MARCH 2026

From Data to Action

Lives Lost: Mortality Trends and Prevention Opportunities For People Experiencing Homelessness in LA County, 2015-2024

Your feedback is important to us. Please take a moment to answer these 3 questions.

County of Los Angeles Public Health

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For additional information:
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Message from the Director

In 2024, the mortality rate among people experiencing homelessness in LA County decreased for the first time since 2014, the first year of data in our inaugural report on homeless mortality, released in 2019. This is heartening good news that reflects the dedicated efforts of our multi-agency LA County Homeless Mortality Prevention Workgroup, together with homeless services providers across the county. But the rate remains far too high and much hard work remains ahead of us. This work will be particularly challenging as we are currently facing major reductions in federal and state resources for homeless services and supports. For the 2026/27 fiscal year, the Homeless Services Authority is projecting a gap of approximately $323 million dollars in funds available to address homelessness. Without this funding, there will be reductions in services and support for both those experiencing homelessness and those without stable housing. So, just as we are beginning to see positive momentum on homeless mortality reduction, we are at risk of losing precious ground.

This report sheds light on the serious and preventable challenges facing people experiencing homelessness in our county. Each data point represents a life marked by hardship in the face of difficult circumstances, and signals our shared responsibility for ensuring dignity, stability, and opportunity for all.

People without stable housing face mortality rates over four times higher than the general population. These disparities reflect systemic barriers—lack of safe housing, limited access to culturally responsive healthcare, unsafe environments, and the ongoing effects of trauma, discrimination, and social inequities.

In the sections that follow, we highlight key measurable indicators that show where we are now and— most importantly—drive our identification of targeted strategies and critical partners needed to turn the curves on these indicators. We center the voices of people with lived experience alongside the dedicated efforts of community-based health and social service organizations, and government departments spanning housing, public health, physical and mental health, public works, and more.

Preventing avoidable deaths among people experiencing homelessness requires shared leadership and strong partnerships. Strategies should be informed by data, frontline expertise, and lived experience. County and city elected officials play a critical role in advancing policies that improve outcomes and investing in proven solutions. Preventing avoidable deaths depends on coordinated action across government, healthcare, community organizations, businesses, philanthropy, and residents. Together, we can build a Los Angeles County where everyone, regardless of housing status, can live safely, secure good health, and access the housing and support needed.

Barbra Ferrer. PhD, MEd
Director, Los Angeles County
Department of Public Health

Executive Summary

In 2024, the annual all-cause mortality rate among people experiencing homelessness (PEH) in LA County decreased by 10%, and the total number of deaths decreased by 300 (**Figure 1**)—the first decreases in these metrics since we began tracking the data. The overall decrease was driven primarily by a 21% decrease in the drug overdose mortality rate (**Figure 5)**. The homicide (**Figure 23)** and coronary heart disease (CHD; **Figure 14)** mortality rates also decreased—by 13% and 12%, respectively. Despite the overall decrease, 2024 saw increases in both the traffic injury mortality rate (25% increase; **Figure 18**) and the suicide rate (21% increase; **Figure 27**). By region, the number of deaths increased among PEH in Service Planning Areas (SPAs) 1 (Antelope Valley) and 6 (South LA) (Map 1), despite decreasing across all other SPAs, with the greatest decreases in SPAs 4 (Metro), 5 (West) and 7 (East). All-cause mortality decreased among White and Black PEH but remained unchanged among Latino/e PEH. Male and female PEH experienced similar decreases. The all-cause mortality rate was 4.2 times higher among PEH compared to the LA County population in 2024—down slightly from 4.4 in 2023 (**Figure 4**). Recommended strategies for continuing to decrease all-cause mortality among PEH include: 1) ensuring access to affordable housing and health insurance, 2) addressing the contribution of mental health disorders to multiple causes of death, and 3) addressing the contribution of systemic racism and discrimination to multiple causes of death (**Recommendations 1.1-1.5**).

The 21% decrease in the drug overdose mortality rate in 2024 was driven by large decreases among Black and White PEH (29% and 28%, respectively). Latino/e PEH experienced a more modest reduction (11%) (**Figure 6**). Male and female PEH experienced similar reductions in overdose mortality (**Figure 7**). Drug overdose mortality decreased among all age-groups except 65+.

Those aged 18-24 saw the steepest decrease (59%) although they had the lowest rates in both 2023 and 2024 (**Figure 8**). The drug overdose mortality rate was 46 times higher among PEH compared to the LA County population in 2024—up from 41 in 2023 (**Figure 9**). The percentage of PEH overdose deaths involving fentanyl decreased from 70% to 59%--the first decrease in this metric since we be began tracking the data (**Figure 10**). Recommended strategies for continuing to decrease PEH overdose mortality include: 1) ensuring that housing options support harm reduction, overdose prevention, and substance use treatment goals, 2) lowering barriers to treatment for PEH not engaged in treatment, 3) expanding harm reduction and overdose prevention services to locations where PEH are present, 4) sustaining and expanding access to clinically effective addiction medication services for PEH, 5) integrating peer-driven services into the continuum of substance use-related services for PEH, and 6) advocating for policies and regulations that make the continuum of substance-use related services more accessible to PEH (**Recommendations 2.1-2.6**).

The 12% decrease in the CHD mortality rate in 2024 was driven by large decreases among White and Black PEH, despite an 8% increase among Latino/e PEH (**Figure 15**). The decrease in CHD mortality was greater among male than female PEH (15% vs. 6%; **Figure 16**). By region, the greatest decreases in CHD deaths were in SPAs 3, 4, and 7 (**Map 3**). The CHD mortality rate was 5.7 times higher among PEH compared to the LA

County population in 2024—similar to the ratio of 5.8 in 2023 (**Figure 17**). Recommended strategies for continuing to decrease CHD mortality among PEH include: 1) sustaining and expanding comprehensive primary care services for PEH, 2) facilitating PEH access to cardiac testing, medications, procedures and care, 3) addressing methamphetamine use disorder as a contributor to CHD deaths among PEH, and 4) training providers to better understand and accommodate the special circumstances of patients experiencing homelessness (**Recommendations 3.1-3.4**).

The 25% increase in the traffic injury mortality rate in 2024 was driven by a 61% increase among Latino/e PEH despite decreases among Black (15%) and White (10%) PEH (**Figure 19**). Male and female PEH experienced similar increases in traffic injury mortality (**Figure 20**). The highest traffic injury mortality rates in 2023 and 2024 were among PEH aged 65+, although there were more deaths in both years among the three youngest age groups, and the latter groups saw the largest rate increases from 2023 to 2024 (**Figure 21**). By region, the greatest increases in traffic injury deaths were in SPAs 2 (San Fernando Valley) and 6 (South LA). SPA 4 was the only SPA with fewer traffic deaths in 2024 than in 2023 (Map 4). The traffic injury mortality rate was 24 times higher among PEH compared to the LA County population in 2024—up from 18 in 2023 (**Figure 22**). Recommended strategies for decreasing traffic injury mortality among PEH include: 1) conducting a more detailed analysis of 2024 PEH traffic injury deaths, and 2) working with state county and city agencies to identify policy, program and infrastructure interventions based of the results of the analysis (**Recommendations 4.1-4.2**).

The 13% decrease in the homicide mortality rate in 2024 was driven by a 25% decrease among Latino/e PEH, despite increases among Black and White PEH (**Figure 24**). The homicide rate decreased by 56% among female PEH, but remained unchanged among male PEH (**Figure 25**). The homicide mortality rate was 14 times higher among PEH compared to the LA County population in 2024—down from 16 in 2023 (**Figure 26**). Our recommended strategy for continuing to decrease homicide mortality among PEH is to sustain and expand violence prevention and intervention services for PEH within Trauma Prevention Initiative communities (**Recommendation 5**).

The 21% increase in the suicide rate in 2024 was the result of 13 more suicide deaths among PEH in 2024 compared to 2023 (**Figure 27**). The majority of those additional deaths were among White PEH (**Table 1**). Male PEH had 15 more suicide deaths in 2024 compared to 2023, while female PEH had two fewer suicide deaths (**Table 2**). Almost all of the additional suicide deaths in 2024 were among PEH under age 45 (**Table 3**), and the highest suicide rates in 2023 and 2024 were among PEH aged 18-24 (**Figure 30**). The greatest suicide rate increase was among PEH aged 65+ but the number of suicide deaths in that age group was too small to report in both years (**Table 3)**. Recommended strategies for decreasing suicide mortality among PEH include: 1) providing outreach and engagement, risk assessment, treatment and postvention response services to PEH, and 2) providing trainings for clinical and non-clinical staff working in interim and permanent housing settings. (**Recommendations 6.1-6.2**).

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Introduction and Organization of the Report

Our Desired Result:

A safer, healthier Los Angeles County, where people experiencing homelessness have dignity and access to the services and supports they need for health and well-being on their journeys toward housing stability.

This annual report on mortality rates and causes of death among people experiencing homelessness (PEH) in Los Angeles County is more than a collection of data on negative outcomes. It is about informing solutions for a healthier future. All people can live longer and healthier lives supported by safety, stability, and effective systems of care.

The health and well-being of people experiencing homelessness are tied to the same basic needs that shape all our lives: housing, care, safety, and economic stability, to name a few. Preventable illness and early death do not result from personal choices alone. They are driven by circumstances that make being healthy difficult, like a lack of easy access to health care and supportive services, unstable housing, and struggles with substance use, mental illness, and economic hardship.

Homelessness is not limited to any one group —life events such as job loss, illness, or family crisis can put anyone at risk. So, when we protect the health and well-being of people experiencing homelessness, we also create safeguards for anyone who may someday find themselves in a similar situation, building a stronger and more caring community for all.

Since 2019, we have tracked the leading causes of death among PEH to help guide actions to reduce them. o this end, our report offers recommendations developed in collaboration with county and city agencies community-based service providers and advocates, and formerly homeless individuals. This ensures that the recommendations are based in data, wisdom, and lived experience.

Together, with the dedication of agencies, advocates, and community members, we strive for a safer, healthier Los Angeles County where everyone—regardless of their housing status—has dignity and access to the services and supports they need to thrive.

Measuring Progress: Using Key Indicators to Track Progress Toward our Desired Result

Key indicators are more than just numbers—they reflect the lived experiences of people in our communities. They reveal when lives are lost too soon and when systems must improve to increase peoples' life chances.

Though they don't tell the whole story, indicators show how well we're progressing toward a desired result by tracking current conditions and trends. They steer us toward critical questions: *Where are harms greatest? Are things improving? Where should we focus our efforts? How can we work together to improve outcomes?*

We selected the indicators in the table below because they:

- Are easy to communicate, making data understandable for all,
- Highlight what matters most, capturing the top five causes of death among PEH in LA County, and
- Are reliable, based on trusted data tracked over time

They serve as an invitation—to align our efforts, take meaningful action, and collaborate across sectors for bold, human-centered solutions that respect the dignity and stories of every person affected.

What the Data Tell Us and How they Guide our Actions

For each indicator, we present the following:

- The Story Behind the Trends: 1) Graphic representations of key indicator and other related data (e.g., demographic breakdowns and comparisons to countywide data), 2) Bulleted summaries of the findings, and 3) A narrative explaining what the data reveal.

Key Indicators	Definitions
1. Annual All-Cause Mortality Rate among People Experiencing Homelessness (PEH)	(Total Number of PEH Deaths in Year/Mid-Year PEH Population Estimate) X 100,000
2. Annual Drug Overdose Mortality Rate among PEH	(Number of PEH Drug Overdose Deaths in Year/Mid-Year PEH Population Estimate) X 100,000
3. Annual Coronary Heart Disease (CHD) Mortality Rate among PEH	(Number of PEH CHD Deaths in Year/Mid-Year PEH Population Estimate) X 100,000
4. Annual Traffic Injury Mortality Rate among PEH	(Number of PEH Traffic Injury Deaths in Year/Mid-Year PEH Population Estimate) X 100,000
5. Annual Homicide Mortality Rate Among PEH	(Number of PEH Homicide Deaths in Year/Mid-Year PEH Population Estimate) X 100,000
6. Annual Suicide Mortality Rate among PEH	(Number of PEH Homicide Deaths in Year/Mid-Year PEH Population Estimate) X 100,000

- Strategies to Change the Trends: Recommended actions to improve outcomes and change the story by turning the curve on the trends.
- Partners and Roles: Organizations and leaders who, together, can play key roles in strategy implementation, along with descriptions of how they can help (See **Appendix A**).

This framework helps us understand the challenges, recognize partners who can help, identify effective actions, and highlight the leadership needed to create positive and lasting change.

Despite anticipated reductions in funding for homeless services and housing starting in 2026, the LA County Homeless Mortality Prevention Workgroup, drawing on years of data and expertise, remains committed to recommending strategies that are supported by evidence and likely to prevent deaths. While budget constraints may affect implementation, our recommendations focus on interventions we are confident can make a meaningful impact.

How this Report is Developed

This report is built on collaboration, data, and expert input. Critical raw data come from the LA County Office of the Medical Examiner, LAHSA, and the LA County and California Departments of Public Health. Appendix B provides a detailed description of how these data are analyzed to produce the key indicators and related findings.

continued on next page

How this Report is Developed

Each year, the analyses are reviewed by the Homeless Mortality Prevention Workgroup, which includes representatives from the LA County Departments of Public Health, Health Services, Mental Health, Medical Examiner, Homeless Services and Housing, and LAHSA.

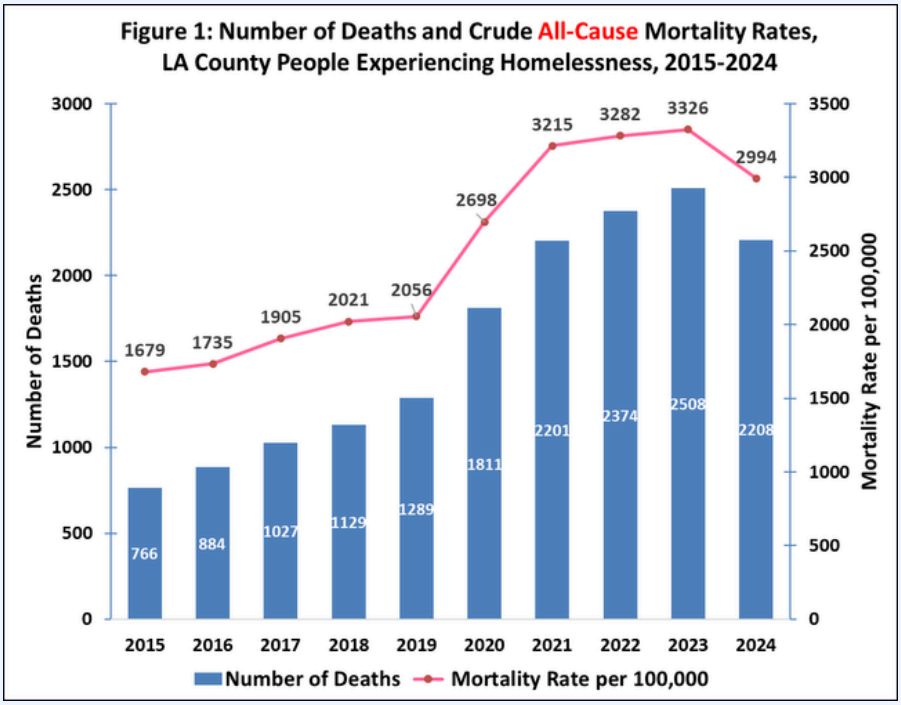
This year, a sub-group focused on traffic-injury deaths was added, including experts from Public Health, Public Works, and the LA City Department of Transportation. At these meetings, subject-matter experts review the latest findings and help develop or update actionable recommendations to address each key indicator.

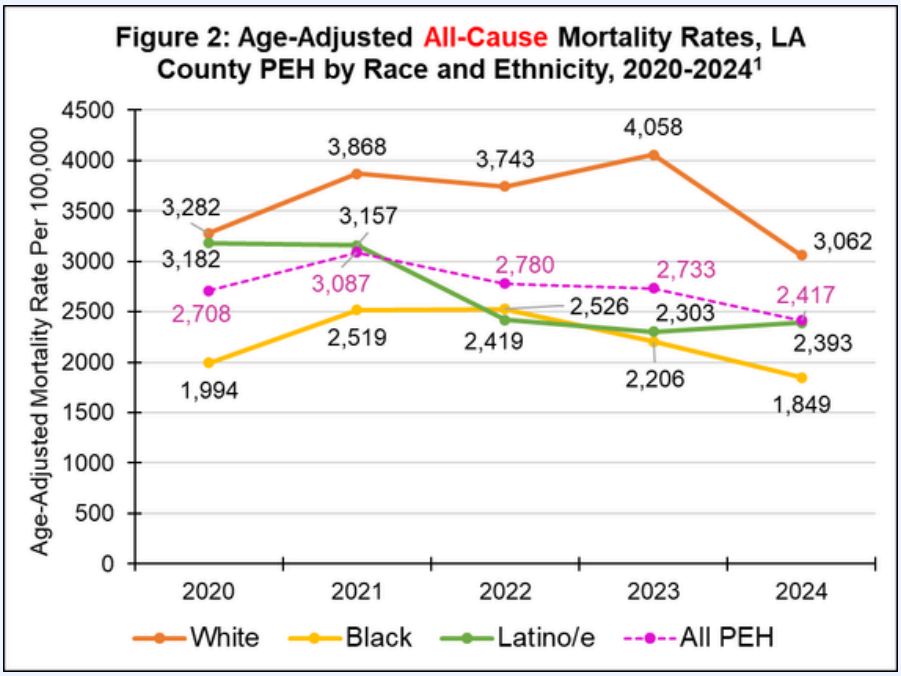
We also seek input from the community, including service providers, advocates, and adults and youth with lived experience of homelessness, convened by LAHSA. Feedback from these groups ensures our interpretations and strategies reflect both expertise and lived experience.

Finally, input from all groups is reviewed by the Workgroup, and the report and recommendations are finalized for public release. This collaborative process ensures the report is data-driven, actionable, and grounded in community insight.

Key Indicator #1

All-Cause Mortality Rate Among People Experiencing Homelessness





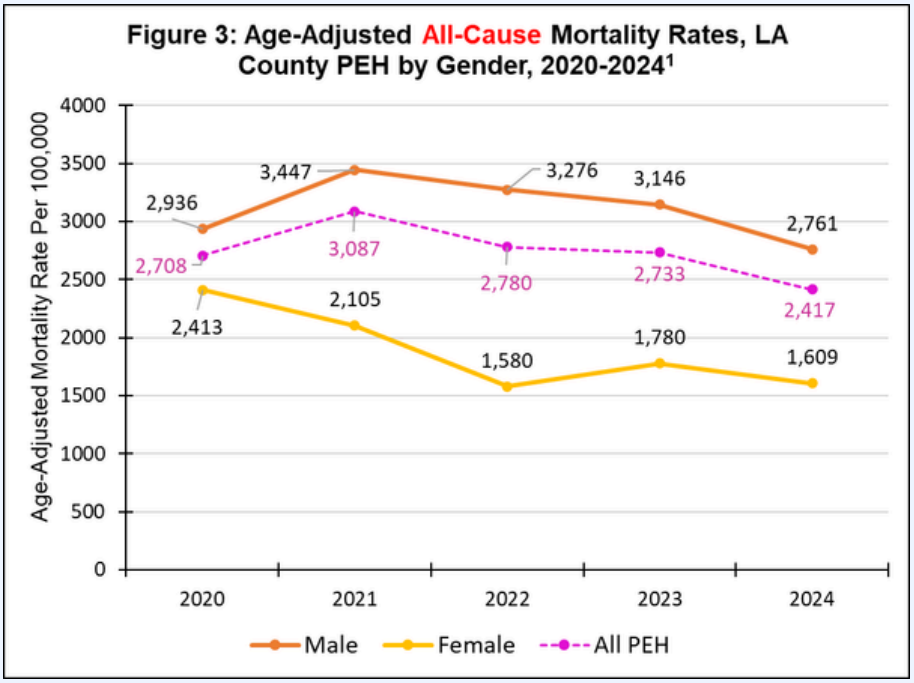
1 American Indians/Alaska Natives (AIAN), Asians, and Native Hawaiians/Pacific Islanders (NHPI) are not included in these graphs per state vital records small numbers suppression rules. Starting in 2023 the age groupings used for age-adjustment changed slightly due to new HUD reporting requirements (see footnote #1 on second page of **Appendix B** for more details).

