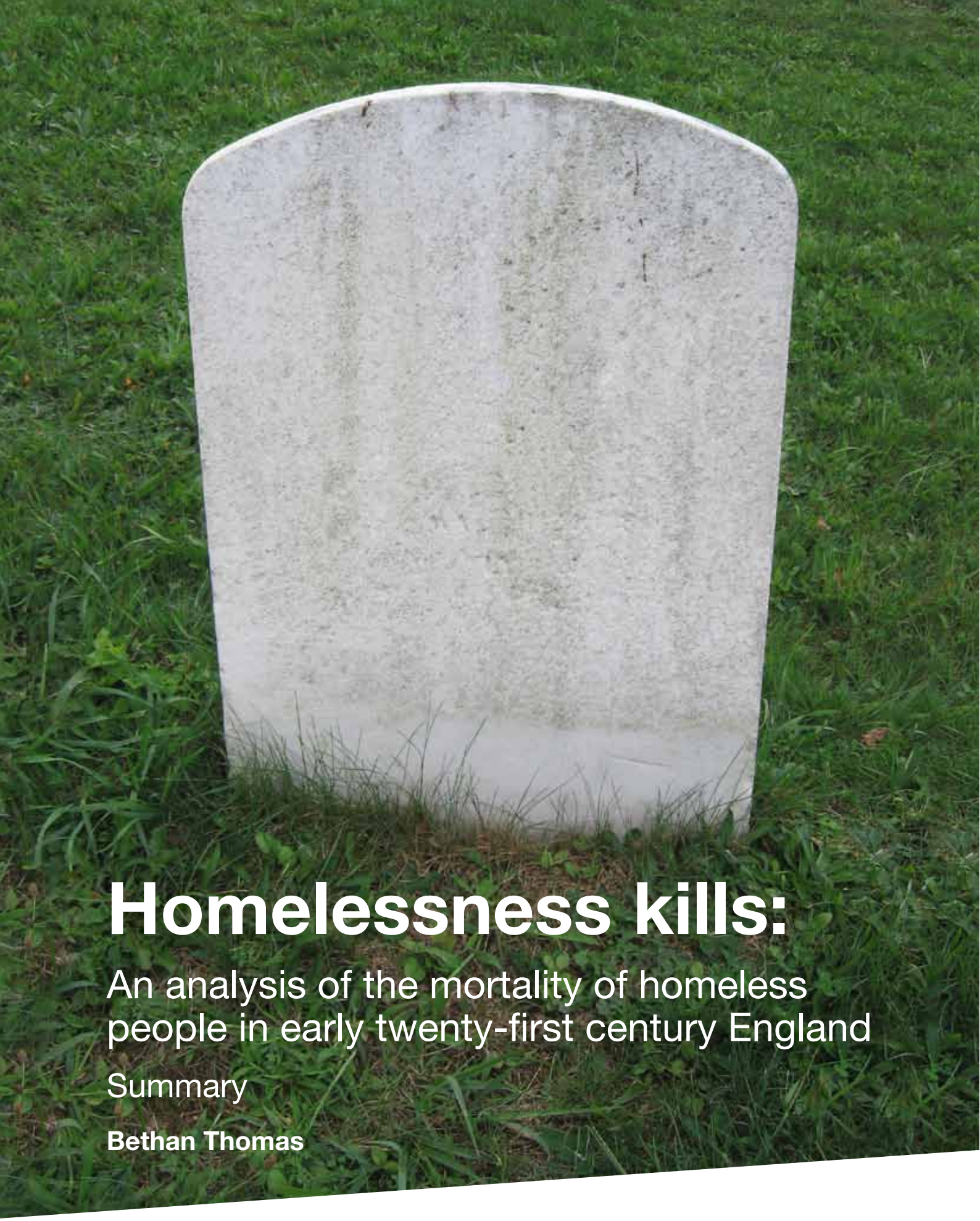

Homelessness kills:

An analysis of the mortality of homeless people in early twenty-first century England

Summary

Bethan Thomas

The University Of Sheffield.

