Central London Community Healthcare NHS
NHS Trust
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Inclusion Counselling:

Improving access to therapy for ex-street homeless & multiply-excluded clients living in hostel accommodation

Providing community healthcare
in London and the Home Counties

Counselling pilot project- established at King George's Hostel in October 2014.

Continued commissioning of project into the longer term, based on initial/ongoing perceived of success in terms of client engagement, stabilisation and some degree of minimisation of harmful/problematic behaviours.

Move on into rehab programmes and settled accommodation in some cases.

Approach & ethos:

Making therapy accessible for individuals considered 'multiply excluded'- e.g. vulnerably housed and/or in active addiction.

Such circumstances are often considered 'beyond the pale' of traditional therapeutic modalities and approaches.

Considered to lack adequate stability of lived-circumstances, and attendant-capacity to tolerate and benefit from the challenges inherent in therapeutic process (sharing past trauma and loss, reflecting on self-concept, difficulties and contemplating meaningful lifestyle change).

Clients are initially referred by hostel keyworkers. Usually verbal/informal introduction or via email.

Followed up with introductory three-way meeting.

In turn followed up with very tentative/informal outreach contact. Being an available presence in hostel. Follow up with agreement to meet for conversation in dedicated practice space, if wanted on that particular day.

Progress on to appointment-based, more regular meetings if initial conversations are found/reported to be helpful.

Is this counselling or therapy as typically understood?

No: lack of formal structure, contracting and fixed boundaries. (Boundaries are still fundamentally important, but flexible and negotiated.) Closer to outreach/link-working in these regards.

Yes: Involves two people talking confidentially about the life-situation and problems of one of them.

Approach progresses towards working in a dedicated practice space for an agreed period, establishing the beginnings of a therapeutic alliance and trustworthy working relationship. Pre-treatment therapy.

Some key considerations:

- Flexible-negotiable approach to building the working relationship and establishing a ‘frame’ requires very careful consideration of boundaries.
- In order to moderate and innovate, very thorough knowledge, understanding and experience of more traditional therapeutic modalities and orientation is required.
- Necessary for establishing a baseline for practice, and for apt interpreting of challenges to the therapeutic frame, and possible meanings and resonances of these to the ongoing work & process.

What the project looks like, on a day to day basis:

Each week- typical timetable:

4-5 Brief, informal/opportunistic conversations with residents.

2-3 Fifty minute counselling sessions with regular clients

An hour+ catch up with staff team, verbal referrals and case-introduction, (informal) reflective practice, three way introductory meetings with new residents.

What the work principally involves:

Primary focus on relationship building:

-Establishing some basis for trust/exploring difficulties with/reasons for mistrust.

-Empathic/negotiable boundary-setting.

-Reflective validation of narrated-perspectives, seeking to foster and develop a common-language.

-Staying largely with the present, priotise exploring current dilemmas, options and needs. Also encouraging exploration of the actual here-and-now encounter between client and practitioner. (Avoid hasty exploration of deeper/past issues and associated risk of retraumatisation.)

What the work principally involves:

Secondary focus on progressing toward establishing a therapeutic alliance:

-Opening pathways to new meaning-making and contemplation of/commitment to lasting change. Preparing for move on from temporary/transitional housing situation, evaluating and considering what that might look like, what might be wanted or hoped for in the future.

-Working with trauma as ‘unresolved narrative’. Beginning to find space in mind to reframe the relationship with troubling and damaging past experiences. (Therapeutic (existential) theory perspective on early/developmental trauma as a shocking, disturbing or otherwise unsupported encounter with meaninglessness and/or loss of structure.)

Conclusions:

Hostel Counselling Pilot is founded on the principles of **Pre-treatment Therapy**, and entails mindful, contextualised-understanding that encounters with clients at very difficult, disorientating stages of their life-journeys are necessarily tentative, partial and intermittent.

It is vitally important to respect fully clients' experience as survivors and the considerable tenacity, fortitude and resourcefulness this will likely have entailed.

In view of this, having **very moderate expectations** in terms of outcome-measures can be helpful, setting objectives around establishing a 'pre-alliance', and supporting pre-contemplative and contemplative stages of change.

Conclusions:

A significant challenge for an ‘in-reach’ counselling project such as this, is one of usefully supporting homeless clients’ progress toward feeling **ready to take responsibility** for their own particular life-situation. Breakthroughs in regard to this can often involve coming to some degree of realistic acceptance of how things are- even in the face of appalling experiences of loss and abuse- and drawing from this greater recognition of capacity to choose, to consider “what can I do to progress from here?”

In light of this, preparation for- and clarification of- what a sustainable, ongoing and individualised journey of recovery might be like, can be a significant part of what engagement in counselling dialogues can usefully offer at a pre-treatment stage.