



The Michael Project, 2007-2010

New perspectives and
possibilities for homeless men

■ PATHWAYS AWAY FROM HOMELESSNESS



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Table of contents

Acknowledgements	iv
Research team	iv
About this publication	iv
Executive summary	1
1. Introduction	3
2. Background and context	5
2.1 Current policy context	5
2.2 Development of the Michael Project model	6
3. The Michael Project model and research design	8
3.1 Accommodation	9
3.2 Assertive case management	10
3.3 Specialist services and supports	10
3.4 Client pathways through the Project	13
3.5 Research design	15
4. Outcomes: Change over time across key domains	18
4.1 Profile of the follow-up group	18
4.2 Housing	19
4.3 Labour market and income	21
4.4 Physical health and mental health	25
4.5 Social participation	31
4.6 Summary: Composite profile and outcomes picture	35
5. Understanding the outcomes	39
5.1 Key interview themes	39
5.2 Critical success factors	43
5.3 Summary	48
6. Economic analysis	50
6.1 Summary	50
6.2 Michael Project client costs on entry	51
6.3 Reduction in expenditure over 12 months	53
6.4 Costs of delivering the Michael Project	59
6.5 Net cost of the Michael Project	60
6.6 Conclusion	61
7. Achievements and challenges	62
7.1 Operational achievements and challenges	62
7.2 Research achievements and challenges	64
7.3 Summary	65
8. Conclusion: Implications for policy and practice	66
8.1 Better understanding the circumstances and needs of people who are homeless	66
8.2 Supporting an integrated model	66
8.3 Looking ahead: building on what exists	67
References	68

LIST OF CASE STUDIES

Illustrative client profile on entry: Matthew (Early 40s)	2
Illustrative client profile on entry: Stephen (Early 20s)	17
Illustrative client outcomes at 12 months: Vincent	36
Illustrative client outcomes at 12 months: Tony	38
Illustrative client outcomes at 12 months: Terence	49

LIST OF TABLES

Table 3-1 Michael Project specialist service providers	12
Table 3-2 Data collection methods	15
Table 3-3 Data collection by site	16
Table 4-1 Accommodation situation on entry and at 12 months among the follow-up sample	20
Table 4-2 Accommodation situation on entry and at 12 months among the follow-up sample, by accommodation group	20
Table 4-3 Difficulties finding work, short and medium term accommodation clients, on entry and at 12 months	23
Table 4-4 Sources of income, on entry and at 12 months	23
Table 4-5 Self-reported ability to manage on current income	24
Table 4-6 Difficulties experienced in the last 12 months due to a shortage of money, short and medium term accommodation clients, on entry and at 12 months	25
Table 4-7 Prevalence of health conditions on entry (lifetime) and at 12 months among the follow-up group	27
Table 4-8 Prevalence of mental disorders on entry (lifetime) and at 12 months among the follow-up group	28
Table 4-9 Levels of psychological distress on entry and at 12 months among the follow-up sample	28
Table 4-10 Past month prevalence of substance use on entry and at 12 months among the follow-up group	30
Table 4-11 Past month prevalence of substance dependence on entry and at 12 months among the follow-up group	30
Table 4-12 Social contact in the past week	33
Table 6-1 Health and justice costs on entry among the follow-up group	52
Table 6-2 Health and justice costs on entry and at 12 months among the follow-up sample	54
Table 6-3 Health and justice costs on entry and at 12 months among short and medium term accommodation clients (73)	56
Table 6-4 Health and justice costs on entry and at 12 months among emergency accommodation clients (22)	57
Table 6-5 Health and justice costs on entry and at 12 months among street-based outreach clients (11)	58
Table 6-6 Estimation of cost of Michael Project, by accommodation type	60
Table 6-7 Estimation of net cost of Michael Project, by accommodation type	60

LIST OF FIGURES

Figure 1-2: Location of Michael Project sites	9
Figure 4-1: Increasing attachment to the labour force of clients in short and medium term accommodation, on entry and at 12 months	22
Figure 4-2 Lifetime prevalence (on entry) and 12-month incidence (at 12 months) of trauma exposure, short and medium term accommodation clients	29
Figure 4-3 Proportion of short and medium accommodation clients who did not have various items of necessity on entry and at 12 months	32
Figure 4-4 Comparison of causes of social isolation on entry and at 12 months among short and medium accommodation respondents	33
Figure 4-5 Mean domain scores for the WHOQoL instrument	34
Figure 5-1 Client assessment of how helpful their case manager was in accessing and providing support in respect to Michael Project services.	44
Figure 5-2 Client assessment of how well they understand the issues facing them and how to deal with them compared to when they first started with Mission Australia	45
Figure 6-1 Combined annual health and justice costs on entry and at 12 months, by accommodation group	59

LIST OF DIAGRAMS

Diagram 3-1 Client pathway through the Michael Project (case management)	13
Diagram 3-2 Client pathway through the Michael Project (outcomes)	14

[Case manager] encouraged me to go to NA meetings. He encouraged me to see the psychologist. Encouraged me to see the drug and alcohol worker. He just was a positive influence, you know. He just really just ... Because I was ... I don't know what I was. I was, well not reluctant but I just was ... I wasn't quite ready to really change but that place, the three months I spent there planted seeds and gave me a lot of hope for moving on.

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Finally, thanks to the Michael Project staff and participants who have enabled this nationally significant research to be undertaken, thereby contributing to an increased understanding of homeless men and the policies and practices required to better support them.

RESEARCH TEAM

The Research Team consisted of Paul Flatau, Elizabeth Conroy, Tim Marchant, Lucy Burns, Bridget Spicer, Kathryn Di Nicola, Robyn Edwards, Alicia Bauskis, Marina Athanassios and Karen Larsen.

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ABOUT THIS PUBLICATION

This publication draws on the 'The Michael Project Research Study Final Report' (Flatau et al., 2011), produced by a research team led by Chief Investigator Professor Paul Flatau, Centre for Social Impact, University of Western Australia (formerly Murdoch University) and including staff at the National Drug and Alcohol Research Centre and Mission Australia. The report is available from Mission Australia. It also draws on background material developed for the Michael Project and the general literature.

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Executive summary

On Census night 2006, almost 105,000 people were homeless in Australia, an increase of almost five per cent over the preceding five year period. In 2008, the Australian Government set out a national approach to reducing homelessness, with headline targets of halving overall homelessness and offering supported accommodation to all rough sleepers who need it by 2020, along with a range of sub-targets (Commonwealth of Australia, 2008).

Mission Australia has been supporting people experiencing homelessness since the middle of the nineteenth century. As a major national not-for-profit agency, Mission Australia has long sought to develop innovative responses to emerging social issues. With the benefit of a philanthropic donation, Mission Australia developed an innovative service pilot project, the Michael Project (2007-2010), to work towards better outcomes with men experiencing homelessness in the Sydney metropolitan region.

The Michael Project was grounded in a belief that support can enhance the agency and capability of men experiencing homelessness. This belief, based in literature and practice, acknowledges that people experiencing homelessness may have multiple and complex issues but also have strengths and capacities and are not passive victims for whom things need to be done. While recognising that there was unlikely to be a quick fix solution given the complexity of the issues faced by many of the men, particularly those with long histories of homelessness, Mission Australia anticipated that through working intensively with the men a platform and process could be developed for individual recovery and social inclusion.

The Michael Project service delivery model was comprised of three parts: temporary accommodation (typically up to three months) or outreach support, assertive case management, and guaranteed access to a range of specialist services and supports. This integrated model built on the existing service delivery system by going well beyond the provision of accommodation with a view to improving outcomes in a range of areas. Importantly, this model of support was directed and delivered from within the existing accommodation support system through a significant community collaboration.

A key part of the Michael Project was a research study led by Professor Paul Flatau. A number of important findings were generated, including:

- While there was a great deal of diversity in the client group on entry to the Michael Project, considered as a whole the men had significantly poorer accommodation and health and wellbeing outcomes than the general population, including high levels of psychological distress and trauma, lack of economic engagement, lower incomes, and only loose connections to mainstream social networks. The disadvantage faced by these men was multiple and entrenched, many having experienced long periods of homelessness, and they were among the most socially excluded people in Australia.
- Over the course of a year, the men made a number of positive changes in a range of areas, particularly in the areas of housing, labour force participation, income and social participation. After 12 months more men were in long term housing, in employment and earning income, and feeling less social isolation. Many had moved on from extremely poor housing and social exclusion circumstances into an improved position in virtually all areas measured. As may be expected, the changes in health and mental health over the 12 month period were, while often positive, less marked than those seen in other areas.
- Notably, the men demonstrated a shift in their perceptions about life and possibilities for action. For example, self-efficacy scores increased slightly after 12 months, and men reported improved quality of life and fewer barriers to finding work after 12 months.
- In addition to changes in material circumstance and perception, there was evidence of a shift in service usage. Significantly, analysis of the health utilisation data suggests that while the fundamental health and mental health issues of the Michael Project clients often remained unchanged, use of the health system over the course of a year had altered substantially. At 12 months a reduction in expenditure of \$8,222 per Michael Project client had been achieved over the year. Importantly, analysis of the health service usage data reveals that many men had moved away from using the crisis end to the community end of the health system.

- The agency of the men themselves is central to the emerging outcomes picture. Clients and case managers indicated that three factors were critical to the overall process of achieving good outcomes. Firstly, people needed to be invited and supported into participation, not driven into it. That is, respect needs to sit at the heart of service provision. Secondly, people should be able to access services when they are needed, as referrals through the service system can be poorly managed leading to delays in support and frustration on the part of clients. Thirdly, there needs to be some stability in people's lives to enable them to access and benefit from the services and support.

The research emerging from the Michael Project provides a better sense than ever before of the life histories and circumstances of men experiencing homelessness. It also provides valuable insight from a service delivery perspective into what works, with whom and why. The Michael Project findings 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. Importantly, the cost savings to government in the health and justice areas alone are sufficient to more than cover the total cost of service delivery. Investing in a range of supports and services that are interconnected across a number of life domains and which are provided when required and at the level of intensity needed, leads to better outcomes for men experiencing homelessness and for society and provides a cost saving to government. In short, the Michael Project demonstrates what happens when more resources are funnelled into the existing system of accommodation support and more is demanded of the system and the people within it.

There are clear implications from the Michael Project for the national targets on reducing homelessness both in terms of the outcomes achieved as well as the way they were achieved through collaboration across sectors and specialties. While we need to continually add to the supply of affordable housing we also need to work with what already exists to address homelessness (including the strong accommodation support system), by fashioning appropriate responses to different groups of people who are homeless, and by supporting cultural change in the wider mainstream service system so that these services are more responsive to the needs of people experiencing homelessness. The evidence emerging from the Michael Project has a role to play in informing and influencing future service delivery. A good example of this is the way the evidence emerging from the Michael Project has gone on to inform Mission Australia's work on the next stage of the project, MISHA (Michael's Intensive Supported Housing Accord). We hope that this is just the beginning.

ILLUSTRATIVE CLIENT PROFILE ON ENTRY: MATTHEW (EARLY 40s)

Matthew had a very long history of homelessness. He left his family home at age 14 due to violence in the home and led a transient lifestyle for many years, picking up any casual work he could find. Matthew struggled to obtain secure accommodation over the years. He first slept rough on the streets at age 18 and since then has spent long periods of time on the streets, in crisis accommodation, boarding houses, caravan parks, drug and alcohol rehabilitation, general hospital and prison. Matthew described periods of homelessness:

...it got to the stage where I was living on the street, I didn't care where I dropped, I just threw my swag down, crawled into it and went to sleep. And I didn't care whether somebody knifed me, bashed me, shot me, whatever...

Matthew had developed some serious physical conditions which caused him severe pain and restricted some of his everyday activities. He suffered from blackouts/fits and had ongoing trouble with an ankle which was broken during a mugging.

...had somebody stomp on my ankle, stole my backpack, my wallet and my mobile. Well I drank two casks of wine, that doesn't help and then somebody came along, stomped on me ankle for good measure, stole everything I had...

Matthew reported exposure to multiple traumatic events in his life, the first occurring at a very early age. He had been diagnosed with depression, personality disorder and a substance use disorder, but had not sought help from a mental health professional for some time. Matthew started drinking alcohol at age eight and his drinking had been a problem for him since then.

Matthew was married for a number of years and at times had held full-time employment, but after the breakdown of his marriage Matthew had become homeless again. In the year prior to entering the Michael Project, Matthew spent most nights sleeping on the streets with some time in crisis accommodation. He also spent one month in hospital. He reported that he had a lack of supportive family and friends during that year. He talked about the desperation he felt:

I was so over it. I just wanted to get away from the street, I wanted to get away from the food vans. I mean don't get me wrong, all the organisations they do a good job but I wanted my own independence back.

Despite his many struggles, Matthew had a good sense of his own efficacy. He had developed ways of coping with his difficult circumstances. For instance he spoke about how he coped with a lack of money:

It is extremely hard but I've always worked out schemes and scams and everything like that to make my life better. I'm not doing anything illegal. I'm doing things like I can't afford to buy a lot of brand name things so I substitute.



I. Introduction

On Census night 2006, almost 105,000 people were homeless in Australia, an increase of around five per cent over the previous five years. The majority of people who were homeless were single, 56 per cent were male, and two thirds were over 18 years of age (Chamberlain and MacKenzie, 2008). Recent data indicates that one in every 100 Australians received support from a government-funded specialist homelessness agency in 2009-10. The largest group of users of this support was single males aged 25 years and over. The most commonly reported reasons for seeking support among this group were financial, health or accommodation-related. In their analysis of the data, the Australian Institute of Health and Welfare (AIHW) notes that for single males aged 25 and over; 'drug, alcohol or substance use was reported in a far higher proportion than for other client groups' (AIHW, 2011a, p15). It is also notable that this group of men are generally supported for the shortest length of time of all client groups (AIHW, 2011a).

In 2008, the Australian Government set out a national approach to reducing homelessness, with headline targets of halving overall homelessness and offering supported accommodation to all rough sleepers who need it by 2020, along with a range of sub-targets (Commonwealth of Australia, 2008).

Despite the scale of the issue and the targets set, much remains unknown about people who are homeless. Filling in some of the gaps in our knowledge about issues such as the length of time people spend homeless, prevalence of physical and mental health issues, barriers to employment and gaps in service access, is important to the type of interventions that are proposed and implemented. Equally, there is a need to understand 'what works' with and for people who are homeless. Developing new knowledge in respect of population profile and service practice will help to ensure that policies and practices are tailored appropriately and thus most likely to contribute to achieving the targets set to reduce homelessness.

This publication reports on a significant service innovation known as the Michael Project. A large-scale research project led by Professor Paul Flatau was undertaken to explore outcomes achieved via the Michael Project, the mechanisms and processes influencing these outcomes and the cost effectiveness of the program. This publication fills in some of the knowledge gaps that exist and adds to the body of evidence that policy makers and practitioners can draw on.

The Michael Project was a significant, three-year, philanthropically-funded pilot in Sydney that aimed to improve the social inclusion of homeless men through enhanced, timely and integrated homeless service delivery. The project was run between 2007 and 2010 by Mission Australia, a large national non-profit community services organisation. The experience of delivering the Michael Project has gone on to inform Mission Australia's work on the next stage of the project, MISHA.

The Michael Project had four objectives, underpinned by a conviction that providing support can enhance the agency and capability of homeless men:

1. To improve the health and wellbeing, social participation and economic participation of homeless men.
2. To improve access to stable, secure and long term accommodation for homeless men.
3. To articulate and implement a new model of support for homeless men.
4. To provide an evidence base for policy and program development in the delivery of services to homeless men.

The purpose of this *Social Innovation in Action* report is to describe and analyse the Michael Project and thereby add to the evidence base about the circumstances and needs of homeless men, describe the outcomes achieved, add to the evidence base about what works in service delivery, share the lessons learnt from the Michael Project with a wide audience external to Mission Australia, inform further service development within the sector, and influence policy development.

This publication contains seven sections:

1. Background and context: addressing the research, policy and organisational context for the development of the Michael Project.
2. The Michael Project model: describing the three components that comprised the Project as well as an overview of the research design.
3. Client outcomes: describing and analysing the changes in circumstances for the men over the course of one year.
4. Understanding the changes: discussing the processes and mechanisms that contributed to change.
5. Economic analysis: discussing the cost effectiveness of the Michael Project.
6. Achievements and challenges: describing the lessons learned from the operational and research dimensions of the Michael Project.
7. Implications for policy and practice: extrapolating from the experience of the Michael Project to understand how to better address homelessness.





2. Background and context

Homelessness has a number of causes which can be structural, social or individual in nature. Structural factors include poverty, unemployment, unaffordable housing, and large scale housing and other social policies, while individual factors can include mental illness or substance abuse (Main, 1998).

Mission Australia has been supporting homeless individuals and families since the middle of the nineteenth century. In this time, approaches to working with people experiencing homelessness have undergone profound change. Currently, Mission Australia operates more than 100 homelessness services working with close to 30,000 people across the country. In addition, a number of other service areas including employment, children and families and youth, work with people that are homeless or at risk of being homeless.

Mission Australia's homelessness services cover a variety of approaches to service delivery, and include prevention services, transitional models of support, and housing first models. This emerges from an organisational perspective that there needs to be a range of options available for a diverse group with often disparate needs, and that homelessness cannot be solely addressed through one service delivery model.

2.1 CURRENT POLICY CONTEXT

Prior to 2009, the two major national programs targeting people who were homeless or at risk of homelessness in Australia were the Crisis Accommodation Program (CAP) and the Supported Accommodation Assistance Program (SAAP).

CAP was the capital funding program that provided for the purchasing, leasing and replacement of dwellings used by governments, churches and welfare organisations to assist those who were homeless or at risk of homelessness in the short and medium term.

SAAP was the accommodation and service response complementing CAP and the main policy response of the Australian government to homelessness. It was created in 1985 as a consolidation of a number of federal and state/territory programs and was supported by the *Supported Accommodation Assistance Act 1994*. The program provided funding to non-government, community and local agencies to provide services to a range of groups: single men, single women, families, young people, and women and children escaping domestic violence. The services provided by SAAP included housing/accommodation, financial/employment, personal support, general support/advocacy, and specialist services (AIHW, 2008).

The election of the Australian Labor Party (ALP) Federal Government in 2007 set underway two simultaneous processes which were to have an impact on policy and program responses to homelessness. The first of these processes was a commitment by the Australian Government to 'halve homelessness by 2020 and offer supported accommodation to all rough sleepers who need it'. The detail of this commitment was set out in a White Paper, *The Road Home*, which laid out a national approach for reducing homelessness and set interim targets for reducing homelessness in certain areas by 2013, including:

- reducing overall homelessness by 20 per cent.
- reducing primary homelessness by 25 per cent.
- reducing the proportion of people seeking specialist homelessness services more than three times in 12 months by 25 per cent (Commonwealth of Australia, 2008).

The White Paper identified three strategies for reducing homelessness:

1. Turning off the tap - services will intervene early to prevent homelessness.
2. Improving and expanding services - services will be more connected and responsive to achieve sustainable housing, improve economic and social participation and end homelessness for their clients.
3. Breaking the cycle - people who become homeless will move quickly through the crisis system to stable housing with the support they need so homelessness does not recur (Commonwealth of Australia, 2008).

The second of the processes to influence approaches to addressing homelessness in Australia was the National Affordable Housing Agreement (NAHA). The NAHA is the main funding instrument through which funding for housing assistance, social housing maintenance and specialist homelessness services (including those which provide accommodation support) are provided. Under the agreement, the Australian and state and territory governments will provide \$1.1 billion in funding over five years.

A National Partnership Agreement on Homelessness (NPAH) was developed to support the NAHA outcome *People who are homeless or at risk of homelessness achieve sustainable housing and social inclusion*. The NPAH (2009-2013) is designed to deliver four outcomes, working towards the White Paper interim (2013) targets:

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.

The reform agenda has outlined a bold new path and energised the sector. However, different states are moving at different speeds and, while there is good progress in some areas, the national picture is varied.

2.2 DEVELOPMENT OF THE MICHAEL PROJECT MODEL

In 2007, a private donor approached Mission Australia with a proposal to fund work with homeless men in the Sydney region. Drawing on the research evidence, practice wisdom and a thorough understanding of current service delivery models, Mission Australia and the private donor worked together to develop and deliver the Michael Project.

In 2007, as the model was being developed, Mission Australia delivered a range of services to homeless men in the metropolitan Sydney region, principally funded through SAAP. These services generally provided clients with short term accommodation of up to three months and supported them through case management. In addition to this, Mission Australia continued to develop innovative responses to working with homeless men, and most notably had completed the redevelopment of Campbell House into the Mission Australia Centre (MAC) in the inner city of Sydney in 2005 (Mission Australia, 2009).

Mission Australia's service delivery experience and knowledge of the national and international homelessness literature suggested that homeless people, compared with the general population, often have:

- Higher rates of health and mental health issues including substance abuse.
- Weaker mainstream social support networks and poorer family relationships.
- Insufficient income linked to weaker attachment to the labour force and poorer educational outcomes.

Additionally, in Mission Australia's experience:

- Access to the diversity of services required by an individual is sometimes limited.
- There are long waiting lists for services.
- Service delivery is often organised in discrete parcels (i.e. not integrated).
- Not all services required are available or available when needed.
- Homeless men often struggle to follow through on referrals to needed health and community services due to a range of reasons, including high personal anxiety and trepidation about negotiating the system.

The result has often been a limited continuum of care for homeless people.

Practice wisdom from Mission Australia services and initial evidence from the new service model operating at the Mission Australia Centre suggested that meeting a broad range of clients' needs across different like domains (health, wellbeing, and social and economic participation) through an integrated service system ensured faster and more effective access to services and the ability to address multiple issues simultaneously. This in turn appeared to lead to better client outcomes and clearer pathways out of homelessness. Emerging evidence from international practice and literature also suggested that clients receiving direct and integrated service responses have better outcomes than those receiving discrete and separate services (see for example Neale & Kennedy, 2002). At the heart of this learning was recognition that accommodation alone is unlikely to be sufficient for most people entering accommodation support services.

Through the Michael Project, Mission Australia sought to build on this practice wisdom in a way that worked with what was already provided through the existing SAAP homelessness service system. It sought to augment and develop the existing service system response in order to meet the shortcomings of that system. The gaps which were identified were initially in respect of those specialist services and supports which homeless men found it difficult or impossible to access, such as a dentist or psychologist, but which would make material difference to their lives.

The Michael Project also asked more of the accommodation support services that Mission Australia was running. For example, prior to the Michael Project, case management was already provided through the Mission Australia accommodation support services but it functioned differently at each of the different sites using different approaches. There was also a limit to how effectively case managers could work with clients given that many of the services that clients needed were not available and there were no funds to purchase them. By providing a range of specialist services and supports, the Michael Project challenged case managers to consider what was now possible when working with their clients.

An important feature of the Michael Project design was that the specialist services were provided from within the accommodation support system. In practice, this meant that Mission Australia's accommodation support services either directly employed the specialist services and supports or contracted them to directly provide a service. It was anticipated that better outcomes for homeless men from the pilot would in turn lead to significant cost savings which would show the cost effectiveness of providing a more effective service system response.

Both the donor and Mission Australia recognised the importance of articulating, recording and evaluating the Michael Project in a systematic and rigorous way. Thus an important component of the Michael Project was a research study conducted by Murdoch University and the National Drug and Alcohol Research Centre (UNSW) in collaboration with Mission Australia. The research project sought to describe the profile of the men entering the Michael Project, the outcomes achieved at three months and at 12 months, identify the mechanisms and processes influencing these outcomes and estimate the cost effectiveness of the program. The centrepiece of this research was the largest longitudinal survey of homeless men yet conducted in Australia, providing evidence of outcomes over time and collecting data through which the health and justice costs of these men could be estimated.¹

¹ For full details of the research design see Section 3.5 and Flatau et al., 2011, Chapter 3.



