



# INTERIM REPORT ON MORTALITY IN SINGLE HOMELESS POPULATION 2020

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2021



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## Why this is an Interim Report

This is an Interim Report on the mortality of single people experiencing homelessness in the Dublin region. The reason it is not complete is due to an inability to access the necessary data to provide a complete report. The report will be finalised when death certificates and inquest reports and data from Central Statistics Office on deaths in general population are available.

The Coroner has agreed to allow a review of the death certificates and inquest reports. This work cannot take place, however, until Covid-19 restrictions are lifted. In addition, there is a backlog of inquests from 2020 and these may not be fully available till the end of 2021.

In order to ascertain whether mortality rates in the homeless population are higher than should be expected, there is a need to compare them to mortality rates in the general population. This is done by creating a standardised mortality ratio (SMR). This is calculated by dividing the number of people who have died in the observed group by the number of people who would have been expected to die. The number expected to die is calculated from the death rate in the general population. Thus, for example, a SMR of 2 would mean that the mortality rate for people experiencing homelessness was twice that of the general population. In comparing mortality rates across a number of years, SMRs are the appropriate rates to use as they take into account any factor that may lead to a rise of deaths in both homelessness and the general population.

Unfortunately, it is not possible to create SMRs for 2019 and 2020, as the data on deaths in the general population in 2019 and 2020 will not be available until October 2021 and October 2022 respectively.

PASS (the bed and case management system used by the DRHE) does not currently differentiate between a single adult household and an adult in a family. For this report it would be useful to analyse the data for single adults (separate from families) for the years 2016-2020, if the PASS upgrade to PASS version makes this possible, this will be completed at a later date.

Lastly, the PASS system provides information on the number of people experiencing homelessness by giving the numbers using emergency accommodation on a certain date of the year. The number of people in a particular year who move through emergency accommodation will be higher than on a single date. People continuously enter and exit homelessness.

## Role of Dublin Region Homeless Executive (DRHE)

The Dublin Region Homeless Executive (DRHE) is provided by Dublin City Council (DCC) as the lead statutory local authority in the response to homelessness in Dublin and adopts a shared service approach across the four Dublin Local Authorities, Dublin City Council (DCC), Dun Laoghaire-Rathdown County Council (DLRCC), Fingal County Council (FCC) and South Dublin County Council (SDCC). The DRHE has five key strategic aims as set out in national homeless policy, underpinned by Legislation, namely the Housing (Miscellaneous Provisions) Act, 1988 and the Housing Act, 2009:

1. The prevention of homelessness,
2. The reduction of homelessness in its extent or duration,
3. The provision of services, including accommodation, to address the needs of homeless households,
4. The provision of assistance under section 10 (b) (i), as necessary, to persons who were formerly homeless, and
5. The promotion of effective co-ordination of activities proposed to be undertaken by the bodies referred to in this subsection for the purposes of addressing homelessness in the administrative area or areas concerned.

## Role of Department of Health (DOH) and Health Service Executive (HSE) in addressing Homelessness

The Department of Health (DOH) and Health Service Executive (HSE) are responsible for the delivery of a range of health-related services and supports to homeless persons. Under the Health Acts, in particular the 1953 Act, the HSE has statutory obligations towards homeless persons; today this is understood to mean responsibility for the delivery of health and social care supports to homeless persons either directly or through Section 39 funded services.

Addressing the health needs of homeless persons and improving their access to healthcare is a key priority for the DOH and the HSE. As part of the public health response to Covid-19, health services for people who are homeless were significantly enhanced, initially in the Winter Plan and subsequently extended to cover all of 2021 (additional expenditure of €11m). In addition, long-term funding of €4m is being provided in 2021 to provided targeted improvements in health services, including mental health, integrated care plans and Housing First.

Supporting individuals and families facing homelessness is a priority for the Government. The Programme for Government commits to reducing and preventing homelessness and provides detail on how the Government will approach this challenge. One key commitment is that the

DOH and the HSE will work with the Department of Housing, Planning and Local Government (DOHPLG) to assess how dedicated funding and resources can be provided to deliver the necessary health and mental health supports required to assist homeless people with complex needs.

## Acknowledgements

I would like to acknowledge all the support from the DRHE and HSE Social Inclusion in writing this report. I would like to thank Johanna Ivers and Tony Duffin for their input.

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## List of Abbreviations

AHB	APPROVED HOUSING BODY
CMR	CRUDE MORTALITY RATE
DRHE	DUBLIN REGION HOMELESS EXECUTIVE
EA	EMERGENCY ACCOMMODATION
HAP	HOUSING ASSISTANCE PAYMENT
HSE	HEALTH SERVICE EXECUTIVE
LA	LOCAL AUTHORITY
LTA	LONG TERM ACCOMMODATION
NIMS	NATIONAL INCIDENT MANAGEMENT SYSTEM
PASS	PATHWAY ACCOMMODATION AND SUPPORT SYSTEM
PEA	PRIVATE EMERGENCY ACCOMMODATION
PEH	PEOPLE EXPERIENCING HOMELESSNESS
SMR	STANDARISED MORTALITY RATIO
STA	SUPPORTED TEMPORARY ACCOMMODATION

## Introduction

This report was requested by the Dublin Region Homeless Executive (DRHE) in response to concerns that the number of deaths in homeless services in the Dublin region had risen in 2020. Deaths of homeless service users are deeply upsetting for other service users and staff who worked with the client. It is important for service providers and statutory agencies to have an effective mechanism for reporting on and reviewing deaths in service to identify whether the death could have been prevented or not. <sup>(1)</sup>

In 2005 the Homeless Agency (precursor to the DRHE) introduced a Death Notification protocol. The purpose of this was to *'to ensure that a respectful, immediate and appropriate response is available for service users, staff, volunteers and management for the death of a person who was either residing in their service for a long period of time or a person who had been accessing their service for a short period of time.'* <sup>(2)</sup>

In 2013 the DRHE revised the policy addressing deaths of service users. The purpose was to create a protocol that outlined for services what to do on discovering a service user had died. The aim was to ensure that there were proper protocols and procedures in place for managing the death; reporting to the appropriate authorities; recording and reporting the death to the DRHE and HSE; and ensuring staff are supported in managing the death itself and any impact the death may have had on staff health

This report is structured as follows.

1. In Chapter 1, the background literature on international and Irish mortality in homeless populations is reviewed. This examines firstly estimates of mortality in people experiencing homelessness and secondly, the identified reasons in the literature for the excessively high mortality rates in this population. It also reviews previous reports on mortality commissioned by the DRHE and describes any recommendations.
2. In Chapter 2, the various types of accommodation the DRHE provides people experiencing homelessness is described.
3. In Chapter 3, the methodology for reviewing the mortality rates 2016-2020 is described.
4. In Chapter 4 the results are outlined.
5. In Chapter 5 the results are discussed.
6. In Chapter 6 a series of recommendations are made. These include recommendations about future methodologies for reviewing mortality within the homeless population; alternate methods for reviewing individual 'critical incident' deaths within homeless services; and suggestions to help reduce mortality within this population.



The effects of the Covid-19 pandemic were not within the scope of this review. However, it is important to acknowledge the considerable efforts of the DRHE and HSE, particularly in terms of investment in services and in taking prescient action to prevent the spread of the infection in a vulnerable population.

## Chapter 1: Background

### Chapter Summary

People experiencing homelessness have amongst the worst health indices in the Western World.

International research demonstrates that their mortality rates are much higher than the housed population. Irish research showed mortality rates that were 3 to 10 times higher for women experiencing homelessness and 6 to 10 times higher for men experiencing homeless in comparison to the general population,

There are several well documented reasons in the literature that can help explain this excess mortality in homeless people.

- a. **Excess Morbidity:** Homeless people have excessively high prevalence of morbidity. This excess is right across the spectrum of disease including excessively high rates of chronic diseases common in the general population (e.g. diabetes, ischaemic heart disease, chronic obstructive airways disease, epilepsy etc.) but also including very high rates of conditions rarely found in the general population e.g. Blood Borne Infections, Cirrhosis of the liver etc.
- b. **Suicidality:** Homeless people have very high levels of mental illness and high rates of suicide. International research shows a six fold increase in suicidality. Irish research shows 1 in 4 homeless people had attempted suicide in their lifetime and 1 in 10 in the previous 6 months.
- c. **Substance Misuse:** There are very high rates of substance misuse amongst people experiencing homelessness. Irish research shows 4 out of 5 people experiencing homelessness have a history of illicit drug misuse. 31% percent were current heroin users and 25% were intravenous drug users. 40% of homeless people drink above the recommended limits of alcohol. People who misuse illicit drugs have significantly raised mortality rates for a range of reasons including overdose deaths, blood borne infectious diseases deaths etc. People who drink alcohol excessively likewise have higher mortality rates from a range of alcohol induced diseases.
- d. **Accidental or Violent Death:** People experiencing homelessness have a high rate of death from both accidental trauma and violence. This is especially so for young people experiencing homelessness between 18-24 years.
- e. **Poverty:** Most homeless people originate from areas of deprivation. It is well recognised that people from areas of poverty have a lower life expectancy.

- f. **Childhood Adversity:** Most homeless people have been exposed to high levels of childhood adversity. Childhood adversity is predictive of a lower life expectancy.

There have been three previous reports on homeless deaths in Dublin.

- In 2008 a report found that the most common cause of death in homeless men was alcohol related.
- Matthews (2013) reviewed deaths in services and made a number of recommendations for action.
- Ivers and Barry (2018) found the Standardised Mortality Rate (SMR) for men was 3 to 10 times and for women 6 to 10 times higher, than for males and females respectively, in the general population. They recommended annual reporting of deaths and the establishment of a committee of key stakeholders to investigate how to use mortality reports to inform best practice.

There is a dearth of literature on interventions in homelessness to reduce mortality. One study in Boston described how the Boston Public Health responded to an increase in deaths amongst the homeless population by convening a committee formed by a wide range of State, municipal and voluntary agencies to firstly, explore why there was an increase in deaths and secondly, how to reduce the number of people experiencing homelessness dying. In addition they developed a number of key interventions discussed later in this report.

Access to primary care is associated with a lower mortality in the general population. While it is not known if access to primary care reduces mortality in people experiencing homelessness it would seem reasonable to ensure there is an ease of access to such services.

Suicidality is a well-recognised cause of premature deaths for people experiencing homelessness. There are a number of interventions that can help reduce the level of suicidality in this population.

Overdose had been identified by Ivers and Barry (2018) as contributing to over a third of deaths in people experiencing homelessness. There are well recognised evidence-based interventions to reduce overdose fatalities which will be explored later in this report.

## 1.1. Overview

People experiencing homelessness have some of the worst health indices in the developed world<sup>(1-3)</sup> Internationally, their death rates have been estimated to be between 3 to 13 times that of the general adult population, with rough sleepers having the lowest life expectancy.

(2, 4–10) Median age of death has been estimated in the UK to be 44 years for men and 42 years for women compared to 76 and 81 years respectively for the general population. <sup>(11)</sup>

In Ireland, Ivers and Barry (2018) reviewed 345 deaths of people experiencing homelessness between 2011 and 2015. They found the median ages of death were 42 years for men and 36 years for women.<sup>1</sup> Compared to the general population, mortality rates in the homeless community were 3 to 10 time higher for homeless women, and 6 to 10 times higher for homeless men. This was in keeping with international mortality rates. Less than 10% of deaths occurred outdoors which they concluded was a low percentage compared to international rates. Lastly, they found that drug and alcohol deaths accounted for more than one third of deaths which again was consistent with international literature. Most of these deaths were opioid related overdoses. <sup>(12)</sup>

There are a number of reasons that explain this high mortality amongst people experiencing homelessness including:

1. Excess prevalence of severe physical illness amongst people experiencing homelessness.
2. Excess prevalence of mental illness and suicidality amongst people experiencing homelessness.
3. The high rate of substance misuse amongst people experiencing homelessness.
4. Excess rate of accidental and violent deaths amongst people experiencing homelessness.
5. Excess rate of violent and accidental deaths amongst people experiencing homelessness.
6. People experiencing homelessness originate from areas of poverty who experience excess mortality and morbidity independent of homelessness.

