Adolescent Mental Health Services (CAMHS).

#### Background

In many local authority areas there is likely to be a cohort of young people aged 16 to 23 with multiple and complex needs. These young people have often been in care, suffered some form of trauma or experienced homelessness.

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Their needs may arise from and include:

- multiple placements
- chaotic families
- drug and alcohol abuse
- offending behaviour
- emotional problems
- mental health issues
- self-harm
- ADHD; Asperger's Syndrome and so on.

Many local authorities find that they cannot place young people in appropriate accommodation so they have to resort to unsatisfactory options like bed and breakfast or expensive options like placing them out of the local area.

Mixed funding has come from a range of sources including:

- Supporting People
- The primary care trust
- Children's Services
- Drug and Alcohol Action Team
- Youth Outreach Services (YOS)

### What we do and how we do it

We aim to offer homeless and disadvantaged young people and care leavers the opportunity to fulfil their potential and move towards an independent and positive future through providing safe, secure and supported accommodation; and to plan for the transition to adult mental health services

#### We aim for our clients to:

- develop independent living skills
- address any emotional, mental and/or physical health issues behavioural/learning difficulties
- address drug and alcohol issues
- engage in meaningful activity, training, education, employment or voluntary work
- improve chances of obtaining and maintaining accommodation
- to move on positively
- reduce the risk of reoffending
- increase confidence and self-esteem
- build positive relationships with family and friends and other social networks.

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Depaul UK developed a new framework for support planning which is aligned with the five Every Child Matters outcomes. A toolkit was developed in-house in conjunction with staff and young people which helps young people to identify their own goals, review their progress and record their achievements.

The projects run an in-house resettlement programme, which helps young people gain points towards their future housing tenancies. The young people all have a Personal Support Plan, and a series of programmes that include techniques such as CBT. Boundaries setting, goal setting, 'parenting' and external interventions are agreed in the plan.

Many young people come with safeguarding issues, and one of the project managers sits on the safeguarding panel.

The projects are integrated into the community and local services. Where possible, families are involved and family mediation is also provided.

### Some outcomes achieved

Both projects measure outcomes consistent with the Every Child Matters agenda through a specifically designed Support Planning template.

- 39% of young people were identified as having a mental health need, and there was a 77% success rate in achieving improvement.
- 54% had a substance misuse need and 22% improved in this area.
- 72% had difficulties with family and friends and 92% successfully improved their relationships.
- Out of 93% who had an identified training/education need, 61% achieved an outcome in participating in training/education.
- Out of 33 young people, all young people moved on positively except for 4 who moved on to other temporary accommodation and 2 to bed and breakfast.

In managing self-harm, over half of the young people improved in this area. 18 per cent of all clients identified a problem with avoiding harm to others. 50 per cent of those felt they had achieved a successful outcome.

The project clearly reduces offending, anti-social behaviour, hospitalisation, mental health high-cost placements, as well as demands on other services.

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### Kids Company, London

#### Snapshot summary

Kids Company is a charity which provides practical, emotional and educational support to marginalised and vulnerable inner-city children and young people. Kids Company currently assists approximately 14,000 children with therapeutic and practical interventions through street level centre that operate predominantly on a self-referral basis, through an educational academy, a therapy house as well as in 38 inner city London schools.

#### Background

The children and young people who come to Kids Company typically present with a lack of basic life skills and disorganised emotional development. As a result they are often unable to organise themselves around social or welfare activities that would sustain them; for example, maintaining financial support through applying for benefits when they are not in paid employment, or managing their finances to prevent them from getting into arrears and spiralling into debt. Gaps in current statutory service provision do not accommodate these developmental challenges.

Services are extremely fragmented and are often experienced by our children and young people as being too complex for them to navigate. They require a comprehensive system of care that is child/young person-centred and that addresses the psychological, emotional and social fragmentation that they struggle with when engaging with current statutory services.

A sample of the case histories of young people accessing one of the Kids Company's street level centres shows the type of problems they experience:

- **84%** – homelessness
- **82%** – substance misuse
- **81%** – criminal involvement, often to feed and clothe younger siblings
- **83%** – sustained complex trauma in childhood
- **87%** – emotional difficulties and mental health problems
- **39%** – young carers struggling to cope

At the two street level centres, 50-60% of the males using the service from age 13 upwards have been excluded from school and before engaging with Kids Company were not in education or employment.

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### What we do and how we do it

In order to meet such complex needs and the myriad of developmental challenges experienced by our children and young people, the model of care adopted by Kids Company involves a 'wrap around' service; a multifaceted approach which takes into account the neglect and fragmented functioning that results from the experiencing of complex/developmental trauma, particularly during their most formative years of development. We therefore employ a widely-skilled team of professionals working at street level so that all the issues can be addressed by one team in one place.

This multidisciplinary approach combines health, housing, emotional wellbeing, mental health, arts, sports, youth justice, education and employment. Our aim is to first stabilise each young person by meeting their practical needs, before helping them to address emotional and behavioural difficulties. These interventions are designed to strengthen, supplement or substitute the child's parenting experience. Once the young person has achieved some sense of stability and calm, we help them to identify talents and interests and so develop aspirations for the future.

The provision of comprehensive reparative care is designed to address the underlying developmental challenges and give our children and young people the relationships, care, structure and enrichment experiences that all children have a basic right to in their lives. Kids Company work is based on attachment theory, and the development of new relations of trust – 're-parenting' – is central. We recognise that this is emotionally challenging work, and all staff are supervised weekly to help recognise, reflect on and manage the emotional issues that are raised.

Despite being labelled as 'hard to reach' by statutory systems, approximately 95% of Kids Company's young people self refer to its services.

For more information, contact Safeguarding:  
[info@kidsco.org.uk](mailto:info@kidsco.org.uk)

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### The Zone, Plymouth

#### Snapshot summary

The Zone is a multi-function centre in Plymouth for 13-25 year-olds, with a wide range of services available for all those who come through its doors, from information and advice services to counselling and activity programmes and other personal support services.

The Zone offers information on:

- sexual health and sexually acquired infections
- pregnancy testing and advice
- contraception and advice
- benefit entitlements and how to claim

The Zone also offers help with:

- daily living difficulties
- problems in forming or maintaining relationships
- self-harm or suicidal behaviours or a sense of not belonging.

#### Background

The Zone is one of the largest voluntary sector youth agencies in the UK.

The majority of the general advice services are for young people aged between 13 and 25 who live, work or learn in the Plymouth area but some projects work with younger children and some with young people from Tavistock and the South Hams areas.

This means that young people do not necessarily indicate what problems they might have simply by visiting The Zone. They can take the time, in a safe and user-friendly atmosphere, to develop the trust to reveal problems that they may have kept hidden.

#### What we do and how we do it

The Zone offers support and advocacy with referrals to other specialist services, such as supported housing projects and hostels, available on a drop-in basis; and cross-referrals within the Zone teams.

There are outdoor activities, residentials, activity days and more, including support in building on existing skills and learning new ones, advocacy, group work and multi-systemic therapy.

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The Zone also houses the Early Interventions in Psychosis service, and the young people's preventive personality disorder network – one of the only NIMHE personality disorder pilots specifically to focus on PD-preventive work with young people.

Insight, for example, is a small multi-disciplinary team, made up of workers from youth and community work backgrounds, community psychiatric nursing, counselling, psychotherapy, social work and occupational therapy. Additionally, the team is supported by input from a psychologist and a psychiatrist on a weekly basis. Although situated in the voluntary sector, Insight has established links with the health and social services.

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### High support schemes for adults

These case studies offer examples of schemes which include a high level of support for clients with emotional or psychological needs, as part of an overall support package.

90 Lancaster Street,  
Multiple Needs Unit, Birmingham

#### Snapshot summary

This Birmingham-based project aims to house, and keep housed, those individuals whose multiplicity of needs impact on their ability to maintain accommodation and who are excluded from direct access accommodation and community facilities.

#### Background

The Multiple Needs Unit is the first of its kind in the UK and was set up nine years ago to house men between the ages of 25 to 45 who experience a multiplicity of needs and who have been serially excluded from all direct access accommodation within the city of Birmingham.

#### What we do and how we do it

Many of our service users experience drug and alcohol issues alongside major mental health and behavioural problems. They often sleep rough for long periods of time, outside the system, unable or unwilling to access benefits or appropriate intervention for their health and social problems.

The project comprises 15 self-contained flats with a communal lounge, training kitchen, laundry and communal gardens. There are 24-hour waking staff (no one works alone) working in the project. We offer a high standard of accommodation that reflects the worth of the individual and acts as a long-term base from which a person can begin to address their needs with appropriate support.

The support offered is on a one-to-one basis and tailored to meet the individual's changing needs through a process of mutual negotiation. In reality this can mean that a support package/plan can sometimes change daily depending on the person's issues/wishes.

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### Responsive and assertive support

Support is both responsive and assertive to needs and behaviours; behaviour that in other settings might lead to eviction is challenged and change is sought through consultation and realistic goal-setting with the individual.

The project staff work across all disciplines and the project has built up strong relationships with health, social services, probation, drug and alcohol services, education services, learning disabilities, local GPs and mental health teams within the Birmingham area to ensure there is a multi-agency approach to meeting service users' needs. Working in this way has enabled us to address the housing needs of one of the most excluded groups in the city of Birmingham.

### Outcomes

Over the past nine years we have successfully housed over 89 individuals whose average stay in direct access, prior to moving to 90 Lancaster Street, would have ranged from a few hours to a few weeks. The average stay of our service users is 12 to 18 months although people can stay up to two years if they wish and we still house four of our original service users. Others have gone on to live successfully in their own homes in the community or moved onto more intensively supported accommodation.

No matter how long they stay, all our service users are in contact with and using mainstream community facilities before they leave 90 Lancaster Street. We believe the work at 90 Lancaster makes an outstanding contribution to this most excluded client group.

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### Home Base – Community Housing and Therapy

#### Snapshot summary

A planned treatment environment for homeless ex-service personnel with psychological difficulties including post-traumatic stress disorder, complex trauma or a diagnosed personality disorder.

#### Background

Each year Community Housing and Therapy (CHT) delivers psychological therapies to around 35 homeless ex-military personnel through its Home Base programme.

Those referred to Home Base will have become homeless partly as a result of the psychological problems they experience. Many suffer from complex trauma, depression or anxiety, or post-traumatic stress disorder (PTSD). A number have a diagnosed personality disorder. These problems are frequently exacerbated by alcohol or drug abuse, unemployment and inadequate life skills. Nearly all will have:

- a very limited support network
- suffer from a lack self-esteem

- feel worthless
- find it hard to form relationships.

#### What we do and how we do it

The Home Base programme consists of four distinct but overlapping and inter-related treatment interventions. However, the programme is designed as a whole with each element complementing and supporting the others.

#### Emphasis on community membership

The programme stresses membership of a community and focuses on the interpersonal and social context of psychological disorders and wellbeing, rather than focusing solely on individual psychopathology or skills training.

A dispersed housing model allows for members' potential for independent living to be tested in a peer-supported environment; but the community structure encourages sharing responsibility and participating in community decision making. This enables service users to support one another in the process of recovery, building on members' experiences of solidarity with comrades, but then takes this work to develop the skills needed to live outside the military.

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### Relationship between symptoms, behaviour and unconscious

Weekly group psychotherapy sessions focus on discussion of the relationship between symptoms, behaviours and unconscious factors. The aim is to enable service users to understand their experiences, particularly those traumatic experiences from their military service, and to link these with any earlier experiences of trauma, especially those in early childhood. This degree of openness relies and builds on the development of a secure attachment with other members of the community.

### Helping individual gain insight into source of problems

In weekly individual sessions psychological disorders are treated through psychoanalytic psychotherapy. This aims at encouraging the person to gain insight into the unconscious, repressed conflicts that are the source of problems with the goal of diminishing symptoms, developing less destructive patterns of relationships and changing anti-social behaviour. This in turn leads to improved social and vocational functioning and personal maturation.

Cognitive behavioural therapy (CBT) is also used to influence dysfunctional emotions, behaviours and cognitions aimed at restoring a more optimistic

outlook about the future. CBT interventions to develop communication skills are particularly effective with complex trauma/PTSD sufferers, who otherwise tend to avoid discussing the traumatic event.

### Emphasis on training for work

Finally, the programme places a strong emphasis on training for work. This aspect of the programme is run in partnership with Training for Life, Transitional Spaces and other organisations which assess employment skills and deficits, and arrange courses and placements for homeless people and former members of the armed services.

In the period April 08–March 09, 52% of clients achieved employment and 28% had started training courses.

### Support for staff

Staff have weekly supervision, in individual and group settings, to develop an open, questioning attitude and respect for clients' experiences, and to understand the relationship between events in the community and the unconscious processes involved in clinical work, particularly transference and projective identification.

Contact John Gale: [jg@cht.org.uk](mailto:jg@cht.org.uk)

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### St George's Crypt, Leeds

#### Snapshot summary

St George's Crypt offers a range of services during the day and night to homeless and destitute people in Leeds.

#### Background

St George's Crypt is not so much a place as a network. Combining direct access with various supported accommodation options and a social enterprise work scheme, plus good links with other agencies in the area, the Crypt has developed a network of pathways which are carefully attuned to the needs and capacities of the service users.

#### What we do and how we do it

At the heart of the Crypt's service is the Care Centre, which by day offers lunch, showers, clean clothes and advocacy to street homeless and destitute people in Leeds. By night, the centre can offer food and shelter, but also a needs and risk assessment; and where possible individuals will be referred on directly to vacancies in other direct access hostels nearby. But if

needs be, the centre itself has 12 beds of Supporting People-funded accommodation, plus three respite beds funded independently, and therefore with no eligibility strings, for up to six weeks.

The Crypt service operates on a principle of 'elastic tolerance' that can confront inappropriate behaviour, but will never reject the individual. So, for example, those who act up at the Centre might be barred for a specific period but will always have the option of returning and negotiating, through, for example, changes to their behaviour, why they should be allowed to try again.

#### Long-stay accommodation for street drinkers

In addition, Regent Terrace, a wet hostel, provides long-stay accommodation with 24-hour cover for 10 street drinkers with long-term alcohol dependency and entrenched high-support needs: a 'wraparound' service at the border of palliative care. Care plans here are slow-paced and long-term, and can include a detox, but the core principles are harm minimisation, with the opportunity to live with dignity.

#### Move-on service for detoxed residents

For move-on within the service, the Crypt has now developed Faith Lodge, a 15-bed unit for detoxed residents wishing to manage without drink or drugs.

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Random testing for substances is part of the agreement – the principle is ‘three strikes and you’re out’ – but individuals can also request more specific testing to strengthen their resolve to quit.

On the ground floor, the accommodation is shared living, with full board. All tenants agree with their key worker to do three hours proactive work, personal development or training every day.

On the top floor, there are five fully independent bed-sits, with one key worker for all five tenants. There are also three move-on houses with shared accommodation. In each house a lead tenant or mentor makes sure basic tasks are done and alerts the resettlement worker if there are problems that need intervention.

### Social enterprises

There are two mini-social enterprises, Nurture and the Charity Shop. Nurture offers skills training and employment opportunities in horticulture. Nurture’s profits can help with financial assistance which helps with ‘no eligibility criteria’ accommodation.

Nurture runs a polytunnel and two allotments, selling salad bags and eco-bags. The shop produces greetings cards and small items of costume jewellery.

Many of the ex-residents stay involved as volunteers or as workers in the Care Centre. They get support – but they are also role models for current residents. Twenty-two per cent of the staff including support workers, cleaners, and admin staff are former clients.

The Crypt is being redeveloped to provide upgraded facilities for service users including 15 self-contained accommodation units; a service users’ lounge, a dental suite, three multi-purpose skills rooms and a new landscaped garden with major input from service users.

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### Leeds NFA Health Centre

#### Snapshot summary

The NFA Health Centre (NFAHC), part of NHS Leeds Community Health Care, provides multi-disciplinary primary healthcare to people of no fixed abode in Leeds, offering:

- 'mental health first-aid'
- group work of varying intensities
- psychological counselling
- case management/care coordination
- development of robust support networks
- support in accessing 'mainstream' services.

#### Background

Approximately 70% of people accessing the NFAHC service experience complex trauma issues with attachment and/or relational difficulties that may manifest as difficulty in establishing or maintaining relationships with others, and accommodation or employment difficulties. The intention is to provide interventions that are timely, accessible, recovery-focused and relevant to the person's current experience and immediate circumstances.

