

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

Second Report

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Abbreviations and glossary

AMHS	Area Mental Health Service
APQ	Activity and Participation Questionnaire
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
HONOS	Health of the Nation Outcome Scale
IHS	Integrated Housing System
ISC	Inpatient Statistics Collection
K10	Kessler Psychological Distress Scale
LSP	Life Skills Profile
MDS	Minimum Data Set
MRN	Medical Record Number
MH-AMB	Mental Health Ambulatory data collection
MHDAO	Mental Health and Drug and Alcohol Office
MH-OAT	Mental Health Outcomes and Assessment Tools
NOCC	National Outcomes and Casemix Collection
NSW	New South Wales
SPRC	Social Policy Research Centre
State HIE	State Health Information Exchange
SUPI	State Unique Personal Identifier
UNSW	University of New South Wales

Comparison time periods – any quantitative analysis in this report compares the two years before HASI with the first two years during HASI

Social and community participation – Formation and engagement in meaningful social relationships and networks and social, community, education and paid and unpaid work

Unstable housing – short-term or broken tenancies, no secure tenancy, homeless or at risk of homelessness:

- 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)

Executive summary

This is the second of three reports in the longitudinal evaluation of the NSW Mental Health, Housing and Accommodation Support Initiative (HASI). The evaluation aims to understand how well the HASI program is working by investigating the effectiveness of support for consumers, the benefits and limitations of the service model(s), and the costs and benefits of the program. This report focuses on outcomes achieved by HASI consumers in regards to housing stability, mental and physical health, and social and community participation. The first report examined the operational effectiveness of the service delivery model (McDermott et al., 2010) and a final report with the full results from the evaluation will be produced in early 2011.

Key findings

Housing stability

One of the primary aims of HASI is to provide people with access to secure housing and support to assist consumers to maintain their tenancy. The results show that most HASI consumers were living in a range of stable accommodation options including public housing, community housing and private housing. Consumers seldom moved house and, when they did, it was usually for positive reasons (e.g. they moved to accommodation more appropriate to their needs). Only a small proportion of consumers living in public housing were in rental arrears or had caused damage to their properties which compares favourably to the broader population of people in public housing.

Mental and physical health

HASI aims to facilitate improved mental and physical health by facilitating access to appropriate services. The results show that the majority of HASI consumers (96 per cent) used health and mental health services more than once each year. The final report will analyse health and mental health services separately. People receiving high and very high support were more likely to use community mental health and psychiatric services more than once a month than people in low and medium support, but were less likely to go to a general practitioner (GP) or use allied health services.

Participation in HASI appears to have had a positive impact on consumers' levels of hospitalisation. Data from NSW Health show a statistically significant decrease in the average number of hospital admissions each year (24 per cent decrease), the mean number of days spent in hospital per person per year (60 per cent decrease), and the average number of days hospitalised per admission (68 per cent decrease). Longitudinal analysis conducted over a four year period shows that people joined the program at a time when their rates of hospitalisation were high, and that the amount of time spent in hospital decreases the longer consumers are in the program. Men and women had different patterns of hospital service use. The data show that women are admitted to hospital more regularly and spend more time in hospital per admission than men, but that men spend more days in hospital per person per year.

Consumers also experienced improvements in their mental health since joining the program according to the results from Kessler-10 (K10), Life Skills Profile (LSP) and Health of the Nation Outcome Scale (HONOS). Although both men and women's mental health improved, the results differ slightly by gender: women had significantly higher levels of psychological distress (K10 scores) than men, but men recorded more living skills deficits (Life Skills Profile) than women. The evaluation found improvements in consumers' mental health across a variety of clinical mental health indicators.

Social and community participation

The majority of HASI consumers have a high degree of independence in their daily living skills, particularly in relation to personal hygiene, cooking, taking medication and transport. The area in which consumers require the most assistance was financial management (budgeting and paying bills).

Consumers were participating in community activities, such as social and recreational activities. More than half of consumers (54 per cent) were independently participating in social and recreational activities, but many consumers receiving high support continued to require the support and assistance of their ASP support workers to be able to participate in the community in a meaningful way.

While most consumers enjoyed regular social contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner (86 per cent) – around one in seven (14 per cent) continued to be socially isolated and have no form of regular contact. The findings show that some HASI consumers (19 per cent) were actively involved in education and training, and participation in paid or unpaid work was another way that consumers were spending their time (31 per cent).

Costs of HASI

The total budget for the program over the last four years was \$118 million accommodation support costs, \$1 million project management costs and previous housing capital investment 2002-07 was \$26 million. This is equivalent to an annual unit cost per consumer ranging from \$11,000 to \$58,000, plus project management costs of between \$200 to \$500 per person, depending on the level of accommodation support and the method of calculating the annual unit costs.

The final report will assess the cost of HASI against the outcomes experienced by HASI consumers. Where possible, comparisons will be made between the HASI consumers and a comparable group, such as the general population, the consumer outcomes from the Stage 1 evaluation, or another comparison group derived from the secondary data sources.

Conclusion

This report shows that the majority of HASI consumers are successfully maintaining their tenancies, are regularly using appropriate services in the community, and have a high degree of independence in activities of daily living. Consumers have experienced some improvements in mental health and have reduced the amount of time spent in

the hospital since joining the program. However, many consumers struggled with their mental and physical health and a minority remain isolated from social networks in the community. The final report will explore these findings in more detail in relation to key findings from interviews with consumers and other stakeholders.

1 Introduction

The Mental Health Housing and Accommodation Support Initiative NSW (HASI) is designed to promote recovery for people with mental illness by providing access to stable housing, accommodation support services, and clinical mental health services. This is the second of three reports on the longitudinal evaluation of the whole of HASI.¹ The evaluation aims to understand how well the HASI program is working by investigating the effectiveness of support for consumers, benefits and limitations of the service model, and the costs and benefits of the program. This report focuses on outcomes achieved by HASI consumers in regards to housing stability, mental and physical health, and social and economic participation.

1.1 HASI aims and service description

HASI is designed to assist people with mental illness to participate in the community, experience improvements in their quality of life, prevent homelessness and support their recovery from mental illness. 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 to live independently in the community. Since the implementation of HASI 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 in each stage. All stages of HASI provide some level of accommodation support services, and most (with the exception of 4B HASI in the Home) provide services to people who are eligible for, or who are currently living in, social housing.

HASI commenced in 2002/03 with the roll out of 100 high support packages (up to 5 hours of support per day, 7 days per week) across NSW. This stage targeted people with high support needs and at risk of homelessness or inappropriately housed, as well as those in inpatient facilities who are unable to exit due to difficulty in accessing

¹ The first report included findings from Round 1 of fieldwork – 112 interviews with consumers and other stakeholders in three sites across NSW – as well as service use data from the HASI Minimum Data Set to examine the operational effectiveness of the service delivery model (see McDermott et al 2010). A final report which will include the full evaluation results will be completed in March 2011.

the levels of accommodation support they require. Between 2003 and 2010, the HASI program significantly expanded. Each stage of HASI has been targeted to meet the needs of mental health consumers, providing a range of support, from low support (5 hours a week) to very high support (8 hours a day), and rolled out in areas of need across NSW:

- HASI Stage 2 commenced in 2005 with the provision of 460 packages of care (up to 5 hours of support per week) for people in social housing requiring lower level outreach accommodation support who are at risk of being unable to sustain their tenancies/accommodation.
- HASI Stage 3 commenced in 2005/06, is an expansion of HASI 1 and provides 126 high support packages (up to 5 hours of support per day, 7 days per week) and accommodation in existing social housing stock.
- HASI Stage 3B commenced in 2006/07, with the provision of 50 very high support packages (up to 8 hours of support per day, 7 days per week) and accommodation in existing social housing stock. This stage targets people who have a mental illness and associated very high levels of disability.
- HASI Stage 4A commenced in 2006/07, expanding on HASI 1 and 3 and providing 100 high support packages and accommodation in existing social housing stock.
- HASI Stage 4B (HASI in the Home) commenced in 2007 with the provision of 240 low support packages and 80 medium support packages (2-3 hours of support every day, 7 days per week). HASI 4B is a model of HASI whereby accommodation support is provided to people regardless of where they live, so for the first time people do not have to live in social housing.

The final report will analyse the management between these HASI stages and supplementation from other programs such as Personal Helpers and Mentors (PHaMS).

1.2 Service delivery framework

HASI is a partnership program between NSW Health, Housing NSW, and non-government Accommodation Support Providers (ASPs). NSW Health is responsible for providing ongoing clinical care to consumers through Area Mental Health Services (AMHS) and funding accommodation support which is provided by ASPs. Housing NSW provides public and community housing properties and manages the tenancies of people who are accepted onto high and very high support packages.

HASI is overseen by the Housing and Mental Health Partnerships Senior Executive Meeting and the Departmental Executive Committee (DEC). The Senior Executive Meeting manages the strategic development, overall governance arrangements and future planning of the initiative and the DEC focuses on interagency policy and operational effectiveness issues.

HASI stakeholder groups are also involved in the program governance. NSW Health hosts HASI bi-monthly forums attended by representatives from all HASI funded ASPs, Area Health Services, and Housing NSW as required. These meetings support the ongoing planning, development and delivery of HASI. If specific development

work is required for the program (such as reviewing changes to the way in which data collected on HASI consumers) a smaller working group is formed from the membership of this meeting.

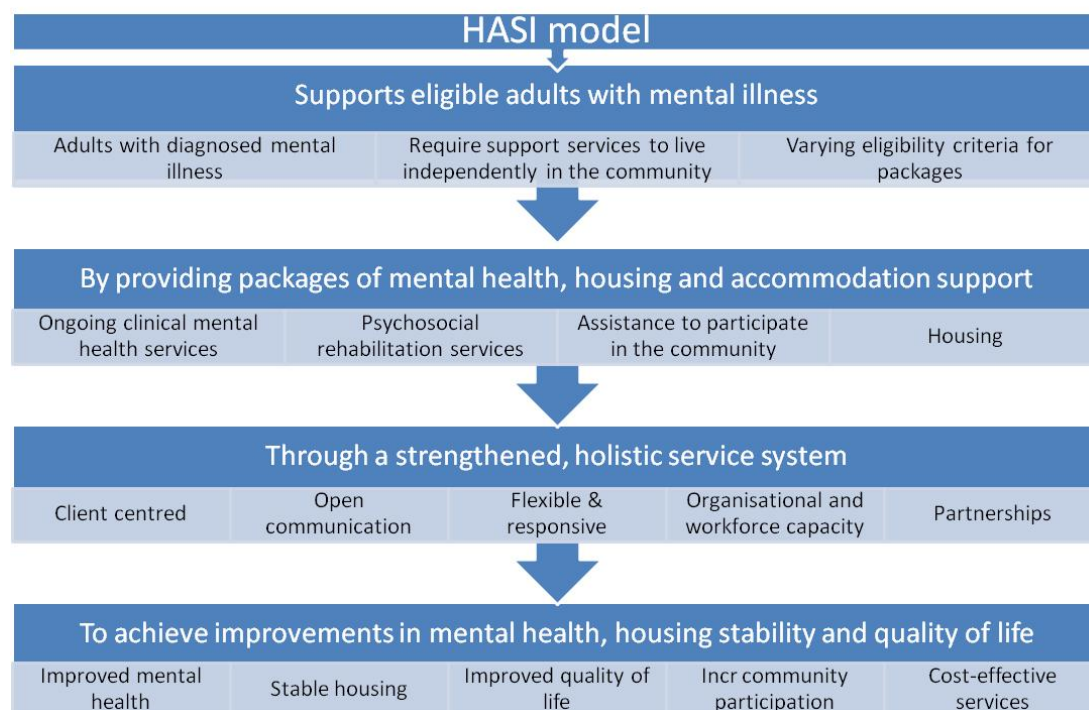
At the local level, HASI is managed by Local Coordination Groups, which aim to foster partnerships between the AMHS, housing provider(s) and the ASPs in each area.

1.3 HASI logic model

The premise of HASI is that some people who have a diagnosed mental illness require support services to live independently in the community. The logic of the program is that:

- If people with a mental illness are supported with appropriate services such as housing, clinical mental health services, rehabilitation services, and assistance to participate in community networks and activities;
- And those services are consumer centred, flexible, responsive and are provided in a collaborative way;
- Then it is likely that the service model will achieve beneficial outcomes for consumers, such as improvements in mental health, access and maintenance of secure housing, improved quality of life and increased community participation.

Figure 1.1: HASI logic model



This report presents preliminary analysis of the effectiveness of the program in meeting its aims and objectives for consumers and an analysis of the costs of HASI. In particular, it provides analysis about whether consumers are:

- maintaining their tenancies;
- accessing appropriate services in the community;
- experiencing improved physical and mental health outcomes;
- building personal relationships;
- involved in community activities; and
- engaging in productive activities such as employment, voluntary work and training.

2 Methodology

This report analyses quantitative data collected from a variety of data sources. Analysis is based on a sample of 895 (77 per cent) HASI consumers who were participating in the program in June 2009 and for whom a start date and demographic data were available.² Sample sizes varied across the data sources but all were subsamples of the 895 identified in the NSW Health HASI Minimum Data Set (MDS). An overview of how these subsamples were derived is included in Appendix B. A comparison of basic demographic characteristics can be found in Table 3.1 and more detail on the demographic differences between the samples can be found in Appendix C.

Table 2.1: Sub-sample characteristics

	Number of consumers	Average age Years	Average time in HASI Months	Gender (Per cent)		Support level (Per cent)	
				Men	Women	Low	High
HASI MDS	895	41	23	53	47	62	38
Housing NSW	163	45	29	52	48	79	21
Mental health admission	197	38	30	59	41	45	55
Inpatient admission	222	39	29	57	43	46	54
K10	242	42	24	56	44	48	52
LSP	268	40	23	53	47	49	51
HoNOS	339	40	23	53	47	51	49
MDS supplement	639	43	24	54	46	62	38

Note: 1. Mental Health ambulatory (community) and emergency department data are available and will be analysed in the final report
 2. Total HASI packages = 1076

Table 3.1 shows that the MDS supplement is the most representative of HASI consumers across the main demographic categories (age, gender, support level and length of time in the program). The gender distribution and average length of time spent in the program is similar across all samples, but there are differences in the average age of consumers as well as the representativeness of consumers receiving lower and higher levels of HASI support in each of the data sets. People receiving high support are overrepresented in the data on mental health admissions, inpatient admissions, K-10, LSP and HoNOS, whereas consumers receiving low support are overrepresented in the Housing NSW sample. Support level, therefore, is likely to have the biggest impact on the results presented in this report.

This section describes the data sources that were used in this report. 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).

² The remaining 272 consumers could not be linked with their demographic data or start date and were therefore excluded from the analysis.

