11 March 2022
Attn: Standing Committee on Estimate and Financial Operations

Dear Committee of the Legislative Council,

Re: Inquiry into the financial administration of homelessness services in Western Australia

Submission title: Too many dying too young

This submission focuses particularly on the sobering rates of premature death among people who have experienced homelessness in Perth since 2017, with an average age of death that continues to be more than three decades younger than that that of the general population.

The focus of this submission is not however just about deaths per se, but relates to wider issues of how the Western Australian Government is responding to homelessness, its causes, and consequences. After all, life expectancy is a widely used marker of social and health equity around the world, including Australia, and if you are homeless in WA, on average you can expect to die three decades younger than people who are housed. Further, monitoring and raising awareness of deaths and life expectancy gaps provides a vital benchmark for action and accountability; the enumeration of the life expectancy gap for Aboriginal and Torres Strait Islander people has for example made us more accountable as a nation for 'closing the gap', with annual report cards tracking progress (or not) on this,[1,2] and each jurisdiction, has in turn, accountabilities for action. Deaths among people who have experienced homelessness in WA and Australia by contrast have been largely invisible, but now need to be visible and preventively acted on in this State.

This submission pertains to the following Inquiry Terms of Reference:

1. *Current funding and delivery of services* – particularly in relation to funding and delivery gaps, as the length of time homeless (e.g., waiting for housing) is predictive of health deterioration and thus premature death.
2. *All Paths Lead to a Home 10 Year Strategy* – particularly relating the scant references to Health in *the Strategy,* and how premature deaths relates particularly to priority action areas 2.2 and 4.1, whereby people are free from harm and put at the centre of responses.
3. *Existing data systems and how data informs service delivery* – including a call to action warranted by emerging evidence of the life expectancy gap in WA, and the implications of this for homelessness and health services (also relating to Priority Action 4.4 of *The Strategy)*.

1. Background on Homeless Mortality – too many dying too young

There is now substantial international, Australian and WA evidence that poor health is a both a major driver and consequence of homelessness.[3-5] Hence, our disappointment that there are scant mentions of health in the WA 10 year Strategy.

Life expectancy is a widely used indicator of social and health equity[6] and is frequently linked to the economic wellbeing of a state or country. While life expectancy in WA and Australia has continued to increase over recent decades, overall life expectancy and average age of death figures mask some disturbing disparities. The life expectancy gap for Indigenous Australians is well known, and there is also a marked social gradient in life expectancy in Australia and WA by socioeconomic status and associated with regional/remote geography.[6,7]

Internationally, there has been to date better data and monitoring of premature mortality among people experiencing homelessness. For example in data released by the Office of National Statistics (UK), there were 726 deaths of people who were homeless recorded in 2018 for England and Wales, with a mean age at death of 45 years for males and 43 years for females.[8] In 2020 figures from the UK Museum of Homelessness, there were 976 known deaths across the UK in 2020; equivalent to one homeless death every nine hours.[9] In another recent UK study by Aldridge and colleagues, based on the analysis of hospital records for 3,882 patients experiencing homelessness, the median age of death was 51.6 years, and one in three deaths were attributable to conditions that could have been prevented or treated.[10]

Of a desktop review by our research team of 28 published studies on death for people who have experienced homelessness, an average age of death of less than 50 years was reported in 57% (n= 16) of these studies,[11-26] and an average age of death of between 50-60 was reported in 39% (n=11) of these studies.[10,27-36] Only one study[37] reported an average age of death over 60 years.

In Australia, deaths among people experiencing homelessness in Australia remain largely 'invisible' with the exception of research that our Home2Health research team has led over the last four years. Deaths among people who have experienced homelessness do not appear in routinely reported national mortality and life expectancy statistics[2] and are not easily identifiable in hospital, coroner or health service data because homelessness status is poorly recorded.

In **Western Australia**, there has been increasing concern and media attention over the last two years pertaining to deaths among people experiencing homelessness in Perth, and this has included coverage of the research lead by our Home2Health research team.

Key summary statistics appear below and we refer the Inquiry Committee to two papers we published mid 2021 on homeless deaths,[38,39] and further details about the methodology underpinning this research can be shared in confidence with the Committee by request.