3. The Michael Project model and research design

The Michael Project model was heavily influenced by a belief in the agency and capability of men who are homeless. This belief was grounded in literature and practice which acknowledges that people who are homeless may have multiple and complex issues but also have strengths and capacities. The core characteristic of a capability approach, synonymous with the work of Sen (1999) is its focus on what people are effectively able to do and to be, that is, on their capabilities. Findings from studies such as Guarnaccia and Henderson (1993) illustrate that homeless people can regard themselves as quite capable of meeting life's demands. Such findings act as a caution to approaches which see people experiencing homelessness as passive victims for whom things need to be done. For Marmot and his colleagues (2004), control is at the heart of the matter. The more control you feel able to exert over your situation, the more likely stress is to be stimulating rather than corrosive. This is supported by the Social Policy Research Centre (SPRC, 2008) study on self reliance among people who were homeless, where respondents frequently identified resuming some measure of personal control over their lives as an important prerequisite for 'getting back on their feet.'

While recognising structural factors associated with homelessness (especially in Sydney which has one of the most expensive housing markets in the country and pockets of high unemployment), the Michael Project was an initiative which sought to work with individual strengths rather than weaknesses and which sought to support the development of self-efficacy.

The development of the Michael Project was supported through an articulated theory of change, a program logic and an outcomes hierarchy. While recognising that there was unlikely to be a quick fix solution, given the complexity of the issues faced by many of the men, Mission Australia hoped and expected that a platform and process could be developed for the men's self recovery and social inclusion. The Michael Project model had the following key characteristics:

- An underlying assumption that support can enhance the **agency and capability** of homeless men.
- A **focus on outcomes** that went beyond accommodation to a range of key domains (health, wellbeing and social and economic participation).
- **Facilitated access** to a range of support services otherwise not available/accessible to homeless men.
- A **suite of services** that were provided across metropolitan Sydney (i.e. They were not site-specific).
- **Delivery of the specialist services** (typically not funded by SAAP) through the homeless service sector.
- The services were **mobile and delivered 'in house'** - services went to clients (rather than clients having to go to services) or clients were transported to services.
- A **case manager for all** residential clients, who facilitated continuity and consistency of care. Outreach workers were case managers for the non-residential clients.

The following principles underpinned the Michael Project service delivery model:

- Individualised – met the diverse needs of clients across the key domains.
- Integrated – a network of diverse service types, with consistent referral/follow up processes and data collection systems.
- Intense – had the capacity to engage clients in multiple services simultaneously (and thereby address multiple issues at the same time).
- Appropriate – services targeted specific identified needs of clients.
- Timely – there was fast access to services and they were available at the right time and place for the client.
- Direct – clients could be directly referred to the different services from any point in the service network.
- Continuous – case management practices and service data collection processes allowed for continuity of care for clients across service types and with minimal time gaps in service use/uptake.

The Michael Project service delivery model consisted of three elements in combination:

1. Accommodation or outreach support.
2. Assertive case management.
3. Specialist services and supports.

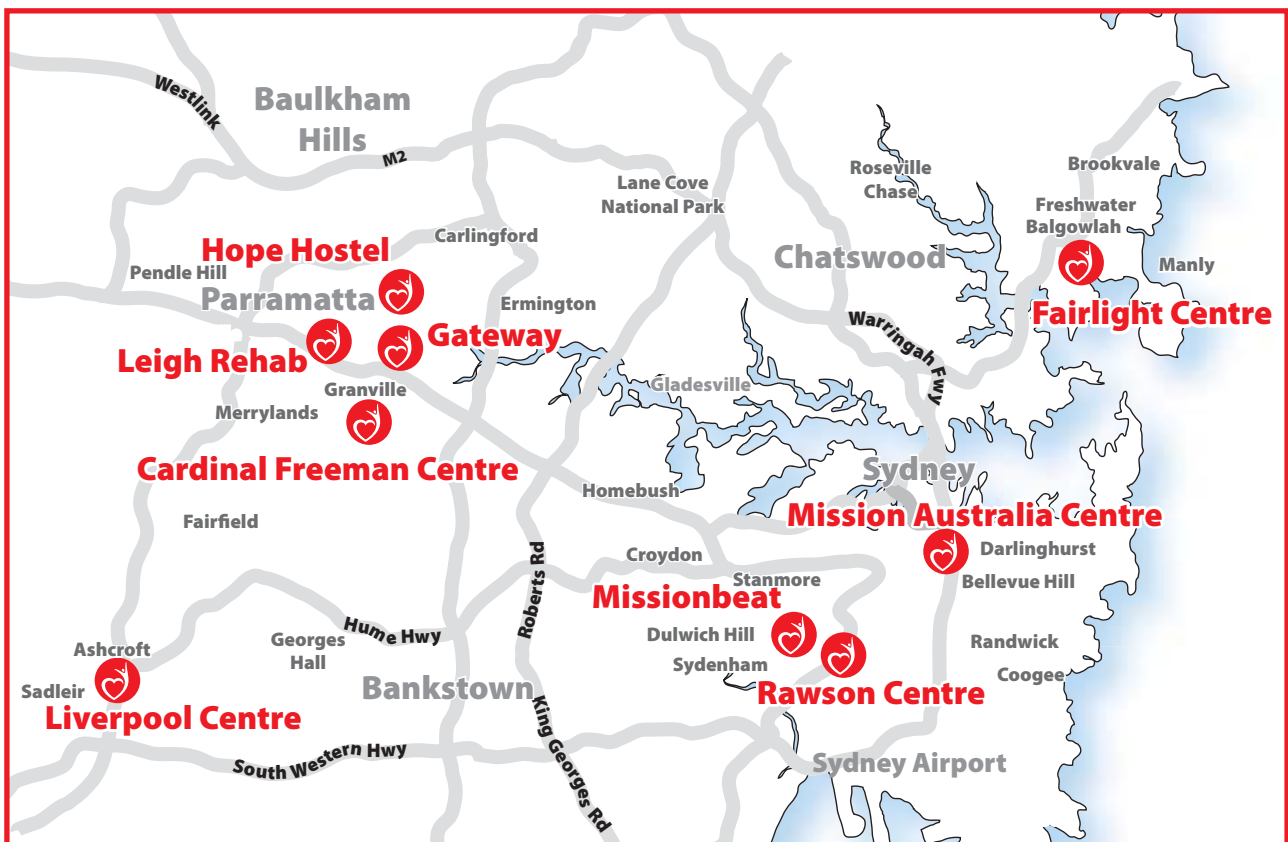
The intention of the Michael Project was that anyone accessing accommodation or outreach support through the services involved (see below) would be offered assertive case management and guaranteed access to specialist services and supports.

3.1 ACCOMMODATION

The accommodation aspect of the Michael Project drew on what was already being provided for homeless men in Sydney under the SAAP program by Mission Australia and its Parramatta Coalition partners. A continuum of accommodation was available, ranging from emergency accommodation (Rawson Centre: 1-3 nights), short term accommodation (Mission Australia Centre, Fairlight Centre and Liverpool Centre: 3 months) to medium term accommodation (Gateway: 12 months). MARSS and the services that form part of the Parramatta Coalition provided a range of accommodation services ranging from short term crisis housing to medium term scattered site accommodation. The accommodation provided at the sites also varied. Most accommodation was provided in a congregate setting which ranged from dormitory-style accommodation, older-style separate bedrooms with shared bathrooms, to modern units with individual bedrooms, shared amenities and a range of facilities on site. The Missionbeat street-based outreach service was also included as a site for delivery of the Michael Project to homeless men.

While men accessed temporary accommodation or outreach services, they would have access to assertive case management and the suite of specialist services and supports. Given that most of the services provided accommodation for a period of 12 weeks, this was likely to be the window during which most men were able to access the assertive case management and specialist services and supports.

Figure 1-2: Location of Michael Project sites



3.2 ASSERTIVE CASE MANAGEMENT

Case management is a client delivery framework widely used within the human services sector. It is used broadly across Mission Australia's diverse suite of community support programs.

The Michael Project sought to operationalise best practice knowledge about assertive case management approaches, and drew on good practice principles outlined in the literature including the value of being persistent, active, following clients' self-directed priorities and timing, respecting clients' autonomy and nurturing trust (see Morse, 1998). The Michael Project case management processes were designed to be persistent, practical, reliable and comprehensive, which were also characteristics of good practice identified in a recent AHURI synthesis of 53 empirical resources (Gronda, 2009).

It is standard practice for all people who come through Mission Australia accommodation support services to be allocated a case manager who works with the individual on their goals. In the case of Missionbeat, the outreach worker was considered as the case manager for the purposes of the Michael Project.

The term 'assertive case management' refers to a set of case management practices that go beyond the previously applied standard SAAP case management at each service. It is a consistent way of working with clients that emphasises active engagement, frequent contact and integrated, timely and appropriate support. Homeless people face a number of barriers to accessing services and programs that could potentially assist them, including practical factors such as cost, transport, eligibility rules or program scheduling, cultural factors, personal factors related to mental health and cognitive functioning, and the stigma associated with being labelled homeless (Watson, 2005). Assertive case management is designed to assist clients to overcome these barriers to participation and provide active support to maximise the benefits for clients.² It built on the case management that was already provided through the accommodation services and involved case managers in its development.

3.3 SPECIALIST SERVICES AND SUPPORTS

Guaranteed access to a range of specialist services was one of the central innovations of the Michael Project. The Michael Project layered a number of specialist services and supports on to the existing footprint of service provision to provide the types of support that were commonly needed by men experiencing homelessness but were difficult to access. Importantly, these services were mobile and delivered 'in house', not from single fixed location as through the Mission Australia Centre (Sydney) and Sacred Heart Mission (Melbourne) or in other international jurisdictions such as the Hunter Street Homeless Health and Social Care Centre (Glasgow, Scotland). The intention was to reach as many men as possible in the Sydney metropolitan region with as many as possible of the services they needed.

The choice of the particular additional specialist services and supports was made on the basis of consultation with service managers and a review of the literature. The services and supports recommended by service managers had not always been explored by the academic literature on homelessness service delivery. The literature review pointed to the proven efficacy of certain services such as dentistry and the outreach nurse but had less to say, for example, with respect to literacy and numeracy training and barber services (Mission Australia, 2008).

The chosen services were grouped in three overlapping domains, namely health and wellbeing, social participation, and economic participation, and were to be accessed by the individuals in consultation with their case manager. The services were:

- Mobile street-based health outreach: this provided outreach nursing care to people on the streets. The principal forms of support were advocacy and social support, case co-ordination and assistance with physical health issues.
- Mobile street-based Aboriginal and Torres Strait Islander outreach: this provided outreach support to Aboriginal and Torres Strait Islander people living on the streets. The worker also provided assistance to non-Aboriginal and Torres Strait Islander clients and also made visits to Aboriginal and Torres Straits Islander clients in Mission Australia crisis accommodation services. The principle forms of support were emotional support, transport and advice and information.

² For further details of the assertive case management approach see Mission Australia. 2008. *The Michael Project: An Assertive Case Management Approach*. Sydney: Mission Australia.

- Dental service: the dental service provided dental care to clients including cleaning and hygiene, fillings, extractions, and pain relief.
- Podiatry service: the podiatry service provided treatment for the feet of clients, including pain relief, nail and foot care, and ingrown toenails.
- Barber service: the barber provided haircutting and shaving services for clients. .
- Occupational therapy: the OT provided clients with support for their daily living tasks.
- Alcohol and drug counselling: the AOD counsellor provided generalist as well as alcohol and other drug counselling to clients.
- Psychological services: the psychologist provided psychological counselling to clients and conducted formal assessments of mental disorders.
- Computer literacy training: this provided clients with accredited training in the use of computers.
- Literacy and numeracy training: this was designed to support the literacy and numeracy needs of the clients.
- Recreational service: the recreational officer provided recreational activities for clients, including gym training, street soccer, and social activities.



These specialist services were generally provided in one of two ways: either specialists were directly employed by Mission Australia, or they were contracted by Mission Australia to provide that service. The service providers either came to the men or men were assisted through transport to access the services. That is, there were as few as possible transport barriers to contact with any of the specialist providers.

Full details of the service arrangements of the specialist services and supports are provided in Table 3-1.

Table 3-1 Michael Project specialist service providers

Service	Overview of activities	Days per week	Location / mobility	Contractual arrangement	Capacity (clients/day)	One-off or ongoing service provision	Individual or group service provision
Mobile street-based health outreach	Provide outreach nursing care.	5 days/week.	Mobile, but central Sydney only. Based with MissionBeat.	Contracted through St Vincent's Hospital.	Approx 35/month.	Both, depending on need.	Individual.
Mobile street-based Aboriginal and Torres Strait Islander outreach	Provide outreach support to rough sleepers.	5 days/week.	Mobile, but central Sydney only. Based with MissionBeat.	Employed by Mission Australia.	Approx 10/day.	Both, but tended to see some people for a long period of time.	Both.
Dental service	Dental services including cleaning and hygiene, fillings, extractions, pain relief.	Started with 2 days/fortnight but increased to 3.	Westmead Centre for Oral Health.	Contracted through Westmead Centre for Oral Health.	6 or 7/day.	Both, depending on need.	Individual.
Podiatry service	Treatment for podiatric conditions including pain relief, nail and foot care, and ingrown toenails.	One day every three weeks, on alternating days.	Based at one service in Western Sydney and one in inner Sydney.	Contracted through a private provider.	Approx 16/day.	Both, depending on need.	Individual.
Barber service	Provide hair cut and/or shave to clients.	As required.	Variety of barbers close to accommodation services.	Voucher or reimbursement to client.	As required.	One-off.	Individual.
Occupational therapy	Assessing capacity for and assisting with daily living tasks.	5 days/week.	Mobile.	Employed by Mission Australia.	Min 2/day, max 4/day.	Ongoing.	Individual.
Alcohol and drug counselling*	Provide general and AOD counselling to clients.	5 days/week.	Mobile.	Employed by Mission Australia.	Min 2/day, max 4/day, avg 3/day.	Both, depending on need.	Individual.
Psychological services	Psychological counselling plus conduct formal assessments of mental health disorders.	4 days/week.	Mobile.	Employed by Mission Australia.	Min 2/day, avg 4/day.	Both, depending on need.	Individual.
Computer literacy training	Certificate I in Information Technology	Classes run twice a week (Tues and Thurs, 4 hours/class, 20 weeks in a semester).	Wentworthville (also at Cartwright for one semester).	Contracted through Parramatta Community College.	Class max of 12.	Ongoing over semester; clients generally only enrolled for one semester.	Group classes.
Recreational service	Provide recreational activities for clients.	5 days/week.	Mobile.	Employed by Mission Australia.	Between 4 and 8 on average day.	Both, depending on need.	Group activities – occasional individual.
Literacy and numeracy training	There was provision for a literacy and numeracy tutor but case managers found it hard to engage with clients around literacy and the program was discontinued early on.						

* Gap between counsellors, December 09 – May 2010.

3.4 CLIENT PATHWAYS THROUGH THE PROJECT

Clients entered the Michael Project through one of the accommodation sites or through an outreach worker attached to Missionbeat. Through the standardisation of case management practices, case managers were to work with each client in a consistent fashion, following a set of core practice steps:

- Referral
- Intake
- Client's Needs and Strengths Assessment
- Case Planning and Goal Setting
- Case Co-ordination
- Review
- Exit Planning and Exit Support
- Case Closure

Some of these steps may occur only once whilst others may have occurred numerous times during the course of the client's work with his case manager. There were also occasions where a case management relationship ended in an unplanned fashion and thus all the core practice steps were not able to be followed. Diagram 3-1 is a visual representation of the client pathway through the Michael Project.

Diagram 3-1 Client pathway through the Michael Project (case management)

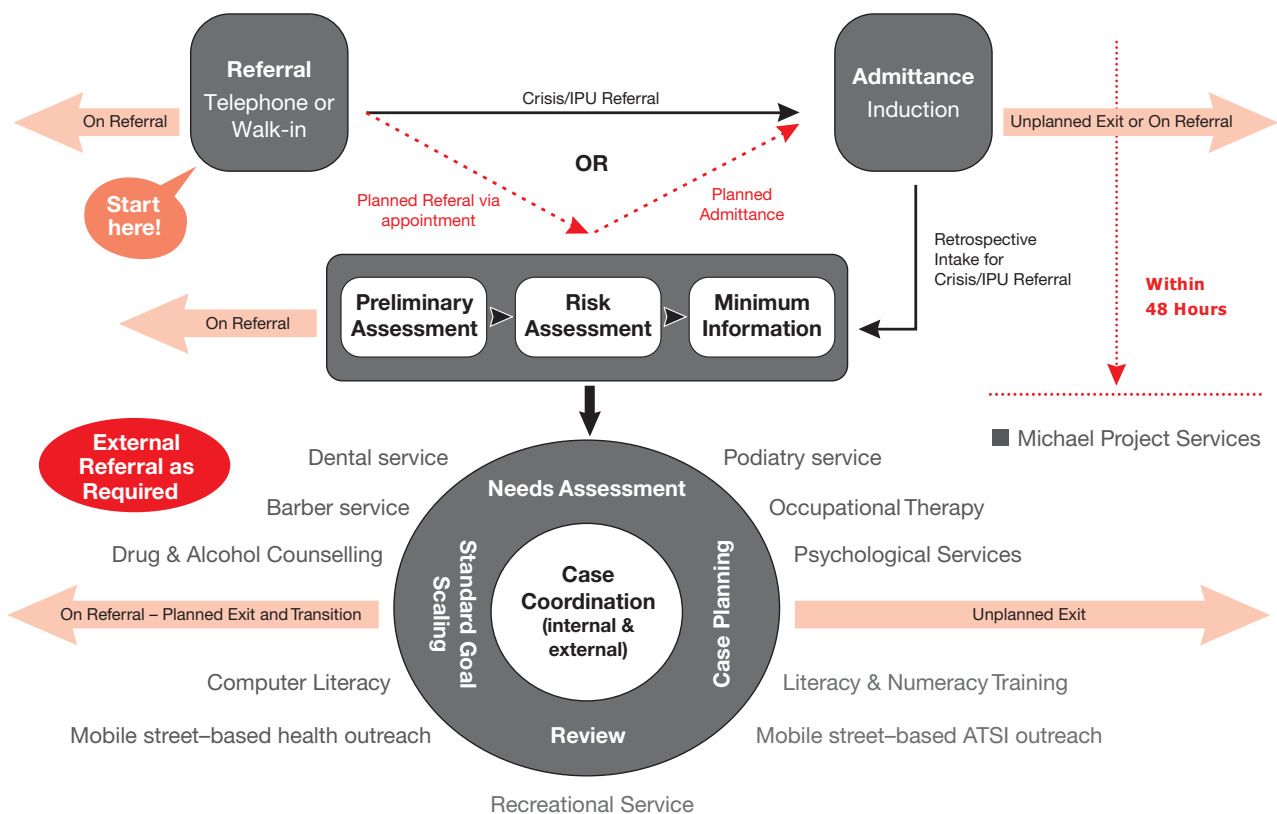
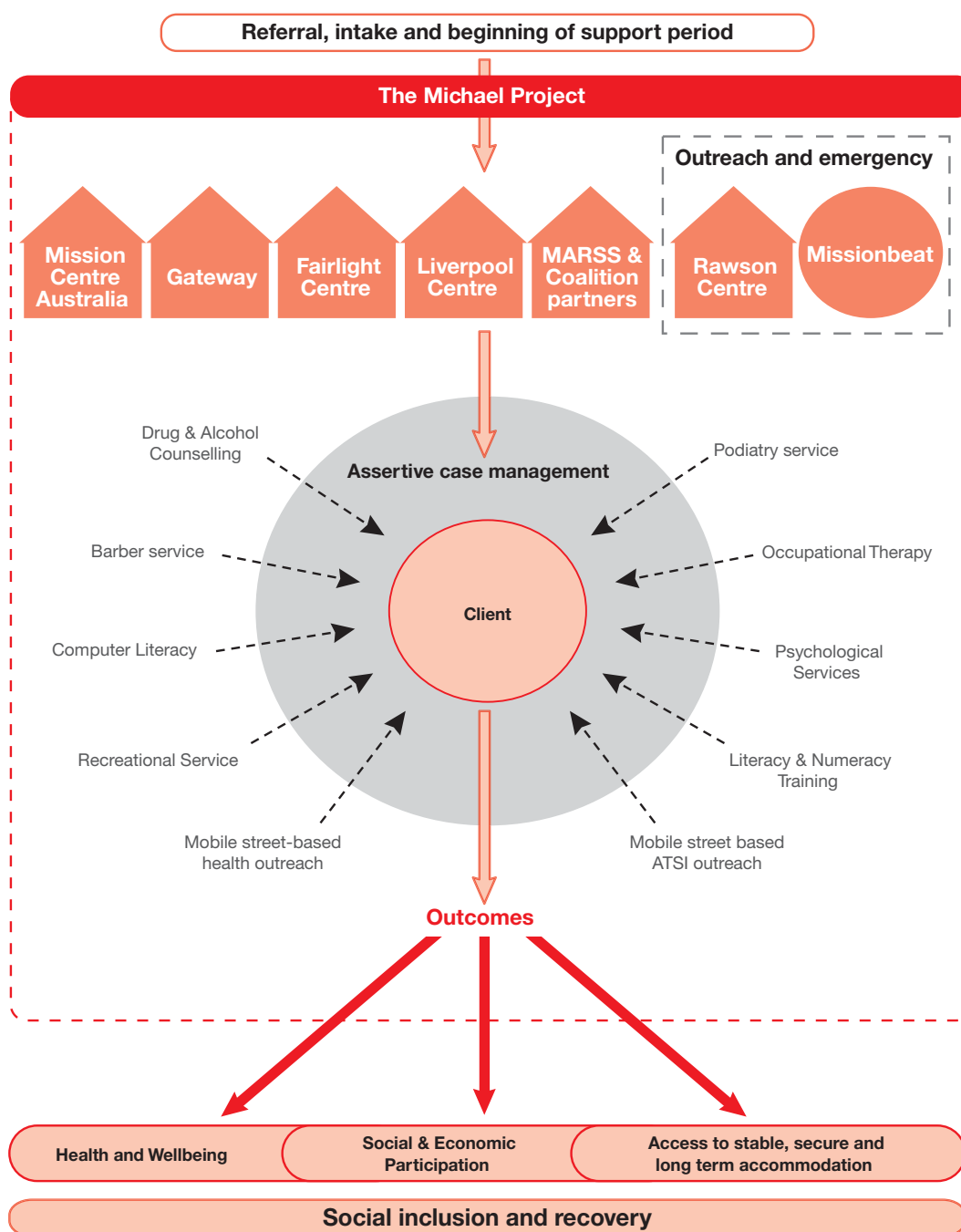


Diagram 3-2 indicates the client pathway through the Michael Project to key outcome domains. The cross-site and mobile nature of the model was planned to allow for greater accessibility to services for a larger number of clients, and recognised the mobility and diverse nature of subgroups of homeless men.

A dedicated project manager and administrative worker were employed to ensure the integrity and coherence of the Michael Project and to support overall smooth running. The administrative worker was responsible for the centralised organisation of the system of referrals, and often managed communication between case managers and the specialist providers. Part of the role also evolved to manage the roster of appointments for the contracted services, for example, the dentist, podiatrist and computer literacy classes. This role was critical to the smooth operation of the Michael Project, acting as an information hub between the various operational staff and enabling case managers and specialist providers to focus on service delivery. The project manager coordinated the various parts of the Michael Project and was particularly responsible for the management of the specialist providers. In centralising the managerial and administrative functions of the Michael Project, the administrative worker and project manager were critical to the implementation and ongoing management of the service.

