Homelessness, Death and Dying: Project Report

The Council to Homeless Persons

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Executive summary

Feared or directly encountered, death is an unwanted companion for many experiencing homelessness. This involuntary familiarity is shared by those working in the sector. Dying – the process of death – is threaded into this reality. Rather than remaining in the shadows, the Council to Homeless Persons made the decision to focus directly on this difficult subject.

Designed as a formative enquiry, the commissioned project set out to identify what is known, and what remains unknown, about the relationship between homelessness, death and dying. More specifically, the aim was to learn how many people experiencing homelessness die each year – what are the metrics of the problem? – and to develop

options that would be helpful in responding to this problem. The outcome of this enquiry is summarised in the current report.

The first stage of the study identified, collated and reviewed published material (see Section 2). The priority in this sub-process was to locate local and international studies that examined statistical questions: rates of death; life expectancy, cause of death, and so forth. Around 100 relevant reports were found and evaluated. The great majority of these reports appeared in refereed journals; a limited number had the status of official report: see the separate, semi-annotated literature review.

The findings drawn from this review were:

- little research has been conducted in Australia, for example, it is not known how many of those who experience, or who have experienced, primary homelessness die annually
- there is an international consensus that homelessness produces what *The Lancet* termed 'extreme health inequalities.' Technically expressed, there is agreement that homelessness produces elevated mortality ratios and reduced life expectancy: those who experience primary homelessness have a 3 to 7-fold chance of dying (Morrison 2009:877) prematurely, typically at around 50 (National Health Care for the Homeless Council, 2006);
- nearly one in three homeless deaths (are) due to causes amenable to timely and effective health care (Aldridge at al., 2019), and.
- the few local studies which are available report conclusions that align with those presented in the international literature.

The second stage of the project focused on identifying what is known about the qualitative dimensions of homelessness, death and dying (see Section 3). A small number of refereed reports were identified. Mindful of this limitation, these studies suggest death and dying is a common spectre in the lived experience of those who are homeless. A range of first-person accounts were also considered. These reports supported the conclusion drawn from the refereed research.

The third stage of the project sought to understand why there is such a paucity of local empirical data. The first step in developing this knowledge was to identify the many agencies and official bodies who play a role in the recording and registering of this data. This review produced a considerable volume of secondary material, including information on how data – 'cause of death', 'housing status'; etc. – is communicated. A series of direct consultations with relevant actors was also undertaken. This process produced a clear conclusion: there is a 'knowledge block' with respect to the data recording and communication of available information about the nexus between homelessness, death and dying.

This is more than a simple gap in our knowledge. The question needs to be asked: why is there a knowledge block? There are several possible levels of explanation. Not the least of these is the presence of a complex and diverse assembly of different actors and agencies, where each operates largely in the isolation of their own practices. It follows that the 'chain of custody' – the information flow – is significantly discontinuous. Moreover, key data fields

are often poorly recorded. This is particularly an issue with respect to 'housing status.' The current exercise concluded this field is often inaccurately recorded in ways that minimise the number of 'no fixed abode' / 'homeless' entries recorded by the Coroner's office, by hospitals, and by the respective departments of Births, Deaths and Marriages.

Another problematic data point is 'cause of death'. Rather than considering the mix of immediate, underlying, intermediate and contributing causes, the project's preliminary investigation suggested that current practices tend to narrowly investigate and review the deaths of those who are homeless. In so much as this is the case, a finding of 'natural causes' tends to be preferred. This pattern that disproportionately records 'natural causes' as the reason for death is a potential issue that has a negative consequence, that is, this disposition undermines the incentive to think in terms of prevention.

Homelessness invites premature death. This is proven even if the local metrics that express this relationship remain empirically opaque and indeterminate. Against this background, a final component of the report canvasses options for delivering more reliable data, for improving the quality of oversight, and for enhancing the possibility that service providers will be able to support those who are experience homelessness at the end of life, to be able to die with dignity.

Even as every effort is being made to minimise its influence, death will continue to shadow those who are homeless, and those who work to support these individuals. Bringing the connections between homelessness death and dying out of the shadows and into the light of day, was the business of this research project.

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1. Introduction

Death is an important subject. Dying has great significance. Both are difficult to consider and to discuss. The Council to Homeless Persons (CHP) made the decision to focus on these subjects in order to relocate death and dying away from the periphery, to the centre of attention. Why was this decision taken?

Death is an unwanted reality amongst those who are homeless. For too long this presence has remained a foreboding threat, a scary companion that lurks menacingly in the shadows. Rather than remain nameless, CHP believes it is time to openly address this presence and to explicitly document its relationship with homelessness. While not exactly taboo, there have been constraints that have limited the examination of this relationship. It is our intention to take these emotional, and yet also very practical, subjects away from the edge of awareness and make them a priority in the wider discussion of homelessness. To do this requires and warrants a dedicated focus.

It tends to be assumed that people experiencing homelessness have higher rates of mortality than the wider population. It is less well known that people experiencing homelessness often die of preventable illnesses – conditions that are, at least to a significant degree, attributable to their homelessness. The available statistics are unable to reveal how many people who die while homelessness, die alone, uncared for and unsupported. Yet this reality contradicts a fondly held social myth.

Mostly, it is expected that death is the culmination of a life that is well-lived; that older people will die having had a long life, and after receiving a good-enough quantum of care and support. In the idealised scenario a person dies at home surrounded by loved ones, or in a situation of care that has prolonged life for as long as possible. For many people experiencing homelessness, this scenario bares no relationship to their reality.

Given that resources for this project were limited, a formative study was the most that could be undertaken. This project commenced in April and concluded in late July. Organised with respect to this strict limitation, the *Homelessness, Death and Dying Project* aimed to document what is known, and what remains unknown, about death and dying, as these subjects relate to homelessness. The project sought to honour and acknowledge the position of Aboriginal people and the complexity of their experiences of homelessness. Greater attention was also directed towards primary homelessness. A secondary priority was to homelessness associated with family violence. Given the constraints and limitations of the project, it was not possible to give this population due attention, nor was it possible to adequately consider youth homelessness, homelessness associated with the LGBTI+ community and the position of refugees and asylum seekers.

Data collection was predominately from secondary sources. Amongst these sources, the key input was derived from a purpose-built literature review. This review identified and summarised almost one hundred items. The great majority of these entries related to published, peer-referred research papers; a far smaller number were from the non-refereed reports ('grey literature') and media transcripts. The findings from the analysis of the literature review informed the body of this current report. Every effort has been made to

ensure this material is rendered in an accessible form for the non-specialised reader, mindful it is impossible to avoid using several key technical terms, for example, 'SMRs' (standardised mortality ratios).

Secondary sources were complemented by data that was directly gathered from local sources, including field visits to, and documents from, specialist homelessness services (SHS), public health services, state agencies and other relevant bodies, such as funeral directors. In these consultations and secondary enquiries, considerable attention was given to identifying the mechanics of, and the difficulties with, data recording, collection and distribution with respect to death, housing status and the causes of death. For example, legislation, and to a degree practice conventions, determine under what circumstances deaths are, or are not, referred to, and accepted by state coroners, for investigation. None of this data is secret, or secretively held. Nonetheless, it was not immediately apparent how this information was collected, collated and passed on.

The project was designed to produce two outputs. The major output is the current report. This report should be considered in conjunction with a separate semi-annotated literature review. An abridged report is a second product. This summary paper was published in the August 2019 edition of *Parity*, the national publication of the Council to Homeless Persons.

Launch Housing, Sacred Heart Mission and Wintringham in Victoria, Hammond (New South Wales) and Micah Projects (Queensland) sponsored the project. Our appreciation to these agencies for their essential support. Without this support this project would not have been possible,

2. The empirical account

2.1 Overview

The relationship between homelessness and premature death has been the focus of sustained research. An editorial in *The Lancet* summarises a key research finding:

> *… being without a home has long been recognised as being associated with increased rates of physical and mental morbidity. Over the past decade, cohort studies have shown that these higher rates of morbidity translate into excess mortality* (Geddes and Fazel, 2011: 2156).

There are multiple reasons why those who experience homelessness face 'excess mortality.'

One cause of premature death is an elevated risk of suicide. A ten-year follow-up study from Denmark reported that death by suicide was six times more frequent for those who had experienced homelessness than for the general population (Nordentoft and Wandall-Holm, 2003: 81). Another cause of premature death is unintentional injury. The above study found that death caused by unintentional injury is fourteen times more likely for those experiencing homelessness than for those who are housed.

Even more striking was this study's finding concerning death due to 'unknown causes.' The study found that people experiencing homelessness died from 'unknown causes' sixty times more frequently than those who were not homeless. It seems homelessness is not only perilous, but the death of people experiencing homelessness is so unremarkable that an astonishing proportion of these deaths are attributable to unknown causes. However, disturbing this possibility may be, it does align with the finding from Maryland United States (US) that 65.2% of the 279 homeless people who died as a result of violence over an eight-year period, '(m)ore than half (65.2%) of deaths were of undetermined intent' (Stanley et al., 2016: S260).

It is impossible for statistics alone to convey the actuality of homelessness. Figures, for example, are unable to communicate the sense of jeopardy experienced by individuals who are homeless. However, limited, statistics do paint a stark general picture. For example:

> *'(the) average age of death of homeless persons is about 50 years, the age at which Americans commonly died in 1900'* (National Health Care for the Homeless Council, 2006).

Other estimates include, 48 years (Toronto), 47 years (United Kingdom (UK)), between 42 and 52 years (USA) and 40 to 49 years (British Colombia). See also Hollows (undated). The above figure for British Columbia should be understood in the context of the local life expectancy being 82.65 – almost double of what it is for those who experience homelessness.

Why is it so perilous to be homeless? Premature death has different classes of cause. In part, a cause of premature death is illness. People experiencing homelessness 'suffer the same illnesses experienced by people with homes, but at rates three to six times higher' (National Health Care for the Homeless Council, 2006). Amongst a larger group of illnesses, the cause of premature death includes tuberculosis, influenza, gastric ulcers, cancer, heart disease, diabetes and hypertension. Mindful the aetiology of these illnesses is often rooted in the circumstances of homelessness – for example, poor nutrition, poor hygiene, stress, exposure to extremes of heat and cold – it is important to note that 'nearly one in three homeless deaths (are) due to causes amenable to timely and effective health care' (Aldridge at al., 2019). Access to an appropriate standard of diagnosis and treatment is frequently unavailable to those experiencing homelessness.

Premature death in the homelessness population is also associated with adverse life events. Suicide, accidental overdose, homicide and life-threatening accident are disproportionately present in the lives of those who currently experience, or who have previously experienced, homelessness. These events are associated with a larger pattern: rates of assault, robbery, intimidation, self-harm and accident are steeply higher than for the general population. Contributing factors include the effects of stigma, loneliness and social exclusion. The findings from the social determinants of health research are clear: at the edges of inequality, health outcomes tend towards the calamitous (Wilkinson and Pickett, 2011).

The above is conclusive. What is not known however, is the detail. This ignorance is most troubling in relation to one set of facts: it is not known how many people die who are

homeless. In Australia, as in a number of other so-called first-world nations, there is no register that records how many people who experience homelessness, die each year. It is also the case that nobody knows the role that a history of homelessness plays in effecting rates of mortality: if a person is currently housed, and this person has had a biography marked by 'iterative homelessness' (Robinson, 2011), to what extent would this history contributed to a premature death?

Australia's ignorance is replicated in many countries. According to Petra Salva, St Mungo's Director of Rough Sleeper Services in London, in the United Kingdom historically there has never been 'nationally collated, robust statistics around rough sleeper deaths' (Salva, 2018). Commenting on this situation, Jeremy Swain, the Thames Reach Chief Executive, said: 'It is extraordinary and unacceptable that national data on rough sleepers is so limited.' He added that a national database would 'be of enormous practical value' (as quoted in Salva, 2018).

These two speakers were quoted in a report from *The Dying Homeless Project*. This project was a collaboration between University College London and The Bureau of Investigative Journalism in the UK. Under the title 'Homelessness kills' (Bureau of Investigative Journalism, 2019), it was reported that this collaborative research project had found that:

> *… an average of 11 homeless people a week have died in the UK in the last 18 months. We have been collecting data dating back to October 2017 …; our tally now stands at 796 people. Of those people we know the age of, more than a quarter were under 40 when then they died.*

The conclusion reached in this report was that these 'figures are a devastating reminder that rough sleeping is beyond dangerous – it's deadly' (ibid, 11.03.2019). This project found that around one-third of these deaths were from treatable diseases. These illnesses include tuberculosis, pneumonia and gastric ulcers; illnesses that can potentially be improved with the right medical care. At least in part, due to the campaign this report spearheaded, '(o)n October 8, 2018 the Office for National Statistics announced it would start producing its own figure on homeless deaths' (Bureau of Investigative Journalism, 2018)

No such decision has been taken in this country. Like many other nations, Australia does not know how many of its citizens die while, or as a result of, homelessness. This is a major problem.

2.2 The relationship between health and housing

The international consulting firm Deloites produced a report entitled *Health Care for the homeless: Homelessness is bad for your health*. The executive summary of this report stated that:

> *Long-term homeless people often die at a much younger age than the general population and have a much poorer quality of life.*

> *Being homeless for even a short period of time increases the risk of long-term health problems'* (Taylor et al., 2012: 2)

The Deloites report outlined the evidence concerning the relationship between homelessness and ill-health. What is the effect of this relationship? As noted earlier, this relationship has been found to produce '(e)xtreme health inequalities' (Geddes and Fazel, 2011: 2156).

International studies show that a person experiencing homelessness is between 3 and 7 times more likely to die than someone of the same age and gender who is positively housed. Morrison (2009: 877) offers this summary:

> *Over 5 years of observation, 1.7% (209/12 451) of the general population and 7.2% (457/6323) of the homeless cohort died. The hazard ratio of all-cause mortality in homeless compared with non-homeless cohorts was 4.4 (95% CI: 3.8–5.2).*

Neilson et al. (2011: 2205) offer a similar conclusion:

> *The overall SMR for men was 5·6 (95% CI 5·4–5·8) and for women was 6·7 (6·2–7·1), and external causes accounted for 1161 (27·9%) of 4161 deaths for which information on the cause was available*

An ambitious UK project set out to study the relationship between homelessness and standardised mortality ratios (SMR). Utilising an inclusive range of secondary data sets, and a complex design, Thomas (2012) set out to quantify the relationship between homelessness and SMR figures. Evocatively titled 'Homelessness kills', this study concluded that the average age of death was 47, with an even lower age for women (43) compared to 77 for the general population, (74 for men and 80 for women).

Moreover, the life expectancy of a 'typical' homeless person is many years less than someone who is not homeless. Nusselder et al, (2013) report that life 'expectancy at age 30 years was 11.0 (95% CI 9.1–12.9) and 15.9 (95% CI 10.3–21.5) years lower for homeless men and women compared to men and women in the general population respectively.' Approached from the opposite direction, if a person is, 'living in the most salubrious housing (this person) can expect to live, on average, more than twice as long as those sleeping rough on the streets (Shaw, Dorling and Brimblecombe, 1999: 2239). In terms of contrast, think of those who are sleeping rough who are in and out of shelters. Roncarati et al, (2018: 1242) studied this group by conducting a 10-year cohort study of 445 unsheltered homeless adults. The study concluded that the age-standardised all-cause mortality rate was almost 3-fold larger than that for a cohort of homeless adults primarily sleeping in shelters, and nearly 10-fold larger than that for the adult population of Massachusetts.

These findings lead to a definitive conclusion: homelessness is perilous. Homicide, assault, suicide, untreated illness – are just some of the risks that research has emphatically correlated with homelessness. Neilson et al. (2018: 63) offer a clear general summation:

> *A mental health or a substance use disorder combined with homelessness considerably increases the risk of death. However, homelessness is also independently associated with high mortality. Differences in the association between homelessness and mortality in men and women suggest the need for sex-tailored interventions.*

Perhaps, the best summary is presented in O'Connell's (2005) seminal report. This review noted that epidemiologists in the nineteenth century had first identified 'an early and intricate relationship between homelessness and early death', and that:

> *Subsequent studies in major cities across the United States, Canada, Europe, Asia, and Australia have confirmed a persistent relationship between a lack of housing and excess mortality. Despite a diversity of methodologies utilised across multiple continents, the current literature reviewed in this paper demonstrates a remarkable consistency that transcends borders, cultures and oceans: homeless persons are 3 to 4 times more likely to die than the general population* (op cit.:15)

It should be noted that homelessness has a number of forms. Although rough sleeping is the most visible of these forms, the contemporary understanding of homelessness is not restricted to 'primary homelessness'. Accommodation that is sub-standard and/or unsafe is generally included in this contemporary understandings (see Appendix 1: Definitions and nomenclature). This point is important because of the relationship between housing status and health.

What is well established is that the relationship between homelessness and health is multi-dimensional. In so much as this is acknowledged, a difficult conclusion emerges: the effects that are documented, the features of the relationship that happen to be highlighted in this or that study, reflect the particular concerns of the investigators more than they summarise the overall effects of the complex relationship between housing status and health. That is, housing status impacts across a spectrum of outcomes – a range includes the costs of public medicine, the health of young children, and the mortality rates of rough sleepers. While the current project has a focus on the latter, it is clear that housing status has impacts across many dimensions of health. The first of these impacts concerns the elevated risk of death that is associated with homelessness.

2.3 Rates of death

Research into mortality rates for those experiencing homelessness is well advanced in a number of locations. In other locations there has been less progress. The initial focus in what follows is local research. This attention is then divided between data on Aboriginal and non-Aboriginal populations, mindful there is little empirical data on the rates of mortality for people experiencing homelessness in Australia. A summary of international research then follows.

