Long-term Counselling in a Post-refuge Environment

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Not all young people are adequately supported by 'mainstream' mental health, counselling, or therapeutic services. They are either considered 'too unwell' for primary care services, or 'not unwell enough' for specialist services; they fall through the gaps. Their way of navigating and surviving homelessness services can be challenging, leaving before a success is achieved or engaging in 'push-pull' dynamics with practitioners. What we present here are our anecdotes on two-years of providing long-term psycho-dynamically informed therapeutic services to young people whose needs have not been met by mainstream services.

Background

For the past decade Hope Street Youth and Family Services (Hope Street) and the Substance Use and Mental Illness Treatment Team (SUMITT) of North Western Mental Health have been in a partnership under the Homeless Youth Dual Diagnosis Initiative (HYDDI).[1] Under this partnership, a Specialist Practitioner/Senior Clinician from SUMITT is co-located within Hope Street and the wider youth homelessness network. The original, and ongoing, aims of the program are to improve the capacity of practitioners within the supported crisis accommodation (youth refuges) services of the youth homelessness sector to identify and respond to issues arising from poor mental health or substance use among the young people that utilise the youth specialist homelessness services (SHS).

An Identified Gap

One of the gaps that arose on a repeated basis for some young people who were engaged with SHS agencies was a large 'missing-middle' in terms of psychological or therapeutic supports. Unless they had relatively uncomplicated psychological needs, they were 'too unwell' for primary care services provided through generalist counselling services or General Practitioners with referrals to more specialist counsellors and psychologists who do not charge any out-of-pocket fees. Unless they posed an immediate risk to themselves or others, they were 'not unwell enough' for specialist mental health services.

Photo by Hilary Faye for Hope Street Youth and Family Services

As a consequence of their needs not being met, some young people find it incredibly challenging to navigate and survive in the sector because of repeated failures perpetrated against them during their formative years. Previous editions of this publication have attested to the high rates of poly-victimisation and complex-developmental traumas perpetrated against young people.[2] The effects that these experiences have upon the way that young people learn to navigate and survive are also well known.[3]

The combination of long wait-lists and previous negative experiences with professionals in clinical settings make some young people reluctant to go and see another stranger. Some of those who do see another stranger report being regularly asked questions such as '…and how does that make you feel?' which, while well meaning, can be particularly harmful for some young people especially when asked by professionals who lack experience working with young people for whom homelessness is just the 'tip of the iceberg'.[4] The young people who have greatest difficulties arising from repeated failures perpetrated against them during their formative years are at the greatest risk of 'falling through the gap'.

The Approach

Two years ago, the HYDDI and Youth Reconciliation Program (YRP) practitioners, with support from Hope Street and SUMITT, began long-term work with some young people beyond their involvement with crisis accommodation services.

The approach brought different and complementary skill sets to the work. The YRP practitioner brought considerable experience in teaching self-soothing and affect-regulation, and principles from Solution-Focussed and Acceptance and Commitment Therapy to teaching distress tolerance and conflict resolution. The HYDDI practitioner brought clinical dual diagnosis and excellence in psychodynamic and psychoanalytic approaches to managing the way that complex traumatic events manifest, as well as a range of additional skills in areas like perinatal mental health skills.

The support entails a lengthy period of engagement coupled with what the Blue Knot Foundation refer to as 'Safety and Stabilisation'[5] This begins with locating a space in which the work can occur. For some young people, the size of a well-furnished large room at a converted convent is much more inviting than a small clinical office. For others, it is the car where eye contact is impossible. Another prefers a quiet space at the back of a cafe which has no connotations with previous abuse in clinical environments. The flexibility in the model under which the HYDDI and YRP practitioners operated allowed them to provide long term therapy. In contrast to the limited sessions available under other funding streams, our work is not constrained by this limitation. Anecdotally, we find that it may take six or ten sessions in order to achieve sufficient rapport to begin working on achieving 'Safety and Stabilisation.' We do this recognising that the complex effect of interpersonal trauma often means that short periods of treatment 'rarely can be meaningful if completed in less than10 to 20 sessions'.[6]

