INTERIM REPORT ON MORTALITY IN SINGLE HOMELESS POPULATION 2020

Dr Austin O Carroll

Why an Interim Report.

Missing Data from Central Statistics Office - Due October 2022

No Access to Coronor data (Death Certificates and Inquest Findings) until a. Post Lockdown and b. When Inquests Complete

Missing Data on Age and Gender of Single Homeless People. Awaiting setting up of Pass 2.

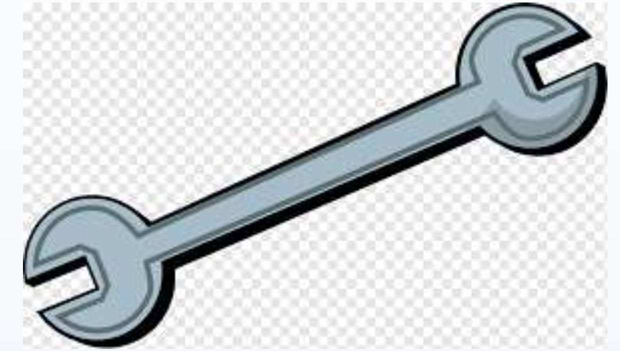
What We Already Know!

- People Experiencing Homeless die younger than they should!
    - Higher rates of Physical Illness.
    - Higher rates of Mental Illness & Suicidality
    - Higher rates of Substance Misuse.
    - Higher Rates of Accidental & Violent Death.
    - Influence of Poverty.
    - Influence of Childhood Adversity.

What We Already Know!

- **There are Interventions that may reduce Mortality of PEH including:**
  - **Multi Agency Response**
  - **Access to Primary Care**
  - **Programmes to reduce Suicidality.**
  - **Programmes to reduce Overdose Deaths.**

Methods



Analysis of Data from DRHE.

- 79 deaths
    - Not known to DRHE (4) 75
    - Excluded Tenancies (6) 69
    - Excluded Long Term Accommodation (21) 48
    - Excluded Deaths Adults in Family Homeless (1) 47

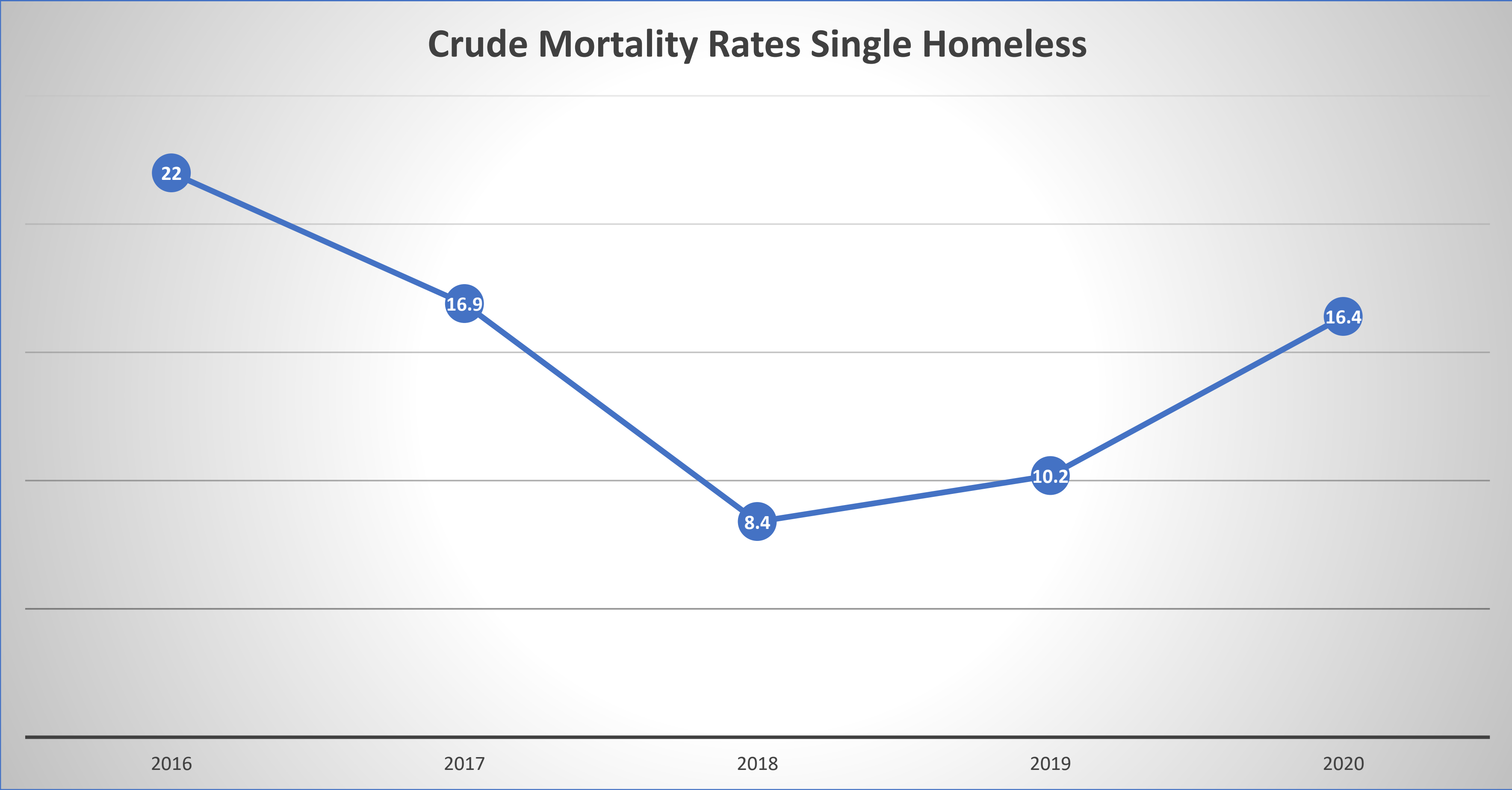
- Of these 47 PEH 44 were in Emergency Accommodation and 3 were rough sleepers.