#### What we do and how we do it

The first step in a person's recovery is engagement. Recognising the difficulty that engagement presents to homeless people, the NFAHC has implemented a 'stepped-care' model of therapeutic interventions tailored to address these challenges.

The first point of access to the service is through a daily drop-in mental health clinic that any person, once registered at the practice, can access whenever they wish to. (The team also works closely with outreach agencies, to facilitate a way into appropriate interventions for those people experiencing difficulty in accessing the service.)

#### Group work of varied intensities

The choices available to people wishing to use the service include group work of varied intensities:

- The 'Drop-In Group' is an open group that people are able to access as and when they wish. It offers mental health advice as well as the opportunity to sample group work and to begin to develop a therapeutic alliance with the group facilitators.
- The 'Wellbeing Group' focuses on supporting people in developing a recovery tool using the WRAP model (Wellbeing and Recovery Action Plan).

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- The 'OK Group' utilises Transactional Analysis Psychotherapy to facilitate a person's understanding of how their intra-psychic process impacts on their lives while supporting the person in bringing about and maintaining positive change.

In addition to these group activities, the staff offer/use:

- Cognitive behavioural interventions
- Transactional Analysis (a humanistic, integrative modality)
- Schema therapy
- Person-centred counselling.

But the staff team also stress that specific techniques are not the key to successful engagement.

Contact: [nigel.dawson@nhs.net](mailto:nigel.dawson@nhs.net)

### Lifeworks – St Mungo's psychotherapy service

#### Snapshot summary

Lifeworks offer individual psychotherapy (up to 25 sessions) to chronically excluded adults in a variety of settings, ranging from a frontline hostel to a medium secure unit in a psychiatric hospital.

#### Background

There is strong evidence for the link between complex needs, complex trauma and homelessness.

Of Lifeworks' clients:

- 52% lost a primary carer in early childhood (often violently, e.g. murder or suicide)
- over half were abused as children – and most have histories of chronic trauma since
- 43% have been in prison
- 70% – 80% have mental health problems
- two-thirds use three or more substances
- all have either been in a psychiatric hospital or a hostel.

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### What we do and how we do it

The objective of Lifeworks is to enable the client to manage their feelings and think things through better, and thereby to facilitate their ability to change the destructive patterns that keep them in chronic exclusion.

There are two key datasets for the outcomes – the evidence-based NIHME Wellbeing Impact Assessment Measure, and the London Housing Foundation (LHF) Outcomes Star, mapped against the stages of the well-evidenced ‘cycle of change’. Both datasets cover the wide range of psychosocial issues that characterise the chronically excluded.

Lifeworks is also being evaluated through the Adverse Childhood Experience (ACE) evaluation, and we are in the process of collecting data on specific client outcomes (e.g. around accommodation, voluntary work, substance use reduction, use of secondary care).

Clients are offered an initial assessment, to clarify that therapy is what the client wants: 67% take up therapy (many of the remaining 33% do not come to the first session for various reasons: e.g. death, imprisonment, moving hostel, eviction, abandonment, already in treatment, etc).

Attendance by those who take up therapy is 75%, positively comparable to rates for many primary care psychological therapy services working with far less damaged populations (and above IAPT targets).

On the NIHME measure, 76% of clients show an overall improvement. On the LHF Outcomes Star, Lifeworks clients are three times more likely to move from pre-contemplation to consolidation (i.e. the whole range of the cycle of change) than non-Lifeworks clients, and more than twice as likely to move from contemplation to consolidation.

One hundred per cent of Lifeworks clients moved from ‘inactive’ to ‘active’ compared to 60 per cent of clients not in Lifeworks.

### Cost-saving and health benefits

People with complex needs often tend to ‘rattle around’ the system, using lots of services but never really moving on; many end up in homelessness hostels.

It costs around £500pw to support someone in a frontline hostel; Lifeworks costs £1,500 per client (assuming they use the full 25 sessions; not all do). If people are ready to move on just a few weeks earlier, there is already a cost saving.

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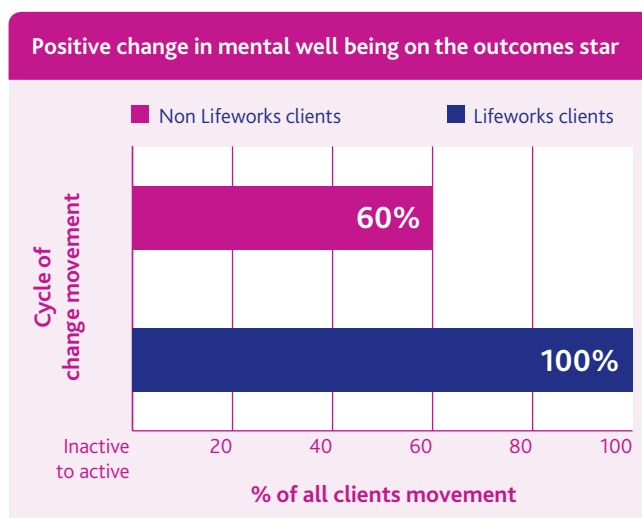
Other cost-benefits are through reduced (re) hospitalisations, including those discharged from the secure unit, and reduced relapse in clients of substance misuse aftercare.

The benefit to our clients is best left to them to articulate:

**"I was drinking and using drugs for a long time; I ...lost it and ended up sleeping rough. I had a lot of family problems and for a long time, thought it was all my fault. Through my work with Lifeworks I now know it wasn't just me, it was all of us... if my parents had used this service things may have turned out different. I think it could have helped them. I now realise that the drink, the drugs, [losing] the flat, the family, it's all linked... If it wasn't for Lifeworks I'd be dead by now, no word of a lie."**

*Lifeworks client*

Contact: [Peter.Cockersell@MUNGOS.ORG](mailto:Peter.Cockersell@MUNGOS.ORG)



The above graph compares data from Outcomes Stars for 58 St Mungo's accommodation-based clients who had participated in Lifeworks with those for 825 St Mungo's accommodation-based clients who had not participated.

The graph shows the percentage of clients who progressed from an 'inactive' phase on the stages of change – either pre-contemplation or contemplation – to an 'active' phase – preparation, action or consolidation. It takes those clients' first star reading on that scale and compares it to their latest reading at the time of the analysis.

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### Leicester Homeless Mental Health Service

#### Snapshot summary

The Leicester Homeless Mental Health Service (HMHS) provides assessment, treatment and support to homeless adults over the age of 16 with mental health difficulties across the city of Leicester. In addition to providing direct mental health services, the team also aims to improve access to all mainstream social and health care services for single homeless people in the locality by advocating with mainstream mental health, social care and primary care providers and commissioners.

#### Background

The team consists of:

- three full-time Registered Mental Health Nurses
- one part-time Associate Specialist Psychiatrist
- one full-time psychologist
- one half-time admin worker; and
- sessional input by a Consultant Psychiatrist (supervision).

There is an additional STR (support worker) post that is funded by PCTs and managed by the mental health charity Rethink in partnership with Leicestershire Partnership NHS Trust (LPT).

This collaborative partnership has been sustained over several years. The Rethink worker works within a recovery model to support clients with their life choices. This post was developed in order to extend service provision in Leicestershire and map further gaps in the service.

#### What we do and how we do it

We have developed a service which is able to respond to clients' needs as they arise and when the client is ready to engage.

#### We aim to:

Improve the quality of life for homeless people in Leicester by:

- providing appropriate, personalised mental health assessment and access to treatment services
- assisting service users to access appropriate accommodation
- facilitating access to mainstream mental health and other services

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- offering individual and group psychological services
- promoting positive mental health.

### We also aim to:

Improve other local services currently accessed by homeless people by:

- sharing models of care with the voluntary and statutory sectors
- disseminating specialist knowledge of mental health to people without a mental health background
- advising other professionals
- providing information and training to other professionals
- liaising between hostel providers and mainstream mental health services
- Informal support and supervision for staff working with people who they often find difficult to engage.

We have developed a service which includes homeless people or those living in temporary accommodation who otherwise might be excluded from traditional mental health services, either because they do not meet specific diagnostic criteria or their chaotic lifestyles make it difficult to negotiate and maintain links with these services.

The support offered, although based on an access criteria of the person being homeless, may also include assisting the transition to new tenancies. Some mental health services focus on severe and enduring illness; others are reluctant to see people with substance-use issues in addition to their mental health problems. We find it possible to assess every homeless person who approaches us (regardless of diagnosis) including people with dual diagnosis, and who are still using substances.

Our goal, when working with people with a history of complex trauma, is as simple and as complex as just staying in touch with them. Many are trapped in a cycle of abusive, transient relationships, aggression or substance misuse which may lead them to be excluded from hostels and back onto the streets. We try to make our service as accessible as possible by meeting people wherever it suits them.

It is accepted that a good therapeutic relationship is crucial to successful therapeutic work, but many of the people we work with have never had a reliable, stable, consistent and trusting relationship with anyone. Much of our one-to-one work therefore is focused on the basics, such as establishing a trusting relationship.

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### Developing the one-stop shop

The team has developed from a 'single post service', to its current provision, following years of negotiation with providers and purchasers. Before the opening of the Dawn Centre (multi-agency homeless accommodation/ day centre/ health services) in January 2006, the logistics of providing a dispersed service were very challenging. The development of the 'one-stop shop' concept has facilitated our communication with other agencies as well as the obvious advantages for the homeless clients. We continue to offer an outreach service to all hostels rather than changing to a clinic based service located only at the Dawn Centre.

Often homeless people have become mistrustful of services. By being accessible and approachable in places where homeless people present, we have been able to build trust and mutual respect. The challenges of supporting homeless people have altered in accordance with the developments in changing legislation and the logistics of accessing dispersed services. Homeless people can be very chaotic in their lifestyles and our clinical practice has to adapt accordingly.

### Building strong links with frontline workers

The team has built outstanding links with frontline workers within the wider homeless service including primary healthcare, housing outreach, tenancy support

and day services, and weekly multi-disciplinary/ inter-agency meetings, facilitate excellent levels of communication. This degree of inter-agency co-operation is a real strength.

### Raising profile of mental health services and homelessness

Through developing good relationships with other services, we can raise the profile of mental health issues. By attending regular forums within local mental health services we also increase raise the profile of homelessness within these services.

Until September 2007, we were unable to access LPT mental health records database at the Dawn Centre initially due to its non-NHS location. Following negotiations, however, access has now been facilitated and this has greatly enhanced our working practice. Similarly, our close working relationship with the Homeless Primary Healthcare Service at the Dawn Centre has been enhanced by having the facility to directly input into their computerised records.

### Seamless service from multi-disciplinary team

Our working practice has adapted to accommodate the developments of the Crisis and Assertive Outreach teams within LPT, which have enabled us to provide a more seamless service without duplicating provision.

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The team is multi-disciplinary but works cohesively. Over time we have built on mutual trust and respect to facilitate joint collaborative working in the best interests of our clients. The nurses have been involved in the implementation of the Homeless Nurses Group UK, which has amalgamated with the Homeless Health Initiative (The Queen's Nursing Institute). This is a networking and peer support group for nurses working with homeless people.

The service participated and was highlighted in national research that looked at access to mental health services for people who are homeless (DH, CSIP, CLG 1 Jan 2007). In April 2008 the team were successful winners of the 'Mental Health & Wellbeing' category of the East Midlands Regional – Health & Social Care Awards, and went on to become finalists at the national event held at Wembley Stadium in July 2008. The service also highlighted as a good practice example in the recent report *Down and Out* (St Mungo's December 2009).

Contact: [Philip.Johnson@leicspart.nhs.uk](mailto:Philip.Johnson@leicspart.nhs.uk)

### The Old Theatre, Broadway, London

#### Snapshot summary

The Old Theatre is an accommodation-based service that supports serially-excluded ex-rough sleepers with complex needs. The project, run by Broadway and commissioned by Hammersmith and Fulham, aims to provide clients with a safe place to call home where they can be supported to develop skills for independence and move on.

#### Background

Previous exclusions show that normal hostel systems have not worked for this client group. The Old Theatre takes a more flexible, creative and individual approach. There is a high staff/client ratio, with 10 workers and two managers providing 24-hour support for 12 residents. House rules and visitors' policies are written with clients to meet their individual needs and to address the issues that contributed to previous exclusions.

There is a team approach: each worker has in-depth knowledge of the clients and can provide support when it is needed. But each client also has a lead key worker to co-ordinate support and provide consistency.

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### What we do and how we do it

There is a focus on health and daily living skills – money management, attending appointments, cleaning and food preparation – alongside substance misuse and mental health specialist support.

In addition, through the use of cognitive behaviour therapy (CBT) and motivational interviewing (MI) techniques, clients are given the opportunity to take responsibility for their actions and change their behaviour. One significant difference between the service and a standard hostel is that many of these services are provided in-house through agreed joint working protocols.

### Access to local specialist services

There are on-site sessions on substance misuse from local specialist services, Outreach and Druglink, and project workers will also co-ordinate referrals to external agencies for support with drug and alcohol use, mental health and physical health. Clients are supported to take part in activities outside the project such as basic skills classes, gardening, music, art, job club, training/education, leisure activities and day trips.

### Managing relations with local community

The Old Theatre service is also highly sensitive to the need to manage relations with the neighbouring community, and do not see this as inconsistent with providing support and feedback to the project's residents. The staff monitor activity outside the project by carrying out regular checks of the local area. When residents are seen drinking outside or causing a nuisance, staff remind clients about the controlled drinking zone, their responsibilities under the project rules, and offer alternative activities inside the project or with external agencies. If the anti-social behaviour continues, project staff contact the police for support to enforce the controlled drinking zone and take further action as necessary.

### Working closely with Street Outreach Response Team

Old Theatre staff also work closely with the Street Outreach Response Team (SORT) to ensure any non-residents involved in street activity are directed away from the project and supported to access appropriate services, such as housing. Project managers attend regular meetings with representatives from the Police, Outreach, Community Safety and Anti-Social Behaviour teams to identify individuals causing a particular problem and agree action around support and enforcement.

Contact David Fisher: [david.fisher@broadwaylondon.org](mailto:david.fisher@broadwaylondon.org)

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### Staff capacity building and support

These case studies demonstrate a variety of ways in which staff can be trained, supported and offered supervision to work with clients experiencing complex trauma.

#### Coaching Skills Training Course – Foyer Foundation

##### Snapshot summary

The Foyer Federation has developed a life coaching skills programme for Foyer staff to support young people with emotional and mental health problems.

The two-day course covers the essential areas of a coaching approach to key work.

##### Background

Practitioners within the **Foyer Federation** staff team identified that when applied to key-working with young people, elements of a Life Coaching approach provided the perfect fit with the Foyer ethos – and, crucially,

enabled services to meet their obligations under the new outcomes framework.

Following on from the success of years one and two of the Foyer Health Programme, funded by the Big Lottery's Well-being Fund, Foyer Managers have been keen to embed the coaching skills model within the Support Planning process for their staff teams.

##### Content

In response to this, the Foyer Federation has now developed a two day Coaching Skills Training Course which covers the following essential areas of a coaching approach to key work:

- Principles of coaching
- The GROW Model
- Communication skills for coaching
- Reflecting on example coaching sessions
- Factors effecting health, happiness and motivation
- Values and beliefs
- Theories of human development
- Learning coaching skills practice

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After day one, staff will be able to start putting their coaching skills into practice. Day two, which will be delivered approximately four weeks later, is designed to support staff to reflect on their practice and to offer further development. We are in the process of attempting to gain accreditation for the course. Each day starts at 10am and ends at 4pm and as these days are very intensive it is important that staff are able to attend for both full days.

Contact Dave Pendle: [dave@foyer.net](mailto:dave@foyer.net)

### Westminster Cognitive Behaviour Therapy Project

#### Snapshot summary

Cognitive Behaviour Therapy (CBT) has been found to be useful in enabling homeless people to address the issues underpinning repeat homelessness

A CBT staff training and supervision project was commissioned by Westminster City Council and delivered by clinical and counselling psychologists.

#### Background

Westminster City Council commissioned a project to evaluate the impact of a CBT training and supervision package, designed and led by a clinical psychologist.

#### Content

The training package consisted of four days of workshops and two follow-up days designed to enable 30 frontline homelessness staff working across Westminster to use four specific CBT skills.

These were:

- engagement in change

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- formulation and cognitive flexibility
- basic change techniques
- monitoring of effectiveness.

