

How homeless men are faring: Baseline report from Michael's Intensive Supported Housing Accord (MISHA)



2012



INTRODUCTION

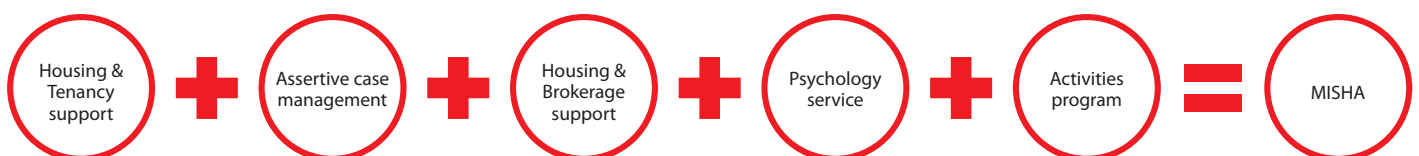
MISHA was developed in response to the learnings of the Michael project – to provide longer term support to clients

Michael's Intensive Supported Housing Accord (MISHA) project is an innovative homeless men's service that links men experiencing homelessness in the Parramatta area to long-term, stable accommodation while supporting them to build the lives they would like to live.

The MISHA service delivery model is based on Assertive Case Management, Supported Housing and Housing First principles: facilitating access to permanent housing on the part of clients and providing a holistic service delivery approach that includes both psycho-social and economic supports to improve well-being and ensure that housing accessed can best be sustained. The MISHA model is client driven, strengths-based and goal-focussed. It has a focus on addressing the psychological impacts and determinants of homelessness and on supporting clients to access meaningful activity, including employment, and to build clients' networks of social support. MISHA seeks to work collaboratively and in partnership with organisations and services.

The MISHA project builds on the already strong links and knowledge developed through the Michael Project on the effectiveness of integrated approaches for clients with multiple needs, and the feasibility (in terms of relative costs and benefits) of providing these services. This baseline report provides an outline of the findings of the MISHA client baseline data analysis.

Figure 1. The MISHA Project model



THE MISHA MODEL

The MISHA Project aims to assist clients to become self-sufficient, by first providing housing and tenancy support.

The MISHA Model is shown in Figure 1 (page 1). A cornerstone of the model, and consistent with 'housing first' principles (Tsemberis, 1999), is the provision of housing regardless of 'housing readiness'. Wrapped around this is an assertive case management approach with access to brokerage and an activities program designed to link participants into their local community. Additionally, the MISHA Project employs a psychologist.

The embedding of psychological services within the MISHA model rather than through partnership with an external agency is in response to the high rate of trauma, mental disorder and difficulty accessing mainstream mental health services among this population. This was one of the key new findings of the Michael Project. Through building collaborative relationships with clients, engaging them in meaningful activity and developing their support networks, the MISHA Project aims to assist clients to become self-sufficient.

It is expected that support services will be provided to clients for 12 to 15 months, on average. However, support services will be tailored to individual client needs and will continue until the client becomes self-sufficient. This will be determined through case management planning and review processes which will indicate when a client has achieved their goals, has built capacity to manage their tenancy and has an established support system (outside of MISHA support services).

The target population for the MISHA Project was unaccompanied adult men aged 25 years or older, classified as being chronically homeless. The latter was defined as twelve months or longer of being homeless, including sleeping rough, staying in accommodation services or residing in boarding houses or other insecure forms of accommodation. The men were also required to be eligible for social housing, have the desire to live independently in the Parramatta area, have an income (for example, government benefit) and be willing to pay rent, and agree to meet with a MISHA staff member on a regular basis.

The MISHA Project sought referrals from existing accommodation services within the Parramatta region (primarily through the

Parramatta Homelessness Coalition). These referrals were targeted at men with low-moderate support needs (approximately two-thirds of all MISHA places). Additionally, an Outreach Engagement Worker was employed to identify entrenched rough sleepers in the Parramatta area and engage them as clients; these clients were preferentially recruited for the high support needs places (approximately one-third of all MISHA places). It was expected that the number of contact hours with the client and the length of time supported would be less for those with low-moderate needs compared to those with high needs, hence a ratio of 2:1 was sought.

Once a client was engaged with the service they were provided with immediate support and the process of accessing a property began. Through partnership arrangements with social housing providers, MISHA facilitated access to properties in the Parramatta area and negotiated security of tenure through a standard lease agreement. Those clients for whom an appropriate property could not be sourced were immediately provided with practical assistance to obtain interim accommodation. A total of 74 properties were secured for the MISHA Project over a 12 month period.

No conditions were placed on clients either to gain or keep their tenancy (other than the normal lease arrangements). Thus clients did not have to maintain abstinence from drug or alcohol use, comply with treatment or demonstrate independent living skills. Additionally, clients were provided with some choice of property (although this was constrained somewhat by delays in the availability of housing), for example, choice of suburb within the Parramatta Local Government Area and choice of scattered or clustered housing (i.e. co-location of property with properties leased by other MISHA clients). Temporary departures from properties due to prison or hospitalisation were managed by the MISHA Project to preserve tenancies. All tenancies leveraged through the MISHA Project are long-term and hence will continue even after case management and other supports are removed.

RESEARCH COLLABORATION

MISHA research examines the effectiveness of the 'housing first' model - this report provides results of the 'baseline' survey to be used for later comparison.

Given the relative infancy of 'housing first' programs in Australia, it was imperative to evaluate the effectiveness of the MISHA model in achieving sustained tenancies and improved psychosocial outcomes for homeless men. A research study is being conducted alongside the MISHA Project and aims to:

- Document the needs and backgrounds of clients on entry to the MISHA Project;
- Assess the effectiveness of the MISHA Project in achieving sustained tenancies, improved health and wellbeing, and self-sufficiency among clients; and
- Demonstrate reductions in costs associated with health, justice, income support and tenancy management as a result of the provision of MISHA services.

The research study comprises both quantitative and qualitative components. The quantitative component involves a 24-month

longitudinal survey with MISHA Project clients and examines how they are faring at five time-points: baseline and every six months thereafter. Survey data will be linked to administrative data such as the intensity of case management provided, uptake of psychological services, and participation in recreational activities.

