Homelessness and Brain Injury Toolkit

A guide for services in Westminster, Kensington and Chelsea, and Hammersmith and Fulham

SUPPORTED BY MAYOR OF LONDON

St Mungo's
Ending homelessness
Rebuilding lives

Change Communication

Groundswell
Out of homelessness

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Contents

Introduction

There is increasing interest in acquired brain injury amongst people who are homeless. Described as a "hidden disability" by Headway UK, brain injury is now understood to be a factor in homelessness in the UK. The Disabilities Trust Foundation published research in 2012 indicating that half of people rough sleeping or in hostel accommodation had experienced serious head injury in their lifetime.

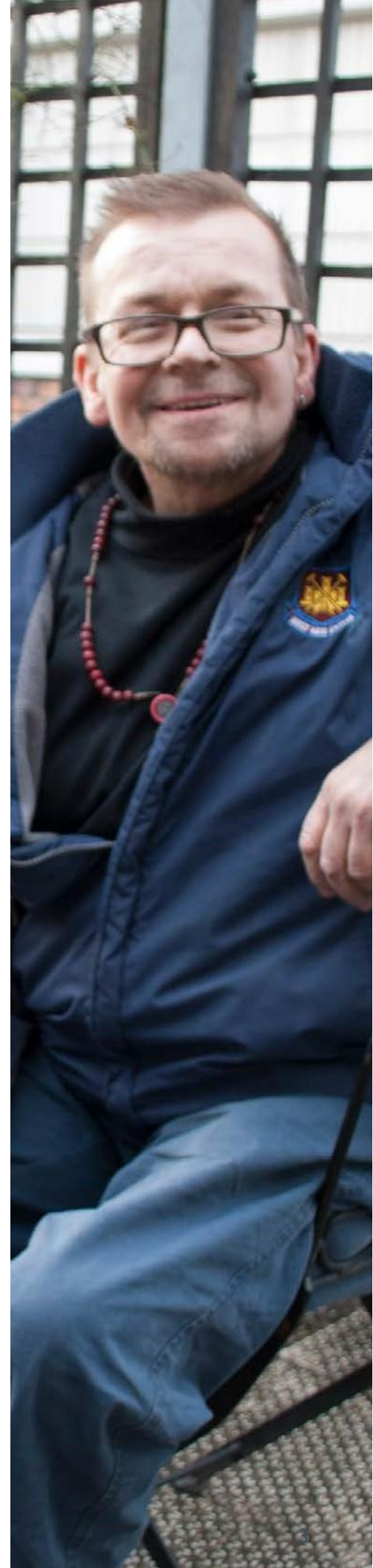
The brain is responsible for our physical, cognitive, emotional and sensory wellbeing – if it is injured, the damage generally impacts across a person's life and over time. We should not, however, resign ourselves to these facts. The Homeless and Brain Injury Project delivered by St Mungo's, Change Communication, Headway East London, Great Chapel Street Medical Surgery, Groundswell, supported by Westminster City Council and funded by the Greater London Authority, took what was known about the subject, pooled resources and shared learning to identify people using homelessness services who may have been affected by brain injury. Working together a clearer understanding of the situation in real terms developed and practical steps were identified to make a positive difference. This Toolkit is the result of that work.

The Toolkit is primarily aimed at staff and organisations working directly with people affected by street homelessness in Westminster, Hammersmith and Fulham and Kensington and Chelsea, but the information it contains may be helpful to anyone with an interest in the issue. It is anticipated that in a changing world some information may become inaccurate so you are encouraged to check service provision and pathways directly with providers.

Thank you for taking the time to read the introduction and it is hoped that the Toolkit will make a positive difference in your work.

Acknowledgements

We would like to extend our thanks to the Greater London Authority for funding this innovative project. We are grateful for the commitment of Westminster City Council, St Mungo's, Change Communication, Headway East London, Great Chapel Street Medical Surgery and Groundswell in working together to bring awareness of this important issue to the fore. Special thanks to the volunteers who contributed to the development of this Toolkit and all staff who took part in the training.

