ENDING HOMELESSNESS IN AUSTRALIA

An evidence and policy deep dive

November 2021

Report prepared by Paul Flatau, Leanne Lester, Ami Seivwright, Renee Teal, Jessica Dobrovic, Shannen Vallesi, Chris Hartley and Zoe Callis

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GLOSSARY

A&E: Accident and Emergency

AAEH: Australian Alliance to End Homelessness

ABS: Australian Bureau of Statistics

ACH: Assistance with Care and Housing program

ACT: Australian Capital Territory

AHURI: Australian Housing and Urban Research Institute

AHBA: Affordable Housing Bond Aggregator

AIHW: Australian Institute of Health and Welfare

AOD: Alcohol and Other Drugs

CALD: Culturally and linguistically diverse

CBD: Central Business District

CHP: Community housing provider

CEARS: COVID-19 Emergency Accommodation Response for Rough Sleepers (South Australia)

COVID-19: Coronavirus Disease 2019

CRA: Commonwealth Rent Assistance

EVHI: Ending Veterans Homelessness Initiative

FDV: Family Domestic Violence

F-SPDAT: Family Service Prioritization Decision Assistance Tool

H2H: From Homelessness to a Home

HGREA: HomeGround Real Estate Agency

HOPE: Home Options and Pathways to Employment

J2SI: Journey to Social Inclusion

LGBTIQA+: Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual

MISHA: Michael's Intensive Supported Housing Accord

NAHA: National Affordable Housing Agreement

NESA: National Employment Services Australia

NHFIC: National Housing Finance and Investment Corporation

NHHA: National Housing and Homelessness Agreement

NPAH: National Partnership Agreement on Homelessness

NRAS: National Rental Affordability Scheme

NSW: New South Wales

NT: Northern Territory

QLD: Queensland

SA: South Australia

SAHA: South Australian Housing Authority

SCRGSP: Steering Committee for the Review of Government Service Provision

SIB: Social Impact Bond

SHS: Specialist Homelessness Services

SHSC: Specialist Homelessness Services Collection

SOMIH: State Owned and Managed Indigenous Housing

TAS: Tasmania

VHR: Victorian Housing Register

VIC: Victoria

VI: Vulnerability Index

VI-SPDAT: Vulnerability Index – Service Prioritisation Decision Assistance Tool

WA: Western Australia

WAAEH: Western Australian Alliance to End Homelessness

FOREWORD

Ending homelessness in Australia requires concerted action to ensure that the underlying drivers of homelessness are effectively addressed and everyone who is experiencing homelessness or who is at risk of homelessness accesses and sustains permanent, safe, and supportive housing. The achievement of these fundamental objectives rest, in turn, on increasing the supply of social and affordable housing, the implementation of a rich tapestry of supportive programs, and the development of a strong enabling environment.

In this report, we argue that a strong enabling environment for ending homelessness is built on four key foundations. First, strong advocacy for, and commitment to, ending homelessness by governments and the community. Second, a powerful funding base to support action. Third, the provision of culturally appropriate and safe services and effective collaboration across services, both in the homelessness sector and in related sectors. Fourth, an effective data, research, and evaluation program with a strong focus on monitoring progress to ending homelessness, understanding what works to prevent homelessness in the first place, and supporting those experiencing homelessness to access and sustain permanent housing.

The Ending Homelessness in Australia report contributes to the research and evidence base for ending homelessness using an ending homelessness model built around addressing drivers of homelessness, meeting the direct needs of those experiencing homelessness, increasing the supply of social and affordable housing and supporting the enabling environment. This report provides a deep dive into the current state of homelessness and its drivers in Australia. It also presents the first detailed examination of the consolidated national Advance to Zero database for the decade 2010–2020. The Advance to Zero database is a community organisation led and controlled database built on homelessness projects using the Advance to Zero methodology (the Zero Projects). The database includes responses to the Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) from those experiencing homelessness (focusing on those who are sleeping rough and in supported homelessness service accommodation) as well as information on the journeys from homelessness to housing as mapped by homelessness services. The VI-SPDAT provides services on the ground with a comprehensive assessment of health and social needs.

Our analysis of the last decade of evidence from the Advance to Zero database (2010–2020) reveals the high level of need that exists among those sleeping rough with long periods experiencing homelessness and the requirement for a supportive housing model for many of those seeking to access permanent, safe, and affordable housing. The analysis further demonstrates the role of key drivers of homelessness and the need to address these drivers and turn off the tap into homelessness.

The report articulates a program of policy action that addresses the causes and underlying drivers of homelessness as well as supporting the enablers of an ending homelessness program. It identifies five key actions to end homelessness in Australia:

1. Leadership and proactivity at the Australian Government level and a national end homelessness strategy applying across the states and territories.
2. An increase in the supply of social and affordable housing directed to an end homelessness goal.
3. Comprehensive application of Housing First programs linked to supportive housing for those entering permanent housing with histories of homelessness and high health and other service needs.
4. Targeted prevention and early intervention programs which address the underlying drivers of homelessness in order to turn off the tap of entry into homelessness.

5. Supportive systems and programs which build the enablers of an end homelessness program: advocacy, commitment and resource flow to ending homelessness; effective service integration; culturally safe and appropriate service delivery including expansion of Aboriginal and Torres Strait Islander-led and controlled services to help address high rates of homelessness in their communities; and improving data quality, evaluation and research around ending homelessness in Australia.

The present report reflects a collaborative effort drawing on the Centre for Social Impact's (CSI) program of building back better from the COVID-19 pandemic, the contributions of the Australian Alliance to End Homelessness and its partners who freely provided access to the national Advance to Zero database, and to Neami National who supplemented the CSI funding for the study.

I would like to acknowledge the tireless work of the CSI team of Leanne Lester, Ami Seivwright, Renee Teal, Jessica Dobrovic, Shannen Vallesi, Chris Hartley and Zoe Callis who worked on this project; the people experiencing homelessness whose journeys and experiences fed into the national Advance to Zero database; and all those working in agencies supporting an end to homelessness in Australia.

Professor Paul Flatau
Director CSI UWA

Photography: Kieran MacFarlane

PREFACE BY KARYN WALSH AND DAVID PEARSON AAEH

Ending homelessness is possible. We know this because more and more communities around the world are working towards this goal through collaborative effort, local measurement and service system improvement with housing that works for those experiencing homelessness.

However, we also know that we cannot change what we do not measure. In Australia, we estimate the number of people experiencing homelessness every five years. This just isn't good enough and is why the Australian Alliance to End Homelessness (AAEH) has supported a national effort to address this through the Advance to Zero Campaign.

The AAEH is an independent champion for preventing and ending homelessness in Australia. We recognise that the scale of homelessness in Australia is both preventable and solvable and that despite the common misconception to the contrary, we can end homelessness in Australia. We are a community of practice that has, since 2013, supported organisations and local communities to work collaboratively to end homelessness in Australia, starting with rough sleeping.

This report provides the first comprehensive analysis of what the communities we work with across Australia have been measuring about homelessness, and in doing so, illuminates where and how we should be focussing our efforts. While the findings in this report are sobering and heartbreaking, we are hopeful that they will serve as a call to action for decision-makers – and a reminder that ending homelessness is not just necessary, but possible.

As a result of this new analysis, we now have the evidence we need to rally communities across the country to call for an end to homelessness in Australia, to bring into our coalitions the additional organisations and leaders needed to solve homelessness. Importantly, this report also gives policymakers substantial data they can use to chart a path out of homelessness – a situation that far too many Australians still find themselves in.

On behalf of the Australian Alliance to End Homelessness, our partners and all the participating communities, we thank Neami, Professor Paul Flatau and the Centre for Social Impact for undertaking this work and producing a report that will be so helpful in our campaign to end homelessness in Australia.

We also wish to thank the efforts of every community that has committed to counting what has been invisible to policymakers across Australia for too long: the names and needs of people experiencing homelessness. Without their effort, voluntarily undertaken, this analysis would not have been possible.

Ultimately, the AAEH exists to bring community, business and government together to inspire action for an end to homelessness in Australia. We hope that this report strengthens and emboldens you and your communities' efforts to contribute to that goal.

Karyn Walsh
Chair, Australian Alliance to End Homelessness

David Pearson
CEO, Australian Alliance to End Homelessness

PREFACE BY PRISCILLA ENNALS NEAMI NATIONAL

This report provides another step in understanding the national state of homelessness in Australia, made possible by this unique collaboration between states, service providers, peaks, researchers, and a commitment to data, evidence and research. This has allowed the pooling of multiple sources of data to build a stronger understanding of what is driving and sustaining homelessness in Australia, and what is needed to shift the dial. This report provides progress towards national benchmarking and our ability to track progress towards ending homelessness.

As part of the Adelaide Zero team between 2018 and 2021, I had first-hand experience of the data driven Advance to Zero approach. I saw the value of real time, pooled data and a By-Name List; how data plus system level coordination could house those most in need (over 500 of the most vulnerable people housed) and deliver the right, ongoing supports to sustain those tenancies. The data interrupted assumptions and practices that were not delivering good outcomes and re-oriented collective community efforts towards a shared goal. This report takes the concept of collaboration further, leveraging the cooperation between communities nationally to build a national database and an ethos of learning fast together.

Evident throughout the report is proof of the intersectional nature of homelessness – how poverty, health, mental health, justice, exclusion, trauma, discrimination, and employment all contribute to, and are impacted by, homelessness. While this is not new knowledge, the scale of the intersecting issues and the impacts, including personal outcomes and economic costs, are laid bare. The report illuminates how chronicity plays a role; early entries to homelessness and length of time homeless both increase the likelihood of chronicity, high need, and high support to successfully exit homelessness. This reinforces the need for housing as a foundational intervention in addressing physical health, mental health, poverty, exclusion, justice, and productivity. High representation of Aboriginal peoples in the homelessness data across Australia reinforces what we know from Neami's services. Culturally appropriate services are critical in improving outcomes here, including services delivered by ACCOs, in partnership with ACCOs or ACHOs, and services embedded with flexible, culturally meaningful service structures, and more Aboriginal staff.

All efforts should be made to prevent people entering the homelessness system, and to minimising time spent sleeping rough or homeless. This means addressing housing and preventing homelessness as a whole-of-government approach and moving beyond a focus on crisis or transitional housing. It means addressing the blatant issues of affordability and housing supply; without a change here, nothing will change. Additional and innovative investment in a range of affordable housing options across markets is needed for this to happen at scale.

But the report also illustrates that we need to do more than this and we know what it is we need to do. A range of levels of post-housing support are needed to meet the requirements of people with clusters of intersecting need. We have effective prototypes of what works that can be scaled and replicated. For a small proportion of people, this means long-term supports, but we also know that for most people, the intensity of this support can be reduced once they have established a sense of safety, belonging, connection and community; a sense of home. Ongoing, light-touch supports and brokerage at times of housing insecurity should not be underestimated as highly effective homelessness prevention strategies.

Congratulations to the team and to all the collaborators who have made this report possible. While these data still have some limitations, it provides a critical further step towards understanding homelessness across Australia. It delivers a rich source of information for policy makers beyond the homelessness and housing sectors, and for communities, collectives and providers seeking to boost their efforts to end homelessness.

Dr Priscilla Ennals
Senior Manager of Research, Neami National

Above: Following the launch of the Western Australian Alliance to End Homelessness The Western Australian strategy to end homelessness in 2018, orchestras, ensembles of all kinds, and hundreds of singers in choirs on the streets of Perth played and sang to Gavin Bryars' 1971 composition Jesus' Blood Never Failed Me Yet. The composition is based on a loop of a man sleeping rough in London singing a stanza of a hymn. The loop was taken from unused footage of a documentary on London rough sleeping.

Campaign Partners at the official launch of the 500 Lives 500 Homes Campaign.

Photography: Katie Bennett

EXECUTIVE SUMMARY

Aims and objectives

The objectives of this report are twofold. First, to collate and assess the current evidence base on the state of homelessness in Australia and its key drivers. Second, to set out an evidence-informed policy and practice agenda towards ending homelessness in Australia.

Our examination of the current state of homelessness draws on publicly available Australian Census and Specialist Homelessness Services Collection (SHSC) data and national data sources on the drivers of homelessness.

The report also presents the first detailed examination of the consolidated national Advance to Zero database for the decade 2010–2020. The Advance to Zero database is a community organisation led and controlled database built on advance to zero homelessness projects (the Zero Projects). The Advance to Zero database includes responses to the Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) from those experiencing homelessness (particularly those who are sleeping rough and in homelessness service supported accommodation) as well as information on the journeys from homelessness to housing as mapped by homelessness services. The VI-SPDAT provides services on the ground with a comprehensive assessment of health and social needs. The Australian Advance to Zero database provides a rich platform from which to understand the circumstances of Australians experiencing homelessness and, in particular, those experiencing rough sleeping and in homelessness services supported accommodation in Australia's cities and regional towns.

Homelessness is a complex problem. If we are to end it, we need to understand and engage all levers available to us. The rapid and varied responses to homelessness during COVID-19 come with positive and negative lessons; documenting these lessons will help to leverage the facilitators and avoid the pitfalls in future efforts to end homelessness.

Part I of the Report provides a heuristic ending homelessness model, a brief outline of the history of homelessness policy in Australia, and an overview of the state of homelessness in terms of the size, structure, and nature of Australia's homeless population.

Part II provides insights into the circumstances of people experiencing homelessness in Australia and their journeys through homelessness and into housing, utilising the Advance to Zero database.

Part III reflects on progress towards ending homelessness in the policy and practice environment by examining policies and initiatives that drive towards an end to homelessness in Australia.

An ending homelessness model

Our examination of homelessness outcomes in Australia draws on a heuristic ending homelessness model. Our heuristic model not only provides a framework for our empirical analyses, but also for our policy and practice agenda of ending homelessness.

An ending homelessness model is presented that conceptualises the structural drivers and individual risk factors that impact on homelessness and those system enablers that act to reduce homelessness. To effectively address the causes of homelessness requires: adequate funding and resourcing of policies and programs; strong representation, voice, and advocacy; collaborative efficacy and culturally appropriate service delivery; and effective monitoring, target-setting, and research. Importantly, an effective end homelessness program requires those working in homelessness services, as well as those in policy, to place those experiencing homelessness, their journey, and goals, at the centre as active, resilient agents of their own journey. The use of this model as a framework allows for the assessment of the state of homelessness itself, the drivers into and exit out of homelessness, and the efficacy of the homelessness service system response.

There are many important collaborations between organisations and communities across Australia, working together to end homelessness. They include peak homelessness bodies as well as place-based collaborations and large and smaller services working on the ground to end homelessness. This report covers the broad spectrum of responses but focuses particular attention on one set of collaborations: the Zero Projects and the analysis of the associated Advance to Zero database. This database conceptualises and measures the ability for a community to end homelessness, while providing ownership of near to real time data to the community itself, to enable effective and collaborative service delivery and advocacy to ensue.

The Australian homelessness policy and practice environment

Homelessness in Australia has been a prominent focus of social policy and practice, particularly since the Rudd Government's 2008 white paper The Road Home: A National Approach to Reducing Homelessness (The Road Home; Commonwealth of Australia, 2008). The Road Home set ambitious targets to provide supported accommodation to all rough sleepers and halve all types of homelessness by 2020 as well as providing a framework for achieving these targets. Programs using different methodologies were trialled nationally within the homelessness space during the period 2008–2013. Australian evidence began to build for new methodologies and means to address the growing issue of homelessness across the country. These approaches addressed homelessness across different cohorts and sectors (children and youth homelessness, family and domestic violence programs, family-based homelessness, single men's and single women's homelessness) and at different stages of the homelessness cycle (the prevention, early intervention, crisis and chronic homelessness stages).

The Road Home created a shift in rhetoric within the Australian homelessness practice and policy space. Stakeholders were emboldened to believe that homelessness could be ended. The shift in rhetoric led to action, and collaboration across homelessness organisations and sectors to improve outcomes for people experiencing homelessness and particularly, to end homelessness. At the federal level, the Road Home program of work and goal of halving homelessness by 2020 were not continued. However, individual homelessness organisations, collaborations of homelessness organisations, peak bodies, and state and territory homelessness housing and homelessness strategies and responses began to fill the void, espousing strong goals around reducing and ending homelessness.

Current effective frameworks for ending homelessness in Australia, such as Housing First programs, a "no wrong door" approach, and working towards preventing homelessness, have their origins both overseas and in Australia, particularly the impetus created by the Rudd Government's The Road Home.

The Housing First model, developed in the 1990s in the United States to address homelessness, began to emerge in Australia in the 2000s. The Housing First model involves a focus on people experiencing chronic homelessness and rough sleepers, first securing permanent and stable accommodation, and then the wraparound support that they need to sustain their housing. Housing First programs demonstrated that providing housing at the beginning of a support period improved wellbeing and tenancy longevity and reduced returns to homelessness (Baxter et al., 2019).

Registry/connections weeks began in 2004 in the United States, and in Australia in 2010, with the aim to understand the vulnerabilities and system inflow points for particularly vulnerable forms of homelessness, chronic homelessness, and rough sleeping. During registry weeks, services collecting actionable information through using standardised instruments (VI, SPDAT, and the consolidated VI-SPDAT) elicited information on the circumstances, vulnerability, risk and service needs of those experiencing homelessness. The process of gathering information was designed to understand who was experiencing homelessness in a given community and assist agencies seeking to end homelessness in that community to prioritise entry into the constrained supply of permanent housing. Over time, this effort was extended with the addition of the By-Name List approach, in which those experiencing homelessness are individually supported in their journey, and the introduction of the Advance to Zero campaigns.

The By-Name List is a key tool for prioritising the most vulnerable and records up to date information about the number of people experiencing homelessness in the community and tracks their movement in and out of homelessness, with the overarching goal of ending homelessness.

The Advance to Zero, or functional zero methodology, adapted from the United States, offers an alternative way of understanding, measuring, and preventing homelessness. The Advance to Zero methodology focuses on understanding the inflows, the number of people who are actively homeless within a community, and the outflows, to better understand overall changes to homelessness, rather than using the number of exits from the homelessness system into the housing system as the key performance indicator. Through the establishment of a collective database, with data input available in real time that is community owned and led, the measurement of inflow and outflow of people into homelessness enables services to improve their understanding of any potential service patterns, and for continuous improvement projects to be tested and assessed with live client data.

The Advance to Zero methodology has been trialled across several regions and programs nationally. Through this methodology, Registry or Connections Week tools are used, assertive outreach is employed, and housing first principles are incorporated.

Trends in homelessness in Australia and its drivers

The two main Australian datasets that provide national evidence on homelessness in Australia are the Census of Population and Housing (an estimate of people who, on census night, are experiencing homelessness), and the Australian Institute of Health and Welfare (AIHW) Specialist Homelessness Services (SHS) data held in the SHSC. The latter dataset provides information on people who sought homelessness and housing support from government funded SHS. These data demonstrate that the homelessness system, and people accessing the system, are dynamic and changing over time: the number of people experiencing homelessness is growing nationally; the demography is changing; certain cohorts such as people experiencing domestic violence and mental health are exhibiting increased vulnerability; there is a large demand for emergency services and housing; and the available supply of social and affordable housing is unable to meet the present need and demand. The latter conclusion is borne out by the fact that the most common exit from SHS is the same state of homelessness an individual entered the system in. People experiencing homelessness are receiving a median of 43 days of support, and presenting issues are increasing. Both these data sources count the number of people, rather than looking at people and housing as a system. Data shows:

- The number of people experiencing homelessness is consistently growing nationally with an estimated national homelessness rate of 50 persons for every 10,000 people (Australian Bureau of Statistics [ABS], 2018b).
- Aboriginal and Torres Strait Islander peoples made up 3% of the Australian population in 2016, and yet accounted for 20% of all persons who were homeless on Census night in 2016 (ABS, 2018b).
- Most of the growth in homelessness reflects an increase in the number of people living in severely overcrowded dwellings, who represent 44% of the estimated total homelessness population. (ABS, 2018b).
- The number of people identified as sleeping rough has increased by 20% since 2011 (ABS, 2018b).
- There are over 1,580 SHS currently providing support and accommodation services to people who are homeless or 'at risk' of homelessness in Australia with an estimated rate of 115 Australian persons for every 10,000 people accessing services in 2019/20, with the service user population predominantly female (AIHW, 2020a).

- SHS client rate of Aboriginal and Torres Strait Islander people (798.3 per 10,000 population), people with experience of domestic/ family violence (47.0 per 10,000 population), people with mental health issues (34.8 per 10,000 population), older people (55 and over; 9.6 per 10,000 population) has increased from 2015/16 to 2019/20 (AIHW, 2020a).
- The majority of those who were experiencing homelessness at the beginning of the support period remained homeless at the end of the support period (63%), whereas 10% of clients at risk of homelessness end up being homeless (AIHW, 2020a).

The causes of homelessness are complex, encompassing a broad range of individual and structural determinants, including housing availability and affordability, economic and employment opportunities (or lack thereof), physical and mental health outcomes, domestic and family violence, and social and community connections.

Trends show:

- Increasing housing stress levels across Australia with the proportion of people experiencing household stress estimated between 6.6% to 13.0%, and 47% of low-income households remaining in housing stress from one year to the next (Household Income and Labour Dynamics in Australia [HILDA], 2018). The availability of public and Aboriginal and Torres Strait Islander community housing has decreased, with 48% of people waiting more than two years to secure public housing (AIHW, 2020h).
- High rates of youth unemployment, which feeds into high rates of youth homelessness youth unemployment (ABS, 2021).
- Increasing population rates of high distress (13% of the population; ABS, 2019d) and illicit drug use (16.4% have used in the last 12 months; AIHW, 2020e); these factors can increase susceptibility to homelessness.
- Domestic and family violence is the leading cause of homelessness for women and their children (AIHW, 2020a).

Insights from the national Advance to Zero database

With the Advance to Zero movement, a community owned and led, near to real-time database system has been developed to improve understanding of homelessness, and the way in which people may come to experience homelessness. The Advance to Zero database provides an ability to analyse data of individual experiences of homelessness across the country, and, in turn, understand pathways into, and out of homelessness in a new way. This data can now be used for identifying and testing ways to end homelessness across the population, and to identify potential points of prevention further upstream in the homelessness journey for an individual. The Advance to Zero database sets a baseline of people experiencing homelessness in communities, giving the ability to improve measurement of the effectiveness of interventions, prevent homelessness, assess the way homelessness is influencing communities across Australia, and to compare and contrast potential ways out of homelessness. The Advance to Zero database represents the most important innovation in homelessness data collection since the advent of measurement in the Census and the implementation of the SHSC, both of which represent important initiatives in homelessness data collection both in Australia and internationally.

Between 2010–2020, there were 20,953 responses collected across six states in Australia in the Advance to Zero database. The data show individuals sleeping rough on entry into the Advance to Zero system are experiencing chronic rough sleeping. The majority of respondents were assessed as being in a high

acuity category needing permanent housing with long-term support, with those sleeping rough, younger respondents, respondents with a serious brain injury or head trauma, learning or developmental difficulties, or a physical disability, having the highest acuity scores. The majority of those with high acuity receive a housing placement, with over one-third being permanently housed. Of the respondents previously housed, most high acuity respondents have returned from housing. The Advance to Zero data examined in the present report provide a strong evidence base for the implementation of a supportive housing model to sit beside Housing First initiatives.

Advance to Zero respondents reported a range of physical, medical, and mental health conditions; nearly all of which were significantly higher than rates seen across the general population. Alcohol and other drug use was high. People experiencing homelessness are overrepresented in health service use statistics, however, the data indicates that a small number of people accounted for a large proportion of health service use. A large proportion of respondents who have had experience with prison or youth detention are sleeping rough. Respondents reported that although they were in control of their finances and their basic needs were met, they did not receive enough money to meet their expenses and a large proportion reported a Centrelink breach.

Advance to Zero respondents indicated that housing, food, and warmth are the most important needs and that a home (and not just shelter) is a requirement for safety, addressing health issues, and wellbeing. Access to medical support, medication, support services, financial security and independence are important requirements for both physical and mental health needs. Family, friends, and social support are important for love and belongingness.

Key results include:

- Between 2010–2020, there were 20,953 responses from those experiencing homelessness collected across six states in Australia (data was not collected in the Australian Capital Territory or Northern Territory). Over one-third (35%) who completed the VI or VI-SPDAT (n=20,620) were sleeping rough, 36% were in temporary accommodation (e.g., couch surfing, staying with friends/family), 8% in short-term accommodation (e.g., boarding house, hostel, caravan) and 6% in crisis and emergency accommodation. Of those sleeping rough, 57% were sleeping on the streets, 17% in a park, and 13% in a car.
- On average, the length of time people stated they experienced homelessness was 3.8 years. On a separate measure, Advance to Zero respondents reported being without permanent or stable housing for an average of 2.6 years. Families on average reported experiencing homelessness for an average of 1.9 years.
- Over one-quarter (26%) of respondents reported they had been discriminated against by homelessness services or housing because of their age, race, appearance, disabilities, gender identity or sexual orientation.
- Dental problems were the most prevalent health condition from lists of identified long-term chronic medical conditions and other physical health conditions (53.9%), followed by asthma (33%), liver disease (28%), dehydration (23.5%), hepatitis (21%), heart disease (18%) and diabetes (10%), with prevalence rates all higher than the general population.
- Almost one-third (31%) of respondents have been taken to a hospital against their will for mental health reasons; 48% have spoken with a psychiatrist, psychologist, or mental health professional in the last six months; and 39% have gone to an emergency department due to feeling emotionally unwell or because of their nerves. Twenty-one per cent report a serious brain injury or head trauma. Common self-reported diagnosed mental health conditions include depression (70%), anxiety (67%), and PTSD (42%).

- Among those who were rough sleeping (with lifetime homelessness of a year or more), 70.2% reported lifetime prevalence of at least one diagnosed chronic long-term medical condition (e.g., asthma, liver disease, hepatitis C), 71.1% reported at least one other identified health condition (e.g.,dental problems, dehydration, skin infections, epilepsy, cellulitis), 79.5% at least one diagnosed mental health condition, and 71.5% reported problematic drug or alcohol use. Two in three (67.6%) had a diagnosed mental health condition and chronic medical or other health condition comorbidity. The Australian Advance to Zero data provides a strong evidence base for expanding the size of a homelessness-focused supportive housing sector in Australia.
- The majority of respondents (53.4%) reported that they had used accident and emergency services in the six months prior to the survey; 39.1% reported use of ambulance services; and 40.3% reported being admitted as an inpatient in hospital. Healthcare usage was significantly higher than the general population across all three services.
- The majority of respondents (53%) accessed healthcare services five or less times in the six months prior to being surveyed, with a small number of people utilising a large proportion of services. Of those accessing services, the average number of times accident and emergency services were used in the prior six months was 3.6 times, an ambulance 2.9 times, and an inpatient in a hospital 2.6 times in the prior six months, much higher than the general population.
- Overall, two-thirds of national Advance to Zero respondents reported that they had been in prison at some time in their lives (compared to the Australian national rate of 202.4 prisoners per 100,000 adults); the proportion of rough sleepers that had been in youth detention in their lives was almost four times that of non-rough sleepers (20% versus 6%). Forty-two per cent of respondents report being a victim of attack since becoming homeless.
- The majority of Advance to Zero respondents identified housing as their primary need to be safe and well. But they also identified other needs such as addressing health and AOD issues, reestablishing connections with their children and love and belonging.
- The majority of respondents (57%) were considered in a high acuity category (with high risk of mortality), needing permanent housing with long-term support. Those sleeping rough, younger respondents, respondents with a serious brain injury or head trauma, learning or developmental difficulties, or a physical disability, had the highest acuity scores.

The By-Name List is a key tool for prioritising the most vulnerable and records up to date information about the number of people experiencing homelessness in the community. Homelessness services in Advance to Zero projects use the By-Name List to track individuals' movement in and out of homelessness and permanent housing, with the overarching goal of ending homelessness.

The current By-Name List data captures point-in-time data of the inflow into homelessness through (a) those returned from housing and are 'actively' (i.e., they are identified and recorded as) homeless again, (b) newly identified sleeping rough homeless since the previous month, and (c) those who have returned from an 'inactive' state (where there is no record of their status) and are seeking housing again. Outflow is recorded as those who have been housed and those who are now 'inactive'. Care needs to be taken when interpreting these results as the By-Name List needs to be modified to reflect an accurate outflow to improve understanding of 'inactive' participants.

A snapshot of the month of November 2020 in the By-Name List showed

- Of those that were newly identified, 52% were previously homeless, 45% were currently sleeping rough, and 55% were considered to be chronically homeless (sleeping rough or living in emergency accommodation for the past 6 months or three episodes of homelessness in the past year).

- The majority (78%) of high acuity respondents had returned from housing. Of those who had returned from housing, respondents who had been homeless greater than a year prior to being housed returned from housing at a higher rate than those who have been homeless for less than a year. These results only represent a small proportion of respondents who have been followed up and who have completed a VI-SPDAT and are not necessarily representative of the homeless population.
- The majority of respondents (64%) were temporarily accommodated (around half in crisis and emergency accommodation) which reflects limitations in terms of permanent housing options. One-third of all respondents (36%) were permanently housed . Of those permanently housed, 52.0% were placed in public housing, 19.6% in community housing, 13.0% in private rentals and the remainder in other arrangements (e.g., permanent supportive housing, aged care).
- Those with longer durations of homelessness are more likely to be permanently housed in public housing than those with shorter durations of housing. Two-thirds of permanent housing placements among those with over a year of homelessness were public housing placements. Among high acuity permanent housing placements, 56% were public housing placements. Over half of all Aboriginal and Torres Strait Islander permanent housing placements were public housing placements.
- A greater proportion of respondents under 55 years (20%), and of Aboriginal and Torres Strait Islander descent (24%), were placed in community housing, compared to older respondents (11%) and respondents of other descent (17%). A lower proportion of Aboriginal and Torres Strait Islander respondents were placed in private rental accommodation (7%) than other respondents (13%).

The Advance to Zero database contains some key limitations in its interpretive power, primarily that once an individual flows out of a community, we do not know if they maintain their housing placement or if they are seeking help for their homelessness in other communities. In other words, the place-based nature of Advance to Zero work makes it difficult to interpret the holistic impact of homelessness in a region, because we do not yet have full coverage of the problem. However, this is also acknowledged as an underlying strength of the place-based approach that Advance to Zero is working to implement. Trying to solve the problem of homelessness as a whole and all at once has failed many times; this database and methodology is trying to break up the problem into manageable pieces and support individual communities to end homelessness one person, one cohort, and one community at a time, then expand work towards ending homelessness for all.

The VI-SPDAT used to determine acuity is heavily weighted on measuring wellness in terms of physical and mental health conditions compared to housing and homelessness needs, and requires further work to enhance cultural appropriateness in data collection. The VI-SPDAT is based on self-report data on clinical and healthcare utilisation outcomes, and as such, may under or over represent healthcare utilisation. Creation of a statistical linkage key and matching with government administrative datasets would allow for a more accurate measure of utilisation, a more comprehensive understanding of the 'inactive' group on the By-Name List, and allow tracking of respondents across agencies and jurisdictions to understand where people go when they leave their current community and whether they are still in need of support to end their homelessness. Currently, it is not possible to understand tenancy retention comprehensively and accurately using this dataset alone. Future relationships with housing authorities and community housing providers as well as access to relevant administrative data sources (such as public housing administrative data, Commonwealth income support and Commonwealth Rent Assistance data) would aid in improving understanding of the housing journey.

To be able to provide a true understanding of people experiencing homelessness, more communities are required to take the leap into this way of measuring and recording homelessness interactions, and the Advance to Zero database needs to be improved to provide a reliable and valid assessment for people experiencing homelessness that is going to comprehensively record, understand, and demonstrate specific vulnerability and service needs.

Policies to end homelessness

We identify five key actions to end homelessness in Australia:

1. Leadership and proactivity at the Australian Government level and a national end homelessness strategy applying across the states and territories.
2. An increase in the supply of social and affordable housing directed to an end homelessness goal.
3. Comprehensive application of Housing First programs linked to supportive housing for those entering permanent housing with long histories of homelessness and high health and other needs.
4. Targeted prevention and early intervention programs to turn off the tap of entry into homelessness which address the underlying drivers of homelessness.
5. Supportive systems and programs which build the enablers of an end homelessness program: advocacy, commitment, and resource flow to ending homelessness; effective service integration; culturally safe and appropriate service delivery including expansion of Aboriginal and Torres Strait Islander–led and controlled services to help address high rates of homelessness in their communities; and improving data quality, evaluation and research around ending homelessness in Australia.

Australian Government leadership is a prerequisite for ending homelessness in Australia, as it is at this level that a national vision can be articulated and fully funded. A national agreed–upon agenda to ending homelessness that goes beyond the important base that the National Housing and Homelessness Agreement (NHHA) between the Commonwealth and state and territory governments provides is necessary to achieve aspirational end homelessness goals. A national approach will support increased funding for social and affordable housing projects from the Australian Government, increased funding to homelessness services, greater coordination between Australian Government and state and territory government funded programs and an enhanced national target setting and monitoring environment.

State and territory governments are better placed to identify the projects and services that are required to meet local needs and must be actively engaged in both directing external investments and making investments of their own. Lack of leadership, clarity and consistency at the federal government level has significantly impacted the ability of the homelessness service system to plan, invest, and innovate in line with national and international evidence.

The availability of housing stock is a key factor in the ability to obtain and maintain housing. Housing options continue to be limited for people experiencing homelessness. Recent commitments by state and territory governments in respect of increased social housing supply are particularly important but still fall short of what is required.

Housing First approaches are identified as a sound program foundation to addressing chronic homelessness and have yielded positive outcomes in Australia to–date. State and Territory governments have increasingly embraced the Housing First model, but there remain gaps in full implementation of the model at scale and application of targeted supportive housing options for all those who need it. The high health and service needs of a significant number of those sleeping rough require an expansion of both congregate supportive housing models such as the well–established Common Ground model as well as scattered site options.

Prevention and early intervention approaches recognise the individual and structural drivers that influence homelessness and seek to address homelessness by targeting its drivers, to prevent entry, re–entry, or facilitate rapid exit. Interventions into key target areas such as family and domestic violence affecting women and children as well as adolescents (who experience their first spell of homelessness as a result of FDV in the family home), young people in out–of–home care or involved with the youth justice system, people experiencing mental health issues, poverty or unemployment, could be implemented to assist in preventing homelessness outcomes for people. Given that Aboriginal and Torres Strait Islander people are overrepresented in homelessness statistics and associated support services, culturally appropriate policies and interventions need to be designed with and led by Aboriginal and Torres Strait Islander people and community organisations.

Conclusion

The evidence base continues to tell us that people experiencing homelessness are a diverse group of people with varied histories of homelessness. It, therefore, stands to reason that there needs to be a range of homelessness, housing, and complementary supports in place to effectively work towards ending homelessness. Preventative programs,early intervention programs, crisis support, and housing access and support models are all parts of the puzzle required to meet the needs of those experiencing homelessness at different points of the life course, exhibiting different combinations of needs.

Programs should be delivered in a culturally safe and secure way. Given high rates of Aboriginal and Torres Strait Islander homelessness, a fundamental part of the ending homelessness response is to increase the scale of Aboriginal and Torres Strait Islander–controlled homelessness services. Our analysis of the Advance to Zero data also reveals the high number of those experiencing chronic homelessness in communities served by Zero Projects across Australia with very high health and other service needs. This provides a strong evidence base for the implementation of supportive housing models for those entering permanent housing from a history of high needs.

Excellent progress is being made in various pockets of policy and practice, and effort should be directed to continuing and expanding this progress as well as filling the 'gaps'. State and territory governments have recently announced significant increases in social housing supply and implemented innovative Housing First programs. However, there is currently a gap in terms of a coordinated national end homelessness response which would involve significant new investment by the Australian Government and improved coordination between Australian Government and state and Territory government actions. Housing First and multidisciplinary, medium- to long-term support in permanent housing are two important areas for further development, as is a refocusing of attention on early intervention child and youth homelessness responses and structural systems responses to end poverty, family and domestic violence, and provide employment opportunities to those excluded from the labour market. These are the core structural drivers of homelessness. Beyond this there is a need for a stronger national commitment to aspirational goal setting and targeting and attendant measurement. Likewise, at the local community level, there has been significant improvement in targeted end homelessness approaches and measurement in Zero Projects, though this report notes improvements that can occur in this domain.

While the Australian Government and state and territory governments bear the primary responsibility for housing and homelessness in Australia, in recent years, alternative methods of funding homelessness support have been explored, such as joint investment, impact investment, payment by results and social impact bond models. The Advance to Zero approach is seeking to change the system by focusing on a person-centred, Housing First approach in specific communities putting community-owned, near to real time data about individuals' needs at the centre of decision making and the system itself. With data underpinning decision making, and services designed to meet the presenting needs of the populations, we can work towards ending homelessness in Australia.

1 INTRODUCTION

1.1 Background

Homelessness in Australia has been a prominent focus of social policy and practice, particularly since the Rudd Government's 2008 white paper The Road Home: A National Approach to Reducing Homelessness (The Road Home; Commonwealth of Australia 2008). The Road Home included a significant increase (55% over four years) in Australian Government investment into homelessness, targeted at both increases in social housing stock and service responses to addressing homelessness and its drivers. The Road Home also focused on what it means to be homeless, drawing attention to the multidimensional nature of the social issue that is homelessness so that attention was placed on both underlying structural forces driving homelessness and the journeys followed by individuals and families (Parsell & Jones, 2014).

The Road Home set ambitious targets to provide supported accommodation to all rough sleepers and halve all types of homelessness by 2020. It also provided a framework to achieve these targets. Programs using different approaches were trialled nationally within the homelessness space during the period between 2008 to 2013. Australian evidence began to build for new methodologies and means to address the growing issue of homelessness across the country. These approaches addressed homelessness across different cohorts and sectors (children and youth homelessness, family and domestic violence programs, family-based homelessness, single men's and single women's homelessness) and at different stages of the homelessness cycle (the prevention, early intervention, crisis and chronic homelessness stages).

The Road Home created a shift in rhetoric within the Australian homelessness practice and policy space. Stakeholders in the homelessness space were emboldened to believe that homelessness could be ended. The shift in rhetoric led to action, and collaboration across homelessness organisations and sectors to improve outcomes for people experiencing homelessness and more particularly, end homelessness.

Unfortunately, the Road Home program of work with goals of halving homelessness by 2020 was not continued by the Abbott Government, resulting in a shift in the aspirational homelessness reduction landscape from being driven by the federal government to being adopted by individual homelessness organisations, collaborations of homelessness organisations, peak bodies of organisations and state and territory homelessness housing and homelessness strategies and responses (see Chapter 2 for details). These actions have begun to fill the void left by the Australian Government in terms of an overarching homelessness response which espouses strong goals around reducing and ending homelessness.

Australian homelessness agencies and governments drew strongly on a range of developments in the international homelessness space in the period immediately prior to and following the Road Home. Programs were implemented (and subsequently evaluated) drawing on the Common Ground homelessness to congregate housing model for rough sleepers; the Street to Home initiatives; the 100,000 Homes Campaign led by Community Solutions in the United States; the emergence of Housing First initiatives, city-led plans to end homelessness (e.g., Calgary's 10 Year Plan to end homelessness), and the Foyer model initiatives in the youth homelessness space (Tsemberis et al., 2004; Stefancic & Tsemberis, 2007; Haggerty, 2008; Calgary Homeless Foundation 2011; Kanis et al., 2012; Parsell et al., 2013; Parsell, Tomaszewski & Phillips, 2014; Parsell, Fitzpatrick & Busch-Geertsema, 2014, Parsell & Jones, 2014; Whittaker et al., 2015; Padgett et al., 2016; Whittaker et al., 2016, Whittaker et al., 2017; Holmes et al., 2017; Steen & MacKenzie, 2017).

From these initiatives, two overarching learnings for an evidence-based ending homelessness agenda became apparent. The first was the introduction of Registry Weeks. Registry Weeks were based on the premise that 'you can't solve a problem you can't see', moving community views beyond the idea of quarterly implemented street counts that provide an overview of the raw number of people sleeping rough on a given night. The 2004 Street to Home Initiative in New York, pioneered the creation of a 'homeless registry' to increase services' understanding and associated accountability and capacity to end street and chronic homelessness.

The second was that, counting the number of people being housed wasn't addressing homelessness as a whole. The 100,000 Homes Campaign found that, despite reaching their housing target, the overall number of people experiencing homelessness on any given night hadn't significantly shifted. This gave rise to the idea of counting down the number of people actively homelessness in a system, rather than counting the number of people moving into housing.

This work led to the creation of a larger campaign, known as 'Built for Zero' (Community Solutions, 2021). Employing a homelessness registry and subsequently advance to zero, or functional zero methodology, Built for Zero is a movement, of now more than 80 communities who are working to end homelessness, and through this process, proving this is possible. Built for Zero methodology has now been adopted across several countries, including Canada and Australia. At time of publication, 14 communities in the United States have achieved functional zero for a homeless population in their community. Functional zero is when there are fewer people actively experiencing homelessness than are successfully exiting homelessness (i.e., being housed) at any given time.

In summary, 12 communities have ended veterans' homelessness, five communities have ended chronic homelessness, and three communities have ended both in the United States. The Canada built for zero campaign is also seeing success in their veteran and chronic communities (Built for Zero Canada, 2021). These communities have contributed to the growing body of knowledge that ending homelessness is possible. Through the Built for Zero campaign, 16 communities across Canada and the United States have made homelessness rare, brief, and non-recurring for a population of people experiencing homelessness. In recognition that homelessness is not a static issue, functional zero is not a 'static statistic', rather a way of measuring system capacity over time and demonstrating that homelessness and rough sleeping homelessness can be addressed, dealt with, and resourced in an effective way. End homelessness campaigns in specific locations using a Built for Zero approach is, of course, only one part of an end homelessness program which must also be focused on preventing homelessness in the first instance by addressing structural issues such as poverty, housing system failures, and family and domestic violence, and intervening early in the life course of homelessness in terms of early onset child and adolescent homelessness in a variety of forms such as couch surfing.

Adapting methodologies and achievements from the United States, and seeing the successful cross country applications in Canada, Australian homelessness agencies began conducting Registry Weeks in 2010 (e.g., in Brisbane as part of the 50 Lives 50 Homes project) utilising the Vulnerability Index survey pioneered by Dr. Jim O'Connell of Boston's Healthcare for the Homeless organisation to assess health risks of those sleeping rough and provide a health-based prioritisation of need (Flatau et al., 2018; Roncarati et al., 2020). The work conducted by homelessness agencies in the context of Registry Week collections in Australia's cities together with engagement in ending homelessness initiatives such as those noted above (e.g., Common Ground, Housing First programs) laid the groundwork for the establishment of communities of practice, such as the Australian Alliance to End Homelessness (AAEH) and similar organisations such as the Western Australian Alliance to End Homelessness (WAAEH), the End Street Sleeping Collaboration in Sydney, and the Brisbane Alliance to End Homelessness.

[1] A The following communities have achieved functional zero in the United States: Arlington County, Virginia (ended veteran homelessness December 2015); Bakersfield/Kern Country, California (ended chronic homelessness in March 2020); Bergen County, New Jersey (ended chronic homelessness in August 2016, and veteran homelessness in April 2017); Central Virginia, Virginia (ended veteran homelessness in February 2020); Chattanooga/Southeast Tennessee, Tennessee (ended veteran homelessness in October 2019); Colorado BoS Fremont County, Colorado (ended veteran homelessness in February 2021); Gulfport/Gulf Coast, Mississippi (ended veteran homelessness in September, 2015); Lake County/North Chicago, Illinois (ended veteran homelessness in December 2018); Lancaster City & County, Pennsylvania (ended chronic homelessness in January 2017); Montgomery County, Maryland (ended veteran homelessness in December 2015); Norman/Cleveland County, Oklahoma (ended veteran homelessness in January 2017); Rockford/Winnebago/Boone Counties, Illinois (ended veteran homelessness in December 2015, ended chronic homelessness in January 2017); Texas Balance of State – Abilene, Texas (ended veteran homelessness in November 2018, ended chronic homelessness in January 2020); and, Virginia Balance of State – Petersburg, Virginia (ended veteran homelessness in February 2021; Community Solutions 2021).

[2] The following communities have achieved functional zero: Medicine Hat, Alberta (achieved functional zero for chronic homelessness in March 2021); and London, Ontario (achieved functional zero for veteran homelessness in October 2020). (Built for Zero Canada 2021).

Registry weeks were implemented by homelessness agencies and involved volunteers, local and state and territory representatives and community leaders across Australian metropolitan areas (Brisbane, Hobart, Sydney, Perth, Adelaide, Melbourne) and selected regional areas (Flatau et al., 2018). Groups of people took to the streets to undertake a 'census' of rough sleepers in their local communities, first using the Vulnerability Index (VI) and then the broader Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) which focused on a broader set of social needs and priorities (Flatau et al., 2018). This information was then stored in a place where it could be regularly tracked and updated by the community.

Under the leadership of the AAEH community of practice, and operated by Micah Projects in Brisbane, a number of agencies contributed their Registry Week data to a national database. This data included the initial VI data, and subsequently the VI-SPDAT data. This database provided an up to date overview of the vulnerabilities experienced by those experiencing homelessness in each community assessed through this method, and reasons for entry into each system. This was the first time that Australian homelessness agencies had developed a live homelessness snapshot of people experiencing homelessness (primarily, rough sleeping) to this level of granularity. This community owned and led, near-to-live dataset, provided the basis for the first national analysis of Registry Week data in 2018 (Flatau et al., 2018).

Concurrent to participating in Registry weeks, two capital cities in Australia also signed up to the 'a Place to Call Home' initiative with the Institute of Global Homelessness; first with Adelaide in 2017, followed by Sydney. Both cities committed to homelessness reduction goals and functional zero and became 'Vanguard Cities'. These cities were part of a global network of resources working together to exchange ideas, and end homelessness, using shared resources and learnings. This participation on a global scale encouraged innovative thinking and ideas regarding how to address homelessness in new ways. Agencies that had been collecting VI and VI-SPDAT data expanded data collection including information on inflow into homelessness, outflow from homelessness, and activity for each individual in an approach termed the By-Name List pioneered by Community Solutions. Agencies that had been contributing VI and VI-SPDAT data to the AAEH national platform operated by Micah Projects also uploaded By-Name List data and the consolidated dataset was renamed the Advance to Zero database with individual programs adopting the Zero tagline, starting first with the Adelaide Zero Project, and then progressively being adopted in different cities (e.g., the Perth Zero Project, the Melbourne Zero Project, the Port Phillip Zero Project, and the Brisbane Zero Project).

Alongside these developments, state and territory governments have implemented housing and homelessness strategies, many of which explicitly refer to an end homelessness agenda (see Chapter 2), increasing investment in social and affordable housing and homelessness and complementary support, and there have been significant improvements in homelessness service delivery and understanding. For example, advocacy for, and trials of, Housing First approaches to addressing homelessness across the country including the Michael's Intensive Supported Housing Accord (MISHA) program (Conroy et al., 2014) and the 100 Lives 100 Homes or 50 Lives 50 Homes campaigns (Wood et al., 2017). These approaches have included both an improved method of service delivery, such as rapid housing and extended periods of wraparound support in housing, and new methods of financing homelessness support programs such as Social Impact Bond funding, and payment by results funding approaches (Social Ventures Australia, 2020). Across different homelessness sectors we have seen important initiatives acting to prevent homelessness or address the needs of those experiencing homelessness in Australia in recent years. Further to this, the number of volunteer-led groups providing support across life domains to people experiencing homelessness has increased. The way in which homelessness is understood and responded to in Australia has pivoted to respond to the ever-growing numbers and needs of vulnerable people.

The movement to end homelessness in Australia and the development by homelessness organisations of measurement systems to assess need and determine progress in achieving the goal of ending homelessness (the Advance to Zero database) provide an important context to the present report. The report provides the first examination at a national level of the consolidated Advance to Zero data (2010–2020) and complements our report published in 2018 (Flatau, et al., 2018) which provided the first national examination of the circumstances of those experiencing homelessness utilising the VI-SPDAT data collected since 2010.

The COVID-19 pandemic also provides an important context to the present report. COVID-19 presented significant challenges for homelessness, not least of which was the public health challenge of keeping people, many of whom experience significant comorbidities, safe from a highly contagious virus when they lack a safe, stable, and appropriate dwelling in which to isolate (Flatau, Seivwright et al., 2020). Rough sleepers were identified as being triply vulnerable to potential infection by reason of experiencing poorer health, greater risk of mortality and poorer access to healthcare over and above having a safe place to isolate from the virus (Pawson et al., 2020). However, our responses to homelessness in the face of COVID-19 have also shown us what we can achieve if we put together our collective minds and resources. In particular, the transition of thousands of rough sleepers into hotel and other temporary accommodation with the view of placement in permanent housing has demonstrated the great opportunities that exist for ending homelessness as well as revealing some of the bumps on the road to ending homelessness. At the end of the first wave of COVID-19, approximately 33,000 rough sleepers and people who were at risk of rough sleeping were temporarily sheltered across the country (Pawson et al., 2020).

The challenges to homelessness posed by COVID-19 are far from over. Multiple recent actions such as reduction and cessation of economic stimulus measures and ends to moratoria on rent increases and rental evictions, and partial or comprehensive lockdowns, may result in increased numbers of Australians in housing stress, increased demand for homelessness and emergency relief services, and increased inflows into homelessness. This demand may be further exacerbated by underemployment, with hours worked decreasing by 3 million hours per month from June to July of 2021 alone; resulting in an underemployment rate of 8.3% (Australian Bureau of Statistics, (ABS) 2021). There may also be unintended negative consequences from service delivery protocols around support for those not vaccinated. In particular, services adopting protocols that prevent or reduce support to those unvaccinated may exacerbate already deep social exclusion for those experiencing homelessness.

ENDING HOMELESSNESS IN AUSTRALIA: AN EVIDENCE AND POLICY DEEP DIVE

To end homelessness in Australia, we first need to understand what drives homelessness, map the current policy and practice environment, and establish a solid evidence base on the state of homelessness in Australia.

Parts I and II of the Ending Homelessness in Australia report undertake this task. Part I sets our ending homelessness heuristic model, which guides both our empirical analyses as well policy prescriptions, details briefly the history of Australia homelessness responses and provides an overview of the state of play of homelessness in Australia using Census data, the data from the Specialist Homelessness Services Collection (SHSC) and other sources. Part II of the report provides the first national presentation of evidence from the first decade of the Advance to Zero data collected by homelessness agencies across Australia.

The Ending Homelessness in Australia report uses the evidence base to develop a comprehensive program to end homelessness in Australia. Our comprehensive program and mapping of illustrative programs that are working to end homelessness in Australia is set out in Part III of the report.

1.2 Aims and objectives of the report

The goals of this report are twofold. First, to bring together and provide an assessment of the current evidence base on the state of homelessness in Australia and its key drivers. Our examination of homelessness outcomes in Australia draws on a heuristic ending homelessness model which we present in Chapter 2 of the present report. Our heuristic model not only provides a framework for our empirical analyses, but also for our policy and practice framework for ending homelessness, going forward. The heuristic model not only includes the structural and individual drivers of homelessness outcomes, but also those enabling factors that support an ending homelessness agenda such as Aboriginal and Torres Strait Islander-led and controlled homelessness responses; collaborative efficacy; strong representation and advocacy; enhanced data, evaluation and research; and a stronger and more diversified resourcing of homelessness responses.

Our examination of the current state of homelessness draws on publicly available Census and SHSC data, national data sources on the drivers of homelessness and a deep dive analysis of the national Advance to Zero dataset. The Australian Advance to Zero database provides a rich platform from which to understand the circumstances of Australians experiencing homelessness and, specifically, those experiencing rough sleeping in Australia's cities and regional towns. The present report complements research we published in 2018 utilising the national VI and VI-SPDAT data held in the Advance to Zero database, operated by Micah Projects on behalf of the AAEH (Flatau et al., 2018) which has now been updated and added to through the introduction of the By-Name List data and referred to as the Advance to Zero dataset.

Our analysis of the existing evidence base covers the following topic areas:

- Trends in homelessness and its key drivers drawn from a broad range of publicly available databases; and
- An in-depth analysis of the Australian Advance to Zero data including the VI, VI-SPDAT, and By-Name List data covering:
    - Demographic profiles
    - Type of homelessness experienced and duration of homelessness
    - Health, wellbeing, risks
    - Healthcare access and utilisation
    - Justice system interactions
    - Financial capabilities
    - General acuity of presentations
    - Qualitative thematic analysis of responses from those experiencing homelessness to the question "what do you need to be safe and well?"
    - Journeys from homelessness to housing

Our review also puts forward a case for the importance of developing a more robust data and evidence base to support efforts to end homelessness.

The second goal of the present report is to set out an evidence-informed policy and service agenda towards ending homelessness in Australia. We utilise both our ending homelessness heuristic model and the evidence base developed in the report in developing our policy response.

Homelessness is a complex problem and, if we are to end it, we need to understand and engage all the levers available to us (whether they're currently being used or not). Five key actions are required to end homelessness in Australia:

1. Leadership and proactivity at the Australian Government level and a national end homelessness strategy applying across the states and territories.
2. An increase in the supply of social and affordable housing directed to an end homelessness goal.
3. Comprehensive application of Housing First programs linked to supportive housing for those entering permanent housing with long histories of homelessness and high health and other needs.
4. Targeted prevention and early intervention programs to turn off the tap of entry into homelessness which address the underlying drivers of homelessness.
5. Supportive systems and programs which build the enablers of an end homelessness program: advocacy, commitment and resource flow to ending homelessness; effective service integration; culturally safe and appropriate service delivery including expansion of Aboriginal and Torres Strait Islander-led and controlled services to help address high rates of homelessness in their communities; and improving data quality, evaluation and research around ending homelessness in Australia.

The rapid and varied responses to homelessness during COVID-19 comes with positive and negative lessons; documenting these lessons will help to leverage the facilitators and avoid the pitfalls in future efforts to end homelessness.

1.3 Structure of this report

This report is structured into three parts:

Part I provides a heuristic ending homelessness model, a brief outline of the history of homelessness policy in Australia before briefly outlining the state of homelessness in Australia in terms of the size, structure, and nature of Australia's homeless population.

Part II provides insights into the population of people experiencing homelessness in Australia, utilising the Advance to Zero database.

Part III reflects on progress towards ending homelessness in the policy and practice environment by examining policies and initiatives that drive towards an end to homelessness in Australia.

PART I: The state of play of homelessness in Australia

Chapter 2 develops our heuristic ending homelessness model and provides a brief overview of the policy and practice environment.

Chapter 3 provides an analysis of trends in homelessness in Australia and a profile of homelessness, including enumeration (counts) across different data sources, geographic spread, and demographics of people experiencing homelessness.

Chapter 4 provides a summary of the key drivers of homelessness from publicly available data.

PART II: Advance to Zero: Insights into homelessness in Australia

Chapter 5 provides a background into the creation of the Advance to Zero methodology, the application of the methodology and registry/connections week across capital cities in Australia and the associated creation of a national homelessness near-to-live dataset.

Chapters 6–13 analyses the Advance to Zero national database across wellbeing, health, risks, and demography dimensions as well as analysing the By-Name List inflows and outflows data.

Chapter 14 provides a summary of the Advance to Zero findings, with a discussion on data limitations and recommendations for future data collections.

PART III: Policy settings and progress in ending homelessness

Chapter 15 examines responses to ending homelessness in the Australian policy and practice environment utilising our end homelessness model.

Chapter 16 concludes the report, summarising trends towards ending homelessness in Australia and identifying pathways forward.

Photography: Kieran MacFarlane

Part I:

THE STATE OF PLAY OF HOMELESSNESS IN AUSTRALIA

2 HOMELESSNESS IN AUSTRALIA

This chapter presents a heuristic ending homelessness model which guides our empirical analysis and our policy review and a brief overview of recent history of efforts to address homelessness in Australia. Our review of the policy and practice environment covers the funding of housing and homelessness services in Australia, the emergence of movements and alliances to end homelessness, and the need for data, evaluation, and research to support efforts to end homelessness.

2.1 A heuristic model of ending homelessness in Australia

Our model of ending homelessness is presented in Figure 1 below and draws on our previous work (Kaleveld et al., 2018, Mollinger-Sahba et al., 2020). It contains two broad components. The first component relates to the underlying structural and risk drivers of homelessness outcomes and the homelessness journey (Johnson et al., 2008; Chamberlain & Johnson, 2013; Kaleveld et al., 2018; Mollinger-Sahba et al., 2020). These drivers include the impact of housing affordability and housing supply constraints, poverty, racism and discrimination, and labour market barriers as well as mental health issues, long-term health conditions, AOD risk and harm, family and domestic violence and personal relationship impacts.

These structural and risk determinants influence not only the extent to which homelessness occurs in the first place, but whether it is situational and short-term in nature; episodic (homelessness experienced at different points when one or more drivers impact on a person or family's journey) or chronic long-term homelessness (involving long periods of rough sleeping and supported accommodation). Situational, episodic, and chronic rough sleeping homelessness are vastly different experiences that require different responses (Nooe & Patterson, 2010). Chronic homelessness exhibits significant hysteresis effects where current homelessness is impacted on by the past history of homelessness itself. Much of homelessness and housing policy is directed to mitigating and addressing the adverse impacts of drivers of homelessness.

In setting out the drivers of homelessness, it is important to recognise the life-cycle nature of homelessness (see Figure 2 below). Flatau et al. (2013) revealed high levels of intergenerational homelessness and childhood and teenage homelessness among adults in Australian Specialist Homelessness Services (SHS). In this sense, homelessness can be 'passed through' generations. Women and their children experience homelessness resulting from family and domestic violence and children and teenagers may run away from or be thrown out of home as a result of family and domestic violence (Flatau et al., 2013). Children in out-of-home care arrangements have historically faced high rates of homelessness as have young people in the juvenile justice system. Young people may also experience mental health, physical health, social and labour market issues. Around half of all adults in Australian SHS reported experiencing homelessness as children and/or adolescents which focuses attention of preventing first experiences of homelessness during this time, as well as intervening early to stop later homelessness. On the other hand, half of all adults experience their first spell of homelessness in adulthood and not in childhood or adolescence. No doubt some of these spells will be affected by childhood and adolescent experiences but in other cases they will be affected by drivers and risk factors in adulthood such as experiences of violence, poverty and housing drivers, mental health conditions and long-term health conditions, loss of employment, and dissolution of family relationships.

Figure 1 – Ending homelessness in Australia model

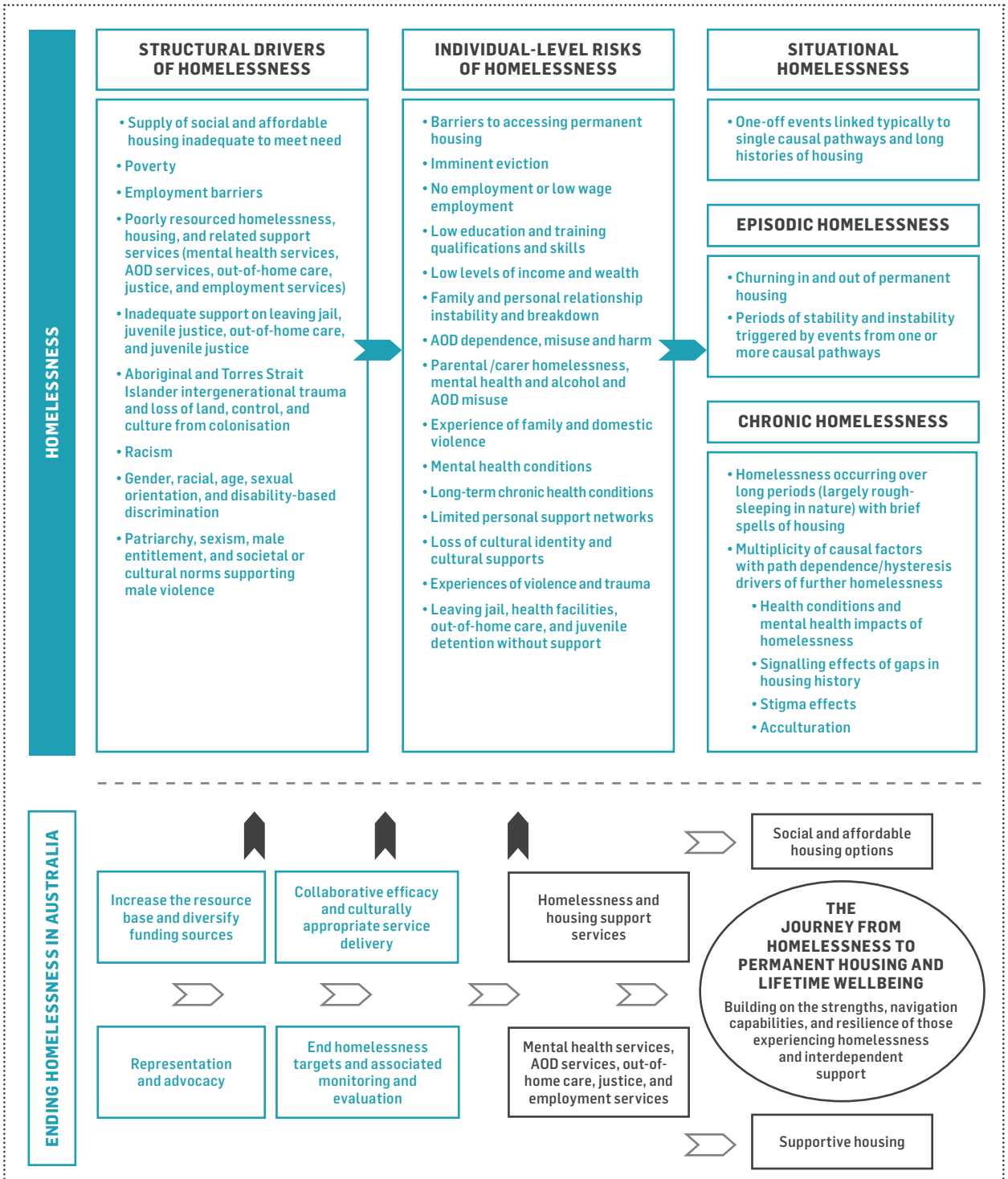
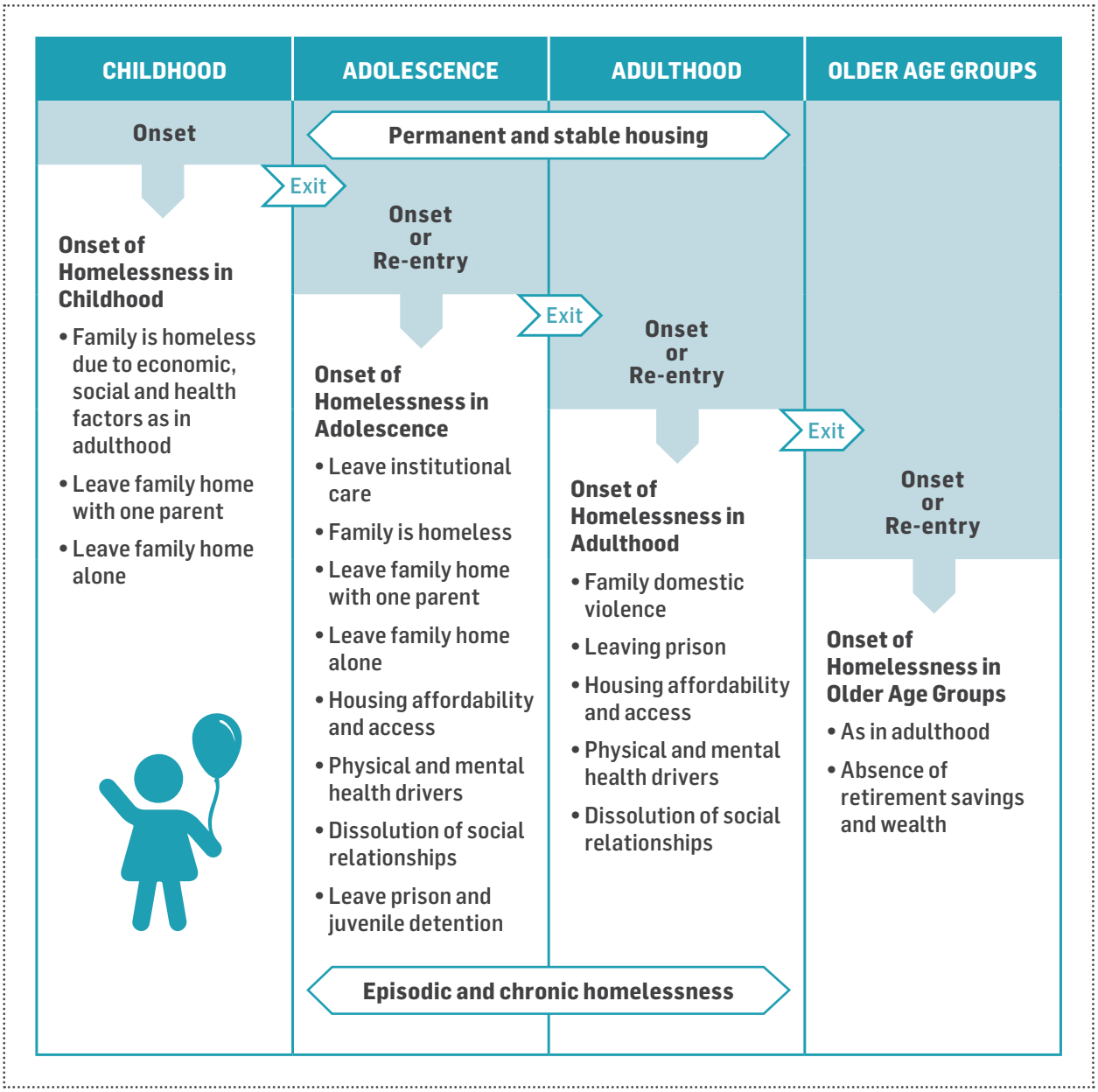


Figure 2 – Homelessness over the life course



A second component of our ending homelessness model relates to the response to homelessness and to the objective of ending homelessness. It has two key components: (1) the service system response to homelessness; and (2) the systems enablers which act to support the homelessness response and put the community on a better footing to ending homelessness. The service system response to ending homelessness is centred on the role of homelessness services and housing providers working with those experiencing homelessness or at risk of homelessness. Alongside homelessness services and housing providers are the complementary services such as mental and physical health services, alcohol and other drugs services, family and domestic violence services, youth services, justice services, employment services, and aged care services who work to support people address issues they face. Such services also work to address the underlying drivers of homelessness, and in so, doing help to turn off the tap and reduce the inflow into homelessness.

Enablers of an ending homelessness program in Australia include the following four components (Mollinger-Sahba et al., 2020):

1. Representation, voice, and advocacy: Increasing public discourse on homelessness, advocating for those experiencing homelessness, and increasing the commitment of the community, funders, and government to ending homelessness.

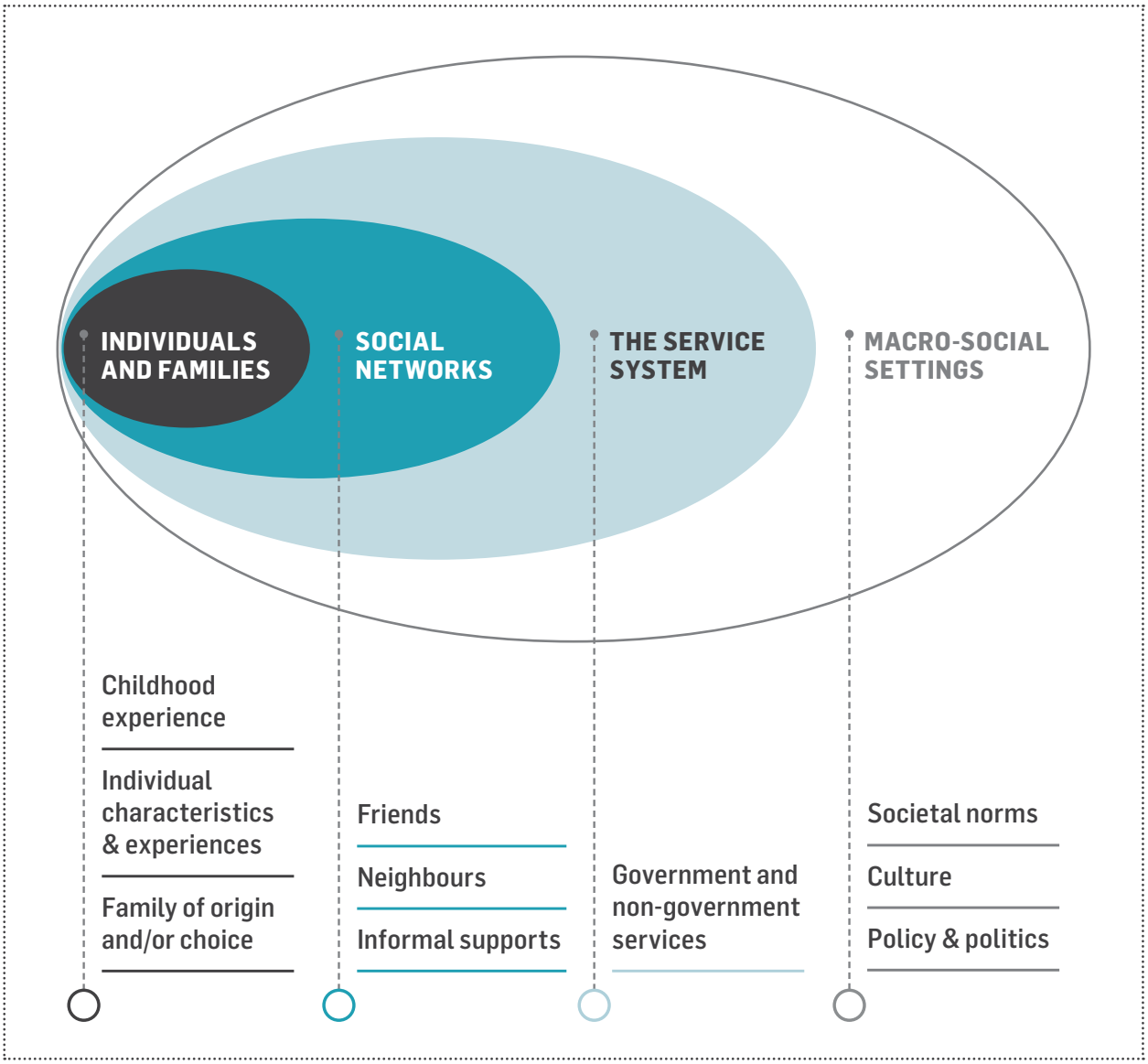
2. Increasing the resource base and diversifying funding: There is a significant level of unmet need in the homelessness service system and a shortage of available affordable housing options. Increased funding to support services and build or unlock housing is required.

3. Collaborative efficacy and culturally appropriate service delivery: The response to homelessness will be more effective the higher the level of service integration across services and the more services are delivered in a culturally appropriate way including by Aboriginal and Torres Strait Islander controlled community organisations.

4. Data measurement, research, and evaluation: To understand how best to address homelessness we need a strong evidence base, targeting setting and evaluation of outcomes achieved at both a program level but broader jurisdictional and Australian level.

To end homelessness requires services to walk alongside those experiencing homelessness on their journey. The individual and their family, and those who are close to them in their social networks, must sit at the centre of an effective service response as in Bronfenbrenner's ecological model presented in Figure 3 (Bronfrenbrenner, 1979).

Figure 3 – Bronfenbrenner ecological model

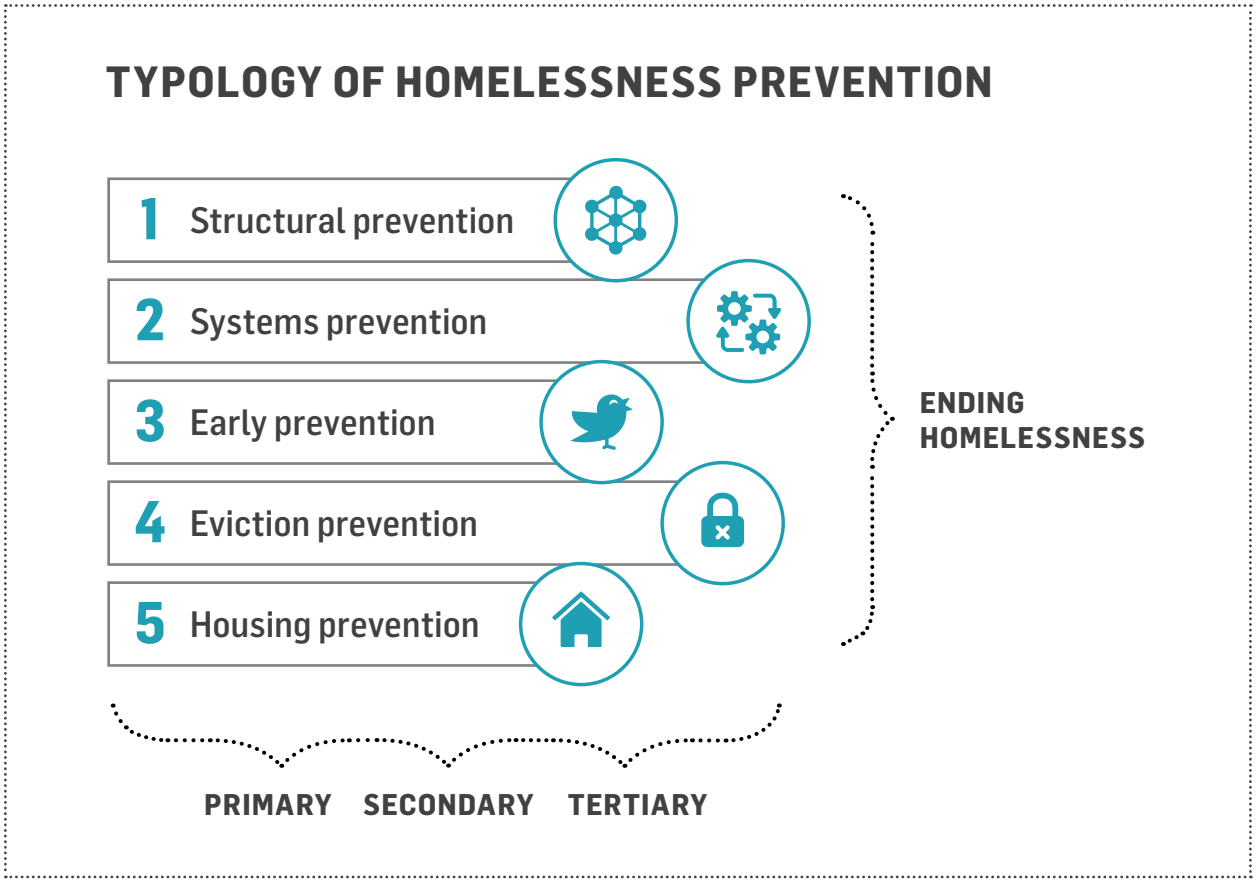


The Western Australian Alliance to End Homelessness 2021 report (Seivwright et al., 2021) highlights effective frameworks for ending homelessness in Western Australia, with a focus on a no wrong door approach, Housing First, and working towards a prevention framework. The principles to be embedded into this approach include: ending homelessness is everyone's responsibility, people are at the heart of each response, the right solutions need to be delivered in the right places by the right people, we do know what works and we hold ourselves accountable for achieving outcomes, and people can get help regardless of which service or agency they connect with. These principles guide the policy section of our report, and form pillars of the discussions regarding ending homelessness moving forward.

