

FEANTSA

Policy Statement

European Federation of National Organisations working
with the Homeless

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Average Age at Death of People Who Are Homeless

Introduction

People who experience homelessness generally possess a complex series of health needs which health services are frequently unable to adequately address. Access to housing which is affordable and of good quality should be considered a key determinant for better health outcomes. There is a clear link between homelessness and i) arising complex health needs, ii) barriers in accessing healthcare and iii) obstacles towards recovery. Therefore it is not surprising to see that when comparing the average age at death of the homeless population with the general population there are significant health inequalities with some studies suggesting that homeless male rough sleepers will die, on average, at the age of 47, with female rough sleepers dying at the age of 43. Due to the lack of EU wide data on the access people who are homeless have to healthcare, and indeed the wider absence of data on homeless populations in some countries, it is difficult to state concretely what the average age at death for people who are homeless is across Europe. However this statement demonstrates the large health inequalities which exist, coupled with the complex health needs homeless people possess which results in their lower average of age death than the general population.

Definitions

What is Homelessness: In terms of defining homelessness this statement uses the European Typology of Homelessness and Housing Exclusion. This incorporates rough sleeping, residing in emergency accommodation such as shelters or hostels or sofa-surfing with friends and relatives. However the available data on the average age at death in this statement relates primarily to rough sleepers, those who are living on the streets. While research indicates that many people who become homeless exit homelessness after only a few days, others can be trapped in homelessness for long periods of time, chronic homelessness, or experience a pattern of repeated exit and return to homelessness, episodic homelessness. The length of homelessness generally correlates to greater health inequalities and the worst health outcomes.

Average Age at Death: The average age at death refers to the average a person who is homeless is likely to die in a shelter/hostel or sleeping rough. This term does not equate to the life expectancy of a homeless person, due to the large number of variables it is not possible to state what the life expectancy of a person who experiences homelessness is. This can depend on a large number of factors including the age they become homeless, the length of their situation of homelessness, experiences of episodic homelessness, the form of homelessness they experience, access to services and their support networks. What is clear however is that being in a situation of homelessness dramatically increases a person's mortality rate and significantly lowers their expected age at death.



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Overview of the Health Profile of People Who Are Homeless

The early age at death for people who are homeless is generally related to the tri-morbidity arising from co-occurring i) poor physical health, ii) mental illness and iii) substance misuse. This should not detract from the wider health problems people experiencing homelessness face, noted in Figure 1 below, but rather highlights the highest risk factors, i.e those most likely to be fatal.

While poor mental health and substance misuse can be a cause of homelessness it is also a consequence. It is not surprising to see that the strain and anxiety of being homeless results in mental illness with many people turning to alcohol or drugs as a coping mechanism. In a study examining peoples' admission to 3 hospitals in Seville 83.7% of patients who were homeless were given a secondary diagnosis of possessing a mental disorder. This indicated that mental illness was not the primary reason for attending the hospital service and that the mental illness had gone untreated for some time. It is estimated that while homeless 4 in 5 will use a new drug, with many indicating that they actively self-medicate for their mental illness with drugs or alcohol, which often serves to further exacerbate their situation of homelessness and their general health. The use of drugs as a coping strategy has also led to the spread of communicable diseases such as HIV, AIDS and Hepatitis C. While possessing such addictive behavior and/or mental illness it is common for other health conditions to go untreated until they become chronic. This is explored further under the next section – Barriers to Healthcare.