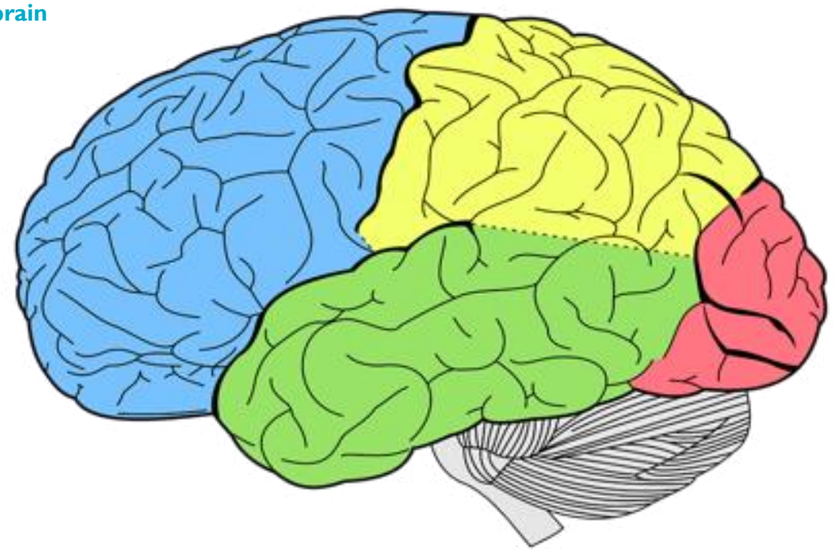


What is brain injury?

The brain is made of soft tissue enclosed within the hard bony skull. The brain requires a steady supply of blood and oxygen. If either is restricted for any length of time brain tissue dies. Alcohol misuse can directly damage brain tissue. Once brain tissue dies it does not regenerate.

The picture below shows the names of different areas of the brain which (in simple terms) control behaviours, emotions and physical actions e.g. the temporal lobe helps us understand language and communicate. If damage occurs to the temporal lobe, communication abilities may be affected.

Side view of brain



Blue – frontal lobe involved in emotions, behaviour control, and memory

Green – temporal lobe involved in communication abilities

Yellow – parietal lobe involved in processing sensory information

Red – occipital lobe involved in vision

Note: the brain is a complex organ, the above information is very general and simplified.

Any injury after birth that restricts blood and oxygen supply to the brain is called an Acquired Brain Injury. This could include things like:

- Trauma i.e. blow to the head
- Cardiac arrest
- Serious asthma attack
- Stroke
- Alcohol misuse
- Brain tumour

The Disabilities Trust has produced an excellent short video "An Introduction to Brain Injury" which explains brain injury:

https://tinyurl.com/24s63s86

How does brain injury affect people?

The brain is complex and controls everything we do, think, feel and say. Every person will have their individual pattern of injury, however there are some common themes:

Cognitive

- The ability to think through problems may be reduced.
- Imagining and understanding consequences of actions may be difficult.
- Putting yourself in someone else's shoes and showing empathy is a complex cognitive skill which may be affected.
- Lack of insight can be very common in people with brain injury.
- Memory may be impaired including short term memory or memory of specific events; some people even forget they have a brain injury.
- Keeping track of time, day and date can be very difficult.
- Working memory, the ability to hold information for a short period of time and manipulate it is very important when planning, problem solving and weighing up things – skill in all these areas may be reduced.
- Communication may be affected in different ways e.g. difficulty with speaking, understanding instructions, thinking in abstract terms e.g. describing something that is not concrete and present such as goals for the future.
- A person with brain injury may 'confabulate', this means talking about things which have no truth in reality, but may be linked to things which are true but have got very confused. This is not deliberate lying.
- Responding to what, where, why, how questions – all common in assessment – may be very challenging for someone with brain injury.

Emotion

- Control of emotional responses may be weakened.
- Emotional outbursts may be common.
- Uncharacteristic emotions may arise, people who know the individual well may feel their personality has changed.
- Conversely, emotional responses may be more flat e.g. humour may not be understood in context.
- Where cognition is affected this may mean a person cannot understand why others behave as they do and in turn their own emotional response may seem inappropriate.
- Some people with brain injury become sexually inappropriate or disinhibited in other ways.

Physical

- Senses may be affected e.g. vision may be blurred, bright lights overwhelming etc.
- Noise may be distressing.
- Coordination of movement may be diminished.
- There may be obvious physical effects such as problems with walking or reduced use on one side of the body.
- Dribbling, difficulty with eating or drinking may develop.
- Hormonal changes can cause weight gain, reduced body hair loss and many other symptoms.

