AHURI Australian Housing and Urban Research Institute

PROFESSIONAL SERVICES

Homelessness amongst Australian veterans: homelessness and its correlates in Australian Defence Force veterans

AUTHORED BY

Dr Miranda Van Hooff
Dr Amelia Searle
Dr Jodie Avery
Dr Ellie Lawrence-Wood
Professor Andrew McFarlane
Centre for Traumatic Stress Studies, University of Adelaide

Dr Fiona Hilferty
Professor Ilan Katz
Mr Fredrick Zmudzki
Social Policy Research Centre, University of New South Wales

FOR

Australian Government Department of Veterans' Affairs

PUBLICATION DATE

May 2019

Suggested citation

Van Hooff, M., Searle, A., Avery, J., Lawrence-Wood, E., Hilferty, F., Katz, I., Zmudzki, F. and McFarlane, A. (2019), *Homelessness and its correlates in Australian Defence Force veterans*, Australian Housing and Urban Research Institute, Melbourne.

Related reports and documents

This report forms part of AHURI's *Inquiry into homelessness amongst Australian veterans.* The other reports in the Inquiry are:

Searle, A., Van Hooff, M., Lawrence-Wood, E., Hilferty, F., Katz, I., Zmudzki, F. and McFarlane, A. (2019). *Homelessness amongst Australian contemporary veterans: pathways from military and transition risk factors*, Australian Housing and Urban Research Institute, Melbourne.

Hilferty, F., Katz, I. Zmudzki, F. Van Hooff, M., Lawrence-Wood, E. and Evans, G. (2019), *Using the Specialist Homelessness Services Collection to examine veteran homelessness*, Australian Housing and Urban Research Institute, Melbourne.

Hilferty, F., Katz, I., Jops, P., Challinor, B., Talbot, A., Evans, G., Van Hooff, M., Lawrence-Wood, E. and Zmudzki, F. (2019). *Homelessness amongst Australian veterans: Findings from the qualitative interviews.* Australian Housing and Urban Research Institute, Melbourne.

Hilferty, F., Katz, I., Van Hooff, M., Lawrence-Wood, E., Zmudzki, F., Searle, A., and Evans, G. (2019), *Homelessness amongst Australian veterans: Final Project Report*, Australian Housing and Urban Research Institute, Melbourne.

Hilferty, F., Katz, I., Van Hooff, M., Lawrence-Wood, E. and Zmudzki, F. (2017). *Inquiry into homelessness amongst Australian veterans: Discussion paper*. Australian Housing and Urban Research Institute, Melbourne.

Disclaimer

Copyright

Acknowledgements

First and foremost, we acknowledge all current and ex-serving ADF personnel who generously gave their time to complete the study. This research was only made possible by their efforts and commitment to the study.

The research team would also like to acknowledge and thank all those who participated in and assisted with this research particularly Sharon Ride and Kym Connolly from the Australian Government Department of Veterans Affairs and Michael Fotheringham from the Australian Housing and Urban Research Institute for their contribution and guidance throughout the project.

Sincere thanks go to our three veteran researchers who were willing to join the project team. Ben Challinor, Adrian Talbot and Geoff Evans assisted greatly in the write-up and interpretation of data from all reports by sharing their expertise, gained from their own experiences as veterans and as providers of support for veterans in crisis.

Other key individuals involved in the conduct and the Transition and Wellbeing Research Programme include:

Principal Investigator

Dr Miranda Van Hooff (Lead), Director of Research, Centre for Traumatic Stress Studies, University of Adelaide.

Investigators

Dr Ellie Lawrence-Wood, Senior Research Fellow, Centre for Traumatic Stress Studies, University of Adelaide.

Dr Stephanie Hodson, National Manager, Veterans and Veterans Families Counselling Service, Department of Veterans' Affairs.

COL Nicole Sadler (Reservist), Senior Specialist, Military and High Risk Organisations, Phoenix Australia, Centre for Posttraumatic Mental Health, University of Melbourne.

Ms Helen Benassi, Mental Health, Rehabilitation and Psychology Branch, Joint Health Command, Department of Defence; PhD candidate, Australian National University.

Professor Alexander McFarlane, Professor of Psychiatry, Head of Centre for Traumatic Stress Studies, University of Adelaide.

Lead statistician

Dr Craig Hansen, Senior Statistician and Epidemiologist, Centre for Traumatic Stress Studies, University of Adelaide.

Statistician

Dr Blair Grace, Centre for Traumatic Stress Studies, University of Adelaide.

Transition and Wellbeing Research Programme Scientific Advisory Committee

RADM Jenny Firman (co-chair), Dr Ian Gardner (co-chair), Professor Ian Hickie, Professor Malcolm Battersby, Professor Mark Creamer, Professor Peter Butterworth, Professor Lyndall Strazdins, Dr Paul Jelfs, Dr Duncan Wallace, GPCAPT Lisa Jackson Pulver, Professor Tim Driscoll, Professor Kathy Griffiths, Professor Beverley Raphael, Dr Graeme Killer.

Centre for Traumatic Stress Studies, University of Adelaide

Dr Amelia Searle, Mr Roger Glenny, Ms Maria Abraham, Ms Jenelle Baur, Ms Ashleigh Kenny, Ms Marie Iannos, Dr Jodie Avery, Dr Elizabeth Saccone, Ms Jane Cocks, Mr Jeremy Hamlin, Ms Judy Bament, Ms Dianne Stewart.

Hunter Valley Foundation

Ms Shanti Ramanathan, Mr David Shellard, Dr Clare Hogue, Ms Phyllis Hartung, Mr Russ Redford and the team of CIDI interviewers.

Nexview Systems

Mr Trevor Moyle, Ms Hong Yan.

Australian Institute of Family Studies

Dr Galina Daraganova, Dr Jacquie Harvey.

Australian Institute of Health and Welfare

Mr Phil Anderson, Mr Nick Von Sanden, Mr Richard Solon, Mr Tenniel Guiver.

Australian Bureau of Statistics

Mr David Haynes, Ms Beatrix Forrest, Ms Michelle Ducat and staff from the Health and Disability Branch, Mr Barry Tynan and staff from the Communications and Dissemination Branch.

Transition and Wellbeing Research Programme Management Team

Ms Kyleigh Heggie, Ms Karen Barker, Dr Loretta Poerio, Ms Melissa Preston, Dr Carmel Anderson, Mr Tim Cummins, Ms Olivia Mahn, Ms Rachel McNab, Mr Christian Callisen, Department of Veterans' Affairs.

COL Laura Sinclair, Ms Jess Styles, Ms Kanny Tait, Department of Defence.

For their assistance in developing the Study Roll: Mr Mark Watson and Ms Megan MacDonald, Department of Veterans' Affairs, and Ms Carolina Casetta and Warrant Officer Class One Iain Lewington, Joint Health Command, Department of Defence.

Other key organisations

Australia Post.

Contents

List of tables

List of figures

Acronyms and abbreviations used in this report

ABS	Australian Bureau of Statistics
ACE	Adverse childhood experiences
ADF	Australian Defence Force
AHURI	Australian Housing and Urban Research Institute
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AUDIT	Alcohol Use Disorders Identification Test
BRS	Brief Resilience Scale (Ohio State University)
CI	Confidence interval
CIDI 3.0	Composite International Diagnostic Interview version 3
CTSS	Centre for Traumatic Stress Studies
DAR-5	Dimensions of Anger Reactions scale
DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders* – 4th edition
DVA	Department of Veterans' Affairs
ESO	Ex-service organisation
GAD-7	Generalised Anxiety Disorder 7-item Scale
GSS	General Social Survey
K10	Kessler Psychological Distress Scale
MEAO	Middle East Area of Operations
MEC	Medical Employment Classification
MECRB	Medical Employment Classification Review Board
MHPWS	Mental Health Prevalence and Wellbeing Study
MilHOP	Military Health Outcomes Program
NCO	Non-commissioned Officer
NDI	National Death Index
NHMRC	National Health and Medical Research Council
OFFR	Commissioned Officer
PCL-C	Post-traumatic Stress Disorder (PTSD) Checklist—civilian version
PGSI	Problem Gambling Severity Index
PHQ-9	Patient Health Questionnaire—9
PMKeyS	Personnel Management Key Solution
PTSD	Post-traumatic Stress Disorder
SE	Standard error
SHS	Specialist Homelessness Services
SHSC	Specialist Homelessness Services Collection

SPRC	Social Policy Research Centre
TWRP	Transition and Wellbeing Research Programme
UK	United Kingdom
UNSW	University of New South Wales
US	United States of America

Executive summary

This report is the first to provide comprehensive estimates of the prevalence and correlates of homelessness in Australian contemporary veterans. The estimates have been derived using population-level data from the Transition and Wellbeing Research Programme (TWRP), the most comprehensive study undertaken in Australia on the impact of military service on the mental, physical and social health of Transitioned[1] and Regular[2] Australian Defence Force (ADF) members and their families.[3] By utilising this data, estimates of homelessness could be generated to represent the entire population of veterans who left Regular ADF service between 2010 and 2014.

Overall, results highlight that the prevalence of homelessness among transitioned veterans can be considered high compared to the general Australian community, and thus is deserving of attention and concern. For example, in the Transitioned ADF, 1 in 5 (21.7%) reported experiencing homelessness in their lifetime, and 1 in 20 reported experiencing homelessness in the previous 12 months (5.3%). In the general population (aged 15 years and older), the equivalent number of people experiencing homelessness in their lifetime is 2.5 million (13%), with 351,000 (1.9%) experiencing homelessness in the previous 12 months (Australian Bureau of Statistics, 2014a). The vast majority of the Transitioned ADF who had ever been homeless had experienced an episode of homelessness within the previous five years (82.5%), and almost one in three reported an episode of homelessness in the preceding 12 months (28.4%).

Veterans with recent homelessness (i.e. during the preceding 12 months) showed an overall profile of risk consistent with the international literature, including a background of greater lifetime trauma, an accumulation of recent life events, higher risk behaviours, higher rates of unemployment and financial strain, poorer social support and worse mental health. Using this information, the Department of Veterans' Affairs (DVA) and the ADF, along with other government agencies and ex-service organisations (ESOs), may be able to better identify veterans at risk, and subsequently offer and tailor their services accordingly.

[1] Representing ADF members who transitioned out of full-time Regular service in the five-year period between January 2010 and December 2014.

[2] Representing a random sample of Regular ADF members serving in 2015.

[3] See https://www.dva.gov.au/health-and-wellbeing/research-and-development/social-research/transition-and-wellbeing-research.

1 Introduction

1.1 Inquiry into homelessness amongst Australian veterans

The AHURI *Inquiry into homelessness amongst Australian veterans* was commissioned by the Department of Veterans' Affairs (DVA) at the end of 2016. The aim of the project is to provide a national estimate of veteran homelessness and examine the nature of homelessness for former ADF members.

As there is no single, robust source of information to examine veteran homelessness, the project employs a mixed methodology and draws on multiple data sources. There are four project components.

1. A rapid evidence review to examine benchmarks and best-practice methods for monitoring homelessness amongst veteran groups, as well as best-practice procedures and interventions to support homeless veterans.
2. Qualitative interviews with a sample of key stakeholders and veterans experiencing homelessness.
3. The linkage of two key datasets: an Australian Defence Force (ADF) dataset that identifies the veteran population (post 2001) and the Specialist Homelessness Services Collection (SHSC). The analysis of these datasets will provide comprehensive information on the mainstream services accessed by the veteran population.
4. A detailed analysis of existing data collected as part of the DVA- and Defence-funded Transition and Wellbeing Research Programme (TWRP) and Military Health Outcomes Program (MilHOP).

This report provides the cross-sectional analysis of Component 4 (using only TWRP data). A second report (Searle, Van Hooff et al. 2019) will provide the longitudinal analysis of Component 4, by combining data from the TWRP and MilHOP. Findings from the rapid evidence review (Component 1) are presented in an AHURI discussion paper (Hilferty, Katz, Van Hooff et al, 2017). Findings from the qualitative data (Component 2) are presented in Hilferty, Katz, Jops et al (2019). Findings from analysis of the linked dataset (Component 3) are presented in Hilferty, Katz, Zmudzki et al (2019). The final project report integrates findings from all four components (Hilferty, Katz, Van Hooff et al, 2019).

1.2 The current report

The primary aim of this report is:

to examine the risk and protective factors for homelessness in ADF veterans, including demographic, organisational, Service-related, transition-related and deployment-related characteristics, the role of mental health and wellbeing (including probable disorder) and treatment-seeking, trauma exposure, substance use and social support.

'Veteran' is a term used to describe those who have left the armed forces. The specific qualifying characteristics can vary across militaries, based on factors such as length of military service, deployment history and discharge status. For the purposes of the broader Inquiry, we define a homeless veteran as anyone who has previously served in the ADF, either as a Regular member or a reservist, and who does not have a stable place of residence (i.e. no tenure).

For the purposes of this specific report (as one component of the overall project), we restrict our definition of 'veteran' to those who have previously served as a Regular ADF member only. This is because the analysis here draws on the Mental Health and Wellbeing Transition Study[4], which assessed one specific veteran population: ADF members who transitioned out of full-time Regular military service in the five-year period between January 2010 and December 2014 (referred to herein as the 'Transitioned ADF').

Although the Mental Health and Wellbeing Transition Study assessed multiple samples of ADF personnel, the Transitioned ADF is the only sample that can be considered 'veterans' by our definition. Nonetheless, in Appendix C we present the overall prevalence and characteristics of homelessness for a second sample, the '2015 Regular ADF'. This sample comprises three separate groups of Regular ADF members in 2015, with the combined results weighted to represent the entire population of Regular ADF members in 2015. Statistics for this sample have been included as a point of comparison, with the transition from Regular ADF service and return to civilian life a major (but by no means sole) point of difference between the two samples.

Using the data recently collected as part of the Mental Health and Wellbeing Transition Study (Van Hooff, Lawrence-Wood et al. 2018) we are able to generate estimates that represent the entire population of contemporary veterans (i.e. veterans who transitioned out of the ADF between 2010 and 2014), rather than relying on estimates of homelessness based on service-use data. No previous estimates of veteran homelessness have drawn on primary data collected from the full population of veterans.

Our overall analysis of the predictors of ADF veteran homelessness is divided into two parts. This report constitutes Part 1, comprising the cross-sectional component of the analysis, and using just the Mental Health and Wellbeing Transition Study data collated in 2015.

Part 2 of our analysis of veteran homelessness will constitute a report on the longitudinal predictors of recent (12-month) homelessness in the Transitioned ADF. This analysis will use data from both the TWRP (collected in 2015) and MilHOP (collected in 2010), for those Transitioned ADF veterans who participated in both studies and who consented to their data from both studies being linked.[5]

This report provides a comprehensive, high-level overview of homelessness in the Transitioned ADF. By identifying key correlates of homelessness in the Transitioned ADF, the report provides a framework for further detailed analyses, highlighting the key priority areas for further DVA and ADF policy development and research.

1.3 Research questions

1 What is the estimated prevalence of self-reported lifetime and recent (12-month) homelessness among contemporary transitioned veterans? What are the causes, and frequency and duration of homelessness in Australian veterans?

In order to address this research question, the following specific questions are examined in Chapter 3 of this report.

[4] Part of the TWRP, the Mental Health and Wellbeing Transition Study comprises five reports and two papers. See https://www.dva.gov.au/health-and-wellbeing/research-and-development/social-research/transition-and-wellbeing-research.

[5] Part 2 of the analysis is *Homelessness amongst Australian contemporary veterans: pathways from military and transition risk factors*, by Searle, A., Van Hooff, M., Lawrence-Wood, E., Hilferty, F., Katz, I., Zmudzki, F. and McFarlane, A (2019).

Chapter 3: Lifetime and recent (12-month) homelessness in Transitioned ADF veterans

- What is the estimated prevalence of self-reported lifetime homelessness among contemporary transitioned veterans?
- What is the estimated prevalence of self-reported recent (12-month) homelessness among contemporary transitioned veterans?
- What are the characteristics of contemporary transitioned veterans with lifetime and recent (12-month) homelessness, including: reasons for homelessness, number of episodes of homelessness, recency and duration of homelessness episodes, help-seeking and barriers to accessing assistance?
- Is there a significant difference between the estimated prevalence of self-reported lifetime homelessness and recent (12-month) homelessness among contemporary transitioned veterans?
- Is there a significant difference between the characteristics of contemporary transitioned veterans with self-reported lifetime homelessness and recent (12-month) homelessness?

Prevalence estimates were generated using data from the TWRP and weighted to represent the entire population (as described in Chapter 2).

1 What are the demographic, Service, and psychosocial, and mental health and wellbeing characteristics of recent (12-month) homelessness in contemporary transitioned veterans?

In order to address this research question, the following specific questions are examined in Chapters 4 and 5 of this report.

Chapter 4: Demographic, service and psychosocial Characteristics of Transitioned ADF veterans with recent (12-month) homelessness

- What are the characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, veterans within the Transitioned ADF? Characteristics examined include: demographic, Service and transition attributes; information regarding civilian employment and DVA support; ex-service organisation (ESO) engagement; criminal, driving and gambling behaviour; psychosocial characteristics; recent life events and traumatic events; and tobacco and drug use.
- Is there a significant difference between the demographic, Service and psychosocial characteristics of Recently Homeless veterans compared with Not Recently Homeless veterans?

Chapter 5: Mental health characteristics of Transitioned ADF veterans with recent (12-month) homelessness

- What are the mental health and wellbeing characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, veterans? Characteristics examined include: post-traumatic stress symptoms, psychological distress, at-risk drinking behaviour, depression and anxiety symptoms, suicidal ideation, and anger.
- Is there a significant difference between the mental health characteristics of Recently Homeless veterans and Not Recently Homeless veterans?

Using TWRP data, a series of weighted logistic regressions were conducted to examine associations between various possible risk/protective factors and several conceptualisations of homelessness.

1.4 Data source

Data for the current report was collected in 2015–16 as part of the Transition and Wellbeing Research Programme (TWRP). This program of research consisted of an integrated suite of three key studies: the Mental Health and Wellbeing Transition Study, The Impact of Combat Study and the Family Wellbeing Study. Together, these studies addressed the mental health and wellbeing of transitioned ADF members and their families, and examined the longitudinal course of mental health among currently serving and transitioned ADF members.

Building upon the work of the TWRP, this report uses data from the Mental Health and Wellbeing Transition Study to determine the correlates of homelessness among Transitioned ADF members, including those with a probable mental health disorder. As homelessness is often associated with mental health status, information about the homelessness status of Transitioned ADF and 2015 Regular ADF was collected as part of the Mental Health and Wellbeing Transition Study. For detailed information pertaining to the Mental Health and Wellbeing Transition Study, including the study objectives, refer to the *Mental health prevalence* report (Van Hooff et al., 2018).

1.5 Background to the current research

1.5.1 The definition of homelessness

There is no universally accepted definition of homelessness, as definitions vary between countries depending on their specific cultural and historical context. Nevertheless, the use of a standard definition of homelessness is important to enable consistent measurement and comparison across populations. In 2012, the Australian Bureau of Statistics (ABS) developed a standard definition of homelessness, which has been used to generate homelessness estimates for the Australian population.

According to the ABS definition (Australian Bureau of Statistics, 2012a), a person is considered to be homeless if:

- their current living arrangement is in an inadequate dwelling, has no/limited tenure, or does not allow control of/access to space for social relations, *and*
- the person has no suitable accommodation alternatives, and does not have the financial, personal, psychological or physical means to make another choice (i.e. they are not simply choosing to live on the streets).

The ABS definition of homelessness is typically more inclusive, compared to other definitions, because it concerns 'home'-lessness, and not just 'roof'-lessness (Australian Bureau of Statistics, 2012a). Their definition encompasses Chamberlain and MacKenzie's (1992) notion that homelessness occurs on a three-level continuum.

- **Primary homelessness** includes people without conventional accommodation, such as those living on the streets, sleeping in derelict buildings or using cars for temporary shelter.
- **Secondary homelessness** includes people who move frequently from one form of temporary shelter to another, including people accommodated by homelessness services, people residing temporarily with family and friends, and those using boarding houses on an occasional basis.

→ **Tertiary homelessness** includes people who live in boarding houses on a medium- to long-term basis. This type of accommodation typically does not have self-contained rooms, with residents sharing bathroom and kitchen facilities.

It is important to note, however, that while the ABS definition includes these three levels of homelessness, it does not distinguish between them in terms of whether they are considered homeless or not.

Homelessness can be measured in terms of *current homelessness*, where one is homeless at the time of data collection (referred to as point-in-time estimates); *lifetime homelessness*, where one may have experienced a period of homelessness at some point during their lifetime; and *homelessness over a specified period*, such as the last 12 months. An episode of homelessness is considered *chronic* if it lasts six months or more.

1.5.2 The prevalence of homelessness

Prevalence of homelessness in the Australian and international community

Given the inconsistency in definitions of homelessness, it is difficult to compare accurately the prevalence of homelessness between populations. Underpinning this is the inherent difficulty of accurately measuring and describing homelessness within populations. This is primarily due to inadequate measurement techniques, and obstacles for capturing and recording homelessness. Methods for measuring homelessness include census-style head counts, self-report surveys, and agency records. Australian homelessness estimates are based on surveys, and more recently on agency records. Self-report surveys, however, have their limitations in terms of sampling and reporting biases. In addition to these limitations, access to homeless populations poses an obstacle to accurate data collection. This is because many homeless people do not seek help from official agencies and therefore are not recorded as 'homeless' (Hamad, 2017). This means that the reliance on official records as one of the main methods of determining the burden of homelessness is likely to result in an underestimation of homelessness prevalence.

The 2016 *Census of Population and Housing* provides the most recent prevalence estimates of homelessness in Australia. On census night, 116,427 Australians (0.5% of the population) were homeless, which represented an increase of 4.6 per cent over the previous five years (Australian Bureau of Statistics, 2018). The 2014 General Social Survey (GSS) asked people about any episodes in their lives when they had been homeless, and the reasons for those circumstances. It found that 2.5 million people aged 15 years and over had experienced homelessness at some time in their lives, equating to approximately 10 per cent of the Australian population. About 1.4 million of these people had experienced at least one episode of homelessness in the last 10 years, of which 351,000 had experienced homelessness in the last 12 months (i.e. about 1.9% of the population) (Australian Bureau of Statistics, 2014a).

Internationally, prevalence rates of homelessness vary across countries due to factors such as immigration and social policy, and welfare systems, as well as variations in the definition of homelessness. In general, there is a wide variation in the reporting of prevalence rates for lifetime homelessness. For example, Hamad (2017) reported estimated lifetime homelessness prevalence rates in the following countries: Japan, 0.006 per cent; United States (US) 0.5 per cent; and Finland 0.14 per cent. However, the author suspected these figures to be underestimates due to poor recording methods (Hamad, 2017). In contrast, other international studies report higher estimates of the prevalence of lifetime homelessness, with rates consistent with those observed in Australia. For example, one study generated homelessness estimates (including *precarious housing*, i.e. sleeping at family's/friends' houses) for the US (14.0%), Belgium (9.6%), Germany (5.6%), Italy (10.5 %) and the United Kingdom (UK) (13.9%) (Toro et al., 2007). If Australia's definition of

'homelessness' was used internationally, there would be over 1.6 billion homeless people worldwide, or around 20 per cent of the world's population (Hamad, 2017).

Prevalence of homelessness in veterans

Veterans, as a group, have been identified as having an increased risk of homelessness (Fargo et al., 2012; U.S. Department of Housing and Urban Development, 2017b; Foreign Affairs Defence and Trade Committee Department of the Senate, 2016; Tsai & Rosenheck, 2015). The wellbeing of contemporary veterans returning from the conflicts of Iraq and Afghanistan is attracting increasing concern, as many of these veterans face complex social, economic and personal challenges re-entering civilian life (Demers, 2011; Fargo et al., 2017). In particular, the increased risk of homelessness for veterans, following their return to civilian life, has received significant media attention in recent years, particularly in the US (Harris et al., 2017; Fargo et al., 2017), though also in Australia (Hilferty et al., 2017). However, to date, systematic quantitative research to understand the processes and pathways by which veterans become homeless has been limited.

Prevalence of homelessness in international veterans

International research on homelessness in veteran populations predominantly comes from the US, thus should be interpreted within the context of the US Department of Veterans Affairs (VA) and Defence systems, as well as the US socioeconomic and political environment. Great concern has been expressed within the American media (Thomas, 2013; Eckholm, 2007; Fairweather, 2006; Williamson & Mulhall, 2009; Woodruff, 2010), as well as by advocates and policy-makers, that veterans who served in Iraq and Afghanistan face a heightened risk of homelessness. These concerns appear warranted, as emerging research indicates that veterans deployed to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are at an increased risk of homelessness compared to those who were not (Metraux et al., 2013). The reasons for this increased risk, however, are not well understood. Population data from US Defence studies has shown that while homelessness occurs for veterans across all war eras, there is a growing number of veterans under the age of 30 who are becoming homeless (Metraux et al., 2017).

There has been substantial progress in the US over recent years towards ending veteran homelessness, since the Obama administration's 2010 pledge to end veteran homelessness by 2015: there was a 45 per cent drop in the number of homeless veterans between January 2009 and January 2017 census nights (U.S. Department of Housing and Urban Development, 2017b). However, the most recent data estimates indicate that around 40,000 veterans were still homeless on a given night in January 2017 (U.S. Department of Housing and Urban Development, 2017b). Moreover, the most recent annual estimates (across 2015–16) showed approximately 124,000 veterans, or 1 in every 177 veterans (0.6%), experienced *sheltered homelessness* (i.e. using emergency shelters or transitional housing programs) at some point over the course of the year (U.S. Department of Housing and Urban Development, 2017a). It is important to note that in excluding all *unsheltered homelessness* (i.e. not using such programs), these annual estimates will underestimate the extent of total homelessness, given over one-third of homeless veterans were unsheltered on a given night (U.S. Department of Housing and Urban Development, 2017b). While UK estimates similarly have several limitations, figures released from their Ministry of Defence in 2014 estimated that the proportion of those 'sleeping rough' who had served in the armed forces ranged from 3 per cent to 6 per cent (Ministry of Defence, 2017).

Prevalence of homelessness in Australian veterans

Media reports have suggested that there is a growing number of Australian ex-serving military personnel experiencing homelessness (Kenny, 2015; Toohey, 2016; Van Extel, 2014). However, there is no currently accepted estimate of veteran homelessness within Australia, as there are no existing data sources available to inform accurate prevalence

estimates or monitor changes in trends. This is a concern for policy-makers, as an accurate understanding of the number and profile of veterans experiencing homelessness is required in order to plan for adequate service responses (Hilferty et al., 2017).

A key priority for the DVA is the prevention and/or reduction of homelessness amongst Australian veterans. Although DVA has no legislated role in the provision of housing and/or accommodation services, it works closely with other government agencies and ESOs to assist members of the veteran community who are homeless or are at risk of becoming homeless (Hilferty et al., 2017). An accurate description of the homeless veteran population is necessary in order to identify and characterise specific groups of veterans with the most need, and to inform prevention and intervention efforts (Tsai et al., 2016).

Previous attempts to estimate the prevalence of veteran homelessness have been undertaken but, to date, they have relied on extrapolations from datasets and none have used primary data collection (see for example, Thomson Goodall Associates 2009; Foreign Affairs Defence and Trade Committee 2016). Our study is the first in Australia to collect primary data and draw on multiple datasets to estimate the prevalence of veteran homelessness.

1.5.3 Risk factors for homelessness

There is a paucity of research concerning the risk factors for homelessness in Australian veterans. Most research in this field has emerged from other countries, thus the following review examines the international literature with regard to veteran homelessness, as well as homelessness in the general population. It is important to note that homelessness in the general population cannot be directly compared with homelessness in veteran populations. This is because there are many factors that make veterans unique compared with the overall population. Furthermore, with regard to homelessness, the experience of Australian veterans may differ from the experience of veterans in other countries.

Risk factors for homelessness in the community

A growing body of evidence highlights a plethora of biographical, demographic and socioeconomic risk factors for homelessness and adverse housing outcomes among the general population (Koegel et al., 1995).

A significant volume of research indicates that experiences in childhood can shape adult life and may affect multiple domains of health and wellbeing (Patterson et al., 2015). Adverse childhood experiences (ACEs), such as physical and sexual abuse, have been shown to have strong associations with negative adult psychological outcomes. ACEs may include: out-of-home placement, poverty, parental instability, residential mobility, poor parental care, problems at school or lack of education opportunity, and stressful events (Patterson et al., 2015; Caton et al., 2005).

Little research, however, has specifically examined ACEs in relation to adverse housing outcomes. While the majority of research in this area has been limited by a focus on small samples of service-seeking homeless people, several epidemiological studies (some of which are longitudinal) have demonstrated significant associations between various ACEs and homelessness (Herman et al., 1997; Roos et al., 2013; Shelton et al., 2009; van den Bree et al., 2009). Moreover, it has been found that ACEs tend to cluster together (Patterson et al., 2015) and a cumulative history of trauma, abuse and neglect is likely to result in a number of neurobiological and behavioural difficulties, including poor social support and coping skills (Galletly et al., 2011). These findings have been replicated in a study examining a sample of homeless adults in a supported housing program, which found numerous childhood problems commonly clustered together, and the homeless adults who displayed such a profile reported greater rates of substance use disorders, and a younger age of onset of psychiatric symptoms, than other homeless adults (Tsai et al., 2011). Thus, it is likely that

a significant proportion of homeless adults have a complex history of multiple ACEs, coupled with various adverse outcomes.

In the general population, other common reasons for homelessness include: violence/abuse/neglect (Tsai & Rosenheck, 2013; Hamilton et al., 2011); alcohol or drug use (Teeters et al., 2017; Hamilton et al., 2011); family/friend/relationship problems (Tsai & Rosenheck, 2013); financial problems (e.g. unable to pay mortgage or rent), mental illness (Tsai et al., 2017; Topolovec-Vranic et al., 2017); job loss (Applewhite, 1997); gambling (Harris et al., 2017); eviction (Dunne et al., 2015); and sometimes natural disaster (Perl, 2015).

Homelessness can result in poor health, barriers to education, poor employment outcomes, poor social connectedness and poor quality of life (Thomson Goodall Associates, 2009; Flatau et al.). Recent South Australian government data highlighted that of the 620 rough sleepers who sought assistance from government-funded homelessness services in inner-city Adelaide in 2015/2016, 52 per cent had mental health issues, 18 per cent had drug issues, 17 per cent had alcohol issues, 10 per cent had a disability and 5 per cent reported family violence (Tually et al., 2017). Whether these factors are precursors or outcomes of homelessness (or neither) is unclear; regardless of the exact nature of this association, the data highlights the vulnerability and complexity of this population.

There is considerable debate about the socioeconomic 'structural' factors that leave people more vulnerable to homelessness (including labour market changes, inadequate housing supply and cuts in income assistance) compared with the 'individual' factors of poverty (gender, ethnicity and age group) (Koegel et al., 1995). For example, research has shown that among homeless people, younger age, employment, earned income, good coping skills, adequate family support, absence of a substance abuse treatment history, and absence of an arrest history are associated with a shorter duration of homelessness. Conversely, older age and a history of arrest are the strongest predictors of a longer duration of homelessness (Caton et al., 2005). Thus, there appears to be a complex interplay between the structural and individual causes of homelessness. Further research is needed to fully understand the nature of these interactions, including the relevant direction(s) of causation, and the relative dominance of different generative mechanisms (Bramley & Fitzpatrick, 2018).

