

Brain Injury and Homelessness

Good practice guidance for frontline services

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Produced by

The Innovation and Good Practice Team

With thanks to

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Published

March 2017

Checklist for support workers

Immediate crisis

- If anyone is in danger call 999 – when the emergency services arrive explain that you believe brain injury may be a factor and they may need an appropriate adult or health treatment. Brain injury can be considered a ‘mental disorder’ for the purposes of a S136 of the Mental Health Act 2007.
- If there is no immediate danger, try to move the person to a calm environment.
- Remove distractions, noise, bright lights, and interruptions.
- Your aim at this point should only be creating a calm, quiet space. This includes you! Limit talking, limit questions, limit fussing.
- See also the section on concussion below – it is important this is checked and treated quickly.

Quick problem solving

- Tell your client what they need to do right now e.g.
“Take that seat please.”
“Stop shouting” then “Let’s sit down here” or “Go to X room / area”
Direct and simple instruction is helpful, be level with your tone and polite, but don’t add unnecessary words. Offering choices is more cognitively demanding because more things have to be decided and ordered.
- Limit the information you provide, your aim is to engage the person in your service right now. Have a cup of tea with them and listen.
- Do they have a friend with them? If so consider inviting them into the room or area – if they are a positive and calming influence it may really help.
- Ask if the person has a mobile, even if they are carrying it they may have forgotten. Check the phone is charged, volume or vibrate is on, and take the number.

Working together over the next few days

- Write down information for your client. Keep it short, simple and clear. Try using short words or days and dates, bullet points or pictures.
- Ask the person if there is anyone who helps them with things. Do they have contact details? You may be able to get background information from their helper that will be important in future.
- Ring and text your client basic details of the next meeting. Remind them the day before, on the day and an hour prior if they have missed appointments before.
- Consider with your team confidentiality and safeguarding procedures in your service in relation to this person and act as appropriate for your setting.

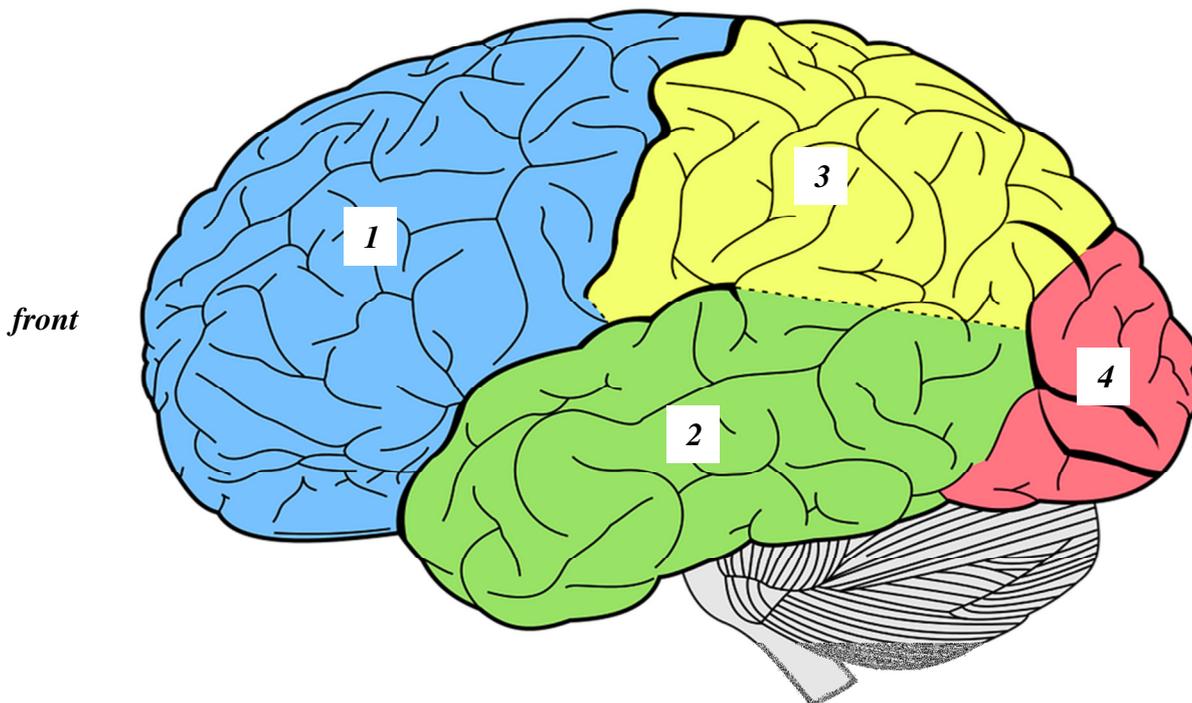
Introduction

This briefing provides frontline staff with information to support people experiencing homelessness who are known or are suspected to have experienced brain injury. There is information about what brain injury is, how it is caused and why people who experience homelessness may be at risk. Most importantly there is information on how to support people with, or suspected to have, brain injury and how to access specialist services, but if you are in a rush and need to know what to do right now, please see the Checklist on p3.