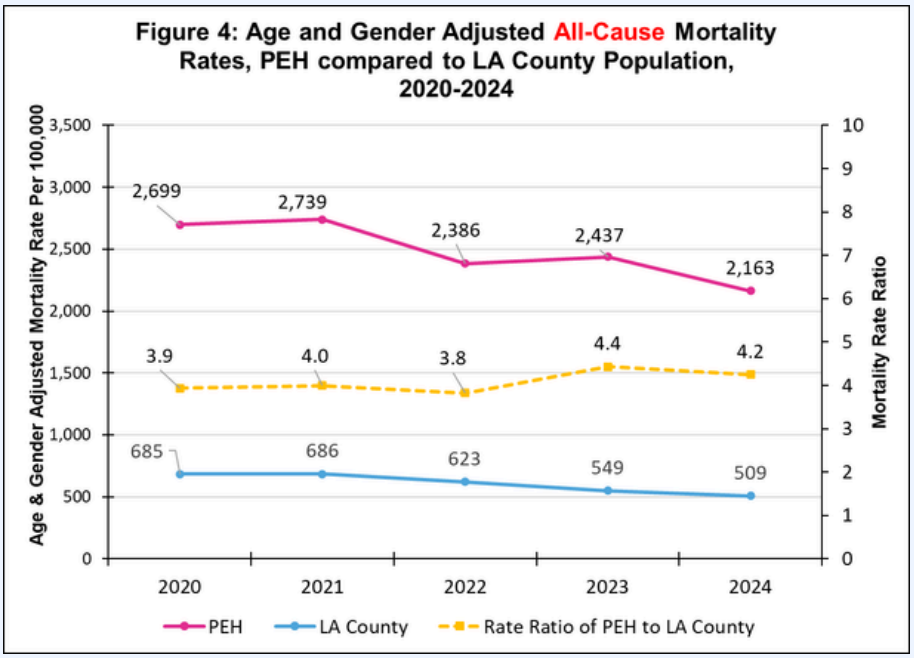
2 Due to a margin of error inherent in all our estimates, annual trends of less than five percent in either direction are considered flat or stable trends.

* See note on next page

Key Indicator #1

All-Cause Mortality Rate Among People Experiencing Homelessness





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2 Due to a margin of error inherent in all our estimates, annual trends of less than five percent in either direction are considered flat or stable trends.

* See note on next page

The Story Behind the Trends

- Overall trend: After a two-year plateau, all-cause mortality among PEH in LA County decreased in 2024—the first reduction since tracking began. The crude mortality rate fell 10%, from 3,326 to 2,994 per 100,000, and the total number of deaths dropped from 2,508 to 2,208 (**Figure 1**).
- Trends by race and ethnicity: Age-adjusted mortality decreased by 25% among White PEH and 16% among Black PEH, while remaining stable among Latino/e PEH (**Figure 2**). From 2020 to 2024, all-cause mortality was consistently higher among White PEH than Black and Latino/e PEH, a pattern also observed in other U.S. cities. These differences likely reflect pathways into homelessness and risk factors beyond individual control, including socioeconomic conditions and long-standing social and economic inequities. Black individuals often become homeless primarily due to socioeconomic hardship, while White individuals may be more likely to become homeless after major trauma, illness, or substance use, which can increase their risk of death once homeless.
- Trends by gender: Both female and male PEH experienced declines in age-adjusted mortality similar to the overall trend (**Figure 3**).
- Comparison to General Population: Even as all-cause mortality decreased, PEH continued to face a mortality rate 4.2 times higher than the general LA County population, slightly down from 4.4 times in 2023 (**Figure 4**).
- Geographic trends: Most of the countywide decrease in deaths was driven by declines in SPAs 4, 5, and 7, while deaths increased among PEH in SPAs 1 and 6 (**Map 1, page 23**).

Every person deserves to live a long life with dignity, safety, and meaning. This indicator represents individuals with unrealized potential. When someone dies too soon—especially under the weight of homelessness—it is not only a personal tragedy but a communal loss. We honor their lives, their strength, and their humanity.

The recent reduction in all-cause mortality among PEH brings new hope after the devastating increases of previous years, but the rate remains alarmingly high. Even as we began to turn the curve in 2024, there were still an average of six Angelenos dying while unhoused every single day. And while the rates decreased among Black and White PEH, mortality among Latino/e PEH showed no change from the previous year.

The four-fold greater mortality rate among PEH compared to the general population reflects more than just individual health and safety challenges. It reveals strains in the systems meant to care for people. These deaths are not inevitable. They areoften the result of treatable conditions—chronic illnesses, infections, substance use—that go unmanaged because people lack the most basic foundations of health: a safe and stable place to sleep, consistent medical care, or someone to call when things get worse. Living outdoors also exposes people to trauma, violence, traffic hazards, and ongoing stress. These conditions accelerate aging and illness, making recovery harder and survival more uncertain.

We can and must change this. Preventable deaths can be reduced—dramatically—by treating housing as essential to health and as a secure platform on which good health can be built and sustained. This means ensuring access to affordable, stable housing options and to the physical, mental and behavioral healthcare services required for lasting well-being.

We must also address and mitigate systemic drivers of discrimination based on race, immigration status, sexual orientation and gender identity, and mental illness—ensuring that communities most harmed by historic neglect are centered in solutions, policy, and investment.

Strategies to Change the Trends

I. Ensure Access to Affordable Housing and Health Insurance to Promote Health and Reduce All-Cause Mortality Among LA County Residents Experiencing Homelessness

When affordable housing gives people a safe, stable place to call home and healthcare is welcoming and easily accessible, we not only save lives with proven policies and programs—we build communities where everyone can live fully and pursue their goals. Nevertheless, we must face the fact that housing and health insurance benefits for PEH are currently entering a period of tremendous fiscal constraint due largely to reductions in federal funding. But rather than compromising our commitment to what we know will work, we make these first recommendations with firm resolve and eyes wide open to the difficulties and challenges that lie ahead.

Recommendation 1.1: Sustain and expand interim and permanent housing options for people experiencing homelessness.
Align the supply of housing options, including recovery bridge housing, long term recovery housing, permanent supportive housing, and Mental Health Service Act housing, with the specific health-related needs of people experiencing homelessness.

Recommendation 1.2: Sustain and expand opportunities to connect people experiencing homelessness to appropriate housing options
Ensure that outreach, health, mental health, substance use, and social service staff are regularly trained on the latest Homeless Management Information System (HMIS) tools (e.g., LA Housing Assessment Tool) to facilitate timely housing referrals and connections. Expand Air Traffic Control models that facilitate access to interim housing.

Recommendation 1.3: Maintain and Expand Medi-Cal Enrollment among people experiencing homelessness Under CalAIM
Maintain and expand Medi-Cal outreach, enrollment and annual renewal efforts for PEH under California Medi-Cal expansion, including presumptive eligibility. Ensure utilization of new covered benefits under CalAIM, including community supports, housing navigation services, transitional rent, recuperative care and enhanced care management.

*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

* Crude rates (defined numerically in column 2 of the key indicators table on page 5) reflect the real-world death experiences of a single population, while adjusted rates allow for fair comparisons across different populations by controlling for factors that influence mortality (e.g., age and gender). The adjusted rates in this report can be compared under the assumption that the different populations have the same age, or age and gender distributions.

II. Recognize and Address the Contribution of Mental Health Disorders to Multiple Causes of Death among LA County Residents Experiencing Homelessness

While mental health disorders don't typically appear on death certificates as causes of death, they have significant and devastating effects on mortality and life expectancy. People with mental disorders have a higher risk of dying from heart disease, cancer and diabetes. Mental health disorders also increase the risk of death from drug overdoses, suicide, and traffic injuries because they can make daily choices and risks harder to manage. Treating mental health disorders can improve a person's health and reduce risks, especially when they have stable housing. Sixty percent of the 2024 decedents we were able to match to recent Homeless Management Information System (HMIS) service records had a mental health disability, and the percentage may be even higher among those not engaged with the homeless services system, who may have less access to housing, healthcare, and other supports that reduce risk. People with mental disorders also suffer from stigma and discrimination, which can lead to shame and prevent them from seeking help.

Recommendation 1.4: Sustain and expand mental health services for LA County residents experiencing homelessness
Include the full range of outreach and engagement, and community and congregate setting-based services for people experiencing homelessness who may also be experiencing serious mental illness.

*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

III. Recognize and Address the Contribution of Systemic Racism and Discrimination to Multiple Causes of Death among LA County Residents Experiencing Homelessness

In 2017, in response to data showing that Black people represented 9% of the LA County population yet comprised 40% of the population of people experiencing homelessness, LAHSA launched the Committee on Black People Experiencing Homelessness. Their first task was to identify opportunities and recommend strategies for increasing racial equity in the homeless service delivery system. By 2025, Black people represented 28% of PEH (**Table 6**). While the Committee's work is far from over, this decrease indicates that collective efforts like these are vital to address the effects of systemic racism and discrimination on marginalized groups within the already vulnerable population of unhoused Angelenos.

In 2024 we finally began to see decreases in all-cause mortality among both Black and White PEH, but not for Latino/e PEH. When we matched 2024 PEH deaths to recent HMIS service records we found that only Latino/e decedents comprised a higher percentage of the unmatched cases (i.e., those with no HMIS encounters) compared to matched cases, which suggests that our homeless services system may be having a harder time reaching Latino/e PEH.

Recent federal immigration enforcement actions, involving indiscriminate raids at people's homes and workplaces, on public transportation, and at other public gathering places are likely to further push Latino/e PEH into the shadows and out of reach of vital services and supports.

Although mortality data rarely include sexual orientation and gender identity, research and community reports suggest that transgender individuals are more likely to experience homelessness, live unsheltered, and encounter discrimination in the homeless services system than their cisgender peers.

Recommendation 1.5: Ensure that health insurance outreach and enrollment, physical and mental health care services, and substance use prevention, harm reduction and treatment services reach PEH who experience discrimination and exclusion due to their race, immigration status, gender identity, sexual orientation and/or mental health status.

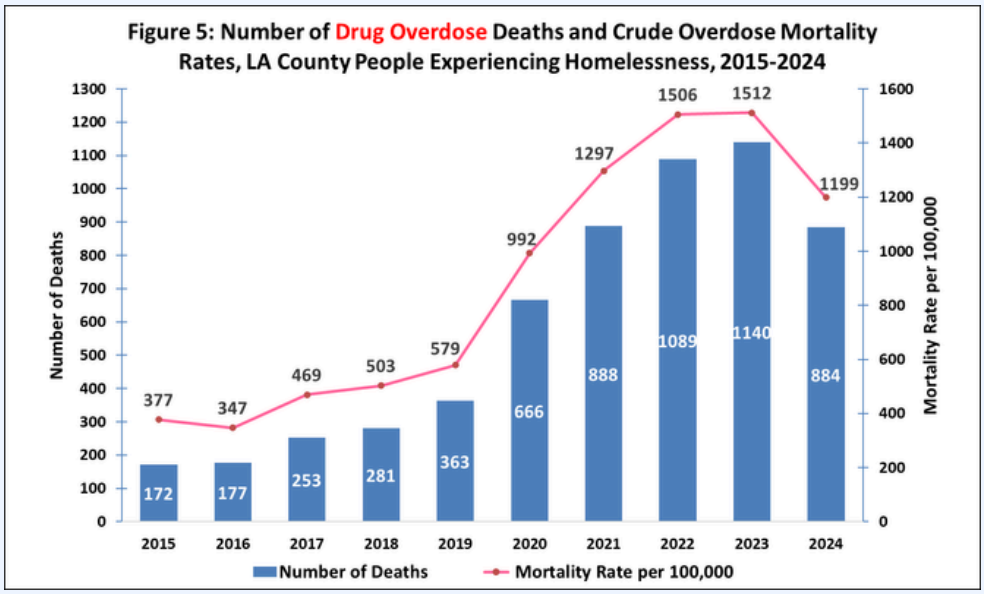
Expand outreach and engagement effort targeting marginalized and hard to reach groups. Hire staff from communities served to improve engagement and trust. Support and maintain workgroups or taskforces that identify and guide strategies to reduce barriers for underserved PEH while advancing the universal goal of equitable access, using the Black People Experiencing Homelessness workgroup as a model.

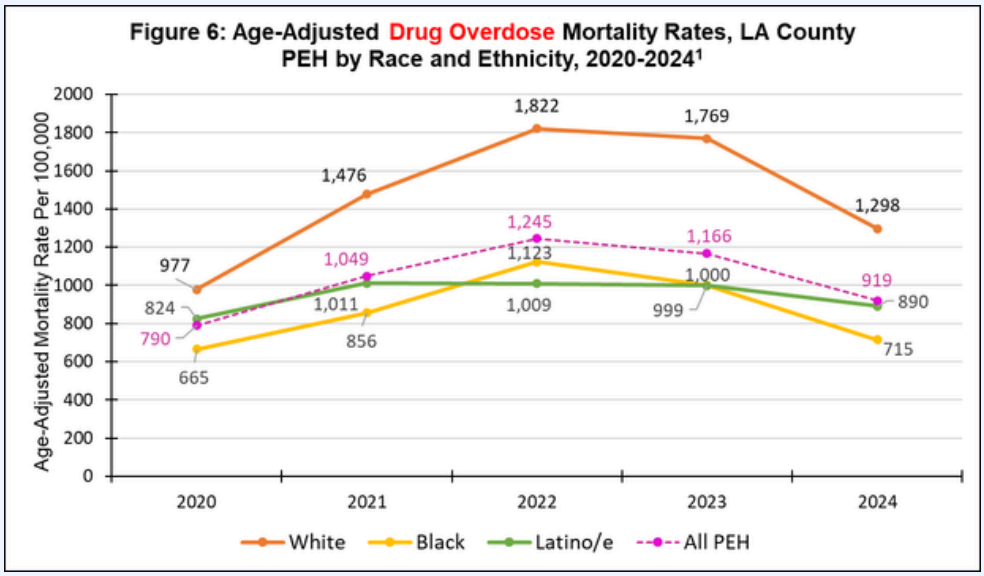
*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

[1] We matched 2024 PEH deaths to 2023 and 2024 service encounter data from LAHSA's Homeless Management Information System (HMIS). 25% of the deaths were matched, suggesting that 75% of 2024 homeless decedents had no recent interactions with the mainstream homeless services system. However, they may have been served by other County or County-funded health or social service agencies.

Key Indicator #2

Drug Overdose Mortality Rate Among People Experiencing Homelessness





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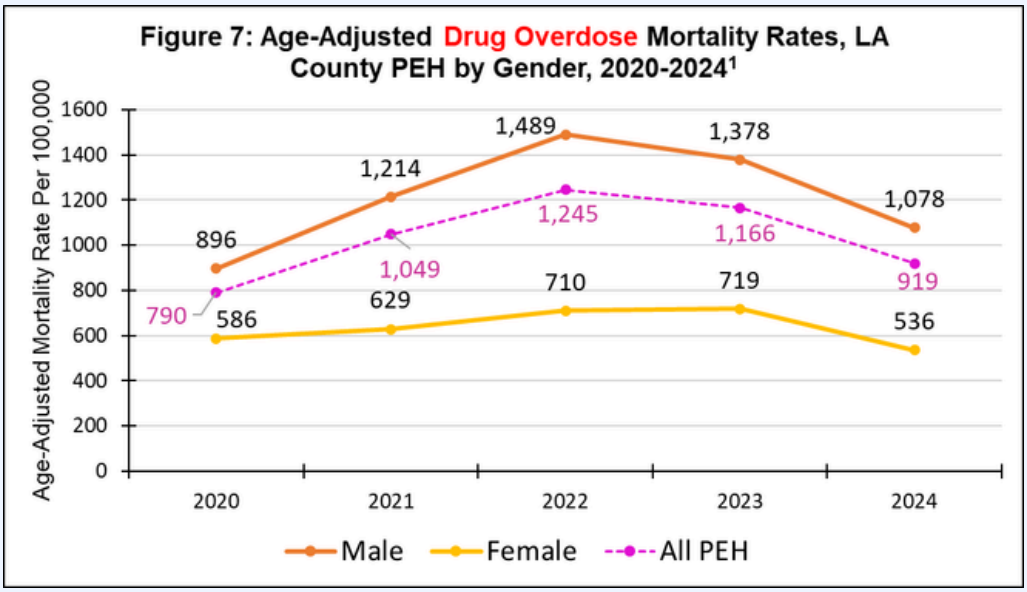
2 Data are presented for 2023 and 2024 only because HUD reporting requirements for age groups changed in 2023 (see footnote #1 on 2nd page of **Appendix B**).

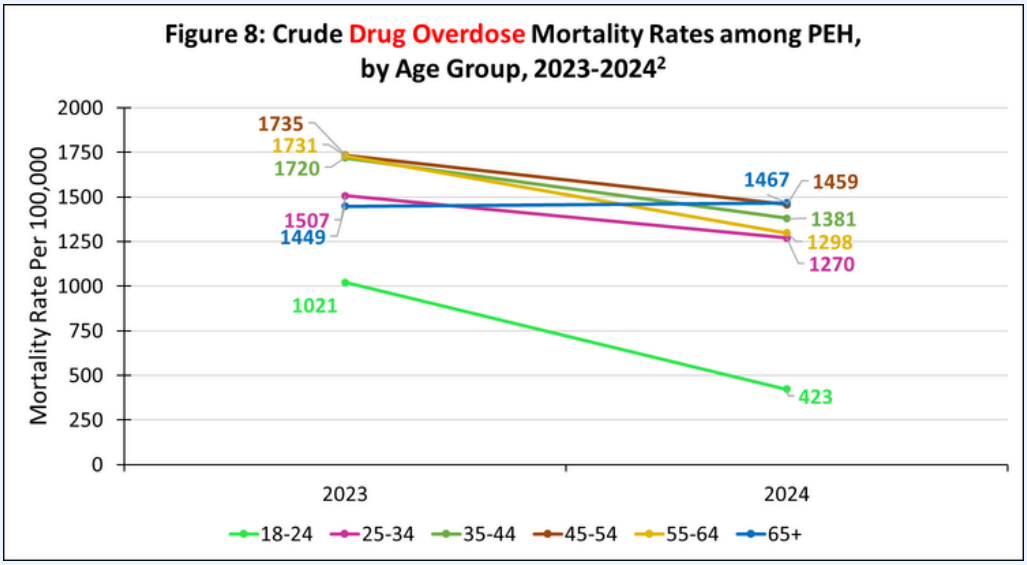
* Percentages of drug types sum to more than 100% each year because overdoses often involve multiple drug types.

