THE STATE OF HOMELESSNESS IN AUSTRALIA'S CITIES:

A HEALTH AND SOCIAL COST TOO HIGH 2018

Photography: Kieran MacFarlane

Paul Flatau
Katie Tyson
Zoe Callis
Ami Seivwright
Emily Box
Lobna Rouhani
Sze-Wan Ng
Noah Lester
Daniel Firth

Centre for Social Impact
The University of Western Australia
(CSI UWA)

aaeh australian alliance to end homelessness

CENTRE for SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA

Authors

Paul Flatau, Katie Tyson, Zoe Callis, Ami Seivwright, Emily Box, Lobna Rouhani, Noah Lester, Daniel Firth, Sze-Wan Ng

Centre for Social Impact The University of Western Australia (CSI UWA)

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Address for Correspondence

Professor Paul Flatau

Centre for Social Impact The University of Western Australia (M098), UWA Business School, University of Western Australia, Crawley, WA, 6009

Paul.Flatau@uwa.edu.au

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The Australian Alliance to End Homelessness (AAEH)

The AAEH is an organisation that, amongst other things, has the vision of ending homelessness in Australia by better understanding the circumstances and vulnerabilities of homeless people in Australia. It is an independent voice that advocates for and fosters evidence-based approaches to resolving all types of homelessness.

The Board of the AAEH is comprised of Chair Karyn Walsh AM (CEO, Micah Projects), Felicity Reynolds (CEO, Mercy Foundation), Keith Bryant (Chair, Wentworth Community Housing), Dr Heather Holst (COO, Launch Housing), Debra Zanella, (CEO, RUAH), and David Pearson (Executive Director, Don Dunstan Foundation).

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Aboriginal and Torres Strait Islander readers are advised that the following document may contain images of people who have died.

Disclaimer

The opinions in this report reflect the views of the authors and do not necessarily reflect those of the Australian Alliance to End Homelessness or any of its organisations.

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ACRONYMS AND ABBREVIATIONS

A&E	Accident and Emergency
AAEH	Australian Alliance to End Homelessness
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CSI	Centre for Social Impact
CSI UWA	Centre for Social Impact The University of Western Australia
NGO	Non-Government Organisation
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
SA	South Australia
SHS	Specialist Homelessness Service
SHSC	Specialist Homelessness Services Collection
TAS	Tasmania
US	United States
WA	Western Australia
VI	Vulnerability Index
VIC	Victoria
VI-SPDAT	Vulnerability Index-Service Prioritization Decision Assistance Tool

PREFACE

In 2010, a group of practitioners, policy makers, and philanthropists gathered in Brisbane inspired by the work of Rosanne Haggerty and Becky Kanis Margiotta from the 100,000 Homes campaign, USA. The campaign set out with the goal of housing 100,000 of the most vulnerable citizens in America — those who were experiencing chronic homelessness.

Here in Australia, at a similar time, we had a watershed moment through the National Agenda for Homelessness set by the Labor Government, and then Prime Minister Kevin Rudd. After a significant consultation process across Australia, the 2008 White Paper *The Road Home* was released with the clear goals to address many key areas to prevent and end homelessness and a visibly articulated goal to end rough sleeping by 2020 in this country.

How were we going to achieve this was the motivation of those who gathered for the first registry week here in Australia. We had taken up Rosanne's challenge in Brisbane, to set out to house the 50 most vulnerable people on our streets. A small goal given we had over 365 people on the streets at the time in Brisbane.

Through agency collaboration, community effort and a methodology that would enable us to know by name who our neighbours were living on the streets, and to track our progress with the one goal of person by person ending their homelessness through housing and individualised support and health services. The Vulnerability Index tool, developed in the USA, was used to understand the individuals on the streets, not just by name, which is the crucial first step, but how long they had been homelessness, their health status, history of institutional care from child protection to adults and services, their participation in the Australian Defence Force, service utilisation across emergency departments, hospitals, watch houses, and prisons.

From that week we established a national network to support each other apply this methodology across local communities in Australia. The new VI-SPDAT was used as a tool to gather the by-name list across many regional and city communities within Australia with the goal of seeing this dream emerge from the grassroots with services, practitioners, NGOs, businesses, foundations all coming together. This was a success and our vison now is to develop an Australian National Campaign, similar to the 100,000 Homes campaign, to reach that goal articulated so well in the White Paper to offer all rough sleepers housing.

The National Database that houses the data of the grassroots efforts has been analysed wonderfully by Paul and his team and gives us perspective that is larger than any one of our individual communities. The data is a story of people, places, and the systems that intersect with the lives of this population of people. As Brene Brown says, "maybe stories are just data with a soul". This data set tells many stories of systems failing our most vulnerable and by virtue is a powerful story of why we as a nation need to do better for the most vulnerable on our streets across our communities.

We need to stop talking about it and do it. It is achievable if we collectively commit to making the changes we need to prevent individuals and families from the cycle of poverty at its harshest moment, when faced with sleeping rough, in a car or a squat. We can change systems to put people's need at the forefront and build housing that is well designed to needs and with support.

The Australian Alliance to End Homelessness members thank Paul and his team for taking this work and producing a report to move us forward as we all strive to find ways to end homelessness in Australia.

Karyn Walsh AM

CEO of Micah Projects

Chair of the Board of the Australian Alliance to End Homelessness

EXECUTIVE SUMMARY

BACKGROUND

Since 2010, Australian homelessness services, largely operating in the inner city areas of Australian cities, have undertaken interviews with over 8,000 people sleeping rough or otherwise homeless in concentrated data collection efforts called Registry Weeks. First implemented by US homelessness services as part of campaigns to end homelessness in US cities, Registry Weeks aim to develop a register of those who are homeless in areas in which homelessness services operate using a common interview schedule. The purpose of the register is for those who are homeless to be known by name and for their housing, health and social needs to be recognised to facilitate the organisation of local services to assist people into permanent housing with necessary supports.

The Australian homelessness services that initiated Registry Weeks in Australia shared the principles of evidence-based responses to homelessness, a focus on Housing First and rapid re-housing approaches, and the development of initiatives informed by robust data and research. The Vulnerability Index (VI) instrument, and following that, the VI-SPDAT (Service Prioritisation Decision Assistance Tool) were used in Registry Week collections as the means of collecting data. Findings from Registry Weeks have assisted agencies to prioritise services to those most in need. In recent times, homelessness agencies have moved away from conducting the VI-SPDAT interviews in set weeks and are now conducting interviews on a rolling basis.

Over the seven years that the VI and the VI-SPDAT has been administered (2010-2017), 8,618 interviews have been conducted with 8,370 people experiencing homelessness across Australian capital cities and regional centres.

The State of Homelessness in Australia's Cities: A Health and Social Cost Too High represents the first analysis of the consolidated Registry Week data across Australia. The consolidated Registry Week data provides the largest and richest collection of information on people experiencing homelessness in Australian capital and regional cities outside the Census and the national administrative data for homelessness services, the Specialist Homelessness Services Collection.

The report aims to:

1. Provide a profile of the backgrounds of people experiencing homelessness in Australia.
2. Examine the length of time those interviewed have spent homeless and have been without stable accommodation.
3. Assess the medical conditions and healthcare needs of those experiencing homelessness, their current use of healthcare, and the accompanying costs to the healthcare system.
4. Understand the history of interaction with the justice system of those experiencing homelessness, and their current exposure to harm and risk.
5. Examine the financial circumstances of those experiencing homelessness and their social needs.
6. Detail in the words of those interviewed what they feel they need in order to be safe and well.
7. Provide recommendations for future strategies and studies that aim to inform best practice approaches to ending homelessness in Australia.

KEY FINDINGS

Who is in the Registry Week collection and where are they from

The Registry Week data is comprised of 8,618 interviews with 8,370 individuals; some individuals were interviewed more than once over the 2010-2017 period. Queensland was the first state to implement a Registry Week collection and remains the largest state in terms of completed interviews with 47.8% of all interviews taking place in Queensland. Western Australia accounted for 19.3% of the interviews; 17.8% of interviews took place in New South Wales, 10.7% in Victoria and 4.5% in Tasmania. Most interviews were conducted in the inner city areas of Brisbane, Perth, Sydney, Melbourne and Hobart.

Overall, males accounted for 66.3% of the unique respondents in the Registry Week data, a substantially higher proportion than both the Census data, in which 58% of the homeless population were male, and the Specialist Homelessness Service Collection which recorded 40% of clients as male. The latter collection includes a significant number of clients of women's refuges which were under-represented in Registry Week collections. Transgender and Other Gender respondents comprised 0.7% of the overall sample. While males represented a higher proportion of the homeless population in each age bracket, the distribution of homeless females was skewed towards the younger age brackets; over half (51.8%) of female respondents in the Registry Week data were aged 34 years or under.

Of the Registry Week respondents, 90.6%, identified as Straight, 2.9% identified as Lesbian/Gay, 3.2% as Bisexual and 0.1% as Queer.

The proportion of respondents identifying as Lesbian/Gay, Bisexual, or Queer is twice that of the Australian adult population (Australian Bureau of Statistics, 2015).

Educational attainment was low amongst the Registry Week respondents. Only 6.6% reported their highest level of education as an apprenticeship or tertiary studies, and a far greater proportion of Registry Week respondents compared with the Australian population reported their highest level of schooling as Year 9 or below.

Indigenous Australians are overrepresented among people experiencing homelessness

Nationally, Indigenous Australians are overrepresented in a myriad of statistics relating to disadvantage and ill-health, and the same is true of the Registry Week data. Approximately one in five people interviewed identified as Indigenous, despite Indigenous people making up only 2.8% of the Australian population (Australian Bureau of Statistics, 2017c). In addition, a higher proportion of Indigenous people than non-Indigenous people interviewed reported sleeping rough, incarceration and youth detention at some point in their lifetime. However, Indigenous Australians were also more likely to report being with others rather than alone while homeless.

People sleeping rough fare worse than those that are not sleeping rough

Total time spent homeless varied significantly among respondents. However, chronic homelessness (long-term persistent homelessness) is the norm for rough sleepers in Australia's cities. Those currently sleeping rough reported the longest cumulative time spent homeless (defined narrowly in terms of rough sleeping plus supported accommodation): mean 6 years; median 3 years. Those experiencing chronic homelessness exhibited elevated lifetime prevalence rates of serious medical conditions. People sleeping rough, report higher levels of problematic alcohol and/or other drug use, and are frequent users of acute health services. They are also more likely to have historical and current interactions with the police and justice system, be a victim of assault, engage in risky behaviours, be less likely to have a healthcare or pension card and be more likely to have a Centrelink breach.

The Registry Week collection reveals high numbers of veterans rough sleeping in Australia's cities many suffering from serious brain injury and head trauma

Unlike the case of the US, where the issue of veterans homelessness has received wide attention and a strong policy response, there has been very limited research into veterans' homelessness in Australia. This is largely because both Census and administrative data sources have not included veterans status and research studies that do include veteran's status have typically been undertaken with relatively small samples.

A total of 457 individuals in the Registry Week data, 83.8% of whom where male, reported that they had served in the Australian Defence Force (and for our purposes were counted as veterans). A much larger proportion of homeless veterans identified as Indigenous (16.5%) relative to the proportion of Indigenous Australians in the Australian Defence Force (1.6%) (Department of Veterans' Affairs, 2016). Educational attainment amongst veteran respondents was higher than for non-veterans.

A larger proportion of veterans versus non-veterans reported that they were sleeping rough at the time of their interviews (61.1% of veterans; 51.5% of non-veterans). The proportion of veterans reporting lifetime experiences of youth detention and foster care, one of the risk factors of homelessness, was not substantially different to the overall sample. However, 43% of Registry Week respondents that identified as veterans reported that they had suffered a serious brain injury or head trauma in their lives, considerably higher than for the non-veteran homeless population.

Veterans were more likely than others to be in receipt of regular income and an amount of that income was sufficient to fulfil their needs, though it is important to note that only 51.3% of veteran respondents reported that they had enough income. Veterans were more likely than non-veterans to report possession of a pension card, and less likely to have had a Centrelink breach in the six months prior to interview than non-veterans. A substantially higher proportion of veterans than non-veterans reported that they had a permanent physical disability that limited their mobility.

Social relations for veterans varied: veterans were less likely to present with others during their homelessness journey than non-veterans, but more likely to report having a pet. They are also less likely to have people that they keep in their life out of convenience or necessity rather than enjoyment of their company, and less likely to have people in their lives that steal from them.

Homelessness is associated with poor health outcomes and results in significant costs to the Australian healthcare system

High rates of chronic conditions, mental illness and alcohol and other drug use were reported by respondents. Rates of cancer, heart disease, HIV/AIDS, Hepatitis C, and diabetes were substantially higher amongst Registry Week respondents compared with the overall Australian population. Asthma, liver disease, kidney disease, emphysema, frostbite and tuberculosis were also highly prevalent among Registry Week respondents. Notably, many of these conditions are attributable to environmental factors (e.g., exposure to the elements) and lifestyle factors. For example, 65.2% of respondents reported problematic alcohol or drug use, which is a risk factor for both infectious diseases such as HIV/AIDS and Hepatitis C, and chronic diseases such as heart and liver disease.

While the VI-SPDAT does not directly ask about diagnosis or presence of mental health conditions, 29.8% of Registry Week respondents have been taken to a hospital against their will for mental health reasons, 48.4% had spoken with a mental health professional in the six months prior to survey, and 36.9% have attended Accidents and Emergency (A&E) due to not feeling emotionally well or because of their nerves.

Respondents also reported high rates of acute healthcare system use (A&E, admission as an in-patient to hospital and ambulance use) which are likely to be associated with poor overall health outcomes. A&E was the most frequently used healthcare service among Registry Week respondents, with an average of 2.5 visits in the prior six months. However, this average includes 42% of respondents that did not use A&E at all; the average number of visits among those that did use the service was 4.35. Rough sleepers were more likely to use A&E than non-rough sleepers. The majority (59.7%) of Registry Week respondents did not have a hospital admission as an in-patient in the six months prior to their survey. However, among those that did have an inpatient admission, the mean number of admissions over the six month period was 2.91. Similarly, while 58.8% of respondents had not used an ambulance in the prior six months, those that did reported a mean of 3.45 ambulance trips to the hospital.

Based on national average healthcare incident costs, the mean cost per person across all three types of healthcare services examined (A&E, ambulance and inpatient admissions) is estimated at $8,970 per person over a six months period. This is a conservative estimate given that there is evidence that average lengths of stay in hospital for those experiencing homelessness is higher than the population average. The mean cost rises for rough sleepers compared with other homeless people. If healthcare costs are only estimated for those respondents that accessed all three types of healthcare services, mean costs rise significantly to $24,987 per person/six months. Of note is that the healthcare costs were not evenly distributed among respondents with some accessing services at higher rates than others. Rough sleepers were much more likely than non-rough sleepers to use ambulance and A&E, and those that had inpatient hospital admissions were more likely to have a higher number of admissions over the six month period.

People experiencing homelessness have high rates of interactions with the justice system and are often victims of assault

High rates of lifetime interaction with the justice system are evident among respondents: 45.1% of the overall sample had been to prison in their lifetimes, and that proportion is substantially higher among males, Indigenous Australians and rough sleepers. In addition, 61.4% of respondents reported that they had interacted with the police in the prior six months, and approximately one third of respondents reported having legal issues at the time of survey.

Similarly, almost one quarter of people reported engaging in risky behaviours, including coerced behaviour, threatening to harm themselves or others, and illegal behaviour such as exchanging sex for money or running drugs.

International studies show that people experiencing homelessness are vulnerable to attack. Among respondents, attacks were common with 44% of people reported being attacked or beaten up since becoming homelessness. Over half (52.5%) of rough sleepers reported that they had been a victim of assault since they had become homeless.

Financial circumstances

While 92.0% of Registry Week respondents reported receipt of regular income, 48.1% of respondents reported that they had enough income on a fortnightly basis to meet all of their expenses and debts. The vast majority (90.3%) of respondents reported that they had control over their finances, but almost one third (30.1%) reported that there was at least one person that believed the respondent owed them money.

Almost one in five (18.2%) of Registry Week respondents had had a Centrelink breach in the previous six months. Rough sleepers were less likely to have enough money, less likely to have a pension or healthcare card, and more likely to have had a Centrelink breach in the previous 12 months. There were no pronounced differences in these rates between males and females, or between Indigenous and non-Indigenous Australians.

Social needs

Registry Week respondents are asked about certain risk and protective factors for their social wellbeing. With regard to protective factors, just over one quarter (26.5%) of respondents reported that they were staying with others at the time of the survey (though not necessarily in accommodation). Almost half (45.8%) of the sample reported that they had activities that they enjoyed, other than surviving, planned. 11.5% of respondents overall had a pet at the time of survey.

In terms of risk factors, 39.8% of respondents reported that they had friends or family that steal their money, cigarettes, drugs and alcohol, or coerce them to do things they don't want to do. Unsurprisingly, then, 38.9% of respondents report that they have people in their life whose company they do not enjoy but keep around out of convenience or necessity.

What do those experiencing homelessness want to be safe and well

Over 4,500 respondents answered the open-ended question "what do you need to be safe and well". Basic needs ranked the most highly. Housing and shelter was overwhelmingly the most frequently raised need for safety and wellbeing, with 84% of respondents referencing a house, home, accommodation, or shelter. Food was mentioned by a substantial proportion of respondents, often in conjunction with shelter, and physical safety for themselves and their belongings was a significant concern for respondents.

Accessible, affordable, and regular healthcare services for both general physical and mental health were mentioned by many participants. Financial resources, referred to as money, income, stable income, financial security and stability were a prominent concern. Over 500 participants mentioned that they want a job or employment.

Love and belongingness were identified as key factors for many respondents. These needs varied and included reuniting with family, developing a strong social support network, and maintaining supports with agencies.

Developing responses from the lived experiences of those experiencing homelessness

From the responses of homeless people themselves it is clear homelessness strategies need to prioritise the achievement of stable permanent housing, as is the case in the Housing First model. In many cases respondents indicated that once they had stable housing they could address their health, drug and alcohol and employment issues. It is also clear that a house alone cannot address the impacts of homelessness, both in terms of its antecedents and outcomes, nor can a house alone fulfil the needs of formerly homeless individuals.

Wraparound support, including physical and mental health services, alcohol and drug services, tenancy support, and employment services will be required both to facilitate the sustaining of a tenancy and the achievement of the individuals' higher wellbeing needs. Justice and legal issues that face those experiencing homelessness services require urgent attention. In other words, a Housing Plus approach is called for.

Homeless people are not concerned with a 'house with a view' but a home that will form the foundation stone for getting their lives back together again, forming relationships and being safe, addressing health issues and gaining employment to provide the financial security and resources to be able to navigate the world around them.

Chapter One

INTRO-DUCTION

"Sustainable housing, stability, love and kindness"

(What do you need to be safe and well?)

Photography by UnitingCare West

Over the last seven years (2010–2017), Australian homelessness services have followed the lead of US and Canadian agencies in going onto the 'streets' and interviewing rough sleepers and those in supported accommodation arrangements. Originally, interviews were conducted in designated 'Registry Weeks' (intensive time periods such as several days or a week) and in later years continuously, using a common instrument the Vulnerability Index (VI) and subsequently various versions of the Vulnerability Index–Service Prioritization Decision Assistance Tool (VI–SPDAT). The VI was developed by US–based Common Ground's Street to Home team based on the research evidence on key predictors of mortality among those experiencing homelessness from studies conducted by Stephen Hwang and Jim O'Connell and others and linked principally to the Boston Health Care for the Homeless Program (Hwang et al., 1997; Hwang et al., 1998). The SPDAT tool was designed by OrgCode Consulting, Inc. to assist service providers to prioritise the service placement process to those most in need focusing on socioeconomic and psychosocial risk factors. The two instruments were combined together to form the VI–SPDAT.

Registry Week data collections are a community–coordinated assertive outreach and triage assessment process to develop actionable data on the health, support and housing needs of people who are sleeping rough and experiencing chronic and episodic homelessness (Mercy Foundation, 2017). Underpinned by a Housing First philosophy, communities have utilised the VI and VI–SPDAT to understand and prioritise the real–time and localised demand for the housing and support services required to move people into safe, permanent and sustainable housing (Australian Alliance to End Homelessness, 2013).

Registry Weeks have been the organising backbone of multiple campaigns seeking to end rough sleeping both internationally and in Australia. Registry Weeks have occurred across five Australian states, between 2010 and 2017. Beginning with Micah Projects in Brisbane in 2010 (see the Preface to this report by Karyn Walsh AM, CEO of Micah Projects), Registry Weeks in Australia have largely been undertaken in inner–city locations in Brisbane, Sydney, Perth, Hobart, and Melbourne as well as some regional cities.

Central to the running of Registry Weeks has been the use of the VI–SPDAT as a fundamental tool in which to collect data on the vulnerabilities and level of needs of an individual or family. More recently, some organisations have shifted away from administering the VI–SPDAT as an initial triage assessment tool used only during Registry Weeks, to utilisation in everyday service delivery (Mercy Foundation, 2017). Ongoing use of the VI–SPDAT has assisted agencies to identify and track changes in the health and other needs of people who are housed or receiving supports. In the present study, we refer to all collections of data using the VI and the VI–SPDAT instruments as Registry Week collections irrespective of whether these collections were undertaken during intensive periods of interviewing in a designated Registry Week period or were part of ongoing data collections.

In this study we bring together, for the first time, all Registry Week collections undertaken in Australia over the last seven years. As a result, our consolidated data set includes data from 8,618 interview responses from 8,370 respondents (including 238 respondents who were interviewed twice and 10 respondents with three responses). This provides the largest collection of detailed information on the circumstances of those experiencing homelessness in Australian capital cities and regional cities available. We utilise this rich and extensive data to provide a profile of those experiencing homelessness, particularly rough sleepers, including aspects of their histories, their health conditions and mental health and alcohol and other drug needs, their interaction with the health care system and the justice system, their current income and employment circumstances, their social needs and social connections. We utilise information on interactions with the health care system to estimate costs to the health system of those experiencing homelessness. We end our analysis with an investigation of responses to the question: What do you need to be safe and well? Quotes from responses to this question are included in the study to illustrate what those experiencing homelessness themselves say they need to be safe and well.

Where appropriate, the report makes connections with the two other major collections of homelessness data in Australia, namely the 2016 Census estimates of homelessness (ABS, 2018) and expressed Specialist Homelessness Service (SHS) support demand in the Specialist Homelessness Services Collection (SHSC) (AIHW, 2018). Unlike the Census or the SHSC of the AIHW, the Registry Week collections do not seek to provide a full population–level perspective of homelessness in Australia. This is because Registry Week collections have been undertaken not in response to administrative requirements or by law but by particular agencies keen to know more about the needs and circumstances of those they support. These agencies have largely been located in the inner city areas of Australian capital cities together with some in regional cities. Hence the title of the report *The State of Homelessness in Australia's Cities*. The sheer size of the collections and the scope of the topics covered gives this report its particular significance. The findings point to very high personal, health and social costs of homelessness leading us to the full title of the report *The State of Homelessness in Australia's Cities: A Health and Social Cost Too High.*

Photography by UnitingCare West

Chapter Two

HOMELESS-NESS IN AUSTRALIA

This chapter examines the two main definitions of homelessness used in Australia, the 'cultural' definition of homelessness and the Australian Bureau of Statistics' definition of homelessness; the differences between the two frameworks and the approach taken to the definition of homelessness in this report (based on Registry Week collections); the extant research evidence on the causes and consequences of homelessness, and key policy measures to address homelessness; and estimates of Australian homelessness based on Census and on homelessness services administrative data.

Photography by UnitingCare West

2.1 DEFINING HOMELESSNESS

There is no internationally agreed upon definition of homelessness or commonly accepted framework for measuring homelessness. All definitions of homelessness incorporate rough sleeping (i.e., unsheltered homelessness) as well as emergency, temporary or transitional accommodation provided to those who would otherwise be without shelter (Chamberlain & MacKenzie, 1992; Edgar, Meert & Doherty, 2004; Department of Housing and Development, 2017).

In Australia, however, what is referred to as a 'cultural' definition of homelessness has been widely used over a long period of time and extends the concept of homelessness beyond the confines of rough sleeping and what has been referred to in some countries as shelter-based homelessness. According to Chamberlain and MacKenzie (1992), a cultural definition of homelessness defines homelessness as residing in non-shelter or accommodation settings that fall below minimum acceptable levels in the society in question. Applied in the context of a high-income society, homelessness not only includes rough sleeping and emergency accommodation provided by homelessness services, but also staying temporarily with others but without tenure rights (e.g., adolescents who have run away due to violence in the parental home and are staying with friends; couch surfing), in short-term housing arrangements without legal tenancy, and in accommodation that lacks private facilities (e.g., many boarding or rooming houses).

The cultural definition of homelessness is an 'accommodation-based definition' (Chamberlain, 2014) which has been used for many years in homelessness research and policy development. It recognises three broad levels of homelessness according to the degree to which people's housing needs are met (or not met), within conventional expectations or community standards (Chamberlain & Mackenzie, 1992):

- Primary homelessness: people without conventional accommodation such as those sleeping rough and in improvised dwellings.
- Secondary homelessness: people moving between various forms of temporary shelter, including staying with friends, emergency accommodation, youth refuges, hostels and boarding houses.
- Tertiary homelessness: people living in single rooms in private boarding houses, without their own bathroom, kitchen or security of tenure.

A second approach to the definition of homelessness used in Australia is that of the Australian Bureau of Statistics (ABS). In 2011, the Australian Bureau of Statistics (ABS) revised its conceptual framework and definition of homelessness to incorporate those core elements commonly associated with Anglo American and European interpretations of 'home', such as a sense of security, stability, privacy, safety and control over living space (Mallett, 2004).

Under the ABS framework, a person is considered homeless if they do not have suitable accommodation alternatives and their current living arrangement meets at least one of the following criteria:

- Is in a dwelling that is inadequate, or
- Has no tenure, or
- If their initial tenure is short and not extendable, or
- Does not allow them to have control of, and access to space for social relations.

The ABS framework is operationalised in the Census in terms of the following categories of homelessness:

- 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.

On the surface, there appears little to distinguish between the two approaches. However, the inclusion in the ABS framework of the conventionally 'housed homeless' (i.e., those who either own their home or rent in the private, public and community rental markets with clear tenure rights) but whose housing does not allow for 'control of, and access to space for social relations' because of severe overcrowding represents a clear point of departure from the cultural definition of homelessness as operationalised in past censuses. As Chamberlain (2014) has suggested, the inclusion of those in conventionally-housed settings may dramatically change the profile of homelessness and may have significant impacts on policy and resource allocation decisions.

Interestingly, the VI-SPDAT tool does not itself provide a definition of homelessness. However, measures of homelessness can be derived from the questions included in the tool. The VI-SPDAT tool includes two sets of questions directly relating to the homelessness status and homelessness history of respondents. These questions provide insights into the current and lifetime homelessness experience of respondents.

Meeting and interviewing people living in Boarding Houses during 500 Lives 500 Homes Campaign Registry Fortnight. Photography: Robyn McDonald.

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".

The question does not allow for a precise point-in-time estimate of homelessness (as is done in the Census) because the reference is to 'sleep at most often' rather than 'sleep last night' or something similar.

Nevertheless, responses to the question provide an answer to where respondents generally slept and can be coded according to particular frameworks of homelessness adopted. A range of specified options are presented to the respondent and the respondent is also provided with an open category in which they can put forward their own answer.

The specified categories fall into four broad groups: (1) rough sleeping categories; (2) supported accommodation categories (including women's refuges); (3) Short-term accommodation without tenure (e.g., boarding house, hostel, caravan); and (4) accommodation in institutional settings (e.g., hospitals, drug and alcohol treatment centres, watch houses, jail, juvenile detention). As will be discussed in Chapter 4, a significant number of respondents used the open-ended option response to list what were clearly temporary accommodation (e.g. couch-surfing) options (which were not provided for in the original list) and a small number put forward responses which were indicative of own permanent housing. Among those 'conventionally housed', the VI-SPDAT did not allow for a determination of whether there was severe overcrowding in the dwellings concerned. This means that it is possible to code responses to ABS or the cultural definition categories other than for the severely overcrowded ABS definition.

