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**Psychological interventions for housebound people with psychosis:  
service user and therapist perspectives in South East London**

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Psychological interventions for housebound people with psychosis: service user and therapist perspectives in South East London.

**Background:** People with psychosis often have difficulty leaving their homes to perform tasks of daily living, which also limits their access to clinic-based interventions to support recovery. Home-based psychological therapy may offer a solution.

**Aims:** To examine service user and therapist perspectives on i) houseboundness in psychosis and ii) the value of home-based psychological interventions, as a first step towards a systematic evaluation.

**Method:** Semi-structured interviews with ten service users and twelve therapists from a large inner city mental health NHS Foundation Trust were thematically analysed.

**Results:** Houseboundness most commonly resulted from anxiety, paranoia and amotivation, indicating the potential usefulness of targeted psychological therapies. Home-based therapy was offered unsystematically, with variable goals. Although beneficial for engagement and assessment, little gain was reported from undertaking a full course of therapy at home.

**Conclusions:** Home visits could be offered by psychological therapists to engage and assess housebound service users, but home-based therapy may be best offered on a short-term basis, targeting paranoia, anxiety and amotivation to increase access to other resources. Given the increased cost associated with home-based psychological interventions, a systematic evaluation of their impact is warranted.

**Declaration of interest:** The authors declare that there is no conflict of interest. The authors alone are responsible for the content and writing of this article.

**Key Words:** Schizophrenia, Community Mental Health, Low intensity, Engagement,  
Access

## 1.0 Introduction

The National Institute for Health and Care Excellence (NICE) schizophrenia guideline recommends that cognitive behavioural therapy for psychosis (CBTp) should be offered to everyone suffering with psychosis. However, despite the high cost of psychosis care, and evidence of the clinical and economic effectiveness of CBTp, access remains problematic (NICE, 2014; Schizophrenia Commission, 2012). In addition to the service factors, such as prioritisation of other service demands over psychological therapies, lack of trained staff and limited supervision, that have limited the routine implementation of psychosocial interventions (PSI) in community settings (Brugha et al., 2012; Brooker and Brabban, 2004), individual patient characteristics influencing engagement may also restrict access (Prytys, Garety, Jolley, Onwumere & Craig, 2011). In particular, for people with psychosis, being housebound may be a key obstacle.

In a recent evaluation of cognitive therapy for psychosis delivered as part of a training course, most service users reported difficulty leaving the house, requiring therapy to be delivered at least partly at home (Jolley et al., 2013). An audit in our local trust indicated that 16.2% of all appointments with service users were home visits (Iredale, 2013). As home visits take considerably longer than a clinic-based appointment, with associated cost implications and mixed evidence for the effectiveness of assertive outreach working, they should be undertaken advisedly (Davies et al., 2014; Sood and Owen, 2014; Bhugra et al., 2014). Further investigation of the nature of houseboundness, and hence the value of home visits, particularly for the delivery of psychological therapies, is warranted.

The majority of studies of houseboundness are in older adults, demonstrating causal relationships between depression and isolation in housebound individuals, with indications of reciprocal relationships between being housebound and deteriorating mental health (Cohen-Mansfield, Shmotkin and Hazan, 2010; Ganguli, Gilby and Belle, 1996). In psychosis, being housebound is a common response to paranoia (Freeman et al., 2007); low mood, poor motivation and low self-esteem have been linked with lower activity levels and worsening positive psychotic symptoms (Waller et al., 2013) and isolation has been linked to increased conviction in delusions and limited recovery (Gayer-Anderson & Morgan, 2012; Jolley et al., 2012; Sunderman et al., 2012). Furthermore, being sedentary in the home exacerbates the physical health problems associated with psychosis (Dixon, Postrado, Delahanty, Fischer & Lehman, 1999) and antipsychotic medication (Robson and Gray, 2007), which in turn can further restrict people to their homes.

Indications are, therefore, that psychological interventions to address co-morbid affective and motivational problems may be usefully offered to housebound individuals, with the expectation of improving engagement in outside activities, and consequent benefit to both mental and physical health. However, no study to date has considered reasons for becoming housebound, and the potential benefits and costs of home-based psychological therapy for people with psychosis.

This study is a preliminary, qualitative evaluation of service user and therapist perspectives on these issues, aiming to guide delivery of therapeutic interventions and future systematic evaluation.