(i) The relationship between homelessness and the premature death of Aboriginal and Torres Strait Islander people

The project's core concern – to examine the relationship between homelessness and premature death – is brought into a particular focus if the position of Aboriginal people is recognised and prioritised. In honouring this priority, the current project is committed to acknowledging the reality of the consequences of Aboriginal dispossession. This is an especially sensitive issue given the significantly higher rates of homelessness experienced by Aboriginal people. However, we are aware that even as we seek to be respectful, there is a risk that our efforts might cause further hurt, or perhaps offence.

Nevertheless, the truth telling cannot be avoided. In the context of the transgenerational trauma that is produced by being involuntarily made homeless in one's homeland (Raphael et al, 1998), the premature deaths of Aboriginal is deeply correlated with:

- material circumstances that are often shocking in their lack of safety and amenity, and
- inadequate access to appropriate diagnostic and treatment services.

In this context, it is only to be expected that homelessness has a negative effect on Aboriginal life expectancy and Aboriginal mortality rates. This effect has not, and probably cannot, be quantified in terms of a single metric or set of metrics. Problematic definitional issues over-determine this uncertainty: (Appendix 1 – 'Definition and nomenclature' – offers background to this statement).

Every indication points to the conclusion that homelessness exacerbates disadvantage, and therefore diminishes life expectancy, and the potential risk of early mortality. Given the nature of the contexts within which homelessness has its impacts, it is difficult to imagine that exact figures on the deaths of Aboriginal people who are or who have been homeless, will become available any time soon, if at all. Not least of these difficulties is that homelessness/inadequate housing is an all too common feature of life of a large number of Aboriginal people.

While these uncertainties need to be acknowledged, there are sets of facts that are beyond dispute. Consideration of the *Closing the Gap* reports presents a clear starting point in convening this data. The 2019 report states that life expectancy for Aboriginal women is 7.8 years less than for non-Aboriginal women and is 8.6 years less for Aboriginal men than for non-Aboriginal men (Australian Government, 2019: 124). Although marginally improved from the figures in 2010-2012, in the report's own words 'the target to close the gap in life expectancy by 2031 is not on track' (ibid: 123).

Mortality rates are somewhat less clear-cut. In their technical report on mortality trends Coleman et al. (2015) concluded that, unlike life expectancy, estimates:

> *… are available annually, because mortality data are published annually (yet reporting) of Aboriginal and Torres Strait Islander mortality depends on identification in death records of whether the*

> *person was of Aboriginal or Torres Strait Islander origin … (and although) Identification was introduced in the 1980s in most jurisdictions, and in 1996 in Queensland … (the) completeness and quality of identification varies between and across jurisdictions and improvement has been slow, particularly in NSW … Data for Victoria, Tasmania and the ACT, are still not considered of sufficient quality to use as a basis for estimating mortality rates*.

However qualified, Coleman et al (2015) report that from 1998 to 2012 in New South Wales (NSW), Queensland (Qld), Western Australia (W), South Australia (SA) and the Northern Territory (NT), Aboriginal and Torres Strait Islander crude mortality rates decreased from 448.7 to 408.6 deaths per 100,000 population. This figure is similar to the Australian Government's 2014 report: 'Compared to non-Aboriginal people, the age-standardised all-cause mortality rates for Indigenous people (NSW, Qld, WA, SA and the NT) in 2009–13 was 1.7 in terms of rate ratio and 400 in terms of rate difference.'

General findings mask specific patterns. For example:

> *Most deaths for Aboriginal and Torres Strait Islander peoples occur in the middle age groups. Most deaths for the non-Indigenous population occur in the older age groups. … In 2008–12, 64% of Aboriginal and Torres Strait Islander deaths occurred before the age of 65 years. The largest gaps were in the 35–59 year age group (based on the sum of years of life lost due to premature mortality). In the 35–44 year age group, the Indigenous mortality rate was 4 times the non-Indigenous rate* (ibid: 1.22 All causes age-standardised death rate).

These, and other, startling comparisons are set out diagrammatically in the above report. This form of presentation animates, even dramatises, what the *Closing the Gap* report hints at.

How does homelessness relate to these larger trends? According to Homelessness Australia (2017)

> *… on Census night 2011 there were 105,237 people experiencing homelessness. Of these 26,744 were Aboriginal and Torres Strait Islander, … In 2014-15 23% of people supported by specialist homelessness services identified as Aboriginal or Torres Strait Islander including more than 1 in 4 children aged 0-10.*

Declaring its figures 'undernummerate' the true number, the Australian Bureau of Statistics (ABS) (2018[iii]) estimates that the rate of homelessness within the Aboriginal and Torres Strait Islander population is 17.5%' (see Appendix 1: Definition and nomenclature). Clearly, Aboriginal people are disproportionally homeless.

To further the understanding of the relationship between homelessness and mortality it is useful to consider how the Aboriginal people are distributed across Australia. The 2016 census found that the great majority of Aboriginal and Torres Strait Islander people (81%) lived in 'non-remote' areas (ABS, 2018). Some sense of the circumstances of the 19% of the Aboriginal population who live in remote Australia can be glimpsed if the work of Paul Torzillo is considered. Torzillo is a respiratory physician at the University of Sydney who has specialised in Aboriginal health and housing. He reports that of the '9,000 houses in about 230 communities affecting about 60,000 people' that his research has inspected there is 'a functioning shower in about a third of those houses. You've got electrical safety in about 11%, and you can store, prepare and cook food in about 8%' (Torzillo, 2018: accessed 21.06.2019).

What are the effects of such inadequate, over-crowded housing?

> *The first (effect) is the high rates of infectious disease in Aboriginal kids, order of magnitude greater rates of respiratory infection and ear disease, there's lots of evidence that they are impacted on hugely by the ability to wash and keep yourself clean. If the hardware doesn't work, you won't be able to clean your kids, wash their face and hands. Childhood illness has a big impact on long-term chronic disease, infective inflammatory conditions drive coronary artery disease, early respiratory infection drives chronic lung disease et cetera* (ibid.)

While the effects of climate change are briefly discussed later in this report, (see 2.5(ii)) we need to be mindful that the impacts of climate change are highly relevant to the living situations of many Aboriginal people, it is also worth noting that over the last years 'some Aboriginal communities … are living in summers now where it's above 45 degrees.' According to Paul Torzillo not only was there 'high 40s for a few weeks over this recent summer, places in WA and central Australia (experienced) temperatures of 51 and 52. It is broadly acknowledged that climate change is going to impact on poor populations first and early and hardest. And Aboriginal people in lots of these communities are already being hit by that.' (ibid)

The danger is not restricted to remote locations. This starkly emphasised by the fact that 12.2% of a sample of 180 rough sleepers in the inner-Melbourne based *Journey to Social Inclusion* sample identified as Aboriginal (Flatau et al., 2018[i]). Similarly, of the 8,818 people experiencing homelessness interviewed in registry weeks between 2010 and 2017 '20% identified as Indigenous, despite Indigenous people making up only 2.8% of the Australian population' (Flatau et al, 2018[ii]). Over-crowding, poor sanitation, inadequate access to medical care, etc, may be more pronounced in remote areas, but this does not mean that disadvantage, including primary homelessness, is not present for Aboriginal people in Australian cities. This noted:

> *Of the 62, 261 Aboriginal and Torres Strait Islander persons living in multi-family households in 2016, 39 per cent lived in non-urban areas of Australia. In the Northern Territory 60 per cent of persons*

> *in multi-family households lived in non-urban areas, followed by Western Australia (51%) and South Australia (49%).*
>
> *Aboriginal and Torres Strait Islander multi-family households were more likely to be overcrowded than one-family households. Almost 30 per cent of multi-family households required two or more extra bedrooms to suitably house all usual residents, compared to 2 per cent of one-family households* (ABS, 2018[ii]).

By the ABS's own account, Aboriginal and Torres Strait Islander peoples have been 'under-enumerated' in the Census. It follows that estimates of homelessness based on Census data will be an underestimation. There is a probable underestimation of homelessness among the Aboriginal and Torres Strait Islander population enumerated in the Census. This may may occur as the information regarding 'usual residence' may have been provided incorrectly. This in effect, masks the incidence of homelessness.

According to Homelessness Australia (2017) on census night 2011:

> *Aboriginal and Torres Strait Islander Australians are 15 times more likely to be staying in improvised dwellings, tents or sleeping rough than non-Aboriginal or Torres Strait Islanders'* (and) *1 in 15 Aboriginal and Torres Strait Islander people receive support from homelessness agencies each year.*

Given this context it is no surprise that the average life expectancy of Aboriginal Australians is notoriously abbreviated. This fact is well documented across the breadth of the Federal Government's *Closing the Gap* reports. It has also been reported that 'Chronic diseases were responsible for 70% of the total health care gap in 2013' (AIHW, 2016]; accessed 18.06.2019). This latter report further noted that 'reducing exposure to modifiable risk factors would prevent 37% of the burden of disease in Indigenous Australians.'

How do the above findings inform our understanding of homelessness in the Aboriginal population? This is a matter of the highest importance, as it is both complicated and profoundly sensitive. Any consideration of reduced life expectancy and, more broadly, of homelessness as it relates to elevated rates of death, must be conducted within the contex of an acknowledgment of the consequences of Aboriginal dispossession. This context is both historical and contemporary. Dispossession, and the effects of colonialism more broadly, have cart-wheeling effects. The transmission of the effects of transgenerational trauma is but one of these (Raphael et al., 1998).

It is not surprising that that reliable statistics on Aboriginal deaths connected with homelessness are unavailable. Many reasons feed into this absence of data. Not least of these reasons is that complex definitional issues are in play. For example, Chamberlain and MacKenzie (2014) proposed that 'spiritual homelessness' should be considered as a specific category of homelessness. All Aboriginal people are in this sense implicitly homeless and the great majority of all premature Aboriginal deaths are connected to their homelessness. If a more traditional and less encompassing definition is used – one that is inclusive of those

living in sub-standard and over-crowded accommodation – a large number of Aboriginal people can be considered homeless. However worthy and well-intentioned, it might well be said that such definitional questions and issues are strictly the business of white-fella logic. For example, if an Aboriginal person living in an over-crowded, poorly maintained housing with little or no domestic amenity is asked: 'do you think of yourself are homeless? This person may well say 'no' if this residence was regarded as being on country.

According to the AIHW (2014) report Homelessness among Indigenous Australians

> *On Census night in 2011, an estimated 26,743 Indigenous people were experiencing homelessness. Taking into account the size of the Indigenous population, 1 in 20 Indigenous people were homeless on Census night in 2011 (this is) 14 times the rate for non-Indigenous people (1 in 284 people).*
>
> *... Among Indigenous people who were homeless in 2011, three-quarters (75%) were living in severely crowded dwellings- these dwellings contained an average of 12 people each. A further 12% were living in supported accommodation for the homeless, 6% were staying in improvised dwellings, tents or sleeping out, and the remainder were staying temporarily with other households, or in other temporary lodgings.*
>
> *… In 2012-13, about 1 in 5 (22%) clients were Indigenous-an estimated 54,885 (SHS) clients. In comparison, about 3% of the total Australian population were Indigenous*
>
> *In 2011, 60% of Indigenous people experiencing homelessness were in Very remote areas. Nearly all (97%) Indigenous homeless people in Very remote areas were living in severely crowded dwellings.* (AIHW, 2014: v).

How much is homelessness correlated with the causes of illness and early death? One relevant report stated that '… up to one-third of the difference in life expectancy could be attributed to differences in income, school education, employment status and overcrowded housing' (as quoted in AIHW, 2016: 304).

Vignette A: Edna's funeral fund and the Weeroona Aboriginal Cemetery

After leaving, or being moved off, missions in Victoria many Aboriginal people gravitated to the Fitzroy/Collingwood area of inner-city Melbourne. These people struggled not only with racism but with housing, employment and poor access to health care. Deaths were common, especially amongst those experiencing homelessness. Objecting to her people being buried without dignity in unmarked graves, Edna Rose Browne established a funeral fund in the 1960s. Initially known as 'Edna's funeral fund', for some years all funding was community raised as the fund received no state support.

As well as committed, fundraising was also creative. According to Lorraine Patten (more widely known as Aunty Bunta):

> *My aunty, my mother's sister, Edna Brown, came in and said: 'I've got a cabaret and I want you to come and help me to put it on. I'm on my own',''* she told The Saturday Age. The purpose, she was told, was '*to raise money for an Aboriginal Funeral Fund. As we were decorating the hall, Aunty Edna said she'd been to a funeral and there was a preacher, herself and a gravedigger, and this person was getting buried as a pauper, straight in the hole, straight up. She was very upset and she told me: 'I swore to God that none of my people would ever get buried like that again'''* (Gordon, SMH 28.02. 2012).

Alma Thorpe, Edna's daughter, said that her mother established the initial fund because 'She couldn't stand that our country was taken off us, and aboriginal people were buried as paupers. She said she found out they were buried standing up. That's a pauper's funeral standing up in a hole' (Thorpe, 2018).

In the late 1980s, while working as a project officer in Aboriginal Affairs for the Victorian Government, Aunty Bunta chanced upon an unanswered letter in a file. It had been written many years earlier by Aunty Edna and another prominent Elder, Stewart Murray, seeking support for an Aboriginal cemetery in Melbourne. Aunty Bunta was inspired to take up the cause. She helped formalise a campaign, all the while keeping up internal pressure. Her persistence paid off. In 1992, the deed to a block of land in Greenvale was secured. Funding was also secured to establish a morgue, crematorium and other related services. The Weeroona Aboriginal Cemetery was Aunty Bunta's proudest achievement, serving as chairperson for 10 years. It is a site of great importance to the Aboriginal community.

(ii) Rates of death: Non-aboriginal Australians

The earliest research on rates of death located by the current project was conducted in Melbourne in the late 1980s. Based on a large sample of men experiencing homelessness who were in contact with an inner-city service, Jordan (1994) reported that homeless men died at a rate of between 3 to 5 times the average rate. This study – *Going bad: Homeless*

men in an Australian city – may not have the prestige of a refereed report, but it remains a benchmark study.

Another non-refereed report summarises the data Launch Housing has collected over a number of years of in-house research (Hollows, 2019: *in press*). Based on a review of the agency's internal register of client deaths, during the 12-month period between June 2018 and June 2019:

- there were 47 known deaths of current or former clients, mindful this is recognised as an underestimate of the true figure
- the average life expectancy of the client at time of death was 43.5 years with the median life expectancy 42 years
- 13% identified as Aboriginal
- at the time of death, 30% were not currently being supported by Launch Housing, or were living in long term Launch Housing properties with no support attached.

More generally, a review of Launch Housing data suggests there were approximately 85 deaths of current or former clients between 1/1/17 and 13/1/19 (Hollows, undated.). It should be noted that this figure is considerably higher than the figure that Victoria's state oversight body requires to be reported through its Critical Incident Management System: see 4.2(vii).

Launch Housing is a large, dedicated service for those experiencing homelessness, but it is only one of the many such services that are active in Victoria. In the above report an estimate of the number of deaths that are likely to occur across Victoria per annum is formulated. This estimate contributes significantly to outlining the scale of the issue and will be summarised at some length.

This estimate is based on the following:

- Australian Institute of Health and Welfare (AIHW) crude death rate of 6.5 deaths per 1,000 annually nationally.
- intentional research from the UK, European Union, the USA and Canada has found a mortality rate for people experiencing homelessness of between three times (used as a lower limit) and six times (used as an upper limit) compared to the general population.
- the 2016 ABS Census that indicated there were a total of 24,817 people in Victoria who were counted as homeless, with 6,204 people as rough sleeping in contact with Specialist Homelessness Services (SHS). This total increases to 9,926 if people couch surfing are included.

Victoria only	Expected mortality (6.5 per 1,000)	3 times as lower limit (less expected mortality)	6 times as upper limit (less expected mortality)
6,204 (rough sleepers and SHS users)	40	81	202
9,926 (rough sleepers, SHS users and couch surfers)	65	129	323
Average	52	**105**	**262**

However speculative, the above estimate *only* seeks to represent deaths amongst those experiencing primary homelessness. It is also restricted to *one* state. Recognising these qualifications and limitations, if the true scale of the problem is to be appreciated a further projection is needed. That is, a calculation could be organised to be Australia-wide in ambit and, secondly, to be inclusive of those living in overcrowded, unsafe and insecure housing. If this broadening was undertaken the above estimate would be expanded very significantly.

Such an imagining can be expressed in a number of ways. For example, the above restricted estimate can be transposed into two deaths per week at the minimum, moving to five a week at the higher estimate. If these latter figures were scaled up to reflect Victoria's share of the national population – roughly, one-quarter – the count would be between 8 and 20 deaths per week, mindful that this estimate would only be representative of those experiencing primary homelessness.

Several relevant refereed studies were also identified. These local reports focused on specific sub-populations, particularly those with a mental health diagnosis. Babidge, Buhrich and Butler (2001) accessed mortality rates for a cohort of 708 homeless subjects, 506 of whom had a diagnosis of schizophrenia. This study found that the standardised mortality ratio (SMR) for this population was 'three to four times higher than people in the general population of New South Wales' over a ten-year period (ibid: 105).

A current longitudinal study also has the potential to significantly contribute to knowledge concerning the relationship between homelessness and mortality. Sacred Heart Mission's *Journey to Social Inclusion* project is following-up a cohort of iteratively homeless people whose outcomes are being closely monitored in progressive reports, for example, Miscenko et al., (2017) *Chronic homelessness in Melbourne: The experiences of Journey to Social Inclusion Mark II study participants* and Flatau et al. (2018) *Chronic homelessness in Melbourne: First-year outcomes of the Journey to Social Inclusion phase two study*. Over the course of this investigation, data will become available on rates of mortality for those included in the sample. To a degree, if a focus on mortality was prioritised, it is possible that

important results might also become available in data that was obtained in the seminal Street to Home program (Johnson and Chamberlain, 2015).