Diagram 3-2 Client pathway through the Michael Project (outcomes)



3.5 RESEARCH DESIGN

3.5.1 Aims

The aims of the Michael Project Research Study were to:

1. Document the needs and backgrounds of homeless men on entry to the Michael Project.
2. Assess the effectiveness of the Michael Project in achieving positive outcomes with homeless men.
3. Understand the processes and mechanisms through which the Michael Project influences client outcomes.
4. Estimate the cost-effectiveness of the Michael Project.

3.5.2 Research Plan

A comprehensive research design was developed by the research team involving five different data collection methods, using both quantitative and qualitative methods (see Table 3-2 below), as well as a cost-effectiveness analysis. Employing this combination of methods ensured the research questions were addressed within the available budget, and that a thorough program evaluation was conducted which answered the research questions from the perspectives of Michael Project clients, case managers, specialist providers, and service managers and allowed for triangulation of the data collected. This enabled an investigation of whether the findings were consistent across different methods, an important credibility check on the results.

Table 3-2 Data collection methods

Method	N	Sample (n)	Timing
Qualitative/ Quantitative			
1. Client surveys	253	Clients	Baseline November 2008 - August 2009 Wave 2: 3 months post-baseline February 2009 - November 2009 Wave 3: 12 months post-baseline November 2009 - August 2010
2. Case manager surveys	13	Case managers	12 months post-baseline November 2009
Qualitative			
3. Case studies	20	Clients (14) Case managers (6)	12 months post-baseline November 2009 - August 2010
4. Specialist provider interviews	11	Specialist providers	12 months post-baseline February 2010 - June 2010
5. Managers' focus group	8	Service managers ³	Following completion of data collection September 2010

The chief instrument was a client survey administered at three points in time. Given the different duration and form of support available through the accommodation services, two versions of the same survey were developed: the long form and the short form. The short form was designed to be of shorter duration and to be administered to clients from outreach and emergency accommodation. The long form was to be administered to the clients of all the other services. The information collected on the clients of the short and medium term accommodation is therefore more detailed than that captured for outreach and emergency accommodation clients. Table 3-3 provides details on the data collection by site.

³The service managers were key managers involved in the Michael Project. This included the Michael Project manager; the NSW adult accommodation Operations Manager; and the Service Managers of the sites/services involved in the Michael Project.

Of the total number of men who received support over the life of the Michael Project, a sample of 253 homeless men completed the baseline survey on entry (the target being 250). The men were interviewed shortly after entry into one of the accommodation services, and their responses to these interviews provide a profile of the needs and issues of men experiencing homelessness. Missionbeat clients were interviewed on the street and may have been sleeping rough, accommodated in any one of the crisis accommodation services in the inner city or in another type of accommodation. Using a sophisticated location system the same men were subsequently interviewed at three months and after a year to provide data on change over time.⁴ At 12 months, 106 men (target being 100) in a range of circumstances were located and agreed to be interviewed.

Table 3-3 Data collection by site

Service	Survey group	BASELINE SAMPLE (Completed baseline survey)		FOLLOW-UP SAMPLE (Completed baseline and W3 survey)	
Missionbeat (outreach)	Outreach and emergency accommodation group (short form)	N = 97	N=253	N = 33	N = 106
Rawson Centre (emergency accommodation)					
MAC	Short and medium term accommodation group (long form)	N = 156		N = 73	
Fairlight Centre					
Liverpool Centre					
Gateway					
MARSS					
Hope Hostel*					
Leigh Transitional Rehab*					
Cardinal Freeman Centre*					

* Parramatta Coalition services

⁴ For further details of the location system in design and operation see Flatau et al., 2011, Chapter 3

ILLUSTRATIVE CLIENT PROFILE ON ENTRY: STEPHEN (EARLY 20s)

Case study: Stephen

Stephen was one of the youngest clients of the Michael Project. Family conflict and other problems at home prompted Stephen to leave home at age 15. He spent the next five years staying with friends and relatives, in caravan parks, and sleeping rough. Speaking of his decision to leave home he said:

First of all I decided to, what would you say, to sum it up, leave ... I don't know, separate myself from my family and stuff for other reasons. It's a real long story, but as far as it goes for me getting to the point where I needed accommodation is that I had none at all, I was sleeping at parks. And I didn't even know that the refuges and stuff existed really, it was sort of a new thing to me.

He moved interstate at age 18 and lived in various forms of unstable accommodation and on the streets in Sydney before seeking assistance from Mission Australia and entering the Michael Project.

On entry to the Michael Project Stephen did not have any longstanding physical illnesses and scored above average for the general population on a measure of self-efficacy (the ability to deal with a variety of stressful situations). He showed considerable initiative and determination to improve his current situation.

Oh the survival tactics that I pulled out was just incredible... I guess the only thing you can do is give up or keep trying. I chose to keep trying and that involves just day by day, just keep doing it, keep going to places and just basically trying to stay on your feet basically.

However, Stephen had experienced a number of traumatic events in his life time. He found it extremely difficult to talk about and did not give details about when he first experienced a traumatic event and which event was the worst. Although he had never been diagnosed with a mental illness, he scored in the 'very high' category for level of psychological distress. Speaking about the impact of being homeless on his mental health he said:

You're always wound up, you're always really ... You can be defensive or aggressive if someone asks you a simple question. You can be just real temperamental, mood swings and stuff like that can happen, just because like I mean, it's proven, under stress people change, their whole characters change. And if that happens for a long time the person isn't the same person, you know and that's a big thing about it. That's where a lot of people that have been on the street lose friends and that's just more stuff on their shoulders. It just gets too much.

The year prior to entry to the Michael Project had been very tough for Stephen. He was living on the streets and experienced times when he didn't have enough food, clothing or shelter. He missed out on important events and socialising with friends because of a lack of money. Moving from place to place and having to rely on other homeless people for support made Stephen feel vulnerable and unsafe at times. Speaking about this time in his life he said:

... in the environment of the streets and stuff, first of all I found I started to get gloomy, you know what I mean. And sort of hopeless, put it that way. Not because I wanted to. I tried hard to think of a lot of stuff you know and I wasn't getting anything back sort of thing. Out of all this effort that I wasted on trying to find places and stuff, it was like well, it's not working, you know what I mean. Yeah, I nearly lost it, really. Like the whole thing was just too much to bear really. It's just like a big weight on your shoulders.



4. Outcomes: Change over time across key domains

The Michael Project was ambitious in scope, aiming to work with homeless men not only to improve their access to stable and secure accommodation, but also to improve their physical and mental health and wellbeing, social participation and economic participation. Measuring how well the Michael Project had achieved these aims was a key objective of the research study. The study aimed to find out both whether the Michael Project had an immediate impact on the men involved (for the picture after 3 months see *How homeless men are faring: Some initial outcomes from the Michael Project*, Mission Australia, 2011) and also whether changes to their circumstances were evident after a period of one year.

Twelve months after entry to the Michael Project, 106 of the original group of 253 homeless men were located and agreed to complete a survey with a member of the research team. This section reports on the changes seen after one year for this group of 106 men ('the follow-up group') in the following areas:

- Housing and accommodation.
- Labour market and income.
- Physical and mental health.
- Social participation.

In order to compare the circumstances of Michael Project participants as they were on entry to the program and then one year on, this section draws only on the data from the 106 participants who completed in full both the survey on entry and the survey at 12 months. This means that some of the figures which are reported in this section differ slightly from those reported in the earlier publication, *Increasing our understanding of homeless men* (Mission Australia, 2010) which analysed the profile of the total group of 253 men.

As previously noted, participants receiving outreach and emergency accommodation support completed a shorter survey than those receiving support in short and medium term accommodation and therefore some results are only available for the latter group. The data presented in the Tables and Figures in this section is for the total group of 106 men.⁵

4.1 PROFILE OF THE FOLLOW-UP GROUP

The follow-up group ranged in age from 19 to 68 with the greatest proportion aged 35 to 44. On entry to the Michael Project, 62 per cent of the men were single, 6 per cent married or in a de-facto relationship and 29 per cent separated or divorced. Over half of the participants had at least one child (61%), with the majority of these having between one and three children. Overall, 9 per cent of participants were of Aboriginal background. A greater proportion of Aboriginal people accessed the Michael Project through the mobile outreach and emergency accommodation services (21%) compared to those in short and medium term accommodation (4%). Approximately a quarter were born overseas representing a wide range of both English and non-English speaking nationalities. Of those born overseas, the vast majority reported they could speak English well or very well and the largest proportion arrived under the family migration visa category (53%). Approximately half had obtained some form of post-school qualification. These included trade certificate (23%), diploma/certificate (19%) and bachelor/post graduate degree (9%). Participants from the short and medium term accommodation were asked about their schooling and of those, almost three quarters (72%) had completed year 10, 11 or 12.

Participants recruited from the outreach and emergency accommodation sites did not differ substantially from those recruited from the short and medium term accommodation sites in terms of their demographic profile. However, as mentioned above, more Aboriginal people were recruited from outreach and emergency accommodation and there were differences in education profile.

⁵ Full details are available in Flatau et al., 2011.

The profile of the 106 follow-up group has been compared to the full group of 253 to see how the profile differs. In overall terms, the follow-up group was very similar to the full group on entry with the following exceptions: the follow-up sample had a slightly different age distribution (although the mean age remained similar), a greater number of respondents had children and, among the outreach and emergency accommodation group, there was a greater proportion of respondents who were employed and a smaller proportion who had no post-school education.

4.2 HOUSING

One of the key objectives of the Michael Project was to improve access to stable, secure and long term accommodation for men who were homeless. Services and programs designed to support clients' entry into housing formed an important part of the Michael Project, both directly through assertive case management and indirectly through a range of specialist services. This section examines how the housing and accommodation situation of Michael Project participants changed from the point of service entry to one year on.

4.2.1 Housing circumstances on entry to the Michael Project

On entry there was considerable disadvantage relating to clients' housing circumstances in terms of their accommodation situation immediately prior to the Michael Project, their history of homelessness including prevalence and onset of homelessness and the cumulative period of homelessness. The overall picture for the follow-up group on entry was of a very poor accommodation situation:

- Over a quarter of the men were sleeping rough immediately prior to entry.
- More than 85 per cent had slept rough at some time in their lives (97 per cent of outreach and emergency accommodation clients; 82 per cent of short and medium term accommodation clients).
- The cumulative time spent sleeping rough was extensive, with the average time for those who had ever slept rough approaching five years for outreach and emergency accommodation clients and more than a year for short and medium term accommodation clients.
- The average age at which Michael Project participants first experienced homelessness was in their late 20s, although the short and medium term accommodation clients tended to be slightly older than their outreach and emergency accommodation counterparts.
- Slightly less than half of short and medium term accommodation clients had spent some time in gaol, while approximately 70 per cent had spent time in an inpatient health facility, about one third had lived in a caravan park and about five per cent had lived in foster care or an orphanage.

4.2.2 Twelve month change in housing circumstances

After 12 months, substantial changes had occurred in accommodation status for men in the Michael Project. Table 4-1 shows a comparison between the accommodation status on entry to the Michael Project and at 12 months for the follow-up group. Most of the men were in SAAP at baseline as entry into the Michael Project was necessarily through a SAAP-funded service. The overall trend shown by these figures is a movement out of SAAP/CAP accommodation into other types of housing, and most notably into public and community housing.

As shown in Table 4-2, among the short and medium term accommodation clients there was a substantial shift from supported accommodation, with only 16 per cent of participants from this group remaining in supported accommodation at 12 months. The short and medium term accommodation service group had also moved into various forms of both short and long term accommodation after one year. Just over a quarter (29%) of participants in this group were living in temporary or short term accommodation settings. A substantial proportion of participants were living in either public or community housing (33%) or private rental accommodation (10%). In general, the vast majority of participants in the short and medium term accommodation service group had moved out of supported accommodation, many into public and community housing.

Among clients of the outreach and emergency accommodation services, there was a small increase in the proportion who were sleeping rough at 12 months. Importantly, however, there was a large decrease in the proportion staying in supported accommodation and a shift to other accommodation situations, including 21 per cent of clients who had moved into public and community housing and 18 per cent to temporary and short term accommodation settings. The general trend among clients of the outreach and emergency accommodation services was a move away from crisis and transitional accommodation into a variety of other accommodation settings including temporary, short and long term housing.

Table 4-1 Accommodation situation on entry and at 12 months among the follow-up sample

	All participants [†]			
	On entry		At 12 months	
	n	%	n	%
Slept rough/no accommodation	4	3.8	7	6.6
SAAP/CAP accommodation	100	94.3	23	21.7
*Temporary accommodation setting	0	0.0	6	5.7
** Short term accommodation	0	0.0	21	19.8
***Institutional/residential shelter	1	1.0	2	1.9
long term boarding/lodging tenure	0	0.0	2	1.9
Public and community housing	0	0.0	31	29.2
Private rental accommodation	0	0.0	8	7.5
Family home (rent free/other)	0	0.0	3	2.8
Own dwelling	1	0.9	1	0.9
Other & missing	0	0.0	2	1.9
Total	106	100.0	106	100.0

[†] In this report, figures are reported for those participants who responded to the question. Further details are available in Flatau et al., 2011.

Table 4-2 Accommodation situation on entry and at 12 months among the follow-up sample, by accommodation group

	Clients of Outreach and Emergency Accommodation				Clients of Short and medium term Accommodation			
	On entry		At 12 months		On entry		12 months	
	n	%	n	%	n	%	n	%
Slept rough/no accommodation	4	12.1	6	18.2	0	0.0	1	1.4
SAAP/CAP accommodation	29	87.9	11	33.3	71	97.3	12	16.4
*Temporary accommodation setting	0	0.0	2	6.1	0	0.0	4	5.5
**Short term accommodation	0	0.0	4	12.1	0	0.0	17	23.3
***Institutional/residential shelter	0	0.0	1	3.0	1	1.4	1	1.4
long term boarding/lodging tenure	0	0.0	0	0.0	0	0.0	2	2.7
Public and community housing	0	0.0	7	21.2	0	0.0	24	32.9
Private rental accommodation	0	0.0	1	3.0	0	0.0	7	9.9
Family home (rent free/other)	0	0.0	1	3.0	0	0.0	2	2.7
Own dwelling	0	0.0	0	0.0	1	1.4	1	1.4
Other & missing	0	0.0	0	0.0	0	0.0	2	2.7
Total	33	100.0	33	100.0	73	100.0	73	100.0

* Temporary accommodation – living with extended family member or friend or acquaintance (excluding holiday stays)

** Short term accommodation – caravan, boarding/lodge/rooming house (not long term tenure), and hostel, hotel or motel

*** Institutional accommodation – General hospital, psychiatric facility, prison, detention/remand/correctional facility, youth training centre, drug or alcohol rehabilitation centre, residential out-of-home care, other

Additionally, there was an increase in the proportion of short and medium accommodation participants who reported an existing long term tenancy they could return to in the next six months, from six per cent on entry to 25 per cent at 12 months. Although further explanatory data is not available on this question, the results suggest that some men may have rebuilt relationships sufficiently to start to begin to think about moving back in with their family, or that their resource networks had increased and they had become aware of additional sources of accommodation.

4.2.3 Summary

Many of the men in the Michael Project had a history of living in various states of homelessness or insecure housing. Most entered the Michael Project via a Mission Australia supported accommodation service, but 12 months later a relatively small percentage of the men remained in supported accommodation. Those in the outreach and emergency accommodation group had moved onto a variety of long term, short term and temporary accommodation settings. A substantial proportion of the short and medium term accommodation group had moved into public or community housing or private rental, as well as some into shorter term accommodation settings. Generally, the trend was for the men to move out of supported accommodation and into other forms of housing. At 12 months many of the men were in more secure and longer term forms of housing.

4.3 LABOUR MARKET AND INCOME

Homelessness is associated with poor labour market and income circumstances. Improving the economic participation of homeless men was one of the primary objectives of the Michael Project with services and programs designed to support clients' entry into the workforce a key part. One of the objectives of assertive case management and the computing skills program was to provide direct assistance to the clients who may require assistance to obtain employment by equipping them with the basic skills required in many positions in the current job market. Indirectly, assistance with mental health and drug and alcohol issues and care for physical health problems enhances clients' ability to gain and/or maintain employment or simply to begin to seek out employment opportunities. This section examines how the employment situation and income of Michael Project participants changed from the point of service entry to one year on.

4.3.1 Labour market and income circumstances on entry to the Michael Project

On entry to the Michael Project, many of the men were experiencing considerable disadvantage with respect to their economic circumstances. Many of them said that they could not get by on their current level of income. Directly linked to this lack of income on entry, these men reported a high incidence of material hardship and feelings of social isolation.

Key points about the labour market and income situation of the follow-up group on entry include:

- Ninety five per cent of the group were not employed.
- Over half (54%) of all short and medium term clients, while not currently employed in full-time work, had held full-time positions in the last two years.
- For short and medium term accommodation clients, ill health or disability proved to be the greatest barrier in their efforts to gain employment.
- The major source of income for the majority of all participants was 'unemployment benefit' and 'sickness/disability benefit' (although this conceals an important difference: for short and medium term accommodation clients the majority were on unemployment benefit, while outreach and emergency accommodation clients were more likely to be on sickness/disability benefit).
- Most believed that their income was not enough, or only just enough, to get by on.
- A number of major consequences of their lack of money emerged, including that about a half (48%) of the short and medium term clients indicated that they went hungry as a consequence of not having sufficient income.

4.3.2 Twelve month change in labour market and income circumstances

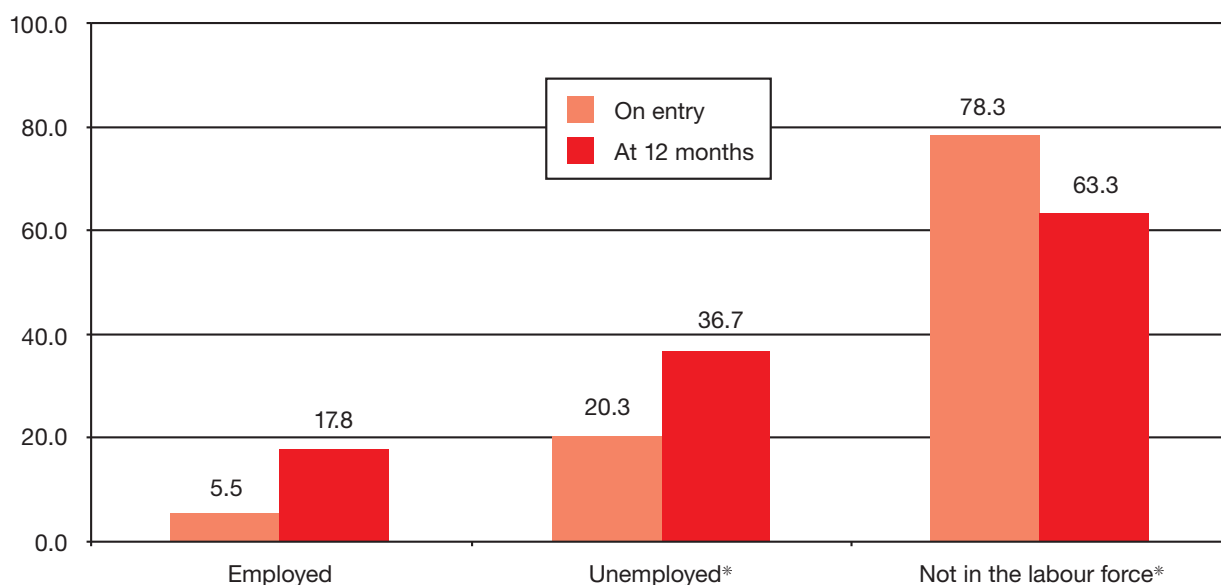
After 12 months there were important changes in labour force participation and sources of income for the Michael Project participants.

Overall, there was an increase in the proportion of clients engaged in employment, from 10 per cent to 18 per cent. This increase is attributable to changes for men within the short and medium term accommodation group, among whom the rate of those employed increased from 6 per cent to 18 per cent as demonstrated in Figure 4-1. In real numbers, nine additional men within this cohort were working at 12 months than were on entry to the Michael Project. At 12 months almost one in five men in this cohort were working. Clients in outreach and emergency accommodation, on the other hand, experienced a slight (3%) decrease in employment.

On entry to the Michael Project, two-thirds of those who were employed reported that they were paid for the work they did. At 12 months, this had increased to more than eight in ten. This indicates that clients were moving into employment with improvement to their income position.

The short and medium term accommodation group were asked a more detailed set of questions that ascertained, among those who were not employed, whether they were 'unemployed' or 'not in the labour force'. Being unemployed means actively seeking work and being available to start work, while not in the labour force means being available to start work but not actively seeking it. As shown in Figure 4-1, the proportion of those who were unemployed rose over 12 months, while the proportion of those who were not in the labour force fell. This is a positive outcome, as these clients are demonstrating an improved engagement with the labour market which is increasing their likelihood of obtaining employment in the future.

Figure 4-1: Increasing attachment to the labour force of clients in short and medium term accommodation, on entry and at 12 months



* Percentages reported for the 'Not in the labour force' and 'Unemployed' categories in this Figure are for those men who were not employed at the time of survey.

There are a number of reasons many Michael Project participants were not employed after 12 months. Table 4-3 shows the difficulties that clients in the short and medium term accommodation group reported facing in finding work on entry and at 12 months. Some of these were related to personal needs or circumstances, including illness or disability, or lacking necessary skills and education. Other reasons were structural in nature, for example, there being too many applicants for available jobs or being no vacancies at all or in particular lines of work. Generally, however, fewer of the men reported experiencing any of these barriers at 12 months than they did on entry to the Michael Project, indicating that participation in the service assisted the men to overcome some of the difficulties they face in gaining employment.

While these results point to the need for ongoing support and assistance to a group with significant disengagement from the labour market, overall they show a significant turnaround in the employment situation of Michael Project clients.

Table 4-3 Difficulties finding work, short and medium term accommodation clients, on entry and at 12 months

	Clients of short and medium term accommodation	
	On entry %	At 12 months %
Lacked necessary skills/education	36.2	31.9
Considered too young by employers	7.2	1.4
Considered too old by employers	29.0	20.3
Insufficient work experience	29.0	29.0
No vacancies at all	36.2	15.9
No vacancies in line of work	33.3	23.2
Too far to travel	30.4	26.1
Own illness or disability	47.1	35.6
Language difficulties	2.9	1.4
Unsuitable hours	8.7	5.8
Difficulties re childcare/family responsibilities	5.8	4.4
No feedback from employers	30.4	22.1
Too many applicants for available jobs	26.5	27.5

As shown in Table 4-4, in the period between entering the Michael Project and one year later there was a significant increase in the number of clients that have wages or salary as their current source of income. This is consistent with increases in the percentage of clients employed at 12 months. The proportion of clients receiving the sickness/disability benefit remained relatively constant among each group while the percentage of clients receiving unemployment benefits decreased. This indicates that clients in receipt of sickness/disability benefits still experienced difficulties entering the work force while some clients on unemployment benefits were able to make the transition to employment.