Risk factors for homelessness in veterans

Limited research to date has explored the pathways to homelessness among contemporary veterans, despite the attention that this issue has received in the popular media (Kull et al., 2003-04). Research has suggested that vulnerability to homelessness among veterans is best conceptualised as resulting from the accumulation of pre-military, military, and post-military risk factors (Tsai & Rosenheck, 2015; Metraux et al., 2013; Rosenheck & Fontana, 1994; Tsai et al., 2013). Pre-military risk factors, such as ACEs (Tsai & Rosenheck, 2015), have been shown to be associated with an increased risk of homelessness in veterans, as is the case among the non-veteran population (Montgomery et al., 2013; Patterson et al., 2015; Rosenheck & Fontana, 1994). Although a direct link between military factors (such as deployment, length of Service, role) and homelessness has not been demonstrated, military experiences can be indirectly linked to homelessness, through their association with increased risk of substance abuse (Teeters et al., 2017), mental health problems (Oster et al., 2017; Hodson & McFarlane, 2016; Balshem et al., 2011), poor social support (Weber et al., 2017; Graziano & Elbogen, 2017), and employment challenges (Metraux et al., 2017; Tsai & Rosenheck, 2015). Beyond these factors, the vulnerability to homelessness among veterans following their discharge is heightened by other challenges associated with reintegration into civilian life (Bergman et al., 2014; Harvey et al., 2011; Hatch et al., 2013; Sayer et al., 2010; Sheilds et al., 2016).

It has been noted that there is a pressing need to update this line of research (Metraux & Tseng, 2017), as the military and post-military experiences of the current-era of veterans

differ markedly from their predecessors (MacLean & Elder, 2007). In particular, the combat experiences of those deployed to Iraq and Afghanistan differ substantively from veterans of earlier-era wars (such as Vietnam), which has resulted in a different mix of challenges related to health, mental health and substance abuse in this cohort (Metraux et al., 2013; Rosenheck & Fontana, 1994). Upon discharge from the military, recent-era veterans have encountered an incredibly challenging macroeconomic climate, characterised by very high unemployment rates that have, at times, exceeded 10 per cent in the US. In addition, military occupations and training are not always transferable to the civilian workforce, meaning that some veterans are at a disadvantage in the employment market (National Coalition for Homeless Veterans, 2018). These adverse economic factors have been linked to increased rates of homelessness (O'Toole et al., 2002) and may hinder a veteran's ability to obtain stable employment and successfully reintegrate into civilian life (Elnitsky et al., 2017).

Besides structural factors such as an extreme shortage of affordable housing (especially for a group that may not have already established itself in the housing market), many veterans also live with the lingering effects of post-traumatic stress disorder (PTSD) and other mental health conditions, as well as substance abuse (Hatch et al., 2013; Jones et al., 2013; Pinder et al., 2012). The impacts of these conditions can be exacerbated by a lack of family and social support networks (Metraux et al., 2013; Tsai & Rosenheck, 2015). Indeed, mental illness (including substance abuse) has been found to be one of the most consistent risk factors for homelessness amongst veterans (Tsai & Rosenheck, 2015; Blackstock et al., 2012; Metraux et al., 2013). Substance abuse (including alcohol, tobacco and other drugs) has been associated with future risk of homelessness in recent-era veterans, as well as being related to length of homelessness, becoming homeless again following successful housing, and chronic homelessness in various veteran samples (Edens et al., 2011; Gordon et al., 2006; Harris et al., 2017; Metraux et al., 2013; O'Connell et al., 2008; The Royal British Legion, 2010; Wenzel et al., 1993).

The relationship between homelessness and the type of mental health problem in veterans appears complex, and is not limited to the post-traumatic responses commonly associated with military service. For example, while 23 per cent of one sample of homeless UK veterans had spent time in a psychiatric unit, only a small number had PTSD, with other mental health problems (due to childhood or post-separation experiences) being more common (The Royal British Legion, 2010).

1.5.4 Service use and barriers to use in Australian homeless veterans

Individuals experiencing homelessness often need to access a number of different services. These include: income support or welfare services; public and community housing services; primary healthcare services; clinical treatment services (including mental health and drug and alcohol services); employment and training services; education and early childhood services; aged care services; immigration services (including asylum seeker and refugee services); and legal and court services. The type, extent and duration of service needs of different groups of homeless people varies widely, and needs are influenced by demographic characteristics, the length of time and patterns of homelessness experienced, and individual causal factors ((Burt et al., 2010)).

As discussed previously, not all individuals experiencing homelessness access specialist services, and in fact many may not be aware of the services and support available (Black & Gronda, 2011). Against this background, it is important to understand the extent to which homeless veterans are using the programs and services available to them, so that service utilisation and the effectiveness of outreach efforts can be accurately gauged (Tsai et al., 2016).

In Australia, besides residential care, the DVA does not provide housing or accommodation services. However, the DVA may be able to provide some support and assistance to veterans who are homeless or at risk of homelessness (Department of Veterans' Affairs,

2018). One DVA program, known as 'Time Out' Crisis Assistance, can provide short-term accommodation, which allows veterans the opportunity to access services provided by Open Arms (previously Veterans and Veterans Family Counselling Service—VVCS), to assist in rebuilding family relationships or addressing other problems that may have led to homelessness. Additionally, ESOs are able to provide assistance to current and former ADF members, such as welfare support, employment programs and assistance with DVA claims. These organisations include the Bravery Trust, Homes for Heroes, Veterans Off the Streets Australia, Vietnam Veterans Association of Australia (NSW Branch), V360 Australia, and the Returned Services League. Moreover, homelessness services available to the general community—including those provided by the Salvation Army, First Point, Link2Home, Homelessness Gateway and Shelter Me—can also be accessed by Australian veterans experiencing homelessness.

There are many barriers to accessing services that may affect homeless people in general, including logistical and practical service system barriers, service model/practice barriers and individual barriers (Black & Gronda, 2011). Barriers include:

- lack of knowledge about the services available and how to contact them
- lack of personal skills to access services (e.g. self-confidence, communication skills)
- lack of money/resources to access services, including lack of transport
- disconnection from mainstream society and service systems
- lack of trust and suspicion of services, including fear of government and bureaucracy
- feeling unsafe (particularly for women who have experienced violence)
- lack of identification and other documentation
- lack of telephone and mailing address, which make it difficult to retain contact
- higher likelihood of poor health, physical or psychiatric disability
- substance abuse problems or criminal history
- competing priorities, such as obtaining food and other basics
- lack of social support
- difficulty in keeping appointments due to cognitive impairments or chaotic lifestyle.

2 Methodology

Data for the current report was collected as part of the TWRP, specifically the Mental Health and Wellbeing Transition Study. Accordingly, this chapter provides the methodological detail for the specific aspects of the Mental Health and Wellbeing Transition Study that apply to this report. For the full Mental Health and Wellbeing Transition Study methodology, including a comprehensive description of all the measures used in the survey, refer to the *Mental health prevalence* report (Van Hooff et al., 2018).

2.1 Study design

In phase 1 of the Mental Health and Wellbeing Transition Study, Transitioned ADF and 2015 Regular ADF members were assessed for mental health issues, psychological distress, physical health problems, wellbeing factors, pathways to care and occupational exposures, via a 60-minute self-report survey completed online or in hard copy. Each participating sample received a slightly different questionnaire, relevant to their current ADF status and tailored to their demographic, Service and deployment history. However, the core validated measures of psychological and physical health remained the same. The survey contained nine questions specifically related to homelessness, which, together with the extensive other data collected, enabled the development of a risk and protective profile of homelessness among recently transitioned veterans in the current report. For specific details regarding the self-report measures investigated in the current report, refer to Section 2.6.

Whilst data was collected from both Transitioned ADF and 2015 Regular ADF members, the current report only presents findings on homelessness and its correlates within the Transitioned ADF sample (described below).

2.2 Sample

The current report uses data from one of the TWRP's six overlapping samples: *the Transitioned ADF***.** This sample comprised all ADF members who transitioned from the Regular ADF between 2010 and 2014, including those who transitioned into the Active Reserves and Inactive Reserves, as well as those who were discharged completely from the Regular ADF (i.e. Ex-serving members). Results from this group were weighted to represent the entire population of the ADF that transitioned from the Regular ADF between 2010 and 2014. For a detailed description of all six samples used in the TWRP, refer to the *Mental health prevalence* report (Van Hooff et al., 2018).

The 2015 Regular ADF sample was not included in the current report, for the following reasons: their current-serving status meant they did not fit the definition of veteran used for this report; and relatedly, the experience of homelessness in this group would, by nature, be less prevalent and qualitatively different from that in the Transitioned ADF, given that housing provision (such as live-in accommodation or service residences) or assistance (such as rent allowance) is a condition of serving in the ADF. This provision of housing acknowledges that ADF members need to move location regularly and/or at short notice (Department of Defence, 2018). Thus, the results for this sample are confined to Appendix C.

2.3 Response rates

Of the Transitioned ADF population (24,932), 96 per cent (23,974) were invited to participate in the study. Of those invited, 4,326 (18%) completed a survey. Table 1 shows survey response rates for the Transitioned ADF by Service, sex, rank and medical fitness.

Females (20.9%) were more likely to respond to the survey than males (17.6%). In terms of rank, Officers exhibited the highest response rate (32.0%) followed by Non-commissioned Officers (28.4%) and Other Ranks (7.7%). When response rates in the different services were compared, members of the air force (24.9%) were most likely to respond, whereas navy (15.7%) and army (17.0%) members were least likely to respond. Finally, individuals who were classified unfit (20.9%) had a higher response rate than members who were classified as fit (17.0%).

Table 1: Mental Health and Wellbeing Transition Study survey response rates for Transitioned ADF, by Service, sex, rank and medical fitness

	Transitioned ADF (N = 24,932)			
	Population	**Invited**	**Responders**	**Response rate (%)**
Service				
Navy	5,671	5,495	863	15.7
Army	15,038	14,465	2,463	17.0
Air force	4,223	4,014	1,000	24.9
Sex				
Male	21,671	20,713	3,646	17.6
Female	3,261	3,261	380	20.9
Rank				
Officer	4,063	3,939	1,259	32.0
NCO	7,866	7,393	2,097	28.4
Other Ranks	13,003	12,642	970	7.7
Medical fitness				
Fit	18,273	17,525	2,981	17.0
Unfit	6,659	6,449	1,345	20.9
Total	24,932	23,974	4,326	18.0

Notes: 1. Data are unweighted. 2. Response rates are calculated as the proportion of those invited to participate in the study. 3. NCO = Non-commissioned Officer.

Source: Adapted from Van Hooff, Lawrence-Wood et al. (2018).

2.4 Statistical analysis

Analyses were conducted using Stata version 14.2[6] or SAS version 9.2[7] software. All analyses were conducted using weighted estimates of totals, means and proportions, except where specified otherwise. Standard errors (SEs) were estimated using linearisation, except where specified otherwise.

For all measures, the number and proportion (n and %) of ADF members in each subgroup were generated, or else mean total scores among subgroups were generated where appropriate. For categorical variables, missing data were coded as a discrete response category, in order to have complete data for all survey responders which could then be weighted to represent the entire population. Thus, in many instances (i.e. where a variable had missing data), proportions for a variable (e.g. the proportion of Recently Homeless veterans across the five age-group categories) do not add up to 100 per cent. However, the proportion of missing data was mostly low (e.g. proportions for the five age-group response categories summed to 97.8% for the Recently Homeless veterans, with 2.2% missing data).

In making an inference about the differences between groups (e.g. demographic differences between Recently Homeless and Not Recently Homeless veterans), we have used 95 per cent confidence intervals. A confidence interval (CI) can be defined as a range of values for a variable, so that this range has a specified probability of including the true value of the variable. The specified probability is called the 'confidence level', and the end points of the confidence interval are called the 'confidence limits'. By convention, and for this analysis, the 'confidence level' is usually set at 95 per cent. The 95 per cent confidence interval is defined as 'a range of values for a variable of interest constructed so that this range has a 95 per cent probability of including the true value of the variable'. Simply, it means that we can be 95 per cent sure that truth is somewhere within the 95 per cent confidence interval. With only 95 per cent confidence, there is a 5 per cent probability of being wrong (i.e. that the true value might lie either below or above the two confidence limits).

Consequently, 95 per cent confidence intervals can correspond with hypothesis (significance) testing of results using $p < 0.05$. Hypothesis testing produces a decision about any observed difference: either that the difference is 'statistically significant' or not. If the confidence intervals of two comparison estimates overlap, this represents a difference that *is not* statistically significant. If the confidence intervals do not overlap, this represents a difference that *is* statistically significant. Thus, 95 per cent confidence intervals not only show the largest and smallest effects that are likely to take place, but statistical significance ($p < 0.05$) can also be inferred from them (Gupta, 2012). Accordingly, in this report, when identifying whether there are significant differences, we have discussed whether two different values are 'significantly different', meaning that their confidence intervals do not overlap.

2.5 Weighting

The statistical weighting process used in the Mental Health and Wellbeing Transition Study replicated that used in the 2010 Mental Health Prevalence and Wellbeing Study

[6] StataCorp. (2015) Stata Statistical Software: Release 14, College Station, TX: StataCorp LP.

[7] Copyright © 2008, SAS Institute Inc., Cary, NC, USA.

(MHPWS) (McFarlane et al., 2011), and allowed for the inference of results for the entire Transitioned ADF population.

Survey responder weights were used to correct for differential non-response to the survey by the Transitioned ADF. The weighting procedure involves allocating a representative value or 'weight' to the data for each responder, based on key variables that are known for the entire population (including responders and non-responders). This weight indicates how many individuals in the entire population each actual responder represents. Weighting data allows for the inference of results for an entire population (e.g. the Transitioned ADF) by assigning a representative value to each 'actual' case (responder) in the data. For example, if a case has a weight of 4, that case then counts in the data as 4 identical cases. By using known characteristics about each individual within the population (in this case age, sex, rank and medical fitness), the weight assigned to responders indicates how many 'like' individuals in the entire population (based on those characteristics) each responder represents. Weighting is used to correct for differential non-response and to account for systematic biases that may be present in study responders. This methodology provides representative weights for the population to improve the accuracy of the estimated data, and requires that every individual within the population has actual data on the key variables that determine representativeness.

The Transitioned ADF weights were derived from the distinct strata of sex, Service, rank, and medical fitness (a dichotomous variable derived from Medical Employment Classification (MEC) status). There were 313 (1.2%) of the total Transitioned ADF population with missing information on the strata variables, which reduced the final weighted population for analyses to 24,932.

To maximise the actual data available for analysis, weights were calculated for each separate section of the survey. This addressed the issue of differential responses to various sections of the survey, where individuals potentially completed some but not all parts of the survey. A 'survey section responder' was defined as anyone who answered at least one question in that particular section of the survey. In total, there were 29 section responder weight variables. For the purpose of analysis, the weights used always related to the primary outcome variable of interest.

2.6 Measures from the Mental Health and Wellbeing Transition Study used in the current report

The following measures from the Mental Health and Wellbeing Transition Study self-report survey were used in the current report to assess homelessness and its correlates. The measures used to assess the definition and characteristics of homelessness (detailed in Section 2.6.1, below) consider the Transitioned ADF and the 2015 Regular ADF. All remaining measures in this report (detailed in Sections 2.6.2–2.6.9) include only the responses of the Transitioned ADF (and not the 2015 Regular ADF).

2.6.1 The definition and characteristics of homelessness

In this report, *lifetime* and *recent* homelessness were calculated using an algorithm derived from the ABS' definition of homelessness (Australian Bureau of Statistics, 2012a). The algorithm used eight questions within the self-report survey, taken from the 2010 General Social Survey (GSS) (Australian Bureau of Statistics, 2011).

Initially, respondents were asked whether they had ever experienced certain common 'homeless' circumstances (e.g. stayed in a shelter), due to not having a permanent place to live. If respondents answered 'yes' to any of these questions, they were asked about the nature of these circumstances. This was so that homelessness outside one's own control (e.g. due to alcohol or drug use or mental illness, indicating there was no viable housing alternative) could be identified—as opposed to one not having a permanent place to live solely for reasons of personal choice (e.g. house sitting or saving money). This *lifetime* homelessness was explored by the reasons why it occurred, and how often it had occurred over the respondent's lifetime.

Respondents who had experienced lifetime homelessness and also indicated that their most recent episode was 'less than 12 months ago' were classified as *Recently Homeless* or experiencing *recent (12-month) homelessness*. Characteristics of Recently Homelessness veterans were explored in comparison with Not Recently Homeless veterans (no episode of homelessness in the past 12 months).

The ABS definition of homelessness was used in this study because:

- → the definition is robust, largely measurable, and is used by key sectoral stakeholders such as Homelessness Australia, the national peak body
- → the definition will enable future benchmarking of this study's results with national datasets, specifically the Census (including the new homelessness estimates due March 2018)
- → the prevalence estimates for this study will be based upon data already collected via the TWRP and MilHOP surveys—and the related questions in these surveys were based on the ABS definition.

As the existing TWRP and MilHOP datasets do not include information about the adequacy of dwellings or control of social space (core components of the ABS statistical definition), our definition centres on stability in housing.

It is important to note that the ABS definition does not distinguish between forms of homelessness (e.g. primary, secondary and tertiary) as described by Chamberlain and MacKenzie's (1992) The prevalence estimate calculated for this study therefore will distinguish between veterans experiencing recent homelessness (i.e. during the previous 12 months) and those who have experienced it in their lifetime only, while also exploring self-perceived risk of future homelessness.

The variables used to define and describe homelessness are summarised below.

Types of housing situation experienced because of not having a permanent place to live

Two questions regarding housing situations, used in combination, were used to assess homelessness. Participants were asked, firstly, if they had ever experienced certain living circumstances because they did not have a permanent place to live, such as staying with relatives or squatting in an abandoned building. Additionally, they were asked what led to them being without a permanent place to live, such as building or renovating a home, or financial problems (e.g. unable to pay mortgage or rent).

Frequency and duration of homelessness episodes

Further to this, respondents who indicated they had ever been without a permanent place to live (in the above-mentioned questions) were asked to indicate: how many times they had been without a permanent place to live; the factors that led to their most recent episode; and the recency and duration of their most recent episode.

Respondents who indicated their most recent episode was 'less than 12 months ago' were classified as Recently Homeless—this group forms the focus of the two results chapters examining the correlates of veteran homelessness (Chapters 4 and 5).

Assistance and barriers to assistance for homelessness

Respondents who had ever experienced homelessness were asked about the kind of assistance or services they may have accessed, such as housing service providers, crisis accommodation or supported accommodation assistance programs. Those who did not seek assistance were asked to specify a reason (e.g. did not know of any services, or did not trust support services).

It is important to understand a significant limitation of these questions in analysing homelessness among transitioned veterans. The question regarding recency of most recent homelessness episode was categorical, and suffered from a lack of precision, in that there were only five time periods given as response options, with some time periods being quite wide (e.g. '2 years to 5 years ago'). Thus, when combined with dates relating to the beginning and end of full-time Regular military service (in calendar years, e.g. 2012), it could not always be determined whether homelessness had occurred prior to, during, or after full-time Regular military service. For example, given that surveys were completed in 2015, homelessness in relation to transition could not be determined for a veteran who transitioned in 2012 and was homeless 2–5 years ago (i.e. at some point between 2010 and 2013). As this was the case for 47 per cent of the veterans who were Recently Homeless (i.e. during the last 12 months), such a variable had too much noise to be considered for further use. Thus, in our results, we only discuss homelessness in relation to lifetime and previous 12 months, and not in relation to transition. While it is likely that the majority of Recently Homeless Transitioned ADF had experienced this homelessness post transition, the survey responses were unable to verify this.

2.6.2 Demographic, service and transition characteristics

Respondents were asked about the following demographic information: age, sex, relationship status, education, employment status, main source of income, and whether they had been living in stable housing (that they owned, rented or stayed in as part of a household) over the past two months. They were also asked about the following service characteristics (that applied to them on transition from the Regular ADF): rank attained (Officer, Non-commissioned Officer or other rank); the service in which they served; how their medical fitness was classified; how long they served in the Regular ADF; and whether they had ever been deployed. The following transition characteristics were also assessed: their transition serving status (Ex-serving, Active or Inactive Reservist), the years since they had transitioned, their type of discharge (medical or other), the main reason they gave for transition, and their DVA client status.

2.6.3 Civilian employment and DVA support

Respondents were asked whether they were employed in a civilian job or not, and if so, how many hours they had worked in the past week and in what employment industry. They were also asked whether they had had a 3-month period of unemployment since transition, had been supported by DVA since transition (if they had a gold card or a white card), and had any problems paying money that they owed, and were also asked to categorise their financial situation.

2.6.4 Ex-service organisation and voluntary group membership, and criminal behaviour

Respondents were asked about the number of ESOs and other voluntary groups they had joined. Respondents were also asked about their criminal behaviour since they had transitioned, regarding being arrested, convicted or imprisoned for a crime.

2.6.5 Gambling and driving behaviour

Gambling

Respondents completed the Problem Gambling Severity Index (PGSI) (Stinchfield, 2007), a widely used nine-item scale for measuring the severity of gambling problems in the general population. Each item is scored from 0 to 3, with items summed to create a total score: the higher the total score, the greater the risk of problem gambling behaviour.

Driving

Respondents completed three items examining risky driving—specifically regarding driving over the speed limit and driving while affected by alcohol—which were sourced from the Australian Institute of Family Studies (AIFS) (Smart et al., 2005). Participants were asked to consider the last 10 times they drove, and indicate how many times in that period they engaged in risky driving behaviour. These three items were summed to create a total risky driving score.

2.6.6 Psychosocial characteristics and resilience

Respondents completed a scale that assessed social strain (i.e. negative social interactions) and social support (i.e. positive social interactions) from family and friends (Schuster et al., 1990). Respondents completed two parallel sets of five items (two regarding support and three regarding strain) in reference to (1) family and (2) friends. Higher total scores on these constructs indicate greater social strain and greater social support.

Respondents completed Ohio State University's Brief Resilience Scale (BRS) (Smith et al., 2008), which assesses the ability to bounce back or recover from stress. Respondents were asked to indicate the extent to which they agreed with six statements (e.g. 'I tend to bounce back quickly after tough times') on a five-point scale. All items were summed (after reverse-scoring some items) and then averaged to create a total score.

2.6.7 Recent life events and traumatic life events

Respondents were asked about life events that they may have experienced in the past 12 months, using a modified 15-item version of the List of Threatening Experiences (Brugha et al., 1985). Participants were asked to indicate 'yes' if the event had occurred in the last 12 months. Examples of events include: 'your parent, child or spouse died', 'you had a major financial crisis' and 'you broke off a steady relationship'. Items were examined individually, as well as being summed to create a total recent life event count score.

Respondents were also asked to indicate which traumatic events they had experienced in their lifetime, using a 27-item checklist that was adapted from the Post-traumatic Stress Disorder (PTSD) module of the Composite International Diagnostic Interview version 3 (CIDI 3.0) (Haro et al., 2006). The listed traumas included: participating in combat, exposure to toxic substances, involvement in a life-threatening motor vehicle

accident, being sexually assaulted or molested, and an 'other' category. Items were examined individually, as well as being summed to create a total trauma exposure count score.

2.6.8 Tobacco and drug use

Respondents were asked questions assessing tobacco usage, taken from the 2013 National Drug Strategy Survey (Australian Institute of Health and Welfare, 2014b) and the 2010 MHPWS (McFarlane et al., 2011). Specifically, participants were asked a series of questions about their past and present tobacco use, including frequency of use, the ages they started and stopped smoking daily, and the types of tobacco products they had smoked in the last year. Based on these responses, participants were classed as a 'current smoker', 'former smoker' (had smoked at least 100 cigarettes in their lifetime but do not currently smoke), 'tried smoking' (had smoked a full cigarette or equivalent but had not smoked at least 100 cigarettes) or 'non-smoker' (had never smoked a full cigarette or equivalent).

Recent (during the past 12-months) and lifetime drug use was assessed using modified items from the 2013 National Drug Strategy Survey (Australian Institute of Health and Welfare, 2014b). Transitioned ADF were asked a series of questions about two categories of drugs: (1) illicit drugs (including meth/amphetamines, marijuana, heroin, methadone or buprenorphine, cocaine, hallucinogens, ecstasy, ketamine, GHB, inhalants, opiates, opioids); and (2) prescription-type drugs (including painkillers/analgesics, tranquilisers/sleeping pills) for non-medical purposes (where the term non-medical purposes was defined as either alone or with other drugs in order to induce or enhance a drug experience). Participants were asked if they had ever used these drugs in their lifetime or in the last 12 months, and the age that they first used them.

2.6.9 Mental health and wellbeing

The following mental health problems were assessed using validated checklists, as described below.

Post-traumatic stress disorder (PTSD) symptoms

The Post-traumatic Stress Disorder (PTSD) Checklist—civilian version (PCL-C) (Weathers et al., 1993) was used to examine symptoms of post-traumatic stress. The PCL-C is a 17-item self-report measure designed to assess the symptomatic criteria of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). The 17 questions of the PCL-C are scored from 1 to 5 and are summed to give a total symptom severity score of between 17 and 85. An additional four items from the newly released PCL-5 were also included, giving researchers flexibility to also measure PTSD symptoms according to the most recent definitional criteria.

Psychological distress

The Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) was used to measure psychological distress. The K10 is a short 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent four-week period. Items are scored from 1 to 5 and are summed to give a total score between 10 and 50. Various methods have been used to stratify the scores of the K10. The categories of low (10–15), moderate (16–21), high (22–29) and very high (30–50) that are used in this report are derived from the K10 cut-offs used in the 2007 ABS National Survey of Mental Health

and Wellbeing (Slade et al., 2009) and were used to identify levels of psychological distress in the 2010 MHPWS (McFarlane et al., 2011).

At-risk drinking behaviour

The Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993) was used to examine at-risk patterns of drinking. The AUDIT is a brief self-report screening instrument developed by the World Health Organization (WHO). This instrument consists of 10 questions that examine the quantity and frequency of alcohol consumption, possible symptoms of dependence, and reactions or problems related to alcohol. The AUDIT is an instrument that is widely used in epidemiological and clinical practice for defining at-risk patterns of drinking (Babor et al., 2001). Currently the recommended WHO risk categories are utilised with ADF populations and are therefore the scoring categories utilised in this study. This process identifies four bands of risk: Band 1 (scores of 0–7) represents those who would benefit from alcohol education; Band 2 (8–15) represents those who are likely to require simple advice; Band 3 (scores of 16–19) represents those for whom counselling and continued monitoring is recommended; Band 4 (Scores of 20–40) represent those who require diagnostic evaluation and treatment, including counselling and monitoring (Babor et al., 1989; Babor et al., 2001). Two supplementary items of the AUDIT were also included in the questionnaire, as well as additional items on consumption, to ensure comparability with the Australian Health Survey 2011–12 (Australian Bureau of Statistics, 2012b).

Depression symptoms

Self-reported depression was examined using the Patient Health Questionnaire—9 (PHQ-9) (Kroenke et al., 2001). The nine items of the PHQ-9 are scored from 0–3 and summed to give a total score between 0 and 27. The PHQ-9 provides various levels of diagnostic severity, with higher scores indicating higher levels of depression symptoms.

Suicidal ideation and behaviour

Suicidal ideation and behaviour over the previous 12 months was assessed via four items that looked specifically at suicidal thoughts, plans and attempts. Three of the items in this section were adapted from the National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2008) and the final item was devised by researchers for use in the current study.

Generalised anxiety

The Generalised Anxiety Disorder seven-item scale (GAD-7) was used to examine symptoms of Generalised Anxiety Disorder (Spitzer et al., 2006). Respondents were instructed to rate the amount of time they had experienced each one of the seven symptoms during the last two weeks. The seven questions were scored from 1–3, whereby the respondent must indicate how often they have been feeling that way: not at all (0); several days (1); more than half the days (2); or nearly every day (3). Scores for the seven questions were summed to give a total score between 0 and 21.

Anger

The five-item Dimensions of Anger Reaction scale (DAR-5) (Forbes et al., 2004) assesses anger frequency, intensity, duration, and the perceived negative impact on social relationships, as rated over the past four weeks. Items are summed to create a total score of 5–25, with higher scores indicating a higher frequency of anger. This scale has been used in Australian Vietnam veterans, and US Afghanistan and Iraq

veterans, and shows strong unidimensionality, and high levels of internal consistency and criterion validity (Forbes et al., 2004).

3 Lifetime and recent (12-month) homelessness in Transitioned ADF veterans

Key findings

→ In the Transitioned ADF, 1 in 5 (21.7%) reported experiencing homelessness in their lifetime, and 1 in 20 reported experiencing homelessness in the previous 12 months (5.3%). In the general Australian population (aged 15 years and older), the equivalent number of people experiencing homelessness in their lifetime is 2.5 million (13%), with 351,000 (1.9%) having experienced homelessness in the previous 12 months (Australian Bureau of Statistics, 2014a).

Of those who had ever experienced homelessness (i.e. lifetime homelessness):

→ the majority reported experiencing one or two episodes of homelessness in their life (62.7%)

→ the vast majority had experienced an episode of homelessness within the previous five years (82.5%), and almost one in three reported an episode of homelessness in the preceding 12 months (28.4%)

→ in most cases, the most recent episode of homelessness lasted three months or less (51.7%), but a sizeable minority (15.5%) reported a more chronic homelessness experience (i.e. six months or more)

→ the most commonly cited reason for lifetime homelessness was 'family/friend/relationship problems' (40.7%), followed by 'financial problems' (34.6%), and then 'mental illness' (20.4%).

→ the vast majority of those who had experienced homelessness in the last 12 months reported that they had not sought assistance for their homelessness (61.0%); where assistance was sought, Transitioned ADF most frequently reported accessing job services, mental health services and counselling, and then housing service providers

→ those who had sought assistance were most likely to report that this assistance was not helpful (47.1%)

→ among those who did not seek assistance, the most commonly reported reason was that support was not required (54.3%); while nearly one in three reported that they did not seek support because they didn't know of any support services (26.1%); and just over one in six reported not trusting support services (17.4%).

3.1 Introduction

Chapter 3 provides the estimated prevalence of lifetime and recent (12-month) homelessness, and the characteristics of this homelessness, among the Transitioned

ADF. Outcomes are weighted up to the entire population, using the technique described in Chapter 2 of this report, and thus represent estimates of these characteristics for the entire Transitioned ADF (N=24,932).

The following research questions are addressed in this chapter.

- → What is the estimated prevalence of self-reported lifetime homelessness among contemporary transitioned veterans?
- → What is the estimated prevalence of self-reported recent (12-month) homelessness among contemporary transitioned veterans?
- → What are the characteristics of contemporary transitioned veterans with lifetime and recent (12-month) homelessness, including: reasons for homelessness, number of episodes of homelessness, recency and duration of homelessness episodes, help-seeking and barriers to accessing assistance?
- → Is there a significant difference between the estimated prevalence of self-reported lifetime homelessness and recent (12-month) homelessness among contemporary transitioned veterans?
- → Is there a significant difference between the characteristics of contemporary transitioned veterans with self-reported lifetime homelessness and recent (12-month) homelessness?

3.2 Lifetime homelessness in the Transitioned ADF

3.2.1 Prevalence of lifetime homelessness in the Transitioned ADF

Table 2 presents the estimated proportion of the Transitioned ADF that had ever experienced homelessness.

Among the Transitioned ADF, approximately 1 in 5 reported experiencing homelessness in their lifetime (21.7%), compared to 1 in 3 (13%) in the general population, and 1 in 6 (15.7%) reported being without a permanent place to live for reasons of personal choice.

Table 2: Estimated prevalence of lifetime homelessness in the Transitioned ADF

	Transitioned ADF N = 24,932		
Lifetime homelessness status	**n**	**Weighted N**	**% (95% CI)**
Never homeless or without a permanent place to live	2,803	14,551	58.4 (56.6, 60.1)
Homeless	798	5,400	21.7 (20.2, 23.2)
Without a permanent place to live	565	3,910	15.7 (14.3, 17.1)

Denominator: Transitioned ADF cohort.
Note: Approximately 4.0% of Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.2.2 Reasons for lifetime homelessness in the Transitioned ADF

Table 3 presents the estimated proportion of Transitioned ADF who had ever been homeless, by the reasons for their homelessness.

Of the 10 listed reasons for lifetime homelessness, five were frequently provided by homeless veterans. By far the most commonly cited reason for homelessness was 'family/friend/relationship problems' (40.7%), which was followed by 'financial problems' (34.6%), experienced by approximately 1 in 3 homeless veterans, and then 'mental illness' (20.4%), 'lost job' (20.3%) and 'tight housing/rental market' (18.3%), which were all experienced by approximately 1 in 5 homeless veterans.