It is well understood that women are especially vulnerable if they are homeless. This vulnerability is dramatised when the media focus in on particularly shocking deaths. The gruesome killing of 25-year-old Courtney Herron in an inner-city park in Melbourne in June 2019 was the most recent of these deaths. At this point annualised figures are not available for such deaths. More broadly, women die at an alarming rate as a result of family violence: 'one woman a week was killed by a current or former partner in the two years from 2012-13 to 2013-14' (AIHW, 2019). Although it is well established that family violence is often the prompt for women to become homeless, much remains unknown. For example, what is the rate of death for women who are homeless as a consequence of family violence?

It might be contended that all women who are temporarily residing in refuges are, by definition, homeless. If this premise is accepted, it would be possible to count the total number of murders that annually occur for women fleeing family violence and to 'read' this figure in relation to homelessness. A similar calculation could be developed with respect to the disproportionate number of Indigenous women who experience family violence.

Coda

Mindful the meaning of homelessness is radically different for each group, might non-Aboriginal Australians who are homeless share a similar risk profile to those in the category 'Australian Aboriginal people who are homeless?' While acknowledging this caveat, there are some commonalities in the situation of both groups: physical jeopardy, unhygienic conditions; often overcrowded accommodation, little or no access to bathing; poor, even non-existent, cooking facilities, and so forth. For both groups, there will be more disease and co-morbidity, and inadequate access to timely diagnosis and appropriate treatment. As a consequence, there is a greater chance of premature death.

In so much as the comparison has validity, it follows that estimates of mortality for the non-Aboriginal homeless might approximate the figures that have been found for Aboriginal Australians. Given there are no reliable calculations for mortality rates for homeless non-Aboriginal Australians, there is perhaps some value in expecting that this rate might approximate the appalling figures that have been found for Aboriginal populations in inadequate, over-crowded locations.

(iii) Rates of death: International research

In a large, register-based study from Finland, Stenius-Ayoade et al. (2017) reported that 'Homelessness is associated with a five-fold mortality compared with the controls.' Based on a complex, multi-stage methodology, a study from the United Kingdom produced a more finely grained finding:

> *Homeless people (have) … an average age of death of 47 years old and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women. … At the ages of*

> *16-24, homeless people are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more likely to die than the general population, and 55-64 year olds one and a half to nearly three times* (Thomas, 2012).

A number of factors are understood to be associated with an elevated risk of premature death amongst those who experience homelessness. These include mental health problems, a history of multiple drug use and prison and/or institutional care. For example, Morrison (2009:877) reported that

> *Homelessness had differential effects on cause-specific mortality. Among patients who had been hospitalised for drug-related conditions, the homeless cohort experienced a 7-fold increase in risk of death from drugs compared with the general population*

Neilson et al. (2013: 50) reported that 'Alcohol and drug use disorders were predictors of death by unintentional injury for both men and women', whereas 'schizophrenia spectrum disorders and personality disorders were … significant predictors among men' but not for women.' Gender is definitely a primary viable: 'Homeless women 18–44 years of age were 10 times more likely to die than women in the general population of Toronto' (Cheung and Hwang, 2004: 1243). These authors also state that:

> *In studies from a total of seven cities, the risk of death among homeless women was greater than that among women in the general population by a factor of 4.6 to 31.2 in the younger age group and 1.0 to 2.0 in the older age group … Excess mortality is far greater among homeless women under age 45 years than among older homeless women. Mortality rates among younger homeless women often approach or equal those of younger homeless men* (ibid: 50).

Acquired brain injury (ABI) is another element in the homelessness equation. Although far less commonly the focus of research than mental health and alcohol and other drugs (AOD), this diagnoses is often present in the admixture that makes up what is sometimes referred to as 'case complexity.'

The current project was able to identify only one research report on this under-researched variable. This study – a complex, Glasgow-based study that sought to inclusively generate a 'census' – concluded that amongst those people experiencing homelessness, there was an almost three-fold increase in mortality for those who had sustained a serious head-injury compared to those with no history of head injury. That is, over a seven-year census period, 33.6% of those in the head-injured group had died compared to 13.9% with no history of head injury (McMillan et al., 2015*).* This general finding was disaggregated for age:

> *The standardised mortality ratio for HHI (those who had been hospitalised for head-injury) aged 15-34 (17.54) was particularly high. These findings suggest that HHI is common in the homeless relative to the general population and is a risk factor for late mortality in the homeless population*.

The risk that is present with ABI and homelessness can be clearly seen when international research is linked to local research. According to Flatau et al (2018) 21.6% of rough sleepers in the Melbourne-based *Journey to Social Inclusion* sample reported they had been diagnosed with an ABI. Mindful this figure may well underestimate the scope of the problem, the risk of early death for these people is brought into focus if their prospects are examined through the lens of McMillan et al's (2015) research. If the latter's findings held, the local group will be two-and-a-half times more likely to die prematurely compared to those who are homeless who do not have an ABI (33.6% to 13.9%).

2.4 Immediate causes of death

(i) Patterns of death

The pattern of deaths among people experiencing homelessness is strikingly different to the general population (Office of National Statistics 2018). Nilsson et al. (2013: 50) summarise the generally accepted position:

> *Homelessness is associated with social deprivation, an unhealthy life style with elevated levels of psychiatric disorders, especially substance use disorders, somatic disorders, violence, injuries and unmet healthcare needs.*

A study from the Canadian province of British Columbia reported that homeless individuals are twice as likely to die by accident, suicide, or homicide compared to those in the general population (Condon and McDermid 2014). In the same report, the median age of death for a homeless person in the province what calculated to be between 40 and 49. This is almost half the life expectancy for the average British Columbian, which is 82.65 years. Elsewhere in Canada (Toronto) the median age of death was 48 years (Toronto Public Health 2017). A study in France concluded that the 'homeless died at 49 years old on average compared with 77 in the general population in 2008–10' (Vuillermoz et al, 2016: 1028).

A recent interdisciplinary review examined 33 studies that researched the dangers that are present within the homeless milieu. The key conclusion of his study was that

> *… the homeless are subject to disproportionate rates of distinct categories of common crime, including assault, robbery, and theft* (Ellsworth, 2019: 96).

This general finding is given more detail in Stanley et al's. (2015) large study of violent deaths in Maryland (US). This report noted that, over a seven-year period, of the 279 deaths

where the victim was reported to be homeless '(m)ore than half (65.2%) of deaths were of undetermined intent, 21.2% were homicides, and 13.6% were suicides.' (ibid: S260). This finding recalls a statistic quoted in the introduction – that death by unknown causes was more than 60 times more likely in those experiencing homelessness (Nordentoft and Wandall-Holm, 2003). If you die in the shadows, the cause of death does not appear to as salient as is the case in the general population.

It is accepted that being homeless exposes people to danger because a person experiencing homelessness is more likely to be exposed to the risk of assault (as Ellsworth noted above). This is also because people who are homeless tend to have a poor health status and experience 'multi-morbidities.' This is due in part, because those experiencing homelessness tend to eat poorly, live in less hygienic conditions, and are less likely to receive timely medical attention. These effects are cumulative, especially for those who experience 'iterative homelessness' (Robinson, 2011).

According to Stenius-Ayoade et al. (2015), a ten-year, controlled follow-up study concluded that a pattern of iterative homelessness resulted in an almost five-fold increase in mortality. This study found that the risk of death was particularly elevated for the homeless aged ≤50 years. This study also concluded that while 34% of deaths were due to external causes, medical causes were also common (SMR 3.6). This study also concluded that psychiatric hospitalisation was a significant predictor of death. (ibid: 841).

(ii) Suicide

Local research

The project was only able to identify a limited number of local studies on suicide and self-harm amongst those who experieced homelessness. The most pertinent of these reports is Arnautovska, Sveticic and De Leo's (2014) *What differentiates homeless persons who died by suicide from other suicides in Australia?* Based on data from Queensland's suicide register the study concluded that:

> *Homeless persons had almost twice higher suicide rate than non-homeless counterparts … were more often male, of young age, single/never married, non-Indigenous, unemployed, had at least one physical illness or other stressful life event prior to death, had drug and alcohol abuse problems, and also were more likely to have evidence for an untreated mental illness* (ibid: 583).

One unpublished, directly relevant empirical report was located: Horn (1998) *Suicidal behaviour amongst homeless people and its association with selected risk factors*. Given its local focus and specificity, this report will be quoted in some detail. The study focused on a group of 741 people who were clients of a community homelessness agency. The study reported that:

- 28% of the cohort had experienced one or more types of suicidal behaviours or self-harm

- 18% had attempted suicide at least once in the past year
- 38% had made an attempt whilst a client of the agency
- one-third of those attempting suicide had made three or more attempts, with women significantly over-represented in this group
- one client had completed suicide in the study period
- 22% of all clients had engaged in self-harm considered to put their life at serious risk with over half (57%) of this sub-group had regularly or constantly undertaken self-harming activities, and
- more generally, the rate of attempted suicide for homeless people is at least six times that of the general population.

Local reports on rates of suicide and self-harm in relation to youth homelessness are also rare. One non-refereed study found that one in ten homeless young people reported that they had attempted suicide in the previous three months, and 28 per cent who had made an attempt had not told anyone (Rossiter et al., 2003). Another local report examined 'the experiences of 864 young people, aged 12-25 years old, at intake and exit from Brisbane Youth Service support who were experiencing homelessness over a 12-month period' (Vichta and Hail-Jares, 2017). The research focused on the mental health of two of those groups – couch surfers and rough sleepers, and found that young couch surfers had a higher rates of both suicide risk and rates of self-harming behaviour.

In terms of local research on suicide, it is important to acknowledge the position of Aboriginal Australians experiencing homelessness. According to the ABS in 2017, the suicide rate among Aboriginal and Torres Strait Islander people was approximately twice that of non-Indigenous Australians (ABS, 2018[iv]). Our research could not locate data that correlated this figure with homelessness. Most likely, Aboriginal Australians who are homeless are at a heightened risk of self-harm and suicide (see Appendix 1: Definition and nomenclature).

International Research

A large Canadian study sought to 'identify personal, clinical, and suicide method-related factors that distinguish homeless and precariously housed people who die from suicide from those who are not homeless at the time of suicide' (Sinyor et al.,2017). The study reviewed coroner records for 'all suicide deaths in Toronto from 1998 to 2012. Data abstracted included housing status as well as demographics and clinical variables such as the presence of mental illness and suicide method.' The researchers found that:

> *Homeless and precariously housed people were each younger than non-homeless people (P < 0.0001). Compared with non-homeless, homeless people were more likely to be male and less likely to be married, to have interpersonal conflict, or to leave a suicide note. Homeless people and precariously housed were more likely to have died by fall/jump than non-homeless people (62%, 57%, and 29%, respectively) … Homeless and precariously housed people are overrepresented among suicide deaths in a large urban center and*

differ demographically, clinically, and in their suicide method from non-homeless people who die by suicide.

Breaking down the above findings reveals a more detailed picture. For example, another Canadian study that focused on those who were between 14 and 25 years, found that over a five year period there was a standardised mortality ratio of 11.4 amongst homeless youth, and that suicide was responsible for half of these fatalities (Roy et al,. 2004: 574). Amongst those with a mental health problem, Desai et al (2003: 365) reported that '26.9% (of a sample of 7,224) reported an attempt that resulted in a non-psychiatric hospitalisation, and 8% reported a suicide attempt in the previous 30 days.' Interestingly, these finding are broadly consistent with what Horn reported in his 1998 Australian study. (See above.)

In teasing-out this material it is important to ask: what is the relationship between suicide and self-harm? Mindful that suicide is not necessarily preceded by acts of self-harm, there is nevertheless a statistical relationship. A good starting point is offered by Coohey et al. (2015) who found that more than half of those who experience homelessness have had thoughts of suicide, or have attempted suicide.

The most authoritative, and the most frequently cited investigation of the relationship between suicidal thoughts, self-harm and suicide was undertaken by Carroll, Metcalfe and Gunnell (2014). These researchers undertook a systematic meta-analysis of 177 published reports. They reached the conclusion that:

Approximately half of all people who die by suicide have previously self-harmed … (W)ithin the UK, 15–20% (of the people who suicided) visit a hospital for self-harm in the year prior to their death. The rate of suicide in the self-harm patient population is up to 100 times higher than that of the general population.'

The report's key finding was that the 'risk of suicide in the 12 months after an index attempt was 1.6% (CI 1.2–2.4) and 3.9% (CI 3.2–4.8) after five years.' These authors concluded that 'One in 25 patients presenting to hospital for self-harm will kill themselves in the next five years.' Given the strength of the relationship between self-harm and suicide, Arensman et al. (2014) reported:

… the risk of self-harm among people who are homeless is 22 times higher compared to those with a fixed residence (4,165 vs 186 per 100,000 population).

In the light of this report, there seems no doubt that homelessness is closely affiliated with self-harm and suicide.

(iii) Family Violence

On average in Australia, one woman a week is murdered by her current or former partner **(**Bryant and Bricknall, 2017). It is also known that family violence is an increasingly common reason for seeking homelessness services: see Johnson, Ribar and Zhu (2018) for a broad review. According to Livsey (2017):

The AIHW found that 106,000, or 38% of people requiring services, sought support due to domestic and family violence in 2015-16. This was a 33% increase from 2011–12, when the collection began, and a 14% increase from 2014–15.

Domestic and family violence was the most common reason for accessing services in Victoria, the Northern Territory and Western Australia. The latter had the highest rate (43%), while the Northern Territory and Victoria came close behind with 40% and 42% respectively. Nationally, 35% of people access homelessness services for this reason.

It follows that a troubling intersection can be expected to exist between homelessness, family violence and premature death. Little empirical data is available. This clear, likely inferences can be derived from what data is on the record.

For example, Box et al (2018) reported that around 10% (853) of the 8,618 homeless people interviewed across Australia in registry weeks between 2010 and 2017 were women 'sleeping rough.' This group were '… most frequently on the streets, in cars, in parks, and other locations not designed for habitation.' This report also noted that women sleeping rough were significantly more likely to use accident and emergency departments, and ambulances than men sleeping rough and women not sleeping rough. In addition, women sleeping rough were more likely to use hospital inpatient services than women not sleeping rough.

In the current exercise, it is not possible to 'granulate' these findings. For example, field reports repeatedly testify to the violence that homeless women experience from their (also homeless) partners. Exactly how many deaths occur as a result of this violence is not known.

(iv) Homicide, overdose and fatal accident

In addition to an elevated rate of death due to illness, those experiencing primary homelessness are subject to a heightened incidence of violent, unexpected death. A profile of the causes of death, including 'deaths by misadventure', is offered in a table taken from the third edition of. *Dying on the Streets Homeless Deaths in British Columbia* (Hannon, 2017):

Classification of Deaths

	2006	'07	'08	'09	10	11	12	13	14	15	Total	%
Accidental	12	26	25	22	16	10	12	10	23	40	196	49.7
Natural	10	10	16	9	5	10	6	8	12	13	99	25.1
Suicide	4	3	4	7	6	3	5	3	7	7	49	12.4
Undetermined	2	4	2	3	4	1	5	5	1	8	35	8.8
Homicide	3	-	2	1	1	-	1	2	2	1	15	3.8
Total	31	43	40	43	32	25	28	27	45	70	394	

Source: British Columbia Coroners Service (Hannon, 2017)

From this table it is clear that 'accidental death' – a category that includes being run over by a car, accidental poisoning, drowning, a fall from a traffic on-ramp, etc. – accounts for close to 50% of all deaths. Homicide then accounts for another 4%. Given the above table does not itemise overdose deaths, it is reasonable to expect a good number of the roughly 10% of 'undetermined' deaths would fall within this description.

This table is not cited as a proposed template. Rather, the purpose is to broadly outline a pattern that is generally observed. Putting suicide to one side – see 2.4(ii) above – what is seen in this table is that a very large proportion of deaths are inadvertent and also dramatic. It is also important to note a fact that sits outside context of this table: 'inadvertent and dramatic death' is disproportionally present in the lives of those who are homeless: '(w)hen comparing the means of death of the homeless population against that of the general population, homeless individuals are more than three times as likely to die by accidental means' (Hannon, 2017:10).

Local data is scarce in relation to homicide, overdose and accidental death for those who are homeless. For indicative purposes international reports will be cited for each of these causes.

Two particular refereed studies were identified that, *inter alia*, examined homicide. Albeit now more than twenty years old, a heavily cited paper (Hwang et al., 1997: 625) reported that 'Homicide was the leading cause of death among (homeless) men who were 18 to 24 years of age.' The second study – Stanley et al. (2016) – investigated violent deaths in Maryland in the USA over an eight-year duration. This latter study reported that 279 homeless individuals had died. Mindful that '(m)ore than half (65.2%) of deaths were of undetermined intent, 21.2% were homicides' (ibid: S260).

This latter finding can be more dramatically expressed: more than 50 homeless persons were murdered over an eight-year period. If the 60+ percentage of 'undetermined' deaths is considered, then this figure is likely to be significantly higher.

To a degree, these findings are particular to a specific time and place: to the inner-cities of the USA. Nonetheless, they point to the reality that those experiencing primary homelessness are exposed to a greater risk of homicide. Several murders in Melbourne highlight that this same phenomenon is not unique to the USA. These homicides include the savage killing of 42-year-old Wayne 'Mouse' Perry in 2014 and 43-year old Christian Williams in 2016. The murder of 25-year old Courtney Herron in 2019 is the most recent example of this phenomenon. It is also worth noting that this murder was by a person the victim knew – a man who was also experiencing homelessness.

