



From the Seattle-King County Health Care for the Homeless Network
January 2009



Traumatic Brain Injury, Cognitive Impairment and Homelessness: Some Practical Tips to Enhance Communication and Goal Setting

There is growing evidence that traumatic brain injuries are very common among homeless people. These injuries have often occurred in the person's past: shaken baby syndrome, physical abuse in childhood, sports injuries, auto accidents, fights, falls, war injuries and gunshot wounds are a few examples of traumatic brain injuries (TBI) that your client may have incurred over their lifetime, in the distant past, or very recently. Your client may not be able to recall being injured, as memory impairment is often a symptom of TBI. They, and others, may not attribute the difficulties they experience in daily life to head injuries that they have sustained. Thus, the problem of TBI among homeless people remains hidden.

Traumatic Brain Injury is defined by the Centers for Disease Control as "a disruption in the normal function of the brain caused by a blow or jolt to the head or by a penetrating injury...which can range in severity from mild to severe." Mild TBI, which may manifest only as a transitory change in consciousness after a head injury, should be taken seriously, particularly since there seems to be a cumulative effect of multiple mild TBI's. Any TBI can result in cognitive impairment

What is cognitive impairment? Cognition simply put, is the ability to think. Thinking, when you think about it, is very complex and encompasses a multitude of highly nuanced functions: pondering, wondering, questioning, intuiting, reflecting, remembering, recalling, reminiscing, imagining, concentrating, planning, predicting, interpreting information, reading, writing, processing information, learning, decoding, deciding, judging, understanding, comprehending, initiating and sequencing actions, articulating thoughts, expressing feelings, calculating, solving problems, orienting. And that is a short list! Just imagine the mental processes needed to perform a seemingly simple activity, like paying a bill or two.

TBI can also result in personality and behavioral changes. The brain injured person may exhibit impulsive behavior, a lack of inhibition, problems with setting boundaries with others, irritability and difficulty managing emotions, particularly frustration and anger. The inability to manage these behaviors can result in problems with friends, neighbors, care givers and may lead to verbal altercations and physical fights. These behaviors are typically not tolerated by society, and the head injured person may find himself facing criminal charges and incarceration. Impaired decision making and poor boundary setting make the brain injured person easily manipulated by anyone who would like to exploit them.

In this issue:

Traumatic Brain Injury, Cognitive Impairment and Homelessness 1

Smoke Free Support Corner 4

(Continued on P. 2)

Traumatic Brain Injury (continued)

How and why should I assess my client for TBI? The client may come to you with a history of TBI, or you may develop a hypothesis that they may have a history of TBI. A client who has difficulty managing his day to day living, is extremely forgetful, has difficulty expressing himself, has trouble following simple directions, frequently loses things, is easily frustrated and has difficulty forming relationships, may be a TBI victim.

Of course your client may also be affected by a host of other conditions that share some common characteristics of TBI. Psychiatric disorders, post traumatic stress disorder, learning disabilities, developmental disabilities, attention deficit disorder, substance use disorders are a few such conditions. However, it is still worth investigating the possibility that there may be a TBI that is contributing to the client's difficulties. Developing an understanding about why your client behaves as he does can help you cope with often frustrating behaviors. Remember it is not because your client doesn't *want* to do the right thing, sometimes his injury just won't *let* him do the right thing.

There are several tools available which can help you explore this possibility:

- ◆ Mini Mental State Examination: <http://www.bami.us/MiniMental.htm>
- ◆ Montreal Cognitive Assessment: <http://www.mocatest.org>
- ◆ Ohio State University TBI Identification Method (OSU TBI-ID)
- ◆ Repeatable Battery for the Assessment of Neuro-psychological Status (RBANS): <http://harcourtassessment.com/>

Whether you choose to perform a formal brief assessment or refer your client for a more extensive neuropsychological examination, this information can help you formulate a stronger plan of care and strategize more effective interventions for your client.

Understanding your client's baseline functioning before sustaining a TBI can be a challenge for you. Often, the client may have no family members or friends who knew him before the incident. It is important to find out what your client's current cognitive abilities and limitations are before designing interventions. Do not assume that your client can (or cannot) read, write do simple math, use a calendar, or tell time.