#### **1.1.1. Excess prevalence of severe physical illness amongst people experiencing homelessness**

It is known that chronic disease accounts for the majority of preventable deaths in the general population, in particular, cancer, cardiovascular and respiratory disease.<sup>(15–19)</sup> People

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<sup>1</sup> It is important to note that median age is not the same as average age or life expectancy. Median age is the calculated by putting all the ages of people who died and finding the midpoint. The mean age is calculated by adding all the ages together and dividing by the number of deaths. Life expectancy is a statistical assessment of the number of years a person can be expected to live based on date of birth, age, gender and other biological or social factors. Median age is affected by the age of the population e.g. the median age of a nursing home will be very high whereas the median age of university students will be low. The advantage of the median age is it is not as affected by outliers as the mean age can be. This is particularly important if you are dealing with small numbers.

experiencing homelessness carry an excess burden of chronic disease including respiratory and cardiovascular disease.<sup>(3–5,19)</sup> Lewer et al (2019) found rates of chronic respiratory disease to be over 7 times higher in people experiencing homelessness compared to the general population.<sup>(18)</sup> People experiencing homelessness also experience excessively high rates of infectious diseases. Tuberculosis is common in people experiencing homelessness due to the combination of poor nutrition, excess alcohol consumption and over-crowded living circumstances. Blood borne viruses are common due to the high rate of substance misuse. <sup>(4, 19)</sup>

In Ireland, it has been found that 89% of people experiencing homelessness suffer from, at least, one physical health condition compared to 27% of the general population. 69% report having at least one chronic disease. One in three report a blood borne virus infection (1 in 33 having HIV; 1 in 25 Hepatitis B; and 1 in 4 having Hepatitis C) and 1 in 25 report being diagnosed with tuberculosis. 16% reported having liver conditions. <sup>(20)</sup>

Certain groups within homelessness are particularly vulnerable to the high morbidity rates. Older homeless three times more likely to have a chronic medical condition and have higher age-specific mortality rates than the general population.<sup>(21)</sup> Homeless young people are at risk from victimisation, violence and sexual risky behaviour including engagement in prostitution.<sup>(22,23)</sup>

### **1.1.2. Excess prevalence of mental illness and suicidality amongst people experiencing homelessness**

People experiencing homelessness are recognized as suffering with excessively high rates of mental illness including depression, anxiety and schizophrenia. <sup>(3, 24–30)</sup> In Ireland it has been estimated that 1 in 2 people experiencing homelessness report being treated for depression; 2 out of 5 for anxiety; and 1 in 10 a psychotic illness including schizophrenia. <sup>(20)</sup>

Internationally, people experiencing homelessness have been found to have a 2 to 6 fold increased risk of suicide compared to the general populations.<sup>(7,31–33)</sup> A US study found that the rate of suicide amongst people experiencing homelessness is 9 times that of the general population.<sup>(35)</sup> The rate amongst people experiencing homelessness with schizophrenia has been found to be particularly high.<sup>(34)</sup> Irish research found that 1 in 4 people experiencing homelessness attempted suicide in their life time and 1 in 10 in the previous 6 months.<sup>(20)</sup>

The factors that contribute to the high rate of suicidality in the homeless population can be grouped into two separate categories. The first category relates factors that occur prior to homelessness. The experience of childhood adversity and trauma is strongly associated to an increased risk of suicidality.<sup>(36–40)</sup> In addition, the financial stress caused by inability to pay rent and the experience of eviction are very traumatic and contribute to poor mental health and suicidality. <sup>(41)</sup> The second category relates to the trauma caused by the experience of being homeless which has been demonstrated to worsen mental health symptoms and increase suicidality. <sup>(36, 40, 42–44)</sup>

### **1.1.3. The high rate of substance misuse amongst people experiencing homelessness**

It is known that people experiencing homelessness have high rates of addiction <sup>(13-16)</sup> O'Reilly et al (2015) estimated that 80% of people experiencing homelessness in Dublin had a history of past or current illicit drug use. They further found that just over 30% of the homeless population reported current heroin usage; 25% of the population were injecting drug users; and 35% took street benzodiazepines.<sup>(17)</sup> Clinicians working in GMQ report clients taking up to the equivalent of 600mg diazepam daily with 2-300mg daily being a frequent amount ingested. Alcohol misuse is also common with up to 40% of people experiencing homelessness in Dublin reporting drinking above the recommended limits and 22% drinking on a daily basis.<sup>(17)</sup>

The harms of drug addiction are well documented including, increased mortality due to overdose or blood borne infections; poorer health; and higher mortality. Internationally it has been found that in recent years, substance misuse has become the leading cause of death in people experiencing homelessness accounting for up to 34% of deaths. <sup>(4, 18-21)</sup> Bauer et al (2016) found that polysubstance misuse was an increasingly common finding in over-dose deaths. They further found that one third of people experiencing homelessness who had overdosed had been in touch with clinical services in the 3 months prior to their deaths.<sup>(22)</sup>

Likewise, the harms of alcohol misuse are well documented. People experiencing homelessness who are dependent on alcohol are 4 to 7 times more likely to have liver dysfunction; twice as likely to suffer serious trauma; 2 to 3 times more likely to have a neurological disorder (most commonly being epilepsy); twice as likely to have nutritional deficiency; 1.5 times as likely to have hypertension, chronic obstructive pulmonary disease, peptic ulceration, nerve damage and arterial disease.<sup>(4, 19, 23)</sup>

Ivers and Barry (2019) found in Dublin that drug and alcohol were the most common cause of death in people experiencing homelessness where cause of death was known, accounting for just under 40% of such deaths and being involved in a further 17% of deaths.<sup>(12)</sup> Walsh (2013) estimated substance misuse to account for a third of deaths in people experiencing homelessness.<sup>(24)</sup>

### **1.1.4. Excess rate of violent and accidental deaths amongst people experiencing homelessness**

Violence has been found to be a significant cause of death particularly of homeless men aged 18-24 years.<sup>(4)</sup> Substance misuse and mental illness are often found to be the main precipitants of violent death. <sup>(25)</sup>

Accidental death is also a common cause of death.<sup>(26)</sup> Walsh (2013) found people experiencing homelessness were 3 times as likely to die of a road traffic accident.<sup>(24)</sup>

### **1.1.5. People experiencing homelessness originate from areas of poverty who experience excess mortality and morbidity independent of homelessness**

Areas of deprivation are known to experience worse morbidity and mortality rates than their wealthier counterparts.<sup>(27,28)</sup> It is known that most people experiencing homelessness originate from areas of deprivation where mortality and morbidity rates are significantly higher than the general populations.<sup>(14, 56, 57)</sup>

#### **1.1.6. People experiencing homelessness have excessively high rates of adversity in childhood which is associated with lower life expectancy.**

It is recognised that people who have had high levels of childhood adversity have a lower life expectancy.<sup>(31–34)</sup> People experiencing homelessness experience higher rates of adverse childhood experiences than the domiciled population.<sup>(35–38)</sup> The association is possibly mediated by the associations between childhood adversity with poor physical and mental health, violence, substance misuse and suicidality.<sup>(39–45)</sup>

### **1.2. Previous Reports on Deaths in Services**

In 2008 the Homeless Agency published a report on deaths in homeless services. It reviewed 53 deaths of homeless services users. Its main finding was that the most common cause of death in men appeared to be due to the effects of prolonged alcohol misuse while the main cause of death in women seemed to be accidental drug overdose.<sup>(46)</sup>

In 2013 a review was commissioned by the DRHE and HSE on the policy on the death of a service user to be conducted by E Matthews.<sup>(47)</sup> The Matthews report recommended the following:

- A monitoring function/framework be established within the DRHE which would examine and analyse the data/information within agreed parameters.
- The implementation of a critical incident process to review any deaths that are potentially not from 'natural causes'. It defined a critical incident review as '*where a death occurs suddenly and the client has not seen a GP for 30 days, and/or the death is as a result of an accident (e.g. fall), suicide, overdose or violence and/or where a post mortem has been arranged*'. It recommended this review should not be utilized in a negative way or seen as punishment. The review, it suggested, should be at organisational level and led by the CEO, or their nominee, of the relevant residential or day service.
- The establishment of a common Risk Assessment Tool to enable organisations to identify clients who have a propensity to self-harm, overdose or harm others.
- The development of a process in collaboration with the DRHE, HSE, Ambulance Services and Gardaí to review deaths of rough sleeping DRHE clients.
- The establishment of a reporting system for deaths of services users in hospital settings to the DRHE/HSE.
- The establishment by the HSE of a cross Liffey integrated service for the provision of psychiatric services to homeless persons with mental health care issues.

In 2015 the DRHE and HSE Social Inclusion commissioned a report from Trinity College Dublin to review deaths between 2005 and 2015. Ivers and Barry (2018) reviewed 345 deaths over this period.<sup>(48)</sup> They found the following:

- Just over three quarters (75.7%) of deaths were male and just under a quarter female
- The median age of death was 42 years (44 years for a male and 37 years for a female).
- Drug and alcohol intoxication accounted for 2 out of 5 deaths where cause of death was known. In a further 17% of cases while drugs and alcohol were not identified as the main cause of death, they were identified as being implicated in the death.
- People experiencing homelessness were more likely to die of overdose than the general population.
- Most service users died in hospital (51%) while only 8% died outdoors.
- They calculated Standardized Mortality Rates (SMR) for homeless men and women for 2011- 2015 and found the SMR for men was 3 to 10 times and for women 6 to 10 higher than the males and females respectively, in the general population.

Ivers and Barry (2018) made several recommendations including:

- The annual and national reporting of deaths occurring in persons experiencing homelessness.
- At a national level to explore the establishment of a committee to investigate how the local authority-based regions (9 in all) can be used most effectively to inform policy, configure appropriate health and homeless services and improve health responses for homeless persons. This should include representation from key stakeholders.

### **1.3. Literature on Interventions to Reduce Mortality in People Experiencing Homelessness (PEH)**

There is only one published study that specifically reviewed interventions to reduce mortality amongst people experiencing homelessness. In Boston in 1999 there was an increase in deaths in people experiencing homelessness. The Department of Public Health convened a task force including representation from the medical community social welfare agencies; street outreach workers; the local police department; homeless advocates; homeless experts by experience; and researchers from local universities.

The task group initially conducted an evaluation of the deaths over a number of preceding years. They found that of the 40 to 80 deaths per year between ages 24-30 were people who died on the streets. They further analysed the data on those who died of what were judged to be preventable causes (i.e. excluding terminal illness such as cancer or cirrhosis; homicide; trauma). Of the clients they identified as having preventable causes of illness all had significant physical morbidity; the vast majority had alcohol or substance misuse issues and the majority had a severe and persistent mental illness. The task force were surprised to find



contrary to their presumptions, this cohort had not fallen through the service Safety net but had multiple points of contact with medical, psychiatric and substance misuse services.

The task force developed a series of initiatives seeking to reduce the number of people dying on the street.

- Monthly multi agency meetings were convened to discuss deaths and identify if interventions could have been made to prevent them.
- A risk assessment was created to identify those most at risk of premature death. This high risk group were reviewed by the specialised primary care service on a weekly basis and efforts were made to ensure they engaged with primary care and preventative services.
- Patients with untreated alcohol or substance misuse were engaged with more assertively to seek to persuade them to engage in community or inpatient treatment.
- Local hospitals agreed to avoid late night discharges.
- Improving collaboration between local hospitals, emergency services, emergency hostels and police departments to ensure people experiencing homelessness were accommodated at night.
- Outreach Services and emergency beds were expanded.

The authors concluded that more formal research was required on potential interventions to reduce deaths in homelessness and suggested integrated approaches involving a range of interventions, offered a potential avenue for reducing mortality of people experiencing homelessness.<sup>(49)</sup>

#### **1.4. Access to Primary Care**

It is recognised in the literature that access to primary care is associated with a longer life expectancy.<sup>(50)</sup> Unfortunately, it is also well recognised that homeless people are poor utilizers of mainstream primary care services.<sup>(51)</sup> Access to specialized primary care services for PEH has been demonstrated to improve uptake of such services and improve management of acute and chronic medical conditions for this population. Of note, to date, though we know access to primary care improves life expectancy, to date access to specialised services has not been demonstrated to reduce mortality in PEH.