Drawing on the public health model of prevention, the Canadian Observatory on Homelessness (2021) understands homelessness prevention through a primary (structural level, applies to all), secondary (interventions for people at imminent risk of homelessness), and tertiary (support provided to people who have previously experienced homelessness to ensure it is non-recurring) lens. These lenses are then applied across five key prevention areas.

As demonstrated in Figure 4, ending homelessness requires intervention on multiple levels. There needs to be understanding of inflow points into homelessness to work towards prevention; emergency responses in place for people who enter homelessness and support while they are experiencing homelessness; housing, accommodation and supports to provide both bricks and mortar; and ongoing support to maintain a tenancy and address issues peripheral to homelessness (Canadian Observatory on Homelessness, 2021). Preventing homelessness and working towards ending homelessness can be achieved in synergy. The Advance to Zero methodology made significant inroads in achieving both prevention and ending homelessness in coaction.

Figure 4 – Homelessness prevention model



Source: Canadian Observatory on Homelessness, 2021.

2.2 Homelessness policies and programs in Australia

As noted in the Introduction, The Road Home placed a major (albeit temporary) national spotlight on homelessness as a social issue in Australia. As Pawson et al. (2018) note, most discussion about housing in Australia centres on "constrained access to tax-advantaged property ownership" (p.15). Home ownership is an important piece of the affordable housing puzzle. However, without inclusion of affordable renting across all markets (social, community, and private), systematic consideration of the structural and individual drivers of homelessness, and the levers available to address drivers across all levels and functions of government, homelessness is an inevitable outcome.

The Road Home recognised this and set forward ambitious targets and provided funding that supported homelessness services, supported individuals, and sought to increase the supply of affordable housing. Concurrent with the Australian Government's increase in focus on the issue of homelessness, evidence emerged in the international context about how policy and programs can address homelessness from an ending homelessness lens. Historically, homelessness services provided crisis accommodation, facilitated support for the issues individuals faced alongside their homelessness, such as substance misuse and mental health issues (as these issues are important drivers of homelessness), and sought to provide a pathway into permanent housing. Addressing the factors that drive an individual into homelessness increases their readiness for housing and thus increases the likelihood that any tenancy secured being sustained. However, such a perspective underestimates the role of stable housing in addressing the issues that people face alongside their homelessness.

Substantial evidence for Housing First, a model developed in the 1990s in the United States to address homelessness, began to emerge in the late 2000s. The Housing First model involves first securing permanent and stable accommodation for people experiencing homelessness, and then focuses on providing the support they need to sustain that accommodation. Housing First places value on housing as a universal human right; providing the bricks and mortar as a first point of engagement, rather that encouraging an individual to stay connected or work on goals secondary to their homelessness to 'earn' the right to a housing offer. Evidence and appetite for Housing First began to filter into Australia in the early 2010s, indicated by an Australian Housing and Urban Research Institute (AHURI) report that examined US Housing First outcomes and scoped the implementation of Housing First in Australia (Johnson et al., 2012).

Housing First strategies were implemented with a particular focus on people experiencing chronic homelessness and rough sleepers, specifically programs developed from overseas programs, such as those of Community Solutions in the United States, and St Mungo's in the United Kingdom. These programs began to highlight a need for improved data and analysis of homelessness programs. What Housing First also further highlighted, was the need for improved housing supply and associated pathways for people experiencing homelessness, with no preconditions attached to the housing offer.

2.3 Funding of housing and homelessness in Australia

The Australian Government and State and Territory governments share funding for the largest source of financing of homelessness and related housing responses in Australia through the National Housing and Homelessness Agreement (NHHA). State and territory governments bear the primary responsibility for implementing housing and homelessness policies in Australia although the Australian Government funds and manages an important youth based homelessness initiative, Reconnect, provides significant support in terms of older age homelessness through the Assistance with Care and Housing (ACH) program, specialist homelessness residential aged care provision and the general Commonwealth Home Support Programme and Home Care Packages. The Australian Government has also supported the development of the community housing sector through the National Housing Finance and Investment Corporation (NHFIC) provision of grants for capacity building services and concessionary loans via the Affordable Housing Bond Aggregator (AHBA). Beyond homelessness and housing support, the Australian Government provides support through complementary mental health, health, and other programs, as well as direct support to individuals through income support payments which reduce the impact of poverty, Commonwealth Rent Assistance payments, as well as indexed funding for selected homelessness initiatives, services, and peak bodies through the NHHA. States and territories are responsible for developing strategies for addressing issues of housing affordability and homelessness in their jurisdiction and the allocation of federal funding in line with those strategies, as well as filling funding gaps and shortfalls.

The NHHA represents an amalgamation of the National Partnership Agreement on Homelessness (NPAH), which provided funding specifically for homelessness services, and the National Affordable Housing Agreement (NAHA), whose remit was housing affordability more broadly. Introduced in 2018, the NHHA replaced NAHA after the latter received criticism from government for its failure to meet its core objective of increasing social housing stock, as well as a lack of transparency and accountability, such that states and territories were not required to report on their allocation of federal funding nor explain why objectives weren't met (Thomas, 2017). The NHHA was drafted during a period of transitional funding for NPAH; the NHHA now includes homelessness-specific funding.

The NHHA aims to improve access to affordable, safe, and sustainable housing outcomes across the housing spectrum, including people who are homeless or at risk of homelessness. The policy areas of the NHHA include affordable, social and community housing, tenancy reform, home ownership, and planning and zoning reform initiatives. Homelessness funding under the NHHA is targeted at priority cohorts that are at increased risk of experiencing homelessness, namely women and children affected by family and domestic violence, children and young people, Aboriginal and Torres Strait Islander peoples, people experiencing repeat homelessness, people leaving institutional care (e.g., out-of-home care, prison, hospital), and older people (Department of Social Services, 2020).

Under the NHHA, each state and territory government must match Commonwealth funding for homelessness, report standardised data on the outcomes specified in the agreement and must have a publicly available housing and/or homelessness strategy on their website.

Table 1 outlines the strategies in place, by jurisdiction.

Table 1 – Overview of state and territory government housing and homelessness strategies

Jurisdiction	Housing strategy	Homelessness strategy	Other complementary strategies
NSW	Housing 2041. NSW Housing Strategy[1] Housing 2041. 2021–2022 Action Plan[2]	NSW Homelessness Strategy 2018–2023[3]	Future Directions for Social Housing in NSW: Social & Affordable Housing Fund[4] NSW Premier's Priorities[5] Together Home[6] Domestic and Family Violence Prevention and Early Intervention Strategy 2017–2021[7] NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022[8] NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025[9] Strategic Plan for Suicide Prevention in NSW 2018–2023[10]
VIC	Homes for Victorians[11]	Victoria's Homelessness and Rough Sleeping Action Plan[12]	Free From Violence: First Action Plan 2018–2021[13] Mental Wellbeing Strategy 2019–2023[14] Victoria's 10-year Mental Health Plan[15] Koolin Balit: Victorian government strategic directions for Aboriginal health 2012–2022[16]
QLD	2017–2027 Housing Strategy[17] Queensland Housing Strategy Action Plan 2021–2025[18] Aboriginal and Torres Strait Islander Housing Action Plan 2019–2023[19]	Housing and Homelessness Action Plan 2021–2025[20]	Dignity First[21] Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021[22] The Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018–2023[23] Domestic and Family Violence Prevention Engagement and Communication Strategy 2016–2026[24]

Continued on page 19.

Jurisdiction	Housing strategy	Homelessness strategy	Other complementary strategies
WA	Western Australian Housing Strategy 2020–2030[26]	All Paths Lead to a Home: Western Australia's 10-Year Strategy on Homelessness 2020–2030[27]	Path to Safety: WA's strategy to reduce family and domestic violence 2020–2030[28] Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025[29] A Safe Place: A WA strategy to provide safe and stable accommodation, and support to people experiencing mental health, alcohol and other drug issues 2020–2025[30]
SA	Our Housing Future 2020–2030[31]	Future Directions for Homelessness[32]	Homelessness Prevention Fund[33] South Australian Aboriginal Housing Strategy[34] South Australian Mental Health Strategic Plan 2017–2022[35]
TAS	Affordable Housing Strategy 2015–2025[36] Affordable Housing Action Plan 2019–2023[37]	Tasmania's affordable housing action plan 2019–2023: Actions to address homelessness[38]	Taking Action: Tasmania's Primary Prevention Strategy to Reduce Violence Against Women and Children 2012–2022[39]
NT	Northern Territory Housing Strategy 2020–2025[40]	Pathways out of homelessness. NT Homelessness Strategy 2018–2023[41]	Five-year Action Plans Mental Health Strategic Plan 2019–2025[42] Domestic, Family & Sexual Violence Reduction Framework 2018–2028[43]
ACT	ACT Housing Strategy[44]	ACT Housing Strategy Chapter 2: Reducing Homelessness[44]	

Source: NSW (NSW Housing Strategy, 2021a[1], 2021b[2]; NSW Government, 2018[3]; NSW Government, 2016[4]; NSW Government, 2021a[5], 2021b[6]; NSW Ministry of Health, 2016[7]; Mental Health Branch, 2018[8]; 2020[9]; Mental Health Commission of NSW, 2018[10]).

VIC (Vic.gov.au., 2021[11]; Department of Health and Human Services Victoria, 2015[15], 2017[12]; Victoria State Government, 2018[13]; VicHealth, 2019[14]; Department of Health, 2012[16]).

QLD (Department of Housing and Public Works, 2017a[17], 2017b[18]; Queensland Government, 2016[24], 2019[19]; Department of Communities, Housing and Digital Economy, 2020[21], 2021[20]; Queensland Health, 2016[22]; Queensland Mental Health Commission, 2018[23]).

WA (Department of Communities, 2020a[26], 2020b[27], 2020c[28]; Mental Health Commission, 2018[29], 2020[30]).

SA (South Australian Housing Authority, 2020a[31], 2020b[32], 2020c[33], 2021[34]; South Australian Mental Health Commission, 2017[35]).

TAS (Department of Communities Tasmania, 2015a[36], 2015b[37], 2016c[38]; Department of Premier and Cabinet, 2012[39]). NT (Department of Local Government, Housing and Community Development, 2019[40]; Department of Territory Families, Housing and Communities, 2018[41]; Department of Health, 2019[42]; Northern Territory Government, 2018[44]). ACT (Australian Capital Territory Government, 2018[44]).

The NHHA broadens the scope of NAHA and NPAH by including the full spectrum of housing options, from crisis accommodation, to social housing, through to home ownership. It guarantees and indexes funding for homelessness services, providing a degree of certainty to funded services (which had been missing over the previous five years) thus allowing them to make sound resource allocation decisions. The lack of certainty of funding through the NPAH left services feeling unsure of their capacity to continue the employment of staff and support of existing and new clients. The collection of a nationally consistent dataset not only increases transparency and accountability, but also allows for systematic tracking and analysis of housing affordability issues across Australia.

Requiring states and territories to have strategies in place and to match federal homelessness funding dollar-for-dollar has also been positive for transparency, accountability and energising state and territory responses. However, it has also been argued that these measures 'pass the buck' of responsibility for both funding and outcomes disproportionately to states and territories. This is already evident with state and territory funding of homelessness services already exceeding federal funding. In addition, indexation of funding is positive and necessary, but does not amount to a real increase in funding. The increasing number of Australians experiencing homelessness and housing stress, as well as high levels of unmet demand for social housing and SHS serve as strong indications that a real funding increase is necessary (Milligan, 2018).

In a broader sense, the level of responsibility taken on by states and territories with respect to housing has pros and cons. Pros include the ability of state and territory governments to allocate funding according to local needs and issues, and the freedom of state/territory governments to invest in innovative initiatives or alternative investment approaches to housing should they have the appetite. In addition, states and territories can collaborate closely with non-government service providers to monitor emerging needs and the effectiveness of responses in their jurisdiction. Negative aspects include potentially differential responses and subsequent outcomes across states, which could lead to very different housing experiences depending upon where one lives which is counterintuitive in the context of a national agreement. In addition, the NHHA puts responsibility for housing outcomes in state and territory hands despite many major mechanisms for achieving housing affordability, such as taxation policy, immigration policy, and income support levels, being well outside of the scope of state and territory governments (Milligan, 2018).

One of the aims of this report is to evaluate policy and program responses to housing and homelessness in relation to ending homelessness in Australia. Accordingly, the scope of this report is not to assess how each state and territory allocates and supplements its federal funding against housing and homelessness outcomes achieved. Rather, this report examines the categories of policy and practice responses to different aspects of homelessness – prevention and early intervention, crisis response, systemic change efforts, and COVID-19 responses. The report details some current approaches within these categories in different jurisdictions and highlights particularly ambitious or successful approaches around Australia.

2.4 Beyond government: The homelessness service sector driving initiatives to end homelessness

Due to the demand for housing and homelessness support being higher than available supply, homelessness remains a persistent and growing issue. At present, 84.6% of homelessness funding is provided by the Australian Government (Flatau et al., 2016). This makes the homelessness sector particularly vulnerable to changes in government, and reliant on short-term contracts that are largely output driven. In recent years, alternative methods of funding homelessness support have been explored, such as joint investment, payment by results, and social impact bonds.

Government expenditure on homelessness services increased by 27% from 2014 to 2018; however, during the same time, social housing expenditure increased by just 4% over the same time period (Pawson et al., 2020). The homelessness sector (interpreted broadly to include governments and services) has introduced or sustained initiatives to address the chronic housing shortage, and issues that cause, and are caused by experiencing homelessness. These include programs that have been explicitly part of the end homelessness agenda such as Housing First initiatives and supportive housing models such as Common Ground and the Foyer model.

Innovative financing models have also been applied to an end homelessness goal. The Journey to Social Inclusion (J2SI) program, for example, developed in inner Melbourne over two phases before receiving social impact investment funds for a third scaled up phase. J2SI is a long-term support program for people experiencing chronic homelessness. The program adopts a Housing First supportive housing model built around an assertive case management approach that involves mental health, drug and alcohol, quality of life, and independence skills. The Aspire Social Impact Bond implemented in South Australia was Australia's first social impact bond to address homelessness. Aspire program participants receive up to three years of support, in a Housing First multidisciplinary model.

Further to the emergence of new and different homelessness support programs, many smaller-scale examples of supportive initiatives for homelessness have also come to fruition. Some examples of such responses include:

- The Tiny Homes Foundation (n.d.): A not-for-profit organisation working with service providers in NSW, VIC, New Zealand, and remote community locations. Commencing with a pilot project utilising housing first methodology and wraparound supports in Gosford, NSW, Tiny Homes Foundation has pulled together industry and support services to work towards ending homelessness for individuals who are part of their programs. Tiny Homes Foundation also increases economic participation through utilising Work for the Dole voluntary participants to create the tiny homes for dissemination to land sites.
- Beddown (n.d.): A service that converts large spaces (such as carparks) that are commonly used during the day but are vacant at night, into pop-up accommodation for people who are sleeping rough. Partnering with other charitable organisations that supply complimentary services such as food, shower and laundry facilities, clothing etc., Beddown has partnered with Secure Parking carpark operators and has implemented night-time bed spaces in various carparks across Australia. A service with the ethos of expediting itself, Beddown acknowledges that having a safe place to sleep for the night helps to repair some quality of life, before working towards finding a permanent home.
- Orange Sky (n.d.): This service has constructed vans with built in laundry facilities and built-in shower facilities. These vans are mobile and can support people experiencing homelessness and rough sleeping across Australia, within their communities. Utilising volunteers to provide a space for conversation, Orange Sky helps to de-stigmatise the homelessness experience and build occupation in individuals' days.
- Thread Together (n.d.): A service providing new clothes to people who are experiencing homelessness, survivors of domestic violence, youth at risk, Aboriginal and Torres Strait Islander identifying communities, refugees, and individuals who have been long-term unemployed. Thread Together saves clothes from potential landfill and disseminates them to vulnerable Australians through charitable partnerships. As of 2021, Thread Together has partnered with over 100 charities to provide clothing to hundreds of thousands of vulnerable Australians.
- Mettle Women Inc. (n.d.): A national gift delivery service employing women experiencing homelessness due to family and domestic violence in crisis shelters/refuges. Mettle provides paid employment and training to women to make their transition from homelessness into work an empowering journey.

As demonstrated above, the experience of, and experiences resulting from homelessness need to be addressed at a broad range of levels and domains. Ideas implemented within the sector have improved wellbeing for people experiencing homelessness. Beyond different funding mechanisms, different program structures, intervention methods, and initiatives have been explored within the homelessness space. However, it is difficult to ascertain if the above work is preventing people from entering homelessness. Prevention is difficult to quantify as success of prevention is within what does not happen or avoided services. Prevention often requires persistent and long-term opportunity development behavioural change in the population of interest, and benefits are not often perceived to be accrued by the funding body (Fineberg, 2014).

2.5 Advance to Zero and the importance of data, evaluation and research in ending homelessness

Advance to Zero is a methodology Australia has adapted from trials and learnings in the United States. In 2014, Community Solutions exceeded its aim of housing 100,000 people experiencing homelessness in the US, achieved in under four years. What was identified, however, was that achieving this housing milestone didn't have a significant influence on the number of people who were still homeless in any of the communities due to the continued inflow of new people entering homelessness (Community Solutions, 2021). The counting up method of addressing homelessness was reviewed by the team, and it was identified that this structural way of perceiving homelessness may be overlooking aspects of homelessness, and in order to end homelessness an alternative way of understanding and measuring it needed to be applied.

The question was posed: What about counting down to zero people experiencing homelessness, as opposed to counting up the number of people placed in housing outcomes? Four key problems with the homelessness system were identified in the table below (Table 2), and addressed through the Advance to Zero methodology.

Table 2 – Problems with the present system and association solutions posed through the Advance to Zero methodology

Problem	*Identified solution*
• There is not a singular agency responsible for ending homelessness in a community, many agencies hold small funding pieces, and nobody has a whole-of-system view.	• Create a central team including homelessness services and service peripheral to homelessness, such as the local government, healthcare services, housing authorities. This team to meet regularly.
• Funding is based on the success of individual agencies, not a collective community reducing homelessness or reaching certain milestones.	• Create a database that is collectively owned and entered in to, to enable a community to have ownership and understanding of whether efforts to reducing homelessness are working.
• Annual street counts provide a snapshot of the community people are trying to support, what is needed is a system to take line of sight as to how people are moving through the system, when they are moving through it.	• Build into the collectively community owned and led database mechanisms to know people experiencing homelessness, by name and understand their needs in real time.
• Cities have improved the number of houses to communities without making a significant difference in the overall numbers of people experiencing homelessness.	• The community use the database to assess vulnerabilities and needs of people on the list, and allocate appropriate housing options for their needs, resulting in a greater possible likelihood of tenancy retention.

Source: Community Solutions, 2021.

The four problems identified were complex and required ongoing sector commitment and change to undertake. In a system where people were largely competing against one another for funding, services had to pool resources and commit to working together, in-kind commitments were required to create the foundations of the database, and ensure comprehensive understanding of it. Street count processes required collective review, and peripheral systems related to homelessness needed to be involved.

In order to be able to document movement within a community, who was leading support for an individual, their consent information and VI-SPDAT results, a community database was established where key organisations were able to access, amend, and add service information for individuals. This dataset was community owned and led, which encouraged collective ownership of the results within the community, and enabled services to tweak, test, and amend supports and interventions to assess if they improved outcomes for clients in real time. This database enabled continuous improvement projects to be tested and assessed with live client data.

Rather than a street count, a comprehensive real-time mechanism to account for inflow and outflow of people in the community helped services to improve their understanding of any potential service patterns, or peripheral service issues. For example, through this mechanism, potential inflow issues from prison were identified. The platform enabled services within the community to respond to the inflow issues and attempt methods to stem it, in real time.

Without a comprehensive understanding of the housing options available for people, a 'zero' approach would not work. It was swiftly identified that communities needed to include public, community, and alternative housing providers in the conversation around housing options for people on the list. Agencies pooled housing options available and decided collectively who on the community list would be most in need, most appropriate, and most likely to succeed in available housing options. Length of time active on the list and previous tenancies were also able to be considered when making a housing allocation decision.

Through implementing these changes, the system became less convoluted for people experiencing homelessness, while services were able to understand their impact and efficacy, as well as where people experiencing homelessness were coming from, and whether or not that was shifting over time. VI-SPDAT data also gave agencies an overview of how persistent particular health issues were within the community, to look towards prevention or support with these issues.

Through the online database, the community was able to track at a high level, inflows and outflows and active numbers of people experiencing homelessness at any given time. At the end of each month, a snapshot was taken to assess progress towards a calculation identified as advance to zero, or functional zero. Community Solutions (2021) tested the idea of advance to zero with communities of Veterans.

Based on the idea that, because homelessness isn't a static state, that a goal to end homelessness shouldn't be either, functional zero is achieved when the average monthly housing move in, or placement rate (usually a three-month rolling average) is higher than the number of people actively experiencing homelessness for that month. Functional zero needs to be sustained for three months for communities to be able to claim that they have achieved it. Effectively, if there are more housing pathways than people flowing in a system, this demonstrates a system with the ability to end homelessness.

3 TRENDS IN HOMELESSNESS IN AUSTRALIA

In this chapter we provide an overview of the state of play of homelessness outcomes and homelessness-related service delivery in Australia by providing estimates of the size and profile of the homelessness population across Census and Specialist Homelessness Services Collection (SHSC) data sources. In a broad sense, the Census and SHSC data sources tell us that the profile of people experiencing homelessness in Australia is increasing in diversity and has also changed over time. We know that the number of people experiencing homelessness or at risk of homelessness is growing nationally, the demography is changing and that certain cohorts are experiencing increased vulnerability. The data also highlights that there is a large demand for both emergency services and permanent housing, with over 260 requests for support, primarily for accommodation support, going unassisted each day in Australia . Exits into permanent housing from homelessness support services are not the majority of exits of those who began their support period experiencing homelessness, pointing to a demand for housing that is unable to be met by present supply.

The Census and SHSC data sources are presently the only two data sources with comprehensive national coverage. But as our analysis of the Advance to Zero database in the following chapters will show, the Advance to Zero database is providing rich insights into the circumstances and homelessness journeys of those sleeping rough and accessing supported accommodation in Australia's cities. As coverage of the Advance to Zero database expands and is linked to more Project Zero communities, the Advance to Zero database will play a more prominent role in shedding light on homelessness in Australia and more particularly Australia's journey to end homelessness.

3.1 Enumerating the homeless population in Australia

Two main data sources can be used to estimate the size of the homeless population in Australia and those receiving support services through the homelessness support system: the Census of Population and Housing, and the SHSC data. As we note, each source provides a different lens on homelessness in terms of the definition of homelessness adopted, the scope of data collection, and sampling.

With regard to sampling, the Census triangulates data collected from all members of the population to assess whether someone was experiencing homelessness on Census night. People are counted as rough sleepers if they indicate that on Census night that they were living in improvised dwellings, tents, or sleeping out; reported no usual other address; did not own or rent the place they slept; were not in a household where at least one member worked full-time; or where the household income was more than $2,000 per week (ABS 2018a). Persons in supported accommodation facilities, living in boarding houses and other temporary lodgings, temporarily staying with other households (determined through use of algorithms relating to responses from a variety of questions in the Census); and in severely crowded dwellings are then added to the rough sleeping group to arrive at an overall estimate of those experiencing homelessness on Census night. This deductive methodology is useful for providing an estimate of homelessness among the overall population; however, it is very much an estimate. This is particularly with the case with respect to the estimate of those temporarily staying with other households as it is not based on specific questions in the Census, but algorithms based on responses to Census questions (see Kaleveld et al., 2018, p. 8–9, for a broader discussion of the limitations of Census estimates of homelessness).

The SHSC data pertains to people who sought help for homelessness and housing support from government funded specialist homelessness services (SHS). By seeking help, people themselves are directly indicating that they are experiencing homelessness or are at risk of homelessness. A limitation, however, is that not everyone who experiences homelessness seeks help and not all those who receive support are provided with that support by SHS.

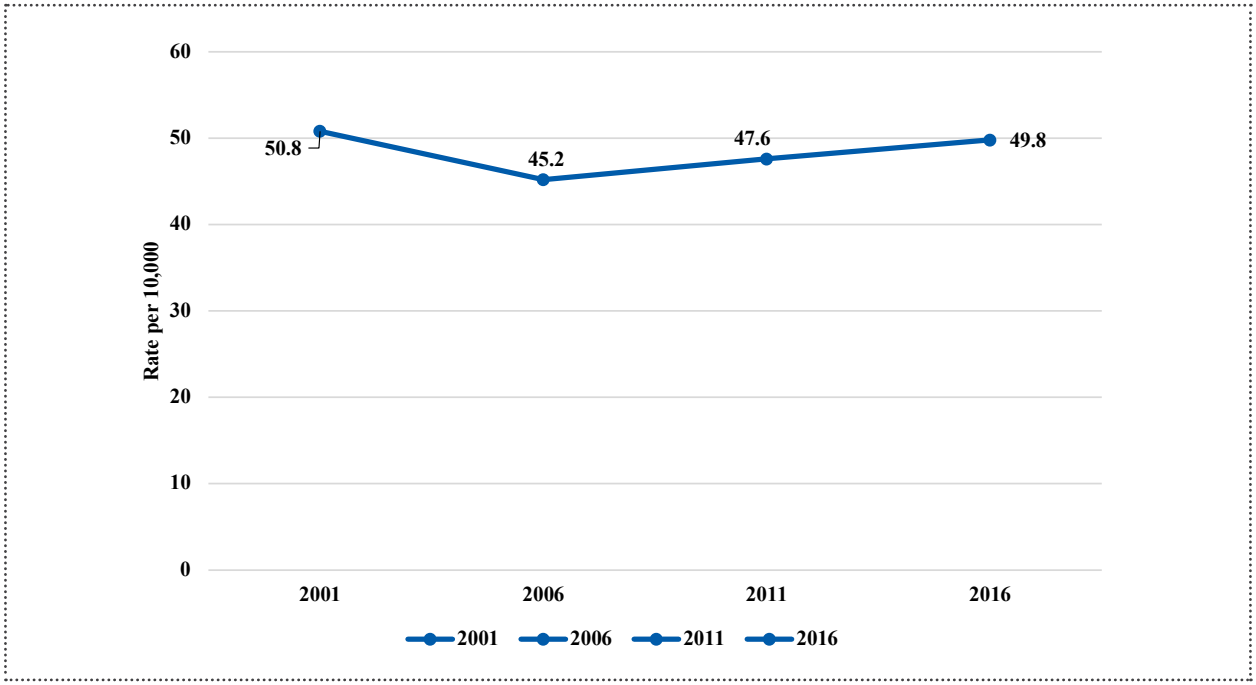
3.1.1 Census

The most reliable method to make comparisons of overall homelessness across states and territories of the prevalence of homelessness is by using the Census. The Census measures homelessness across six categories:

- Those living in improvised dwellings, tents, or sleeping out (rough sleeping);
- Those in supported accommodation for the homeless;
- Those staying temporarily with other households;
- Those in boarding houses; in other temporary lodgings; and
- Those in severely overcrowded dwellings.

Using this framework, ABS estimated that more than 116,000 people were experiencing homelessness in Australia on Census night in 2016. Homelessness in Australia remains a significant issue with an estimated 116,427 people staying in temporary or emergency accommodation, in severely overcrowded dwellings, or sleeping rough on census night, in 2016 (ABS, 2018b; Figure 5). This translates to a national homelessness rate of 50 persons for every 10,000 enumerated in 2016, a rise (5%) from 48 persons in 2011 and 45 persons in 2006 (ABS, 2018b). The estimate of homelessness includes 8,200 people who were sleeping rough. People living in severely overcrowded dwellings represented almost half (51,088 persons or 44%) of the estimated total homeless population.

Figure 5 – Australian homelessness rate (per 10,000 estimated resident population) from 2001 to 2016



Source: ABS, 2018a (Census of Population and Housing: Estimating homelessness, 2016).

In terms of homelessness trends between 2001 and 2016, the Northern Territory, Queensland, and Western Australia had a decreasing rate of homelessness. Conversely, New South Wales, Tasmania and the ACT had an increasing rate of homelessness. However, Victoria, South Australia and the nation overall recorded no marked change to their respective rates of homelessness. To further illustrate the discrepancy in changes to homelessness rates across Australia during this period, the homelessness rate rose by 27% in New South Wales, while it fell by 11% in Western Australia. Table 3 outlines the rate per 10,000 of homelessness in each Census year between 2001 and 2016 by state and indicates the overall direction of the trend.

Table 3 – Homelessness rate (per 10,000 estimated resident population), by state and territory, 2001, 2006, 2011, 2016, Census

States and territories	*2001*	*2006*	*2011*	*2016*	*Direction of change 2001–2016*
New South Wales	36.4	33.9	39.7	50.4	↑
Victoria	38.9	35.3	41.7	41.9	–
Queensland	54.8	48.3	43.9	46.1	↓
South Australia	39.8	37.0	36.4	37.1	–
Western Australia	53.6	42.3	41.0	36.4	↓
Tasmania	27.5	24.0	31.0	31.8	↑
Northern Territory	904.4	791.7	723.3	599.4	↓
ACT	30.4	29.3	48.7	40.2	↑
Australia	50.8	45.2	47.6	49.8	–

Source: ABS, 2018b (Census of Population and Housing: Estimating homelessness, 2016).

Most of the growth in homelessness reflected an increase in the number of people living in severely overcrowded dwellings (ABS, 20018b; Table 4). Two thirds of this rise is attributable to a doubling of the number of people in this homelessness group who were born overseas, which may reflect cultural differences in household composition and preferences with regard to space or may reflect lower economic means as people try to establish themselves in Australia (Easthope et al., 2018). The sheer size of the severely overcrowded group means that it has a very strong influence on homelessness indicators. Indicators used to measure the presence or absence of severe overcrowding for ABS purposes derive from the Canadian National Occupancy Standard, which specifies that a household should have no more than two people per bedroom, that room sharing is appropriate among two adults if they are in a relationship, that parent(s) should have a separate bedroom, that children of the same sex can share a room at any age, and children of both sexes aged under 5 can share a room (ABS, 2012).

As noted previously, Chamberlain (2014) questions the inclusion of housed-homelessness in the statistical definition for a number of reasons. With regard to conceptualisation, he argues that the number of bedrooms per person is not a useful measure for determining security and safety of a dwelling. For example, people with abusive partners or parents or couch surfing youths could reside in a dwelling with an adequate number of bedrooms and still not meet the physical and/or tenure-related safety and security requirements of the ABS statistical definition. Regarding operationalisation, he notes that the Census does not measure key elements of the dwelling required to ascertain whether a person is part of the housed-homeless population such as whether a lease is in place and its length, whether there is access to an adequate kitchen and bathroom, and whether the person feels safe. Accordingly, estimates of homelessness that include housed-homelessness are likely to be inaccurate, may not reflect need, and may distort the true picture of homelessness and result in the direction of resources to areas that are not best aligned with where need lies.

Table 4 – Number and percentage of people experiencing homelessness in Australia by category of homelessness (2011–2016), Census

ABS homelessness category	*2011*	*2016*	*Direction of change*
Persons living in improvised dwellings, tents, or sleeping out	6,810 (7%)	8,200 (7%)	–
Persons in supported accommodation for the homeless	21,258 (21%)	21,235 (18%)	↑
Persons staying temporarily with other households	17,374 (17%)	17,725 (15%)	↓
Persons living in boarding houses & other temporary lodgings	15,626 (16%)	18,181 (16%)	–
Persons living in severely overcrowded dwellings	41,370 (40%)	51,088 (44%)	↑
Total	102,439 (100%)	116,427 (100%)	↑

Source: ABS, 2018b (Census of Population and Housing: Estimating Homelessness, 2016).

In terms of composition of the homeless population, nearly 60% of people experiencing homelessness in the 2016 Census estimate were aged under 35 years, with youth aged 12–24 making up 24% of total homeless persons (Table 5), and the largest increase in homelessness being reflected by the 25–34 years age group (up 32% from 2011; Table 6).

The proportion of males in other temporary lodgings has increased from 43% to 51% from 2011 to 2016.

Table 5 – Number of people experiencing homelessness by age group, state/territory and Australia, 2016 Census

Age group	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia
Under 12	3,963	3,372	2,979	804	1,208	212	3,132	183	15,872
12–18	2,677	2,010	1,710	638	741	162	1,899	109	9,955
19–24	6,365	4,360	2,744	953	1,183	236	1,647	239	17,725
25–34	8,715	5,502	3,968	1,143	1,859	267	2,427	336	24,224
35–44	5,041	3,387	2,936	851	1,290	216	1,732	266	15,745
45–54	4,537	2,876	2,893	845	1,218	233	1,446	220	14,278
55–64	3,626	1,818	2,549	576	891	162	905	266	10,682
65–74	1,939	980	1,418	302	481	92	376	62	5,651
75 and over	846	518	473	123	136	33	141	23	2,289

Source: ABS 2018a (Census of Population and Housing: Estimating homelessness, 2016).

Table 6 – Percentage of people experiencing homelessness in Australia by category of homelessness by age and sex (2011–2016), Census

	Persons living in improvised dwellings, tents, or sleeping out		Persons in supported accommodation for the homeless		Persons staying temporarily with other households		Persons living in boarding houses		Persons in other temporary lodgings		Persons living in 'severely' crowded dwellings		All homeless persons	
Per cent	*2011*	*2016*	*2011*	*2016*	*2011*	*2016*	*2011*	*2016*	*2011*	*2016*	*2011*	*2016*	*2011*	*2016*
Age groups (years)														
Under 12	5.9	5.6	25.8	19.4	9.8	7.7	1.0	1.1	0.0	0.0	24.3	19.0	17.0	13.6
12–18	5.4	3.5	14.2	12.0	5.1	3.9	2.7	2.2	2.8	1.9	14.8	11.8	10.4	8.5
19–24	8.4	6.5	11.5	11.4	12.5	12.2	14.1	12.6	9.5	6.9	18.3	20.3	14.6	15.2
25–34	17.0	18.2	15.4	14.7	21.9	21.8	20.2	21.3	20.2	16.8	17.8	23.4	18.3	20.8
35–44	22.3	21.4	14.6	15.2	15.5	15.1	15.8	15.2	19.6	15.9	10.2	10.4	13.8	13.5
45–54	20.3	21.8	9.5	12.8	13.0	14.0	19.3	18.4	19.2	18.0	8.0	7.7	11.9	12.3
55–64	12.8	14.6	5.0	8.2	13.1	14.1	15.5	16.2	17.4	19.6	3.7	4.4	8.2	9.2
65–74	6.1	6.7	2.2	4.0	6.9	8.9	7.9	9.0	9.1	17.1	1.5	1.9	4.0	4.9
75 and over	1.8	1.7	1.8	2.3	2.2	2.3	3.4	3.9	2.2	4.1	1.3	1.1	1.9	2.0
Sex														
Male	67.6	66.3	49.5	50.8	56.0	58.6	74.8	73.3	43.2	51.2	50.8	54.0	56.5	57.9
Female	32.4	33.7	50.5	49.2	44.0	41.4	25.2	26.7	56.8	48.8	49.2	46.0	43.5	42.1

Source: ABS, 2018b (Census of Population and Housing: Estimating homelessness, 2016).

The number of people identified as sleeping rough in Australia on Census night 2016 was 8,200 (a 20% rise since 2011). Males are over-represented in this homeless group (66%), yet female representation has increased 1.2% nationally. There was a rise in the proportion of Aboriginal and Torres Strait Islander peoples in this group (27%) compared to 2011 (25%), and the proportion of youth aged 12–24 years decreased 13% since 2011 (ABS, 2018b). Aboriginal and Torres Strait Islander peoples made up 3% of the Australian population in 2016, however, accounted for 20% of all persons who were homeless on Census night in 2016 (down from 26% in 2011), and 9% of people sleeping rough (ABS, 2018b).

Table 7 displays the rates per 10,000 of overall homelessness by Aboriginal and Torres Strait Islander status and by state/territory. The Northern Territory's Aboriginal homelessness rate of 2082.6 per 10,000 Aboriginal people exceeds all other states and territories.

Table 7 – Rate of homelessness (per 10,000 estimated resident population) by Aboriginal and Torres Strait Islander status, state/territory and overall, 2016 Census

Aboriginality	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*NT*	*ACT*	*Australia*
Aboriginal	105.4	163.8	238.6	273.8	344.6	55.2	2082.6	146	361
Non-Aboriginal	45.9	36.7	35.3	29.8	25.9	29.9	84.1	32.3	37.8
Not stated	93.7	107.5	78.0	75.5	36.4	40.3	148.8	149.9	86.6

Source: ABS 2018a (Census of Population and Housing: Estimating homelessness, 2016).

3.1.2 Specialist Homelessness Services

In contrast to the Census, the Specialist Homelessness Services collection (SHSC) provides an on-going enumeration of those experiencing homelessness or at risk of homelessness supported by Specialist Homelessness Services (SHSs) funded under the NHHA. As such, the SHSC is a service-based perspective on homelessness.

There are over 1,580 SHSs currently providing support and accommodation services to people who are homeless or 'at risk' of homelessness in Australia. Services provided by SHSs include, but are not limited to case management, referrals, practical support, material aid, alcohol and other drug and mental health support, counselling, legal and court support, advice and information; and in some cases, short or medium-term (transitional) accommodation (AIHW, 2020a).

For the purpose of the SHSC, a person is defined as being homeless if they are living in either:

- Non-conventional accommodation or 'sleeping rough', or
- In short-term or emergency accommodation due to a lack of other options (e.g., refuges, crisis shelters, couch surfing or no tenure, living temporarily with friends and relatives, insecure accommodation on a short-term basis, and emergency accommodation arranged by a specialist homelessness agency).

The SHSC definition of homelessness is narrower than the Census definition as it excludes those in severely crowded dwellings.

A person is 'at risk' of homelessness if they are at imminent risk of losing their accommodation (e.g., have received an eviction notice) or is experiencing at least one risk factor that is known to contribute to homelessness such as those that threaten or harm the physical, emotional, social, cultural or economic safety of a person; including living in severely crowded conditions (AIHW, 2020a). This represents a divergence in both definition and measurement of homelessness across the Census and SHSC systems.

As Table 8 illustrates, in 2019/20, Victorians (174.8 per 10,000 people), Tasmanians (120.6 per 10,000 people), and Northern Territorians (418.0 per 10,000 people) accessed SHS at a higher rate than Australia overall at 114.5 per 10,000. In terms of trends in SHS access over time, rates have increased in New South Wales, Victoria, Western Australia, Northern Territory, and Australia overall; have decreased in Queensland and ACT; and have remained stable in South Australia and Tasmania. Victoria, Tasmania, and the Northern Territory record much higher rates of SHS access than the national average.

Table 8 – Specialist Homelessness Services (SHS) clients, (per 10,000 estimated resident population), by state and territory, 2011/12–2019/20

States and territories	*2011/12*	*2016/17*	*2019/20*	*Direction of change 2011–2020*
New South Wales	72.2	96.0	87.0	↑
Victoria	155.6	178.0	174.8	↑
Queensland	94.9	89.0	84.6	↓
South Australia	118.9	122.9	109.7	–
Western Australia	90.0	95.3	95.2	↑
Tasmania	120.2	152.6	120.6	–
Northern Territory	284.6	332.3	418.0	↑
ACT	152.2	117.5	97.1	↓
Australia	105.8	117.2	114.5	↑

Source: AIHW Specialist Homelessness Services Collection (AIHW 2020a).

In 2019–20, there were 290,500 people assisted by SHS across Australia – a rate of 114.5 people per 10,000 of Australia's estimated residential population (AIHW, 2020a). Almost half (42%) were homeless at the start of the support period, with 18,265 (9.7%) sleeping rough, 30,945 (16.4%) staying in short-term or temporary accommodation and 31,244 (16.5%) couch surfing or with no tenure (AIHW, 2020a).

Each State and Territory manages their own system for the assessment and case management of clients accessing SHS. As a result, SHS agencies deliver a range of eligibility-based programs ranging from practical support to the provision of short-term housing. It is not always within the capacity of SHS to offer services to all those who request it. On average, there were 260 instances of unassisted requests per day across Australia during 2019–20 (AIHW, 20120a). Over three-quarters (76%) of these requests related to individuals or families needing some type of accommodation support; and the majority of unassisted requests came from females (67%) compared to males (33%), reflecting the overall service user population, which is predominately female (AIHW, 2020a).

The varying characteristics of, and risk factors experienced by, different cohorts create different needs from the homelessness service system. It is therefore important to understand the prevalence and trends in homelessness in Australia among particular cohorts. Table 9 displays the rate per 10,000 of Australians accessing SHS, by cohort, in each year between 2015–16 and 2019–20. Increases in SHS usage were recorded between 2015–16 and 2019–20 among the following four cohorts in Western Australia:

1. Aboriginal people
2. People with mental health issues
3. People with drug and alcohol issues
4. Older people (55 years and over)

Table 9 – Specialist Homelessness Services (SHS) client rate (per 10,000 estimated resident population) by priority group in Australia, Specialist Homelessness Services, 2015–16 to 2019–20

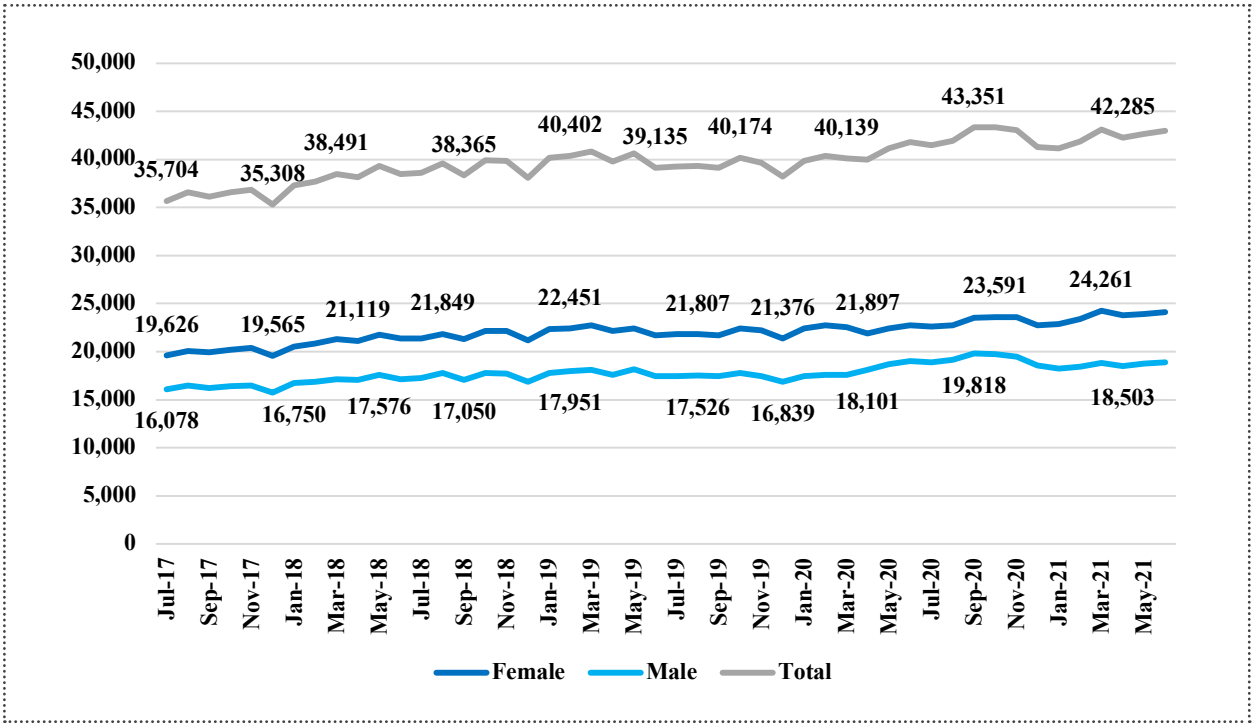
Client group	2015–16	2016–17	2017–18	2018–19	2019–20	Direction of change from 2015–16 to 2019–20
All clients	117.2	119.2	117.4	116.2	114.5	↓
Aboriginal and Torres Strait Islander people	779.4	806.4	753.2	782.0	798.3	↑
People with experience of domestic/family violence	44.3	47.4	49.2	46.6	47.0	↑
People with mental health issues	30.3	31.9	32.9	34.6	34.8	↑
People with drug and alcohol issues	11.2	11.3	11.0	11.2	11.2	–
Young people presenting alone (15–24)	18.7	18.3	17.6	17.2	16.7	↓
Older people (55 and over)	8.6	9.3	9.8	9.7	9.6	↑
Children on protection orders	3.9	3.8	3.5	3.7	3.5	↓
People leaving care	2.9	2.9	2.8	2.7	2.7	↓
People exiting custodial arrangements	3.3	3.4	3.4	3.8	3.7	↓
People with disabilities	4.1	4.5	3.2	2.9	2.6	↓

Source: Specialist Homelessness Services Collection (AIHW, 2018b, 2020a).

Figures 6 to 9 plot raw numbers of homeless and at-risk of homelessness clients as well as the share of all clients who are homeless (as opposed to at risk of homelessness) accessing SHS in Australia from mid-2017 to June 2021. The raw numbers for both groups show a drop in clients accessing SHS in April 2020, coinciding with the outbreak of the COVID-19 pandemic and likely attributed to nation-wide lockdown measures which resulted in many services cutting back direct service delivery for a period. The increases seen in June 2021 may be due to the impact of the end of various pandemic supports in early 2021, such as eviction and rental increase moratoriums, and financial supplements (e.g., JobKeeper and the Coronavirus Supplement).

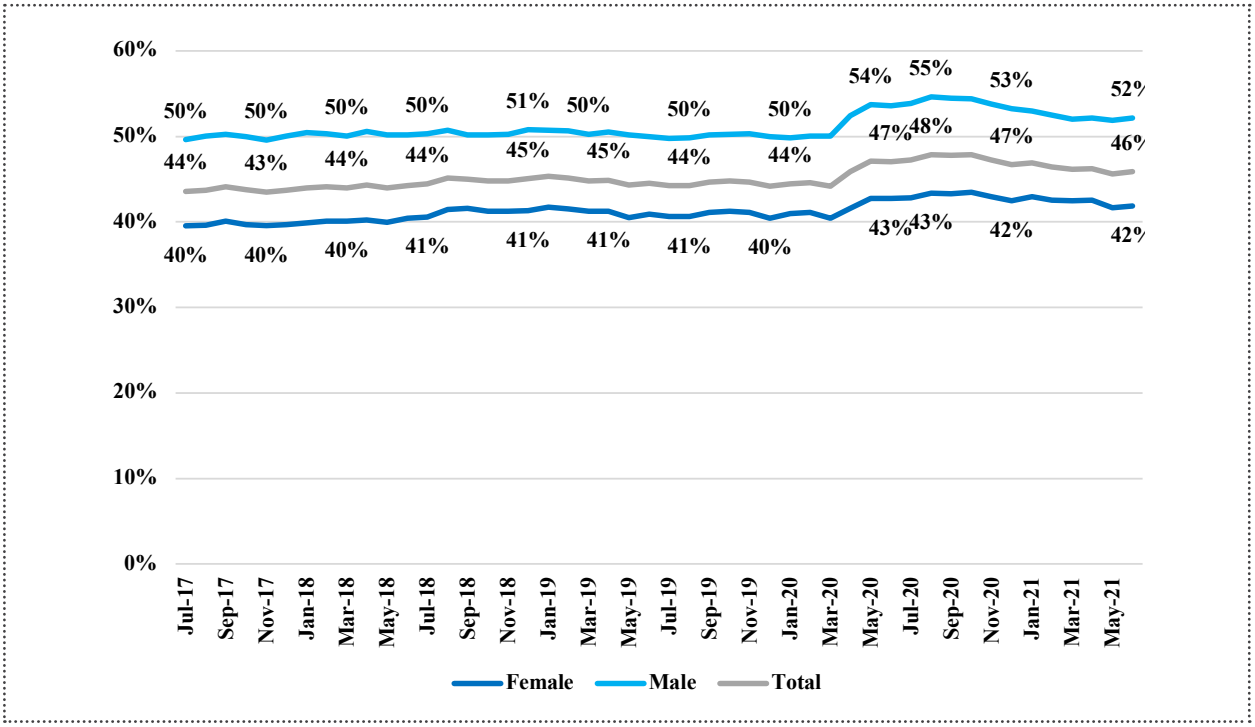
The monthly series also show that a higher proportion of male clients are homeless compared to female clients, while the opposite trend is seen in clients at risk of homelessness. The primary explanation for this difference is that there are large numbers of women and children experiencing family and domestic violence who begin their support period from a point of housing rather than homelessness. They are, therefore, not technically in homelessness using the SHS definition, but their housing immediately prior to entry to support is unsafe. As reflected in the steady 'at risk of homelessness' figures between 2015 and 2020 (Table 10), another group making up this category are those that are being supported to maintain their tenancies.

Figure 6 – Number of clients accessing Specialist Homelessness Services (SHS) in Australia who were homeless on entry to support



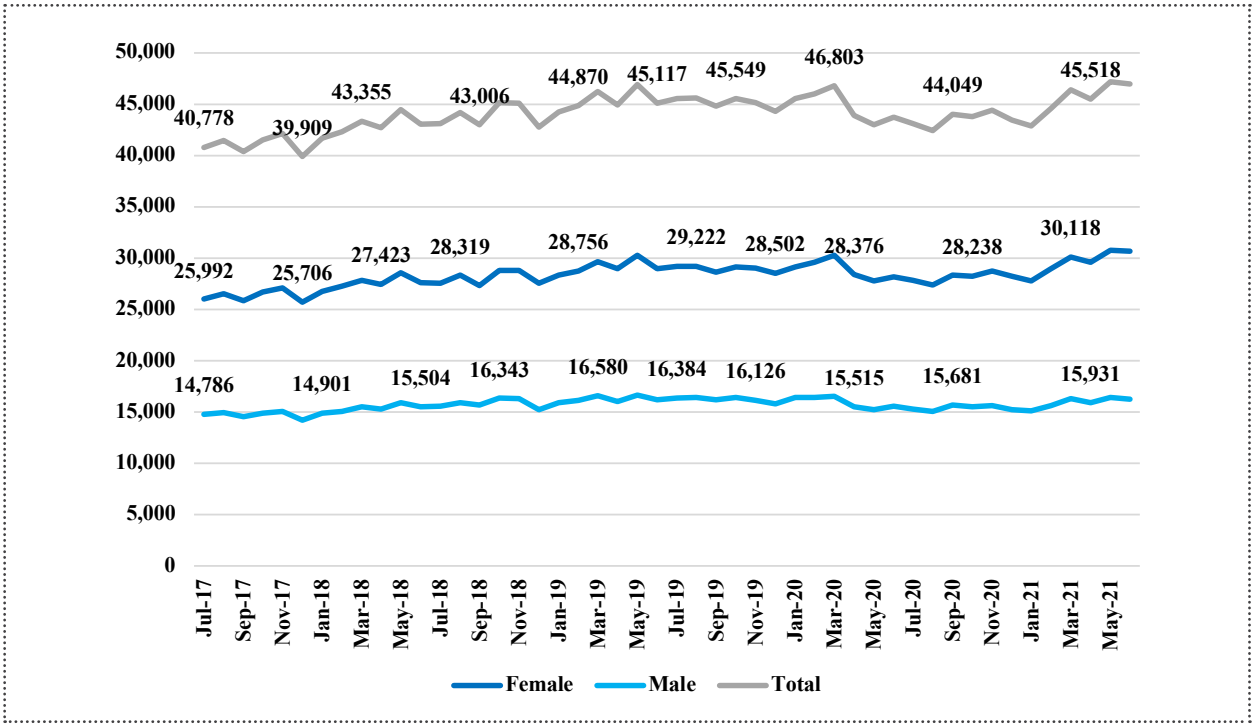
Source: AIHW 2021 Specialist Homelessness Services: monthly data, Cat. No. HOU 321.

Figure 7 – Per cent of all Australian Specialist Homelessness Services (SHS) clients who were homeless on entry to support



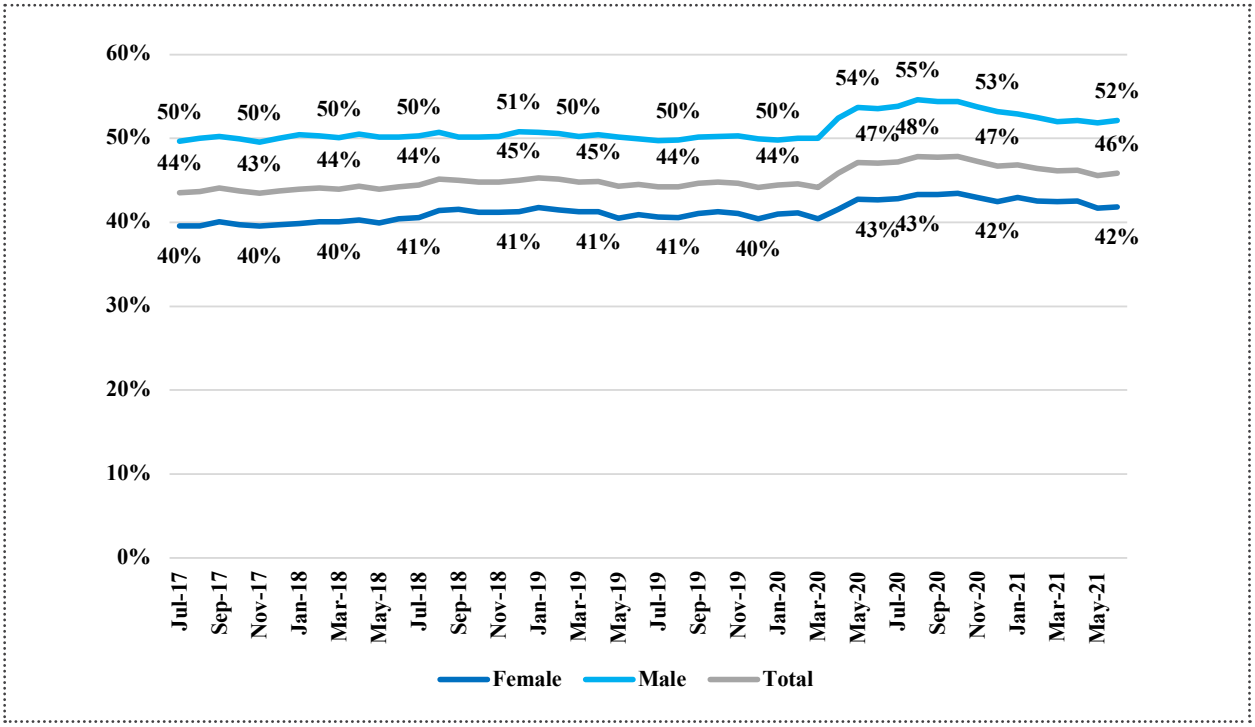
Source: AIHW 2021 Specialist Homelessness Services: monthly data, Cat. No. HOU 321.

Figure 8 – Number of clients Accessing Specialist Homelessness Services (SHS) in Australia who were at risk of homelessness on entry to support



Source: AIHW 2021 Specialist Homelessness Services: monthly data, Cat. No. HOU 321.

Figure 9 – Per cent of all Australian Specialist Homelessness Services (SHS) clients who were at risk of homelessness on entry to support



Source: AIHW 2021 Specialist Homelessness Services: monthly data, Cat. No. HOU 321.

Table 10 displays the rate per 10,000 of Australians experiencing domestic and family violence accessing SHS, in each year between 2015–16 and 2018–19. Increases in SHS usage were recorded between each year, resulting in an approximate 26% increase in people contacting SHS between 2015/16 to 2019/20 as a result of experiencing domestic and family violence. The National Housing and Homelessness Agreement which commenced on 1 July 2018 provides funding for publicly available housing and homelessness strategies and consider women and children affected by family and domestic violence to be a national priority.

In 2017/18, domestic and family violence was the most common reason for clients seeking housing assistance from specialist homelessness services, with 61% at risk of homelessness when presenting for support (AIHW, 2019a). Of clients reporting domestic and family violence, 47% were single parents with children. On average, each client has two support periods per year, and the average total length of support is 43 days per year. Most were housed when seeking support, with clients in public or community housing increasing from 16% to 23% over the support period.

Of note are the following statistics in the 2018/19 financial year:

- Females made up 90% of adult (18 and above years) SHS clients experiencing domestic and family violence;
- Half of all SHS clients under 18 years report experiencing domestic and family violence;
- Each client reporting experiencing domestic and family violence who contacted SHS received an average of two support periods in a year (AIHW, 2019a).

It was more common for people experiencing domestic and family violence to be in housing or short-term accommodation than experiencing homelessness or coming from institutional settings.

Table 10 – Specialist Homelessness Services (SHS) client rate (per 10,000 estimated resident population), clients who have experienced domestic and family violence, Specialist Homelessness Services, 2015–16 to 2019–20

	2015–16	2016–17	2017–18	2018–19	2019–20	Direction of change from 2015–16 to 2019–20
Number of clients	92,349	105,619	114,757	121,116	116,419	↑
Proportion of all clients	36	38	40	42	40	↑
Rate (per 10,000 population)	39.3	44.3	47.4	49.2	46.6	↑
Housing situation at the beginning of the first support period (per cent of all clients)						
Homeless	37	38	39	39	37	↓
At risk of homelessness	63	62	61	61	63	↑
Length of support (median number of days)	40	38	39	43	54	↑
Average number of support periods per client	1.8	1.9	1.9	2.0	2.0	↑
Proportion receiving accommodation	41	39	37	35	36	–
Median number of nights accommodated	32	31	31	31	30	↓
Proportion of a client group with a case management plan	64	64	64	65	69	↑
Achievement of all case management goals (per cent)	22	21	20	20	19	↓

Source: Specialist Homelessness Services Collection (AIHW, 2018b, 2020).

In addition to need, rates of access to SHS reflect the nature of the service system, including the availability and accessibility of services. Another element pertaining to the nature of the SHS system is the type of support provided. In 2019–20, the median length of support received was 43 days, nationally (Table 11). The median number of nights accommodated was 28 days, nationally.

Table 11 – Median length of support, days in support periods and nights accommodated, 2017/18 and 2019/20, Australia

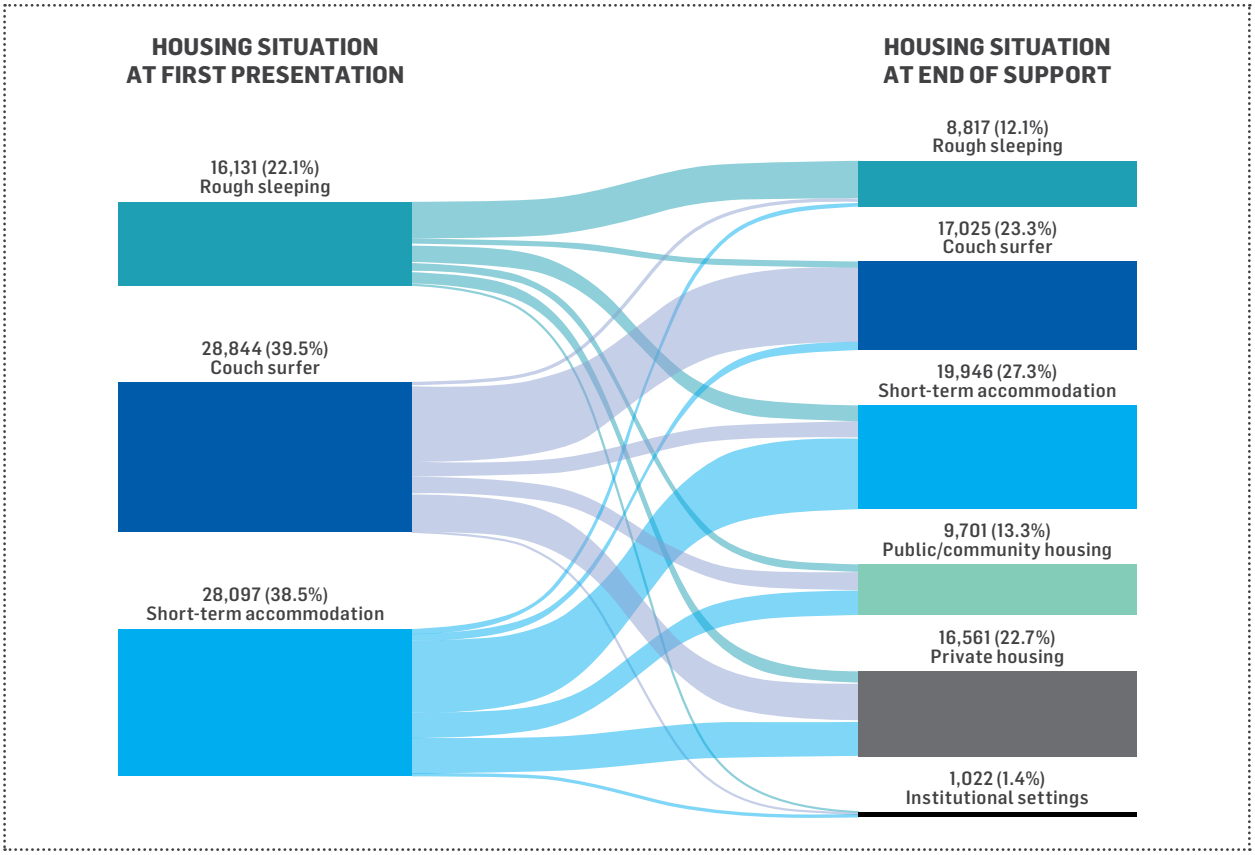
Support	*2017/18*	*2019/20*
Median length of support (days)	39	43
Median length of accommodation (nights)	32	28

Source: Specialist Homelessness Services Collection (AIHW, 2020a).

In the case of those experiencing homelessness on entry, the majority completed their support period in the same homelessness position that they began their support period in (Figure 10). In other words, those that began their support period rough sleeping, in supported accommodation, or couch surfing remained in the same state at the end of the support period. However, while the majority of those who were experiencing homelessness at the beginning of the support period, remained homeless at the end of the support period, there are also relatively large positive transitions from homelessness to both public/community housing (13.3%) and private rental housing (22.7%).

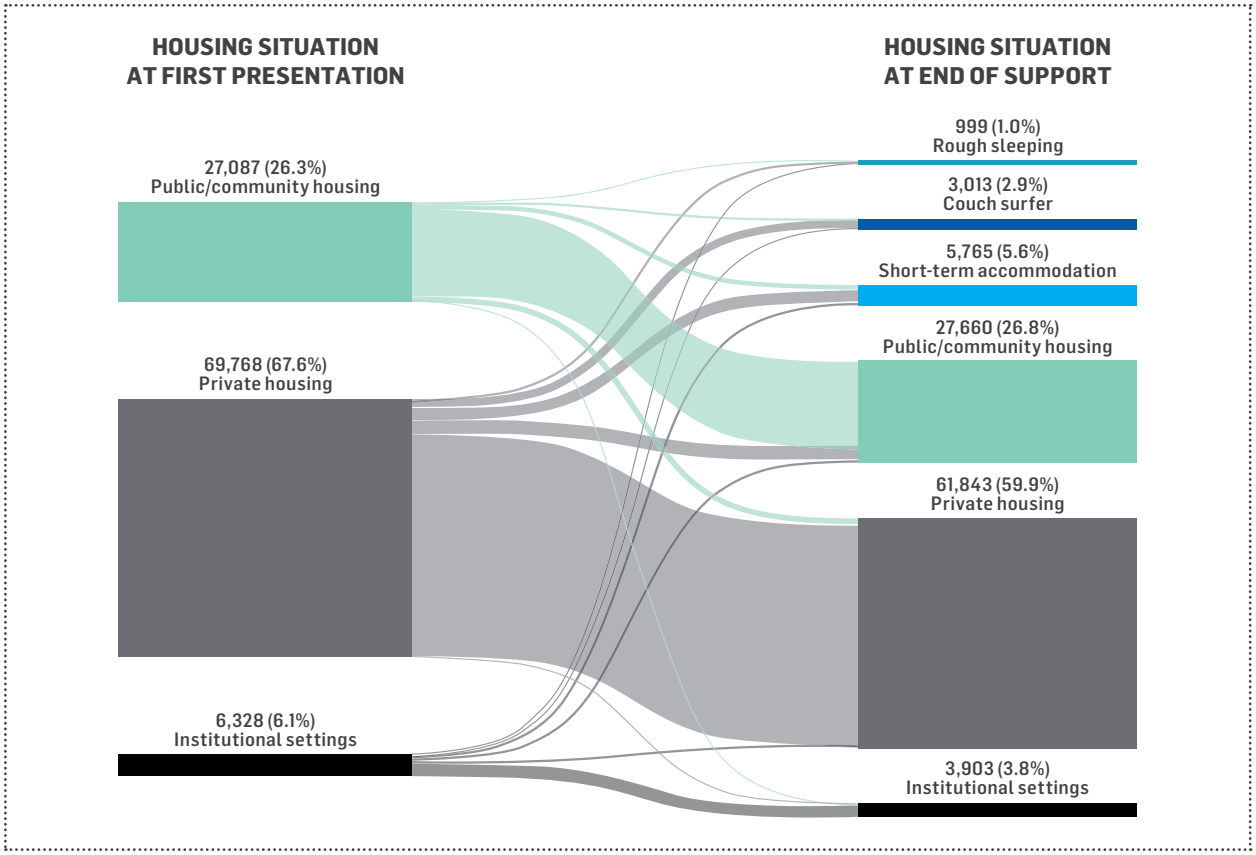
In the case of those at risk of homelessness, the very low proportion of clients that move from housing to homelessness and remain in the same permanent housing state is a very positive outcome showing that the vast majority of SHS clients at risk of homelessness at the beginning of the support period remained housed through their support period (Figure 11). However, these aggregate results need to be 'unpacked'. For example, often in cases of family and domestic violence the support period begins from a position of housing. While the support system is largely able to maintain the housing status of women and children experiencing family and domestic violence, the transition from unsafe to safe housing is the key outcome that is sought and the existing SHS outcomes data does not adequately provide information on whether such an outcome is achieved.

Figure 10 – Housing tenure outcome for clients of Specialist Homelessness Services (SHS) with closed support periods who were experiencing homelessness at the start of support in Australia, 2019–20



Source: AIHW 2020a Specialist Homelessness Services Annual Report 2019–20.

Figure 11 – Housing tenure outcomes for clients of Specialist Homelessness Support Services (SHS) with closed support periods who were at risk of homelessness at the start of support in Australia, 2019–20



Source: AIHW 2020a Specialist Homelessness Services Annual Report 2019–20.

This chapter used national ABS Census and SHS data to summarise the state of homelessness in Australia. The data points to a system that is currently not able to respond to the demand and need at a rate that will lead toward stemming, and eventually ending, homelessness. Services at present are unable to match the need for support, with over 260 unassisted daily requests, and the most common exit from SHS being the same state of homelessness an individual entered the system in. People experiencing homelessness are receiving a median of 43 days of support, and presenting issues are increasing.

The homelessness system, and people accessing the system are dynamic and changing over time. SHSC data points to an increase in particularly vulnerable cohorts of people accessing support services, such as people experiencing domestic violence and mental ill health among other vulnerabilities, often experiencing them simultaneously. Though the insights provided from ABS and SHSC data are wide, they are not yet deep in the sense that they do not point specifically to the underlying structural inflow and systemic causes of homelessness, and continue to count number of people, rather than looking at people and housing as a system.

In recent years, organisations across Australia have been seeking to fill some of this structure and knowledge gap through applying overseas homelessness intervention methods to a local context. Housing First methodology, registry/connections weeks, and Advance to Zero methodology have been trialled across several regions and programs nationally. Housing First programs sought to address the structural issues regarding homelessness exits from support services and demonstrated that providing housing at the beginning of a support period improved wellbeing and tenancy longevity and reduced returns to homelessness. Registry/connections weeks aimed to understand the vulnerabilities and system inflow points for particularly vulnerable forms of homelessness, chronic homelessness and rough sleeping. Advance to Zero methodology introduced the idea that, rather than counting the number of exits from the homelessness system into the housing system as a point of success, you needed to first understand the inflows, and the number of people actively homeless within a community to really understand if you are, in fact, making a difference to homelessness. These applications and others were opportunities to both understand and improve the homelessness system in Australia.

4 PREVENTING HOMELESSNESS

The aim of this section is to summarise key structural drivers for homelessness for which data is publicly available with an aim to understanding the broad set of policies that address the underlying causes of homelessness and sit alongside a Housing First supportive housing program if Australia is to end homelessness. As noted in our heuristic model of ending homelessness, the causes of homelessness are complex, encompassing a broad range of individual and structural determinants, including housing availability and affordability, economic and employment opportunities (or lack thereof), physical and mental health outcomes, domestic and family violence, and social and community connections.

4.1 Housing affordability

The availability and accessibility of safe, secure, and affordable housing plays a vital role in preventing entry into, and facilitating a sustained exit from, homelessness. Increasing rents, higher housing prices, and low wages growth, lead to a decrease in housing affordability.

- The proportion of low-income households experiencing housing affordability issues and housing stress has increased over time (AIHW, 2021e).
- The upward trend in the persistency of housing stress since 2001 has stabilised at a high level.
- From 2006–2016, the shortfall of private rental affordability for people on low incomes grew by 54% (Pawson et al., 2020).
- There has been a steady increase in the trends of 'owner with a mortgage' with a comparable decline in percentage of 'owners without a mortgage' since 2000, suggesting that it may be more difficult for Australians to own a home outright (AIHW, 2017). The percentage of households who are renting has steadily increased over time, suggesting that it may be more difficult for Australians to enter the housing market. Finally, public housing renters have decreased.
- There has been an overall trend towards increasing rents in 2021, with median rents showing the highest annual growth since July 2008. Almost one-third of Australians rent their housing, with Australian rents rising on average nearly 9 per cent over the past year (2021; capital cities 7.5%; regional area 12.5%) – the highest annual growth in dwelling rents since July 2008 (Pascoe, 2021).

In response to the COVID-19 pandemic, most Australian states and territories implemented eviction moratoriums and measures to vary rent obligations in residential tenancies, rooming houses and residential parks. However, these measures have now been lifted, with landlords increasing rents in 2021 (Pascoe, 2021; CoreLogic, 2021). On top of this, the additional payments for individuals on JobSeeker and Youth Allowance Payments came to an end in April of 2021 (Anglicare, 2021). An estimated 5–15% of tenants Australia wide may now by in rental debt as moratoriums end, this equates to between 324,000 and 973,000 Australians (Henriques-Gomes, 2020).

This increase in rent, potential rent back payments, and current employment difficulties can all contribute to increasing housing stress levels. Considering the role of housing stress as a driver of homelessness, the high proportion of low-income households remaining in housing stress from one year to the next is concerning, as being continually under housing stress can impact on workforce participation, education attainment, social security and health, putting householders in a financially unstable position and making them increasingly susceptible to homelessness.

The lack of affordable housing also puts households at an increased risk of experiencing housing stress, for low-income earners, with the latest findings from the 2021 Rental Affordability Snapshot finding that less than 0.5 per cent of rentals were affordable for individuals on government payments and only 1.2 per cent of rentals were affordable for singles on minimum wage (Anglicare, 2021). The relatively steady increase in proportional housing costs for renters in state or territory housing is a major concern, and could contribute to an increase of inflow into homelessness if not addressed.

4.2 Housing supply

Accessible social housing is a vital measure in preventing low-income households from entering homelessness as well as providing a housing exit point from homelessness. Social housing refers to housing provided for people on low incomes or with particular needs by government agencies (public housing), State Owned and Managed Indigenous Housing (SOMIH), community housing, or Indigenous Community Housing (ICH).

- The number of social housing dwellings has stagnated particularly in the public housing sector and indicates that public housing is not keeping pace with population demand.
- The number of households on the public housing waiting list has significantly decreased from 2015 to 2018, whereas the number of households on the Aboriginal and Torres Strait Islander community housing waiting list has significantly increased.
- The average waiting time for public housing is over two years for those not in greatest need.
- It is estimated that approximately 650,000 more social and affordable homes are needed to meet demand by 2036 (437,000 social houses and 213,000 affordable homes; Troy et al., 2019).

The government is involved in housing assistance in three main areas: social housing services, financial assistance (private housing), and specialist homelessness services. The data demonstrates a need in Australia for greater investment and policy development in the realm of public housing. The National Housing and Homelessness Agreement (Department of Social Services, 2018) aimed to improve access to affordable, safe, and sustainable housing across the housing spectrum. The Federal Government Budget 2021 focuses on promoting access to home ownership through the expansion of the New Home Guarantee, introduction of a Family Home Guarantee, and increasing the value of voluntary contributions that can be released under the First Home Super Saver (FHSS) Scheme for a house deposit. However, the budget has failed to address supply shortages of social housing stock, the availability of affordable housing options, and tenure insecurity in the low-income private rental sector.

