ENDING HOMELESSNESS IN AUSTRALIA

An evidence and policy deep dive

Bulletin No 2
Findings from the Advance to Zero database: A decade of community-led data collection among those experiencing homelessness in Australia's cities

Ending homelessness in Australia: An evidence and policy deep dive Bulletins

- Bulletin 1: Ending homelessness in Australia: Understanding homelessness; taking action

- Bulletin No 2: Findings from the Advance to Zero database: A decade of community-led data collection among those experiencing homelessness in Australia's cities

The Ending Homelessness Report

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Contact

Professor Paul Flatau,
Centre for Social Impact,
The University of Western Australia.
Crawley, Western Australia, 6009
Paul.Flatau@uwa.edu.au

KEY POINTS

1. This bulletin presents findings from a decade of data collection (2010-2020) by homelessness services on the needs and journeys of those experiencing homelessness which focuses on those sleeping rough with high needs and often long periods of homelessness. This is the first comprehensive analysis of this rich community-led data comprising responses from 20,953 people.

2. Since 2010, homelessness services have used registry/connection weeks to understand the needs and vulnerabilities of those experiencing homelessness with particular focus on those sleeping rough over an extended period. Homelessness services have collected actionable information through using standardised instruments eliciting information on the circumstances, vulnerability, risk and service needs of those experiencing homelessness. The Advance to Zero dataset comprises the VI-SPDAT together with the By-Name List and is used by homelessness services to understand the circumstances of those experiencing homelessness and the inflows, the number of people actively homeless within a community, and the outflows into permanent housing. Using this information, homelessness services prioritise the most vulnerable, following people through the journey from homelessness to housing to understand if we are making a difference to homelessness one community at a time.

3. *Homelessness:* Over one-third of respondents reported that they most frequently slept rough, with the majority of those sleeping on the streets. The majority of the remaining Advance to Zero respondents reported that they most frequently slept in crisis and emergency accommodation services, temporarily in peoples homes or in short-term boarding houses. The majority of respondents were considered to have high acuity needs requiring 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. On average, people had experienced homelessness for 3.8 years with around 40% reporting many years of homelessness.

4. *Health:* Respondents reported a range of long-term serious medical conditions and diagnosed mental health conditions nearly all of which were significantly higher than rates seen across the general population. Very high rates of foot and skin infections and dental problems were evident among respondents. One-third of Advance to Zero respondents reported being taken to hospital against their will because of mental health issues and a similar number reported going to accident or emergency due to mental health reasons. Problematic alcohol and other drug use was reported by the majority of respondents. Self-reported use of hospitals among Advance to Zero respondents is, on average, much higher than the general population but there are large differences among respondents with a small number of people accounting for a large proportion of health service use; the majority of respondents accessed healthcare services five or less times in the six months prior to being surveyed. Of those who utilised health services, the estimated annual costs of those sleeping rough is 1.4 times higher than non-rough sleepers.

5. *Justice:* A large proportion of respondents report they have been in juvenile detention or prison in their lifetime, with 3 times as many rough sleepers reporting having been in youth detention than non-rough sleepers. Four in ten respondents report being the victim of attack since becoming homeless.

6. *Financial and social outcomes:* While the majority of respondents are in receipt of regular income, most do not have enough money to meet their basic needs. Four in ten respondents 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, or have people in their life whose company they do not enjoy but are around out of convenience or necessity.

7. Respondents indicated housing, food and warmth are the most important needs. Large numbers of respondents reported that permanent housing was fundamental for a sense of safety and wellbeing, access to medical support, medication, support services, financial security, employment and independence. Family, friends, and social support are important for love and belongingness.

8. A snapshot of the By-Name List for November 2020, showed the majority of newly identified respondents had a history of homelessness and were temporarily accommodated. Housing placement is dependent on age and Aboriginal and Torres Strait Islander status, with a greater proportion of younger and Aboriginal and Torres Strait Islander respondents placed in public and community housing, and non-Aboriginal and Torres Strait Islander respondents placed in private rentals.

