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HOUSING AND ACCOMMODATION SUPPORT INITIATIVE: EVALUATION

REPORT II

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The views expressed in this publication do not represent any official position on the part of the Social Policy Research Centre, but the views of the individual authors

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Abbreviations

ABS	Australian Bureau of Statistics
AHS	Area Health Service
AMHS	Area Mental Health Service(s)
ASP	Accommodation Support Provider(s)
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CID	Client Information Database
CMH	Centre for Mental Health
DoCS	Department of Community Services
DoH	NSW Department of Housing
GAF	Global Assessment of Functioning Scale
GP	General practitioners
HASI	Housing and Accommodation Support Initiative
HP	Housing provider
OH&S	Occupational Health and Safety
NGO	Nongovernment organisation
NSW	New South Wales
PWI	Personal Wellbeing Index
SPRC	Social Policy Research Centre
TAFE	Technical and Further Education
UNSW	University of New South Wales

Executive Summary

This report presents the summary findings of the second phase of a longitudinal evaluation of the Housing and Accommodation Support Initiative Stage One (HASI) from May to October 2005. HASI is jointly funded by NSW Health and the NSW Department of Housing (DoH). A three-way partnership between the two government departments and non-government organisations (NGOs), 'HASI is designed to assist people with mental health problems and disorders requiring accommodation (disability) support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness'.[1]

This evaluation is based upon qualitative and quantitative data collected from 205 stakeholders, including clients (n=79), housing providers and Area Mental Health Service (AMHS) and Accommodation Support Provider (ASP) personnel. The complete version of the second report will be publicly available soon. This report should be read in conjunction with the first evaluation report (Morris et al 2005).[2]

The key findings from this second phase of the three-part evaluation are as follows.

Client outcomes

Demographics

- At the time of the second interview, 69 per cent of HASI clients were male, 56 per cent were under 34 years of age and 72 per cent had a diagnosis of schizophrenia;
- Almost two-thirds of all HASI clients (63 per cent) had at least a dual diagnosis when they started the program - 26 per cent had an intellectual disability and 37 per cent a substance use disorder. Twelve clients experienced mental illness, intellectual and physical disability as well as a substance use disorder.

Mental health, physical health and service use

- The program has resulted in intensive monitoring of mental health and provided continuity in access to mental health professionals.
- 66 per cent of clients reported that their mental health had improved, although the rate of improvement had slowed between the first and second evaluation phases.
- According to the Global Assessment of Functioning scale, which measures clients' psychological, social and occupational functioning on a continuum from good mental health to serious illness, the psychological functioning of two-thirds

[1] NSW Health and NSW Department of Housing (2005), *Housing and Accommodation Support Initiative (HASI) resource manual* (draft version 1.7), Sydney: NSW Health and NSW Department of Housing.

[2] Some of these findings were as follows: 85 per cent successfully maintained their tenancy; compared to the year prior to involvement in HASI, clients were having fewer and shorter hospitalisations admissions; and most clients reported improved family relationships.

of HASI clients improved. The mean score shifted from 38, indicating 'serious impairment', to 65, signifying 'generally functioning pretty well'.

- The proportion of HASI participants hospitalised decreased between evaluation phases. Seventy-one per cent of clients either retained their no hospitalisation status since starting HASI, or experienced a decrease in admissions between evaluation phases. The average frequency and duration of admissions, however, remained stable. Twenty-nine per cent of clients had increased admission rates. The majority (68 per cent) of hospitalisations were planned admissions.
- Almost half of the clients who came to the program with a substance use disorder (46 per cent, or 15 people – 9 males and 6 females) were no longer experiencing substance use issues by the second phase of the evaluation. Substance use continues to be reported as an issue for eighteen clients.
- Physical health problems, such as diabetes, were commonly identified, consulted about and treated across the cohort. Access to mental and physical health professionals remained high between the evaluation phases. Compared to the Australian population with mental health disorders, HASI clients were much more likely to seek and receive treatment from health professionals.[3] For example, 89 per cent of HASI clients had seen a psychiatrist and 86 per cent had seen a GP since starting the program.

Living skills, community participation & personal relationships

- On average, HASI clients increased their level of independence across all fourteen living skill areas measured (exercise, diet, transport, cooking, banking, medication, shopping, laundry, cleaning, budgeting, accessing community services, making appointments, dressing and bathing/showering).
- A minority of HASI clients remained fully dependent on the ASP for a range of skills. There was a slight shift from independence to receiving some support from the ASP in a few cases in each living skill area. This may reflect poor client wellbeing and/or an increased willingness among clients to accept ASP assistance.
- ASP organised activities continued to provide a pathway to independent community participation for clients. In areas where these activities do not currently occur, clients and case managers were eager for their introduction.
- It was beneficial to clients when the ASP offered access to a combination of community-based activities and services (those organised by the ASP, disability based and mainstream). Such diversity ensures that clients, who are willing and ready, have the resources and pathways available to them to maximise their participation in the community.
- Of clients interviewed in phases I and II, 43 per cent reported working and/or studying in the six months prior to the second interview. Almost one-third had re-

[3] Hickie, I. B., G. L. Groom, et al. (2005), 'Australian mental health reform: Time for real outcomes', in *Medical Journal of Australia*, 182(8): 401-406; Henderson, S., G. Andrews, et al. (2000), 'Australia's mental health: An overview of the general population survey', in *Australian and New Zealand Journal of Psychiatry* 34: 197-205.

entered the workforce in either a volunteer (six clients) or a paid capacity (eight clients in open employment and six in supported employment).

- Although client relationships with family and friends continued to improve, 54 per cent of clients reported feeling lonely.

Tenancies

- Eighty-eight per cent of clients maintained their tenancies. Four clients were rehoused to more suitable locations and another seven left their tenancies after exiting the program.
- A minority of clients experienced tenancy problems. These were largely related to complaints from neighbours about poor property care and/or noise and nuisance (11 clients), rental arrears (7 clients) and unauthorised co-tenancies (5 clients).

Exits

- The seven clients who exited the program were from four different HASI sites - one client died, two moved to other locations and the remaining four left the program because they were acutely unwell.
- The HASI program involves intensive support and, as such, it can feel very intrusive. Willingness to participate and an understanding of what this entails has proved critical in the outcome of some clients. The degree of active psychosis and the level of insight into symptoms can also be instrumental.

Program and governance issues

- The referral and assessment process has been fine-tuned between evaluation phases to enhance the suitability of clients for HASI.
- ASPs continued to adapt their support to improve client outcomes.
- Some ASPs improved on and others continued to demonstrate their capacity to provide psychosocial rehabilitation. A few areas could benefit from consulting with an occupational therapist, or a similar specialist, to further develop key worker skill at facilitating independence.
- Interagency relationships between the ASPs, AMHS and housing providers further developed between the evaluation phases. There was increased clarity in roles and ways to fulfil responsibilities. There was also improved understanding of client needs and the most appropriate ways to meet these needs through interagency collaboration.
- While the clinical services from AMHS personnel have not changed due to HASI, case managers have had greater opportunity to focus on their core business.
- Both NSW DoH and NSW Health are benefiting from the enhanced working relations between key HASI stakeholders to support people who experience chronic mental health issues to reside in the community.

Outcomes data did not vary significantly between rural, region or NGO providers. The evaluation will complete its final phase of fieldwork in March and April 2006. The third report will be completed in June 2006 and the final report in August.

1 Introduction

This report constitutes the second of three reports that provide a longitudinal evaluation of HASI Stage One. HASI is an innovative partnership between NSW Health, NSW DoH and NGOs. Jointly funded by NSW Health and DoH, 'HASI is designed to assist people with mental health problems and disorders requiring accommodation (disability)[4] support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness'. HASI also endeavours to 'demonstrate the benefit of a partnership approach' (NSW Health and NSW DoH 2005).

The program has a recovery focus and provides permanent housing and long term support in recognition that the clients have long term disability needs and may have recurring episodes or ongoing levels of psychiatric symptoms and disability. The initiative is grounded in a growing body of research that highlights the importance of stable accommodation and ongoing support in the long-term recovery of people with serious mental health issues (Tsemberis and Eisenberg 2000; Chilvers, Macdonald et al. 2004; Dadich and Swift 2004; Freeman, Malone et al. 2004; Rog 2004; Browne and Courtney 2005).

Over 100 people with complex mental health problems and high levels of psychiatric disabilities are currently participating in HASI Stage One across nine sites within five area health services in NSW: Greater Western, Hunter/New England, Northern Sydney/Central Coast, South Eastern Sydney/Illawarra, Sydney South West and Sydney West. Running concurrently with HASI Stage One are HASI Stage Two (low support) and Stage Three (high support). This evaluation covers only HASI Stage One.[5]

The Social Policy Research Centre's (SPRC) commissioned evaluation of HASI Stage One examines the implementation, process and effects of HASI over a two-year period.[6] This report focuses on client outcomes thus far, along with service provision and governance issues. This document should be read in conjunction with the first evaluation report (Morris et al 2005). These two reports will be supplemented by a third and final evaluation phase, which will be conducted in March and April 2006.

The purposes of the evaluation are both formative, to inform development of the program, and summative, to evaluate the effectiveness of HASI. This report fulfils

4 As defined in the 2002 NSW Health: Housing and Accommodation Support Framework for People with Mental Health Problems and Disorders 'accommodation support' is a component of disability support that specifically assists an individual to maintain their role functioning, skills and independence in relation to their accommodation.

5 Stage One is for over 100 high support clients. HASI Stage Two is a low support outreach for 460 people who are in established accommodation, but may be at risk of losing this without support. Stage Three has 126 places for individuals with high support needs. This stage is currently being implemented. As the research evaluates only HASI Stage One, from here on the report refers to the evaluation outcomes as 'HASI', rather than specifying the stage.

6 UNSW and NSW Health have granted ethics approval. All results are presented in such a way as to protect confidentiality and privacy.

these purposes by drawing implications from the findings and comparing the data from Phase I and II.

1.1 Methodology

Between September and October 2005, fieldwork was conducted for a second time across all nine HASI sites. Seventy-nine clients were interviewed. Of these clients, sixty-four had been interviewed in the Phase I (February and March 2005). The additional fifteen clients were either clients who had chosen not to participate in the evaluation in Phase I (six individuals) or new clients (nine people). Table 1.1 details the numbers of stakeholders participating in Phase I and II. AMHS and ASP staff changes, between the two contact points, were considerable (Section 3).

Table 1.1: Evaluation Cohorts Phase I and II

Stakeholder group	Interview February/March	Interview September/October	Interview Phase I and II
Clients	71	79	64
ASP key workers	61	61	46
ASP managers	10	11	8
AMHS case managers	30	35	14
AMHS team leaders and managers	9	10	6
Housing provider personnel	11	9	9

The report is divided into two main sections – client outcomes and program and governance issues. Qualitative and quantitative data is drawn upon throughout each of these sections. Data is triangulated, where possible, between the stakeholders and varying sources. Client outcomes, for example, are determined by interviews and surveys with clients ASP, AMHS and Housing Provider (HP) stakeholders. These are further supported by data collected within a Client Information Database (CID), which was completed by ASP personnel. The CID contains non-identified material on ninety HASI clients who are currently participating in the program. This data can be used as population data because it includes all active participants in the HASI program. Of the people entered in the CID in Phase II of the evaluation, the majority (seventy-seven) were included in the first database. Therefore comparisons can be accurately made with this cohort.

In all cases where comparisons are provided, data is only based upon stakeholders who participated in Phase I and II of the evaluation. Statistics listed throughout the report reflect the number of respondents to each particular question or area. In all cases, the proportion and the number are listed.

1.2 Progress in the Evaluation

This is the second of four evaluation reports on HASI. It is based upon surveys, interviews, a client information database and assessment tools (such as the Global Assessment of Functioning and Personal Wellbeing Index). The Camberwell Assessment of Needs (CANSAS) was also going to be used as a tool to track changes over time among the client group. Completing the CANSAS can be a lengthy process, but it is voluntary. NGOs have found this instrument to be useful for case management when clients consent to participate in the assessment process. During the evaluation Phase I and II, client participation in the CANSAS was low. Therefore,

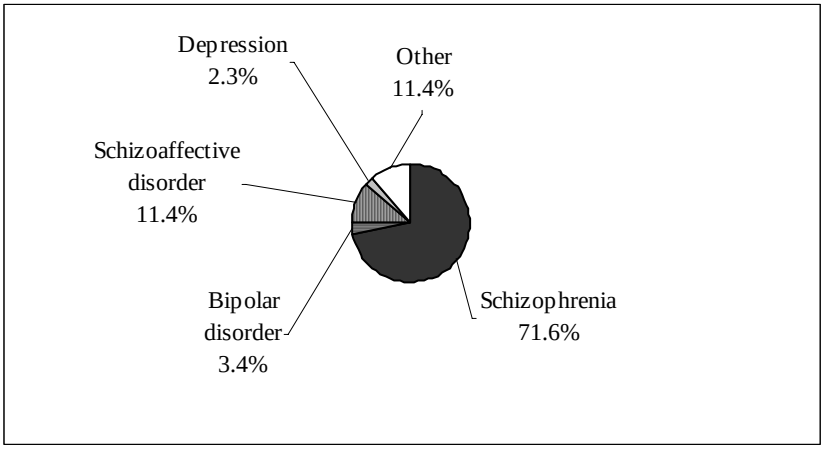
from a research perspective, the minimal data received is not sufficient. The Centre for Mental Health has agreed that it will not be used in the last evaluation Phase.

The third report will be based on the final Phase of fieldwork to occur in March and April 2006. It will include a cost-effective analysis if the required data (costs, housing outcomes, hospitalisation and MHOAT data for the intervention and comparison groups) is obtained from the Centre for Mental Health and the NSW Department of Housing. The third report will also compare client hospitalisation trends prior to and since joining the HASI program. Preliminary hospitalisation data was received from the Centre for Mental Health after this report was presented to the HASI Evaluation Reference Group. The third report will be presented to the Reference Group in June 2006. The fourth and final report will draw on the findings of the prior three reports draw conclusions about the process and outcomes evaluation of HASI. These will inform future development of the program.

1.3 Client Demographics

Given that the majority of HASI clients remained consistent between Phase I and II (77 of 90 clients), it is not surprising that client demographics were similar to the first report. Males continued to be dominant in the program (69 per cent), over half (56 per cent) of all participants were still under thirty-four years of age and most had a clinical diagnosis of schizophrenia (72 per cent).