One training day was also delivered to the managers of the services in which the staff worked in order so they could have an understanding of what was being done and to encourage buy-in.

The supervision was delivered in groups of three, for 90 minutes every two weeks for six months by qualified clinical and counselling psychologists, who were themselves supervised by the lead psychologist.

### Evaluation

It was predicted that the training and supervision package would:

- reduce staff burnout
- increase staff members' perceptions of effective working with this complex group
- reduce negative beliefs about the population

Validated questionnaires were used to measure changes in these factors. In addition, data on services users' general mental health functioning and incidence of asocial behaviours were gathered in order to evaluate the effect of the package on service user outcomes.

### Results

#### Staff outcomes

Data were gathered before the training, after training and after six months of supervision. Thirty staff completed all the questionnaires before the training, 28 completed the measures after the training and 12 people completed the supervision package. The results showed that burnout dropped after the training course and further, significantly reduced over the course of the supervision package.

#### Client outcomes

Client outcomes were measured by the staff at up to four time points over the six months of supervision.

A number of behavioural measures were used (e.g. the number of incidents of aggression in a given time period) in addition to the CORE (Clinical Outcomes in Routine Evaluation) as the main outcome measure of general mental health.

Both the behavioural and CORE data were highly variable in terms of number of completed sets. Not enough behavioural data were gathered to provide a useful interpretation, however the CORE data showed improvements between Times One and Three, and then a slight worsening at Time Four, after six months

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(although the levels did not return to the Time One levels, showing an overall improvement). The rise in Time Four scores may have been due to two individuals increasing their scores significantly, possibly due to crises or difficult environmental factors. This is of course a common occurrence within the population.

### Conclusion

This project provides further evidence that CBT can be a useful tool for frontline homelessness workers, and that the training and supervision package was effective in reducing staff burnout and increasing perceptions of effective working with a complex client group, as well as reducing negative beliefs about the population. There is some evidence that this is associated with improvements in mental health, although data supporting this needs further work. The project won the collaboration award at the London Regional NTA awards ceremony in 2009.

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Nik Ward: [nik.ward@gmail.com](mailto:nik.ward@gmail.com)

## The Department of Health's Knowledge and Understanding Framework

### Snapshot summary

The key goal of the Knowledge and Understanding Framework (KUF) is to improve service user experience through developing the capabilities, skills and knowledge of the multi-agency workforces in health, housing, social care and criminal justice who are dealing with the challenges of personality disorder (PD).

### Background

We believe that the KUF can contribute to improving the service user experience by:

- increasing the level of awareness and support offered to staff
- reducing stress, burn-out and unhealthy working environments
- making services more efficient and effective.

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The validated multi-level educational package includes the following:

- Personality Disorder Virtual Learning Awareness Programme ('Raising Awareness')
- Validated Undergraduate Degree Programme ('Developing Understanding and Effectiveness')
- Validated Masters Degree Programme ('Extending Expertise, Enhancing Practice')

These high-quality educational programmes are delivered by leading practitioners and service user consultants.

The Awareness Programme has a number of packages available including a Train the Trainers version. The BSc and MSc programmes are available as single stand-alone modules (suitable as units of learning for Continuing Professional Development), or as whole programmes with associated qualifications.

### For more information

There is a lot more detail about the programme aims and specific modules of these courses at the personality disorder website. Visit: [www.personalitydisorder.org.uk/training/kuf/index.php](http://www.personalitydisorder.org.uk/training/kuf/index.php)

## Behaviour Support Service, Brighton and Hove

### Snapshot summary

The Behaviour Support Service is a dedicated team set up to support the work of supported housing providers across the city. The long-term aim is to develop mechanisms to ensure that the psychological factors that affect people's progress towards more secure housing can be addressed in a coordinated and comprehensive way.

The team consists of counsellors and psychologists. The team draws on ideas from:

- cognitive behavioural therapy (CBT)
- solution-focused therapy
- motivational interviewing

The service remit is to focus on behaviour change to break the cycle of eviction/abandonment, street homelessness, hostel life/tenancy, and eviction/abandonment.

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### Background

The behaviour support service was set up in response to:

- an increasing emphasis in the housing sector on resettlement and proactively trying to help more people move on towards living more independently
- a recognition that the emotional and psychological needs of clients have an impact on so many aspects of providing housing support and on resettlement outcomes
- evidence that psychological interventions can be effective in addressing common issues that block effective resettlement (e.g. emotional distress, behavioural issues) and in reducing repeat homelessness.

### How the service works

We have encouraged support workers to refer:

- new clients who have a history of eviction/ abandonment
- clients who are accumulating warnings because of behaviour that could put their tenancy/licence at risk
- clients who, in their experience, have non-practical blocks to 'move-on' or have had an unsuccessful attempt at move on.

In order to do this effectively the team was set up to deliver:

- one-to-one client work and staff consultation re clients when this is more suitable
- regular free training courses (modules of eight weekly 3-4 hour sessions for eight staff) in theories and techniques the team use for working with this client group. These courses support frontline staff to gain skills and develop their practice to meet the complex needs of this client group; a dedicated website called 'Mortarnet' [www.mortarnet.org.uk](http://www.mortarnet.org.uk)

### Dedicated website

Mortarnet also serves as a good practice guide for staff as it helps enhance understanding of psychological theories and knowledge of interventions that can help hostel staff work with the different roles required of them. For example:

- beginning a key working relationship with a service user
- goals and support planning and ways of looking at working with clients who are difficult to engage with
- dealing with overwhelming emotions, fear and anxiety, low mood, guilt and shame, managing our own stress
- positively managing risk and challenging behaviour
- ending a key working relationship with a service user.

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The website also includes the 'experience exchange' for people to share good practice ideas throughout the city. The experience exchange links the bands 2, 3 and 4, of the integrated support pathway i.e. supported accommodation across the city to bring together new ideas for working with service users and to access more support from Behaviour Support Service.

Below is an example of information shared on experience exchange after understanding and enhancing motivation training:

**"I think I quite often leap to resolve the situation myself... in these kinds of instances where in some (not all) it might be better to slow things down and assist the client to think of resolutions themselves. Giving the client the chance to find the solution himself not only helped resolve the problem, but seemed to have a calming effect on him when initially he'd been quite distressed"**

Contact: [Karen.orourke@brighton-hove.gov.uk](mailto:Karen.orourke@brighton-hove.gov.uk)

### Mark's story

Mark was referred to our service in September 2008 as his behaviour was putting his tenancy at risk, i.e. threatening suicide, self-harm and noise nuisance. Alcohol and drug use was often a trigger to these events.

Since leaving care Mark has had nearly three and a half years of living independently over the last 20 years. The rest of the time he has a history of B&B, rough sleeping and staying in hostels. He said he had received a personality disorder diagnosis although he is not currently linked in with a mental health team. He has also described being subjected to physical and sexual abuse during his childhood.

In the previous six months of his referral to our team he had incurred eight warnings and one Notice to Quit (NTQ).

In the first six months of our work together he incurred two warnings and was evicted for assault. He then moved to B&B and once back with the support pathway we started working with Mark again. During the last six months of our work together and through joint working with other agencies Mark incurred one warning for noise nuisance and although exhibiting some of the same behaviour patterns, he has maintained his tenancy to date.

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### Art of Defusing training, Bedford

#### Snapshot summary

For the past three years this training course has been made available to staff working in hostels in Bedford. It has been run by Jo Bunker, a qualified trainer with experience in this field and has equipped more than 50 frontline workers to deal effectively with conflict in a residential setting.

#### Background

The course was funded by the council as a result of the Rough Sleepers Reduction Plan which outlined the need to reduce evictions from hostels due to anti-social behaviour. This plan was produced by a multi-agency task group from the Bedfordshire Supported Housing Forum, following the 2007 Rough Sleepers Count.

#### Impacts of the course

The course has had a number of positive impacts since its introduction including:

- the opportunity for hostel workers from different agencies to train and network together
- enabling good practice to be shared within the context of training

- relationship building between the trainees that has resulted in 'added' benefit to the clients of their respective services. For example, easier sharing of information around the client's support needs.

The feedback highlighted:

- how valuable the training was in personally equipping staff – and in some cases bringing about changes to policy and procedures for hostels
- that staff related much better and more effectively across agencies than before with sideways referrals happening, where appropriate, to prevent evictions.

#### Outcomes from the course

From April 2007-March 2008 43 people were evicted for anti-social behaviour (ASB) from Supported Housing in Bedford.

After the first course in November 2007, and two further courses in November 2008, the number of evictions for ASB dropped to 25 by April 2009; nearly a 50% reduction.

The service with the highest number of evictions in 2007 invested time training all their staff on this course and saw a 68% drop in their evictions for ASB, from 22 in 2007 to only 7 by October 2009.

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The overall number of evictions has dropped from 180 in 2007 to 59 in 2009; a 67% reduction.

### Evictions protocol

A Task & Finish group has been launched from the Bedfordshire Supported Housing Forum to investigate the benefits of implementing an Evictions Protocol in Bedford or even across the county.

This is primarily being driven by a desire to prevent more evictions and improve the joint working between all agencies involved in delivering support to clients in Supported Housing accommodation.

Contact Mike Milner: [Mmilner@bedford.gov.uk](mailto:Mmilner@bedford.gov.uk)  
or Jo Bunker: [jobunkertraining@gmail.com](mailto:jobunkertraining@gmail.com)

## Novas Scarman psychological skills training

### Snapshot summary

The training programme aims to skill up frontline-housing staff to help them work more effectively with clients with increasingly complex needs – and how to avoid burnout themselves.

### Background

In January 2009 the Novas Scarman group was awarded £42k from the Bristol Primary Care Trust to put together a psychological skills training package for frontline housing staff working with hostel residents, of whom many have experienced repeat homelessness, complex trauma and substance misuse.

Hostel residents may also have had problems accessing psychological therapies being introduced locally through the Improved Access to Psychological Therapies (IAPT) initiative in primary care, due to their chaotic lifestyles, difficulties establishing trust and exclusion criteria because of their drug or alcohol use.

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We also wanted to develop some of the applications in homelessness services from some of the new 'mindfulness based' approaches such as:

- Mindfulness Based Cognitive Therapy (MBCT)
- Acceptance and Commitment Therapy (ACT).

### Teaching clients acceptance skills

Some of these approaches differ slightly from Cognitive Behavioural Therapy (CBT) in that they emphasise teaching clients acceptance skills rather than developing cognitive restructuring or challenging negative thoughts.

However, both approaches place a strong emphasis on obtaining a trialled clinical evidence base. ACT also places a strong emphasis on exploring what matters most to clients and helping them structure behaviour change and enhanced psychological flexibility on the basis of uncovering valued directions to live by.

Both of these approaches try to support clients in learning different strategies to deal with difficult thoughts, feelings and emotions rather than struggling to avoid them through substance misuse and self-harm.

### Preventing staff burnout

A potential positive effect of this training is on preventing staff burnout, which again can feed into poor client care. We also aimed to teach some bedrock counselling skills including effective listening and empathy which are sometimes lost in a pressured environment to secure housing outcomes.

In February 2009 we held a successful conference in Bristol involving health and social care commissioners, staff and clients that looked at national work, which had utilised psychological approaches when working with clients receiving housing support.

By July 2010 we will have trained 80 staff and 20 staff in MBCT from organisations that provide housing, substance misuse and mental health support; as well as support to women involved in the sex industry.

### Next phases:

- to build in a process of clinical supervision to allow staff to develop skills in this area; and
- to look at organisations that can work together to do small-scale group work with clients that can be evaluated.

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### Psychological approaches with relevance across range of problems

What has been particularly rewarding is that some of the trainers have been clinical psychologists who are more accustomed to dealing with clients with the psychological aspects arising from chronic pain management. The possibility of some types of psychological approaches having relevance across a whole range of problems and client groups raises exciting opportunities in health and social care.

Contact: [Ross.Hughes@novasscarman.org](mailto:Ross.Hughes@novasscarman.org)

### Framework Housing Association, Nottingham

#### Snapshot summary

Framework works in close partnership with statutory mental health services as many of our service users face serious and challenging mental health difficulties. These links, together with the organisation's investment in a Lead Practitioner in mental health, have helped create a consistent and considered approach to the training and supervision needs of staff in enhanced mental health awareness.

#### Background

Framework is the largest provider of supported housing and housing-related support to homeless and vulnerable people in Nottinghamshire. Framework's philosophy is that everyone has 'mental health' issues; but many of our service users face particular challenges in their mental health relating to areas of trauma, deprivation, exclusion and the accumulated disadvantage which many may bear.

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#### Modular approach to training

Framework has devised a modular approach to promoting the mental health awareness and skills of their staff. Framework has rolled-out these sessions 20 times or so over the past five years. We continually review feedback and make relevant changes in line with contemporary research and current best practice.

The basic modules include:

- mental health awareness
- recovery
- dual diagnosis
- personality disorder
- self-harm
- statutory mental health services
- the Mental Capacity Act 2005
- 'advanced' mental health and self-harm

The modules are delivered either by external partners or internal 'champions', including input from service users. Framework has adopted an organisation-wide approach to training which aims to bring all staff up to NVQ Level 3 in Advice and Guidance or the equivalent.

Framework's Mental Health and Longer-Term Services have also gained Level 2 Practice Development Unit

Accreditation with Leeds University. Training modules delivered by the Nottinghamshire Healthcare Trust's Dual Diagnosis team and the personality disorder service are also seen as useful vehicles for establishing good partnership working.

#### Supervision and reflective practice

In addition to regular line management supervision, staff have the opportunity to access additional support, mentoring, and supervision from colleagues, peers, partner agencies, and the Lead Practitioner in mental health. For example, the Trust's Dual Diagnosis Team runs monthly group supervision sessions for any Framework staff who face difficult issues or challenges in supporting someone with a dual diagnosis. This allows us to deliver an effective service to people who might otherwise bounce from pillar to post in search of help and support.

Service user involvement plays an important part in our work and in the training and development of staff. Without doubt the most inspiring contributions in the in-house 'Recovery' training we deliver are those from service users. Personal testimonies and representations of recovery from service users, together with the staff's own skilled interventions and interactions inspire staff to work from a perspective of strength and with creativity and hope.

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## Section 2: Case studies

### Making partnership working a reality

Partnership working is a term that is used a great deal, but turning it into reality takes openness, commitment, creativity and persistence and the supervision framework helps this happen. There are no magic wands when it comes to developing an informed, aware, skilled, emotionally literate and recovery-focused workforce.

This training and supervision programme has helped create a culture which is built on openness, continuous learning, bottom-up thinking, reflective practice and the embracing of evidence-based practice. For example, staff and service users have run reflective practice groups on issues as diverse as dealing with complaints, positive endings, hoarding, self-harm, and working with service users who have pets.

Staff in the third sector are often well placed, by virtue of the close contact they have with service users, to offer real, tangible, solution-focused support to people with mental health problems. Once these building blocks are in place, it takes continuing learning, support, supervision, reflective-practice and practice development to create a culture in which we can deliver the best service and opportunities for recovery, to the most disadvantaged and excluded members of our society.

Contact: [graeme.green@frameworkha.org](mailto:graeme.green@frameworkha.org)

### Young People in Focus: health and wellbeing scheme

#### Snapshot summary

#### An accredited staff training programme

Young people in focus has developed an accredited training programme on promoting young people's health and wellbeing for supported housing workers. For more information please see [www.youngpeopleinfocus.org.uk/courses/open\\_courses/supportedhousing.html](http://www.youngpeopleinfocus.org.uk/courses/open_courses/supportedhousing.html)

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## Section 3: Definitions and weblinks

### Psychological disorders which can predict homelessness – some key definitions

This section offers some key definitions of psychological disorders, together with some useful weblinks on psychological techniques and approaches.

#### Complex trauma

Complex trauma (or Complex PTSD, Type II Trauma) refers to the psychological problems and linked patterns of thoughts, feelings and behaviours which tend to result from prolonged exposure to traumatic experience. It is associated with repeated situations in which the individual loses control or is disempowered and from which there is no apparent escape. Extreme examples of such experiences may be hostage situations or torture, or more commonly childhood abuse of any form and domestic violence.

When such ongoing traumatic experience occurs within the context of a care relationship, e.g. parents or care-givers being the primary abusers, attachment processes can be fundamentally disrupted. This may then cause problems in forming relationships later in life, as well as difficulties with regulating emotions and attempts to avoid unpleasant emotional or cognitive experiences (experiential avoidance).

