Homelessness

Clinical Senate Meeting: Homelessness – No fixed address – can we still deliver care?

11 November 2016

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Definitions of homelessness

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'Cultural' Definition of Homelessness

Chamberlain & MacKenzie (1992)

Primary homelessness	Secondary homelessness	Tertiary homelessness
Sleeping rough on the streets, under bridges, in parks, cars, deserted buildings or improvised dwellings **('Rough Sleepers')**	**Emergency /supported accommodation** **Shelters/refuges** Caravan parks Home of friends or family(couch surfing)	Boarding houses Hostels

'Statistical' Definition of Homelessness

ABS 2012 Information Paper

When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- Is in a dwelling that is inadequate;
- Has no tenure, or if their initial tenure is short and not extendable;
- Does not allow them to have control of, and access to space for social relations.

Those in <u>overcrowded dwellings</u> defined as homeless in the ABS definition but not in the cultural definition

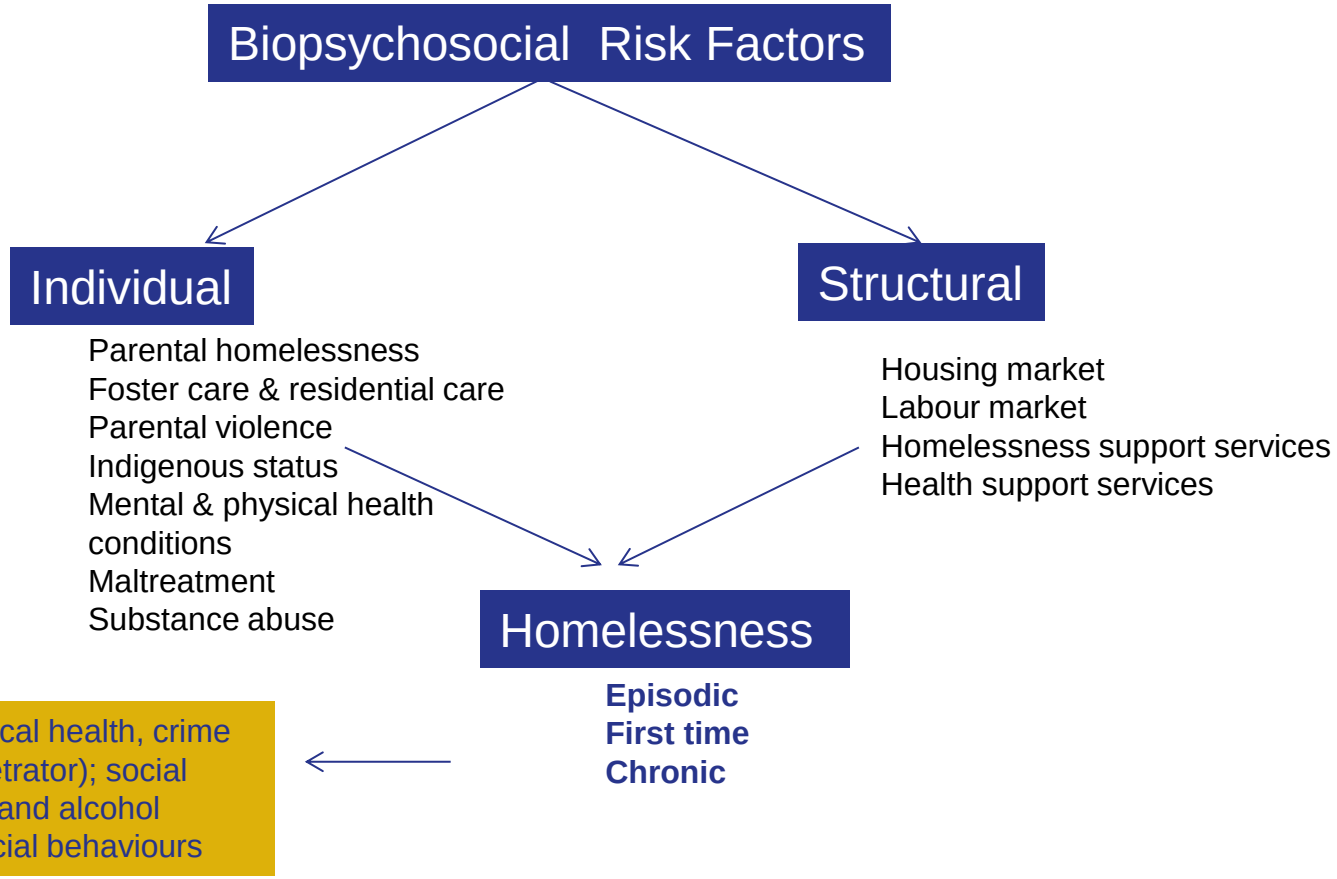
Key Facts

105, 200 Australians
homeless Census 2011

1 – sleeping rough or in improvised dwellings (6%)
2 – emergency accommodation, refuges, temporary private arrangements (38%)
3 – in substandard conditions including boarding houses, caravan parks and substandard dwellings (56%)

256, 000 clients of Specialist homelessness services in 2014–15
44% women
25% Indigenous people
30% born overseas
74% under age 44

The ecological model of homelessness



Chronic homelessness:
In the US defined as continuous homelessness for the past 12 months or four episodes in the past three years and must have a disabling condition (US Federal Government, 2015)

Ecological model of homelessness. Adapted from Nooe & Patterson (2010) & Whittaker

Narratives: Intergenerational homelessness

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Parental Influences
Measures: parent conflict scale, parent mental health issues, problematic parent alcohol use/drug use, parent jail time

