



## **Moving On From Homelessness Services: Enabling Factors and Obstacles**



January 2016

## Background

In June 2015 I was awarded £4000 from the *Catalysts for Change* programme delivered by the Queens Nursing Institute Scotland for a practice-base project to investigate the enabling factors and barriers to moving on from homelessness care services to mainstream community networks.

There were three main reasons for looking at the issue of moving on from homelessness services. First was the massive cost (in the widest sense) to society as well as individual clients of a revolving door scenario of repeat homelessness.

Second, the evidence we have within homelessness services suggested that moving on is hugely difficult for a number of clients. In 2010, a GP employed at the Edinburgh Access Practice (EAP) through the Fellowship in Health Inequalities initiative carried out a study in which he identified two important questions: “Is there anything professionals working within the homeless health sector can do to break down the internal and external barriers which prevent homeless people from engaging in mainstream care?” and “Can we identify at the outset who will “move on” quickly as opposed to those who are “always on the move” around homelessness?” The qualitative evidence gathered and analysed for this project suggests that there are things we can do to address the internal and external barriers, and that we can identify individuals who may struggle to ‘move on’ early in their care journey.

The third reason was that a review of how homelessness services are delivered in Edinburgh is taking place in the context of the [Inclusive Edinburgh review](#). This review relates to the need to “achieve better outcomes for people” and encourage continued “integration of health and social care [not] limited to services provided by the Council’s Health and Social Care and NHS Lothian.” In other words, integrated, creative, public and social partnering is being recognised as essential if we are to achieve the aim of improved outcomes for people experiencing health, social, and economic inequalities.

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# Moving On From Homelessness Services: Enabling Factors and Obstacles

## Introduction

I began this practice-based project with the intention of examining systemic enabling factors and obstacles to moving on from homelessness services to mainstream community networks. I was interested in learning about transitioning to mainstream care through listening to peoples' stories about their experiences of homelessness and its potential resolution.

However, it became clear early on in my project that participants were not generally concerned with systemic issues in homelessness services; in the main, participants reported positive experiences of working with services. Instead they told me that the main area of struggle for them was intrapersonal and interpersonal relating, and that this was key to their functioning in all situations. I was still interested in learning about systemic enabling factors and obstacles, but in response to what participants were saying I altered my original focus, making relationship dynamics a more specific focus of my enquiry.

To gather evidence from the project participants I used an attachment-based model of psychotherapy in interviews known as Exploratory Goal Corrected Psychotherapy (EGCP).<sup>1</sup> Using this model of approach in interviews I audio recorded two consultations with each individual project participant, one on their experiences of care and another on their experiences of the term 'homelessness'. I analysed their transcripts for both enabling factors and obstacles faced in transitioning from specialist homelessness services to mainstream community networks.

I will begin with an introduction to the three projects I worked with for this project. The evidence gathered from two of these projects (Street Fit Scotland and CoCo Counselling) will be analysed in a separate paper. I will then give a brief introduction to attachment-based concepts, their relevance to homelessness services, and how this approach helped me gather evidence on enabling factors and obstacles to moving on.

My analysis of a transcript from my interview with Mr A will then be covered. Throughout this analysis, attachment-based concepts will be highlighted for their importance in looking at the main features of Mr A's case, and also for their importance as evidence about the issues people face in moving on from homelessness services in general. Implications for professionals are also considered in this paper along with general themes gathered from the transcripts on homelessness.

In my conclusion I will make recommendations on the evidence gathered from all the transcripts.

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<sup>1</sup> Heard D, Lake B, McCluskey U. Attachment therapy with adolescents and adults: theory and practice post Bowlby. London: Revised Edition Karnac; 2012. See also: [www.unamclluskey.com/](http://www.unamclluskey.com/)

## Projects involved

I worked with three projects in this project:

1. The Edinburgh Access Practice: NHS Lothian (salaried) GP Practice specialising in homelessness & health inequalities
2. Street Fit Scotland: Social enterprise project specialising in health, fitness & wellbeing for people with significant experiences of exclusion, eviction & discharge from care services
3. CoCo Counselling: A social enterprise counselling project made up of a small group of counsellors who are registered with The British Association for Counselling and Psychotherapy (BACP). This is an affordable and accessible counselling service for adults and young people over 16

I recruited thirteen individual participants for the project, nine of whom I met in one-to-one psychotherapy consultation once a week. The nine were known to me for more than one year, they were no longer homeless, and had found that moving on from homelessness services was not straightforward. The other four individual subjects were seen by CoCo Counselling staff.

Each one of the participants in this project has a personal story of trauma, and each one of them was considered move on ready by homelessness services prior to their stories being heard in a supportive and companionable, attachment-based manner. It is important to note that they were, however, not representative of the greater majority of people who present to housing services as homeless; for upwards of 60% of presentations the provision of a home is sufficient.

An important aspect in the design of my project was ensuring that clients were met with in venues other than those familiar to them from contact with homelessness services. It was felt to be important with respect to looking at moving on to be engaging in environmental spaces more connected with wider community networks away from traditional homelessness service settings.

For participants in the Street Fit Scotland focus groups in particular, outside visits became focal points in enabling discussion regarding welcome and the fact that as one participant put it:

*It's the first time...with Street Fit Scotland...I've wanted anyone to be my pal for nothing...just a wee chat...I know I have a lot of problems...I'm working on them...before this I was never, ever accepted...I have never been welcome anywhere...*

(SFS-1A)<sup>2</sup>

Visits to sites such as Edinburgh Castle were used to encourage feedback in focus group meetings, and in health and wellbeing workshops that I delivered for this group. This proved an effective way of focussing our discussion on belonging and homelessness in general.

The evidence gathered on enabling factors and obstacles to moving on from homelessness services, from both these projects, will not be covered in this paper. What I discovered with the group of

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<sup>2</sup> Street Fit Scotland, focus group 1A

individual participants is that the evidence they have provided me with proved too complex to be analysed alongside that from the other two projects. To do that evidence justice I will analyse it in a separate paper.