#### **1.5. Suicidality**

Suicidality is recognised internationally as being a significant contributor to the high mortality in homeless populations. Interventions that have been demonstrated to reduce the risk of suicide include the following:

1. **Provision of Housing.** Housing people with the housing first project has been found to result in a reduction in symptoms of mental illness and suicidality.<sup>(52)</sup>
2. **Programmes to improve social connectedness.** Suicide risk has been found to diminish with improvements in social connectivity.<sup>(53)</sup>
3. **Physician suicide risk assessments.** Medical assessments of those who express suicide has been shown to reduce the risk of suicide.<sup>(53)</sup> Suicidal intention in homeless people is associated with a history of depressive symptoms, substance misuse (in particular intravenous illicit drug misuse); recent arrest; multi-morbidity and a history of traumatic brain injury.<sup>(54)</sup> Suicidal ideation is a predictor of suicide in homeless populations.<sup>(55)</sup>
4. **Access to mental Health Services.** Access to mental health services has been demonstrated to have a positive impact on mental health outcomes including reduction in risk of suicidality.<sup>(56)</sup>
5. **Trauma Informed Care Approach.** Evidence internationally, demonstrates, a trauma informed approach is well received by clients; has excellent outcomes in reduction in mental health and trauma symptoms and substance misuse outcomes; and decreases usage of secondary care services such as Emergency Departments and inpatient admissions.<sup>(57,58)</sup>

## 1.6. Death by Overdose

It is known from previous reports that death by overdose contributes significantly to the mortality rate in people experiencing homelessness. There is a significant literature on interventions to reduce mortality by overdose. Such interventions include:

- A. Reducing Risk of Fatal Overdose Interventions
- B. Reducing Risk of Overdose Interventions
  - a. Conduct Non-Fatal Overdose Reviews: Increase Awareness amongst drug users of the risks of overdose.
- C. Reducing Vulnerability to Overdose
  - a. Increase access to outreach and low threshold services.
  - b. Remove barriers to access to services.
  - c. Empower drug users to protect themselves.
  - d. Adopt a public health approach to overdose deaths.

## **1.7. Summary**

In summary, there have been few interventions to reduce mortality that are specific to homeless populations. However, there is a wealth of evidence on interventions on how to reduce deaths from suicidality and overdose which are known to contribute significantly to the excess mortality of homeless populations.

## Chapter 2: Homeless Accommodation Typology

### Chapter Summary

Homelessness in this report refers to clients that have been assessed as homeless by the DRHE and or Dublin Local Authorities. This equates to those who are roofless or houseless according to the European Typology of Homelessness.

There are a number of differing accommodation supported by the DRHE:

- Temporary Emergency Accommodation. (TEA)
- Supported Temporary Accommodation. (STA)
- Private Emergency Accommodation. (PEA)
- Long Term Accommodation. (LTA)
- Social Tenancies.

\*It is important to note that LTA and social tenancies are not regarded as homeless accommodation by the Census.

### 2.1. Definition of Homelessness

The term homelessness can encompass a huge array of living arrangements. The European Typology of Homelessness (ETHOS) is the most widely use definition for research purposes in Europe. This classifies homelessness under several categories and subcategories. The main categories are:

- Rooflessness (without a shelter of any kind, sleeping rough).
- Houselessness (with a place to sleep but temporary in institutions or shelter).
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence).
- Living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).<sup>(59)</sup>

For the purposes of this review we are looking mainly at clients in the first two categories i.e. rooflessness and houselessness. A qualification is that they are have been assessed as homeless by the DRHE and/or one of the four Dublin Local Authorities.

## 2.2. Emergency Accommodation in the Dublin Region

Within homeless services in the Dublin Region, there are a number of different types of temporary accommodation. These can be grouped separately under Family and Single Homeless Emergency Accommodation.

- i. In December 2015, there were 683 families accessing emergency accommodation in the Dublin Region. The number of families presenting as homeless continued to rise reaching a peak in July 2018, which saw 1,367 families accessing homeless services in Dublin. The main cause for this increase has been attributed to structural-economic causes i.e. increasing rents and insufficient housing options.<sup>(60, 61)</sup> this figure has since significantly decreased, as of March 2021, there were 681 families residing in emergency accommodation in the Dublin Region. The majority of families are placed in family hub type accommodation.
- ii. Single people experiencing homelessness include people who are singles or in couples accommodation but do not have children. Currently as of March 2021, there are 3,073 adults, single or couples without children residing in emergency accommodation in the Dublin Region. There are three different forms of accommodation for people experiencing homelessness:
  - **Temporary Emergency Accommodation (TEA):** TEA's provide emergency accommodation with no (or minimal) support.
  - **Supported Temporary Accommodation (STA):** STA's provide accommodation for a minimum of 6 months in hostels, with onsite professional support. STA's are run by organisations in the voluntary sector.
  - **Private Emergency Accommodation (PEA):** PEA accommodation is provided by private operators. Supports are provided to services users on a visiting supports basis.

## 2.3. Other Accommodation & Services funded by the DRHE

Of note the DRHE also funds the following types of accommodation which are not classified by the census as 'homeless' accommodation.

### 2.3.1. Long Term Accommodation (LTA)

The Census Homeless Methodology Liaison Group agreed, in advance of the Census field operation, that persons in LTA would not be included in the main results in this report. The rationale behind this decision was that although these long-term residents may require a certain level of support, they are for the most part considered tenants (although some have license arrangements) and therefore should not be included in the homeless population count. There are 3 different Categories of LTA. (See Table 1).

**Table 1: Categories of Long Term Accommodation (LTA) & Number of Units**

<b>Property Category</b>	<b>Number of Units</b>
Cat 1 & 2 - High support (Multiple co morbidities)	195
Cat 3 - Medium Support	68
Cat 4 - Low Support	68 Beds & 151 Apt.

The criteria for entry into LTA mean that these facilities are occupied by a disproportionately unhealthy and vulnerable population. (See Table 2).

**Table 2 : Entry Criteria for Long Term Accommodation (LTA) - DRHE**

**General criteria for Long Term Accommodation**

- A history of homelessness and/or at serious risk of becoming homeless, having no alternative housing option available;
- A mental health conditions (as assessed by the relevant mental health professionals) – dual diagnosis, self-harm, suicidal ideation, personality disorders;
- A history of misuse of substances;
- Borderline learning difficulties;
- Disability or mobility issues - acquired brain injury etc.
- Physical health problems – requiring help with personal care (dressing, washing, toileting, eating, incontinence etc.)
- Offending behaviours (including sex offenders);
- Challenging behaviours;
- Domestic violence;
- Vulnerability because of age

### **2.3.2. Social Tenancies**

Social Housing tenancies including Approved Housing Body (AHB) Housing First, Local Authority and Housing Assistance Payment HAP) tenancies, these may have visiting support services which are funded by the DRHE.

## Chapter 3: Methodology

### Chapter Summary

This chapter outlines the methods used in reviewing the mortality of People Experiencing Homelessness (PEH) in 2020.

The aims of the review were to

1. Calculate mortality rates for PEH for 2020 and compare to 2016-19.
2. To identify causes of death and
3. To review known variables to identify if there are any important associations.

The data was reviewed differently to previous mortality reports:

- Deaths in LTA and social tenancies were excluded as these are not counted as homeless in the official census figures.
- Deaths in the family homeless accommodation were separated from those in the single adult homeless population. This was done as it was noted there were minimal deaths amongst people in family homeless accommodation.

### 3.1. Aim of the Review

The aim of this review was threefold:

1. To calculate the mortality rates for people experiencing homelessness in Dublin in 2020 and compare it to mortality rates calculated for each year of 2016; 2017; 2018; 2019.
2. To identify and review the causes of death of people experiencing homelessness in 2020.
3. To review known variables associated with deaths in the single homeless population (gender; age; location of death; chronicity of homelessness; accommodation typology at time of death; and linkage with services at death).

### 3.2. Methods of Review

This report is a retrospective analysis of deaths of clients registered with DRHE homeless accommodation and clients registered as rough sleeping by DRHE in 2020. It includes a retrospective analysis of deaths in 2016; 2017; 2018; and 2019 for comparative purposes.

As outlined in the preamble, due to the non-availability of both data from the general and homeless populations it is not possible to generate Standardised Mortality Rates. This will be

produced in the Final report once the data becomes available. Thus, references to SMRs are removed from this Chapter. Similarly, as data on individual deaths is not yet available from the Coroner, this will not be reviewed until the Final Report and is not referenced in this Chapter.

Data held by the DRHE on people experiencing homelessness for the years from 2016 – 2020 was collected and analysed. This analysis focussed on the following:

1. **Calculation of Crude Mortality Rates (CMR).** Crude Mortality Rates (CMRs) are calculated by dividing the number of people who died by the number of people in the population and multiplying by 1000. This calculation gives you the number of people who died per 1000 people of the population in question.
2. **Crude Mortality Rate**  
$$\frac{\text{Number of Deaths}}{\text{Number in Population}} \times 1000 = \text{Number of deaths per 1000 population}$$
3. **Subgroup Analysis.** Further analysis was to be conducted on other subgroups (aside from gender and age). These subgroups were as follows:
  - a. Crude Mortality Rates by accommodation type.
  - b. Crude Mortality Rates by Duration of Homelessness.
4. **Median Age Calculation.** The Median Age of Clients in EA and LTA was calculated.
5. **Analysis by Location of Death.**

### 3.3. Data Collection and Analysis

#### 3.3.1. Numerator data in the homeless population (i.e. Deaths of people experiencing homelessness)

The data on deaths of people experiencing homelessness (PEH) was provided by the DRHE. This data on both numbers of clients homeless in Dublin and number of deaths in the homeless population was obtained from the DRHE. The DRHE used the 'PASS' database to identify those clients who have been assessed as homeless and placed in emergency accommodation.

This database captures all clients who link in with a range of homeless services. In essence it captures clients who use emergency 'accommodation and also rough sleepers. Rough sleepers are recorded either via contacts made with the Central Placement Service, Local Authorities and/or Dublin Outreach and Housing First Teams. Of note, the data provided by the DRHE includes both families and single people experiencing homelessness. Table 3 below captures the number of deaths reported to the DRHE for the Dublin Region.



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Table 3: Number of deaths reported to the DRHE 2020

EA – STA	29
EA – PEA (1 family accommodation)	12
Off site (street deaths) – Had active placement in EA	4
Rough Sleeping - Known to DRHE not availing of Service	3
Unknown to DRHE – not accessing homeless services	3
Tenancies (AHB/ HF / LA)	6
Visitor to PEA - Unknown to DRHE	1
LTA Tenancy	21
<b>Total</b>	<b>79</b>

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This data was scrutinised, and a number of adjustments were made to the data, by this author, resulting in a dataset that was different from the data analysed in the 2015 Mortality report. The changes and rationale for changes are as follows:

- I. Death of those described as not service users were removed because there was limited/no data available.

This accounted for the removal of **4** deaths from the dataset.

- II. Data for deaths of clients in social tenancies who receive visiting supports from organisations funded by the DRHE were included in previous report. In this report these were removed for the following reasons :

- a. Such tenancies are not counted as homeless accommodation in the national census.
- b. Including the number of clients in tenancies in the numerator for calculating mortality rates would also require including the number of people resident in such tenancies in the denominator. As such tenancies are not considered to be homeless accommodations this would have caused the dataset to be flawed.

This accounted for the removal of **4** deaths from the dataset.

- III. Data for deaths of clients in Housing First Tenancies were removed. These were removed for the following reasons:

- a. Such tenancies are not counted as homeless accommodation in the national census.
- b. Including the number of clients in such tenancies in the numerator for calculating mortality rates would require also including the number of people resident in such

tenancies in the denominator. As above, this would have resulted in a flawed dataset.