Deaths associated with, or directly caused by, drug overdoses are another component of the category 'violent, unexpected death.' Although the table from British Columbia did not itemise death by overdose, it is clear this category of death is a significant, and probably an increasing factor in the deaths that occur within the homeless population. The prior

question here is: what proportion of those experiencing homelessness use dangerous drugs?

Illustrative, although not definitive, Vila-Rodriguez F et al's (2013) *The Hotel Study: Multimorbidity in a community sample living in marginal housing* reported that '(s)ubstance dependence was ubiquitous (95.2%), with 61.7% injection drug use.' That such a high proportion of those studied engaged in, at least from time to time, intravenous drug use, leads directly to the heightened prospect of drug overdose. It should therefore not be surprising that, amongst others, Baggett et al (2013: 189) found that overdose was, the 'leading' cause of death amongst the homeless population: more than cancer and heart disease, '(d)rug overdose accounted for one-third of deaths among adults younger than 45 years.' Although less dramatic as a finding, Lim et al. (2015) also found that mortality risks were 'significantly higher' for those using drugs.

Morrison (2009) conducted a very large retrospective cohort study. This study reported that:

> *Homelessness had differential effects on cause-specific mortality. Among patients who had been hospitalised for drug-related conditions, the homeless cohort experienced a 7-fold increase in risk of death from drugs compared with the general population.*

Whether this startling finding holds for those experiencing homelessness in Australia is unclear. That opiates are readily available, and that many experiencing homelessness are multiple drug users is well known. More, anecdotal reports from Specialist Homelessness Services practitioners consistently cite drug overdose as a prominent, if not necessarily the leading, cause of death for those experiencing homelessness. Figures are available for overdose, for example, approximately 900 Victorians died between 2014 and 2018 from a heroin-related drug overdose (Victorian Coroner, 2019). What is not clear is how many of these deaths involved those who were also experiencing homelessness. Most likely, it would be a disturbing number.

The third kind of violent, unexpected death, involve accidents. A prominent sub-group of these accidents involve cars. For example, it was reported that:

> *… a homeless man is dead after being hit by two cars in Melbourne's north. The 26-year-old pedestrian was hit by one car and then immediately the other at Reservoir just after 11pm yesterday, police said'* (Channel 9 News, 07.07.2019).

In Hannon's (2017) bulletin from British Columbia it is made clear that those experiencing homelessness are disproportionately prone to being hit by cars. This specific cause of death combines with a panoply of other misadventures. These include, but are not restricted to, drownings, poisonings, falls, and serious head or somatic injury where the antecedent cause remains uncertain. Those experiencing primary homelessness are at an extreme risk of misadventure.

The first report of this pattern identified is the present study was by Alstrom, Lindelius and Salum (1975: 245):

> *The mortality in a series of 6,032 homeless men in Stockholm was investigated. The observation period was up to three years. The observed number of deaths amounted to 327 compared to the expected 86·7, corresponding to an excess mortality ratio of about four. Mortality was raised for all the causes of death studied. Most striking, however, was excess mortality from accidents and diseases of the digestive and respiratory systems. Accidental deaths were remarkably numerous*.

More recent reports consistently support this generalisation. For example, Stenius-Ayoade et al. (2017: 841) investigated cause-specific mortality using a register-based, case-control study of 617 homeless men and an age-matched control group of 1,240 men from the general population. These cohorts were followed for 10 years between 2004 and 2014. The study reported that '(e)xternal causes caused 34% of the deaths' and were the leading cause of death. Aldridge et al. (2018: 241) reached the same conclusion: 'data points were highest for deaths due to injury, poisoning, and other external causes.'

(v) Illness and disease

As distinct from violent, unexpected death, those currently experiencing homelessness – and/or who have previously experienced significant periods of homelessness – also die as a result of natural causes. Heart attack, cancer and respiratory failure, for example, are common causes of death for the general population as well as amongst the homeless.

The key question is: to what extent is the truncated lifespan of those who are homeless related to the inadequacy of medical detection practices and/or the lack of appropriate medical treatment? As examined in *2.3 Rates of death*, it is clear that homelessness tends to result in premature death. This finding is firmly established and has been understood for decades. What has not been clear until relatively recently is that a significant proportion of this reduction in lifespan is due to:

- potentially treatable conditions not being diagnosed early enough, and
- treatment programs for these conditions not being adequately administered.

In such instances, deaths can therefore be considered preventable.

A recent study – Aldridge, Menezes, Lewer et al. (2019) – set out to investigate the causes of death among homeless people in a population-based, cross-sectional study of linked hospitalisation and mortality data. The purpose of this study was to evaluate the possibility that death might be preventable. The conclusion reached was:

> *Nearly one in three homeless deaths were due to causes amenable to timely and effective health care. The high burden of amenable deaths highlights the extreme health harms of homelessness and the need for greater emphasis on prevention of homelessness and early healthcare interventions (ibid: 4:49)*

This finding was put into everyday words by a partner in the Bureau of Investigative Journalism (BIJ)research: if '(n)early a third of homeless people die from treatable conditions' this means that 'hundreds of deaths could potentially have been prevented.' The following is a direct quote from the BIJ report:

> *While many might assume hypothermia or drug and alcohol overdoses kill the majority of homeless people, this latest research by UCL shows that in fact most homeless people die from illnesses. Nearly a third of the deaths explored by UCL were from treatable illnesses like tuberculosis, pneumonia or gastric ulcers which could potentially have improved with the right medical care.*
>
> (For example) *In February 2018, 48-year old Marcus Adams died in hospital after suffering from tuberculosis. The same year, 21 year old Faiza died in London, reportedly of multi-drug resistant pulmonary tuberculosis. Just before Christmas in 2017, 48-year-old former soldier Darren Greenfield died from an infection and a stroke in hospital. He had slept rough for years after leaving the army* (Bureau of Investigative Journalism, 11.03.2019). .

In response the publication of this report, Matthew Downie, Director of Policy and External Affairs at Crisis UK, argued that it is 'heartbreaking' to know 'that so many vulnerable people have died of conditions that were entirely treatable'. According to the BIJ report, 'homeless people are much more likely to die from certain conditions than even the poorest people who have a place to live.'

Vignette B: The homeless memorial

As in other locations, in the Melbourne suburb of St Kilda an annual commemorative service is held for those who have died whilst experiencing homelessness. This service is held immediately in front of a stone memorial that was installed to commemorate all those who have died. This memorial sits in a park, next to a community garden and adjacent to a sports oval. It is a fine setting for remembering and dignifying. This event has been held each year since 2001.

Chosen to take place on the winter solstice – the coldest, shortest day of the year – this event is both honouring and poignant. This year was the nineteenth annual service. A mixed crowd attended; perhaps, a hundred people were present. Free food and drink, and clothing, was available.

The service began with a Smoking Ceremony / Welcome to Country led by David Tournier, a Boon Wurrung man. As a generous reference to the many who have died without a home, David acknowledged 'those who are now no longer walking on this country.' Spoken word and choral performances were bookended by a minute silence. In varied and deep ways those present were engaged. Many lingered long after the formal part service was completed. If interested, a fine video of an earlier service can be accessed: https://drive.google.com/file/d/1ZjaMDYtg3itTnPaXjVohWX-2FH02CKfq/view

2.5 Intermediate causes

(i) Overview

It is well established that there is a multi-dimensional relationship between homelessness and health. For example, 'we know that 15% of a new child asthma cases in Europe can be attributed to indoor dampness and the mould that comes out of it' (Jacobs, 2018: accessed 21.06.2019). Just as primary homelessness takes its toll, inadequate, overcrowded and unsafe housing has a profound health impact. According to the Chief Scientist for the US *National Centre for Healthy Housing*: '(In New Zealand) 10% of hospital admissions per year are attributed to household crowding.

Certain environments are hazardous due to toxicity and/or infecting agents. Poor nutrition, including outright malnutrition, dental problems, sexually transmitted disease, tissue injuries and infection are all associated with increased risk. Compromised health and poor immune function go hand in hand. A deteriorating cycle can be difficult to slow, let alone defeat.

Premature death can be the cumulative result of one or more non-immediate factors. For example, if a person has little or no access to bathing, facilities for cooking, healthy food, hygienic accommodation and regular medical care, this person will be more likely to contract disease, suffer from co-morbidities and over time, tend toward a diminished resistance to disease. It follows that there will be a heightened risk of acquiring one, or more, chronic health conditions. Bundled together, these intermediate causes promote premature death. This prospect can be related to current, and/or earlier, periods of homelessness.

There is a clear and well-understood relationship between homelessness and poor health. This understanding, is presumed in what follows. Due to the resource constraints of this project, amongst a larger cluster of health issues, two intermediate causes that contribute to premature death will be briefly noted. These two have been selected, as they are less well documented than the more widely understood general health concerns.

(ii) Extreme weather

Cold snaps, heatwaves and floods are expected to become more frequent and more extreme as climate change accelerates. If extremes of heat and, more generally, if extremes of climate are considered in aggregate, it is likely that the vulnerabilities of homeless persons will deepen. This is relevant to the circumstances of rough sleepers, but also to all those in marginal living circumstances. This emerging context can be expected to approach what has already been reported in in countries such as Turkey (Altun,, Yilmaz and Azmak, 1999) and India (Babu, Joseph and Kadur, 2012; Chaudhary et al., 2017; Garg et al., 2016).

In a study published in the *International Journal of Disaster Risk Reduction* Nicolay et al. (2016: 72) warn that '… People who are homeless have increased vulnerabilities that

predispose them to poor outcomes from heat related illnesses.' Mostly likely, this finding is also relevant to preparedness for low temperatures.

In a report titled *Mortality among the homeless: Causes and meteorological relationships*, Romaszko et al. (2017) investigated the relationship between homelessness and weather in Olsztyn, located in north-east Poland. Their conclusion:

> *Most deaths occurred in the conditions of cold stress (of different intensity). Deaths caused by hypothermia were thirteen-fold more frequently recorded among the homeless than for the general population. A relative risk of death for a homeless person even in moderate cold stress conditions is higher (RR = 1.84) than in thermos-neutral conditions.*

Interest in this subject has certainly deepened since Ramin and Svoboda (2009) published what they claimed was the first paper to examine the impact of climate change on those who experience homelessness

(iii) Stigma, non-predictability and gloom

Why do a disproportionate number of homeless people suicide, attempt suicide, assault others or be assaulted by others, binge drink and consume drugs recklessly? This class of question is not simply about germs or contaminated living quarters. Nor is it simply about a person's biography or their purported flaws. What is at issue is the fact that humans are social beings who are sensitive to how we are seen by others. 'Five months before his death, Marty confessed he had nowhere to stay. He was ashamed' (Webb, 2019).

Homelessness affronts self-respect, as it also provokes many non-homeless people to deride those who are homeless. One (progressive) newspaper ran with the following headline: *The big stigma is it's the homeless person's fault* (The Guardian, 07.08.2017).

Those who experience homelessness regularly report being 'dissed.' A recent Australian book – *No fixed abode* (Smith, 2017) – gives a voice to those who experience this disrespect. The following is taken from the synopsis of this book:

> *Most Australians find it hard to look at a 'homeless' person. They prefer to stare straight ahead and pretend that the hungry, damaged and lonely human being in their peripheral vision simply doesn't exist. Apparently, it's just easier that way. If refusing to even make eye contact is hardwired in the masses, then talking to them and listening to their stories is out of the question.*
>
> *This book gently addresses that callous disconnect by giving otherwise stifled, invisible Australians a face and a voice. By exploring the stories of people from around Byron Bay who've fallen through society's cracks, readers can only better understand some of the common trajectories of disenfranchisement – and what a truly horrible thing it is to be without a home.*

> *People of no fixed abode are in the critical eye of those who live comfortably and don't want their neighbourhoods to play host to 'social misfits' and 'undesirables'. They have no money and therefore, in the eyes of our consumerist world, they don't contribute to the economy. It's sad to admit but if a human being has no money then, as far as capitalist society is concerned, they have no worth. They become invisible and almost cease to exist.*

How is a dynamic of disregard created? A self-reinforcing circuit is in play given that 'many assumptions (about) the causes of homelessness lead to stigma and prejudice' (McQuistion et al., 2008). The key assumption in this circuit is the premise that the homeless person is to blame for the fact that they are homeless. In effect, the implicit, and sometimes explicit, accusation is that this person is choosing not to function independently. Bauman (2005: 5) observed: '"dependence" has become a dirty word: it refers to something decent people should be ashamed of.' Rather than understanding homelessness as the result of larger structural forces, such as an absence of affordable housing or as the fallout from an economic depression, many people have been trained to blame the individual and ignore the impact of the broader social context.

What are the cumulative effects if individuals experience repeated patterns of active social disapproval? Irving Goffman (2009), a noted sociologist and author of the seminal study on social stigma, argued that repetitive experiences of derision resulted in what he termed 'spoiled identity.' Much is summarised in this phrase. Goffman's key idea is that a process of castigation inflicts damage on the private sense of self: see also *The stigmas of homelessness* (Homelessness and Housing; undated).

As well as impacts on mood, cognition and behaviour, castigation diminishes the body's ability to fight off, and recover from, disease. That is, a person's social situation can have physiological significance. This is the territory of social epidemiology. The findings from this rapidly expanding body of empirical research are directly relevant to the prospects of early death which confront those experiencing homelessness. For example, in *The Spirit Level: Why greater equality makes societies stronger* (2011) Wilkinson and Pickett engage a social model of health to acknowledge the effect that social relationships – both positive and destructive – have in relation to physical well-being.

Aligning with multiple reports from social epidemiology, Wilkinson and Picket offer a way of theorising how the repeated instances of disrespect experienced by those in stigmatised groups provoke stress responses, reactions that spike cortisol levels (amongst other effects). Over time, such antagonisms have been found to impair immune function. One becomes more likely to succumb to, and less likely to recover from, disease.

This level of explanation strengthens the descriptions offered by traditional medical research. For example, when a report proposes a dispassionate position – that homelessness may 'impose additional risks through exposure to hazardous environments' (Morrison, 2009: 877) – the reader is led to think of bio-hazards such as germs and, to a degree, physical risks such as assaults. What this description occludes, what it does not

bring to consciousness, are the 'total social facts' (Mauss, 2002) that are inherent to the experience of homelessness.

> (Total social facts are) *… phenomena (that) are at once legal, economic, religious, aesthetic, morphological and so on. They are legal in that they concern individual and collective rights, organised and diffuse morality; they may be entirely obligatory, or subject simply to praise or disapproval. They are at once political and domestic …* (ibid: 76),

A 'domestic' milieu that is unsanitary is one element in the factuality of homelessness. An environment that is unpredictably unsafe, is another. In so much as homelessness is experienced as timeless, as iterative and without end, another dimension to the factuality of homelessness emerges: the sense of helplessness and gloom.

That it was broadly reported there were no rental options in any Australian capital city that someone on New Start or Youth Allowance could afford in April 2019 speaks to the possible sources this gloom (Anglicare, 2019). Amongst a range of qualitative reports, Button and Baulderstone (2013) present an account of the hopelessness and unpredictability that is often associated with the experience of sleeping rough and what Robinson (2011) describes as the 'felt' dimensions of homelessness.

(iv) Troubling intersections

So far, much has been overly-summarised. Moreover, resource constraints mean a great deal has been completely neglected. Of particular concern is that death's relationship with homelessness can be expected to play out with a terrible power for particularly vulnerable groups. For example, in testimony to the Victorian Mental Health Royal Commission, it was stated, that the suicide rate for young LGBTI Victorians was higher than for any other group. It is arguably very likely, that if homelessness is threaded into this calculation, a significant correlation would be found given that: 'We have very, very bad data collection around this' (Ro Allen, as quoted in Perkins, 2019: 4) as the Commissioner for Gender and Sexuality noted.

Homelessness amongst refugee and asylum seekers is also likely to be correlated with premature death. One advocate – Melanie Noden, CEO of Sydney's Asylum Seekers Centre (ASC) – argued that:

> *Asylum seekers are the most vulnerable of the homeless … It is the most critical issue for them with over 70 per cent currently being homeless, or about to become homeless, when they arrive at our door. …* (These people) *have very limited access to other homelessness services. ..* (and between 2013 and 2014*) our caseload has doubled and now stands at over 1,400 asylum seekers including women, men and children* (Meredith, 2014: 12).

Again, no good metrics are available. We do not know how many homeless refugee and asylum seekers die – from accidents, treatable illnesses, suicide etc, – each year. We do not even know how many people are homeless within the refugee and asylum seeker population. The only figure identified in the current exercise was from a study undertaken by Flatau et al. (2015:1). This study found, albeit from a small sample, that six per cent of the respondents reported insecure housing circumstances including 'couch surfing' in year three of the follow-up. If this figure held for the yearly intake of, say, 20,000 this would mean there are a very large number of vulnerable, highly at-risk people experiencing homelessness.