3 Except Alcohol+ Other opiates include: methadone, morphine, oxycodone, hydrocodone, oxymorphone, tramadol, and codeine.

Key Indicator #2

Drug Overdose Mortality Rate Among People Experiencing Homelessness





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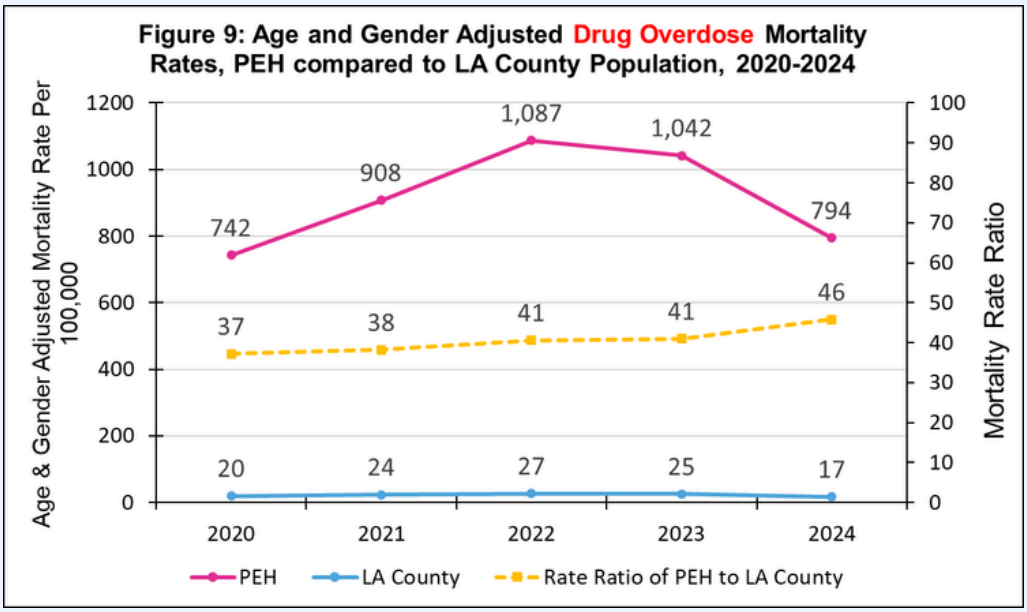
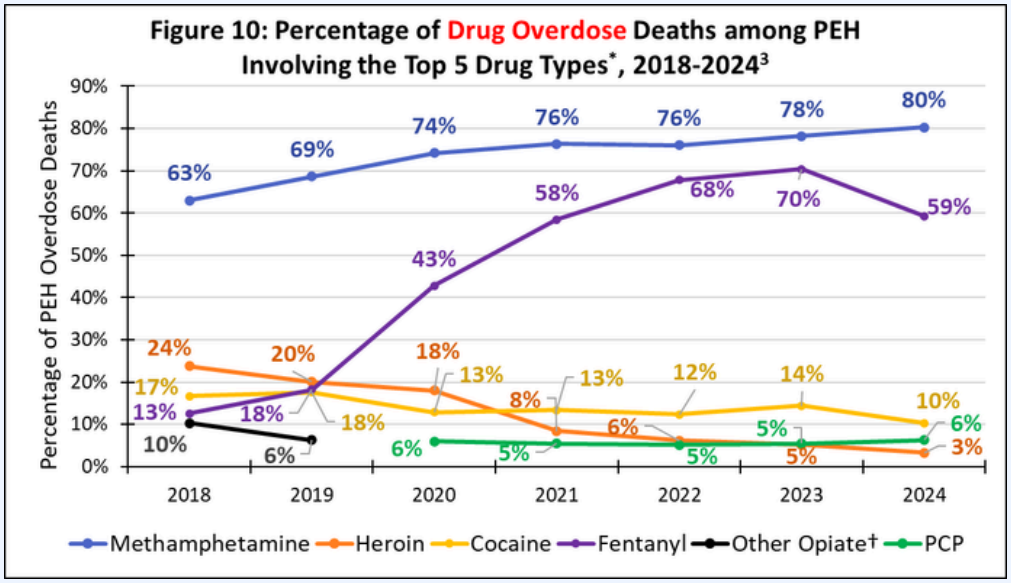
* Percentages of drug types sum to more than 100% each year because overdoses often involve multiple drug types.

3 Except Alcohol+ Other opiates include: methadone, morphine, oxycodone, hydrocodone, oxymorphone, tramadol, and codeine.

Key Indicator #2

Drug Overdose Mortality Rate Among People Experiencing Homelessness





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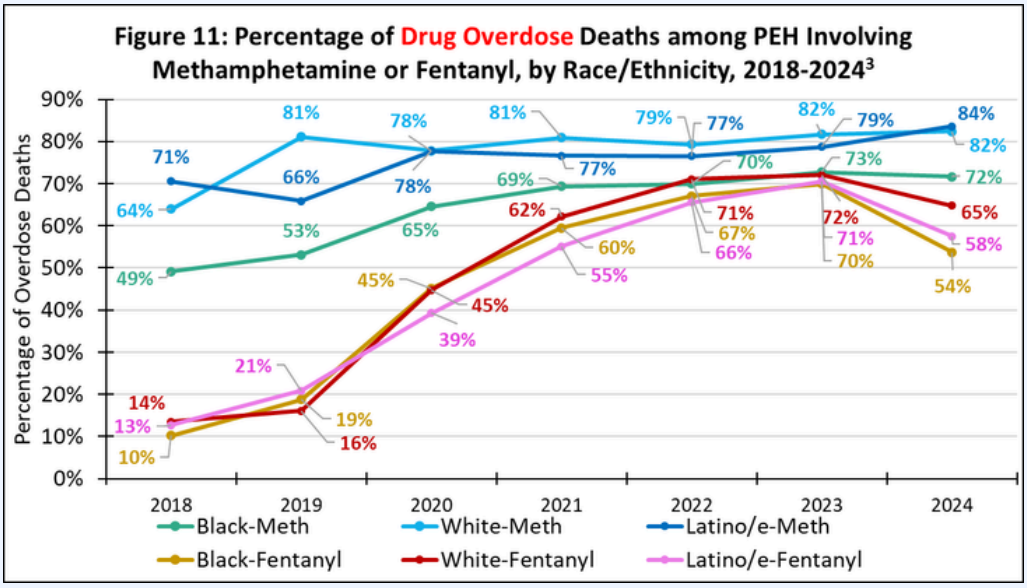
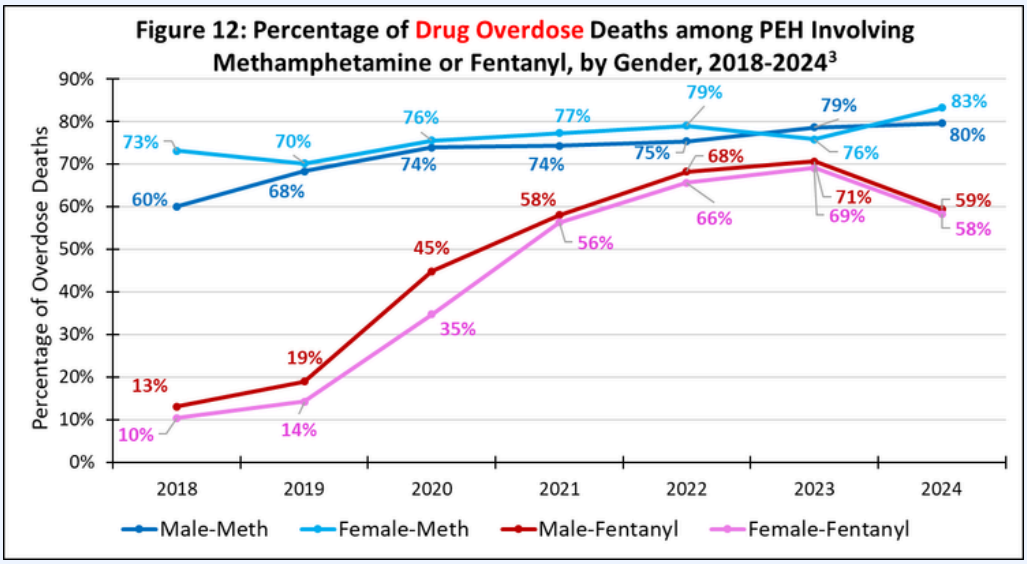
Key Indicator #2

Drug Overdose Mortality Rate Among People Experiencing Homelessness





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* Percentages of drug types sum to more than 100% each year because overdoses often involve multiple drug types.

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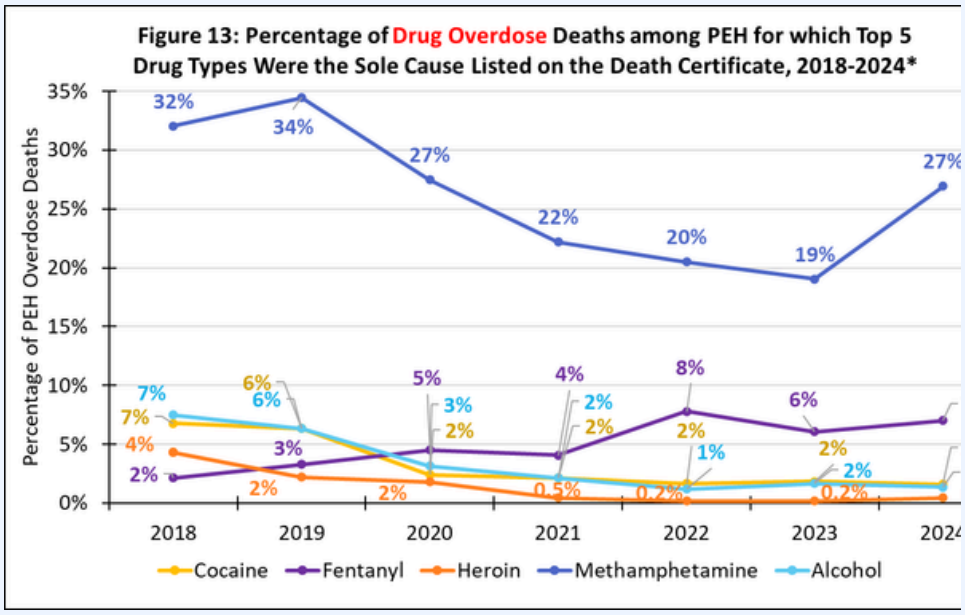


The Story Behind the Trends

- Overall trend: After a sharp rise from 2019 to 2022 and a brief plateau in 2023, drug overdose deaths among PEH in LA County fell in 2024. The crude overdose mortality rate dropped 21%, to 1,199 per 100,000 (**Figure 5**).
- Trends by race and ethnicity: Age-adjusted overdose mortality decreased by 29% among Black PEH, 27% among White PEH, and 11% among Latino/e PEH (**Figure 6**).
- Trends by gender: Both women and men experienced similar declines in age-adjusted overdose mortality (**Figure 7**).
- Trends by age: Most age groups saw lower overdose rates, with the largest drop—59%—among 18–24-year-olds. Rates among PEH aged 65 and older remained stable (**Figure 8**).
- Comparison to General Population: Even as drug overdose mortality decreased substantially, PEH continued to face dramatically higher overdose risks than the general LA County population. In 2024, their overdose mortality rate was 46 times greater, up from 41 in 2023 (**Figure 9**).
- Geographic trends: The number of overdose deaths fell in SPAs 2, 4, 5, 6, 7, and 8. Overdose deaths were unchanged in SPA 3 and rose 57% in SPA 1 (**Map 2, page 23**).
- Substance-specific trends: The share of overdose deaths involving fentanyl decreased by 11% overall (**Figure 10**). Reductions were largest among Black PEH (16%), followed by Latino/e PEH (13%) and White PEH (7%) (**Figure 11**), with similar decreases among both men and women (**Figure 12**). In contrast, deaths involving only methamphetamine rose from 19% in 2023 to 27% in 2024 (**Figure 13**), and were more common among older PEH (not shown).

People with substance use disorders come from all walks of life. Many of our friends, family members and neighbors suffer from addiction. People experiencing homelessness who use drugs should receive the same dignity, care, and chance to heal as those who are housed. Compassion, not judgment, opens the door to safety, connection, and hope.

From 2019 to 2022 LA County experienced a devastating surge in drug overdose deaths, largely due to the increased availability of fentanyl, a highly potent synthetic opioid. People experiencing homelessness were among the most affected, with almost half of all deaths caused by drug overdoses—up to three deaths every single day—at the peak of the crisis. Thankfully we began to turn the curve on PEH overdose deaths in 2024, but the rate is still twice as high as it was in 2019, so much work remains to be done.

While drug use likely plays a role in some people becoming homeless in the first place, recent research shows that over a third of PEH who ever used drugs regularly, started doing so after their first episode of homelessness.

Substance use among PEH is often rooted in untreated trauma, chronic pain, and mental health conditions. For these individuals, drug use is not about recreation, but about coping with the harshness of life on the streets.

We can save lives by transforming our approach—from one of punishment to one of evidence-based care and human dignity. That means fully embracing harm reduction strategies, expanding safe consumption spaces, and making low-barrier treatment and recovery services available where people already are.

People with lived experience must be part of designing these systems, shaping policy, and leading change. By investing in community-based care, trauma-informed support, and systems that meet people with compassion—no matter where they are—we can reduce preventable deaths and build a county where recovery and health are truly possible for everyone.

1 Assaf RD, et al. Illicit Substance Use and Treatment Access Among Adults Experiencing Homelessness. *JAMA*. 2025; 333 (14): 1222-1231.

Strategies to Change the Trends

IV. Reduce Drug Overdose Mortality among LA County Residents Experiencing Homelessness

Recommendation 2.1: Ensure that housing options for people experiencing homelessness support harm reduction, overdose prevention and substance use treatment goals.
Expand the range of housing options, across the housing continuum, that support prevention and treatment goals such that: 1) harm reduction, overdose prevention, and substance use treatment services are readily accessible to people in all permanent and interim housing settings; 2) people who use drugs do not lose their housing due to substance use; and 3) recovery-oriented housing is accessible to residents desiring abstinence-focused living environment.

Recommendation 2.2: Sustain and expand the Reaching the 95% Initiative to lower barriers to SUD treatment for people experiencing homelessness who don't seek treatment.
1) Remove abstinence as a prerequisite for initiating treatment; 2) extend the duration of engagement in substance use treatment services; and 3) increase the presence of community-based outreach and engagement teams to help people experiencing homelessness receive substance use treatment services.

Recommendation 2.3: Expand and extend harm reduction and overdose prevention services wherever people experiencing homeless are located.
Ensure that people experiencing homelessness have access to syringe services, naloxone and fentanyl test strip distribution and education, oxygen administration, low-threshold access to addiction medications like buprenorphine and methadone, and screening and referral for substance use treatment and physical and mental health services in all settings including jails, hospitals, interim housing, shelters, and encampments. Support outreach, consultation, and health hub services directly accessible to PEH.

Recommendation 2.4: Sustain and expand access to clinically effective addiction medication services for people experiencing homelessness.
Ensure that all physical health, mental health, and substance use treatment providers who serve people experiencing homelessness can provide clinically effective addiction medication services with minimum barriers to access in all settings where they can be feasibly administered.

[1] http://publichealth.lacounty.gov/sapc/public/reaching-the-95.htm?hl#:~:text=The%20Reaching%20the%2095%25%20(R95,way%20society%20perceives%20these%20conditions

Recommendation 2.5: Integrate peer-driven and peer-led services into the continuum of substance use prevention, harm reduction and treatment services for people experiencing homelessness

Ensure that people with lived experience have a direct role in shaping and delivering substance use-related services for Los Angeles County residents experiencing homelessness.

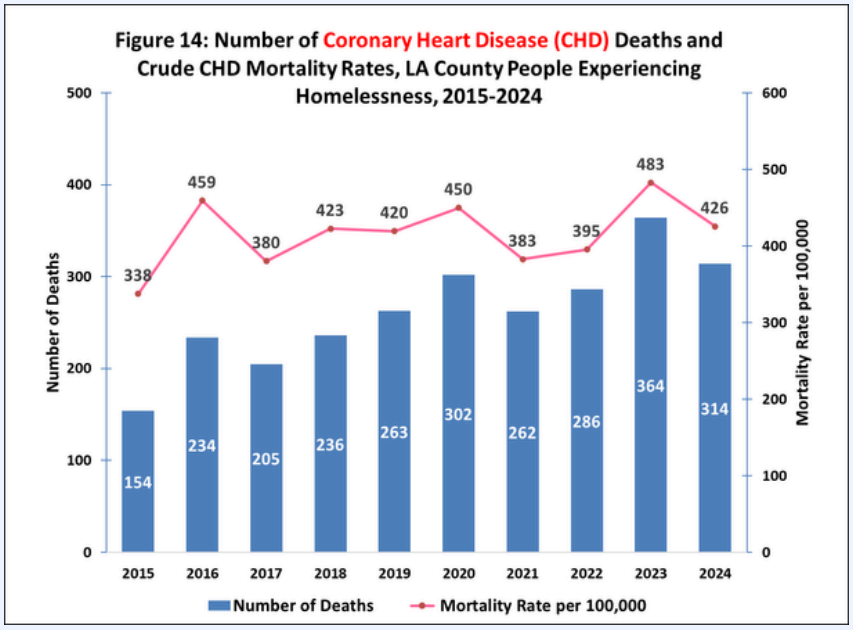
Recommendation 2.6: Advocate for policies, regulations, and laws that make the continuum of substance use prevention, harm reduction and treatment services more accessible to people experiencing homelessness.

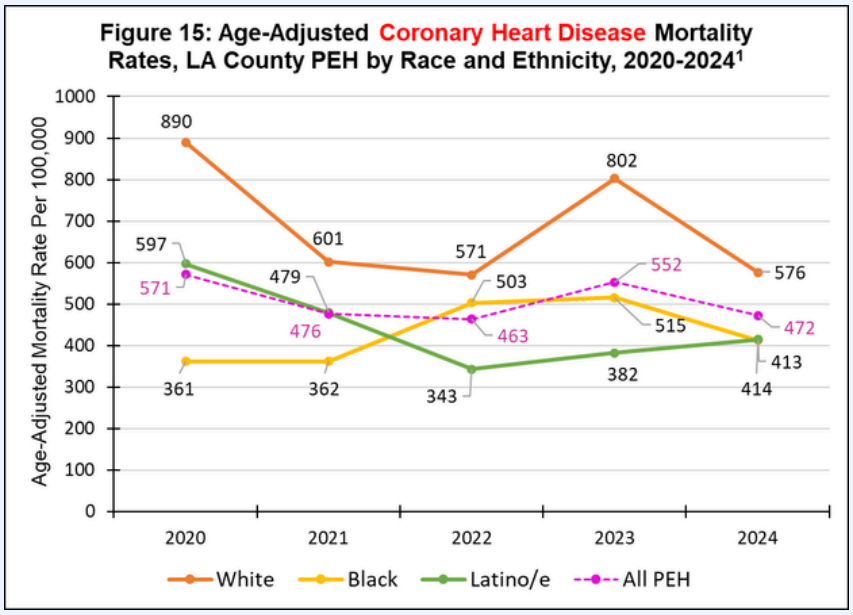
Continue to identify and advance opportunities to establish safer consumption sites when there is a legal pathway to do so. Ensure people experiencing homelessness who are incarcerated receive and on re-entry are linked to comprehensive medical, mental health, and substance use care, particularly substance use treatment, including universal access to all clinically effective addiction medications.

