Australian Government
Australian Institute of Health and Welfare

Specialist homelessness services client pathways: analysis insights

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About

The AIHW Specialist Homelessness Services Collection includes information about clients receiving homelessness services support from 1 July 2011 onwards. These data have been analysed to examine service usage patterns and demographics for specific cohorts. Additional insights will be added regularly to this report.

Cat. no: HOU 324

- Explore study cohort articles
- Data

Findings from this report:

- In 2019–20, 56% of clients who experienced persistent homelessness were female and 51% were under 25 years old
- Around 3 in 5 returning to homelessness clients in 2019–20 had a current mental health issue or had experienced FDV
- In 2011–13, 52% of young SHS clients aged under 18 had experienced homelessness at some time
- Almost half (48%) of young clients aged 18 to 24 who received SHS support in 2018–20 had been a client previously

Introduction to the SHS longitudinal data

The Specialist Homelessness Services (SHS) Collection (SHSC) commenced on 1 July 2011. Data are provided by over 1,700 government-funded agencies that deliver homelessness services to people in need of support. These data are based on interactions between clients and service providers and are collected at fixed points in time:

- at the start of a support period
- at the end of every month during a support period
- at the end of a support period.

SHS Agencies provide these data to the AIHW on a monthly basis. For detailed information about the SHSC see Specialist Homelessness Services Collection.

More information about the SHS data

The following resources provide important details of the AIHW SHSC that assist in interpreting the longitudinal analyses of the data:

SHS National Minimum Data Set – describes the collection and usage attributes of the data, including definitions of the variables collected.

SHS data quality statements – published annually and provide key insights into the coverage, relevance and accuracy of the data.

SHS Collection Manual (PDF 2.6 MB) – provides a 'user friendly' guide to collecting data for agency workers including how the questions are structured.

SHS annual report – summary report on clients and services provided within a financial year. These reports provide useful information on the characteristics of clients and of their service use, including for key client groups and are accompanied by interactive data cubes.

SHS monthly data – high level summary data released quarterly on the number of clients receiving support each month.

In addition to this, the SHSC data have potential to support longitudinal analyses. Specifically, the types of support provided to clients over time can be examined and can provide valuable insights into the experiences of SHS clients over time and as well as important evidence for future policy development.

The AIHW has explored this previously in reports that examined patterns of service usage across multiple years, for example:

- Couch surfers: a profile of Specialist Homelessness Services clients (1 July 2011 to 30 June 2015).
- Sleeping rough: a profile of Specialist Homelessness Services clients (1 July 2011 to 30 June 2015).
- People in short-term or emergency accommodation: a profile of Specialist Homelessness Services clients (1 July 2011 to 30 June 2015).
- Older Clients of Specialist Homelessness Services (1 July 2013 to 30 June 18).

SHS clients can be either experiencing homelessness or at risk of homelessness

When interpreting SHSC results, it is important to note that not all clients in the data are homeless. Many are 'at risk' of homelessness and some of these never experience formal homelessness. For example, more than half (56%) of clients with closed support started their first support period of 2020–21 at risk of homelessness and 67% finished their last support period of 2020–21 at risk of homelessness (AIHW 2021).

Longitudinal analyses

The analyses of SHSC data presented here are based on longitudinal data constructed from support-period level data from 2011–12 onwards. Analyses of these data examine aggregate client characteristics within 3 study periods (see Box Intro.1). These study periods facilitate the analysis of client characteristics within a set cohort period (defining study period), over periods of past SHS support (the retrospective study period) and their future SHS experiences (the prospective study period).

The SHS longitudinal data contain information for over 1 million individual clients nationally since 1 July 2011. The data offer a unique opportunity to quantitatively explore, and in some cases, validate or replicate, the myriad qualitative studies on homelessness that, while rich in depth (being based on interviews, questionnaires, or case notes), are often based on relatively small sample sizes.

Longitudinal analyses of SHSC data cannot answer all questions about people experiencing insecure housing. The analyses presented here make the most of the available data by providing unique insights into the support profile of SHS clients over long periods of time. They also highlight areas that may warrant further and more detailed investigation through further research or other analyses of data.

Box Intro.1: SHS longitudinal analyses - Study period approach

The SHSC longitudinal data are analysed by partitioning a client's time receiving SHS support into 3 periods (also Figure Intro.1):

Defining study period

This is the key period for which client characteristics and experiences are aggregated. It can vary in length for each analysis but is typically 12 months, to include an adequate sample of clients and to cover a long enough period to capture client outcomes. All clients will have at least one support period in this period, because the cohort is defined by clients who met a certain set of conditions within that time.

For example, a defining study period may be limited to women with a family or domestic violence experience/service needs within the period of 2015–16. Characteristics of these clients and their service use patterns would be aggregated within the 12-month defining study period. The 12-month period is different for each client, beginning on their first day of support that meets that inclusion criteria – in this case, being an FDV client and support starting in 2015–16.

Most analyses will also look at the patterns of service use before (retrospective period) and after (prospective period) the defining study period.

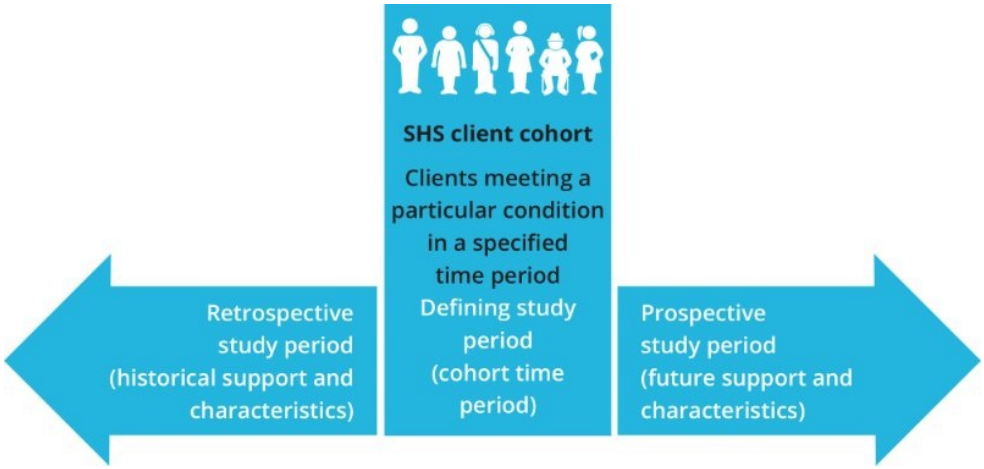
Retrospective study period

This period examines data for clients that needed SHS support before the defining study period. Analyses in the retrospective period examine whether a client experienced particular circumstances (for example, homelessness, unemployment, used a particular service type) in the past. A client's presence in the retrospective period is itself a characteristic that can be studied. For example, clients that are not in the retrospective period may be considered 'new' to SHS services in the defining study period.

Prospective study period

This period examines data and outcomes for the clients that continue receiving support into the future. The most basic outcome is whether a client needed SHS support in this period – that is, whether they can be considered as an ongoing or long-term user of SHS (continuous or otherwise), compared with clients whose SHS engagement finished during the defining study period. More detailed analyses examine whether specific events occurred during the prospective study period, such as whether the client was homeless or what services the client used.

Figure Intro.1: Study period approach to longitudinal analyses



Cohort variable derivations

Some client characteristics or circumstances are associated with the use of SHS services in the past or future, relative to the defining study period. For example, clients with mental health issues in the defining study period may be more likely to have both a history of service use (in the retrospective period) and a need for ongoing service use (in the prospective period).

However, variations in state-territory specific policies and service delivery models mean that the likelihood of a client using particular services may vary between states-territories. Therefore, to assess the factors associate with past and future SHS support separate Modified Poisson Regression models were created for each state. These models are descriptive. That is, they are intended to describe which client variables are associated with past or future service use without proposing or testing specific causal pathways.

In these models, the outcome variable (receipt of SHS support) was a binary measure (yes or no) and did not distinguish between clients that needed SHS support only once in the retrospective or prospective study period and those that required frequent support. Risk ratios were created to measure the association between the use of SHS support and a set of client characteristics (see Glossary entry on Relative Risk for how to interpret the results).

These associations are presented as relative risks, which are the probability of an event occurring in one group – typically one that has been 'exposed' to a condition – versus the probability of the event occurring in a non-exposed group. It is a ratio of the absolute risk (probability of an event occurring) between the two groups and is usually reported either as ratio of risk (for example, the risk of using SHS in the future is 1.25 times for Indigenous clients versus non-Indigenous clients) or a percentage (for example, Indigenous clients have a 25% increased risk of using SHS services in the future).

Given the connotations associated with the word 'risk', which is more commonly used among studies where the outcome is an adverse event, the results of the descriptive modelling are not described as 'risk' but as the change in relative likelihood (probability) (for example, Indigenous clients are 25% more likely to continue to use SHS services). A value of 1.00 indicates no difference between the two groups; values greater than 1.00 indicate an increasing 'risk' or likelihood for the 'exposed' group and a value less than 1.00 indicates decreased risk (Andrade 2015).

Ninety-five percent (95%) confidence intervals are also presented to indicate the statistical precision and significance. The result is interpreted as having a statistically significant impact (that is, not due to chance) if the interval does not cross the value of 1.

Understanding factors associated with past and future SHS support

Client characteristics/vulnerabilities

Details of SHS clients who meet the criteria for inclusion within the priority cohort are extracted from the complete longitudinal dataset (2011–12 to the latest data available) (Figure Intro.2). The data for these clients are then partitioned into 3 study periods (see Box Intro.1, Figure Intro.1).

Within each of these 3 study periods (retrospective, defining, prospective) a client can have any number of support periods. Within each support period, client circumstances are recorded as they were at 3 times – the week before support commenced, at the start of support ('at presentation') and when support ended. A subset of information is also recorded within each month of the support period, which includes services and assistance provided during the month and the client's situation on the last day they received a service in the month.

For longitudinal analysis, most client characteristics were measured by examining whether a particular event or situation occurred at any of the 3 times for any of the support periods that occurred within each study period. For example, the housing situation characteristic within the defining period captures whether the client was homeless at any of the 3 times during any support period in the defining study period.