9. There remains a need for a stronger longitudinal representation of the data through both linking the Advance to Zero and By-Name List datasets 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.

10. *People experiencing homelessness are a diverse group of people with varied needs and histories of homelessness. There needs to be a range of homelessness, housing, and complementary supports in place to effectively work towards ending homelessness. 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.*

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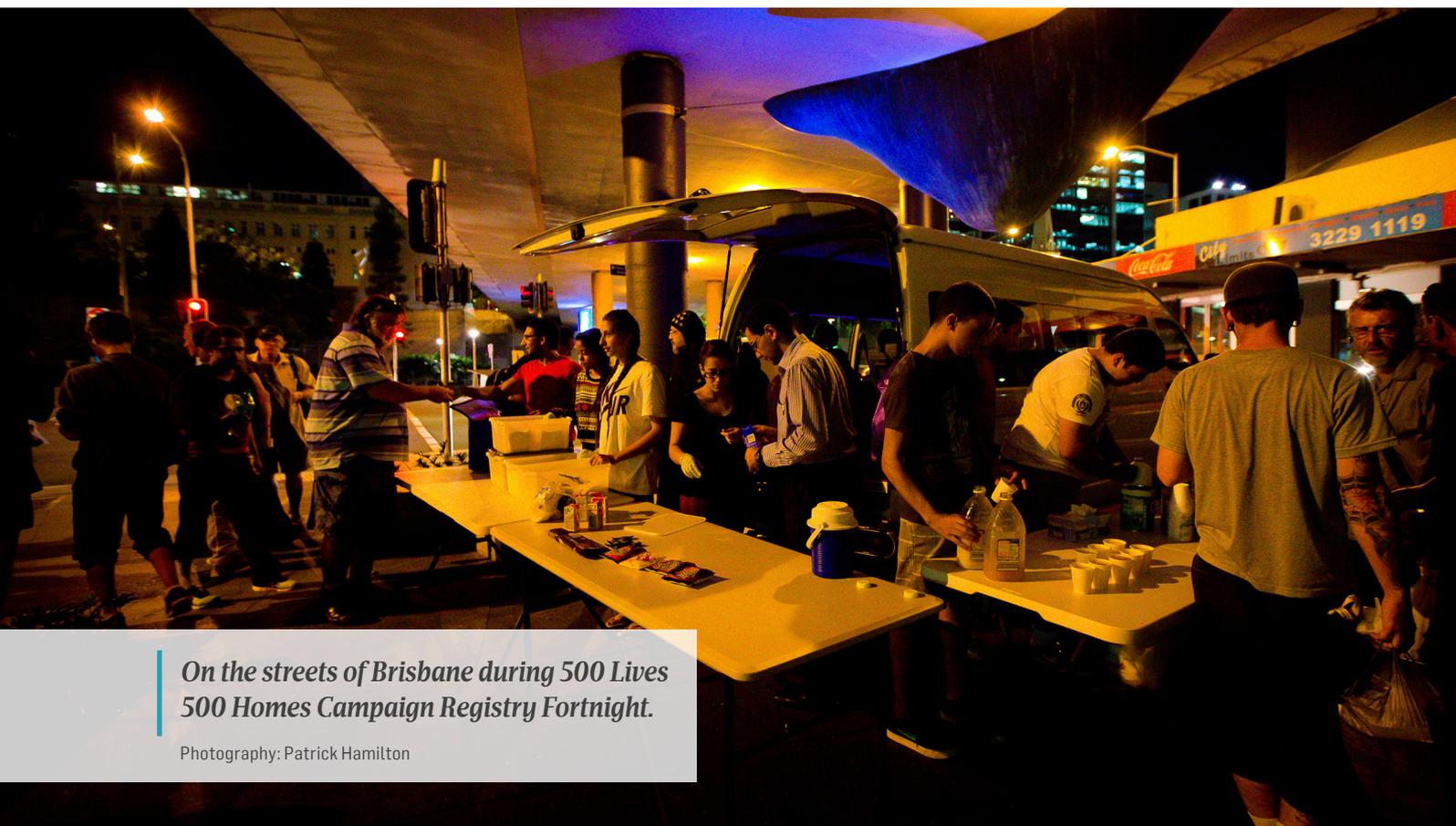
On the streets of Brisbane during 500 Lives 500 Homes Campaign Registry Fortnight.

