I. National Homeless Mortality Overview

The Scale of Homeless Deaths in the U.S.

The U.S. government does not conduct an official count of the number of people who die while experiencing homelessness. When a person experiencing homelessness (PEH) dies, their housing status is rarely recorded. However, the National Health Care for the Homeless Council identified 68 cities and counties who recorded the deaths of people experiencing homelessness in 2018. These 68 jurisdictions found at least 5,807 people without homes who passed away that year. Homeless death counts for each city or county are collected from a combination of local news reports, medical examiner office and coroner findings, through a public records request, and direct correspondence with local organizers of Homeless Persons' Memorial Day. News reports of death counts conducted by local community advocates, shelters, homeless service providers, and religious organizations are by far the most common group that contribute data to this count.

An under-estimate: For many reasons, the estimate of 5,800 homeless deaths in 2018 underestimates the total number of homeless deaths that occur in the U.S. each year. First, it represents death counts from only 2% of all U.S. counties. Second, each death count reported by a city or county likely misses many deaths each year because a decedent's housing status is unrecorded, is incorrectly recorded as housed, the death is not investigated by a medical examiner or coroner, or the death is unknown by community members compiling the annual homeless death count.

> **The estimate of 5,800-46,500 deaths among people experiencing homelessness per year highlights the vast, and largely hidden, scale of homeless deaths in the U.S.**

A rough estimate of the proportion of PEH who die each year can be determined using data from jurisdictions that conduct both a death count and a homeless "point in time" (PIT) count.[i] Based on the 27 jurisdictions with this data for 2018, a range of mortality between 3% and 8% can be determined (calculated by dividing the mortality count number deemed homeless through the PIT count). By applying these proportions from 27 cities to the national PIT count (where the PIT report counted nearly 553,000 individuals), it is estimated that between 17,500 and 46,500 homeless deaths occurred in 2018.

These figures should not be interpreted as firm estimates of total annual homeless deaths. Research indicates PIT count data significantly underestimate homelessness prevalence, homeless death rates likely vary considerably across cities and counties, and most death count reporting among PEH are not comprehensive. However, 5,800 deaths are known and upwards of 46,500 deaths among PEH are estimated, which highlights the vast, and largely hidden, scale of homeless deaths in the U.S.

Homeless Death Reports

Some cities and counties, mostly those with large homeless populations, conduct annual or biannual reviews or reports of homeless deaths. These reviews are often conducted by medical examiner offices with the intent to provide information on the number of homeless deaths, the causes and manner of death, and further demographics.

Across most examined communities, homeless deaths have substantially increased over the past five to ten years.

The following summary is based on homeless deaths reviewed in:

- Los Angeles County, CA
- Sacramento County, CA
- San Francisco, CA
- Santa Barbara County, CA
- Santa Clara, CA
- Denver, CO
- O'ahu, HI
- State of Maryland
- New York City, NY
- Multnomah County, OR
- Philadelphia, PA
- Nashville, TN
- Austin, TX
- King County, WA

In most cases, findings from 2018 reports were used (reports in Appendix B).

Across most of the included cities and counties, homeless deaths have substantially increased over the past 10 years. For example, homeless deaths have increased in New York City from 177 in 2008 to 290 in 2018, an increase of more than 50%. Similarly, in Los Angeles County, homeless deaths have doubled from 518 in 2014 to 1,038 in 2019. It is difficult to determine the impact of increased reporting of homeless deaths in recent years, however, as more jurisdictions focus on these deaths and report this data, stronger evidence will emerge of the number of people dying while experiencing homelessness in the U.S.

Demographics of Those Who Died

Gender

Men account for approximately three in four of homeless decedents. In Austin, Texas, 87% of people who died while experiencing homelessness were male, compared to 13% female. The proportion is lower in some places, such as Multnomah County, Oregon, where 76% of homeless decedents are male and 24% are female. Only San Francisco, California, reported homeless deaths for transgender individuals (<1%) and no city or county recorded homeless deaths for non-binary individuals.

Age

Few cities or counties consistently report the age of people who died while homeless, but the data from a few jurisdictions suggests more than half of deaths occurred among people aged 45 or over. In **Philadelphia**, people aged 45+ accounted for 55% of all homeless deaths. In **Denver**, the average age was 47, and in **Seattle/King County** it was 54. **Multnomah County, Oregon**, women died on average at age 44 and men at age 48, while in **Sacramento County, California**, women died on average at age 43 and men at age 52.

Sacramento County calculates that "using a national life expectancy average of 75 years old, homeless lives in Sacramento are cut short by an average of 33% or about 30 years for homeless women and 23 years for homeless men."

