

MISSION AUSTRALIA

The MISHA Project



From Homelessness to Sustained Housing 2010-2013

Research Report

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Executive Summary

MISHA (Michael's Intensive Supported Housing Accord), a philanthropically-funded project, began in late 2010 with the aim of providing homeless men with support to enter and sustain permanent housing, ensure access to mental and physical health supports, reduce social isolation and equip the men to live successfully within the community. The service delivery model employed in the MISHA project drew on: 1) the principles of Assertive Community Treatment (ACT), which emphasises a multi-disciplinary team approach to the holistic management of a client's needs; and 2) the Housing First model, which is based on the rights to and benefits of permanent housing and consumer choice. The program used scattered site housing leased via social housing providers and a MISHA support team with strong links to existing community programs operating in the Parramatta area.

In addition, the target group was further restricted to men aged 25 years or older, who were eligible for social housing in NSW, had an income (or be eligible for income support) and were willing to pay rent on time, and willing to meet with a MISHA staff member on a regular basis.

Clients were recruited for the MISHA project from two main sources: the Western Sydney Housing Coalition of local housing and homelessness services; and direct outreach carried out amongst rough sleepers in the Parramatta area or through other services working with rough sleepers, such as a local soup kitchen.

The main aim of the MISHA research project was to evaluate the service model with respect to client outcomes and the direct economic benefits to government and wider society of the program. It also aimed to make a significant contribution to the evidence base informing government policy in the housing and homelessness fields.

Specifically, the research aimed to:

1. Document the needs and backgrounds of chronically homeless men on entry to MISHA;
2. Assess the effectiveness of MISHA in:
 - a. Sustaining tenancies
 - b. Improving the physical and mental health of clients
 - c. Improving the economic and social participation of clients.
3. Understand the processes and mechanisms through which MISHA influenced client outcomes; and
4. Estimate the cost-effectiveness of the MISHA model.

The research used a mixed methods approach comprising a number of quantitative and qualitative approaches. The primary method of analysis was the collection and analysis of longitudinal client survey administered at five time points over a 24-month period and commencing on entry to MISHA. The client survey included measures in relation to demographic characteristics,

homelessness and housing histories, employment and income outcomes, physical and mental health status and outcomes, social isolation and relative deprivation, health service utilisation and contact with the justice system. The baseline sample was completed by 75 MISHA clients on entry to the program with the final follow up sample comprising 59 clients after a 24 month period. The survey data was supplemented by MISHA administrative data for clients, the usefulness of which was sometimes impeded by differences in the way information was entered by different caseworkers.

The qualitative components of the study consisted of in-depth interviews with fourteen clients as well as seven in-depth interviews and a focus group involving 6 MISHA staff. This component aimed to complement the quantitative data collection by providing a more detailed and nuanced picture of both the process and impact of MISHA services. In order to more fully understand the process of sustaining tenancies, nine case studies were undertaken of tenants' housing experience focusing on both tenants who successfully retained their tenancies as well as those who were evicted from their properties.

The economic evaluation examined the cost to government of mainstream service use by MISHA participants and how this use and associated cost changed over time. It also examined the cost of delivering the MISHA program and the extent to which this was offset by a decrease in the cost of mainstream services use by participants.

The key findings of the study are as follows:

- The majority of participants were able to sustain their tenancies for the entire two year follow-up with retention of tenancies around 90%. This was despite the fact that many participants experienced tenancy issues at least intermittently during the follow-up period.
- The mental health of participants was poor at entry and there was little improvement during the two year follow-up period; levels of psychological distress were higher than general population estimates, but remained stable over time.
- There were mixed results with regard to social participation. There was an improvement in participants' rating of their physical environment and their satisfaction with their social relationships. More participants reported social contact with others and there were marked reductions in social isolation due to a lack of social support and community involvement. However, quality of life measures of self-assessed wellbeing did not rise over the time period.
- Incomes and employment status of the follow-up group improved somewhat over the two years. More participants were employed and there was a significant fall in the number of respondents who were not in the labour force. Among those in the labour force, those employed increased from 10% to 15% after 24 months.

- The recurrent cost of MISHA support is estimated at \$27,914 per client, for an average support period of 2.04 years, or approximately \$14,000 a year. After considering health, justice and welfare offsets, the net cost is \$9,260 per client per year. In total, the cost of mainstream health, justice and welfare services reduced from \$32,254 per participant in the baseline period, to \$24,251 per participant in the 24 month follow-up period. This represents a large savings to government of \$8,002 per participant per year.
- There is also the potential for other cost offsets, such as reduced incidence of eviction and reduced use of crisis/emergency accommodation services once the client is in stable housing. Sensitivity analysis show that if cost offsets from tenancy failures avoided (\$2,400 per client) and reduced use of crisis/emergency accommodation (\$6,427 per client) are incorporated, the net recurrent cost of support would be reduced to \$9,865 per client, or \$4,836 per client per year, and the program would be cost neutral just under three years after support commenced.
- If a similar program were to be implemented by government, the cost of support net of savings from reduced use of mainstream services would be comparatively low. In the short to medium-term, it is likely that the program would be at least cost neutral, and if cost offsets are sustained may create significant long-term whole of government savings.

The study highlights a number of important lessons for either continuing the project beyond its current end date or in setting up other similar projects. It also provides useful benchmarks, both for Mission Australia in its management of such programs, and for the wider homelessness service sector involved in similar Housing First-type projects.

The critical elements of the MISHA model that contributed to its effectiveness are as follows.

- Good quality and permanent housing available to clients, irrespective of their previous circumstances and equipped to a modest but 'normal' standard;
- Dedicated and skilled staff, providing assertive and wide-ranging case management support, including living skills and tenancy support;
- A focus on building client independence and self-reliance, including allowing clients to make mistakes but learn from them;
- A committed relationship with housing providers to manage tenancy problems regardless of the chronicity or seriousness of the problems;
- Brokered or supported access to a full range of health and ancillary services;

- In-house psychological support and counselling; and,
- Opportunities for clients to socialise and engage in educational, sporting and other activities to improve social well-being.

There were some limitations or difficulties experienced by the MISHA project that potentially reduced the effectiveness of the program. These would need to be addressed if the project is to be extended or other similar initiatives established:

- Developing relationships with existing service networks before service provision starts;
- Systematic assessment of client intake before housing placement;
- Staggered client intake to allow full assessment and case planning, although this may be difficult while suitable and affordable housing remains in short supply;
- Securing housing – where possible in smaller clusters than was able to be achieved for some sites in MISHA – at a pace consistent with client intake and with some flexibility to allow matching of clients with housing suitable for their individual needs;
- Developing effective tenancy protocols and channels of communication with housing providers from the start of the program; and,
- Sufficient support for case workers to adapt to the principles of Housing First plus a ratio of caseworker to clients that reflects an appropriate caseload consistent with the level of support needed.

Many of the difficulties experienced with implementing the program reflected inevitable teething problems associated with starting a new, and, to some extent, experimental program. These were mostly overcome or addressed as the program matured. Additionally, these implementation issues need to be considered in light of the outcomes achieved, in particular, a 24 month sustained tenancy rate of over 90% and the majority of participants managing independently with minimal or modest support.

Although the psychosocial outcomes were less strong, this is consistent with international evaluations of Housing First programs and may reflect the complexity of issues that participants presented with. Two years may not be long enough for substantial improvement in these areas to emerge. Overall the findings indicate that it is possible to implement a Housing First approach in an Australian setting with remarkable success.

Introduction

In 2007, Mission Australia embarked on a collaboration with a private benefactor to develop a new service, known as The Michael Project. The Michael Project aimed to improve the lives of homeless men through an innovative program of timely and integrated service delivery including a comprehensive network of wrap-around support services made available in-house to homeless men in Sydney. The Michael Project ran from 2007 to 2010. The findings from the Michael Project research study, led by Paul Flatau from the University of Western Australia, suggest that 'an integrated, targeted and timely model of service delivery offered from within the existing accommodation support system can have a beneficial impact for men experiencing homelessness and can lay a platform for recovery and social inclusion' (Flatau et al. 2012 p. 2). Building on the success of the Michael Project, further funding was provided by the benefactor to progress the model to the next stage by providing support to enter and sustain housing in an innovative Housing First approach. The result was Michael's Intensive Supported Housing Accord (MISHA).

After almost 12 months of planning, MISHA began in late 2010 and was implemented for a period of three years from this point. MISHA facilitated access to long-term housing for homeless people and provided holistic service delivery on entry and a period thereafter. The model was based on engagement of homeless men and selection into the MISHA model followed by case-managed, entry into social housing. Tenancy support was provided for the duration of the project together with access to in-house psychological services and a range of external social support services. The purpose of the latter set of services was to build social networks and link tenants to meaningful community and employment options. The program aimed to work with clients to achieve housing stability, improve social inclusion, and equip participants to live successfully in the community.

The MISHA model is based on a Housing First approach which is a recent and successful policy response from the US that aims to reduce chronic homelessness. It is distinct from older, and many argue, less successful continuum of care 'treatment first' models of homeless to housing, where access to housing is contingent on first establishing one's 'housing readiness' by treating existing mental health, substance use or physical health issues. Once deemed housing ready, clients are expected to live mostly independently without support (Gulcur et al., 2003). Instead, Housing First programs are underpinned by the assumption that it is only when chronically homeless people are given access to permanent housing that they will be able to overcome these longstanding personal issues. Consequently, Housing First offers housing to clients without conditional requirements of successful 'treatment' or sobriety.

This report provides findings on a research study undertaken in relation to the MISHA project over its first three years of operation. The research study was led by Paul Flatau from the University of Western Australia and included Kaylene Zaretsky of the University of Western Australia, Elizabeth Conroy, Marina Athanassios and Marlee Bower of the University of Western Sydney, and Lucy Burns and Tony Eardley of the University of New South Wales. The study explores the outcomes achieved by clients in the MISHA project, follows the lives of the men as they enter housing from homelessness and experience life in permanent accommodation, as well as the cost effectiveness of the program.

This report contains seven chapters in addition to the present one.

Chapter 2: Provides background and context to the MISHA project addressing the policy and organisational context for the development of the MISHA project.

Chapter 3: Presents the MISHA model of housing, support and client selection and discusses the practical implementation of the model including client recruitment, the role of staff and the determination of housing placements.

Chapter 4: Presents the research framework used in the study which was based on a multi-method approach using a longitudinal client survey, MISHA administrative data, in-depth interviews and focus groups, tenancy case studies and an economic evaluation of costs of delivery and cost offsets to the program (i.e. costs to government reduced as a result of the program).

Chapter 5: Provides evidence from the longitudinal survey and MISHA administrative data on outcomes achieved over time by the MISHA clients in terms of housing, labour markets and income, physical and mental health, social participation and quality of life outcomes.

Chapter 6: Summarises results from qualitative analysis of interviews with clients and staff seeking to understand more fully the outcomes achieved by the clients, the journey they followed and their views and perspectives.

Chapter 7: Presents an economic analysis of the MISHA Project covering not only the direct costs of service provision but also the impact to government budgets of changes to use of health, justice and welfare services.

Chapter 8: Outlines the key findings of the study, provides our assessment of the overall achievements and challenges of the MISHA Project, and discusses implications for policy and practice.

2. Background and Context

Mission Australia has been supporting homeless individuals and families since the middle of the nineteenth century and homelessness support represents one of the key areas of Mission Australia's work. Mission Australia's homelessness services cover the full range of service options including prevention and early intervention services, crisis and transitional models of support, and Housing First models. Homeless people are a diverse group with often disparate needs. Those needs cannot be solely addressed through one service delivery model.

2.1 Homelessness in Australia

On the night of the 2011 census (9 August 2011), there were 105,237 people who were homeless or 0.5% of the Australian population (Australian Bureau of Statistics, 2012). This represented an 8% rise in the five years to 2011, although most of the increase resulted from the rise in the number of people living in severely crowded dwellings.

Homelessness has received significantly more attention in recent years than previously with the previous Labor Government investing significantly (along with State and Territory Governments) in homelessness programs to: prevent homelessness; develop more connected and responsive services to achieve sustainable housing; improve economic and social participation and end homelessness for their clients; and break the cycle of homelessness by facilitating people to move more quickly into stable housing with the support they need so homelessness does not recur (Commonwealth of Australia, 2008). The vehicles for increased investment in homelessness were the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH). The NPAH (2009-2013) was designed to deliver four outcomes:

1. Fewer people will become homeless and fewer of these will sleep rough.
2. Fewer people will become homeless more than once.
3. People at risk of or experiencing homelessness will maintain or improve connections with their families and communities, and maintain or improve their education, training or employment participation.
4. People at risk of or experiencing homelessness will be supported by quality services, with improved access to sustainable housing.

A one year 2013-14, transitional National Partnership Agreement on Homelessness (the transitional NPAH) was introduced in 2013 and provided for continuity of homelessness services under the 2009-13 NPAH.

2.2 The Michael Project

In 2007, Mission Australia embarked on a collaboration with a private benefactor to develop a new innovative program of timely and integrated service delivery. The Michael Project ran from 2007-2010 and was a ground-breaking initiative in providing on-site integrated service delivery to homeless men. The model comprised three parts:

1. Existing outreach and supported accommodation services provided by Mission Australia;
2. Renewed investment in assertive case management; and
3. Direct provision of specialist allied health and support services. The specialist services included an outreach nurse, Indigenous outreach worker, podiatrist, dentist, occupational therapist, psychologist, drug and alcohol counsellor, recreational officer and computer literacy tutor.

The Michael Project ran from 2007-2010 and was a ground-breaking initiative in providing on-site integrated service delivery to homeless men.

An important component of the Michael Project (also funded by the same benefactor) was a research study conducted by Murdoch University and subsequently the University of Western Australia and the National Drug and Alcohol Research Centre (UNSW) in collaboration with Mission Australia. The research project profiled the men entering the Michael Project and the outcomes achieved at three months and at 12 months, seeking to identify the mechanisms and processes influencing these outcomes and estimate the cost effectiveness of the program (Flatau et al. 2012). The centrepiece of this research was the largest longitudinal survey of homeless men yet conducted in Australia. The Michael Project demonstrated positive change in outcomes for clients: after 12 months more men were in long term housing, in employment and earning income, and feeling less social isolation and there was evidence of a shift to lower health service in spite of little change in health and mental health issues facing Michael Project clients (Flatau et al. 2013).

One of the key conclusions from the Michael Project was that the availability of long-term affordable housing limited the degree of success in the housing area. Michael's Intensive Supported Housing Accord (MISHA) was developed in response to these limitations and builds on the lessons and experiences of the Michael Project. In particular, MISHA recognised the need for a Housing First response to homelessness.

2.3 Housing First and similar approaches

Central to Housing First is the separation of housing and services; treatment and case management are available but are not compulsory.

Housing First has several other guiding principles. Clients must be given rapid access to permanent housing, consumer choice regarding where they wish to live and an overarching aim of community integration of clients (Tsemberis, 2010). The Housing First approach acknowledges that recovery is an ongoing process, and that psychological or physical health issues and substance use will not disappear when clients enter housing. And, Housing First programs differ from other integrated social housing programs like Common Ground, in that no more than 15-20% of subleased units within a block or complex can be allocated to Housing First consumers, in order to promote community integration (Tsemberis & Eisenberg 2000).

Overall, North American Housing First programs have found much higher rates of tenancy retention than other homelessness to housing models, proving an effective means of reducing homelessness. A two year longitudinal study between 99 Housing First clients and 126 continuum-of-care clients found retention rates of 88% and 47% respectively (Gulcur et al., 2003). When extended to four years, Housing First clients had a retention rate of 75% compared to 48% for the comparison group (Padgett et al., 2006).

The Common Ground program is another model of integrated social housing originating out of the USA which differs to Housing First in a number of aspects. As stated above, it takes a congregate housing approach in which clients are placed into affordable long-term and independent housing within a single complex. Secondly, clients have access to on-site mental, psychosocial and physical health services; in Housing First, these services are accessed via existing community programs. Third, clients are encouraged to build strong communities within the buildings they inhabit whereas Housing First focuses on re-integration into the broader community. Worldwide, Common Ground programs are linked to Street to Home programs that recruit homeless people from the street. Common Ground has been implemented nationwide in Tasmania, Adelaide, Sydney and Melbourne (Australian Common Ground Alliance).

In the first two years of the Common Ground program being established in New York, 'street homelessness' reduced by 87% in the surrounding locality. In the US, the Common Ground program has helped to enable over 5000 people overcome homelessness since 1990 (Johnsen and Teixeira, 2010). Common Ground has an extremely low eviction rate of less than 1% across permanent supportive housing residences (Johnsen and Teixeira, 2010). Common Ground services in the US have not yet been subject to independent evaluation in terms of tenancy sustainment rates, changes in community or social inclusion.

In developing the MISHA model, Mission Australia and the donor drew upon supported housing models with an established evidence base overseas and focused on the Housing First approach. It also drew on learnings from the Michael Project and the benefits of an integrated service delivery approach.

In developing the MISHA model, Mission Australia and the donor drew upon supported housing models with an established evidence base overseas and focused on the Housing First approach. It also drew on learnings from the Michael Project and the benefits of an integrated service delivery approach. Additionally, Mission Australia drew on its extensive working knowledge of, and direct engagement in, the specialist homelessness service system in western Sydney and utilised this network together with the opening up of social housing placement options that became available in the Parramatta region of Sydney.

The opportunities that arose from these social housing placement options resulted in MISHA operating in the Parramatta local government area. Moreover, Parramatta has a significant homeless population. A count undertaken by Parramatta City Council and the University of Western Sydney in February 2010 found that there were 81 people sleeping rough (similar to the Census 2011 count of 85; Australian Bureau of Statistics 2012) and there were many more homeless people staying in crisis accommodation; 285 on the night of the count. Based on 2011 Census data for Parramatta, there were 2,137 homeless people in the different forms of homelessness including sleeping rough, supported accommodation options, those staying temporarily with other households, those in boarding houses and other temporary lodging, and those in 'severely' crowded dwellings.

3. The MISHA Model

The overall goal of MISHA was to work with clients to achieve housing stability, improve social inclusion and equip them to live successfully within the community. This chapter provides a comprehensive outline of the MISHA model as it was originally envisaged, including the tenancy and case management components and client eligibility. It also provides a critique of how the project was implemented and unfolded over time.

3.1 The MISHA model

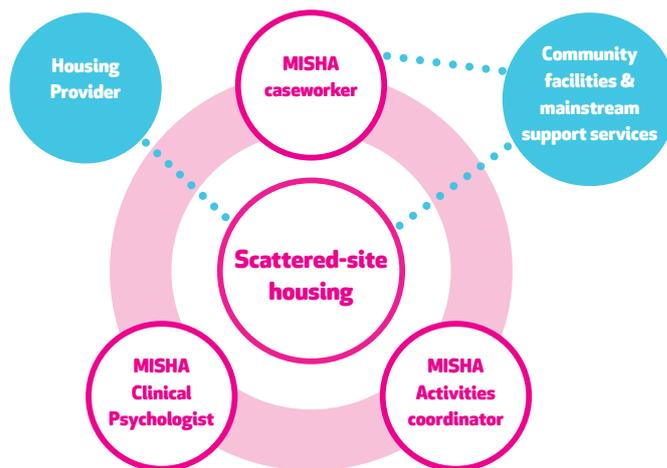
The MISHA service delivery model drew upon two guiding principles, namely, Assertive Community Treatment (ACT) and Housing First. Housing First represents a shift away from continuum of care models to one of human rights and consumer choice and a clear focus on accessing housing options. ACT is a well-articulated model of case management that emphasises a multi-disciplinary team approach to the holistic management of a client's needs (Bond et al., 2001). The list of principles that informed the development of MISHA is shown in Box 1.

Box 1: Principles of MISHA service delivery

1. Client driven, strengths based and goal focussed service delivery.
2. Facilitation of Housing First followed by holistic and tailored support services.
3. Mode of practice that is multi-disciplinary, outreach based, assertive, intensive and provides a continuity of relationship for the client.
4. Positive and creative approach to client work that is motivational, emphasises choice and expands client's horizons.
5. Strong focus on addressing the psychological impacts and causes of homelessness; on meaningful activity, including employment; and on building client's networks of social support.
6. Equipping clients with knowledge, skills and confidence that enables them to effectively perform the functions of finding, accessing and coordinating the support and services they want and need.
7. Working collaboratively and in partnership with organisations and services.
8. Being responsive – to clients, the organisations we work with, the community we work in, to emergent research and best practice and continually improving the way we work.

The MISHA model itself comprised scattered site housing leased via social housing providers and a MISHA support team (see Figure 1). The support team included caseworkers, a clinical psychologist and an activities coordinator. All other services were accessed via existing community programs, including some that were provided by Mission Australia.

Figure 1 – The MISHA model showing links to external services



3.1.1 Housing

Sourcing Properties

MISHA clients were given access to permanent housing through standard leases with collaborating social housing providers (Housing New South Wales, Bridge Housing, St George Housing and Mission Australia Housing). The original proposal aimed to secure 70 properties however, the final number of properties obtained was 74. Properties were acquired in two stages. In the first stage, MISHA worked in conjunction with community housing providers to negotiate the use of their properties for individual clients as they were assessed. At the time that MISHA was being established, the Australian Government had embarked on an economic stimulus strategy that involved investing in the construction of new affordable housing. This meant there were more properties being built by community housing organisations and more properties available for programs like MISHA.

Around the same time, the NSW Government was undertaking an urban renewal program for social housing. This strategy was aligned with NSW commitments under the National Partnership Agreement on Housing (NPAH) and involved a refurbishment of existing properties. Many of the properties obtained by MISHA were sourced through this program and were originally bedsits that had been remodelled into one bedroom apartments, with separate bathroom and living spaces. The total number of properties sourced from Housing NSW in this second phase was 35. Client assessments were then undertaken to fill these properties with eligible clients.

Eligibility was based on the following criteria (discussed in details below):

- Be aged 25 years or older
- Be eligible for social housing in NSW
- Have the desire to live independently in the Parramatta area under a lease agreement with a community housing provider
- Give consent for their personal information to be collected from and disclosed to relevant organisations such as community housing providers and MISHA selection panel members
- Have income and be willing to pay full rent on time
- Be willing to meet with a MISHA staff member on a regular basis.

As there were more men who fell into the client target group and met the eligibility criteria for MISHA, client assessment was based on relative need and suitability. Relative need was determined using an intake assessment tool incorporating risk assessment elements. Service Managers determined suitability based around client mix and the community housing properties that were available. To select clients for a 'high support' place, Service Managers requested and reviewed recommendations from the Outreach Engagement Worker based on the men they had been engaged with. In terms of 'low-moderate' support places, key government and non-government agencies in the Parramatta area were invited to submit targeted referrals.

The 74 housing units eventually obtained for the project included a mix of larger clustered groups of 15 or 20 dwellings in large multi-unit blocks (belonging to Housing NSW), smaller clustered groups of between two and eight units, and some single units in smaller complexes (belonging to a range of community housing organisations). Most units were brand new, built as part of the Nation Building program, and staff reported there being some maintenance issues initially which had to be resolved with the providers.

Establishing the tenancies

Through the partnership agreements described above, MISHA negotiated for clients to have security of tenure through a standard lease agreement. This lease agreement stood alone and was separate from the case management provided by MISHA meaning that a client could keep their property indefinitely and beyond their initial support period. The tenancies were established with the understanding there were no conditions

placed on the security of tenure other than that expected of a standard lease agreement. Thus, there was no requirement for a client to be abstinent from alcohol or other drug use, to engage with mental health services or to have previously established their ability to live independently through other programs. Additionally, given the high prevalence of mental disorder and incarceration among the target population, it was anticipated that MISHA would liaise with social housing providers to ensure security of tenure during short-term hospital stays or custodial sentences.

MISHA caseworkers assisted clients to register for income support payments and then social housing if they were not already registered. Their eligibility was based on the fact they were homeless and thus in need of permanent housing. The social housing providers trusted MISHA caseworkers' assessments of clients' suitability and arranged for them to be housed as soon as practical.

MISHA caseworkers also helped clients to complete the relevant forms to establish the tenancy. They typically accompanied clients to their initial meetings with the social housing provider where they were advised about the terms of their tenancy agreement. These meetings most often occurred at the office of the social housing provider and sometimes at the client's property when the housing provider's office was too far for the client to travel.

MISHA also contributed to the establishment of tenancies by purchasing new whitegoods, furniture and other items considered essential household goods. Additionally, they arranged for clients' belongings to be moved into their new homes.

Location and client choice

In line with Housing First principles, a scattered housing approach was taken – although the limited availability of housing meant that some of the tenants were grouped together in complexes with other MISHA clients, ranging from one or two to 20. Housing was located around the greater Parramatta area, including Guilford, Lidcombe, Merrylands, Colyton, Mt Druitt, Fairfield, Northmead, Smithfield and South Granville. The number of clients at each location can be seen in Figure 2.

Clients had some choice in the location of their housing, such as whether they preferred to live in the same complex as other MISHA clients or not, but the extent of choice was limited by the availability of social housing in the area.

Figure 2 – Number of clients accommodated at each housing site

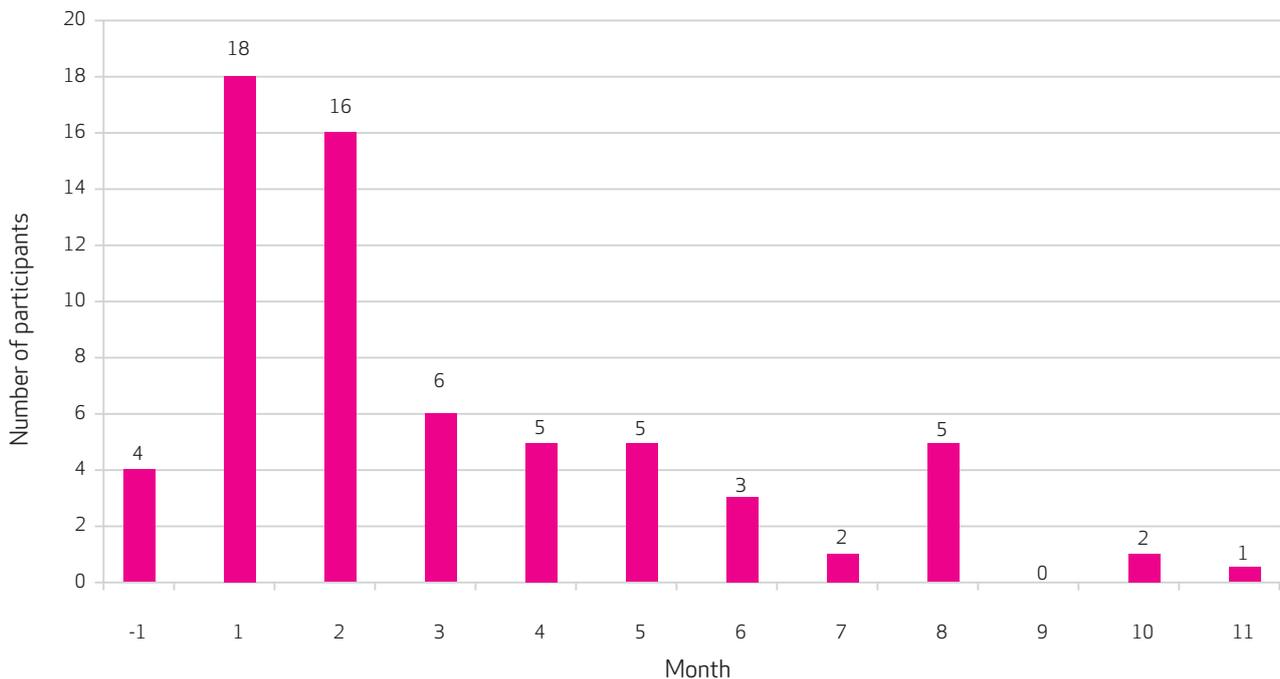


Immediate access to housing

Housing First principles emphasise the need for immediate access to housing (Tsemberis, 2010). While many of the MISHA clients were housed within 1-2 months of being accepted into the project, some were housed much later owing to delays with the construction and release of properties or because they were hospitalised for an extended period. The length of time MISHA clients waited to be housed after being accepted into the program can be seen in Figure 3.

