DEPARTMENT OF HEALTH

Minnesota Homeless Mortality Brief: Insight from People with Lived Experience

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Executive summary

In 2021, the CDC Foundation selected the Minnesota Department of Health (MDH) to create a Center of Excellence on Public Health and Homelessness (www.health.state.mn.us/communities/homeless/coe/index.html) (the Center). The Center's mission is to reduce severe disease and death among people experiencing homelessness. To advance this mission, MDH partnered with the Health, Homelessness, and Criminal Justice Lab at Hennepin Healthcare Research Institute (HHRI) on the Minnesota Homelessness Mortality Report, 2017-2021 (www.health.state.mn.us/communities/homeless/coe/coephhmr.pdf).

The report found that the mortality rate for people experiencing homelessness in Minnesota was three times higher than the general population and mortality rates for American Indians experiencing homelessness were five times higher than the general population. To better understand this disparity, MDH staff interviewed eight people with lived experience to understand how homelessness affected their health. The following key themes emerged among the people interviewed:

- **Prevalence of Adverse Childhood Experiences (ACEs)**
  ACEs are defined as any abuse, neglect, or violence within the family household. This also includes any exposure to severe, persistent mental health symptoms and substance use disorder. Everyone interviewed reported multiple childhood experiences that met the ACEs criteria.
- **Increased medical fragility and risk of death**
  Interviewees reported suffering from medical conditions in their middle-age that typically affect much older people. They also reported challenges with caring for their health when sleeping on the streets or in shelters.
- **American Indian people experiencing homelessness face unique challenges**
  American Indian people experiencing homelessness interviewed for this brief identified challenges finding culturally specific housing, designed by and for indigenous people, that didn't have long waiting lists.
- **High-risk substance use is a cause and consequence of homelessness**
  While people from all sociodemographic groups use drugs, interviews identified specific ways that homelessness may cause people to use drugs to stay awake or fall asleep or seek street drugs when they cannot fill prescriptions.
- **Need for suitable housing and additional services**
  Interviewees expressed barriers to access available programs and a need for suitable housing along with health care and other services.

The interviews demonstrate the importance of soliciting and responding to the perspectives of people with lived expertise. These interview findings can help inform statewide efforts to improve the homeless response system through interagency efforts to prevent child abuse and neglect, improve shelter conditions, and offer a wider array of service-rich supportive housing options.

Words of gratitude

The Minnesota Department of Health's Center of Excellence on Public Health and Homelessness expresses its gratitude to everyone who shared their experiences for this report. We appreciate the courage required to share their painful and complicated journeys of experiencing homelessness. We look forward to advancing this work and continuing to share these stories to evolve the way we view homelessness and to develop policies and interventions. In collaboration with people with lived expertise, we hope to improve the lives of those still experiencing homelessness in Minnesota. We are also grateful to the CDC Foundation for their financial support for this project.

Background

In 2021, the CDC Foundation selected the Minnesota Department of Health (MDH) as one of three national Centers of Excellence on Public Health and Homelessness. The Centers were created to promote collaboration between public health departments, homeless service providers, health care providers, and academic centers to reduce infectious disease and mortality risks for people experiencing homelessness. MDH established an advisory group with representation from these partners as well as advocates and people with lived experience of homelessness to guide the direction of the Center.

Part of the Center's mission is to generate new data and build coalitions to reduce severe morbidity and death among people experiencing homelessness. To advance this mission, MDH contracted with the Health, Homelessness, and Criminal Justice Lab at the Hennepin Healthcare Research Institute (HHRI) to conduct Minnesota's first-ever mortality report of people experiencing homelessness.

The following are the three key findings from the Minnesota Homeless Mortality Report, 2017-2021 (www.health.state.mn.us/communities/homeless/coe/coephhmr.pdf):[1]

- The rate of death is three times higher among people who experience homelessness in Minnesota than the general Minnesota population.
- American Indian people experiencing homelessness have 1.5 times higher rates of death than other people experiencing homelessness and 5 times higher rates of death than the general Minnesota population.
- Deaths from substance use are 10 times higher among people experiencing homelessness than the general Minnesota population.

To better understand the findings from the mortality report, MDH staff conducted interviews with eight people with lived experience of homelessness. This brief summarizes the findings from those interviews and their implications for policy. The report uses pseudonyms to protect the privacy of the interview participants.

