JOURNEY TO SOCIAL INCLUSION

Chronic homelessness in Melbourne: The experiences of Journey to Social Inclusion Mark II study participants

Findings from Darja Miscenko, Shannen Vallesi, Lisa Wood, Monica Thielking, Kathryn Taylor, Jessica Mackelprang and Paul Flatau

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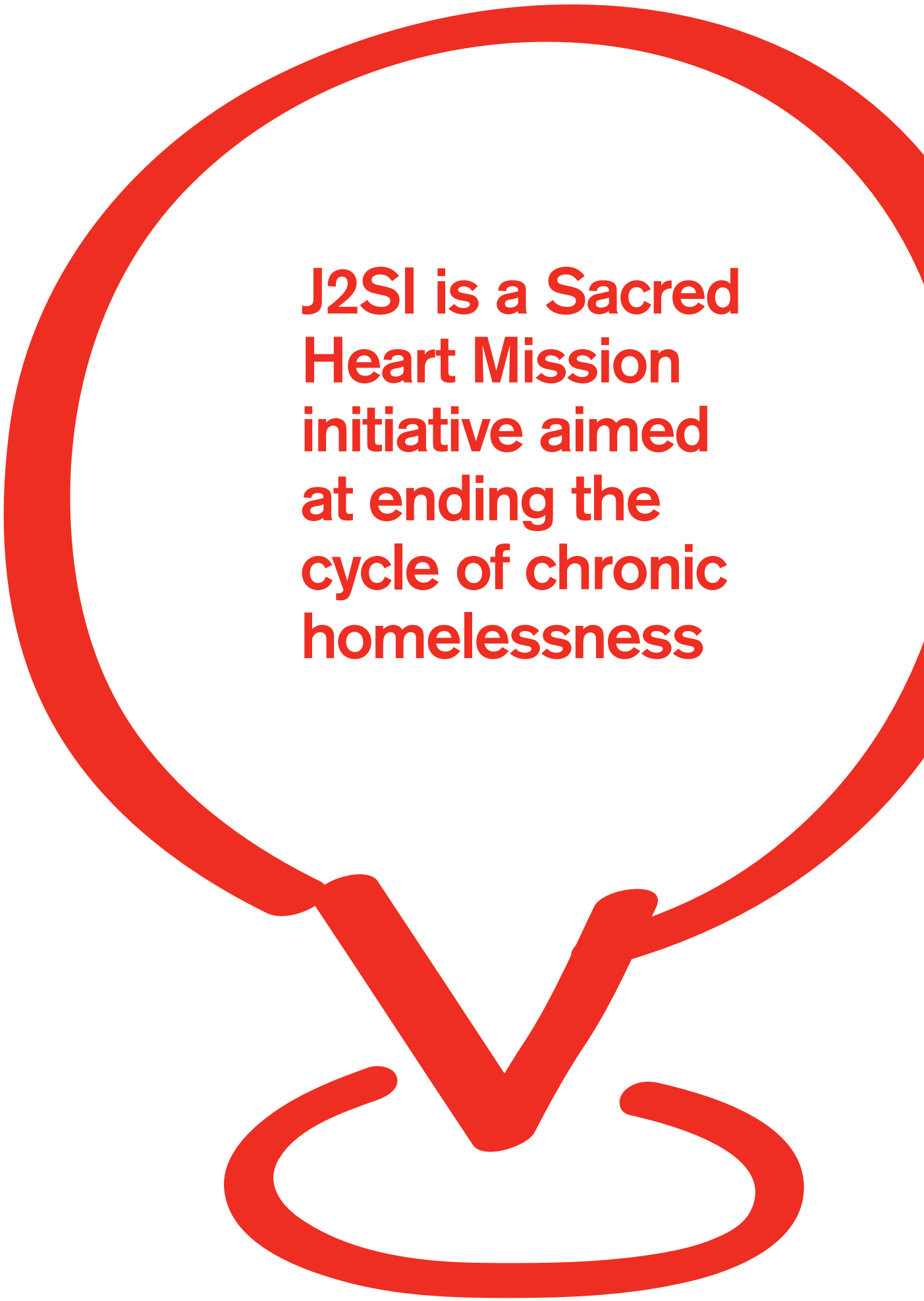
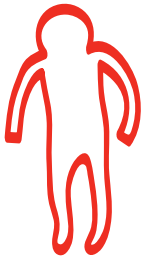

J2SI is a Sacred Heart Mission initiative aimed at ending the cycle of chronic homelessness

A TYPICAL J2SI CLIENT



69%

ARE MALE WITH AN
AVERAGE AGE OF 40

5%

ARE EMPLOYED

96%

HAVE SLEPT ROUGH DURING THEIR LIFETIME
AND FOR THIS GROUP THEY HAVE SPENT
13% OF THEIR LIFE SLEEPING ROUGH

90%

HAVE A CHRONIC MENTAL OR
PHYSICAL HEALTH CONDITION

87%

HAVE EXPERIENCED PSYCHOLOGICAL
DISTRESS. 70% HAVE EXPERIENCED POST
TRAUMATIC STRESS

84%

REPORT USING SUBSTANCES OTHER
THAN TOBACCO OR ALCOHOL

92%

REPORT HAVING CONTACT WITH THE
HEALTH SYSTEM IN THE LAST YEAR

50%

REPORTED TO EMERGENCY
IN THE LAST YEAR

Acknowledgements

The authors would like to thank all participants for their valued contribution to the J2SI Mark II research study and for giving so generously their time to complete the Journey to Social Inclusion Mark II (J2SI Mark II) Baseline Survey.

We would also like to thank our three partner agencies in this study (i.e., Sacred Heart Mission (SHM), VincentCare and St Mary's House of Welcome) and their staff for their assistance in implementing the study. In particular, we would like to thank the J2SI Mark II Steering Committee and J2SI Mark II Evaluation Committee; SHM CEO, Cathy Humphrey; SHM General Manager, Leanne Lewis; SHM Manager for J2SI, Anna Paris; and the SHM baseline survey interview team: Debra Hopkins, Angela Merriam, Matthew Teran, Kay Gravel and Daryl Taylor for their support of the project.

Drafts of the present report were reviewed by the J2SI Mark II Steering Committee and J2SI Mark II Evaluation Committee, and we thank members for their comments. We would like to thank SHM , the Victorian Government and individual philanthropists for their generous support of the J2SI Mark II program and research study. The two universities engaged in the study, University of Western Australia and Swinburne University of Technology, also provided significant in-kind support for the study, including a PhD scholarship.

The opinions in this report reflect the views of the authors and do not necessarily reflect those of SHM, partner organisations, the J2SI Mark II Steering Committee or the J2SI Mark II Evaluation Committee.

The J2SI Mark II Research Study

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About Sacred Heart Mission

Sacred Heart Mission is an incorporated association with more than 35 years' experience in providing individualised support and care services to people who are experiencing homelessness and disadvantage. Since opening our doors in 1982, the Mission has evolved into an innovative organisation, sustained by a deep pool of generosity and support from the community. Further information about SHM is available at www.sacredheartmission.org

Suggested citation

Miscenko, D., Vallesi, S., Wood, L., Thielking, M., Taylor, K., Mackelprang, J. & Flatau, P. (2017). *Chronic homelessness in Melbourne: The experiences of Journey to Social Inclusion Mark II study participants,* St Kilda, VIC: Sacred Heart Mission. Retrieved from https://www.sacredheartmission.org/understanding-homelessness/homelessness-projects-reports

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Abbreviations

3-ILS	The UCLA 3-item Loneliness Scale
ABS	Australian Bureau of Statistics
ACPMH	Australian Centre for Posttraumatic Mental Health
AHURI	Australian Housing and Urban Research Institute
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
ATSI	Aboriginal or Torres Strait Islander
BTQ	Brief Trauma Questionnaire
CEO	Chief Executive Officer
CSI	Centre for Social Impact
DASS	Depression Anxiety Stress Scales
ESSI	ENRICHD Social Support Instrument
E group	Comparison group
GP	General Practitioner
GPD	General Psychological Distress
ISEL-12	Interpersonal Support Evaluation List
J group	Intervention group
J2SI	Journey to Social Inclusion
J2SI Mark II	Journey to Social Inclusion Mark II
K10	Kessler Measure of Psychological Distress
KRW	Key referring worker
PTSD	Post Traumatic Stress Disorder
PCL-C	PTSD CheckList – Civilian Version (PCL-C)
RCT	Randomised controlled trial
SD	Standard deviation
SHM	Sacred Heart Mission
SISES	Single-Item Self-Esteem Scale
S-WEMWBS	Short-version Warwick-Edinburgh Mental Wellbeing Scale
UWA	University of Western Australia
WHO	World Health Organisation
WHOQOL	World Health Organization Quality of Life
WHOQOL-BREF	World Health Organization Quality of Life Brief Version

Contents

List of Tables

List of Figures

1. Introduction

The Journey to Social Inclusion Mark II (J2SI Mark II) program is an innovative homelessness program implemented and administered by Sacred Heart Mission (SHM) in Melbourne. The program aims to break the cycle of chronic homelessness by providing rapid access to sustained permanent housing and improving the health, well-being and social outcomes of participants. It builds on the pilot J2SI program undertaken between 2009 and 2012 (Johnson & Tseng, 2010; Johnson et al., 2011; Johnson et al., 2012; Johnson et al., 2013; Johnson et al., 2014; Parkinson, 2012; Parkinson & Johnson, 2014). The J2SI service model is based on five key elements: assertive case management and service coordination, housing access and sustaining tenancies, trauma-informed practice, building skills for inclusion, and fostering independence (Sacred Heart Mission, 2016).