Table 4-4 Sources of income, on entry and at 12 months

	All participants	
	On entry %	At 12 months %
No income	0.0	0.9
Registered/awaiting benefit	1.0	1.9
Unemployment benefit	54.7	42.5
Sickness/disability benefit	39.6	37.7
Wages/salary	6.6	14.2
Own business	0.9	0.9
Spouse's/partner's income	0.9	0.0
Worker's compensation	0.0	0.0
Other sources	6.6	4.7

On entry, many clients were experiencing great difficulty surviving on their income. At twelve months the percentage of clients among both groups who described their income situation as 'not having enough to get by on' had decreased significantly as shown in Table 4-5. This decrease was greatest for clients of outreach and emergency accommodation services, with more clients feeling that they now had just enough to get by on or enough to get by on but not back on track.

The number of clients who felt that they now had enough to get by on plus a few extras more than doubled for both groups, with 9 per cent of short and medium term accommodation clients indicating that this is how they felt about their income situation on entry increasing to 24 per cent at 12 months. Outreach and emergency accommodation clients reported an increase in this area from 7 per cent to 15 per cent. No clients, however, felt at 12 months that they had much more income than they needed to get by on.

Table 4-5 Self-reported ability to manage on current income

	All participants	
	On entry %	At 12 months %
Not enough to get by	29.0	19.0
Just enough to get by on	31.0	38.1
Enough to get by but not on track	30.0	21.9
Enough to get by plus a few extras	8.0	21.0
Much more than I need	2.0	0.0
Total	100	100

Clients of short and medium term accommodation services were asked about difficulties experienced due to a shortage of money. Clients experienced fewer difficulties at 12 months than on entry, as shown in Table 4-6, with most declines being more than 10 per cent.

The most significant result, however, is the halving of the percentage of clients who could not afford their own place and spent time living on the streets, which fell from 55 per cent to 27 per cent. The percentage of clients who couldn't afford their own place and stayed with friends or relatives also fell significantly from 70 per cent on entry to 38 per cent at 12 months. The experience of fewer difficulties due to monetary problems, especially in relation to secure housing, reflects an improved income situation for clients and has resulted in greater stability in their lives.

Table 4-6 Difficulties experienced in the last 12 months due to a shortage of money, short and medium term accommodation clients, on entry and at 12 months

	Clients of short and medium term accommodation	
	On entry %	At 12 months %
Had to go without food when I was hungry	47.9	43.8
Got behind with rent or mortgage	45.2	31.5
Moved house because rent/mortgage too high	31.9	20.5
Couldn't maintain payments for utilities	26.0	27.4
Had to pawn/sell or borrow from money lender	49.3	38.4
Had to ask welfare agency for food/clothes etc	72.6	60.3
Wore badly fitting or worn out clothes	47.9	28.8
Couldn't go out with friends because unable to pay own way	60.3	52.1
Unable to attend wedding or funeral	23.9	13.7
Couldn't get to important event because no transport	34.2	37.0
Couldn't afford own place, stayed with friends/relatives	69.9	38.4
Couldn't afford own place, lived on streets	54.8	27.4

4.3.3 Summary

Homeless men entering the Michael Project came from a position of significant economic disadvantage. One year on there was a distinct move towards a stronger employment and income position among the follow-up group. Higher employment (and greater engagement with the workforce for those not employed) as well as more clients earning their own income as opposed to receiving a government pension or benefit were tangible outcomes from involvement in the Project. The decrease in barriers to employment and an improvement in clients' perceived ability to survive on their current income were also important changes. They point to increased capabilities among clients that may lead to improved involvement with the labour market and the likelihood of better income.

4.4 PHYSICAL HEALTH AND MENTAL HEALTH

Homelessness is associated with a range of physical and mental health problems. Improving the health and wellbeing of homeless men was one of the primary objectives of the Michael Project, and assertive case management and services and programs designed to support clients' health and wellbeing formed a key part of the Project. An objective of the psychological counselling, substance use counselling, podiatry, dental, occupational therapy and outreach nursing was to provide direct assistance to clients who may require improvement in these areas. Indirectly, assistance with other issues through other Michael Project specialists also had the potential to enhance health outcomes. This section examines how the health and wellbeing of Michael Project participants changed over the course of one year.

4.4.1 Physical and mental health circumstances on entry to the Michael Project

On entry many men were experiencing considerable disadvantage related to their health position. Overall, there were significant physical and mental health issues, particularly those relating to psychological distress and trauma, as well as serious issues to do with substance abuse.

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

- 57 per cent of participants indicated they had a longstanding physical health condition, including in particular musculoskeletal problems, vision problems and neurological problems.
- More than two-thirds of clients reported having been knocked unconscious in their lifetime.
- The lifetime prevalence of diagnosed mental disorder was substantially higher than estimates of mental disorder among Australian males. For example, there is only 12 per cent prevalence among the Australian male population for mood disorder compared to 33 per cent of the Michael Project participants, 20 per cent versus 30 per cent for anxiety disorder and 35 per cent versus 50 per cent for substance use disorder (ABS, 2008).
- More than two-fifths (41%) of the participants reported that they were receiving medication for a mental health problem and a slightly smaller proportion (38%) were currently receiving support from a mental health service.
- Nearly half of all clients scored in the high and very high distress categories for psychological distress. This is in contrast to distress levels measured in the Australian male population where the majority of individuals score in the low (69%) and moderate (21%) range of psychological distress (ABS, 2003).
- The majority of men (95%) had experienced one or more traumatic events (the most common being witnessing another being seriously injured or killed (69%)), whereas life-time trauma exposure was 65 per cent among Australian males (Creamer et al, 2000, Australian National Survey of Mental Health and Wellbeing (NSMHWB)).
 - Participants were typically in early adolescence when they experienced their first traumatic event (median age = 11 years) while their worst exposure occurred in early adulthood (mean age = 20 years).
 - Many people in the general population experience traumatic events, but only a small proportion go on to develop posttraumatic stress disorder (PTSD) (about 1% of males in the general population). A much higher proportion of Michael Project clients had PTSD (18% of short and medium accommodation clients).
- Substance use was highly prevalent among Michael Project participants. With the exception of lifetime alcohol use, substance use was substantially higher among the Michael Project participants compared to those completing the 2010 National Drug Strategy Household Survey.

4.4.2 Twelve month change in physical and mental health circumstances

Few substantial changes were seen after 12 months in the physical and mental health circumstances of the Michael Project participants.

Physical health

Table 4-7 shows the lifetime prevalence (collected on entry) and 12-month prevalence (collected at 12 months) of physical health conditions among the follow-up group. The proportion of participants reporting health conditions on entry and at 12 months cannot be directly compared because the data on entry reflects lifetime prevalence and the 12 month data measures recent prevalence (i.e. over the past year).

Generally, participants in the follow-up group experienced a high rate of health issues at 12 months, which is not surprising given the longstanding and chronic nature of many of the illnesses identified on entry.

Table 4-7 Prevalence of health conditions on entry (lifetime) and at 12 months among the follow-up group

	All participants	
	On entry (over lifetime) %	At 12 months (over 12 months) %
Infectious disease	12.5	11.5
Cancer	2.9	4.8
Blood/immune disease	4.8	2.9
Metabolic problems	3.8	6.7
Neurological problems	14.4	8.7
Vision problems	14.4	20.2
Hearing problems	9.6	11.5
Circulatory problems	11.5	16.3
Respiratory problems	10.6	12.5
Digestive problems	6.7	19.2
Skin problems	2.9	13.5
Musculoskeletal problems	16.3	26.0
Genitourinary problems	1.9	1.0

Overall, there was a similar prevalence between the outreach and emergency accommodation group and the short and medium term accommodation group in terms of vision problems, respiratory problems, digestive problems and musculoskeletal problems. However, there were also some differences. At 12 months, the outreach and emergency accommodation participants had a higher 12-month prevalence of infectious disease, neurological problems, and hearing problems relative to the short and medium accommodation participants.

The lifetime prevalence of traumatic brain injury resulting in a loss of consciousness was similar (and very high) for both accommodation groups (around 69%). Outreach and emergency accommodation participants however were more likely to experience this in the intervening follow-up period (24% vs 7%). This possibly reflects greater vulnerability to traumatic events associated with sleeping rough.

Mental health

A variety of measures of mental health were collected on entry to the Michael Project and again after 12 months. As with the physical health results, few of the men seemed to experience substantive changes in their mental health status in the year following entry to the Michael Project.

Mental health disorder

Table 4-8 shows the prevalence of diagnosed mental disorder on entry (over the clients' lifetime) and at 12 months (in the past year).

Both on entry and at 12 months, the most prevalent mental health disorders were substance use, mood and anxiety disorders. In general, the incidence of mental disorder at 12 months was higher among short and medium accommodation respondents compared to outreach and emergency accommodation respondents, which possibly reflects greater access to mental health services and hence to diagnosis rather than a genuine difference in incidence of mental disorder. Overall, there was a continued high incidence of mental disorder across the follow-up group, particularly with respect to these three disorders.

Table 4-8 Prevalence of mental disorders on entry (lifetime) and at 12 months among the follow-up group

	All participants	
	On entry %	At 12 months %
Mood disorder	33.7	7.7
Anxiety disorder	29.8	10.6
Personality disorder	11.5	1.9
Psychotic disorder	14.4	6.7
Dissociative disorder	1.9	1.0
Substance-use disorder	50.0	7.7
Eating disorder	1.0	1.0
Impulse-control disorder	9.6	2.9
Other	5.8	1.0

Psychological distress

There was evidence of some small changes in levels of psychological distress among the Michael Project participants (see Table 4-9). Overall, there was a slight but important shift away from the category of high distress, which accounted for just under one-third of all respondents at entry and just under one-quarter of respondents after 12 months. This shift was most evident for the short and medium accommodation participants; there was little change in levels of psychological distress among the outreach and emergency accommodation group.

In sum, these changes represent a very minor improvement in the psychological distress levels of the men.

Table 4-9 Levels of psychological distress on entry and at 12 months among the follow-up sample

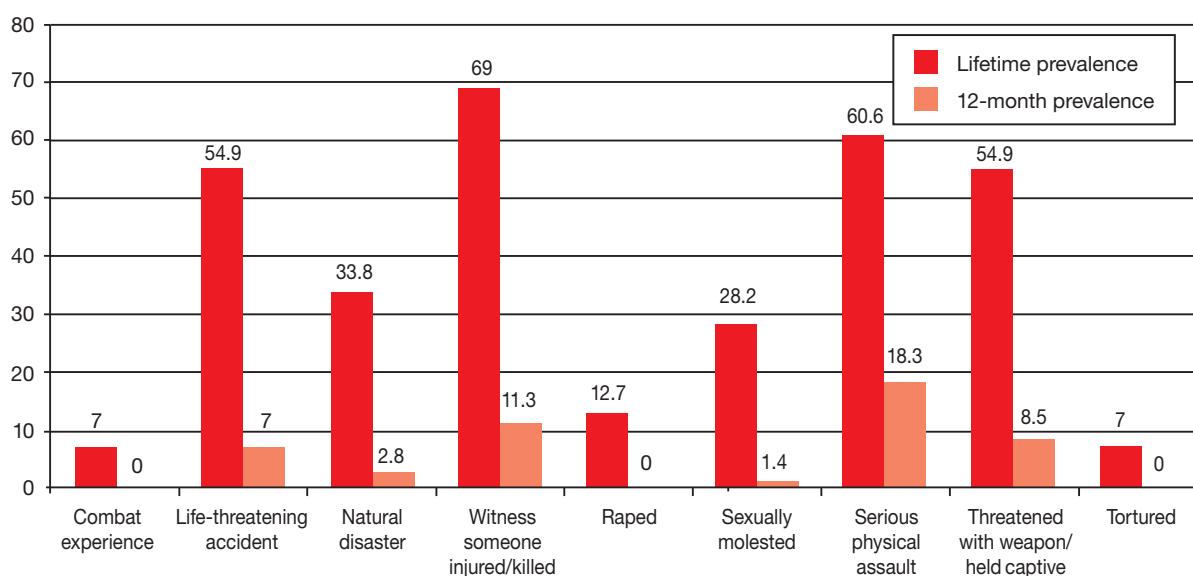
	All participants			
	On entry		At 12 months	
	n	%	n	%
No/low distress (score range: 10-15)	34	32.1	38	35.8
Moderate distress (score range: 16-21)	23	21.7	25	23.6
High distress (score range: 22-29)	31	29.2	24	22.6
Very high distress (score range: 30-50)	18	17.0	19	17.9
Total	106	100.0	106	100.0

Trauma

As noted previously, the experience of trauma among the participants was considerably greater than for the general Australian male population, with PTSD about 18 times more likely among Michael Project clients. Figure 4-2 shows exposure to traumatic events on entry to the Michael Project and after 12 months. At 12 months, almost one third of the short and medium accommodation participants in the follow-up sample had experienced at least one traumatic event in the preceding 12 months and just under half of those who had been exposed to trauma had experienced multiple traumatic events. The type of trauma experienced during the follow-up period was similar to the most commonly experienced traumas on entry, with the most common being serious physical assault, witnessing someone being injured or killed, being threatened with a weapon or held captive or being involved in a life-threatening accident.

Additionally, around one in five participants both on entry and at 12 months screened positive for PTSD. However, among those re-exposed to trauma over the 12 month period, the proportion of participants classified with PTSD increased to 39%.

Figure 4-2 Lifetime prevalence (on entry) and 12-month incidence (at 12 months) of trauma exposure, short and medium term accommodation clients



Psychosis

There was a decline in the proportion of respondents who screened positive for psychotic disorder in the twelve months preceding interview, from 9% on entry to 3% at 12 months.

Substance use

Table 4-10 shows use of substances in the preceding month on entry and at 12 months. A small increase in 'past month use' at 12 months was evident for cannabis while the proportion of those reporting past month use of heroin declined. Use of other opioids, alcohol, amphetamines and tranquilisers was similar on entry and at 12 months. There were some differences in the patterns of use among the two accommodation groups: cannabis use declined among outreach and emergency accommodation respondents but increased among short and medium accommodation respondents. Additionally, there was an apparent decline in the past month use of alcohol among the outreach and emergency accommodation group but not among short and medium accommodation respondents.

At 12 months, as shown in Table 4-11, there was an apparent decline in the proportion of the follow-up group with conditional dependence on alcohol and cannabis⁶; this decline appears to be greater for short and medium accommodation respondents relative to outreach and emergency accommodation respondents. The number of respondents screening positive for dependence on entry and at 12 months is too small to make meaningful comparisons across the two time points for the other substances.

⁶ Dependence was estimated only among participants with past month substance use and thus reflects conditional dependence among those who had used each substance in the preceding month.

Table 4-10 Past month prevalence of substance use on entry and at 12 months among the follow-up group

	All participants			
	On entry		At 12 months	
	n	%	n	%
Heroin	14	13.5	7	6.7
Opioids other than heroin	6	5.8	6	5.8
Alcohol	67	64.4	65	62.5
Cannabis	31	29.8	36	34.6
Amphetamines	10	9.6	9	8.7
Cocaine	4	3.8	2	1.9
Tranquillisers	7	6.7	9	8.7

Table 4-11 Past month prevalence of substance dependence on entry and at 12 months among the follow-up group

	All participants			
	On entry		At 12 months	
	n	%	n	%
Heroin	8	57.1	2	28.6
Opioids other than heroin	5	71.4	3	50.0
Alcohol	41	64.1	28	42.4
Cannabis	23	71.9	19	51.4
Amphetamines	6	54.5	4	44.4
Cocaine	3	75.0	2	100.0
Tranquillisers	3	42.9	3	33.3

Note: Dependence was estimated only among participants with past month substance use and thus reflects conditional dependence among those who had used each substance in the preceding month.

4.4.3 Summary

Homeless men entering the Michael Project faced serious physical and mental health challenges that were significantly different in dimension to those faced by the general public. After a period of one year, there had been few changes in the physical and mental health circumstances and substance use habits of the Michael Project participants.

One year on, a substantial proportion of respondents continued to experience physical health problems. In particular, close to a quarter of participants from the outreach and emergency accommodation follow-up group experienced new incidents of traumatic brain injury.

After twelve months, there appeared to be a small positive shift in the severity of general psychological distress and general anxiety. However, a sub-set of respondents were re-exposed to trauma during the follow-up period and the prevalence of PTSD at 12 months was highest for this group. The decline in the 12-month prevalence of psychosis was a rare substantial improvement in mental health.

Substance use and conditional dependence was common on entry and there were conflicting findings at 12 months: overall, there was an increase in cannabis use, a decline in heroin use, and alcohol use remained stable. There was however a decline in conditional dependence on alcohol and cannabis and these improvements were greatest for short and medium accommodation respondents.

The picture which emerges is of a group of men who continued to face serious physical and mental health issues after one year. Of particular concern is that sub-group of men whose situation was marked by new incidents of brain injury or trauma, the experience of which appears to be strongest amongst the outreach and emergency accommodation group.

4.5 SOCIAL PARTICIPATION

Homelessness is associated with poor participation in mainstream social networks and a lack of family support. Improving the social participation of homeless men was one of the primary objectives of the Michael Project.

An objective of the assertive case management and recreational program in particular was to enhance the social participation of men who were homeless. Indirectly, assistance with mental health and drug and alcohol issues and care for physical health issues can serve to enhance social participation. This section examines how the social situation of Michael Project participants changed from the point of entry to the Michael Project and one year on.

4.5.1 Social circumstances on entry to the Michael Project

The results from the baseline survey point to considerable disadvantage relating to social participation. While there were some strengths in terms of contact with others or in relation to self-efficacy, the overall picture was of a poor social situation characterised by a poor quality of life.

Key information about the social situation of the follow-up group on entry includes:

- Most short and medium term accommodation participants lacked a range of items that the broader Australian community found essential (Saunders et al., 2007), including a decent and secure home (92%), up to \$500 for an emergency (86%) and being able to buy medicines when needed (15%).
- High prevalence of social isolation which involved lacking the means to participate, such as a lack of money (78%), lack of paid work (65%), and lacking a support system of family and friends, including absence of supportive family members (62%).
- Overall, more than half of the men on entry had had any contact with family members in the week preceding the survey, but a much higher percentage (87%) reported they had regular social contact with others.
- Michael Project clients had a strong overall self-efficacy score, higher than homeless populations internationally.
- Compared to the Australian community averages, the men had significantly lower mean scores on all quality of life domains with the greatest difference being in the social relationships domain.

4.5.2 Twelve month change in social circumstances

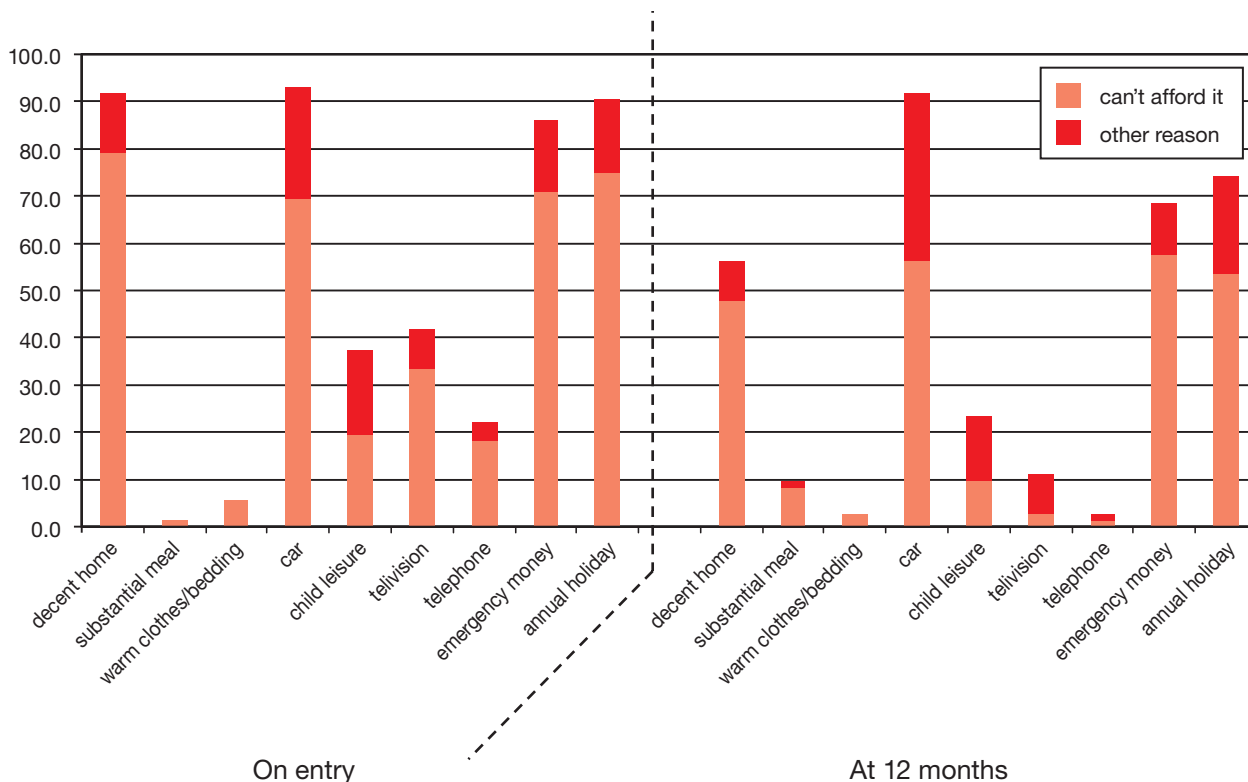
Deprivation

On entry to the Michael Project, many of the men indicated that they did not have items that have been identified by the community as being of necessity (Saunders et al., 2007). Figure 4-3 shows the proportion of short and medium accommodation respondents in the follow-up sample who reported they did not have items of necessity on entry and at twelve months, respectively. There were substantial declines in the proportion of respondents lacking these items at twelve months. In particular, there was a large decline in the proportion of respondents reporting the lack of a decent and secure home, from 92 per cent on entry to 56 per cent at 12 months.

Substantial declines between the baseline and 12 month surveys were also noted for other material possessions: the proportion of respondents lacking a television declined from 42 per cent to 11 per cent and those lacking a telephone from 22 per cent to three per cent. Additionally, more respondents indicated that reasons other than affordability were responsible for them not having these items at 12 months compared to on entry.

There was a decline in the number of participants at twelve months being unable to maintain emergency savings (86% vs 69%). There were similar declines in the number of those who could not take an annual holiday (90% vs 74%) and provide leisure activities for their children (38% vs 23%). The number of participants reporting a lack of medication, medical treatment and dental treatment is too small for meaningful comparisons between on entry and at 12 months.