[1] http://publichealth.lacounty.gov/sapc/public/reaching-the-95.htm?hl#:~:text=The%20Reaching%20the%2095%25%20(R95,way%20society%20perceives%20these%20conditions

Key Indicator #3

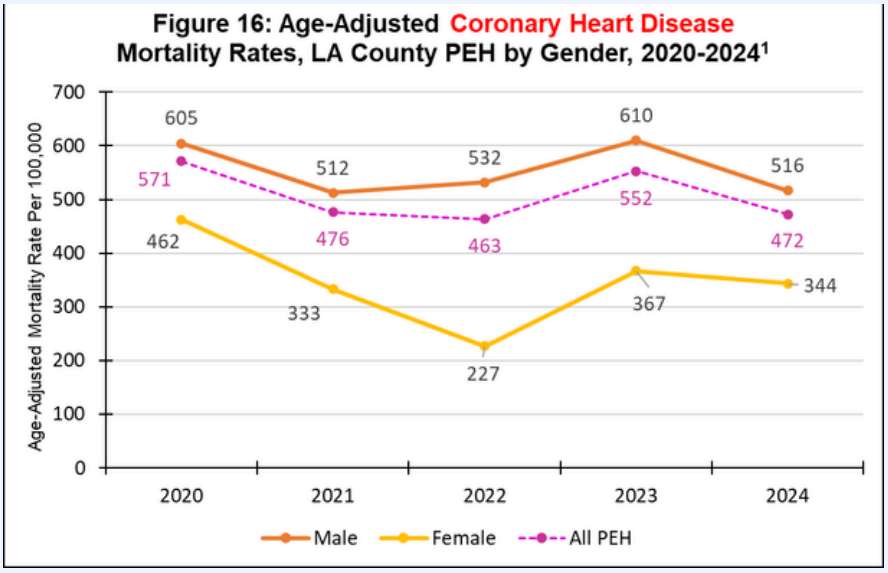
Coronary Heart Disease Mortality Rate Among People Experiencing Homelessness

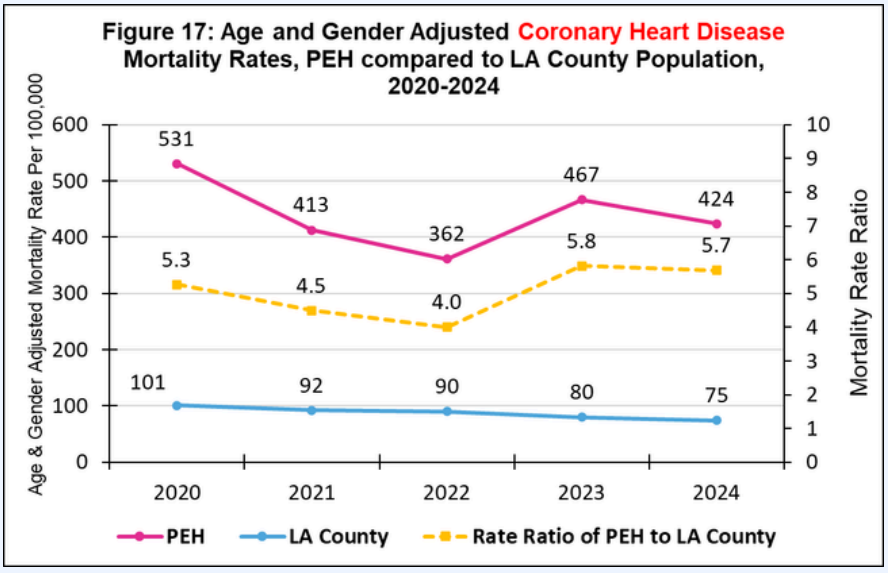




Key Indicator #3

Coronary Heart Disease Mortality Rate Among People Experiencing Homelessness





The Story Behind the Trends

- Overall trend: After a spike in 2023, the crude coronary heart disease (CHD) mortality rate among people experiencing homelessness (PEH) in LA County fell 12% in 2024, to 426 per 100,000 (**Figure 14**).
- Trends by race and ethnicity: Age-adjusted CHD mortality decreased by 28% among White PEH and 20% among Black PEH, while increasing by 8% among Latino/e PEH (**Figure 15**).
- Trends by gender: Age-adjusted CHD mortality fell 15% among males and 6% among females (**Figure 16**).
- Comparison to general population: While CHD mortality decreased among PEH, the rate remained 5.7 times higher than in the general LA County population (**Figure 17**).
- Geographic trends: Countywide reductions were driven primarily by decreases in SPAs 3, 4, and 7. CHD deaths increased among PEH in SPAs 1 and 2 (**Map 3, page 24**).

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A healthy heart can be the foundation for a long and healthy life. We all deserve the opportunity to maximize our heart health through access to healthy foods and activities, and regular preventive health care, as well as freedom from overwhelming environmental stressors that can damage heart function. Good physical health is the foundation for connection, joy, purpose, and the ability to thrive.

Coronary heart disease (CHD) continues to be the second leading cause of death among people experiencing homelessness. In 2024, while the rate decreased overall and among Black and White PEH, it increased among Latino/e PEH. Meanwhile, the CHD mortality rate among PEH is still close to six times greater than the rate in the general population.

While heart disease typically develops gradually, the risk factors—uncontrolled high blood pressure, chronic stress, poor nutrition, exposure to extreme weather—are part of daily life for people without stable housing. People sleeping outside or cycling through shelters often lack access to preventive care, regular medication, or a safe place to rest when symptoms arise. The basics of chronic disease management—routine checkups, healthy food, and rest—are out of reach.

We can change this story. By bringing preventive services, chronic disease management, and specialty cardiac care directly to people where they are, we remove barriers before they become emergencies.

Strategies to Change the Trends

V. Reduce Coronary Heart Disease Mortality among LA County Residents Experiencing Homelessness

Recommendation 3.1: Sustain and expand comprehensive primary and preventive care services for people experiencing homelessness.
Prioritize those at risk for or suffering from coronary heart disease and other chronic heart conditions by ensuring continuity of field-based interventions such as medication adherence support (e.g., direct dispensing), influenza vaccination, and access to point of care devices and capabilities such as electrocardiogram, ultrasound, and labs to ensure timely diagnosis and management.

Recommendation 3.2: Expedite and facilitate unhoused patients' access to cardiac testing, medications, procedures and care.
Facilitate voluntary placement in recuperative care and other supportive interim housing settings to better diagnose and manage cardiac disease. Ensure ready access to high quality cardiologists for PEH with complex cardiac conditions through specialty referral authorization/scheduling and transportation services.

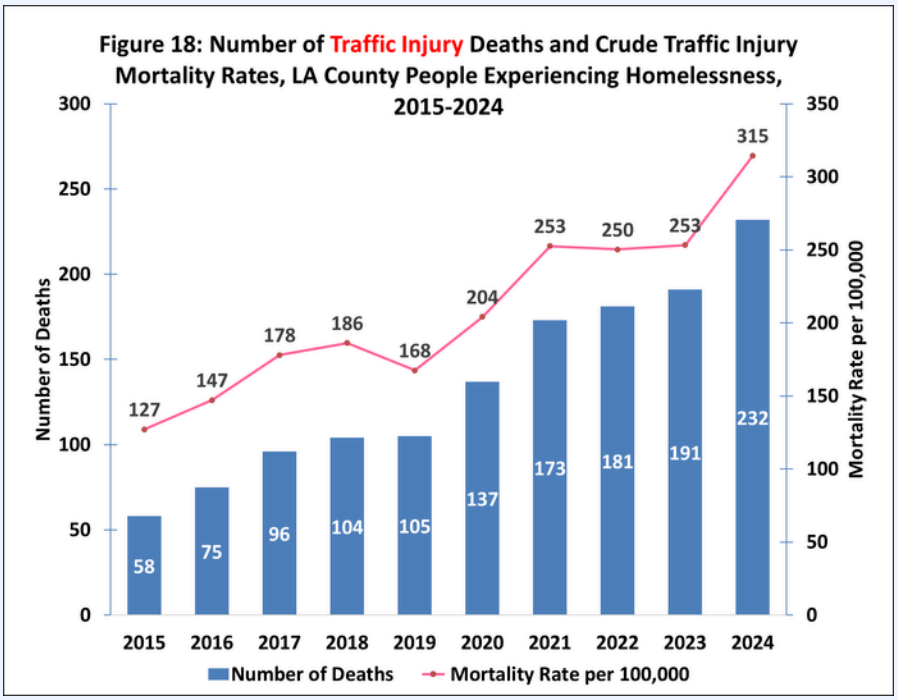
Recommendation 3.3: Address substance use disorders as contributors to cardiovascular deaths among people experiencing homelessness.
Stimulant use disorders (particularly methamphetamine use disorders) are a significant risk factor for premature cardiovascular disease and death. Prioritize field-based stimulant use disorder interventions for those clients with existing heart disease and additional risk factors predisposing them to heart disease.

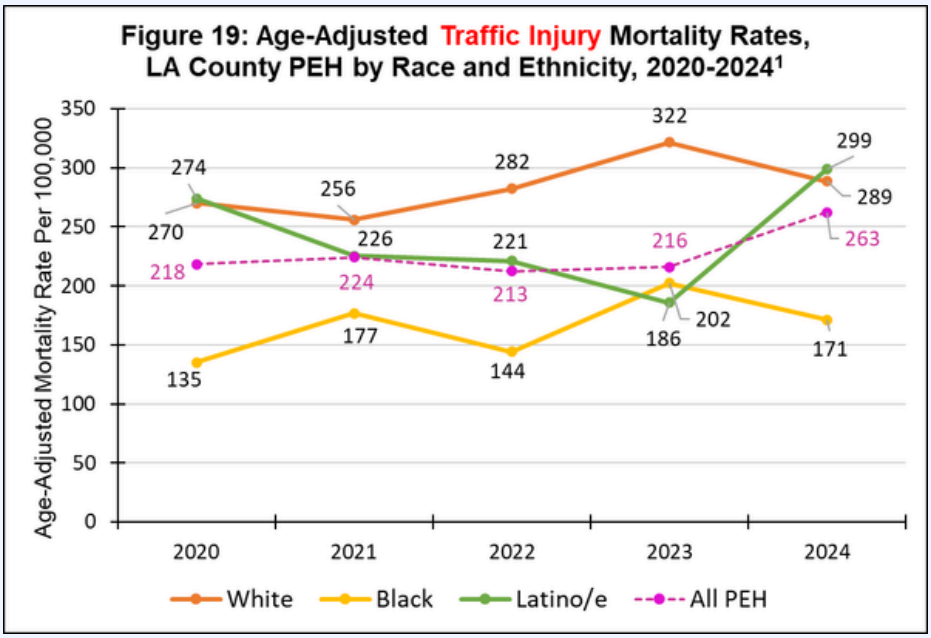
Recommendation 3.4: Train health care and social service providers to better understand and accommodate the special needs and circumstances of people experiencing homelessness when making chronic disease management recommendations.

Accommodate these special needs when delivering cardiac care and other disease and case management, including simplifying medication regimens, addressing the social and psychiatric needs of clients, accounting for insecure physical environments, and delivering health and social care in a non-judgmental and appropriately paced way.

Key Indicator #4

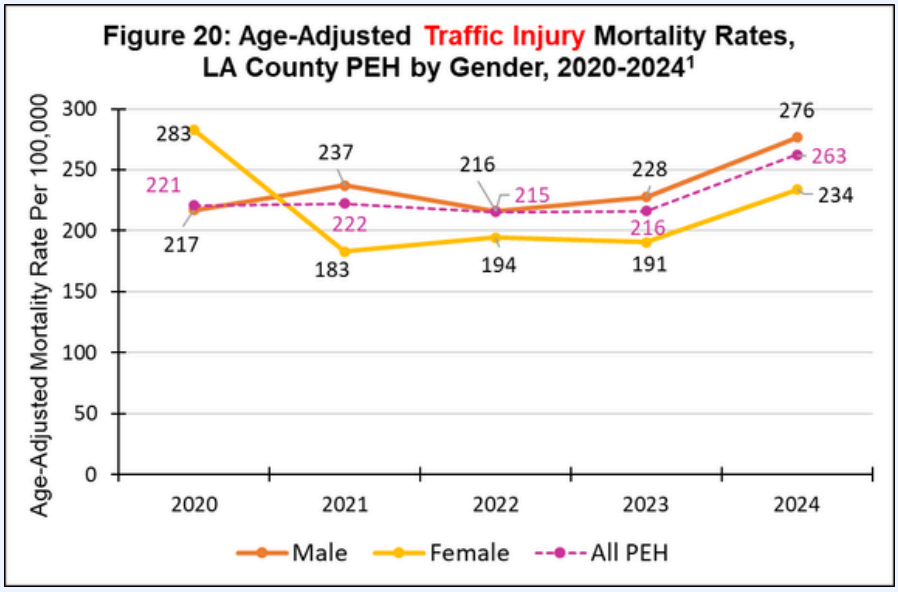
Traffic Injury Mortality Rate Among People Experiencing Homelessness

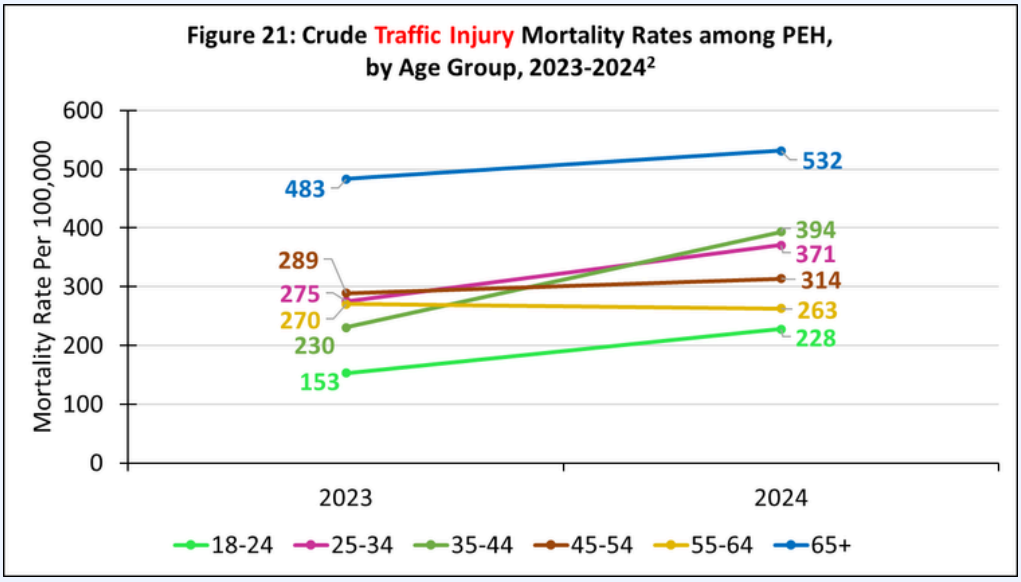




Key Indicator #4

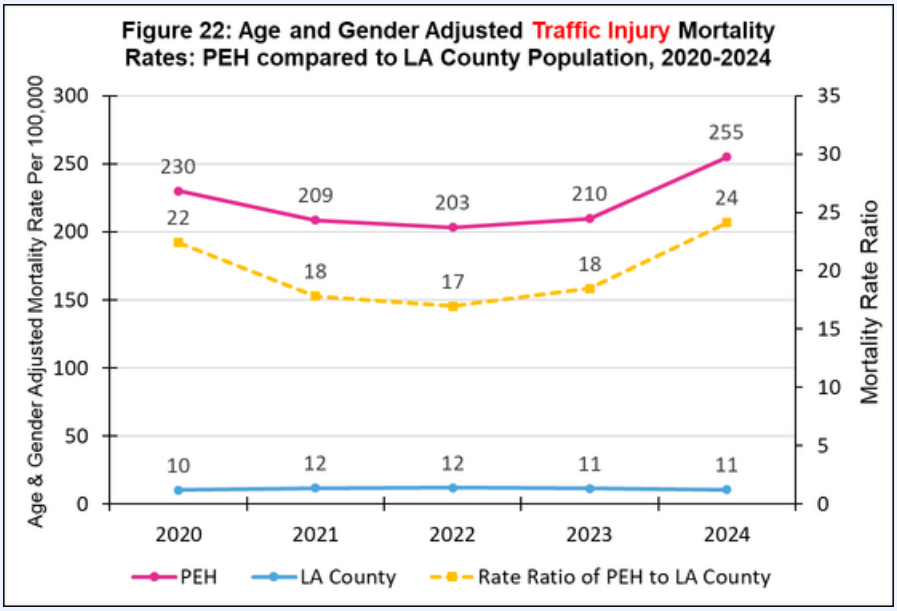
Traffic Injury Mortality Rate Among People Experiencing Homelessness





Key Indicator #4

Traffic Injury Mortality Rate Among People Experiencing Homelessness



The Story Behind the Trends

- Overall trend: After a two-year plateau, the traffic-injury mortality rate among PEH in LA County rose 25% in 2024, reaching 315 per 100,000. This was nearly double the rate in 2019, the only year the rate decreased since tracking began (**Figure 18**). More than 95% of these decedents were pedestrians or cyclists (not shown).
- Trends by Race and Ethnicity: Age-adjusted traffic-injury mortality increased by 61% among Latino/e PEH, while rates decreased by 10% among White PEH and by 15% among Black PEH (**Figure 19**).
- Trends by Gender: Both female and male PEH saw increases similar to the overall trend (**Figure 20**).
- Trends by Age: PEH aged 65+ had the highest traffic-injury mortality rates in both 2023 and 2024. The largest increases occurred in younger groups, with the 35–44 age group experiencing a 71% rise from 2023 to 2024 (**Figure 21**).
- Comparison to General Population: In 2024, PEH faced a traffic-injury mortality rate 24 times higher than the general LA County population—the highest rate ratio observed since 2020 (**Figure 22**).
- Geographic Trends: Traffic-injury deaths increased among PEH in SPAs 1, 2, 5, 6, 7, and 8; there was no change in SPA 3, and a slight decrease in SPA 4 (**Map 4, page 24**).

1 American Indians/Alaska Natives (AIAN), Asians, and Native Hawaiians/Pacific Islanders (NHPI) are not included in these graphs per state vital records small numbers suppression rules. Starting in 2023, the age groupings used for age-adjustment changed slightly due to new HUD reporting requirements for age groups (see footnote #1 on 2nd page of **Appendix B** for more details).

2 Data are presented for 2023 and 2024 only because HUD reporting requirements for age groups changed in 2023 (see footnote #1 on 2nd page of **Appendix B**).