2. *What is known about homeless deaths in WA*

Since 2017, the Home2Health research team (now based at the he University of Notre Dame Australia), has developed a robust methodology for documenting and verifying deaths among people who have previously experienced, or who are currently experiencing, homelessness in Perth. As this data includes only deaths our team has confirmed notification of, it is conservative and has limitations (see latter points regarding this). However, it has been recognised by the Australian Alliance to End Homelessness[38] and homelessness colleagues and researchers in other jurisdictions, as the most comprehensive and recent data on homeless deaths in Australia at present, and featured in two invited papers and the launch of the Parity special issue on homeless deaths in August 2021.[40]

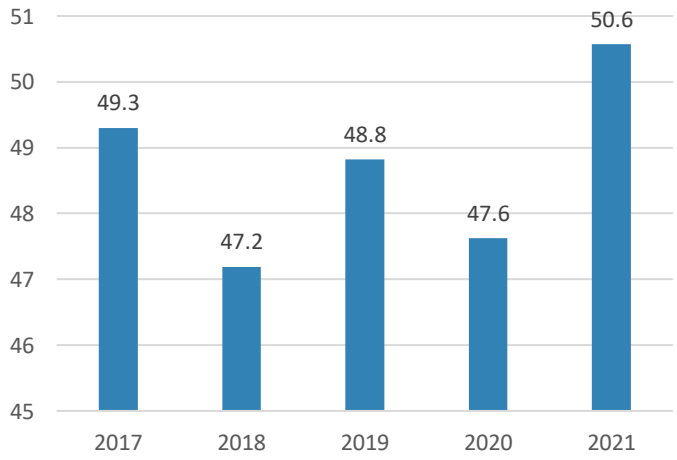

Figure 1: Average Age of Homeless Deaths in Perth Over 5 Years

Our deaths database includes 281 homeless deaths between 2017 and 2021, with an overall average age of death is 48.8 years, which is congruent with many of the published studies mentioned in the background section (see Figure 1).

In 2021, there was 70 known deaths of individuals who experienced homelessness in Perth; equivalent to 1.3 people dying every single week. The median ages of death in this 2021 homeless deaths cohort was 51 (52.1 years for males and 45.3 for females, which contrasts grimly to a median age of death in Australia in 2019 of 81.7 years (78.8 years for a male and 84.8 years for a female).41 **This is a three decade gap in the median age of death.**

Limitations of our data and likely underestimation of deaths among people who have experienced homelessness in WA: Sadly, we know these figures on deaths are conservative: currently recorded deaths do not include deaths in outer areas of Perth (e.g., Mandurah) or regional WA, or deaths not known to the health services that provide data for our ethics approved research. There are also deaths that have been reported to our team that are awaiting full verification and these are not included.

As homelessness is often 'invisible' in published health data,[42] and is not routinely or adequately identified in national or state health data systems,[43,44] there is no 'single source' of data at present that comprehensively identifies deaths among people who have experienced homelessness. This is the same situation internationally, and as articulated in a recent **Homeless Mortality Data Toolkit**[45] released by the US National Health Care for the Homeless Council, multiple sources of data are required. The methodology developed by the Home2Health team is comprehensive and congruent with recommendations set forth in this toolkit. Due to overall the lack of identification of homelessness within health data systems, we believe that this database we have developed is the most comprehensive deaths registry relating to homelessness in Australia.

3. The human face of deaths should not be forgotten

That the human face of homeless deaths not be overlooked was the subject of our recent paper published in Parity, entitled *Each one a Life*.[39] The following excerpt from that paper is but one example that illustrates how prolonged homelessness contributes to health deterioration and in the end, premature death.

> For individuals with a chronic health condition, the impact this can have on daily life and wellbeing can be all-consuming. Imagine having multiple chronic health conditions, and trying to manage these while living on the street. Keeping track of medications, making medical appointments, getting to health services are all common challenges, compounded by lack of sleep, poor nutrition, and anxiety.
>
> Naomi* was a **47-year-old female** with a severe auto-immune disease that affects multiple organs. It caused chronic renal failure, heart failure, and painful oesophageal ulcers. Naomi was rough sleeping and staying in women's refuges for at least a year before her death. In addition to her extensive physical ill-health, Naomi had experienced repeated abusive domestic violence from a prior partner, and had been hospitalised with injuries from this on numerous occasions.
>
> On her last hospital admission prior to death, Naomi had 15 different prescribed medications to treat her various health conditions. As noted by Dr Amanda Stafford from the RPH Homeless Team, *"It is impossible to manage such a complex disease and its health complications if you are living on the street."*
>
> As is quite common among homeless patients who have experienced trauma, Naomi discharged herself from her last hospital admission (for oesophageal ulcer bleeds and a clot) 'against medical advice'. She passed away six weeks later, in May 2020.
> *Excerpt from article published in Parity, July 2021* * not her real name