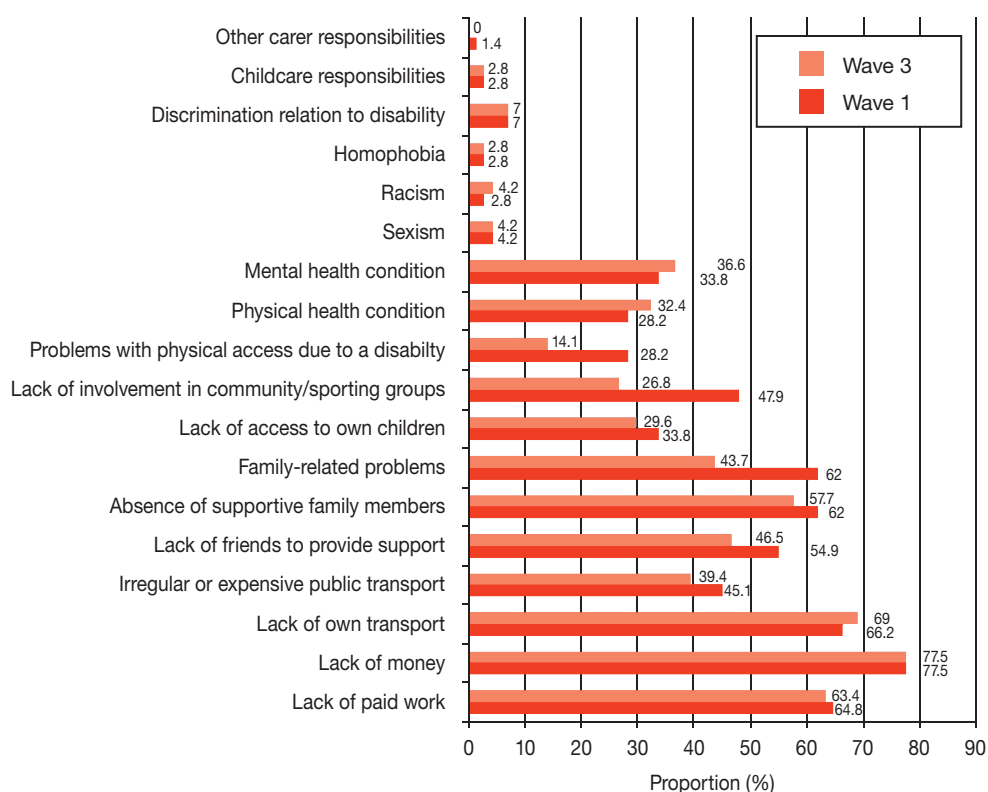
Figure 4-3 Proportion of short and medium accommodation clients who did not have various items of necessity on entry and at 12 months



Social isolation

Comparing the follow-up group's experiences of social isolation on entry and at 12 months (Figure 4-4), there was a reduction in the proportion of participants reporting some causes of social isolation. There was a decline in the proportion of short and medium term accommodation respondents reporting social isolation resulting from: problems with physical access due to a disability (from 28% on entry to 14% at 12 months); a lack of involvement in community or sporting groups (from 48% to 27%); and family related problems (from 62% to 44%). In addition, smaller declines were seen in the proportion experiencing isolation due to a lack of supportive friends (55% vs 47%) and irregular or expensive public transport (45% vs 39%).

Figure 4-4 Comparison of causes of social isolation on entry and at 12 months among short and medium accommodation respondents



Social contact

Table 4-12 shows social contact in the past week on entry and at 12 months. The picture at 12 months is similar to on entry. This result was consistent for men from both accommodation groups. The pattern of social contact at 12 months was similar to that observed on entry wherein a greater proportion of short and medium term accommodation respondents had contact with family in the preceding week compared to outreach and emergency accommodation respondents.

Despite there being little change over the 12-month follow-up period, these data indicate the majority of the follow-up sample had regular social contact with others, while around half had recent contact with their family.

Table 4-12 Social contact in the past week

	All participants	
	On entry %	At 12 months %
Contact with family	50.0	51.0
Contact with others	88.5	86.5

General self-efficacy

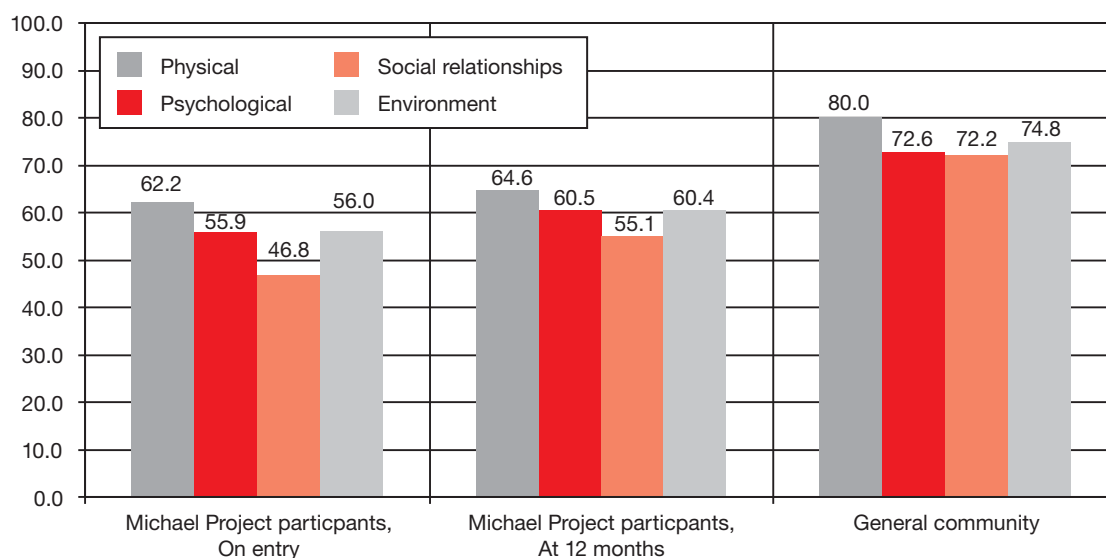
General self-efficacy is the belief in one's competence to tackle novel tasks and to cope with adversity in a broad range of stressful or challenging encounters, as opposed to specific self-efficacy, which is constrained to a particular task at hand (Luszczynska et al 2005). It is noteworthy that the mean General Self Efficacy (GSE) score of the short and medium term accommodation clients was relatively high on entry to the Michael Project (mean score: 29.7; range: 11-40). Cross-cultural studies using the General Self Efficacy Scale have yielded mean scores ranging from a minimum of 20 in a Japanese sample to a maximum of 33 in a Costa Rican sample; the mean score for English speaking countries (e.g. Great Britain and the United States) was 30 (Scholz et al., 2002). The mean score of this group was also significantly higher than similar population groups, such as people experiencing severe mental illness (Murphy and Murphy, 2005). A strong sense that 'I can solve most problems if I invest the necessary effort' is reported. A small proportion (7%) of the Michael Project follow up group on entry had a score of 20 or less and 30 per cent scored 33 or higher. There was slight positive change in general self-efficacy at 12 months (mean score: 30.3) compared to on entry (29.7) for the follow-up group.

Quality of life

Figure 4-5 shows the mean quality of life scores for Michael Project participants on entry and at 12 months compared with the general community. It is apparent from this figure that important changes were made in each of the four domains. The largest improvement was seen in the social relationships domain, for which the mean score improved from 47 on entry to 55 at 12 months.

Importantly, however, while there were improvements from entry to at 12 months for both accommodation groups in all domains, the degree of change differed between the two accommodation groups. Both accommodation groups evidenced an increase in the mean score for the psychological health domain, although this was greater for clients from short and medium term accommodation. There was a larger increase in the mean score for the social relationships domain among outreach and emergency than for short and medium accommodation participants. Although there was little change in the mean score of the environment domain among the short and medium term accommodation respondents, those recruited through the outreach and emergency accommodation services demonstrated a large increase in the mean score for this domain. There was only a small improvement in the physical health domain for both the outreach and emergency accommodation respondents and the short and medium accommodation respondents.

Figure 4-5 Mean domain scores for the WHOQoL instrument



4.5.3 Summary

On entry to the Michael Project, homeless men faced considerable disadvantage related to social participation, including high rates of deprivation and social isolation and low quality of life scores. However, there were generally high rates of self-efficacy among Michael Project clients, with the average levels close to community norms.

At 12 months, improvements had been made in many areas, including a decline in rates of deprivation and improved access to a number of items considered essential for life, reduced experiences of social isolation, and increased quality of life in the psychological, social relationships (for short and medium term accommodation clients) and environment (for outreach and emergency accommodation clients) domains.

Overall, a positive picture emerges at 12 months. The improvements seen in reduced deprivation, increased social inclusion and better quality of life, matched with a retention in high levels of self-efficacy, provide grounds for optimism about what is possible.

4.6 SUMMARY: COMPOSITE PROFILE AND OUTCOMES PICTURE

Upon entering the Michael Project, homeless men faced serious challenges much greater than those faced by the general Australian community. As has been demonstrated, these men were doing it tough by the standards of a number of national and international indicators.

At 12 months the evidence from the research points to important positive changes in a number of areas:

- Housing: fewer men were in supported accommodation and more were in long term housing.
- Employment and income: more men were in employment and earning an income, there was a decrease in reports of barriers to finding work, and fewer men were reporting that they didn't have enough to get by on.
- Social participation: fewer men reported missing out on the essentials of life, there were fewer reported reasons for social isolation and there was a positive change in quality of life.

As may be expected, the changes in health and mental health over the 12 month period were less marked than those seen in other areas.

While a degree of caution needs to be exercised in analysing the changes at 12 months due to sample size and methodological limitations,⁷ a common theme emerges from the data captured in the various domains. A consistent shift can be seen out of poor positions into slightly better and, occasionally, to much better positions. This is a shift that is noticeable across all the various domains, even including mental health (e.g. psychological distress). The measures where there was no change or a change for the worse (e.g. mental disorders) are very much the exception.

A key finding of the research presented is a shift in the material circumstances of the men, for example, moving from crisis support to long term accommodation or gaining employment or moving into the labour force.

It is also evident that there has been a strong shift in men's perception of their circumstances. Evidence of this can be found in their experiences related to finding work, their feelings of social isolation and most notably in their quality of life. Taken together with high self-efficacy scores, which met community norms at baseline and after 12 months, these findings provide grounds for optimism.

Considered as a whole, the circumstances of these men improved over a 12 month period. While it is also important to remember that, compared to the general Australian public, the accommodation, labour and income, physical and mental health and social participation of these men continues to be substantially below community averages, considered overall it is apparent that new points of stability have emerged from which to provide a platform for individual recovery and social inclusion for the men involved.

⁷ Flatau et al., 2011.

ILLUSTRATIVE CLIENT OUTCOMES AT 12 MONTHS: VINCENT

Vincent is an older man who has recently been successful in overcoming a long term drug addiction. After four months in rehab he made the difficult choice of not returning to his former life in regional New South Wales in order to stay clean and make a new future for himself. He found himself at one of the Michael Project accommodation services where he lived for three months.

During his time at the accommodation service he was introduced to the Michael Project. His case manager provided assertive case management which he felt was really helpful in motivating him to seek help and find more permanent accommodation. He said:

[Case manager] encouraged me to go to NA meetings. He encouraged me to see the psychologist. Encouraged me to see the drug and alcohol worker. He just was a positive influence, you know. He just really just ... Because I was ... I don't know what I was. I was, well not reluctant but I just was ... I wasn't quite ready to really change but that place, the three months I spent there planted seeds and gave me a lot of hope for moving on.

While at the accommodation service he received support from the Michael Project psychologist who continued to treat him on a regular basis after he moved out. Vincent appreciated the support he had received and identified a number of ways in which she had helped him to make positive changes in his life:

And she always, always just gave me something to think about, you know what I mean. Go away and think about this for example, do or try this as an alternative or perhaps this. And she understood a lot of things, a lot of personal things I'd ended up discussing with her that I would never thought I'd be talking to a woman about.

Vincent suffered multiple trauma from the age of 14 and had a long history of homelessness starting from the age of 16 when he stayed with friends because he had nowhere else to go. At age 18 he was sent to gaol and had spent a total of 12 months in goal over his lifetime. These early experiences of trauma, homelessness and gaol coincided with a serious drug problem for which he first received intensive treatment in a rehabilitation centre at age 19. The cumulative time he had spent in the various homeless states was approximately five years. This is less than many other Michael Project clients, but still indicates a lifetime of hardship. He explained:

I've spent 30 years of my life just ... The way I look at it and I am pretty down on myself, I think I've committed the worst crime to mankind you know what I mean. I've wasted a life and there's no second chances, there's no retakes, there's no double rehearsals, it's just God gives you one chance, right, and one chance only. And what you do with that is entirely up to you. You've got to put in a bit. And I've just spend 30 years taking and I'm trying to come to terms with that. At this late stage in my life and it's really ... It's a bit overwhelming at times.

Vincent tended to distinguish himself from many of the other homeless men he had contact with during his time in crisis accommodation and at first was very reluctant to seek accommodation at the service. He explained:

Well I didn't want to go there. I was in rehab and I got knocked back for their halfway house and someone, one of the guys said try the [Accommodation service]. And I said 'Oh piss off, I'm not going to a homeless doss house' and I didn't want to. I was reluctant to go there. And I went there and things changed. I was ... The guy that runs the place [case manager], he just bent over backwards to sort of help me. The psychologist, the Michael Project psychologist, I love that lady. I mean, she just changed my life.

Vincent said he liked the fact that the Michael Project was not pushed on him, but rather was available if he felt he needed it. He felt that it had been very important for him to be in control of his own life and the support that he received. In fact he felt that the personal motivation to change was very important for recovery from drug and alcohol abuse and homelessness. He said:

Yeah, well no one else does it for you... People might say well there it is but you've got to work to get it. You don't just ... They're not just giving it to you... It's not something that can be given to you on a silver platter.

(continued over)

Vincent is now living in an apartment in the city which he can afford with subsidies from Housing NSW. While Vincent still experiences very high levels of psychological distress he volunteers regularly and has a very strong desire to 'give back' to the community. He deems himself 'unemployable' given a life-threatening medical condition and limited education (he has completed Year 10) but hasn't let that stop him from helping others in need. He says that the last 18 months have been 'very, very good' which is reflected in substantial change to his self-efficacy, and while he has doubts about his future he looks forward to living his life to make a difference.

I don't know. I just ... I want to improve things, I just want to ... I've got this overwhelming desire to leave my ... Not my mark, I want to do something good.



ILLUSTRATIVE CLIENT OUTCOMES AT 12 MONTHS: TONY

Tony is in his late twenties. At the time of interview he was living in an unlicensed boarding house in Sydney's inner west. With the assistance of Mission Australia's Employment Solutions he had recently secured a casual part time job in the city.

Twelve months earlier, Tony had entered a Michael Project accommodation service. Some years before he had completed Year 10 but presently was unemployed and not looking for work and not enrolled in any education. He had previous experience of drug rehabilitation, having spent a year in a program, and some subsequent experience of homelessness. He had a serious physical health condition which needed to be managed in an ongoing way.

Tony engaged with a case manager and the Michael Project dentist and barber. His case manager said he was withdrawn and 'struggled the whole time he was here' with drug use. Even though Tony was referred to the drug and alcohol counsellor, he declined the service because he had been through numerous treatment and rehabilitation programs in the past and was not ready to engage again with another service. His case manager explained,

He's been to all the detoxes and rehabs and knows all the principles of keeping clean. Everything he'd learned in those services. But yeah, he just struggled to put it into practice.

Tony explained how 'I just sort of shut down a bit' and was not ready to utilise services. He said that he had to leave the accommodation service when he got behind with his rent and was still using. He did not have anywhere to go and would have been on the streets except for a vacancy in a boarding house and payment of bond and rent in advance from NSW Housing.

He spoke about his reason for joining a methadone program after leaving the accommodation service.

People who were doing what I was doing were dying quite a lot. Like just every week someone I knew was dying or would die...and I just thought I don't want to die.

At face value it may look as if Tony was doing well - having both housing and employment. However his interview painted a picture of a young man struggling with narcotics addiction, who was socially isolated and suffering blue moods and depression.

Tony talked about some of the problems he was facing. Because of debts he was paying off, he had been living on \$10 a day. He needed to travel to and attend a hospital every day to collect his methadone. He was physically unwell with a serious physical health condition, and suffered from depression. He spoke about his struggle to get through the day in relation to living skills and feeding himself. To the researcher's question, 'do you feed yourself well?' he said:

Oh I'm trying to. Yeah, it's always a bit of a struggle for me, to eat properly but I'm trying...it's more the motivation, just getting the motivation to cook and eat. I find it more of a chore. It's pretty sad, finding it a chore to eat.

He said that even though there were other young men living at the boarding house, 'we all just keep to ourselves.' He did not have a social life and did not go out to pubs or parties. He has stopped seeing his past friends who he used drugs with.

Tony said he held a lot of doubts about his future, and had high levels of psychological distress and a low feeling of self-efficacy. However, he talked about his new job as a positive step for him, and could also see some of the value in what he'd been through:

Tony: It's worked out really well for me because I've got an older brother who has been on the same sort of path as me for all these years and I didn't think he'd ever get out of it but from what I went through I sort of ... I've pushed him and he's over the last year, he's managed to get himself off methadone and into ... He sort of did what I did and followed me around through the programs and he's actually ended up in [accommodation service] now and he's doing really well.

Interviewer: So through your knowledge you've been able to assist him a little bit?

Tony: I'd like to think so, yeah. And that's definitely made it all worth it. He's really taking ... From what I hear he's taking everything and he's really doing well.



5. Understanding the outcomes

The illustrative case studies of Vincent and Tony (and Terence at the end of this section) provide a first-person experience of some of the outcomes described in Section 4 and offer insights into the factors and processes influencing these outcomes.

This section reports on the qualitative component of the study, which is central in helping to understand the quantitative results and in explaining how and why the outcomes described were achieved. It helps to begin to identify some of the critical factors through which the Michael Project was able to have an impact on the lives of clients. The qualitative component of the research study included interviews with clients, case managers, specialist providers and management staff.

This section is divided into two parts:

1. Key themes emerging from the interviews on how best to support homeless men.
2. An analysis of the critical success factors of the Michael Project.

5.1 KEY INTERVIEW THEMES

Three key themes on how best to support homeless men emerged from the interviews with the clients and the case managers:

- Invitation to participate.
- Responsive and timely support.
- Stability of accommodation and support.

5.1.1 Invitation to participate

The literature is clear about the importance of treating people experiencing homelessness with respect. McNaughton (2005) found that the nature, quality and level of support received from staff was identified by homeless people as key in developing pathways out of homelessness. An AHURI research synthesis drawing on research by Smith (2004) and Beer (2005) emphasised the importance of respecting a person's strengths while delivering access to needed supports and services (Gronda, 2009).

The Michael Project embedded respect for people experiencing homelessness into the fabric of the model by creating an open model. This model offered an 'open hand' of support where people could access the services they needed when they needed them rather than a program that needed to be worked through in a prescribed way. This drew on what is known about the value of autonomy, of 'being in control of one's life', and the way this leads to better outcomes in health and wellbeing (Marmot, 2004).

As evident from Section 4, most of the men in the sample had long histories of involvement in the social welfare system, often beginning at a young age. The consequences of this can be diverse. There are men in the sample who would rather remain on the street 'sleeping rough' than become involved with the welfare system. Their response can be grounded in their previous experience with resistance to any attempt to provide supports and services other than on their terms. There are also those who have reached a point of deep frustration with themselves and are looking to change, and are thus ready to work with a case manager and avail themselves of the services and supports that are available. Along the spectrum may be those who express a desire to change one day but not the next or those who make a number of attempts to engage before being able to do so.

While one of the key features of the Michael Project was assertive case management, which was carefully balanced according to the needs of each individual. Overall, the men seemed to respond well to an invitation to participate that was offered at a time and with a level of intensity they were happy with. Given the reluctance of this client group to use services, whether because of anxiety, trepidation or other reasons including being unable to access services, this appears to be a positive result (Black & Gronda, 2011).

That clients could make their own decisions about when to address certain issues was central to the philosophy of the Michael Project. One client spoke at length about the importance of being able to choose from the suite of services those they needed, rather than having to submit to a program being imposed on them. He was an older man who valued his independence and thus the 'invitation to participate,' as he did not want often much younger welfare workers 'telling him what to do.' Speaking of the Michael Project:

There was quite a lot of it to like. You weren't made to do anything, which is great, the choice was then yours.

In many cases, clients made a decision about focusing on some issues rather than others, given their own priorities and knowledge about their own circumstances. Sometimes this meant that the client had to prioritise and put off other needs. While some felt that employment was their primary need, others prioritised issues such as health and stable housing. One man spoke about how he had prioritised dealing with an alcohol addiction over gaining paid employment. He was living in a half way house and volunteering in a drug and alcohol rehabilitation centre. He displayed a good understanding of what was needed for a full and long term recovery and explained that seeking paid employment at this time could potentially derail his progress. Another man, also with drug and alcohol addiction issues, was actively seeking employment and believed that employment would be beneficial in keeping his drinking under control.

The Michael Project approach allowed clients to take an active role in identifying and addressing their needs. While many had needs in a range of different areas, with the assistance of a case manager, clients could address the needs they felt would be the most helpful in achieving their goals.

In some cases people chose to avail themselves of only the accommodation and case management but not any of the specialist services on offer through the Michael Project. A range of reasons can be offered as to why this may be the case.

Some may have simply been seeking respite from their current environment:

...I stayed there for a couple of months. And that was where I sort of regathered myself...

The relationship established with their case manager was in some cases sufficient to support them to where they needed to go, particularly into accommodation. For some their relationship with the Michael Project would have been too slight, perhaps a night or two spent in emergency accommodation, or their issues too great. Many staff acknowledged the high level of need in the emergency accommodation and outreach clients in particular, as well as the complexity of their needs:

These clients have quite major problems but they still wouldn't do it [use the services]. They still couldn't or wouldn't do it...they have other drivers, which are generally drug and alcohol, and mental health.

These men may simply not have been ready to take advantage of the services on offer. The clients' lack of motivation could be a key barrier to accessing the specialist services:

...a lot of those clients were more interested in hanging around those day centres and getting meals than going to the dentist. And it's funny because they were in pain, they needed to go to a dentist but it was a problem for the client, I suppose, to be able to take that step to go to a service.

Clients' drug and alcohol addictions also played a significant role in stopping clients from accessing services which could assist them.

The client group is saying yes [to appointments] when they're feeling well. They might be under the influence of something. But in the morning...they've got to start thinking about where they're going to use. So would they have gone anyway? And I actually think that maybe they might not have because their primary presenting issues are where do I score today or how do I continue to use?

Finally, the Michael Project, while offering a guaranteed access to a range of specialist services, could not offer every service required and many of the men were part of support groups or linked into services outside the Project.

5.1.2 Responsive and timely support

Clients entering the Michael Project were often in a crisis situation and presented with a range of different complex needs, as described in Section 4. According to Neale & Kennedy's (2002) study, clients regarded good services as those that enabled them to work at a number of goals, not just their housing and immediate issues. Integrated service responses were more highly valued than those that only worked on a limited number of issues. Speaking of the Michael Project, one client said:

Yeah, and they don't get so tunnel vision. That this is my issue, this is all I have, this is my only problem. Well, why did this happen, because of all these other issues that were kind of floating around before so how can we all manage that.

With some variation across the Michael Project specialist service providers, the rate of attendance at services booked was high, with an average attendance rate of 85 per cent across all services. This indicates that once a booking had been made, clients generally demonstrated a high level of commitment to turning up to that appointment.

While there may have been initial reluctance to take up services, once people engaged with a service or services they did so strongly, that is, repeatedly. The services with the highest rates of attendance were the occupational therapist and the computer literacy tutor, indicating that these services saw clients for a high number of repeat visits.

It is also evident from the survey data that a substantial majority of clients were able to access the required service when needed. For example, of those who answered the question in respect of the psychologist, 85 per cent agreed or strongly agreed that they got this service when needed.

Interviews with clients and case managers showed that the Michael Project was able to simultaneously meet their needs in a range of different areas through the provision of responsive and timely support.

Access to services was facilitated through the case manager, who was well placed to assess, in consultation with the client, their needs and readiness as well as encouraging them to access the services they needed. One case manager explained:

I guess the clients really, they know sometimes what their issues are but they don't know how to solve it. And by directing them to the appropriate outlets or professionals that in itself is quite beneficial for them and then those professionals can do their role.

Clients responded well to this way of working and some clients particularly valued being able to pick and choose the services they wanted to access and when they accessed them. For many clients prioritising their needs and goals for the future was a process that involved discussion with their case manager over a period of time. Initial resistance to accessing services was often broken down through ongoing encouragement and allowing the client to decide when and if they were ready to access the service. It was very important that, when this work had been done, a service would be available.