The qualitative component involves in-depth interviews with the MISHA staff one year into the Project, and a follow-up focus group with case managers and other project staff at 18 months. In-depth interviews will also be conducted with 14 clients, approximately 18 months post-baseline. The qualitative data will contribute to our understanding of the critical success factors and challenges in delivering supported housing, and will also help to elucidate the mechanisms and processes by which client outcomes are achieved.

FINDINGS FROM THE BASELINE SURVEY

The survey's purpose is to assess the level of need at entry to supported housing.

This publication reports on findings from the baseline survey conducted with clients prior to, or just after, they moved into their properties. Clients completed the baseline survey as part of their assessment process. The survey's main purpose is to measure a client's level of need at entry to supported housing and thus provide a benchmark for establishing outcomes at 24 months. The

survey measures need across multiple domains including homelessness and housing, income and economic participation, physical and mental health, and quality of life. Although a broad range of findings is presented in this report, particular attention is given to the health and social wellbeing data.

CLIENT BACKGROUNDS

68% of clients surveyed had completed up to Year 10 level of schooling, around a quarter were born overseas, while 45% had a prison history.

Seventy-five homeless men completed the MISHA Baseline Survey. They ranged in age from 24 to 66 years with half of the participants aged 45 years or under. Most of the men were single (72%) or divorced (17%) and just under half of the participants had children.

A substantial proportion of men completed their school education to at least Year 10 level (68%), with 19% having graduated Year 12 and 43% with a trade certificate or diploma. A small proportion of the men had tertiary qualifications (6%).

Aboriginal and Torres Strait Islander men accounted for approximately 9% of the sample. Approximately one quarter (24%) of the sample were born overseas, most of whom were born in New Zealand or the United Kingdom. Among those born overseas, the predominant means of entry into Australia was through family migration (53%); refugee/humanitarian migration was reported by 20% of the sample, while skilled migration was reported by 7%.

Almost half the participants (45%) had a prison history and the median age at which they were first imprisoned was 22 years of age.

HOMELESSNESS AND HOUSING HISTORY

Around one third of respondents were housed within one month of commencement of support.

Fifteen participants (21%) were classified as having a recent history of chronic rough sleeping. This was defined as six months of continuous rough sleeping or four or more separate episodes of sleeping rough in the past year. Immediately prior to entering the MISHA Project (i.e. commencement of case management support), approximately one-third (30%) of participants were sleeping rough (see Table 1). These findings are consistent with the service recruitment target for 'high and complex needs' clients.

Table 1 shows that upon entry to the MISHA Project, there was a reduction in the number of men sleeping rough, staying in temporary accommodation and institutions/residential facilities and a concomitant increase in the number of men in social housing. This change can be more clearly seen in Figure 2 which shows the number of participants housed per month since entry into MISHA. The direction

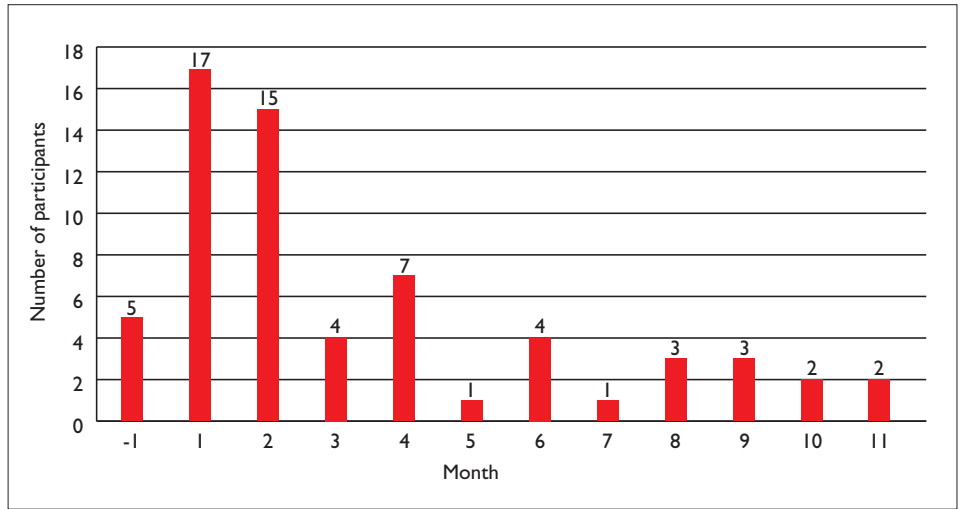
of provision of accommodation as soon as possible following entry to the program is a mainstay of the MISHA program.

Approximately one-third, 34 percent (22 participants) were housed within one month of the commencement of support. A further 23 percent (15 participants) were housed between one and two months after support commenced. This is in-line with 'housing first' principles regarding rapid housing of homeless persons. The delay in housing some participants was due in part to delays to the availability of housing (all properties were part of the Australian Government's stimulus package and hence were either newly built or refurbished properties), as well as a small number of participants being hospitalised for extended periods of time, and hence were housed upon discharge.

Table 1: Accommodation immediately prior to and on entry to the MISHA Project (n=74)

Accommodation type	Prior to the MISHA Project		At commencement of the MISHA Project	
	No.	Percent	No.	Percent
No shelter (rough sleepers)	23	31.1	14	18.7
Emergency, short-term & medium-term accommodation	26	35.1	27	36.0
Temporary accommodation (e.g. couch surfing, caravan, boarding house etc)	15	20.3	10	13.3
Institutional residential (e.g. hospital, prison etc.)	5	6.8	1	1.3
Other accommodation (garage, room only)	2	2.7	2	2.7
Public & community housing	3	4.0	21	28.0
Total	74	100	74	100

Figure 2. Number of participants housed per month from the date of commencement with the MISHA Project (n=64)