Race and Ethnicity

Homelessness is caused by historical and structural oppression. White people account for the bulk of homeless deaths in most places that report data, accounting for 48% of deaths in **Philadelphia** and 83% in **Multnomah County, Oregon.** Black people (who, along with Indigenous

Advocacy Spotlight: City of Philadelphia

1. Philadelphia dedicated over $40 million in new funding for programs to expand work started by the Philadelphia Resilience Project, which includes about $30 million to the Office of Homeless Services.
2. Philadelphia also increased funding and public awareness to address the opioid crisis (a leadings cause of death), taking the following action steps:
   a. Increased low barrier shelter beds in areas hardest hit by the opioid crisis
   b. Increased the number of treatment beds
   c. Increased the availability of treatment on demand
   d. Distributed Naloxone (the overdose-reversing drug to organizations serving people experiencing homelessness) including faith-based organizations
   e. Empaneled the Mayor's Task Force to Combat the Opioid Epidemic
   f. Launched the Philadelphia Resilience Project, the City's unified response to America's nationwide opioid crisis; and
   g. Increased public awareness and education through community meetings and citywide public service announcement campaigns about opioids and treatment.
3. Recognizing that providing homes ends homelessness, the city's permanent supportive housing supply has increased by about 400 units since 2016, ensuring more people with serious challenges like chronic homelessness and opioid use disorder can access the stability of a home.

Advocacy Spotlight: Colorado

2020 resulted in three advances in substance use disorder (SUD) treatment after a mortality review found that nearly 70% died from an overdose of methamphetamine [alone or in combination with other substances]:

1. Increased funding for SUD treatment resources in the criminal justice system and requiring people in custody to have access to medication-assisted treatment.
2. Legislative requirements for harm reduction measures such as requiring insurance carriers to cover medications for opioid use disorder, allowing pharmacists to sell needles/syringes, establishing immunity to anyone attempting to administer an opioid antagonist (i.e. Naloxone) in good faith, etc., and expanded treatment coverage and coordination of care for people using substances
3. A successful Denver ballot initiative established a 0.25% sales tax on non-essential items which will create 1,800 units of housing over 10 years, increased access to services including SUD treatment, and increased resources for service providers.

people, are most impacted by homelessness in the U.S.) constituted the next largest group in many places, from 6% in **Santa Clara County, California,** to 38% in Philadelphia. In **Santa Clara County,** Latinx people made up 31% of homeless decedents.

Asian, Indigenous, and mixed-race people accounted for smaller proportions of homeless decedents, likely reflecting the racial make-up of the community, but perhaps also more likely to be undercounted. In most cities and counties, People of Color were overrepresented among homeless decedents compared to the general population, but underrepresented within the homeless population.

Cause of Death

Many homeless death reports include a breakdown of the causes of death (contributing factors) and manner of death (direct way someone passed away). Causes of death were inconsistently reported, making it difficult to compare across cities and counties, but various jurisdictions noted significant findings:

- **Natural and accidental deaths:** In **Denver**, 33% of deaths were due to natural causes and 47% due to accidents.
- **Substance use disorder**: New York City, 32% of deaths were due to substance abuse
- **Trauma and violence**: **Multnomah County** found 11% of deaths were due to homicide and 10% due to suicide. **Los Angeles County** found 24% of deaths were due to trauma or violence.
- **Cardiovascular disease:** In **New York City**, 28% of homeless deaths were attributed to cardiovascular issues

Housing status: Several jurisdictions report the housing status of homeless decedents and seasons in which homeless deaths occur. In King County, Washington, 55% of homeless deaths are among the unsheltered population, whereas 53-63% of deaths in Multnomah County, Oregon, are among the sheltered population.

Seasonal deaths: Reported homeless deaths are also relatively evenly distributed across seasons. In **Maryland**, deaths were most likely to occur in winter (29%), whereas in **Denver** and **Santa Clara County, California**, summer deaths were more common.

Estimating a National Count

The greatest limitation to establishing a national count is the small number of communities currently counting homeless deaths. Collaborations with state records systems also complicate a national count because larger states (e.g., those best-poised to do a count) have more decentralized public health systems, making it more difficult to coordinate data collection across multiple local medical examiner systems.

Achieving a universal national count of homeless deaths will require more standardized data than currently exists. Medical examiners' documentation is relatively consistent, but data systems with the information are often owned by local jurisdictions, resulting in data inconsistencies.

Advocacy Spotlight: Los Angeles

Based on the mortality review, the Center for Health Impact Evaluation created these advocacy recommendations to prevent homeless deaths.

1. Expand and improve substance use disorder services for people experiencing homelessness
2. Expand reach of street medicine teams and allow Medi-Cal (California's Medicaid program) reimbursement for street medicine treatment in non-clinical settings
3. Expand housing options with the priority for people experiencing homelessness completing substance use disorder treatment and those fleeing violence and abuse
4. Improve supports for justice-system-involved people experiencing homelessness, including treatment diversion for those with substance use disorder and treatment for those incarcerated
5. Establish safe use sites with needle exchange and increase distribution of Naloxone to people experiencing homelessness to prevent overdoses
6. Conduct annual updates of LA County's Homeless Deaths Report
7. Conduct longitudinal analyses of deceased homeless clients County service records
8. Protect people experiencing homelessness from COVID-19

Similarly, death records are stored at the state level, but some data elements are reported in nationally standardized formats. Fortunately, HUD requires standardized universal data elements in Homeless Management Information Systems (HMIS).