This baseline report is the first report released as part of the Journey to Social Inclusion Mark II (J2SI Mark II) research study. The research study is led by the Centre for Social Impact University of Western Australia (CSI UWA) in partnership with Swinburne University of Technology. The present report provides a detailed profile of study participants, all of whom are adults (aged 25-50 years) living in Melbourne who are currently homeless or at immediate risk of homelessness and have experienced chronic homelessness in their lives (see sections 2 and 3 for definitions of homelessness used and the detailed eligibility criteria for the study). The report summarises the socio-demographic profile of study participants along with their histories and current experience of homelessness and housing; their labour force status; mental and physical health outcomes; their use of, and dependence on, alcohol and other drugs; quality of life and wellbeing outcomes; contact with the health and justice systems; and their social supports and connections.

The J2SI Mark II impact evaluation is a three-year, mixed methods, multi-site randomised controlled trial (RCT). The J2SI Mark II Baseline Survey, on which the report is based, was administered to research study participants prior to randomisation.

Following completion of the J2SI Mark II Baseline Survey, study participants were randomised to an intervention group (the 'J' group; i.e., those who were enrolled in the J2SI Mark II program), and a comparison group (the 'E' group; i.e., those who do not receive J2SI Mark II support but remain eligible to receive existing standard service provision). As measurement of participant outcomes in this report occurred prior to the start of the J2SI Mark II program, the findings are not influenced by whether participants were randomised to the J2SI Mark II program or the comparison group.

The study excluded individuals who were already receiving intensive long-term support from another homelessness program. However, participants in the study were typically receiving some level of support from specialist homelessness services at the time of enrolment, whether in the form of outreach and day centre support or crisis or transitional accommodation. The J2SI Mark II evaluation utilises a broad range of data including longitudinal survey data, qualitative interview and focus group data, and linked administrative data from Victorian and Australian government agencies across a range of domains (i.e., health, housing, justice, labour force and income support) to develop a rich profile of study participants and the pathways they follow over time.

The objectives of the J2SI Mark II research study are to:

- Describe histories, needs, circumstances and pathways of those experiencing chronic homelessness in Melbourne;
- Assess the impact of the J2SI Mark II program implemented by SHM compared to that derived from existing standard service provision in the following domains: education, employment and income; social inclusion; mental health; physical health; housing; and, service usage;
- Examine the cost of the J2SI program compared with existing service provision and assess the overall cost-effectiveness of the J2SI Mark II program (accounting for differential cost offsets); and,
- Provide a framework for scaling up the J2SI intervention pending positive evaluation findings.

2. Homelessness

The Chamberlain and MacKenzie (1992, 2003, and 2008) cultural definition of homelessness is used by the J2SI Mark II program to assess eligibility of a prospective respondent for the program. Homelessness is defined as a state in which individuals do not have access to the minimum accommodation standards that Australians believe all have the right to expect. The cultural definition of Chamberlain and MacKenzie encompasses three components: (1) primary homelessness (i.e., sleeping rough in public places, cars, derelict buildings or improvised dwellings); (2) secondary homelessness (i.e., emergency and transitional supported accommodation, refuges, caravan parks or 'couch surfing' with family and friends because no own accommodation); and, (3) tertiary homelessness (i.e., boarding houses and hostels with shared kitchen and bathroom facilities and no right of tenure). The J2SI Mark II program is specifically targeted toward those who have experienced 'chronic homelessness', defined as either rough sleeping (i.e., primary homelessness) for 12 months continuously at some point in the past and/or at least three episodes of any form of homelessness (i.e., primary, secondary and/or tertiary homelessness) in the last three years.

Homelessness is an issue of deep personal and community concern. It is often the result of complex, interrelated personal, social, health, and economic factors. There is a considerable body of evidence that the prevalence of physical health conditions, particularly infectious diseases, and mental health issues and impacts are higher among those experiencing homelessness than the general population and that multi-morbidity across substance use disorders and other mental health disorders is prominent (Drake, Osher, & Wallach, 1991; Bassuk et al., 1998; Teesson et al., 2000; Fichter & Quadflieg, 2001; Goering et al., 2002; Teeson et al., 2003; Glasser & Zywiak, 2003; Fazel et al., 2008; Baggett et al., 2013; Madianos et al., 2013; Vila-Rodriguez et al., 2013; Palepu et al., 2013; Baggett et al., 2014; Fazel et al., 2014; Spicer et al., 2015). People experiencing homelessness are over-represented in a range of health services, such as emergency department presentations, and hospital and psychiatric care (Salit et al., 1998; Kushel et al., 2002; Culhane et al., 2002; Corporation for Supportive Housing, 2004; Kim et al., 2006; Perlman & Parvensky, 2006; Social Policy Research Centre, 2007; Flatau et al., 2008; Hwang et al., 2011; Flatau et al., 2012; Chartier et al., 2012; Zaretzky et al., 2013; Zaretzky & Flatau 2013; Conroy et al., 2014, Fazel et al., 2014; Cheung et al., 2015; Fuehrlein et al., 2015; Wood et al. 2016; Parsell, Petersen, & Culhane, 2016). They are also overrepresented in the criminal justice system, with homelessness and mental health drivers playing a significant role in this overrepresentation (Gelberg, Linn, & Leake, 1988; Greenberg & Rosenheck, 2008). In many cases, but not all, histories of intergenerational homelessness, violence and neglect in the family home and early onset of homelessness are evident among adults experiencing homelessness (Flatau et al., 2013).

3. The J2SI model

SHM has worked with some of the most vulnerable and disadvantaged members of the Melbourne community since 1982, particularly those experiencing homelessness (Sacred Heart Mission, 2014). SHM offers multiple services that aim to address the underlying causes of persistent disadvantage and help to break the cycle of homelessness. In 2006, SHM conducted a survey of service users and found that over half of their clients had been homeless for more than two years and two-thirds had been excluded from mainstream services and participation in social activities (Grigg & James-Nevell, n.d.). These findings triggered SHM to explore alternative approaches to ending long-term homelessness and to develop new ways to reconnect people with the 'mainstream' community. From this, SHM developed a new service model called Journey to Social Inclusion (J2SI).

J2SI is a SHM initiative aimed at ending the cycle of homelessness by taking a relationship-based, trauma-informed and strengths-based approach in the context of long-term assertive case management. J2SI focuses on capacity building and skills-based support to assist clients to maintain tenancies, gain training and employment, and establish stronger social connections as well as independence.

The J2SI service model differs markedly from standard approaches supporting those experiencing homelessness in its low client-staff ratio (6:1) and dedicated three-year intervention. The J2SI model draws on local and international research, which has shown that individuals experiencing chronic homelessness benefit from individually tailored, ongoing, intensive support (Johnson & Tseng, 2010). The J2SI model takes a system-based approach through its emphasis on partnerships with housing providers and partnerships with relevant agencies relating to the health, drug and alcohol and social needs of its clients. The J2SI program was piloted from 2009-2012 and supported 40 individuals from SHM in Melbourne's St Kilda suburb over the three-year period. St Kilda is an inner city seaside suburb of Melbourne. In its early years, St Kilda was home to Melbourne's affluent but subsequently developed an entertainment precinct and became known for low-cost housing, hostels and rooming houses and homelessness. The pilot evaluation found that 75% of participants were able to maintain stable housing 4 years after enrolment (evaluation continued for one year after the end of the intervention). 80% of participants self-reported reduced health services utilisation (e.g., fewer emergency department or psychiatric unit admissions; Johnson et al., 2014).

Based on findings and lessons learned from the J2SI pilot program, the J2SI model was refined with a view to scaling up the model and making it more cost-effective. (i.e., J2SI Mark II). The refined program is the subject of the present research study and this baseline report. The J2SI Mark II program includes an expanded number of intervention participants (from 40 to 60 in each group) and a wider geographical catchment than the pilot (expanding from St Kilda to other areas of Melbourne) based on a partnership model with two other specialist homelessness services, VincentCare (Ozanam Community Care) and St Mary's House of Welcome. J2SI Mark II also draws on findings from an extensive study commissioned by SHM, MIND Australia, Inner South Community Health and VincentCare Victoria and undertaken by the Australian Centre for Posttraumatic Mental Health (ACPMH) and the University of Melbourne on the relationship between trauma and homelessness (O'Donnell et al., 2014). J2SI Mark II adopted a higher client-staff ratio (6:1) than the pilot (4:1) to test whether desired outcomes of the program could still be achieved using a more cost-effective staffing profile.

Participation in the J2SI Mark II program is restricted to those who voluntarily wish to be in the research study and meet the following criteria:

- They are currently experiencing primary, secondary or tertiary homeless or they are housed but have been housed for six months or less and are at direct risk of homelessness due to having received a notice to vacate or a breach notice without a secure housing option available;
- They have experienced chronic homelessness in their lifetime; and,
- They are aged 25-50 years, are permanent residents, have entitlement to Centrelink income support payments and are not currently engaged in a long-term, homelessness intensive support program.

The following groups were explicitly deemed ineligible for the research study:

- People not fluent in English who would require an interpreter service (budget constraints preclude interpreter service support);
- People experiencing unmanaged mental illness of a severe nature such that it precludes them from being able to provide informed consent and complete a survey even with a guardian present;
- People who for any reason are unable to a) give informed consent, or b) participate fully in the intervention or study even with guardian present;
- People deemed by agency staff to pose an identifiable safety risk to agency staff, researchers, other people or the participant themselves.

4. Research methodology

The mixed methods research design adopted in the J2SI Mark II research study includes the collection of longitudinal survey data from study participants (intervention and comparison groups), qualitative interviews with a random sample of study participants, and semi-structured interviews with service providers.