Photography: Patrick Hamilton

In 2010, Micah Projects conducted interviews in Brisbane with those sleeping rough and in homelessness services utilising a tool called the Vulnerability Index (VI) as part of Australia's first Registry Week. The Vulnerability Index 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. 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 ambulance arrivals. It is a survey administered to people with informed consent, with some opportunity for the interviewer to provide assessment. Micah Projects conducted the VI as part of the 50 Lives 50 Homes campaign in Brisbane; one of the projects around Australia that adopted an end homelessness agenda built around Housing First principles which include rapid entry to permanent housing with support.

By the end of 2013, the VI had been utilised by agencies to assess over 2,300 rough sleepers and those being supported by Australia's homelessness services 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.

As data collection developed by homelessness services, the VI was combined with the Service Prioritization Decision Assistance Tool (SPDAT) which provided a broader assessment tool for frontline agency workers to

assist them in prioritising the health and housing needs of individuals and families who are homeless. Over time, this effort was extended with the addition of the By-Name List approach, in which those experiencing homelessness are individually named and supported and tracked in their journey from homelessness to permanent housing. The consolidated VI-SPDAT and By-Name List data now forms part of the Advance to Zero database being used by homelessness services adopting an Advance to Zero homelessness methodology. The Advance to Zero, or functional zero methodology, adapted from the United States, focuses on understanding the inflows and the number of people actively homeless within a community, to better understand overall changes to homelessness (inflows and outflows), rather than counting 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 and community owned and led, a 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 real time client data.

The Australian Advance to Zero database captured 20,953 responses between 2010 and 2020 from those experiencing homelessness collected from homelessness agencies across six states in Australia (data was not collected in the Australian Capital Territory or Northern Territory). The 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.
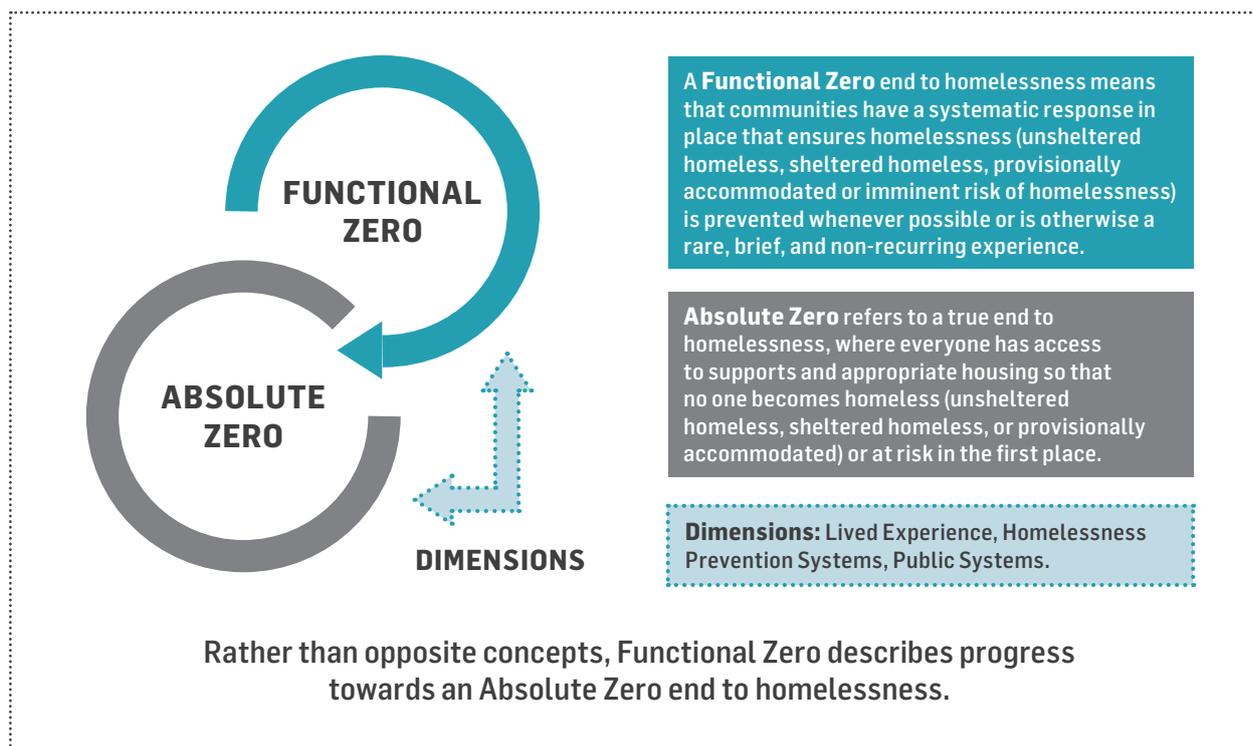

