Evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI): First Report

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Table of Contents

List of Tables

List of Figures

Abbreviations

AMHS	Area Mental Health Service
ASP	Accommodation Support Provider
CALD	Culturally and Linguistically Diverse
CTTT	Consumer Trader and Tenancy Tribunal
DEC	Departmental Executive Committee
DSRC	Disability Studies and Research Centre
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
ISP	Individual Service Plan
MDS	Minimum Data Set
MHDAO	Mental Health and Drug and Alcohol Office
NGO	Non-government organisation
NSW	New South Wales
OT	Occupational Therapy
PWI	Personal Wellbeing Index
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive Summary

The Housing and Accommodation Support Initiative (HASI) aims to provide people with mental illness in New South Wales (NSW) with access to stable housing, accommodation support, and clinical mental health services. HASI is designed to assist people with mental health disorders to participate in the community, to experience improved quality of life, prevent homelessness and, most importantly, to support their recovery from mental illness. Approximately 1167 consumers are currently participating in the program

The Social Policy Research Centre (SPRC) was contracted in 2009 to undertake a mixed method evaluation of the initiative. The evaluation aims to understand the effectiveness of the whole of the HASI program by investigating the support for consumers, benefits and limitations of the service model, and the cost effectiveness of the program. This first report of the evaluation draws on program data and 112 interviews with stakeholders and consumers from three sites in NSW to understand the profile of current clients, the types of services provided by HASI and the framework for service delivery. The report focuses on the processes of HASI and the services provided to clients by ASPs, which are based on the principles of rehabilitation, client centred support and flexibility. While a brief outline of client reported outcomes is included, quantitative client outcomes drawn from administrative data collected from NSW Health and Housing NSW, the HASI Minimum Data Set (MDS), and the MDS Supplement will be included in the next report.

Key findings

Preliminary findings suggest that HASI is successfully attracting its target group. The profile of clients suggests that, with the exception of people from Culturally and Linguistically Diverse backgrounds, there are no substantial gaps in the demographic makeup of HASI clients. Women and people from an Indigenous background are better represented among HASI clients than they were in the evaluation of Stage One, all clients have at least one diagnosed mental illness, and many also have a secondary mental illness or other co-morbidity. Although this preliminary analysis suggests that HASI is attracting the intended target group, more research is needed on the extent to which HASI is attracting people who have insecure tenancy.

Stakeholders reported that the target group is identified and selected through clear referral pathways, which have improved over time due to the growing awareness of, and support for, the program in most Area Mental Health Services (AMHS). In areas where there are multiple Accommodation Support Providers (ASP), however, there was some confusion around referral pathways into the program. Local selection committees have been effective in selecting clients that fit the program's target group. These committees work well because there are common procedures which guide the process but also flexibility to adapt to the local service context. ASPs also work well together to coordinate the selection process. Preliminary evidence suggests there was, however, some variation in selection processes according to how ASPs assess a person's ability to participate in rehabilitation activities.

Stakeholders and clients were overwhelmingly positive about the support provided by ASP staff. The preliminary data also suggests that ASPs have different interpretations

of recovery based practice, and that it can be difficult to strike a balance between providing client centred support and assisting clients to develop the confidence to become more independent from ASP staff.

The HASI model is founded on partnerships between and within NSW Health, Housing NSW and ASPs. Overall, partnerships between and within these groups are generally effective. The AMHS and ASPs have built particularly sound working relationships, and the relationships between the ASPs and housing providers are generally appropriate. Four factors remain important to facilitating effective working relationships: having clear roles and responsibilities, maintaining open communication, having a commitment to work together, and having sound local governance processes.

At a State level, the governance structure appears to be working well. Two issues have been identified that require further investigation: the way ASP funding has been rolled out and the resulting structural rigidity of the program and issues related to how accommodation is accessed under the program. The flexibility of support provided means that when a client's support hours decrease, ASPs reduce the number of hours spent with the client. This has resulted in outstanding support hours and a funding surplus, which was used by evaluation sites to address local needs. Given that the provision of flexible services is crucial to promote an individual's recovery process, one of the key challenges facing HASI is how to tailor the structure of the program and current funding model so that it encourages both flexibility and accountability. Further investigation of the accommodation related issues will be undertaken in the next phase of the evaluation.

Clients interviewed for the evaluation overwhelmingly reported that their lives had improved since they began receiving HASI services. Most clients interviewed had a history of insecure housing and this improved while they were in HASI. Clients experienced substantial improvements in their mental health since becoming HASI clients, including developing better ways of managing their illness to stay out of hospital. Overall, clients reported being less satisfied with their physical health than their mental health. Some clients experienced improved social relationships and increased involvement in community activities, education and employment, although many clients were still struggling with feelings of isolation and loneliness.

Conclusion

The HASI program continues to provide much needed services and support to adults with mental illness in NSW. Even with some ongoing challenges evident in the delivery of services and coordination between partners, the current service model appears to be working well to deliver support for clients. The next evaluation report, which will be completed in August 2010, will focus on the extent to which the HASI model is achieving its intended impact on current clients.

1 Introduction

The Housing and Accommodation Support Initiative (HASI) aims to provide people with mental illness in New South Wales (NSW) with access to stable housing, accommodation support, and clinical mental health services. Initially funded to provide service to 100 people in 2002, the HASI program has since expanded to support over 1000 mental health consumers across NSW. The Social Policy Research Centre (SPRC) was contracted in 2009 to undertake a mixed method evaluation of the initiative. The evaluation aims to understand how well the whole of the HASI program is working by investigating the effectiveness of support for consumers, benefits and limitations of the service model, and the cost effectiveness of the program.

This is the first report of the 2009-2011 whole of the HASI program evaluation. This report presents preliminary analysis about how the program is meeting its objectives in relation to the effectiveness of the service model and partnerships. While it includes a preliminary discussion of how the program is achieving outcomes for clients, this is not a major focus of this report and will be included in future reports. The report provides a demographic and service use profile of current HASI clients. It also draws on 112 interviews with stakeholders and consumers from three sites in NSW to examine emerging issues in relation to the effectiveness of the service model and key partnerships, and the program's governance structure.

1.1 Aims of HASI

HASI is designed to assist people with mental illness to participate in the community, to experience improved quality of life, prevent homelessness and, most importantly, the program assists in the recovery from mental illness. It aims to achieve this by linking people with mental illness to clinical mental health services, secure housing and accommodation support.

The specific aims of the program are to:

- provide people with mental illness ongoing clinical mental health services and rehabilitation within a recovery framework;
- assist people with mental illness to participate in community life and to improve their quality of life;
- assist people with mental illness to access and maintain stable and secure housing; and
- establish, maintain and strengthen housing and support partnerships in the community.

The program is available to adults with a diagnosed mental illness who require support services (and, in most cases, housing) to live independently in the community. Since the implementation of Stage One in 2002, which funded high level support services, HASI has expanded to provide low to very high levels of support to people with mental illness across NSW. Although the core objectives of HASI have remained the same since the program's inception, the service delivery system has evolved and

different groups of mental health consumers have been targeted. All stages of HASI provide some level of accommodation support services, and most (with the exception of 4B or HASI in the Home) provide services to people who are eligible for, or who are currently living in social housing.

1.2 Service delivery framework

HASI is a partnership model between NSW Health, Housing NSW, and non-government organisations (NGOs). NSW Health is responsible for providing ongoing clinical care to clients through Area Mental Health Services (AMHS) and funding accommodation support which is provided by NGO Accommodation Support Providers (ASPs). ASPs also work with local AMHS staff to provide client focused care planning and access to appropriate services (NSW Health, 2006: 25). Finally, Housing NSW provides a mix of public and community housing properties to people who are accepted onto high and very high support packages as well as tenancy management services.

The governance of HASI is overseen by the Housing and Mental Health Partnerships Senior Officers Meeting and the Departmental Executive Committee (DEC). The Senior Officers Meeting manages the strategic development, overall governance arrangements and future planning of the initiative, whereas the DEC focuses on policy and operational effectiveness issues. In addition, the HASI stakeholder group also discusses and provides advice to the DEC on policy and operational matters. At the local level, HASI is managed by Local Coordination Groups, which aim to foster partnerships between the AMHS, Housing provider(s) and the ASPs in each area.

1.3 HASI logic model

The premise of HASI is that some people who have a diagnosed mental illness require support services to suit their individual needs to live independently in the community. The logic model of the program is illustrated in Figure 1.1. It follows three key assumptions:

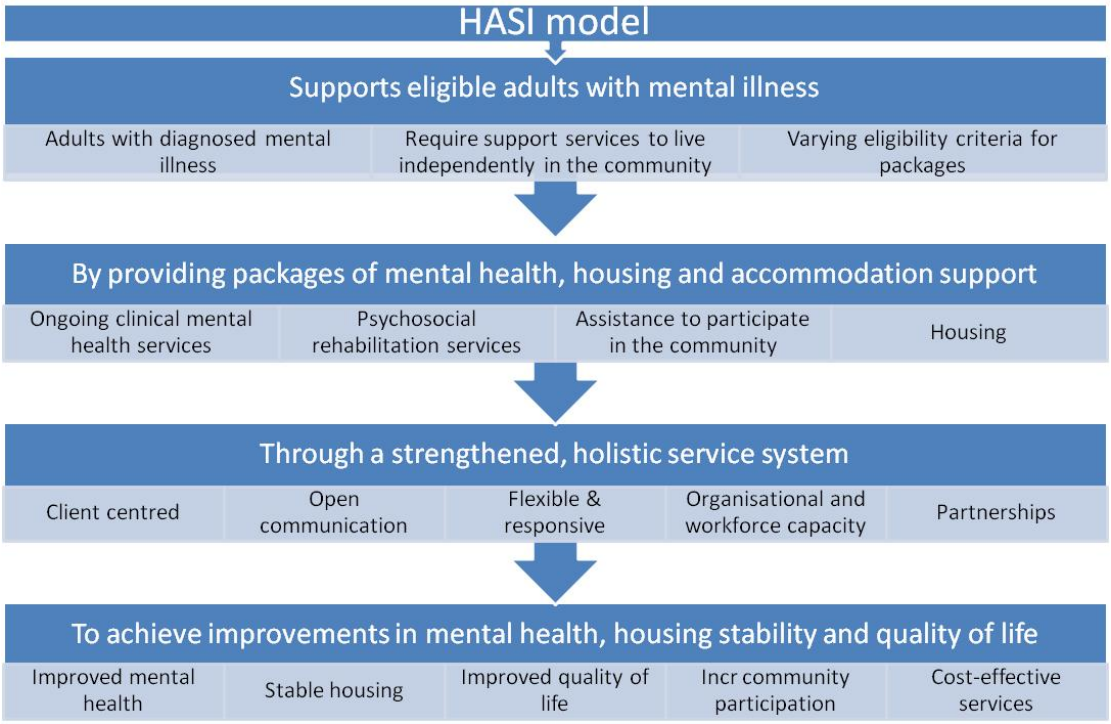
- If people with a mental illness are supported with appropriate services and support such as housing, clinical mental health services, rehabilitation services, assistance to participate in community networks and activities;

- And those services are provided in a co-ordinated and collaborative way that is defined by organisational capacity, strong partnerships and is client centred, features open communication, is flexible and responsive;

- Then it is likely that the service model will achieve beneficial outcomes for clients, such as improvements in mental health, access and maintenance of secure housing, improved quality of life and increased community participation.

The evaluation tests the hypothesis of the HASI model. This report focuses predominantly on who is the target group of the program, what kind of support is delivered and how this support is being delivered. Preliminary outcome themes are explored, however, outcomes will be the major focus of the next report.

Figure 1.1: HASI Logic Model



1.4 Conclusion

This report provides a preliminary analysis of the profile of clients who are currently accessing HASI, and some early findings from the qualitative data regarding the changes experienced by clients of the program. The report also flags emerging issues around the supports provided to clients, partnerships, and governance.

2 Methodology

This is the first report of the 2009-2011 evaluation of the HASI program. The evaluation draws on a longitudinal, mixed methods approach to meet the three key aims of the evaluation, which are to:

- Review the effectiveness and efficiency of the program as a whole in meeting its aims and objectives for clients around the areas of tenancy, service access, mental and physical health, social connections, community participation, and quality of life;

- Assess the effectiveness and efficiency of the HASI stages individually and collectively including the operational effectiveness of service delivery and partnership models, as well as the costs and benefits of the model.

- Contribute to ongoing improvements in the support provided to HASI clients and to partnership arrangements.