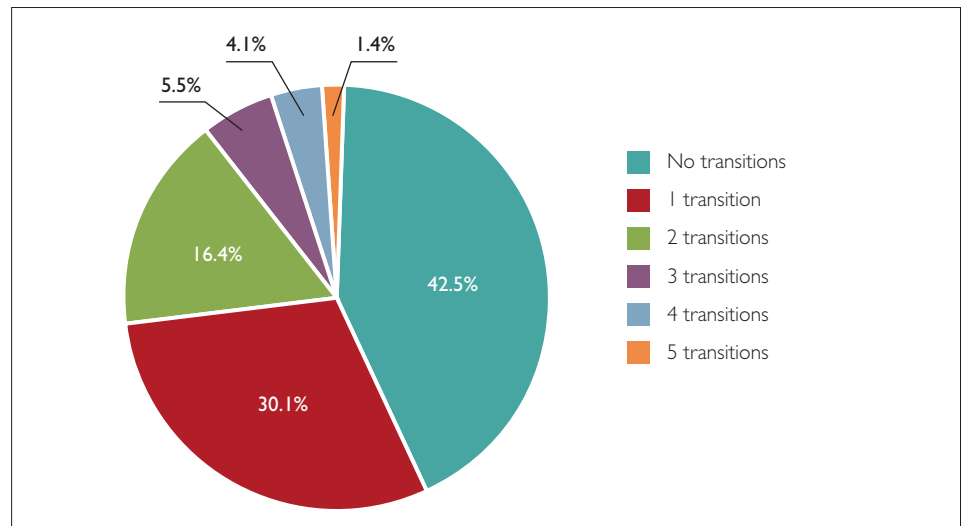


There was limited movement between different forms of accommodation (including no accommodation) among the participants in the 12 months preceding the baseline survey. Figure 3 shows that almost half (43%) the participants were 'stable' in their accommodation. Approximately one-third had moved between two different forms of accommodation, and only 11 percent had moved between three or more accommodation types. This finding is inconsistent with the perception of high transience among the homeless population, however most likely reflects the recruitment of a substantial number of clients from local

accommodation services, including one that provides up to 12 months of temporary accommodation.

Thirteen percent of participants had been barred or blacklisted from private rental or social housing in the past. One-fifth (21%) of participants had lost a tenancy in the year prior to the baseline survey. Eleven participants were evicted and five left for other reasons including feeling unsafe due to other household members, problems or disputes with housing providers, health problems (including substance use) and not having enough time to pay rent. None were evicted for antisocial behaviour.

Figure 3. Proportion of participants experiencing no, single and multiple transitions between different types of accommodation (including no accommodation).



**ECONOMIC PARTICIPATION:
EMPLOYMENT AND INCOME**

Over half of respondents found that their own ill health or disability made finding employment difficult.

Not surprisingly, the majority (87.8%) of participants were not employed. Of this group, 14 participants were classified as unemployed and the remainder were not in the labour force. Eight participants had some form of employment; two of these

participants were currently employed full time. Just over a quarter of the sample had been full time employed within the past two years (see Figure 4). Few people had never worked full time.

Figure 4. Last full-time employment position among MISHA Project participants (%)

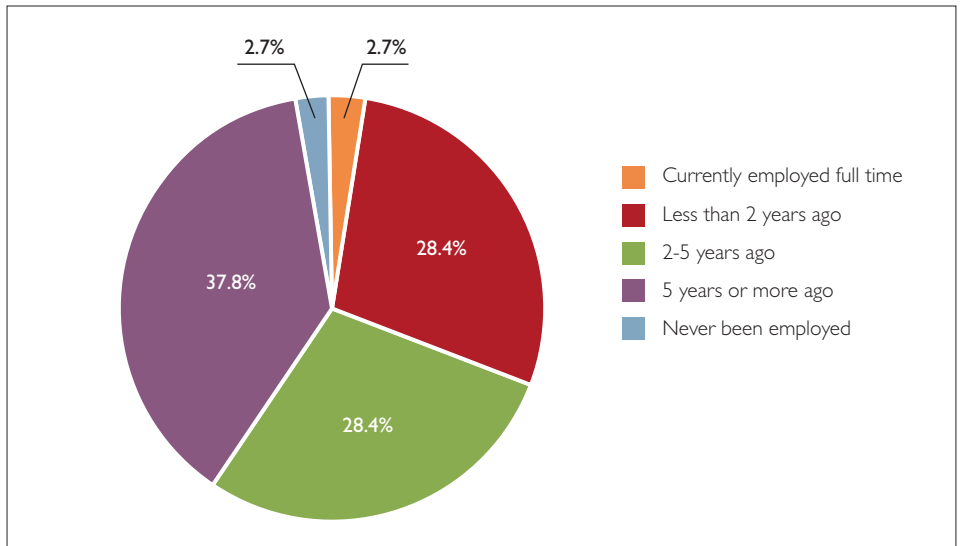
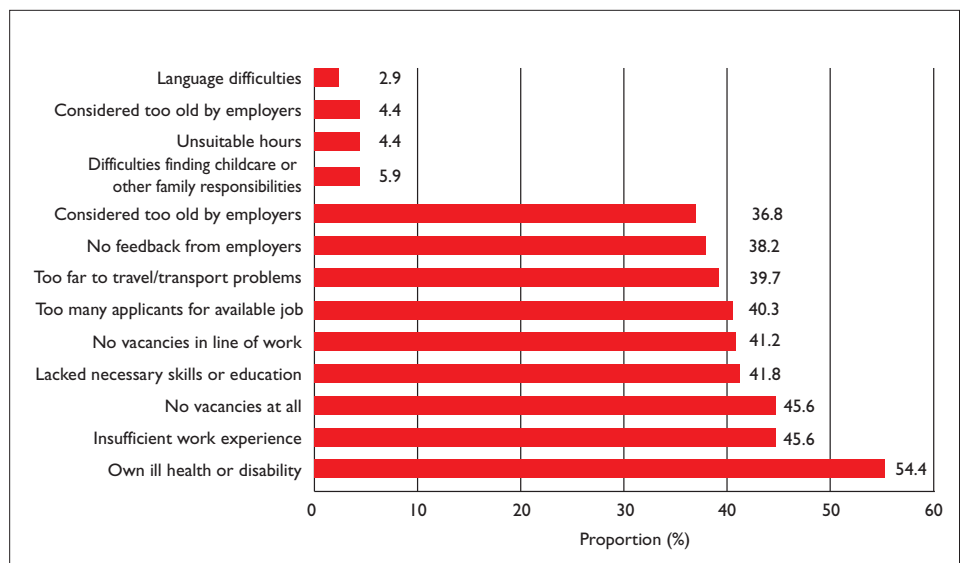


Figure 5 shows the proportion of participants reporting particular difficulties in finding work. The most commonly endorsed difficulty was 'own ill health or disability' which was reported by more than half (54.4%) of the

participants. Insufficient work experience and a lack of vacancies were reported by a little less than half (45.6%) the sample, and 42% indicated they lacked the necessary skills or education.

