In search of good data. But do we understand homeless mortality better? A review of two Irish reports on the deaths of people experiencing homelessness

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Interim Report on Mortality in Single Homelessness Population 2020, by O'Carroll, A. (2021) Dublin: Dublin Region Homeless Executive https://www.homelessdublin.ie/content/files/Interim-Report-on-Mortality-in-Single-Homeless-Population-2020-Dr-Austin-OCarroll.pdf

Deaths among people who were homeless at time of death in Ireland, 2019, by Lynn, E., Devin, J., Craig, S. and Lyons, S. (2023) Dublin: Health Research Board. https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2023_Publications/12726_HRB_Deaths_among_homeless_people_Statlink_11_FA_WEB.pdf

(since writing of this review, a new report with figures from the 2020, was published by the HRB and these data will be published annually going forward)

Introduction

Deaths of people experiencing homelessness usually remain hidden from the public view. If they appear in the news, it's most probably some shocking case or a single figure that was tallied by some grass-roots initiative. Homeless mortality is an under researched subject both in health and in social sciences. This comes as a result of the fact that there are no systematically collected data in most high-income countries. This search for data that wasn't there, was captured in the UK, for instance, by an investigative journalist Maeve McClenaghan a few years back (2020). A large part of the knowledge about homeless mortality, usually from the public health perspective, is based on some linking of administrative databases,

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which is not always possible. And we still don't know enough and there are many studies that collect own data, hand sift through cemetery records (Olech et al. 2021), interview people queued to the soup kitchen (Cheung and Hwang 2004), hand-check shelters' postcodes (Thomas 2012) and rely on data crowding (Homeless Deaths Count).

Ireland has some of the most interesting data on homelessness. Thanks to the PASS system, longitudinal data about individuals and families accessing "homeless" accommodation is collected. Also, the Health Research Board is undertaking systematic annual data collection concerning the deaths of people experiencing homelessness. Hardly any constituency in the high-income world is doing that. Recently two reports on homeless mortality in Ireland were published. This is a review of these two studies. Additionally, the aim of this piece is to show some of the challenges of quantitative research in that field and to reflect on researching homeless mortality in general.

There is an increasing number of people accessing emergency accommodation in Ireland (see monthly government reports: Homelessness Data 2023). Both studies under review here were commissioned and conducted following a concern that the number of homeless deaths in Ireland may be increasing, that it is not a well-understood phenomenon, and that it is crucial to identify what can be done in order to prevent deaths of people who experience homelessness.

First, there is a report requested by the Dublin Region Homeless Executive (DRHE), Dublin City Council's authority, and conducted by Austin O'Carroll published in 2021 (from now on O'Carroll's report). Second, a study commissioned by the Department of Health and conducted by the Health Research Board, which was published in 2023 (here HRB report) and authored by Ena Lynn, Joan Devin, Sarah Craig, and Suzi Lyons. The HRB is a government agency responsible for funding, co-ordination, and oversight of health research. O'Carroll's study is called "interim" due to unavailability of some data at the time of writing. The HRB report is called a "feasibility study", as I understand it, to also explore the future possibilities of ongoing systematic data collection and which has been agreed from 2020 onwards. Although there were some previous efforts to map homeless mortality in Ireland, present studies show, that this task is still in its initial stage.

O'Carroll's study

O'Carroll's report was an attempt to gather robust data about deaths occurring while people were experiencing homelessness. Data on people accessing Temporary Emergency Accommodation (TEA), Supported Temporary Accommodation (STA), and Private Emergency Accommodation (PEA) in Dublin were taken into account, as well as on rough sleepers registered by the DRHE. Calculations were made for the year 2020 but also for 2016-2019 by ways of comparison. O'Carroll does an excellent job presenting the data, explaining why certain cases are excluded, how indicators are calculated and what they mean.

In total 47 cases were identified. Data on age, sex, type of accommodation, duration of homelessness, and location of death was available. Since the data came from DRHE, no causes of deaths were reported. Crude Mortality Rates (CMR) were calculated and compared (more on that further below). Findings are in line with what we know from literature and previous Irish studies – people experiencing homelessness die young and prolonged homelessness leads to increased risk of death.

O'Carroll sets several recommendations that are based more on literature and the general knowledge about Irish homelessness, and less on the data that was analyzed here. For instance, interventions that could reduce mortality include: adopting a multi-agency response, improving access to care, mental health services and overdose prevention programs. With regards to research, O'Carroll suggests activities on different levels of analysis: aggregate data reporting, individual death analysis, and a critical incident review that could be used to put the mortality data to better use. It is implied, in my opinion, that none of this was really happening in the Irish context at the time of writing this report.

