Pathways from Acute Mental Health Care for Individuals Experiencing Homelessness

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Background

There is a well-established body of literature that shows individuals experiencing homelessness have a higher prevalence of chronic disease, including mental illness, than those in the general population and the economic impact on the Western Australian (WA) health system is sobering.[1] WA Health data from the 2014–15 financial year indicates that there were 31,654 inpatient days and 5,048 Emergency Department presentations for patients coded as homeless or No Fixed Address, with average length per separation three times higher than that of non-homeless patients in the same year.[2] This equates to a conservative cost of $79 million to the WA health system in that year alone.[3] Conversely, some of the strongest evidence around reducing hospital demand has emerged for interventions targeted specifically to those who are homeless and have chronic mental health issues.[4]

The prevalence of mental health issues within the homeless population is extraordinary. Within a 1,070 homeless patient cohort identified over a one-year period at our hospital group, 91 per cent had documented contact with state funded mental health services. Data from the Royal Perth Hospital Homeless Team's first two and a half years of operations showed that 12 per cent of their 824-patient cohort (99 individuals) had a formal diagnosis of schizophrenia, over 10 times the world-wide population prevalence of one per cent.[5] However, hospital presentations for mental health among homeless people is only the tip of the iceberg; undiagnosed and under-or un-treated mental illness in individuals with no fixed address is common.

In spite of this, homeless patients in psychiatric inpatient and community mental health settings seldom have their most fundamental needs addressed, namely stable, suitable accommodation and appropriate levels of community support.[6] Without these basics in place, good mental health cannot be achieved.

The Mental Health Homeless Pathway Project (MHHPP) in Perth is working to address this gap.

The MHHPP Model of Care

In May 2019, the MHHPP was established to improve service delivery by the mental health services of the Royal Perth Bentley Hospital Group (RPBG) for patients experiencing homelessness. The RPBG mental health service comprises 92 inpatient beds over three locations, two community outpatient clinics, a specialised Aboriginal mental health service and a small capacity mental health outreach service for rough sleepers.

Prior to the establishment of MHHPP, it had been identified that 30 per cent of inpatient mental health beds in RPBG were occupied by individuals experiencing homelessness. Many repeatedly cycled in and out of the mental health services. Others had long in-patient admissions (>28 days), occupying expensive inpatient beds because of a lack of any appropriate discharge options, largely related to housing.

The MHHPP is run by a Project Manager with a social work background and extensive experience in community homelessness services. She liaises with members of each of the RPBG mental health services to identify and assist their mental health patients experiencing homelessness.

Key Elements of the MHHPP

- *Identify current RPBG mental health inpatients and outpatients experiencing homelessness*
- *Build and strengthen pathways to stable accommodation.*
- *Build collaborative partnerships with community organisations.*
- *Provide staff training and education.*

The MHHPP is an active participant of the 50 Lives 50 Homes Housing First Program, which to date, has permanently housed over 240 rough sleepers.[7] By being a partner of this program, MHHPP is able to refer individuals directly from the hospital to services that aim to rapidly house and provide wrap-around support to some of the most vulnerable rough sleepers in Perth.

Hospital Use

In the one-year period (from 9/5/2019 to 24/4/2020) that MHHPP has been operating for, a total of 1,070 individuals with no fixed address were identified within RPBG. Of these, 870 had documented mental health service engagement and were considered 'in scope' for this project.

Hospital use has been calculated for the first 261 patients seen by MHHPP in RPBG hospitals during a two-year period prior to the project. These 261 patients accumulated a total of 1,936 Emergency Department presentations and spent 14,119 days admitted as an inpatient in the year before the MHHPP. In WA, the average cost of an Emergency Department presentation is $838, and each day spent in a psychiatric inpatient bed costs $1,475.[8,9] Based on these figures, for the 261 individuals they used approximately $22.5 million of hospital healthcare usage in a two-year period. If the averages for the 261 were consistent for the whole cohort of 870 in-scope individuals, this could amount to approximately $75 million in hospital use over two years.

