Domicile Unknown

Second Annual Medical Examiner Review of deaths among people experiencing homelessness in Multnomah County in 2012

MULTNOMAH COUNTY

street roots

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Introduction

At least 56 people experiencing homelessness died in Multnomah County in 2012.

This is the disturbing finding of the second annual report of data compiled by the Oregon State Medical Examiner and reported by Multnomah County, the City of Portland and *Street Roots*. We undertook this analysis to better understand what happens when someone in our community lacks shelter, one of the most basic of human needs. While any one person's path to homelessness may be caused by complex individual and environmental factors, the end of that path, as revealed here, is often devastatingly simple: a lonely, premature death on our city streets. In the richest nation on earth, in a county of great strengths and abundance, this is unacceptable.

We want to thank the Oregon State Medical Examiner and the Multnomah County Medical Examiner's Office whose generosity made this report possible. The Medical Examiner is responsible for investigating the deaths of individuals who appear to have died from specific causes or circumstances such as accidents, overdoses, or suicide. Therefore, this data does not reflect all deaths among people experiencing homelessness in Multnomah County in 2012. It does not, for instance, include those who may have been receiving medical care and died in the hospital of natural causes. As a result, this report almost certainly undercounts the total number of people experiencing homeless who died on our streets last year.

The findings in this report provide important information for the public and for policy makers about those who died while homeless and the circumstances that contributed to preventable or premature deaths. As a community, we have worked to provide homes for many people in need, particularly military veterans. But falling incomes and stagnant job growth have countered government, philanthropic and faith-based services for housing the homeless. The sluggish economy has pushed more people, including working families with children, into unstable or unsuitable housing. Substance abuse and addiction cost federal, state and local governments nearly $468 billion a year in health care and criminal justice, but only 2 percent of that spending goes toward prevention and treatment.[1]

In this time of scarce resources and rising need, we need to move people from the uncertainty of the streets into safe, permanent homes.

Similar to the "2011 Domicile Unknown" report, the vast majority of people who died in 2012 were men. The deceased ranged in age from 21 to 72 years, with an average age of about 46. These ages are well below the average life expectancy in Multnomah County of 71 years. [2]

For many of these people, the end of life was violent or painful. More than half were accidental deaths and included death from overdose, drowning, burns and hypothermia. Ten people died by suicide. This region's epidemic of heroin overdoses is also obvious, with toxicology results showing heroin as the cause of death in 17 of the 56 people.

This report reveals the physical and mental vulnerability common among those who lack basic shelter. We sincerely hope this analysis will help our local governments, community partners and policy makers better plan, coordinate and target our community's prevention efforts.

We also see this report as the painful reminder that each of the 56 people documented in these findings were members of our community and our families: a son, daughter, aunt, brother, mother and friend. This report is dedicated to their memories.

Deborah Kafoury
Commissioner
Multnomah County

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Methods

Data Source

The Oregon State Medical Examiner maintains a database of all deaths investigated under its jurisdiction. In December 2010, the data field "**domicile unknown"** was added to the database for Multnomah County so that deaths of individuals who may have been homeless at the time of their death could be more easily identified to produce this report. The domicile unknown category is selected when death investigators cannot identify an address or place of residence for the person who died despite multiple attempts by the investigator to identify one through interviews with relatives and social contacts.

According to ORS 146.090 the Medical Examiner investigates and certifies the cause and manner of all human deaths that are:

(a) Apparently homicidal, suicidal or occurring under suspicious or unknown circumstances;
(b) Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;
(c) Occurring while incarcerated in any jail, correction facility or in police custody;
(d) Apparently accidental or following an injury;
(e) By disease, injury or toxic agent during or arising from employment;
(f) While not under the care of a physician during the period immediately previous to death;
(g) Related to disease which might constitute a threat to the public health;
(h) In which a human body apparently has been disposed of in an offensive manner.

For the period Jan. 1, 2012 through Dec. 31, 2012, we extracted from the database the age, sex, race, cause, date, and manner for death for records in which the individual's address was noted to be 'domicile unknown'.