In terms of summary, two further points should be noted. Gender and Aboriginality – as specific, and as related, categories – are key dimensions in terms of identifying the factors that produce heightened rates of premature death. Exact figures may not be available, but it clear that gender and Aboriginality are correlated with the 'extreme health inequalities' (Geddes and Fazel, 2011: 2156) that are characteristic of homelessness. Box et al (2018) reported that:

> *Despite 3.3% of Australian women in the 2016 Census identifying as Indigenous Australians (Australian Bureau of Statistics, 2018), 39% of women sleeping rough, and 14% of* (homeless) *women not sleeping rough identified as Indigenous in the Registry Week data. The over-representation of Indigenous women is evident across all categories of those not sleeping rough, with the exception of those housed. The proportion of women sleeping rough that identified as Indigenous was significantly higher than the proportion of men sleeping rough who identified as Indigenous (21%).*

Broadly, key Australia-specific metrics concerning the relationship between homelessness and death are missing. In part this reflects the nature of the field: 'By the very nature of homelessness, they (sic) are rarely on any formal register or record that would allow them to be counted' (Taylor et al., 2012: 3).

More to the point, recording and research efforts have been inadequate. International authors may emphatically state that '(b)eing homeless for even a short period of time increases the risk of long-term health problems' (ibid: 2), but this finding has not been locally queried let alone quantified. More uncertain still is the long-term impact of iterative homelessness in itself, and differentially – with respect to those who are now well-housed, compared to those who are still homeless. A great deal is currently glimpsed, but it is not well grasped.

It is not clear, for example, how many of those who die from heroin overdose are homeless. In one Australian state, the coroner reported that deaths from heroin overdose rose from 136 in 2014 to 220 in 2017 before declining to 201 in 2018 (Victorian Coroner, 2019). If these figures are interpreted in the context of international research – 'the homeless cohort experienced a seven-fold increase in risk of death from drugs compared with the general population (Morrison (2009:877) – it would follow that a disturbing proportion of the approximately 900 Victorians who died between 2014 and 2018 from a heroin-related drug

overdose were experiencing homelessness. If the exact number was known, the scale of the problem would be apparent. Unfortunately, the number of people who die from drug overdose while experiencing homelessness remains unknown.

2.6 Underlying factors

The underlying cause of homelessness, and therefore of premature death for those without secure and adequate housing, is understood within one theoretical tradition as a consequence of a problem with housing affordability, or other structural factors, or group of factors: rising inequality, changes in the labour market, and so forth. A contrasting school of thought understands homelessness (or poverty; obesity; etc.) as a failure of individual agency or impairment in individual functioning – that mental illness, trauma, etc., that has disabled the capacity for self-reliance (Johnson et al, 2015). In each school of thought, the terms 'underlying cause' and 'underlying factor' have a similar meaning.

Denoted in both terms is the idea that explanation trumps description – that analysis concerns root causes, rather than by statements of what is obvious and superficial. For example, it could be said that the cause of poverty is that some people do not earn enough money. Such an account is not detained by a commitment to understand, say, the mechanics, history and trajectory of poverty as a complex phenomenon. In contrast, a meaningful explanation of poverty seeks to proceed from what is observable, to an account that articulates the dynamics, the forces and interactions that result in the phenomenon of poverty. Such a process necessarily involves judgment and theorisation. In contrast, description presents a non-judgmental depiction of a phenomenon.

Within medicine, the term 'underlying cause' has a very different meaning. This usage is technical and particular. The underlying cause is:

> '(a) the disease or injury that initiated the train of morbid events leading directly to death, or
> (b) the circumstances of the accident or violence that produced the fatal injury' (WHO 2008).

There is a logical tradition that informs this definition. Decision making in health care, based on evidence from epidemiological and empirical research, requires the disciplined reporting of a well-understood convention for how death is documented. Unless recorded reliably, it is not possible to evaluate the effectiveness of medical treatments and programs of public health.

> *'Complete and accurate **death** certificates, which document the immediate, **underlying**, intervening and contributory **causes of death of** the decedent, underpin the production **of** high quality statistical data and the ability to produce **cause**-specific mortality statistics. By using the WHO-recommended Medical Certificate **of Cause of Death** and coding the data using the International Statistical Classification **of** Diseases and Related Health Problems, 10th revision (ICD-10) (World Health Organisation [WHO] 2008), it*

> *is possible to produce mortality statistics that are comparable between countries, national and subnational populations, for specific population groups and over time* (The Free Library, 2019)

The instrument that puts this logic into action is the Medical Cause of Death Certificate (MCDC). If this instrument is used consistently – within and across nations – reliable data can be collected and compared (Byass 2007).

What potentially links the medical with the everyday meaning of 'underlying cause' is the notion of prevention:

> *The purpose of uniquely identifying the underlying cause is to identify the precipitating factor that could potentially have been prevented. Conditions thought to have been contributory but not part of the sequence of events leading to the death can be reported in Part II of the certificate* (ibid: 2019).

The notion of prevention aligns with a key role undertaken by the Coroner's Office in each state and territory: 'Wherever possible, a Coroner will suggest ways to prevent similar deaths or fires by making well-informed and practical recommendations based on the evidence before them' (Coroners Court of Victoria Annual Report 2017–2018: 12). The following seeks to examine the notion of prevention – of giving form to how prevention could be the focus of an intervention.

Vignette C: Alex – a rough sleeper

Alex (46) is experiencing primary homelessness. His health is troubled by a compromised immune and respiratory function. He encounters an opportunistic event (a viral insult; a chance tissue injury) that results in him contracting a minor infection. This malady lingers before coarsening in the context of a damp, unventilated squat. Alex's health status deteriorates and he progresses from mild fever to pneumonia. This trajectory repeats a pattern that is well-established across Alex's long medical history. Alone, more or less immobile, and with little or no access to hygiene and nutrition, Alex's condition further deteriorates. Marked by worsening impairments to cardiac and lung function, circulation, vision and cognition, over the days, systemic failure becomes manifest. Vitality fatally ebbing, unable to raise a hack, Alex declines into an anoxic death.

The immediate cause of Alex's death was documented as respiratory failure due to pneumonia; the underlying cause of death 'chronic obstructive airways disease' (COAD). Technically accurate, this formulation is reductive as it relies on a protocol of proximate, medical simplification. An adequate description of cause – rather than a narrowing vision of aetiology – requires an interest in what medicine might describe as intermediary and contributing causes. Such a formulation is necessarily bio-psycho-social (Borrell-Carrió, Suchman and Epstein, 2004). Multiple underlying factors – conjoint influences that are

dynamic, complex and multi-dimensional – need to be articulated, if a sufficient understanding is to be advanced.

Aldridge et al. (2019) found that one-third of rough sleeper deaths were preventable – that is, that these deaths were the result of treatable conditions. In so much as this finding is valid, it follows that an underlying factor in the pattern of premature death presented by this cohort, is an absence of an intervention by appropriate health care. In Alex's case the impact of a minor infection began a cart-wheeling deterioration – a downward spiral that could almost certainly have been arrested by timely, on-site medical attention. Unless the cause of death is articulated in a holistic manner, preventative interventions will not be envisaged. Why? Because explanations of death will tend toward 'natural causes' as the preferred disposition. In so much as this is the pattern, it will be assumed that nothing can be done.

3. Death and dying in the lifeworld of homelessness

3.1 Overview

The current project could only locate a limited number of qualitative reports that sustained a focus on death and dying amongst those experiencing homelessness. One of these studies concluded those experiencing primary homelessness tend to be:

- 'worried about dying and EOL (end-of-life) care
- (have) had frequent encounters with death; and
- voice many unique fears, such as dying anonymously and undiscovered' (Song, Bartels, Ratner et al., 2007: 435).

This complex relationship with death and dying has multiple dimensions. One of these dimensions concerns family and friends. The above study reported that, if a person experiencing homelessness enters a palliative care program – an event that signals one is approaching death – they will often display a 'demonstrated ambivalence towards contacting family' (ibid: 439). Why might this be the case?

The end of life normatively summons mixed feelings and reflections: *what have I achieved and can be proud of?; what do I regret and feel ashamed of?; who do I miss and want to connect with?* The approach of death may not create these thoughts and feelings, but it will intensify them. In this context, the prospect of having contact with one's family and friends can incite a 'come here, go away' dynamic. The urge towards reunion is both compelling and aversive; shame jostles with rebellion. This process may involve only a few actors, or it might involve many.

That people experiencing homelessness have an active and complex engagement with death may surprise. This reaction is likely to reflect the social position that death has been allocated, not only in the discourse of homelessness, but in western culture more generally. Given this uncomfortable location, the subject seems difficult and awkward. It follows that death, – and all that is associated with death: fear; decay; cold; darkness; helplessness – become topics than need to be abbreviated, euphemised, avoided or even denied. That death is not easily discussed, or that its presence is completely ignored, should therefore not surprise. (Song, Bartels, Ratner, et al., 2007)

People who experience homelessness are very likely to have encounters with death and dying. They know that it means to feel deeply unsafe, to be assaulted, and to see others assaulted; to hear that someone they knew has suicided, or has overdosed; to live with the fear of accidents and mortal illness – more so than the majority of those who are housed. Many have seen the bodies of others who have died while homeless. These experiences leave traces, sensitivities that may or may not have been coated-over. However poorly or well memories have been suppressed, unless timing and quality of contact align, it is unlikely that those who are experiencing homelessness will spontaneously talk about the hopes and fears that they have concerning death.

Given a reticence to talk directly, how might practitioners and service leaders identify that those experiencing homelessness are, quite possibly, hard-wired into this subject? A number of sources are available. First person accounts provide one stream of information:

> Luke, 40: *I'd been four years out of the mines. … I had a nervous breakdown on the trucks. They helped me out, but I couldn't keep working. I was getting massive migraines and I'd never had headaches in my life. I'm a "freshie"* (in Byron Bay). *If it weren't for these guys* (more experienced homeless people)*, who have educated me and taken me under their wing, I'd be buggered. … Two of my mates – freshies like me – have committed suicide this year due to the hardship. They were like me – smiling but behind gritted teeth.*
>
> Coco, 59: *I've had my scrapes over the years, but not too bad. I have been attacked, and seen a guy get stabbed. It's a racial thing. I've been locked up for 10 days for not having ID when I was drunk*.

The above are taken from *No fixed abode: Stories from the streets around Byron* (Smith, 2017). Importantly, the forward to this collection was written by Gregory Smith, a man who spent many years homeless, who is now an academic at Sothern Cross University. What is clear in these, and other first-hand accounts, is that death and its associates are very much part of the lived reality of homelessness.

Another line of information is the 'little tells' encountered by those working in the sector. One of these can be an attachment to staying on the street: *Hey, if I black-out* (have a seizure, overdose, fall over and become unconscious; go into coma), *there is a fair chance one of the bros' will see me and yell for an ambulance.'* The fear being telegraphed here concerns the person's profound sense of vulnerability. An independent unit may be safe, is preferable in many obvious ways, but there is also the sense of jeopardy associated with being unaccompanied. As well as being perceived as unsafe in this particular, and perhaps over-valued way, there is also the anxiety associated with dying 'anonymously and undiscovered' as was noted by Song, Bartels, Ratner et al. (2007).

Passing away alone in one's bed-sit way is not a popular vision of dying well; no one would describe this as dying with dignity. The following is a first person quote from a qualitative study of those experiencing homelessness in Ireland:

> *Sean (60) never thought about getting older and says he does not often worry about dying, although he says someone did tell him he should make a will. What does worry Sean deeply is the thought that he might die and not be found for some weeks.* (Walsh, 2014)

Deaths go unnoticed with increasing frequency. At times it is the rise in the malodorous from a silent dwelling, that triggers interest and an eventual report. Few are not unsettled at the prospect of this spectre.

Within the scope of the current project, it is not possible to adequately summarise all the relevant qualitative literature, nor the data that has arisen in the consultations that have been undertaken with practitioners. What is possible is to normalise, and to a degree particularise, what was broadly-noted in the introduction to this report – that death is an unwanted companion, a structuring presence, that persists in the shadows of those who live on the margins of society:

> *Homeless persons have significant personal experience and feelings about death, dying, and EOL care, much of which is different from those previously described in the EOL literature about other populations* (ibid: 435).

The current project was *not* designed to directly access the thoughts and experiences of those experiencing homelessness. To a degree, this topic area has been investigated in the medical literature. Putting to one side the research relating to accessing palliative care, only two recent reports were identified. (Webb, Mitchell, Nyatanga et al., 2017; Hudson, Shulman, Low, et al. 2017) More relevant are qualitative, sociologically-oriented studies. These paint a consistent picture. For example, in the Melbourne Street Count (2015) section discussing 'How safe do you feel?' the opening comment is:

> *The need to always be alert, 'always watching your back', 'always on the lookout for people that might harm you' – were commonly relayed. Getting things stolen and getting bashed were also frequently mentioned. Women in particular said that they did not feel safe at all, but being with a partner helped. Others slept in groups where people took turns at 'being on watch' to help them feel a little safer.*

In the direct quotes that followed, the section began with statements from three different speakers:

> *I felt safer in jail.*
>
> *I feel like I am going to get robbed and bashed. With having anxiety this is worse. I am always worried about this.*
>
> *Where I am at the moment I feel safe. Sometimes I get a bit edgy. I sleep with a group – not a big group, but enough to look after each other. We keep this spot to ourselves. We take turns at sleeping and looking out.*

In addition to first-person accounts, a great deal of knowledge has been accumulated by those in direct contact with people experiencing homelessness. Consultations did take place with this group and their managers. Although limited in number, these discussions confirmed what was expected: like many who experience homelessness, service providers also have powerful experiences of, and complex feelings about, death. Once the subject was compassionately raised, it seemed there was much that was ready to be said.

Two specific themes emerged. Keeping in mind that the status of these themes is tentative, and given the very limited number of consultations that were undertaken, each will be briefly outlined.

The first relates to 'finding a body.' For practitioners this experience is, and tends to remain, startling and resonant. With or without notice, this encounter is reported to be visceral, evocative and shocking. Time is said to stand still. The term 'trauma' is not apt; this word was not used. Nonetheless, in these encounters, the ordinary pales as everything else recedes. Mediated by the nature of the relationship between the now dead person and the practitioner, the meaning of this encounter varies, say, between the significant and the extreme. The state of the body is another variable. Doubtless other variables are present, such as the practitioner's biography and their length of time in the field. However mediated, it seems there remains something elemental, something primitive and deeply memorable, about these encounters with death.

The second theme that emerged concerned responsibility. In settings which have a strong relationship-based ethic, workers often develop a deep connection with service users and can feel a great sense of loss in the event of their death. Evident in local unpublicised deaths, the same intense phenomenon plays out horizontally when it gets about that a well-known character, someone who is not only recognised but is affectionately regarded, has met with a violent end. Convolutions from these losses reverberate through the whole sector and the wider community and society.

In these meetings with death, there is the sense that more should and could have been done; that I, or we, or they, all of us, should have helped more, or better, or for longer. Expressed more or less directly is a mixture of remorse and helplessness, of emptiness and yearning, of being left impotent, in the face of death. Conveyed to the listener, and most likely directly experienced by the speaker, was a call to go back, return and change things. No doubt consciously understood as impossible, nonetheless there was a keening impulse to not let go. Different levels of intensity might be present, but a sense of protest, of disrupted connection, seemed ubiquitous. The caring instinct was embedded in identity; this nexus could not be forsaken.

In the subjectivity of the homeless, there is a seam of experience, that traces the person's internal and external relationships with death. However refracted, it seems professionals will also connect with this same seam of experience. It therefore makes sense that the emotional impact of death on workers and, more broadly, the impact of the regularly encountered intense events, will need to acknowledged and systemically responded to.

3.2 Access to palliative care

There is an emerging interest in the professional literature in 'end of life' (EOL) and palliative care in relation to homelessness. This interest also appears from time to time in the in the popular media. The following quote was taken from a feature in a regional Australian newspaper:

> *A month ago John (not his real name) was given three months – at most – to live. Suffering end stage liver disease due to alcohol abuse and hepatitis C, he has limited mobility, requires weekly fluid draining from his abdomen and such low blood pressure that a doctor advised in a letter that he was "likely to faint or pass out on minimal exertion''. This letter, dated June 10 2016, stated the 44-year-old's life expectancy was "measured in weeks, perhaps two to three months at most. His liver and kidney function is getting worse. He requires close attention by doctors and nurses who are specialists in managing end stage liver disease,'' it stated.*
>
> *Yet on Monday, John was discharged from Wollongong Hospital; deemed ineligible for palliative care* (Wachsmuth, 2016).

Professional interest seems particularly focused on the barriers that inhibit, or even prevent, those experiencing homelessness from being able to access palliative care. For example, an early report was prepared by Tarzian, Neal and O'Neil (2005). More recent international reports seem to consistently advance a similar finding. For example, Stone, Hudson and Shulman, 2017. Shulman, Hudson and Low (2018: 36) reported that their study:

> *… documents growing concern that many homeless people are dying in unsupported, unacceptable situations. It highlights the complexities of identifying who is palliative and lack of appropriate places of care for people who are homeless with high support needs, particularly in combination with substance misuse issues*.

This same phenomenon was reported in the local consultations undertaken in the current project. It is apparent that identifying, acknowledging, and engaging with death and its implications involves resourcing and programs, as it also involves recognising what is involved non-materially. Feelings, meanings, connections – being able to name what is present but awkward – these are also dimensions that have a place.

4. What is not known – and why?

4.1 Overview

Australia has no register of those who die while experiencing homelessness, (nor is there a homelessness register). Without the former it is difficult, perhaps impossible, to know how many people die prematurely as a result, of homelessness. While consistent trends are mapped in repeated international research reports, underlying uncertainty persists: how many premature deaths are attributable to homelessness in this country? As examined in 2.1 – 2.3, no reliable metrics are available.

It is well-established, that homelessness is danger to life; for decades a clear statistical relationship has been on the record. That is, there is proof that life expectancy is radically reduced, and that those experiencing homelessness die at an elevated rate. What has not been established in this country, is the number of people with different experiences of homelessness and/or significant periods of homelessness, who die prematurely as a result of these experiences.