The J2SI Mark II research study also includes a linked administrative data component in which administrative data on the health, justice, housing and homelessness trajectories of study participants will be linked (with the consent of respondents) to outcomes of the treatment to build the evidence based on impacts experienced in other sectors and the potential cost savings of the intervention and control groups over time. Costings of J2SI Mark II service support levels will be developed and used in conjunction with participant survey data and linked administrative data to complete an economic evaluation of the J2SI Mark II model.

This report summarises findings from the baseline survey which was administered to all respondents by interviewers prior to randomisation (i.e., at baseline). Follow-up surveys will be undertaken with the intervention and comparison groups every six months for the next three years (seven time-points in total). The survey instrument was developed specifically for this study, but where possible, used existing validated tools to capture data on housing status and related mediators, moderators, and outcomes (physical and mental health status, quality of life, substance use, and contact with services). In this report, the 'J group' refers to participants currently engaged in the J2SI program (intervention), and the 'E group' refers to participants accessing existing services (comparison).

The baseline survey instrument elicits self-report data in the following areas:

- **Homelessness and housing:** Homelessness and housing history; affordability; mobility/stability/continuity; location; quality, security and privacy;
- **Education, employment and income:** Participation in education, current labour force status, characteristics of current jobs, employment history, and income (including both labour and non-labour income);
- **Physical health:** General health, chronic diseases, and access to treatment/services;
- **Mental health:** Depression, anxiety and stress (DASS-21); psychological distress (K10); wellbeing (S-WEMWBS); diagnosed mental health conditions; engagement with mental health professions and treatment; hospitalisation; other mental health issues; resilience/empowerment; and self-esteem (SISES);
- **Alcohol and drug use and dependence:** Alcohol, smoking and substance use (ASSIST), harm and drug use and access and use of relevant services;
- **Trauma:** Stressful life events (BTQ) and traumatic stress symptoms (PCL-C);
- **Service usage:** Health services; homeless services; housing services; and contact with justice system, welfare systems, employment services, and training services;
- **Social inclusion:** Relationships and support (ESSI), independent living skills, social participation (ISEL-12), and loneliness (the UCLA 3-item Loneliness Scale);
- **Quality of life:** Overall well-being, WHOQOL-BREF.

The J2SI Mark II research study received ethics approval on 8 December 2015 (RA/4/1/7904) from The University of Western Australia's Human Research Ethics Committee. Participants provided informed consent to be part of the research study and were provided with an information sheet that included an overview of the study, their potential time requirements and obligations, what will happen to the information they supply and their right to withdraw consent at any time.

5. Participant recruitment

In December 2015, those receiving or seeking a service at SHM and their partners, VincentCare and St Marys House of Welcome, were advised of the J2SI Mark II program, the eligibility criteria to participate in the program (see above), and the research study. Key referring workers (KRW) from each of the three partner agencies collaborating in the J2SI Mark II program assessed program eligibility of those interested in participating in the program.

Eligible participants were randomly assigned following the baseline survey to one of the two groups (J group

or E Group) using a simple shuffled envelope system in which the randomisation outcome is listed in the envelope and neither the interviewer nor the interviewee are aware of the outcome listed. SHM advised the research group that use of computer generated allocation in the pilot study generated a level of concern on the part of the participants as to whether allocation was in some way 'rigged' to achieve a particular outcome. They indicated a strong preference that a non-computer-generated number approach be used in the randomisation process.

The initial recruitment target was 60 participants in the J group and 70 participants in the E group. The higher number of E participants was planned to account for the expected higher level of attrition anticipated in this group and to allow for better matching with the treatment group at the analysis point, if required.

6. Data Collection

Data collection for the J2SI Mark II baseline survey commenced on 7 January 2016 and ended on 30 September 2016. Study participants who were randomised to the J group following the completion of the baseline survey were directed to the SHM J2SI Mark II service team. As a result of reviewing the status of J group participants, the SHM J2SI Mark II service team determined that six participants had mistakenly been deemed eligible for support because they were in receipt of a significant support program already or had been residing in public housing for an extended period that exceeded those outlined in the eligibility criteria. Those respondents were removed from the J2SI Mark II program and their baseline survey results have been excluded from this report, as they were not actually eligible for the research study. The J2SI Mark II service team have advised the research team that eight J respondents are no longer receiving support because they have moved outside the geographic scope of the program. Data from these eight respondents have been maintained in the baseline survey results.

Not all participants randomised to the J group engaged with the program. Twelve J group respondents were deemed 'inactive' by the SHM J2SI Mark II service team because, during three continuous months, assertive attempts to contact and engage with the J2SI participant failed. This included not being able to locate or contact the participant after the baseline assessment or having the participant miss agreed appointments, not respond to regular messages, or disengage with the program. In addition, participants were deemed inactive by the SHM service providers if they consistently communicated over the three-month period in question that they did not want to participate any longer with the J2SI service. None of this group indicated that they wanted to withdraw from the research study. This group of survey respondents remain in the research study and are included in the analyses reported here.

As a result of attrition in the J2SI Mark II program, a second round of recruitment was undertaken through to 30 September 2016. The final baseline dataset includes 179 randomised participants: 84 in the J group and 95 in the E group. Of the 84 randomised to the J group, 64 were active participants in the J2SI Mark II program as of 30 September 2016. Of the remaining participants in the J group, 12 were 'inactive' and 8 had left the Melbourne area, thereby precluding support from the SHM team. It is important to note all 12 'inactive' participants remain in the research study, as do those who left the geographic scope of the program. One participant from the E group formally withdrew from the research study and their survey responses have not been included in this report. Figure 1 details enrolment in the study and the breakdown of research study participants.

We examined whether there were any significant differences between the E and J groups. Table 1 presents outcomes for the two groups for selected indicators. There were no significant differences between the E and J groups other than a smaller proportion of participants in the E group who experienced homelessness prior to the age of 18. The J group participants deemed inactive by the J2SI Mark II program administrators differed from the active J group in terms of a significantly lower level of attained education.

We note that a relatively high number of J group participants were deemed inactive (n=12, 14.3%) or moved outside the geographic scope of the program

(n=8, 9.5%). Inactive participants impose relatively high costs in program administration, as they utilise program resources via contact attempts and record keeping. There were substantial replacement costs associated with recruitment of additional participants. Factors that potentially drive inactivity are not apparent, since, apart from lower educational attainment, there were no differences between the inactive and active J group members in terms of demographic characteristics.

The following sections offer a detailed description of participants at baseline in the combined J and E groups (only excluding those found to be ineligible and the one E group respondent who elected to withdraw from the study), including their socio-demographic profile, family history of violence and abuse, problems experienced over their lifetime, contact with the health and justice systems, housing history, physical and mental health status, use of alcohol and other drugs, employment status and income sources, social support and connections, quality of life, and expectations about their life outcomes in the future. Where appropriate, a comparison with the J2SI pilot study population and other comparable homelessness populations are made. In addition, statistically significant differences between J and E groups are reported.

