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Deaths of people with a homelessness or housing support need in West Sussex: 2020/21–2022/23 review

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Contents

Acknowledgements

Behind the data presented within this report are human lives that have ended, many of them prematurely. Each individual had their own personality and story, and had people who knew and cared for them who have felt their absence.

With thanks to the organisations who formed the partnership group to develop this project and to all the organisations who provided data for the review. Thanks also to following people in West Sussex County Council who contributed to developing and reviewing this report: Robert Whitehead, Jacqueline Clay, Daniel MacIntyre, Alison Challenger and Mark Dow.

Introduction

This report:

- Explores issues relating to the health of people experiencing homelessness or at risk of becoming homeless.
- Presents data from homelessness organisations' case histories on the suspected causes of death of a number of people who have died in this group.
- Will support the work of organisations and services working with this group, both singly and together.

This report does not:

- Present data on the official causes of deaths of people in this group.
- Describe increases or decreases in the number or rates of death (mortality trends) in people in this group.
- Contain recommendations for activity or action.

Background

Homelessness is an experience that drives social exclusion and inequalities in outcomes[1,2]. Amongst people experiencing, or at risk of, homelessness, co-occurring health and care needs are common, as are overlapping or prior experiences of social exclusion and disadvantage, such as substance misuse, mental ill-health, time spent in prison, domestic abuse, poverty and adverse childhood experiences[1,3-5].

Many of these needs and disadvantages may have a bi-directional relationship with homelessness, meaning that these issues can increase the risk of becoming or remaining homeless, whilst homelessness can increase the risk of, or exacerbate, these issues[6,7]. These bi-directional relationships can act to strengthen inequalities in health and social outcomes for people who experience multiple and compounding needs and disadvantage.

Compared to the general population, health amongst people experiencing homelessness is far poorer, with increased rates of morbidity, multi-morbidity, premature ageing and frailty, and early mortality that is estimated to be more than double that of the general population[2,6,8]. In England and Wales, the average age of death of people experiencing homelessness is estimated at around 43-45 years[9], which is nearly half the average age of death amongst the general population[10].

Over the last decade, the estimated number of deaths amongst people experiencing homelessness in England and Wales has risen significantly*, increasing by 53.7% from 2013 to 2021[9]. Although the estimated number of deaths fell in 2020, when significant support was targeted towards accommodating rough sleepers during the COVID-19 pandemic, the 2021 estimate is more in line with pre-pandemic levels. In England and Wales in 2021, an estimated 741 deaths of homeless people were registered, with around 12% of these occurring in the South East region (an estimated 90 deaths).

In West Sussex, local homelessness and housing support organisations have raised the need to better understand the factors driving early mortality in this vulnerable population. To contribute to the local

* The Office for National Statistics estimates the number of homeless death registrations per year and defines homelessness for this estimate as all persons recorded at death as: rough sleeping, no fixed abode or in emergency accommodation, night shelters, hostels and so on.

evidence base around the issues faced by this group, this review of the client death reports and cases histories held by these organisations has been undertaken.

These organisations provide services for a wide range of people with a homelessness or housing support need. These services include statutory[11,12] and non-statutory temporary accommodation, day-centres and community hubs, and outreach in the community, including support for those at risk of homelessness and ongoing support for previously homeless people who have progressed to move-on or permanent accommodation.

This review has taken a partnership approach, involving commissioning leads and the main providers of homelessness and housing support services across West Sussex in the review process, including the scoping and development of the review.

Aim

The aim of this review is to understand the histories, risk factors and vulnerabilities in the lives of people who died within a three-year period (2020/21 – 2022/23) whilst engaged with homelessness and housing support services in West Sussex.

Inclusion criteria

Clear inclusion criteria were developed at the outset of the review, in collaboration with relevant partners within the homelessness services and the county council.

A three-year sample of individuals who were known to homelessness services in West Sussex who died between April 2020 and March 2023 (i.e., financial years 2020/21, 2021/22 and 2022/23) were included in the review. Deaths from the preceding years were not included to minimise the risk of historical issues, rather than current, affecting the findings.

Within scope were:

- Single people and childless couples (i.e., excluding families with children).
- Individuals who were in one of the following five categories:
    1. Rough sleepers
    2. Sofa-surfers
    3. In unsupported temporary accommodation (e.g., B&Bs, hotels)[†]
    4. In supported temporary accommodation (e.g., hostels, refuges)[‡]
    5. In move-on or permanent accommodation with multiple needs/disadvantage and in contact with services.

Each of the main homelessness and temporary accommodation providers in the county, encompassing the four main homelessness charities and the six district and borough councils[§], were invited to participate in

[†] Unsupported temporary accommodation is generally provided by the local authority (the district and borough councils) within their statutory duties under the Homelessness legislation[11,12].
[‡] Supported temporary accommodation is typically provided by the homelessness charities.
[§] In West Sussex, there are seven district and borough areas: Adur, Arun, Chichester, Crawley, Horsham, Mid Sussex and Worthing. The district and borough council for the Adur and Worthing areas is joined, meaning that there are six district and borough councils overall (Adur & Worthing Councils, Arun District Council, Chichester District Council, Crawley Borough Council, Horsham District Council and Mid Sussex District Council).

the review. Each of the homelessness charities participated, as did four of the six district and borough councils.

Collectively, these providers support thousands of people each year, including those who are accommodated by the services and those who receive support to prevent first initiation, or relapse, of homelessness. In reading this report, it is important to appreciate the number of deaths compared to the overall number of people known to services; the 60 individuals included in this review represent a small proportion of the overall population who are supported by services.

Caveats and limitations

When reading and interpreting the findings of this review, there are several important caveats around the scope and methodology to bear in mind:

- **This review relates to people who were known to homelessness services but who were not necessarily rough sleeping or living in unstable accommodation around the time of death.** Around half of the deaths reviewed were of people living in temporary accommodation and a third were of people living in permanent accommodation with ongoing support from homelessness services. **Only a small number of these deaths were of people who were rough sleeping around the time of death.** Whilst all of the deaths related to vulnerable individuals, many with multiple and compounding needs, this is not a homogeneous group.
- **Not all of the homelessness and housing support providers who were invited to participate in the review did so**. There may, therefore, have been additional deaths that would have fit the inclusion criteria that are not included in this review. Additionally, **deaths of people with a housing support need who were *not known* to the participating services in West Sussex are not included**. This review presents a snapshot of the risk factors and vulnerabilities experienced amongst this cohort, rather than a definitive enumeration of these issues.
- This review used individual case histories provided by the participating homelessness and housing support organisations. This **information was not triangulated against other sources**, such as health, care and other support services, or county coroner inquest files. This was not intended from the outset. When, for example, physical or mental health issues are reported, this is as identified in the homelessness service provider's case notes and not taken from, nor compared against, health records themselves.
- **The volume of data contained in the case histories was variable**. Some case histories included several years' worth of detailed information and others were very limited, with some providing no or little data on one or more of the characteristics and experiences of interest.
- The **total number of deaths reviewed is relatively small** (60 deaths over the three-year period met the inclusion criteria), therefore **statistical significance is not assigned**.
- Care has been taken to ensure that **individuals cannot be identified**.
- Thematic analysis of the data was undertaken to develop the review's findings. **Themes were developed iteratively by the author and, as is inherent with qualitative analysis, are ultimately a subjective interpretation of the collected data**; were another reviewer to analyse the data, there may be some variation in the themes identified.
- This report **does not make recommendations** for specific actions and it did not set out to do so. The objectives of this report are to review the data and provide key findings.

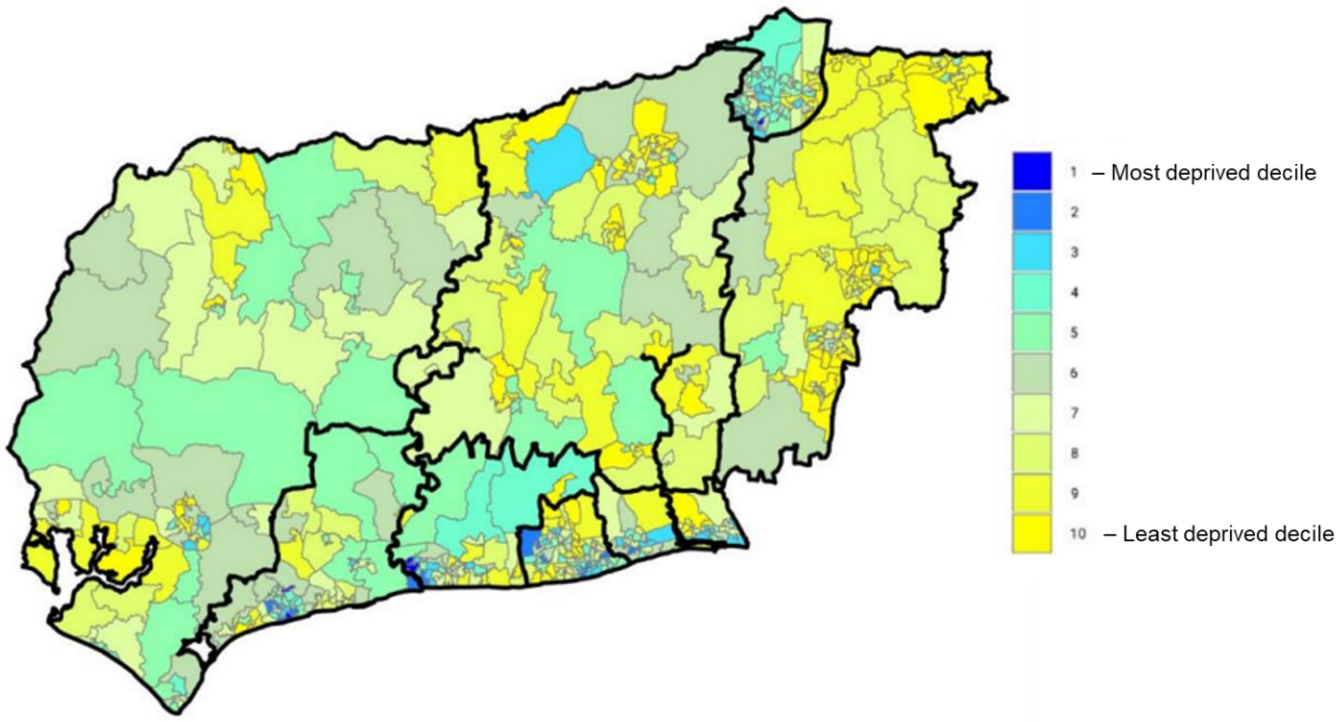
West Sussex context – place and population

West Sussex is a largely rural county, with the population concentrated along the coast and in several towns. The county shares a border with the counties of Hampshire, Surrey and East Sussex, and the densely populated urban area of Brighton and Hove. West Sussex has two tiers of local government: the county council and six district and borough councils, each with different responsibilities, such as social care and housing support.

Although West Sussex is relatively affluent overall, several areas are amongst the 20% most deprived in England, including a handful of neighbourhoods in Arun and Crawley that are amongst the 10% most deprived[13] (Map 1).

Around 900,860 people live in West Sussex (as of 2023). The county has an ageing population, with an older age profile compared to the South East region and England. Around 23% of West Sussex residents are aged 65 years and above (19% in England), although there are differences across the county. Crawley, in particular, has a younger age profile, with a proportionally greater number of children aged under 18 years and adults of working age (18-64 years)[14].