Neami National's Street to Home providing outreach and homelessness support in central Adelaide.

Photography: Amy Piesse

Figure 1 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.

Results from an analysis of the Advance to Zero database cover housing and health outcomes, health utilisation, justice, financial and social wellbeing. Key results are summarised below.
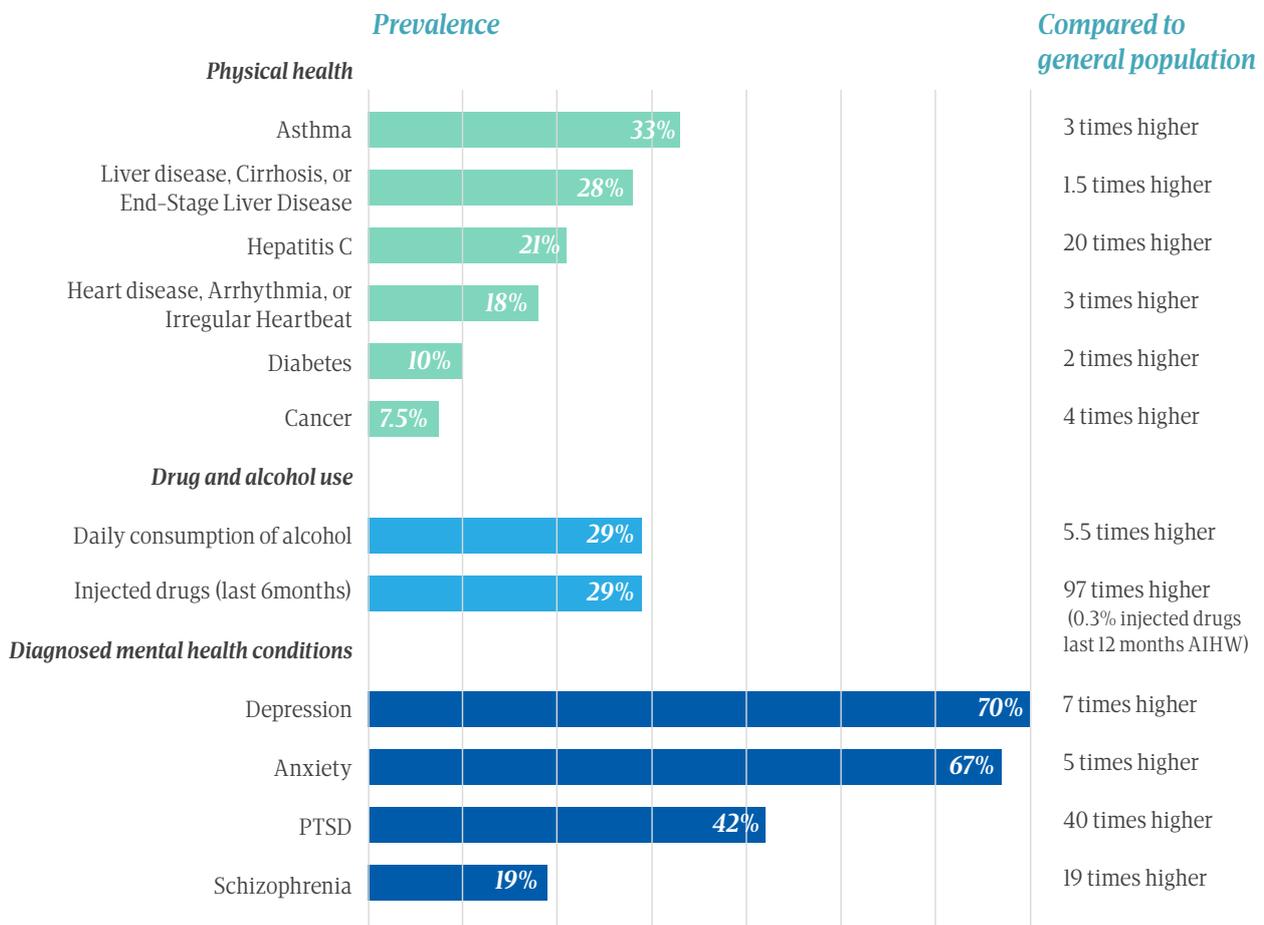
HOMELESSNESS HISTORIES