2.1 HASI Minimum Data Set (MDS)

Data from the HASI MDS are collected by ASPs who complete an application form, which includes questions about gender, age, mental health status and tenancy history, when a referral is received (Appendix D). Once a person is accepted into the program, ASP staff complete a report detailing the services consumers received in areas such as housing and health at the commencement of service delivery and each quarter thereafter (Appendix D).^{3,4} HASI program data were first collected in July 2006, but there are large gaps in the data for the first two monitoring periods (July-September and October-December 2006) so reliable data are only available from 1 January 2007.

Because ASPs collect some data about housing outcomes, the MDS was analysed in this report to develop an understanding of these outcomes for HASI consumers. In particular, the MDS includes information about how many consumers moved house and why, the number of Consumer, Trader and Tenancy Tribunal (CTTT) actions, as well as the proportion of consumers with complaints made about them to housing providers. The analysis draws on the snapshot of current consumers (n=895) in the April to June 2009 reporting period for whom demographic and service use data were available and for whom these data could be linked.⁵

Limitations to analysing the HASI MDS

MDS is intended to collect data for monitoring services provided by ASPs. Its primary purpose is not to monitor housing use, but it does include some data on housing outcomes that can be used to supplement data collected from Housing NSW. Given this context, one of the expected limitations of the MDS is that the housing data is not complete. A substantial amount of missing data for some of the variables, especially in relation to housing indicators, means that it should only be interpreted as supplementary data as it was intended. For example, while the total sample is 895, information about CTTT actions was available for 289 people. This limits the robustness of the analysis to only adding to the interpretation of the other Housing NSW outcomes data and restricts the extent to which analysis of change over time can be conducted.

Other expected limitations about the level of detail available on consumers' housing profile from MDS include that there is no record of whether consumers are living in public housing, community housing, private rental accommodation or their own homes, which limits the analysis of housing outcomes in relation to different types of accommodation. A final expected limitation is that information recorded about

³ This information is completed by ASPs 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.

⁴ The MDS forms included in the Appendices were used to collect the data for this report. The forms were extensively revised in 2010.

⁵ Due to the way that data are collected, it was not always possible for ARTD or InforMH to link the demographic data collected upon entry to the service use data that are reported quarterly. In the April to June 2009 quarter, service use data were submitted for 1,167 consumers, but could only be linked with the demographic data of 895 consumers (77 per cent).

consumers' housing status and outcomes may be incomplete because it is recorded by ASP staff rather than housing providers. For example, the MDS asks ASPs to record tenancy risk factors when consumers enter the program. The last report found a low proportion of consumers experienced tenancy risks before entry, but interviews with consumers for the first evaluation report showed that many had long histories of insecure housing. This suggests that housing data from this source may be incomplete and should only be interpreted with the Housing NSW data and in light of the qualitative data in the first and final reports.

2.2 Housing NSW data

Information about consumers' housing profile and outcomes was also transferred from Housing NSW for a sub-sample of HASI consumers living in public housing properties. Data from Housing NSW were drawn from the Integrated Housing System (IHS) in order to understand the extent to which HASI consumers are able to maintain their tenancies. The variables included: the number of times people moved house and their reasons for moving, whether people owed money to Housing NSW for damage caused by the tenant, and the number of people in rental arrears.

HASI consumers were identified in the IHS through a flag that was introduced into the system in January 2009. As a result of its recent implementation, the flag does not identify former HASI consumers who are housed in a Housing NSW property but who had left before this time. The data extraction identified 409 people in IHS with a HASI flag, however, it was only possible to confirm the HASI entry date for 163 people. Although this sample is smaller than originally anticipated, it provides a useful snapshot of HASI consumers who are public housing tenants.

Contextual information about tenants who were previously on the priority housing list as well as all tenants in public housing in NSW is included in the analysis to understand how the profile of HASI public housing tenants compares.

Limitations to analysing the Housing NSW data

One of the main limitations of Housing NSW data is that the sample does not include people living in community housing. Efforts were made to include community housing data early in the evaluation, however, due to decentralised data collection mechanisms across the sector, it was not possible to collect data about people living in these properties. It is, however, likely that people in Housing NSW properties are similar to those who are living in community housing. Eligibility for public and community housing was similar during the period HASI has operated and, since April 2010, all clients apply for social housing through a common access system called Housing Pathways, regardless of whether they are applying for public or community housing or both.⁶ Property allocation policies in terms of location, number of bedrooms, accessibility and transfers are similar in both sectors, and both groups have the same access to long term tenure.

⁶ When people apply for social housing, they can choose whether they want to live in public housing or community housing. Under Housing Pathways, they can apply for either or both types of housing.

Information about people living in community housing properties is included in the housing data collected as part of the HASI MDS, however, it is not possible to analyse the profile of community housing tenants as a subsample of the main HASI consumer group because the type of housing is not identified in the MDS. It is also important to note that the data taken from both the IHS and the MDS are limited in what they can reveal about long term tenancy outcomes, which makes it difficult to conclusively comment on the impact of HASI on tenancy.

2.3 NSW Health data

De-identified data about hospitalisations, community mental health services and clinical mental health measures were provided by NSW Health and extracted for the evaluation by InforMH, which is responsible for collecting, analysing and reporting information on mental health services in NSW.⁷ InforMH identified 810 HASI consumers in the data, but demographic details and HASI entry dates could only be matched for 604 consumers.

Mental health hospital admissions

Data about hospitalisations were analysed to test whether the time spent by HASI consumers in hospital changed after they joined the program. The evaluation of HASI Stage One, which focused on people receiving high levels of support, found that the number of hospital admissions and the number of days per admission decreased after people entered HASI (Muir et al., 2007).

Data for the current report were extracted for all inpatient admissions, including emergency department visits, mental health admissions and other hospital admissions, from July 2001 to June 2009.⁸ The collection of continuous data made it possible to analyse changes in hospital service use for a sample of people who had been in HASI for two years to understand changes in hospitalisation over time. Given this criterion, data about all inpatient admissions were available for 222 people and mental health hospital admissions data were available for 197 people.

Mental Health Outcomes and Assessment Tools (MH-OAT)

To examine whether consumers experienced changes in their mental health since starting HASI, the evaluation examined data about consumers' levels of psychological distress, living skills and behavioural issues gathered as part the National Outcomes and Casemix Collection (NOCC). This information is collected by Area Health Service staff when consumers of the mental health system are in hospital and when

⁷ HASI consumers were identified in Health data sets through their Medical Record Number (MRN) which was collected from Area Health Services by HASI ASPs during the July-September 2009 quarter of data collection for the HASI MDS. MRNs were supplied to InforMH which then matched records with the relevant encrypted State Unique Personal Identifier (SUPI), which is a unique number that can be used to link consumers of public mental health services in various NSW Health datasets. The final dataset as provided to SPRC was completely deidentified, it was not possible for the researchers to be able to identify actual individuals from the data provided.

⁸ Data were compiled by InforMH from the NSW Health Admitted Patient Data Collection in the State Health Information Exchange (HIE).

they receive services provided by community mental health teams. NOCC data contains four different mental health measures including the:

- Kessler Psychological Distress Scale (K-10);
- Health of the Nation Outcome Scale (HONOS);
- Life Skills Profile (LSP-16); and
- Activity and Participation Questionnaire (APQ-6).

The K10 is a ten-item consumer self-report questionnaire designed to measure psychological distress. It includes questions about levels of nervousness, agitation, fatigue and depression and whether consumers have experienced aspects of distress over the last four weeks. Each item in the K10 is scored from one (none of the time) to five (all of the time). This evaluation includes the data for a sample of 242 people who had scores calculated both before and during their participation in HASI.

Table 2.2: Kessler 10 scores

Scores	Risk of psychological distress
1-15	Low or no distress
16-29	Medium distress
30-50	High distress

Source: (Kessler et al., 1994)

Unlike the K10, which measures levels of distress among the general population, the clinician-rated LSP-16 is designed to measure the life skills of people with schizophrenia and other major psychiatric disorders. A shorter version of the original LSP-39, the LSP-16, is collected by clinicians as part of MH-OAT. This measure is deficit based rather than strengths based: it focuses on self care, anti-social behaviour, withdrawal and compliance (Alan Rosen et al., 2006).⁹ A higher score on the LSP-16 indicates poorer functioning (A. Rosen et al., 2001). Potential scores on this measure range from 0 to 48. LSP-16 data were available for 291 consumers before and during their involvement with HASI.

The Health of the National Outcome Scale (HoNOS) is a clinician rated mental health measure used to measure changes in problem areas that are commonly associated with mental illness.^{10,11} The severity of each problem over the past two weeks is rated by clinicians on a five point scale from zero (no problem within the period rated) to four (severe or very severe), and so the higher the score, the more problems experienced by consumers. Scores before and during consumer involvement with HASI were available for a sample of 341 consumers.

⁹ The domains in LSP-39 are labelled: self-care, non-turbulence, social contact, communication and responsibility.

¹⁰ HoNOS65+ is used for people over the age of 65 years.

¹¹ These include: aggressive behaviour, self injury, problem drinking or drug taking, cognitive problems, physical illness or disability, problems with hallucinations or delusions, problems with depressed mood, other mental and behavioural problems, problems with relationships, problems with activities of daily living, problems with living conditions, and problems with occupation and activities.

A non-clinical, self-report measure of social and community participation, the Activity and Participation Questionnaire (APQ-6), was introduced by NSW Health in June 2009. It asks consumers to indicate whether they have work or are looking for work, enrolled in any courses, and whether they are participating in any social activities. The questionnaire also includes a section asking whether consumers would like to become involved in any activities in the future. While this measure has the potential to provide valuable information on the level of social activities and community engagement, it is not analysed for this report due to the small number of consumers for whom information was available. At the time data were collected, scores were only available for 49 HASI consumers, and only one person had more than one APQ-6 score. If the APQ-6 becomes a widely used tool, it has the potential to be useful for both clinicians and evaluators to understand social outcomes that may be experienced by mental health consumers.

Mental Health Ambulatory (MH-AMB) Data Collection

The Mental Health Ambulatory (MH-AMB) data collection includes information about the type of community mental health services that HASI consumers have used. This includes services such as general community mental health services, allied health and rehabilitation appointments. These data were analysed to understand whether there was a change in the use of community mental health services after consumers entered HASI. Approximately 400 consumers were identified in the MH-AMB data collection, representing 376,802 visits to community mental health services (July 2001- June 2009). The statistical software package used to analyse data for this report could not process such a large amount of data, so the data will be analysed for the final report using alternative software.

Limitations to analysing the NSW Health data

The primary limitation of this analysis is the lack of a comparison or control group, which means that the evaluation is unable to confirm that the changes experienced by HASI consumers would not have otherwise been experienced by other people with mental illness not in HASI. In the early stages of the evaluation it was intended that data would also be collected on a group of people with comparable characteristics from the NSW Health data to compare against HASI clients but, given that these data sets do not include a variable indicating the type of support people receive, it was not possible to draw an accurate comparison group using de-identified data. Therefore, while the analysis demonstrates changes for this group of consumers over time, caution needs to be taken when attributing these changes to HASI. In future, it would be important to explore the possibility of designing an experimental or quasi-experimental study to address this limitation.

The source of comparison most frequently used in this report is results from the evaluation of HASI Stage One. It is important to note, however, that the samples in the current and previous evaluation have different characteristics. The evaluation of Stage One involved consumers who were provided with social housing and received high levels of support, whereas consumers in the current evaluation range from receiving low to high levels of support. Furthermore, although most current consumers are eligible for social housing, not all consumers are living in either public

or community housing as some of them live in private rental properties or their own home. Comparing results against the HASI Stage One evaluation, therefore, has

The second limitation relates to the interpretation of results from the K-10, LSP-16 and the HoNOS. Results in these sections were calculated by taking the average of scores before and during HASI, but it is important to note that data was not collected from clients at regular intervals (e.g. every three months), meaning that the averages are based on a different number of scores for each client collected at different times. The averages may therefore hide broader improvements or fluctuations in consumers' mental health condition over time.

2.4 MDS supplement

At the start of this evaluation it was identified that information about social indicators, such as economic participation and community connections, was not routinely collected for the existing datasets.¹² To address this, the researchers included a one page supplementary questionnaire to be completed by ASPs in the July-September 2009 reporting period of the MDS and again in the July-September 2010 reporting period (Appendix E). The questionnaire was designed so that ASPs could fill out the items on behalf of consumers in relation to living skills, service use, health and mental health status, education, employment, and family relationships. There was a 91 per cent response rate for the MDS supplement (1065 forms were returned), but only 639 (55 per cent) could be linked with the consumers' demographic data and HASI start date.

Limitation to analysing the MDS supplement

The primary limitation of the supplement data is that, for most consumers, it was not collected at baseline. It therefore provides only a point in time measurement and cannot be used to understand changes experienced by consumers over time.

2.5 Conclusion

This section has provided an overview of the sources of data, sample sizes, and limitations of the data sources. The remainder of the report presents results from the data analysis. The next section details the housing profile and housing outcomes of current consumers, and subsequent sections provide data on consumers' service use, mental health, physical health, hospitalisation, and social and economic outcomes. The final report will analyse the characteristics of people for whom outcomes improved, remained the same or deteriorated (eg. ranges in outcomes; effect sizes; and direction of change).

¹² NSW Health has now introduced the APQ-6 which will address this gap in future.

3 Housing profile and outcomes

HASI assists people with mental illness to access and maintain stable and secure accommodation. This is an important component of the program given that people with mental illness often have problems with stable tenancies, which can be correlated with continuing poor mental health outcomes (Bleasdale, 2006; Flatau et al., 2008).

This section examines the housing profile and outcomes of two samples. The first part uses HASI MDS data (n=895) to describe the housing profile and outcomes for all HASI consumers.¹³ The second section examines the housing profile and outcomes for a sub-sample of HASI consumers who are public housing tenants and who could be identified in the Housing NSW dataset (n=163).

3.1 Housing profile and outcomes of all HASI consumers

Housing profile of all HASI consumers

Of the current consumers in the program for whom linked data were available (n=895), around half had access to secure accommodation at the time they were accepted into the program. These people lived in public housing (41 per cent), community housing (9 per cent) or private rental (7 per cent). The remaining consumers did not have stable accommodation prior to entering HASI and were experiencing primary, secondary or tertiary homelessness.¹⁴ 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 per cent), in a boarding house (2 per cent) or were in hospital (16 per cent; Table 4.1).

¹³ Longitudinal analysis of housing outcomes is limited due to limitations of the MDS data, difficulty identifying consumers in the Housing NSW data, and the lack of consistent data on community housing and other forms of housing. See methodology for a more detailed discussion of these limitations.

¹⁴ As defined by Chamberlain, C. and Mackenzie, D. (1992), 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues*, 27(4), 274-297. They 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 3.1: Consumers by type of accommodation at entry to HASI

	Number of consumers ¹ (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

Source: HASI MDS

Note: 1. Data missing for 56 consumers

ASPs noted the existence of a tenancy risk factor in one in four consumers entering the program (25 per cent, n=223). Nearly half the consumers receiving very high support had at least one identified tenancy risk factor (48 per cent; Table 3.2).

