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A COMPARISON OF THE PRESENTATION OF PERSONALITY DISORDERS WITHIN A HOMELESS POPULATION. DO THOSE THAT ACCESS MENTAL HEALTH SERVICES PRESENT DIFFERENTLY TO THOSE THAT DO NOT?

BY

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THESIS ABSTRACT

This thesis examines the relationships between internalising and externalising coping behaviours and access to mental health services within a homeless population, in an attempt to examine whether those who access services present differently to those who do not. Maladaptive behaviours are considered to be one of the major reasons for tenancy breakdowns and inability to access services, yet research on coping behaviours among homeless samples is scarce. Despite complex mental health needs, a large percentage of the homeless population do not access mental health services. Therefore, this study aimed to improve current understanding of the multiple processes and factors involved in the psychopathology of homeless persons and thus help in clarifying existing barriers to the utilisation of services. The final sample consisted of 41 participants who had been recruited from Southampton based homeless hostels and day centres and who were asked to complete a questionnaire pack consisting of the Millon Clinical Multiaxial Inventory-III, The ASEBA adult self-report form, and a devised measure assessing access to mental health services. The study showed higher prevalence rates for internalising behaviours among those that accessed secondary mental health services compared to those who accessed primary services or no services. The study was not without its methodological limitations, although findings do contribute to existing research with homeless populations. Further research is needed to determine whether high externalising scores are associated with access to the criminal justice system.

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LITERATURE REVIEW

WHAT IS KNOWN ABOUT THE RELATIONSHIPS BETWEEN PERSONALITY DISORDER AND COPING BEHAVIOURS IN PATHWAYS TO BECOMING AND REMAINING HOMELESS?

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(SEE APPENDIX A FOR NOTES TO AUTHORS)

ABSTRACT

This paper reviews existing literature on the homeless population worldwide, with a particular focus on research conducted in the UK, in order to identify who the homeless are in the UK and what provisions exist for them in current government policies and initiatives. It begins by reviewing studies that attempt to identify risk factors for homelessness. Risk factors are discussed through macro (economic) and micro (individual) level concepts and the role they have in both causing and maintaining homelessness. Current estimates of mental illness among the homeless are reviewed as well as the effect of resettlement on mental illness. The paper then focuses on pathways into homelessness, paying particular attention to the relationship between trauma, personality disorder and coping styles within the homeless population and the specific role that some coping behaviours have in chronic homelessness. Literature is examined from the fields of mental health, personality disorder and coping conducted with general, psychiatric, and homeless populations and explores the complex relationship between individual risk factors, personality disorders and subsequent coping behaviours, in an attempt to understand the contribution they have to the process of becoming and remaining homeless. Finally, the paper examines existing models that have attempted to incorporate risk factors in explaining pathways to homelessness and concludes by hypothesising a model that includes both personality disorder characteristics and coping behaviours in perpetuating homelessness. The paper concludes by discussing future directions for research among this vulnerable population.

1. INTRODUCTION

Over the past two decades literature has emerged that attempts to examine the many pathways to homelessness and the factors that are involved in maintaining homelessness. It is unquestionable that social policies and access to affordable housing impacts on rates of homelessness, causing variation in findings of studies conducted in the UK and elsewhere. For example van Vilet (1989), points out that homelessness is not a major concern in the Netherlands where social housing is readily available. This paper will review worldwide literature alongside studies that are specific to UK populations, as firstly; research into homelessness in the UK continues to be limited and secondly; findings from studies conducted in the USA, UK and elsewhere, continue to show similar trends in respect to individual factors involved in homelessness.

In the UK, 'homelessness' is most commonly defined and discussed in terms of homelessness legislation, the first of which was introduced as the Housing Act (Burrow, Pleace & Quilgars, 1977). The legal definition of 'homelessness' is pitched in broad terms as being without secure accommodation for a period of at least one month or being at risk of losing secure accommodation in the next 28 days. In reality, those who are actually accepted as homeless (the statutory homeless) and eligible for support by Local Authorities are a much narrower group. Those who are not clearly entitled to support are largely single people without dependents who usually reside in hostels, bed and breakfasts and other temporary accommodation, leading authors to refer to them as the 'Hidden

Homeless' (www.crisis.org.uk). Also, the literature usually makes a distinction between 'the homeless' and 'the chronically homeless', as some individuals experience only a single isolated episode of homelessness while others experience repeated cycles where they may sleep rough, move into hostels, secure accommodation and then lose tenancies before returning to the street. Chronic homelessness is therefore characterised either by a repeated pattern of tenancy breakdowns and cycling in and out of homelessness or by a prolonged and sustained period of homelessness. Across the world the homeless population has changed significantly in the past three decades and this review will begin by briefly identifying who the homeless are in the UK, what the research to date tells us about the mental health needs of these populations and what it reveals about the pathways into homelessness.

Multiple studies conducted within the homeless population have commented on the disproportionately high rate of reported childhood abuse and some studies have begun to examine how early experiences can become a major factor in the pathway to becoming homeless (Craig & Hodson, 1998; North, Pollio, Smith & Spitznagel, 1998; Morrell-Bellai, Goering & Boydell, 2000; Rayburn, Wenzel, Elliott, Hambarsoomians, Marshall & Tucker, 2005). Numerous studies within the psychiatric and general population have linked trauma experienced during childhood, namely abuse (Derksen, 1995) to personality disorder.

Studies that have measured Axis II disorders show that personality disorders represent a significant percentage of the mental health problems prevalent within the homeless population, with rates of prevalence varying from 6 – 50% (Fischer & Breakey, 1991; Pollio, North, Thompson, Paquin & Spitznagel, 1997; Scott 1993). However, there continues to be a shortage of research and therefore a lack of understanding about the exact nature of personality disorders within the homeless and the association with childhood trauma. Virtually no studies have examined how childhood abuse relates to the anti social behaviours, relationship difficulties and difficulties regulating emotion that are seen in homeless populations, difficulties that interestingly might warrant consideration of a diagnosis of personality disorder in the general population. Furthermore, there is a lack of research that adequately explores how early abuse and ensuing mental illness can result in inflexible coping behaviours and poor relations with others that in turn seriously undermine the abilities of the homeless to seek, access and utilise services appropriately.

Literature on theories of personality disorder describe various personality traits that form complex enduring patterns of perceiving, thinking, and relating to others that are displayed across a wide variety of social and interpersonal settings. Millon (1981) argues that the coping strategies of individuals who are personality disordered are limited and inflexible. He suggests that they tend to utilise the same methods for coping repeatedly regardless of whether they achieve favourable outcomes or not (Millon & Davis, 2000). A huge amount of research

with the homeless population has focused on the relationship between mental illness and substance abuse but few have explored the possibility that substance abuse may act as one part of a limited and inflexible coping repertoire for homeless individuals who may be personality disordered.

This paper will review literature identifying individual risk factors that contribute to becoming and remaining homeless. It will examine literature from the fields of personality disorder, coping behaviours and mental health conducted with general, psychiatric, and homeless populations and explore the complex relationship between individual risk factors, personality disorders and subsequent coping behaviours, in an attempt to understand the contribution they have in the process of becoming and remaining homeless. The paper examines existing models that have attempted to incorporate risk factors in explaining pathways to homelessness and the author concludes by hypothesising a model that builds on existing theories to indude both personality disorder characteristics and coping behaviours in perpetuating homelessness. Finally, the review will consider findings from research so far and the implications for future directions with this vulnerable group.

2. HOMELESSNESS AND MENTAL HEALTH

2.1 Who are 'the homeless' in the UK?

Throughout the 1980's research into homelessness focused on distinguishing the sociodemographic characteristics of homeless populations in an attempt to identify those most at risk of becoming homeless. Toward the end of the 1980's studies revealed a different type of homeless population, one that challenged the existing stereotype of the homeless as older, alcoholic males. The contemporary homeless were noted to be younger and more heterogeneous than previous populations, included a greater number of single women and an overrepresentation of minorities (Fischer and Breakey, 1991; North, Eyrich, Pollio & Spitznagel, 2004). In the UK today this finding is mirrored and the population of homeless persons is diverse: it includes representatives from all ethnic groups, young, old, women, men, single persons and families and people with physical and/or mental health problems (Burt, 1992; Robertson & Greenblatt, 1992; Stein & Gelberg, 1995; Office of the Deputy Prime Minister ([ODPM] 2003). The majority of the homeless population in America and Europe consists of unemployed, single men and women aged between 31 – 50 years (Fernandez, 1996; O'Flaherty, 1996; Rossler & Salize, 1996).

A recent article by Smith (2006) discussed available health services in the UK for three differing homeless populations; single homeless, youth homeless and family homeless. In the UK a broad system of support exists for diverse

homeless populations under homelessness legislation. Previous government policies have been directed toward breaking the cycle of social exclusion through providing targeted services to those not receiving them and promoting measures to increase take-up of services by homeless people (Department of Health, [DOH] 1996; Department of Transport, [DETR] 1999). The ODPM and the DOH have jointly recently issued good practice guidance on the delivery of health services to homeless people (ODPM, 2004).

Family homeless

Women head 90% of homeless families, they are a heterogeneous group, largely younger and socially more stable, than homeless men (Martens, 2002). Women who are homeless have proportionally higher rates of major mental illness than homeless men (Fernandez, 1984; Herzberg, 1987; Bassuk, Rubin & Lauriat, 1984; Breakey et al., 1989). In the UK the proportion of women among the adult homeless population is currently estimated to be between 10 - 25% (Martens, 2002). The vast majority of studies into homelessness have recruited participants from hostels, streets and day centres, therefore homeless families are often not included in these studies. The majority of families in the UK are placed either in permanent social housing or in temporary accommodation, as hostel accommodation or bed and breakfast is now banned for the use of families (Smith, 2006).

Single homeless

Throughout the 1980's the number of single homeless people living on the streets grew and a census in 1991 reported the figure to reach over 2,000, with 47% sleeping rough in Greater London alone (1,275). However, many believe that this figure was greatly under-enumerated (Randall, 1998). The growth of numbers sleeping rough led to the establishment of the Rough Sleepers' Initiatives from 1990 to the late 1990's (DETR, 1999). This action plan aimed to reduce numbers by two thirds and tackle issues of mental ill health, which affects approximately 30 - 50% of rough sleepers (Griffiths, 2002).

To date, single homeless people live in a variety of supported accommodation, namely hostels, but 2007 statistics from the Annual Rough Sleeping figures suggest that approximately 498 single homeless people still continue to sleep rough in the UK (www.communities.gov.uk).

Youth homeless

Of equal importance to the growth of the street homeless population during the 1980's was the change of composition of both street and hostel populations. In 2005 the Office of the Deputy Prime Minister ([ODPM] 2005a) found an increasing number of young people among all single homeless, which some believe was due to the withdrawal of income support entitlement from young people aged 16 and 17 in 1988 (Evans, 1996). Largely the demographic profile of the young homeless in the UK are aged between 16 and 25 years, they are

predominantly white (60%), male (63%) and single (93%), (Anderson, Kemp & Quilgars, 1993; Craig & Hodson, 2000). Young homeless people are accommodated in specialist hostels for the age group 16 -25 years.

Recently, it has been noted that older and younger homeless persons have different vulnerabilities in terms of mental illness (DeMallie, North & Smith, 1997). Some studies suggest that older homeless persons report lower incomes and poorer health and are more likely to meet the criteria for life time alcohol use disorder than their younger counterparts (DeMallie, North & Smith, 1997). This supports research by Morris (1997) who also found that those who had been homeless for an extended period of time were twice as likely as the newly homeless to mention drugs or alcohol as the reason for their homelessness. Another study reports that a greater number of younger homeless participants meet the criteria for lifetime drug-use disorders and post traumatic stress disorders, than their older counterparts (Martens, 2002).

2.2 Difficulties assessing prevalence rates of mental illness within the homeless population

Early research (1980's) into the prevalence of mental health problems within homeless populations resulted in huge variations in rates; 2 – 90% for mental health problems, 4 – 86% for alcohol problems and 1 – 70% for drug abuse (Fischer, 1989). The wide variation in prevalence rates can be explained in part through methodological differences. Differences in definitions of homelessness,

sampling strategies and methods of case ascertainment were crucial aspects of design that impeded comparisons between studies. How homelessness is defined has an important bearing on data as it determines how participants are selected. Also, prevalence rates may be considerably inflated by reporting lifetime rather than current alcohol, drug and mental disorders. It is also true that researchers rarely assess prevalence for more severe disorders, such as personality disorder. When personality disorder is assessed, studies seldom measure for the whole spectrum of disorders, often focusing solely on antisocial personality disorder. In addition to this, research so far has failed to consider the number of people in prison who were homeless prior to arrest, a potentially major oversight when considering the high prevalence of mental illness, including severe disorders that are found among the prison population (Jelovac, Simunovic & Bencek, 1996).

Choice of sampling sites is also likely to influence prevalence rates of mental illness among the homeless. For example, if providers have exclusionary rules aimed at intoxicated or manifestly disturbed or violent people, an underestimation of mental illness is likely if participants are sampled from such hostels that exclude those who act bizarrely. Lastly, estimates that rely on self-reported behaviour naturally depend on the level of insight and willingness for self disclosure of the participants. To arrive at the most accurately determined estimations of prevalence, studies ought to be compared while controlling for problem definition and method of assessment, similarity of sampling techniques

and sites, and demographic composition of the sample. For more comprehensive reviews of the methodological issues in assessing the prevalence of mental illness among homeless populations, see reports by Fischer and Breakey (1991); Susser, Conover and Struening (1990); Burnam and Koegel (1988); Koegel and Burnam (1992).

2.3 Current estimates of prevalence rates of mental illness within the homeless population

Smith (2006) notes that reporting research evidence from the UK is complicated by the existence of different health and housing authorities for England, Wales, Scotland and Northern Ireland. However, in 1994 the first Psychiatric Morbidity Study (PMS) for the general population was immediately followed by a survey of 1,100 homeless persons. Importantly, the sample was taken across four different types of homeless provision resulting in the only full survey of the mental health of all homeless people which includes homeless families (Gill, Meltzer, Hinds & Pettigrew, 1996). The survey allowed rates of mental health in the homeless population to be compared with that of the general population and also partly distinguished between the homeless populations because of the way in which the sample was drawn to include residents of hostels specifically catering to homeless people; homeless people, mostly families, housed temporarily in private sector leased accommodation; people staying in night shelters; and homeless people sleeping rough who visited day centres.

Hostel populations

Among the hostel sample the prevalence of anxiety and depression disorders was 38% compared to 14% for the general population, psychosis was 8% versus 1% for the general population, alcohol dependence 16% versus 5% and drug abuse 6% versus 3% for the general population. Young homeless people (16-24) living in hostels scored highest on severe alcohol disorder, drug dependence, and anxiety and depression disorders, but lowest on psychosis (Gill, Meltzer, Hinds & Pettigrew, 1996). This is particularly interesting when considering the number of homeless persons who receive treatment within inpatient mental health services for psychotic type illnesses.

Private sector leased and short life accommodation populations

Among the sample drawn from private sector leased and short-life accommodation (of which 63% were women) the prevalence of anxiety and depression disorder was the same as that found among hostel homeless of all ages (38%), Gill, Meltzer, Hinds & Pettigrew (1996). Interestingly, both alcohol dependence and drug dependence rates were lower than the general population and dissimilar to the other three homeless samples, something which contradicts findings that many homeless mothers use illegal drugs/and or alcohol (Marshall, 1996; Wagner, Menke & Ciccone, 1995). Findings from Smith and North (1994) help explain these differences, in that rates of alcohol use in homeless women varied from 12.7% in mothers with children present in the household, to 33.3% in mothers whose children were not present. This study highlights the fact that

children may act as a protective factor for increased drug/alcohol use among women who are heads of homeless families.

Day center and night shelter populations

Among the sample taken from day centers and night shelters, rates of mental illness were higher than the other samples. Anxiety and depression disorders were 15-20% higher among the night shelter and day center users than the hostel and private sector accommodation residents. Drug dependence was also much higher, at 22% (night shelter users) and 13% (day centre users) compared with 3%, 6% and 2% for the general, hostel and private accommodation populations and similar trends were found for alcohol dependence (Gill, Meltzer, Hinds & Pettigrew, 1996). That some homeless populations (those living in hostels and in temporary accommodation) had higher rates of Axis I problems but similar rates of psychosis than the general population, raises the question of the relation between mental illness and housing crises and in particular what happens when people become resettled, this will be discussed in a later section.

The prevalence of psychological disorders among homeless adults has consistently found that the vast majority of homeless people experience at least one psychological disorder (Buhrich, Hodder & Teeson, 2000; Herman, Susser, Struening & Link, 1997; Kamieniecki, 2001; Goering, Tomiczenko, Sheldon, Boydell & Wasylenki, 2002). A recent controlled study found overall lifetime prevalence rates of 82 – 93%, including severe mood disorders, abusive

histories, drug dependence and psychosis (Fichter & Quadflieg, 1999). In the UK recent studies have estimated that 55% of the homeless population have mental disorders (Craig & Hodson, 1998; Holland, 1996). When sex comparisons are drawn they reflect the trends found in the general population, with both drug and alcohol problems more frequently reported in men and mental health problems at a higher prevalence among women (Fischer & Breakey, 1991).