### **Attachment-based relating in homelessness services**

The work of Dr Una McCluskey and colleagues, notably Dr Dorothy Heard and Dr Brian Lake is an extension of the John Bowlby and Mary Ainsworth paradigm, to enable work with adult clients, and a different understanding of the self.<sup>3</sup> One of the conceptual foundation stones of the John Bowlby and Mary Ainsworth paradigm was that they noted “sensitive care-giving as a foundation for psychological health.”<sup>4</sup> “Later, Heard et al. (2009) developed the concept of caregiving and discriminated between effective and ineffective caregiving.”<sup>5</sup>

In terms of attachment-based theory, in this paper I specifically mention only careseeking and fear, nevertheless, it is important to note that McCluskey, Heard and Lake’s collaborative work identified the dynamics of attachment to consist of several systems, to enable a person to maintain and restore wellbeing, as necessary following a threat to self. The seven biologically based systems they identified are those for: 1) attachment-careseeking 2) caregiving 3) self defence 4) interest sharing with peers 5) sexuality 6) internal environment & 7) external environment.<sup>6</sup>

Sensitive caregiving was noted by participants in my project as something they regularly experienced from homelessness services; however, they also reported regularly experiencing being disorganised when in a caregiving context. I considered this to be a further important reason for listening to participants’ experiences of care, both the historical and contemporary experiences of care that were familiar to them.

When we seek to provide care for another we need to pay attention to the dynamics of attachment, not to do so may leave both us as caregiver and our clients/patients as careseekers frustrated, and encourage less than helpful defensive careseeking strategies.

We know that when people who seek care and those who provide it meet together in a group or one-to-one setting, both are immediately involved in an “attachment-eliciting activity”. (McCluskey 2005)<sup>7</sup> In common with many people who are homeless the participants in this project “have had sustained exposure to toxic experiences...from an early age.” (Maguire N, et al, 2009)<sup>8</sup> These

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<sup>3</sup> *ibid*, p6

<sup>4</sup> Bowlby, J., *A Secure Base*, Routledge Classics, 1988, pxiii

<sup>5</sup> Una McCluskey and James Gunn, *The Dynamics of Caregiving: Why Are Professional Caregivers Vulnerable to Anxiety and Burnout, and How do we Support Their Wellbeing*, published in *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, Vol. 9, July 2015: pp. 188-200. Page 191. *See also: Heard D, Lake B, McCluskey U. Attachment therapy with adolescents and adults: theory and practice post Bowlby. London: Revised Edition Karnac; 2012*

<sup>6</sup> Heard D, Lake B, McCluskey U. *Attachment therapy with adolescents and adults: theory and practice post Bowlby. London: Revised Edition Karnac; 2012*

<sup>7</sup> McCluskey U, *To Be Met as a Person*, London, Karnac Press, 2005, preface pXV

<sup>8</sup> Maguire, N., et al., *Homelessness and Trauma: a review of the literature*, University of Southampton, School of Psychology, 2009

negative experiences of care have stayed with them, and led them to be less than confident of receiving attentive care when in a potential caregiving context. An attachment-eliciting activity for them is an activity which evokes fear and triggers instinctive defensive responses, an activity therefore that needs experienced anew to enable vitality rather than emotional collapse. In her work on attachment dynamics in adults, McCluskey suggests that when frightened, in pain or facing threat to their lives adults tend to adopt one of four careseeking stances:

1. They will have confidence in their strategies for getting help and be clear and direct in their communication.
2. They will have no confidence that their needs will be addressed and attended to and so will only seek help *in extremis* and then in a way that minimises the extent of their problem, thereby giving inadequate information to the potential caregiver.
3. They will be uncertain, half hopeful, half sceptical, and therefore communicate in contradictory and ambiguous ways.
4. They will be bewildered, unclear, uncertain and disorganised about the state they are in and what would relieve it, fearing any response could potentially make things worse, thus avoiding seeking help in the first place and being frightened/angry when in a caregiving context.

(McCluskey, 2005)<sup>9</sup>

All the transcripts I analysed for this project suggested that out of the four careseeking stances above, number one would be the least familiar to participants. The evidence from this project suggests that this could be an impediment to moving on.

The participants that I met with individually in psychotherapy consultation were all familiar with the term careseeking, so I designed the following topic guide based around careseeking to use in our audio recorded interviews: “What do you know about how you careseek and has anything changed about this since we began to meet together?” The rationale behind this topic guide was that I wanted to know: a) how do you seek care? b) What do you know about how you seek care? c) What are your experiences of being cared for?

Due to time constraints I was only able to interview six clients using this topic guide. I will focus on one of the six, Mr A, noting the importance of confident careseeking in enabling health and wellbeing.

I will conclude my analysis of Mr A’s case with brief notes on fear and careseeking followed by; general careseeking themes noted from all six transcripts; the importance of awareness of attachment related dynamics for staff groups; the often neglected area of how to deal with positive feedback; the potential idealizing of a caregiver and a note on the importance of a ‘secure base’.

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<sup>9</sup> McCluskey U, To Be Met as a Person, London, Karnac Press, 2005, p3

## **Mr A: The importance of confident careseeking in enabling health & wellbeing and the activation of fear**

Mr A attended as usual for consultation with me a fortnight prior to his careseeking experiences being audio recorded. At the time he was experiencing distressing symptoms for which emergency medical care was needed. However, in keeping with his familiar style of 'seeking care' he minimized his distress and in doing so potentially distracted us both from his immediate need for care. Mr A had a tightly swollen left calf, and was in extreme discomfort and pain. His breathing was difficult, he had taken maximum ibuprofen for the eight to ten days since he began to feel pain, and he had not consulted his GP. This man was articulate, degree educated, and habituated to a need to instinctively miscue any potential caregiver. He can comport himself well even in the midst of being distressed.

In order for Mr A to get in touch with his own "skills, resources and capacity to act and influence events" in his life he needed a response that attuned to his current "internal state of arousal." (McCluskey 2005)<sup>10</sup> The main verbal cue he gave me was "oh I am just a little tired" and casually later in our conversation, "a bit sore...been taking ibuprofen..." He needed immediate care; between us both and in collaboration with his responsive and thoughtful GP he eventually received the hospital care he needed. Mr A's careseeking style in this instance potentially put his life at risk.