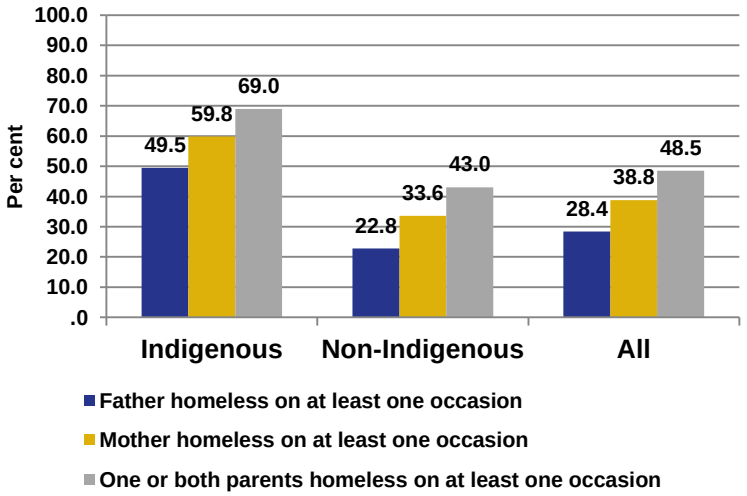
Parent Homelessness

Childhood Influences
Measures: out of home care, ran away before 18 years old, juvenile detention

Offspring Homelessness
Measures: primary homelessness before 12 years old, any homelessness before 12 years old, primary homelessness before 18 years old, any homelessness before 18 years old

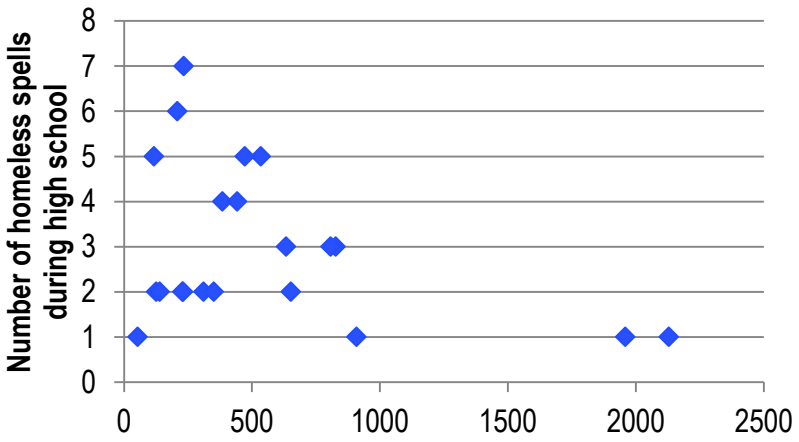
Demographics
Measures: gender, age, married, long-term relationship, Indigenous English speaking, Indigenous non-English speaking

Offspring Outcomes
Measures: offspring conflict, offspring mental health issues, offspring alcohol abuse, offspring drug abuse, offspring jail time