4. Causes of the causes of death

Since our research team began communicating about our data on deaths among people who have experienced homelessness in Perth, we have consistently stated that our data **does not convey** homelessness as the direct cause of death, as this is clearly not a 'cause of death' in a clinical sense of

the word. There is indisputable evidence however that the experience of homelessness is associated with a much higher risk of mortality and reduced life expectancy. Published evidence indicates that premature deaths of people experiencing homelessness may relate to any or a combination of the following:[10,14,24,33,46-51]

- Late detection of preventable disease and poor access to prevention and screening services. For example, late detection of cancer & or advanced diabetes requiring amputation.
- Difficulty adhering to treatments for existing health conditions when homeless; medications are often stolen or lost, and people can find it difficult to book or get transport to health appointments
- 'Deaths of despair' – a phrase now being used in international literature to refer to those deaths relating to drug overdoses, suicide and alcohol-related disease amongst people who have experienced compounded social and economic disadvantage. The COVID-19 pandemic has been reported overseas to have further exacerbated the likelihood of deaths of despair
- the co-existence of multiple chronic health conditions, worsened by the brutality of sleeping and surviving on the streets. International studies show that those experiencing homelessness have much earlier onset of frailness and conditions often associated with older age.
- Poor sleep quality, limited access to healthy food options, hygiene constraints, all of which contribute to poorer health outcomes.

To argue that homelessness did not literally cause death is a moot point and not helpful. In this country there is counting and alarm by contrast about deaths in custody in WA and wider Australia (whatever the medical or coronial inquiry determined cause of death) and should be just as alarmed about the three decade gap in life expectancy associated with chronic homelessness in WA.

Again, the human face of homeless deaths speaks more powerfully than thousands of words, as reflected in the following case study abridged from one of our papers on homeless deaths published in the Parity journal special issue in August 2021:

> [redacted] was a [redacted] **year old male,** with a 10-year history of rough sleeping in Perth. He was one of 7 children, and had 3 children of his own, but had lost contact with most of his family in the few years prior to becoming homeless. [redacted] has been through a number of traumatic experiences in his earlier life including a serious car accident as a toddler that hospitalised his mother for a year, and the tragic death of his youngest brother at age 21. Struggles with alcohol plagued him most of his life, and contributed to being in and out of jobs over the years. Family and others had offered to help [redacted] get off the street, but as one of his sister's recounts, he was too proud to accept assistance, and felt that he himself was to blame for his situation. "[redacted] *was a warm, caring person, a poet who just got lost in the world" she noted.*
>
> [redacted] slept most often in a park where he felt safer, but each day for 10 years sat on the steps of [redacted] in the Perth CBD. Here Homeless Healthcare's Street Health outreach nurse and GP would stop by regularly to see how [redacted] was doing, and gradually he opened up that he had a plan "*to get a house, job and rekindle my relationship with my children and grandchildren.*" He went onto the priority list for public housing, and UnitingWA arranged interim accommodation while he waited for housing.
>
> In early 2020 [redacted] contracted a chest infection and was experiencing shortness of breath when he tried to walk even a short distance. He had had minimal contact with doctors for much of his adult life, but COPD was suspected and he attended hospital to get some tests. He was diagnosed with a chest infection and Stage 4 lung cancer. [redacted] had quit smoking just a few months before, but had been a pack a day smoker since his early teens, taking its toll on his lungs and health.
>
> [redacted] sadly passed away in September 2020, only a few weeks after his diagnosis. A public housing offer came through for him just 8 weeks after his death. In his final month, [redacted] was able to fulfill his wish to rekindle his relationship with family, talking regularly with his sisters, and reconnecting with his children. [redacted] was well loved in the Perth CBD community as the friendly man who sat on the [redacted] steps, and there were many tributes left to him on the steps.