The VI-SPDAT instrument also includes questions relating to the history of homelessness. While there are minor local variations to the way these questions were asked, they relate to the total length of time the respondent had lived on the streets or in emergency accommodation; the total length of time the respondents had lived without stable accommodation; and the number of times respondents had changed address.

Photography by UnitingCare West

2.2 THE DETERMINANTS AND COSTS OF HOMELESSNESS

People who are homeless are the most marginalised in society, suffering from acute levels of poverty and disadvantage (Australian Council of Social Services, 2016) and social exclusion (Australian Social Inclusion Board, 2012) resulting in profound negative effects on a person's physical and mental health, education and employment opportunities (AIHW, 2017). People who are sleeping rough experience high levels of fear, anxiety and violence (Buckner, 2004) with rough sleepers in the United Kingdom and Wales almost 17 times more likely to be the victim of assault than the general population (Sanders and Albanese, 2016).

Homelessness reflects the interplay of structural determinants and individual-level determinants (Shinn & Weitzman, 1990; Early, 2005; Nooe & Patterson, 2010). Structural drivers of homelessness include shortage of affordable housing, increasing costs of rent, high unemployment, and poverty (Elliott & Krivo, 1991). Physical health conditions (Hwang, 2001; Fazel, Geddes & Kushel, 2014) and mental health disorders including experiences of trauma and substance use disorders have been found in both international and Australian studies as critical individual-level determinants of homelessness (Teesson, Hodder & Buhrich, 2000; Buhrich, Hodder & Teesson, 2000; Fazel et al., 2008; Flatau et al., 2012; O'Donnell et al., 2014; Conroy et al., 2014; Spicer et al., 2015; Miscenko et al., 2017). There is a strong relationship between histories of incarceration and juvenile detention and associated impacts on employment and housing opportunities (Galea & Vlahov, 2002; Greenberg & Rosenheck, 2008).

Domestic and family violence is the main reason women and children leave their homes in Australia (AIHW, 2018), and children who experience homelessness are more likely to experience it as an adult (Australian Government White Paper, 2008). Parental history of neglect of children, violence in the family home, incarceration, mental health disorders, and homelessness drive early onset homelessness, often through children running away from home and couch-surfing, a history of out-of-home care which itself is strongly linked to youth homelessness, and intergenerational homelessness (Whitbeck, Hoyt & Ackley, 1997; Flatau, et al., 2013; Wildeman, 2014; Thielking et al., 2015; Flatau et al., 2015).

Elevated rates of communicable and chronic diseases, intentional (e.g., assault) and unintentional injury, and mental health and substance use problems among homeless people lead to elevated rates of healthcare utilisation, resulting in a significant cost burden to the healthcare system (Flatau et al., 2008; Flatau & Zaretzky, 2008; Zaretzky, Flatau & Brady, 2008; Poulin et al., 2010; Hwang et al., 2011; Hwang et al., 2013; Zaretzky et al., 2013; Wood et al., 2016; Parsell, Petersen & Culhane, 2016; Zaretzky et al., 2017). MacKenzie et al. (2017) estimated the total cost of identified health and justice services for young people experiencing homelessness in Australia at $747 million per year.

For many people, experiencing homelessness may be a temporary or one-off experience resulting from a significant or unexpected life event, and from which they will recover and go on to find secure stable housing (AIHW, 2017). Conversely, for some it can be a prolonged and chaotic experience involving transitioning from unstable and emergency accommodation to sleeping rough, resulting in a state of chronic homelessness (Mercy Foundation, 2017). The US Department of Housing and Urban Development considers someone chronically homeless if they have been continuously homeless for at least 12 months or have experienced homelessness on at least four separate occasions in the last three years, with combined duration of at least 12 months (Department of Housing and Urban Development, 2017). Those people experiencing chronic homelessness who 'sleep rough' in cars, parks and public places have disproportionate rates of co-occurring primary and mental health conditions, disability (Pleace, 2000; Parsell, 2011), trauma (AIHW, 2018), substance abuse, incarceration and unemployment (AIHW, 2017). It is among this group—the chronically homeless—where the costs of homelessness are especially pronounced (Zaretzky et al., 2017).

In recent years, there has been a concerted effort in many countries to end chronic homelessness through the introduction of programs that go beyond crisis support and the provision of shelter. Three priority program areas are: (1) rapid transition to housing, e.g., Housing First programs (Tsemberis, Gulcur & Nakae, 2004; Padgett, Gulcur & Tsemberis, 2006); (2) integrated service delivery in the homelessness, mental health and drug and alcohol domains, as well as systems-level integration (Rosenheck et al., 1998); and, (3) assertive community treatment and intensive case management (Nelson, Aubry & Lafrance, 2007, Coldwell & Bender, 2007). Studies that target these domains, particularly those which take a Housing First approach, have shown promising outcomes (e.g., reduced hospital costs) for adults experiencing chronic homelessness, as well as for homeless people with chronic medical problems (Culhane, Metraux & Hadley, 2002; Corporation for Supportive Housing, 2004; Pleace et al., 2013; Conroy et al., 2014; Wood et al., 2016; Parsell, Petersen & Culhane, 2016).

2.3 ESTIMATES OF HOMELESSNESS IN AUSTRALIA

Estimates of homelessness in Australia are drawn from the Census and the Specialist Homelessness Services Collection (SHSC) managed by the Australian Institute of Health and Welfare (AIHW). The very size of the Registry Week collection also means that the Registry Week collection can provide insights into the national profile of homelessness in relation to homelessness in capital cities and regional cities. These sources of data vary in terms of their definition of homelessness, purpose, scope, coverage, collection method and reference periods (AIHW, 2017).

2.3.1 THE CENSUS

The purpose of the Census is to provide a broad, point-in-time indication of the scale of homelessness in Australia according to its defined homelessness groups (see chapter 2.1). In 2016, there were 116,427 total enumerated homeless people in Australia.

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, 2018). 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, 2018). 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.

Most of the growth in homelessness reflected an increase in the number of people living in severely overcrowded dwellings (ABS, 2018). Two thirds of this rise is attributable to a doubling of the number of people in this homelessness group who were born overseas. As noted previously, Chamberlain (2014) questions the inclusion of this dimension within a homelessness context. 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 compares the number of bedrooms in a dwelling with a series of household demographics such as the number of usual residents, their relationship to one another, their age and their sex (ABS, 2012).

The rate of homelessness per persons rose in New South Wales (NSW), Victoria (VIC), Queensland (QLD), South Australia (SA) and Tasmania, and dropped in Western Australia (WA), the Australian Capital Territory (ACT) and the Northern Territory (NT) (ABS, 2018). Nearly 60% of homeless people in 2016 were aged under 35 years, with youth aged 12–24 making up 32% of total homeless persons, and 42% of the increase in homelessness being reflected by the 25–34 years age group (up 32% from 2011) (ABS, 2018).

The number of people identified as sleeping rough on Census night 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 (Indigenous) peoples in this group (27%) compared to 2011 (25%), and the proportion of youth aged 12–24 years decreased by 13% since 2011 (ABS, 2018). Indigenous 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, 2018).

People who are sleeping rough are consistently under-enumerated in the Census (ABS, 2018), and are less likely to be accessing Specialist Homelessness Services (SHS) support (AIHW, 2017). On their own, research into an individual's experience of homelessness and subsequent service use, and localised street counts, are limited in their capacity to present an overall picture of rough sleeping in Australia. By design, they represent small samples of a larger population (Parsell et al., 2016) across multiple locations in Australia, and suffer from a reliance on self-reported data and the effect of transience in homeless populations through high attrition rates (Zaretzky & Flatau, 2013).

People who are sleeping rough, youth, Aboriginal and Torres Strait Islander peoples, and people escaping domestic and family violence are thought to be consistently under-enumerated in the Census generally. In 2016, the net undercount rate for Indigenous peoples was 17.5%, some of which may have been homeless on Census night (ABS, 2018). Interpretations of 'usual residence' in the Census, from which homelessness proxies are derived, may differ due to the cultural background of the person, high levels of couch surfing in young people, and transience of those people who are sleeping rough (ABS, 2018). Indeed, an Indigenous population survey conducted in a remote community in northern WA, found an 11% increase in the usual resident's population compared to that found by the ABS. The survey trained local Indigenous people in identifying, engaging and eliciting household population information from residents (Taylor et al., 2012).

In 2016, Census collections moved away from utilising a large workforce to knock on every door in an attempt to deliver Census forms to people at the residence, to a largely online method of collection. The non-response rate of the latest Census was slightly higher but comparable to 2011, and undercounts of young age groups and Indigenous people remain a concern (Harding et al., 2017).

The Census is completed once every five years and the length of time between Censuses means data cannot capture or provide information on the various time-oriented aspects of homelessness such as duration and repeat periods of homelessness (AIHW, 2017). Homelessness is typified by transience with 13% of SHS support periods being closed because contact was lost with the client (AIHW, 2018).

2.3.2 SPECIALIST HOMELESSNESS SERVICES COLLECTION (SHSC)

There are over 1,500 Specialist Homelessness Services (SHS) currently providing support and accommodation services to people who are homeless or 'at risk' of homelessness, in Australia. Services 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, 2018).

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' (primary homelessness), or
- In short-term or emergency accommodation due to a lack of other options (secondary homelessness).

'At risk' of homelessness is defined as a person who is at risk of losing their accommodation 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, 2018). This represents a divergence in both definition and measurement of homelessness across the ABS and SHSC systems; wherein a person living in severely crowded conditions is considered to be homeless (ABS) whereas in the SHSC the same person (if being supported) may be treated as being at risk of homelessness.

Over 2016–2017, there were 288,273 people assisted by SHS agencies across Australia – a rate of 119 people per 10,000 of Australia's estimated residential population (equating to an average of 59,900 people each day) (AIHW, 2018). Almost half (43.7%) were homeless at the start of the support period, with 24,698 (8.6%) sleeping rough, 42,493 (14.7%) staying in short-term or temporary accommodation and 40,796 (14.2%) couch surfing or with no tenure (AIHW, 2018). A large proportion (39.9%) of total clients were homeless in the previous month prior to support, including 42,486 (16.4%) who were sleeping rough and 60,644 (23.5%) who were staying in short-term or emergency accommodation. SHS data collection stops with the end of a support period. Therefore, it is not possible to gauge or track the medium or longer-term client outcomes associated with receiving SHS agency support.

Each State and Territory manages their own system for the assessment and case management of clients accessing SHS supports. As a result, SHS agencies deliver a range of eligibility-based programs ranging from practical support to provision of short-term housing. It is not always within the capacity of SHS agencies to offer services to all those who request it. On average, there were 261 instances of unassisted requests per day across Australia during 2016 and 2017 (AIHW, 2017). Over two thirds (72%) of these requests related to individuals or families needing some type of accommodation support; and the majority of unassisted requests came from females (66%) compared to males (34%), reflecting the overall service user population, which is predominately female (AIHW, 2018). As transitions in bilateral partnerships occur to newer agreements such as the National Homelessness and Housing Partnership (NHHP); changes too can occur in the way in which jurisdictions manage both the delivery of services and their collection of data, potentially impacting SHSC annual data (AIHW, 2018).

Based on the ABS's 2010 Social Science Survey, 60% of the 1.1 million adults who had experienced at least one episode of homelessness in the previous 10 years, had not sought assistance whilst they were homeless (ABS, 2012b). Further, in The Road Home, the Australian Government reported that only 19% of people experiencing homelessness utilise SHS on a given day (Australian Government, 2008). The SHS system is unable to provide a measure of the extent of homelessness within a community nor the housing and support needs required to end that homelessness. Without such information, it is possible only to mitigate the known homelessness in a community, within the capacity of current service delivery and resources (AIHW, 2017).

The purpose of the SHSC is to collect information on client demographics, identified support needs and support provided; that is, SHSC data provides useful information on the profile of homelessness across Australia and a measure of the expressed demand for homelessness services (AIHW, 2017). However, differences in the way homelessness is defined, the point-in-time nature of the Census collection, the inherent service nature of the SHSC data, and the way in which jurisdictions deliver and manage SHS support services results in a degree of misalignment with Census data.

The ABS utilise numerous enumeration strategies in an attempt to mitigate Census data collection issues and provide useful comparisons of Census data with SHS data. For validation purposes, the ABS work with SHS agencies to identify those dwellings representing supported accommodation for people who are homeless; that is, for those people staying in short-term or temporary crisis accommodation (secondary homelessness) or transitional housing. A detailed breakdown of this information was not available in the 2011 Census (ABS, 2011), and not yet available for the 2016 Census. In 2011, Census estimates relating to the number of people staying in supported accommodation for the homeless are higher than SHSC estimates; in all jurisdictions excepting NSW where there was an under-estimation (n=834). The most significant Census over-estimations were in VIC (n=3,437) and SA (n=842). This demonstrates an area of misalignment across Census and SHS data systems relating to homelessness in Australia.

Chapter Three

THE AUSTRALIAN REGISTRY WEEK DATA COLLECTIONS

In this chapter we examine the history of Registry Week collections around the world and in Australia and detail where and when collections have taken place.

Photography by UnitingCare West

3.1 THE HISTORY OF REGISTRY WEEK

Registry Week data collections involve the collection, by homelessness services, of actionable data using standardised instruments eliciting information on the circumstances, vulnerability, risk and service needs of those experiencing homelessness. The term 'Registry Week' refers to the fact that the collection of data has traditionally been undertaken in concentrated time periods (e.g., over a week) involving service agencies and volunteers going out on the streets and to supported accommodation sites and conducting interviews with those experiencing homelessness where they are located. There is also the notion of developing a 'register' of those experiencing of homelessness in the localities served by agencies and getting to know those who are homeless by name and according to their needs and circumstances.

As in the US, Australian Registry Week data collections have utilised the Vulnerability Index (VI) and, subsequently, the VI-SPDAT instrument, which combines the VI with the Service Prioritization Decision Assistance Tool (SPDAT). A number of homelessness services, using the VI-SPDAT, have recently moved away from a concentrated time period for data collection, the 'Registry Week', to on-going data collection.

We use the term 'Registry Week data collections' to refer to all those data collections in Australia that have undertaken data collection in a coordinated fashion using the VI-SPDAT, led by agencies in the Australian Alliance to End Homelessness. Australian Registry Week collections are different from community-initiated 'street counts' (such as the Street Count in Melbourne) which provide useful localised demographic, transience and intended service use information for people who are sleeping rough, at a point-in-time in the sense that street counts typically use a short survey instrument designed to rapidly capture key pieces of information.

Registry Week data collections began originally in the United States as part of the Common Ground campaign to permanently house chronically homeless rough sleepers in New York, in 2004. The 2004 Street to Home Initiative pioneered the creation of a 'homeless registry' to increase community accountability and capacity to end street and chronic homelessness by identifying and assessing the health and housing needs of people experiencing homelessness in a community, using the Vulnerability Index (VI) (Leopold & Ho, 2015).

In 2007, Project 50 in Los Angeles, in liaison with Common Ground, administered the VI tool over a nine day period (called Registry Week) among those living on the streets and in 'shelters'. Project 50 administered the VI to gather data for its 50 Homes Housing First initiative (Leopold & Ho, 2015). Following the Project 50 initiative, other Housing First campaigns began across the US which then led to Common Ground establishing the national 100,000 Homes Campaign (The Campaign). The Campaign adopted a Registry Week data gathering and community engagement approach using initially the VI and subsequently the VI-SPDAT (as developed by Community Solutions, a US-based not-for-profit established by Rosanne Haggerty, formerly of Common Ground and OrgCode Consulting Inc.)

Critical to the Registry Week methodology is that data collected via the VI-SPDAT provides the information required for planning the unique housing and support needs of individuals and families. That is, homelessness systems are more aptly prepared to channel the required resources to those with the greatest needs, in addition to other discretionary support services. 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, Gulcur & Nakae, 2004; Padgett, Gulcur & Tsemberis, 2006).

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).

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 homeless people, including veterans. By the end of the 4-year campaign involving multiple housing, health and other support agencies, 105,580 people in 186 communities had been housed by 2014 (Leopold & Ho, 2015).

It is not possible, in a tool designed to rapidly collect information across a large number of people, particularly those sleeping rough on the streets, to capture all aspects of vulnerability and service needs. Hence, there will always be limitations in any tool utilised in this circumstance due simply to time, place and circumstance constraints (many interviews are undertaken on the streets at night).

Nevertheless, the VI-SPDAT does have some key limitations that are worthy of mention. First, there are relatively few questions on housing and homelessness itself. For example, there is no question on where the respondent slept on the previous night, only where the respondent slept most frequently, and this question does not provide an exhaustive set of options. There are also no questions relating to time first experienced homelessness. However, there are questions on time spent homeless and length of time since the respondent was stably housed. In terms of mental health, there are no options presented on diagnosed mental health conditions, though respondents may themselves elect to advise of long-term diagnosed mental health conditions. Only a few questions address the issue of use of alcohol and drugs and dependence. At the same time there are detailed questions on lifetime and current health conditions, though not the same conditions are listed for both lifetime and current health conditions. Questions relating to socio-demographic background conflate different concepts (such as schooling and post-school education) and are limited in scope.

The VI-SPDAT is utilised to collect self-report (and interviewer) data on clinical and healthcare utilisation outcomes and there is little matching with objective records, posing a number of data quality issues (Parsell, 2011). However, this is a common issue in surveys of vulnerable people. The VI does not give any weight to the specific risks associated with homelessness other than duration and sexual identity, and there is non-explicit mention of partner and dependents. This is significant. Although females represent less of the rough sleeper population in Australia than males, they are more likely to experience rape (Sanders & Albanese, 2016), have dependents living with them on the street (Micah Projects, 2017), and represent the annual majority of SHS agency unassisted requests (AIHW, 2018). Those 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.

Interviewing people during 500 Lives 500 Homes Campaign Registry Fortnight in Brisbane. Photography: Patrick Hamilton.

Interviewing people sleeping rough during 500 Lives 500 Homes Campaign Registry Fortnight in Brisbane.

3.2 REGISTRY WEEK COLLECTIONS IN AUSTRALIA

The VI is a survey and methodology for analysing and prioritising individuals based on the presence or absence of eight clinical conditions that increase the risk and vulnerability of death, in people who are sleeping rough. Studies in the US indicated that co-occurrence of homelessness (6 months or more) with one or more of the 8 identified clinical conditions resulted in an individual being at a higher risk of death (Hwang et al., 1997, 1998). The VI captures information on the number of hospitalisations and emergency department visits per year, age, and numerous chronic diseases. It is a survey administered to people with informed consent, with some opportunity for the interviewer to provide assessment.

In 2010, the VI was utilised to assess and rank the demographic and clinical 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 was utilised by agencies to assess over 2,300 rough sleepers during seven Registry Weeks in seven cities across Australia. Data collected via use of the VI is entered into a database developed by Common Ground USA, and is utilised by organisations as part of their ongoing service delivery post-Registry Week. The 'register' has formed the basis for various Street to Home and Housing First programs across Australia.

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; and
- Tenancy experience and history of housing and homelessness.

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 that impact on ability to access stable housing, other supports, and maintain tenancies. The VI-SPDAT is a scoring system and identifies those which need the most prioritization; those that score 0-4 in this assessment require only affordable housing, those that score 5-9 require affordable housing and brief support. Those that score 10 or more require affordable housing and long-term assistance (Micah Projects, 2017).

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 5 states from 2010-2017 and have largely been undertaken in inner-city locations in Brisbane, Sydney, Perth, Hobart, and Melbourne.

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, 2017). 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, 2017). 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.

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 there was no post-housing support required (16%), almost half (43%) required short-term support from SHS agencies, and long-term support was required for less than one third of households (29%).

In 2016, VI-SPDAT data collected from people sleeping rough and in temporary accommodation during a Registry Week in Perth coordinated by homelessness service RUAH formed the basis of the 50 Lives 50 Homes project, a collective impact campaign aiming to harness and expand existing supports to permanently house 50 of the most vulnerable rough sleepers in Perth. Analysis of VI-SPDAT data identified high levels of trauma, disability, multiple co-occurring health conditions and contact with the justice and hospital system (Wood et al., 2017). VI-SPDAT data is being used to identify and form appropriate support responses to the unique needs of individuals and families and track changes in a range of health, mental health and wellbeing, housing and risk behaviour indicators (Wood et al., 2017). The 50 Lives 50 Homes campaign is a collaboration across 27 organisations and although the goalpost of housing 50 individuals and families was achieved within the first year, partners continue to provide ongoing support to an additional 53 cases utilising the VI-SPDAT to track changes in housing and other outcomes.

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 three years. 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. Not all collections of data using the VI-SPDAT may have been entered into the central Micah databases. These collections are clearly not included in the present report.

Between 2010- 2017, there were 8618 responses collected across five 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 2017. Data is available for Western Australia (WA), Queensland (QLD), New South Wales (NSW), Victoria (VIC), and Tasmania (TAS), and not for other states and territories in Australia.

As outlined in Table 3.1, just over one third (34.4%) of responses were collected via administration of the VI instrument only. 1058 responses (12.3%) were received using the Families-SPDAT only. Over half (52.9%) of the total responses were collected by way of the VI-SPDAT, with only 0.5% (or 41 responses) deriving from slightly different versions of the VI-SPDAT (Youth VI-SPDAT, Families-VI-SPDAT and Individual VI-SPDAT).

Table 3.1 Registry Week Collections by type of collection (total responses)

	NUMBER	PER CENT
VI Survey	2,961	34.4
VI-SPDAT Survey	4,558	52.9
Families-SPDAT Survey	1,058	12.3
Youth VI-SPDAT	26	0.3
Families VI-SPDAT	14	0.2
Individual VI-SPDAT	< 5	-
TOTAL	8,618	100.0

Source: Registry Week Data Collections 2010-2017

In terms of geographic distribution, almost half (47.8% or 4,166) of responses were collected from agencies operating in Queensland; 1,662 responses or 19.3% of responses were collected in Western Australia and 1,531 or 17.8% in New South Wales. Fewer responses were collected from Victoria and Tasmania and there were no collections in South Australia, Northern Territory and the ACT (Table 3.2).

Table 3.2 Registry Week data collections by state of collection (total responses)

	NUMBER	PER CENT
Queensland	4,116	47.8
Western Australia	1,662	19.3
New South Wales	1,531	17.8
Victoria	923	10.7
Tasmania	386	4.5
TOTAL	8,618	100.0

Source: Registry Week Data Collections 2010-2017

The number of responses collected in each year across the 2010–2017 period has varied. 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 relatively low number in 2017 likely represents a lag between data collection and data entry, quality assurance and upload into the AAEH database.

Table 3.3 Registry Week Collections by year of collection (total responses)

YEAR	NUMBER
2010	812
2011	414
2012	750
2013	413
2014	1,842
2015	1,577
2016	1,841
2017	953

Source: Registry Week Data Collections 2010-2017

All Registry Week collections occurred in either capital cities or in major regional cities. We coded all locations listed in interviews (where there was sufficient information to do so) to the Australian Statistical Geography Standard (ASGS). The ASGS is a framework defining geographic boundaries across all regions of Australia. The ASGS works from the smallest geographical unit 'mesh blocks' which then aggregate to form SA1s (areas with little or no permanent residing population), SA2s (medium sized communities that interact socially and economically), SA3s (similar to local Government areas in urban locations or regional areas), SA4s (largest sub-state areas) through to states and territories and then to the whole of Australia (ABS, 2016).

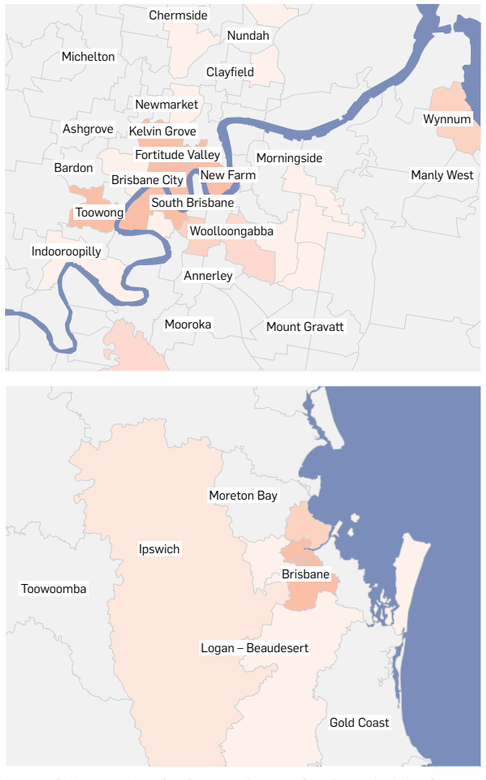
3.2.1 QUEENSLAND

The first Registry Week collection in Australia was held in Brisbane in 2010. There were 310 interviews collected in 2010. As with most Australian Registry Week collections, the vast majority of interviews were collected in the inner Brisbane City area (200 interviews). 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. 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 2014 Registry Week collection remained focused on the inner city area of Brisbane with 612 interviews conducted. However, 219 interviews were conducted in areas immediately adjacent to inner city of Brisbane. The 2014 Queensland collection also marked collections across the wider Brisbane area with 465 interviews conducted across greater Brisbane beyond the Brisbane Inner City SA4 region. There were also collections undertaken in Ipswich (SA4) and Logan – Beaudesert (SA4). A similar geographical profile of interviews is evident in remaining collections in the period 2015–2017. Figure 3.1 and Appendix Table 1 shows the distribution of interviews across regions in Brisbane and other cities in Queensland.

The largest Queensland collections cover Inner City Brisbane comprised of Brisbane City, Fortitude Valley, Spring Hill, New Farm, West End and South Brisbane. Smaller collections include Greater Brisbane, Ipswich, Logan – Beaudesert, Townsville, Cairns, Gold Coast, Moreton Bay, and Toowoomba.

Figure 3.1 Queensland Registry Week Collections



Largest Collections: Inner City Brisbane (Brisbane City, Fortitude Valley, Spring Hill, New Farm, West End and South Brisbane)

Other Collections: Greater Brisbane, Ipswich, Logan – Beaudesert, Townsville, Cairns, Gold Coast, Moreton Bay, Toowoomba

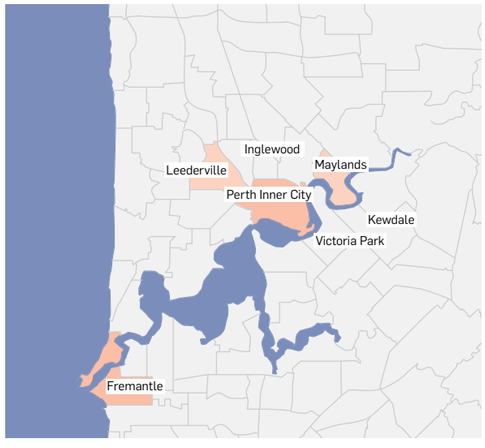
Source: Registry Week Data Collections 2010-2017.

3.2.2 WESTERN AUSTRALIA

In Western Australia (WA), Registry Week collections began in 2012 and were conducted again in the period 2014 to 2017. The 50 Lives 50 Homes campaign originally ran over three consecutive years; resulting in a sharp increase of surveys conducted during 2014 (n=175), 2015 (n=205) and 2016 (n=391). The campaign has been a catalyst for the ongoing use of the VI-SPDAT as part of ongoing service delivery (RUAH, 2018), resulting in high numbers of surveys being collected on an ongoing basis in 2017 by multiple organisations in Perth and Fremantle.

As evident, in Figure 3.2 below and in Appendix Table 2 the WA collections are highly concentrated in inner Perth (City, Northbridge, East Perth, Highgate, Leederville, Subiaco, West Perth, North Perth). Fremantle collections began in 2016 and represent the second largest collection. Smaller collections are evident in Rockingham and the North East, North West and South East corridors.

