Homelessness and health: data and evidence

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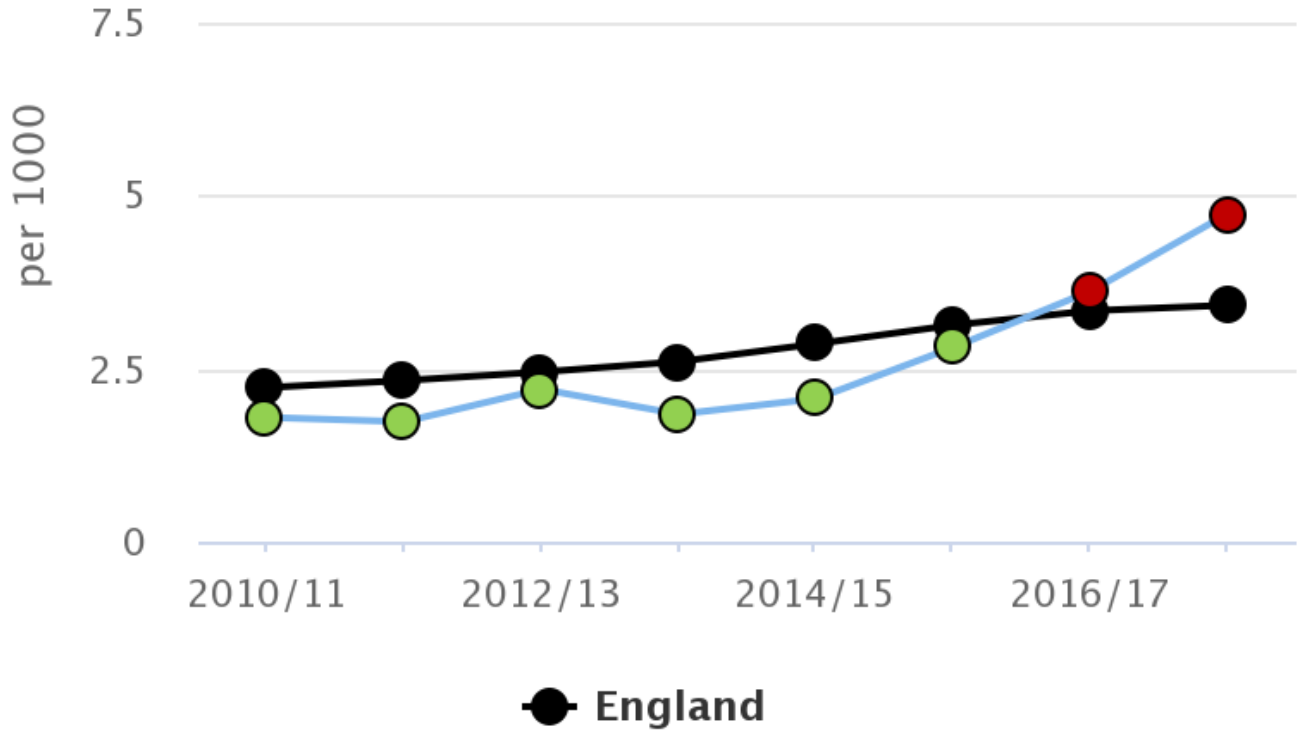
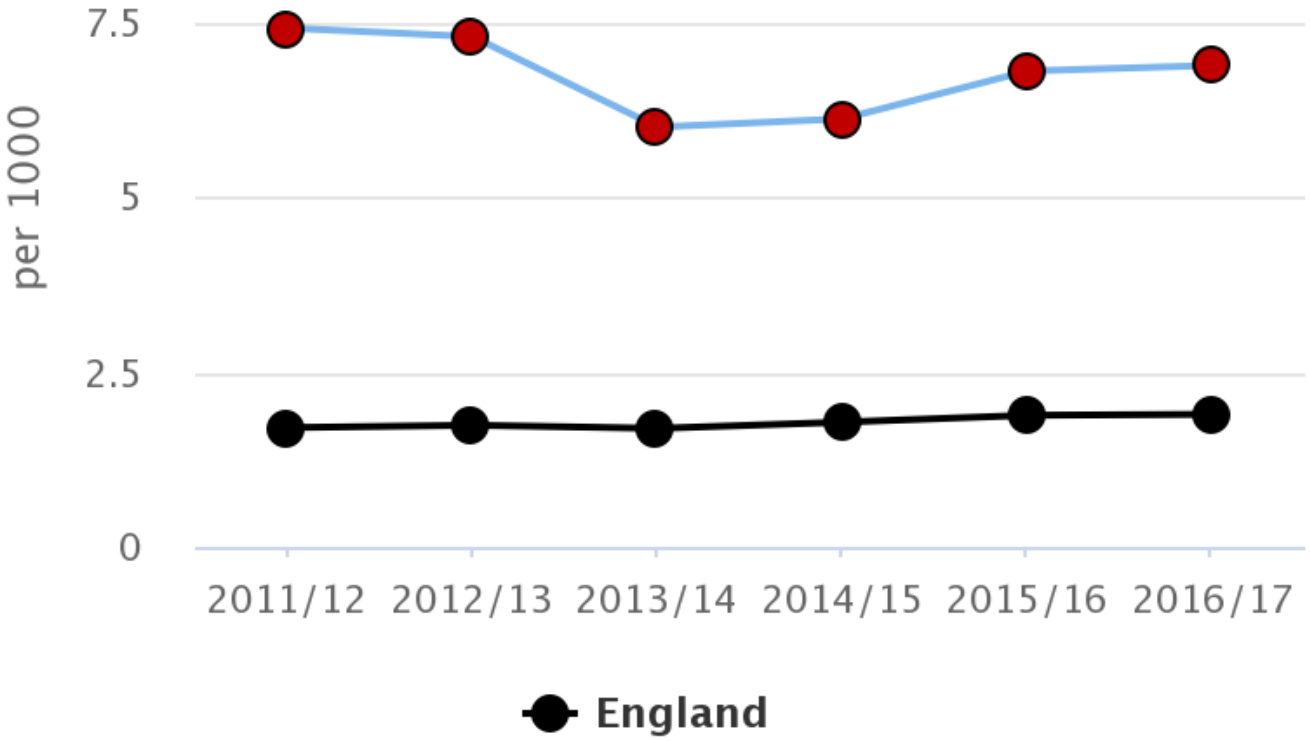
Households in temporary accomodation