Results

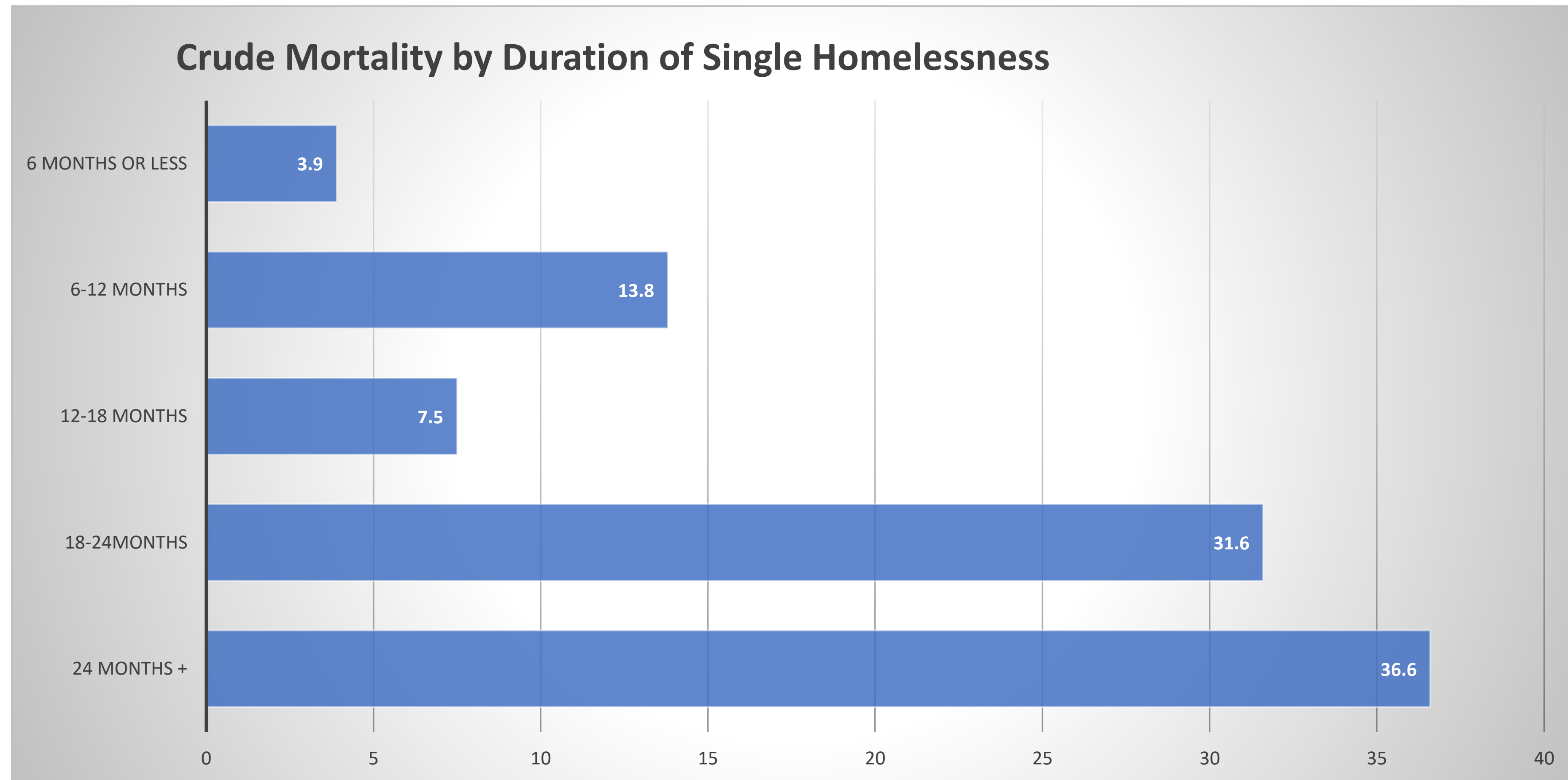
- Seeming Increase in Number of Deaths in Homelessness in 2020.

