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PRIMARYCARE
Better Health - Better Life

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HoTS
Health on The Streets
a CCPC Initiative

Health on The Streets

Supporting Documentation for Business Case

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Coast & Country Primary Care

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Coast & Country PRIMARYCARE
Better Health - Better Life

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Foreword

In March 2019 Coast & Country Primary Care secured Federal funding to pilot the Health on The Streets (HoTS) program. The funding was secured through an Expression of Interest to Ms Lucy Wicks, Federal Member for Robertson, and granted under the Community Health and Hospitals Program (CHHP) with a contract executed in October 2019.

HoTS was born from our years of providing non-clinical Assertive Homeless Outreach (AHO) under the Partners in Recovery (PIR) program from 2013-2018. Due to changes to PIR's guidelines in 2018, when the focus shifted to transitioning clients to the NDIS, our AHO activities could no longer be supported despite a growing need for homeless outreach. Figures from the Australian Bureau of Statistics (ABS) shows that homelessness on the Central Coast increased by 35% between 2011-2016.

People experiencing homelessness are recognised as having a higher frequency of chronic health conditions and greater instances of comorbidities than the general population. As a result, this group of people will often present at public hospitals or other health care institutions with complex or critical conditions due to neglect of their own health care. It is also well known that if someone within this cohort lives with mental illness, they often fail to monitor their mental health or comply with medication. In these circumstances people will often decompensate and come to the attention of the public, requiring police or emergency service intervention, hospitalisation, and lengthy treatment in a public hospital setting.

HoTS addresses many of these issues through the provision of healthcare services, assessments and supports from a custom van which travels to rough sleeper hotspots and responds to community referrals. HoTS also provides screenings, health planning, mental health assessments, drug and alcohol assessments, sexual health assessments, and appropriate interventions.

Through our years providing AHO we recognised the challenges faced by people experiencing homelessness, accessing basic healthcare being one of those challenges. By engaging a registered nurse, teaming them with experienced outreach workers, and providing them with a custom-fit van, the team is able to go into the community where people are sleeping rough and provide on the spot care and referrals.

Many homeless services are confined to a specific locality, limiting access due to the myriad of barriers faced by rough sleepers and those with transient housing, including lack of transportation, isolation, or previous negative experience. Being a mobile service, HoTS is flexible and adaptable to a person's circumstances, making it better suited to meet the needs of this cohort and to provide an effective and efficient multi-disciplinary approach to the complex issue of homelessness and health.

Since establishing HoTS in March 2020, we have established trusting relationships with clients through our professionalism, integrity, and by being able to deliver what we promise. This cohort is one that is highly wary of outsiders, but open with sharing information between one another. The relationships we have built have enabled us to assist our clients to actively identify and engage with primary care providers and appropriate allied health services.

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The pilot included several key objectives and key outcomes, as listed below, to measure the impact of the pilot program.

Key Objectives:

- Reduce hospital demand.
- Reduce the medical, psychological, and financial burden of the homeless and those sleeping rough on individuals and the community.
- Promote mental health and wellbeing.
- Assure the rights of people with mental health problems and mental illness and enable them to participate in society.

Outcomes:

- Lessen the impact of physical and mental health issues on the individual and the health system; including lessening the demand on hospital services and reducing the stigma that surrounds mental health issues.
- Provide homeless people and those sleeping rough with access to medical and psychological and homeless outreach services in the location where they are (including referrals to other services) and assist them to participate in society.
- Improved health outcomes for homeless people and those sleeping rough.

The interactions completed by the HoTS team have diverted non-urgent cases from hospitals, reduced emergency hospital admissions, and improved health care and the general state of physical and mental health across the population.

In March 2020, when the COVID-19 Pandemic locked down the Central Coast within one week of launching the program, the HoTS team focussed on assertive outreach and did not undertake clinical interventions, to ensure the health and safety of staff and clients was prioritised. Clinical interventions were reintroduced in July 2020.

In combination with our clinical services, our outreach team has enhanced the opportunities of homeless and rough sleepers by assisting them to access appropriate services, such as accommodation, social security, and rehabilitation services, to name a few.

Taking referrals from community services, politicians, council, and first responders, the HoTS team is often the first line of contact for people experiencing homelessness; the first step in getting them on the journey to regain their hope.