West Sussex is less ethnically diverse than the South East region and England. Aside from Crawley, where around 38% of residents identify as a minority ethnicity, around 84% of West Sussex residents identify as White British[15].



Map 1. National index of multiple deprivation deciles (IMD 2019) by lower super output area (LSOA) in West Sussex[16].

Methodology

Data collection

A database for data collection and analysis was co-produced with partners within the homelessness services, to ensure the usefulness and relevance of the data collected. Development of the database and methodology was also informed by the approach taken by previous local audits of suicide and drug-related deaths[17,18], alongside review of the literature and review of the data fields captured by the quarterly Multiple Disadvantage Audits undertaken by the Changing Futures programme[19].

Individuals who met the inclusion criteria were identified by the homelessness services and their case histories supplied by the service to which they were most well or recently known. Where duplication of individuals by multiple services was identified, all sources were used to provide the most detailed picture. Case histories typically included registration forms, service timelines, risk assessments, needs assessments and fatality reports.

Information was received from the four main homelessness charities in the county: Turning Tides, Stonepillow, Crawley Open House and Bognor Housing Trust. Responses were received from four of the six district and borough councils: Arun District Council, Horsham District Council, Mid Sussex District Council and Crawley Borough Council.

Data were collected as discrete variables from the case histories, meaning that the qualitative insights in each case history were recorded in pre-defined categories for each data field. This method is beneficial in allowing quantification of the characteristics and issues of interest, but this synthesis inevitably results in some of the richness and nuance of the data being lost.

Data were also collected qualitatively, via “free-text” boxes in which the reviewer could record additional information which would not fit within the categorical fields.

For each individual, a narrative summary was produced upon completion of data entry from their case histories, describing their history, risk factors and vulnerabilities.

Data quality and categorisation methods

The volume of information available varied for each individual included in the review, with some case histories including several years’ worth of detailed information and others having limited information available. It is important to note that, for most individuals, the case histories were received from a single organisation, with a primary remit of housing and homelessness support. Triangulation of these histories with information from other care and support services, or county coroner inquest files, was not in scope of this review.

The approaches adopted to enable categorisation of several key fields, and some of the challenges posed by data quality issues in doing so, are described below.

Housing situation

Housing status was categorised according to the five main housing situations defined in the review’s inclusion criteria, with further sub-categorisation of the specific type of accommodation. There are different types of temporary accommodation, which are typically provided by different services:

- Unsupported temporary accommodation is generally provided by the local authority (the district and borough councils) within their statutory duties under the Homelessness legislation[11,12].

- Supported temporary accommodation is typically provided by the homelessness charities (and includes Housing First). Support is provided for a variety needs, such as tenancy management, benefit claims, health-related conditions, and more. The level of support ranges from low to high support. High support temporary accommodation typically provides 24/7 staffing, whilst medium and lower support temporary accommodation varies in the number of hours that staff are available.

Each individual's housing status was based on their last recorded housing situation around the time of death. However, the transient lifestyles of many of these individuals should be borne in mind – many individuals had been in and out of various types of accommodation throughout their lives, including changes in their housing situation that were recent to their deaths. In most cases, the individual had been in this final housing situation for at least a few weeks, although there were some cases where the individual's housing situation had changed less than a week before their deaths. Notably, the housing status of the single individual who was evicted from temporary accommodation and began rough sleeping on the day of death was categorised as temporary accommodation, due to the immediacy of this change before death.

Suspected cause of death

The homelessness organisations who provided the case histories for the review are not routinely informed of the official cause of death, and triangulating information on the suspected cause of death with coroner's reports was not in scope for this review (in contrast with the methodology of previous local audits of suicide and drug-related deaths). As such, all causes of death, as recorded by homelessness organisation providing the case histories, should be treated as suspected. Where information on suspected cause of death was available, causes were grouped into broad categories with more specific sub-categories within these. The International Classification of Diseases version 10 (ICD-10) codes[20] and Office for National Statistics (ONS) groupings for leading causes of death[21] were used to inform categorisation. Due to varying levels of detail provided, a mix of hierarchical categories is presented together (although no category presented overlaps), with the aim of presenting as much useful information as possible.

Important points to note:

- In many cases, the *mechanism* of death, rather than the *underlying* cause was recorded. For practicality, these have been grouped according to relevant broad categories of death (e.g., the mechanism of heart attack has been grouped into cardiovascular issues). However, it should be borne in mind that categorisation in this way may not fully reflect the circumstances of death (i.e., what caused the heart attack is unknown).
- In some cases, multiple factors suspected to cause the death were recorded, without indication of which of these was the primary suspected cause. In these cases, all suspected causes have been recorded as sub-categories (meaning the sub-categories will not sum to the total number of deaths).
- Where deaths were suspected to be due to drug overdoses, in most instances it was not known whether these were intentional or accidental deaths. As such, these have been grouped together.

Physical health, mental health and substance misuse issues

Where health information was available, the level of detail recorded was variable and the information likely incomplete. For example, there were some cases where it appeared likely that the individuals involved had not been forthcoming in disclosing their health issues.

There was also uncertainty around whether the recorded issues had been clinically diagnosed, particularly for mental health and substance misuse issues. Depression, for example, was frequently recorded but often not specifically defined as a clinical diagnosis.

To avoid underestimation, all health issues that were believed to be affecting the individual's health or ongoing wellbeing, whether or not they were stated as being clinically diagnosed, have been recorded. The categorisation methods were as follows:

- To inform categorisation of physical health issues, the ICD-10 codes were used (as with deaths). In recording physical health issues, there were instances where detail that would allow different health conditions to be distinguished was lacking (e.g., where 'fatty liver disease' was recorded, it was not known if this was non-alcoholic or alcoholic fatty liver disease). Due to this varying level of detail, a mix of hierarchical categories are presented together (although no category presented overlaps), with the aim of presenting as much useful information as possible.
- The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[22] was used to inform categorisation of mental health issues, alongside the Adult Psychiatric Morbidity Survey[23]. Additional common mental health issues, that may not themselves have resulted in a clinical diagnosis (had they been assessed by a medical professional) or may have been a symptom of other issues, such as low mood and difficulties sleeping, were also recorded to provide a fuller picture of the issues experienced by this cohort. Importantly, although alcohol and drug addictions are officially classed as a mental health issue, this report does *not* classify substance misuse issues with mental health issues. This has been done to highlight the high levels of co-occurring substance misuse and other mental health issues in this cohort, which are described in detail separately in the report.
- Alcohol and drug misuse issues (collectively termed 'substance misuse issues') were implicit where lists of substances stated to be used by each individual were available, although it was often not known if these were addictions, particularly for drug misuse. To avoid underestimation, where an individual was identified as misusing alcohol or any drug, this was recorded as a substance misuse issue.

Where co-occurring issues are described, it is important to remember and balance the above – that these are not necessarily clinical diagnoses, that the issues described may vary in their severity and that the information available for many individuals is likely incomplete.

Drug types

There are a variety of methods that can be used to categorise drugs used, including pharmacological grouping, common treatment/prescribing intent and legal classification. Legal classification[24], as per the Misuse of Drugs Act 1971, was used in this review, with the aim of most clearly showing the variety of drugs stated to be used.

Self-neglect

In the statutory guidance for the Care Act 2014, self-neglect is identified as a distinct category of abuse and is defined as being: *"Where someone demonstrates lack of care for themselves and/or their environment and refuses assistance or services. It can be long-standing or recent"*. The guidance further describes self-neglect as: *"a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding"*[25].

Guidance from the Sussex Safeguarding Adults Board (SSAB)[26] and the Social Care Institute of Excellence (SCIE)[27] around identifying self-neglecting behaviours further describe an element of severity in the behaviours, such as a lack of self-care "*to an extent that it threatens personal health and safety*".

To identify behaviours that could be indicative of self-neglect, the statutory guidance for the Care Act 2014 and the SSAB and SCIE guidance were used to define seven categories of self-neglect, as follows:

- Poor personal hygiene and health (including poor diet and malnutrition)
- Ongoing misuse of their own medication (not including isolated instances of overdose)
- Neglecting their environment/home (including hoarding, squalor, lack of household maintenance)
- Failing to access / refusing assistance or services – alcohol or drug treatment
- Failing to access / refusing assistance or services – health services
- Failing to access / refusing assistance or services – social services
- Neglecting personal affairs (including debt issues that may risk eviction)

There were a number of challenges in identifying and categorising possible self-neglecting behaviours in the individuals included in this review, which included:

- A lack of detail on the extent of the harm that an individual may have been doing to themselves, the duration of the behaviour and the reasoning behind the behaviour (if any). For example, an individual recorded as missing healthcare appointments (i.e., failing to access health services) could have been indicative of self-neglecting behaviour, with severe consequences, or it could have been a short-term issue relating to factors outside of the individual's control.
- The common report of individuals disengaging with services, particularly for those who may have had a 'blip' and then resumed engaging.

To overcome this uncertainty, a pragmatic approach to categorisation was taken, whereby individuals were categorised as displaying behaviours of self-neglect if they had ever repeatedly displayed the behaviour or if the behaviour was seen to be ongoing in the case histories.

In interpreting this report's findings, it is important to be aware that the statutory guidance for the Care Act 2014 states that: "*self-neglect may not prompt a section 42 enquiry*" for safeguarding. This may have been the case for many of the individuals who have been categorised as showing behaviours of self-neglect in this review. However, it is also worth considering that 'low' levels of self-neglect may represent an early warning signal or indicator of future or worsening self-neglect.

Adverse childhood experiences

Adverse childhood experiences (ACEs) are negative events or situations, experienced during childhood and adolescence, that can increase the risk of a wide range of poor health and social outcomes over the life course[28,29].

The list of ACEs defined by the UCL Institute of Health Equity's 2015 report on ACEs[30] was used to categorise these experiences in this review. These can be broadly divided into maltreatment of the child (sexual, physical or emotional abuse; or neglect) and household adversity (living with adults with mental health or substance misuse issues; a parent in prison or on probation; witnessing domestic violence; parental separation or death; or living in care).

It is important to note, however, that information about ACEs may not have been routinely captured by the homelessness organisations who provided the case histories for this review. Additionally, it is possible that changing social and cultural attitudes over time may have influenced the willingness of individuals to disclose such personal information or their awareness that they may have had 'adverse' experiences – i.e., some ACEs may have been more normalised as acceptable behaviours or not thought of as adverse experiences in the past, meaning that older adults may be more likely to not think or wish to disclose these experiences. For these reasons, the number of individuals who were identified as having had ACEs in this review is likely an under-estimate.

Multiple Disadvantage

Changing Futures is a Sussex-wide, nationally funded programme that aims to improve outcomes for adults who are experiencing multiple disadvantage[19]. This programme defines multiple disadvantage as adults who are experiencing three or more of the following five issues:

- homelessness (or a housing need)
- substance misuse
- mental health issues
- domestic abuse
- contact with the criminal justice system.