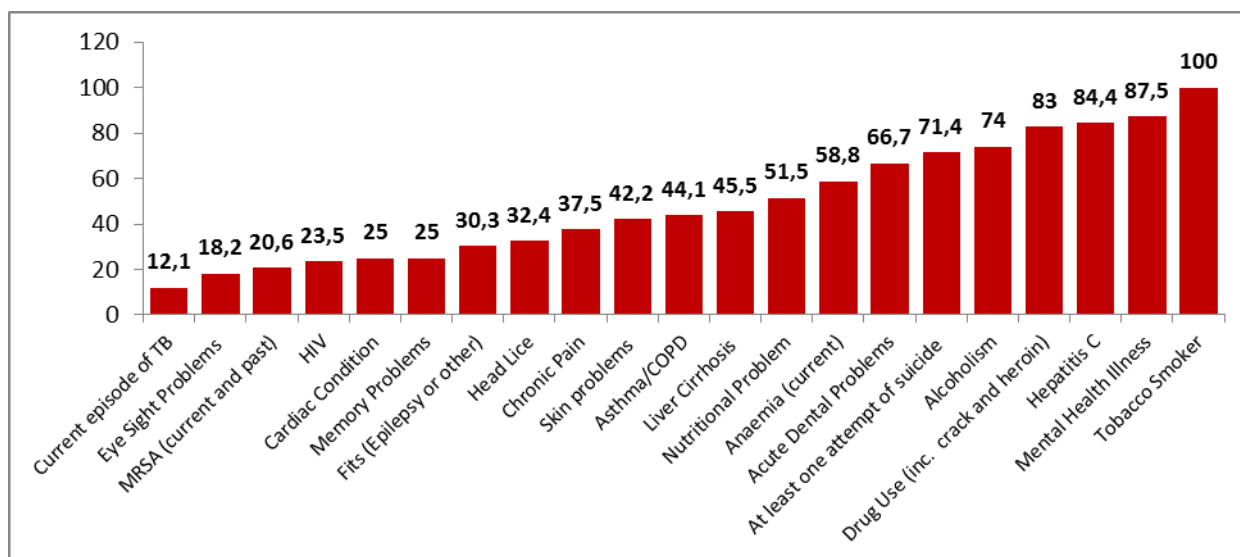
Additionally the WHO have noted that shelters which exhibit overcrowding and poor sanitation leads to increased respiratory, gastrointestinal and dermatological diseases. This is important as those who rough sleep may frequently attend services at shelters, adding to their complex health needs. This has been reflected by an overview, under Figure 1, of the conditions 34 clients at St. Mungo's possessed, for which clients on average reported having 10.5 of the listed conditions, with some possessing up to 19 conditions

¹*Características De Los Ingresos Hospitalarios De Las Personas Sin Hogar En Sevilla 2016* – Patricio, Ajuria & Castro

²*Healthcare for the Homeless: Homelessness is bad for your health* – Deloitte Centre for health Solutions

³*Poverty and Social Exclusion in the WHO European Region: Health Systems Respond 2010* World Health Organization Europe

Figure 1: Summary of the Morbidity Burden of Clients at St. Mungo's



Source: *Economic Evaluation of the Homeless intermediate Care Pilot Project*

The clients within this study possessed a variety of serious conditions including renal failure, osteomyelitis of the spine, acute bacterial endocarditis with septicemia, necrotizing fasciitis, jugular vein thrombosis, end-stage liver failure, MRSA infection, acute syphilis, pulmonary TB and Wernicke's encephalopathy. While one report compiled by Crisis in the UK estimates that the average age at death for people who are homeless is 47 for men and 43 for women, the estimate average age at death at St. Mungo's, though only relating to 7 clients, was 38. The previously mentioned study in Seville noted that people who are homeless can expect to die 23 years before the general population. Similarly in Denmark people who are homeless are estimated to die 20 years younger compared to the general population.

This demonstrates, in the very first instance, the complicated health profile of people who are homeless. There is no single medical condition homeless people are uniquely exposed to while living rough or in shelters which contribute to their lower average age at death, rather it is the multiple treatable conditions, all or most of which go chronically untreated. Therefore the high and premature mortality rates are not solely related to the specific health conditions but the wider issue of the accessibility of healthcare, which is explored in the next section.

⁴ *Economic Evaluation of the Homeless Intermediate Care Pilot Project 2009* - Hendry

⁵ *Economic Evaluation of the Homeless Intermediate Care Pilot Project 2009* - Hendry

⁶ *Características De Los Ingresos Hospitalarios De Las Personas Sin Hogar En Sevilla 2016* – Patricio, Ajuria & Castro

⁷ *End of Life Care for Homeless People* – FEANTSA 2015



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Barriers to Healthcare

People who are homeless face a series of barriers to accessing health care: understanding and addressing these barriers will help reduce the health inequalities which homeless people face and raise their average age at death. Barriers can be divided into those which are specific to being homeless (prioritization of needs, hospital discharge, and stigmatization) and those which will continue to persist once housed (health illiteracy and bureaucracy). The distinction is important as it demonstrates that even after a person has been housed they still remain vulnerable and face barriers towards accessing health services.