The program is currently funded until 30 June 2022.

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Market Description

Homelessness is not just the result of too few houses – its causes are many and varied. Domestic violence, a shortage of affordable housing, unemployment, mental illness, family breakdown and drug and alcohol abuse all contribute to the level of homelessness in Australia (FaHCSIA, 2008a). Homelessness is not a choice (ABS 2012).

Homelessness on the Central Coast

When looking specifically at homelessness on the Central Coast, we have used a variety of data sources to develop a picture that shows homelessness rising, comorbidities across the population, and prolonged time experiencing homelessness.

A publication by Central Coast Council from 2019 shows a 35% increase in homelessness across the region from 2011 to 2016, to between 4,100 to 8,500 people who are homeless or marginally housed. Although the rate of homelessness is lower than metropolitan regions, the rate of homelessness grew at twice the rate in our region. Worryingly, 40% of those experiencing homelessness in the region have been homeless for longer than three months; three times the national average of homelessness (one month).

Homelessness NSW shows that in NSW visible homelessness, those sleeping rough (without a bed eg. cars and outdoors) is 7%, indicating that there are between 287 and 595 rough sleepers on the Central Coast, with the remainder experiencing less visible homelessness.

The following statistics from Coast Shelter from their 2017-2018 Accommodation Survey provide a real-world snapshot of homelessness on the Central Coast during that time.

- Number of people provided with accommodation: 807
- People in need that were able to be provided with accommodation: 20%
- Percentage of people seeking accommodation that were women: 62%
- Percentage of people seeking accommodation that were children (accompanied by a parent): 40%
- Percentage of people experiencing homelessness due to violence or domestic abuse 39% (the largest cohort of people seeking assistance)
- Largest age demographic seeking accommodation: 15-17 year olds
- Percentage of people accommodated who identified as being Aboriginal and/or Torres Strait Islander: 25%

In November 2019, NSW Health Department of Communities and Justice undertook a collective impact survey of rough sleepers on the Central Coast. Of the people they surveyed, their findings include:

- The average age of homelessness was 49 years old.
- People experienced homelessness 1.54 times in the year prior to the survey.

- The average number of years spent sleeping rough was 5.46 years.
- The average age people first experienced homelessness was 31 years old.
- 50% avoid seeking healthcare when unwell.
- 16% have a physical disability.
- 60% experience dental problems.
- Depression, anxiety, and PTSD represent the most common mental health diagnoses.
- Over 60% experience problematic drug and alcohol use.
- 50% have a tri-morbidity of mental health, substance abuse, and a chronic health condition.

Registry Week

The Registry Week data has been collected using the Vulnerability Index (VI) instrument followed by the VI-SPDAT (Service Prioritisation Decision Assistance Tool). Over the seven years that the VI-SPDAT was administered (2010-2017), 8,618 interviews were conducted with 8,370 people who were experiencing homelessness across Australian capital cities and regional centres.

Based on information collected in Registry Week, a national average cost and mean cost per person of hospital and ambulance usage amongst the homeless has been calculated as follows:

- Ambulance: $3,268 per person/six months
- Emergency Department Admission: $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).

Across a twelve-month period mean total health costs are as high as $50,000 per person.

The data collected showed that the frequency with which these services are being accessed includes:

- 27.1% reported three or more visits to emergency
- Rough sleepers were more likely to report three or more visits to emergency (29.9%) than non-rough sleeping homeless people (24.9%)
- 59.7% of Registry Week participants did not have a hospital admission in the six months prior to the survey
- For those who did have an in-patient admission, the mean number of admissions over the six month period was 2.91.
- 58.8% of people surveyed had not used an ambulance in the previous six months.
- For those who did use an ambulance, the mean number of trips was 3.45 trips to the hospital.

People experiencing homelessness, and those at risk of homelessness, are not simply numbers or statistics, they are individuals who, for whatever reason, have become disconnected from their communities and have consequently lost their capacity to return to an independent life. Assertive outreach programs are designed to meet this problem and are based on the principles of enabling a flourishing life.