Those experiencing homelessness in the Australian Advance to Zero database were largely sleeping rough or in temporary, short-term accommodation of various forms and many exhibited long periods of homelessness.

- 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 in housing or in the service system because of age, race, appearance, disabilities, gender identity or sexual orientation.

- 57% were considered high acuity needing permanent housing with long term support in supportive housing models, 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.

HEALTH OUTCOMES

Respondents reported a range of physical, medical and mental health conditions: nearly all of which were significantly higher than the rates observed in the general population.

	Prevalence	Compared to general population
Physical health		
Asthma	33%	3 times higher
Liver disease, Cirrhosis, or End-Stage Liver Disease	28%	1.5 times higher
Hepatitis C	21%	20 times higher
Heart disease, Arrhythmia, or Irregular Heartbeat	18%	3 times higher
Diabetes	10%	2 times higher
Cancer	7.5%	4 times higher
Drug and alcohol use		
Daily consumption of alcohol	29%	5.5 times higher
Injected drugs (last 6months)	29%	97 times higher (0.3% injected drugs last 12 months AIHW)
Diagnosed mental health conditions		
Depression	70%	7 times higher
Anxiety	67%	5 times higher
PTSD	42%	40 times higher
Schizophrenia	19%	19 times higher

- Cellulitis, foot/skin infections, scabies dehydration, epilepsy and dental problems were reported as major health issues by many respondents

- Problematic Alcohol and other drug use was reported by 65% of respondents.

- Almost one-third (31%) of respondents reported having been taken to a hospital against their will for mental health reasons.

- 48% reported speaking with a psychiatrist, psychologist or mental health professional in the last six months.

- 39% reported going to an Emergency Department due to not feeling emotionally well or because of their nerves.

- Twenty-one percent reported a serious brain injury or head trauma.

HEALTH SERVICE UTILISATION

- Self-reported use of hospitals among Advance to Zero respondents is, on average, much higher than the general population but there are large differences among respondents. A significant minority of people in the Advance to Zero database account for a large proportion of health service users.

- The majority of respondents reported accessing healthcare services five or less times in the six months prior to being surveyed.

- 53% of respondents reported accessing the hospital accident and emergency department in the last six months. On average, respondents utilised hospital accident and emergency department services 1.93 times in the last six months.

- 40% reported being an in-patient in a hospital in the last six months. On average, respondents utilised in-patient hospital services 1.04 times in the last six months.

- 39% reported using an ambulance to be taken to hospital in the last six months. On average, respondents utilised an ambulance to be taken to hospital 1.13 times in the last six months.

Of those who utilised health services, the estimated annual costs of those sleeping rough is higher than non-rough sleepers. Both sets of estimates are well above general population averages.