4.3 Poverty and unemployment

Two important economic drivers of homelessness are poverty and unemployment. Poverty and unemployment lead to financial and housing stress, poor physical and mental health, and social exclusion, all of which are drivers of homelessness. Homelessness can also make it more difficult for individuals to find and keep a job, further compounding the difficulty in obtaining a sustained exit from homelessness.

- The rate of poverty in Australia varies across states and territories with 13.6% living below the poverty line of 50% of median income, including 18% of young people, and 14% of children (Davidson et al, 2020).
- There has been a consistent increase in Australian youth (15–24 year olds) unemployment (11%), a social group who are already disproportionately impacted by economic downturns and homelessness. Other contributing factors to homelessness within this social group include family conflict and low income.
- While not as high as the youth unemployment rate, trends in the general population were also worrying until the recent fall in July 2021, where the unemployment rate had decreased from a high of 7.4% in July 2020 to 4.6% in July 2021 (ABS, 2021).

The youth unemployment rate as well as underemployment rose sharply in Australia in the midst of the COVID-19 pandemic but began to fall in the first six months of 2021. Youth unemployment is the single factor most frequently associated with youth homelessness (Australian Human Rights and Equal Opportunity Commission, 1989). Preventing entry into homelessness by supporting economic participation and education among young people in the general population is, therefore, critical.

To support jobs growth, the Federal Government Budget 2021–22 has allocated $7.8 billion in personal income tax cuts to support low- and middle-income earners and $16 billion in tax cuts to small and medium businesses by 2023–24. The Federal Government's plans to increase employment vary from attracting business to Australia to create more Australian jobs, tax incentives to encourage innovation and investment, and investing $6.4 billion in 2021–22 to build skills through training and apprenticeships. Increasing jobs will contribute to curbing the increasing unemployment rate, one of the largest drivers of homelessness.

4.4 Young people in custody and out-of-home care

There is an established link between young people with experience in the justice system or who have experienced out-of-home care and lifetime risk of repeat episodes of homelessness. Flatau et al. (2015) found that almost two thirds of the homeless youth in their study had spent time in out-of-home care.

Presently, when a young person reaches the age of 18, they 'age out' of the out-of-home care system, and their supports for the most part cease. Ageing out of out-of-home care or the guardianship system is a particularly difficult time for young people, and research shows approximately 50% of young people who are ageing out of the system will experience their first episode of homelessness in their first year after ageing out (AIHW, 2020a). All other things being equal, the following characteristics were likely to increase the chances of experiencing homelessness for young people who had a history of out-of-home care:

- Having experienced at least one out-of-home care placement in a 24-hour group home situation;
- Having run away more than one time while in the out-of-home care system;
- Having experienced physical abuse before entering the out-of-home care system;
- Having no contact or connections with their biological parents; and
- Having engaged in any illegal activities such as underage drug and alcohol use (AIHW, 2020b; Dworsky et al., 2013).

Additionally, the number of young people in custody has decreased. This is particularly impressive when it is considered that the general population of youth would have risen in this time, and there has consequently been a notable decrease not just in the number but also in the proportion of youth that are detained in custody. However, Aboriginal and Torres Strait Islander youth justice and out-of-home care trends remain an area of deep concern.

- Aboriginal and Torres Strait Islander youth are significantly overrepresented in juvenile detention figures (AIHW, 2021a, 2021b). In 2019–20, Aboriginal and Torres Strait Islander youth were 14 times more likely to be in youth detention than non-Aboriginal and Torres Strait Islander youth. The rate of Aboriginal and Torres Strait Islander youth in detention was 142 per 10,000 compared to 9.8 per 10,000 non-Aboriginal and Torres Strait Islander youth.
- The disproportionate number of children in out-of-home care among the Aboriginal and Torres Strait Islander population is concerning.

Western Australia had the highest rate of Aboriginal youth detention, with the rate for Aboriginal young people 21 times the rate for non-Aboriginal young people. The Western Australian Premier's Priorities document sets a target of less than 50% of young offenders returning to detention within 2 years of release by 2022–23. The achievement of this goal would significantly contribute to reducing the number of youth detainees in custody, since it would involve the successful implementation of strategies for youth leaving

detention to re-enter society, implying the economic involvement of the youth as functioning members of society. Long-term, this will lead to fewer adult prisoners, as those who go to juvenile detention multiple times are far more likely to end up in prison as adults (AIHW, 2021a, 2021b).

To achieve a long-term reduction in the rates of Aboriginal and Torres Strait Islander homelessness, the rate of Aboriginal and Torres Strait Islander children in out-of-home care will have to be reduced significantly. Aboriginal and Torres Strait Islander specific solutions are fundamental with stronger support networks for this vulnerable group needing to be developed. In a welcome move, most state and territory governments have agreed to extend care to the age of 21.

4.5 Physical and mental health

Poor health has a dual effect on an individual's risk of homelessness. While the management itself of ill health is costly, poor health can also inhibit an individual's economic and social participation. This economic burden can make it more difficult to manage day-to-day expenses, lead to poverty, personal vulnerability, and disaffiliation, rendering an individual more susceptible to homelessness. Consequently, the experience of homelessness in and of itself often worsens health, with poor access to preventative health services, cost barriers to affordable health care and medications, and technological barriers limiting appointment reminders and telehealth initiatives. The homeless population is disproportionately affected by poor physical and mental health, and substance misuse; and these often concurrently occur with high rates of multimorbidity and tri-morbidity observed in Australian homeless populations (Vallesi et al., 2021).

- The proportion of Australians with fair or poor self-assessed health status has remained stable (ABS, 2019d).
- The percentage of Australians reporting high/very high psychological distress has been increasing over time (ABS, 2019d).
- Aboriginal and Torres Strait Islander Australians are more than three times more likely to use outpatient mental health care services than Australians of other descent (AIHW, 2020c).

The WA Sustainable Health Review released in 2019, acknowledged the disproportionately poor health of people experiencing homelessness, and provided a number of recommendations around improving health care access, treatments, and outcomes for this group (Sustainable Health Review, 2019).

The Federal Government has policies and plans, as well as initiatives and programs to improve the lives of people living with mental ill-health, their families, carers, and communities. National policies and plans helping to guide government action on mental health issues include: Fifth National Mental Health and Suicide Prevention Plan; Vision 2030; National Mental Health Policy; National Mental Health and Wellbeing Pandemic Response Plan; COVID-19 National Health Plan; Roadmap to National Mental Health Reform; and the National Mental Health Workforce Strategy Taskforce (Department of Health, 2021a). Primary Health Networks, websites, digital mental health support, Medicare rebates, and support programs receive funding for people who need support.

The Federal Government in its 2020-2021 Budget has allocated $2.3 billion towards a national response to mental health, wellbeing, and suicide prevention (National Mental Health Commission, 2021). Priority populations include Aboriginal and Torres Strait Islander peoples, children and families, rural and remote communities, parents and carers, men, women, young people, and lesbian, gay, bisexual, transgender, intersex, queer and gender diverse (LGBTIQA+) peoples.

Overall, Aboriginal and Torres Strait Islander Australians are disproportionately impacted by higher rates of mental health issues than other Australians. Among Aboriginal and Torres Strait Islander populations, deaths from suicide are twice as high, hospitalisation rates for intentional self-harm are three times as high, and the rates of high/very high psychological distress is over two times as high compared to the overall population (AIHW, 2020d).

The rate of homelessness among Aboriginal and Torres Strait Islander Australians is far higher than for Australians of other descent. In Australia, 20% of those counted as homeless identify as Aboriginal and Torres Strait Islander, despite the Aboriginal and Torres Strait Islander population making up around 3% of Australia's total population (ABS, 2017a). Given the significant role of poor mental health as a driver of homelessness, the high rates of mental illness among the Aboriginal and Torres Strait Islander population must be addressed.

4.6 Alcohol and other drug use

Substance misuse can be both a contributing factor to homelessness through impaired economic participation or loss of social support networks and also a consequence of homelessness. From a psychosocial perspective, people experiencing homelessness are susceptible to abuse and assault while rough sleeping and feelings of shame, worthlessness, isolation, and mental illness, including depression, which can exacerbate their susceptibility to alcohol and drug abuse.

- A positive shift in Australian drinking culture is taking place as can be seen in the increase of Australians who are 'ex-drinkers.' Inversely, the per cent of those who 'drink daily' has shown a gradual decline (AIHW, 2021c).
- There has been a positive growth in 'abstainers' and a slight fall in both 'risky' and 'low risk' drinkers (suggesting that some from the 'low risk' category have moved to 'abstainers' rather than shifted to 'risky' category). The AIHW has defined 'risky' drinking as consuming more than 2 standard drinks on average every day (AIHW, 2021c).
- The rate of those that have used or continue to use an illicit drug in Australia is increasing. This is concerning as it suggests that the measures currently being implemented are not functioning to an adequate capacity (AIHW, 2021c).

The Federal Government identifies illicit drug use as a severe problem within Australian society and has developed a 10-year National Drug Strategy 2017–2026 framework which contains plans and strategies, funds programs and research, and worked with other organisations to help reduce the harmful effects of drugs (Department of Health, 2021b). The National Drug Strategy identifies three different types of priority areas of focus in implementation: actions (including access to evidence informed treatment services and support), priority populations, and substances.

The National Ice Action Strategy 2020–21 distributed $131.5 million to allow Primary Health Networks to commission new and existing drug and alcohol treatment services based on local need (Ministers Department of Health, 2019). The National Alcohol Strategy 2019–2028 is aimed at working to prevent and reduce harmful drinking and focuses on four national priority areas: improving community safety by introducing safer drinking environments, reducing injury and violence, and improving treatment; improving management of the availability, price, and promotion of alcohol; ensuring people have access to treatment, information, and support services; and improving awareness of how alcohol-related harm impacts the Australian community.

Additional funding has also been provided for research including extending AIHW drug surveys and data collections ($7.3 million), $1.5 million for the National Surveillance System for Alcohol and Other Drug Misuse and Overdose Project, Alcohol and Drug Foundation Drug Information Directory, and the Drug and Alcohol Review, and $561,000 to support Cancer Council Victoria to update and maintain the Tobacco in Australia: Facts and Issues publication (Greenhalgh et al., 2020).

4.7 Family and domestic violence

Family and domestic violence (FDV) is the leading cause of homelessness for women and their children. However, FDV rates are notoriously difficult to calculate accurately, owing to the fact that most incidences of domestic violence and sexual assault go unreported, non-physical behaviours are less likely to be recognised as violence against women, definitions of FDV vary according to the legislation in each state, and there is an increasing awareness and social acceptance of reporting FDV.

- The prevalence of FDV offences including physical, sexual, and emotional abuse and coercive control have increased in recent years (AIHWA, 2021f).
- Only two in five women report that the police had been notified after the most recent incident of physical or sexual violence, indicating that FDV rates are severely underreported (AIHWA, 2021f).

When interpreting the peak observed in 2019–2020 it is necessary to consider the potential impact of COVID-19 on trends of FDV offences (Boxall et al., 2020). COVID-19 has been linked to increased reports of FDV and in conjunction with lockdowns, has been linked to increased economic insecurity and social isolation (known contributors to FDV; Australian Institute of Criminology, 2021).

4.8 Summary

Homelessness can be prevented through addressing 'structural' and 'individual' determinants of homelessness including: housing availability and affordability; economic and employment opportunities; physical and mental health outcomes; and FDV. Housing availability, housing affordability, rental increases, poverty, and current employment difficulties contribute to housing stress, impacting on households and their ability to have access to safe, secure, and affordable housing, and making them increasingly susceptible to homelessness. To reduce the inflow into homelessness, the increasing housing stress levels seen across Australia need to fall, with low-income earners having greater accessibility to public housing and affordable housing options.

Poverty rates are stable or increasing, with youth unemployment rates also increasing. These two economic drivers lead to financial and housing stress, poor physical and mental health, and social exclusion, all of which increase susceptibility to homelessness. Young people with experience in the justice system or who have experienced out-of-home care, have a higher risk of homelessness. Addressing the youth unemployment rate through increasing jobs, and continuing decreasing rates of youth detainees in custody and children in out-of-home care will reduce the youth inflow into homelessness.

The homeless population is disproportionately affected by poor physical and mental health, and substance misuse. Increasing population rates of high distress and illicit drug use can increase susceptibility into homelessness. FDV is the leading cause of homelessness for women and their children. While definitions of FDV vary according to the legislation in each state, increasing awareness and social acceptance of reporting FDV have meant that housing and wraparound support is increasing for women and their children experiencing or at risk of experiencing FDV.

While this section has used publicly available data to summarise key drivers of homelessness, the following section uses the Advance to Zero database collected by homelessness service agencies to provide substantial detail and context about people experiencing homelessness. The combination of these two data sources allows for the identification of key areas and a policy and practice agenda required to end homelessness, which is outlined in Part III.

Table 12 – Drivers of homelessness in Australia

Drivers	Indicators	Most current values	Trend over time
Housing affordability	Proportion experiencing household stress in capital cities (2013–2016)[1]	Sydney – 13.0% Melbourne – 9.7% Brisbane – 10.5% Adelaide – 8.4% Perth – 8.8% ACT & Urban Northern Territory – 6.6% Urban Tasmania – 9.5%	Increasing
	Proportion of low-income rental households spending more than 30 per cent of their gross income on housing costs (2017–2018)[2]	Greater capital city area – 47.8% Rest of state – 35.6	Decreasing Decreasing
	Proportion of low-income households remaining in housing stress from one year to the next (2013–2016)[1]	47.3%	Stable
	Housing affordability (2017–2018)[2]	Owner – 16% Owner with a mortgage – 3% Renter – private landlord – 20% Renter – state or territory housing – 23%	Stable Decreasing Decreasing Increasing
	Home ownership (2017–2018)[2]	Owner without a mortgage – 30% Owner with a mortgage – 37% Renter – private landlord – 27% Renter – state of territory housing – 3%	Decreasing Increasing Increasing Decreasing
	Rental affordability index (Q3, 2021)[3]	Sydney– Acceptable Melbourne – Acceptable Brisbane – Acceptable Adelaide – Unaffordable Hobart - Unaffordable Perth – Acceptable ACT - Unaffordable	Stable Increasing Decreasing Decreasing Decreasing Decreasing Stable

Continued on page 47.

Drivers	*Indicators*	*Most current values*	*Trend over time*
Housing affordability (Continued)	Rental growth[4]	Capital cities – 12.5% Regional areas – 7.5% Sydney - 7.2% Melbourne – 1.8% Brisbane – 9.7% Adelaide – 8.3% Hobart – 12.8% Perth – 14.5% Darwin –20.9% Canberra – 9.6%	Increasing
Housing supply	Number of social housing dwellings (2019)[5]	Indigenous community housing – 17,700 Community housing – 100,200 Public housing – 305,200	Decreasing Increasing Decreasing
	Number of applicants on waiting list (2019)[5]	Public housing – 148,500 Indigenous community housing – 12,100	Decreasing Increasing
	Waiting time to secure public housing accommodation (2020)[5]	72% greatest need within one year 38% not in greatest need within one year 48% not in greatest need more than two years	

Source: [1] The Household, Income and Labour Dynamics in Australia (HILDA) Survey: Selected Findings from Waves 1 to 16, 2018.
[2] ABS 4130.0 – Housing Occupancy and Costs, 2017–18.
[3] Rental Affordability Index, SGS Economics & Planning.
[4] Core Logic Quarterly Rental Review, September 2021.
[5] AIHW Housing assistance in Australia 2020.

Table 12 – Drivers of homelessness in Australia (Continued)

Drivers	Indicators	Most current values	Trend over time
Poverty	Australian poverty rates (2017–2018)[1]	Poverty line -below 50% *median income* Australia – 13.6% New South Wales – 13.7% Victoria – 12.7% Queensland – 15.3% Western Australia – 12.9% South Australia – 14.2% Tasmania – 12.6% Northern Territory – 7.5% Australian Capital Territory – 8.6%	 Increasing Increasing Decreasing Increasing Decreasing Decreasing Stable Decreasing Stable
	Unemployment rate (2021)[2]	Youth – 10.7% General population – 4.6%	Increasing Decreasing
Young people – in custody and out-of- home care	Youth detainees in custody (Sept 2020)[3]	Aboriginal and Torres Strait Islander youth Youth of other descent – 26	Decreasing Decreasing
	Children in out-of-home care (2019–2020)[4]	Aboriginal – 23.0 per 1000 All – 1.9 per 1000	Decreasing Decreasing
Physical and mental health	People that report their health status as fair/poor (2017–2018)[5]	Fair/poor – 14.7%	Stable
	Proportion of persons with High/Very High psychological distress (2017–2018)[5]	High/very high – 13.0%	Increasing
	Outpatients mental health care services (2018–19)[6]	Aboriginal and Torres Strait Islander Australians – 1200 per 1000 Non-aboriginal Australians of other descent – 340 per 1000	

Continued on page 49.

Drivers	*Indicators*	*Most current values*	*Trend over time*
Alcohol and druguse	Alcohol Consumption in Australia, people aged 14 years or older (2019)[7]	Never drunk – 15.0% Drink daily – 5.0% Ex-drinker – 8.9%	Stable Decreasing Increasing
	Alcohol lifetime risk status, people aged 14 years or older (2019)[7]	Lifetime risk – 16.8% Abstainers – 24.0% Low risk – 25.0%	Decreasing Increasing Decreasing
	Illicit Drug use (2019)[7]	Ever used – 43.0% Used in last 12 months – 16.4%	Increasing Increasing
Domestic Violence	Family violence offences (2019–20)[8]	Homicide – 145 Sexual assault – 10,162	

Source: [1] Davidson et al, 2020. Poverty in Australia 2020: Part 1, Overview. ACOSS/UNSW Poverty and Inequality Partnership Report No. 3, Sydney: ACOSS.
[2] ABS 6020.0 – Labour Force, Australia.
[3] AIHW, 2020. Youth detention population in Australia.
[4] AIHW Child Protection Australia 2019–20.
[5] ABS 4364.0.55.001 - National Health Survey: First Results, 2017–18.
[6] AIHW, 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020.
[7] AIHW 2021. Alcohol, tobacco & other drugs in Australia.
[8] ABS, 2020. Recorded Crime – Victims.

On the streets of Brisbane during 500 Lives 500 Homes Campaign Registry Fortnight.

Photography: Patrick Hamilton

Part II:

ADVANCE TO ZERO: INSIGHTS INTO HOMELESSNESS IN AUSTRALIA

5 THE ADVANCE TO ZERO DATA COLLECTION

In this chapter we examine the history of Registry Week, Connection Weeks, and similar collections around the world and in Australia; detail where and when collections have taken place; and describe how the Advance to Zero database has been formed.

5.1 The history of Registry and Connections Weeks

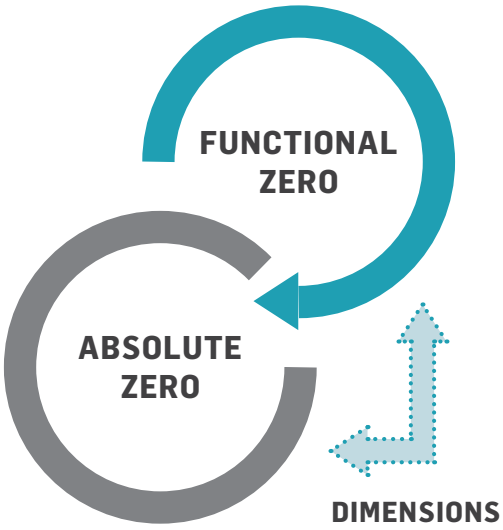
Registry Weeks began in 2004 in the United States as part of the Common Ground campaign to permanently house chronically homeless rough sleepers in New York. The 2004 Street to Home Initiative pioneered the creation of a 'homeless registry' to increase services understanding and associated accountability and capacity to end street and chronic homelessness. Through identifying and assessing the health and housing needs of people experiencing homelessness in a community, first using the Vulnerability Index (VI; Leopold & Ho, 2015), followed by the VI-SPDAT, Registry Weeks grew the oversight and understanding of pathways into, and out of homelessness. The creation of this registry and its associated impact peaked interest within the homelessness sector, prompting other communities to implement this approach.

Registry Week events involve services collecting actionable information about the vulnerabilities and needs of people experiencing homelessness. Through using standardised instruments eliciting information on the circumstances, vulnerability, risk and service needs of those experiencing homelessness, Registry Weeks utilise the information collated to identify and understand the mismatch of resources and needs within their community. The frame of 'Connections Week' was introduced in South Australia for the purpose of shifting the phrasing away from 'registering' a person, toward connecting with a person experiencing homelessness, and thereby connecting them to the resources they may need. As most communities implementing functional zero methodology use the phrase 'Registry Week', this term will be utilised throughout the text (Figure 12).

In 2007, Los Angeles local leaders commissioned a Registry Week approach to house 50 of the most vulnerable and at risk of death individuals living on Skid Row. Called Project 50, volunteers and Common Ground staff, administered the VI tool over a nine-day period (Registry Week). The VI was undertaken with those living on the streets and in 'shelters'. Project 50 exceeded the target of housing 50 people from the constructed registry, and provided momentum for Housing First approaches to end homelessness (Leopold & Ho, 2015).

Following the Project 50 initiative, other Housing First campaigns began supporting the momentum of the approach across the US, leading to Common Ground establishing the national 100,000 Homes Campaign (the Campaign). The Campaign adopted a Registry Week approach using initially the VI and subsequently the VI-SPDAT (as developed by Community Solutions, a US-based not-for-profit established by Roseanne Haggerty, formerly of Common Ground and OrgCode Consulting Inc.)

Figure 12 – Functional Zero and Absolute Zero homelessness definitions



A **Functional Zero** end to homelessness means that communities have a systematic response in place that ensures homelessness (unsheltered homeless, sheltered homeless, provisionally accommodated, or imminent risk of homelessness) is prevented whenever possible or is otherwise a rare, brief, and non-recurring experience.

Absolute Zero refers to a true end to homelessness, where everyone has access to supports and appropriate housing so that no one becomes homeless (unsheltered homeless, sheltered homeless, or provisionally accommodated) or at risk in the first place.

Dimensions: Lived experience, homelessness prevention systems, public systems.

Rather than opposite concepts, Functional Zero describes progress towards an Absolute Zero end to homelessness.

Source: Canadian Observatory on Homelessness, 2017.

The VI-SPDAT is an amalgamation of both the VI and the SPDAT assessment tools, and is implemented with individuals, young people, and families experiencing homelessness. The VI is a survey and methodology for analysing and prioritising individuals based on the length of time spent homeless (greater or less than 6 months) and the presence or absence of eight clinical conditions found in US studies to increase the risk and vulnerability of death, in people who are sleeping rough (Hwang et al., 1997; Hwang et al., 1998). In addition to duration of homelessness and health conditions, the VI captures information on the number of hospitalisations and emergency department visits per year, and age. It is a survey administered to people with informed consent, with some opportunity for the interviewer to provide assessment.

The VI allowed organisations to assess and rank an individual's likelihood of death based on a number of health-related risk factors and their homelessness status, and was based on a study which identified the demographic and clinical factors associated with an increased risk of death in homeless individuals. The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for frontline agency workers to assist them in prioritising the health and housing needs of individuals and families who are homeless (OrgCode Consulting, 2015).

The SPDAT tools are designed to help guide case management and improve housing stability outcomes and have been used by communities across the USA and Australia since 2010. The SPDAT is a scoring system developed by OrgCode Consulting that collects information on various domains of wellbeing, including:

- Mental health and wellbeing
- Cognitive functioning
- Physical health and wellness
- Use of medication and substance use
- Experience of abuse and trauma
- Risk of harm to self and others
- High risk behaviours and exploitive situations
- Interaction with emergency services
- Legal issues and justice system interaction
- Daily functioning and money management
- Social relationships and networks
- Self-care and daily living skills, meaningful daily activity
- Tenancy experience and history of housing and homelessness

Combined, the VI-SPDAT provides a comprehensive assessment of the history of homelessness, risks, socialisation, and daily functioning aspects, and vulnerabilities a person entering the homelessness system is facing, combined with a method by which to assess and triage supports required. Over the last decade, successive campaigns to end homelessness in Canada, Europe, and Australia have utilised the VI-SPDAT to assess and prioritise the housing needs of an individual based on chronic homeless status, medical vulnerability, and other social risk factors (Leopold & Ho, 2015).

In the US, the 100,000 Homes campaign aimed to provide permanent housing to 100,000 chronically or vulnerable people experiencing homelessness, including veterans. By the end of the 4-year campaign in 2014 involving multiple housing, health, and other support agencies, 105,580 people in 186 communities had been housed (Leopold & Ho, 2015). Critical to the Registry Week is that information from the VI-SPDAT informs planning the unique housing and support needs of individuals and families within that community. That is through this information, systems are more aptly prepared to channel the required resources to those with the greatest needs, in addition to other discretionary support services. This information also contributes to the dissemination of affordable housing and housing first initiatives. Access to affordable housing is required to end rough sleeping and temporary housing in homelessness support accommodation, and the Housing First philosophy is seen as a first step in ending a person's homelessness, rather than providing housing subsequent to various preconditions being met, such as sobriety or employment (Tsemberis et al., 2004; Padgett et al., 2006).

It is not possible to create an assessment for people experiencing homelessness that is going to comprehensively record, understand, and demonstrate specific vulnerability and service needs. The heterogeneity of the population alone ensures limitations in generalising assessment results. However there will always be limitations in any tool utilised with the homeless population during a Registry Week due simply to time, place, and circumstance constraints (e.g., many interviews are undertaken on the streets at night, and people undertaking the interviews are meeting each other for the first time).

Nevertheless, the VI-SPDAT does have some key limitations that are worthy of mention, many of which have been addressed in recent iterations of the tool. First, there are relatively few questions on housing and homelessness itself. While concerns from previous iterations have been addressed insofar as ensuring time frame of homelessness experience and length of time since stably housed now being included in the survey, the housing and homelessness section of the survey is only weighted light when compared with other sections of the assessment, for example the wellness section. The wellness section in the most recent iteration of the VI-SPDAT has expanded significantly on both physical and mental health conditions. Several questions in the new tool also are a collective proxy indicator for disability, and it was not as possible to collate this measure in previous survey versions. The addition in the latest version of questions regarding the potential to experience violence from a friend or relative is weighted higher than other sections of the tool. There was one question introduced in the new tool that was assigned a score of 2, regarding imminent threat of violence or harm. Many additional questions in the recent iteration addressed concerns of previously implemented versions. There remain some cultural concerns regarding implementation of the tool with Aboriginal and Torres Strait Islander identifying communities, these are presently being worked on within working groups.

The VI-SPDAT is utilised to collect self-report data on clinical and healthcare utilisation outcomes and there is little matching with objective records, posing a number of data quality issues (Parsell et al., 2017; Brown et al., 2018). However, this is a common issue in surveys of vulnerable people. The addition of questions regarding imminent risk of violence were added to assess risks of people while homeless. They are not able to be used as a proxy indicator for experiencing domestic violence, as such this is not something that is able to be ascertained from the tool. Although females represent a smaller proportion of the rough sleeping population in Australia than males, they are more likely to experience rape (Sanders & Albanese, 2016), have dependents living with them on the street, and represent the majority of SHS agency unassisted requests (AIHW, 2018a). Further consultation is required to add a sensitive question to the tool regarding present experience of domestic violence.

As in the US, Australian Registry Week events have utilised the VI and, subsequently, the VI-SPDAT. Many homelessness services using the VI-SPDAT, have used the information it collects to inform decision making triaging access to housing, rather than the historical point in time 'street counts' that do not paint a comprehensive picture of associated individual vulnerabilities, system inflows and outflows.

Registry Weeks usually occur in a concentrated time period (e.g., over a week) and involve both workers from related services and volunteers conducting interviews with people experiencing homelessness in their presenting environment, where they are usually staying. The information collected from these interviews is then collated to form a register of the names and associated vulnerabilities experienced by those who are homeless within the community of interest. This register works to bridge a knowledge gap, getting to know those who are homeless by name and according to their needs and circumstances, while also building an understanding of collective issues and inflows related to the community.

The building and maintenance of a register goes beyond just improving the understanding of what homelessness looks like within your community. Figure 13 outlines the four key problems that a data informed register and broader Advance to Zero methodology seeks to address.

Figure 13 – Housing First veterans examples using a By-Name List

Problem	*Identified Solution*
• There is not a singular agency responsible for ending homelessness in a community, many agencies hold small funding pieces, and nobody has a whole-of-system view.	• Create a central team including homelessness services and service peripheral to homelessness, such as the local government, healthcare services, housing authorities. This team to meet regularly.
• Funding is based on the success of individual agencies, not a collective community reducing homelessness or reaching certain milestones.	• Create a database that is collectively owned and entered in to, to enable a community to have ownership and understanding of whether efforts to reducing homelessness are working.
• Annual street counts provide a snapshot of the community people are trying to support, what is needed is a system to take line of sight as to how people are moving through the system, when they are moving through it.	• Build into the collectively community owned and led database mechanisms to know people experiencing homelessness, by name and understand their needs in real time.
• Cities have improved the number of houses to communities without making a significant difference in the overall numbers of people experiencing homelessness.	• The community use the database to assess vulnerabilities and needs of people on the list, and allocate appropriate housing options for their needs, resulting in a greater possible likelihood of tenancy retention.

Source: Community Solutions, https://community.solutions/

Central to the data and tracking of the Advance to Zero methodology is the By-Name List. The data points on the register inform 7 points of a dynamic system, enabling near-to-live oversight of a homelessness service system: 3 points of inflow, two of active, and two of outflow (Figure 14).

- ***Inflow***
  - ***Returned from housing:*** When an individual has previously been active in the community, has since returning to the homelessness community being measured on the register as a result of a housing placement ceasing. This point is collected to understand the relationship between the housing system and homelessness numbers within the community. As the data is collected over time this data point can help to identify structural inflow information, so that the community can work to address this moving forward, such as common types of housing being exited (e.g., rental or social housing), or common reasons of exit (e.g., eviction).

- ***Newly identified:*** When an individual is counted within a community for the first time. It is important to understand who is new to the community, and who may have returned from other means, so that vulnerabilities can be assessed in real time and any potential reasons for the new inflow can be addressed.
- ***Returned from inactive:*** When an individual has previously been active in the community, has since returned to homelessness community being measured on the register. There could be many identified reasons for returning from an inactive status to the community. These reasons include returning from a facility, such as a hospital or prison, returning after exiting the community measurement area, re-engaging with services after a period of not being contactable for 90 or more days. This point is collected to understand the systemic reasons for returning to a homelessness system and can give rise to continuous improvement work within the community.

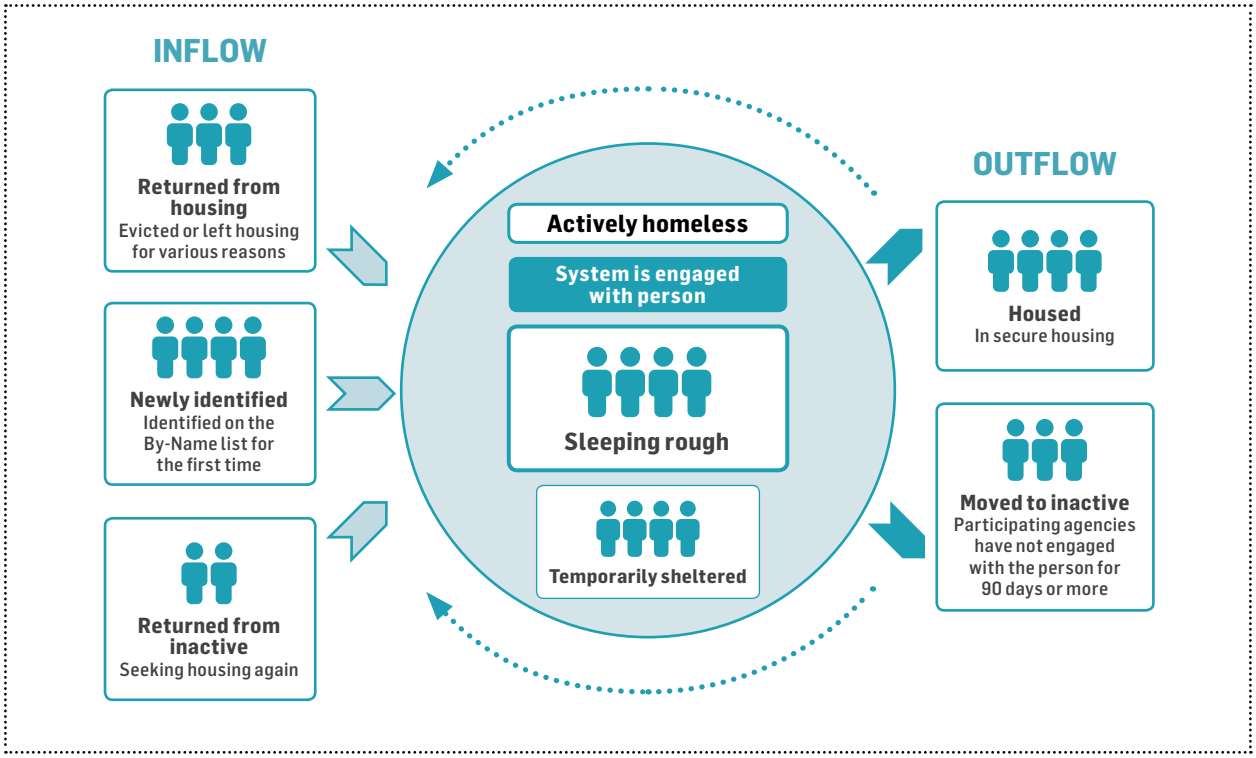
- ***Actively homeless***
  - ***Sleeping rough:*** When an individual is actively engaged in the community and is known to be sleeping rough
  - ***Temporarily sheltered:*** When an individual is actively engaged in the community and is known to be in emergency shelter, temporary lodging/boarding facilities or backpackers' facilities.
- ***Outflow***
  - ***Housed***: When an individual exits the homelessness system through obtaining a secure, long-term housing placement. This is a key metric in calculating functional zero
  - ***Moved to inactive:*** When an individual exits the homelessness system through being no longer actively in the community. There are multiple reasons for this status, including: exiting the community being measured, being non-contactable by services for over 90 days (with multiple attempts to locate them), unknown death, or entering a facility such as a hospital or prison.

These six points create a dynamic overview of a homelessness system within a community. In Australia, the numbers of people in each point are recorded in real time, and publicly reported at the end of each month, when a community has capacity to do so. An individual cannot be in more than one of the categories at one time. This means that the point that they are in at the end of the month is reflected in statistics of Australia's public dashboards. In other words, if an individual is homeless at the beginning of a month, and then obtains housing within the month, they will be marked at the end of the month in the housed point, so as to not conflate or confuse the numbers or count multiple people across different conditions/points.

There are limitations in the outflow points and how they can feed back to inflow. For example, the only way an individual would be marked as returned from housing and marked in inflow, is if they returned to their community seeking help. It is rare that access to government and community housing lists are able to be cross referenced to assess tenancy retention, and even more difficult to access private rental listings to ascertain the numbers. Also, the number of people within the active category should be reflective of only the community being assess for functional zero, so if people have left their housing and have not returned to the community, they should remain in outflow regardless.

Inactive as an outflow point is also quite limited, for similar reasons to housed. The only way that you would know if an individual has returned to the community is if they have actively contacted a service or returned to the community being measured. What makes the inactive point more ambiguous than housed is that it is not possible to be sure about where an individual has gone if they have been uncontactable, and if they are still in need of support. So, while they may be inactive within the community, they may still need support. Finally, without cross-referencing to death records it is not possible to determine with accuracy if a person in the inactive category remains alive. Given high rates of mortality among chronic rough sleepers this remains an important issue.

Figure 14 – Inflow outflow definition diagram for rough sleepers



Source: Don Dunstan Foundation, 2020

Australian Registry (or Connection) Week events that build a By-Name List are different from community-initiated 'street counts' (such as the Street Count in Melbourne). Street counts provide useful localised demographic, transience, and intended service use information for people who are sleeping rough, at a point-in-time, usually implementing a short specific questionnaire. Through implementing both the VI-SPDAT and an associated By-Name List recording system to capture and continuously track information, Registry Weeks can provide a baseline for near to real time data that can provide ongoing information that is rich in detail and continuously updated. This information can be used to inform service delivery and improve understanding of why individuals have entered a community in the first place, deepening understanding of inflow pathways into homelessness, and enabling continuous improvement projects that could potentially address some of this inflow to take place.

500 Lives 500 Homes Campaign Partner Red Cross Young Centre ready to start the Registry Fortnight.

5.2 Registry Week collections in Australia

In 2010, the VI was utilised to assess associated vulnerability factors present in people who were sleeping rough in Brisbane, during the first Australian Registry Week. It became the basis for the 50 Lives 50 Homes campaign coordinated by Micah Projects, a community-based organisation in Brisbane delivering social inclusion programs and support services to people across multiple areas of need, including housing, healthcare, and employment. By the end of 2013, the VI had been utilised by agencies to assess over 2,300 rough sleepers over seven Registry Weeks in five cities across Australia. Data collected via the VI was entered into a database with the support of Common Ground USA, developed by Micah Projects and was utilised by organisations as part of their ongoing service delivery. The register formed the basis for various Street to Home and Housing First programs across Australia through demonstrating the importance of near to real time data in understanding homelessness within a community, and its potential causal factors.

The Advance to Zero database captures information on over 20,000 people experiencing homelessness between 2010 and 2020 (Table 13). As outlined in Table 14, two-thirds of responses (13,932) were collected via administration of the Individual VI-SPDAT instrument only. A further 14.2% (2,974) responses were received using the VI and 11.6% or 2,436 responses were received using the Families-VI/VI-SPDAT. Under 2% of responses were received from the Youth VI-SPDAT, largely collected among young people in Victoria.

Table 13 – Registry Week data collections by state of collection (total responses)

	Number	Per cent
Queensland	7,171	34.2
Western Australia	2,505	12.0
New South Wales	2,289	10.9
South Australia	1,280	6.1
Victoria	7,322	34.9
Tasmania	386	1.8
Total	20,953	100.0

Source: Advance to Zero Data 2010–2020

Table 14 – Registry Week collections by type of collection (total responses)

	Number	Per cent
VI Survey	2,974	14.2
General VI-SPDAT Survey	1,281	6.1
Youth VI-SPDAT	347	1.7
Families VI/ VI-SPDAT	2,436	11.6
Individual VI-SPDAT	13,932	66.5
Total	20,953	100.0

Source: Advance to Zero Data 2010–2020

Since 2014, Registry Weeks in Australia have utilised the VI-SPDAT, an amalgamation of the VI and the SPDAT. It is an evidence-informed tool used to assess acuity of homelessness and prioritise and activate appropriate intervention. Acuity refers to the level and severity of issues a person experiences that impact their perceived ability to access stable housing, other supports, and maintain tenancies. The VI-SPDAT is a triage tool, designed to quickly assess the health and social service needs of rough sleepers and match them with appropriate support and housing interventions (Homeless Hub, 2017). Its purpose is to provide data to inform decisions, not make decisions – the score produced by the tool alone should not be used to prioritise households for housing (De Jong, 2017; Brown et al., 2018). It assesses vulnerability across four broad domains: history of housing; risks; social and daily functions; and wellness. These domains were collated to provide a total vulnerability score. There have been several iterations of the VI-SPDAT, the most recent version expanded on the wellness section significantly, enabling a deeper understanding of the way in which specific health, mental health, and substance use behaviours contributed to vulnerabilities in the population VI-SPDAT scoring groups, acuity, and recommended levels of support are shown in Table 15. Appendix 7 outlines the included variables for each type of collection. The table below outlines the scoring differences between the most commonly used versions in Australia.

Table 15 – Scoring grouped changes in the VI-SPDAT

Common assessment tool				
VI-SPDAT #1 scores	*VI-SPDAT #2 scores*	*Acuity*	*Triage category*	*Recommended level/type of support*
8+	10+	High	Secure supportive housing	Assessment for secure supportive housing
4–7	5–9	Medium	Rapid re-housing	Assessment for rapid re-housing (private rental brokerage-type assistance, for example)
0–3	0–4	Low	Light touch support	No intensive supports to be provided to access or maintain housing

Source: Adelaide Zero Project VI-SPDAT version 1&2; OrgCode and Community Solutions.

The number of responses collected in each year across the 2010–2020 period has varied (Table 16). As expected, in line with the collaborative efforts undertaken by agencies across Australia in 2014, there was a dramatic increase in the number of responses recorded which was sustained over 2015 and 2016. The increase in 2017 represents data collection from Sydney and Victoria being added to the Advance to Zero database, as evidenced in the table below.

Table 16 – Registry Week collections by year of collection (total responses)

Year	Number
2010	812
2011	417
2012	752
2013	412
2014	1,806
2015	1,517
2016	1,809
2017	3,163
2018	3,540
2019	3,111
2020	3,614

Source: Advance to Zero Data 2010–2020.

In terms of geographic distribution, one-third or 7,334 responses were collected from agencies operating in Queensland; one-third or 7,476 responses collected in Victoria, 2,624 or 12.2% of responses were collected in Western Australia, and 2,348 or 10.9% in New South Wales. Fewer responses were collected from South Australia and Tasmania and there were no collections in the Northern Territory and the ACT (Table 13). Appendices 1 to 6 present Tables showing the number of responses in each State by the type of collection, by year.

Data collected via the VI-SPDAT during Registry Weeks have represented a catalyst for increased collaborations between agencies, ongoing identification and registration of rough sleepers, and numerous ongoing campaigns which seek to reduce and end rough sleeping, in Australia. Registry Weeks have been the organising backbone of multiple campaigns seeking to end rough sleeping both internationally and in Australia, to date, Registry Weeks in Australia have occurred in 6 states from 2010–2020 and have largely been undertaken in inner-city locations in Brisbane, Sydney, Perth, Hobart, Adelaide and Melbourne.

Registry Week gave rise to understanding the names, vulnerabilities, inflows and demographics of people sleeping rough in the community (Community Solutions, 2021). This methodology came to be based on the premise that, understanding the vulnerabilities of a community of people would give the ability to tailor supports to their needs, and work on addressing causational factors of homelessness from multiple systemic angles. Achieved through collective impact and continuous improvement projects, this work moved homelessness agencies towards the ultimate goal of making sure that homelessness was rare, brief, and non-recurring when it did occur within a community (Community Solutions, 2021).

In 2014, a coalition of 34 government and nongovernment agencies aimed to apply a Housing First approach to house 500 of the most vulnerable individuals and families in Brisbane over a 3-year period (Micah Projects, n.d.). The campaign began with a community-wide registry, where local agencies and volunteers utilised the VI-SPDAT to survey 2,694 families, young people, and adults in the Brisbane Local Government Area who were homeless or vulnerably housed (Micah Projects, n.d.). The campaign exceeded its goal by housing 580 individuals and family households, resulting in a 24% reduction in family homelessness and 32% reduction in rough sleeping among those on the register.

In early 2017, of those 406 households that had moved into permanent housing at least 3 months prior to follow-up, the majority of tenancies had been sustained (88%). The VI-SPDAT assisted organisations to identify that, for some (16%) no post-housing support was required, almost half (43%) required short-term support from SHS, and 29% required long-term support. This led to the 50 Lives 50 Homes campaign in late-2015 in Perth (Wood et al., 2017; Vallesi et al., 2018; Vallesi et al., 2020) which supported 427 individuals during the five years it ran.

The Australian Alliance to End Homelessness (AAEH) is leading a national campaign of communities working to end homelessness with an initial goal to end rough sleeping in Australia. The AAEH has trained communities in use of the VI-SPDAT to assess vulnerable rough sleepers and measure outcomes and progress (Reynolds et al., 2013). Micah Projects in Brisbane, a member of the AAEH, is the administering body for the VI and VI-SPDAT collections and it is these collections that form the basis for the present report – the Advance to Zero data. Not all collections of data using the VI-SPDAT may have been entered into the central Advance to Zero database. Additional data has independently been collected from Sydney and Victoria and added to the Advance to Zero data.

Between 2010-2020, there were 20,953 responses collected across six states in Australia by multiple agencies administering the VI, SPDAT and VI-SPDAT to individuals and families sleeping rough and staying in temporary accommodation. In the following pages we present an overview of the locations of the VI, SPDAT and VI-SPDAT (hereafter called VI-SPDAT) data collected by agencies during Registry Weeks and as part of ongoing service delivery, between 2010 and 2021. Data is available for WA, QLD, NSW, VIC, SA, and TAS, and not for other states and territories in Australia.

5.2.1 Queensland

The first Registry Week collection in Australia was held in Brisbane in 2010. Across 2010, there were 316 interviews collected in 2010, using the VI. As with most Australian Registry Week collections, the vast majority of interviews were collected in the inner Brisbane City area. However, there were also smaller collections in Chermside in northern Brisbane and also in Townsville. Smaller collections were undertaken between 2011 and 2013.

A second major Registry Week collection was held in Queensland during 2014 using the VI-SPDAT, resulting in a sharp increase in the number of surveys conducted (1,490). This is not surprising given the concerted effort by agencies to 'register' homeless and vulnerable individuals in Brisbane for the 500 Lives 500 Homes campaign. The last largest collection period was during the COVID response in Brisbane in 2020, when services completed VI-SPDATs with participants entering the emergency housing response program as part of the Department of Housing's response to the pandemic.

Survey collections since 2015 have increased from 594 interviews in 2015 to 1,310 interviews in 2020 (see Appendix 1, Table 47).

5.2.2 Western Australia

In Western Australia (WA), Registry Week collections began in 2012 (190 interviews, using the VI) and were conducted again in the period 2014 to 2020, using the VI-SPDAT. The 50 Lives 50 Homes program ran from late 2015 to late 2020; resulting in a sharp increase of interviews conducted during 2014 (n=150), 2015 (n=171) and 2016 (n=686). The program was a catalyst for the ongoing use of the VI-SPDAT as part of ongoing service delivery, resulting in high numbers of interviews being collected on an ongoing basis in 2017 by multiple organisations in Perth and Fremantle.

Data collection broadened around 2017, with some agencies surveying people experiencing all types of homelessness at intake and/or during service provision and moving away from a reliance on Registry Week data. In addition, from 2020 onwards, regional data were collected in Bunbury, Geraldton, Mandurah, and Rockingham, with Version 3 of the VI-SPDAT being used from early 2021 (see Appendix 2, Table 48).

5.2.3 New South Wales

In New South Wales (NSW), registry Week collections began in 2010 with 331 interviews conducted, the vast majority being in the inner-city areas of Sydney. Data from NSW collections are available for all years, with limited data for 2017. The vast majority of collections in NSW have been conducted in inner city Sydney but other collections have been undertaken in the Penrith Nepean region in 2012, 2014, and 2016 (See Appendix 3, Table 49). Other NSW collections have been conducted in Bondi and Lake Macquarie.

New South Wales launched its By-Name List in October 2019 and has since collected data for over 1,000 people. Whilst the majority of records are from the Sydney, South Eastern Sydney, and Northern Sydney District, By-Name List records are being entered all over the state: from the Mid North Coast, Northern NSW to Illawarra Shoalhaven and Southern NSW and Murrumbidgee, Far West, and Western NSW. Data has recently been collected during connections weeks in Sydney (2019) and Byron Bay (2020), and de-identified data provided to the national database and to international partners.

5.2.4 Victoria

Registry Week was first held in 2010 in Inner Melbourne involving 165 interviews, using the VI. Collections have continued across the 2010–2020 period with a large increase in the number of interviews collected in 2017 (1947 interviews) and 2018 (2,033 interviews; see Appendix 6, Table 52). To date, most responses making up the youth component of the Advance to Zero data were collected in Victoria. Since 2017, VI-SPDAT has been collected via the Entry Points and Assertive Outreach teams in the inner City. Interviews have been concentrated in two areas namely the Melbourne City SA3 area covering the City itself, Southbank, South Melbourne, Carlton, North Melbourne, Kensington, St Kilda, Fitzroy, East Melbourne, Collingwood and Richmond as well as the Port Phillip SA3 region covering St Kilda.

5.2.5 Tasmania

In Tasmania (TAS), there have been a total of 386 interviews conducted over the period 2011 to 2017, using the VI (see Appendix 5, Table 51). Despite remaining fairly stable until 2015, the number of surveys conducted in Tasmania has decreased substantially since 2016. No data is available from 2018 onwards. As in other states, the focus of the Tasmanian collections is on the inner Hobart area with smaller collections in North West and North East Hobart.

5.2.6 South Australia

In South Australia (SA), there have been a total of 1,280 interviews conducted over the period 2017 to 2020 (see Appendix 4, Table 50). Interviews have been conducted for people rough sleeping in the Adelaide Central Business District (CBD). In both 2017 and 2018 Connections Week (Registry Week) was undertaken. During Connections Week, groups of client-facing staff and volunteers canvassed the Adelaide CBD and implemented the VI-SPDAT with rough sleepers. The first Connections Week in May 2017 established the first register for rough sleepers, and the 2018 Connections Week was undertaken as an opportunity to test the validity of the live registry. In December 2019, Adelaide became the first community outside North America to achieve a quality data By-Name List (Community Solutions, 2020).

5.3 Linked administrative data collections

Robust data collection and evaluation is critical in the health, justice, and community sectors to inform the prioritisation and funding of services, identify gaps, and assess what is or isn't working to improve outcomes. Homelessness is often 'invisible' and is not routinely or adequately identified in national or state health, justice, and community data systems (Metraux & Tseng, 2017). Nationally and internationally, there is increasing emphasis on the need for more evidence-based and integrated healthcare for people who are homeless (Bax & Middleton, 2019), with calls for measurable outcomes to be collected (Metraux & Tseng, 2017) including cost effectiveness (Parsell et al., 2017).

Concordance studies between self-report surveys and administrative data for people experiencing homelessness have mixed results, with some showing high rates of agreeance (Hwang et al., 2016, Lemieux et al., 2017), moderate rates of agreeance (Metraux et al., 2014) and some showing very low rates of agreeance (Edwards et al., 2020). While there are no studies specifically measuring the concordance of the VI-SPDAT and administrative health and justice records, one study in the US has measured the sensitivity and specificity of these measures (King, 2018). This PhD thesis found overall that the VI-SPDAT was not entirely reliable or valid, questions on medical history and utilisation of services generally showed high specificity (the people who said no in the survey and were not diagnosed/utilise services) but very low sensitivity (the people who answered yes in the survey and did have a diagnosis/utilise services)(King, 2018). Preliminary analysis of VI-SPDAT data in Perth is showing the opposite, with high sensitivity and low specificity in relation to health utilisation and moderate concordance observed between the measures (Vallesi, unpublished).

While the VI-SPDAT was indeed created to assist with decision making around service access and housing rather than for research and evaluation purposes. In lieu of access to robust administrate sources, the VI-SPDAT provides rich information about a large cohort of people experiencing homelessness. It is particularly useful in the sense that it is standardised collection tool used both across Australia and internationally.

Administrative records can help to identify the health and justice outcomes, and service usage more accurately of people experiencing homelessness (Metraux et al., 2014). Connecting the VI-SPDAT and By-Name List data to program data and/or to administrative records would enable a richer picture of the impacts of homelessness, pathways into housing, and the impacts on housing on other health and justice outcomes to be captured. However, it should be noted that administrative records can be timely and costly to obtain access to, and certain measures would need to be undertaken to ensure confidentiality is kept.

An example of an evaluation program that accessed health and police administrative data sets in the 50 Lives 50 Homes evaluation can be seen in Box 1.

Box 1 – The 50 Lives 50 Homes administrative data linkage

The 50 Lives 50 Homes program is a collective impact Housing First program, that ran in Perth from late 2015 to late 2020. The program involved collaboration from over 30 agencies across the homelessness, health and community sectors. The key aim of 50 Lives 50 Homes was enabling rapid access to housing and providing wrap-around support without pre-condition.

A team from the Centre for Social Impact, The University of Western Australia was approached to undertake an evaluation of Perth's first Housing First project. As part of the evaluation, it was important to measure the overall impact that housing had on other sectors such as the health system and justice system in order to measure the cost benefit of delivering such a service.

All participants in the 50 Lives 50 Homes program were linked to administrative hospital records from the Department of Health, and WA Police administrative records. This linkage process made it possible to measure hospital use pre and post housing (emergency department presentations, inpatient admissions, and ambulance arrivals) and contacts with the police pre and post housing (offending and victimisation records). Changes in types of presentations (e.g., for mental health and injuries) and offending (survival crimes and property damage) were also measured to determine behaviour changes once housed.

Individuals who were housed for at least one year had a reduction of approximately $10,000 in health service use and approximately $1,500 in police contacts (Vallesi et al., 2020).

Adelaide Zero Project.

Photography: David Pearson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TEAM 13
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6 A DEMOGRAPHIC PROFILE OF RESPONDENTS

Between 2010–2020, there were 21,541 responses from 20,953 respondents (some respondents were interviewed more than once) collected across five states in Australia by multiple agencies administering the VI, SPDAT and the VI-SPDAT to people sleeping rough and staying in temporary accommodation. This chapter provides a demographic profile of those respondents. Data is available for Western Australia (WA), Queensland (QLD), New South Wales (NSW), Victoria (VIC), and South Australia (SA).

6.1 Identity

The Advance to Zero database includes four questions on the identity of respondents (based on different versions of the VI-SPDAT). Not all questions were asked in all surveys (see Appendix 7, Table 53) and there were some variations in wording. These questions were:

- ***Gender:*** "What is your gender". Options provided were: Male, Female, Transgender, Intersex or X, Declined to state.
- ***Sexual identity:*** "Do you identify as". Options provided were: Straight, Queer, Lesbian or Gay, I don't know / questioning, Bisexual, Other, Declined to state.
- ***Cultural identity:*** "Do you identify as (mark all that apply)". Options provided were: Australian, European, Aboriginal, Middle Eastern, Torres Strait Islander, American, South Sea Islander, South East Asian, Pacific Islander, South American, New Zealander, African, British, Maori, Scottish, Irish, Other (specify), Declined to state.
- ***Citizenship and residency status:*** "What is your citizenship or residency status". Options provided were: Australian Citizen, Australian Permanent Resident, Visitor Visa ,Working and Skilled Visa, Studying and Training Visa, Family and Spousal Visa, Refugee and Humanitarian Visa, Bridging Visa, New Zealand citizen, Other (specify), Declined to state.

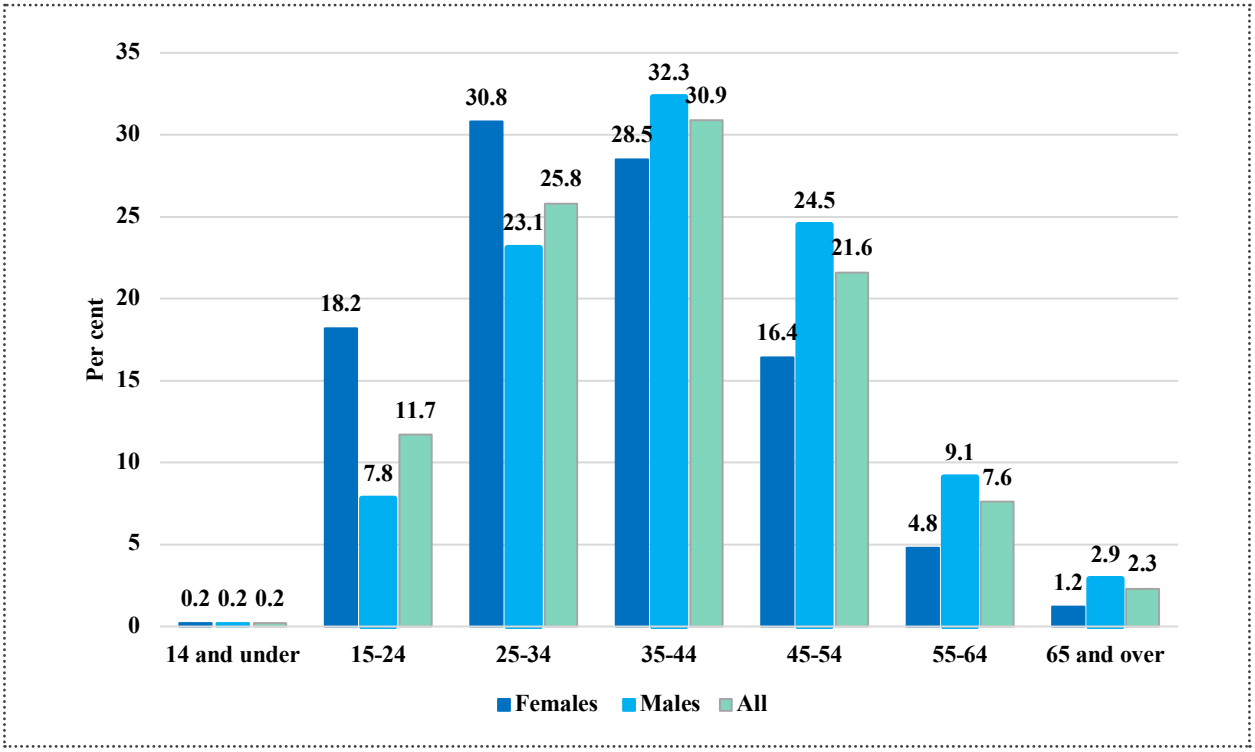
In the Family, Individual and Youth VI-SPDAT v3, these questions were:

- ***Gender:*** "Your Gender is best described as". Options provided were: Female, Male, Sistergirl, Brotherboy, Transgender, Gender diverse, Non-binary, Questioning/Unsure, Prefer not to say, Prefer to self-describe (specify), Declined. Additionally: "Intersex Variation" was included. Options provided were: Yes, No, Unsure, Prefer not to say, Declined to state.
- ***Sexual identity:*** "Your sexual identity is best described as". Options provided were: Asexual, Bisexual, Gay, Heterosexual, Lesbian, Pansexual, Queer, Questioning/Unsure, Prefer to self-describe (specify), Prefer not to say, Declined to state.
- ***Cultural identity:*** "What is your ancestry/ethnic cultural background (mark all that apply)". Options provided were: Australian, Indigenous Australian, English, Irish, Scottish, Italian, German, Chinese, Greek, Vietnamese, Hmong, Kurdish, Maori, Lebanese, Other (specify), Declined to state.
- ***Citizenship and residency status:*** "What is your citizenship or residency status". Options provided were: Australian Citizen, Australian Permanent Resident, Visitor Visa, Working and Skilled Visa, Studying and Training Visa, Family and Spousal Visa, Refugee and Humanitarian Visa, Bridging Visa, New Zealand citizen, Other (specify), Declined to state.

Of the total unique respondents (n=20,953) identified in the National Advance to Zero sample, there was valid information on 19,600 respondents with two-thirds identifying as male (63.1%), with females representing one third (35.0%), and transgender and other gender representing 1.0% of all respondents (Table 17). Men represent a higher proportion of the National Advance to Zero collection than the Census 2016 homeless population (58%; ABS, 2018b) and the Specialist Homelessness Services Collection (SHSC) count of clients (40%; AIHW, 2020a). The much higher representation of males in the National Advance to Zero collections relative to the SHSC reflects primarily a focus on adult rough sleepers in the National Advance to Zero collections (more likely to be male) and the fact that National Advance to Zero collections have been predominately administered by inner city agencies where the representation of women's refuges is relatively low. The vast majority of both male and female respondents are Australian citizens or permanent residents.

There is significant variation in age distributions by gender apparent in the data (Figure 15). There was a larger proportion of female respondents in the 15–24 (18.2%) and 25–34 (30.8%) year age brackets compared to males (7.8%) and (23.1%), respectively. Males were more likely to be represented in all remaining age brackets compared to females.

Figure 15 – Age distribution by gender



Source: National Advance to Zero 2010–2020.

Notes: Estimates based on unique respondents (excluding missing values). All includes 'Other gender' (includes Intersex or X, Other gender identity, unknown, declined to state).

With the exception of the VI and the Youth VI-SPDAT v2, respondents completing all other versions of the VI-SPDAT were asked a question on their sexual identity. The majority of those respondents identified as Straight (78.7%) with 2.2% identifying as Lesbian/Gay, and 0.7% as Bisexual (Table 17). These proportions are in line with those from other data collections. For example, in 2020, the General Social Survey of the ABS found that 4.0% of the Australian adult population identified as gay, lesbian, or a sexual identity other than heterosexual (ABS, 2020a).

Table 17 – Gender and sexual identity of respondents

	Number	Per cent
Gender		
Males	12,369	63.1
Females	6,865	35.0
Other gender identity	190	1.0
Missing	176	0.9
Total	19,600	100.0
Identity[3]		
Straight	7,876	78.7
Lesbian/Gay	216	2.2
Bisexual	72	0.7
Other gender identity	65	0.6
Missing	1,777	17.8
Total	10,006	100.0

Source: National Advance to Zero 2014–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

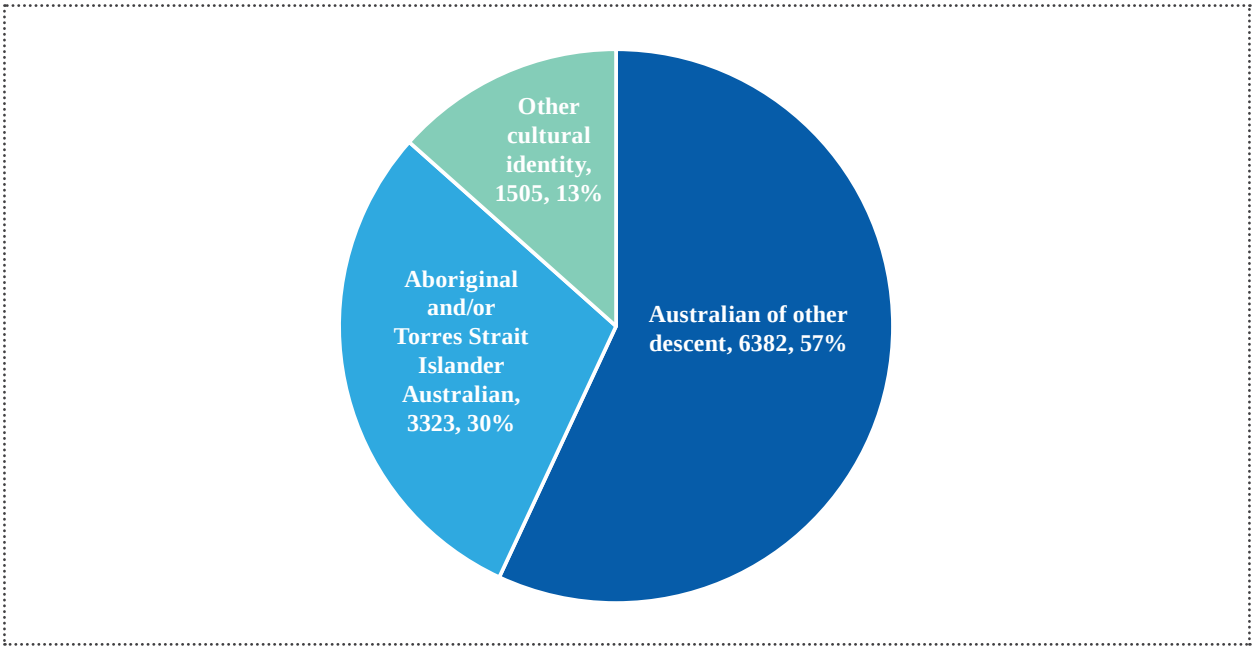
[2] 'Other gender' includes Intersex or X, Non-binary, Transgender, Other gender identity, unknown, declined to state.

[3] A question on sexual identity was not included in the Australia VI and Youth VI-SPDAT V2 surveys.

A question on cultural identity was included in all versions of the VI, SPDAT and VI-SPDAT. Respondents could list more than one cultural identity and also could self-report their own cultural identity. Where more than one identity was listed, we used the following priority rules. If at any stage Aboriginal, Torres Strait Islander was ticked or if the respondent included these two phrases or 'Indigenous' in the other category the respondent was classified as an Aboriginal and/or Torres Strait Islander Australian. If the respondent at any stage listed Australian identity (but had not already been classified as Aboriginal and Torres Strait Islander Australians) then the respondent was classified as an Australian of other descent. All other respondents who ticked or listed another identity were then classified as Other cultural identity.

There is a significant overrepresentation of Aboriginal and Torres Strait Islander people in the National Advance to Zero collections compared with the representation in the Australian population more generally (3.1%). Among valid responses, 30% of respondents identified as Aboriginal and Torres Strait Islander peoples, 57% as Australians of other descent, and 13% as another cultural identity (Figure 16). The proportion of respondents identifying as Aboriginal and Torres Strait Islander is roughly in line with the SHSC count of Aboriginal and Torres Strait Islander clients (AIHW, 2020a) and slightly greater than the 2016 Census results (ABS, 2018b). The representation of Aboriginal and Torres Strait Islander people in the National Advance to Zero collections will be affected by the fact that the National Advance to Zero collection has been in capital cities in the main and largely in inner city areas with a focus on rough sleepers.

Figure 16 – Cultural identity of respondents, number, per cent



Notes: National Advance to Zero 2010–2020.

A question on citizenship and residency status was included in Family versions 1 and 3, all versions of the VI-SPDAT, VI, Youth Version 3 and SPDAT. Among valid responses, 90% of respondents identified as Australian citizens while 7% identified as permanent residents (Table 18). Thirty-three respondents had a bridging visa, and six had a refugee or humanitarian visa. When exploring the 'other' category, one respondent was an asylum seeker, and four respondents had protection visas. The proportion of respondents identifying as refugees, asylum seekers or on humanitarian or protection visas was low and in line with earlier reports on refugees and housing which found little to no primary homelessness reported within this group. Flatau et al. (2014) and Flatau, Smith et al. (2015) found that refugees within their study had initially experienced secondary homelessness through couch surfing, had successfully moved into stable permanent accommodation.

Table 18 – Citizenship and residency status of respondents

	Number	*Per cent*
Australian Citizen	10,823	90.1
Australian Permanent resident	858	7.1
Bridging Visa	33	0.3
No answer/refused/declined to state	76	0.6
Don't know	5	0.0
Family and spousal visa	1	0.0
New Zealand Citizen	15	0.1
Other	194	1.6
Refugee and Humanitarian Visa	6	0.0
Total	12,011	100.0

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

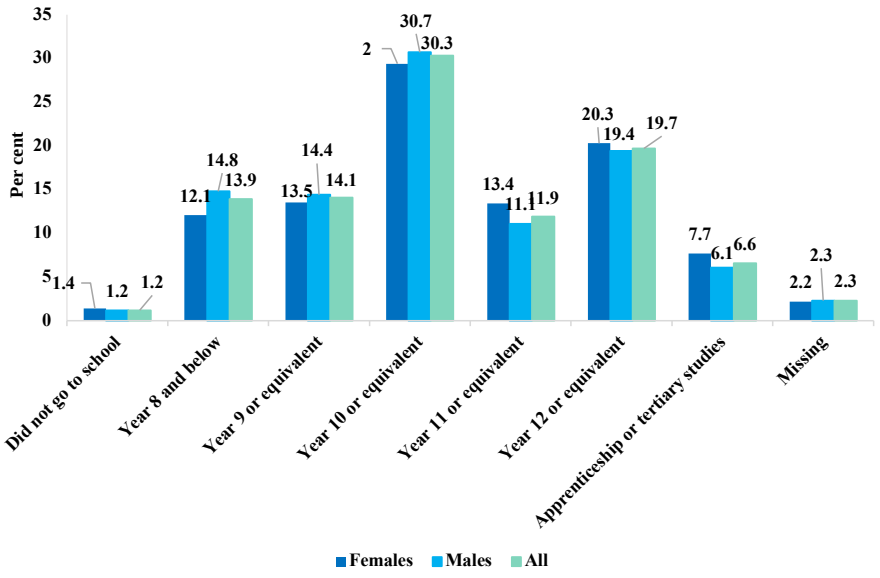
6.2 *Education, partnering and living arrangements*

A key determinant of labour market and income outcomes is educational attainment. The question included in National Advance to Zero collections relevant to educational attainment is "What is the highest year of school you completed?". This question was only included in the VI and the Family and Individual VI-SPDAT v1 (see Appendix 7, Table 53). The VI, Family and Individual VI-SPDAT v1 were collected in Queensland, Western Australia, New South Wales, and Victoria, with the VI also collected in Tasmania. While the Individual and Family VI-SPDAT v1 was still being collected, albeit less than v2 and v3, as recently as 2020, the VI had not been collected in any State since 2018 (see Appendices 1 to 6). While the question included may be interpreted as referring only to schooling, the options presented include 'Apprenticeship or tertiary studies' indicating that the intention is to include all educational attainment possibilities.

Among people aged 20 and over in Australia who stated an educational attainment outcome, 35% held a degree or higher and 32% held an Advanced Diploma and Diploma, Certificate level IV or Certificate level III (ABS, 2020b). In contrast, among National Advance to Zero respondents, only 6.6% responded that their highest level of schooling was an Apprenticeship or tertiary studies (Figure 17). A similar proportion of National Advance to Zero respondents, as in the Australian adult population, indicated that they had completed Year 12. However, a greater proportion reported that their highest level of schooling was Year 11 or below (ABS, 2020b). As evident in Figure 17, there was no significant difference between women and men in the National Advance to Zero collections in terms of educational attainment.

A question on whether the respondent was with others ("Are you with others?") was only included in the Australia VI and Individual VI-SPDAT v1 (Appendix 7, Table 53). Both the VI and Individual VI-SPDAT v1 were collected in Queensland, Western Australia, New South Wales, and Victoria, with the VI also collected in Tasmania. While the VI-SPDAT v1 was still being collected, albeit less than v2 and v3, as recently as 2020, the VI has not been collected in any State since 2018 (see Appendices 1 to 6). The listed responses were partner, children/dependents, friend, parents, I am not with others. As outlined in Table 19 (Figure 18), most respondents who provided a response to the relevant question indicated that they were alone – i.e., not with others (61.4%). Around two in five respondents indicated that they were with a partner, friend, or parents. A greater proportion of homeless men indicated that they were alone compared to homeless women, and a lower proportion of Aboriginal and Torres Strait Islander respondents presented alone than other respondents. Females were also more likely to have children/dependents with them than males.

Figure 17 – Education attainment by gender, per cent



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] All includes 'Other gender' (includes Intersex or X, Other gender identity, unknown, declined to state).

[3] A question on education was only included in the Australia VI, Family and Individual VI-SPDAT v1 surveys.

Table 19 – Living arrangements by gender of respondents

	Number	Per cent
Alone		
Males	2,312	73.9
Females	768	24.6
Other gender identity	47	1.5
Missing	1	0.0
Total	3,128	100.0
With friends		
Males	613	73.5
Females	206	24.7
Other gender identity	9	1.1
Missing	6	0.7
Total	834	100.0
With partner		
Males	405	49.8
Females	401	49.4
Other gender identity	3	0.4
Missing	3	0.4
Total	812	100.0
With parents		
Males	39	55.7
Females	30	42.9
Other gender identity	1	1.4
Missing	0	0.0
Total	70	100.0
Children/dependents		
Males	103	41.9
Females	140	56.9
Missing	2	0.8
Other gender identity	1	0.4
Total	246	100.0
Total	5,090	

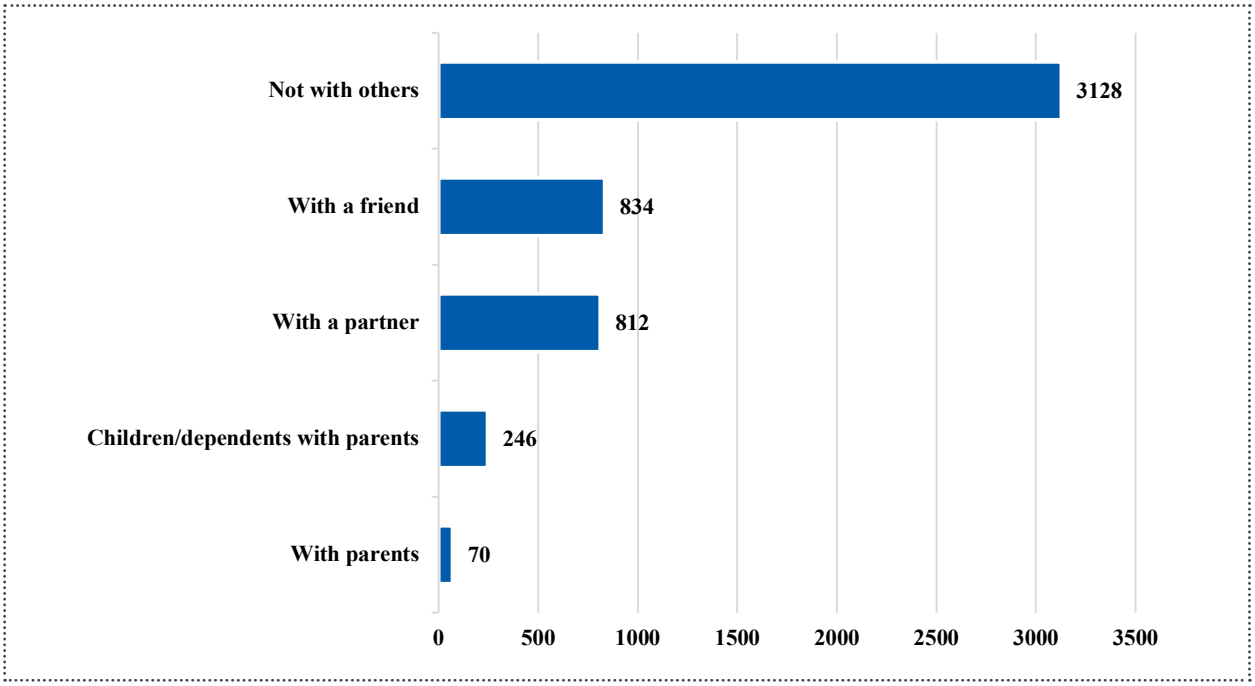
Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] 'Other gender' includes Intersex or X, Non-binary, Transgender, Other gender identity, unknown, declined to state.

[3] A question on presenting with others was only included in the Australia VI and Individual VI-SPDAT v1 surveys.

Figure 18 – Partnering and living arrangements, number



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] A question on presenting with others was only included in the Australia VI and Individual VI-SPDAT v1 surveys.