Data Analysis

Prior to analyzing this data, we reviewed all of the narrative reports by Multnomah County Deputy Medical Examiners, plus any supplemental information they later obtained. Sixty-six individuals who died in 2012 were noted to have "domicile unknown" by the Medical Examiners Office. Of those, the narrative text in 56 (85%) instances supported homeless status as defined by the US Department of Housing and Urban Development.[3] In the remaining ten cases, there was either inadequate information available to make a retrospective determination, or there was information indicating that the person who died did indeed have a permanent residence. This analysis is limited to the 56 cases in which the investigation indicated the person was experiencing homelessness in Multnomah County at the time of death.

Because of the limitations of using Medical Examiner data for this report, we compiled only the frequencies of each variable and did not attempt to analyze difference in this group of homeless decedents to any other group nor to estimate specific rates. Frequencies were compiled using EpiInfo 7 (Centers for Disease Control and Prevention, Atlanta, GA). For the season of death, the year was divided into October-March and April-September. A variety of terms are used on death certificates for deaths caused by substance overdose; we combined these multiple terms into an overall category of 'overdose'. In addition, since some deaths were caused by multiple substances, we built a table listing all of the individual agents and combinations of agents identified through toxicology tests by frequency.

Results

Total Deaths

During the calendar year 2012, the Medical Examiner identified 56 deaths in Multnomah County among people determined to be homeless. There were 2,151 total reportable deaths in the county recorded by the Medical Examiner in that same period.

Age

Deaths among the group whose domicile was unknown ranged from age 21 to 72 years with an average age of 45.6 years; 73% of deaths were among people aged 30 to 59 years. Forty-eight (86%) of the 56 people who died were males.

Table 1
Age (Years) at Death among Homeless Multnomah County Medical Examiner Cases, 2012

	Male	Female	Total
Mean	45.2	47.9	45.6
Median	45	44.5	45
Range	21 to 69	29 to 72	21 to 72

Age Group	Male	Female	Total
20-29	5 (10.4%)	1 (12.5%)	6 (11%)
30-39	11 (23%)	1 (12.5%)	12 (22%)
40-49	17(35%)	3 (37.5%)	20 (36%)
50-59	9 (19%)	0 (0%)	9 (16%)
60-69	6 (12.5%)	2 (25%)	8 (14%)
70-79	0 (0%)	1 (12.5%)	1(2%)
Total	48	8	56 (100%)*

*Total equals 101% because of rounding

Race

In this data set, Hispanic ethnicity was considered as a distinct race. The Medical Examiner was able to assess race in 51 (91%) of the 56 decedents. Forty-two (82%) of deaths were listed as White; smaller numbers of Black/African-American, Native American, and Hispanic deaths were identified; no deaths among those of Asian race were reported in this data set.

Table 2
Race and Ethnicity among Homeless Multnomah County Medical Examiner Cases, 2012

Race	Number (%)
Black/African American	5 (10%)
Hispanic	3 (6%)
Native American	1 (2%)
White	42 (82%)
Total	51 (100%)

Season

Since people experiencing homelessness are exposed to the environment without permanent shelter, we looked at the frequency of deaths during colder (October-March) and warmer (April-September) periods of the year. A similar number of deaths were identified during both periods. Overall, twenty-seven (57%) of the 47 deaths occurred in an outdoor setting. In one case (occurring in December), hypothermia was the direct cause of death.

Table 3
Season of Death among Homeless Multnomah County Medical Examiner Cases, 2012

Season	Number (%)
April – September	29 Deaths (52%)
October – March	27 Deaths (48%)

Cause and Manner of Death

The Medical Examiner database includes information on the cause and manner of death. The manner of death is classified as Natural, Accidental, as a Suicide, Homicide, or as Undetermined. Natural deaths are those that do not occur as the result of external causes, usually medical conditions; Natural deaths related to alcohol are typically caused by liver failure or bleeding. The most common causes of Accidental deaths are trauma and drug or alcohol overdose.

