Enabling Homeless People to access Psychological Help

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Homelessness in London and Westminster 2021

2021 FIGURES

London accounts for 27% of the total number of people sleeping rough in England

714 : 2,688

Westminster consistently remains the local authority with the highest number of people sleeping rough 242

34% for London

9% for England

Homeless Link (2021)
Westminster Homeless Health counselling service

Based in Westminster Homeless Services

• Two Homeless Day Centers
• Two Specialist Homeless GP surgeries

Referral Sources

• Homeless Health Nurses (CLCH NHS Trust)
• Homeless Mental Health Team (JHT)
• IAPT
• MH Hospital
• Hostels
• Self-referral
Initial Aim

RE-MORALISE

- rough Sleepers
- Sofa Surfers
- Hostel residents
- Temporarily accommodated

To relieve immediate distress & reactivate basic coping resources.
Extraordinary Challenges

Marginalisation/Exclusion
- sleep deprivation
- Hunger
- blood sugar levels
- Cold
- Survival
- Fleeting Attention
- Multiple Appointments
- Stigma
- Compound trauma *

Clinical
- Tri-morbidity *
- Complex Trauma *
- Toxic Help *
- ‘Epistemic Mistrust’ *
- Emotional Deregulation

Systemic
- Continuum of Harm *
- No recourse to public funds
- Ref Criteria
- Waiting lists

*(see Appendix 1)
Westminster Homeless Health Counselling Service (WHHCS)

Enhanced Service

IN ADDITION TO INITIAL AIMS, WE FOUND OURSELVES HAVING TO

- **REMEDiate**
  focus on symptom relief/management

- **REHABIlitate**
  unlearn maladaptive coping processes and replace them with more adapted ones

BUT HOW TO ENGAGE
1. PRETREATMENT

- Stages of Change, (Prochaska & Norcross 2003)
- Common Language development
- Motivational Interviewing (Miller & Rollnick, 2012)
- Trauma-Informed Care Principles, (SAMHASA, 2014)

2. TRAUMA RECOVERY STAGES

(Herman, 2015)
- Safety (emotional regulation and stable circumstances)
- Remembering & Grieving
- Restoring Relationships

3. ATTACHMENT

- Secure Base’ (Bowlby, 2005, Holmes, 2018).
- Mentalization’ (Bateman & Fonagy, 2004, 2006, 2016)

4. SUPPORT, ADVICE, SIGNPOSTING
• **DROP-IN (1:1) - SELF REFERRAL**
  • variable time sessions
  • secure base, **re-moralize**, empower & support engagement with other services

2. **DROP-IN GROUPS**
  • 1.5 hrs sessions
  • clinical focus: secure base, **re-moralize**, accustom to group dynamics, enhance mentalisation

3. **COUNSELLING (APPOINTMENTS)**
  • Up to 50 mins
  • reframe narrative of failure
  • re-moralize/ remediate/ (part) rehabilitate
  • Gender Specific

4. **FOLLOW-UP SUPPORT**
CLINICAL FOCUS:

PRE-CONTEMPLATION/CONTEMPLATION STAGE
– Relief from distress (cannot contemplate changing)
– Given up hope of changing (past failures at changing)
– Explore Ambivalence, Reframe Narrative of Invalidation

NO EXPECTATION OF RETURNING - MAKE IT WORTHWHILE TO!

• Demonstrate Care – cup of tea, empathy, compassion
• Emphasis on own Body Language – Not to re-traumatize
• Transparency/‘Mutuality’/levelling of power differences
• Motivational Interviewing – ‘Active Listening’
• Common Language development
• Attachment style
• Trust & Safety (emotional & material)
• Support, stabilize, assess, advise, signpost - Refer in/out

RE MORALISE
Support & Discussion Groups (drop-in)

- no appointment necessarily
- 1.5 hr sessions

CO-DESIGNED & FACILITATED WITH EX-SERVICE USER

PRE-CONTEMPLATION/CONTEMPLATION

DROP – IN AND ‘OPEN MEMBERSHIP’

PRE-GROUP SOCIAL TIME

BASED ON AA PRINCIPLES AND YALOM 'GROUP DYNAMICS', (2005)
SESSION STRUCTURE

• VERBAL SIGNING IN
  • encourage all to participate
  • all invited (but not obliged) to introduce themselves
  • describe the reasons for interest in the Anger Group
  • open discussion (re anger issues; members led)