Outcomes

Of the 870 'in scope' individuals (No Fixed Address+mental health service use), 30 per cent or 257 individuals have completed the validated homelessness acuity triage tool, the VI-SPDAT (Vulnerability Index-Service Prioritisation Decision Assistance Tool), with 188 (73 per cent of responders) scoring over 10, indicating extremely high levels of chronicity and complexity in this group and their requirement for long-term stable housing and long-term community based supports.[10]

However, despite having identified 188 high acuity homeless individuals (VI-SPDAT 10+), only 32 of them (12 per cent) have been able to access accommodation options and/or community caseworker support in the homelessness community sector so far. This is partly due to long-term underfunding of this sector, leading to a chronic shortage of homelessness case workers relative to the demand and acuity of the homeless population and the saturated capacity of the existing caseworkers. It is compounded by the lack of available, suitable and affordable housing which leads to caseworkers remaining engaged with clients over long periods of homelessness. Despite these difficulties, the MHHPP manager was able to directly assist 27 patients into long-term housing with appropriate supports.

Artwork provided by The Artful Dodgers Studio, a program of Jesuit Social Services

The MHHPP manager has also trained 111 frontline mental health clinicians (social workers, mental health nurses) to administer the VI-SPDAT survey. This improved staff identification and needs assessments of their homeless patients, allowing appropriate services to be identified.

The MHHPP was able to resolve the situation of some patients with long inpatient stays because of the manager's extensive homelessness expertise. This is powerfully illustrated through the following case study:

MHHPP Patient Case Study

Background: *Dan is a male in his early forties with severe, treatment resistant schizophrenia and a long history of intimidation and aggression towards others. He was brought to hospital by the police in mid-2018. He was under the Mental Health Act after breaching his Community Treatment Order (CTO) due to non-compliance with anti-psychotic medication. As a result, Dan had become increasingly volatile and aggressive towards staff and residents in his group home and was threatening to kill a staff member there.*

Presentations and length of stay: *Dan remained an inpatient for 11.5 months due to a lack of a suitable discharge option.*

Outcomes: *The MHHPP commenced while Dan was still an inpatient. Dan's VI-SPDAT score was 14 indicating high acuity so he has been accepted into a Housing First program. He moved into a private rental and receives support through his community mental health provider and an after-hours support service. He is now receiving the Disability Support Pension and has an NDIS package with funding approved and a support plan. Dan reports enjoying activities such as fishing and going shopping.*

Current situation: *Dan remains well, compliant with medication and has had no Emergency Department or inpatient admissions since his discharge from the mental health ward.*

Why MHHPP is Needed

The Western Australian Office of the Auditor General reviewed the use of state funded mental health services from 2013–2017. Within the 212,000 cohort of state funded mental health services users, just 10 per cent of individuals used 90 per cent of all state funded mental health in-patient bed days. This 2019 report recommended rigorous review of this high use cohort to develop alternative *'pathways that enable these people to spend as much time as possible in the community and then move through more intensive services as they need to'*.[11]

While the Auditor General's report did not state the proportion of these individuals experiencing homelessness, we suspect that many homeless people are in this cohort. Within RPBG data, we have already identified that homeless individuals occupy 30 per cent of RPBG mental health inpatient beds at any one time.

If homelessness in mental health patients was rapidly addressed via much cheaper social inputs such as housing and supports, rather than expensive hospital care, the result would be better patient outcomes and considerably lower cost to the public purse. This situation highlights the divide between generally well-funded health services like hospitals, that are heavily impacted financially by social problems like homelessness, and the community homelessness sector which is chronically underfunded so cannot address the cheaper housing and support needs of the homeless population which would reduce their healthcare usage.

Conclusion

Contacts with the hospital can often be the portal through which the road to housing and recovery begins.[12]

The MHHPP is an example of a service that is actively identifying and engaging with RPBG's homeless patients in their mental health services. The MHHPP is attempting to link them with appropriate services upon discharge to access the accommodation and support they require. We have identified that better patient outcomes and allocation of public services could both be achieved in this high-cost patient cohort by connecting mental health services to rapid access to the fundamental basics of good mental health and wellness, a stable and safe place to stay and appropriate supports to stay well.

Endnotes

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