Homelessness and the Brain Conference

Liverpool

16th September 2016

Housekeeping

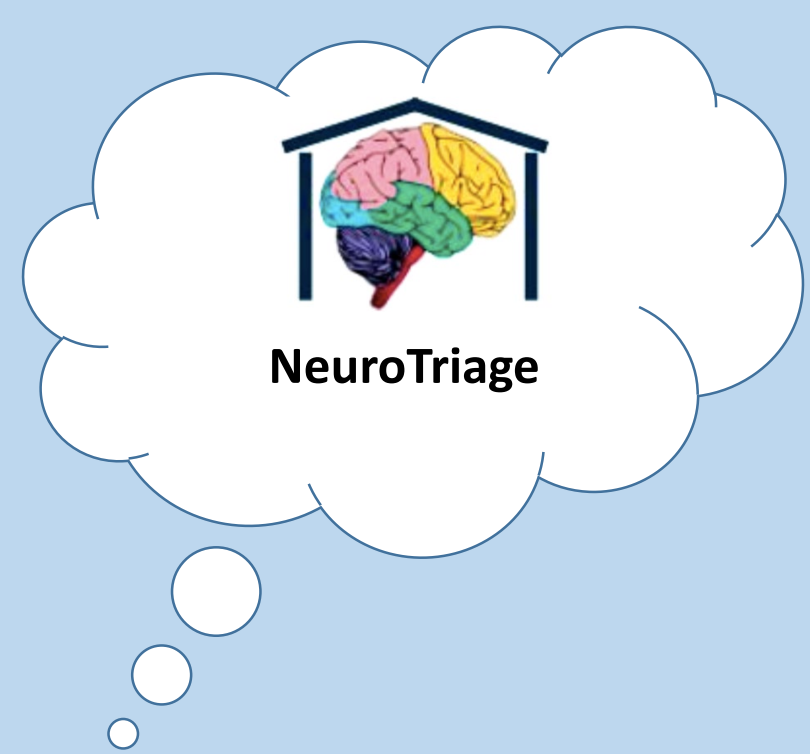
- Helpers – Rebecca, Ste, Sue, Cormac and Natalie
- Moving about during the day

- Fire exits
- Toilets

- Photography
- Social media
- Feedback

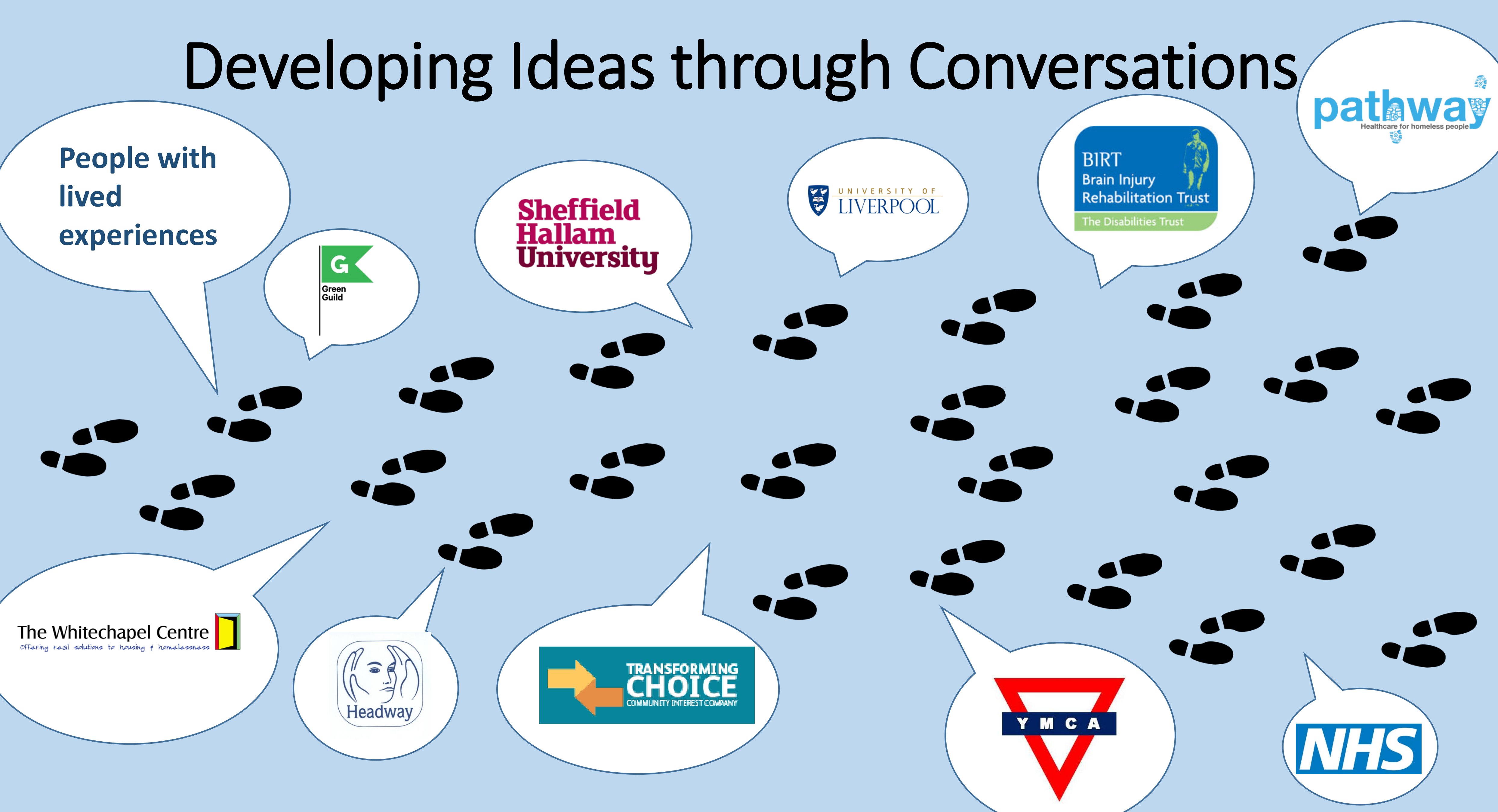
Why homelessness and the brain?

- **There is a higher prevalence of brain injury in the homeless population**
- People with a brain injury are more vulnerable to becoming homeless
- **People with unrecognised neuropsychological needs often fall between service gaps or 'bounce' between services**
- How can we better meet the needs of this largely hidden population?



Neuro Triage

- 12-months in development (and continues to be developing)
- A collaborative project seeking ways to connect with people to better meet the neuropsychological needs of the homeless community



Developing Ideas through Conversations
People with lived experiences
Green Guild
Sheffield Hallam University
UNIVERSITY OF LIVERPOOL
BIRT
Brain Injury Rehabilitation Trust
The Disabilities Trust
pathway
Healthcare for homeless people
The Whitechapel Centre
Offering real solutions to housing & homelessness
Headway
TRANSFORMING CHOICE
COMMUNITY INTEREST COMPANY
YMCA
NHS

Homelessness and the Brain

Friday 16th September

Elizabeth Gidney Suite

Liverpool Guild

Entrance via the Reilly Building

Brownlow Hill

University of Liverpool

L69 7ZX

Event Programme

9.00 Registration opens
9.30 Welcome Address

9.45 Steph Grant: *How and why do some brain injured people become homeless in Sheffield?*
10.30 Guy Soulsby: *Introductions to traumatic brain injury and homelessness*

11.00 Break

11.15 Dr Stephen Mullin: *Multiple Risk Factors for Acquired Cognitive Impairment in Homeless Populations*
11.45 Workshops A Jo Iddon and Laura Binsale: *Person-centred approaches to brain injury*
Workshop B Dr Sarah Butchard: *Human-rights based approaches working with difficulties in the aging brain*

12.45 Lunch

1.30 Jacq Applebee : *Minorities and Marginalization in Homeless Populations*
2.15 Workshops A & B

3.15 Break

3.30 Waves of Hope Service User panels
4.15 Final thanks and close of day

Hopes for today

- A day for conversations
- Space to listen to one another
- Time to learn from one another
- Connecting with one another beyond today

“How and why do some brain injured people become homeless in Sheffield?”