HRB report

The HRB report was published in 2023 used the 2019 deaths data. Data was drawn from coronial files, which pertains to all sudden and unexpected deaths which occur, including violent deaths caused by accidents, suicide, overdose etc. From these the deaths of all individuals that occurred in 2019 while experiencing homelessness were selected. The definition of homelessness was assigned by HRB researchers from the information available in the coronial files and classified into one the four categories: (1) without accommodation, e.g., rough sleepers, (2) temporary or crisis accommodation, (3) severely substandard or highly insecure accommodation, and (4) homeless in an unknown situation. Data was collected using the National Drug-Related Deaths Index (NDRDI) methodology.

More variables were available here than in O'Carroll's report. Crucially, cause of death was reported. Thanks to the NDRDI, also other variables concerning addictions and mental health problems were accessible. They especially concerned history of addictions, data from toxicology reports, contact with treatment and mental health services, records of other illnesses and some socio-demographic data as well.

There were 84 deaths identified in 2019. Most individuals had a history of substance abuse. More than 38% had mental health problems. A proportion were known to have epilepsy, some were not following treatment. Fifty deaths took place in Dublin, thirty four in a public space.

The authors call for more research, they see potential in linking existing data sets, especially linking homelessness data bases, such as PASS, with the NDRDI. Also, a number of policy recommendations conclude the report: increase provision of addiction services, trauma-informed and sex-specific mental health services, more focus on epilepsy; provide better harm reduction measures such as supervised injection facilities, naloxone training etc.

Is a comparison even possible?

If I wanted to learn more about the deaths of people experiencing homelessness in Ireland, I would obviously take both reports into account. On the face of it, some findings are similar – the total numbers of deaths (47 in Dublin, 84 in the whole country), very low mean (or median) age of death (respectively: 43 and 40 years).

There are differences in numbers between these two reports and data that come from the same year (2019). Of course, the HRB looked at the whole of Ireland while O'Carroll at Dublin. O'Carroll finds 3 rough sleepers who died in 2019 and 8 people who died outdoors (not the same cases, however an overlap possible). Fifty out of 84 deaths in the HRB report occurred in Dublin, 40.5% of all deaths occurred in a public space, public building etc. There is no way to tell from the report how many deaths occurred "outdoors" in Dublin, but likely more than 8; there were 18 deaths of people categorized as "rough sleepers". As different methodologies were used and crucially the HRB report had access to the final coronial record then clearly comparisons may be difficult.

Table 1. A comparison of crucial elements of the two studies

	O'Carroll 2021	*HRB 2023*
Location	Dublin region	Ireland
Year	2020 (2016-2019)	2019
Data about deaths	Reported to the DRHE, in TEA, SEA, PEA and rough sleeping	Reported to the coroner and classified as homeless in one of 4 situations
Estimation of the population of PEH	DRHE January 2020, in TEA, SEA, PEA	Not applicable
Causes of deaths	No data on causes of deaths	Coronial files include violent, overdose etc. deaths
Main comparison	CMR by accommodation type and duration of homelessness	Focus on causes of deaths, especially poisoning and mental health problems

PEH people experiencing homelessness

CMR crude mortality rate

TEA, SEA, PEA Temporary Emergency, Supported Temporary and Private Emergency Accommodation

DRHE Dublin Region Homeless Executive

First of all, the reports draw data from two different sources. While O'Carroll uses "homelessness data" from the DRHE, HRB uses "deaths" data from the coroner's office (see Mostowska 2023). O'Carroll calculates mortality rates (CMR thus number of deaths in a year/size of the population x 1 000). As a denominator he uses the number of individuals in TEA, SEA, PEA in January 2020 as reported by the DRHE. Is that the "right" denominator? There is no one way to say how large the "homeless population" is and it is a choice often constricted by the availability of data. Crude Mortality Rates are a principal outcome of O'Carroll's report. He concludes that the CMR is higher for single people (in comparison with those in family accommodation), higher for people experiencing long-term homelessness (especially longer that 18 months), higher for people living in long-term accommodation. These indicators, however, remain "crude", they could not have been adjusted for age or sex, and we know that health criteria impact placement in different types of accommodation.