To allow comparison to this local service data, the number of individuals included in this review who were experiencing the above issues was quantified. Individuals were categorised as having housing, substance misuse or mental health issues if these were recorded to be ongoing at the time of death, whilst domestic abuse and contact with the criminal justice system (i.e., offending) were categorised as any recorded history, as per the Changing Futures Multiple Disadvantage Audit methodology. Individuals were not categorised as having a housing need if they were living in permanent accommodation at the time of death and were not stated as being at risk of eviction. It is worth noting that several individuals had recently moved into permanent accommodation before their deaths and were therefore not categorised as having a housing need (although all had a history of requiring support from housing and homelessness services).

Data analysis

Descriptive statistics were produced for the quantitative data. Care was taken to ensure that individuals are not identifiable. Where there was a risk of disclosure of identifiable information due to small numbers, some categories were combined to mitigate this.

The qualitative summaries were analysed using thematic analysis. Themes were developed iteratively by the author and, as is inherent with qualitative analysis, are ultimately a subjective interpretation of the collected data; were the data to be analysed by another reviewer, there may have been some variation in the themes identified.

Findings

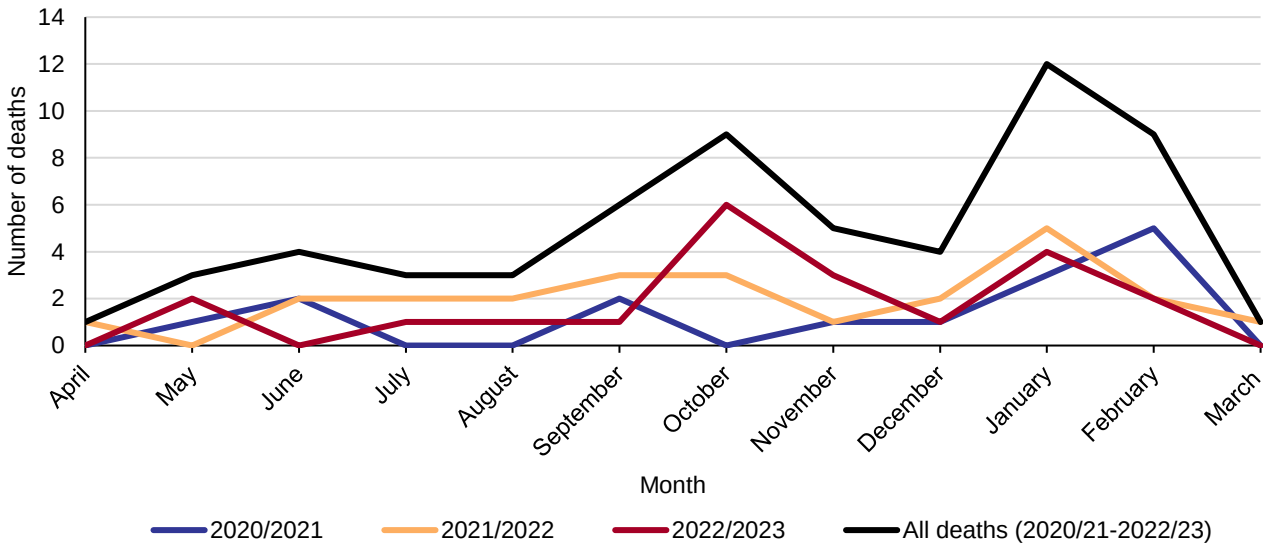
Number and timing of deaths

In the three-year period between April 2020 and March 2023 (inclusive), there were 60 deaths of people known to homelessness services in West Sussex which met the agreed criteria. There were:

- 15 deaths in April-March 2020/21
- 24 deaths in April-March 2021/22
- 21 deaths in April-March 2022/23

Cumulatively over the three years, there was higher frequency of deaths in the autumn and winter period (September to February), with a peak in January of each year (figure 1).

Figure 1. Number of deaths recorded between April 2020 and March 2023, shown cumulatively and by financial year (2020/21, 2021/22 and 2022/23).



It is possible that the effects of the COVID-19 pandemic were a factor affecting the outcomes of people experiencing, or at risk of, homelessness during this period. The first national 'lockdown' in England began a week before the time-period in scope for this review (lockdown began in late March 2020), with further lockdowns in November 2020 and January-March 2021. At this time, the government-backed 'Everyone In' initiative asked local authorities to provide accommodation to rough sleepers, and those at risk of rough sleeping, who were at risk of, or who had been diagnosed with, COVID-19, including those who would not normally be entitled to assistance under homelessness legislation[31].

In this review, COVID-19 was not mentioned as a suspected cause of death in any of the individuals where cause of death information was available.

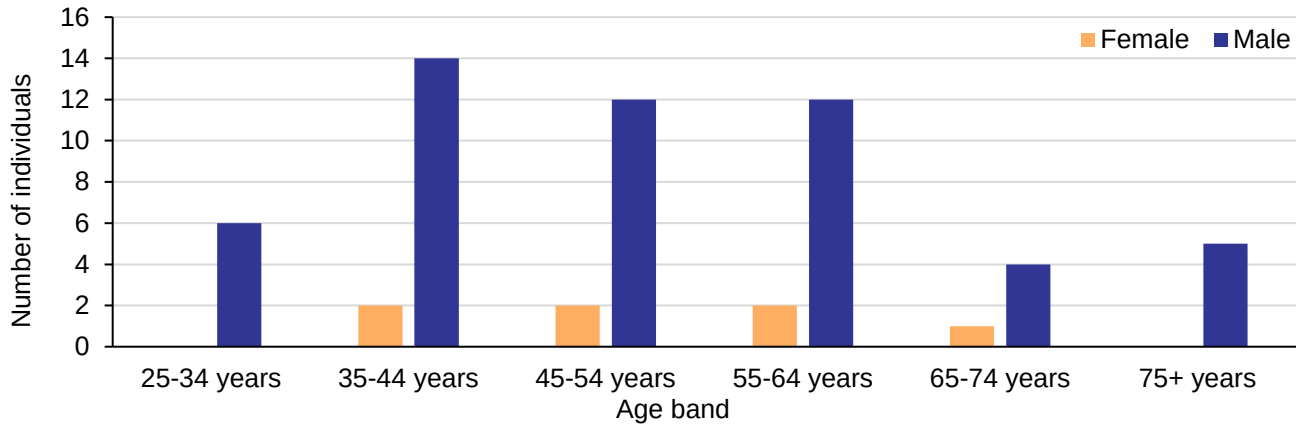
Demographics

Almost 9 in 10 deaths were males (n=53).

The age of death ranged from people in their mid-twenties through to people in their late-eighties, with those aged 35-44 years, 45-54 years and 55-64 years each accounting for around one-quarter of deaths reported (figure 2).

The mean age of death of the 60 individuals included in this cohort was 51 years; however, as this is only a small sample of the entire population of people experiencing, or at risk of, homelessness in the UK, this is not directly comparable with the mean age of death in the UK general population.

Figure 2. Number of individuals by age-band and sex.



Around 80% of deaths were in those of White British or Irish ethnicity (n=48) and slightly more than 10% of deaths in those of Eastern European ethnicities (n=8). Of this latter group, all individuals were male and most were from Poland.

Where relationship status was recorded (n=46), most individuals were single, separated, divorced or widowed (n=44). In six of these individuals, relationship/family breakdown was known to be a factor in their homelessness.

Where the most recent employment status could be discerned (n=40), most individuals were found to be out of work at the time of death. Many of these individuals were sick or disabled (short- or long-term) and a similar number unemployed. However, considering the high level of physical and mental health issues in this cohort, there is some uncertainty about the whether those who were categorised as being unemployed were not working *because* they had been signed off as sick or disabled.

Additional information about demographic characteristics is provided in table 1.

Table 1. Demographic characteristics.

Characteristic	Female (n=7)	Male (n=53)	Total (n=60)
Age			
25-44 years	2	20	22
45-64 years	4	24	28
65+ years	1	9	10
Sexual orientation			
Heterosexual	6	40	46
Homosexual		2	2
Not known	1	11	12
Gender identity			
Cisgender	5	39	44
Not known	2	14	16
Ethnicity			
White British or Irish	7	41	48
Other White (Eastern European)		8	8
Minority ethnicities (excluding Other White)		4	4
Relationship status (last recorded)			
Single	4	31	35
Separated, divorced or widowed	2	7	9
Married		2	2
Not known	1	13	14
Employment status (last recorded)			
Unemployed	2	15	17
Sick or disabled (long-term or short-term)	1	13	14
Retired		5	5
Working full-time or part-time		4	4
Not known	4	16	20

Housing situation

Half of the individuals known to homelessness services were living in temporary accommodation around the time of death (n=30). Slightly over half of those living in temporary accommodation were in supported temporary accommodation (n=17), and most of these in 24/7 high support accommodation (table 2). Many of these individuals also had experience of rough sleeping or sofa-surfing described in their case histories.

Just over a third of individuals were living in move-on or permanent accommodation around the time of death (n=23). Many of these individuals also had experience of living in temporary accommodation, rough sleeping or sofa-surfing described in their case histories.

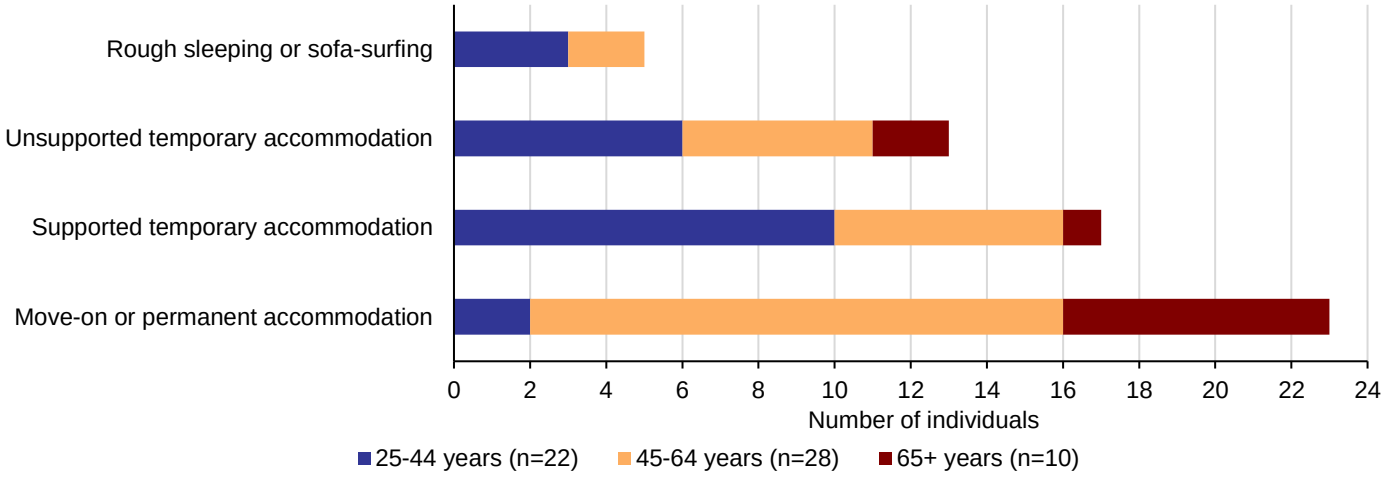
A small number of individuals were sofa-surfing or rough sleeping at the time of their deaths (n=5). Due to small numbers of sofa-surfers and rough sleepers and uncertainty in whether those recorded as being of ‘no fixed abode’ were sofa-surfing or rough sleeping, these categories are combined.

Table 2. Housing status at time of death.