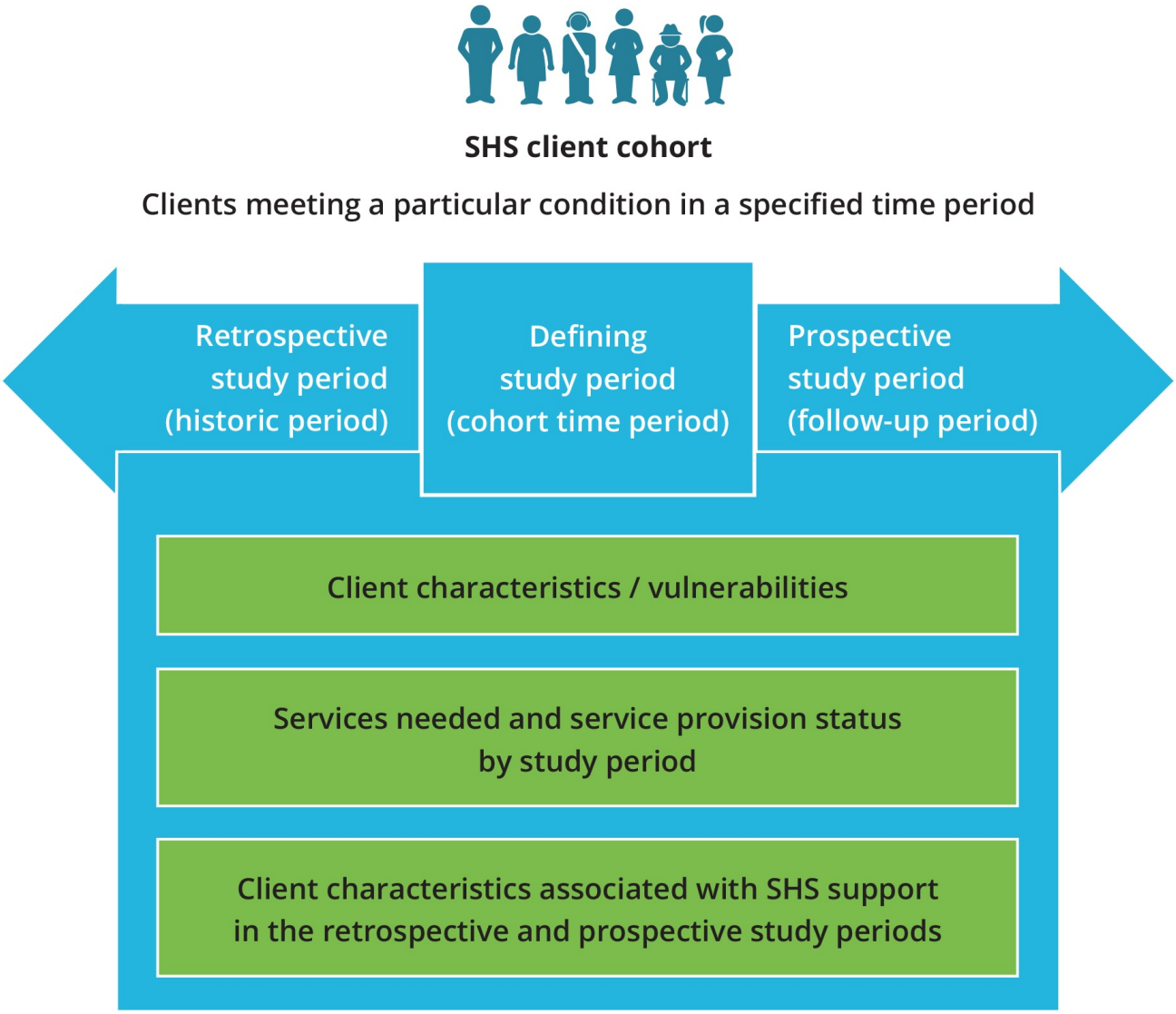
Client characteristics such as Indigenous status and whether a person was born overseas are derived using data from all support periods in the longitudinal data. If a client was ever recorded as being Indigenous or born overseas, they will be considered as such, even if in some support periods the data are missing or different. Although it is recognised that this method may lead to an overestimation of Indigenous clients, this method was used because identification barriers and sensitivities are more likely to lead to a reduced propensity to identify as Indigenous in administrative data collections (ABS 2012).

The client's state or territory, age and sex are all recorded as at the start of the first support period in the defining period and used subsequently across all study periods. Other SHSC products may use a different approach.

Vulnerabilities including mental health issues, drug and/or alcohol problems, and experience of family and domestic violence (FDV) issues are assessed within each study period using the same criteria as detailed in the Specialist homelessness services annual report.

Longitudinal variable derivations are explained in more detail in the Methodology section.

Figure Intro.2: Longitudinal analysis overview

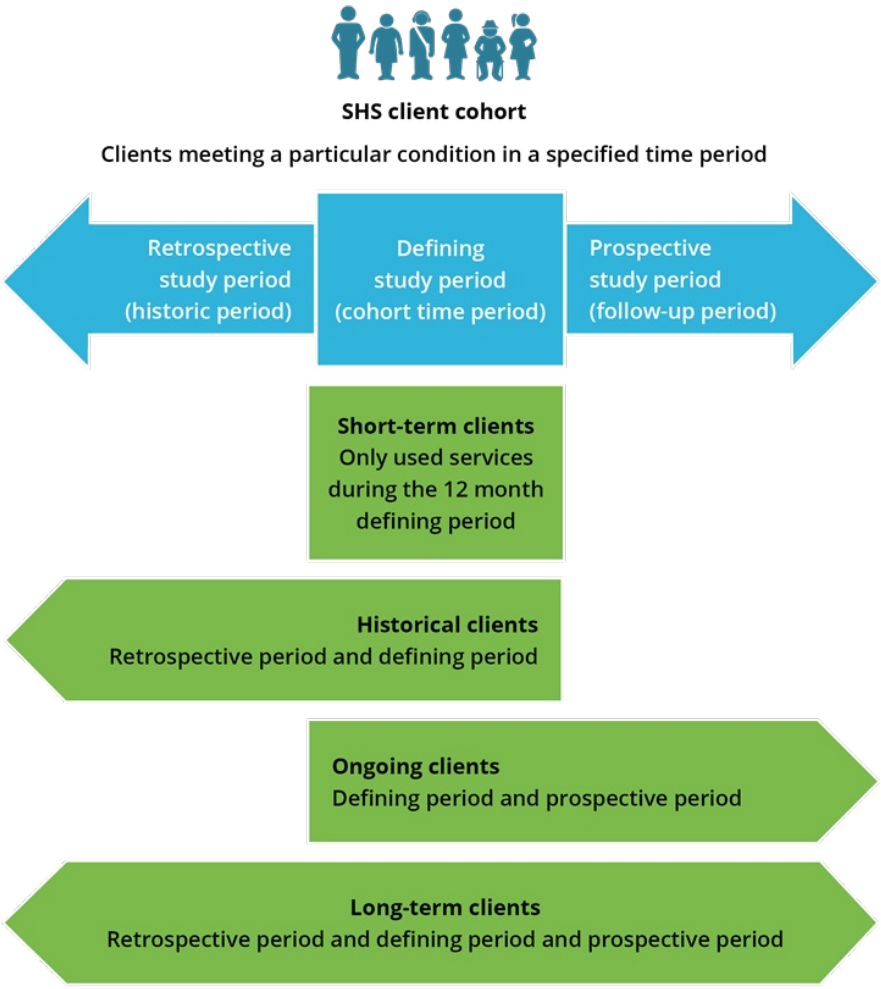


A client's SHS support over time can also be examined by combining information from the discrete study periods into four service engagement profile groups (Figure Intro.3):

- Short-term clients, who only received SHS support during the defining study period.
- Historical clients, who received SHS support in the retrospective period and the defining study period only.
- Ongoing clients, who received SHS support in the prospective period and the defining study period only.
- Long-term clients, who received SHS support in all 3 study periods.

The challenge with this approach is that it is not clear whether ongoing clients will become long terms clients as time progresses which means detailed analyses using this classification of clients is less robust than other approaches. Therefore, this type of approach is only used when commenting on a client's characteristics and use of SHS support over a set period.

Figure Intro.3: Service engagement profile groups



Services and assistance needed and service provision status

The SHSC collects information on the needs of clients during a support period. Information about what services were needed and whether they were provided or referred is collected at the beginning of a support period. Some information is updated at the end of each month that a client is supported and again at the end of each support period. For longitudinal analyses, a client's need for a service is recorded if the client needed that service at any time in each study period (retrospective, defining or prospective). The need is recorded only once in each study period regardless of the number of support periods or months over which the need was recorded or the number of times it is required within each study period. The aggregation of these data means that throughout each study period, the intensity of support is not assessed. Clients requiring or receiving a lot of support in each study period are not distinguished from clients requiring or receiving minimal support.

Where agencies are unable to provide services directly to clients or unable to fully meet the need, they often refer the client to other organisations (either other specialist homelessness agencies or organisations in other sectors) that can provide those services.

All information on services provided to clients are recorded in the same way as service needs. That is, a service is recorded as provided or referred if the client was provided or referred that type of service/assistance at any time within the study period. In each case, a service is flagged as provided or referred only once in each study period, regardless of how many times the client needed that service. A client was that provided (or referred) in only a portion of the instances in which that service was required will still be flagged as having received that service.

The individual instances of a need being unmet is not assessed in these longitudinal analyses.

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Explore study cohort articles

Each study cohort examines the characteristics and experiences of a group of specialist homelessness services (SHS) clients and provides valuable insights into the support profile of vulnerable client groups over time. Each web article draws on SHSC data from 2011–12 onwards, national as well as state or territory breakdowns have been provided where possible.

Specialist homelessness services clients

- Specialist homelessness services client pathways: Clients supported in 2015–16
- Specialist homelessness services client pathways: Clients supported in 2018–19

Repeat homelessness

- Specialist homelessness services client pathways: Clients experiencing persistent homelessness in 2019–20
- Specialist homelessness services client pathways: Clients returning to homelessness in 2019–20

Children and young people

- Specialist homelessness services and income support among young people
- Specialist homelessness services client pathways: Children on care and protection orders in 2014–17
- Specialist homelessness services client pathways: Young clients aged 18 to 24 in 2018–20
- Specialist homelessness services client pathways: Young clients aged under 18 in 2011–13
- Specialist homelessness services client pathways: Young clients presenting alone in 2015–16

Client vulnerabilities

- Specialist homelessness services client pathways: Clients exiting custodial arrangements in 2014–17
- Specialist homelessness services client pathways: Clients with mental health issues in 2015–16
- Specialist homelessness services client pathways: Clients with problematic drug or alcohol use in 2015–16

Indigenous Australians

- Specialist homelessness services client pathways: Indigenous clients in 2015–16

Family, domestic and sexual violence

- Specialist homelessness services client pathways: Female clients with family and domestic violence experience in 2015–16

Older people

- Specialist homelessness services client pathways: Older clients in 2014–17

Overview of SHS client groups

Overview of specialist homelessness services client groups

Women and children experiencing family and domestic violence

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts, including women and children affected by family and domestic violence (FDV).

Why are they important

Women who experience family and domestic violence are considered an important sub-group of clients experiencing homelessness; national policies are aimed at preventing or ameliorating homelessness in this sub-group (CFFR 2018). In Australia, 1 in 6 women (17% or 1.6 million) have experienced physical or sexual violence from a current or former intimate partner since the age of 15 (ABS 2017). For women who are housing secure – self-reported housing situation – an episode of violence increases the probability that they will subsequently be at-risk of homelessness or homeless (Scutella et. al 2012; Diette and Ribar 2015). In 2020-21, approximately 68,100 females over 18 years affected by family and domestic violence received SHS support, which is 54% of all adult female SHS clients (AIHW 2021).

According to Scutella and others (Journeys Home 2012), the second most common reason a person became homeless was 'domestic and family violence or abuse', after 'Relationship/family breakdown'. In 2021, the main reason females sought assistance from SHS agencies was 'family and domestic violence', higher than the number of clients who chose accommodation services as the main reason for seeking assistance (AIHW 2021).