Figure 5. Difficulties experienced in finding work



With regard to income, 37 participants (49%) were in receipt of unemployment benefits and 35 participants (47%) were in receipt of sickness or disability benefits; the latter is consistent with the previous finding of 'own health and disability' being a barrier to employment for many MISHA participants. Some participants also received income from wages or salary (9%), one participant earned income from their own business, and two received workers compensation payments. Participants were asked to indicate how well

they were managing on their income; these results are shown in Figure 6. While a small proportion (14%) indicated they did not have enough to get by on, the largest proportion of participants felt they had just enough to get by on, (45%). Approximately two-fifths stated they had enough to get by on, however half indicated it was not enough to get back on track, while the other half indicated they had enough for a few extras. Not surprisingly, none of the participants endorsed the statement 'I have much more than I need'.

Figure 6. The extent to which participants report they are currently managing on their income

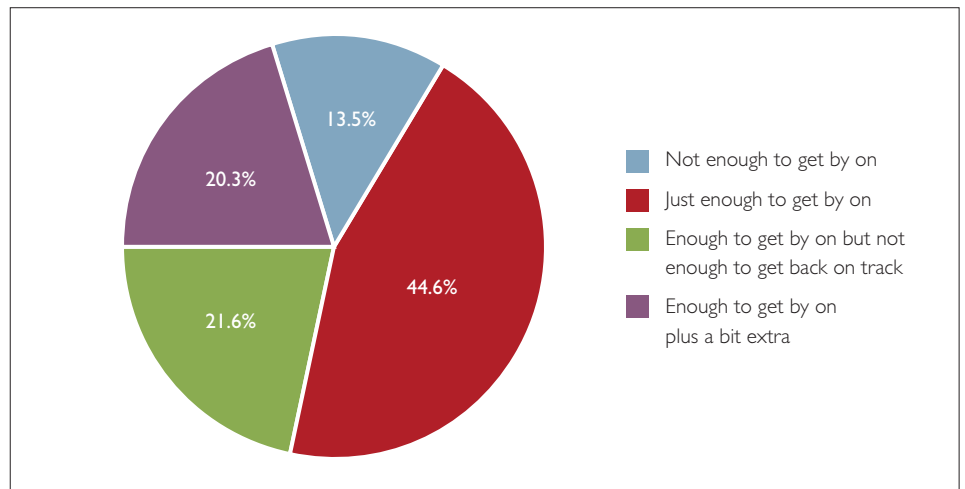
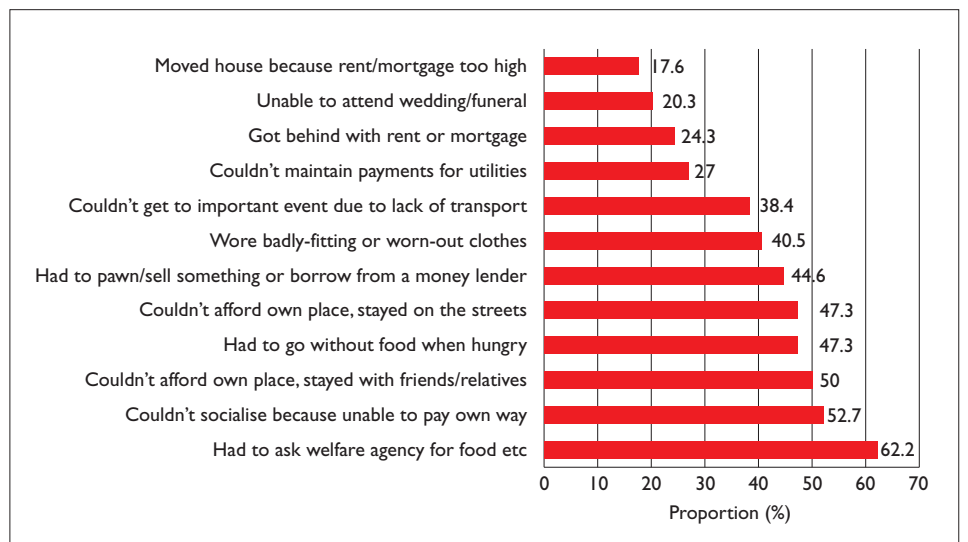


Figure 7 shows the proportion of participants who experienced different forms of disadvantage because of a shortage of money. Almost two-thirds (62%) had to ask welfare agencies for support, approximately half could not go out with friends because they were

unable to pay their way (53%), and half could not afford their own place and either stayed on the streets (47%) or stayed with friends/relatives (50%). A little less than one-half of participants had to go without food when they were hungry (47%).

Figure 7. Experiences in the past 12 months because of a shortage of money



HEALTH AND WELLBEING

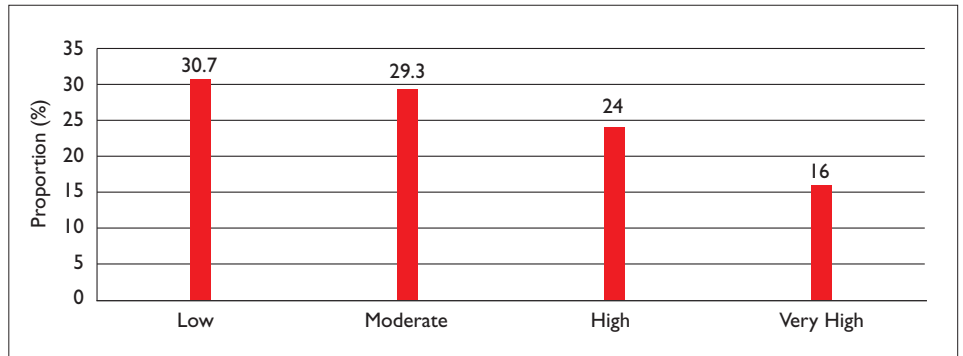
89% of participants reported exposure to at least one traumatic event and 40% were classified as having high to very high levels of psychological distress.

Participants reported a range of longstanding health problems including musculoskeletal problems (20%), respiratory problems (15%), circulatory problems (15%), vision problems (12%) and neurological problems (12%). More than half (58%) of the sample had lost consciousness following a head injury and almost three-quarters (72%) were classified as having a functional disability using the Australian Bureau of Statistics Disability Module.

