POPULATION HEALTH SERIES REPORT

phn MURRAY

An Australian Government Initiative

HOMELESSNESS

Leadership Collaboration Respect Accountability Innovation

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

Recognition of lived experience

We recognise the individual and collective contributions of people with a lived and/or living experience of health issues, and their families, loved ones and supporters.

It is through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services that we will find the expertise we need to move towards the health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of people who live with or care for someone with health concerns.

Contributors and attribution

Murray PHN would like to extend sincere thanks to the many contributors to this population health series report including the members of the Community and Clinical Advisory Councils, Medical Advisors, and to local healthcare consumers, professionals, community members and other stakeholders. We also acknowledge the contributions of Murray PHN staff who were involved in the planning, data collection, analysis and reporting, as well as consultants Impact Co.

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Executive summary

Murray PHN's Population Health Series: Homelessness report describes the outcomes of a comprehensive analysis of the health and service needs of people experiencing or at risk of homelessness in the Murray PHN catchment. The report seeks to highlight priorities, strengths and gaps in primary healthcare capacity to meet the health needs of this population and to identify opportunities to improve access to services.

The report is informed by quantitative and qualitative data to develop insights for service planning, capacity building, and system coordination and integration. Population health data on the location, demographics, and health needs of people experiencing or at risk of homelessness were identified and analysed, together with analysis of stakeholder consultations that included health service providers, housing and homelessness service providers, Murray PHN Clinical and Community Advisory Councils, Medical Advisors and subject matter experts.

Priorities from this report:

- The North West sub-region including Mildura and Swan Hill LGAs had the highest rates of homelessness and marginal housing in the Murray PHN catchment These rates were higher than the state average indicating a need for targeted responses (ABS, 2021).
- There were more people accessing Specialist Homelessness Services in the Murray PHN catchment (20 per 1,000) compared to the state average (15 per 1,000), which requires equitable proportionate investment. Eleven LGAs had service access rates above the state average, with the highest rates in Mildura, Shepparton, Wodonga, and Swan Hill (AIHW, 2022-23).
- There were higher rates of people living in marginal housing in the Goulburn Valley and North West sub-regions compared with Murray PHN and state average rates (ABS, 2021). Marginal housing includes crowded dwellings, improvised dwellings, and housing in caravan parks, which is likely to have increased since the 2021 census due to natural disasters and floods in these regions and higher costs of housing and living expenses.
- Teenagers and young adults (10-29 years) accounted for approximately a third of the homeless population across all age groups, which demonstrates the importance of youth-friendly, developmentally appropriate primary health services.
- Aboriginal and/or Torres Strait Islander Peoples comprised 10% of the homeless population in the Murray PHN catchment, exceeding the state average of 4%. This demonstrates that ACCHO-led services are critical for meeting the health and service needs for this population group. Rates of homelessness in First Nations People were higher than average in the North West sub-region (21 per 1,000, versus the state 17 per 1,000).
- There were twice as many females at-risk of homelessness that accessed Specialist Homelessness Services compared to males (AIHW, 2022-23), which is likely due to multiple factors including family violence and caring responsibilities.
- Client access rates to family violence services were higher in the Murray PHN catchment (635 per 100,000) compared with the state average (518 per 100,000) and was almost five times the average rate in Mildura (2,403 per 100,000) and over three times the average rate in Swan Hill (1,637 per 100,000). There were 8 LGAs in the Murray PHN catchment with rates above the state average (AIHW, 2022-23).
- Rates of chronic conditions were higher in the Murray PHN catchment compared with the state for all conditions (except for Dementia that was equal to state), which is likely due to rural health inequities and ageing populations (ABS, 2021).

- Stakeholder consultations identified several additional priority groups which were: single parents and families, older people including older single women, Culturally and Linguistically Diverse populations, people with a refugee or migrant background, low-income earners and people with no employment or job insecurity, people with mental health issues and trauma history, veterans including young veterans, people leaving state institutions, and people with disability.

With a focus on the above prioritised population groups and regions, the following key recommendations should be addressed:

- Commission tailored services to enhance primary healthcare access for people experiencing or at risk of homelessness applying learnings from existing community-based exemplar models including in-reach, outreach and after hours services.
- Support and advocate for strategies and funding that improves access to mainstream primary healthcare services and encourage flexible and contextualised models of care.
- Strengthen existing health navigation services and build capacity with the non-health sector to support equitable access to health services.
- Support and facilitate collaboration and communication between service providers and to strengthen and build coordinated cross sector systems that improve continuity of care and health outcomes.
- Provide workforce development and support capacity building activities that improve understanding of homelessness, the impacts on health and healthcare access, and best practical strategies and models.

Key insights

Population trends		Data reference
ABS 2021 Census rates of homeless and marginally housed	There were 2705 people homeless and 2297 people marginally housed. This equates to a rate of four people homeless and three people marginally housed for every 1000 people in the region, slightly lower and equal to state average rates respectively.	Table 3
	Of people who were experiencing homelessness, there was a higher proportion of people in improvised dwellings/sleeping out, in supported accommodation or staying temporarily with other households than the state average, but fewer people living in boarding houses.	Table 3
	Of people who were marginally housed, there was a higher proportion of people in other improvised dwellings or marginally housed in caravan parks than the state average, but fewer living in other crowded dwellings.	Table 3
	The North West sub-region of the Murray PHN catchment has the highest rates of homelessness or marginally housed people followed by Goulburn Valley.	Table 4
	Four LGAs had above the catchment average rate of seven homeless or marginally housed people per 1000. These were Swan Hill (20) Greater Shepparton (13) Mildura (11) and Wodonga (eight).	Table 6
Specialist Homelessness Service (SHS) clients	In 2022-23 financial year, 13,974 people accessed SHSs, which is equivalent to a rate of 20 per 1000 people and is higher than the state rate (15).	Table 5
	More SHS clients are recorded as at risk of becoming homeless on first presentation to a service (7459) than those recorded as homeless (5119) or not stated (1396).	Table 5
	The North West sub-region had the highest rates of SHS clients (35 per 1000 people) with the other areas having fairly similar rates: Goulburn Valley (19) North East (18) and then Central Victoria (17). The rate for all sub-regions was higher than the state rate (15).	Table 5
	Seven LGAs had above the catchment average rate of SHS clients (20 clients per 1000 people) and 12 LGAs had a rate above the state rate (15). The top four LGAs were Mildura (40), Greater Shepparton (30), Wodonga (29) and Swan Hill (29).	Table 7
Age and gender	More males (53.9%) than females (46.1%) were homeless or marginally housed according to the 2021 Census.	Figure 8
	There were more female (61.4%) than male (38.6%) SHS clients in 2022-23. The largest discrepancy was in SHS clients recorded as at risk of homelessness with 4804 females compared to 2390 males.	Figure 9
	Young adults accounted for the highest proportion of homeless and marginally housed people with 10.9% of the total being in the 20-24 years age group, and 29.6% between the ages of 15 and 29 years.	Figure 10
	A larger proportion of people who were marginally housed (21.4%) were age 55 years and older compared to those who were homeless (14%).	Figure 10

First Nations Peoples	The rates of homelessness for First Nations Peoples for the catchment was 14 per 1000 and is slightly lower than the state rate (17). However, the North West sub-region rate was higher (21).	Table 9
	In the 2021 Census, 10% of all people who were homeless in the Murray PHN region identified as Aboriginal and/or Torres Strait Islander, which is higher than the state (4%) and the average across all non-metropolitan areas of Victoria (8%).	Table 10
Priority groups	Stakeholders noted that population groups more likely to experience or be at risk of homelessness included, young people, older people (particularly older single females), First Nations People, single parents and families, and people from culturally and linguistically diverse groups. People who have recently left state care (including hospitals, out of home care or correctional facilities), and people who experience overcrowding, hoarding or squalor, are also at risk.	Table **13**
	People who are more likely to experience a higher risk of homelessness include victim/survivors of family violence and other trauma, people with lower incomes or insecure employment and those who are socially isolated. In the Murray PHN catchment people affected by natural disasters (such as recent floods) also experience homelessness and dislocation.	Table **13**

Health needs		Data reference
Prioritisation of health needs across Murray PHN	Modelling of available data determined that the LGAs with the highest level of health needs for people experiencing or at risk of homelessness are Greater Shepparton, Mildura, Greater Bendigo, Swan Hill and Campaspe.	Table A1 Appendix
Self-reported long term health conditions	Overall, the rates of self-reported long term health conditions in the Census were higher in homeless or marginally housed people in the Murray PHN catchment compared to the state.	Table 12
	The most common health issues reported in the Census by homeless or marginally housed populations were mental health conditions (127 per 1000 people), asthma (80), arthritis (57), diabetes (37) and heart disease (29). The Murray PHN rates were higher than the state for each of these conditions.	Table 12
	Rates of self-reported long term health conditions were highest in North East and Central Victorian sub-regions and lowest in the North West.	Table 12
	Mental health was the most prominent health issue identified in both the quantitative and qualitative needs analysis.	Tables 12 and 14
Other notable health issues	Alcohol or other drug dependence was prominent and often presented together with mental ill-health.	Table 14
	Dental health issues were noted, with treatment difficult to access and often not sought until people experience significant pain.	Table 14
	Premature ageing and early mortality were reported as common issues, as well as women's and reproductive health.	Table 14
	Other wellbeing issues related to insecure housing were raised by stakeholders including social isolation, being victims of violence or other crimes, environmental hazards (e.g., exposure to extreme weather, unsanitary conditions, etc) and difficulties adhering to prescribed medication plans.	Table 14

Recommendations

Category	Recommendations	Data reference
Tailored models of primary healthcare	Commission primary care outreach and/or in-reach services in key locations with demonstrated high need.	Table 17
	Support and advocate for in-reach services that promote the integration of primary care practitioners, such as nurses and allied health professionals, into non-health settings that are trusted and used by people experiencing homelessness as 'soft entry points' to services.	Table 17
Accessible mainstream primary healthcare	Support health and non-health services to reduce the impact of practical barriers in accessing healthcare including lost IDs (e.g. Medicare card), transport and contacting clients who may not have access to a telephone and/or fixed postal address and other issues, such as accessing funds for food, housing and other basic needs.	Tables 15 and 18
	Advocate and support GPs to provide more bulk billing services to people experiencing homelessness, and services where there are no on-the-day fees.	Table 19
	There is a general need for longer consultations to provide comprehensive care for people with complex needs.	Table 19
	For rural areas that might have poorer access to specialist services, alternative strategies are needed to connect people experiencing or at risk of homelessness with mainstream local services.	Table 19
Flexible service models	People experiencing or at risk of homelessness often need access to primary healthcare on short notice, therefore flexible models are needed with capacity for drop in/walk-in appointments. Telehealth services often have shorter waiting times compared to clinic-based appointments. However, face-to-face appointments are necessary for people without phones.	Table 19
Service navigation	Strengthen existing health navigation services that support people to access healthcare services.	Table 19
	Advocate for and support capacity building within the non-health sector (such as homelessness services) to strengthen service navigation and carer support services to ensure people can access equitable primary and other care.	Table 19
Coordination and linking of services	Support communication and collaboration between hospitals, primary healthcare providers, homelessness and other service providers working with people experiencing or at risk of homelessness to enhance understanding of available services, referral pathways and community needs and deliver well integrated and co-ordinated supports.	Tables 16 and 18
	Housing and other community services need access to information on available primary healthcare services so that they can provide effective advice and support to people who are experiencing or at risk of homelessness to find and access the services that they need.	Table 19
	Develop and implement a housing and homelessness services directory in Murray HealthPathways.	Table 19

Capacity building	Workforce development and education is needed to build understandings of homelessness by service providers to create mainstream primary care services that better meet the needs of people experiencing and/or at risk of homelessness.	Table 15
	Provide and support capacity building activities that improve skills and confidence of health professionals to build and maintain positive relationships with consumers experiencing or at risk of homelessness and to actively reduce stigma and discrimination in the healthcare sector.	Tables 15 and 19
Trauma-informed care	Support and advocate for the integration of trauma-informed care principles into primary healthcare to better serve the complex needs of people experiencing or at risk of homelessness.	Table 15
Cross-sector services that support access to primary healthcare	Advocate for and contribute to cross-sector collaborative efforts supporting local initiatives such as Housing First programs that seek to improve housing for vulnerable groups.	Table 16
Relational commissioning	Build collaborative and flexible engagement between Murray PHN and key stakeholders and consumer advocates working with people with lived experience of homelessness and/or risk of homelessness for more tailored and responsive commissioning to meet local needs. This may include strengthening existing programs and/or replication of effective models in areas with high needs.	Table 17
Future Needs Assessment processes	Aim to include health service consumers with lived experience of homelessness and risk of homelessness in future consultations around the health and service needs.	Data limitations section Attachment C
	Actively seek to understand experiences of stigma, discrimination, and racism within healthcare systems.	

Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CALD	Culturally and Linguistically Diverse
CV	Central Victoria (Murray PHN sub-region)
DFFH	Department of Families, Fairness and Housing
FV	Family Violence
GP	General Practitioner
GV	Goulburn Valley (Murray PHN sub-region)
HNA	Health Needs Assessment
LGA	Local Government Area
MADCOW	a moniker for Make a Difference, Change our World
NE	North East Victoria (Murray PHN sub-region)
NW	North West Victoria (Murray PHN sub-region)
PHN	Primary Health Network
SHS	Specialist Homelessness Service(s)
UTI	Urinary tract infection

Section 1: Narrative

Introduction

In the Australian Government's May 2023 budget, funding for Primary Health Networks towards a new Homelessness Access to Primary Health Care Program was announced. Murray PHN has undertaken health and service needs analysis to inform this commissioning and ongoing needs analysis which is core activity for all PHNs. The purpose of this analysis was to:

- identify and describe the health needs of people experiencing and at risk of homelessness, to understand experiences, issues and priorities
- identify and understand service gaps for people experiencing homelessness where there are demonstrated challenges and barriers to primary care access and navigation
- develop recommendations for commissioning, system coordination, and workforce capacity building to enhance primary healthcare access and outcomes for people experiencing homelessness.

Background

Definition of experiencing and being at risk of homelessness

Homelessness refers to the situation when a person does not have access to stable, safe and functional housing. A person can be described as at risk of homelessness if they are at risk of losing their accommodation or experiencing one or more of a range of factors (such as financial stress, housing affordability stress, inadequate or inappropriate accommodation), that can contribute to homelessness (AIHW, 2024b).

Estimating homelessness at the population level

This report primarily draws on two data sources to estimate the population who are experiencing or at risk of homelessness across the Murray PHN region. These are:

- Australian Bureau of Statistics (ABS) Census of Population and Housing
- Australian Institute of Health and Welfare (AIHW) Specialist Homelessness Services (SHS) reports.

These data sources have different methods of estimating the number of people experiencing homelessness and people who are at risk of homelessness.

The ABS Census data is collected at a whole population level. Each person's self-reported current housing situation is used to classify all respondents as 'homeless' or 'marginally housed' or 'not homeless or marginally housed' on Census night. For the purposes of this report, we have interpreted these groups to be currently *experiencing homelessness* and *at risk of homelessness,* respectively.

As AIHW SHS data is only collected from people who present to services for seeking support, all SHS clients are deemed to be either homeless or at risk of homelessness. Data provided by the AIHW classifies people as either *homeless*, *at risk of homelessness* or *not stated* on first presentation to a service provider.

For more information on the definitions of homelessness used in these data sources please see *Attachment C - Data collection and analysis methods* on page 66.

First Nations Peoples

Data on the experiences of Aboriginal and/or Torres Strait Islander Peoples has been included in this report throughout. Further information on the health and service needs of First Nations Peoples

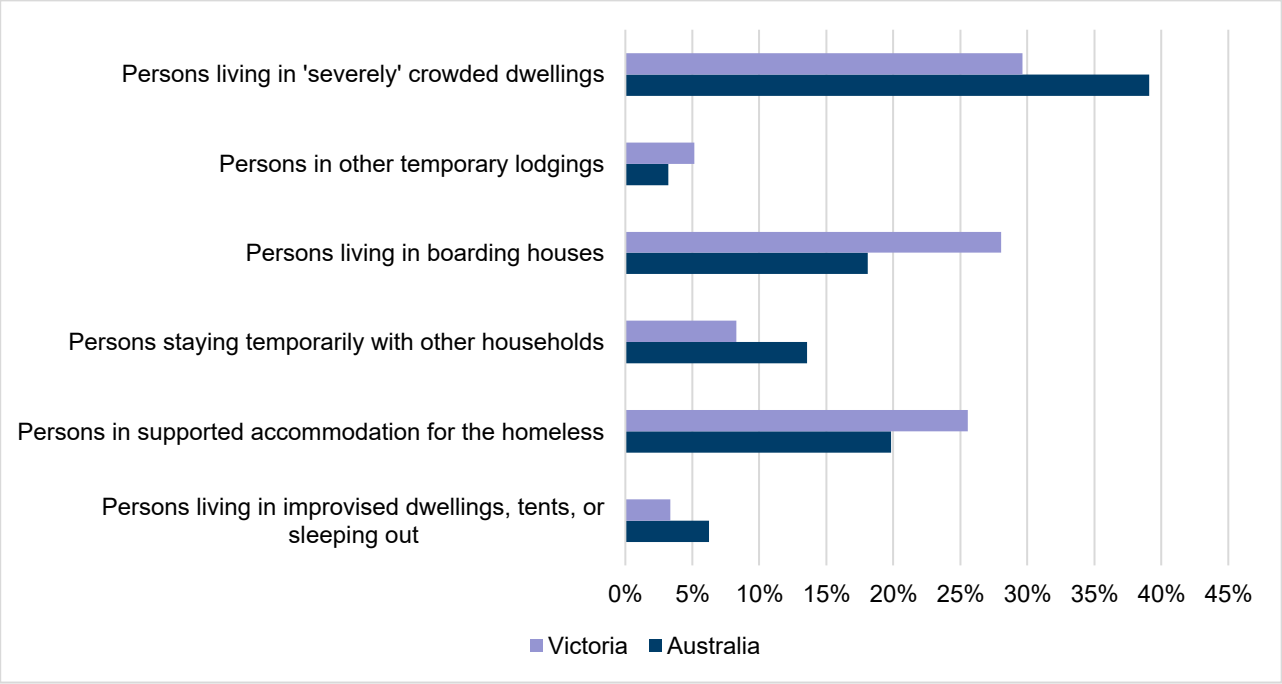
across the Murray PHN catchment are considered in more depth in a separate population health series report (see Population Health Series: First Nations, Murray PHN 2024).

Homelessness in Australia and Victoria

Population level homelessness

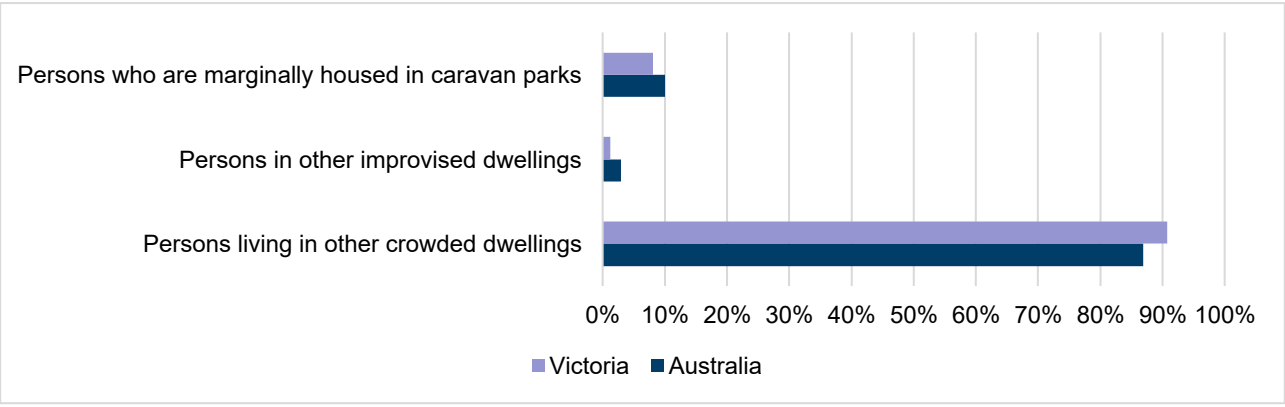
In 2021, on Census night, approximately 122,488 people in Australia were recorded as homeless; of this number 30,602 were in Victoria (by state/Australia; ABS 2021) (see Figure 1). Another 93,186 people across Australia were recorded as being in marginal housing, 21,307 of whom lived in Victoria (by state/Australia; ABS 2021) (see Figure 2).