Housing status at time of death	Female (n=7)	Male (n=53)	Total (n=60)
In move-on or permanent accommodation with multiple needs / disadvantage and still in contact with services	**1**	**22**	**23**
Social housing (local authority/housing association)	1	11	12
Private renting		6	6
Housing for older people (sheltered housing)		2	2
Move-on supported housing TA		2	2
Residential care/nursing home		1	1
In supported temporary accommodation (e.g., hostel, refuge)	**4**	**13**	**17**
Supported housing TA – high support	4	9	13
Supported housing TA – low/medium support		2	2
Housing First		2	2
In unsupported temporary accommodation (e.g., BnB, hotel)		**13**	**13**
Rough sleeper or sofa-surfing	**1**	**4**	**5**
Other		**1**	**1**
Not known	**1**		**1**

Most of those aged 25-44 years were in temporary accommodation, with a handful who were rough sleeping or sofa-surfing or in move-on/permanent accommodation. Just under half of those aged 45-64 years were in temporary accommodation and half were in move-on/permanent accommodation. Most individuals aged 65 years and older were in move-on/permanent accommodation (figure 3).

Figure 3. Housing status at time of death by age-band.



Circumstances of death

Suspected cause of death

For a quarter of individuals, information on the suspected cause of death was not available (n=15). Varying levels of information was available in the case histories for the remaining 45 individuals.

Physical health issues and illnesses were the most common broad category in both males and females, accounting for around two-thirds of deaths where the suspected cause was stated (n=29). Many of these deaths involved chronic conditions, such as cancers, chronic obstructive pulmonary disease (COPD) and liver issues (table 3). Deaths suspected to be caused by a cardiovascular issue were common, although it should be noted that many of these were due to heart attacks and heart failure, which are *mechanisms* of death, rather than the *underlying* cause.

Suspected drug overdoses accounted for a fifth of deaths where the suspected cause was stated (n=9) and were mostly in males. Two-thirds of these were in individuals aged 25-44 years.

A handful of cases involved accidental injuries (n=5), including falls, drowning and choking.

Two of these deaths were suspected to be suicides, which were both in younger males (aged 25-44 years). One of the suspected suicide deaths was caused by an overdose, and the other caused by intentional self-harm (excluding self-poisoning).

By age, most deaths attributed to physical health issues were in those aged 45 years and older and accounted for the greatest portion of deaths in this age group. External causes of mortality were more common in those aged 25-44 years and accounted for the greatest portion of deaths in this age group.

Table 3. Suspected causes of death, shown as broad cause and specific cause.

Suspected cause of death	25-44 years (n=22)	45-64 years (n=28)	65+ years (n=10)	Total (n=60)
Physical health / illness	**3**	**17**	**9**	**29**
Cardiovascular issues	1	5	6	12
Cancer		2	2	4
COPD		2	2	4
Pneumonia	1	3		4
Infection		3		3
Liver disease (including alcoholic)	1		1	2
Other (natural causes)			2	2
Other (multiple organ failure)		2		2
Other (alcoholic ketoacidosis)			1	1
Intestinal disease			1	1
Specific cause unknown		3		3
External causes of mortality	**11**	**5**		**16**
Overdose	6	3		9
Accidental injury	3	2		5
Intentional self-harm (excluding self-poisoning)	1			1
Homicide	1			1
Not known	**8**	**6**	**1**	**15**

Note: Where multiple specific suspected causes of death were recorded for any one individual (n=7), all specific causes are presented, meaning the specific cause sub-categories will not sum to the total number of deaths.

Location of death

Where location of death was stated (n=50), most deaths occurred either in the individual's home (n=22) or in hospital or a hospice (n=17). Nearly two-thirds of those who died at home were living in supported or unsupported temporary accommodation (n=8 in supported temporary accommodation and n=6 in unsupported temporary accommodation).

Ten deaths occurred in public places or outdoors, with eight of these deaths in younger individuals (aged 25-44 years) and mainly due to causes other than physical health issues (table 4).

Of the nine suspected overdose deaths, five occurred in the individual's home and three in public places or outdoors.

Table 4. Location of death by age-band and suspected cause of death.

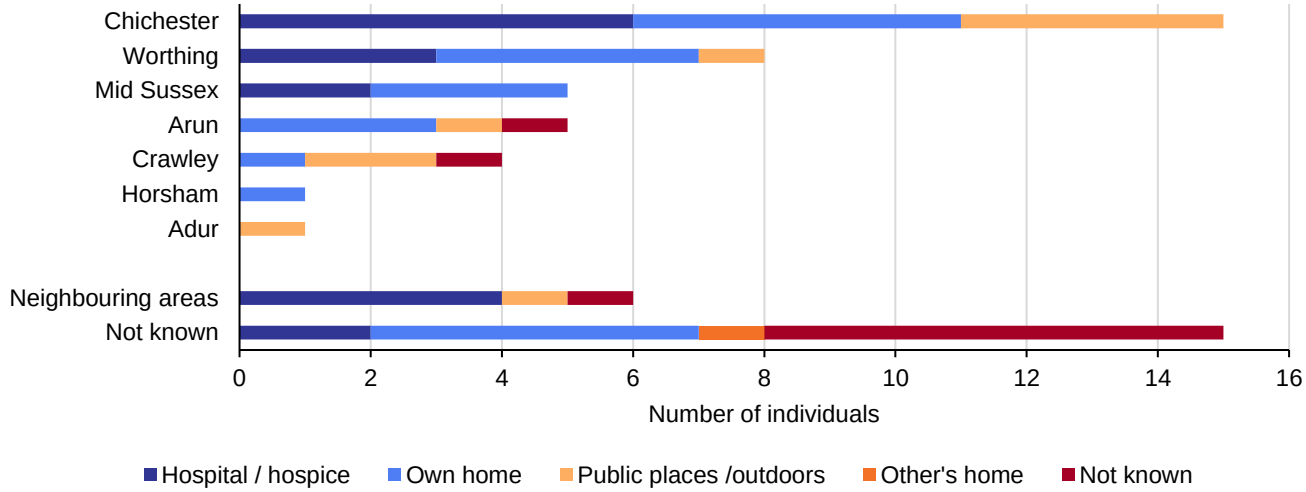
	Indoors				**Public places / outdoors**				**Not known** (n=10)
	Own home (n=22)	Hospital/ hospice (n=17)	Other's home (n=1)	Total (n=40)	Street /road (n=6)	Park, woods, or lake (n=3)	Other (n=1)	Total (n=10)	
Age									
25-44 years	9	2	1	**12**	4	3	1	**8**	**2**
45-64 years	9	10		**19**	2			**2**	**7**
65+ years	4	5		**9**					**1**
Suspected cause of death									
Physical health / illness	7	15		22	1			1	6
Overdose	5			5	2	1		3	1
Accidental injury	2	1		3	1	1		2	
Intentional self-harm*							1	1	
Homicide					1			1	
Not known	8	1	1	9	1	1		2	3

* Excluding poisoning

Where the location of death was stated, most deaths occurred in the Chichester area (n=15), followed by the Worthing area (n=8). It is important to be aware that the location of death can reflect the location of specific services – notably hospitals. The Chichester and Worthing areas each have a hospital located within them, in which several of the deaths occurred (figure 4). It should also be noted that not all district and borough councils provided information for this review.

Several deaths occurred in neighbouring areas, such as Brighton, Portsmouth and Surrey.

Figure 4. Area of death (West Sussex districts and boroughs) by location of death.



Note: location of death can reflect the location of specific services, such as hospitals, and not all district and borough councils provided information for this review.

Physical health, mental health and substance misuse problems

Physical and mental health issues were very commonly recorded amongst this cohort, with significant overlap between different types of conditions. In this section, physical health, mental health and substance misuse issues are initially described separately, followed by an examination of co-occurring issues.

It is important to note that, where health information was available in the case histories, the level of detail recorded was variable and it is likely that this information is incomplete. To avoid underestimation, all health issues that were believed to be affecting the individual's health or ongoing wellbeing, whether or not they had received a clinical diagnosis, have been recorded.

Physical health

Physical health issues that were ongoing around the time of death were recorded for 51 individuals. Many of these were long-term conditions, including cardiovascular issues (e.g., high blood pressure, circulatory issues, heart failure), liver issues (e.g., alcohol-related liver disease, cirrhosis), respiratory issues (e.g., COPD, asthma), diabetes and chronic pain (table 5). Having more than one long-term physical health condition was common, with at least half of all individuals identified as having more than one long-term physical health condition. This is likely an under-estimate, however, as physical health problems were often recorded in broad terms, meaning that many issues that were described could not be definitively classified as long-term conditions and there was uncertainty as to whether some descriptions would include multiple long-term issues (e.g., "heart problems").

Past adverse health events that could have long-term health effects, such as heart attacks and strokes, were also recorded for several individuals (n=8).

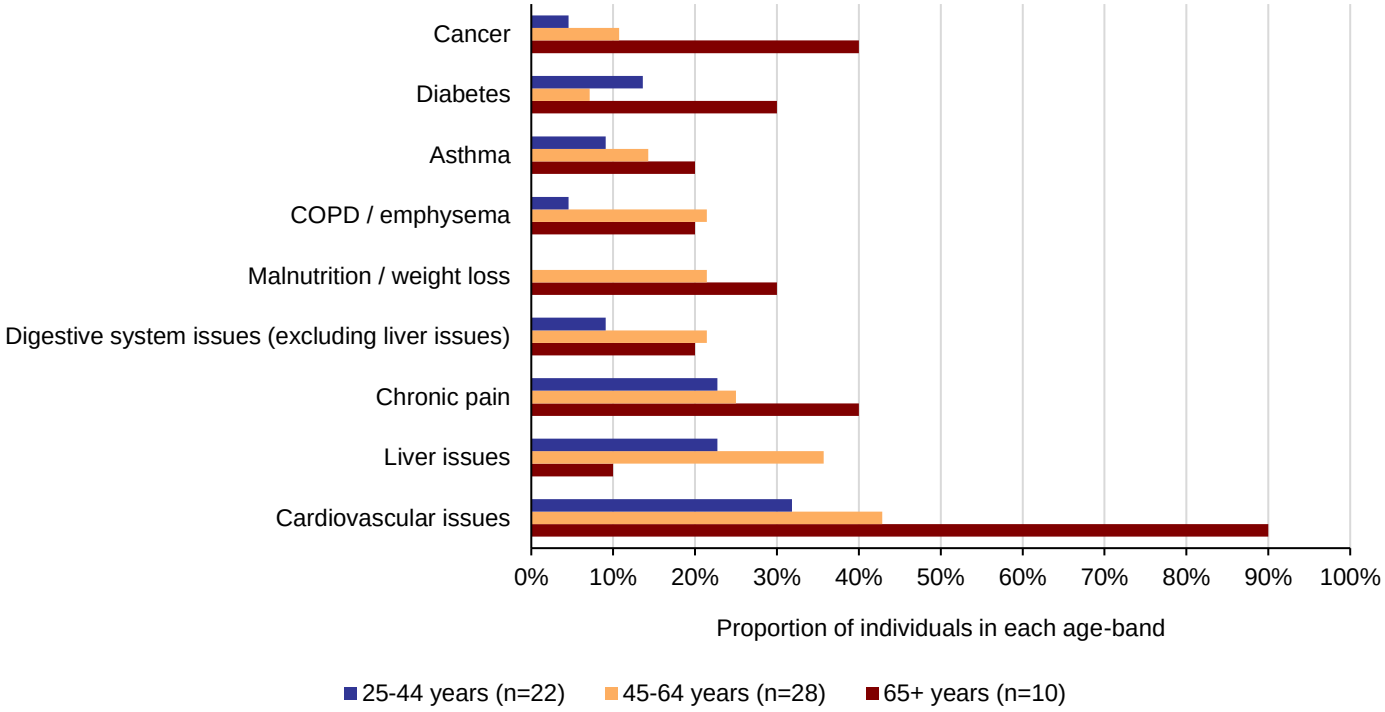
Physical health issues (past and ongoing) often related to harmful lifestyles, including abscesses and hepatitis infection from injecting substances. The effects of long-term alcohol dependence and self-neglect were common, such as alcohol-related liver disease and damage to the digestive system, and often resulted in malnutrition and weight loss.