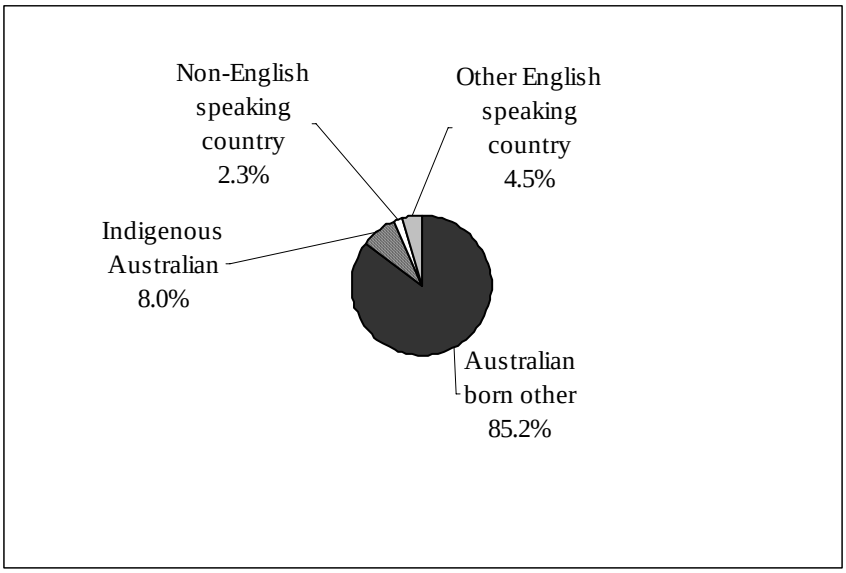
Figure 1.1: Mental Health Diagnosis (n=88)



Most clients were born in Australia. Seven clients (8 per cent) identified as Indigenous, higher than the proportion in the Australian population (2.3 per cent; ABS 2005). Four clients were born in a non-English speaking country and two were born in another English speaking country (see Figure 1.2). Individuals who first spoke a language other than English continue to be underrepresented among the HASI cohort (7 per cent compared to 20 per cent of the population).[7]

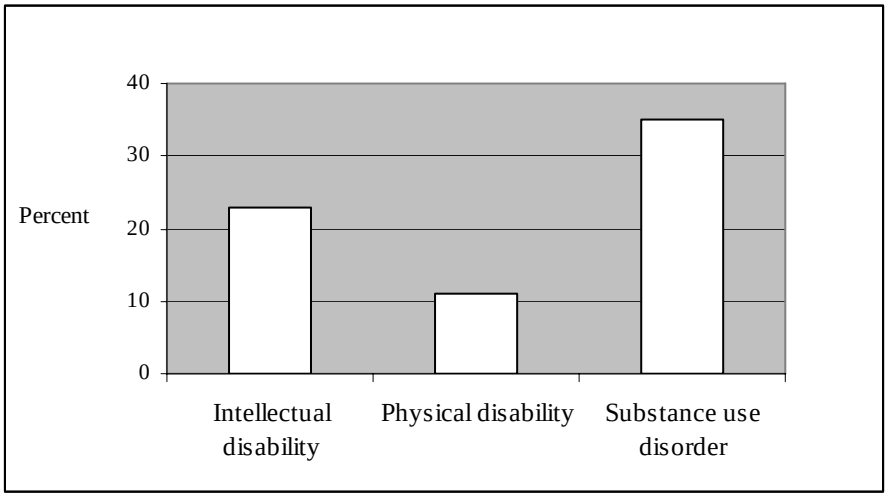
[7] Australian Bureau of Statistics (2003), *Census of population and housing: Population growth and distribution, Australia, 2001*, No. 2035.0, Canberra, ACT: Australian Bureau of Statistics.

Figure 1.2: Client Cultural Background (n=88)



Compounding mental illness for 63 per cent of clients (55 of 88) were additional diagnoses. Eight clients (9 per cent) had a physical disability, 23 (26 per cent) an intellectual disability (Figure 1.3; 20 per cent of the Australian population has a disability; ABS 2003). Over one third (33 clients; 37 per cent) a substance use disorder. Of the 55 clients with more than one diagnosis, 43 had a dual diagnosis and 12 had three diagnoses.

Figure 1.3: Dual Diagnosis (n=88)



As Figure 1.3 demonstrates, substance use disorders were the most prevalent of the comorbidities. Population demographics show men are almost 2.5 times as likely as women to experience this problem (Henderson, Andrews et al. 2000: 197). Yet for the HASI group, while there were twice as many males (22) with substance use disorders at the start of the program than females (11), as a proportion of each gender group, females were slightly more likely than males to be recorded as having substance use problems – 35 per cent of all males and 38 per cent of all females.

Notably, almost half of the clients who came to the program with a substance use disorder (46 per cent, or 15 people – 9 males and 6 females) were no longer experiencing substance use issues by Phase II of the evaluation. Substance use continues to be a problem for eighteen clients (20 per cent).

Thus the majority of HASI clients have complex needs and experience multiple disabilities. These challenges, however, have not necessarily been barriers to positive outcomes, as discussed in Section 2.

2 Client Outcomes

> My life would be a terrible misery without [HASI]. With the medication and support I'm on top of the problems and I can enjoy life. For many, many dark years I was very suicidal all the time because I just did not enjoy being alive. I was in so much emotional and mental pain and being psychotic and too scared and taking drugs to numb it all out; something had to give. … It took ten years to get that support. I was in and out of [hospital] like a revolving door. Now I've got the support I need, plus the very effective medication … and now I'm quite well. (HASI client)

Outcomes continued to improve for most clients during Phase II of the evaluation, but at a slower pace. Mental health improvements were measured from client perceptions, the Global Assessment of Functioning (GAF) and service provider observations. Most clients had no hospitalisation or decreased their hospitalisation admissions since Phase I. Access to health treatment improved above Australian averages for people with a mental health condition. Independence skills development progressed, although still required considerable support for some people. Most dramatic was social engagement with family, friends, community and economic participation. Despite this half the participants are experiencing loneliness. Only a minority of tenancies had difficulties or were relocated. This section provides data to support these findings.

2.1 Overall Client Changes

Over the past six months most HASI clients registered some level of positive change, although there were discrepancies in the rate at which client's circumstances altered. Progress was profound in some clients, limited in others and negative in a few.

Clients and both ASP and AMHS personnel noted greater stability, improved living skills, mental and physical health gains, decreases in the frequency and duration of hospitalisation and increased social skills and participation in the community, as some of the positive outcomes of the program. Consequently, as an AMHS manager concluded, a number of HASI clients are 'reclaiming some of their status as individuals, resuming their place in their community and experiencing and appreciating their own space and relationships with other people'.

A person's hospitalisation and accommodation history appeared to largely influence the type and extent of change for individuals. As will be shown, those clients who were previously living in group homes or hospitals had made smaller gains in terms of their skills acquisition and sense of independence, than those living in other situations prior to the program. Yet, for these clients, HASI has provided them with housing stability and continuity of care, which has resulted in the 'fulfilment of basic life needs' (case manager). Regular and stable shelter, food, income and social contact were seen as 'really positive' outcomes for those who continue to be severely disabled by their psychiatric conditions.

Clients who were previously living with their parents had some level of stability in regard to basic needs prior to the program, although relationships were often tenuous. For most of these clients, changes have been marked by greater independence and improved living skills, but more profound were the improvements in their

relationships with family, development of other social networks and increased participation in the community. Clients at this stage in their lives were beginning to seriously identify and commit to longer term goals with greater independence.

There were some setbacks among a minority of the HASI participants. While independent living enables HASI clients to live in the community, it has exposed significant vulnerability in some clients, which on occasion has been exploited. Substance use persists as an issue among a group of clients and it has continued to trigger hospitalisations. A few clients are at a crossroad in regards to their future in the HASI program; some threatening to leave, others temporarily breaking from the program and a few have disengaged from support. For a few clients, earlier improvement was followed by a trough, as evidenced in their Global Assessment of Functioning (GAF) and hospitalisation trends. Yet, despite some negative outcomes, with the structure of HASI support, most of these clients were still maintaining a higher level of functioning in their daily life than they had prior to entering the program.

2.2 Mental Health

Measures of change in mental health

The mental health of the majority of HASI clients has continued to improve, according to client, case manager and key worker perceptions. Clinical assessment data were not available to the evaluation. Of those who responded in the second interview (n=75), 63 per cent of clients reported that their mental health had improved in the last six months (44 per cent a bit and 19 per cent a lot). Case managers who were interviewed were slightly more optimistic, reporting positive changes in mental health for 69 per cent of their clients.

For clients who answered this question in the first and second cohort (n=54), the noticeable difference was in regard to the extent of change. Improvement continued but it had slowed down for many of these clients (see Table 2.1). In Phase I, for example, 43 per cent of respondents stated their mental health was ‘much better’ and 30 per cent ‘a bit better’ since starting HASI. In Phase II, while 66 per cent reported further improvement, the extent of that improvement had shifted to 44 per cent ‘a bit better’ and 22 per cent ‘a lot better’. Thus positive change continued, albeit at a slower pace than after first joining the program. Further reinforcing the improvement in mental health among this cohort were the ten clients who had reported no change in their mental health in the first Phase of the evaluation. Fifty per cent of this group cited better mental health in the second interview.

Table 2.1: Client Perception of Change in Mental Health, between Entry to Phase I and Phase I to II, number of clients (n=54)

		Mental health change between entry and Phase I						
		Much better	A bit better	Same	A bit worse	Much worse	Unsure	Total
Mental health change between Phase I and II	Much worse	2	1	0	0	0	0	3
	A bit worse	1	2	0	0	0	0	3
	Same	3	2	4	1	0	0	10
	A bit better	9	10	2	0	1	2	24
	Much better	7	1	3	0	1	0	12
	Unsure	1	0	1	0	0	0	2
	Total	23	16	10	1	2	2	54

The GAF tool corroborates the improvement in client mental health. The GAF is a scale (0-100) for rating overall psychological functioning. ASP personnel completed the GAF at Phase I and II based on clients' psychological, social and occupational functioning on a continuum from good mental health to serious illness. This tool is a useful clinical measure of functional change across a group (Söderberg, Tungström et al. 2005).

Where ASPs had completed the GAF in Phase I and II (n=67), forty-five clients experienced an improvement in functioning (see Table 2.2). At first contact, the median GAF score of the group was 38, indicating that the majority of the group had 'some impairment in reality testing ***or*** impairment in speech and communication ***or*** serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood' (their emphasis, Brown 1994: 32). By the second interview, as a group, the median of the GAF increased by 27 points to 65 (see Table 2.2). This is especially profound when the description of functioning is examined. Individuals rated between 61-70 points have 'mild symptoms in one area ***or*** difficulty in one of the following: social, occupational, or school functioning. ***But***, the person is generally functioning pretty well and has some meaningful interpersonal relationships' (their emphasis, Brown 1994: 32).

It is important to note that despite the significant positive change, seventeen clients, according to the ASP, experienced a decrease in functioning. The range of decrease was between four and thirty points, with an average of fifteen. An additional five clients did not experience a change in their GAF between Phase I and II (Table 2.3). Overall, however, Figure 2.1 illustrates a virtual reversal in function trends between the first and second Phase of the evaluation. Fewer clients were experiencing severe symptoms and very poor functioning and greater numbers had 'mild symptoms' and 'meaningful' relationships.

Figure 2.1: Global Assessment of Functioning Score Comparisons for Matched Cases, Phase I and II (n=67)

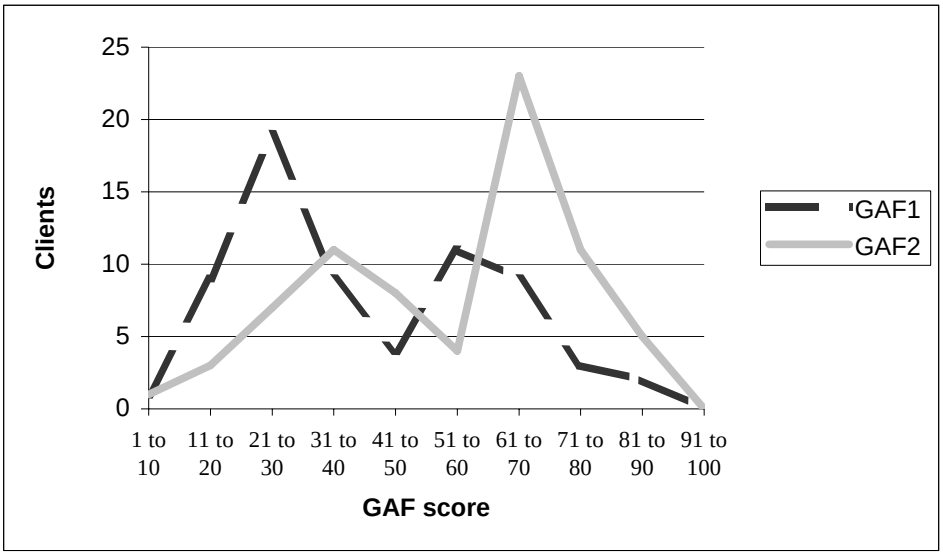


Table 2.2: Global Assessment of Functioning Scores, Phase I and II (n=67)

	GAF at first contact	GAF at second contact
Average score	41.9	55.3
Median	38	65
Range	7 to 87	7 to 90

Table 2.3: Change in Global Assessment of Functioning Scores by Clients with Increased and Decreased Scores

	Increased score Phase 1 to II	Decreased score Phase I to II
Number of cases*	45	17
Range of change	1 to 55 points	4 to 30 points
Average change	25 points	15 points

* GAF unchanged in 5 cases

Table 2.2 and Table 2.3 show changes in mental health based on client and AMHS and ASP personnel's perceptions. While perception is subjective, it is indicative of change because these perceptions are shaped by and in turn influence people's behaviour, reactions and responses. By triangulating perceptions across stakeholder groups and with other data, the reliability of this source is further demonstrated, as can be seen with the more objective hospitalisation rates.

Hospitalisations

The first report showed significant decreases in the frequency and duration of hospitalisations across the HASI cohort compared to hospitalisation rates prior to participation in the program. Overall, there was a decrease in the proportion of HASI

participants hospitalised between Phase I and II, but admission and duration rates remained fairly stable.[8]

As Table 2.4 shows, between the first and second evaluation stages 36 per cent (28 clients) who were participating in the program during both phases were hospitalised. This decreased from the 43 per cent (33 clients) who were hospitalised between starting the program and the first evaluation. When hospital admission and duration rates are compared as a proportion of time, however, there is no change. Averaged across the number of admissions, the duration of hospital stays remained at 9 days per admission and the proportion of time clients spent in hospital compared to days out of hospital stayed at 4 per cent.