## 2.0 Method

### 2.1 Participants

Service users and therapists were identified through local community psychosis services. All therapists working in a borough-based<sup>1</sup> recovery service<sup>2</sup> and an early intervention service<sup>3</sup> were invited to be interviewed. Therapists suggested service users to whom they had offered or been requested to offer home-based interventions who may be willing to be interviewed.

## 2.2 Measures

Service user interviews focused on experiences of leaving the house; visiting the team base; access to psychological therapy; and service satisfaction. Houseboundness was categorised according to ability to leave the house at all, and, if able to leave the house, frequency and distance of outings, and ability to attend the team base. Experience of therapy was categorised according to location (home-based or team-based), mode of delivery (individual or family/group), and service context (Community Mental Health Team (CMHT) or other). Service user demographics (age, gender, ethnicity, and length of illness) were collected through self-report, supplemented by the clinical record.

Therapist interviews focused primarily on the past year, investigating experiences of working with housebound service users; perceptions of the reasons for houseboundness; and individual practice of, and rationale for, offering home visits and home-based therapies. Therapist interviews were anonymised and therefore only therapist gender and service setting were recorded.

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<sup>1</sup> United Kingdom National Health Service mental health provision in our locality, is organised by governmentally-defined administrative areas (London boroughs), each of around 280,000 population.

<sup>2</sup> The recovery service worked with adults (aged 18-65 years) who had an established psychotic illness. At the time of the project, the typical therapist to service user ratio was 1:750.

<sup>3</sup> The Early Intervention Service worked with adults and young people (aged 14 to 35 years) who have experienced a first psychotic episode. Early Intervention services are designed to provide high levels of support at an early stage in illness development in order to prevent relapse. At the time of the project, the typical therapist to service user ratio was 1:200.



## 2.3 Procedure

Service users were approached initially by staff who secured agreement for the interviewer to make contact. Therapists were contacted directly by email and at routine meetings, with the agreement of service leads. All interviews were completed face to face, by the first author (CI), at a time and place to suit the interviewees, lasting 15 minutes on average. Responses were transcribed verbatim. Approval was gained through the local trust audit committee (ref. PSYCHLO-13-18).

## 2.4 Qualitative analyses

Historical and current reasons for houseboundness were obtained from service user direct reports and therapist indirect reports of service users they had worked with. Service user and therapist interviews were then thematically analysed, as separate datasets, by the first author, using the method of Braun and Clarke (2006). Analysis comprised: i) reading and re-reading interviews; ii) surface coding using Nvivo8 (2008); grouping and re-grouping codes into wider themes; iii) continuous checking of code and theme 'fit' through reapplication to original transcriptions. Fit of excerpts to themes was second rated (by co-author SJ). Inter-rater reliability was high (service user themes: 93%; therapist themes: 85%). As substantial commonality was found in identified themes between the two participant groups, combined themes are reported.

## 3.0 Results

### 3.1 Participant characteristics

#### 3.1.1 Service users

Ten service users were interviewed (3 Male; 7 Female), aged 42 to 57 years (Mean: 48.1, SD 7.4). All were from the recovery service, with an average illness history of 8.3

years (Range: 1-20; SD 6.1); 70% were from black or minority ethnic (BME) backgrounds. All service users reported that they found leaving the house distressing. Just under half (40%) would not leave the house alone; 20% could go out locally (i.e. their own street/estate) but less than once a week; 20% could go out locally more than once a week; and only 20% could get as far as the clinic base. Nearly two thirds (60%) of service users had previously accessed therapy at a clinic base before becoming housebound (group therapy, n=6; individual therapy, n=3). At the time of the survey, 40% of service users were accessing psychological therapies in the home, either family therapy provided by the CMHT (n=2) or individual low intensity CBT offered through research from an outside organisation (n=2).

### 3.1.2 Therapists

Twelve therapists (4 Male; 8 Female) were interviewed from the promoting recovery (PR, n=8) and early intervention (EI, n=4) services. Of the therapists, by profession, ten were clinical psychologists, five of whom were in senior positions, one was a CBTp therapist and a Mental Health Nurse and one was a trainee clinical psychologist. Seven therapists (T1, T2, T5, T8, T10, T11 and T12) had worked with a service user at their home over the last year; four (T3, T4, T6 and T7), due to service restrictions, had not, and therefore drew on previous work with housebound service users.

