

Homelessness: A silent killer

A research briefing on mortality amongst homeless people

December 2011

CRISIS

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Summary

This briefing draws on and sets out the interim findings of a study investigating homeless mortality¹ in England.

Key points:

- The average age of death of a homeless person is 47 years old and even lower for homeless women at just 43, compared to 77 for the general population.
- 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 are over 9 times more likely to commit suicide than the general population
- Deaths as a result of traffic accidents are 3 times as likely, infections twice as likely and falls over 3 times as likely.
- Being homeless is incredibly difficult both physically and mentally and has significant impacts on people's health and well being. Ultimately, homelessness kills.

Despite improvements in the health of the general population over the last 15 years, the average age of death for homeless people still remains shockingly low at just 47 years old, and with the average age for homeless women being even lower at 43. This compares to an age of 77 for the general population.²

As might be expected, the causes of death for homeless people differ from those of the wider population. Whilst disease causes the vast majority of deaths amongst the general population, homeless people are more likely to die from external causes. There are much higher incidences of suicide and deaths as a result of traffic accidents, infections and falls are also more common.

It is a stark fact that drugs and alcohol are major causes of death amongst homeless people. The links between drug and alcohol abuse and homelessness are well established³ and drugs and alcohol are known to be both a cause and consequence of homelessness. Four out of five people start using at least one new drug since becoming homeless.⁴

The study paints a bleak picture of the consequences of homelessness and the extremely detrimental impact it can have on people's health and well being. Ultimately, it shows that homelessness is killing people.

This needs to be a wake up call. Homeless people are amongst the most vulnerable in our society and it is clear that despite significant investment in the NHS and improvements in homelessness services they are not getting the help they need to address their health issues. Government must do more improve the health of single

¹ The study looks at the mortality of single homeless people which includes those sleeping rough, in hostels and in other hidden homeless situations

² In the same time frame and using the same methodology between 2001-2009

³ For example, of rough sleepers in London, 53% have problems with alcohol and 39% with drugs (from the CHAIN database (Broadway)

⁴ Crisis (2002) *Home and Dry*

homeless people and to ensure that they and the specialist services they need are a priority in the restructuring of the NHS.

But this alone is not enough, with homelessness rising, far more needs to be done to stop people becoming homeless in the first place. Government must act now to ensure that help is available to all homeless people who need it when they need it and that no one is left with no option but to sleep rough.

Background to the research

Crisis last commissioned research on homeless mortality in 1996⁵, until now the most recent study on this issue. Given the significant changes in both homelessness and the NHS since 1996, we believed it was timely to reconsider the health and mortality of homeless people.

This new research, carried out by Dr Bethan Thomas from the Geography Department at the University of Sheffield on behalf of Crisis, estimates the average age of death not just for rough sleepers (as previous studies have) but for the wider homeless population, including those who reside in night shelters and homeless hostels.

This study investigates homeless mortality in England for the period 2001-2009. It draws on a number of different datasets to identify the death certificates of homeless people and from this ascertains ages and causes of death (for more information see appendix on methodology). The initial findings of this study fit with previous studies looking at homelessness and health.

The next phase of the research will investigate cause of death by age and analyse more detailed causes of death. It is hoped that mortality by different accommodation type and area can also be investigated. The full research report will be published in summer 2012.

⁵ Grenier P (1996) *Still dying for a home*, Crisis

Age of Death

The interim findings clearly show that the average age of death, whether mean or median, is far lower for homeless people. Homeless people die on average 30 years before the general population.

Table 1: Mean and median age of death for each of the categories

Dataset	Men		Women		People	
	mean age of death	median age of death	mean age of death	median age of death	mean age of death	median age of death
General population	74	77	80	83	77	80
Homeless population ⁶	48	47	43	42	47	46

For all homeless people the mean age of death is 47 and for homeless women it is even lower at only 43.