Barriers while Homeless

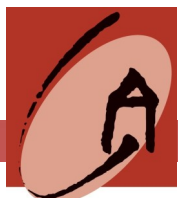
1. **Prioritization of Needs:** Homeless people face a series of challenges on a daily basis and healthcare is only one of many. It is not uncommon for a person who is homeless to ignore their symptoms and focus on what they perceive to be the most urgent priority, such as accessing shelter or sourcing food. Additionally the longer a person is homeless their sensitivity to illness differs from the general population and they may not even notice or feel their symptoms after time: this should be considered in a context where a person may be i) mal-nourished, ii) exhibiting addictive behavior with drugs or alcohol, iii) suffering from depression, stress or another mental illness and/or iv) suffering from the traumatic and violent environment associated with living rough. As a result they tend to only access health services when their condition reaches a crisis point and are critically ill, thus resulting in inpatient care, which is far more costly for services. This is often not a pleasant experience for people who are homeless and as a result many avoid subsequent medical treatment.
2. **Hospital Discharge:** In cases where a person who is homeless is admitted as an in-patient, after time they may be very ill but not ill enough to occupy a bed in a hospital and are forced to discharge, often with no support or shelter. A study from the UK has highlighted that this results in an extremely inefficient and costly use of services by a patient who is homeless, noting that many are re-admitted for the same condition within a 28 day period. Another London-based study identified that 10% of people who are homeless that are discharged from hospital are too unwell to recover from their illness, let alone the other multiple conditions they may have. This was also reflected in Seville with an average 10% of homeless patients being discharged against medical advice. In the context of hospital discharge it's important to note that many homeless people lack a support network of friends and families. From statistics accumulated by St. Mungo's 28% of clients had no close friends to rely on, more than half of them spent most of their time alone, of which only 25% thought this was unacceptable. The continuity of care is critical in the recovery process and it is imperative to

⁸ *Poverty and Social Exclusion in the WHO European Region: Health Systems Respond 2010* World Health Organization Europe

⁹ *Healthcare for the Homeless: Homelessness is bad for your health* – Deloitte Centre for health Solutions

¹⁰ *The Sanctuary : Development Perspectives 2011* – London Pathway End of Life Care

¹¹ *Características De Los Ingresos Hospitalarios De Las Personas Sin Hogar En Sevilla 2016* – Patricio, Ajuria & Castro



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ensure that the patient has a support network to aid their recovery. It should also be noted that people who are homeless live chaotic lifestyles with little structure and routine and are not accustomed to hospital environments where they do not feel comfortable which can potentially lead to self-discharges from hospitals.

- 3. Stigmatization:** People who are homeless, and the services they require, can often be thought of as an undeserving group who are responsible for falling into a situation of homelessness, and are thus labelled with undesirable characteristics and behaviors. This subsequently results in healthcare for homeless people being thought of, and structured or funded as, a “Cinderella Service”, a service which is considered relatively unimportant and largely neglected. In a survey examining 500 services in the UK 57% had faced cutbacks due to austerity with 48% of the total services believing their services were adversely affected. The Queen’s Nursing Institute found that most homeless people feel invisible and excluded from health services and 71% of non-homeless health specialists reported not being confident to care for homeless people, with well-intentioned medical professionals noting that they harbored stigmatizing tendencies. Health services need to be inclusive and foster an environment where people who are homeless feel valued and equal to others, and where medical professionals are confident in treating people who are homeless. In this context some people who are homeless can also be selective of the service they attend, and may only present to a certain service on a given day in order to be treated by a specific medical professional who previously treated the patient in a respectful and dignified manner.

Barriers for Formerly Homeless People

- 1. Bureaucracy:** Health services can be extremely difficult to navigate when a person does not have health insurance, a fixed address or identification documents. Even once housed bureaucratic and organizational barriers can prevent formerly homeless people from presenting to health services. Additionally where a person presents to a service they may be given an appointment but find the waiting time intolerable and find it difficult to maintain appointments, as such intensive supports are required to help both homeless and formerly homeless people maintain their access to healthcare in a system which places bureaucratic barriers to healthcare.
- 2. Health Illiteracy:** People who experience homelessness are generally from a poorer socio economic background and may be health illiterate. Coupled with poor mental health this means that the services they require need to be more tailored not just to their needs but also their capacity to understand their conditions. For example a study in Vienna noted a doctor will usually spend 1-5 minutes with a patient from the general population but consultations can expect to last on average 16 minutes for a patient with current or past

¹² *Rough Treatment for Rough Sleepers: An Investigation into the way that medical treatment for homeless people could be improved 2011* – Brighter Futures Academy

¹³ *Poverty and Social Exclusion in the WHO European Region: Health Systems Respond 2010* World Health Organization Europe

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experience of homelessness. The longer period is rooted in the complex health needs but also difficulties in communicating the problem.