Women leaving violence travel a diverse range of housing pathways, including moving between housing tenures and markets, depending on their resources, choices and needs; FDV often leads to homelessness, but victim-survivors sometimes decide to remain in or return to a violent relationship because of a lack of available and appropriate housing (Flanagan et. al 2019).

Pathways out of homelessness

The options generally available for victim-survivors of FDV are social housing and subsidised private rental housing (Flanagan et. al 2019). Social housing access is limited as it is targeted for those with the most complex needs (Flanagan et. al 2019). Payments of Commonwealth Rent Assistance (CRA) are one of the ways private rental housing is subsidised (Flanagan et. al 2019). However, once the subsidy ends, housing is again unaffordable. The increase in rent is another challenge for victim-survivors accessing private rental housing (Flanagan et. al 2019).

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Clients with a mental health issue

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts. While not specifically listed as a priority cohort, clients with a mental health issue (MH clients) are vulnerable to experiencing homelessness (Brackertz et al. 2020).

Why are they important

Housing and mental health are intertwined. For example, research has found the odds of experiencing homelessness among people with a mental health issue was nearly double that of people without a mental health issue (Nilsson et al. 2019). Similarly, an increased prevalence of mental health conditions among people experiencing homelessness, especially, 'severe' mental conditions such as schizophrenia and bipolar disorder (Ayano et al. 2019; Gutwinski et al. 2021). The most recent National Survey of Mental Health and Wellbeing found that 1 in

2 (54%) people with a history of homelessness reported an experience of a mental health condition, compared with almost 1 in 20 (19%) people without a history of homelessness (ABS 2008). In this way, mental health issues may equally be a contributor and/or outcome of housing instability/homelessness – rather than, simply a cause (Johnson and Chamberlain 2011).

The relationship between homelessness and mental health is complex and bidirectional (Brackertz et al. 2020). An interaction between various structural and individual factors contribute to the likelihood of experiencing homelessness, and the likelihood of mental health issues, particularly, for low-income households (Bentley et al. 2011). Mental health issues reduce a person's capacity to maintain stable housing circumstances (Flatau et al. 2022). For example, an Australian study found that among people who experienced severe psychological distress, the likelihood of experiencing financial hardship – in the next year – increased by 89% (Brackertz et al. 2020). Equally, however, experiencing homelessness can amplify mental ill-health, such that mental health issues may be triggered and/or exacerbated (Kaleveld et al. 2018). For instance, past research into Australia's homeless population found that the proportion (about 15%) of people who reported a history of mental health issues before entering homelessness was similar to the proportion of people who reported developing a mental health issue after entering homelessness (Johnson and Chamberlain 2011).

Pathways out of homelessness

Providing people with mental health issues with safe, secure, and appropriate housing and support services is critical for mental health recovery and sustaining stable housing (Brackertz et al. 2020; Flatau et al. 2022). Yet, given the diversity of mental health issues and varied pathways out of homelessness, addressing the needs, challenges, and circumstances of this cohort is complex and multifaceted (AIHW 2021). This is because the types of mental health support and homelessness services required will vary by person and local context (State of Victoria 2021). As a result, establishing an integrated and collaborative support system, based on a person-centred approach to service delivery and support, is crucial for facilitating exits out of homelessness (Productivity Commission 2020; NMHC 2020; Spinney et al. 2020), especially for people with complex needs, such as those who experience severe symptoms and/or other issues associated with homelessness and disadvantage including disabilities, problematic gambling, and problematic drug and/or alcohol use (Whittaker et al. 2017; Moore et al. 2011; Nower et al. 2015).

Through fulfilling the basic need for housing, people with mental health issues are afforded an opportunity to not only focus on their recovery, but also access the appropriate support services for treatment and rehabilitation (Honey et al. 2017; Holland 2018; Maslow 2013; NMHC 2017). Critically, it also enhances a person's capacity to successfully engage in activities that help maintain stable housing circumstances, such as employment, studying, and the reestablishment of social networks (Flatau et al. 2022; Johnstone et al. 2016; van der Laan et al. 2020).

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Clients with problematic drug or alcohol use

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts. While not specifically listed as a priority cohort, problematic drug or substance use (SUB clients) can exacerbate housing instability (Lalor 2020) and potentially lead to homelessness.

Why are they important

Substance abuse is a typical pathway into homelessness and a factor which makes it difficult to exit, leading to longer periods of homelessness (Chamberlain and Johnson 2011). The Journeys Home research project utilised longitudinal survey data to identify 'clear associations between homelessness and risky drinking, cannabis use and illegal/street drug use' (Scutella et al. 2014). The Journeys Home data also provided insights into the direction of the relationship, suggesting that some forms of substance use can lead to homelessness (particularly risky alcohol use) (McVicar et al. 2015).

A study conducted by the AIHW between 2011 and 2014 found that a significant proportion (77%) of SHS clients who also used alcohol and other drug treatment services (AODTS) were also experiencing other vulnerabilities (such as having a current mental health issue, experiencing domestic and family violence, being young or aged 50 and over) (AIHW 2016). Half (51%) of the matched SHS and AODTS population reported experiencing a current mental health issue.

Pathways out of homeless

Homelessness is often a barrier to accessing alcohol and other drug treatment services; treatment at many rehabilitation and detoxification services is contingent on the individual providing a discharge address (Vallesi et al. 2021). In addition, traditional housing services frequently allocate supported accommodation contingent on drug and alcohol rehabilitation and other restrictions such as abstinence during the period of accommodation (Lalor 2020). Consequently, clients who cannot achieve or sustain abstinence find it difficult to obtain appropriate treatment or housing. Access to housing that is safe, affordable and stable supports an individual's mental health and facilitates recovery (Duff et al. 2021).

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Children and young people

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts, one of which is children and young people.

Why are they important

Youth homelessness remains a persistent social problem in Australia. On any given night, almost 4 in 10 (38% of the homeless population or 44,200) people who experience homelessness are estimated to be under the age of 25 (ABS 2018). Similarly, longitudinal research into the Australian experience of homelessness and housing insecurity found that almost 3 in 4 participants first experienced homelessness before the age of 25 (Scutella et al. 2012). Some risk factors involved in young people's entries into homelessness include family conflict (including domestic violence or abuse), problems at school (including academic failure and suspension), a history of problem behaviours and problematic substance and/or alcohol use (Grattan et al., 2021; Heerde et al. 2020, 2021). Conversely, the structural factors involved in the underlying conditions of youth homelessness include limited affordable housing, financial insecurity, and accessibility issues with welfare services (Johnson et al. 2015; Mackenzie et al. 2020; Pearl et al. 2021).

Experiences of homelessness can have serious ramifications for young people's social, physical and emotional development and health and wellbeing (Flatau et al. 2016; Grattan et al. 2021). The disruption to daily life and stresses associated with experiencing homelessness has negative implications for their education, transition to employment and, the development of healthy and stable social networks and skills (Heerde and Patton 2020; Robards et al. 2019). Once homeless, young people may be exposed to situations that reinforce their situation, such as violence, mental health issues and interactions with the justice system (Gaetz et al. 2018).

Compared to the general population, young people experiencing homelessness experience greater levels of psychological distress, problematic substance and/or alcohol use and social isolation (Medlow et al. 2014). Further, young people experiencing homelessness are at increased of risk of developing and/or exacerbating health issues and mental health conditions (Flatau et al. 2016; Hodgson et al. 2013;). Critically, longitudinal data from the Journey Home research project demonstrated that the likelihood of experiencing persistent homelessness was highest when people first experienced homelessness at a young age compared to a later age (Scutella et al. 2012). In this way, young people experiencing homelessness are a group especially vulnerable to experiencing long-term homelessness (Brackenhoff et al. 2015).

Pathways out of homeless

Although housing is necessary for any pathway out of homelessness, housing alone does not ensure exits out of homelessness for most young people (Alves and Roggenbuck 2021; Scutella et al. 2012). Young people experiencing homelessness require tailored support for their transition into stable housing based on their unique pathways, circumstances and distinct range of needs in various domains and sectors (Wang et al. 2019). The provision of support that not only addresses their needs, but also helps them in developing their capacity to live independently and maintain housing stability is an important consideration for service delivery. Although the type of support required varies by young person, common supports include help with navigating different services and systems, reconnecting with family, and education and employment (Mackenzie et al. 2020; Gaetz et al. 2018; Wang et al. 2019).

An integrated and collaborative system, undergirded by a person-centred approach is critical to facilitating successful pathways out of homelessness (Flatau et al. 2022). Indeed, evidence from the Australian experience of youth homelessness highlights that care that addresses young people's unique social, psychological and emotional needs, as well as their unique circumstances and priorities is critical towards facilitating the maintenance of stable housing for young people (Flatau et al. 2015; Turnbull et al. 2021). Young people who are not afforded such care may be left unprepared and ill-equipped for independent living. In turn, rendering them at an increased risk for further harm and/or re-entry into homelessness (Alves and Roggenbuck 2021; Mendes and Purtell 2020; Turnbull et al. 2021).

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Clients exiting custodial arrangements

In June quarter 2022, there were 40,600 persons in custody in Australia and 15,400 who were released from prison (ABS 2022).

Homelessness and custodial experiences are often intertwined; homelessness often precedes, and is strongly associated with, entering custodial arrangements, and both youth and adults exiting custodial arrangements have greatly increased chances of experiencing homelessness (AIHW 2021). The 5th National Prisoner Health Data Collection, conducted in 2018, found that one-third of prisoners had experienced homelessness in the 4 weeks before entering prison, and over half (54%) expected to be homeless after release (AIHW 2019). In addition to this, there is considerable churn within the prison population; 46% of prisoners released in 2017–18 had returned to corrective services (either prison or community corrections) within 2 years (SCRGSP 2021).

Recent longitudinal research using Australian data (Moschino and Johnson 2019) suggests, however, that homelessness itself does not increase the risk of incarceration (that is, controlling for various personal and circumstantial factors largely mitigates the effect of homelessness on incarceration), though addressing housing needs around 6 months after release does reduce rates of reincarceration.

Pathways out of homelessness

The relationship between housing insecurity and imprisonment and re-imprisonment is relatively well established (Martin et al. 2021). Post-release housing assistance can be an effective measure in addressing the imprisonment–homelessness cycle. Critically, rates of re-imprisonment have shown to be less for ex-prisoners with complex needs who receive public housing compared with those who receive private rent assistance only (Martin et al. 2021). Conversely, ex-prisoners who rely on social networks or short-term housing solutions have an increased likelihood of re-imprisonment 6 months after release (Moschion and Johnson 2019). Despite this, only 14% of prison discharges in 2018–19 received Specialist Homelessness Services (SHS) support (AHURI 2021). Not only do people exiting custody face challenges securing stable housing they also need support maintaining the tenancy, including assistance paying rent and bills on time and managing relationships with neighbours (POA 2020).

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Indigenous Australians

Aboriginal and Torres Strait Islander people are the Indigenous peoples of Australia. They are not one group, but comprise hundreds of groups that have their own distinct set of languages, histories and cultural traditions (AIHW 2022).