Rates of mood disorders, psychotic disorders and trauma related disorders have all been found to be over represented amongst homeless youth (Cauce, Paradise, Ginzler & Embry, 2000; Herman, Susser, Struening & Link, 1997; Kamieniecki, 2001) and severity of psychological distress is indicated by the high rates of suicidal behaviours in this group (Molnar, Shade, Kral, Booth & Watters, 1998). Moreover suicide attempts have been found to be independently predicted by a history of childhood trauma (Molnar et al., 1998).

At times, the mass of research on mental illness within the homeless population yields conflicting results. However a consensus has emerged that the homeless are much more likely than the general population to suffer from the full range of mental illnesses, including severe disorders and that they require a wide range of support services that address the high diversity and severity of need. The high rates of mental illness among the homeless and the question of whether it precedes or postdates homelessness has urged researchers in recent years to examine the effects of resettlement on mental illness.

2.4 The effect of resettlement on mental health problems in homeless populations

Research into the effect of resettlement on mental health problems is conflicting. One study found that neither previous mental illness nor alcohol dependence were predictors of tenancy failure among 67 cases in London and Sheffield (Crane and Warnes, 2002). Instead resettlement outcomes related to type of housing that was occupied and to the degree of social involvement of a newly resettled person. This contradicts a recent finding with a similar population, that high degrees of alcohol consumption and mental illness severity increased the risk of deterioration of housing arrangements, leading to the conclusion that permanent housing is not sufficient for improving mental health (Quadflieg and Fichter, 2007). Craig, Hodson, Woodward and Richardson (1996) found that when they re-interviewed young homeless participants in London a year later, just over half were in stable housing circumstances. Among this follow up sample 19% had experienced chronic mental illness throughout the transition, 8% had a new onset and 22% had recovered. Recoveries were noted to occur in subjects with less severe disorders, predominantly depression.

Interestingly, a study conducted with homeless families found that rates of mental illness at a one year follow up had halved on re-housing. In particular, after one year the proportion of mothers with mental illness at the level of clinical depression had fallen from 52% to 26% (Cumella, Gratton & Vostanis, 1998; Vostanis, Gratton & Cumella, 1998; Vostanis & Cumella, 1999). In comparison a

later study which sampled families from a hostel with special support services for families did not find such favourable outcomes, lending support to the argument that permanent housing may be particularly beneficial for the mental health of homeless families and that specialised support services within hostels cannot compensate for permanent housing.

Given the differing results found here across populations of homeless people, it cannot be said that mental illness is due wholly to the status of being homeless as it would be logical to assume that once placed in permanent housing, recovery would occur. The argument that housing is not enough has led to huge government initiatives in the UK, such as Supporting People (Randall & Brown, 2003), Sustainable Communities (ODPM, 2005a), and Creating Sustainable Communities (ODPM, 2005b). Nonetheless, studies that demonstrate a reduction in neuroses on resettlement show that both support and prevention must be built on the availability of secure permanent accommodation provided by social housing agencies. Meanwhile research from 2000 onwards continues to try and answer the question of whether mental illness precedes or postdates homelessness and has begun to focus on possible pathways to becoming homeless.

3. PATHWAYS TO HOMELESSNESS

3.1 Macro and Micro risk factors

The early approaches to studying homelessness, which focused on finding 'profiles of the homeless' were criticised for diverting attention away from what is often termed 'macro' factors, such as lack of affordable housing, benefit cut backs, low wages, lack of employment opportunities and the role these have in causing and maintaining homelessness (Breakey, 1997; Cohen & Thompson, 1992; Snow & Anderson, 1993; van Vilet, 1989). Those who advocate for change at the macro level maintain poverty is the one factor common to all homeless persons, whether this be due to a lack of education, work skill, physical or mental disability, substance abuse problem, minority status, sole support parent status or the absence of an economically viable support system (Snow & Anderson, 1993; Morrell-Bellai, Goering & Boydell, 2000).

While acknowledging the importance of macro level factors, the denial of individual vulnerabilities such as mental illness and substance abuse, makes it more difficult to secure funding for needed services (Fischer & Breakey, 1991) and to understand how people may become and remain homeless (Morrell-Bellai, Goering & Boydell, 2000; Martijn & Sharpe, 2006; Smith, 2006). Moreover the identification of individual vulnerabilities is essential to the design of effective prevention services (Rosenberg, Solarz & Bailey 1991). Current research now recognises that physical, social and psychological (micro) factors interact with

economic (macro) factors to bring about homelessness and it is widely accepted that pathways to becoming and remaining homeless are complex and diverse and will vary within particular subgroups. Many studies have focused on the individual risk factor of childhood adversity and its importance in the pathway to homelessness.

3.2 Childhood adversity and trauma as a risk factor for homelessness

Research into the experience of trauma amongst homeless people has found that traumatic events are virtually universal (Buhrich, Hodder & Teeson, 2000), with significant numbers of young homeless persons reporting that childhood trauma was a major factor for initial homelessness (Bruegel & Smith, 1999). Interestingly, childhood trauma has also been consistently linked to the development of personality disorder, a severe mental disorder that represents a significant percentage of mental illnesses within the homeless (Mathews, 2006). For these reasons childhood adversity is discussed as a major risk factor for homelessness.

A recent interview of 78 homeless participants with co-occurring disorders found that 79.5% (62/78) acknowledged a history of either physical and/or sexual abuse at some point in their lifetimes. Of this population 100% of the homeless women with co-occurring disorders had experienced a life-altering traumatic event, while 68.6% of the men also reported trauma histories (Christensen et al., 2005). Subsequently the authors advocate for providers to recognise the

prevalence and impact of trauma in the lives of homeless people, particularly in those with co-occurring disorders.

Domestic violence has often been identified as a precursor to family homelessness and many researchers have found higher prevalence rates of victimisation among homeless than among housed mothers (Bassuk & Rosenberg, 1988; Wood, Valdez, Hayashi & Shen, 1990; Weitzman, Knickman & Shinn, 1992) with one study citing abuse to be ten times higher than among African American domiciled women (D'Ercole & Struening,1990).

Similar results have been found among the young homeless, with one study reporting that 67% of the young homeless interviewed reported a history of either sexual or physical abuse or both (Ryan, Kilmer, Cauce, Watanabe & Hoyt, 2000). This is particularly important in light of findings that suicide attempts in the young homeless have been found to be independently predicted by a history of childhood trauma (Molnar et al., 1998). A UK study with homeless youth (Craig & Hodson, 1998) found a significant difference between the homeless and their control domiciled population in psychiatric disorders and childhood adversity. Bruegel and Smith's study in the UK (1999) found that being hit during the course of arguments at home was one of seven discriminant variables that categorised young people into currently homeless and not currently homeless.

Evidence also exists of older homeless people having experienced violence in childhood or other forms of abuse, including sexual abuse (Crane & Warnes, 2002; Crane,1999; Morrell-Bellai, Goering & Boydell, 2000; Randall & Brown, 2003; & Ravenhill, 2003)

Further evidence for the importance of trauma comes from studies that have consistently found foster care placement during childhood to be a risk factor for homelessness (Koegel, Melamid & Burnam, 1995; Susser, Struening & Conover, 1987; Mangine, Royse & Wiehe, 1990; Bassuk et al., 1997). Findings suggest that foster care may interfere with the formation of secure attachments and deprives some children of the skills and supports necessary to establish themselves as self sufficient adults. In summary, research has consistently shown childhood adversity is higher among the homeless than the domiciled and that this is a common factor across the three groups of homeless; family, single adult and youth homeless.

Koegel, Melamid and Burnam (1995) suggest that the problems homeless individuals experience as adults have clear analogs in their experiences as children. The economic vulnerability, residential instability and interpersonal difficulties that reduce effective functioning in the competitive vocational and housing arenas are not new to the homeless. The UK's second Psychiatric Morbidity Study (PMS) of the general population, taken in 2000, (Office of Population Censuses and Surveys [OPCS] 2000) revealed that a history of

violence in the home was found among 16% of those with a mental disorder versus 4% of those without and sexual abuse at 9% versus 2% of those without.

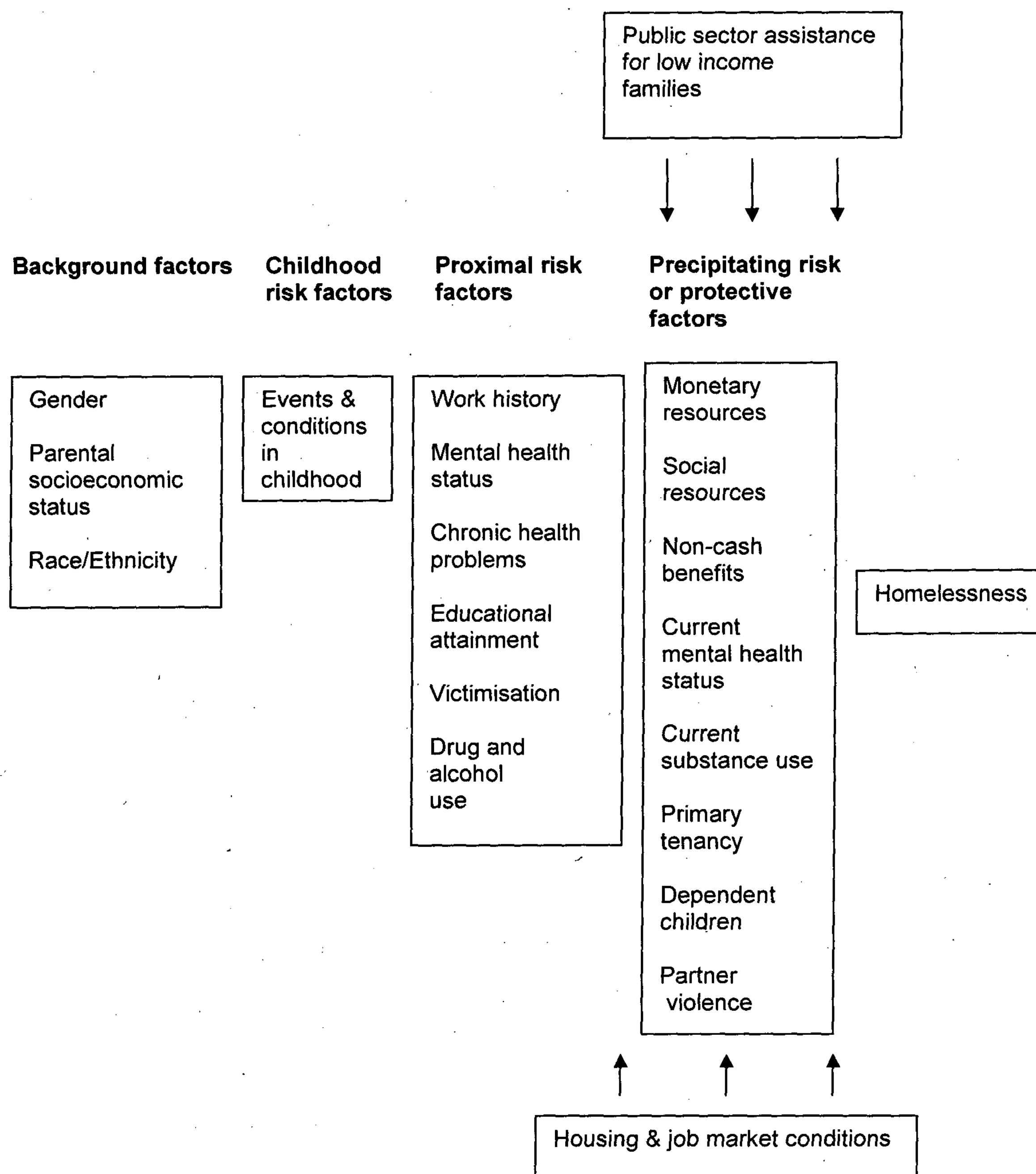
Many studies have highlighted risk factors for homelessness but few have postulated how these factors can develop into a pathway for homelessness with the exception of Koegel, Melamid & Burnam (1995). They postulate that poverty, problematic role models, psychologically damaging experiences, family dysfunction and distress work directly and indirectly to produce risk for homelessness, shaping, influencing and constraining the intra and inter-personal resources that children can draw from as adults. For instance they may create predispositions to substance abuse and mental illness; they may culminate in family constellations that in later life are either unable, unwilling or unavailable to provide social support; they may contribute to the development of personalities and perspectives that disrupt an ability to obtain and maintain employment or; may affect the ability to develop a network of enduring, caring social ties. All these experiences may feed one another, promoting the kind of situational crises that are likely to precipitate homelessness and to maintain homelessness. Recently hypothesised pathways to homelessness successfully incorporate many of the issues that have been discussed so far.

3.3 Models of pathways into homelessness

Wright and Weber (1987) developed a model that explored pathways into homelessness, including types and interactions of various risk factors including

social factors and individual factors. Although useful in identifying those who may be most at risk of becoming homeless it does not provide a way of understanding how the factors interact to cause homelessness. Another attempt to explain risk factors as pathways to homelessness was made by Susser, Moore and Link (1993) who built on previous lists of risk factors to include background factors, childhood factors, proximal factors and precipitating factors (see figure 1)

Figure 1 - Risk and protective factors for family homelessness



Model proposed by Susser, Moore and Link (1993)

Susser, Moore & Link (1993) have considered a wide variety of risk factors and have shown how each factor may fall into one of four stages that precipitate becoming homeless but the model is specific to homeless families and still does not adequately explain the interaction of the factors as causal pathways to homelessness.

A recent small study with youth homeless used a quasi-qualitative methodology to generate hypotheses about the pathways to youth homelessness (Martijn & Sharpe, 2006). Some of the major findings of the study were that (1) trauma is a common experience amongst homeless youth prior to homelessness and figured in the causal pathways to homelessness for over half of the sample; (2) once homeless, for the majority of youth there is an increase in the number of psychological diagnoses, including drug and alcohol diagnoses. In-depth analyses were conducted to identify the temporal sequence for each individual, with a view to establishing a set of causal pathways to homelessness and trajectories following homelessness that characterised the people in their sample. Five pathways to homelessness and five trajectories were identified that accounted for the entire sample (n=35) but the authors found that pathways two, three and four represented 94% of the sample (Martijn & Sharpe, 2006), these are described below;

Pathway Two – Trauma and psychological problems (the absence of drug and alcohol)

In contrast to pathway one (where all participants had experienced a trauma - half preceding drug or alcohol abuse and half postdating the trauma) all the participants in this group (n=8) experienced trauma preceding any psychological disturbance. The most common disorder was PTSD. (Martijn & Sharpe, 2006).

Pathway three – Drug and alcohol and family problems

All participants in this group met criteria for either drug and/or alcohol abuse or dependence. Four of the participants in this group met criteria for various psychological disorders, including schizophrenia (Martijn & Sharpe, 2006).

Pathway four – Family problems

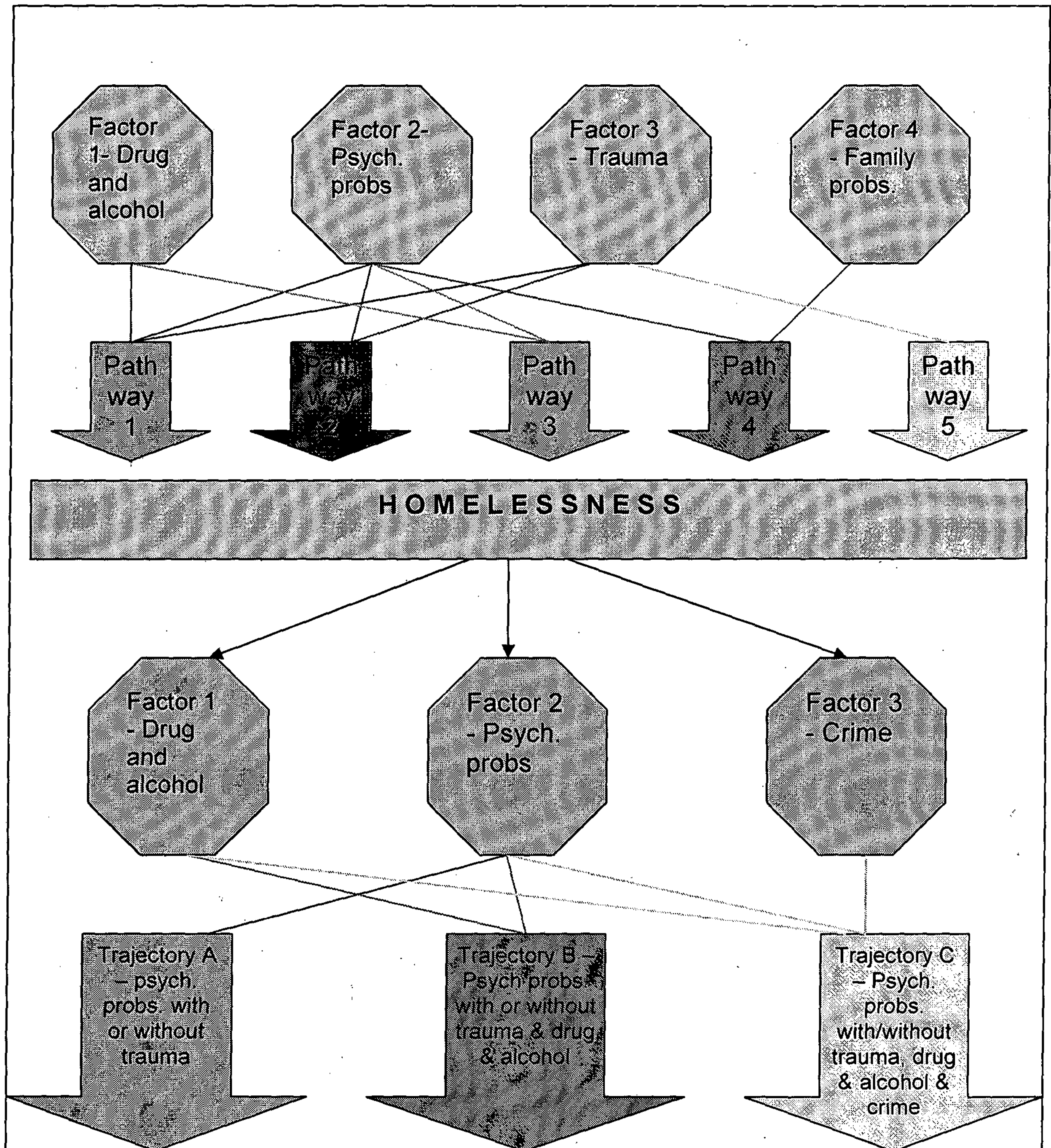
Of the seven participants in this pathway, five reported a history of neglect necessitating periods of absence from the familial home, with two cases resulting in periods in care during childhood. One participant reported physical abuse in childhood, and the other reported emotional abuse. Of these, only one met the criteria for any psychological disorder prior to homelessness and none met criteria for drug or alcohol abuse/dependence prior to their first episode of homelessness (Martijn & Sharpe, 2006).