Why is there this absence of solid information? Initially, we assumed the lack of reliable figures represented a simple arithmetical gap. That id we pushed a little harder, dug a little deeper, or try for a little longer, we assumed, a clear result would be found. After a period of active investigation, we came to a different view: there is a knowledge *block*, not a simple knowledge *gap*. However, this conclusion was not immediately obvious. On the contrary, it took considerable effort to tease-out the actualities of practice and procedure that, taken as a systemic whole, produce a situation where figures cannot be reliably obtained and calculated.

We concluded that the accounting failure is the result of a dynamic set of interacting factors. For example, a relatively simple factor is a lack of precision in how 'housing status' is registered in medical records. Why is this absence relevant? In the event of the death of someone who is homeless, a number of record entry options are possible: the hospital system might default to 'unknown', to 'usual address', or be retrospectively filled in by this person's next-of-kin if the deceased person is identified and a relative located. 'No fixed address' may, or may not be, an option. These imprecisions apply whether the person who has died is or was known to the service, is or was unknown at the point of admission.

Similarly, decisions in relation to the disposition 'cause of death' depend on a set of values that tend to be inconsistently applied. For example, the decision to refer a death to a Coroner, and perhaps for the Coroner's Office to accept this referral as a reportable death, is influenced by a mix of considerations. Not least of these variables is the location where a person dies, (on the street; in a nursing home, etc.) as well as who has found the body (police; a staff member in a shelter; etc.). In different cases, it appears that different practice habits, procedures and protocols apply. Most likely, there is an interplay between these three influences.

Broadly, our contention is straightforward: there tends to be less oversight if a person is, or is presumed to be, homeless. This idea is supported by the international research: as noted

in 2.1, relevant reports have concluded the disposition, 'unknown cause of dealt', is far more frequent for homeless persons than for those who are housed.

Rather than investigate if a death is preventable – as is often the case with, say, gastric ulcers or hypothermia, or if a death is the result of one of the misadventures and adverse life events that are overly likely within the homeless population – it seems that the default decision will tend towards a 'natural cause' judgment, if a person is unidentified and/or is of 'unknown address'/'no fixed address.' Whether the person died in hospital as someone of 'unknown address'/'no fixed address', or arrived at the hospital unidentified but very ill, or was found by police on the street and recorded as dead-on-arrival, it seems likely that there is a diminishing probability that the 'case' will be referred to a Coroner for consideration. If the above represents a trend, then relationship between homelessness and premature death is obscured and masked.

If we want to do better, we need to know what in this recording or accounting process is not working well. To do this we need to find out what currently happens. The current project undertook research to identify, and to aggregate, local practices. This data is not secret, but is opaque and had not to our knowledge, been systematically compiled. In what follows, we present a cross-system account of the elements that, when considered as a whole, make it impossible to gauge accurately how many people die when they are homeless, or when they have experienced significant periods of homelessness.

To introduce this account, a scenario is presented below. This scenario maps an example that serves to illustrate the difficulties that are inherent in an attempt to quantify the number of people who have died while homeless. What is relevant here is to identify the different legislative regulations, local procedures, informal practices and possible dispositions that are applied inconsistently by the relevant official bodies. The collective effect of these disparities and incongruities is to produce what might be termed a 'Swiss-cheese' effect.

Vignette D: George – a rough sleeper

George is a 57-year old male. Early one morning, his body was found in a park on the edge of a metropolitan city. The jogger who found the body contacted the police, who later arrived to find a dishevelled looking male with no identification. The night had been cold, and though no wallet or other identifying information was found, the two police who attended did not think anything suspicious took place. Assuming George's death was due to natural causes, homicide detectives were not summoned. George's dead body was then transferred to the coroner's morgue.

At this point, the body was given a temporary registration. Eventually George was identified and an out-of-date address noted. After an on-paper review, the Coroner's Office did not accept that the death was reportable in terms of their interpretation of the Coroner's Act. That is, no process was undertaken to accurately establish cause of death.

No one having claimed the body, a pauper's funeral was arranged. At public expense George's body was released to a designated funeral service where the body was prepared

for burial in the designated area of a large metropolitan cemetery. Based on the received information, the funeral director completed a notice of death document and forwarded this to Department of Births, Deaths and Marriages. The data finally registered at BDM's recorded George's correct name, the wrong address and an uncertain cause of death.

Comment

In this scenario, a number of variables are illustrated. These include:

- the effect of location: if the death had taken place in, say, a nursing home rather than in a public park the nature of the oversight, the in-play protocols and practices, are likely to be more stringent;
- the mix of protocol and discretion: was it a matter of discretion or procedure – or a little of both – that determined whether the attending police officers, or their command, decided to, or decided not to, instigate an investigation of the death?
- identification does not necessarily result in an accurate 'housing status' entry: If Alex had been carrying identification, and/or had an established unit registration at the hospital, his housing status is likely to default to 'usual abode' (which was an out-of-date entry). Alternatively, a next-of-kin may have been located. The question then is: would this person be happy to have George's address nominated as 'homeless'/'no fixed abode?'
- the discretion the Coroner's Office has to accept, or to refuse, to investigate a death and to adjudge that this death was the result of natural causes rather than a preventable event.

4.2 How death is recorded: Numbers, housing status and cause

No coherent chain of custody carries information from the time a death is verified, to the point at which this death is registered with the state Births, Deaths and Marriages authority. Why is this the case? There are more than a dozen nodes in the network that records, reviews and transmits this data. Moreover, each actor in this network has a different purpose, culture and set of protocols. These entities, it might be said, are loosely coupled.

This is not an abstract point with respect to how the number of deaths, as well as 'housing status' and 'cause of death', is recorded. The current study has found discontinuities between the individuals, organisations and official bodies that comprise the chain of custody that holds and carries information concerning the above categories of data. This discontinuity has a serious consequence: it is currently impossible to identify reliable statistics, that is, facts that could be used to quantify the complex relationships that link homelessness with death.

The project set out to identify the key metrics that linked homelessness with premature death. At the local level, this goal could not be achieved. What follows is an account of why this goal cannot be achieved through the current assembly of individuals, organisations and official bodies involved in the processes of making and recording decisions about the death

of someone who is/was homeless. Mindful that this task is incomplete, identifying the elements and relationships that generate this knowledge block has involved a good deal of effort. While nothing was hidden, much remains implicit and opaque.

A note on what follows is in order. While each of the agencies in the 'network' are described, it should be kept in mind that this apparently linear listing does not necessarily correspond to the chronological sequence of events that is observed after a particular death. A degree of commentary is offered in relation to each agency with respect to their relationship to the recording and passing on of information on 'housing status' and 'cause of death.' Where it is known, reporting lines are noted. A flow chart depicting the practical sequence of events is set out in Appendix 3. However, it should be noted, that what follows is only a case study from one State: Victoria. Details may vary between different jurisdictions. Lastly, a degree of patience is needed to work through the detail involved in such a complex sequence of events and processes.

(i) Ambulance

In the event a person dies, or is regarded as very seriously ill, it is expected an ambulance will be called if this situation is not taking shape within a hospital. This is the case whether the dead/dying/seriously ill person is known, or is not known to, the proximate other who places this call.

Paramedics, but not other first responders, can verify the person is dead if this 'obviously so.' If this status is not finalised on site, a formal verification of death declaration is done by a General Practitioner, an accident and emergency doctor, or more senior hospital physician. In at least one Australian State a formal *Verification of Death* form can also be completed, and then forwarded on, by a registered nurse, midwife or qualified paramedic.

In terms of governing practices, it is important to note the categorical distinction between the procedure for assessing whether a person is deceased – the verification of death process – and the more complex matter of a medical practitioner issuing of a Medical Certificate of Cause of Death (MCCD). The latter is subsequently discussed: see 'Coroner's Court' and 'Medical personnel' below.

Cause of death may seem obvious, but remains formally uncertain at this point. Police may also attend. It is not clear what, if anything is reported to whom beyond their home hospital by ambulance staff in the event they are called to a body.

It is important to note that the location of the body makes a difference to what processes and assumptions seem appropriate. For example, if an older person appears to die peacefully in their family home, this is a different scenario to someone dying in a hospital, nursing home, shelter or public place such as a street or a park. Unless a medically qualified person completes a Certificate of Cause of Death (MCCD) testifying that death was due to natural causes – that the death is not 'reportable' – it is not legal for the body to be immediately 'released' to a funeral director.

Frequently at this point, a homeless person's housing status will be unclear and the body could also remain unidentified. This uncertainty reflects the liminal status occupied by many who are homeless. (Chamberlain and Johnson, 2018)

(ii) Hospital

What is the procedure in a hospital with respect to how 'housing status' is recorded as a data field? For example, what is the process if someone is dead-on-arrival at a hospital with identification, or without, identification, or if someone dies in hospital with identification, or without, identification? The following is a verbatim transcript taken from one inner-city hospital's written responses (column 2) to questions from the project team (column 3). A limited commentary is also set out (column 4).

	Question	Response	Comment
1	Under what circumstances is the notation 'no fixed address/abode' recorded?	Usually by ED either for an unidentifiable patient – who will have the details completed later once they are able to confirm the demographics or someone who is experiencing homelessness	'Usually' is an important qualification
2	Does your system accept 'unknown' as an option for address?	When you enter '1000' as the post code this defaults the suburb as no 'NO FIXED ABODE' and the address 'UNKNOWN'. Both the address and suburb can be overwritten from the default.	Interesting distinction b/n suburb as no 'NO FIXED ABODE' and the address as 'UNKOWN'; what is the prompt to enter '1000?'; also, does 'UNKNOWN' swallow 'NO FIXED ABODE' … or the reverse?
3	Will your system accept a non-entry for the address field?; if not, is there a default option for address, e.g. 'no fixed address'; 'unknown'	Suburb, Address and Post code are mandatory in PAS	See 2
4	If a person is admitted without their identity being known – for example, if a person is unconscious or is unwilling to complete the	Patient can be given a Unit Record number with largely unknown fields filled in and updated at a later point or merged with an existing UR	

	registration formalities – are these people admitted as 'temporary registration' for the purpose of initiating service	in the PAS system when more details are known	
5	If a person is dead-on-arrival, how is the address field completed if no next-of-kin becomes available?	If unable to verify anything from police or ambulance or personal belongings then it would be left blank	In this event, 'homelessness' would never be recorded
6	Can those records with the entry 'no fixed address / abode' be aggregated with respect to records of death?; if so, could age and gender also be identified?	Yes	Promising!
7	Might a non-entry to the field 'next of kin', be correlated with 'no fixed address?'	Yes	Again, promising

A comment from an insider at a different hospital presents another dimension of difficulty: *'What complicates (recording reliability) … is that we presently do not have one universal system, even though (the main patient management system), to the best of my knowledge, is regarded as the 'source of truth' for cardinal identifiers.'*

Some sense of the systemic complexity is presented in a you-tube instruction video for those trying to learn how to use a complex, real-time, on-line patient management and recording system: see https://www.youtube.com/watch?v=m6eFhWmZ7Ew.

Hospitals are formidably large institutions. Systems have to manage industrial volumes of disorderly data. In this context, a degree of indeterminacy will exist irrespective of how well the information system is designed and practiced. This indeterminacy is well understood. As has been long recognised, a degree of imprecision is mandatory in each and every 'people processing organisation'. (Hasenfeld and Paton, 1983)

Hospitals have a powerful disincentive against, even an aversion to tolerating, patient 'duplicates' in their records system. Therefore, the tendency is to favour either/or entries and drop-down menus. These habits may produce the perverse effect of making it more difficult to reliably record 'homelessness' as an entry in the housing status field as 'unknown', 'last / previous place of residence', etc., may be incited to appear as more amenable default entries.

(iii) Police

In the case of a death, the police must be notified. Nevertheless, there are exceptions to this rule, for example, hospitals. In addition to abiding with state-based legislation regarding reportable/non-reportable deaths, we are not clear what practices and procedures organise police responses subsequent to officers attending the site of a death. Presumably, a report of death document must be prepared. In the Victorian instance, we understand this is the 'Report of Death Form 83.'

It is also not clear whether the attending officers always confer with local/central command before finalising this report; nor is it clear under what circumstances the assessment and the recommendations in the initial report are subject to hierarchical oversight and, if so, what options/dispositions are available.

What seems clear in the abstract, if not in practical detail, is that a judgment call is made in relation to whether a death:

- seems natural
- must be forwarded to the coroner as a reportable death because it occurred in a particular setting, for example, the deceased person was in state care, or
- appears 'suspicious' and is therefore reportable as it warrants further investigation.

How much discretion is involved in this decision making process, and how much this process is subject to variables such as prevailing organisational and cultural norms, the pressure of workload, and so forth, is uncertain.

As is the case at every point in the post-death reporting chain, the documentation that is prepared includes an entry in relation to housing status. Most likely, there is little that can be done by officers other than to cite the most obvious entry. In the case of an apparently homeless individual, it is unlikely a next-of-kin will be available, but a wallet or a companion might be on hand. Often, there will not be the occasion to be thorough in the preparation of this entry.

In this situation, official protocol may stipulate that 'unknown' is the preferred default. It is also possible that 'any kind of address', such as an old address found on a document like a driving licence, might find its way onto an official form. In each of these cases, there is the possibility that an erroneous entry with respect to housing status will be filed. In so much as this occurs, there is a prospect a redundancy will then be re-cycled at subsequent points in the chain.

Although more complex, it is also possible that attributions concerning cause of death, may also be subject to practices that are, to a degree, based on organisational and cultural assumptions. For example, it would not be exceptional that someone might assume a 'parkie' found dead, but who had not been obviously roughed-up, has passed away from "natural causes" rather than from a treatable condition. This possibility is discussed at more depth in the Coroner's Court section: See below.

(iv) General practitioners

General practitioners can complete the Medical Certificate of Cause of Death (MCCD). This means these practitioners have been delegated a significant degree of discretion with respect to allowing a body to be released to a funeral service. The converse is also present: a medial practitioner can refer a death to the Coroner. However, the Coroner reserves the right to refuse to agree that this death is reportable.

(v) Nursing homes

If a residence is registered at a nursing home (such as Wintringham in Victoria) two independent, generally retained medical practitioners are required to make a judgment about whether a death is reportable. Most likely, one of these practitioners would complete the Medical Certificate of Cause of Death (MCCD).

(vi) Coroner's court

In each state, the coroner's court undertakes a decisive role. In brief, this body:

(i) determines whether a death referred to the Court by the police and/or a medical practitioner will, or will not, be judged 'reportable' within the terms of the respective Coroner's Acts. In effect, the Court reserves the right to decline to investigate;

(ii) determines whether a death that it has judged reportable requires investigation (a) by inquest or (b) can be considered by findings alone. According to the 2017-2018 Victorian Coroner's Court Annual Report (p. 4) there were 6,642 investigations undertaken and 49 inquests held; according to the Victorian Coroner's Court 'Inquests' webpage there were 'about 100 inquests are held each year – that's less than five per cent of all investigations' (Coroners Inquests; accessed 27.06.2019). Whichever figures is correct, the point is that inquests are rare, and

(iii) in the event the court judges there is a potential pattern with respect to what might prevent deaths, the court can make comments and recommendations, for example, that pertinent regulations might be varied or better access to services and resources ensured.

An official flow chart outlines the sequencing options of the Victorian Coroner's Court: https://www.coronerscourt.vic.gov.au/inquests-findings/investigation-process/death-investigation-process.

Establishing cause of death is intrinsic to determining findings and conducting inquests. Less obviously, this issue is embedded in decisions about whether a referral is found to be reportable. While this matter is clear in many situations, a degree of ambiguity suffuses others because a full explanation of the cause of death is dynamic and multi-layered. This is often the case with those who are, or who have experienced, homelessness.

For example, the immediate cause of death may be clear, but 'a full explanation of the cause of death includes:

- the immediate cause of death, such as the heart stopping

- the intermediate causes, which triggered the immediate cause, such as a myocardial infarction
- the underlying causes, which triggered the chain of events leading to death, such as atherosclerosis
- any other diseases and disorders the person had at the time of death, even though they did not directly cause the death'. (Wiki, accessed 14.07.2019)

What determines whether a death referred to the Coroner's Court will be judged to be reportable and, perhaps even more crucially, to be the result of natural causes? In terms of the latter, if the scope of cause of death review is operationalised in terms of a narrow definition – as opposed to one that is inclusive of both intermediate and underlying causes – a lesser range and number of audits will be undertaken.

With approximately 40,000 deaths a year in Victoria alone, it seems unlikely that the interpretation of the legislative requirements of a State's Act, would not, to a degree, be subject to resource considerations vis-à-vis the range and number of investigations that are undertaken. Similarly, the strength and vociferousness of the relevant stakeholder group is likely to have some influence in decision-making. In this circumstance it would not be exceptional to assume that, in the absence of signs of violence, a 'parkie' found dead on a cold night would be judged to have passed away from natural causes rather than as a result of a treatable and/or preventable condition.

This is at issue because the articulation of 'intermediate' and 'underlying' causes of mortality, potentially relates to the issue of prevention. A certain politics is therefore intrinsic to how 'cause of death' is documented and theorised. This politics relates to the matter of written findings: 'A written finding following an investigation into a death will usually, if possible, include, (iv) comments or recommendations made by the coroner aimed at preventing similar deaths, in some cases'. (Coroners Inquests; accessed 27.06.201).

Less complex for the current purpose is the question; 'how is the housing status of the deceased person determined and recorded?' Verbal reports indicate that the Coroner's Court tends to re-cycle whatever information has been received in the original reports forwarded by police and/or medical practitioners. In turn, this information is transposed into the format that is preferred in official Coroner's Court documents. The following is a part-transcription of a 'Third Schedule – Deaths in the State of Victoria' coroner's inquest report taken from 1961.