Rate has doubled in recent years – there are around 2,000 households in temporary accommodation



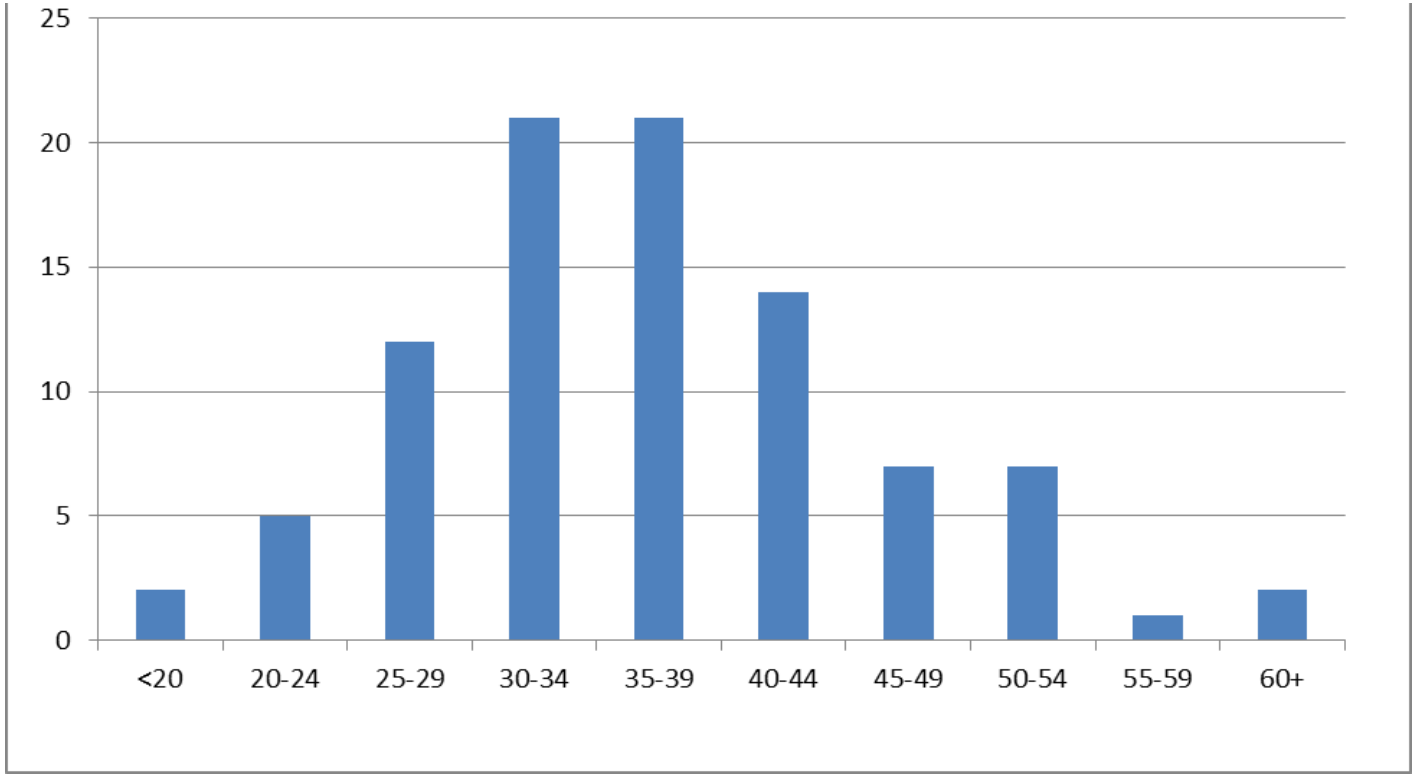
Family homelessness

Number of applications above England average



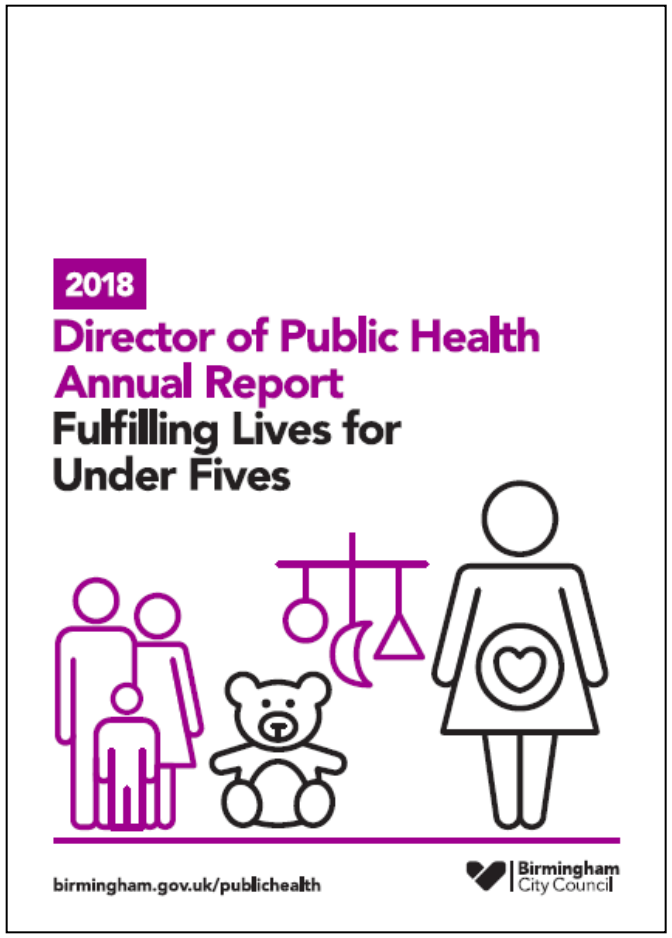
Rough sleeping

- 2018 rough sleeper count: 91 individuals, predominantly male



Causes of Poor Health

Family and child health



Adverse childhood experiences include:

- Child abuse – physical, verbal or sexual
- ‘Dysfuntional’ household – substance misuse, domestic violence or criminal behaviour

They can have long term negative impacts on health.

