Consensus based good practice guidelines for clinical psychologists working in and with homelessness

Dr Jen Wells and Dr Anna Tickle
Clinical Psychologists

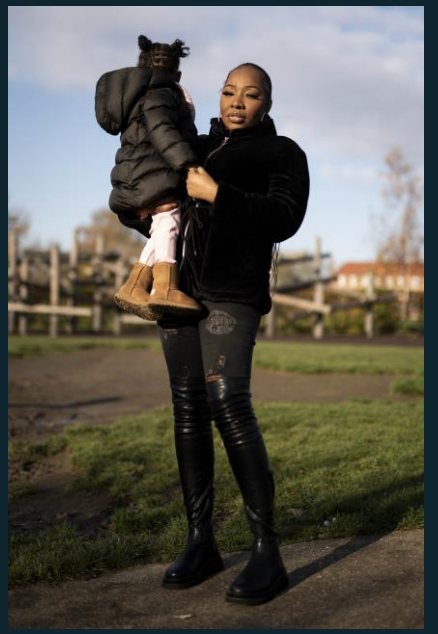
6th December 2023

Outline

- Poll
- Homelessness: definitions and prevalence
- Homelessness and clinical psychology
- Existing inclusion health guidance
- Guidelines for clinical psychologists

Poll

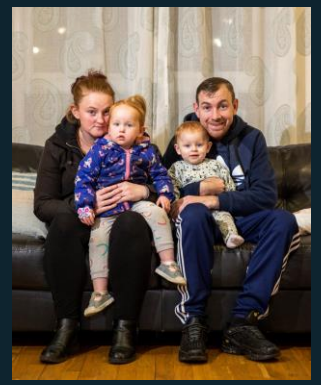
https://www.menti.com/al6p2ra3xjei



ACP UK
ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Homelessness

- Legal definition: ‘a household has no home in the UK or anywhere else in the world available and reasonable to occupy’.
- Rooflessness
- Houselessness (temporary accommodation, institution / shelter)
- Insecure housing (e.g. insecure tenancy, domestic abuse, sofa surfing)
- Inadequate housing (e.g. unfit, overcrowded, caravans on illegal campsites)



The (miserable) statistics

Rising since 2010, attributed to austerity2,3. Most recent figures4:

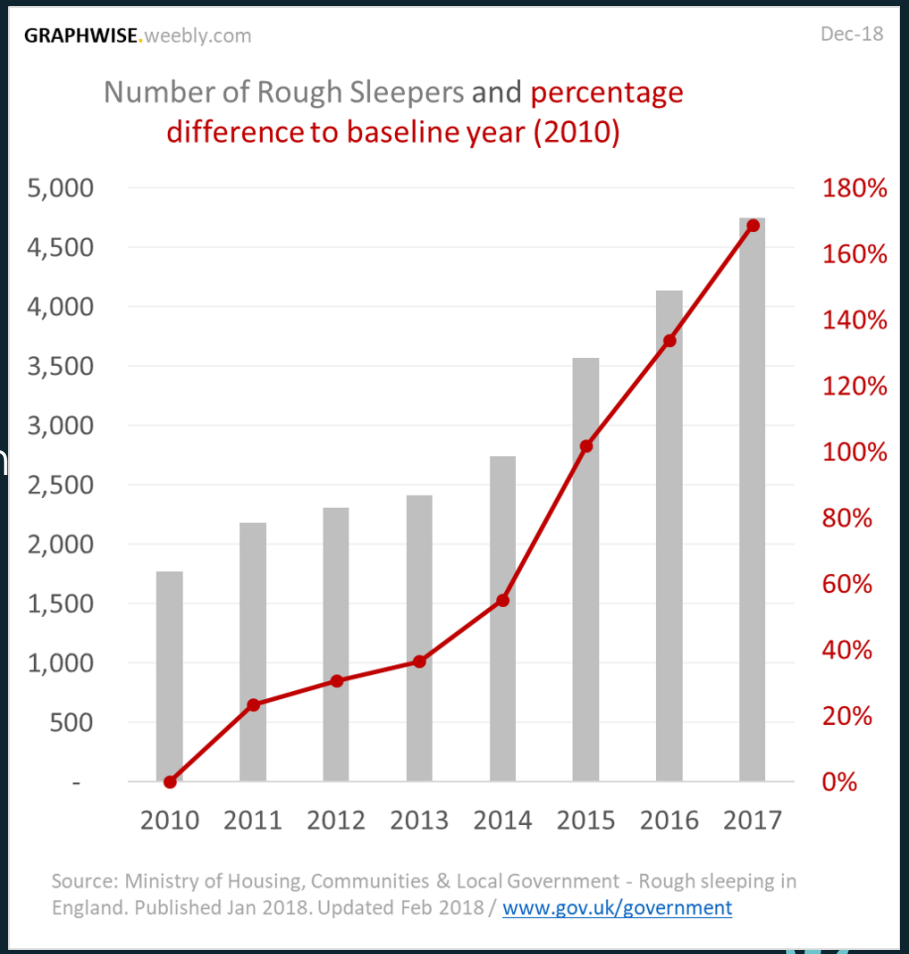
England: 271000 people, including 123000 children (6% increase on 2021-22)

N. Ireland: 8120 households (Jan – Jun 2022; 9.6% increase on previous six months)

Scotland: 32242 households: 36848 adults; 16263 children (9% increase in open applications for support)

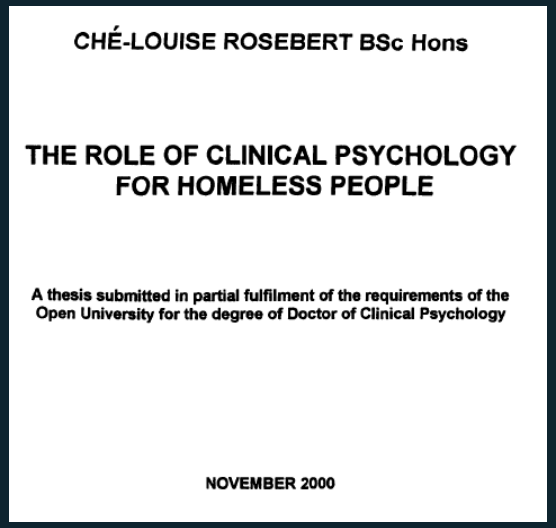
Wales: 12537 households (7% increase on 2021-22).

Rough sleeping figures based on 'head counts'. Women often hidden but increasing presence.



ACP UK
ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Homelessness and Clinical Psychology



CHÉ-LOUISE ROSEBERT BSc Hons

THE ROLE OF CLINICAL PSYCHOLOGY FOR HOMELESS PEOPLE

A thesis submitted in partial fulfilment of the requirements of the Open University for the degree of Doctor of Clinical Psychology

NOVEMBER 2000

Clinical Psychologist x 11

Crisis UK

London, Greater London

EH8, Edinburgh

Newcastle upon Tyne, Tyne and Wear

SA1, Swansea

£44,606 - £60,983 per year

Permanent, Part-time, Full-time

Psychologically informed services for homeless people

Good Practice Guide

February 2012

This document is interactive and has been linked for easy navigation and use. Link through pages using the document map or the colour coded menus on the right.

Acknowledgments

We are very grateful indeed to the many colleagues around the country who contributed so much to this guide and who provided case studies.