Table 3: Estimated reasons for lifetime homelessness in the Transitioned ADF

	Transitioned ADF n = 5,400		
Reasons for no permanent place to live	**n**	**Weighted n**	**% (95% CI)**
Tight housing/rental market	133	987	18.3 (15.1, 22.0)
Violence/abuse/neglect	60	362	6.7 (5.0, 9.0)
Alcohol or drug use	65	478	8.9 (6.7, 11.6)
Family/friend/relationship problems	335	2,197	40.7 (36.5, 45.0)
Financial problems (e.g. unable to pay mortgage or rent)	260	1,865	34.6 (30.5, 38.8)
Mental illness	172	1,100	20.4 (17.4, 23.7)
Lost job	137	1,096	20.3 (17.0, 24.1)
Gambling	12	80	1.5 (0.8, 2.8)
Eviction	24	170	3.2 (1.9, 5.1)
Natural disaster	#	-	-
Other	127	815	15.1 (12.3, 18.4)

Denominator: Transitioned ADF cohort who had ever been homeless.
 # Cell size too small to be reported.

3.2.3 Number of homelessness episodes over the lifetime in the Transitioned ADF

Table 4 presents the estimated proportion of Transitioned ADF who had ever been homeless, by how many times they had been homeless during their lifetime.

The majority of the Transitioned ADF (62.7%) who reported being homeless in their lifetime had been homeless only once or twice, with smaller proportions of homeless veterans having experienced repeated episodes of homelessness in their lifetime.

Table 4: Estimated number of homelessness episodes over the lifetime in the Transitioned ADF

Times with no permanent place to live	Transitioned ADF n = 5,400		
	n	Weighted n	% (95% CI)
One	344	2,233	41.4 (37.2, 45.6)
Two	178	1,151	21.3 (18.0, 25.0)
Three	80	569	10.5 (8.1, 13.6)
Four	19	147	2.7 (1.6, 4.7)
Five or more	59	355	6.6 (4.9, 8.9)
Don't know	80	615	11.4 (8.9, 14.5)

Denominator: Transitioned ADF cohort who had ever been homeless.
Note: Approximately 6.0% of Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.3 Most recent episode of homelessness in the Transitioned ADF

3.3.1 Reasons for most recent episode of homelessness in the Transitioned ADF

Table 5 presents the estimated proportion of Transitioned ADF who had ever been homeless, by the reasons for their most recent episode of homelessness. Overall, the Transitioned ADF were most likely to state that 'financial problems (e.g. unable to pay mortgage or rent)' (14.5%) was the reason for their most recent episode, followed by 'family/friend/relationship problems' (14.0%), then 'mental Illness' (12.6%).

Table 5: Estimated reasons for most recent episode of lifetime homelessness in the Transitioned ADF

Reasons for most recent episode of homelessness	Transitioned ADF n = 5,400		
	n	Weighted n	% (95% CI)
Tight housing/rental market	34	255	5.5 (3.6, 8.3)
Violence/abuse/neglect	23	150	3.2 (2.0, 5.3)
Alcohol or drug use	36	257	5.5 (3.8, 8.1)
Family/friend/relationship problems	102	650	14.0 (11.2, 17.5)
Financial problems (e.g. unable to pay mortgage or rent)	90	673	14.5 (11.4, 18.3)
Mental illness	89	583	12.6 (10.0, 15.7)
Lost job	34	279	6.0 (4.0, 9.0)
Gambling	6	35	0.8 (0.3, 1.9)
Eviction	6	59	1.3 (0.5, 3.3)
Natural disaster	#	-	-
Other	17	123	2.7 (1.5, 4.8)

Denominator: Transitioned ADF cohort who had ever been homeless.
 # Cell size too small to be reported.

3.3.2 Recency of most recent episode of homelessness in the Transitioned ADF

Table 6 presents the estimated proportion of Transitioned ADF who had ever been homeless, by how long ago their last episode of homelessness occurred.

The vast majority of Transitioned ADF had experienced an episode of homelessness within the previous five years (82.5%), and almost one in three reported an episode of homelessness in the preceding 12 months (28.4%).

Table 6: Estimated recency of most recent episode of lifetime homelessness in the Transitioned ADF

Recency of most recent episode of homelessness	Transitioned ADF n = 5,400		
	n	Weighted n	% (95% CI)
Less than 12 months ago	201	1,317	28.4 (24.4, 32.8)
12 months to less than 2 years	147	1,082	23.3 (19.5, 27.6)
2 years to less than 5 years	187	1,430	30.8 (26.6, 35.4)
5 years to less than 10 years	58	350	7.6 (5.5, 10.3)
10 years or more	85	313	6.7 (5.5, 8.2)
Don't know	15	130	2.8 (1.6, 4.9)

Denominator: Transitioned ADF cohort who had ever been homeless.
Note: Approximately 0.5% of Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.3.3 Duration of most recent episode of homelessness in the Transitioned ADF

Table 7 presents the estimated proportion of Transitioned ADF who had ever been homeless, by how long their most recent period of homelessness lasted.

In most cases, the most recent episode of homelessness lasted three months or less (51.8%), but a sizeable minority (15.5%) of 'ever homeless' veterans reported a more chronic homelessness experience (i.e. six months or more).

Table 7: Estimated duration of most recent period of homelessness in the Transitioned ADF

Duration of recent episode of homelessness	Transitioned ADF n = 5,307		
	n	Weighted n	% (95% CI)
Less than 1 week	74	561	12.1 (9.3,1 5.6)
1 week to less than 2 weeks	52	472	10.2 (7.5, 13.6)
2 weeks to less than 4 weeks	72	479	10.3 (7.8, 13.5)
1 month to less than 2 months	87	564	12.2 (9.5, 15.5)
2 months to less than 3 months	59	327	7.0 (5.1, 9.6)
3 months to less than 4 months	99	721	15.5 (12.4, 19.3)
4 months to less than 5 months	30	166	3.6 (2.2, 5.7)
5 months to less than 6 months	38	260	5.6 (3.9, 8.1)
6 months or more	99	721	15.5 (12.4, 19.3)
Don't know	27	238	5.1 (3.3, 7.9)

Denominator: Transitioned ADF cohort who had ever been homeless.
Note: Approximately 9.0% of the Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.3.4 Assistance sought for most recent episode of homelessness in the Transitioned ADF

Table 8 presents the estimated proportion of Transitioned ADF who had ever been homeless, by any services from which they sought assistance when most recently homeless.

Overwhelmingly, the Transitioned ADF were most likely to report that they had sought no assistance (61.0%). Among the services accessed, the most frequently reported were job services (9.2%), mental health services (7.6%), and counselling (6.7%), followed by housing service providers (6.4%).

Table 8: Estimated types of assistance sought for most recent episode of lifetime homelessness in the Transitioned ADF

Assistance sought for most recent episode of homelessness	Transitioned ADF n = 5,400		
	n	Weighted n	% (95% CI)
Housing service providers	40	297	6.4 (4.5, 9.2)
Crisis accommodation	14	88	1.9 (1.1, 3.4)
Mental health service	62	353	7.6 (5.8, 10.0)
Church or community organisation (St Vincent de Paul, Salvation Army, etc.)	18	111	2.4 (1.3, 4.3)
Health service	31	187	4.0 (2.7, 6.1)
Job service	46	427	9.2 (6.7, 12.6)
Counselling service	53	309	6.7 (4.9, 9.1)
Supported accommodation assistance program	#	-	-
Shelter	7	37	0.8 (0.3, 2.0)
Solicitor/legal aid	17	108	2.3 (1.4, 4.0)
Hospital	20	123	2.6 (1.6, 4.4)
Police	10	74	1.6 (0.8, 3.2)
Other	45	307	6.6 (4.7, 9.3)
No	396	2,828	61.0 (56.5, 65.2)

Denominator: Transitioned ADF cohort who had ever been homeless.
 # Cell size too small to be reported.

3.3.5 Helpfulness of assistance services for most recent episode of homelessness in the Transitioned ADF

Table 9 presents the estimated proportion of Transitioned ADF who had sought assistance for their most recent episode of homelessness, by whether the services were helpful.

Homeless veterans who had sought assistance were most likely to report that this assistance was not helpful (47.1%).

Table 9: Estimated helpfulness of assistance services for most recent episode of lifetime homelessness in the Transitioned ADF

Assistance helpful for most recent episode of homelessness	Transitioned ADF n = 1,323		
	n	Weighted n	% (95% CI)
Yes	78	485	37.7 (29.8, 46.4)
No	78	606	47.1 (38.5, 56.0)
Don't know	27	167	13.0 (8.3, 19.8)

Denominator: Transitioned ADF cohort who received assistance.
Note: Approximately 2.0% of Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.3.6 Barriers to assistance for most recent episode of homelessness in the Transitioned ADF

Table 10 presents the estimated proportion of Transitioned ADF who had not sought assistance for their most recent episode of homelessness, by reasons why they did not seek assistance.

Among those who did not seek assistance, the most commonly reported reason was that support was not required (54.3%). Nearly 1 in 3 reported that they did not seek support because they didn't know of any support services (28.5%), and just over 1 in 10 reported not trusting support services (12.7%).

Table 10: Estimated barriers to assistance for most recent episode of lifetime homelessness in the Transitioned ADF

Reasons for not seeking assistance	Transitioned ADF n = 1,323		
	n	Weighted n	% (95% CI)
Did not know of any	95	805	28.5 (23.1, 34.5)
Do not trust support services	54	359	12.7 (9.2, 17.3)
Could not find one	#	-	-
Service was full	#	-	-
Refused help	28	227	8.0 (5.3, 12.0)
Bad experience with service in the past	30	222	7.9 (5.1, 11.9)
No need/not required	224	1,535	54.3 (48.2, 60.3)
Other	41	280	9.9 (6.8, 14.2)

Denominator: Transitioned ADF cohort who received no assistance.
 # Cell size too small to be reported.

3.4 Recent (12-month) homelessness in the Transitioned ADF

3.4.1 Prevalence of recent (12-month) homelessness in the Transitioned ADF

Table 11 presents the estimated proportion of Transitioned ADF by recent (12-month) homelessness status, which was coded according to whether any recent episodes of homelessness indicated were specified as 'less than 12 months ago'.

Approximately 1 in 20 of the Transitioned ADF (5.3%) reported having been homeless in the last 12 months. This is compared to 351,000 (1.9%) in the general Australian population aged over 15 years (Australian Bureau of Statistics, 2014a).

Table 11: Estimated prevalence of recent (12-month) homelessness in the Transitioned ADF

	Transitioned ADF N = 24,932		
Homelessness in the last 12 months	**n**	**Weighted n**	**% (95% CI)**
Yes	201	1,317	5.3 (4.5, 6.2)
No	4,059	23,235	93.2 (92.2, 94.1)

Denominator: Transitioned ADF cohort.
Note: Approximately 1.5% of Transitioned ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

3.4.2 Reasons for recent (12-month) homelessness in the Transitioned ADF

Table 12 presents the estimated proportion of Transitioned ADF who had been homeless in the last 12 months, by the reasons for their homelessness. Overall, the Transitioned ADF were most likely to state that 'mental illness' (21.1%) was the reason for their homelessness in the last 12 months, followed by 'family/friend /relationship problems' (18.8%), and then 'financial problems (e.g. unable to pay mortgage or rent)' (16.2%).

Table 12: Estimated reasons for recent (12-month) homelessness in the Transitioned ADF

	Transitioned ADF n = 1,317		
Reasons for no permanent place to live	**n**	**Weighted n**	**% (95% CI)**
Tight housing/rental market	8	64	4.9 (1.9, 11.7)
Violence/abuse/neglect	8	28	2.2 (1.0, 4.4)
Alcohol or drug use	13	88	6.7 (3.5, 12.4)
Family/friend/relationship problems	41	247	18.8 (13.2, 26.0)
Financial problems (e.g. unable to pay mortgage or rent)	32	214	16.2 (10.5, 24.3)

Reasons for no permanent place to live	Transitioned ADF n = 1,317		
	n	Weighted n	% (95% CI)
Mental illness	46	278	21.1 (15.5, 28.1)
Lost job	11	86	6.6 (3.0, 13.6)
Gambling	#	-	-
Eviction	#	-	-
Natural disaster	#	-	-
Other (please specify)	7	53	4.0 (1.6, 9.9)

Denominator: Transitioned ADF cohort who were homeless in last 12 months.
 # Cell size too small to be reported.

3.4.3 Duration of recent (12-month) homelessness episode in the Transitioned ADF

Table 13 presents the estimated proportion of Transitioned ADF who had been homeless in the last 12 months, by how long their most recent period of homelessness lasted.

In most cases, veterans' homelessness episodes in the last 12 months lasted three months or less (51.8%), and a sizeable proportion of these (45.7%) could be termed 'transitional' (i.e. lasting less than one month). A sizeable minority (18.5%) reported a more chronic homelessness experience (i.e. six months or more).

Table 13: Estimated duration of recent (12-month) homelessness episode in the Transitioned ADF

Duration of recent episode of homelessness	Transitioned ADF n = 1,317		
	n	Weighted n	% (95% CI)
Less than 1 week	35	256	19.4 (13.2, 27.6)
1 week to less than 2 weeks	22	188	14.3 (9.1, 21.8)
2 weeks to less than 4 weeks	23	158	12.0 (7.1, 19.6)
1 month to less than 2 months	30	156	11.8 (7.6, 18.0)
2 months to less than 3 months	16	90	6.8 (3.6, 12.6)
3 months to less than 4 months	14	93	7.1 (3.6, 13.4)
4 months to less than 5 months	8	43	3.3 (1.3, 8.4)
5 months to less than 6 months	6	28	2.1 (0.8, 5.2)
6 months or more	36	243	18.5 (12.3, 26.9)
Don't know	11	61	4.6 (2.3, 9.1)

Denominator: Transitioned ADF cohort who were homeless in last 12 months.
 # Cell size too small to be reported.

3.4.4 Assistance sought for recent (12-month) homelessness episode in the Transitioned ADF

Table 14 presents the estimated proportion of Transitioned ADF who had been homeless in the last 12 months, by any services from which they sought assistance when they were most recently homeless.

Overall, the Transitioned ADF were most likely to report that they had 'no' assistance (61.2%). Where assistance was sought, Transitioned ADF most frequently reported accessing job services (12.1%), mental health services (11.0%), and counselling (7.8%), and then housing service providers (7.3%).

Table 14: Estimated type of assistance sought for recent (12-month) homelessness episode in the Transitioned ADF

Assistance sought for most recent episode of homelessness [a]	Transitioned ADF n = 1,317		
	n	Weighted n	% (95% CI)
Housing service providers	11	96	7.3 (4.0, 13.0)
Crisis accommodation	#	-	-
Mental health service	27	144	11.0 (6.9, 16.9)
Church or community organisation (St Vincent de Paul, Salvation Army, etc.)	9	50	3.8 (1.6, 8.5)
Health service	9	41	3.2 (1.3, 7.6)
Job service	15	159	12.1 (7.0, 20.0)
Counselling service	19	103	7.8 (4.5, 13.4)
Supported accommodation assistance program	#	-	-
Shelter	#	-	-
Solicitor/legal aid	6	35	2.7 (0.9, 7.5)
Hospital	7	50	3.8 (1.5, 9.3)
Police	#	-	-
Other	13	85	6.5 (3.3, 12.3)
None	143	869	61.2 (52.9, 69.0)
Assistance helpful for most recent episode of homelessness [b]			
No	32	225	48.1 (34.5, 62.1)
Yes	28	178	37.9 (25.4, 52.3)
Don't know	11	65	14.0 (7.0, 26.0)

[a]Denominator: Transitioned ADF cohort who were homeless in last 12 months.
[b]Denominator: Transitioned ADF cohort who were homeless in last 12 months and sought assistance.
 # Cell size too small to be reported.

3.4.5 Barriers to assistance for recent (12-month) homelessness in the Transitioned ADF

Table 15 presents the estimated proportion of Transitioned ADF who had had been homeless in the last 12 months and had not sought homelessness assistance, by reasons why they did not seek assistance.

The majority of Transitioned ADF responded that they had 'no need/ not required' support (53.8%). Following that, just over one in four reported that they did not seek support because they 'did not know of any' (26.1%), and just over one in six reported not trusting support services (17.4%).

Table 15: Estimated barriers to assistance for recent (12-month) homelessness in the Transitioned ADF

	Transitioned ADF n = 807		
Reasons for not seeking assistance	**n**	**Weighted n**	**% (95% CI)**
Did not know of any	29	211	26.1 (17.6, 37.0)
Do not trust support services	26	140	17.4 (11.7, 25.2)
Could not find one	#	-	-
Service was full	#	-	-
Was refused help	8	58	7.2 (3.3,14.8)
Bad experience with service in the past	9	56	6.9 (3.2, 14.2)
No need/not required	69	434	53.8 (43.1, 64.2)
Other	18	120	14.9 (8.3, 25.6)

Denominator: Transitioned ADF cohort who were homeless in last 12 months who did not seek assistance.
 # Cell size too small to be reported.

4 Demographic, service and psychosocial characteristics of Transitioned ADF veterans with recent (12-month) homelessness

4.1 Key findings

Demographic factors

Compared with Not Recently Homeless veterans (no episode of homelessness in the past 12 months), Recently Homeless veterans
(i.e. homeless during the last 12 months) were:

→ significantly younger

→ less likely to be in a relationship

→ less likely to have higher education levels

→ more likely to be unemployed or underemployed

→ more likely to be experiencing financial strain

→ less likely to be financially comfortable

→ more concerned about having stable housing in the next two months.

Military service factors

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ more likely to be of lower rank

→ less likely to have served in the air force

→ more likely to be classed as medically unfit

→ more likely to have served for a shorter length of time.

Transition and civilian employment factors

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ more likely to now be completely Ex-serving, and less likely to now be Active Reservists

→ more likely to have transitioned out of service within the previous 12 months

→ more likely to have been medically discharged

→ less likely to have discharged at their own request

→ more likely to be unemployed, and have had a period of unemployment greater than three months since transition

→ more likely to report financial strain.

Social connectedness

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ less likely to have joined ESOs and other voluntary groups (statistical trend only)

→ more likely to report lower family and friend social support, and higher family and friend social strain, and show an overall pattern of less family and friend contact

→ more likely to report lower levels of satisfaction with partners, children and friends.

Risky behaviours

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ more likely to report engaging in risky driving and risky gambling behaviour

→ more likely to have been arrested or convicted.

Recent life events and lifetime trauma

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ more likely to report experiencing numerous recent life events; in particular, events that involved the self or partner

→ more likely to report a greater number of lifetime traumatic events.

Tobacco and drug use

Compared with Not Recently Homeless veterans, Recently Homeless veterans were:

→ more likely to be current smokers, and less likely to be former smokers

→ more likely to have used recreational or prescription-type drugs for non-medicinal purposes.

4.2 Introduction

Chapter 4 provides a detailed summary of the demographic, Service, psychosocial and health risk characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless (no episode of homelessness in the past 12 months) Transitioned ADF. Outcomes are weighted up to the entire population, using the technique described in Chapter 2, and thus represent weighted estimates of these characteristics for the entire Transitioned ADF (N=24,932).

The following research questions are addressed in this chapter.

1. What are the characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, veterans? Characteristics examined include: demographic, Service and transition attributes; information regarding civilian employment and DVA support; ESO engagement; criminal, driving and gambling behaviour; psychosocial characteristics; recent life events and traumatic events; and tobacco and drug use.
2. Is there a significant difference between the demographic, Service and psychosocial characteristics of Recently Homeless veterans and Not Recently Homeless veterans?

4.3 Basic demographic characteristics of Transitioned ADF with recent (12-month) homelessness

Table 16 presents various demographic characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless (no episode of homelessness in the past 12 months) Transitioned ADF.

In terms of age, there was an overall trend where Recently Homeless veterans were more likely to be in the two youngest age groups (and less likely to be in the older age groups) than Not Recently Homeless veterans. Recently Homeless veterans were significantly more likely to be aged 18–27 years (37.8% vs 19.6%), and significantly less likely to be aged 48–57 years (5.5% vs 14.0%), or 58-plus years (1.4% vs 8.2%).

While a slightly higher proportion of Recently Homeless than Not Recently Homeless veterans were women, this difference was not significant.

For relationship status, Recently Homeless veterans were significantly less likely to be in a relationship compared with Not Recently Homeless veterans (44.9% vs 76.4%). When broken down further, this difference was mostly due to Recently Homeless veterans being sizeably and significantly less likely to be ‘married (living together)’ (19.0% vs 49.3%). While Recently Homeless veterans were slightly more likely than Not Recently Homeless veterans to be in the two relationship categories involving ‘not living together’, the differences between the groups were very small, in categories that were low-prevalence overall, and were not statistically significant.

There was a trend for Recently Homeless veterans to have slightly lower educational qualifications overall than Not Recently Homeless veterans, with a slightly larger proportion of Recently Homeless than Not Recently Homeless veterans having attained only secondary school or certificate-level education. However, none of the differences for the individual response categories were statistically significant.

Regarding employment, compared with the Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to be ‘not working (receiving sickness allowance/disability)’ (24.9% vs 8.0%) or ‘unemployed/looking for work’ (14.4% vs 4.6%), and significantly less likely to have ‘full-time work greater >= 30 hours’ (35.2% vs 58.5%) or be retired (1.6% vs 5.8%).

Recently Homeless veterans were significantly more likely than Not Recently Homeless veterans to report their main source of income as being an ‘invalidity service pension’

(13.6% vs 4.9%), 'MRCA compensation'[8] (7.9% vs 3.7%) or 'other allowance' (12.5% vs 4.0%), and significantly less likely to report their main source of income as 'wage/salary' (37.9% vs 62.0%) or 'age service pension' (0.2% vs 3.8%).

Recently Homeless veterans were significantly more likely to report being concerned/worried regarding having stable housing in the next two months than Not Recently Homeless veterans (45.0% vs 9.4%).

Table 16: Estimated demographic characteristics in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Age group [a]						
18–27	53	498	37.8 (29.9, 46.4)	404	4,556	19.6 (18.0, 21.3)
28–37	78	499	37.9 (30.2, 46.2)	1,167	8,217	35.4 (33.6,37.2)
38–47	47	200	15.2 (11.0, 20.5)	1,057	4,952	21.3 (20.0, 22.7)
48–57	13	73	5.5 (2.8, 10.5)	843	3,249	14.0 (13.1, 14.9)
58+	6	18	1.4 (0.7, 2.6)	538	1,906	8.2 (7.6, 8.8)
Sex						
Male	160	1,082	82.2 (75.7, 87.2)	3,431	20,253	87.2 (86.8, 87.5)
Female	41	235	17.8 (12.8, 24.3)	628	2,982	12.8 (12.5, 13.2)
Relationship status [a]						
Yes, de facto (living together)	27	171	13.0 (8.3, 19.8)	599	4,327	18.6 (17.1, 20.2)
Yes, in a relationship (not living together)	21	133	10.1 (6.1, 16.3)	194	1,616	7.0 (5.9, 8.1)
Yes, married (living together)	43	250	19.0 (13.6, 25.8)	2,410	11,455	49.3 (47.5, 51.1)
Yes, married (not living together)	9	37	2.8 (1.4, 5.5)	70	342	1.5 (1.1, 1.9)

[8] Compensation under the Military Rehabilitation and Compensation Act.

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No, not in a relationship	99	694	52.7 (44.5, 60.8)	705	4,969	21.4 (19.8, 23.1)
Education [a]						
Primary school	#	-	-	7	24	0.1 (0.1, 0.2)
Secondary school, up to grade 10	13	133	10.1 (5.6, 17.5)	282	1,565	6.7 (5.9, 7.7)
Secondary school, grades 11–12	42	353	26.8 (19.8, 35.1)	648	4,881	21.0 (19.4, 22.7)
Certificate	48	414	31.4 (24.0, 39.9)	911	6,672	28.7 (27.0, 30.5)
Diploma	53	241	18.3 (13.6, 24.2)	992	4,902	21.1 (19.8, 22.5)
Bachelor	21	83	6.3 (3.7, 10.5)	419	2,022	8.7 (7.8, 9.7)
Post-graduate qualification	23	80	6.1 (4.0, 9.1)	741	2,820	12.1 (11.3, 13.0)
Employment status [a]						
Full-time work greater >= 30 hours	75	463	35.2 (27.8, 43.4)	2248	13,601	58.5 (56.8, 60.3)
Have a job but not at work (illness/ vacation)	#	-	-	30	179	0.8 (0.5, 1.2)
Home duties	#	-	-	102	521	2.2 (1.8, 2.8)
Not working (sickness allowance/ disability)	55	328	24.9 (18.8, 32.2)	351	1,865	8.0 (7.2, 9.0)
Part-time work < 30 hours	17	111	8.4 (4.7, 14.6)	496	2,435	10.5 (9.5, 11.6)
Retired	6	21	1.6 (0.8, 3.4)	366	1,335	5.8 (5.2, 6.3)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Student attending university	14	136	10.4 (5.9, 17.6)	173	1,443	6.2 (5.3, 7.3)
Student attending school	#	-	-	15	128	0.6 (0.3, 1.0)
Unemployed /looking for work	24	190	14.4 (9.2, 22.0)	167	1,062	4.6 (3.8, 5.4)
Volunteer work	#	-	-	41	213	0.9 (0.6, 1.3)
Main source of income						
Wage/salary	79	499	37.9 (30.3, 46.2)	2,319	14,407	62.0 (60.3, 63.7)
Own business/ partnership	7	63	4.8 (2.1, 10.6)	144	804	3.5 (2.8, 4.2)
Age pension	#	-	-	3[#]	-	-
Invalidity service pension	32	179	13.6 (9.2, 19.5)	227	1,126	4.9 (4.2, 5.6)
VEA[1] compensation	#	-	-	15	67	0.3 (0.2, 0.5)
SRCA[2] compensation	#	-	-	19	68	0.3 (0.2, 0.5)
MRCA[3] compensation	18	104	7.9 (4.6, 13.0)	136	848	3.7 (3.0, 4.4)
Dividends/ interest/ investments	#	-	-	22	116	0.5 (0.3, 0.8)
Carers' allowance	#	-	-	12	82	0.4 (0.2, 0.7)
Child allowance	#	-	-	20	109	0.5 (0.3, 0.8)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Other allowance	19	165	12.5 (7.6, 19.9)	127	935	4.0 (3.3, 4.9)
Age service pension	#	-	-	257	891	3.8 (3.5, 4.3)
Super'n	14	65	4.9 (2.8, 8.5)	384	1,499	6.5 (5.9, 7.1)
Other	19	133	10.1 (6.0, 16.5)	277	1,646	7.1 (6.2, 8.1)
Worried about stable housing in the next 2 months [a]						
No	117	693	52.6 (44.3, 60.8)	3614	20,350	87.6 (86.3, 88.8)
Yes	82	593	45.0 (36.9, 53.4)	334	2,172	9.4 (8.3, 10.5)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months
 # Cell size too small to be reported.
[a] Note: Proportions on this variable do not sum to 100% within the transitioned ADF groups due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
[1] Veterans' Entitlement Act
[2] Safety, Rehabilitation and Compensation Act
[3] Military Rehabilitation and Compensation Act

4.4 Service characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 17 presents several Service (upon transition from the ADF) characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Recently Homeless veterans were of lower rank compared to those who were Not Recently Homeless. Compared to Not Recently Homeless veterans, they were significantly more likely to have been an 'other rank' (67.1% vs 51.3%), and significantly less likely to have been an Officer (10.8% vs 16.6%) or a Non-commissioned Officer (22.0% vs 32.1).

Recently Homeless veterans were significantly less likely to have been in the air force than Not Recently Homeless veterans (10.8% vs 17.2%).

When examining medical fitness, Recently Homeless veterans were significantly more likely to have been classed as 'unfit' than Not Recently Homeless veterans (44.0% vs 25.8%).

Compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to have served in the Regular ADF for 4–7.9 years (50.8% vs 35.4%), and significantly less likely to have served for 20+ years (6.7% vs 24.1%).

There was no sizeable or significant difference between groups concerning deployment status.

Table 17:Estimated Service characteristics in the Transitioned ADF with recent

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Rank						
Commissioned Officer	47	143	10.8 (8.3, 14.0)	1,190	3,848	16.6 (16.3, 16.8)
Non-commissioned Officer	84	290	22.0 (17.8, 27.0)	1,983	7,458	32.1 (31.7, 32.5)
Other Ranks	70	884	67.1 (61.0, 72.8)	886	11,930	51.3 (50.9, 51.8)
Service						
Army	131	888	67.4 (59.4, 74.5)	2,302	13,946	60.0 (59.5, 60.5)
Navy	35	287	21.8 (15.4, 30.0)	811	5,292	22.8 (22.3, 23.2)
Air force	35	142	10.8 (7.5, 15.2)	946	3,997	17.2 (16.9, 17.5)
Medical fitness						
Fit	91	738	56.0 (48.3, 63.5)	2,843	17,250	74.2 (73.8,74.7)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Unfit	110	579	44.0 (36.5, 51.7)	1216	5,985	25.8 (25.3, 26.2)
Time in Regular ADF [a]						
1 month–3.9 years	23	200	15.2 (10.0, 22.6)	283	2,668	11.5 (10.2, 12.9)
4–7.9 years	78	669	50.8 (42.6, 59.0)	874	8,231	35.4 (33.7, 37.2)
8–11.9 years	31	159	12.0 (8.1, 17.5)	573	3,087	13.3 (12.1, 14.6)
12–15.9 years	23	99	7.5 (4.6, 12.0)	444	1,945	8.4 (7.6, 9.2)
16–19.9 years	17	60	4.6 (2.8, 7.3)	246	895	3.9 (3.4, 4.3)
20+ years	24	89	6.7 (4.5, 9.9)	1,537	5,604	24.12 (23.3, 25.0)
Ever deployed [a]						
Yes	164	1,017	77.2 (69.2, 83.7)	3,219	17,510	75.4 (73.7 ,77.0)
No	36	289	22.0 (15.7, 29.9)	766	5,232	22.5 (21.0, 24.2)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months
[a] Note: Proportions on this variable do not sum to 100% within the transitioned groups due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

4.5 Transition characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 18 presents transition characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Regarding their current (i.e. post-transition from Regular service) military status, compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to now be completely Ex-serving (58.9% vs 42.6%), and significantly less likely to now be Active Reservists (13.7% vs 26.5%).

Overall, there was a trend for Recently Homeless veterans to have transitioned more recently than Not Recently Homeless veterans. More specifically, compared with the Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to have transitioned within the last year (33.7% vs 18.5%).

Recently Homeless veterans were significantly more likely to have had a medical discharge than Not Recently Homeless veterans (39.3% vs 19.2%). Recently Homeless veterans were significantly less likely to non-medically discharge due to their own request (32.1% vs 55.0%).

The main reasons for transition were also different between the two groups. Compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to have transitioned due to 'personal experience of harassment/bullying/ discrimination in the ADF' (32.6% vs 12.9%), 'personal experience of violence in the ADF' (9.2% vs 1.8%), 'disciplinary action or criminal offence' (7.2% vs 1.7%), 'my service was terminated' (16.6% vs 8.3%), 'physical health problems' (39.7% vs 20.7%), and 'mental health problems' (42.3% vs 17.3%). Additionally, compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly less likely to have transitioned due to 'better employment prospects in civilian life' (9.7% vs 22.2%).

There was no sizeable or significant difference in the proportions of Recently Homeless and Not Recently Homeless veterans who were DVA clients.