2. VERBAL SIGNING OUT
  • All invited (but not obliged) to summarize any personal highlights gained from the session.
  • help consolidate any learning
'Drop-in' Support & Discussion Groups (principles)

PRINCIPLES

VALIDATE

- group dynamic habituation
- How get, keep, let go of attention?
- 'open dialogue'
- share techs, contacts, services, signpost
- Common language building/use

KEEP ON TASK

- All invited (but not obliged) to summarize any personal highlights gained from the session.
- help consolidate any learning

SAFETY/TRANSPARENCY

- Peer Support
- Empowerment,
- Voice
Individual Counselling

- appointments only
- Up to 50 min sessions

CONTEMPLATION/ACTION/RELAPSE/MAINTENANCE

CONSOLIDATE

- Trust, safety, attachment style, boundary tolerance, remembering & grieving

PD (NICE GUIDELINE 78, (2009)

BRIDGING LANGUAGE - RE-SRIPTING - PSYCHO-EDUCATION

Trauma Recovery Stages

SUPPORT REFERRALS
MANAGE ABSENCES & ENDINGS
‘CRITICAL TIME’ INTERVENTIONS
CULTURAL, HISTORICAL, GENDER ISSUES
Ilustrative Case Study 'Mr. X'

BACKGROUND

- lives in a hostel, wanders the streets, crying
- once highly functional – successful businessman
- violent, alcoholic Ex-Partner
- history of ineffective MH treatments
- ASHAMED/HUMILIATED
- DISBELIEVING of any EFFECTIVE HELP
- Hopeless, Chronically suicidal
- refuses medication
- refuses to see any MH professional
'Mr. X' treatment

PRE-ENGAGEMENT
(PRE-CONTEMPLATION STAGE OF CHANGE)

• Used Drop-In intermittently
• Active listening revealed main waiting room to be ‘triggering’
• demonstrated care by freeing an individual room to wait in.
• Common Language Building
  ◦ revealed an ‘Invalidating’ and emotionally deprived history
  ◦ life script of un-redeeming failure, unworthy of help,
    confirmed by history of ‘Toxic Help’.
"Mr. X"
treatment

ENGAGEMENT
(CONTEMPLATION/ACTION STAGE)

Appointment Based Counselling

• Life journey reframed as:
  ○ Undiagnosed ‘Traumatised Personality’ (PD)
  ○ History of ‘Toxic Help’ due to addressing presenting issues only, e.g. depression, anxiety; but not PD.

• Self-blame Contextualised as ‘Internalisation’ of:
  ○ Historical & Contextual ‘Invalidating Script’,
  ○ ‘Disorganized’ Attachment Style
  ○ Negative Identity ‘My life is a disaster’,
  ○ ‘I am beyond help’, ‘People are right’.
'Mr. X' treatment

**ENGAGEMENT**
**CONTEMPLATION STAGE**

Appointment Based Counselling

3. Hope inspired by describing
   - Practical and Therapeutic support available
   - PD treatment referral option when ready

4. Acknowledging and working with chronic suicidal Intent
   - One weekly session to three weekly sessions
   - ‘Crisis Plan, Samaritans,
   - Planning for ‘Trigger Points’ like Christmas
'Mr. X' treatment

CONTRACTING
(CONTEMPLATION ACTION STAGE)
Accessing MH Social worker, Housing, PD treatment centre

ACTION STAGE
Engaging with above services
MAINTENANCE STAGE (RELAPSE PREVENTION)

PERMA (Seligman, 2011):

- Positive emotions (on regular basis)
- Engagement (Total absorption in something)
- Relationships (positive ones)
- Meaning – (belonging to & serving something bigger than the Self)
- Achievement (Sense of mastery, accomplishment)
Further Service Characteristics

- All 3 Counselling Modes can be attended in parallel. Rich synergy between joint attendance individual and group work.
- Critical Time Intervention - Support calibrated according to need.
- Open Door – Secure Base – People can re-engage once discharged.
- Referrals out – supported.
- Weekly Counselling Team meetings.
- Clinical Supervision – Reflective Practice.
- MDT case meetings.
Pre-treatment Therapy

is a Psycho-social approach using evidence based practice:
  • trauma informed care
  • Attachment Theory and Mentalization
  • Motivational Interviewing

Conclusion

Further Developments

Commissioned Pre-treatment Therapy Services:
  • Humber Teaching NHS Foundation Trust, Assertive Engagement Team
  • South East Essex Community Psychological Services
  • CLCH NHS Trust, Specialist Weight Management Service

Endorsed by Homeless and Inclusion Health faculty
  ▪ Faculty Mental Health and Homelessness Forum
Compound Trauma: Cumulative effect of several unresolved trauma – something homeless people very exposed to (Cockersell, 2018).

