Evidence Brief

January 2023

Family and Community Services Insights, Analysis and Research (FACSIAR)

Pathways to homelessness for people with mental health issues in NSW

This Evidence Brief presents key findings about people experiencing mental health issues from Taylor Fry's Pathways to Homelessness report. We also discuss implications for policy and practice. By better understanding the experiences and pathways of people experiencing mental health concerns, supports can be put in place earlier to improve outcomes. The analysis uses a linked dataset that includes Specialist Homelessness Services (SHS) and 18 other NSW Government and Commonwealth services.

Key messages

- The Taylor Fry analysis shows that over the six years to June 2017, 1 in 7 (14%) people accessing homelessness services reported mental health as the main reason for seeking assistance. Males and females were equally represented among this group.
- The likelihood of accessing homelessness services is closely linked to mental health service use. People with mental health issues are between 3 and 26 times more likely than the wider NSW population to access homelessness services within a year of accessing a range of health services.
- People accessing homelessness services with a mental health service need have a very intensive service use history. Cross-sector service use for this group is higher across all services analysed when compared with broader users of homelessness services. People with evidence of acute mental health issues in their service history are 9 times more likely to present to homelessness services.
- Homelessness service use history combined with court presentations appear to be relevant predictors of homelessness experiences and potential intervention points for people with mental health issues. Custody exits also represent another potential intervention point for this cohort.
- People experiencing mental health issues are one of the fastest growing groups of clients accessing SHS (AIHW 2021). Increased focus on providing housing supports for those exiting health facilities presents an important intervention point.

Introduction

The Department of Communities and Justice has worked with Taylor Fry to conduct a detailed investigation into the services people use before, during and after experiencing homelessness in NSW. Part of the study looked closely at the pathways to homelessness for people experiencing poor mental health.

In 2020–21, almost one-third (32%) of clients who presented to SHS for assistance in NSW reported a current mental health issue (AIHW 2021). Clients experiencing mental health issues are one of the fastest growing groups of clients accessing SHS (AIHW 2021). Since 2011–12, the number of clients accessing SHS with a current mental health issue has increased from around one-fifth (19%) to one-third (32%) in 2020–21 (AIHW 2021). Understanding the service use pathways of this growing group may assist in providing effective early support and reducing demands on the homelessness system.

This Evidence Brief provides an overview of key findings and policy implications from the Pathways to Homelessness report for people presenting to homelessness services with a mental health need. Policymakers and practitioners are encouraged to use this as a basis for further consideration with stakeholders in their specific areas. Better understanding the experiences and pathways into homelessness for this cohort can help us design and implement preventative and early intervention responses to improve outcomes.

Further detailed information about the data and findings is available in the full report.

Why is understanding homelessness for people experiencing poor mental health important?

The relationship between mental health and homelessness is complex. While mental health issues are a key risk factor for homelessness, being homeless also exacerbates existing mental health concerns (Costello, Thomson & Jones 2013). Rates of serious mental illness and cognitive impairment are disproportionately high in people experiencing homelessness (Moledina et al. 2021). Mental health issues also affect a large proportion of Australians, with some surveys suggesting as many as 1 in 5 (20%) Australians have a current mental health issue (ABS 2018). Not only is the incidence of mental illness among people experiencing homelessness significantly higher than the general population, but young people appear particularly affected (Boyle 2020).

The causal pathways and relationships between factors such as homelessness, trauma, and mental health are well established but not fully understood (Kalevald et al. 2018). While research has shown that people who experience homelessness might also experience mental health issues, it is not always clear whether the homelessness event triggers, exacerbates or magnifies existing mental health issues (Kalevald et al. 2018 & Brackertz et al. 2018).

People living with a mental illness can experience heightened psychological distress and impaired decision-making which can contribute to poor health outcomes, reduced support and experiences of financial hardship (AIHW 2021). Common symptoms of mental illness such as memory loss, anxiety, compulsive behaviours and hallucinations can also affect a person's capacity to maintain a tenancy and live with others (Robinson 2003).

To gain a better understanding of the homelessness experiences of people with mental health support needs we also need to understand broader service use. This is one of the key aims of the Pathways to Homelessness research.

How was the Pathways to Homelessness analysis designed?

The analysis undertaken by Taylor Fry examined a large dataset of linked information including SHS and Temporary Accommodation (TA) data, data from 15 other datasets from NSW Government, and 3 Commonwealth health and welfare services to better understand homelessness.

The linked dataset covers 625,861 people, with a case and control design:

- The **case cohort** is 202,927 people who accessed SHS in NSW from 1 July 2011 to 30 June 2017.
- The **comparison (control) group** is a random sample of 422,934 people in NSW, matched for age and sex.

The dataset is large enough to be able to meaningfully talk about homelessness risk for the entire NSW population.

A range of analyses were applied to the data, including descriptive analysis, predictive modelling, pathway analysis and cost estimation. These form the basis for the findings presented in this brief. More information on the questions that guided the analysis, the data sets included and the approach undertaken is provided at the end of this brief and is available in the full report.