Many of the services provided by the Michael Project were difficult to access through mainstream channels. This was largely due to prohibitive costs but also long waiting lists, difficulties in physically accessing the service (transport etc.) and a lack of awareness of available services. For instance, many of the men indicated that it had been a long time since they had visited a dentist, with cost being the main barrier to access. One man described his experience before the Michael Project:

I'm thinking no, no I don't have money to go to dentist why? Because it's not covered by Medicare... I thought \$200, that's a lot of money! And \$200 is like a lot of groceries.

The Michael Project not only provided free access to dental services, but clients were assisted with transport, there was no queuing and frequently a case manager was present at dental visits. Also, the fact that the dental service was a part of the Michael Project meant that clients were more likely to be treated with understanding and respect.

Many of the Michael Project services were available on-site with an 'open door mentality'. Clients were often able to decide on the day if they wanted to attend the service, taking into account their complex needs and lack of stability. For many, this approach was the difference between being able to access the service or not. One staff member explained:

This is an in-house service that had the flexibility to come and go and if you don't turn up for the first two sessions then chances are you'd still be offered a third, fourth and fifth. And that will remain unless the client leaves the service. So there's an open door mentality that I think has really encouraged the clients to eventually cross the line and get into it [support].

A number of staff also spoke about the benefits of providing ongoing access to services that would often be limited in the public sector (e.g. through restrictions on the number of consultations or the requirement of having to go back to a GP to get another referral for additional treatment):

You know it wasn't a tight structure... We'd continue to persevere and be flexible for those people. Out in the community you wouldn't get that flexibility.

Significantly, case managers and managers promoted the Michael Project to clients in a proactive way.

We had [MP] posters up. That's the first thing they saw when they walked through the door. Because that's a good thing to see straight away. The Michael Project, it's a positive thing, I'd say 'well do you need any of these services?' to every client who came in here. And that was great to be able to do that. We'd never been able to do that before.

5.1.3 Stability of accommodation and support

As is evident from Section 4, most men entered the Michael Project with a high level of instability in their lives. Housing was one of the core needs that the men had, although it was by no means the only one. Other research has shown that better housing, income and employment outcomes are achieved for clients with longer periods of support. A recent study by the Social Policy Research Centre (Eardley et al., 2008) of 650 SAAP clients found that 'the strongest positive influence on outcomes was the length of time clients had been getting help from the service'.

Participants accessed the Michael Project through a variety of temporary accommodation services, ranging from emergency to medium term. However, the Project sought to work with the men through assertive case management to access longer term housing. This could take a variety of forms and may depend on the nature of the service. For example, men coming into the emergency accommodation might be referred to short term accommodation by their case manager, while men in short term accommodation might work with their case manager to access long term community housing. From the interviews it was clear that those men who were able to find stability in accommodation were better able to:

- seek employment;
- address mental health issues;
- address physical health issues;
- participate in positive social activities;
- reconnect with their families; and
- find more permanent accommodation.

Stability was an important feature of the Michael Project, not only in terms of accommodation but also in terms of the longevity and consistency of access to the specialist providers. As noted in the previous section, being able to provide ongoing access to services in a way that would not be possible in the public sector was beneficial for clients.

The perseverance is pretty key, that and the longevity. So being able to persevere over a long period of time and to maintain a presence that's consistent.

Staff commented that this consistency in the availability of services led to a better continuation with treatment by clients, particularly as clients were able to develop a trusting relationship through their ongoing contact with the specialist providers. Staff emphasised the importance of trust for this client group. Because they were familiar with Mission Australia, clients were often more willing to attend other services that they could access through Mission Australia.

Those men accessing the Michael Project through mobile outreach and emergency accommodation were likely to have a lighter involvement with the Project than those accessing the service through the short and medium term accommodation services. This was related to both stability of accommodation and the stability in the lives of the client group. Although the model was designed to enable these men to utilise the specialist services, they did so to a lesser extent than the clients of the short and medium term accommodation.

It was anticipated that the outreach services and emergency accommodation would provide some initial points of stability which could in turn provide a basis for further engagement in the Michael Project. There are examples where this was the case but in the vast majority of cases the instability in the lives of these men proved a barrier to accessing the Michael Project in a more ongoing way.

The case manager at the emergency accommodation service explained that the Centre did not have a day shift and clients had to leave at 7am, making it difficult to support clients to keep and get to appointments.

We might do the referral, we'd talk to them for hours about the referral...the centre was closed [at 7am] and by 12 o'clock the clients had forgotten about referrals...if we had a caseworker during the day to catch the client in the morning we probably would have been a bit better in our referrals.

The emergency accommodation service introduced strategies to enhance access, for example, through a trial of weekly on-site visits by the psychologist, and the use of volunteer barbers and hairstylists to cut the men's hair at the centre. The case manager reported the haircuts were very popular, 'because their hair is a big issue.' Reasons for the success of the haircuts include that it did not require a big commitment from clients, was non-judgmental, could be fun and offered a 'soft entry' point for the men. But even with these strategies to build up points of stability with the men, the overall precariousness of their lives appeared to limit the effect of the Michael Project.

The short and medium term accommodation services by contrast provided a more purposeful environment through which men could access the Michael Project specialist services, although this was not without its challenges. Even there, clients often had a relatively short period in which to engage with services and could often spend all of that time engaged in dealing with their most imperative issues. For some this might be drug and alcohol issues while for others it might be seeking out longer term accommodation.

From my first meeting I was told the first thing you've got to do is start looking for a place because... [accommodation service] was very temporary.

In other words, even the accommodation services did not always provide a sufficiently long term and stable base from which men could access a suite of sophisticated services. While some of the services, such as the psychologist and drug and alcohol counsellor, were able to offer some further sessions to the men after they had moved on, this was on a case by case basis, dependent on where the men had moved to and the logistics of keeping appointments generally without the support of a service and case manager.

While there were clear limitations to the accommodation available, the evidence from the interviews indicates that for clients in the short and medium term accommodation, through temporary accommodation, assertive case management and access to specialist services the Michael Project could help establish and set underway a platform and process for individual recovery and increased social inclusion.

5.2 CRITICAL SUCCESS FACTORS

This section describes the factors that contributed to the success of the Michael Project.

5.2.1 Clients' own strengths and willingness to take risks and make changes in their lives

Many of the men indicated that their living situation had been unstable for many years. Some clients referred to physical traumas or injuries they had suffered while homeless, as well as life-threatening health situations related to long term homelessness. Furthermore, most expressed some concern about their future, and for some this uncertainty was distressing. For others, not to end up like the older men they saw on the streets and in soup kitchens was motivating.

Clients' motivation to change was a recurring theme across client and case manager interviews. Many of the men were critical of themselves and other men who were homeless, most often seeing it as a personal failing. Clients frequently made comments about it being up to the individual person (who was homeless) to change their lives. Some clients referred to their own lack of motivation, though more often made negative comment about the lack of motivation of other homeless clients. Case managers noted how hard it often is for individuals to make change and how clients typically perceived as engaging in 'risk taking activities' can present as conservative, as 'stuck' and unable to make change. One client recognised how hard it is:

Recovery is very much an individual program. But it requires a lot of support. Because you have to change your way of thinking basically and that's very difficult... In my case forty years I've been thinking about things a certain way. To change that it's not easy.

While there were high levels of anxiety among some participants, most showed strong signs of self-efficacy. Having secure housing and meaningful activity seemed central to these feelings of self-efficacy. A number of men were able to report that their housing situation had significantly improved. For example, some had been sleeping rough at the time of the baseline survey or doing the rounds of the inner city hostel circle. Twelve months later, at the time of interview, a number of men had secured longer term accommodation with a community housing provider or through Housing NSW, or were about to be re-located to their own independent housing. Some recognised the good place in which they now found themselves, one for example describing it as 'brilliant.' Another was able to congratulate himself on how well it had turned out:

Yeah, I've done the hard yards. I've been to appointments and done everything I've been asked to do and I don't regret one bit of it.

While the majority of men were not in paid employment at the time of the interview, having something to do during the day was very important to many. Many commented on the dangers of not having anything to do and the perils this could lead to. Those who were working or involved in volunteering noted the importance of this: of doing something meaningful and participating in the local community.

Feelings of self-efficacy were particularly evident in the way the men spoke about their interactions with services, in their personal relationships and in the lives they were currently leading. For many there was a strong desire for independence, self-sufficiency and having control over their own life. One man wanted the restoration of his relationship with his mother to be on his terms. He felt it was very important that she understood he was an independent adult and that he was in control of his

own life. Another man placed a high value on being in control of his treatment for mental illness and other health issues and also participating in decision making with regard to the support he received from homeless services. He expressed a very strong desire to be informed and consulted on the ways in which he was being assisted.

I mean, if people said to me 'You've got to be here' I wouldn't have been. I wouldn't have gone. I don't like to be told I have to do it. I don't need to do it. Unless it's something that's going to benefit either the place where I'm in or myself.

Others, while recognising how things were changing for the better, remained more circumspect:

I still can't get it out of my head that it's all going to go wrong but every day it doesn't I feel better.

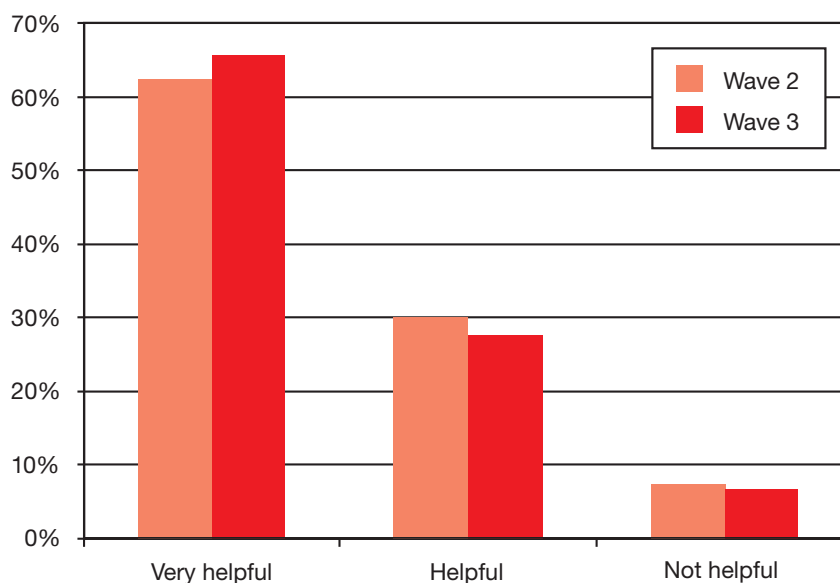
5.2.2 The role of the case manager

- In mediating Michael Project services and linking the different parts of the program together in a way which delivered an holistic and integrated service.
- In focusing on active engagement with the client, rather than imposing a program.

The Michael Project, through its assertive case management approach, sought to operationalise best practice. The central means through which access to specialist services and supports was facilitated was through a client's case manager. As part of the client survey, participants were asked how helpful their case manager was in accessing and providing support in respect of Michael Project services (see Figure 5-1).

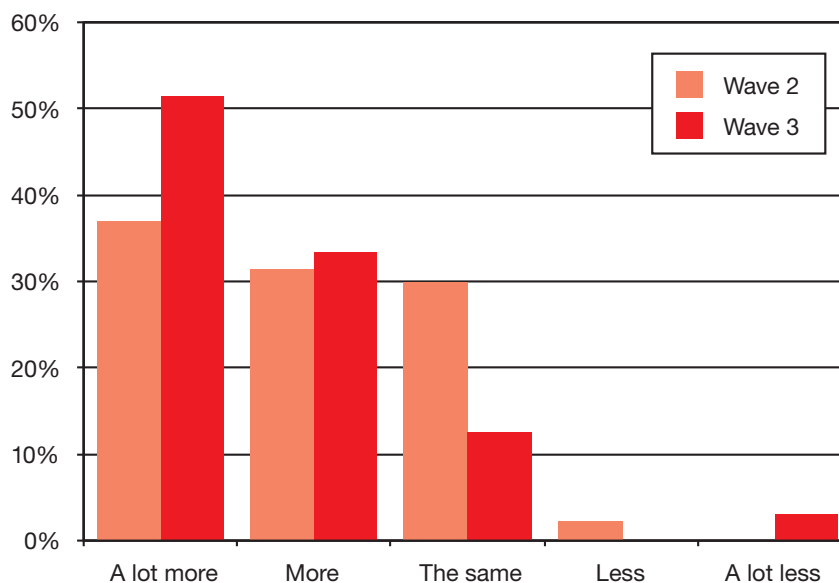
In both the three month and 12 month surveys, the majority of participants (92.5% and 93.3% respectively) felt that their case manager had been helpful or very helpful in accessing and providing support with respect to Michael Project services. Clearly client support of the assertive case management approach was as strong, as was case manager support.

Figure 5-1 Client assessment of how helpful their case manager was in accessing and providing support in respect to Michael Project services.



Participants were also asked to comment on how well they understood the issues they faced and how to deal with them, compared to on entry (see Figure 5-2). At 12 months, most participants felt they had 'more' or 'a lot more' understanding than when they first entered the Michael Project.

Figure 5-2 Client assessment of how well they understand the issues facing them and how to deal with them compared to when they first started with Mission Australia



Case managers had a central role in the Michael Project. They identified clients' needs within the context of dialogue and development of a case plan, worked with clients on their long term housing needs, informed the client of the available specialist services, made referrals to these specialist services based on the case plan and client choices, followed up referrals and appointments, facilitated transport to services (for example the dental clinic at Westmead), and reviewed, monitored and encouraged the use of these services as applicable.

While the Michael Project could have been presented as just another program to which clients had to submit, this was generally not the case. Client access to the specialist services was encouraged, facilitated and supported; however, utilisation of services was generally not a requirement. This is important given that the interview data suggested clients are resistant and resentful towards welfare or case managers who just tell them what to do.

A critical factor, underscored in interviews with both clients and case managers, was the quality of the case manager/client relationship. There is good evidence to suggest that the assertive case management model adopted for the Michael Project allowed for respectful and genuine working relationships between case managers and clients. Clients will more often consider and accept the advice of their case managers when there is an established relationship based on trust and genuine care. One case manager described it as 'walking alongside the men'. Another case manager explained his approach to working with a client who was initially resistant to using the specialist services:

I just rolled with the resistance...I didn't challenge any of his behaviour to begin with. And then once I'd built up a rapport with [client], because without that I found I wasn't going to get anywhere. So once I built up that rapport with him it was easy work with [client].

Case managers had a critical role in supporting clients to achieve the goals outlined in their case plan. They were often instrumental in establishing stability in the lives of clients, helping them to see the possibilities for improving their lives, and facilitating access to services once the client expressed an interest. One case manager described the goals he was working on with a young man who was seriously undernourished after a period of rough sleeping:

He was quite dangerously underweight...I knew one of the reasons for that was not eating properly, being out on the street, probably having to walk all the time, kicked out of this place and the other. So we concentrated very heavily on talking about eating well, eating regularly...[other goals were] feeling safe and secure, starting to feel proud about where he was living, starting to put on normal weight...and a normal sleeping pattern.

The critical role of the case manager in encouraging and persuading men to utilise services cannot be underestimated. For example, there were some who were quite resistant to counselling:

I explain to them that the psychologist is coming to your door, to see you, in your home, in your lounge room. Do you know how much that would cost you...and my general comment is 'the worst thing that can possibly happen out of that is that you'll learn something'.

Timing was important as was recognising windows of opportunity for the client.

We know people are in different times of their recoveries...and they go through different periods and when they're ready to make a change then we're [case managers] ready to help them. But it's just finding that time. Grabbing it, seizing it.

Client motivation to change was a recurring theme across the client and case manager interviews. Some clients referred to their own lack of motivation, although more often they made negative comment about the lack of motivation of other homeless clients, especially those using drugs and alcohol. Clients made comments along the lines that it was up to the person themselves to make changes in their lives (see p43). Nonetheless, it was clear from the interviews that where a positive relationship was developed with their case manager, as in the case of Vincent (illustrative case study, see p36), this could play an important role in increasing client motivation levels.

5.2.3 Specialist services: different services had different impacts

The selection of specialist provider services emerged from the practice experience of service managers and case managers and from an assessment of the national and international literature with respect to individual services or services in combination. The profile of the men outlined in Section 4, for example the rates of substance use, mental health issues, social isolation, and lack of employment, appear to validate the choice of specialist services included in the Michael Project.

The specialist services each worked in different ways and with different impacts.

Outreach services responded to clients' primary health needs, and sometimes intervened in life-threatening situations. One man recounted how he had come to know the Aboriginal and Torres Strait Islander outreach worker and then through this relationship received support from the outreach nurse who had transferred him to hospital for emergency treatment. The nurse also assisted him to manage his diabetes.

The psychologist and drug and alcohol counsellor were able to assist clients to deal with, manage and address problems and challenges in their lives, including depression, anxiety, relationship difficulties and drug and alcohol abuse. One client explained how the drug and alcohol counsellor had assisted him:

...just by listening to me, not judging me, not telling me what to do like the welfare workers.

The dental service, barber, podiatrist and occupational therapist improved clients' physical appearance, self-confidence and wellbeing. As one man recounted:

...I got all my dentures all done. Got my teeth all done...I'm glad too. I told my boys, 'Hey boys look I got teeth'. 'Dad you got teeth. Yeah, I can tell my friend 'Dad's got teeth.'

The recreation program improved clients' physical and mental health, connected them into the wider community and assisted with socialising and friendships. One of the youngest clients of the Michael Project was able to connect with the Project through a recreation initiative in the inner city. This was his first step in getting involved in the Project and subsequently finishing his Year 10 schooling.

Education courses provided clients with skills in computer literacy and facilitated work readiness. The courses also linked clients into a world with more opportunity and wider horizons than the scene of soup kitchens and hostels for homeless men. One case manager described how one man he was working with used the course to develop his resume and went on to secure part time work.

While there were strengths to each of the specialist services and supports they were much more than discrete individual services. Case managers and staff all pointed to outcomes that were beyond specific service treatments to observed improvements in client's general wellbeing, confidence and self esteem.

5.2.4 Ongoing support for clients and transition to independence

The focus of the model was to work with clients while they were in one of the accommodation services or accessing outreach services. Given that most of the accommodation options provided accommodation for a period of 12 weeks, this was likely to be the window in which most men were able to access the assertive case management and specialist services and supports. However, men were supported following their exit from the Michael Project on a case by case basis, through their case manager and/or specialist services and supports as relevant. The psychologist and the drug and alcohol counsellor in particular were able to offer further sessions to the men, although this was at their discretion and dependent on range of factors such as where the men had moved. Where ongoing support for clients to support the transition to independence occurred this seemed particularly advantageous for clients.

5.2.5 Relationships

Case manager-Specialist relationship

One of the key strengths identified was the way that the Michael Project enabled the strengthening of working relationships between the case manager and specialist providers. Certain mainstream services, such as psychology and dental care, can be particularly difficult for homeless men to access. There are also barriers such as stigma, cost and lack of transport which affect their access to other mainstream services such as the barber and recreational facilities. The Michael Project allowed case managers to facilitate timely access to these services and in such a way that was appropriate to their clients. One case manager described the Michael Project:

The idea of it was brilliant. Being able to provide certain services that the clients can't necessarily get in other ways...like the podiatry, the psychologist, dental work and some of the courses...that was really helpful, to be able to have those resources for the clients to use. That helped further their other outcomes, self esteem, physical health or mental health.

From the perspective of case managers the Michael Project provided them with many more options than they had prior. Case managers were able to utilise 11 additional services to help support their clients. A number of case managers commented that the specialist services provided an extension to their case management work.

...unfortunately we're not experts at everything so we do need those other resources available to us, of skilled and professionals that can kind of assist our work in managing the client's life, basically I guess... it just gives them more support, more people involved, caring about them.

In fact, the relationships established between some of the case managers and specialist service providers allowed for a collaborative approach to supporting clients. One case manager talked about how he developed a relationship with the occupational therapist.

I spoke to him at length when he first came along, one on one in my office, and said well what can you do? And I gave him my understanding of occupational therapy and he said yes we do all that and we do a little bit more.

Specialist-Specialist relationship

The Michael Project also provided opportunities for interaction between service providers, which is not always possible in standard service delivery contexts. While case managers maintained responsibility for the overall support of the client during their period with the Michael Project, specialists developed relationships and ways of working that contributed to holistic care.

While regular team meetings helped to build these relationships it was in the process of caring for clients where key strategic partnerships were developed. These relationships took on three predominant forms:

- Working together in the care of a client.
- Working together while one specialist took a lead role in care for the client.
- Peer support.

Strong working relationships were developed between specialists, for example, between the nurse and the Indigenous outreach worker, and between the psychologist and the drug and alcohol counsellor. The psychologist and nurse also had some opportunities to work together for the benefit of clients. Often this involved the nurse discussing with the psychologist the needs of particular clients identified as having potential mental health issues. In many cases the psychologist would provide advice for the best way to support the client, including referrals to a psychiatrist, and in some cases she would go out and conduct an assessment.

5.2.6 Offered from within the homelessness system

As has been previously discussed, the specialist services offered through the Michael Project were generally provided in one of two ways: either specialists were directly employed by Mission Australia, or were contracted by Mission Australia to provide that service. The service providers either came to where the men were or men were assisted through transport to access the services. That is, there were no transport barriers to contact with any of the specialist providers. The value of specialist services being offered from within the homelessness system was recognised:

...I guess being a professional in the industry, was because the services were overseen by welfare organisations there was much more of an understanding towards the client and the client base, rather than when we have clients who just go to independent places because they don't have the background and training in what it is to be working with people...so much more advantageous for our clients...like if we're sending someone from here up to go and have their eyes checked or something and they just present as they are and they just go in and there's no explanation or understanding around their situation with the person at the front counter...

The 'open door mentality' that this contributed to has been commented on above. It allowed clients a number of opportunities to access the available services and provided support in accessing the services. In turn, this helped to support the case manager – specialist relationship as well as the relationship between specialists to ensure high quality service provision.

5.3 SUMMARY

What is evident from the research on outcomes presented in Sections 4 and 5 is that, considered as a group, the men were in better circumstances at 12 months compared to where they were on entry. A number of factors contributed to these positive outcomes.

From the evidence presented in this section the agency of the men themselves is central to the emerging picture of a group whose social inclusion is improving. High self-efficacy scores were noted in Section 4 and this quantitative evidence was affirmed in interviews with the men. Considered overall, the interviews with the men present a picture of a high degree of self-efficacy and increasing levels of self-esteem. Through use of the Michael Project, a platform and process for individual recovery and increased social inclusion has been established.

From the evidence presented in this Section three factors appear critical in this process of building this platform: people need to be supported into participation, not driven into it, which is to say that respect needs to sit at the heart of service provision; they need to be able to access the services they need when they need them and not be referred on; and there needs to be some stability in people's lives.

Key means of helping to support this process are accommodation, assertive case management and specialist services delivered from within the homelessness service system. As has been demonstrated in this Section, the case managers worked with the men to identify goals and develop case plans. They had an important role that was strongly recognised by the men in helping them to access the Michael Project services. There was also strong support for how well the men now understood the issues facing them.

Guaranteed access to specialist services was also of great value to a significant number of the men, whether it was through individual one-on-one support or group participation. The outcomes often went beyond the specific service outcomes to improvements in individual confidence and self-esteem.

Above all, the holistic and interdisciplinary approach to meeting client needs was vital in providing accessibility and flexibility.