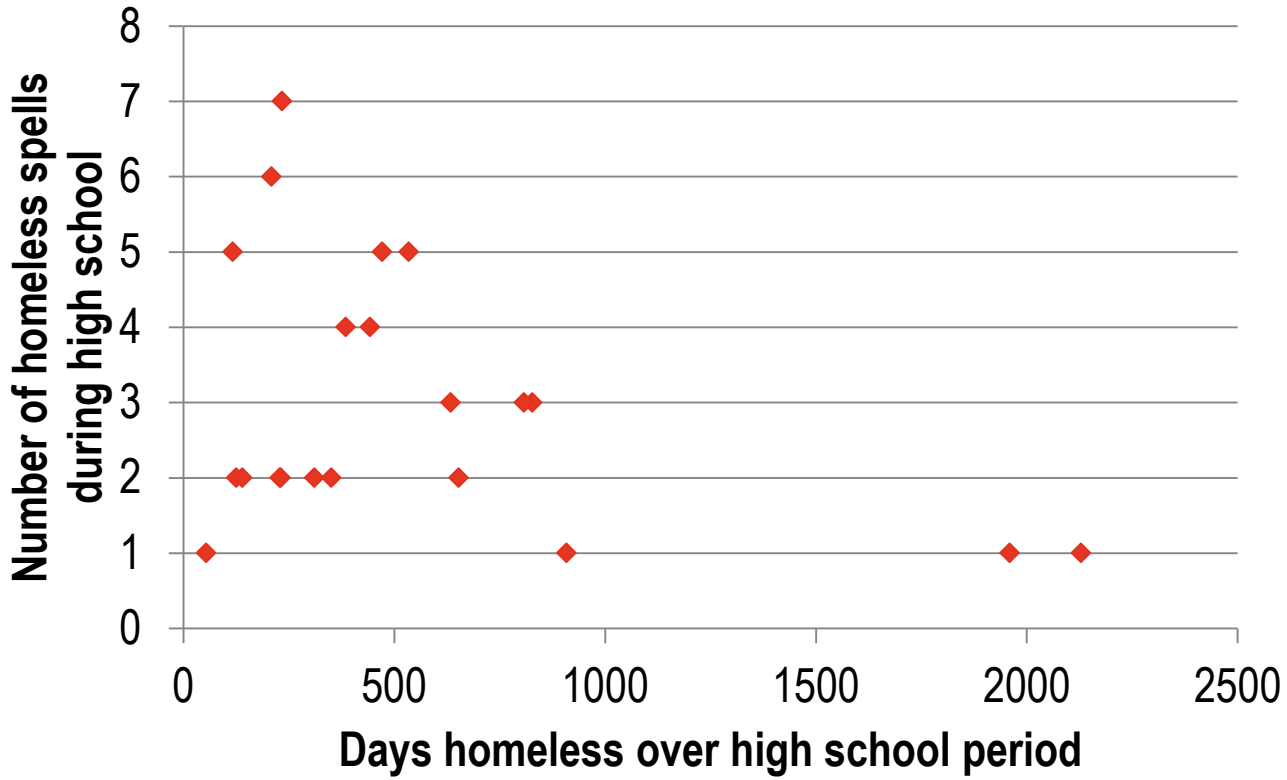
Flatau et al. 2013 & Leighton

Narratives: Children and Young People



- Two-thirds of young homeless have been in out-of-home care
- More than half (56%) of homeless youth had run away from home because of violence between parents or guardians on at least one occasion. Of those who ran away from home because of violence between parents/carers, the median age of their first experience leaving home was only 10.
- One in five (20%) homeless young women had attempted suicide in the past six months compared to around one in ten (12%) young men. More than one in four (28%) of young homeless women engaged in non-suicidal self-injury behaviours compared with 17% of young men.
- Just over half (55%) of homeless youth who had attempted suicide in the past six months had not received any counselling or professional support for this.

High School students and homelessness

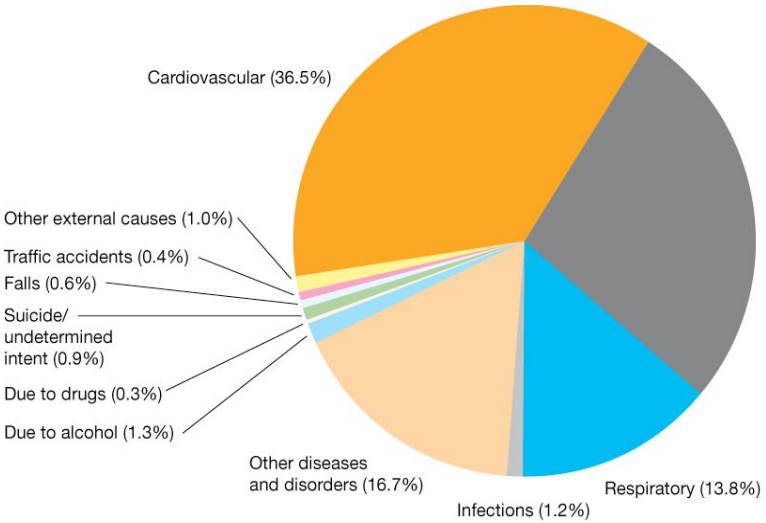


Yarra Ranges study

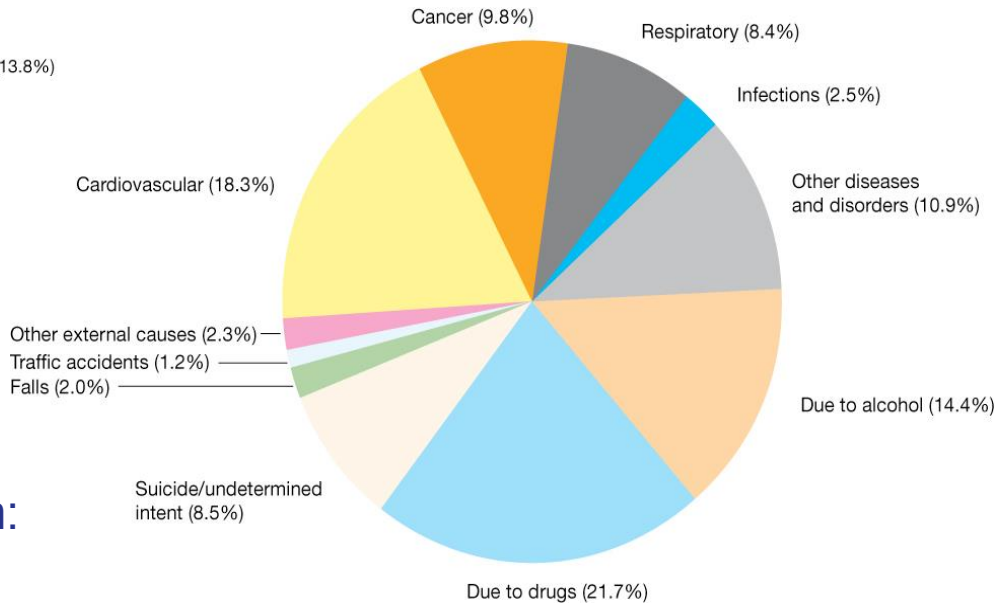
Health profile

- Frequently involves multiple conditions which may be complex and diverse
  - chronic physical illness – e.g., Cardiovascular diseases, tuberculosis, hepatitis C and HIV, cognitive impairment
  - mental illness – high rates of psychiatric disorders
    - Mental health disorders often a precursor of homelessness (Sullivan, Burnam, & Koegel, 2000) but also impacted by duration of homelessness (Fazel et al. 2014)
  - substance abuse – high rates of alcohol abuse and tobacco/substance misuse
  - premature mortality
  - Comorbidity between mental health conditions and substance misuse (Teesson et al., 2000; Teeson et al., 2003 Fazel et al., 2008; Baggett et al., 2014; Fazel et al., 2014; Spicer et al., 2015)
- Each on their own can be addressed, but
  - Frequently multiple conditions
  - Usually delayed intervention
  - Typically severe outcomes
  - Often compounded by lack of access to services
- Consequently high service needs
  - representation in ED,
  - Hospital – typically with longer length of stay - issues with discharge
  - ICU and psychiatric care
  - (Culhane et al., 2002; Corporation for Supportive Housing, 2004; Flatau et al., 2008; Hwang et al., 2011; Flatau et al., 2012; Zaretzky et al., 2013, Conroy et al., 2014, Fazel et al., 2014; Spicer et al., 2015).