Figure 1: Proportional distribution of people recorded as homeless across the six 'homeless' operational groups in the 2021 Census



Source: ABS (2021). Public data: accessible to all audiences

Figure 2: Proportional distribution of people recorded as homeless across the three 'marginally housed' operational groups in the 2021 Census



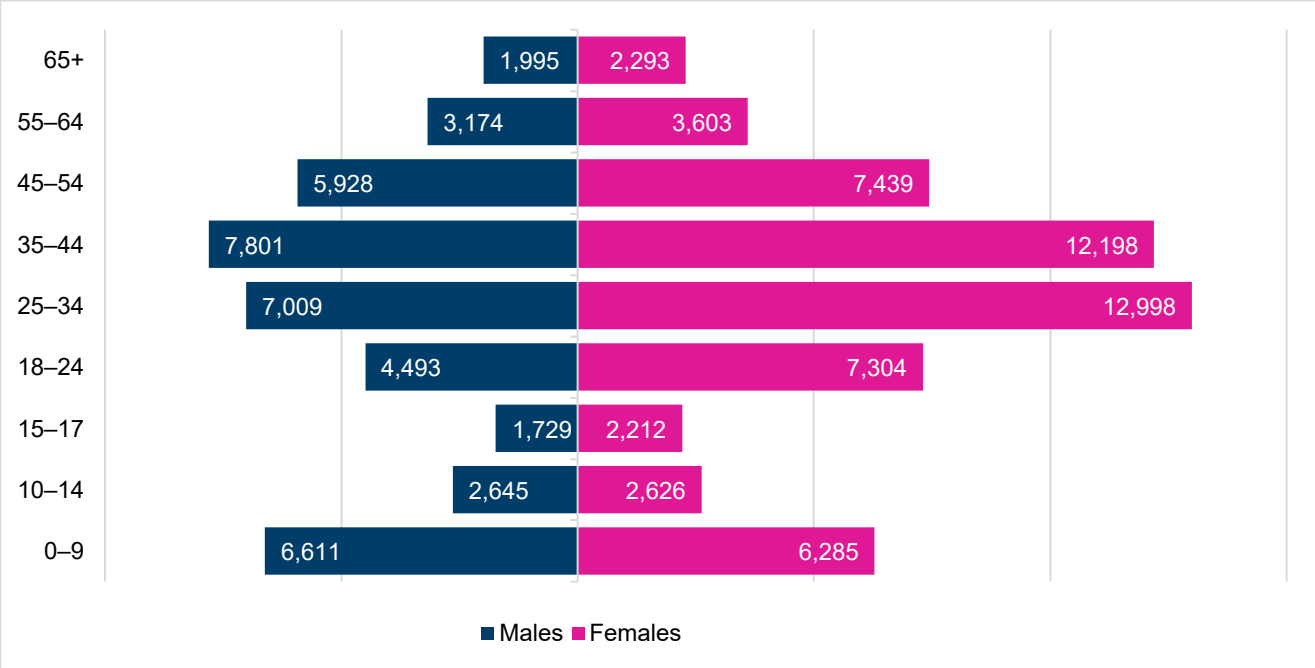
Source: ABS (2021). Public data: accessible to all audiences

Specialist Homelessness Service use

In the 2022-23 financial year, 273,648 people across Australia were recorded as seeking support from SHSs. Of these, just more than 98,000 sought assistance in Victoria (by state/Australia; AIHW 2022-23).

More females sought support from SHSs than males; 59% of clients were female nationally, and 58% in Victoria (by state/Australia; AIHW 2022-23).

Figure 3: Count of SHS clients in Victoria by age and gender 2022-23 financial year



Source: AIHW (2022–23). Public data: accessible to all audiences

Priority groups within SHS clients

Of the approximately 85,000 SHS clients in Victoria:

- 38% experienced family and domestic violence
- 10% reported experiencing problematic drug or alcohol use
- 38% clients had a current mental health issue.

Approximately 3200 clients (3.8%) reported all three of the above concerns (by state; AIHW 2022-23).

Reasons for seeking support from a SHS

Client reasons for seeking support from SHSs is available at the national and state levels but is not available at PHN or LGA geographies. The Victorian results (see Table 1 and 2 below) provide insight into reasons why people may be seeking assistance from local SHSs.

Table 1: Reasons for clients seeking assistance from a SHS in Victoria (clients may indicate more than one reason)

Reason for seeking assistance	Males	Females	Total clients (N)	Total clients (%)
Financial	23,734	31,070	54,804	56.1%
Accommodation	23,777	27,285	51,062	52.2%
Interpersonal relationships*	15,688	34,332	50,020	51.2%
• *Sexual abuse*	*307*	*1,640*	*1,947*	*2.0%*
• *Family and domestic violence*	*10,166*	*29,042*	*39,208*	*40.1%*
• *Non-family violence*	*1073*	*1558*	*2631*	*2.7%*
Other	18,284	18,211	36,495	37.3%
Health*	10,912	13,128	24,040	24.6%
• *Mental health issues*	*7741*	*10,207*	*17,948*	*18.4%*
• *Medical issues*	*4369*	*5298*	*9667*	*9.9%*
• *Problematic drug or substance use*	*3476*	*2568*	*6044*	*6.2%*
• *Problematic alcohol use*	*1322*	*760*	*2082*	*2.1%*
Not stated	311	274	585	. .

Source: AIHW (2022–23). Public data: accessible to all audiences

*Subtotals in grey highlight more detailed reasons related to health and wellbeing that contribute to the totals for interpersonal relationships and health categories

Table 2: Main reason for clients seeking assistance from a SHS in Victoria (clients indicate only one main reason)

Main type of reason for seeking assistance	Males	Females	Total clients (N)	Total clients (%)
Interpersonal relationships	8464	23,988	32,452	33.3%
Accommodation	14,912	15,416	30,328	31.2%
Financial	8803	11,624	20,427	21.0%
Other	7467	4393	11,860	12.2%
Health	1228	1062	2290	2.4%

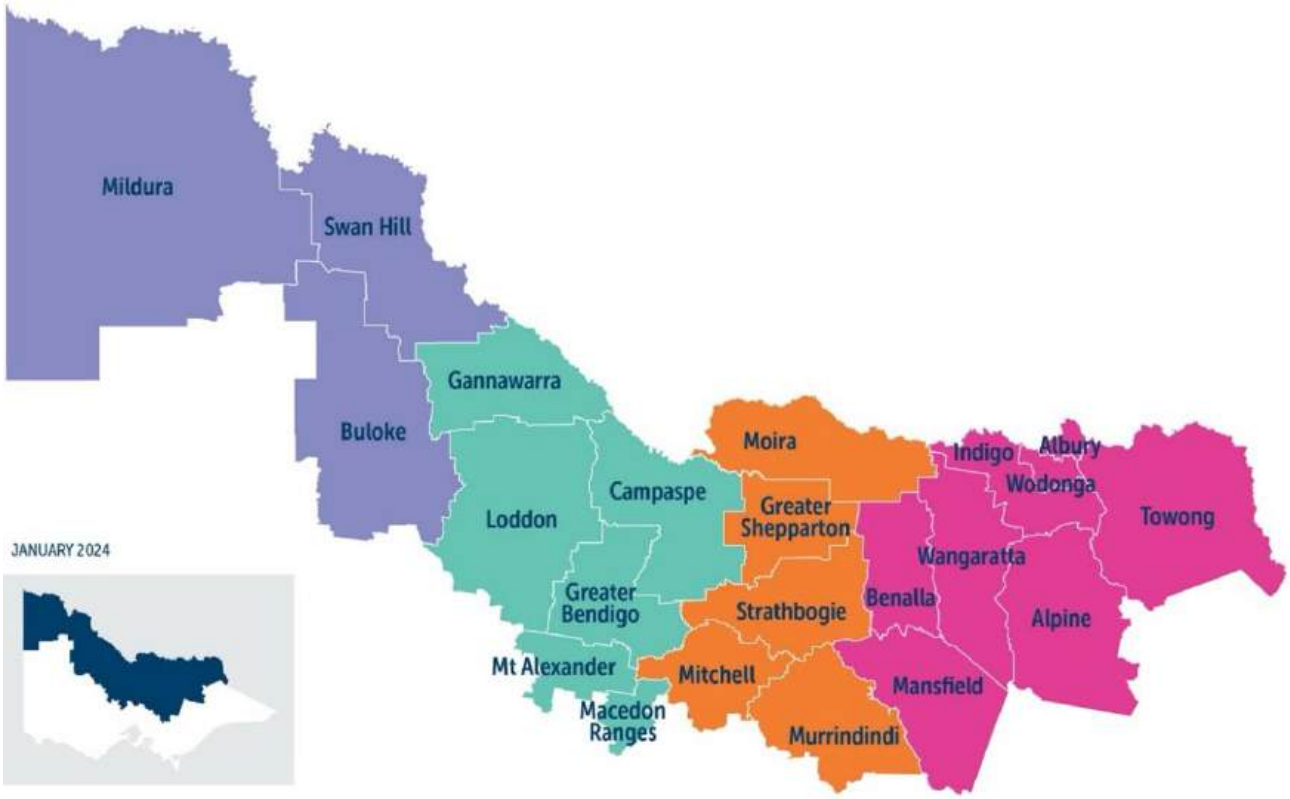
Source: AIHW (2022–23). Public data: accessible to all audiences

The Murray PHN catchment

The Murray PHN catchment (Figure 1) encompasses almost 100,000 square kilometres, 22 Local Government Areas, and is home to approximately 644,577 people (by PHN catchment; ABS 2022) including almost one third of all First Nations Peoples living in Victoria. The catchment covers 44 per cent of the entire state of Victoria. The Murray River forms the northern border of the catchment, which is inclusive of Albury NSW.

The catchment includes Mildura (Latji Latji Country) in the north, Albury (Wiradjuri Country) to the east, and Woodend (Dja Dja Wurrung Country) in the south. Communities in this catchment are diverse. They range from rural agricultural communities, rapidly growing regional centres, small regional communities, tourism destinations and rural distributed communities.

Figure 4: The Murray PHN catchment



	Total population	Local government areas (LGAs)	GP full-time equivalent	Aged care services	General practice services	Public hospitals	Private hospitals	ACCHOs
North West Vic	84,559	3	75	39	25	9	1	1
Central Vic	251,963	6	294	62	73	13	3	3
Goulburn Valley	178,008	5	200	85	48	10	4	1
North East Vic	192,817	8	203	60	48	12	7	2
Murray PHN	707,347	22	772	246	194	44	15	7

*Population and service mapping by LGA; ABS (2021) and Murray PHN CRM (2024). Murray PHN population calculated by LGA.

Overview of needs assessment process

Population data

Population data were retrieved from a range of sources for the quantitative analyses. A detailed list of the data indicators, definitions and sources that were analysed and presented in this report is provided in Attachment A - Data sources and definitions (page 62). Data sources were preferred if they had been released in the last five years. The geographic filters used were PHN and LGA as they are the most relevant to Murray PHN's planning and partnership work and provide accurate representations of local and regional diversity. Key data were grouped into the Murray PHN's four sub-regions (CV, NE NW and GV) to inform more in-depth local planning.

Health and service needs data sources:

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- Crime Statistics Agency (Victoria)

Stakeholder consultation

Consultation and engagement for this health and service needs analysis was conducted between December 2023 to March 2024. Consultations involved 34 organisations, including SHS, rural and regional health services, housing services, local councils, and community health and social services. In addition, input was gathered from Murray PHN subject matter experts, Clinical and Community Advisory Councils and Medical Advisors. Full details of the key stakeholders involved can be found in Attachment C - Data collection and analysis methods.

These consultations were conducted through seven in person and online focus groups, as well as eight semi-structured interviews. The development of the question guide was informed by key themes from a rapid review of relevant submissions to the Parliament of Victoria's Inquiry into homelessness in Victoria conducted in 2020 (Legislative Council Legal and Social Issues Committee 2022). Full details of the rapid review can be found in Attachment D – Rapid review of submissions to the Inquiry into Homelessness in Victoria.

Section 2 – Outcomes of health and service needs analysis

Population data findings

Census data

A greater proportion of people experiencing homelessness in the Murray PHN region are living in supported accommodation, staying temporarily with other households or sleeping out (rough sleeping) or in improvised dwellings compared to the state. Similarly, there is a greater proportion of those who are marginally housed living in other improvised dwellings or caravan parks (see Table 2 below) (ABS, 2021).

Table 3 : Housing status on Census night 2021 for Murray PHN and Victoria

	Murray PHN*			Victoria		
	Count (persons)	Proportion	Rate per 1000 people	Count (persons)	Proportion	Rate per 1000 people
Homeless						
People living in improvised dwellings, tents, or sleeping out	206	7.6%		1022	3.3%	
People in supported accommodation for the homeless	863	31.9%		7820	25.6%	
People staying temporarily with other households	463	17.1%		2531	8.3%	
People living in boarding houses	242	8.9%		8578	28.0%	
People in other temporary lodgings	138	5.1%		1583	5.2%	
People living in 'severely' crowded dwellings	793	29.3%		9068	29.6%	
Total*	**2705**	**100%**	**4**	**30,602**	**100%**	**5**
Marginally housed						
People living in other crowded dwellings	1654	72.0%		19,334	90.7%	
People in other improvised dwellings	92	4.0%		257	1.2%	
People who are marginally housed in caravan parks	551	24.0%		1716	8.1%	
Total*	**2297**	**100.0%**	**3**	**21,307**	**100%**	**3**
All groups total	**5002**	**-**	**7**	**51,909**	**-**	**8**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN totals calculated using LGA level data

Table 4: Housing status on Census night 2021 for Murray PHN sub-regions

Rank	Sub-region	Count (persons)			Rate per 1000 people		
		Homeless	Marginally housed	Total	Homeless	Marginally housed	Total
1	NW	594	515	1109	7	6	13
2	GV	676	825	1501	4	5	9
3	CV	851	498	1349	3	2	5
4	NE	577	445	1022	3	2	5
Murray PHN		**2705**	**2297**	**5002**	**4**	**3**	**7**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN and sub-region totals calculated using LGA level data. Sub-regions ranked by rate of total homelessness and marginally housed.

Specialist Homelessness Services clients

In 2022-2023, SHS agencies assisted almost 273,600 clients across Australia representing a rate of 10.5 clients per 1000 population. Victoria has the second highest rate of all Australian states at 14.8 clients per 1000, with only the Northern Territory recording a higher rate (AIHW, 2024b)

The rate of SHS clients per 1000 people in the Murray PHN catchment is higher than the state rate. Within the Murray PHN region, the North West sub-region has substantially higher rates than the rest of the catchment (see Table 4). This finding reflects the AIHW analysis showing that North West SA4 region has the highest SHS client rates in Victoria (by SA4, AIHW 2022-23) (see Table 6). The trend of SHS client count for Murray PHN from July 2014 to June 2023 shows that the number of SHS clients has remained relatively consistent over time (see Figure 5).

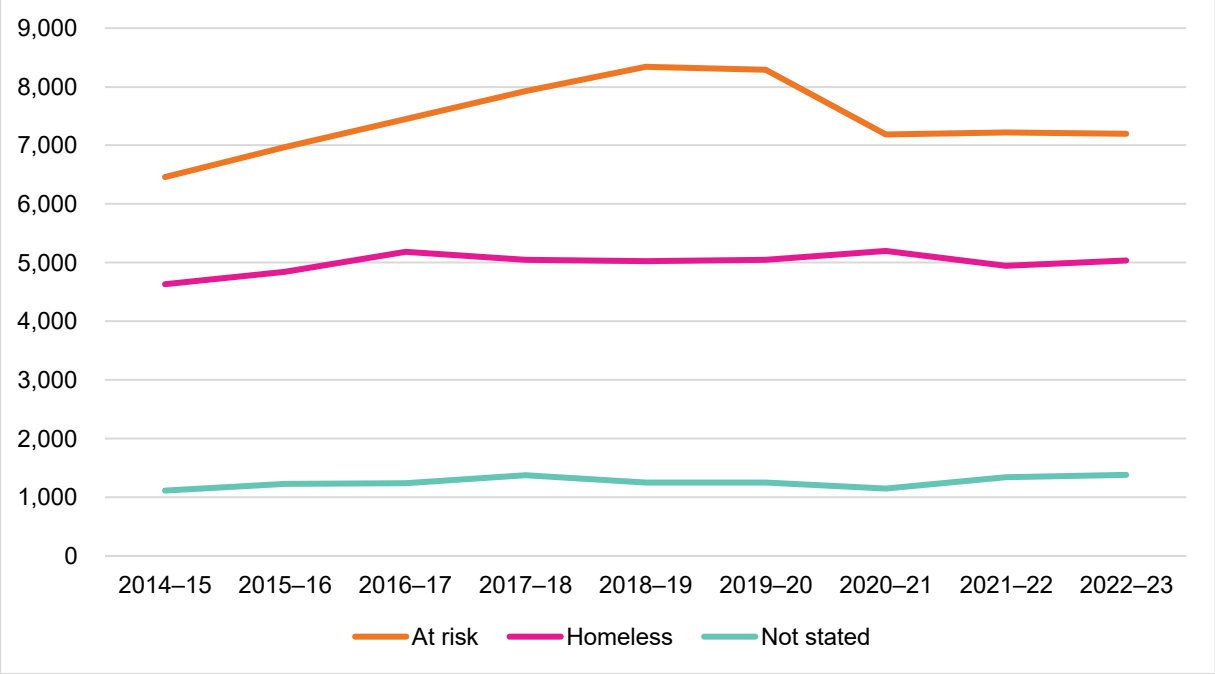
Table 5: SHS Clients homeless or at risk of being homeless for Murray PHN sub-regions

Rank	Sub-region	Count (clients)				Rate per 1000 people			
		Homeless	At risk	Not stated	Total	Homeless	At risk	Not stated	Total
1	NW	869	1520	562	**2951**	10	18	7	**35**
2	GV	1273	1743	335	**3351**	7	10	2	**19**
3	NE	1414	1740	230	**3384**	7	9	1	**18**
4	CV	1563	2456	269	**4288**	6	10	1	**17**
Murray PHN		5119	7459	1396	**13,974**	7	11	2	**20**
Victoria		-	-	-	**98,343**	-	-	-	**15**

Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN and sub-region totals calculated using LGA level data. Sub-regions ranked by rate of total homelessness and marginally housed.