Particular thanks are offered to:

Helen Keats, National Rough Sleeping Advisor, Department for Communities and Local Government

Dr Nick Maguire, Chartered Clinical Psychologist and Deputy Director, PG Dip/Cert in Cognitive Behaviour Therapy, University of Southampton

Robin Johnson, RJA Consultancy, Joint Editor Housing Care and Support

Peter Cockersell, Psychoanalytic Psychotherapist; Director of Health & Recovery, St Mungo's; Director of Homeless Healthcare CIC

SPY Design and Publishing Ltd for design and production www.spydesign.co.uk

For further information on any aspect of the guide please contact:
helen.keats@communities.gsi.gov.uk

Click to go to →

Document Map

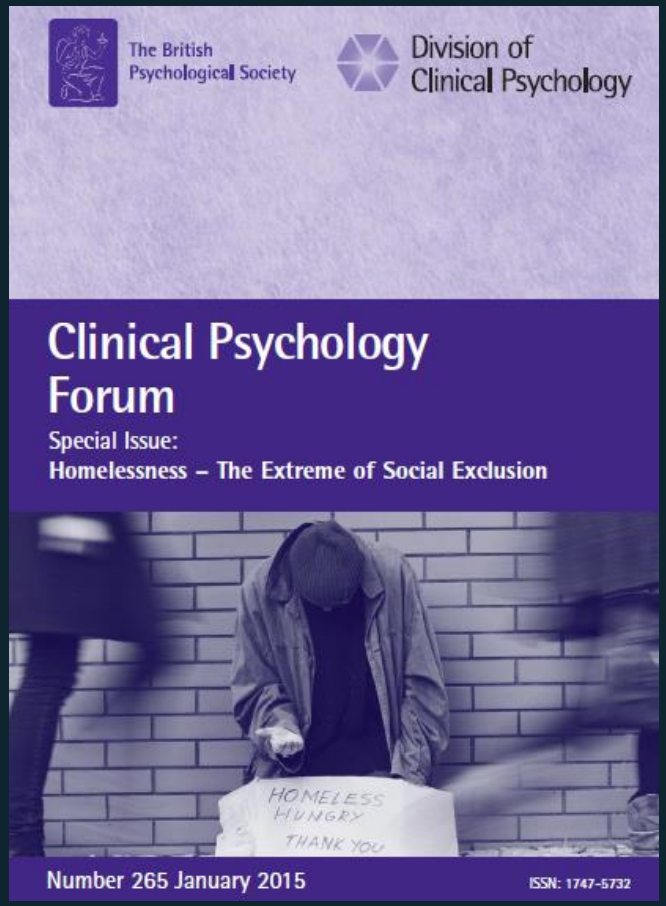
Introduction

Psychologically Informed Environments (PIE)

Five key areas

Case studies

Appendix



The British Psychological Society

Division of Clinical Psychology

Clinical Psychology Forum

Special Issue:
Homelessness – The Extreme of Social Exclusion

Number 265 January 2015

ISSN: 1747-5732

www.acpuk.org.uk

ACP UK
ASSOCIATION OF CLINICAL PSYCHOLOGISTS

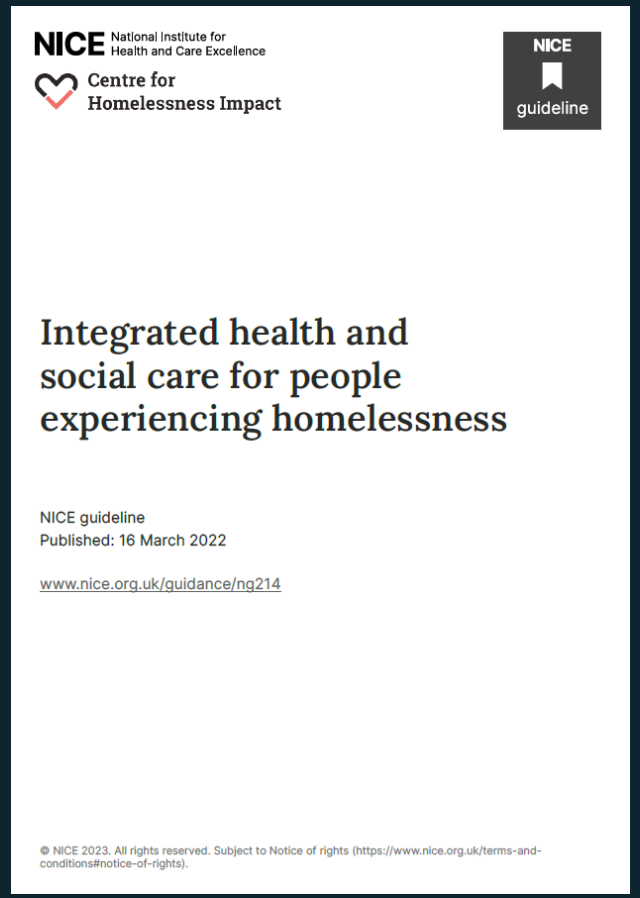
Standards for mental health services

Many Inclusion Health patients have mental health problems and experience difficulty in accessing and maintaining therapeutic relationships with mental health services.
The particular vulnerability of those who have experienced traumatic events such as homelessness is recognised in the Five Year Forward View for Mental Health,[26] and the scandal of large numbers of long-term rough sleepers experiencing mental illness has been highlighted by St Mungo's.[99] There is a growing understanding that although psychosis is more prevalent amongst people experiencing homelessness, severe and enduring mental illness is not the main disease category. The mental health problems associated with social exclusion are predominantly anxiety and depression, complicated by complex childhood trauma and personality disorder, and underdiagnosed disabilities such as autism spectrum disorder, learning disability and acquired brain injury. Dependency on alcohol and/or drugs presents a common complication.

Standards for community mental health services

Where there are significant numbers of homeless or other excluded people, specialist services may be necessary; in other areas enhanced access to mainstream services may suffice. In both situations, services should be provided to the standards outlined. A willingness to work around relatively high rates of non-attendance at appointments will help to ensure that patients are not further excluded. It is crucial that mental health services are integrated with other health services and that there is good communication between them.

Assessments by mental health professionals can be pivotal in enabling someone who is homeless to access appropriate accommodation, or improve the ability of an existing housing service to understand and help someone. Mental health professionals should ensure that their assessments consider this and do not remain focused on gatekeeping access to particular treatments.



1.5.1 Design and deliver services in a way that **reduces barriers to access and engagement** with health and social care

1.5.2 Do **not penalise people experiencing homelessness for missing appointments**, for example, by discharging people from the service. Consider seeking specialist help, such as peer supporters or independent advocates, to support the person to attend appointments and re-engage with care after missing appointments

1.5.4 Commissioners and service providers should follow the recommendations on **improving access to services in NICE's guideline on common mental health problems**.

1.5.5 Ensure that people experiencing homelessness with multiple health or social care needs are **not excluded from services because of restrictive eligibility criteria**. For example, people with mental health problems are not denied access to mental health services because they have drug and alcohol treatment needs (see also NICE's guideline on coexisting severe mental illness and substance misuse).

1.5.12 **Consider moving people up waiting lists** for health and social care appointments if they are experiencing homelessness because their circumstances may mean they are at higher risk of deterioration and premature death.

https://www.nice.org.uk/guidance/ng214

Many reasons Clinical Psychologists should be developing service provision

- **Overrepresentation of:**
  - psychological trauma and mental health problems: predictor and consequence of homelessness[10,11].
  - 82% have at least one diagnosed mental health problem, compared to a national population average of 12%. 25% have coexisting mental health and substance use needs; a further 25% report self-medicating with drugs or alcohol. Of those with a mental health diagnosis, diagnosis predated homelessness for 72%.
  - neurodevelopmental issues / neurodiversity
  - neuropsychological issues / acquired brain injury
  - physical health problems that influence mental health and behaviour

- **Trained in:**
  - specialist assessment, formulation and intervention; multi-professional working and 'complex clinical contexts'
  - working with staff teams and organisations, including understanding issues of staff wellbeing and vicarious trauma.
  - reflective scientist-practitioner approaches

- **But:** many approaches to developing psychologically- and trauma-informed environments.
- Practice-based evidence since 2012 PIEs guidance but no updated guidance for psychologists, services and commissioners.

