Deaths Among People Experiencing Homelessness: Each One, a Life

Lisa Wood, Associate Professor, School of Population and Global Health
and Shannen Vallesi, Research Associate, School of Population and Global Health

Deaths among people experiencing homelessness in Australia remain largely 'invisible' — these deaths do not appear in routinely reported national mortality and life expectancy statistics,[1] and they don't tend to make newspaper headlines nor obituaries.

Yet each death is and was a human life.

Whilst we are ardent advocates for the need for Australia to follow the United Kingdom (UK) lead in reporting annually on homeless deaths,[2] and for preventable homeless deaths to be actually prevented,[3] we should never lose sight of the people behind the statistics.

In 2020 alone, our team was notified of 56 deaths in the Perth homeless population through homeless health services we work alongside. Since we began 'counting' homeless deaths in 2016, we have recorded 177 deaths, with an average age of death of 47.9 years (age range 17 to 77). We are well aware these are not the only deaths, but only include those with a verified date of death.

Each of these deaths marks the end of the life of a unique individual, with different journeys into homelessness, and a raft of different factors and experiences shaping the consequences of homelessness and its impacts on their physical and mental health and social wellbeing. And as each story conveys, no one sets out in life to be homeless.

Each One a Life…

Dismally, there are dozens of case studies and stories of people experiencing homelessness who have died prematurely in the last two years in Western Australia (WA) alone. Below we highlight just a handful, but it's important to remember that each one was a life. The names used are not real, but sadly the stories are, and there are many others like them across Australian our cities and towns.

Trauma is one of the most pervasive commonalities among people who have died prematurely. Trauma in turn often underlies mental health and alcohol and drug use issues.

Daniela* was a 22-year-old female who had been sleeping rough on the streets for over three years, before getting housed. She had experienced childhood trauma and sexual abuse, contributing to her history of problematic drug and alcohol use and mental health issues, including suicidal ideation and self-harm. Daniela was well known to mental health services, and had been admitted to hospital previously following suicide attempts. She had an inpatient admission in early February 2020, was discharged, and sadly died by suicide several days later.

Warren* was 33-years old when he died. He had been homeless for three-quarters of his life, having become homeless at the age of eight after his family abandoned him. Warren had a long history of suicidality and methamphetamine and heroin dependence since his early teens, which he stated he used to *'escape the reality of his life.'* Trauma had contributed to his complex mental health issues, including EUPD, psychosis, and self-harming (often feeling that voices in his head were telling him to harm himself). Warren had not had contact with his family for many years, but a couple of years before his death, expressed that he had children that he wanted to reconnect with.

When not sleeping on the streets or in a tent, Warren couch surfed with friends or had short periods in accommodation, but struggled to retain accommodation due to his drug dependency. Over the few years prior to his death, his mental health further deteriorated, with increasing presentations to Emergency Departments (EDs) with evidence of self-harm, psychotic symptoms and suicidal ideation. Warren was well known to the mental health system but was often wary of engaging with health and homelessness services until at crisis point. He died in July 2019. Cause of death not known.

For individuals with a chronic health condition, the impact this can have on daily life and wellbeing can be all-consuming. Imagine having multiple chronic health conditions, and trying to manage these while living on the street. Keeping track of medications, making medical appointments, getting to health services are all common challenges, compounded by lack of sleep, poor nutrition, and anxiety.

Naomi* was a 47-year-old female with a severe auto-immune disease that affects multiple organs. It caused chronic renal failure, heart failure, and painful oesophageal ulcers. Naomi was rough sleeping and staying in women's refuges for at least a year before her death. In addition to her extensive physical ill-health, Naomi had experienced repeated abusive domestic violence from a prior partner, and had been hospitalised with injuries from this on numerous occasions.

On her last hospital admission prior to death (for oesophageal bleeds), Naomi had 15 different prescribed medications to treat her various health conditions. As noted by Dr Amanda Stafford from the RPH Homeless Team, *'It is impossible to manage such a complex disease and its health complications if you are living on the street.'*

As is quite common among homeless patients who have experienced trauma, Naomi discharged herself from her last hospital admission (for oesophageal ulcer bleeds and a clot) 'against medical advice'. She passed away six weeks later, in May 2020.

