# Appendix 7: The experience of mental ill-health and homelessness can have tragic effects including mortality

Launch Housing has established a client death register. We record, monitor and review client deaths for the purposes of research, advocacy and continuous quality improvement. Deaths that occur as a result of mental illness or that are connected to the mental health system are generally reviewed.

## The pre-mature death of people experiencing homelessness

**People experiencing homelessness have far higher mortality rates than the average population**

Homelessness is a significant health inequality[i] and is regarded as an important and modifiable predictor of mortality.[ii] Homelessness is also an independent risk factor for death and is more hazardous than being in 'conventionally' deprived socio-economic circumstances.[iii]

There is limited Australian data on the mortality rate for people experiencing homelessness or the impact of mental health on mortality rates. Research in Australia suggests that the mortality risk exceeds that of non-homeless people by up to six times.[iv]

Reporting the deaths of people experiencing homelessness in Victoria is highly variable and there is no clear oversight (or responsibility) in reporting, monitoring and instigating remedial actions.

## Launch Housing monitors client deaths including those associated with mental ill-health

**Results from Launch Housing's Client Death Register (June 2018- 19)**

- There were 45 known deaths of current or former clients.
- The average life expectancy of this cohort was 42 years of age.
- 86% of this cohort had a diagnosed or self-disclosed mental illness; 7% did not have a mental illness; and 7% did not disclose information about mental illness due to the type of service they received.
- 41% of people were in contact with mental health services at the time of their death.
- A further 20% of people had had contact with mental health services at some point in their lives.
- 47% of people had more than one mental illness.
- 64% had a diagnosis of depression, anxiety or both.
- 47% of people had a psychotic illness.
- 17% had a form of personality disorder.
- 11% had PTSD.

**Case studies - The two case studies below provide insight into the typical and tragic circumstances surrounding client deaths. To ensure anonymity, they represent a composite of the stories and experiences of a number of clients.**

'Maria'* completed suicide at age 32, approximately one month after being discharged from a psychiatric inpatient unit. 'Maria' was deeply entrenched in the homelessness sector, with her first episode of homelessness occurring at age 18.

'Maria' was diagnosed as Bipolar at age 17, and Borderline Personality Disorder at age 20. Her experience of homelessness exposed her to significant trauma, and she was diagnosed with PTSD at age 25. 'Maria' was a polysubstance user, and had enormous trouble securing a dual diagnosis service.

'Maria' cycled between alcohol and other drug services and the mental health sector, which highlighted the problem of 'boundary' disputes between the two sectors and who had primary responsibility. 'Maria' found it very difficult to maintain housing due to drug use and poor mental health, and cycled in and out of homelessness. She was evicted from crisis accommodation services, rooming houses and other emergency accommodation.

'Maria' was residing in public housing at the time of her death and received services from Launch Housing. 'Maria' had had four psychiatric admissions in the two years prior to her death and was on a Community Treatment Order. Her girlfriend advocated for her admission to a residential mental health service, however this did not eventuate. Ultimately, 'Maria' took her own life. It is likely that 'Maria' would have benefitted if the alcohol and drug sector, mental health and homelessness sectors were better able to coordinate service provision.

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'Ben'* died at age 24, whilst residing at a residential mental health service. 'Ben' was diagnosed with Schizophrenia at age 17, and Depression at age 20. His family experienced homelessness when 'Ben' was 10, and he experienced significant trauma as a result of this. His family was supported by a Launch Housing service at the time of his death.

'Ben' was hospitalised as a psychiatric inpatient two months prior to his death and was discharged to a residential mental health service one month prior. He was psychotic at the time of his death but was not considered to be a danger to himself and was therefore held at the residential service. On the day he died, 'Ben' left the service, went for a walk, and was hit by a car.

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* Not the actual name of the clients whose stories were used to inform these case studies

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[i] FEANTSA (2016) Policy Statement: Average Age at Death of People Who Are Homeless, September

[ii] Nilsson, S.F., Laursen, T.M., Hjorthøj,C., & Nordentoft, M. (2018) Homelessness as a predictor of mortality: an 11-year register-based cohort study, Soc Psychiatry Psychiatr Epidemiol, 53:63–75

[iii] Morrison DS (2009) Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. Int J Epidemiol 38:877–883

[iv] Arnautovska, U., Sveticic, J & De Leo, D. (2014) What differentiates homeless persons who died by suicide from other suicides in Australia? A comparative analysis using a unique mortality register, Soc Psychiatry Psychiatr Epidemiol (2014) 49:583–589