Inefficient Use of Services

Resulting from the aforementioned barriers and obstacles to accessing healthcare, homeless people make inefficient use of services, relying heavily on inpatient care and A&E services. In the UK it is estimated that homeless people are 6 times more likely to use A&E in hospitals and will spend 3 times longer in hospital resulting in their average cost to the health service to be more than 4 times that of the general population. Similarly in Seville it is estimated that homeless patients will stay in hospitals 4.8 days longer than the general population. While figures in the UK differ, one study by St. Mungo's estimated that a patient who has experienced homelessness would cost the service GBP12,216, however following an initiative which targeted their specific needs and placed an emphasis on primary care the cost dropped to GBP 3,957. The same initiative which focused on 10-12 service users estimates that they reduced homeless patients presenting to A&E by 39.8% and the number of hospital admissions by 79.8%, resulting in savings of GBP 100,000. Through addressing the aforementioned barriers to healthcare it is possible to vastly improve the quality of health of homeless patients by providing better access to primary healthcare and address their health problems before they become chronic, which subsequently presents cost savings to hospitals.

7 Steps to Improve Health Services for People Who Are Homeless:

1. Available and proximate – health services provided on site in homeless shelters demonstrate the greatest potential to improve homeless peoples' health. Services need to be regularly and routinely available.
2. Access to GP Services – those that rough sleep and do not have access to shelter accommodation often face barriers to primary and community care services. Many mainstream GPs refuse to register a homeless person for bureaucratic reasons. Where specialist care does exist people who are homeless are often excluded if they are not registered in temporary or emergency shelter in the area. Removing these barriers allows greater access to primary health services and ultimately will reduce the burden on A&E and hospitals.
3. Integrated service delivery – following a medical consultation a doctor or nurse makes a direct referral to a specialist, if required. Referrals should have regard for the urgency of the condition and aim to avoid long waiting times considering the risk that the homeless person may move area or forgo or forget to attend future medical appointments.
4. Multi-disciplinary teams – Interdisciplinary case management is a hallmark of good practice. Shelters should coordinate meetings between doctors, nurses, mental health clinicians, including psychologists as well as psychiatrists, and social workers to foster closer cooperation and ensure all necessary parties are aware of the individual health needs of patients.

¹⁵ *Healthcare for the Homeless: Homelessness is bad for your health* – Deloitte Centre for health Solutions

¹⁶ *Características De Los Ingresos Hospitalarios De Las Personas Sin Hogar En Sevilla 2016* – Patricio, Ajuria & Castro

¹⁷ *Economic Evaluation of the Homeless Intermediate Care Pilot Project 2009* - Hendry



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5. Social Worker integration – patients should have the option to be accompanied by a social worker at medical appointments to ensure they fully understand their condition and the support any follow-up treatments and appointments.
6. Non-bureaucratic services – health services shouldn't place an administrative burden on clients.
7. Appropriately trained staff – staff working with people who are homeless should be given appropriate training to i) understand how social exclusion impacts on health and help-seeking behavior, ii) develop appropriate communications skills to foster a doctor-patient relationship and iii) understand the limitations homeless people face in adhering to treatment including lack of stable housing or appropriate storage for prescription drugs.

Housing First

One of the most important interventions needed to support health services for people experiencing homelessness is the adequate provision of housing, to enable a person to recuperate from their illness while also acting to prevent illness in the first instance. A study published in 1999 examined the health outcomes for different types of homelessness, comparing rough sleepers in London, with hostel users in Oxford and B&B residents in Brighton. Though dated, the study found rough sleepers were 25 times more likely to die prematurely than the general population, hostel users were 7 times more likely to die and B&B residents 4-5 more likely to die. This demonstrates that the best intervention to support the health of people who are homeless is to provide stable and secure accommodation. In this regard the housing first model has illustrated that people who are placed in stable and secure accommodation reap much improved health outcomes.