Table 13: Single Service Users Registered with DRHE in Homeless Accommodation (as per Census) Service at Time of Death					
Year	**2016**	**2017**	**2018**	**2019**	**2020**
Number of Deaths	**36**	**32**	**19**	**26**	**47**

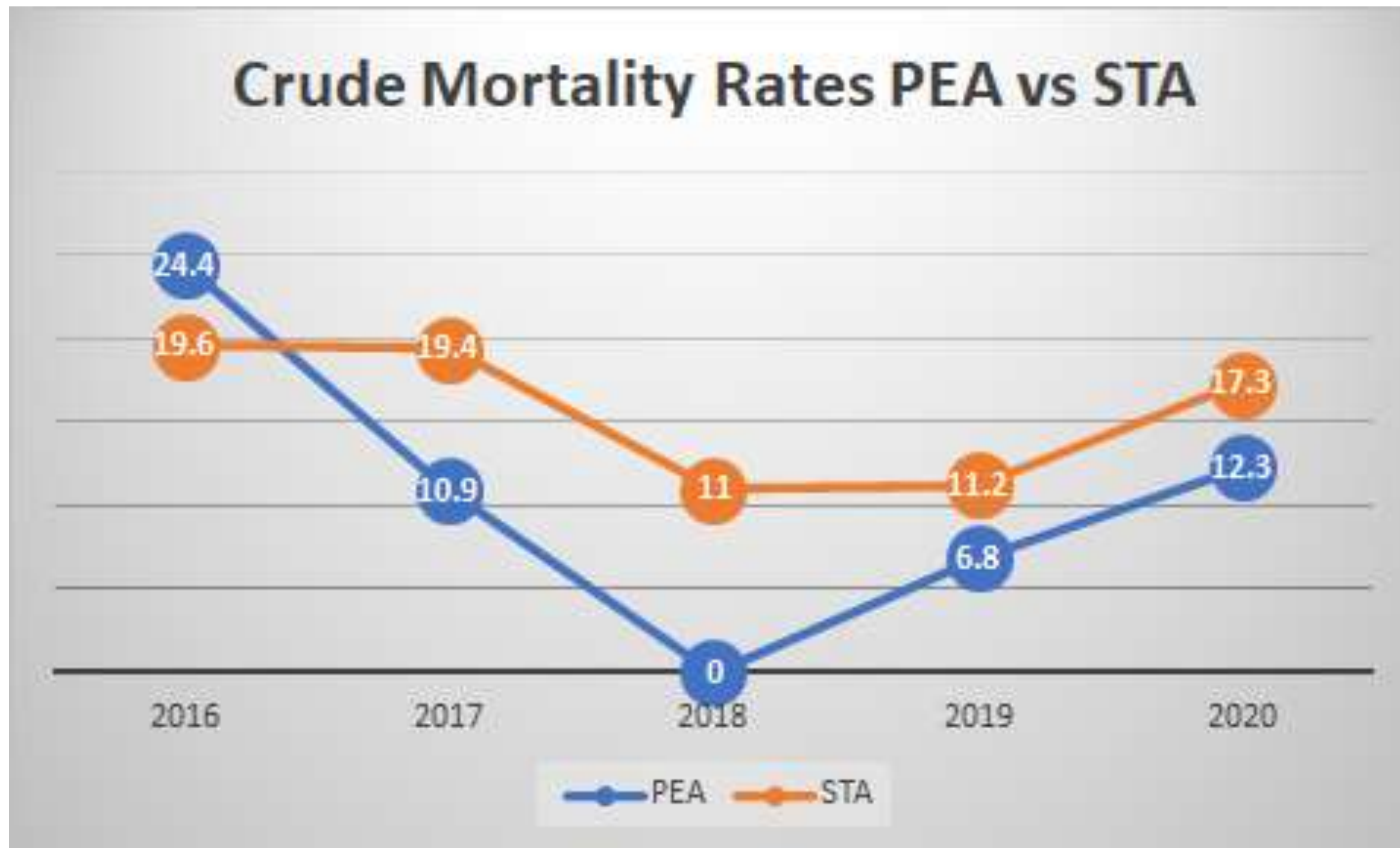
Crude Mortality Rates vary from Year to Year.