This accounted for the removal of **2** deaths from the dataset.

- IV. Data on deaths in family homeless accommodation was separated from data on deaths in single homeless accommodation. The rationale for this was on initial perusal of the data it was clear that the death rate in family homeless accommodation was considerably lower than in single homeless accommodation (see Table 4) and combining the two populations was inflating death rates for adults in families experiencing homelessness and artificially deflating it for those in singles accommodation.

**Table 4: Number of Adult Deaths in Family Homeless Accommodation 2016-2020**

<b>Year</b>	<b>Adult</b>	<b>Male</b>	<b>Female</b>
2016	2	0	2
2017	3	0	3
2018	2	1	1
2019	0	0	0
2020	1	0	1
<b>Total</b>	<b>8</b>	<b>1</b>	<b>7</b>

This accounted for the removal of **1** death from the dataset.

- V. Data for deaths in Long Term Accommodation (LTA) was not included and data of number of residents in LTA was not included. However, this data was analysed separately.

The reason for this were:

- a. LTA is not considered homeless accommodation by the census or DRHE. Such accommodation is treated as a tenancy.<sup>2</sup>
- b. However, the accommodation is funded by DRHE and so the number of deaths is important to analyse. Therefore it was decided to analyse deaths in these accommodations separately.

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<sup>2</sup> See rationale for excluding these groups in Methodology Chapter.

Of note, the entry criteria for LTA (see Table 5) mean that LTA are occupied by a particularly medically vulnerable group based on age, medical profile and substance misuse background. One would thus expect a higher mortality rate in these facilities.

This accounted for the removal of **21** deaths from the dataset.

Thus, the final numerator data for single homeless in Emergency Accommodation and Rough Sleeping was as in Table 5.

#### **INTERIM REPORT**

The following data was used for the purposes of the Interim Report as it was not possible to obtain the full denominator data as explained in preamble: Thus the final figure for single people either rough sleeping or placed in Emergency Accommodation is 47, having excluded deaths that occurred in all types of tenancy, family accommodation and not known to homeless services in Dublin.

**Table 5 : Number of Deaths of Single Homeless Service Users 2016-2020**

<b>Year</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>EA</b>	<b>34</b>	<b>32</b>	<b>18</b>	<b>25</b>	<b>44</b>
<b>Rough Sleeping</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>3</b>
<b>Total</b>	<b>36</b>	<b>32</b>	<b>19</b>	<b>26</b>	<b>47</b>

#### **3.3.2. Denominator Data on Homeless Population (Number of People Experiencing Homelessness)**

The denominator data was provided by the DRHE for the years 2016-2020, using the monthly reported figures from January of every year. Adjustments were made in this dataset to mirror those implemented in the Numerator data (i.e. exclusion of data on long term accommodation and tenancies; and separation of single/family homeless). (See Table 6).

**Table 6: Population of People Experiencing Homelessness in Singles Accommodation in the Dublin January 2016 –January 2020**

Year	2016	2017	2018	2019	2020
EA - STA + PEA + TEA	1636	1894	2261	2550	2865
EA - STA	1120	1340	1623	1689	1678
EA - PEA	491	551	629	888	1214
EA - TEA	64	66	67	72	62
Number who accessed Multiple Accommodations.*	39 (2%)	66 (3%)	58 (3%)	99 (4%)	89 (3%)

\*Due to these clients using differing sites these clients were excluded for analysis from denominator for calculating CMR for PEA and STA. Of note these numbers account for between 2-4% of clients.

**Table 7: Population of People Experiencing Homelessness in Family Accommodation in Dublin Region January 2020**

Total Families	Total adults	(of which) single parent families	Total dependants
1162	1682	642	2553

In reviewing the data, it became apparent a more accurate estimate of the population of homeless people would take into account ‘flow data’ of all service users over the year. Homelessness is a fluid state with people entering and exiting homelessness continuously.

The denominator data provided for singles accommodation did not include a figure for the population of rough sleepers. However, the data provided by DRHE refers to the number of homeless people using DRHE services over a single week. They conducted an audit in November 2020 of 127 rough sleeping individuals on the PASS system, 89% had used Emergency accommodation in the past, 655 had used it in the previous 3 months and 20% had a bed allocated to them on the night of the rough sleeper count. Therefore, it was decided not to add any extra based on rough sleepers to the denominator figure.

### 3.3.3. Numerator Data on Deaths in the Single Population in Long Term Accommodation

The Numerator data of number of deaths in LTA was obtained from the DRHE (See Table 8)

**Table 8: Deaths of Single Persons in Long-term Accommodation**

Year	2016	2017	2018	2019	2020
LTA	17	15	19	14	21

**3.3.4. Denominator Data on Single Persons in Long Term Accommodation.**

The Denominator of the number of Single Persons residents in LTA was provided by the DRHE. Due to the method of recording numbers in LTA the numbers provided were a reasonable approximation. (See Table 9).

**Table 9: Population of Single Persons in Long-term Accommodation**

Year	2016	2017	2018	2019	2020
LTA	388	388	388	394	394

**3.3.5. Data on Deaths by Single/Family Homelessness; Accommodation Type; Chronicity of Homelessness.**

Lastly, it was also decided to do additional analysis of mortality rates based on other factors including accommodation factors and chronicity of homelessness for 2020 alone.

As noted there are a number of differing types of accommodation options in homelessness with differing levels of support. It was decided to compare CMRs for clients in PEAs vs clients’ resident in STA’s. Secondly, though Long Term Accommodation are not included as homeless accommodation it was deemed to be important to include an analysis of CMRs for clients in this accommodation for the purposes of transparency.

It was further decided to review whether duration of homelessness had any potential influence on death rates for single clients in Emergency Accommodation (EA). Thus CMR was generated for people experiencing homelessness according to the lengths of time in EA homelessness as defined in Table 10.

**Table 10: Classification of Duration of Homelessness**

Length of Time – in Months
60 months +
24-60 months
18-24months
12-18 months
6-12 months
6 months or less

Lastly, it was also decided to analyse accommodation status at death. In particular, it was felt important to identify whether the number of people who died while rough sleeping had changed significantly over time.

## Chapter 4: Results

### Chapter Summary

There were 79 deaths reported for 2020. 4 of these were not registered with DRHE or known to be homeless. 21 were in LTA and 6 in tenancies which are not recognised by the Census as Homeless. There was 1 death in family accommodation. There were 44 deaths of single homeless people either rough sleeping or placed in emergency accommodation.

Crude Mortality Rate (CMR) for Singles Emergency Accommodation and Long Term Accommodation (LTA) are provided for the years 2016 -2020.

CMR for Family Accommodation is provided for 2020.

CMRs for Supported Temporary Accommodation (STA) and Private Emergency Accommodation (PEA) are provided for the years 2016 – 2020.

CMRs by duration of homelessness demonstrate that the longer one is homeless, the higher the death rate. The rise in death rates is particularly steep after 18 months.

Median age of death for 2020 was 43 years (Males 46 years and Females 33 years). This is similar to other years 2016-2020.

The percentage of homeless people who died outdoors in 2020 was 9.3%. This was marginally higher than previous reports. Of note over half of those who died on the street had been in Emergency Accommodation the previous night.

### INTERIM REPORT

As explained in the preamble, due to incomplete data, for the purposes of the interim report, we are only reporting crude mortality rates. Standardised Mortality Rates would be a more accurate estimate of the mortality.

### 4.1. Overview

There were 79 deaths reported by the DRHE for the year 2020. However, 4 of these deaths were not registered with the DRHE. 21 were in LTA and 6 were in social tenancies neither of which are recognised as homeless accommodation by the Census. This brings the number down to 48 clients. There was only 1 death in family homelessness. Thus, in adult single homeless accommodation supported by the DRHE and recognised by the Census as being homeless accommodation there were 47 deaths in 2020. The corresponding figures for 2016-2019 can be seen in Table 11.

**Table 11: 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

However, over that same period of time there has been an increase in the number of single people experiencing homelessness so one would expect more deaths (see Table 12).

**Table 12: Total Population Adult Single Homeless Accommodation (excluding LTA and Social Tenancies) in the Dublin Region**

Year	2016	2017	2018	2019	2020
Total	1636	1894	2261	2550	2865

## 4.2. Crude Mortality Rates

Thus in order to obtain an accurate picture we need to review death rates. Taking into account limitations outlined in preamble to this document, we can estimate Crude Mortality Rates (CMRs) for the Family Homeless Population for 2020 and for Single Homeless Population for the period between 2016 and 2020. CMRs are provided in singles accommodation for those in EA and rough sleeping separately from those in LTA (as outlined in methodology section).

### 4.2.1. Crude Mortality Rates Family Homeless Adults

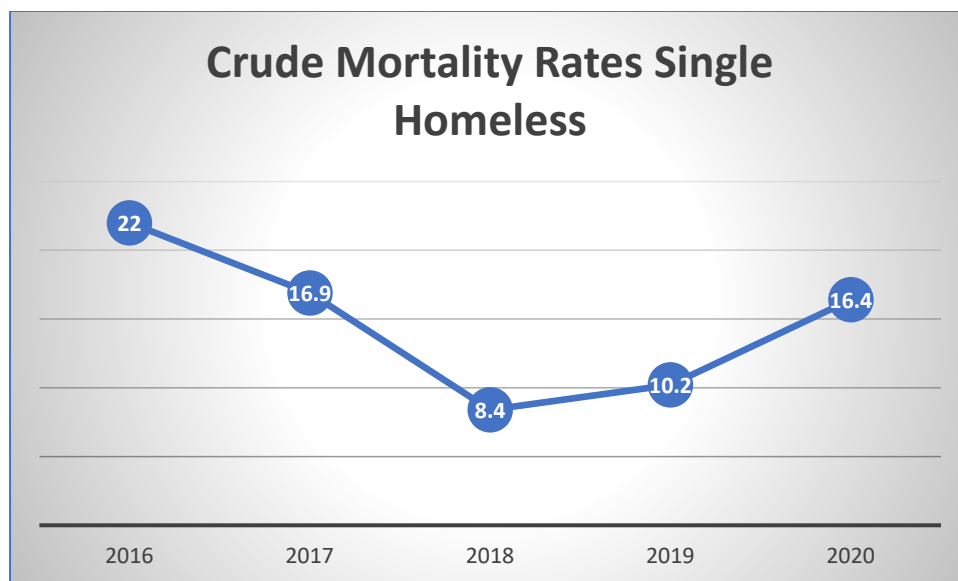
The Crude Mortality for 2020 for Family homelessness was 1.2.

### 4.2.2. Crude Mortality Rates Single Homeless

There were 44 people who died in Single Emergency Accommodation of whom 33 (75%) were male and 11 (25%) were female. This discrepancy between males and females can be explained by the fact that the homeless population is predominantly male.

The CMR for 2020 for single homelessness in Emergency Accommodation was 16.4. As can be seen from Figure 1, this represents an increase since 2019 (when CMR was 10.2) but a decrease since 2016 (when CMR was 22).