A study conducted in 2015, examined the cause of death for formerly homeless people who were provided with accommodation under housing first between 2008-2013 and compared the causes of death with people experiencing homelessness in a series of other studies. Housing First is a model of providing housing where safe and stable accommodation are viewed as the starting point rather than an end point for addressing peoples' housing needs. This is a rights based approach where the client's needs and rights are given first priority. This approach, as seen under figure 2, results in improved health for clients as stable housing provides the means to address the tri-morbidity factors of i) poor physical health, ii) mental illness and iii) substance misuse.

¹⁸ Life chances in Britain by Housing Wealth for the homeless and vulnerably housed 1999 – Shaw, Dorling & Brimblecombe

¹⁹ Examining Mortality Among Formerly Homeless Adults Enrolled in Housing First: An Observational Study, 2015 – Henwood, Byrne and Scriber



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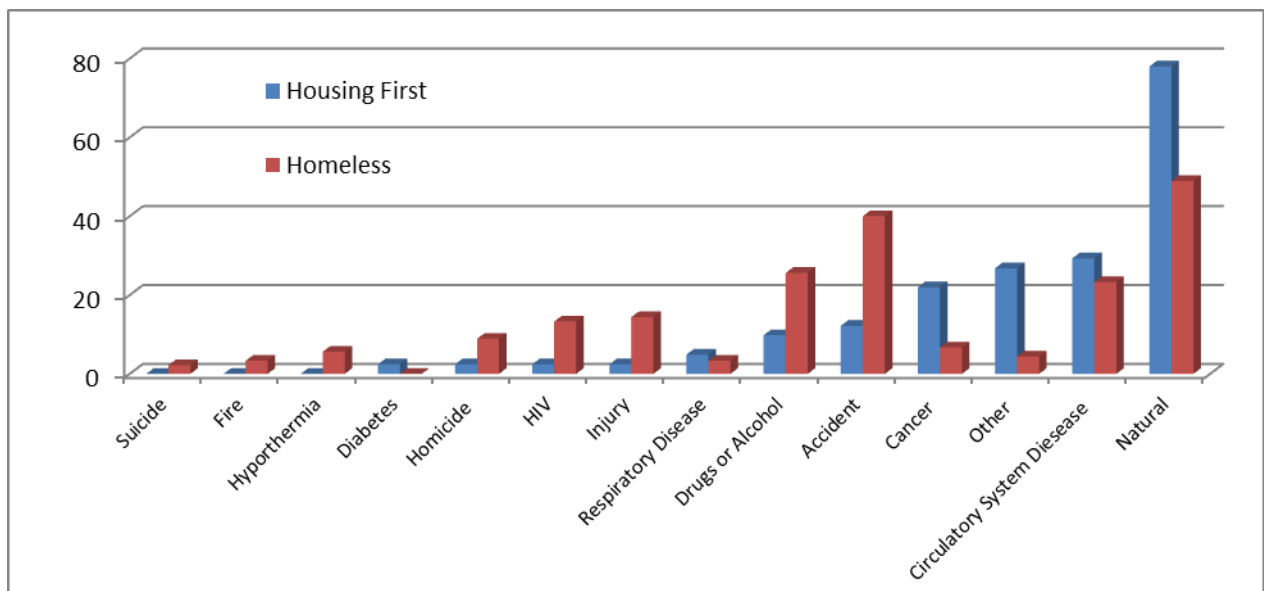
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Figure 2: Comparison of the causes of deaths between Housing First participants and people who are homeless



Source: *Examining Mortality Among Formerly Homeless Adults Enrolled in Housing First: An Observational Study, 2015*

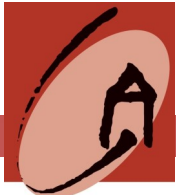
The figures indicate that access to housing causes a shift in health needs. People experiencing homelessness are at a particular risk of the factors previously discussed in this statement such as drug and alcohol related deaths, HIV and accidents or violence on the streets. Conversely those participating in housing first are much more likely to die from cancer or other natural causes, indicating a dramatic change in their overall health needs.

Best Practices

This section lists some instances of best practice of health services which are targeting the health needs of people who are homeless in a more effective manner. Service providers and policy makers can learn from how these initiatives approach treatment for people who are homeless.