Headway UK produces a wide range of information booklets and factsheets about the effects of brain injury. These are free to access online and can be posted to you for a small fee. The Headway Information Library also has lots of information and ideas about how to manage these effects and implement supportive strategies that staff and services users may wish to try.

https://www.headway.org.uk/about-brain-injury/individuals/information-library/

Brain Injury and Me contains a number of video clips of people talking about their brain injury which may be helpful in understanding what the effects of ABI 'look like'.

https://www.headway.org.uk/about-brain-injury/individuals/brain-injury-and-me/

Common causes of acquired brain injury

There are a number of ways that the brain can be damaged including:

Road traffic collisions

Assault

Accidents and falls

Alcohol misuse can play a role in all the above and also directly damage brain tissue

People who are homeless are most likely to present to Accident and Emergency Departments as a result of assault, accident or alcohol misuse[1] and these events carry a risk that the brain may be injured. We also know that rough sleeping is extremely harmful to health; brain injury can be caused by stroke, tumours in the brain, and heart attacks.

Domestic Violence

Women may be homeless as a result of domestic abuse. Staff working in this field report that perpetrators of domestic violence may specifically target the head during an assault. Strangulation is a high-risk indicator in domestic violence and deprives the brain of oxygen. Both may lead to brain injury and assaults of this nature may have happened many times to your client.

Alcohol Related Brain Damage

Alcohol misuse can cause a range of different conditions that affect the brain. This includes Wernicke-Korsakoff Syndrome and alcohol related dementia. Some of these terms are used interchangeably which is not helpful as the prognosis for the different conditions may differ. The Alzheimer's Society has produced a factsheet about ARBD which explains this in more detail and provide tips on supporting someone with these types of difficulties.

https://www.alzheimers.org.uk/download/downloads/id/1765/factsheet_what_is_alcohol-related_brain_damage.pdf

Concussion

Concussion should not be ignored. It is very important to respond to a blow to the head in the appropriate way. See the NHS website for details:

http://www.nhs.uk/conditions/Concussion/Pages/Introduction.aspx

If a client discloses that they have experienced a recent head injury check that they have taken the advice outlined above. If they have not, use the information in the link to explain why it is important and do so as soon as possible.

[1] http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Why it matters

Brain injury is described by Headway UK as a "hidden disability". It may not be identified by services and its links with homelessness are only now starting to be explored. The consequences of this affect not only those suffering from such injuries but have implications for wider society as well.

By raising awareness around brain injury and homelessness, the costs on both individuals and on the general population can be managed, with benefits for everyone.

Here's why brain injury matters:

Prevalence

160,000 people are admitted to hospital in the UK each years as a result of Traumatic Brain Injury

In 2013-14, one person was admitted to a UK hospital with a head injury every three minutes

About **1.3 million people** in the UK are living with disabilities from Traumatic Brain Injury

An estimated **60%** of adult offenders in the UK have experienced Traumatic Brain Injury

Prevalence in the Homeless Population

Research shows that almost **half of people** who are homeless have experienced head injuries

90% of people who are homeless and have experienced head injury reported their first head injury had been sustained prior to becoming homeless

Brain injury can play a major role in an individual becoming homeless as it may cause problems with communication, memory and behaviour as well as increase the risk of family breakdown and loss of employment

The Personal Cost

Traumatic Brain Injury puts young people at higher risk of poor mental health and offending

Head injuries double a person's risk of later mental illness and increase the risk of earlier death

Those with invisible brain injuries may be 'bounced' between mental health and substance misuse services due to the hidden nature of the underlying problem

The Social Cost

£15 billion

Traumatic Brain Injury costs a total of **£15 billion**[2] nationally every year

£440,000

The long-term cost of head injury in a young offender is around **£140,000**[3]

+50%

Head injury increases the risk of someone offending by at least **50%**[4]

Serious Case Review

SOMERSET SAFEGUARDING ADULTS BOARD

The Somerset Safeguarding Adults Board conducted a Serious Case Review in June 2016.

'Tom' had sustained a Traumatic Brain Injury in a road traffic accident and took his own life in 2014.

The review found that Tom's brain injury left him vulnerable to harm but his mental capacity was assumed by too many decision-making professionals.

The Serious Case Review emphasised the importance of a coordinated, multi-agency approach to supporting vulnerable people.

2 https://www.centreformentalhealth.org.uk/news/item/traumatic-brain-injury-costs-ps15-billion-year-uk-says-new-research/
3 https://www.theguardian.com/society/2010/mar/01/jail-young-offenders-rehabilitation
4 Centre for Mental Health https://www.centreformentalhealth.org.uk/traumatic-brain-injury

What help is there for people affected by brain injury?