Crisis

About Crisis

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

We are determined campaigners, working to prevent people from becoming homeless and advocating solutions informed by research and our direct experience.

We have ambitious plans for the future and are committed to help more people in more places across the UK. We know we won't end homelessness overnight or on our own. But we take a lead, collaborate with others and together make change happen.

About the author

Dr Bethan Thomas is a Research Fellow attached to the Social and Spatial Inequalities Group (SASI) in the Department of Geography at the University of Sheffield. She has researched extensively on inequalities in Britain. Her publications include *The Grim Reaper's Road Map* and *Bankrupt Britain*. SASI conducts interdisciplinary research which contributes to an evidence base for policy development aimed at reducing social inequalities.

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Foreword

Too much discussion of health and social policy, too much measurement of its success and failure, appears, on occasion, to take place in a vacuum, untainted by the realities of the world at the time.

This study by Crisis is the first to estimate mortality for homeless people at a national level in England. This study is timely for several reasons. Firstly, because the numbers of homeless people and rough sleepers are once more on the rise. And, secondly, because its publication coincides with an NHS reorganisation that focuses attention on health inequalities.

The fact that the average age of death, emerging from the study, is in-keeping with previous, smaller scale studies carried out over the past 20 years, is both credible and shocking – there is little evidence that we are improving outcomes for the most vulnerable in our society. It is worth reflecting that virtually, every day, since 1948, the NHS has been said to be in crisis, and that for the last 64 years, morale within it has invariably never been lower. And yet, it is the most trusted and cherished national institution in our society. Such knowledge matters because it can ward off false despair – there is something we can do at this moment to respond to the indictment of these inescapable mortality figures for homeless people.

Specifically, the Health and Social Act includes a statutory duty at all levels in the NHS from the Secretary of State downward to 'have regard to the need to reduce health inequalities and commission accordingly'. In the NHS Outcomes Framework 2012/13, the first of five domains is 'preventing people from dying prematurely'. In the Public Health Outcomes Framework 2013/16, the vision is 'to improve and protect the nation's health and well-being, and improve the health of the poorest fastest', and Outcome 1 is 'increased healthy life expectancy', while Outcome 2 is 'reduced differences in life expectancy and healthy life expectancy between communities – through greater improvements in more disadvantaged communities'.

The timing for action has never been more propitious. This comprehensive study provides an urgent prompt that improving healthcare integration, access and outcomes for homeless people will be crucial to the NHS meeting its new duties.

Professor Aidan Halligan
Chair, Pathway Homeless Health Service
Chair, Faculty for Homeless and Inclusion Health, College of Medicine
Director of Education, University College London Hospitals

Main findings

- From the records of deaths in England between 2001-2009, 1,731 were identified as having been homeless people.[1] Of these 90% were male and 10% female whereas the gender split of deaths of the adult general population is 48% male and 52% female.

- Nearly a third of the deaths of homeless people identified from the records were in the London region.

- Homeless people are more likely to die young, with an average age of death of 47 years old and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women. It is important to note that this is *not* life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation.

- At the ages of 16-24, homeless people are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more likely to die than the general population, and 55-64 year olds one and a half to nearly three times.

- Drug and alcohol abuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths. Homeless people have seven to nine times the chance of dying from alcohol-related diseases and 20 times the chance of dying from drugs.

- 'Homeless men and women had similar mortality ratios for deaths due to alcohol, while for deaths due to drugs, men were seventeen times, and women thirteen times, more likely to die than the general population. Men were also more likely to die from cardiovascular problems than women

As these findings clearly indicate, being homeless is incredibly difficult both physically and mentally and has significant impacts on people's health and well being. Homelessness leads to very premature mortality and increased mortality rates. Ultimately, homelessness kills.

Introduction and method

This study investigates the mortality of homeless people in England for the period 2001-2009. It is a follow-up to previous research carried out by Crisis.[2]

It is the first research that attempts to analyse homeless mortality at the national level for all causes of death and how these differ from the general adult population. It looks at a wider dataset than previous studies which have been limited in that they have drawn solely on coroners' reports.