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts, including Indigenous Australians (CFFR 2018).

The 2020 National Agreement on Closing the Gap is a partnership between governments and Aboriginal and Torres Strait Islander people that aims to overcome the inequality experienced by Aboriginal and Torres Strait Islander people (Commonwealth of Australia 2020). This agreement outlines a number of socio-economic outcomes and targets, one of which relates to the availability of secure appropriate and affordable housing for Aboriginal and Torres Strait Islander people that is aligned with their priorities and need.

Aboriginal and Torres Strait Islander people remain disproportionately affected by experiences of homelessness and housing instability (ABS 2018; AIHW 2018; Memmott and Nash 2016). Despite making up 4% of the total national population (as at 30 June 2021) (ABS 2022), 1 in 5 people who were homeless on Census night are Indigenous Australians (or 23,400 people): a rate of homelessness almost 10 times the rate among non-Indigenous Australians (ABS 2018). Moreover, past longitudinal research in Australia suggests that Indigenous Australians are significantly more likely to experience persistent homelessness than non-Indigenous Australians (Scutella et al. 2012). Indigenous Australians are not only overrepresented among the national homeless population, but also are a group especially vulnerable to both entries into and/or experiencing ongoing episodes of homelessness (ABS 2018; AIHW 2018, 2021).

The pathways and experiences of homelessness of Indigenous Australians are distinct from non-Indigenous Australians (Spinney et al. 2016; Memmott and Nash 2016). The high-rate of homelessness stems from various complex factors associated with the impact of colonisation, housing shortages in both Indigenous communities and Australia and cultural identity (Memmott et al. 2012). Some of the structural factors involved in Indigenous homelessness include low income, educational attainment, and poverty (Birdsall-Jones and Shaw 2008; Keys Young 1998; Habibis 2013). While individual risk factors associated with Indigenous homelessness include family violence, substance disorders and unemployment (AIHW 2018), these factors can either be a contributor and/or outcome of, insecure housing circumstances or alternatively, other social problems, such as poverty (Flatau et al. 2005). In this way, effectively addressing Indigenous homelessness requires recognition of an Indigenous person's needs, values and preferences, as well as their culture.

Safe and secure housing is basic human right integral to health and wellbeing. Strong evidence exists for the role of homelessness in the deterioration people's physical and mental health. Therefore, addressing Indigenous homelessness is a critical step towards improving the health and wellbeing of Indigenous Australians and remains a national priority.

Pathways out of homelessness

Safe, secure and culturally appropriate housing and support is critical for Indigenous Australians to exit homelessness and sustain stable housing. Because of the complexities involved in Indigenous homelessness, special support and care is required when addressing the needs of Indigenous Australians. Indigenous Australians with complex needs related to their homelessness, such as experiences of family violence, mental health issues and legal issues are especially in need of support (Flatau et al. 2022). Further, Indigenous Australians who experience homelessness require tailored support based on not only their specific needs, but also based on considerations of the challenges unique to their pathway into homelessness, for instance an Indigenous person's local context and their cultural understandings, values and norms (Memmott et al. 2011; 2012). Accordingly, an integrated and collaborative support system that emphasises culturally appropriate service delivery that addresses the needs and circumstances of Indigenous Australians is crucial in facilitating a pathway out of homelessness (Flatau et al. 2022).

Culturally safe and appropriate service delivery and intervention has been identified as key factor in successfully promoting Indigenous pathways out of homelessness (Flatau et al. 2022). Indeed, the provision of long-term housing in combination with context-specific, tailored support based on an Indigenous person's culture, circumstances and needs have shown some success in facilitating housing stability (Moran et al. 2016). This support may include ongoing support for drug and alcohol issues, family issues and/or physical and mental health issues (Chamberlain and Johnson 2013).

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Older people

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts, one of which is older people (CFFR 2018).

Older people in Australia are a rapidly growing group among Australia's homeless population. An increasing number of older people are impacted by poverty and financial insecurity, such that older clients have been one of the fastest growing SHS client groups since the collection began (Peterson and Parsell 2014; AIHW 2021). The risk of and/or the experience of homelessness can be exacerbated by issues associated with later life, including health issues, cognitive decline and limited social networks (Thredgold et al. 2019). When considering Australia's ageing population in light of these trends, the risk of and/or experience of homelessness is projected to increase in the coming decades (ABS 2018; AHRC 2019).

Older people experiencing homelessness have unique health and welfare vulnerabilities and high rates of geriatric symptoms - such as frailty, cognitive impairment and mobility issues - and mortality compared to older people with housing (Canham et al. 2020; Crane and Joly 2014). Further, older people experiencing homelessness are significantly more likely to have functional disabilities, chronic diseases, and other complex physical and mental health needs than younger people experiencing homelessness (Crane and Warnes 2010; Humphries and Canham 2021). Older people experiencing homelessness often lack access to the appropriate treatment and support services required to manage their health conditions, as they unable to provide a fixed address or may be unfamiliar with navigating support systems. As a result, many older people are left with worsening or persistent health conditions that are exacerbated by their poor living conditions (Humphries and Canham 2021).

The structural factors involved in homelessness, such as unaffordable housing, may impact older people differently due to their unique housing needs and financial circumstances (Mission Australia 2017). There are a number of different pathways into homelessness for older people, some have had intermittent periods of homelessness and others have experienced chronic homelessness for many years (Thredgold et al. 2019). More common for older people, however, is first time homelessness in later life (Peterson and Parsell 2014). Cultural factors related to economic disadvantage in later life, such as historically low wages for women, have contributed to increases in first time homelessness among older people in recent times, especially, older women (AHRC 2019). For example, older women are more likely to have lower retirement savings than older men and thus, may be at greater risk of homelessness in unaffordable housing circumstances (AHRC 2019). However, it should be noted that older women are often statistically invisible due to the nature of women's homelessness (Peterson and Parsell 2014). This is because older women experiencing homelessness typically stay with friends and family, live in their car, or live in a severely overcrowded dwelling, rather than seek assistance from Specialist Homelessness Services (SHS) (Mission Australia 2017).

Pathways out of homelessness

Many older people are not getting the support they need, and service providers often lack the capacity to support the needs of older people (Royal Commission 2021; Thredgold et al. 2019). Older people experiencing homelessness are more likely to require support for complex and/or multiple mental and/or physical health issues, which often require specialised care. Recent Australian research on older people homelessness identified that a lack of resources dedicated to supporting older people's needs in the SHS system, and lack of access to income support and services as key barriers in older people's pathway out of homelessness (Thredgold et al. 2019). In other words, some older people require support navigating (e.g., information) and/or accessing (e.g., travelling) service systems, whereas others require support with accessing income support (e.g., aged care pension) and health and aged-care services. On the other hand, the service system is currently ill-equipped to provide the appropriate support to help these older people (Humphries and Canham 2021).

Older people experiencing chronic homelessness – who are often men – more likely require support for the needs, challenges and circumstances contributing to their homelessness, such as problematic alcohol and substance use, limited social networks and multiple health issues (Humphries and Canham 2021). Conversely, older people experiencing homelessness for the first time – who are often women – more likely require support overcoming barriers to service, such as travelling to or accessing information about homelessness, healthcare and community services.

Irrespective of the contributing factors, access to secure, affordable, and age-appropriate housing and support services is required for older men and women to successfully exit homelessness (Flatau et al. 2022). Yet, given the complexity and diversity of the unique needs of older people, addressing the needs, challenges, and circumstances of this cohort is difficult and multifaceted (Peterson et al. 2014). Older people experiencing homelessness have distinct needs regarding housing and support services compared to younger people experiencing homelessness (Power et al. 2018). For example, many older people require support with aged care, employment, and service system navigation in combination with housing. As a result, establishing an integrated and collaborative support system that promotes an age-appropriate and person-centred approach towards service delivery is critical in helping older people exit homelessness successfully (Humphries and Canham 2021; Thredgold et al. 2019).

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Children on care and protection orders

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments to address priority policy areas and priority cohorts, including children on care and protection orders (CPO), and their access to affordable, safe and sustainable housing. The agreement also details the provision of homelessness services and support for people at risk or experiencing homelessness (CFFR 2018).

Child abuse and neglect is often associated with disadvantage and issues such as poverty, homelessness, drug and alcohol addiction, domestic violence and mental health issues (DSS 2021).

In 2020–21, around 8,300 children with a care and protection order received support from specialist homelessness services (AIHW 2021). Most (68%) children on a CPO presented with a single parent or carer and almost a quarter (23%) presented alone (23% of children on a CPO presented alone in their first SHS support period in 2020–21) (AIHW 2021); they may have absconded from their home due to family violence, abuse, or neglect (Noble-Carr & Trew 2018).

Around 16% of CPO clients accessing SHS in 2020–21 cited housing crisis as a reason for seeking assistance, an umbrella term often describing the interplay of housing supply, affordability and availability among other factors impacting access to safe and secure housing (AIHW 2021). The *journeys home* research suggest that the state of the housing market is strongly associated with an individual's risk of homelessness, citing higher rates of homelessness in areas of higher housing costs (Bevitt et al. 2015).

Children require safe, secure, and stable home environments to maintain mental and physical wellbeing for their development into adulthood, with short periods of being at risk of or experiencing homelessness associated with an increased likelihood of experiencing negative health outcomes in the long term (AIFS 2012; Bassuk et al. 2014; Clair 2019; Flatau et al, 2016). Children experiencing homelessness are also at increased risk of being homeless as adolescents and adults (Flatau et al. 2012).

Pathways out of homelessness

A critical element of a child's wellbeing within out-of-home care within the child protection system is placement stability, and child protection agencies prioritise this where possible (AIFS 2021; Prentice 2018; Seselja 2017). Being placed on a child protection order means that a young person can be placed in a residential or foster care household (Noble-Carr & Trew 2018). For some young people, being placed on a child protection order does not always lead to a safe, stable, and secure housing situation. Reviews of outcomes and experiences for children in care have found that many (for example, nearly two-thirds of children in Victoria; CCYP 2020) experience placement instability (marked by multiple placements) during their time in care.

This instability can exacerbate the trauma that the children have experienced, and can lead to adverse outcomes for children transitioning from out-of-home care, including increased chances of experiencing homelessness, mental health issues, and interactions with the youth justice system (AIFS 2011; CCYP 2020).

Young people in out of home care legally exit the system at 18 years old, with the transition from care to independence challenging for many young people. For example, a study found that young people in care were concerned about losing caseworker and carer support and social networks when they left the care system as well as facing financial difficulties and homelessness (McDowall 2020). This survey of 325 respondents found that 17% transitioning from care were homeless immediately on leaving care and 35% were homeless in the first year after leaving care.

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Clients experiencing repeat homelessness

The National Housing and Homelessness Agreement (NHHA) describes the roles and responsibilities of governments in delivering homelessness services across Australia. The agreement specifies that states and territories address priority policy areas and priority cohorts, including people experiencing repeat homelessness (CFFR 2018).