Selection criteria: Defining homelessness

Homelessness is a complex and multi-faceted issue, and the stories included in this brief are not meant to be comprehensive. Interview participants all had experiences that met the U.S. Department of Housing and Urban Development (HUD) definition of homelessness. This includes sleeping in shelters, transitional housing programs, homeless encampments, on the streets, or other places "not suitable for human habitation." Our Advisory Group members have stressed that the HUD definition, and the data sources used to measure it, excludes people who are "doubled-up" with family, friends, or acquaintances. This exclusion has a particular impact on measuring homelessness in more rural areas with fewer homeless services. However, this brief follows the HUD definition for consistency with the Minnesota Homeless Mortality Report.

Findings

The following key themes emerged in our eight interviews of people with lived experience of homelessness:

1. Prevalence of Adverse Childhood Experiences (ACEs)
2. Increased medical fragility and risk of death
3. American Indian people experiencing homelessness (PEH) face unique challenges
4. High-risk substance use is a cause and consequence of homelessness
5. Need for suitable housing and additional services

Each of these themes are discussed in more detail below.

Theme 1: Prevalence of Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) include physical abuse or neglect by a parent, sexual abuse, growing up with someone with an alcohol or substance use disorder in the household, experiencing incarceration of a household member, living with a family member experiencing mental illness, domestic violence, and loss of a parent. While the interview protocol did not explicitly ask about ACEs, it became clear during the interviews that all interviewees had experienced ACEs. For some, this was caused by parents with a mental illness or alcohol or substance use disorder. Others were exposed to inappropriate or traumatic behaviors from adults during adolescent homeless episodes.

The interviewees' experiences are consistent with other research on ACEs among people experiencing homelessness. A 2021 national review of studies estimated that 90% of people experiencing homelessness had one or more ACEs and 54% had four or more ACEs. By contrast, an estimated 39% of the U.S. population have one ACE exposure and 3-5% have four or more. [2] The 2018 Homelessness in Minnesota survey by the Wilder Foundation included questions about seven of the 11 ACEs. Nearly three out of four adults experiencing homelessness in Minnesota reported having at least one ACE and 59% reported multiple ACEs.[3]

ACEs increase the risk of adult homelessness because they can negatively affect people's academic performance and job prospects, disrupt family relationships and social networks, and increase the likelihood of mood disorders, like major depression, and substance use disorders. Not only do ACEs increase the risk of homelessness as an adult, but the more ACEs someone experiences, the longer they are likely to remain homeless.[4,5]

Theme 2: Increased medical fragility and risk of death

The rate of death is three times higher among people who experience homelessness in Minnesota than the general population.

-Minnesota Homeless Mortality Report, 2017-2021

Several interviewees shared the challenges of maintaining their health while homeless, including Jane, who was homeless for much of her early adulthood.

Jane's story

Jane's first homeless episode occurred at a very young age when her mother had lost their housing. She had grown up in a small rural town where alcoholism, drug use, abuse, neglect, and homelessness were common. Jane spent the better part of two decades on and off the streets, dealing with a substance use disorder, abusive partners, and food insecurity.

"I slept with people, been raped, sold drugs, did what I had to do to survive." (Jane)

In 2017, Jane became very ill. Although Jane was only in her late 30s, she had the medical fragility of someone significantly older. She was diagnosed with endocarditis, an inflammation of the heart that usually occurs in people 60 years or older but can also occur through infection from injection drug use. The condition required that she spend several months in the hospital.

When she was ready to be discharged from the hospital, Jane successfully advocated to be released to residential treatment rather than back into homelessness. After her 30-day stay in treatment, she went to a shelter where she shared a room with several women who were using drugs. She worried that this could jeopardize her sobriety, but the wait to get into permanent supportive housing was long, and she had no other option but to stay. Despite these challenges, Jane was able to maintain her recovery with the support of buprenorphine, a medication for opioid use disorder.

"You will never understand what it's like to not have anywhere to go, nobody to call, nowhere to go." (Jane)

Theme 3: American Indian people experiencing homelessness face unique challenges

American Indian people experiencing homelessness have 1.5 times higher rates of death than other people experiencing homelessness and 5 times higher rates of death than the general Minnesota population.