Figure 1: Enrolment in the J2SI Mark II Research Study

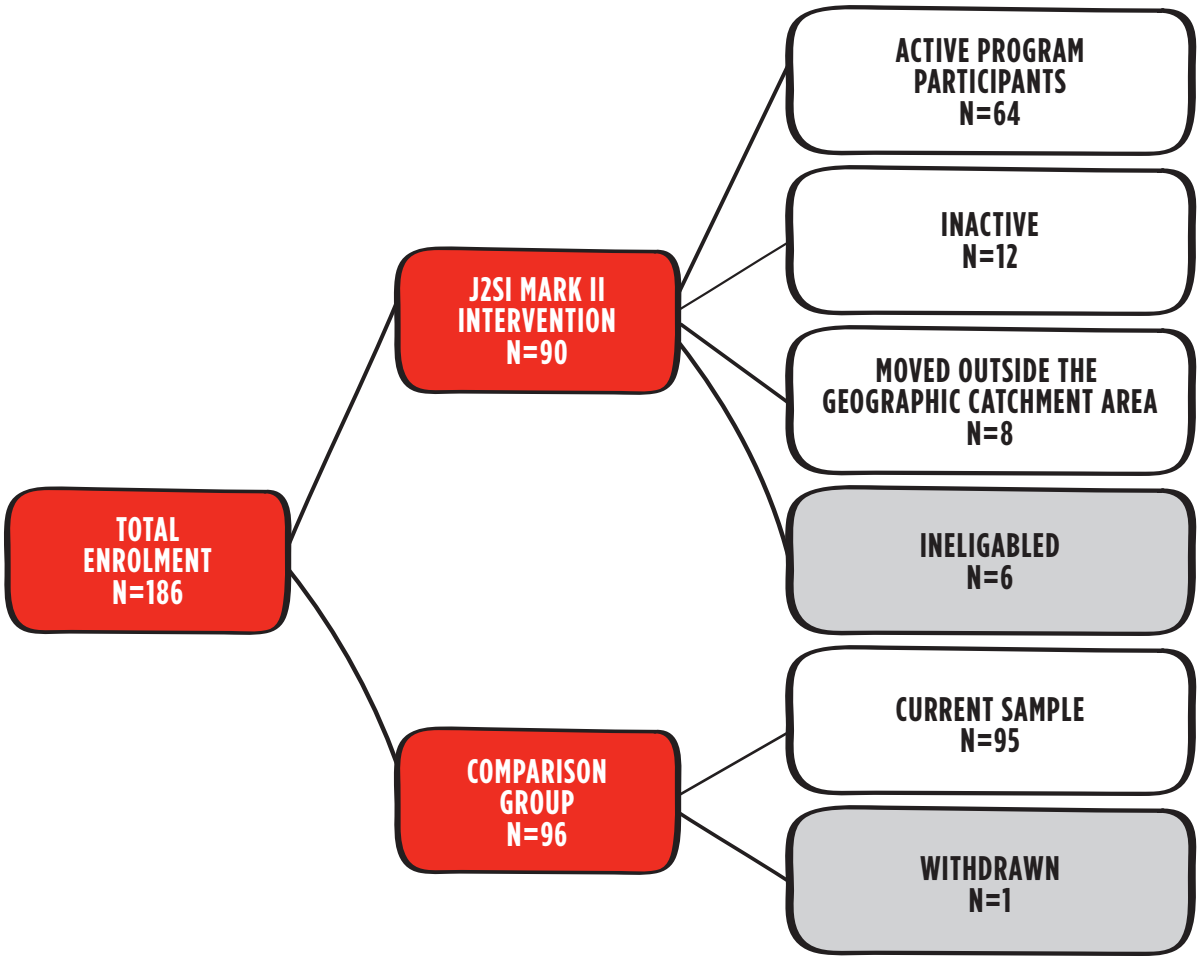


Table 1: Housing and Homelessness History of Participants

Selected characteristics	J group				E group total (n=95)	Full baseline sample (n=179)
	Active in program (n=64)	Inactive (n=12)	Not in geographic catchment (n=8)	J group total (n=84)		
Female (%)	29.7	25.0	12.5	27.4	33.7	30.7
Mean age (years)	39.8	41.6	41.4	40.1	38.7	40.2
Highest level completed education ≥ year 12 (%)	39.1	16.6*	37.5	35.8	30.5	33.0
Aboriginal and Torres Strait Islander (%)	9.4	8.3	0.0	8.9	15.8	12.9
Ever slept rough (%)	93.8	100	100	95.2	96.8	96.1
Experienced homelessness <18 years (%)	78.1	66.7	87.5	77.4	63.2*	69.8
Employed (%)	3.1	8.3	0.0	3.6	5.3	4.5
Reported a chronic physical or mental health condition (%)	93.8	83.3	100	92.9	89.5	91.1
Mean K10 score	31.4	30.4	27.6	31.2	29.2	30.8

*Note: Sample size (n) in brackets. Active in the program refers to J group participants who were active in the program as of 30 September 2016. Inactive refers to J group participants deemed inactive by program administrators as of 30 September 2016. Not in geographic catchment refers to J group participants who have moved interstate since the completion of baseline interview. The proportion of respondents with chronic physical and mental health conditions was calculated based on those respondents who indicated having been diagnosed with at least one chronic physical health condition (e.g., heart disease or other cardiovascular disease, stroke, osteoarthritis/rheumatoid arthritis/osteoporosis, hepatitis C, and/or HIV/AIDS) or had been diagnosed with a mental health condition. *Significant at p<0.05 (compared to J group total).*
Source: J2SI Mark II Baseline Survey

7. Socio-demographic profile of J2SI Mark II participants

About one-third of J2SI Mark II participants were female (30.7%)[1]; which is a smaller proportion than both the J2SI pilot study (49.0%; Johnson, Parkinson, Tseng, & Kuehnle, 2011) and the proportion of females in the general homeless population in Australia (43.5%; Australian Bureau of Statistics, 2012). This lower proportion of females is reflective of the high number of rough sleepers among the J2SI Mark II respondents (men are overrepresented among rough sleepers) compared to Australia's homeless population. In Australia, women comprise 32.4% of those experiencing primary homelessness, but 40.8% and 49.2% of secondary and tertiary homelessness, respectively (for example, in refuges for women escaping domestic violence; Australian Bureau of Statistics, 2012). The mean age of J2SI Mark II respondents was 39.4 years (standard deviation [SD] 6.5; J2SI pilot: 36.5 years; Johnson et al., 2011), with males being slightly older (40.0 years) on average than females (37.8 years). More than a half of all respondents (51.4%) were han 35 years (only 6.7% younger than 30). The proportion of males older than 40 years (55.7%) was higher than females (40.0%) by 15%.

A small proportion of J2SI Mark II respondents (13.0%) identified as of Aboriginal or Torres Islander (ATSI) origin, with similar representation among males (12.0%) and females (15.0%). While this is a much lower proportion than the 25% of people experiencing homelessness in Australia in 2011 who identified as Aboriginal or Torres Strait Islander (Australian Bureau of Statistics, 2012), this is due principally to the J2SI Mark II study being conducted in Victoria, which has a smaller Indigenous population compared with other states.

1. One respondent identified as inter-gender and one respondent identified as transgender. These respondents are not included in the analyses that report descriptive statistics split by sex.

One percent of Victorian residents identify as Aboriginal or Torres Strait Islander, compared to 3.0% in Australia (Australian Bureau of Statistics, 2016a). In terms of the highest level of education obtained, the majority of J2SI Mark II respondents attended secondary school, but did not complete year 12 (60.3%). About a quarter of all respondents completed either secondary school (12.3%) or TAFE qualifications, a trade certificate, an apprenticeship or a similar qualification (15.1%). A small proportion only completed primary school (5.0%).

The majority (82.1%) of J2SI Mark II respondents were single at baseline, which is similar to the proportion in the J2SI pilot (81.0%; Johnson et al., 2011); a small proportion (6.7%) reported living with a partner. Sixty percent reported having children. Specifically 55.3% had children they have given birth to or fathered,13.5% reported having adoptive children or stepchildren (i.e., children they considered their own, but did not give birth to or father), and 1.2% reported having children they care for or are a guardian of. In the J2SI Mark II sample, nearly half (44.7%) of respondents had children under 18 years of age (J2SI pilot: 42.0%; Johnson et al., 2011) and a quarter (25.1%) had children aged 18 or over. Of those who had children, on average, respondents had two children under 18 years of age (median=2, maximum=13) and 2.5 children over 18 (median=2, maximum=6).

8. Homelessness and housing

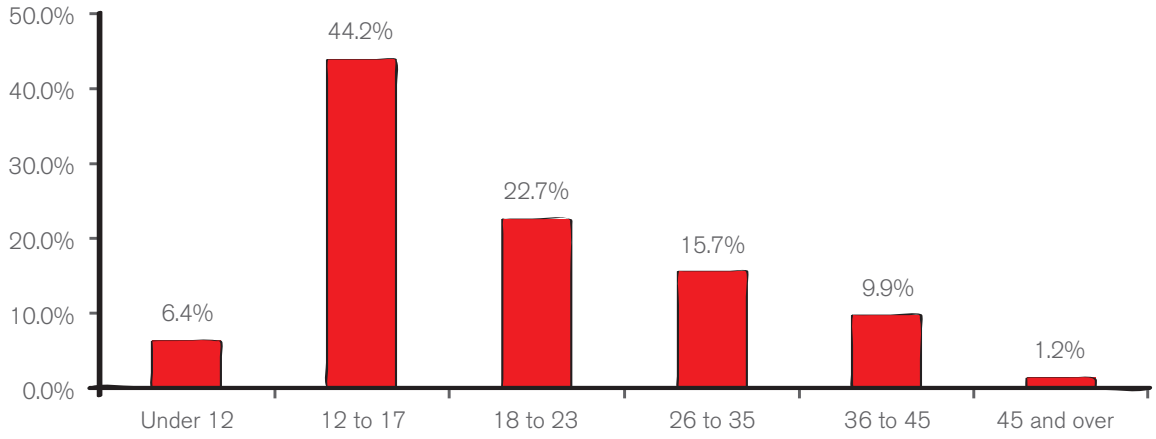
Table 2 summarises the main types of homelessness and housing experiences of J2SI Mark II respondents. Recall that program eligibility requires current homelessness or risk of homelessness and a history of chronic homelessness. Nearly all respondents reported experiencing sleeping rough at some point in their lifetime (96.1%). On average, those who reported ever sleeping rough had spent 12.5% of their lifetime in such circumstances. Considering the mean age of respondents was 40 years, this equated to an average of 5.0 years sleeping rough (per person). The majority of those who experienced sleeping rough also indicated that it occurred four or more times in their lifetime (89.5%). The mean age of the first occurrence of rough sleeping was 21 years with the youngest occurrence at age 5 and the oldest at age 48 (see Figure 2). Half (50.6%) of J2SI Mark II respondents first experienced rough sleeping before the age of 18, which is a higher proportion than findings from the Flatau et al.'s (2013) study of intergenerational homelessness and early onset homelessness among adults receiving support from homelessness services (36.9%).
Other types of homelessness were slightly less prevalent than rough sleeping in the J2SI Mark II study

Table 2: Housing and homelessness history

		Of those who experienced the specified housing circumstance		
Type of housing circumstance	**Ever experienced (%)**	**Relative duration in lifetime (%)[1]**	**Mean age of first occurrence**	**Frequent occurrence of housing type(%)[2]**
Rough sleeping (sleeping on the streets, parks, cars etc.)	96.1	12.5	21.3	89.5
Couch surfing (temporarily staying with family and friends)	74.3	14.5	20.3	41.7
Crisis/emergency and transitional accommodation (supported housing for those experiencing homelessness)	54.2	11.5	25.6	19.6
Temporary accommodation (caravans, boarding/lodging house, or hostels)	86.6	10.2	24.8	83.2
Institutional or residential facilities (jail, alcohol & drug rehabilitation, mental health facilities)	88.3	5.2	25.4	65.2
Public or community housing (government and not-for-profit housing for low income people)	89.9	6.8	27.4	73.3
Private rental accommodation	81.0	7.9	23.5	55.9
Own home	12.8	19.4	27.3	4.3

(1) Relative duration in a lifetime was calculated as a proportion of respondent's life spent in a specific housing situation. For example, 10% of a lifetime for a person aged 30 would be 3 years.
(2) Percentage of respondents who reported experiencing a specific housing situation more than 4 times in their lifetime. Source: J2SI Mark II Baseline Survey

Figure 2: Age first experienced sleeping rough



Source: J2SI Mark II Baseline Survey

sample, with 86.6% reporting that they had ever lived in temporary accommodation (e.g., a caravan, boarding/ lodging house, hostel). Of those that did, the majority (83.2%) reported having frequent experiences of this in their lifetime. Three quarters (74.3%) of respondents reported living with extended family or friends because they had nowhere else to live, with more than a third of respondents (41.7%) experiencing this situation four or more times in their lifetime. Half (54.2%) of all respondents reported living in a short- or medium-term homelessness accommodation at some point in their life. Short-term homelessness accommodation refers to crisis and emergency accommodation lasting between one night and three months, while medium-term accommodation is often transitional accommodation lasting between three and nine months. Comparing different baseline groups, respondents from the J group had a significantly longer lifetime duration of living with extended family or friends (17.3% of lifetime) compared to E group (12.2% of lifetime, $p<.05$), as well as a higher rate of occurrence of this housing situation (J group: 2.38 times; E group: 2.01 times, $p<.01$). This was the only category of housing in which differences were observed between the E and J groups.
Almost half (44.1%) of the J2SI Mark II study sample reported being evicted from some form of housing in their lifetime. The majority (36.5%) of evictions were from private rentals, followed by public (20.0%) and community housing (14.8%). Public housing refers to government owned and managed housing, while community housing is housing managed by not-for-profit housing organisations (e.g., housing associations, co-operatives and church-owned organisations) providing rental housing for low-income people.