Table 3.2: Tenancy risk factors by support level at entry to HASI

	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

Source: HASI MDS

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

Table 3.3: Type of tenancy risk factor at entry to HASI

	Number of risk factors ¹	Percent (%)
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	-

Source: HASI MDS

Notes: 1. Of the 223 consumers who had a tenancy risk factor, a total of 284 risk factors were identified. Most consumers did not have a risk factor (662 or 75 per cent)

Housing outcomes of all HASI consumers

The findings indicate that HASI consumers are successfully maintaining their tenancies. According to the MDS data, 90 per cent (n=806) of consumers have not ended a tenancy since joining the program. Of the 80 tenancies that ended, 86 per cent (n=69) were for planned reasons such as moving to more appropriate or other long term housing (Table 3.4).

Table 3.4: Reasons for tenancy completion

Reasons for tenancy completion ¹	Number of completions ² (n)	Percent (%)
Planned reasons		
Consumer moving to other long-term housing	33	41
Housing inappropriate for consumer's needs	26	33
Planned end of tenancy	5	6
Consumer moving to higher-support accommodation	5	6
Unplanned reasons		
Eviction	8	10
Abandoned property	2	3
Non-renewal of tenancy due to failure to meet tenancy obligations	1	1
Total	80	100

Source: HASI MDS

Notes: 1. Includes HASI consumers living in public housing, community housing, and private Accommodation. Most consumers did not move (806 or 90 per cent).
 2. n=80 is the total number of completed tenancies where a reason for the completion is known. 89 people moved (completed a tenancy) at least once and some of the 89 people moved more than once since starting HASI equaling a total of 103 completed tenancies. Reasons for 23 of the 103 moves are missing, therefore n=80.

Data on the number of CTTT actions, which occur when tenancy agreements are breached, and complaints against tenants, also show that the vast majority of HASI consumers are successfully maintaining their tenancies.¹⁵ Only one per cent (n=6) of all consumers were recorded in the MDS as having a CTTT action in the most recent quarter, and complaints were made against only four per cent (n=27) of consumers. The number of CTTT and complaints did not vary by consumers' support level (Table 3.5).

¹⁵ These figures may be underreported because CTTT actions and complaints may not always come to the attention of ASPs, which may therefore provide lead to a more optimistic interpretation of clients' situation than is otherwise warranted.

Table 3.5: CTTT actions (n=686) and complaints (n=690) by support level, June 2009

	Low or medium		High or very high		Total ¹	
	Consumers	Percent	Consumers	Percent	Consumers	Percent
	(n)	(%)	(n)	(%)	(n)	(%)
One or more CTTT actions ²	2	0.5	4	1	6	1
One or more complaints ³	13	3.0	14	5	27	4

Source: HASI MDS

Notes: 1. This includes HASI consumers living in public housing, community housing, and private Accommodation.

2. Data missing for 209 people

3. Data missing for 205 people

Longitudinal analysis suggests that the number of CTTT actions has remained stable over time. Data from the first four quarters consumers were in HASI demonstrate that consumers had a low number of CTTT reports from the time they started in the program. Only two per cent (n=6) had a CTTT hearing in their first two quarters in HASI, and only one per cent (n=1) in the third and fourth quarters in the program (Table 3.6).

Table 3.6: Longitudinal analysis of CTTT actions

	CTTT actions 0-6 months (n=289) ¹	CTTT actions 7-12 months (n=289)
No CTTT action (%)	98	99
One or more CTTT action (%)	2	1
Total ² (%)	100	100

Source: HASI MDS

Notes: 1. Only 289 consumers had complete data on this item during their first 12 months in the program.

2. This includes HASI consumers living in public housing, community housing, and private accommodation.

The majority of HASI consumers who received complaints also appears to have remained stable over time when data about a subset of consumers who had been in the program for 12 months or more (n=294) are analysed (Table 3.7).

Table 3.7: Longitudinal analysis of nuisance and annoyance complaints

	People with complaints 0-6 months (n=294) ¹	People with complaints 7-12 months (n=294)
No complaints (%)	92	93
One or more complaints (%)	8	7
Total ² (%)	100	100

Source: HASI MDS

Notes: 1. Only 294 consumers had data consistently reported on this item during their first 12 months in the program.

2. Includes HASI consumers living in public housing, community housing, and private accommodation.

3.2 HASI consumers living in public housing

This section focuses on a subsample of HASI consumers who are public housing tenants (n=163). The profile of these consumers is discussed in relation to the profile of public housing tenants in NSW to gain a better understanding of how HASI consumers in public housing properties differ from other public housing tenants.¹⁶

Profile of people living in public housing

Data collected from Housing NSW shows that HASI consumers are much more likely than other public housing residents to live alone. Almost nine in ten (88 per cent) HASI public housing residents live alone, compared to one in two public housing tenants (51 per cent; Table 3.8). As a result, a much higher proportion of HASI consumers reside in one bedroom apartments than other public housing tenants (53 per cent compared with 25 per cent; Table 3.9). The key question about the type of properties in which Housing NSW consumers reside, however, is whether these properties are appropriate for consumers. For example, do any HASI consumers living alone experience loneliness or exploitation from other people making inappropriate use of their accommodation and putting their tenancy at risk. These questions will therefore be explored in the final report in relation to the interviews conducted with clients and stakeholders.

Table 3.8: People per household, public housing subgroups, June 2009

People per household	Percent HASI consumers in public housing (n=163) (%)	Percent all public housing residents in NSW (n=121,120) ¹ (%)
1	88	51
2	6	25
3	4	11
4	1	7
5	-	4
6	0.6	2
7	-	1
Total ²	100	100

Source: Housing NSW, IHS database

Notes: 1. Data missing for 147 people

2. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

¹⁶ Comparisons between HASI consumers and all public housing residents are made to understand the conditions in which HASI consumers are living. It is important to note that these groups have different characteristics and therefore conclusions drawn from these comparisons need to be made with caution.

Table 3.9: Number of bedrooms, public housing subgroups, June 2009

Number of bedrooms	HASI consumers in public housing (n=163) (%)	All public housing residents in NSW (n=121,273) (%)
1 ¹	53	25
2	32	28
3	13	39
4	2	8
Total ²	100	100

Source: Housing NSW, IHS database (n=163)

Notes: 1. Includes studio apartments
2. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

Outcomes for HASI consumers in public housing

At June 2009 most HASI consumers living in public housing properties were paying their rent on time, and only a small number (3 per cent, n=5) were in rent arrears of two weeks or more. Table 4.10 shows that, although the housing profile of HASI consumers differs from the general population of people in public housing, the proportion of HASI consumers in rent arrears is the same as all public housing residents and the subsample of residents housed through the priority housing list.¹⁷

Table 3.10 Two or more weeks of rent in arrears, public housing subgroups, June 2009

	Percent HASI consumers in public housing (n=163) (%)	Percent all public housing residents in NSW (n=121,273) (%)	Percent priority housing residents in NSW (n=17,455) (%)
People not in arrears	97	97	96
People with two or more weeks in arrears	3	3	4
Total ¹	100	100	100

Source: Housing NSW, IHS database

Notes: 1. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

While it is expected that all public housing tenants will require repairs to be made to their properties due to general wear and tear, some repairs are due to damage caused by tenants. Data from Housing NSW's Rechargeable Repairs account (RRP) show that most HASI consumers in the sample (93 per cent) did not owe money to Housing NSW for repairs caused by damage to their property. Only a small proportion of

¹⁷ HASI consumers are also compared against people who were placed in public housing after being on the waiting list for priority housing because these groups may have more comparable characteristics. People are eligible for priority housing if they are eligible for social housing, in urgent need of housing and unable to access housing in the private rental market. People are in urgent need of housing if they are living in unstable housing, at risk of harm, or living in very inadequate accommodation (Housing NSW, 2008, fact sheet on priority housing, <http://www.housing.nsw.gov.au/NR/rdonlyres/6E8E2485-29B4-4BB3-A8A9-381138374582/0/PriorityHousingDec2006.pdf>, accessed 5 October 2010).

HASI consumers (4 per cent; n=7) owed more than \$100 to Housing NSW for damage caused by the tenant. As Table 4.11 illustrates, this figure is comparable to the broader population of public housing tenants and the subsample of tenants housed through the priority housing list.

Table 3.11 Damage to public housing properties (people with an RRP balance of \$100 or more) by public housing tenants, June 2009

	Percent HASI consumers in public housing (n=163) (%)	Percent all public housing residents in NSW (n=121,273) (%)	Percent priority housing residents in NSW (n=17,455) (%)
No balance or balance less than \$100	96	97	96
Balance greater than \$100	4	3	4
Total ¹	100	100	100

Source: Housing NSW, IHS database

Notes: 1. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

3.3 Conclusion

This section has shown that HASI consumers are maintaining secure accommodation. Data from the MDS indicates that HASI consumers had a low tenancy turnover and consumers who ended a tenancy mostly did so for positive reasons such as moving to more appropriate accommodation. Other housing indicators also provided evidence to suggest that consumers are living in secure accommodation. For example, complaints and CTTT actions were rarely made against consumers.

HASI consumers living in public housing are more likely than other public housing residents to live alone and to live in a one bedroom property. Of key importance, the number of HASI public housing consumers who are in rental arrears or who cause damage to their properties closely reflects the proportion of all public housing residents. This is an important finding because it demonstrates that the HASI program is successfully supporting consumers to maintain their tenancies to the same levels as the population of public housing residents.

The final report will include analysis about the relationship between HASI and the Joint Guarantee of Service (JGOS) arrangements between NSW government agencies; the impact of the federal rollout of affordable housing on the availability of housing; the expenditure of rollover HASI funds on other services until housing was available; and HASI partnership management questions such as a risk plan or referral pathway for changes in mental health when consumers are disengaged from their ASP or clinical case managers.

3.4 Summary of housing profile and outcomes

- Over half of the current HASI consumers (57 per cent, n=481) lived in stable housing before entering the program.
- The overwhelming majority of HASI consumers have maintained a secure tenancy (90 per cent, n=806) since joining the program.
- Eighty nine people (10 per cent) moved since joining the program; 86 per cent of tenancies that ended did so for positive or planned reasons, such as moving into more appropriate accommodation.
- HASI consumers generally uphold the conditions of their tenancy agreements. In the most recent quarter, only one per cent of all consumers were recorded as having had a CTTT action and complaints were made about four per cent of consumers.
- HASI consumers living in public housing are more likely than other tenants to reside in one bedroom property, to be accommodated in a unit or apartment, and to live alone.
- HASI consumers are just as likely to manage their rental payments and maintain their properties to a suitable standard as other public housing tenants who are not in the HASI program.

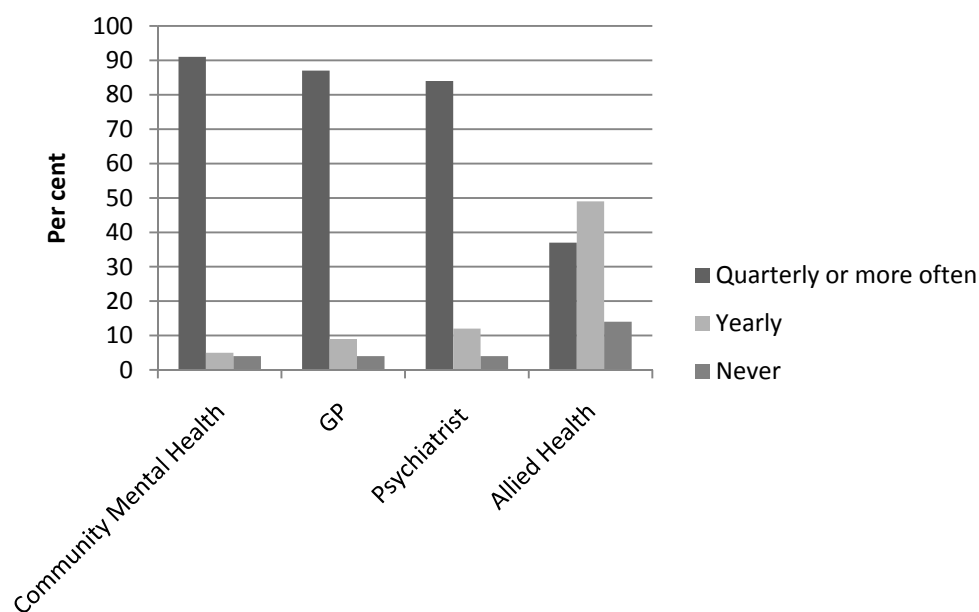
4 Physical and mental health outcomes

The intention of HASI is that, in providing stable housing and accommodation support, consumers should experience improved access to services in the community, a decrease in mental health hospitalisations, and improved mental and physical health. This section explores each of these outcomes in turn.

4.1 Service use

Data on the type and amount of services used were available from the MDS supplement and NSW Health. Findings from the MDS supplement indicate that the majority of consumers (96 per cent, n=611) used health and mental health services at least once during the previous year, and about 86 per cent had used allied health services (eg. Dental, optometrist) (Figure 4.1).¹⁸ These findings are similar to results from the evaluation of HASI Stage One, which showed that 96 per cent of high support consumers had visited a community mental health professional, 94 per cent had visited a GP, and 94 per cent had used psychiatric services since entering HASI.

Figure 4.1: Health service use, September 2009 (per cent, n=639)



Women used some services more frequently than men (GPs $p < 0.01$ and allied health services $p < 0.05$).

People receiving high and very high support were significantly more likely than those in low and medium support to use community mental health ($p < 0.001$) and

¹⁸ Information was available for a total of 639 consumers from the MDS Supplement; these data were recorded by ASP staff about consumers' access to health and mental health services and is therefore a subjective measure from the staff, which is unlikely to be a complete record of all occasions of service.

psychiatric services ($p < 0.01$) more than once a month, but were less likely to go to the GP or use allied health services.¹⁹ The final report will analyse qualitative data about whether these patterns of service use are self-motivated or because of ASP support; and service plans to assist people to maintain service use after they leave HASI.

Mental Health ambulatory service use data will be analysed in the final report.

4.2 Mental health hospital admissions

This section examines whether consumers have experienced any changes in the level of mental health hospital admissions since joining the program. This was the strongest positive indicator of the impact of the program in the previous evaluation of HASI Stage One.²⁰ The analysis in this section has been conducted about a cohort of HASI consumers who had complete data available two years prior to joining HASI, and who had been in the program for approximately two years ($n=197$).^{21,22} This analysis explores changes across the sample and provides some detailed analysis based on gender. The final report will include an analysis of whether the services used by consumers differed by support level, age and, if possible, diagnosis. It will also analyse other inpatient data and emergency presentations.