ILLUSTRATIVE CLIENT OUTCOMES AT 12 MONTHS: TERENCE

Terence is in his 40s and at the time of the interview was living at a men's accommodation service. He had a long history of unstable housing and homelessness. After his divorce 10 years ago he struggled to find work and housing and has suffered from serious depression. At one point he was living in public housing rental but was unable to pay rent and had to leave.

A mental health crisis a few years ago, during which he tried to kill himself, led him to hospital and he was discharged to an accommodation service. From there he was referred to a Michael Project accommodation service where he has had accommodation for a period that has been extended beyond what is strictly allowed due to his circumstance and a lack of exit points.

At the time of the interview Terence was not in the labour force, although he had a trade. His highest schooling was Year 10 and he had a trade certificate. Terence has had multiple traumatic events in his lifetime with the first at age five, where he witnessed an horrific incident. He currently has very high levels of psychological distress and has a very low sense of self-efficacy.

Although not at first, Terence eventually made good use of the Michael Project services including assertive case management, the psychologist, dentist, podiatrist, barber, occupational therapist, recreation officer and the computer course. In addition to the support he received from the Michael Project, he also received support from a community mental health team and other mainstream health service providers.

Terence considered the most positive aspect of the Michael Project to be the recreation program, in part because he had a good relationship with the recreation officer, "Me and [the recreation officer] got on pretty good. He was a good fella...nothing worries him." While Terence had at first spent weeks locked inside his room seeing no-one, the recreation program got him out of the house and engaged in many activities aimed at enhancing his physical and mental wellbeing, and social and friendship networks. As part of the program, Terence went to the gym twice a week, theatre, beach and walked the City to Surf. He was also very happy with the access and transport to services, "we get a pretty good driving service here too." Two days a week the recreation officer would take the men from the accommodation service to the gym in the morning and then from the gym to the computer course.

His case manager observed changes in Terence (and other accommodation service clients) as a direct result of the recreation program:

Terence was a difficult case because he was in his room all the time. Never go out, never...I come and I say 'come on, out from the room'. It take months, you know, then [recreation officer] come in and they go to the gym, they go to the picnic, whatever the recreation officer was doing, Terence started coming out. Not only him, everyone. Because they want to be in their room, isolation, you know and this is my worry here with my clients.

Terence spoke about being homeless in the past and losing housing and employment due to manic depression. He had a period of living in a boarding house where 'they would take all your money, like whatever pension I got.'

I've been homeless in the past, for three months I lived in my car because I didn't know about any services. I just got kicked out of a place [on the private rental market], put all my belongings in the car and off you go...I got blacklisted, I couldn't pay the rent. Lost a job, couldn't pay rent. That's the thing with manic depression. See I get normal for a little while. I go out and get a job, get a high, lose a job. Then you get depressed about losing a job and it's a vicious circle.

Terence was married in the past and has two children. He said that when the marriage broke down he lost his housing. He was seeing his children about once a month, but would like to see them more often. They did not like coming to the accommodation service and he was not allowed visitors in his room.

At the time of the interview, Terence was to be re-located to his own one-bedroom unit. While he felt some anxiety about the move and the possibility of being isolated and on his own, on balance he believed the move to be a step forward for him as it would provide independent housing. Significantly, his case manager would be able to continue to support him in his new accommodation for a period of two years. This was an important acknowledgement of the need to provide outreach support to men during their transition to independence. His goals for the future were to move into his new housing, see his children more often and purchase a car.



6. Economic analysis

One of the objectives of the Michael Project Research Study was to conduct a cost effectiveness analysis, to see whether improved outcomes for homeless men result in cost savings to government and mainstream agencies such as public hospitals.

The research emerging from the Michael Project has demonstrated that there have been improved outcomes in many aspects of a client's life as presented in Sections 4 and 5. From a cost perspective, positive outcomes experienced by clients may be reflected in a reduction in the costs and subsequent government outlays associated with homelessness. In addition to the provision of homelessness programs, costs relating to homelessness may include eviction from public or community housing, placement of children in care, a decrease in net taxation payments and an increase in welfare payments. A 2008 AHURI study focusing on expenditure associated with health and justice services revealed that clients of Western Australian homelessness programs had much higher average costs in these areas than the general population in their year prior to receiving support. Reduction of costs in these areas has significant potential to offset the cost of running homelessness programs up to several times over (Flatau et al., 2008).

A similar set of health and justice services to those examined by the AHURI study have been included in the Michael Project. This section will look at the savings to government expenditure in these health and justice services resulting from improved outcomes among Michael Project clients.

This section:

1. Compares the health and justice costs incurred by clients over the 12 months prior to their entry into the Michael Project with the costs incurred by members of the general population (to show service usage and costs involved).
2. Compares the health and justice costs of the Michael Project clients over the 12 months after their entry into the program with their costs in the 12 months preceding entry (to show changed service usage and reduction in expenditure achieved over 12 months following entry to the Michael Project).
3. Examines the cost of delivering the Michael Project over a 12 month period.
4. Compares the cost of delivering the Michael Project with the reduction in expenditure generated by the Michael Project, to demonstrate the net savings to government in health and justice service delivery.

6.1 SUMMARY

Examination of the average health and justice contacts of the 106 men on entry revealed that health and justice costs were much higher than the general population for all clients.

At 12 months, the health costs of the men were significantly lower than they were on entry to the Michael Project, but still at higher levels than the general population. On entry the health costs on average were \$20,985 for the preceding 12 months. After 12 months, health costs on average were \$12,763, resulting in a cost saving of \$8,222 per Michael Project client. Importantly, analysis of the health service usage data reveals that many men had moved away from using the crisis end to the community end of the health system and were reporting a range of improvements that, while not captured in this cost benefit analysis, are still significant and point to ongoing reductions in expenditure over time.

Justice costs were also lower at 12 months than they were on entry, but to a lesser extent. On entry the justice costs on average were \$3,370 for the preceding 12 months, while after 12 month average justice costs were \$3,147, resulting in a cost saving of \$224 per Michael Project client.

For clients of the short and medium term accommodation services, the amount of money saved by the reduction in health and justice service utilisation was more than the cost of delivering the program. In short, for this group there was a net saving in delivering the Michael Project.

For clients of the street-based outreach and emergency accommodation services, there was also a reduction in health and justice spending. However, for these groups, the savings were of a smaller magnitude and did not entirely offset the cost of delivering the Project.

However, given the proportion of men who were clients of the short and medium term accommodation, an overall cost saving was achieved by the Michael Project.

6.2 MICHAEL PROJECT CLIENT COSTS ON ENTRY

As discussed in Sections 4 and 5, the characteristics of the Michael Project participants differ from the general population in areas such as higher incidence of mental and physical health conditions and higher drug and alcohol usage. As a consequence they have greater requirements for assistance from health services and a greater likelihood of contact with the justice system.

Table 6-1 displays the average annual health and justice costs of the follow-up group on entry compared with the average population costs. Column 5 reports the annual difference in the average cost for a member of the general population in NSW in 2008-09 and the average cost for a Michael Project client.

For example, the average number of nights in hospital per person in the general population is 0.76 nights. The average cost per person for an overnight stay in hospital is \$1,338 per night and therefore the population average cost is \$1,023 per person. For Michael Project participants an average of 5.08 nights per person was reported on entry, which multiplied by the same unit cost gives an average cost of \$6,972. The difference between these two values is \$5,769, which represents the annual difference per person for overnight hospital stays comparing an individual from the general population and a Michael Project participant.

Average cost and annual difference per person has been calculated for the Michael Project participants considered as a group. On entry the annual health and justice costs of Michael Project participants were \$24,355 compared to \$2,275 for the general population, meaning that the average Michael Project participant cost \$22,080 more than the average member of the general public over a 12 month period.

The overall health and overall justice costs for Michael Project clients are significantly higher than the general population. Upon entry, both health and justice costs for Michael Project clients were around 10 times more than the general population.

Michael Project participants were greater users of ambulance services and nights in hospital, mental health facilities and drug and alcohol detox/rehab compared to the general population.

They were also more likely to incur justice costs such as court appearances, nights in prison, remand, detention or correctional facility.

Table 6-1 Health and justice costs on entry among the follow-up group

	Population Statistics		On entry - All Clients (106)		Annual cost diff. \$ (5) = (4)-(2)
	Avg. occ (1)	Avg. cost \$ (2)	Avg. occ (3)	Avg. cost \$ (4)	
Health services					
GP	5.65	234	0.59	25	-209
Medical specialist consultation	1.17	80	2.52	173	93
Psychologist	0.12	11	1.65	149	138
Nurse or allied health professional consultation	0.56	45	2.61	212	167
Casualty or Emergency	0.32	56	1.34	234	178
Outpatient	2.55	282	2.91	322	40
Ambulance	0.13	89	1.14	764	675
Nights in hospital	0.76	1,023	5.08	6,792	5,769
Nights in mental health facility	0.12	79	3.61	2,440	2,361
Nights in drug and alcohol detox/rehab	0.02	6	33.48	9,875	9,869
Total Annual Health Cost		1,905		20,985	19,080
Justice services					
Victim of an assault/theft	0.05	97	0.14	264	167
Stopped by the police in street	0.16	14	3.20	272	258
Stopped by the police in vehicle	0.63	42	0.80	53	11
Apprehended by police	0.0020	0	0.74	125	125
Court	0.06	62	0.81	859	797
Visits to or from justice officers	0.16	14	0.80	68	54
Nights held by police (other than remand, detention, prison)	0.0005	0	0.33	74	74
Night in prison	0.40	110	2.76	761	651
Nights in remand, detention or correctional facility	0.12	32	3.24	894	862
Total Annual Justice Cost		370		3,370	3,000
Total Costs		2,275		24,355	22,080

*Average costs have been expressed as whole numbers. General population average cost for 'Apprehended by police' and 'Nights held by police (other than remand, detention, prison)' are \$0.34 and \$0.11 respectively.

6.3 REDUCTION IN EXPENDITURE OVER 12 MONTHS

Obtaining information from the men after 12 months allows for an estimation of their reduced service usage, and therefore the difference between their average health and justice costs on entry and at 12 months.

Table 6-2 reports the health and justice costs of the 106 clients that form the follow-up group of clients on entry and at 12 months.⁸ Columns 2 and 4 report the average cost on entry and at 12 months respectively and Column 5 presents the difference between these two values, that is, the costs savings realised by the 12 month point. Negative numbers in column 5 represent an increase in costs at 12 months whereas positive numbers represent a reduction in costs. There are important cost savings in respect of both health and justice service usage at 12 months.

Health

At 12 months there was an increase in service usage of GP, medical specialist consultations and allied health consultations, and in outpatient services, but a decrease in the use of ambulance services and a significant decrease in nights spent in hospital, mental health facilities and drug and alcohol detox and rehab services. Approximately 75 per cent of the cost reductions achieved were through a substantial decline in 'nights in drug and alcohol detox/rehab.'

This appears to demonstrate a movement away from the crisis end of the system to the community-based end; a movement away from a more chaotic usage of the health service system to more ordered service use which is shifting towards community norms (although there is still some way to go).

Table 6-2 shows that **there is a reduction of \$8,222 in total annual health costs at 12 months for all clients in the follow-up group**, which is the average annual health cost for Michael Project clients at baseline (\$20,985) less the average annual health costs after 12 months (\$12,763).

Justice

The justice picture is less clear, with a substantial decrease in nights spent in remand, detention or a correctional facility and a decrease in the amount of time spent in court, but an increase in the occurrences of being stopped by police on the street.

Table 6-2 shows a saving of \$224 in total annual justice costs at 12 months for all clients in the follow-up group, which is the average annual justice costs for Michael Project clients at baseline (\$3,370) less the average annual justice costs after 12 months (\$3,147).

⁸ The cost profile of clients who completed both the survey on entry and at 12 months, while similar, are not entirely representative of all clients on entry. See Flatau et al., 2011, for details.

Table 6-2 Health and justice costs on entry and at 12 months among the follow-up sample

	On entry - All Clients (106)		At 12 months - All Clients (106)		Annual cost diff. \$ (5) = (2)-(4)
	Avg. occ (1)	Avg. cost \$ (2)	Avg. occ (3)	Avg. cost \$ (4)	
<i>Health services</i>					
GP	0.59	25	8.47	350	-326
Medical specialist consultation	2.52	173	2.66	182	-10
Psychologist	1.65	149	1.21	109	40
Nurse or allied health professional consultation	2.61	212	3.40	276	-64
Casualty or Emergency	1.34	234	0.84	147	88
Outpatient	2.91	322	4.74	525	-203
Ambulance	1.14	764	0.92	613	152
Nights in hospital	5.08	6,792	4.04	5,403	1,389
Nights in mental health facility	3.61	2,440	2.15	1,454	986
Nights in drug and alcohol detox/rehab	33.48	9,875	12.56	3,704	6,171
Total Annual Health Cost		20,985		12,763	8,222
<i>Justice services</i>					
Victim of an assault/theft	0.14	264	0.16	300	-35
Stopped by the police in street	3.20	272	6.29	535	-263
Stopped by the police in vehicle	0.80	53	0.41	27	26
Apprehended by police	0.74	125	0.52	88	37
Court	0.81	859	0.67	711	148
Visits to or from justice officers	0.80	68	1.53	130	-62
Nights held by police (other than remand, detention, prison)	0.33	74	0.30	67	7
Night in prison	2.76	761	2.79	769	-9
Nights in remand, detention or correctional facility	3.24	894	1.89	520	373
Total Annual Justice Cost		3,370		3,147	224
Total Costs					8,446

The picture emerging from Table 6-2 is clear. At 12 months the overall health and justice costs for the follow-up group were significantly lower than they were on entry to the Michael Project. Table 6-2 shows a 39 per cent decrease in health costs and a 7 per cent decrease in justice costs. **The total annual cost saving for Michael Project clients is \$8,446.**

This 12 month picture is particularly significant given that the most intense interaction with the Michael Project is likely to have been over three months, given that was the typical length of accommodation support.

6.3.1 Differences between accommodation groups

The total picture given above conceals some notable differences within the follow-up group. The patterns detected in Sections 4 and 5 of important differences between those who accessed the Project through the short and medium term accommodation and those who accessed it through outreach and emergency accommodation are reaffirmed in the analysis of service usage and health and justice costs.

For the purpose of attaining the most accurate costs picture here, the outreach and emergency accommodation group has been further divided into outreach clients and emergency accommodation clients (notwithstanding dangers of diminishing sample size and consequent methodological limitations).

Short and medium term accommodation clients

As shown in Table 6-3, clients in short and medium term accommodation reported very high health costs of \$21,876 on entry. This fell significantly at 12 months, primarily due to a much lower average number of nights in drug and alcohol detoxification/rehabilitation facilities. The average cost for nights in mental health facilities also fell, as did casualty and emergency costs.

The lower usage of emergency and casualty services are likely to in part explain the significant decrease in overnight hospital stays and resulting \$2,291 saving in this area. Justice costs increased slightly for this cohort, primarily due to one client who was in prison at 12 months but not on entry, which was reflected in an increase in the average number of nights in prison among this group.

Table 6-3 Health and justice costs on entry and at 12 months among short and medium term accommodation clients (73)

	On entry short and medium term accommodation clients (73)		At 12 months short and medium term accommodation clients (73)		Annual cost diff. \$ (5) = (2)-(4)
	Avg. occ (1)	Avg. cost \$ (2)	Avg. occ (3)	Avg. cost \$ (4)	
<i>Health services</i>					
GP	6.43	266	7.63	315	-49
Medical specialist consultation	2.71	186	2.40	164	22
Psychologist	2.08	188	1.33	120	68
Nurse or allied health professional consultation	2.77	225	3.26	265	-40
Casualty or Emergency	0.90	158	0.66	115	43
Outpatient	2.11	233	5.86	649	-415
Ambulance	0.85	569	0.66	440	128
Nights in hospital	3.03	4,051	1.32	1,760	2,291
Nights in mental health facility	4.06	2,741	2.30	1,556	1,186
Nights in drug and alcohol detox/rehab	44.95	13,259	13.55	3,997	9,262
Total Annual Health Cost		21,876		9,380	12,496
<i>Justice services</i>					
Victim of an assault/theft	0.10	179	0.10	179	0
Stopped by the police in street	2.36	200	2.47	210	-9
Stopped by the police in vehicle	0.68	46	0.55	36	9
Apprehended by police	0.44	75	0.32	54	21
Court	0.68	727	0.55	581	145
Visits to or from justice officers	1.05	90	1.63	139	-49
Nights held by police (other than remand, detention, prison)	0.15	33	0.16	37	-3
Night in prison	0.92	253	2.97	820	-567
Nights in remand, detention or correctional facility	3.34	921	2.53	699	222
Total Annual Justice Cost		2,523		2,754	-231
Total Savings					12,264

Emergency accommodation clients

As shown in Table 6-4, emergency accommodation clients had the highest overall health costs on entry and at 12 months. Number of nights in hospital represented 74 per cent of the total cost in each time period. Due to sustained high costs in this area, only a small decrease in overall health costs was realised. As with clients in short and medium term accommodation, justice costs rose slightly for this group, primarily due to an increase in the average number of occasions of being stopped by police in the street.

Table 6-4 Health and justice costs on entry and at 12 months among emergency accommodation clients (22)

	On entry emergency accommodation clients (22)		At 12 months emergency accommodation clients (22)		Annual cost diff. \$ (5) = (2)-(4)
	Avg. occ (1)	Avg. cost \$ (2)	Avg. occ (3)	Avg. cost \$ (4)	
Health services					
GP	8.09	335	7.73	320	15
Medical specialist consultation	2.86	196	4.36	299	-103
Psychologist	0.86	78	1.41	127	-49
Nurse or allied health professional consultation	3.18	258	3.00	244	15
Casualty or Emergency	2.55	445	1.05	183	263
Outpatient	1.55	171	2.24	248	-77
Ambulance	1.82	1,217	1.05	700	517
Nights in hospital	13.73	18,369	12.82	17,153	1,217
Nights in mental health facility	3.95	2,673	2.73	1,843	830
Nights in drug and alcohol detox/rehab	3.82	1,126	7.32	2,159	-1,033
Total Annual Health Cost		24,869		23,275	1,594
Justice services					
Victim of an assault/theft	0.32	594	0.36	679	-85
Stopped by the police in street	5.64	479	15.68	1,333	-854
Stopped by the police in vehicle	0.18	12	0.14	9	3
Apprehended by police	1.18	201	0.82	139	62
Court	1.27	1,350	1.09	1,157	193
Visits to or from justice officers	0.27	23	1.91	162	-139
Nights held by police (other than remand, detention, prison)	0.68	151	0.73	162	-10
Night in prison	0.41	113	0.05	13	100
Nights in remand, detention or correctional facility	0.45	125	0.68	188	-63
Total Annual Justice Cost		3,050		3,843	-793
Total Savings					801

Street-based outreach clients

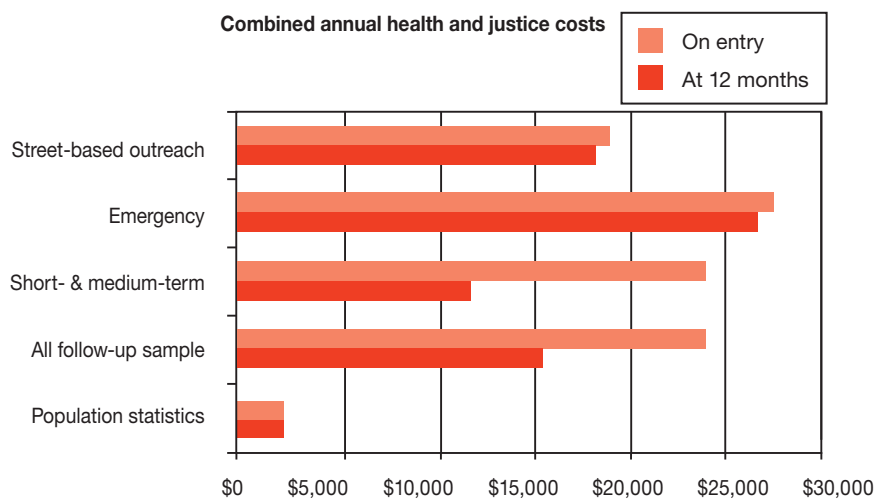
The group of clients receiving outreach support was the only group with health costs rising at 12 months. This is primarily due to an increase in the number of nights spent in hospital. Clients receiving street-based outreach had the highest justice costs among all groups on entry. This is largely due to high costs associated with average nights in prison or other correctional facilities. Due to a significant decrease in average number of nights spent in these facilities, costs fell sharply at 12 months.

Table 6-5 Health and justice costs on entry and at 12 months among street-based outreach clients (11)

	On entry street-based outreach clients (11)		At 12 months street-based outreach clients (11)		Annual cost diff. \$ (5) = (2)-(4)
	Avg. occ (1)	Avg. cost \$ (2)	Avg. occ (3)	Avg. cost \$ (4)	
Health services					
GP	7.27	301	15.45	639	-338
Medical specialist consultation	0.55	37	1.00	68	-31
Psychologist	0.36	33	0.00	0	33
Nurse or allied health professional consultation	0.45	37	5.09	413	-377
Casualty or Emergency	1.82	318	1.64	286	32
Outpatient	10.91	1,207	2.09	231	976
Ambulance	1.73	1,156	2.36	1,582	-426
Nights in hospital	1.36	1,825	4.55	6,083	-4,258
Nights in mental health facility	0.00	0	0.00	0	0
Nights in drug and alcohol detox/rehab	15.00	4,425	16.45	4,854	-429
Total Annual Health Cost		9,339		14,158	-4,819
Justice services					
Victim of an assault/theft	0.09	170	0.18	340	-170
Stopped by the police in street	3.91	332	14.33	1,218	-886
Stopped by the police in vehicle	2.82	187	0.00	0	187
Apprehended by police	1.82	309	1.27	216	93
Court	0.70	743	0.64	675	68
Visits to or from justice officers	0.18	15	0.09	8	8
Nights held by police (other than remand, detention, prison)	0.90	200	0.36	81	119
Night in prison	21.00	5,793	6.82	1,881	3,912
Nights in remand, detention or correctional facility	8.18	2,257	0.00	0	2,257
Total Annual Justice Cost		10,007		4,419	5,588
Total Savings					769

As seen from the tables above and illustrated in Figure 6-1 below, results on entry and at 12 months revealed that the costs incurred by clients in the 12 months following their entry into the Michael Project were substantially less than they were in the 12 months prior to entry. The total follow-up cohort, as well as clients within each of the accommodation groups, realised a cost saving at 12 months.

Figure 6-1 Combined annual health and justice costs on entry and at 12 months, by accommodation group



The short and medium term clients generated the greatest annual cost savings of \$12,264 per person, which was substantially higher than the emergency accommodation and street-based outreach groups which attained cost savings of less than \$1,000 (\$801 and \$769 respectively). How these savings compare to the costs of delivering the Michael Project is examined in the following section.

6.4 COSTS OF DELIVERING THE MICHAEL PROJECT

The cost of operating the Michael Project including accommodation, assertive case management and the 1:1 specialist services and supports was obtained through an *Agency Cost Survey* and the use of administrative data. The cost arrived at is inclusive of all expenditure associated with the function of the Michael Project, and is provided on a 'Michael Project cost per client' basis as shown in Table 6-6.

The cost of operating the homelessness programs was obtained through an *Agency Cost Survey*.⁹ Responses were supplied by the seven participating Mission Australia Michael Project services. Five of these provide short and medium term accommodation, another provides emergency accommodation and the other is a provider of a street-based outreach program. The cost of delivering assertive case management was also captured in the Survey and the cost of homelessness support is inclusive of expenditure associated with this function of the Michael Project. For consistency with average utilisation, program costs are, where possible, reported on a per client basis. A weighted average of total service cost was derived for the five short and medium term accommodation services and divided by an estimate of the total number of clients accessing these services¹⁰ to provide a per client unit cost. The per-client cost for the single emergency accommodation service was based on total cost over an estimated total number of clients.