FIGURE 1: CRUDE MORTALITY RATES SINGLE HOMELESS



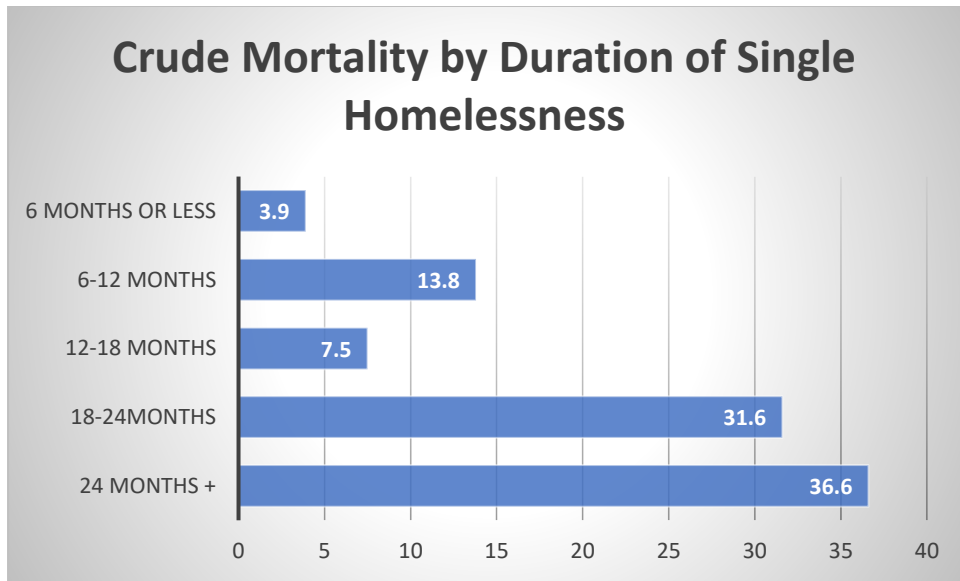
Of note care must be taking in interpreting this data for the following reasons. Firstly, it is only crude mortality for the whole population and is not weighted by age or gender. Secondly, as already noted it does not take into account the flow of people in and out of homelessness over the year 2020. Thirdly, the figures are based on a population from January 2020 when the population in homelessness was 2,865. By January 2021 this had risen to 3,054. Therefore, the numbers had increased over 2020 which would have exacerbated the magnifying effect of not taking into account flow data on crude mortality rates.

#### 4.2.3. Crude Mortality Rates by Duration of Homelessness

Crude Death Rates were calculated for clients based on the duration of their homelessness. A clear association can be observed with the longer the duration, the higher the mortality. This increase in mortality becomes particularly steep after the 18 month cut off. Essentially a person who was over 18 months homeless had a crude mortality over 8 times higher than a person who was homeless for 6 months or less. Again it is difficult to interpret this data as we do not have age or gender data and cannot assess whether this increased mortality is related to differing age/gender profiles of each accommodation.



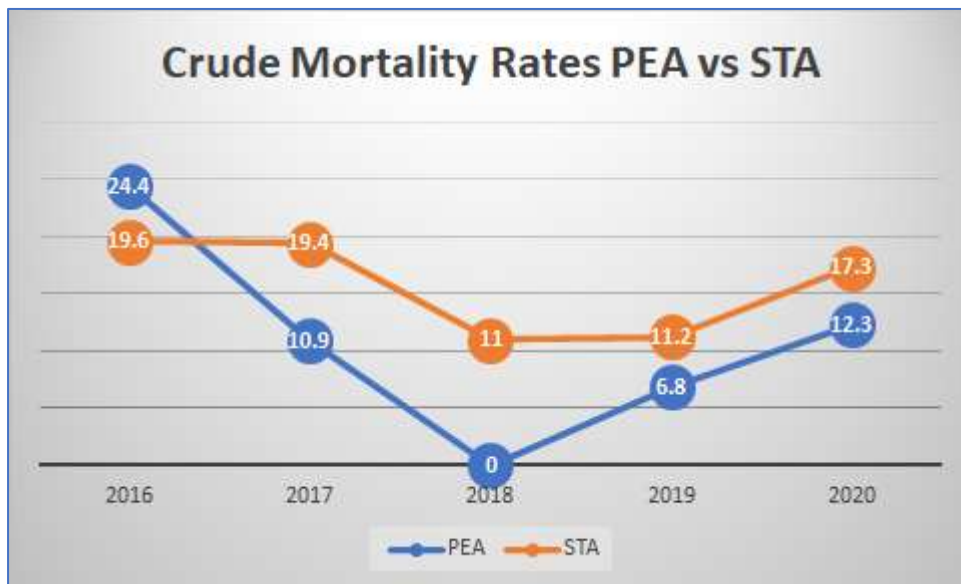
FIGURE 2: CRUDE MORTALITY BY DURATION OF SINGLE HOMELESSNESS



**4.2.4. Crude Mortality Rates by Accommodation**

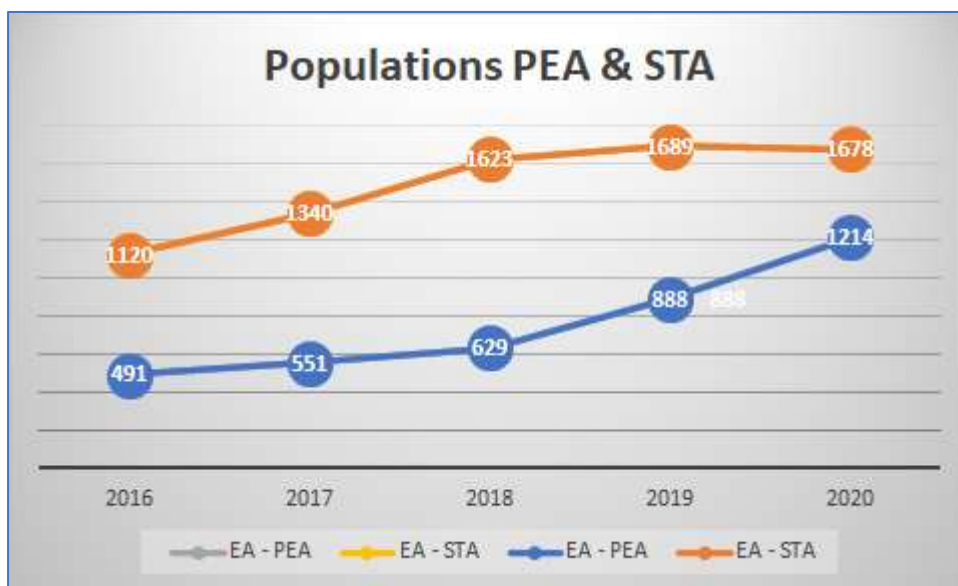
On reviewing mortality rates by accommodation since 2017 the mortality rate has been higher in STA’s compared to PEAs. (See Figure 3). Data on age and gender is not available and so it is not possible to ascertain if these factors may have influenced this higher rate.

FIGURE 3: CRUDE MORTALITY RATES PEA VS STA



Of interest in 2016, 30% of homeless people resided in PEA and 70% in STA. With the rise in the number of people who are homeless, the majority of new accommodation options was obtained in the PEA sector so that by 2020, 42% were residing in PEAs and 58% in STAs.

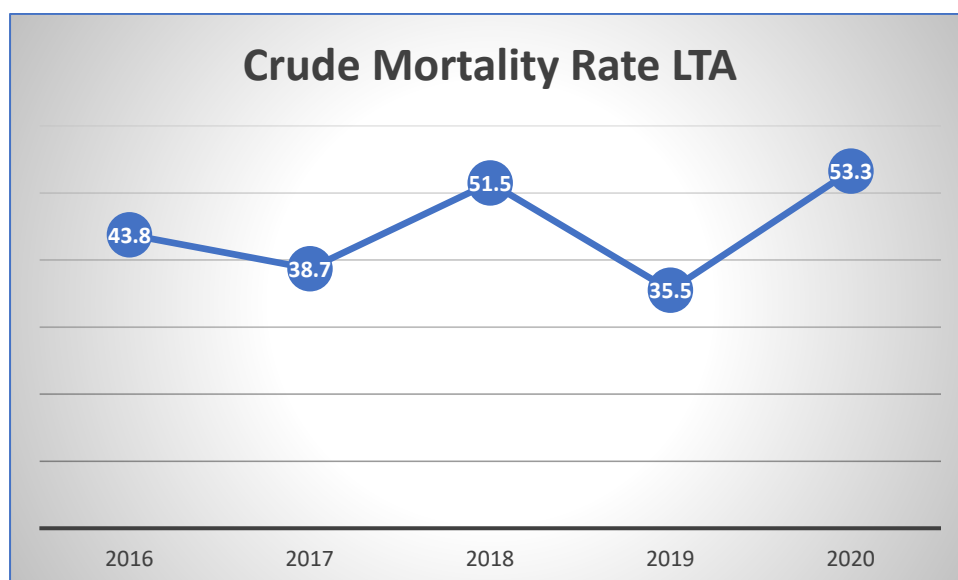
FIGURE 4: POPULATIONS PEA & STA



#### 4.2.5. Crude Mortality Rates in Long Term Accommodation (LTA)

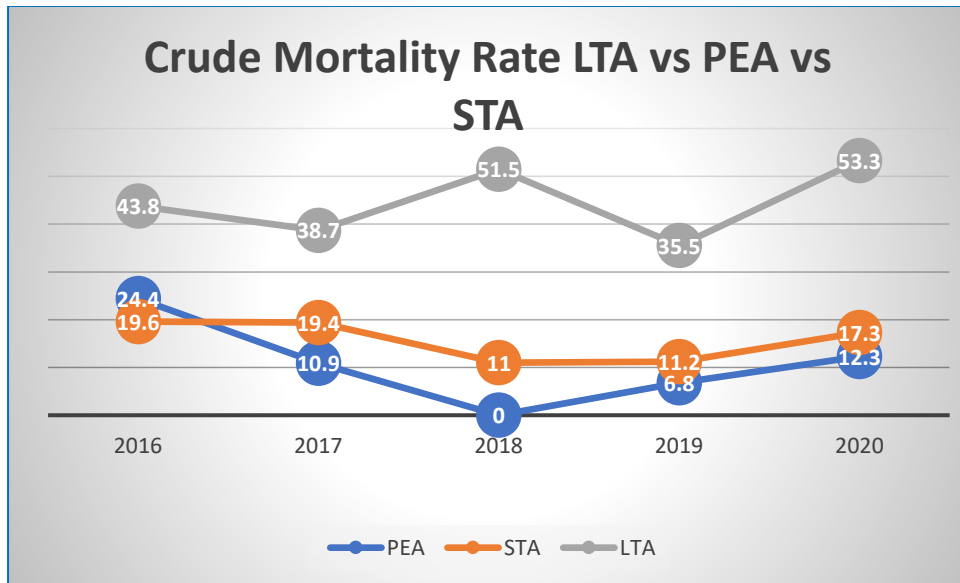
There were 21 deaths in LTA. Of these 15 were male and 6 were female deaths. The CMR for those in LTA in 2020 was 53.3. This represented a large increase since 2019 (CMR 35.5) and a lesser increase since 2018 (51.5) (see Figure 5).

FIGURE 5: CRUDE MORTALITY RATES LTA



CMRs for LTA were much higher than CMRs for PEAs and STAs (see Figure 6).

FIGURE 6: CRUDE MORTALITY RATE LTA vs PEA vs STA



### 4.3. Deaths of Rough Sleepers

There were 3 deaths of rough sleepers (2 female and 1 male). It is not possible to calculate the crude mortality rates as the number of rough sleepers over the year is unknown. Rough sleeper counts estimate over periods of about a week all rough sleepers identified by certain defined outreach workers. In November 2020, the rough sleeper count identified 127 individuals as rough sleeping over a particular week. If one took this as the denominator data the Crude Mortality Rate would be 23.6 but this would be a significant overestimate. However, the numbers of deaths of rough sleepers has been consistently low since 2016 (See Table 13).

Table 13: Deaths of Rough Sleepers 2016-2020

Year	2016	2017	2018	2019	2020
Rough Sleeping	2	0	1	1	3

### 4.4. Median Age of Death

The median age of death for Emergency Accommodation in 2020 was 43 years (Males 46 years and Females 33 years) (See Table 14).

The Median age in single EA homeless accommodation varied between 37 and 43 years between 2016 and 2020. The median age for men was generally consistently higher than the median age for women. It is hard to interpret this data as this could be related to the differing age profile of the male and female population in single homeless emergency accommodation.

**Table 14: Median Age by Accommodation Type**

	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

**Table 15: Median Age Death 2016 – 2020**

Year	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

The median age of death for Long Term Accommodation in 2020 was 54 years. (Males 53 years and Females 55 years)

#### 4.5. Location of Death

Most people (whether residents of EA or LTA) died in their own accommodation (See Tables 16 and 17). 8 people died outdoors. Of these 1 was not known to DRHE. It is important to recognise that people who die outdoors are not the same as rough sleepers. Of the 7 who were known to DRHE services and died outdoors, 4 were registered in emergency accommodation and had been staying the previous night in their assigned emergency accommodation and 3 were rough sleepers and not registered in any accommodation.