Despite the best efforts of homeless organisations and government initiatives over the last decade, homelessness is very much still with us; due to the combination of the continuing economic downturn and the coalition Government's cuts to welfare, particularly housing benefit, homelessness is on the rise again.[3] It is therefore important that we know what the health effects of homelessness are on the individuals concerned, with mortality the ultimate health effect. In addition to concern for the individuals affected by homelessness, poor health and mortality we need to consider the costs in health, welfare and other social

budgets that homelessness engenders.

The previous Crisis research, together with studies on homeless mortality undertaken in North America and Northern Europe, found that homeless people suffer high mortality rates and premature mortality. The average age of death in the research commissioned previously by Crisis was found to be 47 years in 1991-92 and 42 years in 1995-96. Research in the USA over the last 30 years has found an average age of death ranging from 41 to 51, and mortality rates 1.6 to 10 times that of the general population. In Denmark, studies in the 2000s found standardised mortality ratios ranging from 3.8 to 6.7 for homeless people compared to the general population.[4]

This study is the first that investigates the mortality of homeless people for all causes of death at the national level in England. It looked at national death records and matched the postcode given in each of them to the known addresses of homeless projects to ascertain the number of deaths that were likely, with varying degrees of certainty, to be attributed to homeless people. The ages and causes of death were analysed and standardised mortality ratios then constructed to draw comparisons between the circumstances faced by homeless people and those of the general population.

Almost by definition, it is difficult to count homeless people and it is also difficult to count deaths of homeless persons as death certificates do not record the deceased's housing status. When a death is registered however, the registration authorities do their utmost to link the deceased to an address. A rough sleeper might be linked to the last hostel at which they stayed or a day centre that they regularly used.

The research looked first at individual level mortality data for the years 2001-2009 supplied by the Office for National Statistics (ONS). The records of people aged over 16 were extracted and from this any death records that had a postcode that matched the postcodes of known homelessness projects obtained. These postcodes were further checked against the Royal Mail's Postcode Address File and the census headcount in order to ascertain whether each record could be of a homeless person or not. Advice centres and day centres were included in an attempt to include rough sleepers who might use such centres as a contact address. Due to the difficulties in disaggregating the postcode data, different scenarios were constructed (see full report for further explanation) reflecting differing probabilities of deaths being attributable to homeless people.

Using these methods, a dataset of 1,731 deaths were drawn from the 4,573,667 deaths recorded between 2001-2009. This dataset includes those who are definitely homeless and where there is a high probability that some of the additional deaths were of homeless people (the HP scenario as discussed in the main report). The analysis of the causes of death and standardised mortality rates are based on these records.

It is important to note that this research is based on estimates and will exclude some homeless people. For example, any homeless person's death that was not registered to a postcode containing homeless accommodation, or advice or day centre – e.g. they were registered at a previous address, a hospital, to parents or family, or in some instances, no address - would not be included in this research. This research also excludes domestic violence shelters due to suppression of postcodes and those who have previously been homeless but are now in their own accommodation. Given these caveats it is likely that this research underestimates the number of deaths of people who are and have been homeless.