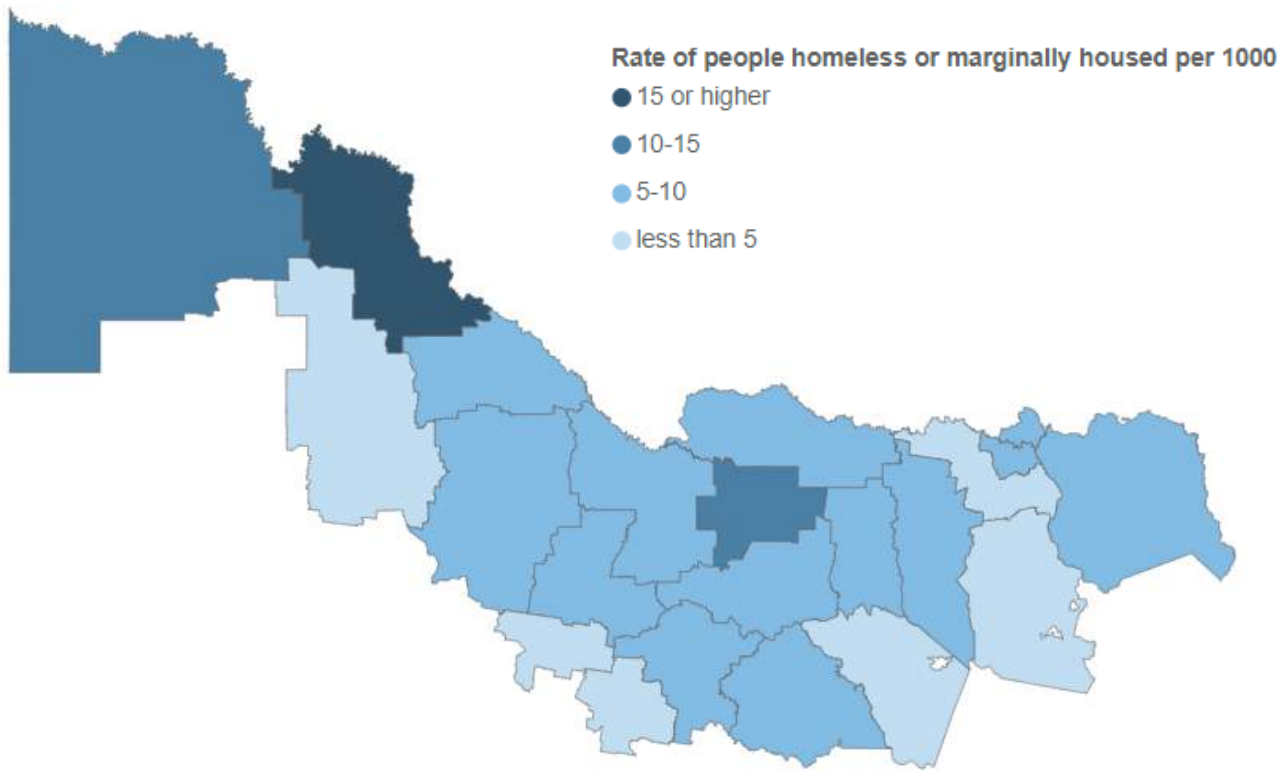
Figure 5: Trend of SHS client count for Murray PHN - July 2014 to June 2023



Source: AIHW (2014-23). Public data: accessible to all audiences

Geographical distribution of people experiencing homelessness

Figure 6: Rate of people who were homeless or marginally housed on Census night by LGA



Source: ABS (2021). Public data: accessible to all audiences

Table 6: Housing status on Census night 2021 by LGA

Rank	LGA	Count (persons)			Rates per 1000		
		Homeless	Marginally housed	Total	Homeless	Marginally housed	Total
1	Swan Hill	239	192	**431**	11	9	**20**
2	Greater Shepparton	415	494	**909**	6	7	**13**
3	Mildura	345	305	**650**	6	5	**11**
4	Wodonga	207	132	**339**	5	3	**8**
5	Strathbogie	27	57	**84**	2	5	**7**
6	Greater Bendigo	562	246	**808**	5	2	**7**
7	Murrindindi	36	64	**100**	2	4	**7**
8	Loddon	21	29	**50**	3	4	**6**
9	Campaspe	118	122	**240**	3	3	**6**
10	Moira	81	100	**181**	3	3	**6**
11	Wangaratta	126	47	**173**	4	2	**6**
12	Towong	8	25	**33**	1	4	**5**
13	Albury	167	104	**271**	3	2	**5**
14	Benalla	18	49	**67**	1	3	**5**
15	Mitchell	117	110	**227**	2	2	**5**
16	Gannawarra	22	26	**48**	2	2	**5**
17	Buloke	10	18	**28**	2	3	**4**
18	Mansfield	15	29	**44**	1	3	**4**
19	Mount Alexander	42	27	**69**	2	1	**3**
20	Alpine	23	22	**45**	2	2	**3**
21	Indigo	13	37	**50**	1	2	**3**
22	Macedon Ranges	86	48	**134**	2	1	**3**
Murray PHN		2705	2297	**5002**	4	3	**7**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN totals calculated using LGA level data. LGAs ranked by rate of total homelessness and marginally housed.

Table 7: SHS clients by LGA

Rank	LGA	Count (clients)				Rate per 1000 people			
		Homeless	At risk	Not stated	Total	Homeless	At risk	Not stated	Total
1	Mildura	618	1195	440	**2253**	11	21	8	**40**
2	Greater Shepparton	826	1035	148	**2009**	12	15	2	**30**
3	Wodonga	497	652	103	**1252**	12	15	2	**29**
4	Swan Hill	231	298	95	**624**	11	14	4	**29**
5	Gannawarra	53	136	52	**241**	5	13	5	**23**
6	Wangaratta	316	309	42	**667**	11	10	1	**23**
7	Campaspe	364	410	63	**837**	9	11	2	**22**
8	Greater Bendigo	917	1406	144	**2467**	8	12	1	**20**
9	Mount Alexander	95	297	5	**397**	5	15	0	**20**
10	Benalla	95	120	29	**244**	7	8	2	**17**
11	Moira	195	212	76	**483**	6	7	3	**16**
12	Indigo	48	206	5	**259**	3	12	0	**15**
13	Albury	408	348	26	**782**	7	6	0	**14**
14	Mitchell	200	358	85	**643**	4	7	2	**13**
15	Buloke	20	27	27	**74**	3	4	4	**12**
16	Loddon	40	43	0	**83**	5	6	0	**11**
17	Strathbogie	20	66	10	**96**	2	6	1	**8**
18	Murrindindi	32	72	16	**120**	2	5	1	**8**
19	Towong	10	27	5	**42**	2	5	1	**7**
20	Alpine	25	51	15	**91**	2	4	1	**7**
21	Macedon Ranges	94	164	5	**263**	2	3	0	**5**
22	Mansfield	15	27	5	**47**	1	3	0	**5**
Murray PHN*		5119	7459	1396	**13,974**	7	11	2	**20**
Victoria		-	-	-	**98,343**	-	-	-	**15**

Source: AIHW (2022-23). Public data: accessible to all audiences

*Total Murray PHN figures calculated using LGA data. LGAs ranked by rate of total SHS clients.

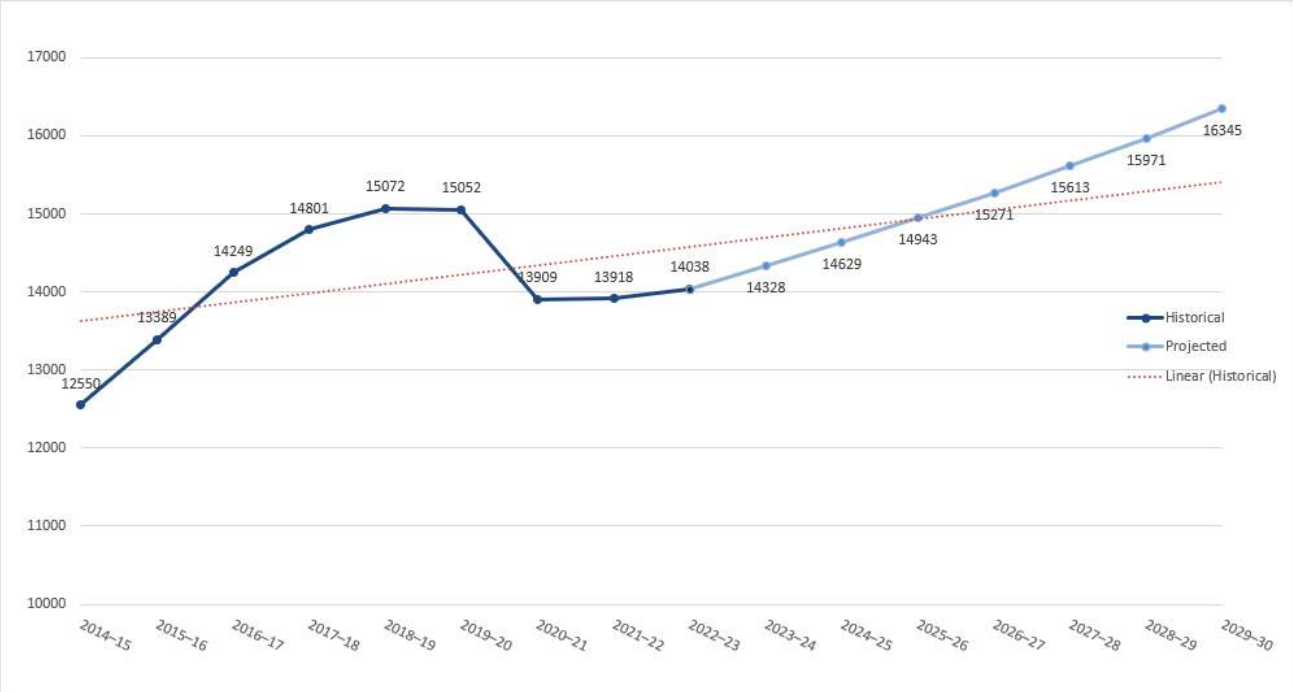
Projected SHS client population

The number of people seeking support from SHSs increased between 2014-2015 and 2018-2019 at an average rate of 4.5 per cent.

The number of SHS clients declined during the COVID pandemic which is likely to reflect a range of factors including an increased level of emergency and short-term accommodation provided to people experiencing homelessness and reduced capacity for people to leave unsafe or inadequate housing situations due to lockdowns and other limitations.

Since 2021, SHS client numbers have stabilised and started to rise again. Projected SHS client numbers based on these historical trends are in Figure 7.

Figure 7: Trend and projected SHS client numbers for Murray PHN



Source: AIHW (2014-23). Public data: accessible to all audiences

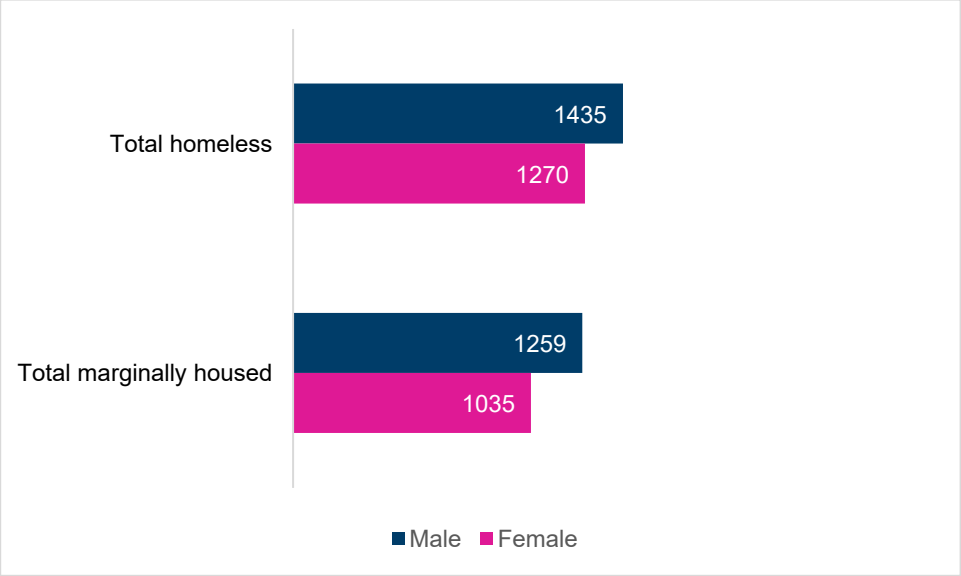
*Murray PHN total calculated using LGA level data

Population subgroups

Gender

In 2021, more males (53.9%) than females (46.1%) were recorded as homeless or marginally housed across the Murray PHN catchment.

Figure 8: Gender breakdown of people who are homeless and marginally housed for Murray PHN

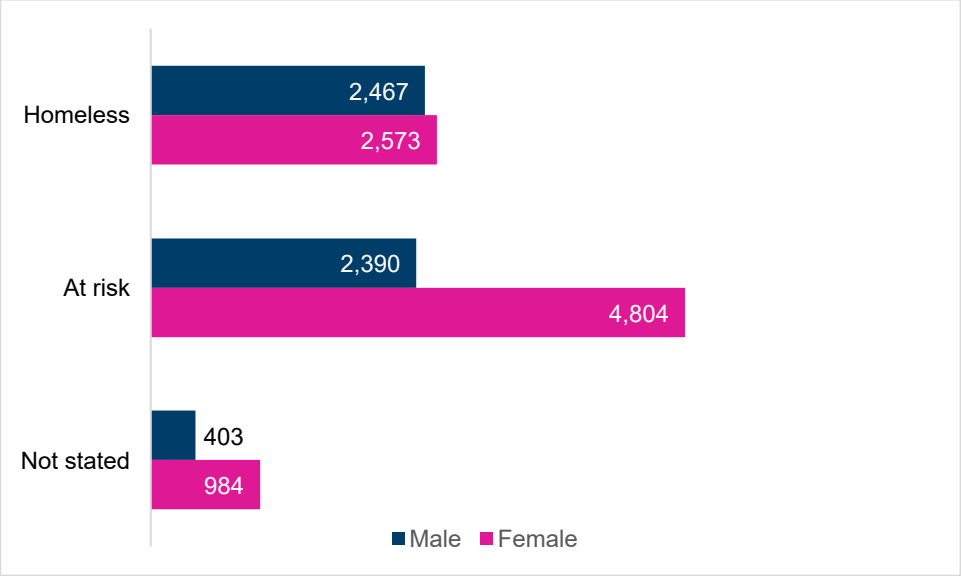


Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN totals calculated using LGA level data

This trend is reversed in the SHS client population, with more females (61.4%) than males (38.6%) sought support from a SHS in the 2022-23 financial year with the largest difference seen in the 'at risk' group.

Figure 9: Gender breakdown of SHS clients for Murray PHN by homelessness status



Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN totals calculated using LGA level data

Table 8: Gender breakdown of SHS clients for Murray PHN by LGA and homelessness status

Rank	LGA	Rate per 1000 people				
		Total	Homeless		At risk	
			Females	Males	Females	Males
1	Mildura	**40**	11	11	29	12
2	Greater Shepparton	**30**	13	12	19	12
3	Wodonga	**29**	11	12	20	10
4	Swan Hill	**29**	10	11	19	9
5	Gannawarra	**23**	3	7	16	10
6	Wangaratta	**23**	10	11	14	7
7	Campaspe	**22**	10	9	15	7
8	Greater Bendigo	**20**	7	8	17	6
9	Mount Alexander	**20**	4	5	10	20
10	Benalla	**17**	6	8	11	6
11	Moira	**16**	7	6	11	3
12	Indigo	**15**	2	3	6	18
13	Albury	**14**	8	7	8	4
14	Mitchell	**13**	4	4	11	4
15	Buloke	**12**	2	5	9	0
16	Loddon	**11**	7	4	10	1
17	Strathbogie	**8**	3	0	7	4
18	Murrindindi	**8**	2	2	7	3
19	Towong	**7**	0	3	6	3
20	Alpine	**7**	2	1	5	2
21	Macedon Ranges	**5**	2	2	5	2
22	Mansfield	**5**	2	1	5	0
Murray PHN*		**20**	7	7	14	7

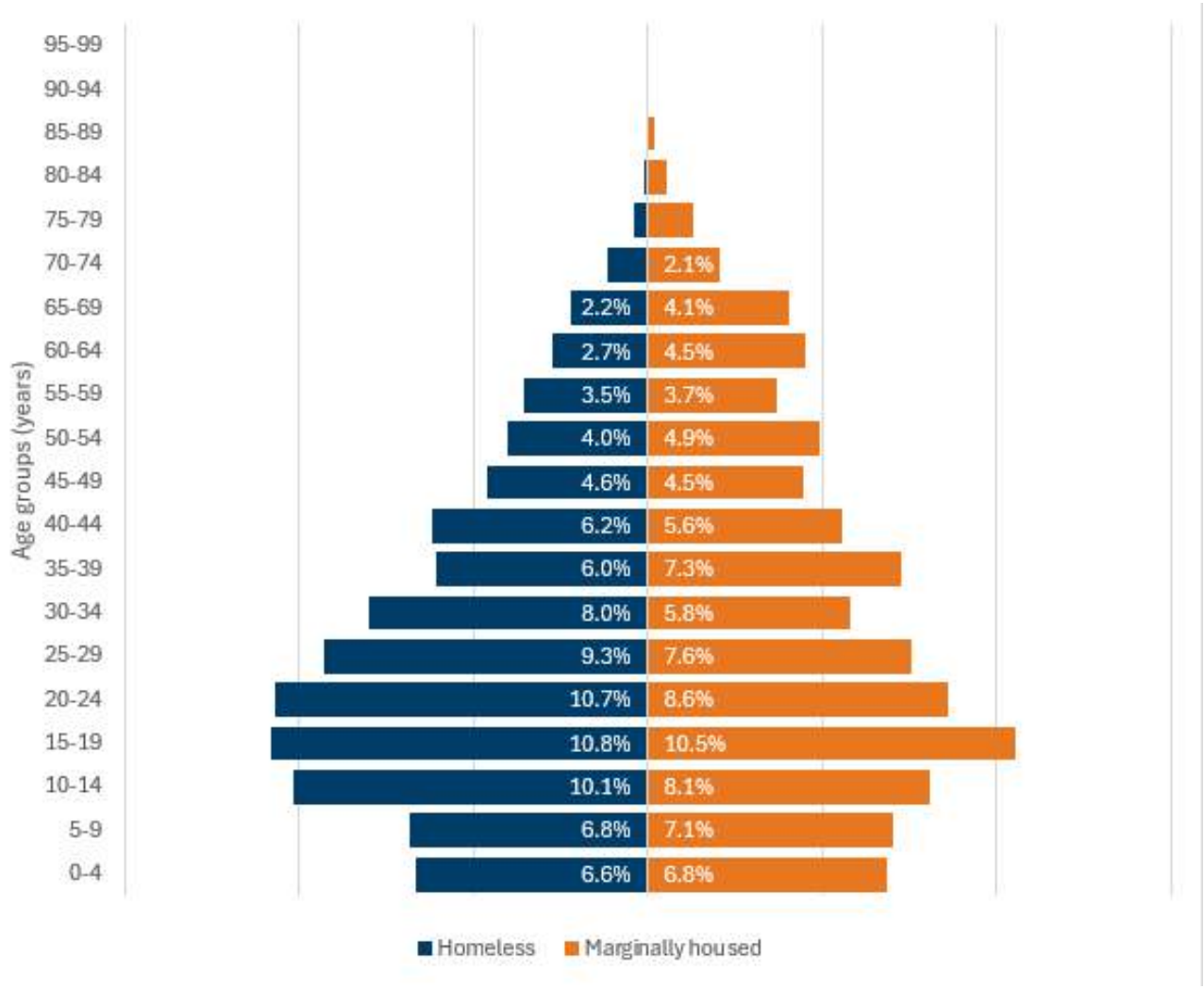
Source: AIHW (2022-23). Public data: accessible to all audiences

*Total Murray PHN figures calculated using LGA data. LGAs ranked by rate of SHS clients.

Age

The age of people that are homeless or at risk of homelessness is skewed towards young adults, with just over one third of this population (36.5%) being between the ages 10 to 29 years old.

