

Homelessness and brain injury: What role do we play as socially-conscious service providers?

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The homeless population is vulnerable to the impact of health inequalities and complex unmet needs. Neuropsychological deficits are particularly prevalent, with considerable risk of traumatic brain injury, dementia and the neurological effects of substance misuse. Services must adapt pathways and protocols to provide much-needed support. There are economic, clinical, political and academic arguments for doing so, but is there the motivation from our profession and the context in which our profession works?

Homelessness in the UK

HOMELESSNESS IS associated with chronic health and social problems, including mental health issues, substance misuse, childhood trauma and abuse (Hwang, 2014; Fazel, et al., 2014; McDonagh, 2012). Evidence suggests this is a growing problem, with figures up 55 per cent on 2010 levels (Homeless Link, 2014a). Government figures show the number of rough sleepers on any given night in England has seen a 30 per cent increase from 2744 to 3569 in autumn 2015 (Department for Communities and Local Government, 2016a). The number of people in temporary accommodation has increased by 52 per cent since 2010 to over 73,000 in June 2016 (Department for Communities and Local Government, 2016b).

An unmet neuropsychological need

Research has shown an association between homelessness and head injury in particular, with prevalence rates reported between 43 and 53 per cent in recent studies (Hwang et al., 2008; Mackelprang et al., 2014). In addition, rates of hospitalised head injury are over five times greater in the homeless, compared to the general population (McMillan et al., 2014). Cognitive impairment is

widely reported amongst the homeless, with Spence et al. (2004) commenting ‘in psychiatric services that assess homeless people access to neuropsychological assessment seems essential’ (p.378). It can be difficult to determine from cross-sectional studies whether such deficits arise from being homeless or contributed to homeless status. Yet the majority of head-injured homeless adults report a head injury occurring prior to becoming homeless, suggesting it places a person at significant risk (Hwang et al., 2008; Oddy, et al., 2012; Topolovec-Vranic et al., 2014).

The path to homelessness is rarely linear; it is a complex traumatic process, which often includes many missed opportunities to intervene. Yet, the reality is stark: 40 per cent of local councils have ‘inadequate access to prevention tools’ such as employment and accommodation support, as well as mental and physical health services targeting complex cases (Homeless link, 2014a). Without early intervention, we will inevitably see an increase in neuropsychological indicators of trauma, neglect, organic, and substance-related neurological damage in this population. Ultimately, as well as failing the

individual, we see increased levels of health, police, and social services impacts:

Premature rates of death and the prevalence of chronic and multiple health conditions among homeless people paint a very stark picture of the human cost to this inequality, and the scale of the challenge to overcome. (Health Audit, 2014)

Homeless people are more likely to present at Accident and Emergency than those who are not homeless, and yet narratives of treatment such as this are all too common ‘I had a bag of morphine tablets and a letter to show the police why I was carrying them, but that was it. The staff told me to go home and put my feet up. They knew I was homeless so how could I do that?’ (Gulland, 2016).

The demographics of homelessness reflect those of traumatic brain injury populations: 73 per cent of street homeless people are male, 60 per cent have mental health difficulties, 44 per cent are aged 18–21, many have had traumatic childhoods and come from impoverished backgrounds, and we often see them ending up with criminal records (Homeless Link 2014b; St. Mungo’s, 2016). Older homeless people are also of increased vulnerability due to issues such as dementia, elder abuse, isolation and premature cognitive aging (Pannell & Palmer, 2004). Those with neuropsychological needs may be placed in hostels or homes that do not meet their cognitive needs, which will increase the likelihood of difficulties managing their placement and the potential for placements to break down. There is also the additional impact on relationships with services when memory, attention, decision making and/or language are impaired with or without intoxication, as well as any co-presenting learning or mental health difficulties. This is likely to further decrease the likelihood not only of access to services, but of the maintenance in care and support.