Complex Trauma: PD; estimated at 68% and 58% using diagnostic measures, (Maguire et al 2009, cited in DOH, 2010).

Continuum of Harm: How systemic interactions can multiply and entrench complex disadvantage (Johns et al, 2021).
**Epistemic Mistrust** – where due to a history of trauma, recipients do not believe what they are told and assume the communicator’s intentions as malevolent, and the communication not coming from a deferential source (Bateman & Fonagy, 2016).

**Toxic help** – Figures or treatments designated to help, but the effect of which is negative and the patient carries the blame for the intervention’s failure (Conolly, 2018a, 2018b).

**Tri-morbidity** – a combination of Physical, Mental, Addictions based ill health. (Faculty for Homeless and Inclusion Health, 2013).
Re-moralise, Remediate, Rehabilitate

Part of the Clinical Outcomes in Routine Evaluation framework (CORE).

This popular UK clinical audit instrument is based on a 3 phase model of psychotherapy

(Lepper & Riding, 2006,p12)
<table>
<thead>
<tr>
<th>Engagement Stage</th>
<th>Goal</th>
<th>Interventions</th>
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<tbody>
<tr>
<td>1. Pre-engagement</td>
<td>Trust</td>
<td>Demonstrate Care Understand Language ‘Active Listening’, Observe, listen, reflect, ask what words/ phrases &amp; gestures mean, discover what is important</td>
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<td>2. Engagement</td>
<td>Motivation to change</td>
<td>Explore Ambivalence Reframe Narrative of Invalidation Use Common Language: Ask questions Agree counselling role Verbalise aspirations Jointly define goals Jointly id supports</td>
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<td>3. Action</td>
<td>Material commitment to Change</td>
<td>- Support Ref In/Out</td>
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<td>- Use ‘Bridging Language’</td>
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<td>Apply ‘Common Language’ to language used by other services</td>
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<td>- Reframe Service terms, phrases to be consistent with ‘Common Language’.</td>
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<td>- Prepare service staff re client language and/or ‘trigger’ terms, phrases.</td>
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<td>4. Maintenance</td>
<td>Change Consolidation</td>
<td>Review the Work Completed</td>
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<td>Reinforce Support Systems,</td>
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<td>Redefine <em>Client-Worker Relationship</em>, but ‘Open Door’ to *Remoralise’ &amp;</td>
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<td>Redirect to <em>Established Support Systems</em></td>
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Trauma Informed Principles

1- Safety – Physical & Psychological
Suicide risk?, How can we become a ‘secure base’? Great attention to body language so as not to ‘re-trigger’.

2. Trustworthiness & Transparency – operations and decisions conducted transparently, rationale openly shared and explained including need for boundaries.

3. Peer Support - Peer support and mutual self-help are key vehicles for establishing safety and hope – See ‘Support & Discussion Groups’.

5. Empowerment, Voice & Choice - supported in shared decision-making, choice and goal setting – ‘Menu of service provision to choose from – attend all?’

6. Cultural, Historical & Gender Issues - actively moves past cultural stereotypes and biases, offers, access to gender responsive services, and recognizes and addresses historical/cultural trauma – openly acknowledge cultural context to Asylum Seeker trauma – Woman Counsellor re Women specific needs.
References(1)


References (2)


References (3)

References (5)

Faculty for Homeless and Inclusion Health, 2013,


**Herman, J.**, (2015), Trauma and Recovery, The Aftermath of Violence From Domestic Abuse to Political Terror’, Basic Books
References(6)


References (7)


References (8)


SAMHSA’s Trauma and Justice Strategic Initiative, 2014, ‘SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach’, https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf, accessed 09.05.2021

