**Mortality among rough sleepers, squatters, residents of homeless shelters, hotels, and sofa surfers**: **a pooled analysis of UK birth cohorts**

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**Abstract**

**Background**

Homelessness encompasses a wide spectrum of experience. Rough sleepers and people attending homeless shelters have been found to be at an increased risk for mortality. It is unclear whether risks are also elevated those squatting, living temporarily in low-cost hotels, or ‘sofa surfing’ with friends or family members. This study examines mortality in a representative nationwide sample of people who have slept rough, squatted, lived in shelters, low-cost hotels and sofa surfed.

**Methods**

Using unpublished data from two national birth cohorts, The National Child Development Study and the 1970 British Birth Cohort study, Cox proportional hazards models and random effects meta-analysis were used to analyse associations between homelessness and different types of homeless experience (rough sleeping, squatting, staying in a homeless shelter, low-cost hotel, and sofa surfing) and mortality.

**Results**

Out of the 23,678 participants, 1,444 (6.1%) reported having been homeless and 805 (3.4%) deaths occurred. Homelessness was associated with an increased risk of mortality (hazard ratio (HR) 1.68, 95% confidence interval (95% CI) 1.24-2.26). Mortality risk was raised across the spectrum of homeless experience, from sleeping rough: 4.71 (2.38-9.30), to squatting: 6.35 (2.73-14.75), staying in a homeless shelter: 4.89 (2.36-10.11), staying in a low-cost hotel: 3.38 (1.30-8.79), through to sofa surfing: 2.86 (1.84-4.42). Associations remained after separate control for socioeconomic status, mental health, substance use, accidents and assaults, and criminality.

**Conclusions**

Mortality rates were raised across all types of homeless experience, including squatting and sofa surfing not previously been reported. Studies that have omitted the less severe, but more prevalent use of low-cost hotels and sofa surfing, may have underestimated the impacts of homelessness on mortality.

**Key words:** homelessness, squatting, sofa surfing, mortality, cohort study

**Key Messages**

* This study tests the associations of different types of homeless experience (rough sleeping, squatting, staying in a homeless shelter, low-cost hotel, and sofa surfing) with mortality using two national representative birth cohorts.
* All types of homeless experience were associated with an increased risk of mortality. Those for squatting and sofa surfing have not previously been reported.
* Housing policies should be revised to reduce the use of housing in low-cost hotels.
* The scope of homelessness prevention should be expanded to also include less severe forms of homelessness.

**Introduction**

Worldwide it is estimated that nearly 1.6 billion people have inadequate shelter.1 Previous research on mortality among homeless individuals has focused primarily on the extreme end of the spectrum, with people sleeping rough or in homeless shelters. Relative to the general population, these groups experience a striking increased risk of mortality, with some studies indicating mortality rates may be as high as 10 times those apparent in the general population. 2-3 More often, however, homeless people are placed in short-term low-cost collective dwellings, such as a hostels (e.g., YMCA/ YWCA), or single occupancy low-cost hotels with shared access to bathroom facilities.4, 5 Individuals with limited housing options may also choose to initially ‘sofa surf’ living with family or friends temporarily. Whilst these insecurely housed groups are typically less disadvantaged than rough sleepers, the number of people sofa surfing in the United States has been estimated to be ten, 6 and England eight times higher,5, 7 than the number rough sleeping.

 In view of the paucity of evidence on the risk of mortality at the less severe end of the homelessness experience, we compared mortality rates across the spectrum from rough sleeping to sofa surfing to a general population comparator who had not been homeless, and sought to explain any associations using information on individuals socioeconomic, lifestyle, substance use, and criminal justice experiences.

**Methods**

We used data from the 1958 Birth Cohort study (also known as the National Child Development Study) and the 1970 British Birth Cohort study. Described in detail elsewhere, 8, 9 these are on-going, geographically-representative, prospective birth cohort studies with samples drawn from England, Scotland, and Wales. The 1958 cohort was approved by the National Health Service Research Ethics committee.The 1970 cohort was approved by the London Central Research Ethics Committee. Written informed consent was given by parents of study participants before the start of data collection. We adhered to the guidelines for STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) in the reporting in this manuscript.10 The year of assessment for all variables is provided in Supplementary Table S1 (available as Supplementary data at IJE online).