It is surprising that the average age of death for women tends to be lower than for men as generally women have a longer life expectancy. The full report will consider the reasons behind this in more detail but some possible explanations could be that not all homeless women have been identified in this study, in particular because domestic violence refuges are not included, or that homeless women survive less well on the streets than men.

The following graphs show the age distribution at death of the general population (Figure 1) and the homeless population (Figure 2). In each graph, the men are on the left and the women on the right. In the general population as we would expect, there are few deaths of young people, the numbers increasing with increasing age. Male deaths outnumber female deaths until the 80-84 age band, reflecting male lower life expectancy.

The graph showing the distribution for the homeless population (Fig. 2) has a dramatically different shape to that for the general population. There are far fewer female deaths, the majority being male, and the majority of deaths being at much younger ages, particularly from 30 to 64.

⁶ In this study this means these are deaths of people who are definitely homeless and where there is a high probability that some of the additional deaths were of homeless people (for more details see appendix on methodology)

Figure 1: Age distribution of deaths of general population

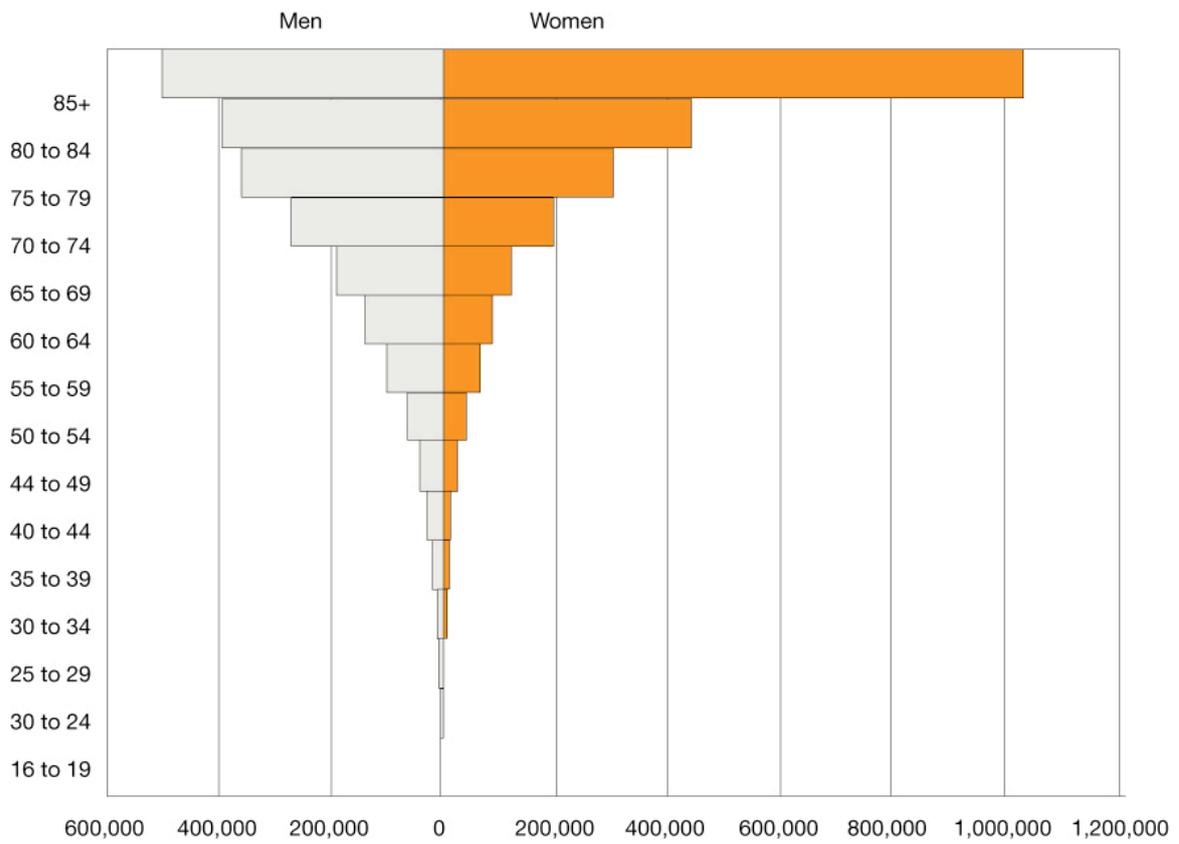
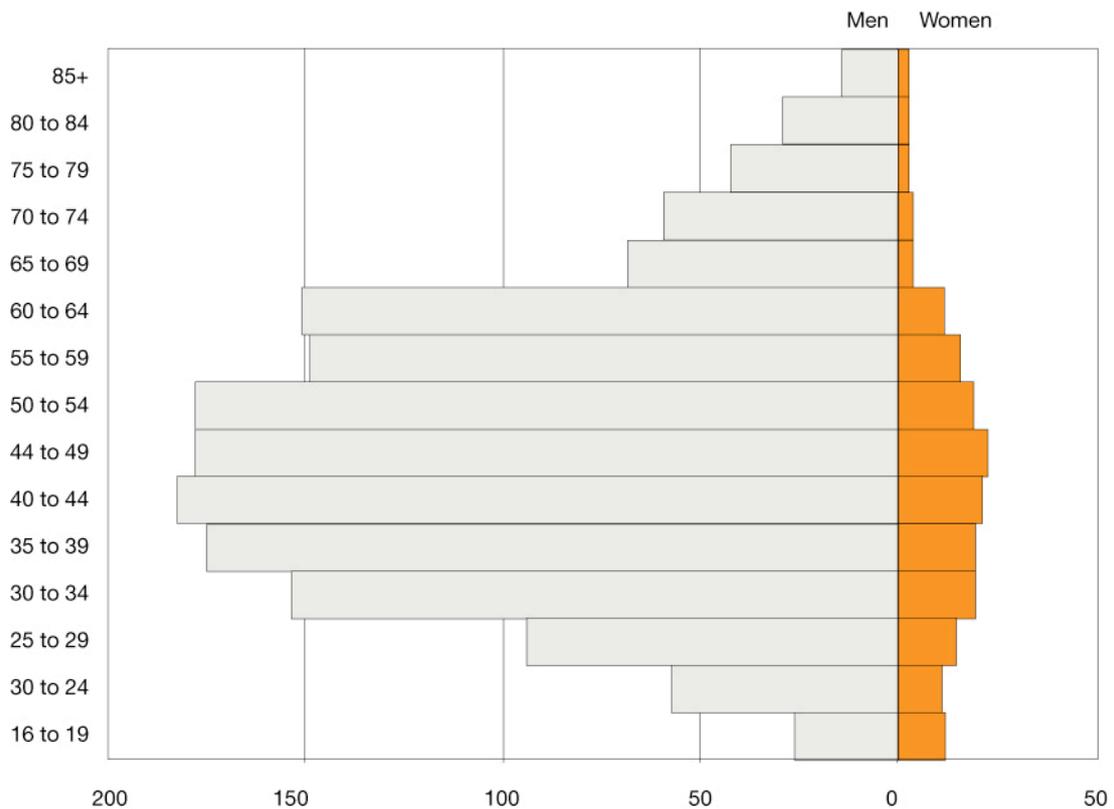


Figure 2: Age distribution of deaths of the homeless population



Causes of death

The distribution of causes of death for the general population is shown in Pie chart 1. As would be expected, the majority of deaths are from diseases, with cardiovascular disease and cancer accounting for nearly two thirds of deaths.

The distribution of causes of death for the homeless population is graphed in Pie chart 2 and it can be seen that the distribution is very different from that of the general population.

It is clear that homeless people are far more likely to die from external factors than the wider population. Whilst cancer and cardiovascular disease again feature prominently as causes of death, there are far lower incidences of these deaths than in the general population. This is unsurprising given that homeless people tend to die at a younger age and these diseases are frequently associated with old age.