Links are made between complex trauma and the psychiatric diagnosis of 'borderline personality disorder' (BPD), particularly when interpersonal problems and self-harm are evident. Indeed, some authors argue that the two terms describe the same phenomena. Similar links are made between complex trauma in childhood and attachment disorders.

#### Personality disorder

There are many different theoretical and diagnostic approaches to the definition of personality disorder (PD), but generally it is the diagnosis applied to patterns of thoughts, emotions and difficulties in interpersonal functioning and impulse control, which often result from difficult experiences in childhood and concomitant attachment problems.

The American Psychiatric Association (APA) defines PD as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it'. The World Health Organisation (WHO) also states that PD is a set of 'deeply ingrained and enduring behaviour

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patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations’.

Recognising that PD and other formal illnesses can co-exist, the APA uses a number of ‘axes’ to describe different forms of mental health problem or incapacity. PD is classed as an ‘Axis II’ disorder (as opposed to depression, anxiety and psychosis which are ‘Axis I’ disorders). A number of different sub-types of PD can be discriminated, but the number and descriptions of these subtypes differ according to which diagnostic system is used, i.e. the APA system (DSM-IV) or the WHO system (ICD-10). Explicit links are currently being made between one particular subtype (borderline personality disorder) and complex trauma (see above).

This term is not used for children and young people under 18 as their personality has not been fully formed. There are, however, strong traits which can become apparent from early childhood and which are compounded by trauma and lack of attachment to carers. These are often described as attachment difficulties or disorders.

The stigma and ‘therapeutic nihilism’ previously associated with a diagnosis of personality disorder may account in part for the often low or erratic prevalence of

PD reported in some surveys of non-clinical staff, such as in homelessness services.

<http://psychcentral.com/personality/>  
[www.rcpsych.ac.uk/campaigns/changingminds/mentaldisorders/personalitydisorder.aspx](http://www.rcpsych.ac.uk/campaigns/changingminds/mentaldisorders/personalitydisorder.aspx)

### Post traumatic stress disorder

Post traumatic stress disorder (PTSD, Type I Trauma) is an anxiety disorder usually caused by exposure to a highly traumatic event in which personal safety or integrity is seriously threatened. Symptoms can include re-experiencing the original trauma in the form of flashbacks or nightmares; avoidance of situations associated with the trauma; increased arousal and anger outbursts, sleep difficulties and hyper vigilance for threat. There are a number of very useful neurological and psychological models accounting for these symptoms in terms of causes and maintenance.

### Conduct disorder

Conduct disorder is a diagnosis used for children under 18 with a pervasive pattern of behaviour which violates social norms or the rights of others. Such behaviour may include verbal and physical aggression; cruel behaviour towards people and animals; destructive behaviour; lying; truancy; vandalism; and stealing.

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A number of factors are thought to underpin these behaviours, including genetic predisposition, environmental factors and inconsistent or absent parenting styles. There is some neurological evidence implicating a lack of empathy and concern in the cause of such behaviours. Note that if these behaviours persist into adulthood (18+ years) a diagnosis of antisocial personality disorder may be given (ASPD).

### Oppositional disorder

Young people who demonstrate a number of persisting behaviours for at least six months, including loss of temper, being angry and resentful, being argumentative, shifting blame to others, demonstrating spiteful or vindictive behaviour, and defying rules can be described as having oppositional disorder.

### Persistent, pervasive problems

A number of key factors distinguish complex trauma in principle from PTSD. Whereas PTSD is a psychological reaction to a single event or set of discrete events, complex trauma is a reaction to ongoing traumatic experience from which the individual cannot escape.

Theories accounting for the symptoms of PTSD (e.g. flashbacks, nightmares and mood disturbance) are well

documented and investigated. Theories describing the generation of symptoms of complex trauma still require empirical evaluation.

However, clinical observations and anecdotal evidence, supplemented by recent findings in neuroscience, strongly suggest that the same processes underpin complex trauma and PD, further suggesting that the two are linked or are the same. Equally, the behaviours demonstrated by people with PTSD and complex trauma are similar. The behaviours observed in people with PD can be described as ways of coping with the traumatic experience of difficult childhoods.

The literature review [www.personal.soton.ac.uk/nm10/Complex\\_Trauma.doc](http://www.personal.soton.ac.uk/nm10/Complex_Trauma.doc) on prevalence and homelessness suggests a particularly strong and close overlap between these different presentations; and it may be that among people who are homeless or in insecure accommodation, and more generally among those with chaotic lifestyles, the distinction between these clinical syndromes may be less clear-cut than it is for the rest of the population.

It may therefore be more useful to think of PD as long-standing or 'chronic' complex trauma, that is a reaction to ongoing and sustained traumatic experience.

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### Co-morbidity

A number of theories describe the way in which drug and alcohol use functions as a maladaptive coping strategy for individuals with underlying mental health difficulties of all kinds. There are a number of factors, physiological, emotional and psychological, which are believed to be related to drug use.

Dialectical behaviour therapy (DBT) particularly emphasises the role of substance and alcohol use as an emotion regulation strategy. For those who do not have the skills to regulate their own strong emotions (see [emotion regulation](#)), taking drugs or alcohol is the fastest way to change their internal state, both cognitive and emotional. Emotions may be dulled or eradicated through the use of narcotics, a process sometimes referred to as 'experiential avoidance'.

Other theories suggest that drug and alcohol use is related to how people manage the distress caused by constantly thinking about difficult experiences. Ruminations about experiences which make someone feel afraid, shameful or guilty may be dulled by drugs or alcohol. Anecdotal clinical evidence suggests that some people use alcohol to help them sleep (although alcohol will interfere with the quality of sleep), which again may be partly related to rumination.

One of the most powerful motivations for continuing to take narcotics is to prevent the difficult physical symptoms associated with non-use. These may exacerbate the negative emotions prevalent in people with psychological difficulties. Finally, there is some evidence that people believe that using narcotics helps them to maintain relationships with others, either through loss of inhibition or through a peer group based around acquisition and use of a particular substance.

### Attachment

Neglect and abuse in childhood has many effects, not least on the process of attachment in early childhood and separation in adolescence.

Infants become attached to adults who respond appropriately to their needs for example with food, contact, attention etc. If the infant does not receive this kind of care, or it is unpredictable or inconsistent, attachment may be disrupted.

Disrupted attachment is often described on two dimensions, avoidance and anxiety. Avoidant infants may grow up believing that others will never meet their needs, or even that they are not worthy of care, resulting in mistrust of others and avoidance of close relationships even though proximity may be craved.

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Anxiously attached infants may grow up hyper vigilant for signs of neglect, and make behavioural attempts to prevent others from leaving them (which paradoxically may increase the likelihood of this happening).

Neglect, physical, emotional or sexual abuse in childhood have all been found to disrupt the attachment process. Such effects are reversible as children can develop multiple attachments with carers, and this is a positive message for interventions and services. They can however also lead to more entrenched relationships and emotional difficulties in later life if the cycle is not broken by a secure and stable environment and by developing positive experiences of themselves and the adult world.

### Emotion regulation

Emotion regulation refers to the process whereby we attempt to regulate strong, usually unpleasant, emotions either before they occur or afterwards. These skills are learnt incrementally over the lifespan, but much formative experience in emotion regulation occurs in childhood and adolescence.

Infants who do not suffer abuse or neglect may learn that having signalled distress, consequent attention from care-givers reduces those unpleasant emotions. In this way, emotional experience is made 'valid', i.e.

the infant becomes aware that their distress is valid and others are available to soothe. Later, when language is developed, children may learn to describe their emotional state with the help of information from care-givers, through labels applied to specific emotions (e.g. jealousy, anger). Again, attention to these emotions validates them, and the child is taught strategies to manage them. Throughout childhood and adolescence a great deal is learnt about acceptable and unacceptable presentation of emotional states because boundaries are made explicit.

If the environment in which the child grows up does not serve these functions, the individual may grow up unable to self-soothe, and may seek other ways of avoiding unpleasant emotions (for example drug or, alcohol use or self-harm) and may be prone to periods of unregulated emotions (e.g. anger, anxiety) associated with antisocial or self-destructive behaviours.

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### Psychological techniques and approaches – useful weblinks

The evidence of feedback from frontline services suggests that there is a wide range of specific psychological techniques and approaches which may be suitable, including:

#### Cognitive behavioural therapy

[www.nhs.uk/conditions/cognitive-behavioural-therapy/Pages/Introduction.aspx](http://www.nhs.uk/conditions/cognitive-behavioural-therapy/Pages/Introduction.aspx)

#### Dialectical behavioural therapy

<http://behavioraltech.org/resources/whatisdbt.cfm>

#### Psychodynamic psychotherapy

<http://easyweb.easynet.co.uk/simplepsych/204.html>  
section 3.6

#### Cognitive analytical therapy

[www.acat.me.uk/catinintroduction.php](http://www.acat.me.uk/catinintroduction.php)

#### Rational emotive behavioural therapy

[www.rebtinstitute.org/public/](http://www.rebtinstitute.org/public/)

#### Social problem-solving therapy ('Stop and think')

[www.britannica.com/bps/additionalcontent/18/32682944/Problem-Solving-Therapy-for-People-with-Personality-Disorders-An-Overview](http://www.britannica.com/bps/additionalcontent/18/32682944/Problem-Solving-Therapy-for-People-with-Personality-Disorders-An-Overview)

#### Acceptance and commitment therapy

[www.contextualpsychology.org/act](http://www.contextualpsychology.org/act)

#### Mindfulness-based cognitive therapy

[mbct.co.uk/](http://mbct.co.uk/)

#### Systemic / family therapy

[www.aft.org.uk/home/familytherapy.asp](http://www.aft.org.uk/home/familytherapy.asp)

Many of these specific techniques will require specialist training and supervision, and can only be, or are best, delivered by specialist staff, working in collaboration with housing and resettlement staff. However, in many cases, a broad awareness and recognition of the psychological dimension to dysfunctional behaviour can be shared amongst all staff who are dealing with such difficulties.

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Training can significantly enhance the capacity of frontline services in all sectors to manage such difficulties. Moreover, there is also increasing evidence that it may not necessarily be the particular techniques that are used that most count, but rather the strength of the relationship with the staff member or peer mentor, and in particular the setting or context in which engagement takes place.

Effective engagement should contain the following three elements:

- Client involvement and responsibility, particularly in the process of change;
- Supportive, interested and well-trained staff; and
- Input from specialist mental health workers.

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## Section 4: Guidance and good practice

### The psychologically informed environment (PIE)

Below is an excerpt from: *Social Psychiatry and Social Policy in the 21st Century; new concepts for new needs*, Robin Johnson and Rex Haigh, 2010.

Wherever an agency has effective control over most aspects of the day-to-day lives of the individuals living there, as for example in a hospital or a prison, we have in effect 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 have an environment that is, or can be, consciously planned for the purpose – despite whatever inevitable constraints there may be. The concept of a “psychologically informed environment”, or PIE, then describes the outcome of any attempt to identify, adapt and consciously use those features of the managed environment which would allow the resources and functioning of the service to be focused on addressing the psychological needs and emotional issues thrown up by the residents.

As we have seen with the Places for Change programme, the possibility of a more carefully planned and also “psychologically informed” environment in residential resettlement settings, such as in homeless

persons hostels, women’s refuges and foyers for homeless youth, is currently being actively explored. Similarly, in the context of the prison service, the concept of a psychologically informed environment may also in many situations be more useful than the earlier notion of a Therapeutic Community (or TC), at least as narrowly 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 equally clearly there are other successful and constructive prison and youth offender institutions, which are not modelled on TCs, and yet which in some perhaps less clearly articulated way do manage to create and use positive relationships very effectively. Here, we may now need to find another vocabulary, to describe what is most effective in the most constructive prison regimes; it is likely that such factors are ‘highly distilled’ in formal TCs, but could also be developed in another fashion, as PIEs.

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

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is a key concern, a genuinely constructive environment always aims to do more than simple containment of challenging behaviour. A PIE 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, or engagement with treatment and therapy.

As to how it may approach the task, however, the field is entirely open. 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, contracts or regulations.

### Variety

Other than that, there is no particular school of thought or of human understanding that necessarily underpins or informs the thinking in 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”. It might be any form of psychological theory that informs the work of the staff, from psychodynamics to behaviourism, from Gestalt to evolutionary psychology, Transactional Analysis, Dialectical Behavioural Therapy,

NLP to existential humanism. 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, the original template for compassionate care, has a good claim to the name.

But wherever that psychological thinking can then be translated meaningfully into a carefully considered approach to designing and managing the social environment, then we have a PIE. Although training may well help, the key to psychological thinking here is not received wisdom, or even acquiring new skills, but reflective practice – and 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 changes they can.

It is the changes in day-to-day running, derived from reflective practice and discussion, that mark the development of the PIE. 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 detail, introduction of a PIE may need to be more tightly programmed. But the common thread is that these changes come about

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through the conscious application of careful thinking about the emotional and psychological needs and potential of the resident 'clientele'.

Finally, while 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 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. A planned environment can be planned on many levels.

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### Reflective practice

Reflective practice is an essential component of effective, safe work with people who suffer complex trauma. This is just as applicable when working psychologically in an informal way as when working formally as a psychologist or psychotherapist. Reflective practice is typically organised in small groups, and may be facilitated by a person trained in a psychotherapeutic model (e.g. CBT/DBT, psychodynamic therapy, person-centred therapy).

In the non-specialist area of work (e.g. with frontline hostel workers) reflective practice is advantageous in three distinct ways:

- Firstly, by aiming to recognise and understand people's difficulties, it helps to generate amongst clients a sense of being understood and heard. It enables key workers to identify and to defuse potential conflicts, and so to ensure safe practice.
- Secondly, it enables staff to get some perspective on the emotional challenges of 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. Recent evidence shows

that negative beliefs about people experiencing complex trauma reduced and perceptions of effective working increased.

- 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.

There are obvious time and cost commitments involved in enabling frontline 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. Costs can be reduced by running groups rather than individual reflective practice sessions, but it must be borne in mind that all members should have adequate opportunity to discuss their practice.

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### Personalisation pilots and invest to save

#### Preventing and tackling rough sleeping: Impacts and outcomes – for individuals and communities

Preventing and tackling rough sleeping has positive impacts for individuals, communities and the public purse. In this paper we present case studies from around the country that show that while initial investment is required to develop and sustain pathways from the streets, overall cost savings can be evidenced together with improved quality of life for individuals.

We have set this out in the following sections:

- 1 Case studies from around England**
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### 1. Case studies from around England

#### Camden

For the year 2008/09 Camden had 15 former rough sleepers move on and sustain accommodation and five failed to move on in a planned way, giving a success rate of about 67%.

For the year 2009/10 (to end December) 16 former rough sleepers have moved on with one unplanned move giving a success rate of 94%. However, five of these new tenancies are of less than three months duration, so it is still early days.

Each sustained tenancy represents an improved quality of life for the individual, and a reduced presence on the streets which contributes to improved community safety.

The following individual case studies reflect the outcomes achieved for individuals (and their communities) by assertive and consistent support and enforcement action.

#### Frank's story

In 2008 'Frank' came to the attention of the Housing Options Service via probation.

Frank was first verified by the (then) Contact and Assessment Team (street outreach) in 2001 aged just 21. Over the next six years CHAIN (the London data base used by all street outreach services and funded by CLG) indicates he continued to be street active and was booked in and out of a number of emergency hostels.

During this time Frank was committing a string of offences (23 in total) ranging from theft to public disorder. He was also drinking up to 15 cans of strong lager a day and this seemed to trigger his offending behaviour. Frank admitted he had abused alcohol from the age of 12 when he witnessed his father's death.

Housing Options were able to accommodate Frank in Parker House hostel in an assessment bed (part of the Hostel Pathways Model). He was soon referred to Cambria House which was a

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move-through bed space. This prepared Frank for independent living and he was assisted in updating his CV and encouraged to look for work.

The Pathways and Move-On Team (PMOT) identified a suitable flat for Frank and within a month he had moved in. The PMOT also referred him to Camden Floating Support for resettlement support which was particularly important for Frank as he had a long chaotic past starting from a young age.

The key worker continues to see Frank and confirmed that he has not touched alcohol while he has been living in his own flat. Frank identified isolation as being a potential problem so he was assisted in buying a dog and now feels much more stable and secure and has a dog to keep him company.