For example, figures from the Fifth National Hepatitis C Strategy 2018–2022 show that early intervention and treatment of Hepatitis C produces a savings of $4 for every $1 spent. The HoTS team have completed 166 Hepatitis C tests in their first 15 months and have supported 16 people to commence treatment. These figures also do not include the implied impact of assertive homeless outreach services providing the 'exit pathway out of homelessness'.

Stakeholders

We have strong relationships with a variety of stakeholders who are very supportive of the HoTS program. As well as referring people to our program, our stakeholders also promote the program's services and outcomes, increasing community awareness.

The following list represents key stakeholders for the HoTS program.

Governments:

- Federal
  - Federal Member for Robertson, Lucy Wicks
  - Federal Member for Dobell, Emma McBride
- State
  - State Member for Gosford, Liesl Tesch
  - State Member for Terrigal, Adam Crouch
  - State Member for The Entrance, David Mehan
  - State Member for Wyong, David Harris

Peak Health Bodies:

- Primary Health Network
- Local Health District
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)

Homeless Service Providers:

- Coast Shelter
- Mary Macs
- Wyong Neighbourhood Centre
- Toukley Neighbourhood Centre
- OASIS (Salvation Army)
- Specialist Homelessness Services (SHS) Uniting, CRT, Doorways (centre-based) and Connector response team (assertive outreach)
- Specialist Homelessness Services (SHS) Bungree, Wesley Mission, Baptist Care

First Responders:

- Police
- Ambulance
- PACER – Mental Health Credential Nurse and Police teams
- Local Health District Mental Health Liaison Officer

Governments Departments and Councils:

- Central Coast Council
- National Parks & Wildlife Service

Primary, Tertiary, and Allied Health:

- General Practitioners
- Pathology
- Gosford and Wyong Hospitals – social workers, OTs, ER Doctors, etc.

Mental Health and Community Services:

- Detox centres – Marumali (Wyong)
- The Glen Centre
- Salvation Army Dooralong
- Kamira
- Parramatta Mission – Community Living Supports
- Central Coast Homeless Interagency

CCPC Internal Stakeholders:

- Board
- Management
- Staff

Along with the extensive list of stakeholders, the Central Coast Community is a key stakeholder for the HoTS program. Community awareness of the program has grown considerably since its inception, and the support shown by the community is evident in the frequent requests we receive from individuals, businesses, and community groups to get involved.

To date, we have received small donations of goods from the following businesses and groups:

- Douglas Hanley Moore
- Radiometer
- Bunnings Erina
- The Rotary Club of The Entrance
- Hats for Homeless
- The Salty Salon
- Woolworths Erina
- Shoebox Revolution

Competitor Analysis

There are no other services in the Central Coast region that provide Clinical Outreach to people experiencing homelessness. We have found examples of similar services in other parts of Australia, all of which are in capital cities and focus on medical outreach. To our knowledge, HoTS is the only Clinical Outreach service in the country and it is located in a regional area.

Based on our research, the Homeless Medical Outreach services found in capital cities are typically not run full time but only provide a few hours or days each week. Many of these services don't accept referrals or offer assertive outreach to link people up with ongoing support services that may help them gain housing, employment, or other basic needs.

The Medical Outreach programs we have identified around the country include:

- Street Side Medic, Sydney
- St Vincent's Hospital Homeless Outreach Team, Sydney
- Sunny Street, Brisbane
- Freo Street Doctor, Perth
- cohealth Street Doctor, Melbourne