Safety is a basic human right. Every person—housed or unhoused—deserves to move through their community without fear, and to live in environments that protect, not endanger, their lives. We all want streets and neighborhoods where our loved ones can walk, travel, and rest without risk.

Over the past 10 years, the rate of traffic injury deaths among people experiencing homelessness in LA County has increase by two and a half times, and the number of annual traffic injury deaths has quadrupled.

In 2024, there were an average of almost 5 traffic injury deaths among PEH every week, and the mortality rate was highest among Latino/e PEH. Almost all of these deaths were among pedestrians and cyclists hit by cars, and most occurred at night. These are not random accidents. They are the outcomes of people being forced to live, walk, and sleep in spaces not designed for human habitation, such as in freeway underpasses and along busy roadways.

These losses are not just tragic—they are preventable. We can prevent these deaths by redesigning our streets and public spaces with equity and safety at the forefront. That means improving lighting, building sidewalks, slowing traffic, and ensuring safe crossings—especially in areas where people experiencing homelessness live and travel.

It also means inviting those with lived experience into the planning process and treating their insights as essential. When we build inclusive infrastructure that puts people first, we create a more humane, safer Los Angeles County—where no one has to risk their life just to get through the day.

Strategies to Change the Trends

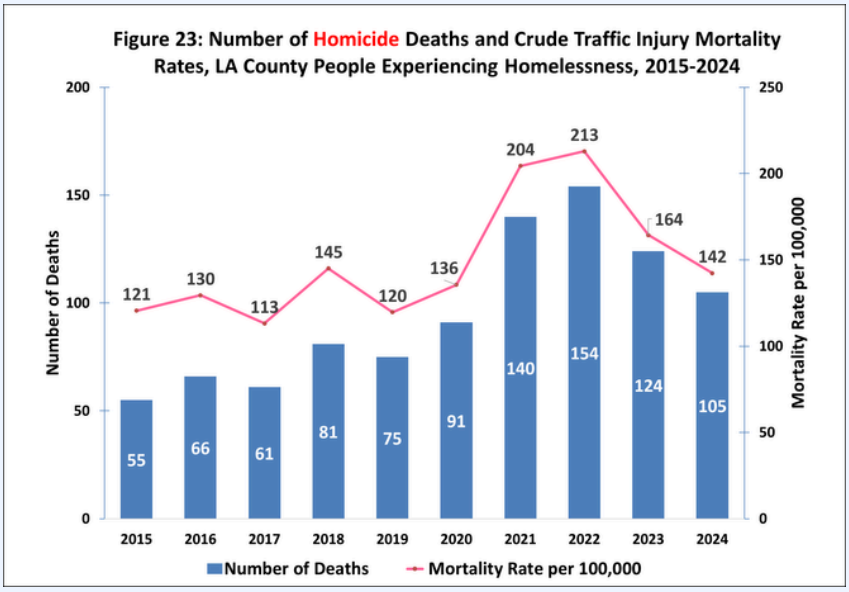
VI. Reduce Traffic Injury Mortality among LA County Residents Experiencing Homelessness

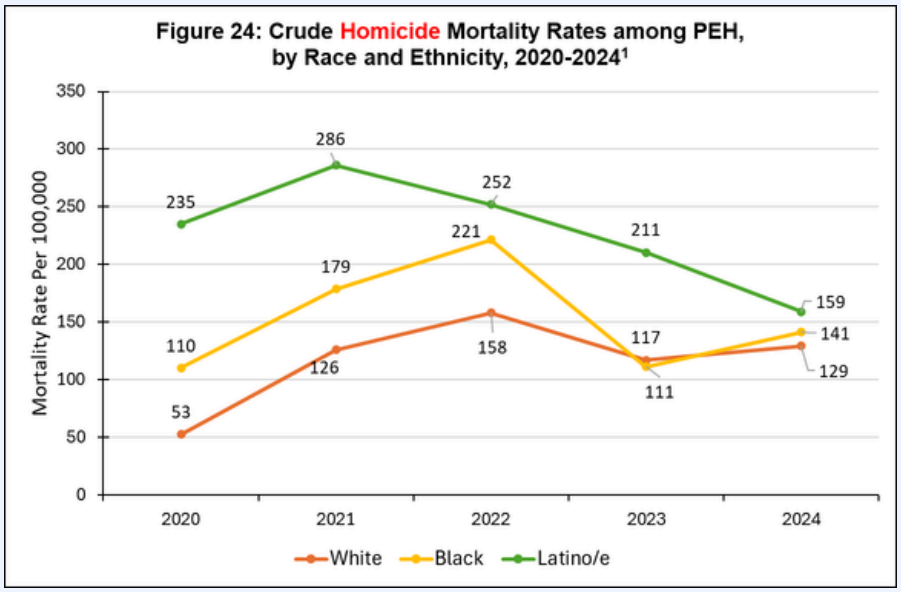
Recommendation 4: Conduct a more detailed analysis of 2024 traffic injury deaths among people experiencing homelessness to inform preventive policy, program, and/or infrastructure interventions.
Classify deaths by roadway type, situational context, proximity to encampments and other relevant landmarks, demographics and geographic clustering to identify most frequent causes of collisions. Convene workgroup of relevant agencies based on roadway types (e.g., Caltrans for interstate highways) geographic clustering (e.g., local transportation agencies and homeless Continuums of Care) and other relevant factors to identify mitigation strategies.

*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

Key Indicator #5

Homicide Mortality Rate Among People Experiencing Homelessness

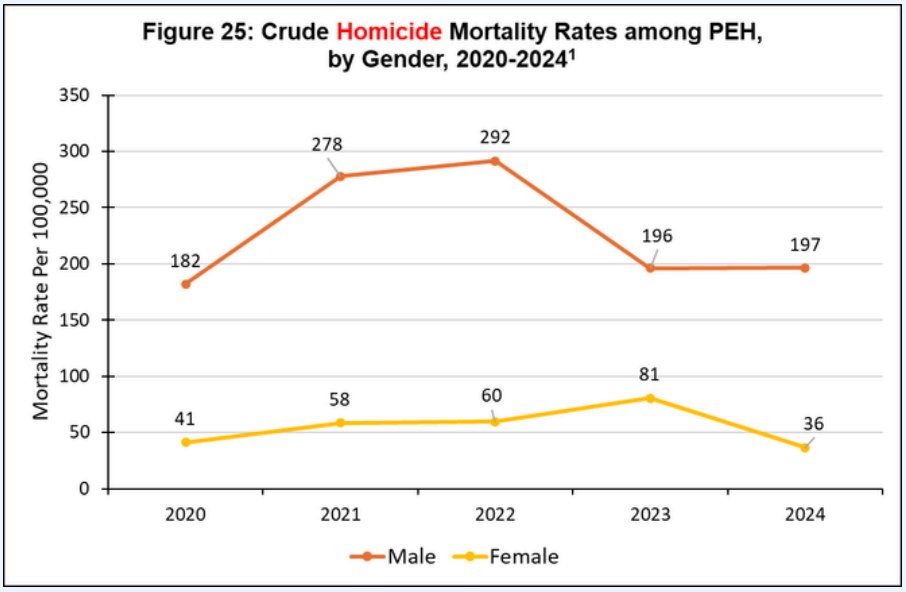


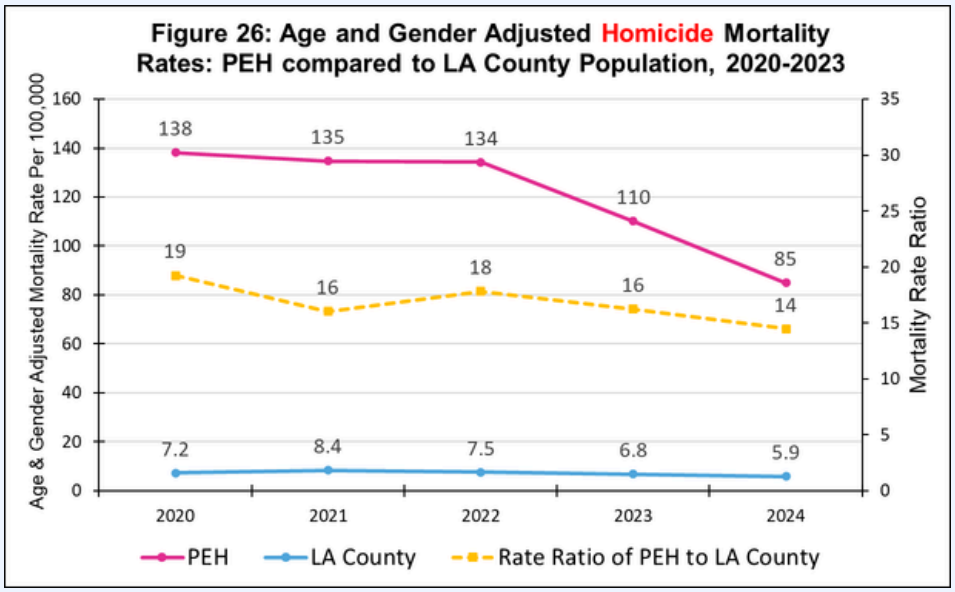


[1] The annual numbers of PEH homicide deaths were too small to allow for age-adjustment of the data for these demographic comparisons. Each year, over 80% of homicides occur among PEH aged 18-54, and the proportions of male and female PEH, and White, Black and Latino PEH in this age range are very similar, so a lack of age adjustment is unlikely to significantly distort the resulting trends by gender and by race and ethnicity.

Key Indicator #5

Homicide Mortality Rate Among People Experiencing Homelessness





[1] The annual numbers of PEH homicide deaths were too small to allow for age-adjustment of the data for these demographic comparisons. Each year, over 80% of homicides occur among PEH aged 18-54, and the proportions of male and female PEH, and White, Black and Latino PEH in this age range are very similar, so a lack of age adjustment is unlikely to significantly distort the resulting trends by gender and by race and ethnicity.

The Story Behind the Trends

- Overall trend: After peaking in 2021–2022, the PEH homicide mortality rate continued to decline by 13% to 142 per 100,000 in 2024, although it remained slightly higher than pre-peak levels (**Figure 23**).
- Trends by race and ethnicity: Homicide mortality decreased by 25% among Latino/e PEH, but increased by 27% among Black PEH and by 10% among White PEH (**Figure 24**).
- Trends by gender: Male PEH homicide mortality remained stable, while female PEH saw a 56% decrease, driving the overall reduction (**Figure 25**).
- Comparison to general population: PEH experienced a homicide rate 14 times higher than the general LA County population. This represents the second consecutive year the rate ratio has decreased and the lowest level since tracking began in 2020 (**Figure 26**).
- Manner of death: Among PEH homicides, 59% involved firearms and 18% involved sharp force. In 2023, 67% involved firearms and 18% involved sharp force (not shown).

[1] The annual numbers of PEH homicide deaths were too small to allow for age-adjustment of the data for these demographic comparisons. Each year, over 80% of homicides occur among PEH aged 18-54, and the proportions of male and female PEH, and White, Black and Latino PEH in this age range are very similar, so a lack of age adjustment is unlikely to significantly distort the resulting trends by gender and by race and ethnicity.

Those of us fortunate enough to live free from the constant fear or threat of violence may take this for granted as a "normal" state of being. When violence is not a part of our everyday existence, we are free to pursue our interests, goals and dreams without the constraining forces of mental and physical trauma that violence brings. Everyone, regardless of their housing status, should be able to enjoy the benefits of a life free from violence.[1]

People without the protective shield of a stable residence are at greater risk of experiencing all types of violence, including interpersonal, sexual, and hate-related violence. Homicide mortality is an indicator of only the most extreme form of violence. In 2025, 57% of female and 34% of male PEH in LA County had experienced some form of domestic or intimate partner violence.

After peaking at three murder victims per week in 2022, the homicide rate decreased by a third from 2022 to 2024.

While the decrease in 2023 was due to a steep drop among men despite an increase among women, the continued decrease in 2024 was driven entirely by a halving of the homicide rate among females. Nevertheless, while the homicide rate continued to decrease among Latino/e PEH in 2024, that year saw small upticks in murders among both White and Black PEH (**Table 1**), and the rate was still higher that year than in all years but one from 2015-2020.

Sustaining this momentum in violence reduction requires a prevention-oriented and trauma-informed approach, rather than a focus on punishment and criminal justice. This involves intervening soon after violence occurs to interrupt the cycle through engagement, assessment, education and referrals to services. It also requires active street outreach by trained community violence intervention workers to mediate conflict, control rumors, stop retaliatory violence and promote peace in the community.

Finally, in order to foster the conditions for a more peaceful community, we must strengthen the capacity of grassroots organizations to engage in violence prevention and intervention work and engage community stakeholders and leaders in prioritizing strategies that meet local needs.

When we view violence as preventable rather than inevitable, identify risk and protective factors, and test interventions at different levels and in different settings, we take active steps toward freeing all of our neighbors--housed or unhoused--from the violence that limits their ability to thrive.

Strategies to Change the Trends

VII. Reduce Homicide Mortality among LA County Residents Experiencing Homelessness

Recommendation 5: Sustain and expand violence prevention and intervention services for people experiencing homelessness within Trauma Prevention Initiative (TPI) communities.

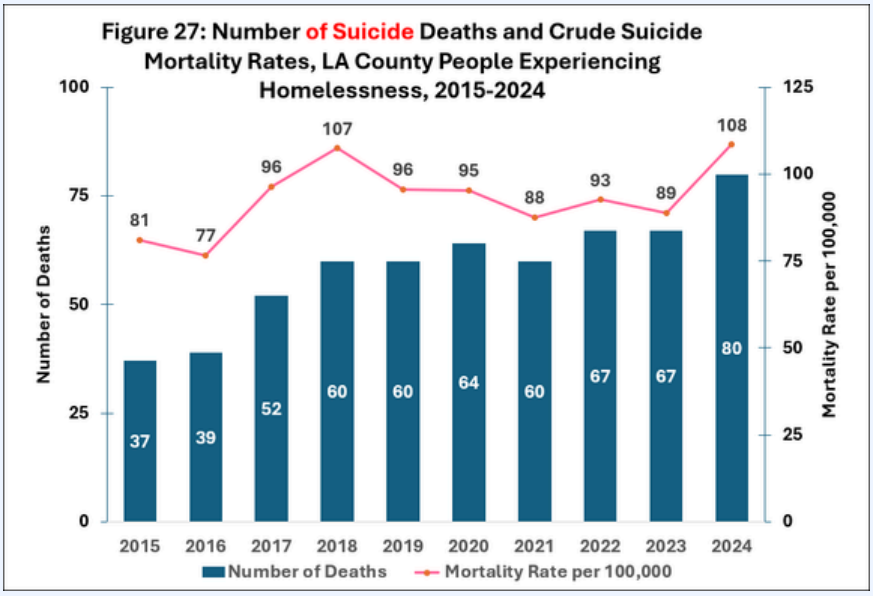
Ensure that TPI services, such as Street Outreach and Community Violence Intervention and Hospital-based Violence Intervention, are available to individuals who are experiencing homelessness, including ensuring that adequate resources and referrals are in place to help people victimized by violence obtain housing.

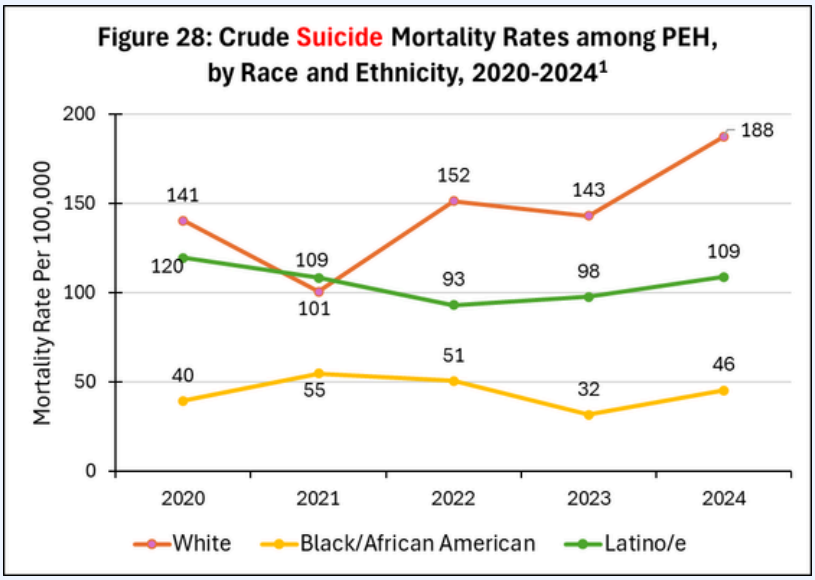
*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

1 Results from LAHSA's annual demographic survey of people experiencing homelessness, 2025: https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data.

Key Indicator #6

Suicide Mortality Rate Among People Experiencing Homelessness



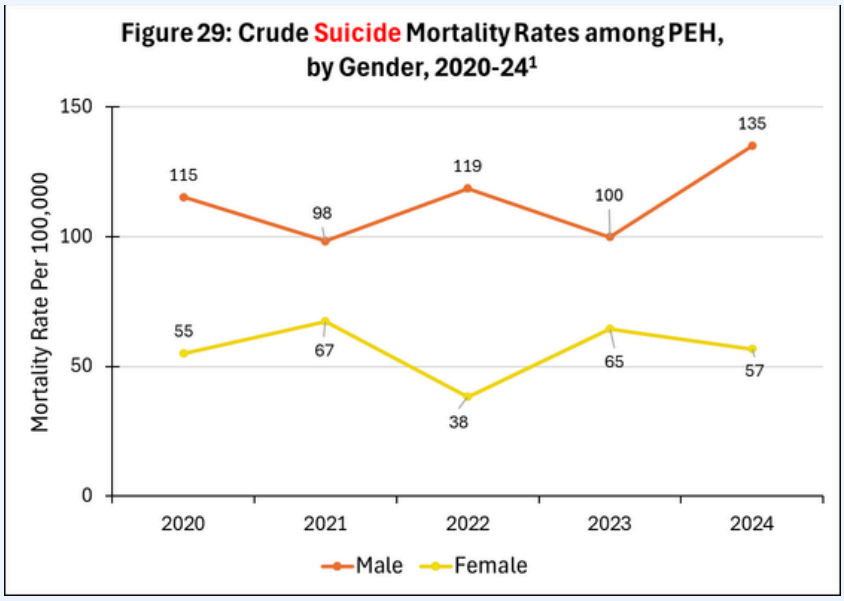


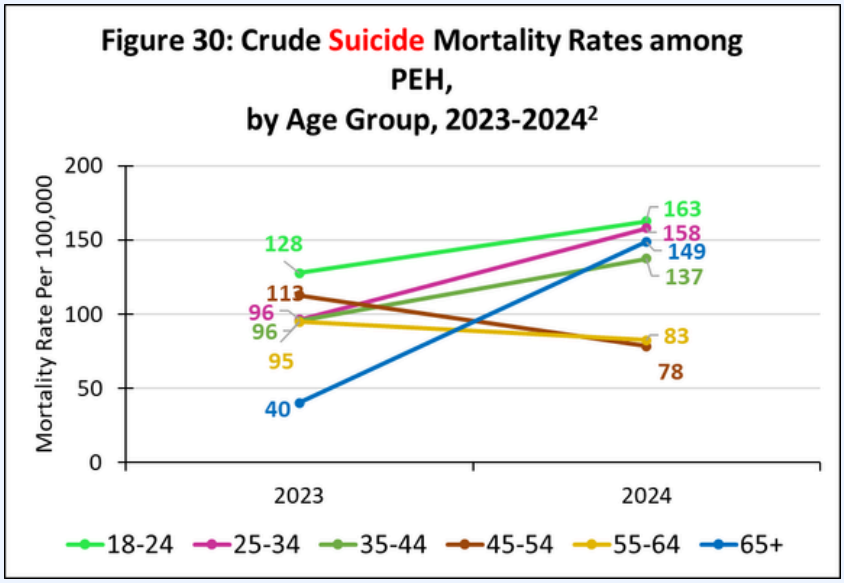
1 The annual numbers of PEH suicide deaths were too small to allow for age-adjustment of the data for these demographic comparisons. Each year, almost 80% of suicides occur among PEH aged 18-54, and the proportions of male and female PEH, and White, Black and Latino PEH in this age range are very similar, so a lack of age adjustment is unlikely to significantly distort the resulting trends by gender and by race and ethnicity.

