From Symptoms to People

A Counsellors' Enhanced Response

to Multiply Excluded Homeless People'

Slide Design, Paul Ashton

John Conolly, January 2015

In her report of the multiple exclusion homelessness research programme, McDonagh (2011), described how homeless people were exposed to further exclusion by:

their complex needs being construed by hostels, as evidence of chaotic behaviour, rather than vulnerability, and therefore not meeting their acceptance criteria.

John Conolly, January 2015

Homeless Cycle of Exclusion

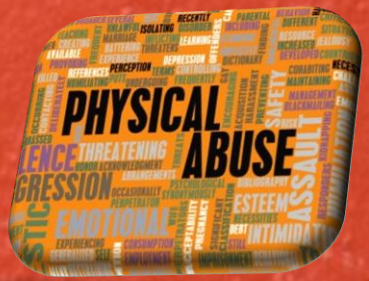
Finds a night shelter

Needs to drink to avoid DTS is told to leave

Gets placed in hostel

Arrested for fighting with another resident

Out of prison back on the street



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The Challenge of Complex Trauma – Personality Disorder

It is estimated that: 70% of Single Homeless (Maguire et al, 2009).

73% Prison Population, (Ministry Justice,2007).

77% of Suicides (DOH, 2009).

67% Mental Hospital Populations, (NIMHE 2003). Have PD as opposed to :

4% of General Population (Coid et al, 2006).

High Stakes

One particularly dangerous aspect of PD is that in their search to meet their emotional and psychological needs, PD patients will continually up the ante until the destruction wrought upon themselves or others is so great that it can be no longer ignored, and usually culminates in emergency admissions (Burns, 2006).

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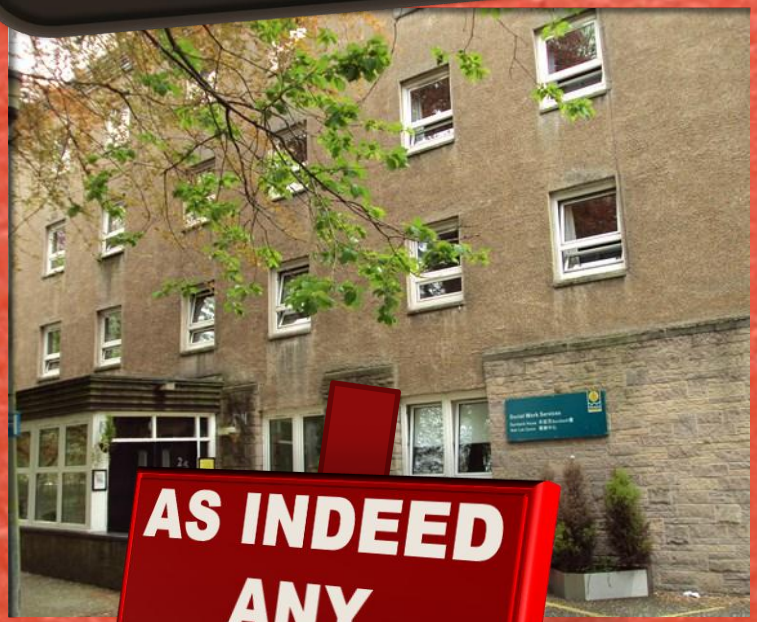
Enhanced Response



By failing to respond in the ‘enhanced ‘manner needed to engage, and help homeless people address their underlying vulnerabilities, these hostels become yet another part of the ‘marginalisation process’.

AS INDEED ANY SERVICE!!

John Conolly, January 2015

Perfect Integrated 'Patients'

Historically homeless people, due to their unsettled circumstances and state of mind, have been perceived as unable to make use of mh and psychological services.

In my own Psychology and Psychotherapy trainings the following were very much stressed as patient pre-requirements:

- Psychological mindedness
- Ability to reflect
- Connect with and articulate feelings

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2. Perfect Integrated ‘Patients’

Be Crisis and addiction free (as impedes the above)
Stable situation (housed)
Be able to develop and maintain a ‘therapeutic’ alliance
Regular attendance
This to withstand the emotional rigours and challenges of treatment aimed at replacing destructive defences with constructive ones.

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Marginalised & Marginalising Patients

However, When I started I found homeless patients would:

- Miss their appointments , attend sporadically only, or simply drop out.
- Be extremely suspicious of my intentions or want me to be their best friend or both within even the same session.
- Have limited attention spans
- Be unable to reflect
- Be unable to access their feelings or be overwhelmed by them and self-medicate or self-harm.
- Have outbursts of fury and be intimidating if not threatening, to me, to others
- Be in a Crisis
- Have a variety of urgent pressing non psychological needs

I don't think outside the box I think of what I can do with the box

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Enhanced Clinical Practice

I found that I would:

- Validate and empathize with people a lot more
- Be more transparent regarding my thoughts, feelings, decision making processes, requirements
- I would explain things a lot more
- I found the need to 'suspend judgment', to keep an 'open mind' to be that much greater
  - Otherwise I would disbelieve experiences told me, which lay beyond not just my own experiences but even beyond my own conception of what might be possible

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Enhanced Clinical Practice Ctd.

I would **liaise** with keyworkers
I would **negotiate boundaries**, rather than assume I could **demand** them.
Be more **flexible** re Session duration and Non-attendance
I established '**Drop ins**' with no expectation of repeat sessions
As long as I thought people would gain from talking with me I would see people **mildly to moderately intoxicated**
Sessions would **follow individuals' attention spans** rather than a rigid pre-determined time period
The **number of weekly sessions would be according to patient need**, so that in periods of crisis they could be increased.