The University of Nottingham | Framework For your future | opportunity NOTTINGHAM Believing in people. Inspiring change. | homeless link | ACP UK

Practice-based guidelines:

Clinical Psychologists working with and in Homelessness

Authors: Dr Jennifer Wells (University of Nottingham),
Dr Anna Tickle (Opportunity Nottingham and Framework) and
Dr Danielle De Boos (University of Nottingham)

January 2023

www.opportunitynottingham.co.uk
0115 850 4128
@OppNottingham YouTube Search for Opportunity Nottingham

COMMUNITY FUND
Opportunity Nottingham is made possible by funding from the National Lottery Community Fund.

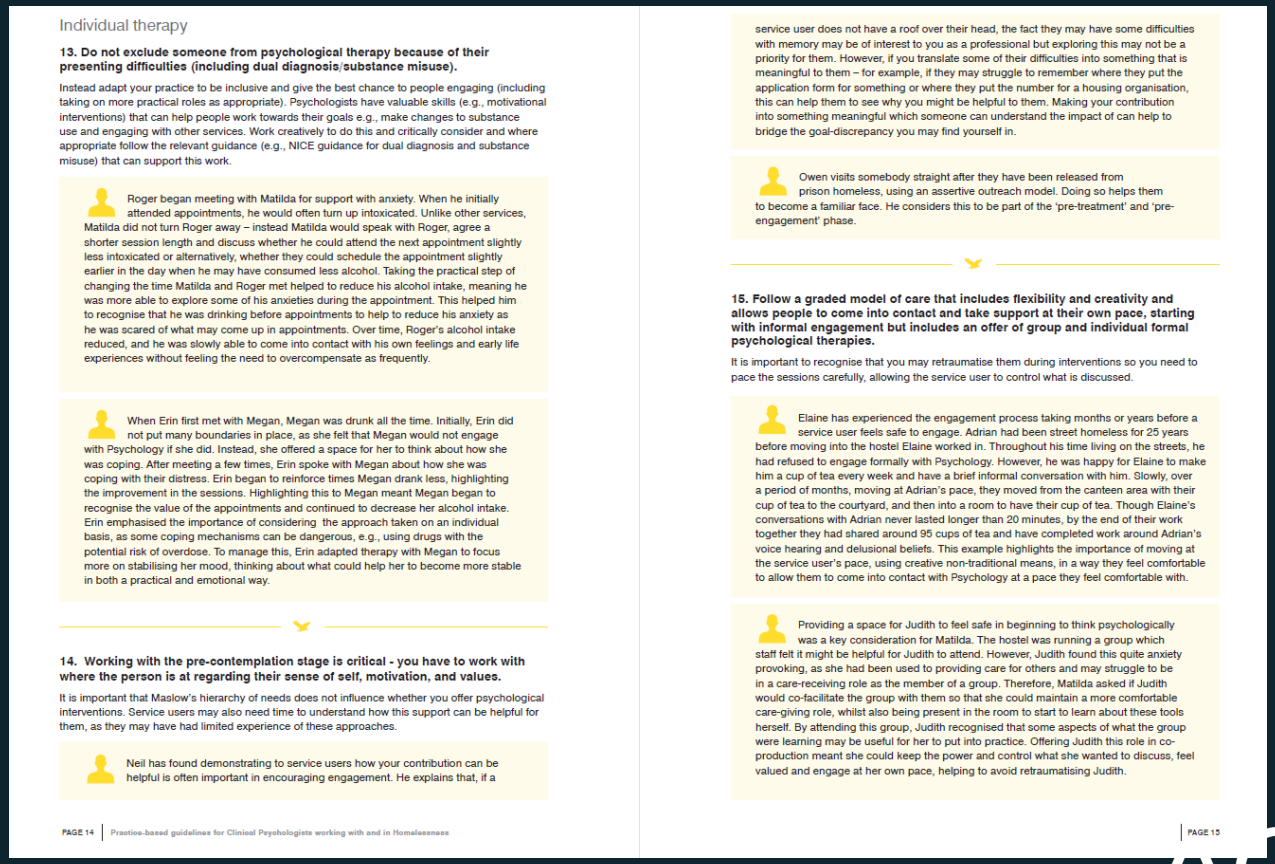
Contents

Introduction ... PAGE 04
Acknowledgements ... PAGE 04
Direct working guidelines ... PAGE 05
- Approach ... PAGE 05
- Multi-agency working ... PAGE 10
- Individual therapy ... PAGE 14

Indirect working guidelines ... PAGE 21
- Relationships with and support for staff ... PAGE 21
- Supporting staff to support service users, including building therapeutic skills ... PAGE 25
- Approaching systems change ... PAGE 31
- Contributing to the evidence base ... PAGE 36

Resources ... PAGE 37

23 direct and 26 indirect guidelines endorsed



Individual therapy

13. Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse).

Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g., motivational interventions) that can help people work towards their goals e.g., make changes to substance use and engaging with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g., NICE guidance for dual diagnosis and substance misuse) that can support this work.

Roger began meeting with Matilda for support with anxiety. When he initially attended appointments, he would often turn up intoxicated. Unlike other services, Matilda did not turn Roger away – instead Matilda would speak with Roger, agree a shorter session length and discuss whether he could attend the next appointment slightly less intoxicated or alternatively, whether they could schedule the appointment slightly earlier in the day when he may have consumed less alcohol. Taking the practical step of changing the time Matilda and Roger met helped to reduce his alcohol intake, meaning he was more able to explore some of his anxieties during the appointment. This helped him to recognise that he was drinking before appointments to help to reduce his anxiety as he was scared of what may come up in appointments. Over time, Roger's alcohol intake reduced, and he was slowly able to come into contact with his own feelings and early life experiences without feeling the need to overcompensate as frequently.

When Erin first met with Megan, Megan was drunk all the time. Initially, Erin did not put many boundaries in place, as she felt that Megan would not engage with Psychology if she did. Instead, she offered a space for her to think about how she was coping. After meeting a few times, Erin spoke with Megan about how she was coping with their distress. Erin began to reinforce times Megan drank less, highlighting the improvement in the sessions. Highlighting this to Megan meant Megan began to recognise the value of the appointments and continued to decrease her alcohol intake. Erin emphasised the importance of considering the approach taken on an individual basis, as some coping mechanisms can be dangerous, e.g., using drugs with the potential risk of overdose. To manage this, Erin adapted therapy with Megan to focus more on stabilising her mood, thinking about what could help her to become more stable in both a practical and emotional way.

14. Working with the pre-contemplation stage is critical - you have to work with where the person is at regarding their sense of self, motivation, and values.

It is important that Maslow's hierarchy of needs does not influence whether you offer psychological interventions. Service users may also need time to understand how this support can be helpful for them, as they may have had limited experience of these approaches.

Neil has found demonstrating to service users how your contribution can be helpful is often important in encouraging engagement. He explains that, if a service user does not have a roof over their head, the fact they may have some difficulties with memory may be of interest to you as a professional but exploring this may not be a priority for them. However, if you translate some of their difficulties into something that is meaningful to them – for example, if they may struggle to remember where they put the application form for something or where they put the number for a housing organisation, this can help them to see why you might be helpful to them. Making your contribution into something meaningful which someone can understand the impact of can help to bridge the goal-discrepancy you may find yourself in.