Table 18: Estimated transition characteristics in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Serving status						
Ex-serving	129	776	58.9 (50.5, 66.9)	1,508	9,905	42.6 (40.9, 44.4)
Active Reservist	27	180	13.7 (8.8, 20.6)	1,359	6,166	26.5 (25.2, 27.9)
Inactive Reservist	43	337	25.6 (18.7, 34.0)	1,173	7,059	30.4 (28.7, 32.1)
Years since transition [a]						
0	24	96	7.3 (4.7, 11.1)	349	1,837	7.9 (7.0, 8.9)
1	63	444	33.7 (26.2, 42.1)	766	4,302	18.5 (17.1, 20.0)
2	34	258	19.6 (13.8, 27.0)	772	4,714	20.3 (18.8, 21.9)
3	32	215	16.3 (10.8, 23.8)	826	4,867	21.0 (19.5, 22.5)
4	27	138	10.5 (6.74, 16.0)	625	3,382	14.6 (13.3, 15.9)
5+	11	84	6.4 (3.2, 12.3)	490	2,681	11.5 (10.4, 12.8)
Type of discharge/resignation [b]						
Medical	91	518	39.3 (32.0, 47.2)	800	4,464	19.2 (18.2, 20.3)
Non-medical	109	782	59.4 (51.4, 66.9)	3,161	18,096	77.9 (76.7, 79.1)
Compulsory age	#	-	-	175	606	2.6 (2.3, 3.0)
Own request	71	423	32.1 (25.1, 40.1)	2,305	12,769	55.0 (53.2, 56.7)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Unsuitable for further training	#	-	-	42	454	2.0 (1.4, 2.7)
End of fixed period	#	-	-	77	479	2.0 (1.6, 2.7)
End of initial enlistment period/return of service obligation	#	-	-	109	1,238	5.3 (4.4, 6.5)
Limited tenured appointment (Officers)	#	-	-	22	85	0.4 (0.2, 0.6)
Not offered re-engagement	#	-	-	8	63	0.3 (0.1, 0.6)
Accepted voluntary redundancy	#	-	-	148	526	2.3 (2.0, 2.6)
Compassionate grounds	#	-	-	23	127	0.6 (0.3, 0.9)
Non-voluntary discharge administrative	14	81	6.2 (3.2, 11.5)	61	642	2.8 (2.1, 3.6)
Other	12	118	8.9 (4.7, 16.3)	191	1,107	4.8 (4.0, 5.6)
Reason for transition						
Better employment prospects in civilian life	16	127	9.7 (5.5, 16.4)	830	5,159	22.2 (20.7, 23.8)
Lack of promotion prospects	25	238	18.0 (12.0, 26.2)	662	3,772	16.2 (14.9, 17.7)
Inability to plan life outside of work	34	236	17.9 (12.3, 25.5)	656	4,326	18.6 (17.1, 20.2)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Impact of service life on family	59	359	27.2 (20.6, 35.1)	1343	7,543	32.5 (30.8, 34.2)
Pressure from family	21	116	8.8 (5.4, 14.0)	289	1,536	6.6 (5.8, 7.6)
Didn't want to be away from home	24	128	9.7 (6.0, 15.4)	657	3,747	16.1 (14.8, 17.5)
Pregnancy	#	-	-	51	366	1.6 (1.2, 2.2)
Posting issues (i.e. unhappy with location or nature of postings)	35	201	15.2 (10.2, 22.0)	867	4,667	20.1 (18.7, 21.6)
Too many deployments	#	-	-	132	681	2.9 (2.4, 3.6)
Not enough deployments	24	177	13.5 (8.6, 20.4)	349	2,541	10.9 (9.7, 12.3)
Because of my experiences on deployment	28	183	13.9 (9.1, 20.8)	322	2,041	8.8 (7.7, 10.0)
Work not exciting or challenging enough	26	177	13.4 (8.6, 20.4)	444	2,940	12.7 (11.4, 14.0)
Dissatisfaction with pay	15	110	8.3 (4.5, 14.9)	276	1,740	7.5 (6.5, 8.6)
Personal experience of harassment/ bullying/ discrimination in the ADF	63	429	32.6 (25.3, 40.8)	504	2,993	12.9 (11.7, 14.2)
Personal experience of violence in the ADF	17	121	9.2 (5.5, 15.1)	61	409	1.8 (1.3, 2.4)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Disciplinary action or criminal offence	8	94	7.2 (3.4, 14.6)	37	384	1.7 (1.2, 2.4)
My service was terminated	35	218	16.6 (11.3, 23.7)	339	1,934	8.3 (7.4, 9.4)
Physical health problems	76	522	39.7 (32.0, 47.9)	830	4,804	20.7 (19.4, 22.0)
Mental health problems	92	557	42.3 (34.5, 50.5)	728	4,015	17.3 (16.0, 18.6)
Other	27	201	15.3 (9.9, 22.8)	818	4,354	18.7 (17.4, 20.2)
DVA client status						
DVA client	104	614	46.6 (38.6, 54.8)	1,938	9,480	40.8 (39.2, 42.4)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
 # Cell size too small to be reported.
[a] *Note: Approximately 6.0% of both groups had a missing value for this question.*
[b] *Note: Approximately 1.0% of the Recently Homeless, and 3.0% of the Not Recently Homeless, veterans had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.*

4.6 Civilian employment and DVA support characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 19 presents civilian employment and DVA support for Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Recently Homeless veterans were significantly more likely to be not employed than Not Recently Homeless veterans (57.5% vs 33.9%). However, among those employed, there were no sizeable or significant differences between the Recently Homeless and Not Recently Homeless veterans in terms of the number of hours worked in the past week. Among those employed, there were no sizeable or significant differences between Homeless and Not Recently Homeless veterans in the type of employment specified.

Recently Homeless veterans were significantly more likely to have had a period of unemployment greater than three months since transition compared to Not Recently Homeless veterans (72.8% vs 41.9%).

While a slightly larger proportion of Recently Homeless than Not Recently Homeless veterans were receiving DVA support (specifically, white cards), this difference was not statistically significant.

Recently Homeless veterans were more likely to report a negative financial situation than were Not Recently Homeless veterans. Specifically, compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to report that they were ‘just getting along’ (50.3% vs 33.1%), ‘poor’ (14.4% vs 4.7%), or ‘very poor’ (16.2% vs 1.1%), and were significantly less likely to report that they were ‘very comfortable’ (2.6% vs 11.4%) or ‘reasonably comfortable (15.0% vs 45.2%).

Recently Homeless veterans were significantly more likely to state that they had problems paying money that they owed than were Not Recently Homeless veterans (52.3% vs 19.2%).

Table 19: Estimated civilian employment and DVA support in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
Civilian employment and DVA support	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Civilian employment [b]						
Employed	86	547	41.5 (33.6, 49.9)	2,391	14,878	64.0 (62.4, 65.7)
Not employed	114	757	57.5 (49.1, 65.4)	1,594	7,874	33.9 (32.3, 35.5)
Hours worked in past week [a, b]						
0–20 hours	#	-	-	241	1,595	10.7 (9.25, 12.4)
21–40 hours	43	309	56.6 (43.6, 68.8)	1,138	6,902	46.4 (43.9, 48.9)
41–60 hours	29	167	30.5 (20.1, 43.5)	749	4,700	31.6 (29.3, 34.0)
61–80 hours	#	-	-	89	555	3.7 (2.9, 4.8)
80+ hours	#	-	-	109	772	5.2 (4.1, 6.5)
Civilian employment industry [a]						
Agriculture, forestry and fishing	#	-	-	49	339	2.3 (1.6, 3.2)
Mining	6	28	5.2 (2.1, 12.0)	212	1,516	10.2 (8.7, 11.9)
Manufacturing	#	-	-	87	717	4.8 (3.8, 6.1)
Electricity, gas and water supply	#	-	-	68	490	3.3 (2.5, 4.4)
Construction	7	87	16.0 (7.5, 1.0)	152	1,275	8.6 (7.2, 10.2)
Wholesale trade	#	-	-	22	185	1.2 (0.8, 2.0)

	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
Civilian employment and DVA support	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Retail trade	#	-	-	111	1011	6.8 (5.5, 8.4)
Accommodation, cafes and restaurants	#	-	-	4,008	355	2.4 (1.7, 3.3)
Transport and storage	8	28	5.2 (2.6, 10.1)	221	1,309	8.8 (7.5, 10.3)
Communication services	#	-	-	88	605	4.1 (3.2, 5.2)
Finance and insurance	#	-	-	33	208	1.4 (0.9, 2.1)
Property and business services	#	-	-	60	393	2.6 (1.9, 3.6)
Government administration and Defence	15	85	15.6 (8.6, 26.6)	567	2,498	16.8 (15.4, 18.3)
Education	#	-	-	117	591	4.0 (3.2, 5.0)
Health and community services	9	30	5.47 (2.9, 10.0)	212	1,159	7.8 (6.6, 9.1)
Cultural and recreational services	#	-	-	25	171	1.2 (0.7, 1.8)
Personal and other services	#	-	-	140	871	5.9 (4.8, 7.1)
Emergency services	7	46	8.45 (3.5,19.1)	145	984	6.6 (5.4, 8.0)
Unemployment: at least 3-month period since transition [b]	138	959	72.8 (65.2, 79.3)	1587	9,735	41.9 (40.1, 43.7)
DVA support since transition						
Any treatment support	92	699	52.5 (42.6, 62.2)	1681	10,180	43.1 (41.3, 45.0)
White card	79	645	48.4 (38.8, 58.2)	1486	9,189	38.9 (37.0, 40.8)
Gold card	13	54	4.0 (2.4, 6.7)	198	1,003	4.2 (3.6, 5.0)

Civilian employment and DVA support	Recently Homeless n = 1,317			Not Recently Homeless n = 23,535		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Financial situation						
Prosperous	#	-	-	83	397	1.7 (1.3, 2.2)
Very comfortable	6	34	2.6 (0.9, 7.0)	593	2,697	11.4 (10.4, 12.5)
Reasonably comfortable	41	198	15.0 (10.6, 20.9)	1,920	10,670	45.2 (43.4, 47.0)
Just getting along	100	662	50.3 (42.1, 58.5)	1,248	7,822	33.1 (31.4, 34.9)
Poor	25	190	14.4 (9.2, 21.9)	147	1,105	4.7 (3.9, 5.6)
Very poor	27	214	16.2 (10.7, 23.9)	39	282	1.1 (0.8, 1.7)
Problems paying money owed [b]						
Yes	98	688	52.3 (44.0, 60.4)	687	4,542	19.2 (17.8, 20.8)

[a] Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months who had civilian employment.
Denominator for all other variables is simply Transitioned ADF 12-month Homeless vs Not Homeless.
 # Cell size too small to be reported.
[b] Note: Proportions on this variable do not sum to 100% within the transitioned group due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

4.7 Ex-service organisation engagement and incarceration characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 20 presents ESO engagement and incarceration characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Overall, there was a slight trend for Recently Homeless veterans to have joined fewer ESOs and other voluntary groups than Not Recently Homeless veterans, although these differences were small. The only statistically significant difference across these two variables was that compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to *have not* joined any other voluntary groups (76.4% vs 64.3%).

Regarding criminal behaviour, Recently Homeless veterans were significantly more likely to have been both arrested (10.9% vs 2.5%) and convicted (8.4% vs 1.7%) than Not Recently Homeless veterans.

Table 20: Estimated ESO engagement and incarcerations in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,385			Not Recently Homeless n = 23,176		
ESO engagement and incarcerations	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Number of ex-service organisations joined [a]						
0	115	1,005	72.6 (63.7, 80.0)	2,213	16,138	69.6 (67.7, 71.5)
1	33	267	19.3 (12.8, 28.0)	786	4,707	20.3 (18.8, 22.0)
2	10	56	4.0 (2.0, 7.8)	214	1,274	5.5 (4.7, 6.5)
3	#	-	-	59	333	1.4 (1.1, 2.0)
4	#	-	-	15	76	0.3 (0.2, 0.6)
5+	#	-	-	10	43	0.2 (0.1, 0.3)
Number of other voluntary groups joined [a]						
0	118	1,058	76.4 (68.4, 82.9)	2,055	14,899	64.3 (62.2, 66.3)
1	31	185	13.4 (9.0, 19.5)	694	4,392	19.0 (17.4, 20.6)
2	11	96	7.0 (3.4, 13.8)	326	1,832	7.9 (7.0, 9.0)

ESO engagement and incarcerations	Recently Homeless n = 1,385			Not Recently Homeless n = 23,176		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
3	#	-	-	129	827	3.6 (2.9, 4.5)
4	#	-	-	34	201	0.9 (0.6, 1.3)
5+	#	-	-	25	154	0.7 (0.4, 1.1)
Criminal behaviour since transition						
Arrested	16	147	10.9 (6.3, 18.1)	55	575	2.5 (1.8, 3.4)
Convicted	9	113	8.4 (4.1, 16.2)	37	400	1.7 (1.2, 2.5)
Imprisoned	#	-	-	2[#]	-	-

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
[a] Note: Proportions on this variable do not sum to 100% within the transitioned group due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
 # Cell size too small to be reported.

4.8 Driving and gambling characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 21 presents driving and gambling behaviour of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Overall, a greater proportion of Recently Homeless than Not Recently Homeless veterans engaged in all three risky driving behaviours assessed. However, differences were statistically significant for only two of these behaviours: compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to have driven more than 25 km/h over the limit (35.9% vs 23.1%), and to have driven when probably affected by alcohol (26.7% vs 11.8%).

Recently Homeless veterans were also more likely to engage in risky gambling behaviour. Specifically, Recently Homeless veterans were significantly less likely to be a 'non-problem gambler' (77.9%) than Not Recently Homeless veterans (86.7%). Thus, by inference, Recently Homeless veterans were significantly more likely to be problem gamblers than Not Recently Homeless veterans, although the differences for each of the three specific gambling risk categories were not significant.

Table 21: Estimated driving/gambling behaviour in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
Driving and gambling behaviour	**n**	**Weighted n**	**% (95%CI)**	**n**	**Weighted n**	**% (95%CI)**
Number of times over the last 10 times that you drove more than 25km/h over the limit [a]						
0	93	786	58.8 (49.1, 67.8)	2,559	17,028	72.2 (70.1, 74.1)
1	14	135	10.1 (5.5, 17.7)	216	1,668	7.1 (5.9, 8.3)
2	13	113	8.4 (4.2, 16.1)	142	1,144	4.9 (3.9, 6.0)
3	5	18	1.4 (0.6, 3.0)	81	532	2.2 (1.7, 3.0)
4	0	0	-	42	376	1.6 (1.1, 2.3)
5+	27	214	16.0 (10.1, 24.3)	190	1,736	7.4 (6.2, 8.7)
Not applicable	#	-	-	100	782	3.3 (2.6, 4.2)
Dichotomised variable						
Did not drive more than 25km/h over the limit	97	822	61.5 (51.8, 40.4)	2,659	17,809	75.5 (73.5, 77.4)
Drove more than 25km/h over the limit	59	481	35.9 (27.3, 45.6)	671	5,455	23.1 (21.3, 25.1)
Number of times over the last 10 times that you drove between 11 and 25km/h over the limit [a]						
0	55	470	35.2 (26.5, 44.9)	1,624	10,539	44.7 (42.6, 46.8)

Driving and gambling behaviour	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95%CI)	n	Weighted n	% (95%CI)
1	16	144	10.8 (5.9, 19.0)	338	2,478	10.5 (9.2, 11.9)
2	16	117	8.7 (5.0, 14.8)	376	2,697	11.4 (10.1, 12.9)
3	14	107	8.0 (4.2, 14.6)	230	1,499	6.4 (5.4, 7.5)
4	10	85	6.3 (2.9, 13.1)	132	935	4.0 (3.2, 4.9)
5+	46	378	28.2 (20.3, 37.8)	588	4,635	19.6 (17.9, 21.4)
Not applicable	#	-	-	84	735	3.1 (2.4, 4.0)
Dichotomised variable						
Did not drive between 11 and 25km/h over the limit	58	502	37.6 (28.7, 47.4)	1,708	11,274	47.8 (45.7, 49.9)
Drove between 11 and 25km/h over the limit?	102	831	62.1 (52.3, 71.0)	1,664	12,246	51.9 (49.8, 54.0)
Number of times over the last 10 times that you drove when probably affected by alcohol [a]						
0	108	890	66.6 (57.0, 74.9)	2,870	19,478	82.6 (80.8, 84.2)
1	18	142	10.7 (59.5, 18.3)	199	1,554	6.6 (5.5, 7.8)
2	6	53	4.0 (1.4, 1.1)	65	488	2.1 (1.5, 2.8)
3	6	59	4.4 (1.8, 10.5)	29	261	1.1 (0.7, 1.7)
4	#	-	-	8	88	0.4 (0.1, 10.6)

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
Driving and gambling behaviour	**n**	**Weighted n**	**% (95%CI)**	**n**	**Weighted n**	**% (95%CI)**
5+	10	86	6.4 (3.1, 12.9)	47	391	1.7 (1.2, 2.3)
Not applicable	9	81	6.0 (3.0, 11.9)	138	1,125	4.8 (3.9, 5.9)
Dichotomised variable						
Did not drive when probably affected by alcohol	117	971	72.6 (63.2, 80.3)	3,008	20,602	87.3 (85.7, 88.8)
Drove when probably affected by alcohol	42	358	26.8 (19.1, 36.1)	348	2,782	11.8 (10.4, 13.3)
Gambling [a]						
High-risk gambler (8–27)	6	51	3.7 (1.5, 9.0)	63	568	2.4 (1.8, 3.2)
Moderate-risk gambler (3–7)	12	131	9.6 (4.9, 17.8)	136	1,023	4.3 (3.5, 5.3)
Low-risk gambler (1–2)	13	121	8.8 (4.5, 16.6)	190	1,433	6.1 (5.1, 7.3)
Non-problem gambler (0)	130	1,066	77.9 (68.4, 85.1)	2961	20,439	86.7 (85.1, 88.2)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months
 # Cell size too small to be reported.
[a] Note: Proportions on this variable do not sum to 100% within the transitioned group due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

4.9 Psychosocial characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 22 presents psychosocial characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Across all of the psychosocial measures, Recently Homeless veterans showed a greater degree of risk (e.g. less support) than Not Recently Homeless veterans.

Recently Homeless veterans evidenced lower family and friend social support, and higher family and friend social strain, compared with Not Recently Homeless veterans. This can be seen in the overall mean levels of support and strain, as well as some of the individual response categories. Specifically, regarding family, compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to 'never' (8.9% vs 1.4%) or 'sometimes' (37.6% vs 20.6%) experience family social support, and significantly less likely to 'often' experience family social support (41.7% vs 70.6%). Additionally, Recently Homeless veterans were significantly more likely to 'sometimes' (48.4% vs 29.2%) and 'often' (11.9% vs 5.6%) experience family social strain than the Not Recently Homeless group, and were significantly less likely to 'rarely' experience family social strain (26.5% vs 45.1%). Furthermore, regarding friends, compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to 'rarely' experience friend social support (23.4% vs 13.3%).

Recently Homeless veterans showed an overall pattern of less family contact than Not Recently Homeless veterans, with a lower proportion of Recently Homeless veterans having daily or weekly contact, although only the difference for weekly contact was statistically significant (34.4% vs 49.4%).

Compared with Not Recently Homeless veterans, Recently Homeless veterans showed significantly lower mean levels of satisfaction both with partners (6.2% vs 7.7%) and children (4.9% vs 7.6%).

While an overall pattern of less friend contact for Recently Homeless compared with Not Recently Homeless veterans was evident, differences were only small (and smaller than those seen for family contact), and none of the individual category differences were significant. Similar to results for partner and children satisfaction, Recently Homeless veterans showed significantly lower mean levels of satisfaction with friends than Not Recently Homeless veterans (5.8% vs 7.0%).

Finally, there was no sizeable or significant difference in resilience scores for the Recently Homeless and Not Recently Homeless veterans (18.0% vs 17.9%).

Table 22: Estimated psychosocial characteristics in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
Psychosocial relationships	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Family social support [a]						
Never	10	121	8.9 (4.2, 17.9)	48	325	1.4 (1.0, 2.0)
Rarely	26	160	11.8 (6.9, 19.4)	217	1,579	6.7 (5.7, 7.9)
Sometimes	62	511	37.6 (28.7, 47.4)	735	4,849	20.6 (18.9, 22.4)
Often	72	567	41.7 (32.5, 51.6)	2,513	16,633	70.6 (68.6, 72.5)
M., SE, (95% CI)	*2.1*	*0.1*	*(1.9, 2.3)*	*2.6*	*0.02*	*(2.6, 2.7)*
Family social strain [a]						
Never	22	175	12.9 (7.6, 1.0)	596	4,440	18.8 (17.1, 21.0)
Rarely	48	360	26.5 (18.8, 36.0)	1,638	10,637	45.1 (43.0, 47.3)
Sometimes	75	658	48.4 (38.8, 58.2)	1,058	6,876	29.2 (27.3, 31.2)
Often	23	162	11.9 (7.2, 19.1)	204	1,317	5.6 (4.7, 6.7)
M., SE, (95% CI)	*1.6*	*0.08*	*(1.4, 1.7)*	*1.3*	*0.02*	*(1.2, 1.3)*
Friends social support[a]						
Never	6	48	3.6 (1.4, 8.5)	139	933	4.0 (3.2, 4.8)
Rarely	41	316	23.4 (16.0, 32.8)	454	3,147	13.3 (11.9, 14.8)
Sometimes	68	552	40.8 (31.6, 50.7)	1,550	10,788	45.8 (43.6, 47.9)
Often	51	434	32.1 (23.6, 41.8)	1,232	8,365	35.5 (33.4, 37.6)
M., SE, (95% CI)	*2.0*	*0.08*	*(1.9, 2.2)*	*2.2*	*0.018*	*(2.1, 2.2)*

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
Psychosocial relationships	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Friends social strain [a]						
Never	51	386	28.5 (20.8, 37.9)	1,303	8,638	36.6 (34.6, 38.8)
Rarely	87	726	53.7 (43.9, 63.2)	1,741	12,092	51.3 (49.1, 53.5
Sometimes	23	203	15.0 (9.1, 23.7)	294	2,229	9.5 (8.2, 10.9)
Often	#	-	-	22	198	0.8 (0.5, 1.4)
M., SE, (95% CI)	*0.9*	*0.1*	*(0.8, 1.1)*	*0.8*	*0.0*	*(0.8, 0.8)*
Family contact [a]						
Daily	#	-	-	171	1,130	4.8 (4.0, 5.7)
Weekly	69	462	34.4 (26.4, 43.4)	1,724	11,648	49.4 (47.3, 51.5)
Monthly	55	482	35.9 (27.3, 45.5)	943	6,132	26.0 (24.2, 27.8)
Every 3 months	11	116	8.7 (4.2, 17.0)	204	1,269	5.4 (4.5, 6.4)
Less often	24	179	13.3 (8.2, 20.9)	359	2,263	9.6 (8.5, 10.9)
Family satisfaction						
Partner M., SE, (95% CI)	*6.2*	*0.42*	*(5.4, 7.1)*	*7.7*	*0.06*	*(7.6, 7.8)*
Children M., SE, (95% CI)	*4.9*	*0.4*	*(40.0, 5.8)*	*7.6*	*0.06*	*(7.5, 7.8)*

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
Psychosocial relationships	**n**	**Weighted n**	**% (95% CI)**	**n**	**Weighted n**	**% (95% CI)**
Friend contact [a]						
Daily	12	87	6.3 (3.2, 12.1)	249	2,049	8.7 (7.5, 10.1)
Weekly	65	614	44.4 (35.2, 53.9)	1,545	10,982	46.6 (44.5, 48.8)
Monthly	48	355	25.6 (18.6, 34.2)	973	6,418	27.3 (25.4, 29.2)
Every 3 months	21	194	14.0 (8.5, 22.3)	275	1,799	7.6 (6.6, 8.8)
Less often	20	134	9.7 (5.6, 16.2)	346	2,185	9.3 (8.2, 10.5)
Friend satisfaction						
M., SE, (95% CI)	*5.8*	*0.28*	*(5.3, 6.4)*	*7.0*	*0.05*	*(6.9, 7.1)*
Resilience						
M., SE, (95% CI)	*18.0*	*0.19*	*(17.6, 18.3)*	*17.9*	*0.04*	*(17.8, 18.0)*

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
 # Cell size too small to be reported.
[a] *Note: Proportions on this variable do not sum to 100% within the transitioned group due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.*
M. = mean, SE = standard error,

4.10 Recent life event characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 23 presents recent life events (i.e. during the last 12 months) of Recently Homeless, compared with Not Recently Homeless, Transitioned ADF.

Overall, it can be seen that Recently Homeless veterans experienced a greater number of recent life events than Not Recently Homeless veterans: their mean number of events was significantly higher (4.3 vs 1.7), and they were significantly more likely to experience any (i.e. one or more, as opposed to none) recent life events (94.1% vs 67.1%). When examining the distribution of recent life events, the vast majority of Recently Homeless veterans experienced three or more events (74.1%), whereas the majority of Not Recently Homeless veterans experienced 0–2 events (74.1%).

Recently Homeless veterans were significantly more likely than Not Recently Homeless veterans to experience 12 of the 14 recent life events assessed. While becoming unemployed/seeking work, relationship (i.e. spouse/partner) problems, and suffering a serious illness/injury/assault were among the top four most common events for both Recently Homeless and Not Recently Homeless veterans, a notable difference was that having a major financial crisis was the second most common event for Recently Homeless veterans (44.9%), but seventh for Not Recently Homeless veterans (12.6%). Additionally, for Not Recently Homeless veterans, reported events more commonly involved relatively distant contacts (i.e. relatives, neighbours), while for Recently Homeless veterans, events more commonly involved the self or partner.

Table 23: Estimated recent life event characteristics in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Number of recent life events (M., SE, 95% CI)	4.3	0.2	(3.8, 4.7)	1.7	0.4	(1.6, 1.7)
Total number of recent life events (last 12 months)						
0	8	77	5.7 (2.5, 12.7)	1,239	7,676	32.5 (30.7, 34.4)
1	11	74	5.5 (2.7, 11.0)	941	5,750	24.4 (22.7, 26.1)
2	25	193	14.4 (9.0, 22.1)	642	4,064	17.2 (15.8, 18.8)
3	36	260	19.3 (13.1, 27.6)	401	2,669	11.3 (10.1, 12.7)
4	21	131	9.7 (5.9, 15.7)	205	1,449	6.1 (5.2, 7.2)
5	23	187	13.9 (8.8, 21.3)	116	854	3.6 (2.9, 4.5)
6	25	165	12.3 (7.6, 19.3)	68	512	2.2 (1.6, 2.9)
7	13	113	8.4 (4.6, 14.8)	35	210	0.9 (0.6, 1.3)
8	8	57	4.2 (2.0, 8.9)	22	125	0.5 (0.3, 0.9)
9	6	62	4.6 (1.8, 11.1)	23	113	0.5 (0.3, 0.7)
10	#	-	-	#	-	-
11	#	-	-	#	-	-
12	#	-	-	#	-	-
13	#	-	-	#	-	-
14	#	-	-	#	-	-
Any recent life event [a]	172	1,264	94.1 (87.2, 97.4)	2,465	15,825	67.1 (65.2, 68.9)
Type of recent life event						

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Suffered a serious illness, injury or assault	66	497	37.0 (28.9, 45.8)	645	3,852	16.3 (15.0, 17.7)
Serious illness, injury or assault in relative	43	364	27.1 (19.9, 35.7)	533	3,342	14.2 (12.8, 15.6)
Death of parent/child/spouse	11	73	5.4 (2.8, 10.2)	261	1,323	5.6 (4.9, 6.5)
A close family friend or another relative (aunt, cousin, grandparent) died	53	410	30.5 (23.0, 39.2)	919	5,713	24.2 (22.6, 25.9)
Had a separation due to marital/relationship difficulties	76	507	37.7(29.6, 46.6)	307	2,026	8.6 (7.5, 9.8)
Broke off a steady relationship	51	382	28.4 (21.1, 37.1)	232	1,811	7.7 (6.6, 8.9)
Had any serious problem with a close friend, neighbour or relative	59	471	35.1 (27.0, 44.0)	510	3,108	13.2 (11.9, 14.5)
Became unemployed or were seeking work unsuccessfully for more than one month	111	863	64.2 (55.4, 72.1)	704	5,188	22.0 (20.3, 23.8)
Were sacked from job	39	252	18.7(13.1, 26.1)	195	1,321	5.6 (4.7, 6.6)
Had a major financial crisis	81	604	44.9 (36.3, 53.9)	390	2,964	12.6 (11.2, 14.0)
Had problems with the police and a court appearance	26	210	15.6 (10.0, 24.0)	105	817	3.5 (2.8, 4.3)
Something valued was lost or stolen	31	293	21.8 (15.0, 30.6)	175	1,229	5.2 (4.4, 6.2)
Had problems with custody of children	25	199	14.8 (9.4, 22.5)	156	908	3.9 (3.2, 4.7)
Had relationship problems with spouse/partner	98	601	44.7 (36.3, 53.5)	891	5,904	25.0 (23.3, 26.8)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
 # Cell size too small to be reported.
[a] Note: Based on weighted counts, less than 1.0% of 12-month Homeless and Not Homeless groups had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Note: M = mean, SE = standard error.

4.11 Traumatic event characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 24 presents traumatic life events of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Overall, a similar pattern to the recent life event data (in the previous section) was seen, where Recently Homeless veterans experienced a greater number of traumas than Not Recently Homeless veterans. The mean number of traumas was significantly higher (4.0% vs 2.9%), and they were more likely to experience any (i.e. one or more, as opposed to none) trauma (82.7% vs 75.2%), although this difference was not significant. When examining the distribution of traumas, the vast majority of Recently Homeless veterans experienced three or more traumas (63.1%), whereas the majority of Not Recently Homeless veterans experienced 0–2 traumas (54.1%).

When considering trauma type, overall the Recently Homeless veterans were more likely to report in the affirmative for most of the 26 trauma types, compared with the Not Recently Homeless veterans, although several of these differences were small. This, combined with wide CIs for many of the traumas experienced by Recently Homeless veterans, meant that significant differences were observed for only 5 of the 26 traumas. These traumas could be considered sexual (‘raped’, ‘molested’) or interpersonal (‘stalked’, ‘someone close had an extremely traumatic experience’, ‘seen someone badly injured/killed’) in nature.

The overall rank order of trauma prevalence was very similar for Recently Homeless and Not Recently Homeless veterans. The six most prevalent traumas were exactly the same for both groups, with the order of the remaining traumas being very similar. For example, the two most common traumas for both groups were ‘saw someone badly injured/killed’ (Recently Homeless 50.0%, Not Recently Homeless 36.3%) and ‘someone close died unexpectedly’ (Recently Homeless 37.0%, Not Recently Homeless 28.1%).