The youth represented in the five pathways to homelessness were re-visited to determine if the factors that preceded homelessness changed following

homelessness. In analysis a factor was only considered if its onset postdated homelessness. There were five identifiable trajectories but overall all participants with diagnoses of psychological or addictive disorders prior to homelessness fell into trajectories A - D. This demonstrated that whatever way the young participants came to be homeless, once they were homeless they developed additional psychological or drug problems and a sizeable proportion (33%) turned to crime to either support their basic needs or their drug habits.

The trajectories following the onset of homelessness were characterised by four main factors: drug and alcohol use, psychological disorders, trauma and crime, the two most prevalent factors being drug and alcohol use and psychological disorders. Although early life experiences and trauma were important pathways to homelessness, they did not differentiate between youth with different trajectories. That is to say that trauma was still a common experience following homelessness but no longer distinguished between the trajectories. Martijn and Sharpe (2006) suggest this most likely reflects the universality of trauma while homeless, thus it fails to become a distinguishing factor following homelessness. The idea of homelessness as a trauma in itself is supported by many authors (Christensen et al., 2005; Goodman, Saxe and Harvey, 1991; Padgett, Hawkins, Abrama and Davis, 2006). Figure 2 shows the five pathways to homelessness and the most common trajectories (A, B & C) that followed the onset of homelessness for the young homeless participants in Martijn and Sharpe's study (2006).

Figure 2 Pathways to homelessness and trajectories following the onset of homelessness (Martijn & Sharpe, 2006)



Martijn & Sharpe's (2006) study is pioneering in that it brings together existing research on risk factors for becoming and remaining homeless and has made a

comprehensive start at linking risk factors and examining their relationships as causes and consequences of homelessness. The study adds to the literature on pathways to homelessness whilst making sense of the extensive existing research on risk factors, strongly suggesting that four main factors interrelate to cause homelessness. The longitudinal design also highlighted crime as a significant factor only after the onset of homelessness, a fact which could help to challenge the negative view of the homeless as inherently criminal.

However, the study had several limitations including a very small sample size (n=35) and the conclusions should be met with caution. The sample size reduces the potential for generalisability of the findings and a larger sample is needed to determine whether the pathways are exhaustive and generaliseable. The sample was drawn from four different services but did not include homeless youth sleeping rough or those who were not in contact with services. Also, participants were not randomly selected but were approached by researchers to take part in the study therefore the findings may not be truly representative of homeless youth throughout Australia. One very obvious limitation of the study is the lack of acknowledgement of macro level factors in the process of becoming homeless. The study also relied on retrospective recall in a group of young people with marked psychopathology raising the issue of the reliability of reports, although researchers did make attempts to reduce recall bias through the use of well-validated diagnostic interviews and timelines to anchor recall. Also, research has shown that young homeless people do report histories of childhood

abuse accurately, according to available corroboration (Lipschitz, Bernstein, Winegar & Southwick, 1999). Such results led Urquiza (1991) to argue that retrospective research is a consistent, viable and economical source of family violence data.

Despite limitations, the strength of Martijn and Sharpe's research (2006) lies in the methodology, as it allows examination of the relationships between numerous factors simultaneously. Although preliminary, the research comes closer to providing an understanding of the interaction between highly salient factors that have been found to be important time and again through decades of research. Further research needs to be conducted on a larger scale, should endeavor to include homeless youths that sleep rough and would be beneficial if extended to include other homeless groups (e.g. family homeless and older single homeless people) in determining whether these pathways could adequately explain their experiences too.

Further work towards understanding pathways to homelessness comes from other qualitative work (Morell-Bellai, Goering & Boydell, 2000), using the framework of macro and micro level factors and interviewing of participants (N = 330). The findings support those of Martijn and Sharpe (2006) as negative childhood experiences (including sexual, physical or emotional abuse, having alcoholic parents), abuse experiences in adulthood, mental health problems, substance abuse problems and interpersonal conflict within the family of origin

were the most salient individual factors in pathways to homelessness. These factors map on to those identified by Martijn and Sharpe (2006) very closely. Although poverty was examined in the macro level factors as immediate precursors to homelessness it was also found to be a common experience during childhood. Again, this lends support to the previously discussed notion that in later life, these families are either unable, unwilling or unavailable to provide social support to the individual (Koegel, Melamid & Burnam, 1995) and that childhood poverty limits the financial resources available to the individual as an adult, undermining their ability to prevent homelessness (Morrell-Bellai, Goering & Boydell, 2000). Interestingly, over half of the individuals in the qualitative sample talked about difficulties in interpersonal relating, something that is also a key indicator of personality disorder.

Among the major findings for the macro level factors involved in remaining homeless were acceptable supportive counseling, employment at an acceptable wage, safe and affordable housing and a general lack of incentives for individuals to change their situation (e.g. hostels provided for all of the basic needs and no expectations were placed on them to work toward changing their situation) Morrell-Bellai, Goering & Boydell (2000). The most common individual (micro) factors identified in the process of remaining homeless, were impoverished support networks and substance abuse problems (Morrell-Bellai, Goering & Boydell, 2000) Again, these factors map onto those identified by Martijn & Sharpe (2006). An important difference was found between the newly homeless

and the chronically homeless, with the chronically homeless reporting to have suffered childhood abuse of longer duration and greater severity compared to the first time homeless group and to be more likely to have experienced out of home placements as a child (Morrell-Bellai, Goering & Boydell, 2000). The issue of chronicity is an area which again produces conflicting results. Certainly, it is important to consider what might be preventing the chronically homeless from sustaining tenancies and the research to date has highlighted that the available coping behaviours of these individuals are most likely to be problematic for agencies. These coping behaviours can be understood by examining the literature on coping in the personality disordered population.

4. PERSONALITY DISORDER

4.1 The concept of personality disorder

An individual's personality is comprised of various personality traits that form complex, enduring patterns of perceiving, thinking, and relating to others that are displayed across a wide variety of social and interpersonal settings. When these traits become inflexible, maladaptive and cause significant distress and/or functional impairment, a disorder of personality is considered to exist (American Psychiatric Association, APA, 1994). A personality disorder is defined by the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994, p.629) as *'an enduring pattern of inner experience and behaviour*

that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment'. The concept of personality disorder has been continuously changing throughout each successive edition of the DSM, with the definitions being expanded and refined as well as new disorders being added while others have been removed (Derksen, 1995).

Within the DSM-IV (APA, 1994), Axis II describes 12 primary personality disorders which have been grouped into three clusters. Cluster A is characterised by unusual and eccentric traits and encompasses the paranoid, schizoid and schizotypal personality disorders. Cluster B is characterised by behaviour that is erratic, emotional or dramatic and includes the antisocial, borderline, histrionic and narcissistic personality disorders. Lastly, Cluster C is characterised by traits of fear and anxiety and includes the avoidant, dependent and obsessive-compulsive personality disorders. See Appendix C for a brief description of the 12 DSM-IV personality disorders. The passive aggressive personality disorder and the more recent depressive personality disorder appear in Appendix C of the DSM-IV, as they require further investigation (Millon & Davis, 2000).

4.2 Theories of personality disorder

There are many theoretical conceptualisations on the development of personality disorder and this paper will briefly review some of the most prominent theories in the field; the Biological, Psychodynamic, Interpersonal and Cognitive Perspectives. For more detailed accounts readers are directed to Lezenweger and Clarkin (2005), Millon and Davis (2000), Linehan (1993;1993b) and Livesley (2001).

The Biological Perspective

Temperament is often referred to as the biological foundation of personality, the first domain of personality to come into existence with all aspects of personality forever constrained by the first domain that develops. Temperament however is only one aspect of human biology and the existence of neurotransmitters that seem to be specialised for certain functions rather than others, lends support to the theory that each neurotransmitter may relate to some content dimension of personality. Cloninger (1987) proposed a theory based on the interrelationship of three genetic-neurobiological trait dispositions, each of which is associated with a particular neurotransmitter system. Specifically, novelty seeking is associated with low basal activity in the dopaminergic system disposing the individual to exhilaration or excitement in response to novel stimuli, leading to the pursuit of potential rewards and active avoidance of both monotony and punishment. Reward dependence is seen as a tendency to respond to signals of reward and to resist extinction of behaviours previously associated with rewards or relief from

punishment. These three dimensions form the axes of a cube whose corners present various personality constructs. However, Cloningers model (1987) does not account for all of the personality disorders that appear in the DSM-IV and the personality disorders that do correspond, do so only loosely (Millon & Davis, 2000). In a review of the literature on the influence of genetics in personality Thapar and McGuffin (1993) argue that the evidence for heritability is most strong for antisocial and schizotypal personality disorders.

The Psychodynamic Perspective

Freud (1905, 1923) postulated that personality develops through psychosexual stages, where each stage gives way to the next and presents the individual with a set of maturational challenges. Certain personality traits are believed to be associated with frustrations or indulgences during these stages. Furthermore personality is considered to be composed of the 'irrational' id consisting of basic survival instincts and the two main drives of personality; sex and aggression, the superego, which attempts to incorporate societal and moral values and the more rational ego which develops to mediate between the demands of the id and the constraints of the superego and the environment. This process is said to be highly vulnerable to feelings of anxiety and consequently defense mechanisms such as acting out, denial, repression or splitting are used to reduce perceived anxiety and protect the ego from becoming overwhelmed. Kernberg (1996) advocates classifying various personality types in terms of three levels of structural organisation; psychotic, borderline and neurotic.

Although many psychodynamic ideas have lost credibility over time, the defense mechanisms continue to inform contemporary theories of personality disorders with some believing that each personality disorder prefers a particular subset of defenses over the others (Millon & Davis, 2000).

The Interpersonal Perspective

The perspectives discussed so far attempt to understand personality mostly in isolation from the environment. In contrast the Interpersonal Perspective argues that personality is best conceptualised as the social product of interactions with significant others (Lezenweger & Clarkin, 2005). Sullivan's (1953) contribution lay in realising that some forms of mental illness are created and perpetuated through maladaptive patterns of social interaction and communication. According to Sullivan (1953) personality is *"the recurrent set of interpersonal situations which characterise a person's life"* (pp.110). However the discovery that the origins of pathology might be interactional rather than individual was only a beginning and did not explain how disordered communication develops. Interpersonalists argue that others are essential to the formation of our self identity and that the communications we experience as most validating confirm our ideal self. Confusing communications leave us uncertain as they are either inconsistent with our concept of who we really are or else portray the self in an undesirable way, threatening self esteem and arousing anxiety and insecurity. The Interpersonal Theory provides a contrast to the Psychodynamic Theory, where Freud maintains that anxiety is a signal to the ego that instinctual drives

are on the edge of breaking into conscious awareness, anxiety within the Interpersonal Theory cannot exist unless others are at least symbolically involved in thought (Millon & Davis, 2000). The interested reader is directed to Kiesler (1996) for a more detailed review of this theory.

The Cognitive Perspective

The Cognitive approach proposes that an individuals behaviour can be explained by examining the contents of internal mental structures called schemata which mediate cognitive processing at every level, interpreting situations and events, and attaching meaning to them whilst subsequently governing the individual's emotional and behavioural responses (Beck, Freeman and Davis, 2004). Pretzer and Beck (1996) suggest that family environment, significant life events and social learning processes play a major role in the development of maladaptive schemas and thus in the development of personality disorder. While core beliefs are useful in decreasing cognitive load they also inhibit the development of other approaches and an appreciation for other perspectives.

Beck, Freeman and Davis (2004) hypothesised that each personality disorder can be characterised by a specific set of beliefs and behavioural responses. For example, the avoidant personality type will display withdrawn behaviour linked to the belief that they are unlovable and the belief that other people will reject the real them. Numerous research studies have supported the proposition that particular dysfunctional beliefs are associated with each personality disorder,

leading to the inclusion of specific cognitive components within the treatment of personality disorder (Arntz, Dreessen, Schouten & Weertman, 2004; Beck et al., 2001). The Cognitive approach along with Biosocial theories have formed the basis for recent treatments of personality disorder, in particular Dialectical Behaviour Therapy (DBT) as proposed by Linehan (1993; 1993b), developed specifically for the treatment of Borderline Personality Disordered clients.

The Schema-focused Approach

This model expands on conventional Cognitive Behaviour Therapy by placing more emphasis on the therapeutic relationship, affective experience, and the discussion of early life experiences. Young (1999) proposes an expansion of the short-term cognitive model proposed by Beck and Freeman (1990) to include five theoretical constructs; Early maladaptive schemas, Schema domains, Schema maintenance, Schema avoidance and Schema compensation. Early maladaptive schemas are self perpetuating unconditional beliefs and feelings about oneself in relation to the environment and Young (1999) identifies eighteen early maladaptive schema which sit within one of five schema domains. Finally, Young (1999) proposes three schema processes: maintenance, avoidance, and compensation and maintains that these processes explain how schemas function within the individual, as well as how they are maintained, avoided and overcompensated. In relation to personality disorder among the homeless Young's inclusion of avoidance and overcompensation provide a basis for understanding why clients may adopt behavioural styles that are dysfunctional.

Young (1999) maintains that each schema is associated with certain dysfunctional behaviour patterns that tend to characterise the persons approach to partners and significant others, these are employed to cope with the high emotional intensity and unpleasantness that is experienced when a schema is activated. For example, a person who holds the schema that they have insufficient self-control or self-discipline might surrender to the schema through behaviours that are excessive in drinking, gambling, drug or alcohol use, and may lose control of their emotions easily. To avoid the schema this person may rarely set any long-term goals but to overcompensate he/she will tend to make short-lived intense efforts to complete projects or to exercise self-control. Within the Schema Therapy treatment of personality disorder, Young (2003) proposes that the behavioural pattern breaking stage is the most crucial part of therapy and advocates that without it, relapse is likely. Young's approach (1999; 2003) is the most coherent for aiding our understanding of the destructive behaviours that are frequent among the homeless population and how these behaviours relate to personality disorder among this population.

4.3 The concept of personality disorder within the homeless population

As discussed, research with the homeless has consistently found trauma/negative childhood experiences, psychological pathology, drug and alcohol use and interpersonal conflict within the family to be highly salient precipitating factors in the pathway to homelessness across homeless populations. The Cognitive approach to the development of personality disorders

emphasises the powerful influence of such early life experiences and suggests these play a major role in the development of maladaptive schemas and thus in the development of personality disorder (Pretzer & Beck, 1996).

Numerous studies have consistently linked the experience of abuse in childhood to borderline personality disorder (Links, Steiner, Offord & Eppel, 1988; Herman, Perry & Van der Kolk, 1989; Lobel, 1992; Weaver & Clum, 1993; Laporte & Guttman, 1996). Taking into account the high rates of childhood abuse among the homeless it is not unreasonable to suggest that many homeless individuals are vulnerable to developing personality disorders and that the existence of personality disorders may be masked by the more noticeable coping behaviours that many homeless people exhibit (e.g. drug/alcohol use). This theory is supported by research that finds homeless people are more likely to receive diagnoses of substance dependence problems than a diagnosis of personality disorder (Salize et al's., 2001).

According to Dialectical Behaviour Therapy (DBT) literature, in the process of adapting to extreme circumstances, survivors of trauma may develop methods of coping that are effective in the short run but harmful over a long period of time (Linehan, 1993; 1993b. DBT directs attention to the interrelatedness of behaviour patterns and of skills deficits. It acknowledges that learning psychosocial skills is particularly hard when a person's immediate environment or larger culture do not support such learning. Some of the skills taught in DBT

(emotion regulation, interpersonal effectiveness and distress tolerance skills) could arguably be appropriate for many homeless individuals in light of the similar challenging behaviours for which the therapy was devised, such as suicide threats, self damaging and impulsive behaviours and drug and alcohol misuse. The idea that homeless services could develop to include more skills based training in order to address the coping deficits of this population is supported by research that finds high rates of personality disorder among the homeless.