What you can do

If you work in a frontline setting such as street outreach, hostels, and day centres you may be working with people who have a brain injury. There is help available for people, but it can be difficult to find, services are patchy and there may be criteria for accessing them which your client does not meet. It can be resource intensive for your service to support your client to access specialist services and your client may not wish to engage with the process. This does not mean that you should not try! It is possible that the difficulties a client experiences may have been attributed to substance use or mental health difficulties by staff when brain injury may in fact be a root cause – without addressing the suspicion of brain injury other interventions may fail leaving the client in the 'revolving door'.

Information gathering

Your first step is to assess the client and gather information about possible brain injury. Memory difficulties may mean that the person you are concerned about does not remember they have a brain injury so asking directly may not provide you with any useful information. The term 'brain injury' or 'brain damage' may carry a stigma or stereotype images for some people so it may be best to avoid it. Instead you might ask about 'blows to the head,' being 'knocked out' or accidents.

Case study

Bill had slept rough for many years in the past, but was now accommodated in a hostel. Bill appeared to have a pattern of behaviour whereby he would experience a difficulty in the hostel and become abusive and threatening to staff. This had led to his many evictions from hostels followed by another long period of rough sleeping.

Bill was referred to the St Mungo's Homelessness and Brain Injury Project in 2017 because he was refusing to engage in any planning for his resettlement, his personal hygiene was rapidly deteriorating and he was increasingly abusive to others. Staff were concerned that Bill would be evicted and return to the streets as winter began.

After taking information from staff and speaking with Bill, the Homeless and Brain Injury Project concluded that Bill may have experienced a number of blows to the head which may have affected his thinking and behaviour. The following recommendations were implemented by hostel staff as a result:

- Placing photographs of the key staff for Bill on his bedroom wall with brief descriptions as to what they could help Bill with so that Bill remembered who did what and got the right person first time.
- Maintaining a core consistent staff team around Bill to aid memory and relationship building.
- Using a 'map', pictures and timeline to help Bill understand his resettlement plan.
- Providing clear instruction where no choice was available and providing limited choice when appropriate so as not to overwhelm Bill.
- Writing short bullet points for Bill to help him remember what he needed to do next.

Bill immediately responded to these techniques and was successfully resettled within a few weeks. Bill remains accommodated and is working on plans for his next, permanent, home.

Record Keeping

In your assessment focus on the behaviour you witness to help you consider whether brain injury may be a factor for your client. Keep a record of this behaviour and use information from Headway UK to see if there are similarities:

https://www.headway.org.uk/about-brain-injury/individuals/effects-of-brain-injury/

Use a screening tool

A validated screening tool for brain injury, for use by non-specialists has been devised by the Disabilities Trust Foundation called The Brain Injury Screening Index (BISI). The BISI helps to identify whether the client may have experienced damage to the brain and the level of that damage. This could be very helpful information to present to medical professionals in attempts to access appropriate support for your client.

The Disabilities Trust Foundation provides guidelines for services on how to administer the BISI to ensure the results are as accurate as possible. There are 11 questions designed to be quick and simple to use, but some services may find their setting presents other challenges e.g. if you are trying to administer the BISI on a noisy street, or other clients are present.

The BISI is free but trademarked and to access it you will need to contact BrainKind and register your interest. If your service would like to use the BISI contact the Disabilities Trust Foundation directly here:

https://brainkind.org/for-professionals/brain-injury-screening-index-bisi/

The Disabilities Trust Foundation also provide a Brain Injury Needs Index (BINI) which can be used for longer term support planning.

Raising the brain injury with the client

After your observations, you may think brain injury is a possibility and so consider how to raise this with the client. Some clients might be relieved to know that there is a possible physical issue that may account for some of their difficulties, but others may not. Some suggested wording is below, but you will know your client best so think about how they may react to decide on the most appropriate approach:

- I've been reading about the brain and found it really interesting.
- The brain is in charge of everything we do from talking to remembering birthdays.
- If someone has a bang to head / accident / fight the brain can get injured just like your arm might get broken.
- When that happens it can affect someone's mood or memory / communication.
- You told me that you had an accident / fight back in 2017, did you or others notice any difference in your mood / thinking / memory after that?

You could use a picture with information about which parts of the brain control which things e.g. frontal lobe controlling emotional response to support the conversation. Headway UK also have videos of people with brain injury talking about their story which you may want to try.