Alijah* was a 46-year-old Aboriginal man who had spent at least 15 years living mostly on the streets or parks with only short periods in temporary accommodation. Efforts to assist him with housing were hampered by his severe alcoholism as accommodation providers will not accept people with active substance use issues. He had frequent ED presentations with intoxication and repeated bouts of alcohol-induced pancreatitis requiring hospitalisation. His pancreatic function progressively declined leading to unstable diabetes developing in 2014 which required insulin therapy to survive.

Alijah's situation, combining sleeping rough, active alcoholism and diabetes that required regular food and insulin therapy was impossible to manage in the community and resulted in frequent hospital admissions with diabetic coma, from which he would discharge himself to the streets once improved. In 2019, he returned to Country but two months later was transferred back to Perth after having a heart attack. The pattern of frequent hospitalisations with diabetic coma continued for a further six months before he died of heart failure in hospital in May 2020.

The grim reality is that even once someone who has experienced chronic homelessness is housed, their risks of premature death often remain high. Chronic health conditions and the erosion of mental health and hope whilst homeless, takes its toll:

Fabian* was a 46-year-old male with chronic paranoid schizophrenia and longstanding auditory and visual hallucinations. He was studying pharmacy when he was diagnosed in his early 20s. After being kicked out of home, he had multiple transitional accommodation placements and periods of rough sleeping. Fabian had a number of serious physical health issues, including diabetes, hepatitis c, obesity, hypertension and ischaemic heart disease.

Upon discharge from a lengthy stay in a mental health unit, his Mental Health Homeless Pathways (MHHP) Social Worker supported to get him into transitional accommodation and on the priority housing list for the Housing Authority. He was also linked with an After-Hours Support Service (via *50 Lives 50 Homes Housing First*) for weekly support. Fabian had told them he loved going to the park and listening to music, so staff from the After-Hours team would often take him to Kings Park for a walk and chat. After three months of being in transitional accommodation, a forever home was allocated to him. Here he settled happily in his own space with his *'black leather couch and TV'*.

Tragically, in December 2019, Fabian was found dead in his unit by police after a welfare visit had been requested because his social worker has become concerned about not hearing from him. It was deemed a death by natural causes. Fabian had only been housed for two weeks when he died. As reflected by his MHHP Social Worker:

'Sadly, this happens all the time — people get housed and they pass away soon after… they relax, let go and are no longer in that heightened state of survival — and sadly pass away.'

And finally, there is far too many deaths from health conditions that are preventable or able to be treated if detected earlier. For people who have been rough sleeping for many years, and who face barriers to healthcare and housing access, it can come too late:

Neil was a 63-year-old male, with a 10-year history of rough sleeping. He was one of seven children, and had three children of his own, but had lost contact with most of his family in the few years prior to becoming homeless. Neil has been through a number of traumatic experiences in his earlier life including a serious car accident as a toddler that hospitalised his mother for a year, and the tragic death of his youngest brother at age 21. Struggles with alcohol plagued him most of his life, and contributed to being in and out of jobs over the years.

Family and others had offered to help Neil get off the street, but as one of his sister's recounts, he was too proud to accept assistance, and felt that he himself was to blame for his situation. He would sleep at a park where he felt safer, but each day for 10 years sat on the steps of Trinity Church in the Perth central business district, often reading a book. He was well known and respected by people working in the city who would pass by. Here Homeless Healthcare's Street Health outreach nurse and GP would stop by regularly to see how Neil was doing, and gradually he opened up that he had a plan 'to get a house, job and rekindle my relationship with my children and grandchildren.' He went onto the priority list for public housing, and UnitingWA arranged interim accommodation while he waited for housing.

In early 2020 Neil contracted a chest infection and was experiencing shortness of breath when he tried to walk even a short distance. He had had minimal contact with doctors for much of his adult life, but COPD was suspected and he attended hospital to get some tests. He was diagnosed with a

chest infection and Stage 4 lung cancer. Neil had quit smoking just a few months before, but had been a pack a day smoker since his early teens, taking its toll on his lungs and health.

Neil sadly passed away in September 2020, only a few weeks after his diagnosis. A public housing offer came through for him just eight weeks after his death.

In his final month, Neil was able to fulfill his wish to rekindle his relationship with family, talking regularly with his sisters, and reconnecting with his children. Unfortunately, due to COVID-19 lockdown, his son was not able to get to Perth.

Neil was well loved in the Perth CBD community as the friendly man who sat on the Trinity church steps, and there were many tributes left to him on the steps.

(permission has been granted from Neil's family to use his name and photo).