4.4 Prevalence rates of Personality disorder within the homeless population

Prevalence rates of personality disorder within the homeless vary widely, with estimates ranging from 6% - 50% (Fischer & Breakey, 1991; Pollio, North, Thompson, Paquin & Spitznagel, 1997; Scott, 1993) for reasons which will be discussed later. Stein and Gelberg (1995) argue that homeless persons who are severely mentally ill are at a significantly higher risk of prolonged or chronic homelessness and worryingly, these highly vulnerable individuals are thought to be among the least likely to be utilising available services (Pollio et al. 1997, Ball, Cobb-Richardson, Connolly, Bujosa & O'Neall, 2005). This is not surprising in light of Salize et al's., (2001) findings that 91.7% of personality disorder-related problems went untreated or unrecognised within the homeless services.

Overall, prevalence rates of personality disorders in the homeless are significantly higher than those found in the general population, which is estimated at 11% (Ekselius, Tillfors Furmark & Fredrikson, 2001). In comparison a recent study conducted in Edinburgh found 40% of participants met the criteria for a diagnosis of borderline personality disorder, 28% for paranoid personality disorder, 12% for antisocial personality disorder, another 12% for impulsive personality disorder, 4% for schizoid personality disorder and a further 4% met criteria for avoidant personality disorders (Campbell, 2006). An earlier study by Rouff (2000) found differing results using the Structured Clinical Interview for DSM-III-R Axis II Disorders (SCID-II, First, Spitzer, Gibbon & Wiliams, 1995) among homeless individuals in Chicago. The author estimated that 14% had schizoid personality disorder, 38% paranoid personality disorder, 19% antisocial personality disorder, 18.2% schizotypal personality disorder and 12.4% borderline personality disorder. Despite the different prevalence rates, the aforementioned studies demonstrate that cluster A and cluster B type personality disorders are most prevalent within the homeless population.

Rouff (2000) began to untangle how personality disorder relates to homelessness and found that schizoid personality traits were positively correlated with chronicity of homelessness. According to cognitive approaches, for schizoid persons early neglect or mistreatment by others creates intense unmet needs for love and social contact and correspondingly, frustration and rage. The schizoid person unconsciously fears that the expression of this rage

and longing will get out of control thus he or she avoids contact with others altogether. Although just one approach to explaining schizoid personality disorder, it adequately explains how trauma and early experiences are salient in the pathway to becoming homeless and some of the resulting psychological processes that contribute to the process of remaining homeless. Undoubtedly, there are other factors that contribute to the process of remaining homeless and as previously identified drug and alcohol use is a salient one.

4.5 Co-morbidity of substance abuse and personality disorder.

Studies with populations that are substance dependant can also help to inform an understanding of the relationships between trauma, personality disorder and coping behaviours like alcohol and drug misuse. Numerous studies have found a high prevalence of personality disorder among individuals with substance abuse disorders and prevalence rates vary from 37% to 60% (Barber, et al., 1996; Bowden-Jones, et al., 2004; Gonzalez & Rosenheck, 2002). Using the Structured Clinical Interview for DSM (SCID II - First, Spitzer, Gibbons & Williams, 1995), researchers found 60% of substance dependent inpatients met criteria for a personality disorder (Brady, Dustan, Grice, Danksy and Kilpatrick, 1995). Similarly Morgenstern, Langenbucher, Labouvie & Miller (1997) found that antisocial, borderline and paranoid personality disorder were linked to more severe symptomatology of alcoholism, supporting other research by Barber et al., (1996) and Nace, 1990).

The limited attention to personality disorders in homeless studies is unhelpful when considering the fact that the full range of Axis II disorders (not just antisocial) is highly co morbid with Axis I disorders commonly seen in this population. Meanwhile, the advancement of research that explores personality disorder among the homeless continues to be impeded by methodological issues.

4.6 Why is Personality Disorder rarely measured among the homeless populations?

Firstly, the difficulties in measuring personality disorder stem from problems with the concept of personality disorder in itself, as it is constantly evolving, with definitions and criteria being expanded and refined while new disorders are identified and added and others removed. Researchers have suggested that the diagnostic criteria of DSM-III-R personality disorders are problematic, citing problems with overlapping criteria and the use of self-report in diagnosing personality disorders (Westen, 1997). Studies also show high co-morbidity with numerous Axis I disorders (Ekeselius, Tillfors, Furmark & Fredrickson, 2001; Pretzer & Beck, 1996). This focus on Axis I disorders has inadvertently led researchers to largely ignore the existence of Axis II personality disorders among the homeless, instead most studies have tended to focus on antisocial personality disorder specifically (North, Pollio, Thompson, Ricci, Smith & Spitznagel, 1997; North, Smith & Spitznagel, 1997; Smith, North & Spitznagel, 1992). Prevalence rates have been varied in studies so far due to the use of

differing measures, such as self report questionnaires like the Millon Clinical Multiaxial Inventory (MCMI; Millon, Millon & Davis, 1994) and Personality Diagnostic Questionnaire – Revised (PDQ-R; Hyler, Skodol, Oldham, Kellman & Doidge, 1992) and structured or semi-structured clinical interview assessments, such as the Structured Clinical Interview for DSM (SCID II; First, Spitzer, Gibbon & Williams, 1995). The MCMI-III has also been associated with over-estimation of the prevalence of personality disorders (Zimmerman, 1994). Another factor which impacts on the measurement of personality disorder is the fact that homeless individuals are notoriously difficult to retain in therapy, meaning that some of these methods of assessment would deter potential participants. The transitional nature of the homeless persons' life also results in high attrition rates among studies. Also, researchers may have avoided measuring for personality disorder in the past due to a well-intentioned desire to avoid further blaming or stigmatising of these severely vulnerable people. Whilst it is not the intention to ignore, underestimate, or oversimplify major socioeconomic factors or suggest that an individual's personality is the cause of homelessness, research, community and clinical initiatives cannot continue to overlook these significant personality problems and the implications they have for coping.

5. COPING

5.1 Theories of coping

Lazarus and Folkman (1984) defined coping behaviours as the cognitive and behavioural efforts used to manage internal or external demands that are seen as challenging or exceeding one's personal resources. Coping behaviours refer to the way in which an individual attempts to reduce or eliminate both the source of stress and the associated emotional impact. Folkman and Moskowitz (2004) suggest that the degree of stress vulnerability or resiliency can be understood by examining overall coping styles, which have been categorised as either adaptive, problem focused responses directed toward managing problems or emotion-focused and avoidant responses, used to diminish the emotional distress triggered by the stressor. Adaptive approach coping strategies include planned problem solving, cognitive restructuring and seeking social support. Alternatively, avoidant strategies include wishful thinking, denial, avoidance of negative emotions and social withdrawal (Compas, Connor, & Osowiecki, 1997). The literature on coping behaviours indicates that avoidance coping is associated with higher levels of psychological distress and psychopathology (Beutler, Moos, & Lane, 2003; Compas et al. 1997). In conclusion both coping styles can be useful in certain stressful situations in the short-term, but recurring avoidance coping behaviour is generally maladaptive and interferes with appropriate action and emotional processing.

5.2 Coping and personality disorder

Difficulty coping with stressful situations as well as having inflexible and maladaptive coping repertoires are considered to be among the core features of personality disorder (Millon & Davis, 2000; Linehan, 1993). Studies have found strong correlations between personality disorder and less adaptive, avoidant coping strategies (Vollrath, Alnaes & Torgersen, 1994). Watson and Sinha (1999) found that certain types of personality disorders were related to particular styles of coping, for example, cluster B personality disorders (dramatic) were strongly correlated to escape-avoidance and confrontive coping whereas cluster C disorders (anxious) were associated with escape-avoidance, accepting responsibility and a negative relationship to problem solving. This provides support for earlier findings that the 'dramatic' clusters tend to use acting out, splitting, devaluation and dissociation while 'anxious' clusters are characterised by the use of passive aggression and hypochondriasis as defenses (Millon & Davis, 2000).

Studies have shown that personality disordered pathology has a significant relationship with higher levels of depression, anxiety, avoidance coping and substance use (Kruedelbach, McCormick, Schulz & Grueneich, 1993; Quirk & McCormick, 1998). However, the limited amount of research and methodological limitations of these studies (e.g. use of student samples) make it difficult to generalise these findings without further research, particularly as the studies so far (with the exception of Watson & Sinha, 1999) have examined only the

relationship between coping (or defense style) and personality disorder, and have not taken into account the influence of high emotional reactivity, something that is characteristic of the personality disordered.

5.3 Coping among the homeless population

Being homeless is in itself considered to be an enormously stressful and traumatic experience (Goodman, Saxe & Harvey, 1991; Rayburn et al., 2005) placing already vulnerable individuals at an increased risk of further psychiatric problems, traumatisation and repeated tenancy breakdown (Milburn & D'Ercole, 1991). Very few studies have directly investigated the role of coping behaviour within the homeless population and the associated impact on general psychological adjustment. Rayburn et al., (2005) found that childhood sexual and physical abuse, living in a shelter, physical violence, and death of a relative or friend predicted avoidant coping in a sample of sheltered homeless and low income housed women. Whereas active coping and depression predicted mental health service seeking among traumatised women.

Votta and Manion (2003; 2004) found that homeless youths report a higher prevalence than non homeless youths of substance use and criminal involvement; a greater use of avoidance coping behaviours; more negative life events; and increased levels of depressive symptomatology. The authors conclude that coping style and negative self worth contribute to the chronicity of

mental health problems, exacerbate risk factors and act as barriers to service utilisation.

The role of coping behaviour in the psychological well being of the homeless warrants further research, particularly in light of existing research that links it to probability of service utilisation. The models proposed so far have failed to take into account the role of coping behaviours in maintaining homeless and have largely ignored substance use as a coping behaviour. Furthermore the exploration of the relationship between trauma, personality disorder and substance use as a coping behaviour could reveal important psychological processes that impact on remaining homeless.

6. THE RELATIONSHIP BETWEEN TRAUMA, PERSONALITY DISORDER AND SUBSTANCE ABUSE IN MAININTAINING HOMELESSNESS.

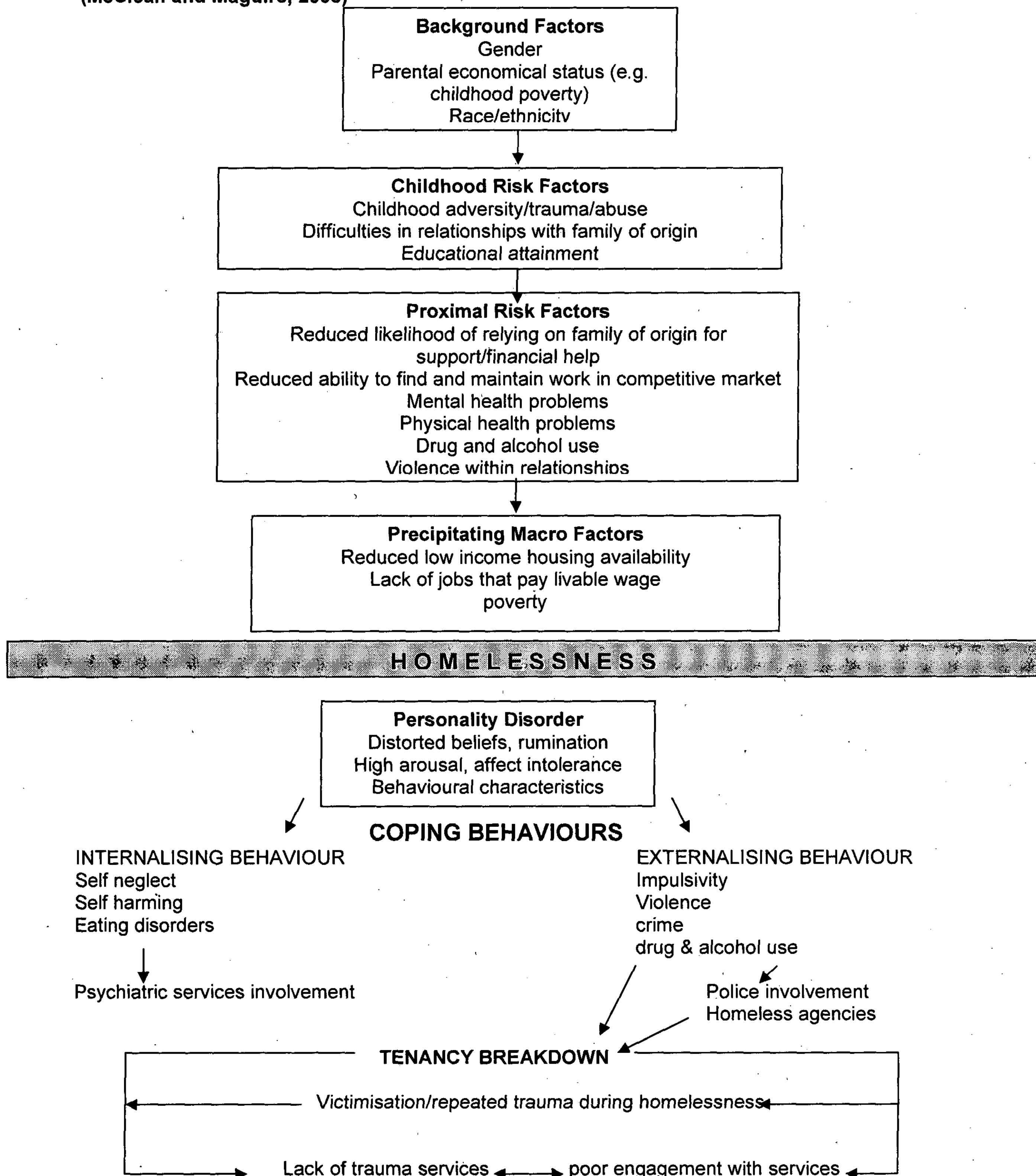
Substance abuse is a major contributor to chronicity of homelessness (Morris, 1997). Furthermore, there is support for the argument that childhood abuse relates to remaining homeless through findings that the chronically homeless report childhood abuse of longer duration and greater severity compared to the first time homeless (Morrell-Bellai, Goering & Boydell, 2000). Finally, substantiation for the argument that personality disorder may account for a significant percentage of the chronically homeless comes from findings that

homeless persons who are severely mentally ill are at a significantly higher risk of prolonged or chronic homelessness (Stein & Gelberg, 1995).

6.1 Model incorporating known risk factors, personality disorder and coping behaviours in maintaining homelessness.

Given what we know about the behaviours or coping strategies that are commonly reported in the personality disordered it is not surprising that these individuals may be among some of the chronically homeless. Antisocial behaviours such as aggression, drug and alcohol use, impulsivity and criminal acts coupled with a tendency to repeat these unhelpful behaviours time and again make it very difficult for individuals to retain tenancies and to interact appropriately with professionals and support agencies that aim to stabilise the individual. Instead the individual lurches from crisis to crisis drawing on the limited repertoire of coping skills he/she has for regulating their emotions and sense of self. The following model (figure 3) attempts to bring together the risk factors that have been found to be salient in homelessness and the role of personality disorder and coping behaviours in causing and maintaining homelessness.

Figure 3 – Model incorporating risk factors, personality disorder and coping behaviours (McClean and Maguire, 2008)



The finding that substance abusing individuals with a history of assault were significantly more likely to have a personality disorder (Brady, Dustan, Brice, Dansky & Kilpatrick, 1995) led the authors to suggest that the development of a personality disorder may be one mechanism of coping with an assault. This lends support to the above model, as does the recognition that as well as being an effective coping strategy for avoidance of painful or difficult situations and memories, substance abuse is also suspected as an effective method for self-medicating against mental illness (Khantzian, 1985, Warner et al., 1994).

Among the literature there appears to be a pattern emerging which identifies cluster A and B type personality disorders as those that have high associations with childhood abuse and those that are highly correlated with substance abuse. The nature of the relationship between substance use disorders and these personality disorders is complex but we can draw on literature from the field of personality disorders in understanding that certain personality traits that are characteristic of these disorders, such as sensation seeking, impulsivity and affect-intolerance predispose and increase the vulnerability for repeated substance use and put the homeless individual at an increased risk of tenancy breakdown. Clinically the persistent and pervasive deficits in social, emotional, cognitive, perceptual, motivational, identity and impulse control functioning that define personality disorder would seem to provide a common description of the impairment observed across heterogeneous homeless populations. These deficits combined with affective and behavioural dysregulation would

understandably impede the effective use of available services and the ability to maintain stable housing and employment (Koegel, Melamid & Burnam, 1995). Some of the paranoid, hostile and bizarre symptoms of the homeless may be adaptive coping behaviours or at least understandable given the extreme challenges of living on the streets or in a hostel.

7. CONCLUSIONS AND FUTURE DIRECTIONS

As discussed the pathways into becoming and remaining homeless are diverse and involve a number of psychological factors that interact together with social and economical factors to increase vulnerability to homelessness and the likelihood of remaining homeless. A large percentage of homeless individuals experience significant mental health and substance use disorders and personality disorder and dual diagnosis represent a significant proportion of these difficulties. Increased investigation into personality disorder within this population is necessary to further our knowledge, particularly in light of findings that this highly vulnerable co-morbid group are at risk of repeated tenancy breakdown, chronic homelessness and further trauma, whilst being among the least likely to be utilising services. Further research would enable a more coherent understanding of the types of behaviours that characterise personality disordered homeless persons and will help to identify their particular support needs. Further studies examining the associations between personality disorder,

substance dependence and coping behaviours in the homeless are essential in aiding our understanding of tenancy breakdowns and for informing and directing services. Studies that have examined these relationships have used qualitative methods with longitudinal designs as they enable a detailed investigation into the exact nature of relationships between risk factors.