NeunerHAUSARZT

In Vienna the NeunerHAUSARZT project provides medical services in multi-disciplinary teams in 10 homeless hostels across the city. This is a low threshold and low barrier service, providing weekly medical consultations on site for homeless people, with doctors using their networks to make referrals to relevant specialists who are familiar with the needs of the homeless. The project bridges



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the gap between the health and social sectors, by also offering training to medical staff on the needs of people who are homeless. Once service users avail of the medical consultations they are also given additional information on wider access to primary and community health care. Nearly 75% of the service users did not have a registered family doctor or GP, indicating that the service has proven successful in reaching out to a group of people which previously did not avail of primary health services.

London Pathways

Discharge from hospitals can be a difficult transition point for people who are homeless. In many instances people who are very ill, but not so unwell to occupy a hospital bed, can be discharged with no secure shelter, which prevents a full recovery from their condition and frequently results in a return to hospital. London Pathways represents an integrated approach between housing officials and medical professionals. GP's who specialize in homelessness meet with patients who are homeless in the wards and connect them with the housing office, or in some cases family, to help them secure housing ahead of their discharge from hospital. The initiative also works directly with patients to help them participate fully in the decision making about their care and assist clinical colleagues treat the multiple morbidities people face.

Find and Treat

In London a mobile health unit has been funded which travels across the London boroughs and screens homeless people for TB, using x-rays to identify and diagnose cases of TB. Find and Treat includes identification and treatment of TB and supported case management for the service user. The initiative has proven to be cost-effective. There are now plans to purchase a similar unit to cover the North of England as due to demand the unit is often requested outside of London, it has also been used in Dublin (Ireland) and owing to the success of this project the Netherlands are keen to introduce a similar project. The services creates a medical file for the homeless person which is stored with the unit for whenever the patient next presents to the service. This is a service which provides proximity to the service user on a regular basis and is tailored to their chaotic lifestyles by storing medical details within the unit for the next time they present to the service. Staff working with the unit are also specialists in working with people who are homeless.

Infirmiers de Rue

Based in Brussels, Infirmiers de Rue (IDR, Street Nurses) is an outreach program which actively goes out and finds people living on the street and provides them with basic healthcare. The teams are



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made up of a combination of medical and social workers, which foster a relationship with people who are homeless and introduce them to other specific care facilities, listening to their individual needs and providing them with relevant advice. The outreach program involves the dissemination of practical information for people who are homeless, or their caretakers, including maps of public fountains, free public conveniences, information on how to better maintain their personal hygiene when sleeping rough and how to protect against hypothermia or dehydration. The program also distributes information on how to buy balanced meals for EUR3.5 a day when you live in the street. This initiative takes the focus on addressing the unmet basic needs of people who are homeless while also playing an active role in solving the issue of permanent housing, knowing the positive role that housing can play in security, health and recovery. IDR develops a housing first program, but permanent housing in institutions (such as an elderly home) is also provided according to the specific needs of some patients. Following the patients from rough sleeping until they receive stable or permanent housing is a process that can take several years.

However this period also allows the organization to build up a strong bond with the patient. Intensity of follow-up decreases with time and stability, but contact is always kept with all the patients, in order to prevent relapse of homelessness or medical conditions. When possible, a voluntary helper comes every two weeks to visit the patient and have fun together. The aim is to teach, after years of survival, how to enjoy life.

Psychologically Informed Environments (PIE)

The use of Psychologically Informed Environments (PIE) has been used as proven an effective method in addressing many of the complex health needs people who are homeless present with. PIE is a client centered model of care which consciously tailors a service to take into account the psychological make up, the thinking, emotions, personalities and past experiences of its clients, in how it functions. This model of service is becoming increasingly popular in the homeless sector. The Thames Reach's 'Waterloo Project' in London, a hostel for rough sleepers with complex needs, operates as a psychologically informed environment. The service employs a Clinical Psychologist who provides one-to-one psychodynamic psychotherapy for clients, and reflective practice for the manager and staff. Focus Ireland have used the PIE approach with homeless families in their services, employing a Counselling Psychologist to provide clinical input. PIEs has also been implemented successfully with young people, children in care, women involved in prostitution, and people with severe and enduring mental illness or dual diagnosis. Positive outcomes include improved staff understanding, retention and satisfaction, and improved client-staff relationships, less incidents, less evictions, improved clinical scores, and higher positive move-on rates.



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