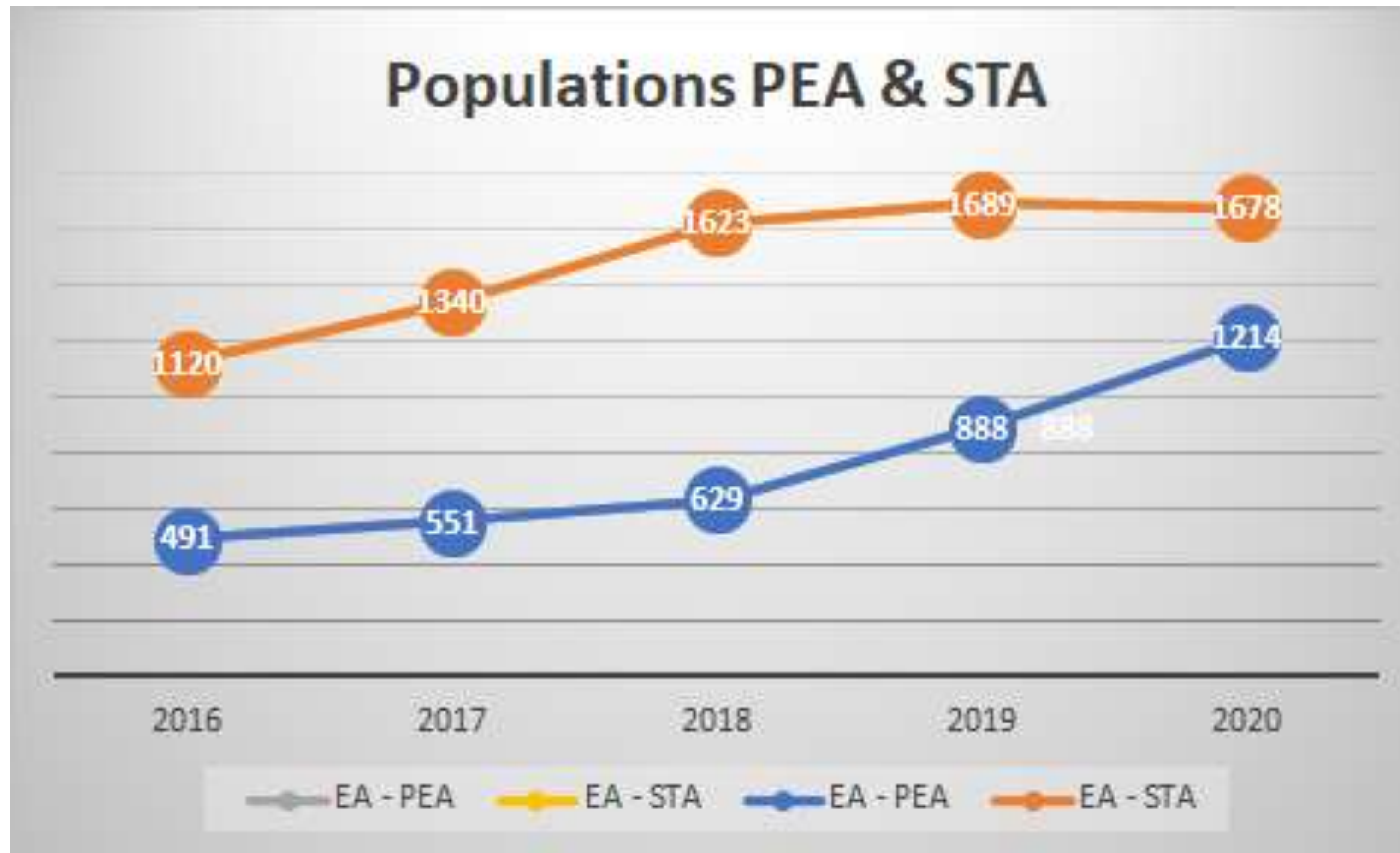
The Longer one is Homeless the higher the death rate.