Building Trust and Enhancing Communication. Before performing any evaluative exams or referring the client to another provider, it is important to begin building a solid trusting relationship with him. The brain injured client may be very wary of strangers. Being patient and reliable will help create and sustain trust. Because the brain injured person's thinking is impaired, the person working with him must make adaptations to communication. Approach the client in a calm unhurried manner, address him by name and introduce yourself and explain your role clearly and briefly. Wear a name tag if possible.

“Your client may also be affected by a host of other conditions that share some common characteristics of TBI. Psychiatric disorders, post traumatic stress disorder, learning disabilities.”

(Continued on Page 3)

According to the HCH Clinician's Network, here are

“Practical Case Management Techniques for Clients with Cognitive Disabilities”

Emotional Support

- Speak clearly, using a calm and reassuring tone, in an adult voice.
- Use client's name to get attention and maintain eye contact.
- Eliminate the impossible; do only what is realistic.
- Avoid confrontations and arguing.
- Encourage client to slow down; it's all right to take one's time.
- Use non-verbal expressions: nodding, smiling, and pointing.

Reducing Confusion

- Provide orientation. Use calendars, clocks/watches, signs.
- Avoid confrontation; don't ask clients to justify their decisions.
- Redirect as necessary; model calm behavior.
- Keep environment structured and familiar.
- Assess level of stimulation needed.

Memory Aids

- Help clients keep a memory journal.
- Help maintain a regular, predictable, structured routine.
- Always write appointments down on client's calendar.
- Help client set small goals; break complex tasks into simple steps

Traumatic Brain Injury (continued)

Speak clearly and somewhat slowly, address the client respectfully as you would any adult. Brain injured people can be sensitive to perceived condescension and nagging. Use simple language. Avoid jargon and acronyms, sarcasm and irony. Arrange to meet in a quiet, private, hospitable and comfortable space. Your appointments with the TBI client should address only one or two identified issues. Check in to make sure you and your client are “on the same page”. “Let me make sure I have every thing straight. I will meet you here on Wednesday at 9:30 and we will go see Dr. Jim. After we see him, we will get coffee at Cherry Street. Do I have that right? Okay. Let me write that on your calendar and my calendar. Thanks.”

Goal Setting and Organization. TBI clients benefit from a harm reduction approach and using Motivational Interviewing techniques. Because the TBI client may have difficulty with initiative and motivation, you may need to help the client come up with goals he would like to work toward. Avoid overwhelming the client with too many choices; stick to one very short term goal (getting a change of clothes, a pair of shoes) and one more complex goal (getting an appointment with a mental health provider, looking into housing options). To help the client be in charge of his care plan, ask rather than tell. “How would you feel about getting a place to live?” “I'm concerned about some of the issues you have told me about, and I would like to have some help from another person who can help us with that. Would you like to meet Dr. Jim at the clinic?”

When you meet with your client, it may be helpful to reintroduce yourself, restate your role and reiterate your previously agreed upon goal for the appointment.

As you observe the client working toward these goals, you can continually assess his ability to organize. Can he read, write, use a calendar, clock, a telephone, or computer? Can he use public transportation? Careful and sensitive observation will allow you to make appropriate care plans based on the clients abilities and saves the client from enduring a battery of tests that can leave him frustrated and unhappy. You can gently observe and validate your findings: “I see you have trouble with clocks. How do you find out what time it is?”

(Cont. on P. 4)

Traumatic Brain Injury (continued)

If he is unable to tell time or use a calendar, you will need to come up with other ways to inform and remind him. If he stays in a shelter, you can enlist the assistance of a shelter manager or on-site case manager; they may be able to remind your client about your next appointment. You also can begin to assess other areas of self-care such as his ability to obtain or prepare food, bathe, dress, and otherwise take care of himself. As you observe the client, note if he seems to have any difficulty seeing or hearing. Sensory deficits can add an extra burden to the cognitively impaired client.

At the end of your appointment, be sure to go over what you did, and praise him for approaching a goal. Commit to a follow up appointment. It may be useful to set a routine visit at the same time and day of week. If possible, try to arrange other appointments likewise (e.g., Monday at 10: Dr. Jim. Wednesday at 10: chemical dependency counselor.)