Homelessness itself is a traumatic experience and research shows that the inability to cope with stress effectively contributes to the chronicity of homelessness, through tenancy breakdowns, as well as increasing mental health problems and decreasing likelihood of seeking and utilising services. However, research continues to be limited in the area of coping among the personality disordered homeless population. Substance use has been found to be a coping strategy that is used to avoid or regulate negative affect among the personality disordered. It is important for researchers to identify other types of coping behaviours that homeless personality disordered individuals may be utilising that make them hard to engage with, thus elevating the risk of prolonged homeless. Further research into the role of impulsivity, affect intolerance and sensation seeking would also be helpful in determining influence on continued substance use.

Despite recent advances in both homeless and mental health service policies, the recognition, provision and utilisation of specialised mental health services is low within the homeless population. Consequently, further research is needed to

identify what types of services have good outcomes and at what stage in the homeless process particular services are needed. For example there is an obvious need for services that recognise the high levels of trauma experiences among the homeless although the optimal time for offering these services would need to be considered. Similarly, the need for early intervention has been highlighted in preventing the first-time homeless from becoming chronically homeless and the need for hostels to move toward something other than a basic needs provision to a service that encourages and motivates individuals to change their situation.

In conclusion the homeless are an exceptionally vulnerable group. Literature seems to suggest that particular personality traits and coping behaviours can act as mediating factors in the initial and prolonged use of substances. Therefore the knowledge of pathways and interaction of risk factors is essential in order to define the needs of the homeless more precisely and to develop integrated preventative services as well as improving the existing reactionary services that attempt to address their complex needs.

Search terms used for literature review via OVID: Homelessness; Personality Disorder; Coping Behaviours; Substance Dependence; Internalising; Externalising.

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EMPIRICAL PAPER

THE RELATIONSHIP BETWEEN PERSONALITY DISORDER, COPING BEHAVIOURS AND ACCESS TO MENTAL HEALTH SERVICES AMONG THE HOMELESS.

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(SEE APPENDIX B FOR NOTES TO AUTHORS)

ABSTRACT

This study investigated the relationships between personality disorder, internalising and externalising coping behaviours and access to mental health services within a homeless population, in an attempt to examine whether those who access services present differently in terms of their behaviours, to those that do not. The final sample consisted of 41 participants who had been recruited from Southampton-based homeless hostels and day centres. Personality disorder was assessed using the Millon Clinical Multiaxial Inventory-III. Internalising and externalising coping behaviours were assessed using the Achenbach System of Empirically Based Assessment (ASEBA) Adult Self-report Form and access to mental health services was assessed using a devised measure. Overall, the results showed that internalising behaviours were significantly higher among those who met the criteria for personality disorder than those without. Externalising behaviours were not significantly higher. There was also no significant difference in the externalising behaviours of those who accessed services and those who did not. Internalising behaviours were significantly higher among those who accessed services than those who did not and were also significantly higher in those who accessed secondary mental health services, in comparison to those who accessed primary services. These findings highlight a vulnerable group, the majority of whom appear to be accessing some level of mental health service. The study is not without methodological limitations and future research will need to continue to explore

factors involved in homeless psychopathology to order to adequately meet the complex needs of this population.

1. INTRODUCTION

Studies have shown that a large proportion of the homeless population experience significantly high levels of mental health problems, with personality disorders and dual diagnosis representing a significant percentage (Fischer & Breakey, 1991; Scott, 1993; Rouff, 2000; Campbell, 2006). Research has also demonstrated this population are among the least likely to be utilising available mental health services (Pollio, North, Thompson, Paquin & Spitznagel, 1997; Ball, Cobb-Richardson, Connolly, Bujosa & O'Neall, 2005), a worrying fact in light of evidence that severe mental health problems have been found to one of the leading risk factors for both initial and prolonged homelessness (Stein & Gelberg, 1995, Craig & Hodson, 2000).

Inflexible coping styles and maladaptive coping behaviours are thought to be core features of personality disorder (Millon, 1981). Research investigating the relationship between coping styles and psychological disturbance has found the use of disengaging coping styles, and internalising and externalising behaviour problems to be significantly higher among homeless youths than non homeless (Votta & Manion, 2003). Among the general population research demonstrates that coping styles are associated with health service seeking (Lawson, Lyne, Bundy & Harvey, 2007; Goodman, 2004), however very little research has been conducted to examine the relationship between coping behaviours and propensity to access mental health services among the homeless population

(Rayburn, Wenzel, Elliott, Hambarsoomians, Marshall & Tucker 2005). This paper will focus on the relationships between personality disorder, coping behaviours and access to mental health services as these variables have been highlighted through existing research as highly important in the likelihood of remaining homeless.

When personality traits become inflexible, maladaptive and cause significant distress and/or functional impairment, a disorder of personality is considered to exist (American Psychiatric Association, APA, 1994). A personality disorder is defined by the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994, p.629) as *'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment'* (See Appendix C for brief description of the 12 DSM-IV personality disorders).

Due to methodological differences between studies, prevalence rates of personality disorder within the homeless vary widely, with estimates ranging from 6% - 70% (Bassuk, Rubin & Lauriat, 1984; Fischer & Breakey, 1991; Pollio, North, Thompson, Paquin & Spitznagel, 1997; Scott, 1993). However, a recent study using the MCMI-II found that 59% of a homeless population sampled had characteristics that placed them in the clinical range for a diagnosis of personality disorder (Mathews, 2006). Some of the more common personality disorders

found are those which interfere with a person's capacity to establish helpful and supportive relationships, such as the schizoid, antisocial and avoidant types (Breakey et al., 1989). Furthermore, personality disordered characteristics, such as increased impulsivity, mood disturbance, substance dependence, poor coping skills and antisocial behaviour have been identified as major contributors to repeated tenancy breakdowns and therefore prolonged homelessness (Stein & Gelberg, 1995; Phelan & Link, 1999; Campbell, 2006). Sadly, these highly vulnerable individuals are thought to be among the least likely to be utilising available services (Pollio et al. 1997, Ball et al. 2005).

In the UK, the mental health needs of homeless people are not specifically mentioned within the Mental Health National Service Framework. Historically homeless people have found it difficult to access mental health services through primary care because of not being registered with a GP. However, multi-disciplinary mental health teams have been set up in response to the Department of Health's Homeless Mentally Ill Initiative (DOH, 1996). These teams aim to work with homeless people who are currently out of touch with mainstream services and provide a direct service to homeless people at a variety of locations. Nonetheless, the overall provision of mental health care for homeless populations is limited and there is a reliance on mainstream psychiatric services which are often inaccessible, inappropriate and are unable to take into consideration the complex needs of this population (Griffiths, 2002). Furthermore, homeless people can find it hard to engage with services because

of previous bad experiences, the transient nature of their lives and unhelpful coping behaviours, such as substance abuse.

High rates of personality disorder have been found among individuals with substance use disorders, with this dually diagnosed group being particularly difficult and costly to treat (Gonzalez & Rosenheck, 2002; Nace & Davis, 1993). The association between substance abuse and homelessness has also been well documented over the years (Fischer & Breakey, 1991; North, Eyrich, Pollio, & Spitznagel, 2004). When considering the relationship between personality disorder, homelessness and substance abuse it is useful to bear in mind that personality disorder is not a matter of bad character, but rather a serious psychiatric condition defined by maladaptation to social environments and failures in social role function. This description would seem to capture a broader group of homeless individuals than does any other psychiatric disorder. With the possible exception of severe borderline personality disorder, definitions of dual diagnosis exclude the personality disorders (Drake, Osher & Wallach, 1991), although the prevalence of personality disorders far exceeds the prevalence of other 'serious and persistent mental illness' among substance abusers. Although homeless persons with schizophrenia and substance abuse clearly deserve attention as a highly vulnerable group, equally and perhaps more in need (given higher prevalence) of services (given limited access and use) are clients with personality disorders. The need for greater services, however, is complicated by

the fact that these dually diagnosed individuals often do not acknowledge their disorder or need for help.

Worryingly, an estimated 91.7% of personality disorder-related problems have been found to be untreated or unrecognised within homeless services (Salize et al, 2001) and it is estimated that 38% of homeless persons with a serious mental illness have never received any treatment (Koegel, Burnam & Farr, 1988). When they do access services, the maladaptive coping behaviours of some homeless individuals are often associated with poor attendance, failure to follow through on referrals, noncompliance with medications and suicidal behaviours (Ball et al. 2005). Furthermore their interpersonal behaviours often antagonise and reduce the effectiveness of the medical, mental health, vocational and case management staff trying to help.

Given the existing literature on personality disorder and substance use and the high prevalence of substance use among the homeless, it is fair to assume that substance abuse may be a coping behaviour that is employed by many homeless people as a way of avoiding or disengaging from their current situation. Literature on personality disorders, particularly from the Cognitive field, suggests that substance use is just one of many maladaptive coping behaviours from a limited repertoire that the personality disordered use to cope with intolerable feelings about themselves and others (Linehan, 1993; 1993b; Young, 1999; Young, Klosko & Weishaar, 2003).

'*Coping*' is defined as a person's pattern of responses to stressful situations (Lazarus and Folkman, 1984). Successful coping requires approaches that seek to avoid the problem (avoidant coping) as well as those that actively deal with it, that is, active coping (Roth & Cohen, 1986). Avoidant coping has short-term benefits of reducing stress and anxiety but is counter productive in the long term because it prevents assimilation and resolution of the trauma. Conversely, although active coping increases distress in the short-term it allows for appropriate action and eventual resolution of the trauma.

Inflexible and dysfunctional coping strategies are considered to be among the core features of personality disorders. According to Millon (1981, p.9) *"an adaptive inflexibility, a tendency to foster vicious or self-defeating circles, and a tenuous emotional stability under conditions of stress"* are three features crucial in differentiating pathology and normality of behaviour. Furthermore, these behaviours tend to perpetuate and intensify pre-existing difficulties. Vollrath, Alnaes and Torgersen (1994) maintain that personality disordered individuals tend to lack the ability to approach a stress situation in an active, rational way, and to use interpersonal relations for advice and emotional support. Instead there is a tendency for behavioural passivity and mental detachment from one's own goals. There also exists an inappropriate way of dealing with feelings, by dwelling on them and discharging them in an uncontrolled way and alcohol and drugs are used as further means to reduce emotional distress. The theory that substance use is employed to escape or regulate negative affect has been

postulated many times (Courbasson, Endler & Kocovski, 2002) and numerous studies have shown that emotion-focused, avoidant coping responses are highly prevalent among those who abuse drugs and/or alcohol (Moos, Brennan, Fondacario & Moos, 1990; Nyamathi, Stein & Swanson, 2000). In comparison with anxiety or depression, where a surplus of cognitive avoidance coping has been observed (Billings & Moos, 1984; Kobasa, 1982) the coping deficits in personality disorders seem to be more extensive, adding behavioural and interpersonal coping deficits to the cognitive detachment.

Preliminary evidence suggests that coping is related to mental health outcomes in homeless individuals. Studies have found that homeless youths with a disengaging coping style are at a greater risk for depression, substance use and high internalising and externalising behaviours (Compas, Orosan & Grant, 1993; Votta & Manion, 2004). Banyard & Graham-Bermann (1998) found similar results with homeless mothers, as avoidant coping strategies related to depression. Littrell and Beck (2001) demonstrated that reliance on active, problem-focused coping strategies was associated with lower levels of depression among African American homeless or insecurely sheltered men. However research into coping styles and association with psychopathology among the homeless remains scarce. There is however more information on the relationship between coping and propensity to access mental health services.

Greater reliance on approach/active coping (e.g. tendency to seek information, guidance and support) is associated with entry into professional treatment among general populations (Beutler, Moos & Lane, 2003) and similar findings have been demonstrated among individuals with alcohol use disorders (Timko, Moos, Finney and Lessar, 2000). Avoidance coping has also been associated with treatment entry (Avants, Warburton & Margolin, 2000) however, this finding seems to be due to the association between avoidance coping, depression, and other aspects of dysfunction, which impel individuals to seek treatment.

A recent study, conducted with homeless women, is the only research to date that investigates how coping, along with depression, influences mental health service seeking among the homeless (Rayburn, Wenzel, Elliott, Hambarsoomians, Marshall & Tucker, 2005). Results showed that active coping was a predictor of mental health service seeking and that coping was significantly more important than the enabling variables examined (e.g. inability to access medical care, assistance from a social worker). The authors concluded by stating that enhancing active coping for all homeless women from one standard deviation below average to one standard deviation above average could potentially increase total mental health service utilisation by one quarter. This is supported by research from Ball et al., (2005) who propose that personality disordered homeless individuals need help to improve adaptive functioning. Research into coping and access to mental health services among other homeless populations remains extremely limited and is non existent for the

subgroup of the personality disordered homeless. This lack of research may be due to the difficulty in conceptualising and defining coping styles, as models vary from avoidance - active, engaging – disengaging and emotion-focused - problem-focused. Furthermore, for research among homeless populations it may be more useful to focus on the types of behaviours that homeless individuals employ (e.g. internalising and externalising) as behaviours seen among the homeless that would normally be viewed as maladaptive or avoidant among the general population could be viewed as necessary survival strategies within the context of homelessness.

There is a mass of research that examines the maladaptive coping behaviour of substance abuse within the homeless population, however, there continues to be a lack of research with this group that examines the impact of other behaviours on access to mental health services. Internalising and externalising behaviours have been examined in terms of gender and cultural differences, for example Kramer, Krueger & Hicks (2008) note that women exhibit higher levels of internalising behaviours and lower levels of externalising behaviours than men, findings which have resonances in studies with children and their parents (Cowan, Cohn, Cowan & Pearson, 1996). They also maintain that these gender differences indicate risk factors for common mental disorders and indicate future research would benefit from focusing on both the latent factor and individual syndrome levels in explaining gender differences in psychopathology.

A great deal of the literature on internalising and externalising behaviours relates to children and adolescents but some of the findings are interesting alongside knowledge of the histories of the homeless. For example, researchers have found that fathers' attachment histories predict more variance in teachers' descriptions of children's externalising behaviours, whereas mothers' attachment histories predicted more variance in internalising behaviours (Cowan, Cohn, Cowan, Pearson, 1996). Niemela et al., (2006) found that adolescent boys who report frequent drunkenness have significantly more psychopathological deviance, especially externalising syndromes and suicidality. Interestingly, refraining from drunkenness was found to associate with a variety of psychological problems, including internalising syndromes leading the authors to conclude that abstaining from drunkenness during late adolescence indicates greater internalising symptoms, such as isolation, anxiety, depression, somatic symptoms and less adaptive social functioning.

Hilker (2003) evaluated the relationship between exposure to violence and internalising symptoms with two outcome variables, somatic complaints and health care utilisation, in a sample of children attending a paediatric primary care clinic. However, Hilker (2003) found no differences in rates of violence exposure, somatic complaints, or internalising symptoms between high and low utilisers of health care. Lastly, in relation to internalising and externalising behaviours in those with personality disorder, Paris (2005) suggested that high internalising and externalising behaviours are present as childhood precursors for adults who

later go on to receive a diagnosis of borderline personality disorder. The exploration of internalising and externalising behaviours has been conducted among homeless youths (Votta & Manion, 2003; 2004) with authors stating that the high levels of externalising behaviour problems reported are concerning, given similarities in the levels of substance abuse and criminal involvement reported by the study's sample and other studies of homeless youths. Undoubtedly the presence or absence of these types of behaviours will impact on the individuals' ability to gain access to and appropriately utilise offered mental health services.

In the UK the majority of mental health care for the general population is carried out via primary care teams, namely GPs. The GP also remains the first point of contact for homeless individuals experiencing mental health difficulties, through regular clinics that are held in hostels and day centres. Generally, it is the GP along with staff from voluntary agencies who decide whether an individual needs more intensive intervention before a referral is made to secondary care services (e.g. psychologist, counselor, community mental health nurse or psychiatrist) (www.Homelesspages.org.uk). There are however a percentage of homeless persons that will already be accessing some level of mental health service prior to becoming homeless, whether this be due to prior engagement with services, engagement whilst in prison or prior to homelessness, a period of care in an inpatient facility. There is recognition in the literature that excessive splitting and chaotic behaviours are particularly difficult for professionals who have contact

with these individuals (Campbell, 2006). Specific externalising behaviours, such as self harming, physical neglect, repeated drug and alcohol use prove difficult for hostel staff to tolerate (Campbell, 2006). What is not known is which types of behaviours cause enough concern in GPs to instigate referrals to these secondary services, although we can hypothesise that it is the same types of externalising behaviours that cause concern to hostel staff and result in tenancy breakdowns.

Research demonstrates that maladaptive behaviours, such as persistent substance use, impact negatively on tenancy outcomes for both youth homeless (Craig and Hodson, 2000) and older populations (Pollio, North, Thompson, Paquin & Spitznagel, 1997; North, Pollio, Smith & Spitznagel, 1998). Psychoanalytically orientated research by Campbell (2006) discusses the impact of such behaviours on tenancies and notes that the large numbers of professionals and others involved with difficult to manage cases bears testament to the fragmentation and splitting processes so evident in the object relations of people with personality disorder. The majority of those homeless individuals referred in her study had substantial contact with the police and criminal justice system in adulthood. There have only been three studies that have directly investigated the coping responses of homeless individuals (Nyamathi, Keenan & Bayley, 1998; Votta & Manion, 2003; 2004; Rayburn et al., 2005). All studies concluded that maladaptive coping contributed to chronicity of mental health problems, exacerbated risk factors and acted as barriers to service utilisation.