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.



1. Blue: frontal lobe involved in emotions, behaviour control, and memory
2. Green: temporal lobe involved in communication abilities
3. Yellow: parietal lobe involved in processing sensory information
4. Red: occipital lobe involved in vision

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

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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

How does Brain Injury affect people?

The brain is complex and controls everything we do, think 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 is common in people with brain injury.
- Memory may be impaired, including short term memory or memory of specific events.
- Working memory is very important when planning, problem solving and weighing up things – all may be reduced.
- Communication may be affected in different ways e.g. being able to explain your current situation and understanding instructions.
- 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.
- 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.

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- There may be obvious physical effects such as problems with walking or reduced use on one side of the body.
- Dribbling, difficulty with eating, choking may be present.
- Hormonal changes can cause weight gain, reduced body hair loss and many other symptoms.

Common causes of Acquired Brain Injury:

- 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 A&E as a result of assault, accident or alcohol misuse¹ so it is not surprising that recent research suggests half of people experiencing homelessness have brain injury.²

Domestic Violence

Women may become 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:

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

Concussion

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

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 haven't, use the information in the link to explain why it is important to do so.

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

² www.thedtgroup.org/foundation/brain-injury-and-homelessness/

What are the links between brain injury and homelessness?

You will see from the list above skills we take for granted every day can be greatly diminished by brain injury e.g. remembering to pay bills, attending health appointments, understanding instructions, getting along with other people etc. All of these are necessary to plan, gain and maintain accommodation, employment and personal relationships.

Street outreach workers report cases of clients who were living independently in mainstream society and enjoying a life, but who ended up on the streets some years after road traffic collision which caused brain injury and gradually led to their life unravelling.

Case Study

An outreach team came across a new rough sleeper called Asha. In conversation, Asha mentioned he had fallen from a height on a night out a few years ago, sustaining a head injury.

Asha agreed that the Outreach Team could speak with appropriate others about his situation, and this led to confirmation of the head injury and provided details about the change in Asha's behaviour after it occurred. These changes had led to Asha abandoning his accommodation – he had become far more unreasonable and impulsive, and would respond angrily rather than talk about things.

The Outreach Team obtained information from organisations such as Headway UK, which gave them more confidence in raising the issue of brain injury with Asha and adapting ways of working to best support him. Asha accepted accommodation and knows where to go for help about his head injury when he wishes to.

Brain injury may also explain why some clients do not respond to de-escalation techniques which generally appeal to the cognitive abilities of empathy and reason; repeat behaviours which are undesirable and quickly exhaust the warning system; forget appointments and break benefit claims; and do not understand or act on information they are provided with.

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 that your client doesn't meet. It can be resource intensive for your service to support someone to access specialist services and they might not wish to engage with the process. All the same, if you don't try you will never know, and it could make a world of difference to the client eventually.

Case Study

Bev was a long term rough sleeper with low level mental health issues. Outreach staff noticed that Bev had begun to move one side of her body in an awkward fashion. Bev, when asked, put this down to the weather.

Outreach staff arranged for Bev to see a nurse because they thought damage to the brain may have affected Bev's ability to control her movements and understand what had happened to her.

After seeing Bev, the nurse was concerned that a stroke might have caused the physical problems and affected her thinking abilities. Bev did not want to go to hospital for medical assessment.

A Section 136 was carried out on the basis that Bev was suspected to have a disorder of the mind caused by brain injury (stroke), was a danger to herself and in need of care. Following the hospital stay Bev accepted accommodation after more than a decade of rough sleeping.

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 might be best to avoid it. Instead you might ask about 'blows to the head,' being 'knocked out' or accidents.

Record Keeping

In your assessment, focus on the behaviour and evidence 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: 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 Group 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 DT Group provide guidelines for services as to 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 while other clients are present.

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The BISI is trademarked and to access it you will need to contact the DT Group and register your interest. If your service would like to use the BISI contact the DT Group directly here:

www.thedtgroup.org/foundation/about-the-foundation/brain-injury-screening-index/

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 xxxx, 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 that you might 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 the NHS can do

If you and your client think that brain injury might 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:

www.healthy london.org/homeless/161214healthcarecards

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:

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.