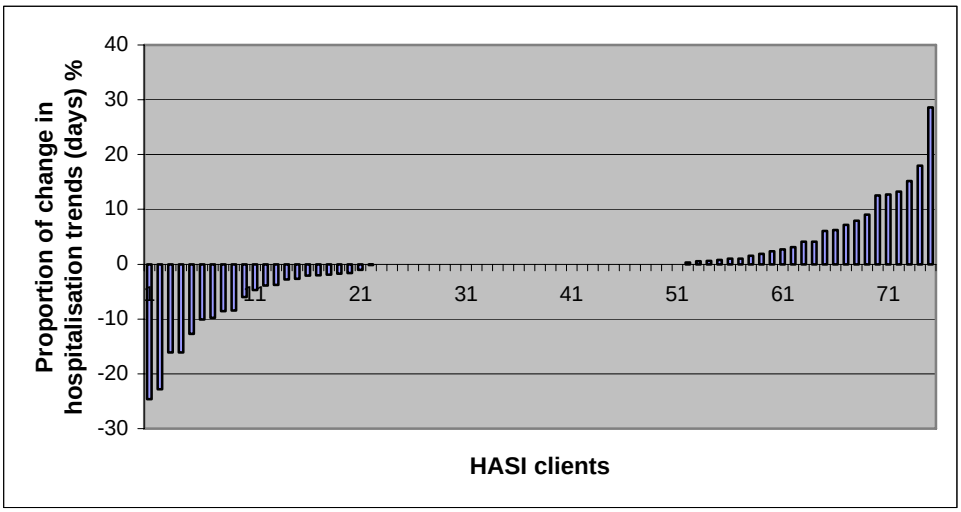
Table 2.4: Hospitalisation Frequency and Duration, Phase I and II (n=77)

	HASI entry to Phase I	Phase I to II
Proportion of clients admitted to hospital	43%	36%
Hospitalisation rates as a proportion of days in HASI*	4%	4%
Average days per admission	9	9

Note: * 977 hospital days (106 admissions) between entry and Phase I; 655 (74 admissions) between Phase I and II. When these periods of time are equalised, the proportion of hospital days remained the same.

When hospitalisation rates are analysed for individuals, most clients had no admissions or decreased their days in hospital during the six months between Phase I and II. Forty three per cent (33) of clients continued to have no hospital admissions between Phase I and II; and 29 per cent (22) experienced decreased hospital days. Only 29 per cent (22) experienced an increase in hospital days (Figure 2.2).

Figure 2.2: Individual Client Change in Proportion of Hospital Days between Phase I and II, percentage change (n=77)



[8] The final report will use hospitalisation data from the NSW Department of Health. It will compare client hospitalisation trends twelve months prior to the program with trends since clients joined HASI.

Throughout the HASI implementation, the duration of client hospital stays have remained low. This could be attributed to the high number of planned admissions – 68 per cent of all admissions (50 of the 74). Rather than becoming acutely unwell and presenting to hospital through accident and emergency, client hospitalisations were often planned. In numerous situations case managers and support workers intervened before clients became very unwell or had an episode. One client voluntarily admitted himself to hospital after the death of his brother because in the past he had not coped with grief. He remained in hospital for only 'five or six days' and 'with the admission he didn't become acutely unwell' (case manager). This client was proud of his hospital record since his involvement in the program:

> Apart from that precaution, I've only been in hospital twice in eighteen months and for me going back on my previous record … that's a marked improvement, because I'd be in hospital at least once a month. My hospital records are at volume 3; they're that thick with all the admissions I've had.

Two clients checked themselves into hospital for mental health problems, despite the AMHS personnel's perception that this was unnecessary. 'There was a period where she spent six weeks in hospital… A lot of it was very manipulative stuff. They wanted to discharge her, but she wouldn't go' (key worker). This problem has since been overcome with changes to the client's medication and support plan.

According to many case managers and ASPs, the twenty-four unplanned admissions were largely triggered by medication non-compliance or drug and/or alcohol abuse. One client was hospitalised after she breached her Community Treatment Order. Another client spent fifty days in hospital after approximately six months of refusing to take his medication. Another client was admitted twice after 'playing with his meds'.

In one area, crystal methamphetamine was deemed responsible for putting two clients into hospital. The ASP and case manager of one of these clients were frustrated by the client's drug taking because her friends and mother supplied the crystal methamphetamine and marijuana, which make her so unwell. The case manager felt that 'we've lost control because she's in and out of hospital [and because] the hospitalisations don't help because they don't treat her, they just keep her so she's safe.' While her case manager has become slightly despondent, this client emphasised that since she started HASI, 'I haven't been in hospital anywhere near as much as before the program'.

One client was admitted after he presented to emergency with the DTs (Delirium Tremens) from alcohol withdrawal. His case manager believed hospitalisation was the 'best form of care because of his big alcohol intake'. While he spent three weeks 'drying out', his mental state 'did not deteriorate' and the psychiatric nurses who had worked with him previously commented, 'It's the best we've ever seen him' (case manager). The ASP's supervision of his medication, his case manager believed, was 'maintaining that level of wellness'.

Twenty-six clients with hospitalisation histories prior to the program have remained out of hospital since joining HASI. In past years, one client has been hospitalised in January, September and December, but she was not admitted to hospital in the last

twelve months. While another client had twenty-five hospitalisations in a twelve month period since joining HASI, over the same period prior to the program, she had forty admissions.

Understanding improvement in mental health

Clients and their families largely attributed improved mental health to changes in the type of medication and/or the appropriate use of medication. The mother of another client explained that after a change in medication her daughter has started to talk more frequently. While the client's mental health remains poor, the improvement in her communication has given her family the opportunity to 'know what her opinion is … [and to] connect to her more as a person, compared to the nothingness that was there before' (mother). Medication can be instrumental in clinical change to mental health, and clients noted its effect because of its tangible nature. Other factors, however, are likely to have also contributed to the general improvement in mental health among the HASI clients.

The program has resulted in closer, more intensive monitoring of mental health. HASI provides clients with consistent clinical support. Without the program, clients are not guaranteed such support and those who had case managers prior to HASI did not necessarily attend appointments with any regularity. The ASP support in all sites includes, where required, assistance with making appointments, appointment reminders and transportation to appointments. Coupled with this, and perhaps most importantly, the ASPs can monitor and intervene when signs of poor mental health present themselves. According to one AMHS manager, this has been instrumental in decreasing the frequency and length of hospitalisations among clients.

> I think we get a better view of crisis with HASI. Instead of the crisis coming with a crash, there is a build up and there are more opportunities to provide intervention before things reach breaking point. … We work together more to improve the safety net or bring about changes. That's better for preventing a crisis.

Thus while change in medication may have occurred for a number of clients, critical to this is the ongoing, regular monitoring of client mental health from the AMHS and ASP. Establishing direct cause and effect for the change in mental health is not possible, given the complexity of both the issue and the program, but the stable housing and intensive support provided by HASI has correlated with a general improvement in mental health among other outcomes evident below.

In summary, client mental health and their subsequent use of treatment improved during Phase II of the evaluation. Clients experienced less unplanned hospitalisations, more stable use of medication and access to mental health professionals as required.

2.3 Physical Health and Treatment Prevalence

Literature shows that individuals with mental illness are more likely to have poorer physical health problems than their counterparts, but are less likely to receive treatment (Jones, Macias et al. 2004). HASI is helping to overcome what Samele (2004: 141) describes as a 'serious neglect in preventing, detecting and managing' physical health problems in people with severe mental illness. One of the major

outcomes of HASI is an identification of physical health problems and subsequent consultation and treatment by appropriate health professionals.

Compared to the Australian population with mental health disorders, HASI clients were much more likely to seek and receive treatment from health services. Based on the Australian National Mental Health Survey, fewer than four in ten (35 per cent) Australians with a mental disorder received any health treatment in a twelve month period. Only 8 per cent had seen a psychiatrist and 29 per cent a general practitioner (Hickie, Groom et al. 2005; Henderson, Andrews et al. 2000). Comparatively, 89 per cent of HASI clients had seen a psychiatrist and 86 per cent had visited the GP. In addition, 92 per cent had consulted with AMHS personnel, 22 per cent had visited a psychologist or counsellor, 38 per cent other specialists and 43 per cent had consulted with an allied health professional since starting the program.

Table 2.5 indicates the number, mean and median of consultations with health professionals for clients involved in Phase I and II. In addition to these consultations, nine clients were hospitalised for physical health problems. In total, the group spent eighteen days hospitalised for poor physical health.

Table 2.5: Total Health Services Used by Clients Since Entering HASI (n=76)

Health service	Total number of visits	Median number of visits per client	Mean number of visits per client
General practitioners	997	10	13.1
Psychiatrists	1074	4	14.1
Psychologist or counsellor	358	0	4.7
Other specialist	190	8	2.5
Community Mental Health Team	2421	6	31.9
Emergency service	497	1	6.5
Allied health services	297	2	3.9

Clients have received a variety of treatment. The parents of one client explained the ASP's focus on their son's physical health: 'They've had him to the dietician. He's had $1300 worth of dental work done and he gets his teeth cleaned once every three months. He goes to a podiatrist, gets his skin cancers checked and sees the doctor about once a month'.

Since joining HASI, many clients have become aware of physical health problems that they previously ignored, were ignorant of or uninformed about because poor mental health took precedence. Diabetes, asthma, hepatitis, gallstones, incontinence, bowel and liver problems were some of the physical health complaints. Despite this increasing awareness, around half of all clients (41 per cent), case managers (49 per cent) and key workers (50 per cent) perceived an improvement in client physical health. This is likely to have resulted from the number of consultations with health professionals, coupled with ASP education on healthy lifestyles.

Two sites strongly focused on healthy eating and physical activity in providing support. In one area, a key worker developed an eight-week healthy eating and exercise program. It included a healthy lunch and a variety of recreational activities, such as Tai Chi and walking. The other site also encourages physical activity with walking, swimming and tennis groups. They too promote healthy food alternatives. Some clients were positive about the healthy change in their lives: 'My goals were to

get weller [sic], lose weight and get a bit of exercise each week and I've done that. I've started to buy fruit again'.

While one NGO uses the 'ABC of Healthy Living' to encourage healthier choices, a support worker employed by the organisation felt defeated in her attempt to encourage the clients to eat well because 'at the end of the day, they have their own money and if they want a hamburger and chips, they just buy it'. Physical health is not always a priority for clients and therefore key workers often worked on healthy lifestyle education with only those who showed interest. Clients often sacrificed physical health for stress relief in the form of nicotine, with almost 80 per cent of clients smoking (67 of 84 respondents). While there is some recognition of potential physical health damage, there was little willingness to give it up. As one client stated, 'smoking may well inflict its toll, … [but] I've said to the GP that I still need the smokes to deal with stress. At the moment I'm loving every puff'. In areas where the ASP did not commonly offer physical activity, case managers and family members emphasised the need for its introduction.

Since the last report, there was a small rise in the number of clients reporting poorer physical health. Of those who responded to this question in both interviews (n=52), 12 per cent reported a decline in physical health since starting the program during the first interview, while 17 per cent reported similarly in the second. This was partly because the period between the two interviews included winter and a number of clients complained about colds, the flu and associated respiratory problems. It could also be a result of increased consultations with health professionals and a subsequent new awareness of health problems.

In summary, stable housing and support has enabled HASI clients to access treatment for physical conditions at a rate above that of other Australians with a mental health condition.

2.4 Facilitating Independence

Increased independence

One of the outcomes of HASI is increased independence among the majority of clients. Tenancies provided clients with the opportunity, some for the first time in their lives, for independence. Clients who moved from the family home or an institutional setting were most appreciative of independent living. 'The rent assistance makes it affordable for me to live independently', commented one resident. Another noted, 'My independence has increased because I have somewhere to go home to'. After years of living in an abusive relationship, one client has 'regained a lot of independence' she had when she first left home at 15 years of age. Thus having a physical space afforded clients an opportunity for independence.

The extent to which this opportunity was utilised differed between clients. The independence stemming from living alone was not necessarily transferred onto living skills within the home and in daily life. Living skills are a focus of the support provided and some clients have made marked improvements in their skill and independence levels over the last six months. According to ASP personnel, as a group HASI clients increased their level of independence across all living skill areas (see Table 2.6). For the first times in their lives, some clients had learnt 'survival skills; to cook, clean and wash' (client).

Table 2.6: Client Level of Independence with Living Skills as Determined by ASP, per cent

Living skill (n=73 unless otherwise stated)	Independent Phase I	Independent Phase II	Increase in proportion independent
Exercise (n=72)	22.2	55.6	33.4
Diet (n=72)	16.7	47.2	30.5
Transport	34.2	63.0	28.8
Cooking	30.1	57.5	27.4
Banking	27.4	52.1	24.7
Medication	12.3	35.6	23.3
Shopping	8.2	30.1	21.9
Laundry	42.5	63.0	20.5
Cleaning	16.4	35.6	19.2
Budgeting	13.7	31.5	17.8
Accessing community services	26.0	43.8	17.8
Making appointments	15.1	32.9	17.8
Dressing (n=72)	69.4	80.6	11.2
Bathing/showering	67.1	78.1	11.0

Increases in independence stemmed predominately from improvements in those who were rated as 'supported less than half the time' at the first interview and, to a lesser extent, those ranked as 'supported more than half the time'. Some HASI participants had progressed from being fully dependent on the ASP six months ago to becoming completely independent in the case of medication (four clients), banking (three clients), diet, laundry and transport (one client in each).

A key worker explained the change in one of her clients. 'Twelve months ago [he] had no idea about how to keep his house clean and tidy … he's gone from full dependency to only two hours of support a week. He now recognises his house needs cleaning, which for him is amazing'. Clients too recognised their increased independence inside and outside the home: 'I'm more independent now. I'm shopping on my own [and] I do my own cooking'. A client from another area noted her new found autonomy outside her home, 'I've got a lot of independence now. … I go to the doctors by myself, I did the computer course on my own … [and] I might go and meet my friend at the club or go out elsewhere'. While both these clients continue to be reliant on ASP support for other tasks and emotional support, they are developing both skills and confidence. The manager of one AMHS believed HASI was providing a pathway towards independence for clients in his area: 'I think in a general sense the clients have an ... you wouldn't call it an empowerment, but they have an ability to deal with some of their issues more independently'.