ANNUAL COST/PERSON	SLEEPING ROUGH	NOT SLEEPING ROUGH
Ambulance	$6,714	$4,526
Accidents and emergencies	$4,862	$3,600
In-patient hospital	$30,740	$23,152

JUSTICE OUTCOMES

- *36%* of respondents reported that they had been in prison at some point in their lifetime
- *20%* of rough sleepers had been in youth detention compared to *6%* of non-rough sleepers
- *42%* of respondents report being a victim of attack since becoming homeless

FINANCIAL WELLBEING

- *92%* of respondents report that they are in receipt of regular income
- *53%* report that they do not have enough money to meet their basic needs
- *19%* report that they had received a Centrelink breach

SOCIAL WELLBEING

- *44%* have planned activities for happiness
- *41%* 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
- *40%* report that they have people in their life whose company they do not enjoy but are around out of convenience or necessity.
- *11%* have pets

WHAT DO YOU NEED TO BE SAFE AND WELL

- Respondents indicated housing, food and warmth are the most important needs
- Permanent housing is a requirement for a sense of safety and wellbeing and to address health, alcohol and other drug needs as well as support reunification with children and gain employment.
- Access to medical support, medication, support services, financial security and independence are important requirements for both physical and mental health needs.
- Family, friends, personal relationships and social support are important for love and belongness needs

WHAT DO YOU NEED TO BE SAFE AND WELL?

Respondents 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 as a framework, we manually coded the valid responses into categories and subcategories. Table 1 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 permanent housing and safety are not fulfilled**, as is inherently the case with individuals experiencing homelessness.

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. Importantly, the home is a place where health needs can be better addressed, social relationships flourish, and employment opportunities realised.

Figure 2 Maslow's Hierarchy of Needs
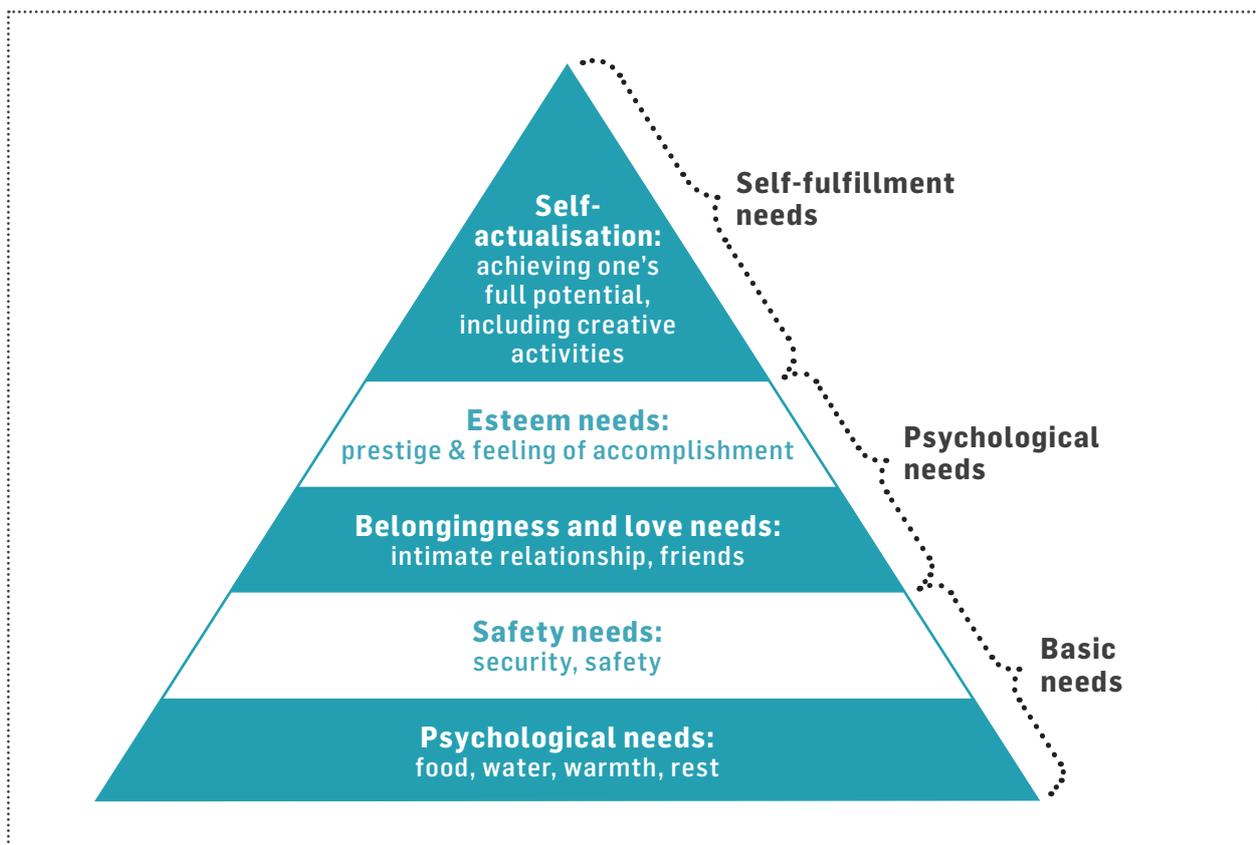
Source: Maslow(1943). A theory of human motivation.