Dental health was poor: Almost one-quarter (23%) of participants had false teeth or dentures and approximately three-quarters had lost at least one adult tooth. Among the latter, the mean number of teeth lost was 14. This is striking given half of the participants were aged 45 years or less.

Figure 8 shows the level of psychological distress among participants. Psychological distress was measured over the past 30 days using the Kessler 10 instrument (Kessler et al, 2002) and includes indicators of mood and anxiety problems. Forty percent of participants were classified as having high to very high levels of distress at baseline. Given that 19 percent of participants were housed prior to the baseline survey and 32 percent were housed within one month of completing the baseline survey, a large proportion of men entered their accommodation in high states of distress. This has important implications for case management workloads.

Figure 8. Levels of psychological distress among MISHA respondents (n=75)

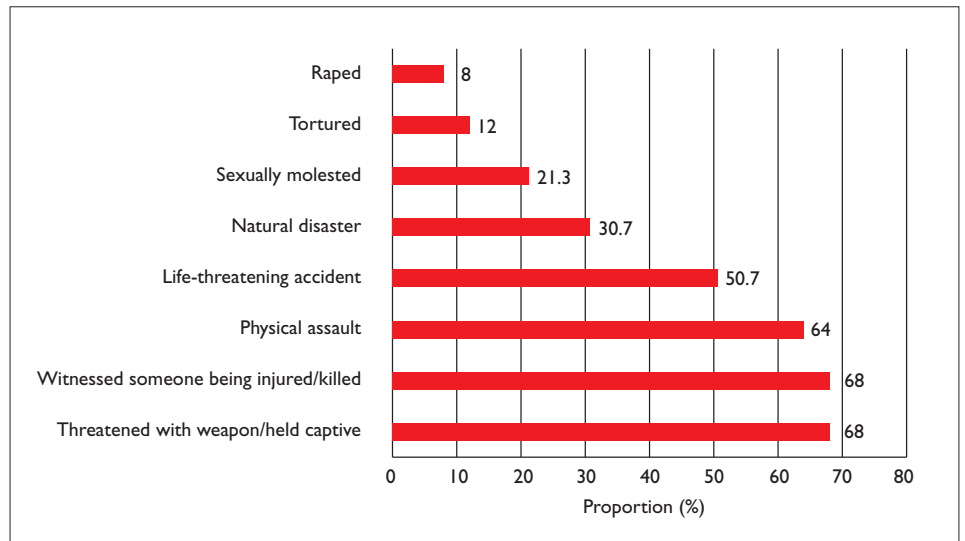


Exposure to trauma was high with the majority (89%) of participants reporting at least one traumatic event. This compares to 64% of males in the Australian general population (Creamer et al, 2001). Figure 9 shows the proportion of participants experiencing different traumatic events. The most commonly experienced traumas were being threatened with a weapon or being held captive, witnessing another person being seriously injured or killed, and being physically assaulted. Approximately two-thirds of the sample had experienced each of these trauma types. Half the participants had been involved in a life-threatening accident and almost one-quarter had been sexually molested. The latter is substantial given this is a male sample and sexual assaults are typically

less prevalent among males relative to females. For example, the lifetime prevalence of sexual molestation found in the 1997 National Survey of Mental Health and Wellbeing (NSMHWB) was 3.5% among males and 10.2% among females (Creamer et al, 2001).

The proportion that screened positive for post traumatic stress disorder (PTSD) among this trauma-exposed group was 23%; among the total sample the rate was 20%. These rates are similar to the findings of the Michael Project. Taylor and Sharpe (2008) report even higher rates of PTSD on the basis of a clinical interview and a sample of both male and female homeless people.

Figure 9. Lifetime prevalence of exposure to different traumatic events among all MISHA respondents

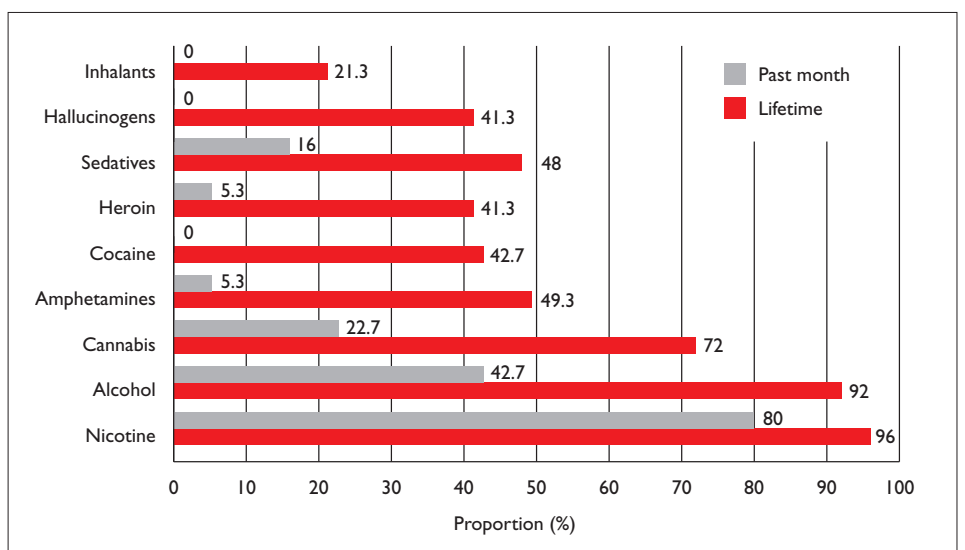


Substance use was high among the participants (see Figure 10). Almost all participants had smoked at some point (96%), almost three-quarters had tried cannabis (72%) and almost half of participants had tried other illicit drugs such as amphetamines, sedatives, cocaine, heroin and hallucinogens. Apart from nicotine, past month prevalence of substance use was substantially lower than the lifetime rates. This may reflect an under-reporting of recent substance use. Despite assurances to the contrary, clients may still have been hesitant to disclose recent substance use to MISHA staff in case it jeopardised their

housing. Additionally, they may not have felt ready to address their substance use problem and hence may not have wanted MISHA staff to know the extent of their use. MISHA staff commented that it often took some time for many of the underlying issues of clients to emerge.

Among those that had used alcohol and cannabis in the past month, the rate of dependence was 46% and 43%, respectively. The rate of dependence on the other drug types could not be determined because there was an insufficient number of participants admitting recent use.