The increasing ability to function independently consequently means many clients are receiving less support than previously. This was not always looked upon favourably: 'I don't understand why they're so strict on me with the time they spend with me. ... I get my own way to volunteering and to swimming now, and soon I might have to start making my own way home. It takes me two buses … They [workers] don't come around much anymore.' Despite this client's frustration and disappointment about her decreased contact, she has made considerable gains towards independence. Prior to the program, she spent fourteen months in hospital after a suicide attempt and had not worked for almost seven years. She now volunteers once a week for the ASP organising client activities, such as tennis and trips to major community events. She

has also completed an eight-week community computer course and intends to study at TAFE in 2006.

Dependence

Although many clients had increased their independence in regard to living skills, more than one in ten HASI clients remained fully dependent on the ASP for a range of these skills – budgeting (31 per cent), medication (18 per cent), banking (16 per cent), cleaning (15 per cent), laundry, transportation (both 14 per cent), shopping (13 per cent), using community services (13 per cent), making appointments (12 per cent) and cooking (11 per cent). There was a slight shift from independence to receiving some support from the ASP in some cases (between one and six clients for each of the skills, with an average of 3 clients). This may be a reflection on an individual deteriorating in mental health and/or becoming increasingly willing to accept ASP assistance.

There were concerns among stakeholders working in a couple of the sites about clients becoming dependent on service providers. These concerns stemmed largely from the approach some ASPs and/or key workers took. Some case managers felt key workers were too ready to do 'things for' the clients, rather than 'providing support and the skills for them to go off and do it themselves'. Another case manager resolved that 'the promotion of dependence' was 'a reasonable compromise' for the positive outcomes of HASI. He blamed the lack of resources within the community for this dependence, but he also acknowledged that 'knowing how to maximise independence in the client' was a 'philosophy' and 'skill' lacking in the organisation and among its key workers. Two case managers from two different areas suggested that occupational therapists should be consulted by ASPs to assist them to promote independence.

Concern regarding dependence often came from case managers, but some key workers also expressed similar sentiments: 'There is lots of co-dependence. We're not always putting ownership back onto the clients' (key worker). Dependence was admitted, but justified by some ASP personnel in some situations. One ASP manager stated 'we're all interdependent on people'. A key worker noted while one man 'relies on the service, … he needs that support'. In a rural area, the ASP manager believed three clients were 'dependent' on the service, but each of these clients had come from out of the area and therefore had moved away from family and other networks. Thus she believed, 'at this point I don't think it's unhealthy'.

A clear split between independent and dependent clients is far too simplistic. Clients were on a continuum of skill and confidence levels. While ASP personnel encouraged growing independence, high levels of psychiatric disability left many clients either very gradually building skills and confidence or remaining dependent on extensive support. One case manager noted that for her 'the biggest worry' is that her client 'could become dependent on the services'. This client continues to require high levels of domestic, social and other support: 'He needs reminding … he doesn't have the confidence to do things on his own… He's still in a protected environment'. Yet she conceded that in developing his support plans she and the ASP have 'lifted the level of difficulty for him' and 'his social interactions are far more healthy'. Since starting the program he now 'enjoys the company of other people and he'll seek it out' (case manager). Like this client, changes in many individuals' social lives have been profound.

In summary, most clients are continuing to increase their levels of independence. Some clients remain almost fully dependent, but their level of confidence is gradually increasing, which may eventually lead to greater independence.

2.5 Community Connections and Support Networks

> Social isolation and severe psychiatric disabilities seem to go hand in hand. Yet, over 2,000 years of philosophical thought … suggests that human beings are essentially, necessarily, social beings. (Davidson et al. 2001: 11)

Community participation

Mainstream activities

An area where the boundaries between fostering independence and avoiding dependence become blurred is in relation to community participation. Among the three NGOs providing accommodation support, there are stark differences in how community participation is facilitated. At the first Phase of the evaluation, one NGO was providing organised group activities four days a week, another used group activities once or twice a week and the third relied on existing disability support programs or mainstream community activities. Each of these methods had varying success, depending on the capacities and interests of the clients within each of the areas. Utilising disability support programs to facilitate participation enables ASPs to draw upon existing community resources. One NGO assists clients to access other NGO and AMHS group programs, along with other disability based activities, such as targeted TAFE classes. These are valued and clearly beneficial for some clients. A variety of programs, however, is not always readily available, especially in rural areas. These programs are also limiting because while some clients benefit from attending them, others dislike the 'disability' association. The manager of one ASP explained:

> There are programs we can link them into, but a lot of them don't want to link into them because mainly people with intellectual disabilities attend those programs, not people with mental illness. So they don't feel comfortable in the groups.

Although the same area has a support group run by and for people with mental illness, according to a number of stakeholders, it has similar barriers because of its label. The alternative for this area, and others within the same NGO, was one-on-one social outings between a key worker and client or mainstream activities. The client and key worker social outings were and still are a well-regarded part of ASP support and while they are facilitating an increase in social skills, they have not, thus far, provided a pathway to independent community participation.

ASP organised activities

ASP organised activities are another a transition mechanism for fulfilling this role. Examples are barbeques, picnics and sport activities in public spaces. Group activities have played an important role in developing social skills and fostering confidence among some clients, enabling them to participate independently. The manager of one ASP that organises group activities acknowledged that at the beginning of the

program the clients were ‘very scared’ to participate in the community because ‘they don’t have very good social skills’. This ASP has put in ‘a lot of effort into developing confidence and to be able to move people forward’. Similarly, an ASP manager in another area, recognised the role they were playing in providing a bridge between social isolation and community integration:

> You can’t just say, ‘Off you go into the community.’ We find that we actually have to do it first, run it ourselves … It has been more beneficial than when we have just gone, ‘Here you go, off you go’, and most clients won’t actually do it. They really don’t feel that they are part of that community, so they don’t feel like they can join in.

One organisation got almost all their clients involved in squash by providing a ‘safety net’ of attending as a group and ‘giving people the confidence and the skills’. In another area, a client’s motivation to attend the local gym diminished after he was taken there by a key worker and instructed to ‘Go for it’. Perhaps a graded program and participation with a key worker and/or other HASI clients may have assisted this client to build his skills and confidence to continue attending the gym on his own (case manager).

By attending group activities, some clients have developed friendships and have since ‘met up and done some things themselves’ (ASP manager). Clients in a number of areas have moved from group swimming, fishing and barbeques to doing these activities either alone or with another client independent of the ASP. A client who suffers from severe paranoia and who rarely left his house prior to HASI now attends all ASP activities and, in the last six months, has completed some casual paid work and participated in leisure activities on his own, such as hiring a fishing boat and going on a day cruise. A client from another area has moved from being unable to go out alone to attending football matches with friends. While it is difficult to link ASP organised activities with her increased confidence and social participation, she acknowledges that being encouraged to meet her key worker in town is beneficial:

> I used to try and force myself to do things on my own and I’d be shaking like a leaf and I’d probably end up schitzing [sic] out before I got home. … Once a fortnight I make an effort to go into town and meet my key worker. We go out and have lunch in town and we might wander through the shops. … Once I wouldn’t have even ventured out to do that.

In the same site, another client’s only social contact, besides family, was with the ASP group activities. Prior to the program, this client’s social confidence was so poor that he constantly wore dark glasses, kept his head down and rarely communicated. While he still has plenty of room for development, his key worker is amazed at his progress:

> He’s very slowly getting more and more communicative. … At art camp, I couldn’t believe it, at one stage … he was the centre of attention in a three-way conversation. And when you ring him on the phone now he’ll initiate a little bit of conversation. And sometimes when he’s out with other people he’ll say, “How are you today?” and maybe ask them something else.

This client attends both weekend activities and the NGO's weekly art group. Approximately ten clients from across three sites attend each week. This group produced 2005 and 2006 calendars, which included their art works. At the 2006 launch, HASI artists presented and sold their pieces.

A client in another area who said very little when he first joined the program has become more responsive when asked questions and will now initiate some conversation. His parents are impressed with his progress, especially since he recently joined a local sporting team. The parents of another client were also 'amazed' at the improvement of their son's social skills: 'Eight months ago he wouldn't have chatted to strangers … He went out with us on Friday night and … he met some neighbours and he talked to them'.

In areas where group activities were frequent, case managers praised the ASP personnel's efforts to 'give support and encourage the people to go [into] the community'. Another case manager noted how 'rehabilitative' these group activities were for the HASI clients in her area:

> There is lots of confidence building. They learn what to buy for a barbecue and the appropriateness of behaviour. They get an insight into their social skills; it provides reality testing regarding how they present to other people. And it can offer informal group therapy processes. This is what mental health is all about.

Since the first Phase of the evaluation, the NGO which did not previously conduct group activities has introduced them in some sites. These are usually barbecues held once every three weeks. Despite the infrequency, ASP personnel and clients noted the positive outcomes they have witnessed in a short time. One key worker described the social benefits for the clients, along with contribution these outings made to strengthening the relationships between clients and workers: 'We just have a barbie [sic] and a laugh and a joke. They see us in a different light. We're not bad guys, good guys all the time. We can actually enjoy ourselves and have a good time too'. The manager at this site felt it was too soon to determine the impact of these outings, but acknowledged that it was getting clients 'out of the house with other people … and the fact is they enjoy it'. These barbecues have also highlighted areas where clients require further support: 'It's also a good opportunity for staff to informally assess their social skills. Prior to that we had no idea that [one of our clients] had quite a thing about mistreating people and animals' (ASP manager). Clients were also positive about these group activities, but would like them to occur with greater frequency (once a week) and expand to include other recreational activities, tennis for example.

Case managers and families were also enthusiastic for an increase in these activities. The rehabilitation co-ordinator at the AMHS in one area expected social activities to be an integral part of the ASP's role: 'We had an expectation of more social activities. Twice a week or just every weekend would be great. … I think there is a real need for social things; there are definite social gaps'. Another case manager noted that while 'everything has improved' in regard to ASP support since the last interview, she would 'like to see a lot more activity' to help address both recreation and healthy living. The parents of HASI clients living in the four areas where the ASP does not organise group activities, were generally eager to see their adult children participate in

the community: '[They] need to have more social programs ... The worse thing is sitting around doing nothing all the time'. These mothers were not critical of the ASP, rather they wished for funding to be directed towards regular social activities.

Constraints on community participation

Facilitating community participation can be constrained by resources of the community, the capacity, interest, motivation and budgets of clients and the service provider's approach to solving these problems. The AMHS manager in a rural area reported that limited options in the community had both social and psychological effects on the ASP: 'There is a limited range of those sorts of resources. It tends to change a worker's perception about what they can do to make something happen'. A case manager in another rural area lamented, 'We just don't have the services to pass these guys onto'. For example, that if the mental health team provided activities, the minimal public transport hindered client participation. Some clients 'aren't able to just get on a bus' and others do not perceive the financial cost of taking public transport to be worthwhile. 'Trying to encourage them to do something in the private sector it comes back to fares and costs, even though they get paid, they don't see those types of things as important, they're thinking about cigarettes and food'. In contrast, where ASP organised activities occur, transportation is initially provided and, by participating in activities at minimal costs, clients develop an understanding of the benefits of social participation and budgeting for these activities:

> It gets me out and about and out of the house. I'm still going swimming, playing tennis. … I would never have lost those eight to ten kilos [without the ASP] because I never would have exercised. My life would have consisted of barricading myself inside my house, all the windows locked, the blinds drawn ... For several years I only came out once a fortnight at pay day to get smokes and food. With the support I've got now I live a fulfilling life and I enjoy it. Look around, a beautiful sky, a beautiful day. (HASI client)

The limitations noted above have been overcome in other areas. All communities have parks where gatherings can occur at very minimal cost to the clients. ASPs have techniques to assist individuals to budget for activities and some operate a savings fund for these activities, if clients request. Most of their outings, however, are at no cost – a walking group and tennis club (one of the clients negotiated to use the court for free) – or at minimal cost – providing their own food for a barbecue picnic, fishing and swimming.

The capacity of the individual plays an instrumental role in community participation. While one client participates in all the ASP organised activities, he has made little progress in regard to moving on to mainstream activities because he is 'totally delusional all the time'. The case manager of a client from another area explained that at this stage her client is unlikely to progress into mainstream participation because of 'his cognitive functioning': 'It's the steps of getting there. I just don't think he can manage those steps because his functioning is quite low and quite impaired. On the surface it might look all right, but it's just not there'. She added that when situations like this arise, ASP personnel need to understand and respect clients' choices: 'You can encourage someone, but you have to be ok when they say, "No, I've chosen not to do that". If people put too much pressure on them, it will bring them unstuck'.

Similarly, a case manager in another area emphasised, 'You can't overdo things with [the client]' because in the past this has resulted in self-harm. Yet this client clearly needs a balance in her life because if she has nothing to do with her days 'she doesn't think she has a reason to get up in the morning'.

Summary

ASP personnel were generally aware of the capacities, abilities and needs of individual clients, but not always. Perhaps what should be emphasised here is that it has been beneficial to have a combination of support available to ensure clients, who are willing and ready, have the resources and the pathways made available to them to maximise their participation in the community. Coupled with this, ASPs should heed SANE Australia's concerns that many established disability programs 'do not provide pathways to integration with the local community, and may actually perpetuate isolation from society by their insularity in service provision' (SANE Australia 2005). These conclusions are reinforced in the next section.

Work and education

The increase in the number of clients who have worked or studied since Phase I indicates the strong improvement in community participation. Of the respondents interviewed twice, 43 per cent reported either working or studying in the past six months. Almost one-third (33 per cent or 20 clients) had worked in a paid (8 clients in open employment and 6 in supported employment) or voluntary (6 clients) capacity. An additional ten clients were actively looking for work; thus the workforce participation rate among respondents interviewed twice (n=61) was 39 per cent, compared to 29 per cent of people with mental illness across the Australian population (Hickie et al. 2005: 402).

Half of the HASI clients working at the time of the second interview were new to the workforce, with the other half maintaining the working status they had at the time of the first interview. Furthermore, another nineteen interviewees (32 per cent) wished they had a job. Thus while participating in the HASI program, almost one-third of clients interviewed in Phase I and II had re-entered the workforce either in a voluntary or paid capacity and an additional third wanted to work.

Clients worked in a range of industries, either part-time or on a casual basis. Those in supported employment were largely working in factories, packing or processing goods. Individuals in open employment were mainly in labouring positions in the gardening, car detailing, cleaning, building and factory areas. Employment gave some HASI clients a sense of worth and achievement. A client working up to 32 hours a week in a chicken factory talked about the change to his life since he got his job in May 2005:

> I didn't like just sittin [sic] around all day and just eat, like dole bludgers do or whatever. I'm not that sort of person. … I'm happy with the job I've got here. It's good money. The people are good; they're really understandable. One time I had to have me depot and [the ASP] couldn't take me, so one of my work mates took me up to the hospital. … I've had to call in sick cause of my mental health about once a month; I just call in sick and they understand. I haven't

> really felt this good in my life, I could say. Things are starting to fall together. … I can see progress in the long [term].