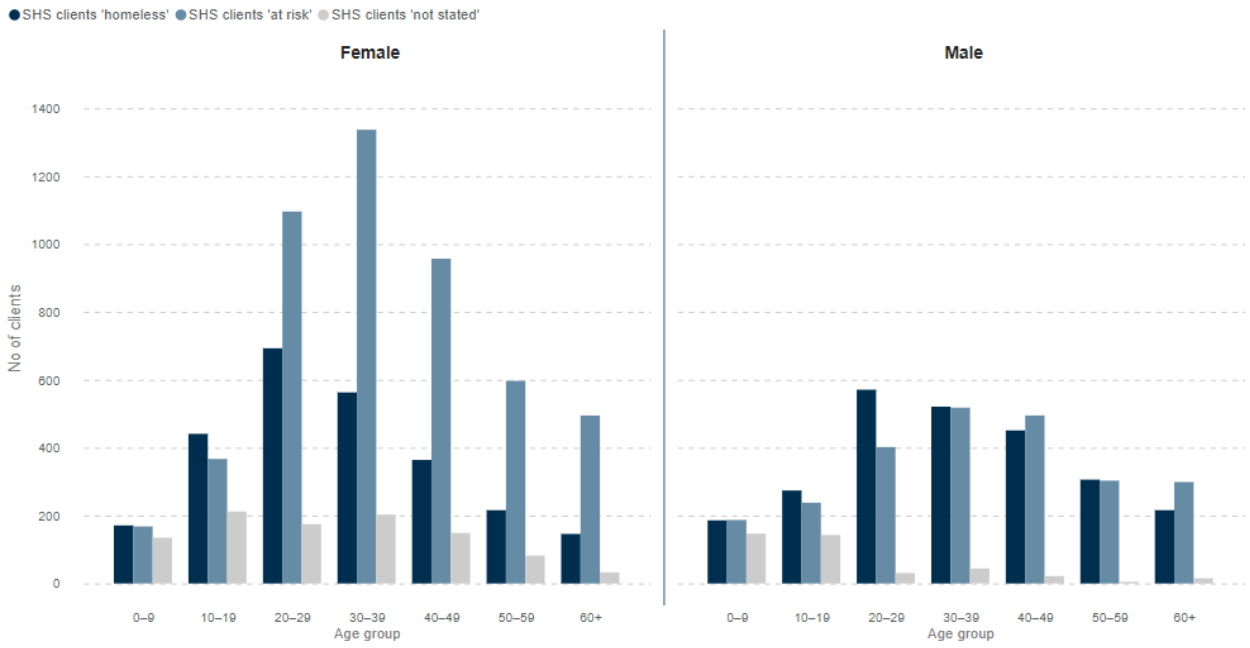
Figure 10: Population age profile people experiencing homelessness vs marginally housed for Murray PHN



Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN totals calculated using LGA level data

Figure 11: Distribution of SHS clients by gender and age group and homeless status for Murray PHN



Source: AIHW (2022-23). Public data: accessible to all audiences

*Total Murray PHN figures calculated using LGA data

First Nations Peoples

The following section of the report compares the First Nations homelessness within Murray PHN sub-regions to the total population for Greater Melbourne, the rest of Victoria and Victoria's state rate. This comparison only includes the homeless operational group (six categories) and excludes all people who are marginally housed.

Table 9: Rate per 1000 Aboriginal and/or Torres Strait Islander People recorded as homeless on Census night 2021

Murray PHN catchment					Victoria		
CV	GV	NE	NW	**Total**	Greater Melbourne	Rest of Vic	**Total**
15	11	11	21	**14**	18	16	**17**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN figures calculated using LGA level data. These figures do not include people who were marginally housed

Table 10: Proportion (%) of all people recorded as homeless who identified as Aboriginal and/or Torres Strait Islander People

Murray PHN catchment					Victoria		
CV	GV	NE	NW	**Total**	Greater Melbourne	Rest of Vic	**Total**
9%	8%	10%	13%	**10%**	2%	8%	**4%**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN figures calculated using LGA level data. These figures do not include people who were marginally housed

Case Study: LMARG Aboriginal Youth Project

The Loddon Mallee Aboriginal Reference Group (LMARG) has set a target to reduce homelessness among Aboriginal youth (aged 10-17 years) within the Murray PHN catchment. LMARG collaborates with various Aboriginal organisations, including Bendigo & District Aboriginal Co-operative, Mallee District Aboriginal Services, Murray Valley Aboriginal Cooperative, and Njernda Aboriginal Corporation. Additionally, it partners with Murray PHN and health service providers, such as Bendigo Health, and state government agencies including the Department of Education, the Department of Families, Fairness and Housing (DFFH), the Victorian Department of Health, the Department of Justice and Community Safety, as well as the National Indigenous Australians Agency (NIAA).

LMARG assists in advising various services on matters related to children, including education, mental health support, alternatives to youth detention, increased access to primary health services, employment support, guidance and other opportunities. In its efforts to address homelessness, LMARG works closely with DFFH and has proposed to introduce care alternatives for Aboriginal young people with short and longer-term needs, such as cottage homes supported by the Regional Housing Fund and Housing First model (LMARG, 2024).

People receiving specialist support for family violence

In 2022-2023, more than 5000 family violence victim/survivors were assisted by family violence (FV) specialist agencies for women and children (specialist FV service clients) in the Murray PHN region. The rate of specialist FV service clients was higher across the Murray PHN region compared to the state.

Eight LGAs had rates higher than the state, with rates in Mildura and Swan Hill being higher than both the catchment and state rates (by LGA; AIHW, 2022-23).

Table 11: Specialist FV service clients in Murray PHN LGAs in 2022-23 financial year

Rank	LGA*	Client count	Rate per 100,000 population
1	Mildura	1382	2403
2	Swan Hill	347	1637
3	Greater Shepparton	681	980
4	Buloke	59	969
5	Wodonga	408	921
6	Gannawarra	81	771
7	Campaspe	284	734
8	Greater Bendigo	880	708
9	Moira	156	508
10	Mitchell	277	508
11	Murrindindi	76	488
12	Benalla	61	419
13	Loddon	32	413
14	Wangaratta	110	365
15	Mount Alexander	66	321
16	Alpine	34	257
17	Towong	15	242
18	Strathbogie	28	239
19	Indigo	41	233
20	Macedon Ranges	84	159
21	Mansfield	7	66
-	Albury	Not available	Not available
	Murray PHN total count	5109	-
	Murray PHN average LGA rate	-	635
	Victoria average LGA rate	-	518

Source: Crime Statistics Agency (Victora) (2022-23)

Pink highlights indicate LGA rates above the state average rate. LGAs ranked by rate.

Health issues within people experiencing or at risk of homelessness

Census data on self-reported long term health conditions shows that nearly half of people experiencing or at risk of homelessness in the Murray PHN catchment report at least one long term

health condition, and in all but one condition (dementia) the rates in the Murray PHN catchment were higher than the state.

Table 12: Rates per 1000 people of health conditions in people who are homeless or marginally housed

Health condition	Murray PHN region					Victoria
	Central Victoria	Goulburn Valley	North East	North West	Total	
Arthritis	82	56	65	31	57	36
Asthma	91	73	103	64	80	62
Cancer (including remission)	21	14	24	14	18	10
Dementia (including Alzheimer's)	3	3	0	0	3	3
Diabetes (excluding gestational diabetes)	42	45	25	17	37	32
Heart disease (including heart attack or angina)	21	31	31	14	29	19
Kidney disease	13	2	4	4	9	6
Lung condition (including COPD or emphysema)	8	26	22	14	20	13
Mental health condition (including depression or anxiety)	163	125	147	73	127	92
Stroke	12	9	3	5	10	6
Any other long-term health condition(s)	92	56	98	44	65	57
No long-term health condition(s)	518	586	489	616	550	603
Not stated	172	161	216	178	178	187

Sources: ABS (2021) Public data: accessible to all audiences

*Murray PHN and sub-region totals calculated using LGA level data

Table highlights indicate sub-regional rates with higher levels of ill-health compared to the state rate.

Stakeholder consultation findings

Priority groups

The population groups prioritised by stakeholders within the Murray PHN catchment closely reflect priority groups in Victoria and Australia (see Attachment D - Rapid review of submissions to the Inquiry into Homelessness in Victoria).

Stakeholders noted that it is important not to overlook the less visible homeless or at-risk populations that are often living in unstable or insecure housing as *"they are often unknown to services so can be particularly hard to reach and/or support"* (Stakeholder, North East sub-region).

Table 13: Priority groups identified in stakeholder consultations

Category	Description
Demography	• Young people • Single parents and families • Older people and including older single women.
Cultural background	• First Nations Peoples • Culturally and Linguistically Diverse population groups • People with a refugee or migrant background.
Socio-economic or other marginalisation	• Low-income earners • Victims/survivors of family violence • People with a trauma history • Those who are socially isolated • Veterans (including younger veterans) • Unemployed or those who struggle to find and keep steady jobs.
Living situation	• People in overcrowded living situations • People leaving state care (including prisons, out of home care, and health services) • People in areas affected by natural disasters such as recent floods (including those who lost homes, and those affected by resulting house rental increases) • People who rent or are in insecure housing, especially those who: – experience challenges with hoarding and/or squalor; or – have dearly loved companion animals/pets which may limit housing options
Health issues	• People experiencing mental illness and/or AOD problems • People with disabilities and/or chronic illness • People with cognitive impairment such as intellectual disability or acquired brain injury.

Health needs

Table 14: Health needs identified in stakeholder consultations

Health needs	Description
Mental illness	Mental health stands out prominently for these populations. People may experience a range of mental health issues and co-morbidities, including AOD use, developmental disabilities, and/or challenging behaviours.
Premature ageing and early mortality	Premature ageing was noted, caused by environmental exposure and poorer access to basic needs. Early death was also noted by several stakeholders and highlighted in an investigation by The Guardian Australia (Knaus, 2024).
Women's health and reproductive health	Concerns raised by stakeholders around reproductive and women's health issues including management of UTIs, access to contraception, 'period poverty' and pregnancy support.

AOD dependence	Stakeholders report a relationship between AOD use and homelessness.
Dental health	Dental and oral health is a concern, because dental treatment may not be sought until pain becomes intolerable and help-seeking often ceases once pain abates. Cost is a major barrier.
Diet-related illness and disease; malnutrition and dehydration	Malnutrition, dehydration and diet-related diseases, such as diabetes and coronary heart disease, were highlighted.
Medication non-adherence	Adherence to medical treatment and/or medication use was noted as a challenge due to cost, storage, theft, and other psychosocial factors e.g. mental illness, AOD dependence.
Family violence	Historical, recent or current experience of family or domestic violence were reported as common, particularly for women, young people and single parent families.
Victims of violence, assault and crime	People experiencing homelessness were described as being at an increased risk of being victims of crime, including theft and physical assault, often with no recourse for the perpetrators.
Social isolation	Stakeholders noted the impact of isolation on general wellbeing and mental health, and the benefits of support networks on socialisation and navigation of health systems.
Environmental harms	Access to drinking water and ‘cooling off’ points within cities, and shelter from extreme weather (e.g. heatwaves, floods, storms) is fundamental to dignity, human rights, and health.
Hoarding and/or squalor	Homelessness may be associated with hoarding and/or squalor which can cause physical and mental health issues, with substantial impacts on health, safety, housing stability and access to home-based health services (e.g. occupational therapy assessments).

Housing as a social determinant of health	Housing (in)affordability, rising cost of living and escalating rental costs were frequently noted by stakeholders as having flow-on impacts on the health and wellbeing of many community members, in particular people experiencing or at risk of homelessness. Some people were noted to get stuck in a feedback loop between poor health and limited access to housing: inadequate housing limits their capacity to make substantial health gains, while poor health creates yet another barrier to securing adequate housing. The overwhelming challenge of improving health access for people experiencing or at risk of homelessness under the cloud of other major systemic issues, such as housing shortages, was captured by one service provider who stated: *"While any intervention is good, without addressing systemic issues like housing it sometimes feels like all we are doing is plugging holes in a sinking ship".*

Service needs

During the stakeholder consultations, discussion continually returned to the problems faced by people experiencing or at risk of homelessness, with less focus on system strengths or possible solutions. This likely reflects the considerable challenges and injustices that people experiencing or at risk of homelessness encounter in accessing mainstream health systems and suggests that their health needs are not being met.

Table 15: Service needs, gaps and challenges identified in stakeholder consultations

Service needs	Description
People experiencing homelessness often have complex health needs	People experiencing or at risk of homelessness face a range of health challenges, including physical ailments, chronic diseases, and mental health issues. Mental health emerged as the most significant health concern for this population and is often co-occurring with AOD use issues. Stakeholders noted that the social context of insecure housing means health issues are often not well managed, and the stress inherent in the experience of homelessness or the risk of becoming homeless can further impact on health and wellbeing. These issues together with low levels of health literacy mean that people in this group often require significant time and support to access primary healthcare.
Healthcare is a lower priority when in 'survival mode'	When living in unstable circumstances people are often living in 'survival mode' meaning that immediate needs such as food and shelter take priority over everything else. Health tends to only be prioritised at crisis point or when pain becomes intolerable, at which point accessing primary healthcare in a timely manner is difficult. Once the initial problem settles people may have other priorities which prevent ongoing and follow-up treatment which can result in poorer health outcomes.
Practical barriers to accessing the mainstream primary health system	Common barriers were practical issues such as: • lost or non-existent identification documents or Medicare card • no access to a telephone or fixed address for communications

	• lack of secure place to store of belongings while attending appointments • inability to safely store medications, particularly those that need refrigeration • lack of access to shower or laundry facilities making it difficult to access services without experiencing stigma • costs of services such as gap payments. • lack of transport and/or cost of transport. Many people on lower incomes or at risk of homelessness may be living on the fringes of larger cities or in small towns services, so travel distances to health services may be increased.
Stigma and discrimination	People experiencing homelessness commonly experience stigma and discrimination in their daily lives. Stakeholders reported that many mainstream healthcare settings can look and feel clinical or imposing which can feel unwelcoming and/or unsafe to this population. Previous negative experiences of healthcare also contribute substantially to this population's capacity to engage with primary healthcare. Untreated or inadequately managed mental health issues and substance use problems were identified as significant barriers to accessing primary care. In addition, some policies in healthcare settings can unintentionally exclude this group from getting the care they need. One notable example was given of a health provider having a 'three strikes and you're out' policy for inappropriate or aggressive behaviour that essentially 'locks' people out of any future service access.
Trust and rapport	Establishing rapport and building a trusting relationship between service providers and people experiencing or at risk of homelessness is often key to providing high quality healthcare. It was frequently reported that a lack of these connections between this population group and mainstream primary healthcare workers is a major barrier to healthcare access. A lack of continuity of care was also cited as a barrier. Stakeholders reported a common scenario in which people see a different GP each visit with different treatment decisions being made or advice given, which can be frustrating and confusing. In these situations, patients must tell their story multiple times which contributes to further lack of trust and unwillingness to engage with healthcare services when needed.
Adequate housing	Stakeholders emphasised the importance of adequate housing in improving health outcomes, and there is robust evidence supporting Housing First initiatives. Some examples of Housing First initiatives in the Murray PHN region include the state-funded Education First Youth Foyers. The Shepparton Foyer is delivered in partnership by Berry Street, Beyond Housing and GOTAFE. Another Foyer, set to open in Wodonga in 2025, is a partnership between Junction Support Services, Beyond Housing and Wodonga TAFE. Stakeholders noted the importance of these programs in enhancing the overall health and wellbeing of people experiencing or at risk of homelessness, while also noting that demand far exceeds supply. Other notable programs reported to prevent homelessness include the Tenancy Plus support program and the Sustaining Tenancies at Risk (STAR) program.

Support post-discharge from tertiary and residential facilities	Discharge destinations from hospitals and other residential facilities are relevant for primary care coordination and prevention. A concern raised during consultations was the practice of hospitals discharging people back into homelessness. This issue highlights the State's established duty of care, similar to its responsibilities in other State care systems such as justice/corrections and out of home care. A hospital-based service provider in the Goulburn Valley sub-region noted that despite the determined efforts of hospital staff, the lack of refuge beds or supported and temporary accommodation across the area meant that sometimes staff had no choice but to discharge people into unstable housing or onto the streets. This situation likely contributes to higher rates of hospital readmissions among people experiencing homelessness, as these patients often return within weeks.

Case study: Supporting an older man at risk of homelessness

Housing Justice, part of Arc Justice in Bendigo, assisted an older man who was at significant risk of homelessness and was also managing health issues, including mental illness and cataracts. Though he was housed, he felt unsafe in the housing complex where he lived, and this compromised his housing security. The Housing Justice team collaborated with him to connect with support services, including Vision Australia to address his vision impairment. They successfully arranged surgery improving his vision and mobility.

However, logistical challenges remained, and the client required other practical support such as arranging transportation for medical appointments and post-operative care. The absence of a support network further complicated his ability to follow crucial post-surgery care instructions. This highlights the need for comprehensive support services for older, isolated individuals in similar situations.

Strengths and opportunities to address service gaps

Table 17: Strengths and opportunities identified in stakeholder consultations that can address service gaps

Opportunity	Description
Tailored approaches to primary health service delivery	**Strengths** Stakeholders highlighted the benefits of outreach services, where health practitioners or teams provide primary healthcare directly within the community. One example is GV Health's 'Jabba the Bus' initiative, which delivered vaccination services during the COVID-19 pandemic, significantly improving access for hard-to-reach groups. Additional outreach services reported within the Murray PHN catchment for people experiencing or at risk of homelessness include: • **Rumbalara Aboriginal Co-operative**: Recognised for its comprehensive wrap-around services in the Greater Shepparton and Mooroopna region. The service model includes a Culturally Safe medical clinic, after hours transport, housing and homelessness support and emergency relief. • **Albury Wodonga Aboriginal Health Service (AWAHS)**: Stakeholders emphasised the critical role AWAHS plays in delivering health and welfare support, including outreach and community transport to Aboriginal and Torres Strait Islander People in Albury, Wodonga and the surrounding areas. • **Bendigo Community Health Services**: A nurse accompanies a 'community connector' to engage with individuals experiencing or at risk of homelessness, linking them to essential health interventions and primary care. In-reach services were also identified as vital, promoting the integration of primary health practitioners, such as nurses and allied health professionals, into non-health settings frequented by individuals at risk of homelessness. These models build trust and rapport with health staff, providing 'soft entry points' to services. The local charity MADCOW (a moniker for Make a Difference, Change our World) based in Bendigo, is an example of a successful multidisciplinary in-reach service for individuals experiencing homelessness (see case study page 37 of this report).
	Gaps and opportunities Outreach and in-reach primary care models for people experiencing or at risk of homelessness are relatively uncommon in the Murray PHN catchment. Stakeholders generally supported these models, noting their effectiveness in engaging these populations, noting services such as the Salvation Army's Access Health Program in St Kilda and the Freo Street Doctor program in Perth as national exemplars of best practice. There are opportunities to invest in and strengthen existing programs that are performing well in the region, and to replicate successful models in areas with high needs. A key challenge identified across all care models is the difficulty of providing healthcare to transient populations. Stakeholders emphasised the need for healthcare models that can meet people where they are. Additionally, outreach and in-reach services were considered as most cost-effective and feasible in areas with substantial client numbers. For rural and remote areas, alternative strategies are needed to connect individuals at risk of homelessness with mainstream local services.

Case study: A holistic approach to addressing the needs of homeless persons in Bendigo

In response to the rise in homelessness during the COVID-19 pandemic, the MADCOW charitable organisation was established in 2020. Supported by philanthropic contributions, the initiative of Bendigo Baptist Community Care launched a community 'hub' and homelessness cafe in the Bendigo CBD, offering essential services such as showers, storage, laundry, kitchen and dining spaces, and clinical facilities. The Hub serves hot meals as well as coffee and desserts, to many dozens of individuals daily.