Figure 1: Age distribution of deaths of general population

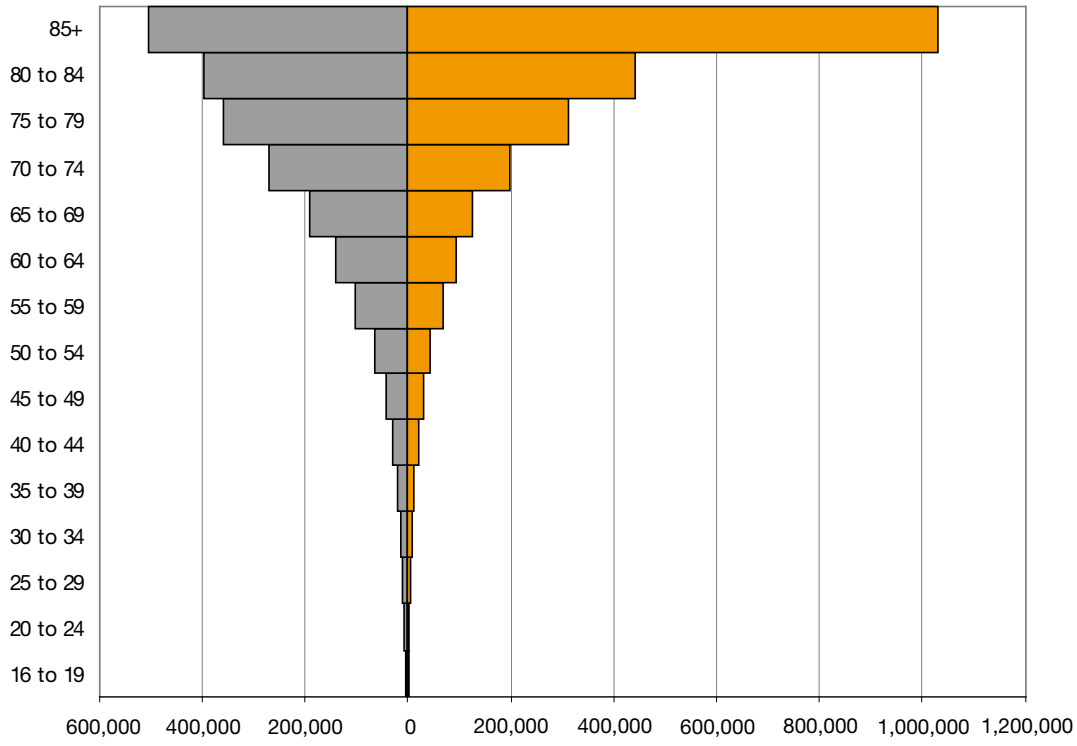

Figure 2: Age distribution of homeless people (scenario HP)

