In Search of Good Data – But do we Better Understand Homeless Mortality? A review of two Irish reports on the deaths of people experiencing homelessness

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Introduction

Deaths of people experiencing homelessness usually remain hidden from the public view. If they appear in the news, it is most probably some shocking case or a single figure that was tallied by some grass-roots initiative. Homeless mortality is also an under researched subject both in health and in social sciences. This comes also a result of the fact that there are no systematically collected data. This search for data that was not there, was captured, for instance, by an investigative journalist Meeve McClenaghan (2020). A large part of the knowledge about homeless mortality, usually from the public health perspective, is based on some linking of administrative databases. But we still do not know enough and there are many studies that collect their own data, sift through police reports (Romaszko et al., 2017), interview people queued to the soup kitchen (Cheung and Hwang, 2004), hand-check shelters' postcodes (Thomas, 2012), and rely on data crowding (Homeless Deaths Count).

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Ireland has some of the most interesting data on homelessness. Thanks to the PASS system, longitudinal data about individuals and families accessing "homeless" accommodation is collected. Yet, there is no systematic data collection concerning the deaths of people who are or were supported by this system. Hardly any constituency in the Global North is doing that. Two reports on homeless mortality in Ireland were recently published. This is a review of these two studies. Additionally, the aim of this piece is to show some of the pitfalls and challenges of such research and to reflect on researching homeless mortality in general.

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

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

O'Carroll's Study

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

In total, 47 cases were identified. Data on age, sex, type of accommodation, duration of homelessness, and location of death was available. Since the data came from DRHE, no causes of deaths were reported. Crude Mortality Rates (CMR) were

calculated and compared (more on that further below). Findings are in line with what we know from literature and previous Irish studies – people experiencing homelessness die young and prolonged homelessness leads to increased risk of death.

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

HRB Report

The HRB report was published in 2023. It uses the data from 2019 to avoid the 'troublesome' years when data was influenced by the COVID-19 pandemic. Data was drawn from coronial files, which contain cases of violent deaths caused by accidents, suicide, overdose, etc. From this set, a subset of deaths that occurred while experiencing homelessness was selected. The definition of homelessness follows thus what the coroner classified into one the four categories: (1) without accommodation, e.g., street-based sleepers, (2) temporary or crisis accommodation, (3) severely substandard or highly insecure accommodation, and (4) homeless in an unknown situation. Further, more data on the cases was obtained. It is not entirely clear to me, but I guess that these cases were crossed-referenced with deaths in the National Drug-Related Deaths Index (NDRDI) database, an epidemiological database which records all poisoning deaths by drugs and/or alcohol.

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

There were 84 deaths identified in 2019. Most individuals had a long history of problematic substance use. More than 38% had mental health problems. Many were known to have epilepsy, some were not following treatment. Fifty deaths took place in Dublin, 34 in a public space.

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

Is a Comparison Even Possible?

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

One may wonder, however, about the inconsistencies between these two reports and data that come from the same year (2019). Of course, the HRB looked at the whole of Ireland while O'Carroll only at Dublin. O'Carroll finds three street-based sleepers who died in 2019 and eight people who died outdoors (not the same cases, however an overlap is possible). Fifty out of 84 deaths in the HRB report occurred in Dublin, 40.5% of all deaths occurred in a public space, public building, etc. There is no way to tell from the report how many deaths occurred 'outdoors' in Dublin, but likely more than eight; there were 18 deaths of people categorised as "rough sleepers". Discrepancies between these numbers may raise doubts. But in fact, these numbers are low (in statistical terms) so it is hard to judge how significant the differences are. More importantly, however, a number of issues (summarised in Table 1) make this data hardly comparable at all.

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

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

PEH people experiencing homelessness

CMR crude mortality rate

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

DRHE Dublin Region Homeless Executive

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

In the HRB study, data came from files from the coroner's office, which, by definition, means that all deaths were premature, violent, suspicious, caused by poisoning, etc. A subset of those deaths was selected, namely those that occurred to 'homeless' people. The overlap with the DRHE population is hard to guess. Twenty six out of 84 cases were in substandard or insecure homelessness or unknown types of homelessness. These cases are perhaps an extra on top of the narrower definition used in O'Carroll's study. Apart from a cross table of poisoning/non-poisoning death with a type of homelessness, no further analysis by type of homelessness was presented. Some descriptive statistics were calculated for the whole set of 84 cases. These numbers are difficult to interpret. For instance, 55% of deaths occurred due to poisoning. This was not compared with all deaths that the coroner investigated. I think it would be relevant to know, for instance, what was the overall proportion of deaths by poisoning and what part of them happened to people experiencing homelessness?

In the HRB type of study, we look at the outcome (death) first and then see who was homeless. Actually, it is hard to tell what the cause and effect is. Was homelessness caused by problematic substance use and mental health problems? Or the other way around? In the O'Carroll type of study, we look at the condition (homelessness) first, and then see who has died. Here we potentially have a better way of controlling the independent variable that interests us (types of homelessness, duration of homelessness), but we would have to look at the whole population as well. However, to understand the impact of homelessness, a more in-depth study reconstructing homelessness history for each person would be required. As a result of those limitations, both reports contribute to the same bias. By focusing on those who died (and especially those who died a violent death as in the HRB report), they paint a

very sombre picture but with little room for context. What does the situation look like in a vulnerable group as a whole? How does it compare to other (vulnerable or privileged) groups?

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

As researchers, we would like to have more reliable data – to calculate robust Standardised Mortality Ratios (SMR) and conduct an even more detailed and refined statistical analysis – ideally, to see what the impact of homelessness itself is on health and death. We would like to have an annual study following the same methodology to identify potential trends.

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

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

Finally, as critical researchers, we should ask, why there is only such data? Why do our conclusions have to be so limited? Authors of these two reports have done what they could, but it begs the question: why aren't there more systematic efforts to collect this data? There are fundamental methodological problems obviously (how to define the population!), but as Cooper and McCulloch (2023) argue, there is a general invisibility of homelessness experiences in life and in death. Bhandar (2022) calls it an "organized abandonment" of state responsibilities to citizens and residents to provide basic levels of safety and security. In relation to homelessness, Cooper and McCulloch (2023, p.222) understand it as "a pervasive way of governing and organising homeless people in ways that lead to their exclusion, prolong their

suffering and amplify the risk of premature death". Of course, it is not a complete neglect. Some data are made available, some hypotheses are confirmed, some conclusions are drawn. These reports are two valuable contributions. But do we understand better to what extent is this a case of organised abandonment? And why? Are we getting closer to understanding the impact of homelessness on health and to preventing those deaths?

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