Table 5. Physical health issues recorded in the case histories.

Physical health issue	Total number of individuals (n=60)	Proportion of all individuals (%)
Cardiovascular issues	28	47%
Liver issues	16	27%
Chronic pain	16	27%
Digestive system issues (excluding liver issues)	10	17%
Malnutrition / weight loss	9	15%
COPD / emphysema	9	15%
Asthma	8	13%
Diabetes	8	13%
Cancer	8	13%
Epilepsy	5	8%
Kidney issues	4	7%
Abscess (due to injecting)	3	5%
Nerve damage	3	5%
Obesity	1	2%
Glaucoma	1	2%
Total number of individuals with physical health issues identified in records	**51**	**85%**

As might be expected, the prevalence of physical health issues increased with age (figure 6), although it is notable how common many serious health conditions were in relatively young individuals. People in their late thirties and early forties were often described as having poor physical health, including cardiovascular issues and liver issues resulting from alcohol dependency.

Figure 6. Most common physical health issues (reported in at least 10% of all individuals) by proportion of those in each age-band.



Mental health

Mental health issues that were ongoing around the time of death were recorded for 44 individuals, with a similar proportion of males and females experiencing issues. It is not known whether these were clinical diagnoses in many cases.

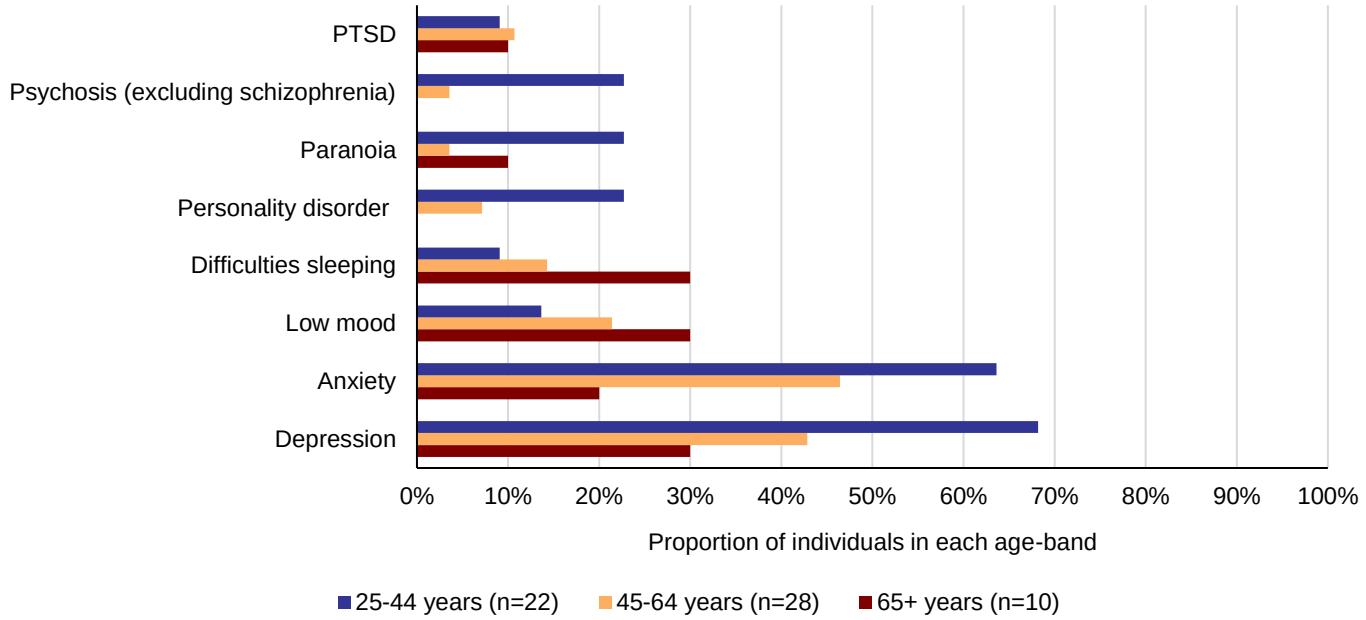
Depression (n=30) and anxiety (n=27) were common issues across the cohort, with many individuals experiencing both issues (n=17) and other mental health problems (table 6). Other mental health issues included psychotic illnesses (including schizophrenia and psychosis), personality disorders, post-traumatic stress disorder, bipolar disorder and problematic gambling.

Table 6. Mental health issues recorded in the case histories.

Mental health issues	Total number of individuals (n=60)	Proportion of all individuals (%)
Depression	30	50%
Anxiety (including panic attacks, phobias and obsessive compulsive behaviour)	28	47%
Low mood	12	20%
Difficulties sleeping	9	15%
Personality disorder	7	12%
Paranoia	7	12%
Psychosis, including hearing voices (excluding schizophrenia)	6	10%
PTSD	6	10%
Problematic gambling	4	7%
Bipolar disorder	4	7%
Schizophrenia and other psychotic disorders	3	5%
Eating disorder	1	2%
Total number of individuals with mental health issues identified in records	**44**	**73%**

By age, mental health issues were more commonly recorded in younger individuals, at approximately 85% of people aged 25-44 years experiencing one or more mental health issue, compared to around 70% of people aged 45-64 years and 50% of people aged 65 and above (figure 7).

Figure 7. Most common mental health issues (reported in at least 10% of all individuals) by proportion of those in each age-band.



Alcohol and drug misuse

Past and current alcohol misuse was very common, and in proportionally similar numbers of males and females. Five in six individuals were identified as having any history of alcohol misuse (n=50). Of these, 80% were stated or suspected to have been alcohol dependent at some point in their lives (n=40). Around the time of death, ongoing alcohol misuse remained highly prevalent (n=40), and in many cases long-term alcohol misuse was thought to be a risk factor leading to the individual's death (see physical health issues above).

Drug misuse was also common – although to a lesser extent than alcohol misuse – with around half of all individuals identified as having any history of drug misuse (n=29). A quarter of individuals were identified as having ongoing drug misuse problems around the time of death (n=15).

In those who were recorded as ever misusing drugs, around half were described as having misused heroin (n=15). Misuse of crack cocaine and cocaine were also common, as was cannabis misuse (table 7). Misuse of prescription medications was frequently described, which, in several cases, was stated as being misuse of the individual's own prescription medications.

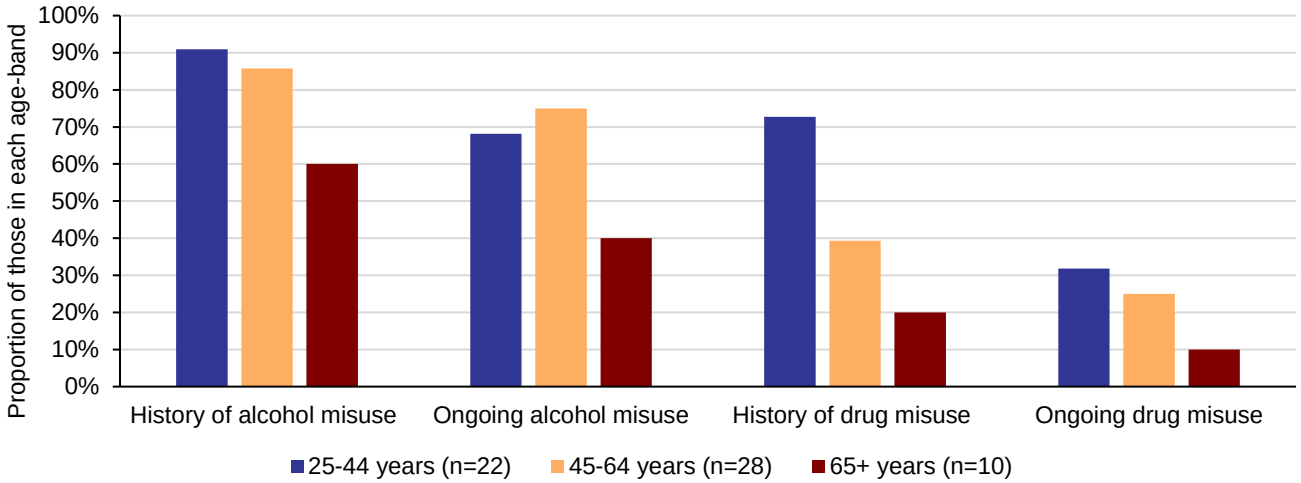
It was not possible to identify from the data where drugs had been used together (i.e., at the same time). However, the number of drugs stated to ever have been used by each individual (not necessarily at the same time) could be quantified. This ranged from one to nine drugs. Stated misuse of three or four drugs was most frequently recorded, and misuse of both heroin and cocaine/crack cocaine was most commonly recorded. It is possible, however, that these are under-estimates of the number of drugs being used, as it is possible that a focus on the 'main' drug(s) being misused may have meant that other drugs that were less frequently used were not recorded.

Table 7. Types of drugs ever misused, as recorded in the case histories.

Class and type of drug	Number of individuals (n=60)
Class A	
Heroin	15
Crack cocaine	12
Cocaine	12
LSD	2
Magic mushrooms	1
Class B	
Cannabis	15
Amphetamines	3
Ketamine	1
Codeine	1
Class C	
Benzodiazepines	4
Pregabalin	4
Zopiclone	1
Class unknown or non-controlled drugs	
Prescription medications (unspecified)	7
NPSs (including synthetic cannabinoids)	5
Opioids/opiates (excluding heroin)	3
Co-codamol	1
Paracetamol (over the counter)	1

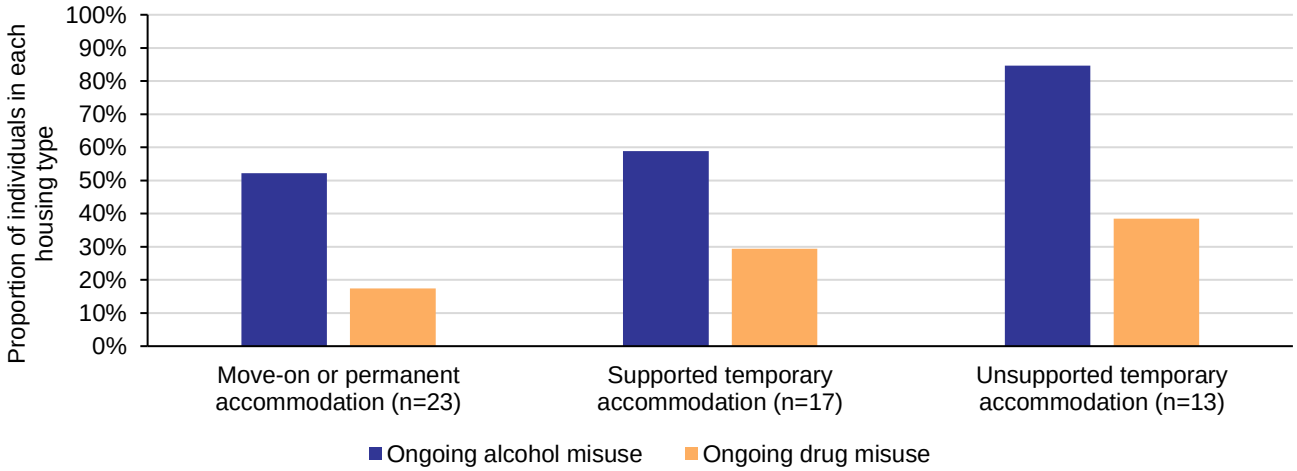
Past and current misuse of alcohol and drugs was proportionally less common in those aged 65 years and above (figure 8). A recorded history of drug misuse was most common in those of a younger age, with nearly three-quarters of those aged 25-44 years having any history of drug misuse, compared to two-fifths of those aged 45-64 years and one-fifth of those aged 65+ years.