Be clear that you are raising the issue because help may be available to improve their situation. Remember that you may need to raise this issue a few times before someone feels comfortable taking the next step.

What can the National Health Service do?

If you and your client think that brain injury may be a possibility the next step will be to seek a medical diagnosis or confirmation. This does not prevent you from accessing other support services such as those in the "What others can do" section. Indeed obtaining information from the likes of Headway may be a really good way of managing some of the difficulties in the meantime.

Contact a GP

Your client may already be registered with a GP, but if not you may find this information useful:

https://groundswell.org.uk/resources/healthcare-cards/

The GP will need to know what has raised the concerns about brain injury so be prepared to provide details about your observations.

GPs have an enormously wide brief and may not be experts in brain injury. Headway UK provide this document for GPs to help them work with patients with brain injury.

https://www.headway.org.uk/media/2807/management-of-acquired-brain-injury-a-guide-for-gps-factsheet.pdf

You may want to read it before the appointment to help you know what to ask for. A copy for the GP / surgery may be helpful for them so bring it along to the appointment.

The GP may carry out a Mini Mental State Examination. The MMSE is a set of 30 questions which helps provide information about the memory, attention and language abilities of the person answering and it was devised for use where dementia is a concern. Dementia is a progressive organic brain disease which is not the same thing as a brain injury therefore a 'high score' (which indicates that the client is performing well on this test) may not mean that your client does not have a brain injury. The MMSE is a useful quick way of seeing whether there may be cognitive issues, but where a range of other information is available including client self-reports, staff observations etc. a higher score on the MMSE should not be a reason for a GP not investigating further.

The GP may be able to access your client's medical records and may have information about previous conditions which affect the brain or clear information about previous brain injury. This may be helpful in finding out what rehabilitation was provided at the time and will also help to tease out whether some client difficulties are caused by brain injury or other factors such as substance misuse or mental health problems. This could be significant including in relation to what medication is suitable for your client e.g. Haloperidol may not be suitable for people with brain injury.

If your client and GP agree that brain injury may be a concern, then a referral to specialist services such as Neurology, Community Rehabilitation Teams or Memory Clinics may be the way forward. These services are very busy so it's important the GP understands your client's circumstances fully – the GP or service can then prioritise the case appropriately. Provide information about:

- The nature and extent of the homelessness experienced. Is the client rough sleeping? Explain the health risks of this.
- Are the cognitive issues causing more risk taking on the streets or putting their current accommodation at risk?
- Does the suspected brain injury prevent the client seeing the dangers of rough sleeping or other behaviours?
- Is the client not accepting help or services because of the effects of brain injury?
- Is the brain injury directly affecting their ability to manage their health? Can they remember medication? Do they experience health problems but are cognitively unable to address them?

Community Neuro-Rehabilitation Teams

Community Neuro-Rehab Teams may exist in your area. These teams usually have Occupational Therapists, Psychologists, Physiotherapists and Speech and Language Therapists that can assess the impact of brain injury on everyday functioning for a client and work with them to devise goals and therapy programs to meet them. Commonly the Neuro-Rehab Team will use a mixture of direct therapy, adaptions and strategies to manage the effects of brain injury.

Some areas have staff that help people navigate the most appropriate pathway for their brain injury. The purpose of the role may vary in different areas and the staff may have different job titles, but Neuro-Navigator is a fairly common term. Some more explanation of this role is provided by CNWL available here:

https://tinyurl.com/24s63s86

Initial contact for enquiries or advice can be made using the following details, but note these are for London only

http://www.abil.co.uk/community-rehabilitation-local-teams/#more-165

In all cases it may be wise to first contact Headway UK or your local Headway group, if one exists, who may have detailed knowledge of which services are in your area.

What can the local authority do?

Homeless people with a brain injury may be in need of protection from abuse or neglect, help with their social care needs and / or housing options. If so the local authority has responsibilities for these areas.

Safeguarding

Protecting adults from abuse is known as "safeguarding" and it refers to the work carried out to prevent or stop abuse and neglect of vulnerable adults.

If you are concerned that your client is experiencing neglect or abuse, your local authority Safeguarding Team can provide advice and support to address the issue. Ensure you follow your own organisation's Safeguarding procedure and remember, if a crime is taking place the police may need to be involved.