6.3 Veterans

Information on the prevalence of homelessness among veterans in Australia is improving. Veterans' status will be included in the 2021 Census, and from July 2021 it has also been included in the SHSC. However, it is still difficult to obtain estimates of the number of people who are Australian veterans living in Australia at any given time. In the US, there is considerable evidence that veterans, especially male veterans, are overrepresented in the homeless population, citing post-traumatic stress disorder, substance abuse and active duty service as some of the risk-factors leading to veteran homelessness (Perl, 2015). Wood, Flatau et al. (2021) provided a detailed examination of homelessness among veterans using data from the VI and VI-SPDAT surveys over the period 2010–2017. Veterans reported spending an average of 6.3 years on the street or in emergency accommodation (compared with an average of five years for their non-veteran counterparts) and reported higher prevalence physical health, mental health and social issues compared with non-veteran rough sleepers.

The VI and VI-SPDAT surveys contain the question "Have you ever served in the Australian Defence Force?" or "Are you a current or previously serving member of the Australian Defence Force?". There are no questions included in the VI and VI-SPDAT on whether the respondent served in an area of operation. As such, we cannot operationalise a definition of a veteran that requires serving in an area of operation. Nevertheless, not all definitions of a veteran have relied on this requirement (e.g., the Foreign Affairs, Defence and Trade Committee's (2016) report Mental Health of Australian Defence Force Members and Veterans). In this study, we define a veteran as an individual who has identified as a current or former member of the Australian Defence Force, regardless of whether they were involved in active service or not. As family members are also entitled to receive support from Department of Veterans Affairs, it is currently being considered to expand the question to include 'are you the family member of anyone currently or previously serving'.

As indicated in Table 20, 540 people (5.3%) over the period 2010–2020 were veterans; the majority being males (82.8%). Women comprised 16.5% of the veterans' population. This is reflective of the make-up of the Australian Defence Force in which 19.2% of the permanent force consists of women and 80.8% consists of men (Australian Government, 2020). Similar to findings in the US, a greater proportion of veterans achieved

a higher level of education than non-veterans, with 78% of veterans having achieved an educational level equivalent to or above Year 10, compared to 68% of non-veterans. The higher educational attainment of veterans has been found as a significant distinguishing factor when comparing them to non-veterans (Tessler et al., 2002). However, it has been noted that their higher levels of education have not reduced their likelihood of becoming homeless (Rosenheck & Koegel, 1993).

A very high proportion of homeless veterans identified as Aboriginal and Torres Strait Islander (22.4%). This compares with Aboriginal and Torres Strait Islander Australians only representing 2.3% of the Australian Defence Force between 2019 and 2020 (Australian Government, 2020), suggesting that Aboriginal and Torres Strait Islander veterans may experience greater difficulties in returning to civilian life upon discharge compared to other veterans. The average age of homeless veterans is significantly higher than the average age of homeless non-veterans, with the veteran average almost 8 years higher than the non-veteran average.

Table 20 – Veterans by gender of respondents

	Number	*Per cent*
Veterans		
Males	447	82.8
Females	89	16.5
Other gender identity	2	0.4
Missing	2	0.4
Total	540	100.0
Non-veterans		
Males	6,339	62.5
Females	3,661	36.1
Other gender identity	97	1.0
Missing	51	0.5
Total	10,148	100.0
Percentage veterans	5.3	
Veteran status (refused)	25	
Veteran status (unknown)	102	
Veteran status (missing)	786	
Veteran status (not applicable)	6	
All respondents	11,607	

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] 'Other gender' includes Intersex or X, Non-binary, Transgender, Other gender identity, unknown, declined to state.
[3] A question on Veteran status was not included in either version of the Youth VI-SPDAT.

7 THE EXPERIENCE OF HOMELESSNESS

This chapter examines the form of homelessness experienced by respondents to National Advance to Zero surveys together with estimates of the duration of homelessness experienced and time spent away from stable accommodation. How a profile of homelessness differs between those with different characteristics is also examined. Advance to Zero communities largely focus on individuals and families experiencing either, or a combination of chronic homelessness and rough sleeping.

7.1 Types of homelessness

As noted in Chapter 2, the question put to respondents about their current homelessness status is as follows: "I am going to read types of places people sleep. Please tell me which one you sleep at most often". Respondents chose the response that best reflected their circumstances or put forward their own response. The question does not allow for an assessment of point-in-time estimates of homelessness (as is done in the Census) but provides evidence on where respondents generally slept. All responses were coded to the following set of classifications:

Homeless

- Sleeping rough
- Other homeless
  - Crisis and emergency accommodation
  - Temporary accommodation (e.g., couch-surfing)
  - Short-term accommodation (e.g., boarding house, hostel, caravan)
  - Multiple other homeless states selectedl

Institutional accommodation (e.g., hospital, drug and alcohol facility, prison)

Permanently housed

Table 21 presents estimates of homelessness among National Advance to Zero respondents. A leading focus of agencies conducting National Advance to Zero collections has been on understanding the vulnerabilities and service needs of rough sleepers and of those utilising their accommodation services. Not surprisingly, the majority of respondents' responses fall into these two homeless categories. Just over a third of responses fall into the rough sleeping category (35.0%). A further 35.9% respondents generally sleep in temporary accommodation (largely couch-surfing arrangements), 6.0% respondents primarily sleep in crisis and emergency accommodation and 8.1% in short-term accommodation arrangements such as boarding houses, hostels, and caravans. Only a small proportion lie outside the homelessness categories including in sleeping in institutional (1.6%), hospitals, drugs and alcohol facilities, and prison, and in permanent housing (6.6%). Responses in the latter category all relate to open-ended category responses which can be difficult to classify.

Table 21 – Place slept most frequently (responses)

	Number	Per cent
Homeless	18,509	89.7
Sleeping rough	7,218	35.0
Other homeless	11,291	54.8
Crisis and emergency accommodation	1,229	6.0
Temporary accommodation (e.g., couch-surfing)	7,409	35.9
Short-term accommodation (e.g., boarding house, hostel, caravan)	1,666	8.1
Other homeless states selected	987	4.8
Institutional accommodation (e.g., hospital, drug and alcohol facility, prison)	321	1.6
Permanently housed	1,356	6.6
Missing	434	2.1
Total	20,620	100.0

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on all responses (excluding missing values).

Table 22 shows where those who nominated rough sleeping categories slept most often. Sleeping on the 'street' represents by far the most frequent response (57.1%) followed by the park (16.5%). The next most frequent response is sleeping mostly frequently in a car (12.5%). Those sleeping in a car may be in a somewhat different position to others in the rough sleeping group as they may have relatively more resources available to them than others in the rough sleeping group and somewhat greater stability in their lives.

Table 22 – Place slept most frequently among rough sleepers (responses)

	Number	Per cent
Streets	4,071	57.1
Park	1,175	16.5
Car	891	12.5
Squat/Cave	350	4.9
Train station/bus station	161	2.3
Bushland	152	2.1
Tent	147	2.1
Beach/riverbed	113	1.6
Carpark	52	0.7
Toilets	10	0.1
Construction site	5	0.1
Total Sleeping Rough	7,127	100.0

Source: National Advance to Zero 2010–2020.

The pattern of rough sleeping among women and men is quite different. While one-quarter of female responses in the National Advance to Zero collections were rough sleeping, two in five men were in the rough sleeping category (Table 23). The 2016 Census also showed higher rates of males sleeping rough (ABS, 2018b). This is consistent with the fact that women are more likely to access crisis and emergency accommodation than men, particularly women's refuges, consistent with high rates of domestic violence. Close to two-thirds of veterans are also rough sleepers (Table 24).

A greater proportion of people aged above 25 years were sleeping rough than younger age groups, with the highest proportion of people sleeping rough being evident in the 45–54 years old age bracket (42.0%) followed closely by those aged 35–44 (38.0%)(Figure 19). The proportion of those rough sleeping aged under 25 was 27.0% with 59.0% falling in the other homeless category. The largest group young people in the other homeless category fell in the temporary accommodation category (e.g., couch surfing). This profile is also consistent with the 2016 Census results (ABS, 2018b).

Table 23 – Place slept most frequently by gender (responses)

	Number	*Per cent*
Males		
Sleeping rough	5,376	42.0
Not sleeping rough	6,812	53.2
Inadequately described	624	4.9
Total	12,812	100.0
Missing	174	
Females		
Sleeping rough	1,704	24.0
Not sleeping rough	5,040	71.1
Inadequately described	347	4.9
Total	7,091	100.0
Missing	132	
Other gender identity		
Sleeping rough	53	41.1
Not sleeping rough	65	50.4
Inadequately described	11	8.5
Total	129	100.0
Missing	3	
Gender (missing)	279	
Total	20,620	

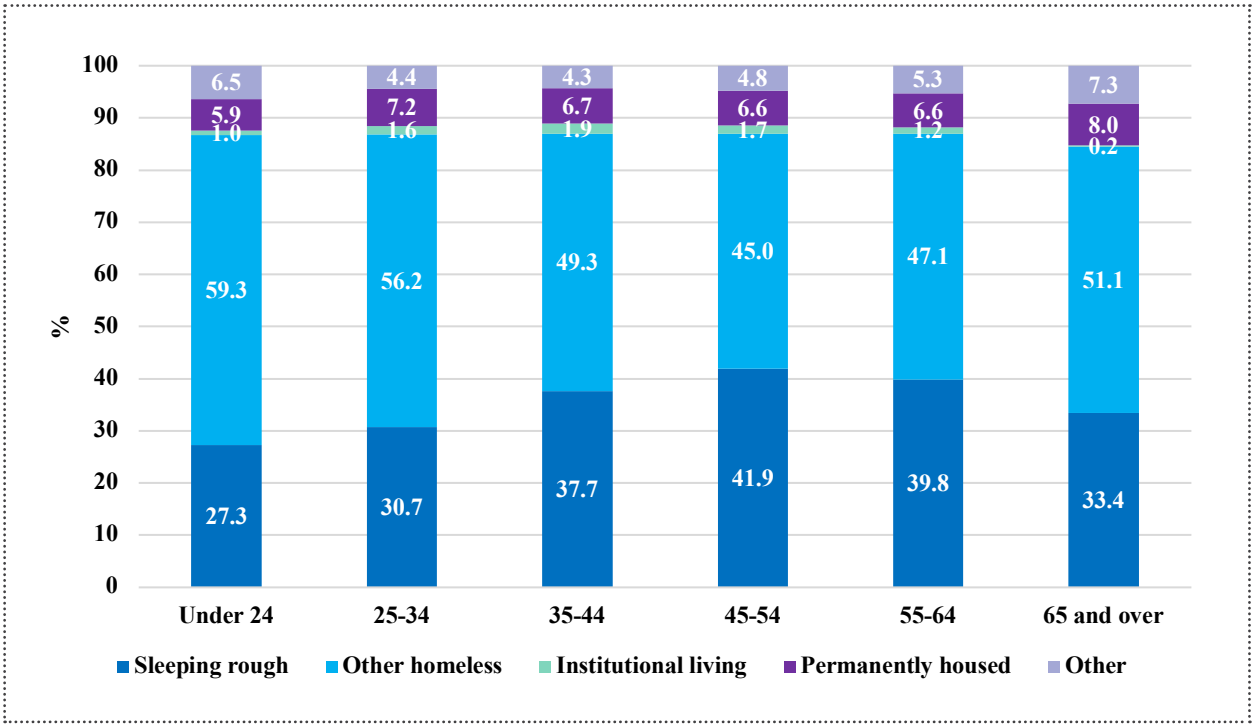
Source: National Advance to Zero 2010–2020.
Notes: [1] Other gender includes Intersex or X, Other gender identity, unknown, declined to state.

Table 24 – Place slept most frequently by veteran status (responses)

	Number	Per cent
Veterans		
Sleeping rough	315	59.2
Not sleeping rough	182	34.2
Inadequately described	35	6.6
Total	532	100.0
Missing	8	
Non-veterans		
Sleeping rough	5,014	50.0
Not sleeping rough	4,312	43.0
Inadequately described	704	7.0
Total	10,030	100.0
Missing	118	
Veteran status (refused)	25	
Veteran status (unknown)	102	
Veteran status (missing)	6,661	
Veteran status (not applicable)	6	
Total	17,482	

Source: National Advance to Zero 2010–2020
Notes: [1] Estimates based on all responses (excluding missing values).
[2] A question on Veteran status was not included in the Youth VI-SPDAT surveys.

Figure 19 – Place slept most frequently) by age (responses), per cent



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on all responses (excluding missing values).

[2] In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

Aboriginal and Torres Strait Islander Australians have a similar rate of rough sleeping than Australians of other descent (55.1% compared with 50.4%; Table 25). Those who identify in another cultural category other than Aboriginal and Torres Strait Islander Australian or Australians of other descent exhibit the lowest rough sleeping rate (46.8%). The 2016 Australian Census reported that approximately 3% of Australians identify as Aboriginal and/or Torres Strait Islander but make up a disproportionate 20% of people experiencing homelessness (ABS, 2018b). In the 2016 Census results, a greater proportion of Aboriginal and Torres Strait Islander Australians stayed in 'severely' overcrowded dwellings compared to other Australians (70% vs 42%; ABS 2018). Overcrowding limits a household's ability to access basic household amenities that are important in maintaining a healthy living environment – such as washing, laundry, hygienic storage and preparation of food, and safe household waste management (AIHW, 2011). As a result, Aboriginal and Torres Strait Islander Australians are more likely to experience poor health related to hygiene, diet, and substance misuse; factors that contribute to the gap in life expectancy between Aboriginal and Torres Strait Islander and other Australians.

Those who experienced out-of-home care (including residential care and foster care) as a child have a relatively high risk of experiencing homelessness both as a child and teenager and as an adult (Flatau et al., 2013; Flatau et al., 2015a,b). The National Advance to Zero collections reveal a very high proportion of respondents with a history of out-of-home placement and contact. As evident in Table 26, almost two-thirds of respondents in the National Advance to Zero collections have a history of out-of-home care. Those with a history of out-of-home care also have a higher representation in the rough sleeping category than the non-rough-sleeping category. Individuals experiencing homelessness with a history of out-of-home care are experiencing significant barriers to exiting homelessness, a lack of social resources and development of independent living skills, combined with a lack of trust in services and workers among other present vulnerabilities, especially when a young person is sleeping rough.

Table 25 – Place slept most frequently by cultural identity (responses)

	Number	Per cent
Aboriginal and/or Torres Strait Islander Australian		
Sleeping rough	1,955	55.1
Not sleeping rough	1,385	39.0
Inadequately described	211	5.9
Total	3,551	100.0
Missing	76	
Australian of other descent		
Sleeping rough	2,663	50.4
Not sleeping rough	2,246	42.5
Inadequately described	372	7.0
Total	5,281	100.0
Missing	112	
Other cultural identity		
Sleeping rough	44	46.8
Not sleeping rough	46	48.9
Inadequately described	4	4.3
Total	94	100.0
Missing	1	
Aboriginal and/or Torres Strait Islander Identity not indicated (missing)	11,505	
Total	20,620	

Source: National Advance to Zero 2010–2020
Notes: [1] Estimates based on all responses (excluding missing values).

Table 26 – Type of homelessness by an experience of foster care or institutional care as a child (responses)

	Number	Per cent
Sleeping rough		
Yes	4,516	70.2
No	1,801	28.0
Unknown	80	1.2
Refused	37	0.6
Not applicable	1	0.0
Total	6,435	100.0
Missing	783	
Other homeless (includes crisis and emergency accommodation, temporary accommodation, short-term accommodation)		
Yes	1,083	21.1
No	3,993	78.0
Unknown	22	0.4
Refused	21	0.4
Not applicable	2	0.0
Total	5,121	100.0
Missing	5,183	
Institutional accommodation		
Yes	60	26.7
No	164	72.9
Unknown	1	0.4
Refused	0	0.0
Not applicable	0	0.0
Total	225	100.0
Missing	96	
Permanently housed		
Yes	32	16.9
No	151	79.9
Unknown	1	0.5
Refused	1	0.5
Not applicable	4	2.1
Total	189	100.0
Missing	1,167	

Continued on page 83.

	Number	Per cent
Other		
Yes	205	24.5
No	623	74.3
Unknown	8	1.0
Refused	2	0.2
Not applicable	0	0.0
Total	838	100.0
Missing	149	
Missing	434	
Total	20,620	

Source: National Advance to Zero 2010–2020
Notes: [1] Estimates based on all responses (excluding missing values).

7.2 Duration of homelessness

The length of time people experience homelessness has been associated with poor health outcomes resulting in higher healthcare system use and associated costs (Zaretzky et al., 2017). Accordingly, duration of homelessness is an important indicator for identifying and prioritising at risk people into homelessness services.

Cumulative duration of homelessness is covered in the Australia VI and Australia VI-SPDAT surveys. In the Australia VI survey the question was worded as "What is the total length of time you have lived on the streets or shelters?" In the VI-SPDAT by the question: "What is the total length of time you have lived on the streets or in emergency accommodation?" Note that the question does not ask for the total length of time spent homeless using either the Australian cultural definition on of homelessness or the ABS definition of homelessness.

In addition to the question on the cumulative duration of homelessness, the National Advance to Zero collection asks a number of other relevant questions relating time spent homeless. These questions are:

- How long has it been since you lived in permanent stable housing?
- What is the total length of time you and your family have not had your own tenancy? (Australia F-SPDAT).
- How long has it been since you and your family lived in permanent stable housing? (Families VI-SPDAT).

In relation to the issue of the cumulative time spent homeless (rough sleeping and emergency and crisis accommodation), the mean duration of homelessness is 46.0 months (or 3.8 years; Table 27). There is high degree of variation in the cumulative time spent homeless as evident in the standard deviation (72.3 months) and the difference between the quintiles of cumulative time spent homeless. Quintiles divide the ranked distribution of the values of the cumulative time spent homeless into five equal groups. The bottom quintile (or bottom 20%) has a quintile value of three months. This is the only group with a value below a year. The second 20% has a value equal to a year (12 months). The median duration of homelessness (the 50th percentile value) is 18 months (or 1.5 years). The third quintile value is 24 months (or 2 years. At the fourth quintile point the value is 72 months or 6 years with the fifth quintile (maximum value) is 63 years.

When respondents are segmented into place slept most frequently, people sleeping rough show a higher mean cumulative time spent homeless (74.6 months) as well as median cumulative time spent homeless of 36 months (or 3 years) than for all National Advance to Zero respondents. Correspondingly, those who stated that they slept most frequently in other homeless states (such as in emergency and crisis accommodation) have much lower mean cumulative time spent homeless (39.4 months) as well as median cumulative time spent homeless (12 months or 1 year).

In terms of time since last had stable accommodation, the mean length of time spent without stable accommodation is 30.6 months while the median length of time is 6 months. The results are less than the cumulative time spent rough sleeping and in emergency and crisis accommodation with similar differences in duration outcomes between rough sleepers and other people experiencing homelessness.

Among families interviewed in National Advance to Zero collections, the total length of time since the family had had a tenancy (on the basis of the Australia F-SPDAT results) the mean cumulative length of time is 15.4 months while the median or 50th percentile length of time since the family had a tenancy was 4 months.

Table 27 – Time spent homeless (months; respondents)

	Individuals		*Families*	
	What is the total length of time you have lived on the streets or emergency accommodation?[3]	*How long has it been since you lived in permanent stable housing?*[4]	*What is the total length of time you and your family have not had your own tenancy?* *(Australia F-SPDAT)*	*How long has it been since you and your family lived in permanent stable housing?* *(Australia VI-SPDAT)*
N	8,380	7,885	1,408	1,042
Mean (Months)	46.0	30.6	23.1	15.4
SD	72.3	79.0	42.8	34.2
Median	18.0	6.0	8.0	4.0
Quintiles				
Q0	0	0	0	0
Q1	3.0	1.2	1.0	1.0
Q2	12.0	4.0	5.0	2.0
Q3	24.0	11.0	12.0	60
Q4	72.0	36.0	36.0	21.0
Q5	756.0	2,015.0	456.0	456.0

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Responses that exceeded the respondents' age were removed from analysis.

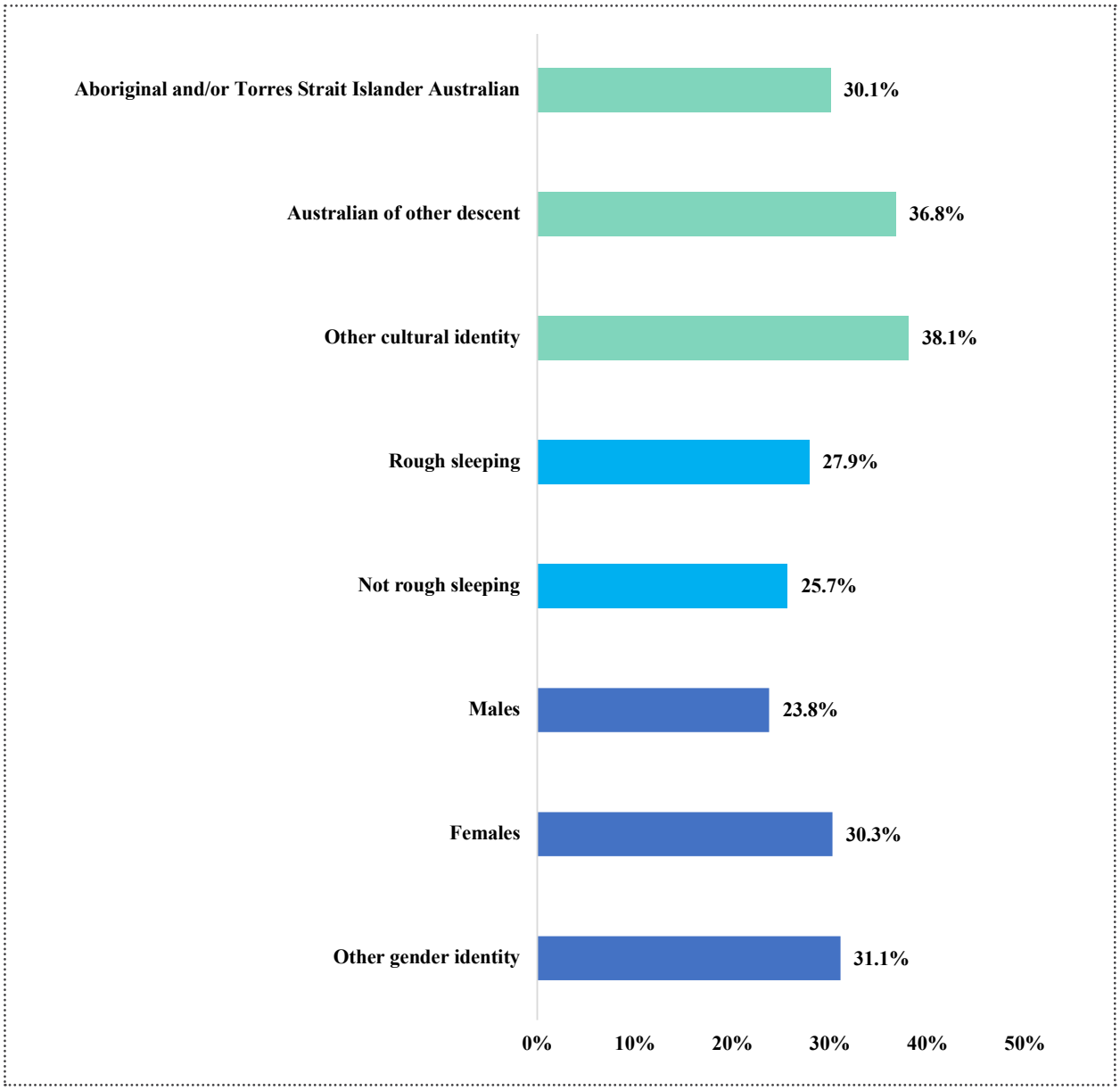
[3] the Australia VI survey the question was worded as "What is the total length of time you have lived on the streets or shelters?"

[4] Question was only included in the Australia VI-SPDAT, Youth VI-SPDAT and Individual VI-SPDAT surveys.

7.3 Discrimination

The General VI-SPDAT, Family, Individual and Youth VI-SPDAT v3 surveys included a question on discrimination (see Appendix 7, Table 53). The surveys asked "When it comes to homelessness services or housing, do you feel you have ever been discriminated against because of things like your age, race, appearance, disabilities, gender identity or sexual orientation?". Overall, one-quarter (26%) reported they had been discriminated against. A higher proportion of females and those identifying as other gender identity reported discrimination within homeless services and housing (Figure 20). While the General VI-SPDAT was only collected in South Australia (2017–2020) and New South Wales (2020), the Family and Individual VI-SPDAT v3 surveys were collected across Queensland (2019–2020), Western Australia (2020) and New South Wales (2019–2020). The Youth VI-SPDAT v3 was only collected in small numbers during 2020 in Queensland and Western Australia.

Figure 20 – Discrimination within homeless services and housing, per cent



Source: National Advance to Zero 2019–2020.

Notes: [1] Estimates based on all responses (excluding missing values).

[2] In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

[3] Question on discrimination only included in the General VI-SPDAT, Family Individual and Youth VI-SPDAT v3 surveys.

8 HEALTH OUTCOMES

Homelessness and poor health outcomes are strongly associated, as homelessness can lead to and exacerbate poor health outcomes. Conversely, some health conditions, such as mental illness may contribute to the onset of homelessness (Frankish et al.,2005). People experiencing homelessness are more likely to suffer poor health and premature mortality than the general population (Fazel et al., 2014; Aldridge, Story et al., 2018, Aldridge, Menezes et al., 2019; Pearson et al., 2021). Further, people experiencing long-term homelessness are significantly overrepresented in this area (O'Connell, 2004). Population studies in the United Kingdom (UK) and USA have identified an approximate life expectancy gap of 30 years between people who are experiencing homelessness and those who have not. With a recent Australian study finding that even a single episode of homelessness contributed to early mortality (Seastres et al., 2020). People experiencing homelessness, among other socially excluded populations in high income countries have a mortality rate ten times that of the general population, generally compounded by the presentation of multiple morbidities simultaneously (Davies & Wood, 2018).

Premature mortality has been shown to be closely associated with chronic health conditions such as infectious diseases (HIV and tuberculosis) and heart disease as well as other factors like substance misuse, injury, poisoning and suicide (O'Connell, 2004; Aldridge et al., 2018, Aldridge et al., 2019), with a UK study finding that a third of deaths among people experiencing homelessness were preventable (Aldridge et al., 2019).

High exposure to risk factors such as alcohol and other drugs, tobacco, and mental illness are likely to explain the premature mortality and poor health outcomes among people experiencing homelessness; which are further intensified by poor access and cost of healthcare and medications, especially preventative health care access (such as cancer-screening, sexual health information and screening, and products such as NRT to assist quitting smoking)(Fazel et al., 2014; Davies & Wood, 2018). Barriers to health care access include many health services relying on appointment notification systems rather than walk-in systems, however, people experiencing homelessness often do not have access to a phone or email to receive these reminders (Scutella et al., 2020; Davies & Wood, 2018). Additionally, short appointment times mean that individuals with chronic co-morbidities may not be able to access information about all their health issues at once. Further barriers include feelings of shame and blame from mainstream providers, and long-waiting times to accessing specialist services (Scutella et al., 2020; Davies & Wood, 2018).

Beyond the presence of health issues, there are also multiple barriers to people experiencing homelessness being able and comfortable to access health care. People experiencing homelessness commonly identify avoiding medical help due to feelings of judgment and discrimination, lack of relationship with a medical professional, transiency causing barriers in building a relationship with a medical professional in one area, and stigmatisation felt by mental health presentations or drug and alcohol use. These factors further entrench the poor health outcomes associated with the forementioned risk factors. Additionally, people who are rough sleeping chronically have more urgent basic needs than healthcare access that they first must pay attention to, often rough sleepers will be concerned with where they are sleeping, ensuring their possessions are safe, and sourcing their next meal, giving little room to be able to address health concerns (Davies & Wood, 2018).

It is, therefore, difficult to address the relationship between poor health outcomes and homelessness without considering the social determinants of health; housing, access to services, perception of discrimination and existing relationships with healthcare providers, previous experiences of interactions with healthcare providers, employment, as well as lifestyle factors including nutrition, tobacco, and alcohol and other drug use.

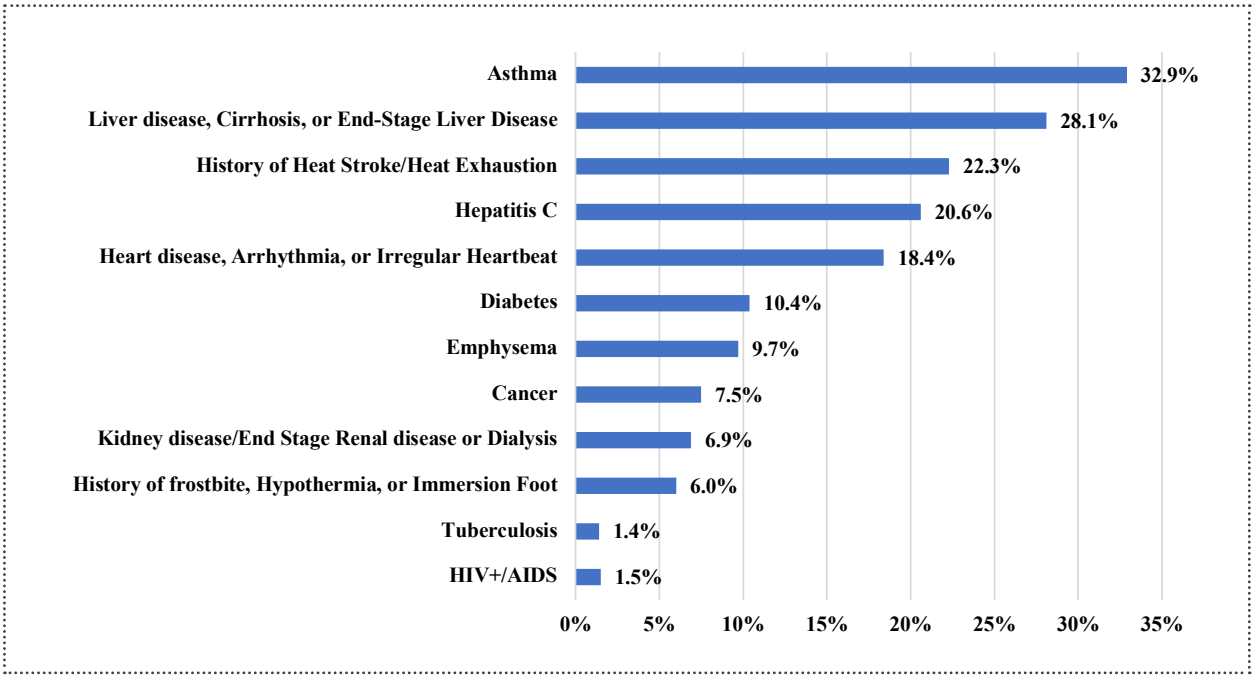
In this chapter, we examine the health outcomes of National Advance to Zero respondents.

8.1 Physical health conditions

The relationship between (poor) physical and mental health outcomes and homelessness is well-established. Like many correlates of homelessness, poor health is both a risk factor for and consequence of homelessness (Frankish et al.,2005). High exposure to risk factors such as alcohol and other drugs, tobacco and mental illness contribute to premature mortality and poor health outcomes among people experiencing homelessness

which are further intensified by poor access to healthcare and medications (Fazel et al., 2014). Of concern is that National Advance to Zero participants showed high rates of chronic conditions when asked if they have ever had, or if a healthcare provider had every told them that they have any of a number of listed long-term medical conditions. The most prevalent conditions include asthma (32.9%) followed by liver disease (28.1%), heat stroke/exhaustion (22.4%), hepatitis C (20.6%), heart disease (18.4%), diabetes (10.4%) and emphysema (9.7%), nearly all of which were significantly higher than rates seen across the general population (Figure 21).

Figure 21 – Lifetime prevalence of selected medical conditions, per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

While studies have reported high rates of mortality among those experiencing homelessness caused by infectious diseases such as HIV and tuberculosis (O'Connell, 2004; Fazel et al., 2014), these diseases were low among National Advance to Zero respondents 1.5% and 1.4% respectively. There currently isn't any data surrounding causes of death for people experiencing homelessness in Australia to determine the impact of these conditions on mortality in an Australian context. Australia also has a comparably low proportion of the population with HIV/AIDS when compared with other high-income countries, such as the United States. In 2019, estimated rate of infection with HIV in the United States was 12.6 per 100,000 population, whereas the rate of infection in Australia 4.2 per 100,000 (HIV.gov, 2021).

Some of these conditions can be explained through lifestyle factors such as tobacco smoking, poor diet, physical inactivity, alcohol and other drug misuse, and/or exposure to harsh environmental conditions, of which people experiencing homelessness are more likely to be affected by. In addition to an increase in lifestyle risk factors, experiencing homelessness may limit people's ability to manage certain physical conditions. For example, homelessness limits the ability of people to access and manage diabetes medications that require refrigeration and sterile environments for injecting, as well as a healthy balanced diet that minimises risk of diabetic shock (hypoglycaemia). Efforts to improve health care access, health literacy, medication compliance and ultimately reduce excessive mortality among people experiencing homelessness should focus on the primary underlying cause of ill-health, lack of housing causes and are explored below.

Table 28 shows a count of the number of people that reported experiencing a variety of health conditions when interviewed, as well as conditions that people reported when asked if there were any other conditions that they were affected by. Only counts for these conditions are reported in the table, as any prevalence estimate for these conditions is likely to be an underestimate due to people not being prompted as to the specific conditions in earlier versions of the VI-SPDAT.

One limitation of the physical health data collected is that the VI-SPDAT does not explicitly distinguish between ever having or currently having the different types of health conditions. For diseases that are not chronic or at end stage, this makes it difficult to prioritise service delivery to those that are most at risk. In addition, while high rates of risky lifestyle factors are likely to play a role in the prevalence of some physical conditions, the VI-SPDAT does not specifically ask about lifestyle factors such as tobacco and access to nutritional food. Future iterations of the VI-SPDAT may consider including factors relating to lifestyle factors to further inform the cause and effect of certain conditions and potential health promotion strategies that homelessness programs could put in place to support lifestyle changes that reduce health risks. Separating alcohol and other drugs may also help to inform this.

Table 28 – Lifetime prevalence of medical conditions

	Yes	*No*	*With condition (per cent)*
Kidney disease/End Stage Renal disease or Dialysis	794	10,750	6.9
History of frostbite, Hypothermia, or Immersion Foot	690	10,860	6.0
Liver disease, Cirrhosis, or End-Stage Liver Disease	1,857	4,746	28.1
HIV+/AIDS	177	11,329	1.5
History of Heat Stroke/Heat Exhaustion	2,596	9,017	22.3
Heart disease, Arrhythmia, or Irregular Heartbeat	2,129	9,466	18.4
Emphysema	1,117	10,439	9.7
Tuberculosis	167	11,318	1.4
Diabetes	1,203	10,346	10.4
Asthma	3,851	7,857	32.9
Cancer	858	10,653	7.5
Hepatitis C	2,390	9,215	20.6
Other[1] health condition			
Hepatitis[2]	5		
Mental Health problems[2]	9		
Cardiopulmonary Illnesses[2]	8		
Liver problems[2]	1		
Lung problems[2]	1		
Infections[2]	9		
Pregnancy problems[2]	1		
Seizure problems[2]	10		
Thyroid problems[2]	2		
Eye diseases[2]	1		
Neurological problems[2]	15		
Bone related illnesses[2]	30		
Gastroenterological diseases[2]	2		
Other[2]	46		

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Categories drawn from coding of self-reported "other" responses.

Future VI-SPDAT iterations may also wish to consider which physical health items contain a score and which do not. It does not appear entirely clear as to why certain health conditions have an attributed score. Arguably, all mentioned physical health conditions would place significant strain on someone experiencing homelessness.

Do have a score attached to them if respondent says "yes"	*Do not have a score attached to them if the respondent says "yes"*
• Cellulitis	• History of frostbite, hypothermia or immersion foot
• Kidney disease/end-stage renal disease or dialysis	• HIV+/AIDS
• Liver disease, cirrhosis, or end-stage lived disease	• History of heat stroke/heat exhaustion
• Heart disease, arrythmia, or irregular heartbeat	• Asthma
• Emphysema/chronic obstructive pulmonary disease (COPD)	• Tuberculosis
• Diabetes	• Dental problems
• Cancer	• Foot/skin infections
• Hepatitis C	• Scabies
• Chronic Digestive Condition	• Dehydration
• Epilepsy	• Convulsions

Source: Advance to Zero VI-SPDAT for Individuals, 2017.

Respondents were also asked whether they experience a number of conditions often associated with homelessness. (Note that in the most recent version of the VI-SPDAT the set of "physical health conditions" was combined with the list of medical conditions included above in Figure 21). As seen in Table 29 dental problems were the most prevalent condition (53.9%) in this second set of physical health conditions, followed by dehydration (23.5%), skin infections (17.1%), epilepsy (7.9%), cellulitis (5.4%) and scabies (3.2%). Housing people would presumably provide people with access to resources to improve their hygiene practices and reduce the occurrence of these conditions.

Table 29 – Respondents reporting experiencing selected physical health conditions or issues at time of survey

Do you have any of the following?	*Yes*	*No*	*With condition (per cent)*
Cellulitis	473	8,237	5.4
Foot/skin infections	1,621	7,875	17.1
Scabies	277	8,409	3.2
Dehydration	2,046	6,667	23.5
Epilepsy	791	9,188	7.9
Dental problems	4,707	4,030	53.9

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Categories drawn from coding of self-reported "other" responses.

In 2019–2020, respondents completing the General VI-SPDAT, Family, Individual or Youth VI-SPDAT v3 were also asked whether there are any medications they are not currently taking as prescribed by their doctor, and, if so, to select the reasons this occurs. Around one in ten respondents reported not currently taking their medication as prescribed due to; forgetting to take them (11.9%), being unable to afford them (11.2%), not liking the side effects (10.2%), having the medications taken or stolen (8.9%), or not agreeing the medications are needed (8.7%). A small proportion of respondents reported being unable to source their medications (7.2%), misusing their medications (4.3%), or selling them instead of taking them (1.3%). Around 5% of respondents selected an 'other' reason for not taking their medications as prescribed.

8.1.1 Asthma

The rate of asthma reported by respondents is almost three times the rate of the general population (32.9% and 12%, respectively; NPS MedicineWise, 2020). It is also estimated that 57–82% of people experiencing homelessness smoke tobacco, which has been found to contribute to the development of asthma (Soar et al., 2020).

8.1.2 Liver disease

Overall, 28.1% of respondents reported having or having ever had a liver condition including liver disease, cirrhosis or end-stage liver disease. In Australia, liver disease is the 20th leading cause of death (ABS, 2019b). Liver diseases are associated with high alcohol use and hepatitis. To note, 64.9% of respondents also said that they have a problematic alcohol or drug problem, which may account for the high prevalence of liver disease in the sample. Liver cirrhosis progression can be prevented by stopping alcohol consumption. Aboriginal and Torres Strait Islander Australians are also at greater risk of developing liver disease (Valery et al., 2020).

8.1.3 Heat stroke

Overall, 22.4% of respondents reported suffering from a history of heat stroke or heat exhaustion. This is likely to be due to lack of shelter, continual exposure to the sun and dehydration.

8.1.4 Hepatitis

Hepatitis C is one of the most common notifiable infectious diseases in Australia and 80% of people that contract Hepatitis C will develop liver disease (NSW Government Health, 2019). Among National Advance to Zero respondents, 20.6% reported having Hepatitis C, which is much higher than the rate in the Australian general population (0.78%; MacLachlan et al., 2020). However, Australian notification rates are much higher among injected drug users, Aboriginal and Torres Strait Islander Australians and people from high prevalence countries (MacLachlan et al., 2020). One reason for the high rate of Hepatitis C in the National Advance to Zero sample is that the disease is most commonly contracted through injected drug use by way of contaminated needles (NSW Government Health, 2019). Almost one-third of respondents reported using injection drugs in the six months prior to the survey (see Table 6.5 in 6.3 Drug and Alcohol Use).

8.1.5 Heart disease

Heart conditions including heart disease, arrhythmia or irregular heartbeat were experienced by 18.4% of respondents. This is substantially higher than the national rate of 5.6% (AIHW, 2020c). The AIHW reports that coronary heart disease is very common and kills more Australians than any other disease (ABS, 2019b). Studies of homeless populations have also found high rates of mortality from heart disease (Fazel et al., 2014). Heart disease is a largely preventable through the introduction of various lifestyle changes including quitting smoking, healthy eating, and physical activity (Fazel et al., 2014; AIHW, 2020c).

8.1.6 Diabetes

Diabetes was reported by 10.4% of respondents in the National Advance to Zero dataset which is twice that reported for the general population in Australia (4.9%; AIHW, 2020c). In the general population, diabetes is more prevalent in males than females and in older Australians. Aboriginal and Torres Strait Islander Australians are also twice as likely to have the illness (ABS, 2019c). In 2018, diabetes was a contributing factor to 10.5% of all deaths in Australia (AIHW, 2019b). Homelessness has been related to poor nutrition, access to health care and barriers managing medication which may increase the likelihood of diabetes being poorly controlled among this population group (Fazel et al., 2014).

8.1.7 Emphysema

Emphysema comes under the umbrella of Chronic Obstructive Pulmonary Disease (COPD). Emphysema was reported by 9.7% of respondents. In the general population 14.5% of people aged 40 years and over have COPD and this number increases to 29.2% for those aged 75 years and over (Lung Foundation Australia, 2018). COPD is strongly associated with tobacco use. While tobacco smoking rates have decreased among the general population (11.6%; AIHW, 2020c), smoking prevalence remains high among people experiencing homelessness with estimates ranging from 57–82% (Soar et al., 2020).

8.1.8 Cancer

Cancer is responsible for 19% of the total burden of disease in Australia and is a major cause of morbidity. Overall, 7.5% of survey respondents reported having or having had cancer. At the end of 2010, the prevalence of those who had cancer (including those who were diagnosed within the previous five years) in the Australian population was 1.7%. The proportion of people in the sample with cancer is higher than that of the general population. However, one limitation to the data is the lack of breakdown of types of cancer, as at least 30% of cancers are preventable through lifestyle changes such as quitting smoking, eating healthy, exercising, and sun protection (Anand et al., 2008; Wilson et al., 2017).

8.1.9 Kidney disease

Overall, 6.9% of respondents reported having or having had kidney disease or end stage renal disease with dialysis. Kidney diseases are mainly caused by diabetes or high blood pressure. In the general population, it is estimated that 1.7 million people (1 in 10), aged 18 and over have a form of chronic kidney disease. However, only 10% are actually aware that they have the disease. Thus, the prevalence of 6.9% in this sample may be an underestimate, as it is possible that it is under-diagnosed, either due to lack of health care or detection of symptoms. It has been estimated that the prevalence of end stage renal disease will have increased since 2011 (19,780 cases in 2011 to 31,589 cases in 2020) mainly due to increases in diabetes (AIHW, 2014).

8.1.10 Frostbite, hypothermia, and immersion foot

In particular, people sleeping rough are exposed to the elements which has negative health impacts. Six per cent of respondents have suffered from frostbite, hypothermia, and immersion foot.

8.1.11 Tuberculosis

Tuberculosis is an infection that affects an estimated 1,200 Australians each year (Lung Foundation, 2018). Just over one per cent (1.4%) of respondents reported having or having had tuberculosis.

8.1.12 HIV/AIDS

Overall, 1.5% of respondents have HIV or AIDS, which is much higher than the prevalence in the general population. In 2019, there was an estimated 29,045 Australians living with HIV (Australian Federation of AIDS Organisations, 2021). Infectious diseases such as HIV and tuberculosis have been reported as one of the causes of high rates of mortality seen among people experiencing homelessness (Fazel et al., 2014).

8.2 Mental health, learning and developmental disabilities and brain injury

A large body of evidence reports that people experiencing homelessness are more likely to be affected by poor mental health than the general population, and that mental illness can both be caused and exacerbated by homelessness (Vallesi et al., 2021; Moschion & van Ours, 2021; Russell Kennedy Lawyers, 2021; Mejia-Lancheros et al., 2021).

The current version of the VI-SPDAT includes questions pertaining to diagnoses by medical practitioners of specific mental health conditions. The Australian Institute of Health and Wellbeing uses the Kessler Psychological Distress Scale (K10) to measure psychological distress (AIHW, 2020c), as have a number of Australian studies on homelessness (Conroy et al., 2014; Miscenko et al., 2017). Integrating additional validated tools into the VI-SPDAT to measure mental health may assist in the development and prioritisation of homelessness services throughout Australia.

In addition to the explicit question on diagnosed mental health conditions, various versions of the VI-SPDAT also include proxies to measure mental health through people's self-reported interactions with the healthcare system (see Appendix 7, Table 53). Such interactions may have related to their mental health and/or a diagnosis of a mental health condition, a learning and development disability, having trouble concentrating and remembering things, reporting a serious brain injury or trauma and/or the surveyor reporting signs or symptoms of severe, persistent mental illness of severely compromised cognitive functioning (Wood et al., 2017). These questions are:

- Ever been taken to a hospital against your will for a mental health reason?
- Gone to Accidents and Emergencies at the hospital because you weren't feeling 100% well emotionally or because of your nerves?
- Spoken with a psychiatrist, psychologist or other mental health professional in the last 6 months because of your mental health – whether that was voluntary or because someone insisted that you do so?

Generally, people experiencing homelessness have poor access to healthcare, with multiple barriers contributing to poor access such as location, transport, cost, and feeling shamed by providers (Fazel et al., 2014; Davies & Wood, 2018). Therefore, it is likely that people have undiagnosed mental health conditions, and the National Advance to Zero results are an underrepresentation of mental health conditions across the homelessness population in Australia.

Noting the above limitations, on the basis of the above questions, a large proportion of National Advance to Zero respondents reported accessing health services for mental health reasons or accessing mental health services (Table 30):

- 31.0% of respondents have been taken to a hospital against their will for mental health reasons;
- 48.0% have spoken with a psychiatrist, psychologist, or mental health professional in the last six months; and
- 38.8% have gone to an Emergency Department due to not feeling emotionally well or because of their nerves.

Table 30 – Selected mental health and disability indicators[1,2]

	Yes	No	Per cent Yes
Have you ever been taken to a hospital against your will for a mental health reason?	3,332	7,428	31.0
Have you spoken with a psychiatrist, psychologist or mental health professional in the last 6 months because of your mental health?[3]	4,416	4,787	48.0
Have you ever gone to accidents and emergencies at the hospital because you weren't feeling 100% well emotionally or because of your nerves?[3]	3,561	5,619	38.8
Have you had a serious brain injury or head trauma?	3,920	13,386	20.6
Have you ever been told you have a learning or developmental disability?[3]	2,935	11,433	20.4
Do you have any problems concentrating and/or remembering things?[3]	3,688	2,368	60.9
Surveyor observed signs of mental illness or severely compromised cognitive functioning.	2,428	5,626	30.1

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Mental health questions were included in the Australia VI-SPDAT, Australia F-SPDAT and Australia VI surveys but not in the Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.

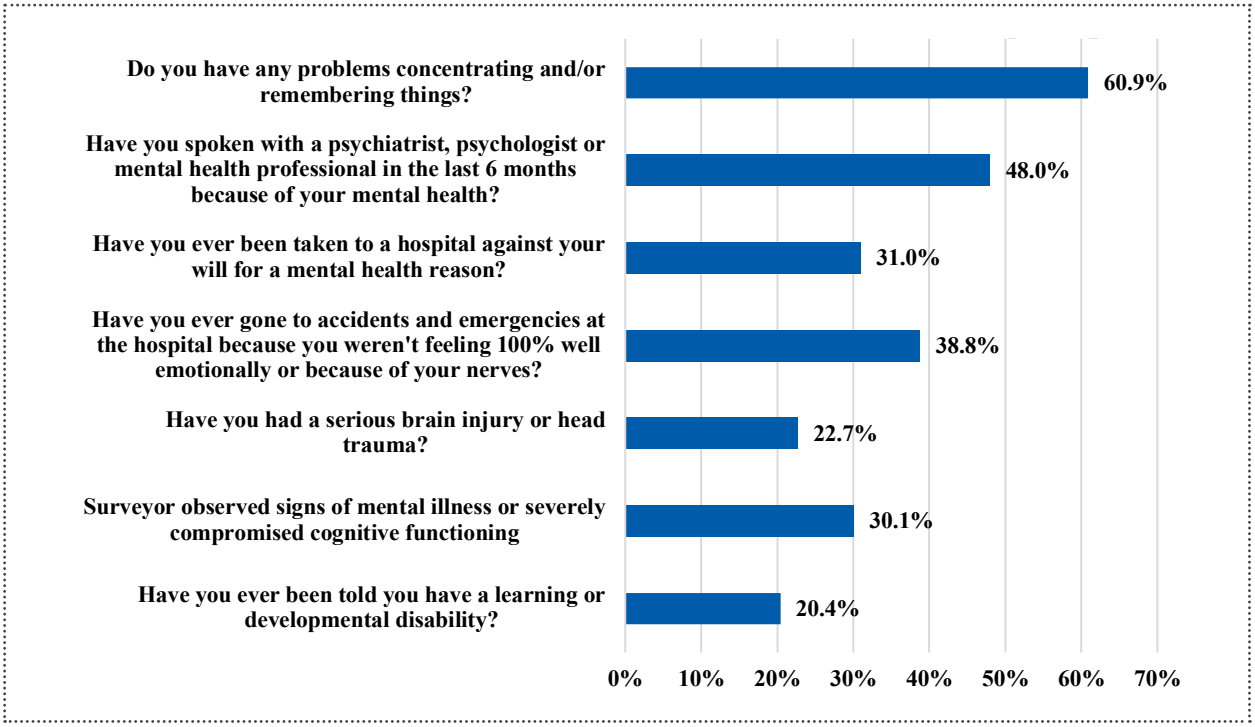
[3] Questions were only included in the Australia F-SPDAT and Australia VI-SPDAT surveys.

Surveyors conducting the VI or VI-SPDAT v1 recorded signs of mental illness or compromised cognitive functioning in over a quarter (30.1%) of respondents (Figure 22). Surveyor observations of respondents were removed from subsequent versions of the VI-SPDAT (see Appendix 7, Table 53).

Mental illness and alcohol and other drug misuse have been associated with people experiencing homelessness using accidents and emergency (A&E) hospital departments at high rates (Fazel et al., 2014). Among National Advance to Zero respondents 34.5% of people sleeping rough reported that they have gone to A&E because they were not feeling emotionally well or because of their nerves, compared to 15.7% of those not sleeping rough.

People experiencing homelessness have been reported to have higher rates of traumatic brain injury and signs of cognitive impairment (Fazel et al., 2014). A high proportion of National Advance to Zero respondents reported conditions aligned with these results. For example, 20.4% reported having been told that they had a learning or developmental disability and 60.9% reported that they have problems concentrating and/or remembering things.

Figure 22 – Selected mental health, disability and brain injury indicators, per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

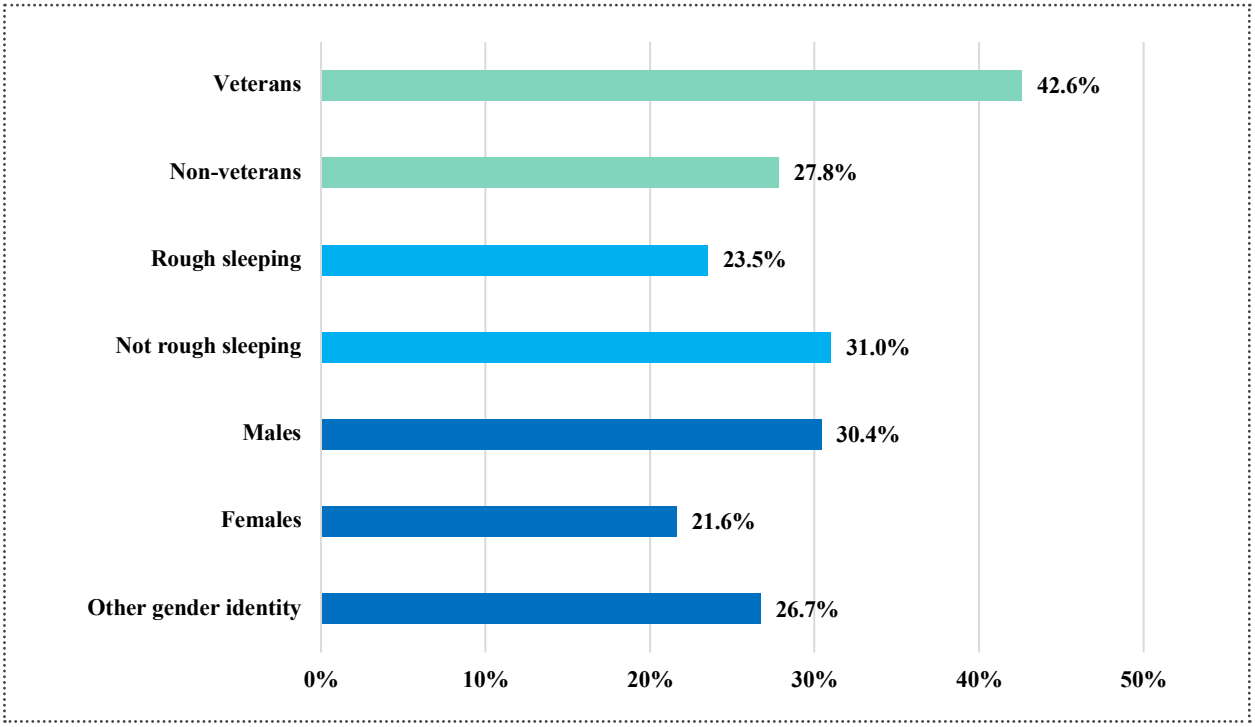
Respondents also reported high rates of serious brain injury or head trauma (22.7%). Research suggests that the consequences of traumatic brain injury (cognitive impairment, social functioning) make it a risk factor for both becoming and remaining homelessness. In addition, people who are sleeping rough are more likely to experience repetitive traumatic brain injury as are men who are experiencing any form of homelessness (Fazel et al., 2014). Survey respondents report that traumatic brain injury impacts their ability to think clearly and make quick decisions regarding their safety, and often feel they are taken advantage of, especially if they are rough sleeping.

It is important that strategies to address homelessness consider traumatic brain injury and its prevention. Of the people surveyed across Registry Weeks, a higher proportion of males (23.0%) to females (16.2%) had experienced a brain injury or trauma (Figure 23). People sleeping rough (28.4%) also had higher rates compared to people who were not sleeping rough (15.9%). Of the respondents that identified as veterans, 42.6% had suffered a serious brain injury or head trauma. A history of trauma has been shown to be associated with poor mental health among men experiencing homelessness (O'Donnell et al., 2014).

Two in five (41.0%) National Advance to Zero respondents reported experiencing emotional, physical, psychological, sexual, or other type of abuse or trauma in their life which they have not sought help for (Family SPDAT v3, Individual VI-SPDAT v2 and v3, and General VI-SPDAT), and/or which caused their homelessness (Family and Individual VI-SPDAT v1 and v2, and General VI-SPDAT; Table 31). Half (50.4%) of males answered "yes", whereas 62.8% of females and 84.2% of other gender identifying respondents answered "yes". These results amplify the need for the integration of trauma informed care into homelessness service delivery models.

In 2019-2020, diagnosed mental health disorders were highly prevalent among National Advance to Zero respondents completing the General VI-SPDAT, Family, Individual or Youth VI-SPDAT v3 surveys, with over two-thirds experiencing depression (70.2%) or anxiety (67.4%; Figure 24). A further two in five reported being diagnosed with post-traumatic stress disorder (42.4%), and around one fifth had bipolar disorder (21.4%), psychosis (19.3%), or schizophrenia (19.1%).

Figure 23 – Self-report of serious brain injury or head trauma, per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Table 31 – Emotional, physical, psychological, sexual or other type of abuse or trauma

("Yes or No – Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?")

	Number	*Per cent*
Males		
Trauma – Yes	1,947	50.4
Trauma – No	1,864	48.2
Refused	53	1.4
Total	3,864	100.0
Missing	3,041	
Females		
Trauma – Yes	1,550	62.8
Trauma – No	902	36.5
Refused	16	0.7
Total	2,468	100.0
Missing	1,926	
Other gender identity[3]		
Trauma – Yes	59	84.2
Trauma – No	11	15.8
Total	70	100.0
Missing	35	
Gender (missing)	254	
Total	11,658	

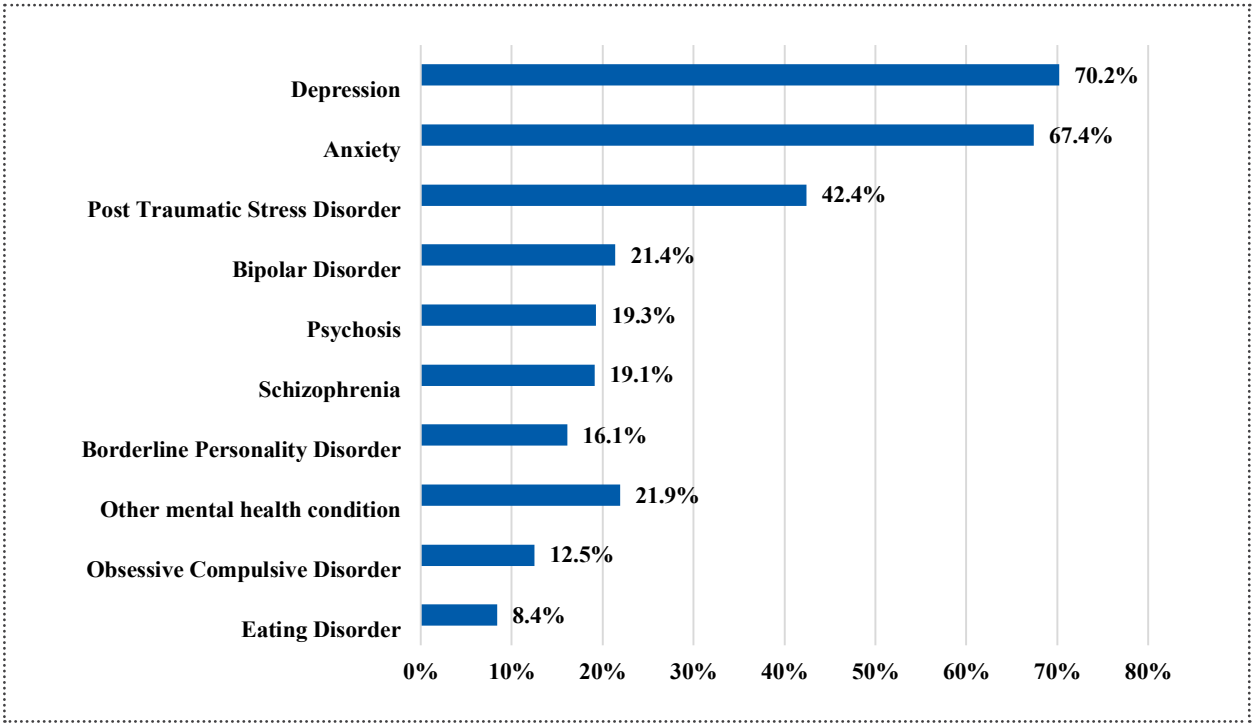
Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique responses (excluding missing values).

[2] A question on unaddressed trauma was included in the Australia VI-SPDAT Version 1 and Version 2, Australia F-SPDAT and Families VI-SPDAT Version 1 and 2 surveys, and General VI-SPDAT.

[3] Other gender includes Intersex or X, Other gender identity, unknown, declined to state.

Figure 24 – Diagnosed mental health disorders, per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Question on diagnosed mental health conditions only included in Australia General VI-SPDAT, Family, Individual and Youth VI-SPDAT v3

8.2.1 Depression

Among National Advance to Zero respondents, 70.2% reported being diagnosed for depression, which is also seven times higher than the general population (10.4%; ABS, 2019d). Overall, around one in five Australian adults experienced a mental or behavioural condition in 2017–18 (ABS, 2019d).

8.2.2 Anxiety

An anxiety diagnosis was reported by over two-thirds (67.4%) of respondents in the National Advance to Zero dataset. This is far greater than the 3.2 million Australians (13.1%) who reported an anxiety-related condition in 2017–18 (ABS, 2019d).

8.2.3 Post-traumatic stress disorder

Following a traumatic event, people may develop post-traumatic symptoms, and a minority will develop post-traumatic stress disorder (PTSD). Around two-in five (42.4%) respondents reported being diagnosed for PTSD, compared with 1.7% of women and 1.3% of men who reported that they had been told by a doctor, nurse, or health professional that they have PTSD as part of the 2017–18 National Health Survey (point prevalence; ABS, 2019d).

8.2.4 Psychosis

Overall, 19.3% of respondents reported being diagnosed for psychosis.

8.2.5 Schizophrenia

Schizophrenia affects approximately seven individuals per 1,000 (just under 1%) across their lifetime. Around one in five (19.1%) respondents in the National Advance to Zero dataset reported being diagnosed with schizophrenia.

8.2.6 Borderline personality disorder

Overall, 16.1% of respondents reported being diagnosed with borderline personality disorder as it is referred to in the VI-SPDAT (or emotionally unstable personality disorder). In Australia, borderline personality disorder is the most common personality disorder, affecting about 1 to 4 in every 100 people at some time in their lives. It's more common in women, and usually the symptoms appear in the teenage years or early adulthood.

8.2.7 Bipolar disorder

Bipolar disorder is considered an affective disorder, characterised by mood disturbances, or changes in affect. Diagnosed bipolar disorder was reported by 21.4% of respondents.

8.2.8 Obsessive compulsive disorder

Approximately one in ten (12.5%) respondents reported being diagnosed for Obsessive compulsive disorder (OCD). OCD is an anxiety related disorder characterised by obsessions (thoughts, ideas or images) and compulsions (acts).

8.2.9 Eating disorder

Eating disorders are a group of mental illnesses typically characterised by problems associated with disordered eating or body weight control, and a severe concern with body weight or shape (Treasure et al., 2010). Eating disorders impacted 8.4% of National Advance to Zero respondents.

8.3 Alcohol and other drug use

Drug and alcohol misuse can both cause and exacerbate a number of chronic health conditions including hepatitis C, heart conditions, and liver disease, which were all highly prevalent among respondents (see Table 28). Among National Advance to Zero respondents a high proportion of respondents (64.9%) report having a drug or alcohol problem ("Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?"), with over a quarter (28.5%) reporting that they had consumed alcohol and/or drugs almost every day in the past month, and a similar amount (29.1%) reporting that they injected drugs or shots in the past six months (Table 32, Figure 25). Among those that reported injecting drugs, 53.8% indicated they were aware of safe injection practices. Surveyors conducting the VI, Family or Individual VI-SPDAT v1 reported that they observed symptoms or signs of problematic drug or alcohol use in 29.9% of respondents.

In Australia, a higher proportion of Aboriginal and Torres Strait Islander people smoke tobacco, use alcohol to risky levels and use other drugs than other Australians (AIHW, 2020c). This trend is similar among National Advance to Zero respondents with 70.3% of Aboriginal and Torres Strait Islander people reporting that they had problematic alcohol or drug use compared to 64.3% of other respondents (Figure 26).

With respect to gender differences, 69.4% of males surveyed reported having an alcohol or drug problem compared to 57% of females and 76.1% of other gender identifying people. People sleeping rough reported higher rates than other respondents (71% vs 58%).

In the Family Version 1 and Individual VI surveys, respondents were asked: "Have you used non-beverage alcohol like metho, cough syrup, mouthwash, rubbing alcohol, cooking wine, or anything like that or have you used inhalants like paint or petrol or anything like that in the last 6 months?" This question presumably was included to reference certain forms of risky alcohol use and use of inhalants. A small proportion of respondents (7.9%) reported using non-beverage alcohol in the previous six months. Likewise, in various surveys, respondents were asked whether they had blacked out because of their alcohol or drug use in the past month? One fifth of respondents (20%) reported having blacked out because of alcohol or drug use in the previous month.

In comparison to the high rates of reported problematic alcohol and/or drug use, a low proportion of people reported ever being treated for drug or alcohol problems and subsequently returning to using them (36.5%). This may indicate that a low proportion of people are accessing alcohol and other drug services. This is consistent with respondents reporting that they had avoided medical help. As discussed in the physical health section, there may be many reasons for this, including not accessing supports due to feelings of discrimination, and a general lack of trust in support services (Davies & Wood, 2018). Knowing that mental health and substance abuse conditions often co-occur among people experiencing homelessness (Zaretzky et al., 2017), and that alcohol and other drug misuse can both cause and maintain homelessness (Fazel et al., 2014), strategies to address and prevent homelessness need to include both alcohol and other drug treatment, as well as mental health support and recovery programs.

Table 32 – Selected indicators of problematic drug and alcohol use

	Yes	*No*	*Per cent Yes*
Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?	7,075	3,821	64.9
Have you consumed alcohol and/or drugs almost every day or every day for the past month?	3,071	7,690	28.5
Have you used injection drugs or shots in the last 6 months?[4]	2,465	5,997	29.1
Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?[2]	3,086	5,364	36.5
Have you used non-beverage alcohol such as metho, cough syrup, mouthwash, rubbing alcohol and cooking wine or used inhalants such as paint or petrol in the last 6 months?[3]	482	5,601	7.9
Have you blacked out because of your alcohol or drug use in the past month?[4]	1,914	7,648	20.0
Surveyor observed signs or symptoms of problematic alcohol or drug abuse.[4]	2,572	6,021	29.9

Source: National Advance to Zero 2010–2020

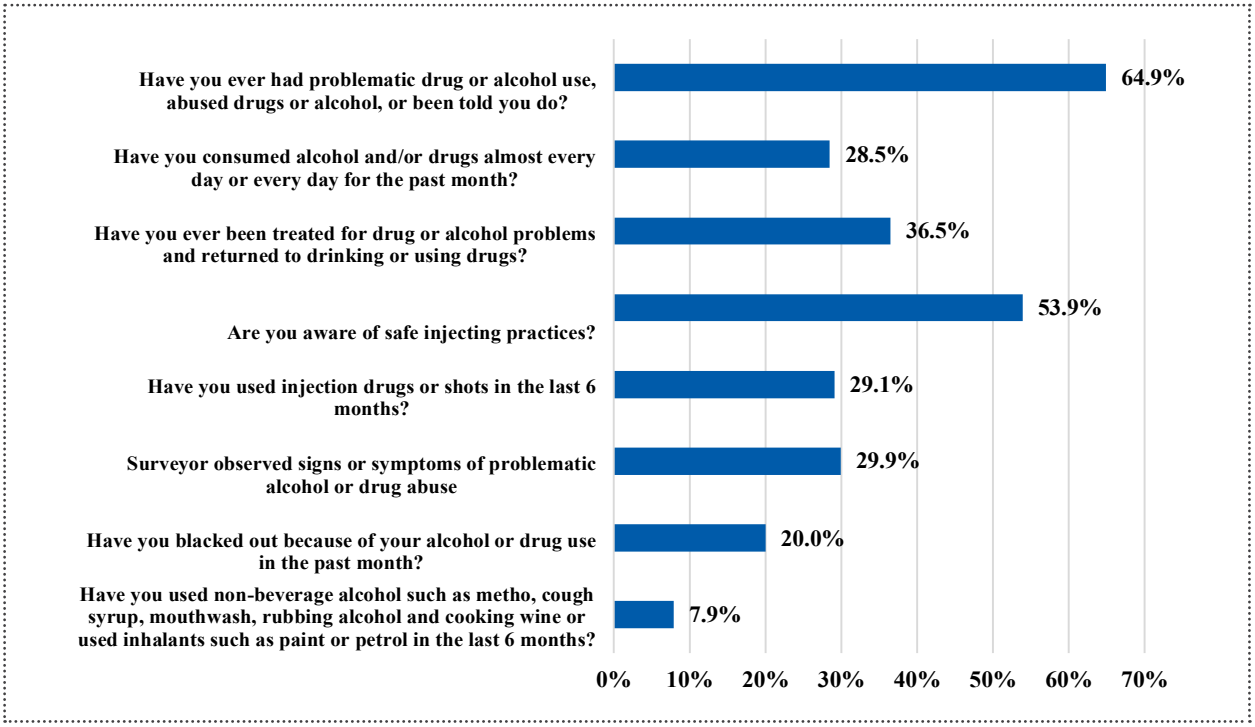
Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Questions were included in the Australia F-SPDAT and Australia VI-SPDAT surveys

[3] Question were included in the Australia F-SPDAT Version 1 and Australia VI-SPDAT Version 1 surveys.

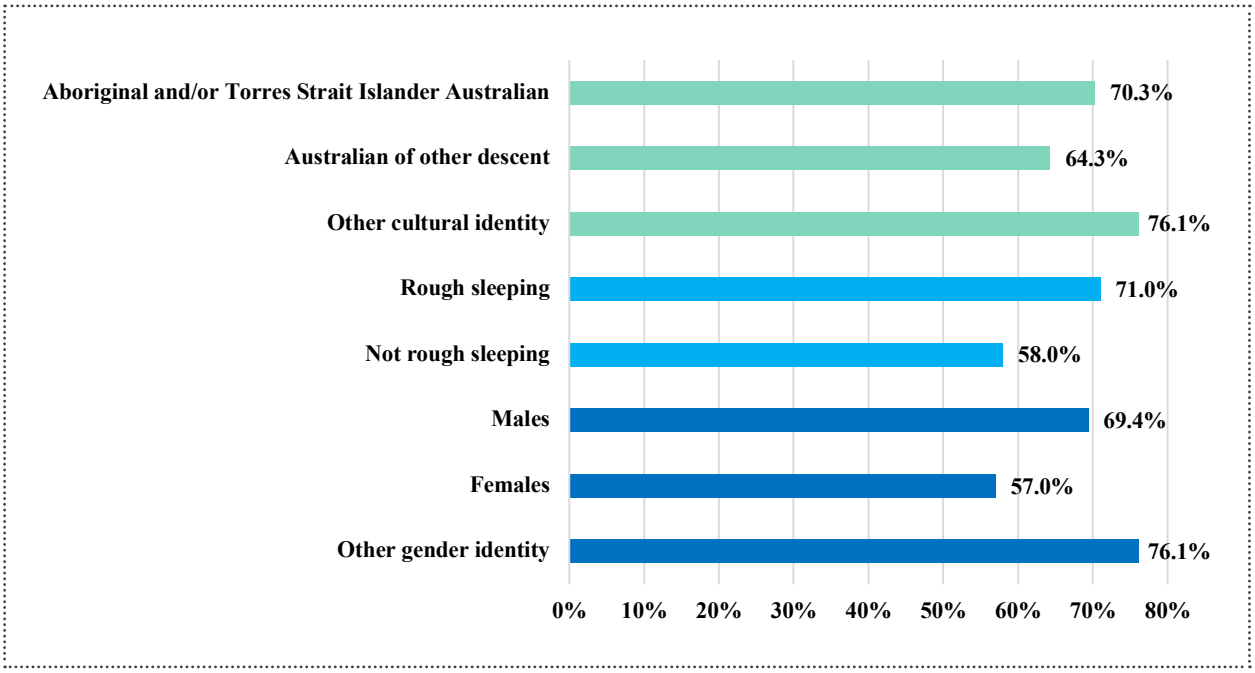
[4] No questions about drug use were asked in the Youth VI-SPDAT v2 survey.

Figure 25 – Selected indicators of problematic drug and alcohol use, per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Figure 26 – Per cent of respondents responding yes to the question 'Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?'



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

SUPPORTIVE HOUSING MODELS

ADDRESSING HEALTH AND OTHER SERVICE NEEDS OF LONG-TERM ROUGH SLEEPERS

Supportive housing models provide long-term support for those entering permanent housing from homelessness who have high health and other service needs. Supportive housing is provided in both congregate settings, such as the Common Ground model, or in scattered site housing. The Australian Advance to Zero data examined in this report provides a strong evidence base for expanding the size of a homelessness-focused supportive housing sector in Australia.

Those sleeping rough not only lie at the extremes of the homelessness-housing continuum, but also exhibit elevated rates of long-term serious health conditions, mental health issues, and high-risk alcohol and substance use. For a significant number, there is long history of homelessness as well as interactions with the out-of-home care and juvenile justice systems as children and adolescents. Experiences of violence and exploitation on the streets are common.

In the Australian Advance to Zero data (2010-2020) examined in this report, 7,218 (35%) indicated that they most frequently slept rough in its various forms (on the streets, in parks, in cars, or derelict houses). Of those currently frequently sleeping rough who also responded to questions related to their history of experiences of homelessness (n=5,488), 4,160 (or 75.8%) reported a year or more of rough sleeping or emergency accommodation and had been
on the streets or in emergency accommodation on average for 8 years (median 5 years).

Below we report the incidence of health and other service needs among current rough sleepers in the Advance to Zero database who reported a year or more of rough sleeping or emergency accommodation in their lifetime (referred to as long-term rough sleepers).*

For current rough sleepers who had experienced rough sleeping for a year or more, 70.2% reported lifetime prevalence of at least one diagnosed chronic long-term medical condition (e.g., asthma, liver disease, heat stroke/exhaustion, hepatitis C, heart disease, diabetes and emphysema), 71.1% reported at least one other identified health condition (dental problems, dehydration, skin infections, epilepsy, cellulitis), 79.5% at least one diagnosed mental health condition, and 71.5% reported problematic drug or alcohol use ("Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?").

The most common self-reported diagnosed mental health conditions among long-term rough sleepers were depression (67.4%) and anxiety (62.4%). Dental problems (41.3%), a serious brain injury or head trauma (35.6%), asthma (29.8%), heat exhaustion (26.2%), hepatitis C (26.6%), dehydration (24.5%) were the most common chronic medical conditions or other health issues identified. Half (51.4%) had at least two chronic medical conditions or physical health conditions. On average, those experiencing long-term rough sleeping homelessness reported 2.6 mental health diagnoses (among the 10 listed), 1.6 diagnosed chronic medical conditions (among the 11 listed), and 1.5 other health conditions (among the 7 listed).