Figure 3.2 Western Australia Registry Week Collections



Largest Collections: Perth City (City, Northbridge, East Perth, Highgate, Leederville, Subiaco, West Perth, North Perth) and Fremantle

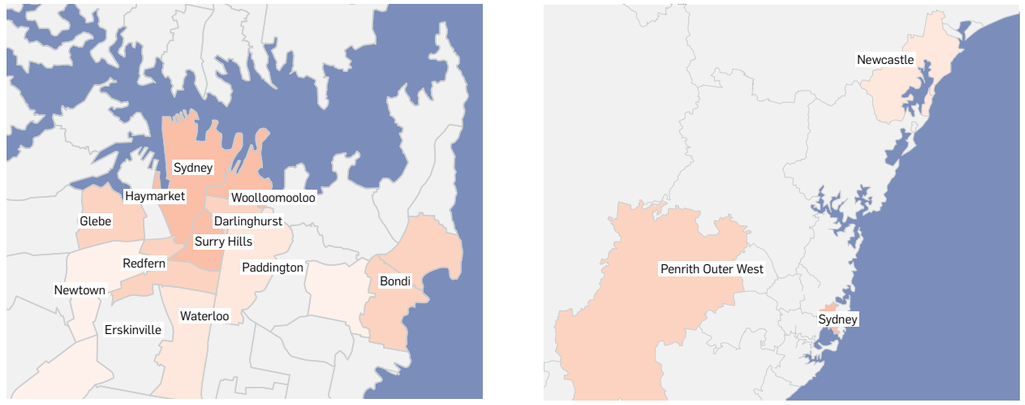
Other Collections: Rockingham, Perth - North East, Perth - South East, Perth - North West

Source: Registry Week Data Collections 2010-2017

3.2.3 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 other than 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. Other NSW collections have been conducted in Bondi and Lake Macquarie.

Figure 3.3 New South Wales Registry Week Collections

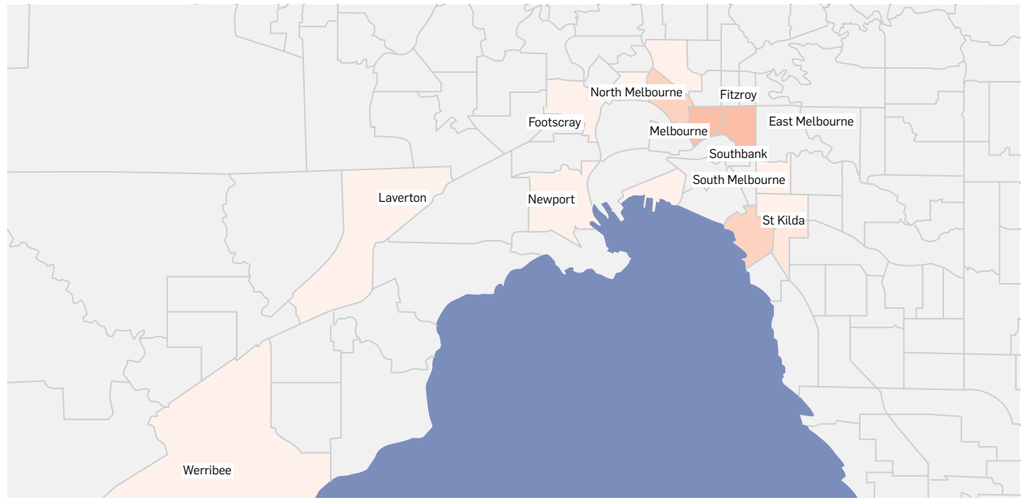


Largest Collections: Inner City Sydney (Sydney City, Woolloomooloo, Darlinghurst, Surry Hills,Glebe, Newtown, Haymarket, Waterloo), Bondi, Penrith, Richmond-Windsor
Other Collections: Other Sydney and Newcastle
Source: Registry Week Data Collections 2010-2017.

3.2.4 VICTORIA

Registry Week was first held in Melbourne Inner (SA4) in 2010 involving 166 interviews. Collections have continued across the 2010-2017 period but at much lower levels than in Qld, WA and NSW. 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.

Figure 3.4 Victoria Registry Week Collections

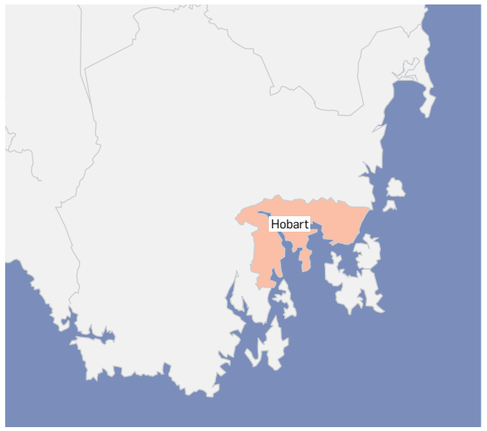


Largest Collections: Inner Melbourne: City, Southbank, South Melbourne, Carlton, North Melbourne, Kensington, Fitzroy, East Melbourne, Collingwood, Richmond and St Kilda
Other Collections: Melbourne West
Source: Registry Week Data Collections 2010-2017.

3.2.5 TASMANIA

In Tasmania (TAS), there have been a total of 384 interviews conducted over the period 2011 to 2017. Despite remaining fairly stable until 2015, the number of surveys conducted in Tasmania has decreased substantially since 2016. 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.

Figure 3.5 Tasmanian Registry Week Collections



Largest Collections: Inner Hobart
Other Collections: Hobart - North West, and Hobart - North East SA3
Source: Registry Week Data Collections 2010-2017.

Chapter Four

A DEMO-GRAPHIC PROFILE OF RESPONDENTS

Between 2010- 2017, there were 8618 responses from 8370 respondents (some respondents were interviewed more than once) collected across five states in Australia by multiple agencies administering the VI, SPDAT and 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 Tasmania (TAS).

Photography by UnitingCare West

4.1 IDENTITY

The Registry Week collection include three questions on the identity of respondents. Not all questions were asked in all surveys 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, Bi-sexual, Other, Declined.
- 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)

Of the total unique respondents (n= 8,370) identified in the Registry Week sample, there was valid information on 8,279 respondents with two-thirds identifying as male (66.3%), with females representing almost one third (33.0%) and Transgender and Other gender representing 0.7% of all respondents (Table 4.1). Men represent a higher proportion of the Registry Week collection than the Census (58%) (ABS, 2018) and the Specialist Homelessness Services Collection (SHSC) count of clients of services (40%) (AIHW, 2018). The much higher representation of males in the Registry Week collections relative to the SHSC reflects primarily a focus on rough sleepers in the Registry Week collections (more likely to be male) and the fact that Registry Week 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 Australian residents.

There is significant variation in age distributions by gender apparent in the data. There was a larger proportion of female respondents in the 15- 24 (24.8%) and 25-34 (27.0%) year age brackets compared to males (9.4% and 21.2%, respectively). Males were more likely to be represented in all remaining age brackets compared to females (Figure 4.1).

A question on sexual identity was included in the Australia F-SPDAT, Australia VI-SPDAT, Families VI-SPDAT and Individual VI-SPDAT surveys but not in the Australia VI and Youth VI-SPDAT surveys resulting in a large number of missing data. Of those who were asked the question on sexual identity, the vast majority identified as Straight (90.6%) with 2.9% identifying as Lesbian/Gay, 3.2% as Bisexual and 0.1% as Queer (Table 4.1). The proportion of Registry Week collections respondents identifying as Lesbian/Gay, Bisexual or Queer.as a whole is roughly twice that of the Australian adult population based on results from the 2014 General Social Science Survey (ABS, 2015).

Table 4.1 Gender and identity of respondents

	NUMBER	PER CENT
GENDER		
Male	5,486	66.3
Female	2,735	33.0
Transgender	42	0.5
Other gender[2]	16	0.2
TOTAL	8,279	100.0
IDENTITY[3]		
Straight	4,977	90.6
Lesbian/Gay	157	2.9
Bisexual	178	3.2
Queer	< 5	-
Don't know	54	1.0
Other	14	0.3
Declined	112	2.0
TOTAL	5,495	100.0

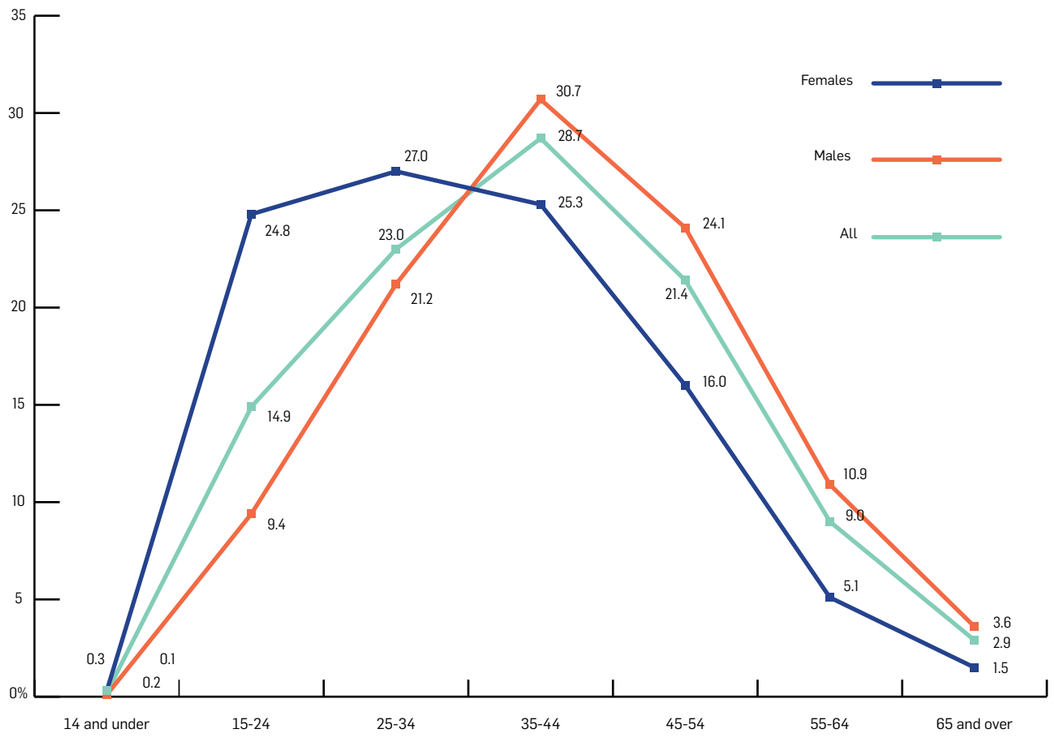
Source: Registry Week Data Collections 2010-2017

Note: (1) Estimates based on unique respondents (excluding missing values). (2) Other gender includes Intersex or X, Other gender identity, unknown, decline to state. (3) A question on Identity was included in the Australia F-SPDAT, Australia VI-SPDAT, Families VI-SPDAT and Individual VI-SPDAT surveys but not in the Australia VI and Youth VI-SPDAT surveys.

A question on cultural identity was included in the Australia F-SPDAT, Australia VI-SPDAT, Families VI-SPDAT and Individual VI-SPDAT surveys but not in the Australia VI and Youth VI-SPDAT surveys. 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 Indigenous Australian. If the respondent at any stage listed Australian identity (but had not already been classified as Indigenous Australian) then the respondent was classified as Non-Indigenous Australian. All other respondents who ticked or listed another identity were then classified as Other cultural identity.

There is a significant over-representation of Indigenous people in the Registry Week collections compared with the representation in the Australian population more generally (2.8%). Among valid responses, 67% of respondents identified as non-Indigenous Australians while 21.0% identified as Indigenous and 12% as another cultural identity. The proportion of respondents identifying as Indigenous is roughly in line with the 2016 Census results (ABS, 2018) and just below the SHSC count of Indigenous clients. The representation of Indigenous people in the Registry Week collections will be affected by the fact that the Registry Week collection has been in capital cities in the main and largely in inner city areas with a focus on rough sleepers.

Figure 4.1 Age distribution by gender



Source: Registry Week Data Collections 2010-2017.

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

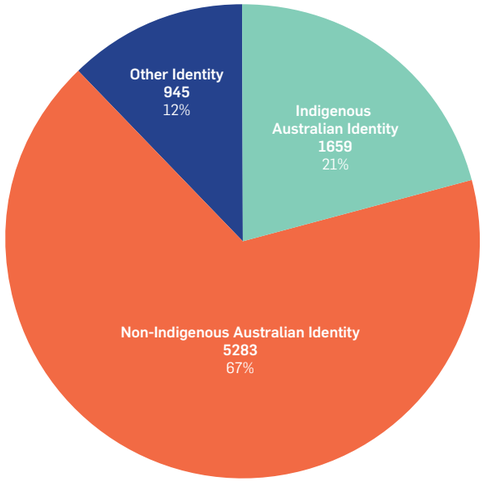
"My own home so I can get married and settle down and know where I am going at the end of work every day"

4.2 EDUCATION, PARTNERING AND LIVING ARRANGEMENTS

A key determinant of labour market and income outcomes is educational attainment. The question included in Registry Week collections relevant to educational attainment is "What is the highest year of school you completed?" While the question included may be interpreted as referring only to schooling the options presented, it includes 'Apprenticeship or tertiary studies' indicating that the intention is to include all educational attainment possibilities.

Among people aged 15 and over in Australia who stated an educational attainment outcome, 25.3% held a degree or higher and 36.3% held an Advanced Diploma and Diploma, Certificate level IV or Certificate level III (ABS, 2018b). In contrast, among Registry Week respondents, only 6.6% responded that their highest level of schooling was an Apprenticeship or tertiary studies. A smaller proportion of Registry Week respondents indicated that they had completed Year 12 than in the Australian adult population. While roughly the same proportion of Registry Week respondents had completed Year 10 and 11 as in the Australian population, a far greater proportion reported that their highest level of schooling was Year 9 or below. As evident in Figure 4.3, there was no significant difference between women and men in the Registry Week collections in terms of educational attainment.

Figure 4.2 Cultural identity of respondents, number, per cent



Source: Registry Week Data Collections 2010-2017.

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

A question on whether the respondent was with others ("Are you with others?") was only included in the Australia VI-SPDAT survey. The listed responses were partner, children/dependents, friend, parents, I am not with others. As outlined in Table 4.2, most respondents who provided a response to the relevant question indicated that they were alone – i.e., not with others (73.5%). Around a quarter of respondents indicated that they were with a partner, friend or parents. Homeless women were less likely to be alone than homeless men and Indigenous people were less likely to be alone than non-Indigenous people. Females were also more likely to have children/dependents with them than males.

Table 4.2 Living arrangements by gender of respondents

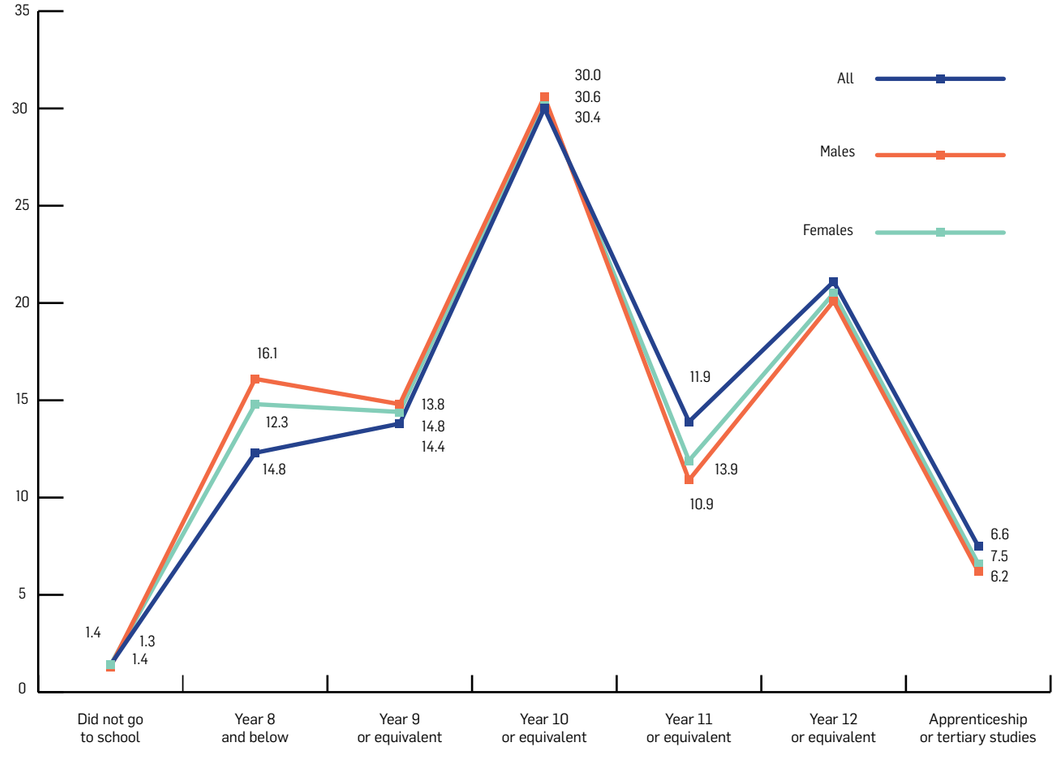
	NUMBER	PER CENT
ALONE		
Male	2054	76.6
Female	603	22.5
Other	18	0.7
Declined to state/unknown	6	0.2
Missing	< 5	-
TOTAL	2683	100.0
WITH PARTNER, FRIENDS AND PARENTS		
Male	510	58.8
Female	349	40.2
Other	5	0.6
Declined to state/unknown	< 5	-
Missing	< 5	-
TOTAL	868	100.0
CHILDREN/DEPENDANTS		
Male	37	36.6
Female	64	63.4
TOTAL	101	100.0
With others (Refused)	16	
With others (Missing)	807	
TOTAL	4475	

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Other gender includes Intersex or X, Other gender identity, unknown, declined to state. (3) A question on presenting with others was only included in the Australia VI-SPDAT survey.

"My children back and our own home"

Figure 4.3 Education attainment by gender, per cent

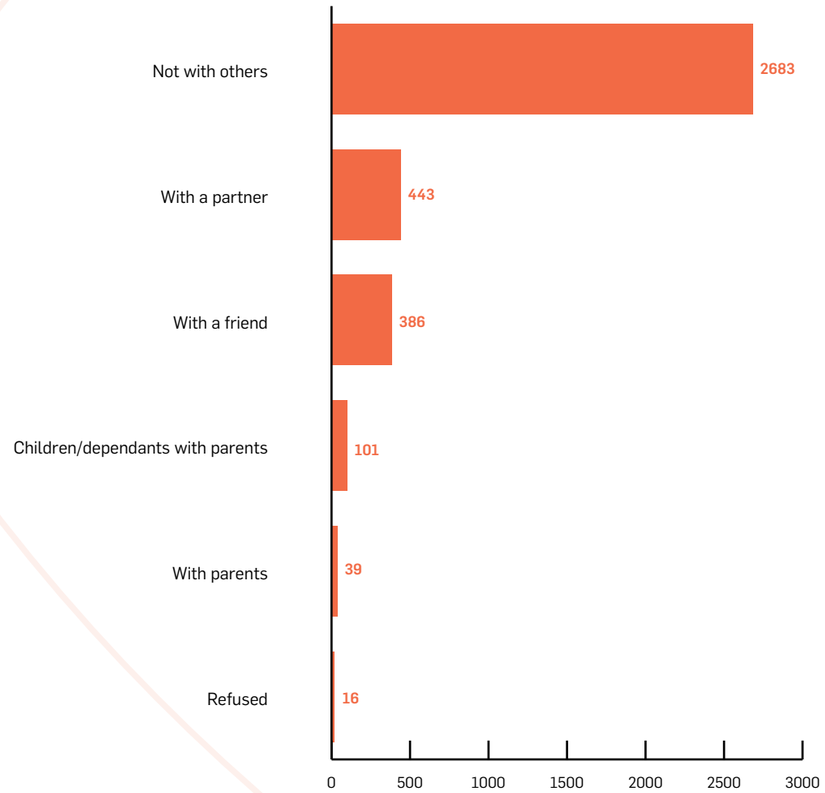


Source: Registry Week Data Collections 2010-2017.

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

Meeting and interviewing people living in Boarding Houses during 500 Lives 500 Homes Campaign Registry Fortnight in Brisbane. Photography: Robyn McDonald.

Figure 4.4 Partnering and living arrangements, number



Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) A question on presenting with others was only included in the Australia VI-SPDAT survey.

4.3 VETERANS

There is a paucity of information on the prevalence of homelessness among veterans in Australia. The prime reason for this is that veteran status has not been included in the Census or in the Specialist Homelessness Services Collection (SHSC). Furthermore, it is difficult to obtain estimates of the number of people who are Australian veterans living in Australia at any given time. In contrast to the Australian case, the issue of veterans' homelessness is a major topic of interest in the US and counts of point-in-time veterans' homelessness have been included in the US *Point-in-Time Estimates of Homelessness* (Department of Housing and Urban Development 2017). 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).

The VI and VI-SPDAT surveys contain the question "Have you ever served in 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 (2016) report *Mental Health of Australian Defence Force Members and Veterans*). In this study, we define a veteran as an individual who is a current or former member of the ADF, regardless of whether they were involved in active service or not.

As indicated in Table 4.3 457 people over the period 2010-2017 were veterans; the majority being males (83.8%). Women comprised 15.5% of the veterans' population. This is reflective of the make-up of the ADF in which 15.5% of the permanent force consists of women and 84.5% consists of men (Australian Government, 2016). Similar to US findings, veterans were more likely to have achieved a higher level of education than non-veterans, with 76.6% of veterans having achieved an educational level equivalent to or above Year 10, compared to 68.8% of non-veterans. The higher educational attainment of veterans has been found as a significant distinguishing factor when comparing them to non-veterans (Tessler, Rosenheck & Gamache, 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 Indigenous (16.5%). This compares with Indigenous Australians only representing 1.6% of the ADF between 2015 and 2016 (Department of Veterans' Affairs, 2016), suggesting that Indigenous Australians may experience greater difficulties in returning to civilian life upon discharge compared to non-Indigenous 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.

"Private residence-not with others, farmland location, remote location and self sustaining."

Table 4.3 Veterans by gender of respondents

	NUMBER	PER CENT
VETERANS		
Male	383	83.8
Female	71	15.5
Other	< 5	-
Declined to state/unknown	< 5	-
Missing	< 5	-
TOTAL	457	100.0
NON-VETERANS		
Male	4994	64.7
Female	2626	34.0
Other	39	0.5
Declined to state/unknown	12	0.2
Missing	47	0.6
TOTAL	7718	100.0
PERCENTAGE VETERANS	5.6	
Veteran status (refused)	15	
Veteran status (unknown)	95	
Veteran status (missing)	59	
TOTAL	8344	

Source: Registry Week Data Collections 2010-2017

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Other gender includes Intersex or X, Other gender identity, unknown, declined to state. (3) A question on Veteran status was not included in the Youth VI-SPDAT.

Chapter Five

THE EXPERIENCE OF HOMELESS-NESS

This chapter examines the form of homelessness experienced by respondents to Registry Week collection 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.

Photography by UnitingCare West

5.1 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
- Sleeping rough and other homeless states selected

INSTITUTIONAL ACCOMMODATION (E.G., HOSPITAL, DRUG AND ALCOHOL FACILITY, PRISON)

PERMANENTLY HOUSED

Table 5.1 presents estimates of homelessness among Registry Week respondents. A leading focus of agencies conducting Registry Week collections has been on understanding the vulnerabilities and service needs of rough sleepers and of those utilising their accommodation services. Not surprisingly, therefore, the majority of respondents' responses fall into these two homeless categories. Just over half of responses fall into the rough sleeping category (52.5%). A further 11.4% respondents primarily sleep in crisis and emergency accommodation. A further 20.6% respondents generally sleep in temporary accommodation (largely couch-surfing arrangements) and 7.7% 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 settings (1.6%) (such as hospitals, drug and alcohol facilities, and prison), and in permanent housing (2.0%). Responses in the latter category all relate to open-ended category responses which can be difficult to classify.

Table 5.1 Place slept most frequently (responses)

	NUMBER	PER CENT
HOMELESS	7,717	96.4
Sleeping Rough	4,204	52.5
Other Homeless	3,437	42.9
Crisis and emergency accommodation	915	11.4
Temporary accommodation (e.g couchsurfing)	1,651	20.6
Short-term accommodation (e.g boarding house, hostel, caravan)	619	7.7
Multiple other homeless states selected	252	3.1
Sleeping rough and other homeless states selected	76	0.9
INSTITUTIONAL ACCOMMODATION (E.G HOSPITAL, DRUG AND ALCOHOL FACILITY, PRISON)	128	1.6
PERMANENTLY HOUSED	158	2.0
TOTAL	8,003	100.0
Inadequately described	65	
Missing	550	

Source: Registry Week Data Collections 2010-2017.

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

On the streets of Brisbane during 500 Lives 500 Homes Campaign Registry Fortnight. Photography: Jo Bennett.

"Better, permanent accommodation; employment; activities to keep occupied."

Table 5.2 Place slept most frequently among rough sleepers (responses)

	NUMBER	PER CENT
Streets	2,255	52.7
Park	744	17.4
Car	488	11.4
Squat/Cave	288	6.7
Tent	115	2.7
Train Station/Bus Station	108	2.5
Bushland	92	2.1
Beach/Riverbed	54	1.3
Carpark[2]	23	0.5
Toilets	6	0.1
Construction Site[2]	< 5	-
Multiple sleeping rough categories specified[3]	27	0.6
Both sleeping rough and not sleeping rough categories specified[3]	76	1.8
TOTAL SLEEPING ROUGH	4,280	100.0

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on all responses (excluding missing values). (2) Categories drawn from coding of self-reported "other" responses. (3) In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

Table 5.2 shows where those who nominated rough sleeping categories slept most often. Sleeping on the 'street' represents by far the most frequent response (52.7%) followed by the park (17.4%). The next most frequent response is sleeping mostly frequently in a car (11.4%). Those sleeping in a car may be in a somewhat different position to other rough sleepers as they may have greater resources available to them than others in the rough sleeping group and somewhat greater stability in their lives.

The pattern of rough sleeping among women and men is quite different. While one-third of female responses in the Registry Week collections were rough sleeping the reverse is true for men with nearly two-thirds of responses falling in the rough sleeping category (Table 5.3). The 2016 Census also showed higher rates of males sleeping rough (ABS, 2018). 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 5.4).

People aged above 25 years were more likely to be sleeping rough than young people, with the highest proportion of people sleeping rough being evident in the 45–54 years old age bracket (64.1%) followed closely by those aged 35–44 (61.5%). The proportion of those under the age of 25 who were rough sleeping was 37.7%, with 58.0% falling in the other homeless category. Temporary accommodation (e.g., couch-surfing) made up the majority of responses from young people that were categorised as other homeless. This profile is also consistent with the 2016 Census results (ABS, 2018).

Indigenous Australians have a higher rate of rough sleeping than non-Indigenous Australians (65.7% compared with 50.7%). Those who identify in another cultural category other than Indigenous Australian or non-Indigenous Australians exhibit the lowest rough sleeping rate (44.5%). 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, 2018). In the 2016 Census results, Indigenous Australians were also more likely to stay in 'severely' over crowded 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, Indigenous 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 Indigenous 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., 2015). The Registry Week collections reveal a very high proportion of respondents with a history of out-of-home care. As evident in Table 5.6, one-quarter of respondents in the registry Week 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.

Photography by UnitingCare West

5.2 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). Both in terms of need and government cost it is an important indicator for identifying and prioritising at risk people into homelessness services.

The topic of the 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 the question was: "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 of homelessness or the ABS definition of homelessness.

In addition to the question on the cumulative duration of homelessness, the Registry Week collection asks a number of other relevant questions relating to 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 61.6 months (or 5.1 years). There is high degree of variation in the cumulative time spent homeless as evident in the standard deviation (86.9 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 four months. This is the only group with value below a year. The second 20% has a value greater than a year (13 months). The median duration of homelessness (the 50th percentile value) is 24 months (or 2 years). The third quintile value is.36 months (or 3 years. At the fourth quintile point the value is 108 months or 9 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 (72.9 months) as well as median cumulative time spent homeless of 36 months (or 3 years) than for all Registry Week collection 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 (39.5 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 58.3 months while the median length of time is 24.0 months (or 2 years). The results are very similar to cumulative time spent rough sleeping and in emergency and crisis accommodation with similar differences in duration outcomes between rough sleepers and other homeless people.

Among families interviewed in Registry Week collections, the mean cumulative length of time since the family had had a tenancy (on the basis of the Australia F-SPDAT results) is 18.5 months, while the median or 50th percentile length of time since the family had a tenancy was 6 months.