Social Care

Contact your local authority social services team if social care is needed by your client. The Care Act 2014 outlines the types of things that promote a person's 'wellbeing' and social services will need to consider this when assessing your client's social care needs. These areas include mental and physical wellbeing, relationships and protection from abuse and neglect. Voices of Stoke has produced an excellent toolkit on the Care Act and accessing social care help. It can be found here:

https://homelesslink-1b54.kxcdn.com/media/documents/VOICES_Care_Act_Toolkit.pdf

Housing

It is likely that your client is homeless given your setting. The local authority will have a Housing Options Service and your client may need support to make, attend and get the most from the appointment and service offered. A brain injury is relevant in this context because it may influence what type of accommodation is most suitable for your client and may require the local authority to consider how best to provide your client with a suitable service.

If your client makes a formal homelessness application as recognised in the Homeless Reduction Act 2017, be aware that case law (R v Waveney District Council ex p Bowers [1983] QB 238, CA) has identified brain injury as falling within the terms 'mental illness' and 'handicap' for the purposes of deciding whether your client may be vulnerable and therefore 'in priority need.' Shelter can provide more information about the importance of the priority need category.

Working with challenging behaviour

As you will see from the section on the possible effects of brain injury it can lead to challenging behaviour. By definition this behaviour is uncomfortable and unwelcome and may be difficult to address, but where brain injury is a factor there may be additional things to consider. Remember that brain injury affects people in individual ways depending upon their pattern of injury so use the suggestions below as a starting point for thinking about how best to help your client. At all times ensure that you use the appropriate policies of your organisation and safety is the priority.

Use Rights and Responsibilities

Clear expectations about rights and responsibilities of all parties is helpful to set expectations from the beginning of any working relationship. When thinking about clients with brain injury you may want to:

- Ensure rights and responsibilities are explained and provided in different formats e.g. easy read lists and pictures rather than lots of text. Consider breaking the expectations down into small chunks of information given at the most appropriate times.
- Routinely reminding clients of rights and responsibilities during your work with them e.g. at the beginning of a keywork session the right to have a keyworker and the responsibility to meet regularly might be useful to mention. This will help to set the expectation at that meeting rather than relying on information given weeks ago and possibly forgotten.
- Emphasise the partnership element of rights and responsibilities i.e. that the organisation has to deliver certain things as does the client to progress the situation. This can help the client to feel of equal value and hold the service to account too.

Plan Ahead

Asking clients about their behaviour when things get more difficult for them before the situation arises can be enormously helpful in preventing or minimising incidents, and enables the action taken by staff to be tailor made for that client. Clients are often pleasantly surprised to be asked what staff should do or avoid doing to cause unnecessary difficulties. This can show real consideration and understanding by services and very naturally leads to negotiation e.g. a client may say that they really don't like warning letters being shoved under their room door, they want people to speak directly to them instead which leads to a conversation about when it is most useful to have those conversations.

When working with someone with a brain injury they may forget what is agreed during this conversation so making a record of the meeting and signing a plan together that can be referred to later may help.

Keep it Visible

Keeping something visible may help to keep it present in the mind for a client with brain injury. Could pictures of the behaviour you want from your clients be used in your setting? If so think about where they will be seen and routinely noticed. Remember to change pictures regularly to provide new interest and make the display clear and simple.

Deal in Real Time

An acquired brain injury can affect a range of cognitive processes and may make it difficult for a client to create a concept of what a future may look like or remember a recent event. For this reason dealing with challenging behaviour in real time is important for people affected by brain injury. In practice this may mean that you do not engage in debate about an incident while it occurs but consider:

- Using distraction to remove the client from the situation e.g. Hi Atul, can you help me make some tea?
- Provide clear simple instruction on what the client needs to do immediately to help e.g. Atul, leave the room.
- Be specific about what the service will do in the very short term to help e.g. I will talk with you in 30 minutes to solve this problem.

As with any challenging behaviour be calm, clear, and aware of your body language to help defuse the situation. When thinking how to reward a client for positive behaviours do so as soon as they occur. If 'Atul' leaves the room and you can, follow him and say thank you. Your aim is to make engaging in the required way always the most comfortable choice for the client.

Keep Going!

The effects of brain injury on memory can be severe. All aspects of memory may be affected so you may have to repeat instructions or expectations many, many times for some clients affected in this way. It will be very important for you to remember that your client is not acting this way because they are choosing to break rules, but because the brain injury makes it difficult or impossible to remember what other behaviour is required. You will require energy and commitment to support your client in their situation.