Diagnosed mental health conditions and problematic drug or alcohol use comorbidity

Almost one in two (49.0%) long-term rough sleepers reported both one or more that they had diagnosed mental health conditions and problematic drug or alcohol use.

Of those long-term rough sleepers with a self-reported diagnosed mental health condition and reported problematic drug or alcohol use, 70.1% were male, 28.1% identified as Aboriginal and/or Torres Strait Islander, 21.3% had experienced youth detention, and 25.0% experienced out-of-home care prior to the age of 18. Sixty-two per cent had experienced violence or threats of violence in the prior six months and reported having 5.5 police interactions, on average, in the prior six months. Forty-two per cent reported owing money. A greater proportion of long-term rough sleeping women (72.3%) with a self-reported diagnosed mental health condition and AOD comorbidity reported experiencing violence or threats of violence in the prior six months compared to males (58.2%).

On average, those with a mental health and AOD comorbidity, reported using Accident and Emergency 2.6 times, and taking an ambulance to hospital 1.4 times in the prior six months. Half (50.4%) had gone to Accident and Emergency as they weren't feeling well emotionally or because of their nerves. Women reported average lower ambulance use (1.2 compared to 1.5 respectively) and lower Accident and Emergency use (1.6 compared to 3.0 respectively) compared to men.

Diagnosed mental health conditions and diagnosed chronic medical health condition or identified physical health issues comorbidity

Two in three (67.3%) long-term rough sleepers reported that they had diagnosed mental health conditions and chronic medical conditions or other identified physical health issues comorbidity.

Of those long-term rough sleepers with a diagnosed mental health condition and diagnosed chronic medical health or identified physical health conditions comorbidity, 68.5% were male, 27.8% identified as Aboriginal and/or Torres Strait Islander, 19.4% had experienced youth detention, and 21.9% had been in out-of-home care. Over one-third reported (37.2%) owing money. Long-term rough sleepers reported having 5.3 police interactions, on average, in the prior six months. A greater proportion of women long-term rough sleepers (58.4%) with a diagnosed mental health and diagnosed chronic medical health or identified physical health condition comorbidity reported experiencing violence or threats of violence in the prior six months compared to males (39.2%).

On average, those long-term rough sleepers with a diagnosed mental health and diagnosed chronic medical health or identified physical health condition comorbidity, reported using Accident and Emergency 2.5 times, and that they had been taken by an ambulance to hospital 1.4 times in the prior six months. Almost half (48.2%) had gone to Accident and Emergency as they weren't feeling well emotionally or because of their nerves. Males reported higher average Accident and Emergency use (2.8 compared to 1.8 respectively) compared to females.

Diagnosed mental health conditions and problematic drug or alcohol use and diagnosed chronic medical health or identified physical health issues tri-morbidity

Among long-term rough sleepers, 43.2% were 'tri-morbid' in the sense that they reported that they had been diagnosed with a mental health condition, reported problematic drug or alcohol use, and reported chronic medical health conditions or identified physical health issues.

Of those long-term rough sleepers who reported tri-morbidity as defined above, 63.9% were male, 26.3% identified as Aboriginal and/or Torres Strait Islander, 20.8% had experienced youth detention, and 27.2% had been in out-of-home care. Almost half (45.1%) reported owing money. A greater proportion of women (75.9%) with tri-morbidity reported experiencing violence or threats of violence in the prior six months compared to males (63.9%). Those with tri-morbidity reported 5.5 police interactions on average in the prior six months. On average, those with tri-morbidity, reported using Accident and Emergency 2.7 times, and taken by an ambulance to hospital 1.6 times in the prior six months. Over half (51.8%) had gone to Accident and Emergency as they weren't feeling well emotionally or because of their nerves. Women reported average higher ambulance use (1.7 compared to 1.5 respectively) and lower Accident and Emergency use (2.2 compared to 2.9 respectively) compared to men.

*Due to data collection procedures using different survey versions over the years, not all types data were collected for each respondent which has resulted in an underreporting of diagnosed mental health conditions (mental health conditions were only collected for Version 3 surveys). Refer to Appendix 7, Table 55 in report for variables by interview type.

9 HEALTHCARE UTILISATION

The utilisation of health care is a function of the need for healthcare, access to healthcare facilities (a function of price and availability), and the preferences of consumers. As evident in the results from Chapter 8, people experiencing homelessness in Australia's capital cities experience poorer health outcomes than the general Australian adult population across a broad range of indicators. These poorer health outcomes lead to individuals rough sleeping experiencing a mortality rate ten times higher than the average citizen (Filke & Aronowitz, 2021). Those experiencing homelessness in Australia's cities are also victims of high rates of assault, which contributes to the high rates of treatment in Accidents and Emergency (A&E) departments observed in this population, resulting in treatment in Accidents and Emergency (A&E) departments at high rates.

Facilities such as hospitals are often accessed at an increased rate by people experiencing homelessness, particularly those sleeping rough, due to not having a regular GP to visit, lacking access to supports outside of the area they are sleeping in, being unable to afford medications, and/or having nowhere else to go. Further, the high prevalence of health conditions and sustained injuries (see Chapter 8) in those experiencing homelessness results in elevated levels of use of public hospitals, A&E departments and ambulances.

In this chapter, we examine healthcare utilisation outcomes among those experiencing homelessness and assess the cost implications of that healthcare utilisation.

9.1 Hospital and ambulance utilisation

The National Advance to Zero collection data discussed in Chapters 6–8, shows that people experiencing homelessness are more likely to experience mental illness, alcohol and other drug misuse and poorer physical health outcomes than the general population. As a consequence, people experiencing homelessness are often overrepresented in acute healthcare services including A&E, ambulance services, and as hospital inpatients. The extant research shows that these factors translate to a significant financial burden on the Australian healthcare system (Flatau et al., 2008; Flatau & Zaretzky, 2008; Zaretzky et al., 2008; Poulin et al., 2010; Hwang et al., 2011; Hwang et al., 2013; Zaretzky et al., 2013; Wood et al., 2016; Parsell, et al., 2017; Zaretzky et al., 2017; Vallesi et al., 2020).

In this section, we examine self-reported use of these healthcare services from respondents to the VI-SPDAT surveys (question on healthcare utilisation were not included the VI Survey). In the VI-SPDAT surveys, respondents were asked:

1. In the last six months, how many times have you been to Accidents and Emergencies at the hospital?
2. In the last six months, how many times have you been taken to the hospital in an ambulance?
3. In the last six months, how many times have you been hospitalised as an in-patient, including hospitalisations in a mental health hospital?

The average per person use of these services and estimated associated costs in the six months prior to being surveyed was calculated. Using publicly available health cost data reviewed by the Independent National Pricing Authority (Health Policy Analysis, 2017) and the Steering Committee for the Review of Government Service Provision's (SCRGSP) on Government Services (SCRGSP, 2021), average usage was translated into a financial cost per person for the use of A&E, ambulance and being hospitalised as an inpatient.

The majority of respondents (53.4%) reported that they had used A&E in the six months prior to the survey (Table 33). Reported use was lower for ambulance use (39.1%) and being admitted as an inpatient in hospital (40.3%). However, usage was significantly higher than the general population across all three services (Zaretzky et al., 2013).

The majority of respondents accessed healthcare services five or less times in the six months prior to being surveyed (see Figure 27, Figure 29, Figure 31). Usage patterns were similar for people sleeping rough and those who were not across all three services (see Figure 28, Figure 30, Figure 32). However, a greater proportion of non-rough sleeping respondents reported zero use or very low use compared with rough sleeping respondents. While existing studies using linked administrative data on the costs of homelessness shows strong correlation with self-report-based results (Clifasefi et al., 2011; Metraux et al., 2014; Wood et al., 2016; Parsell et al., 2017), there is clearly some degree of approximation associated with self-report data as evident in slight increases in people reporting healthcare observed at particular points across all services (10, 15, 20 and 30 visits). This may be a result of people's preference for round numbers when asked open-ended questions. Future survey tool development may consider providing people frequency categories to choose from to reduce this affect.

In general, people sleeping rough accessed services at higher rates than people not sleeping rough. Therefore, distinguishing frequent service users and rough sleepers may be advantageous in identifying and prioritising homelessness strategies that aim to improve people's health outcomes, to ensure those that are most at need are identified.

9.1.1 Accidents and emergency department use

A&E utilisation was the most frequently used healthcare service with the average number of visits in the last six months (including zero visits) being 1.93 (see Table 33, Figure 27). However, 46.6% of all respondents reported that they had not visited A&E in the last six months. Among those who have used the service in the last six months, the average number of visits (the conditional mean) to A&E almost doubles, to 3.61. One indicator of risk or vulnerability is the number of visits to A&E with one indicator used if they have had three or more visits to A&E in the last six months. Among the National Advance to Zero respondents, 21.6% reported three or more visits to A&E. Twenty-seven per cent of those sleeping rough reported three or more visits to A&E compared to 19.1% of non-rough sleeping people experiencing homelessness (19.1%)(Figure 28).

Table 33 – Hospital accident and emergency department visits over the last six months

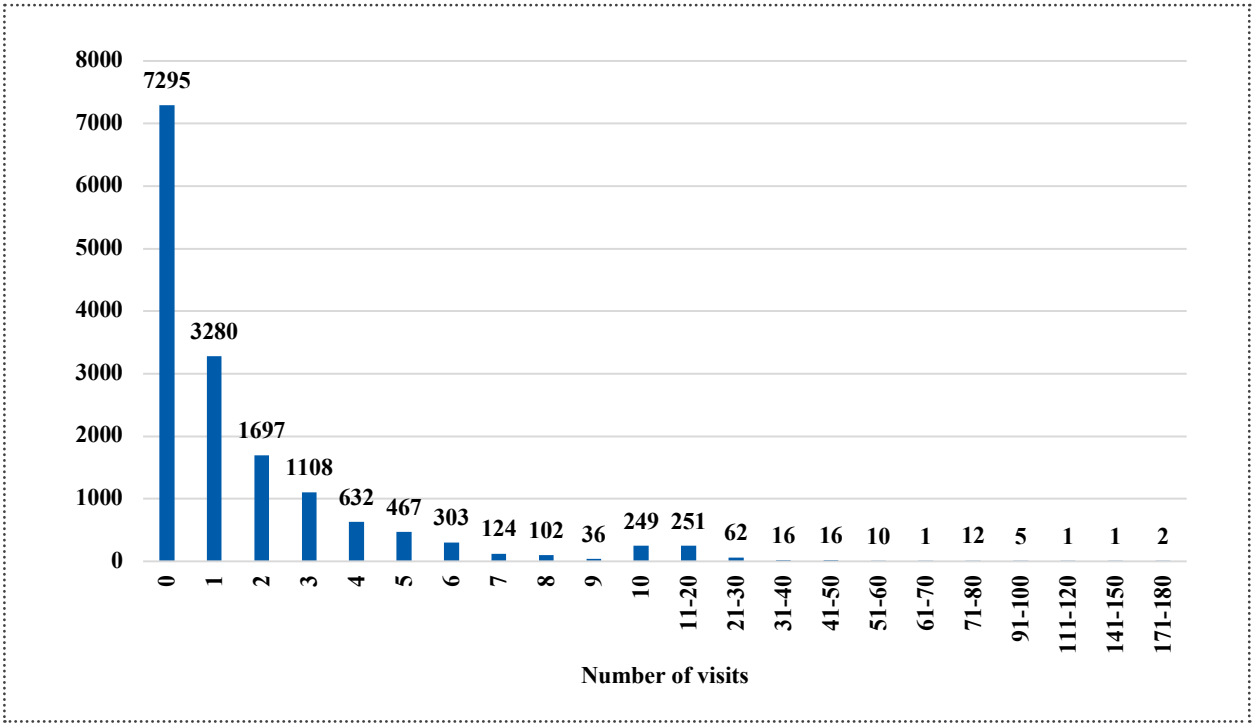
	Frequency	*Per cent*	*Cumulative per cent*
0	7,295	46.6	46.6
1–10	7,998	51.1	97.7
11–20	251	1.6	99.3
21–30	62	0.4	99.6
31–40	16	0.1	99.8
41–50	16	0.1	99.9
51–60	10	0.1	99.9
61–70	< 5	0.0	99.9
71 and over	12	0.1	99.9
Total	15,661	100.0	

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

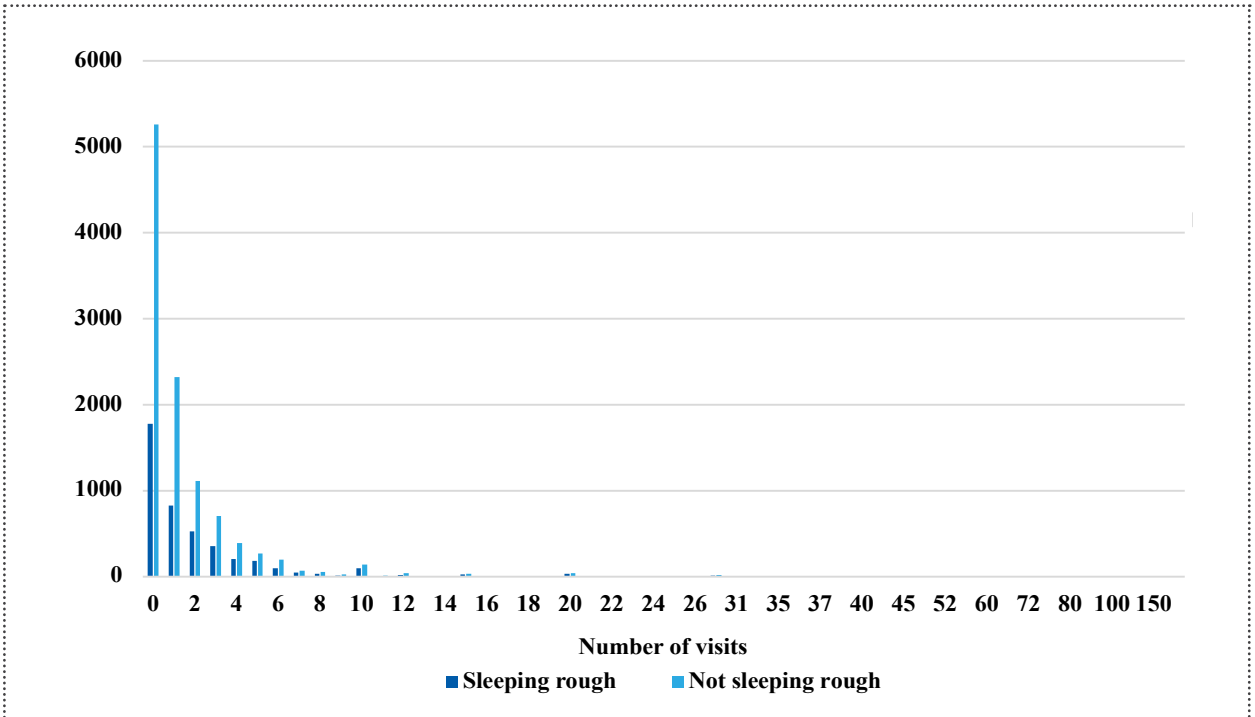
[2] Health service utilisation questions were not included in the Australia VI survey.

Figure 27 – Hospital accident and emergency department visits over the last six months



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Figure 28 – Hospital accident and emergency department visits over the last six months, by rough sleeping status



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

9.1.2 Hospitalisation as an inpatient use

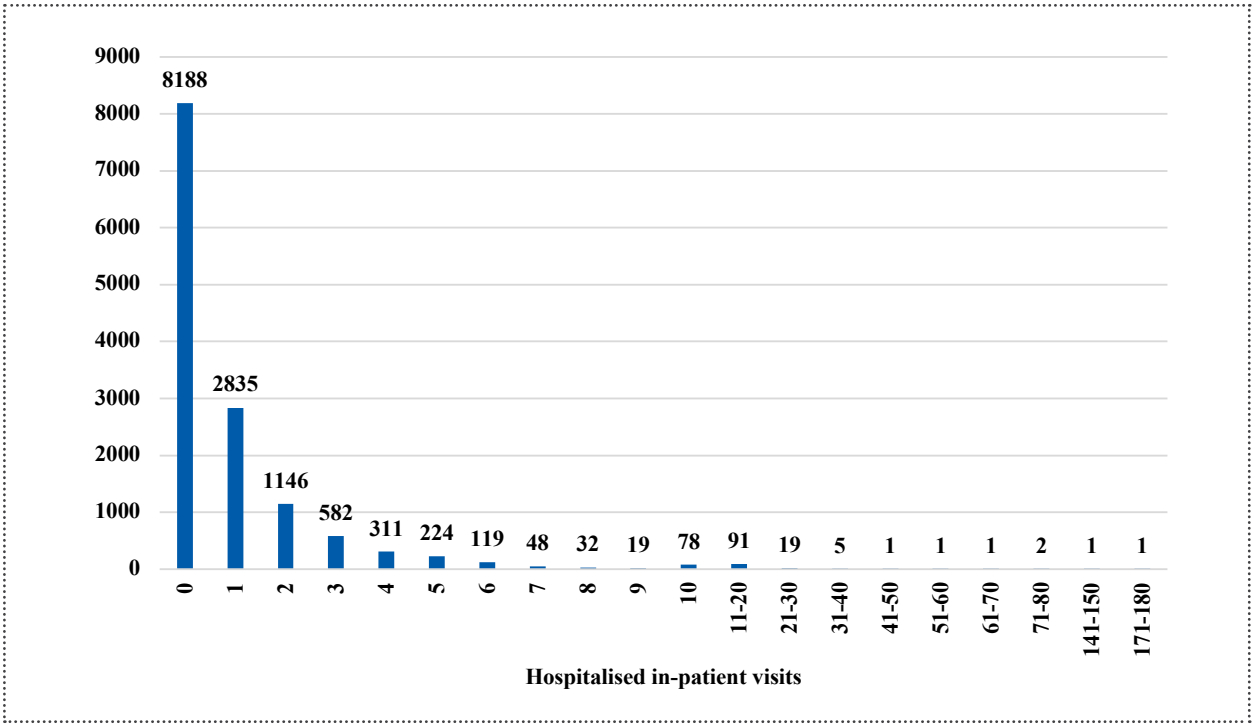
As evident in Table 34 and Figure 29, a majority of National Advance to Zero respondents (59.7%) did not report being an inpatient in a hospital over the last six months. The equates to level of hospital inpatient use being 1.04 hospitalisations as an inpatient in the last six months across all respondents, including those with zero hospital inpatient use (see Table 36). If we exclude those who were not hospitalised as an inpatient in the prior six-month period, the average jumps to 2.59 incidents. Those who reported sleeping rough most of the time had a higher average number of incidents than those who were not frequently sleeping rough (1.47 and 0.93, respectively)(Figure 30). A relatively small number of respondents report three or more inpatient hospital episodes in the last six months with a higher proportion of rough sleepers reporting three or more episodes of inpatient hospital use (15.7% of all rough sleepers) as compared with non-rough sleepers (9.7%).

Table 34 – Number of times hospitalised as an inpatient (including mental health hospitalisations) over the last six months

	Frequency	*Per cent*	*Cumulative per cent*
0	8,188	59.7	59.7
1–10	5,394	39.4	99.1
11–20	91	0.7	99.8
21–30	19	0.1	99.9
31–40	5	0	99.9
41–50	< 5	0	100.0
51–60	< 5	0	100.0
61–70	< 5	0	100.0
71 and over	< 5	0	100.0
Total	13,704	100.0	

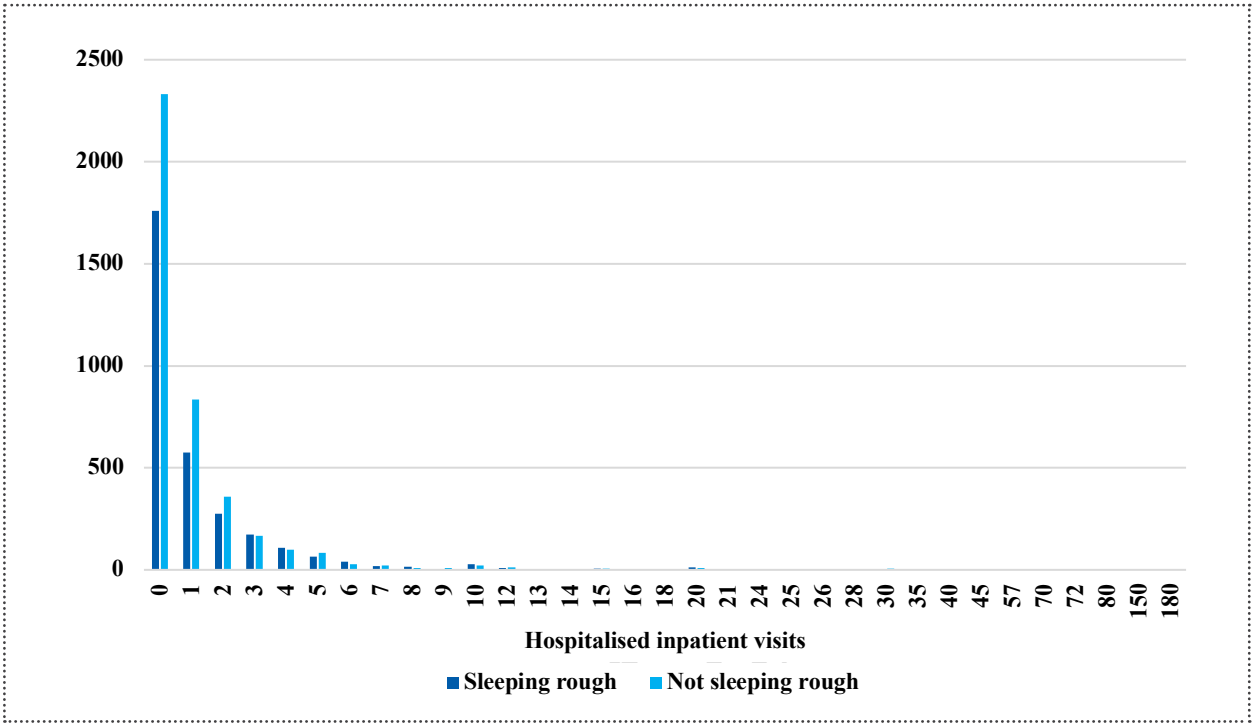
Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] Health service utilisation questions were not included in the Australia VI survey.

Figure 29 – Number of times hospitalised as an inpatient (including mental health hospitalisations) over the last six months



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Figure 30 – Number of times hospitalised as an inpatient (including mental health hospitalisations) over the last six months, by rough sleeping status



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

9.1.3 Ambulance use

Ambulance use was the second most frequently used healthcare service (out of A&E visits, ambulance and inpatient use). Across all respondents, 60.9% reported not using an ambulance to be taken to hospital. Including those with no ambulance-use, the mean number of times of being taken to hospital in an ambulance was 1.13 times in the last six months (Table 35, Figure 31). If only those who did use an ambulance in the six month period are considered, the average jumps to 2.90 incidents. Those reported sleeping rough most of the time had a higher average number of incidents than those who were not frequently sleeping rough (1.67 and 0.95, respectively). Consistent with A&E and hospital in-patient use, a relatively small number of respondents report three or more ambulance-to-hospital episodes in the last six months with a higher proportion of rough sleepers reporting three or more episodes of ambulance use (15.6% of all rough sleepers) as compared with non-rough sleepers 10.4%)(Figure 32).

Table 35 – Number of times taken to the hospital in an ambulance over the last six months

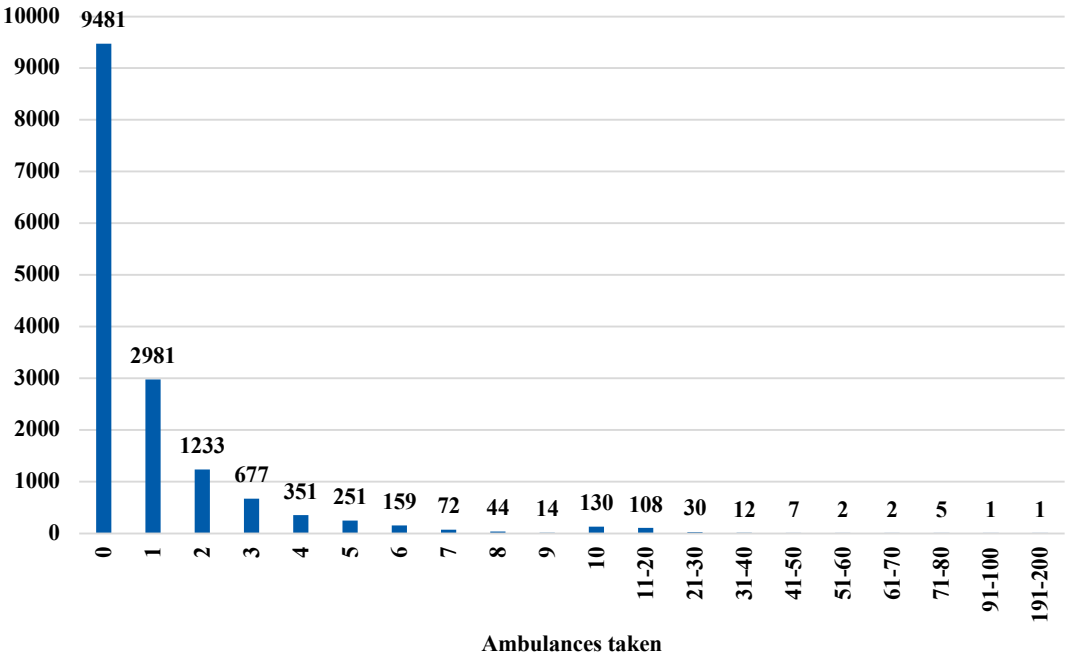
	Frequency	*Per cent*	*Cumulative per cent*
0	9,481	60.9	60.9
1-10	5,912	38.0	98.9
11-20	108	0.7	99.6
21-30	30	0.2	99.8
31-40	12	0.1	99.9
41-50	7	0	99.9
51-60	<5	0	99.9
61-70	<5	0	100.0
71 and over	7	0	100.0
Total	15,561	100.0	

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

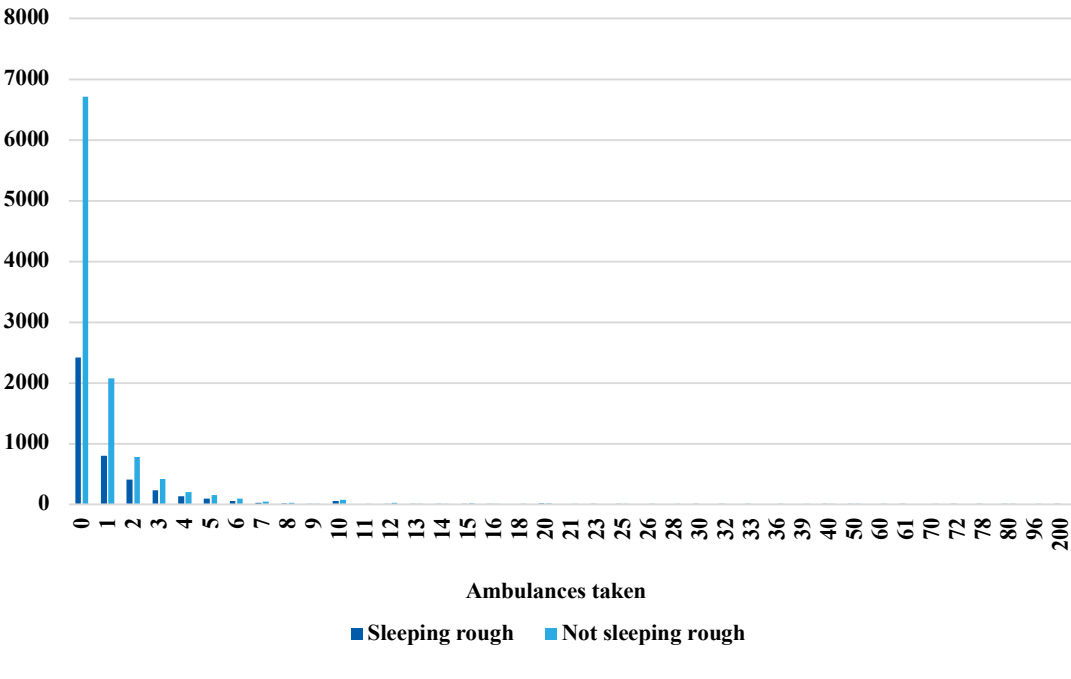
[2] Health service utilisation questions were not included in the Australia VI survey.

Figure 31 – Number of times taken to the hospital in an ambulance over the last six months



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Figure 32 – Number of times taken to the hospital in an ambulance over the last six months, by rough sleeping status



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

9.2 Estimated hospital and ambulance costs

The cost of providing healthcare support depends on the type of support provided (e.g., ambulance, inpatient hospital or A&E presentation), the frequency of incidents of support, the complexity of the condition in question and the care provided, the 'prices' of resources used, and the duration of support. Questions on healthcare utilisation were included in the VI-SPDAT surveys but not the original VI surveys. However, the questions address only the type and frequency of healthcare (on a self-report basis), but not the complexity of the episode of care nor its duration.

These limitations have their greatest impact in the case of inpatient hospital use where the duration of care in particular is critical in the calculation of healthcare costs. To partially overcome these limitations, we use publicly available average cost per incident figures for hospitals and for A&E and ambulance use. These figures reflect average time spent in hospital, hospital type and the case-mix of support. However, if those experiencing homelessness are admitted to hospital for more (or less) nights than the average length of stay, or require more (or less) resources for each day in hospital than others, then the use of average cost per incident figures will be distortionary.

Our approach, given the data limitations we face, is to use Independent Hospital Pricing Authority reviewed hospital cost data (Health Policy Analysis, 2017) and the SCRGSP Report on Government Services (SCRGSP, 2021) indicative cost estimates for an A&E service incident, an ambulance service incident and an in-patient hospital incident. For the purposes of our analysis, the average cost per incident (in 2018–2019 prices) was estimated at $559 for A&E, $1,005 for ambulance, and $4,864 for inpatient hospital admissions (the latter estimate taking into account average length of stay and hospital type). Estimates of cost differ by jurisdiction but we do not account for this in our estimates below and apply national estimates across the board.

In Table 36 we multiply average utilisation by average cost of incident estimates to arrive at estimates of costs per person over six months for all respondents. As evident from our findings on the utilisation of healthcare facilities, the sample of respondents is roughly evenly divided between those with zero occurrences and those with non-zero occurrences over the last six months. Our results are broken down by incident type and whether or not respondents are rough sleeping. For each of the service types examined, the mean costs (over a six-month period) for all respondents are:

- Ambulance: $1,136 per person/six months
- A&E: $1,079 per person/six months
- Inpatient hospital: $5,059 per person/six months
- Total: $7,273 per person/six months (or $14,546 over a 12 month period if the six month result is simply multiple by two).

As noted in the previous section, healthcare use was not evenly distributed across the National Advance to Zero population with people sleeping rough reporting higher use than non-rough sleepers, and others reporting that they did not use a particular healthcare services at all. When we only consider those who did use a particular type of healthcare services to calculate the mean costs for that type of service, mean costs not surprisingly rose. For each of the service types examined, the mean costs (over a six-month period) for those who had one or more incidents in each service type are (Table 37):

- Ambulance: $2,915, per person/six months
- A&E: $2,018 per person/six months
- Inpatient hospital: $11,139 per person/six months.
- Total: $16,071 per person/six months for those who had at least one incident in each service type.

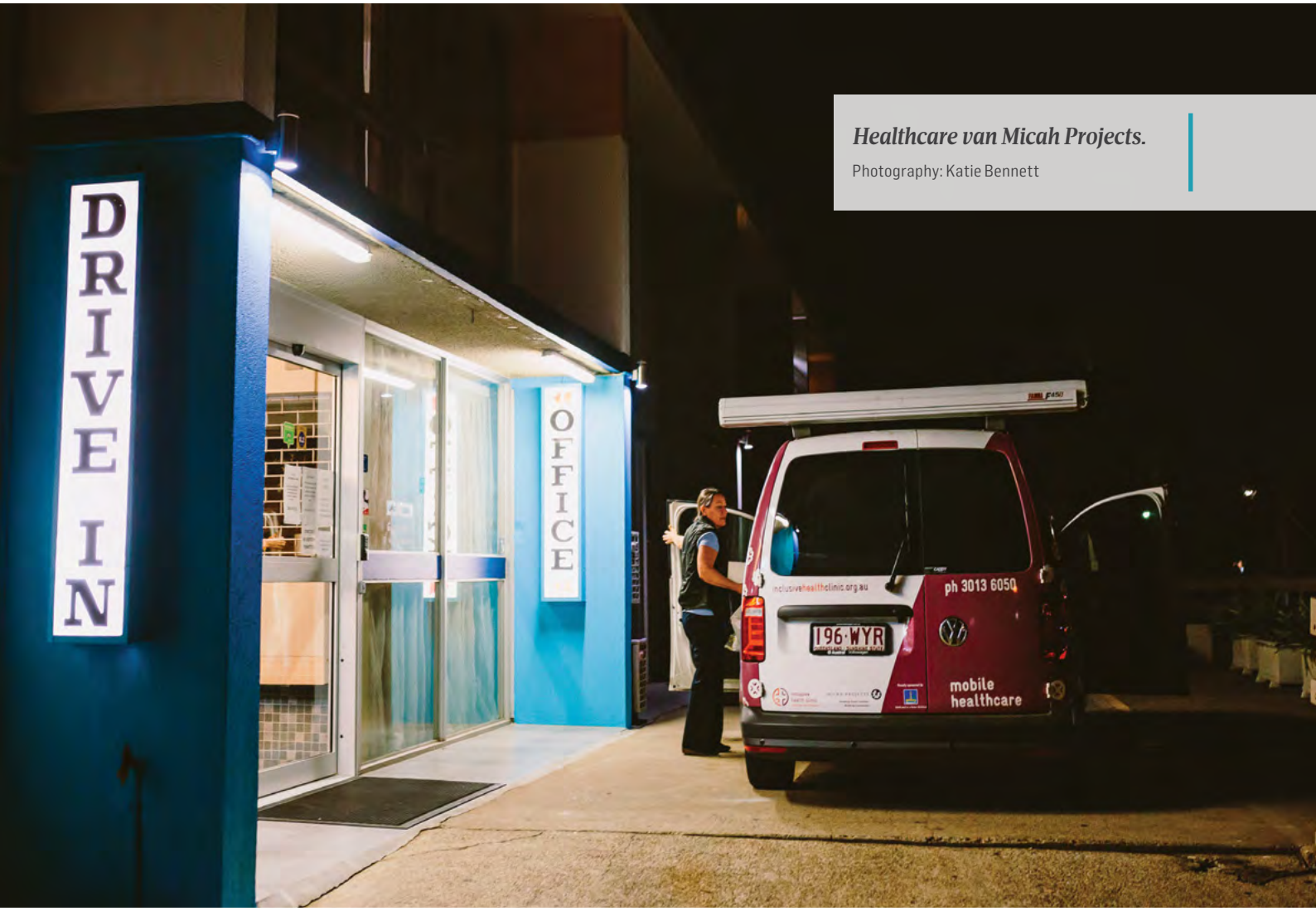
As is evident in the above estimates, taking out those who did not access a particular type of healthcare services results in a more than doubling of healthcare costs. Across a twelve month period mean total health costs are as high as $32,000 for this group.

Among rough sleepers in this group of healthcare users (i.e., those with more than one healthcare occurrence in the specified category), the mean cost for each service type are:

- Ambulance: $3,357 per person/six months
- A&E: $2,432 per person/six months
- Inpatient hospital: $15,370 per person/six months.

These findings are in line with previous studies showing that a small number of people experiencing homelessness, particularly those sleeping rough, incur much higher healthcare costs than the majority of the homeless population (Hwang et al., 2011; Fuehrlein et al., 2014; Zaretzky et al., 2017).

These estimates reveal that the financial impact of homelessness on the Australian healthcare system is very high. The full healthcare cost of homelessness is considerably higher still given that the National Advance to Zero collections are focused on the inner-city regions of Australia's capital cities and do not include all healthcare services accessed by respondents.



Healthcare van Micah Projects.
Photography: Katie Bennett

Table 36 – Health service utilisation and estimated costs for all respondents (include those not utilising services) 6 months prior to the survey

	Ambulance (Cost per incident: $1005)		*Accidents and emergencies (Cost per incident: $559)*		*In-patient (Cost per incident: $4,864)*		*Total*
	Mean number of service uses	*Mean cost/person*	*Mean number of service uses*	*Mean cost/person*	*Mean number of service uses*	*Mean cost/person*	*Mean cost/person*
Sleeping rough	1.46	$1,467	2.56	$1,431	1.37	$6,664	$9,562
Not sleeping rough	0.99	$995	1.64	$917	0.93	$4,524	$6,435
Other	1.60	$1,608	2.90	$1,621	1.23	$5,983	$9,212
Missing	0.96	$965	1.64	$917	0.71	$3,453	$5,335
Total	1.13	$1,136	1.93	$1,079	1.04	$5,059	$7,273

Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Health service utilisation was not included in the Australia VI survey.

[3] In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

Table 37 – Health service utilisation and estimated costs for those who utilised health services 6 months prior to the survey

	Ambulance (Cost per incident: $1,005)			Accidents and emergencies (Cost per incident: $559)			In-patient (Cost per incident: $4,864)		
	Number of people utilising service	Mean number of service uses	Mean cost/person	Number of people utilising service	Mean number of service uses	Mean cost/person	Number of people utilising service	Mean number of service uses	Mean cost/person
Sleeping rough	1,870	3.34	$3,357	2,536	4.35	$2,432	1,423	3.16	$15,370
Not sleeping rough	3,974	2.65	$2,663	5,483	3.22	$1,800	3,862	2.38	$11,576
Other	184	3.71	$3,729	266	4.76	$2,661	187	2.65	$12,890
Missing	52	3.06	$3,075	81	3.40	$1,901	44	2.25	$10,944
Total	6,080	2.90	$2,915	8,366	3.61	$2,018	5,516	2.59	$11,139

Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Health service utilisation was not included in the Australia VI survey.

[3] In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

10 JUSTICE OUTCOMES

The relationship between homelessness and the justice system is complex and intertwined. In Australia, the homeless population are one of the most criminalised groups and, despite committing generally minor offences, are much more likely to be imprisoned (Walsh, 2003). The prevalence of mental illness amongst the homeless population is a compounding factor that increases the likelihood of interaction with the justice system, and particularly incarceration. Sometimes, the pathway is unfortunately more direct than this, in the United Kingdom, the HM Inspectorate of Probation found that, in 2018–19, 19 per cent of women and 16% of men were released from prison, directly into homelessness (Dearden, 2020).

Individuals experiencing mental ill health are more likely to live in conditions that present a greater risk of arrest; such as living with increasing financial stress, experiencing complex and potentially abusive relationships, and facing limited ability or perceived ability to access supports needed to address their mental health. Individuals are also more likely to 'self-medicate' with drugs and alcohol, which in turn often leads to erratic or threatening behaviour that results in arrest and/or imprisonment (Belcher, 1988; Scheid & Brown, 2010). In addition, individuals with a history of homelessness and individuals with conditions or circumstances that are correlated with homelessness, such as trauma, mental illness, defence force service, and chronic health conditions are also significantly more likely to be homeless upon release from prison (Goodman et al., 2000; Hartwell, 2004; Constantine et al., 2010). This creates a revolving door between homelessness and prison.

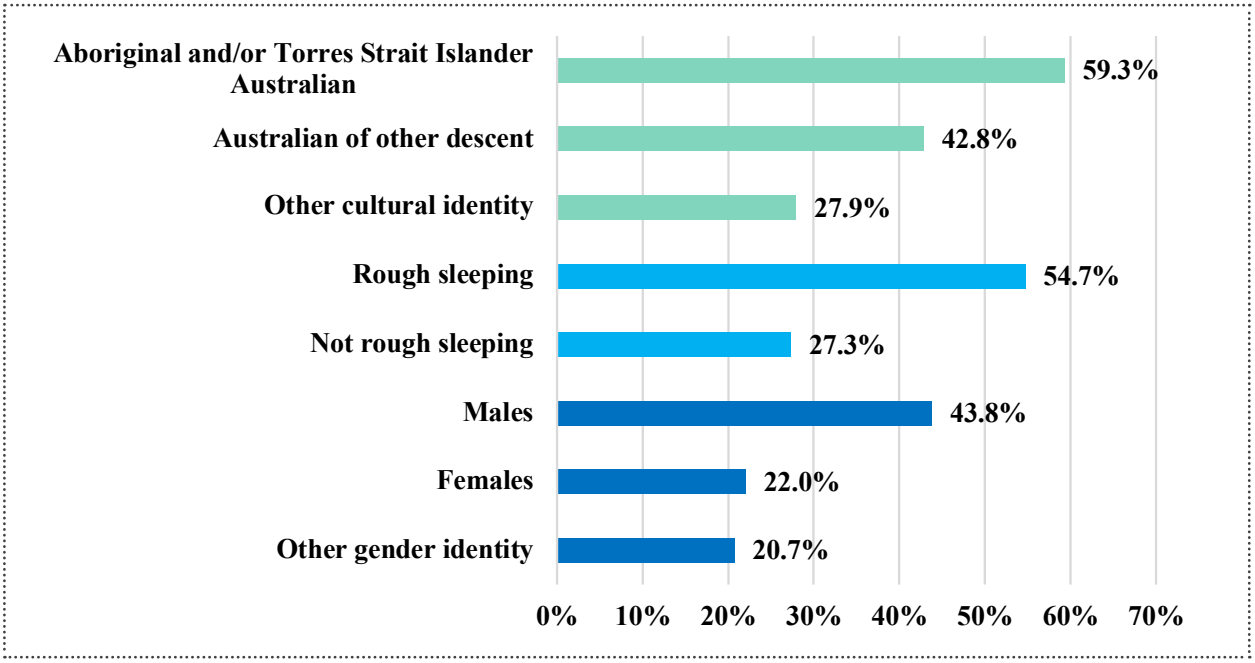
The National Advance to Zero data examines individuals' lifetime experiences of justice system interaction as well as current and recent risk factors for interaction with the justice system as both victim and perpetrator of criminal offences. This chapter presents the results from these questions, breaking down justice system interactions and risks by selected demographic characteristics, relating the findings to extant research.

10.1 Lifetime and current justice interactions

The VI and the Family and Individual VI-SPDAT v1 surveys asked a question relating to incarceration. Figure 33, below, outlines the proportion of respondents reporting that they had been in prison at some point in their life, by Aboriginal and/or Torres Strait Islander identity, gender, and rough sleeping status. Overall, 36.1% of National Advance to Zero respondents reported that they had ever been in prison. A higher proportion of respondents that identified as Aboriginal and/or Torres Strait Islander spent time in prison compared to other respondents (59.3% of Aboriginal and Torres Strait Islander respondents versus 42.8% of Australians of other descent and 27.9% for those that identified with another cultural identity); twice the proportion of males as females reported having ever been in prison (43.8% versus 22.0%); and 54.7% of those sleeping rough versus 27.3% of those not sleeping rough had experiences of imprisonment at some point in their life.

The higher incidence of lifetime experience of imprisonment amongst rough sleepers speaks to the aforementioned revolving door between the streets and prison. Rough sleepers are more likely to be 'moved on' by police; live in conditions that are not legal (e.g., squats); have co-occurring circumstances that increase risk of justice system interaction (e.g., mental health conditions); and have experienced trauma. Additionally, they are less likely to have safe and stable accommodation to live in upon release from imprisonment.

Figure 33 – Lifetime prevalence of incarceration (Have you ever been in prison?)



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Question relating to prison only asked in the VI, Family and Individual VI-SPDAT v1.

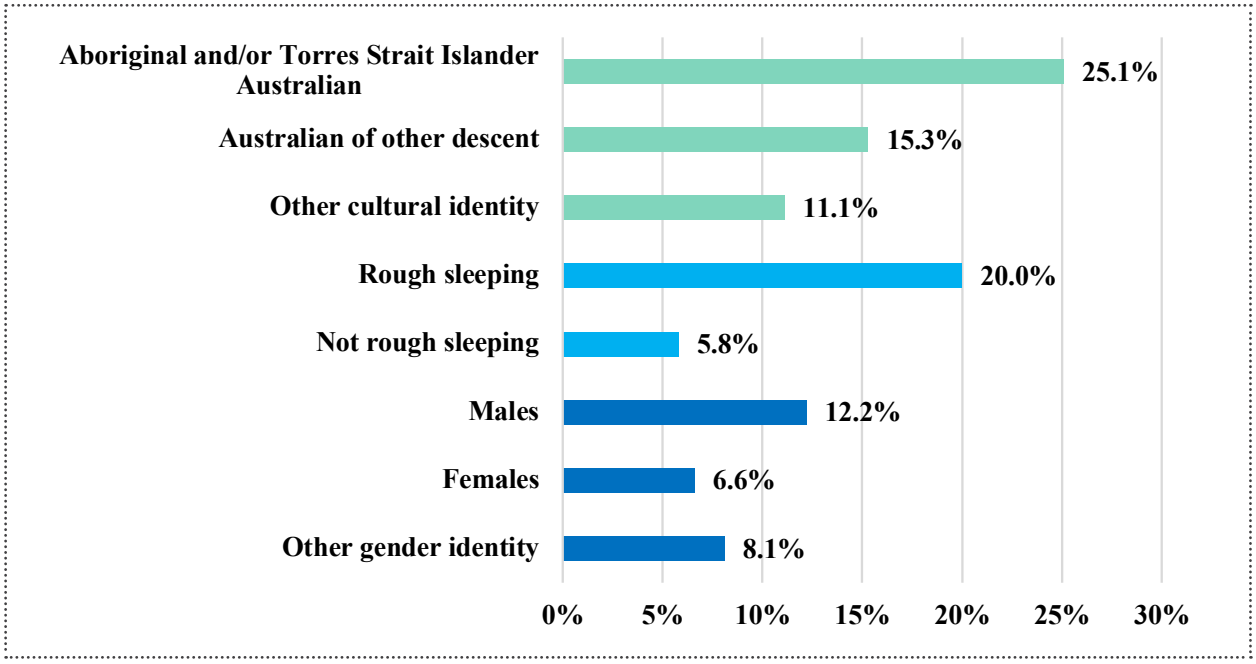
People experiencing homelessness have pointed out several reasons why offending, and reoffending may be a protective behaviour. People sometimes report committing smaller crimes with the intention of being caught and locked up. This could be due to multiple reasons, for example, not being able to obtain a rental property due to a lack of rental history or a history of offending (Smith, 2017). Further reports include being released with the only option of returning to unsafe homes or being homeless, and/or lacking knowledge around how to navigate systems outside of the prison system, so the preference is to return to what they know, and are comfortable within (Dearden, 2020). The higher proportion of Aboriginal and Torres Strait Islander National Advance to Zero respondents reporting experiences of imprisonment is in line with national statistics. Despite representing 3.3% of the overall Australian population (ABS, 2020c), Aboriginal and Torres Strait Islander individuals represent 29% of the Australian prison population (ABS, 2020c). Stated alternatively, Aboriginal and Torres Strait Islander Australians are nine times more likely to be imprisoned when compared with the overall Australian population. Therefore, it is unsurprising, though deeply disturbing, that Aboriginal and Torres Strait Islander identity and homelessness result in a higher rate of lifetime experience of imprisonment.

While the proportion of female National Advance to Zero respondents reporting lifetime experience of imprisonment is half that of male respondents, it is substantially higher than the proportion of female prisoners in Australia. For example, in 2017, only 8% of prisoners in Australia were female.

The National Advance to Zero data on lifetime experiences of youth detention follow a similar pattern to lifetime prison experiences in terms of the relationship between demographic characteristics and incarceration experiences. The proportion (25.1%) of National Advance to Zero respondents that identified as Aboriginal and Torres Strait Islander Australians and had been in youth detention at some point in their lives was greater than other respondents (15.3%)(Figure 34). Just over one in ten (12.2%) male National Advance to Zero respondents had been in youth detention, compared with 6.6% of female respondents. The proportion of rough sleepers that had been in youth detention in their lives was almost four times that of non-rough sleepers (20.0% versus 5.8%).

The national youth detention population in Australia is 91% male and 48% Aboriginal and Torres Strait Islander (AIHW, 2021a, 2021b). On any given night, 2.6 per 10,000 young people are detained in youth detention. Aboriginal and Torres Strait Islander young people are, on average, 17 times more likely to be detained as their non-Aboriginal counterparts (AIHW, 2021a, 2021b). Again, direct comparison between Australian population figures and the National Advance to Zero respondents is not possible. However, a significantly higher proportion of the National Advance to Zero respondents across all demographic variables report experiences of youth detention than indicated in the population figures. When paired with the lifetime prevalence of adult imprisonment, the data suggest that, amongst many people experiencing homelessness, interaction with the justice system starts early in life and is a continual thread. Further, being Aboriginal and Torres Strait Islander, male and/or a rough sleeper substantially correlates with one's likelihood of youth detention and adult imprisonment.

Figure 34 – Lifetime prevalence of juvenile detention (Have you ever been in youth detention?)



Source: National Advance to Zero 2010–2020.
Notes: [1] Question not asked in the Australia VI, Youth VI-SPDAT v2, or General VI-SPDAT surveys.

Further breaking down respondents' lifetime experiences of imprisonment and youth detention by the place they sleep most frequently, a greater proportion of those that are in institutional accommodation have been in prison at some time in the past (64.1%), followed by those that are sleeping rough (56.0%), then by those reporting that they are in an 'other' type of accommodation (39.2%; Table 38). A smaller proportion of those that were in 'other homeless' accommodation (including crisis and emergency accommodation, temporary accommodation, and short-term accommodation, 28.5%) and permanently housed (13.4%) had been in prison. However, the rates of imprisonment for all accommodation types of significantly higher than overall Australian rates. The rates for youth detention follow a similar pattern: a higher proportion of those in institutional accommodation had been in youth detention (23.6%), followed by rough sleepers at 23.5%; 14.3% of those that reported sleeping most frequently in 'other homeless' accommodation had been in youth detention, followed by around one in ten (12.2%) of those in both rough sleeping and not rough sleeping circumstances, and 9.8% of those that were permanently housed.

The exact nature of the relationship between sleeping circumstances (i.e., dwelling and tenure type) and experiences of imprisonment and juvenile detention cannot be determined (e.g., whether a history of imprisonment prevents the attainment of permanent housing or permanent housing prevents imprisonment). However, the data indicates that rough sleeping is significantly correlated with interactions with the justice system and extant research on homelessness and justice suggests a vicious cycle. Those that are rough sleeping are inherently more likely to engage in survival behaviour that leads to justice system interaction (e.g., squatting or trespassing); are more likely to have conditions such as mental health, trauma and chronic health problems that manifest in threatening behaviour that result in arrest and/or imprisonment; and are more likely to exit from prison back onto the streets (Goodman et al., 2000; Hartwell, 2004; Constantine et al., 2010; Leasure & Martin, 2017; Martin, 2017; Schneider, 2018; Madoc-Jones et al., 2018). In the 50 Lives 50 Homes Housing First program, it was found that the majority of offending behaviour was due to "low-harm" crime, including drug possession, stealing, and loitering, and that a lot of police contact was in fact due to them being the victim of crime rather than the perpetrator (Vallesi et al., 2020).

Finally, prior imprisonment also presents a barrier to economic participation (a criminal record makes it difficult to gain employment) and also predicts further criminal offending, two factors which present more barriers to exiting homelessness (Selbin et al., 2018; Pager, 2003; Kurlychek et al., 2006).

Table 38 – Prevalence of lifetime prison and juvenile detention by homeless categories

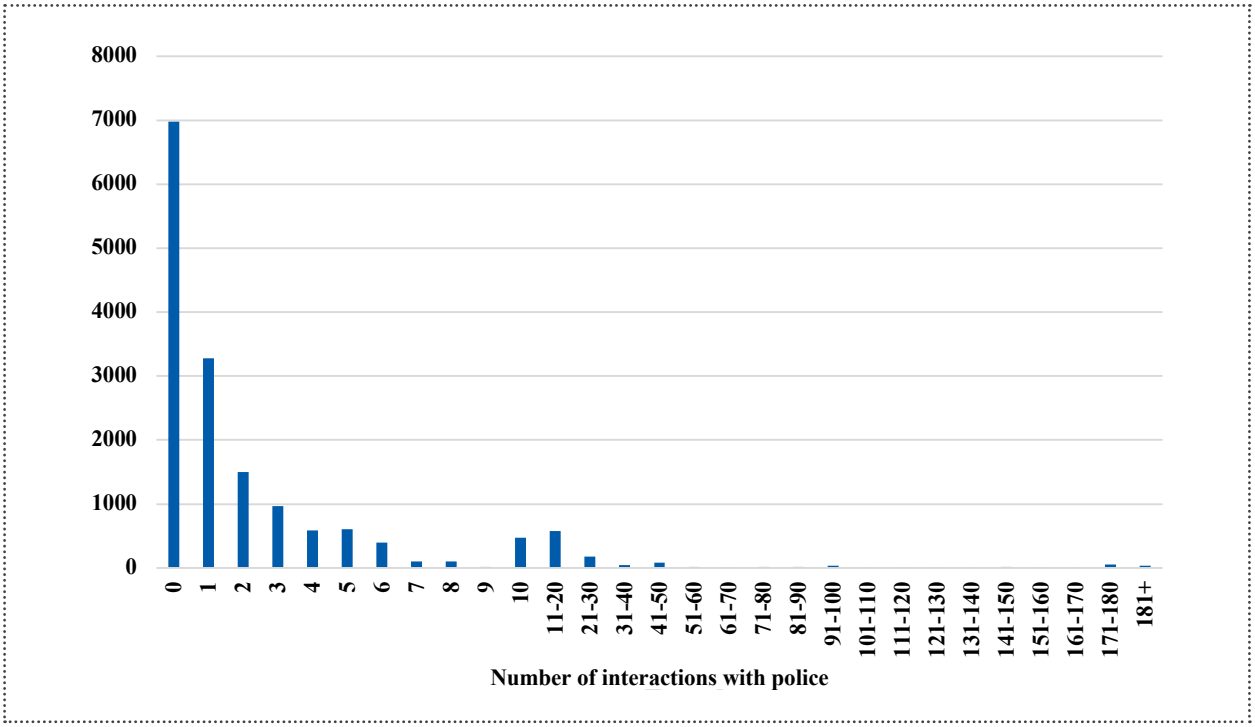
	Have you ever been in prison?		*Have you ever been in youth detention?*	
	Number	*Per cent*	*Number*	*Per cent*
Sleeping rough				
Yes	2,525	56.0	925	23.5
No	1,983	44.0	3,016	76.5
Other homeless (includes crisis and emergency accommodation, temporary accommodation, short-term accommodation)				
Yes	2,345	28.5	553	14.3
No	5,888	71.5	3,331	85.7
Other homeless categories				
Yes	282	39.2	35	12.2
No	437	60.8	252	87.8
Institutional accommodation				
Yes	141	64.1	51	23.6
No	79	35.9	165	76.4
Permanently housed				
Yes	151	13.4	16	9.8
No	973	86.6	147	90.2
ALL RESPONDENTS	14,804		8,471	

Source: National Advance to Zero 2010–2020

Notes: [1] Estimates based on unique respondents (excluding missing values).

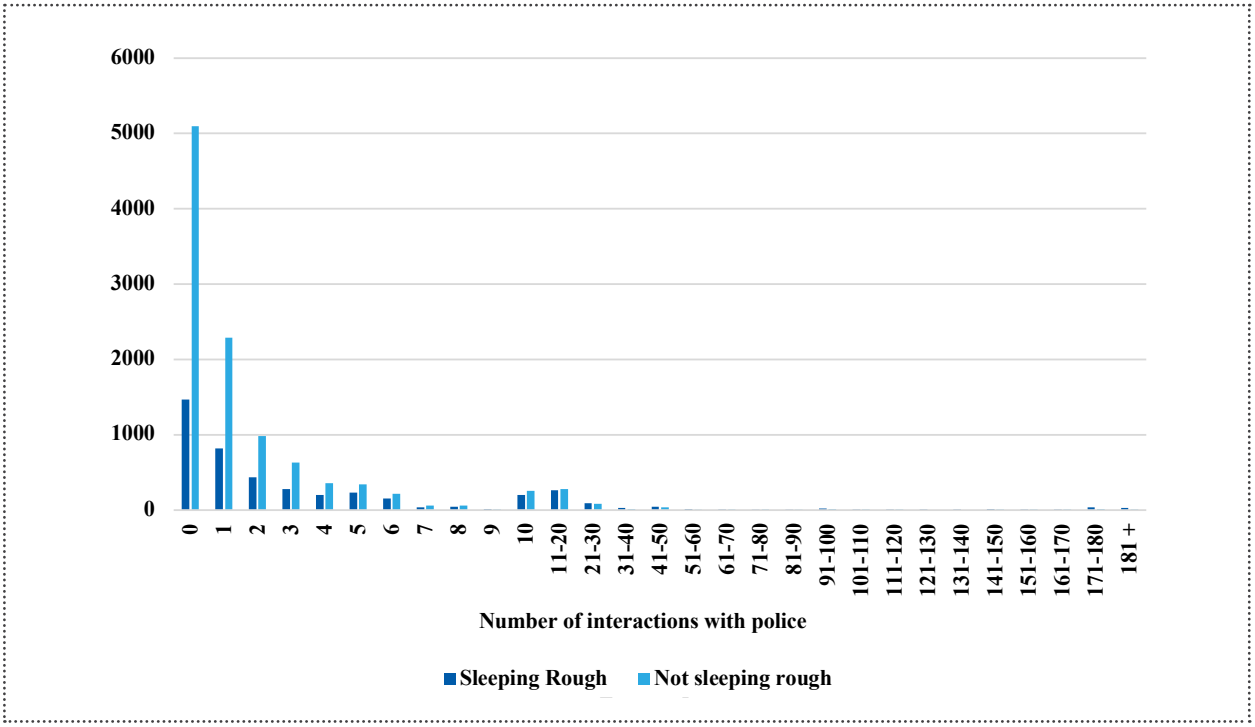
Figure 35, below, illustrates the frequency of National Advance to Zero respondents' interactions with police over the six months prior to the survey. Over two in five respondents that answered this question (43.3%) reported that they had not interacted with the police in the prior six months. A further 20.3% had interacted with the police only once in the previous six months. The majority (82.5%) of respondents had interacted with the police four or less times. However, 91 respondents reported daily or more frequent interactions with the police. On average rough sleepers reported 9.0 interactions with police in the last six months compared to 3.0 interactions for non-rough sleepers (Figure 36).

Figure 35 – Interactions with the police over the last six months (number of times)



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] Question not included in the Australia VI survey.

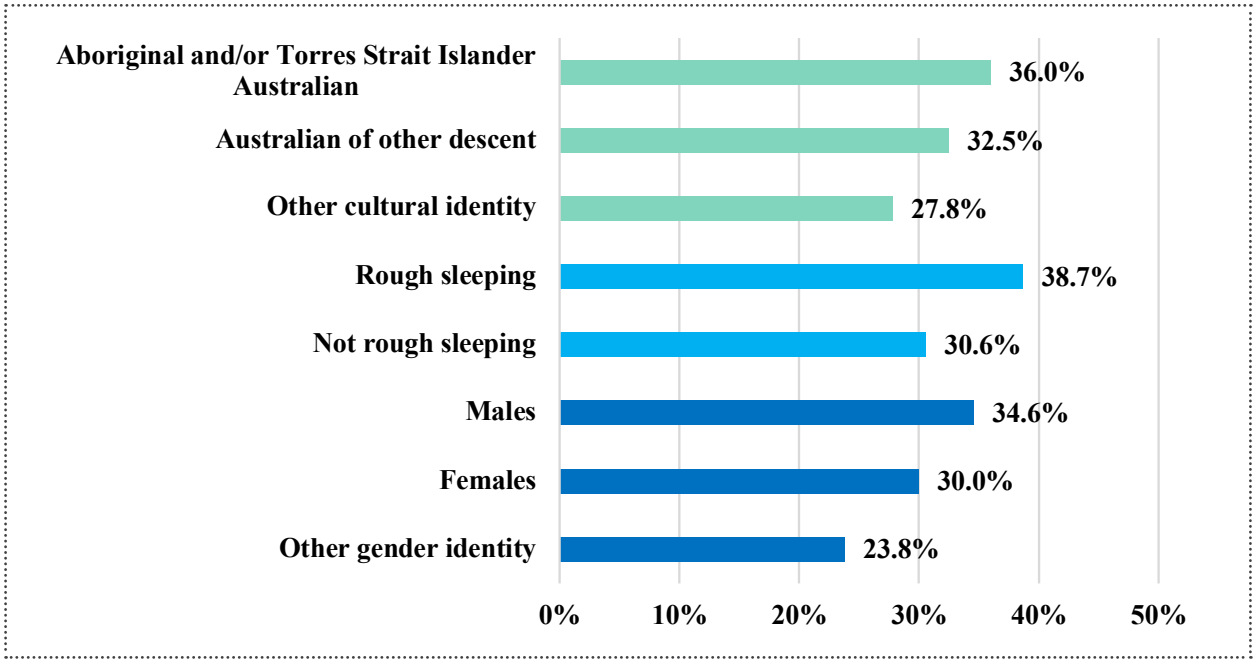
Figure 36 – Interactions with the police over the last six months (number of times), by rough sleeping status



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

National Advance to Zero respondents are asked "Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?". Overall, 32.6% of respondents that answered this question responded affirmatively. Breaking this down by demographic characteristics, 36.6% of those that identified as Aboriginal and Torres Strait Islander Australians reported that they had legal stuff going on at the time of survey, compared with 32.5% of Australians of other descent; 34.6% of males and 30.0% of females; and 38.7% of rough sleepers compared with 30.6% of non-rough sleepers (Figure 37). The potential breadth of these legal issues must be acknowledged; it could encompass family law court issues, criminal offences against property, civil claims, or violent offences. Extant research on people experiencing homelessness's interactions the justice system finds that the majority of offences committed by people experiencing homelessness are minor or petty crimes such as shoplifting or property damage, and further, that many of these offences can be categorised as 'survival behaviours' (Martin, 2017; Vallesi et al., 2020; Kyprianides et al., 2021).

Figure 37 – Serious legal issues facing respondents ("Any legal stuff going on right now that may result in you being locked up or having to pay fines?"), per cent



Source: National Advance to Zero 2014–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Questions were included in the Australia VI-SPDAT, Australia F-SPDAT and Australia VI surveys but not in the Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.

Further breaking down experiences of legal issues by homelessness categories (Table 39), a greater proportion of those who reported that they slept most frequently in institutional accommodation reported current legal issues, with 42.2% of this cohort responding affirmatively. This is relatively unsurprising because institutional accommodation includes prison and watch houses. Over a third (40.7%) of rough sleepers reported current legal issues. Finally, a little over one quarter of the permanently housed (27.3%) reported that they had current legal stuff going on.

Overall, National Advance to Zero respondents who were Aboriginal and/or Torres Strait Islander, male, and/or sleeping rough had higher rates of historical and current interactions with the justice system. Similar trends are evident in national imprisonment rates, where 92% of current inmates are male and 29.4% are Aboriginal and Torres Strait Islander while Aboriginal and Torres Strait Islander Australians comprise 3.1% of the country's population (ABS, 2020c; AIHW, 2019c). Rough sleepers are simply more likely to interact with the police because they are literally on the street and therefore more likely to come in contact with police patrols. However, irrespective of demographic characteristics, the National Advance to Zero data indicate that homeless individuals have substantially higher rates of historical and current interactions with the justice system than their housed counterparts. This has significant implications for policy and practice, which are discussed at the end of this report.

Table 39 – Current legal issues by homelessness categories

	Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	
	Number	*Per cent*
Sleeping rough		
Yes	1,791	40.7
No	2,611	59.3
Other homeless (includes crisis and emergency accommodation, temporary accommodation, short-term accommodation)		
Yes	2,900	31.3
No	6,357	68.7
Other homeless categories		
Yes	156	39.2
No	242	60.8
Institutional accommodation		
Yes	122	42.2
No	167	57.8
Permanently housed		
Yes	353	27.3
No	938	72.7
Total	15,637	

Source: National Advance to Zero 2010–2020.

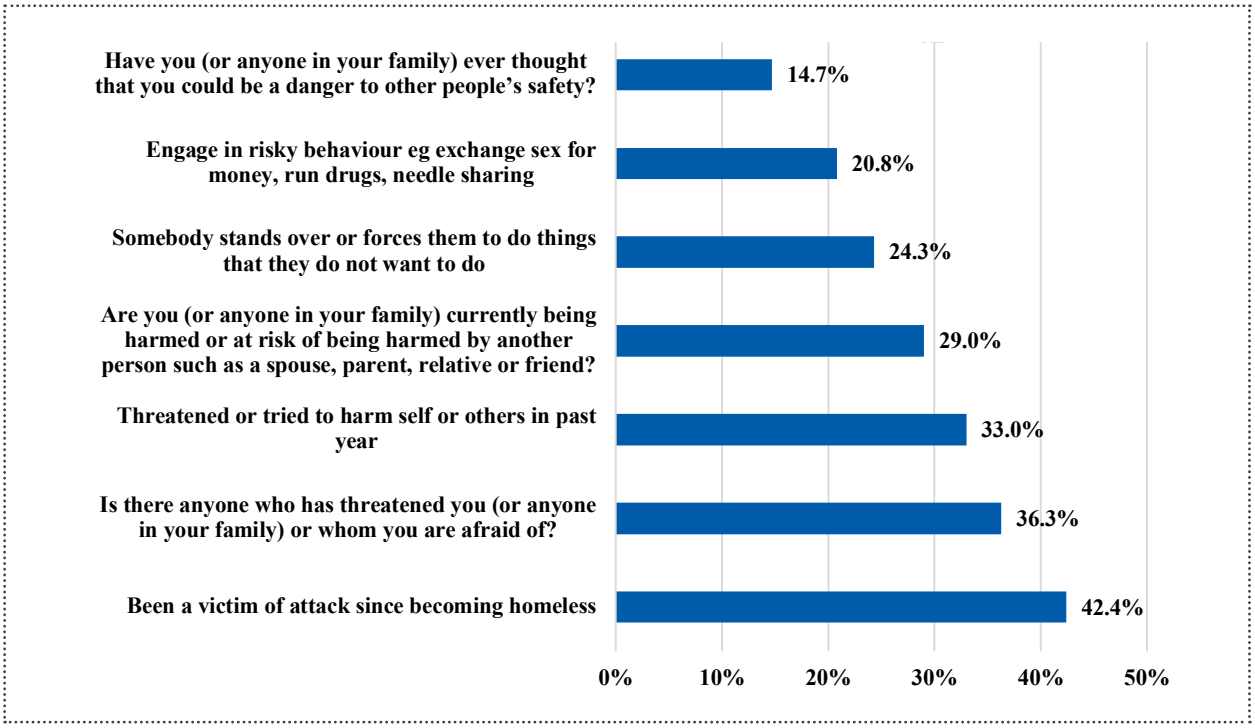
Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Questions were included in the Australia VI-SPDAT, Australia F-SPDAT and Australia VI surveys but not in the Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.

10.2 Harm, risk and crime

It is well established that homeless individuals are significantly more likely than the general population to be victims of crime (Ellsworth, 2019; Turner et al., 2018). Homeless individuals are also more likely than the general population to be perpetrators of crime, however, relative to the offender population, their crimes are more likely to be minor or 'nuisance' crimes (Barak & Bohm, 1989). The National Advance to Zero surveys ask respondents questions about their experiences as a victim of crime and their engagement in behaviour (voluntary or under coercion) that may precipitate interaction with the justice system, namely harming or threatening to harm others, being forced to do things they don't want to do, and engaging in risky behaviours. Figure 38, below, shows the proportion of National Advance to Zero respondents reporting that they have experienced or engaged in the aforementioned experiences.

Figure 38 – Victim of crime, harm to self and others, exploitation and risky behaviours, per cent



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

[2] Questions not included in the Family, Individual, Youth VI-SPDAT v3, or General VI-SPDAT surveys.

Around two in five respondents (42.4%) in the National Advance to Zero data report that they have been attacked or beaten up since becoming homeless. Table 40 examines being a victim of attack by the place that respondents sleep most frequently. A greater proportion of rough sleepers report to have been a victim of attack, with 54.7% reporting that they had, compared with 38.0% of other homeless respondents, which includes crisis and emergency accommodation, temporary accommodation and short-term accommodation. Of those in institutional accommodation, 40.5% reported that they had been beaten up or attacked since becoming homeless and 20.3% of those that were permanently housed at the time of survey reported that they had been a victim of attack.

Table 40 – Victim of crime, harm to self and others, exploitation and risky behaviours

	Attacked or beaten up since becoming homeless		Threatened or tried to harm yourself or anyone else in the last year[2]		Does anybody force or stand over you to do things that you do not want to do?[2]		Risks taken including exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle[2]	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Sleeping rough								
Yes	2,806	54.7	1,704	39.2	1,155	26.5	856	28.1
No	2,322	45.3	2,640	60.8	3,203	73.5	2,193	71.9
Other homeless (includes crisis and emergency accommodation, temporary accommodation, short-term accommodation)								
Yes	3,358	38.0	2,767	30.0	2,172	23.6	1,622	19.2
No	5,488	62.0	6,469	70.0	7,044	76.4	6,842	80.8
Other								
Yes	372	44.8	172	43.9	128	33.2	59	19.5
No	459	55.2	220	56.1	257	66.8	243	80.5
Institutional accommodation								
Yes	98	40.5	123	42.4	70	24.5	84	35.0
No	144	59.5	167	57.6	216	75.5	156	65.0
Permanently housed								
Yes	231	20.3	342	26.4	263	20.5	131	11.5
No	905	79.7	952	73.6	1,023	79.5	1,005	88.5
ALL RESPONDENTS	16,183		15,556		15,531		13,191	

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] Questions were included in the Australia VI-SPDAT, Australia F-SPDAT and Australia VI surveys but not in the Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT v3 surveys.

These rates of attack are generally in line with international figures. Sanders and Albanese (2016) surveyed 458 rough sleepers in the UK and found that they had experienced assault in the prior twelve months at 17 times the rate of the general population. Further, 35% reported being deliberately hit or kicked and 34% reported that they have had things thrown at them while homeless.

National Advance to Zero respondents were asked whether they have threatened or tried to harm themselves or others in the previous year. In the overall sample, 33.0% responded affirmatively to this question. This was slightly higher amongst rough sleepers (39.2%) and those in institutional accommodation (42.4%), and slightly lower among those experiencing 'other' homelessness (30.0%) and those that are permanently housed (26.4%).

One fifth (20.8%) of the overall sample report that they engage in risky behaviour such as drug running, exchanging sex for money, unprotected sex with strangers, or needle sharing. Prevalence of risky behaviour was higher among those in institutional accommodation (35.0%) and rough sleepers (28.1%), lower among those who slept most frequently in an 'other' place (19.5%) or were in 'other homeless' accommodation (19.2%), and lowest among those who were permanently housed (11.5%).

Roughly one in four (24.3%) of the overall sample responded affirmatively to the question "Does anybody force or stand over you to do things that you do not want to do?" This was slightly higher amongst those housed in an 'other' place (33.2%), followed by rough sleepers (26.5%), those in institutional accommodation (24.5%) and among those experiencing 'other homelessness' (23.6%).

Homeless individuals are inherently vulnerable. They tend to have few constructive social supports, few economic resources, and struggle to meet their basic needs (e.g., shelter and food; Sebastian, 1985; Shinn, Knickman & Weitzman, 1991; Booth, Bernard et al., 2004). This in itself increases individuals' likelihood of engaging in risky behaviour voluntarily or being coerced into doing things, and this vulnerability is compounded by the fact that homeless individuals are less likely to resort to the legal system for protection or to have access to the information they need about the legal system (Department of the Attorney General WA, 2017). While some of this hesitance about utilising the legal system may arise from mistrust in a system that has let them down and criminalises them, it may be the case that much of the hesitance comes from a lack of knowledge or belief in one's legal and human rights.

11 FINANCIAL AND SOCIAL INDICATORS AND WELLBEING

11.1 Financial and social indicators

Income and employment are crucial factors related to homelessness. The various versions of the Advance to Zero data collections explored different aspects of these factors (see Appendix 7, Table 53). Economic instability, such as that created by loss of employment and/or insufficient income are significant correlates of first-time homelessness (Nilsson et al., 2019). Further, current or recent employment and the amount of income earned are associated with a shorter duration of homelessness (Zare, 2018), and the absence health conditions that limit one's ability to work is related to exit from homelessness (Zlotnick et al., 1999). Employment can also support the management of mental health conditions, drug and alcohol addiction, and social exclusion, as it provides routine, occupation of time, and the formation of positive social ties.

