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Cognitive Behavioural Therapy and Homelessness: A Case Series Pilot Study

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Abstract. This paper describes a project set up to treat four homeless men using cognitive behavioural therapy (CBT). The referral criteria were that individuals had alcohol and/or substance misuse problems, were roofless (i.e. sleeping rough) immediately before the intervention began and found it difficult or impossible to access hostel places in Southampton. Excessive alcohol use, violence (against self, others and property) and prison sentences were all features of their presentation. The project involved three levels of CBT intervention provided by the clinical psychologist: 1) training for the staff to enable them to work within this model; 2) continued supervision within model to ensure consistency and sustainability; 3) individual formulation (description of the problem within the CBT framework) and psychotherapy. The house itself was also run on a collaborative basis. A number of measures including mental health and social functioning constructs were used to evaluate the project, in addition to some qualitative data. All residents reduced incidents of theft, violence and alcohol consumption. Risk to self and others was also reduced for all residents. Perceived self-efficacy increased slightly for all residents, and staff perceived that they could be more effective, less hopeless, and therefore possibly less stressed as a result of training. More data will be gathered over time.

Keywords: CBT, homelessness, rough sleepers, alcohol and substance misuse.

Introduction

There is a paucity of literature detailing the treatment of homelessness within a psychological perspective, and none specifically related to the use of CBT. The limited research there is in this area focuses on homelessness and substance abuse within a population of war veterans, looking at a combined CBT and therapeutic community (Burling, Seidner, Salvio and Marshall, 1994). An important advantage of a CBT intervention is that the psychological, emotional and behavioural issues implicated in the factors leading to homelessness can be described, or "formulated", then informing an intervention (Persons, 1989).

Much of the literature concerned with the treatment of addictions acknowledges the cyclical nature of addiction and motivation to change, which can of course affect behaviour (e.g. Prochaska and DiClemente, 1982). The repeated relapses associated with these cycles can have a profound effect on staff. Anecdotal evidence indicates that repeated relapse can be

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perceived by staff as being due to their own failure and inefficacy as workers, which can lead to hopelessness, stress and burnout. A staff group working with a consistent formulation of the problems may increase the chances of success of goal-setting and behavioural experiments, which in turn may increase their perceptions of self-efficacy.

The effect of CBT on target behaviours associated with homelessness has not yet been the focus of research. This is a pilot study to investigate the effects of a CBT intervention within the context of a small rehabilitation house. It is also intended to highlight the possibilities of enabling such a marginalized group to access CBT. The main aims are:

1. To formulate target behaviours within a CBT and developmental perspectives. These target behaviours are: i) Sleeping rough; ii) Theft; iii) Violence; iv) Self-harm; v) Problematic alcohol and substance use.
2. To provide CBT interventions to treat the underlying factors implicated in those target behaviours.
3. To enable staff working in this setting to use CBT techniques to help address target behaviours and underlying factors, with the use of the formulations generated and supervision.
4. To train staff to operate within a CBT framework, thereby increasing perceived ability to enable change in clients and reduce hopelessness.

Independent living is also a goal for those of the residents who aspire to this. This is a pilot project, and therefore the data for four case studies have been gathered.

Method

Four residents with alcohol dependence problems were identified from the homeless population in Southampton on the basis of need and repeated tenancy breakdown. After a physiological detoxification, the men moved to a house obtained specifically for the purpose of providing a therapeutic environment. Engagement in a structured therapeutic environment was the first stage of the process, addressing substance abuse, medical, health and social needs. Support workers working 8 hours a day, 7 days a week provide day-to-day support in the house, in addition to individual sessions focused on engagement, validation and helping to set up behavioural experiments.

Procedure

The psychological intervention was designed to operate on several levels, addressing the needs of the residents in a number of different ways:

Staff training. Two groups of staff received 12 hours of training over 3 weeks in the basics of the cognitive model and formulating clients' difficulties within the CBT framework by a clinical psychologist. The training also enabled the support workers involved in the house to support them in setting behavioural experiments, gathering data and monitoring results. Complete data from 15 staff were received and analysed.