*Assessment of Homelessness*

At age 33 years in the 1958 cohort and age 30 in the 1970 cohort, participants were asked if they had ever been homeless (since age 23 in the 1958 cohort and age 16 in the 1970 cohort). Homelessness was defined as having to move out of a residence and having nowhere permanent to live (excluding living with parents). Respondents answering positively were then asked where they stayed while they were looking for permanent accommodation. Multiple responses were permitted, with the options of rough sleeping, a hostel or night shelter for the homeless, squatting (unlawfully staying in an uninhabited building or settling on a piece of land), bed and breakfasts (low-cost hotels), sofa (couch) surfing (staying with a friend(s) or relative(s); herein called sofa-surfing), and ‘other’ places.

*Mortality ascertainment*

Members of the 1958 cohort were followed up on six occasions over 35 years for all-cause mortality, from March 1981 (age 23) until December 2016 (age 58), while participants from the 1970 cohort were followed up five times over 27 years, from March 1986 (age 16) until December 2014 (age 44). Vital status was derived from official death certificates, information from the National Health Service Central Register, or fieldwork and cohort maintenance work (<1% of deaths).

*Covariates*

Covariates were identified *a priori*. In the 1958 cohort, these were assessed at age 33 or 42 years and in the 1970 cohort at age 30. Socioeconomic status was based on responses to enquiries about school leaving age, educational qualifications, and employment status. Mental health problems were ascertained based on specialist treatment for a psychiatric problem since age 16 (1970 cohort only), plus psychological morbidity in both cohorts based on a score of ≥7 on the Rutter Malaise Inventory.11 Self-reports of accidents and assaults that occurred since 16-years that required treatment by a physician were recorded. Substance use assessments included the lifetime use of illicit drugs (cannabis, ecstasy, amphetamines, lysergic acid diethylamide (LSD), poppers, magic mushrooms, cocaine, temazepam, ketamine, crack, heroin, methadone, other), whether they were a daily smoker, and had an alcohol problem, defined as a score ≥2 on the CAGE questionnaire.12 Experiences with the criminal justice system included instances of being arrested, formally cautioned, or convicted in a criminal court. Cohort members then reported on other aspects of their lifestyle including participation in regular exercise, the frequency of consumption of fruit, vegetables, and salad, and height and weight, measured directly by a nurse, to calculate body mass index (BMI).

*Analysis*

A detailed description of attrition in both cohorts is provided elsewhere.13 The main reason for loss to follow-up was members moving and not subsequently being traced. Refusal rates across were relatively low (1958: 13.2%; 1970: 7.3%), deaths were higher in the 1958 cohort and emigration was rare (< 2%). Of the 17,634 individuals originally recruited in the 1958 cohort, 12,477 (70.8%) provided information on exposure to homelessness plus covariates . In the 1970 cohort, the equivalent numbers were 16,571 and 11,201 (67.6%). Missing data per variable ranged from 0 to 32.5% in the 1958 and 0 to 10.5% in the 1970 cohort. There were 19,247 participants (9,436 in the 1958 and 9,811 in the 1970 cohort) with no missing exposure or covariate data which made up the complete data sample. The resulting imputed analytical sample had 23,678 participants (12,477 from the 1958 and 11,201 from the 1970 cohort).

We computed missing exposure and covariate data using multiple imputation by chained equations to generate 20 datasets. The imputation model included all missing exposure and covariate data and the Nelson–Aalen estimate of the cumulative hazard of survival time to increase statistical power.14 To test differences in baseline characteristics by exposure to homelessness we used a logistic regression model. We used Cox proportional hazards models to compute hazard ratios (HR) with accompanying 95% confidence intervals (95% CI) to summarise the association between homelessness and mortality separately for each cohort. We ascertained that the proportional hazards assumption had not been violated in each cohort by inspecting the Schoenfeld residuals. Exposure to any form of homelessness was compared to a reference category of not having been homeless. Next, we compared exposure to each type of homelessness to reference category of never having experienced that type of homelessness.