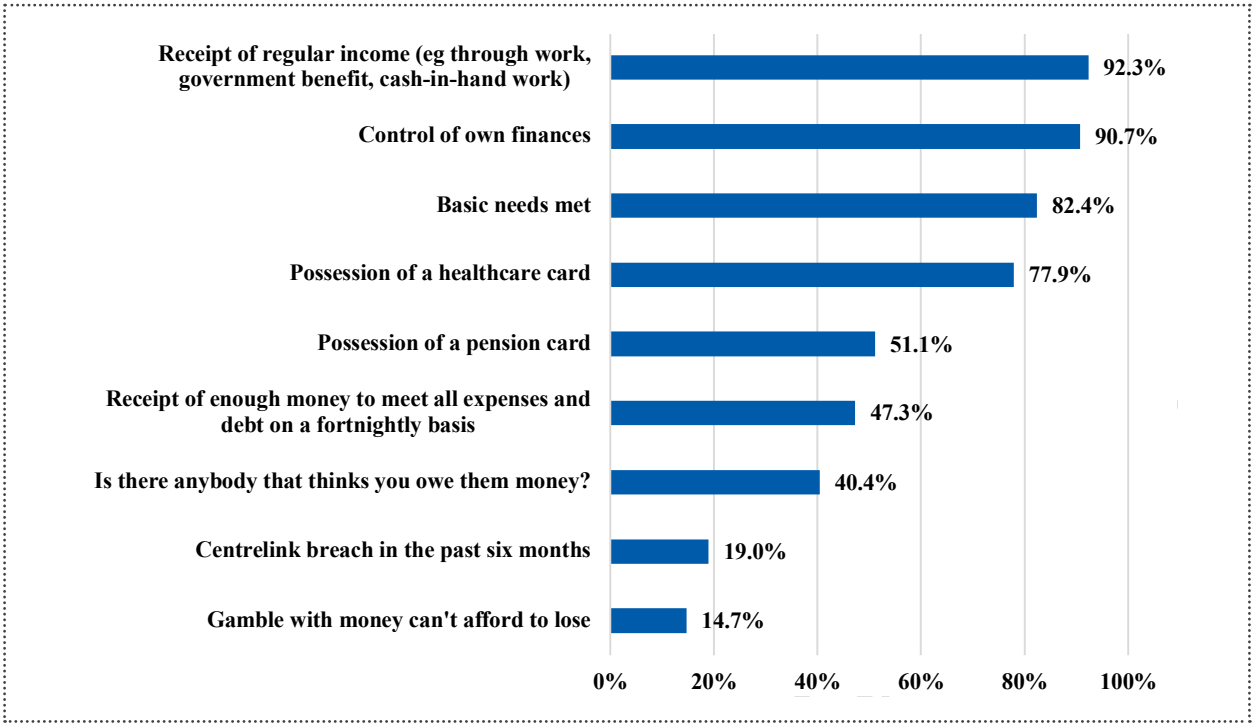
Analysis of the National Advance to Zero data finds that 92.3% of respondents report that they are in receipt of regular income. This largely reflects the broader scope of Australia's income support system relative to that in other countries (outside northern Europe). However, a systematic review of the determinants of tenancy sustainment have found that it is not merely obtaining some form of income, but rather the inability to obtain enough consistent income that presents a barrier to sustaining a tenancy (Boland et al., 2018). Accordingly, only 47.3% of respondents responded affirmatively to the question "Do you have enough money to meet all of your expenses and debts on a fortnightly basis?"

Receipt of welfare benefits is also correlated with lower duration and higher repetition of homelessness episodes (Boland et al., 2018). Instability of income, for example, cessation or significant reduction of Centrelink benefits due to a breach of conditions, can derail an individual's journey out of homelessness. As it can take a number of weeks to restore benefits, it would be highly unlikely that an individual that is in accommodation (be it temporary, short-term or potentially long-term) would be able to maintain that accommodation for the duration of their time without welfare. Further, a recent rental affordability snapshot by Anglicare (2021) found that only 3 properties across Australia in the private rental marker were affordable for people on unemployment benefits. Being in receipt of welfare benefits appears to have a relationship with obtaining, maintaining and having choice over housing options.

Similarly, a person in a state of primary homelessness that loses their Centrelink benefits will be significantly inhibited in terms of securing a tenancy and is likely to be required to spend more time fulfilling other basic survival needs such as obtaining food, rather than engaging in activities that may facilitate exit from homelessness, such as looking for employment. Therefore, the fact that almost one in five (19.0%) National Advance to Zero respondents reporting that they had received a Centrelink breach in the six months prior to survey is a concern.

In terms of other financial indicators, 90.7% of respondents overall reported that they had control over their finances (Figure 39). Most (77.9%) reported that they had a healthcare card and over half (51.1%) had a pension card. Around two fifths (40.4%) of the overall sample responded affirmatively to the question "Is there anybody that thinks you owe them money?"

Figure 39 – Financial indicators , per cent



Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).

Breaking these financial indicators down by demographic characteristics, the data, outlined in Table 41 below, indicate that a smaller proportion of rough sleepers than non-rough sleepers report having regular income (87.8% versus 92.5%) and to have enough money coming in fortnightly (42.3% versus 50.7%). A smaller proportion of rough sleepers have a pension card and healthcare card, and a greater proportion have had a Centrelink breach in the six months prior to survey (22.3% versus 14.8%). There are not particularly pronounced differences between males and females; similar proportions of males and females report receipt of regular income (91.2% versus 89.0%), possession of a healthcare card (77.7% versus 76.8%) and possession of a pension card (50.4% versus 49.9%), and report that they had enough money coming in fortnightly (46.8% versus 47.3%) and Centrelink breach (17.4% versus 18.2%).

The results for the 'Other' gender category (comprised in this case of those that identified as transgender or intersex) are very mixed. A greater proportion of people in the 'Other' gender category do not have a regular income, do not have enough income coming in fortnightly to cover their expenses, nor a pension card or a healthcare card, and report that there is somebody that thinks they owe money. A greater proportion of people in the 'Other' gender category report having had a Centrelink breach in the prior six months.

There are relatively few differences between Aboriginal and Torres Strait Islander and Australians of other descent on these selected financial indicators. Similar proportions of Aboriginal and Torres Strait Islander and Australians of other descent receive enough money fortnightly (46.8% versus 47.8%), have a pension card (47.1% versus 52.8%), or a healthcare card (77.7% versus 78.8%), and have had a Centrelink breach in the prior 6 months (22.2% versus 17.6%). Those who reported that they had a cultural identity that was not Aboriginal and Torres Strait Islander or other Australian were generally worse off across the financial indicators, with the exceptions of Centrelink breach in the prior 6 months and somebody thinking that they owe money.

The relatively small differences in financial indicators of National Advance to Zero respondents within demographic characteristics that are typically correlated with greater disadvantage (e.g., Aboriginal and/or Torres Strait Islander Identity and gender) may be a function of the population of interest. That is to say, it is possible that when an individual has reached a level of disadvantage that renders them homeless, their demographic characteristics are less relevant than their housing status to their financial wellbeing. This is reflected in the data, which indicates that the greatest differences in financial indicators are between rough sleepers and non-rough sleepers.

The final characteristic examined in Table 41, below, is veteran status. Similar proportions of veterans and non-veterans reported receipt of regular income (94.0% versus 92.1%) and receipt of enough money fortnightly (50.6% versus 46.8%). In addition, 59.8% of veterans reported possession of a pension card, compared with 49.4% of non-veterans. This is likely a combination of both Department of Veterans' Affairs pension card and disability pension card due to military-related injuries. A smaller proportion of veterans reported having a Centrelink breach than non-veterans (11.7% versus 18.4%).

Table 41 – Financial indicators by homelessness status, gender identity, cultural identity and veteran status, per cent

	Receipt of regular income (e.g., through work, government benefit, cash-in-hand work)[2]	*Receipt of enough money to meet all expenses and debt on a fortnightly basis*[3]	*Possession of a pension card*[4]	*Possession of a healthcare card*[4]	*Centrelink breach in the past six months*[3]	*Control of own finances*[4]	*Is there anybody that thinks you owe them money?*[2]
Place slept most frequently							
Rough sleepers	87.8	42.3	47.6	75.0	22.3	81.1	36.0
Non-rough sleepers	92.5	50.7	52.5	79.8	14.8	73.7	41.2
Gender identity							
Males	89.0	47.3	49.9	76.8	18.2	80.7	38.8
Female	91.2	46.8	50.4	77.7	17.4	74.2	40.2
Other gender identity[5]	87.3	44.9	39.0	73.4	23.2	74.5	28.5
Cultural identity							
Aboriginal and Torres Strait Islander Australians	89.5	46.8	47.1	77.7	22.2	79.5	34.3
Australians of other descent	93.0	47.8	52.8	78.8	17.6	84.4	32.2
Other cultural identity	84.6	42.9	40.3	65.3	12.6	79.5	28.2
Veteran status							
Veterans	94.0	50.6	59.8	77.7	11.7	82.7	31.9
Non-veterans	92.1	46.8	49.4	77.0	18.4	79.8	32.8

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] Question was not included in the Australia VI survey.
[3] Questions were included in the Australia F-SPDAT and Australia VI surveys but not in the Australia VI-SPDAT, Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.
[4] Question was only included in the Australia VI-SPDAT and Australia VI surveys.
[5] Other gender includes Intersex or X, Other gender identity, unknown, declined to state.

The instruments used in the National Advance to Zero data collections also questions relating to indicators of social wellbeing, encompassing both risk and protective factors for safety and wellbeing. In terms of protective factors, 44.2% of respondents, overall, reported that they engaged in activities that they enjoy, other than surviving, planned (Figure 40). Just over one in four (26.5%) reported that they were staying with others, such as a partner, friends or family at the time of survey (though not necessarily in accommodation). Approximately one in ten (11.0%) respondents reported that they have a pet. This is quite high given the accommodation conditions of respondents and the cost of having a pet. While it is acknowledged that homelessness can be challenging for pet owners, the human–pet relationship is thought to be highly beneficial for the owner, providing emotional wellbeing and safety as well as strengthening against challenges such as social isolation and disconnectedness, loneliness, mental illness and risky lifestyle behaviours (Cleary et al., 2020). Access to essential services that supports pet ownership for people while they are homeless remains critical to keeping both owners and pets safe as they move toward finding housing.

With regard to risk factors for safety, 41.1% report that they have friends of family that take their money, borrow cigarettes, use their drugs, drink their alcohol or get them to do things they don't want to do, and 40.3% report that they have people in their life whose company they do not enjoy but are around out of convenience or necessity. Roughly one in five (16.3%) report that they have a permanent physical disability that limits mobility.

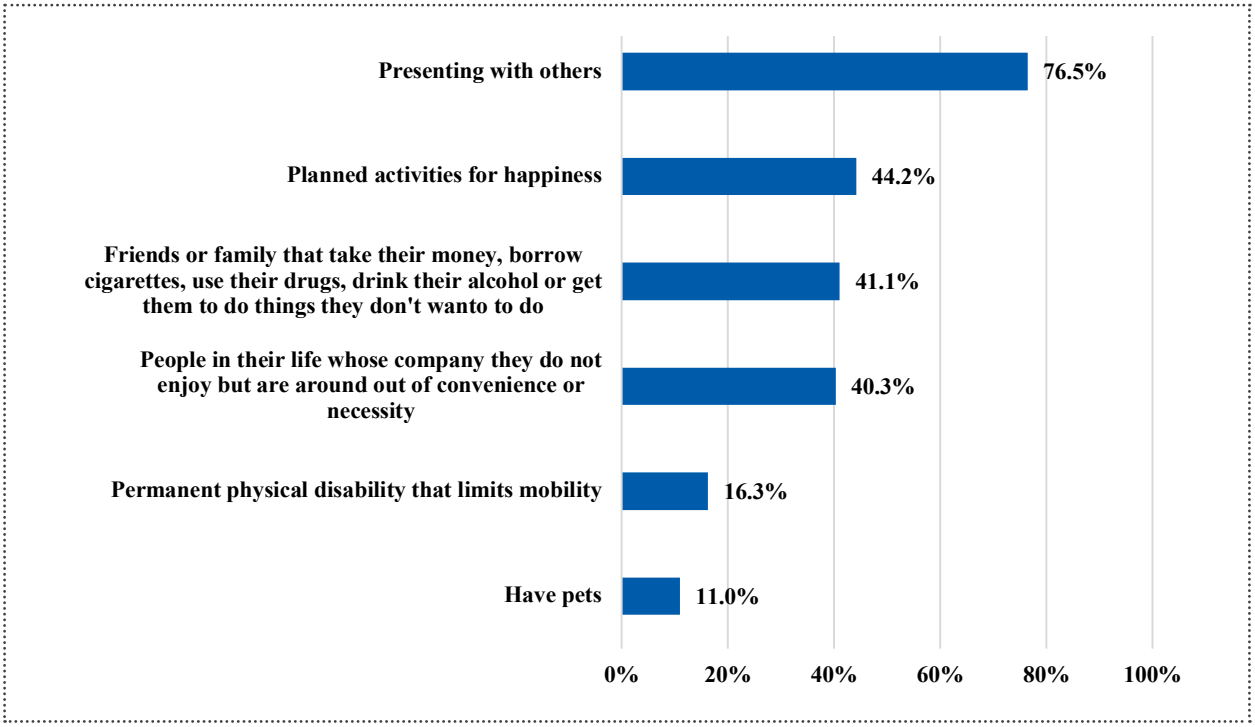
A greater proportion of rough sleepers have a pet than non–rough sleepers, whereas a smaller proportion of rough sleepers present with other people than non–rough sleepers (Table 42). A greater proportion of rough sleepers also report having friends or family that steal their things and people that they keep in their life out of convenience or necessity rather than enjoyment of their company, but less likely to have planned activities that they enjoy other than survival.

A greater proportion of females than males have protective factors such as pets and to be with other people, but also have people that they keep in their life out of convenience or necessity rather than enjoyment of their company and people that steal from them. A greater proportion of males than females have planned activities other than survival that they enjoy.

A higher proportion of Aboriginal and Torres Strait Islander respondents relative to other respondents present with others, but a greater proportion also report having people that they keep in their life out of convenience or necessity rather than enjoyment of their company and people that steal from them.

A lower proportion of veterans versus non–veterans report having a pet. A substantially higher proportion of veterans report a permanent physical disability. A smaller proportion of veterans than non–veterans present with others, however, a greater proportion of veterans have activities that they enjoy other than survival planned. A greater proportion of veterans have people that they keep in their life out of convenience or necessity rather than enjoyment of their company and people that steal from them.

Figure 40 – Social indicators, per cent



Source: National Advance to Zero 2010–2020.

Notes: [1] Estimates based on unique respondents (excluding missing values).

Table 42 – Social indicators by homelessness status, gender identity, cultural identity and veteran status, per cent

	Permanent physical disability that limits mobility	*Presenting with others*[3]	*People in their life whose company they do not enjoy but are around out of convenience or necessity*[2]	*Friends or family that take their money, borrow cigarettes, use their drugs, drink their alcohol or get them to do things they don't want to do*[2]	*Planned activities for happiness*[4]	*Have pets*[2]
Place slept most frequently						
Rough sleepers	18.4	65.1	37.5	46.1	34.7	7.6
Non-rough sleepers	14.3	82.0	14.8	37.4	37.0	5.2
Gender identity						
Males	16.8	75.4	18.0	39.6	38.7	4.7
Females	15.1	79.5	23.5	42.5	28.5	10.3
Other gender identity[5]	14.8	42.0	56.5	57.4	18.2	10.7
Cultural identity						
Aboriginal and/or Torres Strait Islander Australian	16.4	63.7	45.1	49.1	31.5	8.8
Australian of other descent	19.8	59.1	38.8	39.4	36.5	11.3
Other cultural identity	15.1	58.0	33.6	31.3	27.0	7.3
Veteran status						
Veterans	25.1	66.9	23.5	23.5	25.3	9.8
Non-veterans	17.4	71.2	22.5	23.2	20.7	10.2

Source: National Advance to Zero 2010–2020.
Notes: [1] Estimates based on unique respondents (excluding missing values).
[2] Question was not included in the Australia VI survey.
[3] Questions were included in the Australia F-SPDAT and Australia VI surveys but not in the Australia VI-SPDAT, Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.
[4] Question was only included in the Families VI-SPDAT, Individual VI-SPDAT V1, and Youth VI-SPDAT V2 surveys.
[5] Other gender includes Intersex or X, Other gender identity, unknown, declined to state.

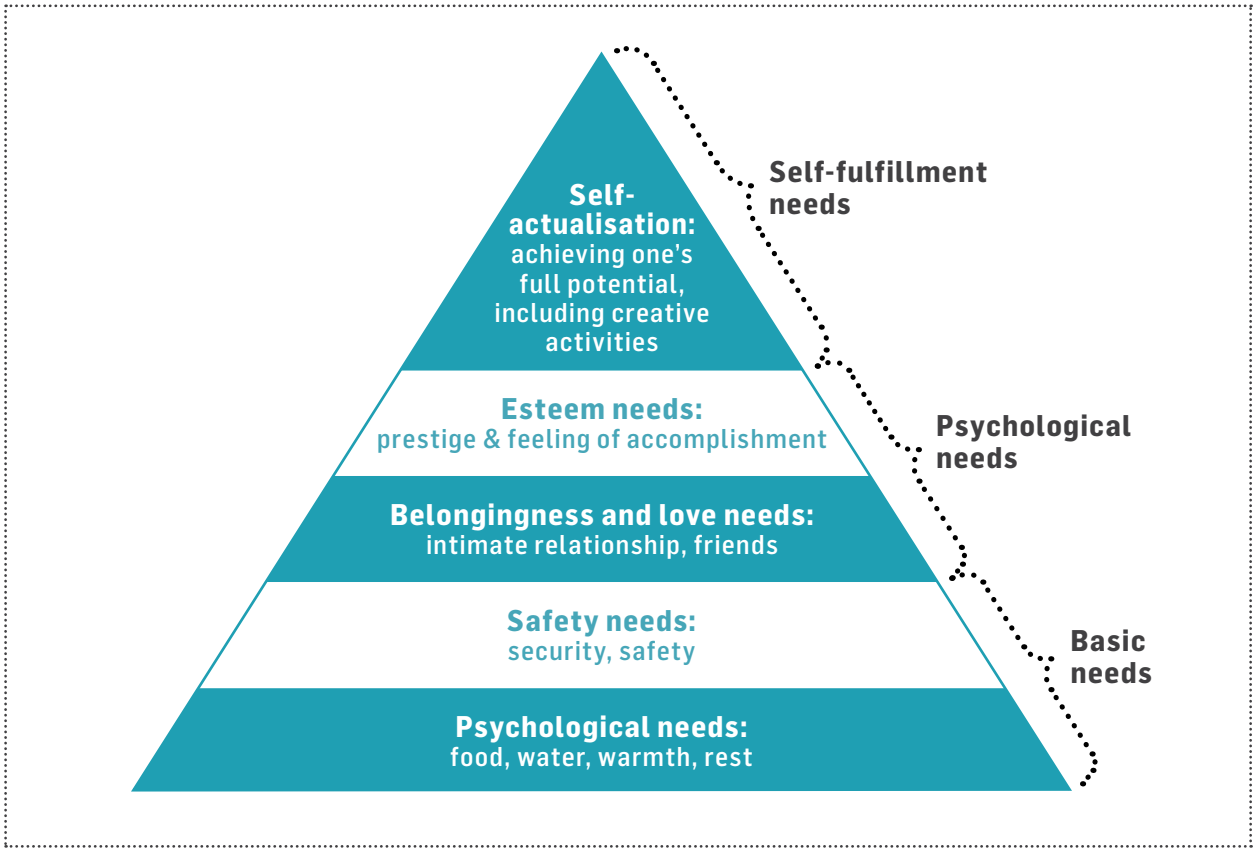
11.2 What do you need to be safe and well?

Respondents of the Australian Family Service Prioritization Decision Assistant Tool (F-SPDAT) and Australian Vulnerability Index Service Prioritisation Decision Assistant Tool (VI-SPDAT) were asked at the end of their survey "what do you need to be safe and well?" This was posed as an open-ended question, leaving respondents able to articulate any needs that were salient to them. A total of 10,678 valid responses were recorded.

Using Maslow's Hierarchy of Needs (Figure 41 below) as a framework, we manually coded the valid responses into categories and subcategories. Table 43 outlines the coding structure that emerged from the data, within the framework and presents key terms by the number of times they were mentioned in the data. These categories and subcategories are not mutually exclusive as respondents were not limited in the number and type of needs they could identify (i.e., it was simply whatever they felt they needed in order to feel safe and well). Self-actualisation needs did not emerge strongly in the data. This is unsurprising given the sample population and the hierarchical nature of the needs; it is difficult for to one realise their full potential if their basic needs such as shelter and safety are not fulfilled, as is inherently the case with homeless individuals.

It is interesting to note, the different phrasing around home in the responses to 'what do you need to be safe and well'. Some attributed the idea of home to a structural idea, shelter, a place to stay or a roof over their head. Others positioned a house, as a social and emotional process, a home to have, to be proud of and call their own, with a more narrative frame.

Figure 41 – Maslow's hierarchy of needs



Source: Maslow(1943). A theory of human motivation.

Table 43 – Categories, subcategories and examples of safety and wellbeing needs

Category	Subcategory	Examples from data
Physiological needs	Food/water	*"Food", "Water", "Food in my belly", "Three meals a day"*
	Warmth	*"Warmth", "Air conditioning", "Warm place", "Warm clothes", "Clothes","Blanket"*
	Rest	*"Sleep", "Comfortable bed", "Just to rest", "Sleep"*
Safety needs	Physical health	*"Regular GP visits", "Bulk billed GP", "Surgery", "Pain medication"*
	Mental health	*"Take care of my mental health", "Mental health support", "Clear mind", "Counselling", "Psychiatrist"*
	Drug and alcohol	*"Stay off the grog", "Stay clean", "Stay away from drugs", "Alcohol", "Rehabilitation", "want to be clean"*
	Security	*"To be safe", "To be away from partner (domestic violence)", "Doors that lock", "Security for my house", "Privacy", "Protection"*
	Housing & shelter	*"Roof over my head", "A house", "Safe place to sleep", "Four walls and a roof", "Housing", "Sanctuary"*
	Stay out of trouble	*"Stay away from people who aren't safe", "Stay out of trouble", "Stop hanging around the wrong people", "Not be in trouble with cops"*
	Stability/routine	*"Stability", "Routine", "To know what to expect", "Stable life"*
	Resources	*"Money", "Stable income", "Enough money to afford rent", "Car licence", "Enough money to live"*
Belongingness and love needs	Friends and family	*"My kids", "Reunited with my family", "Good, true friends", "Contact with my son", "To have my pets with me" , "Love"*
	Social support	*"Be part of a community", "Good company", "Positive people", "Support services", "Support and understanding".*
	Partner	*"A good woman", "My partner", "A girlfriend", "To be able to maintain a relationship", "A wife"*
Esteem needs	Independence	*"To not be controlled", "A sense of independence", "Gaining control of my finances", "To look after myself"*
	Employment	*"A job", "Stable employment", "Paid work", "Work or volunteering", "Part time work", Volunteer"*
	Achievement	*"Self-esteem", "Self-worth", "To be understood", "Respect", "To complete my studies", "To be happy", "Meaning", "Purpose", "Peace", "Gratitude", "Meaning", "Happiness"*
	Entertainment	*"Music", "TV", "Art", "Radio", "Something to do with my time"*

Table 44 – Number of mentions of key terms

Subcategory	Examples from data / key terms	Number of mentions*
Housing, a home and shelter	*"Roof over my head", "A house", "Safe place to sleep", "Four walls and a roof", "Housing", "Sanctuary"*	9,457
Friends and family	*"My kids", "Reunited with my family", "Good, true friends", "Contact with my son", "To have my pets with me" , "Love"*	2,000
Stability/routine	*"Stability", "Routine", "To know what to expect", "Stable life"*	1,713
Physical health	*"Regular GP visits", "Bulk billed GP", "Surgery", "Pain medication"*	1,000
Mental health	*"Take care of my mental health", "Mental health support", "Clear mind", "Counselling", "Psychiatrist"*	1,000
Employment	*"A job", "Stable employment", "Paid work", "Work or volunteering", "Part time work", Volunteer"*	834
Security	*"To be safe", "To be away from partner (domestic violence)", "Doors that lock", "Security for my house", "Privacy", "Protection"*	750+ / 185 (personal safety)
Food/water	*"Food", "Water", "Food in my belly", "Three meals a day"*	618
Resources	*"Money", "Stable income", "Enough money to afford rent", "Car/licence", "Enough money to live"*	500+
Social support	*"Be part of a community", "Good company", "Positive people", "Support services", "Support and understanding".*	408
Independence	*"To not be controlled", "A sense of independence", "Gaining control of my finances", "To look after myself"*	298
Warmth	*"Warmth", "Air conditioning", "Warm place", "Warm clothes", "Clothes","Blanket"*	226
Drug and alcohol	*"Stay off the grog", "Stay clean", "Stay away from drugs", "Alcohol", "Rehabilitation", "want to be clean"*	186
Rest	*"Sleep", "Comfortable bed", "Just to rest", "Sleep"*	186
Entertainment	*"Music", "TV", "Art", "Radio", "Something to do with my time"*	151
Achievement	*"Self-esteem", "Self-worth", "To be understood", "Respect", "To complete my studies", "To be happy", "Meaning", "Purpose", "Peace", "Gratitude", "Meaning", "Happiness"*	129
Partner	*"A good woman", "My partner", "A girlfriend", "To be able to maintain a relationship", "A wife"*	100 (approx)
Stay out of trouble	*"Stay away from people who aren't safe", "Stay out of trouble", "Stop hanging around the wrong people", "Not be in trouble with cops"*	27

Notes: *Multiple response allowed.

11.2.1 Physiological needs

Physiological needs are the needs that are fundamental to survival. Consequently, if a physiological need is unfulfilled, a person will generally pursue that need above their needs in other categories (Maslow, 1943). Food was the most common physiological need expressed by respondents; 618 people raised food as necessary for them to feel safe and well. Many referred to quantity and stability of food, making statements such as "food in the fridge" or "plenty of food in the cupboard", and others talked about quality with statements such as "better foods" or "good healthy food". In addition, when articulating their need for a home, many participants specified that they wanted a kitchen and/or the ability to cook their own meals.

"A stable home knowing that I have enough food and stability to keep the family together."

"Have my own place to call home, somewhere stable and secure for me and my baby."

Warmth was raised as an important physiological need, mentioned by 226 respondents. Within warmth, 45 respondents mentioned clothes or warm clothes and 25 mentioned a shower or hot shower. Warmth was also an important feature that participants were seeking in their accommodation, reflected in statements such as "a dry sheltered area with blankets".

A total of 186 respondents mentioned rest as something needed to be safe and well. Respondents referred to 'a comfy bed', 'a good night's sleep', and being comfortable.

"A comfortable bed, good accommodation, and companionship."

11.2.2 Safety needs

Safety needs, broadly defined as the absence of feeling endangered, were overwhelmingly the most frequently mentioned needs across participants; 9,457 or 87% of respondents identified a home or shelter as something they need in order to feel safe and well. The expression of this need varied, with many making simple statements such as "a house", "accommodation", "a room", "a roof" or "a place to sleep", while others identified factors related to the housing that would be necessary for their sense of safety and wellbeing, such as stability, permanence, privacy and security.

"A roof over my head. I need somewhere to go at night and call home."

"I'm sort of safe but not happy and am quite depressed.
I need a proper place and stability so I can take up a current job offer.'

" A home where I can feel safe, an animal, routine, and structure and a job."

Many participants that stated food as a need for safety and wellbeing also mentioned a home, and a large proportion of participants that mentioned warmth also mentioned housing.

Security was a prominent need, in terms of both physical and psychological safety. Over 750 participants specifically mentioned that having a lock on their room, door(s), or window(s), or a sustained tenancy was essential for their sense of safety.

"A home for my families security and to know this home we have is for a long period."

"A safe environment for the kids and a stress-free home."

With regard to personal safety, 185 respondents mentioned the need to be away from their former partner (with many referencing FDV), friends and/or family.

"A secure place to live in that is safe and practical with no-one around me.
I don't want to be somewhere that would put me in a vulnerable position to be exploited."

Similar to security was staying out of trouble. While some people directly stated that "staying out of trouble" was necessary for them to feel safe and well, for some people, staying out of trouble was about abstaining from drug and alcohol use. For others it was avoiding people that they believed were bad influences, while some referred to limiting their interactions with the justice system:

"To stay away from alcohol and drugs, to seek a counsellor to try an understand what I'm going through, and work to keep me busy."

"Housing, privacy, a job, to see my kids, stay away from trouble."

"A house to have family together, friends, no drugs and no fighting."

"A home; to know that my husband has a job; to know that my children are well; to know enough police and to be able to get help when needed."

Stability and routine were mentioned by 1, 713 respondents as necessary for them to be safe and well. Some referred to the need for stability in accommodation to support their mental health, for others it was to support their sobriety, while many expressed a desire to have a daily routine.

"I need to be in my own place to be mentally stable."

"Not being around strangers, have adequate mental health supports, safe accommodation, and stable employment."

"I need housing, medication management to support engagement with children and child safety – I need access to healthcare and mental health support."

"I need to not be around strangers, have adequate mental health supports, safe accommodation, and stable employment"

11.2.3 Physical and mental health needs

Physical and mental health needs were also prominent with over 1,000 respondents mentioning physical and mental health. Statements about access to medical support or medication, and access to equipment to support daily living such as wheelchairs or supportive chairs. Many people wanted a regular General Practitioner (GP) and dental care. Mental health needs included staying on medication, counselling, and access to support services including crisis support. Finally, respondents mentioned needs relating to substance abuse problems, such as staying away from drugs and/or alcohol, counselling and rehabilitation support, and "healthy living" supports.

"Support to get me back in my feet and help with my mental health and alcohol use, and a new GP."

Resources were mentioned by over 500 respondents. This mainly referred to financial resources; money, financial security and independence, stability, and/or a stable income. Many people also stated their reasons for needing resources to be safe and well, such as for food, clothing, stable housing, and money to support their family.

"Enough money to survive a fortnight."

"Enough money to live a stable life."

"I need my own place which is safe and secure. I want my own bed again. I want paid employment".

11.2.4 Love and belongingness needs

Almost 2,000 participants mentioned friends and family as needs for them to be safe and well. Some participants expressed a desire to regain or retain custody of their children, and stated that their need for shelter was related to getting their children back:

"A home to become stable, then I will be able to go for custody of my boys so we can all become a family unit again."

"A unit or house so myself and my five year old boy can live together."

"I need stability and friends and family."

"Warmth, friends, and stable housing."

Social support needs were expressed through statements such as "more contact with supportive people", "support from family and friends", "quality relationships", "support workers" and supports from agencies.

Almost 100 respondents expressed that their partner or finding a partner, or providing a safe environment for their partner, was important to their safety and wellbeing.

"To get somewhere safe to live for my partner and myself and shut the world out."

Many of the needs categorised into love and belongingness referred to the participants' children or their family, and the need to maintain a safe and stable home.

"A house so the girls can have their own space."

"Independent house with a kitchen, bathroom and a lounge so I can have my kids stay at my own place."

11.2.5 Esteem needs

Esteem needs relate to the need to have a stable, high evaluation of oneself (Maslow, 1943). Esteem in this context has two components – internally attributed esteem which pertains to a personal sense of achievement and confidence, and externally attributed esteem, which results from respect and recognition from other people. Esteem is necessary to feel capable, useful and necessary and, alternatively, to avoid feeling helpless. However, the vast majority of participants who expressed esteem needs, also mentioned love and belonging, and shelter and relationship needs.

In our sample, many respondents mentioned a desire for occupation based activities such as employment, work, a job or education as necessary to their safety and wellbeing. As a result of the achievement and recognition derived from one's work, employment is often classed as an esteem need.

Participants also mentioned needing externally ascribed esteem via independence, freedom, respect, and being understood.

"My own place with my own independence to get to the next step in my life."

11.2.6 Discussion

Maslow's Hierarchy of Needs establishes a framework of needs that motivate human behaviour. Achievement of needs at lower levels of the hierarchy allows for the consideration, pursuit and satisfaction of other needs. It is important to note amongst a homeless population the prominence of shelter, classified as a safety need, as the most salient need over physiological needs. The data does not indicate that shelter is the most prominent need for participants because their physiological states are satisfied. Rather, we suggest that housing needs are so unsatisfied amongst this population that lack of housing inhibits the satisfaction of physiological needs.

Many participants expressed needs that go beyond shelter, mentioning both love and belonging needs and esteem needs, in conjunction with their own home. The frame in which people talked about needs ranged from physiological and structural needs to a sense of belonging or a place in the world that they could feel was theirs. People discussed things like wanting a home so that they would be able to have friends over, have a place to be proud of to show their family. Therefore, housing can be seen as the critical, first step to facilitating the achievement of overall safety and wellbeing but is not the single requirement of addressing homelessness. Consequently, support to achieve these 'higher' needs once housing has been attained is critical to ensure successful and sustained exit from homelessness.

The needs expressed to be safe and well, can be used to design programs and supports that meet more than just housing needs, but create conditions in which companionship and friendship and flourish.

12 VI-SPDAT ACUITY

The Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) helps identify those who should be recommended for each housing and support intervention. Originating in 2013 in the United States, the VI-SPDAT has undergone review and co-design to ensure applicability to an Australian context (OrgCode, 2021). The tool and its scoring have been designed by consulting the literature on the risks facing people experiencing homelessness, and in collaboration with service providers and people with lived experience.

The VI-SPDAT is scored using participants' responses in the following domains: demographics, housing and homelessness history, risks, socialisation and daily functioning, and wellness. The sum of scores across these domains is used to indicate acuity and suggest a concomitant service response. Low acuity indicates that a person needs no intensive supports to access or maintain permanent housing, moderate acuity suggests a person needs permanent housing with tapered support, and people with scores reflecting high acuity are indicated for permanent housing with long-term support.

Scoring differed slightly between survey versions (Table 45), with versions 2 and 3 having wider scoring bands for each category of acuity than version 1.

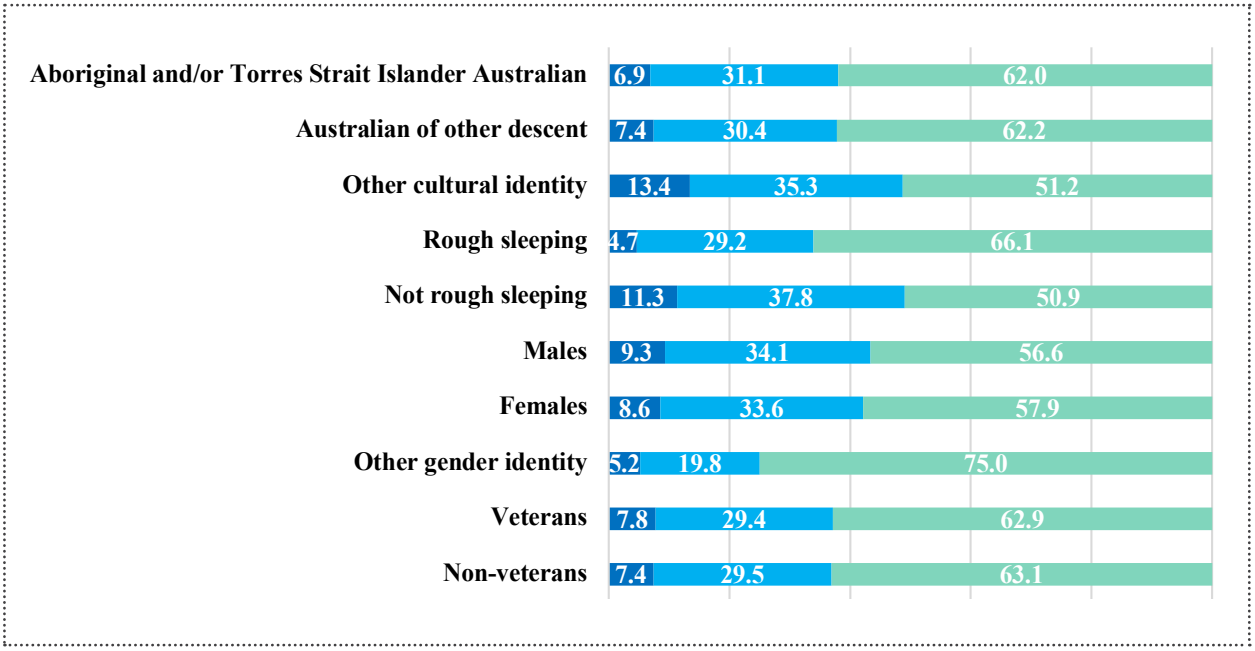
Table 45 – Scoring thresholds for each category of acuity, by VI-SPDAT version, Advance to Zero, Australia

	VI-SPDAT version 1	*VI-SPDAT versions 2 and 3*
Low acuity	0–3	0–4
Moderate acuity	4–7	5–9
High acuity	8+	10+

In the 2014–2020 data, 9% of respondents in the Advance to Zero database were considered low acuity and needing no intensive supports to access or maintain permanent housing, 34% were considered moderate acuity and needing permanent housing with tapered support, and 57% were considered high acuity needing permanent housing with long-term support. This is what we would expect to see in this population given that the majority of people within the database are experiencing rough sleeping, arguably the most vulnerable homelessness experience, thereby resulting in a higher acuity skew.

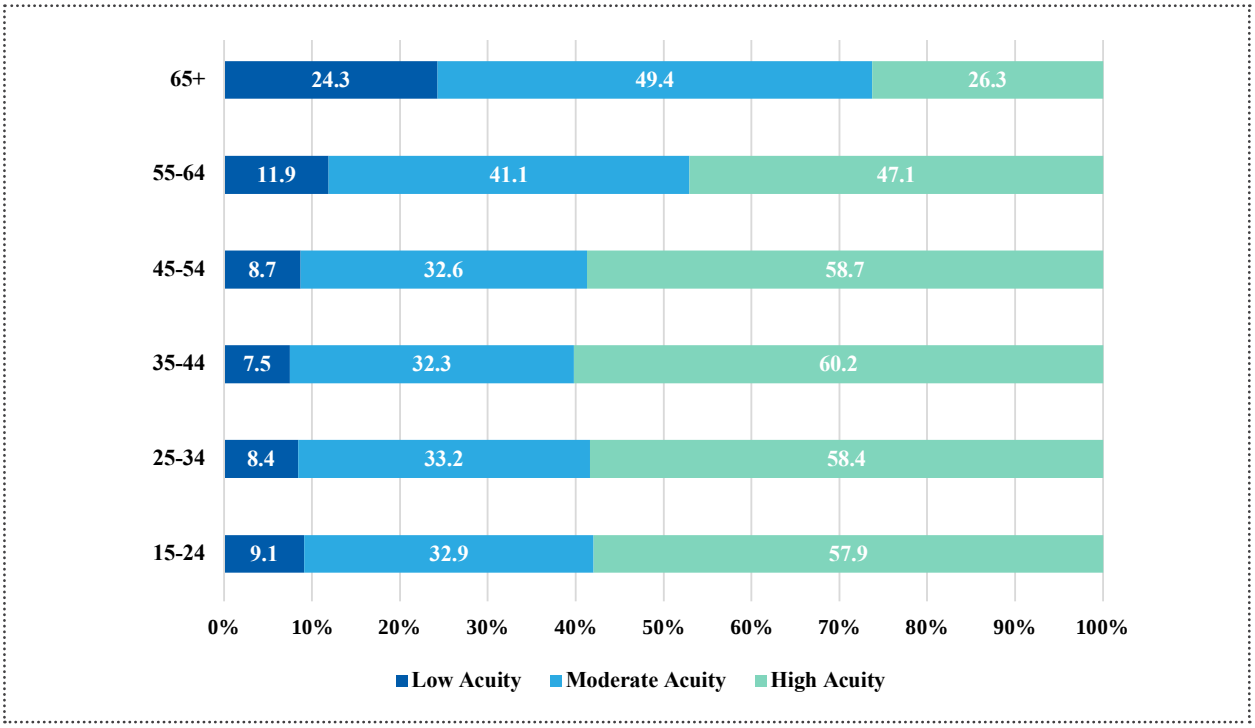
Breaking the data down by demographics, similar proportions of males (57%) and females (58%) had high acuity scores, with a significantly higher proportion of 'other' gender identification reporting high acuity scores (75%) and identified as needing permanent housing with long-term support (Figure 42). Those sleeping rough (66%) had higher acuity scores than those not sleeping rough (51%). A similar proportion of Aboriginal and Torres Strait Islander Australians (62%) and Australians of other descent (62%), and veterans (63%) and non-veterans (63%) had high acuity scores. A greater proportion of participants aged under 55 had higher acuity scores than those over 55 (Figure 43).

Figure 42 – Acuity levels by demographics, Advance to Zero



Source: National Advance to Zero 2014–2020.

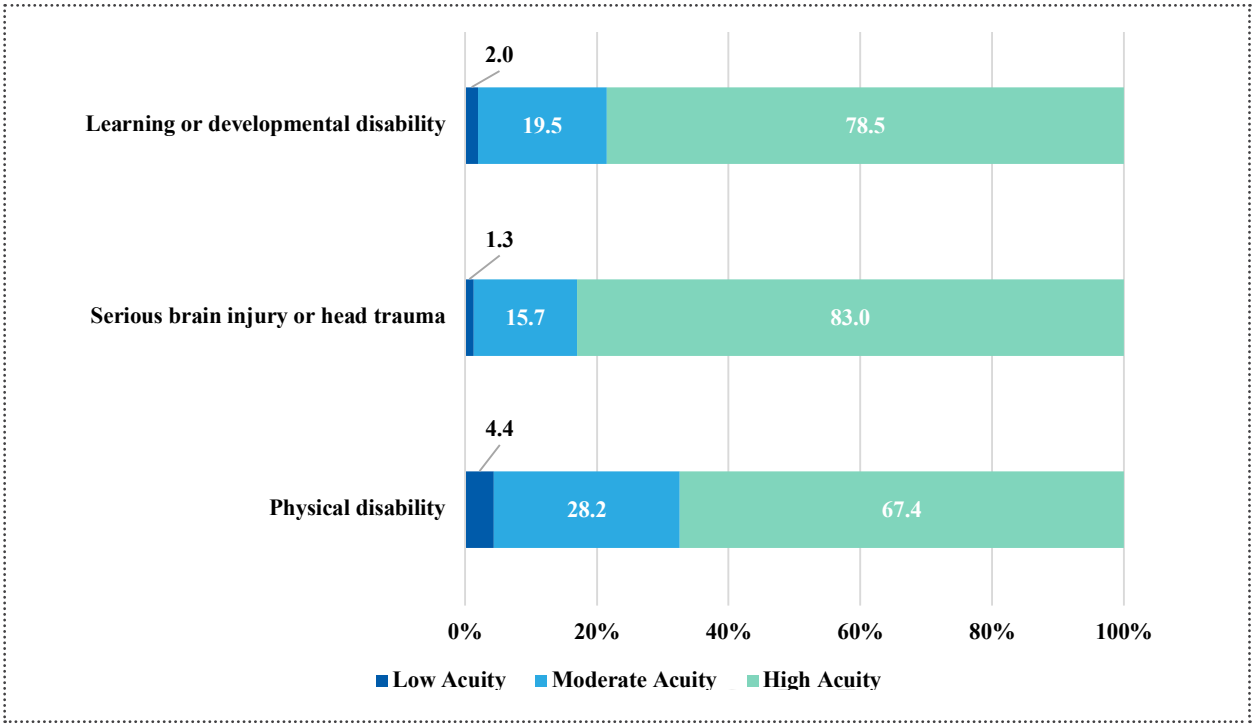
Figure 43 – Acuity levels by age, per cent, Advance to Zero



Source: National Advance to Zero 2014–2020.

Reflecting well-known risk factors of homelessness which are, in turn, factored into the calculation of VI-SPDAT scores, the majority of respondents in the Advance to Zero database with a serious brain injury or head trauma (83%), learning or developmental difficulties (79%), or a physical disability (67%) reported high acuity scores (Figure 44).

Figure 44 – Acuity levels by health indicators, per cent, Advance to Zero



Source: National Advance to Zero 2014–2020.

13 THE HOMELESSNESS JOURNEY

In 2008, then Prime Minister Kevin Rudd declared that he 'did not want to live in a nation where as the country gets wealthier, homelessness gets worse' and released The Road Home white paper (Parsell & Jones, 2014). This paper aimed to reduce homelessness for Australians through multiple system reforms, housing stock, new programs, and a better understanding of data.

In 2017, the Institute of Global Homelessness (IGH; 2017) launched an initiative named the 'a Place to Call Home' initiative. This work was commenced with 13 Vanguard Cities across the globe, including cities in Australia, Uruguay, India, Belgium, Canada, Scotland, the UK, and the United States. The idea was to bring cities working towards common goals across the globe together, to exchange knowledge, advocate for global change, and to make a meaningful impact for people experiencing homelessness in an effective way. Adelaide joined the Vanguard Cities initiative in 2017, followed by Sydney in 2018. As part of the Vanguard Cities initiative, each participating city had to identify a homelessness reduction target, and then report back to the global community regarding these targets. Adelaide set a target of reducing chronic rough sleeping by 50% by 2020; Sydney set a target of reducing rough sleeping in the city of Sydney by 25% by 2020, and 50% by 2025. This participation on a global scale encouraged innovative thinking and ideas regarding how to address homelessness in new ways.

Through participation in these initiatives, the functional zero method of ending homelessness was explored. Functional zero is measured using a community owned and led dataset approach to achieving 'functional zero' for rough sleepers in a city or town area using a combination of quality real-time data and service coordination. Functional zero is achieved where there are enough services, housing, and crisis beds for everyone who needs them, or when there are more people housed each month than becoming homeless. As a result, homelessness is rare and for those that experience it, it is brief and non-recurring.

In early 2019, the Australian Alliance to End Homelessness brought key representatives from capital cities around Australia to co-invest in learning about, and developing, the 'Advance to Zero' approach. Representatives from Perth, Melbourne, Adelaide, and Brisbane all participated in a two-day Action Lab in Perth in February 2019, followed by a second Action Lab in August 2019, where they were joined by a Sydney team.

One of the key tools used to achieve functional zero is the By-Name List. The By-Name List records up to date information about the number of people experiencing homelessness in the community and tracks their movement in and out of homelessness. By knowing people by name and what they are experiencing, plans to end their homelessness can be made. Tracking the inflow and outflow of homelessness in a community allows for the identification and addressing of system bottlenecks, with the overall aim of improving sector responses for better outcomes.

The key purposes of the By-Name List are:

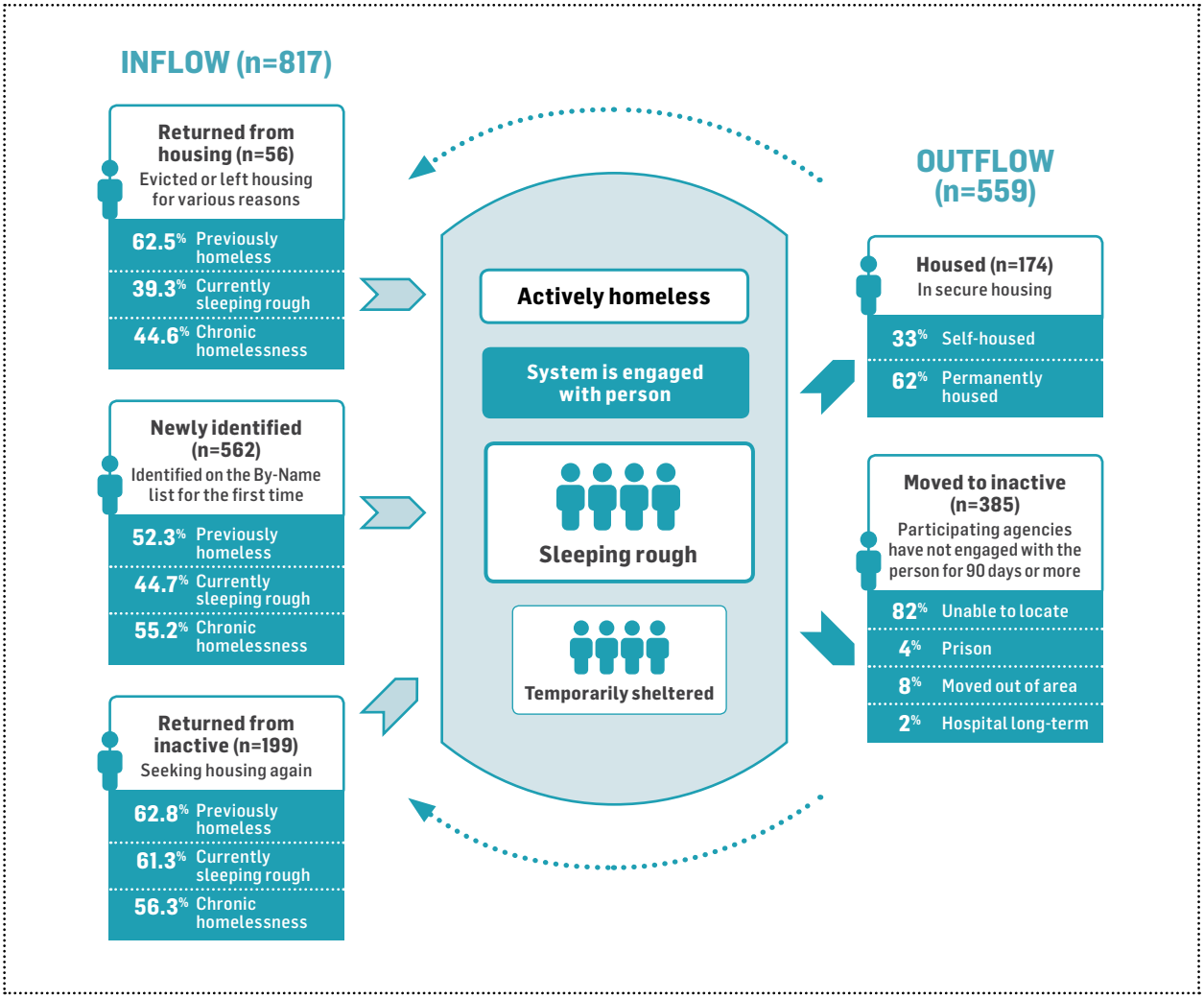
- To understand both the number support needs, and key drivers of homelessness within a community, and have insight into a community in real time.
- To build collective understanding and ownership of homelessness across collaborating organisations within a community.
- To equip communities with the information to seek housing and support solutions tailored to their needs for individual people and families experiencing rough sleeping and chronic homelessness.
- To inform service collaboration and development to improve how the system works to end rough sleeping and chronic homelessness.
- To produce data which is community owned and led, and can be used as an advocacy tool with the aim of ending homelessness (i.e., achieving functional zero).

The By-Name List is a key tool for prioritising the most vulnerable. The introduction of the By-Name List also means that data is captured on all rough sleepers across cities and regions (not just those scoring ≥10 on the VI-SPDAT) to drive effective service provision for everyone, with the overarching goal of ending homelessness.

13.1 By-Name List data capture

The current By-Name List captures point-in-time data of the inflow into homelessness through those returned from housing and are actively homeless again, newly identified sleeping rough homeless since the previous month, and those who have returned from an 'inactive' state and are seeking housing again (an inactive state is obtained when participating agencies have not engaged with the person for 90 days or more). Those that are actively homeless include those who are either sleeping rough or temporarily sheltered and engaged with the system. Outflow includes those who have been housed or have moved to inactive (see Figure 45).

Figure 45 – Inflow and outflow diagram of the By-Name List



Source: Advance to Zero November 2020. Illustration adapted from Community Solutions (2017).

The example above shows By-Name List information for November 2020, which contains information on 1,376 people. A total of 817 people experiencing homelessness (59%) have been classified as inflow (56 returned from housing, 562 newly identified, 199 returned from inactive), and 559 (41%) as outflow (174 housed, 385 inactive).

Of those classified as returned from housing or newly identified, 21% were temporarily accommodated. Of those who returned from inactive, 18% were temporarily accommodated. Temporary accommodation definitions differ slightly between states; most temporary accommodation is defined as emergency accommodation, temporary boarding, motel lodging, and safehouses.

Of those who were housed, 62% identified as permanently housed, and 33% identified as self-housed. Self-housed refers to if an individual has obtained a housing placement through their own self advocacy and resourcing, as opposed to being allocated housing through a general allocations process.

Currently, multiple records may exist per person, with individuals having different identifying numbers dependent on the agencies supporting them, though this varies throughout communities. The large number of persons inactive include those who have not been in contact with agencies in the past 90 days, with a large proportion of these unable to be located, despite multiple attempts through outreach and drop-in providers to locate them. These people may have found housing through another agency, still be homeless and have just not contacted agencies, have been picked up by another agency, have left the area, may be hospitalised, be in rehabilitation, be imprisoned, or have died. Care must be taken when interpreting these figures due to these limitations in the outflow data.

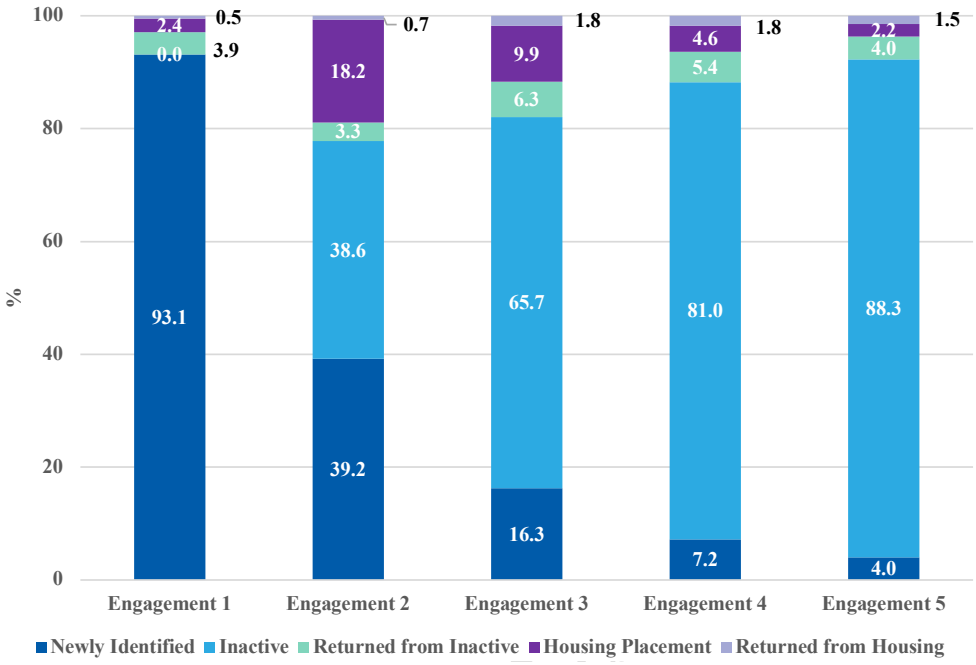
13.2 History of homelessness

The Advance to Zero national dataset contains survey information, By-Name List information, and housing placement information. Combining these three sources of data can give us a history of homelessness (inflow and outflow) by demographics and tenure. The By-Name List is designed as a real-time list of all known people who are either chronically homeless or rough sleeping. The By-Name List captures information on inflow (returned from housing, newly identified, returned from inactive) and outflow (housing placement, inactive), sleeping rough status, and an indicator of chronic homelessness. Housing placements indicate the tenure and housing type of those who received a placement.

The combined dataset contains over 28,500 records from January 2018, relating to over 10,900 individuals, with each individual appearing in the database on average 2.6 times. Each appearance in the database is indicative of a return to interacting with a homelessness service after a period of either being inactive or housed, indicating a cycle of homelessness, or 'churn'.

Useful information can be obtained by looking at the data longitudinally, and following agency engagement over time. Figure 46 shows a slice of the data from 2018 to 2020. At first engagement, the majority of participants are newly identified (93%), with the remainder being on the list prior to 2018. Of participants engaging with an agency, 86% engage a second time, 44% a third time, 24% a fourth time, and 14% a fifth time. Participants 'newly identified' after the first engagement, may have been picked up by another agency or entered a new community and are newly identified within that community. What is of particular concern is the increase in the inactive cohort by engagements. The inactive cohort is the most difficult to quantify, as you do not know if the individual has resolved their period of homelessness, or if they have disengaged from assistance with one agency for another. These difficulties lead to limitations in the ability to make evidenced assumptions about outflow in a community, as the inactive cohort is so broad.

Figure 46 – Agency engagement by inflow/outflow, per cent, Advance to Zero



Source: Advance to Zero national data 2018–2020 survey data, By-Name List and housing placement data.

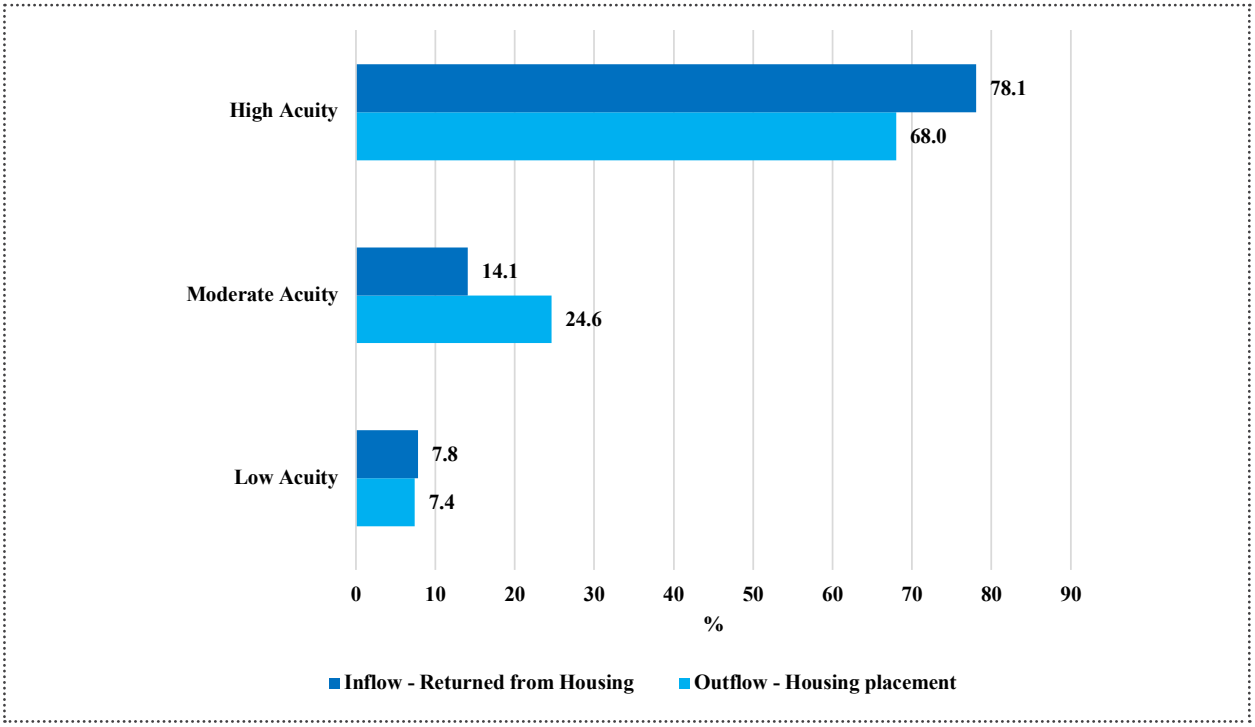
13.2.1 Inflow and outflow

Overall, within the combined dataset, 67% people scored >10 on the VI-SPDAT indicating high vulnerability. Combining the initial VI-SPDAT score and duration of homelessness (months lived on streets or in emergency accommodation) with the By-Name List, indicates the majority of those with high acuity receive a housing placement, but housing placement is not necessarily based on duration of homelessness. Within the combined dataset, 24% were rough sleepers and 33% were chronically homeless as defined by more than six months spent homeless.

A total of 3,732 people were housed between 2018 and 2020. Of the people previously housed, seventy-eight per cent of high acuity respondents have returned from housing, whereas a greater proportion of respondents who have been homeless greater than a year returned from housing than those who have been homeless for less than a year (Figure 47, Figure 48). Sixty per cent of respondents who had returned from housing were male, 43% were Aboriginal and Torres Strait Islander, and 72% were aged between 15–34.

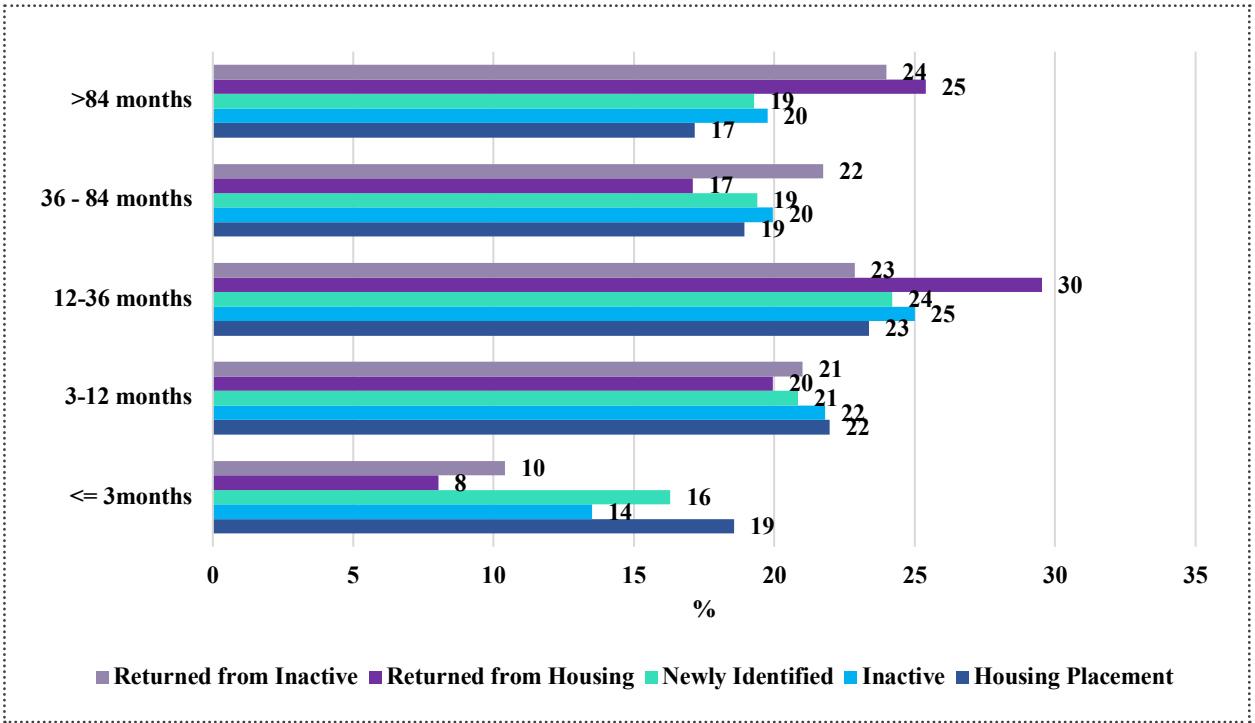
It is difficult to calculate a reliable proxy indicator of housing retention based on these numbers as there are multiple ways that a housing placement could cease and not be notifiable within the Advance to Zero community. For example, if a housing placement ends, or an individual is evicted, this may not be represented in the dataset unless they return to an agency that is entering data into the Advance to Zero platform, or if they return to the community. Future data integrations from the public housing database or social housing database would strengthen the ability of the Advance to Zero data platform to improve longitudinal representation of the data.

Figure 47 – Inflow and outflow by acuity, per cent, Advance to Zero



Source: Advance to Zero national data 2018–2020 By-Name List and survey data.
Notes: [1] Estimates based on multiple respondent records with initial VI-SPDAT score.

Figure 48 – Inflow and outflow by duration of homelessness, per cent, Advance to Zero

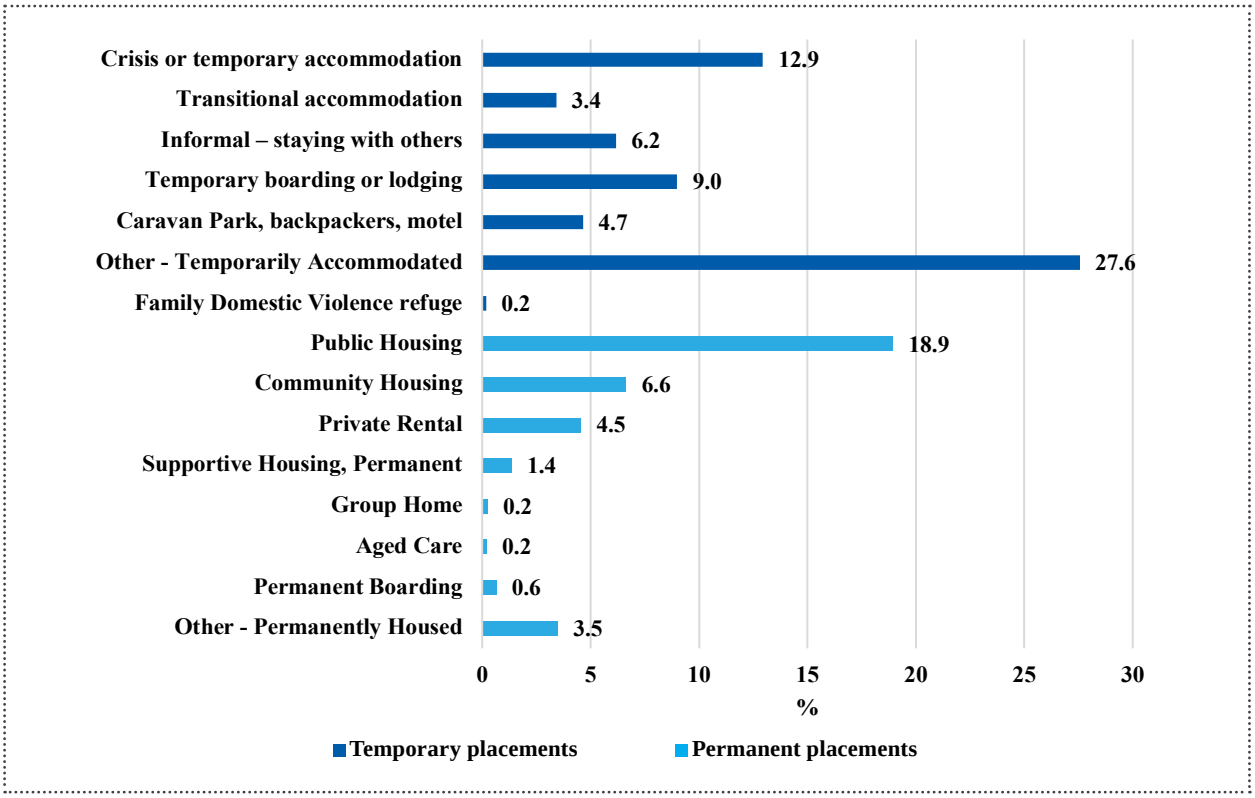


Source: Advance to Zero national data 2018–2020 By-Name List and survey data.
Notes: [1] Estimates based on multiple respondent records with initial homelessness duration (months lived on streets or in emergency accommodation).

13.2.2 Housing placements

When examining available tenure information, 36% of respondents were permanently housed, and 64% were temporarily accommodated. Of those with a permanent placement, 19% of the total group were placed in public housing, 7% were in community housing, 5% were in private rentals, 1% were in supportive housing, and 1% were in a group home, aged care, or permanent housing, and 4% 'other' permanent housing (Figure 49). Among those permanently housed, 52.0% were placed in public housing, 19.6% in community housing, 13.0% in private rentals and the remainder in other arrangements (e.g., permanent supportive housing, aged care). Of those temporarily housed, the largest group is those listed as "Other – Temporarily Accommodated" followed by crisis or temporary accommodation representing 13% of all respondents, 3% in transitional, 6% in informal accommodation, 9% in boarding or lodging, and 5% in a caravan park, backpackers, motel, or refuge accommodation.

Figure 49 – Housing placements, per cent, Advance to Zero



Source: Advance to Zero national data 2018–2020 By-Name List and survey data.
Notes: [1] Estimates based on multiple respondent records.

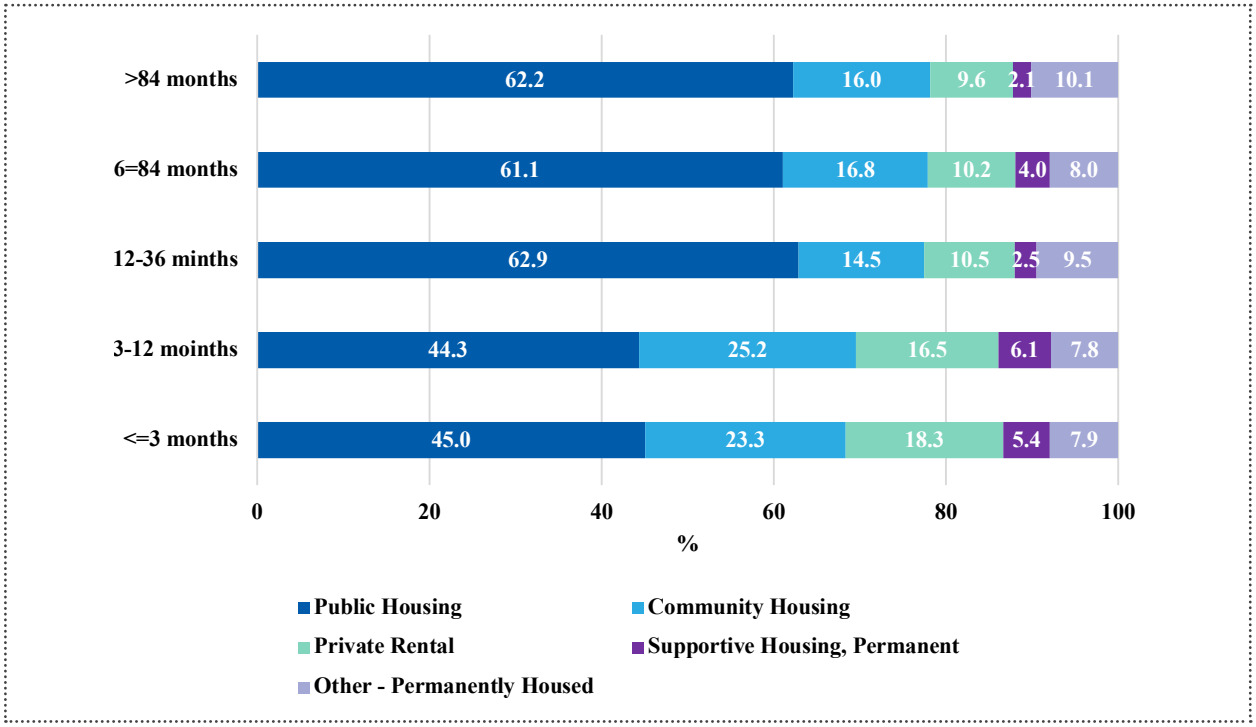
The majority of people with high (56%) and low (50%) acuity were housed in public housing (56%), compared to 42% of respondents with moderate acuity (Figure 50). Overall, a greater proportion of people with a moderate acuity (23%) were housed in community housing compared to high (18%) and low (13%) acuity respondents. Around 12% of high, moderate, and low acuity respondents were housed in private rentals.

A greater proportion of respondents who had been homeless for more than one year were placed in public housing compared to respondents who had spent less time homeless (Figure 51).

Figure 50 – Acuity by permanent housing placement, per cent, Advance to Zero

Source: Advance to Zero national data 2018–2020 survey data, By-Name List and housing placement data.
Notes: [1] Other permanent housing includes 'other', aged care, group home and permanent boarding.

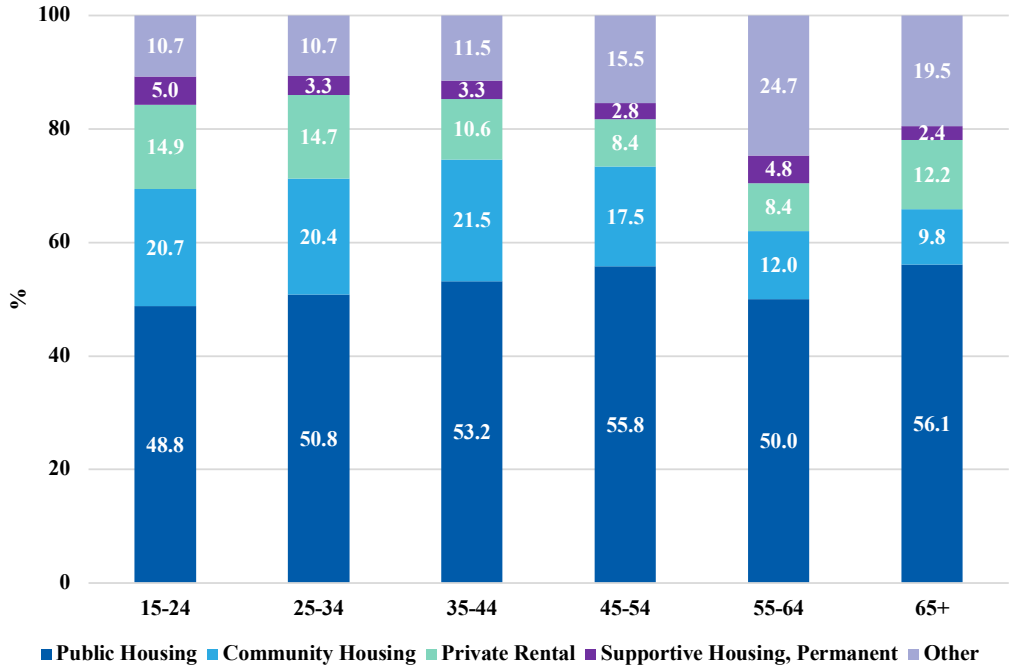
Figure 51 – Homelessness duration by permanent housing placement, per cent, Advance to Zero



Source: Advance to Zero national data 2018–2020 survey data, By-Name List and housing placement data.
Notes: [1] Other permanent housing includes 'other', aged care, group home and permanent boarding.

Irrespective of age, acuity, duration of homelessness, or Aboriginal and Torres Strait Islander identity, public housing remains the dominant form of permanent housing placement. Beyond this key fact, a greater proportion of respondents under 55 and Aboriginal and Torres Strait Islander respondents were placed in community housing compared to older respondents and respondents of other descent. Additionally, a lower proportion of Aboriginal and Torres Strait Islander respondents were placed in private rentals than respondents of other descent (Figure 52, Table 46). Data from the 50 Lives 50 Homes program showed that on average it took twice as long to house an Aboriginal person off the priority list compared to a non-Aboriginal person, and this may also impact the overall proportion of housing placements (Vallesi & Wood, 2021).

Figure 52 – Age by housing placement, per cent, Advance to Zero



Source: Advance to Zero national data 2018–2020 survey data, By-Name List and housing placement data.
Notes: [1] Other permanent housing includes 'other', aged care, group home and permanent boarding.

Table 46 – Tenure by Aboriginal and Torres Strait Islander identity, Advance to Zero

	Number	*Per cent*
Aboriginal and Torres Strait Islander Australians		
Public housing	254	53.9
Community housing	113	24.0
Other permanent housing	53	11.3
Private rental	35	7.4
Supportive housing	16	3.4
Total	471	100.0
Other respondents		
Public housing	255	59.4
Community housing	72	16.8
Other permanent housing	31	7.2
Private rental	55	12.8
Supportive housing	16	3.7
Total	429	100.0

Source: Advance to Zero national data 2018–2020.
Notes: [1] Estimates based on valid tenure and whether the respondent identified as Aboriginal and/or Torres Strait Islander Australian.
[2] Other permanent housing includes 'other', aged care, group home and permanent boarding.