Figure 8. History of, or ongoing, substance misuse by proportion of age-band.



Regarding housing status at the time of death, a greater proportion of individuals who were living in unsupported temporary accommodation, or who were rough sleeping or sofa-surfing, were identified as having ongoing alcohol and/or drugs misuse problems, than those who were in supported temporary accommodation, or move-on/permanent accommodation (figure 9 – NB: due to comparatively low numbers of rough sleepers and sofa-surfers, this group is not displayed).

Figure 9. Proportion of those living in the most common housing types recorded as having ongoing alcohol and drug misuse.



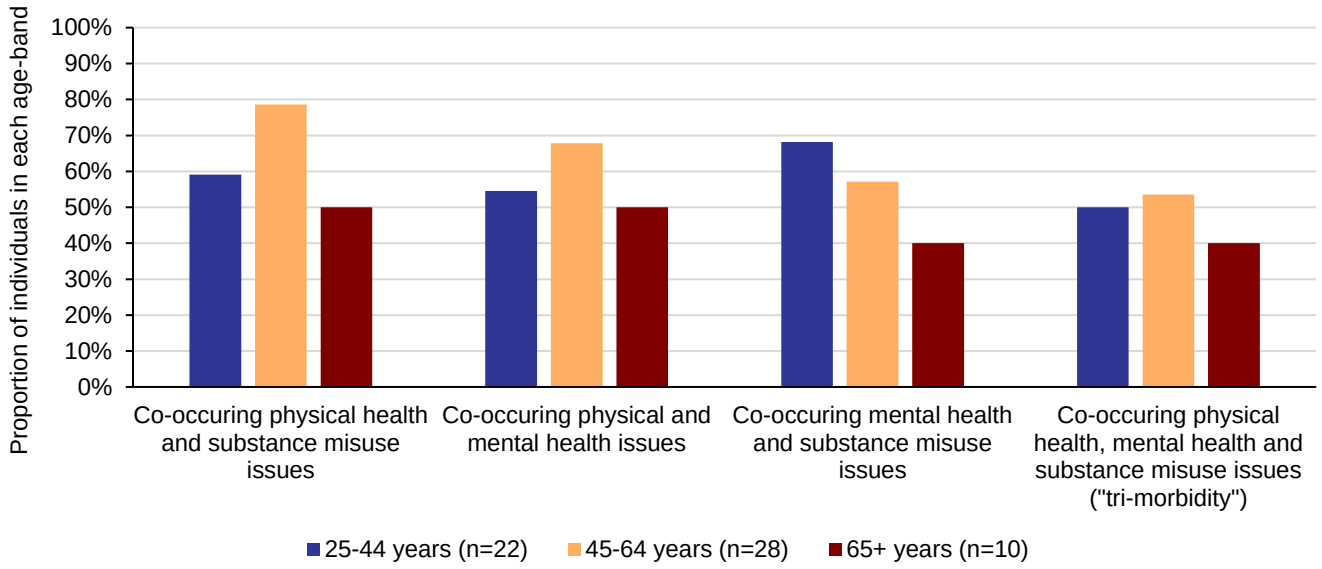
Co-occurring issues

Nearly three-fifths of individuals were identified as having co-occurring mental health and substance misuse issues (n=35). Proportionally, this co-occurrence of needs decreased with age, falling from nearly 70% of the 22 individuals aged 25-44 years to 40% of the 10 individuals aged 65+ years (figure 10). Co-occurrence of physical health and substance misuse issues (n=40) or physical health and mental health issues (n=36)

were slightly more common (as might be expected considering the high levels of physical health issues recorded in this cohort).

Half of all individuals were identified as having a "tri-morbidity"[1] of co-occurring physical health, mental health and substance misuse issues (n=30).

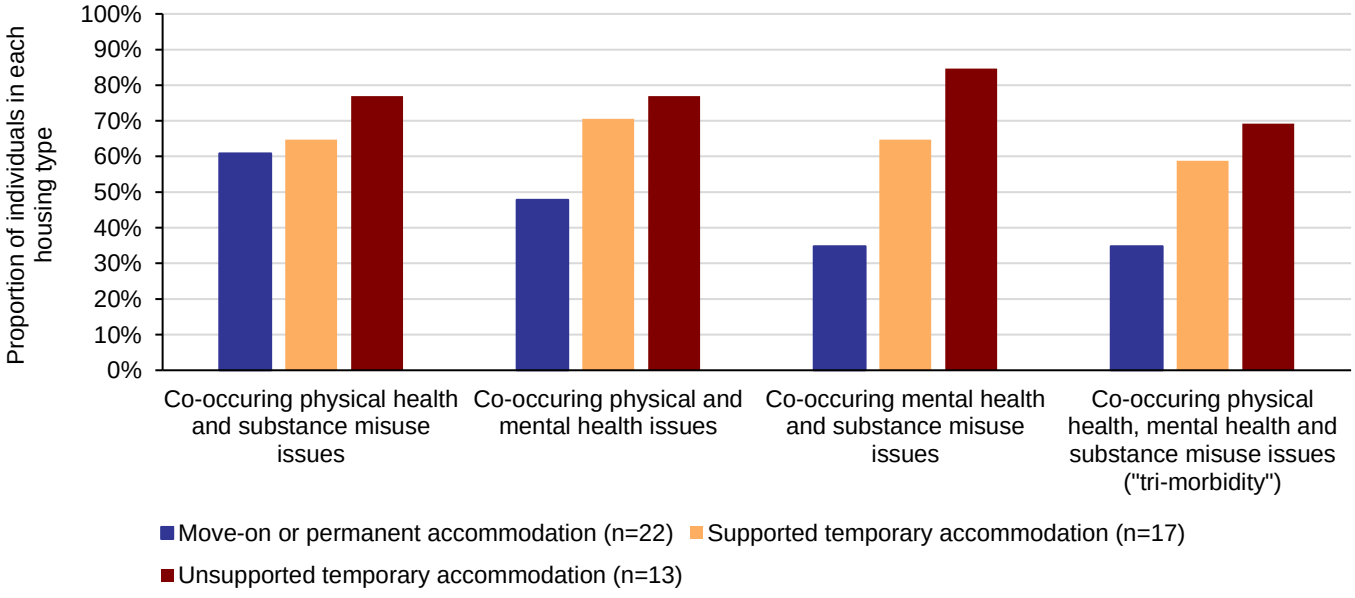
Figure 10. Co-occurring issues by proportion of individuals in each age-band.



By housing status, co-occurrence of health issues was generally highest in those living in unsupported temporary accommodation, with around three-quarters of the 13 individuals having any combination of physical health, mental health or substance misuse issues (figure 11).

Four of the five individuals who were recorded as rough sleeping or sofa-surfing around the time of death were identified as having co-occurring mental health and substance misuse issues.

Figure 11. Co-occurring issues by proportion of individuals in the most common housing types.



Service histories

GP registrations

Five in six individuals were stated in the case histories to be registered with a GP (n=50), although information about the date of last contact with their GP was not consistently available.

There was no large variation in GP registration by age, nor any differences by ethnicity (nine of the ten individuals not stated to be registered with a GP were of White British/Irish ethnicity). Proportionally more males were recorded as being registered with a GP compared to females (nearly nine in ten males compared to around half of the females).

Known to and engaging with mental health services

Of the 44 individuals who were recorded as having ongoing mental health issues around the time of death, around two-thirds were recorded as being known to mental health services (n=28). Only a third of those with ongoing mental health issues were stated to be engaging with mental health services around the time of death (n=15) (figure 12).

Of those with ongoing mental health issues, a greater proportion of females than males were stated to be engaging with mental health services around the time of death (four of five females compared to around one in four males). By age, proportionally fewer of those aged 45-64 years with ongoing mental health issues were known to, or engaging with, mental health services, compared to the under 45s and over 65s.

Five individuals were stated as having ever been an inpatient under the Mental Health Act. Each of these individuals had a recorded history of suicidal ideation and/or attempts and a recorded history of substance misuse.

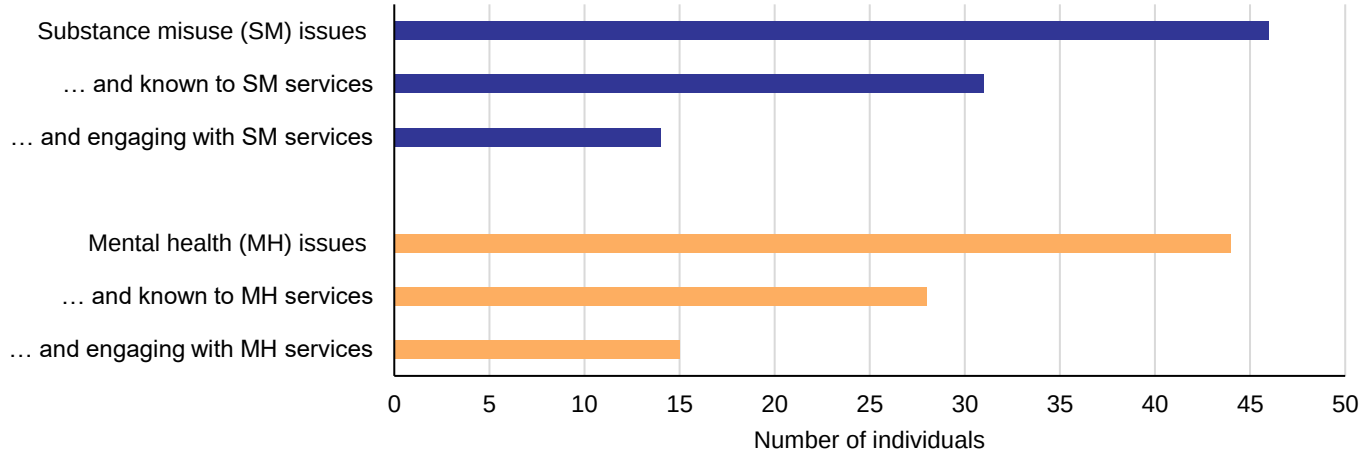
Known to and engaging with substance misuse services

Despite the high burden of substance misuse issues in this cohort, relatively low proportions of individuals were stated to be accessing services (figure 12).