Specialised neuropsychological input is critical to establishing needs, and providing tailored support to the individual as well as the systems and people supporting that person. The cost

otherwise is social, economic and health-related as third sector providers, the police, social, residential and health services all feel the impact of supporting unmet neuropsychological needs. Increased understanding of the neuropsychological needs of the homeless population would, therefore, allow for targeted interventions with increased effectiveness (Argeriou et al., 1995).

Neuropsychological services for homeless people?

If we acknowledge the need for neuropsychological support, then we have a responsibility to find ways to meet that need. We are in a new age of neuropsychological rehabilitation, one in which we ‘get our hands dirty’, get out there and affect change at societal, as well as individual and service levels. The recently published Division of Neuropsychology five-year strategy (British Psychological Society, 2015) includes the following commissioning-based strategies:

S.2.2 To explore the allocation of resources to fund projects into health economics and the cost benefit analysis of neuropsychological services.

S.2.3 To advocate for the inclusion of neuropsychological services in the pathway of all patients with neurological conditions.

Whilst there are mainstream neuropsychological services available, it can be difficult for those experiencing homelessness to access the best forms of input. For example, appointments at neuropsychological and neurological clinics are often missed, with failure to attend resulting in discharge (Hegerty, 2009). If we are to meet the needs of this population, we will have to do so in an innovative manner. It simply won’t work to sit in our cosy clinics and wait for homeless people to come to us; we must go out to them.

We need to be innovative, integrative and inclusive in meeting the neuropsychological needs of the homeless population. Collaborative models have already been shown to be effective in addressing social and mental health needs amongst the homeless (Ster-

giopoulos et al., 2015). Dorney-Smith et al. (2016) present a model for a supportive pathway between hospital and community services, which works across primary, secondary, statutory and voluntary sector teams to ensure holistic assessment, advocacy, care coordination and support as required. This focussed, integrative system led to improvements in well-being, housing status, and hospital culture-change. There have been other initiatives that have attempted to better work with the brain injured and homeless population. For example, the provision of a link worker for the Leeds homeless and prison population by the Disabilities Trust Foundation where between 2012 and 2014, 180 homeless people with a brain injury were supported through one-to-one work and support clinics. Screening assessments found over half the prison population had a brain injury. The provision of a link worker led to increased engagement and enhanced staff skills through training. Unfortunately, this service did not continue beyond the initial research funded project but more information about this innovative project can be found here: http://www.thedtgroup.org/media/4082/160115_linkworker_service_report.pdf (The Disabilities Trust).

There are further examples of integrative and innovative work that Clinical Psychologists are doing to work to the needs of this population, such as the Psychologically Informed Environments work taking place in some UK hostels. Whilst these services don't tend to focus specifically on brain injury, they do provide psychological support through direct therapy and indirectly through staff training, often taking a model specific approach such as Cognitive Analytical Therapy.

What, then, must we do?

Psychologically-informed environments (PIEs) have sought to address the complexity of providing services to this population via accommodation settings which hold the psychological and emotional needs of residents at the forefront of any interaction or decision made about their care (Johnson & Haigh, 2011).

For example, a homeless hostel in Westminster, London, implemented a PIE-approach to care for residents and demonstrated recovery-oriented outcomes towards independent living (Quinney & Richardson, 2014). Similarly, a 51 per cent reduction rate in engagements with the criminal justice system were seen over a year from residents in a London-based PIE hostel run by Clinical Psychologist Emma Williamson (Rhodes, 2016). This 'changing face' of provision extends beyond the Capital; Liverpool YMCA has undertaken a PIE-approach within its services and there are discussions afoot to expand them.

The outcomes of PIE for those experiencing homelessness have been so well received that a recent 'good practice guideline' was published specifically for this population (Keats et al., 2012). Therefore, what we have seen is a drive to adapt and engage *psychological* principles to support paths out of homelessness, but there remains a dearth of understanding and consideration of *neuropsychological* impacts on a person's presentation.

With the clear gap in neuropsychological provision for those experiencing homelessness, it demands that we engineer a path which is connected to a diverse community. The 'providers' must build it in collaboration with existing services and people with lived experiences of the issue at hand. We have to work slowly and think long-term. There are ethical questions to be answered if one does not think about the sustainability of a service both from a financial and a functional perspective.