Table 5.3 Place slept most frequently by gender (responses)

	NUMBER	PER CENT
MALES		
Sleeping rough	3253	61.8
Not sleeping rough	1917	36.4
Both sleeping rough and not sleeping rough categories specified[3]	49	0.9
Inadequately described	47	0.9
TOTAL	5266	100.0
Missing	413	
FEMALES		
Sleeping rough	882	33.1
Not sleeping rough	1745	65.4
Both sleeping rough and not sleeping rough categories specified[3]	24	0.9
Inadequately described	17	0.6
TOTAL	2668	100.0
Missing	119	
OTHER[2]		
Sleeping rough	25	56.8
Not sleeping rough	18	40.9
Both sleeping rough and not sleeping rough categories specified[3]	< 5	2.3
TOTAL	44	100.0
Missing	< 5	
Gender (declined to state)	11	
Gender (unknown)	< 5	
Gender (missing)	92	
TOTAL	8618	

Source: Registry Week Data Collections 2010-2017

Note: (1) Estimates based on all responses (excluding missing values). (2) Other gender includes Intersex or X, Other gender identity, unknown, declined to state. (3) In some cases, there were multiple locations listed in "other" responses as places slept most frequently.

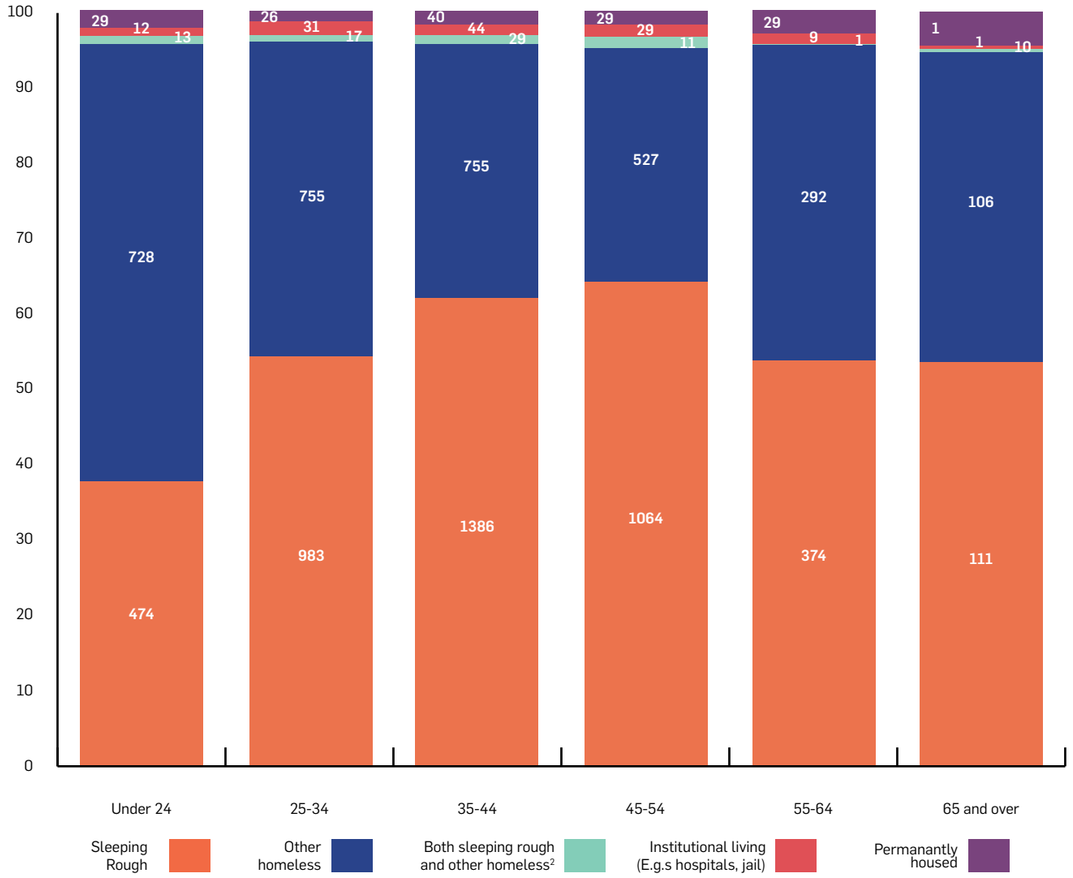
Table 5.4 Place slept most frequently by veteran status (responses)

	NUMBER	PER CENT
VETERANS		
Sleeping rough	270	61.1
Not sleeping rough	168	38.0
Both sleeping rough and not sleeping rough categories specified[2]	< 5	-
Inadequately described	< 5	0.5
TOTAL	442	100.0
Missing	29	6.6
NON-VETERANS		
Sleeping rough	3834	51.5
Not sleeping rough	3480	46.7
Both sleeping rough and not sleeping rough categories specified[2]	70	0.9
Inadequately described	62	0.8
TOTAL	7446	100.0
Missing	493	
Veteran status (refused)	16	
Veteran status (unknown)	105	
Veteran status (missing)	61	
TOTAL	8592	

Source: Registry Week Data Collections 2010-2017.

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) A question on Veteran status was not included in the Youth VI-SPDAT.

Figure 5.1 Place slept most frequently by age (responses), number, per cent



Source: Registry Week Data Collections 2010-2017.

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.

"My own home, [I'm] tired of moving and boarding houses"

Table 5.5 Place slept most frequently by Indigenous status (responses)

	NUMBER	PER CENT
INDIGENOUS AUSTRALIAN		
Sleeping rough	1,056	65.7
Not sleeping rough	519	32.3
Both sleeping rough and not sleeping rough categories specified2	23	1.4
Inadequately described	9	0.6
TOTAL	1,607	100.0
Missing	115	
NON-INDIGENOUS AUSTRALIAN		
Sleeping rough	2,583	50.7
Not sleeping rough	2,421	47.5
Both sleeping rough and not sleeping rough categories specified2	47	0.9
Inadequately described	43	0.8
TOTAL	5,094	100.0
Missing	337	
OTHER		
Sleeping rough	404	44.5
Not sleeping rough	492	54.2
Both sleeping rough and not sleeping rough categories specified2	< 5	-
Inadequately described	8	0.9
TOTAL	908	100.0
Missing	61	
Indigenous Status (missing)	481	
TOTAL	8,603	

Source: Registry Week Data Collections 2010-2017.

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.

Table 5.6 Type of homelessness by an experience of foster care or institutional care as a child (responses)

	NUMBER	PER CENT
SLEEPING ROUGH		
Yes	1241	29.7
No	2867	68.5
Unknown	68	1.6
Refused	8	0.2
TOTAL	4184	100.0
Missing	17	
OTHER HOMELESS (INCLUDES CRISIS AND EMERGENCY ACCOMMODATION, TEMPORARY ACCOMMODATION, SHORT-TERM ACCOMMODATION)		
Yes	721	21.3
No	2637	78.0
Unknown	9	0.3
Refused	12	0.4
TOTAL	3379	100.0
Missing	23	
BOTH SLEEPING ROUGH AND OTHER HOMELESS CATGORIES		
Yes	24	31.6
No	51	67.1
Unknown	< 5	1.3
TOTAL	76	100.0
INSTITUTIONAL ACCOMMODATION		
Yes	33	25.8
No	95	74.2
TOTAL	128	100.0
PERMANENTLY HOUSED		
Yes	24	15.3
No	133	84.7
TOTAL	157	100.0
TOTAL	7964	

Source: Registry Week Data Collections 2010-2017

Note: (1) A question on Foster Care was included in the Australia VI - SPDAT, Australia VI and the Australia F - SPDAT surveys but not in the Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.

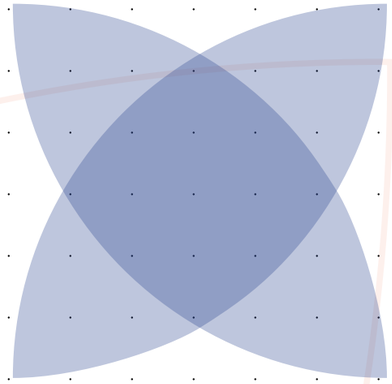
Table 5.7 Time spent homeless (months) (respondents)

	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? (Families VI-SPDAT)"
N	7039	4418	1008	12
Missing	236	84	46	< 5
MEAN (MONTHS)	61.6	58.3	18.5	4.1
SD	86.9	84.1	32.6	3.1
MEDIAN	24.0	24.0	6.0	3.0
Quintile 0	0.0	0.0	0.0	0.0
Quintile 1	4.0	5.0	1.0	1.0
Quintile 2	13.0	14.0	4.0	3.0
Quintile 3	36.0	36.0	11.0	3.8
Quintile 4	108.0	96.0	24.0	8.4
Quintile 5	756.0	756.0	240.0	9.0

Source: Registry Week Data Collections 2010-2017.

Note: (1) Estimates based on unique respondents (excluding missing values). (2) Responses that exceeded the respondents' age were removed from analysis. (3) Question was only included 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?" (4) Question was only included in the Australia VI-SPDAT, Youth VI-SPDAT and Individual VI-SPDAT surveys.

"Safe housing, stable housing, not having to move about when I'm sick"



Photography by UnitingCare West

Chapter Six

HEALTH OUTCOMES

Homelessness and poor health outcomes are strongly associated. Homelessness can lead to and exacerbate poor health outcomes. Likewise, some health conditions, such as mental illness may contribute to the onset of homelessness (Frankish, Hwang & Quantz, 2005). People experiencing homelessness are more likely to experience poor health and die earlier than the general population (Fazel, Geddes & Kushel, 2014 ; Aldridge et al., 2018) with people experiencing long-term homelessness faring particularly poorly (O'Connell, 2004). 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, suicide and poisoning (O'Connell, 2004; Fazel, Geddes & Kushel, 2014). 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 to healthcare and medications (Fazel, Geddes & Kushel, 2014).

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, employment as well as lifestyle factors including nutrition, tobacco, and alcohol and other drug use.

In this chapter, we examine the health outcomes of Registry Week respondents.

Photography by UnitingCare West

6.1 MEDICAL HEALTH CONDITIONS

High rates of chronic conditions such as cancer, respiratory disease, cardiovascular disease and drug overdose have been reported among people experiencing homelessness (Kermode et al., 1998; Morrison, 2009; Hwang et al., 2009; Baggett et al., 2013). Early death in people experiencing homelessness is also highly associated with acute and chronic conditions, more so than AOD misuse and/or mental illness (O'Connell, 2004). Of concern is that Perth Registry Week 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 serious physical health conditions. The most prevalent conditions include asthma (32.9%) followed by heat stroke/exhaustion (23.2%), hepatitis C (21.9%), heart disease (18.7%), liver disease (15.8%), emphysema (10.2%) and diabetes (10.1%), nearly all of which were significantly higher than rates seen across the general population.

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, Geddes & Kushel, 2014), these diseases were low among Registry Week respondents; 1.5% and 1.6% respectively. This may represent advancements in prevention and treatment of these diseases and/or an underrepresentation of diagnosis among this population group. Despite this, mortality remains high among people experiencing homelessness (Fazel, Geddes & Kushel, 2014), and prevalent conditions identified in the Registry Week data are risk factors for premature mortality.

Of note is that many of these conditions can be explained through lifestyle factors such as tobacco smoking, poor diet, physical inactivity, alcohol and other drug (AOD) 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 to minimise risk of diabetic shock (hypoglycaemia). Efforts to improve the health and ultimately reduce excessive mortality among people experiencing homelessness should focus on should focus on both housing and the lifestyle factors that cause poor health outcomes.

Table 6.1 shows a count of the number of people that reported experiencing a variety of health conditions when prompted, as well as conditions that people reported when asked if there were any other conditions that they were affected by. Interestingly 166 respondents reported having or having had a mental health condition despite no specific mental health questions being included in the list. 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.

One limitation of the physical health data collected is that the VI-SPDAT tool 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 tool does not specifically ask about lifestyle factors such as tobacco and access to nutritional food. Future VI-SPDAT survey tools 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 encourage lifestyle changes that reduce health risks. Separating alcohol and other drugs may also help to inform this.

Respondents were also asked whether they experience a number of conditions often associated with homelessness (Miscenko et al., 2017). As seen in Table 6.2 dehydration was the most prevalent condition (22.9%), followed by skin infections (16.2%), convulsions (12.1%), cellulitis (4.7%) and scabies (2.6%). Housing would presumably provide people with access to resources to improve their hygiene practises and reduce the occurrence of these conditions.

"Stable housing to benefit health issues and to get a job"

Asthma

The rate of asthma reported by respondents is almost three times the rate of the general population (32.9% and 11% respectively). High rates of people experiencing homelessness smoke tobacco, which has been found to contribute to the development of asthma (Kermode et al., 1998; McVicar et al., 2015).

Heat Stroke

23.2% 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.

Hepatitis

Hepatitis C is one of the most common notifiable infectious diseases in Australia and almost 50% of people that contract Hepatitis C will develop liver disease (AIHW, 2015). Among Perth Registry Week respondents, 21.9% reported having Hepatitis C, which is much higher than the rate in the Australian general population (0.05%). However, Australian notification rates are much higher among injecting drug users, Indigenous Australians and people from high prevalence countries (The Kirby Institute, 2016). One potential reason for the high rate of Hepatitis C in the registry week sample is that the disease is most commonly contracted through injected drug use by way of contaminated needles (AIHW, 2015). 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).

Heart Disease

Heart conditions including heart disease, arrhythmia or irregular heartbeat were experienced by 18.7% of respondents. This is substantially higher than the national rate of 3.6%, and for Indigenous Australians who experience heart disease at twice the rate of the general population (AIHW, 2016). The AIHW reports that coronary heart disease is very common and kills more Australians than any other disease. Studies of homeless populations have also found high rates of mortality from heart disease (Fazel, Geddes & Kushel, 2015). Heart disease is largely preventable through the introduction of various lifestyle changes including quitting smoking, healthy eating, and physical activity (AIHW, 2016; Fazel, Geddes & Kushel, 2015).

Liver Disease

15.8% 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 11th leading cause of death with men accounting for 2 in 3 premature deaths. Liver disease is associated with high alcohol use and hepatitis. To note, 65.2% 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. Indigenous Australians are also at greater risk of developing liver disease (AIHW, 2015b).

Emphysema

Emphysema comes under the umbrella of Chronic Obstructive Pulmonary Disease (COPD). Emphysema was reported by 10.2% 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 (14.5%; ABS 2015), smoking prevalence remains high among people experiencing homelessness with estimates ranging from 67-86% (Wood et al., 2017; Maddox & Segan, 2017; Ruah, 2016; McVicor et al., 2015; Kermode et al., 1998).

Diabetes

Diabetes was reported by 10.1% of respondents in the registry week dataset which is twice that reported for the general population in Australia (5.1%) (ABS, 2015). In the general population diabetes is more prevalent in males than females and in older Australians. Indigenous Australians are also 3.5 times more likely to be affected (AIHW, 2015b). In 2013, diabetes caused 10% of all deaths in Australia. 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, Geddes & Kushel, 2014).

Cancer

Cancer is responsible for 19% of the total burden of disease in Australia and is a major cause of morbidity. 7.6% of survey respondents reported having or having had cancer. At the end of 2010, the prevalence of 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. However, at least 30% of cancers are preventable through lifestyle changes such as quitting smoking, eating healthy, exercising and being sun smart (Wilson et al., 2017; Anand et al., 2008).

Kidney Disease

6.9% of respondents reported having or having had kidney disease or end stage renal disease with dialysis. Kidney disease is 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. In 2014, 22,100 Australians were treated for end stage kidney disease.

Frostbite, Hypothermia and Immersion Foot

People sleeping rough are particularly exposed to the elements which has negative health impacts. 6.6% of respondents have suffered from frostbite, hypothermia and immersion foot.

Tuberculosis

Tuberculosis is an infection that affects an estimated 1,200 Australians each year (Lung Foundation, 2018). 1.6% of respondents reported having or having had tuberculosis.

HIV/AIDS

1.5% of respondents have HIV or AIDS, which is much higher than the prevalence in the general population. In 2015, there was an estimated 25,313 Australians living with HIV (Australian Federation of AIDS Organisations, 2018). 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, Geddes & Kushel, 2014).

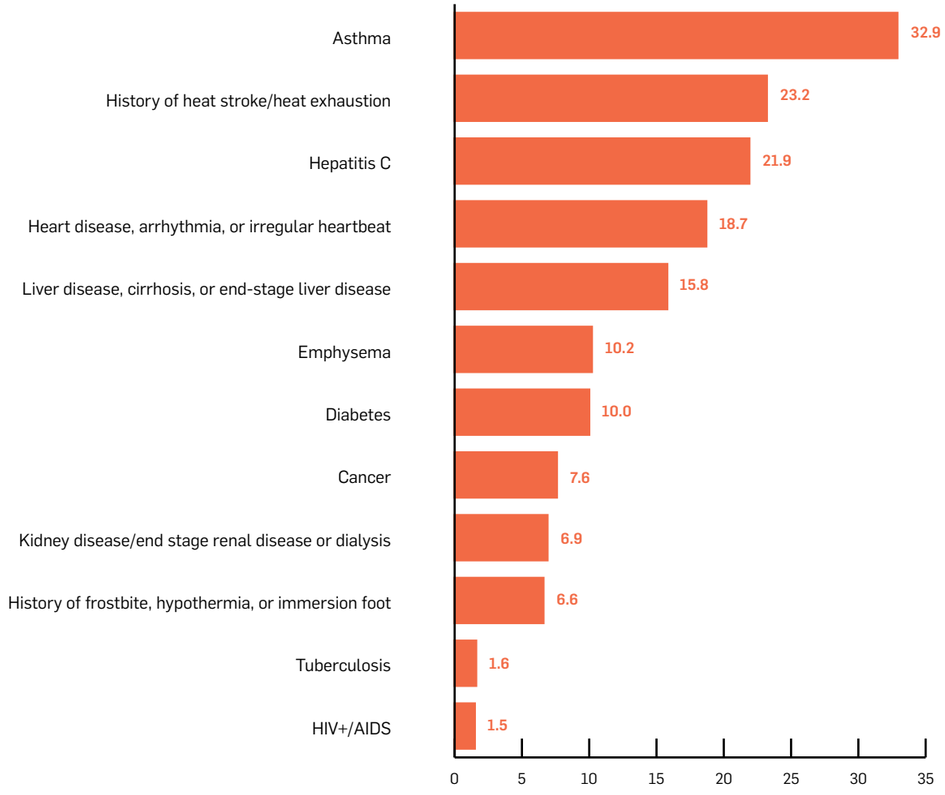
Table 6.1 Lifetime prevalence of medical conditions

	YES	NO	% WITH CONDITION	TOTAL	UNKNOWN	REFUSED	MISSING
DO YOU HAVE NOW, HAVE YOU EVER HAD, OR HAS A HEALTHCARE PROVIDER EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?							
Kidney disease/end stage renal disease or dialysis	561	7591	6.9	8152	113	13	92
History of frostbite, hypothermia, or immersion foot	535	7632	6.6	8167	101	13	89
Liver disease, cirrhosis, or end-stage liver disease	1292	6870	15.8	8162	101	11	96
HIV+/AIDS	119	8027	1.5	8146	112	19	93
History of heat stroke/heat exhaustion	1903	6286	23.2	8189	86	12	83
Heart disease, arrhythmia, or irregular heartbeat	1522	6628	18.7	8150	105	15	100
Emphysema	829	7320	10.2	8149	111	15	95
Tuberculosis	128	8000	1.6	8128	122	11	109
Diabetes	816	7353	10.0	8169	116	14	71
Asthma	2699	5512	32.9	8211	94	12	53
Cancer	615	7514	7.6	8129	118	20	103
Hepatitis C	1788	6378	21.9	8166	99	17	88
OTHER' HEALTH CONDITION							
Skin infections[2]	57						
Seizures[2]	26						
Dental problems[2]	13						
Mental health problems[2]	166						
Cardiopulmonary illnesses[2]	44						
Thyroid problems[2]	10						
Eye diseases[2]	21						
Neurological problems[2]	41						
Bone related illnesses[2]	103						
Gastroenterological diseases[2]	20						
Other[2]	156						
(EVER) HAD A SERIOUS BRAIN INJURY OR HEAD TRAUMA?							
RESPONSES	2372	5755	29.2	8127	127	17	99

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Categories drawn from coding of self-reported "other" responses.

Figure 6.1 Lifetime prevalence of selected medical conditions, per cent



Source: Registry Week Data Collections 2010-2017.

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

Table 6.2 Respondents reporting experiencing selected medical health conditions or issues at time of survey

	YES	NO	PER CENT
Cellulitis	293	5914	4.7
Skin infection	1013	5227	16.2
Scabies	161	6056	2.6
Dehydration	1427	4809	22.9
Convulsions	753	5467	12.1
Epilepsy	553	6046	8.4
Dental problems	2556	2223	53.5

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Questions about current health conditions were included in the Australia VI - SPDAT and Australia VI surveys but not in the Australia F - SPDAT, Families VI-SPDAT, Individual VI-SPDAT and Youth VI-SPDAT surveys.

6.2 MENTAL HEALTH, LEARNING AND DEVELOPMENTAL DISABILITIES AND BRAIN INJURY

"People to talk too, psychiatrist, safe accommodation, help with major health problems"

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 a cause and exacerbated by homelessness (Fazel, Geddes & Kushel, 2014; Miscenko et al., 2017; Aldridge et al., 2018;).

A limitation of the VI-SPDAT tool is that it does not include questions pertaining to specific mental health conditions, nor does it directly ask people if they have been diagnosed with a mental illness. Therefore, the data limits our ability to determine prevalence, mental health risks and resource requirements to appropriately support people's mental health needs through homelessness strategies. The Australian Institute of Health and Wellbeing uses the Kessler Psychological Distress Scale (K10) to measure psychological distress (AIHW, 2017), as have a number of Australian studies on homelessness (Conroy et al., 2014; Misceko et al., 2017). Integrating validated tools into the VI-SPDAT survey to measure mental health may assist in the development and prioritisation of homelessness services throughout Australia.

While the VI and VI-SPDAT surveys do not include explicit questions on diagnosed mental health conditions, various versions of the VI-SPDAT do include proxies to measure mental health through people's self-reported interactions with the healthcare system because of 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 or severely compromised cognitive functioning (Wood et al., 2017). The questions include asking respondents if they have:

- 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 – and whether that was voluntary or because someone insisted that you do so?

Generally, people experiencing homelessness have poor access to healthcare (Fazel, Geddes & Kushel, 2014) and some work to avoid it (Chau et al., 2002). Therefore, it is likely that people have undiagnosed mental health conditions, and the Registry Week results are an under-representation of mental health conditions across the homelessness population in Australia.

Noting the above limitations, on the basis of the questions asked, a large proportion of Registry Week respondents reported accessing health services for mental health reasons or accessing mental health services:

- 29.8% of respondents have been taken to a hospital against their will for mental health reasons;
- 48.4% have spoken with a psychiatrist, psychologist or mental health professional in the last six months; and
- 36.9% have gone to an Emergency Department due to not feeling emotionally well or because of their nerves.

Surveyors also recorded signs of mental illness or compromised cognitive functioning in over a quarter (28.1%) of respondents.

When looking at different cohorts among the respondents, a lower proportion of those who most frequently sleep rough reported speaking to a mental health professional in the last six months compared to those not frequently sleeping rough (45.4% and 50.4%, respectively). There were few differences between females (49.4%), males (47.4%) and other gender identifying individuals (48%).

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, Geddes & Kushel, 2014). Among Registry Week respondents 39% 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 35.3% of those not sleeping rough.

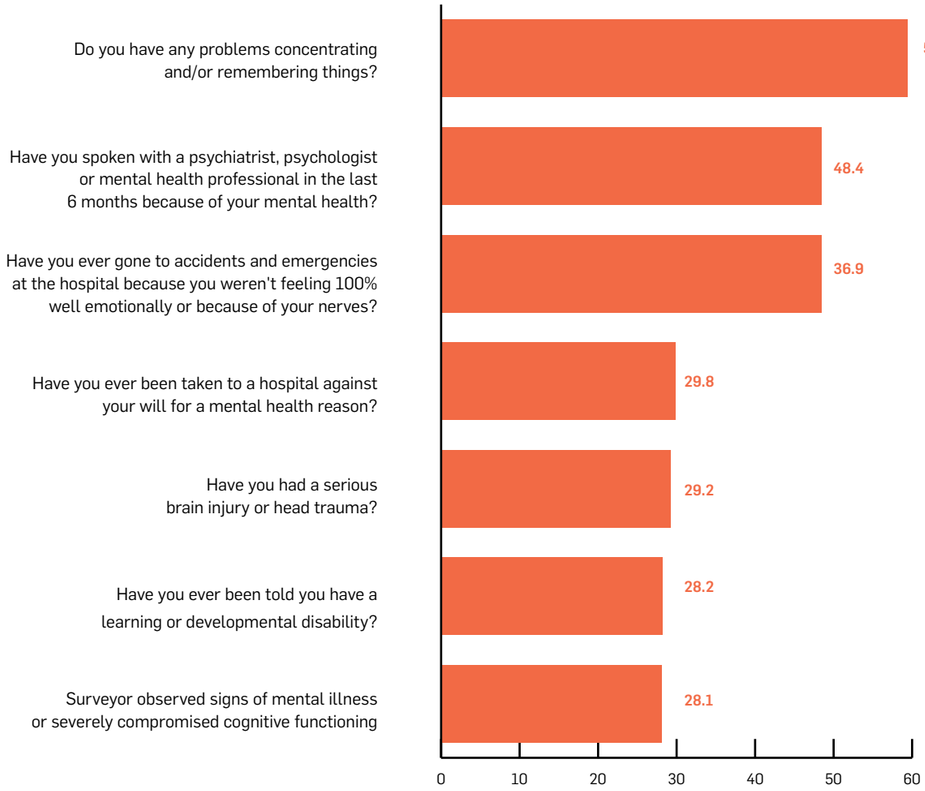
People experiencing homelessness have been reported to have higher rates of traumatic brain injury and signs of cognitive impairment (Fazel, Geddes & Kushel, 2014). A high proportion of Registry Week respondents reported conditions aligned with these results. For example, 28.2% reported having been told that they had a learning or developmental disability and 59.4% reported that they have problems concentrating and/or remembering things.

Respondents also reported high rates of serious brain injury or head trauma (29.2%). Research suggests that the consequences of traumatic brain injury (cognitive impairment, social functioning) is a risk factor for both becoming and remaining homeless. In addition, people who are sleeping rough are more likely to experience repetitive traumatic brain injury as are men who are experiencing homeless (Fazel, Geddes & Kushel, 2014). Therefore, it is important that strategies to address homelessness consider traumatic brain injury and its prevention. Of the respondents surveyed across Registry Weeks, a higher proportion of males (32.4%) to females (21.3%) had experienced a brain injury or trauma. People sleeping rough (32.7%) also had higher rates compared to people who were not sleeping rough (24%). Of the respondents that identified as veterans, 43% 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 (Kim, Howard & Bradford, 2010). Over half (52.9%) of the Registry Week respondents reported experiencing emotional, physical, psychological, sexual or other type of abuse or trauma in their life which they have not sought help for, and/or which caused their homelessness. Between genders, 48.1% of males, 60.1% of females and 84% of people that identified as 'other' reported experiencing abuse or trauma in their life which they had not sought help for, and/or which caused their homelessness. These results amplify the need for the integration of trauma informed care into homelessness service delivery models.

"I need space from others and to be treated well. To get regular mental health check and mentor."