Almost one-third (29%) of clients were housed within one month of being accepted into MISHA; a further 20% were housed by 2 months and 21% by 6 months. MISHA negotiated with other support services in the area to provide accommodation for clients while they waited for access to housing. Regardless of when they were housed, all clients were provided with case management immediately upon being accepted into the program. This is discussed in detail in the next section.

Figure 3 – The month in which participants were housed after being accepted onto MISHA (defined as Month 0)



3.1.2 Support

Case management approach and skills composition

The support team included four full-time caseworkers, some of whom had worked as caseworkers on the Michael Project. The initial plan to employ a multi-disciplinary casework team was not realised due to challenges faced in balancing the number of required caseworkers and the cost of employing allied health professionals within budget constraints. The impact of this on the project outcomes is discussed in Chapter Six.

Each client was allocated a caseworker who utilised an assertive case management approach tailored to the needs and expectations of each client. The role of caseworkers was to:

- Provide practical assistance with clients to help move into their houses and settle in.
- Build rapport with clients and act as a social support.
- Address the psychological and structural impacts and causes of homelessness, improving their positive social support networks with friends and family and in seeking meaningful activity, such as employment.
- Work with clients to give them the skills and practical assistance to function in a domestic context. This included establishing domestic routine and building up their capacity to sustain tenancies.
- Give clients the skills to coordinate support and services they need at any time.
- Act as an intermediary between clients and services, providing advocacy for client's needs.
- Help clients on the way to self-sufficiency beyond the end of MISHA.

Links to specialist support

As indicated in Figure 1 above, some specialist support was provided directly by MISHA (that is, the clinical psychologist and activities coordinator). All other needs were met by linking clients into existing, local services.

The decision to employ a clinical psychologist directly was based on findings from The Michael Project that showed high levels of substance use and other mental disorder in this client population. Consequently, The MISHA Project employed a part-time clinical psychologist who worked with clients to address a range of mental health problems including alcohol and other drug use, depression, anxiety, trauma and grief. The clinical psychologist also provided advice to the caseworkers regarding effective strategies to work with clients experiencing mental illness.

The employment of an activities coordinator aimed to improve the social inclusion of participants by encouraging meaningful and recreational activity. The Activities coordinator organised recreational and training programs for clients. These programs

occurred in the safe and less intimidating MISHA environment and worked to improve clients' self-esteem and social support. The Coordinator also formed relationships with other organisations that could provide meaningful activities for the clients, such as the Milk Crate Theatre, a drama group for homeless persons, and Men's Shed.

MISHA staff also participated in external stakeholder groups, such as the Parramatta Homelessness Interagency. By collaborating with established networks of health and welfare services throughout Parramatta, they were able to facilitate referrals for their clients to access the services they needed. Organisations engaged with in the Parramatta area included the Homeless Persons Information Centre, community housing providers, mental health services, Centrelink and employment services.

3.1.3 Client selection

The target group for MISHA was unaccompanied men who were experiencing chronic homelessness. Clients were defined as being chronically homeless if they had been continuously homeless for 12 months or longer. This included sleeping rough on the street or in an improvised dwelling, staying in accommodation services or refuges, staying with friends or family for brief periods (e.g. couch surfing), staying in hotels or motels, and residing in boarding houses and caravan parks with shared facilities and no security of tenure. Individuals who had been housed for a short period in the past 12 months but had not achieved housing stability were also eligible for the service.

In addition to being chronically homeless, clients also had to meet the following criteria:

- Be aged 25 years or older

There were several services in the Parramatta area that provided supported housing options for young people, hence it was decided that MISHA should target unaccompanied men who were aged 25 years or older. Young people also require a different approach to the management of their health and welfare which would have entailed a different set of skills from the caseworkers as well as a different set of partnerships with support services.

- Be eligible for social housing in NSW

The MISHA Project was allocated 74 public and community housing units for clients. NSW social housing organisations accepted MISHA caseworkers' judgments regarding client's suitability and eligibility for entering housing. These decisions were independent of whether or not clients were on the social housing register, or their placement on this list.

- Have the desire to live independently in the Parramatta area under a lease agreement with a community housing provider

Locating MISHA in Parramatta was a strategic response to the levels of homelessness in the area as well as the knowledge that a supported housing program was planned for inner Sydney but that there was no such model in western Sydney. It was also in response

to analysis of the available services in the area into which MISHA clients could be connected. To ensure the success of the model in sustaining tenancies, clients had to express a desire to live in the Parramatta area. It was anticipated that this would contribute to a client's ability to make connections within their local community and thus assist with the process of social inclusion.

- Give consent for their personal information to be collected from and disclosed to relevant organisations such as community housing providers and MISHA selection panel members

In order to secure properties and establish the tenancies, MISHA required consent from clients to disclose their personal information to community housing providers. Additionally, the appropriateness of each referral was assessed by a selection panel (comprising the MISHA service manager, a MISHA caseworker, and an external stakeholder from the sector) before a property was offered to a client and this required the panel to have access to a client's personal information. Referrals were deemed to be inappropriate if the client's needs would be better served by a residential treatment facility (e.g. drug and alcohol rehabilitation or psychiatric hospital) or disability and aged care support services.

- Have income and be willing to pay full rent on time

All clients were required to have some source of income so as to be able to make a contribution to the rent of their property. This income source included government benefits such as Newstart Allowance or the Disability Support Pension. In practice, if a potential client was currently not receiving income, the MISHA caseworker would assist the client to access the relevant government income support. Additionally, as a social housing tenant, clients were expected to meet the usual tenancy responsibilities regarding rental payments, property maintenance and inspections, and neighbourly conduct.

- Be willing to meet with a MISHA staff member on a regular basis

As a supported housing model, all clients were required to maintain a relationship with a MISHA caseworker although this could be quite minimal. This criterion was stipulated so that MISHA could assist a person to sustain their tenancy and to maintain an opportunity for support if required.

Around one third of MISHA properties were reserved as 'high support' places for clients with multiple and complex needs. The remaining properties were allocated to clients classified as having low or moderate needs. It was anticipated that the difference between lower and higher levels of need would be in terms of total contact hours and length of time supported. This mixture in the level of need among clients was designed to ensure the caseload of MISHA staff was manageable. The recruitment of clients across these need levels occurred predominantly through interagency meetings and informal/formal partnerships that

Mission Australia had with other support services in the area. Additionally, an Outreach Worker was employed to recruit 'rough sleepers' directly from the street as well as via other services that support 'rough sleepers' (such as meal services). The extent to which this planned balance of high and lower needs worked out in practice is discussed further in the next section.

3.2 Project implementation

This section draws on the in-depth interviews with MISHA participants and staff and describes the experience of clients and staff with respect to the client selection process, acquisition of properties and the establishment of the MISHA staff team.

3.2.1 Client recruitment

As described above, clients were recruited for the project from two main sources: the Western Sydney Housing Coalition of local housing and homelessness services; and direct outreach carried out amongst rough sleepers in the Parramatta area or through other services working with rough sleepers, such as a local soup kitchen. Clients recruited from the former source were mainly staying in some form of crisis or transitional accommodation at the time, although many had experience of street homelessness. Several of those interviewed had been referred through another Mission Australia homelessness service, and a number referred to incidents in the past that had led to their homelessness, including psychiatric histories, time spent in gaol, physical injuries and alcohol problems, although some had been in relatively stable housing circumstances before being taken on by MISHA. The following comments were made by clients about how they came to enter into the MISHA project.

"I know the staff at Parra Mission for years because they've helped me with accommodation before and helped me with providers. And what happened with me is that I went and stayed at Hope hostel a few years ago and then they hooked me up with Mission Australian in Harris Park and then they hooked me up with Western Suburbs housing co-op who, um, moved me into a bed-sitter for three months just to get an idea of what sort of person I was, and whether I'd pay and this and that and the other and how clean I was, and when they were satisfied they moved me into a 2-bedroom place in [] and eventually they transferred me into an even nicer place in [], but then I met my girlfriend a couple of years later and after about 6 months of being together with her, I decided to give that unit up and be together with her, a couple of years later, something very bad happened, I got stabbed, and I actually got stabbed by her and um... she went to gaol, but I was still living in the unit. I knew the lease, I knew I'd have to leave so I'd heard about MISHA through ... the staff down at Parramatta at Mission, so I came straight up here..."

(Client aged 45)

“Umm, well, I done 12 months rehab ... like they do, like intense course for 4/5 months, then you go onto a transition house, and then an exit house. And, you know, while you’re in exit they get you back out there, and, umm, then I ran into... Oh my caseworker at the time [name], he found me a boarding house, umm, through Mission Australia and, umm, I lived there for 8 months that’s where I started studying actually, and umm, my caseworker there, goes ‘Oh, you know, would you like, are you interested in the MISHA program?’ And umm, she explained it to me, ‘yep, for sure.’” (Client aged 38)

“Yeah, I, um... had a breakdown in 2008 and, ah, went to hospital in [Manly]. And, ah, to the psychiatric centre. And then, um, I’d been living with my brother and I couldn’t go back there, for no other reason than that neither of us wanted it. I didn’t want to go back there and he didn’t particularly want me back ... I stayed in hospital until... from November until January. And then I, um, went to the, ah, hostel at, ah, Brothers of St Vincent de Paul at [] and they fixed me with Mission Australia. Um, and I went to your, um, ah, Harris Park one, and I was there for 18... 18 months and loved it. I mean, it was... it was excellent. And for me it was just a case of being in the right place at the right time.” (Client aged 66)

In terms of recruitment, the general view of staff was that the recruitment process had worked fairly well, that the clients broadly met the intended criteria and that the mix was an appropriate one. However, some initial difficulties were encountered owing to the project being a pilot and it being the first time this type of recruitment process had been carried out. As the main criteria for acceptance into the program was being male, aged over 25 years, with at least 12 months experience of homelessness and having a link to the Parramatta area and a desire to live there, there was no specific criterion concerning the level of need. According to the staff interviewed, these criteria were met for most if not all of the clients.

Most of this initial recruitment was carried out by an outreach worker, together with a service manager. Staff commented that the intake process felt somewhat rushed and a little haphazard, making it difficult to ensure that the overall client group reflected a balance of chronic rough sleepers and others with less entrenched homelessness, and a mix of need levels. That said, the case management staff interviewed for the research were employed after the initial phase of recruitment had taken place and hence their experience of the intake process and allocation of housing was during the second recruitment phase. As mentioned previously, this second phase involved a stock of 35 properties that became available at the same time.

As one staff member observed:

“We’re learning through trial and error and updating our policies and procedures as we go along.” (Staff member)

The question of balancing those with ‘high’ and lesser needs turned out to be particularly complex and challenging.

“See, high needs is an interesting concept. For us case workers a high need does not necessarily mean crisis needs ... There is not necessarily correlation between the level of crisis and [staff] time ... Lots of guys who were crisis guys were fairly – not independent - but could function independently.” (Staff member)

“For the future of the program we learnt that it’s important that we conduct a thorough assessment. Through the assessment process we can avoid biases such as the difference between high needs (too demanding, severe mental health issues etc.) but also look at service resources and how these can meet clients’ needs.” (Staff member)

Looking back at the process, at the time of the focus group, one staff member, who was closely involved in the original recruitment of clients, commented that having a selection committee involving the project psychologist, the service manager, a case worker and the outreach worker might have helped in ensuring that participating clients were more prepared to engage with the support services MISHA offered:

“... a lot of them just saw it as an opportunity to get a house and once they’d the house they didn’t want to engage in, you know, the programs, or the case managers, the psychologist. They saw it as a door opening to get a house and once they were in the house there was no agreement between our service supporting them and the housing that they had to engage with us. So in that sense, you know, there are a fair few clients that don’t engage in the activities, that don’t engage with the psychologist, that don’t even engage with a basic level of case management. So in that sense it could have been structured a lot better to state that, you know, these are the responsibilities of the client and these are the services we offer, and it hasn’t quite panned out that way with quite a number of our clients.” (Staff member)

In a sense, the above quote underlines the challenges faced by staff in implementing Housing First principles, particularly where the caseworkers could clearly see the advantages and opportunities that the full program offered clients. There were also some reported difficulties, at first, in relations with some members of the local housing services network, where there was a perception of the new project as something of an ‘interloper’. It required some outreach with these agencies to develop an effective working relationship.

3.2.2 The staff team

The staff team for MISHA came from a variety of backgrounds, including aged care, drug and alcohol services, human resources and rehabilitation, recreation, other homelessness services and case management and private industry. Some were already working for Mission Australia in other capacities and some were recruited from external sources. While most had some form of social welfare background, for several this job was their first direct experience in homelessness services. The service manager described setting up the project as a 'big challenge'; the staff team was incomplete at the start, and as described above, this affected the project's ability to manage the recruitment and assessment process in the way originally envisaged. There was some initial staff turnover, with two case managers leaving within the first year.

Building the necessary links with other local services was also difficult at first, because of a degree of suspicion and scepticism from the established local networks about both the model itself and about Mission Australia starting a new service in the area. This scepticism was reported to have dissipated over time, however. Some of the communication issues seem to have arisen over different interpretations of the meaning of 'case management', which for MISHA is considerably more intensive than for some other services.

In spite of these initial difficulties, however, the general view of staff interviewed was that the team worked well together and effectively, even though caseloads were large and staff felt more case workers were needed to provide the level of intensive support required by many clients.

Clients themselves, almost exclusively, held the staff in high regard and were extremely complimentary about them.

3.2.3 Housing placements

A key element of MISHA as a Housing First program was to obtain suitable housing for clients as soon as they were recruited and to move them into this secure housing before supportive services were provided. In practice, this proved more difficult than anticipated. There is a severe shortage of affordable tenancies both through NSW Housing and community housing organisations across the western Sydney area. As a result the MISHA staff had to become involved in complex negotiations with a range of possible providers for this competitive pool of properties. The service manager, who undertook most of these negotiations, reported difficulties dealing with a number of the community housing organisations, who were slow in responding because they were busy managing rapid expansion of their housing stock through the Nation Building stimulus program. There were also delays in completion of the new-builds and many of the housing units came to MISHA only minimally finished. Only one community housing organisation, for example, provided curtains for the windows in the properties.

The delays in acquiring and equipping the properties meant that in practice a significant proportion of clients remained for some time in what the service manager referred to as 'a holding pattern', in some other form of temporary accommodation, until suitable units were found for them. For some clients this 'holding pattern' lasted for as long as nine months.

This is contrary to the ideal housing first model, and some staff saw it as creating difficulties for them in developing the important initial relationships with clients required for an effective case management approach. It also meant that only a limited choice of housing was available to clients:

"Slight, depending on the circumstances and the availability, not really choice on number of bedrooms. Indigenous clients have choice for number of bedrooms or if they have access to children then I think they have the options, but otherwise no." (Staff member)

The transition into housing was also complex and time-consuming. Once a tenancy had been agreed with the owner or head-lessor, this involved negotiating contracts and having them signed, registering clients with NSW Housing if they were not already, organising client exits from existing short-term housing if they had it, assembling packages of basic household furniture and equipment, and having these moved into the premises, helping clients to set up the household goods and getting them to sign for it. In some cases where multiple units in one block became available at the same time, this involved logistical efforts which one staff member described as 'a nightmare'. Staff were also faced with difficult choices between purchasing individual sets of equipment as needed, or bulk purchases, which were cheaper but then presented problems of storage. However, in some cases:

"Luckily we found [removal] companies who gave us a good deal and that worked very well." (Staff member)

Also, one view was that this extended process actually helped in developing a rapport with clients:

"One good thing came out of it - staff had time to build rapport, develop a smooth transition and form bond and respect in that early relationship." (Staff member)

4. Research Framework

This chapter provides an overview of the aims of the research study and the different methodologies employed.

4.1 Aims

The main aim of the MISHA research project was to evaluate the service model with respect to client outcomes and the economic benefits to government and wider society. It also aimed to make a significant contribution to the evidence base to inform government policy in the housing and homelessness fields. The research study was funded by the same donor who funded the MISHA Project. Specifically, the research aimed to:

1. Document the needs and backgrounds of chronically homeless men on entry to MISHA;
2. Assess the effectiveness of MISHA in:
 - a. Sustaining tenancies
 - b. Improving the physical and mental health of clients
 - c. Improving the economic and social participation of clients.
3. Understand the processes and mechanisms through which MISHA influenced client outcomes; and
4. Estimate the cost-effectiveness of the MISHA model.

4.2 Research plan

A comprehensive research plan was developed by the research team in collaboration with the Research and Social Policy Unit at Mission Australia. The research used a mixed methods approach comprising a number of quantitative and qualitative methodologies. The data collection methods used are shown in Table 1 along with the number of respondents and described in the following sections.

Table 1 – Data collection methods used in the MISHA evaluation

Method	n	Sample	Timing
Quantitative			
1. Longitudinal survey	75	Clients	Wave 1: on entry to MISHA (baseline) December 2010 – October 2011
	63		Wave 2: 6 months post-baseline June 2011 – December 2012
	67		Wave 3: 12 months post-baseline December 2011 – November 2012
	58		Wave 4: 18 months post-baseline June 2012 – June 2013
	59		Wave 5: 24 months post-baseline December 2012 – October 2013
2. MISHA administrative data	75	Clients	December 2010 – October 2013
Qualitative			
3. In-depth interview	7	MISHA Staff	February 2012
4. In-depth interview	14	Clients	August 2012
5. Focus group	6	MISHA Staff	September 2012
6. Tenancy case studies	8	MISHA staff & Housing managers	February 2013 – August 2013

The Longitudinal Survey data presented in this report is based on the sample of 59 respondents who completed the baseline, the 12 month survey and the 24 month survey. We refer to this group of respondents throughout as the ‘follow up’ group.

University human research ethics was granted by the University of Western Australia to complete the research study and ratified by the University of New South Wales and the University of Western Sydney.

4.2.1 Longitudinal survey

The primary method of data collection was a client survey administered at five time points over a 24-month period and commencing at entry to MISHA. The baseline survey (Wave 1) was conducted by MISHA caseworkers as part of their initial assessment with clients. All subsequent surveys were conducted by trained research interviewers. The majority of surveys were conducted at the MISHA office in Parramatta but for a small number of participants that found it difficult to attend the office the surveys were conducted at their homes. All participants were reimbursed for their time with either a \$15 (W2 and W4) or \$30 (W1, W3 and W5) gift card for each survey completed.

The client survey included measures on demographic characteristics, homelessness and housing history, employment and income, physical health, mental health, social isolation and relative deprivation, health service utilisation and contact with the justice system. An abridged version of the client survey was used at 6 and 18 months as the reason for these follow-ups was to: a) keep in touch with participants to prevent attrition from the research; and b) obtain additional measures for indicators more likely to fluctuate within a 12 month period.

Participants signed a written consent form prior to participating in the research. Participation in the research was voluntary and non-participation did not affect the provision of support.

All 75 men recruited into the MISHA project completed the client survey at entry. The numbers participating at each follow-up stage were: n=63 at 6 months (Wave 2); n=67 at 12 months (Wave 3); n=58 at 18 months (Wave 4); and n=59 at 24 months (Wave 5)¹. Thus, the participation rates were 84% at the first follow-up and dropped only to 77% by the final wave – a good result for a survey carried out over a two-year period.

4.2.2 MISHA administrative data

In order to gain more information about the time case managers spent on the tenancy and social outcomes of MISHA clients, consent was sought from clients to access administrative data collected on them through Mission Australia's Community Services Information Management System (MACSIMS) database. Data included case file notes for each client. From this, we were able to identify the success of tenancies and whether any tenancy events occurred, such as neighbourhood complaints or property damage.

Although extremely useful, the data gained via MACSIMS had some limitations. There were differences in the way information was entered across the caseworkers. For example, some caseworkers entered information according to client contact regardless of the number of separate issues addressed during that contact. Other caseworkers made separate entries for each issue addressed, even if this occurred within a single contact. This sometimes made it difficult to delineate the time spent by case managers on different issues so these data should be treated with some caution.

4.2.3 In-depth interviews and focus groups

The main purpose of the qualitative component was to complement the quantitative data collection by providing a more detailed and nuanced picture of both the process and impact of MISHA services. This included questions of how the project was implemented and unfolded over time; what issues arose in operating the project and how these were addressed; how clients experienced the services offered and what outcomes they achieved as a result; and what lessons might be learned for either continuing the project beyond its current end date or in setting up other similar projects. This information will be useful both for Mission Australia in its management of such programs and for the wider service sector involved in similar Housing First-type projects.

The qualitative component also aimed to give both clients and staff a 'voice' in the evaluation, since they are the two groups with the most direct experience of it and those most likely to offer useful suggestions for how such projects could be improved.

Seven individual interviews were carried out with MISHA staff during February 2012. These covered the four case managers employed by the project at that time, the service manager, the activities coordinator and the clinical psychologist. The interviews were carried out and transcribed, either fully or in summary, by staff of the Mission Australia Research and Social

Policy Unit, except for that with the MISHA manager, which was conducted by the senior UNSW researcher managing the qualitative component.

For the client interviews, a form of purposive sampling was carried out by a member of the research team, based on an anonymised list of all current clients with key demographic and service data supplied from the client survey data. A randomised sample of 20 participants was initially drawn and this sample was then adjusted to reflect a spread of participants by: age, the form of housing provided, whether they had been chronic rough sleepers, whether they were Indigenous, their assessed level of psychological distress, their level of recent use of alcohol and drugs, and their current level of engagement in social activities - all factors that were of interest in the study.

The selected sample was then approached by a researcher at one of their follow-up client surveys and invited to participate in the in-depth interviews. The list of those who consented was then passed on to the Mission Australia Research and Social Policy Unit who recruited 14 participants from it, taking into consideration an assessment by caseworkers of that client's ability to engage with the research process without causing physical or mental stress. Participants were offered a \$40 voucher as recognition of their contribution to this component of the research. The achieved interview sample included just under one-fifth of the total clientele at the time and was broadly representative of it. Again, the interviews were carried out (in August 2012) and transcribed by staff of the Mission Australia Research and Social Policy Unit.

4.2.4 Tenancy case studies

In order to more fully understand and cost the process of sustaining tenancies, a series of case studies was undertaken with MISHA caseworkers and social housing providers. These case studies focused on six participants who successfully retained their tenancies and three participants who were evicted from their properties.

The six participants who sustained their tenancies were selected through discussions with MISHA caseworkers based on the extent of the tenancy problems they experienced – none or limited tenancy issues (n=2); intermittent tenancy issues (n=2); and persistent tenancy issues (n=2). A member of the research team sought consent from each participant to discuss their tenancies with both their MISHA caseworker and their housing provider and to link this with administrative data held by MISHA on the provision of tenancy support. In-depth interviews were then undertaken with four caseworkers and three housing providers. The interviews were conducted face-to-face, audio taped and transcribed. Tenancy support information was manually coded from the free-text fields in the case management database (de-identified).

¹Four participants died over the course of the evaluation hence the participation rates are calculated on the surviving cohort at each wave.

Information on the three evicted participants was restricted to in-depth interviews with MISHA caseworkers and tenancy support data from the MISHA case management database. None of these participants were able to be contacted in order to gain consent to speak with their social housing provider.

4.2.5 Cost analysis

The cost analysis examined the cost to government of mainstream service use by MISHA participants and how this use changed over time. It also examined the cost of delivering the MISHA program and the extent to which this was offset by a decrease in the cost of mainstream services use by participants. Mainstream services examined in detail included contact with health and justice services and welfare payments received by MISHA participants. Costs incurred in the 12 months prior to the baseline survey were compared with the cost of services used in the 12 months prior to each of the 12- and 24-month follow-up surveys. The cost of health and justice services was also compared with the NSW population average, and the extent to which high average cost of health and justice costs were driven by a small number of participants was investigated. Other issues considered were cost offsets from evictions avoided, savings to government from reduced use of crisis/emergency accommodation once clients are housed, and the cost of providing dwellings.

Use of health and justice services by MISHA clients and their income source(s), including government benefits, was obtained from the client survey. The cost of health and justice services used by survey participants was estimated by applying the unit cost for each service (in 2011-12 dollars) to reported use. Unit costs were estimated from publicly available information including the Report on Government Services (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013), the Institute of Health and Welfare (Australian Institute of Health and Welfare, 2012a, Australian Institute of Health and Welfare, 2012b, Australian Institute of Health and Welfare, 2013a, Australian Institute of Health and Welfare, 2013b, Australian Institute of Health and Welfare, nd) and other publications. These sources were also used to estimate average service use and associated cost for the NSW population (2011-12). The cost of government benefits was estimated using the government benefit rate as of December 2011 (Australian Government, 2011). Refer to Appendix 1 for further details of how the unit costs and population norms were derived and the data sources used.

Data on tenancy failures for MISHA participants and the associated cost was sourced from housing providers. The survey data did not provide direct evidence of the rate of failure without support. None of the participants who completed all three survey waves had a failed tenancy, and only 7% had been in a community or private tenancy in the 12 months prior to baseline, while none had been in a public tenancy. A literature search² provided an indicative rate of eviction from public housing and

an average cost of eviction (Zaretsky et al., 2013). This was used as a comparison to the actual eviction cost incurred by housing providers and an indicative estimate of the offset from tenancy failures avoided.

The client survey provided indicative data on clients' use of crisis/emergency accommodation and how that changed over time. However, participants' accommodation circumstances were recorded in fortnightly blocks. As many homeless people frequently move between different types of accommodation, short stays in crisis/emergency accommodation (for example, overnight stays) are not reflected in the data. It is also likely that the duration of longer stays have been rounded up or down to the nearest number of complete fortnights. For example, a stay of 10 days would be recorded as one fortnight. Therefore these data are indicative only. The cost of crisis/emergency accommodation per day was sourced from the Report on Government Services (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013).

The cost of delivering the MISHA program was examined with reference to recurrent expenditure for a three year period; July 2010 to June 2013. Financial years 2010-13 also corresponded to the period over which survey participants received support. Funding and expenditure data were provided by Mission Australia.