Various sections of the Taylor Fry analysis provide information about small sub-groups of people in order to better understand specific characteristics and service use pathways. This brief focuses on people with mental health issues (See Box 1 for key definitions).

It is important to note that the dataset does not capture the pathways of all individuals experiencing homelessness. The Taylor Fry analysis focuses on people presenting to crisis accommodation services, and more specifically where a person has sought assistance from an SHS provider or Temporary Accommodation (See Box 1 for key definitions). This is a practical decision as high-quality linkable data exists for this group.

Box 1: Definitions

How is mental health need defined in homelessness data?

The Taylor Fry analysis uses a narrow definition of mental health need – capturing those people who have an identified mental health need or who identify mental health issues as their reason for seeking assistance *at the start of an SHS support period only.*

The SHS definition of mental health need is broader and may include, for example, a client who at any stage during their support period have an identified need for mental health or psychological services. For a complete list of factors included in the SHS definition see the Specialist Homelessness Services Annual Report 2018-19.

The analysis also identifies people with mental health needs through their mental health service usage (i.e. emergency department presentations, ambulatory mental health services and hospital admissions, Medicare mental health services and PBS mental health scripts).

How are homelessness services defined?

For this analysis, homelessness services include Specialist Homelessness Services (SHS) and Temporary Accommodation (TA). SHS provide services aimed at prevention and early intervention, as well as crisis and post-crisis assistance to support people experiencing or at risk of homelessness. Temporary Accommodation supplements SHS in providing time-limited accommodation in low-cost motels or caravan parks for clients who are homeless. The intention of Temporary Accommodation is to provide a bridge to give clients a chance to secure alternative accommodation, such as crisis accommodation or private rental. It is a short-term temporary measure rather than a longer-term response.

What are the types of service presentations?

People presenting to homelessness services are classified based on their housing situation:

- People with no shelter or living in an improvised/inadequate dwelling are **rough sleeping**.
- People living in short-term temporary accommodation, or as a couch surfer with no tenure, are **homeless**. This includes people in Temporary Accommodation, noting some may have been rough sleeping.
- People living in social housing, private housing or institutional settings are **at risk of homelessness**.

What did the analysis find?

Key findings about people presenting to SHS with a mental health need and their pathways to homelessness are presented in the following infographic and described more fully in the rest of this brief. Detailed data is available in the full report.

There were about
400,000 presentations
(periods of support) to homelessness services from 2011–2017

14%
were for people with a mental health support need

1 in 10
men had a mental health support need

1 in 10
women had a mental health support need

Those with a mental health support need were:

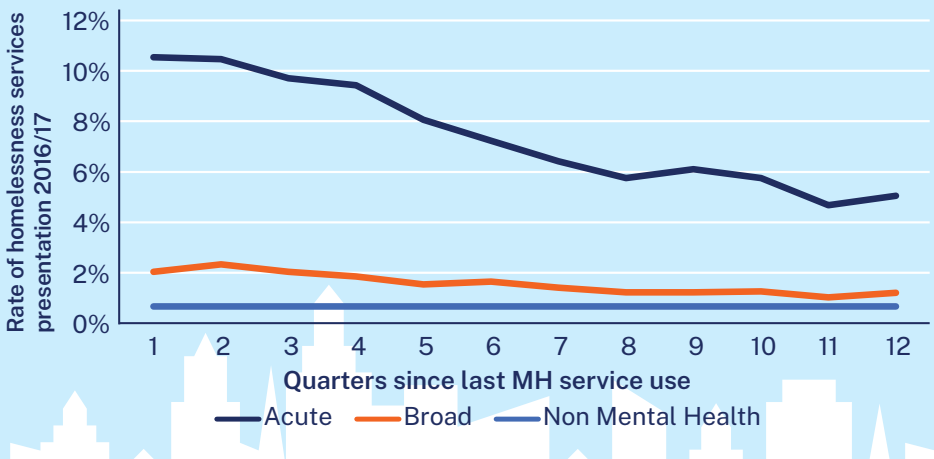
- often young women
- more likely to be rough sleepers
- have an intensive service use history

People with a mental health support need are more likely to use other mental health services

Rates of cross-sector service use for those accessing homelessness services in 2016–17

Homelessness service users who did not have a mental health need	Health services used	Homelessness service users who had a mental health need
6%	Accessed a hospital mental health unit	17%
20%	Used ambulatory mental health services **(all)**	39%
36%	Used Medicare mental health services	54%
34%	Use PBS scripts – mental health	50%

Mental health service use acts like a long-term referral pathway to homelessness services



The likelihood of accessing homelessness services is highest in the 6 months following a service use and declines gradually, taking close to two years for the rate of homelessness services presentations to halve.