Per-client unit costs were unable to be calculated for the outreach clients¹¹. A cost per support period was calculated in its place. As this service is an outreach service providing support to those on the streets when needed, it is likely that a significant proportion of clients accessing the service may use it multiple times in a given year. Cost per support period should be interpreted with caution as it is likely to be lower than cost per client.

⁹ While the costs captured for each of the accommodation services is as complete as possible they are influenced by a variety of funding mechanisms which results in different capital costs (or proxy thereof) for each service.

¹⁰ Estimates were determined from information provided in SAAP NDCA reports.

¹¹ The SAAP NDCA Agency Report for the service that provided support without accommodation lacked information that could be used to estimate cost per client.

In total, clients of 10 homelessness services in NSW utilised Michael Project specialist services.¹²

The Michael Project provided 11 specialist services, which were funded entirely from a philanthropic grant. The per client costs of delivering the Michael Project specialist services was calculated by dividing total annual costs by the recorded number of individual clients accessing the services within that same year. This gives a cost of \$989 per client, which has been added onto each of the per client costs of homelessness program to give the 'Michael Project cost per client'.¹³

Costs were significantly higher for short and medium term accommodation clients, primarily due to longer length of time of support provided to clients. Street-based outreach costs were the lowest; emergency accommodation costs were marginally higher.

Table 6-6 Estimation of cost of Michael Project, by accommodation type

Target group	Net Michael Project cost per client
Short and medium term accommodation client group	8,664*
Emergency accommodation client group	1,761
	Program cost per support period
Street-based outreach client group	1,377

* Costs for one of the five services providing short and medium term accommodation was inclusive of costs incurred by non-accommodation clients of the service. It has not been possible to isolate and remove these costs. As a result this service had an average per client cost of \$12,630 which is substantially higher than what would be expected for a short and medium term accommodation per client cost. Over one third of clients in short and medium term accommodation came from this service and the weighted average is therefore likely to be overestimated.

6.5 NET COST OF THE MICHAEL PROJECT

The net cost of the Michael Project is measured as the gross cost of providing the homelessness accommodation service and the assertive case management along with the Michael Project specialist services, minus any change in the cost of health and justice services.

While the cost is a comprehensive inclusion of both government and non-government sources of funding including a philanthropic grant, savings are measured only in terms of savings to government budgetary expenditure on health and justice services. From the evidence, it is clear there are good outcomes being achieved by men in the study in a range of areas, e.g. in housing and homelessness and economic participation, but the cost benefits of these are not included in this study.

Table 6-7 shows the net cost of the Michael Project by accommodation type. Column 2 shows the total savings results from Tables 6-3, 6-4 and 6-5 for each client group. The difference between these values and the cost per client values (Column 1) produce the net cost or net saving generated by the Project.

Table 6-7 Estimation of net cost of Michael Project, by accommodation type

Target group	Net Michael Project cost per client (1)	Health & Justice Savings (2)	Cost/Saving (3) = (2) - (1)
Short and medium term accommodation client group	8,664	12,264	3,600
Emergency accommodation client group	1,761	801	-960
	Program cost per support period		
Street-based outreach client group	1,377	769	-608

¹² Three services were run by Mission Australia's Parramatta Coalition partners. Only a small proportion of the total number of clients participating in the study were clients of these services and cost data has not been gathered for them. Each of these three services provided clients with short and medium term accommodation. For the purposes of cost analysis it has been assumed that their average cost per client does not differ from the weighted average cost of the Mission Australia providers of short and medium term accommodation. Clients from all ten services have been included, however; in the total number of Michael Project clients (the figure used to derive the average cost of the Michael Project on a per-client basis).

¹³ Not all clients in the follow-up sample were recipients of Michael Project specialist services and supports. See Section 5.1.1.

As can be seen in Table 6-7, emergency accommodation clients and street-based outreach clients experienced higher per-client costs than savings. That is, there is a net cost of delivering the Michael Project to clients in the outreach and emergency accommodation groups. However, it is still important to note that health and justice costs have reduced for these groups, but not to the extent that they nullify or exceed the cost of delivering the Project.

Short and medium term accommodation clients, however, had a significant net saving. That is, the reduction in expenditure resulting from decreasing utilisation of health and justice services outweighed the cost of providing the Michael Project to clients. Given the greater numbers of clients from the short and medium term accommodation, the overall savings from the Michael Project outweighed the costs considerably.

6.6 CONCLUSION

In summary, this chapter has shown that:

1. Prior to entry, health and justice costs for Michael Project clients were much higher than for those of the general population;
2. After involvement in the Michael Project, average health and justice costs for clients were reduced;
3. For short and medium term clients, the cost reduction associated with the Michael Project exceeded the cost of delivering the program, resulting in a substantial net saving. As they also formed the greatest proportion of participants there was an overall net saving generated by the Michael Project.

Health and justice represent significant areas of government expenditure that have experienced savings after client participation in the Michael Project. Improvements in other aspects of a client's life that have been discussed throughout the report, together with these results, indicate that savings may be also made in a range of other areas of expenditure that are strongly associated with homelessness.



7. Achievements and challenges

The evidence presented in Section 4 indicates that improved outcomes were achieved at the 12 month point. Section 5 identified some of the key contributors to these outcomes and Section 6 provided a sense of the costs and savings incurred in achieving in these outcomes. Overall, the key achievements of the Michael Project were to improve service delivery to homeless men and to contribute to the national evidence base on homelessness.

The Michael Project was ambitious and complex. There were clear challenges to those involved in delivering it, as well as in conducting the research. In this section some of the achievements and challenges from both an operational and research perspective are considered. Much can be learnt from these achievements and challenges.

7.1 OPERATIONAL ACHIEVEMENTS AND CHALLENGES

7.1.1 Model development

A key challenge was to develop a model of support in the context of high levels of ongoing need, therefore balancing the desire to act immediately to provide support with the need to adequately ground the proposed intervention. An important lesson to emerge from the process was allowing sufficient time and resources to develop a service model such as the Michael Project, notwithstanding the urgency that exists to work as swiftly as possible to provide support to people in crisis. Consultation, including with clients and practitioners, service mapping and a survey of the relevant literature needs to be effectively built in to any development process, so that the intervention, the rationale and the assumptions behind it are made as clear as possible prior to service implementation. In this respect, the experience of those involved had a significant impact on the development of the next phase of the Michael Project, MISHA.

Like many new interventions, the Michael Project emerged in a rolling fashion. It was launched in October 2007 and began operating in November of the same year with a small number of the specialist services on board. By the time the research commenced in November 2008 the Michael Project was fully operational. From the beginning the Michael Project was flexible and quickly developed into a dynamic operation that could quickly change and grow as operational circumstances demanded, for example in forging good relationships with the Milk Crate Theatre which meant many men were able to access this service, or adjusting to the limitations of the proposed model of literacy and numeracy training.

7.1.2 Holistic and integrated service provision

The Michael Project offered a new holistic and integrated system of service provision for homeless men. It combined the three key elements of accommodation support, assertive case management and 11 specialist providers. It operated across all Mission Australia accommodation support services for men in metropolitan Sydney, as well as those provided by the Parramatta Coalition partners, and crossed geographic, service and program boundaries.

There were many challenges associated with operating such a widespread and dynamic project. Relationships needed to be built and maintained with other agencies. New professional relationships between the case managers and specialist providers had to be negotiated, and issues such as appropriate sharing of client information resolved.

With its geographic sweep and ambition came a number of challenges to ensuring guaranteed access to the specialist providers. In particular, a significant amount of the specialists' time was taken up by travel. The way in which the Michael Project was operationalised worked to ensure a democracy of service provision so clients in one area were not disadvantaged with respect to clients in another, but this was difficult to achieve. Ideally, specialist providers would be based at each of the Michael Project accommodation services.

7.1.3 Case management

At the outset, the different Michael Project accommodation services, while sharing a number of commonalities, lacked a truly consistent approach to case management. It was important for case management practices to be standardised across the accommodation services, both to ensure that there was equitable access to support for Michael Project clients and also to meet the needs of the research study in comparing outcomes for clients across the different services.

The assertive case management approach followed in the Michael Project attempted, with the support of case managers, to lift existing case management practice to a new level and create a set of standard procedures and processes across all adult accommodation services for men in the Sydney metropolitan region. It was a significant challenge for case management practices to be revised in this way and an important achievement that this was done.

One challenge facing case managers was the fine line between assertive case management and the invitation to participate. While the assertive case management model directed staff to actively encourage men to take up the Michael Project services, it was important that participants felt able to take part in a way that was of their own choosing.

The time-limited nature of the intervention meant that concentrated and intense support could be provided by case managers and specialists within a three month period. One of the challenges facing staff was the depth of issues faced by many clients. While the Michael Project was flexible and dynamic, and efforts were made to support the men beyond the term of their accommodation, it was a significant challenge facing the case managers and specialists to only be able to provide intensive support over a three-month period.

7.1.4 Specialist provider program

The specialist providers were managed from within Mission Australia, thereby eradicating administrative barriers to clients accessing services. From the outset, the goal was to guarantee the access of every client entering the Project to all of the specialist providers at any point in time they required. As is evident from Table 3-1 in Section 3 there were two main contractual arrangements for the specialist providers, either direct employment by Mission Australia (e.g. the psychologist) or contracting a mainstream provider (e.g. Westmead Centre for Oral Health with respect to the dentist). The exception was the barber services, where clients were able to go to a barber in their local area and then be reimbursed for the cost.

While the process of establishing these arrangements was often challenging and complex, it also represented one of the real achievements of the Michael Project in bringing mainstream providers into the homelessness service system, but on terms arranged by homelessness services and designed to suit their clients. In this way the Michael Project played a role in supporting cultural change in the wider mainstream service system so that these services become more responsive to the needs of people experiencing homelessness.

7.1.5 Affordable housing

The Michael Project provided temporary accommodation while working with clients to achieve permanent or longer term housing. Good outcomes were achieved despite there not being guaranteed housing exit points built into the Michael Project service delivery model design. However, it is clear that being able to work with people with the aim of finding longer term housing options is also critically dependent on the supply of long term affordable housing. From the research it is evident that there were cases where there were no exit options and men remained in services for an extended period. A key ongoing national challenge is to continue to grow the supply of affordable housing.

7.1.6 Taking part in the research collaboration

Those responsible for operationalising the Michael Project were involved in the research component from the beginning. The operational leadership team played a role in selecting the collaborative research team, in helping the research team to understand the aims of the intervention as well as in familiarising the research team with the various sites. Given the rolling recruitment of clients into the research across 10 sites, case managers served as interviewers on entry (subsequent surveys were carried out by the research team.) The involvement of case managers as interviewers for the baseline surveys had both positive and negative effects. On the one hand, it enabled them to find out more about their clients than they otherwise would through standard intake procedures, allowing them to adjust their service provision and work with clients in ways they had not previously been able to. On the other, conducting the surveys could be time consuming and clients were sometimes reluctant to participate in the research. Overall, the operational staff demonstrated a strong commitment to the research throughout the Project.

7.2 RESEARCH ACHIEVEMENTS AND CHALLENGES¹⁴

7.2.1 A hybrid model of research

The research was carried out through a hybrid model of research that sought to draw on academic, service agency and philanthropic expertise. As such it was very different to a consultancy approach or one from within the service delivery agency. Achievements included building the capacity of the collaborative research team, while challenges included maintaining the cohesion of the team and the different research imperatives. Implementing a hybrid model of collaborative research partnership that drew on academic, service agency and philanthropic expertise was a significant achievement of the Michael Project research.

7.2.2 Understanding the intervention

The pragmatic nature of the proposed intervention meant that it worked with the existing system and consequently was complicated and multi-faceted. In developing the research design, the research team helped to refine the intervention, and maintained ongoing communication with the operations staff to ensure that the implemented program was understood and could inform the research findings.

7.2.3 Appropriate research methods and design

There were a number of challenges faced in terms of identifying appropriate research methods to use with men experiencing homelessness. These included:

- Conducting the research in a dynamic and fluid environment in which the needs of the clients - not the research - was paramount.
- Understanding what could be reasonably asked of men experiencing homelessness, especially those with only light touch contact (such as those from outreach and emergency accommodation services) with the Michael Project. This was about balancing the desire for detailed empirical information from a research perspective with the demands of service delivery.
- Choosing appropriate research instruments that would yield national and international comparative data but which were not so cumbersome as to frustrate clients and staff. A related challenge was that many of the existing instruments which would provide for comparability were from outside the homeless field and therefore may have had limited relevance to clients.
- Tracking a group of homeless men over one year in multiple settings, many of whom left the Michael Project service delivery environment. A significant achievement of the Michael Project was being able to successfully undertake this tracking and conduct the most in-depth longitudinal study of homeless men in Australia. This has also resulted in collecting the best costs data yet available in Australia.
- Committing to report throughout the course of the Project in a range of fora to inform the dynamic policy, research and practice environment while maintaining research rigour and integrity.
- Deciding on the overall research design and method. Consideration was given to a randomised control trial in the design phase but was ruled out because of ethical considerations in giving one group of men a service but denying it to others. This raised issues related to how to find a comparison group.

7.2.4 A vehicle for the voice of men experiencing homelessness

Perhaps the most significant achievement of the research was to provide a vehicle through which men experiencing homelessness were able to voice their issues and an opportunity to contribute to service development. To the researcher's final question 'what's it like for you being involved in the research with the Michael Project', a client in his late fifties responded,

I feel honoured...if my answers help the project in any way, well, I think it's great.

The Michael Project, through inviting clients to participate in surveys and interviews, provided an important opportunity for clients to contribute to service development and give something back to services. It is notable that the desire to contribute or 'give back' was one of the common themes in interviews with men.

¹⁴These challenges and achievements are set out more fully in Flatau et al., 2011.

7.2.5 Integrating operations and research

One of the most noteworthy achievements of the Michael Project was the way in which the operations team and the research team worked together. The hybrid research model that was implemented was mutually beneficial and has resulted in better research and better service delivery including:

- Involvement of operations team in selection of researchers.
- Research influence in clarifying the service model as part of the process of research design.
- Research influence on case management.
- Case managers getting to know clients better through administering the survey.
- Increased understanding of service delivery and client context by researchers due to operational staff input.
- Collaboration of research and operational staff on administrative data collection.
- Participation of research and operational staff in steering committee meetings and consequent transfer of high level information.
- Regular feedback of research results to operational staff.

7.3 SUMMARY

The Michael Project faced challenges both from an operational and research perspective. Meeting those challenges has increased Mission Australia's knowledge about building innovative practice and conducting research in a service environment. The two stand-out achievements of the Michael Project have been:

- To improve service delivery, not just by adding to the services that men who are homeless are able to access but the way in which those services are provided.
- To add to the national evidence base in respect of the profile of homeless men and service delivery to a population with complex needs.

At the heart of the Michael Project was a large community collaboration facilitated by a philanthropic donor, anchored by Mission Australia and animated by the men themselves. Collaboration was at the heart of the intersecting circles of service provision and research: between Mission Australia and the Parramatta Coalition partners, between different specialist homelessness services, between specialist homelessness services and specialist services and supports; between academics, researchers at Mission Australia, operations staff and the pro bono support of FlowConnect.

The Michael Project, using philanthropic dollars to leverage outcomes and facilitate partnerships, provides evidence in action of the maxim contained in the White Paper that addressing homelessness is everybody's business. In particular, the Michael Project research was particularly focused on enabling client and practitioner voice in the research guided by the perspective that if the national targets are to be met it is the wisdom and actions of practitioners within the specialist homelessness system and the views of clients of the system itself that will be key in helping to get us there.

The Michael Project is a concrete example of bridging the gap between the research, policy and practice spheres in the area of homelessness.



8. Conclusion: Implications for policy and practice

The ambitious top level targets set in the White Paper to halve homelessness and offer supported accommodation to all those who need it by 2020 require a whole of community response. The White Paper acknowledges that these targets cannot be met by government, accommodation support services, not-for-profit organisations or individuals alone.

The Michael Project, supported by a philanthropic donation, was a large-scale collaboration that provided support to many homeless men during the life of the Project. This was money that would not have ordinarily been in the homelessness system. With the support of Mission Australia, the Michael Project was able to fund an integrated service model, provide a better range of services and supports than men experiencing homelessness would otherwise have had access to, and support a sophisticated research study.

8.1 BETTER UNDERSTANDING THE CIRCUMSTANCES AND NEEDS OF PEOPLE WHO ARE HOMELESS

In terms of the profile data, some of the Michael Project results confirm what was already known about homeless men, such as their poor mental and physical health and substance use issues. However, some of the knowledge generated by the research study gives us new insight into their circumstances, including their relatively recent attachment to the labour market, their often fragmented or tenuous relationships with family including their children, and their high rates of self-efficacy. Findings regarding psychological distress and trauma were also of note and have served to develop and deepen existing research (Taylor, 2007). These findings are explored in more detail in *Increasing our understanding of homeless men: The Michael Project* (Mission Australia, 2010).

A strong sense of the changes that men who are homeless have been able to make over the course of a year has emerged through the Michael Project Research Study. Positive outcomes were achieved by participants in the three months following their entry into the Michael Project, as documented previously in *How homeless men are faring: Some initial outcomes from the Michael Project* (Mission Australia, 2011).

After 12 months, the same and even stronger positive outcomes were in evidence, which is particularly notable given that it is likely that participants had their most intensive interactions with the Michael Project in the initial three month period. Most importantly of all, as the evidence presented in Sections 4, 5, and 6 demonstrates, the Michael Project collaboration had real impact on the lives of many men, with important implications for meeting the national targets both in terms of the outcomes achieved as well as the nature of the collaboration across sectors and specialties.

8.2 SUPPORTING AN INTEGRATED MODEL

The Michael Project provides an example of a model of support that is effective in supporting men with complex needs to achieve outcomes in a number of areas, using a blend of temporary accommodation, assertive case management and guaranteed access to specialist services and supports. While men over 25 are the single largest group accessing accommodation services, the lessons from the Michael Project may have applicability to other population groups, especially with respect to integrating mainstream services with accommodation support services.

The existing system of accommodation and support is central to the achievement of the outcomes demonstrated in this report. With more resources, more is possible. The Michael Project supported the accommodation support services involved to raise the level of service provision they could offer through increasing the sophistication of their case management practices as well as the range of specialist services and supports that could be directly accessed. Having the specialist providers working in such close proximity with the case managers meant that they could learn from each other and each improve their practice.

The specialist providers were able to acquire a much more detailed knowledge about men experiencing homelessness and how best to work with them, while the case managers were able to see a different side of the men they worked with and be inspired in their practice by seeing the positive changes made by the men in interacting with the specialists.

The Michael Project therefore is the story of what happens when extra resources are funnelled into the existing system of accommodation support and more is demanded of it. It serves as a model of how better outcomes for men with complex needs can be achieved, and a successful example of an approach to homelessness. While acknowledging the positive outcomes that were achieved for the group as a whole, the research clearly demonstrates that the Michael Project, like many interventions, worked better for some than others. The Michael Project is a strong model for a particular group: those men who were in short and medium term accommodation. It is less strong for those who are sleeping rough or staying in emergency accommodation.

It is lessons such as these which have gone on to inform Mission Australia's work on the next stage of the project, MISHA. A key feature of this new initiative is to provide permanent housing to men who are chronically homeless. In addition to permanent housing, MISHA provides an assertive, multi-disciplinary case management service; access to a psychologist; access to meaningful activity including recreational, education and training opportunities; and social network support. Support services are available to clients for as long as they need them, and it is expected that MISHA services will be provided to clients for 12 to 15 months on average. There are lessons to be derived from the Michael Project experience that can be applied across the homeless population as well as to particular groups within it.

8.3 LOOKING AHEAD: BUILDING ON WHAT EXISTS

The Michael Project contains important lessons for the National Affordable Housing Agreement (NAHA) and National Partnership Agreement on Homelessness (NPAH) on how the national targets to reduce homelessness can be met by better supporting the system of accommodation support through increased resourcing and expectations of the system. At the heart of this is the need for the existing system of accommodation support to be better supported to deal with the complexity of many of the clients entering these services. This begins with having the capacity to undertake a comprehensive assessment of the needs of the clients, case planning in consultation with clients and the direct provision of the specialist services and supports that these clients require.

The implementation of an integrated service model that builds on the agency of individuals, provides active and respectful case management and guarantees access to a range of specialist services is key. Many men experiencing homelessness struggle to access mainstream health and other support services when they need them. The Michael Project reduced the administrative barriers to service access by directly employing or contracting a range of service providers who, either full time or part time, were solely dedicated to supporting the needs of Michael Project clients. It is not simply a matter of providing brokerage for people to access services, but providing the services themselves so people do not get lost in the service system but are given priority access.

The White Paper, *The Road Home*, recognised that mainstream services have a lead role in the prevention of homelessness. While acknowledging the importance of mainstream agencies in this preventative role it would be unwise to place too great an expectation on them in working with people once they are homeless. Mainstream services by their very definition work with all members of the Australian community and generally are in significant demand from a broad and varied group. Experience from across the social sector demonstrates how hard it is for groups with complex needs to interface with the mainstream service system that focuses on a primary presenting need. People who are homeless often have high, multiple and complex needs and these clients will only ever be at the margins of any mainstream service population group. The net result is that it is likely that they will be lost in mainstream services and forever end up in the most expensive parts of the system.

Once people become homeless their needs are best met from within the system of accommodation support. The Michael Project offers an approach in which specific mainstream services are integrated into the accommodation support system. The key to this approach is the notion of a hub of specialist services and supports, whether located onsite in an environment such as a community centre which people who are homeless can directly access, or located offsite, where services and supports are made available to clients in their accommodation. At the heart of this approach is a commitment to meeting people where they are at.

If we are serious about the goals of the NPAH to 'reduce homelessness and increase social inclusion' in the timeframe of the national targets, then building on the strongest available resource, the current system of accommodation support and the people within it, is the best way forward. While we need to continually add to the supply of affordable housing, we also need to work with what already exists to address homelessness (including the strong accommodation support system), by fashioning appropriate responses to different groups of people who are homeless, and by supporting cultural change in the wider mainstream service system so that these services are more responsive to the needs of people experiencing homelessness. The Michael Project demonstrates an approach that integrates specialist services within homelessness services. Good outcomes can be achieved through this approach. Enhanced, timely and integrated service delivery can improve the social inclusion of homeless men.

Ultimately, there cannot be a 'one size fits all' approach to homelessness service delivery. The evidence from the Michael Project demonstrates that different groups have different needs and require different service responses. What is an appropriate and proportionate response for one group is not necessarily the same for another. New ways need to be found to further animate the existing service delivery system to ensure that the sort of sophisticated response required is available.

The evidence presented here suggests that identifying accommodation support services as lead agencies while tapping into the experience and capacity of mainstream services offers a concrete way forward. It is only in this way that the spirit and letter of the national targets can be met.

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About Mission Australia

Mission Australia is a Christian community service organisation that has been transforming the lives of Australians in need for more than 150 years.

Today we are one of the nation's leading community services organisations, operating more than 550 community and employment services from 350 sites in metropolitan, rural and regional Australia.

In 2010-11, our services assisted more than 300,000 Australians by providing a hand up, a way forward and hope for the future.

We work towards creating a fairer Australia by advocating for people in need and helping them to get back on their feet. We strengthen families, empower youth, strive to solve homelessness and provide employment solutions.

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