Permanent housing for MISHA clients was provided by Housing New South Wales and a number of community housing organisations (including Bridge Housing, St George Housing, Mission Australia Housing and Affordable Housing). They also provide tenancy management and administrative services. An indication of the recurrent cost incurred by housing providers to manage and maintain properties is obtained from the Report on Government Services (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013). Housing providers indicated that due to advocacy of MISHA case workers more time was often devoted to resolving issues associated with MISHA tenancies than was normal. This implies that the average recurrent cost/dwelling is likely to represent a conservative estimate of the cost incurred by housing providers. Housing providers also incur the capital cost of accommodation. Housing NSW provided the average capital value of public housing properties available to MISHA clients. The annualised value of capital employed was estimated by applying an opportunity cost of capital of 8% (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013) to the average capital value. This implicitly assumes that the average capital of community housing properties and public housing properties available to MISHA are equivalent. This was considered a reasonable assumption, as all properties were one bedroom units in the Parramatta area.

² There is limited documented evidence on the 12 month or 24 month sustained tenancy rates for homeless people where that tenancy does not come with case management support (such as that provided in MISHA).

5. Outcomes: Change over time across key domains

The overall aims of MISHA were to improve the housing stability and social inclusion of clients and to equip them to live successfully within the community. Measuring how well MISHA had achieved these goals was a key objective of the research study. The study aimed to evaluate whether clients had undergone improvements in several life domains over a two year period, including:

- Housing
- Employment and Income
- Physical and Mental Health
- Social Outcomes

Although the Client Survey was completed for 75 men at entry to support, the findings presented in this chapter include only those participants who also completed the survey again at the 12 month and 24 month follow-up. This follow-up group comprised 59 men. The group excludes the four men who died during the follow-up period and the 12 participants who were unavailable to participate in one or more of the follow-up surveys. Reasons for non-participation included: being imprisoned or away visiting family at the time of the follow-up, or declining to participate in the interview at that time.

5.1 Profile of the follow-up group

The follow-up group, which included those who had participated in all three waves of data collection, ranged in age from 24-66 years, with the majority of participants aged in their late thirties to mid-forties. At the commencement of MISHA, 70% of the participant follow up group were single, 5% were in a de-facto relationship and 22% were either separated or divorced. Around half the participants had at least one child, with the majority of these having one to three children. Ten per cent of participants were of Aboriginal descent. Around one quarter of MISHA participants were born overseas, in a wide range of both English and non-English speaking countries. Most of the men who were born overseas had migrated through the family migration visa category. The majority of participants (81%) reported speaking English well or very well. Two thirds of the follow up group had completed high school to at least year 10, and almost half had completed some form of tertiary education, including trade certificates (23%), diplomas (21%) or bachelor degrees (4%).

The demographic profile of the follow-up group (n=59) was compared to those who did not complete all three waves (n=12; excluding the four deceased men) to assess whether the profiles differed at baseline. The two groups had similar demographic profiles at baseline but different homelessness histories. The mean number of transitions between homelessness states and/or stable accommodation was higher for the non-follow-up group than for the follow-up group (1.5 vs 0.8 transitions). The two groups had spent similar amounts of time staying in accommodation services, but the follow-up group appeared to

have spent slightly less time living without shelter or staying with friends/relatives and much less time staying in a caravan park than the non-follow-up group. Additionally, the mean number of weeks spent in boarding/rooming houses was higher in the follow-up than the non-follow-up group. This is shown in Table 2.

Compared to the rest of the sample, the follow-up group had spent more time in prison (100 vs 86 weeks) and hospital or other inpatient health facilities (62 vs 24 weeks). This may suggest that hospital costs and justice costs for the follow-up group have been higher than the group of respondents who did not participate in follow up interviews. There were also differences in housing outcomes for the two groups with the follow-up group having a higher sustained tenancy rate; this is discussed in detail in Section 5.2.

Table 2 – Mean number of weeks spent in different homeless states across the lifetime among participants in the follow-up group compared to the remainder of the sample

	Follow-up group (n=59)	Non-follow up group (n = 12)
No shelter or makeshift dwelling	133	146
Accommodation service	102	101
Friends/Relatives	131	144
Boarding/rooming house	96	69
Caravan Park	24	43

5.2 Housing

5.2.1 Housing circumstances on entry to MISHA

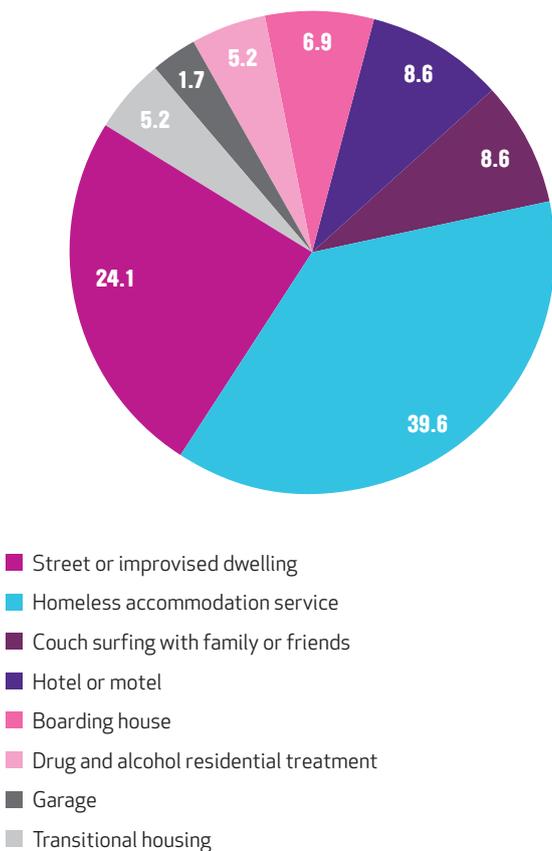
On entry to MISHA and housing, all follow-up group participants had histories of chronic homelessness of some type. Their accommodation histories revealed a poor accommodation experience.

- Around one-third (32%) of participants in the follow-up group had their first experience of homelessness before age 18. A further 20% first experienced homelessness between the ages of 18-24.
- Around one-third of the follow-up participants were sleeping rough immediately prior to entry to MISHA. Seventy-one per cent had slept rough at least once during their life. On average, these participants had spent 3.6 cumulative years sleeping rough, generally starting around age 28.
- The vast majority (95%) of participants in the follow-up group had spent time in crisis accommodation, averaging a cumulative total of two years. The average age participants first experienced sleeping in crisis accommodation was 39 years.

- Participants in the follow-up group exhibited a poor ability to sustain tenancies prior to entering MISHA. Almost 13% had been barred from private rental or public housing in their lifetime, and 4% had been barred from crisis accommodation.

Follow-up group participants were recruited from a variety of homeless circumstances (see Figure 4). Slightly less than one-quarter were recruited from the streets as rough sleepers, 40% were staying in accommodation services for the homeless, and smaller proportions were 'couch surfing' with family and friends (9%) or residing in boarding houses (8%) and hotels (1%). A small proportion of participants (5%) were residing in transitional housing without any prospects of alternative housing with a secure tenure. Additionally, one participant was living out of a garage that they were leasing and a few participants (5%) were in a residential treatment program for substance dependence.

Figure 4 – Baseline accommodation status among participants in the follow-up sample



5.2.2 Two year change in housing circumstances

As described earlier, some participants experienced delays in the construction or renovation of their properties, while others had lengthy hospital stays prior to taking up their lease. Once housed, all participants in the follow-up group retained their tenancies until the 24 month follow-up. This result is impressive given the extensive homelessness histories of these participants and the fact that many of them may not have been considered for social housing without the case management support provided by MISHA.

Over the 24-month follow-up period, some participants temporarily left their properties (but retained their tenancies) for a variety of reasons. One participant regularly returned to the inner city where he had spent much of his time when he was homeless over both years in MISHA; this same client was also hospitalised intermittently for days and weeks at a time for treatment of a serious mental illness. Another participant regularly returned to the park near a Sydney beach where he had stayed whilst homeless and to a homeless meal service in the city where he was used to going. Despite these frequent 'leaves of absence', both participants returned to their properties within a few weeks. Finally, one participant spent nine months in a residential rehabilitation facility for substance dependence in the first year of their MISHA tenancy.

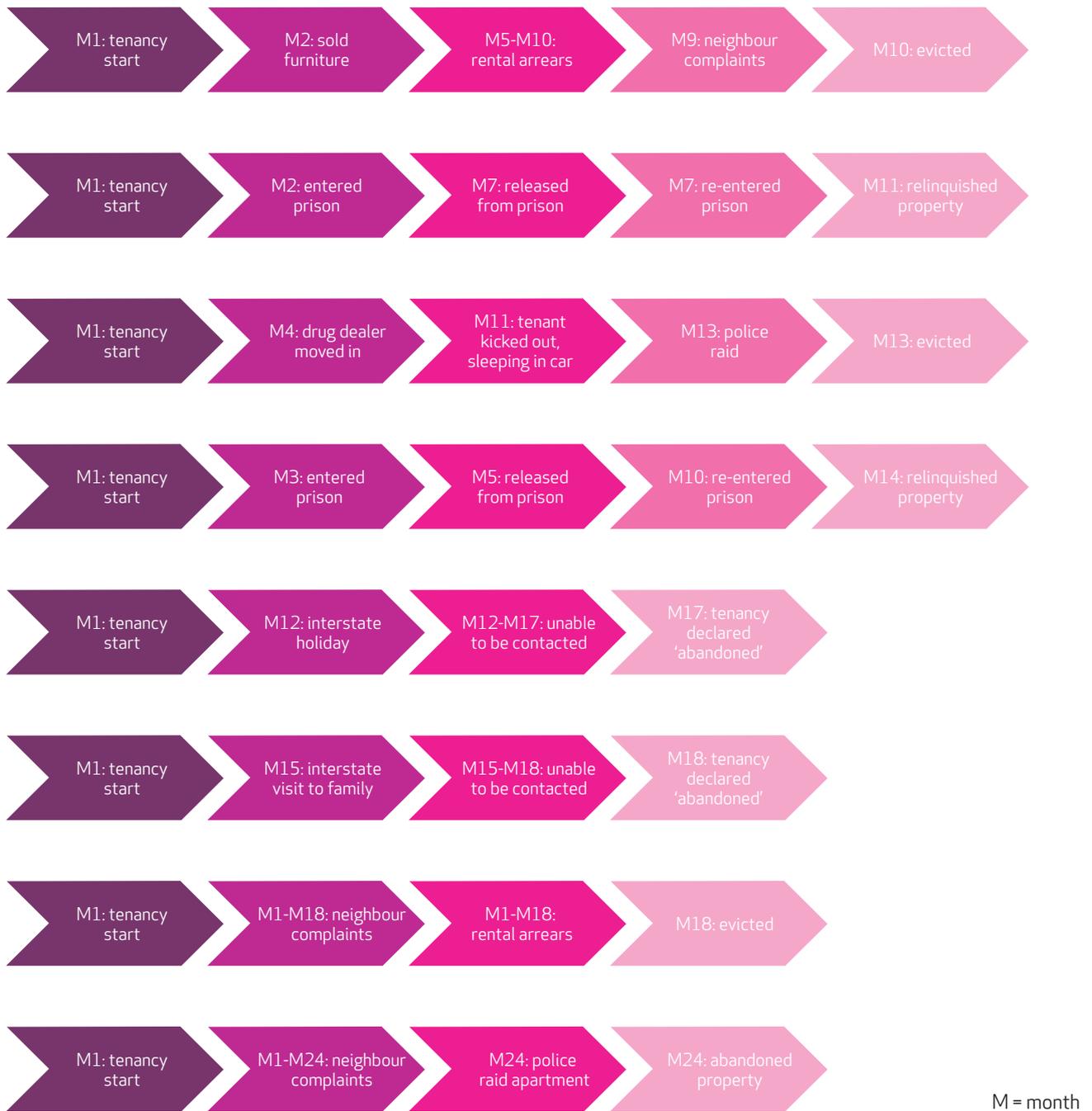
Sustained tenancy rate for the total MISHA sample

For the total sample (excluding the four men who died), the 12-month sustained tenancy rate was 97%; this declined slightly to 89% after two years. These rates are similar to those reported by other street-to-home projects in Brisbane and Melbourne (Parsell et al., 2013, Johnson et al., 2012). The significance of both the 12-month and 24-month sustained tenancy rates achieved by MISHA are best understood by comparing them to the rate of sustained tenancies in the absence of support.

Failed tenancies in the total MISHA sample

As mentioned, several participants had unsuccessful tenancies. The trajectories of these unsuccessful tenancies are shown in Figure 5.

Figure 5 – Failed tenancies among the total MISHA sample during the 2 year follow-up period



Only two participants lost their tenancies within the first 12 months of being housed - one because of an extended period of time in prison, and the other because of a build-up of rental arrears and neighbour complaints. Two more tenancies were lost early in their second year of tenancy, including an eviction due to the participant being coerced out of their property by their drug dealer and a property being relinquished following

the participant’s return to prison. The remaining tenancies were lost in the latter half of the second year of tenancy. Three properties were abandoned, two of which followed what were initially meant to be a short period of absence from the property, and one participant was evicted because of extensive rental arrears and neighbour complaints.

5.2.3 Summary

The housing outcomes delivered by MISHA were substantive and similar to the findings reported by other supported housing evaluations in Australia (such as J2S1). By design, all of the participants were chronically homeless at entry, with a substantial proportion first experiencing some form of homelessness in childhood or adolescence. While some participants took time to settle into their properties, the majority of participants were able to sustain their tenancies at least until the two year follow-up.

5.3 Labour market and income

MISHA aimed to improve the economic participation of participants over the course of the project. This involved improving labour force participation as well as better management of income and expenses. Assertive case management helped motivate job-ready participants to seek employment including helping participants to develop strategies and training to achieve their employment goals. MISHA even supplied appropriate clothing to participants who were successful in obtaining job interviews.

5.3.1 Labour market and income circumstances on entry to MISHA

At the commencement of MISHA, participants in the follow-up group had a generally poor economic and employment profile:

- Almost all of the participants (86%) were unemployed, with just three per cent of participants employed full-time.
- Around a quarter had a full-time job in the last two years. More than a quarter had a full-time job two to five years ago. Forty-one per cent had a full-time job more than five years ago, and just two per cent had never worked full-time.
- The major source of income was government benefits, either Newstart or the Disability Support Pension.

- Almost half of the participants indicated that they did not have enough money to get by on or only had just enough money to get by on.
- A number of major consequences had been experienced due to a lack of money, including that 43% of participants went hungry in the preceding year as a consequence of not having sufficient income.

5.3.2 Two year change in labour market and income circumstances

At the 12 month follow-up, attachment to the labour force showed slight improvement. Employment rates increased among the follow-up group and the proportion of participants classified as not being in the labour force decreased slightly over time. Additionally, there was a positive trend towards seeking employment – a lower number of participants who were ‘marginally attached’ to the labour market and an increase in those who were actively looking for work.

By the two year follow-up, further slight improvements had occurred – the proportion of participants not in the labour force declined by a further 7% and the proportion that was employed increased. It appears, however, that there was a shift in the proportion of the follow-up group classified as unemployed to being ‘marginally attached’, meaning they were no longer actively looking for work despite being available to start work if a job was offered. This increase in the number of participants classified as being ‘marginally attached’ might have been driven by the decline in those classified as not being in the labour force. The qualitative interviews discussed in Chapter Five also indicated that a number of participants had taken up volunteering positions in other charitable or not-for-profit organisations, generally as a result of encouragement or introductions by their case workers. It is possible that some of these positions might lead to paid employment in the future.

Figure 6 – Labour force status among the follow-up group at entry and 12 and 24 months

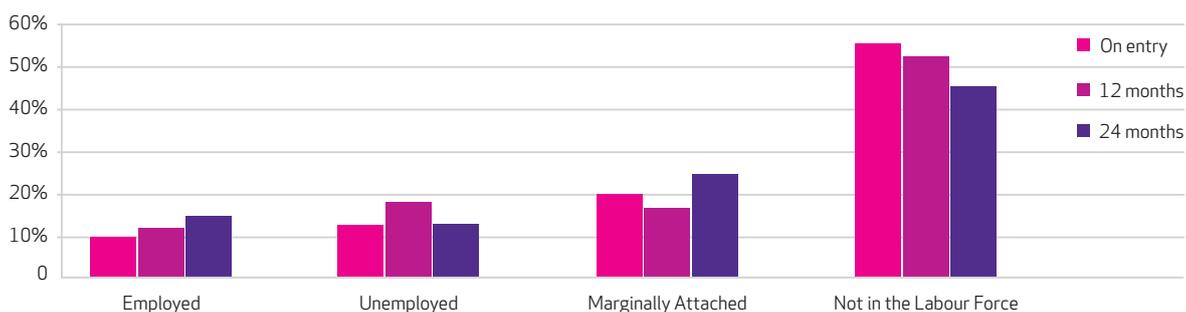


Table 3 illustrates the reasons why participants felt they had difficulty finding employment throughout the project. The most commonly reported difficulty at each wave was 'own illness or disability' and while this remained stable in the first year, there was a slight increase in the proportion of participants identifying this as a difficulty in the second year. This finding is consistent with the large number of participants that were in receipt of the Disability Support Pension at each time point.

Table 3 – Difficulties in finding employment among the follow-up group at baseline and 12 and 24 months

	On entry (%)	At 12 months (%)	At 24 months (%)
Lacked necessary skills/ education	40	39	23
Considered too young by employers	6	9	2
Considered too old by employers	32	30	32
Insufficient work experience	47	44	23
No vacancies at all	45	30	21
No vacancies in line of work	42	26	26
Too far to travel	38	22	26
Own illness or disability	53	52	66
Language Difficulties	4	4	9
Unsuitable hours	6	22	13
Difficulties re childcare/ family responsibilities	6	0	4
No feedback from employers	36	30	17
Too many applicants for available jobs	35	22	28

Some issues that participants had previously reported to be obstacles at baseline were no longer problems at subsequent follow-ups, explaining why some clients were able to improve their standing in the labour market. For example, 40% of participants believed they failed to get jobs because they lacked necessary skills or education. This decreased to 23% at 24 months. Almost half of participants believed that insufficient work experience held them back from finding work on entry to MISHA which decreased to 23% after two years.

The proportion of participants who cited that a lack of feedback from employers inhibited their ability to gain employment decreased from 36% to 17% in the same time period. These findings may be due to the job search training and other employment support organised by the activities coordinator at MISHA.

Over the first year of the project there was a 9% reduction in the number of participants whose predominant source of income was government unemployment benefits (see Table 4). At the commencement of MISHA, almost half of the follow-up group reported that they either did not have enough money to get by on, or that they had just enough money to get by on (Figure 7). The provision of housing, case management and changing income sources appeared to positively impact clients' financial management skills over time. Although the proportion of participants who reported 'not having enough money to get by' increased slightly (3%) at 12 months, it remained stable at 24 months. There was a substantial reduction (20%) at 12 months in the number of participants who reported having 'just enough money to get by'; this increased slightly again at 24 months.

Approximately half of the participants were in receipt of unemployment benefits at baseline and this declined to about one-third at 12 months and then increased again to 42% at two years. In contrast, the proportion of participants whose main income was sickness/disability benefit increased from baseline to 12 months (perhaps in response to caseworkers supporting claimants' health issues) and then declined again at 24 months.

At the commencement of MISHA, almost half of the follow-up group reported that they either did not have enough money to get by on, or that they had just enough money to get by on (Figure 7). The provision of housing, case management and changing income sources appeared to positively impact clients' financial management skills over time. Although the proportion of participants who reported 'not having enough money to get by' increased slightly (3%) at 12 months, it remained stable at 24 months. There was a substantial reduction (20%) at 12 months in the number of participants who reported having 'just enough money to get by'; this increased slightly again at 24 months.

Table 4 – Primary sources of income among the follow-up group on entry and at 12 and 24 months

	On entry (%)	At 12 months (%)	At 24 months (%)
No income	0	0	0
Registered/awaiting disability benefit	0	0	5.4
Unemployment benefit	51	38	42
Sickness/disability benefit	47	51	46
Wages/Salary	11	10	9
Own business	0	0	2
Spouse/partner's income	0	0	0
Worker's compensation	3	7	5.3
Other Sources	4	1.7	1
Old Age Pension	0	1.7	5.1

There was a 9% increase in those who had 'enough to get by on, but not enough to get back on track', which declined again by 4 percentage points at 24 months. Finally, there was a 7% increase in the proportion reporting they had 'enough to get by on and for a few extras' and this remained stable at 2-year follow-up.

Improvements in perceived ability to manage income did not seem always to be influenced by the level of income participants actually had. Figure 8 compares the self-reported ability to manage on current income among participants receiving unemployment versus those on disability benefits. At baseline, compared to participants on unemployment benefits, there were fewer participants on disability benefits reporting they 'didn't have enough' and more of them reporting they 'had enough plus a bit extra'. While similar proportions of participants on unemployment benefits rated themselves as either having 'just enough' or 'enough but not to get back on track', there were more participants on disability benefit that felt they only had 'just enough' and fewer that felt they had 'enough but not to get back on track'.

Figure 8 – Comparison of perceived ability to manage on current income among participants receiving unemployment and disability government benefits

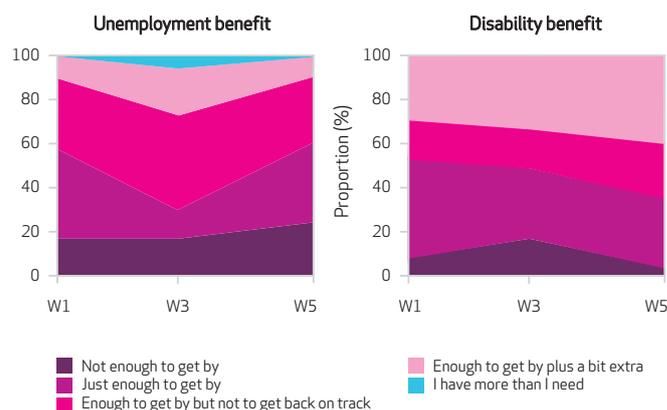
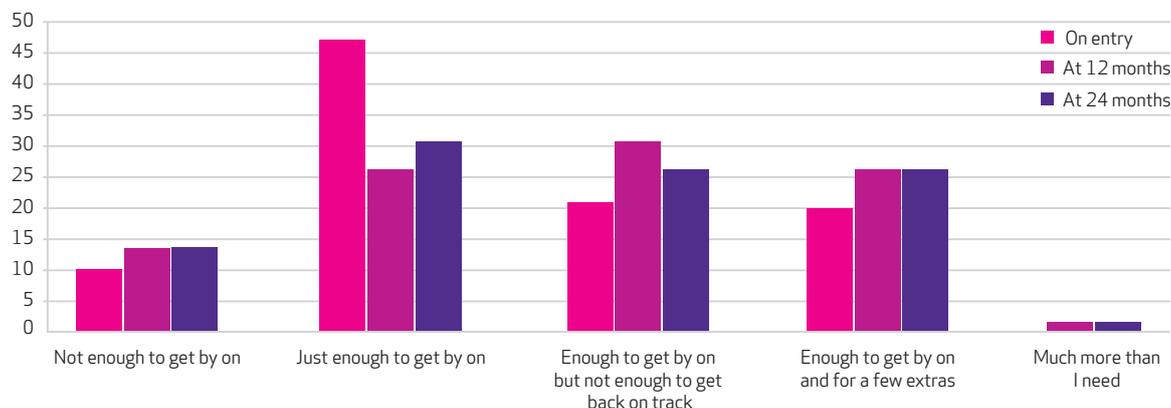


Figure 7 – Self-reported ability to manage on current income among the follow-up group at entry and 12 and 24 months



Self-perceived ability to manage on current income appeared to improve at 12 months among participants receiving unemployment benefits. Unfortunately, this improvement dissipated at the two year follow-up when a higher proportion of participants reported they 'didn't have enough to get by'. This may, in part be a reflection of the fact that, for many, they were now paying bills consistent with being more self-sufficient and managing a house. In contrast, the position of those on disability benefits appeared to worsen at 12 months and improve again at 24 months. For example, the proportion of participants that felt they 'did not have enough to get by' increased at 12 months and then declined again at 24 months to levels similar to that at baseline. In addition, the proportion of participants reporting they had 'enough to get by but not enough to get back on track' or they had 'enough plus a few extras' increased from 12 to 24 months. Interestingly, only a small proportion of participants in the total follow-up group reported they had more than they needed and all of these participants were in receipt of unemployment benefits.

5.3.3 Summary

Overall, the income and employment status of the follow-up group improved slightly over the two years. More participants were engaged in the labour force, including as volunteers, and several clients switched from Newstart unemployment government benefits to the more substantial Disability/sickness Support pension.

5.4 Physical and Mental Health

5.4.1 Physical and mental health circumstances on entry to MISHA

At entry to MISHA the overall health of participants in the follow-up group was poor – they had significant physical and mental health issues and were often not accessing services when needed. Included in the MISHA model of service delivery was the part-time employment of a clinical psychologist who spent two days a week at the office and was available to see participants on an ongoing basis for a range of mental health issues. All other health services were accessed via other community services, which was facilitated by the caseworkers. This section examines how the health and wellbeing of the follow-up group changed over the two years.

Key information about the health status of the follow-up group on entry includes:

- More than half (59%) of participants had a longstanding physical health condition, with the most commonly cited condition being musculoskeletal problems such as arthritis and osteoporosis.

- Almost half of participants (48%) had unmet dental needs at baseline.
- Approximately 40% had been diagnosed with a lifetime mood disorder and nearly 30% had been diagnosed with a lifetime anxiety disorder by a health professional.
- Participants differed in their level of psychological distress at entry; while the majority of participants had low or moderate levels of distress, a substantial proportion (39%) were experiencing high to very high levels of distress.
- On average, participants had been exposed to around three potentially traumatic events over their lifetime.

5.4.2 Two year change in physical and mental health circumstances

Physical Health

Table 5 shows the lifetime prevalence of physical health conditions among the follow-up group, as collected on entry to MISHA and at 12 and 24 months. Over the two years, the proportion of follow-up group participants with at least one longstanding physical problem decreased slightly, from 69% at baseline to 64% at 12 months and then increased to 77% at 24 months. Worsening physical health levels may be explained by the longstanding and chronic nature of the conditions, as well as client's increased awareness of pre-existing physical health problems, rather than necessarily being an indicator of new health conditions.

The occurrence of some health conditions reduced in prevalence temporarily during the 6 months prior to the 12 month follow up – including neurological problems, musculoskeletal and respiratory problems. It is possible that the shift into a more comfortable domiciled lifestyle alleviated the triggers of some of these conditions, such as migraines, breathing issues or muscular pain. However, the prevalence of these health conditions increased again during the 6 months prior to the 24 month follow up.