Mental health is the second most common support need identified in users of homelessness services

From July 2011 to June 2017, mental health was the second most common type of identified support need among people presenting to SHS, after domestic and family violence. People presenting with a mental health support need were more likely to be *rough sleeping* (21%) or *homeless* (18%) with fewer presentations being identified as *at risk of homelessness* (10%), highlighting the heightened vulnerability for this group. For the same six year period, about 1 in 7 (14%) of all presentations (periods of support) to SHS were recorded as having a mental health support need. Mental health specialist support needs are identified at similar rates for females and males – both 11%.

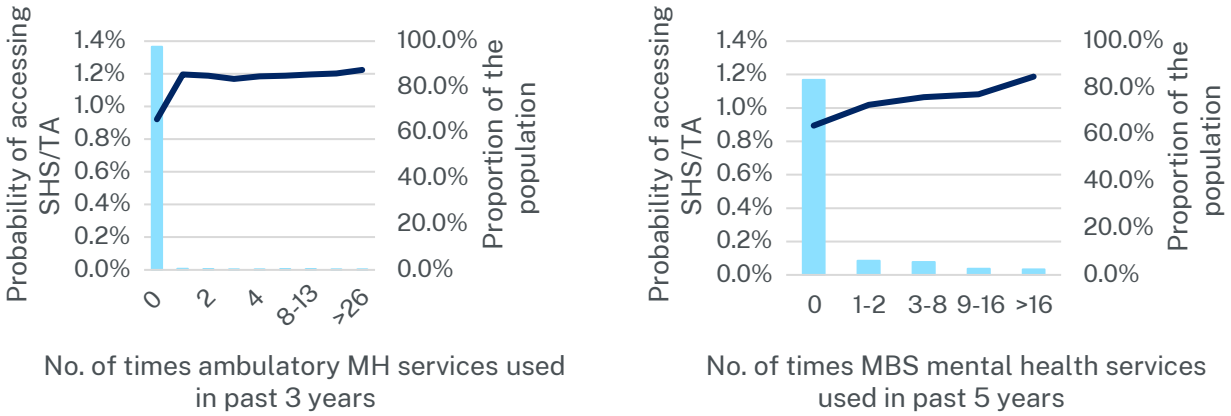
Repeat service use can compound future homelessness risk for some types of health services

Modelling can be used to look at service use history in terms of repeat service use and its impact on potential future homelessness services used in the following year. Figure 1 shows ambulatory mental health services used and Medicare mental health services compared with the rate of SHS presentations that follow in the next year. The model identifies ambulatory mental health services as an important key predictor of future homelessness, with any ambulatory mental health service use increasing the risk of homelessness service use by more than 30%. The rate of homelessness presentations does not continue to rise along with multiple episodes of service use.

It should be noted that 99.3% of the NSW population have not used ambulatory mental health services in a given quarter. The proportion that have more than one episode is also very small (these columns are too small to be seen in Figure 1).

The interaction for Medicare mental health services is different. One or two uses of Medicare mental health services over 5 years increases the risk of homelessness presentation by 14%, however repeated use (>16 times) increases this risk to 33% (Figure 1). This risk compounds with use of other mental health services.[11]

Figure 1: Probability of accessing homelessness services in the next year following use of ambulatory mental health services and Medicare mental health services



Source: Pathways to Homelessness, Figure 25

[1] These relationships are correlations rather than causative effects that are useful for prediction and determining potential intervention points. Often service use correlation can be driven by an underlying factor that is not fully visible in the administrative data. We caution against making causal interpretations for this reason.

People presenting to emergency with a mental health diagnosis represent the most costly users of homelessness services

To determine potential homelessness intervention points, the analysis looks at other government services people used in the year before accessing homelessness services. Users of mental health services represent an at-risk group. The cost of delivering services to this group are higher than other groups experiencing or at risk of homelessness and the general population. Table 1 looks at the risk uplift and coverage based on homelessness presentations for any presentation and only new cases[2] in the six years to June 2017.

What is risk uplift and coverage?

- The risk uplift refers to how many more times a person is likely to access homelessness services if they have accessed a given service.
- The coverage is the proportion of people presenting to homelessness services that also accessed a given service in the previous year.

The most useful service interventions would target groups at high risk (so prevention is well targeted), with high coverage (so a greater number of people are helped) and generate high potential savings. Generally, however, there is a trade-off between risk and coverage, which is clear for this group.

Table 1 shows that:

- People accessing health services, particularly mental health services in the previous 12 months, are more likely to access homelessness services in the next year (risk uplift).
- Risk uplift is highest for people accessing ambulatory mental health services for psychoactive substance use followed closely by personality disorders. However, an intervention targeting this group of people would only reach between 1% and 3% (coverage) of future homelessness presentations.
- Medicare mental health related service use and PBS scripts for mental health only increases risk uplift for homelessness presentation by three, but an intervention targeting these groups of people would reach between 25-27% of future homelessness presentations.

The additional costs[3] across NSW Government services for people who use health services who later go on to access homelessness services is significant. Compared to health service users who do not access homelessness services, the costs across NSW Government services for those that do are between $40k and $79k higher per person over three years. This represents the potential cost savings of an intervention that prevents these health service users from later needing homelessness services.