Steph Grant

Homelessness and Brain Injury

Guy Soulsby
Social Worker

16th September 2016

Homeless people are more likely to have a brain injury than the general population.

American Psychological Association (APA) Spotlight on Disability Newsletter from December 2014

“TBI-related cognitive and behavioral deficits (e.g., limitations in memory; planning and organization; and reasoning, comprehension and problem solving, as well as impulsive decision making) lead to an increased risk for economic and housing instability.”

BI caused by a trauma – in the UK about 75% of brain injuries are traumatic – most by road accidents, assaults and other accidents cause most of the rest or they can be acquired due to an infection, cardiac arrest which deprives the brain of oxygen and brain haemorrhages / aneurysms

lack of forethought/understanding consequences
altered behaviour
irritability
anxiety
lack of self-restraint
disinhibition
inappropriate comments actions/humour
impulsive behaviour
unrealistic ideas of own ability
reduced understanding of the needs of others

Why should BI be likely to lead to homelessness? In an echo of the APA article above the authors of the Glasgow study suggest that

“one possibility is that persisting cognitive and emotional effects of the brain injury may have an impact on a person’s lifestyle, putting them at greater risk of premature death. For example poor organisation, planning and problem solving, impaired judgement and impulsivity are common effects of more severe head injury and may lead to lifestyle choices that lead to ill health and even death.”

Of course, the homeless “lifestyle” where “tri-morbity” is common (a mix of addictions, mental health problems, chronic physical health problems and of course brain injury) might increase the risk of having a brain injury, or causing further brain injury

“Of those people who experience traumatic brain injuries, up to 68% have a history of substance misuse, 50% of people return to pre-injury consumption levels, 14% develop an alcohol and drug problem after a head injury and 60-80% of clients in alcohol treatment will show some form of cognitive impairment.”

“A large scale study of the death certificates of homeless people by Crisis in 2011 calculated the average age of death of homeless men to be 47, and homeless women to be 43. This study suggested that a third of deaths in this group are caused by drug and alcohol, and that homeless people are 9 times more likely to commit suicide.”

“Earlier studies suggest that brain injury often occurs before homelessness and this raises the possibility that better services for people with brain injury could prevent some people from becoming homeless”

It is a fact that young men are more likely to have a brain injury (alcohol, fights, car crashes……..) and the Australian fact sheet noted

“Many families of young adults who have experienced traumatic brain injuries will, within five years of the post-school period, reach ‘breaking’ point particularly where “repeated incidents involving police intervention have occurred. The young person at this point typically finds themselves homeless or potentially homeless with minimal survival skills”.

Given that homeless people are more likely to have had a brain injury – either before becoming homeless or having sustained one since becoming homeless – what can services do to help?

Being aware of the kind of problems a BI can cause and taking them into account when working with people who have had one is likely to be helpful.

Many people with a brain injury will be left with the problems for life and much of the work done in brain injury rehabilitation is about helping people work round these problems

“Following this and previous research studies a Disabilities Trust Foundation brain injury Linkworker has been providing support to homeless people with a TBI in Leeds. Training for front line staff including hostel staff, social workers and housing providers is also being delivered by the Foundation, drawing on Brain Injury Rehabilitation Trust expertise (BIRT)”

It is always worth bearing in mind that a brain injury (or more than one) might be disabling people. The BISI might be useful in teasing this out. Even if people do not report an injury (psychological screening) could pick up the cognitive problems that are characteristic of brain injury if someone can be found to do this. This can then be taken into account when considering the long term support they will need

www.biswg.co.uk

www.headway.org

www.thedtgroup.org

www.braininjuryaustralia.org.au

15 minute tea and coffee break

Acquired Brain Injury and Homelessness

Multiple Risk Factors for Acquired Cognitive Impairment in Homeless Populations

Dr. Stephen Mullin

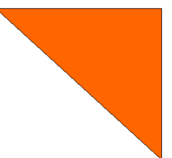
Consultant Clinical Neuropsychologist

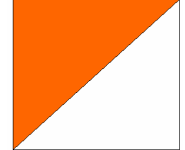
5 Boroughs Partnership Foundation NHS Trust & Taylor Neurorehabilitation Unit, Leigh Infirmary

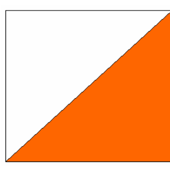
stephen.mullin2@5bp.nhs.uk

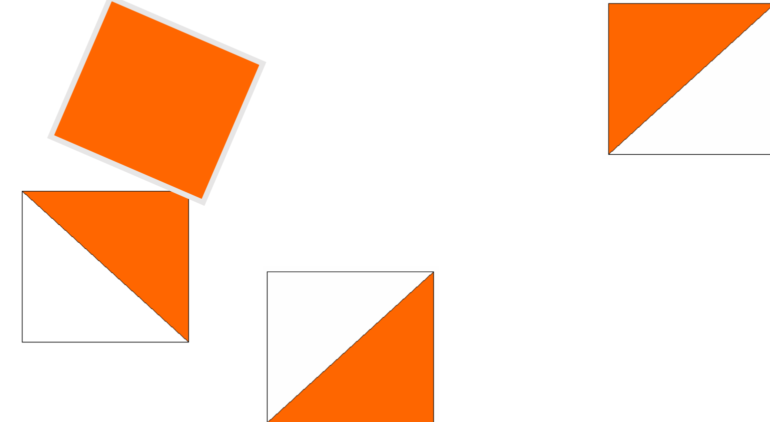
Overview

- Multiple Risk Factors for Acquired Cognitive Impairment:
  - Traumatic Brain Injury
  - Epilepsy
  - Alcohol
  - Stroke and Other Cardiovascular Disease
- Homelessness and Risk
- Barriers to accessing services
- What can be done?









Traumatic Brain Injury

Homelessness and Self-Reported Head Injury:

Not all people who are homeless have an acquired brain injury. But rates are high.

- Oddy et al., 2012 Survey of 100 people in UK:
  - 53% self reported a head injury (defined as 'an injury to the head which knocked you out or at least left you dazed, confused or disorientated.').
  - 70% of participants reported sustaining their first such injury before they became homeless
- Topolovec-Vranic et al, 2014 in a surgery of 111 homeless men in Canada:
  - 45% had a positive screening result for a history of TBI.
  - 73% of (initial) injuries occurred in childhood and 87% percent before the onset of homelessness.

Homelessness and Documented Admission to Hospital for Head Injury

- A study by McMillan et al., (2014) found that of 1,590 homeless people registered with a general practitioner in Glasgow the 30 year prevalence of admission to hospital with a head injury was 13.5%, 5.4 times higher than the general Glasgow population.

Homelessness, Head Injury and Mortality.

- The McMillan (2014) study reported that rate of mortality within the head injured population, over a prospective 6-year period, was twice that of the non-head injured homeless population.

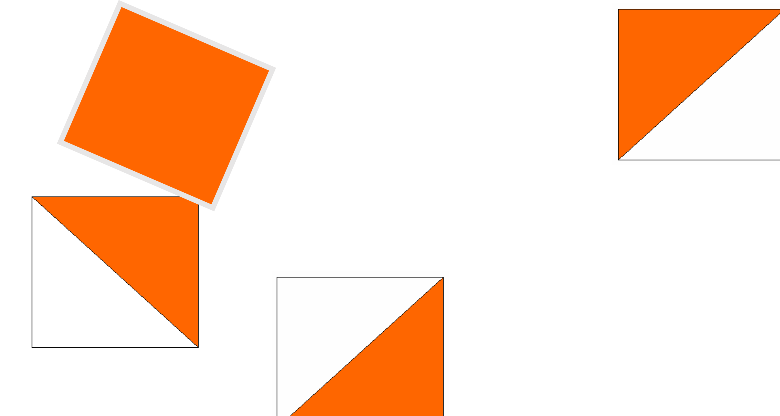
Traumatic Brain Injury and Homelessness

Self reported rates of head injury with a subsequent altered state of consciousness are therefore very high indeed amongst homeless populations.