At entry to MISHA the overall health of participants in the follow-up group was poor – they had significant physical and mental health issues and were often not accessing services when needed

Table 5 – Proportion of follow-up group participants with different types of physical health conditions at entry and 12 and 24 months

	On entry		12 months		24 months	
	n	%	n	%	n	%
Infectious diseases	1	3	4	10	6	11
Cancer	2	6	2	5	5	9
Blood/immune disease	3	9	4	10	2	4
Metabolic problems	4	11	4	10	8	15
Neurological problems	9	27	5	13	11	21
Vision Problems	7	20	7	18	16	31
Hearing Problems	4	11	7	17	9	17
Circulatory Problems	9	26	14	34	15	29
Respiratory Problems	9	26	8	20	21	40
Digestive Problems	4	11	7	17	16	31
Skin Problems	2	6	6	15	6	12
Musculoskeletal Problems	14	39	11	27	20	39
Genito-Urinary Problems	0	0	5	12	0	0

Mental Health

Mental health disorder

Table 6 shows the prevalence of self-reported diagnosed mental disorder on entry (that is, lifetime prevalence), and new diagnoses at 12 months and at 24 months. At every time point the most common mental disorders were mood, substance use, anxiety and psychotic disorders. Apart from psychotic disorder, these disorders are also the most prevalent mental health problems in the Australian general population. The prevalence of mental disorder among the MISHA participants, however, is much higher than that of the general population. The 2007 National Survey of Mental Health and Wellbeing (NSMHWB) found the lifetime prevalence of anxiety disorders was 14%, mood disorder was 6% and substance use disorder was 5% (Slade et al., 2009), compared with 29%, 42%, and 37% respectively for the MISHA men on entry.

Given the reasonably high level of unmet need for mental health treatment at baseline (where over 30% had unmet psychological needs), the incident cases of mental disorder may reflect increased access to mental health support.

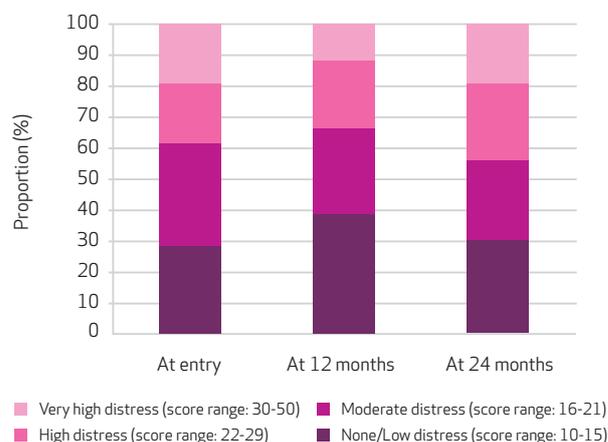
Table 6 – Prevalence of mental disorder at entry (lifetime) and 12 and 24 months among the follow-up group

	On entry		12 months		24 months	
	n	%	n	%	n	%
Mood Disorder	25	42	6	10	10	17
Anxiety Disorder	17	29	7	12	8	14
Personality Disorder	3	5	0	0	2	3
Psychotic Disorder	12	20	4	7	7	12
Dissociative Disorder	3	5	0	0	2	3
Substance-use Disorder	22	37	3	5	4	7
Eating Disorder	3	5	0	0	1	2
Impulse-control Disorder	7	12	0	0	1	2
Other	3	5	0	0	0	0

Psychological distress

Follow-up participants showed little evidence of changes in psychological distress as measured by the Kessler 10 scale, over the two-year period. The mean score on entry was 21, which reduced slightly at 12 months to 19, before increasing once again to 21. This indicates that, on average, MISHA participants experienced upper-moderate to high distress at both entry and over time. This result compares to a mean score of 14 for the Australian male population reported in the NSMHWB (Slade et al., 2011). Whereas almost three-quarters of Australian men are classified with low distress, only about one-third of MISHA participants were classified thus. Figure 9 shows the proportion of the follow-up group classified with different levels of psychological distress at each time point.

Figure 9 – Levels of psychological distress among the follow-up group at entry and 12 and 24 months



The graph suggests that there was a lessening of distress among participants at 12 months. For example, the proportion of participants with low distress increased from 29% to 39% at 12 months while the proportion of participants with very high distress decreased from 19% to 12%. At 24 months the proportion of participants in both of these categories appeared to have returned to baseline levels.

Trauma and post traumatic stress

The lifetime prevalence of trauma exposure was very high. At entry, 91% of MISHA clients had been exposed to at least one traumatic event with the most common being witnessing someone being seriously injured or killed (68%), serious physical assault (64%), being threatened with a weapon or held captive (63%) and being involved in a life-threatening accident (48%) (see Figure 10). These results are consistent with other studies of the Australian homeless population (Buhrich et al., 2000, Taylor and Sharpe, 2008) and higher than estimates of trauma exposure for the Australian male population as a whole (Creamer et al., 2001, Mills et al., 2011).

After 12 months, almost one-quarter (24%) of the follow-up participants had experienced further traumatic events. The rate of trauma exposure at 24 months was similar (25%). The type of trauma experienced during follow-up was similar to that reported

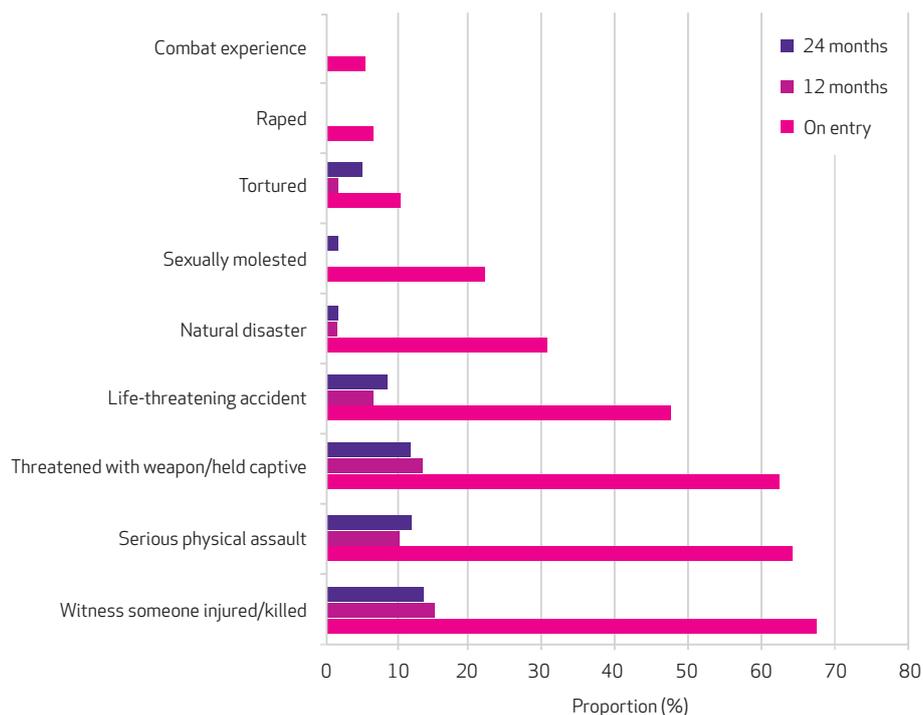
at entry to MISHA – witnessing someone being injured or killed (15% at 12 months, 14% at 24 months), serious physical assault (10% at 12 months, 12% at 24 months), threatened with a weapon or held captive (14% at 12 months, 12% at 24 months) and life-threatening accident (7% at 12 months, 9% at 24 months).

On entry, around 1 in 5 (21%) participants that had experienced a traumatic event screened positive for post traumatic stress disorder (PTSD) in the past month. This is much higher than the 12-month prevalence of PTSD reported for Australian men in the 2007 NSMHWB which was estimated at 4.6% (Slade et al., 2009). The prevalence of post traumatic stress among the follow-up group decreased to 14% at 12 months and rose again to 18% at 24 months. This could reflect persistent post traumatic stress from pre-existing trauma experiences or a newly developed response to re-traumatisation during the follow-up period.

Substance use

Table 7 shows the past-month prevalence of substance use in the follow-up group. The most commonly used substances at each time point were nicotine, alcohol and cannabis. More than three-quarters of participants had smoked in the past month and this remained stable across the two years. This rate of smoking compares to 20% for Australian males aged 18 years and over

Figure 10 – Lifetime prevalence (at entry) and 12 and 24 month incidence of trauma among the follow-up group



(Australian Bureau of Statistics, 2013b). Alcohol was the next most commonly consumed substance with approximately one-half of participants having a drink in the past month. There was a small increase in the prevalence of alcohol use over time, from 45% at entry to 54% at 24 months.

Of the illicit substances, cannabis was the most prevalent, with one-quarter having used this drug in the month prior to commencing with MISHA. Use of cannabis increased to 38% at 12 months and remained stable at 24 months. The use of most other illicit drugs was much less common but all showed a small increase in use over the two years. This might reflect reticence by participants to disclose substance use at entry, given the baseline surveys were undertaken by MISHA caseworkers as part of their assessment process. In contrast, sedative use declined from 17% at entry to less than 10% at 12 and 24 months. Sedative use included the improper use of prescribed medication as well as the use of illicit sources of this drug. It is possible that the decline in sedative use reflects a change in medication management among the follow-up group.

Table 7 – Prevalence of past month substance use on entry and 12 and 24 months in the follow-up group

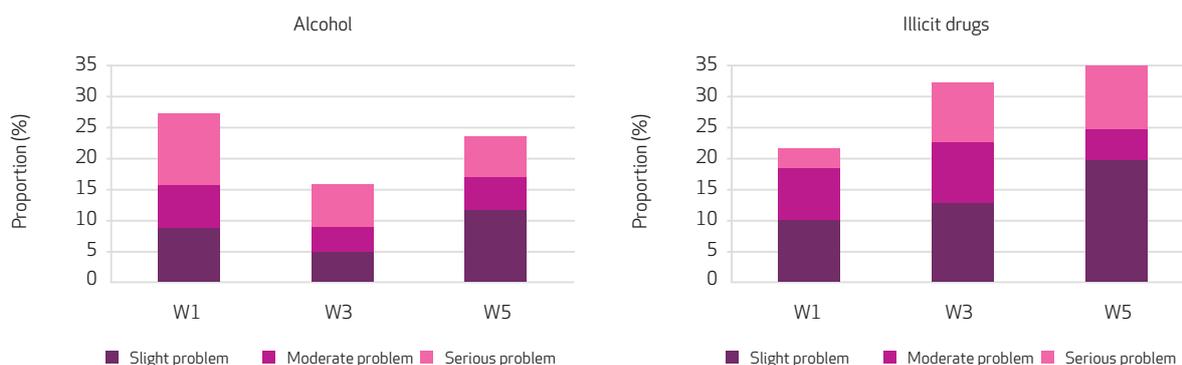
	On entry		12 months		24 months	
	n	%	n	%	n	%
Nicotine	47	80	46	81	47	80
Alcohol	26	45	27	47	32	54
Cannabis	14	24	22	38	21	36
Amphetamines	4	7	8	14	9	15
Cocaine	0	0	1	2	1	2
Sedative	10	17	4	7	5	9
Heroin	2	3	5	9	4	7

Participants were also asked to rate the extent to which they had problems with alcohol or other drug use in the past month.

This is shown in Figure 11 below. The overall proportion of participants reporting any problem with alcohol declined substantially at 12 months, predominantly driven by a decline among those reporting a serious problem. The size of this group remained stable at 24 months but there was an overall increase in alcohol problems due to an increase in the number of participants reporting a slight problem with drinking. In contrast, the overall prevalence of problematic drug use increased over the two years. At baseline, the prevalence of problematic drug use was lower than that of problematic alcohol use, but this finding was reversed by 12 months.

The increase in problematic drug use appears to be driven by increases in both the prevalence of 'slight' and 'serious' problems with drugs. Change in self-reported problematic substance use might reflect true changes in the prevalence of problematic substance use but could also be influenced by increased awareness of a pre-existing substance use problems, particularly if such use interfered with a participant's ability to manage their income or meet their tenancy obligations. Participants may also have felt more comfortable disclosing substance use problems as the period of their housing stability increased. This could also reflect the fact that baseline surveys were conducted by caseworkers whereas follow-up surveys were conducted by trained research interviewers and, as previously suggested, this may have influenced participants' likelihood of disclosing problematic substance use.

Figure 11 – Proportion of participants self-reporting past month problem with alcohol and illicit drugs



5.4.3 Summary

The mental health of participants was poor at entry and there was little improvement during the two year follow-up. Levels of psychological distress were higher than general population estimates and remained stable over time. Similarly, trauma exposure and post traumatic stress were more common in the MISHA sample relative to the Australian male population. A small proportion of participants were re-exposed to trauma during the two year follow-up and levels of post traumatic stress remained stable. With regard to substance use, nicotine was the most commonly used substance and its use remained stable over time. In contrast, there were small increases in the use of most other substances perhaps reflecting under reporting at entry.

5.5 Social Participation

5.5.1 Social circumstances on entry to MISHA

The results of the baseline survey point to substantial social disadvantage among participants as evidenced by high levels of measured social isolation and poor quality social support. This is not surprising given one-third of participants were recruited directly from the street and all of the participants had been chronically homeless for one year or more. Importantly there were also some positive findings, such as self-efficacy and social contact with others. The key findings on social circumstances of the follow-up group at entry to MISHA include:

- High prevalence of social isolation driven by both structural factors, such as a lack of paid work (60%) and lack of money (66%) as well as interpersonal factors such as a lack of supportive family (59%) and friends (50%).
- This experience of social isolation was despite the fact that almost 60% of participants had at least some contact with their family in the past week, and 81% had social contact with other non-family members in the week prior to entering MISHA.
- Participant's rated their satisfaction with health, social relationships and environment as lower than the general Australian population.

5.5.2 Two year change in social circumstances

Social isolation

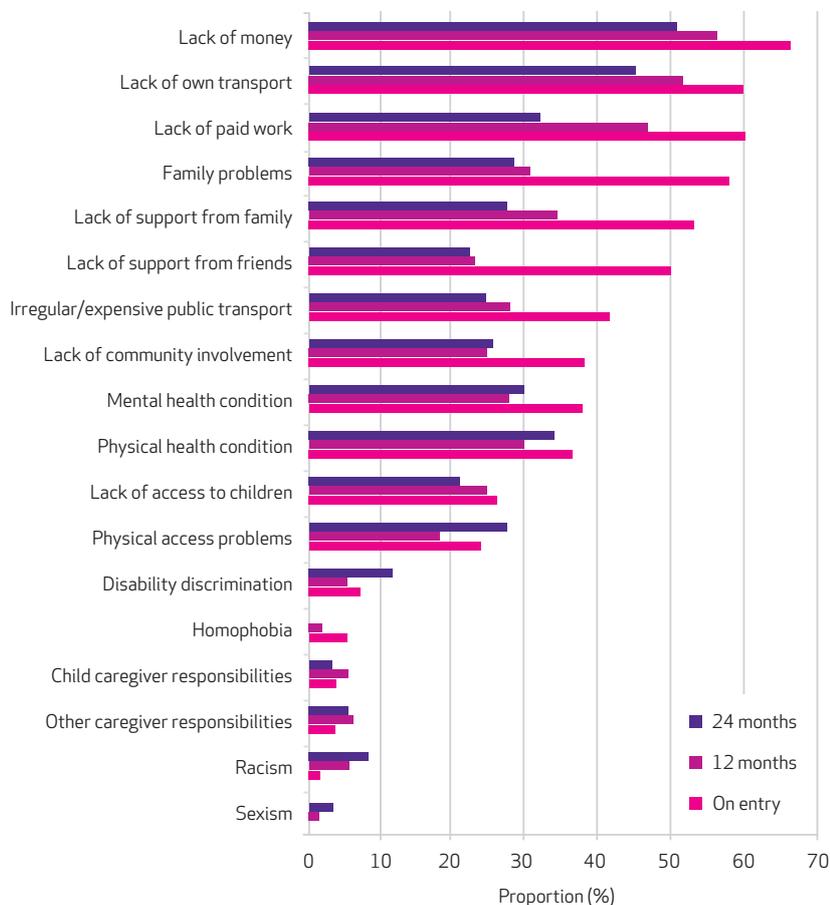
Figure 12 compares the participants' experience of social isolation on entry and at 12 and 24 months.

There was a reduction in the proportion of participants reporting most causes of social isolation over time. The largest reductions were observed for lack of support from friends (from 50% to 22%), lack of support from family (from 53% to 27%), family problems (from 59% to 27%), and lack of paid work (from 60% to 32%). There were slightly smaller reductions in social isolation due to lack of money (from 66% to 51%), lack of own transport (60% to 46%) and lack of community involvement (from 39% to 25%). Additionally, a small number of participants reported an increase in social isolation because of sexism (from 0 to 3%), racism (from 1 to 9%), disability discrimination (from 7 to 12%) and problems due to physical access (24% to 27%). This unexpected result may reflect the fact that participants were now moving more regularly through the community and so being more exposed to such influences as sexism, racism, and disability discrimination.

Overall, these results are positive and suggest improved social participation although substantial barriers remain with respect to employment and transport. The improvement may be explained by the focus of case management in helping participants to reconnect with family and address physical and mental health concerns as well as facilitating recreation and other activities for MISHA clients. Employment and own transport are more difficult areas for case management to target, particularly when the high dependence on disability support payments is considered.

The results of the baseline survey point to substantial social disadvantage among participants as evidenced by high levels of measured social isolation and poor quality social support. This is not surprising given one-third of participants were recruited directly from the street and all of the participants had been chronically homeless for one year or more.

Figure 12 – Causes of social isolation among the follow-up group on entry and 12 and 24 months



Social contact

Table 8 shows the amount of social contact in the past week at entry and at 12 and 24 months among participants in the follow-up group. At entry, 58% of follow-up participants had contact with their family in the previous week. This increased slightly at 12 months and declined again at 24 months. A different pattern is seen for general social contact where there was an apparent linear increase in the proportion of participants reporting contact with others at each time point. At entry, 81% of participants had social contact with others in the previous week. This increased by 10% over two years. The different patterns of social contact could be due to a number of factors, including: residing in large complexes with many neighbours; participation in recreational and social activities facilitated by MISHA; families unwilling to re-connect with MISHA participants; or loss of family members. This pattern of results is similar to the findings reported above regarding the causes of social isolation, where a greater number of participants cited 'family problems' and 'lack of support from family' as reasons for their social isolation compared to 'lack of support from friends'.

Table 8 – Social contact in the past week

	On entry %	12 months %	24 months %
Contact with family	58	63	60
Contact with others	81	87	90

General self-efficacy

Self-efficacy is a belief in one's general ability to overcome adversity and achieve their goals. At entry to MISHA, the mean General Self Efficacy (GSE) score for the follow-up group was 30; this is similar to that reported for other English-speaking general populations such as Great Britain and USA (Scholz et al., 2002). The mean score for MISHA's follow-up sample was also considerably higher than similar population groups, such as people experiencing severe mental illness (Murphy and Murphy, 2006). Baseline mean scores were stable over time, increasing slightly to 32 at the one and two year follow-ups. This result mirrors the findings of the Michael Project, which found stable and high self-efficacy in homeless men over 12 months. These findings illustrate that although MISHA clients may have experienced difficult and impoverished lifestyles, they retain a strong belief in their ability to solve problems and overcome difficulties.

Quality of life

The WHO Quality of Life (Brief) instrument measures quality of life across four domains – physical, psychological, social relationships and environment. Figure 13 shows the mean domain scores for the participants at each survey time point as well as the normative data for the Australian male population (Hawthorne et al., 2006). For each domain and at each survey point, the mean scores for the follow-up group were lower than that of Australian male normative data. There appears to be an improvement in mean domain scores at 12 months. These results are consistent with international research that found increased satisfaction with living arrangements and neighbourhood safety (as measured by the Quality of Life Interview 20) at 12 months among Housing First residents with serious mental illness (Gilmer et al., 2010, Patterson et al., 2013). These studies also found improvements in other domains, including health and relationships.

5.5.3 Summary

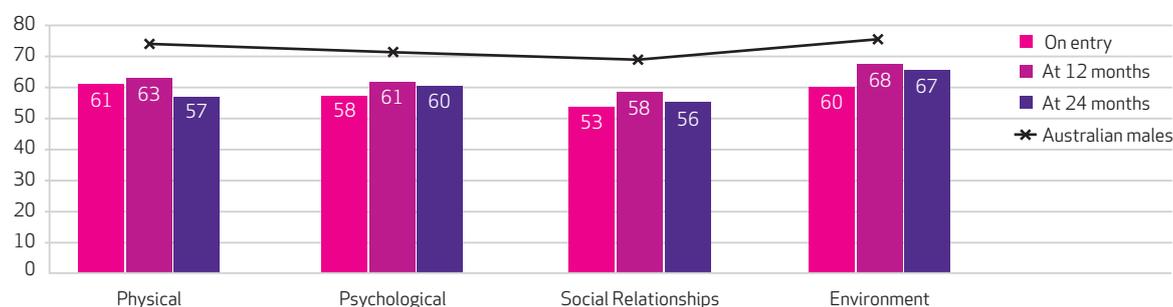
There were mixed results with regard to social participation. While there was an improvement in participants' rating of their physical environment, their satisfaction with their social relationships and physical and psychological wellbeing remained

stable. The finding regarding social relationships may reflect the discrepant findings for other measures in this area. On the one hand, more participants reported social contact with others and there were marked reductions in social isolation due to a lack of social support and community involvement. However, there was little change in the proportion of participants having contact with family or those who felt socially isolated because of a lack of access to their children. The dislocation from family was a challenging issue that many of the participants faced during their time with MISHA. This is discussed further in Chapter Six.

Some factors affecting a person's social circumstances may require more specialised support and/or time to address, such as physical and mental health. Both of these factors were cited as reasons for participants' sense of social isolation at all three survey points. This suggests that more effort is required to address underlying health issues as there appears to be limited improvement in these areas despite improvements in support, housing and social isolation (which are deemed to be important correlates of health and wellbeing).

Unexpectedly, general self-efficacy was high and remained stable over time, perhaps suggesting a degree of resilience among MISHA participants.

Figure 13 – Mean domain scores for the WHO-QoL instrument on entry and 12 and 24 months among the follow-up group and normative data for the Australian male population



6. Qualitative Findings: Enriching our Understanding of the Outcomes

This chapter is based on the qualitative interviews and focus group carried out with MISHA clients and staff which aim to increase our understanding of the factors that contributed to the outcomes reported in the previous chapters. These include aspects of the implementation of the project which differed somewhat from what was originally intended. It also provides an opportunity to hear directly from both clients and staff about their views and experiences of MISHA.

6.1 Housing placements

As noted previously, the housing units obtained for the project included a mix of single dwellings, smaller clustered groups of residences and larger clustered groups scattered across the Parramatta region. Most units were brand new but staff reported there being some maintenance issues initially which had to be resolved with the providers. This resulted in some participants experiencing delays in the construction or renovation of their properties. However, this was a relatively small number as 32% of participants were housed for the full 24 months and another 22% and 25% were housed for 23 and 22 months respectively.

Clients were interviewed from a range of different types of accommodation types, to understand how their experiences of different housing options varied. Staff members observed that both smaller and larger clustered housing could have positive and negative aspects, with clustering providing both positive opportunities for support and socialising, and reinforcement of negative behaviours, while scattered housing could foster both independence and self-reliance, but also isolation and loneliness. An important factor was the frequent presence of MISHA workers and their ability to intervene if and when problems occurred. As one staff member noted of the allocation:

“Yes, it is both good and bad. In terms of alcohol and drugs it is negative for them living together. It is positive in terms of them not isolating, which also means there could be D&A (drug and alcohol) use [...] Overall the way it has worked there are more positives than negatives. [...] The social sphere is mediated by workers, because everyone is attached to a worker. It would be different if they were in a D&A community so that we would not be able to mediate the relationship between clients. So if someone drugs we keep a check on it. If someone is influencing someone we keep a check on it, whereas if they were not your client it is none of your business.” (Staff member)

Overall, clients expressed great satisfaction with the accommodation provided, though some had reservations about the particular locations or their proximity to other MISHA clients. The following comments were typical of the intense pleasure many felt in having secure housing, often for the first time for many years, including the household equipment package provided.

“I’m still kicking myself. Every time I’m waking up in the morning I go, ok, is this real?” (Client aged 59)

“Yeah, it’s me little kingdom compared to where I’ve sort of come from.”

“Well, you know, everything is extended, like, you know, ok you get a roof over your head with the Department of Housing, but you don’t get a fridge, you don’t get this, you don’t get, you know what I mean, you don’t get pots and pans, you don’t get knives and forks... Umm, you know, just the little things that people just take for granted, you know in a sense, I suppose.” (Client aged 57)

“I’ve always lived with other people, so, umm, I guess, phew, how do you say it? I’ve never lived in a brand new place before. I’ve never lived in a place with brand new furniture. So, I was sort of like, when they kept bringing stuff into the house, the furniture and knives, forks, plates, cutlery, I was a bit overwhelmed! I was, ‘slow down!’, you know. It was overwhelming. No-one had ever been that kind to me, so...” (Client aged 49)

The household package was standard for each client and included basic furniture, bedding and kitchen equipment and whitegoods, but not ‘discretionary’ items such as televisions or radios, which clients were expected to source themselves. The service manager commented that ideally they would have liked to work with clients on individual budgeting for this equipment, but there was not time for this and it might also have created perceptions of inequity if clients ended up with different packages of goods.

The security and stability of the MISHA accommodation was one of the elements most strongly noted by clients, but even then there were limits to a perception of it being ‘their own’. As the client with the comment immediately above also observed:

“Yeah...’cos I was all over the place before, I’ve slept on that many lounges ... um, yeah, just the stability of having somewhere to call home. Yeah. Even though I still don’t feel like it’s mine, ‘cos it’s not really is it? It’s still the Department of Housing’s. Yep. I don’t... I haven’t, I still haven’t taken ownership of it.” (Client aged 49)

Because of the scarcity of suitable housing, some clients inevitably ended up living some distance from areas that they already knew or had connections in, and access to transport varied. Nevertheless, few had complaints about the area or the facilities where they were placed, and several made positive comments about connections with neighbours whether they were MISHA clients or other tenants.

"I like it, yeah, no, it's quiet. It's uh, a lot of Asians and that there and families, so it's very quiet. The side I'm on is anyway, I'm on the good side. And I'm in a Housing house there, but usually Housing areas are bad 'cos, you know, you get some, a lot of bad types. But where I am, including me there's only four of us. And, so, it's really good. And uh, there's one younger guy, the man, and the lady next door to me she's about 70, she's a nice old lady – I help her out with the bins and that, 'cos she's getting old now and sick, you know." (Client aged 37)

"Good, except for the shootings, you know, but you can't help that. [laughs] It's good. It's nice and quiet where I'm living. It's a mixed bunch of people that they've put in there, like they've put old people in there, as well as young people, as well as single guys. So, it's a mixture of people in the block, so it's good." (Client aged 46)

"It's good. MISHA have gone to the trouble of selecting the right people to be with each other, which the Housing Department certainly wouldn't do, but yeah everyone there's nice, everyone gets along. I've never seen anyone there have the slightest bit of trouble with another person there. Um... we've got one particular neighbour [name], he loves keeping the place pristine, so that's great, the garbage, he just loves doing it, he takes the garbage out. It's a really nice place, it's quiet and the neighbours surrounding us are quite happy because it's not noisy there." (Client aged 45)

In spite of these generally positive views, however, there were inevitably individual instances where clients reported some feelings of isolation or insecurity within an unfamiliar community, or amongst the MISHA client group itself, and some incidences of violence or threatening behaviour.