Of the 46 individuals who were stated to have ongoing substance misuse issues (alcohol and/or drugs) around the time of death, around two-thirds were recorded as being known to substance misuse services (n=31). This proportion decreased to around a third for those who were actively engaging with substance misuse services (n=14).

A greater proportion of females who were stated to have ongoing substance misuse issues were stated to be engaging with mental health services, compared to males (half of female individuals compared to around a quarter of males). By age, proportionally fewer of those aged 45-64 years with ongoing substance misuse issues were known to, or engaging with, substance misuse services, compared to the under 45s and over 65s.

Figure 12. Number of individuals with ongoing substance misuse or mental health issues who were recorded as being known to, or engaging with, services around the time of death.



Safeguarding

A fifth of individuals were stated to have been referred to local authority safeguarding services (n=12), whilst an additional five individuals had had safeguarding or welfare 'concerns' raised. Proportionally more females were stated to have been referred to safeguarding than males (four of seven females compared to eight of fifty-three males). Those referred to safeguarding increased proportionally with age, from nearly 15% of those aged 25-44 years to 30% of those aged 65+ years.

Self-neglect was the most common reason for a safeguarding referral (three-quarters of referrals cited self-neglect) or for raising a safeguarding or welfare 'concern'. A small number of safeguarding referrals were made for financial exploitation, cuckooing and abuse or neglect by others.

A number of challenges in making safeguarding referrals were identified in the case histories, notably around self-neglect, mental capacity and whether referrals would, or would not, meet the threshold for a safeguarding duty.

Rough Sleeper and Multi-Agency Risk Management (MARM) Panels

Around half of all individuals were recorded as being known to the Rough Sleeper Panel.

Four individuals were stated to have been referred to the Multi-Agency Risk Management (MARM) Panel, all of whom were male and of White British/Irish ethnicity.

Housing placements

Almost all individuals were living in West Sussex at the time of referral into West Sussex homelessness and housing support services. Of the three individuals who lived elsewhere (Portsmouth, Hampshire and Surrey), one was relocated to West Sussex for their own safety, another was placed with a West Sussex unsupported temporary accommodation provider by an external local authority and the third had been sofa-surfing in a neighbouring county before accessing West Sussex services.

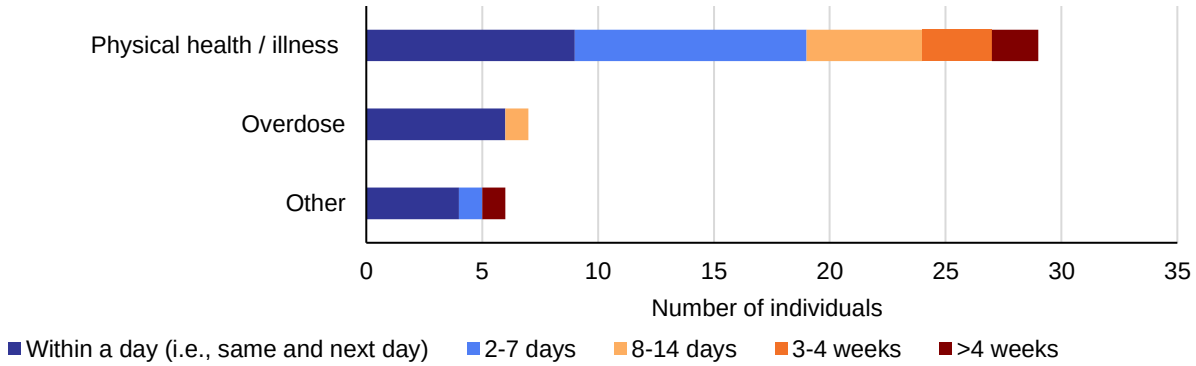
Five individuals were recorded as having been placed in service accommodation out-of-area from where they had accessed services in West Sussex (this included within-county and outside-of-county placements). Where the reason for this was given in the case histories, this included out-of-area placements for the individual's own safety and to move away from the detrimental influence of past social networks.

Time between death and last contact with homelessness services

Information about the time between death and the last recorded contact with the homelessness service who provided the case histories was available for most individuals (n=54). It should be borne in mind that information about the time between death and last contact with *other* agencies or services (e.g., medical professionals, social care providers etc.) was not uniformly available and is thus not presented here.

Around a third of individuals were identified as having been in contact with homelessness services within a day of death (n=21) and a further one-fifth were recorded as having been in contact within one week of death (n=13) (figure 13).

Figure 13. Time between death and last contact with homelessness services by suspected cause of death (where recorded).



Note: Accidental injury, intentional self-harm (excluding self-poisoning) and homicide have been grouped into the 'Other' category due to small numbers.

Risk factors and vulnerabilities

Self-neglecting behaviours

Behaviours that were indicative of self-neglect were commonly recorded in the case histories, with a similar proportion of males and females showing these behaviours. Nearly three-quarters of the cohort (n=43) were identified as having repeatedly or ongoingly displayed at least one behaviour that was indicative of self-neglect, whilst slightly more than a quarter of individuals (n=17) displayed three or more self-neglecting behaviours. Proportionally fewer of the younger individuals (aged under 45 years) displayed three or more self-neglecting behaviours (n=3), compared to around 35-40% of those aged 45-64 years (n=10) and those aged 65+ years (n=4).

Failing to access or refusing assistance from services was the most frequently recorded type of self-neglect across all age-groups, with around two-thirds of those who were showing self-neglecting behaviours failing to access one or both of healthcare (n=29) and alcohol or drug treatment (n=27). For the former, self-neglecting behaviours included repeatedly or ongoingly not taking prescriptions medications (for a variety of reasons), missing healthcare appointments and refusing to attend A&E against medical advice. Poor personal hygiene and health (including poor diet and malnutrition) was also common, being recorded in around half of those identified as showing self-neglecting behaviours (n=23).

By age-group, most of those aged 25-44 years who were showing self-neglecting behaviours were recorded as failing to access or refusing assistance from one or both of healthcare or substance misuse services, with few or no occurrences of the other types of self-neglect (table 8).

Where detail was available on the events surrounding individuals' deaths, several individuals were recorded as showing an increase in self-neglecting behaviours in the weeks and months leading up to death, often accompanied by increases in alcohol consumption and declines in health.

Table 8. Number of individuals showing self-neglecting behaviours.

Type of self-neglect	25-44 years (n=22)	45-64 years (n=28)	65+ years (n=10)	Total (n=60)
Failing to access / refusing assistance or services: health services	8	17	4	29
Failing to access / refusing assistance or services: alcohol or drug treatment	10	14	3	27
Poor personal hygiene and health	6	12	5	23
Neglecting personal affairs	2	3	3	8
Neglecting their environment/home (including hoarding, squalor, lack of household maintenance)		5	1	6
Failing to access / refusing assistance or services: social services		1	2	3
Ongoing misuse of own medication		1	1	2
Total number of individuals with self-neglecting behaviours	**15**	**22**	**6**	**43**

Note: some individuals showed more than one self-neglecting behaviour.

Self-neglecting behaviours were proportionally most frequent in those who were living in supported or unsupported temporary accommodation, sofa-surfing or rough sleeping around the time of death. This ranged from around three-quarters of individuals in supported temporary accommodation, to all those who were sofa-surfing or rough sleeping. Around half of those who were living in move-on or permanent accommodation were showing self-neglecting behaviours.

Self-harm and suicide

Around a quarter of individuals were recorded as having any history of self-harm (n=13), whilst seven individuals were recorded as having a current practice or risk of self-harming behaviours around the time of death (two of whom had no recorded history of prior self-harm).

Nearly half of all individuals were recorded as having any history of suicidal ideation and/or suicide attempts (n=29), whilst a quarter were stated to have attempted suicide or were thought to be at risk around the time of death (four of whom had no recorded history of prior suicidal ideation or attempts).

Self-harm and suicidal ideation and/or attempts were proportionally more common in females than in males, and more common in younger people than in middle-aged or older people:

- Three of seven female individuals were recorded as having any history or current practice or risk of self-harm, compared to nearly a quarter of male individuals (12 of 53 male individuals).
- Nearly two-thirds of all those recorded as having any history or current practice or risk of self-harm were aged 25-44 years (n=9), representing around two-fifths of this age-band.
- Six of seven female individuals were recorded as having any history or current risk of suicidal ideation and/or suicide attempts, compared to half of male individuals (27 of 53 male individuals).
- Slightly more than half of all those recorded as having any history or current risk of suicidal ideation and/or suicide attempts were aged 25-44 years (n=18), representing around four-fifths of this age-band.

Of those with any recorded history or current risk of self-harm or suicidal ideation, or had documented suicide attempts, nearly all were identified as having ongoing mental health and/or substance misuse issues. Furthermore, all of those with any recorded history or current risk of self-harm also had a recorded history or current risk of suicidal ideation or suicide attempts.

Disabilities

Twenty-eight individuals were identified as having at least one type of physical disability. These were most common in middle-aged and older individuals, with around 65% of those aged 45-64 years (n=18) and 70% of those aged 65+ years (n=7) being recorded as having at least one physical impairment (table 9).

Ten individuals were recorded as having cognitive impairments, including acquired brain injuries, alcohol-related brain damage and dementia. All of those stated to have alcohol-related brain damage were aged 45-64 years.

A handful of individuals were recorded as having learning difficulties (n=5) or learning disabilities (n=4). However, in most cases where a learning disability was recorded, the nature of this disability was not known and there is a possibility that the common confusion between learning disabilities (meaning reduced intellectual ability) and learning difficulties (e.g., ADHD, dyslexia etc.) may have inflated the number of individuals recorded as having the former.

Table 9. Physical and cognitive impairments by age.

Physical and cognitive impairments	25-44 years (n=22)	45-64 years (n=28)	65+ years (n=10)	Total (n=60)
Physical impairments	**3**	**18**	**7**	**28**
Progressive conditions and physical health (e.g., cancer, epilepsy, COPD)	4	11	4	19
Mobility disability		11	4	15
Visual impairment	2	3	2	7
Hearing impairment			1	1
Cognitive impairments	**3**	**6**	**1**	**10**
Acquired brain injury (traumatic and non-traumatic)	3	3		6
Alcohol-related brain damage		3		3
Dementia (not including alcohol-induced)		1	1	2

Community safety – offending, domestic abuse and exploitation

Around half of all individuals were stated to have any history of offending (n=32). This was more common in younger individuals, with nearly 70% of those aged 25-44 stated to have any history of offending (n=15) compared to 50% of those aged 45-64 (n=14) and 30% of those aged 65 years and above (n=3). Any history of offending was also proportionally more common in male individuals than females.

Around one-third of individuals were also stated to have been in prison at least once during their lives (n=21), again with a higher proportion of the younger age-groups with this experience (although this age gradient was less steep than for offending).

Three of the seven female individuals were identified as having experienced domestic abuse (and no male individuals). Nearly a fifth of male individuals (n=10) were stated or suspected to have perpetrated domestic abuse (and no female individuals).