When asked to indicate the type of dwelling they have been staying in for the past week and last night, none of the J2SI Mark II respondents reported residing in a private rental accommodation or their own home (Figure 3). About a third (30.2%) of respondents were sleeping rough in the week prior to the baseline survey, with a higher proportion of males doing so in the past week (32.8%) and on the previous night (28.7%), when compared to females (23.6% and 14.5%, respectively). Another third (31.3%) of respondents reported staying in short- to medium-term homeless accommodation in the last week. Females were more likely to be staying in this type of accommodation (last week 36.4%, last night 38.2%) than males (last week 29.5%, last night 30.3%).

Comparing the housing situation last week with the night prior to baseline survey, 12.3% of respondents reported differences; 12 respondents had moved

from sleeping rough in the last week to staying with family or friends or temporary accommodation in the night prior to the survey. Five respondents had moved between different types of short-term accommodation and staying with family or friends. Four respondents spent last night sleeping rough, although they reported staying in some type of accommodation in the last week. Finally, 20.1% of respondents said they were living in their present situation for more than one but less than four weeks, 35.2% for more than four weeks but less than six months, and 35.2% for more than six months.

In the J2SI pilot, housing status (last night) was reported in three broad categories: *housed* (i.e., living in public housing), *homeless* (i.e., residing in a community rooming house, hotel or boarding house, transitional/ medium-term accommodation, crisis accommodation, temporarily staying with family or friends, or sleeping rough), and *marginal* (i.e., living in prison or other institutional setting; Johnson et al., 2011). Using these categories, 90.5% of J2SI Mark II respondents at baseline were experiencing homelessness (J2SI pilot at baseline: 89.3%), 1.7% were marginally housed (J2SI pilot: 4.0%), and the remaining 7.8% were housed (J2SI pilot: 6.7%).

Figure 3: Type of dwelling last week and last night by gender

Source: J2SI Mark II Baseline Survey

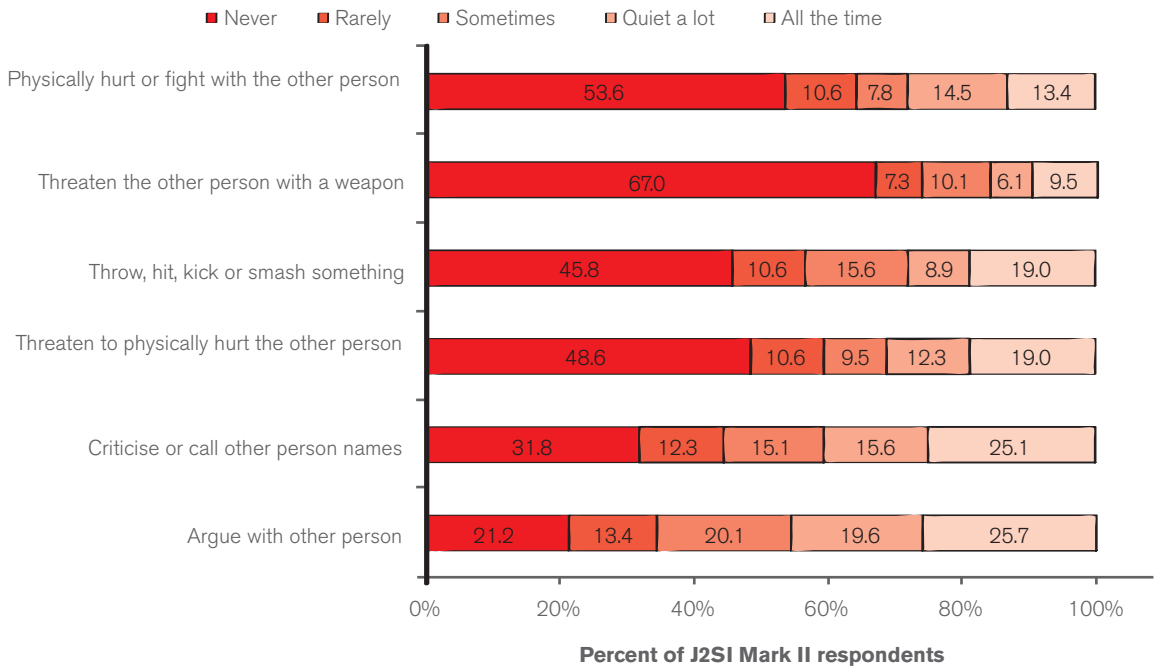
The overwhelming majority of J2SI Mark II respondents (97.0%[2]) indicated that they were not satisfied with aspects of their current housing situation. In particular, a large proportion of respondents indicated that they were not satisfied with the distance from public transport (88.1%), access to services normally used (82.2%), and the location of current housing (80.7%). Other common areas of dissatisfaction with the current housing included affordability (67.4%), physical comfort (e.g., light and temperature; 57.8%), and feeling of safety and security (57.0%). A significantly smaller proportion of respondents from the J group indicated that their current housing did not adequately satisfy their housing needs (30.0%) compared to the E group (46.0%, $p<.05$).

9. Family history and inter-parental conflict

Parental and caregiver conflict in the family home is a significant risk factor of homelessness (Mallett, Rosenthal, & Keys, 2005). Inter-parental conflict refers to all forms of verbal and physical aggression between caregivers (i.e., biological or stepparents, guardians). Half of J2SI Mark II respondents witnessed some form of inter-parental conflict all the time (31.3%) or quite a lot of the time (19.0%) while growing up. Only 18.4% of respondents reported never witnessing violence or abuse between parents (Figure 4).

2. n=135, 75.4% of the overall sample.