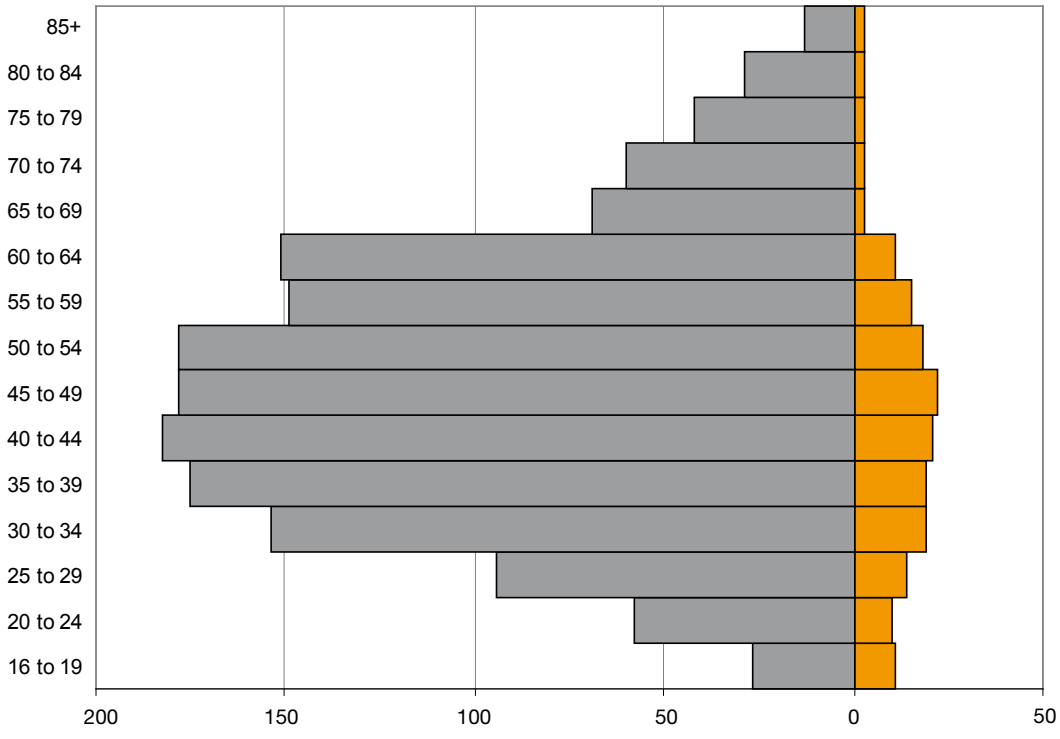

Figure 3: Distribution of causes of death for the general population

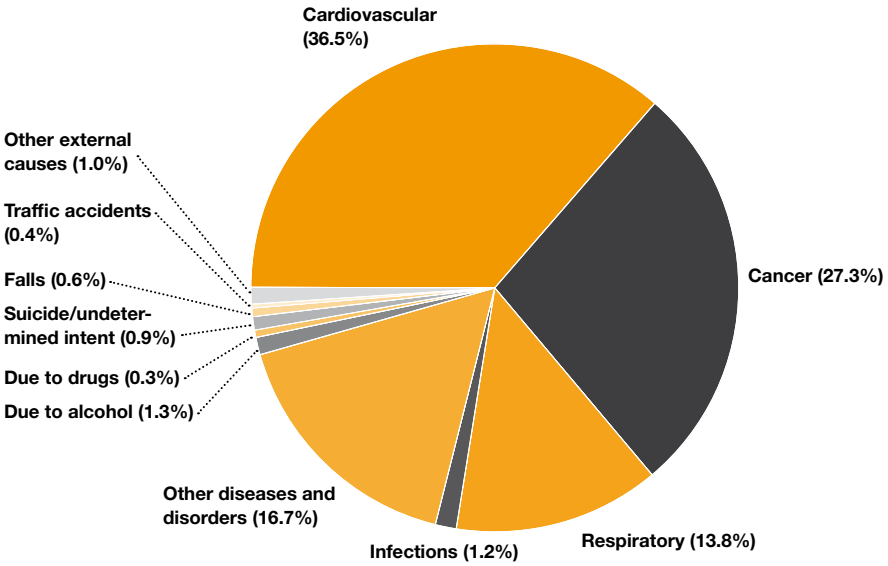

Figure 4: Distribution of causes of death for homeless people (scenario HP)

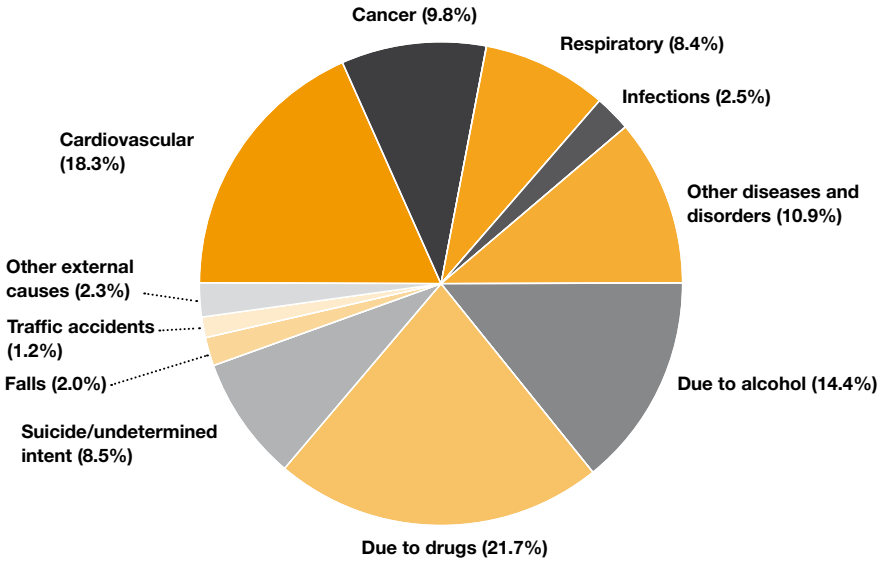

Table 1: Distribution of causes of deaths (scenario HP)