Another client completed some short-term contract work with his AMHS. Working with his case manager, he presented a 'Soothing the symptoms' psycho education course, which covered symptoms, triggers and preventative and reactive techniques. This work significantly benefited this client in regard to his own education, his self-confidence and in providing him with some direction for his future:

> Since I got the work I feel more worthwhile, that I've actually done something constructive and positive with my life. … I'd like to be a consumer advocate. … I've got the experience. I know what it's like talking to the doctors; I know what it's like to get the side effects from the medication, when people don't understand what you're going through.

Most volunteers were working for NGOs. Clients sorted clothes, cleaned and one organised community based activities for the HASI group in her area. Another client was volunteering at a community radio station.

Half of the HASI clients who were working coupled employment with study. The proportion studying decreased slightly between phases. Of the cohort interviewed twice, fourteen clients (23 per cent) were studying during the first interview. By the second interview, nine of these clients continued to study, along with three additional clients, accounting for 20 per cent of the group.

Five participated in community courses, five at TAFE, one at school and another at university. Four clients had completed their study (two at community colleges, one at TAFE and another at university). With the exception of the school student, who pulled out of her High School Certificate because of missed days through poor mental health, the other clients were continuing their studies.

More than one in four clients (28 per cent), who were not studying at the time of the interview, expressed an interest in training or education within the next twelve months. And, as mentioned earlier, almost one in three indicated an interest in working. Few clients, however, had formulated any clear ideas about the area(s) they wanted to pursue. One client expressed an interest to volunteer with animals or to become a brickie's labourer and another was completing a furniture restoration course with an employment assistance agency and hoping to be referred to paid work. Family members were especially eager for clients to work and/or study. ASP personnel understood that a verbalised interest in work or education would not always translate to activity in the immediate future.

In summary, incremental steps towards education and employment have been successful for a large number of clients. These have included increasing confidence through social contact to generate a willingness to enter the workforce; attending educational and training opportunities; voluntary work and supported employment; and casual, part-time and full-time open employment. ASP key workers have facilitated success through careful selection of opportunities appropriate to the client's capacity, support in the workplace, liaising with employers and linking clients with employment support agencies.

Friendships

Work, study and community participation played an important role in assisting some clients to establish and maintain friendships. More than one in four clients (26 per cent) reported increased contact with friends and improved relationship quality (29 per cent). Although the remaining clients reported little change regarding the frequency of contact and quality of their friendships, when the first and second interviewee responses are compared, there was an increase in satisfaction with friendships. Half of those who were dissatisfied in the first interview were satisfied in the second. Furthermore, fewer clients were apathetic about friendship. Two-thirds of those who were neither satisfied nor dissatisfied with their friendships in the first interview were satisfied in the second.

As the HASI program progresses, clients are also increasingly likely to be involved in intimate relationships. On entering HASI, 13 per cent of clients were in these types of relationships. At the first interview this had increased to 16 per cent, and by the second interview 24 per cent were involved in an intimate relationship.[9]

A small proportion (17 per cent) of those who had been apathetic in the first Phase reported being dissatisfied with their friendships in the second; relationships with friends were suddenly important to this group of people. Thus overall the results show that clients were more interested in developing and maintaining friendships.

Indicative of the important role of ASP organised activities were the clients whose only friends were other HASI residents. 'I'm friends with other people in the program, but I don't have friends outside of [it]', was a sentiment shared by a number of clients. Befriending other HASI clients had enabled some individuals to experience sincere friendships; these were 'not just people who bludge off us'.

Another resident continues to be 'wary' of friendships outside of HASI, but he has formed friendships with the ASP workers. While this may be construed as crossing a worker/client relationship boundary, for this HASI resident, they are valued relationships and he is aware of the boundaries: 'I call the [ASP] workers friends. While they will always and ever be professional people, they've all been so very good to me and supportive that I class them as friends, they're worker friends'. For a man whose 'paranoia is the same' and who continues to maintain 'there's a reason why I don't have people close to me', this is a considerable step of learning to trust individuals.

Increased confidence and/or social skills, which developed as a result of group activities, assisted other clients to reconnect with old friends and/or establish new friendships. When this occurred, HASI friendships were still valued because friends from different groups provided varying life perspectives:

[9] These figures are based on the client information database, which was completed by the ASPs. The number of clients are as follows: 14 of the 105 who have been involved in the HASI program throughout its entirety started the program in an intimate relationship, 15 out of 92 clients were involved with the program at the first interview were in intimate relationships and 22 out of the 91 participating in the program at the second.

> I think it helps [having friends with mental illness] because we understand each other more; whereas you find that people who don't have a mental illness are doing so much more than what you could ever dream of.

The HASI program has assisted a client in a rural area to understand and manage his mental illness, find some part-time work and, in turn, increase his self-confidence and develop friendships in what was previously a foreign town. He has made friends at work and with his neighbours and he now has a girlfriend. He explained his improvement in his ability to make and maintain friendships:

> I'm able to communicate better and able to say what I want to say and say what I'm thinking, not having all the things going on. I can talk to people for a longer time and get a good vibe about talking. I've just sort of gotten over the fact that I have to take this medication and I can live a normal life with it and that I don't really look that different to other people.

Not all friendships were felt to be beneficial or satisfactory. Six clients (8 per cent) reported a decrease in contact with friends and three of these clients noted a drop in the quality of their relationships. Two of these clients had recently joined the HASI program and their participation was contingent on them leaving their families and friends in their local towns. The third client, who reported poorer relationships with friends, had spent a considerable period in hospital between interviews. Another client made a conscious decision to stop contact with her friends who use marijuana because they encourage her to smoke the drug and it makes her unwell.

Friendship choices were not always socially acceptable to ASP workers. However, most ASP personnel understood the important role these relationships played in clients' lives. A key worker commented:

> He is frustrating with the crowds he gets into, but … the idea of us in theory is to help people reconnect with the communities of their choice and essentially he has done that. He's got this whole group of friends, that we don't approve of … and he does get up to strife with them, but I think he's mostly happy.

Another client began a relationship with a fellow client, which the ASP manager believed resulted in 'some behaviours that influenced her mental health status, like going out and having too much to drink'. While this client was consequently hospitalised and the relationship ended, it was not felt to be a totally negative experience because the program is 'about being able to make choices, not necessarily the right ones' (ASP manager). The ASP were supporting, educating and monitoring this client, but she was given the opportunity and freedom to make her own decisions.

In summary, HASI clients continue to increase their confidence through social contacts with friends and in intimate relationships. Some clients are wary about their vulnerability in social contacts and experience loneliness and isolation. Developing friendship skills through contact with ASP key workers and fellow HASI participants has been useful for some people.

Family relationships

Like friendships, client satisfaction with family relationships has generally improved over the last six months. Eighty-two per cent of clients who participated in the second interview were satisfied or very satisfied. Three of the four clients who were dissatisfied with their family relationships were very satisfied at the second interview. A further four clients, who were neither satisfied nor dissatisfied at the first Phase, were also satisfied with these relationships.

This satisfaction resulted from clients having more functional relationships with their families. Greater stability in mental health coupled with independent living has assisted some clients to more effectively engage with family members. Individuals reconnected with previously estranged family, others removed themselves from precarious relationships and some diffused past tensions.

Independent living had assisted some clients who were previously living in the family home to have more equitable, less dependent relationships with their families. One client explained that having his own place 'takes the pressure off' and while he still visits his parents' home every weekend and he still sees his siblings at least weekly, he no longer 'need[s] the constant attention they were giving' him. Similarly, a client in another area explained:

> Me being here has in some ways meant we've established a better relationship because with all my ups and downs in life with mental illness [mum] wanted to protect me a lot of the time and wanted to do things for me because she loves me, and I think that ultimately really wasn't helping me because I wasn't learning to do things for myself. It wasn't bad before, but I guess it was a little bit co-dependent on my side.

A key worker felt that one of his client's relationships with his brother had similarly improved: 'When I first started I got the impression that his brother was just coming around and using his phone and eating his food. Now it seems as though they might even plan their time together'.

HASI has provided six clients with not only an independent space to raise their children, but also a supportive environment. While one client only has part custody of her daughter, she really appreciates being able 'to bring up my daughter in my own space in the community'. The case manager of another client commented that the 'best thing that could come out of my and [the ASP's] support is that [the client's son] has a more stable environment to grow up in'. Since joining HASI, another woman has re-established her relationships with her children and grandchild:

> I went through a pretty bad stage with both my kids where I didn't see them at all. I was so far off the wall that they were too scared to have anything to do with me or come near me. When I first moved in I was alone and my daughter was too scared to have anything to do with me. … Over a period of time as the kids have got used to the fact that I'm not so whacko anymore … [they] relaxed and started coming back around.

Her daughter now lives with her and she sees her son and grandchild frequently. Another client's relationships with his family and partner were previously dominated by violence. When he was first housed, the ASP ensured his home was 'a reasonable distance from his mother's place' and his address was kept from her. He now stays with her two days a week, however, and their relationship is sound. This client is also back in contact with his sister and is actively fathering his son.

Change for HASI clients' families

Not surprisingly, some families have also benefited considerably since their family member has been involved in HASI. The program has brought relief and harmony to some families and transformed the lives of others. Relief often derived from finding a place where the individual could live independently while receiving support, therefore alleviating the family of this burden. 'It relieves my worry [and] the pressure from me as the parent', commented one mother. There was also some relief that clients would be cared for once parents passed away:

> We were wondering what we are going to do. When you are in your seventies you never know when you are going to be around and we wanted him set up a bit better. We don't have to worry and that is a big thing.

HASI had enabled some family members to reengage in society – in the workforce and socially. The parents of one client discussed their family's tumultuous past decade and the transformation the family have undergone since their daughter joined HASI:

> When she was here it was a disaster, a total disaster. … The stress is unbelievable. … The whole family was going under, completely going under. The family harmony and the normality of the family including [our daughter] is way improved. … We've got a much more normal life compared to anything we've had since she was a kid. … We could make a feature film out of it. It's been horrendous, unbelievable, like a horror story – violence, bad types, drug dealers, suicide attempts – incredible stuff. It's amazing she's alive. She could have got killed or committed suicide several times. Our whole lifestyle is completely stable now. Now we enjoy her visits.

The father of one young man, who spent two years in hospital prior to the program, was relieved when his son was chosen to participate because he and his wife could no longer cope with him at home:

> It was too much pressure having him at home. I'd get a lot of fat lips and black eyes. He couldn't sleep at night; he'd walk the walls. And because of the situation we'd be uptight and then the more uptight we'd become, the worse he got. [HASI] takes the pressure and the worry off us. It wouldn't have worked anywhere else. … They tried all different places; he hated them. There was nowhere to put [him].

For the mother of a client who has only recently joined the program, HASI has changed her moods and her life: 'I think for me to not have to look at her depressed

and sleeping and not wanting to do anything that all the time is better for my mental health. … Our social lives are different as well. … I felt like I have a life again'.

Not all clients have experienced positive changes in family relationships. Some relationships continue to require ongoing work to strengthen and maintain them. Other clients still have problematic relationships or minimal, if any, contact with family. For some clients in rural areas who were required to geographically isolate themselves from their families to be involved in HASI, this has affected both their relationships and their motivation to be actively involved in the program. One of the clients came from a nearby country town where he had been living with his elderly parents. At fifty years of age and with an intellectual disability, despite ASP explanations, he does not understand why he is required to live in another country town away from his family and friends. A key worker in this area reflected, 'I don't think we should be taking these people away from their families. Loneliness and isolation is a major problem for these [people]'.

Loneliness

The importance of strong community connections should not be underestimated. SANE Australia reported a 'significant association' between an individual's participation in the community and 'feeling less lonely and being able to manage one's illness better' (SANE Australia 2005). Loneliness persisted as a problem among the HASI group. Over half (54 per cent) of respondents (n=75) in the second round of interviews reported feeling lonely. This is far higher than the general population, where approximately 10 per cent feel similarly. However, compared to a SANE Australia study of 258 consumers, HASI clients were proportionately less likely to report being lonely. Two-thirds of the individuals in the SANE research reported 'feeling lonely often or all the time' (Sane Australia 2005).

For the HASI clients interviewed twice, the reported incidence of loneliness had increased slightly. In Phase I, 25 out of the 51 clients who responded to this question in both interviews stated they were lonely in the first interview, compared to 29 clients in the second. This increase was not simply an additional four clients feeling this way. The majority of clients remained consistent in their reporting between interviews. However, five of those who were lonely at the time of the first interview were not during the second. This can be accounted to improved friendships, a new intimate relationship, better relationships with family members and/or increased involvement in community activities. Ten clients did not report being lonely in the first interview, but did so during the second. It is unknown why this occurred for two clients, but the rest could be attributed to the following factors – two clients had relationship break ups; three felt further removed from their families who lived some distance away; a woman was refused co-tenancy with her partner; another was moved to overcome vulnerability from neighbours but this decreased his contact with other people and the remaining person's mental health had improved, which gave him greater desire to improve his social activity.

Thus loneliness was largely contingent on a person's involvement in other spheres in the community and their support networks. Case managers did not generally believe loneliness was an outcome of the HASI set-up, rather a widespread experience: 'Loneliness is a problem among a lot of people. … For the clients that I work with,

loneliness is always an issue, but I don't think the structure of the program has contributed to the loneliness in a significant way'.

In summary, improvements in community connections have been the most striking outcomes in Phase II of the evaluation. Progress has been made for most clients in relation to community participation, work and education, friendships and family relationships. Successful incremental steps for other clients have included learning social skills through contact with HASI workers and other HASI clients.

2.6 Tenancies

At the time of the first evaluation, 85 per cent of HASI clients for whom we were provided with housing data had maintained their first tenancy (62 of 73 individuals). Between the first and second interview this remained fairly consistent. Eleven clients (12 per cent) similarly ended their tenancies. As a proportion of all clients remaining housed by DOH or a community housing provider, however, there was slightly less turn over in the second Phase of the evaluation; 88 per cent maintained their tenancies.