Nine individuals were stated to have experienced exploitation at some point during their lives, with financial exploitation being the most commonly recorded type (n=7). Two individuals were stated to have been cuckooed, whilst the single female individual with a history of exploitation described exploitation by sex work in her past. By age, most individuals stated to have experienced exploitation were aged 45-64 years (n=6, representing around 20% of this age-group, compared to around 10% in those aged 25-44 years and those aged 65+ years).

Adverse childhood experiences (ACEs)

One in six individuals (n=10) had one or more adverse childhood experience (ACE) identified in their case histories, including experiences of physical, sexual or emotional abuse (n=5), living in care (n=4) and other ACEs (n=4), such as witnessing parental domestic violence, living with an alcoholic parent and death of a parent.

The majority of those reporting an ACE were aged 25-44 years. However, it is possible that different social attitudes may mean that older adults were less likely to view their experiences as ‘adverse’ or to disclose such private matters, compared to younger people. Moreover, information on ACEs may not have been routinely captured by the homelessness organisations who provided the case histories for this review,

meaning that it is possible that the number of individuals who were identified as having had ACEs is an under-estimate.

ACEs are well documented as being strongly associated with numerous health and social problems in adulthood[30]. This link was evident in the ten individuals with ACEs included in this review, for whom mental health issues, substance misuse issues and other detrimental behaviours were very common (table 10).

Table 10. Health issues and behaviours of individuals identified as having had adverse childhood experiences (ACEs).

Health issues and behaviours	Individuals with ACEs (n=10)
Mental health issues	10
History of alcohol misuse	10
History of alcohol dependence	6
History of drug misuse	9
History of suicidal ideation/suicide attempts	9
History of offending	7
Physical health issues	6
History of self-harm	5
History of prison	5
Victim of domestic abuse or violence	2

Family and relationships

Nine individuals were recorded as having lost access to their children (three female and six male). In some cases, this was due to children's services involvement, whilst others were the result of the child(ren)'s other parent or guardian refusing them contact. Where the reason for losing access was described, this was because of substance misuse issues and/or mental health issues, which were often concurrent. In some of these cases, this separation was described as having considerable impact on mood or being a trigger for mental health crises or worsening/relapse of substance misuse.

Relationship or family breakdown was recorded as a factor in the homelessness of six individuals. Where more detail was available about the drivers of this relationship breakdown, factors included domestic abuse (both as a victim and a suspected perpetrator) and alcohol misuse.

Main language and immigration status

Ten individuals, all male, did not have English recorded as their first language. Half of these, all aged 45 years and above, were stated to require an interpreter. Polish was the most common main language, spoken by eight of these individuals.

Three individuals, all of Eastern European origin, were described as not having recourse to public funds in their histories, meaning that they had been unable to access benefits when they needed them. Two of these needed an interpreter.

Veterans

Four individuals, all male, were stated to be veterans. Two of these were of immigrants from Eastern European countries. All of these individuals had ongoing physical health issues and a history of alcohol dependence recorded. Ongoing mental health issues were recorded for three of these individuals, two of whom had PTSD (either diagnosed or suspected).

Multiple Disadvantage

Two-thirds of all individuals were identified as having experience of multiple disadvantage, as defined by the Changing Futures programme (n=40) (table 11).

Table 11. Experience of disadvantaging issues, as defined by the Changing Futures programme.

Disadvantaging issue	Total number of individuals (n=60)	Proportion of all individuals (%)
Substance misuse issues (ongoing)	46	77%
Mental health issues (ongoing)	44	73%
Homelessness / housing need (ongoing)	42	70%
History of offending	32	53%
Victim of domestic abuse	3	5%
Three or more disadvantaging issues ('multiple disadvantage')	**40**	**67%**

Thematic analysis

Narrative summaries were produced by the reviewer for each individual included in the review, describing their life histories, risk factors and vulnerabilities. These summaries were then reviewed to identify common themes regarding issues and experiences which acted to decrease the subjects' health, wellbeing or resilience over time. Many of these issues did not directly cause or contribute to death but were thought to be factors that contributed to deterioration over time or acted to inhibit the ability to access and maintain support.

These themes are shown by their prevalence across the cohort in table 12 and briefly described below to give insight into the mechanisms underlying these themes.

Table 12. Qualitative themes identified from review of the case histories, describing issues that acted to decrease the health, wellbeing or resilience of individuals over time.

Theme	Total number of individuals (n=60)	Proportion of all individuals (%)
History of alcohol and/or drug misuse or dependency	54	90%
Difficulties in independent living	52	87%
Compounding issues needing holistic support	51	85%
Physical health problems	50	83%
Mental health problems	48	80%
Poor engagement or disengagement with support services	48	80%
Existing support not working for them or needs not being fully met	45	75%
Gaps, barriers and access to services	35	58%
Self-harm and suicidal behaviour	33	55%
Unstable (or chaotic) lifestyles	33	55%
Family and relationship breakdown	26	43%
Behaviours affecting eligibility to access support	25	42%
Access to employment, training or volunteering	22	37%
Vulnerable to peer influence or cultures of substance misuse	18	30%
Risks attached to a large inheritance/benefit payment	2	3%

History of alcohol and/or drug misuse or dependency

The harmful effects of alcohol and drug misuse or dependency, often continued over long periods (spanning several decades in some cases), was evident in most, if not all, aspects of the cohort's lives. This included substance misuse affecting individuals' behaviour, relationships, ability to maintain their tenancy, employment and personal admin, alongside poor and worsening physical health (and the risk of toxicity or interactions between prescribed medications and substances). In some individuals, purchasing alcohol was prioritised over buying essential goods (e.g., food), paying rent or affording travel costs to see family.

Difficulties in independent living

Many people lacked the personal skills, mental or physical capacity, or resilience needed to live independently. Lack of resilience for independent living was particularly acute in those who lapsed back into harmful behaviours after progressing to move-on or permanent housing. People struggled to manage their own health and personal care, and needed support to access and engage with services, including health and social care services.

Compounding issues needing holistic support

Having multiple compounding needs, that could interact and exacerbate each other, acted to increase individuals' vulnerabilities and the risk of poor outcomes. This included the co-occurrence of physical and mental health issues, substance misuse issues, social care needs, housing problems, employment difficulties, offending behaviours and other issues. The accumulation of needs could create barriers to accessing support, whether that be from unstable lifestyles or the requirements of services that individuals struggled to meet and so on.

Physical health problems

Ongoing physical health problems, often the result of long-term substance misuse and poor lifestyle behaviours, were very common. Although these issues were being managed by health professionals in many cases, other individuals struggled to manage their health needs, and it is likely that many individuals did not access services consistently or delayed their presentation to health services.

Mental health problems

Mental health and emotional wellbeing issues, encompassing feelings of loneliness and low self-worth through to acute mental illnesses, often acted to lower the resilience of individuals and to increase their risk of other harmful behaviours, such as self-medicating with alcohol or drugs. In some individuals, the difficulties and setbacks of their personal situation was seen to negatively affect their mood.

Poor engagement or disengagement with support services

Not being engaged with support services, disengaging from one or more of these services, or engaging only at the point of crisis, meant that many individuals did not receive the longer-term care and support that they needed or sufficient consistency in this support. These behaviours were often indicative of self-neglect or part of a wider pattern of poor self-care. In some individuals, health issues and personal setbacks resulted in a loss of motivation and subsequent disengagement with support.

Existing service provision not working for them or needs not being fully met

Many people had significant or compounding needs (including mental health, substance misuse, personal care etc.) that were not able to be fully met in their current placement. In some cases, this posed a risk to individuals' continuing abstinence, health or safety.

Several individuals inconsistently engaged or stopped engaging with their existing care (e.g., taking prescription medications for physical and mental health issues; or engaging with substance misuse services), thus potentially putting their health at risk, because they didn't feel that this provision worked for them.

Gaps, barriers and access to services

Some individuals faced barriers which affected their ability to access services. Some of these were personal, such as discomfort or reluctance in disclosing health needs, and others practical, such as mobility issues, a need for translation support, immigration status and not being registered with a GP due to a transient lifestyle. In some cases, greater communication between services may have enabled better support for individuals and a shared awareness between relevant agencies of the risks and needs that the individuals had.

Self-harm and suicidal behaviour

Past or ongoing self-harm and/or suicidal thoughts or attempts were a common indicator of the personal difficulties faced by this cohort and the erosive impact these could have on resilience. Some individuals had attempted suicide or self-harmed to an extent that it risked their life numerous times throughout their lives.

Unstable (or chaotic) lifestyles

Cycles of personal instability, repeated evictions and recurring disengagement with health or other services put many individuals at risk of poor and worsening health. In some individuals, this reflected chaotic behaviours entrenched over many years, whilst others experienced periods of stability punctuated with relapses into substance misuse or mental health crises. This fluctuation of circumstance, need and ability/willingness to engage presented considerable challenges in supporting these people.

Family and relationship breakdown

Difficulties with families, relationship breakdowns and having reduced contact with (or prohibited access to) under-18 children acted to reduce the resilience of many individuals, or was a factor leading to their homelessness. In some cases, being denied contact with their children triggered spirals of worsening mental health or substance misuse.

Behaviours affecting eligibility to access support

Aggression, violence and other 'unmanageable' behaviours, as well as repeated rule-breaking, continuing substance misuse and lack of engagement, led many individuals to become ineligible for support. This included evictions from temporary accommodation placements and substance misuse recovery programmes. Several individuals were recorded as having had numerous evictions, with some repeated over the space of a few months and others over the space of several years.

Access to employment, training or volunteering

Difficulties in accessing employment, training or volunteering were identified in the case histories as a barrier to maintaining or regaining independence for some individuals. Job losses were identified as a factor leading to homelessness in some individuals, with difficulties finding new employment persisting in the following period. Where individuals were not engaging in these more meaningful uses of time, which could otherwise have been a source of resilience, this was thought to be a risk factor for continuing harmful behaviours.

Vulnerable to peer influence or cultures of substance misuse

Being part of, or exposed to, a culture of substance misuse and harmful behaviours put some individuals at risk of continuing or relapsing into substance misuse, or of engaging in anti-social or illegal behaviours. This vulnerability to negative peer influence – or inability to say ‘no’ – inhibited some individuals’ abilities to break the cycle of harmful behaviours.

Risks attached to a large inheritance or benefit payment

In a small number of those who were misusing substances, receiving a large sum of money enabled them to increase their alcohol or drug consumption, thus increasing their risk of overdose or alcohol-related harm. This also put them at risk of exploitation by others.

Conclusion

Amongst this group of people who died whilst experiencing, or at risk of, homelessness, multiple and compounding needs were common. This cohort experienced a high level of physical health, mental health and substance misuse issues, with a high prevalence of chronic health conditions. This high burden of health need was compounded by a high level of additional risk factors and vulnerabilities, including self-neglecting behaviours and social care needs, self-harming and suicidal behaviours, offending behaviours, employment difficulties, and other issues. Most of this cohort had difficulties living independently, poor engagement or disengagement with services, and experience of gaps, barriers or instances where existing service provision was not working for them. The fluctuation in circumstances, needs, and ability or willingness to engage with services presented challenges in providing support.

This report does not make recommendations for any specific actions; however, its findings can be used to support the work of organisations and services working with this group, both singly and in partnership as a joined-up health, care and social support system. Consideration of the report's findings by system leaders, via relevant governance structures, will support systems to improve the health and care of this vulnerable population.

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