A fortnight after the consultation when Mr A had tentatively told me that his left calf was a little swollen, I audio recorded his thoughts on careseeking. I reminded him of our previous conversation: "What I heard from you when you came here that morning was, 'oh I am just a little tired' and casually later in our conversation, 'a bit sore...been taking ibuprofen...'"<sup>11</sup> Together we then reflected on how casually he had disregarded his symptoms which clearly pointed to a risk of pulmonary embolism and left untreated were a threat to his life.

We talked of how responsive his GP was once I alerted him to Mr A's symptoms, how he was cared for at the hospital where his blood levels were checked and where he was commenced on warfarin and was now in receipt of daily injections. Mr A laughed out loudly at the thought of his disregard of self but he was beginning to be curious and exploratory in our conversation. Yes, he had been cared for in this instance and none too soon, but now he began to tell me what he knew about his own careseeking.

*What do I know about it? My own careseeking...I would say I wait until the very end...I wait until the very last point...And then it's kind of like, okay if I don't go...I could die...<sup>12</sup>*

I then asked: "I am curious...I wonder if we can get any more information out of what happened last week...the very first thing that comes to mind of when you actually really needed help?" He answered emphatically:

*Back when I was with my mum and brother....You know, the toxic relationship just eats away and in the end, and I am not lying here, I didn't even know who I was. It*

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<sup>10</sup> McCluskey U, To Be Met as a Person, London, Karnac Press, 2005, p76ff

<sup>11</sup> Mr A-transcript CS

<sup>12</sup> ibid



*had gotten where...it just eats at you and you're just like okay, I am in survival mode, basically, you've eaten away at so much of me as a human being...there's nothing there! The relationships are so toxic...*<sup>13</sup>

Again, a pause, and suddenly he heard anew this emotionally important snippet of information on his story. This important emotional information became known to Mr A in the context of an attachment-based, supportive and companionable, exploratory care relationship. It is “essential for a therapist to have a theory centred on emotions that will guide him or her when actually interacting with clients.”<sup>14</sup> Here was another human being interested in his story. This was an emotionally charged exploratory journey that we were embarking on together. The human relational dynamic we engaged in has its origins in infant-caregiver interactions; we are born with the expectation of being met as a person. (Sutherland 1993)<sup>15</sup>

This beginning of a dialogue between self and other in an attachment-based context of love, affection and care is a physiologically exhausting but hugely vitalising activity for people whose internalised sense of self-worth has been made toxic from an early age. Importantly, both careseeker and caregiver are vitalised.

In this instance, my caregiving and Mr A's careseeking were working together well; we were not frustrated. Being responded to (cared for) helped him instinctively make the connection to one significant historical example of disregard from both his mum and brother, and at the same moment connect to how that was not good enough. Caregivers and careseekers are very capable of miscuing each other as to what is the problem that needs attended to.

People who have had contradictory experiences of caregiving will often tend to miscue professional caregivers so that any attempt at caregiving is frustrated and can end up as a frustrating experience for both parties.

(McCluskey, 2013)<sup>16</sup>

What Mr A described was only one of many experiences that have got in the way of him looking after himself throughout his life. Almost with a sense of astonishment he reminded himself: “I would say I wait until the very end...I wait until the very last point...And then it's kind of like, okay if I don't go...I could die...”<sup>17</sup> Subsequent conversations evidence his huge excitement at realizing that careseeking works, that he may not be ignored when he asks for help, and if ignored this is not good enough as a response and can be addressed.

Mr A's case is an example of the beginning of a sustainable attentiveness to one's needs, and it is not only a health need that may be more timeously addressed by confident careseeking. More confident careseeking can help improve one's experiences in all relationship contexts. The antecedents to less than confident careseeking are helpfully described by John Bowlby in his essay, “On knowing what

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<sup>13</sup> *ibid*

<sup>14</sup> Heard D, Lake B, McCluskey U. Attachment therapy with adolescents and adults: theory and practice post Bowlby. London: Revised Edition Karnac; 2012, p10ff

<sup>15</sup> McCluskey U, To Be Met as a Person, London, Karnac Press, 2005, preface pXV, see also: Sutherland, J., D., Bulletin Of The Menninger Clinic, Winter; Vol. 57 (1), pp. 3-32; discussion 1-2, 1993

<sup>16</sup> Heard D, Lake B, McCluskey U. Attachment therapy with adolescents and adults: theory and practice post Bowlby. London: Revised Edition Karnac; 2012. See also: [www.unamclluskey.com/](http://www.unamclluskey.com/)

<sup>17</sup> Mr A-transcript CS

you are not supposed to know and feeling what you are not supposed to feel.”<sup>18</sup> In Mr A’s case, the second category below is especially apposite.

The scenes and experiences that tend to become shut off, though often continuing to be extremely influential in affecting thought, feeling, and behaviour, fall into at least three distinct categories:

- a. those that parents wish their children not to know about;
- b. those in which parents have treated children in ways the children find too unbearable to think about;
- c. those in which children have done, or perhaps thought, things about which they feel unbearably guilty or ashamed.

(Bowlby, 1988)<sup>19</sup>

Tragically, having been deeply hurt as a child was an experience recalled by all the project participants but present too was the capacity, and need to make sense of these experiences. Sustainable attentiveness to one’s needs as an adult is not arrived at easily when you have known what it is to be hurt deeply as a child; as Mr A describes:

*I look back now and I feel myself getting better and better. It’s almost like...a different person but that person was in immense pain, from the second he woke up to the second I went to sleep I was in immense pain.*<sup>20</sup>

A common feature in all participants in this project was recalling experiences where they had replicated unhelpful careseeking strategies throughout their lives to the detriment of potential loving, affectionate and caring relating with self and other. Importantly, however, the willingness of project participants to stay with, and make sense of emotionally toxic experiences evidences that change is possible, and age is no barrier. Indeed I would suggest from the evidence gathered here, that helping people to make changes in their strategies for seeking care is also essential in order for them to sustain move on from homelessness. Mr A has, however, now begun the process of attending to his care needs.

*Am I beginning to care for me? Definitely! When something comes up seek the care that you need!*

Mr A<sup>21</sup>

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<sup>18</sup> Bowlby, J., *A Secure Base*, Routledge Classics, 1988, p111

<sup>19</sup> *Ibid* p

<sup>20</sup> Mr A-transcript CS

<sup>21</sup> *ibid*

## Fear and careseeking

Confident careseeking is a skill applicable in all walks of life. Careseeking, however, is only one part of the story of the internal biological systems activation we access in order to look after ourselves. It is important to note that at times of threat we will also be accessing other internal biological systems in seeking for assuagement of distress.