The same analysis presented in Table 1 was repeated for young people aged 16-24 years. There were few noticeable differences specific to young people, with the exception of the risk uplift for Emergency Department mental health presentations being noticeably lower for young people (x9) when compared with the broader NSW population baseline (x21).

[2] New cases are those who have not accessed SHS or Temporary Accommodation in the prior three years and are limited to the period 2014/15 to 2016–17.

[3] More information on unit costing assumptions can be found in Appendix C of the full report.

Table 1: Two-way analysis results of homelessness service use and selected health services used in the previous 12 months

		Any homelessness presentation			New cases[2]	
		Risk uplift	Coverage	Additional 3-yr costs across NSW govt.	Risk uplift	Coverage
Ambulatory mental health	Any	x13	16%	$58k	x9	12%
	Psychoactive substance use	x26	3%	$52k	x15	2%
	Personality disorders	x25	1%	$62k	x12	1%
Emergency Department	Any	x3	42%	$51k	x2	36%
	Mental health diagnosis	x21	3%	$79k	x11	2%
Admitted patients	Any	x2	26%	$55k	x1	22%
	Mental health diagnosis	x15	3%	$67k	x10	2%
Medicare services	Any	x1	80%	$41k	x1	78%
	Mental health related	x3	25%	$47k	x3	23%
PBS scripts	Any	x1	64%	$40k	x1	62%
	Mental health related	x3	27%	$49k	x2	24%

Notes: For any homeless presentations, the NSW population baseline rate is 0.73% p.a. For new cases, the baseline is 0.55% p.a. 'New cases' are new homelessness presentations where there has been no homelessness support in the previous 3 years.

Source: Pathways to Homelessness, Table 30 and Table 31.

Cross-agency data can help us understand service pathways and intervention points

This section looks at two ways to identify people with poor mental health in cross-agency data:

- People with mental health needs as a reason for seeking assistance from SHS (**mental health need group**[4]). The data allows for a backwards view – we can look at previous service use for people who accessed SHS with mental health as a reason for seeking support, to identify potential early intervention points.

[4] Referred to in the full report as the "mental health service need cohort".

- People identified as having mental health needs through service usage (**mental health service users**[5]). The data provides a forwards view – it looks at people who potentially have a similar need for support (in this case people with mental health service use history in the last three years) and whether they present to homelessness services in future. Analysis for this second group is split into two cohorts:
  - Acute mental health (MH) service users (including services such as emergency department presentations, ambulatory mental health services and hospital admissions).
  - Broader service users (including services such as Medicare mental health services and PBS mental health scripts).

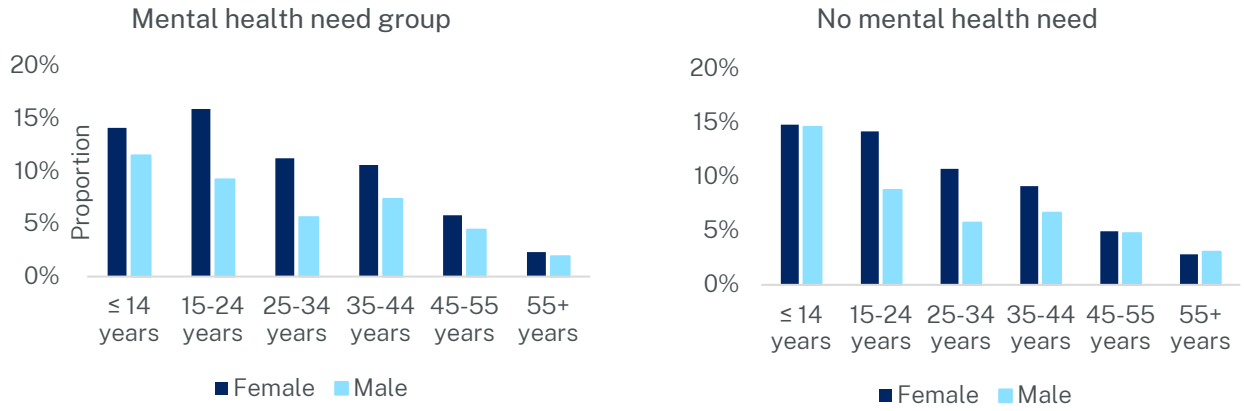
These relationships are correlations rather than causative effects that are useful for prediction and determining potential intervention points. Therefore, caution should be taken in making causal interpretations.

Clients who present to SHS with a mental health need have an intensive service use history

In 2016–17, 7,200 people presented to SHS needing support for a mental health issue representing about 12% of all people accessing SHS that year.

People who present to SHS with a mental health need share a similar demographic profile with the rest of the SHS population. As Figure 2 shows, an identified mental health service need is slightly more common for females with the biggest gap (relative to males) for those aged under 25. Compared with the broader SHS population, the largest difference for females was in the 15 to 24 years age group (14.1% versus 15.9%).