Table 24: Estimated traumatic life events in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Mean number of lifetime traumatic events (M., SE, 95% CI)	4.0	0.3	(3.5, 4.5)	2.9	0.6	(2.8, 3.1)
Total number of lifetime traumatic events [a]						
0	26	188	13.9 (8.9, 21.0)	740	5,415	23.0 (21.3, 24.7)
1	20	164	12.1 (7.1, 19.8)	609	4,009	17.0 (15.5, 18.6)
2	16	95	7.0 (3.9, 12.3)	561	3,318	14.1 (12.8, 15.4)
3	27	200	14.7 (9.3, 22.4)	400	2,405	10.2 (9.1, 11.4)
4	22	178	13.1 (8.1, 20.6)	367	2,309	9.8 (8.7, 11.0)
5	17	116	8.6 (5.1, 14.2)	308	1,649	7.0 (6.1, 8.0)
6	9	104	7.6 (3.7, 15.3)	244	1,255	5.3 (4.6, 6.2)
7	11	74	5.4 (2.9, 10.0)	170	942	4.0 (3.3, 4.8)
8	11	58	4.2 (2.2, 8.1)	118	561	2.4 (2.0, 2.9)
9	7	43	3.1 (1.3, 7.2)	70	381	1.6 (1.2, 2.2)
10+	16	85	6.3 (3.3, 11.4)	163	900	3.8 (3.2, 4.6)
Number of lifetime traumatic events (collapsed) [a]						
0	26	188	13.9 (8.9, 21.0)	740	5,415	23.0 (21.3, 24.7)
1–2 traumas	36	259	19.1 (13.0, 27.1)	1,170	7,326	31.1 (29.3, 32.9)

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
3–9 traumas	104	772	56.9 (48.1, 65.3)	1,677	9,503	40.3 (38.5, 42.2)
10+ traumas	16	85	6.3 (3.4, 11.4)	163	900	3.8 (3.2, 4.6)
Any lifetime traumatic event [a]	156	1,115	82.2 (74.4, 88.1)	3,010	17,730	75.2 (73.4, 76.9)
Type of lifetime traumatic event						
Participated in combat, either as a member of a military, or as a member of an organised non-military group	66	427	31.4 (24.1, 39.8)	1,024	6,170	26.2 (24.6, 27.8)
Served as a peacekeeper or relief worker in a war zone or in a place where there was ongoing terror of people because of political, ethnic, religious or other conflicts	61	368	27.1 (20.3, 35.2)	1,159	5,964	25.3 (23.8, 26.9)
Was an unarmed civilian in a place where there was a war, revolution, military coup or invasion	7	67	5.0 (2.0, 11.7)	120	679	2.9 (2.3, 3.6)
Lived as a civilian in a place where there was ongoing terror of civilians for political, ethnic, religious or other reasons	8	54	4.0 (1.6, 9.6)	140	699	3.0 (2.4, 3.6)
Was a refugee—fled from home to a foreign country or place to escape danger or persecution	0	0	-	19	117	0.5 (0.3, 0.8)
Kidnapped or held captive	#	-	-	33	184	0.8 (0.5, 1.1)
Exposed to a toxic chemical or substance that could cause serious harm	54	333	24.5 (18.1, 32.4)	1,075	5,870	24.9 (23.3, 26.5)
Involved in a life-threatening automobile accident	31	236	17.4 (11.6, 25.3)	563	3,030	12.9 (11.7, 14.1)

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Had any other life-threatening accident, including at work	39	289	21.3 (15.0, 29.3)	577	3,280	13.9 (12.7, 15.3)
Involved in a major natural disaster, like a devastating flood, hurricane or earthquake	36	273	20.1 (14.1, 27.9)	627	3,560	15.1 (13.8, 16.5)
Involved in a man-made disaster, like a fire started by a cigarette, or a bomb explosion	28	197	14.5 (9.4, 21.7)	392	2,392	10.1 (9.0, 11.4)
Had a life-threatening illness	18	63	4.6 (3.0, 7.1)	346	1,714	7.3 (6.5, 8.2)
Badly beaten up by a spouse or romantic partner	9	35	2.6 (1.4, 4.8)	81	555	2.4 (1.8, 3.0)
Badly beaten up by anyone else	23	156	11.5 (7.1, 18.3)	307	1,968	8.3 (7.3, 9.5)
Mugged, held up, or threatened with a weapon	41	306	22.5 (16.0, 30.9)	608	3,759	15.9 (14.6, 17.4)
Raped	19	106	7.8 (4.5, 13.1)	149	810	3.4 (2.9, 4.1)
Sexually assaulted or molested	27	192	14.1 (9.1, 21.3)	309	1,582	6.7 (5.9, 7.6)
Stalked—followed or activities tracked in a way that caused feelings of being in serious danger	22	156	11.5 (7.1, 18.3)	208	1,146	4.9 (4.2, 5.7)
Someone very close died unexpectedly	70	502	37.0 (29.1, 45.8)	1,133	6,625	28.1 (26.4, 29.8)
Son or daughter had a life-threatening illness or injury	6	26	1.9 (0.9, 4.1)	190	873	3.7 (3.2, 4.3)
Someone very close had an extremely traumatic experience, like being kidnapped, tortured or raped	23	191	14.1 (8.8, 21.7)	279	1,737	7.4 (6.4, 8.4)
Saw someone being badly injured or killed, or unexpectedly saw a dead body	93	678	50.0 (41.3, 58.7)	1,483	8,548	36.3 (34.4, 38.1)

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Did something that accidentally led to the serious injury or death of another person	14	101	7.5 (4.0, 13.5)	162	880	3.7 (3.1, 4.5)
Did something on purpose to either seriously injure, torture or kill another person	15	84	6.2 (3.6, 10.5)	166	1,073	4.6 (3.8, 5.5)
Saw atrocities or carnage such as mutilated bodies or mass killings	33	196	14.4 (9.6, 21.1)	484	2641	11.2 (10.1, 12.4)
Experienced any other extremely traumatic or life-threatening event	33	213	15.7 (10.6, 22.7)	507	2607	11.1 (10.0, 12.2)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
[a] Note: Approximately 2.0% of Not Homeless and 4.0% of Homeless had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
 # Cell size too small to be reported.

4.12 Tobacco and drug use characteristics of the Transitioned ADF with recent (12-month) homelessness

Table 25 presents smoking status and drug use of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless, Transitioned ADF.

Compared with Not Recently Homeless veterans, Recently Homeless veterans were significantly more likely to be current smokers (31.0% vs 14.3%), and significantly less likely to be former smokers (19.9% vs 31.5%).

Additionally, Recently Homeless veterans were significantly more likely than Not Recently Homeless veterans to have used both recreational drugs (e.g. meth/amphetamines, marijuana, heroin, cocaine) (49.0% vs 33.2%), and prescription drugs for non-medical purposes (e.g. painkillers, sleeping pills) (15.6% vs 7.7%).

Of those who had used drugs, Recently Homeless veterans were more likely than Not Recently Homeless veterans to have used in the past 12 months (although this was only bordering on significance for prescription drugs). However, age of first use did not sizeably or significantly differ between Recently Homeless and Not Recently Homeless veterans.

Table 25: Estimated tobacco and drug use characteristics in the Transitioned ADF with recent (12-month) homelessness

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Smoking status [a]						
Current smoker	45	418	31.0 (23.1, 40.3)	501	3,365	14.3 (12.9, 15.7)
Former smoker	42	269	20.0 (14.1, 27.5)	1,240	7,418	31.5 (29.7, 33.3)
Tried smoking	44	313	23.2 (16.8, 31.2)	777	5,442	23.1 (21.4, 24.9)
Never smoked	49	324	24.1 (17.3, 32.4)	1,151	7,040	29.8 (28.1, 31.7)
Collapsed grouping						
Current smoker	45	418	31.0 (23.1, 40.3)	501	3365	14.3 (12.9, 15.7)
Former smoker/tried smoking	86	582	43.2 (34.8, 52.0)	2,017	12,861	54.5 (52.5, 56.5)
Never smoked	49	324	24.1 (17.3, 32.4)	1,151	7,040	29.8 (28.1, 31.7)
Ever used any of the listed illicit drugs* [a]						
No	98	658	48.8 (40.0, 57.7)	2,625	15,396	65.3 (63.3, 67.2)
Yes	80	660	49.0 (40.1, 57.9)	1,041	7,829	33.2 (31.3, 35.2)
Age of first drug use (M., SD, 95% CI)	18.8	0.563	(17.7, 19.9)	18.5	0.158	(18.2,18.8)
Used any of the listed illicit drugs in the last 12 months*						
No	42	346	25.6 (1.6, 34.2)	775	5,415	23.0 (21.2, 24.7)
Yes	40	321	23.8 (16.9, 32.5)	288	2,595	11.0 (9.7, 12.5)

	Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Used any prescription drugs for non-medical purposes** [a]						
No	150	1,111	82.4 (74.6, 88.2)	3,441	21,483	91.1 (89.8, 92.2)
Yes	29	211	15.6 (10.3, 23.1)	238	1,818	7.7 (6.6, 8.9)
Age of first non-medical prescription drug use (M., SD, 95% CI)	25.0	1.177	(22.7, 27.3)	25.1	0.639	(23.9, 26.4)
Used any prescription-type drugs for non-medical purposes in the last 12 months**						
No	11	109	8.1 (4.2, 15.0)	126	898	3.8 (3.1, 4.7)
Yes	19	114	8.5 (5.0, 14.1)	121	965	4.1 (3.3, 5.1)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months in the last 12 months.

[a] Note: Proportions on this variable do not sum to 100% within the Transitioned and Regular ADF groups due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

** Listed drugs include meth/amphetamines, marijuana, heroin, methadone or buprenorphine, cocaine, hallucinogens, ecstasy, ketamine, GHB, inhalants, opiates, opioids.*

** Prescription-type drugs include painkillers/analgesics, tranquilisers/sleeping pills.*

5 Mental health characteristics of Transitioned ADF veterans with recent (12-month) homelessness

Key findings

Compared with Not Recently Homeless veterans (no episode of homelessness in the last 12 months), Recently Homeless veterans (i.e. homeless during the last 12 months):

→ reported higher psychological distress, and were significantly more likely to score in the very high band, and significantly less likely to score in the low band on the K10

→ reported higher levels of post-traumatic stress symptoms, being significantly more likely to score in the very high band and significantly less likely to score in the low band on the PCL-C

→ were significantly more likely to score in the highest band for at-risk drinking and significantly less likely to score in the lowest band on the AUDIT

→ had more depressive symptoms, being significantly less likely to score in the minimal band, and more likely to score in the severe band on the PHQ-9

→ reported more anxiety symptoms, being significantly more likely to score in the moderate and high bands, and less likely to score in the low band on the GAD-7

→ were significantly more likely to report recent suicidal ideation, plans and attempts (i.e. during the previous 12 months). Overall, two-thirds of Recently Homeless veterans reported one or more instances of recent suicidality compared with just over a quarter of those Not Recently Homeless.

5.1 Introduction

Chapter 5 provides a detailed summary of a number of mental health problems experienced by the Transitioned ADF with recent (12-month) homelessness status. Probable disorders could be inferred from scores falling within the 'high' bandings on validated mental health scales for post-traumatic stress symptoms, psychological distress, at-risk drinking behaviour, depression symptoms, and generalised anxiety. Suicidality and anger were also assessed. Outcomes are weighted up to the entire population, using the technique described in Chapter 2, and thus represent weighted estimates of these characteristics for the entire Transitioned ADF (N=24,932).

The following research questions are addressed in this chapter.

1. What are the mental health and wellbeing characteristics of Recently Homeless (i.e. during the last 12 months), compared with Not Recently Homeless (no episode of homelessness in the last 12 months), veterans? Characteristics examined include: post-traumatic stress symptoms, psychological distress, at-risk drinking behaviour, depression and anxiety symptoms, suicidal ideation, and anger.

2. Is there a significant difference between the mental health characteristics of Recently Homeless veterans and Not Recently Homeless veterans?

5.2 Mental health characteristics in the Transitioned ADF with recent (12-month) homelessness

Table 26 presents mental health and wellbeing characteristics of Recently Homeless (i.e. during the last 12 months), compared with Transitioned ADF who were not recently homeless.

Overall, Recently Homeless veterans were doing worse than Not Recently Homeless veterans on all of the seven broad aspects of mental health and wellbeing examined. For all continuous variables, Recently Homeless veterans had significantly higher mean scores than Not Recently Homeless veterans. Moreover, for the categorical variables (i.e. risk bandings on mental health scales), the general trend was that the majority of Not Recently Homeless veterans fell into the first one or two bandings (representing essentially low or minimal risk), whereas the majority of Recently Homeless veterans fell into the top two bandings (representing essentially high or very high risk) (See Table 26 and Figure 1).

This trend was less pronounced for at-risk drinking, assessed using the AUDIT, as the scores of both Recently Homeless and Not Recently Homeless veterans tended more towards the lower end of the risk scale; while the majority of Recently Homeless veterans were still not in the lowest risk banding, they were spread more evenly across the remaining three bandings.

Generally, compared with Not Recently Homeless veterans, Recently Homeless veterans were less likely to feature in the two lowest bandings, and more likely to feature in the remaining risk bandings, although these differences were not always significant. Specific results are now discussed in turn.

For psychological distress (using the K10), Recently Homeless veterans were significantly less likely than Not Recently Homeless veterans to be in the low category (14.9% vs 49.6%), and significantly more likely to be in the very high category (48.9% vs 17.9%).

For post-traumatic stress symptoms (using the PCL-C), Recently Homeless veterans were significantly less likely than Not Recently Homeless veterans to be in the low category (33.4% vs 61.2%), and significantly more likely to be in the very high category (41.4% vs 14.6%).

For at-risk drinking (using the AUDIT), Recently Homeless veterans were significantly less likely than Not Recently Homeless veterans to be in Band 1 (45.5% vs 66.2%), and significantly more likely to be in Band 4 (20.6% vs 5.7%).

For depression symptoms (using the PHQ-9), Recently Homeless veterans were significantly less likely than Not Recently Homeless veterans to be in the minimal category (10.8% vs 47.5%), and significantly more likely to be in the moderately severe (18.6% vs 8.4%) and severe (36.4% vs 9.0%) categories.

Finally, for anxiety symptoms (using the GAD-7), Recently Homeless veterans were significantly less likely than Not Recently Homeless veterans to be in the minimal category (20.4% vs. 56.3%), and significantly more likely to be in the moderate (21.6% vs 10.4%) and severe (36.8% vs 10.0%) categories.

Recently Homeless veterans were significantly more likely to report in the affirmative for all four questions regarding suicidality (involving two types of suicidal thoughts, and suicide plans and attempts) than Not Recently Homeless veterans. Overall, the majority of Recently Homeless veterans (66.7%) reported experiencing any (i.e. at least one instance of) suicidality in the past 12 months, compared with just over a quarter of Not Recently Homeless veterans (27.8%).

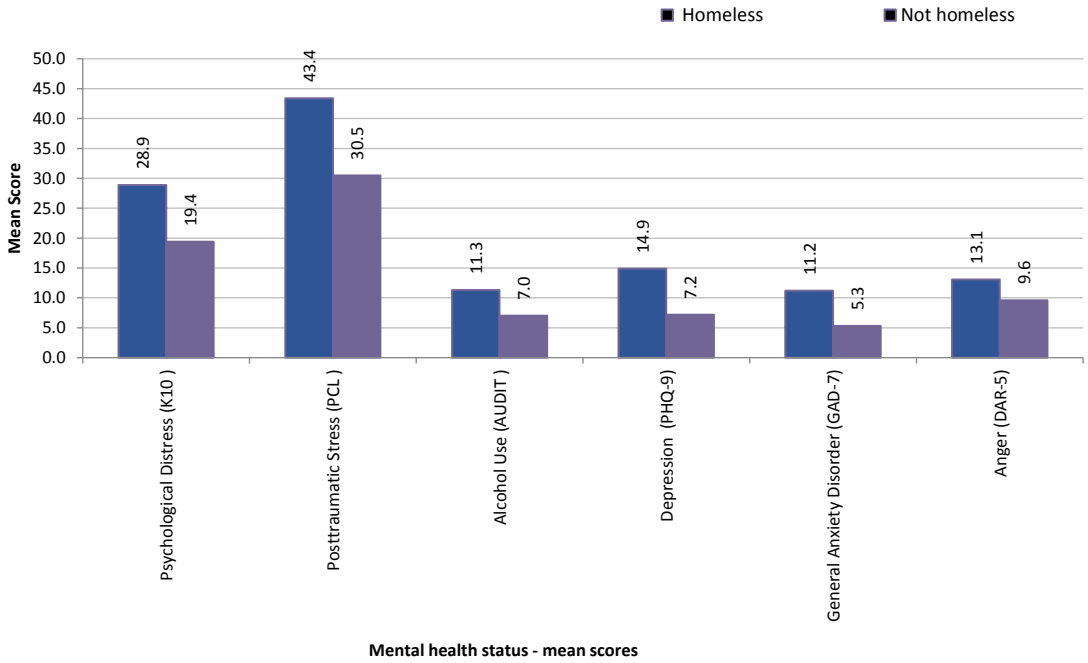
Table 25: Estimated mental health characteristics in the Transitioned ADF with recent (12-month) homelessness

		Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
		n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Psychological distress (K10) [a]	Low (10–15)	28	201	14.9 (9.7, 22.1)	1,996	11,703	49.6 (47.8, 51.5)
	Moderate (16–21)	31	187	13.9 (9.0, 20.7)	713	4,251	18.0 (16.6, 19.5)
	High (22–29)	39	283	21.0 (14.7, 29.0)	522	3,087	13.1 (11.9, 14.4)
	Very high (30–50)	97	661	48.9 (40.5, 57.4)	680	4,223	17.9 (16.5, 19.4)
	M., SE, (95% CI)	*28.9*	*1.0*	*(27.1, 30.8)*	*19.4*	*0.2*	*(19.1, 19.8)*
PTSD (PCL-C) [a]	Low (17–29)	56	453	33.4 (25.4, 42.4)	2,359	14,426	61.2 (59.3, 63.0)
	Moderate (30–39)	23	147	10.8 (6.6, 17.3)	499	3,279	13.9 (12.6, 15.4)
	High (40–49)	21	147	10.8 (6.4, 17.7)	309	1,885	8.0 (7.0, 9.1)
	Very high (50–85)	83	561	41.4 (33.3, 50.0)	559	3,442	14.6 (13.3, 16.0)
	M., SE, (95% CI)	*43.4*	*1.7*	*(40.1, 46.7)*	*30.5*	*0.3*	*(29.9, 31.1)*
Alcohol use (AUDIT) [a]	Band 1 (0–7)	83	613	45.5 (36.8, 54.4)	2,525	15,623	66.2 (64.3 ,68.1)
	Band 2 (8–15)	39	297	22.0 (15.3, 30.7)	790	5,277	22.4 (20.7, 24.1)
	Band 3 (16–19)	15	119	8.8 (4.7, 15.9)	158	1,050	4.5 (3.7, 5.4)
	Band 4 (20–40)	41	278	20.6 (14.6, 28.3)	205	1,339	5.7 (4.8, 6.7)
	M., SE, (95% CI)	*11.3*	*0.8*	*(9.7, 12.9)*	*7.0*	*0.1*	*(6.8, 7.3)*
Depression (PHQ-9) [a]	Minimal (0–4)	22	146	10.8 (6.6, 17.1)	1,893	11,189	47.5 (45.6, 49.3)
	Mild (5–9)	39	266	19.7 (13.7, 27.4)	927	5,520	23.4 (21.8,25.1)

		Recently Homeless n = 1,396			Not Recently Homeless n = 23,536		
		n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
	Moderate (10–14)	29	184	13.7 (8.8, 20.6)	431	2,572	10.9 (9.8, 12.1)
	Moderately severe (15–19)	37	252	18.6 (12.8, 26.3)	322	1,980	8.4 (7.4, 9.5)
	Severe (20–27)	68	492	36.4 (28.7, 44.9)	351	2,131	9.0 (8.1, 10.1)
	M., SE, (95% CI)	*14.9*	*0.7*	*(13.6, 16.2)*	*7.2*	*0.1*	*(6.9, 7.4)*
Generalised anxiety (GAD-7) [a]	Minimal (0–4)	40	276	20.4 (14.3, 28.3)	2,236	13,269	56.3 (54.4, 58.1)
	Mild (5–9)	46	286	21.2 (15.1, 28.8)	889	5,237	22.2 (20.7, 23.8)
	Moderate (10–14)	40	291	21.6 (15.3, 29.6)	410	2,443	10.4 (9.3, 11.6)
	Severe (15–21)	70	497	36.8 (29.1, 45.3)	383	2,352	10.0. (8.9, 11.1)
	M., SE, (95% CI)	*11.2*	*0.5*	*(10.1, 12.2)*	*5.3*	*0.1*	*(5.1, 5.5)*
Suicidality [a]	Felt life not worth living	128	890	65.9 (57.5, 73.4)	1,046	6,319	26.8 (25.2, 28.5)
	Felt so low thought about committing suicide	103	690	51.1 (42.6, 59.5)	746	4,604	19.5 (18.1, 21.1)
	Made a suicide plan	59	347	25.7(19.3, 33.3)	278	1,618	6.9 (6.0, 7.8)
	Attempted suicide	21	145	10.7 (6.5, 17.1)	58	360	1.5 (1.1, 2.1)
	Any suicidality	129	901	66.7 (58.3, 74.1)	1,084	6,549	27.8 (26.1, 29.5)
Anger (DAR-5) [a]	M., SE, (95% CI)	13.3	0.5	(12.4, 14.3)	9.6	0.1	(9.4, 9.8)

Denominator: Transitioned ADF 12-month Homeless vs Not Homeless in the last 12 months.
[a] Note: Proportions on this variable do not sum to 100% within the transitioned group due to a small amount of missing data (e.g. less than 5%). However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
M. = mean, SE = standard error,

Figure 1: Estimated mean scores for recent (12-month) homelessness for the K10, PCL-C, AUDIT, PHQ-9, GAD-7 and the DAR-5



6 Discussion

This report is the first to provide comprehensive estimates of the prevalence and correlates of homelessness in Australian contemporary veterans. Using the recently collected TWRP data, estimates could be generated to represent the entire population of veterans who had left Regular ADF service between 2010 and 2014.

Overall, results highlighted that the prevalence of homelessness among transitioned veterans could be considered high compared to the general Australian community, and thus is deserving of attention and concern. Veterans with recent homelessness (i.e. during the last 12 months) showed an overall profile of risk consistent with international literature, including a background of greater lifetime trauma, an accumulation of recent life events, higher risk behaviour, higher rates of unemployment and financial strain, poorer social support and worse mental health. These results will now be discussed in detail.

6.1 Homelessness in transitioned ADF members

6.1.1 Prevalence of homelessness

For both lifetime and recent (12-month) homelessness, estimates were much higher in the Transitioned ADF (21.7% and 5.3% respectively) compared with recent Australian community estimates (approximately 10% and 1.9% respectively) (Australian Bureau of Statistics, 2014a). It should be noted that our prevalence estimates cannot be compared directly with estimates for US and UK veterans, which apply to a narrow segment of the wider homeless population (e.g. those sleeping rough or in shelters—as discussed in the introduction) (Ministry of Defence, 2017; US Department of Housing and Urban Development, 2014; US Department of Veterans Affairs, 2016). However, the patterns identified are broadly consistent with US findings, where veterans have consistently been over-represented in homelessness statistics (U.S. Department of Housing and Urban Development, 2017a).

It is important to note that the estimates generated in our study were not standardised to account for various demographic differences between the Transitioned ADF and the Australian community population (e.g. age, sex, employment), which might explain some (but unlikely all) of the prevalence differences. Additionally, while we used the ABS definition of homelessness, our operationalisation needed to be adapted due to slightly different survey questions used—thus, we could not directly assess adequacy of the dwelling and control of space, and so our more inclusive definition may have had the effect of slightly inflating estimates.

Despite any slight definitional or statistical differences, it is safe to say that there is a higher prevalence of homelessness in transitioned ADF members than in the general Australian population. This is concerning and requires further consideration, in the form of more detailed research and tailored intervention and service provision.

Regardless of the various other contributing factors to homelessness (such as mental health issues, drug use, etc.), leaving military service can be considered to represent a risk, both directly—such as loss of full-time work, stable housing and identity, and even loss of community if ADF members return to their home towns after long periods away—and indirectly—due to the loss of military support services as a safety net when life events occur, such as relationship breakdown. These correlations are investigated further in the *Homelessness amongst Australian contemporary veterans: pathways from military and transition risk factors* report (Searle, Van Hooff et al. 2019), which provides insights into the longitudinal predictors of homelessness.

The results highlight that homelessness among contemporary veterans is not *solely* related to transition from ADF service. A larger proportion of the veteran population was found to have experienced homelessness in their lifetime (21.7%) than had experienced homelessness in the preceding 12 months (i.e. closely succeeding their ADF transition) (5.3%). Thus, at least some

of these instances of lifetime homelessness are likely to have occurred prior to any ADF service (although our data are not able to confirm this). In fact, at least 14% (likely greater if we had enquired beyond veterans' most recent episode of homelessness) of those reporting lifetime homelessness had experienced an episode of homelessness more than five years ago, which thus definitely preceded their transition date. This greater lifetime risk of homelessness may have increased this group's current (post-transition) risk—this is consistent with research that indicates experiencing one homelessness episode increases vulnerability to subsequent episodes (Lipton et al., 2000; McQuistion et al., 2014; O'Connell et al., 2008). Underlying repeated homelessness episodes might be more chaotic and disadvantaged backgrounds, including early life adversity and trauma, and chronic conditions such as risky behaviours (e.g. substance use) and mental health issues (McQuistion et al., 2014; O'Connell et al., 2008). Relatedly, our results found that Recently Homeless veterans on average reported exposure to a greater number of lifetime traumatic events than those Not Recently Homeless veterans. Thus, homelessness in veterans may be, at least partly, linked to a complicated life history that they bring with them to the ADF. However, this was not statistically examined here.

6.1.2 Characteristics of homelessness

Reported lifetime homelessness had mostly involved only one or two discrete episodes, although a significant minority of Transitioned ADF had experienced repeated episodes. When considering recent (12-month) homelessness, the duration of homelessness episodes lasted three months or less for most veterans (51.8%), and a sizeable proportion of these could be termed 'transitional' (i.e. lasting less than one month) (45.7%). However, a sizeable minority of homeless veterans (15.5%) reported a more chronic homelessness experience (i.e. six months or more). These cases of both repeated and chronic homelessness are of particular concern; however, due to the small number of veterans reporting this, correlates could not be examined any further within our data. Other studies have demonstrated that repeatedly and chronically homeless individuals have poorer mental health and wellbeing than those experiencing temporary homelessness (McQuistion et al., 2014; O'Connell et al., 2008).

Reasons for homelessness (both lifetime and 12-month) were generally related to issues involving a change in income and household structure, such as job loss, relationship breakup and financial problems, which is consistent with the literature (Balshem et al., 2011). Unsurprisingly, mental health was a prominent reason for both lifetime and recent homelessness for the Transitioned ADF. The link between mental disorder and homelessness has been well documented (Balshem et al., 2011; Metraux et al., 2013; Rosenheck & Fontana, 1994; Tsai & Rosenheck, 2015); however, there is less clarity regarding the direction of this association. In the follow-up longitudinal analyses (Searle, Van Hooff et al. 2019), this issue will be examined further.

6.1.3 Help-seeking for homelessness

The overwhelming majority of homeless veterans had not sought support. Similarly low rates of service use have been documented among a nationally representative sample of US veterans (Tsai et al., 2016), and in the Australian community more broadly (Black & Gronda, 2011).This highlights the importance of population-level statistics that are not dependent on service use—it is clear that the majority of homeless veterans in our data would not be identified using the Specialist Homelessness Services Collection (SHSC) dataset. Interestingly, of those veterans who did seek help, the majority did not find the assistance helpful. This may relate to the fact that the Transitioned ADF generally sought help for issues with relatively complicated resolution processes (e.g. via mental health or job services, or counselling), rather than simply accessing housing services to find a new home. In any case, it is concerning that transitioned veterans, in whom we have documented a high prevalence of homelessness, are either not accessing services or not receiving the help that they need from services. Thus, service providers cannot either see/reach them, or else properly help them. In knowing this, much more now needs to be discovered as to what homeless veterans want from services, so that those services are able to

properly meet their needs. Qualitative research among the broader homeless veteran community (i.e. not just those using services) would help to answer this question.

It is noteworthy that the vast majority of homeless veterans had not sought help as they didn't think they needed it. While it would appear on the surface that there is not an obvious major barrier to seeking help, this perception of not needing help could be somewhat distorted in Ex-serving ADF members given that the military fosters an ethos of 'soldiering on' through discomfort and distress. It has been well documented that military members report reluctance to seek help or disclose mental health issues due to concerns over social stigma, including being seen as weak, and instead want to fix things themselves (French et al., 2004; Gould et al., 2010; Iversen et al., 2011; McFarlane et al., 2011; Sareen et al., 2007). In fact, within the transitioned ADF population studied here, we have previously documented that a sizeable proportion of veterans might reconsider seeking help for their mental health in future due to concerns including 'feeling worse if I couldn't solve my own problems' and 'people would have less confidence in me', both endorsed by over one-third of veterans (Forbes et al., 2017). Additionally, of those who were concerned about their mental health but had not sought help, 80 per cent reported this was because 'I can still function', and 77 per cent agreed they 'prefer(red) to manage myself' (Forbes et al., 2017). Thus, it would seem that in Australian contemporary veterans, a tough mentality and perceptions of stigma may impede help-seeking for a variety of adverse situations.

Moreover, a significant minority did report barriers to seeking help, such as not knowing where to get help, and issues with trust or previous bad experiences. These results highlight a significant opportunity to connect with ADF personnel *prior* to transitioning and experiencing homelessness regarding relevant services (this is discussed more in Section 6.4).

6.2 Correlates of homelessness in transitioned ADF members

Among the Transitioned ADF, those who were Recently Homeless (i.e. had experienced homelessness in the previous 12 months) had a constellation of risk factors that distinguished them from those who were Not Recently Homeless (no episode of homelessness in the last 12 months). In general, Transitioned ADF members who were Recently Homeless were younger, less likely to be in a relationship or married, less well educated, more likely to be unemployed or underemployed, and experiencing financial strain. With the exception of age, which may be a risk factor unique to veteran populations, this risk profile is consistent with what is observed in the general community (Topolovec-Vranic et al., 2017; Tsai et al., 2017; Applewhite, 1997; Tsai & Rosenheck, 2015).

In terms of their military careers, Recently Homeless veterans were of lower rank at transition, reported shorter length of Service, were more likely to have been classified as medically unfit, and were more likely to have been medically discharged. They were also less likely to report discharging at their own request or for positive reasons (such as improved employment prospects). All of these Service-specific factors are likely to place individuals at a disadvantage in the labour market on transition, and subsequently impede their ability to secure housing, as well as impairing reintegration to civilian life more generally. Our results suggest that the first two years of transition could be a critical period for engagement with support services, as Recently Homeless veterans were more likely to have transitioned in the previous two years than Not Recently Homeless veterans.

Importantly, Recently Homeless veterans had overall poorer social connectedness across all domains examined. Lack of family and social support has been found internationally to be a risk factor for homelessness (Metraux et al., 2013; Tsai & Rosenheck, 2015). While this would be, at least partly, a consequence of their homelessness, it may also have contributed to it and could exacerbate the experience.

Recently Homeless Transitioned ADF were more likely than Not Recently Homeless veterans to report risky driving and gambling behaviour, smoking and drug use. This is broadly consistent with recent evidence linking the sensation-seeking behaviours of driving while intoxicated,

gambling and aggressive conduct with various durations of homelessness in a large sample of US veterans (Harris et al., 2017). As previously mentioned, substance abuse (including alcohol and tobacco) is one of the most consistent correlates of homelessness in veterans (Tsai & Rosenheck, 2015). In this study, Recently Homeless veterans were also more symptomatic on all of the mental health measures examined. As highlighted in both US and UK research, PTSD is by no means the sole or even strongest mental health correlate of veteran homelessness, with a wide profile of mental health issues apparent in homeless veterans, including anxiety and mood disorders, and schizophrenia (Ministry of Defence, 2017; Tsai & Rosenheck, 2015).

In addition to the above risk factors, Recently Homeless Transitioned ADF reported more recent life events and, importantly, a greater exposure to traumatic events across their lifetime—which is consistent with international literature in both veterans (Rosenheck & Fontana, 1994; Tsai & Rosenheck, 2015) and the broader community (Herman et al., 1997; Roos et al., 2013; Shelton et al., 2009; van den Bree et al., 2009).

All of these factors are known to be interrelated, but the causal pathways between them are not clear. However, our results do provide the beginnings of a model of vulnerability, in which a number of these factors could be identified and measures put in place to mitigate risk. The transition *Mental health prevalence* report (Van Hooff et al., 2018) highlighted that younger age and shorter length of Service were associated with poorer mental health outcomes. Similarly, Recently Homeless veterans were more likely to be younger, of lower rank, and have served for less time than Not Recently Homeless veterans. These factors may be a proxy for higher mental health problems (which may have precipitated discharge, but equally may have occurred after transition), but they may also reflect lower socioeconomic position and fewer skills/qualifications (specifically in relation to civilian employment). How all of these factors work together to influence homelessness was not within the scope of this report; these types of multivariate longitudinal associations will be explored in the second component of our analyses (Searle, Van Hooff et al. 2019).

6.3 Limitations

There are several limitations that must be considered when interpreting these results. First, due to homelessness being a relatively low-prevalence condition, there were only 220 Transitioned ADF veterans completing the survey who had experienced recent (12-month) homelessness. In weighting these results to represent the entire Transitioned ADF (N=24,932) and those estimated to be Recently Homeless (N=1,317), the confidence intervals surrounding the estimates for the Recently Homeless group were fairly wide in several instances. As a result, what might seem like a reasonable point prevalence[9] difference between the Recently Homeless and Not Recently Homeless groups was often not statistically significant due to the wide confidence intervals of the Recently Homeless overlapping those of the Not Recently Homeless. This lack of precision is unfortunate, but is inherent in homelessness research (Tsai et al., 2016) given the low prevalence of the condition and the difficulties in recruiting homeless veterans (discussed in more detail below). Even with population-level data, a low-prevalence condition (i.e. homelessness) can be difficult to disaggregate into smaller subgroups (e.g. ‘experienced a particular trauma’) for analysis.