Situations that trigger careseeking also trigger fear. These are different systems with different goals – one is survival with wellbeing with the cooperation of someone else (careseeking system) – the other is the survival of the self at all costs, irrespective of the effect on anyone else (fear system). The system for self-defence incorporates both systems. The more experience a person has of an effective caregiver helping them to manage stressful situations, the more the person will be able to both seek appropriate help and access memories of how they have been helped to manage in the past. If the fear system dominates when the person is in self-defence, this will override their careseeking system and they will not seek help – they ‘forget’ anyone is around who could help.

(McCluskey, 2011)<sup>22</sup>

Mr A continued to take ibuprofen which evidences that he knew something was amiss, however, this adult knowing was rendered less effective due to ‘hard-wired’ experiences of not being cared for. There are likely “several fear states, each with its own genetics, incentives, physiological patterns, and behavioural profiles”, in other words “the mechanisms that allow organisms to respond to threats are different from the mechanisms that give rise to conscious fear.”<sup>23</sup>

This man was in a potentially life threatening situation and instinctively in survival of the self-mode, he reached out for pain relief, for example, but was unable to access survival with wellbeing because his knowing was being dominated by one of several, physiologically embedded fear states. I know from our conversations that this man has had positive experiences of care in his adult life, but when you have been hurt deeply as a child it is hard to connect to the idea that anyone is around who may be able to help when you are in distress, or indeed that anyone will be interested in your wellbeing to stay around long enough to make sure that you are okay.

A potentially fatal outcome was averted for Mr A, and retrospectively in the process of making sense of what had happened to him he was able to make hugely important emotional connections. These connections will enable him in linking in with wider mainstream community networks, and ensure a sustained move on from homelessness care. However, hugely important emotional connections of this nature, while vitalizing, also need time to be made sense of when arrived at in adulthood. When the context within which an individual is making sense, is compounded by homelessness, a transition phase becomes ever more necessary otherwise any moving on from homelessness will be time

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<sup>22</sup> McCluskey, U., The therapist as a fear-free caregiver: supporting change in the dynamic organisation of the self, *The Association for University & College Counselling Journal/AUCC*, May 2011, p14

<sup>23</sup> Joseph E. LeDoux, Coming to terms with fear, *Centre for Neural Science and Department of Psychology, New York University*, [www.pnas.org/cgi/doi/10.1073/pnas.1400335111](http://www.pnas.org/cgi/doi/10.1073/pnas.1400335111), November 2013, p1 & 6

limited. Evidence at the Edinburgh Access Practice suggests that a significant number of clients return to homelessness services on average within three years of moving on.<sup>24</sup>

### General careseeking themes noted from all six transcripts

Each one of the participants in this project told their own story of disappointments, frustrations, toxic early family relationships, violence and sexually abusive experiences from primary caregivers in most cases, and from paid carers during periods spent living in institutional child care settings. A commonly recounted experience for each participant was learned survival careseeking strategies; defensive compensating for absent/inconsistent care through caregiving to others. These learned strategies have had a huge impact on how they relate to care as the following quotes show. The quotes highlight experiences that will remain an impediment to sustained moving on unless addressed alongside all care interventions, be they housing, social work, health or other interventions.

*I don't know how to ask for help. And you know something, **I wouldn't ask for help**...I feel as if...I'm not being funny, I feel as if I'm wasting my time asking anybody for help...*

Mr LB<sup>25</sup>

*Well, I never had a father...he never spent any proper time with me, or a mother, you know, I was always just myself, alone...and then in care...in care!...I was fucking abused...**I don't ask for help**...I don't know how to...I don't trust it...*

Mr IL<sup>26</sup>

***I don't want help off anybody**...growing up and stuff, and in the children's homes, all the things that happened to me and that...When people offer me help, I sit there and go, why are they offering me help? What do they want? When I was younger I always felt people wanted something when they offered me help....Yeah, I give care...with my money, I give it away...I like giving to people...I suppose in a way it's like trying to buy care...*

Mr IQ<sup>27</sup>

***I very rarely go for help, direct help**...at the worst scenario I even say 'I might as well kill myself', which is where the emotional blackmail kicks in...that was the final straw in our marriage...there's an element in me which is almost dishonest as if I have to be...Like I am trying to fool other people cos I'm trying to fool myself.*

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<sup>24</sup> EAP recent audit

<sup>25</sup> Mr LB-transcript CS

<sup>26</sup> Mr IL-transcript CS

<sup>27</sup> Mr IQ-transcript CS

*For instance the antidepressants, I'm taking the prescription but I'm not taking them... The only help available to me is help that I don't want.*

Mr MG<sup>28</sup>

*I think I have always, somewhere deep in the back felt alone really...it's not very good...rabbit in the headlights but I don't think I come across as that...I come across well and people don't see...I look for ways to run away...I feel quite alone...just hold it together until I get out of the situation...my head always says it is too scary...**I don't trust help...I don't ask for help...***

Ms MR<sup>29</sup>

The instinctive careseeking styles evident in these transcripts were a significant impediment for these individuals being able to make use of care, whether that was care from housing, health, social work or other providers. I am not intending to suggest here that a person's move on from homelessness be individualized as a personal problem that can be resolved by psychotherapy alone. Psychotherapy alone is not a "solution for social exclusion or for homelessness", there are, for example, "socio-political issues, in particular concerning the structural causes of homelessness" that we risk losing sight of if we make this complex societal issue one of personal behaviour alone.<sup>30</sup>

## **Issues for professionals**

### ***The importance of awareness of attachment related dynamics for staff groups***

The importance of an awareness of attachment related dynamics not only concerns health and clinical staff, it is equally important, for example, for housing staff. Housing staff are significant caregivers and as such they also need to pay attention to careseeking styles in both themselves and their clients.