"So you get a lot of shootings, umm, you know. Most Lebanese, I get on pretty good with some of them, not all of them, some won't even acknowledge that you're there so, you know." (Client aged 55, Indigenous)

"Yeah, that [name] guy and that, like they take him down to get food vouchers and that, he'll go and sit outside Woolworths or something and sell them. "Oh, do you want to buy this?" And he'll go and buy grog and that, but yet they keep helping... helping him and that and keep... keep a roof over his head and that, yet he's broken into my house, he broke in like, not Friday just gone, the Friday before and stole my lawnmower and shit. I got, I didn't bring the paperwork, but I got more paperwork at home, the coppers said to me "Mate, are you willing to go to court?" And I said "Yeah, I am." I'll do anything to see that prick behind... sorry, I didn't mean to swear. I'll do anything to see him behind bars. Like, it's just crap. And, you know I... me living in a... like an area there, the stress and that I got through, like... I can't... Like, it's a nice day

outside today. I can't even go home and leave my front door... just close the security door and leave the front door open to let a bit of fresh air in and that. I've got to close my front door, close my back door, and I leave it open this much to let a bit of fresh air through. You know, I just don't feel safe." (Client aged 30)

The shortage and delays of available housing also meant that opportunities to match clients with particular types of housing and locations were limited. There was also little flexibility to carry out transfers where requested, although staff reported that as the project stock increased they were able to move a few clients where there were particular difficulties for them in the original placement.

6.2 Sustaining tenancies

As the quantitative data shows, MISHA has been remarkably successful at helping clients to sustain their tenancies, with all but two still holding onto their accommodation for at least one year, and a 12-month sustained tenancy rate of 97%. Of those two, one had been evicted because of continuing and unresolvable problems (and had since gone to prison) and one had relinquished their property because of a lengthy custodial sentence. Three others were in prison at the time of the 12-month survey, but still retained their tenancies at that point, as the MISHA model allows for tenancies to be retained during absences of up to three months with a minimal continuing payment (usually \$5 per week). A number of other clients had needed to be away for periods of time in hospital or drug rehabilitation services, and such arrangements usually worked successfully, although there could be communication problems with housing providers.

"When clients need to be away, Housing (NSW) will be contacted to reduce the rent. Housing sometimes fails to understand our needs and also to keep track of the communications and requests. This is generally due to the high turnover in Housing and the number of restructurings as well. Otherwise Housing is pretty much on board for other things. The have been fewer issues with the other housing providers, but hospitals or rehabs of detoxing could still be an issue to maintaining the tenancy." (Staff member)

In the second year, another tenant had relinquished their property owing to the length of their custodial sentence and there had been two further evictions, while three other tenancies had been abandoned. This meant that over the 24-month period, excluding the deaths, a total of seven tenancies could be regarded as having 'failed', bringing the two-year success rate down to just over 89%. This compares well, as we understand it, with other similar Housing First homelessness projects and is substantially better than is normally found in schemes where people are housed without the level of intensive support offered by MISHA.

So how were these successful outcomes achieved? It is clear from comments of both clients and staff that sustaining tenancies was not without its problems. A number of clients had fallen behind with rental payments, caused damage to properties, had disputes (some violent) with neighbours and other MISHA clients, or had other kinds of difficulty living on their own in the housing provided. The fact that these problems had been managed within the program with little resort to eviction is one of the greatest strengths of the MISHA project. These results are a product of both the type of assistance provided by staff to clients and of regular communication carried out with housing providers to ensure that problems did not get out of hand.

Establishing effective channels of communication with housing providers took time, however. Staff reported in the focus group that at first there was virtually no communication with providers, whether Housing NSW or CHOs, but that this had improved over the course of the project.

Clients were asked whether they had difficulties with keeping up rent payments; most in our interview sample said they did not, because with their case workers' help they had set up direct rent deductions from their income support payments through Centrepay, and that they helped them with managing their money.

“Um, no, not really. If I do have any problems, the people here - they're right on top of it. They're really willing and happy to help.”

(Client aged 45)

“Nope. I get a bit behind in my rent 'cos I buy, like, collections of stamps and stuff but I've always, like, paid up front, so...”

(Client aged 55, Indigenous)

Our sample did not include the one client who had been evicted at this point and it is possible that others did not want to talk about difficulties with managing that they did have, although some talked about these in areas other than money. Further, as described earlier, there was a 7% increase in the proportion of MISHA tenants reporting that they had 'enough to get by on and for a few extras', a 9% increase in those who had 'enough to get by on, but not enough to get back on track' and a 20% decrease in the number of participants who reported having 'just enough money to get by'.

However, keeping the right balance between intervening to help clients where there were problems and allowing them to develop independence and self-reliance was still a challenge for case workers, especially where there were mental health or drug and alcohol issues.

“There are safety nets. If they keep their Centrepay going it should not be a problem. For some of them, due to mental health and D&A use and if this gets on top of things it is difficult, they stop their Centrepay. If I suspect a tenant is behind, I contact the housing provider and ask where they are at and make a call out. I don't want to warn or notify them [the client] beforehand. The housing provider would

be the one to contact and notify. As long as they are in agreement, they are flexible. It is very time-consuming, the paper work and bureaucracy getting information, but do-able. For some clients who work it should be alright, but you need to make sure you are on top of it.” (Staff member)

One case worker observed that in her experience the three-month point after moving into the housing was a critical point, in that clients were likely to present well in that period and maintain stability while they were getting accustomed to their surroundings and the rules. Then problems could start occurring: *'After that, issues with responsibility start to emerge. They take themselves off Centrepay start to fall behind in their rent etc.'* This is consistent with a wider issue about what the service manager described as a 'non-linear' process of recovery by clients, whereby problems often emerged at a later stage once the 'honeymoon' period after settling into the housing had passed.

In the view of the staff member quoted above, discussions between MISHA and the housing providers about rent arrears often came too late: *'Often the client will be quite in debt (\$500 or \$600) before we are contacted'*. She also felt that clients needed to be more responsible and accountable, and better prepared for independent life: *'While they are receiving a lot from the service without having anything demanded of them in return they'll never learn to do anything on their own'*.

As well as help with keeping up rent payments, case workers also provided help with living skills, where needed. While some clients were well able to manage tasks such as cooking and cleaning, others needed more support, so staff carried out weekly, or more frequent, visits to monitor personal hygiene and household cleanliness. Some of those with the highest needs were linked up with home care services for an initial period of six weeks, providing support with shopping, cleaning and other services. Again, it was a question of striking the right balance between intervention and encouragement of self-reliance appropriate for the individual.

“The living skills are a difficult thing to decide because one cannot tell them what they should do, but the majority of them are already doing a great job. Living skills help clients to set priorities in life because some of them are unpredictable, but no one is expected to step on their toes telling them what they should be doing. These are the things that need to be communicated to community housing, not to intrude in the personal life of clients. The main focus is that the responsibility of having a house gives them a frame to avoid going back to the street.”

(Staff member)

The comments offered by clients did not suggest any particular differences according to whether they were housed in smaller or larger clustered housing; although several noted that they sometimes shared meals or cooking with other neighbouring clients and helped each other out in various ways.

“Umm, me, my next door neighbour and a neighbour two up, we all came together, we had this little arrangement where one of us cooked every third day. We all chipped in for the tucker and one would take turns at cooking and someone would wash up, so we’ve still got that happening now.” (Client aged 49)

Reflecting on this issue later in the focus group, staff agreed that while outcomes varied considerably depending on the individual, the tenants in the larger clustered housing tended to have more difficulties. The atmosphere in these places could be ‘quite volatile’, partly because of clients being vulnerable to negative influences or being drawn into other clients’ problems.

6.3 Assertive case management

We have seen from comments above that while assertive case management has been a key to helping client sustain tenancies, the level of engagement with case management by clients has been mixed, with some staff expressing the view that clients did not engage sufficiently with the support offered, thus limiting their opportunities to develop greater self-reliance. This was a theme that ran throughout the staff views on many of the different aspects of the MISHA model.

6.3.1 Key elements

As noted in chapter 3, the key elements of case management offered within MISHA included the following:

- Helping clients settle into the housing and visiting to make sure that they were managing with cooking, cleaning and personal hygiene. Helping them develop these living skills where needed, including taking them shopping.
- Helping clients obtain or continue Centrelink income support payments and manage payments for rent and services such as utilities, and negotiating concessionary payment schemes where needed.
- Making referrals and appointments for other services, including medical services such as doctors, hospitals, dentists, and drug and alcohol rehabilitation or counselling, and often transporting clients to and from services.
- Where possible, helping clients to engage in meaningful activities, including those that might lead to participation in employment or education and training, but also those with a more social or health-related purpose.
- Supporting clients to build or rebuild social connections, including with families and friends.
- Providing support at times of crisis, while aiming to build independence and self-reliance for the time when intensive support ends.

In addition to the caseworkers, the MISHA staff included a clinical psychologist and an activities coordinator.

As the service manager described it, this form of case management is deliberately intensive and carries with it expectations about client engagement, even if, as some staff members saw it, these expectations were not sufficiently embedded in agreements with clients at the time of recruitment. One view expressed in the staff focus group, which other staff supported, was that there needed to be some form of ‘service level agreement’ between clients and the housing provider which spelled out the need to engage with case workers and thus gave MISHA itself more leverage with clients if they wished to retain their housing. This proposal was recognised as somewhat controversial, as it tends to run counter to the pure ‘housing first’ principle of voluntary engagement with support services. However, the Pathways to Housing program in the USA stipulate fortnightly contact with the multidisciplinary ACT team, although there is no expectation of engagement (Pathways to Housing). Despite the challenge of engaging clients in case management, almost all clients sustained their tenancies for a minimum of two years.

6.3.2 Staff views

There were two central themes underlying staff comments about case management: first, that not enough clients engaged adequately with the support services offered; and secondly, that it was difficult to maintain the right balance between assertive intervention where staff felt clients needed to engage and a more ‘hands-off’ approach based on the idea that clients needed to develop their own independence, including making mistakes. To some extent there was a tension between these two themes. Case management approaches were also influenced by what most staff saw as heavy caseloads – around 20 clients each – which made it important to have a manageable mix of clients needing higher and lower levels of support. As one staff member pointed out in the focus group, enforceable compliance was perhaps only feasible with smaller caseloads, such as the 8-12 per case worker more common in other services.

However, willingness or unwillingness to engage could both create extra demands on case workers’ time.

Q. “If they are willing to engage, does that mean you spend more time or less time with them?”

A. “If they are, yes. Not willing, that’s as hard as well. It is finding the balance. Once you need the engagement and they don’t want to engage, that’s hard as well, that’s time consuming. Because even if they don’t want to engage, providing more assertive outreach to them is time consuming because you’ve got to ask them 10 time running and for that you would visit them 10 times! This is spending too much time in rapport building. This may not be directly addressing the issues. So basically we need more workers.” (Staff member)

6.3.3 Client views

The clients interviewed all expressed considerable appreciation of their case workers and the help they provided, while in some cases recognising that they needed to be pushed to engage or did not always respond in the way that they knew they should.

“She’s always trying to help me and get me into different services and get me into this and get me into that, always, [name] is a legend in every way ... she’s a top lady. She really cares about her clients.” (Client aged 45)

“She just, she pushes me, in a good way, like, every second week she’ll expect me to do what she’s asked two weeks before and ... so she’s, um, good hard support if you want to call it that. She’s helped me, yeah.” (Client aged 37)

One, who lived in a block with several other MISHA clients but said that he never saw them, described how at an earlier stage his case worker had provided a lot of help.

“Ah, yeah, in the past, when I was really depressed, and, um, she was the only way I got anywhere, you know. So, GPs and all that sort of thing. She was my taxi service. [laughs]” (Client aged 57, Indigenous)

Another said that he did not really need a lot of help but was always glad to have contact with his case worker:

“Great, yeah. Yeah, excellent. I don’t require a lot of heavy... heavy maintenance. Um, but I’m always glad to see him, and he’s always there if I want to see him. And I always... we keep in touch at least twice a week, and ring each other [...] Ah, well actually, he’s always there to talk to. He’s... and, ah, he’ll pick me up and take me anywhere that I want to go. Yeah, most of the time I make my own way to places. Occasionally I’ll go... go with [case worker]. He takes me shopping all the time. He’s looking for a... a cleaner for me and, ah, he’s... he’s there if I need him, really.” (Client aged 66)

Some clients were also reluctant to ask for help where they judged themselves as in relatively less need than others.

“I’ve been asked whether I need help because of my age and I refuse it, so...you know, I’m quite ... I don’t want to take up another person’s time when, especially if somebody else needs them...” (Client aged 55, Indigenous)

6.4 Physical and mental health issues

Of the 14 clients interviewed, six were assessed at the time of entering the MISHA project as presenting with high levels of psychological distress, four with moderate levels and four with low levels. Most had some history of problematic use of drugs or alcohol, and half reported having used alcohol or drugs in the month preceding entry into the project. In addition, in the initial interviews, a number reported ongoing physical health issues (consistent with the survey evidence), recent accidents or injuries (including brain injuries) and hospitalisations. This provides an indication of the challenges posed for the project in helping these men to live a safe and healthy life, and to sustain their tenancies in this context.

6.4.1 Non-linear recovery process

The client survey data showed that the level of reported health-related difficulties and mobility issues appeared to increase while clients were in MISHA. For example, the proportion of participants with at least one longstanding physical problem decreased slightly, from 69% at baseline to 64% at 12 months and then increased to 77% at 24 months. However, access to a variety of services also increased. This is consistent with the idea that settling into secure housing and beginning to get help with physical and mental health issues may well bring recognition and perception of these issues to the fore for many clients thus leading to the ‘non-linear’ recovery process identified by staff.

One of the main areas of staff work with clients, especially in the initial period after they moved in, was to organise access to health services and psychological support. Arrangements made with local dental services were reported to have been particularly successful, with a number of clients commenting on their satisfaction with having dental problems addressed, often after years of neglect. This involved a considerable amount of time for case workers, however, since clients seldom had their own transport and often needed help to get to appointments, as well as in dealing with a range of health service providers. Staff said addressing such a wide range of complex needs made case planning a difficult and slow process.

A key issue involved addressing problems of drinking, drug use and smoking that were common in the client group and improving health generally through physical activities. Several clients noted how their overall health had improved as a result of engaging with MISHA activities.

“Oh yeah, you know, I even gave up the alcohol and the drugs and the cigarettes – I haven’t had a smoke for the last eight and a half months all up... oh yeah, I can, you know, umm, I have enough self-esteem to do City to Surf four years running.” (Client aged 47)

6.4.2 Mental health issues

Staff reported that access to mental health services in the Parramatta region was particularly problematic. Services in the area were 'patchy', had long waiting lists and were reported as showing little interest in working cooperatively with the MISHA project, in spite of approaches by both the service manager and the clinical psychologist. Even when clients were able to access local services, the psychologist, who accompanied them, reported waits of up to four hours to be seen, which acted as a strong deterrent for clients to continue attending.

This meant that having a psychologist on the MISHA staff was a key resource. The clinical psychologist was involved in client assessment (though not in the original intake process), referrals and direct counselling or therapy, using a combination of methods including cognitive behavioural therapy, which he saw as useful for people in these circumstances. At the time of his interview (18 months into MISHA) the clinical psychologist was seeing approximately one-third of the total clientele on a regular basis. In his experience, the main issues for clients concerned: *relationships*, as evident in the high rates of social isolation reported in the survey; *trauma*, with 91% of survey respondents reporting at least one traumatic event before entry into the program (often from early childhood experiences such as abuse as well as some workplace traumas); and *problematic alcohol and drug use*, with almost half of respondents in the survey reporting problematic issues with substance abuse on entry.

"In most cases their trauma is the reason why they use alcohol and other drugs. Sometimes these guys have a lack of education and the only way they deal with their past and current problems is AOD. Anxiety and depression are also present. Sometimes trauma triggers the anxiety and depression symptoms." (Staff psychologist)

A good example of this was one client who reported a childhood of sexual abuse and violence which had created a deep inability to trust people, and consequent depression and low self-esteem which led to a serious drink and drug problem.

"Well it's, you know, it's not, to be at war with yourself all your life's not a pleasant existence you know? When you're not valued as a child and told that you mean something to someone, you don't have any value. Where do you get the value from? If it's not given to you, if it's not nurtured into you by those who are supposed to nurture you, you grow up with the feeling that I don't mean, I don't fit in, I don't matter, I don't, umm... We have this, we're all born with that longing to belong somewhere and I ended up belonging in the wrong places. So, you know, I've struggled with liking who I am and I probably will for the rest of my life... and I, I go good for a while, I'm happy with my efforts, then for some reason I sabotage everything and I go back to hating myself... So today I'm... not too bad." (Client aged 49)

This client displayed a considerable degree of insight, but still felt trapped by his past, aware of how he needed to change his life but doubtful about his ability to do it.

"Umm, I need to... umm, get back to being with sober friends... Stop isolating, stop hiding, stop pretending everything's alright... Umm, I need to start mixing with the right people, to get back into the groove of... umm... living successfully I guess... 'cos I don't feel I'm succeeding at the moment. But then again I don't keep plans so I can't fail can I? I'm a bit of a shifty when it comes to things like that... If I don't commit, you can't say you owe me, you know what I mean?"

Nevertheless, he was seeing the psychologist regularly and finding this helpful.

"Umm, I trust [name - psychologist]. Umm, he's a good listener, it's what I need. Umm, he doesn't tell me what to do, he just, you know, we look at options and stuff and... ah, it's nice to know there are the [name] of this world, umm, it can be a very lonely place. Umm, I'm very, I've been very independent in many ways, where I try to figure things out myself, not always coming out with the right solutions, so it's good to bounce things off other people who are a bit wiser than me."

Another client with a range of problems, including agoraphobia, talked about how it was difficult to open up in therapy but that he was persisting.

"Well, she [case worker] persisted in getting me through to see the psychologist [name]. And since I've been seeing the psychologist, yeah I have starting to work through the sort of things that I need to work through and that's a good thing because I've been avoiding psychologists especially since I got stabbed, I've been avoiding everything, I don't want to even think about what happened. I've mentioned it twice already, but... yeah, I'm finding it difficult to open up to him, but as time goes by, I'm sure I'll be able to open up with him more." (Client aged 45)

Case workers also reported finding the psychologist a very useful resource for them in talking through issues they had with clients (although the psychologist himself emphasised that there were strict confidentiality limits to how much he could divulge of what clients told him in counselling). However, one also thought there were some barriers to clients using the psychologist, both cultural (because he is of non-English speaking background) and because of a stigma attached to seeking that kind of assistance.

6.5 Meaningful activity

The concept of 'meaningful activity' is broad and imprecise, but essentially it conveys the idea that clients should be encouraged to participate in activities which might (a) help with achieving clients' own life goals, (b) lead on to economic activities which could help to build their financial independence and self-reliance, (c) improve their physical and mental health, and (d) enrich their lives generally.

6.5.1 Types of activity

In pursuit of these aims, the range of activities offered by MISHA was wide-ranging and included the following:

• Working groups	• Art classes
• Gardening classes	• Street soccer
• Men's Shed activities	• Computer classes
• Play reading	• Financial literacy workshops
• Cooking classes	• Fire safety class
• Fathers' support	• TAFE outreach classes
• City to Surf training and race entry	• Social barbecues
• Help with job search/ volunteering opportunities	• Milk Crate Theatre

Some of these activities were organised in partnership with other organisations, such as TAFE and Fit for Good (City to Surf training), the local Men's Shed, libraries and a local fathers' support service. The coordinator was also able to source donated tickets for shows, sports matches and cinemas, and groups of clients would attend these.

6.5.2 Barriers to engagement

While staff felt that a number of these activities were helpful in boosting clients' well-being, this was perhaps the area where staff felt MISHA was the least successful in terms of engaging clients in the activities offered. There was some frustration expressed at the number of times in which an activity had been organised and few clients took part, in spite of informing them through frequent newsletters and calendars, and through their case workers.

"Sometimes they say yes to it and they don't come along. It is hard and challenging. To get them is a challenge and to chase them to attend activities. We cannot go and force them. This is sometimes an issue. This may be because of past experiences – they're not capable of doing it, [it

presents] a hindrance to activities, homelessness for a while ... and this is a new beginning and it is frightening for them to start all over again. I encouraged clients by talking to case managers, tried ringing them and sending text messages but failed. I do talk to them occasionally to remind them to get engaged." (Activities coordinator)

The barbecues tended to be the most popular (with up to around 18 clients often attending), as free food was provided and they represented an easy and unthreatening social environment. There was also a sense that this kind of social activity could help clients 'open up'.

"They've got barbecues and they've got different, everything's here so you know... I guess, put it this way, it gets you out of the house and you start meeting other tenants, other clients of MISHA, so it's nice 'cos you meet up with friends and different people and things like that, so." (Client age 59)

"Yeah, some of the activities, like the barbecues they have here is good because you socialise with other people, you socialise with the staff. Um, and, being where I am and talking to people on a daily basis, I think it's opened me up a little bit, too. I'm not, say, closed up in a shell, I can talk to people... look people in the eye now, when I'm talking to them." (Client aged 46)

Case workers and the psychologist also talked of these as good places to meet clients and talk informally about how they were getting on, outside of a 'work environment'.

In the Activity Coordinator's view, the barriers to engagement in these activities were predominantly health and other issues in their lives, which made it hard for them to get out and involved.

"Most of the men are in D&A (drug and alcohol) and it's hard for them to get out of the house when there are drug and other issues in their lives. That is understandable. Barriers do reduce with time, smoking gets reduced, clients not drinking for a while. When they are socialising they talk about these things and it is good to hear there are steps forward." (Activities coordinator)

On the other hand, there was an opposing view amongst staff that for some clients these activities were not that important, compared with dealing with some of the central issues in their lives. As one observed,

"I see more progress in people who are more getting the problem fixed, getting to detox, to rehab, getting medical support – these are achievements. [...] Lots of the guys who were considered lazy, they were [in] intensive self-therapy, doing mundane things and not engaging in too many activities, but that's the way they do. Their main focus is on themselves, which is a bit selfish but it is maintaining, not ruining, their health." (Staff member)

However, some of the activities were directly linked with employability, such as an interview workshop where clients learned to write resumes and practice one-to-one interviews. The activities coordinator saw this as leading to some of the voluntary work that several clients were involved in.

“This was really good for them, it was fairly good attendance and enjoyed by MISHA clients. Yes, there are clients who are doing voluntary work, e.g. one client doing volunteering in Foodbank. It was after the training - he started becoming very interested and he started applying and making resumes and did well. There is also one who is working with Parramatta catering mission. With their learning skills they were capable of understanding how important it is looking for a job.” (Activities coordinator)

6.5.3 Client perspectives

Some clients were aware of these activities but were also conscious of (and sometimes apologetic about) rarely taking part, often seeing them as simply unimportant, outside their range of interests, or beyond their present capacities.

Q. “And has [case worker name] put you in touch with any of these other activities they have on offer here?”

A. “Yeah, yeah, but I don’t do ‘em. Nah, I’ve done the fire safety one. So, you know, unless it’s important I couldn’t be bothered.” (Client aged 57)

Q. “What about the activities that the MISHA program organises? Do you get involved in any of those?”

A. “Nah. Walking, art classes ...”

Q. “You’re just not that into those things?”

A. “Nah” (Client aged 30)

“Well, like I said, they try and get me involved in programs, barbecues, things like that, but I’m constantly declining. But they don’t give up... they keep going... it amazes me actually... I’m surprised they haven’t forgotten all about me. It’s not just [case worker], it’s everyone who works here, everyone seems to be really good people. They seem to have picked a really good bunch of people, caring people.” (Client aged 46)

Some of those not wishing to be involved were also doing other activities of their own outside MISHA. Indeed, some of the men who were not interested in the activities MISHA offered ended up starting a gardening group with the support of MISHA workers. Sometimes, non-engagement in MISHA activities reflects an understandable reluctance to be involved in ‘organised’ social activities similar to that experienced by many

of the general public, not necessarily an indication of project failure. However, it could also be a feature of social isolation or psychological difficulties that are hard to overcome and require long-term support.

6.6 Improving social networks and interactions

Part of the aim of the activities program discussed above was to counter social isolation and help clients develop or re-develop social contacts and networks where these might have been weakened as a result of the life experiences associated with prolonged homelessness. This included contact with children and/or families.

As discussed earlier with respect to the survey outcomes, on entry, 65% of respondents reported a lack of money, 60% reported a lack of own transport and 40% reported mental health or physical health conditions as a cause of social isolation. Additionally, only 58% reported having contact with family in the past week.

The interviews suggested a mixed picture of achievement in this respect. Engagement in the activities program seemed to bring benefits for those who took part, but participation overall was limited and, in the view of some case workers, should necessarily be seen as subordinate to some of the other ‘core’ elements of case management. Overall, the survey results indicate a number of decreases in the causes for social isolation, such as a lack of money declining from 65% to 50%, and reports of contact with others in the past week increasing from 81% on entry to 90% at the end of the 24 months.

6.6.1 The impact of living close to other MISHA clients

Also, as stated earlier in this report, living in close proximity with other MISHA clients seemed to have a mixed impact. For some clients it provided a ready-made source of friendship and social interaction, but it could also reinforce bad habits, such as drinking and drug-taking, or in some cases could keep clients who already had social phobias or felt threatened by other clients even more enclosed and isolated. On the other hand, several clients living in some of the larger clustered settings (cited above) talked positively of neighbourly behaviour and interactions which reinforced their ability to live independently. Another living in one of the smaller clusters talked of the mutual company provided between him and a friend he had made in the MISHA client group.

“Yeah. I’ve got a friend, he comes over, ‘cos sometimes he gets a bit lonely. So it’s company for him and it’s company for me ... we try and sorta keep in touch with each other.” (Client aged 59)

The predominant view of staff seemed to be that these smaller clusters of housing were the best option overall, but that they had little choice in the range of housing available when setting up the project.

6.6.2 Contact with families

Although contact with children and families was not an issue staff referred to extensively in their interviews, it was clearly an important part of clients' lives either in its presence or its absence. However, the survey evidence suggested only a marginal improvement in contact with family over the 24 months of the study as 60% of participants reported having contact with family in the past week at the end of the program, only slightly above the 58% of participants on entry.

Most of the clients interviewed referred to having children, many of whom were now adults in their own right, and for several, renewing lost contact with these had been a crucial, and sometimes painful, part of the process of rebuilding their lives since joining the MISHA program. Some told long and complex stories of stressful family relations over many years.

Asked about whether he saw his family regularly, one said:

"Family, no, because my family live in Queensland. [laughs] But, I do try to aim to get up there once a year to see them. I do have good relations with them, and I do contact them once a week on the phone.

Q. "Has that improved with being... since you've been part of MISHA, or was that always the case?"

A. "No, it's ... I came to MISHA, I had no contact with my family whatsoever, they helped me to find who I needed to find." (Client aged 46)

Another talked of the shock and surprise when his daughter contacted him.

"Yeah, it's ah, it was a bit of a shock when she phoned me up. I thought it was one of the calls you get that's selling stuff, you know, that marketing thing, and she said this is (name), I thought ok, we know your name... And she said 'Oh, I've got a phone call coming in, I'll phone you back'. I said 'no problem' and then when she phoned back she said 'it's (name)', and I go 'I know you're (name) but (name) who?' She said '(name), your daughter'. So I was, pardon my French but, ooh ah! I didn't know what to do! I didn't know whether to cry or... yeah. It just came out of the blue, so. And it's ah, a bit hard to swallow, but I'm getting there, so, it's, ah, it's going to take a little bit of time." (Client aged 59)

Others saw MISHA as having had little impact on family relations, however, or did not want to attempt to recontact families because of negative memories.