Figure 10. Lifetime and past month prevalence of substance use among MISHA participants



HEALTH SERVICE USE

More than half of participants had recent contact with a mental health specialist, however almost one in five had never used mental health services.

The majority of participants (85%) had seen a GP at least once in the previous 12 months. Approximately one-third (29%) of participants had attended the Emergency Department at least once and been admitted into hospital in the past year. Only a small proportion had been admitted to an inpatient psychiatric facility (8%) or an inpatient drug and alcohol facility (4%) in the 12 months preceding their baseline survey. While the level of contact with hospitals was higher than that of the general population, recent contact with community-based GP's for most clients is a positive finding.

Figure 11 shows the most recent contact with different specialist health professionals. The most commonly accessed health professionals in the past three months were mental health professionals (52%) and drug and alcohol professionals (39%). Podiatrists were the least commonly accessed health professional with the majority (73%) of participants never having seen a podiatrist. This is consistent with the previous finding of low unmet need for podiatric care. Almost all participants had seen a dentist (97%) with approximately one-quarter having done so in the past 6 months and just over half of participants having done so within the past 12 months.

Figure 11. Recent contact with various health professionals among MISHA participants (n=75)

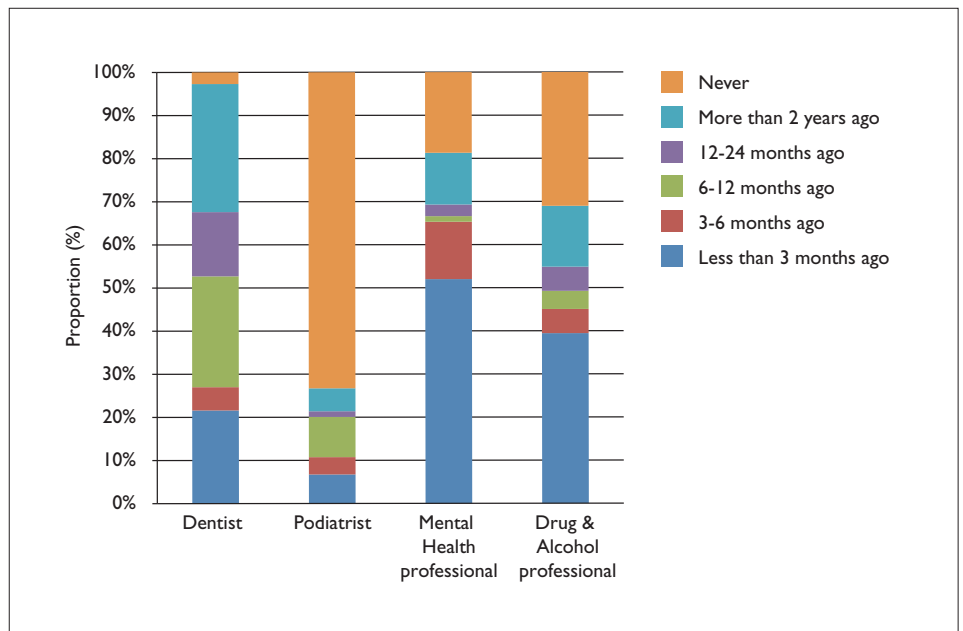


Table 2 shows the level of need for, and access of, different health services. Almost half of participants indicated that they needed dental care in the previous year but did not access it. In contrast, unmet need for podiatric care was much less (19%). Mental health service utilisation was high with more than one-half of participants accessing support at the time of the baseline survey, however, just over one quarter indicated unmet need for mental health support in the year prior to the interview. Approximately one-third of

participants were accessing substance use treatment at the time of the survey but one-quarter indicated they had not been able to access this treatment in the past 12 months despite needing to.

Overall, the vast majority (92%) of participants indicated they had access to medical treatment if needed. Only four participants (5%) indicated they did not have access and that this was because they could not afford it.

Table 2 Health service use and unmet need in the 12 months preceding entry to MISHA (n=75)

	Number of participants	Proportion (%)
Physical Health Treatment		
Needed dental care past 12 months but did not access	35	46.7
Needed podiatry care past 12 months but did not access	14	18.7
Mental Health Treatment		
Currently require support from a mental health professional	38	50.7
Currently receiving support from a mental health professional	42	56.0
Needed mental health treatment past 12 months but did not access	21	28.0
Drug and Alcohol Treatment		
Currently require support from a drug and alcohol professional	23	30.7
Currently receiving support from a drug and alcohol professional	26	35.1
Needed drug and alcohol treatment past 12 months but did not access	18	24.7
Community Treatment Order		
Been on CTO in past 12 months	4	5.4
Current CTO	1	1.3

PROBLEMS AND COPING

Drinking too much and drugs were reported to be a serious problem for approximately one-third of participants.

Participants were asked about a series of problems they may have experienced over their lifetime (Figure 12). 'Drinking too much' and 'taking drugs' were reported to be a serious problem for approximately one-third of participants. Approximately one-quarter of participants had serious problems with 'getting along with family', 'doing things on the spur of the moment', 'repeating the same mistakes', 'mixing with bad company' and 'getting into trouble with the police'. When the proportions are combined for those endorsing individual problems as either 'moderate' or 'serious', the top ten lifetime problems were: 'feeling depressed, anxious or stressed'; 'being bored'; 'repeating the same mistake'; 'doing things on the spur of the moment'; 'drinking too much'; 'mixing with bad company'; 'taking drugs'; 'managing money/debt'; 'getting on with family'; and 'being lonely'.

Participants were also asked to rate the degree to which they had experienced these same problems in the past month. This data is shown in Figure 13. The first thing to note is that the prevalence of serious problems is much less than the lifetime rates, indicating that although participants are still experiencing a range of problems, the severity of these problems is much less. Interestingly, the top ten ranked problems are almost identical to those previously reported for the lifetime rates; there are shifts however in the degree to which each is rated as a 'moderate' or 'serious problem'. 'Feeling depressed, anxious or stressed' and 'being bored' remain as the two most commonly experienced problems, although the proportion of participants endorsing these as 'moderate' or 'serious' problems declined from 57% to 32% and 47% to 30%, respectively. 'Being lonely' became a more

**PROBLEMS AND COPING
(CONTINUED)**

serious problem for participants; while it was ranked 10th in the lifetime ratings, it was ranked 3rd in the ratings of past month problems. In contrast, 'mixing with bad company' drops out of the top ten altogether and is replaced with 'dealing with physical

health problems'. 'Repeating the same mistake' drops to 7th position, 'managing money/debt' drops one position to 8th, while 'drinking too much' and 'using drugs' drop to 9th and 10th position, respectively.