Each Death Has a Ripple Effect

2020 was a difficult year on many fronts and COVID-19 shone a light on the poor response (particularly in WA) to get people off the street and into safe accommodation. Each of the 56 known deaths in the Perth homeless community in 2020 had a ripple effect.

For people who are rough sleeping, it is devastating and confronting to see others in your own situation dying too young:

> *Homelessness means Community. When you hit the streets, your best friend is anyone else who is homeless. From them you get all the street info of where to get food, blankets and how to be street savvy. I have known about others who have taken their own lives because they can't hang on. Communities, such as tent camps, feel the loss of a friend as just as you would a neighbour next door. Human emotion is no different living on the streets. Deaths among the street community scars and affects all of us for life. Should I have gone too?*
>
> — Jonathan Shapiera, WA Council of Lived Experience

It impacts on staff in homelessness and homeless health services who work at the coalface with people experiencing homelessness.

> *With people who have fallen through the cracks of the health, housing and social systems, it takes regular reaching out to build a personal connection. Being a friendly, familiar non-judgemental face is vital in our street health outreach, and it can take a long time for people with deep hurts to open up and be willing to accept assistance. If they then pass away, it is hard not to worry that you didn't do enough, and you grieve the loss of someone you had gotten to know.*
>
> — Homeless Healthcare Outreach Nurse

> *It is hard as we get to know people over the years when they come to Homeless Healthcare for appointments. Sometimes we might be the only people they get to chat to in a day. So it is really sad when we get an email from the Coroner's office, or a phone call from an ambulance driver or the police about someone that has just died. And it is really heartbreaking if we find out they died alone or on the street.*
>
> — Homeless Healthcare Receptionist

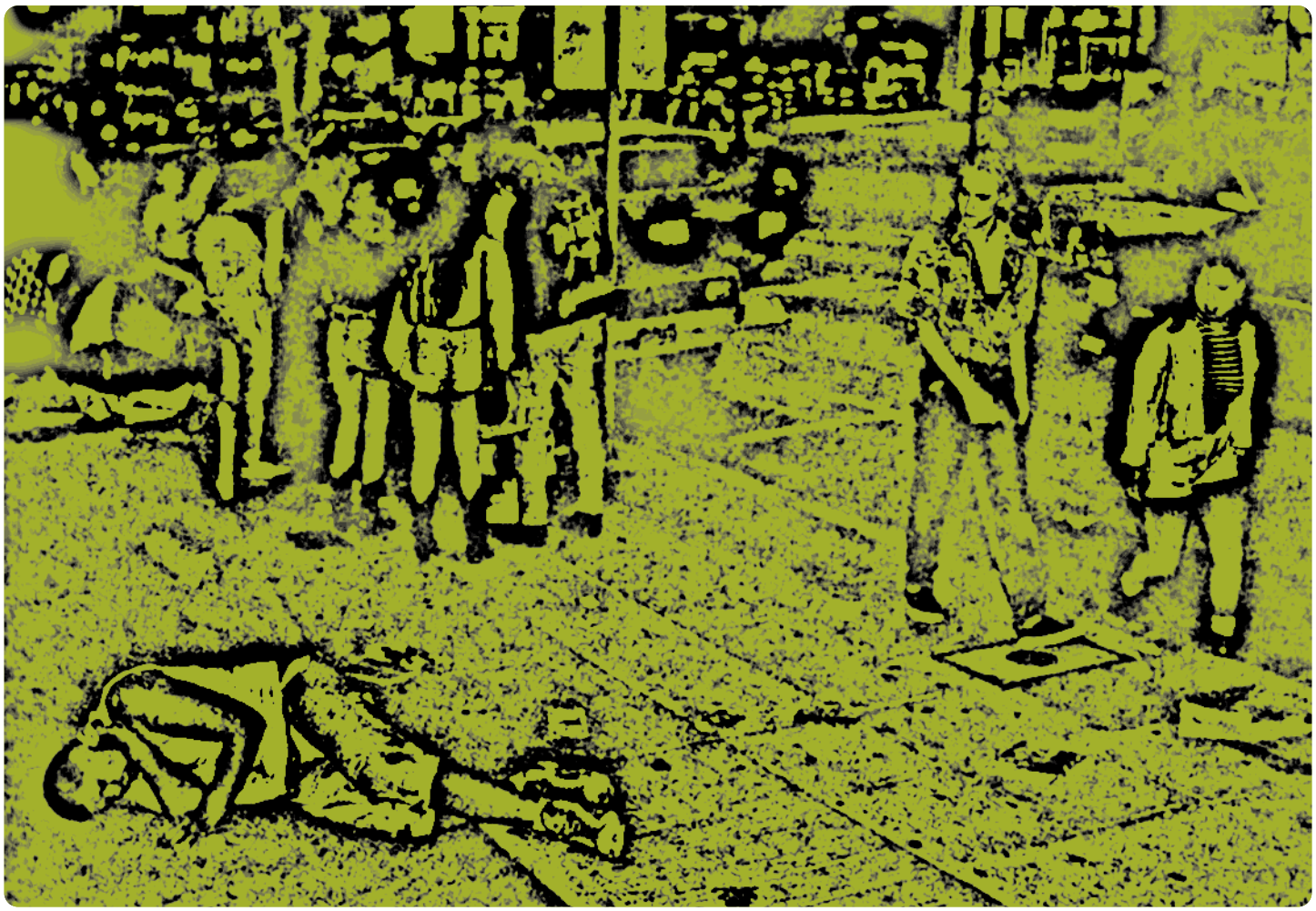
However, as sagely noted by Dr Amanda Stafford who has worked at the coalface of homelessness and health for the past seven years:

