APPENDIX 10

Southampton City Council
A Psychological Approach to Homelessness: Research at the University of Southampton

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Introduction

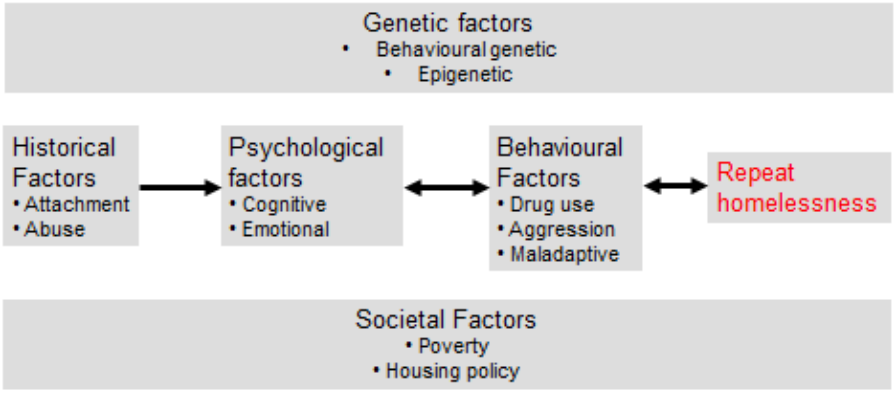
Homelessness in all its forms continues to blight our 21st Century, post-industrial society. The last national rough sleeping snapshot figures published by Communities and Local Government (Autumn 2013) indicated that 2414 people were sleeping on the streets of England. This is likely to be an underestimate. There are around 40,000 hostel bed spaces at any one time in England, giving a measure of the total single homeless population (but excluding homeless families).

Figures released by Crisis in 2013 give an indication of the chronic health problems and early death rates of rough sleepers. They cite the mode age of death as being 44, the mean age 47, factors including drug and alcohol use, suicide, homicide and untreated health issues.

Narratives around the causation and maintenance of homelessness and rough sleeping are often characterised by the polemic debate around the role of society vs the role of the individual, i.e. it's all society's fault or it's the fault of the individual. Where the debate is political, these extremes are sometimes tied up with left and right wings respectively.

One way of synthesising this dialectic debate is to consider the individual in relation to their environment. Psychology provides theoretical and empirical frameworks for such a consideration. Wider issues such as societal and genetic factors can also be noted in the following model:

POSSIBLE MODEL DESCRIBING THE AETIOLOGY AND MAINTENANCE OF HOMELESSNESS



Work done over the last 8 years has investigated the roles of cognitive, emotional and behavioural factors in this model.

Research into psychological factors implicated in homelessness

We have conducted a fair amount of formal research investigating psychological factors implicated in homelessness, together with the evaluation of psychological interventions to treat those issues. The University works in close partnership with local providers Society of St James, TwoSaints and the Booth Centre (Salvation Army). Much of our research is dependent on these close relationships and could not be done without them. The data from this research has been or is in the process of being written up for publication in peer-reviewed, academic journals.

The mental health issues suffered by rough sleeping and hostel-dwelling people are well documented. These include anxiety, depression, psychosis and personality disorder (although this latter term is dubious in terms of validity), with associated drug and alcohol use, and self-harm. We have identified prevalence rates of serious mental health problems (e.g. the diagnosis of personality disorder) which are in line with other research conducted by Crisis. We have also identified some of the underlying processes associated with these diagnoses, which inform the interventions needed.

A significant factor identified in our research is the role of childhood neglect and abuse, and associated difficulties in managing emotions. These difficulties are associated with substance abuse and self-harming behaviours, which in turn often result in behaviours which lead to tenancy breakdown. Our research has also indicated that attachment problems, again related to early abuse and neglect, results in establishing and maintaining healthy relationships, again a significant barrier to healthy, societal living. Such factors can be particularly important when living in structured, social environments such as hostels or shared housing. Add to this difficulties in managing practical issues such as rent, bills etc. and some of the processes leading to repeated eviction become apparent.

Interventions

A number of psychological interventions are designed to address a number of these factors. For example, cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) take a skills approach to the treatment of emotion management and relationship difficulties, and have been shown to be effective in increasing functioning of people suffering the complex mental health difficulties described above.

Such interventions may enable people operate better in structured environments, although it needs to be acknowledged that 1) these skills take time to acquire, and housing can be an issue during transition; and 2) the existing health services set up to deliver these interventions tend to operate to the exclusion of homeless groups (e.g. on the basis of current use, transitional housing).

In addition, engagement in primary care needs to be a priority, as a way of intervening early in health problems before they become chronic, and as pathways to health care other than expensive, chaotic use of e.g. emergency departments of hospitals.

We can make wider use of the psychological knowledge generated through training delivered in hostels. We have data indicating that through training we can enable hostel staff to make use of cognitive and behavioural frameworks to 1) understand apparently self-destructive behaviours; 2) understand their own cognitive and emotional reactions to client behaviours; and 3) enable clients

to understand their own urges to behave in ways which are to their own and others' detriment. We can also enable an understanding of engaging clients in the process of change, firstly in terms of thoughts about change, then perhaps behavioural change itself. This work is progressing under the label of 'psychologically informed environments'.

Commissioning of services according to realistic and meaningful outcomes is essential to this way of thinking. Service providers need to be able to answer the question 'what will change as a result of what you do?'. In this way providers may be encouraged to think creatively about their areas of expertise in delivering tangible and measurable change. Monitoring of these changes may contribute to a culture of evidence-based commissioning, where services are clear with commissioners about what outcomes may be expected, and commissioners then hold the services to that contract.

Meaningful outcomes (as opposed to inputs and outputs) are often difficult to define. However, for this population, behaviours across a number of domains (e.g. incidence of types of antisocial behaviour, drug and alcohol use etc.) are the most tangible of outcomes. At some point, manifest behavioural change should be a measure of success of an organisation. Organisations can of course at any point start to measure change as a result of their interventions. This is sometimes called 'evidence-generating practice'. Any organisation that wishes to increase the efficacy and quality of its services will need to engage with evidence, in terms of consumption and generation.

Summary

Psychological services (and psychologically augmented services such as psychologically informed environments) are showing potential not just to the individuals concerned, but in terms of savings to budgets across DH, MoJ, DWP and CLG (and local individual authorities).

The understanding of the psychological models is progressing, with a concomitant understanding of the nature of the type of psychological interventions necessary. However it is not just the type of intervention which needs attention, but how they are provided given the difficulties of engaging people with long-standing problems in change. Partnerships between the University and local providers are essential in this.

Evidence-based commissioning of services would be aided by a culture of evaluation, particularly around behavioural change attributable to the interventions created by those services.

A note of caution should be sounded. The problems suffered are complex, and interactions with health and housing structures increase the complexity of the issues. No one intervention or set of interventions will be a panacea and significant work needs to be done to increase the sophistication of psychological and environmental interventions.