Some known unknowns:

- Missed routine contact with health services or vaccinations.
- Educational impacts and school attendance. Take up of free early years education and other welfare.

Poor mental health and it's role in causing homelessness:

An in depth study looking at mental health and homelessness in Nottingham helps our understanding (link)

- A clear linear trajectory could sometimes be traced, for example from trauma, to mental ill health, to drug or alcohol abuse, to homelessness, but it was usually more complex.
- With few exceptions, respondents had some form of mental health issue prior to their first episode of homelessness.
- Only a small number of times where mental health issues were clearly the primary and immediate trigger for homelessness

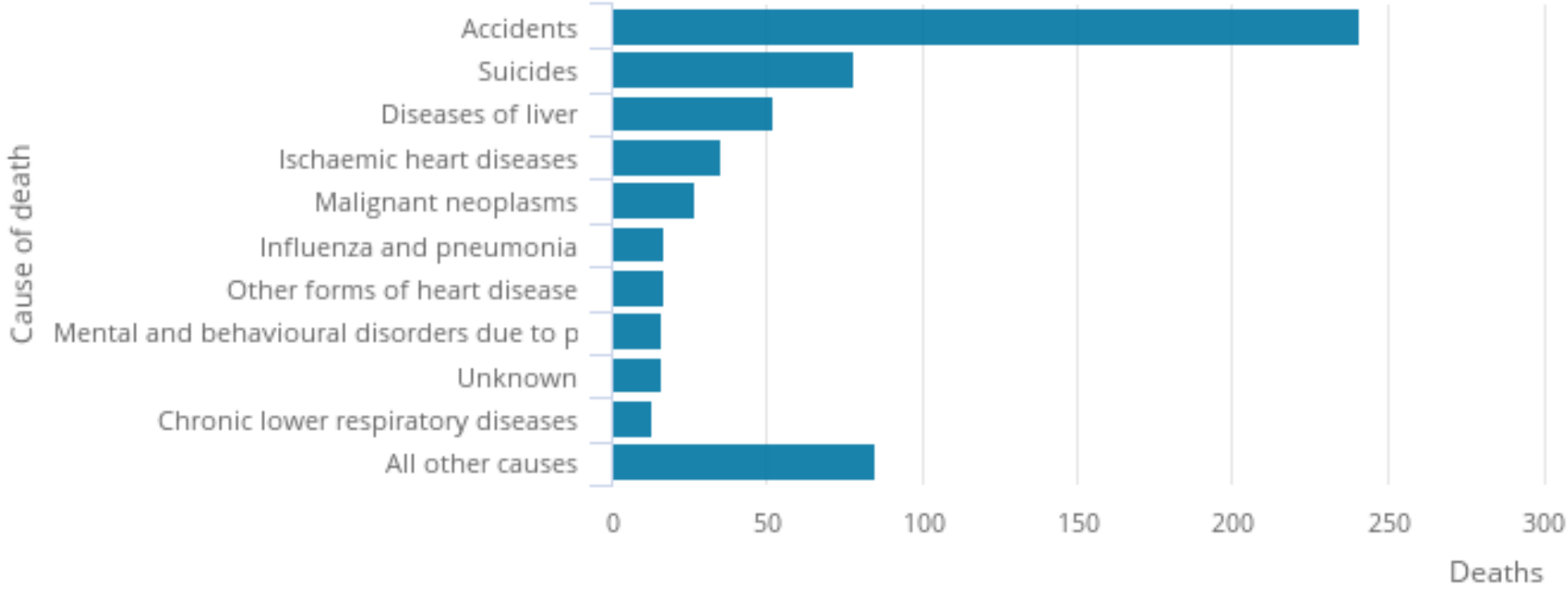
Deaths of homeless people in England and Wales

ONS calculated some ‘best estimates’ between 2013 and 2017 – homelessness isn’t recorded at time of death and covers a wide definition.