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Extension of Pilot

Program Overview

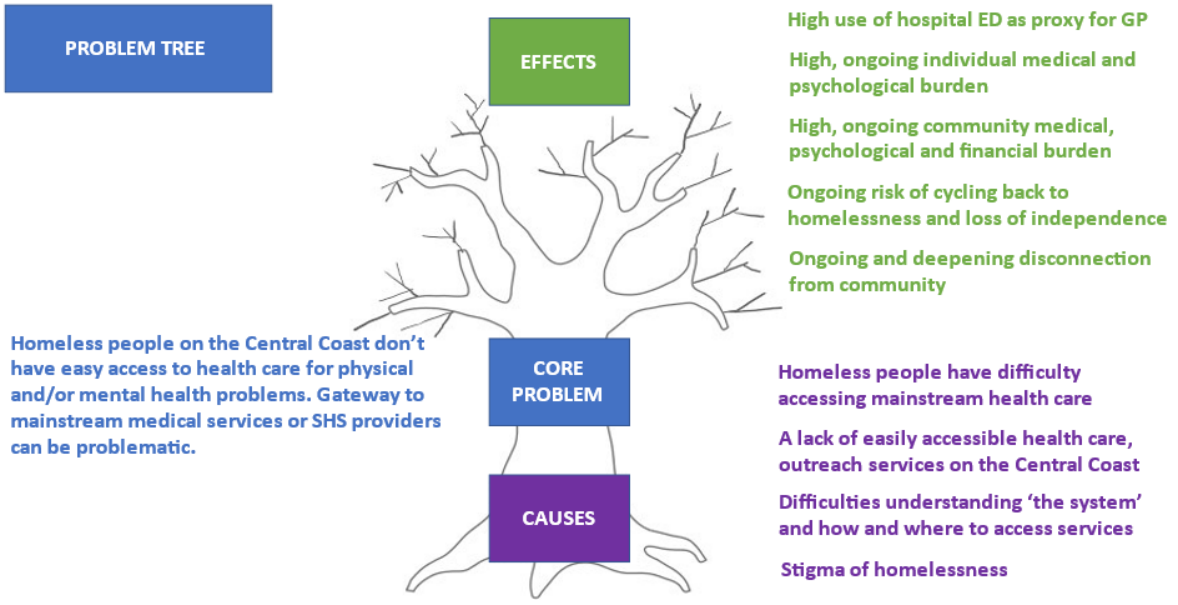
Health on the Streets (HoTS) is an assertive outreach and health care program, currently being piloted on the Central Coast, New South Wales. The pilot began in March 2020 and is set to conclude in July 2022. It is a mobile service, delivered out of a specially converted high roofed vehicle, providing primary health care, outreach, and referral services to the homeless and those at risk of homelessness in the locales of Wyong and Gosford. The service is staffed by trained clinical and outreach personnel and provides assessment, care coordination, clinical intervention, advocacy and refers to a strongly supportive network of health and community-based services including those provided by Coast & Country Primary Care (CCPC).

The regular and ongoing availability of this mobile service builds trust and rapport across this group of people, who are vulnerable and often suspicious, encouraging them to access regular health care – both physical and mental - and Specialist Homelessness Services (SHS). The overall vision for the program is to bridge the gap in health care for homeless people and facilitate and enable the vulnerable and disconnected to re-establish connection to mainstream society.

Currently the HoTS program is funded under the generalist Community Health and Hospitals Program (CHHP) (Mental Health) launched by the Morrison government in 2018, immediately prior to the federal election. The CHHP, aims to reduce pressure on hospitals and build capacity at community level, was implemented shortly after Morrison formed a new government in 2019.

Problem and Solution Trees

We have undertaken a problem tree analysis to map the cause and effects of homelessness and determine appropriate solutions for this cohort.



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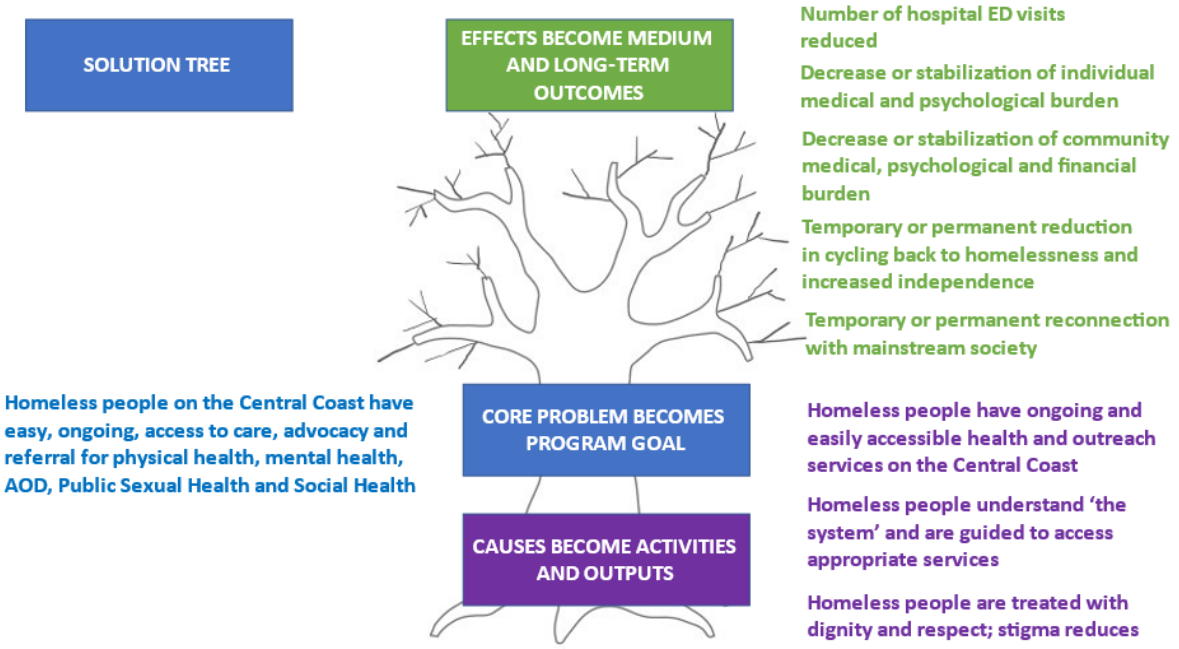