Individual formulation and treatment. The psychologist worked individually with the residents, initially assessing with a view to a comprehensive formulation, which is drawn up

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collaboratively with the resident. Weekly sessions then followed, designed to address the goals drawn up in the assessment phase, according to the CBT framework.

Supervision sessions. The support workers receive weekly supervision from the clinical psychologist. This enabled continual adherence to the CBT framework and reflective practice.

Individual sessions with support workers. Each resident receives weekly sessions with the support worker to set up and monitor behavioural experiments, as well as monitor emotional issues and crises.

Group meetings. Weekly group meetings facilitated by the support workers enabled the residents to set their own house rules and systems, and discuss any important issues as they arose.

Outcome measures

Quantitative (normative and ideographic self-report) and qualitative data on residents' experiences were gathered at three time points: initial assessment, entry into the project (between 1 and 3 weeks later) and 10 weeks after entry. The following primary measures were chosen to tap constructs that may change as a direct result of a CBT intervention: 1) Self-efficacy (Schwarzer and Jerusalem, 1993); 2) Alcohol dependence (Raistrick, Dunbar and Davidson, 1983); 3) Functioning, risk and total scores of the CORE (CORE Systems Group, 1998).

Functioning is an indication of social activity and ability to draw on personal resources. Risk is indicative of risk to self and/or others. The total score gives an indication of overall psychopathology. Higher scores indicate worse problems.

The following self-report data were also gathered as primary outcomes: 1) Nights spent sleeping rough; 2) Violent incidents involving harm to others or property; 3) Shop-lifting and other theft; 4) Alcohol consumption (in units). An anxiety and depression scale was also used as secondary data. These would be expected to change in the long term, but probably not within the short term.

A novel questionnaire was developed in consultation with an expert CBT clinician to investigate any change in perceptions of working with the client group due to training. CBT training is designed to increase the staff's perceived hopefulness and self-efficacy when enabling clients to change. In this way, hopelessness and therefore stress levels can be reduced. The questionnaire therefore focused on perceived ability to enable change and perceived stress levels, e.g. "How confident do you feel about enabling clients to improve strategies or ideas to help them cope in the future?", and "How often do you become stressed as a result of difficult interactions with individual clients?" Each question was scored on a 5-point Likert scale with descriptors. The questionnaire was administered before and after the 3 weeks of training, the responses being anonymized to minimize response bias.

Results

The main results can be summarized as follows.

1. All residents scored higher than the CORE clinical norms on all subscales, indicating a high level of psychopathology. In particular, high levels of risk were noted for three

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residents compared to the clinical norms, possibly reflecting a high level of risk to self and others (rather than self alone).
2. CORE data over time produced mixed results. Indicated risk reduced for all residents between time 1 and time 3, functioning score increased for two and reduced for two, and total score increased for two and reduced for two.
3. Incidents of theft, violence and sleeping rough reduced to zero for all residents except for one, whose average number of incidents of violence per week halved, from five to 2.5. Alcohol dependence appeared to decrease marginally for three clients, and one indicated complete independence (although this is doubtful in this short time frame). These dependence results did not reliably relate to alcohol consumption, which varied with funds available.
4. Self-efficacy marginally increased for all clients.
5. Anxiety and depression decreased marginally for one client, but the results were mixed for the other three.
6. In terms of staff training, a highly significant difference was noted between the questionnaire scores at the start and end of training ($t = 6.089$; $df = 14$; $p < .001$).

Discussion

This exploratory data set appears to indicate that a CBT approach is useful in enabling tenants to start to address problems of homelessness. In particular, the reductions in violence and criminal activity are most striking, in addition to the impact on nights spent sleeping rough and risk to self and others. Functioning is also increased, but the other indicators of mental health are mixed in terms of results. The positive results could of course be due only to their move into accommodation. However, these men were selected for the project because they had a history of difficulties maintaining tenancies, and tended to lose them quickly, often within a matter of weeks as a result of anti-social behaviour. A controlled trial will be needed to answer this question. It is also important to note the high levels of psychopathology, according to the CORE data.

The staff training data are encouraging. It seems that staff do in fact believe that they will be more able to deal effectively with the complex problems that this population poses, and they feel somewhat more hopeful and anticipate less stress. Further data will be collected over time.

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