What is still not known is whether it is these externalising behaviours (e.g. aggressive behaviours, drug and alcohol use, impulsivity and anti social behaviours) that prompt referrals to services or whether it is the internalising behaviours, such as somatic symptoms, anxiety, depression, withdrawal and suicidal thoughts that prompt homeless healthcare GPs to refer on. Therefore the role of specific behaviours in determining access to care and the relationship between these behaviours and personality disorder among the homeless clearly warrants further investigation.

1.1 PRESENT STUDY

The relationship and interaction between personality disorder and coping behaviours among the homeless population are areas of much needed investigation. The knowledge and recognition of specific behaviours of particular subgroups within the homeless is necessary in order to identify which individuals gain access to services and which do not. This will enable development of more appropriate, integrated services that can address the complex needs of the personality disordered homeless (Breakey & Fischer, 1990). The primary aim of this study was to empirically investigate the internalising and externalising behaviours of a homeless population and the associated relationship with access to services and personality disorder. It was hoped that this research would contribute to a more comprehensive understanding of how coping behaviours affect access to mental health services for the homeless and also help aid the understanding of the complex relationship between coping and personality

disorder in the homeless population. In turn it is the researchers hope that the study will contribute to the development of more appropriate mental health and psychological support services for this particularly vulnerable and complex population group.

Research Questions and Hypotheses:

RQ1: Do those with personality disorder present differently in terms of coping behaviours, than those without personality disorder?

Hypothesis 1: There will be significantly higher rates of externalising and internalising coping behaviours in personality disordered participants than non-personality disordered participants.

RQ2: Why do some homeless people exhibiting personality disorder type behaviours gain access to services when others don't? Is the difference due to the type of coping behaviours employed?

Hypothesis 2: There will be significant differences in the internalising and externalising coping behaviour scores for those who access mental health services (i.e. GP, psychologist, community mental health nurse, psychiatrist) and those who do not access mental health services at all:

A) Those participants accessing services (primary and secondary) will display lower rates of externalising behaviours than those participants not accessing mental health services at all.

B) Those participants accessing services (primary and secondary) will display higher rates of internalising behaviours than those participants not accessing mental health services at all.

2. METHOD

2.1 DESIGN

The study used a non-repeated, quasi experimental group design, with the independent variable being those who access mental health services and those that do not and the dependant variables being personality disorder and coping behaviours.

Within the study, the participants were required to complete a set of questionnaires. This questionnaire method was used to maximise participation and given the nature of the setting and sample, has been shown to be a viable and practical alternative to structured interview approaches (Eisen, 1995; Trull & Goodwin, 1993).

2.2 PARTICIPANTS

A total of 59 participants took part in the study. These participants were recruited from two different homeless hostels accepting self-referrals and mutli-agency referrals, with the only acceptance criterion being 'homelessness'. One of the

hostels operated as an admission and assessment centre, with a maximum intended stay of eight weeks (although many residents had been there for a number of years) and the other was a hostel intended for a maximum stay of six months. Two different day centres were also used to recruit participants. Of the 59 participants that took part, 34 were classed as hostel homeless and 25 as street homeless, 49 were male and 10 female. The age of the sample ranged from 18 – 58, with a mean age of 33. Of the 59 questionnaire packs completed, nine were excluded from the personality disorder analyses, as the scores were deemed invalid on the MCMI-III scoring profile. These invalidity conditions were deemed to be met when more than 12 missing responses were present, when two or more validity scale items were endorsed and/or when extreme scores were obtained on the disclosure index. According to the authors these scores indicate that the participant may not have paid sufficient attention, may have misunderstood the item content and/or may have over or under-reported symptoms to such a degree that it becomes impossible to interpret the results appropriately (Millon, Millon & Davis, 1994). An additional four of the questionnaire packs were excluded from the internalising and externalising analyses, as the T scores obtained on the internalising scales were extremely low (30 – 34). The authors suggest that extremely low scores (those obtained by less than 4% of the authors normative sample) reflect the respondent has either not understood the form or has not been candid (Achenbach & Rescorla, 2003). Five further participants had to be excluded due to missing data on internalising and externalising scores.

Therefore the final sample used within the analyses consisted of 41 participants, 24 hostel homeless of which 19 were male and 5 female, and 17 street homeless of which all were male. While there is generally a smaller representation of women among the homeless community (Stein & Gelberg, 1995), this sample contained considerably fewer women than men (five females versus 36 males) and as such, no gender differences could be investigated.

2.3. MEASURES

Millon Clinical Multiaxial Inventory-III (MCMI-III: Millon, Millon & Davis, 1994);

This 175 item self report questionnaire is one of the most widely utilised and researched clinical assessment inventories in the field of personality pathology (Craig, 1999). The MCMI-III uses a 'true/false' rating scale and provides a measure of 24 disorder scales: 14 personality disorders (Axis-II) and 10 clinical syndromes (Axis I), including drug and alcohol dependence, where these two scales have independently been shown to have adequate diagnostic sensitivity (Craig, 1997) and do not contribute to the total personality disorder score. This measure also contains three 'modifier' indices (disclosure, desirability and debasement) that are used to identify invalid responses such as random responding, over-disclosure or under-disclosure.

Raw scores are converted to base rate (BR) scores, which incorporate normative data and adjust for potential affective states or invalidity conditions, thereby enhancing diagnostic efficiency (Millon, Millon & Davis, 1994). BR scores range from 0 to 115 for each of the 24 disorder scales measured and according to the authors, a total cut-off score of 85 and above for each of these scales indicates that the individual is definitely within the disordered range; a score of 75 to 85 shows that some or most of the features are present; and a score below 75 indicates no presence of pathology for that particular characteristic. However, some authors have argued that the MCMI has a slight tendency to overestimate the presence of disorders (Zimmerman, 1994) and so in accordance with the recommendation made by Craig (1999), the higher cut-off score of 85 was used in this study. Therefore, the participants were categorized as 'personality disordered' when they scored above 85 on at least one of the PD sub-scales.

The MCMI-III contains a small enough number of items to encourage its use in a variety of complex settings, whilst being large enough to permit the assessment of a wide range of clinically relevant behaviour. Furthermore, the measure can be completed in approximately half an hour and is also designed to be used by those who can read at a sixth-to-eighth grade level (Millon, Millon & Davis, 1994). These features help to maximise retention of participants by reducing fatigue, which makes the MCMI-III a recommended diagnostic screening tool in personality disorder research (Derksen, 1995).

The MCMI-III is grounded within clinical theory, reflects the DSM-IV criteria and contains normative data from a variety of samples (Millon, Millon & Davis, 1994). Furthermore, this measure has previously been used to assess personality disorder within substance users (Craig, 2000; Grabarek, Bourke & Van Hasselt, 2002; So, 2005); to assess PTSD (Craig & Olsen,1997); and to assess psychopathology within homeless populations (Dipaolo, 1997; Stewart, 1999; Summerall, Rate, Lopez, Hunter & Weaver, 2000).

The MCMI-III has good internal consistency (above .80 for 20 of the 26 scales) and test-retest reliability (ranging from .82 to .96), although most studies have demonstrated only mild to moderate correlations of the MCMI-III scales with other similar measures (ranging from .20 to .77) (Craig, 1999; Millon, Millon & Davis, 1994). Some studies suggest poor convergent validity between the self-report MCMI-III and structured clinical interview measures (Craig, 1999; Marlowe, Husband, Bonieskie, Kirby & Platt, 1997), however a recent study found that the MCMI-III was significantly better at diagnosing anti social personality disorder among substance abusers than the Structured Clinical Interview for DSM-III-R Axis II Disorders (SCID-II, First, Spitzer, Gibbon & Wiliams, 1995), Messina, Wish, Hoffman & Nemes (2001). For screening and research purposes, the consensus appears to be that self-report questionnaires are an informative and practical alternative to structured interviews (Trull & Goodwin, 1993). Taking into account the time constraints and nature of the setting and sample, the MCMI-III was selected as the most reliable and

appropriate measure to assess psychopathology with this sample (see Appendix D for example items)

Achenbach System of Empirically Based Assessment; Adult Self-Report ages 18-59 (ASEBA; Achenbach & Rescorla, 2003)

This Adult Self-Report inventory (ASR, 18-59 age range) is designed to assess a broad spectrum of problems, including substance abuse as well as adaptive and maladaptive functioning. The instrument includes quantified items that are scored on scales for empirically based syndromes and on six DSM-oriented scales (depressive problems, anxiety problems, somatic problems, avoidant personality problems, ADHD problems and anti social personality problems). In addition to quantified items and scales, the instrument also obtains clinically useful, individualised qualitative information and provides scales for internalising and externalising behaviours. The items are rated on a scale that ranges from 'not true' to 'sometimes or somewhat true' to 'very true or often true'. Raw scores, which incorporate normative data, are converted to T scores. These T scores range from 25 – 100 for the internalising, externalising and total problem scales and according to the authors, a total cut-off score of 63 and above for each of these scales indicates that the assessed attribute is definitely within the disordered range; a T score of 60 – 63 indicates the individual falls into the borderline clinical range (93rd-98th percentile).

The ASR has good internal consistency; adaptive functioning scales were moderately high, ranging from .60 to.78, (which are reasonable for scales that have relatively few items). For the empirically based problem scales, the alphas ranged from .51 to.97, with only one alpha <.70 (thought problems syndrome) and for the DSM oriented scales, alphas ranged from .68 to .88, with only one alpha <.70 (Anxiety problem scale). Test re-test reliability is also good with the empirically based problem scales reported at .88, Total problem scales at .94 and DSM-oriented scales at .83, with all test-retest r's being significant at p<.01 (Achenbach, 1997).

The ASR can be self-administered in approximately 20 minutes under diverse conditions and is suitable for respondents who have at least fifth grade reading skill. The ASR has also been utilised with substance abuse populations (Achenbach, 1997), and clinical samples (Achenbach & Rescorla, 2003) whilst the youth self report version has been utilised with homeless youths to assess coping behaviours (Votta & Manion, 2003; 2004) making it a feasible measure to use with this homeless sample (see Appendix E for example items).

Devised Measure regarding 'access to mental health services'.

This measure was devised to gain information on participants' access to mental health services. Participants were asked if they had ever sought contact with the hostel GP or other health care professional regarding psychological difficulties, as well as the type of professional seen, number of times they had contact with

them in the past two years and whether they had ever experienced inpatient care for psychological difficulties. Finally participants were asked if they had ever experienced difficulty gaining access to people or places that they felt could help them with psychological problems (see Appendix F for example items). It was hoped that this information would help to conceptualise the relationship between coping behaviours and access to differing types of mental health services, as well as allowing participants to be separated into those that access services and those that do not.

2.4 PROCEDURE

The hostels and day centres agreed to participate in the research and managerial and some support staff were briefed in the study and the measures involved. The only exclusion criterion for the study was the ability to understand basic spoken or written English as interpreters or alternative language test forms were not available. Assistance was provided to those participants who required support with completing the questionnaires (N=7) by either reading the questions aloud, clarifying queries or providing word definitions. All the participants were required to answer the test items independently in order to ensure confidentiality and the validity of the questionnaires (Millon, Millon & Davis, 1994; Achenbach & Rescorla, 2003).

Initially, posters including information about the study and what would be involved (see Appendix G) were placed around the hostel communal areas to

generate interest in the study. The poster directed readers to request a leaflet (see Appendix H) from hostel staff if they were interested in taking part and the contact details of the researcher were made available in order to answer any questions. Interested participants were encouraged to give their names to staff and following this the details of where and when the study was taking place were confirmed.

Given the complex nature of the setting and sample, the procedure needed to be flexible to enhance participation. Therefore, several sessions were held over a period of several weeks prior to the mid morning and evening meals in communal areas of the hostels and day centres. On arriving, each participant was allocated to a table, given a questionnaire pack and an emphasis was placed on separateness and confidentiality. The researcher requested that participants read the enclosed information sheet, detailing the purpose of the study, confidentiality and right to withdraw (see Appendix I). The researcher then reiterated the study aims and procedure, reminding participants of the right to withdraw and asked the participants to complete the screening tool (see Appendix J), this enabled the researcher to identify which participants might need assistance. The researcher then requested the participants to sign the enclosed consent form (see Appendix K) and to complete the questionnaire pack. The pack contained four measures, the MCMI-III; ASEBA; the devised measure and one other measure used by a fellow researcher. The combining of the questionnaires with those of a fellow researcher enabled combined data

collection thus recruitment of a greater number of participants. As this researcher was also using the MCMI-II it had the added advantage of reducing costs. The questionnaires were coded to ensure confidentiality and anonymity. The questionnaires took approximately 30 minutes to 55 minutes to complete, depending on reading speed. Once finished the participant sealed the envelope and handed the pack to the researcher. At this point the handout sheet (see Appendix L) and a £5 food voucher were given to the participants in consideration of their time. They were asked to sign a voucher confirmation sheet (see Appendix M).

On completion of the questionnaires each participant was categorised as either accessing mental health services or not accessing mental health services based on whether they had ever seen the hostel GP or any other professional regarding psychological difficulties versus never having seen anyone regarding psychological difficulties. Objective/confirmatory data on participants' diagnosis, substance dependence histories and coping behaviours could not be obtained due to confidentiality agreements.

The study was approved by the School of Psychology Ethics Committee (see Appendix N for approval email) and The Research Governance board and was sponsored by the University of Southampton (see Appendix O for letter confirming sponsorship).

3. RESULTS

DATA ANALYSIS:

Firstly the distribution of the data was examined using Kolmogorov-Smirnov tests and assumptions of normal distribution were met for all of the variables indicating that parametric tests would be most appropriate for analysis of data.

SAMPLE CHARACTERISTICS:

The mean internalising and externalising T scores for the entire sample were compared to those reported in the ASEBA manual as normative data for non-referred samples (Achenbach & Rescorla, 2003), see Table 1 for means.

Table 1 showing mean internalising and externalising T scores for the homeless sample and non-referred sample (Achenbach & Rescorla, 2003).

	Mean T Scores	
	Internalising	Externalising
Homeless sample	64.3	64.8
Non-referred sample	50.3	50.3

Both the internalising and externalising mean T scores for this homeless sample were higher than the reported norms. Fifty four percent (N = 22) of the final sample had externalising scores in the clinical range and 61% (N = 25) of the sample had internalising scores in the clinical range. Using the recommended

cut-off score of 85, 28 participants (56%) in the sample met the diagnostic criteria for at least one personality disorder diagnosis and 22 (44%) did not. Twenty eight participants (68%) accessed some form of mental health service and 13 (32%) did not access any mental health service at all. In terms of the type of service accessed, 19% (N = 8) accessed the GP only and 49% (N = 20) accessed some form of secondary/tertiary care (e.g. psychiatrist, psychologist, community mental health nurse). Seven participants (17%) reported they had encountered difficulty in gaining access to services that they felt would be beneficial to their mental health.

Hypothesis 1: *There will be significantly higher rates of externalising and internalising coping behaviours in personality disordered participants than non-personality disordered participants.*

In order to test hypothesis 1 an Independent samples t-test was performed which confirmed that the personality disordered group reported significantly higher internalising scores than the non personality disordered group (see table 1) ($t = 3.156$, $DF = 39$, one tailed $p = < 0.005$). The personality disordered group did not report significantly higher externalising scores than the non personality disordered group (see Table 2). Appendix C gives a brief description of the DSM-IV personality disorders and the clusters they fall into.

Table 2: Means, range and standard deviations of internalising and externalising scores for PD and Non PD groups

	Personality Disordered group			Non-Personality Disordered group		
	Mean	Standard Deviation	Range	Mean	Standard Deviation	Range
Internalising scores	69.58	12.86	35 – 91	56.88	12.46	38 - 82
Externalising scores	67.62	12.71	34 - 90	60.71	11.69	47 - 90

Hypothesis 2:

A) Those participants accessing services (primary and secondary) will display lower rates of externalising behaviours than those participants not accessing mental health services at all.

B) Those participants accessing services (primary and secondary) will display higher rates of internalising behaviours than those participants not accessing mental health services at all.

In order to test hypothesis 2A an independent samples t-test was performed. Overall, there were no significant differences between the externalising scores of those who accessed services and those that did not.

In order to test hypothesis 2B an independent samples t-test was performed which confirmed that the mean internalising scores of those who accessed services (primary and secondary) was higher than that of participants who did not access services at all (see Table 3). This difference was significant ($t = 2.70$, $df = 39$, $p = < 0.05$) two tailed, confirming the hypothesis that participants accessing

services will display higher rates of internalising behaviours than participants not accessing mental health services.

Table 3: Means, range and standard deviations of internalising and externalising scores for those who accessed and did not access mental health services

	Accessed services			Didn't access services		
	Means	Standard Deviation	Range	Mean	Standard Deviation	Range
Internalising scores	68.07	13.14	41 – 91	56.23	12.85	35 - 77
Externalising Scores	65.43	10.95	47 – 90	63.31	16.08	34 - 90

Following the finding that internalising scores were significantly higher for those who accessed services than those who did not, a one way analysis of variance (ANOVA) in combination with a post hoc Scheffe was performed to establish whether there were differences in the internalising and externalising scores for those accessing primary mental health services (i.e. hostel GP), those accessing secondary services (psychiatrist, psychologist, community mental health nurse, counsellor) and those not accessing any form of mental health service at all. It was hoped that this analysis would provide some understanding about the types of behaviours that homeless individuals accessing secondary services display, and whether these differ to behaviours exhibited by those who access primary services. The one way ANOVA revealed no significant differences between the three groups in terms of externalising scores. However, the ANOVA did reveal a

difference in the internalising scores of participants in terms of what type of service they accessed ($F(2,38) = 8.79$, $p < 0.005$). Those participants who accessed secondary services had significantly higher internalising scores than those who did not access mental health services at all ($p < 0.005$). Also, those who accessed secondary services had significantly higher internalising scores than those who accessed the GP only ($p < 0.05$). The ANOVA revealed no significant differences in the internalising scores of those who did not access any form of mental health service and those who accessed the hostel GP (primary mental health services).