Figure 12. Lifetime prevalence of various problems among MISHA participants (n=75)

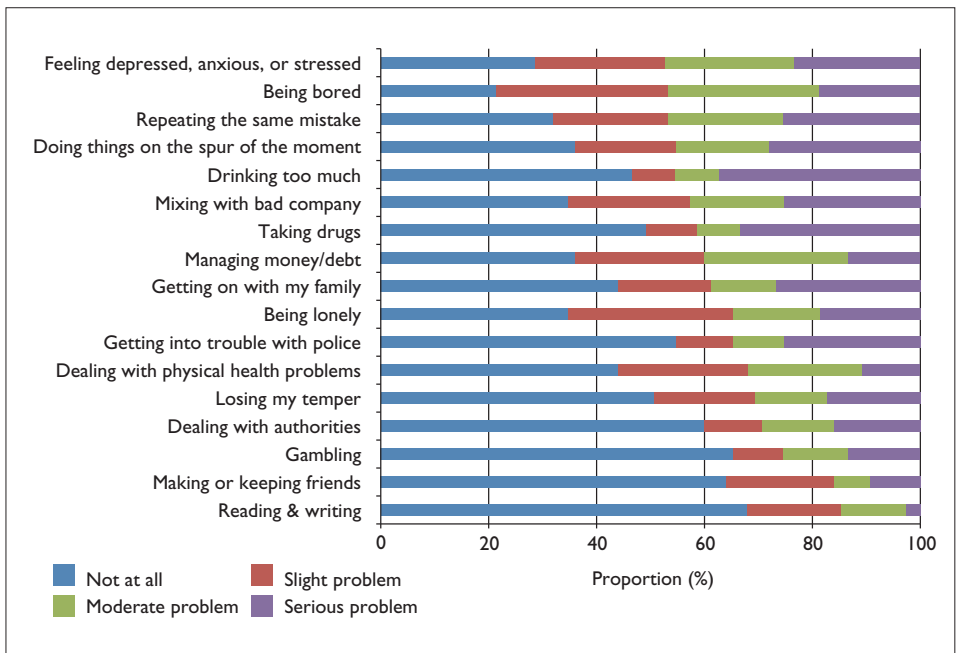
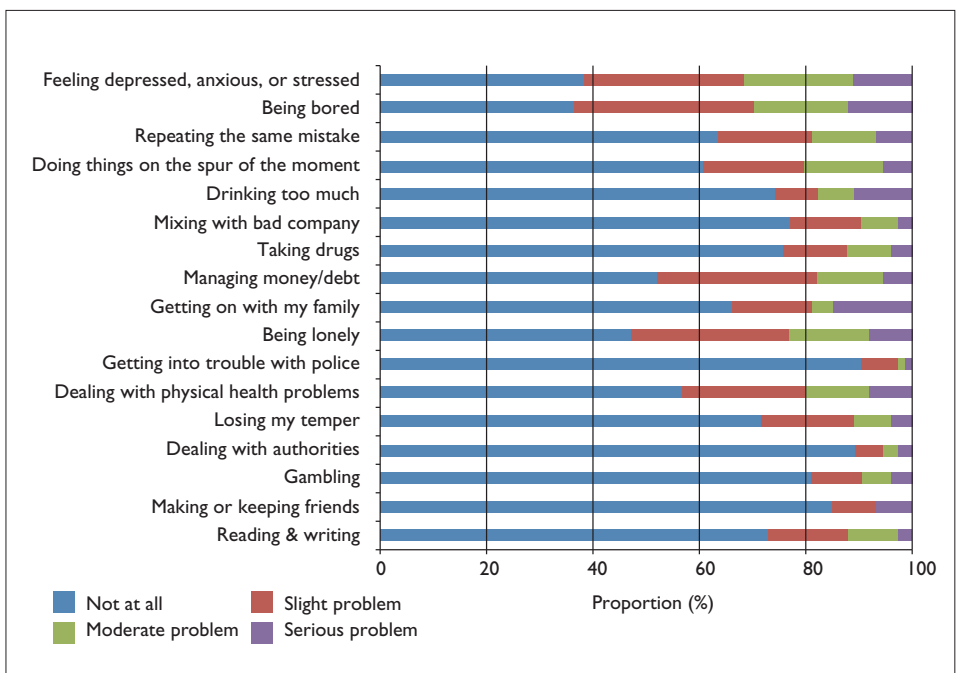


Figure 13. Past month prevalence of various problems among MISHA participants (n=75)