I don't think outside the of box I think of what I can do for the person living in that box

John Conolly, January 2015

Professional 'Super Ego'

All the while however, I would be aware that I was not following my original training, that I was going beyond it.

Something Colleagues and myself came to label: 'THE PROFESSIONAL SUPEREGO' (Greenway, 2014,)

There was a constant concern NOT to confuse 'Boundary crossing with 'Boundary violation' (Gutheil, 2005):

Boundary crossing - temporary, non –exploitative deviations from 'classical/general practice that do no harm and actually help

Boundary violation, - harmful deviation from the norm

One major distinguishing factor being whether these deviations can be discussed in the public domain, in Supervision, with other colleagues.

Slide Design, Paul Ashton

Pre-treatment

New ways of conceptualising the nature of an enhanced psychological approach to multiply excluded homeless people are emerging such as:

PRE-TREATMENT

‘ an approach that enhances safety while promoting transition to housing, and/or treatment alternatives through patient centred supportive interventions that develop goals and motivation to create positive change’ (levy 2013)

Slide Design, Paul Ashton

John Conolly, January 2015

Pre-treatment Principles 1 - 3

1. Promote Safety – crisis intervention, use opportunity for further work

2. Develop relationship – engage in a trust, safety and autonomy promoting manner while developing goals (Motivational Interviewing techniques, Person centred listening skills)

3. Common Language Construction – try to understand homeless person's world by learning meaning of his/her gestures, words, and actions – promoting mutual understanding and jointly defined goals

Slide Design, Paul Ashton

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Pre-treatment Principles 4 - 5

4. **Facilitate and Support Change** – point out discrepancies, explore ambivalence, reinforce healthy behaviours and developing skills, as well as needed supports – use **Change Model & Motivational Interviewing Principles**. (Miller & Rollnick, 2013).

5. **Cultural and Ecological Considerations** - **Prepare and support homeless person for successful transition and adaptation** to new relationships, ideas, services, resources, treatment, accommodation etc.

Conclusion - Levels of Enhanced Response

1.Individual practitioner

Enhanced Clinical Practice,

Supervision,

Experts By Experience

2.Service level

Psychologically Informed Environments –

PIES

3.Institutional Level

- **Faculty Guidelines**
- **Curriculum Development (Unis of Brighton, Westminster)**
- **Research**

4.Government Level

- **Knowledge and Understanding Framework for Personality Disorder - KUF PD.**
- **Knowledge and Understanding Framework for Homeless/Exclusion Health???**

Slide Design, Paul Ashton

John Conolly, January 2015

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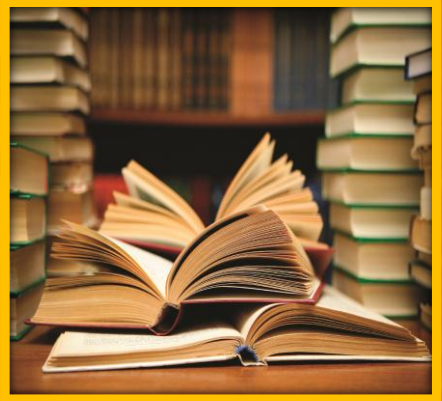

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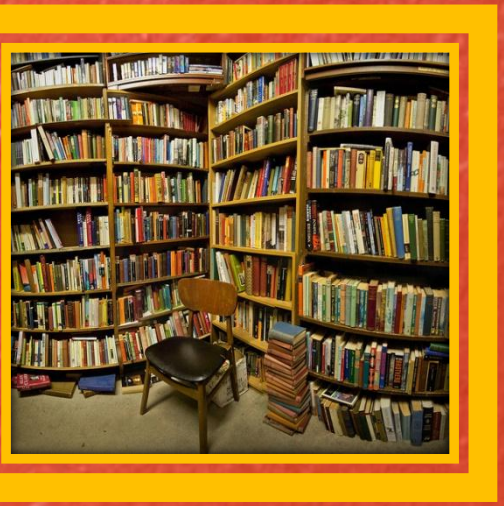

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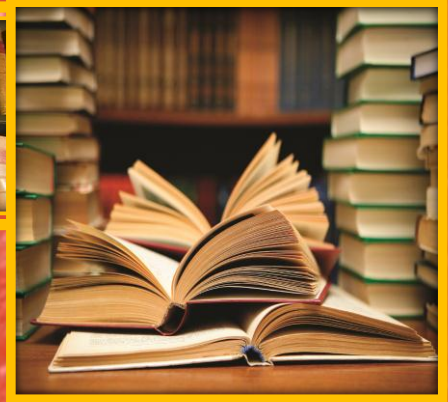

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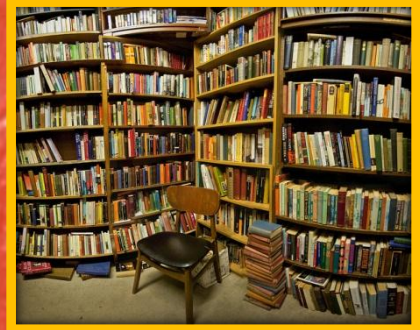

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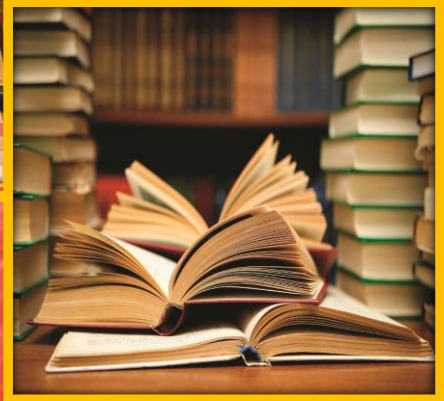

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