A larger share of the homeless population in most countries is homeless for only a short period before finding a more stable housing solution (OECD 2020). Events such as sudden unemployment or illness, or relationship breakdown may result in a short period of homelessness. However, there are a smaller, but more visible, share of the homeless population experiences longer or multiple episodes of homelessness. This report is focused on those people who experience repeat periods of homelessness.

There are a variety of terms used to describe multiple episodes of homelessness, such as, chronic homelessness, persistent homelessness or long-term homelessness. The exact definition on the length of homelessness and/or the number of episodes varies.

For the purpose of the NHHA performance indicators, clients of Specialist Homelessness Services (SHS) experiencing repeat homelessness are measured by two indicators:

Indicator Persistent homelessness: Describes the number of SHS clients who have been homeless for more than 7 months over a 24-months study period, that is, 30% of the study period. The homeless months do not need be consecutive. Clients must have at least one support period with a homeless housing status during the specific financial year, e.g. 2021–22. Data is based on the housing situation recorded on the last service provision date of each month during a client's support period, therefore, may not reflect whether a client was continuously homeless over the entire period.

Indicator Return to homelessness: Describes the number of SHS clients who experienced an episode of homelessness during the financial year and a pattern of homeless–housed–homeless in the 24-months prior to the most recent record of homelessness. Data is based on the housing situation recorded on the last service provision date of each month during a client's support period, therefore, may not reflect whether a client had continuous days experiencing homeless or more secure housing. (AIHW 2022a).

These cohorts are not mutually exclusive, that is, SHS clients can experience both persistent and a return to homelessness in a period. In 2021–22, approximately 44,200 SHS clients experienced repeat homelessness (AIHW, unpublished). Of these clients, 35,200 clients experienced persistent homelessness and 16,100 clients returned to homelessness (AIHW 2022a).

Approximately 30% of all individuals experiencing homelessness had chronic patterns of homelessness (HUD 2022). They are a highly disadvantage group and are likely to have complex needs, for example, more than one of the following:

- developmental disability
- traumatic brain injury
- serious physical health problems
- history of abuse and/or trauma
- mental illness
- mental disorder
- psychiatric disability
- addictions (to alcohol and/or drugs)
- literacy problems.

Chronically homeless people may cycle through services and temporary accommodation (such as boarding houses), or living permanently or semi-permanently on the streets (Zaretzky et al. 2013).

Pathways out of homeless

Programs targeted at supporting people with long histories of homelessness and more complex needs typically require more intensive and longer periods of support. These programs are typically of higher cost, greater likelihood of improved client outcomes but often positive changes occur in small increments over a long period (Zaretzky et al. 2013).

The national and international evidence has established that the longer someone is homeless, the more difficult it is to assist them to stabilise their life (AHURI 2018). Thus, early intervention strategies, targeting at individuals who have recently become homeless and that aim to ensure that short periods of homelessness do not become chronic, are crucial.

Evidence shows that Housing First is an effective approach leading to improvements in housing stability for young people and adults (Morton 2020, Wang 2019, Munthe-Kaas 2018). Housing First prioritises rapid rehousing into stable accommodation, as opposed to stepped models which involve moving people from crisis accommodation into transitional and then long-term housing. After housing has been secured, other supports are put in place to address health and well-being issues to help people sustain housing and avoid repeat homelessness.

Interventions by service providers for people experiencing repeat or ongoing homelessness requires the establishment of trust and wrap-around support services including health, and drug and alcohol services (Mackie et al. 2017).

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Technical notes

Technical notes

Conceptual overview

People facing housing insecurity, that is, those experiencing homelessness or at risk of homelessness, can access support from Specialist Homelessness Services (SHS) across Australia. The Specialist Homelessness Services Collection comprises data that are collected as part of agency's interactions with clients or potential clients. As such, the data are 'found', rather than 'made', meaning that the data were not specifically designed or collected for detailed research into the life experiences of people facing housing insecurity, instead they are a by-product of service provision. Such data sets are commonly known as administrative datasets. As is the case with many administrative datasets, this means that the SHS data have limitations and may not be suitable for testing specific hypotheses (Connelly et al. 2016).

Furthermore, although the SHS collection is relatively rich in the depth and variety of variables collected about clients and their needs, the structure of the data is not intrinsically suited to longitudinal analyses. Significant reworking is required to transform administrative data from a series of point-in-time snapshots (for example, at the time a client starts a support period and monthly time points thereafter) to a longitudinal product capable of providing insights into the 'prolonged situation of life' (Pattaro et al. 2020) that is associated with social disadvantage.

The need for significant reworking is typical of administrative data sets – the benefits and limitations of which have been reviewed in numerous studies (Productivity Commission 2013, Hurren et al. 2017, Spallek et al. 2020), though each administrative data set is nuanced enough warrant its own evaluation in the context of longitudinal work. This section therefore describes the SHSC data in terms of its potential for longitudinal analyses – primarily in terms of scope and structure.

Each longitudinal study undertaken with the SHS data will have its own derivation method and, consequently, the potential and limitations of the data will vary for each study cohort. The broad principles described in this section will, however, generally apply to all analyses using the SHS longitudinal data set.

SHS scope

A key feature of administrative data like the SHS collection is that the fundamental unit of collection is not individuals but is instead the services provided to individuals. This means that an individual only features in the data when they receive (or, in the case of the SHS, requests) a service. This is perhaps the biggest limitation of administrative data sets, including the SHS collection, as it limits the coverage of the data and introduces significant potential bias. It also is a key determinant of how the longitudinal data are structured for analysis.

Coverage

The SHS longitudinal data comprises information about clients that received services. This includes people that are already homeless as well as those **at risk** of becoming homeless. As such, **the SHS longitudinal data cannot provide insights into the incidence or prevalence of homelessness in Australia**; the best estimate for that remains the Australian Census, which in 2016 found that there were over 116,000 homeless people (including over 51,000 people in severely overcrowded dwellings) on census night, which featured nearly 19,000 people aged 55 and over (ABS, 2016).

At any given time, there is a group of people in Australia that are homeless or at risk of becoming homeless. The size of this group is unknown, but a subset seek support from SHS agencies, and a further subset receive services and are subsequently included in the SHS longitudinal population (Figure Methods.1).

Some of those people experiencing homelessness, or at risk, will approach SHS agencies and request services. The number of potential clients that do not approach SHS agencies is unknown. Of those that do approach agencies, some do not receive any service and are not part of the SHS longitudinal dataset; a limited amount of information is available on these interactions (see Unassisted requests). Those people who receive any service will have administrative data collected and form the basis of the SHS longitudinal data.

The absence of these otherwise-eligible clients means that, if the intent is to study the phenomenon of homelessness, the SHS collection only covers a subset of the population of interest. It also means that there is potential for significant bias in the characteristics of the clients captured in the SHS longitudinal data.

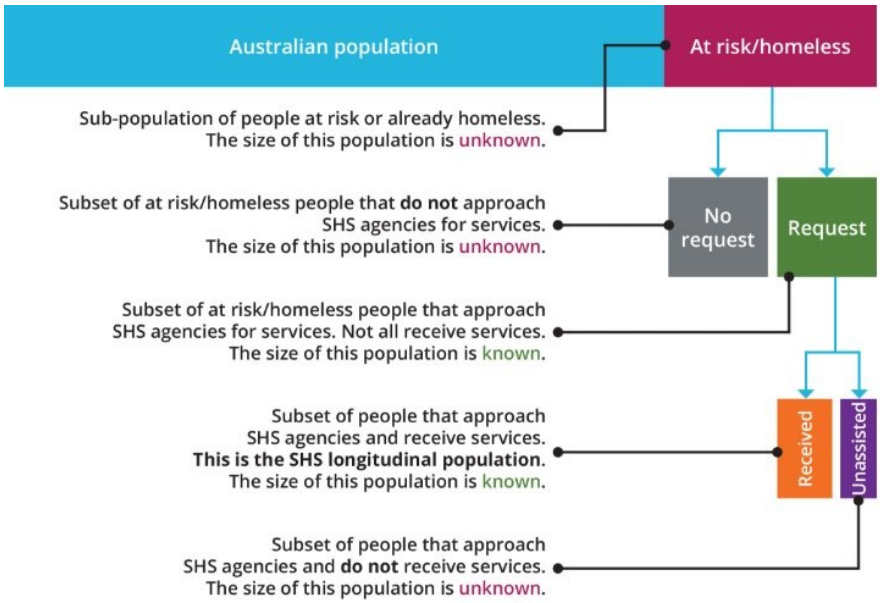
Bias

At each step in Figure 1, there is significant potential for bias to affect which clients are represented in the SHS longitudinal data.

In the first step, only a subset of people who are homeless or at risk of homelessness approach services; most people who experience homelessness do not approach SHS agencies. Insights into this bias are available from the General Social Survey, which in 2014 sampled nearly 13,000 dwellings in Australia (ABS, 2015). Of the subset of people that experienced homelessness in the previous 10 years, only one third sought assistance from a service organisation for their most recent episode of homelessness, most likely because they stayed with relatives or friends instead (ABS, 2015). The tendency to seek support from agencies varies with age, ranging from little over one-quarter for those 15 to 34 years old age to over 40% for those 35 to 64 and over 43% for those aged 65 and over (ABS, 2015).

It is not only social capital or alternative sources of support that precludes people from approaching SHS for assistance. Some will be prevented from approaching agencies because of various obstacles, foremost of which is a lack of local services – especially in regional and rural areas (ACOSS, 2019). Cultural barriers may also be relevant, as is a tendency for some client groups (particularly older clients) to not approach services because of a sense of shame or because they do not know about the availability of services (Thredgold et al. 2019). Additionally, states and territories have different service models and may fund the same services through non-SHS funded agencies, in which case a client that only receives that service through non-SHS funded agencies will not appear in the SHS data. Finally, there are a number of services provided by non-government agencies that are not funded by governments; these philanthropic supports are not captured in the SHS data.

Figure Methods.1: Coverage of the SHS longitudinal data, relative to potential coverage



Notes

1. Sizes of boxes depicting subpopulations do not reflect the actual size of each subpopulation.
2. While the number of unmet requests for services is known, the number of people who are unassisted is unknown because the SLK validity rates for unmet requests are low (52% in 2020–21).

Visibility

Longitudinal capabilities are a particular strength of administrative people-centred data, particularly since there is comparatively little loss to follow up compared with surveys. However, a client is only visible in the data for the time during which they receive services. Insight into client characteristics may therefore be sporadic in an incomplete picture of their life journey.

For example, long-term outcomes for a client cannot be measured reliably for SHS clients because the reasons clients no longer access services is not absolute. For example, a client may no longer need services, the client may be getting services elsewhere, or the client may request but not receive services from SHS agencies.

The structure of the SHSC also means that there is no visibility of client characteristics between support periods. For example, there is no way of knowing if a client that presents needing financial assistance is also struggling financially between support periods or if they only request for services when they have financial difficulties.

This is ameliorated, to some extent, in the SHS collection because agencies collect some client characteristics based on recall. For example, agencies ask clients if they have been in a variety of facilities in the previous 12 months, whether they have ever been diagnosed with a mental issue and if they have received services or assistance for those issues or whether the client has been homeless in the previous month or previous 12 months.