In the HRB study, data came from coronial files which by definition means that all deaths were sudden or unexpected caused by poisoning etc. A set of those deaths was selected, namely those that occurred in "homeless" people. The overlap with the DRHE population is hard to estimate. Twenty six out of 84 cases were in substandard or insecure accommodation, and unknown types of homelessness. These cases are extra on top of the narrower definition used in O'Carroll's study. Apart from a cross table of poisoning/non-poisoning death with a type of homelessness, no further analysis by type of homelessness was presented. Some descriptive statistics were calculated for the whole set of 84 cases. For instance, 55% of deaths occurred due to poisoning. Since data was not available at the time, this was not compared with all poisoning deaths that the coroner investigated. Now we know that there were 371 poisoning deaths in Ireland in total, which means 1 in 8 occurred to people experiencing homelessness (HRB 2023).

In the HRB study, we look at the outcome (death) first and then see who was homeless. Actually, it's hard to tell what the cause and effect is. Was homelessness caused by addictions and mental health problems? Or the other way around? In the O'Carroll type of study, we look at the condition (homelessness) first, and then see who has died. Here we potentially have a better way of controlling the independent variable that interests us (types of homelessness, duration of homelessness) but we would have to look at the whole population as well. And to understand the impact of homelessness, a more in-depth study reconstructing homelessness history for each person would be required. This type of study is beyond the scope of the coronial data which is not collected for primary research purposes but to ascertain the manner of death.

As a result of those limitations, both reports contribute to the same bias. By focusing on those who died they paint a very sombre picture but with little room for context. What does the situation look like in a vulnerable group as a whole? How does it compare to other (vulnerable or privileged) groups?

The two Irish reports are symptomatic of the subject. The focus and conclusions are driven by the data that was available. The studies provide some findings, but they seem incomplete, insufficient, and with some limitations. Authors acknowledge these limitations, but justify that data was not available, that there will be a follow up and call for more research. What we are left with is data, which is hardly comparable, and not easy to interpret beyond their "shocking value".

As researchers, we would like to have more comparative data that would put homeless mortality in context. There were some comprehensive studies published that used longitudinal data and linked data from various registers (health, housing, social support) (Morrison 2009, Meyer et al. 2023). Large samples and long observation periods make it possible to calculate robust Standardized Mortality Ratios (SMR) and conduct an even more detailed and refined statistical analysis. Using such data, can speak on various intersecting vulnerabilities and inequalities over lifetime; search for patterns of housing insecurity (and not only homelessness at the time of death) and analyse what is the impact of it on health and death. Unfortunately, these studies are few and one-off, not a part of a systematic data collection over longer periods of time. As researchers, we would like to have an annual study following the same methodology to identify potential trends. Encouragingly, the HRB study will do just this from 2020 onwards.

As practitioners, we would find these SMRs perhaps not that important. We know pretty well that these ratios will indicate mortality rates several times higher than in the general population. And we know what to do: prevent homelessness, reduce health (and other) inequalities. On the one hand, the data from these studies are not statistically robust enough, concern too few cases. On the other hand, for

critical incidents reviews for instance, this data is not complete enough. Here we would like to see more detailed individual stories to understand how the system has failed and how these deaths could have been prevented. Sometimes it seems to me that journalists and reporters are doing a better job finding the way to catch that meso-level of analysis. Take for instance a story of people who died in dumpsters (Gee 2017) or a story on how lonely these deaths are, that they often happen without anyone present, that the diseased remain on the street for hours, that bodies are not claimed for weeks (Fuller 2022).

Finally, as critical researchers, we should ask, why there is only such data? Why our conclusions have to be so limited? Authors of these two reports have done what they could, but it begs a question why aren't there more systematic efforts to collect this data. There are fundamental methodological problems obviously (how to define the population!), but as Cooper and McCulloch (2023) argue, there is a general invisibility of homelessness experiences in life and in death. Bhandar (2022) calls it an "organized abandonment" of state responsibilities to citizens and residents to provide basic levels of safety and security. In relation to homelessness Cooper and McCulloch (2023, p.222) understand it as "a pervasive way of governing and organising homeless people in ways that lead to their exclusion, prolong their suffering and amplify the risk of premature death". Of course, it's not a complete neglect. Some data is made available, some hypotheses are confirmed, some conclusions are drawn. These reports are two valuable contributions. But do we understand better to what extent is this a case of an organized abandonment? And why? And are we getting closer to understanding the impact of homelessness on health and to preventing those deaths?

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