Second, and more broadly, our research suffered similar issues to other homelessness research in managing to recruit a sizeable proportion of recently or currently homeless veterans. While we had the advantage of obtaining the contact details for each member of the contemporary veteran population from the ADF, these details were accurate upon transition, which was up to five years prior to the Mental Health and Wellbeing Transition Study for some veterans. Homeless veterans would also have been more likely to have changed contact details than not homeless veterans, suggesting that they would be under-represented as responders,

[9]Point prevalence is the proportion of a population that has the condition at a specific point in time.

which would introduce some bias into the data. While we were able to statistically weight the data for non-response in order to obtain population-level estimates, greater sampling numbers equates to greater statistical precision in these weighted estimates, which was reflected in our sometimes-wide confidence intervals.

Our results may have also under-represented certain types of homeless veterans. For example, certain veterans, including those with financial problems and those sleeping on the streets, may have been less able to maintain mobile phone numbers, making it more difficult to reach them. Additionally, mental health problems (which were prevalent in our Recently Homeless veteran population) play a large factor in non-response across all social research and, as such, homeless veterans with mental health problems (perhaps also teamed with various other social issues like relationship breakdown, financial issues and substance abuse) may not have had the psychological capacity to respond, even if we were able to contact them. Again, this was largely unavoidable and inherent in studying such a complex population. In fact, as our more inclusive definition of homelessness went beyond primary homelessness (i.e. sleeping on the streets and in cars) to include those in temporary accommodation (e.g. staying with friends/relatives), there was probably less of an issue in accessing those who weren't 'sleeping rough'. However, it is important to consider that, overall, these factors may have had the effect of: (1) reducing precision, (2) underestimating the prevalence of homelessness, and (3) under-representing those with more complex homelessness.

Third, it must be remembered that as all of our results are based on cross-sectional data, we were not able to determine cause and effect relationships between homelessness and the various socio-demographic factors examined, and thus those factors that were related to homelessness must be considered as correlates rather than true risk factors. Specifically, it is not possible to conclude that factors such as mental health issues caused homelessness—it is possible that homelessness caused mental health issues (or that the factors exacerbated each other in a reciprocal fashion), or that both of these factors were spuriously related, confounded by a third variable such as stressful life events. Nonetheless, we are able to say that our examined correlates and homelessness are meaningfully related and in many instances accord with international research, including some prospective evidence (Metraux et al., 2013). These significant correlational findings will be explored more thoroughly using longitudinal data in Part 2 of these analyses (i.e. Searle, Van Hooff et al. 2019).

Fourth, and related to the previous point, our results represent a comprehensive but basic statistical description only, in that we did not adjust our comparisons for covariates in order to rule out confounding by third variables. It is possible that after controlling for demographic factors (e.g. age, sex, rank), the associations between homelessness and variables such as tobacco use are sizeably reduced, and perhaps even no longer significantly different. However, our results provide a detailed profile of Homeless veterans in comparison to Not Homeless veterans, and provide a starting point for more complex statistical analysis.

Fifth, both a strength and a limitation of our results is that they apply only to contemporary veterans (i.e. transitioned between 2010 and 2014). This particular group was studied as they have been under-researched in relation to homelessness, and represent a qualitatively different era from veterans who served and transitioned earlier—with different working conditions, deployments, and subsequent transition pensions/entitlements. Thus, the profile and correlates of homelessness may look quite different in this group. Including veterans from various eras in the one study would create considerable noise in the data. In addition, it is important to study veterans during the first few years following transition, given this represents a critical period of upheaval and change. Leaving the military involves needing to obtain a new job, often a new identity, and new accommodation (sometimes in a new city/state), and thus this period poses a relatively large risk of homelessness compared with subsequent periods (Foreign Affairs Defence and Trade Committee Department of the Senate, 2016). Yet, the first five years following military service is a relatively short time period in which to examine veteran homelessness, and examining a longer time period would undoubtedly reveal a larger problem.

Finally, our data did not have the precision to be able to determine when recent (12-month) homelessness had occurred in relation to military service (i.e. prior to, during or after) and, importantly, in relation to transition (i.e. prior to or after). The transition date variable was only in calendar years (e.g. 2013), and the most recent period of homelessness was a categorical range variable, with some response options being quite wide (e.g. '2 years to 5 years'). Given surveys were completed in 2015–16, homelessness in relation to transition could not be determined from the particular response option combinations provided as examples here, and this was the case for 47 per cent of the Recently Homeless veterans. One would imagine that the majority of recent (12-month) homelessness was following transition, given that: (1) due to its recency it would have overwhelmingly occurred during or following (and not prior to) military service, with at least 82 per cent of the Recently Homeless veterans serving for at least four years; and (2) homelessness during military service is uncommon, with recent (12-month) homelessness prevalence in the currently serving ADF being low (1.5%). However, we had no way of confirming this hypothesis. This uncertainty needs to be elucidated in future research. Regardless of when homelessness occurred for transitioned ADF members, prevention efforts and service delivery coordination should still be the remit of the ADF alongside the DVA, given this task will require both primary prevention efforts prior to transition as well as current intervention.

6.4 Implications for policy and practice

This study's population-level results highlight that the higher prevalence rates of homelessness among contemporary veterans is of concern for policy and practice. Our more inclusive definition of homelessness may have encompassed circumstances that were finite and not seemingly problematic, such as veterans who were staying with friends/relatives for a period of weeks only. However, our results highlight that Recently Homeless veterans have relatively greater vulnerabilities in various aspects of their life (including mental health issues and financial problems), and are likely to be concerned about being without stable housing in the future. Thus, homelessness is not just a problem in and of itself, but represents a complex state that, even when short term, has the potential to become chronic, as the various co-occurring risk factors in these veterans' lives reinforce each other, and thus will require a focussed and multidimensional response.

Our results are not able to speak directly to whether the experience of and circumstances around homelessness of transitioned ADF personnel are qualitatively different from those for the general Australian community and thus require different responses. However, it is plausible that this is true for at least a significant proportion of homeless veterans, given that contemporary veteran homelessness would be, in some measure, influenced by aspects of the transition experience, especially in the immediate years following transition. A component of the veteran homelessness experience may involve unsuccessful reintegration into civilian life (Pedlar & Thompson, 2016; Sheilds et al., 2016). Notably, in transitioning, veterans move from one healthcare system (military) to another (public/private), and may not know how to navigate it in order to access services relating to their homelessness. In our results, we saw that 26.1 per cent of Recently Homeless veterans reported not seeking assistance because they did not know where to go. Moreover, optimal engagement and outcomes would likely result from services that are tailored to veterans' military and transition experiences (Forces in Mind Trust, 2013; Forces in Mind Trust, 2015). In any case, considering prevalence alone, homelessness is a bigger problem for veterans than for the general population, and as such requires a combined ADF/DVA response. In saying this, general community policy and services still need to cater for homeless veterans, especially as some veterans may not trust service/ex-service related organisations (Warner et al., 2011). Responses from various organisations will no doubt be most successful in tackling this issue.

The results provided here will be important for both the ADF and the DVA in terms of how they might support ADF members around the transition period. In particular, the pre-transition period, when members are preparing to leave the ADF, represents an opportunity to educate ADF

members on the support services available—or perhaps more importantly, where to find them—should they ever need them post transition. This approach could prove invaluable for veterans who later become homeless, given one quarter of those not accessing services indicated they 'did not know of any'. In providing such educational programs, it is critical to ensure that the homelessness services suggested will actually appeal to veterans and ultimately prove helpful; if services are not visible/accessible, are linked (or do not highlight the lack of link) to ADF/DVA records and subsequent entitlement eligibility, or do not provide the support that veterans are seeking, then veterans will either not seek them out, or not maintain engagement.

The various correlates of homelessness identified in this report, including risk behaviours such as risky driving, problem gambling, smoking, drug use, and anger and mental health issues, may provide useful for identification of, and potential intervention with, at-risk veterans. While our cross-sectional results cannot reveal whether the factors are causes or consequences of homelessness (or neither), they still present an opportunity to: (1) develop a potential risk profile for ADF members who may need more support over the transition period; and (2) ensure that homelessness services are multifactorial and able to address complex health and wellbeing concerns, and not just a lack of housing. If any of these risk factors influence homelessness in a cyclical manner, then providing the veteran with a house/accommodation may not address the root cause of homelessness, and it may reoccur.

6.5 Concluding remarks

This introductory profile of contemporary veteran homelessness in Australia presents the first comprehensive population-level data on this issue, which clearly warrants further research and policy attention. The results in this report provide a detailed starting point for further action. Using this information, the DVA and ADF, along with other government agencies and ESOs, may be able to better identify veterans at risk, and offer and tailor their services accordingly.

Appendix A: Glossary of terms

Alcohol Use Disorders Identification Test (AUDIT) – Alcohol consumption and problem drinking was examined using the AUDIT (Saunders et al., 1993), a brief self-report screening instrument developed by the World Health Organization (WHO). This instrument consists of 10 questions to examine the quantity and frequency of alcohol consumption, possible symptoms of dependence, and reactions or problems related to alcohol. The AUDIT is an instrument widely used in epidemiological and clinical practice for defining at-risk patterns of drinking.

Australian Bureau of Statistics (ABS) – The ABS is Australia's national statistical agency, providing trusted official statistics on a wide range of economic, social, population and environmental matters of importance to Australia.

Australian Defence Force (ADF) – The ADF is constituted under the Defence Act 1903, its mission is to defend Australia and its national interests. In fulfilling this mission, Defence serves the government of the day and is accountable to the Commonwealth Parliament, which represents the Australian people to efficiently and effectively carry out the government's defence policy. The current program of research aims to examine the mental, physical and social health of serving and ex-serving ADF members, and their families. It builds upon previous research to inform effective and evidence-based health service provision for contemporary ADF members and veterans.

Australian Institute of Family Studies (AIFS) – The AIFS is the Australian Government's key research body in the area of family wellbeing. The AIFS conducts original research to increase understanding of Australian families and the issues that affect them. The current research was conducted by a consortium of Australia's leading research institutions, led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide and the AIFS.

Australian Institute of Health and Welfare (AIHW) – The AIHW is Australia's national agency for health and welfare statistics and information. The AIHW was utilised in the current program of research to develop a 'study roll' by integrating contact information from various sources/databases.

Centre for Traumatic Stress Studies (CTSS) – The CTSS seeks to improve evidence-based practice by informing and applying scientific knowledge in the field of trauma, mental disorder and wellbeing in at-risk populations. The current program of research was conducted by a consortium of Australia's leading research institutions, led by the CTSS at the University of Adelaide and the AIFS.

Confidence interval (CI) – A confidence interval gives an estimated range of values that is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data.

Department of Veterans' Affairs (DVA) – The DVA delivers government programs for war veterans, members of the ADF, members of the Australian Federal Police and their dependents. In 2014 the DVA, in collaboration with the Department of Defence, commissioned the Transition and Wellbeing Research Programme—one of the largest and most comprehensive military research programs undertaken in Australia.

Deployment status – In the Mental Health and Wellbeing Transition Study, deployment status was based on survey responses, and defined as follows.

- *Never deployed*—Individuals who did not endorse any of the listed deployments in the self-report survey (Your Military Career: Deployments) and did not endorse any of the deployment exposures (Your Military Career: Deployment Exposure).
- *Deployed*—Individuals who endorsed one or more of the listed deployments (Your Military Career: Deployments) OR endorsed one or more of the deployment exposures (Your Military Career: Deployment Exposure).

Dimensions of Anger Reactions scale (DAR-5) – The DAR-5 is a concise measure of anger. It consists of five items that address anger frequency, intensity, duration, aggression, and interference with social functioning. Items are scored on a five-point Likert scale generating a severity score ranging from 5 to 25, with higher scores indicative of worse symptomatology. This scale has been used previously to assess Australian Vietnam veterans, as well as US Afghanistan and Iraq veterans, and shows strong unidimensionality, and high levels of internal consistency and criterion validity.

DVA client – The term 'DVA client' was utilised during reporting when referring to DVA clients for the purpose of analyses.

In the construction of the DVA dataset for the 'study roll', DVA created an indicator of confidence against each veteran, with respect to the level of interaction DVA had with each of them, for assessing how confident DVA was in the address accuracy. Each of the following groups were considered DVA clients.

- *High*—where a veteran is in receipt of a fortnightly payment (such as income support or compensation pension) from DVA, it is a sign of regular ongoing contact with the client and therefore DVA would have a high level of confidence that their address would be up to date and correct.
- *Medium*—where a veteran only holds a treatment card (i.e. does not also have an ongoing payment) there is a lower level of ongoing contact with the department and therefore the level of confidence that DVA can assign to the accuracy of the client's address is lower.
- *Low*—where a veteran may not have had their illness/injury liability claim accepted as service related by DVA and has not received a treatment card or pension payment, there is a low level of confidence that their address will be up to date. However, they would still be considered DVA clients.

For the purposes of this report, any individual in the study population, who met any of the criteria above, was flagged as a 'DVA client'. Those with this flag were compared against those without this flag.

Early intervention and prevention – Early intervention and prevention are key concepts in homelessness policy and service delivery, but research, policy and program literatures offer no consistent definition. While the terms are frequently used together, or interchangeably, they are not the same thing.

Prevention and early intervention strategies aim to reorientate the service system away from crisis management and include offering post-crisis support where necessary. They also aim to ensure successful transitions for people exiting institutional settings such as psychiatric care facilities and prisons.

The national and international evidence base has firmly established that the longer someone is homeless, the more difficult it is to assist them to stabilise their life. The responses and resources required are therefore substantively different for someone who is homeless compared to someone at risk of homelessness.

Prevention strategies operate at the structural level (Chamberlain & Johnson, 2003) and occur before a person has become homeless. They aim to:

- address the underlying political, economic and social causes that place people at risk of homelessness (e.g. increasing the supply of affordable housing, improving labour markets)
- identify people who are most at risk of homelessness, and build up their protective factors and decrease their risk factors
- focus on people who are at risk but not actually homeless (e.g. sustain tenancies)
- use broad population-wide strategies that target the general population and at-risk groups; these interventions are not solely in the domain of specialist homelessness services, but

include mainstream services such as housing, health, education, employment and family welfare services (Culhane et al., 2011).

Early intervention strategies are targeted at individuals who have recently become homeless, and aim to ensure that short periods of homelessness do not become chronic.

Ex-service organisation (ESO) – ESOs provide assistance to current and former ADF members. Services can include, but are not necessarily limited to: welfare support, assistance with DVA claims, and employment programs and social support.

Generalised Anxiety Disorder 7-item scale (GAD-7) – GAD-7 is a brief seven-item screening measure based on the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) criteria for Generalised Anxiety Disorder.

Homelessness – Until recently, the most widely accepted definition of 'homelessness' was that developed by Chamberlain and MacKenzie (Chamberlain & MacKenzie, 1992; Chamberlain & MacKenzie, 2008). This definition was based on cultural expectations of the degree to which housing needs were met within conventional expectations or community standards. In Australia this meant having, at a minimum, one room to sleep in, one room to live in, one's own bathroom and kitchen, and security of tenure.

This definition describes three types of homelessness:

- *primary*—rough sleeping
- *secondary*—temporary accommodation (includes people moving frequently from one form of temporary accommodation to another, such as emergency housing, boarding houses or staying with family or friends/couch surfing)
- *tertiary*—inappropriate housing (refers to people staying for longer than 13 weeks in rooming houses or equivalent temporary accommodation).

In 2012 the ABS developed a new definition of homelessness, informed by an understanding that homelessness is not 'rooflessness' (ABS 2012b). A person is considered homeless under this revised definition if their current living arrangement exhibits one of the following characteristics:

- is in a dwelling that is inadequate
- has no tenure or the initial tenure is short and not extendable
- does not allow them to: have control of and access to space for social relations; provide a sense of security, stability, privacy or safety; or provide the ability to control living space.

It is notable that the 2012 ABS definition includes people in severely overcrowded dwellings who are considered not to have control of or access to space for social relations.

Indigenous understandings and definitions of homelessness can differ from those described above and can include 'spiritual homelessness' (the state of being disconnected from one's homeland, separation from family or kinship networks, or not being familiar with one's heritage); and 'public place dwelling' or 'itinerancy' (usually used to refer to Indigenous people from remote communities who are 'sleeping rough' in proximity to a major centre) (Australian Bureau of Statistics, 2014b; Australian Institute of Health and Welfare, 2014a; Memmott et al., 2003).

Indigenous homelessness is not necessarily defined as a lack of accommodation. It can be defined as losing one's sense of control over or legitimacy in the place where one lives (Memmott, Long et al. 2003), or an inability to access appropriate housing that caters to an individual's particular social and cultural needs (Birdsall-Jones et al., 2010). Some public space dwellers who have chosen to live rough may not see themselves as homeless (Memmott et al., 2003).

Gold Card – The Gold Card is the DVA Health Card 'for all conditions'. A Gold Card entitles the holder to DVA funding for services for all clinically necessary healthcare needs and all health conditions, whether they are related to war service or not. The card holder may be a veteran or the widow/widower or dependant of a veteran. Only the person named on the card is covered.

Kessler Psychological Distress Scale (K10) – The K10 is a short 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent four-week period. Items are scored from 1 to 5 and are summed to give a total score between 10 and 50. Various methods have been used to stratify the scores of the K10. The categories of low (10–15), moderate (16–21), high (22–29) and very high (30–50) that are used in this report are derived from the cut-offs of the K10 that were used in the 2007 ABS National Survey of Mental Health and Wellbeing (Slade et al., 2009).

Lifetime trauma Lifetime Trauma exposure questions used in this study were drawn from the post-traumatic stress disorder module of the CIDI 3.0 (Haro et al., 2006). Participants were asked to indicate whether or not they had experienced the following traumatic events: combat (military or organised non-military group); being a peacekeeper in a war zone or a place of ongoing terror; being an unarmed civilian in a place of war, revolution, military coup or invasion; living as a civilian in a place of ongoing terror for political, ethnic, religious or other reasons; being a refugee; being kidnapped or held captive; being exposed to a toxic chemical that could cause serious harm; being in a life-threatening automobile accident; being in any other life-threatening accident; being in a major natural disaster; being in a man-made disaster; having a life-threatening illness; being beaten by a spouse or romantic partner; being badly beaten by anyone else; being mugged, held up, or threatened with a weapon; being raped; being sexually assaulted; being stalked; having someone close to you die; having a child with a life-threatening illness or injury; witnessing serious physical fights at home as a child; having someone close experience a traumatic event; witnessing someone badly injured or killed, or unexpectedly seeing a dead body; accidentally injuring or killing someone; purposefully injuring, torturing or killing someone; seeing atrocities or carnage such as mutilated bodies or mass killings; experiencing any other traumatic event.

Medical Employment Classification (MEC) – The MEC is an administrative system designed to monitor physical fitness and medical standards in the ADF. MEC was divided into four levels (for members currently in, or on discharge from, Regular ADF service).

- *MEC 1*—Members who are medically fit for employment in a deployed or seagoing environment without restriction.
- *MEC 2*—Members who have medical conditions that require access to various levels of medical support or employment restrictions; however, they remain medically fit for duties in their occupation in a deployed or seagoing environment. In allocation of sub-classifications of MEC 2, access to the level of medical support will always take precedence over specified employment restrictions.
- *MEC 3*—Members who have medical conditions that make them medically unfit for duties in their occupation in a deployed or seagoing environment. The member so classified should be medically managed towards recovery and should be receiving active medical management with the intention of regaining MEC 1 or 2 within 12 months of allocation of MEC 3. After a maximum of 12 months, their MEC is to be reviewed. If still medically unfit for military duties in any operational environment, they are to be downgraded to MEC 4 or, if appropriate, referred to a Medical Employment Classification Review Board (MECRB) for consideration of an extension to remain MEC 3.
- *MEC 4*—Members who are medically unfit for deployment or seagoing service in the long term. Members who are classified as MEC 4 for their military occupation will be subject to review and confirmation of their classification by a MECRB.

Medical fitness – Medical fitness, for the purposes of this report, was defined as follows.

- *Fit*—refers to those who are categorised as fully employable and deployable, or with restrictions. Participants were classified as 'Fit' if they fell into MEC 1 or 2, as described above.
- *Unfit*—refers to those not fit for deployment, their original occupation and/or further service. This can include those undergoing rehabilitation or transitioning to alternative return-to-work arrangements, or in the process of medically separating from the ADF. Participants were classified as 'Unfit' if they fell into MEC 3 or 4, as described above.

Medical discharge – An involuntary termination of the client's employment by the ADF, on the grounds of permanent or at least long-term unfitness to serve, or unfitness for deployment to operational (warlike) service.

Mental Health Prevalence and Wellbeing Study (MHPWS) – The ADF's 2010 Mental Health Prevalence and Wellbeing Study (McFarlane, Hodson et al. 2011), part of MilHOP, was the first comprehensive investigation of the mental health of an ADF serving population.

Middle East Area of Operations (MEAO) – Australia's military involvement in Afghanistan and Iraq is often referred to as the Middle East Area of Operations (MEAO). Thousands of members have deployed to the MEAO since 2001, with many completing multiple tours of duty.

Military Health Outcomes Program (MilHOP) – MilHOP detailed the prevalence of mental disorder in current serving ADF members in 2010, as well as deployment-related health issues for those deployed to the MEAO. The current program of research will address a number of gaps identified following MilHOP, including the mental health of reservists, ex-serving members and ADF members in high-risk roles, as well as the trajectory of disorder and pathways to care for individuals previously identified with a mental disorder in 2010.

National Death Index (NDI) – The NDI is a Commonwealth database that contains records of deaths registered in Australia since 1980. Data comes from Registrars of Births, Deaths and Marriages in each jurisdiction, the National Coronial Information System and the ABS. Prior to contacting participants, the 'study roll' for this research was cross-checked against the NDI to ensure that we did not approach deceased members.

National Health and Medical Research Council (NHMRC) – The NHMRC is Australia's peak funding body for medical research. Previous investigations undertaken by the Centre have received NHMRC funding.

National Health Survey – The 2014–15 National Health Survey is the most recent in a series of Australia-wide ABS health surveys, assessing various aspects of the health of Australians, including long-term health conditions, health risk factors, and health service use.

Patient Health Questionnaire—9 (PHQ-9) – The PHQ-9 is an instrument which examines self-reported depression. Each item is scored from 0–3 and summed to give a total score between 0 and 27. The PHQ-9 provides various levels of diagnostic severity, with higher scores indicating higher levels of depression symptoms.

Post-traumatic stress disorder (PTSD) – A stress reaction to an exceptionally threatening or traumatic event that would cause pervasive distress in almost anyone. Symptoms are categorised into three groups: re-experiencing symptoms such as memories or flashbacks; avoidance symptoms; and either hyperarousal symptoms (increased arousal and sensitivity to cues) or inability to recall important parts of the experience.

The Post-traumatic Stress Disorder (PTSD) Checklist—civilian version (PCL-C) – The PCL-C is a 17-item self-report measure designed to assess the symptomatic criteria of PTSD according to the DSM-IV. The 17 questions of the PCL-C are scored from 1 to 5 and summed to give a total symptom severity score of between 17 and 85. An additional four items from the newly released PCL-5 were included for this research, giving researchers flexibility to measure PTSD symptoms according to the most recent definitional criteria.

Personnel Management Key Solution (PMKeyS) – The PMKeyS is an integrated human resource management system that provides the ADF with a single source of personnel

management information. PMKeyS manages information about the entire Defence workforce: navy, army and air force.

Probable mental health disorder – Where probable rates of mental health disorder are presented, these are based on self-report epidemiological cut-offs.

Rank status – Three levels of rank were utilised in the Mental Health and Wellbeing Transition Study:

- *Commissioned Officer* (OFFR)—consists of senior Commissioned Officers (Commander (CMDR), Lieutenant Colonel (LTCOL), Wing Commander (WGCDR) and above) and Commissioned Officers (Lieutenant Commander (LCDR), Major (MAJ), Squadron Leader (SQNLDR) and below).
- *Non-commissioned Officer* (NCO)—consists of senior Non-commissioned Officers (Petty Officer (PO), Sergeant (SGT) and above) and junior Non-commissioned Officers (Leading Seaman (LS), Corporal (CPL) and below).
- *Other Ranks*—consists of Able Seaman (AB), Seaman (SMN), Private (PTE), Leading Aircraftman (LAC), Aircraftman (AC) or equivalent

Reason for discharge – This is the reason for a member transitioning out of the ADF. In the current program of research, reason for discharge was derived from responses on the self-report survey, and classified as follows.

- *Medical discharge*—an involuntary termination of the client's employment by the ADF, on the grounds of permanent or at least long-term unfitness to serve, or unfitness for deployment to operational (warlike) service.
- *Other*—all other types of discharge including: compulsory age retirement, resignation at own request, assessed as unsuitable for further training, end of fixed period engagement, end of initial enlistment period/return of service obligation, end of limited tenure appointment, not offered re-engagement, accepted voluntary redundancy, compassionate grounds, and non-voluntary administrative discharge.

Service status – The ADF is comprised of the following three services.

- *Australian Army*—the army is Australia's military land force. It is a potent, versatile and modern army which contributes to the security of Australia, protecting its interests and people.
- *Royal Australian Navy*—the navy provides maritime forces that contribute to the ADF's capacity to defend Australia, contribute to regional security, support global interests, shape the strategic environment and protect national interests.
- *Royal Australian Air Force*—the air force provides immediate and responsive military options across the spectrum of operations as part of a whole-of-government joint or coalition response, either from Australia or deployed overseas. They do this through the key air power roles: control of the air; precision strike; intelligence, surveillance and response; and air mobility—enabled by combat and operational support.

Stratification – Refers to grouping of outcomes by variables of interest.

Study roll – Participants' contact details and demographic information were obtained via the creation of a 'study roll' by the AIHW. This process involved integrating contact information from the following sources:

- Defence Personnel Management Key Solution (PMKeyS) database
- DVA client databases
- National Death Index (NDI)
- ComSuper member database
- Military Health Outcomes Program (MilHOP) dataset.

Suicidal ideation – Suicidal ideation is defined as serious thoughts about taking one's own life.

Suicidality – The term suicidality covers suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts.

Subsyndromal disorder – This disorder is characterised by symptoms that are not severe enough for diagnosis as a clinically recognised syndrome.

Transitioned ADF – The term Transitioned ADF is used to denote military service leavers. For the purpose of the current study, this included all ADF members who transitioned from Regular ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves.

Transitioned status – Transitioned ADF members were divided into three groups, which broadly represented their level of continued association and contact with the ADF, as well as their potential access to support services provided by Defence.

- *Ex-serving*—individuals who were a Regular ADF member prior to 2010, who have transitioned from the Regular ADF since 2010 and who no longer remain engaged with Defence in a Reservist role. These individuals are classified as discharged from Defence.
- *Inactive Reservist*—individuals who were a Regular ADF member prior to 2010 but who have now transitioned into an Inactive Reservist role.
- *Active Reservist*—individuals who were a Regular ADF member prior to 2010 but who have now transitioned into an Active Reservist role.

Two-phase design – This is a well-accepted epidemiological approach to the investigation of the prevalence of mental health disorders. For the Mental Health and Wellbeing Transition Study, participants completed a screening questionnaire, which is generally economical in terms of time and resources. Based on the results of this screening and demographic information, certain participants were selected for a more accurate but costly formal diagnostic interview.

Veterans' Health Cards – The Health Card arrangements are the main way the DVA, on behalf of the Australian Government, provides convenient access to health and other care services for veterans, war widows and eligible dependents. Arrangements are based on providing access to clinically appropriate and required treatment, which is evidence based. There are three categories of DVA health cards: Gold, White and Orange (see separate entries for Gold and White cards).

Weighting – In this report, weighting allowed for the inference of results for the entire population. This involved the allocation of a representative value or 'weight' to the data for each responder, based on key variables. This weight indicated how many individuals in the entire population were represented by each actual responder. Weighting was applied for the following purposes: to correct for differential non-response; and to adjust for any systematic biases in the responders (e.g. oversampling of high scorers for CIDI 3.0).

White Card – A White Card is a DVA Health Card for specific conditions. It entitles the holder to care and treatment for:

- accepted injuries or conditions that are war caused or service related
- malignant cancer, pulmonary tuberculosis, post-traumatic stress disorder, anxiety and/or depression whether war caused or not
- the symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service).

Years since transition – In order to ascertain the number of years since transition from Regular military service (for Transitioned ADF only), participants were asked to indicate what year they transitioned to Active Reserves, Inactive/standby Reserves, or were discharged out of the Service (Ex-serving). Options included: 0, 1, 2, 3, 4, 5+ years.

Years of Regular service – The following categories were used in the Mental Health and Wellbeing Transition Study to define the number of years of Regular military service: 3 months–3.9 years, 4–7.9 years, 8–11.9 years, 12–15.9 years, 16–19.9 years, 20+ years.

Appendix B: Prevalence and characteristics of homelessness in the 2015 Regular ADF

Table A1: Estimated reasons for lifetime homelessness in the 2015 Regular ADF

Reasons for no permanent place to live	2015 Regular ADF n = 6,309		
	n	Weighted n	% (95% CI)
Tight housing/rental market	177	1,039	16.5 (10.9, 24.1)
Violence/abuse/neglect	81	584	9.3 (4.0, 20.1)
Alcohol or drug use	18	519	8.2 (2.9, 21.5)
Family/friend/relationship problems	586	3,590	56.9 (46.4, 66.9)
Financial problems (e.g. unable to pay mortgage or rent)	141	1,455	23.1 (14.1, 35.4)
Mental illness	35	370	5.9 (1.6, 19.1)
Lost job	60	715	11.3 (5.2, 23.0)
Gambling	2	18	0.3 (0.1, 1.5)
Eviction	36	174	2.8 (1.8, 4.1)
Natural disaster	19	152	2.4 (1.1, 5.4)
Other	173	873	13.8 (10.1, 18.7)

Denominator: 2015 Regular ADF cohort who had ever been homeless.