### 3.2 Reasons for being housebound

Tables 1 and 2 show service user reported reasons for their houseboundness, and therapist reported reasons for the housebound service users with whom they had worked. Anxiety, paranoia, and amotivation were the most commonly reported reasons for being housebound.

Tables 1 and 2 here.

### 3.3 Themes

Identified themes and subthemes are summarised below and in Table 3, together with frequencies of occurrence.

#### 3.3.1 Theme 1: Access to psychological interventions

##### *Service user subtheme: Accessing the clinic base*

Most service users expressed concerns about public transport, which made accessing the base a distressing experience. Mobility problems were another common obstacle: five service users found walking very painful; three to the extent of needing to be driven to the base. Service users living alone relied on support from others or needed a support worker to access the base. Those living with others were often reliant on them to get out. Many service users expressed a dislike of the mental health service base, describing it as “depressing”, “distressing” and “scary”. One service user noted feeling unsafe around other people with mental illnesses.

##### *Therapist subtheme: Taking housebound referrals*

Therapist acceptance of housebound referrals depended primarily on their caseload capacity. All therapists from the early intervention team reported always accepting housebound referrals; therapists serving the larger recovery teams were less likely to work directly with housebound cases. Service requirements to maximize face-to-face therapy time often led therapists to refuse home. Therapist priorities and interests also influenced offers of home-based therapy. For example T2 reported enjoying the challenge and complexity of working with houseboundness, whereas T1 considered assertive engagement work with similar cases to be an inefficient use of time. Half of the therapists reported receiving few or no housebound referrals. This variously

reflected service restrictions; referral biases disadvantaging housebound cases; or a lack of housebound service users in the service. The majority of therapists acknowledged that had they not visited certain clients at home they would not have received any psychological therapy. In some cases, psychological therapy was the only help the service user was receiving.

### 3.3.2 Theme 2; Experience of psychological interventions

#### *Service user subtheme: Unhelpfulness/helpfulness of therapy*

Service users reported positive previous experiences of both individual and group psychological therapies. Five service users were receiving home-based psychological intervention at the time of interview; all found therapy helpful. For three service users psychological therapy was their primary contact with mental health services and in one case had prevented a crisis (overdose) from escalating.

Four service users reported negative past therapy experiences in some cases putting them off further intervention or accessing the base. Two service users reported previous therapy ending badly; feeling abandoned or not receiving closure or follow up. Others reported not enjoying therapy because of their reluctance to discuss the past and revisit bad memories.

#### *Therapist subtheme: Delivering psychological interventions in service users' homes*

All therapists reported home visits to be time-consuming for the individual and costly to the service. Both travel time (therapists reported just under an hour as an average return journey) and preparation time (e.g. packing therapy materials) for home visits increased compared to clinic-based interventions.

Therapists reported that disruption of privacy and physical distractions (smoking, television, lack of space) made the home environment less suitable for therapy than a clinic base. These problems adversely affected the therapeutic atmosphere, service user focus, therapist comfort, and the ability to maintain professional boundaries, often making it hard to distinguish psychological therapy from other professional visits. Problems with environment lessened when delivering therapy in supported accommodation as private spaces were often provided.

Seeing a service user in their own home was also seen as advantageous; providing a more complete assessment of mental state and revealing information that may not be mentioned at a clinic base. Therapists agreed that home visits could be valuable for any client, not just those who were housebound. Home visits had also averted crises, and facilitated in vivo psychotherapeutic work.

#### *Therapist subtheme: Success of home-based psychological interventions*

Psychological therapy was successful in helping the client to leave the house for 75% of cases discussed. For some, this change happened very quickly and for others it was a slower process. In many cases, therapy facilitated attendance at clinic-based team appointments, saving other professionals' time. Some therapists reported establishing clinic-based sessions after home visits. Others emphasized the importance of a client-focused therapy goal rather than aiming simply to leave the house.

#### 3.3.3 Theme 3; Motivation to engage with psychological interventions

Attitudes to future individual psychological therapy were positive (n=8) across the service user group, but group therapy was generally thought of more apprehensively. Half of the service users said they would consider going to a base for psychological

therapy. However, of these service users, many reported feeling unable to attend, and therefore missing previous appointments at the base, suggesting discrepancies between stated intentions and behaviour. Others felt they could not participate in psychological therapy unless it was conducted in their home.