Different models are being developed. As brain injury charities often care for a number of difficult, unfunded cases, author AW has developed a collaborative service in conjunction with a charitable provider, Headway Birmingham and Solihull. This initiative consists primarily of a dedicated caseworker able to engage proactively with both referring agencies and homeless adults, providing neuropsychological and associated rehabilitative inputs and signposting to other medical, social and legal support organisations, where appropriate. The added value and cost-benefits of this 'extra-

Figure 1. Case study

'John', is a 59-year-old white British man who had been homeless for decades. John had been observed talking to himself, responding to hallucinations, was paranoid and forgetful. He had been diagnosed with 'delusional disorder' and 'paranoid schizophrenia' in the 1990s. John had not been collecting his benefits since arriving in the hostel two years ago. He begged in the local area and used the money to buy alcohol. When intoxicated he was abusive to fellow residents, staff and the general public, and had been beaten up as a result of his provocation. Cautioned by the police many times and given anti-social behaviour injunctions, he was at risk of conviction and eviction because of his abusive behaviour and chronic non-payment of service charges. His poor physical health would mean he would be likely to die on the streets. He was not under the care of a mental health team as his troublesome behaviour was seen to be 'behavioural' and solely related to alcohol dependency independent of his mental health.

Susan, a clinical psychologist, offers consultation to hostel staff working with homeless men. To assist staff preparing for a professionals meeting Susan read through John's notes and found that the Addenbrooke's Cognitive Examination-III had been used when John had been admitted to hospital following a fall. The tool was used when John had been sober and indicated he was significantly impaired in all areas (attention/orientation, memory, verbal fluency, language and visuospatial skills). However, the results of this screening tool, as communicated by a mental health professional to all other professionals involved, said it indicated no impairment. Susan has a basic level of neuropsychological assessment skill. She contacted a neuropsychologist colleague for advice and consultation which enabled her to confidently inform the professional group that included social services, the police, an outreach service for the homeless that John was significantly cognitively impaired and that his mental health needed assessment. This information strengthened the doubts around John's capacity.

Outcomes: The police refrained from giving more cautions and injunctions. Social Services successfully applied for an appointeeship that allowed the hostel to pay John's rent and help manage his alcohol intake. The homeless outreach service used a personalised budget to pay for an approved social worker and an approved psychiatrist to assess John's mental health needs. Susan continues to work with the hostel staff on implementing a programme that can mediate the impact of his mental health and cognitive impairment and continues to need expert neuropsychological consultation to do this well. To date John remains in the Hostel.

Figure 1: A recent case study of working to meet the neurological as well as psychological needs of the homeless population.

care' service will be compared with typical Headway provision 'usual care'.

Authors SW and RF are developing a service aimed at supporting the neuropsychological needs of homeless people in Liverpool (<http://www.neurofamilymatters.co.uk/neurotriage>). In collaboratively building 'Neuro Triage', we are engaging with the local homeless population, linking with local voluntary and statutory services that already support this community. Interested parties are working together to create and implement a long-term plan tailored to homeless people experiencing the difficulties associated with brain injury through assessment, collaborative formulation of difficulties and interventions primarily through capacity building between services.

We have also seen services developed by The Disabilities Trust, amongst others. However, maintaining long term financial investment can be difficult. Furthermore, we can see 'territorial behaviour' and 'in-fighting' across services, as they compete for the limited investment available in this area. The projects discussed here, have the potential to reduce recurrent homelessness by using research funding to evidence need and commissioning budgets to develop long-term services.

Ultimately the goal should always be to enhance the capacity of service users and staff, their support networks, and hopefully increase the chances of having access to appropriate housing/health provision being identified. There are too many homeless people either falling through the gaps between services, or being blocked by exclusion criteria. For example, many brain injury services won't accept people with an addiction, and many addiction services won't accept people who have a brain injury. We need more flexibility, innovative outreach provisions, and more collaborative working to skill-up homeless service providers to support people with neuropsychological needs.

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