> *Something I have learnt over the years is that we can't always save people from dying but we can make a big difference to the life they had, however short or tragic.*
>
> — Clinical Lead, Royal Perth Hospital Homeless Team

What Can We Do?

For each, there may have been ways to prevent the trajectories these lives took, or to have intervened earlier to prevent premature death. Unfortunately for these people it's too late, but we can learn from these stories and make targeted efforts to improve the systems that have failed them in the first place.

People experiencing homelessness continue to be over-represented on nearly every health risk factor and morbidity statistic. Australia has had significant public health successes on a number of fronts, including declines in smoking and associated diseases, and reducing deaths from



preventable cancers (cervical and bowel) through proactive screening, but these have made little inroad with people experiencing homelessness.[4]

The notion of 'deaths of despair' is particularly salient in seeking to understand how it is that people experiencing homelessness on average, do not live to even the age of 50. Deaths of despair, a term that originated in the United States and has gained research and policy traction, refers to deaths relating to drug overdoses, suicide and alcohol-related disease amongst people who have experienced compounded social and economic disadvantage.[5] Dual mental health and drug and alcohol issues are common,[6] but people often struggle to navigate the silos between different parts of the health system, and it is immensely difficult to detox from drug use or engage in trauma recovery if you don't have a home.

The appalling gap in life expectancy for people experiencing homelessness is not well known, but should be. Unfortunately, we live in a society that likes to blame people for the situations they find themselves in. But trauma is often what drives people into homelessness, and trauma is compounded when you try to survive day after day without a roof over your head.

— CEO and Medical Director, Homeless Healthcare

While not all deaths are avoidable, there were many points in these lives where homelessness and its enormous consequences might have been prevented. Prevention of homelessness and premature deaths also necessitates greater effective investment into tackling the underlying causes of homelessness — particularly poverty, childhood trauma, and family and domestic violence. The duration of homelessness also contributes to premature deaths and rapid access to housing is fundamental to extending people's lives and to restoring their hope.

Acknowledgments

We would like to thank staff from the Royal Perth Hospital Homeless Team, Mental Health Homeless Pathways Project and Homeless Healthcare for their input into the stories presented in this article.

Immense thanks also to the family of Neil who allowed us to share some of his story and photo.

Last but not least, thank you to the many people experiencing homelessness who we have been privileged to meet and learn from over the last five years; their resilience is humbling.

Endnotes

1. Australian Institute of Health and Welfare 2021, *Deaths in Australia*. *https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia*.
2. Office for National Statistics 2020, *Deaths of homeless people in England and Wales — local authority estimates: 2013 to 2019*.
3. Aldridge RW, Menezes D, Lewer D et al 2019, Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England, *Wellcome Open Research*, vol. 4, no.49.
4. Wood LJ 2020, Homelessness: the imperative for a public health response, *Australian and New Zealand Journal of Public Health*, vol. 44, no,5, pp.341–5.
5. Scutchfield FD, Keck CW, Deaths of Despair 2017: Why? What to Do? *American Journal of Public Health*, vol. 107, no. 10, pp.1564–5.
6. Vallesi S, Tuson M, Davies A, Wood L 2021, Multimorbidity among People Experiencing Homelessness — Insights from Primary Care Data, *International Journal of Environmental Research and Public Health* 2021, 18, no.12, p.6498.