MADCOW addresses basic needs like hydration, food and social connection while fostering relationships built on trust, stability, and positive role modelling. The Hub also has a support team comprising of various health professionals, community workers and volunteers, who offer regular, low-pressure supports, further reinforcing MADCOW's role as a trusted community resource.

MADCOW's 'Beyond the Café' program expands this support by helping individuals define and pursue their own goals, offering pathways to volunteering, employment and housing. This holistic approach highlights MADCOW's commitment to addressing homelessness through community support, meeting basic needs, and empowerment.

Case study: Enhancing healthcare access for people through outreach and integration

In response to the healthcare access challenges faced by at-risk populations, innovative strategies have emerged, including the successful 'Jabber the Bus' outreach vaccination initiative in the Goulburn Valley during the COVID-19 pandemic. This initiative enabled the administration of vaccines to people sleeping rough at known camp and street locations. Stakeholders advocate for expanding outreach efforts, emphasising the need for services to reach individuals unable to access traditional healthcare settings.

Strengthening collaboration between services and identifying local community champions is key to improving integration and referral pathways. Suggestions include creating outreach hubs as one-stop centres and enhancing tenancy support programs to facilitate healthcare access. Additionally, participants highlighted the need for a cultural shift within healthcare settings to allow for longer appointments for people with complex needs. Encouraging clients to book longer appointments with primary care providers is also recommended.

Table 18: Strengths and opportunities identified in stakeholder consultations that can address non-health sector service gaps

Opportunity	Description
Non-health-sector services that support access to primary healthcare	**Strengths** Non-health-sector services were considered crucial to supporting access to primary healthcare for individuals experiencing homelessness. Stakeholders emphasised the importance of practical supports in facilitating health and service access. As one stakeholder noted: *"Don't underestimate how beneficial access to showers, haircuts, and good footwear is to health access."* (Stakeholder, CV) Such practical supports are often provided outside the primary healthcare system. Examples identified during consultations include:

	• SHSs using brokerage funding to facilitate initial GP access and medication purchases. • Provision of showers, washing machines, and other personal hygiene support. • Facilitating health education and service information (for example, The Hive Youth Resource Centre run by YES Unlimited in Albury, often brings in health workers to run workshops on specific health topics, e.g. sexual health, mental health). • Provision of storage lockers for personal belongings and important documents to minimise damage, loss and theft. • Pharmacies agreeing to store medications for patients e.g. refrigerated medications.
	Gaps and opportunities Stakeholders noted several initiatives that may help bridge the gaps and enhance the overall support system for individuals experiencing homelessness. These include: • **Limited access to essential services and necessities,** such as showers, laundry facilities, adequate footwear and fresh drinking water, which can impact health and the ability to access healthcare. Enhancing access to these services and personal hygiene supports through partnerships with community organisations, local councils and local businesses will improve health outcomes. • A significant lack of services to address **hoarding and squalor** was noted across the Murray PHN catchment, including both practical assistance and psychological support. Opportunities include investment in specialised hoarding and squalor services, including both practical cleanup assistance and mental health support, and providing training for professionals. • **Insufficient distribution of health education and health service information**, particularly in community spaces where individuals experiencing homelessness frequently visit. It was recommended that trusted community spaces, such as libraries and community centres, be used to disseminate health education and service information more effectively. • A lack of **storage services** for personal belongings and important documents, which can impede access to health services and other essential supports was noted as a system gap. More storage facilities or lockers would help individuals maintain their health and access services. • Limited or ineffective **integration between non-health sector services and health services** was seen to be hindering coordinated care and support. It was recommended that collaboration be fostered between non-health sector services and healthcare providers to create a more coordinated approach to supporting individuals experiencing homelessness.

Case study: Addressing the challenge of storing belongings in Wangaratta

A critical challenge for the homeless population is the safety of their belongings while attending appointments. In Wangaratta, an innovative but limited solution has emerged, where some homeless individuals leave their items at the local library while running errands or attending medical appointments. Also, recent initiatives, such as a fundraising collaboration between Wangaratta Council and a local high school led to the installation of lockers near essential facilities such as laundries. However, the absence of a dedicated strategy to address homelessness storage across the whole region raises questions about the broader approach. There was support amongst stakeholders for advocacy and lobbying to introduce more storage solutions.

Table 19: Strengths and opportunities identified in stakeholder consultations to improve access

Opportunity	Description
Supporting access to mainstream primary healthcare	**Strengths** Mainstream health services are most effective for individuals experiencing or at risk of homelessness when patients have an ongoing relationship with healthcare providers and receive regular, intensive support with collaboratively set goals. Stakeholders noted that GP telehealth services often have shorter waiting times compared to clinic-based appointments, offering timely care. However, face-to-face appointments are necessary for individuals without consistent phone access. Several programs that support access to mainstream services were highlighted as effective: • **ACCHOs** such as Rumbalara and AWAHS, were recognised for their flexible service models, including community transport to and from appointments and extended clinic hours. These transport services have reportedly reduced missed appointments. • **The Care Finder program** was noted for its navigation support and flexible brokerage to assist older patients to access aged care supports and services, such as My Aged Care. • **Head to Health** connects individuals to various mental health services, including telehealth and acute mental health support. A stakeholder in the NE sub-region described it as their "go-to service" due to its ability to accept new referrals despite long waitlists elsewhere. • **Victorian Dental Voucher Scheme**: Noted for positive outcomes, such as in Bendigo, where clients could access private dental care through vouchers when community dental clinics were unavailable.
	Gaps and opportunities Some of the key gaps in mainstream GP services, as highlighted by stakeholders include: • Fewer GP clinics offering **bulk billing services** making access to affordable care challenging. • **Long waiting lists** and extended waiting times for appointments were reported as common.

	• Many GP clinics were reported to be not accepting new patients, and those with a history of missed appointments or challenging interactions are being 'closed off the books' or having difficulty re-enrolling. • There is a general need for **longer consultations** to address complex needs comprehensively. • **Limited availability of walk-in or short-notice appointments** makes access for this cohort more difficult. • Difficulty accessing GPs or other health professionals who can **prescribe scheduled medications**. Other noted challenges include: • **Perception of services**: Mainstream services may be perceived as 'punitive and clinical' by people experiencing homelessness. GP workload and staff burnout were identified as possibly affecting service quality and person-centred care outcomes. • **Trauma-informed care**: The importance of trauma-informed care principles was emphasised to better serve homeless individuals. One service provider highlighted the need for more compassionate approaches, noting that the current healthcare system is often perceived as "traumatised," reflecting its tendency to be reactive and rigid. *"This highlights the importance of trauma-informed care principles in designing and delivering services for homeless individuals."* (Manager, SHS) Other specific health service gaps included: • **Mental health services**: A critical gap exists in publicly funded and accessible mental health and alcohol and other drug services. Stakeholders highlighted that clients often face significant barriers accessing care unless they are in acute crisis (suicidal or self-harming) or highly engaged and easily reachable by services. This has resulted in a service gap for people who do not fit these two extremes. Additionally, high costs, gap fees, and long wait times for both public and private mental health services further limit access and exacerbate these issues. • **Occupational therapy**: Long waiting lists, particularly for home assessments, were identified as a significant concern, increasing the risk of injury or illness for those awaiting services. • **Dental services**: Access to timely and affordable dental care remains a challenge, with high demand for services across the Murray PHN region exacerbating delays in care and impacting on access, particularly for those experiencing or at risk of homelessness.

Navigating the mainstream primary healthcare system	**Strengths** Some services in the Murray PHN catchment, such as the Care Finder program for older people and the Department of Veterans Affairs health navigation services for veterans, offer health navigation support to certain eligible groups, including those experiencing or at risk of homelessness. Community service workers across the catchment make significant efforts to help individuals experiencing or at risk of homelessness navigate the health system for both immediate and long-term health needs. However, this work is often ad hoc and generally lacks funding. Stakeholders noted that health navigation is most effective when there are local 'champions'—such as issue spotters, community connectors, and navigators—who understand the community and can link the individual with appropriate service providers.
	Gaps and opportunities Navigating the healthcare system and finding appropriate treatment is a significant barrier for this population. Due to a lack of resources for navigation support, stakeholders reported that clients often feel like they are "going around in circles," leading some to give up on seeking help altogether. Formal health navigation services are minimal and typically only available to specific subgroups within the homeless or at-risk population across the catchment. While individual service workers commendably provide ad-hoc health navigation assistance, access to this help is inconsistent, and workers often use time intended for other tasks to perform this unofficial role. Some stakeholders recommended capacity building and incentivising homelessness and housing services, such as SHSs, to better support primary health navigation and access. This could involve funding SHS providers to improve client service processes, such as intake assessments and intervention procedures, as well as providing navigation support and brokerage services to enhance healthcare access. Low levels of health literacy are also a concern for this group as people are often socially isolated which means they do not have a reliable ‘point of reference’, carer or family member to direct or support health access navigation / health seeking behaviours.
Coordination and linking of services	**Strengths** Local Area Service Networks (LASNs) operate across the Murray PHN catchment and support collaboration among homelessness and non-homelessness organisations. Other alliances noted by stakeholders include the Hume Region Alliance, Housing for the Aged Action Group (HAAG), and the Older Persons Advocacy Network (OPAN). Additionally, a feature of Victoria's homelessness system is its Opening Doors Framework, which promotes a coordinated service response through designated access points
	Gaps and opportunities Improving communication and coordination between services - particularly between hospitals, primary health providers, and homelessness services - was identified as a key opportunity. Stronger inter-organisational relationships are considered important for enhancing understanding of available services, referral pathways and community needs. Some stakeholders noted that non-health service providers sometimes struggle to understand how best to support clients in accessing health services. One stakeholder mentioned that while they hear about new services, or government-

	funded programs, they often lack clarity on how these resources are implemented locally or how they can help clients access them. Essential ingredients for improving access to health services, especially for those experiencing or at risk of homelessness, according to stakeholders, is service transparency, visibility and collaboration.
Positive patient/ professional relationships	**Strengths** Stakeholders emphasised that clients, particularly older individuals facing homelessness or housing insecurity, achieve the best health outcomes when they can access regular, intensive and goal-oriented primary care. Continuity of care with the same clinicians allows clients to build trusted relationships, increasing their engagement with the healthcare system. While workforce challenges exist, stakeholders noted that GPs in smaller towns often excel in building strong rapport and trust with patients who are experiencing or at risk of homelessness. Stakeholders also stressed the importance of encouraging GPs, nurses, and allied health professionals to consult in non-clinical settings where people congregate or feel comfortable. For example, in Albury, Charles Sturt University podiatry students provide regular healthcare in-reach services at a local neighbourhood house primarily used by under-serviced Aboriginal and Torres Strait Islander community members and older people. This initiative demonstrates the value of delivering care in familiar, community-based settings. Consistent presence in community-based settings helps establish these professionals as trusted resources. Additionally, there is a need for more adaptable and ad-hoc health education and navigation support. As one primary healthcare provider noted, *"Opportunistic health promotion is how we need to address the issue [of health access]. We need health workers in non-clinical spaces providing health promotion and education."*
	Gaps and opportunities Across the Murray PHN catchment, stakeholders reported significant challenges in recruiting and retaining primary healthcare staff. High turnover rates and staff shortages further complicate access for this vulnerable population. Stakeholders consistently emphasised the urgent need to address workforce shortages in both community support and primary healthcare services. Many organisations in these sectors are understaffed and underfunded, struggling to meet the high demand for services. This strain makes it difficult to provide the high-quality care and continuity that are essential for achieving the best outcomes for clients.

Case study: Barriers to primary healthcare for a person with unmet mental health needs

A homelessness outreach support worker in Bendigo recounted the story of assisting a male client in his 20's, which highlighted the challenges in accessing primary healthcare for individuals experiencing homelessness and mental health issues.

The worker built a rapport with the man, learning over time that he had been diagnosed with schizophrenia and other mental health conditions but had not received his prescribed antipsychotic depot injections for around six months. After gaining the client's trust, the worker was able to support him to reconnect with mental health services and access the medications he needed.

Initially, the worker contacted the local public mental health service that had previously treated the client. However, they were informed that the client had 'disengaged' from care and was no longer listed as an active patient. The worker then reached out to the regional mental health triage service but was told that, because the client didn't pose an immediate risk of suicide or self-harm, he should seek mental healthcare through a general practitioner (GP).

The worker attempted to schedule an appointment with the GP clinic where the client had previously been a patient and was told that the client was no longer "on the books" and that the clinic was not accepting new patients. After some persistence, the worker was able to locate a different bulk-billing GP willing to take on the client's care, allowing him to finally access the necessary medications and treatment.

Section 3: Regional profiles

North West regional profile

The Murray PHN North West sub-region covers three LGA areas of Buloke, Mildura and Swan Hill and has an estimated total population of 84,500 people. Some rural towns within the North West, including Robinvale, have transient and migrating population groups, which means that official statistics such as those in the Census can underestimate the actual residential population (Geografia, 2019).

Table 20: People who are homeless or marginally housed by LGA across the North West sub-region

Rank	LGA	Count			Rates per 1000		
		Homeless	Marginally housed	Total	Homeless	Marginally housed	Total
1	Swan Hill	239	192	**431**	11	9	**20**
2	Mildura	345	305	**650**	6	5	**11**
3	Buloke	10	18	**28**	2	3	**4**
North West		594	515	**1109**	7	6	**13**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data. LGAs ranked by rate of total homelessness and marginally housed (count).

Table 21: SHS clients by LGA across the North West sub-region

Rank	LGA	Client count				Rate per 1000 people			
		Homeless	At risk	Not stated	Total	Homeless	At risk	Not stated	Total
1	Mildura	618	1195	440	**2253**	11	21	8	**40**
2	Swan Hill	231	298	95	**624**	11	14	4	**29**
3	Buloke	20	27	27	**74**	3	4	4	**12**
North West		869	1520	562	**2951**	10	18	7	**35**

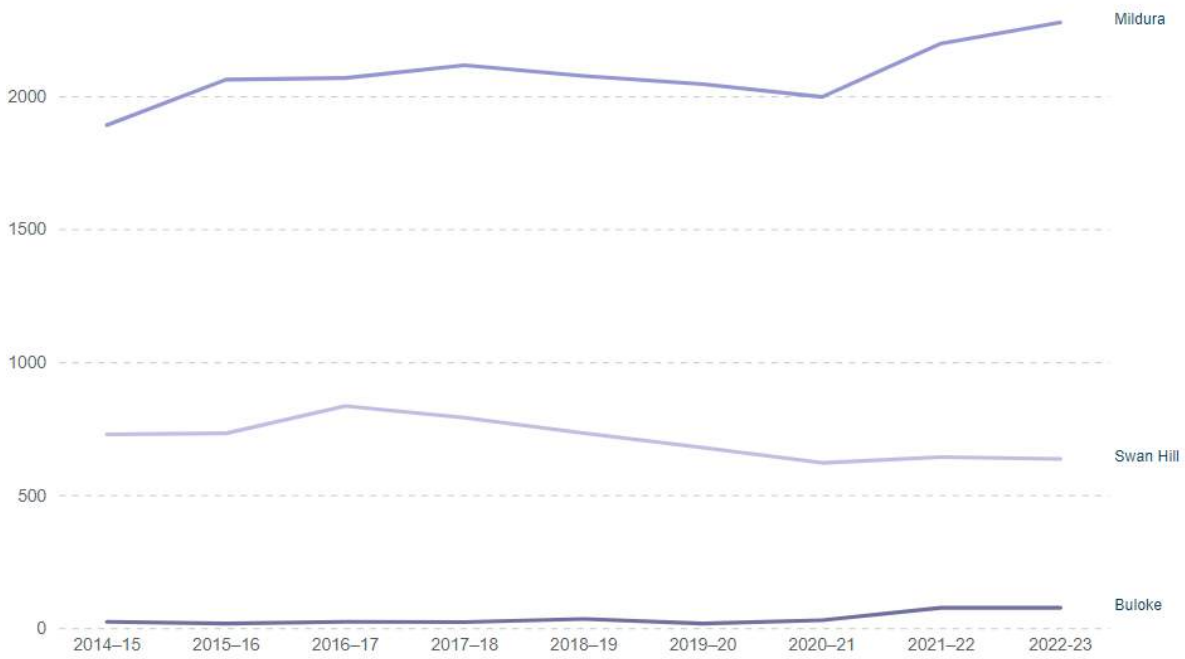
Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data. LGAs ranked by rate of total SHS clients (count).

In the North West sub-region 13 per cent of all people recorded as homeless in the 2021 ABS Census identified as Aboriginal and/or Torres Strait Islander People. This is higher than the catchment (10 per cent) and state (4 per cent).

The homelessness rate for people who identified as Aboriginal and/or Torres Strait Islander was 21 per 1000 people in the North West sub-region. This was also higher than the rate for catchment (14 per 1000) and for state (17).

Figure 12: Trend of SHS client count for the North West sub-region by LGA - July 2014 to June 2023



Source: AIHW (2014-23). Public data: accessible to all audiences

Table 22: Counts of people who are homeless or marginally housed and have long term health conditions in the North West sub-region

	Buloke	Mildura	Swan Hill	Total NW
Arthritis	0	25	9	**34**
Asthma	3	51	17	**71**
Cancer (including remission)	0	13	3	**16**
Dementia (including Alzheimer's)	0	0	0	**0**
Diabetes (excluding gestational diabetes)	0	16	3	**19**
Heart disease (including heart attack or angina)	0	16	0	**16**
Kidney disease	0	4	0	**4**
Lung condition (including COPD or emphysema)	3	8	4	**15**
Mental health condition (including depression or anxiety)	3	61	17	**81**
Stroke	0	6	0	**6**
Any other long-term health condition(s)	3	34	12	**49**
No long-term health condition(s)	16	413	254	**683**
Not stated	0	91	106	**197**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data

Table 23: Rates per 1000 of people who are homeless or marginally housed and have long term health conditions in the North West sub-region

	Buloke	Mildura	Swan Hill	NW total
Arthritis	0	38	21	**31**
Asthma	107	78	39	**64**
Cancer (including remission)	0	20	7	**14**
Dementia (including Alzheimer's)	0	0	0	**0**
Diabetes (excluding gestational diabetes)	0	25	7	**17**
Heart disease (including heart attack or angina)	0	25	0	**14**
Kidney disease	0	6	0	**4**
Lung condition (including COPD or emphysema)	107	12	9	**14**
Mental health condition (including depression or anxiety)	107	94	39	**73**
Stroke	0	9	0	**5**
Any other long-term health condition(s)	107	52	28	**44**
No long-term health condition(s)	571	635	589	**616**
Not stated	0	140	246	**178**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data

Key findings from stakeholder consultations in the North West sub-region

Strengths

Two ACCHOs operate in North West Victoria: Mallee District Aboriginal Services located in Mildura, Swan Hill and Kerang, and Murray Valley Aboriginal Co-operative based in Robinvale, and which provide comprehensive and Culturally Safe primary healthcare for First Nations communities.

Stakeholders recognised Sunraysia Community Health Services as a key health provider in the North West, commending its strong communication and collaboration with other services.

Gaps and opportunities

Stakeholders report that the sub-region faces significant challenges due to a shortage of GPs, particularly in Ouyen. Additionally, concerns were raised about GP availability, accessibility, and affordability. Some clinics in the area, were not taking new patients and/or were unable to offer bulk billing, further limiting access to care.

Central Victoria regional profile

Central Victoria sub-region within Murray PHN covers six LGA areas and has the greatest proportion of the catchment population, with a total population of approximately 250,000 people. Close to half this sub-region's population live in and around the regional city of Bendigo, with many other towns and rural communities spread across the area from the Macedon Ranges in the south to Gannawarra and Campaspe LGAs in the north along the Murray River.