Seven of the clients with terminated tenancy agreements exited the program. The other four were rehoused. Of the seven clients who exited between Phase I and II, one client was deceased and four moved to other secure housing, described below. One of these clients, whose tenancy was terminated as a result of 'noise and nuisance' complaints, continues to live in the community housing provider's HASI designated property until she is provided with a property by DOH. She is currently on the priority list and the ASP and community housing provider believe a property will be provided within a short time frame. Two have moved to group homes and one has returned to live with her partner and children in the family home. The final person moved from a rural area to a metropolitan area. The person without secure housing is currently hospitalised.

Three of the other four clients who were rehoused during this period were provided with more appropriate housing. A client in a rural location moved into a head leased villa from an old DOH flat. He was living in the one bedroom DOH accommodation before he started the HASI program. A client in another area was moved from his tenancy, which was scheduled for demolition, into a new capitally owned townhouse. The third client was relocated after exploitation from neighbours. The fourth client who was rehoused had her first tenancy terminated because of 'noise and nuisance'. Her neighbours made numerous complaints against her, but she was mistakenly placed, with her two-year-old daughter, in an over 55s complex. She continues to be involved with the HASI program and has been relocated to a two-bedroom house in the same community, which has enabled her to maintain her relationships in the area. The housing provider and the client reported no problems with neighbours or her tenancy since she has moved. This client was appreciative of the 'second chance' given to her by the housing provider.

A few clients were interested in moving and generally housing providers were receptive to such requests. One woman submitted a transfer application because she wanted to move closer to her friends and services, such as the local hospital. According to the housing provider, her application has been informally accepted. A client in another area was disgruntled with his flat because of the heat and noise and

applied to move. While the housing provider was open to discussion, they decided to leave him in his current flat because of his history with burning food. They argued that his set of flats is one of the safest they had in regard to fires.

Although there has been little movement among HASI clients, throughput is an issue in regards to what happens to the property after an individual exits the program. If an individual leaves the program and remains in their community housing tenancy, effectively a HASI place is taken up until such time as the person can become a regular housing tenant. Most DOH and community housing providers have a current waiting time of between four and five years. An additional problem occurs if an individual returns to HASI after exiting and their housing has been reallocated to a new HASI participant. The case manager of one client who exited and returned to the program expressed her concern over the unit block her client is currently living in. She is listed for priority housing, but in the meantime she is privately renting a bed sit where 'she has been taken advantage of'.

In summary, most clients have remained in stable housing, moving only because the housing was inappropriate to their needs. A few other clients have either left HASI or moved locations. Policy decisions about managing transition to other housing if a client leaves the program has not been clearly communicated to all stakeholders.

Compared to other tenants with complex needs

Housing providers were generally positive about their experience with HASI clients. Only one housing provider maintained that the HASI tenants were more difficult than their general tenants.[10] This housing provider has had long-term problems with one of their eight tenants and the manager argued that proportionally 'we wouldn't expect one out of eight of our "normal" tenants to have severe property issues'.

Other housing providers believed HASI tenants were comparable to their general clients. Yet when comparing general tenants with complex needs, housing providers were very favourable about the HASI model. HASI residents were thought to be 'easier to deal with because they've got the support workers behind them' (community housing provider). Another community housing provider maintained the HASI clients in her area were as good as some of her general tenants 'who only have 12 monthly inspections' because of their standard of property care: 'The HASI program people are great, they take pride in where they live'. The minimal problems the DoH has had with HASI tenants in one area is evident in the manager's comment, 'You wouldn't even know the HASI clients are there'. While this site has had complaints about two of the tenants and one client recently burnt down his property, the HASI clients are not perceived as difficult. The area manager explained:

> Given that the supports are there, there probably isn't a huge difference because a lot of our clients have complex needs or significant support needs and often the problem is when you can't get the supports in place. That's when it breaks down. The support

[10] While all nine housing providers were interviewed in the second Phase of the evaluation, only six returned the quantitative questionnaire. Of the six, four stated that HASI clients were not more difficult that their generalist tenants, one felt HASI clients were more difficult and the other was unsure.

> is guaranteed, that's what makes it work. Our future direction for housing is about increasingly targeting public housing to people most in need. … We'll be targeting people with complex needs. The positive thing about HASI is that it shows our staff that you can manage that if the right supports are there.

Most clients were overwhelmingly positive about the housing provided and the opportunity given to them. A client, who described himself as 'virtually homeless for two and a half years' prior to the program, felt that obtaining his own accommodation was one of his only achievements in life. 'I've got no job. I've been out of work for eighteen years. I have no money, no degree, but I've got all this', he said proudly pointing around his flat. Another client felt her mental health had improved as a result of a change in medication and having her 'own space'.

In summary, the findings and literature emphasise the importance of independent housing. This is also corroborated by the Royal Australian and New Zealand College of Psychiatrists who 'stress that the social environment of people with schizophrenia needs to be improved' through housing support and other programs (McGorry 2003).

Tenancy problems

While few clients had their tenancies terminated, there were a number of tenancy problems in various sites due to the clients' vulnerabilities. Tenancy problems ranged from complaints from neighbours regarding noise and nuisance to rental arrears, poor property care and co-tenancies. These problems are described below, but they remained a minority of cases.

Co-tenancy

Allowing others to move into the property was an issue experienced across most sites. There was, however, a distinction between individuals sharing with family, a partner or a close friend and those who continually allow others to move in and then collect rent. Five clients in six sites frequently had unauthorised co-tenancies. A key worker of one of these clients explained that even with strategies to decrease this behaviour it continues: 'He will often have people stay or move in because he can get rent out of them ... You get rid of one and then there is another one. … We actually locked his spare room door. It doesn't stop, because he's got the lounge and the garage, but it has helped'. While some of the 'unofficial tenants' often pay rent, clean and/or buy food, others do not and may present greater problems, such as neighbour complaints. Two clients within one area had complaints made about them that were, according to the housing provider, directly in relation to their 'illegal' tenants.

Even for clients who have family and friends move in, the extra housing costs can present financial difficulties for the tenant. The number of people within a house affects water, food, electricity and phone bills. After moving in, the family of one HASI client convinced her to remove the STD bar on the telephone and subsequently spent $700 on telephone calls. The HASI resident cannot make any telephone calls from her home until she pays off this bill.

While the HASI program provides housing for individuals only, there are three exceptions where people were living with others on a full-time basis (two with children and one with a partner). The Service Level Agreements state that the housing

provider is responsible only for the HASI tenant and not any co-tenants. This is not an issue in regard to children, but it presents difficulty for housing providers when dealing with partners as co-tenants. The housing provider of the client whose partner has moved in permanently is unsure how to deal with the situation. At a HASI governance level, the partner should be either asked to leave, or according to tenancy law, if the partner stays, he should be placed on the lease. This presents a quandary for the housing provider in their attempt to aid the HASI client to maintain their tenancy. According to the ASP personnel, case manager and housing provider, this co-tenancy is beneficial. The partner is assisting the client to maintain her tenancy and her mental health has improved. Should the housing provider formalise the arrangement and place the partner on the lease and the relationship breaks down, the HASI tenant could be at risk of losing the property. A manager of a community housing provider explained: 'Under the Residential Tenancy Act you can't put in a clause that says, "If you and your partner don't get on, your partner is the one who has to move out".'

There is clearly an issue among a minority of HASI clients of loneliness and wanting to live with someone else, rather than alone (30 per cent of the second cohort). All clients who expressed the desire to live with someone else, except one, nominated a person they were close to or would potentially be close to, such as a future partner. The following sentiments were shared by a number of clients: 'I still get lonely. I wouldn't mind someone being there when I wake up in the morning. I wouldn't live with a flat mate, but I'd like to live with a partner'. With the exception of one client, HASI tenants who wanted to live with another person did not want to live with a flat mate, another HASI tenant or in a group situation. Overall, clients appreciated and valued their independent living arrangements, with 64 per cent of clients enjoying living alone.

Time had assisted four clients to adjust to living alone; but another four, who had liked living alone at the time of the first interview, disliked living alone when asked a second time. Many HASI clients had shifted from living in a co-tenancy environment, such as with family or institutions, to living alone. While many did not have stability in their housing situation prior to the program, they had company. The majority of clients are currently happy living independently, but as increasing numbers of HASI clients have relationships, the issue of co-tenancy with a partner should be addressed at a governance level.

Rent

The majority of clients (83 per cent) who were provided with tenancy data on (n=41) have continued to regularly pay their rent. Only 17 per cent (seven clients) have been in rental arrears from between two and five weeks, with an average of 3.3 weeks. This has rarely been at the expense of the housing provider, with clients in all except two cases making up the difference. One housing provider lost $123 and the other $294. One client became four weeks behind in her rent because she moved to another country town, stopping Centrepay before she left. She is continuing to catch up with her missed rent. The rent of another HASI client is often late - up to eight weeks at one stage – but this is because one of her relatives organises her rent payments. The minimal problems with rent are largely because most clients either use Centrepay or are with the Office of the Protective Commissioner.

Noise and nuisance and other neighbour complaints

Eleven clients have had complaints made against them by neighbours. Complaints were predominately related to noise and nuisance (four) or property damage/poor property care (five). The other two clients had complaints made against them for having unauthorised people staying for extended periods of time. Only two of the eleven clients with complaints against them had their tenancy terminated as a result. As noted above, one has since exited the program and the other was rehoused.

ASP personnel occasionally play an interventionist role before a neighbour makes a formal complaint to the housing provider. The manager of one ASP explained that they 'maintain the community relationships' in regard to one client whose neighbours complain about his 'music or TV blaring at top decibel in the middle of the night'.

Tensions between HASI clients and neighbours are not merely aggravated by the behaviour of HASI tenants. Neighbours can also create difficulties for some clients. In a rural area a neighbour complained on numerous occasions about the 'noise' a HASI client was allegedly making throughout the night. The community housing provider advised the neighbour to call the police when this noise occurred, but police visits found the noise was largely coming from another property across the road. To the client's relief, the complaints have since stopped.

In some instances, neighbours placed HASI clients in precarious situations, reinforcing the vulnerability of some tenants. One client was exploited for food and cigarettes till his brother threatened the neighbour. Another client in a similar situation had to be relocated. While an ex-HASI tenant has returned to the program, she is yet to be rehoused by the community housing provider. Consequently, she is living in bed-sit style accommodation in a unit block with 'bad influence' neighbours (key worker). While she was coping well with the presence of drugs and alcohol and the exploitation attempts of neighbours, when her key worker returned from a holiday recently 'all her stuff had gone and she was in debt'. Although this client is very vulnerable, she values the social life she has with her neighbours.

Property care

With the support from the ASP, most HASI clients care for their property well. The clients in one area are known to be 'house proud' (ASP manager) and the community housing provider now only completes yearly inspections. Only one housing provider was generally negative about the property care of its clients. The manager of one complained, 'This group of tenants is responsible for the highest level of property damage seen by our organisation … Not only does it cost us to repair the damage, it costs us staff time to deal with it'.

Four sites have significant property care issues with one HASI tenant. One of these client's key workers indicated that he was making small improvements in maintaining his house in a clean and tidy condition and that he was conscious of the need to do so. However, his tenancy is under threat because of his poor property care. The housing provider indicated that they were still working to save this tenancy.

The case manager, ASP and housing provider all acknowledged the damage that another client has done to his property. His case manager reflected, 'It's sad to see a

virtually new two-bed unit reduced to the state it is in' (case manager). The housing provider discussed some of the damage to his property: 'There were holes in walls and cigarette burns in the carpet, [and] the shower was black'.

The ASP finds it difficult to deal with this client in regard to his property care because of the contradiction between his ability and insight and his motivation. His key worker explained, 'He can clean, he just chooses not to. So I'm not going to go there and clean for him, I'll help, but I'm not going to do it for him'. He has insight because when he had an inspection he opened the door and immediately said, "Don't worry I'm going to pay to get the carpet cleaned, I'll replace this that and the other".' This client has the funds to outsource cleaning, but this presents many risks:

> I would be the one who facilitated the cleaner and I would feel responsible. Cleaners are often women and to have a woman there on her own is a problem, especially if his mates are there and they've been drinking. I'd be really nervous. When we had the major clean before there were three of them and it took them hours – they were so grossed out. I ended up having to stay there the whole time because [the client] was drunk and other guys kept coming in.

This client used to clean with his mother for a living and therefore is capable of cleaning. He is also very aware that he has to replace the carpets and other damaged property within the house, but he continues to refuse to clean his property. This threatens the stability of his tenancy. A client in another area similarly has insight into the state of his property because if he knows his case manager is visiting he will clean up the unit.

Since HASI started, fire damage has been a problem with two clients in different areas. The housing provider of a client with pyromania placed her in a block of units planned for demolition. She burnt down that property between entering HASI and the first evaluation Phase, but has maintained her second home and reduced her arsonist tendencies. A client in a rural area destroyed his DoH unit after setting it alight just prior to the second Phase of the evaluation, but the department were fairly unperturbed: 'That's not a huge drama. What surprised the team was how easy it is to deal with those sorts of issues once the supports are there. When that happened [the ASP manager] felt bad and I said, "Look it's not the first time it's happened, we've got 130,000 properties, occasionally they get burnt down"' (Manager).

In summary, the tenancy problems experienced reinforced that the majority of clients have maintained stable housing, with minimal problems with neighbours. Some tenancy problems were due to inappropriate housing, placing the clients at risk from neighbours and members of the public. Other problems were similar to difficulties experienced with other social housing clients.

2.7 Summary of the Successes, Struggles and Exits

It is very difficult to clearly understand cause and effect and appropriately attribute certain characteristics or variables to an individual's outcomes. A case manager was very positive about the 'remarkable gains' her client had made in HASI, but she was unsure 'what HASI has done for her and what she's done for herself'. While no

conclusive comments can be made regarding cause and effect, for many clients there is a correlation between participating in HASI and experiencing positive outcomes.

Across the various stakeholder groups there was general agreement on the key attributes that make an individual more likely to have a successful HASI experience – cognitive functioning and psychological readiness for change and to accept help for this process.

The HASI program involves intensive support. As such it can feel like a very intrusive program. If a client is not able to accept such support 'as good as [the ASP] are, the rest of it just doesn't seem to work' (case manager). Willingness to participate and an understanding of what this entails has proved critical in the outcome of some clients. The degree of psychosis and the level of insight into symptoms can also be instrumental.[11] A number of ASP and AMHS personnel reflected on these prerequisites. The ASP manager in one area regarded clients' 'mental state when they came out of hospital and how they've sustained or not sustained that mental state' as a major determinant to their success in the program. By maintaining a sound mental state, most clients in this area were willing to actively participate in the program and as such are ready to move to the 'next level'. One AMHS manager placed less importance on mental illness and greater focus on the impact of motivation: 'History is a great indicator of the future, but people have the ability to learn and grow. If they have the desire and motivation, then the rest of the issues are workable'.