Change in mental health admissions before and during HASI

Table 5.10 demonstrates that HASI consumers had significantly fewer hospital admissions after joining HASI. There was a 60 per cent decrease in the average number of days people spent in hospital per year, and a 68 per cent decrease in the average number of days hospitalised per mental health admission after becoming a HASI consumer.

¹⁹ In addition to the MDS supplement repeat, the use of community health services will be explored in the final report through further analysis of data from the MH-AMB Collection in the State HIE.

²⁰ Data on all hospital admissions, which includes all emergency department visits, acute admissions, general admissions and psychiatric admissions were also analysed and are included in Appendix D. They show similar trends to those described in this section. This section focuses on admissions to hospital in which the reason for admission was psychiatric and is therefore comparable to the previous evaluation.

²¹ Data were included for a small group of consumers who had been in HASI between one and two years. Their available data were annualised so as to provide a consistent comparison point between consumers.

²² Analysis was conducted about all people who had at least one psychiatric admission over the four year period. Consumers who did not have an admission were excluded from the analysis because it could not be verified that these data were missing or that these consumers had no admissions.

Table 4.1: Pre-HASI and in-HASI participant mental health admissions (n=197), compared with Evaluation of HASI Stage One (n=67)

	Before HASI ¹	While in HASI ²	Per cent change since joining HASI	Evaluation of Stage One (per cent)
Average number of admissions per person per year	1.7	1.3	-24**	-17
Average number of days in hospital per person per year	55.1	23.4	-60***	-81
Average number of days per admission	6.3	2.1	-68***	-78

Source: NSW Health, Admitted Patient Data Collection in the State HIE

Notes: 1. Based on the average number of admissions per person in the two years prior to joining HASI

2. Based on the average number of admissions per person over each consumers' first two years in HASI

** p<0.05, ***p<0.001 Sig. 2-tailed, from paired sample t-test of means across two periods

These results are overwhelmingly positive, but they differ slightly from those in the previous evaluation. The current sample has experienced a larger decrease in the number of hospital admissions per year, but smaller changes in relation to the amount of time spent in hospital per person, and the number of days spent in hospital per admission. These smaller decreases may be due to the fact that people with lower support needs are now accepted into HASI and their profile might be different. This may also be related to another trend which was discussed in the first report – that consumers are still being admitted to hospital once they join the program, but that these are more likely to be planned rather than unplanned admissions. It could also be due to the difference in sample sizes. These possibilities will be further analysed for the final report.

Longitudinal analysis of mental health hospital admissions

Analysis of unit-record data made it possible to examine the average yearly use of mental health admissions across a four year period.²³ To simplify the explanations in this section, 13-24 months prior to joining HASI is referred to as Year 1, 0-12 months prior to joining HASI is referred to as Year 2, 0-12 months in HASI is labelled Year 3, and 13-24 months in HASI is described as Year 4.

The longitudinal analysis reveals some interesting findings. As shown in Figure 5.2, people experienced an increase in the mean number of hospital admissions during the year prior to joining the program. For example, the mean numbers of hospital admissions per year increased from about one and a half admissions per year in Year 1 to two admissions per year in Year 2. The number of admissions per year begins to

²³ The four years include annualised data for the two years immediately prior to joining HASI (13-24 months before HASI and 0-12 months before HASI) and two years immediately after joining HASI (0-12 months in HASI and 13-24 months in HASI).

decrease after consumers entered HASI so that, in Year 3, the number of admissions is the below that in Year 1 and stabilises in Year 4.²⁴

Table 4.2: Mean number of mental health admissions for two years prior and first two years of HASI per person per year, by gender (n=197)

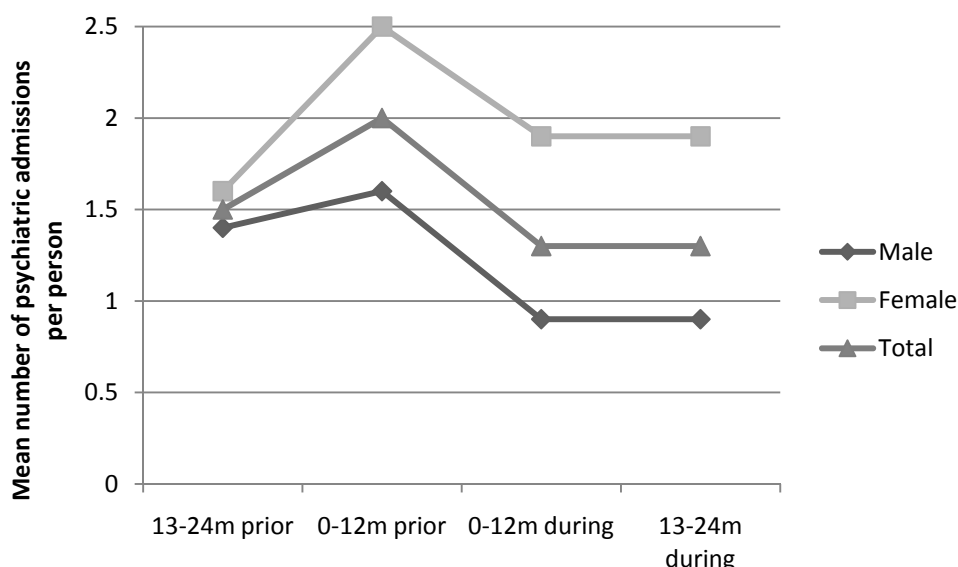
	Consumers	13-24m prior	0-12m prior	0-12m during	13-24m during	Sig. ¹	Effect size ²
Men	116	1.4	1.6	0.9	0.9	.000	.194
Women	81	1.6	2.5	1.9	1.9	.027	.110
Total	197	1.5	2.0	1.3	1.3	.000	.103

Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data.

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

2. Partial eta squared

Figure 4.2: Mean number of mental health admissions for two years prior and first two years of HASI per person, per year, by gender (n=197)



The findings also reveal that men and women have different patterns of mental health hospitalisation. The data show that women in HASI are admitted to hospital more regularly than men and that after joining the program, women continue to be admitted to hospital more often than they did in Year 1 (Figure 5.2).

Annual longitudinal analysis was also conducted on the number of mental health inpatient days. Table 5.12 and Figure 5.3 show a sharp increase in the number of days spent in hospital during the year prior to entering HASI.

²⁴ Further analysis on the effect size will be provided in the final report.

Table 4.3: Mean number of days spent in hospital per person per year, by gender (n=197)

	Consumers	13-24m prior (Year 1)	0-12m prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. ¹	Effect size ²
Men	116	50.9	71.1	25.7	10.9	.000	.320
Women	81	29.7	73.7	39.9	21.3	.000	.247
Total	197	42.2	72.1	31.5	15.2	.000	.272

Source: NSW Health, Inpatient Admissions Database

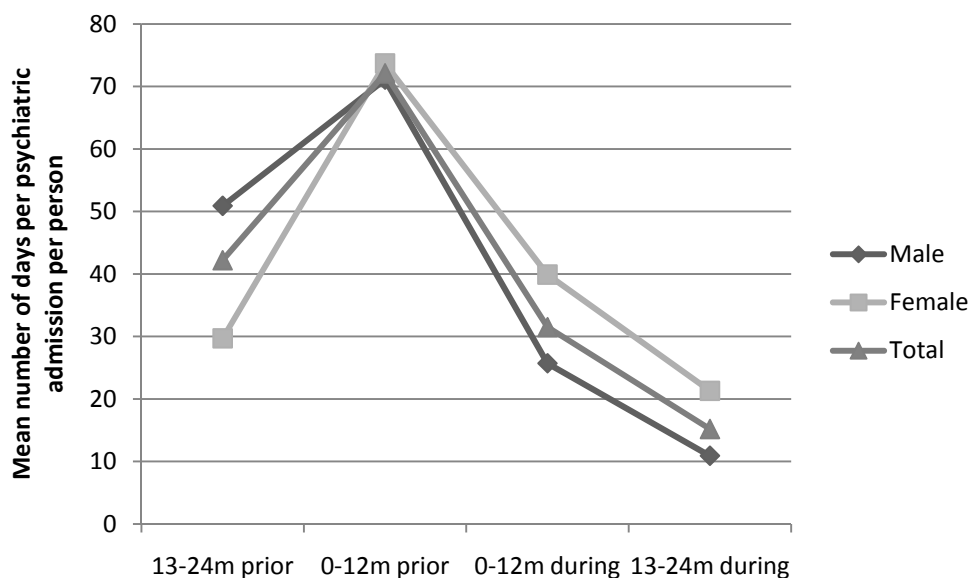
Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

2. Partial eta squared

This could mean that people enter HASI when they have reached a crisis – either the hospital stay makes people more willing to accept HASI services or the extended period of time in the hospital facilitates acceptance into the service. These possibilities will be further analysed for the final report.

Figure 5.3 shows that women spent less time in hospital than men in the two years prior to joining HASI. This trend reverses once people enter HASI and women begin to spend slightly more time in hospital than men in the first year of HASI (Figure 5.3).

Figure 4.3: Mean number of days spent in hospital per person per year, by gender (n=197)



As with the previous graphs, the number of days per admission increased during Year 2 (Table 4.4). Men spent more time in hospital per admission than women before joining the program (Years 1 and 2), and both experienced a sharp decrease in the number of days per admission after entering the program (Figure 4.4). The number of days spent per admission once consumers enter HASI is lower than Year 1 for both

men and women. This indicates that people continue to spend fewer days in hospital while in the program.

Table 4.4: Number of days per hospital admission, per year, by gender (n=197)

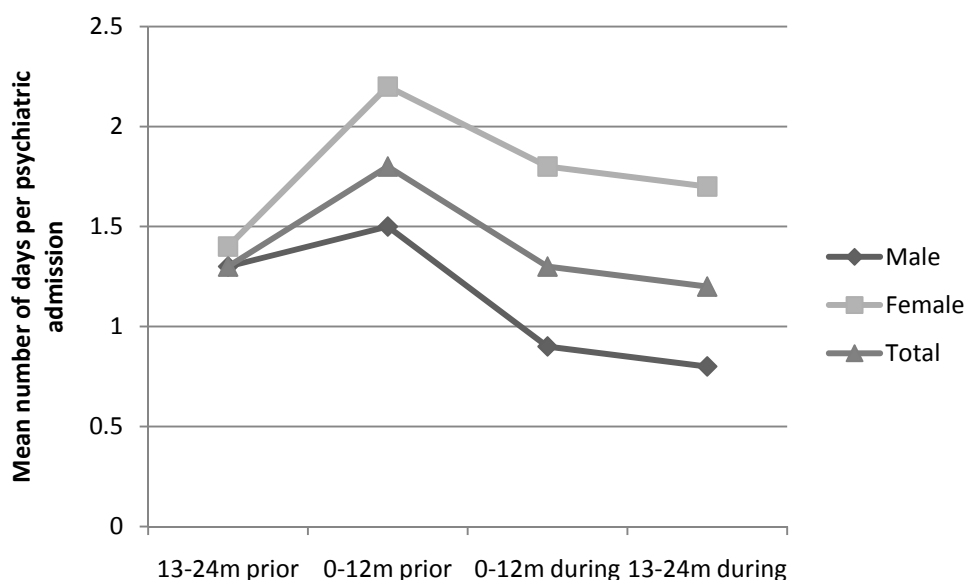
	N	13-24m prior	0-12m prior	0-12m during	13-24m during	Sig. ¹	Effect size ²
Male	116	6.0	10.5	3.0	1.5	.000	.205
Female	81	3.0	7.7	3.5	1.2	.000	.231
Total	197	4.8	9.4	3.2	1.4	.000	.197

Source: NSW Health, Inpatient Admissions Database

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

2. Partial eta squared

Figure 4.4: Mean number of days per mental health hospital admission, per year, by gender (n=197)



According to the statistical test that was carried out on these yearly averages (one-way repeated measures ANOVA) the change across the four year period in relation to the number of hospital admissions, the number of days spent in hospital per person, and the number of days per admission is statistically significant. However, the change *between* years is not always significant. Without a comparison group, it is not possible to know what the trajectory would have been for these HASI consumers had they not been accepted into the program. Furthermore, a longer term comparison is needed to assess this trend over time and to determine whether the spikes in the amount of time spent in hospital, which are likely to continue to happen to HASI consumers throughout their lives, are less severe than when they joined HASI.²⁵

²⁵ Using the SUPI, it will be possible to follow consumers over time to explore this question.

4.3 Mental health outcomes

HASI aims to assist people to achieve improvements in their mental health. To measure changes in consumers' mental health status, consumers' level of psychological distress (K10), life skills (LSP-16) and other behavioural issues (HONOS) were examined. A non-clinical measure collected from the MDS providing a snapshot of the mental health status of HASI consumers as rated by ASP staff is also included.

K10

Before joining HASI, approximately half of the sample was in medium distress, and a quarter of the sample was experiencing high levels of psychological distress according to the K10 (Table 5.1).²⁶ The proportion of the sample experiencing high levels of psychological distress decreased after joining HASI ($p < 0.05$) and the proportion of consumers with low or no distress increased ($p < 0.1$).

Table 4.5: K10 psychological distress scale (per cent)

	Consumers	Low or no distress (scores 10-15)*	Medium distress (score 16-29)	High distress (scores 30-50)**
Before HASI	242	28	45	27
During HASI	242	34	46	20

Source: NSW Health, MH-OAT Collection in the State HIE.

Notes: * $p < 0.1$, ** $p < 0.05$, McNemar test for repeated samples

The reduction in psychological distress is reflected in the small but statistically significant decrease in average scores after people entered the program (Table 5.2). The change is smaller than was found in the evaluation of HASI Stage One, but that is to be expected given the small sample size in the first evaluation (data on this measure were only available on 12 consumers as opposed to 242 in this evaluation) and because HASI now includes a mix of support levels whereas Stage One provided only high support.

Table 4.6: Mean and median K10 scores before HASI and during HASI (n=242)

	Before HASI	During HASI	Change
Mean***	23.2	21.5	-1.7
Median	22.0	20.0	-2.0

Source: NSW Health, MH-OAT Collection in the State HIE.

Notes: *** $p < 0.001$, Paired sample t-test of equality of means

Women have significantly higher levels of distress than men overall ($p < 0.01$). While both groups experienced a decrease in distress levels after they entered the program, the decrease for men was larger and significant at the 10 per cent confidence interval ($p < 0.1$).

²⁶ People were included in this analysis if they had at least two valid scores (one before and during HASI). People who met this criterion had an average of nine scores available per person.