### Tyrone's story

'Tyrone' first approached Housing Options in 2007. He had been living in hostels for the past 16 years and had been evicted from the last hostel for fighting with another resident. This was a year ago and Tyrone had spent the past year sleeping in a car a friend had given him.

After 16 years of living in hostels Tyrone was unsure how or who to approach for assistance. It wasn't until

his health deteriorated to such a degree that he made contact with Spectrum day centre that brought Tyrone to Housing Options.

Tyrone was placed in Endell Street hostel in an assessment bed. After only six months it was clear Tyrone could manage to live independently, he budgeted well, had no issues around substance misuse and was now linked in with a GP.

Tyrone was referred to the PMOT and a one bedroom flat was identified as being suitable. A referral to floating support was made the next day.

His support worker has ensured he is now with a local GP and visits regularly. Tyrone himself has said he cannot believe he finally has a place. He likes to stay in as much as possible as it allows the reality to sink in.

### Ian's story

'Ian' was a verified rough sleeper and in 2008 Camden Safer Streets Team placed Ian into an assessment bed in the Pathway.

Ian had been working in the past but had a breakdown when his mother passed away. He began drinking, lost his job and lost his flat as a result of rent arrears.

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From an assessment bed he was moved into a move-through bed space where he stopped drinking and attended the in-house training the project offered to prepare someone for independent living.

Within a week of being referred to the PMOT he was offered a one-bedroom flat in an area he specifically had asked for. As Ian was slightly older, it was important to him to be around old friends and support networks.

The PMOT referred Ian to Camden Floating Support however after the assessment Ian felt he did not require support and could manage on his own. This was almost two years ago and Ian says he feels much more settled and is hoping to become involved in voluntary work in the near future.

### Lindsay's story

'Lindsay' was a verified rough sleeper who was street active and was using substances. CHAIN records her as going in and out of various hostels and she had numerous shoplifting offences between 2005 and 2007.

In 2007 Lindsay moved into a Single Homeless Project (voluntary sector supported housing organisation) service which specialised in those who were continuing to use substances. She engaged with staff and gradually

stopped using and is now on a reduced methadone script. She has not reoffended while living at the project.

Lindsay became pregnant and as she engaged well with staff at the project and also her social worker she was referred for move-on.

The PMOT were able to find Lindsay a two bedroom flat before she was due to give birth and covered the shortfall in Housing Benefit (Lindsay was only entitled to a one-bed rate prior to giving birth) by a combination of Discretionary Housing Payment and our Homeless Prevention Fund.

The baby is now six weeks old and Lindsay is very happy in her new home which is in an area she wanted and is the appropriate size for her family. She has an 11 year old son who is now able to visit. She is linked in to social services and continues to receive support from them in relation to her child and past substance misuse problems.

### John's story

'John' had been rough sleeping for many years and was in deteriorating health as he drank on the street. Under threat of an ASBO he finally accepted an offer of a hostel place, ending six years of living on the street.

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### Julie's story

'Julie' was a crack-using prostitute under the control of a violent pimp. Her health was very poor and she had lost care of her daughter. Following an ASBO and repeated jailing she accepted help, returned home to her parents, regained access to her child and began training for a job.

All the above cases resulted in the person reflecting that enforcement had saved them. And yet when asked at the time they all said they wanted to stay on the street.

### Barnet

**Barnet benefits from the service provided by the London Street Rescue service, delivered by Thames Reach and funded directly by CLG, because it covers all outer London boroughs without a dedicated street outreach team of their own.**

### Sally's story

'Sally' spent many years on the street supported by soup runs. As her health deteriorated she was visited by a number of local services, but maintained her right to remain on the street.

A GP was asked to visit her on the streets and met with Sally every week over a 10-week period. This assessment identified underlying mental health problems and Sally was sectioned and forcibly removed from the street under powers in the mental health act. She has since made good progress and is now living in residential accommodation and getting involved in a range of activities. She now says she doesn't want to go back to the streets, although she told charity workers for years she wanted to be out there.

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### Kirklees

Kirklees undertook a review of rough sleeping in 2008 and sought funding from CLG for a small grant to pay for a dedicated housing options worker. The worker started in post in late August 2009. He has worked closely with local voluntary sector providers and faith-based day centres to make contact with people known to sleep rough.

Since the beginning of the initiative there have been 10 former rough sleepers who have been taken off the streets and provided with accommodation. Nine have been accommodated in the Councils own temporary accommodation using the powers under section 192(3) of the Housing Act 1996.

One former rough sleeper has been helped to find settled housing in the private rented sector. All of these placements have been sustained to date, despite some challenges.

Kirklees have identified three particularly entrenched rough sleepers for whom tailored options will be needed.

### Sammy's story

'Sammy' has sniffed butane since a teenager, after being introduced to the practice by his father. He has acquired brain damage/ impaired cognitive functioning as a result. He also has some undiagnosed mental health problems – but the Community Mental Health Team requires cessation of his substance misuse before engaging with him.

He is currently in custody (again) for the (repeated) breach of (another) ASBO and was due for release in late February.

Kirklees are planning to hold safeguarding meeting (for vulnerable adults) to plan for his release. Sammy needs supervision in his accommodation because of the risks he poses to himself (and others) – so self-contained accommodation is not appropriate and B&B providers may be unwilling to accommodate him as he has been evicted from most in Huddersfield in the past. Kirklees are planning to speak with local supported housing providers to develop a personalised package.

Stabilising Sammy's accommodation will make a significant contribution to levels of anti-social behaviour in the town centre, and deliver savings against the criminal justice budget by reducing his level of offending.

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### Mick's story

'Mick' is 60 years old and has slept rough in Huddersfield (squatting occasionally) for about 20 years. Has begun to engage with the dedicated worker and was placed in Kirklees' temporary accommodation, provided by the LSVT. However, things have not gone completely smoothly. Mick "trashed" his temporary flat by disconnecting the gas fire, preferring to burn furniture in the place it used to be to recreate an open fire that he is used to (although there is no chimney). He also didn't use the toilet; preferring a bucket (most of the time).

However, Mick has not been aggressive towards staff and continues to engage and say he will accept help. Kirklees have now re-housed him in a local B&B while they consider longer-term accommodation options with him. It is likely he will need a tailored package of support – including some cleaning. Kirklees have committed to continuing to engage with him and will not give up.

### David's story

David is a vulnerable adult, and some learning disabilities are suspected. He was harassed and bullied in his local authority tenancy on a large estate and left his flat without seeking help.

He has been sleeping rough for several years, but began to engage with Ian the worker at the local day centre. He has now been placed in temporary accommodation and Ian, the worker, is navigating the choice-based lettings (CBL) system to secure a sensitive letting in a quiet and safe location.

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### Thames Reach GROW

Thames Reach established the **Giving Real Opportunities for Work (GROW) Project**, which aimed to employ 10% of its workforce from people who have direct experience of homelessness by 2007. This figure now stands at 20%.

The aim of the National GROW Programme is to disseminate the learning and good practice developed through GROW and change the culture of the homelessness sector in England so that it fully embraces employing service users. Thames Reach is being funded by CLG, and supported by Homeless Link to deliver a bespoke consultancy service to homelessness organisations and consortia across the country.

From October 2008 through September 2010, the National GROW Programme is offering a range of support to organisations, including:

- Preparing an organisation for change; principles behind service users employment
- Benefits and challenges of employing service users
- Benchmarking service user employment and

developing monitoring systems

- Identifying and overcoming organisational and regional barriers
- Getting staff on board and addressing resistance
- Changing HR policies to enable direct recruitment into current vacancies;
- Effectively managing potential conflicts of interest, sickness rates, relapse, dual roles
- Developing routes into employment including: service user volunteering schemes and traineeships
- Addressing financial and resource issues.

A service user who is employed in the homelessness sector is transformed from someone who is most often thought of as dependent, needy and incapable, into someone who is enthusiastic, responsible, economically independent, tax-paying, and making a significant contribution to the lives and wellbeing of others. As they transform themselves, so the organisation they work for goes through a parallel transformation – from being an out of touch business with low expectations and an overdeveloped sense of ‘us and them’ to a service user-focused entity with high aspirations, greater flexibility and responsiveness and more effective service delivery. This process of change, in which service users can become leaders, is tremendously exciting and models all that this sector can be. Employing service users:

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- Provides role models for other service users and staff
- Develops a set of talented and knowledgeable new staff
- Increases the diversity of staff teams to better reflect the communities they serve
- Demonstrates to service users, staff and strategic partners that their organisation is sincere and successful in its mission.

### Kay's story

'Kay' has a long history of homelessness and offending, related to drug use. After release from custody, and on moving into a hostel, she came to a point at which she wanted to start sorting out her life.

She saw the GROW trainee programme on a website, and called to see if she might apply. Kay is well spoken and articulate, and was originally told the programme would not be available as it was for people who had been homeless. She explained she had slept rough and was currently in a hostel. As she divulged more about her offending background, she was concerned she would be told she would not be eligible, and was delighted when the GROW programme was fully explained – with its emphasis on rehabilitation and providing an opportunity for people to “give back”.

Kay started with Thames Reach as a GROW trainee in 2008 and is both a full-time project worker in Lambeth, and an ambassador for the scheme. She is a great advocate for the different that being employed has made to her and her family. For example, she reports being able to travel to home at Christmas to see her family in a set of new clothes rather than in old torn ones and the impact this has on her self-esteem.

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### 2. The case for investment

#### Community and budget benefits – Kirklees

It is just six months since Kirklees appointed their dedicated worker and adopted a flexible approach to tackling their rough sleeping population. In this time:

- The police have reported a reduction in complaints about street drinking and a fall in levels of street begging since the 10 regular rough sleepers have been accommodated;
- The local town centre health centre has also reported fewer presentations by people sleeping rough

Kirklees will do further work to evaluate the savings achieved across these different by tackling rough sleeping over the next six months.

#### Reduced costs to health and criminal justice system budgets – Cambridge

Cambridge's Rough Sleeping Manager has established a multi-agency partnership to look at ways of addressing the needs of the most entrenched rough sleepers in the city.

They have adopted the New Directions Index which has been developed by one of the CLG-funded Adults Facing Chronic Exclusion (ACE) projects in south London.

The New Directions Index considers an individuals presenting multiple needs and weights these according to the level of engagement the client has with services. This recognises the fact that chaotic lifestyles and an inability to work with and use support services contributes to the difficulty in helping someone and needs tailored solutions.

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### Jon's story

'Jon' was one of the highest scoring individuals when first assessed using the New Directions Index. His case study has been compiled by Cambridge County Council and shows how despite resource intensive interventions, when a "whole public purse" perspective is taken, the costs of individuals to their wider community can be mitigated and reduce.

Jon is 45 years old. He was taken into care as a baby following a head injury and was diagnosed with a specific learning disability in 1997. He experienced sexual abuse as a young person and has self-harmed since he was nine years old (cutting and burning). From the age of 13, Jon has misused alcohol and solvents; currently he only uses alcohol. He became homeless at 16.

Jon is a risk to others – becoming aggressive when drinking and has committed offences of assault, affray and criminal damage. He has been subject to several ASBOs.

Jon is equally at risk from others and has been financially and physically abused, requiring the use of A&E after assaults on the streets

Since 1996 Jon has committed around 400 offences, appeared in court 260 times and served 120 short term

prison sentences. He has poor physical health and suffered a minor heart attack in 2007.

He was referred to the Safeguarding Vulnerable Adults Team by the council's Rough Sleeping Coordinator after an exercise in which he was identified as one of the most difficult to engage people sleeping rough – in February 2009

A homeless application was made and temporary accommodation (TA) and support arranged in June 2009. However, before he was able to move into the TA he was sent back to prison. When he came out of prison his expectation was to go straight into the TA, but early discharge meant this was not available on the day.

For 12 days in June 2009 he slept rough and was arrested eight times. Jon told the Street Outreach Team worker that: "This always happens – people always promise help but there's always a reason they don't". Jon indicated he finally wanted to work with support services, and find a way out of his current situation. Jon was sent back to prison for the offences in June.

During his time in custody, a Safeguarding Vulnerable Adults case conference was arranged. This time on his release, Jon was housed in temporary accommodation with a raft of support in place from the learning

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disabilities team, the mental health team, the street outreach team, Mind, and the council's homelessness prevention team.

Two weeks later however he was admitted into psychiatric hospital following alleged threats to throw acid over him and cut his feet off.

On discharge, he was able to return to his accommodation which had been kept available for him. He continued to drink heavily, but began to take steps to avoid his old peer group and drinking school and engaged with his support package.

He recently went into hospital for a physical health problem and a detox was arranged while he was an in-patient. Jon has now reduced his drinking and moved back to his flat which, again, had been kept available for him.

The council plans to convert the TA property into an introductory tenancy so Jon will not need to move, now he is more stable and likes the area. Support is ongoing and Jon is still there – the most stable he has been since he was a child.

Jon has not offended since June (almost six months) which is a major achievement for him and his health has improved, leading to significant savings to community safety, police and health budgets.

### Savings to criminal justice system budgets – Leeds

Leeds City Council funds CRI (Crime Reduction Initiative – a voluntary organisation that specialises in street outreach, drug and alcohol services) to provide an assertive outreach service and has an effective supported housing pathway from the streets, with specialist provision. They also have a private rented access scheme for non-statutory households which they have recently reviewed and developed with input from the Crisis project funded by CLG. Crisis is supporting the council to promote this prevention offer actively to raise awareness and improve use of the private rented sector scheme by voluntary sector agencies.

However, Leeds is seeing an increased number of rough sleepers from the A8 and A2 countries, who have no recourse the public funds and cannot access these services.

CRI have therefore developed a supported reconnections offer which is funded through Leeds' Homelessness Prevention Fund. The following case study has been developed to show the savings achieved by this service.

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### VK's story

VK is a Lithuanian national who first came to the UK two years ago. He worked for just under a year before losing his job and accommodation. He was arrested shortly after this for criminal damage and served a six-month prison sentence.

He was released back to the street and was again arrested for robbery and served a further three-month prison sentence.

He was again released to the street and was re-arrested for shoplifting £17 worth of food. Police contacted the local Outreach Team who assessed VK.

VK drinks alcohol to excess two to three days per week. He has evident mental health issues but no diagnosis. He self-harms and has presented at A&E with suicidal ideation.

VK has stated that he had planned to continue to re-offend until he was sent home or received a very long prison sentence. He has received a further 8 week sentence for the shoplifting offence. The Outreach Team plan to meet VK on his release date and take him to the airport for his flight to return home.

### Estimated cost to services from the time that VK lost his accommodation:

- Arrest leading to court proceedings on 3 occasions **£30,000+**
- Assessment for mental health issues **£362**
- 46 weeks in prison **£43,700**
- Total estimated cost is **£74,062**

The average cost of repatriation incurred by CRI in Leeds is £155

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### Invest to save – generic examples

The following examples are based on “typical” rough sleepers and show how the costs of interventions to support and tackle rough sleeping can be offset by savings made elsewhere to the public purse.

Our advice to local authorities is to work through the Local Strategic Partnership (LSP) to ensure that savings to other budgets are recognised and appreciated – to minimise the impact of “budget parochialism”.

### “Prevention first” – private rented sector access schemes (Low needs)

**The client: A 29 year-old man; sofa surfing; working part time; is asked to leave by a friend following argument.**

The costs of providing comprehensive housing options advice and assistance to access the private rented sector (PRS) using a bond scheme is approximately £1,700, including six months of floating support, based on the following costings:

- **£132** ( at £16.50 per hour for housing options advice

– assuming 8 hours used to assess and establish a bond within agreed scheme. The hourly rate may be higher in London, but £16.50 is equivalent to c. £24,000 salary plus NI plus 10 per cent on costs/management overheads)

- **£540** (rent in advance for one calendar month)
- **£162** (assuming a 30% claim rate against a bond of 1 calendar month)
- **£858** (for floating support at average of 2 hours per week at £16.50 per hour for six months)

This assumes the person is able to make their own arrangements for up to one week as they are assured of assistance with moving to a PRS property. Their support needs are assessed as being housing and budgeting related, and can be addressed through floating support, in the PRS.