Figure 6.2 Selected mental health, disability and brain injury indicators, per cent



Source: Registry Week Data Collections 2010-2017

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

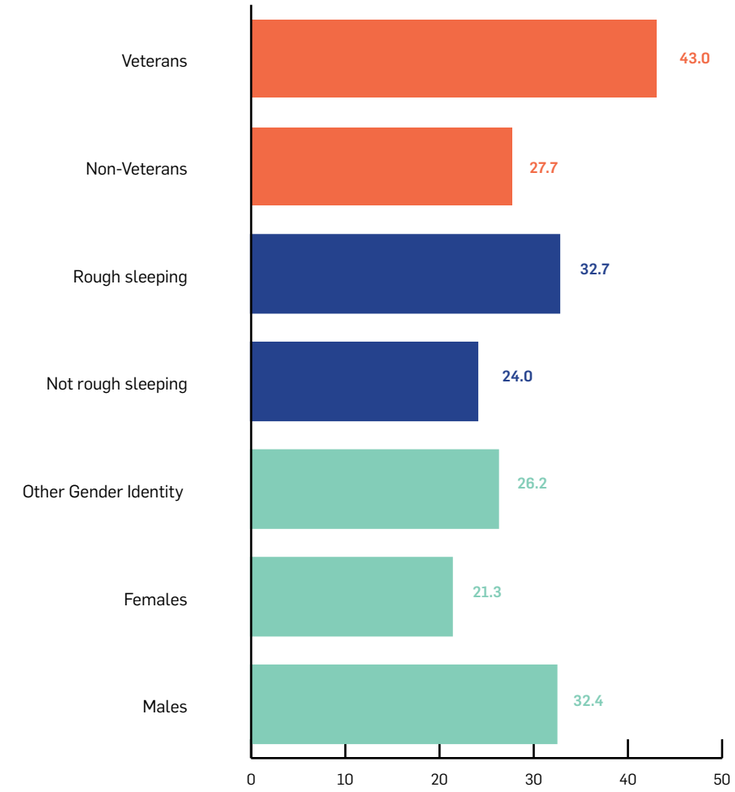
Table 6.3 Selected mental health and disability indicators[1,2]

	YES	NO	PER CENT THAT ANSWERED YES	TOTAL	UNKNOWN	REFUSED	MISSING
Have you ever been taken to a hospital against your will for a mental health reason?	2436	5736	29.8	8172	88	19	50
Have you spoken with a psychiatrist, psychologist or mental health professional in the last 6 months because of your mental health?[3]	2650	2820	48.4	5470	< 5	20	39
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]	2019	3450	36.9	5469	< 5	17	43
Have you had a serious brain injury or head trauma?	2372	5755	29.2	8127	127	17	58
Have you ever been told you have a learning or developmental disability?[3]	1540	3915	28.2	5455	< 5	22	52
Do you have any problems concentrating and/or remembering things?[3]	3236	2214	59.4	5450	< 5	19	60
Surveyor observed signs of mental illness or severely compromised cognitive functioning	2088	5347	28.1	7435	490	12	392

Source: Registry Week Data Collections 2010-2017.

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.

Figure 6.3 Self-report of serious brain injury or head trauma, per cent



Source: Registry Week Data Collections 2010-2017

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

Table 6.4 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	1609	48.1
Trauma - No	1686	50.4
Refused	47	1.4
TOTAL	3342	100.0
Missing	32	
FEMALES		
Trauma - Yes	1259	60.1
Trauma - No	820	39.1
Refused	16	0.8
TOTAL	2095	100.0
Missing	18	
OTHER[3]		
Trauma - Yes	21	84.0
Trauma - No	< 5	-
TOTAL	25	100.0
Gender (declined to state)	11	
Gender (missing)	20	
TOTAL	5543	

Source: Registry Week Data Collections 2010-2017

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) A question on unaddressed trauma was included in the Australia VI - SPDAT, Australia F - SPDAT and Families VI - SPDAT surveys but not in the Australia VI, Individual VI - SPDAT and Youth VI-SPDAT surveys. (3) Other gender includes Intersex or X, Other gender identity, unknown, declined to state.

6.3 DRUG AND ALCOHOL USE

Drug and alcohol misuse can both cause and exacerbate a number of chronic health conditions including hepatitis C, heart and liver disease as discussed above. A high proportion of Registry Week respondents (65.2%) reported having a drug or alcohol problem, with over a quarter (27.5%) reporting that they had consumed alcohol and/or drugs almost every day in the past month, and even more (33.8%) reporting that they injected drugs or shots in the past six months. Surveyors were asked to report if they observed symptoms or signs of problematic drug or alcohol use of which 26.4% of respondents exhibited signs.

"Own place and to get off drugs"

In Australia, a higher proportion of Indigenous people smoke tobacco, use alcohol to risky levels and use other drugs than non-Indigenous people (AIHW, 2017c). This trend is similar among Registry Week respondents with 75.5% of Indigenous people reporting that they had problematic alcohol or drug use compared to 66.7% of non-Indigenous people and 43.9% of people that identified as 'other'.

There were also differences seen between genders with 69.4% of males surveyed reporting an alcohol or drug problem compared to 55% of and 83.3% of people that identified as 'other'. People sleeping rough also reported higher rates than people not sleeping rough (70.4% vs 56.5%).

In the Australia F-SPDAT and Australia 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 (7.7%) reported using non-beverage alcohol (metho, cough syrup, mouthwash, rubbing alcohol, cooking wine, paint, or petrol) 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, to which one fifth of respondents (20.3%) answered yes.

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 (39.7%). This may indicate that a low proportion of people are accessing alcohol and other drug services. 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, Geddes & Kushel, 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.

"House, to get well. [I] never did drugs or nothing until I became homeless, it helps you know"

Interviewing people sleeping rough during 500 Lives 500 Homes Campaign Registry Fortnight in Brisbane. Photography: Linda Kaufman.

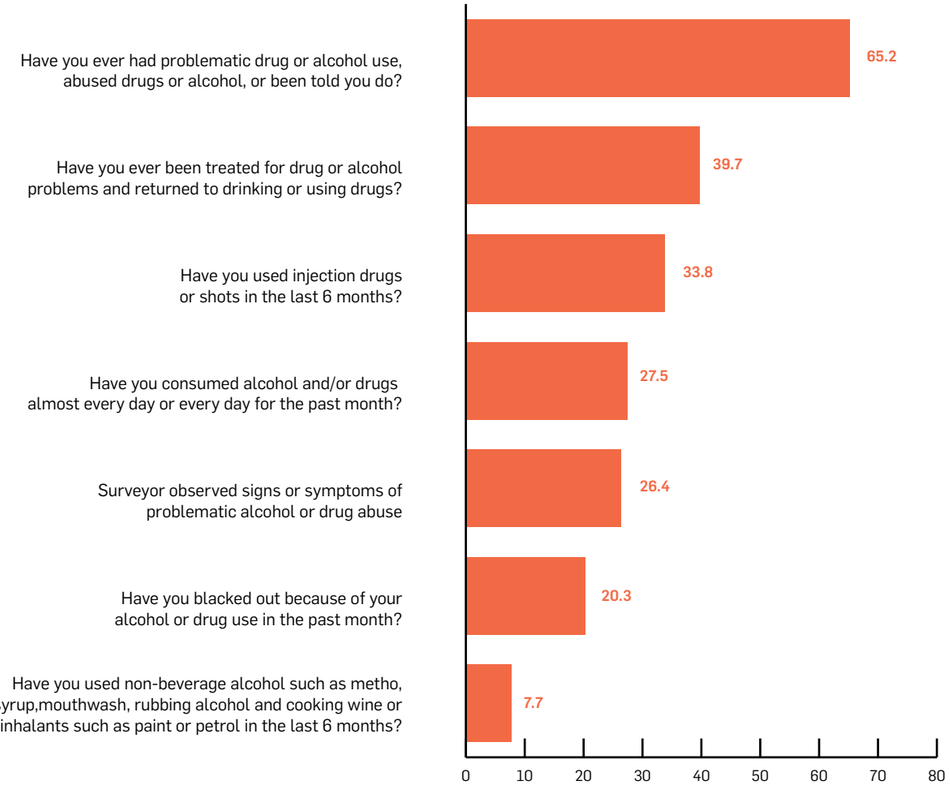
Table 6.5 Selected indicators of problematic drug and alcohol use

	YES	NO	PER CENT THAT ANSWERED YES	TOTAL	UNKNOWN	REFUSED	MISSING
Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?	5376	2875	65.2	8251	53	10	30
Have you consumed alcohol and/or drugs almost every day or every day for the past month?[2]	2255	5959	27.5	8214	67	17	31
Have you used injection drugs or shots in the last 6 months?[2]	2772	5429	33.8	8201	73	16	39
Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?[2]	3264	4949	39.7	8213	63	16	37
Have you used non-beverage alcohol such as metho, cough syrup, mouth-wash, rubbing alcohol and cooking wine or used inhalants such as paint or petrol in the last 6 months?[3]	419	5055	7.7	5474	< 5	11	44
Have you blacked out because of your alcohol or drug use in the past month?[4]	1112	4369	20.3	5481	< 5	15	48
Surveyor observed signs or symptoms of problematic alcohol or drug abuse[2]	1969	5477	26.4	7446	459	13	411

Source: Registry Week Data Collections 2010-2017

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. (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 not included in the Australia VI surveys and Youth VI-SPDAT surveys. (5) No questions about drug use were asked in the Youth VI - SPDAT survey.

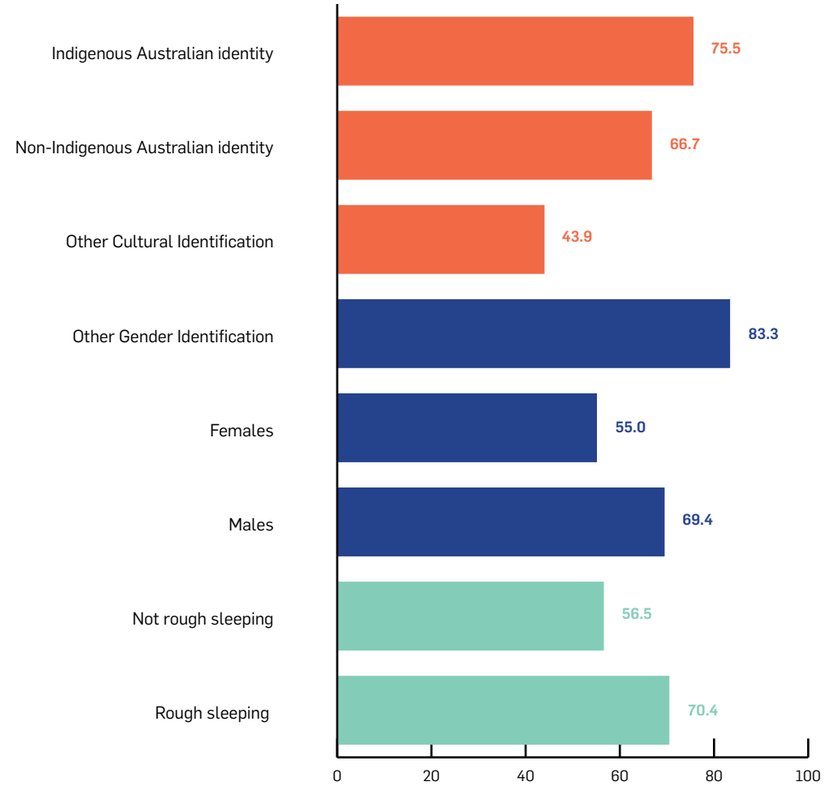
Figure 6.4 Selected indicators of problematic drug and alcohol use, per cent



Source: Registry Week Data Collections 2010-2017.

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

Figure 6.5 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: Registry Week Data Collections 2010-2017.
Notes: (1) Estimates based on unique respondents (excluding missing values).

Photography: Kieran MacFarlane

Chapter Seven

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 6, homeless people in Australia's capital cities experience poorer health outcomes than the general Australian adult population across a broad range of indicators. Those experiencing homelessness in Australia's cities are also victims of assault at very high rates resulting in treatment in Accident and Emergency (A&E) departments at high rates.

Those living in inner city areas in Australia are well served by public healthcare facilities. This combined with the high needs of 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.

Photography by UnitingCare West

7.1 USE OF HOSPITALS AND AMBULANCES

The Registry Week collection data discussed in Chapter 6, 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 over-represented in acute healthcare services including accident and emergency departments (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, Flatau & Brady, 2008; Poulin et al., 2010; Hwang et al., 2011; Hwang et al., 2013; Zaretzky et al., 2013; Wood et al., 2016; Parsell, Petersen & Culhane, 2016; Zaretzky et al., 2017).

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 (n= 5,598) were asked:

- In the last 6 months, how many times have you been to Accidents and Emergencies at the hospital?
- In the last 6 months, how many times have you been taken to the hospital in an ambulance?
- In the last 6 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 data from the Independent National Pricing Authority (2017) and the Steering Committee for the Review of Government Service Provision's Report on Government Services (SCRGS, 2018), average usage was translated into a financial cost per person for the use of A&E, ambulance and being hospitalised as an in-patient.

The majority of respondents (58%) reported that they had used A&E in the six months prior to the survey. Reported use was lower for ambulance (41%) and being admitted as an inpatient in hospital (40%). 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 7.1, 7.2, 7.3). Usage patterns were similar for people sleeping rough and those who were not across all three services (see figures 7.2, 7.4 and 7.6). However, non-rough sleeping respondents were more likely to report zero use or very low use compared with rough sleeping respondents. While existing studies using linked administrative data on the costs of homelessness show strong correlation with self-report-based results (see Clifasefi et al., 2011; Metraux et al., 2014; Parsell, Petersen & Culhane, 2016 and Wood et al., 2016), there is clearly some degree of approximation associated with self-report data. This is evident in the slight increases in people reporting healthcare use 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 with frequency categories to choose from to reduce this effect.

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.

7.1.1 ACCIDENTS AND EMERGENCY DEPARTMENT USE

Accidents and Emergency department (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 2.5 (see Table 7.4). However, 42% 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 4.35. One indicator of risk or vulnerability is the number of visits to A&E with those which have had three or more visits to A&E in the last six months considered to be of higher risk or more vulnerable. Among the Registry Week respondents, 27.1% reported three or more visits to A&E. Those sleeping rough were slightly more likely to report three or more visits to A&E (29.9%) than non-rough sleeping homeless people (24.9%).

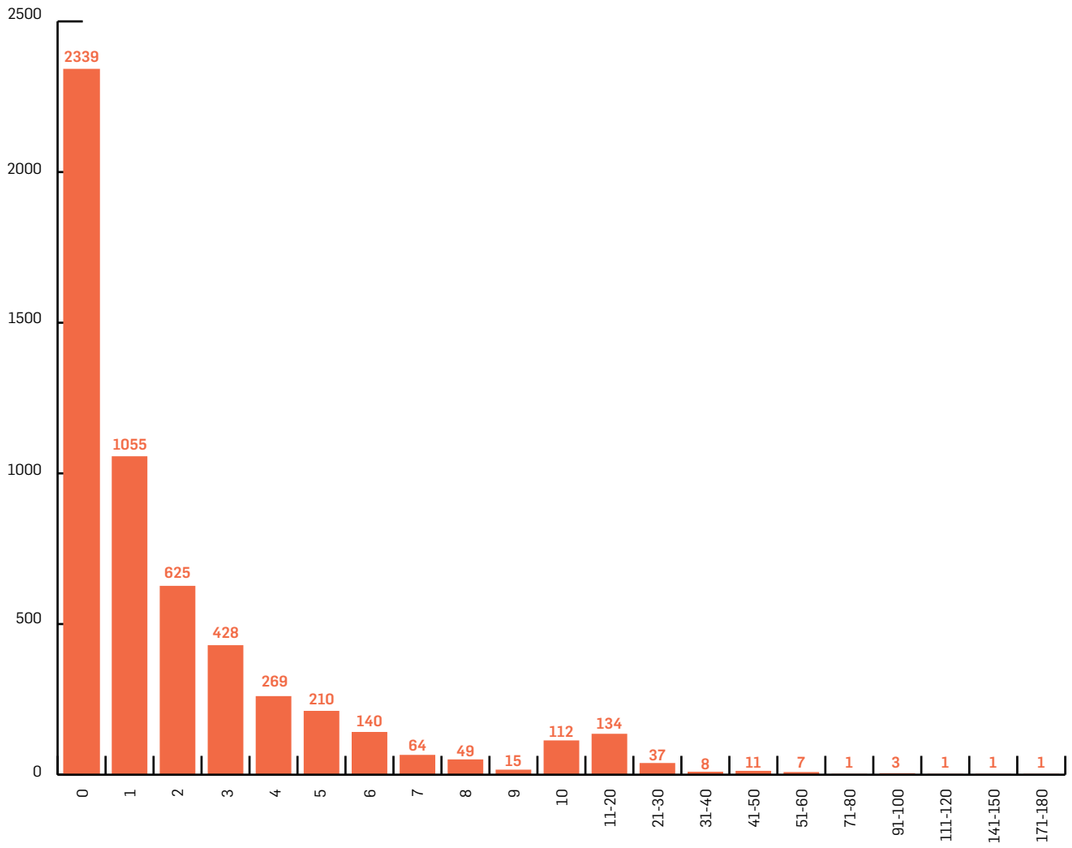
Table 7.1 Hospital Accident and Emergency Department visits over the last six months

	FREQUENCY	PER CENT	CUMULATIVE PERCENT
0	2339	42.5	42.5
1-10	2967	53.8	96.3
11-20	134	2.4	98.7
21-30	37	0.7	99.4
31-40	8	0.1	99.5
41-50	11	0.2	99.7
51 and over	14	0.3	100.0
TOTAL	5510	100	

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Health service utilisation questions were not included in the Australia VI survey.

Figure 7.1 Hospital Accident and Emergency Department visits over the last six months

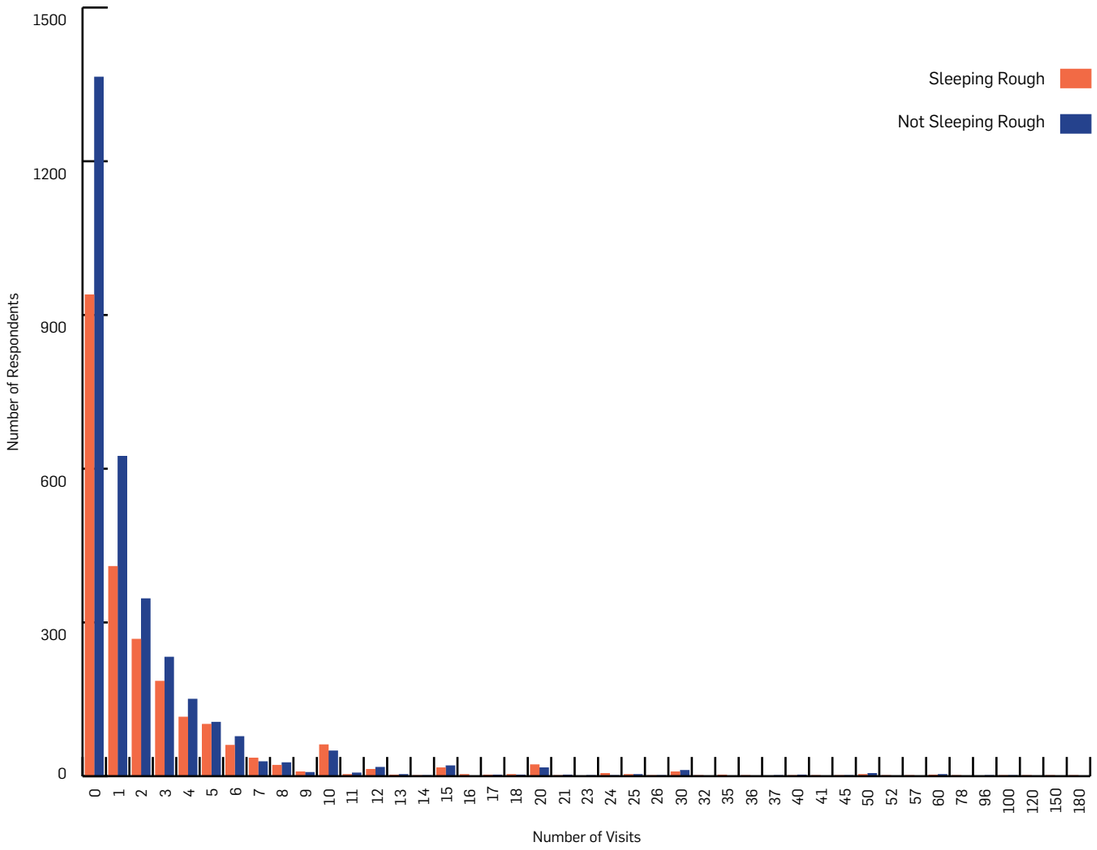


Source: Registry Week Data Collections 2010-2017.

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

"Getting a house, mental health support, medication, family support/communication"

Figure 7.2 Hospital Accident and Emergency Department visits over the last six months, by rough sleeping status



Source: Registry Week Data Collections 2010-2017.

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

7.1.2 HOSPITALISATION AS AN INPATIENT

As evident in Table 7.2, a majority of Registry Week respondents (59.7%) did not report being an in-patient in a hospital over the last six months. The mean level of hospital inpatient use is 1.17 hospitalisations as an inpatient in the last six months across all respondents including those with zero hospital in-patient use (see Table 7.4). If we exclude those who were not hospitalised as an inpatient in the prior six month period, the average jumps to 2.91 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 (3.41 and 2.56, respectively). Relatively small numbers of respondents report three or more in-patient hospital episodes in the last six months with a higher proportion of rough sleepers reporting three or more episodes of in-patient hospital use (15.8% of all rough sleepers) as compared with non-rough sleepers (11.3%).

Table 7.2 Number of times hospitalised as an in-patient (including mental health hospitalisations) over the last six months

	FREQUENCY	PER CENT	CUMULATIVE PERCENT
0	3283	59.7	59.7
1-10	2148	39.0	98.7
11-20	52	0.9	99.7
21-30	11	0.2	99.9
31-40	< 5	-	99.9
41-50	< 5	-	100.0
51 and over	< 5	-	100.0
TOTAL	5501	100	

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Health service utilisation questions were not included in the Australia VI survey.

7.1.3 AMBULANCE USE

Ambulance use was the second most frequently used healthcare service (out of A&E visits, ambulance and inpatient use). Across all respondents (including 58.8% of respondents reporting that they had not used an ambulance to be taken to hospital), the mean number of times of being taken to hospital in an ambulance was 1.42 times in the last six months. If only those who did use an ambulance in the six month period are considered, the average jumps to 3.45 incidents. Those reported sleeping rough most of the time had a higher average number of incidents than those who were not frequently sleeping rough (3.85 and 3.14, 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 (16.6% of all rough sleepers) as compared with non-rough sleepers (13.2%).

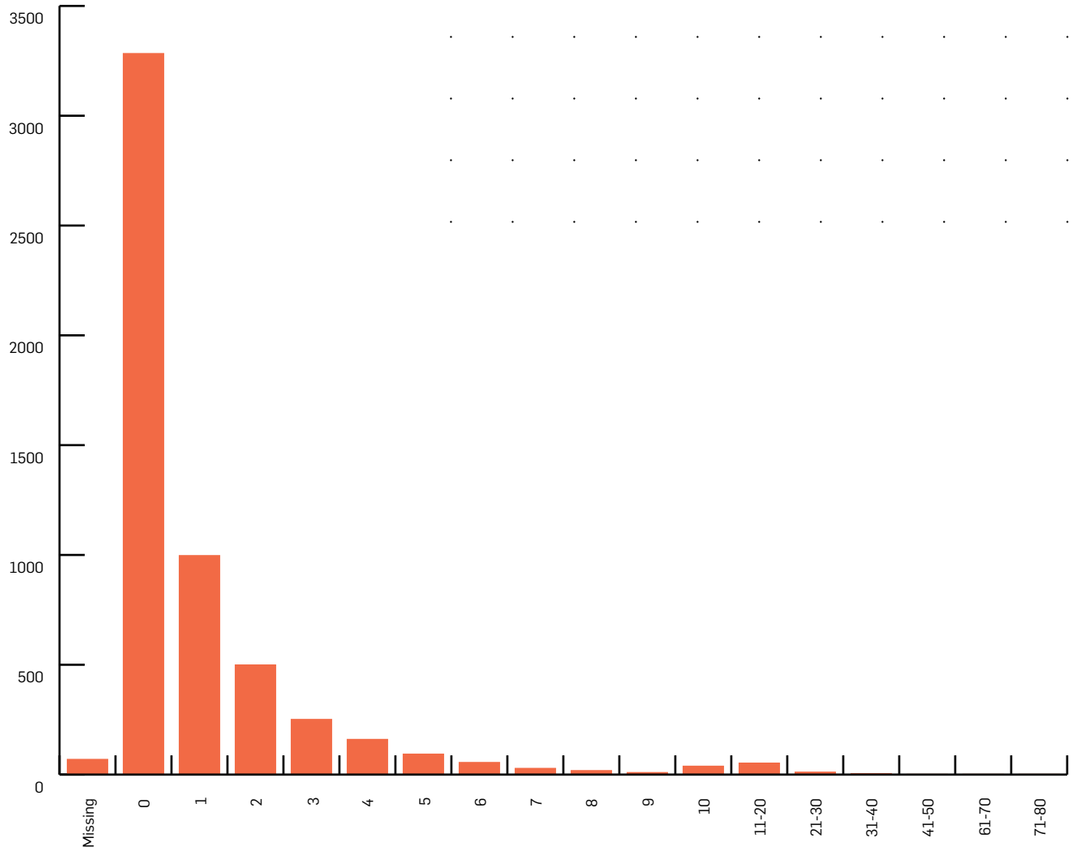
Table 7.3 Number of times taken to the hospital in an ambulance over the last six months

	FREQUENCY	PER CENT	CUMULATIVE PERCENT
0	3239	58.8	58.8
1-10	2184	39.6	98.4
11-20	53	1.0	99.4
21-30	14	0.3	99.6
31-40	7	0.1	99.7
41-50	6	0.1	99.9
51 and over	8	0.1	100.0
TOTAL	5511	100	

Source: Registry Week Data Collections 2010-2017.

Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Health service utilisation questions were not included in the Australia VI survey.

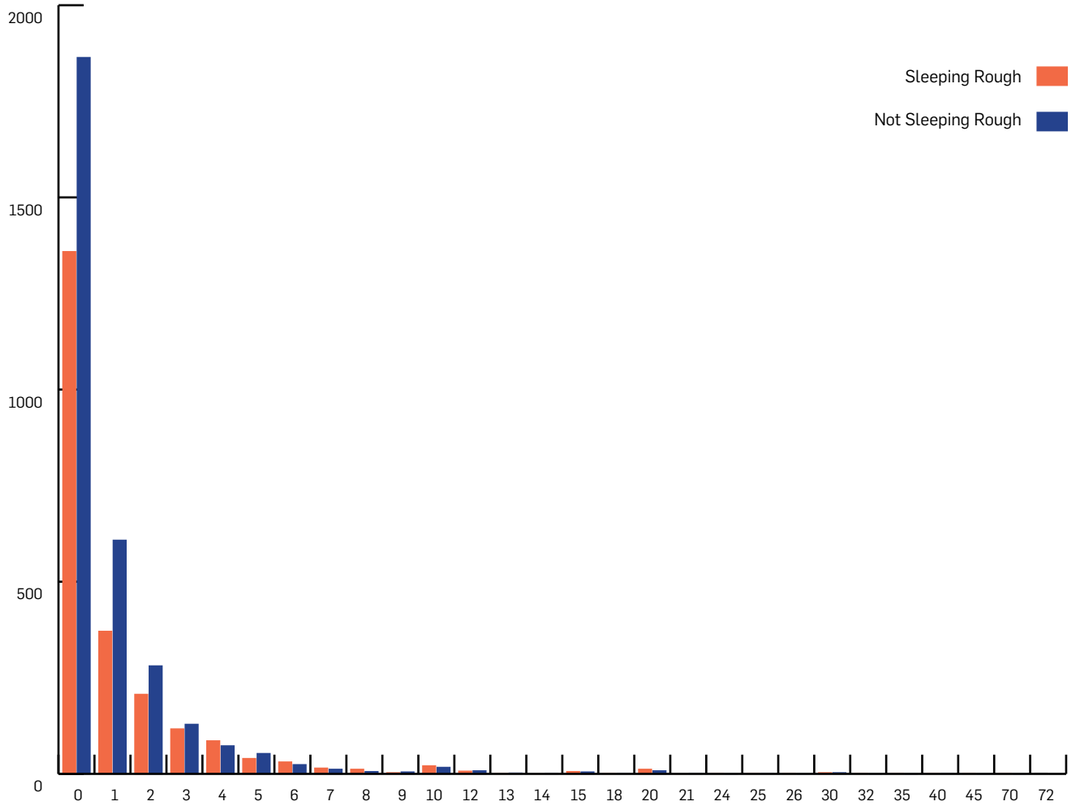
Figure 7.3 Number of times hospitalised as an in-patient (including mental health hospitalisations) over the last six months



Source: Registry Week Data Collections 2010-2017.