There is a high proportion of deaths due to drugs and alcohol, which together account for over a third of all homeless deaths. Problems with drugs and alcohol are often a contributing factor to someone becoming homeless, conversely problems with drugs and alcohol can develop as a response to homelessness, as people use drink and drugs as a coping mechanism to deal with the harsh realities of being homeless.

Four out of five people start using at least one new drug since becoming homeless.⁷ Alcohol and drugs can be used by homeless people as a coping mechanism, as a way of dealing with cold and pain and as way of escaping from a very harsh existence. It is unsurprising then that homelessness can cause or exacerbate drug and alcohol use.

Many homeless people who abuse alcohol or drugs also have mental health problems ('dual diagnosis') and substance related problems "are often a symptom of acute and multiple underlying needs"⁸.

It is also far more difficult for people to address their drug or alcohol problem whilst homeless. 40% of homeless alcohol users believe that a lack of stable housing is the main barrier to their recovery.⁹

Rates of suicide amongst homeless people are also far higher. Homeless people are over 9 times more likely to commit suicide than the general population. We know that homeless people have much higher rates of mental health problems than the general population. The homeless population has twice the levels of common mental health problems when compared to the general population and psychosis is 4-15 times more prevalent.¹⁰

Mental ill health should be considered to be both a cause and a consequence of homelessness. Mental health problems often lead to homelessness – people can become unable to cope with day to day life and sustain their tenancies. Homelessness in turn is an isolating, lonely experience which erodes confidence and self esteem which can cause or exacerbate mental health conditions.

⁷ Crisis (2002) *Home and Dry*

⁸ Grenier P (1996) *Still dying for a home*, Crisis

⁹ Homeless Link (2009) *Drugs and Alcohol Policy Briefing*

¹⁰ Rees S (2009) *Mental ill health in the adult single homeless population*, Crisis

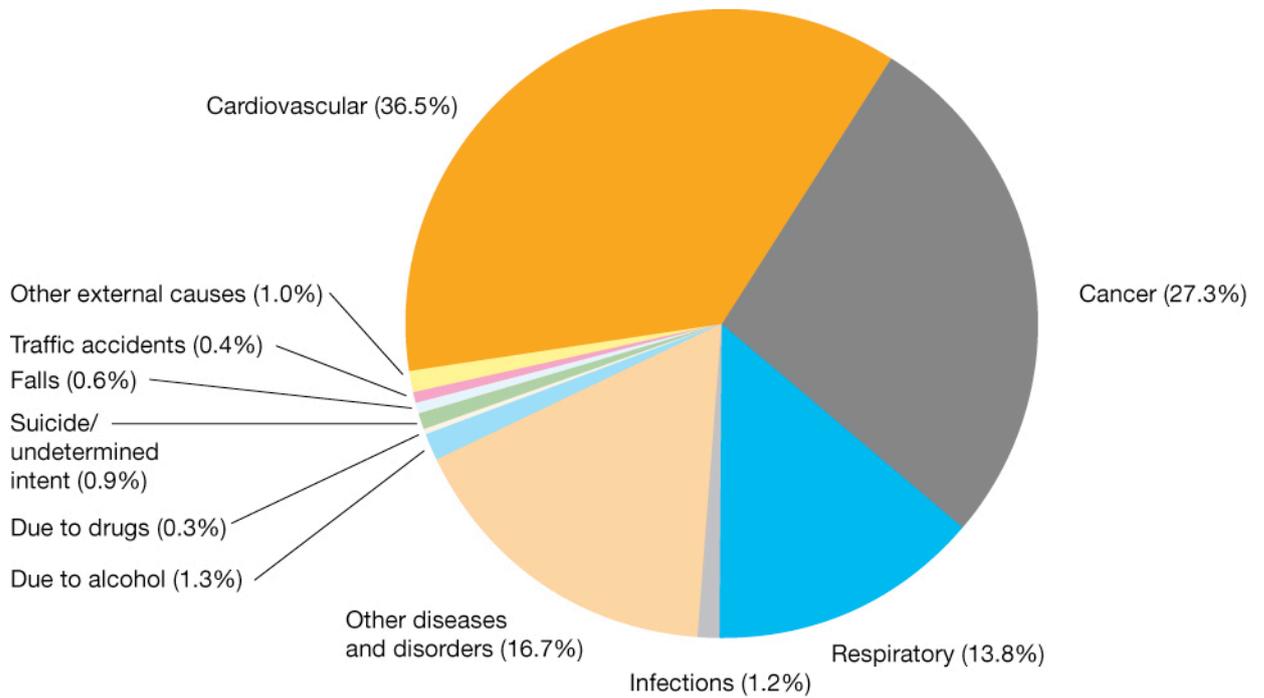
Homeless people are also more likely to die as a result of other external factors such as traffic accidents (3 times as likely), infections (twice as likely) and falls (over 3 times as likely).