Figure 2: Comparison of age and sex for those who accessed SHS in 2016–17 by mental health need



Source: Pathways to Homelessness, Figure 35

As Table 2 shows, people in the mental health need group appear to have an intensive service use history across a range of services, compared to clients without a mental health need. Service use is higher across all sectors for those presenting with a mental health need, with the use of other mental health services particularly high. For example, 17% of people presenting to SHS with a mental health need had spent some time in a hospital mental health unit in the previous five years. This compares with only 6% of people presenting to SHS without a mental health need. Similarly, 39% of people presenting to SHS with a mental health need had accessed ambulatory mental health services in the previous five years compared with only 20% of people without a mental health need. Ambulatory mental health service use for psychoactive substances was 2.2 times the rate of the broader SHS population.

[5] Referred to in the full report as the "mental health service use cohort".

Table 2: Rates of cross-sector service use over the 3 years to 30 June 2016 for those accessing SHS in 2016–17

	No MH need identified	MH need identified	Compared
Emergency Department (ED)	57%	66%	x1.2
ED – mental health related	4%	8%	x2.1
Hospital	40%	49%	x1.2
Hospital – mental health unit	6%	17%	x2.6
Ambulatory mental health	20%	39%	x1.9
Ambulatory mental health – psychoactive substance	4%	8%	x2.2
Medicare mental health	36%	54%	x1.5
PBS script – mental health	34%	50%	x1.5
Controlled drugs	3%	4%	x1.5
Ambulance	29%	40%	x1.4
Legal Aid	22%	29%	x1.3
Victim incident (Police)	39%	48%	x1.3
DFV victim incident (Police)	8%	11%	x1.3
Court appearance/YJC/caution	21%	28%	x1.3

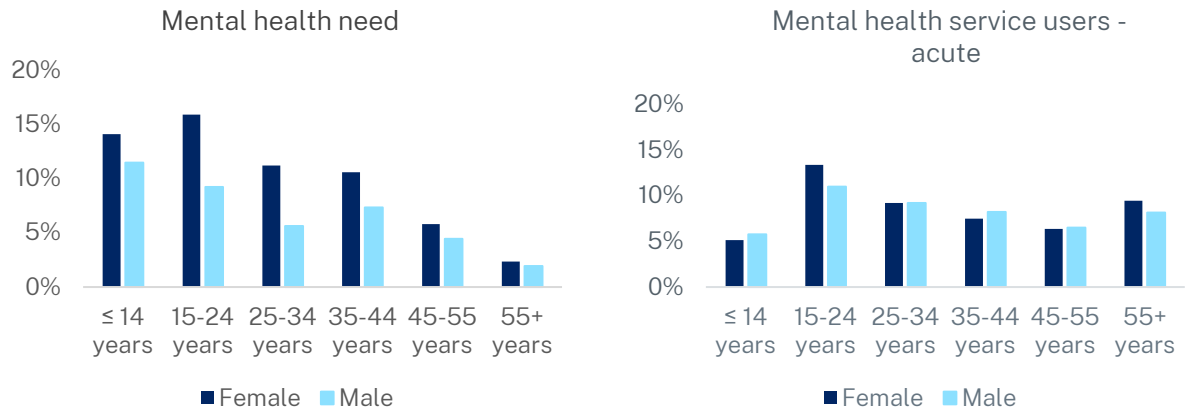
Source: Pathways to Homelessness, Table 39

Intensive mental health service use acts as a long-term referral pathway to homelessness services

This section considers the group who have used mental health services in the three years to June 2016, with analysis split into two cohorts: acute mental health and broader mental health service users. The acute mental health service users group is made up of 217,000 people on a population weighted basis. The broader service users group represents 1.9 million people.

Figure 3 provides a demographic breakdown of the acute mental health service users and mental health need identified groups. Compared to the mental health need identified group where more service users are likely to be female, the gender distribution of the acute mental health service users group is more even, with acute service users only slightly more likely to be female in the 16-23 year age bracket. The acute service users group was slightly older (31% of the group is aged 45 years or older compared with 15% of those with an identified mental health need).

Figure 3: Comparison of age and sex for the two mental health groups – mental health needs and acute mental health service users group



Source: Pathways to Homelessness, Figure 37

The bulk of acute mental health service users are people who have accessed ambulatory mental health services (91%) (Table 3). As contained in the definition, the broader mental health service user group primarily accessed Medicare and PBS services. There was some overlap between the two cohorts. For example, 10% of the broader service users cohort also accessed ambulatory mental health services.