Causes of death



General population mean age of death:
M:74 F:80



Homeless people mean age of death:
M:48 F:43

Ref: Homelessness: A silent killer Report undertaken by Sheffield University for Crisis 2011

Evidence-based health interventions

- ‘Integrated, multidisciplinary health care team with an outreach focus with involvement of local and state agencies, led by primary care physicians’ (Maness et al 2014)

- Components of ideal model of care
  - primary care,
  - outreach,
  - capacity to deal with psychosocial issues
  - **Within a context of stable housing**

- With a need to address:
  - Episodic care
  - Limited access
  - Inadequate treatment capability, particularly in terms of psychosocial demands

Health economic data

- Data from the NHS (*Healthcare for Single Homeless People 2010*) indicates that:
  - Homeless individuals are 5 times more likely to visit ED
  - 4-8 times more likely to be hospitalised
  - Total hospital cost is 4 times more than non-homeless

- There is a need to systematically collect and monitor data for this group in order to
  - Estimate cost-effectiveness of interventions
  - Address the high rate of potentially preventable hospitalisations which not only indicates system failure, but reflects unacceptable inequity and offers the opportunity to deliver savings in the hospital sector

Economic evaluation

- Measures both costs and health outcomes to assess the net cost of delivering improvements in health - usually measured as cost per QALY

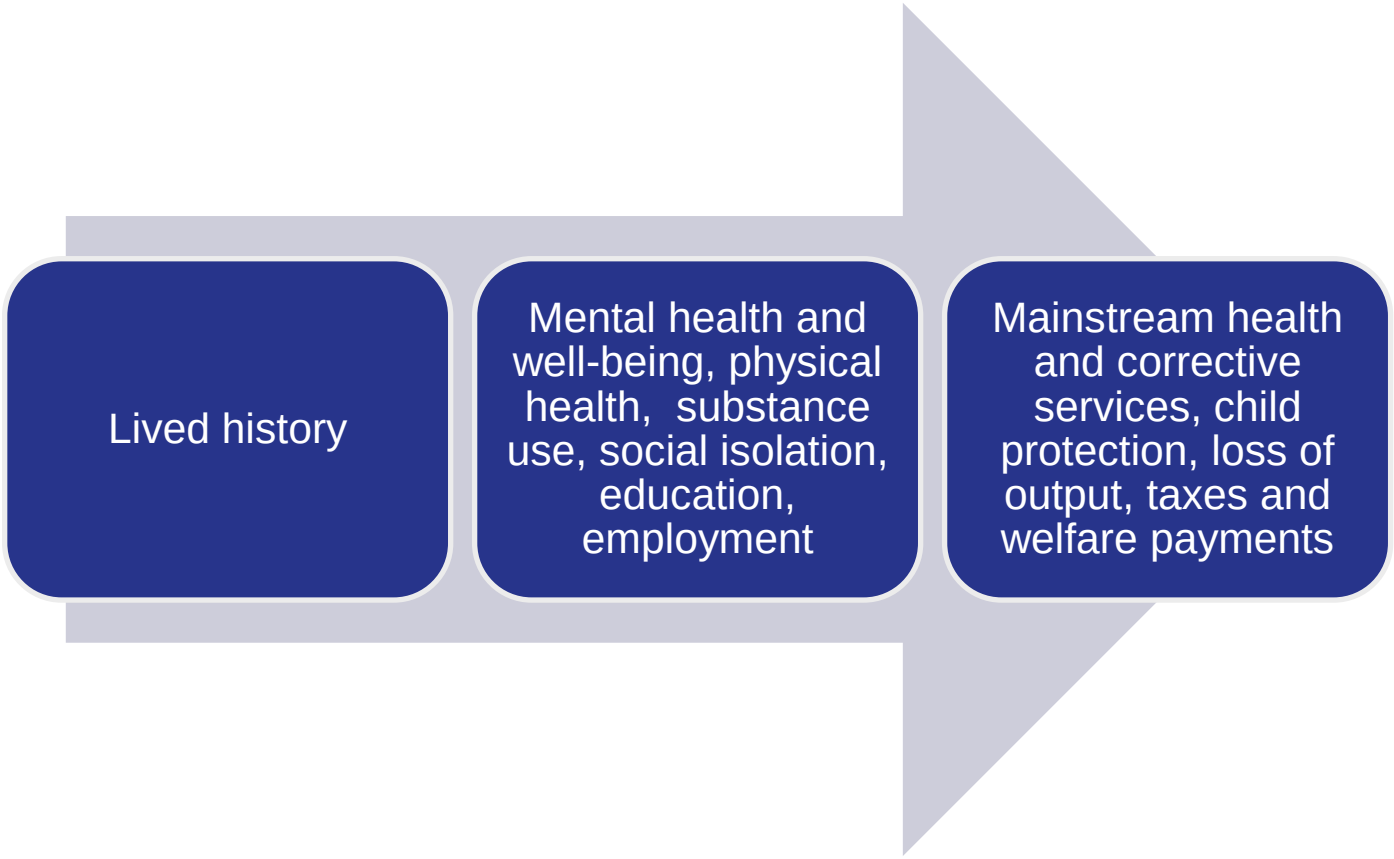
- Outcomes
  - Decreased mortality
  - Better quality of life
- Costs
  - Cost of intervention
  - Savings due to reduced need for critical care
  - In particular, reduction of preventable hospitalisations

- Complexity of this group requires multidisciplinary and integrated care so that evaluation must necessarily focus broadly, rather than on a single condition