-Minnesota Homeless Mortality Report, 2017-2021

The United States Federal Government has a "trust responsibility" to provide for the well-being of tribes in exchange for the land that it took from tribal governments. Forty percent of housing on Indian reservations is considered substandard (compared to 6% of all U.S. housing stock) and one-third of homes on reservations are overcrowded.[6] In addition to poor housing conditions, indigenous populations have endured generational trauma from events like forced land removals and boarding schools designed to strip away native languages and customs, with ongoing harms.[7] In Minnesota, American Indians represent 1% of the total population, but 11% of the population experiencing homelessness.[3]

We interviewed several residents of a transitional housing program for American Indian women to understand their experiences with homelessness.

Juno's story

Juno spent most of her life living in transition. She moved around North Dakota, Minnesota, and Wisconsin while spending significant periods of time living on a reservation. She shared that during her childhood, she was exposed to violence and drug and alcohol use.

Juno became a mother at a young age, having two kids within a year of each other with limited paternal involvement. While living on the reservation, she was fortunate to have some support from her family. Because of the challenges she felt living on the reservation, she moved frequently with the children, often spending long periods of time in a domestic violence shelter.

In the following years, Juno encountered many more struggles. She battled for several years with substance use disorder. She had legal troubles, and her children were removed from her home. When Juno arrived for the last time in the Twin Cities, she hoped to obtain services that were culturally appropriate. Unfortunately, the waiting list for these services was extensive. Juno spent several months living in her car and on the streets before she was able to receive treatment and then find a placement in transitional housing. She shared that she would rather be alone and not have a roof over her head than stay in a shelter. Like other interview participants, Juno felt that shelters were understaffed and under-resourced and did not feel safe.

Stella's story

Stella grew up living in a house on a reservation with her mother and sister. Her mother's partner moved into their home and was abusive to her and her mother. This led to intermittent stays at the domestic violence shelter when her mother would take the children and leave the home to provide safety.

> *"I remember feeling like it was a vacation away because it felt safe." (Stella)*

When Stella turned 18, she moved to the Twin Cities from the reservation. She soon became pregnant and returned to her mother's house so that she could help care for the child. While living with her mother, she had four more children. When she was 28, Stella moved back to the Twin Cities. Stella suffered from mental illness and substance use disorder. She became homeless again and lost custody of her five children.

It was at this point that Stella returned to a domestic violence shelter. Stella struggled to find housing that was safe and affordable. At one point, she was living in a one-bedroom apartment with seven other people. Ultimately, with the help of a supportive case manager, she was able to find stable housing in a program for indigenous women.

Theme 4: High-risk substance use as a cause and consequence of homelessness

Deaths from substance use are 10 times higher among people experiencing homelessness than the general Minnesota population.

1 in 10 substance use deaths in Minnesota are among People Experiencing Homelessness.

1 in 3 deaths among People Experiencing Homelessness are caused by substance use, especially opioids including fentanyl.

-Minnesota Homeless Mortality Report, 2017-2021

While some people may experience homelessness at least in part because of their substance use, homelessness can also make people more likely to use drugs or to use drugs in more dangerous ways. For example, people experiencing homelessness sometimes report using methamphetamines, because it helps them stay alert to threats of theft or personal attack while they are on the streets.[8] Some people experiencing homelessness report using street drugs like methamphetamines as off-brand medication for ADHD because it's difficult to get or fill a prescription while homeless. People experiencing homelessness may also use opioids to help them sleep in difficult conditions or to cope with physical pain or emotional trauma. Interviewees also reported that drugs were sometimes more valuable than money when exchanged for shelter. One interviewee reported that it was easier receiving treatment for her substance use disorder while she was incarcerated than when she was homeless.

"They need to use because they are scared." (Stella)

Theme 5: Need for suitable housing and additional services

Barriers to access

Interviewees identified many barriers to finding housing. Some of these barriers include complicated processes and long wait times for getting a case manager, transportation to and from required meetings, owning all required documents for identification, having access to phones or internet to complete required tasks, and many more. The process to obtain housing can be long and challenging. These barriers were frequently mentioned in all the interviews. When paired with the challenges that homelessness presents, this process can feel defeating. Obtaining housing while facing a mental health episode, trauma, or a substance use disorder can be more than people can cope with and deter people from being able to complete the necessary steps to find housing.

Suitable housing

During the interviews, other concerns about housing became very clear. Housing is more than a roof over your head. A house is a place that you feel safe and can make your home. Most interviewees reported that they have been housed in less-than-ideal circumstances with mice, overcrowding, violence, and other illegal behavior. Several interviewees reported receiving a Section 8 housing voucher but not being able to remain in the program.