Rates of historical admission to hospital for a head injury /TBI are also high – over five times higher than comparable rates in the general population.

In the majority of cases the (first) head injury predates the onset of homelessness.

Homeless people who have a history of head injury are significantly more at risk of death than the wider homeless population – an already highly vulnerable group.



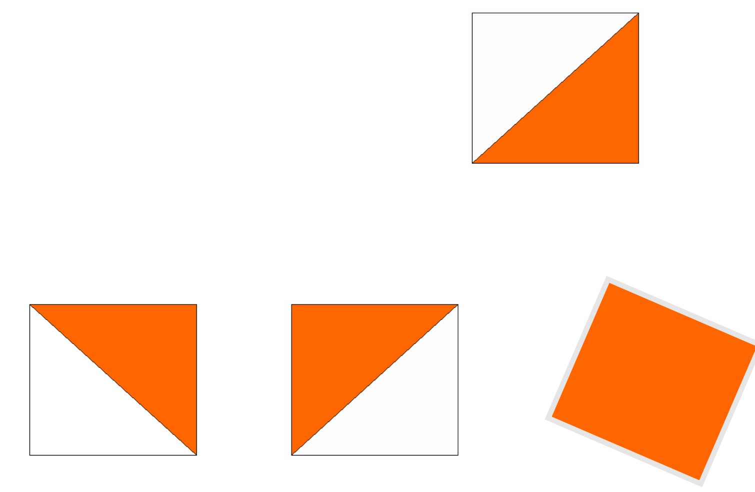
Epilepsy and Seizures

Epilepsy

- A study conducted in Paris in 2003, surveyed 592 adults and found a lifetime history of at least one seizure of 14.5% (Laporte et al., 2006)
  - Of those with seizures, 59.3% were classified as having epilepsy and 40.7% as having Alcohol Related Seizures (I.e. Seizures which either began concomitantly with or followed the onset of alcoholism).
- The prevalence of epilepsy in the sample (8.1%) was far higher than the rate in the general population (<1%).

Seizures and Homelessness

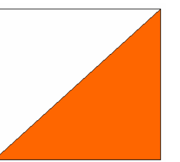
- Like Traumatic Brain Injury, epilepsy is far more common amongst the homeless population than the general population.
- Rates of alcohol related seizures are also high, but not as high as seizures due to epilepsy.



Alcohol

- 'A common stereotype of the homeless population is that they are all alcoholics or drug abusers. The truth is that a high percentage of homeless people do struggle with substance abuse, but addictions should be viewed as illnesses and require a great deal of treatment, counseling, and support to overcome. Substance abuse is both a cause and a result of homelessness, often arising after people lose their housing' (National Coalition for the Homeless, 2009)

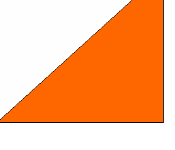
- Chronic alcohol use can lead to damage to the brain and associated cognitive impairment. This is believed to arise from the effects of a deficiency of Thiamine (Vitamin B1), which is associated with chronic alcohol use.
- Alcohol related cognitive impairment is classifiable as either: Wernicke's Encephalopathy, Korsakoff's Psychosis or Alcohol related Dementia.



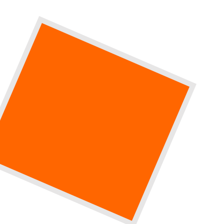
Alcohol, Cognitive functioning and Homelessness

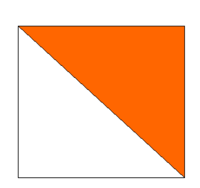
- Homelessness does put people at risk of developing alcohol and substance related problems.
- Chronic alcohol use can be associated with very severe cognitive impairments. If identified early these may be reversible though, if not treated, may become an intractable, lifelong problem.
- Rates of alcohol related cognitive impairment amongst homeless populations is not known but is likely to be higher than in the general population.

Cardiovascular Disease and Stroke



- Homeless adults are two-to-four times more likely to have hypertension and other cardiovascular disease, at younger ages, than either the general population or low-income adults with stable housing (See Quareshi, 2006).
- It has been speculated that this may be due to dietary and lifestyle related risk factors (Quareshi, 2006).





Homelessness and Cognitive Functioning

- As we have seen, being homeless is associated with an elevated risk of having suffered an acquired brain injury.
- Having a stable, secure, home is often considered essential for psychological wellbeing and quality of life (see Maslow, 1943). Does being homeless lead to a reduction in cognitive functioning, irrespective of any history of acquired brain injury?
- This question has been investigated and the answer is 'No'. (Ennis & Topolovec-Vranc, 2014). Being homeless as an adult is not associated, by itself, with any impairment of cognitive functioning.

Summary of [illegible] of ABI Amongst People who are Homeless

Summary

- Over half of people who are homeless may self-report a history of head trauma.
- Analysis of hospital admissions has shown that admissions for Traumatic Brain Injury are over five times higher for people who are homeless.
- Studies report that, for the majority of homeless people with a history of head injury, the injury predates the onset of homelessness.
- Mortality rates are far higher amongst homeless people with a history of traumatic brain injury than other homeless people; which are in turn far higher than amongst the general population.
- Rates of epilepsy are far higher amongst people who are homeless.
- This does not include rates of alcohol related seizures, which are also higher in this population and which may be associated with alcohol related neurological damage.
- Risk factors for cardiovascular disease and stroke are far higher amongst people who are homeless

How does Acquired Brain Injury put people at risk of homelessness?

- Acquired Brain Injury can cause a diverse range of cognitive impairment, dependent upon the location and extent of neurological damage.
- Particularly common are difficulties with:
  - Attention (Concentration);
  - Memory (forming new memories);
  - Executive Functioning (Problem Solving and Reasoning).
  - Other difficulties, such as with language, social cognition, perception and other areas of cognitive functioning may also occur.

Difficulties with Attention

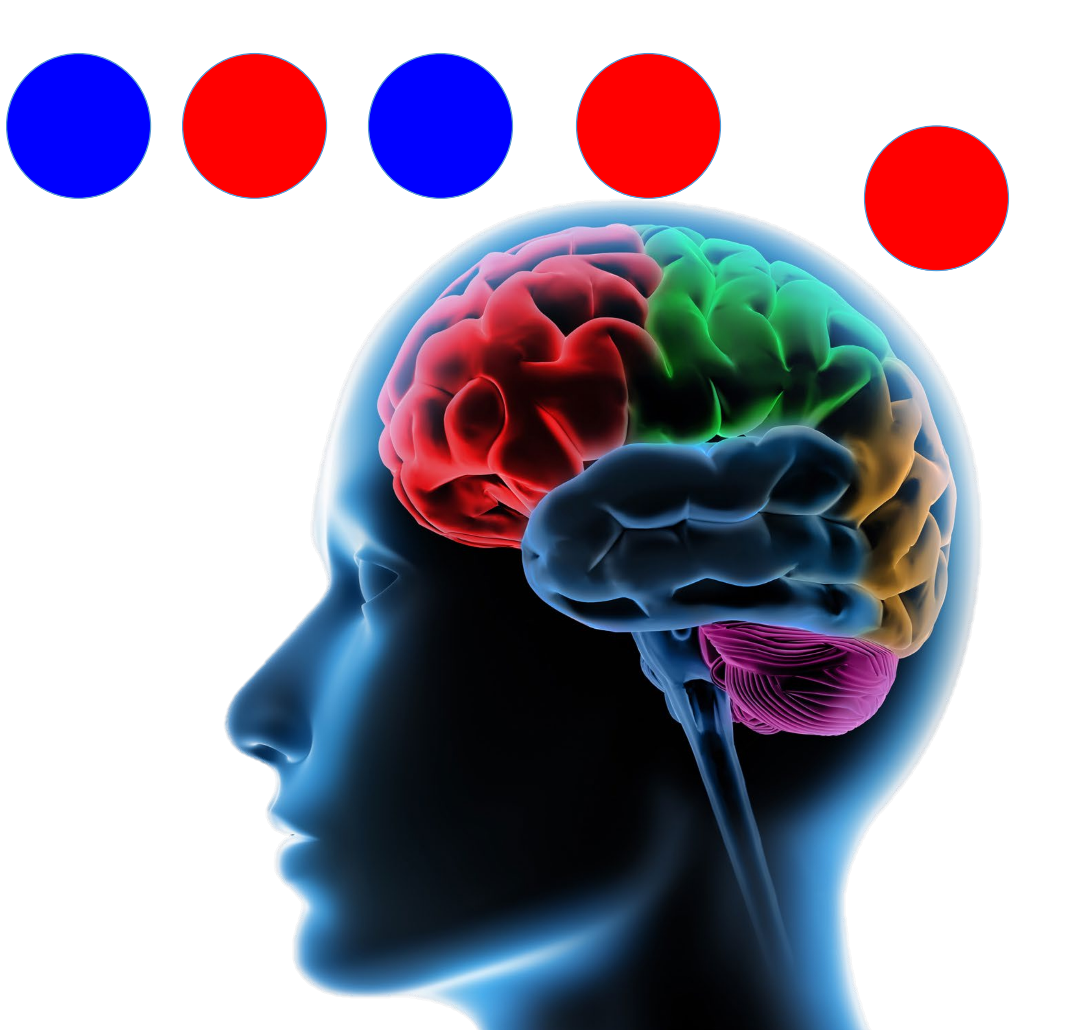
- People may struggle to:
  - Follow conversations
  - Make sense of lengthy forms or documents.
  - Maintain focus despite distractions.
  - Function well in busy or noisy environments.