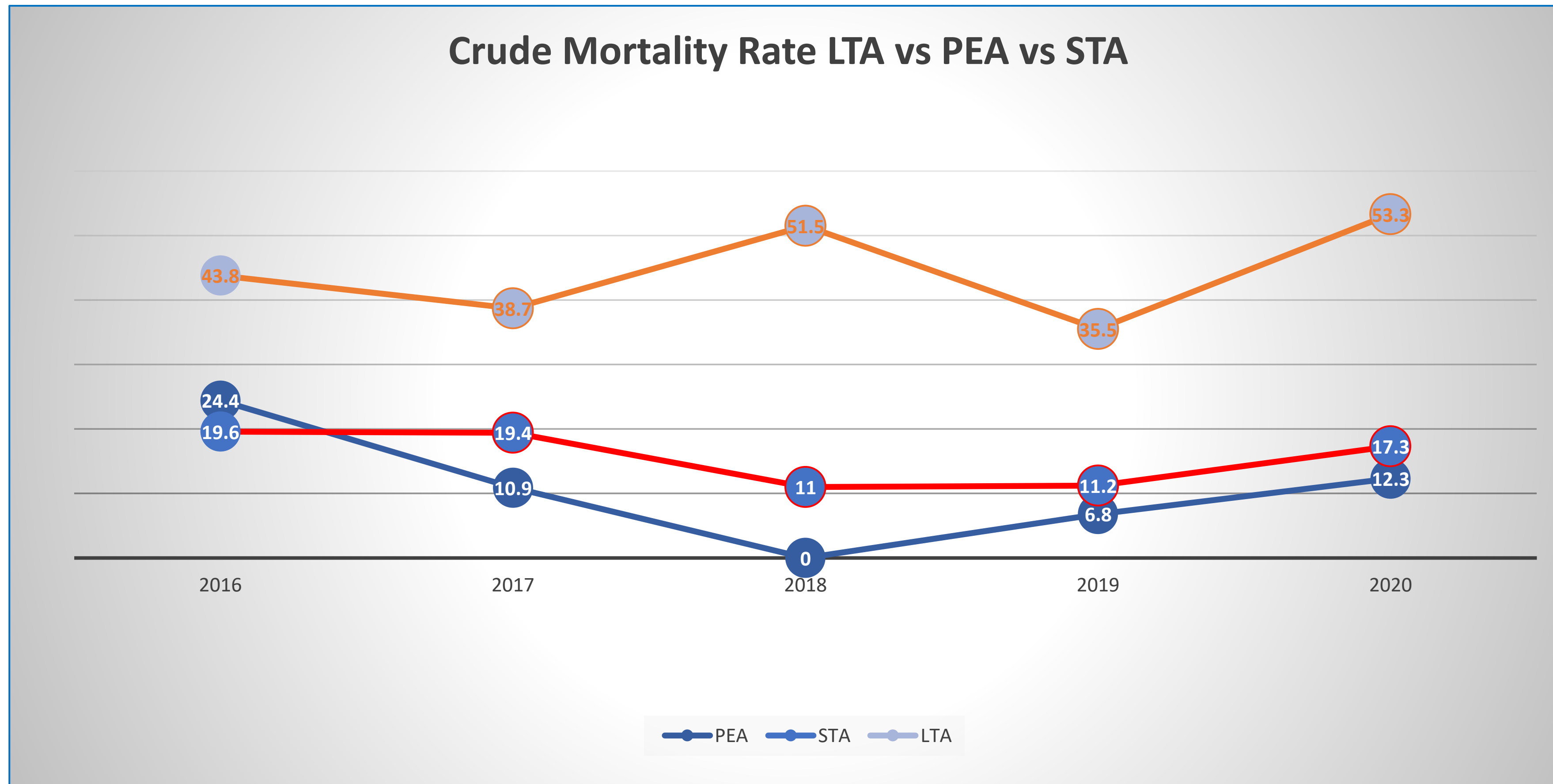
STAs have higher mortality rates but gap is narrowing.