- Think about all the ways the expectation can be provided to the client throughout your work with them.
- Seek help from specialist organisations to support your understanding and techniques.
- Take advantage of supervision, team case discussions and clinical support where you have it to share the load and get new ideas.
- When it does work, give your client, yourself and the team a pat on the back. Take credit where it's due!

Don't Evict or Ban – Support to Progress

All services will try their best to avoid evictions and bans where possible, but it is the case that some clients can sometimes not be safely managed within a service. Many services will try short term exclusions ranging from a few minutes to days as a way of making a situation safe immediately and to create plan for the future. Even after trying this it may become clear that your service is not the right place for the client. In these circumstances it is important to identify with the client exactly what the issues are, what causes the difficulties, what could help, what other support is available and, using all this information, what the future plan is.

Partnership Work

If you suspect a brain injury may be causing some of the challenging behaviour hopefully you and your client will make contact with other organisations that can help. Ask their advice on what more can be done to support your client with changing or minimising challenging behaviour. Headway UK produce some excellent booklets on dealing with anger which may help.

https://www.headway.org.uk/media/3994/managing-anger-e-booklet.pdf

There are specific techniques which can be beneficial and some organisations such as Headway UK, Headway Groups, and The Disabilities Trust may be able to provide training on a range of issues relating to brain injury. Check their websites for more information.

Working with All Clients

You may want to consider whether providing information to all clients about brain injury would be useful. People who are homeless may be at greater risk of some things that cause brain injury such as assault; the information will not only be generally useful but may support greater understanding of the behaviour of people using the service who are affected in this way. This may in turn lead to less incidents and feelings of some people receiving different treatment in your response to them. Homeless Link has a wide range of information, guidance and training about dealing with challenging behaviour that can help your service to provide support to clients to address their homelessness.

What others can do

Headway UK is the largest charity for brain injury in the UK. It has a wealth of information on its website about many different types of brain injury and factsheets on coping with brain injury for those affected including carers. It has a national nurse led Helpline 0808 800 2244 which can be used by individuals and organisations for initial advice or more detailed discussion. Headway UK also campaigns on issues linked to brain injury and carries out research.

http://www.headway.org.uk

There are **local Headway groups** in many areas which may provide services directly to people affected by brain injury. A list is here:

https://www.headway.org.uk/supporting-you/in-your-area/groups-and-branches/

Depending on the size and funding to the local group services can be as diverse as art groups, day services, training, carer's support, and vocational opportunities. The local groups will also be familiar with brain injury services provided in your area. Brain injury and homelessness is becoming increasingly known about and as well as accessing support for individual clients you may want to talk at an organisational level as to what help your services can offer each other.

Acquired Brain Injury Forums exist across the UK and a list of them can be found here:

https://ukabif.org.uk/page/RegionalGroups

Many of the Forums are free to join and have regular events sharing knowledge about brain injury, services and support.

Mental Capacity

The Mental Capacity Act outlines the approaches to be taken where it is possible that a person is unable to make a decision independently. It involves the ability to understand the decision to be made, remember it, weigh up the options and communicate it to others. All aspects of this process may be affected by brain injury, but this may not be fully understood by organisations coming into contact with the client. The Serious Case Review carried out in Hampshire in relation to 'Tom' specifically recommends that brain injury and capacity are foregrounded in all professional assessments.

Homeless Link has good practice guides on Mental Capacity in our field which can be used by you to support you when working in this area:

https://homeless.org.uk/knowledge-hub/mental-health-and-homelessness-resources/

Headway UK produces a guide to the Mental Capacity Act:

https://www.headway.org.uk/media/12010/a-guide-to-the-mental-capacity-act-publication.pdf

The Brain Injury Social Work Group has produced a Good Practice Guide for Social Workers where brain injury may be a factor:

https://t.ly/_9Abj

Understanding how mental capacity can be affected by brain injury may be particularly important when dealing with clients who appear to be making unwise decisions and / or refusing services. Working in partnership with statutory services and others to protect and support an individual if they do not have the capacity to make decisions is essential – use the above documents to guide you and share with others if they have limited experience of this area.

Complex Needs

It is common in homelessness services to work with clients who present with a range of needs caused by different issues e.g. mental health and substance use and contact with the criminal justice system. It can be difficult to unpick the areas and know where to start, however many homelessness services have become adept at working with people who are experiencing a range of challenges by taking a practical approach that broadly works along Maslow's Hierarchy of Needs prioritising physical requirements, health, safety etc.