**Table 16: Location of Death - All Reported Deaths**

Tenancies (AHB/ HF / LA)	5
LTA - Tenancy	14
Hospital	15
EA - STA	23
EA- PEA	12
Outdoors	8
Unknown	2
<b>Total</b>	<b>79</b>

**Table 17: Location of Death - Single Service Users - EA & RS known to the DRHE**

<b>Hospital</b>	<b>7</b>
<b>EA - STA</b>	<b>23</b>
<b>EA- PEA</b>	<b>10</b>
<b>Outdoors</b>	<b>7</b>
<b>Total</b>	<b>47</b>

## Chapter 5: Discussion

### Chapter Summary

A number of conclusions were drawn from the results and literature review.

- Crude Mortality Rates (CMRs) for Single People Experiencing Homelessness (PEH) are high while rates for Family Adult PEH are low.
- CMRs for PEH in 2020 are not excessively high in comparison to previous years.
- Residents of Supported Temporary Accommodation (STA) have higher mortality rates than residents of PEA. This can be explained by the differing placement criteria for each type of accommodation. However, the difference between CMRs for STAs and PEAs is decreasing, while simultaneously the proportion of people living in PEAs is rising.
- Residents of Long Term Accommodation (LTA) have high CMRs. This can be explained by the differing placement criteria for each type of accommodation.
- The longer one is homeless the higher the mortality rates. The mortality rate rises significantly once one is 18 months or longer homeless. This could be related to age profile of those who are long-term homeless; due to the effects of homelessness; or due to the causes for them being long-term homeless e.g. substance misuse or mental illness.
- The percentage of homeless deaths that occurred on the street/outdoors has risen from 8.4% in 2015 to 9.3% in 2020, but remains low internationally.
- The main determinants of early death in PEHs are structural causes.
- 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 Stabilisations 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.
- There are a number of ways of learning from the deaths of people experiencing homelessness.
  - a. Aggregate Data Reporting. This involves in reporting regularly on data collected on homeless deaths over a defined time period.
  - b. Individual Death Analysis. Much learning can be obtained by reviewing individual deaths. There are 2 ways to review individual deaths:
    - i. Critical Incident Review. This involves a just culture approach to review cases so that learning can be obtained to improve services.
    - ii. Rapid Case Reviews on Clusters of Deaths. This process is for when a cluster of cases occur. Rapid investigation over 14 days would enable the identification of any preventable causes of death e.g. new types of illicit substances.
- A culture of blame will inhibit learning from deaths and improving systems. A blame culture causes individuals to hide mistakes and not engage in a process of identifying where systems go wrong and how they can be improved.

## 5.1. Conclusions

On reviewing the data and background literature there are a number of conclusions we can make about the higher mortality rate among persons currently experiencing homelessness in 2020.

### 5.1.1. Crude Mortality Rates for Single PEH are high while rates for Family Adult PEH are low

The crude mortality rates for single PEH varied between 8.4 and 22. These are high CMRs when compared the general population. For example the CMR for Dublin City in 2018 was 7.64 per 1000. In contrast the CMR for adults in family homelessness was low (1.2).

It is important to note that these figures are not directly comparable as the age profile of the general population would be higher. Therefore one would expect, all things being equal that the CMR for the general population would be higher than for the homeless population.

### 5.1.2. Crude Mortality Rates for PEH in 2020 are not excessively high in comparison to previous years

This report found that in 2020 there were a total of 48 deaths of people experiencing homelessness of which 47 deaths occurred in the single homeless population. When one calculates crude mortality rates one finds that while there was an increase from 2018 to 2019

and from 2019 to 2020, however, if one looks at a 5 year period between 2016 and 2020 there was actually a drop in mortality rates. The median age of death (43 years i.e. 46 years for men and 33 years for women) is comparable to the median age of death identified by Ivers & Barry (2018) (i.e. 42 years with 44 years for males and 36 years for females.<sup>(12)</sup> As already noted, the difference between men and women is difficult to interpret as it could be a reflection of the differing age profiles for the male and female homeless populations.

It is hard to ascertain why there is this pattern of declining mortality between 2016 and 2018 and rising again in 2020. The most likely explanation is simple statistical variation i.e. statistically it would be expected that death rates would vary from year to year.

#### **5.1.3. Residents of STAs have higher mortality rates than residents of PEAs but the gap is decreasing**

The finding that the CMRs were higher since 2017 for clients in STA's than in PEAs may be explained by the fact that DRHE placement tends to assign clients who are vulnerable due to age or health profile in STAs due to the higher level of care staff support and access to specialised primary care services. Safetynet provides medical inreach to the majority of STA facilities. However, there is a narrowing of the gap between the death rates between STAs and PEAs. This finding may reflect the increasing use of PEAs in comparison to STAs. The level of support for PEAs may need to be increased to similar to that provided to STAs.

#### **5.1.4. Residents of LTA have high CMRs.**

LTAs have higher CMRs, than those in Emergency Accommodation. However, when one takes into account the fact that LTA's tend to accommodate older and more unhealthy clients i.e. they are the equivalent of nursing homes in the homeless sector this is not surprising. The median age of death in LTAs is higher than in EA (54 years vs 43 years), which probably reflects that older age cohort in LTAs.

#### **5.1.5. The longer one is homeless the higher the mortality rates**

There are three possible ways of interpreting the data on the association between chronicity of homelessness and increased mortality rates.

- Firstly, we know the age profile of those are long-term homeless but not separated by household type (adults in a family or single adults). If those who are single long-term homeless are a more elderly age group this would explain the increased mortality.
- Secondly, it could be related to the effect of homelessness on health. If homelessness is inimical to health, then it is not surprising that the longer one is homeless the higher the mortality rates. The state of homelessness contributes to higher morbidity which in turn contributes to higher mortality.
- Thirdly, the factors that cause excess mortality may be the same ones that cause a person to remain for a long time in homelessness. For example, a person who is a



significant misuser of drugs will have a higher risk of premature death. <sup>(6–49)</sup> O Reilly et al (2015) found that those who were homeless for more than 6 months were most likely to give drugs and alcohol as the main reason for becoming homeless, whereas those less than 6 months were more likely to attribute homelessness to financial reasons. They concluded that those who were short term homeless were less likely to have substance misuse issues which makes it easier to exit homelessness. Thus substance misuse both contribute independently to both chronicity of homelessness and the increased mortality of people experiencing homelessness.

The obtaining of data on age profile by household type would allow us determine whether the first explanation contributes to the explanation for why long-term single homeless people have higher mortality rates. However, it would seem sensible to concentrate resources on addressing the needs of long term homeless people in particular the needs for long term housing, treatment of substance misuse and access to healthcare.

The Housing First programme is targeted in particular at this subgroup of homeless people i.e. those who are long term homeless. Housing First involves placing people into housing and providing wraparound support services including substance misuse and health services when required. Housing First has been demonstrated internationally to improve access to own door accommodation, reduced substance misuse and improved access to healthcare for those who are chronically homeless.<sup>(62)</sup> We do know that Housing First reduces the risk of dying from accidents or blood borne infections.<sup>(63)</sup> However, Housing First has not been demonstrated to reduce overall mortality.<sup>(83, 84)</sup>

#### **5.1.6. The number of homeless deaths outdoors has risen but remains low internationally**

Ivers et al. (2019) found that 8.4% of deaths from the period 2005-15 occurred outdoors. In 2020, 9.3% of deaths occurred outdoors. Internationally, both these figures represent low rates of outdoor deaths. Of these deaths in 2020, 4 out of the 7 were people who had been in accommodation the previous night. It would be important to review these cases in light of the coroner reports to determine circumstances. This will be included in the final report.

#### **5.1.7. The main determinants of early death in PEH are structural causes**

As O'Reilly et al (2018) note '*Homelessness is an unhealthy state.*'<sup>(17)</sup> In seeking to reduce the excess mortality associated with homelessness it would be important to address the two most significant structural determinants of the excess mortality in people experiencing homelessness, poverty and homelessness itself.

Firstly, many of the antecedents to homelessness that contribute to the reasons why people are homeless are independently associated with a poorer health profile and lower life expectancy. Most homeless people originate in areas of deprivation and poverty. <sup>(57, 87–92)</sup> '*Poverty and social exclusion are key causes of homelessness across developed nations.*'<sup>(72)</sup>

This effect of poverty can result in intergenerational homelessness.<sup>(73)</sup> Poverty/social inequality is well recognised as contributing to poorer health and a lower life expectancy.<sup>(27)</sup> Poverty is also independently associated with substance misuse which is associated with an increased risk of homelessness and a lower life expectancy.<sup>(74–77)</sup> Severe and enduring mental illness is also a significant cause of homelessness. It is also associated with a poorer morbidity profile and lower life expectancy.<sup>(78)</sup>

Secondly, homelessness itself is associated with poorer health and lower life expectancy. As Story (2013) describes the health of PEH: *“in comparison with the slope in health inequalities, the health experience of the homeless is more akin to a cliff, with homeless people experiencing a significantly disproportionate burden of morbidity”*.<sup>(79)</sup>

Thus, if policy makers wish to reduce the number of people experiencing homelessness having poor health and lower life expectancy, they need to firstly, address the ‘upstream’ causes of low life expectancy i.e. social and health inequities; the causes of substance misuse; and improve services for patients with severe and enduring mental illness. Secondly, policy makers need to continue to develop and support policies for the prevention of and rapid exit from homelessness. The number of people experiencing family homelessness was dropping prior to the Covid-19 pandemic. However, this reduction in numbers rapidly accelerated during the Covid-19 crisis. This is probably due to the rent freezes and increased availability of rental accommodation with the collapse of the tourist industry. This demonstrates that policy measures can still be taken to reduce the risk of people becoming homeless.

## **5.2. Interventions that May Reduce Mortality**

A number of interventions that have been made to reduce mortality exist in the literature with varying evidence bases as to their effectiveness.

### **5.2.1. Adopting a multi-agency response to deaths in homelessness**

As noted in the background literature there is little published data on interventions to reduce mortality in homelessness. The one intervention that was studied was the adoption of a ‘multi-agency response to the excess mortality in PEH. In Dublin, when deaths are reported in the media, the search for solutions tends to focus primarily on the DRHE and to a lesser extent on the HSE. In Boston, they responded with a multi-agency task force to help improve collaboration between all possible agencies that have significant interactions with people experiencing homelessness and to seek to identify interventions that would reduce mortality. It was not demonstrated these interventions reduced mortality.<sup>(49)</sup> Of note the Matthews Report 2013 made a similar recommendation.<sup>(47)</sup>

### **5.2.2. Improving access to primary and secondary care**

As noted in the background literature, access to primary care services is known to be associated with a longer life expectancy. Further, it is recognised homeless people have

poor access to mainstream GP services and that specialised services improve this access. Dublin is well recognised as having a well-developed network of specialised services at both primary and secondary care. At Primary care level PEH firstly, can access the mainstream GPs free of care by obtaining a medical card. Almost all homeless people should be entitled to a medical card on income grounds. In addition, there is a comprehensive specialised GP and/or nursing service provision from agencies such as Safetynet; GMQ; Thomas Court GP Practice Inreach; Depaul; PMVT; Dublin Simon; MQI; ALDP etc. including fixed site clinics; inreach services; mobile outreach; mobile screening services etc. In regards to secondary care, Dublin has two inclusion health teams in situ in the Mater and St James Hospital and is the first city internationally to have such a service. These teams focus on ensuring all marginalized groups, including homeless people have equitable access to secondary care. In addition, primary and secondary care services collaborate extensively including having regular multi-disciplinary team meetings; treatment programmes for homeless people e.g. those affected by Hepatitis C; and also communications on individual patient issues.

It has been noted that those clients in STA have inreach primary care services delivered onsite. This enables improved access to primary care. During the Covid-19 pandemic nursing and mental health worker teams were deployed to work in PEAs. With the increasing numbers of residents in PEAs and the converging CMRs between STAs and PEAs this access to nursing and mental workers is very welcome. Increasing these health supports and having GPs support these teams would augment the provision of care in this sector.