Table 4.7: K10 before and during HASI by gender (n=242)

	n	Before HASI	During HASI	Sig. ¹
Men	136	21.5	19.7	0.05
Women	106	25.2	23.8	0.19
Sig. ²	-	0.004	0.001	-

Source: NSW Health, MH-OAT Collection in the State HIE

Notes: 1. Paired sample t-test of equality of means

2. Independent sample t-test of equality of means

LSP-16

The life skills of HASI consumers were measured using the LSP-16 and, as stated in the methodology, a lower score on the LSP-16 indicates better life skills.²⁷ Analysis of LSP-16 scores for 291 people before and during HASI shows a small drop, which indicates that consumers' life skills increased since joining the program. This change is statistically significant but, as argued by others, such a small drop is unlikely to be clinically significant (Eagar et al., 2005). This will be discussed further in the final report of the evaluation.

Table 4.8: LSP-16 descriptive statistics before HASI and during HASI (n=291)

	Before HASI	During HASI	Change
Mean***	11.5	10	-1.5
Median	11.0	9.3	-1.7

Source: NSW Health, MH-OAT Collection in the State HIE.

Notes: *** p<0.001, Paired sample t-test of equality of means

The gender differences in life skills (LSP-16 ratings) are the opposite to the psychological distress scores (K10). Men recorded poorer scores than females both before and during HASI on the LSP-16. The improvement for both men and women was statistically significant (Table 5.5). A similar finding was noted by Eagar et al (2005) in their analysis of HONOS and LSP-16 data collected by clinicians in New Zealand over a six-month period. This suggests that, while women experienced more psychological distress, they experienced fewer deficits in life skills than men.

Table 4.9: LSP-16 before and during HASI by gender (n=242)

	Consumers	Before HASI	During HASI	Sig. ¹
Men	154	12.3	10.4	0.002
Women	137	10.6	9.5	0.041
Sig. ²	-	0.023	0.323	-

Source: NSW Health, MH-OAT Collection in the State HIE.

Notes: 1. Paired sample t-test of equality of means

2. Independent sample t-test of equality of means

²⁷ The LSP-16 is designed to capture deficits in life skills and, therefore, higher scores indicate lower levels of functioning in MH-OAT data but the LSP-16 can also be scored to capture consumers' strengths, in which case higher scores equate to higher levels of functioning. The extent to which these scores could be compared to the broader literature on LSP-16 is limited as a consequence.

HONOS

Data on the HoNOS was obtained to measure changes in problem areas that are commonly associated with mental illness.²⁸ The severity of each problem over the past two weeks is rated on a five point scale, and higher scores indicate that consumers have more severe problems across a broader range of areas. Similar to the other mental health indicators, average HONOS scores improved after people entered HASI (Table 4.10). However, unlike the K10 or LSP-16, there were no differences by gender either before or during HASI (Table 4.11). This is different from the Eager et al (2005) study which found a significant difference in the HONOS scores of men and women.

Table 4.10: HONOS descriptive statistics before HASI and during HASI (n=341)

	Before HASI	During HASI	Change
Mean***	10.3	8.8	-1.5
Median	9.9	8.3	-1.6

Source: NSW Health, MH-OAT Collection in the State HIE
 Notes: *** p<0.001, Paired sample t-test of equality of means

Table 4.11: HONOS before and during HASI by gender (n=341)

	n	Before HASI	During HASI	Sig. ¹
Men	182	10.3	8.9	0.001
Women	159	10.5	8.7	0.000
Sig. ²	-	0.685	0.793	-

Source: NSW Health, MH-OAT
 Notes: 1. Paired sample t-test of equality of means
 2. Independent sample t-test of equality of means

The final report will include more analysis of these preliminary results and comparison to other literature that use these standard assessment instruments.

4.4 ASP perceptions of physical health outcomes

In the MDS data ASP staff reported that half the consumers had good or very good physical health according to the ASPs (Table 4.12). Unexpectedly, the physical health of current consumers was rated as substantially poorer than in the evaluation of HASI Stage One.²⁹

²⁸ These include: aggressive behaviour, self injury, problem drinking or drug taking, cognitive problems, physical illness or disability, problems with hallucinations or delusions, problems with depressed mood, other mental and behavioural problems, problems with relationships, problems with activities of daily living, problems with living conditions, and problems with occupation and activities.

²⁹ The only source of data available on consumers' physical health status was the MDS supplement, which used a question designed by the ABS to gather data from ASPs about their perceptions of the physical health of consumers. These data need to be interpreted with caution because the supplement is not a standardised operational measure, nor does it reflect consumer perceptions of their own health.

Table 4.12: ASP perceptions of consumer physical health as compared with the evaluation of HASI Stage 1

	HASI stage 1 evaluation (n=51)	Current consumers (n=636)
Very good or excellent (%)	28	14
Good (%)	37	37
Poor or very poor (%)	35	49
Total (%)	100	100

Source: MDS supplement
 Notes: HASI Stage 1 data collected by ASPs
 Data missing for three current consumers

There were no significant differences between people receiving lower and higher levels of support or differences based on the length of time people had spent in the program. ASPs rated men as having slightly better physical health than women (54 per cent were reported as being in good, very good or excellent health, as opposed to 48 per cent of women) but this difference was not statistically significant.

Although the evaluation of HASI Stage One found that physical health declined over the course of the evaluation, the poor physical health of current consumers is a surprising finding, particularly given that the majority of consumers are accessing health services on a regular basis. This may suggest that by the time people join the program they may have already developed a range of complex health problems, which may not been properly treated before they joined HASI or it could reflect an increase in the identification and treatment of physical health problems once consumers join the program. These possibilities will be further analysed for the final report. The physical health of consumers will be followed up in the next round of interviews.

4.5 Conclusion

This section has shown that according to the MDS data reported by ASP staff, the majority of HASI consumers are using health and mental health services on a regular basis. There was a clear difference between the service use profile of different groups of consumers: women use GP and allied health services more frequently and people receiving higher support use community mental health and psychiatric services more often than those receiving lower support.

The support consumers receive through the program appears to have had an impact on their use of mental health hospital services. Data from NSW Health show a statistically significant decrease in the average number of hospital admissions each year (24 per cent decrease), the mean number of days spent in hospital per person per year (60 per cent decrease), and the average number of days hospitalised per admission (68 per cent decrease). Longitudinal analysis revealed that men and women have different patterns of hospital service use. Women are admitted to hospital more regularly and spend more days in hospital per admission than men, but men spend more days in hospital per person before HASI. The rate and length of stay improved for both men and women when they entered HASI and continued to improve after their first year in the program.

According to the MH-OAT data, small positive improvements in consumers' mental health since joining the program were also identified. Some of these results differ by

gender, as women experience more distress than men (according to the K10), but men have more living skill impairments than women. While clinical mental health measures (from NSW Health) showed small improvements across the sample in both these measures and HONOS for both men and women, data collected from ASPs indicate that half of all consumers are still experiencing poor or very poor mental and physical health. Comparison group data are not available to the evaluation (see explanation in McDermott et al, 2009). Instead, the final report will compare the HASI evaluation results with results for comparable groups from other literature.

4.6 Summary of physical and mental health outcomes

- The majority of consumers (96 per cent, n=611) had used health, mental health, and allied health services at least once during the previous year. These findings are similar to results from the evaluation of HASI Stage One.
- According to data obtained from the MDS supplement women used GP and allied health services more frequently than men. People receiving higher HASI support services used community mental health and psychiatric services more frequently than those on low support, but used GP or allied health services less frequently.
- HASI consumers had significantly fewer mental health hospital admissions after joining HASI. A 60 per cent decrease in the average number of days spent in hospital per year and a 68 per cent decrease in the average number of days hospitalised per admission, and a 24 per cent drop in the number of admissions to hospital per year were gained.
- Longitudinal analysis of hospital use by gender shows that women were admitted to hospital more often than men and spent more days in hospital per admission, but that men spent more days in hospital per person before joining the program. The inpatient rate and length of stay improved for both men and women once they entered HASI and improved further during their second year in the program.
- Analysis of the MH-OAT measures shows small but significant improvements in consumers' mental health since joining the program. There was a statistically significant decrease in the proportion of the sample experiencing high levels of psychological distress (according to K10 scores). Women experienced higher levels of psychological distress than men both before they joined the program and after
- There was a statistically significant increase in the life skills of HASI consumers and a statistically significant decrease in behavioural issues compared with before consumers became involved in the program (according to the LSP-16 and HoNOS).
- ASP staff rated only about half of current consumers as having excellent, very good or good physical health. The poor physical health of the sample may reflect that, by the time people become HASI consumers, they have begun experiencing a cumulative effect of complex health problems that have not been properly treated over their lifespan and are therefore slow to reverse.

5 Social and community participation

HASI aims to assist people with a mental illness to participate in the community. The HASI model suggests that the provision of stable accommodation and appropriate clinical and non-clinical support should assist consumers to become more independent in their daily life, develop or maintain social connections, participate in recreational activities, and find pathways into education and work. This section provides a snapshot of information about these activities for current consumers, including their level of functioning across a range of daily activities, information about their social networks, their involvement in community activities, and participation in education and work.

5.1 Daily living skills

HASI consumers are supported by ASPs to develop daily living skills across a range of areas such as cooking, cleaning and taking medication. The findings indicate that at least 60 per cent of consumers are independent or supported less than half the time in all areas of daily living including personal hygiene, cooking, taking medication and transport, cleaning and exercise. At least one in three consumers requires support more than half of the time with shopping, managing their finances, cleaning and exercising (Table 5.1).

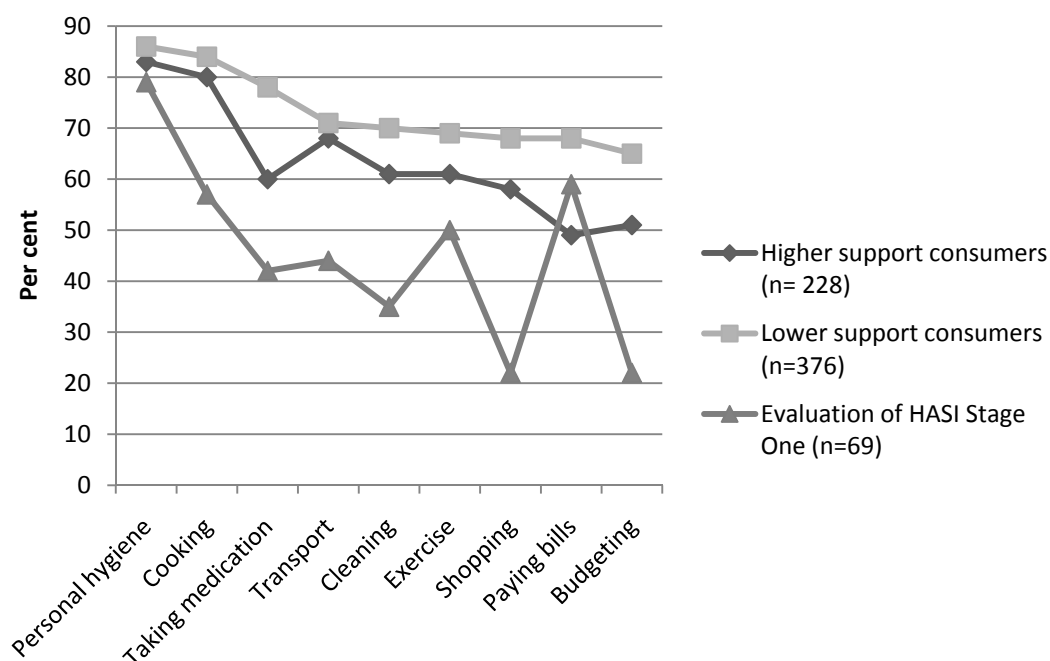
Table 5.1: Independence in activities of daily living, September 2009

	Supported less than half of the time		Supported more than half of the time		Total	
	Consumers (n)	Percent (%)	Consumers (n)	Percent (%)	Consumers (n)	Percent (%)
Personal hygiene	538	85	96	15	634	100
Cooking	515	81	118	19	604	100
Taking medication	448	71	183	29	631	100
Transport	442	70	189	30	631	100
Cleaning	425	67	210	33	635	100
Exercise	419	67	210	33	629	100
Shopping	404	64	231	36	635	100
Paying bills	382	60	251	40	633	100
Budgeting	380	60	255	40	635	100

Source: MDS supplement

Figure 5.1 shows that the levels of independence differs slightly between consumers receiving lower and higher levels of support: for example, consumers receiving lower levels of support are significantly more independent than consumers receiving high support in the areas of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ($p < 0.05$). Both groups, however, have higher levels of independence in daily living skills compared the sample in the evaluation of HASI Stage One. This may be a result of the increased emphasis in the program on the provision of recovery rather than maintenance support, as was discussed in the first report and analysed further in the final report.

Figure 5.1: Proportion of people independent in activities of daily living, current HASI consumers receiving high support (n=228) and lower support (n=376) compared with results from the evaluation of HASI Stage One (n=69) (per cent)



5.2 Community participation

The findings show that most HASI consumers (83 per cent; n=530) are participating in at least one type of community activity (Table 5.2). Similarly high participation levels in social and community activities were found in the previous HASI evaluation (73 per cent; Muir et al 2007: 9).

Table 5.2: Participation in at least one social or recreational activity or group, September 2009

	Currently participating		Not participating		Total	
	Consumers (n)	Percent (%)	Consumers (n)	Percent (%)	Consumers (n)	Percent (%)
Social or recreational activity ¹	530	83	109	17	639	100

Source: MDS supplement

Notes: 1. This includes supported and unsupported group activities, supported individual activities and day programs

Around a fifth of HASI consumers (21 per cent) are participating in a disability day program, nearly two-thirds of consumers (62 per cent) are supported to participate in individual social and recreational activities – such as mainstream exercise classes – and half of all consumers (55 per cent) are supported to attend group activities such as sports or art classes (Table 5.3). People in low and high support have similar levels of participation in supported independent activities, but consumers receiving higher support were significantly more likely to participate in supported group activities (p<0.001) and day programs (p<0.05) than those in lower support. More than half of

participants (54 per cent) regularly attend activities without their support worker and these activities are more likely to be undertaken by people receiving lower levels of support.

Table 5.3: Participation in social or recreational activities by type, September 2009

	Consumers (n)	Currently participating (%)	Not participating (%)	Total (%)
Supported group activity	611	55	45	100
Unsupported group activity	594	54	46	100
Supported individual activity	611	62	38	100
Day program	597	21	77	100

Source: MDS supplement

5.3 Relationships and social connections

Regular contact with family and friends is an important way that people can feel connected to social and community networks. Most consumers within the sample (86 per cent; n=548) have regular contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner (Table 5.5). One in seven (14 per cent; n=91) do not have any form of regular social contact. Men and people in high support are less likely to have any regular form of social contact. While this measure is a good indicator of consumers’ level social contact it does not convey whether consumers’ were satisfied with this level of contact or quality of their relationships with their family members. This will be explored further in the final report based on interviews with consumers.