Health sector perspective

- Cost per QALY is typically the metric for policy in the health sector (PBAC, MSAC)
- Homelessness spans additional sectors, particularly housing, but also justice and welfare
- The element of stable housing is a key component of evidence-based care and recognised as necessary for sustainability of health outcomes
- This has important implications not only for estimation of cost-effectiveness of health interventions but also for coordination of health services

The costs of homelessness



The real costs of homelessness

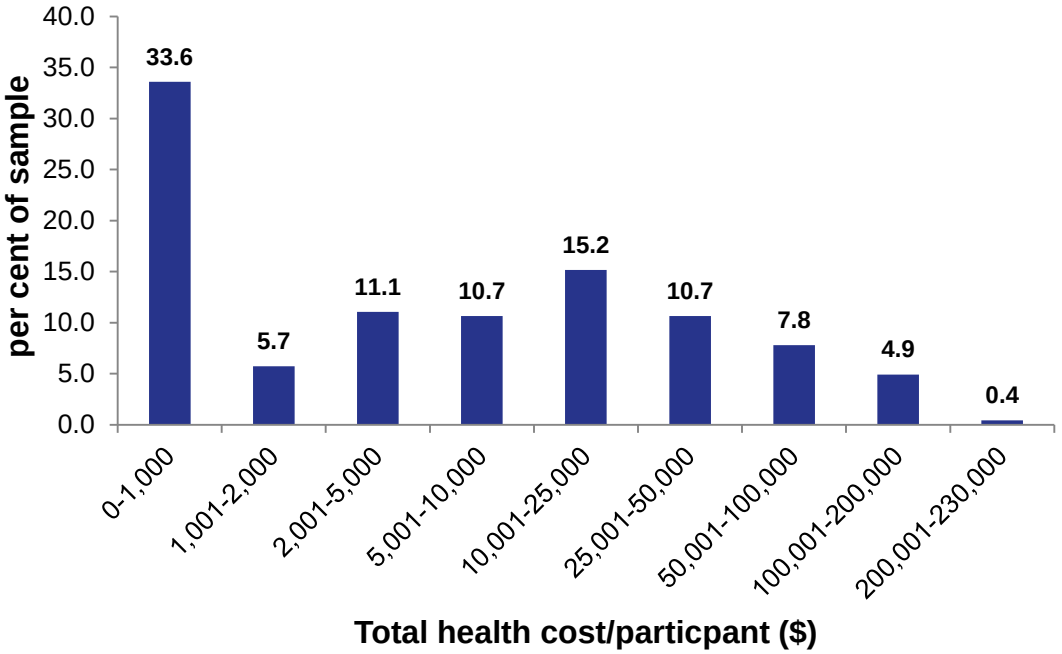
Personal and Social

- Educational and employment outcomes
- Poor physical health
- Mental health and well-being impacts
- Substance use issues
- Crime and justice consequences
- Social connectedness
- Alienation, boredom and social relationships

Economic

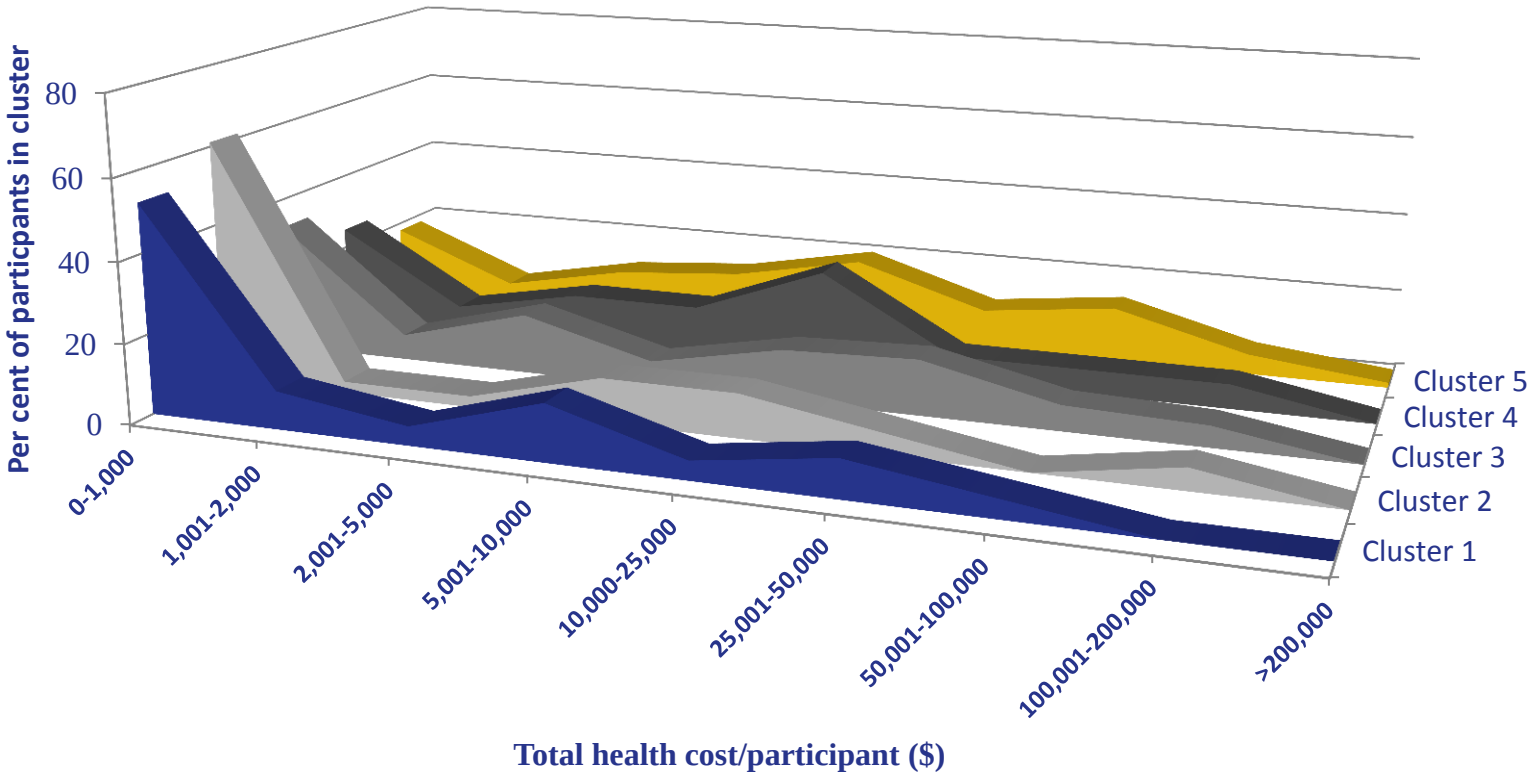
- Mainstream service system costs
  - Health + Justice +Child protection
- Higher income support payments and lower taxes
- Long term economic impacts
  - Productivity + available workforce + economic growth