Table 1 – Number of mentions of key terms

Subcategory	Examples from data / key terms	Number of mentions*
Housing 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: [1] *Multiple response allowed.

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

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

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

"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."

"My own place with my own independence to get to the next step in my life."
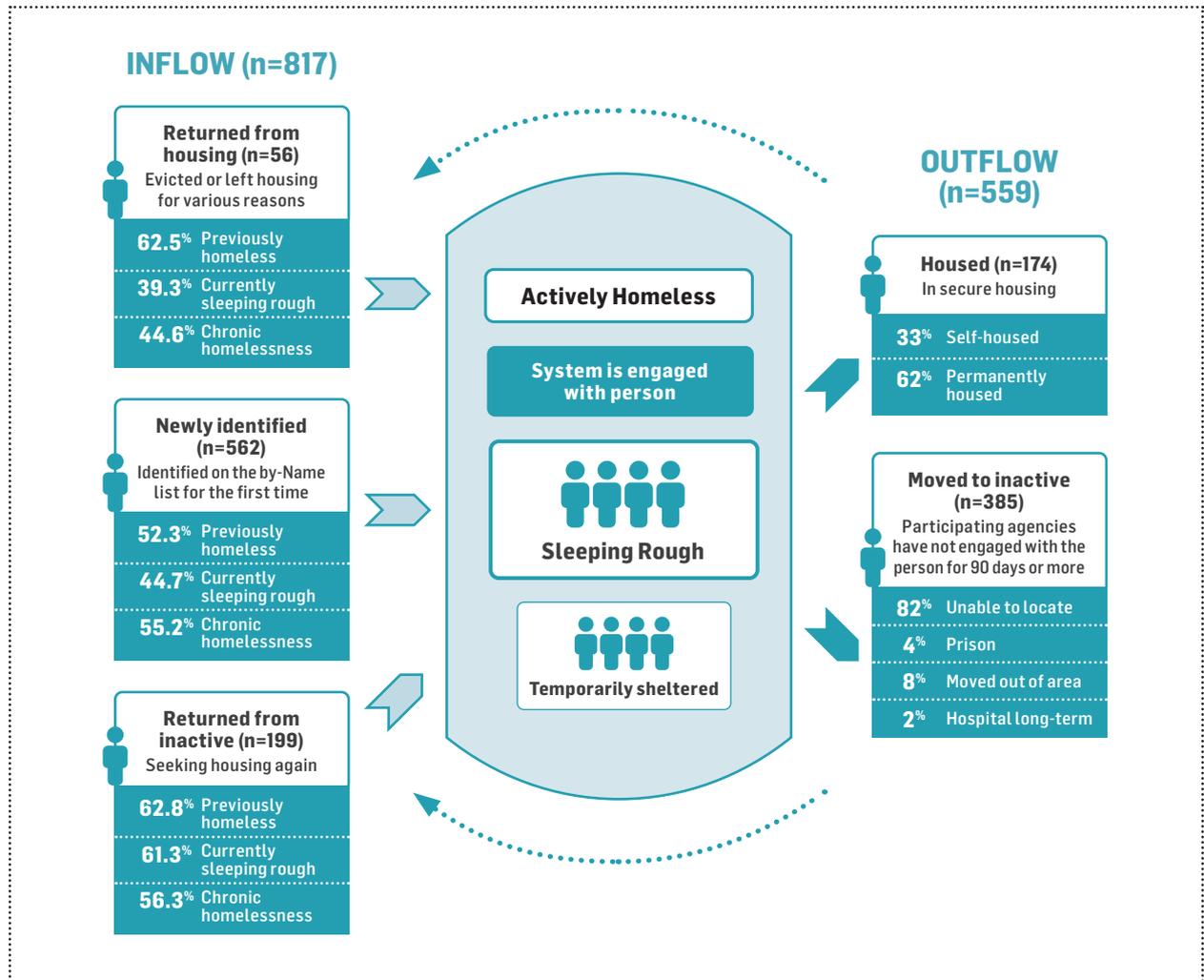
Carlos and Integrated Healthcare Nurse Carla from Micah Projects Street to Home Outreach Team.