14 ADVANCE TO ZERO SUMMARY

The Advance to Zero data used in this report to provide a national profile of the homeless in Australia, is a result of ten years of collective sector works involving services collecting actionable information through using standardised instruments eliciting information on the circumstances, vulnerability, risk, and service needs of those experiencing homelessness and associated inflow and outflow events. From Registry Week to homelessness support, to multi-sectorial meetings, to using data for continuous improvement, Advance to Zero as a methodology was a new way for sectors directly and indirectly related to homelessness to come together, and make decisions regarding best options for people experiencing homelessness.

The Advance to Zero database commences in a community with Registry Week events that comprise surveys of people experiencing homelessness, primarily rough sleeping, using the Vulnerability Index, Vulnerability Index – Service Prioritisation Decision Assistance Tool, and the By-Name List instruments. The VI-SPDAT (an amalgamation of both the VI and the SPDAT assessment tools) is used for analysing and prioritising the health and housing needs of individuals and families who are homeless based on the duration of homelessness, medical vulnerability, and other social risk factors. Following implementation of the VI-SPDAT, individuals associated inflows and outflows from the community are documented, providing a cohesive overview of the homelessness 'system' flow, and providing a more comprehensive understanding of potential points of prevention. This information can be used to inform service delivery, improve understanding of inflow pathways into homelessness, and enabling continuous improvement projects that could potentially address inflow.

Between 2010- 2020, there were 20,953 responses collected across six states in Australia by multiple agencies administering the VI, SPDAT and VI-SPDAT to individuals and families sleeping rough and staying in temporary accommodation. Analysis of this data reveals people's experiences of homelessness across domains of wellbeing – physical and mental health, financial and social. Documentation of inflow and outflow events then charts their journeys through homelessness.

A summary of the results of the analysis of the Advance to Zero database and By-Name List data are below.

14.1 Demographics

Advance to Zero respondents were predominantly male, straight, aged under 50, had limited education, and were sleeping on the streets.

- Advance to Zero rough sleepers surveyed between 2010 and 2020 were mostly male (63.1%), straight (78.7%) and had an average age of 41.8 years
- Over one quarter (29.2%) had educational attainment of Year 9 or lower
- 35.0% were sleeping rough at the time of survey, with 54.8% of the rest being in crisis, temporary, and short-term accommodation. Many of the ~55% in temporary accommodation would have slept rough at some point in their time in the community and Advance to Zero database
- Of those sleeping rough, 57.1% were sleeping on the streets
- Individuals had, on average, spent over 3.81 years (46 months) homeless in their lives. Families had spent almost 2 years (23 months) homeless, on average
- Overall, one-quarter (26%) reported they had been discriminated against. A higher proportion of females and those identifying as other gender identity reported discrimination within homeless services and housing

This demography points to, on average, individuals sleeping rough who are coming into the Advance to Zero system experiencing chronic rough sleeping. This form of chronic homelessness contributes significantly to the decline of health in the population, and points to a need for improved understanding of inflow into systems. To reduce chronicity and work towards prevention in the rough sleeping population.

14.2 Health

Respondents reported a range of physical and medical conditions; nearly all of which were significantly higher than rates seen across the general population.

- 23.5% of respondents in the Advance to Zero database reported that they had experienced dehydration; 22.4% a history of heatstroke/exhaustion; 17.1% skin & foot infections; and 7.9% epilepsy
- Almost one third (32.9%) had asthma, 28.1% liver disease, 20.6% had Hepatitis C, 18.4% had heart disease, arrhythmia or irregular heartbeat, 10.4% had diabetes, and almost ten per cent (9.7%) had emphysema
- Around one in ten respondents reported not currently taking their medication as prescribed due to; forgetting to take them (11.9%), being unable to afford them (11.2%), not liking the side effects (10.2%), having the medications taken or stolen (8.9%), or not agreeing the medications are needed (8.7%).
- Almost one quarter (22.7%) reported serious brain injury or head trauma

These health impacts are often cyclical in nature, in that they are products of, and precursors to, homelessness. Using serious brain injury or head trauma as an example, people often report being victims of assault while homeless, and can also report being victims of assaults or events that have cause traumatic brain injury prior to becoming homeless.

14.3 Mental health

Large proportions of respondents reported mental health diagnoses, higher than rates seen across the general population.

- Almost two thirds (60.9%) of respondents reported that they have problems concentrating or remembering things
- Almost half (48.0%) had spoken with a psychiatrist, psychologist or mental health professional in the last six months
- Almost one-third (38.8%) had gone to an emergency department (ED) due to not feeling emotionally well or because of their nerves
- Over one third (38.8%) reported that they had been taken to hospital against their will for mental health reasons
- A large proportion reported diagnosis of depression (70.2%) and anxiety (67.4%)
- Two in five people (42.4%) reported diagnosis of post-traumatic stress disorder and around one fifth had bipolar disorder (21.4%), psychosis (19.3%), or schizophrenia (19.1%)

There are consultations underway with Aboriginal and/or Torres Strait Islander communities regarding the VI-SPDAT and making it more culturally appropriate to implement with community. One item being discussion is to include best practice ways of asking mental health questions, as there is a disconnect between the western definition of mental health and Aboriginal and Torres Strait Islander social and emotional wellbeing, connection to land, sea, culture, spirituality, family and community.

14.4 Alcohol and other drug use

Alcohol and other drug use was high amongst Advance to Zero respondents.

- Almost two thirds (64.9%) of respondents reported that they had experienced or been told that they had problematic drug or alcohol use or abused drugs or alcohol
- Just over one quarter (28.5%) reported that they had consumed alcohol or drugs almost every day or every day during the past month
- 29.1% reported that they had used injection drugs or shots in the last six months
- Over one-third (36.5%) of respondents reported that they had been treated for drug or alcohol problems and returned to drinking or using drugs
- Twenty per cent reported blacking out because of alcohol or drug use in the past month
- Half (53.8%) were aware of safe injecting practices

14.5 Health service use

The majority of respondents indicated they had not been hospitalised, nor been to an emergency department or used an ambulance in the past six months, indicating that a small number of people accounted for a large proportion of health service use in the population of people experiencing homelessness.

- On average, respondents reported they had been hospitalised 1.04 times in the six months prior to survey. More than half (59.74%) had not been hospitalised at all
- Emergency Departments (Accidents and Emergency) were visited an average of 1.93 times per person in the six months prior to survey
- On average, respondents were taken to hospital by ambulance 1.13 times in the six months prior to survey
- Average per person cost of health service use by respondents in the 6 months prior to survey was $16,071, comprised of $11,139 in hospitalisation costs, $2,018 in Emergency Department costs, and $2,915 in ambulance costs

When compared with the general population, people experiencing homelessness are overrepresented in health service use statistics. Australia spends on average, $7,485 per person per year on health goods and services (AIHW, 2020e). The population of people experiencing homelessness has an expenditure that is double the average, in half the time measurement period. Much work can be undertaken in this area to ensure reduction in this gap.

14.6 Justice

Aboriginal and/or Torres Strait Islander, male, and/or rough sleeping respondents had higher rates of historical and current interactions with the justice system. Additionally, a large proportion of respondents who have had experience with prison or youth detention are sleeping rough.

- Over a third (36.1%) of respondents have been in prison and 9.9% in youth detention, with Aboriginal and Torres Strait Islander, males, and those sleeping rough having greater experiences of imprisonment over their lifetime
- The majority of those that are in institutional accommodation have been in prison at some time in the past (64.1%), followed by those that are sleeping rough (56.0%). Similarly, almost a quarter (23.6%) of those in youth detention are in institutional accommodation or have been sleeping rough (23.5%)
- The majority of respondents (56.7%) reported that they had interacted with the police in the prior six months
- One-third (32.6%) of respondents have serious legal issues
- Two in five respondents (42.4%) have been a victim of crime since becoming homeless, one third (33.0%) have threatened or tried to harm themselves or others in the past year, and one-fifth (20.8%) report that they engage in risky behaviour such as drug running, exchanging sex for money, unprotected sex with strangers, or needle sharing.

Mirroring many other measured aspects of the VI-SPDAT, justice issues are cyclical in nature in that they are causes of and caused be experiencing homelessness. The discharge rate from prison to homelessness in Australia is something that needs to be addressed further in national continuous improvement projects, and offending behaviours in the population of people experiencing homelessness would be beneficial to improve understanding of.

14.7 Financial wellbeing

Respondents reported although they were in control of their finances and their basic needs were met, they did not receive enough money to meet their expenses, with a large proportion reporting a Centrelink breach.

- Most (92.3%) respondents had regular income, control of their finances (90.7%), and a health care card (77.9%)
- Less than half (47.3%) reported that they received enough money to meet their expenses on a fortnightly basis
- Almost one in five (19.0%) respondents reporting that they had received a Centrelink breach in the six months
- 82.2% reported that their basic needs were met
- Over one third (34.6%) said that there was a person or people who believed that they owed them money

Future iterations of the VI-SPDAT may want to assess debt in relation to debt with a housing authority. There were some noted comments regarding lack of ability to find stable accommodation with public housing due to not having the capacity to pay off debt from prior tenancies.

14.8 Social wellbeing

Respondents indicated what they needed to be safe and well, which were coded to Maslow's Hierarchy of Needs.

- Approximately four in ten (41.1%) respondents reported that they have friends of family that take their money, borrow cigarettes, use their drugs, drink their alcohol or get them to do things they don't want to do and that they have people in their life whose company they do not enjoy but are around out of convenience or necessity (40.3%)
- Over one third (37.7%) planned activities for happiness
- About one in ten (11.0%) reported that they have a pet
- Food and warmth are the most important physiological needs, whereas shelter is a requirement for a sense of safety and wellbeing. Access to medical support, medication, support services, financial security and independence are important requirements for physical and mental health needs. Family, friends, and social support are important for love and belongingness. Feeling capable, useful and necessary through employment or education are important for esteem needs.

14.9 Acuity

The majority of respondents (57%) were considered high acuity needing permanent housing with long-term support, with those sleeping rough and respondents aged under 55 having the highest acuity scores. Respondents with a serious brain injury or head trauma, learning or developmental difficulties, or a physical disability also reported high acuity scores reflecting the focus of acuity on wellness within the VI-SPDAT.

14.10 Homelessness journey

The current By-Name List captures VI-SPDAT data, point-in-time data of the inflow (those returned from housing and are actively homeless again, newly identified sleeping rough homeless since the previous month, and those who have returned from an 'inactive' state and are seeking housing again) and outflow (those who have been housed or have moved to inactive) into homelessness within the community of interest/assessment.

- Combining the By-Name List with the Advance to Zero dataset indicates the majority of those with high acuity receive a housing placement, but housing placement is not necessarily based on duration of homelessness.
- Of the people previously housed, 78% of high acuity respondents have returned from housing, whereas a greater proportion of respondents who have been homeless greater than a year returned from housing than those who have been homeless for less than a year.
- Over one-third (36%) of respondents were permanently housed, and 64% were temporarily accommodated.
- Those with longer durations of homelessness are more likely to be permanently housed in public housing than those with shorter durations of housing. Two-thirds of permanent housing placements among those with over a year of homelessness were public housing placements. Among high acuity permanent housing placements, 56% were public housing placements. Over half of all Aboriginal and Torres Strait Islander permanent housing placements were public housing placements.
- A greater proportion of respondents under 55 and Aboriginal and Torres Strait Islander respondents placed in community housing compared to older respondents and respondents of other descent, and a lower proportion of Aboriginal and Torres Strait Islander respondents placed in private rentals than respondents of other descent.

There are a number of limitations to the data within the Advance to Zero dataset. The VI-SPDAT is heavily weighted on measuring wellness in terms of physical and mental health conditions compared to housing and homelessness. Within the wellness section of the VI-SPDAT there are also some issues regarding scoring of particular health conditions when compared to others. While modifications to the new iteration of the VI-SPDAT addresses many concerns of previously implemented versions, there remain some cultural concerns regarding implementation of the tool with Aboriginal and Torres Strait Islander identifying communities. These are presently being worked on within working groups and will work to address issues in both implementation of the VI-SPDAT with community, and questions being asked and their associated appropriateness to ask.

The VI-SPDAT is based on self-report data on clinical and healthcare utilisation outcomes, and as such, may under or over represent healthcare utilisation. At present, people who abstain from accessing health care may receive lower vulnerability scores for the same level of health need than others who access health care services consistently, however people who abstain from accessing health care may score higher in avoiding healthcare services and potential self-diagnosis of health conditions in the wellness section, creating a paradox in assessment of health overall using VI-SPDAT data alone.

Matching with government administrative datasets and other objective records would allow for a more accurate measure of utilisation. Further measures on housing and homelessness, and experiencing family and domestic violence, need to be considered for future iterations. Matching of records would also allow for a more comprehensive understanding of the inactive group in outflow of the By-Name-List insofar as improving understanding of pathways in this cohort, do they continue to access other systems? Are they truly an 'outflow' of the system or are they still in need of support?

The Advance to Zero dataset contains 21,541 VI-SPDAT responses from 20,953 respondents between 2010-2020 collected across five states in Australia by multiple agencies. A small proportion of respondents were interviewed more than once for their vulnerability assessments. Individuals may have more than one VI-SPDAT implemented with them if they are returning to the community implementing By-Name List methodology after a long period of time without contact with the community, or if their circumstances have significantly changed. Currently, multiple records may exist with persons having different identifying numbers dependent on agency in some communities. Statistical Linkage Keys based on respondent demographic details, would allow tracking of respondents across agencies and States and is something that is currently being worked on within the Advance to Zero database working group, and Micah Projects.

The By-Name List methodology was introduced to help communities improve their understanding, ownership, collaboration and collective impact capabilities of their homelessness community, and what factors may be influencing individual inflows and outflows to the community. There remains a need for a stronger longitudinal representation of the data through both linking this dataset with other national datasets to begin to speak to pathways into, and out of homelessness and potential prevention points, and to improve understanding of the 'inactive' component of the By-Name List.

The large number of persons 'inactive' include those who have not been in contact with agencies in the past 90 days, with a large proportion of these unable to be located. These people may have found housing through another agency, may still be homeless and have just not contacted agencies, have been picked up by another agency, may be hospitalised, in rehabilitation, imprisoned, may have left the community or may have died. These limitations result in limited abilities to understanding the homeless community in question in a holistic way. Though we can see movement within a singular community, there is still much work to be undertaken to understand where people go when the leave the community and whether a proportion of, or all individuals are still in need of support to end their homelessness.

There is also currently limited information post entry to housing. As previously mentioned, unless someone returns to the By-Name-List community either through contacting an agency who is using this database, it will not be possible to understand tenancy retention comprehensively and accurately using this dataset alone. In order to understand housing outcomes, future relationships with housing authorities, community housing providers and potential private rental providers being able to access and review tenancies would aid in improving understanding of the housing journey. Including these organisations and providers in the conversation may also improve potential housing options for the community.

Overall, the experiences and outcomes of Advance to Zero respondents indicate complex, multidimensional needs, hence the supports offered need to be adaptable and person-centred, accepting that the journey out of homelessness is not likely to be linear. VI-SPDAT respondents, particularly rough sleepers have a relative kaleidoscope of experiences that demonstrates experiencing homelessness can be a truly heterogenous journey for people. This experience speaks to a need for homelessness support agencies to be able to flexibly respond to individuals needs and experiences of people, in order to work towards ending homelessness within that community, and eventually, within Australia.

Recommendations to improve the limitations within the existing database will assist in providing a reliable and valid assessment for people experiencing homelessness that is going to comprehensively record, understand and demonstrate specific vulnerability and service needs. With a comprehensive understanding of vulnerability and service needs, the homelessness system can pivot resources to work towards stemming inflow, and ensuring periods of homelessness in every community are rare, brief and non-recurring.

14.11 Data linkage

The Advance to Zero data has been used to provide a national profile of the homeless in Australia from clients of homelessness service agencies. Linking of this data to databases that are controlled by state/federal funders such as the Specialist Homelessness Services Collection Data, and other administrative datasets such as health, justice and public housing data, would enable better understanding of the homelessness journey and the determination of the impact of the transition from homelessness on non-housing outcomes such as health and justice utilisation. Continued and/or periodic linkage of data across multiple data sources can help in the design and development of policies and programs, and be used to assess and improve outcomes of those experiencing or at risk of experiencing homelessness. The analysis of linked data can also facilitate an economic evaluation such as a cost-benefit analysis to estimate the economic and social value of providing housing to the Australian community.

Neami National's Street to Home providing outreach and homelessness support in central Adelaide.

Photography: Amy Piesse

Part III:

POLICY SETTINGS AND PROGRESS IN ENDING HOMELESSNESS

15 A POLICY AND PRACTICE AGENDA FOR ENDING HOMELESSNESS

In Part III of the report, we outline a policy and practice agenda for ending homelessness. Our agenda is framed around our ending homelessness model and the existing evidence base, including the data in the present report. We also consider the response of governments and services to COVID-19 and the lessons learned from that response for a program directed to ending homelessness in Australia.

We identify five key actions to end homelessness in Australia:

1. Leadership and proactivity at the Australian Government level and a national end homelessness strategy applying across the states and territories.
2. An increase in the supply of social and affordable housing directed to an end homelessness goal.
3. Comprehensive application of Housing First programs linked to supportive housing for those entering permanent housing with long histories of homelessness and high health and other needs.
4. Targeted prevention and early intervention programs to turn off the tap of entry into homelessness which address the underlying drivers of homelessness.
5. Supportive systems programs which build the enablers of an end homelessness program: advocacy, commitment and resource flow to ending homelessness; effective service integration; culturally safe and appropriate service delivery including expansion of Aboriginal and Torres Strait Islander-led and controlled services to help address high rates of homelessness in their communities; and improving data quality, evaluation and research around ending homelessness in Australia.

15.1 Leadership and proactivity by the Australian Government and a national end homelessness strategy

The Rudd Government's The Road Home of 2008 provided a critical impetus to an end homelessness agenda in Australia. Coordinated leadership at the federal level is required again as an essential element to ending homelessness in Australia, as Federal government policy positions on homelessness have varied substantially over the past 15 years. As mentioned in the introduction of this report, The Road Home articulated a clear, national vision for reducing homelessness and provided a funding and policy framework to support that goal. However, The Road Home was far from perfect. Arguments have been made that it failed to account for inflows into homelessness; that it was unclear precisely how the funding provided should or would be applied to the three strategies of prevention and early intervention, increased service capacity and better service integration, and helping people to sustain tenancies; nor how these strategies would achieve the goal of halving homelessness (Johns, 2012).

The Road Home was also limited by the evidence that was available to define, benchmark and review targets set. For example, there was no national dataset by which to review the 2013 homelessness benchmark specifically, as census data was being used to measure the number of people experiencing homelessness, and this was undertaken in 2011 and 2016 (Parsell & Jones, 2014). This further highlighted the need for data-led strategies to be informed by evidence beyond data points such as the incidence of homelessness through an all of population census. In order to understand the effectiveness of programs and interventions delivered, the evidence needed to be more granular. However, since the publication of the Road Home in 2008 the research evidence base in respect to homelessness, particularly around the costs of homelessness and the cost-effectiveness of homelessness programs has improved significantly (Flatau & Zaretzky, 2008; Zaretzky & Brady, 2008, Flatau et al., 2008; Joffe et al., 2012; Zaretzky & Flatau 2013, 2015; Zaretzky et al., 2013; Flatau et al., 2016; Wood et al., 2016; Parsell et al., 2017; Zaretzky et al., 2017; Flatau, Zaretzky et al., 2020). Additionally, SHSC data improvements and enhancements to the Advance to Zero database and its reach have all worked to improve our ability to measure homelessness and its impacts. However, there is a need for a national framework that sets out clear targets for ending homelessness and measurement of progress in reaching those targets. The WAAEH evaluation framework, dashboard and ending homelessness report provides an example that could be applied at the national level (Zanella et al., 2018; Seivwright et al., 2021; Flatau et al., 2021).

Despite these limitations, The Road Home was a whole-of-government strategy that provided a clear federal vision, a concrete amount and length of funding, and strategic areas on which to focus efforts to address homelessness. In addition, The Road Home placed a strong emphasis on research and evaluation to build an understanding of homelessness and the effectiveness of efforts to address it. Also underpinning the development of The Road Home was a strong consultative process with service providers on the ground and people with lived experience of homelessness which undoubtedly increased the breadth of 'on-the-ground' issues covered by the strategy.

Despite the 'watershed moment' that The Road Home represented, the opportunity it offered to instigate actual change to homelessness policy, practice and to people experiencing homelessness was largely wasted at the national level (Herault & Johnson, 2016). Overall homelessness in Australia under the statistical definition has increased since the 2006 Census (i.e., since just prior to The Road Home), and rough sleeping, the most visible form of homelessness, is a much larger feature of almost all capital cities (ABS, 2018b; Flatau, Tyson et al., 2018). Herault and Johnson (2016) attribute the missing of the opportunity to failed leadership, arguing that the federal advisory councils responsible for guiding change were dominated by those with vested interest in the current system, and that homelessness systems reform was not supported by adequate investment in the supply of affordable housing.

Following their election in 2013, the Abbott Government distanced themselves from The Road Home, resulting in individual states and territories implementing their own individual homelessness policies in response without national or inter-jurisdictional coordination. This has resulted in state governments individualising their response to homelessness and a siloed approach with learnings and cross-fertilisation lost across state and territory borders.

In the following period, a lack of leadership, clarity and consistency at the Federal Government level has significantly impacted the ability of the homelessness service system to plan, invest, and innovate in line with national and international evidence (Black, 2018). After a five-year funding term ended in 2013, housing and homelessness funding via the National Partnership Agreement on Homelessness (NPAH) and the National Affordable Housing Agreement (NAHA) was subject to annual or biennial interim funding arrangements for a number of years (Thomas, 2017). The National Housing and Homelessness Agreement (NHHA), introduced in the 2017/18 Federal Budget, combines funding that was previously allocated across the NPAH and NAHA agreements into one agreement, and provides a guarantee of an indexed level of funding.

As Herault and Johnson (2016) state, successful reform of the homelessness system to better meet the needs of individuals is contingent on structural reform that increases the availability and affordability of housing. Major levers that affect housing affordability, such as tax policy, immigration policy and, indeed, a significant amount of state and territory funding that is put towards increasing social housing stock, are in the hands of the Federal government. Accordingly, if we are to end homelessness, there needs to be, at the federal level, political will and concomitant policy and funding committed to doing so.

Concerns have also been raised about the role that the Federal Government plays in the NHHA, in particular, that the leadership, responsibility and accountability of the Federal Government is lacking despite the Federal Government holding major levers that affect housing outcomes, and that the conditions placed on states and territories in order to receive funding restrict their ability to allocate funding in line with need (Shelter NSW, 2017).

Given this tangled web of bureaucracy, it is unsurprising that the prevalence and prominence of homelessness as a social issue in Australia has only increased, culminating in the February 2020 call for a national inquiry on homelessness, finalised in July 2021. In July 2021, the House of Representatives Standing Committee on Social Policy and Legal Affairs released its final report into the Inquiry into homelessness in Australia report providing an overarching recommendation for the establishment of a ten-year national strategy on homelessness (House of Representatives, 2021).

In addition to this overarching recommendation, a considerable proportion of the report's other recommendations were directed towards actions which require broader leadership by the Federal Government to ensure their implementation. These include an independent review of Commonwealth Rent Assistance (CRA) rates, indexation and interaction with other payments; evaluations of Australian Government sponsored social housing projects; and conditional waivers of historical state and territory government housing debts.

Other recommendations focused on collaboration between state and territory governments, including to develop a needs-based model for funding allocation in future funding agreements, and to identify priority cohorts among the homeless population. The collaboration required to action these recommendations represent quite a shift in the dynamic between state and territory governments and the Federal Government implied in the NHHA, such that a unified vision and more equal footing between the different levels of government would be required.

Importantly, the Inquiry into homelessness in Australia report also recommends that future funding agreements with state and territory governments and housing providers, incorporate the principles of 'Housing First', particularly for any priority groups identified in those agreements.

The acceptance and adoption of the recommendations from the House of Representatives Standing Committee on Social Policy and Legal Affairs released its final report into Inquiry into homelessness in Australia would represent a significant step forward with regard to Federal Government leadership towards ending homelessness. Strong leadership by the Federal Government first involves clearly stating that the goal of the Australian Government is to end homelessness in Australia then investing in evidence-based initiatives to do so. This would require increased funding to account for increases in demand for housing, including a commitment to supportive housing models and homelessness services over the past decade, and to cover the substantial costs of system-level reform. However, when directed towards evidence-based policy and practice, a return on investment over the long-term can be expected, arising from lower use of health, justice, housing and other services and increased economic participation and educational engagement across generations as a result of fewer children, young people, and families facing the adverse experience of homelessness.

While there are many positive interventions being implemented across states and jurisdictions in Australia, the role of the Australian homelessness peak bodies such as Homelessness Australia at the national level and various bodies in the states and territories such as Homelessness NSW, Council to Homeless Persons (Victoria), Council to Homeless Persons (Queensland), Shelter WA, and Homelessness SA act as a catalyst and advocate for the needs of both services providing support and individuals experiencing homelessness. The Australian Alliance to End Homelessness and connected bodies such as the Western Australian Alliance to End Homelessness, the Brisbane Alliance to End Homelessness and various community-based Zero Projects also provide critical communities of practice, intermediary networks and movements to end homelessness. By enacting a national united voice regarding the issues and potential solutions for homelessness, drawing on evidence from across Australia, the collaborative networks of peaks, movements to end homelessness and homelessness services can serve as a conduit between the Federal and state and territory governments, service providers and communities to ensure best practice models are being trialled, solutions to end homelessness are being proven and the government and communities can see how homelessness can be solvable in our country.

Australian Government leadership is a prerequisite for ending homelessness in Australia, as it is at this level that a national vision can be articulated and funded. However, state and territory governments are better placed to identify the projects and services that are required to meet local needs. In addition, in order to successfully implement a national plan for ending homelessness in Australia, state and territory governments have to be actively engaged in both directing external investments and making investments of their own.

As part of the NHHA, state and territory governments are required to develop their own housing and homelessness strategies and to match homelessness funding at least dollar for dollar. As we noted in chapter 2, and as set out in the following section, State and Territory governments have recently implemented new housing and homelessness strategies and action plans which move them well beyond the minimum level of investment in social housing required. States and Territories have recently increased social housing spending significantly. In some cases, homelessness strategies have set explicit targets around reducing homelessness but there is significant room for further development of explicit end homelessness targets and monitoring and evaluation frameworks.

15.2 An increase in the supply of social and affordable housing

15.2.1 Social housing

The experience of The Road Home, along with rental shortages in many states and territories and decreasing housing affordability across the nation have taught us that preventing inflows into homelessness – a critical factor in ending homelessness – as well as ending homelessness for those experiencing homelessness is contingent on adequate housing supply. Interviews with people experiencing chronic homelessness who have been in Housing First programs identified the availability of housing stock as a key factor in their ability to obtain and maintain housing (Parsell, Tomaszewski & Phillips, 2014). Increases in social housing represent a critical part of the overall housing response to end homelessness in Australia as it provides the only viable exit point for many of those who have experienced chronic homelessness with high health needs as the evidence from our review of the Advance to Zero database shows.

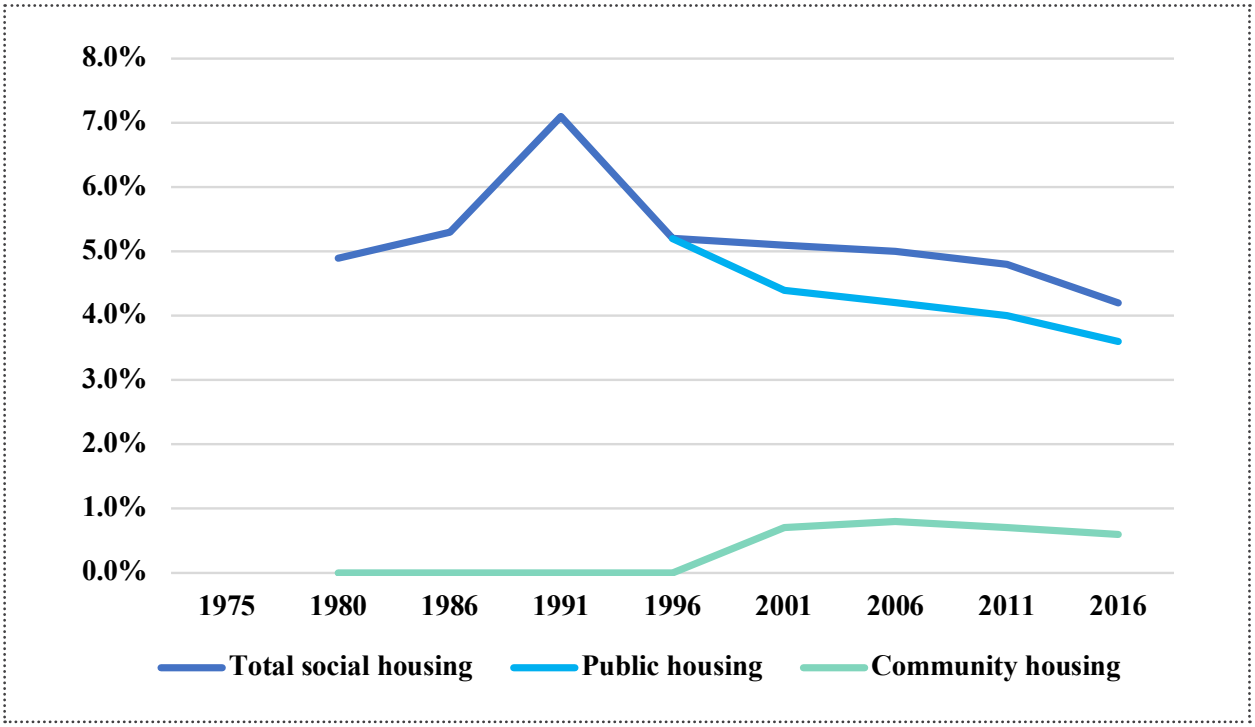
Social housing is defined as "affordable housing provided by the government and community sectors to assist people who are unable to afford or access suitable accommodation in the private rental market" (Australian Government, 2018). It includes public housing, state owned and managed Indigenous housing (SOMIH), and community housing (Australian Government, 2018). Social housing is housing provided by state government or community sector organisations through agreements that set rent at a percentage of the resident's income, usually 25%, to ensure affordability for those who cannot afford housing in the private rental market (Thomas, 2017). Social housing projects can also provide long-term fiscal benefits; for every dollar invested in social housing, it boosts GDP by up to $1.30 (Anglicare, 2021).

Australia's social housing stock increased by only 27,500 dwellings between 2006 and 2020 (AHIW 2021d); an increase in community housing marginally offsetting a fall in public housing. Supply of social housing is significantly outstripped by demand, with 155,141 Australians on the public housing waitlist (AHIW 2021d). Importantly, the waitlist also hides unmet demands from people sleeping rough and very low-income households in housing stress, who are not currently on waiting lists (Lawson et al., 2018) and hidden demands like those who have their waiting list status temporarily suspended (e.g., in NSW if housing applicants are former social housing tenants with prior debt)(Powell & Hartley, 2019).

More generally, housing affordability, for renters has remained of significant concern in Australia. In the private rental market, it was estimated that there was a shortfall of almost half a million dwellings for low-income households (Hulse et al., 2019). The 2020 Rental Affordability Report by Anglicare found that in March 2021, of the 74,266 rental listings across Australia, less than 1% were affordable for singles on government benefits (with zero properties affordable for a single person on Youth Allowance; Anglicare, 2021).

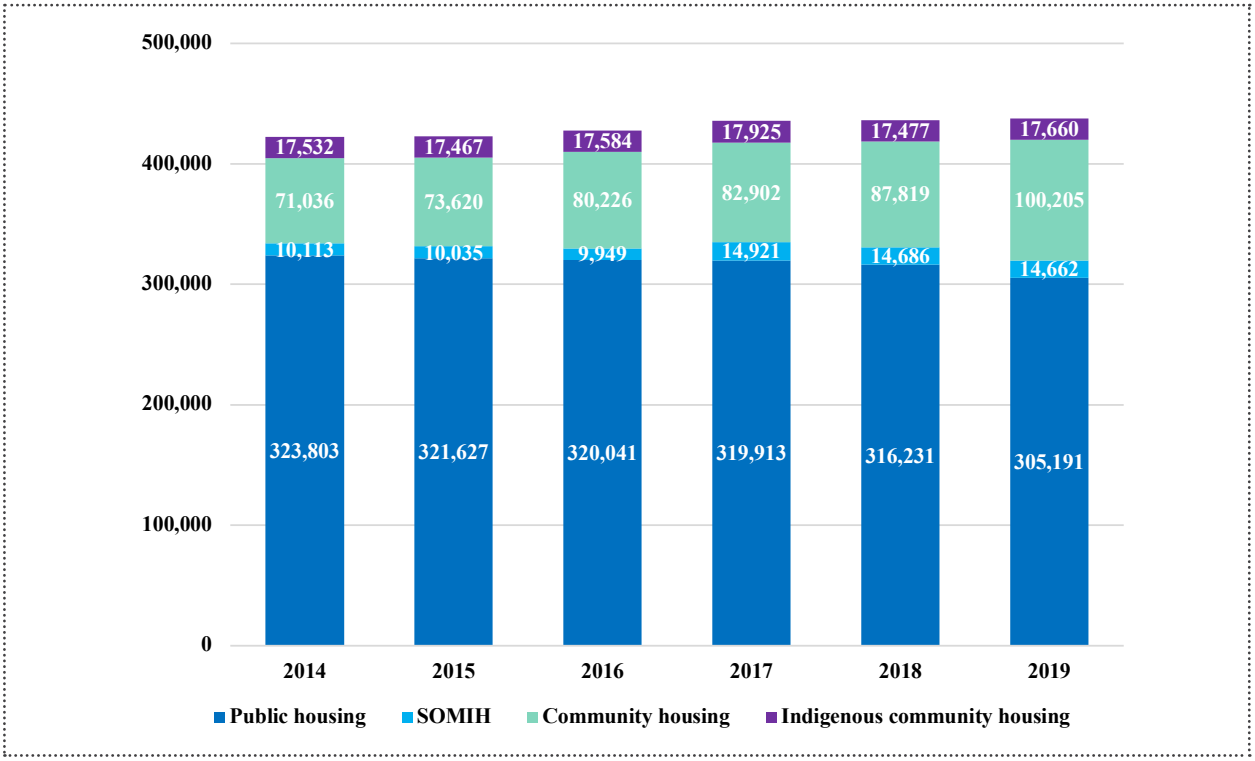
There have long been concerns about stagnation in the development of public housing dwellings and calls to increase the amount of social housing stock, with these calls increasing recently and proposing social housing development as a component of COVID-19 economic recovery (Coggan, 2020; Ziffer, 2020). Despite social and affordable housing being a key policy recommendation for over a decade, Australia's social housing proportionate stock has remained at very low levels; roughly between 4 to 5% of all available housing stock (Parsell & Jones, 2014; Lawson et al., 2018; Lawson et al., 2019). As noted by Troy et al. (2019) and Lawson et al. (2019), the social housing stock has fallen significantly since the 1970s, with only a short rise evident during the Global Financial Crisis via the National Rental Affordability Scheme (NRAS) and the Social Housing Initiative (SHI)(see Figure 53, Figure 54). Lawson et al. (2019) estimated that there was a need for construction of some 730,000 new social dwellings over the next 20 years and they argue for a direct public investment program complementing low cost, long-term concessionary loans by the National Housing Finance and Investment Corporation (NHFIC) to registered community housing providers (CHPs) through instruments such as the Affordable Housing Bond Aggregator (AHBA).

Figure 53 – Trends in Social, Community and Public Housing as a proportion of all households in Australia



Source: AHURI, using ABS Census data, 1981-2016.

Figure 54 – Number of social housing dwellings, all areas, at 30 June 2006 to 30 June 2019



Source: AIHW Housing assistance in Australia 2020.

The growing demand for social housing, the desire to implement stimulatory capital works programs, the strong advocacy from homelessness alliances and peaks, and the implementation of state and territory homelessness and housing strategies, has led to state and territory governments making significant investments in social housing over the last two years. It is likely that the decline in the social housing stock will be arrested and the share of housing drawn from the social housing stock will increase. The total level of new social housing dwellings specified in recent announcements by state and territory governments, is of an historic magnitude and is a fundamental part of an end homelessness agenda. However, aggregate state and territory government investment, while very significant, drops short of the total number of dwellings required to meet underlying demand estimated by Lawson et al. (2018), Lawson et al. (2019). Increased Australian Government funding for social housing investment will be required to meet the remaining social housing gap.

New social housing initiatives for NSW, Victoria, Western Australia, Queensland and Tasmania are set out in Box 2 below.

Box 2 – Recent social housing investments by state and territory governments

NSW: Based on publicly available information, it is estimated that the NSW Government has committed to building 9,386 new social housing properties since 2016, with all properties to be built over a 10-year period (Barnes et al., 2021). Assuming all dwellings will be completed within this period, this provides an average of 938 dwellings per year over the next 10 years (Barnes et al., 2021). Most recently, the NSW Government in the NSW Budget 2020–21 announced $812 million in funding to support the delivery of social housing (NSW Government, 2021c). While on face value this appears to commit the NSW Government to building over 1,200 new dwellings, a considerable number of the properties are accelerated builds of already committed projects. (Barnes et al., 2021). It is estimated that under the NSW 20–21 Budget, the NSW Government committed to providing approximately 780 new properties (including Aboriginal housing). As of 30 June 2020, there were 52,752 applicants on the NSW Housing Register (Productivity Commission, 2021).

Victoria: Victoria has initiated landmark housing funding – $5.3 billion – the largest single investment ever. The program, called the Big Housing Build, intends to construct 12,000 new homes across metropolitan and regional Victoria over a four-year period (Victorian State Government, 2020). This will be made up of 9,300 social housing homes and 2,900 new affordable and low-cost homes built to help low-to-moderate income earners. The program also intends to replace 1,100 old public housing units that are no longer fit for purpose. The social housing stock is expected to increase by 10% as a consequence. Reflecting the interaction between individual and structural factors that is required to address homelessness, 2,000 of Victoria's new social housing homes will be for those experiencing mental illness; 1,000 will be for those who have experienced domestic violence, and 1,000 dwellings will be for Aboriginal Victorians. The Homes for Victorians strategy provides $109 million to help move homeless Victorians into stable housing and $152 million in providing housing for women and children escaping family violence.

WA: The last two years has witnessed a significant shift in investment in social housing in Western Australia. The WA Housing Strategy 2020–2030 launched in October 2020 provided for a 6% net increase in social housing over a 10-year period, equating to an additional 2,600 homes of housing (Western Australian Government, 2020). This came after the WA Recovery Plan announced in July 2020 which included a $319 million Social Housing Economic Recovery package. And in the 2021–22 WA State Budget a record additional $875 million was committed to social housing investment which represents the single largest investment in social housing in WA's history (Western Australian Government, 2021).

Queensland: The Housing and Homelessness Action Plan 2021–25 provides $1.908 billion over four years for social housing investment and homelessness support in Queensland. When taken with the investment undertaken as part of the 2017 10-Year Queensland Housing Strategy an expected 8,845 new social and affordable homes will be available over the eight years from 2017–2025.

Tasmania: The 2021–22 Tasmanian Budget delivered a record $615 million into social and affordable housing, and homelessness initiatives with 3,500 new social houses by 2027.

Public investment in social housing options is fundamental to the end homelessness agenda. Increasing the stock of dedicated housing to support those experiencing homelessness should also involve significant community housing and private investment options. Community housing can access AHBA low cost, long-term loans as well as the Commonwealth National Housing Infrastructure Facility. Heaney et al. (2017) argue that there is a strong evidence base for impact investment options to increase the supply of affordable housing for vulnerable households including those experiencing homelessness. The Synergis Fund in the case of disability housing provides a model for homelessness; in this case impact investment and disability accommodation and support providers act together to increase the supply of supported disability housing.

15.2.2 The private rental market

Social housing provides one permanent housing exit point from homelessness particularly for those with high health needs and long histories of homelessness. There are both access and housing affordability reasons (the setting of rents at 25% of income for most tenants) for utilising a social housing exit-from-homelessness pathway However, the private rental market is also a source of exit from homelessness and one that must play a significant role given social housing supply-side constraints. The private rental market also plays an important role in ending homelessness in that it is a site for tenancy support programs that seek to assist those at risk of homelessness maintain their tenancies.

The Australian Government provides those receiving income support in community and private rental housing with CRA. The provision of CRA reduces the prevalence and extent of housing affordability stress problems for those in the private rental market but, by no means, eliminates housing affordability stress altogether (Ong et al., 2020) and is, of course, conditional on entering the private rental market. Access to the private rental market for those experiencing homelessness can be very difficult. Beyond CRA, assistance to people formerly experiencing homelessness in the private rental market is provided by private rent assistance programs delivered by both state and territory governments as well as not-for-profit organisations, private rental brokerage programs, the former NRAS, private rental tenancy support programs for those at risk of homelessness, and supportive access to private rental housing programs (Flatau & Zaretzky 2008; Flatau et al., 2008; Flatau et al., 2009; Zaretzky & Flatau 2013a,b; Zaretzky & Flatau 2015; Tually et al., 2015, 2016).

Supportive access to private rental housing for those experiencing homelessness is critical in an end homelessness agenda. Two of the most innovative programs in the Australian context were the Platform 70 initiative in Sydney delivered by Bridge Housing as part of the Way2Home program and the HomeGround Real Estate (HGREA) initiative. Platform 70 was part of one of Australia's first Housing First programs in Australia and was developed in partnership with Neami National who delivered intensive psychosocial support services as part of the Way2Home program (Hough 2014; Whittaker et al., 2015; Pinkstone 2016; Whittaker et al., 2016; Whittaker et al., 2017). Bridge Housing in Sydney provided community housing and connection points to real estate agencies and private landlords who provided private rental housing and more than met their target of 70 people housed through the program with 107 people housed and over 70% of participants sustaining their tenancy once the program finished.

Launch Housing's HomeGround Real Estate social enterprise not-for-profit residential real estate agency commenced operations in 2014 in Melbourne and supports those experiencing homelessness enter the private rental market (Heaney et al., 2017). The HGREA utilises a three-tier model which uses income from commercial real estate activities (Tier 1) to subsidise the Affordable Housing Initiative which provides two steams of housing for people who are experiencing disadvantage, particularly those experiencing homelessness: 'Affordable Housing' properties at below market rent (Tier 2) and 'Private Social Housing' properties where rent is set based on tenant income (Tier 3). The HGREA model includes a micro-impact investor segment where private landlords supply properties for rent through the HGREA and receive below market rent (and through a Tax Office ruling claim a tax deduction) supporting affordable housing options for people who are homeless or at risk of homelessness and not able to access affordable public or private housing (Heaney et al., 2017). The HGREA brand is now being applied in other cities in Australia including Sydney through the HomeGround Real Estate Sydney and Bridge Housing.

Box 3 – Ending Veterans Homelessness Initiative (EVHI) in Chicago

The ***Ending Veterans Homelessness Initiative (EVHI),*** undertaken in Chicago, reduced homelessness among veterans in the community by 47 per cent over a 6-year time period (Oo, 2018). This was achieved through an Advance to Zero, By-Name List methodology and the utilisation of housing vouchers, among many other factors. Housing vouchers were used to bolster veterans' base income and ensure they were able to access housing that was affordable for them, in a decentralised way. Private landlords and specific real estate agencies were engaged and provided housing for veterans experiencing homelessness with vouchers (Oo, 2018). There was also an establishment of an emergency fund for individuals who were housed through EVHI. The $100,000 veterans' emergency fund was established through private philanthropy and could be used to cover any unit damage that private landlords might incur in renting units to veterans. This method of engaging an emergency fund acted in a protective way for both individuals experiencing homelessness and for private landlords. It gave private landlords a sense of confidence in providing housing options as they knew any potential damages would be financed. It also ensured that people experiencing homelessness wouldn't incur any debt as a result of rental property damage, something that concerned people, especially if they had existing debt from other rental properties or alternative reasons. The fund incurred less than $1,000 of expenditure for damage to properties. The vast majority was spent to cover first month's rent, security deposit and connection of utilities (Oo, 2018).

15.3 Housing First supportive housing responses to ending chronic homelessness

Housing First is a recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing and then providing additional supports and services as needed (Tsemberis et al., 2004). The aim of a Housing First approach is to provide rapid access to permanent, supported housing for people who are chronically homeless without any preconditions to accessing housing (Tsemberis et al., 2004). Housing First is an approach first popularised in the United States in the 1990s (Tsemberis, 2011) and since then has been implemented in many countries, such as Canada, the United Kingdom, and Australia.

The Housing First model has been implemented in Australia since the early 2000s. In the initial phase, Housing First models acted as pilot programs or operated with time limited funding (Johnson et al., 2012). However, there has been a significant expansion of Housing First approaches in Australia over the last two decades including Common Ground Adelaide in 2006, the Michael's Intensive Supported Housing Accord (MISHA) program, the Way2Home and Platform 70 Project in Sydney, Common Ground Sydney and Common Ground Brisbane (Micah Projects in Brisbane), Street to Home in Melbourne, and the 50 Lives 50 Homes campaigns in various states including Queensland and Western Australia.

Housing First can be conceptualised as both a program structure and a philosophical approach. The philosophical approach denotes that access to secure and permanent housing should be an inherent human right, and the capacity for individuals to exercise choice and control over their tenancy options is paramount to tenancy longevity and success (Clarke et al., 2019). Program structure characterises how the philosophy is enacted within a community, or system, but is constrained by housing stock availability, quality, and access.

Research undertaken by Parsell et al. (2014), identified that people experiencing chronic homelessness with multiple presenting health conditions had a significantly higher level of housing retention in a Housing First program as compared to a treatment first program. Despite the mounting research demonstrating the efficacy of housing first programs, research suggests that not all jurisdictions and services in Australia have embraced the model in its totality. Clarke et al. (2019) suggest that, though stakeholders want to embrace the model, an ethos of 'housing readiness' still remains at a service delivery level. Largely perpetuated by a large demand on a diminishing supply of housing options, housing organisations retain an ability for elements of choice and control regarding their tenants and associated tenancies meaning that many individuals are engaged with support services and temporary housing prior to accessing permanent housing.

However, the recent expansion of homelessness zero projects based on a Housing First principle and new government funding for Housing First programs, is transforming the Australian homelessness landscape. For example, in December 2020, the McGowan Labor Government in Western Australia announced $34.5 million for the Housing First Homelessness Initiative as part of the State's first 10-year strategy on homelessness (Seivwright et al., 2021).

Critical to the effective implementation of a Housing First approach is the adoption of ongoing supportive housing programs for those with high needs that enter permanent housing from homelessness, particularly for those with long spells of homelessness and health comorbidities. Our analysis of the Advance to Zero database provides strong backing for the need for a supportive housing approach to those sleeping rough and in supported accommodation. Significant numbers of those in the Advance to Zero database exhibit high health needs along with other needs. Supportive housing involves the combination of affordable housing with services that help people sustain their housing and live more stable, productive lives.

Supportive housing models have been applied in Australia in the context of Housing First programs both in congregate settings through the Common Ground and Foyer models and in scattered site settings including Michael's Intensive Supported Housing Accord (MISHA) program, the Way2Home, and Platform 70 Project in Sydney, the 50 Lives 50 Homes/Street to Home programs in Brisbane, Melbourne, and Perth (see the following section of Housing First programs).

The Common Ground model includes mixed tenancy arrangements, affordable housing (rents capped at 30% of income or below) onsite tenancy management, tenancy support, and holistic case management including mental health, primary healthcare, recreation and other specialist services, with a central concierge facility to maintain safety. In some cases, a social enterprise model sits alongside the Common Ground. Common Ground models involving joint government and business investment have been implemented in Australia from 2006: Common Ground Adelaide and Port Augusta (2006); Elizabeth St Melbourne Common Ground (2010); the Camperdown Common Ground in Sydney (2011); the Brisbane Common Ground (2012); and Tasmania (2012). The WA Government recently announced that two new Common Grounds would be built and supported in Perth and Mandurah.

Supportive housing models go beyond the private rental and social housing tenancy support models designed to provide time-limited support for those in housing at immediate risk of homelessness and provide care over long periods of time depending on underlying need. While long-term supportive housing models are evident in the disability support sector, in aged care and to a lesser extent community mental health, the homelessness sector has faced significant funding challenges in the past beyond initial two- or three-year funding programs. As outlined in the Housing First section below, we have seen significant recent investment by state and territory governments in Housing First supportive housing models.

Carlos and Integrated Healthcare Nurse Carla from Micah Projects Street to Home Outreach Team.

Photography: Katie Bennett

Box 4 – Sobell supportive housing

Sobell provides long-term housing and support for people with mental health and homelessness issues in Victoria. In this moderate scaled apartment block of 33 one- and two-bedroom units, half of the tenancies provided targeted supports and half are affordable housing. The site is located in Preston, 9km from Melbourne's CBD. Support workers and housing workers are based on-site with a concierge service overnight and on weekends. Communal spaces - a community garden on the rooftop terrace and a community hub – create spaces to connect. The combination of the small scale, mixed tenancies and on-site staffing/concierge provided by Neami National has fostered the development of a vibrant and supportive community where tenancies are sustained long-term.

15.3.1 New South Wales STEP to Home and Together Home

One of the first Housing First programs implemented in Australia was Michael's Intensive Supported Housing Accord (MISHA) program in Sydney (Conroy, Bower et al., 2014) and the Way2Home program. More recently the NSW Government has implemented two major programs, the STEP to Home and Together Home programs which follow Housing First supportive housing principles.

Box 5 – Supported Transition and Engagement Program (STEP)

STEP to Home is a Housing First supportive housing program funded by the New South Wales Department of Communities and Justice under its STEP program funding. STEP to Home is funded to provide 90 long-term housing places with wrap around support for people sleeping rough or experiencing secondary homelessness in Inner Sydney. Properties are secured from the private rental market by Community Housing partners Bridge Housing (lead housing provider), Metro Community Housing and the Women's Housing Company (subcontracted housing providers). Post Crisis Support is provided by Neami National for between 18 months—3 years. Neami provides support to tenants with different levels of intensity subject to their needs and stage on their STEP to Home journey. STEP to Home commenced in 2019 and is scheduled to end in 2022. STEP is delivering long-term tenancies (85% sustained tenancy rate) that are transforming the lives of people who had previously had long histories of sleeping rough. The Neami team effectively utilises the talents and expertise of staff with a lived experience of homelessness and Aboriginal Liaison Officers to improve health, social and cultural connection, and wellbeing outcomes for people they support for up to three years. In a recent evaluation 93% of people housed reported high satisfaction with their housing and community, while 72% said their health had improved since being housed (Centre for Social Impact, 2021).

The Together Home program is a $122.1 million program (as of end 2021) supporting people street sleeping across NSW during the COVID-19 pandemic and beyond into long-term stable accommodation, linked to wraparound supports (NSW Government, 2020a). Together Home will make available properties leased from the private rental market linked to wraparound, flexible supports. The program will operate for two years in a partnership between Department of Communities and Justice and Community Housing Providers. In announcing this funding package, NSW Minister for Families, Communities and Disability Services Gareth Ward argued that is the investment was the largest single investment made to tackle rough sleeping in NSW.

There is some criticism that Housing First policy of rapid housing has not always been applied consistently for those exhibiting multiple morbidities especially those who have experienced a recent failed tenancy. In contrast to rapid housing, the staircase approach is based on the idea that the individual experiencing homelessness has to achieve certain steps, for example: engagement in boarding facilities, abstinence, linking in with mental health supports to ensure housing readiness, thereby subjugating the housing first ethos (Clarket al., 2019).

15.3.2 Aspire Social Impact Bond

The Aspire Social Impact Bond (SIB) commenced in 2017 and was Australia's first homelessness focused SIB, and South Australia's first SIB (Social Ventures Australia, 2017, 2020). This program, delivered by Hutt St Centre, follows a housing first model and provides three years of case management support for people who enter the program. Throughout the three years there is a focus on meaningful engagement with the individual, with a view to work towards strengthening community engagement and identify goals specific to the individual, building occupation and meaning in individuals' lives. Over the three years that Aspire has been assessed, there have been significant recordable reductions in hospital usage, emergency accommodation and accessing justice services in this cohort. Through the three measured years, tenancy retention remains high, at 88%, with only 13 individuals being evicted, and the remainder of individuals choosing to either leave their tenancy or obtaining transfers and not returning to homelessness (Social Ventures Australia, 2020).

15.3.3 Journey to Social Inclusion program

The Journey to Social Inclusion (J2SI) program operates using a Housing First, rapid housing approach combined with three years of case management support for people experiencing chronic homelessness in Victoria. The program has developed over three phases: an initial trail, a scaled-up phase 2 program and currently a third phase further scaled up social impact investment-based model. J2SI, broadly, aims to improve social inclusion outcomes for people experiencing homelessness through both access to housing and five service delivery elements: intensive case management and service coordination, tenancy support and capacity building to maintain housing, trauma-informed practice, building skills for inclusion, and fostering independence (Seivwright et al., 2020). At the end of the program, 82.5% of J2SI phase 2 participants were housed.

15.3.4 50 Lives 50 Homes campaigns

The Brisbane 50 Lives 50 Homes campaign was launched in 2010 and aimed to house and support Brisbane's most vulnerable people experiencing homelessness. Micah Projects Support and Advocacy Workers, outreach workers from other agencies, and community volunteers surveyed people sleeping rough, adding 273 people to the Brisbane register. In January 2011, 50 vulnerable people from the register were housed, with a total of 230 rough sleepers from the original register being housed over four years.

The 50 Lives 50 Homes program was also applied in Perth in a collective impact program that commenced in late-2015 with the aim to house and support the most vulnerable rough sleepers in Perth. 50 Lives was founded on a Housing First approach, working to provide people with safe, stable, and permanent accommodation without preconditions. As of October 2020, 50 Lives transitioned into a broader Perth Zero Project, expanding the model to other communities and adopting an Advance to Zero methodology aimed at ending rough sleeping.

During the five-year period, 427 individuals were supported, with 199 supported into permanent housing (Vallesi et al., 2021b). Individuals supported through 50 Lives continue to be supported through the Zero Project.

The 20 Lives 20 Homes program is a local place-based response to homelessness in the Fremantle area. It is focused on providing supported and sustainable housing for 20 individuals who have been identified as the most vulnerable within the homelessness population of Fremantle. Supported through philanthropic donations, 20 Lives is an extension of the Housing First initiative 50 Lives 50 Homes collaborative impact project. To date the program has supported and housed 26 individuals.

15.3.5 Advance to Zero

The Advance to Zero methodology began implementation after Adelaide agreed to be a Vanguard city, the initiative coordinated by the Institute of Global Homelessness. The Adelaide Zero Project governance structure was not born overnight. Significant work by key agencies was undertaken to bring together services in Adelaide's CBD in 2017, before planning and rollout of the first Connections Week occurred. The first Connections Week occurred in May of 2018, launched by the Don Dunstan Foundation as the independent backbone of the project, and a coalition of 40 partners. Connections Week staff and volunteers canvassed the CBD for two nights and one morning. There was also one team that went out later in the evening to established sites that were empty and flagged by volunteer groups, to ensure that a comprehensive assessment of people sleeping rough in the inner city occurred. During the first Connections week, 143 individuals rough sleeping in the city were engaged with. This began the ability for services to start to know people by name and see how their reported vulnerability impacted on their ability to engage, obtain, and maintain housing (Don Dunstan Foundation, 2020).

Through leveraging existing inner-city governance processes, such as the Vulnerable Persons Framework (VPF), services that already had knowledge and trust in each other were able to take the lead on forming inner city committees. The VPF was already a multi-sector meeting where people identified the most at-risk people experiencing homelessness in the CBD to see if services could be coordinated to support them. Through the Advance to Zero process, this group was changed to be the Coordinated Care group, where organisations from multiple sectors: homelessness, health, hospital avoidance, police and corrections, mental health, AOD services, Aboriginal and Torres Strait Islander specific services, and housing services would come together to share information regarding service access, and create a plan regarding how to support the most vulnerable people experiencing homelessness in the inner city (Don Dunstan Foundation, 2020). There were many governance groups that came to fruition after the first connections week.

Figure 55 below provides an overview of the governance structure for the Adelaide Zero Project.

Figure 55 – Adelaide Zero Project governance structure

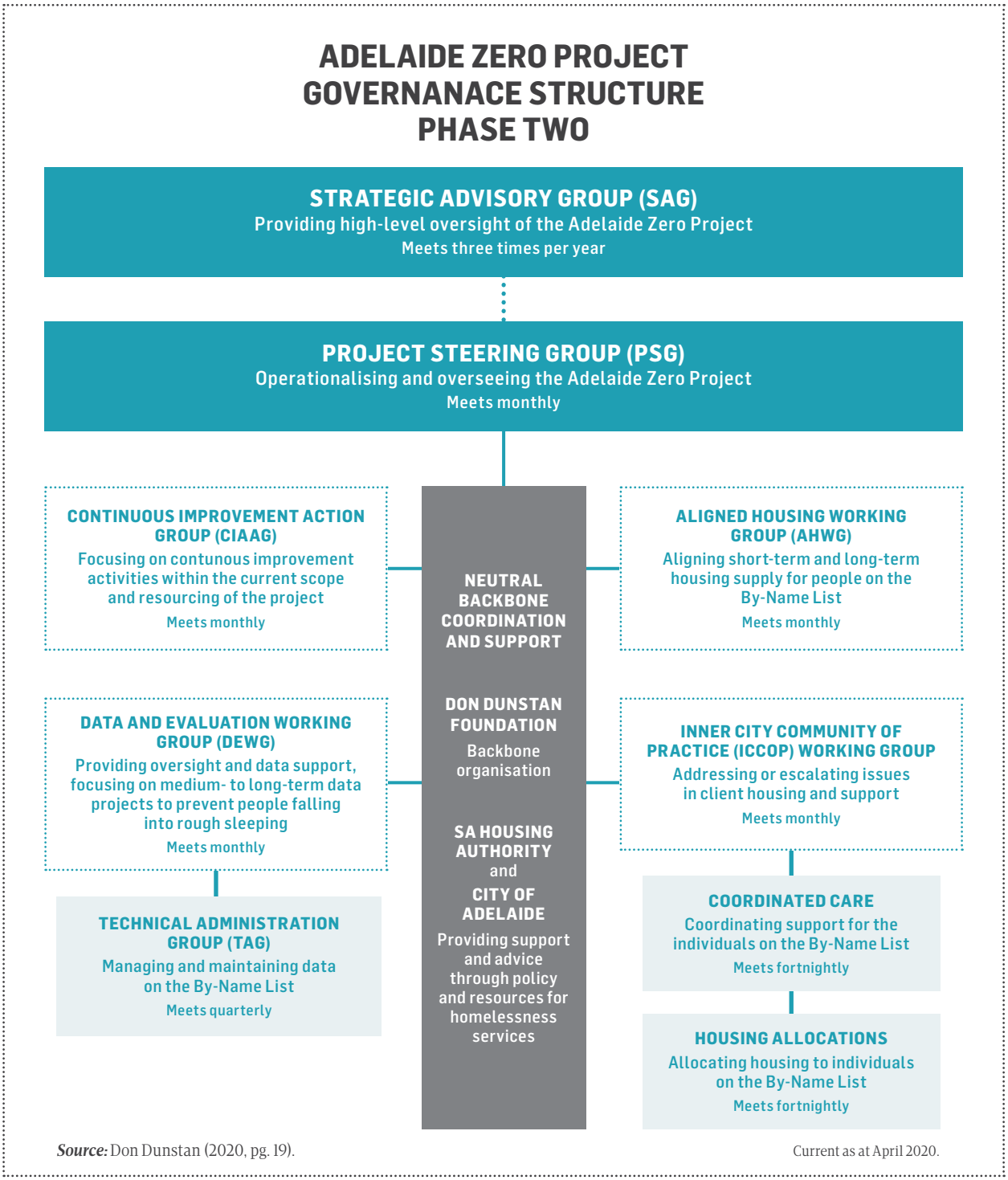


Figure 55 outlines the key groups that were created to ensure the project was working towards set objectives, using data for collective impact and continuous improvement, and working towards making an individuals' experience of homelessness rare, brief and non-recurring. Of particular note are the Housing Allocations group, where homelessness organisations and housing providers come together to have an open dialogue regarding housing options for an individual on the By-Name-List. Through this process there is a collective decision regarding best fit for the housing and individual in need. Factors such as VI-SPDAT score, history of housing, engagement with worker, and advocacy from the homelessness agency are taken into account and collective decisions are made. As of the 30th of December 2020, 532 housing placements had been achieved through the duration of the project.

Zero projects have now been implemented across Australia including the NSW End Street Sleeping Collaboration, the Brisbane Zero Campaign, the Melbourne Zero Project and Port Philip Zero Project, and the Perth Zero project (formerly 50 Lives 50 Homes) with new sites starting in Geraldton, Mandurah, Bunbury, and Rockingham.

Box 6 – Western Australia Housing First Homelessness Initiative

As part of the All Paths Lead to a Home: Western Australia's 10-Year Strategy on Homelessness 2020–2030, $34.5million of funding will be delivering the WA Housing First Homelessness Initiative which will provide accommodation and wrap around support to people sleeping rough in the Perth Metropolitan Area, Rockingham/Mandurah, Bunbury and Geraldton.

Under the WA State Government's Housing First Homelessness Initiative, Moorditj Mia will be WA's first Aboriginal Housing First Support Service. Announced in February 2021, Moorditj Mia (Strong Home) is an Aboriginal-led initiative that will provide culturally appropriate accommodation, employment, health, mental health, financial, and social supports across the Perth metro area. The initiative will be run by a consortium led by Aboriginal Community Controlled Organisation Noongar Mia Mia, alongside Ngalla Maya Aboriginal Corporation and Wungening Aboriginal Corporation.

15.4 Chronic homelessness and COVID-19

The arrival of COVID-19 in 2020 led to state and territory governments adopting a variety of policy and practice measures to both provide temporary and longer-term accommodation for those experiencing chronic homelessness. This section provides an overview of the arrival of COVID-19 in Australia and its impact in relation to ending chronic homelessness as well as lessons learnt more generally for an end homelessness agenda.

Since first emerging in 2019, by early 2020 COVID-19 had spread so far as to become recognised as an international public health emergency by the World Health Organisation (World Health Organisation, 2020). As the virus spread it became apparent that COVID-19 did not pose equal risks to all parts of society, with some groups at an increased risk of exposure and greater likelihood of severe cases and mortality (Lewer et al., 2020).

One group identified as a particular risk of contracting and being severely impacted by the spread of COVID-19 were those currently experiencing homelessness. People experiencing homelessness, particularly those sleeping rough, were identified to be at increased risk of infection by virtue of their limited capacity to practice social distancing, their limited access to infection prevention measures such as hand sanitizers and masks, and reduced ability to self-isolate should they be required to do so (Pawson et al., 2020). The vulnerability of people experiencing homelessness to COVID-19 was also heightened by the higher prevalence of chronic health conditions among the homeless population sleeping rough and in supported accommodation (Flatau et al., 2018). Further, individuals experiencing homelessness were at increased risk of contracting other respiratory diseases which could increase the likelihood of contraction of the virus (Parsell et al., 2020).

The first cases of COVID-19 were confirmed in Australia in January 2020. Following the virus's arrival, SHS, peak agencies and public health experts called upon the Australian Government to implement protections for those experiencing homelessness (Flatau & Hartley, 2020). Criticism has been made of the Australian Government's lack of implementation of a national strategy to guide responses to homelessness during the pandemic, and to recognise the importance of preventative measures for people experiencing homelessness (Homelessness NSW, 2020).

In the absence of a national strategy to respond to homelessness and COVID-19, state and territory governments adopted a variety of policy and practice measures to both provide temporary accommodation to those currently homeless and to prevent further exits into the homelessness system (Hartley et al., 2021). Direct initiatives and a strategy characterized by close coordination between states/territories and frontline SHS aided in the placement of rough sleepers and people at risk of homelessness in secure, temporary accommodation potentially averting a major public health crisis (Mason et al., 2020). Parsell et al., (2020) estimate that, by September 2020, $229 million had been committed to extraordinary homelessness expenditure by the five mainland state governments.

Beyond the state and territory government responses to providing shelter for those sleeping rough, COVID-19 also brought in never-before-seen measures that were supportive of low-income renters and those at risk of homelessness. On the 29th March 2020, the National Cabinet agreed to a moratorium on evictions over the next six months for residential tenancies in financial distress who are unable to meet their commitments due to the impact of COVID-19. This was enshrined into law by all states and territories, except the Northern Territory and Australian Capital Territory. The Victorian Government offered a one-off payment of up to $2000 for renters who are unable to afford rent (Bentley & Martino, 2020). On 2nd April, the Queensland Government announced the COVID-19 Rental Grant. The COVID-19 Rental Grant is a one-off payment of up to 4 weeks rent (maximum of $2000) available to those affected by the COVID-19 pandemic who do not have access to other financial assistance. The grant is paid directly to the lessor of the property.

15.4.1 New South Wales COVID-19 homelessness response

On 27th March 2020, the NSW Government announced a funding package of over $34 million for homelessness services including $14 million specifically for the expansion of temporary accommodation services for those needing assistance (NSW Government, 2020b). As a result of this increased funding, Department of Communities and Justice (DCJ) was able to accommodate a significant number of people sleeping rough into temporary accommodation during the pandemic. Between late March and June 2020, over $29.0 million was spent on the increased temporary accommodation program- providing 131,000 nights of accommodation to over 13,000 people (NSW Audit Office, 2021).

While total numbers for inner city Sydney are difficult to determine, across NSW it is estimated over 1900 people who were sleeping rough were placed in temporary accommodation between 1st April and 19th June 2020 (Pawson et al., 2020). Unique in the approaches to people sleeping rough during COVID-19 in Australia, was the NSW Government's commitment to providing long-term housing for those placed in temporary accommodation. On 8th June, the NSW Government announced the Together Home program (Together Home) a $36.1m investment that aims to support people's street sleeping across NSW during the COVID-19 pandemic into stable accommodation, linked to wraparound supports (detailed further under Housing First).

In 2021, the Centre for Social Impact released an evaluation into the NSW Government's provision of temporary accommodation to people sleeping rough in the inner city of Sydney during the initial wave of the pandemic in 2020. The report, More than temporary? An evaluation of the accommodation of people sleeping rough in inner city Sydney during the COVID-19 pandemic (Hartley et al., 2021) highlights the high levels of commitment and collaboration between DCJ, NSW Health, peak housing and homelessness agencies and the specialist homelessness sector which facilitated the housing and support of large number of people sleeping rough. The primary vehicle for this collaboration was the Sydney Rough Sleeping COVID-19 Taskforce which built upon pre-existing collaborations and DCJ procedures to effectively coordinate temporary accommodation and support to people sleeping rough in inner city Sydney. Other important, commendable features of the NSW Government's response was the use of higher quality temporary accommodation providers and the increased flexibility in relation to length of time in which a person sleeping rough was eligible to receive temporary housing assistance for (Hartley et al., 2021).

However, the report also finds limitations in the approach adopted by the NSW Government in inner city Sydney. This includes the delay between when the first cases of COVID-19 arrived in NSW and the implementation of an enhanced temporary accommodation response to people sleeping rough. This delay not only exposed people sleeping rough to potentially adverse health implications but also created confusion for the specialist homelessness sector who felt they received limited information on how to prevent the spread of COVID-19 amongst their clients. The report also finds that the provision of health, food, and other support services to people in temporary accommodation in inner city Sydney was done so in a delayed and uncoordinated manner (Hartley et al., 2021).

On 26th June 2021, DCJ announced that any permanent resident sleeping rough in Greater Sydney, Wollongong, Blue Mountains, and the Central Coast would also be eligible for temporary accommodation for the duration of the lockdown (Homelessness NSW, email correspondence, June 2021). In July 2021, the NSW Government announced additional funding of $22.3 million to assist people sleeping rough during the Delta outbreak (Lathouris, 2021).

15.4.2 Victoria COVID-19 homelessness response

The response in Victoria included a range of measures such as setting up pop-up homelessness Covid-19 recovery facilities, intensive supports to public housing and purchasing thousands of temporary accommodation (Wynne, 2020). Victoria provided the most funding (approximately $174.6 million) for homelessness initiatives during the impact of the pandemic out of all Australian jurisdictions (Mason et al., 2020).

The Victorian Government provided additional funding of $15 million to support those experiencing homelessness during the pandemic, including almost 6 million for hotel accommodation (Victoria Government, 2020). In June 2020, an additional $9.8 million was allocated to provide temporary hotel accommodation. As a result, 'at least' 4500 households were placed into hotels around the state (Topsfield, 2020). Launch Housing specifically supported 2268 individuals sleeping rough during the pandemic, with 740 clients as of the 28th July. Some of these individuals were placed into four repurposed Victorian aged-care sites, with $9 million used to house 200 homeless individuals (Juanola, 2020).

In June, the government announced that nearly $10 million will be spent extending the stay of people experiencing homelessness in hotels and helping them find long-term housing (Topsfield, 2020). As of July, a landmark announcement was made in which $150 million will be dedicated to extending hotel accommodation for 2000 individuals until April 2021, as they are transitioned into long-term housing. Eleven hundred properties will be leased from the private rental market and 1000 social housing properties will provide the supply source (Topsfield, 2020).

Box 7 – From Homelessness to a Home

On July 28, 2020 the Victorian Government announced the From Homelessness to a Home (H2H) Program. Funding of $150 million provided 1,845 households experiencing homelessness, who were residing in emergency accommodation due to the COVID-19 pandemic prior to 6 December 2020, with access to stable medium- and long-term housing and support packages for a period of up to 18 months and support services up to 24 months. These packages provided for multidisciplinary support across two categories of intensity: medium or increased support needs (targeted and tailored) and high or multiple and complex support needs (intensive).

Registered Housing Agencies, homelessness support agencies and other relevant services came together during late 2020 in partnership and under multiple consortium arrangements to deliver these packages. Following Housing First principles, the primary aim was to house people as quickly as possible to prevent further harm from sleeping rough or living in emergency accommodation.

Housing was provided from a combination of properties owned by the Registered Housing Provider; private rental properties head-leased by the Registered Housing Provider; newly acquired properties owned by the Director of Housing and leased to the Property Services Provider under a General Lease Agreement; and existing Public Housing stock. Access to long-term social housing was secured by ensuring all eligible clients completed a Victorian Housing Register (VHR) application Emergency Management Category (with a new COVID-19 priority reason). This put them at the top of the VHR wait list for social housing.

In November 2021, the Homes For Families program was announced, based on H2H and to be delivered by the existing H2H consortia. Funding of $66 million will provide 250 tailored support packages for households with children in emergency accommodation due to the COVID 19 pandemic and based on the Housing First and cross-disciplinary case management model that has been implemented in H2H. The program will be implemented during December 2021 to February 2022.

In large part due to the introduction of H2H, Port Phillip Zero recently achieved the first meaningful system shift in Australia; a key indicator of progress toward functional zero rough sleeping homelessness. Having established an improvement median with 10 months of quality By-Name List data, the project recorded six consecutive months where the number of people actively experiencing rough sleeping homelessness was below that median. The project also celebrated its first 50 placements into long-term housing during that period.

15.4.3 South Australia COVID-19 homelessness response

In South Australia, the COVID-19 Emergency Accommodation Response for Rough Sleepers (CEARS) was launched, led by a coalition of homelessness and government agencies supported by $8.2 million of government funds. A total of 542 people were placed into South Australian Housing Authority-funded temporary hotel and motel accommodation (Neami national, email communication, July 2020). Part of the South Australian government funding provided temporary accommodation to Aboriginal peoples who were sleeping rough from remote communities (Lensink, 2020). Through this motel scheme, 182 individuals were placed into public housing properties, while 60 others obtained other forms of accommodation, such as private rental, share housing and community housing options (Martin, 2021).

The CEARS response was coordinated by Neami National, in collaboration with Hutt Street Centre and Baptist Care. As of November, 250 rough sleepers were transitioned into long-term housing (Minister for Human Services, 2020).

From the initial CEARS response of placing individuals in emergency motels, the State Government provided one year housing packages to individuals who were housed through the CEARS motel program to ensure tenancy retention and support was provided in the crucial time period of obtaining housing after rough sleeping for a significant time period.

15.4.4 Western Australia COVID-19 homelessness response

A significantly more limited temporary accommodation response was provided by the Western Australia (WA) Government (Hartley et al., 2021). Unlike the other state approaches listed above, WA did not provide funding for widespread access for people sleeping rough to temporary accommodation (Pawson et al., 2020). Western Australia introduced the 'Hotels with Heart' program – a two-week trial in which 30 rough sleepers were placed in the Pan Pacific hotel, 19 of whom completed the trial, with 13 subsequently moved to longer-term accommodation (Kagi, 2020). In addition, at the recommendation of the Department of Communities' Homelessness Task Force, 43 Aboriginal rough sleepers were housed at the Woodman Point Recreation Camp and provided with medical services (Hirini, 2020). Given that Western Australia has approximately 1000 rough sleepers, the response was criticised as vastly inadequate and a missed opportunity (Macdonald, 2020).

On the other hand, the WA Government, through Lotterywest grants provided significant COVID-19 funding to specialist homelessness services (Government of Western Australia, 2021) and brought forward Housing First Homelessness Initiatives (Department of Communities 2020).

15.4.5 Queensland COVID-19 homelessness response

During COVID-19, Micah Projects, together with the Queensland government housed 2,445 households – families and individuals (as at 14 July 2020). Of these, 1,017 households were assisted into permanent housing placements. The response of the Queensland Government to providing temporary accommodation has been criticised as failing to adequately assess the risk and health needs of individuals prior to placing people in temporary accommodation (Australian Association of Social Workers, 2020). Concerns were raised particularly in relation to women affected by family violence being placed in the same hotels as perpetrators of violence, and the people managing problematic substance use co-located with individuals engaging in substance use (Australian Association of Social Workers, 2020). Queensland utilised Housing First programs that were in place, such as the Micah Project, despite a significant commitment ($24.7 million) to 'use the ability to help these Queenslanders into appropriate, permanent accommodation' by August 2020, no additional funding to support a housing first strategy had been announced (Bosely, 2020; Mason et al., 2020).

