Invisible Deaths — Mortality among People Experiencing Homelessness

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Jack died on a street corner. A larger-than-life figure, he stood more than 6 ft, 4 in. tall, exudedcharismatic energy, and embraced the role of "king of the streets." Then, at 49, he died without warning on a busy sidewalk in Boston, not far from Massachusetts General Hospital.

As a street physician caring for people experiencing homelessness, I had just finished residency training when Jack slipped away — the first of my patients to die on the street. I spent the next few days privately grieving his untimely death and searching the local newspapers for any mention of it. Surely if someone else — a student, a health care worker, a regular passerby — had died suddenly in plain view, a stone's throw from a renowned academic medical center, there would have been some recognition in the press. It never came. No obituary was published, and more than 4 years later, there is no trace of him online. No funeral or memorial service was ever held. He did not receive a proper autopsy. His cause of death remains unknown.

Sexually and physically abused as a child, Jack was accused of a crime as a teenager, served time in prison, and was immediately homeless on release. Yet he still managed to develop a deep knowledge of world history, an enchantment with art, and a keen sensitivity to the emotions of his peers. He tried to find work and fulfillment but was plagued by the sequelae of early-life trauma — challenges with executive functioning, emotion regulation, and forming secure attachments — that can permanently alter a person's mind and life course. Like that of many of my patients, his story has a tragic ending.

The epidemic of premature death among people who experience homelessness in the United States is staggering and has continued to grow. The mean age at death in this population is 51 years — nearly 25 years younger than that in the general population and an age at which Americans commonly died in 1900.1 The statistics are particularly striking for certain subgroups, such as people who sleep on the street. Age-adjusted mortality in this group is nearly 10 times that in the general housed population and nearly 3 times that among people who sleep primarily in shelters.2

Various factors contribute to an increased risk of premature death among people experiencing homelessness. People who become homeless have often had exposure to health-harming factors from an early age, such as neighborhood disadvantage and discrimination, that are linked with premature death in other historically excluded populations (e.g., people with severe mental illness and marginalized racial and ethnic groups). People who experience homelessness have a substantially higher disease burden than the general population, including more advanced cardiovascular disease and higher rates of cancer. Limited access to health care, medications, and a safe place to rest contributes to this burden and complicates management of medical conditions.

Substance use, which is often associated with a history of trauma, also leads to a devastating number of overdose deaths among people experiencing homelessness.1 In addition, violence, accidents, and exposure to severe weather cause thousands of deaths every year among people in this population. The Los Angeles County Department of Public Health notably found that relative to the general population, people experiencing homelessness were 41 times as likely to die from a drug or alcohol overdose, 18 times as likely to die from traffic-related injuries or by homicide, 8 times as likely to die by suicide, and 4 times as likely to die from heart disease.

Although no federal agency collects nationwide data on deaths among people experiencing homelessness, a study of data from 10 states found that all-cause mortality in this population increased 238% between 2011 and 2020.[1] The aging of this population, the increased availability of fentanyl, and disruptions in social services during the Covid-19 pandemic have contributed to steep increases in deaths. In some cities, numbers of deaths among people experiencing homelessness have recently doubled.[3]

It is one thing to be aware of these statistics — and another to experience them as a clinician. Although I found Jack's death deeply unsettling, I soon learned that patients cared for by our Boston Health Care for the Homeless Program street team regularly take their last breath under a bridge, in a parking garage, or in a subway station. The profound neglect that people who are homeless experience in life is just as tragic in death. One patient of ours would fantasize aloud during clinical visits about her own death, hoping that it would motivate her estranged son to finally return to her side. But after she died, her body remained unclaimed in a morgue. Another patient died of an apparent gunshot wound, but nobody was available to provide information about his death. A third was stabbed in a fight and continued bleeding while people leaving a concert walked past; after 30 minutes in which no one called 911, he died from cardiac arrest. In many cases, no family member claims the body; if one does, rarely is there money or interest to place an obituary or host a funeral or memorial service. These unrelenting deaths take a considerable toll on other members of the community on the street, who often wonder aloud, "Am I next?"

The indignities that people experiencing homelessness endure during life carry over after death. Our team has found that when a postmortem examination of a person who was homeless is conducted, it is often only a partial or limited examination. Housing status is rarely recorded on local and state death reports; one study found that only 2% of U.S. counties clearly documented deaths among people experiencing homelessness.[4] Furthermore, many people who were homeless remain unidentified after death. These factors not only dehumanize members of an already marginalized population but also thwart data collection on the number and causes of deaths among people experiencing homelessness. This lack of information impairs research. It hinders prevention efforts. And for clinicians caring for these patients, it deepens grief and complicates closure. Over years of practice, I have come to understand that Jack's story is not the exception, but rather a grim rule for people who live on the street. Our patients regularly experience extraordinary trauma, receive inadequate care, and struggle to rebuild their lives, only to die unfulfilled and without any recognition of their existence.

Steps can be taken to recognize people who were homeless after they die — and to support people experiencing homelessness during life. Improving the visibility of these currently invisible deaths could help save lives. One policy change could involve requiring the recording of housing status on death certificates. Collecting standardized data related to mortality among people who experience homelessness, including sociodemographic information and place and cause of death, could enhance understanding of this pressing public health issue among clinicians and policymakers.

Linking mortality data with data on the use of health care and social services could permit identification of potential points of intervention.[3] Postmortem examinations conducted in this population could consistently test not only for the presence of drugs but also for other plausible causes of sudden death. Meanwhile, increased investments in Housing First, street-medicine, and harm reduction programs are critical to reduce rates of disease and premature death. Clinicians should also be trained to help patients who are suffering on the street.[5]

Finally, society needs to make a sustainable commitment to increasing the availability and affordability of housing and to preventing early-life trauma.

Jack's story of inequity in death as in life must not be the norm going forward. Clinicians can advocate for systems of care that could help ensure that the ghosts of neglect, abuse, and other forms of adversity do not continue to haunt vulnerable people to their graves. A lonely, invisible death on the street is an indictment of one of the richest countries in the world — and is ultimately preventable. We should aspire to creating a society in which after a human life ends, each person is seen as meaningful enough to be mourned, missed, and celebrated.

Identifying details have been changed to protect the patient's privacy. Disclosure forms provided by the author are available at NEJM.org.

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