Local Government and Communities Committee  

Homelessness  

Submission from Dr Rebecca Forrester and Dr Gemma Findlay

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Dear Local Government and Communities Committee,

We welcome the call for evidence regarding homelessness by the Scottish Parliament’s Local Government and Communities Committee. We have developed this submission in collaboration with a group of people who have worked with, researched and have direct experiences of homelessness. Our particular interest is in homelessness and head injury\(^1\). We have developed this submission to answer the key questions you posed that may shine a light on this often overlooked population.

We believe that people with a head injury that are experiencing homelessness, or are at threat of homelessness, may be impacted by most, if not all, of the questions you have posed. However, we have used this opportunity to highlight the large gap in service provision and knowledge and hope that this submission may highlight the need for better awareness, recognition, information sharing, assessment and ongoing support for those with a head injury.

We would welcome any opportunity to develop our work with the committee and all other interested parties. We believe that head injury within the homeless community is a vital consideration when planning and developing service provisions in not only preventing homelessness, but in finding lasting routes out of homelessness.

Yours sincerely,

Rebecca Forrester & Gemma Findlay  
Clinical Psychologists

\(^1\)This includes injuries sustained through injury (for example, assaults, falls, road traffic accidents) or illness (for example, Korsakoff’s Syndrome)
Q1. What are the reasons behind why people become homeless?

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

Common neuropsychological sequelae of head injury include: difficulties with planning, organisation, concentration and memory (Tsaousides & Gordon, 2009), all of which are required to gain or maintain employment and secure housing. It is therefore plausible to consider that sustaining a head injury could contribute to the onset of homelessness and/or perpetuate this situation once it has occurred.

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).

A qualitative study looking at the links between head injury and homelessness highlighted the complex nature of this client group (Findlay et al, 2016). Participants were seven homeless individuals with a moderate or severe head injury, recruited from supported accommodations across Lanarkshire and Glasgow. They were asked to talk about their journey to homelessness and in particular, to reflect on any perceived links between head injury and their homeless status. All participants acknowledged impairment following head injury. This ranged from mild difficulties to long-standing psychological, physical and cognitive impairment. Three participants received input from specialist head injury rehabilitation services. In addition to this, three participants identified links between head injury and their ‘homeless’ status. One individual talked about losing her tenancy due to being in hospital for a long period following head injury, highlighting this as a precipitating factor to homelessness. Another participant felt that head injury had perpetuated his homeless status. He described feeling unable to fight his corner (due to cognitive and mobility difficulties), resulting in a prolonged period of homelessness. Some of the participants had limited insight into the effects of head injury and had therefore, never considered the role that this may have played in their homelessness. There was also a dearth of head injury knowledge within the staff groups involved in supporting recruitment. They often lacked awareness that their residents had sustained a head injury and had limited knowledge of the implications of this. Difficulties were attributed to substance misuse, possibly contributing to individuals not receiving neuropsychological assessment for head injury. It is hypothesised that this lack of awareness/knowledge of head injury may be replicated in other professional groups. Participants talked about receiving inadequate support from statutory services (mainly social work and housing). Solliday-McRoy and colleagues (2004) acknowledged that homeless individuals often seek treatment in crisis, with complex difficulties, chaotic lifestyles.
and little social support. It is therefore understandable that subtler issues (for example, mild or moderate cognitive problems) are ignored or missed.

Homeless individuals with a moderate or severe head injury were found to have multiple other significant concerns, including: mental health issues; substance misuse problems and difficult relationships with family. Four out of seven participants identified substance misuse as their primary difficulty, highlighting that head injury and homelessness cannot be studied in isolation. Individuals who are homeless and have sustained a head injury should receive an in-depth assessment which considers the effects of their head injury (cognitive/physical impairment or emotional difficulties) alongside other co-morbid problems (e.g. substance misuse/mental health difficulties). This is necessary in order to ensure that supports/interventions are adapted to suit individual needs.

Care providers, health care professionals and policy makers should be made aware of the prevalence of head injury in this population and the cognitive and behavioural implications that this may have.

**Q2/3. What scope is there for improved joint working with all agencies and groups supporting those with multiple and complex needs, which would also include the health sector? What more could be done to ensure that the needs of homeless people with multiple and complex needs are adequately supported? Are there examples of good practice?**

We are not aware of any services in Scotland who routinely assess for head injury in the homeless population. This is a similar picture to what is seen across the UK. In a recent paper submitted to *The Neuropsychologist* (Forrester et al, in press) the success of collaborative models that have been effective in addressing social and mental health needs amongst the homeless was highlighted:

“Dorney-Smith, Hewett, Khan and Smith (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.” (p. 3)

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; this work carried out between 2012 and 2014 saw that 180 homeless people with a head injury were supported through one-to-one work and support clinics. Screening assessments found over half the prison population had a head 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.thedtggroup.org/media/4082/160115_linkworker_service_report.pdf](http://www.thedtggroup.org/media/4082/160115_linkworker_service_report.pdf). (The Disabilities Trust).
Q4. What needs to happen to improve the delivery of housing options and homelessness prevention services and the outcomes achieved for service users?

We need to reduce the potential of people becoming homeless in the first place, but we also need to consider how to best help people when they do. When we look at the demographic data associated with homelessness, there is a similar pattern with what we’d observe in traumatic head injury populations, 73% of homeless people are male, 60% have mental health difficulties, 44% 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). In addition, we must also be aware of how the identities of homeless people can further exacerbate these issues, for example if they are BAME and/or LGBT, as prejudice against these identities may exist in housing situations. For housing options and outcomes to improve for these populations, we must not blind-side ourselves to their existence and look to more inclusive and tailored ways to appropriately meet their needs.

A group of researchers from Sheffield Hallam University (Grant et al., 2016) investigated the experiences of homeless people who had sustained a head injury to better understand the needs of these individuals and the current gaps in service provisions. From conducting interviews with those with lived experiences of homelessness and head injury, they drew a number of conclusions: head injury screening should be available to frontline staff in contact with homeless people; that specialist head injury services needed to find innovative ways to provide a truly accessible service to this population; preventative support should be prioritised; and that there needed to be a development of pathways of support back into head injury rehabilitation, when needed. The full report can be found here:

http://shura.shu.ac.uk/13718/1/Experiences%20of%20homelessness%20and%20brain%20injury%20FINAL%282%29%20Sept%202016.pdf.

Gaining specialised neuropsychological input is paramount to establishing needs, and providing tailored support to the individual as well as the systems and people supporting that person. The lack of specialised input comes with a social cost; extra demand is placed on services not trained to support a person with neuropsychological difficulties; third sector organisations, the police, social, residential and health services all feel the impact of supporting unmet neuropsychological needs. We know that people with unrecognised neuropsychological needs often fall between service gaps or get ‘bounced’ between drug & alcohol teams, re-housing schemes, Accident and Emergency, and mental health provisions, without a full understanding of their neuropsychological deficits or indeed their strengths. Therefore, it is paramount that we better consider head injury in homelessness, understand its impact and provide assessment, rehabilitation and follow-on support to meet their needs.
References


Appendix

Contributors to the Homelessness and Head Injury Research Group are from:

Glasgow University
Headway Glasgow
Headway Leeds
Headwise, Birmingham
Liverpool University
NeuroTriage CiC
NHS Greater Glasgow & Clyde
Pathway, London
Sheffield Hallam University
St. Michael’s Hospital, Toronto, Canada
The Disabilities Trust, Leeds
Waves of Hope Service Users Forum, Liverpool