Figure A1: Estimated reasons for lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

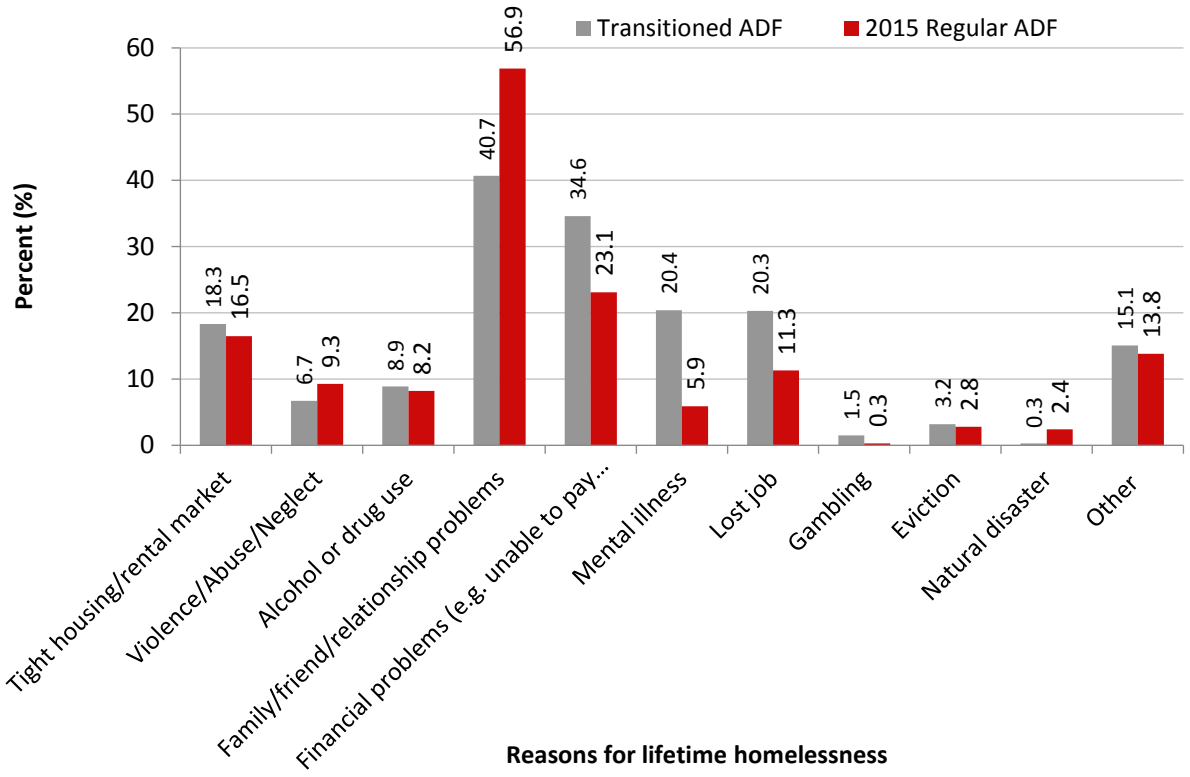


Table A2: Estimated number of homelessness episodes over the lifetime in the

Times with no permanent place to live	2015 Regular ADF n = 6,309		
	n	Weighted n	% (95% CI)
One	414	2,199	34.9 (25.7, 45.3)
Two	275	1,632	25.9 (17.3, 36.7)
Three	118	734	11.6 (6.0, 21.4)
Four	38	130	2.1 (1.4, 3.0)
Five or more	79	448	7.1 (3.4, 14.2)
Don't know	71	855	13.6 (6.5, 26.2)

Denominator: 2015 Regular ADF cohort who had ever been homeless.
Note: Approximately 5.0% of 2015 Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

Figure A2: Estimated number of homelessness episodes over the lifetime in the Transitioned ADF and 2015 Regular ADF

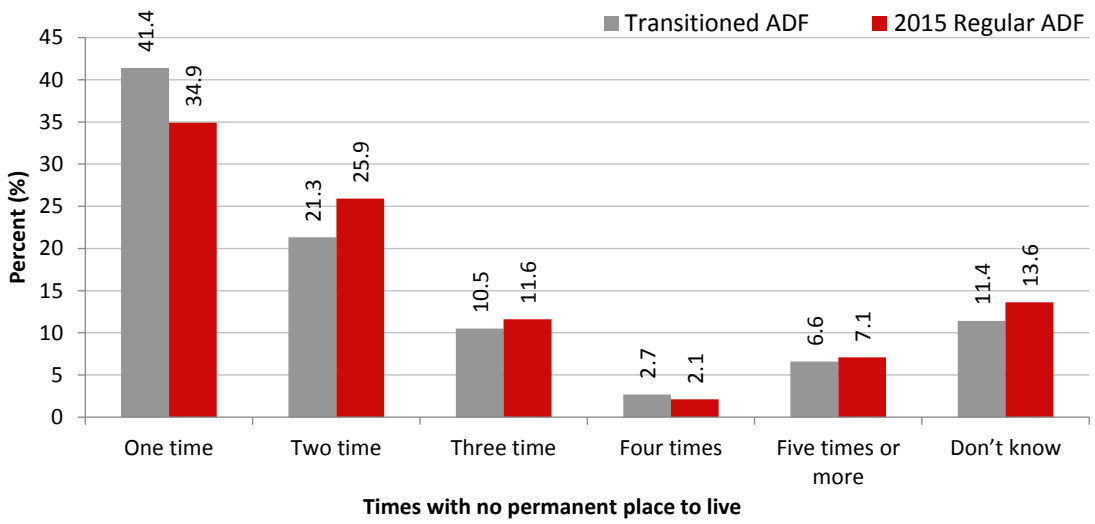


Table A3: Estimated reasons for most recent episode of lifetime homelessness in the 2015 Regular ADF

Reasons for most recent episode of homelessness	2015 Regular ADF n = 6,309		
	n	Weighted n	% (95% CI)
Tight housing/rental market	54	277	5.2 (3.2, 8.4)
Violence/abuse/neglect	23	320	6.0 (1.4, 22.9)
Alcohol or drug use	10	262	4.9 (0.8, 24.8)
Family/friend/relationship problems	124	1,117	21.1 (11.6, 35.1)
Financial problems (e.g. unable to pay mortgage or rent)	38	597	11.3 (4.2, 27.1)
Mental illness	14	272	5.1 (0.9, 24.3)
Lost job	23	566	10.7 (4.0, 25.5)
Gambling	#		
Eviction	12	61	1.2 (0.6, 1.9)
Natural disaster	5	13	0.3 (0.1, 0.6)
Other	16	64	1.2 (0.7, 2.1)

Denominator: 2015 Regular ADF cohort who had ever been homeless.
 # Cell size too small to be reported.

Figure A3: Estimated reasons for most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

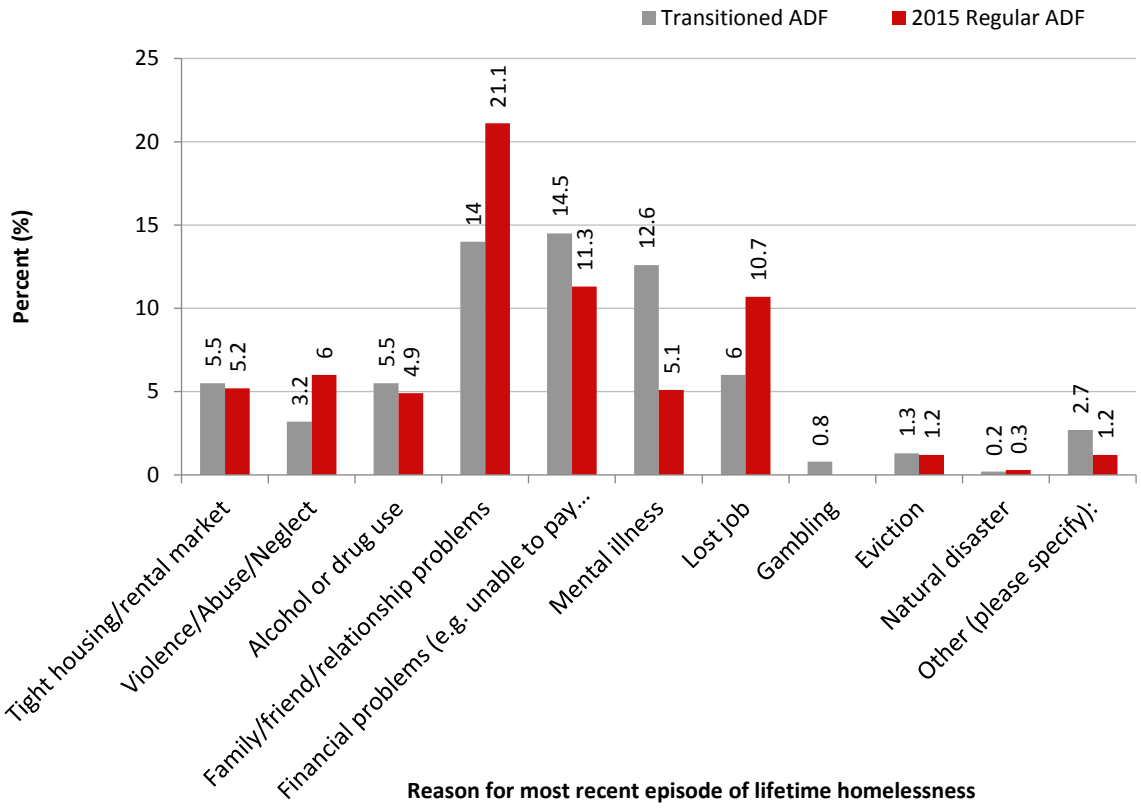


Table A4: Estimated recency of most recent episode of lifetime homelessness in the 2015 Regular ADF

Recency of most recent episode of homelessness	2015 Regular ADF n = 6,309		
	n	Weighted n	% (95% CI)
Less than 12 months ago	92	799	15.1 (7.5, 27.8)
12 months to less than 2 years	52	296	5.6 (2.8, 10.9)
2 years to less than 5 years	111	859	16.2 (8.1, 29.7)
5 years to less than 10 years	180	885	16.7 (11.1, 24.3)
10 years or more	391	2,346	44.2 (32.3, 56.8)
Don't know	6	111	2.1 (0.4, 11.2)

Denominator: 2015 Regular ADF cohort who had ever been homeless.
Note: Approximately 0.2% of 2015 Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

Figure A4: Estimated recency of most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

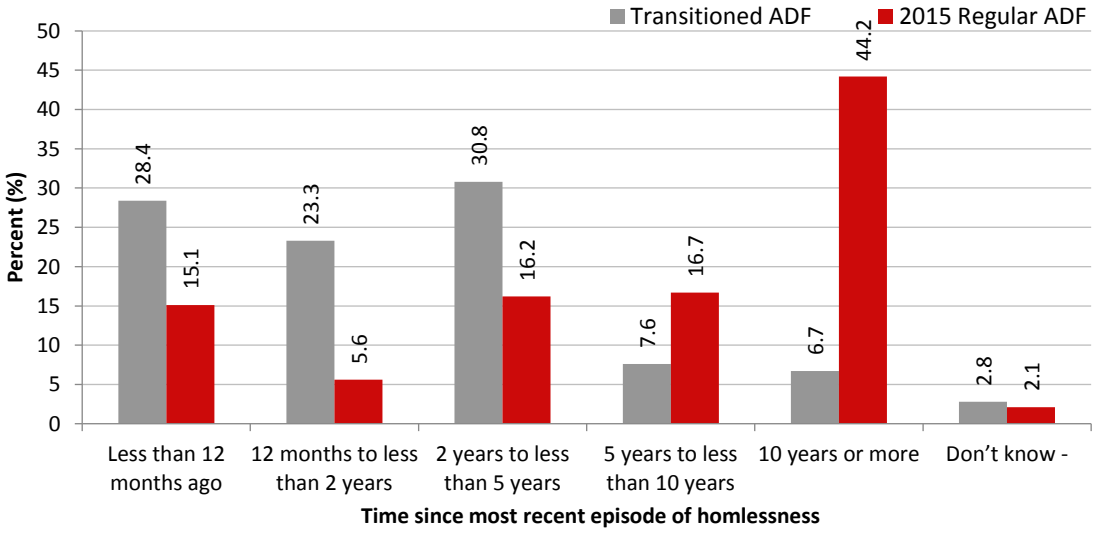


Table A5: Estimated duration of most recent episode of lifetime homelessness in

Duration of episode of homelessness	2015 Regular ADF n = 4,639 n	Weighted n	% (95% CI)
Less than 1 week	50	902	17.0 (8.5 ,31.0)
1 week to less than 2 weeks	40	398	7.5 (2.9, 18.2)
2 weeks to less than 4 weeks	81	342	6.5 (5.0, 8.4)
1 month to less than 2 months	74	278	5.2 (4.0, 6.9)
2 months to less than 3 months	49	164	3.1 (2.2, 4.2)
3 months to less than 4 months	49	186	3.5 (2.5, 4.8)
4 months to less than 5 months	14	69	1.3 (0.7, 2.3)
5 months to less than 6 months	28	145	2.7 (1.2, 6.1)
6 months or more	47	343	6.5 (2.5, 15.7)
Don't know	#	-	-

Denominator: 2015 Regular ADF cohort who had ever been homeless.
 # Cell size too small to be reported.
Note: Approximately 47.0% of 2015 Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

Figure A5: Estimated duration of most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

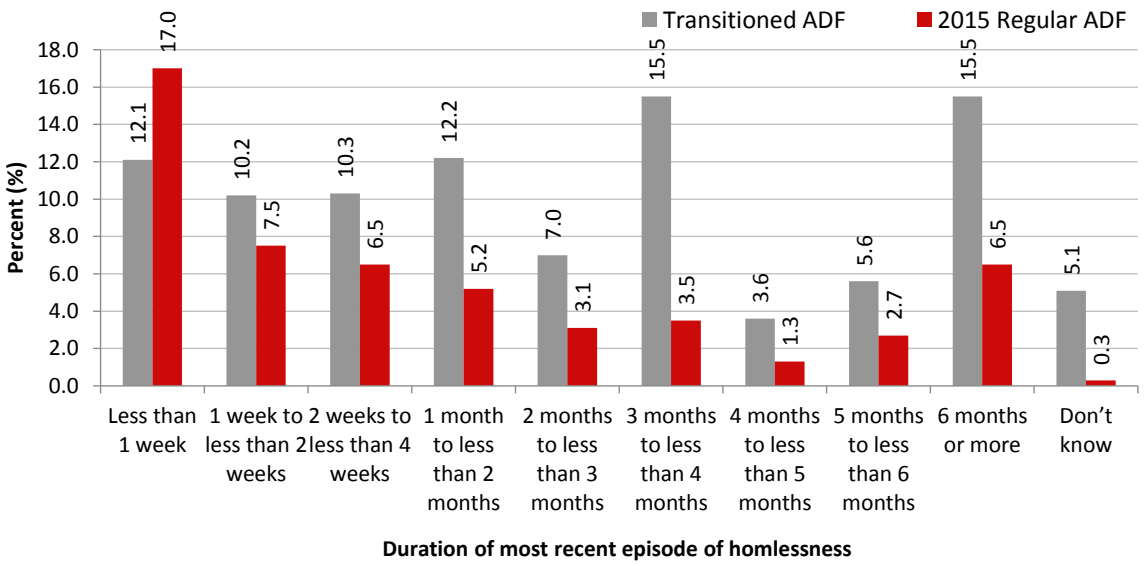


Table A6: Estimated types of assistance sought for most recent episode of lifetime homelessness in the 2015 Regular ADF

Assistance sought for most recent episode of homelessness	2015 Regular ADF n = 6,309		
	n	Weighted n	% (95% CI)
Housing service providers	54	338	6.4 (3.4, 11.6)
Crisis accommodation	7	23	0.4 (0.2, 1.0)
Mental health service	18	62	1.2 (0.6, 2.1)
Church or community organisation (St Vincent de Paul, Salvation Army, etc.)	8	38	0.7 (0.3, 1.6)
Health service	8	26	0.5 (0.2, 1.0)
Job service	11	102	1.9 (0.6, 5.8)
Counselling service	32	109	2.1 (1.4, 3.1)
Supported accommodation assistance program	6	34	0.6 (0.2, 1.8)
Shelter	#	-	-
Solicitor/legal aid	12	42	0.8 (0.4, 1.8)
Hospital	#	-	-
Police	#	-	-
Other	36	143	2.7 (1.8, 4.0)
No	290	2020	38.1 (26.1, 51.6)

Denominator: 2015 Regular ADF cohort who had ever been homeless.
 # Cell size too small to be reported.

Figure A6: Estimated types of assistance sought for most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

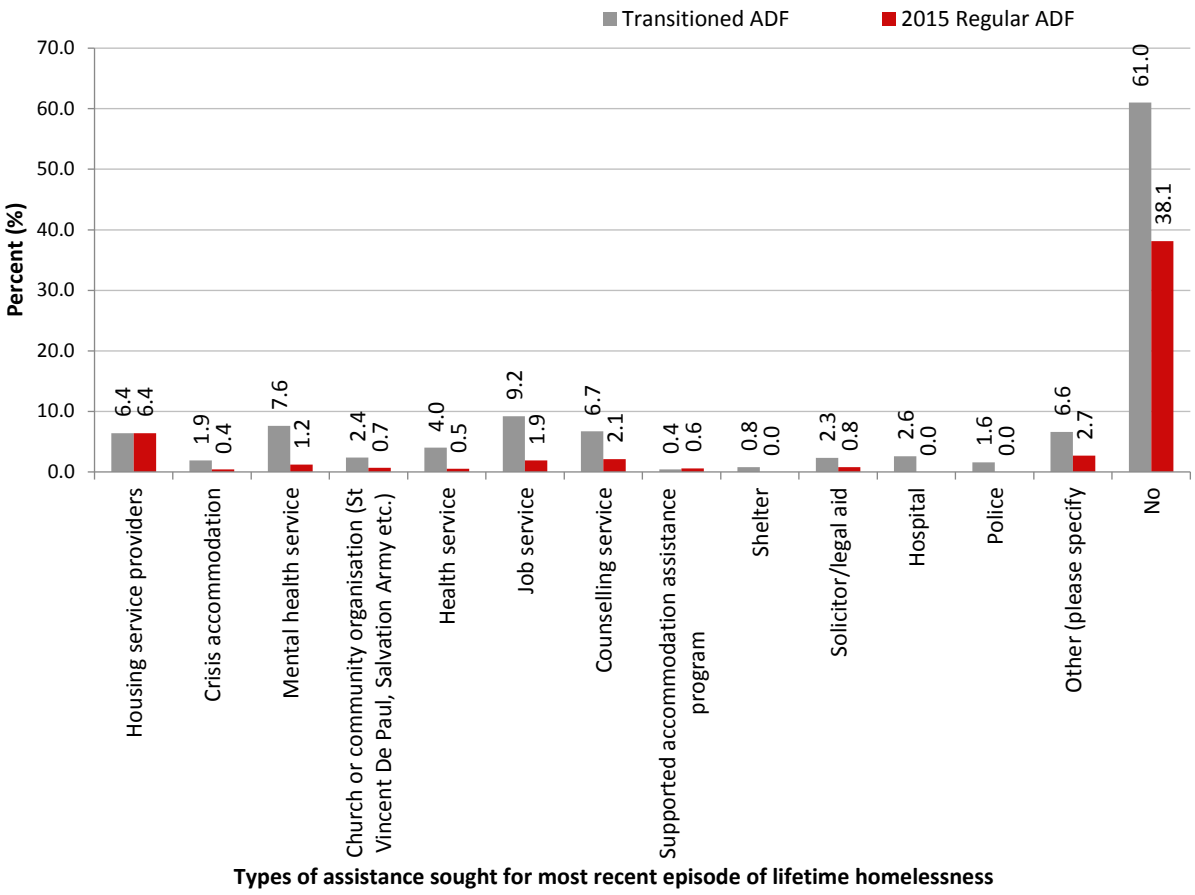


Table A7: Estimated helpfulness of assistance services for most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

Assistance helpful for most recent episode of homelessness	2015 Regular ADF n = 855		
	n	Weighted n	% (95% CI)
Yes	90	412	52.6 (33.7, 70.7)
No	35	318	40.6 (22.6, 61.5)
Don't know	11	43	5.5 (2.6, 11.1)

Denominator: Transitioned ADF and 2015 Regular ADF cohort who received assistance
Note: Approximately, 2.0% Transitioned ADF, and 1.0% 2015 Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

Figure A7: Estimated helpfulness of assistance services for most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

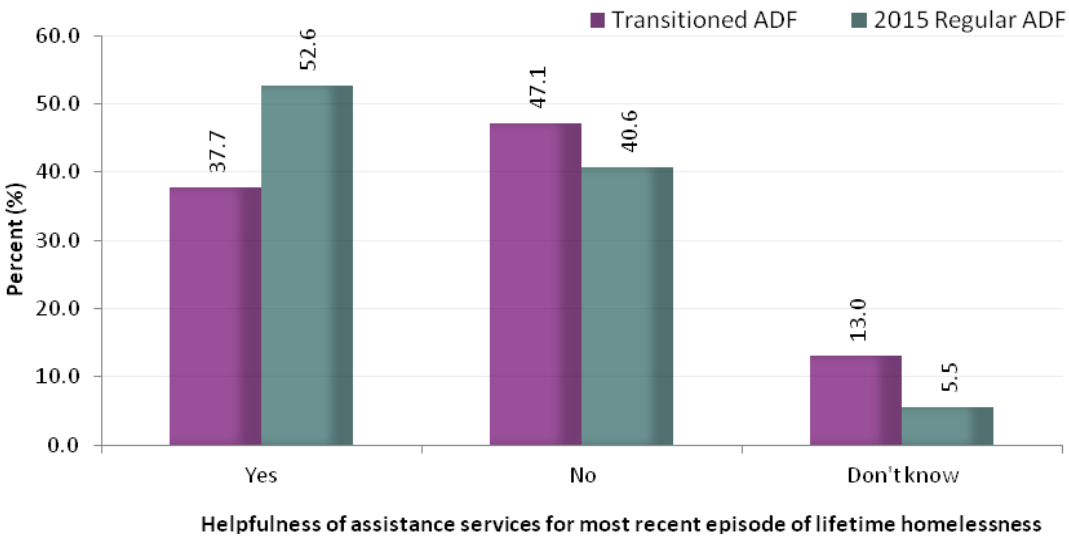


Table A8: Estimated barriers to assistance for most recent episode of lifetime homelessness in the 2015 Regular ADF

Reasons for not seeking assistance	2015 Regular ADF n = 855		
	n	Weighted n	% (95% CI)
Did not know of any	25	329	16.3 (4.0, 47.6)
Do not trust support services	16	89	4.4 (2.3, 8.4)
Could not find one	#	-	-
Service was full	#	-	-
Refused help	17	62	3.1 (1.6, 5.9)
Bad experience with service in the past	8	32	1.6 (0.7, 3.6)
No need/not required	215	1519	75.2 (50.1,90.2)
Other	27	75	3.7 (2.2, 6.3)

Denominator: 2015 Regular ADF cohort who received no assistance
 # Cell size too small to be reported.

Figure A8: Estimated barriers to assistance for most recent episode of lifetime homelessness in the Transitioned ADF and 2015 Regular ADF

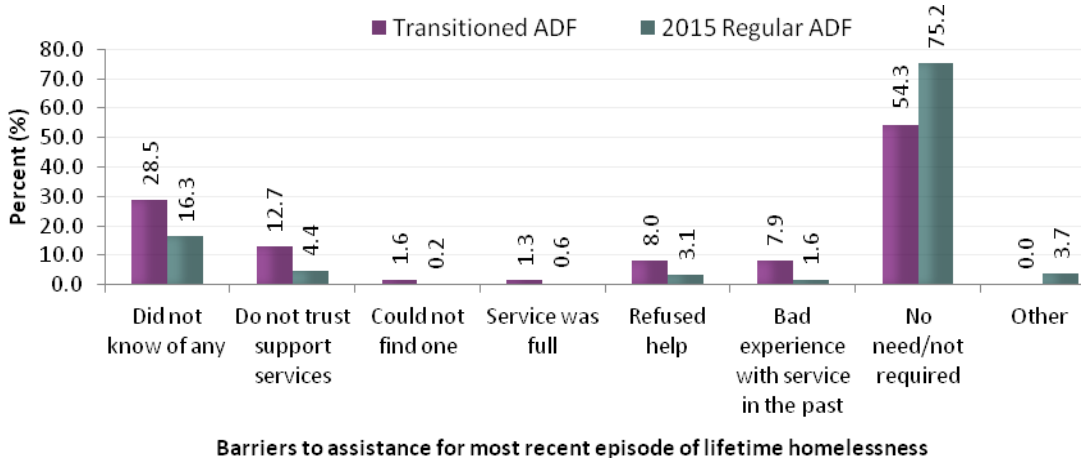


Table A9: Estimated prevalence of recent (12-month) homelessness in the Transitioned ADF and 2015 Regular ADF

	2015 Regular ADF N = 52,500		
Homelessness in the last 12 months	**n**	**Weighted n**	**% (95% CI)**
Yes	92	799	1.5 (0.8, 3.0)
No	8228	51030	97.2 (95.9, 98.1)

Denominator: 2015 Regular ADF cohort.
Note: Approximately 1.0% of 2015 Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.

Figure A9: Estimated prevalence of recent (12-month) homelessness in the Transitioned ADF and 2015 Regular ADF

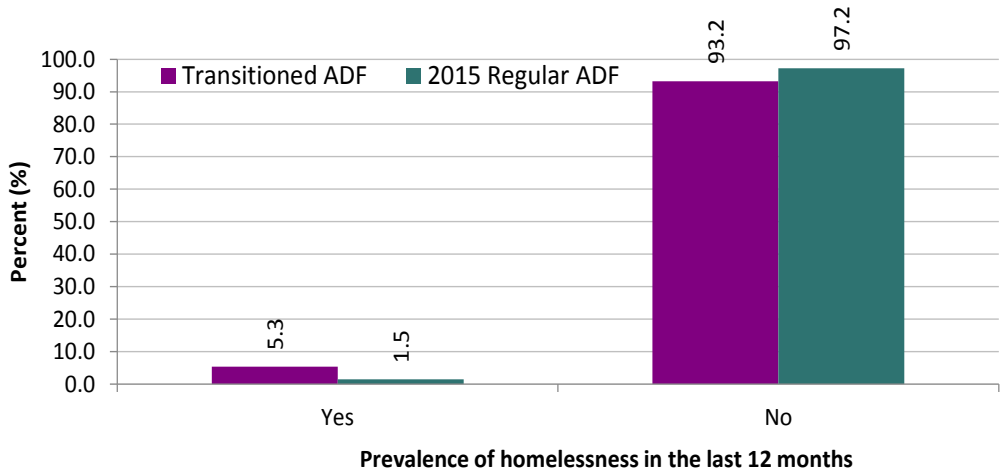


Table A10: Estimated reasons for recent (12-month) homelessness in the 2015 Regular ADF

	2015 Regular ADF n = 799		
Reasons for no permanent place to live	**n**	**Weighted n**	**% (95% CI)**
Tight housing/rental market	11	46	5.7 (2.6, 11.9)
Violence/Abuse/Neglect	#	-	-
Alcohol or drug use	#	-	-
Family/friend/relationship problems	23	79	9.9 (6.4, 14.9)
Financial problems (e.g. unable to pay mortgage or rent)	#	-	-
Mental illness	#	-	-
Lost job	0	0	-
Gambling	0	0	-
Eviction	#	-	-
Natural disaster	#	-	-
Other (please specify):	#	-	-

Denominator: 2015 Regular ADF cohort who were Homeless in last 12 months
 # Cell size too small to be reported.

Figure A10: Estimated reasons for recent (12-month) homelessness in the Transitioned ADF and 2015 Regular ADF

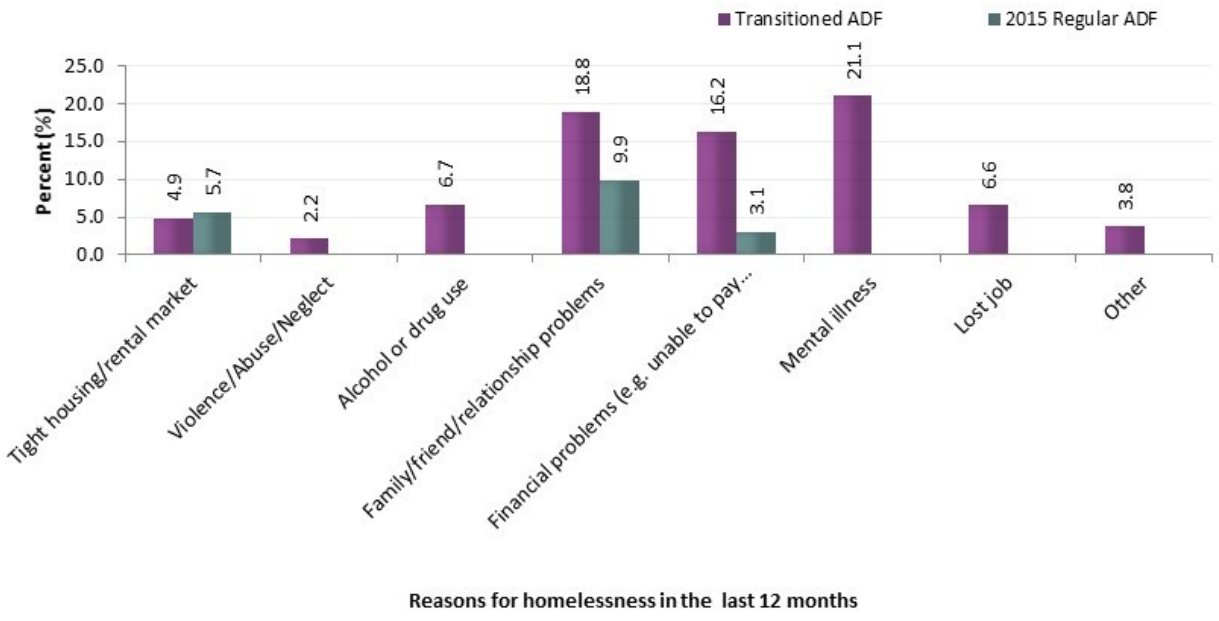


Table A11: Estimated duration of recent (12-month) homelessness episode in the 2015 Regular ADF

Duration of episode of homelessness	2015 Regular ADF n = 799		
	n	Weighted n	% (95% CI)
Less than 1 week	20	459	58.0 (32.7, 78.8)
1 week to less than 2 weeks	8	124	15.5 (2.7, 55.1)
2 weeks to less than 4 weeks	22	68	8.5 (5.3, 13.2)
1 month to less than 2 months	15	67	8.3 (6.1, 11.4)
2 months to less than three months	6	17	2.1 (1.0, 4.5)
3 months to less than 4 months	#	-	-
4 months to less than 5 months	#	-	-
5 months to less than 6 months	#	-	-
6 months or more	#	-	-
Don't know	#	-	-

Denominator: 2015 Regular ADF cohort who were homeless in last 12 months
 # Cell size too small to be reported.

Figure A11: Estimated duration of recent (12-month) homelessness episode in the Transitioned ADF and 2015 Regular ADF

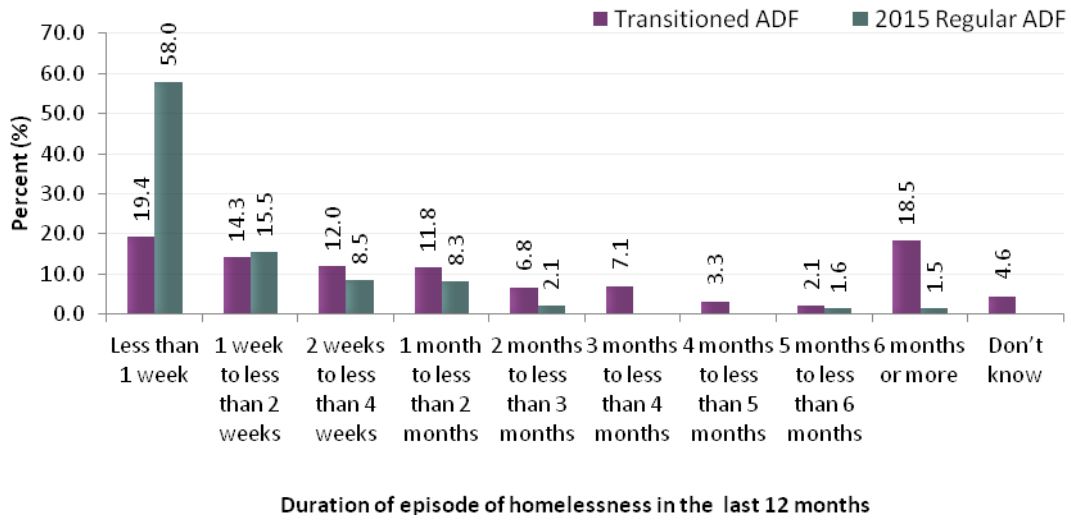


Table A12: Estimated type of assistance sought for recent (12-month) homelessness episode in the 2015 Regular ADF

Assistance sought for most recent episode of homelessness [a]	2015 Regular ADF n = 799		
	n	Weighted n	% (95% CI)
Housing service providers	17	74	9.3 (6.4, 13.2)
Crisis accommodation	0	0	-
Mental health service	#	-	-
Church or community organisation (St Vincent de Paul, Salvation Army, etc.)	#	-	-
Health service	#	-	-
Job service	#	-	-
Counselling service	13	34	4.3 (2.6, 7.1)
Supported accommodation assistance program	#	-	-
Shelter	0	-	-
Solicitor/legal aid	#	-	-
Hospital	#	-	-
Police	#	-	-
Other	8	35	4.4 (2.6, 7.5)
None	56	611	76.5 (71.9, 80.6)
Assistance helpful for most recent episode of homelessness [b]			
No	10	44	19.7 (8.4, 39.7)
Yes	30	169	75.2 (54.4, 88.5)
Don't know	#	-	-

[a]Denominator: 2015 Regular ADF cohort who were homeless in last 12 months.
[b]Denominator: 2015 Regular ADF cohort who were homeless in last 12 months and sought assistance.
 # Cell size too small to be reported.