The alternative would be in the region of £4,730, following a week sleeping rough and then being referred into supported housing projects for a period of 19 months, based on the following costings:

- **£132** (at £16.50 per hour for street outreach contact and assessment service – assuming 8 hours of street/day centre office time required to establish needs and refer into services)
- **£1,000** (for direct access hostel for four weeks assuming

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£250 per week for SP grant – double cover 24/7 at £15 per hour for block grant service for 20 people)

- **£2,730** (for 52 weeks in a second stage supported house – assuming £52.50 SP grant – 1 FTE staff member at £15 per hour covering two shared houses and key working 10 people)
- **£858** (for floating support for six months when moving out)

This assumes that a failure to intervene and prevent homelessness meant the individual was unable to remain with the friend. They slept rough for three nights, and went to a local church group that referred them to a direct hostel in a neighbouring town. They slept rough there for a further two nights, awaiting a vacancy, and had their belongings stolen/damaged by rain. As they were out of their local support network, and had found the experience traumatising, they were unable to maintain their part-time job and needed help to start benefit claims, including a crisis loan, and to rebuild their confidence.

This does not assume any contact with the criminal justice system or a deterioration in physical or mental health/ assault requiring use of A&E during the period sleeping rough.

Minimum saving per person achieved by timely prevention option: £3,300.

### “Housing first” – personalised support packages (high needs)

**The client: Entrenched rough sleeper. Male, aged 40. Has alcohol dependency, linked to chaotic use of A&E and contact with criminal justice system.**

Housing first approach c. £18,000

- **£2,080** cleaning (two hours twice per week at £10 per hour)
- **£520** laundry (£10 per week)
- **£1,000** per annum for replacing furniture/ carpets
- **£10,400** (support worker with alcohol specialism visiting two hours per day Monday – Friday, at £20 per hour – outside London)
- **£5,460** (generic support worker visiting for 1 hour each day, 7 days a week, at £15 per hour – may be more in London)
- **£520** (community alarm at £10 per week)

However, the costs of the status quo (i.e. continued rough sleeping and chaotic lifestyle) are in the region of £25,500, based on the following assumptions:

- **£15,000** per annum for policing (for moving individual on when street drinking; arresting for aggressive begging; court proceedings and short

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sentence in magistrates' court at £4,950 a time; Harries 1999 – CRI estimate this is now nearer £10,000 per court appearance)

- **£4,800** to issue ASBO (Home Office report, 2002)
- **£3,000+** for use of A&E (DH estimate, 2009, for average homeless person; likely to be higher – for example, admission through A&E costs c. £400 per time – for flu/COPD related causes – NHS network March 2006)
- **£2,000** (eight weeks in the night shelter)
- **£480** (costs of DAAT worker seeking to engage – assuming three hours each time client uses night shelter)
- **£300** (costs of additional street cleansing around sleeping site/ drinking sites)

While sleeping rough, the individual drinks c.2 to 3 litres of cider over a 24-hour period, on the streets in the town centre. The individual does not claim benefits consistently due to involvement with criminal justice system, and chaotic lifestyle and so begs, sometimes aggressively. He has been the victim of assaults as well as occasionally being the perpetrator of threatening behaviour and shoplifting, resulting in three arrests and one short sentence. He has been in the direct access hostel eight times over the last 12 months – stays usually last for about a week before a confrontation

leads to him being evicted. He uses A&E for primary care and has had presentations with two overnight admissions and one requiring a three-night stay.

These costs will be recurring, and do not reflect on wider impacts such as loss of trade and impacts on feelings of community safety.

The saving achieved by a personalised care package in own property c. £7,500 per annum. These savings are likely to increase over time as the individual stabilises and the very intensive high level support can be reduced.

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### 3. Longitudinal studies and evidence

There is an emerging body of evidence on the long-term outcomes and impacts secured through investment in preventing and tackling rough sleeping. However, studies on outcomes to date have tended to be qualitative. Evaluation of the long-term impacts and effectiveness of different interventions is still a work in progress for rough sleepers.

#### Economic and Social Research Council studies

CLG is jointly commissioning a series of longitudinal studies on the impacts of tackling rough sleeping. This is being delivered through the Economic and Social Research Council and will provide a body of evidence that is both qualitative and quantitative when the studies report in 2010/11 and beyond. Within CLG, Keith Kirby is overseeing the projects.

#### Supporting People – Cap Gemini evaluation

Supporting People colleagues commissioned a benefits realisation tool from Cap Gemini to support continued investment in the programme. This has shown that

current levels of investment in temporary accommodation services for single homeless people (and thereby preventing rough sleeping) delivers the net financial benefit of £97.0m per annum. This includes a saving of £3,560 for each single homeless person who might otherwise sleep rough, plus the avoidance of additional costs associated with offending, increased use of health services and being assaulted while sleeping rough.

The outcomes data for Supporting People also indicates that 37,500 people were supported through the programme to retain their tenancies during 2008/09, avoiding the costs of homelessness and rough sleeping.

#### Conclusion

Work to date indicates that tackling and preventing rough sleeping makes economic sense as well as improving the life outcomes for individuals, and improving the safety and wellbeing of wider communities.

Contact Rebecca Pritchard:  
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### Working with people with complex needs

To be effective, competent and confident when working with people with mental health problems or complex needs, housing staff need to have good access to advice.

They need support from their own managers and employers as well as regular supervision. Supervision can be provided either from within their service or from

a suitably experienced mental health worker from an external organisation.

Housing providers need to be able to establish good working relationships with key health and social care partners, such as the Primary Health Care Team, Primary Care Trust (PCT) and Mental Health Trust.

#### Key messages in managing clinical risks and benefits

- 80-90% of the work in supporting a person with Mental Health problems or complex needs is establishing a trusting relationship with them.
- Be positive – services will need to agree plans together with the person being supported, which are both hopeful and realistic.
- Communication within your team and between services is critical – do not try to work on your own with an individual without support from within the team.
- Respect confidentiality – but be clear about your boundaries; do not agree to withhold information disclosed to you from colleagues in your team.
- Equally important is good communication with other agencies. Ensure that you have simple and clear agreed protocols for information sharing.
- Stigma and discrimination badly affect people who are homeless or in insecure accommodation and especially those with mental health problems. A non-judgmental, open attitude from the people around them will go a long way toward supporting them.

For further information:

[www.dh.gov.uk/en/Publicationsandstatistics/  
Publications/PublicationsPolicyAndGuidance/  
DH\\_083650](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083650)

[www.dh.gov.uk/en/Publicationsandstatistics/  
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DH\\_076511](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511)

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- All frontline homelessness services need to be aware that many clients are likely to have a range of mental health problems.
- All frontline staff in homelessness services need training in basic mental health awareness and a thorough understanding of what to do if they believe a client may be in need of referral for assessment and treatment.
- All services involved with people who are homeless or in insecure accommodation need to be aware that, even if their clients do not have a formal diagnosis of mental ill health, they are likely to be experiencing poor emotional well being that affects their chance of making a better life.
- A typical client, who has experience of, or is vulnerable to, sleeping rough, will likely have highly complex needs involving poor emotional wellbeing, possible mental illness, likely personality disorder and poly-substance use. 'All-in-one' approaches are the only way to deal with these issues.
- People sleeping rough on the streets have mental health and substance use needs over and above those of the general homeless population. Urgent action and effective, prolonged engagement is needed to target people whose mental ill health is keeping them on the streets.
- Special provision (such as walk-in services) is needed, but ensuring local access through GPs and hostels is the most important.
- Mental health treatment on its own cannot solve an individual's problems. People who are homeless or in insecure accommodation also need good support from the people around them (hostel staff, friends, family etc) in order to get better. What really works is a combination of approaches.
- Medication has its place, but 'talking' therapies are very much in demand and are not so widely available.
- Holistic approaches are the only way to tackle the multiple needs of this client group. The people we spoke to wanted to be seen as people first and foremost and their problems tackled as a whole. Their entire history needs to be taken into account.
- Personal safety and the quality and condition of buildings may seem comparatively unimportant but in fact have a huge impact on this client group's emotional wellbeing and their motivation to make their lives better.

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### Good information, training and support

A lot of help is available including free information and affordable training. Websites such as NHS Choices [www.nhs.uk](http://www.nhs.uk) describe mental health conditions and how they can be treated, using short pod casts. The electronic mental health library NHS Evidence provides more detailed information, aimed at professional carers. [www.evidence.nhs.uk](http://www.evidence.nhs.uk)

We particularly recommend practical awareness training which is available though 'Mental Health First Aid' [www.mhfaengland.org.uk](http://www.mhfaengland.org.uk)

Where needs may be more complex, the Department of Health's 'Knowledge and Understanding Framework' has an online training programme which can support staff and volunteers to establish helping relationships [www.personalitydisorder.org.uk/training/kuf/awareness-level](http://www.personalitydisorder.org.uk/training/kuf/awareness-level)

### Psychodynamic therapies

#### Robin Johnson and Peter Cockersell 2010

All psychodynamic therapy is based on the idea that how and who we are is shaped by dynamic processes. 'Dynamic process' here means that in any system there are relationships between the parts, and that changes in one part of any system will affect the others. In the case

of human beings and our emotional lives, there are four key dynamics or relationships:

- between one person and another (interpersonal);
- between a person and their environment (social);
- between a person's own physiological, emotional, and rational/cognitive selves (intrapersonal); and
- between any one person's past, present and future (biographical) .

For example, one of the most important relationships is that between the baby/child and his/her mother/primary care giver. The experience we have as a baby/child affects how we see and respond to all other relationships. Not only does it affect how we think about things; there is now growing evidence that experience shapes the very physiology of the developing brain. These early experiences continue with us throughout our lives, and play a significant part in shaping who and how we are.

However, psychodynamic therapists believe that these processes continue to be dynamic – that is, responsive to change – throughout our lives. This is essentially a hopeful approach, based both on the idea that what we think, feel and do makes sense (or, often, once made sense in a particular context), and also that we can and do change how we think, feel and behave. However

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we sometimes need specialist help to change deeply entrenched, often unconscious patterns of thinking and behaviour, or even to realise what those patterns are and how they affect us.

In psychotherapy, change is effected primarily through talking and feeling in a safe and holding (or “containing”) environment, and especially through the therapeutic relationship. Psychodynamic psychotherapy uses what the client brings and the relationship between therapist and client to make links between, and understand, the client’s past and present, internal and external, experience. Thinking about and understanding this experience enables the client to work through it, and to manage and (re)mediate its effects on their lives.

However, psychodynamic thinking is not confined solely to one-to-one therapeutic work between therapist and client. The same perspective and values can also be expressed in group work, in peer-to-peer support, and even embedded in an organisational culture, in a way of working which pervades the service model. When the impact of such psychodynamic thinking in the running of a particular service is conscious and explicit, we can talk of a “psychologically informed planned environment”.

Reflective practice is crucial to this understanding and its impact. Even when such awareness is simply implicit – as it seems to be in many of the successful practice examples included with this paper – it may nevertheless still be strongly influential, and many services have developed appropriate responses in a purely intuitive way. This is because psychodynamic processes happen regardless of whether the participants in any social situation are overtly conscious of them or not: they are the natural processes of human ‘being’.

For homelessness resettlement, achieving an initial engagement with the homeless person, and building and sustaining a relationship of trust, is central to the work. Psychodynamic approaches – which place great emphasis on the quality of relationships – have gone furthest in developing the tools to understand these complex interactions. However, one of the main reasons why the psychodynamic approach is popular with the clients themselves (apart from that it works) is that it is a person-centred approach which listens to and respects the reasons why individuals have made the life choices they have, recognises the impact others and the environment have had on them, and works with them to create a better future without denying the awfulness or impact of the past.

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### CBT project, Derby Road, Southampton

#### Summary

- 23 people were referred to the project between September 2001 and April 2004 to be treated using CBT and DBT
- All 23 had some form of alcohol and/or substance abuse problem – nine of these were associated with the use of a Class A substance, and 19 of the individuals had experienced childhood neglect and/or abuse
- Nine people were evicted
- 14 were in accommodation at the end of the project
- At six month follow-up, only two were back on the street.

#### Background

The Derby Road CBT project operated from a small, four-bed shared house in Southampton between September 2001 and April 2004 when it closed down due to the end of the contract with the housing association.

The project was initially set up by the Society of St James in conjunction with Swaythling Housing and

Hants Partnership NHS Trust, with input from the Southampton Street Homeless Prevention Team (SHPT) to address the needs of entrenched rough sleepers who had been excluded from all the hostels in the City. It was funded by the Rough Sleepers' Unit and Southampton City Council.

As well as the usual housing-related support delivered by the project workers, the scheme offered residents access to cognitive behaviour therapy (CBT) and dialectical behaviour therapy (DBT) formulation and intervention techniques, delivered by a clinical psychologist. Residents attended individual and group therapy on a weekly basis to help them address problems that underpinned their antisocial behaviours and repeated tenancy loss.

In addition to this, the project aimed to ensure consistency of approach and collaboration by providing CBT supervision for the project workers. It also enabled the residents to take an active role in managing aspects of the running of the house, through house meetings. The project was carefully evaluated to investigate effectiveness of this novel approach.

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It is important to note that for many residents, the Derby Road CBT project was just one aspect of the multi-agency approach adopted to address their complex needs. Specifically, close liaison with the SHPT was found to be particularly important to follow up evicted residents.

A psychological measure, the Clinical Outcomes in Routine Evaluation (CORE) was used to gather information at four time points:

- before entry into the project
- on entry to the project
- 10 weeks after entry; and
- one year follow-up.

The CORE measures social functioning, problems and symptoms, wellbeing and risk.

Two of the residents showed distinct improvements on the functioning, problems and symptoms and risk subscales after entry into the project. In addition, one improved in terms of his wellbeing and risk, and the fourth improved in terms of functioning and risk. Importantly, all residents improved in terms of risk to themselves and others. This was one of the primary outcomes for the project – reducing antisocial behaviours that lead to tenancy breakdown. In addition,

reductions were noted for all clients for nights spent sleeping rough, violent incidents and criminal incidents.

In total, between September 2001 and April 2004, 23 people were resident in the project. They included;

- 14 street homeless
- Two straight from prison
- Two street homeless via a detox unit
- Five from direct access hostels

Nine residents were evicted over this period, for a number of reasons. These were:

- Four threats to kill
- Two dealing class A drugs
- Two extreme chaos associated with alcohol
- One physical assault on another resident

In terms of length of stay at the project, seven people were resident less than 10 weeks (three were evicted, three left of their own accord and one moved on to supported accommodation). The average number of weeks that the remainder of the people were resident in the project was 21 weeks (the average of all residents was 17.5 weeks). The shortest stay was two weeks (evicted), the longest 62 weeks.

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All residents had some form of alcohol and / or substance abuse problem:

- Seven alcohol alone
- Seven alcohol, cannabis and / or amphetamines
- Nine heroin, crack and / or amphetamines

This level of drug and alcohol abuse represents a significant challenge to agencies and therapeutic approaches. Importantly, nineteen of the residents suffered some form of neglect (83%). This has important implications in terms of possible factors implicated in many of the behaviours which lead to tenancy breakdown.

Other agencies were contacted to establish where residents were living six months after leaving the project.

- Nine were in accommodation in the city
- Three were living out of area
- Two were in direct access hostels
- One lost contact
- Three were in prison
- Two had been killed, one while in supportive housing
- Two were rough sleeping

It appears that there was a very positive outcome for 14 of the 23 people, which is a significant number, given the complexity and challenging nature of the client group and their long history of eviction.

### Background

According to these figures, around 44% of people were successfully moved on to supportive housing (including one of the individuals who was killed), while around 9% were left on the streets, the remainder achieving an outcome somewhere in between. It is therefore possible to speculate that a successful move-on rate of around 45% is realistic for this complex client group. These figures also highlight the need to specify what form of accommodation represents a successful outcome.

A number of important factors were found to be implicated in the success or failure of the project in addressing the needs of this challenging population. Therapeutic engagement skills were crucial in enabling individuals to consider change, and many individuals reported being unused to discussing personal issues.

The type of tenancy has to be considered when engaging a risky population in a hostel environment, as well as the effect of such an environment on the immediate surroundings (i.e. neighbours).

Lastly, the type and hours of support services were found to be important in terms of the practicalities of working with a risky population, in particular, cover at weekends.

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### The use of medication

Some people with Mental Health problems will require day-to-day support in order to manage their prescribed medications. This could involve:

- advice or reminders from housing staff
- use of 'booster packs'; or
- help with monitoring and understanding potential side effects.

MIND produces a series of simple information leaflets about mental health treatments and locations at [www.mind.org.uk](http://www.mind.org.uk).