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

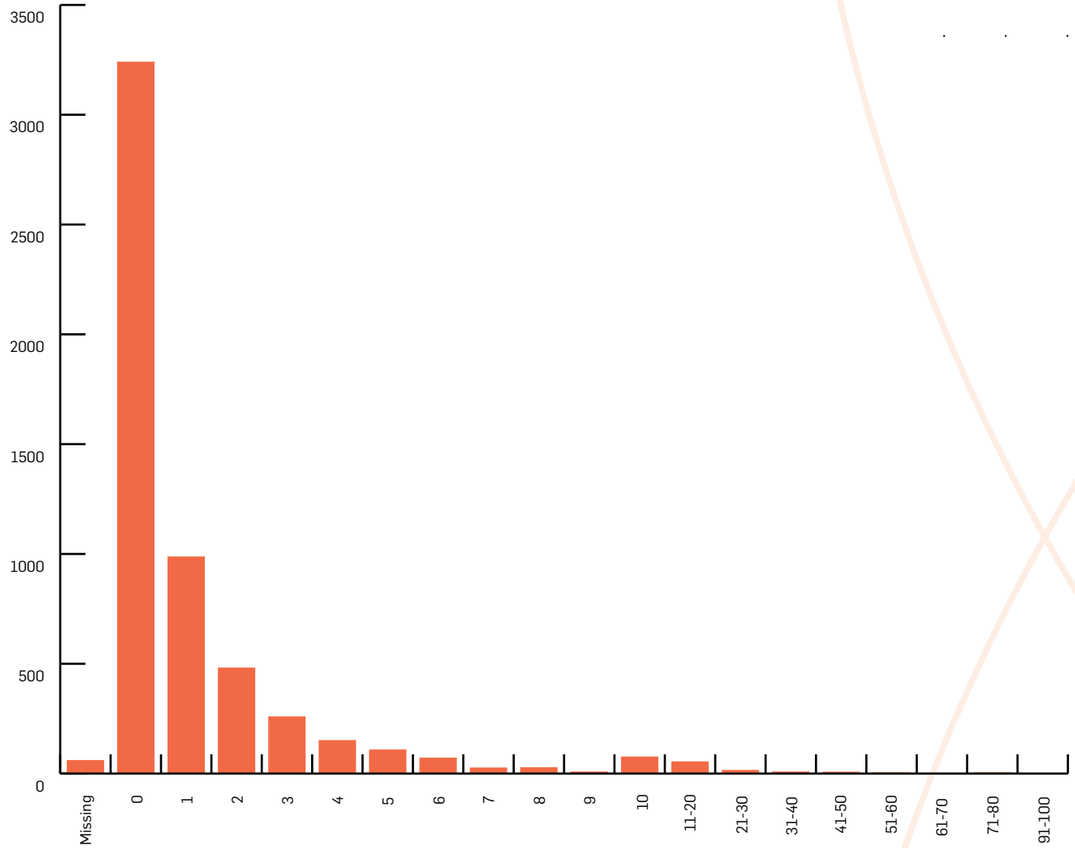
Figure 7.4 Number of times hospitalised as an in-patient (including mental health hospitalisations) over the last six months



Source: Registry Week Data Collections 2010-2017.

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

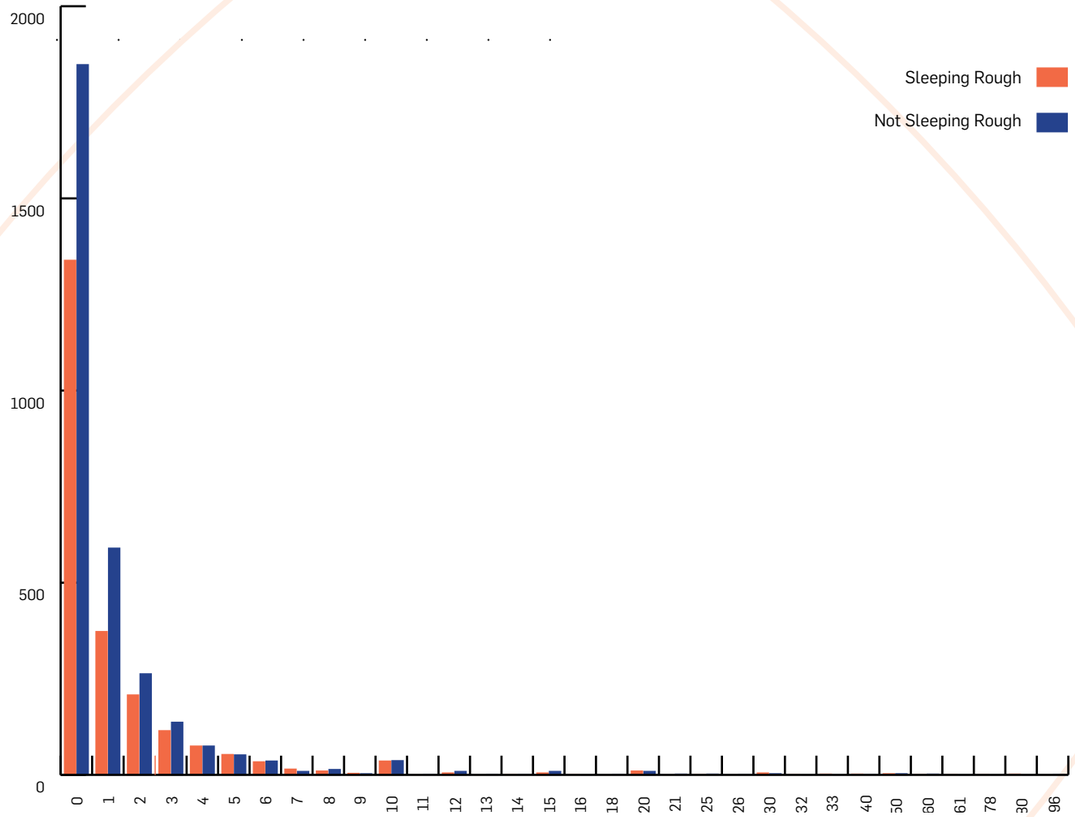
Figure 7.5 Number of times taken to the hospital in an ambulance over the last six months



Source: Registry Week Data Collections 2010-2017.

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

Figure 7.6 Number of times taken to the hospital in an ambulance, by rough sleeping status, over the last six months



Source: Registry Week Data Collections 2010-2017.

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

7.2 ESTIMATED HOSPITAL AND AMBULANCE COSTS

The cost of providing healthcare support depends on the type of support provided (e.g., ambulance, in-patient 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 in-patient 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 spend longer (or shorter) time in hospital than on average or use up more (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 National Pricing Authority (2017) and the Steering Committee for the Review of Government Service Provision's Report on Government Services (SCRGS) (SCRGS, 2018) indicative cost estimates for an A&E service incident, an ambulance service incident and an in-patient hospital incident. On the basis of our analysis of Australian healthcare cost data drawn from Independent National Pricing Authority (2017) and SCRGS (2018) we adopt the following average cost of incident estimates (2016-2017 prices): A&E $630, ambulance $948 and inpatient hospital admissions $5,230 (the latter estimate taking into account average length of stay and hospital type). Estimates of cost differ by jurisdiction but we do not address this question in our estimates below applying national estimates across the board.

In Table 7.4 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: $1,347.27 per person/six months
- A&E: $1,577.52 per person/six months
- In-patient hospital: $6,135.10 per person/six months
- Total: $8,969.65 per person/six months (or $17,939 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 Registry Week 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 service 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:

- Ambulance: $3,268 per person/six months
- A&E: $2,741 per person/six months
- In-patient hospital: $15,216 per person/six months.
- Total: $24,987 per person/six months for those who had at least one incident in each service type ($21,931 per person/six months for those who had utilised both A&E and in-patient health services).

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 $50,000 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: $3,650 per person/six months
- A&E: $3,102 per person/six months
- In-patient hospital: $17,811 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., 2015; 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 Registry Week collections are focused on the inner city regions of Australia's capital cities and do not include all healthcare services accessed by respondents.

Table 7.4 Health service utilisation and estimated costs for all respondents (includes those not utilising services) 6 months prior to the survey

	AMBULANCE (COST PER INCIDENT: $948)		ACCIDENTS AND EMERGENCIES (COST PER INCIDENT: $630)		IN-PATIENT (COST PER INCIDENT: $5,230)		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 (n=2303)	1.61	$1,527.79	2.92	$1,837.20	1.39	$7,291.54	$10,620.68
Not sleeping rough (n=3110)	1.28	$1,209.70	2.21	$1,393.99	1.02	$5,342.93	$7,816.43
Both sleeping rough and not sleeping rough categories specified[3] (n=29)	2.86	$2,713.61	2.50	$1,575.00	1.00	$5,230.00	$9,327.16
Inadequately described (n=41)	1.15	$1,086.88	2.15	$1,352.20	0.83	$4,337.07	$6,776.15
Missing (n=30)	0.79	$744.96	1.53	$966.00	0.44	$2,324.44	$4,030.10
TOTAL (N=5598)	**1.42**	**$1,347.27**	**2.50**	**$1,577.52**	**1.17**	**$6,135.10**	**$8,969.65**

Source: Registry Week Data Collections 2010-2017.

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

	AMBULANCE (COST PER INCIDENT: $948)			ACCIDENTS AND EMERGENCIES (COST PER INCIDENT: $630)			IN-PATIENT (COST PER INCIDENT: $5,230)		
	Number of people utilising service	Mean number 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 (n=2303)	964	3.85	$3,649.91	1364	4.92	$3,101.96	942	3.41	$17,810.87
Not sleeping rough (n=3110)	1262	3.14	$2,981.13	1744	3.94	$2,484.24	1239	2.56	$13,381.03
Both sleeping rough and not sleeping rough categories specified[3] (n=29)	17	4.88	$4,629.11	18	3.89	$2,450.00	13	2.23	$11,666.92
Inadequately described (n=41)	16	2.94	$2,785.13	26	3.38	$2,132.31	15	2.27	$11,854.67
Missing (n=30)	13	1.69	$1,604.53	19	2.42	$1,525.26	9	1.33	$6,973.33
TOTAL (N=5598)	**2272**	**3.45**	**$3,267.96**	**3171**	**4.35**	**$2,741.13**	**2218**	**2.91**	**$15,216.05**

Source: Registry Week Data Collections 2010-2017.

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.

Chapter Eight

JUSTICE

The relationship between people experiencing 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. Mentally ill individuals are more likely to live in conditions that present a greater risk of arrest, and 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 and 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, Dutton & Bennett, 2000; Hartwell, 2004; Constantine et al., 2010). This creates a revolving door between homelessness and prison.

The Registry Week data collections examine 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.

Photography by UnitingCare West

8.1 LIFETIME AND CURRENT JUSTICE INTERACTIONS

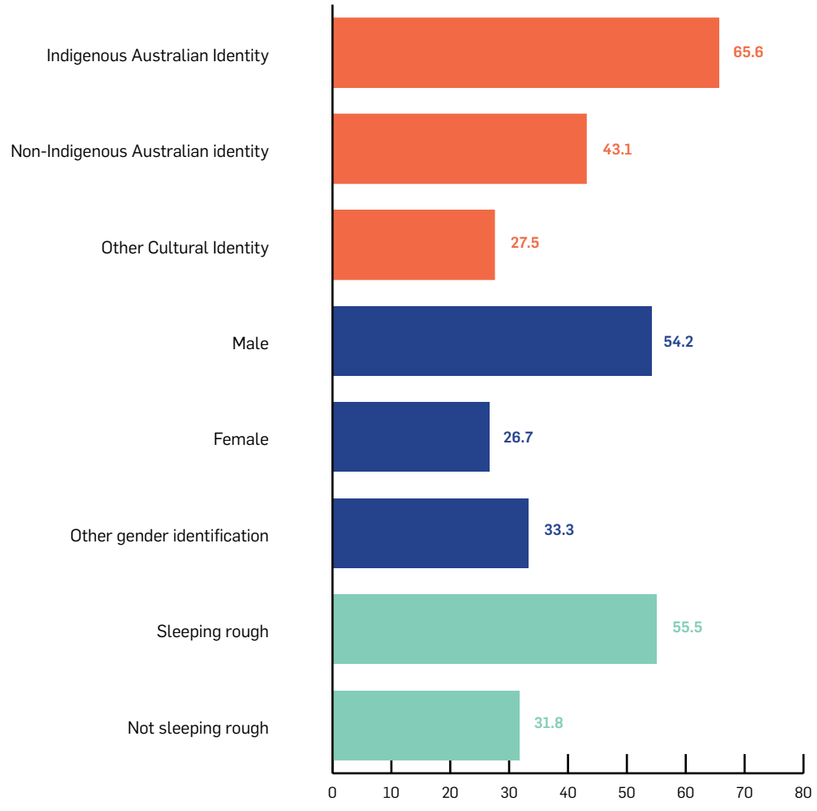
Figure 8.1 below, outlines the proportion of respondents reporting that they had been in prison at some point in their life, by Indigeneity, gender and rough sleeping status. Overall, 45.1% of Registry Week respondents reported that they had ever been in prison. Respondents that identified as Indigenous were more likely than those that identified as non-Indigenous to have spent time in prison (65.1% of Indigenous respondents versus 43.1% of non-Indigenous Australians and 27.5% for those that identified with another cultural identity); over twice the proportion of males as females reported having ever been in prison (54.2% versus 26.7%); and 55.1% of those sleeping rough versus 31.8% 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 live in conditions that are not legal (e.g., squats), are more likely to have co-occurring circumstances that increase risk of justice system interaction such as mental health conditions, trauma and are less likely to have safe and stable accommodation to live in upon release from imprisonment.

The higher proportion of Indigenous Registry Week respondents reporting experiences of imprisonment is reflected in national statistics. Despite representing 2.8% of the overall Australian population (Australian Bureau of Statistics, 2017c), Aboriginal and Torres Strait Islander individuals represent 27.4% of the Australian prison population (Australian Bureau of Statistics, 2017d). Put another way, Indigenous Australians are almost ten times more likely to be imprisoned when compared with the overall Australian population (Anthony, 2017). Therefore, it is unsurprising, though deeply disturbing, that Indigenous status and homelessness result in a higher rate of lifetime experience of imprisonment.

While the proportion of female Registry Week respondents reporting lifetime experience of imprisonment is less than half that of male respondents, it is substantially higher than the proportion of female prisoners in Australia. In 2017, only 8% of prisoners in Australia were female.

Figure 8.1 Lifetime prevalence of incarceration (Have you ever been in prison?)



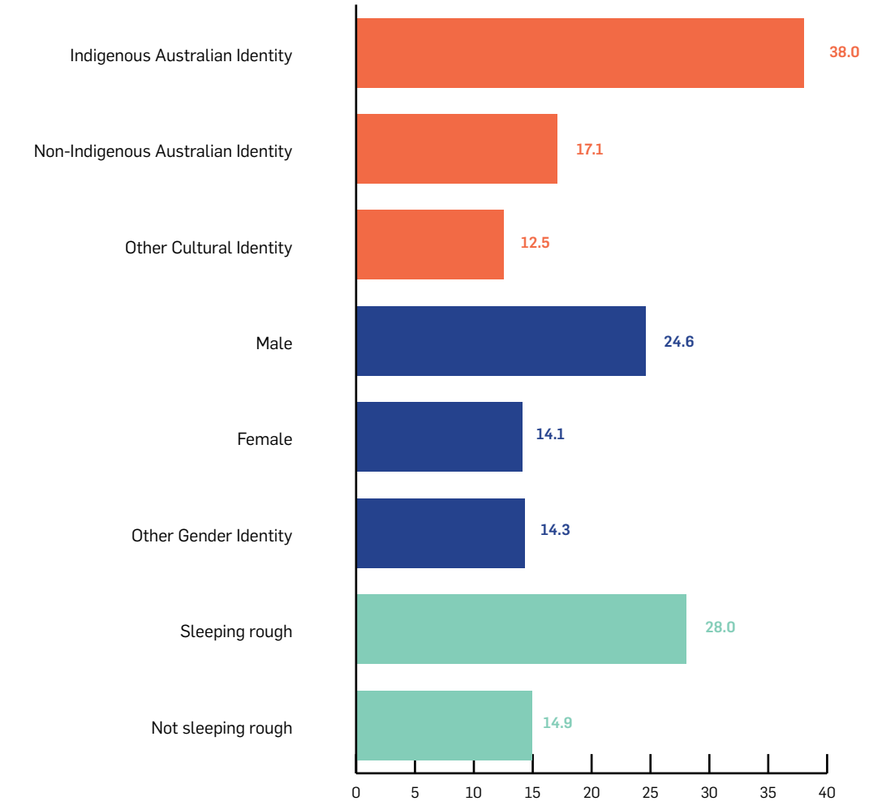
Source: Registry Week Data Collections 2010-2017

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

The Registry Week 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 of Registry Week respondents that identified as Indigenous Australians and had been in youth detention at some point in their lives was over twice that of non-Indigenous Australians: 38.0% of Indigenous Australian Registry Week respondents reported being in youth detention at some point in their lives versus 17.1% of non-Indigenous Australian respondents. Almost one quarter (24.6 %) of male Registry Week respondents had been in youth detention, versus 14.1% of female respondents. The proportion of rough sleepers that had been in youth detention in their lives was almost double that of non-rough sleepers.

The national youth detention population in Australia is 91% male and 53% Indigenous (AIHW, 2017b). A rate of 3.5 per 10,000 young people are detained in youth detention on any given night and Indigenous people are, on average, 24 times more likely to be detained as their non-Indigenous counterparts (AIHW, 2017b). Again, direct comparison between Australian population figures and the Registry Week respondents is not possible. However, a significantly higher proportion of the Registry Week respondents across all demographic variables report experiences of youth detention in their lives 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 Indigenous, male and/or a rough sleeper substantially correlates with one's likelihood of youth detention and adult imprisonment.

Figure 8.2 Lifetime prevalence of juvenile detention (Have you ever been in youth detention?)



Further breaking down respondents' lifetime experiences of imprisonment and youth detention by the place they sleep most frequently, those that are sleeping rough are most likely to have been in prison at some time in the past (55.0%), followed by those reporting that they are in an 'other' type of accommodation (52.1%), then institutional accommodation (52.0%). Those that were permanently housed and in 'other homeless' accommodation (including crisis and emergency accommodation, temporary accommodation, and short-term accommodation) were the least likely to have been in prison at 31.5% and 21.6%, respectively. However, the rates of imprisonment for all accommodation types are significantly higher than overall Australian rates. The rates for youth detention follow a similar pattern: rough sleepers were most likely to have been in youth detention (28.0%), followed by those in institutional accommodation at 21.0%. Almost one fifth (19.2%) of those that reported sleeping most frequently in both rough sleeping and not rough sleeping circumstances had been in youth detention, followed by 15.0% of those in 'other homeless' accommodation and 6.3% 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 indicate 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, Dutton & Bennett, 2000; Hartwell, 2004; Constantine et al., 2010). Finally, prior imprisonment also presents a barrier to economic participation (it's more difficult to get a job with a criminal record) and also predicts further criminal offending, two factors which present more barriers to exiting homelessness (Pager, 2003; Kurlychek, Brame & Bushway, 2006).

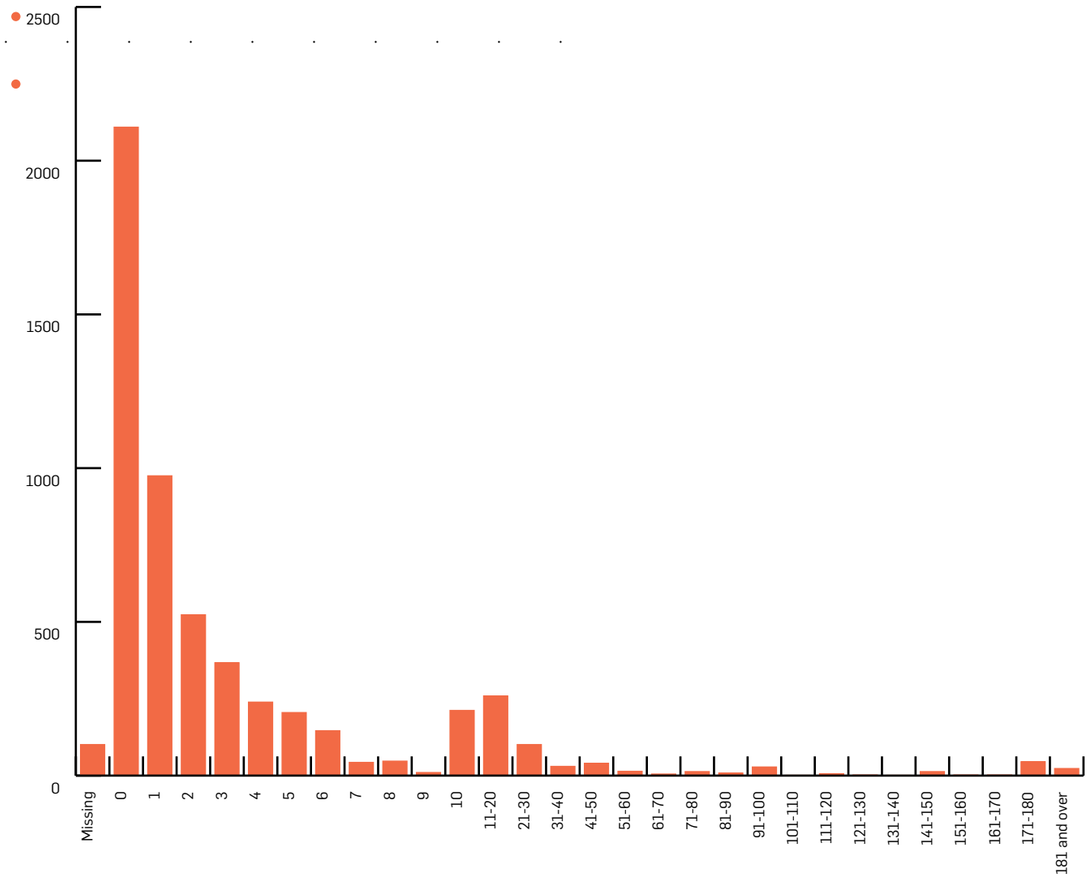
Table 8.1 Prevalence of lifetime prison and juvenile detention by homeless categories

	HAVE YOU EVER BEEN IN PRISON?		HAVE YOU EVER BEEN IN YOUTH DETENTION	
	NUMBER	PER CENT	NUMBER	PER CENT
SLEEPING ROUGH				
Yes	2208	55.0	631	28.0
No	1748	43.5	1612	71.5
Unknown	50	1.2	< 5	-
Refused	10	0.2	11	0.5
TOTAL	4,016	100.0	2,254	100.0
Missing	25		70	
OTHER HOMELESS (INCLUDES CRISIS AND EMERGENCY ACCOMMODATION, TEMPORARY ACCOMMODATION, SHORT-TERM ACCOMMODATION)				
Yes	1,043	31.5	352	15.0
No	2,251	68.0	1,988	84.8
Unknown	8	0.2	< 5	-
Refused	7	0.2	< 5	-
TOTAL	3,309	100.0	2,344	100.0
Missing	35		559	
BOTH SLEEPING ROUGH AND OTHER HOMELESS CATEGORIES				
Yes	38	52.1	5	19.2
No	34	46.6	21	80.8
Unknown	< 5	-	< 5	-
TOTAL	73	100.0	26	100.0
Missing			< 5	
INSTITUTIONAL ACCOMMODATION				
Yes	66	52.0	21	21.0
No	61	48.0	79	79.0
TOTAL	127	100.0	100	100.0
Missing			< 5	
PERMANENTLY HOUSED				
Yes	33	21.6	6	6.3
No	120	78.4	90	93.8
Refused	< 5	-	< 5	-
TOTAL	153	100.0	96	100.0
Missing	< 5		34	
ALL RESPONDENTS	7,739		5,490	

Source: Registry Week Data Collections 2010-2017.

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.

Figure 8.3 Interactions with the police over the last six months (number of times)

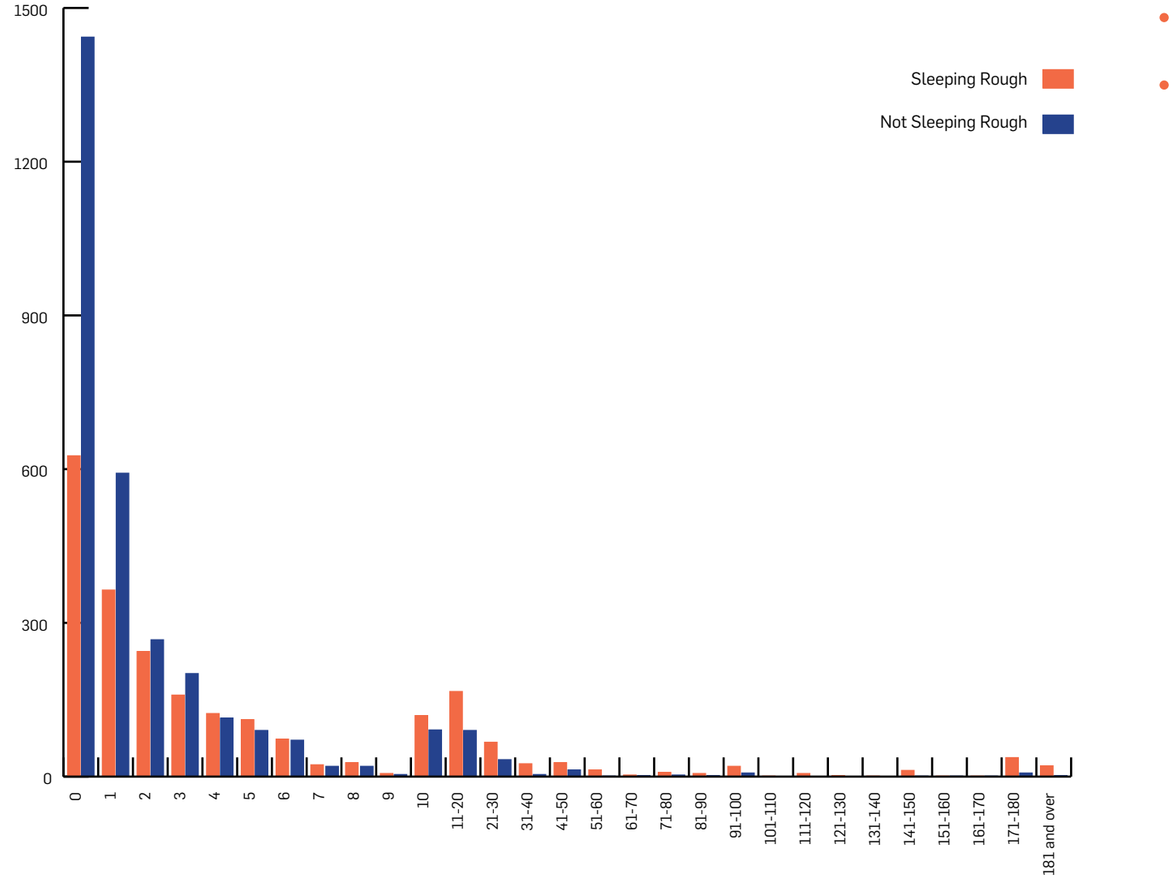


Source: Registry Week Data Collections 2010-2017.
Notes: (1) Estimates based on unique respondents (excluding missing values).

Figure 8.3 above, illustrates the frequency of Registry Week respondents' interactions with police over the six months prior to the survey. Over one third of respondents that answered this question (38.6%) reported that they had not interacted with the police in the prior six months. A further 17.8% had interacted with the police once in the previous six months. The majority (80.8%) of respondents had interacted with the police five or less times. However, 68 respondents reported daily or more frequent interactions with the police.

Examining the frequency of interactions with the police over the last 6 months by rough sleeping status, (Figure 8.4) illustrates that it is rough sleepers that account for the high numbers of police interactions. This makes sense as rough sleeping leaves individuals exposed to patrolling law enforcement officers who have a duty of care to interact with those that are not in safe position.