Two therapists connected making effort to attend the clinic base for psychological intervention with the display of motivation to engage; suggesting that where therapy is taken to a client, this effort, and potentially the motivation behind it, may be lacking. Therapists also observed that engagement problems often arise from referrals motivated by carers or other staff rather than the individual themselves. Two therapists agreed that often home-based psychological therapy referrals reflected the team running out of options or not knowing what else to do. When service users' motivation to participate in psychological therapies is limited, therapists reported arriving for sessions to find clients otherwise occupied, unwilling to engage, or refusing to open the door, engendering therapist perceptions that their efforts are a waste of time.

#### 3.3.4 Theme 4: Case complexity

Therapists mostly described housebound service users as having complex difficulties, requiring a longer duration of therapy; often over a year, and a wider range of therapeutic interventions. One therapist noted the particular need for multidisciplinary input. Therapists reported using a number of different techniques with housebound clients such as graded exposure or acceptance and commitment approaches. Although change was acknowledged to be complex and multifactorial, therapists noted that interventions such as graded exposure, delivered by a supervised assistant psychologist or care coordinator, were sometimes enough to help people to leave the house more often.

### 3.3.5 Theme 5: Social and Support Needs

In some cases service users identified important unmet needs outside the remit of psychological therapy (e.g. help with housing or making friends). Three service users wanted increased social contact; three linked enjoyment of past psychological therapy to having someone to talk to. One therapist suggested that some people want to be seen at home to relieve feelings of isolation consequently finding more interest in general conversation than engaging with psychological processes, reducing the specific impact of therapy.

Table 3 here.

## 4.0 Discussion

This evaluation was designed to investigate service user and therapist perspectives on houseboundness and the perceived value of home-based psychological intervention. The overarching purpose was to inform therapeutic practice, and future systematic evaluation, balancing the need for fair access and potential benefit against high time cost in the context of limited therapy resources, and potential obstacles to effective delivery.

Therapists and service users identified similar causes of houseboundness. Anxiety was most common, closely linked with paranoia. Although delusions were not formally assessed, staying in the house often appeared to be an avoidant safety behaviour, consistent with cognitive models of the maintenance of psychosis (e.g. Freeman et al., 2002; Garety et al., 2007). Low self-esteem, amotivation and apathy were all specifically linked to houseboundness. Physical problems such as obesity, back pain and diabetes, and social care issues were prominent in service user and therapist reports and

were most common amongst those who left the house least, suggesting an interactive maintaining relationship.

Despite the reported obstacles, 40% of participating service users were currently engaged in home-based therapy. Of course, this was influenced by the sampling strategy, and much of the access comprised inconsistent delivery through research studies, rather than the routine service. Routine provision was primarily clinic-based, although offers of home visits notably differed between teams, depending on time, resource, caseload and therapist attitudes. In general, therapists in EI services reported smaller caseloads and a lower percentage of housebound referrals, resulting in a higher likelihood of delivering psychological therapy at home.

Therapists agreed that home visits were a less efficient use of resource than clinic-based appointments. However they were also clear that visiting someone's house could be very helpful, firstly to assess and formulate, and if indicated, to make a genuinely accessible offer of therapy. Therapists perceived home assessments as beneficial to therapy, giving invaluable insight into a service user's situation, and allowing in vivo work to test out home-based fears. With regard to therapy delivered in the home, therapists agreed that an initial offer of home visits could aid engagement. A consensus emerged that continuing therapy work in the home environment, particularly as a stand-alone intervention, tended to jeopardize the quality and focus of therapy, due to the complexity and heterogeneity of need and the unsuitability of some individual's home environments. Most therapists therefore supported the use of brief psychological interventions to help people to leave their homes, with a view to them accessing the base if longer term work was needed. Therapists found a range of therapeutic tools useful, but almost all had successfully employed 'low intensity' interventions to help people leave their house, reflecting recent research findings (Freeman et al., 2013;



Waller et al., 2013). Therapists reported finding this work more efficient when carried out in a multidisciplinary context, so that physical health, social support, and other needs could be addressed separately, thereby maintaining a clear therapeutic focus.