Paying attention to careseeking styles is not only necessary for clients it is also an issue for staff, indeed if we do not pay attention to our own careseeking styles we may struggle to attend to what is being conveyed to us by clients about their internal state of arousal; we may become frustrated and miscued. As professional caregivers we may have had less than satisfactory care experiences, and developed our own defensive strategies, for example:

Compulsive caregiving...not uncommonly leads compulsive caregivers to become professional caregivers. In this role they may not be sufficiently empathic with their clients... [but rather communicating] as a child who has discovered that should he or she look after a parent (most often mother), mother can begin to

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<sup>28</sup> Mr MG-transcript CS

<sup>29</sup> Ms MR-transcript CS

<sup>30</sup> Gabrielle Brown et al., An hospitable engagement? Open-door psychotherapy with the socially excluded, *Psychodynamic Practice*, Volume 17, No 3, August 2011, p311ff

give care of an empathic quality that is not given until the child has empathized with the parent and interacted in a particular way that makes the parent feel cared for and revitalized, and therefore better able to be a more effective parent. Nevertheless the careseeker has to bear his or her own distress until the parent is able to respond.

(Heard, Lake & McCluskey, 2012)<sup>31</sup>

This is emotionally exhausting work and we need to be more attentive to the impact on staff of “processing empathic concern” on a daily basis and how this can potentially “constitute a threat to the individual [staff member], leading to personal distress and compassion fatigue...subsequently decreasing capacity to give care to others.”<sup>32</sup> I make this point especially with reference to staff feeling disempowered to help clients move on in a sustainable way from homelessness services, due in part to demands to move on clients when they are not ready to do so.

### ***The often neglected area of how to deal with positive feedback***

It is a privilege to be in the position of being able to respond to participants in an exploratory, supportive and companionable manner. It is also a hugely vitalizing experience as well as a challenging one.

As part of exploratory therapy we consider that a professional caregiver has to be able to act not only empathically, but also by sending nonverbal signals that show the careseeker that he or she is a person of worth in the eyes of this caregiver.

(Heard, Lake & McCluskey, 2012)<sup>33</sup>

Being related to as a human being can be an overwhelming experience for people whose predominant life experiences have been of rejection. It is important also to remember that when adults are attending to their need for care in one area of their lives “exploration in other directions may be curtailed if not completely inhibited.”<sup>34</sup> This is an important consideration when offering care to people who have multiple crises impacting on their lives, such as both housing and health needs.

A homelessness crisis is about, in almost all cases, more than the absence of a home; its resolution involves care from many different sources. People will vary in how much help they need to be able to make use of available care from homelessness services, however, attending to their careseeking

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<sup>31</sup> Heard D, Lake B, McCluskey U., Attachment therapy with adolescents and adults: theory and practice post Bowlby, London: Revised Edition Karnac; 2012, p68ff

<sup>32</sup>Una McCluskey and James Gunn, The Dynamics of Caregiving: Why Are Professional Caregivers Vulnerable to Anxiety and Burnout, and How do we Support Their Wellbeing, published in Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, Vol. 9, July 2015: pp. 188-200. Page 190

<sup>33</sup> ibid, p82

<sup>34</sup> ibid p5

styles will go a long way toward ensuring they get what care they need to enable a sustainable move on.

The following transcript quotes are evidence of part of a personal exploration process following experiencing attentive relating to self and other. Often caregivers neglect the importance of helping a person to make sense of the impulse to give praise when appropriate; however, this is such an important social skill.

*Do you know what it is? I used to trust people a lot and see now I don't trust anybody at all...Unless it's you. I trust you!*

Mr LB<sup>35</sup>

*I'm really quite worried Doneil that I'm going away and you won't be available...I think you're the only person I'm getting proper help from.*

Mr MG<sup>36</sup>

*I don't know what I would do without you!*

Ms MR<sup>37</sup>

*It's comforting because nobody has ever been like that before with me...when you greet me I can feel the power, the meaningfulness of it, it's genuine...Thank you...I feel more wanted because somebody cares about me...*

Mr IL<sup>38</sup>

*Yeah, it's like that one day, I just went I can't believe it...blood and guts and then everything else came in...it all fell in to place...your imparting of that knowledge...thank God I've found someone that I've learnt about all these different things from. I'm reaching out again for life!*

Mr A<sup>39</sup>

*You look at me as a person. I've been going to the doctors and me and the doctor are rugby mates....he's a rugby man and I just feel when I go to the doctor here [GP clinic at EAP] he isn't looking down and writing stuff but he actually stops and actually looks at me and same with the nurses and yourself, you're actually looking at me. I just feel the staff at the housing were there for me....helped me with housing and stuff...she told me to go to the doctor's...seen the nurse first...he actually spoke to me! How are you!...I thought wow!...Someone actually wants to know how I am!*

Mr IQ<sup>40</sup>

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<sup>35</sup> Mr LB-transcript CS

<sup>36</sup> Mr MG-transcript CS

<sup>37</sup> Ms MR-transcript CS

<sup>38</sup> Mr IL-transcript CS

<sup>39</sup> Mr A-transcript CS

My analysis of the careseeking transcripts in this project has been through reference to an attachment-based psychotherapeutic approach. This approach, however, is not just about clinical work, and as the final quote above evidences staff in all disciplines are already doing something that works. These quotes evidence an experience of “being met as a person” (Sutherland 1993), an energising experience that can mean the difference between a person experiencing an “exploratory or non-exploratory attitude to understanding themselves and their predicaments.” (McCluskey 2011)<sup>41</sup> Moving on from homelessness is a transitional process. It can take time to internally experience being valued, and part of that process involves getting to know that your ‘thank you’ is heard and respected in part because you are heard and respected.

### ***Potential idealizing of a caregiver and a note on the importance of a ‘secure base’***

An important aspect that needs considered when working with positive feedback is the potential of an idealizing tendency typical of a borderline personality disorder presentation. In such cases a client can present as follows: *“The patient takes everything the therapist says as being helpful, providing new insight into problems...[and]...The therapist may begin to feel that they have a special relationship with the patient and become overprotective and believe that they have the answers and understand the patient better than anyone else”.* (Bateman and Fonagy, 2004)<sup>42</sup>

The positive feedback examples described above are evidence of those individuals developing their intrapersonal and interpersonal relationship skills, and are not to be confused with expressions of unhelpful idealizing of a caregiver that they may, however, have engaged in at times in their lives. Positive feedback in a supportive and companionable caregiving context is something that needs to be attended to and thought about; both the receiving of positive feedback and the giving of positive feedback are important attachment related skills, this helps enable a person to feel secure in themselves.