"I don't think they've ... they've changed one way or the other. I don't think the, ah, MISHA has had anything to do with my relationship with my family." (Client aged 66)

"Uh, oh well, they asked me if I wanted, you know, for 'em to get in touch, and I said no. I come from a pretty mixed up background so, yeah, I'd just rather leave it and not worry about it." (Client aged 55, Indigenous)

6.7 Client views of MISHA staff and of their future journeys

Virtually all clients interviewed referred to MISHA and the project staff in highly complementary terms and could think of little that could be improved about it except for having more staff – one referred to his case worker, who left the job in the first year as seeming 'overwhelmed' by the work and 'she didn't feel supported'. A few had some reservations about their housing and MISHA's capacity to deal with disputes between residents in some of the larger clustered settings, but more common were views such as the following.

"All positive, umm ... yeah, nah, they've got a lot of, you know, compassion towards every here. You know, they don't look down on ya." (Client aged 38)

"Positive experience, because yeah, I feel that with my input I've been very honest with you and I know I've said nothing but good things, but that's because I've got nothing bad to say about them – literally there's nothing bad to say about them." (Client aged 45)

"Well just for me personally, they're fantastic. They done everything I asked. I haven't had a complaint, that's about all I can say. They're a good organisation." (Client aged 46)

"They seem to genuinely care about you. I know it's their job but they care. That's what counts." (Client aged 29)

While many of the clients were aware that they still had some way to go to achieve the level of independence that would see them maintain secure housing without external support, they did have goals and often saw a way ahead to achieving them. Some of these goals were ambitious, others much more modest – focused on dealing with small everyday issues. Asked where he saw himself in five years' time, one client made the following comment.

"I imagine I'll be working. I won't be smoking cigarettes. I believe that [named girlfriend] and I will still have a relationship and it'll be a lot healthier ... and um ... and I also see myself volunteering in some capacity and in some way helping um ... some group of people." (Client aged 45)

Another talked of how he felt more able to achieve his goals after being involved in MISHA.

"I achieve them more. They're always expanding, something always comes up and you say 'Oh, I forgot about that'. Sometimes it's a bit of a worry, 'oh, is my rent paid?' or something, but then you go 'oh yeah, that's alright', so yeah." (Client aged 59)

7. Economic analysis

Homeless populations are typically heavy users of mainstream services such as health and justice services and welfare payments. This creates an associated high cost to government (Zaretsky et al., 2013). It has also been found that use of these mainstream services may change when a person is supported to avoid homelessness (Zaretsky and Flatau, 2013). In some instances costs decrease as a result of more appropriate use of health services and decreased contact with justice services. However, costs may also increase, for example when a person has previously had little contact with the health system and services now must address an accumulation of health issues which have been neglected. The same thing can happen when contacts with the justice system occur in the course of addressing previous issues (for example where a person complies with parole requirements) or where time spent without income is reduced due to consistent access to government benefits.

This chapter examines the cost to government of health and justice services used by MISHA participants in the 12 months prior to the baseline survey for the follow-up group of 59 respondents who completed the survey at all three time points, how that compares with the NSW population average, and the observed change in cost for the follow-up group from the 12 months prior to baseline compared to the 12 months prior to each of the 12 month and 24 month follow-up surveys. Similarly, the cost to government of welfare payments received by participants in the 12 months prior to each of the three survey waves was examined. The cost of delivering the MISHA program is then discussed, as well as the extent to which the cost of MISHA support is offset by the change in cost of mainstream health and justice services used by clients and change in welfare payment receipts. Finally, we estimate the value of cost offsets from evictions avoided and reduced use of crisis/emergency accommodation, along with the cost of providing dwellings, and a sensitivity analysis is presented.

7.1 Overview of analyses conducted

The extent to which MISHA clients were heavy users of health and justice services was examined by comparing the cost of services used by MISHA clients in the 12 months prior to the baseline survey with the average annual cost of services used by the NSW population. The extent to which average health costs were driven by a small number of participants was investigated by examining the distribution of 'total health cost' incurred by participants. This was shown through the proportion of participants who incurred a 'total health cost' within defined dollar ranges, for example \$0 to \$1000, \$1001 to \$2,000 and so on. This method was also applied to examine the extent to which high average justice costs were driven by a small number of participants.

The change in use and associated cost of health and justice services over time was assessed by comparing the cost of services used for the follow-up group in the 12 months prior to the baseline with that in the 12 months prior to each of the 12- and 24-month follow-up surveys. The extent to which the change

in the average cost of health and justice services was driven by a small number of clients was investigated by examining the distribution of the 'change in total health cost' and 'change in total justice service cost' incurred by participants, similar to the method used when examining the distribution of the baseline 'total health cost'.

The cost of government welfare benefits paid to MISHA clients at baseline and how this changed over time was examined by comparing the cost to government of benefits received in the 12 months prior to each of the baseline, 12 month follow-up and 24 month follow-up surveys. For each government benefit, the proportion of participants who reported receiving that benefit during the year was multiplied by the average number of fortnights it was received, and the fortnightly rate applied. Participants were not asked the dollar value of welfare payments received during the previous 12 months. The rate applied represents the maximum rate for a single person. It is possible that a small proportion of participants who were receiving the benefit in addition to a wage/salary, were entitled to an amount less than the full benefit. This applied to nine per cent of participants at the 12 month follow-up and 12% at the 24 month follow-up. Therefore, in these latter periods the estimated average cost/person may slightly overestimate the cost to government of Newstart and Disability Support Pension. Also reported is the proportion of participants who received wages/salary, workers compensation, other non-government income sources, and no income source during the previous 12 months, and the average number of fortnights. Survey data does not include the dollar value of these payments. Therefore it is not possible to examine the associated effect on the value of taxation receipts.

The cost of delivering the MISHA project (2010-2013) was examined first at a service level, showing total funding and recurrent cost of support each year, and average cost per client. Average cost/client was estimated by first applying the GDP chain price index (Australian Bureau of Statistics, 2013a) to obtain expenditure in 2011-12 dollars, consistent with mainstream service use. The cost of MISHA support net of the change in cost of mainstream health, justice and welfare services was then estimated. If government were to implement a program similar to MISHA, and the estimated cost offsets were realised, this would represent the whole of government cost of providing support.

Estimates of recurrent cost of MISHA support and the value of health, justice and welfare offsets provide the most objective estimates of program cost given available data. The value of cost offsets from tenancy failures avoided and change in use of crisis/emergency accommodation were estimated using the best available data and a sensitivity analysis presents the net cost per client incorporating these offsets. The cost of failed tenancies avoided was estimated by comparing an indicative cost of evictions for tenancies without support (obtained from the literature) with the actual cost of evictions observed in MISHA. This was estimated first for participants who completed all three survey waves.

However, none of these clients experienced a failed tenancy. Therefore a more conservative estimate was also made, comparing the cost without support with the average cost of failed tenancies across the complete baseline sample.

The base case analysis implicitly assumes the average cost offsets are the same for all sub-groups of clients. As none of the participants who completed all survey waves had a failed tenancy, this is likely to overestimate the average value of offsets. Sensitivity of average net cost/client to the assumed value of cost offsets for clients whose tenancy failed was examined by first assuming that average offsets for those clients with a failed tenancy were 50% those observed for survey participants who completed all three waves; and then by assuming that no cost offsets were realised for those clients whose tenancy failed.

7.2 Use of mainstream health, justice and welfare service

7.2.1 MISHA client use of health and justice services

Table 9 reports the cost of health and justice services accessed by the follow-up group in the 12 months prior to baseline compared with the NSW population average; providing details of the unit cost for each health and justice service (column (1)), average annual service use for the NSW population, the average number of times the service was used by participants in the 12 months prior to baseline, and the difference between these. The final three columns report annual cost per person for the NSW population, the average annual cost per participant, and the difference in cost between these two populations.

On average, participants' use of health and justice services in the 12 months prior to the baseline survey were considerably higher than that of the NSW population, resulting in an average cost to government of \$17,725 per participant, \$15,168 per participant higher than the population average. Health service use accounts for a large proportion of the difference in cost (78.6%). The very high health cost of \$14,015/participant, compared with \$2,088/person for the NSW population, relates predominantly to contact with hospital based services; time in hospital (\$6,140/participant), and in a mental health facility (\$2,107/participant). A smaller but still significant proportion of the difference is associated with visits to a nurse or allied health professional (\$1,089/participant) and visits to an outpatients or day clinic (\$787/participant). Surprisingly, the cost of casualty/emergency visits and use of ambulances, although still higher than the population average, were not markedly high.

Although the vast majority of participants reported use of health services, the very high average health cost was driven by a small proportion of participants. A comparatively large proportion of participants (40.7%) reported spending at least one night in hospital in the previous 12 months, but the very high average cost was driven by four participants (6.8%) who reported between 21 and 90 nights in hospital.

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Only two participants reported spending at least one night in a mental health facility, one for 60 nights and the other for 100 nights. Similarly, although 15 participants (25.4%) reported visits to an outpatient clinic or day centre, the very high average cost was driven by three participants; one reported fortnightly visits, one weekly and the third daily visits.

All justice costs were higher than the NSW population average. The main driver of justice costs is the result of being stopped by police in the street and visits from a justice officer (\$1,610/participant), followed by time spent in prison (\$870/participant). Nearly half of participants (45.8%) reported being stopped in the street or receiving a visit from a justice officer, but costs were primarily driven by two people. One reported being stopped in the street 200 times and one reported 156 visits from a justice officer. Only a small proportion of participants (5.1%, or 3 people) reported spending nights in prison, including one participant who reported 84 nights and one who reported 125 nights.

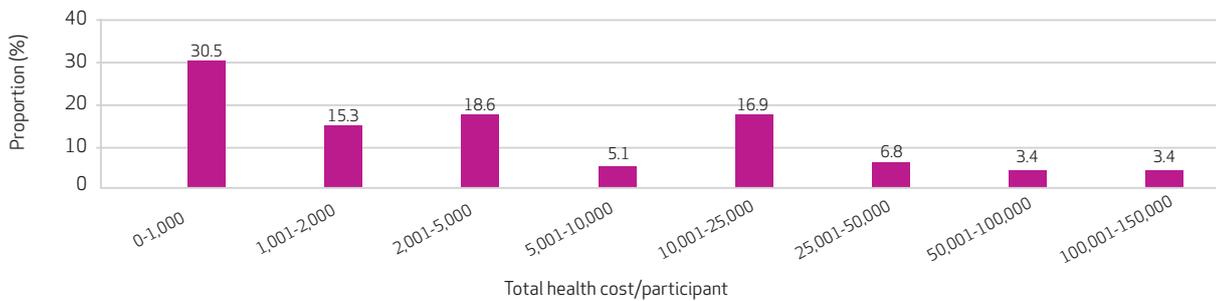
To examine further how representative these high average costs are of cost incurred by the majority of survey participants, the 'total health cost' and the 'total justice cost' incurred by each survey participant was calculated. The following figures display the proportion of participants who incurred a 'total cost' within each defined dollar range. These figures show that while a number of participants did incur very high costs, a large proportion actually incurred very low costs.

Table 9 – Cost of health and justice services used by MISHA clients in the 12 months prior to baseline compared with the NSW population average

	Cost per incident (\$)	Contacts per year - average			Cost per person - average (\$)		
		NSW Population	MISHA Baseline	Difference	NSW Population	MISHA Baseline	Difference
HEALTH CONTACTS							
General practitioner	41	5.31	11.00	5.69	218	451	233
Medical specialist	75	1.24	5.32	4.08	93	399	306
Psychologist	102	0.15	2.75	2.60	15	280	265
Nurse or allied health professional	83	1.23	14.36	13.13	102	1,192	1,089
Casualty or emergency	289	0.31	0.46	0.15	90	132	43
Outpatient or day clinic	128	2.53	8.68	6.15	324	1,111	787
Ambulance	805	0.13	0.44	0.31	105	355	250
Nights in hospital	1,474	0.75	4.92	4.17	1,106	7,245	6,140
Nights in mental health facility	769	0.04	2.78	2.74	31	2,138	2,107
Nights in drug and alcohol centre	254	0.02	2.64	2.62	5	672	667
Total health cost					2,088	14,015	11,927
JUSTICE CONTACTS							
Police contact:							
As victim of assault/robbery	2,285	0.023	0.085	0.062	53	194	141
Stopped in street or visit from a justice officer	201	0.310	8.322	8.012	62	1,673	1,610
Stopped in a vehicle	71	0.870	0.119	-0.751	62	8	-53
Apprehended	381	0.002	0.305	0.303	1	116	115
Held overnight	194	0.001	1.763	1.762	0	342	342
In court	1,253	0.060	0.254	0.194	75	319	243
Night in prison	293	0.590	3.559	2.969	173	1,043	870
Night in other detention	446	0.097	0.034	-0.063	43	15	-28
Total justice cost					469	3,710	3,241
Total health and justice cost					2,557	17,725	15,168

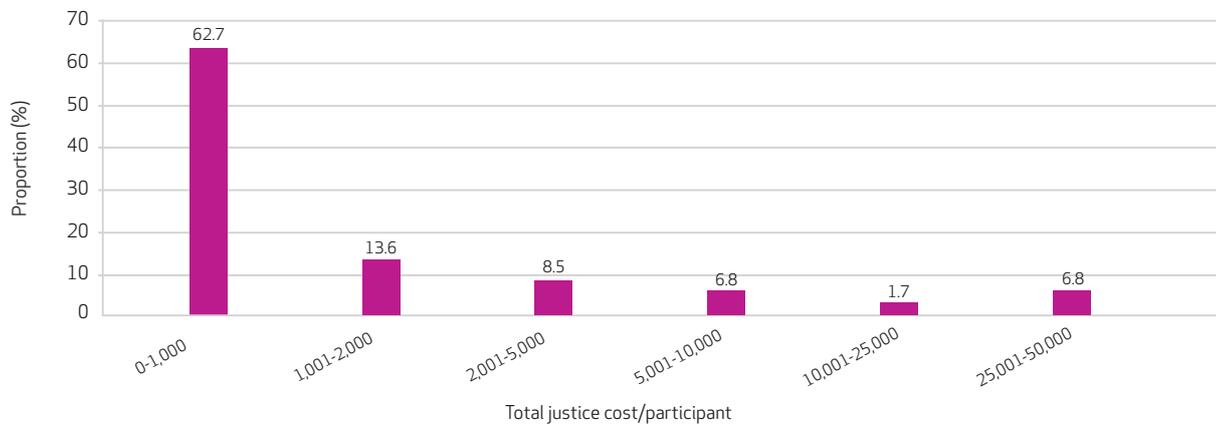
Considering health (Figure 14), 30.5% of participants incurred very low total health costs of \$1,000/year or less, and two-thirds (64.4%) incurred health costs of \$5,000 or less. The very high average health costs are largely driven by the small number of participants (6.8%) who incurred costs of between \$50,001 and \$150,000, three of whom spent considerable time in hospital for a physical or mental health issue and one had daily visits to an outpatient facility.

Figure 14 – Total health cost/participant in the 12 months prior to baseline (n=59)



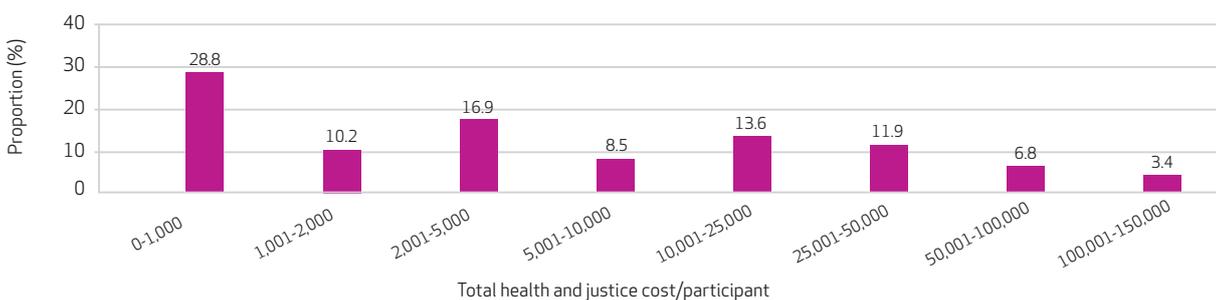
Similarly, Figure 15 shows that 62.7% of participants incurred a total justice cost of \$1,000, or less but 8.5% incurred a cost between \$10,001 and \$50,000. These very high costs related to time in custody, regular contact with police, and one person reporting visits from a justice officer three times per week.

Figure 15 – Total justice cost per participant in the 12 months prior to baseline (n=59)



When considering total health and justice costs combined (Figure 16), 39.0% incurred a comparatively low total cost of \$2,000 or less (compared with an NSW population average of \$2,557/person), and nearly two-thirds (64.4%) incurred total health and justice costs of \$10,000 or less. The very high average total costs were driven by the 10.2% of participants who reported total costs of between \$50,001 and \$150,000, predominantly health related.

Figure 16 – Total health and justice cost per participants in the 12 months prior to baseline (n=59)



The findings of very high average health cost, high average justice cost, and the pattern in the distribution of costs, are consistent with findings from other studies of populations of homeless males (Flatau et al., 2012, Zaretsky and Flatau, 2013, Zaretsky et al., 2013). The level of baseline health and justice cost found for the MISHA clients were similar to those reported in Zaretsky and Flatau (2013); \$18,768 per person (2010-11 dollars).

The Michael Project (Flatau et al., 2012) reported total health and justice costs of \$24,355 per client (2008-09 dollars) in the 12 months prior to baseline. The difference between baseline Michael and MISHA costs primarily reflects differences in nights spent in a drug and alcohol rehabilitation facility.

At baseline, Michael Project participants reported 33.48 nights per client on average in a drug and alcohol rehabilitation facility during the previous year, with an associated cost of \$9,875 per client. In comparison, MISHA clients reported a much lower average of 2.64 nights per person average, with an associated cost of \$672 per person.

Change in health service use: pre- to post-baseline

Table 10 reports the change in health service use by survey participants over time and the associated cost, comparing service use in the 12 months prior to the baseline survey with service use in the 12 months prior to both the 12 month and 24 month follow-up surveys.

Health costs incurred by participants decreased steadily over the support period. Baseline health costs were estimated at \$14,015/participant. This decreased slightly in the early phase of support to \$12,838/participant in the 12 month follow-up survey and then decreased markedly to \$7,448/participant in the 24 month follow-up.

Comparison of the baseline and 24 month follow-up costs showed a considerable decrease in health costs of \$6,567/participant/year or 46.9%, overall. The largest decreases, when comparing baseline with the 24 month follow-up, relate to nights spent in hospital (\$3,747/participant), nights spent in a mental health facility (\$1,277/participant) and outpatient/day clinic visits (\$1,044/participant).

At baseline, Michael Project participants reported 33.48 nights per client on average in a drug and alcohol rehabilitation facility during the previous year, with an associated cost of \$9,875 per client. In comparison, MISHA clients reported a much lower average of 2.64 nights per person average, with an associated cost of \$672 per person.

Table 10 – Cost of health service use in the 12 months prior to baseline, compared with 12 months prior to the 12 month and 24 month follow-up surveys (n=59)

	Cost/ incident incident (\$)	Incidence per year - average			Cost /participant/ year - average (\$)						
		Follow-up		Change	Follow-up		Change				
		Baseline	12 month	24 month	Baseline to 12 month	Baseline to 24 month	Baseline to 12 month	Baseline to 24 month			
General practitioner	41	11.00	11.93	11.80	0.93	0.80	451	489	484	38	33
Medical specialist	75	5.32	5.37	3.88	0.05	-1.44	399	403	291	4	-108
Psychologist	102	3.15	13.44	2.32	10.29	-0.83	322	1,371	237	1,049	-85
Nurse or allied health professional	83	14.36	6.27	11.73	-8.08	-2.63	1,192	521	973	-671	-218
Casualty or emergency	289	0.46	0.51	1.80	0.05	1.34	132	147	519	15	387
Outpatient or day clinic	128	8.68	0.46	0.53	-8.22	-8.15	1,111	59	67	-1,052	-1,044
Ambulance	805	0.44	0.61	0.44	0.17	0.00	355	491	355	136	0
Nights in hospital	1,474	4.92	4.66	2.37	-0.25	-2.54	7,245	6,870	3,498	-375	-3,747
Nights in mental health facility	769	2.78	1.63	1.12	-1.15	-1.66	2,138	1,251	860	-886	-1,277
Nights in drug and alcohol centre	254	2.64	4.86	0.64	2.22	-2.00	672	1,236	164	564	-508
Total health cost \$							14,015	12,838	7,448	-1,178	-6,567

The cost of psychologist visits increased by \$1,049/participant from baseline to the 12 month follow-up, but by the 24 month follow-up they had decreased again to be approximately equivalent to baseline. Similarly the cost of nights spent in a drug and alcohol rehabilitation facility increased by \$564/participant from baseline to the 12 month follow-up. These costs then decreased in the 24 month follow-up period to below baseline levels, creating an overall decrease from the baseline to the 24 month follow-up of \$508/participant.

The change in health service cost is further examined in Figures 17 and 18, which show the proportion of clients with a change in 'total health cost' within each defined dollar range. They show that in the initial period of support total health cost actually increased for many participants, but then decreased in the latter period. The distribution of 'total health cost/participant' for the 24 month follow-up is then shown at Figure 17, displaying the proportion of participants with 'total health cost' over the previous 12 months within each defined dollar range.

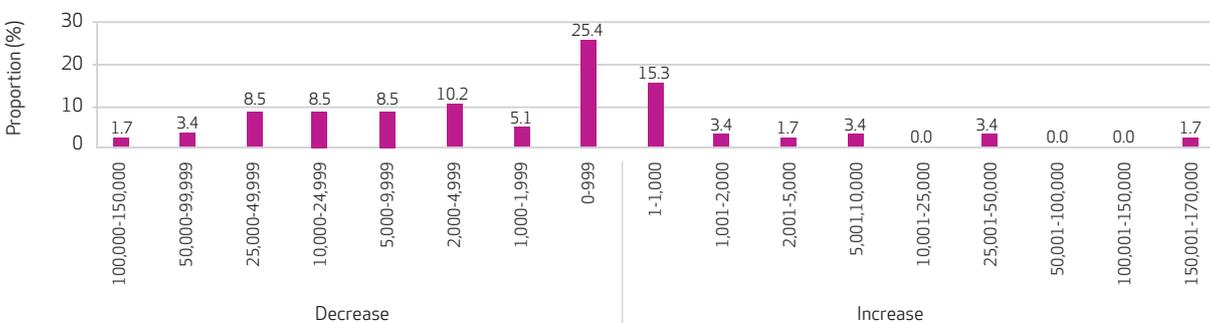
Figure 17 shows that when comparing the 12 months prior to each of the baseline and the 12 month follow-up, in total 52.5% of participants showed a decrease in health costs. However, 47.5% of participants experienced an increase in health cost in this period. In addition, nearly an equivalent proportion of participants (11.9%) incurred a large increase in cost of \$25,001 or more, as incurred a large decrease (13.6%) of \$25,000 or more.

Figure 17 – Change in 'total health cost' per participant – baseline to 12 month follow-up (n=59)



An examination of changes in health costs from the baseline to the 24 month follow-up (Figure 18) shows a very different picture, with the vast majority of participants (71.2%) reporting a decrease in health costs in this latter period compared with baseline. In addition, 13.6% of participants reported a very large decrease in costs of \$25,000/year or more, and only 5.1% reported an increase in cost of \$25,001/year or more.

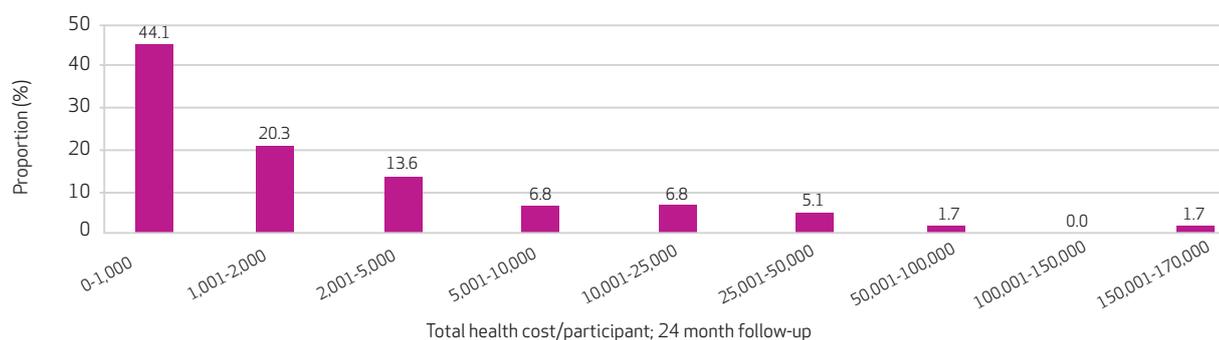
Figure 18 – Change in 'total health cost'/participant – baseline to 24 month follow-up (n=59)



As a result of this broad decrease in health costs, Figure 19 shows that in the 12 months prior to the 24 month follow-up 44.1% of participants incurred health costs of \$1000 or less, and nearly two-thirds (64.4%) incurred cost of \$2,000 or less. Only 3.4% of participants (2 people) incurred costs between \$50,001 and \$170,000.

The pattern of change in health cost is consistent with participants' previously unmet or ongoing needs being met in the initial phase of support, making more efficient use of mainstream services and less use of hospital based services. The average cost of health services then decreases markedly in the latter period of support, as issues are addressed and stabilised. However, there were still a small number of participants with very high health costs in the latter period.

Figure 19 – Total health cost/participant in the 12 months prior to the 24 month follow-up (n=59)



Change in justice contacts: pre- to post-baseline

Table 11 reports the change in justice contacts by survey participants over time and the associated cost, comparing contacts in the 12 months prior to the baseline survey with contacts in the 12 months prior to both the 12 month and 24 month follow-up surveys.

Justice costs steadily decrease from \$3,710/participant in the 12 months prior to baseline, to \$2,646/participant in the 12 months prior to the 12 month follow-up and again to \$1,732/participant in the 12 months prior to the 24 month follow-up. Comparing baseline with the 24 month follow-up this represents a decrease of \$1,977/participant/year, or just over 50% (53.3%). The largest decreases relate to nights spent in prison (\$889/participant) and receiving visits from a justice officer (\$647/participant). There was a small increase in the incidence of being in court (\$255/participant) and being the victim of an assault or robbery (\$194/participant). The cost of being stopped in the street by police increased from baseline to the 12 month follow-up (\$521/participant), but then decreased to well below baseline levels, with an overall decrease from baseline to the 24 month follow-up of \$566/participant.

The change in justice service cost is further examined in Figures 20 and 21, which show the proportion of clients with a 'change in total justice cost' within each defined dollar range. They show that the consistent decrease in justice costs over time reflects a decrease in contacts with the justice system across the vast

majority of participants. The distribution of 'total justice cost/participant' for the 24 month follow-up is then shown at Figure 23, displaying the proportion of participants with 'total justice cost' over the previous 12 months within each defined dollar range.