Some therapists viewed willingness to attend the base as an indicator of commitment to therapy, and better prognosis. The impact of therapist and service user expectations on outcome is complex, and under-researched, but negative therapist expectancies are unlikely to improve outcomes, and this should be considered in developing service protocols. Future research should consider whether motivation to engage in therapy is indeed higher in clinic attendees, and whether this improves outcomes. However, it is important to note that in this evaluation, even if respondents' motivation to engage in therapy was strong, accessing the clinic base was so distressing that they would still be unlikely to do so.

#### 4.1 Limitations

This was a small, cross-sectional, service-specific, and primarily qualitative, evaluation. The thematic analysis was carried out by psychologists, working within teams, with a particular interest in the delivery of psychological therapies: our personal and professional perspectives will inevitably have influenced our interpretation of the data, and this should be taken into account when considering the findings. Future research would benefit from consultation with service user advisors in developing themes. Service users were selected by therapists, and findings might not be representative of the target population. There was no comparison group to demonstrate specificity of findings to housebound service-users. A pragmatic, unstandardised definition of houseboundness was employed. The focus was service-defined, rather than user-led,

and future research should consider the fit of national recommendations with personal recovery goals. Nevertheless, in an unevaluated area of practice, the findings provide guidance for service development and future research.

#### 4.2 Clinical implications

Findings suggest that, because of unsuitable home environments, costs, and time restrictions, a primary aim of home-based therapy should be to facilitate leaving the home to access community resources. However, these obstacles should not limit offers of assessment and of brief therapy at home: findings suggest substantial potential benefits for a sub-population whose discomfort accessing the team-base would otherwise prevent access. The additional reported benefits of home visits suggest clinical worth in routinely offering home-based assessments of need, environment/circumstances, and motivation to engage in therapy for clients with complex and enduring mental health needs. Offering longer-term therapy at home appears less helpful, and current findings would not support this approach.

Given the known difficulties for frontline staff in implementing PSI, even in assertive outreach teams (Bhugra et al., 2014), a home-based assessment by a CBTp therapist may be helpful to contribute to a multidisciplinary assessment and formulation of the houseboundness. Psychotherapy may be indicated when psychotic symptoms such as delusions and hallucinations, or problems with mood, motivation and self-confidence contribute to houseboundness. In order to maximise the advantages of home-based therapy consideration should be given to the importance of establishing boundaries and ensuring other care needs are also met, to promote a clear therapeutic focus. Therapy appears likely to be most cost-effective when problems are specifically targeted, in a brief intervention, to avoid a lengthy home-based involvement.

Unless psychological factors are the sole contributors to houseboundness, our findings suggest that therapy should be delivered in a multidisciplinary context, alongside interventions to address physical symptoms where these contribute to houseboundness (Nour, Laforest, Gauvin & Gignac, 2006) and social needs, where these are the primary concern (Meltzer et al., 2013, Jackson et al., 2008)

Through assessment, stepped targeted care, utilising social or peer support or 'low intensity' interventions, like graded exposure, could be of particular value in alleviating distress and helping people to access the base for further therapy. Training frontline and support staff in these interventions, building on the learning from PSI implementation programmes, may offer a cost-effective means to improve access to therapy for this population.

#### 4.3 Future directions

The audit has identified areas for future service development, evaluation and research. Two key areas warrant further investigation: firstly, identification of the factors specific to houseboundness in psychosis (rather than to houseboundness irrespective of diagnosis, and psychosis irrespective of houseboundness); and secondly, variation in motivation for therapy and outcomes, according to clinic attendance. The effectiveness of low-intensity interventions is already being investigated in a local randomised controlled study (Waller et al., 2014); consideration of the specific impact on houseboundness would be of value.

#### 5.0 Conclusion

Home visits are resource intensive, but of clinical value and sometimes a necessary scaffolding to facilitate equitable access to NICE-recommended psychological intervention. Findings suggest that home-based assessment by a psychological therapist may be needed to formulate individual reasons for houseboundness, and the potential for psychological intervention. Home-based psychological therapy may be best offered in the form of brief, targeted interventions, with multidisciplinary support, to facilitate engagement and access to community resources to promote recovery.