Safety in the work is promoted through up-front recognition that all behaviours serve an adaptive purpose, even those that have caused the young person to become disengaged from services. Our aim is to support them to develop new sets of skills to achieve the same purpose. What we find is that in attempting to develop new sets of skills for dealing with challenging situations, young people often end up spontaneously developing a greater ability to engage in critical self-reflection about why they have acted in a particular way. Our role here is not to provide any interpretations of their behaviours, but to encourage greater self-awareness whether through a reflective listening and questioning, or gently bringing a person's awareness to new patterns that are being described or enacted through the work that we are doing together.

A psychodynamic or psychoanalytic understanding of a person's behaviour emphasises the fact that the way people respond to the young person is what drives the trauma-based behaviours. For the small number of young people who we have worked with in this way, this has manifested in challenging behaviours that directly or indirectly impact the work that is done in the youth homelessness sector and lead to 'burn-out' on the part of young people and practitioners; such as inexplicably leaving accommodation just before a success is achieved, refusing to take offered accommodation, or pushing away practitioners only to demand their presence the next day.[7]

Reflections

The largest success of this model has been our ability to maintain therapeutic engagement with young people who have displayed challenging behaviours that have precluded them from remaining within various accommodation services.

For example, a young man from a refugee background who displayed extreme levels of defensive aggression and misogyny was originally diagnosed with a psychotic disorder partly on the basis of delusions. After achieving a greater degree of self-soothing, a different theoretical approach understood his 'delusions' as fantasies about being powerful that he unconsciously uses to deal with the torture he experienced as a child growing up in a war-zone. Work around finding other ways to feel 'powerful' has greatly decreased the frequency and intensity of defensive aggression or the need to engage in fantasy as a defence. It has also allowed him to explore concepts around masculinity with others in a safer way.

Similarly, a young woman who was the third generation in her family to be placed in residential care, who was using multiple substances, had been diagnosed with a personality disorder and had lost care of her two older children to an abusive ex-partner, worked within this model to learn how she could develop supportive, instead of antagonistic, relationships with homelessness practitioners and the Department of Health and Human Services while she was pregnant with her third child. The learning that was enabled through teaching her self-soothing techniques encouraged her to self-reflect upon the way that she re-enacted antagonistic relationships with the YRP and HYDDI practitioners. She spontaneously ceased all substance use, then engaged proactively with the Department, and now has full-time care for all three children.

We have deliberately limited the focus of our work to a lengthy period of engagement which incorporates 'safety and stabilisation' and only then focusing upon developing skills to better equip young people to navigate and survive beyond their involvement in the homelessness sector. In doing so, we have been able to make significant inroads into superseding and replacing some of the challenging behaviours that are the result of complex psychological needs that are not met by primary care services nor by specialist mental health services.

Endnotes

1. Myeza O 2019, Responding to youth homelessness in Melbourne's north: Partnerships for dual diagnosis, *Parity*, vol. 32, no. 2, April 2019: pp. 29–30.
2. For example, see the entire issue of *Parity*, vol. 31, no. 2, April 2018.
3. For example, see FEANTSA, *Recognising the link between Trauma and Homelessness*, 27 Jan. 2017, retrieved 11 March 2020 from: https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf
4. Blue Knot Foundation, *Complimentary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma*, 2019, p. 14.
5. Ibid, p. 42.
6. Courtois C A, Ford JD and Cloitre M 2009, Best practices in psychotherapy for adults, in Courtois C A, Ford JD (Eds), *Treating complex traumatic stress disorders: An evidence-based guide*, p. 96.
7. See also Leupnit DA, Where we start from: thinking with Winnicott and Lacan about the care of homeless adults, in Spelman MB and Thomson-Salo F (Eds) 2015, *The Winnicott Tradition: Lines of Development – Evolution of Theory and Practice over the Decades*, Karnac Books, London.