Difficulties with Memory

- People may struggle to:
  - Remember essential personal and other information.
  - Remember appointments and deadlines.

Difficulties with Executive Functioning

- People may struggle to:
  - Plan or organise their behaviour.
  - Prevent themselves from acting impulsively.
  - Consider and weigh the longer term consequences of actions.
  - Understand or consider other people's perspective or points of view.



How does Acquired Brain Injury put people at risk of homelessness?

- Neurologically mediated disruption of emotional functioning is common and can include:
  - increased anger and irritability;
  - emotional lability (rapidly changing emotions)
- These difficulties may put people at increased risk of becoming homeless as they may struggle with managing finances; paying bills; accessing appropriate help and support (Highley and Proffitt, 2008).

Barriers to Accessing Services

- The number of A&E visits and hospital admissions per homeless person in the UK is four times higher than for the general public (Homeless Link, 2014).
- This suggests that people may be less likely to see a GP or other health professional.
- An address is required to register with a UK GP. However, people who are homeless are officially entitled to register with a GP using a temporary address, which may be a friend's address or a day centre. Some GP surgeries will register people using the surgery address (NHS.uk).

What can be done?

The following is recommended when working with people who are homeless who may have a history of ABI (Highley and Proffitt, 2008):

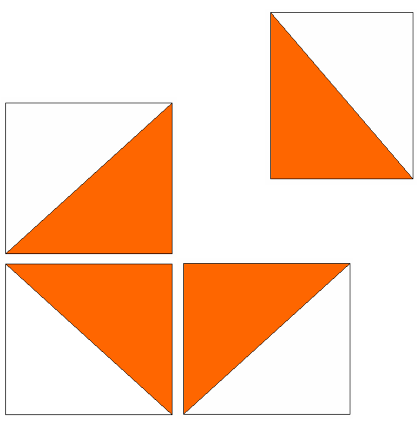
- Meet with people one-on-one, not in a room with others
- Eliminate distractions such as background music and telephones.
- Accompany people to their appointments
- Screen homeless persons for problems with cognitive functioning
- Use neuropsychological test results to support disability claims
- Mandate staff training on Acquired Brain Injury and its sequelae
- Create partnerships with other agencies and facilities for referrals for appropriate care.
- Inform housing providers of the special needs of those with cognitive impairment.
- Pursue further research into the relationship between cognitive dysfunction and homelessness

A Case Example

- Tim, a 57 year old was at risk of becoming homelessness. When referred to neuropsychology he was living in a flat but he was at risk of eviction as his flat was not well maintained and he struggled to pay his bills.
- A housing support professional was doing a great deal of work with Tim to support him.
- Tim had a history of abusing alcohol. He was aggressive at times and on occasion went 'missing' for several days at a time.
- Tim was referred to neuropsychology as he had been referred to mental health services and they identified a history of epilepsy.
- Review of Tim's medical history indicated that he had undergone surgery in the 1980s to treat his epilepsy. He had had a resection of his left temporal lobe. Unfortunately this did not stop the occurrence of seizures.
- Neuropsychological Assessment had been undertaken prior to surgery in 1986 and some years later. Following this, information regarding his history of neurosurgery had been 'forgotten' and was not well known to services supporting him.
- Follow-up neuropsychological assessment conducted in 2016 indicated severe memory impairment and also impairment of executive functioning, similar to but more severe than than 1986 profile.
- With Tim's permission, information regarding the cognitive impairment and his history of neurosurgery and epilepsy was shared with social services and he was supported to have an appropriate package of care and a reassessment of his housing needs.

Neuropsychology and Homelessness

- Homelessness may be caused by multiple factors, including neurological injury or illness but also trauma, abuse and subsequent mental health related difficulties. All such factors need to be understood and to be tackled to address the devastating impact of homelessness, both on individuals and societies.
- Not all people who are homeless have an acquired brain injury or any form of cognitive difficulty: homelessness does not cause cognitive impairment.
- The prevalence of acquired brain injury is, however, far higher amongst homeless populations than corresponding general national rates.
- Acquired brain injury does increase the risk of becoming and of remaining homeless.
- People who are homeless may also have a higher risk of developing an acquired brain injury and may face barriers accessing appropriate treatment and support.
- People who are homeless and who have a history of acquired brain injury are likely to have a disproportionally high risk of death compared with the rates amongst homeless people who do not have a history of head injury.



Thank you

References

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Workshops

A: Mandela Room

B: Elizabeth Gidney (this room)

HOMELESSNESS, AGEING & DEMENTIA

Sarah Butchard
Clinical Psychologist
Mersey Care NHS FT Trust

CONTEXT

‘Older people with dementia are among the most devalued members of our society, regardless of their lifelong characteristics and contributions…individuals who once fitted into the mainstream of society, demonstrating competence and productivity over their life span, now become marginal members within their immediate families and even more so within the larger social framework- bearing the double stigma of age and mental health issues’

Lubinski (1991)

FACTS & FIGURES

- The population is ageing
- Increases in the 'oldest' old
- Chances of experiencing multiple long term conditions increase as we age
- Chances of developing dementia increase as we age
- Homeless day centres, have significant numbers of service users aged between 50 and 65, but very few aged over 65: many will have died before reaching pension age (Crane & Warnes, 2001).
- Hard to define number of people due to lack of clarity about age.

ESTIMATED NUMBERS OF PEOPLE AGED 50+

Group	Estimated number of people at any point in time	Scope
Rough sleepers	300	GB
Living in hostels or equivalent	5,000	England
Self-placed in bed-and-breakfast or other temporary accommodation because they have no other option	12,000	GB
Imminent releases from prison and nowhere to go	100	England & Wales
Staying with friends or family in overcrowded conditions	24,000	England
Imminent risk of eviction	500	England
Estimated Total	**41,900**	

WHAT DO YOU THINK ARE THE ISSUES THAT LEAD TO OLDER PEOPLE BECOMING HOMELESS

- Bereavement
- Relationship breakdown
- No (or limited) support network
- Isolation
- Physical health problems
- Mental health issues
- Limited literacy and numeracy
- Dementia

EXTENSION OF ERIKSON

- Bender & Brown (1997) suggested that there are two stages in older age.

Age	Meaning	Possible risk if task failed	Areas to be explored
60-70 Early Old Age	Social reintegration vs inappropriate role maintenance	Denial of ageing Inability to stop working or substitute activity. Damages relationships	Level of activity Maintenance of work routines Relationships Hobbies/Interests
70+ Later Old Age	Acceptance of past, of limited time left and tasks to be completed	Depression Suicide	Things that need sorting out Unfinished business Over cautiousness Unfulfilled relationships

- Older homeless people are especially vulnerable because of their age, but for many, their vulnerability is made greater by other issues, including:
    - physical disability and sensory impairment
    - mental ill-health and dementia
    - substance abuse and addiction
    - learning disability
    - domestic violence and elder abuse
    - poor housing conditions and isolation
    - premature ageing in those who have been long term homeless.