Table 3: Proportion of each cohort that accessed mental health services that contribute to cohort definition

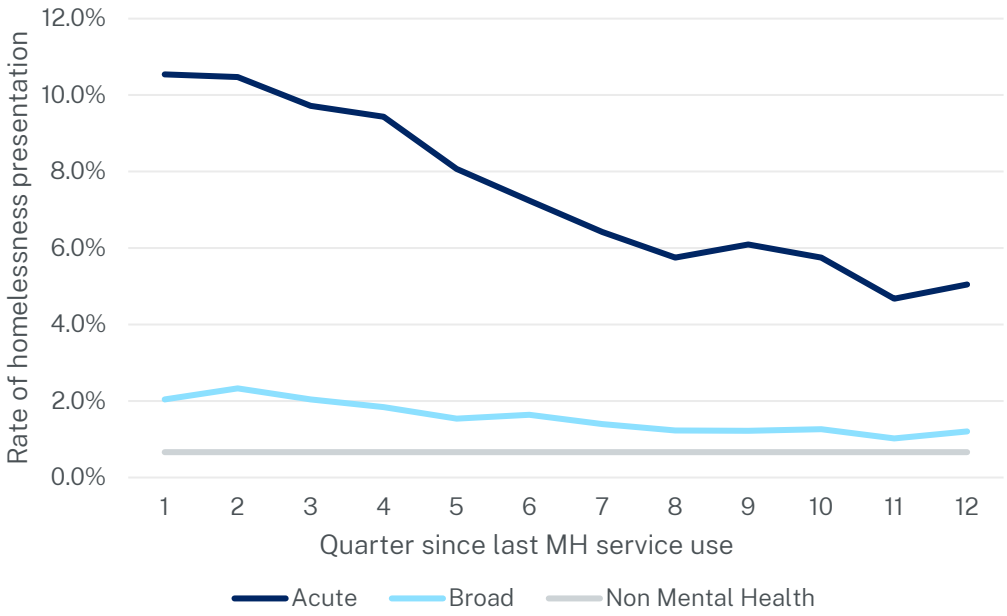
	Proportion who used service	
	Acute service users	**Broader service users**
Ambulatory mental health	91%	10%
Emergency Department mental health	13%	2%
Hospital admissions – psychiatric unit	27%	3%
Medicare mental health	n.a	61%
PBS mental health	n.a	71%

Note: Percentages do not add to 100% as users could access multiple services across the three years.

Source: Pathways to Homelessness, Table 40

Service use data shows the relationship between timing of mental health service use and homelessness presentation (Figure 4). The likelihood of accessing homelessness services is highest in the six months following an acute mental health service use (10.5%) and declines gradually, taking close to two years for the rate of homelessness presentations to halve. It should be noted that mental health service use is less likely to be a one-off event for this group, given the nature of services used (e.g. hospital admission to a mental health unit might be for a period of time). The relationship for acute mental health service users suggests mental health service use acts less like a trigger event but may represent a long-term referral pathway. The rate of homelessness presentation for the broader service users group is closer to the general population.

Figure 4: The rate of homelessness presentations in 2016–17 by time since last mental health service use



Source: Pathways to Homelessness, Figure 36

A history of prior homelessness and recent court presentations can predict future homelessness service use for acute mental health service users

Other service use information can be used to help predict the likelihood of future homelessness presentations among the acute mental health service users group using decision trees[6]. The example provided below in Figure 5 and Table 5 looks at previous homelessness service use and interactions with other service use such as income support receipt, ambulatory mental health service use, court appearances and custody spells.

Figure 5 shows that 11% of acute mental health service users have accessed homelessness services in the last three years but had no court presentations in the last year. People in this 11% subgroup:

- account for 35% of homelessness presentations among the acute mental health service users group
- have a 26.3% likelihood of experiencing homelessness within the next year.