Table 4
Manner and Cause of Death among Homeless Medical Examiner Cases, Multnomah County, 2012

Manner of Death	Immediate Cause of Death	Male	Female	Total
Natural		10 (21%)	4 (50%)	14 (25%)
	Alcohol related	*4*	*1*	*5 (9%)*
	Heart and Vascular Disease	*4*	*3*	*7(12%)*
	Unspecified	*2*	*0*	*2 (4%)*
Accidental		28 (58%)	2 (25%)	30 (54%)
	Drug or Alcohol Overdose	*19*	*1*	*20(36%)*
	Trauma	*4*	*1*	*5 (9%)*
	Drowning	*2*		*2 (4%)*
	Hypothermia	*1*		*1(2%)*
	Burn	*1*		*1(2%)*
	Diabetic ketoacidosis	1		1*(2%)*
Suicide		8 (17%)	2 (25%)	10 (18%)
Homicide		0	0	
Undetermined		2 (4%)	0 (0%)	2 (4%)
	Drowning	*1*		*1 (2%)*
	Seizure Disorder	*1*		*1 (2%)*

Toxicology

Twenty (67%) of the 30 accidental deaths among the homeless were caused by drug or alcohol toxicity. Some overdose deaths were caused by more than one substance but opiates (heroin and oxycodone) were part of the cause of death in 18 (90%) of these 20 deaths.

Table 5
Substances Identified as Causes of Death among Homeless Medical Examiner Cases, Multnomah County, 2012

Opiate Involved	Substance	Number of Cases
YES (18 cases)	Heroin alone	10
	Heroin plus Alcohol	4
	Heroin plus Cocaine	1
	Heroin plus Methamphetamine	1
	Heroin plus Oxycodone	1
	Oxycodone plus Alcohol	1
NO(2 cases)	Methamphetamine alone	1
	Cocaine alone	1
Total	Any	20

Overall Multnomah County Accidental Deaths

In 2012, overdoses caused 129 (32%) of the 407 Accidental deaths identified by the Medical Examiner in Multnomah County. Of these deaths from drugs and alcohol, 114 (88%) were related to opiate overdose. Nearly 1 in 6 of the deaths from overdose, opiate and non-opiate, in 2012 occurred among those who were homeless.

Table 6
Accidental Intoxication Deaths, Multnomah County, 2012

Group	Total Accidental Deaths	Deaths from Drugs and Alcohol		
		Total	Non opiate	Any Opiate
Multnomah County	407	129	15	114
Domicile Unknown	30	20	2	18

Observations

Simply looking at the ages and causes of deaths investigated by the Medical Examiner among the homeless in Multnomah County suggests that virtually all of these losses may have been avoidable. Not only are the 30 accidental and 10 deaths by suicide clearly preventable, they also suggest a lack of support for social, mental, and physical well-being. Even those who died of Natural causes were relatively young; the average age at death among these 14 people was only 56 years, suggesting they may have lacked adequate access to medical care and treatment for their conditions. The average lifespan of a person experiencing homelessness in the United States is about 30 years less than a person who is housed.[4]

As we analyzed the data collected by the Medical Examiner in this year's report, we found dominant themes associated with these preventable deaths.

Heroin

Twenty of the deaths among people experiencing homelessness in 2012 were caused by drug or alcohol overdose. Opiate overdose was most common, with 17 heroin overdoses plus one related to oxycodone.

Opiate overdose is a major public health problem overall in Oregon, where overdoses kill more people annually than motor vehicle accidents. Heroin overdoses statewide rose 42 percent from 2002 to 2011, from 101 deaths to 143 according to the Oregon State Medical Examiner's Drug Related Death Reports. Heroin is also the leading cause of opiate overdose in Multnomah County.

In 2012, of all accidental deaths due to overdose in Multnomah County, one in six was among people who were homeless. Drug and alcohol abuse is prevalent among people experiencing homelessness because substance abuse and homelessness can reinforce one another.[5] People can be more likely to end up homeless once their addiction takes priority over everything else in life. Likewise, substance abuse can destroy relationships with families and friends, leaving someone socially isolated in their illness. At the same time, the struggle to survive on the street can drive some people who are homeless to use drugs and alcohol. Lack of basic shelter can diminish access to treatment and the motivation and support to complete it.

Multnomah County is responding to the epidemic of opiate painkiller and heroin use with policies intended to decrease addiction and overdose. Heroin use frequently overlaps with prescription painkiller use. A 2011 survey of needle exchange clients in Multnomah County showed that 45 percent of heroin users said they were hooked on prescription opiates before they started using heroin. As a result, in 2011, the Multnomah County Health Department adopted a prescribing policy in the county's seven primary care clinics that requires physicians to comprehensively assess a patient physically and mentally, including addiction history, before prescribing opiates. As Multnomah County is Oregon's largest safety net provider of primary health care, the county plays an important role in setting the community standard for all opiate prescribing.