Figure 20 shows that, when comparing baseline and the 12 month follow-up, for over two-thirds (67.8%) of participants justice costs decreased or remained the same. Only one participant (1.7%) incurred a large cost increase of just under \$75,000/year. This participant reported being stopped in the street daily in the 12 month follow-up period, but did not report this occurring at all in the baseline period. For 40.7% of participants the decrease in justice cost was comparatively small, zero to less than \$1,000. This reflects the fact that at baseline (Figure 11) 62.7% of participants had incurred justice costs of \$1,000 or less in the prior 12 months.

When comparing baseline with the 24 month follow-up (Figure 21), the proportion of participants reporting a decrease or no change in justice costs is larger again at 78.0%, with 52.5% reporting a change of less than \$1,000. A comparatively small 3.4% reported a large increase in costs of between \$10,000 and \$25,000. In comparison 8.5% reported a large decrease in cost of between \$10,001 and \$50,000. As a result of these broad decreases in cost, at the 24 month follow-up (Figure 22), 71.2% of participants had incurred a 'total justice cost' of less than \$1,000 in the prior 12 months, and none had incurred justice costs greater than \$25,000. This represents a significant reduction in contacts with the justice system and savings to government.

Table 11 – Cost of justice service use in 12 months prior to baseline, compared with 12 months prior to the 12 month and 24 month follow-up surveys (n=59)

	Cost/ incident incident (\$)	Incidence per year - average						Cost /participant/year - average (\$)									
		Follow-up			Change			Follow-up			Change						
		Baseline	12 month	24 month	Baseline to 12 month	Baseline to 24 month	Change	Baseline	12 month	24 month	Baseline to 12 month	Baseline to 24 month	Change				
Police contact:																	
Victim of assault/robbery	2,285	0.08	0.25	0.17	0.17	0.08	0.17	0.08	194	581	387	387	194	387	387	194	194
Stopped in street	201	5.05	7.64	2.24	2.59	-2.81	2.59	-2.81	1,015	1,536	450	450	1,015	1,536	521	450	-566
Stopped in a vehicle	71	0.12	0.17	0.44	0.05	0.32	0.05	0.32	8	12	31	31	8	12	4	31	23
Apprehended	381	0.31	0.15	0.29	-0.15	-0.02	-0.15	-0.02	116	58	110	110	116	58	-58	110	-6
Visited by a justice officer	201	3.27	0.86	0.05	-2.41	-3.22	-2.41	-3.22	657	174	10	10	657	174	-484	10	-647
Held overnight	194	1.76	0.15	0.08	-1.61	-1.68	-1.61	-1.68	342	30	16	16	342	30	-312	16	-326
In court	1,253	0.25	0.20	0.46	-0.05	0.20	-0.05	0.20	319	255	573	573	319	255	-64	573	255
Night in prison	293	3.56	0.00	0.53	-3.56	-3.03	-3.56	-3.03	1,043	0	154	154	1,043	0	-1,043	154	-889
Night in other detention	446	0.03	0.00	0.00	-0.03	-0.03	-0.03	-0.03	15	0	0	0	15	0	-15	0	-15
Total justice cost (\$)									3,710	2,646	1,732	1,732	3,710	2,646	-1,064	1,732	-1,977

Figure 20 – Change in 'total justice cost'/participant; baseline to 12 month follow-up (n=59)

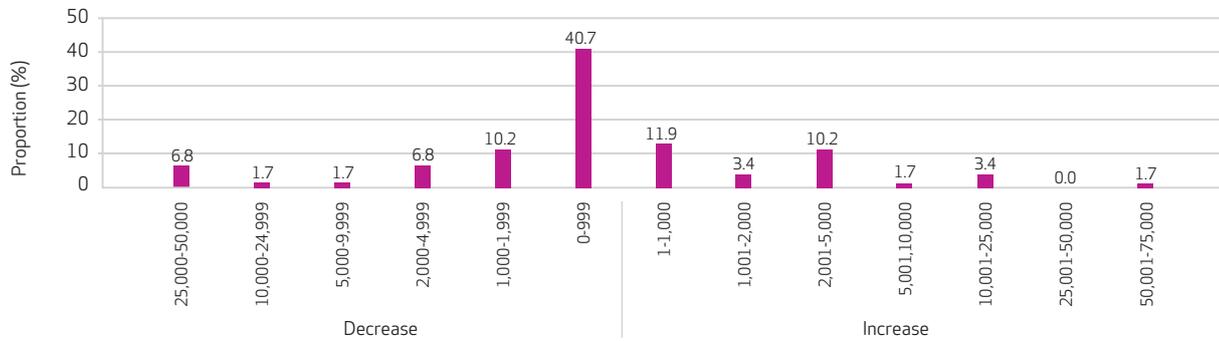


Figure 21 – Change in 'total justice cost'/participant; baseline to 24 month follow-up (n=59)

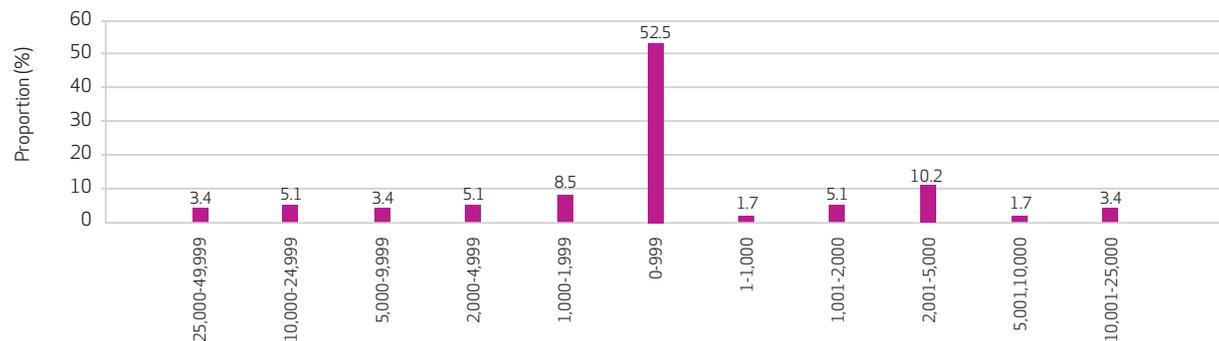
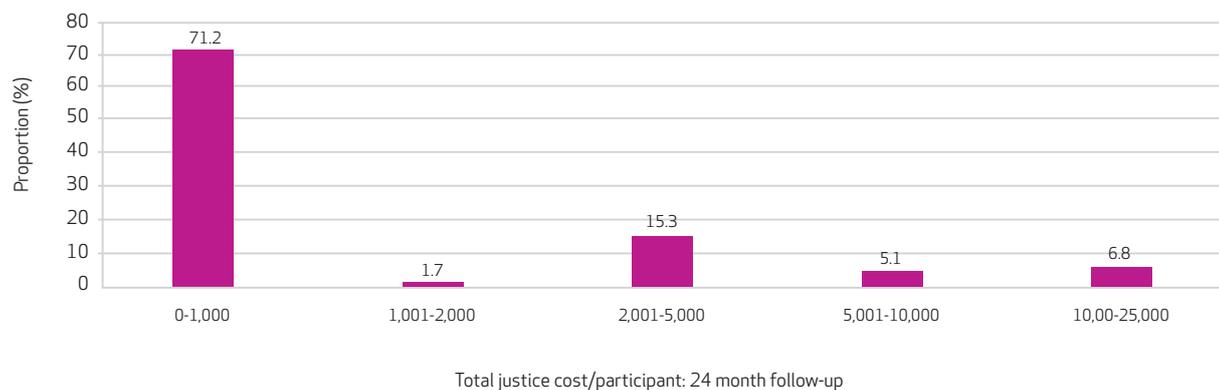


Figure 22 – Total justice cost/participant in the 12 months prior to the 24 month follow-up (n=59)



7.2.2 Government welfare benefits

The third domain where the potential value of government savings is considered is any decrease in government welfare benefits paid. As discussed previously, a small increase in employment and workforce participation was observed from the time of the baseline survey to the 24 month follow-up survey.

All else equal this would result in a decrease in government benefits. However, there was also a decrease in the incidence of clients not having an income source and transfer from Newstart benefits to pensions, which both increased the value of benefits. To estimate the net effect, participants were asked to provide details of their main income source(s) each fortnight for the 12 months prior to each survey wave.

Table 12 reports the income sources of participants over the 12 months prior to each survey wave, and the cost to government of welfare benefits. It shows the proportion of participants who reported receiving the specified income source over the previous 12 months, and the average number of fortnights these participants received the income source.

For government benefits, the average cost per participant is also reported. No data are available on the dollar value of wages and salaries or worker's compensation. Therefore it is not possible to determine the value of these or the extent to which income tax receipts may have changed as a result of increased employment. However, it is likely that any offsetting effect from an increase in taxation receipts would be small.

As can be seen, although there was an increase in the proportion of participants who reported receiving income from wages and salaries during the year, up from 17.2% in the 12 months prior to the baseline to 20.7% for the 24 month follow-up, there was also a slight increase in the cost of government benefits. In the 12 months prior to baseline the total government benefits was \$14,529/participant on average.

This increased slightly to \$15,749/participant for the 12 month follow-up and to \$15,071/participant for the 24 month follow-up. This increase in government benefits was the net result of a decrease in the incidence of participants receiving Newstart, but an increase in other pension types and a decrease in the proportion of participants reporting a period of no income.

The proportion of participants receiving Newstart decreased from 51.7% at baseline to 44.8% in the 24 month follow-up, with an associated decrease in government cost from \$5,500/participant to \$4,811/participant. However, the proportion

The proportion of participants receiving Newstart decreased from 51.7% at baseline to 44.8% in the 24 month follow-up, with an associated decrease in government cost from \$5,500/participant to \$4,811/participant.

receiving aged pension increased from 1.7% to 5.2%, with an associated increase in cost of approximately \$600/participant. Although the proportion reporting receipt of Disability Support Pension over the previous 12 months was the same at baseline and the 24 month follow-up, the average time it was received increased from 22.6 to 24.7 fortnights over the year, with an associated increase in government cost from \$8,446/participant to \$9,233/participant. The men were accorded the correct benefits to which they were entitled once they got onto the MISHA project.

The proportion of participants reporting a period of no income over the previous 12 months decreased steadily from 10.3% for baseline to 6.9% for the 24 month follow-up. This was accompanied by a slight decrease in the average number of fortnights where no income was received.

Although no offset is observed for government welfare benefits, the net increase in net benefits is comparatively small and is associated with a decrease in time spent with no income and increased employment, both positive outcomes.

As discussed at Section 7.1, it is possible that the increase in welfare payments is at least in part offset by an increase in taxation receipts. It is also possible that the value of Newstart and DSP benefits is slightly overstated for the 12 and 24 month follow-up periods. This relates to a small number of participants who reported receiving a wage/salary in the same period as receiving a government benefit.

The benefit received by these participants may have been less than the maximum assumed here. Although the effect on average benefits is likely to be small, it may account for at least a portion of the apparent increase in the value of welfare payments in the 12 and 24 month follow-up periods.

Table 12 – Welfare payments in 12 months prior to baseline, 12 month and 24 month surveys (n=58)

	Baseline		12 Month Follow-up		24 Month Follow-up	
	Incidence	Ave cost \$	Incidence	Ave cost \$	Incidence	Ave cost \$
Government benefits						
Newstart						
Received in previous year %	51.7		41.4		44.8	
Period received (Ave fortnights)	21.8		24.3		22.0	
Cost/person/year (\$)		5,500		4,904		4,811
Disability Support Pension						
Received in previous year %	50.0		51.7		50.0	
Period received (Ave fortnights)	22.6		25.2		24.7	
Cost/person/year (\$)		8,446		9,776		9,233
Aged Pension						
Received in previous year %	1.7		3.4		5.2	
Period received (Ave fortnights)	26.0		24.0		24.7	
Cost/person/year (\$)		336		620		956
Carer's Pension						
Received in previous year %	1.7		0		0	
Period received (Ave fortnights)	18.0		0		0	
Cost/person/year (\$)		232		0		0
Rent assistance						
Received in previous year %	1.7		19.0			
Period received (Ave fortnights)	9.0		23.7		3.4	
Cost/person/year (\$)		16		450	20.5	71
Total Government Benefits \$		14,529		15,749		15,071
Other income Sources						
Wages/salary						
Received in previous year %	17.2		15.5		20.7	
Period received (Ave fortnights)	14.3		16.9		14.4	
Worker's compensation						
Received in previous year %	1.7		3.4		3.4	
Period received (Ave fortnights)	26.0		25.5		26.0	
Other income						
Received in previous year %	0.0		1.7		1.7	
Period received (Ave fortnights)	0.0		1.0		4.0	
No Income						
Experienced period of 'no income' %	10.3		8.6		6.9	
Period 'no income' (Ave fortnights)	6.5		3.2		5.5	

7.2.3 Total savings to government from change in use of health, justice and welfare services

The change in use of mainstream health, justice and welfare services from the 12 months prior to the baseline survey, to the 12 months prior to the 24 month follow-up represents a large savings to government. Table 13 shows that at baseline, the total cost of these services averaged \$32,254/client. Of this, use of health services and receipt of welfare payments accounted for approximately the same dollar amount, each representing approximately 44% of the total cost. The cost of justice services/participant was comparatively small, although still much higher than the population average.

A small overall decrease in total cost of \$1,022/participant did occur from baseline to the 12 month follow-up. The decrease in health and justice costs was in part offset by an increase in welfare benefits. The much larger decrease in total cost of \$8,002/participant occurred when comparing service use in baseline and 24 month follow-up periods, with the total cost in the 24 month follow-up reduced to \$24,251/participant. In addition to these savings, the fact that health and justice costs each decreased by approximately half over this period, but welfare payments increased slightly, means that by the 24 month follow-up welfare payments accounted for 62.1% of the total mainstream service costs examined. Health accounted for a smaller 30.7% of costs and justice contacts only 7.1%. This level of savings to government is associated with better outcomes for MISHA clients; better health outcomes, fewer contacts with justice services and greater access to a stable income source.

7.3 Cost of providing MISHA support

The recurrent cost of delivering the MISHA program is examined first at a service level. The total recurrent cost of support net of the dollar value of cost offsets from the change in client use of mainstream services is then discussed. Finally issues surrounding the cost of eviction, use of supported accommodation services, sustainability of offsets post-support and the cost of providing housing for MISHA clients are examined.

7.3.1 MISHA recurrent project cost

Table 14 reports the recurrent funding for MISHA, 2009-2013, and actual expenditure for 2010-13 in nominal dollars. Total funding for MISHA for 2009-13 was \$2,695,084 (excluding funding tied to research and evaluation), almost all of which came from a major donation. Operational expenditure (excluding expenditure on research) for the period of interest (2010-2013), totalled \$2,334,400. The remaining funding was budgeted to be utilised in the final operational year of the project; 2013-14. Of the operational expenditure (2010-2013), 58.5% of costs were staff related. Only 7.3% related to client brokerage, which is not a significant element of the program. Brokerage was predominantly used to provide white goods and other furniture when establishing clients in their accommodation.

In total, 84 clients were assisted over the three years 2010-2013. The cost per client was estimated by first adjusting annual expenditure to 2011-12 dollars using the GDP Chain Price Index (Australian Bureau of Statistics, 2013a)³. The average recurrent cost of MISHA support over this period was \$27,914/client. Recruitment of clients occurred gradually over the first year of operation, and a small number of new clients commenced later again when tenancies ended. On average, clients had received 2.04 years of support during this period, at a cost of \$13,683/client/year. This cost is potentially higher than if the program were ongoing, as it includes initial program set-up costs incurred in the first year of operation.

How the cost/client compares with similar programs must take into account differences in the service model employed, the complexity of client needs, and the length of support. The cost/client of \$27,914 (average 2.04 years of support) is considerably lower than that reported for Journey to Social Inclusion (J2SI) of \$51,398/client (2012 dollars) over two years of intensive support (Johnson et al., 2012). In contrast, it is higher than the estimated cost of the Way2Home program, where the cost of support was estimated at \$18,500/person housed over the initial two year period of operation (Wilhelm et al., 2012). However, Way2Home offers a mixture of street and in-home outreach services. It is also considerably higher than the \$7,636/client (2010-11 dollars) reported by Zaretsky and Flatau (2013) for street-to-home programs. The programs included in that study had an average support period per client of just 83 days. In comparison MISHA clients receive ongoing support over a period of years.

Table 13 – Total cost of health, justice and welfare services in previous 12 months (Dollars 2011-12)

	Cost/participant		Change in cost/participant		Cost/participant 24 month follow-up
	Baseline	Baseline to 12 month follow-up	Baseline to 24 month follow-up	Cost/participant 24 month follow-up	
Health services	14,015	-1,178	-6,567	7,448	
Justice services	3,710	-1,064	-1,977	1,732	
Welfare benefits	14,529	+1,220	+542	15,071	
Total/participant (\$)	32,254	-1,022	-8,002	24,251	

³The estimate is not sensitive to the discount rate used. With a discount rate of zero, cost is \$27,790/client and \$13,623/client/year.

Table 14 – MISHA funding, expenditure and cost per client; 2009-13

	2009-2010	2010-2011	2011-2012	2012-2013	Total	Per cent of expenditure
Funding and expenditure: nominal dollars						
Funding (\$'000s)						
Donation (operational specific)	1,000.0	650.0	590.9	235.0	2,475.9	
Donation and other income	0	98.4	87.7	33.1	219.2	
Total income: operational	1,000.0	748.4	678.6	268.1	2,695.1	
MISHA expenditure (\$'000s)						
Salaries and related costs		269.1	551.9	545.0	1,366.1	58.5
Client brokerage		116.5	40.0	14.6	171.1	7.3
Rent, utilities and transport		78.7	140.9	145.9	365.6	15.7
Overheads and other costs		123.3	154.3	154.1	431.7	18.5
Total expenditure: operational		587.6	887.2	859.6	2,334.4	100
Cost per client (2011-12 dollars)						
Total number of clients assisted					84	
Cost/client (\$)¹					27,914	
Average duration of support (yrs)					2.04	
Cost/client/year (\$)¹					13,683	

¹ Adjusted to 2011-12 dollars using the GDP chain price index (Australian Bureau of Statistics, 2013a).

Nearly 60% of all operational cost was staff-related. Table 15 shows that on average, over a 2 year period, caseworkers spent approximately 107 hours per client addressing client needs. This is estimated to equate to a cost of around \$4,690 per client over 2 years. Housing and tenancy issues accounted for 17.4% of caseworker time, substance use issues accounted for 8.5%, mental health issues for a further 13.5%, and family relationships for 2.3%. Assistance in relation to all other issues accounted for 58.2% of time spent by caseworkers dealing with individual client issues.

Table 15 – Average hours of caseworker assistance per client (over 2 years) by support type

Support type	Mean hours of support/client	Proportion of total hours (%)
Housing and tenancy	18.6	17.4
Alcohol and other drug use	9.1	8.5
Mental health	14.4	13.5
Family relationships	2.5	2.3
Other issues	62.0	58.2
Total hours per client	106.6	100.0
Caseworker time: Total cost/client (\$)	\$4,690	

7.3.2 MISHA recurrent cost net of change in cost of mainstream services

If a homelessness support program similar to MISHA were to be implemented by government, the whole of government cost would be defined as the program recurrent cost net of cost offsets associated with change in client use of mainstream services. Survey data suggests that there is potential for substantial government savings from a reduction in use of health and justice services, with only a small increase in the cost of welfare benefits.

As shown in Table 16, the recurrent cost per client net of cost offsets would be around \$18,890 per client, or \$9,260 per client per year, assuming 2.04 years of support. If cost offsets observed in year two of support are able to be sustained, the program would be cost neutral 4.36 years after support commenced. This assumes that support is provided to clients on average for a period of 2.0 years, and year 2 offsets are sustainable for a further 2.36 years after support ceases.

In reality, the MISHA program is expected to continue into 2013-14, and clients are receiving ongoing support. Available data does not provide the average cost per closed support period. Further follow-up of client outcomes would also be required to determine client mainstream service use with continued support and post-support. There is the potential for health costs in particular to continue to decrease on average as more clients achieve sustainable health outcomes. However, what is clear is that the cost of support is substantially offset by savings from reduced mainstream service use over the client support period. These offsets would only need to continue for a relatively short period for the program to be cost neutral. This is significant, given the positive housing, health and other outcomes achieved by the program.

There is also the potential for other cost offsets, such as reduced incidence of eviction and reduced use of crisis/emergency accommodation services once the client is in stable housing. As discussed at 7.4 below, consideration of these potential offsets increase the probability of the program being cost neutral.

Table 16 – Recurrent cost per client net of health, justice and welfare cost offsets (Dollars 2011-12)

	Cost/client (\$)
Recurrent cost per client (2.04 years support)	27,914
Cost offsets from change in mainstream service use ⁴	
Year 1	-1,022
Year 2	-8,002
Total offsets	-9,024
Recurrent cost/client net of cost offsets	18,890
Recurrent cost/client/year net of cost offsets	9,260
Number of years of offsets required for program to be cost neutral ⁵	4.36 years

7.4 Other costs and sensitivity analysis

Estimates of recurrent cost of the MISHA program and the value of health, justice and welfare offsets provide the most objective estimates of program cost given available data. Other cost implications of the program include cost offsets from reduced level of tenancy failures, reduced use of crisis/emergency accommodation, the cost of properties made available to MISHA clients, and sustainability of offsets. This section examines sensitivity of estimated net program cost to these issues.

7.4.1 Tenancy failures avoided

None of the survey participants who completed all three survey waves had a tenancy that ended due to eviction or abandonment. Also, very few MISHA clients had been in a tenancy prior to support, with only four clients (6.8%) in the follow-up group reporting having a community housing or private tenancy in the 12 months prior to baseline. Even considering all clients who completed the baseline survey, only six (8.0%) reported having a community housing or private tenancy in the prior 12 months. No participants reported having a public tenancy. Thus, the survey data does not provide an indication of the likely eviction rate for MISHA clients if they were housed without support. Instead, the

⁴Assumes that without support the cost of health, justice and welfare services used would be equivalent to that incurred in the 12 months prior to the baseline survey. The offset in year 1 of support is equivalent to the difference between the cost of mainstream services in the baseline and 12 month follow-up periods. Similarly, year 2 offset is the difference between baseline and the 24 month follow-up mainstream service cost.

⁵Assumes 2.0 years of support. Offset of \$1,022 in the first year of support. The year 2 offset of \$8,002/year is sustained beyond the second year of support.

potential value of these savings is estimated by comparing the cost to housing providers of the tenancy failures that did occur over the entire baseline sample, with a rate obtained from the literature for potential tenancy failure without support.

There are limited data on tenancy retention rates for the chronically homeless. Zaretsky et al. (2013) found that where men who accessed supported accommodation services had previously been in a public tenancy, the eviction rate in the previous 12 months was 50%. No data are available on the potential eviction rate over two years; however, the first 12 months of a tenancy is recognised as the critical period (Susser et al., 1977). In light of these limited data, a conservative assumption is made that without support 50% of tenancies would have ended in eviction. Recall, that for the total MISHA sample (excluding the four men who died), the 12-month sustained tenancy rate was 97%; this declined slightly to 89% after two years. Zaretsky et al. (2013) also provide a conservative estimate of the cost of eviction from a public housing tenancy of \$4,800/tenancy.

This suggests that if the 59 follow-up survey participants were housed without support, and we apply the same eviction rate to the follow-up group as the total MISHA sample, around 50% would have been evicted over the subsequent two years. The cost of eviction is estimated at \$141,600 or \$2,400/person on average. This is a significant additional cost which is saved through the provision of support. No data are available on the rate or cost to providers when properties are abandoned, or tenancies ended due to imprisonment. However, if no support were provided it is likely that these types of events would result in additional costs, costs that have been avoided through MISHA support.

A more conservative view of the cost savings from evictions avoided is obtained by estimating the actual cost of eviction for the complete baseline sample of MISHA clients, and comparing this with the potential cost of evictions if support were not provided. Again, the assumed cost of eviction without support would be \$4,800/eviction, or \$2,400 per person assuming a 50% eviction rate.

Housing providers were able to provide limited details of costs incurred in relation to failed tenancies, resulting in a conservative cost estimate. In total, the eight failed tenancies had a combined estimated cost of \$24,400, or \$3,050 per event on average. Approximately one-third of this cost relates to lost rent while the property was vacant. The cost of a failed tenancy ranged from zero to \$10,700. The three evictions had an average cost of \$4,500 per eviction (somewhat lower than that provided as a conservative benchmark in our previous Zaretsky et al. (2013) study). This is likely to represent a very conservative estimate, as three of the evictions involved a large clean-up but the clean-up cost was only available for these events. The two properties

relinquished due to incarceration had an average cost of \$3,500 per event, and the three abandoned properties had an average cost of \$760 per event. When considered across the complete baseline sample, the cost of actual evictions comes to \$325 per participant, with an associated savings to housing providers of \$2,075 per participant or \$155,625 in total.

7.4.2 Case studies of tenants

To understand the causal mechanisms through which MISHA support helped to sustain tenancies and avoid the costs of eviction we undertook a series of case studies around a series of themes.

1. Educating the client about their responsibilities as a tenant and developing skills to manage a tenancy

MISHA caseworkers spent a substantial amount of time educating clients about their responsibilities as a tenant. The social housing providers found this type of support from the caseworkers significantly improved their own ability to manage each tenancy. In particular, it was the consistency and repetition of the message that was seen as effective.

Case study 1

MISHA caseworkers also worked closely with clients to improve their personal living skills, such as financial management. This was readily apparent for Fred. Fred was a chronic rough sleeper whose problems with drinking and aggression had placed his tenancy at risk.

When Fred decided to stop drinking and commit to his tenancy, his caseworker realised he would need additional skills to enable him to achieve this. He worked closely with Fred, helping him to budget and organised for his rent to be deducted from Centrepay to avoid further rental arrears. He also worked with Fred on developing his skills in cooking, cleaning and gardening. Fred now cooks dinner for his neighbours once a week and runs the community garden at his complex. He currently needs very little assistance from his MISHA caseworker.

2. Advocating on behalf of clients to address tenancy issues

Social housing providers commented that MISHA caseworkers were very good at pursuing outstanding property issues on behalf of their client. They were also strong advocates for a more lenient approach when it came to managing tenancy issues such as rent arrears, and to some extent, this created tension for the social housing provider. By requesting leniency, caseworkers were able to give their clients more time to get used to the responsibilities associated with being a tenant. This leniency often meant they became better tenants with time.

Case study 2

For Dane, a chronic rough sleeper with alcohol dependence and depression, the persistence of his MISHA caseworker was critical in him being able to develop pride in, and a connection to, home. Dane had a history of childhood trauma and was aggressive and defensive in his interpersonal interactions.

This made it difficult for Dane to engage with both his MISHA caseworker and his social housing provider. Dane's caseworker 'wore him down just by always being there' and gradually he began to trust in, and open up to, his caseworker. During the first year of being housed, Dane's aggressive interpersonal style and dependent drinking resulted in rental arrears, property damage and violent conflict with his neighbours, placing his tenancy at significant risk. Dane's caseworker advocated for leniency with both his social housing provider and the tribunal. Now, Dane is a proud homeowner and his tenancy problems are behind him.