Client support networks, the type and nature of support they receive from the ASP and the voluntary aspect of the program were also felt to be crucial to client success. Some ASP personnel believed previously institutionalised clients and those with drug and alcohol issues had made less progress than other HASI counterparts.

Degree of psychosis and cognitive functioning

While the degree of psychosis was not measured as part of the evaluation process, data on diagnosis was collected. Clients with schizophrenia were slightly more likely to have lower functioning scores than their counterparts with other diagnoses.[12] The mean GAF score for individuals with schizophrenia was 57, compared to 65 for those with other diagnosis.[13]

Cognitive functioning affected HASI clients' support needs. On average, clients with an intellectual disability were more dependent on ASP support for most living skills – cooking, cleaning, shopping, laundry, transportation, budgeting, banking, making appointments, taking medication and accessing community services – than those without this type of disability.

Accommodation history and independence levels

On average clients who were previously living in hospital, residential rehabilitation centres or group homes had made smaller gains in terms of their skills acquisition and

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11 NSW CAG have developed an insight model (NSW Consumer Advisory Group, 2004: 16-17).

12 This was based on only those clients who we received diagnosis details and GAF scores (n=85).

13 The average scores deviated slightly from 54.4 (schizophrenia) to 57.7 (other diagnoses).

sense of independence.[14] On entering the program, those who had lived in either of these situations were more dependent than their counterparts who had come from other residential settings. Across nine of the fourteen living skill measures – bathing/showering, diet, exercise, cooking, shopping, budgeting and administering medication – dependence was proportionally higher as a group for HASI clients who had come from hospital, rehabilitation centres or a group home (n=34).[15] In regard to assistance with diet and cooking, clients from these locations were more than twice as likely to be fully dependent or dependent more than half the time on their ASP. In the other six living skill areas – accessing community services, dressing, cleaning, laundry and transportation – there was minimal difference between the dependence levels of two groups (between 0.6-2.3 per cent).

By the second Phase of the evaluation, while both groups showed improvement, a greater proportion of those who had previously lived in hospital, a rehabilitation centre or a group home remained fully dependent or dependent more than half the time on the ASP. Individuals in this group were more likely to be dependent across thirteen of the fourteen living skill measures (using transportation was the only exception). They had, however, decreased the gap between themselves and their counterparts who were living in other settings prior to the program.

Substance use

There were some prevailing negative opinions among a minority of key workers about accepting clients with drug and alcohol disorders into the HASI program. Yet client outcomes reveal that HASI can have a positive affect on those with drug and alcohol issues. As mentioned in the client demographic section of the report, almost half of all clients who started HASI with a substance use disorder (15 of the 33 clients) no longer had drug and alcohol issues by the second Phase of the evaluation.

One of the fifteen clients who had overcome their substance use problems has been free of drugs and alcohol for almost eighteen months and his mental and physical health have benefited considerably. Unfortunately, substance use continues to be problematic for eighteen clients. For many this involves alcohol and drug abuse, but alcohol use was more readily discussed among the clients.

One woman has realised that she needs to keep busy otherwise she binge drinks. While this habit has decreased with HASI assisting her to participate more in her community, she continues to binge drink about once a month. Another client's alcohol consumption increased dramatically between interviews. This client has since been given a new case manager to try and assist her to deal with her alcohol issues.

Alcohol abuse is also a problem for a client in another area. His case manager believes that 'until he addresses his alcoholism, maybe a great deal isn't going to change'. Although this client recognises his alcohol abuse is unhealthy, 'the addiction is great' and it impedes him from moving forward in life. His case manager explained:

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[14] This is based on data from the CID. The conclusions are therefore drawn from population data.

[15] Clients participating in Phase II of the evaluation are used here.

> It's really hard for him one day to the next just to live life. … I'm surprised the alcohol hasn't impacted more on the mental state. Over a period of time it's no doubt affected his cognitive functioning. … He has goals and wants to do things, but the alcohol plays a part in stopping him.

While a number of key workers felt he was inappropriate for the program, the ASP manager believed that despite his refusal for regular contact with the key workers, HASI has assisted him. She focused on his strengths:

> He hasn't been arrested, he's only had one admission to hospital, he has maintained his tenancy, which is the longest he's ever lived anywhere, apart from home, … [and] he hasn't really lived at home since he was eleven. It's not a negative at all. It's only a negative if we think we can't do anything about his drug and alcohol issues.

This manager is astute because attitudes can either help facilitate or work against 'optimal care' (Todd, Sellman et al. 2002: 792). That is, the attitudes of the service providers may affect the long-term outcome of clients with substance use disorders, despite the support services available.

Appropriate support and rehabilitation plans for HASI participants with drug and alcohol disorders, however, should not be overlooked. While there are drug and alcohol rehabilitation services, there are fewer options for individuals who also have a mental illness. There is also little continuity of service within the mental health system for people with this type of dual diagnosis. As a case manager of one HASI client explained,

> We shouldn't just put people in hospital to dry them out. We should have a plan for the whole cycle. … Doctors in the psych ward need to take some responsibility to manage these clients. … We need to come up with a care plan to give someone [with a substance use disorder] the opportunity to reach their goals. … We have to get programs for these people. We shouldn't be discharging them and then not worrying about [their substance disorders].

Struggling clients

Three of the above clients with substance use issues are at potential risk of leaving the program. The woman whose parole is in jeopardy is perhaps at greatest risk of losing her place within HASI. Another female's future position within the program is also questionable. Her case manager felt that the last six months for this client have been 'all downhill'. Between the first and second interview, the client reconnected with friends and family who supplied her with drugs, she discontinued her studies, was admitted to hospital five times, continued to be co-dependent on an unhealthy relationship and disengaged from ASP support. This client left the HASI program for a short period and has since requested to return. With an agreed support program in place, it is likely that she will be permitted back into the program.

A male client with significant alcohol problems is at risk of leaving the program. He has largely disengaged from ASP support and voiced intentions to leave HASI. Despite his precarious position and his lack of positive change over the last six

months, his case manager hopes he remains in the program because it has assisted him to maintain a stable mental state, which has kept him (aside from one admission for alcohol withdrawal) from hospital.

Other clients have struggled over the past six months, but at the time of the interview, ASP and AMHS support had ensured their position within the program remained stable. The AMHS and ASP in one area have focused on 'containment', rather than rehabilitation, in regard to one client. According to the AMHS and ASP manager, since his involvement in the program, the impact of his drug and alcohol, personality disorder and aggression issues on the community have decreased.

One client has struggled in the period between interviews with debt to drug dealers, the loss of many of her possessions (through either exploitation or selling) and increased presentations to accident and emergency at the local hospital. Her case manager acknowledged that she is 'very disabled by the psychiatric stuff', but she maintains that without HASI her client would be presenting to hospital more frequently and having greater problems functioning in daily life. In this situation, key worker and case manager have successfully worked closely together to prevent, intervene and respond to the client's crises.

The role of the ASP and AMHS has been especially important in situations where clients have had negative experiences. One woman with a gambling problem has experienced problems managing her money and has both exploited and been exploited financially in recent months. The ASP and AMHS have since worked with her on this area and she has since joined Gambling Anonymous and come under the Office of the Protective Commissioner. Another client, who was on parole, was charged with assault between the two evaluation phases. Despite the court case and the threat of losing access to his child, with the support of his case manager and the ASP, his mental health remained stable and he has since resolved to receive some anger management training.

Exits

Since the first Phase of the evaluation, seven clients had exited the program. Five sites experienced no exits in this period. Only one of the three rural areas had a client exit; the remaining three metropolitan sites experienced one, two and three exits respectively. Two sites had not experienced any exits since the start of the program and a third site's one exit was not driven by choice (the client passed away). Therefore three of the nine sites have maintained a stable group of HASI participants.

Of the exits across the sites, four were considered too unwell for the program; their mental health needs were found to be too complex for the support available. Two clients left primarily because they wished to relocate to other areas; one of these clients also disengaged from ASP support. The final client passed away in October 2005 from natural causes.

When the reasons for exiting are assessed the two key factors regarding success in the program – cognitive ability and willingness – become pertinent in a number of cases. According to the case manager of one of the women who relocated to another area, the program was not suited to her because of her complicated mental health state – very poor mental health, cognitive impairment and drug and alcohol diagnosis – and

her disinterest in actively participating in the support dimension of the program. Similarly, a woman left the program to live in a group home because of the extent of her disability and her desire to have 'everything done for her' (key worker).

The manager of an AMHS also believed poor psychological functioning coupled with a lack of willingness resulted in one client's 'failure' in the HASI program. The manager maintained that the 'capacity' of the AMHS and ASP to help bring about change was limited if 'people are poorly fitted into the program and if they're non-adherent, non-compliant or non-engaging'. Another stakeholder within an NGO also maintained that client traits resulted in an exit in his area. The client's drug and alcohol issues were believed to result in noise and nuisance complaints and resistance to support. Of concern, however, is the fact that this employee maintained no hope for the client while he was in the program, stating, 'we were pushing shit uphill'. While this client may not have remained in the program despite the attitude of the support provider, as mentioned above, attitudes can be instrumental in client outcomes.

In conclusion, the outcomes for most clients in this phase of the evaluation have continued to be positive. For some clients incremental steps towards improved wellbeing and participation continue to require intensive support from key workers. Exits have been appropriate where clients were unwilling to engage in the program because of the significant commitment it requires on their part to change their lifestyle.

3 Process and Governance

The second aspect of the evaluation is to review the process and governance of the program. This part of the evaluation addresses the question of whether appropriate and effective process and governance arrangements are in place to support the ongoing development of HASI.

Phase II of the evaluation provided staff and managers of the various ASPs, AMHS and housing providers with an opportunity to reflect on the present status of the initiative and changes since the first Phase of data collection. The following section explores the views and experiences of service providers involved in HASI, with particular attention given to the referral and assessment process; the operation and management of the ASPs; the operation and management of the AMHS; and interagency relations between ASPs, AMHS and housing providers.

Table 1.1 details the stakeholder cohorts. Of those consulted during Phase one of the project (other than clients), three-quarters were consulted during Phase II. As Table 1 indicated, the greatest proportion of staff turn over and redeployment was evident among the AMHS case managers (60 per cent).

The first report of the evaluation found that effective partnerships were being developed in most areas. The difficulties being experienced in some areas were mainly related to a sense that the partners operated with difference paradigms (eg. clinical versus social) and were unsympathetic in regard to the practical constraints of organisations (eg. negative views by ASP staff of the limited capacity of AMHS and consequent demands on its case managers; AMHS views of ASP staff as unqualified to work with their clients).

The second round of fieldwork revealed that the process of normalising the partnerships has progressed, with an overall increase in the acceptance of partners and the establishment of relationships between operational staff that underpin better collaboration. The problems that remain in some locations are also discussed below.

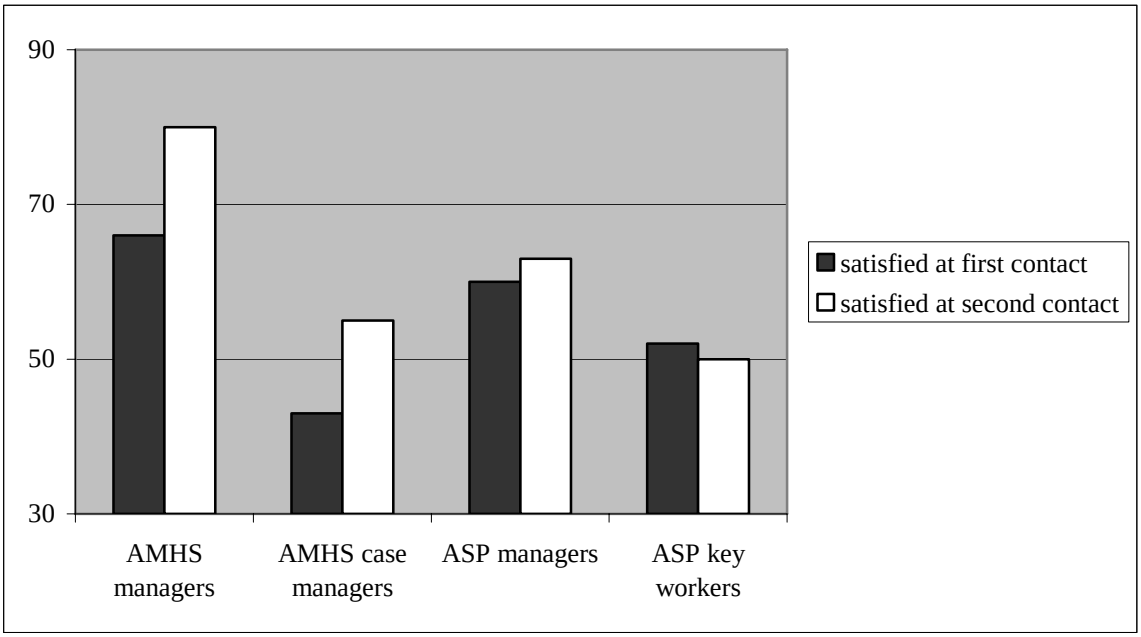
3.1 Referral and Assessment Process

Referral

Most referrals into HASI continue to derive from AMHS (85 per cent of those in the program at the second contact). Referral from other health professionals accounted for 13 per cent of the participants and 4 per cent from other sources.

AMHS staff expressed increasing levels of satisfaction with the referral process. Attitudes of ASP staff were largely unchanged. Many of those not directly involved in the HASI admission process were unsure (32 per cent of AMHS case managers and 24 per cent of ASP key workers). Figure 3.1 shows change in the percentage of stakeholders who expressed a satisfactory or very satisfactory view.

Figure 3.1: Comparing ASP and AMHS Staff Satisfaction with Referral Process, Phase I and II, per cent



There was a general perception that the appropriateness of AMHS referrals to HASI selection committees had improved over time, with better and more comprehensive information being offered on those referred and this allowing for sounder assessments. The appropriateness of referrals to HASI selection committees remains a concern for a minority of ASP staff and managers. Their perceptions, which have not been verified in the evaluation, included that:

- AMHS were 'off-loading' their difficult clients to the HASI;
- AMHS referrers were understating the level of difficulty of clients to improve the chances of their being selected;
- AMHS case managers were naïve about how the ASP might meet the support needs of those with very high and complex support needs; and
- With AMHS turn over, there is a continuous task in promoting the nature of the accommodation support provided by the ASP within the HASI.