2 Data are presented for 2023 and 2024 only because HUD reporting requirements for age groups changed in 2023 (see footnote #1 on 2nd page of **Appendix B**).

Key Indicator #6

Suicide Mortality Rate Among People Experiencing Homelessness





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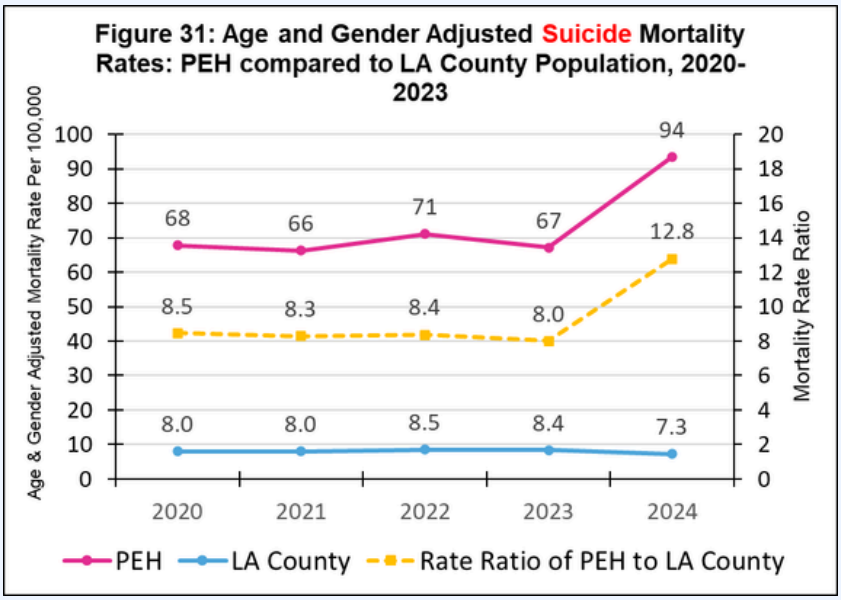

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The Story Behind the Trends

- Overall trend: After gradually declining since 2018, the suicide rate among PEH spiked in 2024 to 108 per 100,000—a 21% increase from 2023 and the highest rate since tracking began (**Figure 27**).
- Trends by race and ethnicity: Suicide rates increased among White, Black, and Latino/e PEH (**Figure 28**).
- Trends by gender: Male PEH experienced a 35% increase in suicide mortality, while female PEH saw a 12% decrease (**Figure 29**).
- Trends by age: PEH aged 18–24 had the highest suicide rate. Rates increased across all age groups except 45–64, with the largest increase among those 65+, though the number of deaths in that group was small (**Figure 30, Table 3**).
- Comparison to general population: The suicide rate among PEH was 12.8 times higher than in the general LA County population, a sharp increase partly due to a decline in the general population suicide rate in 2024 (**Figure 31**).
- Manner of death: Firearms were involved in 15% of suicides in 2024, down from 18% in 2023 (not shown).

Hope for the future and a belief in our ability to play an active role in shaping that future for ourselves and our loved ones, are gifts that should be nurtured and cherished. These hopes and beliefs sustain us and help us through the hard times that we all face.

There are many types of hardships that can test our abilities to stay strong and hopeful in the face of adversity. These include financial difficulties, social isolation, deep feelings of loss, and victimization from sexual or other types of violence--all of which can interact with relatively common mental health conditions like depression and anxiety.

When these experiences become unbearable, and support systems are lacking, suicide can seem like the only option. When homelessness is added to the mix, this tragic option looms even larger.

Suicide has consistently ranked among the top five causes of death of PEH in LA County since 2015, the earliest year for which we have data (**Tables 1-3**). Youth and young adults have suffered from the highest rates of suicide. White and Latino/e PEH have had consistently higher suicide rates compared to Black PEH, and rates are higher among men compared to women. While one year of data does not make a trend, the spike in suicide deaths among PEH in 2024 is concerning, particularly because the ratio of PEH to LA County suicide mortality jumped to almost 13 after remaining stable at close to 8 for four years in a row.

Reducing and preventing suicide among PEH is closely linked with efforts to secure stable housing, since a lack of housing can be a major driver of suicidal thoughts. However, housing placements can take months or even years and the physical and mental trauma of homelessness must be addressed proactively as part of an overall strategy for suicide prevention.

This requires a two-pronged approach. Mental heath professionals must work directly with homeless services agencies to incorporate suicide risk screenings and treatment referrals into shelter and street-based outreach and engagement activities. Additionally, non-clinical and non-mental health staff who interact with PEH must be trained and re-trained to probe for warning signs of suicide through non-judgmental engagement, encourage people to accept help, and connect them to concrete supports.

Being unhoused can exacerbate the despair people may feel from an accumulation of physical, mental, financial, and interpersonal hardships. By sensitizing the entire homeless service and housing workforce to these realities and equipping them with the tools needed to help address them, we can reduce suicide among people experiencing homelessness.

Strategies to Change the Trends

VIII. Reduce Suicide Mortality among LA County Residents Experiencing Homelessness

Recommendation 6.1: Provide Outreach and Engagement, Risk Assessment, Treatment, and Postvention Response Services to People Experiencing Homelessness

Take every measure possible to prevent suicides through direct service strategies provided in collaboration with housing and homeless service agencies, including outreach and engagement, thorough suicide risk screenings, treatment for individuals living with suicidal ideation and behaviors, and suicide postvention response for death by suicide the community.

Recommendation 6.2: Provide Suicide Prevention Trainings for Clinical and Non-Clinical Staff Working in Interim and Permanent Housing Settings

Provide clinical trainings, including Assessing and Managing Suicide Risk (AMSR), as well as consultation and technical assistance to clinical staff and contracted providers at Enhanced Emergency Shelter Programs for transition age youth (TAY), domestic violence shelters, and to clinical staff and contracted providers in County departments who serve PEH in interim housing settings. Provide Question, Persuade, and Refer (QPR) trainings to non-clinical County and contracted gatekeeper staff serving PEH, so they learn how to recognize the warning signs of a suicide crisis and to question, persuade and refer those needing help.

*Please see **Appendix A** for a summary of the partners who will help implement each of these recommendations and the roles they play in the implementation process.*

Additional Data Tables and Maps

Table 1: Top 5 Causes of Death among PEH by Race/Ethnicity[1], 2023 and 2024

Cause	2023						2024						Total
	Latino	Black	White	Asian	AIAN[2]	Total[3]	Latino/e	Black	White	Asian	AIAN[2]	Total[3]	2023 + 2024
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Drug Overdose	418	323	361	18	12	1140	365	201	284	17	11	884	2024
	45%	48%	46%	38%	48%	45%	42%	39%	42%	28%	55%	40%	43%
Coronary Heart Disease	104	119	121	14	*	364	90	97	100	15	*	314	678
	11%	18%	15%	29%	*	15%	10%	19%	15%	25%	*	14%	14%
Transportation-Related Injury[4]	75	56	55	*	*	191	111	46	62	*	*	232	423
	8%	8%	7%	*	*	8%	13%	9%	9%	*	*	11%	9%
Homicide	74	28	19	*	0	124	51	31	20	*	*	105	229
	8%	4%	2%	*	0%	5%	6%	6%	3%	*	*	5%	5%
Suicide	33	*	22	*	0	67	35	*	29	*	*	80	147
	4%	*	3%	*	0%	3%	4%	*	4%	*	*	4%	3%
ALL Causes of Death[5]	926	671	791	48	25	2508	870	518	683	61	20	2208	4716
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

* Non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.
1 Native Hawaiian/Pacific Islander, multiracial, and missing categories not included per state vital records data reporting rules.
2 American Indian/Alaska Native
3 These totals add up to more than the sum of the listed racial and ethnic groups because they include all racial and ethnic groups and responses with missing data for race and ethnicity.
4 >95% of transportation-related injury deaths occurred among pedestrians and cyclists.
5 These totals add up to more than the sum of the top five causes of death because they include deaths from all causes.

Table 2: Top 5 Causes of Death among PEH by Gender[1], 2023 and 2024

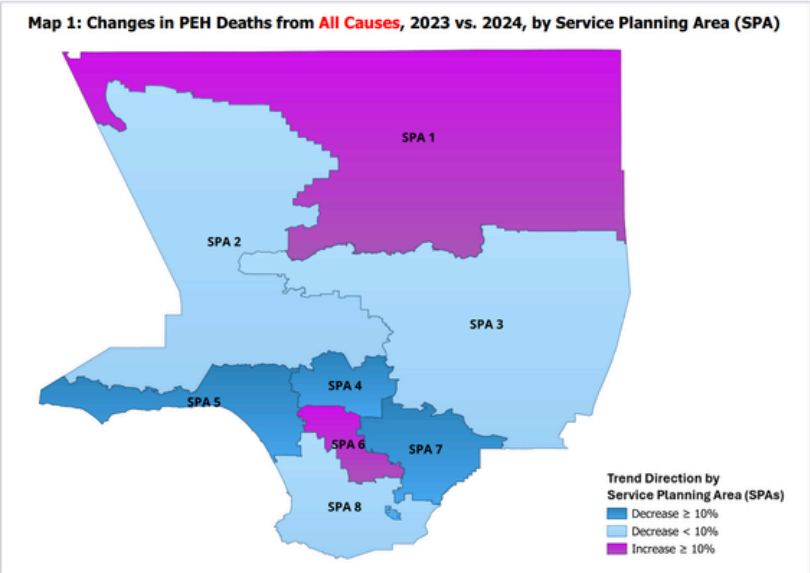
Cause	2023			2024			Total
	Male	Female	Total	Male	Female	Total	2023 + 2024
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	
Drug Overdose	933	207	1140	711	173	884	2024
	45%	46%	45%	40%	42%	40%	43%
Coronary Heart Disease	320	44	364	271	43	314	678
	16%	10%	15%	15%	10%	14%	14%
Traffic Injury[2]	144	46	191	170	62	232	423
	7%	10%	8%	9%	15%	11%	9%
Homicide	104	20	124	96	9	105	229
	6%	5%	5%	5%	2%	5%	5%
Suicide	51	16	67	66	14	80	147
	3%	4%	3%	4%	3%	4%	3%
ALL Causes of Death	2059	448	2508	1792	416	2208	4716
	100%	100%	100%	100%	100%	100%	100%

1 In 2023, all but one of the PEH decedents were coded as male or female. In 2024, all PEH decedents were coded as male or female on the death certificate.
2 >95% of transportation-related injury deaths occurred among pedestrians and cyclists.
* Non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.

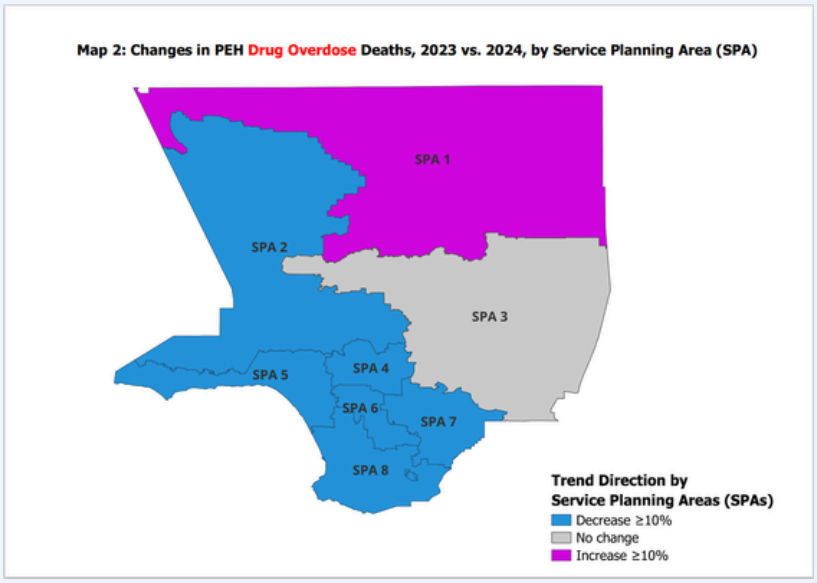
Table 3: Top 5 Causes of Death among PEH by Age Group[1], 2023 and 2024

Cause	2023						2024						Total
	18-34	35-44	45-54	55-64	65+	Total	18-34	35-44	45-54	55-64	65+	Total	2023 + 2024
	n(%)	n(%)	n(%)	n(%)	n(%)		n(%)	n(%)	n(%)	n(%)	n(%)	n(%)	
Drug Overdose	262	313	251	239	73	1140	198	221	223	173	69	884	2024
	62%	61%	51%	38%	23%	45%	53%	49%	48%	35%	23%	40%	43%
Coronary Heart Disease	*	*	43	160	136	364	*	*	41	117	127	314	678
	*	*	9%	25%	43%	15%	*	*	9%	23%	42%	14%	14%
Traffic Injury[2]	47	42	41	37	24	191	61	63	48	35	25	232	423
	11%	8%	8%	6%	8%	8%	16%	14%	10%	7%	8%	11%	9%
Homicide	43	41	20	15	*	124	28	44	15	11	*	105	229
	10%	8%	4%	3%	*	5%	8%	10%	3%	2%	*	5%	5%
Suicide	19	17	16	13	*	67	28	22	12	11	*	80	147
	4%	3%	3%	2%	*	3%	8%	5%	3%	2%	*	4%	3%
ALL Causes of Death	426	513	495	634	317	2508	372	448	464	500	301	2208	4716
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

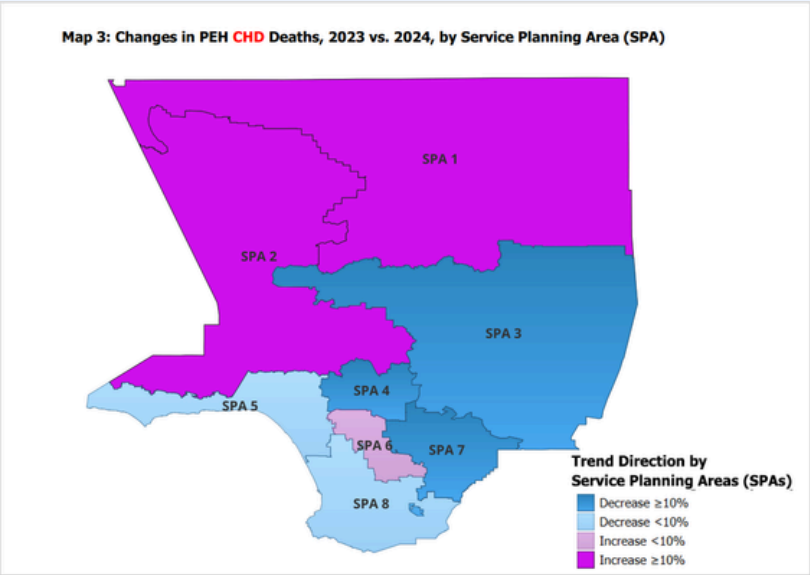
1 There were 18 deaths from all causes among PEH <18 years old in 2023 and 2024 combined. Age data were missing for 248 PEH deaths in 2023 and 2024 combined.
2 >95% of transportation-related injury deaths occurred among pedestrians and cyclists.
* Non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.



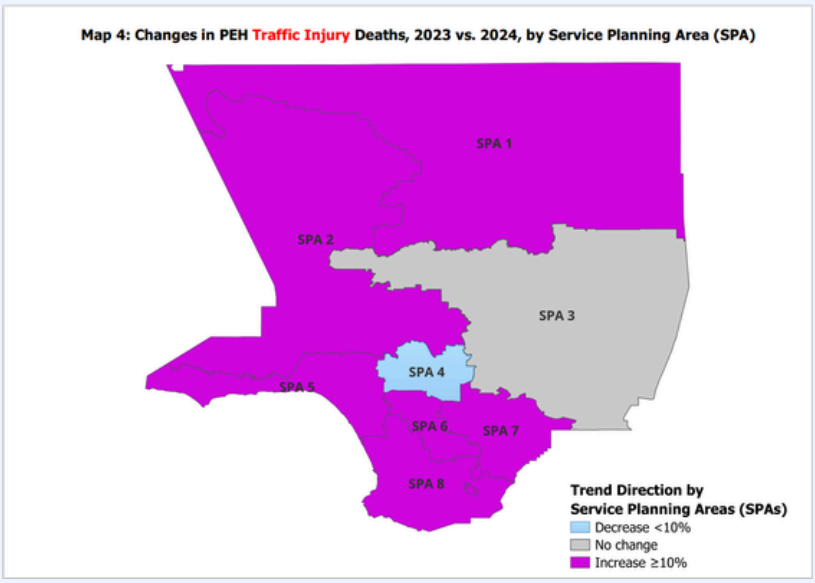
Service Planning Areas (SPAs)	2023 Deaths	2024 Deaths	Difference	Percent Change
SPA 1 (Antelope Valley	79	102	23	29.1%
SPA 2 (San Fernando Valley)	386	370	-16	-4.1%
SPA 3 (San Gabriel Valley)	219	211	-8	-3.7%
SPA 4 (Metro)	834	617	-217	-26.0%
SPA 5 (West)	227	167	-60	-26.4%
SPA 6 (South)	233	267	34	14.6%
SPA 7 (East)	208	170	-38	-18.3%
SPA 8 (South Bay)	297	286	-11	-3.7%



Service Planning Areas (SPAs)	2023 Deaths	2024 Deaths	Difference	Percent Change
SPA 1 (Antelope Valley	28	44	16	57.1%
SPA 2 (San Fernando Valley)	192	155	-37	-19.3%
SPA 3 (San Gabriel Valley)	76	76	0	0.0%
SPA 4 (Metro)	467	323	-144	-30.8%
SPA 5 (West)	99	53	-46	-46.5%
SPA 6 (South)	96	86	-10	-10.4%
SPA 7 (East)	67	50	-17	-25.4%
SPA 8 (South Bay)	105	94	-11	-10.5%



Service Planning Areas (SPAs)	2023 Deaths	2024 Deaths	Difference	Percent Change
SPA 1 (Antelope Valley	*	12	*	Increase ≥ 10%
SPA 2 (San Fernando Valley)	45	50	5	11.1%
SPA 3 (San Gabriel Valley)	44	31	-13	-29.5%
SPA 4 (Metro)	105	78	-27	-25.7%
SPA 5 (West)	27	26	-1	-3.7%
SPA 6 (South)	39	41	2	5.1%
SPA 7 (East)	37	23	-14	-37.8%
SPA 8 (South Bay)	56	52	-4	-7.1%



Service Planning Areas (SPAs)	2023 Deaths	2024 Deaths	Difference	Percent Change
SPA 1 (Antelope Valley	*	13	*	Increase ≥ 10%
SPA 2 (San Fernando Valley)	28	42	14	50.0%
SPA 3 (San Gabriel Valley)	26	26	0	0.0%
SPA 4 (Metro)	35	32	-3	-8.6%
SPA 5 (West)	11	13	2	18.2%
SPA 6 (South)	33	46	13	39.4%
SPA 7 (East)	19	23	4	21.1%
SPA 8 (South Bay)	27	33	6	22.2%

* Non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.