"And he's told me that he can't go back to the streets. So the longer he's stayed in his house the less likely or the less appealing the streets become, and I found that with a lot of the guys. That, yeah, there – there's a therapeutic benefit of just having a house, in terms of his outlook, in terms of his – what he considers normal, in terms of then, what he considers possible, definitely."

3. Acting as an intermediary to facilitate communication between the client and social housing provider

The MISHA clients had higher levels of engagement and trust with their caseworker relative to their social housing provider. This is not surprising given that social housing providers are typically responsible for a large number of tenancies which constrains the amount of time they have to engage with individual tenants. Some MISHA clients would more readily respond to contact from their caseworker. When traditional means of communication (such as telephone calls, letters and visits) failed, the social housing providers would contact the caseworker who would often know how to locate a client and then directly liaise with the client regarding the tenancy issue. This had the effect of reducing the likelihood of a poor outcome for minor breaches.

"Whereas other general clients, you ring them, you can't find them, it stops there. You send the letter, you've got no other point of contact to lead on to find where they are, yeah."

Along with the advocacy engaged in by MISHA caseworkers, this improved ability to communicate meant that social housing providers spent more time with MISHA clients relative to other tenants in their portfolio.

"I feel [MISHA clients] are so lucky. We're always there... compared to other tenants. I feel sometimes, [the other tenants are] on their own."

4. Assisting clients to work through their substance use and other mental health problems

Case managers often indirectly helped clients maintain their tenancies by assisting them to deal with any substance use and mental health problems. Both substance use and mental health problems interfered with a client's ability to maintain their property to a satisfactory standard, make rental payments (sometimes because income was diverted to purchasing alcohol or other drugs), and caused difficulties with neighbours due to disruptive, antisocial or unsafe behaviours. Mental illness also contributed to a client's poor judgement with respect to their choice of friends and acquaintances and in some cases, tenancy problems such as neighbour complaints, could be attributed to the behaviour of acquaintances and friends rather than the client himself.

Case study 3

Lucas had a significant trauma history, including child abuse and neglect, physical assault resulting in a hospitalisation, and an attempt to resuscitate a person who later died. This cumulative trauma load had a significant impact on his functioning.

His marriage broke down and he lost access to his children, he started smoking and injecting drugs, was diagnosed with post traumatic stress disorder and spent 10 years being homeless, including significant periods of rough sleeping. His mental health issues impacted his ability to manage his finances which meant he was often penniless and accrued substantial rental arrears; on several occasions he was threatened with eviction.

Additionally, Lucas found it difficult to trust other people and to feel safe despite now having his own place. His defensive and aggressive behaviour was a challenge for his social housing provider. With the patience and commitment of his MISHA caseworker, Lucas began to understand and accept his mental health problems and traumatic past. This has been a difficult first step for Lucas and one that has now opened the door to treatment and a more stable housing experience.

On the few occasions when it went wrong...

Despite the effort applied to supporting clients in their tenancies, sometimes this simply wasn't enough. In the first twelve months of being housed there were two failed tenancies. Over the longer two year support period there were a total of 8 failed tenancies. In this section we will draw on the experience of the 8 failed tenancies over the two year period, rather than over the 12 month study period discussed above, in order to draw on a broader base of information to understand the reasons for these failures, and as a result better inform improvements in 'housing first' and other interventions aimed at reducing chronic homelessness. Of the eight failed tenancies over two years, two properties were relinquished by clients due to them being in prison, three clients were evicted, and a further three clients abandoned their properties.

Case study 4

Josh was evicted in order to remove a drug dealer and his family that had moved in and ejected Josh from his own property. At the time, Josh was sleeping in his car and had stopped paying rent because he believed he had signed over his lease to his drug dealer.

He didn't disclose his tenancy problems to his caseworker and avoided meeting his caseworker inside his apartment. Thus MISHA were unable to intervene in time to avoid the eviction. Josh had trouble staying engaged with his caseworker, especially when his mental health deteriorated. Although he was linked in with his local community mental health team, he frequently missed his appointments and a clear diagnosis and treatment plan couldn't be established. It also appears that Josh may have felt ashamed about what happened to his tenancy and didn't know how to ask for help.

Prior to accepting his MISHA property, Josh was living in a supported accommodation service that was highly structured and where he had an established network of supports. He would sometimes return to his previous accommodation for a meal and a shower despite having his own property. Josh found living on his own a lonely experience and had difficulty asserting himself in his choice of 'housemate'.

What do the findings tell us?

The case studies highlight the importance of the role of case managers in supporting, educating and working with both clients and housing providers to manage and maintain clients' tenancies. It also highlights the complex needs of many of the clients, and hence the need for a holistic approach to case management. Importantly, the study finds that the provision of housing first and holistic case management to clients with complex housing and personal histories can generate net savings to housing providers and hence a net benefit to the community as a whole.

7.4.2 Reduced use of crisis/emergency accommodation.

Prior to support, MISHA clients in the follow-up sample group made extensive use of crisis/emergency accommodation. In the 12 months prior to their baseline survey, they spent, on average, nine fortnights per participant in crisis/emergency accommodation. This decreased substantially to 0.24 fortnights per participant and then to nil in the 12 and 24 month follow-up periods. At a cost of \$26 per client per day (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013, Table G.3) the cost at baseline equates to \$3,257 per participant. This cost reduced to \$87 per participant at the 12 month follow-up and nil at the 24 month follow-up. Over the two years this represents a total savings of \$6,427 per participant over the survey period.

This represents a significant offset to the cost of providing MISHA support. However, the survey data provides only a rough guide to where a person was living each fortnight over the previous 12 months. As many homeless people move accommodation frequently it is possible that short stays in crisis/emergency accommodation, for example overnight, were not captured in the survey data. Longer stays may have been 'rounded up' or 'rounded down' to the nearest number of complete fortnights spent in this accommodation type. For example, a stay of 10 days may have been rounded up to show a complete fortnight in crisis/emergency accommodation. Therefore this data is indicative only. What is clear though is that there was a substantial reduction in the use of this accommodation type, creating a substantial savings to government.

7.4.3 Cost of housing

MISHA clients have a significant history of homelessness, and very few have spent significant time in public or community housing. The provision of housing to accommodate these clients creates additional demand on already scarce housing resources, including administration, maintenance, and the capital cost. The Productivity Commission provides estimates of the net recurrent cost per dwelling for both public and community housing (Table 17). Given the mix of public and community housing available to MISHA clients, the estimated recurrent cost/dwelling is \$8,586/year. In addition to this, government and community housing providers have capital invested in the properties. The annual cost of this invested capital is estimated at \$15,680/dwelling, based on the average capital value of the public housing properties⁶ available to MISHA clients and applying an opportunity cost of capital of eight per cent (consistent with the rate applied by the productivity commission). The total cost is estimated at \$24,266 per dwelling per year. The recurrent cost is partly offset by rent payments. The average rent paid is estimated based on 25% of the average government benefit received by participants, giving a net recurrent cost of \$4,686 per dwelling per year and net total cost of \$20,366 per dwelling per year. Although this represents a substantial additional cost of support, it should be considered in context. Public and community housing is provided to a range of people with low incomes and other needs that make it difficult or impossible for them to obtain accommodation privately. Therefore, the cost of dwellings should be considered as a cost of providing affordable housing, rather than specifically related to preventing chronic homeless.

⁶ It is assumed that the average value of community housing properties available to MISHA clients is the same as the average value of the public housing properties. All properties are one bedroom units in the Parramatta area, and nearly half of all properties are public housing. Conclusions are not likely to be sensitive to this assumption.

Table 17 – Cost per dwelling NSW (Dollars 2011-12)

	Number of dwellings available to MISHA	Recurrent cost per dwelling ¹
Cost per dwelling/year		
Recurrent cost:		
Public housing	35	7,429
Community housing	39	9,625
Recurrent cost/dwelling: Average		8,586
Opportunity cost of capital invested in MISHA properties ²		15,680
Total cost per dwelling/year		24,266
Cost/dwelling net of rent received		
Estimate of average rent received per property		3,900
Recurrent cost net of rent received		4,686
Total cost net of rent received		20,366

¹ Source: Tables 16A.20 and 16A.22 (SCRGSP (Steering Committee for the Review of Government Service Provision), 2013). Community housing cost/dwelling 2010-11 inflated to 2011-12 dollars using the GDP chain price index (Australian Bureau of Statistics, 2013a)

² Assumes an 8% opportunity cost of capital employed.

7.4.4 Sensitivity analysis

The sensitivity analysis (Table 18) considers the total cost of support once offsets for eviction and reduced use of crisis/emergency accommodation are included. The base case assumes that offsets observed in the second year of support continue. It also implicitly assumes that average offset across all MISHA clients, including those clients with a failed tenancy, is the same as for the 59 follow-up survey participants.

The base case scenario shows that after considering offsets from evictions avoided and reduced use of crisis/emergency accommodation services, the recurrent cost of support is \$9,865 per client, or \$4,836 per client per year. Assuming that the year 2 offsets continue into the immediate future, it would take only 2.79 years for the program to be cost neutral (assuming 2.0 years of support and offsets are ongoing for approximately ten months beyond completion of support).

In reality, MISHA clients are continuing to receive support, so this analysis does not fully reflect the full cost of a closed period of support, nor the value of offsets achievable with this ongoing support. However, it does show that after considering savings from reduced use of mainstream services, the net cost of support is comparatively low and in the medium-term likely to be at least cost neutral. If government were to implement a similar program, and offsets prove to be sustainable, there would be the potential to provide significant long-term whole of government savings.

Scenarios 1 and 2 examine sensitivity of conclusions to the assumption that offsets for clients with a failed tenancy are the same as observed for clients with an ongoing tenancy. Cost per client is estimated first (Scenario 1) assuming that the offset from tenancy failures avoided corresponds to that estimated for the complete baseline sample (which reflected the actual cost of failed tenancies) and that health, justice, welfare and crisis/emergency accommodation offsets for clients with a failed tenancy are 50% of that observed for those with an ongoing tenancy. Scenario 2 assumes the eviction offset is equivalent to that estimated for the baseline sample and where a tenancy failed, no health, justice, welfare and crisis/emergency accommodation offsets occurred.

The analysis shows that, as the number of failed tenancies is small, the net cost of support is not overly sensitive to assumptions surrounding the value of offsets for clients with failed tenancies. Scenario 1 shows that, if the offset for clients with a failed tenancy is 50% of the average observed for clients who completed all survey waves, the average value of health, justice and welfare offsets would be \$8,783 per client. Moreover, the net cost of support, including all offsets, would be \$5,360 per client per year. In the extreme, if mainstream service use by clients whose tenancy failed did not change during or after support, the average net cost of support across all clients would be \$5,725 per client per year.

Table 18 – Sensitivity analysis – recurrent cost of support

	Sensitivity to assumed offsets for clients with a failed tenancy		
	Base case	Scenario 1	Scenario 2
Recurrent cost (\$)			
Cost/client (2.04 years of support)	27,914	27,914	27,914
Less health, justice and welfare offsets	-9,222	-8,783	-8,344
Cost/client net of health, justice, welfare offsets	18,692	19,131	19,570
Less other offsets			
Tenancy failure	-2,400	-2,075	-2,075
Use of crisis/emergency accommodation	-6,427	-6,120	-5,815
Cost/client net of all offsets (\$)	9,865	10,936	11,680
Cost/client/year (\$)	4,836	5,360	5,725
Years to be cost neutral (\$)	2.79	2.93	3.04

7.5 Summary

The recurrent cost of support is estimated at \$27,914 per client, for a mean support period of 2.04 years. After considering health, justice and welfare offsets the net cost is \$9,163 per client per year. In total, the cost of mainstream health, justice and welfare services reduced from \$32,254 per participant in the baseline period, to \$24,251 per participant in the 24 month follow-up period. This represents a large savings to government of \$8,002 per participant per year, at the same time as achieving positive outcomes for MISHA clients.

The majority of this savings came from reduced use of health services, which decreased from \$14,015 per participant at baseline to \$7,448 per participant at the 24 month follow-up. The very high initial health cost is largely driven by a small proportion of participants with heavy use of hospital based services, with 45.8% of participants reporting health costs of \$2,000 per year or less. There was a small decrease in health costs from baseline to the 12 month follow-up, with nearly equivalent proportion of participant reporting an increase in health costs as reported a decrease. In contrast, 71.2% reported a decrease in health costs in the second 12 month period, and the average decrease in health cost was \$6,567 per participant. The pattern of change in health costs was consistent with participants' previously unmet or ongoing needs being met in the initial phase of support, making more efficient use of mainstream services and less use of hospital based services. The cost then decreased markedly in the second period when health issues stabilised.

The cost of justice services was reduced by over 50%, from \$3,710 per participant at baseline to \$1,732 per participant at the 24 month follow-up. This decrease occurred evenly over the two year period and related predominantly to a decrease

in nights spent in prison, visits from a justice officer and being stopped by police in the street. This again results in positive outcomes for clients whilst providing savings to government.

The cost of welfare payments increased slightly, from \$14,529 per participant at baseline to \$15,071 per participant at 24 month follow-up. This was the net result of a small increase in employment, fewer participants experiencing periods of no income and for a shorter time, and a small increase in the cost of Disability Support Pension and Aged Pension. This represents a positive client outcome, achieved for a small increase in government cost.

Sensitivity analysis show that if cost offsets from tenancy failures avoided (\$2,400 per client) and reduced use of crisis/emergency accommodation (\$6,427 per client) are incorporated, the net recurrent cost of support would be reduced to \$9,865 per client, or \$4,836 per client per year, and the program would be cost neutral just under three years after support commenced.

These costs assume that average cost offsets for the eight clients where the tenancy failed are the same as for those clients who completed all waves of the survey. Sensitivity analysis shows that even when it is assumed that no cost offsets are realised for clients whose tenancy failed, the average net cost across all clients is still only \$5,725 per client per year.

In summary the cost analysis shows that if a similar program were to be implemented by government, the cost of support net of savings from reduced use of mainstream services is comparatively low. In the medium-term it is likely that the program would be at least cost neutral, and if cost offsets are sustainable it may create significant long-term whole of government savings.

8. Conclusion

MISHA ran for three years from 2010 to 2013, developing out of the Michael Project with its focus on integrated service delivery but focusing first and foremost on providing homeless men support to enter and sustain permanent housing. The Housing First model adopted as part of the MISHA model is based on the rights to, and benefits of, housing and consumer choice. The MISHA model used scattered site housing leased via social housing providers and a MISHA support team with strong links to existing community programs. Men receiving support from MISHA were chronically homeless on entry to the program, with a substantial proportion first experiencing homelessness in childhood or adolescence.

The present report provides findings on a research study undertaken to examine the MISHA project over its first three years of operation. The study used a mixed methods approach with the focus on a longitudinal survey, the Client Survey, completed with 75 MISHA clients on entry to the program with a final follow up of 59 clients after a 24 month period. Qualitative elements of the study consisted of in-depth interviews with clients as well as in-depth interviews and focus groups with MISHA staff. Tenancy case studies were completed with MISHA staff and managers from the social housing providers.

High rate of sustained tenancies

MISHA provided chronically homeless men with their own tenancy in permanent housing through standard leases with collaborating social housing providers. Given their complex housing histories, the ability of the vast majority of MISHA clients to maintain their tenancy over a two year period is a tremendously important outcome. This finding was compelling and better than expected by those involved in developing the MISHA service delivery model. They indicate that a focus on a Housing First approach can ensure that homeless men sustain their housing. The qualitative research undertaken in relation to the tenancies revealed how precarious many of the tenancies actually were and the importance of the support provided to sustain them. They also reinforce the fact that it cannot be expected that all tenancies will be sustained in a Housing First approach. Most importantly the evidence suggests it is possible to implement a Housing First approach in an Australian setting with high success.

Moderate improvement in other outcomes

Apart from the tenancy sustainability outcome, the MISHA research study suggests that MISHA produced a range of positive outcomes in some areas but little change in other areas. The mental health of participants was poor on entry consistent with prevailing evidence of the mental health of this population. And while it did not deteriorate, little improvement was evident during the two year follow-up period. Levels of psychological distress were higher than general population estimates and remained largely unchanged. Similarly, trauma exposure and posttraumatic stress were more common in the MISHA sample relative to the Australian male population. Levels of post

traumatic stress remained stable during the two year follow-up and a small proportion of participants were re-exposed to trauma over the same period.

Overall, the income and employment status of the follow-up group improved marginally over the two years. More participants were employed and there was a significant fall in the number of respondents who were not in the labour force. Among those in the labour force, those employed increased from 10% to 15% after 24 months. These are positive changes although given the strong relationship between employment, income and mental and physical health, achieving higher rates of employment among the formerly chronically homeless must become a key concern of future homelessness support programs. Several clients switched from Newstart unemployment government benefits to the higher Disability/sickness Support pension (providing more stable income in line with their health needs) and fewer participants experienced periods of no income. These changes help to explain the slight increase in the cost of welfare payments which rose from \$14,529 per participant at baseline to \$15,071 per participant at 24 month follow-up. Higher employment rates (and within that higher full-time employment) among those supported would act to reduce the per participant income support cost over time.

There were mixed results with regard to the broad area of social connectedness, participation and quality of life. While there was an improvement in participants' rating of their physical environment, their satisfaction with their social relationships and physical and psychological wellbeing remained stable. On the one hand, more participants reported social contact with others and there were marked reductions in social isolation due to a lack of social support and community involvement. However, there was little change in the proportion of participants having contact with family or those who felt socially isolated because of a lack of access to their children.

The dislocation from family was a challenging issue that many of the participants faced during their time with MISHA. The results of the baseline survey point to substantial social disadvantage among participants. This is not surprising given one-third of participants were recruited directly from the street and all of the participants had been chronically homeless for one year or more. The results both in terms of mental health and well-being and social participation suggest that even more effort needs to be found to increase the links and connections formerly homeless men have with others and community activity.

The cost of providing MISHA is neutral given the benefits obtained

We estimate that the recurrent cost of MISHA support is \$27,914 per client, for an average support period of 2.04 years. After considering health, justice and welfare offsets (which are significant), the net cost is \$9,163 per client per year. In total, the cost of mainstream health, justice and welfare services reduced from \$32,254 per participant in the baseline period, to \$24,251 per participant in the 24 month follow-up period. This represents a

large savings to government of \$8,002 per participant per year, at the same time as achieving positive outcomes for MISHA clients.

The economic analysis showed that if a similar program were to be implemented by government, the cost of support, net of savings from reduced use of mainstream services, is comparatively low. In the medium-term, it is likely that the program would be at least cost neutral, and if cost offsets are sustainable, it may create significant long-term whole of government savings.

Lessons learned

The report has highlighted a number of difficulties with the implementation of the program and some consequent limitations to how well some of the clients engaged with support services or other activities offered. However, many of these were inevitable teething problems associated with starting a new, and to some extent experimental, program. Mostly these were overcome or addressed as the program matured, and useful lessons have been learned from them, even if some left a legacy well into the life of the project.

The issues faced in implementing MISHA need to be seen in the context of what has, in most respects, been a highly successful project, with retention of tenancies at around 90% over a two-year period. Prior to participating in the MISHA project, many of the clients had longstanding experience of homelessness, and significant mental and physical health issues, often compounded by drug and alcohol use. Yet there is evidence of some improvements in health, well-being and a sense of safety and security. Virtually all clients interviewed referred to MISHA and the project staff in highly complementary terms. Many clients were setting goals for themselves for the future.

Staff were conscious that some clients were still some way from achieving independence and ability to manage tenancies without some outside support, but their assessment was that around 80% of them were 'doing ok', with some just about managing, or 'teetering through', but likely to succeed, and a small group 'still struggling' and liable to lose their hold on housing in the future and return to homelessness if support was discontinued. To a large extent the latter group were predictably those with the most severe issues to start with, including those with drug problems, and those who were insufficiently motivated or unable to engage fully with intensive case management. However, as one staff member said in the focus group, *'I think we're going to be surprised about how well a lot of them do.'*

Based on the research undertaken in this study, the critical elements of the MISHA model that seem to make it as effective as it has been are as follows:

- Good quality and permanent housing available to clients, irrespective of their previous circumstances and equipped to a modest but 'normal' standard;
- Dedicated and skilled staff, providing assertive and wide-

ranging case management support, including living skills and tenancy support;

- A focus on building client independence and self-reliance, including allowing clients to make mistakes but learn from them;
- An effective relationship with housing providers to manage tenancy problems before they become insurmountable;
- Brokered or supported access to a full range of health and ancillary services;
- In-house psychological support and counselling; and
- Opportunities for clients to socialise and engage in educational, sporting and other activities to improve social well-being.

There were also a number of perceived limitations or difficulties which potentially reduced the effectiveness of the program. These would ideally need to be addressed if the project was to be extended or other similar initiatives set up elsewhere.

- Developing relationships with existing service networks before service provision starts;
- Systematic assessment of client intake before housing placement;
- Staggered client intake to allow full assessment and case planning;
- Securing housing – where possible in smaller clusters than what was achievable in MISHA – at a pace consistent with client intake and with some flexibility to allow matching of clients with housing suitable for their individual needs;
- Developing effective tenancy protocols and channels of communication with housing providers from the start of the program; and

Sufficient support for case workers to adapt to the principles of Housing First plus a ratio of caseworker to clients that reflects an appropriate caseload consistent with the level of support needed. The need for additional staff might have an impact on the level of cost savings achieved through such schemes when set against expenditure on the range of public services which derive from homelessness. On the other hand, if the effectiveness of the program is increased these costs are likely to at least balance out.

The shortage of suitable affordable housing is likely to remain an issue, however, for any similar project, which also leads to limited choice of housing type or area. Nevertheless, there has been remarkable success in sustaining tenancies, partly because of the security and pride most clients felt in the housing they had been given, and the support provided by MISHA staff with living skills and managing their incomes to keep up rental payments. The interviews suggest that this can only work, however, if tenancy problems are identified early through clear channels of communication with housing providers.

Appendix 1

Health contacts: NSW population incidence rates and unit costs (2011-12)

	Incidence/year	Cost/ incidence	Source
General practitioner for physical or mental health issue	5.31	41	Department of Health (nd)
Medical specialist consultation	1.24	75	Department of Health (nd)
Psychologist (private consultation)	0.15	102	AIHW (nd) Tables 6.7 and 14.16.
Nurse or allied health professional	1.23	83	Department of Health (nd)
Emergency department	0.31	289	Presentations: AIHW (2013b) Table 5.4 Occasions of service: AIHW (2013b) Table 5.3 Cost/occasion of service (2010-11): SCRGSP(2013) Table 10A.57.
Ambulance	0.13	805	SCRGSP (2013) Tables 9A.31 and 9A.41
Outpatient ¹ hospital, day clinic, mental health facility or drug & alcohol service	2.53	128	Occasions and cost: Hospital, mental health facility, day clinic: SCRGSP (2013) Table 10A.57 Drug and alcohol facility: Occasions AIHW (2013a) Cost/occasion. No data available, assumed equivalent to outpatients hospital.
Times in hospital - at least one night	0.13	8699	Separations, public acute hospitals: AIHW (2013b) Table 7.29 Cost/ separation (excl psychiatric hospital, drug & alcohol): AIHW (2013b) Table 3.18 Days/separation: AIHW (2013b) Table 7.29.
Mental health facility at least one night	0.001	36728	Separations (psychiatric hospital) one night or more: AIHW (2012b) Table S7.1 Cost per patient day (2010-11): AIHW (nd) Table 14.7 Days/separation: AIHW (2012b); Table S7.1.
Times in drug and alcohol facility	0.002	3199	Incidence: AIHW (2012a) Tables C22 and C28 AIHW (2013a) Table 2.2 and discussion regarding treatments. Cost: no data available, assumes equal to daily cost residential mental health services. AIHW (nd) Tables 8.1 and 14.1.
Nights in hospital, one night or more	0.75	1474	Separations, public acute hospitals: AIHW (2013b) Table 7.29 Cost/ separation (excl psychiatric hospital, drug & alcohol): AIHW (2013b) Table 3.18 Days/separation: AIHW (2013b); Table 7.29.
Nights in mental health facility, one night or more	0.04	769	Separations (psychiatric hospital) one night or more: AIHW (2012b) Table S7.1 Cost per patient day (2010-11): AIHW (nd) Table 14.7 Days/separation: AIHW (2012b); Table S7.1.
Nights in drug and alcohol facility	0.02	254	Incidence: AIHW (2012a) Tables C22 and C28 AIHW (2013a) Table 2.2 and discussion regarding treatments. Cost: no data available, assumes equal to daily cost residential mental health services. AIHW (nd) Tables 8.1 and 14.1.
Incidence per year based on NSW population Dec-10 Dec-11 Health costs inflated to 2011-2012 dollars using the CPI Health component (Sydney)	7,179,891 7,258,458		ABS (2012) Table 4 ABS (2013a) Table 5.

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Appendix 2

Justice contacts: NSW population incidence rates and unit costs (2011-12)

	Incidence/year	Cost/incidence	Source
Victim assault/robbery reported to police	0.023	2285	Incidence: SCRGSP (2013) Tables 6A.27 and 6A.29. Cost: assumed equivalent to WA; WA Police (2012) average cost per response/investigation.
Stopped by police in the street or visit from parole or justice officer	0.31	201	Incidence: ANZPAA (2011) Cost: 2 police required to provide back-up Source: NSW Police (2010) Assume ave time taken is half hour, plus a report. NSW Police (2012a): Hourly rate \$122/hour; Report = \$79 (Cost of insurance report)
Stopped by police in a vehicle	0.87	71	Incidence: ANZPAA (2011) NSW Police (2012b) Cost of NSW traffic and commuter services (2010-11) ANZPAA (2011) Number of vehicle related police contacts (2010-11)
Apprehended by police	0.002	381	Incidence: ANZPAA (2011) Cost - Not available, assume equivalent to estimated cost for WA, see Zaretsky et al. (2013)
Court over an incident	0.06	1253	SCRGSP 2013; Cost: Tables 7.5 and 7.6. Finalisations: Tables 7A.9 and 7A.10
Been in prison, remand or correctional facility - males	0.0033	52727	Incidence: SCRGSP (2013) Table 8A.4 Imprisonment rates (male) 2011-12 Cost: SCRGSP (2013) Table 8A.7
Nights held by the police	0.0005	194	Incidence: Not available. Following Zaretsky et al. (2013), assume 20% of arrests. Cost: SCRGSP (2013) Table 8A.7, assumes same as cost of open prison
Nights in prison - males (incl. remand, periodic detention)	0.59	293	Incidence: SCRGSP (2013) Table 8A.1 Cost: SCRGSP (2013) Table 8A.7
Nights in other detention centre (eg. immigration detention centre)	0.097281	445.79	Incidence: Australian Government (2013) Cost: Australian National Audit Office (nd)
Incidence per year (except nights in detention centre) based on NSW population Dec-10 Dec-11	7,179,891 7,258,458		ABS (2012) Table 4
Incidence nights immigration detention based on Australian population	22,512,119		ABS (2013b) Table 4
Justice costs inflated to 2011-2012 dollars using the GDP Chain Price index			ABS (2013b) Table 4

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