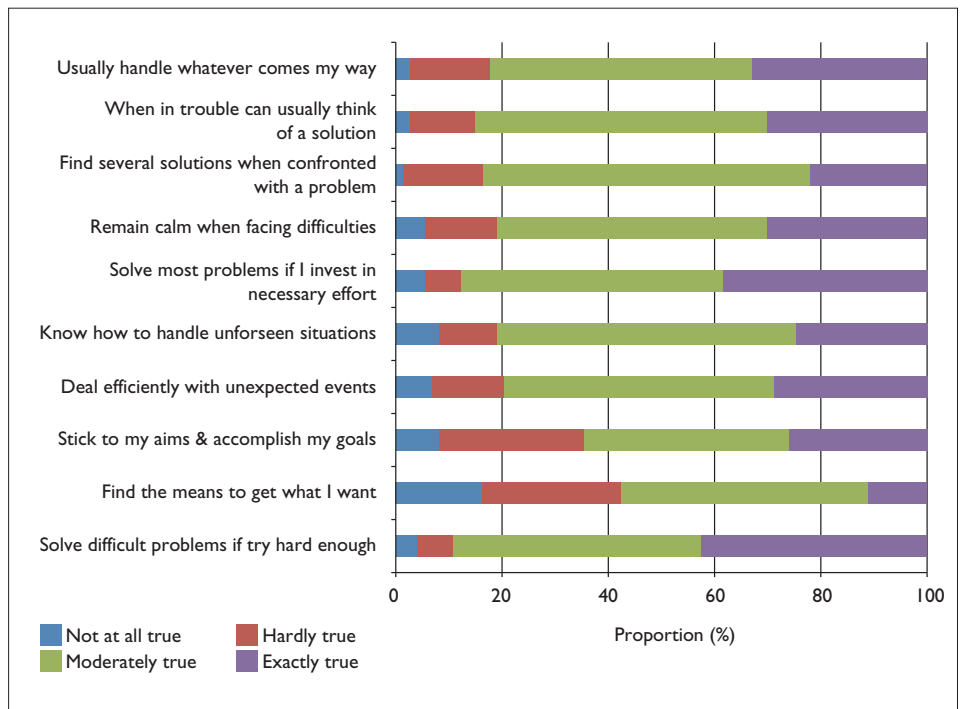


Related to the above measures on the severity of problems experienced by participants, self-efficacy – or the belief in one’s ability to succeed in specific situations – was also assessed. Self-efficacy was measured using the General Self Efficacy Scale (GSE; Schwarzer and Jerusalem, 1995). The MISHA sample had a mean score of 30 (out of a possible score of 40), similar to that of community samples (e.g. Scholz et al, 2002). However, there was high variability among the MISHA participants, from a low of 12 to the maximum score of 40, indicating there are a proportion of MISHA participants who lack confidence in their general ability to manage problems and difficult situations. Figure 14 shows the proportion of MISHA

participants responding to each item as ‘not at all true’, ‘hardly true’, ‘moderately true’ and ‘exactly true’. The majority (at least 80%) of participants indicated most items were moderately or exactly true of them.

There were two items, however, where participants indicated they were less confident. Approximately 40% of MISHA participants endorsed that it was ‘not at all’ or ‘hardly true’ for the item ‘if someone opposes me, I can find the means and ways to get what I want’. A similar proportion (36%) responded in a similar way to the item ‘it is easy for me to stick to my aims and accomplish my goals’.

Figure 14. Item responses to the Global Self-Efficacy Scale among MISHA respondents (n=75)



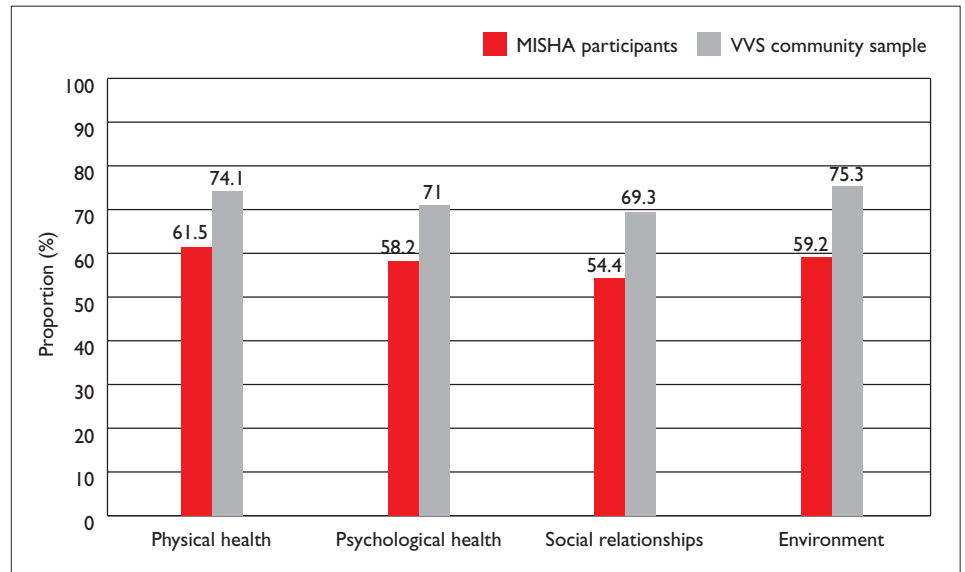
QUALITY OF LIFE

MISHA participants scored lower than the Victorian community sample on all four domains.

Quality of life refers to an individual's overall wellbeing and satisfaction. It was measured using the World Health Organisation Quality of Life (WHOQoL-BREF) instrument which comprises four domains: physical, psychological, social relationships and environment. Figure 15 shows the mean

scores for each of these domains for the MISHA sample and a Victorian community sample of males. Comparable research has been conducted by WHOQOL in Victoria. The MISHA participants scored lower than the Victorian community sample on all four domains, indicating a poorer quality of life.

Figure 15. Mean domain scores for the WHOQoL instrument among MISHA respondents compared with mean scores for the 2000 Victorian Validation Study (VVS) community sample.



PRELIMINARY ANALYSIS AND IMPLICATIONS

More than half of the sample had a longstanding health condition and almost three-quarters were classified with some form of disability.

Prior to commencing with the MISHA Project, participants had experienced numerous difficulties and problems leading to a high degree of marginalisation and social exclusion. This is keenly reflected in the lower mean quality of life scores found for the sample relative to a community sample. It is also demonstrated by the rate of unmet need for physical and mental health services among participants and the heavy reliance on welfare support – including reliance on accommodation and food from support services, as well as disability/unemployment benefits as the primary source of income. The provision of both a *house* and *intensive support* through the MISHA Project will be critical to re-establishing economic and/or social participation for these men.

Physical health and disability was a significant issue for participants. More than half of the sample had a longstanding health condition and almost three-quarters were classified with some form of disability. A little over one-half of the MISHA sample reported their own health or disability impeded them from finding work. Consistent with this, approximately two-thirds of participants were classified as not being in the labour

force and one-third was in receipt of sickness or disability benefits. These findings are consistent with previous research on the link between health status and economic disadvantage.

Trevana and colleagues (2001) found individuals accessing a meal service in inner Western Sydney were 4.5 times more likely to report poor health compared with the broader Sydney population. Moreover, this study found that poor health in this group was significantly associated with accommodation status – that is, those individuals who were homeless were more likely to report poor health than their housed but impoverished peers. Based on these findings, it can be expected that the provision of housing within the MISHA Project could have a significant impact on improving the health of the MISHA participants.

The findings presented in this report establish a baseline pool of information about the characteristics and circumstances of the MISHA client group. Future waves of the survey will be able to measure the progress achieved in the areas of housing and health through the support provided by the MISHA Project.

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