Interviewees also stressed the importance of having culturally responsive housing options. Some examples of this include incorporating Native cultures into the design and development of programs; hiring staff who are reflective of the population served; supporting culturally-specific practices like storytelling or sweat lodges; and accommodating people's wishes to live with their "chosen family."

> *"I was scared to be in my apartment. I could hear people drinking, fighting, and using. I was too scared to be there and had nowhere else to go." (Stella)*

Holistic health services

> *"My use led me back to the streets. I was sleeping in my car and trying to get stable." (Juno)*

Many people who experience homelessness have other co-occurring issues, including mental illness or substance use disorders. When addressing the issues of housing insecurity, it is important to have services in place to help people remain housed. In the interviews, several people mentioned being unsuccessful with previous housing programs, because adequate services were not in place to address mental illness or substance use disorder. Addressing homelessness requires appropriate housing options along with accessible physical and mental health services.

> *"Hopelessness is a way of life that, unfortunately, typically, we get used to." (Jane)*

Policy implications

The findings from these interviews, along with the Minnesota Homeless Mortality Study, demonstrate the importance of stable housing and services for the health of Minnesotans. However, public health departments do not regularly collect or report information about homelessness and housing instability. Capturing this information would allow health departments to better understand what's causing health inequities for unhoused Minnesotans and monitor progress in addressing those inequities. Current MDH efforts to link homelessness and public health data, including this mortality study, are supported by one-time grants. Sustained federal or state funding is necessary to collect and report this information on an ongoing basis.

Another implication for state and local health departments is that homelessness prevention should be a public health priority. This realization could open the door to greater collaboration between health and housing agencies at the state and local level. For example, MDH's Child and Family Health Division, in its 2020 Needs Assessment for the federal Title V Maternal and Child Health Block Grant, identified increasing safe, affordable, and stable housing as a statewide priority. [9] Continuing to identify this as a statewide public health priority in future needs assessments (including upcoming 2025) and annual reporting presents opportunities for ongoing data surveillance and cross-agency collaboration in service of improved access to safe and affordable housing, as well as homelessness prevention.

These interviews also provide examples of how Adverse Childhood Experiences (ACEs) contribute to homelessness later in life. Evidence-based services like home visiting, along with helping families afford basic needs like diapers, can help prevent ACEs. Home visiting programs specifically designed for homeless families have been shown to increase access to services, but they require active participation from homeless service providers.[10] Minnesota has made historical investments to see children and families thrive. To build on these investments, we recommend that the Minnesota Children's Cabinet, the Minnesota Interagency Council on Homelessness, and MDH's Maternal and Child Health division collaborate to improve access to home visiting and other evidence-based services to reduce ACEs.

Many interviewees also described times when they felt unsafe in shelter or opted to sleep outside or in vehicles rather than going to a shelter. The Minnesota legislature approved historic increases in shelter funding in the 2023 session. These investments could fund new shelter beds and allow existing shelters to increase staffing and improve services. Changes in oversight from state agencies could also help address concerns about shelter conditions. The Minnesota Task Force on Shelter made several recommendations to the Minnesota legislature in 2022 to address safety concerns that have not yet been acted upon.[11] These include creating an Office of Ombuds for Shelter Guests to maintain a set of standards for shelters and address violations of those standards reported by shelter guests, staff, or other concerned citizens.

The interviews also demonstrated how a successful homeless response requires more than placing someone in a shelter bed or housing unit. Interviewees often reported going through multiple housing programs before finding a viable long-term housing option for themselves and their families. This highlights the need for offering people a variety of housing choices, with different levels of supports, culturally specific services, and chemical health options ranging from abstinence to active use. As recommended in the Minnesota Homeless Mortality Study, this effort should recognize "housing as a life-saving strategy" to prevent fatal opioid overdoses and include the expansion of integrated housing and substance use disorder treatment models. MDH and local public health can support these efforts by providing technical assistance to shelters and housing programs on implementing harm reduction approaches for people who use drugs.

Finally, these interviews provide another example of why we should center people with lived expertise in our homeless response. Participatory research that centers people with lived experience is an important, if insufficient, part of that power shift. Minnesota's Justice Strategic Plan (https://mich.mn.gov/justice-strategic-plan) includes recommendations for how state agencies, including MDH, can work with historically oppressed and excluded groups to advance housing, racial, and health justice. These include prioritizing people with lived experience in state hiring decisions, paying people with lived experience to advise on agencies' communications and policymaking, and making the state grantmaking process more transparent and accessible.

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