Photography: Katie Bennett

THE BY-NAME LIST

The By-Name List is a key tool of the Advance to Zero methodology used 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.

INFLOW (n=817)

Returned from housing (n=56)
Evicted or left housing for various reasons

62.5%	Previously homeless
39.3%	Currently sleeping rough
44.6%	Chronic homelessness

Newly identified (n=562)
Identified on the by-Name list for the first time

52.3%	Previously homeless
44.7%	Currently sleeping rough
55.2%	Chronic homelessness

Returned from inactive (n=199)
Seeking housing again

62.8%	Previously homeless
61.3%	Currently sleeping rough
56.3%	Chronic homelessness

Actively Homeless

System is engaged with person

Sleeping Rough

Temporarily sheltered

OUTFLOW (n=559)

Housed (n=174)
In secure housing

33%	Self-housed
62%	Permanently housed

Moved to inactive (n=385)
Participating agencies have not engaged with the person for 90 days or more

82%	Unable to locate
4%	Prison
8%	Moved out of area
2%	Hospital long-term

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

A snapshot of the month of November 2020 showed

- Of those that were newly identified, 52% were previously homeless.

- 64% of respondents were temporarily accommodated, 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).

- 68% with high acuity receive a housing placement, with 36% permanently housed.

- Of those who had returned from housing, 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.

- Housing placement is dependent on age and Aboriginal and Torres Strait Islander status, with a greater proportion of respondents under 55 (20%) and Aboriginal and Torres Strait Islander (24%) respondents placed in community housing compared to older (11%) and non-Aboriginal and Torres Strait Islander (17%) respondents, and a greater proportion of non-Aboriginal and Torres Strait Islander respondents placed in private rentals (13%) than Aboriginal and Torres Strait Islander respondents (7%).

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 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% Indigenous, 21.3% had experienced youth detention, and 25.0% out-of-home care prior to the age of 18. Sixty-two percent had experienced violence or threats of violence in the prior six months and reported 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 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% Indigenous, 19.4% had experienced youth detention, and 21.9% out-of-home care. Over one-third reported (37.2%) owing money. Long-term rough sleepers reported 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 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, 63.9% were male, 26.3% indigenous, 20.8% had experienced youth detention, and 27.2% 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.

MOVING FORWARD WITH ADVANCE TO ZERO

The Advance to Zero database and methodology is trying to break up the problem of homelessness 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. 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 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.

CITATION

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Contact: Professor Paul Flatau, Centre for Social Impact, The University of Western Australia. Crawley, Western Australia, 6009 Paul.Flatau@uwa.edu.au