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**Table 1: Reasons given by service users for being housebound**

Reason for houseboundness	Frequency (n=10)	%
Anxiety	8	80.0
Low self-confidence	4	40.0
Amotivation	3	30.0
Depression	3	30.0
Paranoid delusions	2	20.0
Physical disability	2	20.0
Trauma	2	20.0
Voices	2	20.0
Negative symptoms	1	10.0

**Table 2: Reasons given by therapists for previous clients housebound state**

Reason for houseboundness	Frequency (n=23 <sup>1</sup> )	%
Anxiety	16	69.6
Paranoid delusions	12	52.2
Physical disability	5	21.7
Amotivation	3	13.0
Institutionalisation	3	13.0
Low self-confidence	3	13.0
Trauma	2	8.7
Compulsive rituals	1	4.3
Depression	1	4.3
Dysmorphia	1	4.3
Negative symptoms	1	4.3

Key: <sup>1</sup>Work in the previous year in recovery (n=6) or early intervention (n=4), and work preceding the last year (n=13).

**Table 3: Identified therapist and service user themes with frequencies of occurrence and examples**

Super-ordinate Themes	Themes	Examples
1	Access to Psychological interventions	
a	Accessing the clinic base (9SU, 0T) <ul style="list-style-type: none"> <li>Concerns about using public transport (7SU)</li> <li>Dislike of CMHT base (5SU)</li> <li>Reliance on support from others to attend (5SU)</li> <li>Mobility problems (5SU)</li> </ul>	<ul style="list-style-type: none"> <li>“getting the bus [is] an incredibly stressful experience” (SU3);</li> <li>“always leave the place sweating” ... “people there are frightening”... “[the building is] full of suffering” (SU4);</li> <li>“would not have gone to the base [but] someone ... came and drove [me]” (SU1); “[pain is] worse when [I’m] moving around” (SU10)</li> </ul>
b	Taking housebound referrals (0SU, 11T) <ul style="list-style-type: none"> <li>Capacity influences referral acceptance (4T)</li> <li>Service requirements can lead to refusal of home visits/ or lack of referrals (4T)</li> <li>Therapist interests influence referral acceptance (2T)</li> <li>Seeing housebound referrals gives access where it would have been restricted (8T)</li> </ul>	<ul style="list-style-type: none"> <li>“as a full time therapist... [in an EI team I have] more time to see people at home...can afford to spend longer on home visits.... partially why never turned anyone down for therapy who was housebound” (T10)</li> <li>“[service name] only see people at the centre who are willing to attend” (T4)</li> <li>“Never turn down working with people who are housebound. It is more of a challenge but that is encouraged” (T2)</li> <li>“[client] ... would not have access to therapy unless they were seen at home” (T5)</li> </ul>
2	Experience of psychological interventions	
a	Unhelpfulness / helpfulness of therapy (7SU, 0T) <ul style="list-style-type: none"> <li>Previous therapy helpful (6SU)</li> <li>Off-putting previous therapy experiences (4SU)</li> <li>Therapy as main contact with the team (3SU)</li> <li>Therapy averting crisis in the past (1SU)</li> </ul>	<ul style="list-style-type: none"> <li>“[therapy helped to ] lift me out of my mood” (SU7)</li> <li>“didn’t like constantly talking about bad memories it made things worse” (SU10)</li> <li>“[Before therapy I was] not seen by anyone at home”. (SU4)</li> <li>“[Therapist] came round and helped ..... when [I had] been having suicidal thoughts” (SU4)</li> </ul>
b	Delivering interventions in service users homes (0SU, 11T) <ul style="list-style-type: none"> <li>Time consuming and costly (12T)</li> <li>Physical distractions (5T)</li> <li>Disruption of privacy (5T)</li> <li>Adverse effects on therapeutic atmosphere (2T)</li> <li>Therapist discomfort (3T)</li> <li>Blurred professional role (4T)</li> <li>Crisis aversion (1T)</li> <li>Richer assessment (6T)</li> <li>In vivo facilitation (3T)</li> <li>Home visits having value in general (4T)</li> </ul>	<ul style="list-style-type: none"> <li>“Travel times to appointments are also a big issue” (T8)</li> <li>“negotiate issues arising at home to prepare for therapy... turning off the television” (T10)</li> <li>“interruptions from family, extended family and children... if living in a family home” (T7)</li> <li>“People feel they can smoke ... as they are in their own house which can be distracting and also really unpleasant if you are not a smoker” (T1)</li> <li>“hard to refuse cups of tea while at the same time not being rude or offending people” (T6)</li> <li>“If that home visit had not happened the crisis could not have been dealt with” (T7)</li> <li>“you can take in someone’s whole environment...do a far more complete assessment of their wellbeing..” (T2)</li> <li>“.. allows you to carry out behavioral experiments in context ... learning is more applicable” (T6)</li> <li>“huge positives... to see them in their context... to observe things that people don’t talk about” (T1)</li> </ul>