We did not find interactions between homelessness and sex in the association with mortality in either cohort, so data were aggregated and sex adjusted. For each cohort, we adjusted HRs for sex (the basic model), then added socioeconomic status, mental health problems, substance misuse, accidents and assaults, criminal justice contacts, lifestyle and, lastly, all covariates combined. In analyses on exposure to different types of homelessness we adjusted for other types then followed this sequence of adjustments. We then combined the estimates from each cohort using a random effects meta-analysis, resulting in a common HR, and computed the I2 statistic to examine heterogeneity in these estimates.

To examine the influence of missing data we re-ran the analysis on a complete data sample. To understand the influence of different groups of substances we adjusted HRs for sex plus daily smoking, alcohol problems, individual illicit drugs, and opioids (including heroin and methadone). All analyses were computed using Stata 16 (StataCorp, College Station, TX) and R (version 4.03).

**Results**

In the pooled sample, 6.1% of study members (*n*=1,453) had experienced some form of homelessness (6.0% in the 1958 cohort, 6.3% in 1970 cohort). Of those who had been homeless, 75.0% had sofa surfed, 28.6% had stayed elsewhere, 23.6% had used a hostel or homeless shelter, 22.5% had stayed in bed and breakfasts/ hotels, 22.1% had slept rough, and 17.3% had squatted (see Supplementary Figure S1). In people who reported exposure to more than one type of homelessness, sofa surfing plus the ‘other’ category was the most frequently reported combination.

 Table 1 provides the characteristics of study members who had been homeless relative to those who had not been homeless. People who had been homeless reported a markedly higher prevalence of mental health problems, treatments for assault, criminal justice experiences, and smoking compared to those who had not. Opioid use was between five and ten times as common in the homeless than not homeless group (see Supplementary Table S2).

 There were 805 deaths over a median follow-up of 27.2 years (interquartile range [IQR], 19.5-32.7) in the 1958 and 8.7 years (IQR, 3.8-11.2) in the 1970 cohort. Figure 1 shows the association between homelessness and mortality. After pooling and adjustment for sex, relative to people who had never been homeless, experience of any type of homelessness was associated with excess mortality (hazard ratio [HR], 1.68, 95% CI 1.24-2.26). Relative to the sex-adjusted hazard ratios for the association between homeless and mortality, additional adjustment for each set of covariates had a small attenuating effect, and after multivariable adjustment the association was explained.

 Figure 2 reports the associations for the place where the study member stayed when homeless and mortality. The pooled sex-adjusted HR for squatting was 6.35 (95% CI 2.73-14.75), use of a homeless shelter was 4.89 (95% CI 2.36-10.11), rough sleeping was 4.71 (95% CI 2.38-9.30], bed and breakfast was 3.38 (95% CI 1.30-8.79, other places was 3.56 (95% CI 1.56-8.13), and sofa surfing was 2.86 (95% CI 1.84-4.42). Some estimates were imprecise, as evidenced by the wide confidence intervals. The I2 statistic was 0% for most HRs (range 0%-50%). Adjustment for covariates had a small effect on the association between mortality and different types of homelessness. One exception was adjustment for other types of homelessness, which partially attenuated associations with mortality. We found little difference in the pattern of attenuation after separate adjustment for alcohol problems, daily smoking, any illicit drug, and opioid use (see Supplementary Figure S2).

 In the datasets where there was no missing data, the confidence intervals for estimates overlapped with those from the main results using imputed data indicating there were no meaningful differences (see Supplementary Figures S3-5). The I2 statistic ranged between 53% to 79% for the analysis of homelessness and indicating heterogeneity in HR between cohorts. In the analysis of types of homelessness, the I2 statistic was 0% for most estimates, but heterogeneity was found for bed and breakfast (0-64%) and sofa surfing (0%-60%).

**Discussion**

In this paper we have reported for the first time the association between mortality and homelessness across the full spectrum of severity. Based on data from two representative national cohorts, mortality rates were higher across all categories of homeless experience than in a general population comparator group that had not been homeless. In particular, the elevated risks of mortality among those squatting and sofa surfing had not previously been reported.