Population of PEAs and STAs converging



CMR LTAs higher than PEAs and STAs



Rough Sleepers

Table 15: Single Service Users Registered Service at Time of Death					
Year	**2016**	**2017**	**2018**	**2019**	**2020**
Rough Sleeping	**2**	**0**	**1**	**1**	**3**

Median Age 2020

Table 16: Median Age			
	All	**Female**	**Male**
All Deaths in Homeless Service	46	43	46
LTA	54	55	53
All EA Singles	43	33	46
PEA	41.5	36	43
STA	43.5	33	46

Median Age 2016-2021

Table 17: Median Age Death 2016 – 2020					
	2016	**2017**	**2018**	**2019**	**2020**
Median Age	43	38.5	37	43	43
Median Age (Males)	43	38.5	39	43	46
Median Age Females	42.5	37.5	32	41	33

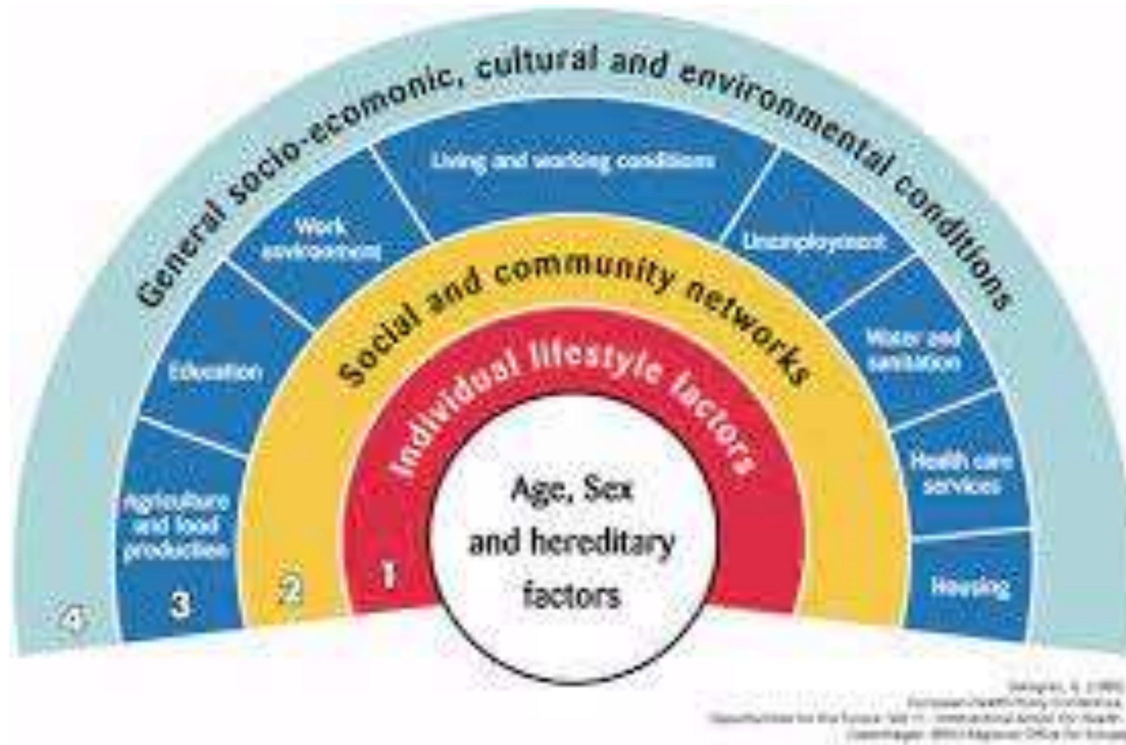
Location of Death – All Reported Deaths

Table 18 : Location of Death - All Reported Deaths	
Tenancies (AHB/ HF / LA)	5 (6%)
LTA - Tenancy	14 (18%)
Hospital	15 (19%)
EA - STA	23 (29%)
EA- PEA	12 (15%)
Outdoors	8 (10%)
Unknown	2 (3%)
Total	79

Location of Death – Single Service Users

Table 19: Location of Death - Single Service Users - EA & RS known to the DRHE		
Hospital	7	15%
EA - STA	23	49%
EA- PEA	10	21%
Outdoors	7	15%
Total	47	

The Main Determinants of Early Death in People Experiencing Homelessness are Structural Causes.



Discussion

- Crude Mortality Rates are not excessively high for 2020.
- Crude Mortality Rates for Single Homeless are high while for Family Homeless are low.
- Crude Mortality Rates are high for long term homeless i.e. > 18 months
  - Age Profile
  - Homelessness
  - Causes of Homelessness.
- Crude Mortality Rates are high for LTAs.
  - This is to be expected.
- Number dying on the streets marginally higher.

- There are Evidence Based Interventions that are known to reduce Mortality.
  a. **Adopting a Multi-Agency Response to Deaths in Homelessness.**
  b. **Improving Access to Primary and Secondary Care.** Dublin is well serviced by specialised (primary) care and inclusion (secondary) care health services.
  c. **Improving Access to Mental Health Services.**

d. **Overdose Prevention Programmes:**

i. Supervised Injecting Centre.

ii. Naloxone Distribution.