As described in the previous section, a logic model theoretical approach is used to provide the basis for understanding how the inputs, activities and outputs of the program impact on the outcomes experienced by clients. In addition, a process evaluation which focuses on how services operate to provide support to clients and foster partnerships between the Housing NSW, NSW Health and ASP service providers in each area as well as at the state level, is being conducted.

This report draws on demographic and service use data from the HASI Minimum Data Set (MDS) and 112 interviews with clients and other stakeholders in three sites across the state. This section provides the details of these methods and also discusses how this report fits in with the broader evaluation. More detail about the evaluation framework and the methods used to address the evaluation questions can be found in the evaluation plan (McDermott et al., 2009). This research received ethics approval from the UNSW Human Research Ethics Committee and the NSW Population and Health Services Research Ethics Committee in 2009.

2.1 Program data

The ASPs complete quarterly reports on each client's service use as part of the monitoring requirements of the program. During the first quarter that a client enters the program, an initial applicant form is completed which includes questions about their gender, age, mental health status and tenancy history. Each quarter thereafter, ASP staff complete a report on each client detailing the services received in areas such as housing and health.[1]

The HASI program monitoring data was first collected in July 2006, and the first two monitoring periods (July-September and October-December, 2006) were pilot

[1] This information is completed by NGOs and is compiled by InforMH, which is a unit within NSW Health responsible for data management. The HASI MDS was previously managed by ARTD consultants.

periods. There are significant gaps in the data for these pilot periods so reliable data cover the period from 1 January 2007 to 30 June 2009.

The MDS was analysed in this report to understand the demographic characteristics and service profile of current clients. The analysis draws on a snapshot of current clients (n=895) in the April to June 2009 reporting period for whom demographic and service use data was available and for whom this data could be linked.[2] It is important to note that Section 3 includes additional data on a larger cohort of clients who exited the program between January 2007 and June 2009.

2.2 Qualitative data

Qualitative interviews with clients and stakeholders were conducted in three locations in NSW in October 2009 to understand the strengths and weakness of the program, the perspectives of clients on the support model, and the impact it has had on clients. Table 2.1 outlines the number of people interviewed in each stakeholder group. It shows that more ASPs were interviewed in this first round of data collection than was originally intended (see McDermott et al., 2009). This is due in part to the instrumental role that ASP staff members play in the program as well as the variety of ASPs in the program. In addition, few family members or carers were interviewed in 2009 because many clients did not have regular contact with family members and some could not be contacted in this round. In the next round of data collection, which will take place in September 2010, researchers will focus on increasing the numbers of family and carers, housing and mental health professionals, and other stakeholders in the sample (e.g. those from relevant peak bodies and advocacy groups).

Table 2.1: Interviews by Stakeholder Group

Stakeholder group	n	Per cent
Mental health professionals	11	10
Housing (public and community)	10	9
Accommodation support providers	29	26
Other stakeholders	2	2
Family or carers	1	1
Client interviews	59	53
Total	112	100

Interviews took place in a metropolitan, regional and rural location in NSW. These locations were chosen to maximise learning outcomes around the way the model operates in areas with a different mix of accommodation support providers, public and community housing providers, and local governance structures. Table 2.2 outlines the spread of interviewees across the three sites and at the state level. It shows that slightly more clients and stakeholders were interviewed in the metropolitan site which was expected due to the larger client cohort in this area. Otherwise, the spread of interviewees across the three areas was relatively even, which provides the evaluation

[2] Due to the way that data is collected, it is not always possible for ARTD or InforMH to link the demographic data collected upon entry to the service use data that is reported quarterly. In the April to June 2009 quarter, service use data was submitted for 1,167 clients, but could only be linked with the demographic data of 895 (77%) clients.

with the opportunity to compare the differences between how HASI operates in a rural, regional and metropolitan area.

Table 2.2: Interviews by Area

Stakeholder group	n	Per cent
Client interviews by area		
Metropolitan	24	41
Regional	20	34
Rural	15	25
Total client interviews	59	100
All interviews by area		
Metropolitan	39	35
Regional	30	27
Rural	26	23
NSW	17	15
Total interviews	112	100

In addition to clients and stakeholders involved at the local service level, interviews were conducted with state level stakeholders (Table 2.3). This included representatives from NSW Health and Housing NSW as well as personnel who hold upper level management positions in NGOs and advocacy groups.

Table 2.3: Interviews by Local and State Level

Stakeholder group	n	Per cent
Local level		
Clients	59	-
Other interviews	36	-
Total local level interviews	95	85
State level		
Total state level interviews	17	15
Total interviews	112	100

Characteristics of client interview sample

An important element of this evaluation are interviews with HASI clients, which assist the evaluation to understand clients' experiences and perceptions of HASI and any changes experienced in their lives while involved in the program. A total of 59 clients were interviewed and this sample is closely representative of HASI clients more broadly. The average age of the interview sample was 39 years, and 8 per cent (n=5) identified as Aboriginal or Torres Strait Islander. Most clients who were interviewed were born in Australia (93%) and only one client indicated that he spoke a language other than English at home (2%; Table 2.4).

Table 2.4: Cultural background of interview sample and current clients

	Interview sample (n=59)		Current clients (n=895)	
	n	Per cent	n	Per cent
Aboriginal or Torres Strait Islander	5	8	62	9
Country of birth other than Australia	4	7	-	-
Language other than English spoken at home	1	2	57	8

Although the sample was similar to HASI clients, it differed in a few key ways. First, it included more males (59%, n=35) than females (41%, n= 24), which were slightly underrepresented compared to the gender ratio of current HASI clients of which 47 per cent are female. Second, clients who participated in the evaluation had been in HASI for approximately two years which is longer than current clients (see Table 4.4). Finally, clients interviewed for the evaluation were slightly under representative of clients receiving low support (49% of sample compared to 56% of all clients) and high support services (25% of sample compared to 32% of all clients), whereas clients receiving medium and very high support were slightly over represented (Table 2.5). This is due to the service makeup of the rural and regional sites but also to comparatively fewer number of support packages in the program as a whole at these sites.

Table 2.5: Client Interviews by Level of Support

	Interview sample (n=59)		Current clients (n=1155)*	
Level of HASI support	n	Per cent	n	Per cent
Low	29	49	641	56
Medium	8	14	75	6
High	15	25	371	32
Very High	7	12	68	6
All levels of support	59	100	1155*	100

Note: *Data was missing for 12 current clients. This total is based on the number of current clients receiving support – See Table 5.1

2.3 Future reports

Additional administrative data from NSW Health and Housing NSW, as well as a supplement to the HASI MDS, will be collected to provide detailed information on client outcomes, and the changes experienced by clients over time. The first round of the MDS supplement was collected on each client by the ASPs in the July-September quarter of data collection in 2009. The administrative data will be collected from NSW Health and Housing NSW in February 2010 and, together with the results from the MDS supplement and more detailed analysis of the qualitative data collected from clients, will be reported on in the second evaluation report in August 2010. This report will also provide an analysis of the costs of the HASI program.

The final report, which will be delivered in February 2011, will provide a detailed analysis of all client outcome data, results from interviews in October 2009 and September 2010, and the costs and outcomes of the program.

2.4 Conclusion

This section has provided an overview of the methods used to collect the data which forms the basis of this report. The next section details the profile of current clients drawn from the HASI MDS and findings from the interviews on referral and selection processes.

3 Client Profile

To be eligible for HASI, a person must be 16+ years of age, have a diagnosed mental illness, require support services (and in most cases housing), and have the ability and desire to live in the community. While there is no upper age limit, individuals are considered to be eligible until frailty is determined to inhibit ongoing involvement in the program. Eligibility for the program varies slightly between lower and higher support level packages depending on clients' level of functioning and whether housing is required. Furthermore, the higher level support packages prioritise people who are in hospital, homeless or at risk of homelessness, and who find it difficult to maintain their tenancy without support (NSW Health, 2006: 17). This section describes the effectiveness of referral processes and the extent to which the program has accessed its intended target group by examining the demographic profile of current clients.

3.1 Client profile

An important element of the referral and selection process is whether the HASI program is accepting clients who match its target group. This section assesses that question by examining the demographic profile of current clients upon entry into the program, which is drawn from the HASI MDS on 895 clients.[3]

Demographics

Of the clients who are currently involved in the program (and for whom data was available), 53% of clients are male and 47% are female.[4] The average age of clients is 41 years. Both characteristics have altered since Stage One, in which women made up only 33 per cent of all clients and the average age of clients was 34 years (Muir et al., 2007b). It is likely that the average age has increased since the evaluation of HASI Stage One because the program has expanded to include a larger cohort of people with different support needs and diagnoses.

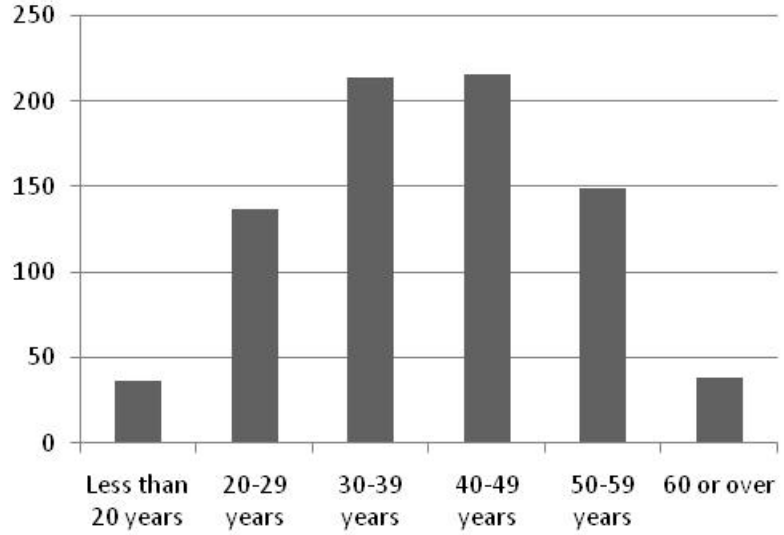
Table 3.1: Clients by Age Group

	n	Per cent
Less than 20 years	36	5
20-29 years	137	17
30-39 years	214	27
40-49 years	216	27
50-59 years	149	19
60 or over	38	5
Total	790	100
Note: Data missing for 105 clients		

[3] Due to missing data, totals do not always equal 895.

[4] Due to missing data these percentages are based on 852 clients (452 male and 400 female).

Figure 3.1: Current Clients by Age Group



Around 9 per cent of current clients in the program identify as Aboriginal or Torres Strait Islander, which demonstrates that they are well represented compared to the general population and compared with other mental health services (Muir et al., 2007b). This figure has increased since the Stage One evaluation, which found that, by Stage Three of the evaluation, only 4 per cent of clients remained in the program. Exit data on Aboriginal or Torres Strait Islander clients will be examined later in this evaluation.

Table 3.2: Clients by Aboriginal or Torres Strait Islander status

	n	Per cent
Aboriginal or Torres Strait Islander	62	9
Non-Aboriginal or Torres Strait Islander	657	91
Total	719	100
Note: Data missing for 176 clients		

In addition to Aboriginal or Torres Strait Islander clients, a proportion of clients are from Culturally and Linguistically Diverse (CALD) backgrounds. Around eight per cent of clients (n=57) indicated that they speak a language other than English at home (Table 3.3). As in the evaluation of HASI Stage One (Muir et al., 2007b), this group of clients remains under-represented compared to the group of people in the population who have mental health and behavioural problems. For example, the prevalence of mental health disorders among people born in non-English speaking countries was 12.6 per cent (Slade et al., 2009: 7).

Table 3.3: Clients by Language Spoken at Home

	n	Per cent
Language other than English at home	57	8
English spoken at home	672	92
Total	729	100
Note: Data missing for 166 clients		

Mental health diagnosis and other co-existing factors

Consistent with the aim of HASI, all clients were reported to have at least one mental health diagnosis, the most common of which was schizophrenia (65%), followed by schizo-affective disorder (11%), depression/anxiety (10%), and bipolar disorder (9%). The characteristics of the client group have changed slightly since the Stage One evaluation, which recorded higher numbers of people with schizophrenia (75%), and a lower incidence of bipolar (3%) and depression (2%) (Muir et al., 2007b).[5]

Table 3.4: Clients by Primary Mental Health Diagnosis

Primary mental illness	n	Per cent
Schizophrenia	548	65
Schizo-affective disorder	91	11
Depression/ anxiety	83	10
Bipolar disorder	75	9
Personality disorder	19	2
Other	29	3
Total	845	100
Note: Data missing for 50 clients		

In addition to the primary mental health diagnoses described in Table 3.4, around a quarter of clients (26%, n=221) had a secondary mental health diagnosis of which the most common was depression or anxiety.