POST HOC TESTS:

In light of the finding that internalising scores were significantly higher among the personality disordered than non-personality disordered a chi square was conducted in order to test whether personality disorder was a discriminating factor in accessing services. The Chi-square assessed whether the personality disordered (PD) and the non-personality disordered (non PD) differed in terms of accessing primary mental health services (hostel GP), secondary mental health services (e.g. psychiatrist) or no mental health service at all. There were no significant associations between presence of personality disorder and type of mental health service the participants accessed, $X^2 (3) = 2.536$, $p = 0.469$ (two sided).

4. DISCUSSION

This study investigated the relationships between coping behaviours and access to mental health services among a homeless population that did and did not meet criteria for a diagnosis of personality disorder. Within this sample, there were significantly higher self-reported internalising and externalising behaviours for those that met the criteria for a diagnosis of personality disorder than those that did not. Overall prevalence of personality disorder within this sample (56%) was similar to that observed in other comparable studies (Mathews, 2006) further highlighting the need for specialised mental health support services within the homeless sector that expect and take into consideration the types of behaviours employed by these individuals.

Internalising and externalising behaviours were both found to be higher among this homeless population than reported norms (Achenbach & Rescorla, 2003) a finding that is comparable to that of Votta and Manion (2003; 2004) who used the same measure of coping behaviours with a sample of homeless youths. Given existing literature on coping styles and health seeking behaviour the researcher predicted that a difference in internalising and externalising behaviours would be found for those who do and do not access mental health services. However in actual fact it was only internalising behaviours that determined whether or not the individual received mental health services.

Thirteen out of forty one participants (32%) in this homeless sample did not access any form of mental health service at all. This is particularly interesting in light of the finding that 38% of homeless persons with a serious mental health problem have never received any treatment (Koegel, Burnam & Farr, 1988). It could be possible that this percentage represents those individuals who may be classified as the avoidant type of personality disorder. Indeed it would be easy within hostels to avoid contact with primary mental health care, as they could simply move on or be absent when regular GP clinics were held. Conversely the percentages who do not access services may feel that they do not have mental health needs that warrant the services of mental health teams.

Internalising behaviours were found to be significantly higher among those who accessed mental health services than those who did not, again highlighting the need for services to be aware of and trained to deal with the types of behaviours that are encompassed by internalising styles, such as high numbers of somatic complaints, suicidal behaviours and high levels of anxiety and depression. Interestingly, there was an insignificant difference in amounts of internalising behaviours between those that accessed no mental health service and those that accessed either a hostel visiting GP or another form of primary homeless health care service. This indicates that those who access primary mental health services present similarly to the percentage that do not access services at all. This may be explained in part by the assessment procedure conducted within the hostels involved in the study and the regular clinics that are held in the hostels, to

which homeless health care GPs attend. It is likely that many of the participants in this study reported having seen a GP for psychological difficulties, when they saw the GP only once as part of a general assessment and registration procedure, rather than seeking out the GP specifically for mental health problems. Future research would need to examine the best way of eliciting this sort of fine detail information, in order to eliminate these queries.

One of the most interesting findings of the study is that internalising behaviours were significantly higher for those accessing secondary services than those accessing no services at all and for those accessing the GP. This finding supported the hypothesis but is contrary to findings of a previous study that found internalising behaviours were not a factor in utilisation of mental health services among traumatised children (Hilker, 2003). However, this lack of association is not surprising when considering that the majority of children are not in control of whether they gain or seek access to services, therefore other factors such as parental anxiety about the child may have greater associations with utilisation of services for this population. The finding that internalising behaviours are higher among those that access secondary services is of particular importance in considering access to mental health services as it reveals that it is specifically internalising behaviours (as one of a number of factors) that gain a certain level of attention and concern from GPs to motivate them to refer on to secondary care services. Given that the study demonstrates that internalising behaviours mark the difference between those that do and do not access services and further that

internalising behaviours mark the difference between those that access primary and secondary mental health services, a major limitation of this study is that it did not measure for Axis I disorders such as anxiety and depression and as such it is not clear whether it is simply higher levels of anxiety or depression that encourage GPs to refer, or whether it is the behaviours per se. Future research using a robust measure of affect could help to clarify this. It is also true that other factors may be preventing homeless individuals from accessing services. Some individuals may feel they have no need to access services or may feel their level of difficulty does not warrant attention. Furthermore individuals may want to distance themselves from services in an attempt to avoid the stigma that is sometimes associated with mental health problems.

The lack of significance between externalising behaviours in those that do and don't access services may simply reflect high levels of externalising behaviours across homeless populations and therefore the reduction of externalising behaviours as a discriminate variable for GPs seeking to refer on. Externalising behaviour in this study was measured through behaviours such as substance use, aggression, impulsivity, theft and involvement with the police which leads the researcher to speculate that those with higher externalising behaviours may be those individuals who are more likely to have had or be involved with the criminal justice system. Further research is necessary to answer this question and could expand on the current study through measuring for past involvement

with the criminal justice system, including number and length of prison sentences.

Although the chi-square analysis was not significant the number of participants (N=14) who met criteria for personality disorder and were accessing secondary mental health services was higher than the number that did not meet criteria but were accessing these services (N= 6) indicating that GPs are noticing the characteristics, behaviours and affects of the personality disordered and referring these individuals for more specialised care. This contrasts with earlier findings that suggest 91.7% of personality disorder related problems among the homeless are unrecognised or untreated (Salize et al., 2001). Further longitudinal research would be needed to determine whether those who are in secondary care go on to receive a diagnosis of Personality Disorder and again, without measuring for affect it is impossible to say whether it is the behaviours per se or the higher levels of affect that prompt these referrals. It is however encouraging that this number of individuals with personality disorder are receiving specialist care. Nonetheless, there was still a percentage of the sample (14%) who met criteria for a diagnosis of personality disorder but were not accessing any form of mental health service at all, which poses the question of whether this is a choice by clients or a failing of services to identify or offer care that is able to meet the complex needs of this subgroup.

A recent survey carried out by Homeless Link (2006) a national organisation for frontline homelessness agencies in England, revealed that 94% of their member agencies work with people with multiple needs. Only 29% of these agencies had access to specialist services to address multiple needs and agencies reported that support available from partners was often inadequate to address existing needs, indeed 35% of respondents found Community Mental Health Teams very difficult to access. The issue of planning robust care planning mechanisms between primary and secondary services and the voluntary sector is an important issue. From the perspective of the voluntary sector there is often a lack of respect for them as equal partners. Despite complex health needs in the homelessness agencies it is rare for agencies to successfully obtain health funding. They find it difficult to access appropriate health care for their client group, even at the primary care level and are often not engaged in care planning by hospitals when clients are admitted or by Community Mental Health Teams (Homeless Link, 2006)

Certainly part of the problem is the discrepancy between the definition that mental health services use of severe and enduring mental illness, which is the gateway to their services, and the day to day experience of hostel managers and experienced staff identifying high levels of mental health need in the client group. One of the many reasons given is because a client is identified as having a personality disorder and therefore deemed untreatable (Mental Health Act, 1983) or that the substance misuse issues make the diagnosis too difficult. If mental

health services are serious about wanting to deliver a better service to this client group then it should be made a priority to respond appropriately when a referral is made by a homelessness agency or a drug and alcohol agency.

The experience of the homeless sector is more positive where there are specialist mental health services for homeless people, such as the area involved in this study. Where these exist a partnership is developed between the third sector agencies and the mental health service and both have an understanding of each other's role. Specialist services tend not to exclude people who have a personality disorder or dual diagnosis and to work in a more holistic way that takes account of the wider housing and social care needs of the client group (Homeless Link, 2006). Unfortunately specialist mental health services for homeless people are reducing. There is no longer funding for the Homeless Mentally Ill Initiative (Department of Health, 1996) and other specialist services have suffered funding cuts from Supporting People (www.centrepoint.org.uk/content/view/46/26/). The recent publication 'The Getting Through Guide - Access to Mental health services for homeless people' (www.socialinclusion.org.uk) identifies a number of specialist services as good practice models and recommends the establishment of specialist services in areas where there are sufficient numbers of homeless people with mental health problems. Perhaps the single most important conclusion is that there need to be clear responsibilities and tailored responses for those with chaotic lives and multiple needs. This applies both at the strategic level, for planning service

provision and priorities - the local strategic partnership – and at the level of individual case management.

Methodological considerations

There are several methodological limitations that restrict the interpretation of findings within this study. The limited number of women in the sample and the relatively small sample size make it impossible to distinguish or determine potential gender affects or detailed differences between coping behaviours. The sample also consisted of individuals who had actively volunteered to take part in the study and therefore raises questions about the generalisability of the present study and possible selection bias. However, the population did include both hostel and street dwelling homeless and therefore it is fairly representative of homeless subgroups, with the exception of homeless families. Efforts were also made to enhance the representativeness of the sample by limiting the exclusion criteria and thereby including participants who presented with various and multiple disorders of varying degrees of severity, thereby creating higher ecological validity.

Another study weakness was the reliance on retrospective self report data given the questionable reliability of this form of data collection. Participants may interpret questions differently, may under-report or over-report pathology and may give responses that are altered by their affective states. This may be a particular concern for certain personality-disordered individuals given their

specific characteristic traits (Millon & Davis, 1996). However the MCMI-III validity scales attempt to take into account these potential complications and adjust the scores accordingly. Similarly, participants who scored extremely low on the coping behaviours measure were removed from the analysis, therefore the study did attempt to control for these issues. It is also hoped that the assurances of confidentiality and anonymity would encourage participants to answer with reduced social desirability. In fact, studies have shown that self-report data from homeless individuals on standardised symptom scales was fairly reliable and valid. Furthermore, apart from their low cost and ease of administration, numerous authors have argued that self-report measures have reliable screening properties, can be compared with normative data and are free from the systematic biases of screening interviews (Ekselius, Tillfors, Furmark & Fredrickson, 2001; Trull & Goodwin, 1993; Zimmerman, 1994).

However, using a structured interview approach in future studies in order to obtain a more detailed psychiatric assessment may be beneficial, although this does rely on the participants' ability and willingness to report accurately on their inner experiences. Another approach that could be used to gain additional information about participants' behaviours is the ASEBA Adult Behaviour Checklist (ABCL- Achenbach & Rescorla, 2003) which can be completed by a person who knows the participant well, such as hostel or day centre staff. The ABCL can be utilised and scored alongside the self report version used in this study and comparisons can be made between behaviour profiles identified by the

participant and behaviour profiles observed by the staff member. Again, this method has disadvantages, in that it requires staff from understaffed, overworked units to commit precious time to the completion of the questionnaire, also issues of confidentiality and data protection will need to be considered in future studies if confirmatory information is sought from alternative sources.

The ASEBA self report form was used in this study as it specifically measures internalising and externalising behaviours and it was felt that this would be a more concrete measure of coping than existing measures which address more global concepts (e.g. avoidance and approach coping), such as the Coping Responses Inventory (CRI - Moos, 1990) The fact that the youth self report version of this measure had been used with homeless youths (Votta & Manion, 2003; 2004) strengthens the support for the use of this measure over others. Authors have also argued that the MCMI-III has a tendency to overestimate the presence of disorder (Zimmerman, 1994). However in accordance with the recommendation made by Craig (1999), the higher cut-off score of 85 was used in this study

The present study did not measure participants' level of satisfaction with the services they were in contact with, an oversight which would have given some interesting information, particularly as 83% of the sample felt they had not experienced any difficulty gaining access to services they thought would be useful. Secondly, the study did not include a measure for affect, something

which impacts on the interpretation of findings from this study, as it is possible that high levels of affect determined whether participants accessed secondary care, rather than or in addition to internalising behaviours. Future studies could include measures for Axis I disorders, such as the Beck Depression Inventory, BDI - Beck & Steer, 1993) and State-Trait Anxiety Inventory (STAI - Spielberger, 1983). Lastly, the study did not control for the presence of severe mood disorder or drug intoxication, which may have affected participants' responses. Nonetheless, existing mood disturbances should not interfere with the assessment of personality pathology given the enduring nature of personality disorder symptomatology (Lezenweger & Clarkin, 1996) and the MCMI-III has incorporated a mood-adjustment condition within its scoring procedure in an attempt to regulate this (Millon & Davis, 1996).

A limited amount of demographic data was collected from the participants in relation to the length of their current tenancy and tenancy history. However, in an attempt to reduce the number of questions and time required from the participants no data was collected on social support levels or reasons for homelessness. This information would have been very useful for exploring a possible relationship between levels of internalising and externalising behaviours and amount of tenancy breakdowns and thus is seen as a major study limitation.

Conclusion

The limitations of the research not withstanding, this study makes an important contribution with regard to the relationships between coping behaviours and access to services among the homeless and the subgroup of personality disordered homeless. The findings from the present study support the concept of complex and differing needs within the homeless population but highlights the ways in which individuals may be attempting to cope. The results indicate that internalising and externalising behaviours are much higher in the homeless population than in the general population and that those with personality disorder exhibit high levels of internalising behaviours relative to those without. Most importantly, the results indicate that high internalising behaviours are one of a number of discriminating factors for access to mental health services, and for the level of mental health care received. This finding raises major questions about the possible pathways for those that have high externalising behaviours. Continued research is imperative to distinguish if high externalising behaviours are a discriminating factor for accessing the criminal justice system rather than the care services. This research would enable a better understanding of the types of behaviours that are employed by those accessing the criminal justice system. It could help to identify those individuals most at risk of experiencing prison and furthermore, could lend valuable information for preventative services. A future research question such as the following would begin to address this: Do homeless persons who have accessed the criminal justice system present differently in terms of coping behaviours to homeless persons who have not?

Overall these findings clearly indicate that the homeless are an exceptionally vulnerable group, who experience multiple difficulties whilst relying on long standing coping behaviours that are maladaptive and do not aid them in engaging with services or staff. All of this takes place within a context of ever-changing services that are, depending on the area, difficult to access and inappropriate for the mental health needs of this population.

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APPENDIX A

CLINICAL PSYCHOLOGY REVIEW – GUIDE FOR AUTHORS

CLINICAL PSYCHOLOGY REVIEW – GUIDE FOR AUTHORS

SUBMISSION REQUIREMENTS: Authors should submit their articles electronically via the Elsevier Editorial System (EES) page of this journal (http://ees.elsevier.com/cpr). The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail and via the Author's homepage, removing the need for a hard-copy paper trail. Questions about the appropriateness of a manuscript should be directed (prior to submission) to the Editorial Office, details at URL above. Papers should not exceed 50 pages (including references).

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

FORMAT: We accept most wordprocessing formats, but Word, WordPerfect or LaTeX are preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used.

Please provide the following data on the title page (in the order given).

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in**

addition to the e-mail address and the complete postal address.

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the Publication Manual of the American Psychological Association, 5th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Please note that journal names are not to be abbreviated.

Reference Style for Journals: Cook, J. M., Orvaschel, H., Simco, E., Hersen, M., and Joiner, Jr., T. E. (2004). A test of the tripartite model of depression and anxiety in older adult psychiatric outpatients, *Psychology and Aging*, 19, 444-45.

For Books: Hersen, M. (Ed.). (2005). Comprehensive handbook of behavioral assessment (2 Volumes). New York: Academic Press (Elsevier Scientific).

TABLES AND FIGURES: Present these, in order, at the end of the article. High-resolution graphics files must always be provided separate from the main text file (see http://ees.elsevier.com/cpr for full instructions, including other supplementary files such as high-resolution images, movies, animation sequences, background datasets, sound clips and more).

PAGE PROOFS AND OFFPRINTS: When your manuscript is received by the Publisher it is considered to be in its final form. Proofs are not to be regarded as 'drafts'. One set of page proofs will be sent to the corresponding author, to be checked for typesetting/editing. No changes in, or additions to, the accepted (and subsequently edited) manuscript will be allowed at this stage. Proofreading is solely the authors' responsibility.
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If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has forms for use by authors in these cases available at www.elsevier.com/locate/permissions phone: (+44) 1865 843830, fax: (+44) 1865 853333, e-mail: permissions@elsevier.com

NIH voluntary posting policy US National Institutes of Health (NIH) voluntary posting (" Public Access") policy Elsevier facilitates author response to the NIH voluntary posting request (referred to as the NIH "Public Access Policy", see http://www.nih.gov/about/publicaccess/index.htm) by posting the peer-reviewed author's manuscript directly to PubMed Central on request from the author, 12 months after formal publication. Upon notification from Elsevier of acceptance, we will ask you to confirm via e-mail (by e-mailing us at NIHauthorrequest@elsevier.com) that your work has received NIH funding and that you intend to respond to the NIH policy request, along with your NIH award number to facilitate processing. Upon such confirmation, Elsevier will submit to PubMed Central on your behalf a version of your manuscript that will include peer-review comments, for posting 12 months after formal publication. This will ensure that you will have responded fully to the NIH request policy. There will be no need for you to post your manuscript directly with PubMed Central, and any such posting is prohibited.