Owen visits somebody straight after they have been released from prison homeless, using an assertive outreach model. Doing so helps them to become a familiar face. He considers this to be part of the 'pre-treatment' and 'pre-engagement' phase.

15. Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies.

It is important to recognise that you may retraumatise them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.

Elaine has experienced the engagement process taking months or years before a service user feels safe to engage. Adrian had been street homeless for 25 years before moving into the hostel Elaine worked in. Throughout his time living on the streets, he had refused to engage formally with Psychology. However, he was happy for Elaine to make him a cup of tea every week and have a brief informal conversation with him. Slowly, over a period of months, moving at Adrian's pace, they moved from the canteen area with their cup of tea to the courtyard, and then into a room to have their cup of tea. Though Elaine's conversations with Adrian never lasted longer than 20 minutes, by the end of their work together they had shared around 95 cups of tea and have completed work around Adrian's voice hearing and delusional beliefs. This example highlights the importance of moving at the service user's pace, using creative non-traditional means, in a way they feel comfortable to allow them to come into contact with Psychology at a pace they feel comfortable with.

Providing a space for Judith to feel safe in beginning to think psychologically was a key consideration for Matilda. The hostel was running a group which staff felt it might be helpful for Judith to attend. However, Judith found this quite anxiety provoking, as she had been used to providing care for others and may struggle to be in a care-receiving role as the member of a group. Therefore, Matilda asked if Judith would co-facilitate the group with them so that she could maintain a more comfortable care-giving role, whilst also being present in the room to start to learn about these tools herself. By attending this group, Judith recognised that some aspects of what the group were learning may be useful for her to put into practice. Offering Judith this role in co-production meant she could keep the power and control what she wanted to discuss, feel valued and engage at her own pace, helping to avoid retraumatising Judith.

References

1. Public Health England (2019). Homelessness: Applying All Our Health. https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health
2. Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S., Watts, B. & Wood, J. (2018). *The homelessness monitor: England 2018*. https://www.crisis.org.uk/media/238700/homelessness_monitor_england_2018.pdf
3. Fransham, M. (2018). Homelessness and public health. *BMJ, 360*: k214. doi:10.1136/bmj.k214. https://www.bmj.com/content/360/bmj.k214?hwshib2=authn%3A1701819117%3A20231204%253A6cddc589-dabb-4b29-957a-2fb78d12bd59%3A0%3A0%3A0%3AyUsZHXNVsXr3BjpAz7MCoQ%3D%3D
4. Geraghty, L. (2 Nov 2023). Homelessness facts and statistics: The numbers you need to know in 2023. https://www.bigissue.com/news/housing/britains-homelessness-shame-cold-hard-facts/
5. Rosebert, C-L. (2000). *The role of clinical psychology for homeless people.* PhD Thesis The Open University.
6. Keats ,H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012). *Psychologically informed services for homeless people. Good practice guide*. Department of Communities and Local Government. https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf
7. Clinical Psychology Forum (2015). Special Issue: Homelessness – The extreme of social exclusion. 265
8. Hewett, N. (Ed.). (2018). *Homeless and Inclusion Health standards for commissioners and service providers.* Available at: https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf
9. The National Institute for Health and Care Excellence (2022). Integrated health and social care for people experiencing homelessness. NICE Guideline [NG214]. https://www.nice.org.uk/guidance/ng214
10. Fazel S, Khosla V, Doll H, Geddes J (2008) The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis. PLoS Med 5(12): e225. https://doi.org/10.1371/journal.pmed.0050225
11. Mejia-Lancheros C, Lachaud J, O'Campo P, Wiens K, Nisenbaum R, Wang R, et al. (2020) Trajectories and mental health-related predictors of perceived discrimination and stigma among homeless adults with mental illness. PLoS ONE 15(2): e0229385. https://doi.org/10.1371/journal.pone.0229385
12. Homeless Link (2022). The unhealthy state of homelessness 2022. Findings from the Homeless Health Needs Audit. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
13. Wells, J., Tickle, A., De Boos, D. (2023). Practice-based guidelines: Clinical psychologists working with and in homelessness. https://homelesslink-1b54.kxcdn.com/media/documents/Practice-based_guidelines_-_Clinical_Psychologists_working_with_and_in_homelessness.pdf

Resources

https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health This website includes:

- free e-learning on homelessness from Public Health England and Health Education England
- written guidance on policy / legislation, core principles for health and care professionals, and how to take action, whether in direct service provision or strategic developments.
- Further resources and reading.

https://www.pathway.org.uk/faculty/ Faculty for homeless and inclusion health

https://homeless.org.uk/ National membership charity for organisations in homelessness sector.

https://www.homelessnessimpact.org/news/introducing-the-first-free-library-non-stigmatising-images-of-people-experiencing-homelessness

Thank you

Jen Wells: Jennifer.wells9@nhs.net, Birmingham Community NHS Foundation Trust

Anna Tickle: Anna.Tickle@frameworkha.org

South London and Maudsley NHS
NHS Foundation Trust

Damage to the brain and changes in cognition: working with people who experience multiple and complex disadvantage