Table 4: Changes in PEH Deaths from All Causes 2023 vs. 2024, LA County by SPA and Zip Code					
Service Planning Areas	**Zip Code**	**2023 Deaths**	**2024 Deaths**	**Difference**	**Percent Change**
SPA 1 (Antelope Valley)	93534	30	41	11	36.7%
	93550	*	17	Increase	Increase
	93535	17	14	-3	-17.6%
	93551	*	12	Increase	Increase
SPA 2 (San Fernando Valley)	91342	24	26	2	8.3%
	91405	23	25	2	8.7%
	91352	24	19	-5	-20.8%
	91605	21	23	2	9.5%
	91343	21	14	-7	-33.3%
	91331	14	20	6	42.9%
	91402	20	11	-9	-45.0%
	91601	18	11	-7	-38.9%
	91311	16	*	Decrease	Decrease
	91335	14	16	2	14.3%
	91505	*	15	Increase	Increase
	91325	14	12	-2	-14.3%
	91307	*	12	Increase	Increase
	91401	*	12	Increase	Increase
	91403	11	*	Decrease	Decrease
	91303	*	11	Increase	Increase
	91406	11	*	Decrease	Decrease
SPA 3 (San Gabriel Valley)	91767	29	24	-5	-17.2%
	91768	*	21	Increase	Increase
	91706	16	*	Decrease	Decrease
	91766	15	13	-2	-13.3%
	91733	15	*	Decrease	Decrease
SPA 4 (Metro)	90026	26	10	-16	-61.5%
	90004	18	22	4	22.2%
	90048	21	18	-3	-14.3%
	90006	20	20	0	0.0%
	90005	19	*	Decrease	Decrease
	90023	16	11	-5	-31.3%
	90031	16	11	-5	-31.3%
	90019	16	*	Decrease	Decrease
	90038	*	13	Increase	Increase
	90029	11	*	Decrease	Decrease

* Zip Codes with less than 11 deaths in both years are omitted from this table, and non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.

Table 4 (Cont.): Changes in PEH Deaths from All Causes 2023 vs. 2024, LA County by SPA and Zip Code					
Service Planning Areas	**Zip Code**	**2023 Deaths**	**2024 Deaths**	**Difference**	**Percent Change**
SPA 5 (West)	90073	17	30	13	76.5%
	90401	25	18	-7	-28.0%
	90404	25	14	-11	-44.0%
	90292	20	*	Decrease	Decrease
	90291	19	13	-6	-31.6%
	90025	19	*	Decrease	Decrease
	90232	14	*	Decrease	Decrease
	90045	11	*	Decrease	Decrease
	90064	*	11	Increase	Increase
	90405	11	*	Decrease	Decrease
SPA 6 (South)	90003	27	18	-9	-33.3%
	90059	12	24	12	100.0%
	90011	15	24	9	60.0%
	90037	18	23	5	27.8%
	90262	23	21	-2	-8.7%
	90044	18	13	-5	-27.8%
	90007	16	14	-2	-12.5%
	90221	11	14	3	27.3%
	90061	9	13	4	44.4%
	90001	11	12	1	9.1%
	90047	11	11	0	0.0%
	90062	*	11	Increase	Increase
	90018	*	11	Increase	Increase
	90002	11	*	Decrease	Decrease
SPA 7 (East)	90650	17	19	2	11.8%
	90023	19	12	-7	-36.8%
	90706	14	*	Decrease	Decrease
	90255	13	13	0	0.0%
SPA 8 (South Bay)	90813	51	39	-12	-23.5%
	90301	12	26	14	116.7%
	90806	20	20	0	0.0%
	90247	15	18	3	20.0%
	90744	16	16	0	0.0%
	90805	16	14	-2	-12.5%
	90802	15	*	Decrease	Decrease
	90502	*	15	Increase	Increase
	90731	*	13	Increase	Increase
	90248	11	*	Decrease	Decrease

* Zip Codes with less than 11 deaths in both years are omitted from this table, and non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules.

Table 5: Changes in PEH Drug Overdose Deaths 2023 vs. 2024, LA County by SPA and Zip Code					
Service Planning Areas	**Zip Code**	**2023 Deaths**	**2024 Deaths**	**Difference**	**Percent Change**
SPA 1 (Antelope Valley)	93534	13	15	2	15.4%
SPA 2 (San Fernando Valley)	91405	16	12	-4	-25.0%
	91601	14	*	Decrease	Decrease
	91352	13	*	Decrease	Decrease
	91311	12	*	Decrease	Decrease
	91605	11	*	Decrease	Decrease
SPA 3 (San Gabriel Valley)	91767	14	*	Decrease	Decrease
	91768	*	12	Increase	Increase
SPA 4 (Metro)	90057	64	43	-21	-32.8%
	90013	54	32	-22	-40.7%
	90021	42	19	-23	-54.8%
	90017	39	24	-15	-38.5%
	90014	34	17	-17	-50.0%
	90012	26	30	4	15.4%
	90028	28	14	-14	-50.0%
	90033	27	20	-7	-25.9%
	90015	20	*	Decrease	Decrease
	90026	17	*	Decrease	Decrease
	90027	15	*	Decrease	Decrease
	90006	*	12	Increase	Increase
SPA 5 (West)	90401	19	*	Decrease	Decrease
SPA 6 (South)	90011	12	14	2	16.7%
	90003	12	*	Decrease	Decrease
SPA 8 (South Bay)	90813	17	18	1	5.9%

* Zip Codes with less than 11 deaths in both years are omitted from this table, and non-zero cells with less than 11 deaths are suppressed per state vital records data reporting rules. SPA 7 is omitted because all zip codes in that SPA had less than 11 deaths in both years.

Table 6: Size and Characteristics of LA County PEH Population 2016-2025										
Year[1]	2016	2017	2018	2019	2020	2021[2]	2022	2023	2024	2025
Total Count[3]	46,874	55,048	52,765	58,936	66,436	67,790	69,144	75,518	75,312	72,195
Gender										
Male (incl. trans.)	66%	68%	68%	68%	67%	66.5%	66%	68%	65%	66%
Female (incl. trans.)	33%	32%	31%	31%	32%	32.5%	33%	31%	33%	33%
Age Group[4]										
<18	8%	9%	9%	9%						
18-24	8%	6%	6%	6%						
25-54	60%	61%	59%	61%						
55-61	16%	16%	16%	15%						
62+	9%	8%	10%	9%						
<18					12%	11%	10%			
18-29					15%	14%	13%			
30-39					20%	22%	24%			
40-49					19%	19%	20%			
50-59					22%	21%	20%			
60-69					11%	11%	11%			
70+					2%	2%	3%			
<18								9%	9%	10%
18-24								5%	4%	5%
25-34								19%	20%	19%
35-44								23%	21%	23%
45-54								19%	20%	20%
55-64								18%	18%	16%
65-69								4%	6%	7%
70+								2%	3%	3%
Race and Ethnicity[5]										
AIAN	3%	1%	1%	2%	1%	1%	1%	1%	2%	1%
Asian	2%	1%	1%	2%	1%	1%	1%	2%	1%	1%
Black	39%	40%	36%	33%	34%	32%	30%	32%	30%	28%
Latino/e	27%	35%	35%	36%	36%	40%	44%	43%	43%	46%
NHPI	.2%	.3%	.4%	.6%	.3%	.3%	.2%	.5%	.5%	.4%
White	25%	20%	25%	25%	25%	23%	21%	19%	21%	19%
Multi-racial	5%	2%	1%	2%	2%	2.5%	3%	3%	3%	4%

1 These estimates are from LAHSA's Point in time counts (total counts) and demographic surveys (demographic data) conducted in late January of each year.

2 Since the point in time count and demographic survey were not conducted in 2021 due to the COVID-19 pandemic, 2021 estimates were calculated by averaging the values for 2020 and 2022.

3 Total count data and sheltered/unsheltered status are for all of LA County. Demographic and chronic homelessness estimates are for the LA CoC only, which excludes Glendale, Pasadena and Long Beach. Percentages do not always add to 100% due to rounding.

4 Available age groupings for age data have changed over the years. Beginning in 2020, 10-year age grouping became available, which allowed for more precise age adjustment of mortality rates. In 2023 those 10-year age grouping were adjusted again.

5 In 2024, LAHSA began reporting PEH race and ethnicity according to new HUD standards, which allows people with multiple racial/ethnic identities to be represented in multiple (i.e., non-mutually exclusive) categories. However, in order for us to validly compare racial and ethnic sub-groups in our analyses, we needed to maintain mutually exclusive categories. This table reports these mutually exclusive race and ethnicity groups for all years, which essentially means that anyone who identifies as Latino/e is counted only in that category, regardless of any additional racial identities. For data using the new HUD defined race/ethnicity categories for 2024 and 2025 please refer to: https://www.lahsa.org/homeless-count/.

6 Chronic homelessness is defined as homelessness of at least 12 months duration (continuous, or at least four separate occasions in the last three years that add up to 12 months), and presence of a qualifying disability.

Shelter Status										
Unsheltered	75%	73%	75%	75%	72%	71%	70%	73%	70%	66%
Sheltered	25%	27%	25%	25%	28%	29%	30%	27%	30%	34%
Chronic Homelessness[6]										
Chronically Homeless	31%	31%	27%	28%	38%	39.5%	41%	45%	42%	42%

1 These estimates are from LAHSA's Point in time counts (total counts) and demographic surveys (demographic data) conducted in late January of each year.

2 Since the point in time count and demographic survey were not conducted in 2021 due to the COVID-19 pandemic, 2021 estimates were calculated by averaging the values for 2020 and 2022.

3 Total count data and sheltered/unsheltered status are for all of LA County. Demographic and chronic homelessness estimates are for the LA CoC only, which excludes Glendale, Pasadena and Long Beach. Percentages do not always add to 100% due to rounding.

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5 In 2024, LAHSA began reporting PEH race and ethnicity according to new HUD standards, which allows people with multiple racial/ethnic identities to be represented in multiple (i.e., non-mutually exclusive) categories. However, in order for us to validly compare racial and ethnic sub-groups in our analyses, we needed to maintain mutually exclusive categories. This table reports these mutually exclusive race and ethnicity groups for all years, which essentially means that anyone who identifies as Latino/e is counted only in that category, regardless of any additional racial identities. For data using the new HUD defined race/ethnicity categories for 2024 and 2025 please refer to: https://www.lahsa.org/homeless-count/.

6 Chronic homelessness is defined as homelessness of at least 12 months duration (continuous, or at least four separate occasions in the last three years that add up to 12 months), and presence of a qualifying disability.

Appendix A: Recommendations, Partners and Roles

Key Indicator #1: All-Cause Mortality Rate Among People Experiencing Homelessness

Recommendation 1.1: Sustain and expand interim and permanent housing options for people experiencing homelessness.
Align the supply of housing options, including recovery bridge housing, long-term recovery housing, permanent supportive housing, and Mental Health Service Act housing, with the specific health-related needs of people experiencing homelessness.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Set policy priorities; Allocate County funds; Enact ordinances on housing and health.
City Mayors and Councils	Set policy priorities; Allocate City funds; Enact ordinances on housing and health; Zoning and permitting authority.
LA County Department of Homeless Services and Housing	Administer interim housing, permanent housing, and enriched residential care housing programs, ensure equitable and timely access to available housing resources, and advocate for increased high-quality housing resources to meet the needs of PEH.
LA County Department of Mental Health	Administer Mental Health Services Act housing program.
LA County Department of Public Health	Administer Recovery Bridge Housing and long-term recovery housing programs.
Los Angeles Homeless Services Authority	Administer federal and state funded interim and permanent housing programs.

Recommendation 1.2: Sustain and expand opportunities to connect people experiencing homelessness to appropriate housing options

Ensure that outreach, health, mental health, substance use, and social services staff are regularly trained on the latest Homeless Management Information System (HMIS) tools (e.g., LA Housing Assessment Tool) to facilitate timely housing referrals and connections. Expand use of Air Traffic Control models to facilitate access to interim housing.

Partners Who Can Help Make This Happen	What Role They Can Play
Community-Based Organizations	Provide housing linkages to PEH.
LA County Department of Public Health	Public health nurses provide housing linkages to program participants who are unhoused.
LA County Department of Health Services	Health care providers and case managers provide housing linkages to PEH.
LA County Department of Mental Health	Social workers and mental health care providers provide housing linkages to PEH.
LA County Department of Homeless Services and Housing	Street-based outreach workers, interim housing case managers, and intensive case managers provide housing linkage and tenancy support services to PEH.
LA County Department of Public Social Services	Health and social service eligibility workers provide housing linkages to PEH.
LA County Department of Child and Family Services	Case managers provide housing linkages to PEH.

Recommendation 1.3: Maintain and Expand Medi-Cal Enrollment among people experiencing homelessness Under California Advancing and Innovating Medi-Cal (CalAIM)

Maintain and expand Medi-Cal outreach, enrollment and annual renewal efforts for PEH under California Medi-Cal expansion, including presumptive eligibility. Ensure utilization of new covered benefits under CalAIM, including community supports, housing navigation services, transitional rent, recuperative care and enhanced care management.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Public Social Services	Health insurance outreach and enrollment.
Managed Care Organizations	Oversight and payment of Medi-Cal network providers.
LA County Department of Homeless Services and Housing	Street-based outreach workers, interim housing case managers, intensive case managers, and Community-Based Engagement and Stabilization Teams (CBEST) staff help PEH access and maintain Medi-Cal and other benefits.
LA County Department of Public Health	Health insurance outreach and enrollment.
Hospitals/Clinics	Provide Medi-Cal enrollment services to PEH. Provide acute, chronic, and preventive medical care to PEH.
Community-Based Organizations	Health insurance outreach and enrollment; Provision of CalAIM housing related benefits.

Recommendation 1.4: Sustain and expand mental health services for LA County residents experiencing homelessness Include the full range of outreach and engagement, and community and congregate setting-based services for people experiencing homelessness who may also be experiencing serious mental illness.	
Partners Who Can Help Make This Happen	**What Role They Can Play**
LA County Department of Mental Health	Administer and provide full range of specialty mental health services to PEH with serious mental illness.
LA County Department of Homeless Services and Housing	Administer and provide complex care management services to PEH with serious mental illness to ensure access to and utilization of available clinic-based and field-based Severe Mental Illness (SMI) treatment services.
LA County Department of Health Care Services	Administer and provide mental health services to PEH with serious mental illness.
Los Angeles Homeless Service Authority	Coordinate provision of mental health outreach, engagement and services in encampments, shelters and permanent supportive housing.

Recommendation 1.5: Ensure that health insurance outreach and enrollment, physical and mental health care services, and substance use prevention, harm reduction and treatment services reach PEH who experience discrimination and exclusion due to their race, immigration status, gender identity, sexual orientation and/or mental health status.

Expand outreach and engagement effort targeting marginalized and hard to reach groups. Hire staff from communities served to improve engagement and trust. Support and maintain workgroups or taskforces that identify and guide strategies to reduce barriers for underserved PEH while advancing the universal goal of equitable access, using the Black People Experiencing Homelessness workgroup as a model.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Enact ordinances that promote equity; Allocate funds for services to marginalized groups.
City Mayors and Councils	Enact ordinances that promote equity; Allocation of funds for services to marginalized groups.
LA County Department of Homeless Services and Housing	Ensure that all outreach, interim housing, permanent housing, case management, and complex care management services are provided with cultural competence and that services are designed and delivered to reach historically underserved and marginalized populations. Utilize data to monitor and improve systems to ensure reduction of racial disparities in access to and utilization of all housing,
LA County Anti-Racism, Diversity and Inclusion Initiative	Develop equity metrics for Measure A implementation and support the equitable distribution of funding and services via the Equity Implementation Committee. Incorporate equity into training and capacity building for organizations working to house homeless TAY and older adults more efficiently.
Community Based Organizations	Recruit, hire and retain staff from impacted communities to improve trust and service uptake; deliver culturally appropriate services; provide feedback and lived experience to shape equity work.

Key Indicator #2: Drug Overdose Mortality Rate Among People Experiencing Homelessness

Recommendation 2.1: Ensure that housing options for people experiencing homelessness support harm reduction, overdose prevention and substance use treatment goals.

Expand the range of housing options, across the housing continuum, that support prevention and treatment goals such that: 1) harm reduction, overdose prevention, and substance use treatment services are readily accessible to people in all permanent and interim housing settings; 2) people who use drugs do not lose their housing due to substance use; and 3) recovery-oriented housing is accessible to residents desiring abstinence-focused living environment.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Set PEH housing policy priorities; Determine funding allocations.
LA County Department of Public Health	Collaborate with housing systems to ensure overdose prevention, harm reduction, treatment, and recovery services are available and accessible to people PEH.
LA County Department of Health Services	Collaborate with housing systems to ensure naloxone is accessible and harm reduction services are available to PEH.
LA County Department of Homeless Services and Housing	Apply and monitor standards for housing systems and coordinate with partners to ensure overdose prevention, harm reduction, treatment, and recovery services are available and accessible to PEH across the housing continuum.
Community Based Organizations	Distribute naloxone and provide overdose prevention, harm reduction, treatment and recovery services in interim and permanent housing settings.

Recommendation 2.2: Sustain and expand the Reaching the 95% Initiative to lower barriers to SUD treatment for people experiencing homelessness who don't seek treatment.

1) Remove abstinence as a prerequisite for initiating treatment; 2) extend the duration of engagement in substance use treatment services; and 3) increase the presence of community-based outreach and engagement teams to help people experiencing homelessness receive substance use treatment services.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Public Health	Establish and oversee components of the Reaching the 95% Initiative.
Community Based Organizations	Implement 95% Initiative through community-based outreach and engagement activities.
Hospitals and Clinics	Facilitate 95% Initiative education and referrals for PEH patients.
Managed Care Organizations	Advance policies and programs that promote the 95% Initiative education and referrals for PEH patients.
LA County Departments of Mental Health, Health Services, and Homeless Services and Housing	Implement 95% Initiative through community-based outreach and engagement activities.