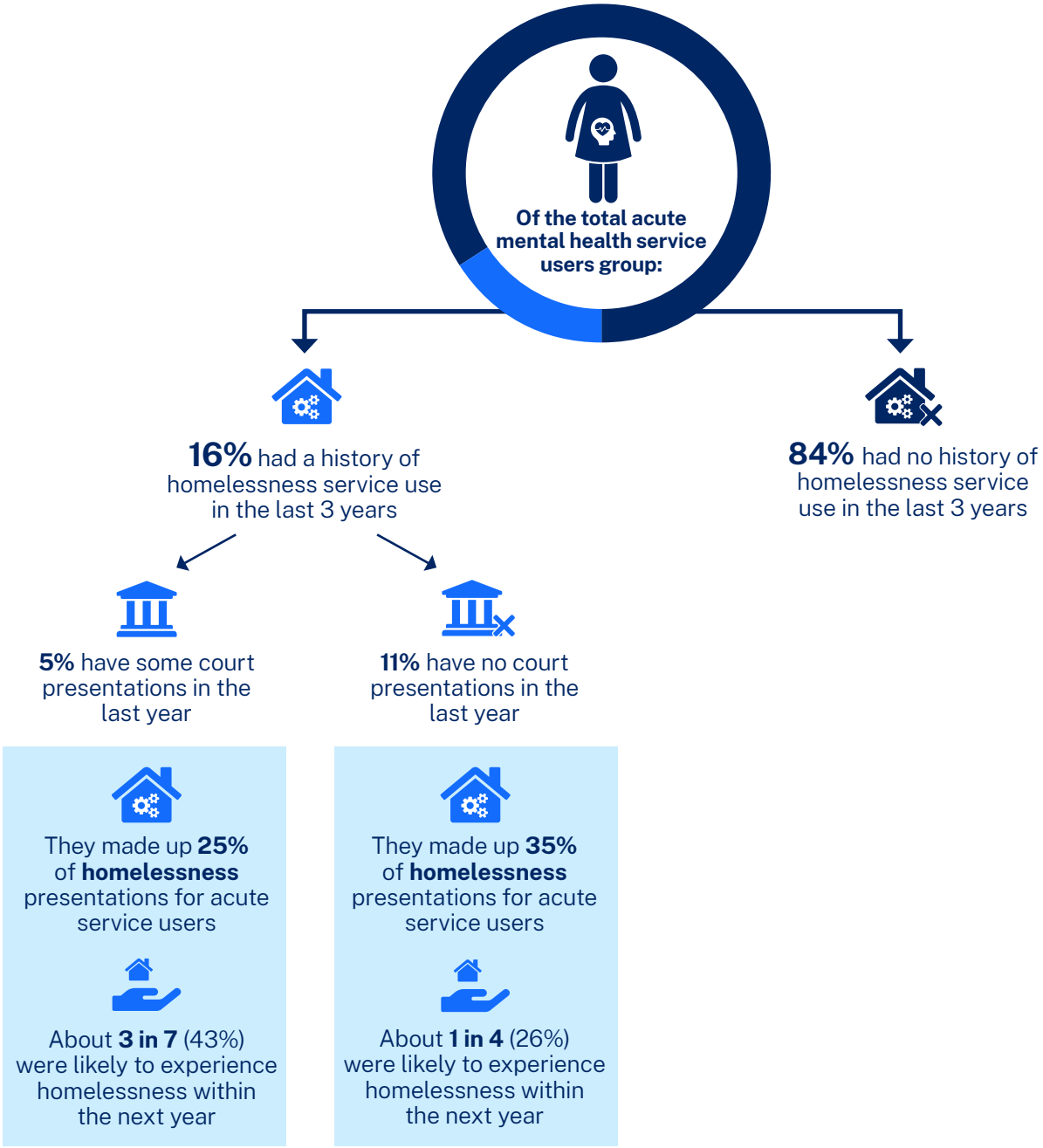
Additionally, 5% of the acute mental health service users group have accessed homelessness services in the last three years and had some court presentations in the last year. People in this 5% subgroup:

- account for 25% of homelessness presentations among the acute mental health service users group
- have a 42.9% likelihood of experiencing homelessness within the next year.

[6] For more information on how decision trees were used by Taylor Fry see Appendix E of the full report.

This suggests that a recent history of court presentation coupled with previous homelessness service use is an indicator of a higher rate of future homelessness service need and may act as a relevant early intervention point for acute mental health service users.

Figure 5: Infographic of example segmentation – Risk of presenting to homelessness services in 2016–17 for acute mental health service users group by history of homelessness service use and court presentations in the last year



Further detail for acute mental health service users is provided in Table 5, which shows a combined service use history characterised by time spent in custody, income support receipt and multiple ambulatory mental health service episodes increases the likelihood of future homelessness, despite no history of previous homelessness service use. Future homelessness risk is particularly dependent on the number of ambulatory mental health service episodes:

- Three or fewer episodes of ambulatory mental health service use puts someone at 12.8% risk of accessing homelessness services in the future.
- A history of more than three episodes of ambulatory mental health services doubles the risk to 27.1%.

Based on Table 5 we can see key intervention points for acute mental health users include court and custody. The overall proportion of acute service users with a history of time spent in custody or court presentations account for 8.2% of this cohort but 32% of homelessness service presentations in the group.

Table 5: Example segmentation – Risk of presenting to homelessness services in 2016–17 for acute mental health service user groups, by income support receipt, ambulatory mental health services, court attendance or time spent in custody in the last year

Service use				Proportion of acute MH service users	Likelihood of homelessness service use in the next year	Proportion of all homelessness presentations in the group
No homelessness service use in last three years	No days in custody in the last year			81%	**3.4%**	33%
	Some days in custody in the last year	Less than 1/3 year on income support in the last year		1.6%	**10.8%**	2%
		More than 1/3 year on income support in the last year	3 or fewer AMHS in the last 3 years	0.7%	**12.8%**	1%
			More than 3 AMHS in the last 3 years	1.2%	**27.1%**	4%
Some homelessness service use in the last three years	No court presentation in the last year			11%	**26.3%**	35%
	Some court presentations in the last year			4.7%	**42.9%**	25%
Total				**100%**	**8.3%**	**100%**

What does this tell us about how we deliver services to people with mental health issues?

Preventing exits into homelessness from health facilities is important

A recent study by the Australian Housing and Urban Research Institute (AHURI) (Duff et al. 2022) sought to develop policy directions for enhancing housing supports for people leaving a range of institutional settings including residential treatment for mental health issues. The study used linked administrative data from Victorian and NSW Government agencies as well as qualitative interviews with stakeholders and service users. Key findings from the study point to a number of improvements including:

- The Housing First model could be used as a guide to enable more effective coordination of discharge planning, transition planning and post-exit support for people leaving institutional settings.
- There is variation in the ways housing issues are managed as well as significant gaps in how services are delivered. Greater integration of housing supports within and across the housing, corrections and youth justice, out-of-home care, mental health and substance use treatment sectors is needed.
- There is evidence that service coordination roles can effectively promote service integration and emerging evidence that service coordination roles should draw on the lived experience of service users to guide this work (Duff et al. 2022).