Dr Jess Barton and Dr Lily Krause,

Highly Specialist Clinical Psychologists

Psychology in Hostels Team

SLAM

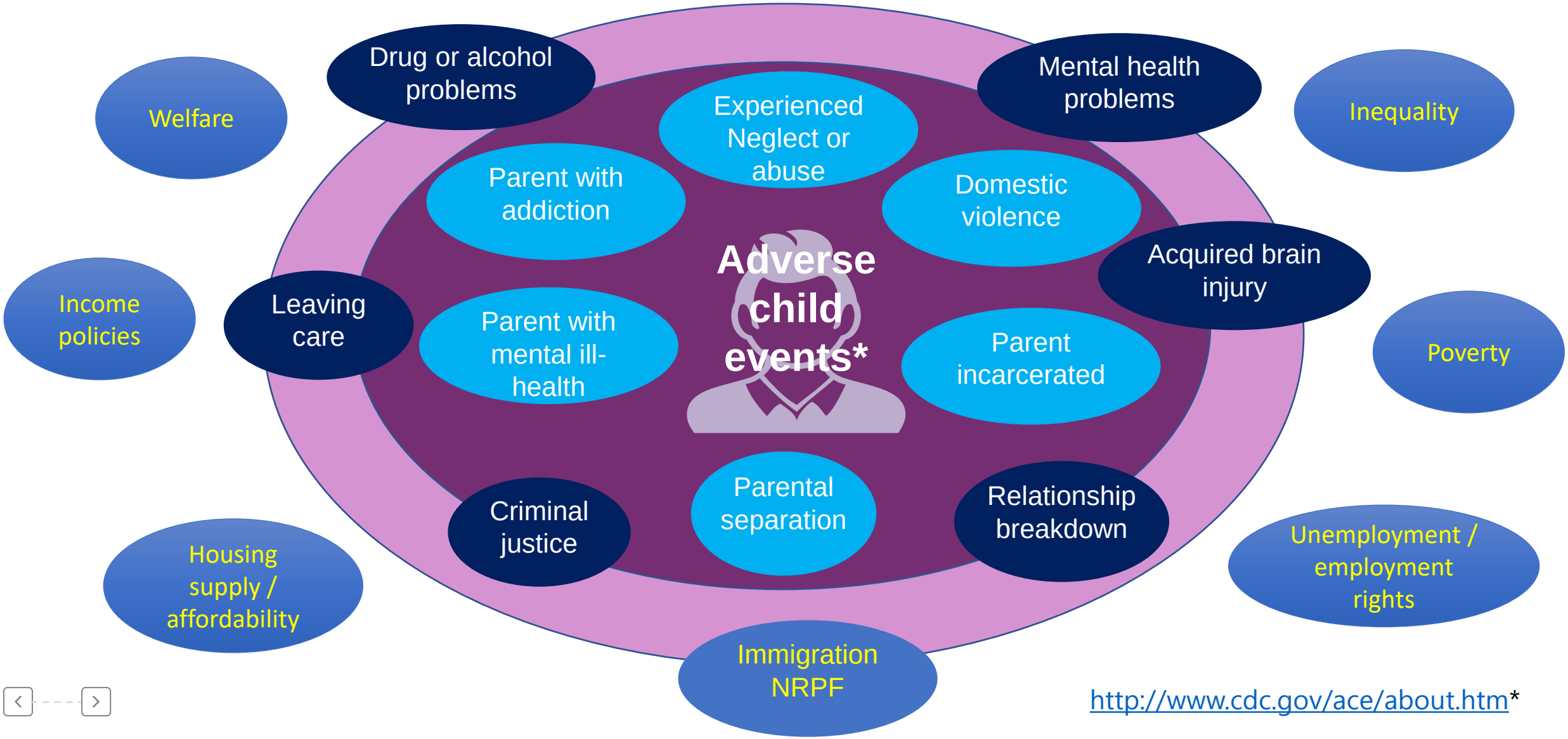
Overview

- About the Psychology in Hostels team
- About the Homeless Neuropsychology Pathway
- Cognition, Brain Injury and Homelessness
- Neuropsychological Formulation in Homelessness
- Challenges associated with working with this client group

About the Psychology in Hostels Team

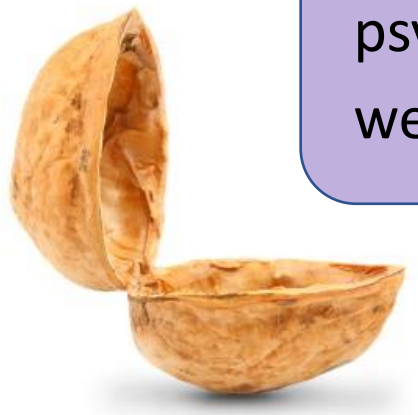
Underlying causes of homelessness

Many routes to homelessness – Structural causes and Individual vulnerabilities



http://www.cdc.gov/ace/about.htm*

What is PIE in a nutshell?

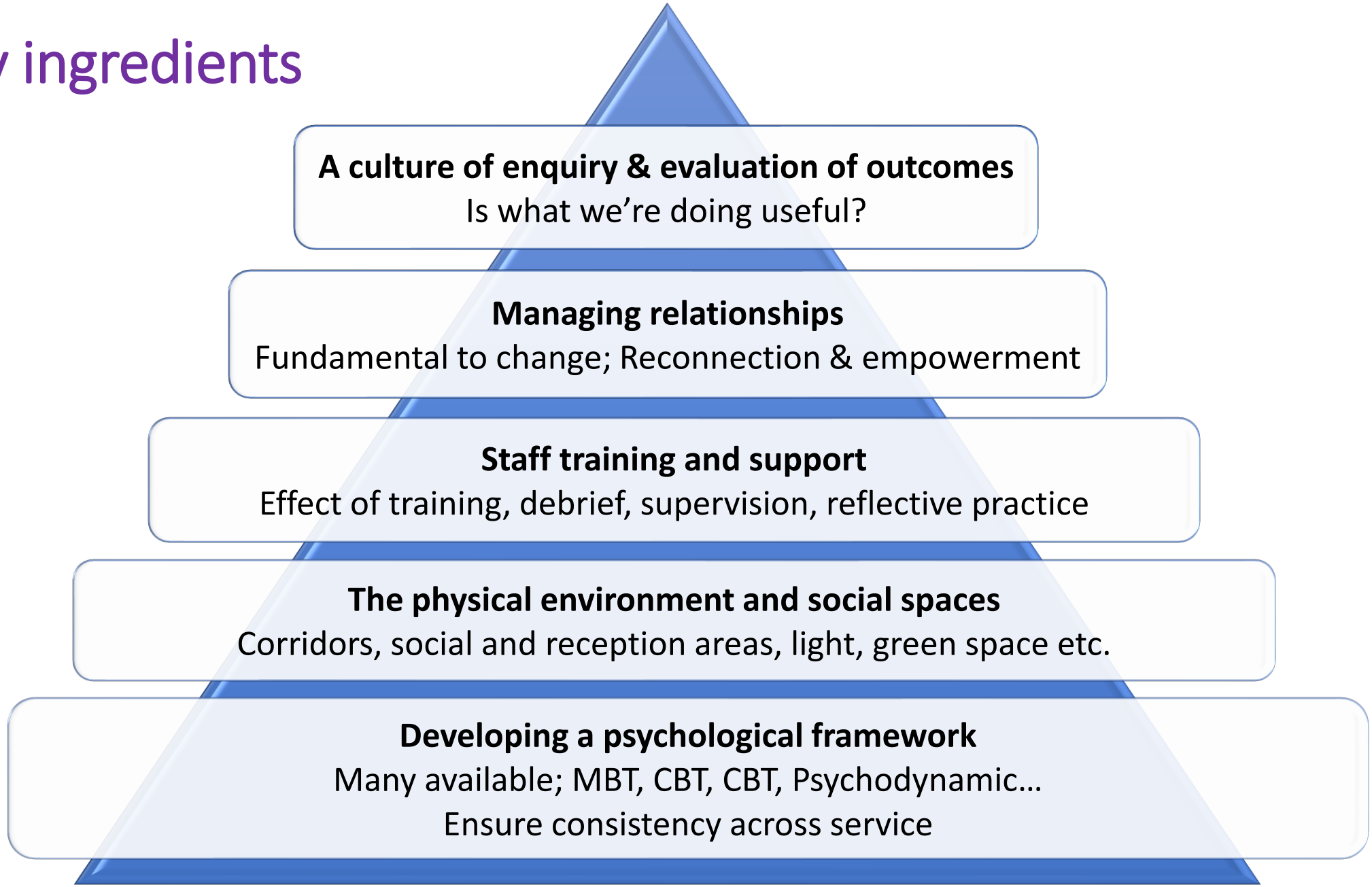


A PIE is any setting/service/organisation with a coherent psychological framework that holds trauma, mental health and wellbeing at the centre of its understanding and interventions.

"…the definitive marker of a PIE is simply that, if asked why the unit is run in such and such a way, the staff would give an answer couched in terms of ***the emotional and psychological needs of the service users****, rather than giving some more logistical or practical rationale, such as convenience, costs, or Health And Safety regulations"*

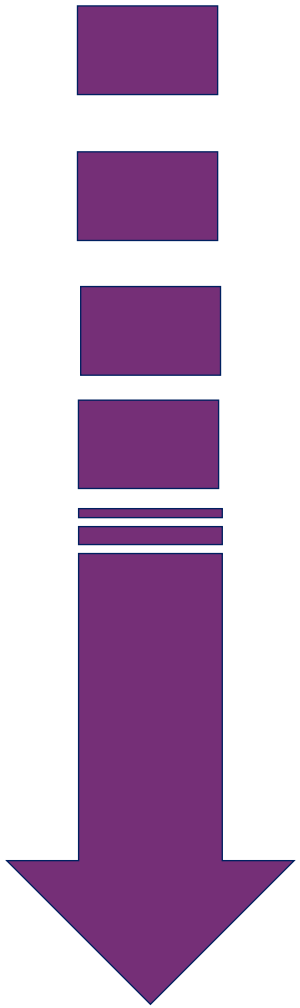
Johnson & Haigh (2010)