Table 3.5: Clients by Secondary Mental Health Diagnosis

Secondary mental illness	n	Per cent
Depression/ anxiety	98	12
Other	61	7
Personality disorder	30	4
Schizo-affective disorder	17	2
Bipolar disorder	11	1
Schizophrenia	4	0.5
No secondary mental illness	624	74
Total	845	100
Note: Data missing for 50 clients		

[5] It is likely that this change has occurred because of the increase in the number of people with low and medium level support requirements.

In combination with a diagnosed mental health illness, more than half (54%; n=460) of current clients reported having a co-existing condition such as a physical or cognitive disability and/or a dependence on alcohol or drugs. Table 3.6 shows that the most prevalent co-morbidity was substance abuse (28%, n=238) followed by physical health problems (12%), intellectual disabilities (10%), physical disability (5%), and acquired brain injury (3%).

Table 3.6: Client Co-existing Conditions

Type of co-existing factor	n	Per cent*
Substance abuse	238	28
Physical health	104	12
Intellectual disabilities	85	10
Other	53	6
Physical disability	45	5
Acquired brain injury	24	3
Total conditions	**549****	**-**
Total clients with at least one co-existing factor	460	54
Total clients with no co-existing factors	385	46
Total clients	**845**	**100**

Note: Data missing for 50 clients
*Based on a total of 845 clients
**Some clients reported more than one condition

Accommodation at entry

Around half of current clients reportedly had access to secure accommodation at the time they were accepted into the program – these clients lived in public housing (41%), community housing (9%) or private rental (7%). The remainder of clients did not have stable accommodation prior to entering HASI and were experiencing primary, secondary or tertiary homelessness.[6] Around two per cent had no access to shelter immediately prior to entering HASI, and 30 per cent were living in insecure accommodation; they were, for example, living with family or friends (11%), in a boarding house (2%) or were in hospital (16%; Table 3.7). Preliminary qualitative, which is discussed in more detail in Section 7, suggests that many clients had a longer history of homelessness and insecure housing prior to entering the program. This will analysed in more detail in the next phase of the evaluation.

[6] As defined by Chamberlain and Mackenzie (1992), 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues,* 27(4), 274-297, who refer to primary homelessness (people who do not have access to shelter including people living on the street), secondary homelessness (people who are living in temporary accommodation such as with family or friends), and tertiary homelessness (people who have access to medium term accommodation such as boarding houses).

Table 3.7: Clients by Type of Accommodation at Entry

	N	Per cent
Public housing	348	41
Hospital	137	16
Living with family or friends	91	11
Community housing	75	9
Private rental	58	7
Homeless	20	2
Boarding house	18	2
Other	92	11
Total	839	100

Note: Data missing for 56 clients

There are a variety of reasons why people with a mental illness may find it difficult to maintain their tenancy and may experience loss of tenancy. Some of the associated risk factors related to tenancy breakdown were identified when clients' entered the program. Preliminary results show that one in four (25%, n=223) current clients accepted into the program had an identified tenancy risk factor. Nearly half of clients receiving very high support had at least one identified tenancy risk factor (48%). Tenancy risk factors, however, were less of an issue for clients receiving other levels of support packages: 24 per cent of low support; 29 per cent of medium support; and 23 per cent of low support. Given that one of the primary aims of HASI is to support people to maintain or access secure housing, it is surprising that these figures were not higher, and indeed site/client interviews have identified that only half of clients interviewed had access to housing prior to HASI (see section 6) The lower than expected identification of risks to tenancy may be due to the way in which this data was collected and should be interpreted with caution, for example, there may have been a lack of information available as to whether some clients' had any associated tenancy risk factors. Further analysis of tenancy risk factors is required as part of this investigation.

Table 3.8: Tenancy Risk Factors by Support Level (%, n=885)

	Low (n=488)	Medium (n=58)	High (278)	Very High (n=61)	Total (n=885)
No risk factor	77	71	76	52	75
At least one risk factor	23	29	24	48	25
Total	100	100	100	100	100

Preliminary analysis of the type of tenancy risk factors experienced by clients before they joined the program shows that around 12 per cent had experienced periods of homelessness (n=107). Other risk factors included previous instances of high housing turnover (10%, n=88), nuisance and annoyance complaints from neighbours (8%, n=75 clients), and previous applications for the Consumer Trader and Tenancy Tribunal (CTTT, 2%, n=14).

Table 3.9: Type of Tenancy Risk Factor by Support Level

	N	Per cent
Periods of homelessness	107	12
High housing turnover	88	10
Nuisance and annoyance complaints	75	8
Applications for orders to CTTT	14	2
Total	284	-

Note: Of the 223 clients who had a tenancy risk factor, a total of 284 risk factors were identified.

Exits from HASI

In recognising that a client's needs will change over time, HASI intends to offer ongoing or time-limited support depending on the individual needs of each client (NSW Health, 2006). Analysis of the program data collected between January 2007 and June 2009 found that 531 clients had exited HASI; proportionally more clients exited the program when they were receiving low support services (27%), compared to those who were receiving medium (11%) and very high (17%) support.[7] It is important to note that medium support services were only introduced in 2007/08 and this may be the reason that a low proportion of clients receiving medium support exited the program.

Table 3.10: Proportion of Clients who Exited HASI by Level of Support (%)

	Low (n=1313)	Medium (n=99)	High (n=693)	Very High (n=117)	Total (n=2222)
Not exited	73	89	79	83	76
Exited	27	11	21	17	24
Total	100	100	100	100	100

Note: Data missing for 40 clients

On average, clients spent about nine months in HASI before exiting, although there was variation in the amount of time spent in the program by people receiving different types of support. For example, exited clients receiving very high support spent approximately fifteen months in HASI, compared with about nine months for exited clients in low support (Table 3.11). It is important to note that exiting HASI does not mean that the client exited or vacated the accommodation provided under HASI.

[7] The data on exits is based on all clients of the HASI program between January 2007 and June 2009.

Table 3.11: Average Months in HASI for Current (n=887) and Exited Clients (n=224)

Support level	Current clients	Exited clients
Low	11.6	8.7
Medium	5.4	3.5
High	13.1	8.9
Very high	13.4	15.3
Total	11.6	9.0
Note: Data missing for 8 current clients and 307 exited clients		

Clients left the program for a variety of reasons (Table 3.12). Forty five per cent (n=222) had a planned exit from the program, meaning that the client, AMHS and the ASPs agreed that the client no longer needed support, required a higher frequency of support, or needed another type of support. Planned exits, in which clients had achieved their rehabilitation goals and no longer needed support from ASPs, were considered by stakeholders to be successful exits:

> What we try and do is 'planned exits' if possible, where we recognise that a consumer is actually doing really well, and they don't particularly want us out of their lives, they just don't want us in their lives. So the way we kind of deal with that is go, "Okay, well let's try and go a week without seeing you, see how that goes. You know, give us a call if you need to but otherwise good luck, let's see how you work it."

Table 3.12: Reasons for Exiting HASI by Level of Support

Reason for exiting HASI	n	Per cent
Client no longer needed support	181	37
Client decided to discontinue support	103	21
Failure to meet tenancy obligation	36	7
Move to higher support accommodation	22	4
Move to other long term housing	19	4
Other	132	27
Total	493*	100
*Note: Data missing for 38 clients		

Close to 30 per cent of the exits from HASI were unplanned, meaning that clients decided to discontinue the support (including those who refused contact with ASPs) (21%;n=103), or did not meet their tenancy obligations (7%;n=36). There were a range of other reasons that clients left the program (27%; n=132) which included admissions to hospital or psychiatric units; moving from the service area; connecting with a more appropriate service; and, in a few circumstances, the client had died.

3.2 Attracting the target group

With the exception of people from CALD backgrounds, HASI clients are fairly representative of mental health service users. Women and ATSI peoples are better represented among HASI clients than they were at the time of the evaluation of Stage One. All clients have at least one diagnosed mental illness, and many also have a secondary mental illness or other co-morbidity. Although this preliminary analysis

suggests that HASI is attracting the intended target group, more research is needed on tenancy to investigate whether the data is accurately capturing risk of tenancy and to further understand the tenancy risk experienced by clients.

Referral pathways

HASI is accessing its target group through the development of strong referral pathways. Potential HASI clients are initially referred to ASPs; referrals most commonly come from mental health clinicians – including Community Mental Health Service teams (60%) and hospital staff (18%) – rather than from social housing or other organisations (Table 3.13). This ensures that people with mental illness are targeted in the referral process. Clinicians suggested that their decision to refer a person to HASI is influenced by a range of factors including the person's current level of functioning, potential to benefit from the program, capacity to live independently, as well as considerations of the service context such as whether vacancies are available in the local area.

Table 3.13: Referrals to the HASI Program

	n	Per cent
Community Mental Health Service	512	60
Hospital	149	18
Public Housing Client Service Team	46	5
Community Housing Provider	21	2
Other HASI provider	14	2
Other	107	13
Total	849*	100

*Note: Data missing for 46 clients

The referral rates for each organisation vary depending on the level of support clients are currently receiving (Table 3.14). It is unsurprising that referrals to high and very high levels of support come primarily from Community Mental Health and hospital services, as these packages intend to serve people with the highest support needs and the most housing vulnerability. Conversely, the rates of referral from housing organisations for low and medium support packages, which are targeted at people who are already housed in social housing properties, were unexpectedly low: only one in ten referrals (n=81) were received from social housing providers or other ASPs.

Table 3.14: Referral Source by Support Level (%, n=849)

	Low (n=475)	Medium (n=54)	High (n=261)	Very High (n=59)	Total (n=849)
Community Mental Health	63	74	59	31	60
Hospital	8	19	27	51	18
Housing NSW	9	0	0	0	5
Community Housing Provider	4	0	0	2	2
Other HASI provider	1	0	2	3	2
Other	14	7	11	14	13
Total	100	100	100	100	100

Note: Data missing for 46 clients

Preliminary evidence from interviews suggests that the lower percentage of referrals from Housing and ASPs could be related to these organisations directing their proposed referrals to AMHS who then become the identified source of referral. As the following quote suggests:

> They might come from housing but general agreement is that housing should contact health and they should agree that that person should be referred, because again they should have a case manager ... we get more referrals from housing ... through HASI 2 because the focus being on people who are not coping with their tenancies. [But overall] most our referrals come from health.

Nevertheless, ASPs in some areas reported that referrals are increasingly coming from other services in the community; indeed, 13 per cent of current clients were referred by 'other' providers such as temporary accommodation services. It is possible that if the rates of referrals from other providers increase, HASI will continue to target people who are homeless or have clearly identified housing risks.

Stakeholders reported that referral pathways have improved since Stage One of HASI due to the growing awareness of, and support for the program, in most AMHS. There was a perception that referral processes were unclear for AMHS in some areas where multiple ASPs provide different levels of support to clients. For example, some ASPs are funded to provide only one level of support (e.g. low support) whereas other ASPs offer a combination of support options (e.g. low, medium, high, very high). This means that referrers must identify and refer people to the appropriate ASP and package level. Many referrers did not understand the differences between ASPs and the packages and, as a result, some ASPs reported that they still receive inappropriate referrals. This demonstrates the continuing need to promote eligibility criteria among referring agencies and the need to simplify the referral processes in some areas. One area with multiple ASPs addressed the confusion by developing a common referral form used by all ASPs to streamline the process of assessing client eligibility and avoid duplication of selection processes.

Selection processes

HASI attracts its target group through appropriate selection processes at the local level. The process of selecting clients is made by local selection committee meetings which include representatives from AMHS, ASPs and housing organisations. This process generally works well because decisions are made locally by key stakeholders and, while there are common procedures which guide the selection process, there is also flexibility to adapt these processes to the local service context.

As a result of this flexibility, however, some variation in selection and acceptance procedures and use of discretion by ASPs was noted. The most common variation in selection processes emerged around the issue of people's capacity to participate in rehabilitation. Although some HASI clients have a secondary mental illness or co-morbidity, some ASP staff were concerned that the program's selection processes screen out people with complex needs because they are perceived to have a lower capacity to participate in rehabilitation activities (and subsequently develop independent living skills which then enable them to successfully exit the program). As a result, clients with complex needs may have been screened out of the program by

some ASPs. Other ASPs, however, were clearly more inclusive of clients with more complex needs.