- Just under 600 deaths a year across England and Wales
- This has increased from 500 a year as recently as 2015.
- 84% male, average age of death was 44 years old – compared to 76 for the male population as a whole.
- No seasonal pattern to deaths
- 34 deaths in the WMCA area in 2017

Deaths of homeless people in England and Wales

Accidental death (including drug misuse) is the largest cause of death



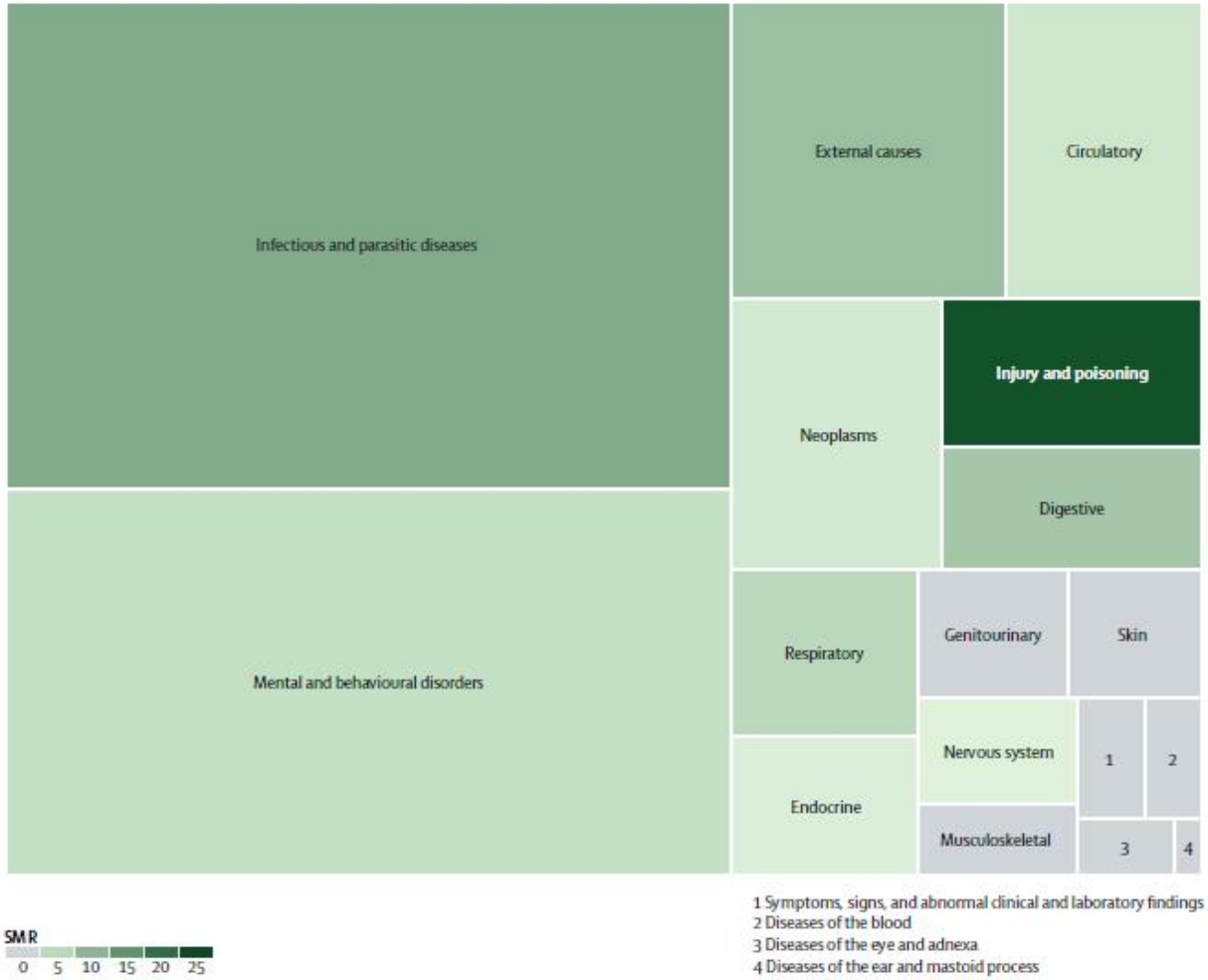
Deaths of homeless people in Birmingham

Table 1: The five local authorities with the most deaths of homeless people
England and Wales, 2013 to 2017