Distribution of causes of death	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorks & Humber
Cardiovascular	17.8	12.7	24.5	19.0	14.6	12.2	12.2	19.8	18.0
Cancer	6.7	5.9	11.8	11.0	10.7	9.4	7.7	12.6	3.3
Respiratory	8.9	9.8	8.8	10.0	10.2	6.1	7.7	9.2	5.7
Other diseases and disorders	15.6	14.7	15.0	*	10.7	10.8	11.5	17.4	13.1
Due to alcohol	8.9	11.8	16.3	17.0	14.1	15.5	14.7	12.6	11.5
Due to drugs	24.4	26.5	12.5	22.0	24.3	24.9	30.1	20.8	36.9
Suicide/ undetermined intent	10.0	7.8	6.9	11.0	11.2	13.1	9.0	4.3	7.4
Other external causes	7.8	10.8	4.3	*	4.4	8.0	7.1	3.4	4.1

Note: * denotes data suppressed to comply with data disclosure rules.

While this study has its limitations in that it does not cover all typologies of homelessness, and because of the difficulties in estimating homeless mortality, it adds significantly to previous research on British homeless mortality and adds to the international literature.

Regional analysis

Nearly a third of the deaths of homeless people identified from the records were in the London region (30.9%), which would reflect the preponderance of homelessness in all its forms in the capital. Outside London the regions with the highest numbers of deaths were the South East (12.3%), the North West (11.9%) and the West Midlands (12%).

As the table above shows, London has a very different distribution of homeless deaths from the other regions, particularly for deaths from cardiovascular causes and due to drugs. In the capital a quarter of homeless deaths were from cardiovascular causes, compared with just under a fifth nationally. Deaths due to drugs account for an eighth of all homeless deaths in London compared with a fifth nationally. This might reflect differences in the homeless population in the capital with a relatively lower proportion of those with the highest and multiple needs.[5]

Standardised Mortality Ratios (SMRs)

Because age and sex has a bearing on death, crude death rates alone cannot be used to fully explain patterns of mortality. Different locations have different age-sex structures and the homeless population is very different in its demographic structure from the national pattern. In order to address the need to examine variations in mortality and carry out a more sophisticated analysis we use indirect age-sex Standardised Mortality Ratios (SMRs), based on deaths under age 65.

SMRs are a means of measuring mortality which take into account the age structure of the population being considered. They are calculated using a standard set of age-specific death rates which are used to determine how many deaths could be expected in a particular population, given its size and age structure. This gives a total number of 'expected' deaths. This figure is then compared with the actual number of 'observer' deaths which did occur.[6]

Main findings using SMRs

- Homeless people aged 16-24 have twice the chance of dying as the general population; those aged 25-34 four times; aged 35-44 year olds five times; aged 45-54 to three times; and aged 55-64 one and a half times the national risk.

- The under 45s have four times the chance of dying than their housed contemporaries, the under 55s three and a half times, and the under 65s two and three-quarter times.

Table 2: Standardised Mortality Ratios (SMRs) for all causes of death by age-group (HP scenario)

Age	SMRs
Age 16-24	200
Age 25-34	418
Age 35-44	513
Age 45-54	305
Under 45	397
Under 55	361
Under 65	279

- For selected causes of death homeless people have even higher mortality ratios compared to the general population:

  > The chances of homeless people dying from alcohol-related causes are seven times higher than for the general population. The average age of death for homeless people from alcohol is 48, slightly below the national average of 51.

  > The average age of death of homeless people due to drugs is 34, very similar to the national average age of 35. The chance of dying from drug-related causes is 20 times higher for the homeless population compared to the general population.