Additionally, some ASPs indicated that they often set their own conditions as part of client's acceptance into the program, as demonstrated in the following quote:

> I make contact with the person or referrer and say they're accepted based on these conditions – basically it can be conditions like they go on a three month probation cause we're worried they're not going to work out – not gonna want to work with us.

Some of the conditions of acceptance, such as that described in the quote above, raise a concern around who can be effectively supported. While most stakeholders perceived the aim of service provision to support an individual's recovery process, the way in which this is interpreted can potentially impact on selection processes, particularly if clients with less complex needs were prioritised over others. These tensions are discussed more fully in Section 5.

3.3 Conclusion

HASI appears to be attracting its intended target group and, with the exception of CALD clients, has distributed services reasonably equitably across different groups within the target population. More information is needed about the assessed tenancy risk experienced by clients accepted into HASI, as well as the complexity of HASI clients to determine whether some people are excluded from the program due to some ASPs increasing focus on prioritising people who are perceived to have a greater capacity to develop independent living skills.

The target group is identified and selected through appropriate referral pathways and selection processes. Referral pathways were reported to be generally working well, and participants appreciated the ability to adapt the process to suit local needs and conditions. There was a perception among ASPs that referral pathways could be confusing for AMHS, particularly in areas where there is more than one ASP, and when ASPs are funded to provide different levels of support. There may be some scope for standardising these processes to avoid service duplication and confusion. Furthermore, if some ASPs are prioritising clients who are perceived to benefit from the program in a shorter timeframe than others, it may create barriers for clients with more complex needs to participate in the program.

3.4 Summary

- The demographic profile of clients shows that: there are slightly more male clients in the program and the median age of current clients is 40 years of age.
- Approximately 9 per cent of clients identify as Aboriginal or Torres Strait Islander and 8 per cent speak a language other than English as their main language at home.
- The most common mental illness experienced by current clients is schizophrenia (65%); 26 per cent of current clients had a secondary mental illness of which the most prevalent is depression/anxiety.

- More than half (54%) of current clients had a co-existing condition. The most prevalent condition identified among current clients was substance misuse (28%) followed by physical health problems (12%) and intellectual disability (10%).

- Preliminary analysis of data on clients' associated tenancy risk factors when they entered the program appears to be underreported. One quarter of HASI clients experienced at least one tenancy risk upon entry into the program, which is considerably low given that one of the primary aims of HASI is to support people who have insecure tenancies.

- Further follow up is needed to understand the tenancy risk experienced by clients accepted into HASI, the extent to which HASI targets or excludes people who have complex needs and to understand the capacity of HASI in each area and whether there are waiting lists for the program.

- Most referrals to HASI (78%) came from AMHS and hospitals. The next phase of the evaluation will seek to understand why most referrals come from health organisations and the implications of this for the future of the program.

- Stakeholders reported that referral pathways have improved over time, due to the growing awareness of and support for the program in most AMHS.

- In areas where there are multiple ASPs, there was a perception that this created confusion around referral pathways due to multiplicity of providers and availability of different support levels. As a result, ASPs continue to receive some inappropriate referrals.

- Most stakeholders reported that the process of selecting people to participate in the program generally worked well because there are common procedures which guide the process but also flexibility to adapt to the local context. Further, ASPs are working well together to coordinate the selection process and overcome issues concerning duplication in assessment procedures across ASPs.

- There was, however, some emerging evidence of variation in selection processes according to how ASPs understand the nature of the recovery process and the role of services to promote their recovery.

4 Service Model

HASI services aim to support an individual's process of recovery, which differs from clinical recovery because it focuses on the lived experience of consumers (Slade, 2009).[8] HASI services aim to support personal recovery from mental illness by providing stable housing, access to clinical services, and rehabilitation services. This section describes the type of services provided to clients and the framework for service delivery.

4.1 Types of services provided by HASI

Depending on the type of package provided, HASI provides accommodation support, clinical mental health services and housing services. This section focuses on the ASP services, which are a key element of HASI and which are measured by the HASI MDS.[9,10] NGOs are funded by NSW Health to provide 1076 packages of accommodation support across the state (Table 4.1). Preliminary analysis of the MDS, however, shows that 91 additional clients were supported by the program in the April – June 2009 reporting period, meaning that a total of 1167 clients were supported by the program in this period.

Table 4.1: Types of Support Packages

Support packages				Clients receiving support	
Support level	Funding per package	HASI package	# funded packages	# current clients	Per cent
Low	$11,000	HASI 2	460	518	45
		Low HASI in Home 4B	160	123	11
Medium	$35,000	Medium HASI in the Home 4B	80	75	6
		Total low and medium	700	716	62
High	$50,000	HASI 1	100	127	11
		HASI 3	126	142	12
		HASI 4A	100	102	9
		Total high	326	371	32
Very high	$70,000	HASI 3B	50	68	**6**
Total			1076	1155*	**100**

Note: Data on the level of support received for the April-June 2009 monitoring period were missing for 12 clients.

8 Slade describes clinical recovery as the idea that person with a mental illness will 'get back to normal' and be symptom free, whereas personal recovery is the idea that a person can live a satisfying and hopeful life despite their illness (2009: 4). The idea of recovery as it relates to HASI services has been briefly described in the HASI Evaluation Plan (McDermott et al 2010) and will be discussed in more detail in the final evaluation report.

9 Details about clinical and housing services will be described in the next report, once NSW Health and NSW Housing data are made available.

10 This section reports on MDS data collected in the April – June 2009 reporting period.

Table 4.1 shows that most clients in the program (62%, n=716) were receiving low and medium accommodation support services, which provide less frequent and intensive support than high and very high support services.[11] Lower support packages are also aimed at eligible people who are already living in social housing (HASI Stage 2), private accommodation, or who live with family (HASI Stage 4B). Thirty eight per cent of clients (n=439) received high or very high support services, meaning that they were provided with accommodation, as well as a higher number of hours.[12] Interviews with ASP staff indicated that the level of support provided to clients varies depending on individual need which can change over time.

ASPs provide support to clients across a range of areas. The average proportion of time ASPs provide to HASI clients differed slightly across the four support levels. The most common areas that ASPs provided support to clients were community access, counselling, personal self care and advocacy (Table 4.2).

Table 4.2: Average Percent of Support Time Spent by Support Level (%)

Identified goal area	Low	Medium	High	Very High	Total
Community access	23	24	21	20	22
Counselling	21	14	22	17	21
Personal self care	17	20	15	26	17
Advocacy	18	15	15	20	17
Domestic skills	11	13	15	15	13
Vocational support	6	5	5	3	6
Income management	5	5	6	6	5
Links w/family and friends	6	7	4	5	5

Note: In the MDS, ASPs are asked to indicate the percentage of their time spent supporting each client in these activities during the reporting period. This provides some indication of how ASPs are spending their time with HASI clients, however, the proportions are inexact and the totals do not equal 100 per cent.

A high proportion of ASP time is spent assisting HASI clients with personal self care, particularly when clients receive medium and very high support. It is somewhat surprising that clients on medium support packages require higher proportion of staff time on this skill than people receiving high levels of support. It may suggest that there are not substantial differences in the characteristics and level of services needed by clients receiving medium and high support packages, or that consumers with high support needs are receiving support in medium packages because there are no vacancies in high support packages. Counselling is also a task that ASP staff spent a substantial amount of time on across the support levels. One participant described this activity as:

> ...providing support and motivation for consumers to live independently in a way they choose. Motivation is a big thing [for clients].

[11] Lower level support services are normally provided five hours per week, one to two days per week as appropriate for each client, while medium support services are funded at a higher rate ($35,000), and provide clients with approximately two to three hours per day, seven days per week.

[12] Normally high support services are up to five hours of support per day, seven days per week and very high services are provided up to eight hours per day, seven days per week.

Only a small proportion of time is spent by ASPs on income management and vocational support, which is to be expected because clients have more pressing needs in relation to community access and personal care. It was not expected that such a small proportion of time is spent assisting clients to build relationships with family and friends. It is possible that linking clients in with more structured social activities that is captured in the 'community access' category, may be a facilitating step towards improving relationships with family and friends.

4.2 Framework for service delivery

HASI aims to provide rehabilitation services that are client focused; based on respect and open communication, are flexible and responsive to client needs, and provided in partnership across the health, housing and NGO sectors (NSW Health, 2006: 7). This section discusses the key aspects of HASI services and how services are provided within this framework.

Rehabilitation

HASI supports an individual's personal recovery from mental illness. This approach to service provision starts from the perspective that clients have the potential to live more independently and encourages clients to believe that they have this capacity:

> [O]ne of our philosophies is hope, you know sometimes we have to carry that hope for our consumers, and always having someone believe in you is a massive motivation for them.

In addition, ASP staff work with consumers to identify the independent living skills needed to live more independently in the community. The support provided by ASPs, therefore, is structured around the goals that clients set for themselves through the development of an Individual Service Plan (ISP). Ideally these plans are developed together with clients, their family and carers, the ASP and sometimes AMHS clinicians during an initial period of building trust after clients are accepted into the program. This process was described by one ASP as flexible depending on the client's situation:

> I'll spend from one to eight visits to build rapport and trust and gradually bring in the paperwork. We start with the consent form on the first or second visit, who they have in their life, and other services. We then broaden the picture of what's happening around them. The needs assessment helps them to get a picture of their life, then we set goals. In all of that there is getting a feel for someone, what communication works for them to feel comfortable, where the challenges are or may be in the time ahead, the referrals [to other organisations] I may make.

Information about the goals HASI clients have identified is included in the MDS; Table 4.3 outlines these goal areas, and the proportion of clients in each level of support who have identified each area as a goal.

Table 4.3: Proportion of Clients Who Set Goals in Each Area by Support Level (%)

Identified goal area	Low	Medium	High	Very High	Total
Social/community participation	80	88	82	81	81
Community tasks	70	86	77	87	74
Self-care	66	86	77	88	72
Domestic skills	63	77	76	87	69
Use of health services	63	73	62	76	64
Work, education and/or training	44	40	49	24	44
Other	32	26	28	30	30

The goal most frequently set by HASI clients relates to participating in social and community activities (81%), followed by engaging in community tasks such as going to appointments, doing shopping and using public transportation (74%), and carrying out activities of self care (including learning strategies to manage the symptoms of mental illness, such as exercise classes).

Table 4.3 also highlights that clients set different goals depending on the level of support that is received. A higher proportion of clients receiving very high support, for example, set goals across most areas, with the exception of work, education and training, which only a small proportion of clients set as a goal. The extent to which these goals vary according to support level will be explored in more detail later in the evaluation.

Once clients identify their goals, ASP staff support clients to meet their goals. Clients seemed fairly satisfied with the way ASPs worked with them to achieve their goals. For example, one client explained:

> When I first came – we wrote down goals – one was getting physically well and I've avoided that – we have done a little bit of swimming and weight watchers but nothing much else. I've resisted doing that and she has respected that. She just brought it up out of the blue the other day and I thought 'yeah it's time'. (F, 55, low support)

Clients interviewed for the evaluation emphasised that while they valued the practical support they received from ASP staff with activities such as shopping, cleaning, transport, getting to appointments, and budgeting, what they also valued highly was the human and social contact with ASP staff.

> I value the visits each day… I really value the contact because I'm so isolated. (M, 49, very high support)

According to the MDS, clients are making progress towards their goals; data from the April – June 2009 reporting period shows that the vast majority of clients partly or fully attained the goals they set for themselves (Table 4.4). The more difficult areas for clients appeared to be work, education and training, which is understandable given that these activities require the highest levels of skills, confidence and capacity, and that ASP providers may not prioritise these goals in the support provided to clients. The high percentages of clients who have partially or fully met goals across most areas also indicate that ASPs are supporting clients to set achievable and meaningful goals.

Table 4.4: Proportion of Clients who Partly or Fully Attained their Goals by Support Level (%)

Identified goal area	Low	Medium	High	Very High	Total
Social/community participation	95	90	95	95	95
Use of health services	94	90	92	92	93
Self-care	92	81	94	91	92
Community tasks	91	88	90	91	90
Domestic skills	87	88	93	87	89
Work, education and/or training	83	73	82	69	82
Other	65	50	71	75	66

The support provided to clients, as indicated in Table 4.2, mirrors the priority goal areas set by clients. For example, social and community participation is the most frequently selected goal across the client group, and ASPs report that they spend the largest proportion of time facilitating community access. This suggests that the support provided to HASI clients is, at least in part, client driven.