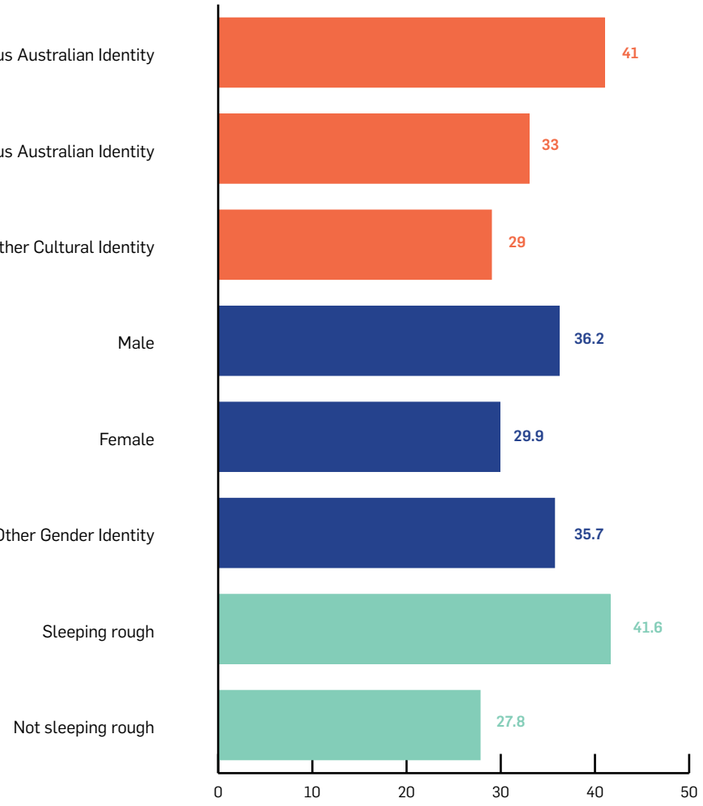
Figure 8.4 Interactions with the police over the last six months (number of times), by sleeping rough status



Source: Registry Week Data Collections 2010-2017.
Notes: (1) Estimates based on unique respondents (excluding missing values).

Registry Week 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, 33.8% of respondents that answered this question responded affirmatively to this question. Breaking this down by demographic characteristics, 41% of those that identified as Indigenous Australians reported that they had legal stuff going on at the time of survey, compared with 33.0% of non-Indigenous Australians; 36.2% of males versus 29.9% of females; and 41.6% of rough sleepers compared with 27.8% of non-rough sleepers. 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 homeless people's interactions with 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' (Barak & Bohm, 1989; DeLisi, 2000; Walsh, 2003).

Figure 8.5 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?"



Source: Registry Week Data Collections 2010-2017.

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 8.2, below), those who reported that they slept most frequently in institutional accommodation were the most likely to report current legal issues, with 44.7% of this cohort responding affirmatively to the question. This is relatively unsurprising because institutional accommodation includes prison and watch houses. 41.6% of rough sleepers reported current legal issues, followed by 41.4% of those that reported that they most frequently slept in both rough sleeping and non-rough sleeping situations, then 27.5% of those in 'other homeless' accommodation. Finally, a little over one fifth of the permanently housed (21.7%) reported that they had current legal stuff going on.

Accommodation, driver's license, money

Overall, Indigeneity, male gender and rough sleeping are strongly related to historical and current interactions with the justice system among Registry Week respondents. This is reflected in national imprisonment rates; 92% of current inmates are male and 27.4% are Indigenous while Indigenous Australians comprise 2.8% of the country's population. 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 Registry Week 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 8.2 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	961	41.6
No	1344	58.2
Unknown	< 5	-
Refused	< 5	-
TOTAL	2309	100.0
Missing	15	
OTHER HOMELESS (INCLUDES CRISIS AND EMERGENCY ACCOMMODATION, TEMPORARY ACCOMMODATION, SHORT-TERM ACCOMMODATION)		
Yes	791	27.5
No	2080	72.3
Unknown	< 5	-
Refused	6	0.2
TOTAL	2877	100.0
Missing	26	
BOTH SLEEPING ROUGH AND OTHER HOMELESS CATEGORIES		
Yes	12	41.4
No	17	58.6
Unknown	< 5	-
TOTAL	29	100.0
Missing		
INSTITUTIONAL ACCOMMODATION		
Yes	46	44.7
No	57	55.3
TOTAL	103	100.0
Missing	< 5	
PERMANENTLY HOUSED		
Yes	28	21.7
No	100	77.5
Refused	< 5	-
TOTAL	129	100.0
Missing	< 5	
TOTAL	5,490	

Source: Registry Week Data Collections 2010-2017

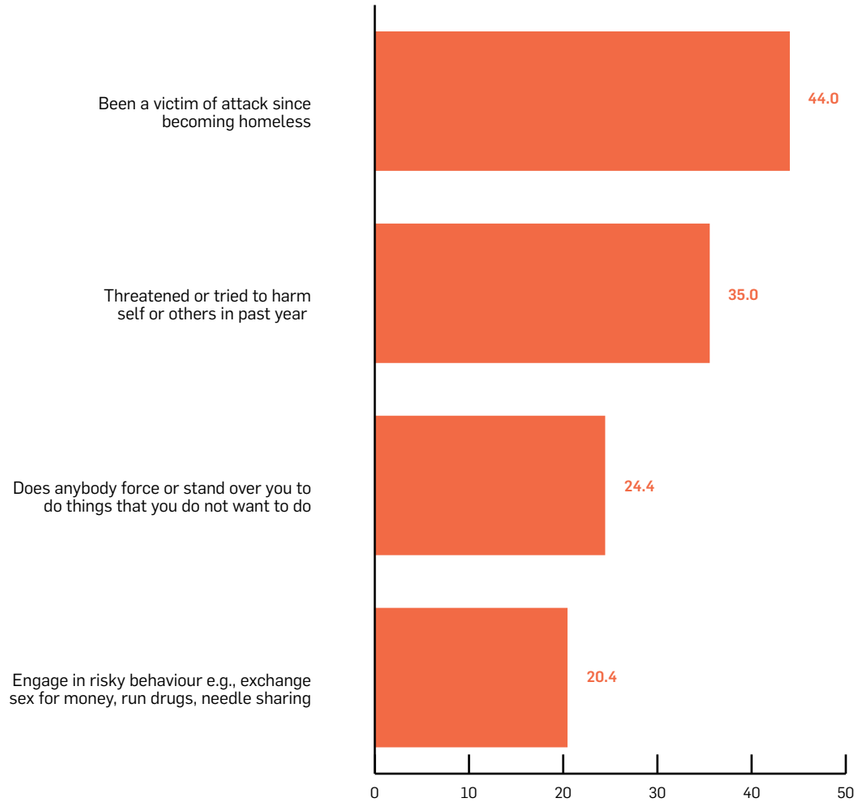
Notes: (1) Estimates based on unique respondents (excluding missing values). (2) Questions were included in the Australia VI - SPDAT, Australia F - SPDAT and Australia VI surveys but not in the Families VI - SPDAT, Individual VI - SPDAT and Youth VI-SPDAT surveys

8.2 HARM, RISK AND CRIME

It is well established that people experiencing homelessness are significantly more likely than the general population to be victims of crime (Fitzpatrick, La Gory & Ritchey, 1993; Lee & Schrek, 2005; Sanders & Albanese, 2016). 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 Registry Week collections ask respondents some questions about their experiences as a victim of crime and 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 8.6, below, shows the proportion of Registry Week respondents reporting that they have experienced or engaged in the aforementioned incidents.

"Staying off the streets; staying away from bad people"

Figure 8.6 Victim of crime, harm to self and others, exploitation and risky behaviours



Source: Registry Week Data Collections 2010-2017.

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

Almost half of respondents, 44.0%, in the Registry Week data report that they have been attacked or beaten up since becoming homeless. Table 8.3 examines being a victim of attack by the place that respondents sleep most frequently. Rough sleepers are more likely to have been a victim of attack than not, with 52.5% reporting that they had, compared with 34.2% of other homeless respondents, which includes crisis and emergency accommodation, temporary accommodation and short-term accommodation. Of those in institutional accommodation, 37.0% reported that they had been beaten up or attacked since becoming homeless and 26.1% of those that were permanently housed at the time of survey reported that they had been a victim of attack.

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 – 35% reported being deliberately hit or kicked and 34% reported that they have had things thrown at them while homeless.

Registry week respondents are asked whether they have threatened or tried to harm themselves or others in the previous year. In the overall sample, 35.5% responded affirmatively to this question. This was slightly higher amongst rough sleepers (39.1%) and those in institutional accommodation (40.4%), and slightly lower among those experiencing 'other' homelessness (32.6%) and those that are permanently housed (34.1%).

Almost one quarter (24.2%) 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 amongst rough sleepers (27.5%) and those who slept most frequently in an 'other' place (34.5%), lower among those in institutional accommodation (22.5%) and the permanently housed (19.4%), and lowest amongst those who were in 'other homeless' accommodation (14.8%).

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 rough sleepers (26.2%) and, somewhat surprisingly, the permanently housed (25.4%). The latter may be explained by formerly homeless individuals feeling more constrained in their permanent housing arrangement, or being more susceptible to suboptimal tenancy arrangements (e.g., abusive landlords).

People experiencing homelessness 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 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 is a logical assertion that much of the hesitance will come from a lack of knowledge or belief in one's legal and human rights.

"I dont need anything other than a big dog and me cause thats all I can rely on they let you down"

Table 8.3 Victim of crime, harm to self and others, exploitation and risky behaviours

	HAVE YOU EVER BEEN ATTACKED OR BEATEN UP SINCE BECOMING HOMELESS?		HAVE YOU 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]		DO YOU EVER DO THINGS THAT MIGHT BE CONSIDERED TO BE RISKY LIKE EXCHANGE SEX FOR MONEY, RUN DRUGS FOR SOMEONE, HAVE UNPROTECTED SEX WITH SOMEONE YOU DON'T REALLY KNOW, SHARE A NEEDLE, OR ANYTHING LIKE THAT?[2]	
	NUMBER	PER CENT	NUMBER	PER CENT	NUMBER	PER CENT	NUMBER	PER CENT
SLEEPING ROUGH								
Yes	2,121	52.5	905	39.1	607	26.2	638	27.5
No	1,875	46.4	1,401	60.5	1,707	73.7	1,669	72.0
Unknown	39	1.0	< 5	-	< 5	-	< 5	-
Refused	< 5	-	11	0.5	< 5	-	12	0.5
TOTAL	4,039	100.0	2,317	100.0	2,316	100.0	2,319	100.0
OTHER HOMELESS (INCLUDES CRISIS AND EMERGENCY ACCOMMODATION, TEMPORARY ACCOMMODATION, SHORT-TERM ACCOMMODATION)								
Yes	1,147	34.2	942	32.6	661	23.0	427	14.8
No	2,184	65.2	1,934	66.9	2,207	76.6	2,444	84.8
Unknown	10	0.3	< 5	-	< 5	-	< 5	-
Refused	10	0.3	15	0.5	12	0.4	11	0.4
TOTAL	3,351	100.0	2,891	100.0	2,880	100.0	2,882	100.0
BOTH SLEEPING ROUGH AND OTHER HOMELESS CATEGORIES								
Yes	35	47.9	10	34.5	6	20.7	10	34.5
No	38	52.1	19	65.5	23	79.3	19	65.5
TOTAL	73	100.0	29	100.0	29	100.0	29	100.0
INSTITUTIONAL ACCOMMODATION								
Yes	47	37.0	42	40.4	23	22.8	23	22.5
No	80	63.0	62	59.6	77	76.2	79	77.5
TOTAL	127	100.0	104	100.0	101	100.0	102	100.0
PERMANENTLY HOUSED								
Yes	40	26.1	44	34.1	33	25.4	25	19.4
No	109	71.2	85	65.9	97	74.6	101	78.3
Refused	< 5	-	< 5	-	< 5	-	< 5	-
TOTAL	153	100.0	129	100.0	130	100.8	127	98.4
ALL RESPONDENTS	7,778		5,490		5,490		5,490	

Source: Registry Week Data Collections 2010-2017.

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

Chapter Nine

FINANCIAL AND SOCIAL INDICATORS AND WELLBEING

"Stable accommodation and a job. Once I have that in place I can start looking at everything else."

Photography by UnitingCare West

9.1 FINANCIAL AND SOCIAL INDICATORS

Income and employment are crucial factors related to homelessness. Economic instability, such as that created by loss of employment and/or insufficient income are significantly correlated to first-time homelessness (Lehmann, Cass, Drake & Nichols, 2007). Further, current or recent employment and the amount of income earned are associated with a shorter duration of homelessness (Caton et al., 2005), and the absence of health conditions that limit one's ability to work is related to exit from homelessness (Zlotnick, Robertson & Lahiff, 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 Registry Week data finds that 92.0% 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, previous studies in the United States and Canada 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 (Zuvekas & Hill, 2000; Shier, Jones & Graham, 2012). Accordingly, only 48.1% 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 (Lehmann et al., 2007; Zlotnick, Robertson & Lahiff, 1999). 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. 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 (18.2%) Registry Week 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, 90.3% of respondents reported that they had control over their finances. Most (77.1%) reported that they had a healthcare card and over half (52.0%) had a pension card. Almost one third (30.1%) of the overall sample responded affirmatively to the question "Is there anybody that thinks you owe them money?"

"Long term accommodation, not worry about where to scrape $ for food etc."

Breaking these financial indicators down by demographic characteristics, Table 9.1 below, indicate that rough sleepers are slightly less likely than non-rough sleepers to have regular income (89.8% versus 93.7%) and substantially less likely to have enough money coming in fortnightly (43.3% versus 51.5%). People sleeping rough are less likely to have a pension card and healthcare card, and are more likely to have had a Centrelink breach in the six months prior to survey (23.5% versus 14.3%). There are not particularly pronounced differences between males and females; females are slightly more likely to report receipt of regular income (93.7% versus 91.1%), possession of a healthcare card (76.1% versus 74.2%) and possession of a pension card (51.8% versus 50.5%), and slightly less likely to report that they had enough money coming in fortnightly (47.7% versus 48.4%) and Centrelink breach (16.4% versus 19.2%).

The results for the 'Other' gender category (comprised of people that identified as transgender or intersex) are very mixed. People in the 'Other' gender category are less likely to have regular income, a pension card, or a healthcare card and more likely to report that there is somebody that thinks they owe money. They are also more likely to have had a Centrelink breach in the prior six months. However, they are more likely to report that they have enough income coming in fortnightly to cover their expenses. The variation in financial indicators for those in the 'Other' gender category may be due to heterogeneity within this group (i.e., that there are male-identifying, female-identifying and non-binary individuals captured). Alternatively, it may be that their homelessness is primarily linked to ostracism by friends and family due to their gender identity rather than the presence of a compounding factors that would increase their welfare dependence (Cochran, Stewart, Ginzler & Cauce, 2001).

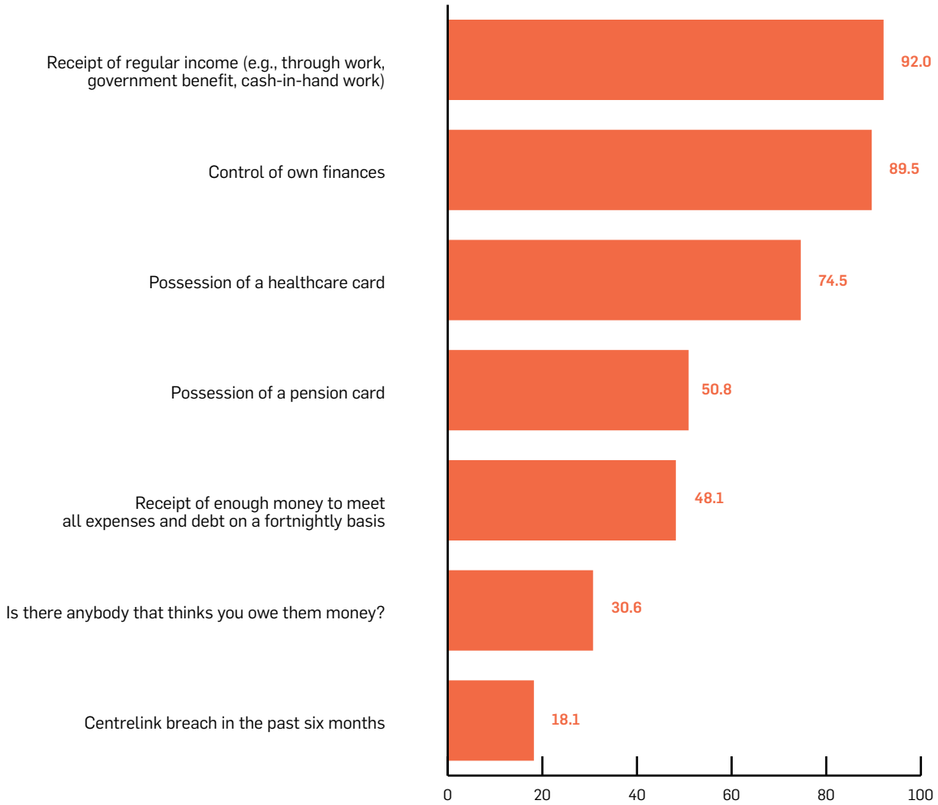
There are relatively few differences between Indigenous and non-Indigenous Australians on these selected financial indicators. Indigenous Australians are slightly less likely than non-Indigenous Australians to receive enough money fortnightly (46.9% versus 48.7%), have a pension card (48.2% versus 53.7%), or a healthcare card (75.5% versus 76.5%), and are slightly more likely to have had a Centrelink breach in the prior 6 months (24.3% versus 17.9%). Those who reported that they had a cultural identity that was not Indigenous or non-Indigenous 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. This may be because recent immigrants and refugees or people without secure immigration status, have greater difficulty obtaining welfare support (Kissoon, 2010). Alternatively, it may be that those who do not identify as (Indigenous or non-Indigenous) Australian have smaller social networks and experience greater social exclusion, and are therefore more likely to become homeless and are less likely to have access to non-employment or non-welfare income (Couch, 2011).

The relatively small differences in financial indicators of Registry Week respondents within demographic characteristics that are typically correlated with greater disadvantage (e.g., Indigeneity 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 7.1, below, is veteran status. Those that reported that they had served in the Australian Defence Force at some point in their lives were slightly more likely to report receipt of regular income (94.4% versus 91.9%) and receipt of enough money fortnightly (51.3% versus 47.8%). In addition, 61.3% of veterans reported possession of a pension card, compared with 50.2% 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. Veterans were also less likely to have had a Centrelink breach than non-veterans (12.9% versus 18.5%).

"Have safe accommodation, have a holiday once a year 'if you save'"

Figure 9.1 Financial indicators, per cent



Source: Registry Week Data Collections 2010-2017.
Notes: (1) Estimates based on unique respondents (excluding missing values).

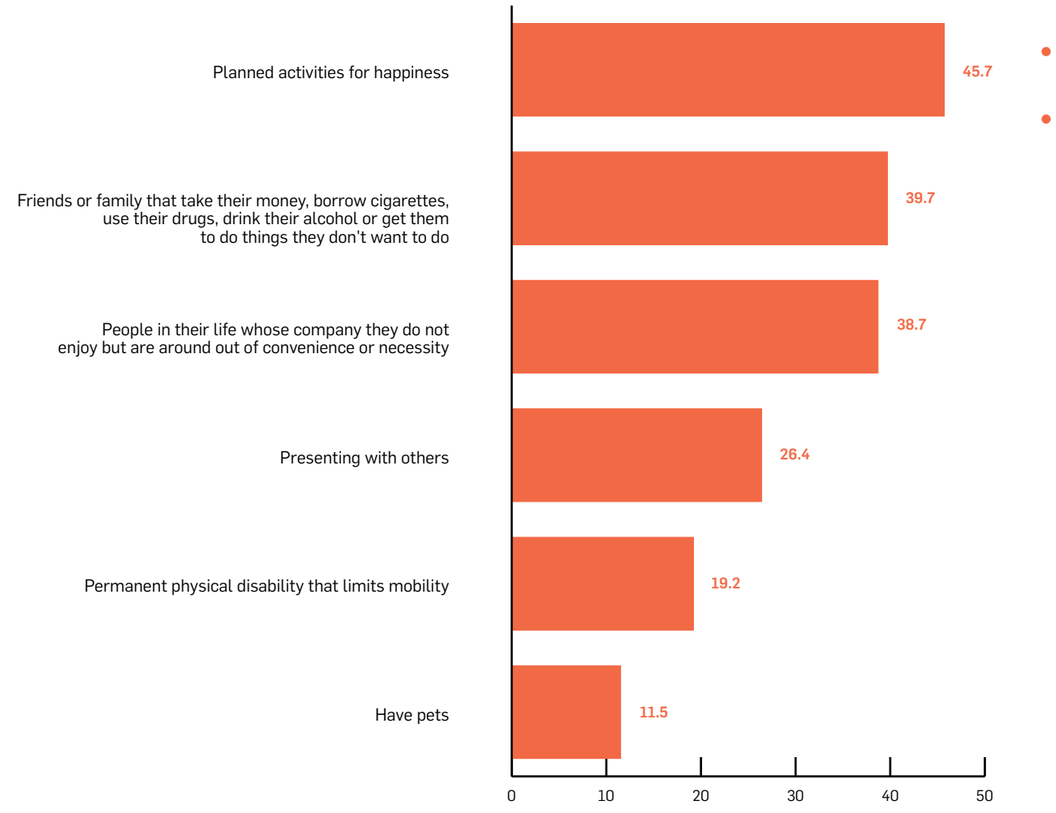
Table 9.1 Financial indicators by homelessness status, gender identity, cultural identity and veteran status, per cent

	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	89.8	43.3	47.2	72.9	23.5	91.4	30.3
Non-rough sleepers	93.7	51.5	54.5	77.0	14.3	87.0	30.8
GENDER IDENTITY							
Males	91.1	48.4	50.5	74.2	19.2	89.9	30.7
Female	93.7	47.7	51.8	76.1	16.4	88.5	30.1
Other gender identity[5]	89.3	52.0	37.5	71.4	20.8	85.4	35.7
CULTURAL IDENTITY							
Indigenous Australians	93.0	46.9	48.2	75.5	24.3	91.4	29.4
Non-Indigenous Australians	93.1	48.7	53.7	76.5	17.9	89.1	31.9
Other cultural identity	84.2	43.6	39.4	63.5	13.2	90.9	27.1
VETERAN STATUS							
Veterans	94.4	51.3	61.3	75.8	12.9	88.5	28.5
Non-veterans	91.9	47.8	50.2	74.6	18.5	89.8	30.5

Source: Registry Week Data Collections 2010-2017.

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.

Figure 9.2 Social indicators, per cent



Source: Registry Week Data Collections 2010-2017.

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

Table 9.2 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]	PETS[2]
PLACE SLEPT MOST FREQUENTLY						
Rough sleepers	19.6	27.8	39.6	44.7	60.2	8.6
Non-rough sleepers	17.9	24.3	37.9	36.0	49.8	13.2
GENDER IDENTITY						
Males	21.2	20.9	36.3	38.8	54.1	7.2
Female	15.6	40.6	42.5	40.9	54.2	18.4
Other gender identity[5]	13.3	21.7	41.7	58.3	60.7	12.0
CULTURAL IDENTITY						
Indigenous Australians	18.6	36.7	45.5	49.9	56.9	8.7
Non-Indigenous Australians	20.8	22.1	37.9	38.5	54.6	12.9
Other cultural identity	14.2	29.2	32.5	31.1	50.8	6.3
VETERAN STATUS						
Veterans	26.4	22.1	36.3	37.0	51.3	12.5
Non-veterans	18.8	26.8	38.9	39.8	54.5	11.5

Source: Registry Week Data Collections 2010-2017.

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.

Meeting and interviewing people living in Boarding Houses during 500 Lives 500 Homes Campaign Registry Fortnight in Brisbane. Photography: Robyn McDonald.

The instruments used in the Registry Week data collections includes questions relating to indicators of social wellbeing, encompassing both risk and protective factors for safety and wellbeing. In terms of protective factors, 45.8% of respondents reported that they engaged in activities that they enjoy, other than survival. 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 (11.5%) respondents reported that they have a pet.

With regard to risk factors for safety, 39.8% 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 38.9% 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 (19.5%) report that they have a permanent physical disability that limits mobility.

Rough sleepers are less likely than non-rough sleepers to have a pet, but more likely to present with other people. They are more likely to have 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 more likely to have planned activities that they enjoy other than survival.

Females are substantially more likely to have protective factors such as pets and to be with other people, but are also more likely to 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. Males and females are equally likely to have planned activities other than survival that they enjoy.

A substantially higher proportion of Indigenous Australians relative to non-Indigenous Australians present with others, but a substantially 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 higher proportion of veterans versus non-veterans report having a pet. A substantially higher proportion of veterans report a permanent physical disability. Veterans are less likely than non-veterans to present with others and are also less likely to have activities that they enjoy other than survival planned. They are also less likely to 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.

9.2 WHAT DO YOU NEED TO BE SAFE AND WELL?

Respondents of the Australian Family Service Priority Decision Assistant Tool (F-SPDAT) and Australian Vulnerability Index Service Priority 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 relevant to them. This question was asked to 4,780 respondents, and a total of 4,632 valid responses were recorded. Of the 148 invalid responses, 44 respondents reported that they were currently safe and well and did not need anything, 23 responded that they were unsure or didn't know, and the remainder had responses that were inadequately recorded and were thus unable to be categorised.

Using Maslow's Hierarchy of Needs (Figure 9.3 below) as a framework, we manually coded the valid responses into categories and subcategories. Table 9.3 outlines the coding structure that emerged from the data, within the framework. 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. Exceptions will be discussed.

Figure 9.3 Maslow's Hierarchy of Needs

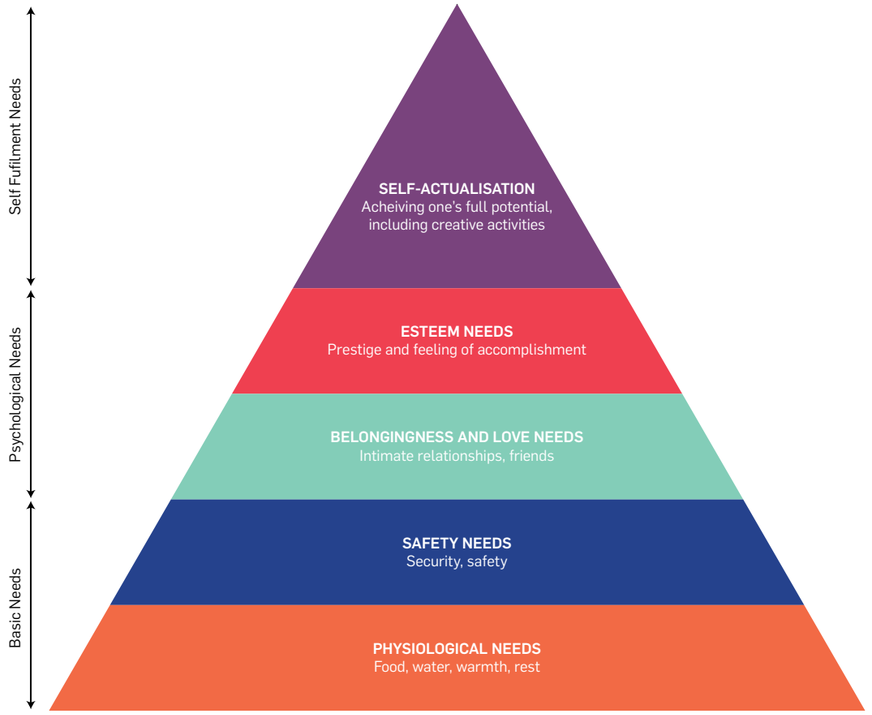


Table 9.3 Categories, subcategories and examples of safety and wellbeing needs

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"
	Rest	"Sleep", "Comfortable bed", "Just to rest"
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"
	Drug and alcohol	"Stay off the grog", "Stay clean", "Stay away from drugs"
	Security	"To be safe", "To be away from partner (domestic violence)", "Doors that lock", "Security for my house"
	Shelter	"Roof over my head", "A house", "Safe place to sleep", "Four walls and a roof", "Housing"
	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"
	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"
	Achievement	"Self-esteem", "Self-worth", "To be understood", "Respect", "To complete my studies", "To be happy", "Meaning", "Purpose"
	Entertainment	"Music", "TV", "Art", "Radio", "Something to do with my time"

Photography: Kieran MacFarlane

9.2.1 PHYSIOLOGICAL NEEDS

Though needs across all categories can be experienced at the same time, 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; 418 people raised food as necessary for them to feel safe and well. Many referred to quantity and stability of food, making statements such as "enough food" or "three meals a day", and others talked about quality with statements such as "decent food" or "good nutrition". In addition, when articulating their need for shelter, many participants specified that they wanted a kitchen and/or the ability to cook their own meals: "Supported, safe accommodation where I can cook my own meals."