Recommendation 2.3: Expand and extend harm reduction and overdose prevention services wherever people experiencing homeless are located.
Ensure that people experiencing homelessness have access to syringe services, naloxone and fentanyl test strip distribution and education, oxygen administration, low-threshold access to addiction medications like buprenorphine and methadone and screening and referral for substance use treatment and other physical and mental health services in all settings including jails, hospitals, interim housing, shelters, and unsheltered settings. Support outreach, consultation, and health hub services directly accessible to people experiencing homelessness.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Set SUD-related policy priorities for PEH in various settings; Determine funding allocations.
LA County Department of Public Health	Oversee and advance contracted overdose prevention, harm reduction, treatment, and recovery services for people PEH.
Community Based Organizations	Provide overdose prevention, harm reduction, treatment and recovery services across settings where PEH reside or congregate.
LA County Department of Health Services	Operate and coordinate harm reduction programs--including the DHS mobile clinic program and harm reduction health hubs--that ensure harm reduction and overdose prevention services are available to PEH.
LA County Department of Homeless Services and Housing	Coordinate with partners to ensure housing systems and outreach programs distribute naloxone and ensure that overdose prevention, harm reduction, treatment, and recovery services are available and accessible to people PEH.
Hospitals and Clinics	Facilitate access to harm reduction and SUD treatment services for PEH patients.
Carceral Facilities (Jails and Prisons)	Facilitate access to overdose prevention, harm reduction, treatment, and recovery services for PEH inmates and reentry population.
LA County Department of Homeless Services and Housing	Coordinate with partners to ensure housing systems and outreach programs distribute naloxone and ensure that overdose prevention, harm reduction, treatment, and recovery services are available and accessible to people PEH.

Recommendation 2.4: Sustain and expand access to clinically effective addiction medication services for people experiencing homelessness.
Ensure that all physical health, mental health, and substance use treatment providers who serve people experiencing homelessness can provide clinically effective addiction medication services with minimum barriers to access in all settings where they can be feasibly administered.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Set SUD treatment policy priorities; Allocate SUD treatment funds.
Managed Care Organizations	Advance policies and programs that promote the use of addiction medications in primary care, specialist medical care, hospital care, and street medicine programs.
LA County Department of Public Health	Oversee and advance the provision of addiction medication services through contracts with substance use treatment agencies that serve PEH.
LA County Department of Mental Health	Advance the provision of addiction medication services as a component of mental health care services for PEH.
LA County Department of Health Services	Advance the provision of addiction medication services through DHS provided services for PEH.
LA County Department of Homeless Services and Housing	Coordinate with partners to ensure PEH in unsheltered, interim housing, and permanent housing locations can access clinic-based or field-based providers in a timely, equitable, and effective manner.
Hospitals and Clinics	Facilitate access to addiction medication services for PEH patients.
Community-Based Organizations	Facilitate access to addiction medication services for PEH.

Recommendation 2.5: Integrate peer-driven and peer-led services into the continuum of substance use prevention, harm reduction and treatment services for people experiencing homelessness

Ensure that people with lived experience have a direct role in shaping and delivering substance use-related services for Los Angeles County residents experiencing homelessness.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Public Health	Build peer-driven models into contracts with community-based substance use prevention, harm-reduction and treatment providers.
Community Based Organizations	Prioritize hiring of people with lived experience for substance use prevention, harm reduction and treatment services.
LA County Department of Mental Health	Coordinate peer-driven mental health outreach and treatment programs with peer-driven SUD harm reduction and treatment program and facilitate referrals.
LA County Department of Health Services	Operate and coordinate peer-driven harm reduction programs and incorporate peer-driven services throughout DHS services for PEH.
LA County Department of Homeless Services and Housing	Coordinate with partners to ensure PEH in unsheltered, interim housing, and permanent housing locations access peer-driven harm reduction programs.

Recommendation 2.6: Advocate for policies, regulations, and laws that make the continuum of substance use prevention, harm reduction and treatment services more accessible to people experiencing homelessness.
Continue to identify and advance opportunities to establish safer consumption sites when there is a legal pathway to do so. Ensure people experiencing homelessness who are incarcerated receive and on re-entry are linked to comprehensive medical, mental health, and substance use care, particularly substance use treatment, including universal access to all clinically effective addiction medications.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Establish policy priorities; enact ordinances; Advocate policy priorities to state and federal government.
LA County Department of Public Health, Health Services, Homeless Service and Housing, and Mental Health	Recommend policy priorities to LA County Board of Supervisors.
Community Based Organizations	Organize communities around policy priorities; Advocate for policies and regulations to LA County Board of Supervisors and to state government.

Key Indicator #3: Coronary Heart Disease Mortality Rate Among People Experiencing Homelessness

Recommendation 3.1: Sustain and expand comprehensive primary and preventive care services for people experiencing homelessness.
Prioritize those at risk for or suffering from coronary heart disease and other chronic heart conditions by ensuring continuity of field-based interventions such as medication adherence support (e.g., direct dispensing), influenza vaccination, and access to point of care devices and capabilities such as electrocardiogram, ultrasound, and labs to ensure timely diagnosis and management.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Set policy priorities; Authorize funding allocations.
Managed Care Organizations	Set priorities for network providers; Support field-medicine initiatives to increase access to and utilization of cardiac disease prevention and treatment services; manage linkages to hospital and specialty care.
LA County Department of Homeless Services and Housing	Through contracted and direct-service providers, offer complex care management and care coordination services for clients at risk for cardiac morbidity and mortality in unsheltered, interim housing and permanent housing settings.
LA County Department of Public Health	Provide education about influenza vaccination and infection prevention to homeless services providers.
Community-Based Organizations	Link PEH clients to appropriate community and clinic based preventive health care services.

Recommendation 3.2: Expedite and facilitate unhoused patients' access to cardiac testing, medications, procedures and care.
Facilitate voluntary placement in recuperative care and other supportive interim housing settings to better diagnose and manage cardiac disease. Ensure ready access to high quality cardiologists for care of PEH with complex cardiac conditions through specialty referral authorization/scheduling and transportation services.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Allocate funds for recuperative care.
Hospitals	Facilitate placement of PEH patients in recuperative care and reimburse providers.
Managed Care Organizations	Facilitate placement of PEH patients in recuperative care and reimburse providers.
LA County Department of Health Services	Provide clinical staffing for recuperative care settings.
LA County Department of Homeless Services and Housing	Prioritize care for patients at risk for and diagnosed with cardiac disease.
Community-Based Organizations	Link PEH clients to appropriate community and clinic based preventive health care services.

Recommendation 3.3: Address substance use disorders as contributors to cardiovascular deaths among people experiencing homelessness.
Stimulant use disorders (particularly methamphetamine use disorders) are a significant risk factor for premature cardiovascular disease and death. Prioritize field-based stimulant use disorder interventions for those clients with existing heart disease and additional risk factors predisposing them to heart disease.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Public Health	Train providers to screen meth-using patients for cardiac disease and make appropriate referrals for cardiac care.
LA County Department of Health Services	Train providers to screen cardiac patients for meth use and provide appropriate referrals for SUD care.
LA County Department of Homeless Services and Housing	Through contracted and direct-service providers, offer complex care management and care coordination services for clients at risk for cardiac morbidity and mortality in unsheltered, interim housing and permanent housing settings. Encourage and support contracted providers to offer Medication Assisted Treatment (MAT) and contingency management programs for PEH with stimulant use disorders.
Managed Care Organizations	Cover full range of cardiac services for patient who use meth.
Community-Based Organizations	Link PEH clients to appropriate community and clinic based preventive health care services.

Recommendation 3.4: Train health care and social service providers to better understand and accommodate the special needs and circumstances of people experiencing homelessness when making chronic disease management recommendations.

Accommodate these special needs when delivering cardiac care and other disease and case management, including simplifying medication regimens, addressing the social and psychiatric needs of clients, accounting for insecure physical environments, and delivering health and social care in a non-judgmental and appropriately paced way.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Homeless Services and Housing	Train contracted and County staff providing outreach, care coordination, and complex care management services in unsheltered, interim housing, and permanent housing settings to provide trauma-informed, specialized care to PEH whose life circumstances necessitate non-traditional, high-intensity, and multidisciplinary care and accompaniment.
LA County Department of Mental Health	Train mental health care providers on special considerations for PEH care.
Hospitals and Clinics	Train hospital and clinic staff on special considerations for PEH care.
Managed Care Organizations	Train network providers on special considerations for PEH care.
Community Based Organizations	Train case workers and community outreach workers on special considerations for PEH care.

Key Indicator #4: Traffic Injury Mortality Rate Among People Experiencing Homelessness

Recommendation 4: Conduct a more detailed analysis of 2024 traffic injury deaths among people experiencing homelessness to inform preventive policy, program, and/or infrastructure interventions.
Classify deaths by roadway type, situational context, proximity to encampments and other relevant landmarks, demographics and geographic clustering to identify most frequent causes of collisions. Convene workgroup of relevant agencies based on roadway types (e.g., Caltrans for interstate highways) geographic clustering (e.g., local transportation agencies and homeless Continuums of Care) and other relevant factors to identify mitigation strategies.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Public Health	Analyze of Medical Examiner and statewide traffic collision data for 2024 PEH traffic injury deaths; Present results to state, county and city partners; Facilitate development of strategies.
Los Angeles Homeless Services Authority	Provide geographic data on encampments and other relevant congregate settings for mapping in relation to traffic injury deaths.
LA County Department of Public Works	Provide input on analysis methods; Assist with development of strategies to reduce PEH traffic injury deaths.
City of LA Department of Transportation	Provide input on analysis methods; Assist with development of strategies to reduce PEH traffic injury deaths.

Key Indicator #5: Homicide Mortality Rate Among People Experiencing Homelessness

Recommendation 5: Sustain and expand violence prevention and intervention services for people experiencing homelessness within Trauma Prevention Initiative (TPI) communities.
Ensure that TPI services, such as Street Outreach and Community Violence Intervention and Hospital-based Violence Intervention, are available to individuals who are experiencing homelessness, including ensuring that adequate resources and referrals are in place to help people victimized by violence obtain housing.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Board of Supervisors	Establish violence and trauma prevention policy priorities; Allocate funds; Enact relevant ordinances.
LA County Department of Public Health	Oversight and leadership of Trauma Prevention Initiative (TPI); Invest in intervention services and build capacity of community-based organizations.
LA County Department of Mental Health	Train community-based organizations and TPI contracted agencies on trauma informed care practices and prevention strategies.
LA County Department of Youth Development	Train TPI contracted agencies and CBOs on available youth development, diversion and school-based services and referral process.
LA County Department of Parks and Recreation	Co-develop/revise referral protocols for individuals experiencing homelessness at County parks in TPI communities.
LA County Justice, Care, and Opportunity Department	Co-develop referrals protocols to Care First Community Investment (CFCI) Initiative funded agencies in or near TPI communities providing supportive services.
Community Based Organizations	Conduct community outreach and engagement; Organize communities around violence prevention, intervention and healing policy priorities; Implement crisis response, violence and trauma prevention interventions.

Key Indicator #6: Suicide Mortality Rate Among People Experiencing Homelessness

Recommendation 6.1: Provide Outreach and Engagement, Risk Assessment, Treatment, and Postvention Response Services to People Experiencing Homelessness

Take every measure possible to prevent suicides through direct service strategies provided in collaboration with housing and homeless service agencies, including outreach and engagement, thorough suicide risk screenings, treatment for individuals living with suicidal ideation and behaviors, and suicide postvention response for death by suicide the community.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Mental Health	Support coordinated outreach and engagement activities including conducting suicide risk screenings and ongoing treatment for individuals with suicide ideation and postvention response.
LA County Department of Health Services	Receive and apply consultations from Department of Mental Health's (DMH) Partners in Suicide Prevention.
LA County Department of Homeless Services and Housing	Receive and apply consultations from DMH Partners in Suicide Prevention.
Los Angeles Homeless Services Authority	Receive and apply consultations from DMH Partners in Suicide Prevention.

Recommendation 6.2: Provide Suicide Prevention Trainings for Clinical and Non-Clinical Staff Working in Interim and Permanent Housing Settings

Provide clinical trainings, including Assessing and Managing Suicide Risk (AMSR), as well as consultation and technical assistance to clinical staff and contracted providers at Enhanced Emergency Shelter Programs for transition age youth (TAY), domestic violence shelters, and to clinical staff and contracted providers in County departments who serve PEH in interim housing settings. Provide Question, Persuade, and Refer (QPR) trainings to non-clinical County and contracted gatekeeper staff serving PEH, so they learn how to recognize the warning signs of a suicide crisis and to question, persuade and refer those needing help.

Partners Who Can Help Make This Happen	What Role They Can Play
LA County Department of Mental Health	Support coordinated outreach and engagement activities including conducting suicide risk screenings and ongoing treatment for individuals with suicide ideation and postvention response.
LA County Department of Health Services	Receive and apply consultations from DMH Partners in Suicide Prevention.
LA County Department of Homeless Services and Housing	Receive and apply consultations from DMH Partners in Suicide Prevention.
Los Angeles Homeless Services Authority	Receive and apply consultations from DMH Partners in Suicide Prevention.

Methods Appendix

PEH Deaths and Population Denominators

Calculating annual homeless mortality rates requires estimates of the number of deaths among PEH and the total mid-year population of PEH each year. Most deaths among PEH are investigated by the Los Angeles County Department of Medical Examiner (ME). To identify the latter, we begin with all deaths flagged as homeless by the ME in our annual ME data file.[1] Next, from the ME flagged deaths we identify and remove those with permanent supportive housing (PSH) addresses in one or more address fields.[2] Then, from among those cases not initially flagged by the ME, we identify and add those with emergency shelter or transitional housing facility addresses in one or more address fields.[2] Finally, remaining non-flagged cases with homeless key words[3] in the investigator notes fields are independently reviewed by two analysts using Department of Housing and Urban Development (HUD) homelessness criteria.[4] Discrepancies are adjudicated by the full team, and cases deemed to meet HUD criteria are added to the ME-investigated PEH death count for that year.

To identify PEH deaths not investigated by the ME, ME PEH records are matched annually to California state death certificate records for LA County. Non-matching state death records are searched for evidence of homelessness, including: 1) emergency shelter and transitional housing addresses in any address fields, and 2) a homeless flag in the new state death record homeless field.[5] Decedents identified as PEH solely based on data from state death records are added to the count of ME-investigated PEH deaths to arrive at a final PEH death count for the year.

To estimate mid-year homeless population denominators for annual rate calculations, we calculate the average of two consecutive January point-in-time (PIT) homeless counts.[6] Because the PIT count was not conducted in January 2021 due to the COVID-19 pandemic, we used the average of the PIT counts for 2020 and 2022 as a proxy for the 2021 count (**Table 6**).

Causes of Death

We determine causes of death based on International Classification of Disease (ICD-10) cause of death codes in the underlying cause of death field in the state death record database. These codes are captured for ME-investigated PEH deaths matched with state death records, and for additional PEH deaths identified solely from state death record data. ICD-10 codes are grouped into cause of death categories according to standards set by the US Centers for Disease Control (CDC).

Geocoding of PEH Deaths

To explore the geographic patterning of PEH deaths we use QGIS to geocode death locations from ME and state death record data. When someone is transported to a hospital after a traumatic event and then dies in the hospital, ME investigators try to determine the event location. When available, we geocode the event location since it is more useful for targeting prevention efforts. Each year, event locations are missing for approximately 10-15% of PEH hospital deaths. For these, we use the hospital address as the death location. We use geocoded death location data to group PEH deaths by Zip Code and Service Planning Area (SPA). This year, we used this geographic information to map changes from 2023 to 2024 in the numbers of total deaths and deaths from the top three causes by SPA. We also created Zip Code tables by SPA with similar information.

1 The ME investigates all violent, sudden, or unusual deaths; unattended deaths; and deaths where the deceased does not have a physician (Govt. Code, § 27491). We obtain our annual ME data file on May 1st of the following year to allow four months for pending cases to be resolved.

2 PSH, Shelter and transitional housing addresses are obtained from the HUD mandated annual Housing Inventory Counts from the

3 Los Angeles, Long Beach, Pasadena, and Glendale homeless services authorities.

4 Key words included: homeless, transient, shelter, lives in van, lives in car, lives in vehicle, no fixed abode, no known residence, tent, encampment, indigent, skid row, vagrant, shed, Room Key, HomeKey, PEH, and institution. https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

5 On April 27th, 2022, new homeless fields were added to the state electronic death record system (EDRS). Prior to that, we searched the address fields for homeless key words, and location descriptions consistent with prior state instructions to local registrars on how to fill out address fields for homeless decedents.

6 The annual PIT count is conducted by the Los Angeles Homeless Services Authority (LAHSA). For example, our estimate of the mid-year population denominator for 2019 is the average of the January 2019 and 2020 counts.

Comparing Mortality Rates Among PEH Sub-Groups and Between PEH and the Total LA County Population

Using PEH demographic survey data collected in conjunction with the annual PIT count (**Table 6**), we compare age-adjusted trends in all-cause, drug overdose, and coronary heart disease mortality rates among PEH by race/ethnicity and gender. Age group data prior to 2020 did not conform to standards required for age adjustment of mortality rates. Because no PEH demographic survey was conducted in January 2021 due to the COVID-19 pandemic, we used the average of the 2020 and 2022 demographic estimates as a proxy for 2021. The 2010 LA County population was used as the standard population for the calculation of age-adjusted mortality rates.

We also compare all-cause and cause-specific mortality rates among PEH to those in the total LA County population. For this comparison, we calculate the annual age and gender-adjusted mortality rates for each group and then divide the PEH rates by the LA County rates to produce mortality rate ratios (MRRs). LA County demographic data are provided by Hedderson Demographic Services and LA County death data come from Provisional Annual Death Data Files for LA County. The 2010 LA County population was used as the standard population for age and gender adjustment.

We also compare all-cause and cause-specific mortality rates among PEH to those in the total LA County population. For this comparison, we calculate the annual age and gender-adjusted mortality rates for each group and then divide the PEH rates by the LA County rates to produce mortality rate ratios (MRRs). LA County demographic data are provided by Hedderson Demographic Services and LA County death data come from Provisional Annual Death Data Files for LA County. The 2010 LA County population was used as the standard population for age and gender adjustment.

Drug Type Analysis for Overdose Deaths

To determine the types of drugs that contribute to overdose deaths, we perform a text-based analysis of ME and state death record cause of death fields for PEH with drug overdose as the underlying cause of death. This analysis is based on a methodology developed and published by epidemiologists at the Food and Drug Administration and the National Center for Health Statistics. Any type of drug mentioned as a primary or contributing cause of death is deemed to be a contributing factor for that death, and multiple drugs can contribute to the same death. Using this methodology, each drug type is ranked according to the percentage of deaths to which it contributed.

1 PEH Demographic estimates are available only for the Los Angeles Continuum of Care which excludes Long Beach, Glendale, and Pasadena. To produce countywide estimates, we assume that the age, gender, and racial/ethnic makeup of the PEH populations in those three cities are the same as that of the rest of LA County. This assumption is reasonable based on available data. Beginning in 2023, the PEH age-group categories available for age adjustment changed slightly. Prior to 2023, the age categories used were: <18; 18-29; 30-39; 40-49; 50-59; 60-69; 70+. In 2023 these changed to: <18; 18-24; 25-34; 35-44; 45-54; 55-64; 65-69; 70+.

2 These mortality data sets are created by the LA County Department of Public Health's Office of Health Assessment and Epidemiology based on death certificate data obtained from the California Department of Public Health. Data for the most recent year are called provisional because they do not yet include out of state deaths for LA County residents.

3 Trinidad J, et al. Using Literal Text from the Death Certificate to Enhance Mortality Statistics: Characterizing Drug Involvement in Deaths. National Vital Statistics Reports. 2016; 65 (9): 1-14.