Table 5.4: Contact with family, friends or a partner, September 2009 (per cent)

	Consumers (n)	No regular contact ² (%)	Daily or weekly contact (%)	Total (%)
Contact with social networks ¹	639	14	86	100

Source: MDS supplement

Notes: 1. Consumers level of contact with family, friends or a spouse or partner

2. Consumers who did not have daily or weekly contact with family, friends or partner

Table 5.5 shows that more than half of HASI consumers have daily or weekly contact with a family member (64 per cent or n= 639), whereas some consumers have minimal contact with family (9 per cent had no contact and 5 per cent usually had contact on annual basis).

Table 5.5: Contact with family members, September 2009

	Consumers (n)	Percent (%)
Daily or weekly	390	64
Monthly or quarterly	140	23
Yearly	31	5
Never	53	9
Total	614	100

Notes: Source: MDS supplement

While most HASI consumers have daily or weekly contact with friends (65 per cent), just under one in five consumers (19 per cent) do not have any contact with friends (Table 5.6). As indicated in the first report and in the previous evaluation, some HASI consumers who have not formed or maintained friendships are experiencing feelings of isolation and loneliness.

Table 5.6: Contact with friends, September 2009

	Consumers (n)	Percent (%)
Daily or weekly	408	65
Monthly or quarterly	92	15
Yearly	11	2
Never	120	19
Total	631	100

Source: MDS supplement

Around one in five consumers (19 per cent; n=118) had a relationship with a spouse or partner (Table 5.7). This is similar to the proportion of consumers who had a spouse or partner at the time of the Evaluation of HASI Stage One (15 per cent; Muir et al 2006: 34). Of the current consumers who had a partner, most (66 per cent) had regular daily or weekly contact with them, whereas for other consumers, contact with their partner was much less frequent.

Table 5.7: Contact with partner, September 2009

	Consumers ¹ (n)	Percent (%)
Daily or weekly	78	66
Monthly or quarterly	7	6
Yearly	4	3
Never	29	25
Total	118	100

Source: MDS supplement
Notes: 1. Per cent of consumers who have a partner (n=118)

5.4 Work and education

Around a third (31 per cent) of current HASI consumers are involved in some type of employment, education or training (Table 5.8). Interestingly, this proportion is lower than that reported in a previous evaluation of HASI, in which 43 per cent of consumers were involved in these activities after being involved in the program for

approximately two years (Muir et al 2007: 9). The findings show that around 19 per cent of HASI consumers are participating in some kind of work (paid or voluntary) which is also lower than the proportion of consumers participating in work (paid or unpaid) in the previous evaluation of Stage One (26 per cent; Muir 2007: 9).

Table 5.8: Participation in work and education, September 2009 (per cent)

	Consumers (n)	Currently participating (%)	Not participating (%)	Total (%)
Work and/or training ¹	639	31	69	100
Paid or unpaid work ²	639	19	81	100

Source: MDS supplement

Notes: 1. Consumers who are involved in at least one type of work, education or training activity

2. Consumers who are involved in at least one type of paid or unpaid employment

Of people who were working, a higher proportion was employed in part-time (11 per cent) rather than full-time work (2 per cent) (Table 5.9). Consumers who received low support were more likely to be participating in part-time work, compared to people receiving high levels of support. While many consumers were not participating in any form of paid employment, 16 per cent were currently looking for work. Men were significantly more likely to be looking for work than women ($p < 0.05$).

Table 5.9: Work and education participation by type, September 2009 (per cent)

	Consumers (n)	Currently participating (%)	Not participating (%)	Total (%)
Education or training	625	17	83	100
Looking for work	620	16	84	100
Part time work ¹	630	11	89	100
Caring for others	618	11	89	100
Volunteer work	623	8	92	100
Full time work ²	626	2	98	100

Source: MDS supplement

Notes: 1. Less than 30 hours per week

2. More than 30 hours per week

Consumers can be involved in more than one activity

Another way in which HASI consumers spent their time was through volunteering: a higher proportion of men were undertaking voluntary work than women. Close to one-fifth of consumers (17 per cent) were participating in some type of education and training, with slightly more men (53 per cent) studying than women (47 per cent), however, this difference is not statistically significant.

Some consumers (11 per cent) are also involved in caring for children or dependent family members or friends. Mirroring patterns in the general population, HASI consumers involved in care work were more likely to be women than men (81 per cent compared to 19 per cent, $p < 0.05$).

5.5 Conclusion

Most HASI consumers have a high level of independence in their daily living skills, particularly in relation to personal hygiene, cooking, taking medication and transport. Achieving high levels of independence in these skills has enabled consumers to participate in social networks and community activities such as recreational activities, education and employment.

More than half of participants (54 per cent) independently participate in social and recreational activities, but many consumers receiving high support continued to require the support and assistance of their ASP support workers to be able to access and participate in the community in a meaningful way. While most consumers enjoyed regular social contact, one in seven continued to be socially isolated as they did not have any form of regular social contact with family, friends or a partner. Some consumers were actively involved in some kind of education or training; participation in paid or unpaid work was another way in which consumers spent their time.

The final report will analyse the participation results by level of HASI support (eg. daily living skills for high support packages, work and education for low and medium support?); the quality of social relationships; the impact on family, carers and siblings; reconnection with family and friends; and referrals to education and employment support.

5.6 Summary of social and community participation

- At least 60 per cent of consumers were reported to be independent or supported less than half the time in all areas of daily living including personal care, cooking, taking medication and transport, cleaning and exercise.
- Approximately one in three consumers required support more than half of the time with shopping, managing their finances, cleaning and exercising.
- Consumers receiving lower levels of support were significantly more independent than consumers receiving high support in the areas of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ($p < 0.05$). Both groups, however, had higher levels of independence in daily living skills compared to the results from the first evaluation which focused on consumers receiving high support.
- Most HASI consumers (83 per cent; $n=530$) were participating in at least one kind of community activity (including supported and unsupported group activities, supported individual activities and day programs); the previous evaluation of HASI found similarly high participation in social and community activities (73 per cent; $n=50$).
- Most current HASI consumers (86 per cent; $n=548$) had some form of regular social contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner.
- One in seven consumers (14 per cent; $n=91$) do not have any regular contact (daily or weekly) with other such as a family member, friend or partner. Males and people in high support are less likely to have regular social contact with a family member, friend or partner.
- HASI consumers were continuing to participate in education and work, with 31 per cent currently involved in some type of activity (paid or voluntary work,

education and training). This is lower to the evaluation of HASI Stage One which found that 43 per cent of consumers were involved in either work or study after participating in the program for at least 2 years.

- A similar proportion of current consumers were participating in education (19 per cent) as HASI consumers who participated in the evaluation of HASI Stage One.

6 Costs of HASI

The evaluation also includes an economic analysis of HASI. The analysis conducted in the final report will compare the costs of HASI with the benefits consumers experience a result of their involvement in the program, such as changes in service access, physical and mental health, independence in activities of daily living, and social, community and economic participation. This section provides preliminary analysis of the budgeted costs of HASI services between 1 July 2006 and 30 June 2010; although expenditure data would have been preferable to use in this analysis, these data were not readily available from NSW Health or Housing NSW. The per consumer costs are calculated on the basis of the 1076 HASI packages allocated at the time of the costs.

6.1 State level costs

The budget data are an estimated total of central office HASI management costs per year and includes salaries and other costs (Table 6.1). Data collected from Housing NSW and NSW Health show that the state level management cost for 2006-10 was just over \$1 million (\$1,154,765), which is an average of \$208,691 recurrent costs per year (or \$288,691 including establishment costs). The annual state level cost per consumer is \$200 to \$520.³⁰ Most recurrent costs are for project staff whose tasks specifically relate to HASI, such as contract management, tendering, program coordination, policy development.

Table 6.1: HASI central office budget (\$), 2006-2010

	2006-07	2007-08	2008-09	2009-10	Total	Annual average
Recurrent						
Housing HASI project staff ¹	109,815	58,762	34,996	10,127	213,700	53,425
Health HASI project staff ²	81,591	84,855	109,113	143,856	419,414	104,854
Training	0	0	0	155,651	155,651	38,913
Meetings, forums (venue, catering, travel)	11,500	11,500	11,500	11,500	46,000	11,500
Establishment						
Evaluation	0	0	60,000	240,000	300,000	75,000
EOI tender briefing	5,000	5,000	5,000	5,000	20,000	5,000
Total	5,000	5,000	65,000	245,000	320,000	288,691

Source: NSW Housing and NSW Health

Notes: 1. Housing Homeless Unit two Senior Officers Grades 2 and 3 60 per cent 2006-7; 30 per cent 2007-8; 15 per cent 2008-09; 0 2009-10. Community Housing Division one Senior Officers Grade 1 and one Clerk Grade 11/12 3 per cent 2006-09; 1 per cent 2009-10.

2. Health Manager and Senior Project Officer excluded because they are not additional roles specific to HASI. One Project Officer Grade 7/8, .5FTE 5A Grade 9/10 to Sep 2011

When HASI was first established (2002-07), Housing NSW incurred capital expenditure of nearly \$25.8 million to purchase 88 properties (Table 6.2). During the current evaluation period, housing is allocated from existing properties rather than

³⁰ Total current consumers by annual recurrent costs = \$194. Total consumers 2006-2010 2222 by total costs = \$520.

incurring new capital costs. Because HASI consumers are entitled to apply for social housing like any other member of the public and most would have been eligible for social housing regardless of whether they were receiving HASI support, the cost of housing is not included in the cost of the program per consumer.

Table 6.2: NSW Housing HASI capital acquisitions, 2002-07

	Cost (\$)
2002/03	4,779,409
2004/05	3,150,511
2005/06	10,781,041
2006/07	7,065,818
Total	25,776,779

Source: NSW Housing
 Note: Purchase of 88 properties

Regional office cost data from NSW Health and Housing NSW were not included because these costs of services provided at this level would have been incurred regardless of the existence of HASI.

6.2 Accommodation support provider and housing provider costs

The cost of funding ASP support was analysed from the contracted budget data. The budget per package varies according to the level of support and is adjusted each year from cost increases (Table 6.3). The total contracted accommodation support cost 2006-10 for 1076 packages was \$118,278,000, an average of approximately \$31 million per year and nearly \$30,000 per consumer per year.

Table 6.3: Accommodation Support Provider budget (\$), 2006-10

HASI stage	2006-07		2007-08		2008-09		2009-10		
	Per consumer	Total	Per consumer	Total	Per consumer	Total	Per consumer	Total	Total
	('000)	('000)	('000)	('000)	('000)	('000)	('000)	('000)	('000)
1	100	54 5,379	55	5,524	57	5,663	58	5,781	22,347
2	460	10 4,729	11	4,857	11	5,060	11	5,060	19,706
3a	126	51 6,476	53	6,651	54	6,818	55	6,961	26,906
3b	50	70 3,500	72	3,595	74	3,684	75	3,762	14,541
4a	100	50 5,000	51	5,135	53	5,263	54	5,374	20,772
4b ¹	160	- -	11	1,760	11	1,804	12	1,842	5,406
4b ²	80	- -	35	2,800	34	2,870	37	2,930	8,600
Total 1076		- 25,084	-	30,322	-	31,162	-	31,710	118,278
Average		30 -	28 -	-	29 -	-	30 -	-	-

Source: NSW Health

Notes: 1. Stage 4b included both low and medium support packages. This row refers to the low support packages allocated

2. This row indicates the medium packages allocated in Stage 4b

6.3 Preliminary outcomes

The preliminary summary of the outcomes of HASI is derived from the first report and the earlier sections in this report.

Table 6.4: Preliminary HASI outcomes analysis

Outcome	Description
Stable tenancy	Most people maintained a secure tenancy and uphold the conditions of their tenancy agreements. Most moves are for positive reasons. HASI public housing tenants have similar outcomes to other public housing tenants for rental payments and property maintenance
Mental health hospital admissions	Days in hospital per year and per admission and the number of mental health admissions all decreased
Mental health	MH-OAT measures of mental health improved (K10, LSP-16, HoNOS)
Physical health	Staff reported good physical health for half the HASI consumers
Independence in daily living	Most consumers have some independence in daily living skills and many need support for more complex tasks
Social participation	Most consumers have regular social contact with family and friends
Community activities	Most consumers participate in social and community activities
Productive activities	A minority of people participate in education, voluntary and paid work

6.4 Conclusion

The total budget for the program over the last four years was \$118 million accommodation support costs, \$1 million project management costs and previous housing capital investment 2002-07 of \$26 million. This is equivalent to an annual unit cost per consumer ranging from \$11,000 to \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit costs. The final report will assess the cost of HASI against the outcomes experienced by HASI consumers. Where possible, comparisons will be made between the HASI consumers and a comparable group, such as the general population, the consumer outcomes from the Stage 1 evaluation, or another comparison group derived from the secondary data sources. If the cost of the outcome can be clearly quantified (such as hospitalisations) the cost will be calculated. Costs will be analysed for the period before consumers entered the program and during the program and after consumers and will be compared against the unit cost of HASI. Other outcomes that cannot be easily quantified, such as well-being, social contact and functioning will not be costed but will rather be discussed in relation to the other benefits associated with the program for consumers.

Preliminary outcomes analysis is showing positive results in stable tenancies, mental health hospital admissions, mental health, physical health, independence in daily living, social participation and community activities. Only a minority of people are involved in education and voluntary or paid work.

6.5 Summary

- The total budget for the program over the last four years was \$118 million accommodation support costs and \$1 million project management costs.
- The program benefited from the previous housing capital investment 2002-07 of \$26 million. Currently, HASI consumers who require social housing are allocated housing from existing housing stock like all other tenants.
- The annual cost per consumer is \$11,000 to \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit cost.
- Preliminary outcomes analysis shows positive results in stable tenancies, mental health hospital admissions, mental health, physical health, independence in daily living, social participation and community activities. Only a minority of people are involved in education and voluntary or paid work.

7 Conclusion

The results show that HASI is achieving its aims for most consumers. It is assisting people to successfully maintain their tenancies across public housing, community housing and private rental properties. Consumers rarely move house and when they do, it is usually for positive reasons. The majority of consumers living in public housing are paying their rent on time and do not cause damage to their properties, which compares favourably to public housing residents as a whole. Most are regularly using health and mental health services and, as a result, consumers have experienced improved mental health since joining the program. Participation in the HASI program appears to have also had a positive impact on hospital admissions. Results show a statistically significant decrease in:

- the average number of hospital admissions each year (24 per cent decrease),
- the mean number of days spent in hospital per person per year (60 per cent decrease),
- and the average number of days hospitalised per admission (68 per cent decrease).

Longitudinal analysis shows that people tended to join the program at a time when their rates of hospitalisation were high, with the amount of time they spent in hospital decreasing while they are involved in the program.

The majority of HASI consumers have achieved a high degree of independence in relation to their daily living skills. A higher rate of independence was recorded in these activities compared to the evaluation of Stage One (which is possibly related to an increased focus on the provision of recovery based services and this will be further analysed in the final report). Consumers continue to develop their social networks and participate in community activities. While most have regular social contact with other people, around one in seven continue to be socially isolated and have no regular contact with family members, friends or a partner.