Funding Extension

As this is the first clinical outreach program in the country, we are seeking a three-year extension to allow us to capture further data to assess the impact of the program on improving health outcomes for people experiencing homelessness and the associated impact of reduced healthcare cost to the commonwealth due to early interventions.

We have undertaken a needs analysis to determine the additional services needed to better deliver healthcare to people experiencing homelessness. The needs analysis identified that increased clinical capability at point of care assessments, along with increased hours of service and a broader range of healthcare professionals, will help to break the cycle of homelessness.

The first finding was the need to increase point of care assessments and treatments. Throughout the pilot, we have found that following up with clients can be challenging. This can be due to a range of factors such as episodic mental health, lack of contact or transport, or the transient nature of this cohort. For example, we can take blood samples and do assessments, but then tracking them down to follow up with results is difficult. Considering it can take several months to build trusting relationships, increased clinical capacity at point of assessment will reduce the need for follow ups and provide swifter response to healthcare needs.

Secondly, we have identified a need to engage a broader range of healthcare professionals, such as dental, podiatry, and optical. When providing clinical care, we repeatedly see issues with dental health, foot health, and vision and connecting the clientele with these services can prove challenging. By increasing our capacity to engage these services and have them in the HoTS van with the team, we can ensure a more holistic approach and provide care at the point of assessment.

Finally, increasing program hours to include afterhours services on evenings and weekends will allow us to expand our reach. The program in its current form, provides services during business hours, with

three staff dedicated to the program: a Team Leader, a Registered Nurse, and an Outreach Worker. Under the pilot extension, we would seek to add an additional registered nurse and outreach worker. Extending our hours of service to evening and weekends will allow us to engage with people more who are not currently accessing mainstream specialised homeless services. Anecdotal evidence from the HoTS team suggests that rough sleepers may 'bunk down' during the day and be more active and visible of an evening when the streets are quieter.

Referral Pathways

Should our funding be extended for an additional three years, we would focus on increasing referral pathways to take pressure off other service Broadening and streamlining referrals would provide a benefit to the clients receiving our services and lessen the impact on existing services, such as police, ambulance, hospital emergency departments, and specialist homeless services.

Sponsorship

We are keen to develop a Sponsorship Plan to generate additional revenue and to increase community participation.

Since the commencement of the program, we have received many queries from local businesses asking how they can get involved. To date, we have received a number of small donations, such as haircut vouchers or knitted beanies, but would like to implement a more coordinated approach to raise additional funds for the program.