Figure 4: Experiences of inter-parental conflict by frequency of occurrence



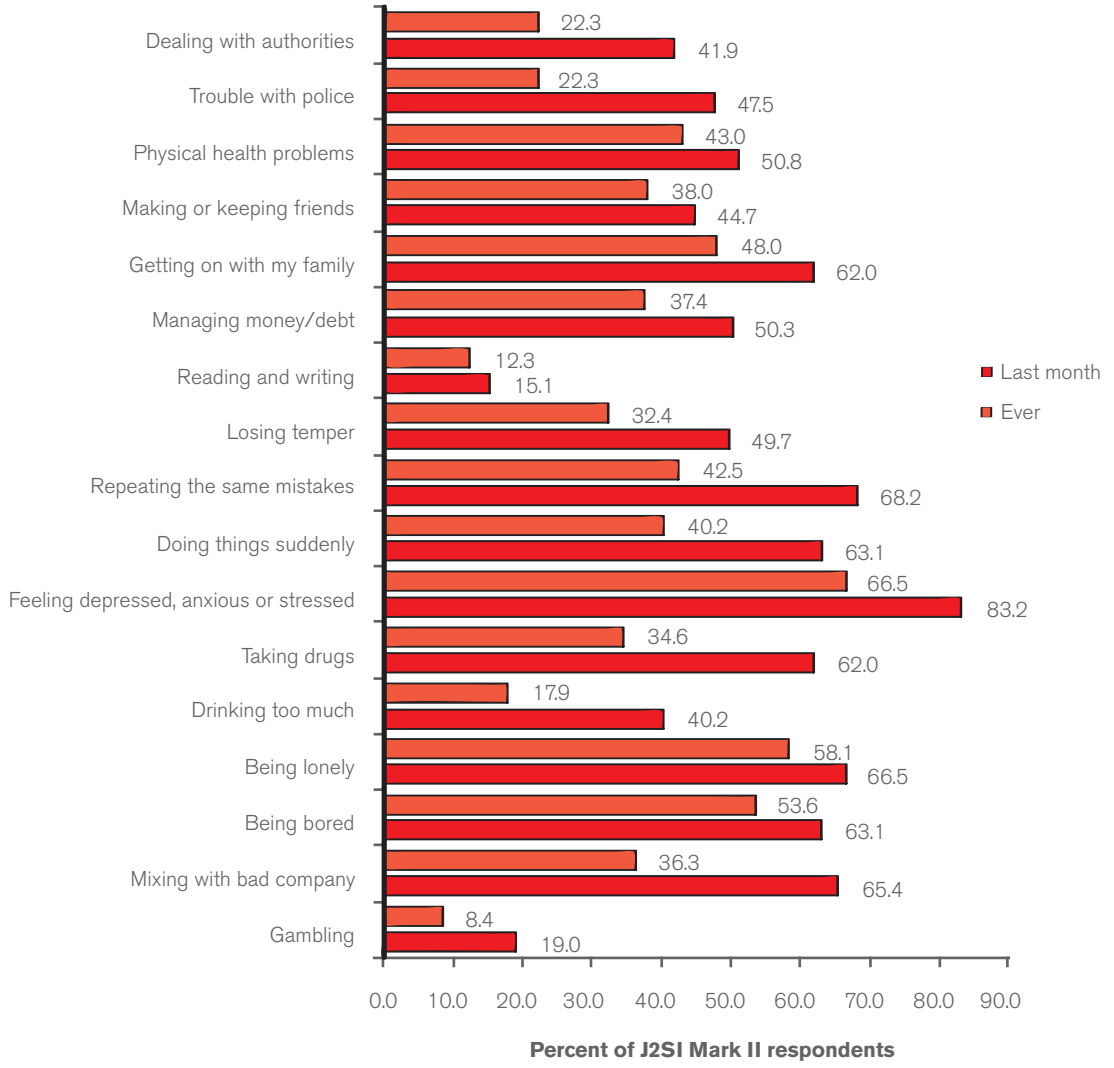
Source: J2SI Mark II Baseline Survey

Between 46-67% of respondents did not experience physical aggression between their parents. A study of intergenerational homelessness in Australia found similar results (40-60% did not experience physical aggression between parents; Flatau et al., 2013). Almost half (44.1%) of J2SI Mark II respondents indicated they left home (ran away) because of verbal and/or physical violence, a proportion similar to a previous Australian study (49.2%; Flatau et al., 2013). Twenty percent left home more than 10 times. However, all J2SI Mark II respondents who left home due to violence between parents were under 18 years of age when they first left, with over half (53.2%) being aged 10 years or under.

10. Lifetime and current problems experienced by respondents

J2SI Mark II respondents were asked about a series of problems people sometimes experience and to indicate if they had ever experienced such problems in their lifetime, rating their responses on a Likert scale (1 ' Not at all' to 4 'Serious problem'). For problems experienced in the lifetime, respondents were also asked to indicate if it had been a problem in the last month. Figure 5 depicts the proportion of respondents who indicated having experienced the nominated issues as either a moderate or serious problem.

Figure 3: Moderate or serious problem experienced by J2SI Mark II respondents in the lifetime and last month



Source: J2SI Mark II Baseline Survey

The majority of respondents reported experiencing a moderate or serious problem with psychological related issues, such as feeling depressed, anxious or stressed (83.2% ever, 66.5% last month), being lonely (66.5% ever, 58.1% last month), and repeating the same mistakes (68.2% ever, 42.5% last month). When the lifetime experience of psychological issues are compared with a previous study (Flatau et al., 2013); we find that approximately 20% more of the J2SI Mark II study population experienced psychological issues in their lifetime (previous study: depressed, anxious or stressed 64.2%; being lonely 53.9% and making the same mistakes 49.5%; Flatau et al., 2013).

A relatively small proportion of respondents reported having a moderate or serious problem with gambling (19.0% ever, 8.4% last month) or with reading and writing (15.1% ever, 12.3% last month). Lifetime experiences of these issues are similar to those

reported in a previous study (gambling 13.4%; reading and writing 17.6%; Flatau et al., 2013).

Comparing the J and E groups, a significantly larger proportion of respondents from the J group (76.2%) reported having a moderate to serious problem of mixing with bad company in their lifetime, than the E group respondents (55.8%, $p<.01$). On the other hand, a significantly larger proportion of E group participants (23.2%) reported having a moderate or serious problem of drinking too much in the last month, compared to the J group (11.9%, $p<.05$). There were no other statistically significant differences observed.

11. Physical and mental health

People who have experienced chronic, long-term homelessness are over-represented in a myriad of health statistics, including premature mortality, emergency department presentations, recurrent hospitalisation and psychiatric care (Fazel, Geddes, & Kushel, 2014; Moore, Gerdtz, & Manias, 2007), and lower use of preventive services (Folsom et al., 2005; Kushel, Perry, Clark, Moss, & Bangsberg, 2002). Factors shown elsewhere to contribute to this include the high prevalence of mental and chronic conditions (Sadowski, Kee, VanderWeele, & Buchanan, 2009), delays in help-seeking (Moore et al., 2007), cost and access barriers (White & Newman, 2015) and living environments not conducive to good health. Overall, many of the J2SI Mark II respondents indicated they had poor health, with a mean self-rated health score of 2.56 (out of 5), where 1 was 'poor' and 5 was 'excellent'. Half of respondents (49.2%) rated their physical health as poor (19.6%) or fair (29.6%), with only 5.6% of respondents rating their health as excellent. Similar trends were observed in a recent study of formerly homeless people in Western Australia (46.0% rated their health as poor or fair and 8.0% as excellent; Wood et al., 2016). A higher proportion of female respondents reported their overall health as poor (29.1%) compared to males (15.6%), with the overall mean rating of health being lower for females (2.29 out of 5), compared to males (2.68 out of 5).

Respondents were asked whether they had been diagnosed with any chronic physical or mental health conditions (e.g., high blood pressure, cardiovascular disease, asthma, cancer, diabetes, schizophrenia, or bipolar disorders). Most J2SI Mark II respondents (91.1%) reported having at least one diagnosed physical or mental health condition at baseline, which is comparable to the J2SI pilot study, where 93.0% reported having a chronic health condition at baseline (Johnson et al., 2011)[3]. The most prevalent conditions were depressive disorders (60.3%), substance-related abuse (56.4%), anxiety disorders (43.6%), hepatitis C (36.9%), chronic back or neck problems (38.0%), and post-traumatic stress (35.2%). Roughly the same proportion of males (91.0%) and females (92.7%) reported having a chronic health condition. More than three-quarters (74.3%) of respondents reported three or more chronic physical or mental health conditions at baseline, which is much higher than the 50.0% of respondents that reported having three or more chronic physical/mental health conditions reported at baseline in the J2SI pilot study. It is also a much higher proportion than a recent survey of people sleeping rough which found that 61.0% of respondents had a tri-morbid health condition (Melbourne Street to Home, 2010). A higher proportion of female respondents reported having three or more chronic health conditions (85.5%) than males (69.7%).

In addition, respondents were asked whether they had experienced a number of additional health complaints often associated with homelessness in the research literature. Almost three-quarters (70.4%) of respondents reported additional health complaints. The most prevalent were dental problems (62.0%); chronic or recurring pain (41.3%); other conditions that restrict physical activity or physical work (39.7%); shortness of breath or difficulty breathing (39.1%); sight problems not corrected by glasses or contact lenses (34.1%); and blackouts, fits or loss of consciousness (32.4%). A much higher proportion of females (80.0%) had reported other health complaints, compared to males (66.4%).

The J2SI Mark II baseline survey included several measures of mental wellbeing, including the Kessler

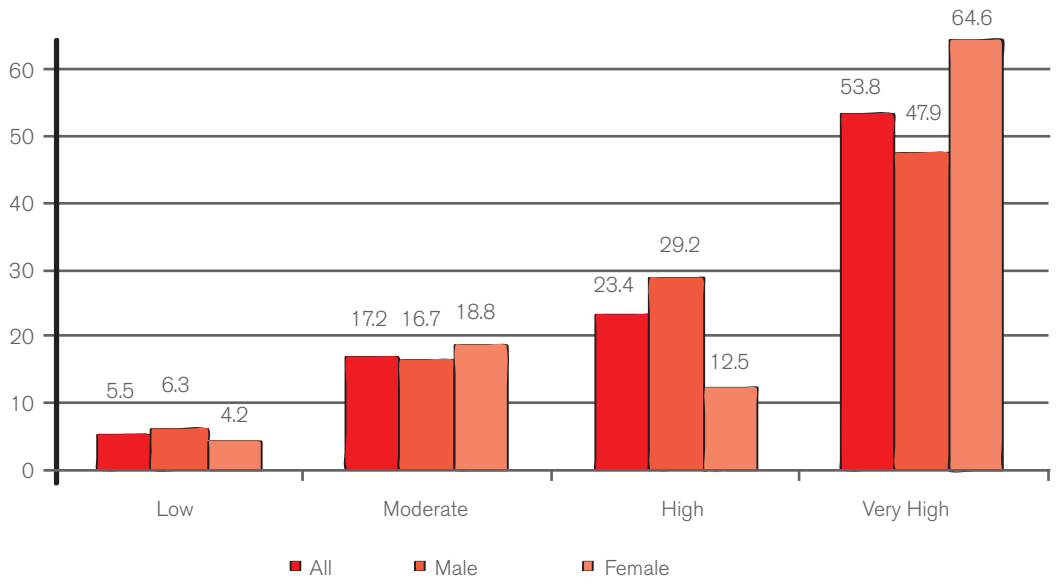
3. Our study queried a longer list of chronic physical and health conditions than the pilot study, which may account for differences.

Measure of Psychological Distress (K10) and the Depression Anxiety Stress Scales (DASS). K10 is widely used measure of psychological distress (Kessler et al., 2002). The interpretation of K10 scores reported here are based on Andrews and Slade's (2001) methodology validated in the Australian context. Three quarters (77.2%) of J2SI Mark II respondents were found to be experiencing high (23.4%) or very high (53.8%) levels of psychological distress, which is dramatically higher than the 11.7% of the general adult Australian public that reported such feelings (Australian Bureau of Statistics, 2015). Whilst other studies have also found psychological distress among people experiencing homelessness to be much greater than the general Australian population (44.8%, Wood et al., 2016; 46.2%, Flatau et al., 2012), the present study population reports extreme levels of high or very high distress. A larger proportion of females reported experiencing very high levels of psychological distress (64.6%) compared to males (47.9%; see Figure 6).