This study clearly shows that homelessness plays a significant role in the health and mortality of homeless people.

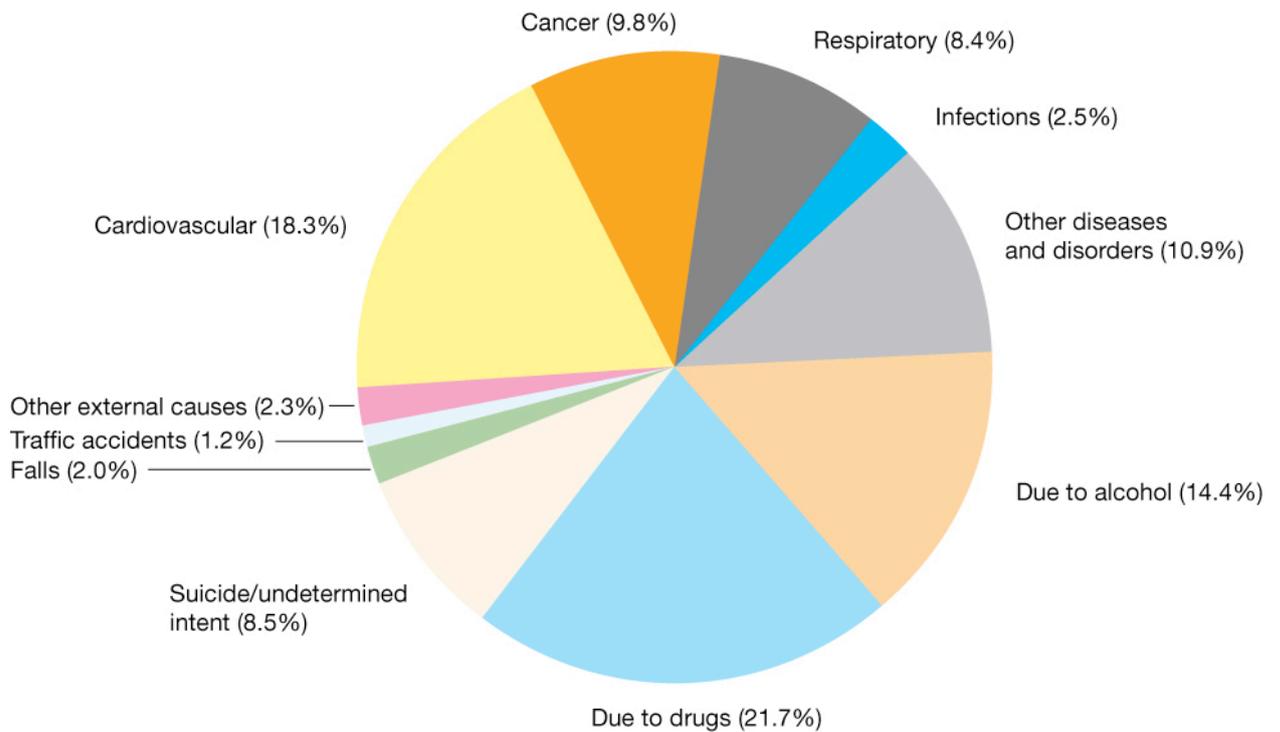
It is still the case that despite overall improvements in the NHS, homeless people are not getting healthcare which meets their needs and there are real gaps in health provision for homeless people. Mainstream services too often do not work for homeless people as they lack flexibility and can be difficult to access. At the same time whilst there are some specialist services, these are far from universal, are often oversubscribed and many are in danger of losing their funding.