The funds raised through a sponsorship program would contribute to additional items that are currently outside the scope of the program, but integral to supporting our clients. This can include:

- Medication
- Medical aids to assist with physical disabilities or medical conditions
- Engagement of specialists and general practitioners to attend hubs
- Fuel vouchers
- Pre-paid public transport cards
- Short-term accommodation
- Mobile phones with a pre-paid sim card
- Food hampers

Risks

Risk	Description	Likelihood	Consequence	Control	Strategy
Workforce	Inability to secure suitably qualified staff.	Unlikely	Very High	Low	1. Robust recruitment and selection strategy. 2. Ensure rate of pay is competitive. 3. Identify and select from existing pool of staff.
Retention	Loss of key staff.	Possible	High	Moderate	1. Develop robust orientation program. 2. Communicate a clear vison for the future and growth opportunities. 3. Development of succession plan. 4. Invest in staff training and development. 5. Engage staff in positive organisation culture.
Standard of Care	Provision of care does not meet acceptable professional standards.	Unlikely	Very High	High	1. Quality audits conducted. 2. Documented policy and procedures outlines legal requirements and standards relating to service delivery and documentation. 3. Consumer surveys conducted annually. 4. Retain accreditation against standards. 5. Scheduled Clinical Governance Committee meetings held.
Culturally appropriate service	Service delivery does not meet the needs of specific cultural groups.	Possible	Moderate	High	1. Staff culture awareness training 2. Client feedback mechanisms and surveys conducted 3. Strong focus on stakeholder engagement. 4. Agreements / contracts / pathways in place for service delivery 5. Monthly monitoring of service provision. 6. Regular meeting with key stakeholders.
Safety and Security	Risk to staff and others when engaging in clinical outreach.	Possible	Moderate	High	1. Risk assessments conducted prior to service delivery 2. Staff, contractor and client feedback mechanisms. 3. Clinical risks reviews at Clinical Governance Committee meetings. 4. Appropriate policies and procedures implemented relating to risk and safety. 5. Emergency procedures established.
Failure to meet outcomes	Performance indicators and/or targets not met	Unlikely	Moderate	High	1. Monitoring of activity monthly and reported to Board. 2. Quality Improvement activities conducted. 3. Regular scheduled meetings with funding body. 4. Established relationship with key stakeholders. 5. Clear referral pathways established. 6. Marketing and communications strategy implemented.
Failure to secure ongoing funding	Unable to sustain service delivery	Possible	Very high	Moderate	1. Monthly financials provided to Board. 2. Realistic allocation of resources. 3. Experienced Chief Financial Officer currently employed at CCPC. 4. Strong relationship with funding body. 5. Delivery of expected outcomes. 6. Explore alternate sources of funding.

Conclusion

Under the extension of the pilot, we will expand the scope of service to reflect the need in the community. The expanded scope will allow a higher volume of referrals, increase point of care clinical capability, broaden the scope of clinicians servicing this cohort, and deliver services for extended hours on evening and weekends.

By broadening the scope of services, we will be better placed to complete an evaluation at the end of the extension that can act as a model for future healthcare-led assertive outreach programs across Australia.

Many homeless people begin their descent into homelessness in poor health, and oftentimes it is this poor health that can exacerbate their inability to remain connected to, or reconnect with, the social world. Typically, people remain connected to mainstream health services in the early stages of homelessness. However, as they cycle into a more permanent state of homelessness, simple health problems can develop into more complex, and more entrenched, problems. More complex health problems not only jeopardise the individual's return to independence, but they also result in higher utilisation of the health care system and the associated costs of complex medical care.

On the other hand, with early intervention and ongoing support, individuals are able to 'take control' of their own health needs. This sense of control, in turn, empowers them to access mainstream primary health care on a regular basis, thereby reducing reliance on the hospital and emergency. The consequences of homelessness compounds ill health. Ill health, in turn further excludes people from adequate health care.

Homelessness proves to be a significant cost burden to the health system, particularly to the acute health care system, due to the vulnerability of homeless individuals, particularly rough sleepers. Early intervention in terms of healthcare reduces the burden to the public health system and reduces the cost both in the short term and long term.

HoTS has the potential to save the public health system more than $5.6M over 3 years. This saving is a direct result of reducing the frequency that rough sleepers access emergency and hospital services but does not factor in the long-term cost savings and social benefits of treating conditions such as cirrhosis of the liver, schizophrenia, and gonorrhoea, nor does it include the impact of the outreach component getting people housed and participating in mainstream society.

Health on The Streets is a unique and effective program. While it has achieved some great outcomes in its first 15 months, extending the funding to this pilot program will ensure that some of the most vulnerable people in our community continue to receive critical clinical services that improve their quality of life and reduce the burden on the public health system.