1	No		
	Description		13th April, 2011, No 12345 / 11
2	(1) When and where died … (2) Usual Place of Residence.		Royal Melbourne Hospital, Parkville No fixed place of abode
3	Name and surname Occupation		XXXXX ZZZZZZ Seaman
4	Sex and age		Male, 58
5	Cause of death Duration of last illness		Bronchopneumonia aggravated by debility and drug sensitivity

	Legally qualified medical practitioner by whom certified and When he last saw deceased		Verdict at inquest held in Melbourne, by the City Coroner, Mr. J. M. Duggan on the 5th of July, 1961

Of interest in the above is the 'Usual Place of Residence' question set out in column two. At issue is the likelihood that the use of this phrase will, or will not, tend to reliably summon the answer 'No fixed place of abode' if this is, in fact, the appropriate answer. As has been argued above, it seems very likely that 'No fixed place of abode' will be under-reported in the context that 'Usual place of abode' will tend to elicit responses such as home address or permanent address more than the 'saltier' alternative.

(vii) State oversight of Specialist Homelessness Services (SHS)

States are likely to have differences in the way deaths are recorded and reviewed by the body with oversight of the organisations who provide services to those experiencing homelessness. The following is therefore a one-off case example.

In Victoria, the Department of Health and Human Services (DHHS) has this key oversight role. DHHS require a Critical Incident Report from a SHS if a death is:

- sudden
- on-site
- involves a (strictly) current client.

This is a limiting set of conditions. In effect, these conditions present a threshold that minimises the number of deaths that are recorded and subject to review: see 5.2

(viii) Specialised Homelessness Services

Putting to one side the requirements of state authorities, in the event of the death of a service user, or a known ex-service user, individual homelessness services appear to have different processes, priorities and philosophies. Size and resourcing are key issues in this variance. Organisational culture is another. That death is a sensitive, even foreboding, subject only adds to the complexity of their situation.

In getting to grips with these various practices and in trying to understand the general picture, a starting point was presented by one senior agency official: '(R)ather than numbers, the data we do have tells us that:

> - we don't know a lot
> - we are not gathering data consistently around deaths in the homelessness population, and
> - services are limited to obtaining details about a client's death (depending on the circumstances) and there is therefore no source of hard evidence.'

In terms of rough science, this observation serves as a useful generalisation. In a minority of settings, the opposite is found. For example, in one setting, the manager has taken the

initiative to add to a hand-written list of names on a noticeboard, whenever they learn that a current tenant has died. The same process occurs if this manager hears that a past tenant has died. Over a five-year period, the list has grown to be just short of double figures.

In another agency the project consulted, there is an organisation-wide commitment to counting and, to a degree, documenting every death that occurs of a current, or former, service user. What is not clear here is if this is even a 'running total' in terms of current and/or past service users. Alternatively, at least one service has an ongoing commitment to recording the deaths of current, and former, service users. (Hollows, 2019: *in press*)

Beyond resourcing and the requirements of everyday operation, might non-rational factors play a role in explaining why there is so little systematic accounting by services in relation to deaths? It could be that a degree of fear of discussions around death, and/or the reviewing of the particulars of a single death, might be emotionally upsetting, or might prompt difficulties in relation to blame and retribution, a fear that would restrain direct engagement. Although limited, there was also some feedback indicating that in some settings, there was a degree of reticence, perhaps even defensiveness, about discussing client deaths. More likely, the exposure practitioners have to death and its difficult nature, in the context of the way that death is positioned awkwardly in the larger culture, tends to push this subject into the background: see 3.1.

A good deal remains unknown. No doubt there are differences in information recording protocol and practices between, for example, different types of residential service (hospices; supported independent living centres, etc.) and community-based programs, and others. These differences are likely to exist within the arms of large agencies, as well as between differently auspiced agencies.

The legislative position of SHS reinforces this inconsistency. Both practically and symbolically, it is no small fact that SHS organisations do not automatically receive reports from coronial investigations. In part, this is what the senior agency official quoted above meant when s/he noted that 'services are limited (in) obtaining details about a client's death.' It seems that while SHSs have a great deal of responsibility, they have little status and authority before the law.

That State-based authorities seem determined to only minimally record and review relevant deaths is another important determinant. It could be said, that there is not much, if any, encouragement for SHS to systematically review deaths, in order to promote service improvements. Such improvements could firstly, aim to minimise the risk of death. Secondly, improvement could aim to deal more progressively with deaths that are statistically inevitable within such a vulnerable population.

In terms of the reliability of the information chain, SHSs are very restricted in recording not only the number of deaths, but details in relation to cause of death. How 'housing status' is received and recorded is likely to be another uncertainty.

(ix) *SHIP: Specialist Homelessness Information Platform*

All contacts with those receiving services from a SHS, are reported to SHIP. It appears that SHIP holds no data with respect to the recording of death.

(x) Funeral services

It appears to be customary for the contracted funeral director to either:

- directly complete the registration of death form that is required to be forwarded to the relevant Department of Births, Deaths and Marriages (BDM) subsequent to a burial service, or
- directly advise the next-of-kin, or whoever else has contracted with the funeral director, how to complete the registration of death form.

This is directly relevant to how a person's housing status comes to be finalised with each state's BDM.

For example, the official NT government website designed to guide people in how to register a death, states that the writer should provide 'the last residential address of the deceased.' It also states that a 'death registration statement is usually completed by one of the following:

- the funeral director
- the person who arranges for the disposal of the remains
- a local health worker' (https://nt.gov.au/law/bdm/register-a-death).

The advice received in a consultation with a senior funeral director was that it would be unusual to record the deceased person's address as homeless/of no fixed abode. To do so would be 'unseemly' at such a sensitive time.

(xi) Births, Deaths and Marriages

The chain of custody ends with the relevant state department of Births, Deaths and Marriages: see BDM registration Act 1996. Like each of the actors in this chain, the final custodian tends to be prisoner to the accuracy of the information that has been passed to them.

(xii) Other actors

The above list of actors is incomplete. Records from each BDM department are likely to be collated and forwarded to the state's records office; in a good number of cases a State Trustee is involved in, for example, arranging and financing a funeral; each state seems to have a 'concessions' branch within its health bureaucracy. This body finances/subsidises funerals for those who cannot afford a commercial funeral; cemetery trusts have at least a degree of responsibility to provide grounds for pauper's burials; churches of different faiths may have a role.

Comment

Developing the capacity to secure accurate statistics around homelessness and death presents a steep challenge. Unavoidably, there are many theoretical and practical

difficulties. Beyond fixed cohorts (such as those in the Streets-to-Home and Journey to Social Inclusion programs, omissions and redundancies are likely. Even within one system, say, a single hospital, data can be unreliable: 'What complicates (data accuracy) is that we presently do not have one universal system even though iPM, to the best of my knowledge is regarded as the 'source of truth' for cardinal identifiers' (quote from a hospital administrator).

A parallel might be apt. There is a long standing, still in-progress difficulty getting each state to adequately record 'Aboriginal'/'non-Aboriginal' in its official collecting of data. That this process has progressed as far as it has is a big step in being able to record details in relation to Aboriginal mortality/age of death. In a similar way, having the above chain normatively and reliably register 'homelessness' and 'cause of death', would be a capacity building step towards developing adequate metrics.

Vignette 5: 'The end of the road for the forgotten ones'

What happens if someone is experiencing homelessness and this person dies? How is a funeral and a burial arranged and financed? Arnold (in press) details much of this process. The following is taken from a newspaper report (Barrett, 2014) and sets out some of what occurs in Victoria.

The funeral:

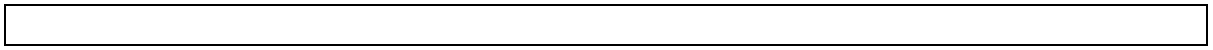
> *Based in Oakleigh, celebrant Ted Worthington founded Bereavement Assistance in 1997. It now operates as a not-for-profit charity, receiving a mix of funding from the state government, private donors, and its own commercial activity. Of 473 funerals it conducted last year, about 200 involved deceased people with no direct relations or means to pay for the service. Mr Worthington's son, Kieran, co-director of the company, says clients are typically referred to them by the Coroner's Court. They arrange for a funeral director, State Trustees rely on four funeral companies to assist with these cases, one social enterprise specialises in the role.*

The cemetery:

> (One option is) *Old Ballan* (Cemetery which) *reopened in 2007 to become one of two cemeteries used by the State Trustees for ''essential care funerals'' – funerals for those who have no family or money left in their will to pay for the service (the other cemetery is at Crib Point, near Hastings).*

Who will try and locate the next-of-kin?

> *In Still Life, a film released this month by the makers of The Full Monty, a South London council worker (played by Eddie Marsan) searches for the next of kin of a community member who has died. It's a poignant and moving story and, while we don't have such dedicated positions in Victoria, sadly, there is still the need here to search for the next of kin of those who have slipped through society's cracks.'*



5. What can be done?

5.1 Background

The aim of this project was to examine the relationship between homelessness, death and dying. A clear finding was reached: homelessness is a mortal threat. Whether in the form of suicide, homicide, overdose, accident or calamitous illness, homelessness and death go hand in glove.

The relationship between homelessness and death is powerfully summarised in the title of a large UK study: *Homelessness kills* (Thomas (2012). This study detailed the correlation between being homeless and a radical elevation in the 'standardised mortality ratio' (SMR). Crudely put, the relationship between homelessness and death is toxic. That is, it has long been recognised that homelessness results in elevated rates of illness and disease – but what is now acknowledged, is that the 'extreme health inequalities' (Geddes and Fazel, 2011: 2156) produced by homelessness go beyond incidental morbidity to accelerated mortality.

The project had a specific aim: to establish how many people die each year as a result of homelessness. This aim could not be realised. However, the reason, or more precisely, the set of factors that make it impossible to quantify how many people die each year as a result of homelessness in Australia, was identified.

This finding is more than a consolation prize. Knowing what prevents reliable figures from being generated, is the first and necessary step in being able to fix this problem. What the current project established was that there is a 'knowledge block' in the information chain that records and passes on this data. This discontinuity clouds our capacity to statistically detail the relationship between homelessness and death.

While a specific figure regarding homelessness related deaths may not have been achieved, what the project *did* achieve was to advance a significantly clearer account of the scale of the problem. Taken together, two findings from the current study enhance the capacity to envisage the scale and dimensions of the problem of 'premature death':

- one inner-city homelessness service reported that approximately 40 service users have been known to die each year (Hollows, 2019: *in press*), and
- international research presents an absolute case that primary homelessness produces a heightened risk of premature death: life expectancy is reduced by several decades, the risk of death is amplified by a factor between three and seven (Stenius-Ayoade et al., 2017; Nilsson et al., 2018), and so forth.

To glimpse the scale of the 'premature death problem', the above can be linked to a known statistic: the number of people who are calculated through the ABS Census to be homeless across Australia.

If all those who are defined as homeless are considered – rather than only thinking about those who experience primary homelessness – it follows that the number of premature deaths of people experiencing homelessness occurring in Australia each year is on a scale

that is genuinely foreboding. That very recent research tells us that 40 per cent of these deaths are – in the narrowest sense of the word – preventable, (Aldridge et al., 2019) only adds to our sense of horror.

Crude arithmetic dictates that each year there will be many premature deaths among the many different cohorts that make up the larger, known numbers of people experiencing all forms of homelessness. For example, it is well documented that many people experiencing homelessness move or transition between primary, secondary and tertiary forms of homelessness. Homelessness in not stable or static experience. What we know of the factors that increase the risk of premature death for people experiencing primary homelessness may well be true, to a greater or lesser degree, for people experiencing secondary or tertiary forms of homelessness, especially as people transition along and perhaps through the scale or categories.

Numbers to one side, the project also contributed to what is known about the relationship between homelessness, death and dying by making an up-to-date summary of the local and international literature more available to the sector. This material is presented in Section 2. A semi-annotated literature review is also available as a discrete resource (see: The Council for Homeless Persons website). Similarly, a contribution was made to better understanding the lived experience of service users, and people who experience homelessness more generally, by identifying and summarising qualitative research and first person accounts on death and dying. (see Section 3)

This qualitative attention also included reference to the lived experience of, and the need to care for, those who work in the sector. Like those experiencing homelessness, service providers also have powerful experiences of, and complex feelings about, death. In this report, an effort was made to normalise, and to a degree particularise, the deep ways that death persists as an unwanted companion for service providers.

Before finalising this overview, it is important to note that prevention emerged as a particular theme in the processing of the data compiled across the three month course of the project. This theme become particularly apparent in relation to the consideration of ‘cause of death’ as a data point in the chain of custody that carries information from the point of a person’s death, to the formal registration of this death with the respective state departments of Births, Deaths and Marriages.

What we found was that there was a de facto tendency to avoid engaging with the question of prevention. Simply put, if the reason a person dies is said to be ‘from natural causes’, this pre-empts the possibility that something could have been done to prevent this death. More practically, if a particular form of expression negates the consideration of a whole class of actions, then this is a practice that needs to be identified and critiqued.

We have identified that menu-driven practices in hospital record systems minimise the chance that ‘no fixed abode’ will be entered in the ‘housing status’ field. Similarly, the disposition to ‘natural causes’ operates as a kind of default setting for ‘cause of death’. That this happens is not the fault of any single individual or organisation. No malicious design is at issue; technical and cultural practices evolve, and tend to become normalised and

naturalised. Independent of their origin, once these are identified as problematic, such practices need to be reviewed.

5.2 Possible improvements

A number of possible options for improvement have emerged from the consultations that were undertaken. These are set out below.

(i) A register of deaths

There is no consistent method for recording and reporting the deaths of people experiencing homelessness in any Australian state or territory; no official or elective body has this oversight function. What is needed is an effective approach to reporting (and reviewing) the deaths of those who experience homelessness, independent of whether these people were, or were not, current or previous clients of specialist homelessness services.

If this problem is to be properly solved there needs to be a central register. This conclusion was recognised in the UK when in 2018 the Office of National Statistics was charged with the responsibility for recording the deaths of those who are homeless. Without a register, attempts to estimate the number of deaths lack reliability. For example, in the absence of a register, Vuillermoz et al. (2014: 690) found that different approaches to estimation produced totals that massively under-estimate the true figure.

Different options present to auspice and organise a register. In Victoria the Coroner administers the state Suicide Register and the Overdose Death Register (and, to a degree, quantifies family violence fatalities by mapping 'homicide by relationship' and intimate partner violence data. (Coroner's Court Annual Report, 2017-2018) These duties could be seen to align with the task of registering the deaths of those who experience homelessness. Coroner's offices in any state could undertake this same function.

Distinct from a Coroner's office, other state or national bodies could also be considered, for example, the AIHW and the ABS; an existing homelessness peak body; a free-standing new body with, or without, a linkage to an existing homelessness peak body. The consideration of options raises the possibility that an elective body, in contrast to a statutory or other official body, might be given the role of acting as a registry point. Although far from ideal, it is possible a more or less formalised arrangement could be made that all relevant agencies agree to systematically record, and then forward to a nominated body, all data on homelessness deaths. This arrangement could be organised on a time-limited or permanent basis. At the least, this would encourage, perhaps even require, local homelessness agencies to commit to thoroughly identifying, recording and collating data on deaths. Presently, this commitment is generally lacking.

Whatever form a registering process might take, it remains there will be persistent methodological challenges. The following introduces one of the important challenges:

(u)nderestimation of homelessness among the Aboriginal and

> *Torres Strait Islander population enumerated in the Census may occur as "incorrect" information regarding "usual residence" may have been provided which masks their homelessness.* (ABS, 2018[iii])

The underestimation problem is not restricted to Aboriginal Australian; it generalises into the larger population. The current project documented the way a pattern of under-recording 'no fixed address', cart-wheels along the whole information chain from when a death is initially documented, to how entries concerning this (and other) data fields are finalised by each state's Births, Deaths and Marriages authority.

(ii) Reviewing causes of death

The reliable registration of the number of deaths is one priority. That each death is appropriately reviewed is a related, yet distinct need. The latter is a key issue as it seems that, to a degree, there is a tendency to attribute the death of a person experiencing homelessness to 'natural causes' unless there are overt signs of misadventure or assault. As canvassed in the body of the current report, in so much as this is the practice, the disposition 'natural causes' will be preferred. Such a preference has a particular consequence: it pre-empts the possibility that prevention might be an option.

A Coroner has a broad mandate to consider what can be done to reduce preventable deaths: recommendations that seek to reduce risks are able to be advanced. (Bugeja and Dwyer 2016) This will not be considered if 'treatable conditions' are subsumed within the category of 'natural causes' as this interpretation has a practical effect: it prevents the coronial interest in the consideration of preventable deaths. If a pattern of death that is significantly avoidable is normalised as a "natural" occurrence, then there will be no recommendation for a legislative change be considered, no recommendation for an amendment to regulations, and no recommendation that better access to services be guaranteed.

It is also possible that deaths referred to the Coroner as 'reportable' might not be accepted as reportable on the same grounds: why investigate the death of a person experiencing homelessness where there are no overt signs of misadventure or assault? The office of the Coroner reserves the right to not accept that a referral is reportable. A certain politics may be at issue in relation to this judgment. The current project has not been able to discern what proportion of referrals are declined by the Victorian Coroner. Presumably, individuals and groups who have status and profile are less likely to declined. It is not clear if persons experiencing homelessness are in that category.