Michael Project Self-Report One-Year Health Care Costs



Study	Total health care cost/participant ($)	
	Mean	Median
Michael Project study (n=243)	20,023	4,604

Michael Project Self-Report One-Year Health Care Costs



Cluster attributes:

Cluster 1 – None had diagnosed mental and/or long-term physical health condition(s) all had an AOD dependence issue

Cluster 2 – None had diagnosed mental and/or long-term physical health condition(s) and none had an AOD dependence issue

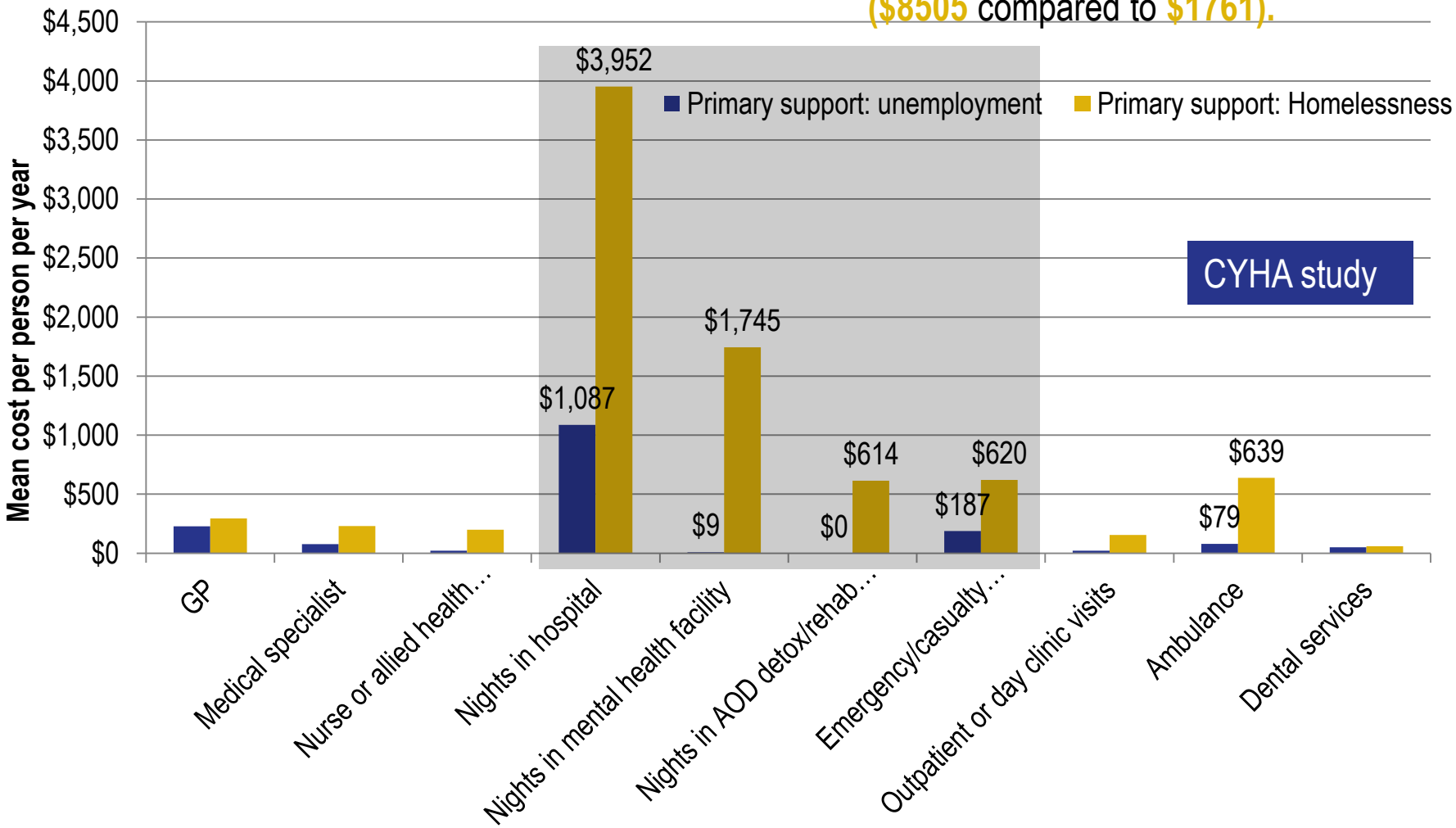
Cluster 3 – All had diagnosed mental and/or long-term physical health condition(s) and none had an AOD dependence issue

Cluster 4 – All had diagnosed mental and/or long-term physical health condition(s), 75% had an AOD dependence issue. Distinguishing feature was a long lifetime experience of sleeping rough.