It is also apparent that homelessness is itself a factor in poor health and death. We must therefore ask why people are still becoming homeless and what can be done to prevent it. It is well established that one significant issue is that too many homeless people are turned away when they approach their local authority for help. The failure of local authorities to address the basic housing needs of applicants can cause single homeless people to fall into rough sleeping and a situation where significant health issues develop.

Pie chart 1: Distribution of causes of death for the general population



Pie chart 2: Distribution of causes of death for homeless people



Recommendations

Between April 1997 and March 2011 spending on the NHS grew from £46 billion to £132 billion.¹¹ This increase is not only much larger than in past decades, but has also been more sustained than previously. Whilst this has brought real improvement to the health of the general population, homeless people's health has remained persistently poor and homeless people continue to die at a far younger age.

As well as the tragic consequences for individuals, there are also significant financial implications. The cost of acute services for the hostel population alone is estimated at £85 million per annum for 40,500 people¹². This equates to over £2,100 per person per year and is probably an underestimate.

It is clear that more needs to be done to tackle the health inequalities that persist for homeless people.

Recommendation 1: Steps must be taken to improve homeless people's health

- a) **The restructure of the NHS must prioritise the needs of homeless people**
 - We welcome the new duty placed on the Secretary of State to reduce health inequalities but believe this duty should extend to commissioning consortia who must specifically recognise the health needs of homeless people.
 - Homeless people should be a priority for the new NHS commissioning board not least as localised commissioning with an emphasis on competition and financial accountability means that costly, specialised services are unlikely to be a priority. Services such as GP practices, homelessness and mental health teams and TB services should continue to be funded.
 - Health and Wellbeing Boards must include representatives from the housing and homelessness sectors who can advise on the links between health care and housing and homelessness.
- b) **Reform health service delivery for homeless people**
 - Mainstream healthcare services such as GP surgeries should be reformed to remove the barriers which homeless people face to accessing their services, such as making it easier to register without a permanent address and providing more out-of-hours and drop-in services.
 - Health provision and information should reach out to and be made available within existing homelessness services such as hostels and day centres in order to reach homeless people more effectively.
- c) **Ensure provision meets needs and is integrated and holistic**
 - Physical and mental health services need to be joined up to provide a holistic approach to meeting the specific needs of homeless people
 - There must be an increase in the number and type of drug and alcohol treatments available as well as specialist services for those with 'dual diagnosis' of mental health and substance misuse
 - More services should be provided for homeless people who continue to use drugs and alcohol, in order that their drug use does not remain hidden and so that interventions – including harm reduction initiatives – can be implemented.

That homeless people die at such a young age is a tragedy. That homelessness could be easily prevented and is not is a scandal. As well as addressing the health of

¹¹ Office of Health Economics (2011) *Total health care expenditure, UK, 1973/74 - 2010/11*

¹² Healthcare for Single Homeless People (2010) Office of the Chief Analyst, DH

people who become homeless, we must prevent people from being homeless in the first place.

Recommendation 2: Change the law so that all single homeless people have the right to meaningful written advice and assistance and emergency accommodation when they need it

It is shocking that in the 21st century there is no right to shelter - a single homeless person can approach their council for help and still be turned away to sleep on the streets.