### **5.2.3. Improving access to mental health services**

The Irish mental health policy document A Vision for Change (2006), made several recommendations regarding the provision of mental health services to homeless people including that there should be clear direction to which community mental health teams are responsible for homelessness; the appointment of two CMHTs for homeless people on either side of the Liffey; CMHTs should provide care to homeless people on an outreach basis; a ten bedded crisis unit for homeless people who need monitoring but who would not meet the criteria for psychiatric admission.<sup>(80)</sup>

The 2019 national strategy for suicide preventions specifically names the need to focus on vulnerable groups who have been demonstrated both internationally and nationally to have high rates of suicide, including homeless people. The strategy called specifically for the following to be implemented for such vulnerable groups.

1. Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.
2. Improve access to effective therapeutic interventions (e.g. counselling, DBT, CBT) for people vulnerable to suicide.

As a result of the Vision for Change report (2006) two mental health teams for homeless

people were established on the North and South sides of the Liffey. These services accept referrals from primary care of clients with mental health difficulties not including substance misuse issues in the absence of severe mental illness. This fails to capture a large proportion of homeless people with depressive/anxiety symptoms or suicidal ideation including most of those with dual diagnosis (i.e. the coexistence of a mental health and substance misuse condition).

Clients with dual diagnosis generally come under the remit of addiction psychiatrists. However, there are no addiction psychiatrists specifically allocated to homeless services and there is no outreach addiction psychiatric team available to the Dublin homeless population. The delineation between general and addiction psychiatric services has been found to result in an insurmountable barrier to treatment for homeless people with dual diagnosis leaving many without access to mental health treatment.<sup>(17,51,58,81)</sup> Dual diagnosis is particularly harmful to those affected as it usually results in a downward spiral where the mental illness worsens the substance misuse which in turn has a deleterious effect on the mental illness, both of which often cause the person's homelessness status to worsen.<sup>(58, 82–84)</sup> As a result of these issues, there have been calls for an inreach mental health team, that has the capacity to deal with dual diagnosis, in the homeless sector separate to the two existing homeless psychiatric services.<sup>(17, 58)</sup> Of particular importance would be that such a team would have access to hospital beds for patients with dual diagnosis who are expressing suicidal ideation.

As regards the recommendations of the national strategy for suicide prevention for access to counselling (in particular dialectical and cognitive behavioural therapies) there is very poor access to such services in the homeless sector.

#### 5.2.4. Overdose prevention programmes

As noted there are a number of interventions that are known to reduce the risk of death from overdose. Many of these interventions are available in the Dublin setting including:

- a. **Supervised Injecting Centre.** With the Misuse of Drugs (Supervised Injecting Facilities) Act 2017, the legislative groundwork was implemented to allow for the development of a Supervised Injecting Centre in Ireland.
- b. **Naloxone Distribution:** In Ireland, Naloxone is provided with a doctor's prescription and has been distributed amongst opioid users; their families; and also hostel staff. However, the distribution has not reached every person who is at risk of overdose. Ideally, strategies to widen the distribution of Naloxone such as non-requirement for a prescription and/or pharmacy distribution should be considered.
- c. **Access to Opiate Substitution Treatment.** There are a number of service options for OST in Dublin for people experiencing homelessness including the Addiction Treatment Clinics (in particular the National Drug Treatment Centre) and GMQ Granby and MQI. During the Covid-19 Pandemic the access time to OST dropped from

12 weeks to 3 days. This had a dramatic effect on increasing access for untreated opiate users to treatment. Recently it was identified that some clients were disengaging from treatment and not being followed up. In response, the HSE set up a Reach and Engage Service to identify clients who had disengaged and clients who were not accessing OST and to engage them into treatment.

- d. **Access to Other Addiction Treatments:** There are a range of addiction treatments available including:
  - i. Community Benzodiazepine and Alcohol Detoxes.
  - ii. Inpatient Alcohol and Drug Detox
  - iii. Inpatient Stabilisations Centre specifically for homeless people
- e. **Overdose Risk Assessments:** There is no national overdose risk assessment processes in place nor are there protocols for management of clients identified as having such an increased risk.
- f. **Non-Fatal Overdose Reviews:** It is reported anecdotally that there are a large number of non-fatal overdoses that occur in homeless services. Prior non-fatal overdose are predictive of subsequent fatal drug poisonings.<sup>(85)</sup> People with a history of drug poisoning have been found on average to have 2 non-fatal overdoses per year.<sup>(86)</sup> In Wales there is a process for registering and reviewing non-fatal overdoses. These reviews are followed by an offer of support to engage with services so as to prevent further overdoses. Annual statistics on non-fatal overdose are maintained.<sup>(85)</sup> In Ireland, while records of non-fatal overdoses are kept, there is no process for reviewing non-fatal overdoses or notifying their health provider of such an event. There is also no reporting of numbers of non-fatal overdoses.
- g. **Availability of Low threshold Services.** There are a number of agencies already providing low threshold services in the Dublin region.
- h. **Overdose awareness.** There are a number of agencies who provide overdose awareness training and information including low threshold services; outreach services; accommodation providers etc.
- i. **Access to Primary Care Services.** As already noted Dublin has a comprehensive specialised primary care network and secondary care inclusion services.

FIGURE 7: KEY APPROACHES FOR REDUCING OPIOID-RELATED DEATHS



### 5.3. There are a number of ways of Learning from the Deaths of People Experiencing Homelessness

While structural causes may be the main reason for the excess mortality of PEH, it is vitally important that we monitor the deaths of homeless people to identify if there any interventions that could have occurred that would potentially have prevented any of these deaths. Learning acquired from reviewing deaths can be used to improve systems that could help prevent future deaths of PEH.

There are a number of ways of learning from the deaths of homeless people. These include looking at aggregate data on mortality (as in this report) but also by reviewing individual deaths.

#### 5.3.1. Aggregate data reporting

The DRHE has commissioned one report in 2015 on aggregate data on the deaths of homeless people. Such data is important in monitoring trends in+ mortality deaths. Comparative analysis of such data across a range of years can reveal trends. These can help identify if there is any area that may need an intervention to reduce mortality. The data that are important to monitor include:

- Standardised Mortality Rates (SMRs) by Gender per Annum.
- SMRs by chronicity of homelessness.
- SMRs by Single vs Family Homeless per Annum.
- Location of Deaths (in particular number of people dying when rough sleeping).
- Deaths from Overdoses.

Such reporting could be improved by using computerised programmes that could analyse data and produce reports for the DRHE. This would require the collection and storage of information in formats that would enable such analysis.

Of note, the DRHE/HSE are not in a position to make a judgment on causation of death. Such causation can only be obtained from the death certificate of the deceased person. Further data on events leading to causation of death can also be obtained from Coroner Inquest reports. Having reviews of causation of deaths provides valuable data in helping identify whether there is an increase in preventable deaths e.g. a rise in overdose deaths would be of concern that services were not meeting the needs of people experiencing homelessness with substance misuse problems.

### **5.3.2. Individual death analysis**

This report reviewed the total numbers of deaths of people experiencing homelessness. However, it did not delve into the detail of each individual case. Developing an ability to review individual cases to see if there were any potential intervention points that would have prevented a death could provide rich data that could inform the development and improvement of service delivery. It would also be very useful, and potentially more valuable, to examine individual deaths and review were there any potential interventions that could have prevented or reduced the risk of that death. For example, a cursory review of two suspected overdose deaths in 2020 revealed that two clients died when rough sleeping. They had disengaged from opiate substitute treatment only 6 weeks prior to their death. This knowledge resulted in the service developing an outreach service to re-engage those who dropped out from treatment back into meet the clinicians. Reviews of deaths from overdose, suicide, preventable physical disease, the effects of addiction etc. can often help identify where services missed opportunities to intervene or where there were gaps in service provision.

There are two process that could yield valuable learning on how to potentially reduce the mortality of homeless people. Critical incident reviews would provide learning by examining in detail the circumstances leading to deaths that were identified as potentially preventable. Rapid reporting would provide data on clusters of deaths to identify if the clusters were products of statistical chance or were a result of a preventable cause.

### **5.3.3. Critical Incident Review**

The development of a critical incident review process was recommended by the Matthews Report (2013).<sup>(47)</sup> A critical incident is any unintended event that occurs when a patient is in service that results (or could reasonably have resulted) in death, injury, harm or serious disability to the client and does not result primarily from any medical condition that affects the patient or from any known risk inherent in the delivery of service. Critical incident review involves applying a structured analysis using best practice methods, to determine what occurred, how it occurred and why it occurred and what is the learning that can be

obtained to enable service improvement for the service itself, the wider organisation or nationally.

A key principle of critical incident review is that a just approach be adopted. The purpose is to identify individual or system failings that will allow individuals and/or systems to learn how to avoid similar incidents in the future. Leape (2009) noted that the most significant impediment to error prevention is that we punish people for making mistakes.” Leape suggested that in critical incident management:

- We need to move from looking at errors as individual failures to realising they are caused by system failures.
- We must move from a punitive environment to a just culture.
- We must move from secrecy to transparency.
- Care must change from being clinician-cantered to being patient-cantered.
- We must move our models of care from reliance on independent, individual performance to interdependent, collaborative, inter-professional teamwork.
- Accountability must be universal and reciprocal, not top-down.<sup>(87)</sup>

Of note a just culture recognises individuals should not be held accountable for system failings, it is expected that individuals display the appropriate professionalism in the fulfilment of their duties. A just culture does not tolerate unprofessional and wilful disregard of clear risks to patients or unprofessional behaviour e.g. working while intoxicated or falsifying records etc.

In response to the Matthews report, all organisations who are funded by the HSE in the homeless sector are required as part of the Quality & Safety section of their Service Level Agreement (SLA) with the HSE, to conduct critical incident reviews for deaths where the Gardaí are called; the death is suspicious; or the HSE and/or the medical team treating the patient were not aware of the person suffering from any known serious medical condition. The findings of this critical incident review is then appraised by the organisation to identify any learning and then relayed to the HSE. The HSE will likewise appraise the report for any learning for the wider system.

There are some gaps in the present critical incident review system:

Firstly, it only applies to organisations that have a Service Level Agreement (SLA) with the HSE. Deaths that occur in or under services that have no such SLA do not conduct such a review e.g. PEAs would not have HSE SLAs.

Secondly, the organisations do not necessarily have access to all the information regarding the death. For example, if a client was attending an addiction treatment service; had been in



hospital the week before; attended a GP; and had been in trouble with the Gardaí; any or all of those services may have information relevant to understanding the causation chain for that individual's death. There are no data sharing arrangements with such organisations to obtain this information.

Lastly, incidents in the homeless sector are not automatically reported to the National Incident Management System (NIMS). If a client is under mental health services and commits suicide they are reported to NIMS. However, if a homeless client who is not linked to services died by either overdose or suicide they are not reported to NIMS. It is important to record people who die from preventable causes with known treatment options that are not accessing the services that may have prevented their deaths on NIMS.

#### 5.3.4. Rapid Case Reviews on clusters of deaths

As well as having an annual mortality review and critical incident review processes it is also important to have the ability to respond to clusters of deaths in PEH. The reason for this is that while such clusters will occur randomly by statistical chance, that there may be times when there is a preventable cause for these deaths. For example there was a report of a 'bad batch of Lyrica (Pregabalin) medication and it was suggested this could explain four deaths of homeless people in Dublin.<sup>(88)</sup> Such a rapid case review was commissioned by the HSE for suicide deaths in west Dublin in 2020.<sup>3</sup>

This approach was also adopted in Wales for clusters of deaths amongst substance misusers. In the Welsh model, a lead officer is appointed to coordinate the investigation. This lead officer reports to a Harm Reduction Group. Harm Reduction groups are set up with a range of representatives. (See Table 18).