The creating of a ‘secure base’ was important for Mr A, for example, his route in to homelessness followed on from a relationship breakdown precipitating a mental health crisis that led to hospitalization, with antipsychotic medication and antidepressants being prescribed as part of his care & treatment. Whether a focus on careseeking style may have been usefully introduced or not at this crisis stage in his journey of care (hospitalization) would need further investigation.

The creation of a ‘secure base’ from which he could to begin to get his life back was what Mr A recalled from his time in hospital. Such ‘secure base’ building is the platform that enables both our careseeking and caregiving skills, and helps us in making “intimate emotional bonds with other individuals...[which is a]...principal feature of effective personality functioning and mental health.”<sup>43</sup>

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<sup>40</sup> Mr IQ-transcript CS

<sup>41</sup> McCluskey, U., The therapist as a fear-free caregiver: supporting change in the dynamic organisation of the self, The Association for University & College Counselling Journal/AUCC, May 2011, p12

<sup>42</sup> Bateman A, and Fonagy, P, Psychotherapy for Borderline Personality Disorder: mentalization-based treatment, Oxford University Press, 2004, p242ff

<sup>43</sup> Bowlby, J., A Secure Base, Routledge Classics, 1988, p136



Mr A is no longer taking antipsychotics but remains on antidepressant medication, more importantly though in his own words, *“Am I finding my voice again? Definitely!”*<sup>44</sup>

### **Themes from interviews on participants’ experiences of the term ‘homelessness’**

Although the participants had indicated at the outset that they were not really concerned with systemic issues, nevertheless their experiences of homelessness services was something I felt needed to be heard. I designed a topic guide to help me get a sense of what participants’ homelessness stories were. The main themes in their transcripts are noted here, beginning with a brief note on homelessness from a service perspective.

The topic guide I designed to get subjects to describe their experiences of homelessness was: “Following on from where we are in our conversations so far I am curious about this term homelessness and what it means to you. Can you describe it at all?” The rationale behind this topic guide was that I wanted to know: a) How had homelessness impacted on their lives? b) What the term homelessness meant to them. c) How can homelessness services better enable people to move on to mainstream community networks?

There is no such thing as a typical client in homelessness services. There are common features that are sadly seen all too often in many presentations, but as the participants in this project emphasised, they are people first, with their own individual story.

However, as Suzanne Fitzpatrick et al have shown, common features are statistically relevant, and, for example, help us in thinking through homelessness service’s design priorities; the following are noted in a 2012 briefing paper on multiple exclusion homelessness in the UK.

There is a growing concern in the UK about the need for a more sophisticated understanding of severe and multiple disadvantage – sometimes called ‘deep social exclusion’ – to inform better responses to people with complex needs[.]...This reflects a heightened awareness that the populations at the sharpest end of problems such as homelessness, substance misuse, poor mental health, and involvement with the criminal justice system are often costly to society as a whole[,...]...but at the same time are extremely vulnerable individuals who often ‘fall between the gaps’ in policy and services[.]...

(Fitzpatrick et al, 2012)<sup>45</sup>

Despite all this in a paradoxical way arrival at the door of homelessness services can be turned in to a real opportunity for people.

Homelessness is...in many cases, a ‘late marker’ of severe and complex disadvantage which can be identified across the life course of individuals...Raising awareness and understanding about homelessness as a late manifestation of

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<sup>44</sup> Mr A-transcript H

<sup>45</sup> Suzanne Fitzpatrick, Glenn Bramley and Sarah Johnsen, Multiple Exclusion Homelessness in the UK: An Overview of Key Findings, Briefing Paper No.1, 2012, p1. See also [www.sbe.hw.ac.uk/research/ihurer](http://www.sbe.hw.ac.uk/research/ihurer)

social and health inequity will help to make the life-course approach to its prevention more explicit.

(Hetherington K & Hamlet N, May 2015)<sup>46</sup>

These quotes point to the need for preventative measures and the need to recognize “childhood trauma...as an early sign” of potential later life disadvantage.<sup>47</sup> For the adults in this project it was not too late to make a difference. They have each arrived at the door of homelessness services following many care contact points, through hospital care for example, for both general and mental health emergencies. Paying attention to social and health experiences of inequity across their life-course has better enabled them to navigate their journey through all care interventions, and not only the care needed to address the circumstance of homelessness.

There were positive statements made by participants in this project about their experiences of homelessness services.

*I think there is a lot of good stuff that you get...there are some hostels that really try, especially these days. It's all changing from when I first used homelessness places, they get you involved with therapy or get you painting and things...*

Mr HR<sup>48</sup>

*See when I was in the Salvation Army...I can look at it now and say it was probably the best years of my life. Because the help I got was unbelievable, really unbelievable...brilliant, absolutely brilliant...you know something I wish now I could go back to that. Aye, I really do...when I went into the Salvation Army to when I left it was probably the best years of my life. Oh, aye, I'd go back there in a minute. I really would, I'd go back there in a minute...*

Mr LB<sup>49</sup>

*Services are very generous in what they have to offer and even though a lot of my experience of all that has been imparted upon me has not been so great, don't get me wrong I am grateful...*

Mr 1A<sup>50</sup>

*I think becoming homeless made me realise something...I mean I got offered help, places offered me help and I accepted it this time. Because I could sort of see that the person that was helping me seen me...I think the thing I've experienced more out of everything is the staff care.*

Mr IQ<sup>51</sup>

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<sup>46</sup> Katy Hetherington & Neil Hamlet, Scottish Public Health Network Restoring the Public Health response to Homelessness in Scotland, May 2015, p4

<sup>47</sup> *ibid* p10

<sup>48</sup> Mr HR-transcript H

<sup>49</sup> Mr LB-transcript H

<sup>50</sup> Mr 1A-transcript H

There were also negative experiences of what was made available to participants at the temporary accommodation stage, and once they were housed, alongside at times a sense of hopelessness that they were now stuck in a worse situation.