Sporadic visibility is a fundamental concern when using the SHS data for longitudinal analyses and is a key determinant of how the SHS data are structured for longitudinal analyses.

SHS structure

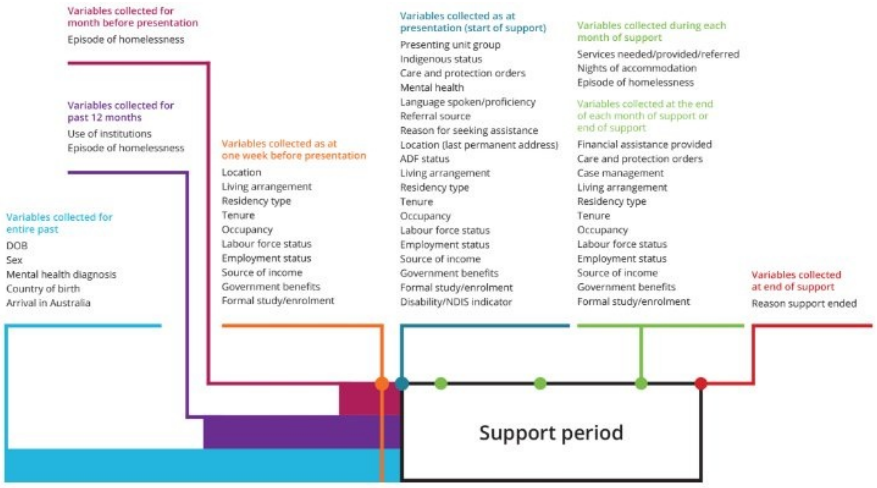
SHS agencies collect a minimum amount of data as described by the Specialist Homelessness Services National Minimum Data Set, depicted in Figure Methods.2. It demonstrates the sporadic nature of the client visibility in the dataset. Each time a client begins a period of support (i.e. when a client first receives a direct service from a SHS agency) the agency will undertake an assessment of the client's needs and collect various client characteristics at the time of presentation and, for some variables, at various times before presentation (see the SHS Collection Manual). For each subsequent month, the agency will collect the variables on the 'ongoing client form'. The last month in which the client received services will include information from the ongoing client form that could not be completed while services were ongoing (for example, the reason why support ended; see the SHS Collection Manual).

The data from the initial client form, the ongoing monthly client forms, and the final ongoing client form are aggregated to create support-period level data for each client. The support-period data form the foundation of the SHS longitudinal data.

Each client can have multiple support periods created through interactions with one or more agencies; these support periods can overlap and, in some cases, multiple support periods can start at the same time with different agencies. With the exception of accommodation services, clients can receive the same or different services from agencies at the same time; accommodation can only be received from one agency at a time. The variables listed in Figure Methods.2, which are collected for each support period, can therefore be inconsistent for a client over a given time interval, depending on how many support periods they have.

This is important for assessing which variables can be aggregated across study periods in the SHS longitudinal data and, subsequently, how these should be interpreted.

Figure Methods.2: Variables collected in the SHSC, by timing relative to a support period



Study period derivation

The basic premise of the longitudinal analysis of SHSC data is that, within the constraints of the support-period data structure, there are meaningful variables that can be aggregated (summarised) for a client in their past (retrospective), present (defining) and future (prospective) periods. Furthermore, that these clients can be meaningfully studied as diverse cohorts that are defined based on client characteristics available in the SHSC data.

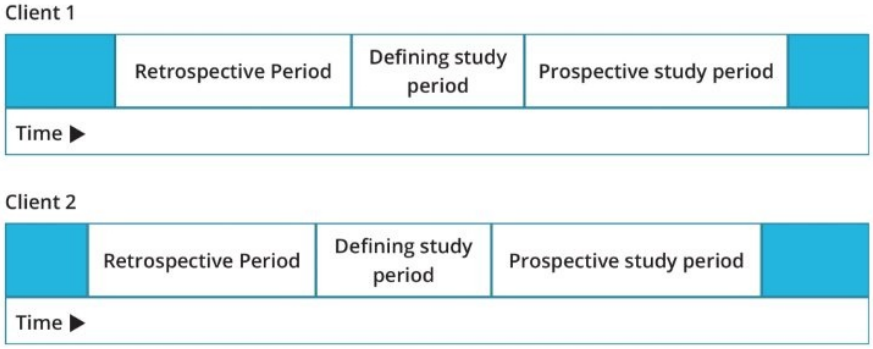
The size of the defining study period is the same for each client. This ensures that aggregations (for example, whether the client was ever homeless, or whether the client needed accommodation) can be compared across clients because they are measured over the same length of time.

This means that the defining study period, which is defined by the client meeting a particular condition in a particular time interval, will have different start and end dates for each client, based on when they first met the condition. For example, for older clients the condition might be that the defining study period commences from the start of their first support periods in which they are aged 55 or over within a given time period (such as 2015–16).

The shifting start and end dates for the defining study period means that the retrospective and prospective study periods will also shift, as shown in Figure Methods.3.

The figure demonstrates that to allow for a consistent sampling time for each client their start and end periods need to be allowed to shift based on the timing of the start of their cohort conditions being true; variables from any support periods that start within these intervals will be aggregated (summarised) into those intervals.

Figure Methods.3: Representation of offset study periods for two example clients



When appropriate values are aggregated for each study period, each client can be characterised by aspects of their past SHS experiences (retrospective period), their SHS experiences during the defining study period – which is typically central to the definition of that cohort – and their SHS experiences after that time (prospective study period). For example, a cohort of women experiencing family and domestic

violence might analyse:

- their conditions during the defining study period, such as living and residential arrangements, presenting unit circumstances, or employment conditions, as well as their service need and provision
- their conditions before that time – some will have had a history of SHS usage, others will not. This in itself is an interesting variable for study, as is the services needed and provided
- their conditions after the defining study period, which can also be characterised by whether or not they return to SHS and, if they do, what type of services they required or received.

Comparison cohorts

The longitudinal analyses characterise client's pathways and outcomes by aggregating some client characteristics or experiences within each study period.

Some client characteristics are fixed and do not vary over time. The client's state or territory (which can vary but is kept fixed in the longitudinal analyses), sex and age are all recorded as at the start of the first support period in the defining period. Variables such as Indigenous status and whether a client was born overseas are fixed for clients across all support periods. In both cases, if the variable is "true" in any support period (that is, Indigenous versus non-Indigenous or not-stated, overseas-born versus Australian-born or not-stated), then the client is marked as such in all their support periods.

Other characteristics are aggregated within study periods. For example, within each of the three study periods (retrospective, defining, prospective) a client can have any number of support periods. Within each support period, client circumstances are recorded at three times – the week before support commenced, at the start of support ("at presentation") and when support ended.

Variables are aggregated in a binary manner by examining whether a particular event or situation occurred at any of the three times for any support periods that occur within each study period.

The longitudinal study variables are aggregations within study periods, and therefore differ significantly from similar variables in annual SHS reporting. For example, a homeless client in the SHS annual report will have been homeless when they started their first support period in the reporting year. In the longitudinal data, however, the homeless variable is a binary marker that records whether the client experienced homelessness at any of the three time points in any support period in each study period.

The longitudinal variables essentially answer the question, "Was the client ever known to be [homeless/not employed/a couch surfer/and so on]?". For example, if a client was homeless in any time period (week before, at presentation, at the end) of any support period then the longitudinal variable *homeless* will be true. Conversely, if they did not report being homeless at any time they will not be recorded as homeless; *this applies even if homeless status is unknown in some or in all time periods*. This is a significant difference to the approach used in the annual reporting of the SHS data, for which clients with unknown status are treated differently (for example, excluded from proportions).

Regardless of when a support period ends, the client characteristics in each support period are aggregated into the study period in which that support period commenced. In a small number of cases a support period may cross study periods. For example, if a client started a support period close to the end of their retrospective study period, this support period might end during the defining study period. In such a case, the client characteristics would be aggregated into the retrospective period.

Detailed information on how data items in the SHSC are derived can be found in the Technical information page within the Specialist homelessness services annual report.

Client vulnerabilities

For research and analysis purposes, SHS clients were assessed for the presence of vulnerabilities including mental health issues, drug and/or alcohol problems, and experience of family and domestic violence (FDV) issues, all of which are known to be risk factors in housing instability. The derivation of these vulnerabilities is outlined below.

Clients with a current mental health issue

For each support period, a client is considered to have a current mental health issue if they were 10 years or older at the start of the support period and the client had any of the following:

- reported 'mental health issues' as a reason for seeking assistance at the beginning of the support period
- was formally referred to the specialist homelessness agency by a mental health service
- reported at the beginning of the support period that they had been in a psychiatric hospital or unit in the last 12 months
- reported at the beginning of the support period that they were receiving services or assistance for their mental health issues or had in the last 12 months
- had psychiatric hospital or unit as their dwelling type either a week before presenting to an agency or when presenting to an agency
- reported psychiatric hospital or unit as their dwelling type during that support period
- required psychological services, psychiatric services, or mental health services during that support period.

Clients with problematic drug and/or alcohol use

For each support period, a client is considered to have problematic drug and/or alcohol use if they were 10 years or older at the start of the support period and the client had any of the following:

- reported 'problematic drug or substance use' or 'problematic alcohol use' as a reason for seeking assistance at the beginning of the support period
- was formally referred to the specialist homelessness agency from a drug and alcohol service
- reported at the beginning of the support period that they had been in a rehabilitation facility in the last 12 months
- had rehabilitation facility as their dwelling type either a week before presenting to an agency or when presenting to an agency
- reported rehabilitation facility as their dwelling type during that support period
- required drug or alcohol counselling services during that support period.

Clients who have experienced family and domestic violence (FDV)

Before 2019–20, a client was considered to have experienced family and domestic violence if 'domestic and family violence' was reported as a reason for seeking assistance (only reported at the beginning of the support period) or they required family/domestic violence services during that support period.

From 2019–20 onwards, a client is considered to have experienced family and domestic violence (which includes both victim-survivors and perpetrators) if:

- domestic and family violence' was reported as a reason for seeking assistance (only reported at the beginning of the support period)
- they were formally referred from a non-SHS family and domestic violence service provider (only reported at the beginning of the support period)
- they required family/domestic violence services during that support period.

Before 2019–20, the SHS data did not distinguish between victim-survivors and perpetrators among FDV clients. Therefore, a small proportion of the clients included in FDV study cohorts will be perpetrators, some of which may also be victim-survivors.

Young people presenting alone

Young people are defined as clients aged 15–24 who presented alone at the start of the support period.

Clients leaving care

Clients are counted as transitioning from care arrangements if:

- the dwelling type was: hospital (excluding psychiatric), psychiatric hospital or unit, disability support, rehabilitation or aged care facility
- their reason for seeking assistance was transition from foster care/child safety residential placements or transition from other care arrangements.

Clients who were exiting custodial arrangements

Clients are counted as leaving a custodial setting if:

- their dwelling type was: adult correctional facility, youth or juvenile justice detention centre or immigration detention centre or
- their reason for seeking assistance was: transition from custodial arrangements or
- their source of formal referral to the agency was: youth or juvenile justice detention centre, or adult correctional facility.