ISSUES ASSOCIATED WITH AGEING

- Research shows that ‘home’ can be more important for people in later life (Heywood et al 2002).
- Older people are likely to spend more time in their home than younger people.
- The home and its surroundings can be important because of memories and friendship and family networks.
- There can also be associations with negative emotions (eg fear of abuse and violence).
- Most services are for young people (under 25).
- Sheltered housing wardens do not have the capacity to deal with tenants with extra support needs.

DEFINITION OF DEMENTIA

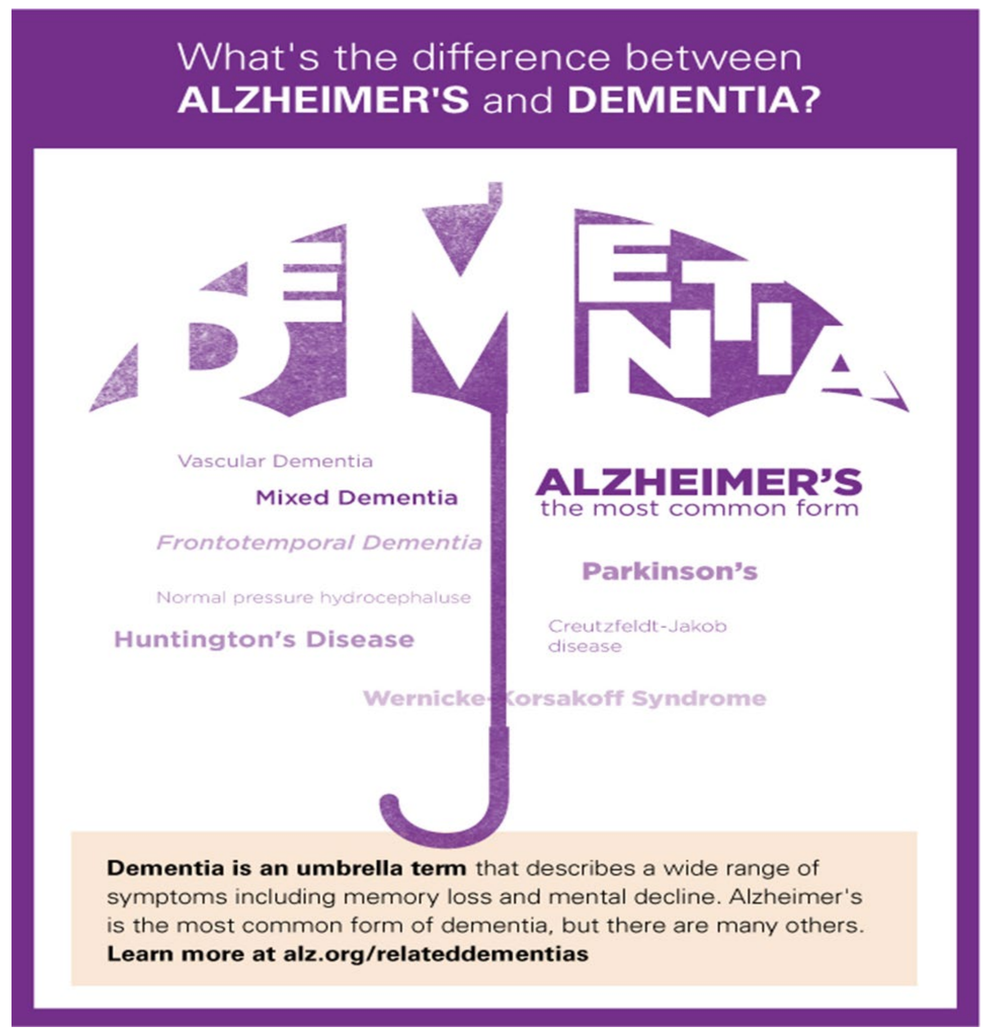
"The global impairment of higher cortical functions including memory, the capacity to solve problems of day to day living, the performance of learned perceptual-motor skills, the correct use of social skills and control of emotional reactions, in the absence of gross clouding of consciousness. The condition is often irreversible and progressive."

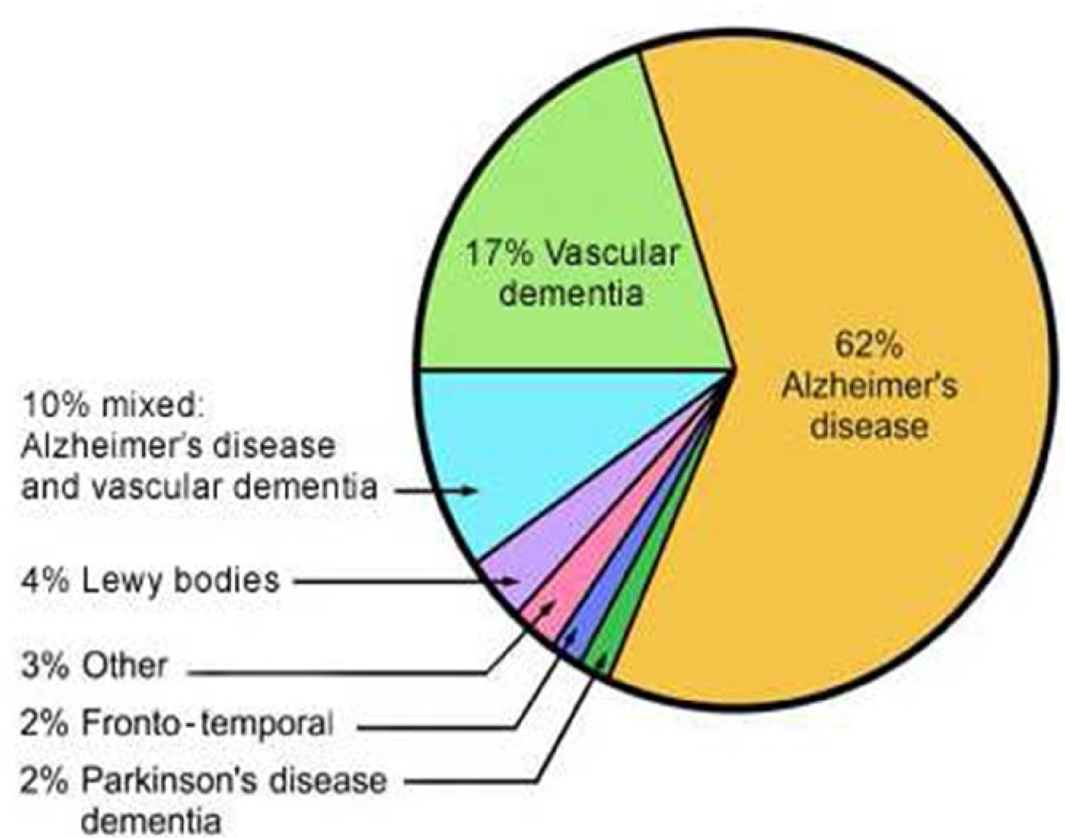
World Health Organisation (1986)