The evaluation of Stage One found that the activities undertaken by ASPs were based on four different approaches: person-centred rehabilitative, person-centred disability, advocacy, and non-person centred directive (Muir et al., 2007a). In this evaluation, ASP staff reported that they prioritise the provision of rehabilitation activities over other types of support. Accordingly, some clients, particularly those receiving low support, reported that the services they receive from HASI have become more rehabilitation oriented since they started the program:

> They are stricter about going for a coffee or a sandwich. They are stricter – it [support provided by ASPs] has to be about a goal whereas before it was more relaxed. Over the years it has become a bit more strict. (M, 42, low support)

> A yeah it's just got more rehab – we used to go for a swim and have a chat. I probably would have preferred a bit more notification that things were changing but you hear one thing and all that. Since the new manager came it all changed. (M, 41, low support)

Furthermore, there was a considerable amount of variation in interpretations of what rehabilitation support entails. These different interpretations were influenced by the values of the ASPs and the way that individual staff members interpreted their roles. For example, one ASP staff member was less concerned about her clients achieving goals within a short time period than other colleagues:

> My view is quite broad as to what that [rehabilitation] might mean – I could go and visit someone once or twice a week and get to understand how they work and it may be that we don't get down to any particular goal until a few months after that because we've just started to talk about it. Whereas I do hear some people on staff and in their view continually want to relate activities to specific goals at all times.

An emerging finding from the evaluation is that some ASP staff believe that the program should provide time limited support because, if clients remain in the program over a long period of time and require ongoing disability or maintenance support, they were blocking other people from entering the program. It was perceived to be preferable to accept people who have a greater capacity to become fully independent rather than someone who may require ongoing support.

Preliminary results suggest that some ASPs have altered their expectations of the program and perceive the primary aim of HASI is to support clients to achieve defined outcomes in a set time period. This has implications for the groups of high need clients which may lead to their deprioritisation in the selection process, however, further information about the selection process is needed to confirm this early finding. If this were the case, the initial objective of HASI (to fill a specific gap in the service system) would be partly compromised or changed.

According to stakeholders, HASI continues to successfully provide rehabilitation services to consumers. Yet some ASP staff were interpreting the aim of recovery based services to support clients to develop the capacity to live independently within a limited timeframe. This may influence the types of consumers who are accepted into the program, and may disadvantage people who have complex needs, challenging behaviour, or a long history of institutionalisation.

Client centred services

The model of support delivered by ASPs is designed to work with the strengths of each client and, to accomplish this, participants reported that the types and amount of support are tailored to the needs of individual clients. While experiences of the client centred approach to service provision were generally positive, this aspect of ASP services was most strongly emphasised by clients receiving low support.

> I like the support, the care. The whole round thing – the umbrella – it's absolutely terrific…. I don't know what I'd do without them. (F, 65, low support)

Another client described that she appreciates HASI support because she is treated like a human being rather than being defined by her mental illness:

> They [ASPs] don't treat you like a number, they treat you like a person. A lot of people in life – a lot of people treat you like a number not a human being. That's what I thought when I first came to [name of ASP] I thought I'd be a number again cause you're so used to being a number. But I was sort of taken aback 'cause I was treated like a human. (F, 47, low support)

Most clients reported that they feel included in decision-making, which was a new experience for many clients, who were used to being told what to do:

> It's not like they are watching all the time. They are checking with me what I'm going to do rather than telling me what to do. (F, 55, low support)

While most clients agreed that they felt included in decision-making, one client, however, said that he sometimes felt 'bossed around'.

Respecting client's choices was another important element of the support model. ASP staff described this as essential because:

> That's affording them the dignity of choice, the dignity of failure, the dignity of making up their own minds.
>
> It's about having what we have – having a choice to live on their own ... [acknowledging choice] was a really important breakthrough for mental health [services].

Even though the majority of clients were positive about the support they received from ASP staff, a few clients expressed their concern about the attitudes of some ASP staff. Some clients, for example, were concerned that some staff were not well trained in how to work with people who have different types of mental illness and other clients stated that some workers speak to them as if they were children. The way in which staff communicate with clients is crucial to ensure that clients feel respected.

Along with respecting client choices, regular contact is another important element that assists ASP staff to develop trust and rapport with clients. This is important to reassure clients that HASI support will remain with them over time, regardless of whether the client rejects support from the ASP. This way, clients are reassured that support will be there when clients need it, and that they will not be abandoned:

> We go [to clients] 'look, we're here, you might crack the shits with us, that's natural you know and we'll back off for a couple of weeks if that's what you want us to do, but we're not going to back away completely. We're not going to abandon you'.

While ASPs were generally enthusiastic about the program and the perceived benefits for clients, some staff were concerned about the potential for clients to become too dependent on the program. Dependency in the sense of relying on a service is not in itself a negative result, it is only detrimental for clients if the ASP is not promoting their efficacy and working towards linking clients with other activities and services in the community. Dependency may be caused by both structural factors, such as a lack of transportation meaning that some clients become reliant on their worker to access the community, or interpersonal factors, such as a lack of social connections which meant that they dependent on the service for emotional support too.

Stakeholders were aware of the potential for clients to become too reliant on individual workers, and tried to address this by setting professional boundaries with clients, rotating workers, and referring clients to other organisations. Aside from reducing dependency on HASI or on a particular worker, the aim of this is to also assist clients to expand their support network and skills.

> I guess there's a dependency that can be formed if we're not aware. I know a particular client … [he was developing a] dependency on a particular staff member. So we had to look at that and then start not allowing or not permitting that staff to be the only worker. We did a

> lot of referring out to other agencies. There's a lot of resistance from the consumer but we're still [working] quite diligently [referring the client to other services] to break that dependency.

Most of the clients interviewed as part of the evaluation were exceedingly positive about the quality of service they received from ASPs; they particularly appreciated the client centred support, inclusion in decision-making and respect. ASPs were aware, however, that one of the downsides of providing client centred support is that clients have the potential to become overly dependent on ASP staff, which may detract from their individual process of recovery, and some ASPs had implemented a number of strategies to address this concern. It is also important to acknowledge that in an intensive program like HASI, client dependency will be an ongoing concern and, for some clients, it will be an important part of building trust and undertaking the recovery process. Reliance on a support service is not in itself a negative development; however, it may be that ASPs need to address this as part of broader efforts to encourage clients to develop their confidence and self esteem.

Flexibility of support

Because HASI rehabilitation services intend to assist clients to become more independent, flexibility is the third key element of support. Even though services are delivered through a range of support packages, described in Table 4.1, ASP staff stated that support hours remain flexible depending on client needs. One ASP staff member explained that he saw the criteria around the support hours associated with each funding package as more of a guideline than a rule. For example:

> Certainly I had a case about two months ago where I had a consumer that had been homeless for 12 months on a HASI Two package, moved into his own home. That's a massive change for anyone, you know, I'm not going to just see this guy for five hours in a week to get him prepared for that. You know, it took a couple of extra hours before – a couple of extra hours during that week to get him prepared and then an extra few phone calls in the week after, just to make sure that he's settled and everything's going alright.

Many of the ASP staff believed there was flexibility in how support was delivered to individual clients, and many clients appreciated how adaptable ASP staff were in meeting their individual needs.

> ...[name of worker] was an emotional support at the time. He saw me more than what the HASI program [said it should] ... he was supposed to see me one day a week but he was trying to see me more. (M, 41, low support)

Another benefit of flexible services is that ASPs can respond to crises by spending additional hours with clients who need more support. The downside to this practice, however, is that the needs of some clients are prioritised over others, which may result in some clients feeling that they do not always receive as much support as they would ideally like. While clients were overall very satisfied with the flexible nature of

the support, the potential downside of flexible support for clients was that some perceived that some staff were not always available or reliable.

> Like when they're busy and they need to do something or like they give you a time, they should be on [time]. When they come, sometimes they're late. (M, 26, high support)

Several clients felt they would like more time with ASP staff. There were a variety of reasons for this: some clients wanted more contact with ASPs on weekends, others wanted ASPs to spend more time with them when they visited, and other clients expressed concern that they missed out on receiving support if ASP staff were absent from work.

The flexibility of support has implications for the way in which the program is funded. Currently, clients receive a package of support with a certain number of hours, but because clients are supported to become more independent, many require less support over time. This is not an issue if clients can easily be transitioned to a more suitable level of support. Preliminary findings suggest that transitions between packages are easiest when the ASP provides more than one level of support; when an ASP delivers only one level of support, it is possible that the continuity of care is lost because the client is required to transition to another NGO to receive a different level of support. In such situations, clients must adjust to the new service environment and staff.

With that said, however, smooth transitions can occur between multiple ASPs in one location when there are strong partnerships between the NGOs and these partnerships are supported by formal processes. In one site, this process works well because:

> ...the NGO is working so closely with them [the clients] and knows their needs. The NGO actually does the referral to the lower support, and then it just goes through the selection process as per the usual methods.

This comment also shows that, when clients transition between support packages, they are required to exit the program and to go through the selection process again. In this way, if there is a waiting list for packages in a particular site, transitions between levels can be impeded when no vacancies exist.

Stakeholders and clients reported that HASI provides flexible services that can be adapted to the particular needs of each client. To do this, however, sometimes requires transitioning clients between different levels of support in the program, which works particularly well when NGOs provide multiple levels of support and when there are strong relationships between HASI partners at the local level. Further implications for the funding model are discussed in Section 5.

Workforce and organisational capacity

The fourth key element of HASI support is to build workforce and organisational capacity to work with people with mental illness to promote recovery based practice. Stakeholders who participated in the evaluation identified the importance of promoting staff skills and workforce development, as well as developing strong

internal processes as important contributors to carrying out HASI support appropriately and effectively.

Staff skills and workforce development

ASP staff who work with clients on a daily basis are central to the HASI model, because their daily interactions with clients are rehabilitation focused. To apply the theory of rehabilitation to daily practice, ASP staff require the skills to develop rapport with clients, respect client decisions, support them to learn new skills, and to access the community without being too directive. Staff also require a good understanding and awareness of different types of mental illnesses and co-morbidities. ASPs strive to recruit highly skilled staff and, as a result, many clients spoke highly of the staff:

> I like all the staff. They are well chosen whoever does the choosing. They are caring professionals – they are good at what they do. (M, 49, very high support)

A few clients suggested that ASP staff could benefit from additional training in mental health so that they develop a greater understanding of other issues clients may face in addition to their mental illness (e.g. abuse, trauma, drug and alcohol issues). One site assisted staff to become aware of client needs by including consumers in staff training.

Some areas had trouble recruiting staff who have the knowledge to work with people with mental illness and who understand how to provide recovery focused support. Several ASP managers, for example, stated that people with a background in disability services have strong skills in maintenance support, but require upskilling to implement the principles of rehabilitation in their practice with HASI clients. ASPs recognised the importance of contributing to staff development, and did so by offering training opportunities (e.g. risk management and Occupational Health and Safety) and providing opportunities for staff to perform management roles.

ASP staff reported that, while their work is rewarding, it can also be challenging and isolating. Most staff work individually with clients and sometimes are required to spend a substantial amount of time travelling to see clients each day. They sometimes found it difficult to support and empower clients to make decisions, set goals and take action to achieve them, particularly because client needs can change can change from day to day. In the words of two frontline workers:

> Unless people [clients] are well the rehabilitation is very hard to do. That's the struggle for myself – you have got to set people with the whole thing.

> You can't take anything for granted in this line of work. Just because someone has been going really well doesn't mean you won't open the door and things crash. Particularly the end of the week I think I've got one more visit left and I go out and that will be the one where something goes wrong.

Some ASPs utilised a defined team approach to supporting clients; this enabled continuity of care and the opportunity for different staff to contribute new ideas and solve problems, while also reducing the potential for reliance on one staff member. Yet a related challenge for support workers who work as part of a team is that workers may have different styles of working with clients which create inconsistencies in the support:

> I guess the biggest challenge is we all have different ideas on how to work with someone, we all have different approaches, but we try and do it the best we can to create the minimalist disruption I guess to the service users

Strong supervision structures and support from management are also crucial in maintaining quality and consistency of staff, however, the emphasis on this differed across the ASPs that participated in the evaluation. Finally, some ASPs had implemented informal activities to support staff, such as monthly potluck barbeques and weekly afternoon teas which gave staff the opportunity to debrief and unwind at the end of the week.

Internal processes

In addition to developing strong staff skills, stakeholders reported that is important for ASPs have strong internal processes to promote open communication between workers at all levels and that there are strategies in place to assess and manage risk. Good record keeping procedures and communication between support workers was important in supporting clients.