Cluster 5 – All had diagnosed mental and/or long-term physical health conditions(s) and all had an AOD dependence issue

Health care costs (12 mths)

The annual per person cost of health care use by the homeless group is five times that of the comparison unemployed group ($8505 compared to $1761).



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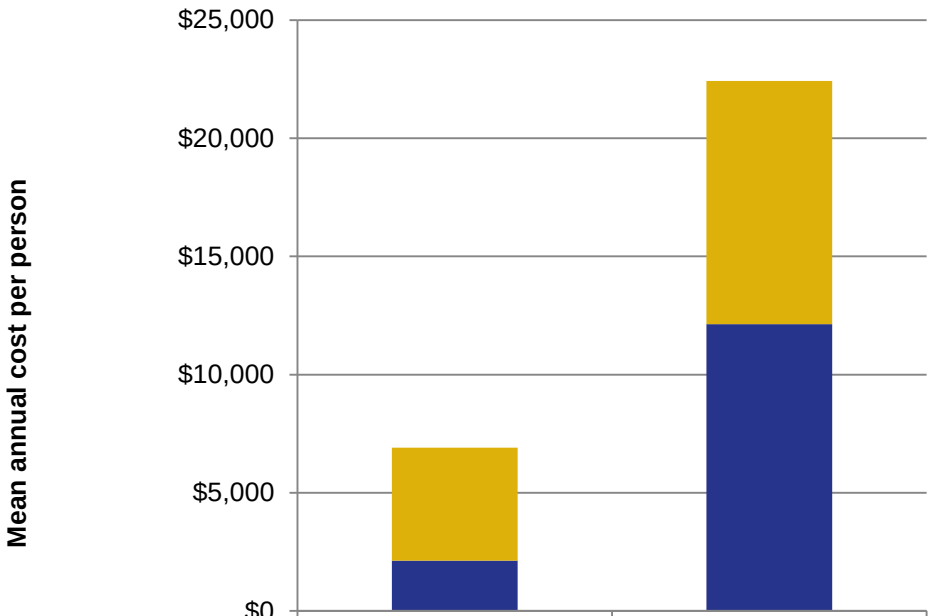
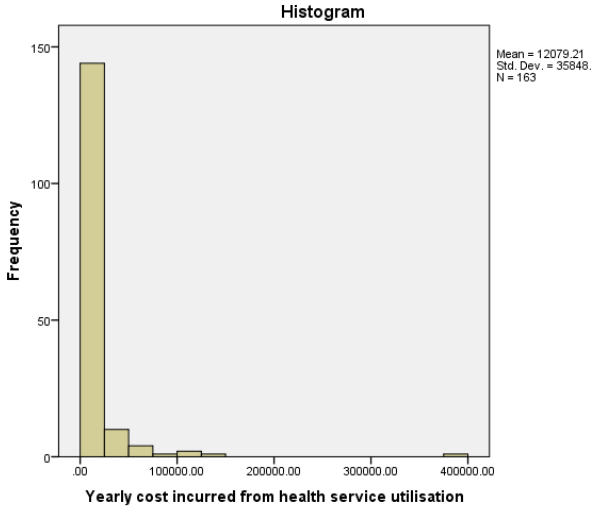
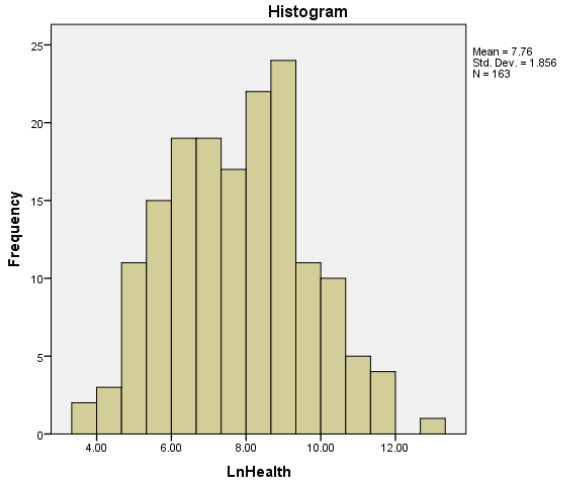


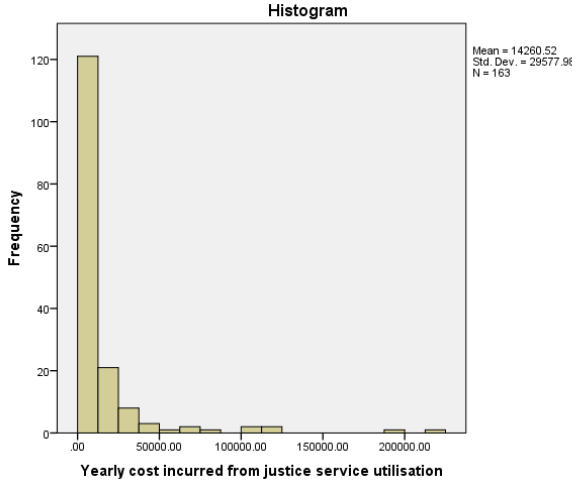
	Not diagnosed with mental illness (N=196)	Diagnosed with mental illness (N=179)
Justice services	$4,778	$10,285
Health services	$2,127	$12,135