"My own accommodation so I can go home at night and cook my own tea. I am fed up with street food"

Warmth was raised as an important physiological need, mentioned by 131 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 shelter, reflected in statements such as "a warm, dry, place to sleep".

Rest was not mentioned frequently as something needed to be safe and well. While there was significant allusion across the sample to both mental and physical exhaustion as a result of their homelessness or housing situation, only 60 people mentioned rest as salient. Most of these people referred to a bed (35 participants), making statements such as "a warm comfy bed to sleep on" or "a good bed", while others mentioned "more sleep" or "a good night's rest".

9.2.2 SAFETY NEEDS

"Safe, secure, affordable housing"

Safety needs, broadly defined as the absence of feeling endangered, were overwhelmingly the most frequently mentioned needs across participants; 3903 or 84% of respondents identified 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 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, affordability, and security. For example:

"Secure housing with a lock on my front door"

An important observation here is the prominence of shelter, which is classed as a safety need, over physiological needs. According to Maslow's Hierarchy of Needs, the satisfaction of physiological needs should override the pursuit of needs further up the hierarchy. However, Maslow (1943) himself states that 'the healthy, normal, fortunate adult in our culture is largely satisfied in his safety needs' (p378), and suggests that to observe safety needs in action one must look to economic and social 'underdogs'. Indeed, he acknowledges that if safety needs are activated (i.e., an individual feels endangered), these needs can dominate the individual to the same extent as physiological needs, even dominating them.

Therefore, while the data is limited in that it is comprised of short-form responses to a single question about safety and wellness asked at the end of the Australia VI-SPDAT and F-SPDAT surveys, it is important to state that the data does not indicate that shelter is the most prominent need for participants because their physiological states are satisfied. Rather, we suggest that shelter needs are so unsatisfied amongst this population that lack of shelter inhibits the satisfaction of physiological needs. Alternatively, participants may feel that their other needs, including physiological needs will be satisfied if they have a home. Both of these propositions are supported in the relationship between food and shelter and warmth and shelter; 362 out of the 418 (87%) of participants that stated food as a need for safety and wellbeing also mentioned shelter. Similarly, 78% of participants that mentioned warmth also mentioned shelter.

Security was a prominent need, in terms of both physical and psychological safety. Fifty participants specifically mentioned that having a lock on their room, door(s), or window(s) was essential for their sense of safety, while many others mentioned that the ability to securely store their belongings so they didn't get stolen was essential. With regard to security of tenure, many participants expressed that they were fed up with moving against their volition:

"A home that is mine that I'm not told to get out all the time"

With regard to personal safety, 20 respondents mentioned the need to be away from their former partner, with seventeen referencing domestic violence, and some additional respondents mentioned staying away from their friends and/or family.

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:

"Somewhere to live, not [be] in trouble with cops, and money"

"Stay away from people that are bad, away from drugs"

Stability and routine were mentioned by 173 respondents as necessary for them to be safe and well. Some referred to the need for stability to support their mental health, for others it was to support their sobriety, while many expressed a desire to have a routine for their children – either to regain custody of them or to get them back into school.

9.2.3 PHYSICAL AND MENTAL HEALTH NEEDS

Physical and mental health needs were also prominent. 437 respondents mentioned physical health and 415 mentioned mental health, and 224 of those mentioned both. Statements about access to healthcare or access to affordable healthcare such as "access to bulk-billed healthcare" or "affordable doctors" were common amongst the sample. In addition, many people wanted a regular General Practitioner (GP) or regular visits with a GP. Mental health needs included staying on medication, counselling, and access to support services including crisis support. Physical health needs were broader, ranging from surgeries, pain management and dental work to exercise, healthy meals and generally "being healthy". Finally, 130 respondents mentioned needs relating to substance abuse problems, such as staying away from drugs and/or alcohol, and rehab.

Resources were mentioned by 522 respondents. This mainly referred to financial resources; 260 respondents simply mentioned "money", though others expanded on this, mentioning financial security, stability, and/or a stable income. Driver's licences and/or a car were mentioned by 25 respondents. Many people also stated their reasons for needing resources to be safe and well, such as "to be able to buy food", "money for medications" or "money so as to avoid stealing out of cars".

9.2.4 LOVE AND BELONGINGNESS NEEDS

Love and belongingness needs refer to feeling like one has a place in society and that they give and receive love. Many participants mentioned friends and family as needs for them to be safe and well, or their family's safety as being essential for their own wellbeing. Many participants expressed a desire to regain or retain custody of their children, and indeed many stated that their need for shelter was related to getting their children back:

"A priority listing with Housing Authority to get shared custody of kids"

While several people expressed a desire to be left alone to look after themselves, more were cognisant of a need for social support, including from support services. Social support needs were expressed through statements such as "a good support network", "nice neighbours" and "maintain supports with agencies". Religious faith was also an important social support for some participants.

Sixty respondents expressed that their partner or finding a partner was important to their safety and wellbeing. This was expressed simply as "my partner" or "my wife" for those with partners they viewed as important for their safety and wellbeing, or "a good woman", "a girlfriend" or "a stable relationship" for those who were seeking a partner.

Love and belongingness are essential to human wellbeing (Lee & Robbins, 1995; Van Ryzin, Gravely & Roseth, 2009; Van Orden et al., 2008). Indeed, neuroscientific studies have indicated that the brain centres that respond to physical pain are similarly activated in response to social exclusion (Eisenberger, Lieberman & Williams, 2003). However, love and belongingness needs tend to only become salient upon fulfilment of physiological and safety needs (Maslow, 1943). This may serve to explain why love and belongingness needs were not mentioned very extensively by respondents in this sample. Almost half of the needs categorised into love and belongingness referred to the participants' children – either the participant remaining with their children, regaining access to their children, or maintaining a safe and stable home for their children's wellbeing. Individuals not experiencing homelessness are much less likely to have serious concerns about their children living with them or being safe because, in most cases, access to children and children's safety would be a given. In addition, love and belongingness needs were rarely mentioned in isolation (i.e. without mention of physiological or safety needs in the same answer). Therefore, it may be that because more basic needs such as shelter and food are unsatisfied, love and belongingness needs take a figurative back seat for our respondents.

Another potential explanation for the relatively low expression of love and belongingness needs are the social networks that homeless individuals develop on the street. Some studies find that homeless individuals' social networks can be quite similar on various attributes to housed individuals (Rowe & Wolch, 1990; Goodman, 1991). Other studies have found that a barrier to exiting homelessness is the loss of those social ties developed on the street or guilt at leaving friends on the street. Thus, it may be that due to the importance of social ties, some members of our sample develop social networks and feel the concomitant sense of belonging.

Cookie in his new home which was established during the 500 Lives 500 Homes campaign. Photography: Craig Holmes.

9.2.5 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 ascribed esteem which pertains to a personal sense of achievement and confidence, and externally ascribed esteem, which results from respect and recognition from other people. Esteem is necessary to feel capable, useful and necessary and, on the other side, to avoid feeling helpless.

Employment is often classed as an esteem need as a result of the achievement and recognition derived from one's work. In our sample, 518 respondents mentioned a desire for employment as necessary to their safety and wellbeing. Employment would certainly contribute to fulfilment of esteem needs, and the esteem expected from a job is evident in our sample through statements such as "getting back to work" and "getting work, getting my life back on track". However, it does appear that employment is viewed as more pertinent to satisfying safety and (to a lesser extent) physiological needs than to fulfilling esteem needs. Indeed, 87% of participants that expressed a need for employment also expressed a need for shelter, and several articulated that a job was a means to obtain stable income to allow them to obtain and sustain a tenancy:

> "Money, employment which leads to housing"
>
> "Job and house – know that I can pay my rent and survive"
>
> "Just a job – I would be set. Can't survive on Centrelink"

Expressions of achievement varied for our participants and included a desire to enter or re-enter education, having a sense of meaning and purpose, to generally "getting life together". For example:

"Be safe around people. Be included in society and the community"

Entertainment such as books, television, sports and music were mentioned by some participants as important to their safety and wellbeing, and 40 participants referred to the need for independence.

Esteem needs were substantially less prominent than physiological and safety needs in our sample. We believe that this can largely be attributed to the unfulfilled basic needs experienced in this population.

9.2.6 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, therefore, not surprising that, amongst a homeless population, shelter is overwhelmingly the most salient need. However, it is critical to note that housing is not the single requirement of addressing homelessness. This is demonstrated in our data by the fact that most participants express needs that go beyond shelter. In fact, as we illustrate in this chapter, most refer to the attainment of a life, not just a home.

"A roof on top of my head, to cook and to study to be able to move on with my life."

Therefore, housing can be seen as the critical, first step to facilitating the achievement of overall safety and wellbeing. The time that was previously spent looking for shelter and food will need to be filled, and the satisfaction of the fundamental needs gives rise to a desire for higher fulfilment – employment, education, respect, understanding, contribution. Consequently, support to achieve these 'higher' needs once housing has been attained is critical to ensure successful and sustained exit from homelessness.

Chapter Ten

CONCLUSION

Photography: Kieran MacFarlane

In 2008, an increased focus and recognition of the disadvantage and vulnerability faced by people experiencing homelessness, in particular, those without shelter 'sleeping rough' or in crisis and emergency accommodation; led the Australian Government to begin an ambitious long-term plan to reduce overall homelessness by half and provide supported accommodation to all rough sleepers who needed it, by 2020. The national policy priority outlined a whole-of-government commitment to expand services delivering prevention, early intervention and transitional support for those already homeless (Commonwealth of Australia, 2008). The creation of a national homelessness policy was an acknowledgement that previous responses to rough sleeping and homelessness more generally had been inadequate and largely unsuccessful.

The Road Home program of 2008 reinvigorated the homelessness sector in Australia and led to increased funding for housing programs and homelessness services. While the interest and engagement of governments to homelessness alleviation was to wane, a new network of agencies arose in 2010 working to end homelessness around Australia. These agencies, based largely in the inner city areas of capital cities across Australia, shared the principles of evidence-based responses to homelessness, a focus on Housing First and rapid re-housing, and the development of initiatives informed by robust data and research. They went on to form the Australian Alliance to End Homelessness. A Registry Week approach, following the US end homelessness initiatives, was adopted by these agencies in 2010 to build a register of those who were homeless in areas in which they operated so that those who were homeless were known by name, their housing and health needs recognised and local services organised to assist people into permanent housing. The Vulnerability Index instrument and following that the VI-SPDAT instrument was used in registry Week collections as the means of collecting data.

Between 2010- 2017, agencies undertook 8,618 interviews with 8,370 respondents (some respondents were interviewed more than once over time) across five states in Australia with people sleeping rough and staying in supported crisis and emergency accommodation and forms of temporary accommodation. This report is the first analysis of the consolidated Registry Week data across Australia, and provides the largest and richest collection of data on people experiencing homelessness in Australian capital and regional cities outside the Census and the Specialist Homelessness Services Collection. The Registry Week collection provides deep insights into the circumstances and needs of those experiencing homelessness and their service priorities.

The Registry Week data confirm again the high rate of homelessness among Indigenous people. Given that the vast bulk of surveys were conducted in inner city areas of Brisbane, Perth, Sydney, Melbourne and Hobart, the report indicates that Indigenous homelessness is an issue of deep concern in the inner city areas of both our capital cities as well as in regional, remote and very remote regions. The Report also highlights the deep links between Indigenous homelessness and the justice system. Two-thirds of those identifying as Indigenous in the Registry Week collections indicated that they had been in prison at least once in their life and more than a third report that they had been in juvenile detention at some point in their lives.

Veterans' homelessness in Australia remains an under-researched area. Veterans' status is not included in either the Census or Specialist Homelessness Services Collection and so the number of veterans experiencing homelessness or receiving support from a Specialist Homelessness service is not known. The present report reveals the depth of veterans' homelessness in Australia's cities. The true extent of veterans' homelessness is likely to be larger. While respondents were not asked whether they served in a theatre of operation they were asked whether they had 'ever served in the Australian Defence Force?' Respondents who answered yes to this question were listed as a veteran. There were 457 veterans who were interviewed as part of the Registry Week collection representing 5.6% of all respondents. Veterans were more likely to be rough sleepers than the general homeless population interviewed. They also had roughly similar lifetime experiences as non-veterans. However, veterans were more likely than non-veterans to have experienced brain injury or head trauma. Of the respondents that identified as veterans, 43% had suffered a serious brain injury or head trauma.

The Registry Week data aligns with findings in the literature that show homelessness to be associated with chronic disease and medical conditions linked to premature death as well as mental health conditions and alcohol and other drug misuse, and high rates of chronic disease. These conditions lead to an increase in A&E visits, ambulance use, and inpatient admissions. Many health conditions are associated with and worsened by risky lifestyle factors such as poor diet, tobacco smoking, and alcohol and other drug use. For example, as mentioned in Chapter 6, heart disease is a largely preventable disease through the introduction of improved lifestyle factors such as healthy eating and cessation of smoking. The social determinants of health recognise that people's lifestyle factors are often influenced by their environments. Improving people's access to environments that promote healthy lifestyle choices therefore has the opportunity to reduce healthcare costs in the long-term. Future strategies to improve people's health and therefore, reduce the over-representation of people experiencing homelessness in the healthcare system should consider creating service delivery models that promote healthy lifestyle choices.

Housing has been shown in our previous studies to have a positive impact on healthcare utilisation and healthcare costs over time (Conroy et al., 2014, Wood et al., 2016; Wood et al., 2017). With potential multi-departmental cost savings, there is a strong case for increased funding of ongoing programs that aim to not only prevent and reduce homelessness, but promote healthy lifestyle choices that support people to effectively prevent and manage mental illness and chronic physical conditions. Existing housing first approaches integrated with ongoing social and health support could result in healthcare cost savings over the longer-term (Zaretzky 2017; Wood et al., 2016).

While the data suggests that healthcare cost savings may be small for some people and larger for others, interventions that include people with current low healthcare costs may result in future cost saving by preventing the escalation of factors that could contribute to higher healthcare costs in the future and should therefore not be left out of broader strategies. Furthermore, those with low government costs in one area such as healthcare may in fact generate high savings elsewhere such as income support payments. Moreover, while existing priority rules for entry into resource-constrained housing programs have given some weight to those with significant medical conditions and high use of healthcare services, an aim of end homelessness campaigns in Australia is to eliminate chronic homelessness irrespective of healthcare cost impact. Finally, the evidence suggests that some people may actively avoid health services (in spite of a need for care) resulting in an escalation of poor health outcomes that could have been avoided through earlier interventions and pre-screening (Chau et al., 2012).

The current iteration of the VI-SPDAT does not include direct questions on diagnosed mental health conditions or include validated short instruments of mental health and well-being. Furthermore, future VI-SPDAT tool reiterations should consider including questions relating to healthcare services other than ambulances, A&E and in-patient

hospital stays, particularly primary care services and analyse the overlap between service use. In addition, a person's healthcare costs may change over time and/or be affected by seasons. VI-SPDAT data offers a snapshot of people experiencing homelessness throughout Australia and therefore, does not take into account variances that may occur over time. Further examination, preferably over a longer period is needed to provide stronger evidence to inform best practice interventions to tackle homelessness.

Homelessness, physical safety and interactions with the justice system intersect in a number of ways. A lack of physical safety in one's home (i.e., exposure to violence) is often a major contributing factor to a person's first homelessness experience, particularly amongst women and youth (Martijn & Sharpe, 2006; Baker, Billhardt, Warren, Rollins & Glass, 2010; Thielking et al., 2015). It is also well known that the homelessness often leads to experiences of traumatic events such as physical assault, sexual assault, forced behaviour and substance abuse (Goodman, Saxe & Harvey, 1991; Hopper, Bassuk & Olivet, 2010; Coates & McKenzie-Mohr 2010). These behaviours and their concomitant trauma can then interact to increase a person's risk of interacting with the justice system. In addition, interaction with the justice system (arrest or imprisonment) prior to a person's first homeless episode is correlated with longer duration and more frequent homelessness episodes (Caton et al., 2005).

Further, recent experiences of homelessness were found to be higher amongst the prison population in the United States, indicating that homelessness itself may place individuals at greater risk of imprisonment (Greenberg & Rosenheck, 2008). In Australia, one in four (25%) people entering prison reported being homeless in the 4 weeks prior to imprisonment, 19% of whom were in short-term or emergency accommodation and another 6% in unconventional housing or sleeping rough (AIHW, 2015).

A vicious cycle is evident here: a large proportion of homeless people have trauma or conditions that contributed to their first homeless episode and serve to increase the duration and repetition of their homeless episodes. Time spent without stable tenure, particularly rough sleeping, increases the likelihood of engaging in risky or coerced behaviour and, in turn, interacting with police and subsequent arrest and incarceration (Shinn, Knickman, & Weitzman, 1991; Booth et al. 2004). These adverse experiences on the street and/or in prison re-traumatise or, in cases where pre-existing trauma is not present, traumatise the individual. In addition, both the streets and prison pose threats to health. Prisoners have higher levels of mental health problems, risky alcohol consumption, tobacco smoking, illicit drug use, chronic disease and communicable diseases than the general population (AIHW, 2015). There are clear links between homelessness and health, with homeless people having an estimated 2-5 times higher mortality rates than the general population, especially from suicide and unintentional injuries. Homeless people also have higher rates of infectious diseases, chronic conditions, mental health issues and substance misuse, and accelerated ageing compared with the general population (Fazel et al. 2014).

Thirty-one per cent of prisoners in Australia reported that they expected to be homeless upon their release (AIHW, 2015). Consequently, homeless individuals who are incarcerated have to overcome significant individual and structural risk factors in order to exit homelessness. If they are able to address their mental and physical health issues (which have been created and compounded by their living situations), they now have a criminal record which presents a barrier to their economic participation.

This revolving door between prison and the street presents many opportunities for practice and policy. It supports the current Housing First policy: a stable tenancy will immediately reduce vulnerability and, consequently, the need to engage in risky or coerced behaviour to fulfil basic needs, thus reducing the likelihood of engaging in criminal behaviour of this nature. However, it is also clear that additional support will be required to maintain a tenancy. Homeless individuals are more likely to have experiences such as trauma, mental health issues, and physical health issues, both as precursors to and consequences of the homeless experience that make participating in society more difficult. Imprisonment and interaction with the justice system compounds these risk factors, increasing the likelihood of recidivism and repeat homelessness episodes. Therefore, in order to stop the revolving door, support services that address these needs and risk factors are essential.

With direct regard to policy, the crimes that homeless people commit are more likely to fall into the 'petty' categories rather than serious or violence crimes, and they are more likely to be imprisoned for these crimes than members of the general population committing crimes of this nature. A substantial proportion of the overall prison population also expect to be homeless upon release. Therefore, reforms to the criminal justice system that present alternatives to incarceration for crimes committed by those that are homeless, and particularly crimes that can be directly attributed to the person's homelessness (e.g., stealing food, trespassing), are indicated. In addition, the provision of housing support or transitional support upon release from prison for those that anticipate immediate homelessness would facilitate the closure of the revolving door.

Finally, it is critical in the development of policy and practice options in the future around programs to end homelessness in Australia to focus on the views of those experiencing homelessness. Our report ends with an analysis of the responses to the question: "What do you need to be safe and well?". We utilised Maslow's Hierarchy of Needs to examine the responses. Far and away the dominant response was housing and shelter. The wording of many responses was consistent with a Housing First approach: the need to have permanent accommodation and stability first so as to address other issues. However, most participants express needs going well beyond housing. In particular, the focus is on employment, respect, understanding, belonging: to get work and income, enter meaningful relationships, address health and alcohol and other drug needs and achieve safety. The responses of those experiencing homelessness provides the foundation for a holistic policy and practice response built around meeting the hierarchy of needs we all have.

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APPENDIX

Appendix Table 1
Number of responses in Queensland by location of interview, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	TOTAL
BRISBANE									
BRISBANE - INNER CITY SA4									
Brisbane Inner SA3	200	57	116	89	612	316	380	331	2,101
Brisbane Inner - East SA3	1	2	3	4	20	4	6	3	43
Brisbane Inner - North SA3	8	5	6	9	129	26	28	29	240
Brisbane Inner - West SA3	2	0	1	1	70	54	78	54	260
TOTAL	211	64	126	103	831	400	492	417	2,644
BRISBANE - NORTH SA4									
Bald Hills - Everton Park SA3	0	0	0	0	0	0	0	1	1
Chermside SA3	15	1	1	0	86	3	9	4	119
Nundah SA3	0	0	0	0	28	2	8	7	45
Sandgate SA3	6	5	2	0	21	6	1	2	43
TOTAL	21	6	3	0	135	11	18	14	208
BRISBANE - SOUTH SA4									
Holland Park - Yeronga SA3	5	7	8	8	57	33	40	42	200
Mt Gravatt SA3	0	0	1	0	79	14	17	9	120
Sunnybank SA3	0	0	1	0	39	33	63	18	154
Rest of Brisbane - South SA4	4	2	2	2	57	6	13	2	88
TOTAL	9	9	12	10	232	86	133	71	562
BRISBANE - EAST SA4									
Wynnum - Manly SA3	1	1	0	1	55	3	9	8	78
Rest of Brisbane - East SA4	0	0	1	0	3	1	1	11	17
TOTAL	1	1	1	1	58	4	10	19	95
BRISBANE - WEST SA4	5	0	2	5	40	4	4	4	64
ALL BRISBANE	247	80	144	119	1,296	505	657	525	3,573
REST OF QUEENSLAND									
Cairns SA4	13	0	0	0	0	0	0	0	13
Gold Coast SA4	0	0	1	5	1	0	0	0	7
Ipswich SA4	1	0	3	1	49	12	14	4	84
Logan - Beaudesert SA4	2	1	0	0	27	7	10	7	54
Moreton Bay - North SA4	0	0	1	0	2	0	1	1	5
Moreton Bay - South SA4	1	0	1	0	8	1	7	0	18
Toowoomba SA4	0	0	0	0	8	0	0	0	8
Townsville SA4	39	0	0	0	0	0	0	0	39
Other QLD	12	29	23	8	102	69	38	29	310
REST OF QUEENSLAND	68	30	29	14	197	89	70	41	538
QUEENSLAND	315	110	173	133	1,493	594	727	566	4,111

Source: Registry Week Data Collections 2010-2017

Appendix Table 2
Number of responses in Western Australia by location of interview, major collection years

	2012	2014	2015	2016	2017	TOTAL
PERTH						
PERTH - INNER SA4						
Perth City SA3	173	155	198	500	276	1303
Cottesloe - Claremont SA3	1	0	0	13	3	17
TOTAL	174	155	198	513	279	1,320
PERTH - SOUTH WEST SA4						
Fremantle SA3	0	0	0	80	18	98
Rockingham SA3	1	0	0	32	1	34
Rest of Perth - South West SA4	0	1	0	6	3	10
TOTAL	1	1	0	118	22	142
PERTH - NORTH WEST SA4	0	2	0	18	8	28
PERTH - NORTH EAST SA4	4	19	18	32	5	78
PERTH - SOUTH EAST SA4	2	3	18	21	7	51
PERTH	181	180	234	702	321	1,619
REST OF WESTERN AUSTRALIA						
Mandurah SA4	3	0	0	0	0	1
Other WA	6	0	4	0	10	18
REST OF WESTERN AUSTRALIA	9	0	4	0	10	19
WESTERN AUSTRALIA	190	180	238	702	331	1,638

Source: Registry Week Data Collections 2010-2017

Appendix Table 3
Number of responses in New South Wales by location of interview, major collection years

	2010	2011	2012	2013	2014	2015	2016	TOTAL
SYDNEY								
SYDNEY - CITY AND INNER SOUTH SA4								
Sydney SA3	290	77	46	48	1	445	1	909
Rest of Sydney - City and Inner South SA4	7	0	0	1	0	0	0	8
TOTAL	297	77	46	49	1	445	1	917
SYDNEY - OUTER WEST AND BLUE MOUNTAINS SA4								
Blue Mountains SA3	0	0	17	2	15	0	8	42
Penrith SA3	2	0	77	4	45	1	55	185
Richmond - Windsor SA3	0	0	18	3	6	0	15	42
St Marys SA3	0	0	0	0	0	0	3	3
TOTAL	2	0	112	9	66	1	81	272
SYDNEY - INNER WEST SA4	2	0	1	0	0	1	0	4
SYDNEY - INNER SOUTH WEST SA4	3	0	0	0	0	5	1	9
SYDNEY - SOUTH WEST SA4	1	0	0	0	0	0	1	2
SYDNEY - EASTERN SUBURBS SA4	8	2	4	0	0	0	39	53
SYDNEY - PARRAMATTA SA4	2	0	0	0	0	2	0	4
SYDNEY - SUTHERLAND SA4	0	0	0	0	0	18	13	31
SYDNEY - NORTHERN BEACHES SA4	1	0	2	1	0	0	1	5
SYDNEY - NORTH SYDNEY AND HORNSBY SA4	8	1	1	0	0	3	0	13
SYDNEY - BLACKTOWN SA4	0	0	16	0	4	2	0	22
SYDNEY - BAULKHAM HILLS AND HAWKESBURY SA4	1	0	18	0	1	0	1	22
SYDNEY	325	80	200	59	72	477	138	1,354
REST OF NEW SOUTH WALES								
Newcastle and Lake Macquarie SA4	0	0	0	0	0	0	49	53
Other NSW	6	8	21	3	3	58	16	115
REST OF NEW SOUTH WALES	6	8	21	3	3	58	65	168
NEW SOUTH WALES	331	88	221	62	75	535	203	1,522

Source: Registry Week Data Collections 2010-2017

Appendix Table 4
Number of responses in Victoria by location of interview, major collection years

	2010	2011	2012	2013	2014	2015	2016	2017	TOTAL
MELBOURNE									
MELBOURNE INNER SA4									
Melbourne City SA3	103	107	40	100	16	132	118	17	633
Port Phillip SA3	32	15	9	26	13	11	30	0	136
Rest of Melbourne Inner SA4	10	16	3	16	1	6	12	3	67
TOTAL	145	138	52	142	30	149	160	20	836
MELBOURNE - INNER EAST SA4	0	2	0	0	0	0	0	0	2
MELBOURNE - INNER SOUTH SA4	0	0	1	0	0	0	2	0	3
MELBOURNE - NORTH EAST SA4	0	1	0	1	0	2	0	0	4
MELBOURNE - NORTH WEST SA4	0	0	0	1	0	0	0	0	1
MELBOURNE - OUTER EAST SA4	0	1	1	0	3	2	0	0	7
MELBOURNE - SOUTH EAST SA4	1	0	0	1	0	0	0	0	2
MELBOURNE - WEST SA4	9	8	0	1	0	0	2	9	29
MELBOURNE	155	150	54	146	33	153	164	29	884
REST OF VICTORIA	11	5	5	10	2	4	2	0	39
VICTORIA	166	155	59	156	35	157	166	29	923

Source: Registry Week Data Collections 2010-2017

Appendix Table 5
Number of responses in Tasmania by location of interview, major collection years

	2011	2012	2013	2014	2015	2016	2017	TOTAL
HOBART								
HOBART SA4								
Hobart Inner SA3	48	90	48	41	36	25	11	299
Hobart - North West SA3	8	6	9	5	12	3	0	43
Hobart - North East SA3	0	3	0	6	6	2	0	17
Hobart - South and West SA3	0	3	0	0	0	0	0	3
HOBART	56	102	57	52	54	30	11	362
REST OF TASMANIA	5	5	4	3	3	2	0	22
TASMANIA	61	107	61	55	57	32	11	384

Source: Registry Week Data Collections 2010-2017

Contact Address

Professor Paul Flatau, Centre for Social Impact The University of Western Australia (M098), UWA Business School, University of Western Australia, Crawley, WA, 6009.

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