Five key ingredients



Graded Proximity of Interventions

Claustrophobic-Agoraphobic Dilemma



- Container: *Hostel & Management Structure*
  - Shared Leadership
  - Environment
- Indirect Work: *Hostel staff level interventions*
  - MBT training
  - Consultation
  - Reflective practice
  - Staff Guidelines
- Informal: *Informal activities* (medial proximity)
  - Playing Games
  - Gardening
  - Cups of tea
  - Dog Walking
- Direct: *Formal therapeutic work*
  - Specialist Ax + referrals
  - 1:1 & Group MBT
  - MBT Art Group
  - + Other Approaches

Evidence base for PIE

Clients in services that use PIE are found to be:

- 2.5 times less likely to be evicted
- 20% more likely to have positive move-on's
- 315% increased contact with primary care
- 38% increase in engagement with addiction services after 6 months of being in a PIE service, and at 18 months 62% of drug users and 75% of drinkers were engaged with treatment
- 51% reduction with criminal justice system
- Reduced staff burn-out

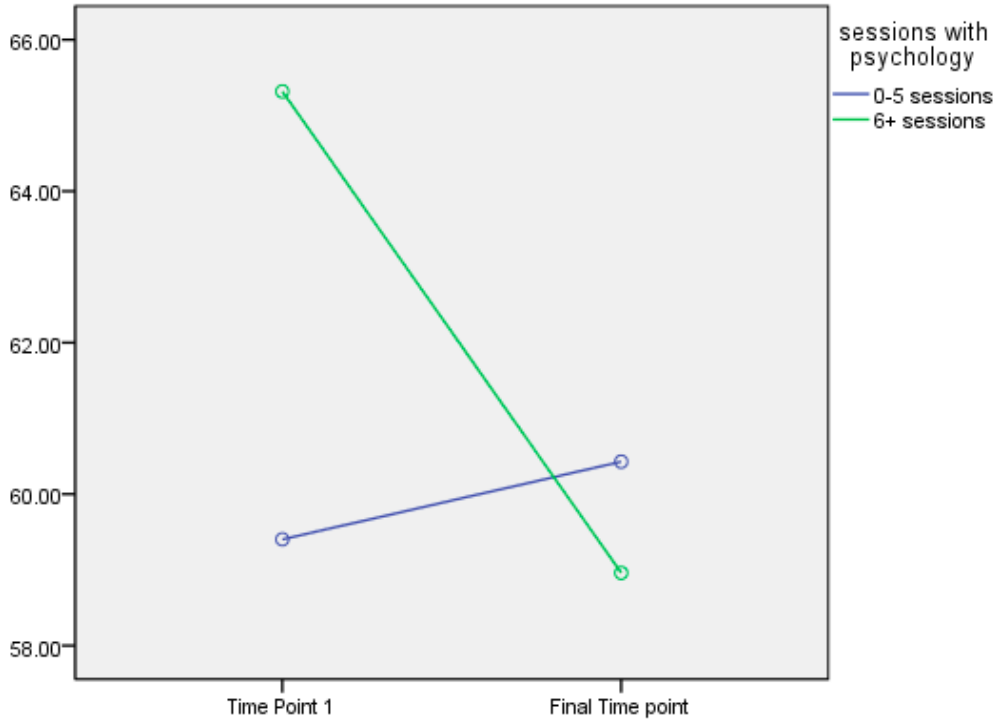
Cockersell 2016

Outcomes > MH, Economic & Social Impact

- Reaching unmet need: 78% attendance rate
- Large effect size improvement MH. Reduce: Self-harm, Aggression, Substance Use, D.&Ax
- Rough sleeping - 82% & Evictions -67%
- Resettlement: 6+ Psy. appt positive (p=0.016)

  13+ no exits prison/eviction/abandonment (p < 0.001)
- A&E attendance -57% ; Hospital in-patient admissions -27%
- Addictions Tx +61% compared to 2yr baseline
- All types Criminal Justice reduced. Nights in Custody – 84%, Prison Stay - 87% (£2000 pp pa)

CORE-10 SELF-REPORT DATA
6+ Psych Sessions



Total CORE score at Time Point 1 and Final Time point

About the Homeless Neuropsychology Pathway

Service offer

Aim to support clients who are:

- **Homeless and/or open to homelessness services** (this would include those in hostels or other forms of temporary accommodation)
- AND have a **diagnosed or suspected brain injury**
- AND are **not able to access support through other neuropsychological specific services**.
- The will also include the staff who work with them.

Vision: The aim of the HNP is to address the unmet neuropsychological needs for individuals experiencing homelessness and brain injury and to improve their outcomes.

Staffing

- 1.0 WTE Band 8A Highly Specialist Clinical Psychologist/Neuropsychologist – NHP Operational Lead.
  - 0.2 Harrow Road
  - 0.2 Neuro pathway specific delivery and leadership
  - 0.4 Joint Homelessness Team (offering specialist psychological and neuropsychological assessment and treatment).
- 0.4 WTE Band 7 Specialist Clinical Psychologists
- 0.2 WTE Homeless Neuro GP Specialist

What we offer

- Specialist neuropsychological assessment
- Specialist neuro GP assessment and interventions
- Recommendations and cognitive rehabilitation
- Support or advice around mental capacity assessments
- In relation to brain injury:
- Support for family and friends
- Consultation for services
- Education and training
- Support or advice to refer to other services

Homelessness and the impact on the brain

Why think about the brain and cognition in the context of homelessness?

- **Tri-morbidity** – mental health, physical health and substance misuse problems are common in homelessness and all can increase the risk of cognitive problems
- **Brain injuries are really common** – 51% have experienced traumatic brain injuries + alcohol related brain injury + neurodegenerative conditions + other acquired brain injuries – strokes + tumours
- **Brain injuries may be a cause of homelessness** (70% (→87%) report first injury pre homelessness)

Why think about the brain and cognition in the context of homelessness?

- And then people are **more at risk of brain injuries whilst experiencing homelessness** (hospital admissions for traumatic brain injury are 5x higher for people who are homeless)
- **Brain injuries can cause cognitive and mobility problems** which can make living life safely harder

What can interfere with how the brain works for people experiencing homelessness?

What can interfere with how the brain works for people experiencing homelessness?

- Mood and mental health
- Trauma
- Psychiatric medication and seizures
- Traumatic brain injury
- Neurodegenerative conditions
- Substances – legal, illegal, alcohol (see more on next slide)
- Many more…. tumours, strokes etc

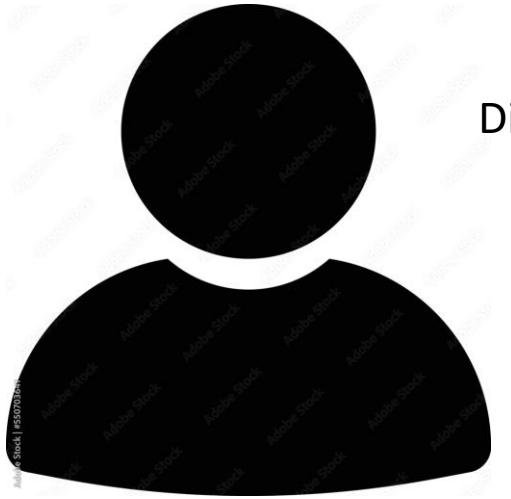
The acute effects of alcohol – signs of encephalopathy (brain swelling)

Abnormalities in the eyes or vision – for example, jerky movements, double vision, drooping eye

Confusion and disorientation

Memory impairments

Hallucinations



Dietary deficiencies (low vitamin B1)