Some of these clients were still in custody at the time they began receiving support.

Older clients

Older clients are defined as those who were aged 55 and over at the start of any of their support periods.

Children on care and protection orders

Children are counted within this cohort if:

They were under 18 and were on a care and protection order (CPO) either the week before presenting for a service or on presentation and had the following care arrangements:

- residential care
- family group home
- relatives/kin/friends who are reimbursed
- foster care
- other home-based care (reimbursed)
- relatives/kin/friends who are not reimbursed
- independent living
- other living arrangements
- parents.

The cohort also includes clients aged under 18 who reported ‘transition from foster care and child safety residential placements’ as their reason for seeking support from SHS.

Indigenous clients

Clients are counted as Indigenous if they were recorded as identifying as Indigenous during any of their support periods, regardless of timing, and regardless of whether they were recorded as non-Indigenous in any or all other support periods.

Longitudinal variables

The longitudinal analyses characterise client's pathways and outcomes by aggregating some client characteristics or experiences within each study period.

Some client characteristics are fixed and do not vary over time. The client's state or territory (which can vary but is kept fixed in the longitudinal analyses), sex and age are all recorded as at the start of the first support period in the defining period. Variables such as Indigenous status and whether a client was born overseas are fixed for clients across all support periods. In both cases, if the variable is "true" in any support period (that is, Indigenous versus non-Indigenous or not-stated, overseas-born versus Australian-born or not-stated), then the client is marked as such in all their support periods.

Other characteristics are aggregated within study periods. For example, within each of the three study periods (retrospective, defining, prospective) a client can have any number of support periods. Within each support period, client circumstances are recorded at three times – the week before support commenced, at the start of support ("at presentation") and when support ended.

Variables are aggregated in a binary manner by examining whether a particular event or situation occurred at any of the three times for any support periods that occur within each study period.

The longitudinal study variables are aggregations within study periods, and therefore differ significantly from similar variables in annual SHS reporting. For example, a homeless client in the SHS annual report will have been homeless when they started their first support period in the reporting year. In the longitudinal data, however, the homeless variable is a binary marker that records whether the client experienced homelessness at any of the three time points in any support period in each study period.

The longitudinal variables essentially answer the question, "Was the client ever known to be [homeless/not employed/a couch surfer/and so on]?". For example, if a client was homeless in any time period (week before, at presentation, at the end) of any support period then the longitudinal variable homeless will be true. Conversely, if they did not report being homeless at any time they will not be recorded as homeless; this applies even if homeless status is unknown in some or in all time periods. This is a significant difference to the approach used in the annual reporting of the SHS data, for which clients with unknown status are treated differently (for example, excluded from proportions).

Regardless of when a support period ends, the client characteristics in each support period are aggregated into the study period in which that support period commenced. In a small number of cases a support period may cross study periods. For example, if a client started a support period close to the end of their retrospective study period, this support period might end during the defining study period. In such a case, the client characteristics would be aggregated into the retrospective period.

Homeless

This variable refers to whether the client ever reported being homeless during the study period and is examined at all 3 time points of each support period in each study period (week before, at presentation, at the end).

Couch surfer

This variable refers to whether the client ever reported their housing situation as 'couch surfer' (specifically, living in a house, townhouse or flat but without tenure). It is examined at all 3 time points of each support period (week before, at presentation, at the end).

Presented for support alone

Presenting unit refers to the composition of the group when presenting to SHS agencies for support. This variable refers to whether a client was ever recorded as having presented for support (that is, started a support period) alone. Unlike many other variables, this is only recorded in the SHS data at the start of support periods. Counts of clients with values of No include cases where the variable is not stated or unknown.

Children presenting alone:

Children may be reported as presenting alone to an SHS agency for several reasons:

- It is possible that a child physically presented with an adult to an agency, but only the child required and received SHSC services. In this case, the child is reported as 'presenting alone' as the accompanying adult does not have an SHSC support period that can be linked to the child client.
- Alternatively, a child may have presented with an adult to an SHS agency and both received services, but the agency worker may not have properly linked the child to the accompanying parent/guardian when opening a support period for the child; hence the child is reported as presenting alone.
- Service was sought by and provided to the child only (without an accompanying adult) and therefore the child is the only client and is reported as presenting alone.

In addition, South Australia has a comparatively high number of children reported as presenting alone. This may be due to a difference in how presenting units are recorded in South Australia's client management system.

Presented for support with child(ren)

Presenting unit refers to the composition of the group when presenting to SHS agencies for support. This variable indicates whether the client presented for support (that is, started a support period) as part of a group which contained one or more children. Unlike many other variables, this is only recorded in the SHS data at the start of support periods. Counts of clients with values of No include cases where the

variable is not stated or unknown.

Experienced FDV

This variable refers to whether the client had experienced FDV in any support period in the study period. Specifically, those clients where:

- domestic and family violence was reported as a reason for seeking assistance (only reported at the beginning of the support period)
- they required family/domestic violence services during that month.

Had mental health issues

This variable refers to whether the client identified as having had a mental health issue in any support period in the study period. Specifically:

- they indicated that at the beginning of a support period they were receiving services or assistance for their mental health issues or had in the previous 12 months
- their formal referral source to the specialist homelessness agency was a mental health service
- they reported mental health issues as a reason for seeking assistance
- their dwelling type was as a psychiatric hospital or unit either a week before presenting to an agency, or when presenting to an agency
- they had been in a psychiatric hospital or unit in the previous 12 months
- at some stage during their support period, a need was identified for psychological services, psychiatric services, or mental health services.

Had problematic drug or alcohol issues

This variable refers to whether the client had problematic drug or alcohol issues in any support period in the study period. Specifically, they:

- recorded their dwelling type as rehabilitation facility
- required drug or alcohol counselling
- were formally referred to the SHS from an alcohol and drug treatment service
- had been in a rehabilitation facility or institution during the past 12 months
- reported problematic drug, substance or alcohol use as a reason for seeking assistance or the main reason for seeking assistance.
- The identification of clients with problematic drug and/or alcohol use may be current or recent; referring to issues at presentation, just prior to receiving support or at least once in the 12 months prior to support.

Never employed in study period

This variable refers to whether the client did not have employment at any time in the study period. That is, the client was either unemployed or not in the labour force at all time points of all support periods in the study period (the 3 time points are, week before, at presentation, at the end of the support period).

It is intended to reflect the vulnerability of clients that have no independent means of financial support.

Not employed at least once in study period (Not Employed).

This variable refers to whether the client had periods of not being employed. It is a marker of whether the client was either unemployed or not in the labour force, in at least one time point during the study period. The client may have been employed at some time during the study period.

It is intended to reflect the vulnerability of clients that have no independent means of financial support. It is examined at all 3 time points of each support period (week before, at presentation, at the end).

Owned home

This variable refers to whether the client had tenure in a home as the owner at any time in the study period. Ownership can be outright (fully owner), mortgaged or shared equity or part of a rent/buy scheme.

Accommodated

This variable refers to whether the client was provided any form of accommodation in the study period and includes short term or emergency accommodation, medium term or transitional housing, or long-term housing.

Ended support period in public or community housing, started elsewhere

This variable refers to whether the client ever reported their housing situation as 'Public or community housing - renter or rent free' at the end of a support during the study period and they did not report 'Public or community housing - renter or rent free' at the start of the support period.

Started in public or community housing, ended elsewhere

This variable refers to whether the client ever reported their housing situation as 'Public or community housing - renter or rent free' at the start of a support during the study period and they did not report 'Public or community housing - renter or rent free' at the end of the support period.

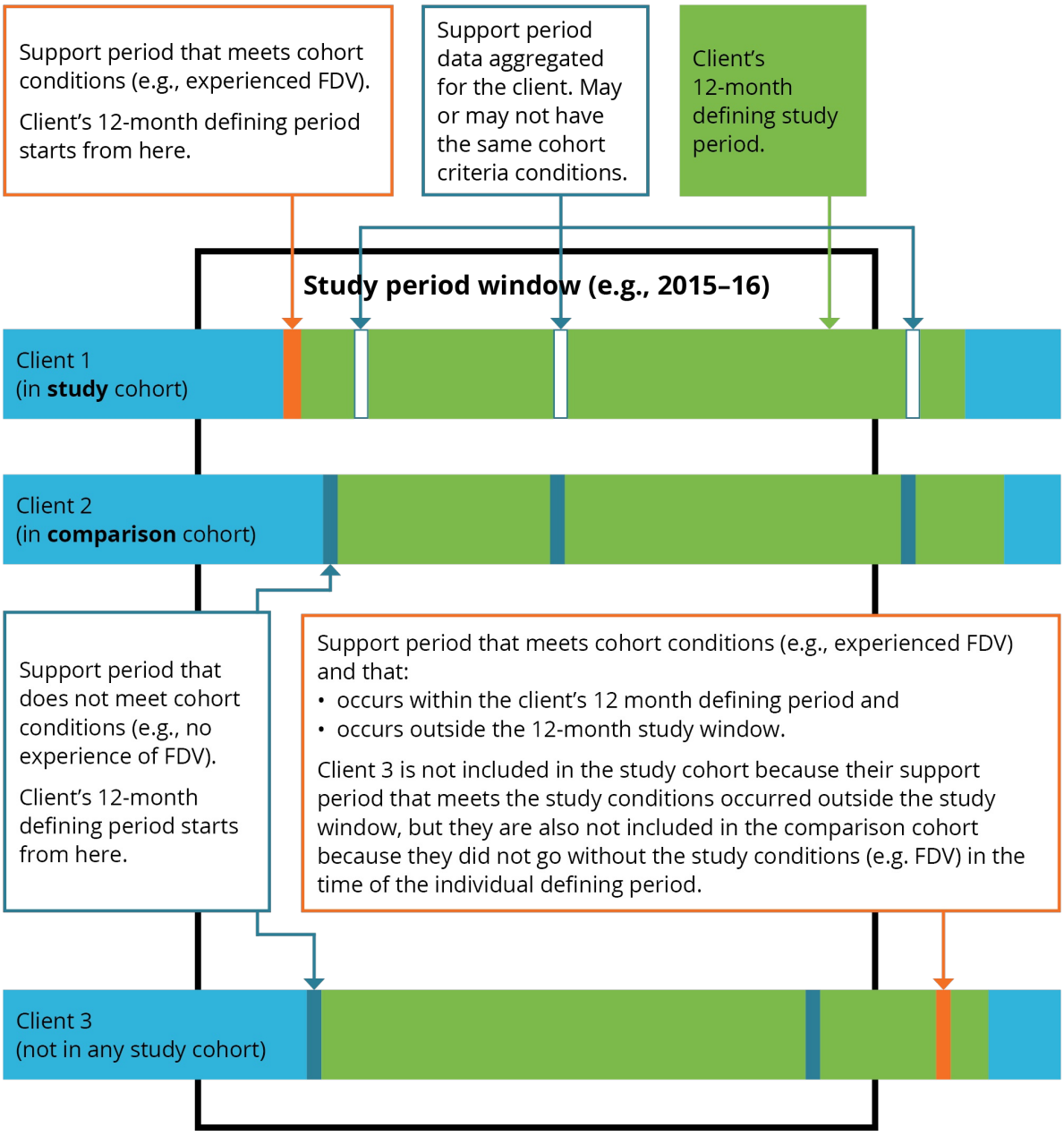
SHS data derivations

For many cohorts, the longitudinal analyses also include a comparison cohort, that is, a set of clients that lack the distinctive feature(s) used to define the study cohort. For example, the FDV cohort may be defined as clients that experienced FDV anytime during the defining study period (for example, 2015–16). Importantly, data for the 12 months following the first support period in the defining study period is aggregated into the defining study period for that individual client (Figure Methods.4). The comparison cohort would then be defined as clients that did not experience FDV in the 12 months from their first support period in the defining study period.