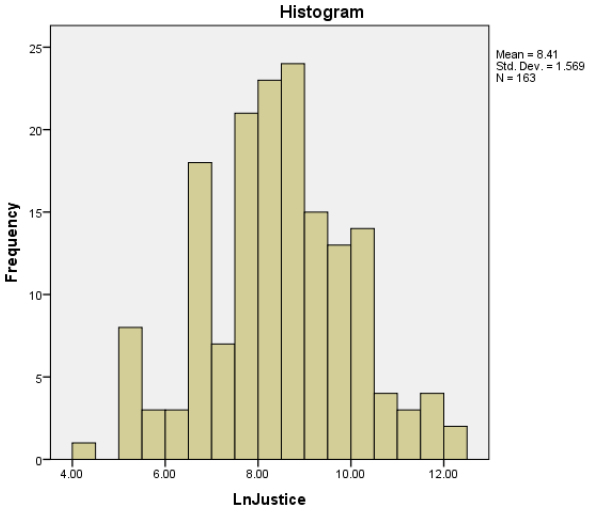
CYHA study

What drives Health and Justice Service Costs?









Very high proportion with zero costs

Smaller number with high costs

Very similar profile to the adult homeless

CYHA study

The impact of NPAH Programs on health costs

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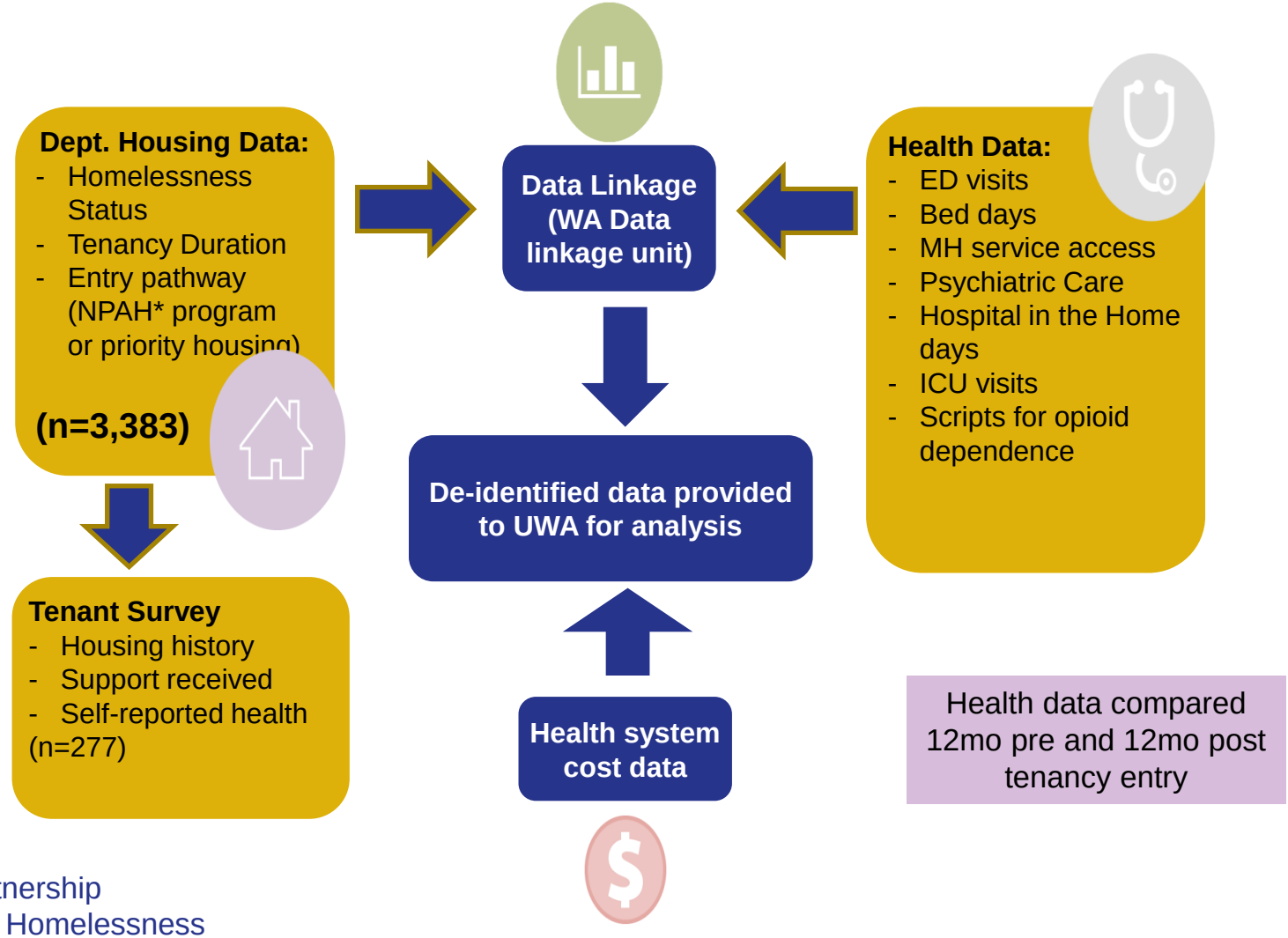
METHODS: TAPPING INTO BIG DATA AND DATA LINKAGE



* National Partnership Agreement on Homelessness

SIGNIFICANT COST SAVING TO GOVERNMENT ASSOCIATED WITH REDUCED HEALTH SERVICE USE

- Reductions in health service use after entering a public housing tenancy (for the 3,383 people in the study) was calculated as $16,394,449 in one year or **$4,846** per person per year.
- Costs on average **$6462** per person/year to provide support via NPAH program
- For NPAH clients, the health system cost savings were **$13,273** per person/year.
- For NPAH clients receiving support upon exiting a mental health unit, cost savings are **$84,135** per person/year.

Greatest health $ savings when couple housing with support

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