> You try and build up a rapport with one particular person, because I've got a lot of abandonment issues, you know…You have to repeat your story all over again and you're sick of talking about it, but I don't know. Maybe they jot in a few things in the diary…[Q: So, more communication between them as well would be useful?] Yeah, that'd be good. (M, 33, low support)

Thoroughness in record keeping by staff was important for providing consistent support but so was the development of a support network among staff to facilitate information sharing and collective problem solving. The role of leadership in ASPs should not be underestimated – approachable, supportive and on-site management important for sustaining good practice and consistency in approach by ASPs.

While ASP staff regularly worked together as part of a team to support clients which included sharing information, a cause for concern was inconsistent adherence to client confidentiality. Greater emphasis on, and processes to support, client confidentiality needs to be re-visited by some ASPs.

Risk assessment and management is crucial to ensure the safety of the client, ASP staff and others. Risk management plans work well when they are developed from the initial client referral and when the AMHS shares information with the ASP about the client's mental illness, behavioural issues, and risks. This level of information sharing did not occur in all sites, and some raised concerns that ASP staff are exposed to avoidable risks to their personal safety. One ASP stated:

> If you got a complex client – clinical services won't pass on all the history with the fear that agencies will knock the client back, but not providing the facts is creating a problem for us because we don't know how to react to situations. We are better off knowing all the facts and talking about how to address these issues because the reality is we've probably heard it all before.

While most ASPs have developed risk management strategies, these need to be reviewed and updated on a regular basis in order to remain relevant to the organisation. Otherwise there is a danger that ASPs are compromising the safety of their workforce.

Partnerships

The final key element of HASI services is the relationships between HASI partners. This is discussed in more detail in the next section (Section 6).

4.3 Conclusion

HASI services aim to support each individual's recovery process, and the program aims to achieve this through the provision of stable housing, access to clinical services, and accommodation support services. This section focused on the services provided to 1167 clients, which are based on the principles of rehabilitation, client centred support, flexibility, and improving workforce and organisational capacity. Stakeholders and clients provided overwhelmingly positive feedback about the support provided by ASP staff. Nevertheless, the preliminary data also suggests that ASPs have different interpretations of recovery based practice. There remains tension around providing client centred support and ensuring that clients do not become overly reliant on this support.

4.4 Summary

- HASI aims to support clients in their recovery process through the provision of stable housing, access to clinical services, and accommodation support services.
- This section focused on support services provided to clients by ASPs; access to housing and clinical services will be discussed in future reports.
- ASPs are currently providing support to 1167 clients across NSW; however, due to the flexibility of the service provision an additional 91 clients were receiving support through HASI. Overall, around 62 per cent of clients were receiving low or medium levels of support.
- The most common activities ASP staff assisted clients with were: accessing the community, developing skills in personal self care, counselling and advocacy.
- ASPs provide rehabilitation focused services to support each individual's process of recovery and they work with clients to identify and achieve goals. The support provided by ASPs, therefore, is structured around the goals that clients set for themselves in their Individual Service Plans.

- The goal most frequently identified by clients was to engage in social and community activities, followed by engaging in community tasks and carrying out activities of self care. The support provided by ASP staff closely matches the goals set by clients.

- The process of rehabilitation is understood differently by some ASP staff. There was a perception among some staff that clients who continue to need disability or maintenance support over a long period of time are a less suitable client group for HASI, which should instead be prioritising support for people who have the capacity to become independent within a shorter period of time.

- ASP services are tailored to individuals, involve clients in decision-making, respect their choices and provide consistency of support. Some stakeholders were concerned, however, that some clients become too reliant on ASP staff members. This highlights the important role of ASP staff in supporting client efficacy.

- Support services are flexible to meet changing client needs. This is not an issue so long as clients can be transferred to lower support packages if their support needs decrease. This can be problematic, however, if ASPs have only one level of support and do not have strong partnerships with other ASPs in the local area.

- The provision of accommodation support works well when staff are highly professional, committed to the philosophy of personal recovery and have the opportunity to continually develop new skills. The effectiveness of HASI support is also assisted by strong internal risk assessment and management processes, communication strategies, and confidentiality procedures.

5 Partnerships and Governance

HASI services are provided through a partnership model at the local level that involves NSW Health, Housing NSW and NGOs: NSW Health is responsible for delivering clinical services through AMHS as well as funding accommodation support services which are delivered by ASPs, while Housing NSW supplies accommodation, provides tenancy management services and funds community housing. As described in the previous section, ASPs provide daily rehabilitation support to clients. This section of the report draws on the qualitative fieldwork with stakeholders to describe the relationships between partners, the extent to which they are working together, and factors that facilitate and/or hinder effective partnerships.

5.1 Partnerships

Relationships between local partners

Overall, interviewees reported that relationships between local partners are generally working well. Relationships between AMHS and ASP providers, ASP and Housing providers and ASP personnel from different organisations were reported to be particularly strong.

ASP and AMHS staff reported that their relationships are usually based on mutual respect, particularly when they perceived they added value to each other's roles. A mental health clinician, for example, stated that one of her clients:

> ... has an excellent [ASP] worker who knows her really well so if she has concerns about her mental health, she'll call me and she'll offer extra support around those periods. I really trust her opinion in terms of her assessment especially because I have faith in her skills and she's really reliable.

The relationship between these two partners is enhanced when AMHS staff believe that the ASPs are providing a service which supports AMHS to focus on their clinical roles and spend more time on clients who do not receive HASI. Collecting and analysing evidence about the HASI partnership model is important because it contributes to an increased understanding of what constitutes effective relationships between providers in the mental health and NGO sectors.

Mutual work between ASPs and Housing providers is primarily based around client need, meaning that these two partners work together when clients experience a problem associated with housing, such as complaints from neighbours or rental arrears, or if the client requires more suitable accommodation. In these cases, ASPs often perform an advocacy role on behalf of clients. This level of contact was generally believed to be appropriate by both ASP and housing personnel.[13] Furthermore, housing staff at the local level generally felt well supported by ASPs. HASI provided them with key contacts and support and, as the following housing stakeholder reported, this level of contact is often not achieved for people with a mental illness who live in social housing, and who are not HASI clients:

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[13] Further communication and personal relationships would be too time consuming for housing personnel who are often working with multiple ASP organisations in their community.

> With our other clients you don't get the support or communication [from the mental health teams]. But with HASI they [ASP] are there all the time.

Stakeholders at Housing NSW and in community housing valued the important role of ASPs in assisting clients to maintain their tenancies because it allows housing providers to focus on tenancy management:

> When we do something jointly [with ASP] it works better for everybody. We still need the commitment that both parties would have to put towards the agreement. We feel we're a housing provider and we assist up to a point but we don't feel we have to do the social worker part and unfortunately [the broader community] sees us like that sometimes.

A small number of ASPs reported that they had difficulties working with housing providers due to confusion among housing staff as to the different roles of clinical and ASP staff and a limited knowledge of the needs of the client group. The issue of roles and responsibilities is discussed later in this section.

With the expansion of the program, multiple ASPs now provide services across NSW and in overlapping geographical areas, which requires ASPs to work with staff from AMHS and Housing NSW and with each other. Some stakeholders were concerned that the competitive funding model utilised by NSW Health may result in competition rather than collaboration between ASPs. Despite this, preliminary analysis from evaluation of sites suggests that relationships between multiple ASPs in each location appeared to be based on mutual respect and co-operation, and the ASPs worked together well in the evaluation areas.

The final set of relationships between local HASI partners – that which is between housing providers and AMHS staff – were less evident, and there was reported to be minimal direct communication between these organisations. Housing staff felt that, in most cases, this is an appropriate arrangement:

> When they have an ASP case manager - it is easier for us rather than talking to a health organisation first.

Even so, it is important that some connection between housing providers and AMHS remains. For example, of a client exits from the program and no longer requires or wishes to be supported by the ASPs, often they will remain client of the AMHS.

Factors impacting on partnership effectiveness

As HASI is now an established program, relationships between partners appear to be working relatively well due to four broad factors: clear roles and responsibilities; open communication; a commitment to working together; and sound governance processes.

Clear roles and responsibilities

The clear delineation of roles and responsibilities is crucial to developing positive working relationships. The evaluation of HASI Stage One found that clarity of roles

and responsibilities increased over time (Muir et al., 2007a) and the current evaluation demonstrated that role delineation remained relatively clear. It is necessary that roles and responsibilities are continually clarified because of staff turnover and the program's expansion into new geographical areas.

Where roles and responsibilities are not clear, tensions can emerge between partners which can compromise working relationships. For example, a small number of ASP staff reported that they have difficulties engaging housing providers who do not understand the HASI model and are confused about the difference between clinical and non-clinical roles. Tensions also emerged over discrimination between clinical and non-clinical roles such as assisting versus supporting clients with their medication. One ASP staff explained a situation in which her role needed to be clarified:

> They [AMHS] are wanting us to be more responsible with clinical involvement. We had to really put our foot down and say that's not our role, that's not what we're trained in or qualified in. That's your area.

One of the key operational lessons that emerged from the evaluation of HASI Stage One was that signing of Service Level Agreements (SLA) would strengthen the program by clarifying partner roles and illuminating partner obligations to share information (Muir et al., 2007a: 29). While SLAs played an important role in justifying and legitimising HASI partnerships within their respective organisations during the establishment of HASI, now that the program is established, partnerships are driven by the commitment of the people involved.

There was greater clarity around roles and responsibilities where both formal and informal strategies had been implemented. For example, in one area a joint statement had been co-convened by ASPs and AHMS which outlined clinical versus non-clinical roles. Another area established an initiative so that both ASPs and AMHS staff could develop an appreciation of the different work contexts in which they operate:

> ASPs go to work with mental health and vice versa. They have developed a new respect for the work each other do: NGOs stopped criticising Health for not taking their calls, and Health realised that NGOs are professional and do a good job. It created an informal professional relationship and helped staff to call each other and problem solve.

Open communication

Open communication is the second key element of effective partnerships. To accomplish this, strong communication strategies between stakeholders at all levels, including upper governance, middle managers and frontline workers, is needed. When communication channels are weak, particularly between managers and front line workers, partnerships were undermined. This was particularly the case for frontline Health and Housing Staff: if they have a limited understanding of the HASI model and the expectation to partner with ASP personnel, front-line ASP workers sometimes struggled to develop these relationships.

While open communication between HASI partners is important, not all partners require detailed information about each client's situation. For example, Housing providers need to understand how HASI operates and what this means for their clients, but these providers do not require detailed information about client goals or their mental illness. One ASP stated that the information they share with housing providers includes:

> Of course we provide risk information, we don't want anyone getting hurt, we want to make sure [Housing knows], if there's going to be noise and nuisance issues. It's not about sharing that information – it's about the fact we don't believe the housing provider needs to know the ins and outs of every aspect of someone's life to be able to provide them with an appropriate house.

Some housing providers at the local level felt that HASI remains clinically oriented and that HASI forums focus on recovery and mental health services to the exclusion of discussing housing related issues. Some stakeholders suggested it would be useful to bring housing providers together to discuss these issues and to network with each other.

Commitment to working together and to the program

Effective partnerships require a significant investment of time and, therefore, necessitate an organisational and individual commitment to working together. Good working relationships were premised on a commitment from the partners to maintain and develop productive working relationships. ASPs reported that they had built up strong relationships with key partners over time, but that there were ongoing challenges with maintaining these relationships due to staff turnover.

Part of this commitment includes recognising and respecting the recovery oriented philosophy of the program and respecting differences in organisational values and approach. In some cases, where differences in organisational values and philosophies were discussed, productive dialogue occurred around how to improve the program and create greater consistency between ASP providers and/or how to better complement clinical roles. In practice, however, it could be difficult for providers from different organisational cultures to work together. One mental health clinician stated:

> [We have] the cultures of the more bureaucratic and hierarchy [based] ... health system versus the more organic and consumer friendly NGO... I think there's a bit of a clash there…they [NGO] work from a very consumer-focused perspective….the mode of our interventions is more directive and we're actually saying to consumers, almost "you have to do this"… our partner organisation, [name of NGO], I see that their workers are not pushing and they're much less directive. I actually like that approach ... but for some of my colleagues that's a little bit confronting.

A commitment to working together assisted the partnership to overcome challenges that arose from having multiple providers operating in an area, such as co-ordinating referral processes (see Section 4). Furthermore, a commitment to working together

helped to decrease duplication in selection processes and increase joint training initiatives and information flow.