New York City reported 104 deaths of homeless individuals from COVID as of October 14, 2020 (95 of which were identified in emergency shelters). In shelters from March-August 2020, the City estimated the age-adjusted COVID-19 mortality rate to be approximately 4 deaths per 1,000 individuals, or 78% higher than the city-wide age-adjusted mortality rate.[1], The age-adjusted mortality rate increased 19% from May to August of 2020, but increased 46% among homeless single adults, driving the disparate mortality rates further apart.[1]

This also suggests that the surge in cases in the unhoused population lagged behind the rest of the city, instead of facilitating transmission rates early in the disease curve.

COVID-19 Homeless Deaths

The experience of homelessness itself (structural oppression and discrimination, irregular access to quality health care, living in areas not meant for human habitation, etc.) places people without homes at greater risk of symptomatic infection and mortality from COVID-19. As of December 2020, at least 226 people experiencing homelessness have died from health problems attributable to COVID-19. These death counts have been collected from a combination of local news reports and public record requests of public health departments in 18 cities and counties. Most of these deaths occurred in places with larger homeless populations, especially **New York City** (104) and **Los Angeles** (44).

Similar to the discussion of homeless deaths for any cause, these estimates substantially undercount the true impact of COVID-19 on homeless mortality. While the lack of data means the true number of homeless deaths due to COVID-19 may never be known, research shows there is a clear connection between evictions and increased COVID-19 incidence and mortality[ii].

In addition, several large cities are reporting significant increases in homeless deaths in pandemic months compared to the same month in prior years (full reports should be out in early 2021). Most of these deaths are not attributable to COVID-19. They may be related to disruptions in health care and social service provision to people experiencing homelessness, reduced informal support for people living unsheltered, and the closure of emergency shelters.

Impact of COVID-19 on Mortality and Awareness

As the novel coronavirus reached the United States, experts anticipated that people without homes would suffer higher rates of mortality from COVID-19. Individuals experiencing homelessness experience multiple, compounding risks for exposure to viral transmission, chiefly due to the difficulty of isolation or quarantine given their precarious housing status. Once infected, COVID-19 is more dangerous for people without homes due to their higher rates of chronic illnesses. They are also more likely to require targeted surveillance testing to accurately

detect and isolate cases, as some studies confirm an underutilization of health care services even when infected. One CDC-led study in King County, Washington, showed that just 2% of individuals in their sample received diagnoses from independent health care sources.[iii]

Overall, scarcely any information exists about the impact of the SARS-CoV-2 pandemic and fatal cases on individuals experiencing homelessness across the United States. Housing status is absent from more popular national dashboards from the CDC, state health departments, or the Johns Hopkins Coronavirus Resource Center. Just a handful of urban centers with dedicated surveillance efforts via their congregate and non-congregate shelter agencies provide the most reliable data. While these efforts tended to be supported by federal agencies like the CDC early on,[iv] ongoing and sustainable efforts are likely to rely on local public health agency resources.[v]

Cases--and therefore deaths--from COVID-19 among those experiencing homelessness are unlikely to end in the near future. Sustained transmission will be difficult to contain due to undetected asymptomatic or mild cases in both the homeless population and among the general public.[vi]

Dedicated, reliable, and standardized surveillance systems will improve the understanding of the impact of COVID-19 on the mortality rate for PEH. Since most jurisdictions fail to collect information about housing status, communities will require dedicated coordination across public health systems, namely with the COVID-19 case tracking systems and the Medical Examiner's office. Likewise, while public health tracking systems for COVID-19 may attempt to identify fatal cases, they are also unlikely to capture housing status ad provide the full cause-of-death information that Medical Examiners' records contain.

References:

[i] The U.S. Department of Housing and Urban Development (HUD) requires local jurisdictions to count the number of people experiencing homelessness each year on a given night in January. While this report uses data from the 2018 PIT count, the 2019 PIT count data found even more people experiencing homelessness on a given night—increasing to 568,000.

[ii] Leifheit, Kathryn M. and Linton, Sabriya L. and Raifman, Julia and Schwartz, Gabriel and Benfer, Emily and Zimmerman, Frederick J and Pollack, Craig, Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality (November 30, 2020). Available at SSRN: https://ssrn.com/abstract=3739576 or http://dx.doi.org/10.2139/ssrn.3739576

[iii] Tobolowsky et al., 2020.

[iv] Mosites et al., 2020; Tobolowsky et al., 2020.

[v] Coalition for the Homelessness, 2020.

[vi] Baggett et al., 2020; Mosites et al., 2020.