iii. Access to Opiate Substitution Treatment.

iv. Access to Other Addiction Treatments:

1. Community Benzodiazepine and Alcohol Detoxes.
2. Inpatient Alcohol and Drug Detox
3. Inpatient Stabilizations Centre

v. Overdose Risk Assessments:

vi. Non-Fatal Overdose Reviews:

vii. Availability of Low threshold Services.

viii. Overdose awareness.

ix. Access to Primary Care Services.

Learning from Deaths in Homelessness.

Aggregate Data Reporting.

Individual Death Analysis:

- Critical Incident Review.
- Rapid Case Reviews on Clusters of Deaths.

A Culture of Blame will Inhibit Learning from Deaths and Improving Systems

Recommendations

Data collection and analysis.
1,000
Q1
Q2
Q3
Q2
Q3
Q4

Learning from Deaths in Homelessness.

Implementation of a Critical Incident Analysis Framework. Recommendations are made on how to develop this process.

Five Yearly Reports on Mortality Trends.

Introduction of a Rapid Review Process for Clusters of Deaths.

Recommendations seeking to reduce Mortality of People experiencing homelessness.

- Reduce Long-term Homelessness. The Housing First model is the optimum approach to achieve this objective.
- Multi Agency Committee to Review Five Yearly Mortality Reviews.
- Ensure Access to Primary Care Services in PEAs.
- Improve Access to Mental Health Treatment in particular those with Dual Diagnosis

Recommendations seeking to reduce Mortality of People experiencing homelessness.

Reduction of Overdose Fatalities

- Improve access to Naloxone.
- Implement the Supervised Injecting Centre Policy.
- Access to OST for PEH be as quick as possible.
- Develop protocol for Overdose Risk Assessment.
- Develop protocol for review of Non-Fatal Overdoses.

Conclusions.

People Experiencing Homelessness Die Younger than they should.

If you want to reduce premature mortality of PEH:

- Address Social Inequality.
- Stop People becoming Homeless.
- Address Housing Issues.
- Support Housing First to reduce Longterm Homelessness.
- Address Overdose
- Address Suicidality
- Have a Learning System to Improve the Quality and Safety of Services.