Table 24: People who are homeless or marginally housed by LGA in the Central Victoria sub-region

Rank	LGA (EN)	Count			Rates per 1000		
		Homeless	Marginally housed	Total	Homeless	Marginally housed	Total
1	Greater Bendigo	562	246	**808**	5	2	**7**
2	Loddon	21	29	**50**	3	4	**6**
3	Campaspe	118	122	**240**	3	3	**6**
4	Gannawarra	22	26	**48**	2	2	**5**
5	Mount Alexander	42	27	**69**	2	1	**3**
6	Macedon Ranges	86	48	**134**	2	1	**3**
Central Victoria		851	498	**1349**	3	2	**5**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data. LGAs ranked by rate of total homelessness and marginally housed (count).

Table 25: SHS clients by LGA across the Central Victoria sub- region

Rank	LGA	Client count				Rate per 1000 people			
		Home-less	At risk	Not stated	Total	Home-less	At risk	Not stated	Total
1	Gannawarra	53	136	52	**241**	5	13	5	**23**
2	Campaspe	364	410	63	**837**	9	11	2	**22**
3	Greater Bendigo	917	1406	144	**2467**	8	12	1	**20**
4	Mount Alexander	95	297	5	**397**	5	15	0	**20**
5	Loddon	40	43	0	**83**	5	6	0	**11**
6	Macedon Ranges	94	164	5	**263**	2	3	0	**5**
Central Victoria		1563	2456	269	**4288**	6	10	1	**17**

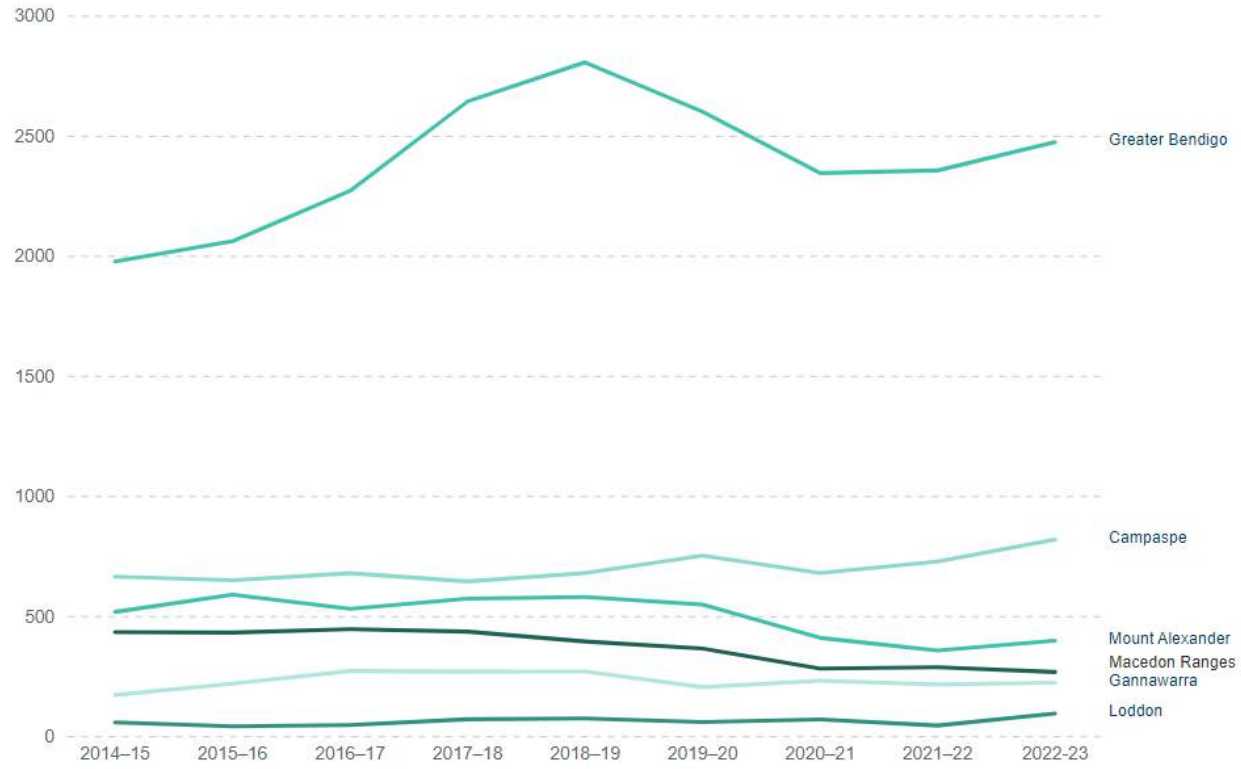
Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data. LGAs ranked by rate of total SHS clients (client count).

In the Central Victoria sub-region nine per cent of all people recorded as homeless in the 2021 ABS Census identified as Aboriginal and/or Torres Strait Islander People. This is slightly lower than the catchment (10 per cent) but higher than the state (four per cent).

The homelessness rate for people who identified as Aboriginal and/or Torres Strait Islander was 15 per 1000 people in the Central Victoria sub-region. This is slightly higher than the rate for Murray PHN (14 per 1000) but slightly lower than the state (17).

Figure 13: Trend of SHS client count for the Central Victoria sub-region by LGA - July 2014 to June 2023



Source: AIHW (2014-23). Public data: accessible to all audiences

Table 26: Counts of people who are homeless or marginally housed and have long term health conditions in the Central Victoria sub-region

	Campaspe	Gannawarra	Bendigo	Loddon	Macedon Ranges	Mt Alexander	CV total
Arthritis	22	15	40	11	12	11	**111**
Asthma	17	8	69	10	15	4	**123**
Cancer (including remission)	10	0	7	3	9	0	**29**
Dementia (including Alzheimer's)	0	0	0	0	4	0	**4**
Diabetes (excluding gestational diabetes)	16	3	25	8	5	0	**57**
Heart disease (including heart attack or angina)	5	0	12	3	6	3	**29**
Kidney disease	4	0	9	0	4	0	**17**
Lung condition (including COPD or emphysema)	4	0	4	3	0	0	**11**
Mental health condition (including depression or anxiety)	33	11	113	19	26	18	**220**
Stroke	4	4	3	0	5	0	**16**
Any other long-term health condition(s)	18	9	61	10	16	10	**124**
No long-term health condition(s)	134	23	427	10	76	29	**699**
Not stated	27	0	171	5	16	13	**232**

Sources: ABS Census of Population and Housing 2021 Tablebuilder (LGA and LTHP by OPGP)

*Murray PHN region totals calculated using LGA level data

Table 27: Rates per 1000 of people who are homeless or marginally housed and have long term health conditions in the Central Victoria sub-region

	Campaspe	Gannawarra	Greater Bendigo	Loddon	Macedon Ranges	Mount Alexander	CV total
Arthritis	92	313	50	220	90	159	**82**
Asthma	71	167	85	200	112	58	**91**
Cancer (including remission)	42	0	9	60	67	0	**21**
Dementia (including Alzheimer's)	0	0	0	0	30	0	**3**
Diabetes (excluding gestational diabetes)	67	63	31	160	37	0	**42**
Heart disease (including heart attack or angina)	21	0	15	60	45	43	**21**
Kidney disease	17	0	11	0	30	0	**13**
Lung condition (including COPD or emphysema)	17	0	5	60	0	0	**8**
Mental health condition (including depression or anxiety)	138	229	140	380	194	261	**163**
Stroke	17	83	4	0	37	0	**12**
Any other long-term health condition(s)	75	188	75	200	119	145	**92**
No long-term health condition(s)	558	479	528	200	567	420	**518**
Not stated	113	0	212	100	119	188	**172**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data

Key findings from stakeholder consultations in the Central Victoria region

Strengths

There are two ACCHOs providing effective and Culturally Safe primary care in the Central Victoria sub-region: Bendigo and District Aboriginal Co-operative located in Bendigo (Dja Dja Wurrung Country) and Njernda Aboriginal Corporation based in Echuca (Yorta Yorta Country) (refer to the First Nations population health series report).

Stakeholders highlighted several strengths in the Central Victoria sub-region. Bendigo Community Health Services (BCHS) was noted as an example of a service that effectively supports various community needs, including women's health, alcohol and other drugs, allied health and paediatrics. Stakeholders noted that community health service like BCHS are often highly accessible and visible.

It was reported that BCHS is engaging people who are experiencing homelessness through outreach via libraries and other community spaces for incidental health education and direct support. BCHS was said to exemplify this approach with nurse practitioners and generalist community health nurses connecting people experiencing homelessness with health services.

Another initiative that was singled out as an exemplar is the charity MADCOW, which connects people experiencing homelessness with health and social services through in-reach activities, such as the MADCOW café (see case study page 37 of this report). Local neighbourhood houses hosting pharmacist-led health education sessions, was another example of support for community health in the region.

Gaps and opportunities

A significant challenge in Central Victoria is limited GP availability, particularly in the LGAs of Greater Bendigo and Mount Alexander Shire. Stakeholders report that many clinics in the sub-region are often not able to accept new patients.

Stakeholders also reported the general lack of coordination and communication between services. It was noted that there were difficulties in accessing some government-funded programs that were publicly announced but not able to take on client referrals.

There is an opportunity to build on the success of service models such as MADCOW and BCHS to improve service coordination and access.

Goulburn Valley regional profile

The Goulburn Valley sub-region comprises of five LGAs and has a population of approximately 170,000 people (by LGA). Several communities in the Goulburn Valley have been affected by natural disasters in recent years including floods in Shepparton and Rushworth in 2022, which displaced many residents causing property damage and homelessness creating pressure on local housing stock availability and increasing rents causing forced relocation.

Table 28: People who are homeless or marginally housed by LGA across the Goulburn Valley sub-region

Rank	LGA	Count			Rates per 1000		
		Homeless	Marginally housed	**Total**	Homeless	Marginally housed	**Total**
1	Greater Shepparton	415	494	**909**	6	7	**13**
2	Strathbogie	27	57	**84**	2	5	**7**
3	Murrindindi	36	64	**100**	2	4	**7**
4	Moira	81	100	**181**	3	3	**6**
5	Mitchell	117	110	**227**	2	2	**5**
Goulburn Valley		676	825	**1501**	4	5	**9**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data. LGAs ranked by rate of total homelessness and marginally housed (count).

Table 29: SHS clients by LGA across the Goulburn Valley sub-region

Rank	LGA	Client count				Rate per 1000 people			
		Homeless	At risk	Not stated	**Total**	Homeless	At risk	Not stated	**Total**
1	Greater Shepparton	826	1035	148	**2009**	12	15	2	**30**
2	Moira	195	212	76	**483**	6	7	3	**16**
3	Mitchell	200	358	85	**643**	4	7	2	**13**
4	Strathbogie	20	66	10	**96**	2	6	1	**8**
5	Murrindindi	32	72	16	**120**	2	5	1	**8**
Goulburn Valley		1273	1743	335	3351	7	10	2	19

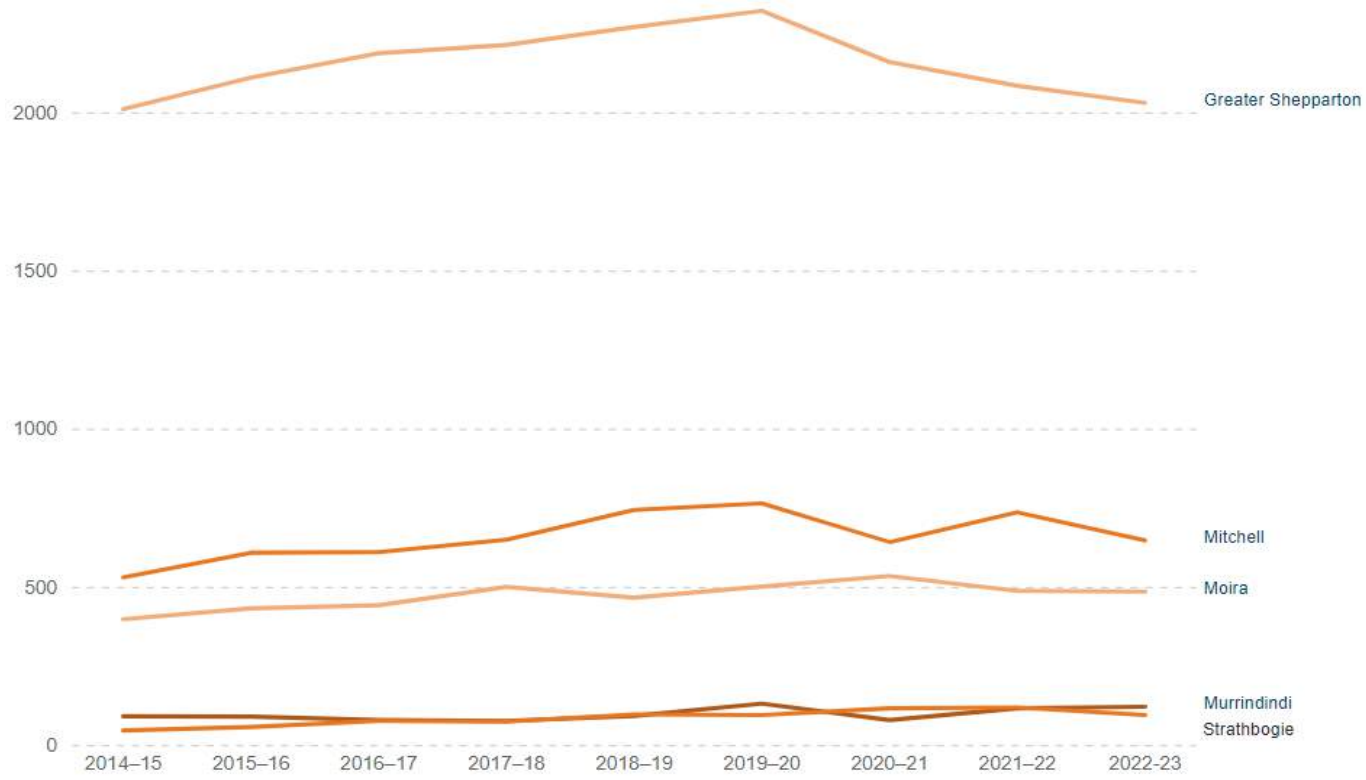
Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data. LGAs ranked by rate of total SHS clients.

In the Goulburn Valley sub-region eight per cent of all people recorded as homeless in the 2021 ABS Census identified as Aboriginal and/or Torres Strait Islander. This is slightly lower than the catchment (10 per cent) but higher than the state (four per cent).

The homelessness rate for people who identified as Aboriginal and/or Torres Strait Islander was 11 per 1000 people in the Goulburn Valley sub-region. This is lower than the rate for the catchment (14 per 1000) and for state (17).

Figure 14: Trend of SHS client count for the Goulburn Valley sub-region by LGA - July 2014 to June 2023



Source: AIHW (2014-23). Public data: accessible to all audiences

Table 30: Counts of people who are homeless or marginally housed and have long term health conditions in the Goulburn Valley sub-region

	Greater Shepparton	Mitchell	Moira	Murrindindi	Strathbogie	Total GV
Arthritis	50	13	18	3	0	**84**
Asthma	55	30	17	4	3	**109**
Cancer (including remission)	9	0	8	4	0	**21**
Dementia (including Alzheimer's)	4	0	0	0	0	**4**
Diabetes (excluding gestational diabetes)	38	4	15	8	3	**68**
Heart disease (including heart attack or angina)	18	4	11	9	4	**46**
Kidney disease	0	0	3	0	0	**3**
Lung condition (including COPD or emphysema)	18	7	9	0	5	**39**
Mental health condition (including depression or anxiety)	100	44	23	9	11	**187**
Stroke	9	0	0	0	5	**14**
Any other long-term health condition(s)	51	17	13	3	0	**84**
No long-term health condition(s)	552	116	89	63	60	**880**
Not stated	145	36	33	15	12	**241**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data

Table 31: Rates per 1000 of people who are homeless or marginally housed and have long term health conditions in the Goulburn Valley region

	Greater Shepparton	Mitchell	Moira	Murrindindi	Strathbogie	GV total
Arthritis	55	57	99	30	0	**56**
Asthma	61	132	94	40	36	**73**
Cancer (including remission)	10	0	44	40	0	**14**
Dementia (including Alzheimer's)	4	0	0	0	0	**3**
Diabetes (excluding gestational diabetes)	42	18	83	80	36	**45**
Heart disease (including heart attack or angina)	20	18	61	90	48	**31**
Kidney disease	0	0	17	0	0	**2**
Lung condition (including COPD or emphysema)	20	31	50	0	60	**26**
Mental health condition (including depression or anxiety)	110	194	127	90	131	**125**
Stroke	10	0	0	0	60	**9**
Any other long-term health condition(s)	56	75	72	30	0	**56**
No long-term health condition(s)	607	511	492	630	714	**586**
Not stated	160	159	182	150	143	**161**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN sub-region totals calculated using LGA level data

Key findings from stakeholder consultations in the Goulburn Valley region

Strengths

The ACCHO operating in the Goulburn Valley sub-region is Rumbalara Aboriginal Co-operative Limited located in Mooroopna which provides comprehensive and Culturally Safe care for Aboriginal and Torres Strait Islander Peoples and Communities. The flexible service model at Rumbalara includes community transport to and from appointments and extended clinic hours which were strengths noted by stakeholders.

Stakeholders noted the care finder program run by Wintringham in Shepparton as a high quality service for the Goulburn Valley. The program, commissioned by Murray PHN, supports vulnerable older people in accessing aged care services.

GV Health's 'Jabba the Bus' COVID-19 outreach model was also highlighted as effectively reaching people experiencing homelessness for vaccinations during the COVID pandemic. This model could provide an exemplar or be adapted for general healthcare outreach.

Another service identified by stakeholders as an important service was Beyond Housing's Tenancy Support which provides important tenancy support across North East Victoria and the Goulburn Valley, helping people sustain their private tenancies. The service was considered a possible opportunity for future capacity building activities.

Gaps and opportunities

Limited number of bulk-billing services in the Goulburn Valley sub-region is leading to affordability issues for patients, with fewer options available, especially in smaller towns.

While Beyond Housing plays a critical role in the supply and management of community housing and tenancy support, the scope of its resourcing was perceived by stakeholders to be limited. Some services perceived that Beyond Housing have reduced their scope of services over time, noting that the service no longer has the capacity or mandate to assist clients in finding new housing, which limits their support capabilities.

GV Health reported that a major barrier to them providing high level of patient care is the lack of accommodation options at the point of discharge, such as homeless refuges and temporary accommodation. This is leading to patients being discharged back into homelessness and subsequently returning to the hospital.

North East regional profile

The North East sub-region within Murray PHN covers eight LGAs with a total population of almost 200,000 people. Around half of this region's population live in and around the twin regional cities of Albury and Wodonga that are separated by the Murray River, and the NSW/Victoria state border. The North East sub-region includes diverse regional and rural communities and encompasses the eastern part of Victorian highlands and ski fields which are major tourist attractions and experience an influx of workers and travellers during the winter months.

Table 32: People who are homeless or marginally housed by LGA across the North East region

Rank	LGA	Count			Rates per 1000		
		Homeless	Marginally housed	**Total**	Homeless	Marginally housed	**Total**
1	Wodonga	207	132	**339**	5	3	**8**
2	Wangaratta	126	47	**173**	4	2	**6**
3	Towong	8	25	**33**	1	4	**5**
4	Albury	167	104	**271**	3	2	**5**
5	Benalla	18	49	**67**	1	3	**5**
6	Mansfield	15	29	**44**	1	3	**4**
7	Alpine	23	22	**45**	2	2	**3**
8	Indigo	13	37	**50**	1	2	**3**
North East		577	445	**1022**	3	2	**5**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data. LGAs ranked by rate of total homelessness and marginally housed.