	2013		2014		2015		2016		2017	
1	Camden	21	Birmingham	18	Birmingham	20	Camden	23	Manchester	21
2	Birmingham	16	Lambeth	14	Westminster	19	Birmingham	18	Birmingham	18
3	Lambeth	16	Bristol, City of	13	Camden	19	Liverpool	17	Lambeth	17
4	Tower Hamlets	12	Manchester	12	Tower Hamlets	12	Brighton and Hove	13	Liverpool	17
5	Bournemouth	12	Newcastle upon Tyne	12	Leeds	12	Southampton	12	Bristol, City of	17

Source: Office for National Statistics

Matches the results of a very large review of evidence



Healthcare issues amongst Birmingham's homeless

University of Birmingham analysis of 928 patients registered at the Health Exchange (link)

- Mental health – highest prevalence was 21.3% alcohol dependent, next highest was substance dependence at 13.5%.
- Infectious disease – Hepatitis C had a prevalence of 6.3%. This is lower than other studies in Glasgow, Leicester and Dublin. 9.4% had STIs.
- Physical health – 4.2% on the register for hypertension.
- High levels of multi-morbidity.

Studies in London have found increased risks of Tuberculosis amongst people who are homeless, problem drug users and prisoners.

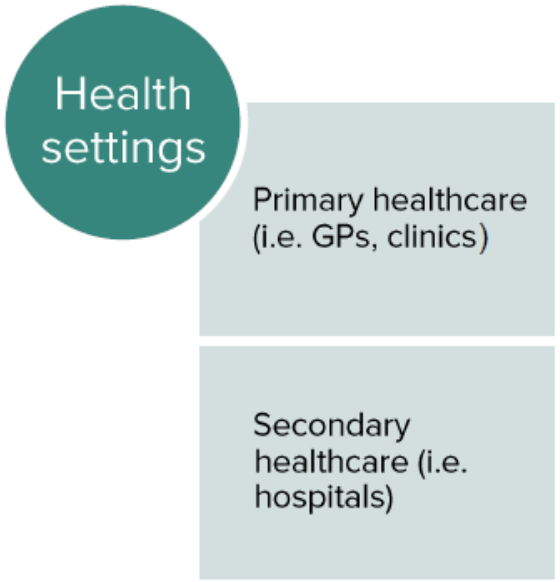
What works

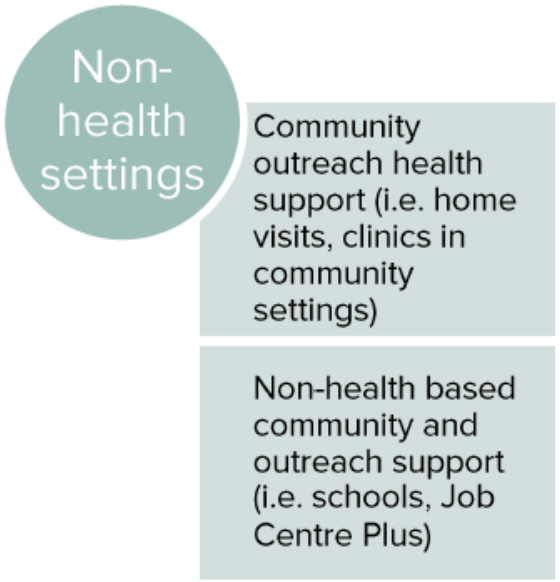
Adverse Childhood Experiences – DPH report recommendations

- Preventing long term negative impacts: Opportunities should be developed with **adult Mental Health clients** (including personality disorder, complex family presentations), **children's social care** (Child Protection and Child In Need) and **Primary Care**.
- Identifying children suffering an Adverse Childhood Experience: Opportunities should be developed into an Early Emotional Help system framework for Primary schools. This should be a **partnership of schools, the voluntary sector and NHS**, which responds to children with difficult and concerning behaviour.
- Preventing Adverse Childhood Experiences: Sharing the understanding of impacts of adverse experiences with parents during the antenatal period by the Local Maternity System and Forward Thinking Birmingham.