  > The average age of homeless people committing suicide (or where the intent was undetermined) is 37 compared to the national average of 46. Homeless people are three and a half times more likely to commit suicide than the general population.

  > Homeless people have nearly seven times the chance of dying from HIV and hepatitis than the general population.

  > Homeless people have three times the chance of dying from chronic lower respiratory diseases than their housed

contemporaries, with an average age of death of 56 compared to 76.

> Homeless people are twice as likely to die as the general population to die from heart attacks and chronic heart disease, at an average age of 59 – 16 years lower than the 75 of the general population.

> Homeless people have seven times the chance of dying from falls than the general population, with an average age of death of 45 compared to 77.

Table 3: Average age of death and SMRs for cause of death (HP scenario)

Cause	SMRs for homeless people	Homeless people	General pop.
Alcohol	710	48	51
Drugs	1971	34	35
Suicide	340	37	46
HIV & Hepatitis	682	41	
Respiratory	306	56	76
Heart attacks	190	59	75
Falls	716	45	77

Underlying causes

This study has focused on the actual mortality figures and has not looked in detail at what might lie behind them. Clearly, however, being homeless precludes a healthy lifestyle. Poor sleep quality, inadequate diet, difficulty in maintaining personal hygiene, and problematic access to health care and maintaining a treatment regime can lead to sub-optimal health. Additionally, many homeless people have alcohol, drug, or mental health problems, often multiple, that can lead to neglect of, and exacerbate, any physical health issues. These issues, in themselves, often lead to premature death.

Smoking, alcohol and drugs in turn increase the risk of respiratory, cardiovascular disease and cancer. As well as being direct causes of death, they also contribute to the premature deaths of the older age group who survive the immediate risks of smoking, alcohol and drugs, but later succumb to longer term effects.

Finally other research evidence and the experience of those working with homeless people is clear that poor health is exacerbated by limited access to appropriate health services and limited integration between services. The poor outcomes homeless people often experience from the health service mean that health conditions are not always treated effectively and can in turn lead to worse conditions developing.

Implications for public policy and recommendations

The findings of this research highlight the shocking truth about how homeless people are being failed by the health system. The upcoming restructure and reform of the NHS provides an opportunity to tackle this and create a health service that truly works for homeless people.

The Health and Social Care Act will bring about a huge restructure of the NHS. Primary

Care Trusts are being abolished, with commissioning budgets and responsibilities handed over to Clinical Commissioning Groups (CCGs) made up of GPs and hospital staff. Local Health and Wellbeing Boards will oversee healthcare provision in their areas and local authorities will hold a ring fenced public health budget. At a national level, the NHS Commissioning Board will oversee the delivery of the Government's outcomes framework across the whole system and the Secretary of State for Health will have a new legal duty to reduce health inequalities throughout the NHS.

The new structure presents both challenges and opportunities. There is a real risk that in the face of pressure to demonstrate outcomes and the proposed payment by results system, CCGs will find it difficult to provide services for homeless people. This could be exacerbated by an unprecedented budget squeeze on the NHS. Longstanding problems with the system remain, such as the lack of specialist drug and alcohol services, and a lack of coherence and consistency over integration, access and outcomes for homeless people both within the health service and in how it interacts with housing and other services.

However, localised commissioning does have the potential to make sure services are more responsive to the needs of their communities. For this to work, analysis, planning and delivery must take account of the needs of the whole community, including marginalised, mobile and vulnerable groups such as homeless people. Perhaps most significantly, the new duty will enshrine in law for the first time a commitment that health outcomes for the most vulnerable will be prioritised.

This research points to a series of recommendations to improve the healthcare that homeless people experience generally and in the context of the new NHS structure.

1. **The restructure of the NHS should ensure the health needs of homeless people are a priority**

   The mortality rates faced by homeless people make the new duty to reduce health inequalities all the more important. The NHS national commissioning board should take a lead on commissioning specialist services. Health and Wellbeing Boards should include representatives from the housing and homelessness sectors who can advise on the links between health care and housing and homelessness. Homelessness should be considered as part of the Joint Strategic Needs assessment. The Care Quality Commission should review the standard of healthcare homeless people experience and make recommendations for improvement.