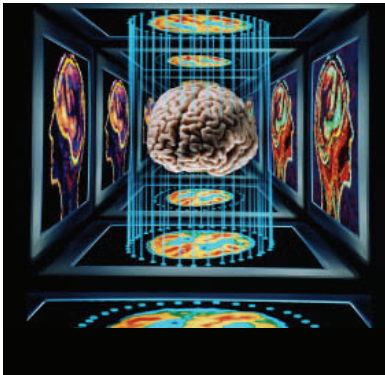
Small rewards can positively reinforce appointments: coffee, a snack, a pair of socks or other inexpensive item can be an incentive for your client.

Other Considerations. Your client may not be able to handle money, budget, pay bills or shop safely. Procuring a Payee service can be very helpful, particularly if your client is moving to housing. The broader world will not necessarily take your client's TBI condition into consideration. Failure to pay rent or other bills can have serious repercussions.

Your client may need help with life skills as he moves into his own living space. He may need guidance around maintaining his home, cleaning, doing laundry, food storage and preparation, garbage removal, and general organization. Help him keep his home environment simple, uncluttered and neat. Help him develop habits that will enhance his independence and organization. Have a coming home routine and a leaving the house routine. Coat, wallet, phone and calendar and keys go in the same place every time he comes in. If he can read, post a sign on the door: "Keys? Wallet? Coat? Phone? Calendar?" Pictographs may be useful.

Your client may be on several medications, so good med management is essential. If he can go to an agency that provides this service great. If not, assist him as needed with setting up weekly medi-sets or with bubble packs of medications. Have him carry a wallet sized card with the names and dosages of all his meds.

The approaches briefly outlined here can be applicable to a client with any sort of brain dysfunction. Clients with dementia, Alzheimer's disease, developmental disabilities, organic brain syndrome, stroke or any other condition that impacts cognition can benefit from a case management approach that is trauma informed, and employs harm reduction and Motivational Interviewing techniques. A trusting, mutually respectful relationship with a hospitable, compassionate, informed and professional care provider is beneficial to any client. All clients, regardless of what circumstances brought them into their current situation, deserve this.



“The approaches briefly outlined here can be applicable to a client with any sort of brain dysfunction.”



Could Smoking Cause Some Mental Illness?

An unsettling new explanation for the strange link between cigarette smoking and mental illness has quietly emerged from research done during the last few years. Experts long have known that psychological disorders are unusually common among cigarette smokers. One 2000 Harvard University study, for instance, concluded that almost half of all cigarette smokers in the United States have some form of mental illness.

Studies show that almost 90 percent of people with the most serious mental disorders, such as schizophrenia, smoke cigarettes. Individuals with mental illness also are among the heaviest smokers. So what started first? The illness or the smoking?

Mental illness occurs first, according to the time-honored theory. People with mental illness start smoking, and smoke more, because nicotine relieves their symptoms and makes them feel better. In addition, they may be more psychologically vulnerable to nicotine addiction or the allure of tobacco advertising. New studies, however, suggest that cigarette smoking is the cause - not the consequence - of some psychiatric disorders, including common conditions that involve depression and anxiety.

How could cigarette smoking cause mental illness? Experts don't know. Some suspect that the nicotine and other chemicals in cigarette smoke may damage or change the normal activity of brain cells. Others think that nicotine and high levels of carbon monoxide in cigarette smoke work together to cause symptoms of psychological illness.

The take-home message is this: All our clients deserve to be offered help in quitting smoking and there are free resources in Seattle and King County to help them.

Contact Nori de la Pena @ norilyndelapena@kingcounty.gov or 206-263-8168. Or contact the [Washington State Tobacco Quit Line](#) (1-800-QUIT-NOW, 1-877-2NO-FUME in Spanish) for resources and referrals. The Quitline provides free nicotine patches and gum for all Washington residents.



Health Care for the Homeless Network

401 Fifth Avenue, Suite 1000
Seattle, WA 98104
(206) 296-5091

<http://www.kingcounty.gov/health/hch>