Appendix 1 – About CCPC

Coast & Country Primary Care (CCPC) is an experienced not-for-profit organisation that has been providing programs and services that help our community since 2001. Our vision, Better Health Better Life, is at our core and we live that vision every day through the delivery of a broad range of programs and services that improve health and wellbeing to over 85,000 people annually.

As a leading provider of Mental Health and Community Services on the Central Coast, 2020 saw us further expand across New South Wales, with programs and services now being delivered in Taree, Forster, Port Macquarie, Kempsey, Coffs Harbour, and Grafton.

Our collaborative and innovative approach ensures that our clients are supported to improve their health and well-being, increase their sense of community inclusion and participation, and to increase their resilience and independence.

CCPC is governed by a Board of Directors, providing a balanced mix of health, business and financial management experience. This is complimented by an executive team with extensive experience and a strong understanding of the regional healthcare environment.

We have extensive frameworks to effectively manage risk, finances, governance, and quality. Our Governance framework ensures that we remain aware of changing legislation, compliance obligations, macro policy and best practice service delivery requirements to ensure our services remain current and legally compliant.

Our Risk Management Framework minimises risks to our organisation, funders, and individuals, protects our assets and interests, and limits the impact of any unavoidable risk. At regular intervals, our strategic and high-level operational risks and incidences are monitored and reviewed using a risk management matrix to ensure that controls are appropriate and effective and that emerging risks are captured. Our framework is integrated through internal audits, business planning, setting of roles and responsibilities, strategic planning, and program management.

Our Quality Management System comprises of established, documented, and implemented quality policies and related procedures. These policies and procedures set the requirements for providing services which meet our customer requirements, whilst satisfying the requirements for accreditation and industry standards.

CCPC has an established Clinical Services Governance Committee, reporting to the Board, that meets regularly to provide leadership and oversight of the safety and quality of care provided by CCPC. The Committee has documented Terms of Reference and its membership includes general practitioners, allied health, management, and Board.

We hold accreditation against ISO Quality Management Standards 9001:2015; National Home Care Standards; RACGP General Practice Standards; NDIS Quality and Safeguarding Practice Standards. External financial and quality audits are conducted each year.

Appendix 2 - Cultural Competency

CCPC is committed to ensuring that our staff work in a way that is culturally safe and respectful. Approximately 16% of HoTS clients identify as Aboriginal or Torres Strait Islander. We have an established and endorsed Reconciliation Action Plan (RAP) in place which is a strategic document that supports our business plan. Implementation of the following activities highlight our strengths:

- All employees and Board members must undertake online "Share Our Pride" training modules prior to commencing employment.
- An ATSI Employment and Retention Strategy exists and is embedded within our Business Management System.
- Where appropriate we ensure our recruitment is conducted for identified roles and job advertisements include the statement, 'Aboriginal and Torres Strait Islander people are encouraged to apply'.
- Recruitment and induction processes provide support and opportunity for self-identification.
- Policies and procedures exist to ensure there are no barriers to staff participating in NAIDOC week, other cultural events, and "sorry business".
- Aboriginal and Torres Strait Islander artwork that represents the mission and values of CCPC is displayed in the office.
- The employment of many ATSI staff in our Aboriginal and mainstream programs and services shows our continual commitment in demonstrating the importance that culture, community, health and wellbeing play in integrating a collaborative workforce approach.

Our staff are provided opportunities to enhance their cultural responsiveness through professional development and our management team are committed to our cultural framework, with monthly management meetings receiving updates from our internal RAP Committee which ensures we provide a culturally safe and supportive environment. Our staff regularly participate in local ATSI events and represent CCPC on committees, forums, and working groups within the local ATSI community.

CCPC is committed to ensuring input from Aboriginal people through continued engagement with community and providers, ongoing investigation of opportunities for improved service provision, employment of identified persons (including a local Aboriginal Elder), cultural awareness training provided through local ATSI community and an Aboriginal Elder, and consistent policy and planning reviews conducted by our RAP Committee and Management team.