APPENDIX B

THE BRITISH JOURNAL OF PSYCHOLOGY – NOTES TO AUTHORS

BRITISH JOURNAL OF PSYCHOLOGY – NOTES FOR AUTHORS

The Editorial Board of the *British Journal of Psychology* is prepared to consider for publication:

(a) reports of empirical studies likely to further our understanding of psychology
(b) critical reviews of the literature
(c) theoretical contributions

Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 8000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The Journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship (including personal acknowledgements and institutional affiliations) should be confined to the title page (and the text should be free of such clues as identifiable self-citations, e.g. 'In our earlier work...').

4. Online submission process

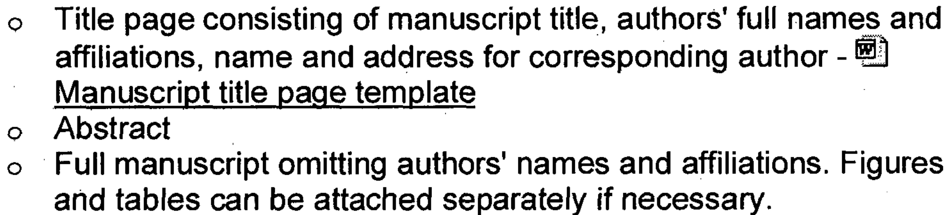
1) All manuscripts must be submitted online at http://bjp.edmgr.com.

First-time users: Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

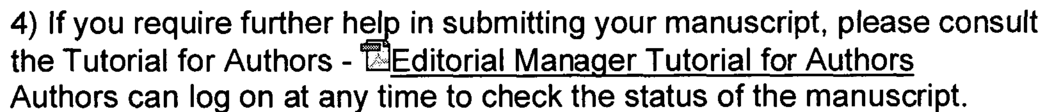
Registered users: Click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:



- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - Manuscript title page template
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.



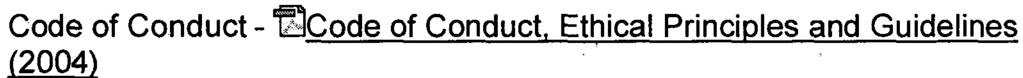
4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager Tutorial for Authors
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association, Washington DC, USA (http://www.apastyle.org)

6. Publication ethics


Code of Conduct - Code of Conduct, Ethical Principles and Guidelines (2004)

Principles of Publishing - Principles of Publishing

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

9. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

10. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs
- Tables, figures, captions placed at the end of the article or attached as a separate file

APPENDIX C

BRIEF DESCRIPTIONS OF THE DSM-IV PERSONALITY DISORDERS

Brief descriptions of the DSM-IV personality disorders

Paranoid Personality Disorder:	characterised by a persistent pattern of distrust and suspiciousness, in that others' intentions/actions are unrealistically interpreted as threatening and demeaning (no psychotic symptoms present)
Schizoid Personality Disorder:	characterised by a pattern of indifference and detachment from social relationships across all contexts and a restricted range of emotional expression
Schizotypal Personality Disorder:	characterised by a pattern of acute discomfort in close relationships as well as odd/eccentric behaviour with a tendency to experience psychotic symptoms
Antisocial Personality Disorder:	characterised by a pervasive pattern of disregard and violation of the rights of others and a history of severely irresponsible and threatening behaviour
Borderline Personality Disorder:	characterised by a pattern of instability and impulsiveness that encompasses most aspects of the individuals functioning including interpersonal relationships, self image, affect and behaviour
Histrionic Personality Disorder:	characterised by a pattern of exaggerated emotionality and intense, attention-seeking behaviour
Narcissistic Personality Disorder:	characterised by a pattern of distorted, inflated view of self as special and superior with a need for admiration and a lack of regard for others
Avoidant Personality Disorder:	characterised by a pervasive pattern of behavioural, emotional, and cognitive avoidance and presenting with feelings of inferiority, sensitivity to criticism and social inhibition

Dependent Personality Disorder:	characterised by a pattern of submissive and clinging behaviour related to intense fears of separation/abandonment and the excessive need to be taken care of
Obsessive-Compulsive Personality Disorder:	characterised by a pattern of rigid preoccupation with orderliness, perfectionism and control and presents with excessive obsessional and compulsive behaviour
Passive-Aggressive Personality Disorder:	characterised by a pattern of negativism, ambivalence, resistance and unwillingness to meet the expectations of others
Depressive Personality Disorder:	characterised by a pattern of intense pessimism and negativity with feelings of guilt, worthlessness and abandonment

APPENDIX D

EXAMPLE TIEMS FROM THE MCMI-III

81. I am ashamed of some of the abuses I suffered when I was young.

82. I always make sure that my work is well planned and organised.

83. My moods seem to change a great deal from one day to the next.

84. I'm too unsure of myself to risk trying something new.

85. I don't blame anyone who takes advantage of someone who allows it.

86. For some time now I've been feeling sad and blue and can't seem to snap out of it.

87. I often get angry with people who do things slowly.

88. I never sit on the sidelines when I'm at a party.

89. I watch my family closely so I'll know who can and who can't be trusted.

90. I sometimes get confused and feel upset when people are kind to me.

APPENDIX E

EXAMPLE ITEMS FROM THE ASEBA ADULT SELF REPORT FORM

Please print your answers. Be sure to answer all items.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

---

0 1 2 63. I would rather be with older people than with people of my own age

0 1 2 64. I have trouble setting priorities

0 1 2 65. I refuse to talk

0 1 2 66. I repeat certain acts over and over

0 1 2 67. I have trouble making or keeping friends

0 1 2 68. I scream or yell a lot

0 1 2 69. I am secretive or keep things to myself

0 1 2 70. I see things that other people think aren't there

0 1 2 71. I am self-conscious or easily embarrassed

0 1 2 72. I worry about my family

0 1 2 73. I meet my responsibilities to my family

0 1 2 74. I show off or clown

0 1 2 75. I am too shy or timid

0 1 2 76. My behaviour is irresponsible

APPENDIX F

EXAMPLE ITEMS FROM THE DEVISED 'ACCESS TO SERVICES' MEASURE

1) Have you ever sought contact with the hostel healthcare GP regarding psychological difficulties? Yes No

2) Have you ever had contact with any other professionals regarding psychological difficulties? Yes No

3) If yes, what type of professional did you/do you see?

Hostel GP
Community Mental Health Nurse
Psychiatrist
Psychologist
Counsellor
Other--

4) Roughly how many appointments have you had regarding psychological problems

in the past 2 years?---

5) Have you ever experienced inpatient care for a psychological problem?

Yes No

6) Have you ever experienced difficulty gaining access to people/places that you felt could help you with psychological problems? Yes No

Participant id ......

APPENDIX G

EXAMPLE OF STUDY POSTER

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

WHAT IS THE PURPOSE OF THIS STUDY?

- TO LOOK AT THE PERSONAL CHARACTERISTICS & DIFFICULTIES THAT HOMELESS PEOPLE FACE.
- THIS STUDY MAY HELP IN CREATING MORE SUITABLE & BETTER SERVICES FOR HOMELESS PEOPLE.

HOW DO I TAKE PART?

- FILL IN SOME QUESTIONNAIRES WHICH WILL TAKE ABOUT 30 – 40 MINUTES.
- TO THANK YOU FOR TAKING PART, YOU WILL BE GIVEN A £5 ASDA VOUCHER

IF YOU ARE INTERESTED:

- PLEASE ASK A STAFF MEMBER FOR A LEAFLET GIVING FURTHER DETAILS.
- YOU CAN THEN PUT YOUR NAME DOWN TO TAKE PART IN THE STUDY DURING NOVEMBER & DECEMBER 2007.

EXAMPLE H

EXAMPLE OF STUDY LEAFLET

University
of Southampton

School of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

WHAT IS THE PURPOSE OF THIS STUDY?

To look at the personal characteristics and difficulties that homeless people face. This study may help in creating more suitable and better services for homeless people.

DO I HAVE TO TAKE PART?

It is up to you to choose whether or not you want to take part but even if you choose to take part, you will still be able to stop and withdraw at any time without giving a reason and this will not affect the services you receive.

WHAT WILL I HAVE TO DO IF I TAKE PART?

You will be asked to fill in some questionnaires. Altogether they should take around 30 – 40 minutes to fill in. If you would rather fill out the questionnaires with help from somebody this can be arranged.

IF I TAKE PART IN THE STUDY, WILL MY INFORMATION BE KEPT CONFIDENTIAL?

All the information collected from the questionnaires will be made anonymous (so no names or confidential information will be used). The information will be kept strictly confidential and in a safe place. The results of this study will be written up in a report and you can get a summary of these results if you want.

WHO WILL BE DOING THE RESEARCH?

Our names are Mohammed Munawar, Louisa McClean & Vicky Levell. We are trainees on the Doctoral Programme in Clinical Psychology at the University of Southampton. This study has been reviewed by the School of Psychology Research Ethics Committee, University of Southampton.

WHAT DO I NEED TO DO IF I AM INTERESTED IN TAKING PART?

If you would like to take part, please give your name to a staff member. We will be visiting during November & December 2007 and we will arrange a convenient time for you to take part in the study.

TO THANK YOU FOR FILLING IN THE QUESTIONNAIRES, YOU WILL BE OFFERED A £5 FOOD VOUCHER

APPENDIX I

INFORMATION SHEET

University of Southampton

School of Psychology
Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom
Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

You are being asked to take part in a research study. Before you decide, it is important for you to understand why this study is being done and what it will involve. Please take some time to read this information carefully and talk to me or a staff member if you want to. Please ask if there is something that is not clear or if you would like more information. Thank you for reading this.

WHAT IS THE PURPOSE OF THIS STUDY?

This study will look into some of the personal characteristics of people who are homeless and the difficulties they face. It is hoped that the study may help in creating more suitable and better services for homeless people.

DO I HAVE TO TAKE PART?

It is up to you to choose whether or not you want to take part. If you do decide to take part, you will be given this Information Sheet to keep. If you fill out the questionnaires, this will be taken as you giving informed consent to be included as a participant in this study. Even if you choose to take part, you will still be able to stop and withdraw at any time without giving a reason and this will not affect the services you receive.

WHAT WILL I HAVE TO DO IF I TAKE PART?

You will be asked to fill in 5 questionnaires. They should take a total of 20 to 30 minutes to fill out. Once you have completed the questionnaires, you will be asked to put them in the envelope given to you so I can collect them. If you would rather fill out the questionnaires with help from somebody or during an interview, please tell me or a member of staff and this can be arranged.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

All the information collected from the questionnaires will be made anonymous (so no names or confidential information will be used) and the information will be kept strictly confidential and in a safe place. The overall results of this study will be written up in a report and you can also get a summary of these results if you want.

WHAT ARE THE POSSIBLE DISADVANTAGES OF TAKING PART?

If you become upset or distressed while filling out the questionnaires, you will be free to stop participating and support will be available from staff members and myself if you want.

Please turn over

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

The information from this study will help us understand some of the difficulties homeless people face and so hopefully let us know what further services might be needed to help people in similar situations to yourself. Also, as a way of saying 'Thank You' for filling out the 5 questionnaires, you will be offered a £5 food voucher.

WHO AM I AND HOW DO YOU CONTACT ME?

My name is Vicky Levell and I am a trainee on the Doctoral Programme in Clinical Psychology at the University of Southampton. This study is being done as part of my training and has been reviewed by the School of Psychology Research Ethics Committee, University of Southampton.

If you have any questions or would like further information, please contact me at:

School of Psychology
Doctoral Programme in Clinical Psychology
University of Southampton
34 Bassett Crescent East
Southampton
SO16 7PB
Tel: 02380 595320

Thank you

APPENDIX J

SCREENING FORM

School of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
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SO17 1BJ

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588

University of Southampton

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

SCREENING FORM

DO / CAN YOU READ ONE OF THE DAILY NEWSPAPERS (E.G. THE MIRROR, THE INDEPENDENT)?

☐ **YES** ☐ **NO**

DO / CAN YOU FILL IN YOUR OWN BENEFIT FORMS WITHOUT ANY HELP/SUPPORT?

☐ **YES** ☐ **NO**

FOR THIS STUDY, HOW WOULD YOU PREFER TO FILL IN THE QUESTIONNAIRES?

Please tick one box. You will be able to change your mind on the day, if you wish.

☐ **FILL IN QUESTIONNAIRES BY MYSELF**

☐ **FILL IN QUESTIONNAIRES WITH SOME HELP**

☐ **FILL IN QUESTIONNAIRES IN AN INTERVIEW**

Participant name: **ID number:**

Researchers: Mohammed Munawar, Louisa McClean, Dr Nick Maguire.
School of Psychology, Doctoral Programme in Clinical Psychology, University of Southampton, Highfield, Southampton, SO17 IBJ. 02380 595321

APPENDIX K

CONSENT FORM

University of Southampton

School of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588

CONSENT FORM

AN INVESTIGATION OF THE PERSONAL CHARCTERISTICS WITHIN A HOMELESS POPULATION

Researchers: Louisa McClean & Nick Maguire
School of Psychology, Doctoral Programme in Clinical Psychology
University of Southampton
34 Bassett Crescent East
Highfield
Southampton, SO16 7BB

1. **I confirm that I have read and understood the Information Sheet that was given to me (for the above study) and have had the chance to ask questions.**

2. **I understand that I have a choice to take part in this study and that I can stop at any time (without giving any reason) without my care being affected.**

3. **I have agreed to take part in this study.**

4. **I agree to the findings of the study to be shared with the hostel and staff of the hostel but understand that information will be shared whilst protecting my identity.**

----------------------------	--------------------	-------------------------
Name of participant	Date	Signature
----------------------------	--------------------	-------------------------
Name of participant	Date	Signature

Participant Identification Number for this study:------------------------------------

APPENDIX L

HANDOUT SHEET

University
of Southampton

School of Psychology
Doctoral Programme in Clinical Psychology

University of Southampton Tel +44 (0)23 8059 5321
Highfield Fax +44 (0)23 8059 2588
Southampton
SO17 1BJ United Kingdom

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

Thank you for taking part in this study.

From time to time, everyone feels angry, scared, worried or sad, especially when things are not going very well in their life. Sometimes, these kinds of feelings can last for quite a long time and it can affect the way people feel about themselves, the way they think about things and the way they cope and do things in their everyday life.

This may not apply to you, but if it does, you might find it helpful to get some advice and support.

WHERE TO GET HELP

If you feel you need some help and support, or if you just want someone to talk to, Please contact any of these people who will be able to help you:

- Your support worker at the service
- Dr (the service's healthcare GP) on
- The Samaritans on: 08457 90 90 90.

Researchers: Mohammed Munawar, Louisa McClean, Dr Nick Maguire.
School of Psychology, Doctoral Programme in Clinical Psychology, University of Southampton, Highfield, Southampton, SO17 IBJ. 02380 595321

APPENDIX M

VOUCHER CONFIRMATION SHEET

University
of Southampton

School of Psychology
Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588

A STUDY OF THE PERSONAL CHARACTERISTICS OF THE HOMELESS POPULATION

VOUCHERS CONFIRMATION SHEET

'I confirm that I have received my £5 food voucher given to me as a Thank You for participating in this study'

Date	Name of participant	Signature of participant	Signature of researcher

APPENDIX N

SCHOOL OF PSYCHOLOGY ETHICS APPROVAL EMAIL

This email is to confirm that your ethics form submission for "A comparison of the presentation of personality disorders within the homeless population. Do those that access services present differently to those that do not?" has been approved by the ethics committee

Project Title: A comparison of the presentation of personality disorders within the homeless population. Do those that access services present differently to those that do not?
Study ID : 284
Approved Date : 2007-11-02 16:24:16

Click here to view Psychobook

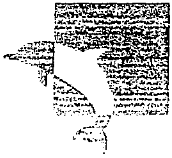
You will now need to complete a form for indemnity insurance which can be found online at the link below:
Research Governance Form

http://www.psychology.soton.ac.uk/psyweb/psychobook/admin/ethics/research_governance.doc

This will need to be returned to the address provided on the form

APPENDIX O

UNIVERSITY OF SOUTHAMPTON SPONSOR APPROVAL LETTER



University of Southampton

Legal Services – Research Governance Office

RGO REF: 5467

Miss Louisa McClean
School of Psychology
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

20 November 2007

Dear Miss McClean

Project Title: A Comparison of the Presentation of Personality Disorders With a Homeless Population. Do Those That Access Mental Health Services Present Differently to Those That Do Not?

I am writing to confirm that the University of Southampton is prepared to act as sponsor for this study under the terms of the Department of Health Research Governance Framework for Health and Social Care (2nd edition 2005).

The University of Southampton fulfils the role of Research Sponsor in ensuring management, monitoring and reporting arrangements for research. I understand that you will be acting as the Principal Investigator responsible for the daily management for this study, and that you will be providing regular reports on the progress of the study to the Research Governance Office on this basis.

I would like to take this opportunity to remind you of your responsibilities under the terms of the Research Governance Framework, and the EU Clinical Trials Directive (Medicines for Human Use Act) if conducting a clinical trial. We encourage you to become fully conversant with the terms of the Research Governance Framework by referring to the Department of Health document which can be accessed at:

http://www.dh.gov.uk/assetRoot/04/12/24/27/04122427.pdf

In this regard if your project involves NHS patients or resources please send us a copy of your NHS REC and Trust approval letters when available.

Please do not hesitate to contact me should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

Yours sincerely

Dr Martina Prude
Research Governance Manager

cc: File