Future analysis in the final report will focus on how these outcomes may or may not differ according to support level consumers receive and age. These findings will also be discussed in relation to the two rounds of interviews with consumers and other stakeholders, and in relation to the costs of the program.

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Appendix A: MDS sample characteristics

This report focuses on a sample of 895 current HASI consumers.³¹ This sample was chosen because demographic information was available on these consumers in the April – June 2009 quarter of data collection from the HASI MDS. This section provides an overview of the characteristics of this sample. A more detailed discussion of this sample can be found in the first evaluation report (McDermott et al., 2010).

Table A.1: Gender

	n	Per cent
Male	452	53
Female	400	47
Total	852	100

Note: Data missing for 43 consumers

Table A.2: Age

	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 consumers

Table A.3: 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 consumers

³¹ Due to missing data, totals do not always equal 895.

Table A.4: 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 consumers

Table A.5: Consumers 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 consumers

Table A.6: 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 consumers

Table A.7: 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 consumers with at least one co-existing factor	460	54
Total consumers with no co-existing factors	385	46
Total consumers	845	100

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

Table A.8: Support level by gender

	Low (n=477)	Medium (n=54)	High (262)	Very High (n=59)	Total (n=852)
Male	47	48	60	71	53
Female	53	52	40	29	47
Total	100	100	100	100	100

Table A.9: Proportion of consumers who exited HASI by level of support (per cent)

	Low (n=1313)	Medium (n=99)	High (n=693)	Very High (n=117)	Total (n=2222)
n	1313	99	693	117	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 consumers

Table A.10: Reasons for exiting HASI

Reason for exiting HASI	n	Per cent
Consumer no longer needed support	181	37
Consumer 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 consumers

Appendix B: Data sources and samples

Data source	Description of the sample	Time period collected	Potential number of consumers	Number of consumers identified and linked to their demographic data and start date	Notes
HASI MDS	Consumers who have participated in HASI since March 2007	Quarterly (Mar, June, Sept, Dec) 2007 – 2009	n=2222	n=895	These are consumers of the program at June 2009 who had demographic data available. This sample of 895 people is the basis for all analysis in this report
MDS supplement	Point in time survey of all consumers who were participating in HASI during the Sept 2009 and Sept 2010 reporting periods	Two points in time - Sept 2009, Sept 2010	n=1065	n=639	1065 forms were returned but only 639 could be linked with their demographic data and start date.
Admitted Patient Data Collection NSW State HIE	Data on all hospital admissions, including general, mental health and emergency. Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period	Continuous Data (2000 – 2009)	n=1107	SUPIs could be identified for 810 people 604 could be linked with their demographic data and start date	Of these 604 consumers: 415 people had inpatient data; 222 had complete data and had been in HASI for at least two years 372 had psych data; 197 had complete data and had been in HASI for at least two years 353 people had ED data; 82 had complete data and had been in HASI for at least two years
Mental Health Outcomes and Assessment Tools (MH-OAT) Collection NSW State HIE	Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period	Continuous data (2000 – 2009)	n=1107	SUPIs could be identified for 810 current consumers 604 could be linked with their demographic data and start date	Of these 604 consumers: K10: 414 with some data; 242 had scores available both before and after their HASI start date Honos: 518 with some data; 339 had scores available both before and after their HASI start date LSP: 409 with some data; 268 had scores available both before and after their HASI

					<p>start date</p> <p>APQ6: 49 with some data; 1 had scores available both before and after their HASI start date. This measure was not used due to the small sample size</p>
<p>Mental Health Ambulatory Data Collection (MH-AMB) NSW State HIE</p>	<p>Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period</p>	<p>Continuous Data (2000 – 2009)</p>	<p>n=1107</p>	<p>SUPIs could be identified for 810 people</p> <p>604 could be linked with their demographic data and start date</p>	<p>Of these 604 consumers: 400 had ambulatory data. These data will be analysed in the final report.</p>
<p>NSW Housing – Integration Housing System dataset</p>	<p>Sample drawn from public housing tenants who have been in HASI from about 2002.</p>	<p>Different types depending on variable. Data collected between 1999 – 2009</p>	<p>Unknown</p>	<p>409 current and former HASI consumers identified in IHS by the HASI flag</p>	<p>164 consumers could be linked to their demographic data and start date.</p>

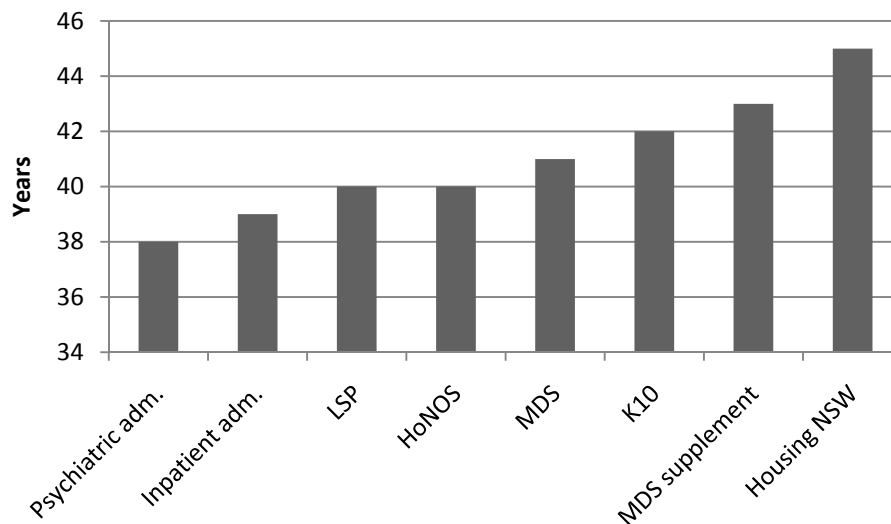
Appendix C: Sub-sample characteristics

Age

Table C.1: Average age, by subsample

	n	Average age (years)
MDS	895	41
Housing NSW	163	45
Mental health adm.	197	38
Inpatient adm.	222	39
K10	242	42
LSP	268	40
HoNOS	339	40
MDS supplement	639	43

Figure C.1: Average age, by subsample

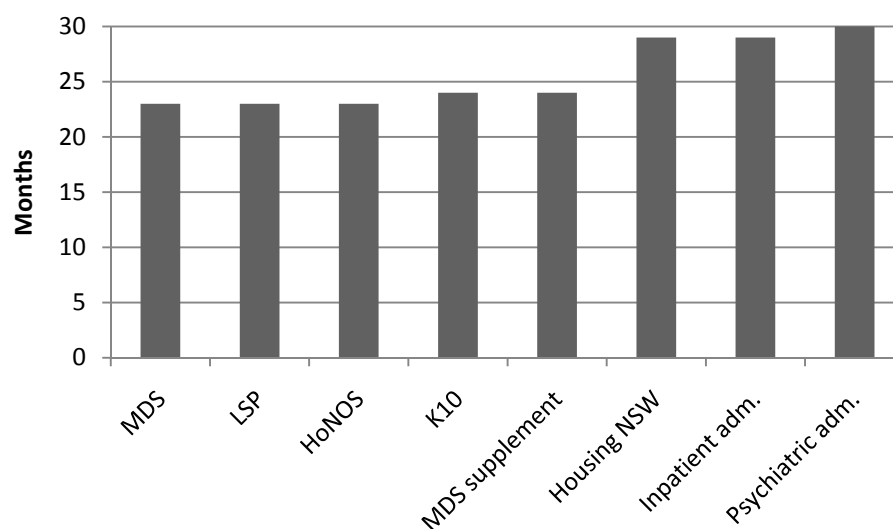


Length of time in the program

Table C.2: Average time in HASI, by subsample

	n	Ave time in HASI (months)
MDS	895	23
Housing NSW	163	29
Mental health adm.	197	30
Inpatient adm.	222	29
K10	242	24
LSP	268	23
HoNOS	339	23
MDS supplement	639	24

Figure C. 2: Length of time in the program, by subsample

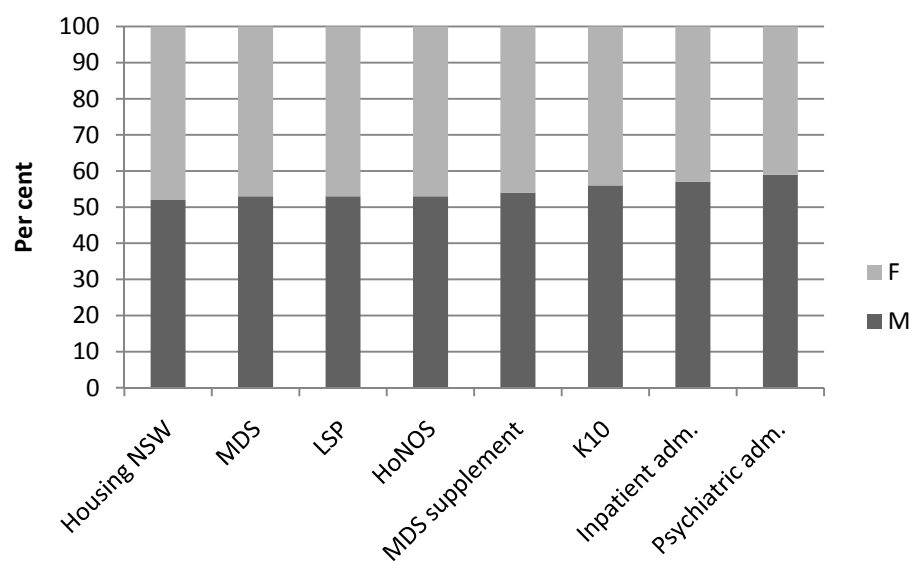


Gender

Table C.3: Gender distribution, by subsample (per cent)

	Consumers	Gender (per cent)	
		Men	Women
HASI MDS	895	53	47
Housing NSW	163	52	48
Mental health admissions	197	59	41
Inpatient admissions	222	57	43
K10	242	56	44
LSP	268	53	47
HoNOS	339	53	47
MDS supplement	639	54	46

Figure C. 3: Gender distribution, by subsample (per cent)

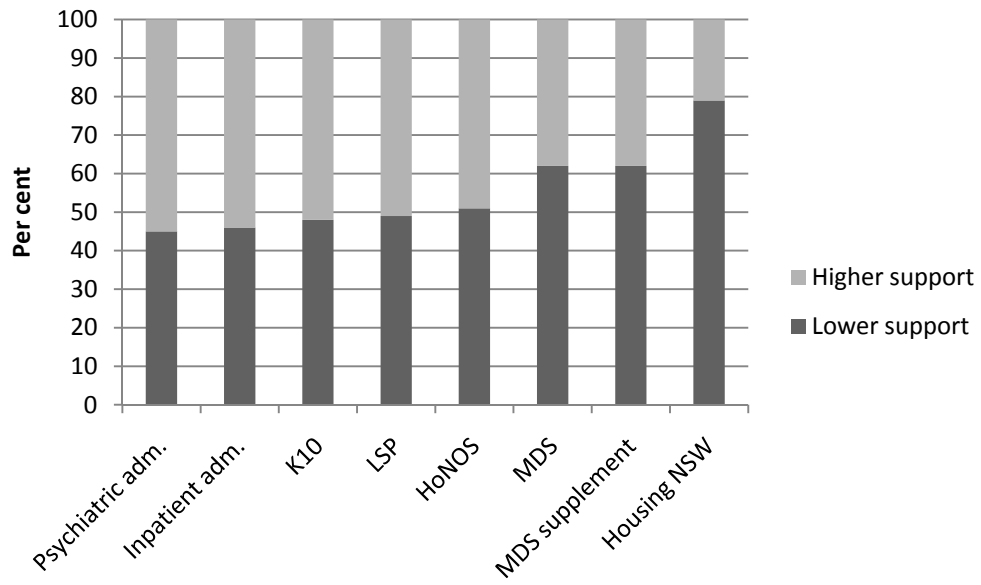


Support level

Table C.4: Support level, by subsample (per cent)

	n	Support level (per cent)	
		Lower support	Higher support
HASI MDS	895	62	38
Housing NSW	163	79	21
Mental health admissions	197	45	55
Inpatient admissions	222	55	46
K10	242	48	52
LSP	268	49	51
HoNOS	339	51	49
MDS supplement	639	62	38

Figure C.4: Support level, by subsample



Appendix D: Inpatient admissions

As in the evaluation of Stage One, this evaluation found considerable decreases in hospitalisation of HASI consumers after entering the program.³² The data show statistically significant decreases ($p < 0.05$) in the average number of mental health hospital admissions each year (23 per cent decrease), the mean number of days spent in hospital per person per year (61 per cent decrease), and the average number of days hospitalised per admission (66 per cent decrease). Of the 222 people for whom there was complete inpatient data over a four year period, 197 people (89 per cent) had had an admission at some point over the four year period.

Table D.1: Pre-HASI and in-HASI participant hospital admissions, all types (n=222)

	Before HASI ¹	While in HASI ²	per cent change since joining HASI
Average annual hospital admissions per person per year	1.6	1.2	-23**
Average number of days spent hospitalised per person per year	55.1	21.4	-61**
Average number of days hospitalised per admission	6.3	2.1	-66**

Notes: 1. Based on the average number of admissions per person in the two years prior to joining HASI
 2. Based on the average number of admissions per person over each consumers' first two years in HASI
 ** $p < 0.05$, Sig. 2-tailed, from paired sample t-test of means across two periods

Table D.2: Longitudinal analysis of mean annual hospital admissions, all types, per person, per year (n=222)

	n	13-24m prior (Year 1)	0-12m prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. ¹	Effect size ²
Male	127	1.3	1.5	0.9	0.8	.000	.180
Female	95	1.4	2.2	1.8	1.7	.030	.092
Total	222	1.3	1.8	1.3	1.2	.000	.086

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA
 2. Partial eta squared

³² Hospitalisation in this section includes emergency department visits, general hospital admissions, acute admissions, and psychiatric admissions.