DEMENTIA

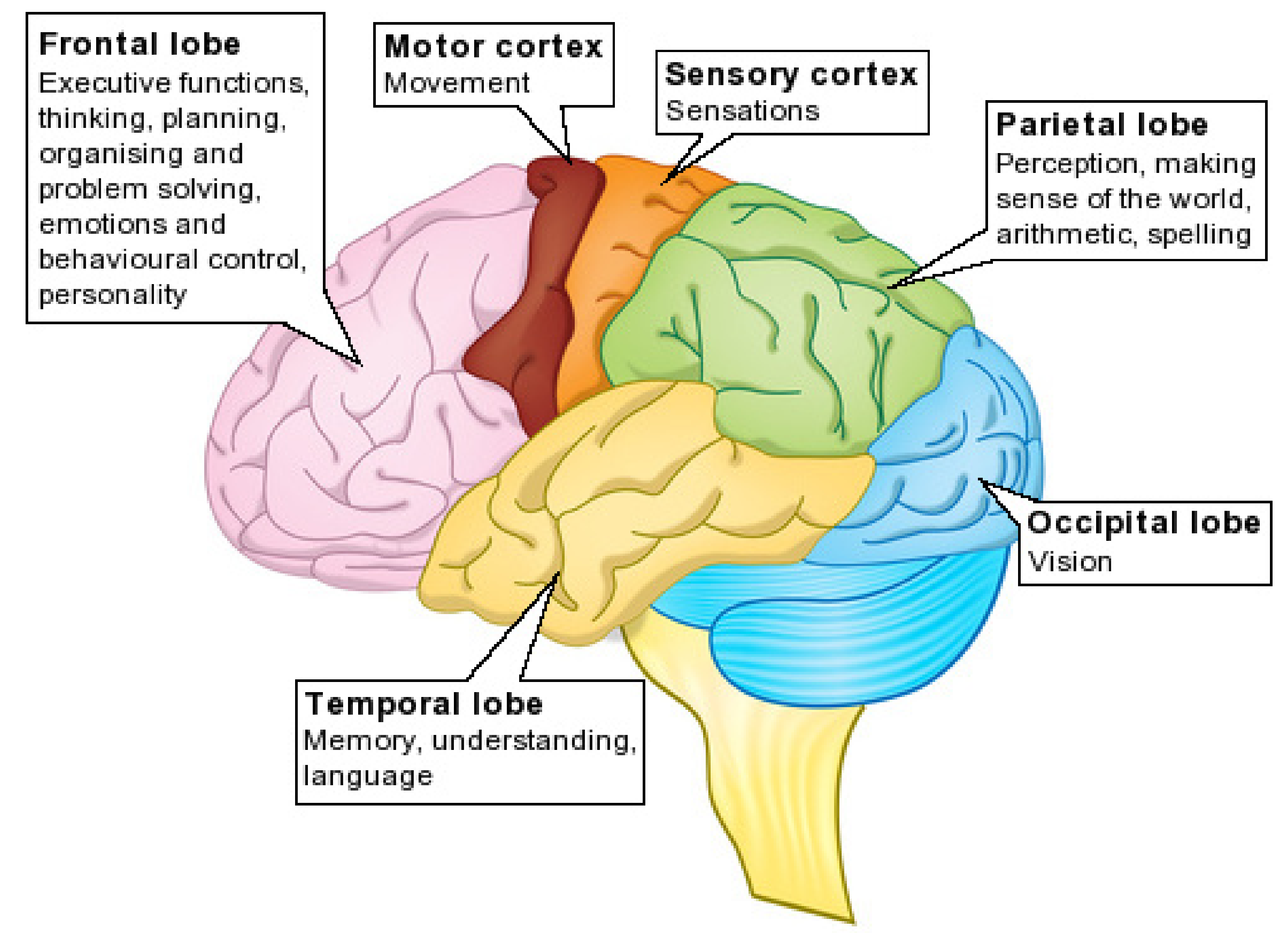
Dementia Bingo!!

TYPES OF DEMENTIA



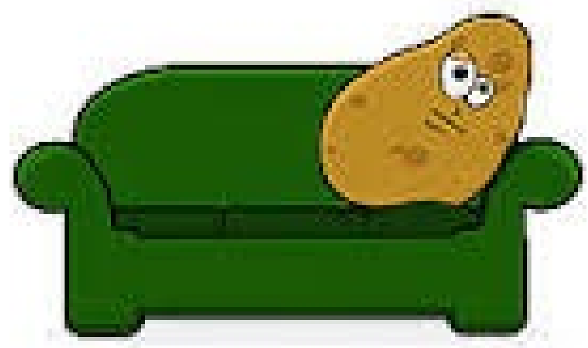

17% Vascular dementia
62% Alzheimer's disease
10% mixed: Alzheimer's disease and vascular dementia
4% Lewy bodies
3% Other
2% Fronto-temporal
2% Parkinson's disease dementia

THE BRAIN REVISITED



RISK FACTORS

- Smoking
- Alcohol – drug excessive use
- Hypercholesterolaemia
- General anaesthetics
- Head injury
- Inactivity
- Relatives
- Obesity
- Hypertension and hypotension
- Cardiac arrhythmias
- TIAs, CVAs, cerebral ischaemia.
- Angioplasty, CABG
- Ischaemic heart disease
- Diabetes (Type I or II)



FRONTO-TEMPORAL DEMENTIA

- Clinically, FTD presents either with changes in personality, behavioural problems and/or executive impairment, or as a primary progressive aphasia syndrome (PPA).

- Mean age of onset = 52-56 years.

- The behavioural presentation of FTD is often referred to as "frontal variant" FTD (fvFTD).

- Presentation of an insidious and progressive disorder of personality and behaviour of at least 6 months' duration with at least 5 of the following:

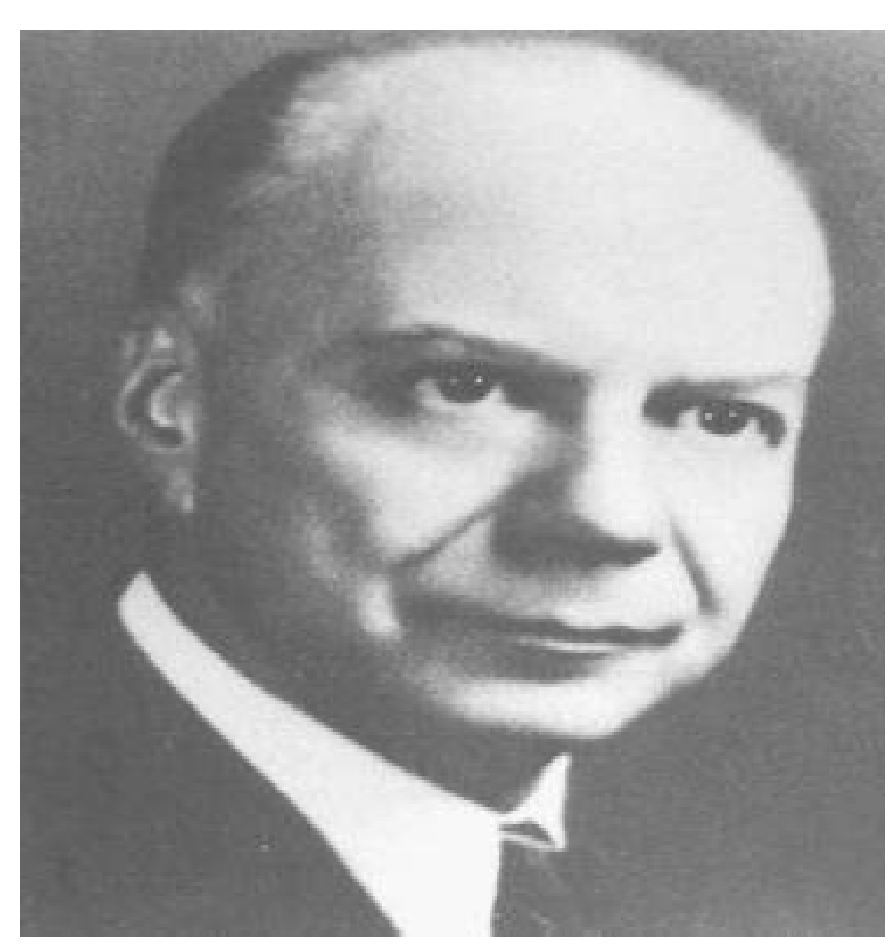
- Loss of insight
- Disinhibition
- Restlessness
- Distractibility
- Emotionally labile
- Reduced empathy or unconcern for others
- Lack of foresight and planning
- Impulsivity
- Social withdrawal

- Apathy or lack of spontaneity
- Poor self-care
- Reduced verbal output
- Verbal stereotypes or echolalia
- Perseveration (verbal or motor)
- Features of Kluver-Bucy syndrome (gluttony,sexual hyperactivity)