2. **The delivery of mainstream health services should be reformed to meet the needs of homeless people.**

   Primary health services should be flexible and responsive to the needs of homeless people, including ensuring vulnerable groups and those without a permanent address are easily able to register with GPs and through providing out of hours or drop in services. Accident & Emergency departments and providers of secondary health services should ensure that homeless people receive appropriate care, building on the work of approaches such as that undertaken by Pathway to ensure that they are linked in with homelessness services and that all patients are discharged properly and with secure accommodation to go to.

3. **Specialist services should be protected and improved**

   There are some strong services in parts of the country, such as GP surgeries and the Find and Treat tuberculosis service, which have developed a specialism in working

with homeless people. These and the funding they rely on should be protected in the reorganisation of the NHS. The experience they have developed should be built upon to commission further specialist services. In particular, there has long been a need for far more drug and alcohol and dual diagnosis services.

4. Services should reflect the demographics of homeless people

Services should be tailored to the demographic needs of the local homeless population. Socio-cultural beliefs can affect homeless people's approach to and behaviour regarding substance use so it is important to take account of cultural background, for example when delivering drug and alcohol services.

5. Prevent and resolve homelessness

The research is clear that homelessness quite literally kills. Accommodation needs to be provided alongside health services. More needs to be done to prevent people becoming homeless in the first place as well as supporting people to break out of homelessness. Local authorities and other homelessness services should take account of the specific needs of young homeless people, ensuring help and accommodation offered is age appropriate, and statutory duties to support and house 16 and 17 year olds and young care leavers are fulfilled. It remains a shocking fact that there is no right to shelter in England. Crisis has long argued that the support offered to single homeless people should be improved, through strengthening the duty to provide homelessness assistance, advice and accommodation for all homeless people, not just those currently considered in 'priority need' to ensure no-one can be turned away when they seek help.

Endnotes

1. This figure of 1,731 is based on the HP scenario which includes those that were definitely homeless and a high probability that some of the additional deaths were of homeless people.

2. In 1991-92 called *Sick to death of homelessness* and in 1995-96 called *Still dying for a home*.

3. Fitzpatrick. et al. (2011) *The Homelessness monitor Tracking the impacts of policy and economic change in England 2011-2013 Year 1: Establishing the baseline*, London, Crisis

4. Centers for Disease Control and Prevention (CDC) (1987), 'Deaths among the homeless in Atlanta, Georgia', *MMWR*, 36:297-299; CDC (1991), 'Deaths among Homeless Persons: San Francisco', *MMWR*, 40: 877-880; Hanzlick, R & Parrish, R.G. (1993), 'Deaths among the homeless in Fulton County, GA, 1988-90', *Public Health Reports*, Jul-Aug, 108(4): 488-491; Hibbs, J.R, et. al. (1994), 'Mortality in a cohort of homeless adults in Philadelphia', *NEJM*, 331(5): 304-309; O'Connell, J.J. (2005), *Premature Mortality in Homeless Populations: A Review of the Literature*, Nashville: National Health Care for the Homeless Council; Barrow, S.M. et al (1999), 'Mortality among homeless shelter residents in New York City', *AJPH*, 89(4): 529-534; Nordentoft, M. & Wandall-Holm, N. (2003), '10 year follow up study of mortality among users of hostels for homeless people in Copenhagen', *BMJ*, 327(7406): 81; Nielsen, S.F, et. al. (2011), 'Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study', *The Lancet*, 377(9784): 2205-2214.

5. See Fitzpatrick, S. Johnson, S., and White, M. (2011) 'Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections', *Social Policy & Society,* 10:4, 501-12.

6. ONS (2008), *Standardised Mortality Ratios - the effect of smoothing ward-level results* London: ONS.

7. Pathway is a model of integrated healthcare for single homeless people and rough sleepers. More information is available at www.londonpathway.org.uk

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