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The GP might 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. 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) doesn't necessarily exclude the presence of a brain injury. The MMSE is a quick, useful 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 find information about previous conditions which affect the brain or clear information about previous brain injury. This might 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 is a concern, then a referral to specialist services such as Neurology 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 associated health risks of rough sleeping.
- 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?

Adult Neuro / Rehab Community Teams

Some areas have special teams that work with people with brain injury in the community. In London, for example, some areas have staff that help people to navigate the most appropriate pathway for their brain injury, similar to the role of a Care Coordinator in Social Services. 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 was provided at an Acquired Brain Injury Forum for London event and slides are available here: www.abil.co.uk/abil-september-2016-conference-improving-pathway-brain-injury/

Initial contact for enquiries or advice can be made using the following details, but note these are for London only www.abil.co.uk/community-rehabilitation-local-teams/#more-165

In all cases you might want to contact Headway UK or your local Headway group, if one exists, who may have detailed knowledge of which services are in your area.

What the local authority can do

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

Safeguarding

Protecting adults from abuse is known as 'safeguarding' and 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 that, if a crime is taking place, the Police should be involved.

Social Care

Contact your local authority social services team if social care is needed by your client. The Care Act 2014 outlined 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. Age UK have produced an excellent factsheet on the Care Act and accessing social care help. It can be found here:

www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS41_How_to_get_care_and_support_fcs.pdf?epslanguage=en-GB?dtrk=true

Housing

It is likely that your client is homeless, given your service type. The local authority will have a Housing Options service and your client might 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 Housing Act 1996, 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.' An NHAS factsheet with further information about the importance of the priority need category is available here:

www.homeless.org.uk/connect/blogs/2016/jan/04/new-vulnerability-assessment-guide-for-frontline-workers

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: www.headway.org.uk

There are **local Headway groups** in many areas which may provide services directly to people affected by brain injury: www.headway.org.uk/supporting-you/in-your-area/groups-and-branches/

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Depending on the size of and funding to the local group, services can be as diverse as art groups, day services, training, carers' 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 about 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:

<http://ukabif.org.uk/regional-groups/>

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

Positive approaches to 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 that safety is the priority, both for you and the person you are supporting.

Use rights and responsibilities

In all settings, having 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, 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. This will help to set the expectation at that meeting rather than relying on information that may have been 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 to tell you about their behaviour when things get more difficult for them – before this situation arises – can be enormously helpful in preventing or minimising incidents, and enables staff to tailor their response to the individual person. 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.

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When working with someone with a brain injury, they may forget what is agreed during this conversation. It might help to make a record of the meeting and both sign a plan that can be referred to later.

Keep it visible

Keeping information visible can help to keep it present in the mind of 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, simple and focused on positives.

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 Sam, can you help me make some tea?
- Provide clear simple instruction on what the client needs to do immediately to help e.g. Sam, 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 this as soon as they occur. If Sam leaves the room and you can follow, say thank you and do a nice thing together if possible and safe. Your aim is to always 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 an expectation can be communicated to someone 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 try their best to avoid evictions and bans where possible, but it is sometimes the case that some clients cannot be safely managed within a service. Services might try short term exclusions as a way of

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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, agree their future plan.

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 to change or minimise challenging behaviour. Headway UK produce excellent booklets on dealing with anger which may help.

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 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 causes of brain injury such as assault, so 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 help people understand why your response is tailored differently to meet each person's needs.

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.

Research links

Homelessness and Brain Injury UK research

www.thedtgroup.org/foundation/brain-injury-and-homelessness/#LEE

Guardian article on homelessness and brain injury

www.theguardian.com/housing-network/2016/oct/19/homeless-brain-injury-nhs

Research from Canada about Traumatic Brain Injury and Homelessness

www.ncbi.nlm.nih.gov/pmc/articles/PMC2553875/

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

www.stmichaelshospital.com/media/detail.php?source=hospital_news/2013/20130516_hn

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

<https://thepsychologist.bps.org.uk/homelessness-and-brain>

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 if a person has problems with these areas regardless of cause.

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

Traumatic Brain Injury is damaged cause by a trauma to the head. This usually means a blow to the head whether caused by a car accident, fall or fight.

Validated Screening Tool is a questionnaire which has been checked to ensure it provides information on whether a person may have difficulties in the area being tested e.g. brain injury, communication etc. The Tool must be used as directed to remain accurate.



What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. We work to make services better and campaign for policy change that will help end homelessness.

Let's end homelessness together

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www.homeless.org.uk

Twitter: @Homelesslink

Facebook: www.facebook.com/homelesslink

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