IMPLICATIONS

- Often misdiagnosed
- Loss of insight means a person may not seek help
- Relatives/ friends often driven away by behaviour changes
- At risk due to disinhibition
- Struggle to follow plans etc
- May become harder to manage household tasks

DEMENTIA WITH LEWY BODIES



DLB DIAGNOSTIC CRITERIA

Two core features are sufficient for a diagnosis

- Fluctuating cognition with pronounced variations in attention and alertness
- Recurrent visual hallucinations that are typically well formed and detailed
- Spontaneous features of parkinsonism

Suggestive features

- REM sleep behaviour disorder
- Severe neuroleptic sensitivity
- Low dopamine transporter uptake in basal ganglia

DLB DIAGNOSTIC CRITERIA

Supportive features

- Repeated falls and syncope
- Transient, unexplained loss of consciousness
- Severe autonomic dysfunction, e.g., orthostatic hypotension, urinary incontinence
- Hallucinations in other modalities
- Systematized delusions
- Depression
- Relative preservation of medial temporal lobe structures on CT/MRI scan
- Generalized low uptake on SPECT/PET perfusion scan with reduced occipital activity
- Prominent slow wave activity on EEG with temporal lobe transient sharp waves

IMPLICATIONS

- People are often mistaken for being drunk
- Visiospatial problems may lead to increased falls
- Memory often not too bad so misdiagnosed
- Hallucinations can be very vivid and disturbing
- Disorientation

KORSAKOFF SYNDROME

- Chronic memory disorder caused by a severe deficiency of thiamine.
- Korsakoff syndrome is most commonly caused by prolonged, excessive alcohol use.
- Can also be associated with AIDS, chronic infections, poor nutrition or wide spread cancer.
- Difficulties with laying down new information.
- Gaps in long term memory
- Issues with confabulation

WERNICKE ENCEPHALOPATHY

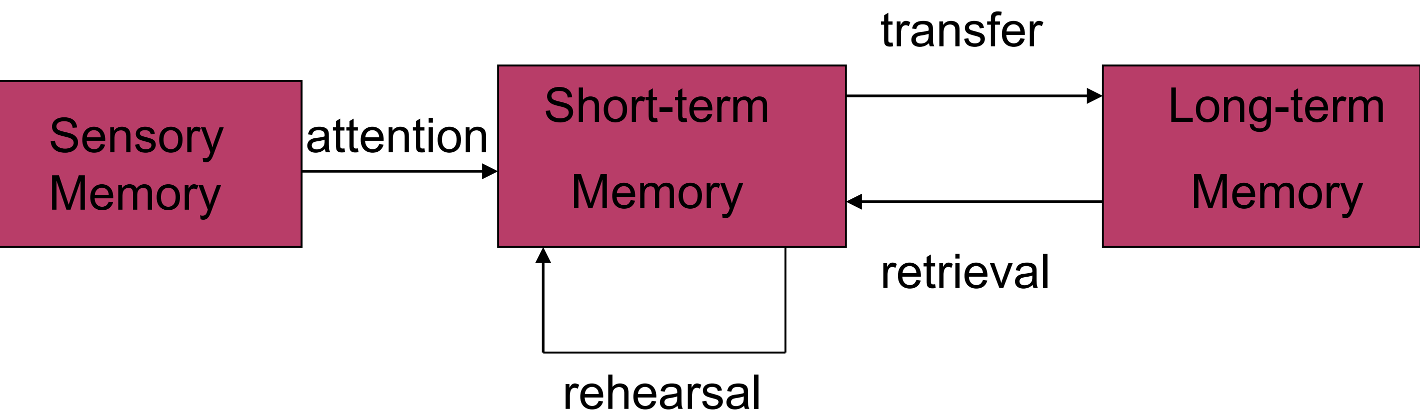
- Korsakoff syndrome is often preceded by an episode of Wernicke encephalopathy.
- Causes life threatening brain disruption.
- Symptoms include
  - Staggering and stumbling
  - Lack of coordination
  - Abnormal involuntary eye movements

MILD COGNITIVE IMPAIRMENT (MCI)

- a recent term used to describe people who have some problems with their memory but do not actually have dementia.
- It is a form of memory loss that may affect a person's score on neuropsychological tests, but does not mean that they have dementia
- Some people will be in the early stages of Alzheimer's disease or another dementia. Others, however, will have MCI as a result of stress, anxiety, depression, physical illness or just an 'off day‘
- People who have MCI are at an increased risk of on to developing Alzheimer's disease (or another form of dementia). In studies carried out in memory clinics, 5-10 % of people with MCI went on to develop dementia

Changes Associated with Ageing	Possible Symptoms of Dementia
Occasionally forgetting recent events, details of conversations and appointments but remembering them later.	Frequently forgetting recent events, conversations and appointments and having no recollection of them even when prompted. Noticing that you are forgetting personal information that you would previously have remembered e.g. your address.
Forgetting people's names, particularly when you haven't seen them for a while.	Not recognising people you have known well e.g. family members and close friends.
You are more worried about your memory than other people are.	Other people are expressing a lot of concerns about your memory but you are less aware of these problems.
Getting confused about the day of the week or the date but being able to work it out.	Getting confused about the day of the week or date and being unable to work it out. You may also forget the year, month, season or be confused by the time of day.
Sometimes struggling to find the right word in a particular situation (it will often come back to you when you stop thinking about it).	Frequently forgetting words or using the wrong word in the wrong situation.
Visual changes associated with changes with the eyes e.g. cataracts.	Making mistakes with the way that you see things and make sense of the world e.g. thinking that things are closer to you than they are, seeing objects that are not there, misidentifying objects.
Needing more help with using new technology e.g. computers, new microwaves, mobile phones.	Difficulty completing tasks that you have previously found easy and struggling to learn how to use new technology even with a lot of practice.
Changes in preferences regarding how to spend time, likes and dislikes.	Significant changes in personality and in behaviour.
Potential preference for staying at home, particularly when the weather is bad etc.	Withdrawing from most social activity and losing a lot of confidence in these situations.
Becoming more set in your ways.	Becoming more impulsive, distractible and less able to stop yourself saying things that others may consider inappropriate.

MEMORY



UNDERSTANDING A PERSON'S REALITY

- Because new memories are not been laid down recent information will not be remembered.
- As connections break down older memories can also suffer.
- Newer memories are the first to go – like packing a suitcase.

MEMORY BOOKCASE

- ‘ We cannot understand dementia simply in terms of the medical model and as the effects of damage to the brain. We need to understand the other things that are happening in a person’s life’

- Cheston and Bender 2000

KITWOOD'S EQUATION

- D = NI + B + P + H + SP

- NI = Neurological Impairment
- B = Biography
- P = Personality
- H = Health
- SP = Social Psychology

HUMAN RIGHTS BASED APPROACH

What are Human Rights?

A set of rules for governments

To respect and protect individuals

Based on common values

Developed over centuries

Now set down in law!

THE FREDA PRINCIPLES ARE A SET OF VALUES WHICH UNDERPIN THE ESSENCE OF HUMAN RIGHTS.

THE FREDA PRINCIPLES ARE:

fairness

respect

Human Rights

principles

autonomy

equality

dignity

A HUMAN RIGHTS BASED APPROACH

THE PANEL PRINCIPLES

- Participation
- Accountability
- Non-Discriminatory
- Empowerment
- Legality

HUMAN RIGHTS BASED APPROACH TOOLS
MAKING COMPLEX DECISIONS

- When trying to make decisions ask yourself:
  - Is it legal?
  - Is it legitimate?
  - Is it necessary?
  - Is it proportionate?
  - It is the least restrictive option?
- Also consider:
  - Is there anything proactive I could do?
  - Are there rights and risks I need to balance?