Figure A12: Estimated type of assistance sought for recent (12-month) homelessness episode in the Transitioned ADF and 2015 Regular ADF

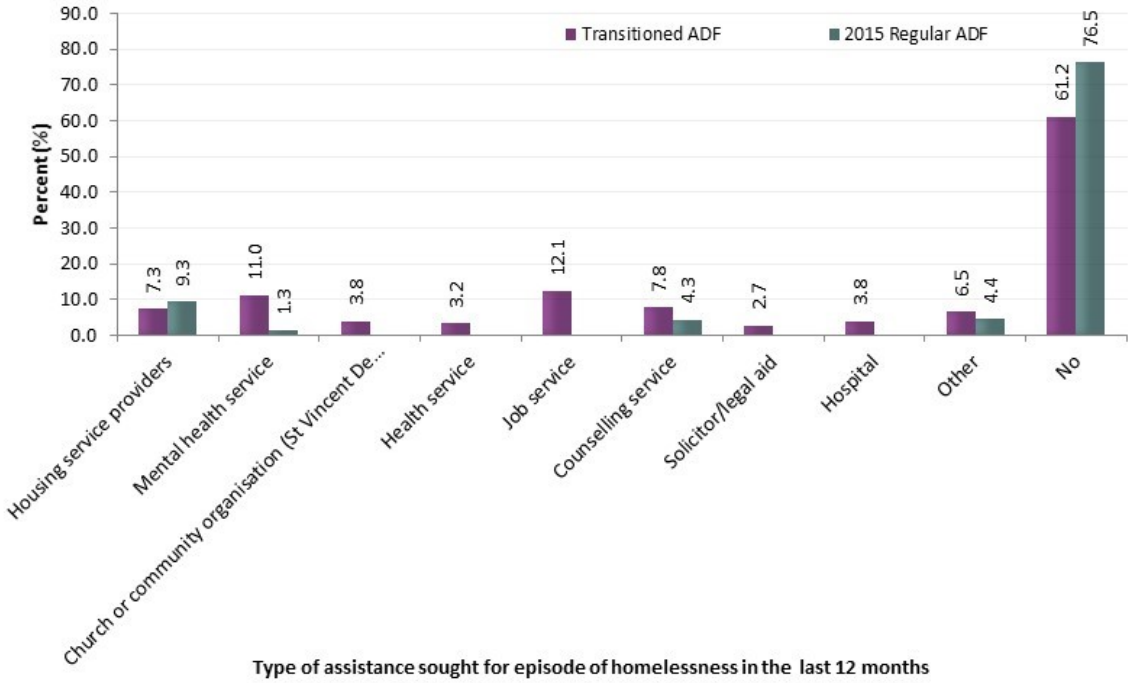
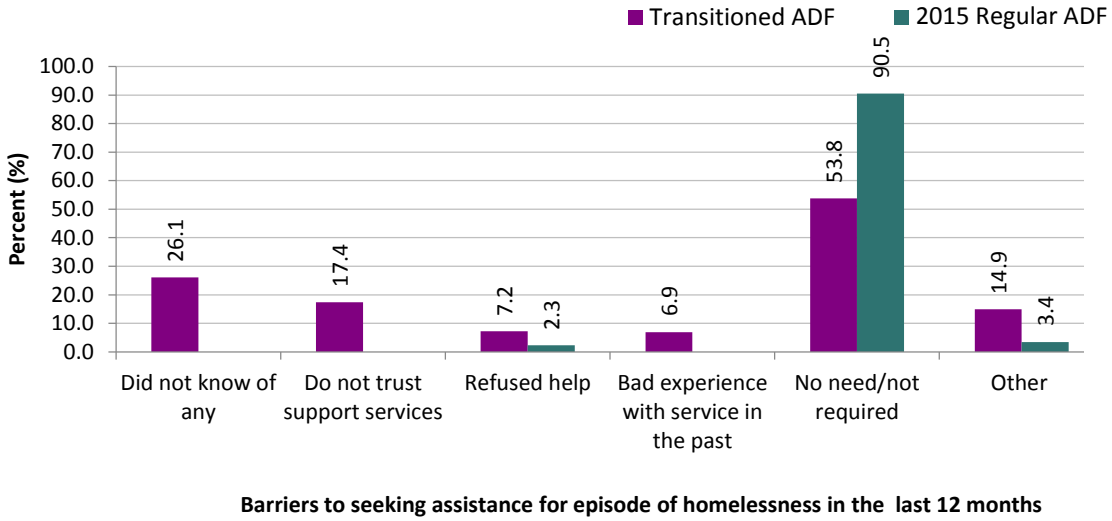


Table A13: Estimated barriers to assistance for recent (12-month) homelessness episode in the 2015 Regular ADF

	2015 Regular ADF n = 611		
Reasons for not seeking assistance	**n**	**Weighted n**	**% (95% CI)**
Did not know of any	#	-	-
Do not trust support services	#	-	-
Could not find one	#	-	-
Service was full	#	-	-
Refused help	#	-	-
Bad experience with service in the past	#	-	-
No need/not required	37	554	90.5 (86.5, 93.5)
Other	7	21	3.4 (1.5, 7.6)

Denominator: 2015 Regular ADF cohort who were homeless in last 12 months who did not seek assistance.
 # Cell size too small to be reported.

Figure A13: Estimated barriers to assistance for recent (12-month) homelessness episode in the Transitioned ADF and 2015 Regular ADF



References

Applewhite, S. (1997). Homeless Veterans: Perspectives on Social Services Use. *Social Work,* 42(1), 19-30.

Australian Bureau of Statistics. (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results.* [Online]. Cat no. 4326.0. Canberra: Australian Bureau of Statistics. Available: http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf [Accessed October 2017].

Australian Bureau of Statistics. (2011). *General Social Survey-Summary Results* [Online]. Cat. 4159.0. Canberra: Australian Bureau of Statistics. Available: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4159.02010 [Accessed September 2017].

Australian Bureau of Statistics. (2012a). *4922.0 Information Paper - A Statistical Definition of Homelessness* [Online]. Cat no. 4922.0 Canberra: Australian Bureau of Statistics. Available: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features22012?opendocument&tabn

Australian Bureau of Statistics. (2012b). *Australian Health Survey: First Results 2011-12* [Online]. Cat no 4364.0.55.001. Canberra: Australian Bureau of Statistics. Available: http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/1680ECA402368CCFCA257AC90015AA4E/$File/4364.0.55.001.pdf

Australian Bureau of Statistics. (2014a). *General Social Survey: Summary Results* [Online]. Cat 4159.0. Canberra: ABS. Available: http://abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/C6BF68E57D3A308CCA256E21007686F8?opendocument

Australian Bureau of Statistics (2014b). *Information paper: Aboriginal and Torres Strait Islander peoples perspectives on homelessness*: cat. no. 4736.0, ABS, Canberra.

Australian Bureau of Statistics. (2018). *Census of Population and Housing: Estimating homelessness, 2016* [Online]. Cat no. 2049.0. Canberra: Australian Bureau of Statistics. Available: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2049.0Main+Features12016?OpenDocument

Australian Institute of Health and Welfare. (2011). *2010 National Drug Strategy Household Survey report.* [Online]. Drug Statistics Series No. 25. Cat. no. PHE 145. Canberra: AIHW. Available: https://www.aihw.gov.au/getmedia/85831350-afb6-4524-8d8d-764fa5d2d1f8/12668-20120123.pdf.aspx [Accessed September 2017].

Australian Institute of Health and Welfare (2014a). *Homelessness among Indigenous Australians,* AIHW, Canberra.

Australian Institute of Health and Welfare. (2014b). *National Drug Strategy Household Survey detailed report: 2013* [Online]. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW. Available: https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2013-detailed/contents/table-of-contents [Accessed November 2016].

Babor, E., Fuente, J., Saunders, J. & Grant, M. (1989). *The Alcohol Use Disorder Identification Test : Guidelines for use in primary health care,* Geneva: World Health Organization, Division of Mental Health.

Babor, T. F., Higgins-Biddle, J., Saunders, J. B. & Monteiro, M. (2001). *The Alcohol Use Disorders Identification Test (AUDIT): Guidelines for use in primary care.,* Geneva: World Health Organization, Department of Mental Health and Substance Dependence.

Balshem, H., Christensen, V., Tuepker, A. & Kansagara, D. (2011). *A Critical Review of the Literature Regarding Homelessness Among Veterans* [Online]. VA-ESP Project # 05-225: 2011. Available: http://www.hsrd.research.va.gov/publications/esp/homelessness-REPORT.pdf

Bergman, B. P., Burdett, H. J. & Greenberg, N. (2014). Service Life and Beyond – Institution or Culture? *The RUSI Journal,* 159(5), 60-68.

Birdsall-Jones, C., Corunna, V., Turner, N., Smart, G. & Shaw, W. (2010). *Indigenous homelessness* [Online]. AHURI Final Report No. 143, Australian Housing and Urban Research Institute, Melbourne. Available: http://www.ahuri.edu.au/publications/projects/p80368.

Black, C. & Gronda, H. (2011). *Evidence for improving access to homelessness services,* Melbourne: Australian Housing and Urban Research Institute.

Blackstock, O. J., Haskell, S. G., Brandt, C. A. & Desai, R. A. (2012). Gender and the Use of Veterans Health Administration Homeless Services Programs Among Iraq/Afghanistan Veterans. *Medical Care,* 50(4), 347-352.

Bramley, G. & Fitzpatrick, S. (2018). Homelessness in the UK: who is most at risk? *Housing Studies,* 33(1), 96-116.

Brugha, T., Bebbington, P., Tennant, C. & Hurry, J. (1985). The List of Threatening Experiences: a subset of 12 life event categories with considerable long-term contextual threat. *Psychological Medicine,* 15(1), 189-194.

Burt, M., Carpenter, J., Hall, S., Henderson, K., Rog, D., Hornik, J., Denton, A. & Moran, G. (2010). *Strategies for improving homeless people's access to mainstream benefits and services,* Washington: US Department of Housing and Urban Development.

Caton, C. L., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., Felix, A., McQuistion, H., Opler, L. A. & Hsu, E. (2005). Risk factors for long-term homelessness: findings from a longitudinal study of first-time homeless single adults. *American Journal of Public Health,* 95(10), 1753-1759.

Chamberlain, C. & Johnson, G. (2003). *The development of prevention and early intervention services for homeless youth: intervening successfully,* AHURI Positioning Paper No. 48, Australian Housing and Urban Research Institute, Melbourne.

Chamberlain, C. & MacKenzie, D. (1992). Understanding contemporary homelessness: issues of definition and meaning. *Australian Journal of Social Issues,* 27(4), 274-297.

Chamberlain, C. & MacKenzie, D. (2008). *Australian census analytic program: counting the homeless 2006,* cat. no. 2050.0, ABS, Canberra.

Culhane, D., Park, J. & Metraux, S. (2011). The patterns and costs of services use amongst homeless families. *Journal Of Community Psychology,* 39(7), 815-825.

Demers, A. (2011). When veterans return: The role of community in reintegration. *Journal of Loss and Trauma,* 16(2), 160-179.

Department of Defence. (2018). *ADF Pay and conditions Manual, Chapter 7 Part 1: General information and indexes* [Online]. Canberra: Department of Defence. Available: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-7/default.asp [Accessed 13/03 2018].

Department of Veterans' Affairs. (2018). *Homelessness - DVA and Ex-Service Organisation support* [Online]. Canberra: Australian Government. Available: https://www.dva.gov.au/health-and-wellbeing/home-and-care/homelessness-dva-and-ex-service-organisation-support 2018].

Dunne, E. M., Burrell, L. E., Diggins, A. D., Whitehead, N. E. & Latimer, W. W. (2015). Increased risk for substance use and health-related problems among homeless veterans. *American Journal of Addiction,* 24(7), 676-680.

Eckholm, E. (2007). *Surge seen in number of homeless veterans is anticipated,* The New York Times, p. p. A22.

Edens, E. L., Kasprow, W., Tsai, J. & Rosenheck, R. A. (2011). Association of Substance Use and VA Service-Connected Disability Benefits with Risk of Homelessness among Veterans. *The American Journal on Addictions,* 20(5), 412-419.

Elnitsky, C. A., Fisher, M. P. & Blevins, C. L. (2017). Military Service Member and Veteran Reintegration: A Conceptual Analysis, Unified Definition, and Key Domains. *Frontiers in Psychology,* 8, Article 369.

Fairweather, A. (2006). *Risk and protective factors for homelessness among OEF/OIF veterans.,* San Francisco: Swords to Plowshares, 2006.

Fargo, J., Metraux, S., Byrne, T., Munley, E., Montgomery, A. E., Jones, H., Sheldon, G., Kane, V. & Culhane, D. (2012). Prevalence and Risk of Homelessness Among US Veterans. *Preventing Chronic Disease,* 9, E45.

Fargo, J. D., Brignone, E., Metraux, S., Peterson, R., Carter, M. E., Barrett, T., Palmer, M., Redd, A., Samore, M. H. & Gundlapalli, A. V. (2017). Homelessness following disability-related discharges from active duty military service in Afghanistan and Iraq. *Disability and Health Journal,* 10(4), 592-599.

Flatau, P., Thiekling, M., MacKenzie, D. & Steen, A. (2015). *The cost of youth homelessness study,* Western Australia: Swinburne University Institute for Social Research.

Forbes, D., Hawthorne, G., Elliott, P., McHugh, T., Biddle, D., Creamer, M. & Novaco, R. W. (2004). A concise measure of anger in combat-related posttraumatic stress disorder. *Journal of Traumatic Stress,* 17(3), 249-256.

Forbes, D., Van Hooff, M., Lawrence-Wood, E., Sadler, N., Hodson, S., Benassi, H., Hansen, C., Avery, J., Varker, T., O'Donnell, M., Phelps, A., Frederickson, J.,

Sharp, M., Searle, A. & McFarlane, A. (2017). *Pathways to Care: Mental Health and Wellbeing Study,* Canberra: Department of Veterans' Affairs.

Forces in Mind Trust (2013). *The transition mapping study: understanding the transition process for service personnel returning to civilian life,* London: Forces in Mind Trust.

Forces in Mind Trust (2015). *Better understanding the support needs of Service Leaver families: Engagement Programme Report.,* United Kingdom: Brian Parry Associates.

Foreign Affairs Defence and Trade Committee Department of the Senate (2016). *Mental health of Australian Defence Force Members and Veterans,* Canberra: Commonwealth of Australia.

French, C., Rona, R. J., Jones, M. & Wessely, S. (2004). Screening for physical and psychological illness in the British Armed Forces: II: Barriers to screening--learning from the opinions of Service personnel. *Journal of Medical Screening,* 11(3), 153-157.

Galletly, C., Van Hooff, M. & McFarlane, A. (2011). Psychotic symptoms in young adults exposed to childhood trauma--a 20 year follow-up study. *Schizophrenia Research,* 127(1-3), 76-82.

Gordon, A. J., McGinnis, K. A., Conigliaro, J., Rodriguez-Barradas, M. C., Rabeneck, L. & Justice, A. C. (2006). Associations between alcohol use and homelessness with healthcare utilization among human immunodeficiency virus-infected veterans. *Medical Care,* 44(8), S37-S43.

Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., Kearney, S. & Greenberg, N. (2010). Do stigma and other perceived barriers to mental health care differ across Armed Forces? *Journal of the Royal Society of Medicine,* 103(4), 148-156.

Graziano, R. & Elbogen, E. B. (2017). Improving Mental Health Treatment Utilization in Military Veterans: Examining the Effects of Perceived Need for Care and Social Support. *Military Psychology,* 29(5), 359-369.

Gupta, S. K. (2012). The relevance of confidence interval and P-value in inferential statistics. *Indian Journal of Pharmacology,* 44(1), 143-144.

Hamad, R. (2017). 'Us and them': What homelessness looks like around the world Available: https://www.sbs.com.au/topics/life/culture/article/2017/07/04/us-and-them-what-homelessness-looks-around-world.

Hamilton, A. B., Poza, I. & Washington, D. L. (2011). "Homelessness and Trauma Go Hand-in-Hand": Pathways to Homelessness among Women Veterans. *Women's Health Issues,* 21(4, Supplement), S203-S209.

Haro, J. M., Arbabzadeh-Bouchez, S., Brugha, T. S., De Girolamo, G., Guyer, M. E., Jin, R., Lepine, J. P., Mazzi, F., Reneses, B., Vilagut, G., Sampson, N. A. & Kessler, R. C. (2006). Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health Surveys. *International Journal of Methods in Psychiatric Research,* 15(4), 167-180.

Harris, T., Kintzle, S., Wenzel, S. & Castro, C. A. (2017). Expanding the Understanding of Risk Behavior Associated With Homelessness Among Veterans. *Military Medicine,* 182(9), e1900-e1907.

Harvey, S. B., Hatch, S. L., Jones, M., Hull, L., Jones, N., Greenberg, N., Dandeker, C., Fear, N. T. & Wessely, S. (2011). Coming home: social functioning and the mental health of UK reservists on return from deployment to Iraq or Afghanistan. *Annals of Epidemiology,* 21(9), 666-672.

Hatch, S. L., Harvey, S. B., Dandeker, C., Burdett, H., Greenberg, N., Fear, N. T. & Wessely, S. (2013). Life in and after the Armed Forces: social networks and mental health in the UK military. *Sociol Health Illn,* 35(7), 1045-64.

Herman, D. B., Susser, E. S., Struening, E. L. & Link, B. L. (1997). Adverse childhood experiences: are they risk factors for adult homelessness? *American Journal of Public Health,* 87(2), 249-255.

Hilferty, F., Katz, I., Van Hooff, M., Lawrence-Wood, E. & Zmudzki, F. (2017). *Inquiry into homelessness amongst Australian veterans,* Melbourne: Australian Housing and Urban Research Institute.

Hodson, S. & McFarlane, A. (2016). Australian veterans - Identification of mental health issues. *Australian Family Physician,* 45(3), 98-101.

Iversen, A. C., van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., Thornicroft, G., Wessely, S. & Fear, N. T. (2011). The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC Health Services Research,* 11, 31.

Jones, M., Sundin, J., Goodwin, L., Hull, L., Fear, N. T., Wessely, S. & Rona, R. J. (2013). What explains post-traumatic stress disorder (PTSD) in UK service personnel: deployment or something else? *Psychol Med,* 43(8), 1703-12.

Kenny, M. (2015). *Homeless diggers reveal Austrlia's double standards* [Online]. The Sydney Morning Herald. Available: http://www.smh.com.au/federal-politics/political-news/homeless-diggers-reveal-australias-double-standards-20150420-1mpicz.html

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E. & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine,* 32(6), 959-976.

Koegel, P., Melamid, E. & Burnam, A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health,* 85(12), 1642-1649.

Kroenke, K., Spitzer, R. L. & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine,* 16(9), 606-613.

Kull, S., Ramsay, C. & Lewis, E. (2003-04). Misperceptions, the Media, and the Iraq War. *Political Science Quarterly,* 118(4), 569-598.

Lipton, F. R., Siegel, C., Hannigan, A., Samuels, J. & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services,* 51(4), 479-486.

MacLean, A. & Elder, G., Jr (2007). Military service in the life course. *Annual Review of Sociology,* 33, 175-196.

McFarlane, A. C., Hodson, S., Van Hooff, M., Verhagen, A. & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study: Full Report,* Canberra: Department of Defence.

McQuistion, H. L., Gorroochurn, P., Hsu, E. & Caton, C. L. (2014). Risk factors associated with recurrent homelessness after a first homeless episode. *Community Ment Health Journal,* 50(5), 505-513.

Memmott, P., Long, S., Chambers, C. & Spring, F. (2003). *Categories of Indigenous 'homeless' people and good practice responses to their needs* [Online]. AHURI Final Report No. 49, Australian Housing and Urban Research Institute, Melbourne. Available: http://www.ahuri.edu.au/publications/projects/p20168.

Metraux, S., Clegg, L. S., Daigh, J. D., Culhane, D. P. & Kane, V. (2013). Risk Factors for Becoming Homeless Among a Cohort of Veterans Who Served in the Era of the Iraq and Afghanistan Conflicts. *American Journal of Public Health,* 103(S2), S255-S261.

Metraux, S., Cusack, M., Byrne, T. H., Hunt-Johnson, N. & True, G. (2017). Pathways into homelessness among post-9/11-era veterans. *Psychological Services,* 14(2), 229.

Metraux, S. & Tseng, Y.-P. (2017). Using Administrative Data for Research on Homelessness: Applying a US Framework to Australia. *Australian Economic Review,* 50(2), 205-213.

Ministry of Defence (2017). Veterans Key Facts. United Kingdom: Ministry of Defence.

Montgomery, A. E., Cutuli, J. J., Evans-Chase, M., Treglia, D. & Culhane, D. P. (2013). Relationship among adverse childhood experiences, history of active military service, and adult outcomes: homelessness, mental health, and physical health. *American Journal of Public Health,* 103(S2), S262-S268.

National Coalition for Homeless Veterans. (2018). *FAQ About Homeless Veterans* [Online]. Washington. Available: http://nchv.org/index.php/news/media/media_information/ [Accessed 07/02/2018

O'Connell, M. J., Kasprow, W. & Rosenheck, R. A. (2008). Rates and risk factors for homelessness after successful housing in a sample of formerly homeless veterans. *Psychiatric Services,* 59(3), 268-275.

O'Toole, T. P., Gibbon, J. L., Seltzer, D., Hanusa, B. H. & Fine, M. J. (2002). Urban homelessness and poverty during economic prosperity and welfare reform: changes in self-reported comorbidities, insurance, and sources for usual care, 1995-1997. *Journal of Urban Health,* 79(2), 200-210.

Oster, C., Morello, A., Venning, A., Redpath, P. & Lawn, S. (2017). The health and wellbeing needs of veterans: a rapid review. *BMC Psychiatry,* 17(1), 414.

Patterson, M. L., Moniruzzaman, A. & Somers, J. M. (2015). History of foster care among homeless adults with mental illness in Vancouver, British Columbia: a precursor to trajectories of risk. *BMC Psychiatry,* 15, 32.

Pedlar, D. & Thompson, J. M. (2016). *Toward a Military-CivilianTransition Theory and Conceptual Framework: Report of the International Summit held at the University of Southern California in March 2016.,* Los Angeles, CA: University of Southern California.

Perl, L. (2015). *Veterans and homelessness* [Online]. (CRS Report RL34024). Washington, DC: Congressional Research Service. Available: http://digitalcommons.ilr.cornell.edu.proxy.library.adelaide.edu.au/key_workplace/1481/

Pinder, R. J., Greenberg, N., Boyko, E. J., Gackstetter, G. D., Hooper, T. I., Murphy, D., Ryan, M. A., Smith, B., Smith, T. C., Wells, T. S. & Wessely, S. (2012). Profile of two cohorts: UK and US prospective studies of military health. *International Journal of Epidemiology,* 41(5), 1272-1282.

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J. & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American Journal of Public Health,* 103(S2), S275-S281.

Rosenheck, R. & Fontana, A. (1994). A model of homelessness among male veterans of the Vietnam War generation. *American Journal of Psychiatry,* 151, 421–427.

Sareen, J., Cox, B. J., Afifi, T. O., Stein, M. B., Belik, S. L., Meadows, G. & Asmundson, G. J. (2007). Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care: findings from a large representative sample of military personnel. *Archives of General Psychiatry,* 64(7), 843-852.

Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R. & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption--II. *Addiction,* 88(6), 791-804.

Sayer, N. A., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A. & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatr Serv,* 61(6), 589-97.

Schuster, T. L., Kessler, R. C. & Aseltine, R. H., Jr. (1990). Supportive interactions, negative interactions, and depressed mood. *American Journal of Community Psychology,* 18(3), 423-438.

Sheilds, D. M., Kuhl, D., Lutz, K., Freder, J., Baumann, N. & Lopresti, P. (2016). *Mental health and Well-Being of Military Veterans During Military to Civilian Transition: Review and Analysis of the Recent Literature,* Canada: Canadian Institute for Military and Veteran Health Research & Scientific Authority, Veterans Affairs Canada.

Shelton, K. H., Taylor, P. J., Bonner, A. & van den Bree, M. (2009). Risk factors for homelessness: Evidence from a population-based study. *Psychiatric Services,* 60(4), 465-472.

Slade, T., Johnston, A., Oakley Browne, M. A., Andrews, G. & Whiteford, H. (2009). 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australian & New Zealand Journal of Psychiatry,* 43(7), 594-605.

Smart, D., Vassallo, S., Sanson, A., Cockfield, S., Harris, A., Harrison, W. & McIntyre, A. (2005). *In the driver's seat: Understanding young adults' driving behaviour. Research report No. 12,* Melbourne, Victoria: Australian Institute of Family Studies.

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P. & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International Journal of Behavioral Medicine,* 15(3), 194-200.

Spitzer, R. L., Kroenke, K., Williams, J. B. & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine,* 166(10), 1092-1097.

Stinchfield, R., Govoni, R., & Frisch, G. R. (2007). A review of screening and assessment instruments for problem and pathological gambling. *Research and Measurement Issues in Gambling Studies,* 1, 179-213.

Teeters, J. B., Lancaster, C. L., Brown, D. G. & Back, S. E. (2017). Substance use disorders in military veterans: prevalence and treatment challenges. *Substance Abuse and Rehabilitation,* 8, 69-77.

The Royal British Legion. (2010). *Literature review: UK veterans and homelessness* [Online]. Available: https://media.britishlegion.org.uk/Media/2283/litrev_ukvetshomelessness.pdf

Thomas, A. (2013). *Homeless Heroes - Dateline* [Online]. SBS Dateline. Available: https://www.sbs.com.au/news/dateline/story/homeless-heroes

Thomson Goodall Associates. (2009). *Veterans at Risk Research Project* [Online]. Canberra: Department of Veteran's Affairs. Available: https://catalogue.nla.gov.au/Record/3509731

Toohey, P. (2016). How we're failing our Australian veterans left with post-traumatic stress disorder and homelessness. *news.com.au* [Online]. Available: http://www.news.com.au/national/how-were-failing-our-australian-veterans-left-with-posttraumatic-stress-disorder-and-homelessness/news-story/e400d62f1729585d481e5518edf2c64d.

Topolovec-Vranic, J., Schuler, A., Gozdzik, A., Somers, J., Bourque, P.-É., Frankish, C. J., Jbilou, J., Pakzad, S., Palma Lazgare, L. I. & Hwang, S. W. (2017). The high burden of traumatic brain injury and comorbidities amongst homeless adults with mental illness. *Journal of Psychiatric Research,* 87(Supplement C), 53-60.

Toro, P. A., Tompsett, C. J., Lombardo, S., Philippot, P., Nachtergael, H., Galand, B., Schlienz, N., Stammel, N., Yabar, Y., Blume, M., MacKay, L. & Harvey, K. (2007). Homelessness in Europe and the United States: A Comparison of Prevalence and Public Opinion. *Journal of Social Issues,* 63(3), 505-524.

Tsai, J., Edens, E. L. & Rosenheck, R. A. (2011). A typology of childhood problems among chronically homeless adults and its association with housing and clinical outcomes. *Journal of Health Care for the Poor and Undeserved,* 22(3), 853-70.

Tsai, J., Hoff, R. A. & Harpaz-Rotem, I. (2017). One-year incidence and predictors of homelessness among 300,000 U.S. Veterans seen in specialty mental health care. *Psychological Services,* 14(2), 203-207.

Tsai, J., Kasprow, W. J. & Rosenheck, R. A. (2013). Latent homeless risk profiles of a national sample of homeless veterans and their relation to program referral and admission patterns. *American Journal of Public Health,* 103 Suppl 2, S239-S247.

Tsai, J., Link, B., Rosenheck, R. A. & Pietrzak, R. H. (2016). Homelessness among a nationally representative sample of US veterans: prevalence, service utilization, and correlates. *Social Psychiatry and Psychiatric Epidemiology,* 51(6), 907-916.

Tsai, J. & Rosenheck, R. A. (2013). Conduct disorder behaviors, childhood family instability, and childhood abuse as predictors of severity of adult homelessness among American veterans. *Social Psychiatry and Psychiatric Epidemiology,* 48(3), 477-86.

Tsai, J. & Rosenheck, R. A. (2015). Risk Factors for Homelessness Among US Veterans. *Epidemiologic reviews,* 37, 177-195.

Tually, S., Skinner, V., Faulkner, D. & Goodwin-Smith, I. (2017). *The Adelaide Zero Project: Ending Street Homelessness in the Inner CIty - Discussion Paper,* Adelaide, South Australia: Goverrnment of South Australia.

U.S. Department of Housing and Urban Development. (2017a). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress PART 2: Estimates of Homelessness in the United States over the course of a year* [Online]. Available: https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf

U.S. Department of Housing and Urban Development. (2017b). *The 2017 Annual Homeless Assessment Report (AHAR) to Congress. PART 1: Point in Time Estimates of Homelessness* [Online]. Washington DC. Available: https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

US Department of Housing and Urban Development (2014). *The 2014 annual homeless assessment report (AHAR) to Congress (Part 1): Point-in-time estimates of homelessness,* Washington, DC.

US Department of Veterans Affairs. (2016). *VA Programs for Homeless Veterans fact sheet* [Online]. Washington DC: US Department of Veterans Affairs. Available: https://www.va.gov/HOMELESS/docs/Homeless-Programs-General-Fact-Sheet-Sep-2017-FINAL.pdf

van den Bree, M. B., Shelton, K., Bonner, A., Moss, S., Thomas, H. & Taylor, P. J. (2009). A longitudinal population-based study of factors in adolescence predicting homelessness in young adulthood. *Journal of Adolescent Health,* 45(6), 571-578.

Van Extel, C. (2014). *Thousands of Iraq and Afghanistan veterans homeless.* [Online]. ABC News 23 June 2014. Available: http://www.abc.net.au/radionational/programs/breakfast/6285260. [Accessed 15 February 2017].

Van Hooff, M., Lawrence-Wood, E., Hodson, S., Sadler, N., Benassi, H., Hansen, C., Grace, B., Avery, J., Searle, A., Iannos, M., Abraham, M., Baur, J. & McFarlane, A. (2018). *Mental Health Prevalence, Mental Health and Wellbeing Transition Study,* the Department of Defence and the Deparment of Veterans' Affairs Canberra.

Warner, C. H., Appenzeller, G. N., Grieger, T., Belenkiy, S., Breitbach, J., Parker, J., Warner, C. M. & Hoge, C. (2011). Importance of anonymity to encourage honest

reporting in mental health screening after combat deployment. *Archives of General Psychiatry,* 68(10), 1065-1071.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A. & Keane, T. M. (1993). *The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility.,* Paper presented at the 9th Annual Conference of the ISTSS: San Antonio, TX.

Weber, J., Lee, R. C. & Martsolf, D. (2017). Understanding the health of veterans who are homeless: A review of the literature. *Public Health Nursing,* 34(5), 505-511.

Wenzel, S. L., Gelberg, L., Bakhtiar, L., Caskey, N., Hardie, E., Redford, C. & Sadler, N. (1993). Indicators of chronic homelessness among veterans. *Psychiatric Services,* 44(12), 1172-1176.

Williamson, V. & Mulhall, E. (2009). *Coming home: The housing crisis and homelessness threaten new veterans* [Online]. Washington DC: Iraq and Aghanistan Veterans of America. Available: http://issuu.com/iava/docs/coming_home_2009/1 [Accessed February 2017].

Woodruff, B., Cameron, I., & Romo, C. (2010). *Coming home: The new homeless among veterans* [Online]. ABC News. Available: http://abcnews.go.com/ThisWeek/coming-home-homeless-homeless-veterans/story?id=12478952 [Accessed February 2017].

Australian Housing and Urban Research Institute

Level 1
114 Flinders Street
Melbourne Victoria 3000

T +61 3 9660 2300
E information@ahuri.edu.au

ahuri.edu.au

ACN 090 448 918

twitter.com/AHURI_Research
facebook.com/AHURI.AUS
evid.in/AHURI_LinkedIn