a) Just moved in to temporary accommodation

*It was the most depressing, dingy place but I suppose it was what they had...you've got to, y' know, to then get onto the next rung of the ladder. You've got to get on with it...it's almost like time served or something, isn't it? You've got to sit it out and it can take six months, take nine months and then eventually, you know, you can get onto the...But then it was the worst room I could have been put in, at the back, there's a sort of crevice, a dead end, a window here, facing into a wall... it was no further than you and I sitting apart [five feet +], with this fan, an extractor fan that the pigeons all sat in. The extractor fan for the building is just there, all covered in pigeon's faeces and everything and if you didn't put the light on the room would be black all the time.*

Ms MR<sup>52</sup>

*But when you close that door it's just complete...the loneliness hits you just like a brick. You look at the bed and it's like...it's like going maybe back to Victorian times I think, and you've got like a plastic sheet over the mattress, basic bedding, very thin and it's horrendous. It's just really, really worse than the street...*

Mr IL<sup>53</sup>

b) About to move on from temporary accommodation to permanent accommodation

*Yes, otherwise I didn't get a great deal of help from the homeless scene...I almost didn't last long enough waiting to get a place. You certainly need to give better options than lonely tower blocks, if I had been offered something like this I would not have taken it I would have gone back out on the road, back on the streets.*

Mr MG<sup>54</sup>

*I have seen these places, totally scruffy, unsafe places. I'm just a great believer that I've seen people move into these places and they drink straightaway.*

Mr HR<sup>55</sup>

c) After moving on to permanent accommodation

*You can do whatever you like in it so you can make it your home but that doesn't include factors out-with your control, like your neighbours, and that's the biggest*

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<sup>51</sup> Mr IQ-transcript H

<sup>52</sup> Ms MR-transcript H

<sup>53</sup> Mr IL-transcript H

<sup>54</sup> Mr MG-transcript H

<sup>55</sup> Mr HR-transcript H

*problem that I've had, you know, being attacked, tyres slashed, all these kind of things...The noise...It's been going on since I first moved in. I remember the first weekend, they had a party upstairs and nobody did anything about that. And the other thing...the more general thing, that's stuck in my head...is I'm still homeless now because...well, specifically because I'm still on benefits. There are so many places that I've seen that say 'No DSS' to apply for so I still feel as if I'm homeless because I can't simply go to somewhere that is appropriate to me...all these places just say they don't accept DSS. I'm stuck...*

Mr DF<sup>56</sup>

*After I'd moved into the property and it was in such dereliction, disrepair, and a real hovel. ...given a...I'm very thankful for anything that's been given, donated, towards me - a microwave...what did I have...a microwave and a bed and my housing officer flippantly said, "Well, what more do you want?" What more do you want! And this was...but I haven't really gone into too many details but he then said, "You have a microwave, you have somewhere to sleep, what more do you want?" And it's like, and that in itself makes it feel like, not only is it ... there's a sort of oppressive aspect to that because it's then the fact that OK ...really it's insulting at the level that I know what is acceptable as far as the standard is concerned but this just general, sort of, derelict state, is this it?*

Mr 1A<sup>57</sup>

d) Moving in to permanent accommodation may be a terrifying experience for some

Along with the positive and negative statements above there were also at times explicit acknowledgements by participants that something about their story made it difficult for them to make use of what property and help they were offered through homelessness services. They knew they were not ready for moving on but they also felt stuck, in that not being ready to move on meant they were defined as somehow not capable, not engaging or maybe just plain difficult people.

The reality was that the pace of transition was too quick for them, and there was not enough coordinated thinking between and within health and housing, for example, that would have prioritised the pace of transition as something to pay attention to. Paying attention to the pace of transition, appropriate for each individual, may have allowed the following comments about what living in a house may mean for them to be heard sooner.

*Yeh, that's right. I've never had somewhere solid to sleep and when I actually did find somewhere to sleep I couldn't bear it. I was so frightened...Well, when they sort of...when the services sort of found me a place to have a bit of shelter, like in a little flat, a move on flat I can never deal with it, I always sort of turn back to, turn back to drink. I don't know...you see...I don't know...services used to get me places and I'd walk, I'd be so unsure and so frightened straightaway.*

Mr HR<sup>58</sup>

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<sup>56</sup> Mr DF-transcript H

<sup>57</sup> Mr 1A-transcript H

*So as long as there is a house, that's it, you're no longer homeless so they don't actually look at your specific need and in my case, getting the diagnosis [Asperger's Syndrome] afterwards of a disability...that doesn't...there's no recourse to go back and say "This isn't appropriate for these reasons". As you know, I've been fighting that for 3 years.*

Mr DF<sup>59</sup>

*Well, I don't believe it's mine. I think someone's going to come and take it away from me, you know... I think somebody's going to knock on the door and say, "Right, get out", you know, even though it's a secure tenancy. But I just think negative and I think someone's going to come in...I don't know, because another thing as well, like, if I make something to eat, if I can be bothered, I always clean up after me. I make sure the place is spick and span. It's like someone's going to come knocking on that door. When I get up in a morning I always make the bed up again and put the duvet back up. So, everything's got to be perfect because I'm expecting somebody to take it away from me...I never had a home...*

Mr IL<sup>60</sup>

*I'm not used to being in a home...For instance, the environment I'm in at the minute resembles a home, feels...it's starting to feel like a home and I'm becoming partly at home within it. But having said that...but even though these are positive attributes... having said that, I have never been in an environment such as that, a home environment, on my own. I'm not used to being on my own in that kind of home environment. I'm used to being on my own in an extremity because that seems...I've become familiar with living in extremes...I have always had to*

Mr 1A<sup>61</sup>

e) Good working relationships; a citizenship of homelessness and avoiding stigma

Homelessness services as a whole value and support the building of good working relationships with clients. In so doing they may inadvertently foster a paradox similar to that described by Mills et al in their study on specialist primary care services to homelessness: *"[In] maximizing flexibility and fostering relationships between patients and the clinical team [the practice becomes part of] a citizenship of homeless persons while simultaneously aiming to help people move out of homelessness into a more settled state."*<sup>62</sup>

However, similar to Mills et al the evidence in this project suggests that the potential obstacle of creating a settled citizenship of homeless persons can be avoided by reframing the *"problem of*

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<sup>58</sup> Mr HR-transcript H

<sup>59</sup> Mr DF-transcript H

<sup>60</sup> Mr IL-transcript H

<sup>61</sup> Mr 1A-transcript H

<sup>62</sup> E D Mills, C D Burton & C Matheson, Engaging the citizenship of the homeless-a qualitative study of specialist primary care providers, Family Practice, Vol. 32, No. 4, 462-467, May 2015, p466

*'weaning' people off highly supportive services into one of helping people engage with wider communities while maintaining their homeless citizenship for as long as it is helpful.*"<sup>63</sup> There may be a small percentage of people for whom independent living is not a realistic option, and in such cases 'weaning' people off highly supportive services would not be the best option.