Figure D.1: Mean annual hospital admissions, all types, by gender (n=222)

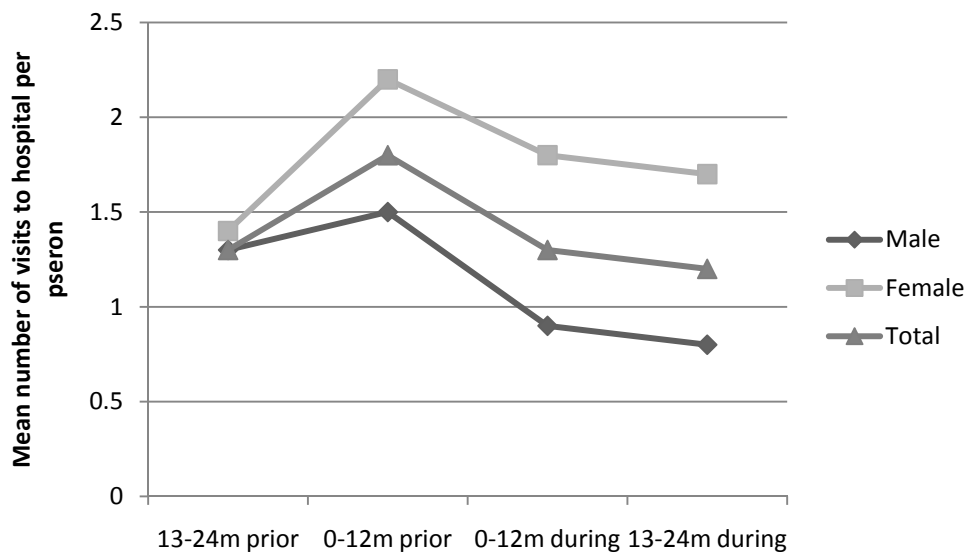


Table D.3: Longitudinal analysis of mean days in hospital per person, per year, all types of admissions (n=222)

	n	13-24m prior (Year 1)	0-12m prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. ¹	Effect size ²
Male	127	54.1	68.4	24.3	9.9	.000	.282
Female	95	26.2	67.2	35.8	18.4	.000	.216
Total	222	42.2	67.9	29.2	13.6	.000	.243

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA
 2. Partial eta squared

Figure D.2: Mean number of days spent in hospital per person, per year, by gender, all types of admissions (n=222)

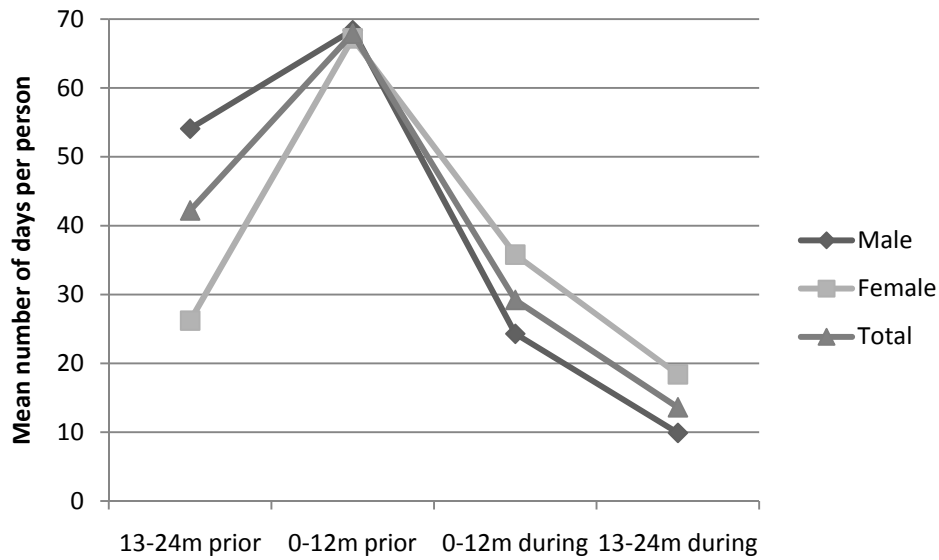
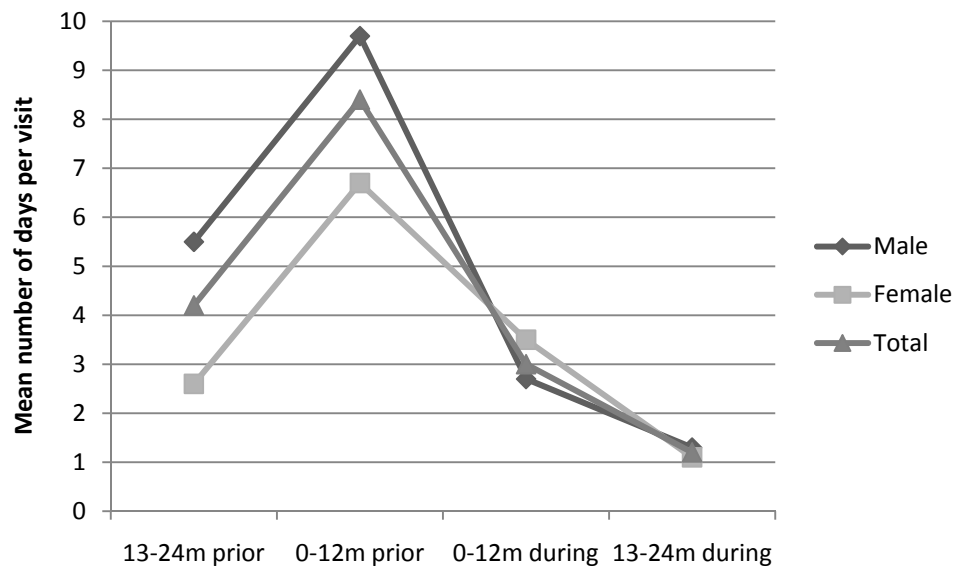


Table D.4: Longitudinal analysis of mean days in hospital per admission per year, all types, by gender (n=222)

	n	13-24m Prior (Year 1)	0-12m Prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. ¹	Effect size ²
Male	127	5.5	9.7	2.7	1.3	.000	.188
Female	95	2.6	6.7	3.4	1.1	.000	.207
Total	222	4.2	8.4	3.0	1.2	.000	.177

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA
2. Partial eta squared

Figure D.3: Mean number of days per admission, pear year, by gender, all types (n=222)



Appendix D: Minimum Data Set (MDS) forms

Version 10 – 2009

HASI Monitoring Form 1: Applicant profile

A separate form is to be completed for each HASI application received in the reporting period where a decision about the application outcome has been made.

Pilot forms: Submission to ARTD by MAIL (PO Box 1167, Queen Victoria Building, NSW 1230) or EMAIL: hasi.monitoring@artd.com.au

1. Service name: _____

2. Service outlet: _____

3. Applicant/ client code

--	--	--	--	--	--

4. Reporting period
 1 January – March 2009
 2 April – June 2009
 3 July – September 2009
 4 October – December 2009

5. Informed consent
 1 Yes 2 No

Application and referral

6. Date application received: _____

7. Referral source
 1 Public Housing Client Service Team
 2 Community Mental Health Service
 3 Hospital
 4 Community Housing Provider
 5 Referral from other HASI program
 6 Other, specify: _____

8. Name of referring organisation: _____

9. Date application processed by selection committee: _____

Eligibility

10. Applicant date of birth (16 years or older): _____

11. Accommodation at time of application
 1 Public housing
 2 Hospital, date of admission: _____
 3 Community housing
 4 Private rental
 5 Homeless
 6 Boarding house
 7 Living with family or friends
 8 Unknown
 9 Other, specify: _____

Specify name and location of accommodation: _____

12. Primary and secondary diagnosed mental illness (tick one primary and one secondary only)

	Primary	Secondary
a) Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
b) Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
c) Schizo-affective	<input type="checkbox"/>	<input type="checkbox"/>
d) Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
e) Depression/ anxiety	<input type="checkbox"/>	<input type="checkbox"/>
f) Other diagnosed mental illness	<input type="checkbox"/>	<input type="checkbox"/>

Specify other: _____

13. Co-existing factors impacting on mental illness (tick all that apply)

1 Intellectual disability
 2 Substance abuse
 3 Physical disability
 4 Physical health issues
 5 Acquired brain injury
 6 Other, specify: _____

14. Predicted support hours per month: _____

Applicant characteristics

15. Gender
 1 Male 2 Female

16. Cultural/ language background

	Yes	No	Not known
a) ATSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Language other than English spoken at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify language: _____			
c) Need interpreter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Country of birth: _____

18. Tenancy risk factors

1 High turnover in housing/ accommodation
Number of tenancies/ houses in last 2 years:

2 Periods of homelessness
Number of days homeless in last 2 years:

3 Nuisance and annoyance complaints related
to tenancy
Number of nuisance and annoyance
complaints for tenancy in last 2 years:

4 Applications for orders to CTTT
Number CTTT applications for tenancy in
last 2 years:

19. Other relevant information: _____

20. Application outcome

- 1 Approved - placed on register
 2 Approved - support package allocated
 3 Rejected, state reason for rejection:

HASI Monitoring Form 2: Clients with Individual Service Plan

A separate form is to be completed for each HASI client who has an ISP during the reporting period.

Pilot forms: Submission to ARTD by MAIL (PO Box 1167, Queen Victoria Building, NSW 1230) or EMAIL: hasi.monitoring@artd.com.au

1. Service provider: _____

2. Service area/ office: _____

3. Applicant/ client code

--	--	--	--

4. Reporting period

- 11 January – March 2009
- 12 April – June 2009
- 13 July – September 2009
- 14 October – December 2009

5. Client status (tick one only)

- 1 Current client throughout reporting period
- 2 New client during reporting period
Specify date: _____
- 3 Support for client finished during reporting period
Specify date: _____

6. Type of Support Package

- 1 HASI 1 (high support \$50,000)
- 2 HASI 2 (lower support \$10,000)
- 3 HASI 3 (high support \$50,000)
- 4 HASI 3B (very high support \$70,000)
- 5 HASI 4A (high support \$50,000)
- 6 HASI in the Home 4B (medium \$35,000)
- 7 HASI in the Home 4B (lower \$11,000)

7. Area Health Service:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> 1 NSCCAHS <input type="checkbox"/> 2 SWAHS <input type="checkbox"/> 3 SSWAHS <input type="checkbox"/> 4 SESIAHS | <ul style="list-style-type: none"> <input type="checkbox"/> 5 NCAHS <input type="checkbox"/> 6 HNEAHS <input type="checkbox"/> 7 GWAHS <input type="checkbox"/> 8 GSAHS |
|---|---|

8. Suburb/ town of residence: _____

9. Postcode: _____

Services provided - ISP

10. Support hours provided by the Support Coordinator to the client under the agreed ISP

- | | |
|---|--|
| a) Total number of face-to-face support hours agreed in the ISP in reporting period | |
| b) Total number of face-to-face support hours actually delivered in reporting period | |
| c) Total number of non-face-to-face support provided in reporting period (eg advocacy) | |
| d) Largest number of direct support hours in any single week in reporting period | |
| e) Smallest number of direct support hours in any single week in reporting period | |
| f) Number of weeks in reporting period where client was in the service but no direct support was provided | |

11. Main support activities/ services during the reporting period (estimate % of total time spent on each)

- | | |
|--|--|
| a) Domestic skills | |
| b) Personal and health self-care | |
| c) Pre-vocational and vocational support | |
| d) Advocacy | |
| e) Income management | |
| f) Counselling/ psychosocial support | |
| g) Links with family and friends | |
| h) Community access/ socialisation | |

12. Please provide details of main support activities: _____

13. Further details of other direct support: _____

14. Referrals (if no referrals, write "0")

a) ...to other support services

b) ...to community or recreation activities

Assessments

15. Have the following assessments been completed for the first time or updated during the reporting period?

a) Global Assessment of Functioning
 1 Yes, first assessment
 2 Yes, assessment update
 3 No
 If yes, indicate GAF score

b) Camberwell Assessment of Needs
 1 Yes, first assessment
 2 Yes, assessment update
 3 No
 If yes, indicate CAN score:

16. Do you have access to MH-OAT data from the Area Health Service for this client?

1 Yes 2 No → if no, go to Q17

17. If you have access to MH-OAT data, are the following scores available

	Unavailable	Available	Score
a) HONOS	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>
b) LSP-16	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>
c) K-10	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>

Support details – goal attainment

18. Has the client attained their individual (ISP) goals in the reporting period in relation to ...

	Yes	Partly	No	Not a goal
a) Self-care (personal hygiene, diet, taking medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Domestic skills (cooking, cleaning, shopping, laundry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Community tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(transport, income mgt, making appointments)

d) Use of health and allied services

e) Social and community participation (family, friends)

f) Work and education/training

g) Other

Specify other goal(s): _____

19. If no, provide details of main strategies in place to improve goal attainment:

20. Inpatient admissions in reporting period (number and stay in days, acute & non-acute. If no admissions, write "0". Do not leave blank)

	No of adm.	Acute days	Non-acute days
a) Unplanned admissions in reporting period	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Planned admissions in reporting period	<input type="text"/>	<input type="text"/>	<input type="text"/>

Tenancy details

21. Did the tenancy end during the reporting period?

1 Yes
 2 No → if no, go to question 24

22. Date client exited tenancy: _____

23. Reason for exiting tenancy

1 Eviction
 2 Abandoned property
 3 Non-renewal of tenancy due to failure of tenant to meet RTA obligations
 4 Housing inappropriate for client's needs
 5 Client moving to other long-term housing
 6 Client moving back to higher-support accommodation
 7 Planned end of tenancy due to end of individual support plan

24. Details of tenancy exit: _____

25. Details for ongoing tenancy

- a) Duration of current tenancy (in months)

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- b) Number of nuisance and annoyance complaints for tenancy in reporting period

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- c) Number CTTT applications for tenancy in reporting period

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- d) Number of weeks in rental arrears at end of reporting period

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26. Factors that put the tenancy at risk over the reporting period: _____

27. Strategies in place to address risk factors:

Closed ISP

28. Was the client's Individual Service Plan closed during the reporting period?

- 1 Yes
- 2 No → if no, there are no more questions

29. Reason for ISP closure

- 1 Client no longer needed support (planned closure)
- 2 Client decided to discontinue support (unplanned closure)
- 3 Non-renewal of ISP due to failure of tenant to meet their obligations
- 4 Client moving to other long-term housing
- 5 Client moving back to higher-support accommodation
- 6 Other, specify: _____

30. Other relevant information about ISP closure:

Appendix F: MDS supplement form

MDS Supplement: September 2009

Date: MRN: Service area:
 MDS identifier: DOB: Gender: Postcode:

1. Thinking about the client now, how would you rate his/her level of independence in each of the following:

	Fully independent	Supported less than half the time	Supported more than half the time	Fully dependent
Personal hygiene and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paying bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Thinking about the client now, how would you rate the his or her health status:

	Excellent	Very good	Good	Fair	Poor
Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How often does the client usually have appointments with the following (approximately):

	Daily	Weekly	Monthly	Quarterly	Yearly	Never
Community mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist, psychologist and/or counsellor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health services (e.g. dental, optometrist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How often does the client usually have contact with the following (approximately):

	Daily	Weekly	Monthly	Quarterly	Yearly	Never	NA
Family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Thinking about the client now, does the client participate in:

	Yes	No	Don't know
Unsupported social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported individual social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported group social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Thinking about the client now, is the client involved in any of the following activities?

	Yes	No	Don't know
Paid work – part time (less than 30 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid work – full time (more than 30 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking for work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education or training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring (for children or other dependent family members/friends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>