There are also a number of structural options that could support the review and oversight function. Perhaps, the role of an "ombudsman or Commissioner for homelessness" could be established. Such a role would have similarities to those in other jurisdictions, for example the Disability Services Commissioner, and other Commissioners, in Victoria. This positon, with the assistance of the Coroners Court, has an oversight role for those who die whilst clients of state funded disability services. In this role, the Commissioner reviews cause of death.

In contrast to the oversight role undertaken by this Commissioner, in at least some states, the relevant state government oversight body has eligibility criteria that overly screen-out a proportion of the deaths that occur with SHS-related service users. (In Victoria this body is the Department of Health and Human Services; in other states the relevant department's title will be different). This practice precludes the recording and review of a number of deaths on the grounds that these deaths have not occurred 'during service delivery', were not sudden, did not occur on-site, and did not involve a current client in the strictest sense of the phrase. The result of this gating practice is that the number of 'Critical Incident Reports' is markedly less than the number of deaths that have occurred. This results is that there are less opportunities to review and improve services, given that less occasions for review are available. For the current purpose of this project, this practice is problematic.

The international literature has something to say in relation to how cause of death is processed. Nordentoft and Wandall-Holm (2003: 81) reported that death caused by unintentional injury is fourteen times higher for those experiencing homelessness than for those that are housed, and that death from 'unknown causes' is sixty times more frequent than for those who were not homeless. This finding aligns with the finding from Maryland in the United States that more 65.2% of the 279 homeless people who died as a result of violence over an eight-year period, '(m)ore than half (65.2%) of deaths were of undetermined intent.' (Stanley et al., 2016: S260)

A great deal remains unknown concerning the cause of death of those who experience homelessness. Keeping in mind the above, it would be good to be confident that there are as few 'unknown' dispositions as possible. It would also be good to be confident that the sub-group 'preventable deaths' did not slide into the generic category 'natural causes' whether this relates to treatable illnesses or, more generally, factors that are contributory or intermediate. Those who are experiencing homelessness deserve the same degree of attention as those who are housed.

(iii) Evidence building

Consistent with the need to have a structured approach to data collection (see 5.2(i) above), additional research is needed. Both quantitative and qualitative local research could be commissioned. There are several local cohorts that could potentially provide important data on the longer-term effects of homelessness, for example, the Journey to Social Inclusion evaluations; the Street to Home program evaluations and the Journeys Home: Longitudinal Study of Factors Affecting Housing Stability. A systematic data matching process with Births, Deaths and Marriages would be likely to generate important results.

(iv) Policy and program reform

In so much as the premature death of those who are currently experiencing homelessness, or who have previously experienced significant periods of homelessness, is seen as a priority, programs can be maintained, established and extended that minimise this risk.

These programs include those:

- preventive measures that seek to target contributing factors such as family violence, mental health, and alcohol and drugs use and dependence.
- early intervention programs that are aimed at those clients/patients of services who are particularly 'at risk' of homelessness, for example, those discharged from institutional settings, including hospitals. Mental health care and release from prison.
- outreach models aimed at supporting people who were previously homeless and placed into social housing to support and sustain their tenancies,
- tertiary specialist homelessness services to be more effective at resolving homelessness promptly – through expanded Housing First models, stronger measures for effective Assertive Outreach (for example, No Second Night Out provisions) and expansion of Wintringham models with health and palliative care resourcing for the aged homeless and at risk of homelessness.

(v) Living with death: Humanising and preparing for death

Death is, and will remain, a persistent companion to service users and service providers alike. Being able to talk about death and dying – with those who are homeless; with others in the sector – may be and feel awkward, but it is often both the caring and the responsible choice. The following is taken from 'Dying matters: Let's talk about it':

> *'When homeless people die their death is often perceived as untimely and undignified by those supporting them. We can't always say that we're surprised that they died but we might wish we'd been able to talk more openly about their wishes for the end of life* (https://www.dyingmatters.org/page/homeless-people).

The UK-based group who wrote the above, argue it is important to 'mainstream' an attention to death and dying. They contend that assisting people die with dignity is an inherently important aim.

This aim has a practical dimension: that there is access to palliative care; that 'advanced directives' are considered. It also has an emotional and symbolic aspect. That service providers are able and prepared to talk directly about death is a central part of this latter component. Staff support, an affirming, non-blaming work environment and a respect for the lived experience of the practitioner, is a pre-condition for being able to talk directly about all issues, including death and dying.

(vi) Promoting awareness of how many people die because of homelessness

Although it is not known how many people die who are homeless, it is known that these deaths occur at a rate that is many times greater than that of those who are housed. This fact should be disseminated so that the awareness of the findings of local and international research can be raised. Publicising the findings of this project speaks to that idea.

Appendix 1: Definition and nomenclature

Definition and nomenclature remain contested: see Livsey (2017) for an accessible, non-specialist summary. In brief, differences in context, ideology and purpose generate variations in definition and nomenclature. For example, in the US the McKinney-Vento Act provides a legislative definition for homelessness:

> *An individual who lacks a fixed, regular, and adequate night-time residence; and a person who has a night-time residence that is (a) supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalised; or (c) a public or private place not designed for, not ordinarily used as, a regular sleeping accommodation for human beings" (*as quoted by Homelessness and Housing; undated)

Purposes to one side, no single theorisation is consensual, Chamberlain and MacKenzie (2014) offer an account of the issues that definition presents. Whilst it is not appropriate, nor is it feasible, in the current exercise to expand on their account several points should be emphasised.

What the ABS terms 'under-enumeration' is a key problem with respect to figures on aboriginal homelessness. To a significant degree this problem is endemic because there are particular '(cultural) differences in understanding of the concepts of home and homelessness in the Aboriginal and Torres Strait Islander peoples' context' (ABS, 2018[iii]). That is:

> *Perceptions of homelessness from Aboriginal and Torres Strait Islander people indicate that some people who would not consider their current living circumstances as homeless, would be classified as homeless under a statistical measure … Examples of this include people sleeping on the land or in an improvised dwelling in order to be connected to country and/or connected to family or community. Whilst these people have no alternative accommodation, they may not perceive themselves to be homeless and would not seek out homelessness services, yet will be included in Census homelessness estimates. In contrast, there were situations where a person would see themselves as homeless but would not be classified as such under the definition, such as a person who felt disconnected from their country and/or family or community but was living in an otherwise adequate dwelling* (ibid.).

Alice Clark, Executive Director, Shelter SA, discussed how Aboriginal homelessness needs to be understood in the context of Australian Aboriginal history. These ideas were presented in several contributions to *Parity*. Respectively titled 'We cannot simply bury our heads in the

sand Part 1: Genocide and Assimilation' and 'Home is when I am safe from harm: Meaning of Home and Mainstreaming', these papers offer an analysis that humanises and historicises questions of definition and nomenclature (Clark, 2013[a]; 2013[b]).

Clark's contribution goes some way towards understanding what the ABS term 'underenumeration': an '(u)nderestimation of homelessness among the Aboriginal and Torres Strait Islander population enumerated in the Census may occur as "incorrect" information regarding "usual residence" may have been provided which masks their homelessness' (ABS, 2018[iii]). This comment points to a larger complication – the question of nomenclature. This complication is not restricted to the aboriginal populate. Rather, it is expressed at each level of the record keeping system..

For example, in the standard Victorian registration of death certificate – the Third Schedule of the Births, Deaths and Marriages protocol – the applicant is asked to specify the 'Usual place of residence?' of the person who has died As discussed in Stn 4.2, the person who completes this field may be (more or less) guided to enter an incorrect response, and/or may be reluctant to enter 'no fixed place of abode.' Possibly, an earlier, more conventional address, or the ambiguous 'unknown', will be recorded. Consistent with the earlier ABS observation, the number of entries recorded as homeless in the Births, Deaths and Marriages schedule – as formally of 'no fixed place of abode' – will underestimate the true figure. Similar complications are present at other levels of information recording, e.g. in hospitals.

In some respects, the ABS's six-level 'operational categories' concept has advantages. Mindful of these advantages, and also that any system of definition and nomenclature remains problematic, in this report we have adopted the 'cultural definition':

(i) people in improvised dwellings and rough sleepers: primary homelessness
(ii) persons in supported accommodation for the homeless: secondary homelessness
(iii) individuals staying temporarily with other households: secondary homelessness, and
(iv) boarding house residents: tertiary homelessness (Chamberlain and MacKenzie, 2014)

Included in this definition are the 'housed-homeless' – those in insecure, over-crowded, unhygienic and/or unsafe accommodation. It is not clear how victims of family violence, or children who have been abused – that is, those that are housed but endangered – are classified in this schema.

According to conservative commendatory, the use of inclusive definitions 'produces' an inflated count of those who are homeless:

> *By including the 'housed homeless' (such as those living in supported accommodation) and people who would never consider themselves to be homeless, the current official definition distorts*

> *resource allocation and dilutes out those most in need; chronic rough sleepers. It is in the interest of the 'homelessness industry' — the academics, charities and NGOS that undertake research, conduct advocacy, and lobby government for more taxpayer-funded spending on the alleged problems and solutions — for the numbers of homeless to be artificially high* (d'Abrera, 2018)

This comment makes it clear there are ideological, as well as technical, dimensions in any consideration of definition and nomenclature.

There are also theoretical and practical implications that need to be considered. For example, after twenty years of iterative homelessness, a person might spend their final two years of life at a purpose-built hospice. Although no longer experiencing homelessness, given their history when this person dies should their address be recorded for the BDMs register as 'No fixed place of abode?' A similar situation is presented for many chronically homeless persons who dies after several years in the Street to Home or Journey to Social Inclusion programs.

There is a dilemma here. If these deaths are recorded as 'housed' this disguises the impact of homelessness; twenty years of homelessness has severe effects of the prospects for longevity. On the other hand, if these deaths are recorded as 'homeless' this is an example of a naming practice that inscribes identity in terms of a category that, in a sense, is being seen to totalise their identity. Selfhood is not commensurate with objectification

Appendix 2: Debates

(i) Cause of death

It is often stated that the deaths of those who experience homelessness:

> *… are most commonly the result of accidents, such as drug overdoses, traffic accidents and drowning. But in the general population, the vast majority of deaths are from natural causes'* (Kaiser Health News, 23.04.2019).

Embedded in this claim is a binary. People either die from natural causes, or from an unexpected, formally traumatic event. This premise can be critiqued at several levels.

As discussed earlier, many deaths are the result of absent, inadequate or inappropriate medical attention. Cancers, gastric ulcers, diabetes, hepatitis, and many other dangerous conditions, can run their course and cause people to die. The issue is, of course, that 'treatable conditions' (Aldridge et al., 2019) are not being appropriately managed. In this situation it is an error to say people have died from 'natural causes' even if the immediate cause of death is disease that is associated with a 'natural' cause

More theoretically, distinctions between immediate, intermediate and underlying causes of death are contestable. In many examples it is presumably the case that a full description of the cause of death involves a consideration of multiple, non-linear factors. An issue that looms large in theorising this issue is the question of prevention. For example, if the task of formulating cause of death is approached holistically, many more deaths would be understood to be preventable. This matter is further discussed in the section that considers the role of the coroner: see 4.2.

(ii) Is homelessness an independent factor?

What are the direct effect of homelessness and precarious housing on the mortality (and morbidity) of people experiencing homelessness? Kenny (2019: 4) suggested that a 'relatively small group of people with complex, or high, needs require housing with longer term, flexible support, that is Housing First. We do not know the degree to which the experience of homelessness has impacted on the group's health and well-being.' In this context the question is: does intervention make a difference to rates of morbidity and death over time?

One frequently cited study - *Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study* concluded::

> *Living in shelters, rooming houses, and hotels is associated with much higher mortality than expected on the basis of low-income alone. Reducing the excessively high rates of premature mortality in this population would require interventions to address deaths*

> *related to smoking, alcohol, and drugs, and mental disorders and suicide, among other causes* (Hwang et al., 2009: p.b4036).

Hwang et al (2009) argue there is excess mortality associated with homelessness and marginal housing beyond that associated with low income alone. Similarly, Morrison (2009) argued that homelessness is an independent risk factor for death and is more hazardous than being in 'conventional' deprived socio-economic circumstances. As a leading researcher puts it:

> *It is not clear whether the observed mortality risk among the homeless can be explained by their high prevalence of morbidity or whether homelessness itself is an independent risk factor for death. … homelessness may either potentiate the risks associated with morbidities, for example because of lack of access to medical care, or impose additional risks through exposure to hazardous environments'.* (Morrison, 2009: 877)

This research concluded that, holding for SES, 'Homelessness is an independent risk factor for deaths from specific causes. (Morrison, 2009: 877)

It seems possible that while Housing First (HF) programs for those who have experienced iterative homeless over a long period may not necessarily reduce rates of mortality, these programs improve quality of life. That is, the most evaluated HF models has been concerned with those with co- or tri-morbidity factors. For example, Henwood, Byrne and Scriber (2015) report that:

> *Results suggest HF participants face excess mortality in comparison to members of the general population and that mortality rates among HF participants are higher than among those reported among members of the general homeless population in prior studies. However, findings also suggest that causes of death may differ between HF participants and their homeless counterparts. Specifically, chronic diseases appear to be more prominent causes of death among HF participants*

A different view was put by Kerker et al. (2011: 546) who 'compared estimated population-based health outcomes for New York City (NYC) homeless families with NYC residents overall and in low-income neighbourhoods.' This project 'matched a New York city family shelter user registry to health records from registries maintained by the NYC Department of Health and Mental Hygiene (2001–2003) on mortality related to tuberculosis, HIV/AIDS, and a blood lead test' and concluded that:

> *Overall adult age-adjusted death rates were similar among the 3 populations. HIV/AIDS and substance-use deaths were 3 and 5 times higher for homeless adults than for the general population; only substance-use deaths were higher than for low-income adults … Morbidity and mortality levels were comparable between homeless and low-income adults* (ibid: 546).

At this point, it seems to be an open question with the majority view holding that homelessness is an independent factor.

(iii) Is substance abuse a mental health category?

Some studies bundle psychiatric diagnoses and substance use disorders. For example,

> *The excess mortality in the population experiencing homelessness compared with the general population was reduced by 50% after adjusting for psychiatric diagnoses, including substance use disorders* (Nilsson et al., 2018:63)

Similarly, Geddes and Fazel (2011: 21570) write:

> *'… in the Danish psychiatric register are known to be reasonably reliable for severe mental illnesses such as schizophrenia, by definition they only detect treated episodes in primary and secondary care; and more detailed diagnostic information, such the specific substances used, must be viewed with a degree of caution'*

Very likely, most in the field would not conflate substance abuse issues and mental health problems. This is an example of a taxonomic debate.

Appendix 3: Post-death flow chart

The following attempt to set out the salient decision and reporting sequence

Body found/someone dies: can be declared dead if 'obviously so' by paramedics (but not by other first responders). If this status is not finalised on site, formal *Verification of death* declaration is done by GP, A and E medico or hospital doctor. Body is identified or is not-identified at this point

The location of the body makes a difference to what protocol is instigated, for example family home v. park v. nursing home v. shelter). Broadly, 'cause of death' is at issue – either seems natural / non-problematic, or otherwise. If a person is a ward of the state, or is 'in care' with an official body, the death must go to the coroner. Clarification of identity may be an ongoing issue.

2: (i) Decision re 'reportable', or (ii) 'non-reportable': made by GP (if there is a relevant / available one), two GPs (in NHs), senior A and E physician / ward medico if in hospital. Police also have a role; details re their protocols unclear at this point

Is there an assumption that 'parkies' have died of natural causes? If so, there are less Coroner's reviews that would otherwise be the case.

3.1: (i) referred to coroner: either 'finding' or 'inquest': go to

(ii) 'Cause of death' not regarded as problematic; go directly to (4)

3.2: (i) Coroner conducts process to make (ordinary) finding or inquest finding re cause of death' (and more)

3.3 (i) Coroner releases body

Body has to be 'released'; legally owned by senior n-of-k, but in practice GP/hospital have this call (if the coroner is not involved)

4. Funeral director

5. Burial

6. Births, deaths and Marriages: After burial, death must be registered with BDMs in order to

be registered: forms asks 'the last residential address of the deceased'

Comment

(a) There is a chain of custody regarding the data point 'housing status.' At each point between 1: 'Body found / person dies' and 6. 'Registration of death' with BDMs; there are slippage points in how this data point is entered. For example:

- at 1: the person may carry an old address in their belongings; they may have no identification
- at 6: the official application form asks for 'the last residential address of the deceased?' (at least in the NT). Who fills this out, and the 'social set' that is invoked, as much as the particular cast of the question, invites disparate responses.

More, form-filling practices:

- at hospitals, nursing homes, et al.,
- the practitioner's reliance on old entries in their files, and/or
- the accuracy of received information (say, at the Funeral Director's) add more that is imprecise at points 2, 3, 4, and 5.

It is the last point – the registration of a death with BDMs – that seems to be the key variable. How this information is constructed seems likely to be influenced by fuzzy inputs.

For example, the official NT government website says:

> 'After the person has been buried or cremated, the funeral company will usually help the family to register the death': (https://nt.gov.au/law/bdm/register-a-death).

This means the funeral director advises on how to respond to the question '(what is) 'the last residential address of the deceased?' Standing next to the funeral director, how likely is it that a next-of-kin will always respond: 'Yeah, Aunt Maple was homeless' if, in fact, that is the correct answer?

The cumulative effect?; A 'knowledge block' has been created. This block prevents reliable information being collected about the number of homeless people who die.

(b) 'Cause of death' is frequently reported as 'unknown' for homeless person (at least that is what the international literature says). In so much as this is true in Australia, it seems likely that the chain of decision making around ensuring there is accuracy in entries at completing this data point might also build a 'knowledge block.'

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