The importance of managing medication is described in the NMH DU booklet, 'Getting the medicines right'. [www.nmhd.org.uk/silo/files/getting-the-medicines-right--jul-2009.pdf](http://www.nmhd.org.uk/silo/files/getting-the-medicines-right--jul-2009.pdf)

Very many people who are, or have been, homeless may have a problem with alcohol or street drugs which can be a cause or consequence of a mental health problem. Mental Health Services describe this as a dual diagnosis. For further information on this: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_062649](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649)

### Childhood experiences

Margaret E. Blaustein, Director of Training and Education, at The Trauma centre JRI, Brookline, MA, identifies adverse childhood experiences and outcomes and the resulting behavioural adaptations. Her presentation (see weblink) defines complex trauma and outlines appropriate interventions. [www.degpt.de/daten/2007%20-%20Blaustein.pdf](http://www.degpt.de/daten/2007%20-%20Blaustein.pdf)

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### Collaboration models for complex trauma and severe social exclusion

These papers offer some top-level research to help commissioners explore a wide range of issues surrounding complex trauma.

Meeting these more complex psychological and emotional needs cannot be achieved by any one agency or sector working in isolation, however sophisticated their work. Co-operation and collaboration between agencies will typically be necessary, both to ensure effective pathways into and between services at various stages of engagement, and to enhance the capacity of each agency to work with sensitivity and awareness, and with the resilience and range of specialist skills that may be brought to bear.

Needs and the available resources or services will vary widely across the country, and it is not possible or even appropriate to specify or promote any particular model. It is perhaps most important that developments are well attuned to local circumstances and opportunities.

Various possible models of inter-agency and inter-service collaboration, and the implications for funding, local commissioning and accountability, are outlined below. These range from awareness and skills training and sessional input by health professionals, to fully-integrated services, managed networks and psychologically informed planned environments.

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Model	Description	Resources	Notes
<b>Resettlement services with additional clinical in-put</b>  <b>1: Awareness and skills training</b>	<p>Awareness and skills development for frontline staff, intended to enable workers to become suitably sensitive to relevant psychological issues.</p> <p>Skills development would enable workers to become adept at using specific relevant skills themselves, and more confident in referring to specialist services where appropriate.</p> <p>See for example the DH “KUF” (Knowledge and Understanding Framework) programme for staff from all agencies, for responding more effectively to complex needs and longstanding emotional problems (with particular reference to personality disorder).</p> <p><b>NB:</b> some reciprocal training from housing and resettlement staff to enable MH workers to understand housing issues would also be helpful.</p>	<p>Resources for additional in-put can be provided by any funding source; the skills in-put may be delivered by statutory or third sector services.</p> <p>Outcome measures would normally be based on the enhanced effectiveness of resettlement efforts.</p> <p>Established training programmes exist which could be suitably adapted. <a href="http://www.babcp.com">www.babcp.com</a></p> <p>KUF programme consists of six online modules supported by virtual learning environment and three seminars. <a href="http://www.personalitydisorder.org.uk/training/kuf/awareness-level">www.personalitydisorder.org.uk/training/kuf/awareness-level</a> <a href="http://www.personalitydisorder.org.uk/assets/resources/169.pdf">www.personalitydisorder.org.uk/assets/resources/169.pdf</a></p>	<p>Needs to be accessible for all levels of staffing, including ancillary staff and volunteers, peer support etc. Training that includes former service users as trainers is believed to be particularly effective.</p> <p>Awareness training will aid development of a 'psychologically informed environments (PIE) and meeting 'enabling environment' standards (see E).</p> <p>Training enhances access to and/or provision of individual therapy in sessional in-put for selected service users.</p>

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<b>B</b>	<b>Resettlement services with additional clinical in-put</b>  <b>2: "In-reach" sessional in-put</b>	<p>Specific on-site counselling, group work or comparable in-put, for hostel/foyer/refuge service users, provided by specialist MH staff or counsellors.</p> <p>Suitable skills might include Art Therapy; Cognitive Analytic (CAT); Cognitive Behavioural (CBT); Dialectical Behaviour (DBT); Interpersonal (IPT); Integrated Arts; Mentalisation Based (MBT); Psycho-Analysis; Psychodynamic; Transactional Analysis (TA) Counselling has similarities see: <a href="http://www.bacp.co.uk">www.bacp.co.uk</a></p>	<p>Resources for specialist clinical in-put would normally to be provided from health and social care funding, commissioned locally, monitored and regulated according to clinical outcome measures.</p> <p>Resources for arts or other skills training may be provided by a range of funding sources.</p>	<p>Clinical in-put needs to involve techniques from established evidence-based therapies.</p> <p><b>NB:</b> Can include group work, psychodrama, creative arts, or other skills development for service users, and can include or complement more generic primary care health in-put.</p> <p><b>NB:</b> Individual-focused work may not address 'whole system' factors or team dynamics.</p>
<b>C</b>	<b>Multi-agency environment</b>	<p>Co-location of services from different agencies, for a more holistic approach and greater sensitivity and ease of access to services for service users</p> <p>The distinction between sessional in-put and a full multi-agency environment may not be clear-cut. But co-location implies a more concentrated presence on site of each of the component parts, and a location which is not primarily identified with any one agency</p>	<p>Resources for specific services would normally be funded and commissioned by the specific relevant funding body, and accountable separately.</p> <p>Sharing premises, publicity and reception functions can provide some savings; streamlining of referral and co-working may be particularly cost effective for more complex needs and preventive work.</p>	<p>Co-location reduces the visibility and possible stigma of using any particular service, and would facilitate access to therapeutic in-put for reticent or reluctant service users.</p> <p>Co-location of services encourages cross-referral and co-working between agencies, and can mean that full disclosure of underlying problems is under the control of the individual service user.</p>

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	Model	Description	Resources	Notes
<b>D</b>	<b>Multi-source funding for a single agency environment</b>	Sophisticated joint funding arrangements to allow a single agency to deliver services flexibly across a range of health, social care and housing support activities and commissioned outcomes	Resources may be block purchased or delivered via personal budgets, or tiered with any combination of the two.	Multi-source funding for a single 'core' agency does not preclude the possibility of additional specialist in-put from another service, as in A, B or C.
<b>E</b>	<b>Psychologically Informed Environment 'PIE'</b>	<p>A managed environment, such as a hostel, refuge, foyer or day care service, where procedures etc have been carefully modified to meet the needs of the particular client group.</p> <p>Service design and delivery in a PIE would typically be under constant review by the staff team, through reflective practice. Service design thinking should include the appropriate staff mix, roles for service users, layout of the building, timetables, etc</p> <p>NB: for these purposes, a therapeutic community ("TC") can be regarded as a particular example of a PIPE. Both are examples of an "enabling environment"</p>	<p>A PIE will typically be managed by a single staff team, though this team may be multi-disciplinary and/or include staff from various agencies. Each agency's funding and commissioning then needs to reflect the ambition to create a single, coherent service.</p> <p>DH's KUF awareness training is suitable for promoting reflective practice (see 1) <a href="http://www.personalitydisorder.org.uk/training/kuf/awareness-level">www.personalitydisorder.org.uk/training/kuf/awareness-level</a></p>	<p>Reflective practice, supported by training (see A), can specifically address the whole psychosocial environment, in the name of maximum engagement and flexibility to meet complex needs.</p> <p>NB: Can also be tailored to work for a managed clinical network (F, below) for support and treatment pathways from specialist services</p> <p>The Royal College of Psychiatry's 'Enabling Environment' award is currently in pilot stage. <a href="http://www.enablingenvironments.com">www.enablingenvironments.com</a></p>

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	Model	Description	Resources	Notes
<b>F</b>	<b>Managed clinical network</b>	Explicit co-ordination of services to ensure coherent and streamlined support and care pathways, with measures to identify and cover gaps, bottlenecks or shortfalls.	Although particular individual components of a managed clinical network may be funded and commissioned separately, monitoring and performance management measures need to be more sophisticated, as outcomes are particularly inter-dependent.	A managed network concentrates on pathways and communications between services  “Nidotherapy” might be seen as an individual-focused managed clinical network.
<b>G</b>	<b>Individual family/systemic interventions</b>	Work directly with families and significant others.  Examples are Intensive Fostering; Family Group Conferences; Family Therapy.	Family and systemic interventions are normally funded and commissioned as specialist services via health and social care.  Housing and resettlement staff may be involved as facilitators or, in the case of ASBO plus schemes, as stakeholders.	Training is available for individual staff.  May also address ‘whole system’ factors.

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### Cognitive and behavioural therapeutic interventions to tackle homelessness – research synopsis

Nick Maguire, Helen Keats & Suzanne Sambrook – December 2006

#### 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).

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### 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 £90m 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%, 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% 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.

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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 injecting 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.

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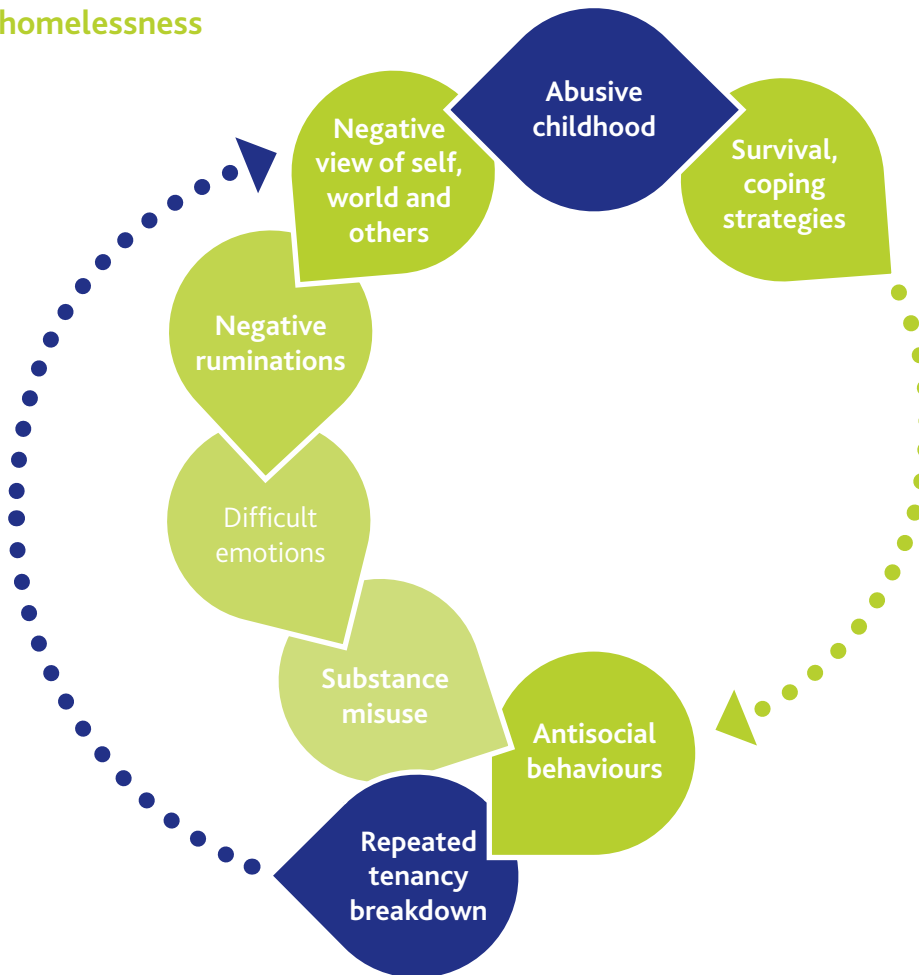
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### Possible pathway to homelessness



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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.

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.

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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.

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Between September 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

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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

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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 reference

NICE Guidelines, Mental Health:  
[www.nice.org.uk](http://www.nice.org.uk)

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### How psychological factors related to traumatic experience and personality disorder are associated with chronic homelessness

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#### Summary

This paper outlines how psychological factors related to traumatic experience and personality disorder are associated with chronic homelessness. It reports a systematic review of the literature which supports the conclusion that psychological disorders strongly predict homelessness and provides indicative evidence that psychological interventions can improve the life chances of homeless people. It concludes that additional research is required both to establish the most effective psychological interventions for chronic homelessness in the UK cultural context, and to evaluate the effective transfer of research knowledge from research to service delivery settings.

#### Introduction

Homelessness is a complex problem which, for many people, results from an interaction between environmental and mental health factors. For many years, social policy and funding sources in the UK have focused on factors such as poverty, housing provision, and the practical aspects of being homeless (e.g., Supporting People, ODPM, 2003). More recently, however, research has highlighted the individual factors that may underpin homelessness. Although the homeless population is heterogeneous and there are many disparate circumstances underpinning the reasons why people find themselves without a home, many aspects of chronic homelessness, including rough sleeping, eviction and repeated tenancy breakdown are thought to result from severe and enduring mental health problems. There is strong evidence that those

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who experience repeat homelessness experience such problems. For example, US research indicates that approximately 91% of a homeless sample had received some form of primary psychiatric diagnoses, with about 40% suffering psychoses and 29% chronically misusing alcohol.<sup>5</sup> In the UK, schizophrenia is present in an estimated 31% of the homeless population;<sup>6</sup> Axis I disorder (e.g., depression, anxiety) in an estimated 50-75%,<sup>7</sup> and Axis II problems (personality disorder; PD) present in up to 70% (PD is considered in more detail shortly). Many of these different problems are commonly co-morbid in homeless people.

Thus, homelessness may be more than simply not having somewhere to live owing to unforeseen circumstances. The experience of agencies working with homeless people is that unless and until the underlying psychological issues behind the presenting problem are identified and addressed, homelessness is likely to be repeated. This means that the problem of homelessness cannot be solved by the provision of accommodation alone.

There is a reasonable literature on the prevalence of personality disorders (PD) in the homeless population,<sup>8</sup> but the extent to which PDs may be implicated in the aetiology and/or maintenance of homelessness is not yet certain. Although few studies have systematically diagnosed personality disorders, unstructured clinical assessments suggest rates up to 70% (although rates are highly varied;<sup>9</sup>) with schizoid, borderline, dependent, and antisocial features often identified.<sup>10</sup> Antisocial personality disorder has received some attention, with estimated rates of 10-40% in the homeless population.<sup>11</sup> Recent evidence investigating the prevalence of PD in a UK population of street homeless and hostel dwelling adults found that 58% reached diagnostic levels (Maguire, Munwar, Levell, McClean & Matthews, in preparation<sup>12</sup>).

5 Bassuk, Rubin & Lauriat, 1984  
6 Timms & Fry, 1989  
7 Drake, Osher, & Wallach, 1991

8 e.g. Fazel, Khosia, Doll & Geddes, 2008  
9 Fazel et al, 2008  
10 Tolomiczenko, Sota & Goering, 2000  
11 Caton, Hasin, Shrout, Opler, Hirschfield et al. 2000  
12 For a comprehensive systematic review and meta-analysis of the mental health literature, the reader is referred to Fazel, Khosla, Doll & Geddes (2008); Rees (2009).

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Research shows that PDs are often the product of traumatic childhood and adolescent experiences. The experience of sustained exposure to traumatic events has recently been termed complex trauma<sup>13</sup>. This sustained exposure to toxic experience distinguishes complex trauma (or Type II Trauma) in principle from post-traumatic stress disorder (PTSD, or Type I Trauma), which describes cognitive, emotional and behavioural reactions to a single event. Although circumstantially complex trauma makes clinical sense in terms of a high prevalence of childhood abuse and neglect in the entrenched homeless population, very little research has been conducted on how the resulting personality disorders lead to entrenched or repeat homelessness.

### Literature search strategy

The aim of the literature review was to identify all relevant published work emanating from the scientific and mainstream communities on personality and psychological factors (including complex trauma) thought to be implicated in repeat homelessness. To maximise transparency, a formal search strategy was adopted. Two major search engines were used (Web of Science and Google Scholar), in addition to which the

meta-engine EBSCO Host, which searches CINAHL, MEDLINE, PsycARTICLES and PsycINFO, was also employed. Search terms included combinations of the following, where an asterisk (\*) denotes any subsequent string of characters (e.g. homeless\* would include homeless and homelessness): homeless\*, aetiology, complex trauma, personality disorder, antisocial, borderline, child\* neglect, child\* abuse, childhood, psychology\*, impulsivity. In addition, experts in the field were consulted to contribute papers that were not identified in the first search. Similarly, the reference lists of recent reviews were trawled for papers not initially identified.