**Table 3: Identified therapist and service user themes with frequencies of occurrence and examples**

c	Success of home based psychological interventions (0SU, 7T)	<ul style="list-style-type: none"> <li>• 75% success helping clients to leave the house (Total calculated across therapist reports)</li> <li>• Goal not always to leave home (4T)</li> <li>• Therapy has facilitated attendance at team base (4T)</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“the goal of the therapy was not always to leave the house and therefore some people didn’t necessarily make it out” (T8)</i></li> <li>• <i>“One person was having sessions at the team base instead of at home within 5-6 weeks” (T8)</i></li> <li>• <i>“By the end of therapy clients had established clinic based appointments” (T7)</i></li> </ul>
3	Motivation to engage with psychological intervention (10SU, 5T)	<ul style="list-style-type: none"> <li>• Positive attitudes to psychological therapy (8SU)</li> <li>• Discrepancies between intended attendance and behaviour (4SU)</li> <li>• Could only engage with home-based therapy (5SU)</li> <li>• Importance of referrals coming from client rather than team for motivation (3T)</li> <li>• Motivation as a barrier to home based therapy (2T)</li> <li>• Therapists link motivation to attendance (2T)</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“I’d try anything” (SU3)</i></li> <li>• <i>“could force myself to go to the base [for therapy] if needs be .... would really like it.” But has only managed to make it to the base once in past year, and is seen by all staff at home.(SU10)</i></li> <li>• <i>“if therapy was only offered at a team base...would not attend” (P1)</i></li> <li>• <i>“Problems can be family or care givers referring for therapy when the service user doesn’t want to engage in it.... [therapy is] often seen as another resource to care coordinators when they can’t do anything else.... it’s these cases that waste time” (T4)</i></li> <li>• <i>“the service user may not actually be prepared to engage upon arrival... may not be in, or if they are in may be unwilling to engage.... may be asleep or just occupied with something else” (T4)</i></li> <li>• <i>“there is a question of whether or not they are really motivated enough to engage with the service, especially if they are not completely housebound and do go elsewhere” (T5)</i></li> </ul>
4	Case complexity (0SU, 9T)	<ul style="list-style-type: none"> <li>• Longer duration of therapy (5T)</li> <li>• Need for multidisciplinary input (1T)</li> <li>• Change is complex and multifactorial (1T)</li> <li>• Wider range of interventions (2T)</li> <li>• Use of ‘low intensity’ interventions (3T)</li> <li>• Support from junior staff members (4T)</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“...requires<sup>a</sup> a huge investment of time and the cases are often very complex” (T2)</i></li> <li>• <i>“a team effort... medical reviews, care coordinator input alongside psychology”(T2)</i></li> <li>• <i>“It (therapy) was very complex... to explain the improvement (in leaving the house)” (T7)</i></li> <li>• <i>“work ends up being centred around anxiety rather than psychosis... use other methods” (T3)</i></li> <li>• <i>“for all<sup>a</sup> behavioural experiments and graded exposure were used to some degree” (T7)</i></li> <li>• <i>“Extra Low intensity work was done with her to help this by an assistant psychologist” (T11)</i></li> </ul>
5	Social and support needs (5SU, 1T)	<ul style="list-style-type: none"> <li>• Making friends (1SU)</li> <li>• Housing (1SU)</li> <li>• Therapist as someone to talk to (3SU, 1T)</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“...to be more sociable, I need friends...I only see family” (SU1)</i></li> <li>• (team) <i>“... is not helpful for the main difficulties...housing and relocating” (SU6)</i></li> <li>• <i>“some people want to be seen at home to remove feelings of social isolation and just need befriending and want social contact.” (T4)</i></li> </ul>

**Key:** SU= service user: T= Therapist <sup>a</sup>Housebound people receiving therapy/ working with housebound people