Poorly coordinated walking

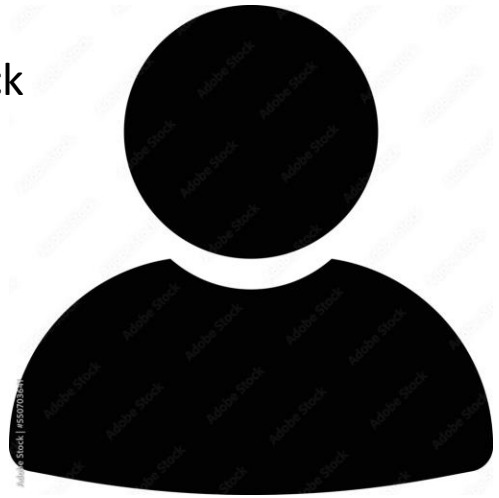
Poor balance

Korsakoff's syndrome

Behavioural changes - disorders of drive, control, monitoring, and emotional content

Memory: memory stuck in the moment – difficulties looking into the past or future

Confabulation – holding a false memory without intentionally trying to deceive someone



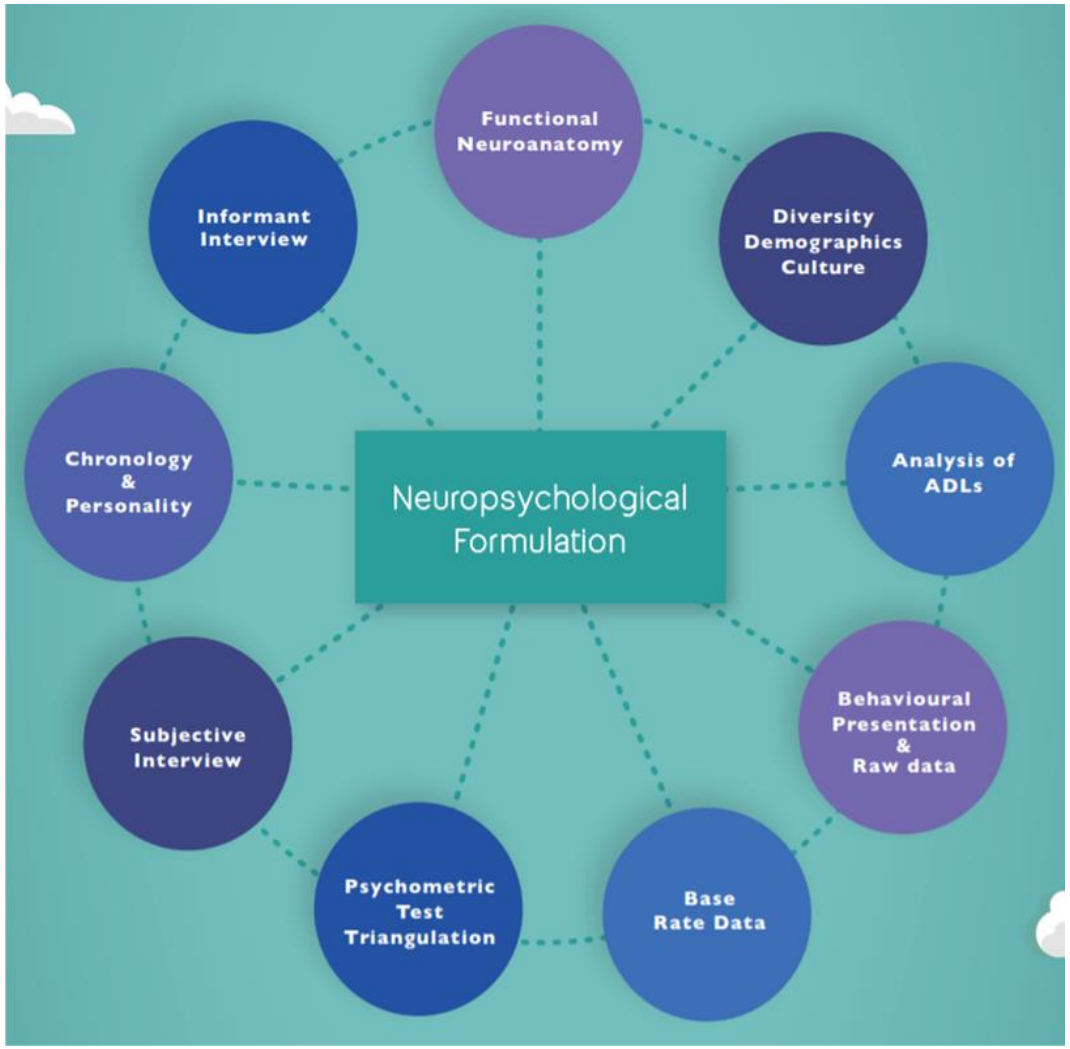
Personality change

Poor insight/ reduced awareness of changes in cognition

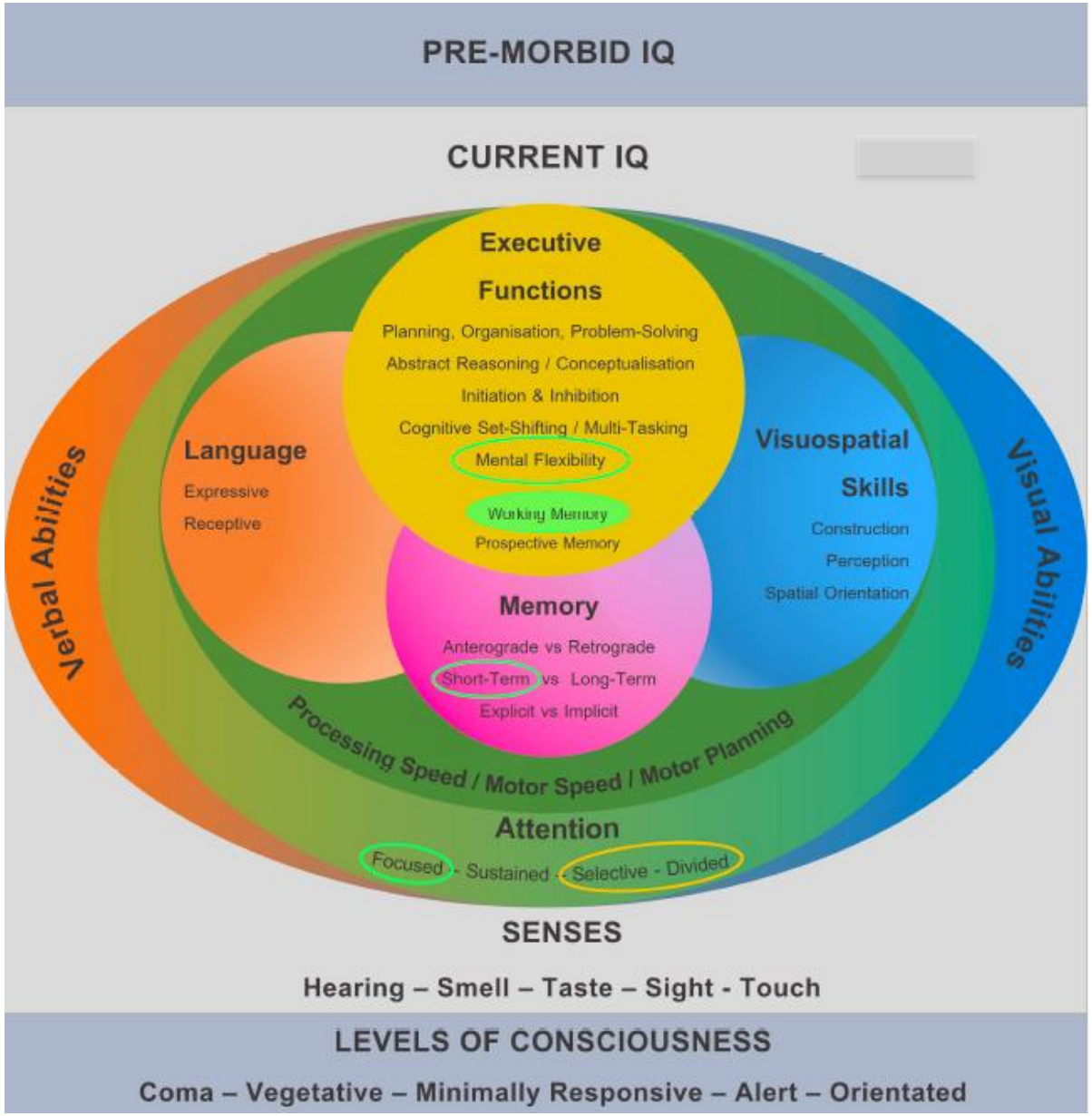
Other cognitive impairment (though some abilities well preserved)