5. *Implications and Recommendations for this Inquiry*

5.1 Recommendations re TOR 1: Current funding and delivery of services

Clearly there is no single service or funding intervention that will single handily prevent premature homeless deaths, but from our own research within WA and nationally, and published literature, we contend that the following warrant greater attention if we are to make progress in this state in curbing homeless deaths and the life expectancy gap:

1. *Priority pathways for accommodation* (supported where necessary) for people who have chronic health conditions, as managing chronic health conditions is nigh impossible if you are living on the street. Too many of the case studies collated by our team relate to people whose health severely deteriorated while continuing to sleep rough, in some cases people literally have died while on the waitlist for public housing in WA. During the 50 Lives 50 Homes program (that preceded the zero project), the existence of multiple health conditions was taken into account as part of the vulnerability score computed by the VI-SPDAT that was used to triage and prioritise rough sleepers for the 50 Lives Housing First initiative and permanent long term housing. Since 50 Lives morphed into the zero project and wider commitment to Housing First as part of the WA 10 year strategy, we are concerned that the public housing prioritisation of rough sleepers with chronic health conditions has been a bit lost, and given the continued burgeoning of the general and priority public housing waitlist, the loss of housing prioritisation for chronic rough sleepers with multiple health conditions has moral and fiscal implications, as all our research and published evidence shows that hospital use increases the longer people remain homeless.
2. *Dying with Dignity – what options if homeless in WA?* The work of Dr Caroline Shulman a GP in the UK has found that people rough sleeping or in transitional accommodation do not have adequate support as their health deteriorates and often require repeated unplanned and emergency hospital admissions in the last months, weeks or days of life. Universally, an individuals wishes are paramount in end of life care, but this can be immensely difficult if you are without a home, and often without family and other supports. Homeless Healthcare over the years has supported patients to access and receive caring palliative care and has powerful case study accounts of supporting patients to re-unify with children and other family to assist them to die in greater peace. However, in the main, the end of life needs of people homeless are hidden in WA and Australia. By contrast, in the last 5 years in the UK, there has been more targeted attention in recent years to upskilling homelessness support and accommodation services in this area, and to ensure there are pathways and options to d*ying with dignity* for those without a home or support. This includes rapid access to supportive accommodation, trauma-informed palliative care, and above all, and exploration of ways to bring support to where people feel most comfortable themselves.
3. *Dedicated and ongoing funding for post-hospital respite care for people who are homeless.* One of the recommendations of the recent Productivity Commission report on mental health was for the ceasing of discharges to homelessness from government institutions, with explicit mention of hospitals. Evaluations by our research team for the RPH Homeless team and for WA Health as part of its *homelessness discharge facilitation fund* pilot, have shown the substantial health and economic benefits of curbing the escalation of hospital use and deterioration of health conditions by ensuring people are not discharged back to homelessness. However this has only been done at some hospitals to date on a small scale and limited budget, albeit showing economic and health returns. More recently, in October 2021, WA's first Medical Respite Centre (MRC) for people who are homeless and needing medical care after hospital discharge was opened; this was a recommendation of the Sustainable Health Review, but only has funding for a 2 year pilot. Whilst

early days for the MRC, there is strong evidence internationally and from Melbourne and Sydney for the health and fiscal benefits of this, and this recent abridged quote from a MRC resident speaks volumes:

> *" I have wanted to end my life and attempted to do so most of my adult life, but coming here, I now want to live; I feel safe, I feel listened to, and my health issues and worries are being sorted. It has saved my life"* MRC resident, age 65, Homeless Healthcare evaluation interview, March 11 2022.

4. *Funding for specialist homelessness health providers* (such as Homeless Healthcare) to expand access to preventive health and primary care. The barriers to primary care for people experiencing homelessness have been well documented,[52,53] and these contribute to the deterioration of health that then often results in costly hospital ED presentations and lengthy inpatient admissions.[54] With a UK study finding that a third of the deaths among homeless people were preventable,[10] it is imperative that additional resourcing is allocated to increasing preventive health and primary healthcare access to reduce the burden on tertiary services. Even small amounts of funding can make a significant difference, as shown in our teams evaluation of a collaboration between Homeless Healthcare and Cancer Council WA to pilot provision of free access to nicotine replacement therapy to people who are homeless to assist them to quit smoking. Tobacco use remains the largest preventable cause of death in Australia, yet 80% of people homeless smoke, and high levels of dependency make it difficult to quit.