The DASS instrument provides an indication of general psychological distress (GPD) and includes three sub-scales to measure the negative emotional states of depression, anxiety, and stress (Crawford et al., 2011; Lovibond & Lovibond, 1995).[4] The GPD mean score for the J2SI Mark II respondents at baseline was 52.2 (SD 31.9), similar to that reported by J2SI pilot participants at baseline (mean of 54.5; Johnson et al., 2011) but considerably higher than in the general Australian population (mean of 16.5, SD 19.2; Crawford et al., 2011). Similar results were found for each sub-scale. For depression, the J2SI Mark II respondents scored in the moderate range (mean 18.8, SD 12.3), similar to the J2SI pilot (moderate range, mean 19.1, SD 12.6), and higher than the general population (normal range, mean 5.02, SD 7.54). For anxiety, the J2SI Mark II respondents scored in the moderate range (mean 14.2, SD 10.4), slightly lower than the J2SI pilot (severe range, mean 15.2, SD 13.8), but higher than the general population (normal range, mean 3.36, SD 5.07). For stress, the J2SI Mark II respondents scored in the moderate range (mean 19.3, SD 11.5), similar to the J2SI pilot (moderate range, mean 20.2, SD 13.1),

4. In the survey the short form (DASS21 which has 21 questions) was administered and scores were converted to full DASS scores according to formulas provided in the DASS manual (Lovibond & Lovibond, 1995).

Figure 6: Level of psychological distress by gender



Source: J2SI Mark II Baseline Survey

and higher than the general population (normal range, mean 8.10, SD 8.40). Female J2SI Mark II respondents reported higher mean scores on all DASS sub-scales: depression (22.2; males: 17.2), anxiety (18.7, males: 12.0), and stress (23.9, males: 17.2). Unsurprisingly, the mean GPD for females (64.8) was much higher than for males (46.3).

The J2SI Mark II baseline survey included the abbreviated PTSD Checklist-Civilian version (Short PCL-C) scale that was initially developed for assessing symptoms of post-traumatic stress in primary care (Lang et al., 2012). The mean summative score of the short PCL-C in the study population was 17.6 (out of maximum possible 30, SD 6.9) at baseline. An individual is considered to have screened positive for post-traumatic stress if the sum of the scale items is 14 or greater (Lang et al., 2012). Over two thirds (69.8%) of respondents had a sum score of 14 or greater, with a higher proportion of females scoring 14 or greater (80.0%) compared with males (64.8%). The mean sum score was therefore also higher for females (19.7, SD=7.0) than males (16.5, SD=6.7). The prevalence of post-traumatic stress was much higher in the study population, than the general Australian population, where approximately 12% of people will experience Post-Traumatic Stress Disorder (PTSD) in their lifetime, and 6% in any given 12-month period (Australian Bureau of Statistics, 2008).

Over half (55.9%) of J2SI Mark II respondents reported seeking assistance for dealing with traumatic experiences. Of those respondents, most sought assistance from a general practitioner (GP; 65.0%), a support or caseworker (58.0%), or a counsellor (55.0%). Of the respondents who sought assistance with traumatic experiences, the majority found it helpful (84.0%). Of those who did not find the assistance received helpful, some mentioned not caring enough about themselves or not being ready to receive assistance as the primary reason for not finding the assistance helpful.

12. Use of health services

The majority of J2SI Mark II respondents (91.6%) reported that they had contact with doctors, hospitals, or health workers in the past year, with a GP being the most frequently used health service (88.3% of respondents, see Table 4). Per patient report, the average number of visits to the GP among those who used that service in the last 12 months was 14.6 (SD=19.4). Other frequently used health services in the last 12 months included visiting a mental health professional (54.7%; average of 11.7 visits), an emergency department (50.3%; 3.1 visits on average), and dental services (44.1%; 2.9 visits on average). Over a third (40.2%) of respondents were admitted to hospital overnight in the last 12 months. Of those, the average number of nights in hospital was 13.8. Other overnight stays included a mental health facility (12.8% of respondents; average nights spent: 18.6) and alcohol and drugs detoxification or rehabilitation facility (9.5% of respondents; average nights spent: 79.3). Future reports will more closely examine the economic costs of health service use, using methodology developed in our previous studies (Wood et al., 2016). However, the level and frequency of health services use in the present study population is comparable to recent findings from a large Western Australian sample of people who had been homeless (Wood et al., 2016).

Table 3: Use of health services and frequency/duration in the last 12 months

Type of service		If used, number of visits/nights	
	Percent used	Mean number of visits	SD
General practitioner	88.3	14.6	19.4
Specialist doctor	76.0	4.4	6.3
Mental health professional	54.7	11.7	17.4
Nurse or allied health professional	41.9	10.0	15.8
Hospital admission (overnight)	40.2	13.8	27.3
Mental health facility (overnight)	12.8	18.6	27.9
Drug and alcohol detoxification or rehabilitation (overnight)	9.5	79.3	75.8
Emergency department	50.3	3.1	2.8
Outpatient	26.8	6.8	9.7
Ambulance	40.8	2.7	2.7
Dental services	44.1	2.9	2.7

Source: J2SI Mark II Baseline Survey

13. Use of alcohol and other drugs

The WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is used to detect and manage substance use and related problems (WHO ASSIST Working Group, 2002). The ASSIST instrument was included in the J2SI Mark II baseline survey to assess the frequency of use and risk scores associated with the use of certain substances. Almost all J2SI Mark II respondents (98.9%) reported using tobacco, alcohol, or other substances (e.g., cannabis, amphetamines) at some point in their lifetime, with the majority (93.9%) having used three or more substances (including tobacco and/or alcohol) in their lifetime (Table 4). The majority (95.5%) reported using at least one substance in the last 3 months, with 84.2% reporting use of substances other than tobacco and alcohol. Two-thirds (69.3%) of respondents reported using three or more substances (including tobacco and/or alcohol) in the last 3 months. The majority of both males (96.7%) and females (92.7%) had used at least one substance in the last three months.

In terms of frequency of usage, 87.0% reported using tobacco products daily or almost daily in the last three months. This is considerably larger than the 16.1% of the general Australian population who indicated that they smoke daily (Australian Bureau of Statistics, 2013). In contrast, only 18.2% reported daily or weekly consumption of alcoholic beverages. However, this is still triple the 6.9% of Australian adults who consumed alcohol daily in 2013 (AIHW, 2014). Over half (57.9%) reported using other substances daily or almost daily in the last 3 months. A higher proportion of males reported smoking daily or almost daily in the last 3 months (89.8%) compared to females (81.6%). Similarly, more males than females consumed alcoholic beverages daily or almost daily in the last 3 months (21.4% and 10.6%, respectively). However, a higher proportion of females reported using other substances daily or almost daily (65.3%) in the last 3 months compared with males (54.2%).

More than a half of all respondents (57.5%) had a high-risk level (ASSIST score of 27+ out of 31 for tobacco/39 for all other substances) associated with use of at least one substance (including alcohol or tobacco). A larger proportion of males (59.0%) had a high-risk level associated with the use of at least one substance than females (52.7%). When alcohol and tobacco were excluded, 41.2% of the respondents reported a high-risk level. The proportion of J2SI Mark II respondents in each risk level per substance is reported in Table 4.

Comparing J and E groups, mean ASSIST risk scores for alcoholic beverages were significantly higher in the E group (14.8) than the J group (10.89, $p<.05$). However, the ASSIST risk score for tobacco products was significantly higher in the J group (20.37) than the E group (17.89, $p<.05$). There were no other differences in substance use observed.

Table 4: Proportion of sample per ASSIST risk level by substance (percent)

	ASSIST risk level		
	Low	**Moderate**	**High**
Tobacco products	8.9	68.7	22.3
Alcoholic beverages	31.3	50.3	18.4
Cannabis	26.3	60.3	13.4
Cocaine	86.0	12.3	1.7
Amphetamines	40.8	37.4	21.8
Inhalants	88.3	11.7	0.0
Sedatives or sleeping pills	52.5	39.7	7.8
Hallucinogens	82.7	16.8	0.6
Opioids	45.3	30.7	24.0
Other[1]	99.5	4.5	0.0
All substances	4.5	38.0	57.5
All drugs (excluding tobacco and alcohol)	15.1	43.6	41.2
All drugs and alcohol (excluding tobacco)	7.3	41.9	50.8

Note: 1. Other substances were self-reported by the respondents. Examples include synthetic marijuana and DMT. Low risk: respondents scored 0-10 for alcohol or 0-3 for all other substances. Moderate risk: respondents scored 11-26 for alcohol or 4-26 for all other substances. High risk: respondents scored 27 and above.

Source: J2SI Mark II Baseline Survey

14. Labour force status and income

Table 5 reports the labour force status of respondents and the reasons for not being employed in the last week. A very small proportion (4.5%) of the J2SI Mark II respondents were employed in the last week (i.e., worked for payment or profit). Roughly the same proportion (4.0%) reported working in the J2SI pilot (Johnson et al., 2011). Almost a quarter (22.9%) of respondents were not employed, but reported that they were available to work and looking for work, thus meeting the definition of unemployment (J2SI pilot: 24.0%). Over half (57.0%) of J2SI Mark II respondents were unable to work due to a health condition or disability, with a larger proportion of females unable to work due to a health condition (67.9%) compared with males (53.3%). The unemployment rate in the sample (79.9%) far surpassed that of the general homeless population (21.3%) and general population (5.7%; Australian Bureau of Statistics, 2012, 2016b).

When asked to indicate when they had last worked for at least two weeks in a job of 35 hours or more per week, 43.6% of respondents reported more than five years ago; 20.1% reported between two and five years ago and 24.0% reported less than 2 years ago. A smaller proportion of respondents (12.3%) indicated that they never worked in a job of 35 hours or more per week.