Preventing homelessness to improve health and wellbeing

- Rapid review to understand effective interventions – there were broken down by primary, secondary and tertiary prevention.





Preventing homelessness to improve health and wellbeing

- **Welfare Rights and consumer advice, includes housing advice.** Existing evidence shows advice helps prevent homelessness and provides financial gains; can include improvements to mental health and wellbeing.
- **Holistic in-tenancy support.** Existing evaluations largely positive about benefits including reduced A&E use; gaining employment and improved mental health.
- **Targeted support and advocacy to people leaving institutions.** Strong evidence base to build on. Existing evidence shows that effective discharge planning from health settings can improve health outcomes and prevent repeat homelessness.
- **Critical time intervention (CTI)** targeted at groups in the community. Evidence points to positive impact on both reducing repeat homelessness and providing a cost effective solution.

What works in inclusion health

- **Pharmocological interventions.** Directly observed therapy for HIV/TB. Vouchers or material incentives for adherence. Opioid replacement therapy is highly effective for individuals with substance use disorders.
- **Psycosocial interventions.** Combined motivational interviewing, cognitive behavioural therapy, and contingency management have been shown to be effective for prevention of reincarceration.
- **Case management.** Multidisciplinary team with low caseloads, community based services, and 24 h coverage reduced homelessness, with a greater improvement in psychiatric symptoms.
- **Harm reduction.** Targeted screening for TB and Hepatitis C. Hepatitis B vaccinations and needle exchanges are both very effective.

What works in inclusion health

Wider determinants – housing and employment

- Housing first. Significantly improved stable housing status and quality of life, and reduced contacts with the criminal justice system. Evidence more mixed for improving mental health, substance use, and community functioning outcomes.
- The Individual Placement Scheme model of supported employment in ordinary workplaces beneficial for people with severe and enduring mental health problems.
- Respite care (ie, short-term recuperative care for homeless individuals after hospital discharge) can reduce the number of future hospital admissions and use of emergency departments in homeless populations

Transition points and care protocols

Transfer points between healthcare and related settings and the community have an agreed protocol in place and are used to enable continuity of care and prevent crisis for the population. Eg:

- Urgent and emergency care
- Hospital discharge – physical health
- Hospital discharge – mental health
- Substance misuse treatment
- Prison release
- Police custody
- Transition from adolescence to adulthood
- Transition from other institutional care

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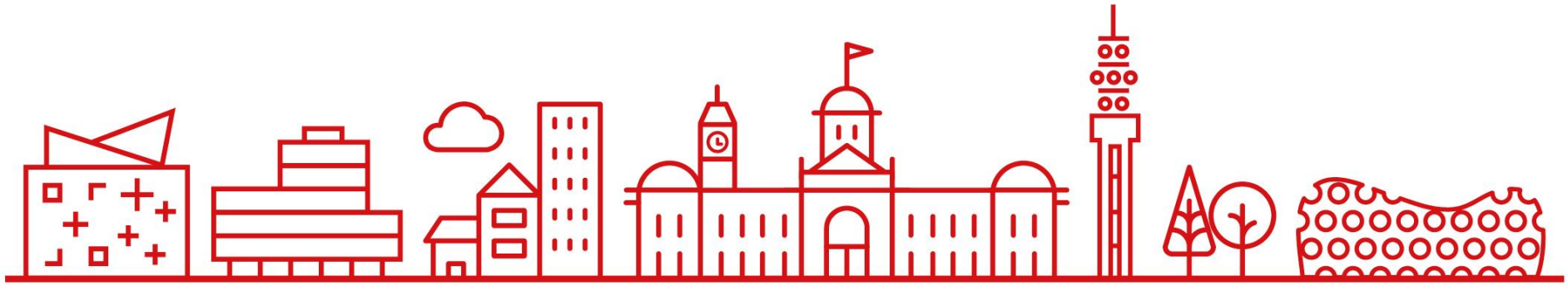

Making a positive difference everyday to people's lives

Birmingham City Council