5. *Advocate to the Commonwealth for Medicare to provide rebates for clinical work/support done as part of street outreach* to support people "where they are". Currently, Medicare only provides rebates for primary care services delivered at a GP clinic, in the patient home/hostel or an aged care facility, hence all of Homeless Healthcare's street outreach work by nurses is philanthropically funded and limited to a set number of days per week, and there is no funding for GP outreach. Yet those most vulnerable and often with undiagnosed or poorly managed health conditions are very wary of attending clinics. Colleagues in several cities in the UK have received government funding for larger homeless outreach capacity that includes mental health nurses, general nurses, GPs, and dual diagnosis (mental health and alcohol and drug use) trained specialists - literally taking health and social care to the streets, alleyways, squats and other places people survive in, but with government investment to do so. We encourage the Inquiry Committee to speak further to Homeless Healthcare for further insights on this gap.

5.2 Recommendations re TOR 2: All Paths Lead to a Home 10 Year Strategy

Congruent with international studies, the longer a person remains homeless, the poorer their health outcomes become and the likelihood of premature death increases. Not having a home is the most fundamental driver of poor health and high hospital utilisation among people experiencing homelessness But conversely, as our evaluation of 50 Lives 50 Homes[55-57] and the work of Homeless Healthcare[46,58] and the RPH Homeless Team[4,59,60] have shown, stable housing coupled with wrap around health and social supports enables many health and psychosocial issues to be addressed, and just as importantly, restores hope and a sense of a different future.

1. *Greater recognition needed in Strategy of the need for more access to primary and preventive health care for people experiencing homelessness***.** As shown in recent UK data, around a third of homeless deaths were preventable, and others estimate this to higher. People experiencing homelessness face substantial physical, psychosocial and logistical barriers to accessing primary care.[58] Over 85% of RPH Homeless Team patients were not receiving primary care when they were first supported by the RPH Homeless team.[61] Yet many of the issues with which people

experiencing homelessness present to hospital could be better dealt with by general practice and social services, recognising that an acute hospital setting is not best placed to deal with chronic disease.[62,63] Sustainable funding is required to this level of primary care.

2. *Rapid housing of rough sleepers has to be accelerated if the 10 year Strategy commitment to Housing First is to be genuine.* While it is pleasing that Housing First is a cornerstone of the Strategy, it has to be more than aspirational to house people rapidly, as non-negotiable core tenet of Housing First is that individuals are rapidly housed and then connected with support to address underlying issues. In WA, this is the biggest impediment to this being a reality, and hence the biggest threat to the effectiveness of the Strategy is the dire shortage of social housing and long waitlist for public housing that now exceeds 17,000 people in WA.

   The longer people are homeless, the more their health deteriorates, and risk of premature death increases. In the 50 Lives 50 Homes program that preceded the Zero project, the rough sleepers being supported had spent on average 5.2 years homeless prior, followed by an average wait time to get housed of 30 weeks.[57] This is NOT rapid housing.

3. *Need for agility in 10-year Strategy for unprecedented events that impact on people homeless.* No one could have anticipated the onset of the COVID-19 pandemic. However, the COVID-19 pandemic has shone a sobering spotlight on the acute health and social vulnerabilities of this population, with our published research showing that more than one-third of people experiencing homelessness having one or more risk factors for COVID fatality.[64] Furthermore, as highlighted in our widely cited letter to the Medical Journal of Australia, minimising the risk of transmission and infection is extremely difficult due to the inherent challenges associated with a lack of sanitation and regular hand washing facilities, inability to self-isolate and reduced healthcare access.[65] More broadly, COVID-19 has exacerbated the shortage of affordable housing and contributed to the rising number of people new to homeless being observed in WA By Name List data, and being seen by homelessness services and the RPH Homeless Team.

   The Strategy could not have anticipated the extent of this pandemic. But a good strategy should be 'live', responsive and agile. Yet in various meetings I (Professor Wood) have attended with government and non-government agencies since March 2020 to now in relation to COVID-19 and its implications for people experiencing homelessness, there have been few mentions of the Strategy, and I am not sure this speaks favourably to how top of mind it is as a platform for action. To illustrate further, in NSW, Victoria, Queensland and South Australia, there were proactive efforts led by the WA equivalent of the Department of Communities to rapidly get rough sleepers off the street when COVID-19 spread began to rise in those states. This has not been the case in WA, and as we write this submission, COVID-19 cases have disturbingly been reported among the Perth rough sleeping population, and given their much lower vaccination rates, co-morbidities, and inability to isolate, our grave concern is that this will lead to a greater poor health and mortality in an already highly vulnerable cohort.