**Table 18: Harm Reduction Groups Representation in the Welsh Model**

- Substance misuse services
- Police
- Ambulance
- Coroners service
- Community Mental Health
- Youth Services/Youth offending Teams
- Social Services
- Housing and Homelessness Services
- Probation Services
- Local Intelligence Network

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<sup>3</sup> <https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/rapid-assessment-and-community-response-to-suicide-in-dublin-south.html>

- Local Hospital Services
- Primary Care
- Prison
- Health Services Executives.
- Department of Health.

Of note, such reviews cannot make determinations as to cause of death as this responsibility lies solely with the Coroner's office. The review is coordinated with the Welsh Coroner's Office. Information is obtained by the Lead Officer from those who are likely to know of the circumstances (peers/ family/ carers/ drug/alcohol workers/ social services/ housing/ prescribers/ Primary care, police etc.). This consultation can take place in person, via phone/video or in writing; individually or as a group. The lead officer must produce a report within 14 days that details at least the following:

- Demographics
- Details on the circumstances around the death including current medication and details regarding contact with health/social care/criminal justice services in the previous six months
- Summary of risk indicators/factors.
- Lessons Learned.
- Recommendations. Where possible any recommendations that can be implemented immediately are applied and subsequently monitored.

Where there is insufficient information the case remains open, until the Welsh coroner's report is completed and reviewed. All case reports are reviewed in light of the final coroner's report in order to produce a final analysis.<sup>(85)</sup>

#### **5.4. A Culture of Blame will Inhibit Learning from Deaths and Improving Systems**

It is widely accepted that quality improvement is best achieved by processes that do not involve blaming individuals or organisations. A system that encourages blame also encourages it's operatives to seek to avoid blame by suppressing information, denying errors occurred and seeking to obfuscate the cause of the error and the path of responsibility. Frank discussion and analysis of mistakes to prevent future ones is prevented. "*The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes*".<sup>(87)</sup> "Ninety three percent of doctors say they would disclose a major error to a patient but less than 5% of errors are reported due to physicians fear of being blamed."<sup>(89, 90)</sup>

In medicine the attribution of blame has been shown to reduce performance in those blamed.<sup>(91,92)</sup> Distrust is fostered and defensive medicine encouraged.<sup>(93,94)</sup> *The drastic*

*consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our own culpability when results are poor, and the medical and societal denial that mistakes must happen all result in an intolerable paradox for the physician.”<sup>(95)</sup>*

Systems that want to encourage the reporting and analysis of mistakes so as to improve quality of care need to operate a blame free environment.<sup>(96)</sup> This approach has been adopted in many industries and disciplines.<sup>(97, 98)</sup> The aviation industry adopted a non-blame approach so mistakes would be reported and investigated. It operates a Safety Reporting system for staff to self-report incidents.<sup>(93)</sup>

As well as encouraging the reporting of errors, blame free cultures promote the offering of sincere apologies and when merited appropriate compensation. *“Apologies—statements that acknowledge an error and its consequences, take responsibility, and communicate regret for having caused harm— can decrease blame, decrease anger, increase trust, and improve relationships.”* Clients are less likely to take a suit if they had been informed of the mistake.<sup>(99)</sup>

## Chapter 6: Recommendations

### Chapter Summary

Recommendations are subject to the completion of the report once coroner records are available.

Recommendations are made in four separate categories.

- Recommendations on data collection and analysis of data are made.
- Recommendations on Learning from Deaths in Homelessness.
  - i. Implementation of a Critical Incident Analysis Framework. Recommendations are made on how to develop this process.
  - ii. Five Yearly Reports on Mortality Trends.
  - iii. Introduction of a Rapid Review Process for Clusters of Deaths. Recommendations are made on how to develop this process.
- Recommendations seeking to reduce Mortality of People experiencing homelessness.
  - i. Reduce Long-term Homelessness. The Housing First model is the optimum approach to achieve this objective.
  - ii. Multi Agency Committee to Review Five Yearly Mortality Reviews.
  - iii. Ensure Access to Primary Care Services in PEAs. During the Covid-19 Pandemic there were nursing, mental health and drug case workers services developed for the PEAs. These should be maintained and augmented with GP services.
  - iv. Improve Access to Mental Health Treatment in particular those with Dual Diagnosis.
  - v. Reduction of Overdose Fatalities:
    - Improve access to Naloxone.
    - Supervised fixed/mobile injecting centres
    - Access to OST for PEH to be maintained as low as possible.
    - Develop protocol for Overdose Risk Assessment.
    - Develop protocol for review of Non-Fatal Overdoses.
- Research Recommendations. Research to be conducted to ascertain:
  - i. Why chronicity of homelessness is linked to a higher mortality rate.

## 6.1. Overview

It is recommended that the full report be completed once coroner records are available. This is of particular importance for reviewing all deaths that occurred outdoors.

Recommendations have been sorted into four discrete categories.

1. Data Collection.
2. Learning from Deaths in Homelessness.
3. Addressing Causation of Deaths in Homelessness.
4. Research Recommendations

## 6.2. Recommendations on Data Collection

It is recommended that in collecting and analysing data on mortality the following be taken into account:

1. Develop a computerised system that allows for the rapid analysis of data in the following ways:
  - a. Separation of Family and Singles Homeless deaths and populations by gender and age.
  - b. Separation of Accommodation Typologies (STAs; PEAs; TEAs; LTAs) deaths and population by gender and age.
  - c. Deaths according to chronicity of homelessness by gender and age.
  - d. The provision of 'flow data' whereby the population of homeless individuals over a single year can be fully assessed. This should be set up in a manner that allows the number of people who become homeless along with the duration of time they are homeless to allow for a more accurate estimation of the population of people experiencing homelessness for use in the calculation of mortality rates.

Reports should be easily and rapidly obtainable on all these variables.

2. Exclude deaths in types of tenancy that not recognised as homeless for the purpose of the Census. This accommodation types include:
  - a. Long Term Accommodation
  - b. Housing First Tenancies
  - c. Social Housing Tenancies with visiting supports.
3. Separate out the data for Long Term Accommodation separately from the other forms of homeless accommodation.
4. Separate out mortality rates for Family Homeless and Singles Homeless. Data demonstrates that the mortality rates in Family homeless are much lower than

amongst single people experiencing homelessness. Combining both sets of data creates misleading perceptions of the effects of homelessness on families (by inflating the mortality rate) and on singles (by deflating the mortality rate).

### **6.3. Recommendations on Learning from Deaths in Homelessness**

#### **6.3.1. Implementation of a Critical Incident Analysis Framework**

The Death Notification Policy needs to be standardised across all homeless services.

The critical incident reporting system in place needs to be reviewed in discussions with the HSE. It is recommended that the following issues be addressed in this review:

- All deaths have a critical incident review (including those in contact with services without a HSE SLA and those not in contact with any service).
- The HSE should have recourse to a critical incident management review process for those clients where it is identified that the death was potentially preventable but the organisation conducting the review cannot access all the information regarding the death, as the client was involved with other agencies/organisations/bodies. The HSE should develop data sharing agreements with the necessary range of agencies to obtain the necessary information to have a thorough review.
- Critical Incident Reviews should result in a learning plan for the sector that is has clear recommendations that can be realistically implemented to reduce the risks of similar incidents re occurring.
- All serious critical incidents that occur in homeless settings including deaths by suicide or overdose should be reportable to NIMS.

#### **6.3.2. Five Yearly Reports on Mortality Trends**

The DRHE should report on deaths of PEH in DRHE services every five years. This would be facilitated by the introduction of a computerised program and database that would allow for the collection, analysis and report production. The data would be then be reviewed in collaboration with the HSE to identify if there are any trends that deserve more detailed analysis. Such regular reporting was recommended by Ivers & Barry in their 2018 report. The report should also include a review of causation of deaths using data from the Coroner's Office.

### **6.3.3. Introduction of a Rapid Review Process for Clusters of Deaths**

It is recommended that the DRHE and HSE consider roles and responsibilities regarding the review of clusters of deaths. A clusters of deaths is two or more linked deaths (e.g. two people dying in same place; two or more people dying from drug overdose at same time).

## **6.4. Recommendations seeking to reduce Mortality of People experiencing homelessness**

### **6.4.1. Reduce Long-term Homelessness**

While there is little evidence to suggest that housing homeless people improves mortality, it would seem wise to focus on re housing those who are chronically homeless, in particular those who are homeless for over 18 months. The Housing First model is the optimum approach to achieve this objective.

### **6.4.2. Multi Agency Committee to Review Five Yearly Mortality Reviews**

It is recommended that a multi-agency committee be appointed to review the five yearly mortality reports to identify if there is any learning for the sector that would lead to an improvement in services and a reduction of the risk of premature deaths of people experiencing homelessness. This committee should include a broad range of agencies including DRHE; Local Authorities, HSE; Addiction services; Mental Health Services; Local Hospitals (in particular Emergency Departments); Accommodation providers; outreach services; Ambulance Services; Gardaí; homeless experts by experience and homeless advocates. The committee should produce a report identifying how the sector could improve its provision of services and identifying collaborative responses to address the high mortality in the homeless population.

### **6.4.3. Ensure Access to Primary Care Services in PEAs**

Residents of PEAs have had inreach access to addiction, nursing and mental health workers during the Covid-19 pandemic, provided by the HSE. This should be maintained and increased after the pandemic and augmented with access to GP care to provide a General Practice inreach team.

### **6.4.4. Improve Access to Mental Health Treatment particularly for those with Dual Diagnosis**

It is recommended that an outreach mental health team be established, that works with homeless people irrespective of address and that will accept clients who have dual diagnosis. Of importance, outreach would imply that over 50% of their work would be to emergency accommodation, day or rough sleeping services. It is further recommended that this team have access to hospital beds for clients who need inpatient treatment.

It is recommended that homeless people have access to counselling services as recommended by the National Suicide Prevention Strategy 2015-20.

#### **6.4.5. Reduction of Overdose Fatalities**

1. It is recommended that efforts are made to ensure that all opiate misusers; their families and companions; and services that work with such clients have access to naloxone treatment and training.
2. It is recommended that policy for Supervised Injecting Centre be progressed.
3. It is recommended that the access time to OST be at latest as per recommended guidelines i.e. 3 days to assessment and 4 weeks to commencement of treatment.
4. It is recommended that a protocol for overdose risk assessment be developed for homeless opioid misusers. This was recommended by the Matthews Report 2013.
5. It is recommended that non-fatal overdoses reviews be conducted. These should be conducted by the treating physician. Thus, it is essential that addiction physicians are notified of such non-fatal events. Where there is no responsible addiction physician, a nominated clinician with experience in management of addiction should be appointed to review such cases. It is also recommended that non-fatal overdoses be recorded and monitored on an annual basis. A process for notifying physicians and/or exploring treatment options for those not on treatment should be explored by the HSE.

#### **6.5. Research Recommendations**

It is recommended that research be conducted to ascertain:

- Why chronicity of homelessness is linked to a higher mortality rate.

#### **6.6. Conclusions**

There is a propensity in the media to approach the issues of death in people experiencing homelessness from a 'there must be someone responsible' approach. This fails to recognise that the main determinants of low life expectancy in homelessness arises from the causes of homelessness that are associated with high mortality rates such as poverty and drug addiction and the fact that homelessness itself raises the risk of premature mortality. Services need to be constantly vigilant to address any preventable causes of premature mortality in people experiencing homelessness and develop processes to critically review both aggregate death statistics and individual 'critical incident' deaths. Future reviews of mortality need to ensure that they analyse the data in a manner that ensures the results are as accurate and useful as possible. Individual case reviews need to be conducted adopting a 'just culture' approach so that staff are not in fear of being made accountable for system failures or mistakes that do not arise from unprofessional conduct. This will ensure staff will be open and honest and seek to create system solutions that will help prevent future deaths. There are a number of evidence-based initiatives that could be implemented to reduce mortality of homeless people, in particular in reducing the risk of death by substance misuse overdose.



Ireland can be proud of the response to the Covid-19 Pandemic in the homeless population. Compared to other jurisdictions, Ireland had a very low Covid-19 infection and death rate. This was due to the investment both monetary and human and the extensive collaborative effort between the DRHE and HSE. We should build on this success in seeking to reduce the death of people experiencing homelessness going forward.

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