A client may have no recollection of the incident(s) that led to their brain injury. It may be that the injury was many years ago and the client was not known to services at that time. For these reasons, it is possible that behaviour by the client that is seen now by services more familiar with mental illness and substance misuse, is directly and solely attributed to these issues and brain injury is missed.

We hope this Toolkit helps you recognise when brain injury may be a factor in your work. You may need to provide information about brain injury to other organisations to help their understanding. One way of doing this is to take a good case history that allows maximum opportunity to check whether brain injury has occurred. Obviously you will first want to speak with the client to do this, but others may have extremely useful information that the client may have forgotten, or may come from a different perspective that is helpful e.g. family and friends, prior medical history, contact with support organisations. Where serious brain injury has occurred there may be a defining moment where all parties recognise the client changed significantly. It could be that drinking started or got considerably worse at that point, mental health problems may begin or escalate over time after that event etc. This information can be very helpful in understanding why the client is where they are now and who can help. The template at the end of the Toolkit will help you summarise a timeline.

When contacting others to obtain a case history do bear in mind that for loved ones significant to the client a brain injury has been described as "an ambiguous loss". The person prior to the injury may have changed in many ways after the injury, relationships may have altered or ended, the effects of the brain injury may have caused harmful and upsetting behaviour. Brain injury survivors and their loved ones sometimes describe the pre-injured person as being 'dead' and the post injured person as new, almost a stranger. You may be the first person to contact the loved one about the client in years so prepare carefully for the contact taking into account these possibilities and ensure you have information that the loved one can use to seek support as a result.

Further Resources

Homelessness and Brain Injury UK research

Guardian article on homelessness and brain injury

Research from Canada about Traumatic Brain Injury and Homelessness

Article from St Michael's Hospital, Toronto, Canada about rate of brain injury amongst homeless men

Article from The Psychologist published by the British Psychological Association about a conference in 2016 on the Brain and Homelessness

Glossary

Acquired Brain Injury is damage to the brain that occurs after birth i.e. the person was born with a normally developing brain then an event at a later time damaged it.

Brain Injury is damage to any part of the brain no matter the cause

Head Injury is usually used to describe damage to the face or skull which, because the impact may also affect the brain, may also be short hand for brain injury too.

Mini Mental State Examination (MMSE) is a set of 30 questions which seek to provide information about the memory, attention and language abilities of the person answering and it was devised for use where dementia is a concern but is used to identify is a person has problems with these areas regardless of cause.

Neuro-Navigator – staff that help people navigate the most appropriate pathway for their brain injury similar to the role of a Care Coordinator in Social Services. Note they don't exist everywhere.

Template for case history

Below are suggested areas you may want to explore with your client to help build a picture of their experiences.

Before using this form, it is assumed you have a factual record of your client, their accommodation history, physical and mental health, substance use and financial situation.

Use this template to have a discussion about experiences that may involve ABI. No area is compulsory and use sensitivity throughout the conversation.

Some areas may be completely irrelevant, so do not feel the form has to be 'completed'.

General

Name (or identifier)

Current accommodation status

Contact details

DOB

Today's date

Childhood and adolescence

Childhood accidents and illnesses

Hospital admissions during childhood

School history
e.g. attendance, client's views of their school experience, were exams taken and results in general terms

Family / living situation during childhood
e.g. was client in care, who was important to client during this time, what was home life like

Early employment
e.g. what type of jobs has the client had, did they enjoy it, what if anything was difficult for them?

Friendships and other relationships during childhood and adolescence
e.g. did the client have friends, was it easy to make friends, did the client feel understood and supported by others?

Adulthood

Accidents and illnesses

Hospital admissions
e.g. has the client refused to attended hospital or left against medical advice?

Living situations
e.g. what sorts of places has the client lived in, was there a point in which they moved into more unstable accommodation? What else was going on at that time?

Family
e.g. what relationships did the client have, have they continued? Who would they like to be in contact with now? Is there anything that makes contact difficult?

Work
e.g. what type of work did the client do? If they were not working how did they manage financially? Was there a point when they moved into a more unstable financial situation? What else was going on at that time.

Does the client feel that their **abilities in the following areas** have changed? If so what was going on when that happened? Does anyone the client knows well feel they have changed?

Memory

Learning new things

Communicating with others

Managing feelings

For further information please contact

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The Westminster Homelessness and Health Coordination Project
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