Preventing exits from government services into homelessness is critical to reducing the risk and incidence of homelessness across NSW. As the Pathways research findings demonstrate, people leaving health facilities and other services experience unpredictable exit pathways that significantly increase their risk of homelessness. With no single agency able to address the full range of multiple and complex needs that these individuals may be experiencing, an integrated approach and effective working partnerships between government services to support these high risk cohorts are all crucial elements of preventing exits to homelessness.

As the Taylor Fry analysis suggests, intensive cross-sector health service use represents a critical intervention point for people with mental health issues who go on to experience homelessness. The analysis shows that:

- Accessing ambulatory mental health services in the previous 12 months increases the risk of accessing homelessness services in the next year by 13 times. The risk was even greater for admitted patients with a mental health diagnosis (risk uplift x15).
- The costs across NSW Government services over three years are estimated at over $50,000 greater for people accessing ambulatory mental health services who later access SHS, compared to people who access mental health services but don't access homelessness services.

This points to the importance of discharge and transition planning from health services. The discharge process from an institution such as hospital or mental health facility can carry significant risks for homelessness. The transition period can cause instability and expose an already at-risk person to stress that can be destabilising (NSW Government 2018). Therefore, effective hospital and mental health institution discharge processes can have a significant impact on the prospects of improved mental health and housing for people with mental health concerns (Brackertz 2018).

The evidence-base highlights a number of effective mental health interventions targeting people who are homeless or at risk of homelessness

A recent systematic review found some evidence for the effectiveness of a range of mental health interventions targeting homeless populations. Examples include assertive community treatment approaches which were shown to have a moderately positive effect on housing stability for homeless people with mental illness (Moledina et al. 2021). Assertive community treatment consists of a multidisciplinary group of healthcare workers in the community offering team-based care to persons with high levels of need. Teams operate 24/7, providing services tailored to the needs and goals of each service user. There is usually no time limit on the services provided, but transfer to lower intensity services is common after a period of stability (Moledina et al. 2021).

Quantifying and reducing the costs of homelessness across NSW Government

The potential cost savings across NSW Government services of preventing future homelessness for people with mental health issues are considerable. As the analysis shows (see Table 2), the additional costs for people who access both mental health services and SHS, compared to people who only access mental health services are between $40k and $79k per person over three years. Preventing exits from health care settings into homelessness therefore comes with considerable cost savings.

Conclusion

People experiencing mental health issues are one of the fastest growing groups of clients accessing SHS services (AIHW 2021). While the relationship between homelessness and mental health issues is complex, it is clear from cross-sector service use that a history of intensive health system access – particularly mental health services – significantly increases the risk of future homelessness service access. Given this, increased focus on providing housing supports for those exiting from health facilities presents an important intervention point.

The findings highlight the importance of improved data systems to collect, coordinate and use data and research. Enhanced data collection and coordination systems would inform our evidence base to determine the most effective responses for people accessing services that put them at increased risk of future homelessness.

About the Pathways to Homelessness report

Pathways to Homelessness is a key action under the 2018 *NSW Homelessness Strategy* to improve the evidence base for early intervention and prevention for people at risk of homelessness.

The project focused on four key research questions:

1. For people requiring homelessness support, which other government services have they used before?
2. For people using other government services, how likely are they to require homelessness support?
3. Among the people identified, what other risk factors affect their likelihood of using homelessness services?
4. How do government service use costs differ for people requiring homelessness services?

The dataset comprised SHS and Temporary Accommodation data plus 15 other linked NSW Government and 3 Commonwealth Government health and welfare datasets including Centrelink data, Medicare service information, Pharmaceutical Benefit Scheme data, hospital stays; Emergency Department visits; registered births and deaths; ambulatory mental health; ambulance callouts; Controlled Drugs of Addiction; social housing; Temporary Accommodation; private rental subsidy/assistance; out-of-home care; police-recorded victim incidents; Legal Aid; Court appearances; time in custody; and educational attainment. The study cohort comprised 625,861 people.

The analysis used a combination of methods:

- descriptive statistics to understand the key characteristics of homelessness presentations over the six-year period to 30 June 2017
- predictive modelling to identify people with a high likelihood of accessing homelessness services in the future, and associated risk factors to support intervention
- two-way pathway analysis, which looks at homelessness presentations that follow other service use, to identify potential intervention points and estimate the elevated costs across government for people experiencing or at risk of homelessness
- additional analysis on vulnerable cohorts, including financial hardship, mental health conditions, substance use, DFV, exiting custody, and leaving out-of-home care (OOHC).

You can access the full report on the Department of Communities and Justice website.

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