5.3 Recommendations re TOR 3: Existing data systems and how data informs service delivery

As the old adage goes, **you can't change what you don't measure**. Deaths data may be seen by some as depressing, but it can be powerfully harnessed to drive change, as has been seen in national efforts to Close the Gap in Aboriginal life expectancy, and monitor progress on this. Similarly, advocacy and change has come about (or is being increasingly called for) in response to monitoring and reporting in recent years of deaths in custody, deaths among ADF veterans, road fatalities, deaths associated with family and domestic violence, to name but a few.

As noted in a recent AIHW report:

> *"Deaths data are a vital measure of a population's health… examining death patterns can help explain differences and changes in health status, evaluate health strategies, and guide planning and policy-making"* [2]

In relation to TOR 3, this has implications both for current data systems, as well as data gaps:

1. *Improve recognition and recording of homelessness status in government records/data systems.* As reflected in the US toolkit on homeless mortality research,[45] monitoring deaths among people who have experienced homelessness is not straightforward, and in WA and nationally, this is hindered by poor identification and accuracy of homelessness status in routine government data (including hospital records, the State births, deaths and marriages records, and coronial data). Deeper dives into data in WA and other states have shown that the 'address on paper' often relates to a homelessness service or an address where mail can be sent, or where someone is living in an overcrowded dwelling or couch surfing, and the commonly used NFA (no fixed address) acronym has been shown to significantly under-represent the true number of people experiencing homelessness in government administrative records. This was highlighted in a recent Victorian ED study that found that 8% of patients were homeless when screened, but less than 1% were coded as NFA, an eightfold under-estimation of homelessness.[66] Screening for homelessness in the RPH-Bentley Group has similarly found that NFA misses many patients who are in fact currently homeless, and conversely in our research with Homeless Healthcare and the RPH Homeless Team, there are many patients with 'an address' on paper that is actually just where their mail goes, or is the address of a homeless service or relative.

   WA health and corrections/justice services have substantial contact with people experiencing homelessness, and are good starting point sectors for improving accurate recording of homelessness, beyond the default NFA or 'on paper only address'.

2. Support calls for the Commonwealth Government take a leadership role on the enormous life expectancy gaps associated with homelessness, and *commission the AIHW to develop a national homelessness deaths and life expectancy gap reporting framework.* There is national data capture and reporting on deaths and life expectancy in relation to gender, geography (metropolitan, regional, and most recently suburb level) as well as data on deaths related to domestic violence, road fatalities and other injuries, preventable health conditions and so on. Homelessness is a silent void.

3. *Support for the Zero Project to expand further* - More regional communities to commit to keeping track of exactly how many people are experiencing homelessness in their community though the use of real time By-Name-List data (and including in that the deaths data) requires additional support for training and data management.

4. *Support research capacity to expand the Home2Health team monitoring of homeless deaths.* As noted earlier, this is unique and important data for the state and nationally, but has **been done to date entirely without any funding,** by our research team because we view it as so important. The methodology that has been developed and refined over the last few years could be expanded to enable capture of deaths beyond Perth, and to begin to look at causes of death and prevention of these (as has been done in research by UK colleagues on homeless deaths), but this requires funding. Homeless Healthcare and the RPH Homeless Team collaborate with us in compiling this data, but any time they spend on this is also unfunded, and detracts from direct clinical client/patient time.

6. Submission conclusion

Heightened public and media attention to the grim issue of homeless deaths in WA led for calls initially for an Inquiry into this preventable issue, and whilst such a specific inquiry did not transpire, we encourage this parliamentary inquiry to give due consideration to this submission and the issues and implications and recommendations put forth.

We would welcome the opportunity to discuss this further with the Inquiry committee, or to provide any other additional information or evidence you require.

Submission prepared by:

Professor Lisa Wood, Home2Health Team, and Institute for Health Research, Notre Dame University

Ms Shannen Vallesi, Research Associate, Home2Health Team, Notre Dame University and University of Western Australia

Mr David Pearson, CEO, Australian Alliance to End Homelessness

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