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|  | | | | January 28, 2015  NewsBrief  **Ending Homelessness** | |
| **Authored by Dr. Sylvain Roy PhD, C. Psych** | | | | | |
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|  |  |  | This is a special edition of our NewsBrief authored by Dr. Sylvain Roy, a licensed neuropsychologist and the lead clinician at CAMH’s Psychosocial Rehabilitation Assessment Service. He works with the homeless at the Inner City FHT. His practice is focused on the assessment and rehabilitation of patients with severe, persistent mental illness and brain dysfunctions. | |  | |

**Ending Homelessness in Ontario: Addressing the Mental Health and Functional Needs of the Most Vulnerable Amongst Us**

On January 26, 2015, the Ontario Government announced it has established an Expert Advisory Panel whose mandate is simple – to end long-term homelessness (1). This is a step in the right direction and all of us need to step up to the plate to ensure that the Panel will be successful in meeting this daunting challenge.

One of the biggest challenges government has faced over the years is getting clinicians, researchers and community partners to work collaboratively to address the bio-psycho-social factors perpetuating homelessness and ultimately preventing independent community functioning. Unfortunately, we seem to excel at working at odds with one another. Frequently, researchers do not relate to what clinicians do on the ground and engage in research that has little impact on practice change. On the other hand, clinicians are not always up-to-date with the latest clinically useful research. Agencies do not always communicate effectively with one another and various professional groups are not always included in critical health care decisions. At the end of the day, our patients suffer, enter the revolving door of the shelter system and, frequently, they die prematurely. With all of our collective input, the Panel will be provided with the solid information it needs to produce a solid roadmap to turn this around.

**Understanding the Problems Facing the Homeless**

In addition to severe poverty and limited supportive housing options, homeless people face additional problems. Many of my patients have complex co-occurring medical, neuropsychological and psychological conditions, which are effectively preventing them from functioning well within the home or community. Some patients are plagued by memory impairments, while others cannot plan, problem-solve or even reason without difficulty. Just like climbing Mount Everest may seem like an insurmountable feat to most of us, tasks such as dressing, bathing, cooking, managing finances and participating in the community appear insurmountable to most of my patients.

Research suggests that up to 80% of homeless persons may have cognitive impairments (2) affecting memory, attention, cognitive processing speed and executive functions. I see the impact of this cognitive dysfunction in my day-to-day practice. Cognitive impairment may be caused by acquired brain injuries (i.e. stroke or head injury), neurodevelopmental disorders (i.e. Autism Spectrum Disorder, ADHD, schizophrenia, etc.), degenerative illnesses, (i.e. Alzheimer's disease), infectious diseases (i.e. Hepatitis C or HIV/AIDS), vascular problems (i.e. hypertension or heart disease) and/or chronic substance abuse. This is reflected in a recent review paper (3) which reported that the incidence of traumatic brain injury in the homeless population ranged anywhere from 8% to 53%.

Individually, these diseases are associated with unique, but overlapping neuropsychological profiles. Behavioural disinhibition, for example, may follow from traumatic brain injury (TBI), fronto-temporal dementia or crack abuse due to altered frontal lobe functioning. Learning and memory impairments are frequently observed in schizophrenia, Traumatic Brain Injuries and Alzheimer's disease, though each of these may affect different aspects of memory (e.g. encoding, storage or retrieval). Finally, difficulties with balance, visual-construction, judgment, problem-solving and memory can be observed in chronic alcohol abuse due to poor nutrition (thiamine deficiency) and the toxic effects of alcohol on the brain. Many patients may present with more than one of the aforementioned conditions, making them particularly challenging to assess and treat.

There are a number of complicating factors that make matters worse. Persons with brain dysfunction are more likely to have future brain injuries, because one or more of their conditions is associated with an increase in risk. For example, alcohol use after a brain injury increases the likelihood of a second injury (4). Similarly, drug abuse and schizophrenia can lead to erratic and impulsive behaviours, fights and subsequent head injuries. Some drug use is associated with stroke, anoxia due to overdose and other neurotoxic effects. The cumulative impact of multiple brain injuries can have disastrous consequences on a person’s ability to think, problem solve and remember, which in turn directly affects their ability to function independently in the community. A simple, but relevant example in primary health care settings is that of medication adherence. Patients with poor attention or memory may be unable to fill their prescriptions due to the complexity of the task or remember to take medications as prescribed. Such patients could benefit from cognitive compensation strategies and cueing mechanisms to help them with such difficulties. From a health delivery perspective, addressing poor medication adherence, among other functional difficulties, could translate into less frequent emergency room visits and improved health outcomes.