 Our results are consistent with previous findings of higher rates of mortality found in rough sleepers when compared to hostel users, and to a general population comparator group.15 Residents of hotels, motels, and tourist homes, have also been found to experience excess mortality when compared to people who are housed and in the lowest fifth of the distribution.16 Other studies on homelessness using economically matched comparator groups have reported conflicting results.3, 17 We expanded the scope of homeless experience investigated and the risks reported suggest these inconsistencies may be due to the wide range of homeless experience uncaptured in those datasets.

 Our findings could be important in advancing understanding on factors that precipitate and perpetuate homelessness. Across a comprehensive range of explanatory factors, each led to a small reduction in the strength of the association between homelessness and mortality, but no one factor was particularly influential. There was some evidence that adjustment for substance misuse also had a slightly larger impact for those who had squatted relative to other types of accommodation. If this attenuation is consistent with mediation, interventions like improving security in hostels, and access to effective treatments for substance use, may help to mitigate the impacts of these forms of homelessness on mortality. Additional work examining cause-specific mortality according to type of homeless accommodation may help elucidate mechanisms underpinning these associations.

 Homelessness is now increasing in the United States and the number of homeless individuals who are elderly is projected to triple by 2030. 18, 19 As part of the coronavirus 2019 pandemic response, many countries secured low-cost bed and breakfasts for homelessness people requiring isolation or quarantine for confirmed or suspected infection,20 to facilitate social distancing,21 and there was a national moratorium placed on evictions.22 In the UK, these initiatives were associated with a reduction in rough sleeping by around a third, 23 with low-cost hotel use increasing by 17%.5 These findings illuminate additional forms of homelessness like squatting, which has hitherto not received as much attention in policy as being associated with premature mortality. There is increasing concern that once the moratorium on evictions and economic support is lifted homelessness in all forms will increase.24 These results presented indicate that if these concerns are realised life expectancy may reduce in these groups.

 Limitations of our work include the impacts of loss to follow-up. We used multiple imputation to maximize the plausibility of the missing at random assumption and restore sample representativeness. Results were comparable when using the datasets with missing and imputed data, increasing confidence in the findings. Bias due to non-ignorable missing data cannot, however, be ruled out. As both cohorts used household tracking, homelessness people in the present analysis are likely to have a lower mortality risk than previous studies which sampled those who were currently homeless. This difference is likely to have attenuated our estimates of mortality risk towards the null. As exposure to homelessness, treatment for mental health problems and illicit drug use were retrospectively assessed, it is difficult to determine temporal precedence of these events. It is therefore possible that these factors occurred before homelessness and attenuation we found is more consistent with confounding than mediation. Conversely, in the 1958 cohort, criminal justice experiences and illicit drug use were assessed at a subsequent wave to that when homelessness was assessed. In this case, attenuation is more consistent with these factors acting as mediators of the homelessness-mortality relation.

**Conclusions**

Our study provides evidence that exposure to any type of homelessness in early adult life can increase the risk of mortality. Mortality risk was shown to be raised across the spectrum of homeless experience. This included squatting and sofa surfing which had not previously been examined. These findings provide evidence that housing policy may need to be revised to reduce the use of housing in low-cost hotels, and the scope of homelessness prevention expanded to include sofa surfing.

**Ethics approval**

The 1958 cohort was approved by the National Health Service Research Ethics committee.The 1970 cohort was approved by the London Central Research Ethics Committee. Written informed consent was given by parents of study participants before the start of data collection and conform to the Declarations of Helsinki.

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**Data Availability**

Data from the National Child Development Study and 1970 British Cohort Study are available to researchers upon application (https://discover.ukdataservice.ac.uk/).

**Author contributions**

Concept and design: JW and GDB; acquisition of data: MF, JW; analysis: SB, JW, MF, RD; interpretation of data: all authors; drafting of the manuscript: JW; critical revision of the manuscript for important intellectual content: all authors; final approval of the version to be published: all authors; agreement to be accountable for all aspects of the work thereby ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: all authors.

**Conflict of interest**

None declared.

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