Under the existing law, most single homeless people are not considered a priority for housing. They should still get meaningful advice and assistance but too often this doesn't happen and people can be turned away with little or no help and no solution to their housing crisis.

As the first place that many turn, councils are in a unique position to assist people out of homelessness. When they fail to do so, those in need of help can be left with nowhere to go and can quickly spiral deeper into homelessness, causing health problems to develop or be exacerbated and ultimately resulting in people's deaths.

With homelessness rising, we need action now. Unless they have a legal duty, local authorities will never take the action they need to. Crisis believes that the law must be changed so that all single homeless people have the right to receive written advice, real assistance and emergency accommodation when they need it.

As this research shows, homelessness kills and so preventing or resolving it can quite literally save lives.

Appendix: Methodology

This study, by Dr Bethan Thomas from the Geography Department at the University of Sheffield, differs from previous studies in that it attempts to estimate mortality among homeless people for all causes of death. It looks at a wider dataset than previous studies which have been limited in that they have drawn solely on coroners' reports.

The research investigates the mortality of homeless people in England for the period 2001-2009.

Almost by definition, it is difficult to count homeless people and it is not possible to reliably estimate mortality for the previously homeless who have now found secure accommodation and so to discover what the long term effects of a period of homelessness might be. It is also difficult to count deaths of homeless persons. Death certificates do not record the deceased's housing status¹³.

A number of datasets were used to undertake the analysis:

- A dataset of homeless projects comprising accommodation, advice centres and day centres supplied by Homeless Link
- Individual level mortality data for the years 2001-2009 supplied by the Office for National Statistics (ONS).
- The Royal Mail Postcode Address File (PAF). This is the definitive listing of postcodes in the UK. For every postcode, it gives each delivery address, and also what businesses (if any) are there.
- The Census 2001 postcode headcount. This gives the number of people, men, women and households for each postcode in the UK.

When a death is registered, 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 use.

The Homeless Link projects accommodation postcodes were checked against the PAF to ascertain the actual postcode for the location of the accommodation and not, for example, a referral address. Advice centres and day centres were included in an attempt to include rough sleepers who might use such centres as a contact address. Domestic violence shelters have their postcodes suppressed so have been excluded.

From the mortality dataset, the records of people aged over 16 (the general population) were extracted and from this an extract was made of the death records that had a postcode that matched the Homeless Link project postcodes. These postcodes were checked against the PAF and the census headcount in order to ascertain whether each record could be of a homeless person or not.

Some of the matching was simple: there was only 1 address at that postcode and hence any deaths at that postcode must almost certainly have been of a homeless person. Where there is only one homeless project address to a postcode it is generally of a large hostel, such as Salvation Army hostels, or other large accommodation projects such as foyers. Where there are multiple addresses to a postcode the matter is more complicated.

Much of the accommodation for homeless people is targeted at specific age groups so any deaths outside of the age range would not have been of homeless persons, although deaths just outside the age range were included as possible homeless

¹³ Keyes and Kennedy, 1992

deaths. For example, if a postcode contains a foyer for 16-25 year olds, as well as other households, any deaths of older people would not have been homeless deaths; however the death of a 26 year old would be flagged as a possible. Similarly, where accommodation was sex specific any deaths of the opposite sex could be excluded.

The study this briefing draws on is based on the dataset of 1,731 deaths of those who are definitely homeless and where there is a high probability that some of the additional deaths were of homeless people. It is likely that many more of the death certificates corresponded to homeless people but this briefing has focussed on those where there is a greater degree of certainty that the individual was homeless. The full report will explore this in further detail.

About the University of Sheffield

Founded in 1905, the University of Sheffield is one of the UK's leading Russell Group universities with an outstanding record in both teaching and research.



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.

Our innovative education, employment, housing and well-being services address individual needs and help homeless people to transform their lives. We measure our success and can demonstrate tangible results and value for money. 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.



For more information, please contact:

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