These definitions mean that there are also clients who will fit neither category and are subsequently excluded from the analysis. For example, a client who did not experience FDV in 2015–16, but did experience FDV after 2015–16 but within their 12-month defining period.

This is demonstrated in Figure Methods.4 below.

Figure Methods.4: Selection of study and comparison cohorts



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Technical notes

Weighting

Prior to the 2017–18 SHS collection, not all SHS agencies provided data to the AIHW (for example, in 2016–17, 97% of agencies provided all required data). Annual reporting of SHS data used weighting to compensate for missing agency data. For more information, see SHS Annual Report: Technical information.

Weighting has not been used for longitudinal analyses, so the interpretation of results should acknowledge that a small number of clients may be missing from the data (either completely or in part) before 2017–18. From 2017–18 onwards the SHS collection has nearly full coverage.

Relative Risk of service use

For study cohorts that include a comparison cohort, the longitudinal analyses include relative risk of service use between the study cohort and its comparison cohort. These relative risks are provided for all 3 study periods (retrospective, defining, prospective). For service use in the retrospective and prospective periods, clients (from both cohorts) that did not receive any services in that period are excluded from the calculation of relative risk. Therefore, relative risks for those two time periods are comparing the need for each service between clients that were in the SHS data in that period and in the study cohort (and therefore received a service, but not necessarily the one being examined) with the need (or lack of) for each service for clients in the comparison cohort that received at least one service in that period.

Differences in the number of SHS clients between longitudinal and annual data

The number of clients in longitudinal cohorts for a given reporting period will differ to the number of clients receiving services in the same reporting period, as reported in the AIHW SHS annual reports, for a number of reasons:

- The longitudinal cohorts are limited to clients that commenced a support period in a given defining study period (for example, 1 July 2015 to 30 June 2016). Conversely, the SHS annual reports focus on clients that receive support at any time during the reporting period, which will include clients that commenced supported in previous reporting periods (typically around 12% of clients commenced their support in previous reporting periods).
- The longitudinal cohorts are limited to clients that have closed support periods. That is, to be considered for a longitudinal cohort a client needs to commence their support during the defining study period and that support has to finish (at any time). This is so that outcomes can be measured for longitudinal clients. Clients in the annual data can have multiple support periods during the reporting period, some of which may be closed, but the last support period that starts during the reporting period can be open. Therefore, if a client only has open support periods in the reporting period, they will be excluded from the longitudinal data but may be included in annual reporting.
- Both the longitudinal analyses and the annual reporting exclude client with missing identifiers (statistical linkage keys) – this is to allow client data for multiple support periods to be grouped together. The longitudinal analyses apply stricter criteria to the quality of the identifier, however, and therefore excludes more clients.

Typically, a longitudinal cohort will have less clients than the corresponding annual cohort.

Modified Poisson Regression modelling

The SHSC longitudinal analyses make frequent use of binary outcomes as model targets. For example, analyses for the 2015–16 FDV cohort model the likelihood that clients will use SHS support in the future (binary outcomes: yes or no) based on client characteristics and client reasons for seeking assistance during the defining study period).

Modified Poisson Regression modelling with robust error variance was implement using the method of Zhao (2013) because this yields relative risk rather than the odds ratios of logistic regression (Zou 2003).

Importantly, the regression modelling undertaken with the SHSC longitudinal data is neither causal/explanatory nor predictive. That is, it neither aims to test causal hypothesis about what client factors (constructs) are relevant to outcomes (as per causal or explanatory modelling), nor is it predictive (that is, it is not intended to model future outcomes; Shmueli, 2010).

Instead, the modelling of the SHSC longitudinal data is descriptive. Their purpose is to measure the association between the dependent and independent variables Shmueli, 2010). The models are not refined nor are they internally validated; they therefore have no predictive value. Furthermore, there is no *a priori* development of causal theories that would allow the models to explain the reasons for given outcomes. Instead, the results serve as a starting point for further questions that could be subsequently addressed in exploratory models that explore individual causal factors.

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Technical notes

Accommodation services include short-term or emergency accommodation, medium-term/transitional housing, assistance to obtain long term housing, assistance to sustain tenancy or prevent tenancy failure or eviction and assistance to prevent foreclosures or for mortgage arrears.

At risk of homelessness: A person is described as at risk of homelessness if they are at risk of losing their accommodation or they are experiencing one or more of a range of factors or triggers that can contribute to homelessness.

Risk factors include:

- financial stress (including due to loss of income, low income, gambling, change of family circumstances)
- housing affordability stress and housing crisis (pending evictions/foreclosures, rental and/or mortgage arrears)
- inadequate or inappropriate dwelling conditions, including accommodation that is unsafe, unsuitable or overcrowded
- previous accommodation ended
- relationship/family breakdown
- child abuse, neglect or environments where children are at risk
- sexual abuse
- family/domestic violence
- non-family violence
- mental health issues and other health problems
- problematic alcohol, drug or substance use
- employment difficulties and unemployment
- problematic gambling
- transitions from custodial and care arrangements, including out-of-home care, independent living arrangements for children aged under 18, health and mental health facilities/programs, juvenile/youth justice and correctional facilities
- discrimination, including racial discrimination (e.g. Aboriginal people in the urban rental market)
- disengagement with school or other education and training
- involvement in, or exposure to, criminal activities
- antisocial behaviour
- lack of family and/or community support
- staying in a boarding house for 12 weeks or more without security of tenure.

The measurement of this concept in the SHSC is defined in the Data derivation section within the Specialist homelessness services annual report.

Confidence interval: A statistical term describing a range (interval) of values within which we can be 'confident' that the true value lies, usually because it has a 95% or higher chance of doing so.

Client: A Specialist homelessness agency client is a person who receives a specialist homelessness service. A client can be of any age. Children are also clients if they receive a service from a specialist homelessness agency. To be a client the person must directly receive a service and not just be a beneficiary of a service. Children who present with an adult and receive a service are considered to be a client. Children of a client or other household members who present but do not directly receive a service are not considered to be clients.

General services include:

- family/relationship assistance
- assistance for incest/sexual assault
- legal information
- material aid/brokerage
- financial information
- educational assistance
- training assistance
- employment assistance
- assistance to obtain/maintain government allowances
- assertive outreach for rough sleepers
- child care
- assistance for trauma
- assistance for challenging social/behavioural problems
- living skills/personal development
- court support
- advice/information
- retrieval/storage/removal of personal belongings

- advocacy/liaison on behalf of client
- school liaison
- structured play/skills development
- child contact and residence arrangements
- meals
- laundry/shower facilities
- recreation
- transport and
- other basic assistance.

Historical clients received SHS support in the retrospective and defining study periods.

Homelessness: for the purpose of the SHSC a person is defined as homeless if they are living in either:

- non-conventional accommodation or 'sleeping rough', or
- short-term or emergency accommodation due to a lack of other options.

Non-conventional accommodation (primary homeless) is defined as:

- living on the streets
- sleeping in parks
- squatting
- staying in cars or railway carriages
- living in improvised dwellings
- living in the long grass.

This definition aligns closely with the cultural definition of primary homelessness.

Short-term or emergency accommodation (secondary homeless) includes:

- refuges
- crisis shelters
- couch surfing or no tenure
- living temporarily with friends and relatives
- insecure accommodation on a short-term basis
- emergency accommodation arranged by a specialist homelessness agency (for example, in hotels, motels and so forth).

This definition aligns closely with the cultural definition of secondary homelessness.
The measurement of Homelessness in the SHSC is defined in the Data derivation section within the Specialist homelessness services annual report.
The ABS definition of homelessness for estimates derived from the Census of Population and Housing can be found in ABS catalogue 2049.0 (ABS 2012a).

Logistic modelling: A statistical technique that identifies significant relationships between variables (characteristics or factors) and an outcome, after simultaneously accounting for the confounding effects of other factors. Logistic regression is a form of statistical modelling that is often used for categorical response variables, especially binary variables. It describes the relationship between the probability that the response variable belongs to a particular category and a set of explanatory variables. The explanatory variables in logistic regression can be categorical or continuous.

Long-term clients received SHS support in all three study periods.

Not employed: Unemployed or not in the labour force.

Odds ratio: A measure of association between an exposure (such as client characteristics) and an outcome (such as ongoing SHS support). The odds ratio (OR) represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure. An OR greater than 1 indicates that the odds of the outcome occurring are greater in the cohort group, when compared to the non-cohort group. Conversely, an OR less than 1 indicates lower odds of the outcome occurring and an OR equal or close to 1 indicates that the odds of the outcome occurring are the same between the cohort's groups.

Ongoing clients: Ongoing clients received SHS support in the defining and prospective study periods.

Other support services: refer to the assistance, other than accommodation services, provided to a client. They include family/domestic violence services, mental health services, family/relationship assistance, disability services, drug/alcohol counselling, legal/financial services, immigration/cultural services, other specialist services and general assistance and support.

Risk: The probability of an event occurring during a specified period of time.

Relative risk: This measure is derived by comparing two groups for their risk of an event. It is also called the risk ratio because it is the ratio of the risk in the 'exposed' divided by the risk in the 'unexposed'. Relative Risk is calculated by dividing the risk of an event occurring for group 1 by the risk of an event occurring for group 2.

Short-term clients received SHS support only during the defining study period.

Specialist homelessness agency: an organisation which receives government funding to deliver specialist homelessness services to a client. These can be either not-for-profit or for profit agencies.

Specialist homelessness service(s): assistance provided by a specialist homelessness agency to a client aimed at responding to or preventing homelessness. The specialist homelessness services in scope for this collection include accommodation provision, assistance to sustain housing, family/domestic violence services, mental health services, family/relationship assistance, disability services, drug/alcohol counselling, legal/financial services, immigration/cultural services, other specialist services and general assistance and support.

Abbreviations and symbols

Abbreviations

ABS	Australian Bureau of Statistics
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
FDV	Family and Domestic Violence
NAHA	National Affordable Housing Agreement
NDIS	National Disability Insurance Scheme
NHHA	National Housing and Homelessness Agreement
NPAH	National Partnership Agreement on Homelessness
SHS	Specialist Homelessness Services
SHSC	Specialist Homelessness Services Collection
SLK	Statistical Linkage Key

Symbols

—	nil or rounded to zero
. .	not applicable
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data

Data

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