Table 33: SHS clients by LGA across the North East region

Rank	LGA	Client count				Rate per 1000 people			
		Homeless	At risk	Not stated	**Total**	Homeless	At risk	Not stated	**Total**
1	Wodonga	497	652	103	**1252**	12	15	2	**29**
2	Wangaratta	316	309	42	**667**	11	10	1	**23**
3	Benalla	95	120	29	**244**	7	8	2	**17**
4	Indigo	48	206	5	**259**	3	12	0	**15**
5	Albury	408	348	26	**782**	7	6	0	**14**
6	Towong	10	27	5	**42**	2	5	1	**7**
7	Alpine	25	51	15	**91**	2	4	1	**7**
8	Mansfield	15	27	5	**47**	1	3	0	**5**
North East		1414	1740	230	3384	7	9	1	18

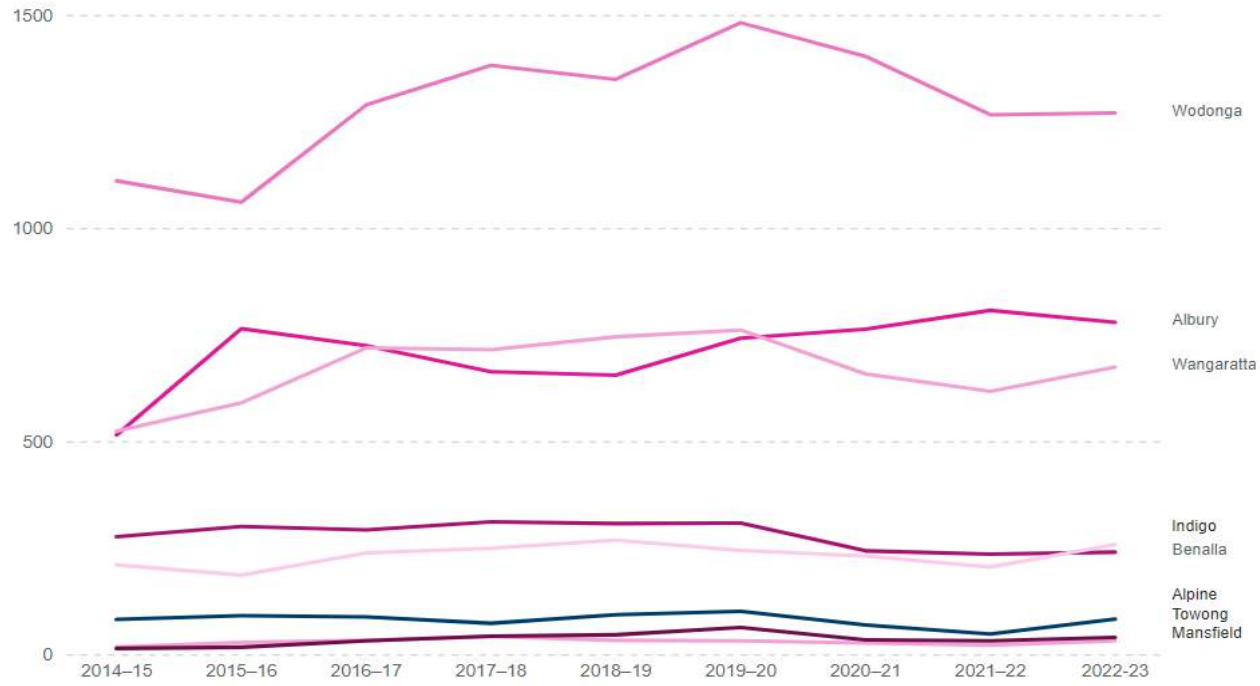
Source: AIHW (2022-23). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data. LGAs ranked by rate of total SHS clients.

In the North East sub-region 10 per cent of all people recorded as homeless in the 2021 ABS Census identified as Aboriginal and/or Torres Strait Islander People. This is the same proportion as the average across the catchment (10%) but higher than state (4%).

The homelessness rate for people who identified as Aboriginal and/or Torres Strait Islander People was 11 per 1000 people in the North East region. This is lower than the rate at both the catchment (14 per 1000) and state (17).

Figure 15: Trend of SHS client count for the Goulburn Valley sub-region by LGA - July 2014 to June 2023



Source: AIHW (2014-23). Public data: accessible to all audiences

Table 34: Counts of people who are homeless or marginally housed and have long term health conditions in the North East sub-region

	Albury	Alpine	Benalla	Indigo	Mansfield	Towong	Wangaratta	Wodonga	Total NE
Arthritis	15	0	5	6	3	6	15	16	**66**
Asthma	24	0	6	7	4	0	23	41	**105**
Cancer (including remission)	4	0	4	4	0	4	3	6	**25**
Dementia (including Alzheimer's)	0	0	0	0	0	0	0	0	**0**
Diabetes (excluding gestational diabetes)	8	0	0	0	0	0	6	12	**26**
Heart disease (including heart attack or angina)	9	0	0	6	3	0	4	10	**32**
Kidney disease	0	0	4	0	0	0	0	0	**4**
Lung condition (including COPD or emphysema)	5	0	3	4	0	0	0	10	**22**
Mental health condition (including depression or anxiety)	34	5	12	7	8	4	19	61	**150**
Stroke	3	0	0	0	0	0	0	0	**3**
Any other long-term health condition(s)	21	9	9	7	6	0	17	31	**100**
No long-term health condition(s)	122	32	34	24	27	24	74	163	**500**
Not stated	69	0	11	8	3	0	55	75	**221**

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data

Table 35: Rates per 1000 of people who are homeless or marginally housed and have long term health conditions in the North East region

	Albury	Alpine	Benalla	Indigo	Mansfield	Towong	Wangaratta	Wodonga	NE total
Arthritis	55	0	75	120	68	182	87	47	65
Asthma	89	0	90	140	91	0	133	121	103
Cancer (including remission)	15	0	60	80	0	121	17	18	24
Dementia (including Alzheimer's)	0	0	0	0	0	0	0	0	0
Diabetes (excluding gestational diabetes)	30	0	0	0	0	0	35	35	25
Heart disease (including heart attack or angina)	33	0	0	120	68	0	23	29	31
Kidney disease	0	0	60	0	0	0	0	0	4
Lung condition (including COPD or emphysema)	18	0	45	80	0	0	0	29	22
Mental health condition (including depression or anxiety)	125	111	179	140	182	121	110	180	147
Stroke	11	0	0	0	0	0	0	0	3
Any other long-term health condition(s)	77	200	134	140	136	0	98	91	98
No long-term health condition(s)	450	711	507	480	614	727	428	481	489
Not stated	255	0	164	160	68	0	318	221	216

Source: ABS (2021). Public data: accessible to all audiences

*Murray PHN region totals calculated using LGA level data

Key findings from stakeholder consultations in the North East region

Strengths

In the North East, there are two ACCHOs operating: the Albury Wodonga Aboriginal Health Service (AWAHS), with sites in Albury, Wodonga and Wangaratta, and Mungabareena Aboriginal Corporation based in Wodonga and Wangaratta. AWAHS was noted for its exemplary role in supporting primary healthcare access for Aboriginal and Torres Strait Islander People on both sides of the river, Albury to the north, and Wodonga and Wangaratta on the south.

Other strengths noted include services provided by The Salvation Army, which has developed new programs to support people experiencing homelessness, indicating a proactive approach to addressing needs. Beyond Housing's Tenancy Support program was also highlighted. The program offers valuable tenancy support to help individuals to maintain tenancies and stay in their rental properties. These programs have potential for future capacity building activities.

Gaps and opportunities

Transport access is a significant issue in the North East with limited health services and inadequate public transport options in some communities, such as Mansfield and Corryong. Improving transportation access and support is considered crucial for accessing healthcare.

Another unique challenge in the North East is the cross-border context. For example, residents in Albury and Wodonga access services interchangeably in both cities, often without any thought to program eligibility or exclusion. Due to the interstate context, collaboration, patient ineligibility and funding limitations were noted as challenges. The need for better coordination and integration of service provision and funding allocation across geographical boundaries to ensure continuity of care for people experiencing homelessness was recommended.

Section 4: Attachments

Attachment A - Data sources and definitions

Table 36: List of data indicators, sources and definitions

Source	Year	Indicator	Definition/Calculation
ABS	2021	Aboriginal and/or Torres Strait Islander Peoples who were homeless (proportion of homeless population)	Aboriginal and/or Torres Strait Islander People in one of the six ABS homeless operational group /No of people in one of the six ABS homeless operational group, by LGA, section of state and state. LGA data via Census Tablebuilder. Victorian data via ABS Estimating homelessness report Table 7.7
ABS	2021	Aboriginal and/or Torres Strait Islander Peoples who were homeless (rate)	Aboriginal and/or Torres Strait Islander people in one of the six ABS homeless operational group /Aboriginal and/or Torres Strait Islander people, by LGA, section of state and state. LGA data via Census Tablebuilder. Victorian data via ABS Estimating homelessness report Table 7.7
ABS	2021	Age group of homeless or marginally housed people	No of people in five year age groups in the nine ABS homelessness and marginally housed groups, by OPGP, LGA and AGE5P, via Census Tablebuilder
ABS	2021	Health condition in people experiencing and/or at risk of homelessness (count)	No of people who were homeless or marginally housed and reported a long term health condition, by OPGP, LTHP and LGA or state. LGA data via Census Tablebuilder, Victorian data via ABS Estimating homelessness report Table 2.3.
ABS	2021	Health condition in people experiencing and/or at risk of homelessness (rate)	(No of people who were homeless or marginally housed and reported a long term health condition/ total people who were homeless or marginally housed)*1000, by OPGP, LTHP and LGA or state. LGA data via Census Tablebuilder, Victorian data via ABS Estimating homelessness report Table 2.3.
ABS	2021	People who were homeless (count)	No of people in one of the six ABS homeless operational groups, by OPGP and LGA or state or Australia, via Census Tablebuilder
ABS	2021	People who were homeless (rate)	(No of people in one of the six ABS homeless operational groups / total people)*1000, by OPGP and LGA or state, via Census Tablebuilder
ABS	2021	People who were homeless or marginally housed (count)	No of people in one of the nine ABS homeless or marginal housing groups, by OPGP and LGA or state, via Census Tablebuilder
ABS	2021	People who were homeless or marginally housed (rate)	(No of people in one of the nine ABS homeless or marginal housing groups/ total people)*1000, OPGP by LGA or state, via Census Tablebuilder

Source	Year	Indicator	Definition/Calculation
ABS	2021	People who were marginally housed (count)	No of people in one of the three ABS other marginal housing groups, by OPGP and LGA or state or Australia, via Census Tablebuilder
ABS	2021	People who were marginally housed (rate)	(No of people in one of the three ABS other marginal housing group / total people)*1000, by OPGP and LGA or state, via Census Tablebuilder
ABS	2021	Proportion of people recorded as homeless in a homeless operational group	(No of people in each of the six ABS homeless operational group /No of people in all six ABS homeless operational groups)*100, by OPGP and Australia, State or LGA, via Census Tablebuilder
ABS	2021	Proportion of people recorded as marginally housed in a marginal housing operational group	(No of people in each of the three ABS marginal housing operational group /No of people in all three ABS marginal housing operational groups)*100, by OPGP and Australia, state or LGA, via Census Tablebuilder
ABS	2021	Gender of people who were homeless or marginally housed	No of males and females in one of the nine ABS homeless or marginal housing groups, by OPGP, LGA and SEXP, via Census Tablebuilder
ABS	2022	Aboriginal and/or Torres Strait Islander population	Total Aboriginal and/or Torres Strait Islander population by PHN Catchment, ABS 2022
ABS	2022	Population	Total population by PHN catchment, ABS 2022
AIHW	2014-23	SHS clients (historical count)	No of people who presented to one or more specialist homelessness agencies during the reporting year by PHN or LGA and homelessness status first reported via SHS annual report data explorer platform PHN (historical) and (2022-23) datasets.
AIHW	2022-23	Age group of homeless or marginally housed people	No SHS clients in 10yr age groups, by gender and homelessness first reported and PHN or LGA, via SHS annual report data explorer platform
AIHW	2022-23	Main reason for seeking assistance from SHS (count of clients)	The client's main reason for seeking assistance at the beginning of support. Where more than one reason for seeking assistance has been provided, the client chooses the main reason.
AIHW	2022-23	Reasons for seeking assistance from SHS (count of clients)	A record of all reasons a client has presented to any specialist homelessness agency during the reporting year. A client can specify multiple reasons for seeking assistance, but each reason is only recorded once per client during the reporting period.
AIHW	2022-23	Gender of SHS clients	No of males and female SHS clients, by gender and homelessness first reported and PHN or LGA, via SHS annual report data explorer platform. State and Australian data from SHS Annual Report 2022-23
AIHW	2022-23	SHS clients (count)	No of people who presented to one or more specialist homelessness agencies during the reporting year by LGA and homelessness status first reported via SHS annual report data explorer platform. State and Australian counts from SHS Annual Report 2022-23

Source	Year	Indicator	Definition/Calculation
AIHW	2022-23	SHS clients (rate)	(No of SHS clients/total population)*1000, by LGA and homelessness first reported . Total population counts taken from 2021 Census. SA4, State and Australian rates from SHS Annual Report 2022-23.
AIHW	2022-23	SHS clients 'at risk' of homelessness	No of people who presented to one or more specialist homelessness agencies during the reporting year with 'at risk' housing status at initial contact, by LGA and homelessness first reported, via SHS annual report data explorer platform
AIHW	2022-23	SHS clients currently 'homeless'	No of people who presented to one or more specialist homelessness agencies during the reporting year with 'homeless' housing status at initial contact, by LGA and homelessness first reported, via SHS annual report data explorer platform.
AIHW	2022-23	SHS clients in Victoria (count)	No of clients by gender, age group and state via SHS annual report 2022-23 (web report, clients, services and outcomes Figure CLIENTS.1).
AIHW	2022-23	SHS client vulnerabilities	Proportion of SHS clients reporting selected vulnerabilities, by state via SHS Annual Report 2022-23.
Crime Statistics Agency	2022-23	Specialist family violence service clients	Total number of family violence victims assisted at family violence specialist agencies for women and children by LGA (Data available for Victoria only, therefore the Albury LGA is not included).
Crime Statistics Agency	2022-23	Specialist family violence service clients (rate)	Rate of family violence victims assisted at family violence specialist agencies for women and children per 100,000 population by LGA (Data available for Victoria only, therefore the Albury LGA is not included).

Attachment B - Brief glossary

Term	Definition
Housing First	A program model that provides individuals experiencing homelessness with immediate access to safe and adequate housing without typical preconditions, along with comprehensive wrap-around services such as healthcare, social support, and education and employment assistance.
Local Area Service Network (LASN)	LASNs are made up of senior representatives of local housing and support agencies, who collaborate to maximise effectiveness of the homelessness system in specific regions.
Opening Doors Framework	Opening Doors provides a coordinated service framework in Victoria where a limited number of entry points are designated and a person's needs are assessed, cases are prioritised, and people experiencing homelessness are connected to services and resources.

Attachment C - Data collection and analysis methods

Quantitative data

Data collection

Quantitative data related to the location, demographics and health needs of people experiencing and at risk of homeless were identified. Relevant data were extracted, stored and manipulated to develop key indicators for both descriptive analysis and the modelling components of this health and service needs analysis.

Details and definitions of indicators used in the descriptive analysis are listed in Table 36 in Attachment A - Data sources and definitions.

Defining homelessness

The two main data sources used have slightly different definitions for homelessness.

Categorisation of homelessness within the ABS Census of Population and Housing

The ABS Census aims to collect data about all people in Australia on Census night.

People recorded as **homelessness** on are those within the following six Homelessness Operational Groups:

- Persons living in improvised dwellings, tents or sleeping out
- Persons in supported accommodation for the homeless
- Persons staying temporarily with other households
- Persons living in boarding houses
- Persons in other temporary lodgings
- Persons living in 'severely' crowded dwellings.

People recorded as being **at risk of being homeless** are those within the following three Homelessness Operational Groups (Marginal housing groups):

- Persons living in other crowded dwellings
- Persons in other improvised dwellings
- Persons who are marginally housed in caravan parks.

People who were recorded as neither homeless or marginally housed are those within the following Homeless Operational Group:

- Not applicable.

Categorisation of homelessness within the Specialist Homelessness Services data

The AIHW (2024a) categorise homelessness and being at risk of homelessness as follows:

SHS clients considered to be **homeless** are those who are living in any of the following circumstances:

- No shelter or improvised dwelling
- Short-term temporary accommodation
- House, townhouse or flat (if they are couch surfing or have no tenure)

SHS clients considered to be **at risk of homelessness** if they are living in any of the following circumstances:

- Public or community housing (renter or rent-free)
- Private or other housing (renter, rent-free or owner)
- Institutional settings (such as hospital, disability support, rehabilitation, correctional facility)

SHS clients who do not provide any information about relevant aspects of their housing situation have their homelessness status recorded as 'not stated'

Quantitative data limitations

Homelessness is by nature at times a hidden and often a transient experience, which makes the number of people without a home or at risk of homelessness difficult to quantify.

Issues around measuring homelessness

While the ABS Census and the AIHW's SHS data reports are useful in estimating the level of homelessness within Australian communities, there are limitations with these data sources. For example, the SHS client data only counts people who present to services, there may be many reasons why people experiencing or at risk of homelessness are not know to SHSs, including location and accessibility of such services in a rural/regional context. A study examining how homelessness is estimated in Australia (O'Donnell, 2020) also suggested that:

- homelessness is more prevalent than typically measured in Australia, affecting a larger cross-section of the community
- homelessness is more diverse in length and severity with more people experiencing temporary and episodic homelessness than captured by point-in-time estimates
- housing exclusion and deprivation, including staying with family/friends or in marginal or sub-market housing are likely to be substantially more common than street or sheltered homelessness, and due to their 'hidden' nature are not necessarily captured in official statistics.

Using population data sets for analysis at the local level

To avoid the release of confidential and potentially identifiable information, details within publicly available data about homelessness are at time suppressed and/or cells are randomly adjusted when extracted at granular levels. Data extracts from the online tools to access ABS and AIHW data used within this report come with the caveat that 'no reliance should be placed on small cells'. Therefore, the data presented here is the best indication available of likely levels of homelessness and associated issues within the Murray PHN area rather than exact numbers.

These strategies to protect the confidentiality of the data also affect calculations made when adding small cells within data sets to obtain totals for larger groups. Efforts were made to minimise the impact of this by using direct downloads for grouped totals wherever practical.

Estimating population rates

All rates presented within this report are crude rates and therefore do not take other factors into account that may vary between population groups such as age or socioeconomic status. As such rates should be interpreted with some caution. Full details for calculations used within this report to estimate population rates are provided in Table 36 in Attachment A - Data sources and definitions.

Impact of COVID on measuring homelessness

The COVID-19 pandemic had substantial social effects within Victoria during the Census data collection period in 2021. Lockdowns and other restrictions together with levels of assistance to people experiencing homelessness may have impacted the housing status of many residents.

The COVID-19 pandemic response in Victoria provided short term and/or emergency accommodation for people to isolate and comply with stay-at-home directives. This accommodation provision peaked during the longer lockdowns in April to December 2020, and again from May to November 2021. Funding and assistance was provided through the Homelessness to a Home program through 2021-2022 to ensure safe housing for people in the later stages of the pandemic recovery and for people to transition from hotel accommodation into more appropriate options.