NEXT STEPS

FORCED THROUGH THE CRACKS

Issues Homeless Minorities Face

Jacq Applebee

TRIGGER WARNINGS

Mentions of:

- Child abuse
- Sexual exploitation
- Domestic violence (including 1 picture)
- Racism
- Homophobia, biphobia and transphobia

MISCONCEPTIONS

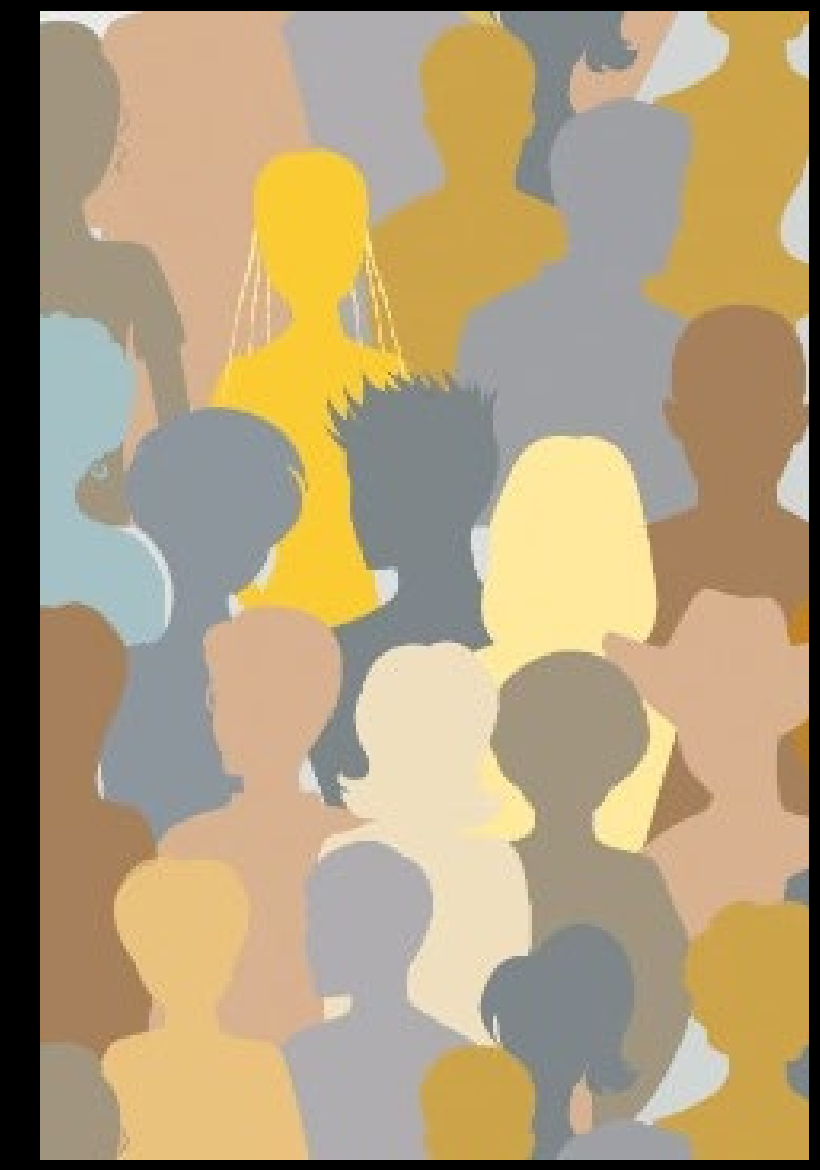
- Homeless =
- Rough sleepers
- Men with drinking problems
- Beggars

REALITY

Anyone can become homeless!

That includes Minorities:

- Young
- Lesbian Gay Bisexual & Trans (LGBT)
- Black Asian & Minority Ethnic (BAME)
- Disabled
- Women
- Elderly



WHY DO THE "REST OF US" BECOME HOMELESS?

- Domestic Violence
- Child Abuse
- Bullying and Harrassment
- Coming out as LGBT to family
- Debt
- Leaving long term care
- Leaving prison
- Relationship breakdown

JUST A TYPICAL DAY…

LESBIAN GAY BISEXUAL AND TRANS PEOPLE

- Sexual Exploitation
- Homophobia, Biphobia and Transphobia in hostels and shelters
- Drug misuse
- Lack of appropriate care
- Having to hide sexuality

BLACK ASIAN AND MINORITY ETHNIC PEOPLE

- Hyper visible means exposure to harm
- Racism from other homeless people
- Institutional Racism from support services
- Language barriers
- Shame from others in community
- Refugee and Asylum status

DISABLED OR LONG-TERM MEDICAL CONDITIONS

- Mobility problems in emergency accommodation
- Getting and storing prescription medicines
- Physical health deterioration
- Lack of support
- Isolation
- Mental health deterioration

YOUNG PEOPLE

- Financial and Sexual exploitation
- Drug issues
- Gangs
- Changes in welfare benefits
- Mental health problems
- LGBT and young

WOMEN

- Domestic Violence effects on physical and mental health
- Closure of Refuges
- Homophobia, Biphobia & Transphobia toward non-straight women
- Trans women and Refuges
- Sanitary protection costs
- Having to hide homeless status
- Unwanted sexual advances

SEXUAL EXPLOITATION TOWARD HOMELESS WOMEN ON CRAIGSLIST 1

anyone looking for a room with perks female only (london)

room or room share .... (female only)

can offer mabe cheapish room but not to cheap as have partner so wouldnt be able to explain it

for discreet fun every now and then white male

so if your looking for cheap room and some fun please reply

- do NOT contact me with unsolicited services or offers

SEXUAL EXPLOITATION TOWARD HOMELESS WOMEN ON CRAIGSLIST 2

☆ **Free Rent 4 a single beautiful Female house cleaner avail Now ,... (W/L**

White British Mature Genuine Gent 50 Seeks a nice Beautiful Single Genuine Open Minded Female for light duties of House work and Chores , Female must be open minded to share same room , Bed etc with gent as well also who would like to be spoilt , at all times in gifts as well to be cared for and looked after well at all times ,....Seeking a nice female who would be house proud and to own a house of her own and to change the interior of her choice to make it her own house ,.....

Usage of all facilities but Gent seeking someone who would not mind to start a loving serious bonding caring Relationship together open to any age nationality and culture please apply with a photograph as well details for mine in return or better still please text myself or whatapps me back on 0739 two three seven one 9 six five any time this is a genuine offer as well advert hope to hear from you soon ,.who ever you may be ? ,....

Regards x

SEXUAL EXPLOITATION TOWARD HOMELESS WOMEN ON CRAIGSLIST 3

Rent free room available for a female, all I want is return is to [illegible] your bum twice a week. Big bum girls preferred

available

private ro

- do NOT contact me with unsolicited services or offers

RECOMMENDATIONS

- Women and Equalities Minister to better tackle domestic violence
- Stop further closures of refuges
- Better education in schools and medical settings about homelessness & where to get help
- Training in the unique needs of minorities who face homelessness
- Look at who turns up to your homeless initiatives. Who isn't there?
- Look at where you're targeting resources
- Think about what are YOU doing for homeless minorities

CONCLUSION

- Staying hidden can protect us from danger
- We already face challenges in society by just existing
- Being homeless increases our vulnerabilities
- We are out there. You need to find us!

Workshops

If A is on your badge – stay in this room

If B is on your badge – go through to the Mandela Room

Many thanks!

Waves of Hope Panels

- Group 1: Nelson Mandela Room with Darren Stockton
- Group 2: Gidney 1 with Nicholas Couchman
- Group 3: Gidney 2 with Stephen Khan

Video link…

- https://www.youtube.com/watch?v=39XdI9bLYJA
- DISCLAIMERS
  - Difficulty finding a relevant video
  - Some American terms and reference to specific treatments in the video
  - Paths to homelessness different for different people, in different places and at different times
  - Using this as a way for reflections and discussions

Some questions to consider

- How did Terry’s brain injury influence his path to homelessness?
- What influence (if any) could Terry’s identity as a Samoan have played in his path to homelessness?
- What barriers may need to be overcome in Terry’s recovery? How can he be supported to overcome these?
- If you were Terry and were homeless – where would you go for support and what would you want to help you to engage with a service?
- How could services have prevented Terry from becoming homeless?

Summary

Special thanks to:

- Green Guild for hosting us today
- All speakers and presenters
- All attendees
- Any questions about Neuro Triage – just come and ask.