15.4.6 Tasmania COVID-19 homelessness response

The end of April 2020 saw $4.3 million in funds dedicated to a housing and homelessness support program in Tasmania (Tasmanian Government Department of Premier and Cabinet, 2020). This funding expanded the Safe Night Space pilot program (begun in December 2019), delivered increased mental health support, increased emergency accommodation provision, increased capacity at existing homelessness shelters, and provided services for youth homeless (Tasmanian Government Department of Premier and Cabinet, 2020). The Safe Night Space program will comprise $2.5 million of the funds, money which will be used to expand the program to Launceston and Burnie and to provide 24/7 accessibility and wraparound support. The youth response includes creating an under 16 Youth Homelessness Taskforce, and supportive youth accommodation facilities in Hobart and Burnie, as well as providing additional services. More homes are also being delivered through the Affordable Housing Strategy (Tasmanian Government Department of Premier and Cabinet, 2020). Notably, the government has not made any commitment (in contrast with Queensland and Victoria in particular) to transitioning rough sleepers to permanent accommodation. It is also not clear if rough sleepers were housed during the COVID-19 period.

15.4.7 Australian Capital Territory COVID-19 homelessness response

In April 2020, the ACT government announced $832, 000 of funding to house its rough sleepers in temporary accommodation (Australian Housing and Urban Research Institute [AHURI], 2020). In comparison with other jurisdictions, it is not clear how many rough sleepers were housed, nor if there are plans to transition these individuals to long-term accommodation (Jervis-Bardy, 2020). The ACT also dedicated $305,000 to refurbish and upgrade public housing units to be used as emergency accommodation, and has provided extra funding in order to fast-track a COVID-19 program to house those experiencing chronic homelessness, so far finding permanent accommodation for 22 people.

15.4.8 Northern Territory COVID-19 homelessness response

The Northern Territory did not accommodate its rough sleepers in hotel and motel accommodation. Rather, funding was increased to existing agencies (Bosely, 2020). For example, public housing units were upgraded to be used as emergency accommodation and agencies such as Argyle Housing and CatholicCare (Bosely, 2020). According to the Aboriginal-led health service, Danila Dilba, up to 300 Aboriginal homeless individuals "have so far been largely forgotten in official planning for the COVID-19 pandemic" (as cited in Zwartz, 2020). NT Shelter in particular views a homelessness support centre in Darwin as a necessity, with plans to build one recently scrapped (Pfeiffer, 2020). However, many Aboriginal people living in Darwin were provided free transport back to remote communities through funding by the NT government (Zwartz, 2020).

15.4.9 Homelessness services

Through COVID-19 it became clear that governments and associated non-government agencies were able to overcome siloed practices and work together to achieve a common goal. Rhetoric surrounding homelessness moved towards a shared understanding of 'the problem' of homelessness, and the ability to frame homelessness in the context of a public health issue rather than an individualised one, encouraged cross-sector participation and positive outcomes for many people experiencing homelessness (Parsell et al., 2020).

15.4.10 Income support

On 23rd March 2020, the Federal Government announced a $550 fortnightly increase to unemployment payments for six months, which was reduced to $250 a fortnight in September 2020 and ended in March 2021 (Pupazzoni & Janda, 2020). The Coronavirus Supplement was paid to both new and existing recipients of the JobSeeker Payment, Youth Allowance Jobseeker, Parenting Payment, Farm Household Allowance and Special Benefit. Two Economic Support payments of $750 were also paid to those eligible, and two additional smaller payments are forthcoming. Prior to the Coronavirus Supplement ending, many advocated that the underlying Job Seeker payment be permanently increased given its positive impact on reducing poverty (Guerrera, 2020). However, only a relatively small increase in the underlying Job Seeker payment was implemented.

On 30th March 2020, the Federal Government announced the introduction of the JobKeeper payment, open to eligible businesses that were significantly financially negatively affected by the crisis. This payment was $1500 per worker per fortnight. While this stimulus measure aimed to help businesses stay afloat, in relation to homelessness, it enabled many people who may have otherwise lost their job to continue to draw an income and potentially maintain their housing. Accordingly, JobKeeper likely reduced inflows into homelessness during COVID-19. The JobKeeper scheme was extended in September 2020 at a reduced rate and again in January 2021 with a further reduction in the rate of payment, before ending in March 2021 (Hayne, 2020; Worthington, 2020).

An examination of the impact of JobKeeper and the Coronavirus Supplement was undertaken by Pawson et al. (2021) in Covid-19: Rental Housing and Homelessness Impacts – An Initial Analysis. They found that the JobKeeper and the Coronavirus Supplement during the initial stage of the pandemic had significant impact on housing affordability stress (Leishman et al., 2020). Similarly, it estimated that 1.3 million households would have been living in housing affordability stress without the income support interventions. This finding is supported as during the initial months of the pandemic in 2020, the average income of the 10% of Australian households with the lowest incomes (decile 1) increased (Biddle et al., 2020).

15.4.11 Domestic violence

Family and domestic violence (FDV) is a key cause of homelessness, and many predicted that COVID-19 lockdowns would lead to an increase in domestic violence (Bradbury-Jones & Isham, 2020; Kofman & Garfin, 2020). Indeed, there is evidence that this has occurred in some areas in Australia (Boxall et al., 2020; Usher et al., 2020; Poate, 2020). In recognition of this, on 29 March 2020, the Federal Government announced $150 million will be provided to support Australians experiencing domestic, family and sexual violence. The funding will boost programs under the National Plan to reduce Violence against Women and their Children and will be implemented by local state and territory governments.

In terms of individual state responses to domestic violence during COVID-19, states and territories have used the Federal funding to implement various policies. In South Australia, part of the allocated $4.5 million has been used to bring forward the opening of two safety hubs for family and domestic violence survivors (Premier of South Australia, 2020). On top of Commonwealth investment, other states such as Western Australia invested in FDV as part of a WA Recovery Plan (Government of Western Australia, 2020) and Queensland invested $5.5 million (Queensland Government, 2020). In Victoria, $20 million was shifted to cover the cost of cover the cost of accommodating 1,500 adult and 400 adolescent perpetrators of family violence, in response to large increases in demand from this group (Clayton, 2020).

15.4.12 Mental health

During COVID-19 mental health funding has drastically increased. A total of $5.7 billion from a Federal level has been invested in mental health support (Ministers Department of Health, 2020), $500 million of which was in direct response to the mental health impacts of COVID-19 (Ministers Department of Health, 2021), including doubling the cap on Medicare-subsidised psychological sessions each year to 20 (Dalzell, 2020). Individual states such as Victoria, facing a drastic increase in mental health concerns such as self-harm presentations, have also significantly increased investment (Ilanbey, 2020).

15.4.13 What have we learnt from the COVID-19 response

The lack of a national strategy on homelessness during the COVID-19 pandemic, left state and territory governments to respond with a variety of policy and practice measures of varying success to both provide temporary accommodation to those currently homeless and to prevent further entries into the homelessness system. Responses included: pop-up homelessness COVID-19 recovery facilities; intensive supports to public housing; upgrade of public housing units to be used as emergency accommodation; purchasing of temporary accommodation; temporary emergency hotel and motel accommodation; assistance into permanent housing placements; increased capacity at existing homelessness shelters; services for youth homeless; funds to specialist homelessness services; income support (increases in unemployment benefits, Jobseeker, Jobkeeper,

Coronavirus supplement); funding to support FDV; and funding to support mental health. The implementation of the COVID-19 response did not always adequately assess the risk and health needs of individuals prior to placing people in temporary accommodation and delays in implementation of temporary accommodation exposed people sleeping rough to potentially adverse health implications. The flow through from temporary to permanent housing was patchy and incomplete reflecting in part the absence of available affordable housing stock but also the lack of firm commitments in all states and territories to provide permanent housing to all those who accessed temporary accommodation.

One critical learning from the COVID-19 response is how quickly governments and the service system can react to address homelessness and meet the needs of those experiencing homelessness who are sleeping rough and in supported accommodation. The COVID-19 response led to significant numbers of those sleeping rough accessing short-term shelter. Additionally, while the transition to permanent housing was patchy and incomplete in many areas, there was a transition from homelessness to permanent housing for those sleeping rough at higher levels than would have occurred otherwise.

15.5 Addressing the drivers of homelessness through prevention and early intervention programs

Prevention and early intervention approaches recognise the individual and structural drivers that drive homelessness and seek to address homelessness by targeting those drivers, to prevent entry or re-entry, or facilitate rapid exit. Individual drivers are those that affect individuals such that their risk of homelessness is increased, for example, experience of FDV and substance abuse issues. Structural drivers are factors that affect all people, that in turn serve to create increased risk of homelessness across the population. Housing affordability, availability of housing (social and other), rental market regulation, and labour market conditions are examples of structural conditions that can increase homelessness.

It is important to note that there is significant overlap between individual and structural factors, such that each individual driver is affected by structural factors, and vice versa. For example, mental health policy and funding, a structural factor, is affected by how many individuals are experiencing mental ill health and the nature of their issues, which in turn affects the services available for an individual experiencing mental ill health and therefore their experiences of mental health issues. However, for the purposes of this report, factors that affect the risk of homelessness among subsets of the population (e.g., young people) are discussed as drivers affecting individuals, and factors that serve to increase homelessness risk across the broader population are discussed as structural drivers.

The drivers of homelessness among individuals often differ by cohort. For instance, young people are at greater risk of homelessness if they have experience of out-of-home care, while older people are at greater risk of homelessness if they don't own a home and have low superannuation. There are some drivers, such as poverty, mental health issues, and FDV, that increase the risk of homelessness across all or most cohorts (Kaleveld et al., 2018). This section will discuss some initiatives around Australia aimed at prevention of or early intervention in homelessness, targeting FDV, out-of-home care, youth justice, mental health, and poverty.

Recent research has highlighted the disparity in both morbidity and mortality related health outcomes for people experiencing all forms of homelessness, citing the need for prevention to occur further upstream in this population. In the United States, recent research identified that the average life expectancy in all people experiencing homelessness was between 42–52 years of age, compared with 78.8 years for the average citizen (Filke & Aronowitz, 2021). Further, all-cause mortality rates were 8.6 times higher than the average citizen in males experiencing homelessness, and 9.6 times higher in females experiencing homelessness, with the rates continuing to increase if only assessing people experiencing rough sleeping homelessness; where individuals rough sleeping experience a mortality rate ten times higher than the average citizen (Filke & Aronowitz, 2021).

The research outcomes above are mirrored in the Australian population, where many states have used metrics to determine the number of people who have passed away on the streets, and the associated health aspects of this population. It was found that people sleeping rough in Australia have a reduced life expectancy (when compared to the average citizen) of 30 years, and an estimated 424 people passed away while sleeping rough (Australian Alliance to End Homelessness, 2021). Homelessness is a public health issue with multiple inflow points that could be addressed, and interventions could be implemented to assist in preventing the above outcomes for people. Some are expanded on below.

15.5.1 Family and domestic violence

Well over one third (41%) of people accessing SHS sought assistance as a result of physical or emotional abuse inflicted by a family member, or required FDV assistance during a support period (e.g., a person seeking assistance for housing stress may, while receiving support for this primary presenting reason, also receive FDV assistance; AIHW, 2020a).

Women and children are most often the victims/survivors of FDV. Experiences of FDV are usually characterised by unequal power and control, including economic resources. This may include the perpetrator having control of bank accounts, having leases or property deeds solely in their name, and preventing the victim/survivor from gaining economic independence, such as through paid work. These factors, in addition to the practical reality that, in order to escape abuse, victims/survivors often have to leave the home in which they are residing or have the perpetrator removed (an often lengthy and complex process that can increase the risk of experiencing violence), mean that FDV is a key driver of homelessness.

Accordingly, FDV is a key target area for strategies focused on the prevention of and early intervention in homelessness. There are several ways to address FDV in order to reduce homelessness, some that target the FDV/homelessness relationship more directly, and others that aim to reduce FDV and acknowledge that a positive 'side effect' will likely be a reduction in homelessness. Examples of policy and interventions that target the FDV/homelessness relationship include reform of state-based Residential Tenancy Acts to reduce or remove penalties associated with breaking leases for people experiencing FDV and/or to allow victims/survivors to take over leases that were held by perpetrators (Webb et al., 2021), increasing the number of crisis accommodation beds available for people escaping FDV, and increasing accommodation options for perpetrators so that victims/survivors can stay in the home.

One example of an initiative in Perth was the 'Safe as Houses' program that commenced as a pilot program in early 2017 to provide integrated and holistic legal and support services to women who are experiencing legal issues due to FDV and are either experiencing or are at risk of homelessness (Wood et al., 2019). It was a partnership between three community legal centres (Tenancy WA, Women's Legal Service WA, and Street Law Centre WA), who collectively identified the need for integrated legal and non-legal support for women who face the challenges of homelessness and FDV.

Further examples of interventions that aim to reduce incidence of FDV include men's behaviour change programs, respectful relationship education (usually targeted at adolescents), media campaigns that promote respect for women, and programs that build women's capacity and confidence for independence from their abusers.

Box 8 – Zonta House

Zonta House Refuge Association is a specialist service provider that has provided safe, essential relief and support to over 500 women and their children since 2015 who have experienced or are at risk of experiencing FDV. Zonta House provides holistic wraparound support through supported refuge and transitional accommodation for women and their children, and the provision of other programs that prioritises a woman's wellbeing and security. Zonta House also provides an accommodation service to women exiting prison who may otherwise be unable to exit prison due to lack of safe, suitable, stable and affordable accommodation.

An impact analysis was designed to build a cross-program holistic understanding of the impact of Zonta House. Client outcomes and impact analysis by CSI UWA involved operationalisation of Zonta House's program logics (which detail the relationships between resources, activities, outputs, and outcomes) through mapping client outcomes to measures and data collections, an innovative cross-program quantitative analysis by linking and cleaning of multiple internal and external datasets, and synthesising outcomes from each Zonta House program to provide an assessment of the overall impact of Zonta House on women experiencing or at risk of experiencing FDV.

The impact analysis showed that engagement in the additional wraparound support to accommodation, which included coordinated services relating to AOD and mental health, employment and training, and access to other specialist support and services, resulted in improved wellbeing, increased independence, better family relationships, and breaking the cycle of FDV (Lester et al., 2021).

Existing qualitative evidence of impact and quantitative program-by-program quantitative analysis are important ingredients to understanding the impact of community programs. An understanding of measurement and evaluation of program outcomes and capacity building in the community sector, will facilitate improvements in program efficacy, inform decisions about future program development, and ensures the provision of high-quality services to meet the needs of clients.

Box 9 – Neami National Safe & Secure Housing Program

The Neami National Safe & Secure Housing Program provides support for women and their children who are in crisis accommodation due to FDV to transition to secure housing in Adelaide. Working in partnership with FDV services, the dedicated team from Neami National assist people to secure housing and work alongside women to provide support for emotional wellbeing, physical health, employment, connections to family and community, and building relationships. Creative use of brokerage money, including for rent payment in advance, is delivering housing outcomes that otherwise would not be possible.

15.5.2 Supporting children, adolescents and young people

At the time of the 2016 Census, children under 12 represented 13.6% of all those experiencing homelessness on Census night in Australia, those between 12–18, 8.5% of the recorded homeless population on Census night and those aged 19–24, 15.2% of the homeless population. Around half of all adults in homelessness services report early onset homelessness prior to the age of 18 and also intergenerational homelessness (Flatau et al., 2013). An ending homelessness agenda means preventing early entry into homelessness and early intervention programs that act to stop any further follow through to adult homelessness.

FDV is a major determinant of early onset homelessness in later childhood, adolescence, and teenage years. Flatau et al. (2013), Flatau et al. (2015a,b) and Thielking et al. (2015) show the close relationship between FDV and children and young people being thrown out of the family home or running away from and experiencing spells of couch surfing and rough sleeping. Addressing FDV at its source not only reduces entry into homelessness for women and children but also separately children, adolscents, and teenagers. In this context, the local community and the school become important sites for addressing homelessness.

Large numbers of the adult homeless population report experiences of out-of-home care (e.g., foster care) prior to the age of 18 (Flatau et al., 2013). Out-of-home care and homelessness are related for a number of reasons. Young people are placed in out-of-home care as a result of unsafe living conditions and have therefore often experienced some form of homelessness (e.g., sleeping rough briefly after running away from home, couch surfing, or residing in overcrowded dwellings (Flatau et al., 2015b; Thielking et al., 2015).

Mendes and McCurdy (2020) identify three key reasons for the increased vulnerability of the out-of-home care child cohort ageing out of the system when compared to other young people in the emerging adulthood cohort.

1. Children entering child protection systems are already coming from a place of disadvantage and have experienced significant trauma, abuse and neglect, limiting their ability to navigate systems, build relationships and engage in future planning.
2. The quality of support young people receive during their foster placement varies significantly, with some young people having no positive relationships with people in a caregiver role, and no positive relationships with other young people who are also 'in the system'. This results in a young person building a sense of lack of trust in systems that are designed to support and protect them and can cause vulnerabilities in help seeking behaviours through to adulthood.
3. When leaving child protective care, leavers lack social resources and understanding of how to navigate systems to get support through transition into adulthood. When in the child protection system, young people report that they do not have the ability to make decisions for themselves, as the 'system' and 'my workers' often make the higher-level decisions without discussing and including young people in them. This results in a lack of experience in higher level decision making, and difficulties in understanding system relationships and how to navigate those systems in adulthood.

In addition, the trauma experienced by young people via the experiences that precede their placement in out-of-home care or while in out-of-home care can create barriers to thriving during adulthood which, in turn, increase risk of homelessness. Finally, the transition from out-of-home care into adulthood, which has historically occurred at 18 years of age, is a key period during which care leavers are at high risk of homelessness. Young care leavers often feel ill-prepared for life as an independent adult, face long waiting lists for social housing and shortages of affordable housing and discrimination in the private rental market (Flatau et al., 2013).

There are several initiatives that seek to lower the risk of homelessness for people with experience of out-of-home care, mostly targeted at the critical juncture of leaving care. One notable example is the Home Stretch campaign, which seeks to raise the care leaving age to 21, from 18. State Governments in Tasmania, South Australia, Victoria, and Western Australia have committed to raise the care leaving age. Flatau et al. (2013) proposed a federally-administered rental subsidy scheme for care leavers that would see their housing costs capped at 25% of income, irrespective of tenure type (social, community, or private housing). Other initiatives include education and training programs targeted at care leavers or those in care, community housing for care leavers, and accelerated access to social housing.

Box 10 – Common Ground Port Augusta

Common Ground Port Augusta is a housing first initiative providing long-term supported tenancies to people experiencing homelessness. As the first regional application of the Common Ground service model, the program is facilitated by partner organisations Housing Choices South Australia and The Salvation Army.

Common Ground seeks to provide a pathway for individuals towards stability and self-sufficiency. The model is based on the premise that access to stable high-quality housing is a vital first step towards a satisfying and balanced life. Common Ground intentionally aims to build the capacity of people previously experiencing homelessness to become independent, productive members of society.

Common Ground actively develops a wide platform of opportunities for its tenants by undertaking individual and small group work, which fosters meaningful linkages with health, education, training, community participation, and employment. These and other opportunities can be a catalyst for an individual to discover skills and respect that lead to positive life change.

Common Ground Port Augusta offers 35 dwellings located across two sites:

- 15 units in Boston Street which target individuals or couples on low incomes, with low support needs requiring affordable accommodation
- 20 purpose built units in Augusta Terrace targeted to individuals or couples requiring on-site support at various levels of low to high needs

Through the service model, Common Ground Port Augusta's objectives are to:

- Reduce homelessness in Port Augusta, particularly for Aboriginal and Torres Strait Islander People
- Provides individualised tailored supports for all residents
- Enables a safe, secure, and supportive home environment
- Housing that reflects cultural values and practices of Aboriginal and Torres Strait Islander people
- Re engage and integrate with the local community
- Integrate services with those already existing in Port Augusta, as well as with local businesses and other community groups.

Box 10 – Common Ground Port Augusta (Continued)

Common Ground Port Augusta, Housing Choices South Australia and The Salvation Army.

Box 11 – The Home Stretch Campaign

There is an increasing recognition of the need to extend the age for leaving care support to at least 21, with international studies finding that homelessness is halved when leaving care support is extended to 21 years (MacDonald, 2021). In Australia, the Home Stretch campaign advocates for this change, and a Home Stretch trial commenced in WA in July 2019. Early findings from the WA trial show that 83% of young people who would otherwise have left care at age 18, reported that their current housing was safe and stable (Lund & Kazim, 2021). Victoria has already extended their Home Stretch trial to support every young person leaving care until they turn 21.

The youth justice system is the set of processes and practices for responding to young people and children who have committed or allegedly committed an offence. While specific policies and procedures differ between each state and territory, some consistency exists in relation to the types of legal orders available to courts. Young people can be charged with a criminal offence if they are aged 10 and over. The upper age limit for the youth system is 17 (at the time of the offence) in all states and territories.

In total, 27,680 between the ages of 12–24 were classified as homeless on Census night 2016 (an increase from 25,197 in 2011). Young people aged between 12–24 account for 24% of the entire population of people classified as homeless on Census night 2016 (ABS, 2018a). However, youth homelessness is likely to be underestimated in the Census (ABS, 2018a).

There is a clear link between youth homelessness and the youth justice system (MacKenzie et al., 2016). The relationship is bi-directional, such that young people who are homeless are more likely to engage in "survival crimes" (e.g., stealing to secure food and accommodation) and are more likely to be visible to police while committing such crimes. Further, young people who interact with the justice system are more likely to become homeless as a result of fewer social and familial supports and difficulty securing accommodation with a criminal record (Stewart & Hurren, 2017). Young people who have had interactions with the child protection system have increased risk of both justice system interaction and homelessness (Stewart & Hurren, 2017).

Interventions that aim to address the relationship between youth justice and homelessness are those that aim to divert young people from the youth justice system, as well as those that target young people who are already involved with the youth justice system and are at risk of homelessness upon release, such as VincentCare's Youth Justice Homelessness Assistance Program. This program offers referrals and linkages to services, including homelessness services, for young people exiting custody.

Box 12 – Salvation Army Youth Services – Upton Rd: Continuum of care for young people experiencing homelessness

The Salvation Army Youth Services – Upton Rd is a program that supports young people who are experiencing or at risk of homelessness. Operating out of a purpose built facility in inner city Melbourne, Upton Rd provides an integrated model of support that ensures a continuum of care across youth refuge accommodation, outreach case management and medium-term housing support. In the 20/21 financial year the program supported approximately 400 young people including singles and families with accompanying dependent children. Young people accessing support from Upton Rd present with a range of support needs including AOD, mental health, justice, FDV, family breakdown, disengagement from education and employment, and financial disadvantage. Upton Rd is a PIE (psychologically informed environment), recognising the uniqueness of the young people it supports and operating from a service model that is designed to assist young people to acquire the personal resources that support them to achieve sustainable housing outcomes. A range of support staff are embedded in the model including case managers, residential support workers, a life and living skills worker, clinical psychologist, youth participation worker, and onsite AOD support.

In recognition of the challenges of the housing sector and limited options for young people within the homeless system, Upton Rd has developed a number of housing pathway programs for young people including: Education pathway properties for young people engaged in mainstream education and the Yarrinup Mother Baby Program, which provides a 12 month accommodation and parenting support program. Both of these programs provide a stepping stone to independent accommodation but ensure young people have continued access to case management, life and living skills, and parenting support. All young people accommodated within these programs are also provided with support to access a private rental when they are ready to transition out of the programs. This focus on facilitating private rental access is central to the Upton Rd model and the youth private rental brokerage program provides practical information and financial support to young people wanting to access the private rental market. In the 20/21 financial year the program assisted 43 young people (including families) to access tenancies within the private rental market and these young people were all provided with ongoing support for the 12 months of their private rental tenancy.

Critical to the Upton Rd's success is the commitment to offering ongoing support to young people to ensure the sustainability of tenancies. The program also recognises that youth refuge accommodation isn't an accommodation option that suits the needs of all young people and therefore the program ensures any young people who decline refuge accommodation or exit early are also offered outreach case management support.

Salvation Army Youth Services – Upton Rd

15.5.3 Mental health and alcohol and other drugs support

Mental health and homelessness are intertwined, such that experiencing mental health issues can lead to homelessness, and experiences of homelessness can create or compound mental ill health (Brackertz et al., 2020). The mechanisms through which mental health issues increase risk of homelessness are varied. For example, mental health issues can make it difficult to obtain and sustain employment, which can lower one's income and, in turn, their ability to meet housing costs (Folsom et al., 2005). Mental health issues can also make it difficult to maintain a home and therefore sustain a tenancy. Homelessness contributes to mental ill health through the stress and trauma associated with not having a safe and stable home (Rees, 2009).

Mental health issues are closely related and often co-presenting with other health issues and factors influencing quality of life. In a Perth study, it was found that two-thirds (67.5%) of individuals accessing a homelessness primary care specialist had at least one mental health diagnosis, and approximately half had a mental health condition and at least one physical health condition or at least one AOD use disorder (Vallesi et al., 2021). Impact scales undertaken with people experiencing homelessness identify that physical and mental health are significantly impacted by changes in quality of life experiences, and this in turn influences their engagement with services (Filke & Aronowitz, 2021). This points to the presence of mental health issues influencing other aspects of quality of life and propensity to engage with services to address their homelessness.

In Australia, among people who were housed at the time of survey; those who had been diagnosed with a mental health condition were twice as likely to have experienced homelessness in their lives than those who had not been diagnosed with a mental health condition (ABS, 2018b). In addition, around 1 in 3 SHS clients aged 10 and over had a current mental health issue (AIHW, 2020). Public perception of people experiencing homelessness also plays in role in the incidence of mental health; people experiencing homelessness have identified that they feel to be the victim of public opinion of them, and they internalise those values and often do not feel as though they can be honest with their loved ones about their situation, increasing the social pressure they are feeling to maintain the perception of a certain lifestyle (Percuso, 2010).

Initiatives that seek to address the homelessness/mental health relationship comprise: those aimed at the general population, such as media campaigns to reduce stigma around experiencing and seeking help for mental health issues, or government funding of Mental Health Care Plans; as well as interventions that support those already experiencing mental health and/or homelessness. Examples of homelessness programs that consider mental health needs include the Michael and MISHA projects run by Mission Australia, and the J2SI project run by Sacred Heart Mission. These projects are Housing First initiatives that provide, alongside rapid housing, intensive case management of the full spectrum of needs of people experiencing homelessness.

Programs that seek to prevent homelessness among people experiencing mental ill health include tenancy support programs, such as those that were funded through NPAH. In addition to multidisciplinary, wraparound support, the mental health stream of NPAH also provided brokerage funds that could be used to support housing – for example for rental bonds.

In South Australia, Neami National has recently introduced the Urgent Mental Health Care Centre. This centre is open from midday to 10:30pm each day, located in the CBD and provides a walk-in space, with barrier free access for anyone experiencing a mental health crisis. This centre was designed as an alternative for accessing Emergency Department hospitals when in crisis, where trained professionals and a peer workforce engage with a person to support them to address mental health crises immediately. These services provide a safe access point for individuals experiencing homelessness, and the general population especially if individuals have had negative experiences in the past with emergency departments, or feel as though they don't have the ability to access emergency department supports. Collaborations with both SA Police and Mental Health Triage ensure that access is broad and deep for people in Adelaide experiencing mental health crises. This is another example of the way in which cross sector collaborations can bridge both access gaps and contribute to an exit pathway from homelessness.

15.5.4 Ending poverty

Poverty in Australia refers to the inability to meet essential needs due to a lack of economic means, and the level of economic means required to afford essentials is determined by a poverty line, usually set at 50% or 60% of median income (Davidson et al., 2018). Given that poverty is characterised by insufficient income to meet essential needs (including housing), and housing costs comprise a large portion of income, poverty is generally considered the most significant risk factor for homelessness (Sharam & Hulse, 2014).

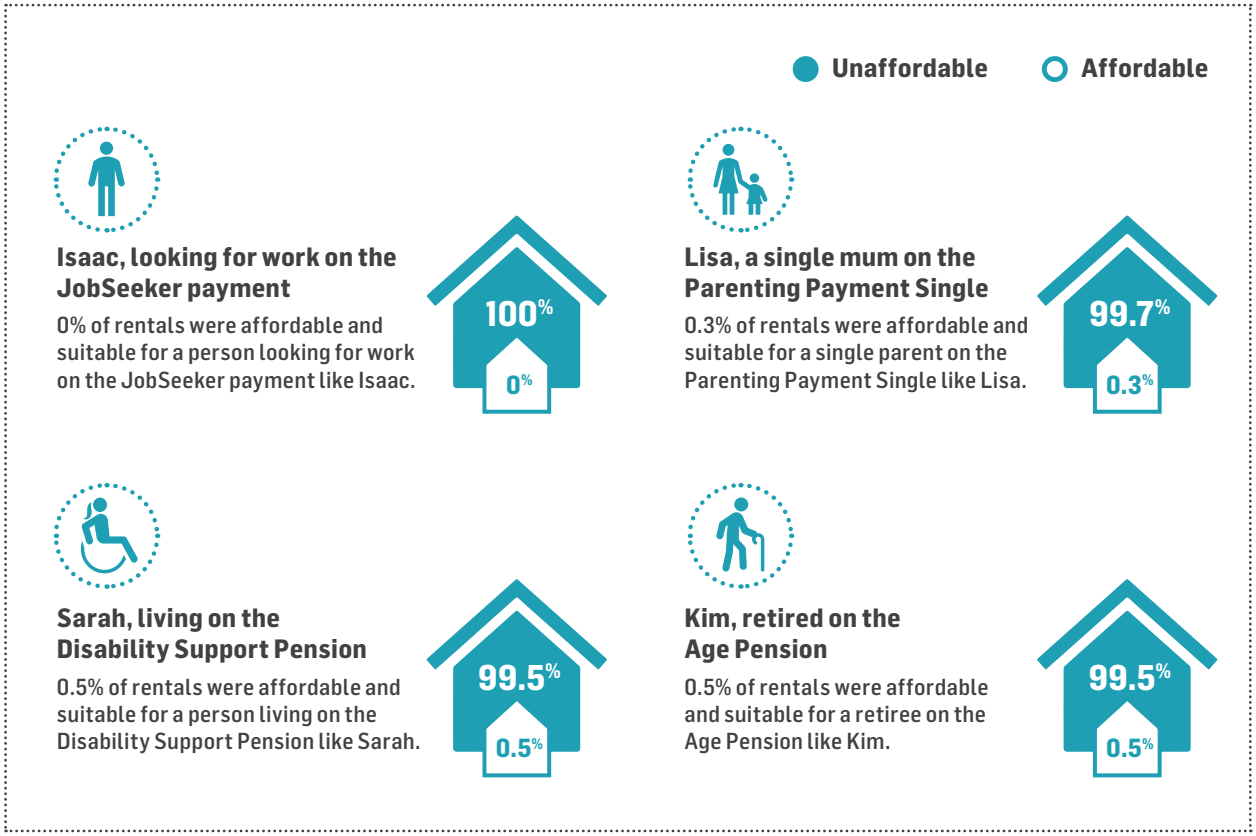
As well as a risk factor for homelessness, poverty is a reflection of the broader structural factors that drive inequality and homelessness. Though not unique to Australia (Fitzpatrick, 2005); the existence of poverty and homelessness in Australia reflects the priorities of government policy and expenditure, such that investment in social and affordable housing has fallen short of demand and income support payment rates have failed to keep up with costs of living. Poverty is also intertwined with the Child Protection system; contacts with the Child Protection system are increasing across the Australian population, though disproportionately so in families living in low socioeconomic areas and households (AIHW, 2017).

Accordingly, interventions that seek to address poverty inherently affect homelessness: if an individual or family was not in poverty, they would be able to afford the essentials for participation in society including housing (Saunders, 2011), which would lead to fewer people experiencing homelessness. Of course, addressing the income aspect of poverty does not necessarily address the attendant issues surrounding poverty that also serve as risk factors for homelessness, such as trauma, mental health issues, and non-constructive social relationships. However, neither poverty nor homelessness can be addressed without increasing income to the point where people can afford the essentials of life.

The Raise the Rate campaign, which sought to increase the rates of income support payments, in particular Jobseeker (formerly Newstart), and ensure ongoing indexation of payment rates in line with wage growth is an example of an initiative that seeks to address poverty (and therefore homelessness). Other examples include the Bridges out of Poverty program, that seeks to educate professionals who work with people experiencing poverty about the 'hidden rules' and competences that can be leveraged to improve the outcomes of people experiencing poverty, as well as the myriad of programs and services provided to meet the needs of people experiencing poverty, such as food, financial counselling and debt consolidation, rent relief, and utility relief.

The current affordability threshold for people renting on a low income, is for rent to be no more than 30% of the household budget. Figure 56 below outlines the 2021 Anglicare Rental Affordability outcomes for people on different incomes looking for rental properties in Australia.

Figure 56 – Rental Affordability for individuals on incomes, 2021



Source: Anglicare, 2021, page 8.

Out of the 2021 rental market assessment undertaken by Anglicare, just three rentals were deemed to be affordable for individuals in receipt of JobSeeker payment. There were zero affordable properties for any individual on Youth Allowance in the entire rental market surveyed. Even families with two parents in full time work on minimum wage will be unable to afford 85% of the rental market surveyed (Anglicare, 2021). Also of note and in need of further consideration is the poverty by which asylum seekers, temporary migrants, and international students may find themselves in without an income, as they are unable to access fiscal supports in Centrelink, or health supports in Medicare (Anglicare, 2021).

15.5.5 Increasing employment opportunities

Employment not only is a means of gaining income and leaving poverty but also provides meaning to individual lives and provides social connections. Conversely, a lack of employment has been shown to have negative influences socially, emotionally and fiscally. There are many reasons why people experiencing homelessness may not be in employment; individuals experiencing homelessness cite: feelings of shame regarding homelessness, lack of consistent work experience, lack of current work referees, inability to get to work reliably, and a lack of self-confidence as reasons they may not be able to obtain and maintain employment.

There are a number of programs across Australia that work at the intersection between employment and homelessness. Recent collaborations between Job Services Australia and homelessness services have had significant success. For example: the Home Options and Pathways to Employment (HOPE) Project, a partnership between National Employment Services Australia (NESA) and Homelessness Australia. This particular collaboration created a resource kit, designed to assist and broach the relationship between both sectors, more specifically to educate each sector regarding the role and requirements of the other. Job providers have access to a resource kit designed to educate and raise awareness about the way in which homelessness impacts a persons ability to access supports, obtain and maintain employment. A resource kit is also available for homelessness services to understand the variety of service options, job seekers rights and responsibilities and the services available specifically for people experiencing homelessness. These cross-sector collaborations are essential in improving exits from the homelessness system.

15.5.6 Addressing high rates of Aboriginal and Torres Strait Islander homelessness

Aboriginal and Torres Strait Islander people are overrepresented in homelessness statistics and associates support services. One in 28 Aboriginal and Torres Strait Islander people (23,000) were homeless on Census night in 2016 representing one in five of those experiencing homelessness (AIHW 2019d) despite making up only 3% of the total population. At the same time, Aboriginal and Torres Strait Islander clients made up a quarter (25%) of all SHS clients in 2017–18 which was more than 9 times that of clients of other descent (AIHW 2019d). Though many policies and interventions have aimed to reduce this overrepresentation, sustained improvement in wellbeing domains is not evident, and seems to be compounded by a discourse that lacks Aboriginal and Torres Strait Islander voices and opportunity for self-determination (Martin et al., 2018).

Addressing high rates of Aboriginal and Torres Strait Islander homelessness in Australia requires action across three domains: (1) addressing at a societal level the Uluru Statement from the Heart calls for voice, treaty, and truth (First Nations National Constitutional Convention, 2017); (2) addressing systemic issues around affordable, adequate, safe and sustainable housing for Aboriginal and Torres Strait Islander people, chronic disease, mental health issues, high rates of incarceration and inadequate housing pathways for Aboriginal and Torres Strait Islander people leaving jail, juvenile detention, out-of-home care and health facilities, and problems of and broader educational, social, and economic disadvantage; and (3) increasing investment in Aboriginal and Torres Strait Islander community housing organisations and homelessness and related support agencies to provide increased reach of culturally appropriate care.

The Western Australian Alliance to End Homelessness: Ending Homelessness in Western Australia 2021 WA report (Seivwright et al., 2021) describes the overrepresentation of Aboriginal people among the homeless population in Western Australia and the increased role of Aboriginal controlled community organisations in leading recently announced Housing First. As part of the implementation of the WA Government's Homelessness Strategy, the Department of Communities, in close collaboration with Aboriginal Community Controlled Organisations (ACCOs) is acting to strengthen the role of Aboriginal organisations and communities in designing and delivering culturally appropriate responses for Aboriginal people; seeking to ensure government policies and practices impacting homelessness reflect an understanding of Aboriginal culture and values; seeking to ensure homelessness response services are culturally responsive and flexible to better meet the needs of Aboriginal people; and to increase the availability of appropriate accommodation and service options for Aboriginal people and families (Seivwright et al., 2021).

Recent initiatives rolled out by the Western Australian Government include a $6.8 million grant to support Aboriginal people sleeping rough as part of the Housing First Homelessness Initiative. The Moorditj Mia 'Strong Home' program will bring together Noongar Mia Mia, Wungening Aboriginal Corporation and the Ngalla Maya Aboriginal Corporation.

15.5.7 Addressing homelessness in culturally and linguistically diverse communities

Kaleveld et al. (2019) argue that culturally and linguistically diverse (CALD) populations face challenges that increase their vulnerability to homelessness and its effects over and above those experienced by others. They define a person as having a CALD background if they meet each of the following criteria:

- being born in a country other than Australia that is Non–Anglo/Celtic; and,
- speaking languages other than English, and/or not speaking English well; and,
- recency of arrival (people who have been in Australia less than 5 years are more vulnerable).

An examination of CALD homelessness is hampered by the fact that datasets and studies do not typically provide data and evidence in a way that those who meet the above CALD definition can be identified. Kaleveld et al. (2019)'s review points to a number of drivers of drivers of homelessness specific to, or, felt more acutely by CALD populations (see Figure 57 below replicated from Kaleveld et al., 2019). Their review of the research evidence suggests that CALD backgrounds are more likely to become homeless than other people, but not necessarily in the 'visible' sleeping rough population (see Flatau, Smith et al., 2015 for case examples of invisible rough sleeping). Those from a CALD background are much more likely to stay in unsafe or inadequate housing for long periods of time than others. Estimates of CALD homelessness are affected by low rates of service engagement by CALD populations, a fact in itself that requires attention from a policy and practice perspective. Flatau et al. (2014) and Flatau, Smith et al. (2015) note that refugees and, more particularly asylum seekers, face additional challenges beyond those experienced by refugees which relate to their lack of access to income support, housing and other services.

In terms of homelessness service responses, models of service delivery may not always be appropriate to the cultural norms of people from CALD backgrounds. Culturally appropriate support may include: translation services; bi–lingual staff reflecting the client cohort; cultural training; strong links to cultural and community groups; and involving culturally specific services where possible (Mission Australia, 2015). More generally homelessness services must be able to compensate for gaps in income security related to residency and visa status and ensure equal access to housing and other services.

Figure 57 – Individual and structural drivers of homelessness specific to, or felt more acutely by, culturally and linguistically diverse populations

Individual drivers

Difficult life transitions

- Fleeing from torture, trauma, war, violence
- Adjusting to new country, language and culture

Family breakdown affecting youth

- Reconfiguration of families
- Tension and conflict due to cultural dislocation
- Effect on youth is more profound

Mental and emotional health

- Trauma and recovery from torture
- Post-traumatic stress disorder
- Mental illness, substance use and dual diagnosis

Family and domestic violence

- Unaware of domestic violence services, refuges or housing options
- Lack of support network to escape violence
- Dependent/partner visas may excerbate vulnerability

Structured drivers

Temporary visa status

- Inability to access income support, some services
- May be ineligible to work

Access to employment

- Difficulties obtaining employment
- Qualifications may not be valid in Australia
- Discrimination and labour market disadvantage

Access to resources

- Financial stress and poverty
- Income support or welfare services

Access to services

- Primary health care (physical/ mental health)
- Employment and training services
- Aged care services
- Legal services
- Specialist homelessness services

Access to housing

- Eligibility for public and community housing
- Housing supply and affodability issues
- Problems accessing private rental accommodation
- Housing stress

Source: Kaleveld, Atkins &Flatau, 2019.

15.5.8 Responding to older age homelessness

Older people experiencing, or at risk of homelessness can access SHS as well as social housing and other housing options. The Commonwealth Home Support Programme also provides support to older people to remain living independently at home and home care packages are available to enable older people to live at home. There is also an important Australian Government program, the Assistance with Care and Housing (ACH) program, which supports older people who are experiencing, or at risk of, homelessness to gain access to the aged care and related services they need. Residential aged care programs provide aged care on a permanent basis and there exist some specialist residential programs that are homelessness specific such as Wintringham in Victoria.

The homelessness and aged care systems are well developed. However, there is a need for stronger funding of the Assistance with Care and Housing program which acts to link the system and with the availability of specialised residential aged care programs across Australia. There are limitations in the extent to which older people experiencing homelessness and who need specialised residential care can access that care across Australia given that there are significant gaps in availability in many areas. Additionally, as with other parts of the social support system, access to the Commonwealth Home Support Programme and home care packages are much easier when in permanent housing rather than in temporary and marginal housing. Older people experiencing homelessness in such an environment are more likely than not to fall through the gaps.

15.6 Enabling the end-homelessness systems response

In our ending homelessness model, we posit that ending homelessness not only requires that we address the drivers of homelessness and provide direct homelessness and housing services but that we achieve the best outcomes possible. Ending homelessness is a truly aspirational goal. It is achievable but requires a supportive and enabling environment that is based on strong advocacy and representation for those experiencing homelessness; a strong and diversified funding environment; an integrated and collaborative support system; and a strong research and evaluation environment with effective aspirational target setting (Mollinger-Sahba et al., 2020).

15.6.1 Advocacy, voice and representation

The homelessness support system has had a long history of strong advocacy from peak homelessness and related bodies. Homelessness Australia acts as a general peak body for Australia's homelessness support system with representation from all sectors. There are important state and territory peak bodies with a long history including the Council to Homeless Persons in Victoria, Homelessness New South Wales, Shelter WA, Shelter Tasmania, NT Shelter and ACT Shelter. Westnet acts as a national peak body for specialist women's domestic and family violence services. The Coalition of Peaks is a peak body that itself comprises over 70 Aboriginal and Torres Strait Islander community peak organisations.

In recent years, that rich tapestry has been further enriched leading to an even stronger voice supporting an end to homelessness.

The Australian Alliance to End Homelessness (AAEH) works with local communities to ensure safe and sustainable housing services are accessible to anyone in need, and is committed to preventing and ending homelessness in Australia. The AEEH initiative the Advance to Zero Campaign supports the adoption of the Australian Zero Homelessness Approach in as many communities as possible in NSW (NSW End Street Sleeping Collaboration), Queensland (Brisbane Alliance to End Homelessness, Brisbane Zero Campaign), SA (Adelaide Zero Project), Victoria (Melbourne Zero Project, Port Philip Zero Project) and Western Australia (Perth Zero and the WA Alliance to End Homelessness).

The Everybody's Home campaign is a network of more than 400 organisational supporters and over 27,000 individual supporters, who are passionate about ending homelessness and the importance of investment in social and affordable housing to achieve that target. The campaign is focused on addressing the issues in the Australian housing system by lobbying the government to act.

The Everybody's Home campaign proposes five simple actions the government can do to fix Australia's housing system which includes: support for first home buyers, a national housing strategy aimed to supply 500,000 new low-cost rental homes to meet the demand for affordable housing, more security for renters by eliminating "no grounds" evictions and unfair rent rises, immediate relief for Australians in chronic rental stress by increasing Commonwealth rental assistance, and a national plan to end homelessness by 2030.

The recent focus of the Everybody's Home campaign is on Federal Government investment into social housing. This includes partnering with Equity Economics in December 2020 to release a report Double Return which highlighted Government investment of $7.7 billion in social housing, including federal funding complemented by funds from the states and territories, would make a huge dent in homelessness, boost the post-pandemic economy by $18.2 billion and create 18,000 jobs each year over four years (Equity Economics, 2020).

Box 12 – The Constellation Project

The Constellation Project was founded in 2018 by the Australian Red Cross, Centre for Social Impact (UNSW), Mission Australia and PwC Australia with the aim of ending homelessness in a generation so that all people have safe, secure, and affordable housing and the support they need to thrive. Constellation's purpose is to identify and accelerate solutions to homelessness through cross-sector collaboration and in 2021 merged with Business Alliance to End Homelessness to work together under the Constellation Project name.

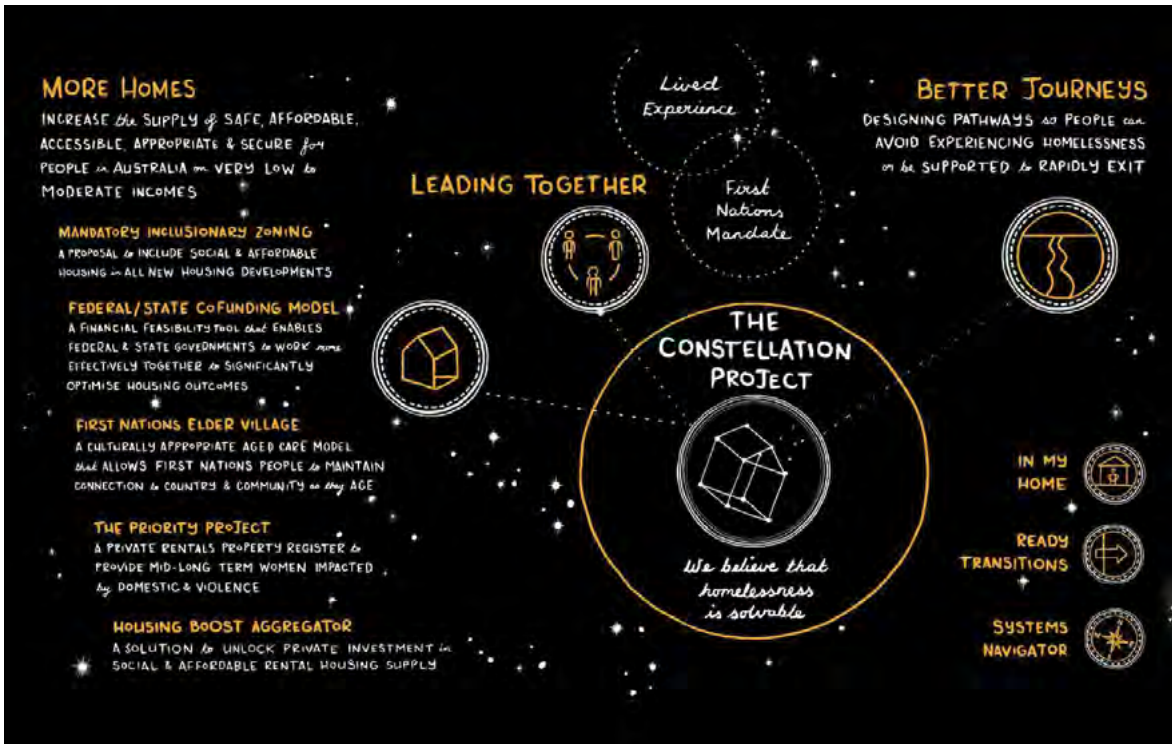
The vision of ending homelessness in a generation is implemented under two strategic pillars; the Solutions Hub discovers and accelerates ideas to reduce homelessness in two areas; creating More Homes by increasing the supply of safe, affordable, accessible, appropriate, and secure homes for people in Australia on very low to moderate incomes; and Better Journeys that aims to provide pathways so people can avoid experiencing homelessness or be supported to exit rapidly. Leading Together which involves influencing decision makers & those that hold the levers for change on social and affordable housing supply and homelessness.

The Constellation Project's Better Journeys is focused on preventing youth (17–24 years old) from experiencing homelessness after leaving the custody of youth justice and / or out-of-home care. The Better Journeys' process is being undertaken via a social lab – a process that brings together a diverse group of people to address complex social problems through research, experimentation, prototyping, and testing of potential solutions.

The insights of people with lived experience of homelessness are embedded at every level of the Constellation Project, including participation as co-designers and co-producers in social labs as well as in executive and advisory roles on the project. The First Nations Leadership Team guides project strategy and execution on the unique and urgent housing needs of Aboriginal and Torres Strait Islander peoples.

(The Constellation Project, 2021).

Box 12 – The Constellation Project (Continued)



Virtual Ending Homelessness Symposium Oct 21 – project on a page.
Captured by Glenn Stephenson, Capture This (https://capturethis.co/about)
Ending Homelessness Symposium October 12th 2021.

There is growing momentum across Australia to bridge silos between health, housing and homelessness sector responses to homelessness. In mid–2020, the Australian Health, Housing and Homelessness Network (A3HN) was established under the AAEH to support a health–informed response to homelessness in Australia. The group meets every two months and brings together key health clinicians, researchers and policy advisers to discuss current initiatives in homeless–health and share key learnings across the sector.

15.6.2 Increasing and diversifying funding for ending homelessness

Homelessness is growing in Australia, and it is clear from the present report that we require an increase in overall funding for social and affordable housing, homelessness and housing services, and related support services. As detailed in this report, there has been a significant recent increase in investment by states and territories in social housing and in homelessness strategies and their related programs. To end homelessness an increase in funding by the Australian Government is required, but beyond that, additional and innovative sources of funding are needed.

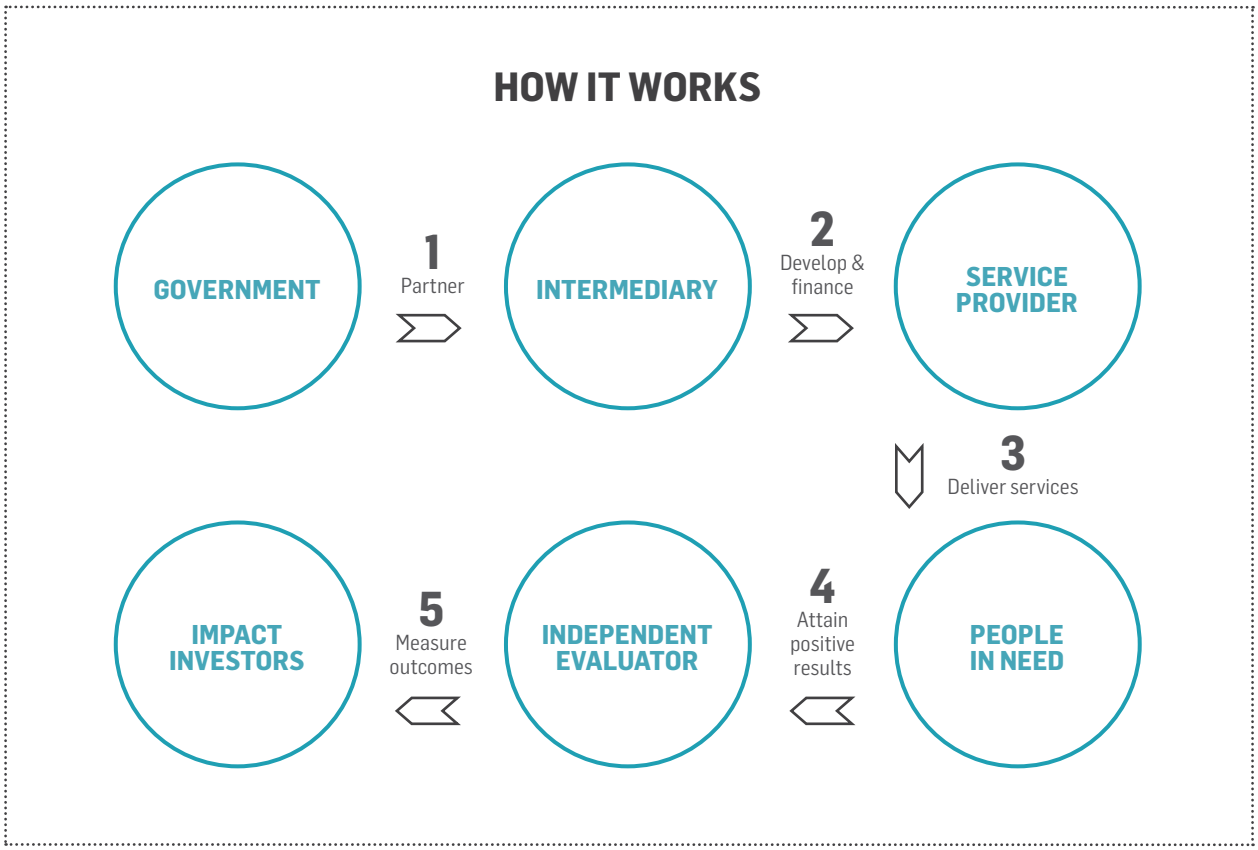
Philanthropic funding in Australia has been critical to the implementation and success of Australia's recent innovative projects directed to ending homelessness. There are many examples of this. Dalton and di Nicola (2020) for example refer to the transformative role that philanthropy had in the implementation and development of Mission Australia's Michael and MISHA projects for those experiencing homelessness in Sydney: "effective philanthropy can have a profoundly positive impact on community organisations' practice and the people and communities they serve. This is one example of a donor and recipient organisation forming a close partnership to radically change the lives of homeless men in Sydney". In Melbourne the Older

Women's Housing Project created by Women's Property Initiatives received funding from the Lord Mayor's Charitable Foundation, Gandel Philanthropy, The Big Issue's Homes for Homes, the Mercy Foundation, the Ian Potter Foundation and the Westpac Foundation. The Home Stretch, Everybody's Home, and Raise the Rate campaigns have all received significant philanthropic funding. Melbourne City Mission's Frontyard, a youth homelessness agency that supports the most high acuity youths received philanthropic funding from the Lord Mayor's Charitable Foundation, Peter and Lyndy White Foundation, Gandel Philanthropy, Joe White Bequest, PwC, Andrew and Geraldine Buxton Foundation and with significant in-kind contributions from the Property Industry Foundation (Lord Mayor's Charitable 2021). Streetsmart was formed in 2003 and raises funds to support small scale homelessness services and grassroots projects that tackle homelessness.

Another form of funding which has had less of a role in Australia is impact investment in which investors provide debt and or equity funding for projects and enterprises that seek to make an impact. At the same time as seeking to make an impact, investors seek to make a financial return . There have been limited examples of impact investment in homelessness in Australia (Heaney et al., 2017; Muir et al., 2018) but they include investment in homelessness-related social enterprises (e.g., Streat) and SIBs. As noted previously, Heaney et al. (2017) provide a strong evidence base impact investment into affordable housing for those experiencing homelessness was a viable option if separate funding was available for support. The Synergis Fund in the case of disability housing provides an example of what impact investment can achieve in terms of affordable housing options.

SIBs have grown exponentially across the globe in the past decade. Emerging in response to current issues in funding models that focus too much on outputs alone, SIBs enable partnerships between the public and private sector for the purpose of funding longer-term programs that can be assessed through outcomes in related sectors, improving understanding of both the social and fiscal impact of a social issue (Social Finance, 2020).

Figure 58 – Social impact bond funding structure



Source: Social Finance, 2020.

Figure 58 outlines the structure and flow of a SIB funded program. Firstly, the government identifies a particular social issue of concern in their community. This could be issues stemming anywhere from child maltreatment, to reoffending, to homelessness and beyond. After identifying an issue of focus, a financial intermediary is contacted, as well as high performing service providers in the industry of interest. The intermediary is then mobilised to generate capital for investment in a program to address and reduce the identified social issue of concern. After capital is sourced, the service provider delivers the program to the population in need of support, with a view to achieve positive outcomes for this cohort. Outcomes are assessed against a baseline cohort to determine whether the intervention has achieved a reduction in associated system use. Results are measured, and based on their success in improving agreed upon metrics, investors are repaid based on the level of reduction in the outcome in question. In 2020, there are now over 160 SIBs being implemented across 28 countries (Social Finance, 2020).

In summary, SIBs are designed to shift funding accountability initially away from government, develop flexibility in service responses to a social issue, enable longer-term support to be provided to the identified vulnerable cohort, and provide social and financial outcomes across investors, the government and, most important the population of interest (Albertson et al., 2018; Broom, 2020). This method of funding can work to address funding shortages in multiple community sectors, this is essential considering only one third of presently funded community services in Australia indicate that they can meet required targets with their current level of funding received (Flatau et al., 2017).

SIBs within the homelessness domain have been implemented across multiple countries in a diverse range of ways. Due to the way in which homelessness crosses multiple sectors and can be attributed to multiple systems, SIBs can be implemented within homelessness in a way that assesses inflow pathways into homelessness as well as systemic relationships between sectors. Homelessness SIBs across the globe work to improve stable housing outcomes, improve coordination between related sectors such as emergency healthcare, homelessness emergency housing, physical and mental health, and criminal justice, with some SIBs assessing relationships between up to 12 service systems (Social Finance, 2020). There are also homelessness SIBs being implemented to improve outcomes for disproportionately affected communities, such as Aboriginal and Torres Strait Islander people.

Though Australia has begun to implement SIB funding in the homelessness sector, there remains potential to explore funding further, especially in relation to improving outcomes for chronic rough sleeping and Aboriginal and Torres Strait Islander people.

15.6.3 Data, research and evaluation

Data, research and evaluation are fundamental enablers to an end homelessness agenda. In the first instance, progress in ending homelessness needs to be measured if there is to be any meaning to adopting an end homelessness program. We need to know whether we are on or off track in moving towards an end homelessness goal. The Western Australian Alliance to End Homelessness adopted a targets-based approach to homelessness in Western Australia and sets that approach within an outcomes measurement and evaluation framework used to produce yearly dashboards and end homelessness reports (see Mollinger-Sahba et al., 2020; Flatau et al., 2021; Seivwright et al., 2021). At the local level, Zero Projects in Australia establish an end homelessness target setting and measurement framework for place-based projects to end homelessness. Secondly, measurement is important to understand the needs of those experiencing homelessness in programs so that those needs can be best addressed. This evidence also provides a platform for advocacy; as is the case with the findings of this report in respect to the need for a supportive housing program. Finally, robust evaluation is necessary to understand the difference individual programs are making.

16 WHERE TO FROM HERE

In launching The Road Home , then Prime Minister Kevin Rudd linked the Australian motif 'a fair go for all' with homelessness policy; all Australians have a right to permanent, safe, secure housing. The Road Home sought to shift homelessness policy to a national, system-level perspective (Parsell & Jones, 2014). A broad national policy lens on homelessness needs to be supported with local place-based programs based on a strong evidence base, and co-design and community input processes.

What the homelessness evidence base continues to tell us is that people experiencing homelessness are a diverse group of people and have diverse histories of homelessness. It therefore stands to reason that there needs to be a range of homelessness, housing, and complementary supports in place to effectively work towards ending homelessness. Preventative programs, early intervention programs, crisis support, and housing access and permanent housing support models for this with high needs are all parts of the puzzle required to meet the needs of those experiencing homelessness at different points of the life cycle and exhibiting different combinations of needs.

We need to address the underlying drivers of homelessness so that we turn off the tap to homelessness. That means addressing social housing shortfalls, improving housing affordability for low-income households, as well as focusing on an end-poverty program, addressing family and domestic violence, and providing supportive mental health programs. Early intervention programs for children and young people experiencing the first early spells of homelessness are critical in light of the strong evidence of links between childhood and adolescent homelessness and subsequent adult chronic homelessness. There are well-established links between leaving child protection care, juvenile and adult justice and homelessness, which require targeted responses.

Programs should be delivered in a culturally safe and secure way. Given high rates of Aboriginal and Torres Strait Islander homelessness, a fundamental part of the ending homelessness response is to increase the scale of Aboriginal and Torres Strait Islander-controlled homelessness services. The Western Australian Housing First Homelessness Initiative includes a number of Housing First programs which are directly delivered by Aboriginal-led and controlled community organisations. Our analysis of the Advance to Zero data also reveals the high number of those experiencing chronic homelessness in communities served by Zero Projects across Australia with very high needs. This provides a strong evidence base for the implementation of supportive housing models for those entering permanent housing from a history of high needs.

Excellent progress is being made in various pockets of policy and practice, and effort should be directed to continuing and expanding this progress as well as filling the 'gaps'. State and territory governments have recently announced significant increases in social housing supply and implemented innovative Housing First programs. However, there is currently a gap in terms of a coordinated national end homelessness response involving significant new investment by the Australian Government and improved coordination between Australian Government and state and Territory government actions. Housing First and multidisciplinary, medium- to long-term support in permanent housing are two important areas for further development, as is a refocusing of attention on early intervention child and youth homelessness responses.

Beyond this there is a need for a stronger national commitment to aspirational goal setting and targeting and attendant measurement. The existing national housing, and homelessness performance indicator framework allows for an assessment of outcomes being achieved in reducing homelessness but does not include direct aspirational target setting on ending homelessness. Likewise, at the local community level, there has been significant improvement in targeted end homelessness approaches and measurement in Zero Projects, though the report notes improvements that can occur in this domain. Real time data that examines vulnerabilities across communities and timeframes equips both support services and funders with appropriate information to make educated judgments on both funding and support provision moving forward. This can lead to relative

confidence in new service models that are evidenced and are addressing gaps in service delivery that can be seen through real time data. The Advance to Zero approach is seeking to change the system by focusing on a person-centred, Housing First approach in specific communities putting community owned, near to real time data about individuals' needs at the centre of decision making and the system itself. With data underpinning decision making, and services designed to meet the presenting needs of the populations, we can work towards ending homelessness within Australia.

While the Australian Government and state and territory governments bear the primary responsibility for housing and homelessness in Australia, in recent years, alternative methods of funding homelessness support have been explored, such as joint investment, impact investment, payment by results, and SIB models. Although SIBs are beginning to be explored through programs such as the Aspire SIB and J2SI, there remains further potential to engage investors in the homelessness space, through direct investment, payment by resultscampaigns, and SIBs.. Both the Aspire SIB and J2SI employ long-term case management and multi-disciplinary wrap around supports to help end homelessness for people experiencing chronic and complex homelessness. There are other ways in which homelessness programs could be supported through social impact funding. For example, Thames Reach in the United Kingdom employed both social impact and payment by results funding to a population of rough sleepers in London. This SIB was measured by five outcomes: reduction in numbers sleeping rough, recorded by the street outreach teams against an active historical baseline; housing obtained and maintained for 12–18 months; reconnections with home country; engagement in employment or training; and, reductions in visits to hospital accident and emergency.

The health impacts of homelessness are often cyclical in nature, in that health impacts are a precursor to, and caused by experiencing homelessness. Once homeless, individuals face exacerbated health issues due to either feeling excluded or being excluded from proper health care. Data-led programs have demonstrated that affordable, housing first and multidisciplinary models can and have provided long-term solutions for people aiming to address and end their homelessness (Parsell et al., 2020). It is recommended that models including housing first and multidisciplinary, medium- to long-term support be explored in order to work toward the goal of ending homelessness.

There is a critical role for homelessness sector peaks (such as Homelessness NSW, Council to Homeless Persons, and Homelessness Australia),the Australian Alliance to End Homelessness (AAEH) and linked movements (such as the Western Australian Alliance to End Homelessness, and the Brisbane Alliance to End Homelessness) in the goal of ending homelessness, bringing together communities and being an advocate for change at a national, jurisdictional and local community level. The AAEH is committed to ending homelessness in Australia through connection with communities around the world who have demonstrated effective initiatives in both preventing and ending homelessness, and applying them to an Australian context.

Though all people experiencing homelessness are at increased risk of many health conditions, and poorer social outcomes, particular attention should be paid to people rough sleeping and those experiencing chronic homelessness, as those individuals are at the highest risk of experiencing co-occurring health conditions that are precursors to premature mortality.

Though this report has demonstrated that there are present and persistent needs gaps in both service delivery and housing options for people experiencing homelessness, it points towards a consistently improved understanding of 'the problem' of homelessness. We can begin to conceptualise homelessness experiences in terms of inflow and outflow pathways, we can assess how and why events may be happening in populations to trigger homelessness, and we can work towards ending the homelessness experience for Australians. With data underpinning decision making, and services designed to meet the presenting needs of the populations, we can work towards ending homelessness.

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APPENDICES

APPENDIX 1

Table 47 – Number of responses in Queensland by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Family VI-SPDAT – Brisbane – Version 1 – 500 Lives	0	0	0	0	353	208	239	163	4	0	1	968
Family VI-SPDAT – Brisbane – Version 2 – Housing First	0	0	0	0	0	0	1	60	221	87	0	369
Family VI-SPDAT – Brisbane – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	109	302	411
Individual VI-SPDAT – Brisbane – Version 1 – 500 Lives	0	0	0	0	1,118	386	482	367	5	0	1	2,359
Individual VI-SPDAT – Brisbane – Version 2 – Housing First	0	0	0	0	0	0	0	268	609	197	1	1,075
Individual VI-SPDAT – Brisbane – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	222	1,001	1,223
Vulnerability Index – Brisbane	260	111	173	132	19	0	0	0	0	0	0	695
Vulnerability Index – Townsville	56	0	0	0	0	0	0	0	0	0	0	56
Youth VI-SPDAT – Brisbane – Version 2 – Housing First	0	0	0	0	0	0	0	1	6	4	0	11
Youth VI-SPDAT – Brisbane – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	4	4
Total	316	111	173	132	1,490	594	722	859	845	619	1,310	7,171

Source: National Advance to Zero 2010–2020.

APPENDIX 2

Table 48 – Number of responses in Western Australia by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Family VI-SPDAT – Geraldton – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	14	14
Family VI-SPDAT – Mandurah – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	0	0
Family VI-SPDAT – Perth – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	0	0
Family VI-SPDAT – Rockingham – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	4	4
Family VI-SPDAT v 1 – Perth	0	0	0	0	0	1	46	21	14	48	24	154
Individual VI-SPDAT – Bunbury – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	1	1
Individual VI-SPDAT – Geraldton – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	37	37
Individual VI-SPDAT – Mandurah – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	0	0
Individual VI-SPDAT – Perth – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	0	0

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APPENDIX 2 (Continued)

Table 48 – Number of responses in Western Australia by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Individual VI-SPDAT – Rockingham – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	24	24
Individual VI-SPDAT v 1 – Perth	0	0	0	0	150	170	640	314	253	313	231	2,071
Vulnerability Index – Perth	0	0	190	1	0	0	0	0	0	0	0	191
Youth VI-SPDAT – Geraldton – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	6	6
Youth VI-SPDAT – Mandurah – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	0	0
Youth VI-SPDAT – Perth – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	1	1
Youth VI-SPDAT – Rockingham – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	2	2
Total	0	0	190	1	150	171	686	335	267	361	344	2,505

Source: National Advance to Zero 2010–2020.

APPENDIX 3

Table 49 – Number of responses in New South Wales by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Family VI-SPDAT – Central Coast NSW – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	1	1
Family VI-SPDAT v 1 – Nepean	0	0	0	0	6	0	12	0	0	0	0	18
Family VI-SPDAT v 1 – Newcastle	0	0	0	0	0	0	3	0	0	0	0	3
General VI-SPDAT – Sydney – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	0	1	1
Individual VI-SPDAT – Central Coast NSW – Version 3 – AAEH	0	0	0	0	0	0	0	0	0	47	8	55
Individual VI-SPDAT – Nepean – Version 1 – 500 Lives	0	0	0	0	68	0	79	2	0	0	0	149
Individual VI-SPDAT – Newcastle – Version 1 – 500 Lives	0	0	0	0	0	0	50	4	4	0	0	58
Individual VI-SPDAT – Sutherland – Version 1 – 500 Lives	0	0	0	0	0	23	15	0	0	0	0	38
Individual VI-SPDAT – Sydney – Version 1 – 500 Lives	0	0	0	0	0	514	43	1	45	58	7	668
Individual VI-SPDAT – Sydney – Version 2	0	0	0	0	0	0	0	0	0	370	219	589
Vulnerability Index – Nepean	0	0	167	9	1	0	0	0	0	0	0	177
Vulnerability Index – Sydney	331	90	55	53	1	2	0	0	0	0	0	532
Total	331	90	222	62	76	539	202	7	49	475	236	2,289

Source: National Advance to Zero 2010–2020.

APPENDIX 4

Table 50 – Number of responses in South Australia by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
General VI-SPDAT – Adelaide – Version 3 – AAEH	0	0	0	0	0	0	0	0	1	324	498	823
General VI-SPDAT v 2017 – Adelaide	0	0	0	0	0	0	0	4	345	107	1	457
Total	0	0	0	0	0	0	0	4	346	431	499	1,280

Source: National Advance to Zero 2010–2020.

APPENDIX 5

Table 51 – Number of responses in Tasmania by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Vulnerability Index – Hobart	0	61	108	61	55	57	33	11	0	0	0	386
Total	0	61	108	61	55	57	33	11	0	0	0	386

Source: National Advance to Zero 2010–2020.

APPENDIX 6

Table 52 – Number of responses in Victoria by interview type, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
Family VI-SPDAT - Mellbourne - Version 1	0	0	0	0	0	0	0	172	223	72	27	494
Individual VI-SPDAT v 1 - Melbourne	0	0	0	0	0	0	0	1,665	1,669	1,084	1,167	5,585
Vulnerability Index - Melbourne	165	155	59	156	35	156	166	30	15	0	0	937
Youth VI-SPDAT - Melbourne - Version 1	0	0	0	0	0	0	0	80	126	69	31	306
Total	165	155	59	156	35	156	166	1,947	2,033	1,225	1,225	7,322

Source: National Advance to Zero 2010–2020.

APPENDIX 7

Table 53 – Variables by interview type

	Family version 1	*Family version 2*	*Family version 3*	*Individual VI-SPDAT Version 1*	*Individual VI-SPDAT Version 2*	*Individual VI-SPDAT Version 3*	*VI*	*Youth VI-SPDAT Version 2*	*Youth VI-SPDAT Version 3*	*General VI-SPDAT*
Demographics										
Age	X	X	X	X	X	X	X	X	X	X
Gender	X	X	X	X	X	X	X	X	X	X
Identity	X	X	X	X	X	X			X	X
Culture	X	X	X	X	X	X	X	X	X	X
Citizenship and residency status	X		X	X	X	X	X		X	X
Education	X			X			X			
Partnering and living arrangements				X			X			
Veterans	X		X	X			X			X
Foster care	X	X	X	X	X	X	X	X		X
Experience of homelessness										
Types of homelessness	X	X	X	X	X	X	X	X	X	X
Duration of homelessness	X	X	X	X	X	X	X	X	X	X
Discrimination			X			X			X	X
Health outcomes										
Physical health conditions	X	X	X	X	X	X	X		X	X

Continued on page 224.

APPENDIX 7 (Continued)

Table 53 – Variables by interview type

	Family version 1	*Family version 2*	*Family version 3*	*Individual VI-SPDAT Version 1*	*Individual VI-SPDAT Version 2*	*Individual VI-SPDAT Version 3*	*VI*	*Youth VI-SPDAT Version 2*	*Youth VI-SPDAT Version 3*	*General VI-SPDAT*
Mental health, learning and developmental disorders										
Mental health against will	X		X	X		X	X		X	X
Observe mental illness	X			X			X			
Mental health professional appointment	X		X	X			X		X	X
Hospital for emotions and nerves	X		X	X		X			X	X
Learning and development disability	X		X	X					X	X
Problems concentrating	X			X						
Brain Injury	X		X	X		X	X		X	X
Trauma – not sought help			X		X	X				X
Trauma caused homelessness		X	X		X	X				X
Trauma – not sought help			X			X				X
Trauma caused homelessness		X			X					
Drug and alcohol use	X		X	X		X	X		X	X

Continued on page 225.

APPENDIX 7 (Continued)

Table 53 – Variables by interview type

	Family version 1	*Family version 2*	*Family version 3*	*Individual VI-SPDAT Version 1*	*Individual VI-SPDAT Version 2*	*Individual VI-SPDAT Version 3*	*VI*	*Youth VI-SPDAT Version 2*	*Youth VI-SPDAT Version 3*	*General VI-SPDAT*
Daily alcohol use	X		X			X	X		X	X
Observe drug and alcohol	X						X			
Drug and alcohol treatment	X		X			X			X	
Non-beverage alcohol	X									
Blacked out	X	X	X	X	X	X			X	
Safe injecting practices			X			X			X	X
Mental health conditions			X			X			X	X
Medications			X			X			X	
Healthcare utilisation										
Accidents and emergency department use	X	X	X	X	X	X		X	X	X
Hopsitalisation as an inpatient use	X	X	X	X	X	X		X	X	X
Ambulance use	X	X	X	X	X	X		X	X	X
Justice										
Prison	X			X			X			
Youth detention	X	X	X	X	X	X			X	X
Police interactions	X	X	X	X	X	X		X	X	
Harm, risk, crime	X	X		X	X		X	X		

Continued on page 226.

APPENDIX 7 (Continued)

Table 53 – Variables by interview type

	Family version 1	*Family version 2*	*Family version 3*	*Individual VI-SPDAT Version 1*	*Individual VI-SPDAT Version 2*	*Individual VI-SPDAT Version 3*	*VI*	*Youth VI-SPDAT Version 2*	*Youth VI-SPDAT Version 3*	*General VI-SPDAT*
Financial and social indicators										
Centrelink Breach	X			X						
Owe money	X	X	X	X	X	X		X	X	X
Money cover expenses	X			X						
Pension card				X			X			
Healthcare Card				X			X			
Control of finances				X	X	X	X			
Money on regular basis	X	X	X	X	X	X		X	X	X
Money gamble			X			X				X
Pets	X	X	X	X	X	X	X		X	X
Mobility Limited	X	X	X	X	X	X	X	X	X	X
Friends and family convenience	X			X						
Friends and family take and borrow money	X			X						
Activities for happiness	X	X	X	X				X		
Safe and Well		X	X		X	X		X	X	X

Source: National Advance to Zero 2010–2020.

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