Qualitative data

Stakeholders

Stakeholder consultations were used to collect qualitative data on health and service needs. Key stakeholders included service providers from the health, homelessness, and community sectors across the Murray PHN catchment area including housing and SHSs, community organisations and charities, primary care services, hospitals and other health services, community legal centres, mental health services, and local and state government departments. These stakeholders play a key role in providing or supporting services to people experiencing or at risk of homelessness and some of these services include, assisting in housing, food, support services (mental health) and other health services.

Snowball sampling was used throughout the consultation process with stakeholders identifying other key organisations or groups within their local communities who could contribute additional perspectives. A list of key external and internal stakeholders is provided in Table 37.

Consultation format

Stakeholder engagement primarily occurred through targeted focus group meetings and semi-structured interviews (in person and online). Other opportunities for gathering information, such as participating in communities of practice meetings were also maximised. Some key organisations were consulted on multiple occasions throughout the consultation process.

Development of focus group questions

A rapid review of relevant organisational submissions to the Parliamentary Inquiry into Homelessness in Victoria (2022) was conducted to inform the focus group questions. This provided background information and identified potential issues around homelessness and access to primary healthcare as a basis for discussion questions. The summary of the key themes from this rapid review and a list of included submissions included the rapid review are detailed in *Attachment D - Rapid review of the Inquiry into Homelessness in Victoria*.

Analysis of qualitative data

Detailed notes were taken in all stakeholder consultation sessions which were analysed thematically. A descriptive coding strategy was initially used to identify codes relating to key questions and the main themes emerging from the data were then identified and summarised. Results from the analysis are presented in this report according to these themes and any key issues highlighted from a specific sub-region presented in the relevant regional profile.

Table 37: List of key stakeholders involved in consultations for the homelessness health and service needs analysis

External stakeholders
• Arc Justice (incorporating Housing Justice) • Bendigo Baptist Community Care • Bendigo Community Health Services • Beyond Housing • Dhelkaya Health • Gateway Health • GV Health • Haven Home Safe • Junction Support Services • MADCOW Australia • Mallee Accommodation and Support Program • Mallee Family Care • Mallee Track Health and Community Service • Many Coloured Sky • Mildura Rural City Council • Mount Alexander Shire Council • NCN Health • Nexus Primary Health • Primary Care Connect • Red Cross • STRIDE • Sunbury and Cobaw Community Health • The Personnel Group • The Salvation Army • Uniting VicTas • Uniting Church in Australia Synod of Victoria and Tasmania • Wellways • Wintringham • Women's Health Goulburn North East • YES Unlimited
Internal stakeholders
• Murray PHN Medical Advisors Group • Murray PHN Clinical Advisory Council • Murray PHN Community Advisory Councils • Murray PHN First Nations Health and Healing team

Resources from the following organisations were also a valuable source of information for this report:

- Council to Homeless Persons
- Australian Alliance to End Homelessness – Australian Health, Housing and Homelessness Network.

Qualitative data limitations

- Targeted consultation with healthcare consumers with lived experience of homelessness or risk of homelessness was outside the scope of this report. However, to ensure the health experiences and perspectives of consumers were obtained, consultation was undertaken with service providers who regularly engage directly with this cohort.
- Accessing key stakeholders face to face was challenging due to the rapid nature of the health and needs analysis. To overcome this a variety of consultation methods was used to maximise participation e.g. face-to-face, online, written feedback, phone calls.

Attachment D - Rapid review of submissions to the Inquiry into Homelessness in Victoria

Between 2019 and 2021 the Legislative Council Legal and Social Issues Committee of the Victorian Parliamentary conducted an Inquiry into Homelessness in Victoria. The inquiry 'examined the changing scale and nature of homelessness across Victoria' (Legislative Council Legal and Social Issues Committee, 2022).

There were 455 written submissions were made to the inquiry. A rapid review of relevant submissions was conducted as part of the literature review for this report and informed the stakeholder consultation session format and question guide.

Of the 455 submissions, there were 208 included in the literature review for this health and service needs analysis. Submissions were included in the review if the organisation met one or more of the following criteria:

- It was located within and/or provided services within the Murray PHN catchment
- It was a key organisation providing health services within Victoria or a peak body for health services/professionals
- It was a leading organisation providing homelessness services across Victoria or a peak body for homelessness and/or other community service organisations.

A full list of organisations whose submissions were included in the rapid review is provided in table 41, and all submissions are available via the Victorian Parliament's website (please refer to Legislative Council Legal and Social Issues Committee, 2022).

Table 41: List of organisational whose submissions were included in this rapid review

Sector	Organisation name
Organisations providing services in the Murray PHN catchment	
Community services sector	• Bendigo Winter Night Shelter • Junction Support Services • Mallee Family Care • North East Support and Action for Youth Inc. • Shadac Inc (The Cottage Shepparton) • St Vincent de Paul Society Victoria • Wintringham
Other	• Committee Echuca Moama • Greater Shepparton City Council • Hands Up Mallee • Mildura Rural City Council • North East Multicultural Association • Old Colonists Association of Victoria
Statewide or National organisations	
Health sector	• Alcohol and Drug Foundation • Alfred Mental and Addiction Health • Ambulance Victoria • Australian Association of Gerontology • Australian Association of Social Workers • Australian Institute of Health and Welfare • Australian Psychological Society • Mental Health Legal Centre

	• Mind Australia Limited • Orygen • Penington Institute • SANE Australia • St Vincent's Hospital Melbourne • The Royal Australian and New Zealand College of Psychiatrists • The Royal Australian and New Zealand College of Psychiatrists Faculty of Forensic Psychiatry • The Royal Women's Hospital • Victorian Alcohol and Drug Association • Windana Drug and Alcohol Recovery Ltd • Women's Health Victoria
Community services sector	• Catholic Social Services Victoria • Council to Homeless Persons • Melbourne City Mission • Mission Australia • Sacred Heart Mission • The Salvation Army

This rapid review sought to understand the key population groups who are at increased risk of experiencing homelessness in Victoria, the common health conditions seen in this population and the barriers and enablers that they often encounter when accessing services (emphasis on health services where possible, but they were not always distinguished from other types of support services). The main findings of this rapid review are presented below.

Population groups

Table 38: Themes around barriers for people experiencing or at risk of homelessness

Theme	Included groups
Priority groups	• People experiencing mental ill-health • AOD users • People with disability • Veterans • People with chronic illness • People who are currently or previously experienced family violence • People with trauma history • First Nations Peoples • People from CALD backgrounds • LGBTQI+ people • People leaving state care (out of home care, corrections facilities or health facilities)
Socio-demographic factors	• Older people • Older women • Women • Young people • Families with children • Young parents • Socioeconomic status • Rural and remote populations

Health conditions

The lack of safe, secure and stable housing, along with complex psychosocial factors, a lack of nutrition and hydration are some of the factors that contribute to poor health in people experiencing or at risk of homelessness in Victoria. Common health conditions in this population can also include mental illness, alcohol and other substance use disorders, chronic illness and cardiovascular disease. People experiencing or at risk of homelessness may commonly have dental health problems, feet and leg issues, skin conditions, and respiratory and eye conditions.

Two of the most pressing health needs, mental health issues and AOD use disorders both have a complex relationship with homelessness. Mental illness and AOD problems may contribute to someone experiencing or becoming homeless, and a lack of stable, safe and functional housing may impact on an individual's ability to effectively manage these health problems. These issues were highlighted by several submissions:

> *"Stable, affordable housing is a fundamental pre-condition for people to achieve optimal mental health and fully participate in society. Without stable housing it is nearly impossible for people to manage their mental illness. However, serious mental illness impacts heavily on an individual's ability to secure and maintain housing." (Mental Health Legal Centre, 2020)*

> *"Dysfunctional use of alcohol and other psychoactive drugs (AOD) can propel people into homelessness and can prolong the experience of homelessness…. Conversely, people who are homeless are at risk of consuming toxic amounts of alcohol and other drugs as a consequence of coping with physical, emotional and mental stress. Problematic alcohol use in particular contributes to family violence which in turn drives many people, usually females, into seeking refuge outside the family home and can lead to homelessness." (Alcohol and Drug Foundation, 2020)*

Barriers to accessing services

For people experiencing homelessness, addressing health needs are often lower priorities compared to basic survival needs such as securing food and shelter. The following barriers for this group in accessing health and other services were identified in the reviewed submissions.

Table 39: Themes around barriers for people experiencing or at risk of homelessness to accessing services.

Theme	Barriers
Services not meeting the needs of the homeless population	• Difficulty navigating services. • Lack of support for complex cases. • Lack of capacity in the health system • Long wait times for services, due to workforce shortage or infrastructure capacity or capability shortage.
Practical barriers	• Cost of services • Problems with or loss of ID/ documents • Distance to services or physical barriers • Unable to prioritise healthcare e.g. lack of housing stability • Other practical barriers e.g. nowhere to store personal belongings
Stigma and emotional barriers	• Stigma or social isolation • Lack of trust • Previous negative experiences with healthcare services • Person declining appropriate care. • Culturally unsafe services.

Mental health and/or AOD use	• Mental health issues making it difficult to engage • AOD use- impacting engagement or access
Consequences of barriers to accessing appropriate care	• Use of emergency dept for non-emergency care

Enablers to accessing services

This rapid review highlighted many potential enablers to improving health service access for people experiencing homelessness.

Table 40: Themes for enablers for people experiencing or at risk of homelessness to accessing services

Theme	Enablers
Types of services	• Early intervention or care for specific people or problems. • Wrap-around services. • Out-reach services. • In-reach services in safe spaces where people congregate. • Support to access and navigate services
Address specific access barriers	• Reduce costs of key treatments. • Recognise time and distance in rural locations. • Virtual care by increasing digitisation of the primary health system - online consults, online booking, email etc as primary communication presents additional barrier to those without reliable access to technology
How services are provided	• Trauma informed services. • Culturally safe care. • Person centred care. • Services designed with clients and those with lived experience.
System wide solutions	• Coordination and integration across service areas and more focus on new innovative shared models of care. • Capacity and capability of information systems for sharing patient related information within primary health system for easy referrals, fast turnaround times and better care of such target population groups. • Healthcare or servicer worker training (often around stigma, cultural safety). • Stigma reduction campaigns.

Attachment E - Literature review

Defining homelessness

There are many definitions of homelessness. Definitions of homelessness as used by the ABS and AIHW have been applied throughout this report.

The ABS defines the that a person is experiencing homelessness when homeless if their current living arrangement are either of these:

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

When presenting data related to SHS support utilisation, the AIHW considers a person homeless if they are living in non-conventional accommodation (e.g. rough sleeping) or short-term or emergency accommodation (such as living temporarily with friends or relatives).

Factors contributing to homelessness

The underlying causes of homelessness are complex. Many factors contribute to people experiencing homelessness including both individual characteristics or experiences that increase vulnerability to homelessness and structural factors can drive an individual into homelessness. The Salvation Army Australia (2024) provides the following examples of these factors to explain the causes of homelessness

Table 42: Factors contributing to homelessness

Structural drivers of homelessness
• An increased cost of living and associated financial stress • A lack of affordable housing options • Long wait times for (government subsidised) housing • Inadequate government support payments to manage rising costs • Long term unemployment • Poverty
Individual experiences
• Family violence, child abuse and sexual assault • Traumatic experiences • Time spent in an institution such as out-of-home care or prison • Experiences of war, violence or persecution • Mental illness • Addiction to alcohol, drugs or gambling
Groups of people more at risk of homelessness
• Females • Single parents or living alone • Aboriginal and/or Torres Strait Islander Peoples • People with mental illness

Source: The Salvation Army Australia (2024)

The 'housing crisis'

The impacts and recent growth in many structural drivers of homelessness is often referred to as a 'housing crisis'. This term was defined by the Victorian Parliamentary Inquiry into the rental and housing affordability crisis in Victoria as, "a multifaceted issue with significant social, economic and government policy implications… when it becomes increasingly difficult for people to afford a mortgage or their rent" (Legislative Council Legal and Social Issues Committee, 2023, p. 55). The Grattan Institute within the final report for the Inquiry described the history and effects of the current situation:

> *Victoria's housing crisis has been building for a long time. Within living memory, Victoria was a place where housing costs were manageable, and people of all ages and incomes had a reasonable chance to own a home with good access to jobs. But housing in Victoria has become increasingly expensive, and public anxiety about housing affordability is rising. Home ownership is falling, renter poverty is rising, and more people are becoming homeless* (the Grattan Institute as quoted in Legislative Council Legal and Social Issues Committee (2023, pp. 56-57)

Six key features of a rental and housing crisis were described in the Inquiry's final report which are:

1. Rising costs - either rent or home prices. Increases often outpace wage growth and can be compounded by inflation
- Financia strain - households under stress to cover housing expenses which impacts ability to manage other essential needs such as healthcare, education and savings
2. Unmet demand - supply of affordable housing does not meet demand, and this scarcity drives prices even higher
3. Economic implications - Broader impacts on people such as workers living further from workplaces and facing longer commutes, decreased job satisfaction and lower productivity.
- Social inequality - People from marginal and vulnerable populations, such as those on low incomes, minority communities and disadvantaged groups, are disproportionately impacted.
- Displacement and homelessness - Vulnerable householders may be forced to relocate to lower cost areas or become homeless.

Homelessness and First Nations Peoples

First Nations Peoples experiences of homelessness are a direct result from historical and ongoing colonisation that forcibly removed Aboriginal and Torres Strait Islander People from their Land and therefore removed access to food and resources, resulting in intergenerational, ongoing socioeconomic impacts.

The Victorian Aboriginal Housing and Homelessness Framework (Aboriginal Housing Victoria, 2020) which states a vision of "Mana-na woorn-tyeen maar-takoort" or "Every Aboriginal person has a home", highlights four key issues causing homelessness for First Nations Peoples. These are:

1. Housing market failure
2. Stress and trauma caused by racism and discrimination and intergenerational disadvantage,
3. Household socioeconomic status and poverty caused by colonisation
4. Systemic failure and racism in housing and homeless assistance systems.

An anti-racism and Culturally Safe housing and homelessness system is needed to address this inequity. Access to appropriately size housing can also be an issue for families which is reflected in target 9a of the National Agreement on Closing the Gap which states "By 2031, increase the proportion of Aboriginal and Torres Strait Islander People living in appropriately sized (not overcrowded) housing to 88%" (Commonwealth of Australia Department of the Prime Minister and Cabinet, 2024) Nationally in 2021, 81.4% of Aboriginal and Torres Strait Islander People were living in appropriately sized (not overcrowded) housing. This was an increase from 78.9 per cent in 2016 (the baseline year) but the objective is not yet met, or on track to be met at the national level (Productivity Commission, 2024).

Demand for Specialist Homelessness Services

SHS assist in providing specialist support services to Australians who are homeless or at risk of homelessness. SHS agencies receive government funding to assist to both people experiencing and people at risk of homelessness. The services are aimed at prevention, early intervention, crisis and post crisis assistance and include accommodation-related services and personal services. SHS agencies vary in size and in the types of assistance provided.

Demand for homelessness support services within communities is so high that the SHS system in its current state is consistently unable to meet it (Spinney et al., 2020). For example, in the 2022–23 financial year, around 165,000 SHS clients nationally (60% of all clients) identified a need for accommodation services but these services were only provided to around half of these clients (AIHW, 2024b). It is also critical to note that not all people in a community who require assistance manage to present to an SHS, and of those who do receive support from a SHS may not have secure housing upon service exit.

Of the 274,000 clients SHS agencies assisted in 2022–23:

- 6 in 10 were female (59% or 162,000 clients)
- 1 in 6 were children under the age of 10 (16% or 43,200 clients)
- 1 in 10 were children and youth aged 10–17 (12% or 32,800 clients)
- the largest age group of adult clients was those aged 25–34 (18% of all clients or 50,000 clients)
- about 14,400 were women aged 55 or older (8.8% of total female clients) and 12,900 were men aged 55 or older (12% of total male clients)
- 1 in 3 (35% or 90,100) clients were living as a single parent with one or more children when they sought support (AIHW, 2024b).

Current program and policy context

Table 43: Key policy and programs related to homelessness

National level	
National Agreement on Social Housing and Homelessness (NASHH)	Provides a framework for funding and service delivery to address homelessness and its associated health issues across Australia. It allocates federal government funding to states and territories to improve social housing and homelessness outcomes. This agreement replaced the National Housing and Homelessness Agreement from 1 July 2024.
National Housing and Homelessness Plan (under development)	The Australian Government is developing a National Housing and Homelessness Plan in collaboration with state and territory governments. The Plan will be a 10-year strategy setting out a vision to inform future housing and homelessness policy in Australia. It is expected to be released in 2024.
National Agreement on Closing the Gap (2020)	Aims to improve health, housing, education, and employment outcomes for Aboriginal and Torres Strait Islander Peoples. Includes specific targets for reducing homelessness, improving housing quality and improving health outcomes.
National Healthcare Agreement (2022)	Sets out the shared responsibilities of the Commonwealth and the states and territories to deliver healthcare services, including to people experiencing homelessness.

National Aboriginal and Torres Strait Islander Health Plan 2021-2031	Provides a framework for improving health outcomes, including addressing the social determinants of health such as housing and homelessness.
Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS)	Ensures access to essential health services and medications for all Australians, including people experiencing homelessness.
National Mental Health and suicide prevention plan (2021)	Addresses the mental health needs of all Australians with an emphasis on supporting high risk groups. The plan notes homelessness as a key issue and outlines a range of priority groups including rural, regional and remote communities and the likely intersectionality between priority groups.
National Disability Insurance Scheme (NDIS)	Provides support to Australians with disabilities, including those who are homeless, to access healthcare and other services.
Victorian and local government level	
Victorian Public Health and Wellbeing Plan 2023-2027	Focuses on improving health outcomes for all Victorians, with specific strategies for addressing the social determinants of health, including housing and homelessness.
Victorian Homelessness and Rough Sleeping Action Plan (2018)	Aims to improve the health and wellbeing of people experiencing homelessness through integrated health support. It includes strategies such as enhanced outreach services, emergency accommodation, and assistance to transition to long-term housing.
Mental Health and Wellbeing Act 2022 (Victoria)	Includes provisions to support mental health services for people experiencing homelessness, ensuring they have access to necessary care.
Mana-na woorn-tyeen maar-takoort: Every Aboriginal Person Has a Home (2020) The Victorian Aboriginal Housing and Homelessness Framework	A comprehensive strategy to address housing and homelessness issues faced by Aboriginal Peoples in Victoria, with a focus on Culturally Safe services.
Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027	A strategy focusing on improving health, wellbeing, and safety outcomes, including initiatives to address housing and homelessness.
Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017-2027	Addresses mental health and social and emotional wellbeing, recognising the impact of stable housing on overall health.
Local government strategies and plans	Local council strategies and plans for addressing homelessness, health, and housing often involve a combination of immediate relief efforts, long-term preventive measures, and collaborative initiatives with state and federal agencies, non-government organisations, and community groups.

Other relevant programs and initiatives

Specialist Homelessness Services (SHS)	Organisations receiving funding under the NASHH that offer a range of service including crisis accommodation or related services or assistance and support services to people experiencing or at risk of homelessness.
Commonwealth Rent Assistance (CRA)	A financial aid program to help low-income individuals afford private rental housing, indirectly supporting those at risk of homelessness.
Housing Establishment Fund (HEF)	Provides financial assistance to individuals and families facing homelessness to secure short-term housing or prevent eviction
From Homelessness to a Home (H2H) and Homes for Families (H4F) programs	Victorian programs aimed at supporting and transitioning individuals and families experiencing homelessness (due to coronavirus or COVID-19) into stable housing.
Crisis and Transitional Accommodation Program	A five-year capital works grant program that opened in 2024, where the Australian Government is providing $100 million for crisis and transitional housing options for women and children experiencing family and domestic violence and older women at risk of homelessness

Attachment F - References

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