5.2 Local governance processes

The local governance arrangements revolve around the Local Coordination and Selection Groups, which involve AMHS, housing providers and ASPs, which were perceived to be valuable in developing and facilitating effective relationships between local partners. In particular, the local coordination group was reported to be necessary to facilitate effective operation of selection committees. Effective local governance structures were facilitated by: the commitment of the people involved, formal and informal communication channels, and regular meetings. These arrangements were particularly strong in areas that had created a partnership coordinator position that was resourced by the AMHS.

Local governance processes were hampered in some areas by the tension between the idea of an equal 'partnership' between the AMHS and ASP when the AHS funds the ASP. The equity of the funder-provider relationships between the AMHS and ASPs was one of the governance lessons that emerged from the evaluation of HASI Stage One (Muir et al., 2007a: 29) and it persists. While this emerged as less of an issue for stakeholders than in the first evaluation of HASI, stakeholders continued to express concern about the potential conflict in the current funding model which pressures ASPs to accept referrals from AMHS over other agencies. For example, one interviewee felt that:

> ...the NGOs are funded by the Department so they have to work within parameters of that Department, so you have to take referrals from Health because you are dependent on them for your future funding. That can often – not intentionally or directly – but it can override things like assessments based on need. I think it's got to be based on need, not just on unblocking hospital beds and getting rid of people who are too difficult out of the hospital system.

Another interviewee also expressed this concern and believed that this governance arrangement was affecting the partnership between the ASP and AMHS more broadly:

> We have a funding and service agreement with the Area Health Service which then means that they believe that they are our boss. That's not conducive to having a good partnership because if they think they can tell us what to do then that's not a partnership.

This was perceived to be an issue for ASPs in their relationship with AMHS at the regional and state level, whereas at the local co-ordination level the perceived tension between clinicians and support workers seemed less apparent. The emerging issue is less about ASPs being 'managed' by AMHS and more that the current governance structure creates confusion among the partners about to whom, and in what ways, ASPs are accountable.

5.3 State governance processes

HASI has a three tiered governance structure at the state level. At the top tier, the Housing and Mental Health Partnerships Senior Officers Group Meeting brings together high level executives from NSW Housing and Health to oversee HASI from a strategic development, governance and future planning perspective. Representatives from these organisations are also represented on the Departmental Executive Committee (DEC), which sits at the next tier of the governance structure, and focuses on policy and operational effectiveness issues arising in HASI. The final tier of the governance structure brings together representatives from ASPs, housing providers, AMHS providers and other stakeholders from across the state. This tier addresses issues at the local level that have broader policy implications for the program.

Figure 5.1: HASI Governance Arrangements

Stakeholders who were knowledgeable about the governance structure at the state level reported that these arrangements are working relatively well. An important aspect of the effectiveness of these structures is that HASI continues to receive support and leadership from senior executive staff in NSW Health and Housing NSW, as well as political support from Ministers. While lead agencies viewed the DEC as resource intensive, they reported that meeting regularly was essential for maintaining HASI as a partnership because it encouraged these partners to work together to resolve operational and governance issues. Due to the commitment of the two departments, regular meetings, and strong communication channels, the partnership between NSW Health and Housing NSW has strengthened considerably. A good example of how the partnership works in practice is through the roll out of new stages of the program, where key decisions are made jointly between the two agencies.

The partnership has grown over time, and progress has been made in addressing perceived barriers to this partnership including how policy priorities of the two organisations are managed. A key priority for NSW Health is to ensure that people

with mental illness have access to accommodation, although it is not their role to provide housing (NSW Health, 2002). Key priorities for Housing NSW include the prevention and reduction of homelessness through the provision of housing solutions for people in need including a focus on assisting people to maintain their tenancies, although it is not Housing NSW's role to provide the support to people requiring assistance to maintain tenancies (Housing NSW 2008). The HASI program has contributed to coordination and integration of these overlapping priority areas through rolling out different levels of packages (high and low support packages) to target people with different needs. For example, the implementation of HASI Stage One targeted people with mental illness who were in hospital and required housing, whereas Stage Two was introduced to offer services to existing public and community housing tenants who had a mental illness and required support. For HASI to continue to operate as an effective partnership at the state level, it is important that shared policy priorities of each agency continue to be recognised and managed.

5.4 Emerging policy issues

Two key issues require further follow-up for the ongoing effectiveness of HASI. These include the way the ASP funding is organised (particularly the structural rigidity in the way the program has been expanded with new funds over time) and the availability of accommodation.

Funding of ASPs

As discussed in Section 5, ASPs are contracted by AMHS to provide support for an agreed number of clients. When HASI was initially implemented in 2002/03, ASPs were contracted to provide high level support services to clients. Since then, a range of support level packages have been created (low, med, high, very high). This has resulted in the program expanding in different ways across different areas – for example, ASPs may be funded to provide one or more level of support. If an ASP is contacted to provide low and high packages then clients can be transitioned across different funding packages as their needs change, whereas if they only receive funding for one level of support then this raises questions about whether the current structural rigidity is a problem for delivering flexible and accountable support services.

Preliminary evidence suggests that ASPs provide flexible support that is dependent on client needs and, as a result of the recovery process, some clients required less support over time even though they continued to be supported by the same funding package. When clients required less support, ASPs often reduced the number of hours spent with the client and, in this way, did not jeopardise the client's recovery process for the sake of fulfilling the number of hours contracted. As a result, ASPs may have extra hours that need to be filled in order to fulfil their contractual obligations. All three areas that participated in the evaluation reported this dilemma and two main strategies were implemented to address this.

The first strategy was splitting high and very high packages so that, rather than serving one client, two clients receive support for fewer hours. The benefit of this practice is that the original HASI client can receive support according to his or her changing needs, as the following quote shows:

> We've got an allocation of 25 packages, and we're supporting 38 to 42 consumers at the moment. [The extra clients] are supported in an outreach capacity because we are not providing all those hours to the people in existing packages because of their recovery journeys.

There are also potential drawbacks to this practice: the ASP may end up supporting too many clients so that the original client is underserviced, or clients with more urgent needs end up receiving support at the expense of clients who have higher levels of functioning even though they may have several goals they would like to achieve with ongoing support.

A second strategy employed to address the issue of unused support hours was to set up HASI packages that were short term and targeted at people who were being discharged after being an inpatient in hospital. The new program was approved by NSW Health, and is explained in the following quote:

> We ended with a surplus in HASI high support and we allocated the hours to clients without accommodation support. We were limited by the contract – had to spend money within 18 months time, so we offered temporary packages first for people moving out of group homes or hospital into housing. We weren't able to use the surplus doing this so we set up a completely new hospital to community transition service. It provides intensive six week service for people leaving inpatient [hospital] to return to their own homes but will be a different target group to HASI clients because they shouldn't need it [the support] after six weeks.

Given that the provision of flexible services is crucial to promote recovery, one of the key challenges facing HASI in future is how to establish a flexible funding model that also builds in accountability for ASPs. Some interviewees thought that block grant funding would be more effective than the current model of package based funding. Another idea proposed was that people could be allocated places in the program and then allowed to move between levels of support as needed on a case by case basis. This would solve the difficulties around moving clients to higher or lower packages, but would make accountability more difficult.

Accommodation

Further investigation is required into the accommodation component of HASI. In the implementation of Stage One, Housing NSW provided accommodation for HASI packages through public and community housing providers. Since additional HASI packages were established, accommodation was attached to most of the packages and some packages are designed to rely on other housing sources. A range of issues related to this requires further investigation, including the way in which accommodation is allocated through the program and ongoing access and type of accommodation for new clients.

5.5 Conclusion

The HASI model is founded on partnerships between and within health, housing and accommodation support services. Overall, partnerships between and within these groups are generally effective. The AMHS and ASPs have built particularly sound

working relationships and the relationships between the ASPs and housing providers are generally appropriate. Four factors facilitate effective working relationships: having clear roles and responsibilities, maintaining open communication, having a commitment to work together and to the program, and having sound local governance processes. Local governance processes were generally effective when the people involved are committed, have strong formal and informal communication channels and when regular meetings are held. The most substantial barrier to strong local governance was the tension between the 'partnership' versus the 'funder' role of the AHS. At a state level, the governance structure appears to be working well, but two significant issues threaten to undermine the HASI model: the rigidity of the structure of the program and issues related to how accommodation is accessed under the program.

5.6 Summary

- HASI services are provided through a partnership model at the local level that involves NSW Health, Housing NSW and ASPs.
- Overall, the relationships between local partners are generally effective. This is particularly the case between AMHS and ASP providers, ASP and Housing providers and ASP personnel from different organisations.
- With the expansion of the program, multiple ASPs now provide services across NSW and many in overlapping geographical areas. There were some concerns that the competitive funding model may result in competition between ASPs, however, preliminary analysis from in-depth evaluation of sites suggests that ASPs worked together well in most areas.
- The local partnerships between housing providers and AMHS is less intensive , and requires a different level and type of commitment than their respective relationships with ASPs.
- The clear delineation of clinical and non-clinical roles and responsibilities is crucial to developing positive working relationships with NGOs. Where roles and responsibilities were not clear, tensions emerged and the partnerships were compromised.
- Open communication is key to effective partnerships and requires strong communication strategies between stakeholders at all levels of the partner organisations
- While open communication is important, not all partners require detailed information. For example, housing providers require information about the HASI program and the clients, but they do not require detailed confidential client information.
- Effective partnerships require a significant investment of time and energy, consequently, organisational and individual commitments are essential to working together. This commitment requires recognising and respecting the recovery oriented philosophy of the program and the differences in organisational values and philosophies.

- Effective local governance structures are facilitated by: the commitment of people involved; strong formal and informal communication channels; the use of the regular meetings to discuss a range of issues including selection of new clients, transitioning of existing clients between support packages, and any other client related issues; and service level agreements.

- Local governance processes are potentially hampered in some areas by the tension between the idea of an equal 'partnership' between the AMHS and ASP when the AMHS funds the ASP. This sometimes creates confusion among the partners about to whom and in what ways ASPs are accountable.

- The overarching governance structure of HASI is working relatively well and progress has been made in addressing the single most important barrier to the partnership – that of different policy priorities between NSW Health and Housing NSW. For HASI to continue to operate as a partnership at the state level, competing priorities need to be recognised and addressed in an ongoing way.

- Two issues – flexibility and accountability of funding for ASPs and issues related to how accommodation is accessed under the program – require further follow-up and redress for the ongoing effectiveness of HASI.

6 Preliminary Client Outcomes

The aim of HASI is to assist clients to achieve secure tenancies, improve their mental and physical health, improve social and community connections and enhance their quality of life. While the main analysis regarding whether the program has achieved its objectives in improving client outcomes will be undertaken in the next phase of the evaluation, this section presents some preliminary analysis of client outcomes based on qualitative interviews with clients (n=59). These findings will be clarified in relation to analysis of other client outcomes data collected as part of the evaluation (for example, secondary data collected by Housing NSW and NSW Health).

6.1 Tenancies

One of the principle aims of the HASI program is to support people with a mental illness to access and maintain secure tenancies. As described in Section 3, approximately half of the client group had access to housing when they joined the program. For this group of clients, the aim of the program is to support them to maintain their tenancy. Interviews with clients uncovered that even if clients reported living in stable housing immediately prior to entering HASI, most had experienced a long history of housing instability. For example, the following client was referred to HASI from hospital, but had experienced periods of homelessness:

> No, I was homeless and I went into hospital and the staff at the hospital helped me get – my father put in the application for Housing NSW. And that's how I got my apartment. I was sort of homeless because they sold the place I was in. (M, 30, high support)

Other clients were living in temporary accommodation such as caravan parks before they were accepted into the program. Therefore, the demographic details within the MDS may underreport the proportion of clients living in unstable tenancies prior to joining the program.

For a second group of clients the program assisted them to access stable accommodation. While the preliminary results suggest that clients continue to gain access to housing through the program, some clients who were new to the program indicated that they were still on a waiting list and did not yet have access to stable accommodation. For example, one client was living in a homeless men's shelter but had applied for public housing through the priority housing scheme at Housing NSW. Commonly, eligible clients for priority housing may have to wait up to 12 months to be housed, although this varies across different areas.

The majority of the clients interviewed for the evaluation were satisfied with the accommodation they were living in and most felt secure in their accommodation. When participants reported that they had moved to a different property since starting the program, it was usually because they were being provided with appropriate accommodation or had moved closer to family and friends. Additional analysis will be undertaken in future reports to examine the ways in which the program has helped clients get access to and maintain their tenancy.