Multnomah County also supports pending legislation to expand overdose rescue strategies statewide by making a drug that reverses overdoses available to drug-users, their friends, families, counselor and others. The drug, Naloxone, is already widely used by paramedics and emergency room staff.

Nonetheless, the number of overdose deaths among those who are homeless also suggests that Multnomah County should consider further strategies designed to specifically address substance abuse among people experiencing homelessness. "Housing access is the bulwark of recovery for a person who is homeless and has a substance abuse disorder and/or mental illness,'' the Substance Abuse and Mental Health Services Administration reports.[6] Therefore, we must prioritize expanding housing resources

specifically for this population. Effective models already exist in our community, from alcohol and drug-free supportive housing to "Housing First" approaches rooted in harm reduction. The stark reality, though, is that wait lists for these resources are currently too long and funding too scarce to meet the breadth of the need. The cost of *not* providing these critical housing resources is extreme – both to our health and public safety systems, but more significantly in the lives lost for lack of access to basic housing and support.

Suicide

Suicide also plays a leading role in preventable deaths among people experiencing homelessness. Ten of 56 deaths documented in this report were by suicide. According to the Oregon Public Health Authority, suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the eighth leading cause of death among all Oregonians in 2010. In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average. The rate of suicide among Oregonians has been increasing since 2000.

The Multnomah County Mental Health Call Center is staffed 24 hours a day, seven days a week by highly-educated, well-trained staff to address mental health emergencies. The staff provide crisis counseling by phone, with translation for non-English speakers; 24/7 mobile crisis outreach for in-person assessment; referral to low-cost or sliding scale agencies; help finding mental health providers, including those who have culturally linguistically specific services; and information about non-crisis community resources. The number is (503) 988-4888 and toll free 1-800-716-9769.

Suicidal calls to the county's crisis hotline have increased. In 2011, the call center received 67,410 calls; 1,637 were suicide calls that were first placed to 911. In 2012, the call volume increased to 68,597 calls, 2,168 were suicide calls from 911. This is the largest call volume the call center has received since it began in 2002.

According to the Suicide Prevention Resource Center, while suicide has many causes and cannot be attributed to one thing, there are factors that increase the risk of suicide and protective factors that may lower the likelihood of suicidal behavior. The Center lists the major risk factors that include: prior suicide attempt(s), mood disorders, substance abuse and access to lethal means. The major protective factors include effective mental health care, connectedness and problem-solving skills.

From years of working to address housing issues, we know that people who are homeless or who are living in tents and cars have less access to primary and mental health care and addiction services and are often very isolated. Mobility also disconnects people from health care so their treatment is delayed. These are protective factors that we can address with street outreach connected to housing placement, rapid rehousing programs, and more supported housing options with behavioral health services.

Health Care

Poor health is a cause and effect of homelessness.[7] Becoming disabled or experiencing a health crisis is often the tipping point for people to lose their ability to afford housing. Likewise, people surviving on the street lack good nutrition, personal hygiene, first aid, and access to medical treatment.

State and federal efforts at health reform offer some opportunities to better identify and strengthen access to health care and thus, homeless prevention efforts.

Health care transformation in Oregon and in Multnomah County has the potential to improve the health of the most vulnerable members of our community and reduce premature deaths. Coordinated Care Organizations (CCOs) in Oregon are tasked with two main goals: improving health outcomes and reducing the cost of health care. Success depends in large part on the CCO's ability to address the social determinants of health. These are the circumstances in which people are born, live, work and age that influence their health.

Housing is a key social determinant. Individuals who have their basic need for shelter met are much more able to take care of their medical concerns and engage in healthy habits. We firmly support the Health Commons pilot projects by Health Share of Oregon members that include a housing component as a strategy to improve health outcomes and reduce health care costs. One project will provide flexible funding to remove barriers to housing for patients. The second is a short-term stabilization project with Central City Concern to provide access to rooms along with medical and housing staff for up to 60 days. The goal is to eventually connect members to stable long-term housing.

We strongly encourage the two CCOs serving people in Multnomah County, Health Share of Oregon and Family Care, to further consider programs that would provide housing for people experiencing homelessness, connect them with a primary care medical home, and track their outcomes. Similar programs have been undertaken in San Francisco, Minneapolis, Boston and New York.[8] New York City's three-year pilot was so successful in reducing healthcare costs and improving health outcomes that it is working to expand it. Medicaid funds are being used to pay for this housing.