Part 2: Neuropsychological Formulation, Onward Referrals, and Barriers to Accessing Treatments

1. Neuropsychological formulation

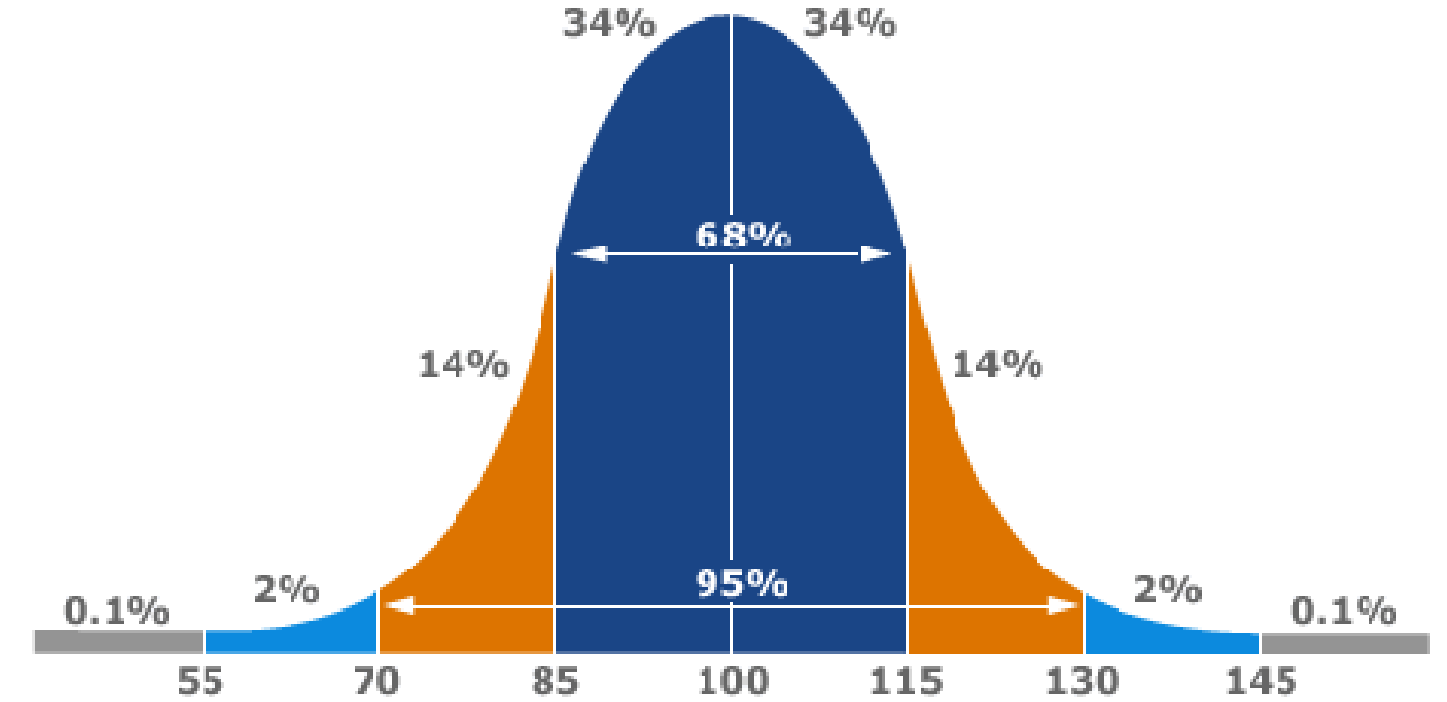


Neuropsychological assessment formulation framework. Dr Sanjay Sunak



Essentials of Neuropsychological Rehabilitation, Wilson & Betteridge 2019

Comparing you vs you



Formulation

- May develop more questions than answers
- May need updating over time
- Is tentative
- Not necessarily diagnostic but interested in difficulties in function
- Often used to help clients and staff working with them
- Used to help clients and staff understand how brain changes can change subjective experience
- Written summaries can be helpful

Compensation vs restoration

In most cases, we need to compensate for difficulties rather than aim to restore them

This means finding a new way to do something

Cognitive Rehabilitation (Sohlberg)

Three phase training model

1. **Awareness training phase**
2. **Practice training phase** – the phase of training where an individual practices implementing his or her system using a variety of structured controlled exercises where the clinician takes data on performance
3. **Generalisation training phase** (settings, behaviours, subjects)

Changing the Environment in Hostels

Hostel environments can be challenging for people with cognitive problems –

Lack of structure
No clocks
No calendars
Difficulties may be masked in hospital because the structures support poor executive functioning; cognitive issues can be missed

Changing the way we communicate

Bear in mind people may have difficulties both understanding what we say and expressing what they have to say

Slow down

Only say one key piece of information at a time

Use actions, gestures or pictures to help

Sometimes writing things down can help (during or for after)

Give people time to respond

Challenges associated with this work

Barriers to Accessing Timely Neurorehab in the Community

- Need extra consideration around engagement, attachment, and trust needs
- May require extra support to understand benefits of treatment (eg motivational interviewing to take up treatment; consider self neglect and history of neglecting own needs as part of formulation)
- The team around the client may require the bulk of the input, even if the client cannot engage in many of the sessions
- Often not accepted by services due to concurrent drug/alcohol problems
- Historical brain injuries not accepted under many statutory services, but if client can still show evidence of learning, they may still benefit from neurorehab
- The HNP attempts to offer cog rehab where possible, but really we need the support of OT's, SLTs etc. to meet the needs of this client group

Ways you can help

- Recognise that cognitive difficulties may impact on appointment attendance, and that non-engagement is not necessarily a question of motivation to engage
- Consider creative ways to engage clients
- Change environments to meet cognitive needs
- Advocate for adequate care for clients who have concurrent substance abuse
- Challenge service structures that inadvertently do not support the needs of this client group
- Offer cognitive screening (MoCA, ACE) to identify if there may be cognitive needs
- Consider onwards referrals to services who may be better able to explore these issues
- Upskill other professionals to identify cognitive needs

Common challenges of working with cognitive problems?

Don’t always know what the root of the problem is

Lots of services don’t want to work with comorbid substance use

Difficulty getting clients on board – reduced awareness of deficits (normalisation of deficits)

Institutionalisation – used to having things done for you

Questions and Reflections

- Do you routinely screen for housing status?
- Do you routinely screen for cognitive difficulties?
- Do you have people who are homeless or at risk of homelessness in your service (and would you know?)
- Does your service facilitate access for people experiencing homelessness, or might you be structurally excluding them?