**Interventions start with an accurate assessment**

First and foremost, society must define homelessness and understand that people can become and continue to be homeless for a variety of different reasons. I have worked with hundreds of individuals over the years. I have served refugees, the young and old, as well as men and women from numerous cultural backgrounds. All have had very different stories. Interestingly, due to the nature of my work, all my patients have had some sort of neuropsychological or mental health condition interfering with their functioning. In the majority of cases, brain related impairments were permanent. Developing an understanding of the people through an assessment allows for individually tailored interventions for the future.

**Finding effective solutions**

Housing is a must. Assisted housing for those who have lost the ability to function independently is critical. When someone has brain dysfunction, it's important to redesign the environment to compensate for their difficulties. Just like an elevator or ramps are needed for persons in wheelchairs, cognitive adaptation training for those presenting with cognitive impairments is needed. Error less training becomes important when memory impairments are profound and personal support workers need to be assigned to patients who cannot take their medications as prescribed. Finally, those that have been victimized need social and psychological supports to address their trauma. Others need help to develop better coping skills. Finally, providing patients with opportunities for retraining and volunteering are also important since it allows them to engage in constructive activities, which in turn offers a distraction and can help compete with urges to reengage in drug use.

**Increasing access to Psychologists makes sense**

As a neuropsychologist, my work involves determining the nature of my patients' cognitive impairments and its impact on their functioning. This is accomplished through the use of standardized tests, which are used to complement interview data, medical histories and behavioural observations. Patients’ results on measures of memory, attention, visual perception, language, executive functions (reasoning, planning, and organization), mood and personality are then compared with the performances of others of similar age, gender and education. The obtained pattern or cognitive profile can be a crucial component of diagnosis. In addition to clarifying diagnoses, neuropsychological reports can be used to document a client’s disability status for the purpose of obtaining benefits and/or for legal purposes (e.g. to enable court diversion when appropriate or to support ODSP applications). Most importantly, neuropsychological reports can alert caregivers to the need for accommodation in services, and make recommendations for support. This can be quite important in planning for a successful transition from shelter to supported housing.

Due to the complexity of a homeless persons’ physical and mental health, primary health settings must think outside the box when developing intervention approaches for this population. Interestingly, community-based rehabilitation programs for brain injury, frequently deal with complex cases. Such community-based programs are generally interdisciplinary, often including neuropsychology and occupational therapy. Because brain injury teams include an emphasis on cognitive and functional abilities, they are better equipped to implement behavioural approaches that have a goal of improving functional cognition. Community brain injury teams have demonstrated that gains are possible for individuals with cognitive impairment when appropriate supports and services are provided. Ontario Family Health Teams (FHTs) and Community Health Centres (CHCs) that include neuropsychologists and psychologists are well placed to refine and implement assessment, as well as rehabilitation programming for the homeless population. In collaboration with other healthcare professionals, such as psychiatrists, family physicians, occupational therapists, social worker, and behavioural therapists, neuropsychologists can play a leading role in supporting homeless individuals.

**Having the right care at the place**

For patients who are homeless, accessing family physicians and nurses in primary health settings is often difficult. FHTs and CHCs have begun to address the issue of access for the homeless; however, problems with community mobility, discrimination, and patient complexity pose significant challenges to both patients and frontline teams. The lack of access to mental health professionals, including psychologists and psychiatrists, who are needed to conduct mental health assessments, identify an accurate diagnosis and the most appropriate treatments is of grave concern. Though Ontario has committed to a ten year Mental Health Strategy, today, the province’s support system for those individuals with mental illnesses can be improved. Access to psychiatrists is limited and despite having several thousand psychologists in Ontario, few of them work in the public system and even less work directly with the homeless. When appropriate services are not available, the homeless increase their use of high cost emergency departments, inpatients beds, shelters and correctional institutions. The alternative is to remain on the streets.

The most vulnerable amongst us, and Ontarians in general, expect that mental healthcare will be readily available. It is our responsibility collectively to ensure this is the case.

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