An important point in relation to this issue of a potential settled homeless citizenship was made by one participant who clearly identified a risk for him, and notably, in identifying the risk he also identified that it was no longer a risk to him.

*It's stigmatizing [homelessness] and the stigmas that are attached to it sink in, you soak it up, my whole understanding of myself got wrapped up in homelessness...as if this was me...my life...I had to shed that skin...*

Mr 1A<sup>64</sup>

Lisa McKenzie, a research fellow at the London School of Economics and Political Science, describes the potential stigmatising nature in any settled citizenship, in her book looking at life on an estate in Nottingham called St Anns.

[T]he men rarely thought about their public profile outside the estate. In effect, the men tried to be invisible on the outside....The levels of fear and exclusion that are experienced in this community also affected issues of mobility, the difficulties that sections of the neighbourhood had in moving in and out of the estate, but also the difficulties that arose from having real emotional attachment to a place, therefore not only belonging to St Ann's, but 'being St Ann's'.

(McKenzie, 2015)<sup>65</sup>

Moving on is about transition, a potentially vitalising and life-giving change of circumstances. Paying attention to attachment dynamics is important in order to ensure that we help our clients to make sustainable changes in their lives, including that of making a home for them and their families. The feedback from participants in this project suggests that homelessness services can work together at the pace of transition needed in individual cases, and indeed it is imperative that they do so in order to ensure sustainable long-term move on. Otherwise, as with some of the citizens of St Ann's, people who are homeless may also remain identified with the very thing that afflicts them: homelessness.

## Conclusion

The subjects in this project have shown that moving on from homelessness is enabled when attention is paid to their careseeking styles, already developed and modified in response to their whole life experiences of care. The patterns of instinctive behaviour through which these

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<sup>63</sup> ibid p466

<sup>64</sup> Mr 1A-transcript H

<sup>65</sup> Lisa McKenzie, *Getting By: Estates, Class and Culture in Austerity Britain*, Policy Press, University of Bristol, 2015, p51

careseeking styles are expressed may not all be unhelpful, but if not attended to and thought about may remain as significant potential obstacles to moving on.

The participants in this project are in the 30-40% group of presentations to housing services. Yes, they need a home, but this intervention in their lives needs to be at a pace that takes account of the social and health experiences of inequity across their life span. Not taking account of such inequities, and case managing appropriately in a supportive and companionable way is costly, resulting in repeat presentations, failed tenancies, increased ill health, and sadly in some cases a lonely death in an empty house.<sup>66</sup>

The subjects above were all referred to me as people with mental health problems, but the scope of my project was not broad enough to explore the inter-relationships between mental illness, care & treatment in hospital and community settings and the place of attachment relationships. A project of this nature would be helpful in enabling homelessness services to look at how they can collaboratively integrate attachment-related concepts in all areas of care such as housing, for example.

I had a 100% attendance record in this project group which suggests to me that the richness and nurture of a supportive, companionable, exploratory, attachment-based relationship is seen as helpful by clients. Much of this work is specialist, however, there are attachment-based approaches that all staff can incorporate in to their practice, this need not just be the domain of clinical health staff.

The evidence in this paper with respect to health suggests the, “need for a *process* approach which supports an effective transition from the (sometimes necessary) use of specialist services...towards (the ideal of) full integration into mainstream health care.”<sup>67</sup> This need for a process approach is equally applicable to all homelessness services. Participants in this project suggest the need for a focus on “transitional” service structures that ensures that, for example, housing & health are communicating fully and offering (and discharging from) their respective inputs at client pace of recovery.<sup>68</sup>

With respect to psychotherapy, yes, participants are also suggesting this as helpful, however, they highlight a need for an inclusive psychotherapy and not one which operates from a clinician standpoint which has the clinician identifying themselves as mostly working “on the edge of conventional psychotherapeutic practice...”.<sup>69</sup> The convention participants are suggesting, if one is

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<sup>66</sup> Edinburgh Access Practice, Practice Mental Health Nurse caseload audit, 2014/15

<sup>67</sup> Isobel Anderson and Siri Ytrehus, Re-conceptualising Approaches to Meeting the Health Needs of Homeless People, School of Applied Social Science, University of Stirling, Stirling FK9 4LA, United Kingdom email: [isobel.anderson@stir.ac.uk](mailto:isobel.anderson@stir.ac.uk) & Diakonhjemmet University College, Institute of Nursing and Health, Oslo, Norway, email: [siri.ytrehus@diakonhjemmet.no](mailto:siri.ytrehus@diakonhjemmet.no), Jnl Soc. Pol. (2012), 41, 3, 551–568 C \_ Cambridge University Press 2012

<sup>68</sup> *ibid*

<sup>69</sup> Gabrielle Brown et al., An hospitable engagement? Open-door psychotherapy with the socially excluded, *Psychodynamic Practice*, Volume 17, No 3, August 2011

needed, is that practiced thoughtfulness (appropriately supervised & theoretically coherent) needs to be a part of individual service delivery and culture, throughout homelessness services.<sup>70</sup>

## Recommendations

1. A practice-based research project to be designed to look at integrating attachment-based concepts within care services used by people who are homeless. This would need appropriately funded and academically supervised
2. Sustainable move on should become a priority across care services, and what we mean by the terms 'move on' should be investigated, with care services, for example, primary and secondary care and housing services collaborating on best practice in relation to homelessness
3. That staff in all homelessness services receive access to appropriate support and supervision, as they wish, to enable them in continuing to provide attentive care.
4. That those staff in all disciplines who work with the 30-40% of people that this project has identified as needing attentive care, are enabled to continue to do this by themselves receiving attentive care with respect to **not** leaving them to shoulder the burden of unrealistic case-loads

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<sup>70</sup> Nick Maguire et. al, Psychologically informed services for homeless people, Good Practice Guide, February 2012



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