6.2 Mental and physical health

One of the main aims of the program is to improve clients' mental and physical health. The qualitative data gathered in this round of the evaluation indicates that people have experienced improvements in their mental health since becoming HASI clients. Most clients attributed part of this change to the fact that ASPs were in regular contact with them which helped them to manage their illness and to stay out of hospital:

> I like that they are very orientated in keeping me out of hospital. Usually I spend four months a year in hospital. This year I have spent two months...I won't go to hospital this Christmas and that will be due partly to me, partly my doctor and partly the [NGO] as well. (F, 55, low support)

> They been saying I've been doing good. I haven't been in hospital for about four years now. (M, 32, low support)

> Since I've been in HASI? No, I haven't been in a hospital for nearly two years. (M, 26, high support)

The positive changes experienced by clients were echoed in their responses to the Personal Wellbeing Index (PWI), which showed that participants were more satisfied with their mental health than people who participated in the evaluation of Stage One (67.7 % compared with 58.2% in Stage One; Muir et al., 2007b). Further analysis of PWI scores is needed to see if there was any variation in PWI scores for clients who had recently joined the program compared to those who had been in the program for a longer period of time.

PWI scores also showed that clients were less satisfied with their physical health than their mental health (59.6% compared with 67.7%). The findings were similar for clients across the different support levels. Analysis of interviews with clients indicated that they were experiencing a range of physical health issues such as:

- Dental hygiene and tooth decay
- Diabetes
- Back, knee, shoulder pain
- Stroke effects
- Thyroid problems
- Podiatry (feet) problems
- Post surgical care (e.g hand and spinal surgery)
- Liver problems
- Multi-organ failure
- Hysterectomy
- Severely reduced mobility

Several clients indicated that they had gained weight – which was commonly attributed to the medication they were taking – and had identified weight loss as a goal:

> It took me three months to put weight on - here are the meds and they're going to make you fat. 'Fat and well or skinny and sick'. I didn't realise when I was seven and a half stone that they [clinical staff] meant this fat. (F, 49, low support)

> I got a bit of weight on, I'm not real happy with my weight. (M, 46, high support)

Clients did not report any improvements in these health conditions since entering the program, but many did talk about the contact they have with GPs and other allied health services, meaning that clients were receiving treatment for their ailments.

Clients who needed and asked for it had access to drug and alcohol services, and several clients who were interviewed said that being in the program had assisted them to overcome AOD issues.

> [The] biggest change in my life is that I've quit smoking marijuana – I feel a heap better for doing that. Support has helped me get off that. Between [HASI NGO] and [Day centre]. Yeah it was those two that got me off marijuana been off it nearly two years now. (M, 28, low support)

Clients reported improvements in their mental health but less satisfied with their physical health, which is consistent with findings with the evaluation of HASI Stage One (see Muir et al., 2007b). The findings presented here are only preliminary and suggestive of broader trends. Further analysis will be undertaken in the next stage of the evaluation on mental health and physical health outcomes. Further analysis will be conducted during the next phase of the evaluation into clients' rates of hospitalisation, before, during and if possible for some clients after they left the program.

6.3 Social connections and community participation

The program also aims to improve clients' social and community connections. As described in Section 4.2, 81 per cent of clients had identified social and community connections as a goal they wanted to be supported in and 95 per cent of clients partly or fully achieved this goal. Preliminary analysis of interviews with clients suggested that some of the benefits for clients in attaining this goal included improved relationships, involvement in community activities, and education and employment.

Relationships

Many of the clients interviewed indicated that they felt socially isolated and have little contact with family members or friends. At the same time, some clients felt that since being involved in the program they felt less isolated because they had developed new friendships with other clients and relationships with neighbours and people they had met through social activities in the community. A few clients also reported that relationships with family and friends had improved as a result of support provided by

HASI, although some clients continued to experience difficult relationships with family.

Community activities

Clients indicated that through the program they had become involved in day centre activities, such as Day to Day Living Program, which is targeted at people who have mental illness. These programs provided clients with a safe place to socialise, learn new skills and join in on planned activities. Exercise was an activity that several clients had become involved in since joining the program, as was fishing, and participation in other day centre activities.

Preliminary analysis of the PWI suggests that the sample of clients interviewed across the different levels of HASI support (n=59) were more satisfied with feeling part of the community compared to the clients who participated in the evaluation of Stage One (71.6 compared with 55.8), which may reflect clients' decreased sense of social isolation. Further analysis is needed to investigate what factors are associated with clients' feelings of being part of the community.

Economic participation

For many clients (45%) participation in education or employment had been identified as a goal and 82 per cent of clients had partially or fully achieved this goal (Section 5). Several of the clients interviewed for the evaluation stated that the program has helped them to manage their mental illness which, in turn, has had a positive impact in enabling them to undertake employment, voluntary work or education and training:

> They got me under an employment agency to get me some work and I'm really looking forward to that as well. (M, 37, very high support)

Several clients, particularly those receiving low support services, mentioned they were currently looking for work and a number of other clients confirmed that they were actively engaged in paid employment. One client described the difference that having a job had made on his life.

> I have been working for four and a half years now. Before that, I wasn't a slob but like I'd just wake up when I wanted to and go to the shop when I wanted to. Now I have to be more disciplined – with appointments and going to work and things... [Q: so what kind of work?] A process worker – it's only low wage – a sheltered workshop. (M, 42, low support)

Two clients indicated that they were involved in voluntary work which was an enjoyable part of their week:

> I go to work one day a week at Vinnies. And that's voluntary work and I love it. Love it. (F, 55 years, low support)

Several clients interviewed for the study expressed an interest in studying or undertaking a training course in the future. Others said they were already participating in education courses:

> But now I've started a course in TAFE at home. Yeah it's good. It's a real basic get started – attainment certificate. When you finish you post 'em in and they send you out more. I've got one at the moment about work environment. (M, 41, low support)

Even though clients overall reported feeling positive about living independently in the community, some clients expressed concern that they still felt marginalised and stigmatised in the community because of their mental illness. Other clients had limited family support or no contact with family members and some said they didn't have any friends. While clients reported developing supportive relationships with ASP staff and other consumers, few clients participated in mainstream services or activities. This will be explored further in future reports.

6.4 Quality of life

Improving clients' overall quality of life is another important objective of the program. Clients interviewed for the current evaluation (n=59) reported feeling more satisfied with their life overall compared with clients in the evaluation of HASI stage one (62.6 compared with 54.4 in Stage One). The results were similar for clients across the different levels of support. Most clients believed that the program has contributed to a better quality of life than they had experience before becoming involved in the program, at which time most clients had been struggling with difficult issues in their lives including:

- Temporary housing or homelessness
- Social isolation
- Hospitalisation
- Drug and alcohol abuse
- Psychosis, anxiety and depression
- Self harm

Most clients, across different support levels, spoke of very difficult times prior to joining the program.

> Well I was more isolated and more depressed. (F, 51, low support)

> Psychologically I was stressed – [living in a] small house... I'd get outside as much as I could. The stress that was involved – had to keep my illness separate from the family 'cause we were all struggling in different ways. I know if I wasn't coping it would have an effect on the family. (M, 29 years, high support)

> It was very lonely – I have very little family in [name of area]. My dad just passed away. All of a sudden there was just nobody there. I guess it was pretty depressing too. (F, 24, low support)

Since being in the program, many clients said they felt that their life had improved. They reported feeling more confident, happier, a sense of hope for the future or less depressed or anxious. Further analysis is needed regarding PWI scores and length of time clients have been in the program.

6.5 Conclusion

Clients interviewed for the evaluation overwhelmingly reported that their lives had improved since they began receiving HASI services. Most clients had a history of insecure housing and, while this improved while they were in HASI, some newer clients remained on waiting lists for accommodation due to shortages in their local area. Clients spoke of substantial improvements in their mental health since becoming HASI clients and, while clients were less satisfied with their physical health than their mental health, all were receiving treatment from General Practitioners (GPs) and other health services. Some clients also spoke of experiencing improved social relationships and increased involvement in community activities, education and employment, although many clients continued to feel isolated and lonely at times.

6.6 Summary

- Interviews with clients found that most had experienced a history of housing instability throughout their lives, although this history was not adequately captured in the MDS dataset.
- While the preliminary results suggest clients continue to gain access to housing through the program, some newer clients indicated that they were on a waiting list and did not yet have access accommodation.
- Most of the clients interviewed for the evaluation were satisfied with the accommodation they were living in and most felt secure in their accommodation.
- The qualitative data indicates that clients experienced improvements in their mental health since participating in HASI. Most clients attributed part of this change to the fact that ASPs were in regular contact and helped to manage their illness.
- Clients were less satisfied with their physical health than their mental health. This was reflected in the interviews, in which many clients reported experiencing a range of physical health issues and weight gain.
- Clients did not report any improvements in these health conditions since entering the program, but many did talk about the contact they have with GPs and other allied health services, which indicates that clients were receiving treatment for their ailments.
- Many clients experienced improved relationships and increased involvement in community activities, education, and employment since joining the program.
- Even though clients overall reported feeling more positive about living independently in the community, some reported feeling marginalised and stigmatised because of their mental illness.

7 Conclusion

HASI is an established program that provides accommodation support, access to clinical mental health services and social housing to people who have a mental illness across NSW. This report drew on program data and qualitative data collected from 112 stakeholders and clients to understand: the profile of current clients; the types of services provided to clients by ASPs; the framework for service delivery; effectiveness of partnerships and governance arrangements; and emerging policy issues.

The data shows that HASI has been successful in identifying and selecting its intended target group. The profile suggests, however, that CALD clients are still underrepresented in the program. The target group has been successfully identified through appropriate referral pathways and selection processes.

The process of ASP support provision, relationships between partners, and the governance of HASI are operating relatively effectively across the program. Stakeholders and clients reported that rehabilitation, client centred support, flexibility, and improving workforce and organisational capacity are the guiding principles of HASI service delivery and in most cases, the HASI service model works well to support clients. In spite of this, some ASP staff perceived the aim of recovery based services as supporting clients to achieve defined outcomes in a set time period, which is different to how support services were delivered in Stage One. ASP staff endeavour to achieve a balance between providing client centred support, ensuring that clients do not become too reliant on ASP staff, and promoting client efficacy and participation in community activities.

Partnerships at the local and state levels are now well established and were generally perceived to be working effectively. At the local level, AMHS and ASPs have built particularly sound working relationships, which are facilitated through clear roles and responsibilities, open communication, a commitment to working together, and sound local governance processes. At a state level, the partnership between NSW Health and Housing has strengthened since Stage One, and progress has been made in addressing tension around shared and competing departmental priorities experienced during the early implementation of HASI.

Clients interviewed for the evaluation overwhelmingly reported that their lives had improved since they began receiving HASI services. Most clients had a history of insecure housing and, while this improved while they were in HASI, some newer clients remained on waiting lists for accommodation due to shortages in their local area. Clients reported substantial improvements in their mental health since joining HASI and, while clients were less satisfied with their physical health than their mental health, all were receiving treatment from GPs and other health services. Some clients also experienced improved social relationships and increased involvement in community activities, education and employment, although many clients continued to experience isolation and loneliness.

Two issues require further follow-up and redress for the ongoing effectiveness of HASI. The flexibility of support provided to clients means that, when a client's support hours decrease, HASI providers reduce the number of hours spent with the client and, as a result, ASPs have outstanding hours, which led to a funding surplus in

the three evaluation sites. All three sites were using the money creatively to address local needs. Given that the provision of flexible services is crucial to promote recovery, one of the key challenges facing HASI is how to establish both flexibility and accountability. Issues related to how accommodation is accessed through the program is another important area that requires further investigation in the evaluation.

7.1 Next steps in the evaluation

This first report of the HASI evaluation has focused on the processes for supporting clients, maintaining partnerships, and governance. The next report, which is due to be completed in August 2010, will concentrate on client outcomes that will be drawn from program and secondary data provided to SPRC by NSW Health and Housing NSW by the end of February 2010. This report will also include preliminary analysis of the costs of HASI as reported by NSW Health and Housing NSW. The final evaluation report will include analysis of interviews, which will be collected in September and October 2010, more detailed analysis of client outcomes, and an analysis of the costs and effectiveness of the program. This report is due to be completed by the end of February 2011.

7.2 Conclusion

The expansion of the HASI program into a multi-level support program for people with a mental illness continues to provide much needed services and support to the target client group. Even with some ongoing challenges evident in the delivery of services and coordination between partners, the current service model appears to be working well to deliver effective support for clients. The extent to which the current model is achieving its intended impact on outcomes for current clients will be further investigated in the next stage of the evaluation, as will the costs and benefits of the program.

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