Almost all J2SI Mark II respondents (97.8%) were receiving government benefits (J2SI pilot: 96.0%; Johnson et al., 2011). The majority of respondents were receiving a disability support pension (49.7%) or Newstart allowance (46.9%). Other sources of income among respondents included untaxed employment payments (e.g., cash in hand, 5.0%), busking or begging (3.9%), and support from family or friends (1.1%).

Table 5: Status of employment and reason for unemployment in the last week

	All (%)	Male (%)	Female (%)
Employed	4.5	4.1	3.6
Unemployed (not working, actively seeking work, and available to start work)	22.9	27.0	15.1
Not in the labour force			
Home duties (including caring for children, friends and/or family)	3.4	2.5	5.7
Student	0.6	0.8	0.0
Not currently engaged in work and not actively looking for work	11.2	11.5	11.32
Unable to work due to health condition or disability	57.0	53.3	67.9
Total not in labour force	72.6	68.9	81.3

Source: J2SI Mark II Baseline Survey

15. Social support

Although people who have experienced long-term homelessness should not be presumed to lack social networks, these may be of a more limited nature or may not include the types of bridging social capital ties that can support people to move out of disadvantaged

circumstances or cope with complex issues (Hawkins & Abrams, 2007; Irwin, LaGory, Ritchey, & Fitzpatrick, 2008). The scale of social support used in this study was developed by the J2SI pilot research team and derived from the Household, Income and Labour Dynamics in Australia (HILDA) survey, to measure the level and type of social support received from various sources outside of a person's relationship with support workers[5] (Johnson et al., 2014). The mean social support score for the J2SI Mark II respondents at baseline was 27.6 (of maximum 49; compared to J2SI pilot mean score of 29.8 at baseline). Females had a slightly lower mean score (26.2) compared with males (28.2). This finding indicates that J2SI Mark II respondents felt an average level of social support from existing social networks. However, when examining mainstream social networks, such as friends and family, survey results indicate that respondents experience issues in these relationships. For instance, 54.2 percent reported that their family never seems to understand their problems, 53.7 percent never receive as much help from family as they need, and 23.2 percent indicated that family always seem emotionally cold to them. Similarly, 40.8 percent reported that their friends never seem to understand their problems, 41.9 percent never receive required help from friends, and 12.3 percent perceived their friends to be emotionally cold to them.

Not surprisingly, J2SI Mark II respondents report high scores on the UCLA 3-item Loneliness Scale (mean 6.9 of maximum 9, SD=1.9), designed to measure individual perceptions of social isolation in large surveys (Hughes, Waite, Hawkley, & Cacioppo, 2004).

16. Quality of life and expectations

The WHO Quality of Life (WHOQOL) tool was designed to assess respondent's quality of life in four domains (Harper, 1998):

- Physical health (e.g., activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort);
- Psychological (bodily image and appearance, negative feelings, positive feelings, self-esteem);
- Social relationships (personal relationships, social support, sexual activity); and,
- Environment (financial resources, freedom, physical safety and security, health and social care: accessibility and quality, home environment).

The brief version (WHOQOL-BREF) was administered as part of the J2SI Mark II survey with respondents rating their mean overall quality of life at 2.6 (Likert scale 1 'Very poor' to 5 'Very good') and their mean overall satisfaction with their health at 2.8 (Likert scale 1 'Very dissatisfied' to 5 'Very satisfied').

Overall, respondents were less satisfied in each of the four domains compared with some of our previous research with people who are homeless. Satisfaction on two domains was an average of 10 points lower than observed in these previous studies: satisfaction with social relationships (39.5 compared with 46.8, Flatau et al., 2012, and 50.1, Flatau, Zaretzky, Brady, Haigh, & Martin, 2008) and satisfaction with their environment (46.1 compared with 56.0, Mission Australia, 2012, and 57.2, Flatau et al., 2008). Satisfaction on two other domains was an average of 15 points lower: satisfaction with psychological health (45.7 compared with 55.9, Mission Australia 2012, and 57.8 Flatau et al., 2008) and satisfaction with physical health (44.9 compared with 62.2, Mission Australia 2012, and 61.3 Flatau et al., 2008). The results indicated a considerably lower level of satisfaction across all four domains compared to the general Australian population (physical health 73.5, psychological 70.6, social relationships 71.5, environment 75.1; Hawthorne, Herrman & Murphy, 2006). Table 7 reports the mean WHOQOL-BREF scores by gender.

5. Sample items included: 'I seem to have a lot of friends' and 'I have someone I can lean on in times of trouble'.

Table 6: Quality of life by gender

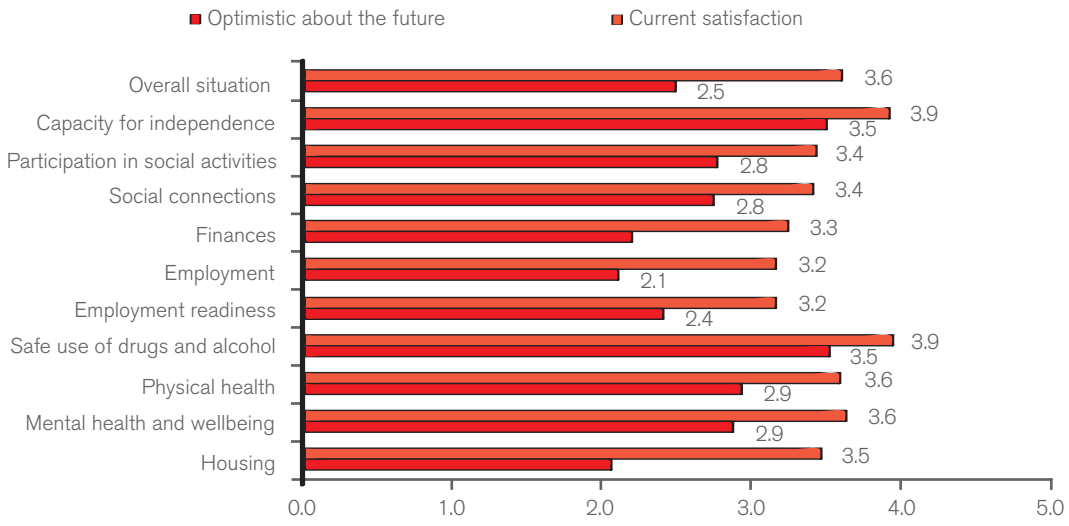
	All	Male	Female
Overall quality of life (out of 5)	2.58	2.67	2.35
Overall satisfaction with health (out of 5)	2.76	2.85	2.53
Quality of life domains (out of 100)[1]			
Physical health	44.9	45.8	42.9
Psychological	45.7	47.5	41.1
Social relationships	39.5	40.6	36.9
Environment	46.1	48.4	41.3

Note: 1. Measured in reference to the last 2 weeks.
Source: J2SI Mark II Baseline Survey

The J2SI Mark II baseline survey also captured respondents' current satisfaction with different life areas, such as housing and employment (Likert scale 1 'Very dissatisfied to 5 'Very satisfied; Figure 7). Respondents indicated the extent to which they agreed that they are optimistic about being able to achieve good outcomes in different areas of life in the future (Likert scale 1 'Strongly disagree' to 5 'Strongly agree). Overall, a larger proportion of respondents were dissatisfied with their current overall situation (58.7% were dissatisfied or very dissatisfied). However, many were optimistic that they will be able to achieve good outcomes overall (62.5% agreed or strongly agreed). The largest gap between current situation and future expectations is related to housing; where more than two thirds were dissatisfied with their current housing circumstances (69.3% dissatisfied or very dissatisfied). However, 57.6 percent agreed or strongly agreed that they were optimistic about achieving good housing outcomes in the future. Other areas of life dissatisfaction included employment (64.2% dissatisfied or very dissatisfied) and finances (65.4% dissatisfied or very dissatisfied). The respondents were mostly optimistic about achieving good outcomes in their capacity for independence (77.0% agreed or strongly agreed) and safe use of alcohol and other drugs (76.0% agreed or strongly agreed).

The only significant difference identified between groups was that E group respondents were more optimistic about achieving good outcomes with regard to social connections in the future (mean 3.58) than the J group (3.23, $p<.05$).

Figure 7: Satisfaction with life outcomes and expectation for the future (mean rating)



Source: J2SI Mark II Baseline Survey

17. Conclusion

These baseline survey findings depict a group of people deeply impacted by complex life circumstances, poor health and homelessness. The study cohort commonly describe experiencing homelessness early in life, with both long periods of continuous homelessness and episodic reoccurrences of housing instability. High rates of physical and mental health problems and concerning levels of social isolation and conflict in relationships were reported. Such histories and issues are frequently observed among people experiencing homelessness. However, the magnitude of problems, and the confluence of multiple and compounding adverse life experiences among many of the respondents in the J2SI Mark II study, pose additional challenges for breaking the cycle of homelessness. Nonetheless, there are also some positive and protective factors identified among a proportion of participants that suggest the capacity for resilience. These include average social support networks and optimism that a range of life circumstances may improve in the future.

The baseline data captured in this first survey of study respondents provides critical context for the project and its evaluation moving forward. Whilst in this initial report the experiences and challenges faced by study respondents have been described individually (for example, homelessness history, quality of life, psychological distress), we recognize that in the lived experience of these individuals, these factors are inextricably intertwined. Multiple factors often need to be addressed to enable people to break the cycle of homelessness.

As subsequent data is collected through six waves of survey administration (and enriched by participant and service provider interviews and linked administrative data), the inter-relationships between health, psychological, and social factors will be explored, including the role that these play in participants' journeys to social inclusion. In particular, we will investigate how the J and E groups differ over time to determine the effectiveness of the J2SI intervention in optimizing outcomes among adults with a history of chronic homelessness in Victoria.

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