In addition, expanded access to health care should be a priority. A major barrier to access primary and mental health care is health insurance. Right now, the access to care is limited among many low-income adults. In 2014, Medicaid eligibility will be expanded to include people between the ages of 19 up to 65 with incomes up to 138 percent of the federal poverty level. This will mean an additional 200,000 people in Oregon will have access to the Oregon Health Plan, the state's Medicaid program, including about 50,000 in Multnomah County. Multnomah County and the City of Portland must have targeted outreach strategies in place to enroll all those who are eligible for coverage, especially those who are homeless.

<u>Housing</u>

Homelessness in general is growing in Multnomah County and across the nation. Over the past decade, despite resources to address the national crisis of homelessness and housing instability, families and individuals have suffered unprecedented unemployment and underemployment. We are struggling to help families and individuals experiencing homelessness return to a home or stay in their home.

Our challenge here is great and growing. In Multnomah County, more than 1,700 people sleep on our sidewalks each night. People of color have experienced this disproportionally. Although they make up only 29 percent of the county's population, nearly half (46%) of those experiencing homelessness are people of color. Children in particular are increasingly at risk. More than 3,000 school children in Multnomah County were homeless last year.

Interventions have succeeded. In the last decade, this community's public and private partners have helped more than 12,000 homeless families and individuals find permanent homes.

City and county leaders have continued their commitment to funding vital homeless and housing programs. In 2012, the City of Portland and Multnomah County each allocated about $10 million to move people into housing, provide rent assistance and operate shelters. Despite that effort, the economy, job market and other forces beyond local governments' control are making it harder to prevent and end

homelessness. As we see from this report, housing is a basic human need, not a luxury. Increasing resources to house more people is a key prevention strategy.

As we see from this report, housing is not a luxury, but is a basic human need and is in fact our key prevention strategy. We must continue to find more resources to develop housing that people can actually afford. In addition, we support the 2013 *A Home for Everyone: A United Community Plan to End Homelessness in Portland-Multnomah County.* That plan calls for using limited housing and shelter resources to meet immediate health and safety needs. As this report demonstrates, lives depend on it.

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[1] The National Center on Addiction and Substance Abuse at Columbia University: "Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets," http://www.casacolumbia.org/articlefiles/380-ShovelingUpII.pdf

[2] Institute of Health Metrics and Evaluation – Life Expectancy by county and sex (U.S.) 1989-2009 http://www.healthmetricsandevaluation.org/tools.data-visualization/lifeexpectancy-county-and-sex-us-1989-2009#/overview/explore

[3] National Alliance to End Homelessness: http://www.endhomelessness.org/library/entry/changes-in-the-hud-definition-of-homeless. HUD has issued the final regulation to implement changes to the definition of homelessness contained in the Homeless Emergency Assistance and Rapid Transition to Housing Act. The definition affects who is eligible for various HUD-funded homeless assistance programs. The new definition includes four broad categories of homeless:

- People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. The only significant change from existing practice is that people will be considered homeless if they are exiting an institution where they resided up to 90 days (previously 30 days) and were in shelter or a place not meant for human habitation immediately prior to entering that institution.
- People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled-up situation, within 14 days and lack resources or support networks to remain in housing. HUD had previously allowed people who were being displaced within seven days to be considered homeless. The proposed regulation also describes specific documentation requirements for this category.
- Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. This is a new category of homelessness, and it applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
- People who are fleeing or attempting to flee domestic violence have no other residence, and lack the resources or support networks to obtain other permanent housing. This category is similar to the current practice regarding people who are fleeing domestic violence.
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[4] Institute of Health Metrics and Evaluation – Life Expectancy by county and sex (U.S) http://www.healthmetricsandevaluation.org/tools/data-visualization/life-expectancy-county-and-sex-us1989-2009#overview/explore

[5] National Coalition for the Homeless *http://www.nationalhomeless.org/factsheets/addiction.pdf*

[6] Behavioral Health Services for People who are Homeless http://store.samhsa.gov/shin/content/SMA13-4734/SMA13-4734.pdf

[7] Health Care and Homelessness http://www.nationalhomeless.org/factsheets/health.html

[8] "If you build it, they won't come back." Modern Healthcare: September 24, 2012 http://www.modernhealthcare.com/section/TOC?date=20120924#