We are proud of our connectivity with the Central Coast Aboriginal community, and this is supported through strong partnerships and engagements with Aboriginal Organisations and service providers on the Coast. We engage with Aboriginal Elders to deliver the best approach for local messaging. We produce documents and resources within guidelines for culture sensitivity, hold presentations of Aboriginal Health Programs and Services at staff meetings and external events, and conduct consumer surveys.

Appendix 3 – Additional Homelessness Statistics

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 according to the Australian Bureau of Statistics (ABS). 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. The ABS also shows 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.

A more detailed review of census data provided the following information:

- There were 116,427 people enumerated in the Census who are classified as being homeless on Census night (up from 102,439 persons in 2011);
- The homeless rate was 50 persons for every 10,000 persons enumerated in the 2016 Census, up 5% from the 48 persons in 2011 and up on the 45 persons in 2006;
- The homelessness rate rose by 27% in New South Wales, while Western Australia fell 11% and Northern Territory and Australian Capital Territory each fell by 17%;
- Most of the increase in homelessness between 2011 and 2016 was reflected in persons living in 'severely' crowded dwellings, up from 41,370 in 2011 to 51,088 in 2016;
- The number of people spending Census night in supported accommodation for the homeless in 2016 was 21,235, little change to those in 2011 (21,258 persons);
- There were 17,503 homeless persons living in boarding houses on Census night in 2016, up from 14,944 in 2011;
- The number of homeless persons living in improvised dwellings, tents or sleeping out in 2016 was 8,200, up from 6,810 in 2011;
- People who were born overseas and arrived in Australia in the last 5 years accounted for 15% (17,749 persons) of all persons who were homeless on Census night in 2016;
- The rate of Aboriginal and Torres Strait Islander peoples who were homeless was 361 persons for every 10,000 of the Aboriginal and Torres Strait Islander population, a decrease from 487 in 2011;
- Homeless youth (aged 12 to 24 years) made up 32% of total homeless persons living in 'severely' crowded dwellings, 23% of persons in supported accommodation for the homeless and 16% of persons staying temporarily in other households in 2016;
- Nearly 60% of homeless people in 2016 were aged under 35 years, and 42% of the increase in homelessness was in the 25 to 34 years age group (up 32% to 24,224 persons in 2016);

The number of homeless persons aged 55 years and above has steadily increased over the past three Censuses, from 12,461 in 2006, to 14,581 in 2011 and 18,625 in 2016 (a 28% increase between 2011 and 2016). The rate of older persons experiencing homelessness has also increased, from 26 persons per 10,000 of the population in 2011 up to 29 in 2016.

Among those people who were not classified as being homeless on Census night but were living in some form of marginal housing and may be at risk of homelessness, the number of people living in

other improvised dwellings increased moderately by 20% to 5,401 persons in 2016, and the number of people living in crowded dwellings requiring three extra bedrooms jumped 33% to 80,877 in 2016, while the number of people marginally housed in caravan parks fell by 18% to 10,685 persons in 2016 (ABS 2021: online).

Registry Week

The Registry Week data has been collected using the Vulnerability Index (VI) instrument followed by the VI-SPDAT (Service Prioritisation Decision Assistance Tool). Over the seven years that the VI-SPDAT was administered (2010-2017), 8,618 interviews were conducted with 8,370 people who were experiencing homelessness across Australian capital cities and regional centres.

In New South Wales the vast majority of collections were undertaken in inner city Sydney although data was collected from Penrith Nepean region in 2012, 2014, and 2016 as well as sporadic data from Bondi and Lake Macquarie. This data, covering years 2010 to 2017, was analysed and presented in the highly detailed report, 'The State of Australian Homelessness in Australia's cities: A Health and Social Cost Too High' prepared by Flatau et al and published in 2018.

Flatau summarises the state of homelessness below:

- 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.
  - 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 (SHS) Collection which recorded 40% of clients as male.
  - 17.8% of interviews took place in New South Wales.
  - 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 hospital emergency departments, and those that had inpatient hospital admissions were more likely to have a higher number of admissions over the six month period.
  - 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.

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

- 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.
  - Homeless people 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.

- 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 [see Appendix 1 for a more detailed view]
  - 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 who 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 month 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 who 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.

- Financial circumstances
  - 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.

- Social needs
  - 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.
  - 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?
  - Housing and shelter were 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.