These search strategies yielded 154 papers for inclusion. The inclusion criteria were that 1) the papers had been published in peer-review journals; and 2) the papers were empirical in content, i.e. including quantitative and/or qualitative data. Purely theoretical papers were excluded, as were books and book chapters which summarized original research. Because this is the first attempt to identify all empirical papers investigating the link between complex trauma and the aetiology and maintenance of entrenched / repeat homelessness, all identified papers have been included in the final table.

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### Results

The results are broken down into five main areas:

- 1 Links between complex trauma and homelessness
- 2 Trauma in relation to other factors in homelessness
- 3 Mental health and homelessness
- 4 Interventions
- 5 Limitations of reported studies

#### 1 Links between complex trauma and homelessness

- It is clear from the vast majority of the literature that there is strong and consistent evidence supporting an association between homelessness and complex trauma. Some papers investigated homelessness as a risk factor for trauma,<sup>14</sup> whereas others noted that trauma precedes homelessness.<sup>15</sup> Other studies quantified this relationship<sup>16</sup> found that for almost three-quarters of cases, PTSD preceded the onset of homelessness).

<sup>14</sup> e.g. Goodman et al., 1991

<sup>15</sup> e.g. Taylor & Sharpe, 2008

<sup>16</sup> e.g., North & Smith, 1992

- There is a complex relationship between traumatic experience, mental health issues, behavioural factors and homeless status. Although a number of models have been proposed, few have been empirically evaluated.<sup>17</sup>
- Evidence from research with young homeless people supports the complexity of the relationship between multiple traumas, homelessness, and mental health outcomes. Young people are more likely than adults to have experienced earlier trauma, abuse, or neglect and been accommodated in care; but are also more likely to experience similar traumas in later life.<sup>18</sup>

#### 2 Trauma in relation to other factors in homelessness

- Early traumatic experiences are associated with such factors as low levels of social support, low levels of family support, and 'deviant' peer associations.
- There is an association between traumatic experience and maladaptive behaviours such as: drug and alcohol abuse; conduct disorders; sexual risk taking (and other sex-related behaviours). Other behavioural factors include sexual victimization, increased use of health and social services, and reduced participation in the labour force.

<sup>17</sup> e.g. Martijn & Sharpe, 2006

<sup>18</sup> Taylor et al., 2006

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### 3 Mental health and homelessness

- There are higher rates of mental health problems, both Axis I (anxiety disorders, depression, dementia and psychosis disorders) and Axis II (personality disorders) than non-clinical populations. Evidence indicates that rates are comparable with psychiatric populations. However these data were mixed, with some studies finding no significant differences for schizophrenia between homeless and non-homeless groups.<sup>19</sup> Young homeless people are more likely than adults to present with emotional disorders (anxiety and depression), substance abuse, self-harm and attachment disorders (from which full-blown personality disorders may emerge).
- Some evidence indicates that psychiatric hospitalisations are higher than other clinical populations for homeless adults, but psychological disorders in this population also tend to remain untreated<sup>20</sup> suggesting that hospitalisation measures underestimate prevalence. Young homeless people find it particularly difficult to access services, because they usually fall between the remit of adolescent and adult mental health services.

### 4 Interventions

- A number of forms of intervention have been found to be useful in treating homeless youths and adults. These include family therapy, therapeutic communities, behavioural contingency programmes, cognitive-behaviour therapy, psychodynamic psychotherapy, 12-step programmes, and generic counselling in the context of supported housing. There is as yet no evidence to support the suggestion of a single treatment of choice.
- Although a number of forms of intervention are highlighted as useful, the research in this field is generally poor in terms of design. There are few controlled trials and no randomised control trials (RCTs).
- The literature often does not clearly define the intervention models used or the settings in which interventions are practised. These two factors are often conflated. Many studies do not specify outcomes in detail or discuss the reliability or validity of their measures, and very few (if any) attempt to establish the process underlying observed change.

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<sup>19</sup> e.g. North et al, 1997

<sup>20</sup> Bassuk et al, 1984

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### 5 Limitations of reported studies

- The term 'trauma' is generally poorly defined in the literature. A number of terms are used in addition to trauma, e.g. 'psychological trauma', 'PTSD', 'traumatic experiences', 'traumatic events'. Some of these terms are used as outcome variables and some are confounded with historical variables, e.g. 'victimization', 'abuse histories', 'childhood abuse'. No papers discriminate between Type I and Type II trauma, or PTSD and complex trauma. These terms and constructs need to be defined and validated.
- Figures for the prevalence of specific disorders and other constructs are greatly dependent on the type of assessment used (e.g., Fazel et al, 2008, the reported prevalence of personality disorders is highly variable, possibly owing to a reliance on clinical diagnosis). This suggests that the type of assessment used should be carefully considered in terms of validity and reliability.
- Literature in the area of mental health is generally sophisticated, using such methodological techniques as meta-analysis,<sup>21</sup> factor analysis<sup>22</sup> and path analysis<sup>23</sup>. Homelessness research has not to date been framed within the tightly defined constructs and

diagnoses identifiable from mainstream medical and psychological research. This may reflect the different approaches of the respective funding bodies.

- The majority of published research in this area originates from the USA. Around three quarters of papers identified were from the USA, the remainder from the rest of the world. Around 10% of papers identified were published in the UK. Although the North American research is strongly suggestive of a link between trauma and homelessness, the extent to which results obtained overseas are completely generalisable to UK populations remains to be determined.

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<sup>21</sup> e.g. Fazel et al, 2008

<sup>22</sup> e.g. Yoder et al, 2008

<sup>23</sup> e.g. Whitbeck et al. 1997



## Section 5: Research

### Recommendations

- 1 Further research is necessary to map the causal relationships between complex trauma and homelessness. Psychological research methods, including longitudinal designs, path analysis, and structural equation modelling can all be used to gain a better understanding of the processes involved.
- 1 The extent to which 'complex trauma' acts as both a causative and maintaining factor for homelessness should be addressed and a common understanding generated.
- 2 The measures used to assess complex trauma should be specified and their reliability and validity established.
- 3 There is a clear case for promoting models of intervention and clinical management which are designed to address the problems associated with complex trauma and PD (e.g. attachment, emotional regulation, interpersonal skills, social problem solving). These therapeutic frameworks are particularly important for young people, in preventing more entrenched behaviours and emotional dysregulation.
- 4 Any intervention or management projects, whether existing or newly commissioned, should be carefully evaluated, with clear outcomes and controlled designs.
- 5 The settings in which such services are delivered should receive careful consideration in terms of practical and therapeutic variables, in addition to service-user defined outcomes.
- 6 Services for young homeless people need to pay particular attention to the transition between children/young people and adult agencies, and to provide interventions tailored to the clients' developmental needs.
- 7 In order to facilitate robust research programmes addressing aetiology, maintenance and treatment issues, research funding from a number of sources should be sought, e.g. government departments, research councils, health and social care organisations.
- 8 Given the conclusions of the review, it will be important to consider the emotional and psychological needs of frontline homelessness staff, which should be recognised, quantified, and addressed.

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### Research synopsis

Biopsychosocial influences in 'complex trauma' and repeat homelessness: the evidence base, and the implications for future research and practice.

#### What does the evidence of prevalence tell us?

There is now good evidence for a high prevalence of personality disorder (PD) among those who are homeless – although much PD may go undiagnosed, and some interpretation is sometimes needed, in context, of data sources such as surveys that initially may indicate lower incidence. It may be the case, for example, that the stigma and “therapeutic nihilism” previously attached to a diagnosis of PD, and the exclusion criteria of some services, has meant that resettlement staff have been reluctant to record personality problems in the absence of a clear authenticated diagnosis.

But there is also growing evidence of many inter-linked difficulties – what in medical terms is called ‘co-morbid symptomatology’ – such as dual diagnosis (PD plus other and/or overlapping complications), or associated and clinically comparable problems, such as substance abuse and suicide, frequent A&E presentations, PTSD.

We therefore suggest that, taken together, these complex presentations are most usefully conceptualised as indicative of a single broad syndrome of “complex trauma” (CT) which we will take as the unifying framework, rather than current perhaps prematurely narrow medico-diagnostic formulations. It is this broader concept, and its links with the narrower diagnostic formulations of personality disorder, which the following chapters then explore.

#### What can we learn from medico-diagnostic approaches?

One key feature that personality disorders typically share with conduct disorders is the phenomenon known technically as ‘ego-syntonicity’. That is, the problematic behaviour patterns which are characteristic of individuals with PD reflect persistent emotions and beliefs which appear natural and normal to the individual concerned; they are not experienced as external, alien or distinct from ordinary experience – which indeed, for this individual, they are not. This feature distinguishes PD and CT from other, more evidently psychiatric phenomena such as panic states, flashbacks, mood swings or hallucinations.

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For this reason, it has been suggested, services working with and supporting individual's with the more deeply entrenched forms of complex trauma – whether as children or as adults – need to pay particular attention to consistency, coherence and clarity in their work. Approaches such as the therapeutic community, Nidotherapy, re-parenting, and other “wrap-around” environments may be a reflection of this need.

### What can the evidence of recent neuroscience tell us?

There is a rapidly growing body of neuroscience providing evidence for stress and trauma at critical developmental stages producing high levels of chemical triggers leading to anomalous brain development in the infant, features which are associated with later behavioural problems. Although dysfunctional for the individuals concerned, this appears to be a natural developmental process, which may even have its origins in evolutionary survival advantage in adaptation to adverse conditions (significantly, some studies on the impact of stressful neighbourhoods indicate an independent and additional impact from wider environmental influences).

The neuroscience of childhood trauma tends to suggest that the developmental “damage” of stress and trauma in childhood may be irreversible; or at

least, markedly less responsive or amenable to change via later influences and experiences. However, this is then counter-balanced and possibly contradicted by other strands in contemporary neuroscience that by contrast stress neural regeneration, plasticity, on-going neurological self-organisation, and so allow more scope for later adaptive (or maladaptive) learning.

The explanatory frameworks that neuroscience currently offers do not however appear to fit or confirm the formal diagnostic categories of personality disorder with any great precision. If these clinical patterns are in fact valid, there would appear to be some other, or further, processes of shaping or selection of the presentations and behaviours that medical services have identified.

### What can the evidence of other disciplines tell us?

Psychology focuses primarily on learning and function rather than diagnosis of pathology; and models of distress and dysfunction in psychology seem to reflect the neuroscience findings of underlying process more closely than the medico-diagnostic formulations of pathology. There are also many studies from social psychology that stress the role of repetitive re-enactment and cyclical re-enforcement of early traumas and schemas – cycles which can in principle be interrupted if managed with care.

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These approaches echo earlier studies from sociology exploring the role of social processes in the management of deviance, including the attitudes and beliefs of staff, as itself impacting significantly upon the course and outcome of dysfunctional behaviour. Micro-social processes, societal reaction, stereotyping and exclusion, the institutional “processing” of discordant behaviour, and the wider shifts in the economy which impact upon social norms and acceptability, all shed further light on the frameworks of society’s response, and the services which are available, to “remedy” the problems.

### What does the evidence of practitioners tell us?

Meanwhile, the experience of clinicians, resettlement staff and others of “what works”, and what remains problematic, offers further evidence of a different kind of the possibility of behavioural adaptation in later life, given the right conditions or environment; but also of the difficulty of “getting it right”. The evidence from healthcare on specific interventions for specific personality disorders is notably equivocal – but it is still incompatible with the “therapeutic nihilism” of the past. This is at least consistent with the messages from relatively successful psycho-educational treatment modalities such as “Stop and Think” with ex-offenders, and peer support, including via therapeutic communities.

Finally there is some evidence of what works both in treatment environments and in homelessness resettlement. In either context, the keys to success seem to involve engagement, safe containment, practical and emotional skills learning. These are precisely the areas where the neuroscience findings have suggested that early childhood trauma may have the greatest problematic impact; but they also suggest that constructive and remedial engagement in later life, though difficult, can be achieved.

### What does the evidence taken as a whole tell us?

These studies, both the neuro-biological and the psycho-social, converge in indicating strong associations with attachment difficulties, emotional dysregulation, poorer social problem-solving as the underlying behavioural issues – all of which are implicated and readily identified with a diagnosis of PD, but they also seem to point towards a more malleable and potentially treatable underlying condition; and all indicating the possible necessary focus of remedial work.

Both the “hard” and “softer” evidence now suggest that emotional and behavioural change is possible; but that it may be significantly harder for individuals traumatised in early years. This may be in part due

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to such individuals' greater reliance on a limited and inflexible repertoire of stress-scenario responses; in part due to the close inter-connected-ness of beliefs and feelings underlying such behavioural repertoires. But it may also be due in part due to the powerful dynamism of re-enactment of such early traumatic schemas, which tends to evoke punitive or rejecting responses in others, so perpetuating rather than breaking the re-enforcement cycle.

Two key principles or features of success are recognising:

- the slow pace of the change process for some, and
- the need for personal and organisational resilience within the service. That is to say, resilience is needed both in the resources and skills of the workforce, and in the way that the service as a whole operates – the formal structure of roles, rules and times, the informal social structures of meeting places and friendship groups, and in the nature and design of buildings, etc.

### Implications and approaches

In short – what evidence there is suggests that personal change work is a harder task with PD and “complex” trauma: but change is possible, though it may be necessary to enlist a wider and more creative

range of influences and interventions in support of the therapeutic or remedial task than more standard approaches such as medication, counselling or behavioural therapy alone. The social context in particular, and the worker/client relationship, may be critical for effective interventions; and for those most at risk, the whole environment may need to be working in tune with the therapeutic aims.

This has considerable implications for the way that, for example, homelessness resettlement services need to be able to work. From this we can therefore claim to have derived an indication of the potential value of novel interventions in resettlement services. There remains some uncertainty over how far the maladaptive behaviour characteristic of PD, CD, CT etc is embedded in the personality through early trauma in critical development periods, how far they remain malleable through constructive, containing and enabling experiences later in life, and how far the failure to develop reflects unintentional mismanagement by welfare and correction agencies.

These are not options and hypotheses that are easily tested in laboratory conditions. We suggest therefore that practice in homelessness resettlement and in community mental health alike needs to be informed by new developments in research and theory; but that

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research and theory development also has much to learn from studies of (emerging) practice.

The case studies on this site give an indication of the kind of ground-breaking work being done in some areas to respond to these needs in innovative ways. The hostel and “managed network” services described in the practice section provide ample scope for studies to enhance our understanding of the maintaining factors of PD/CT in later life. A more collaborative and inter-disciplinary approach to research is likely to be most productive of new insights; and the homelessness sector would appear to be a particularly useful testing ground for more rounded frameworks of understanding.

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### Glossary of acronyms

#### A

ACE	Adverse Childhood Experience/Adults Facing Chronic Exclusion
ADHD	Attention Deficit Hyperactivity Disorder
ACT	Acceptance and Commitment Therapy
APA	American Psychiatric Association
ASB	Anti-Social Behaviour
ASBO	Anti-Social Behaviour Order

#### B

BPD	Borderline Personality Disorder
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#### C

CAHMS	Child and Adolescent Mental Health Services
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CJS	Criminal Justice System
CPN	Community Psychiatric Nurse
CHT	Community Housing and Therapy
CORE	Clinical Outcomes in Routine Evaluation
CPD	Continuing Professional Development

#### D

DAAT	Drug and Alcohol Action Team
DBT	Dialectical Behaviour Therapy
DH	Department of Health
DSM	Diagnostic and Statistical Manual

#### H

HCA	Homes and Communities Agency
HMP	Her Majesty's Prison

#### I

IAPT	Improved Access to Psychological Therapies
IPT	Interpersonal Therapy

#### J

JSNA	Joint Strategic Needs Assessment
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#### K

KUF	Knowledge and Understanding Framework
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### L

LAA Local Area Agreement  
LHF London Housing Foundation  
LSP Local Strategic Partnership

### M

MBCT Mindfulness-Based Cognitive Therapy  
MI Motivational Interviewing  
MTFC Multi-dimensional Treatment Foster Care

### N

NDT New Directions Team  
NICE National Institute for Clinical Excellence  
NIMHE National Institute of Mental Health in England  
NLP Neuro-Linguistic Programming  
NTQ Notice to Quit

### P

PCT Primary Care Trust  
PD Personality Disorder  
PDQ Personality Diagnostic Questionnaire  
PIE Psychologically Informed Environment  
PSA Public Service Agreement

### S

SP Supporting People

### T

TA Temporary Accommodation  
TC Therapeutic Community

### W

WHO World Health Organisation

### Y

YOS Youth Outreach Services  
YOT Youth Offending Team


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