Another problem is the client waiting list for HASI, which is considered by some ASP managers as the best measure of unmet need for the program. As the program has little throughput of consumers there is little incentive for AMHS staff to refer potential clients to the program when it is 'full', and as a consequence referrals are dwindling.

Assessment

Table 3.1 shows that the level of satisfaction for most AMHS and ASP personnel, with the assessment process has remained high.

Table 3.1: Effectiveness of HASI Admission Process, Phase II, per cent

	Excellent	Good	Average	Poor	Very poor	Unsure
AMHS managers (n=10)	40	40	20	0	0	0
AMHS case managers (n=31)	19	26	13	0	3	39
ASP managers (n=11)	18	64	0	0	18	0
ASP key workers (n=45)	18	36	27	4	0	16

Most judged the admission process favourably, recognising it as a positive consultative process between the ASP and AMHS. Reflecting on working relations with an ASP manager, for instance, one case manager stated, '[The ASP manager] appears to value our opinion'. Similarly, an AMHS manager said, 'We had some input into the scoring and some general conversation about who might do best out of the people they've ranked. Ultimately it's a good partnership.'

Housing providers are also represented in selection committees in all but one case. In this one situation a housing provider is excluded from the committee because of historical conflicts around the selection of clients. This continues to cause tension between the partners. Mainly, though, housing providers express an interest in the selection committees but do not see their attendance and input as necessary (e.g.: 'we appreciate that the assessment is about the support needs of the client … we trust our partners; they are the gatekeepers'). In one region the selection committee has established a quorum policy, that all three partners are represented or the meeting does not go ahead - this in response to the housing provider's unwillingness to attend.

Consequent to the maturing working relationships between the key stakeholders, and greater clarity around their roles, many participants were satisfied with the thoroughness of the assessment process. It appears that valuable lessons have been learnt though the course of HASI and assessment processes have been fine-tuned to ensure compatibility between client needs and the support offered by the program. For example, one ASP key worker said, 'We're big on getting clients with insight and who want to engage with the service, we are targeting the right clients, they all have lots of potential', while a AMHS case manager stated, '[At the beginning] they took too many hard cases – most were young people under 25, they took on a lot of hard cases … they've got a much more varied group now'. Assessment processes were seen to be sound where client outcomes were positive, while clients' poor wellbeing suggested that the assessment process deserved greater attention.

While most ASP and AMHS staff were positive about the selection processes some remained critical and typically these were ASP staff. Their concerns included:

- The assessment interview lacks thoroughness and comprehensiveness, with limited information about clients' mental health issues and/or skill capacity; and
- There were limited opportunities to gauge clients' motivation level, 'readiness for change', degree of vulnerability and the likely impacts of their friendship and support networks.

Some ASP staff held the view that HASI was not suitable for people with intransigent substance abuse issues or intellectual disability, though the evidence suggests that people with these characteristics are among those who have benefited the most from participation in the HASI.

One ASP manager was adamant that current protocols around the assessment of clients for HASI were adequate, attributing supposed difficulties in other sites to an inability to adhere to the selection criteria of HASI.

> To be honest quite honest with you, I think lots of the clients in the HASI program are in there inappropriately … younger clients … in the HASI program ... it was designed for clients that have a long-term mental illness, significant history of tenancy failures … We don't have any dramas with [our clients] at all. They're very appropriate. They're all chronically mentally ill, they've all come with a number of hospital admissions, they've all had failures in tenancy – that's what we've looked at and that's what HASI is about.

Many ASP and AMHS personnel stressed the importance of a good match between clients and their support workers. Success is not dependent solely on client attributes – but also those of support staff and therefore that match is important to consider from the very beginning, in the selection process.

3.2 Accommodation Support Providers

As HASI has developed the ASPs have implemented changes in the operation of the program to facilitate greater effectiveness and efficiency.

Stakeholder roles

As relationships with partners have matured there has been greater clarification around the roles and responsibilities of each stakeholder – particularly the role of the ASP in facilitating psychosocial rehabilitation. One AMHS manager for instance, had observed significant change in the support offered to clients by the local ASP – 'they're getting better [at goal setting]. At first it was, "you must do this" … [But] it's a matter of helping them rather than telling them.'

There was also greater understanding around the parameters that surround stakeholder roles within the HASI framework. Considering her initial expectations of the local ASP, one AMHS manager stated – 'we had expectations that [support] would be happening daily. The face-to-face time is less than we expected as well.'

By the same token, others have observed gaps in the service provision of respective ASPs. One case manager for example, reported, '[there needs to be] greater emphasis on clients engaging in meaningful daily activities, besides merely ADLs [Activities of Daily Living] and domestic tasks.' Another recognised the lack of ASP support in the evenings, 'there are increased risks of self-harming due to this service gap.'

Since the first Phase of the study, it appears that ASP personnel have a relatively greater understanding of their role. This was particularly important around matters like medication surveillance where, in some sites, the function of key workers and case managers was somewhat blurred. As one ASP manager explained, 'we might prompt people … but it's the mental health service's responsibility to follow up … it's one of those grey areas that sits 90 per cent with Health and we might pick up the odd 10 per cent here and there.'

Professional relationships with clients

In most sites, key worker and client relations have continued to strengthen. As one ASP manager explained, 'we've probably got to know the clients more and got to know what they do and don't need.' There was greater familiarity with the needs of individual clients and the strategies that were most appropriate to meet these needs. In relation to one client, a key worker observed, '[she] is more comfortable with us and tells us about her appointments.'

Some key workers spoke of an improved ability to identify and attend to the idiosyncratic changes in client wellbeing – 'it's more fine-tuned … a solution-focused approach seems to work for my guys.' Others were relatively more aware of the investigative endeavours they had to undertake to ensure a holistic view of a client's wellbeing – 'I'm more cautious about trusting what clients say … Everything is double-checked. Like I have more contact with employers to see how the client's going.'

Clients were generally content with the supportive efforts of their respective ASPs. Their satisfaction remained high, with 90 per cent saying that they were satisfied or very satisfied with ASP support. Most key workers were regarded as helpful, friendly and accommodating. In reference to one key worker, a client remarked, 'he taught me how to use the washing machine … They're starting to come round more often now … That's a good thing … At least one agency cares about its consumers.'

Some key workers found great benefit in visiting clients in an array of environments, including the workplace and social events. Such interactions allowed them to learn about the client's skills and needs from a different perspective.

Support plans

With greater experience in the operation of HASI, some ASPs have changed their policies, adopting more structure to guide service provision. Key workers spoke of Daily Support Plans with designated visit times and well-defined procedures. Describing the organisation of support provision, one key worker noted, 'we've got our weekly planner and we run a diary.'

The importance of structure was observed by a number of ASP managers and key workers. Structure, particularly when articulated in organisational protocols, eases the management of the agency and facilitates consistency in service provision. One ASP manager stated, 'they have to remain structured to a point because otherwise … staff are running around and chasing their tails … but there will always be some flexibility in the case of clients in crisis or medical appointments or outings.'

However, another ASP manager said that the innovative model of HASI necessitates HASI-specific protocols. Although an ASP may provide other supported accommodation programs, like conventional group homes and have existing policies and pro forma for these programs, these were generally inappropriate for the HASI model.

Structure was complemented by an appreciation for flexibility and creativity. Given the capricious nature of mental health, and the sometimes-chaotic lifestyle of clients, a number of key workers said that it was imperative that they adopt a somewhat ad hoc

approach when working with clients. As one key worker said, 'you can't treat them like a schedule, you need to treat them like a human being … you need to walk a wide bridge as a key worker.' Another key worker who said that it was not always possible to develop support plans with clients shared this sentiment. This in turn diversifies the working day for most key workers; one for instance, stated, 'we pick up a lot of extra responsibilities, which are conveniently covered in our job descriptions under miscellaneous duties.'

The flexibility of the ASPs was an attribute often appreciated by the AMHS personnel. Of case managers surveyed, 88 per cent said that they were satisfied or very satisfied with the supportive efforts of respective ASPs. Understanding that client issues were sometimes complex, case managers from a number of sites valued the ability of key workers to accommodate the changing needs of the client.

Geographical distance between the ASP and the clients it supports can sometimes limit the flexibility of service provision. Some key workers from metropolitan sites said that travel to clients' homes consumes a great deal of their working day; this was a particular problem for part-time personnel. While client homes within the rural sites were generally close to the respective ASP offices, extended travel time was an issue when clients were temporarily hospitalised. One client for instance, was hospitalised some three hours from the ASP office. Consequently, a one-hour visit with this client consumes an entire day.

Theoretical framework of service provision

With the evolving nature of service provision comes a degree of ambiguity around the distinction between psychosocial rehabilitation and disability support.[16] Several key workers expressed a sense of uncertainty about their role in supporting clients with daily affairs and personal development. While some acknowledged that, 'you need both', it was sometimes difficult to balance an approach that facilitated empowerment,[17] with one that was firm, if not directive. Yet, most importantly, this balance needs to suit the requirements of the individual client. As one key worker said, 'it is difficult to balance freedom with an assertive approach.'

This difficulty was acknowledged by a number of AMHS personnel. One AMHS manager for instance, appreciated that the tension between psychosocial rehabilitation and disability support is an inherent part of the HASI model, particularly given the chronicity of the mental health issues experienced by clientele:

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16 Client independence/dependence on ASP support with activities of daily living is explored at 2.4.

17 We have used the National Empowerment Center's broad definition of empowerment, which includes some or all of the following aspects: having 'decision-making power', 'access to information and resources' and 'a range of options from which to make choices (not just yes/no, either/or)'. The Center also includes another twelve aspects that can contribute towards feelings of empowerment, such as 'assertiveness', 'a feeling that the individual can make a difference (being hopeful)', critical thinking, 'learning about and expressing anger', 'understanding that people have rights', 'leaving skills' and/or 'increasing one's positive self-image and overcoming stigma'. For the full list see Chamberlin, 2006.

> [ASP] staff are going to come along and encourage them to take medication, and do the shopping, washing and cooking. That is likely to cause a reaction; to press buttons. If I had someone do that to me, it would press my buttons. Even if I didn't think I needed that, or even if I did think it was better for me, it would piss me off! … An inevitable part of working with people with mental illnesses is this boundary of responsibility. We have to learn where it is and the only way you learn where it is by approaching it. That's a valuable learning experience for the client and the staff.

One case manager expressed the concern that because of time constraints, expedience may triumph over empowerment. To get clients' chores completed, for instance, some key workers may find it easier to adopt an assertive approach.

ASPs have an explicit role in empowering clients. There is some evidence that this is not universally underpinned by management practices. Staff in one area felt that they were often encouraged to perform tasks for, rather than with their clients. Some clients regarded the support as intrusive and invasive. Describing a key worker, one client stated, 'she's pushy! … She comes in and puts all my things away! She clears away the bench – maybe I want it like that! … My whole life revolves around housework … There's no chance to have a nervous breakdown!'

Management

As Table 3.2 shows, recruitment and selection of staff continued to present a medium level of difficulty for ASP managers. Training was identified as slightly difficult, followed by staff retention. Occupational health and safety and supervision were considered to have the lowest level of difficulty.

Table 3.2: ASP Managers' Level of Difficulty with Human Resource Management, Phase I and II

	ASP managers mean score*	
Level of difficulty with	Phase I (n=10)	Phase II (n=11)
Recruitment and selection	5.4	4.0
Training	3.5	3.2
Staff retention	2.0	2.7
Occupational health and safety	1.6	2.2
Supervision	1.3	1.4

Note: * 0 no difficulty to 10 high difficulty

Several factors were implicated in staff turn over: the low pay, rostered hours, newness of the services, the match between personnel and client needs and the increased employment opportunities that become available to experienced staff. Vacant positions placed greater pressure on remaining staff in some locations, increasing their workloads. Managing continuity of support to clients is a challenge when staff leave and are replaced. In some cases clients had had several changes in key worker.

Some ASPs have adopted strategies to prevent key worker burnout. These include regular social gatherings to facilitate team building and alleviate stress. Other strategies utilised by ASP include the rotation of key workers to get a better fit with clients and greater use of informal debriefing sessions when required. Within some

ASPs, informal debriefing opportunities for key workers were available not only with fellow key workers, but also with senior personnel. This suggests that while management structures within an ASP may provide role clarification, they need not divide personnel.

Training

Staff training continued to be a major priority within ASPs, particularly in those sites with a higher number of staff changes. Some of the ASPs have responded to these needs by accessing external opportunities for professional development; this includes those offered by DoCs and the local AHS. In-house training has also been conducted, as well as the use of expert guest speakers. Most staff had access to training in the six months between contacts. Many expressed a desire for more training opportunities.

Given the evolving nature of service provision, different training needs have also emerged. ASP managers, at the second contact, were relatively more aware of the skill-base and experience of individual key workers. They were also more aware of individual client needs and the approaches required to address these effectively. Further to this, enhanced recovery among some clients has given rise to new or different needs. As articulated by one ASP manager, 'it's only as time has gone on that we've seen who has drug and alcohol issues and we've realised that we needed to get on top of this.'

Some AMHS case managers suggested that key workers receive more training in the assessment and management of mental health issues as this would enhance their role in facilitating the psychosocial rehabilitation of clients.

Occupational health and safety

The evolving nature of service provision has also allowed for the greater identification and management of occupational health and safety (OH&S) issues. For instance, to ensure staff safety, one ASP has created the internal position of OH&S Officer. Another has implemented a number of new protocols, particularly during client visits. As the manager explained:

> We've got the mobile phone system where people always have a mobile … We've got a movement board where people write where they're going, what time they're due back. We've got a rule that if someone hasn't been back for half and hour, you ring them, check where they are.

More familiar with their role, some of the key workers also spoke of an increased understanding of OH&S issues – 'I'm more aware of them, like carrying a torch at night and being aware of where the car is parked in proximity to the client's home.' A few staff felt that their organisations were not serious about OH&S issues.

Policies varied between the ASPs around home visits by staff. One encourages key workers to visit clients in pairs. Some ASPs have identified situations when this approach should be taken, while others found it unnecessary.

Resource management

Across the nine sites, there was a unanimous desire for greater funds to enhance service provision. The management structures of the three ASPs vary in the degree to which managers exercise financial delegation at the local service level. This influenced the degree to which local ASP managers felt that they could shape their service to reflect and respond to local conditions.

There were typically few services within the HASI sites that supplemented the rehabilitative efforts of the ASPs. The response of AHS varies significantly from one site to the next in terms of the provision of social, leisure and pre-vocational programs, clubhouses and consumer and carer advocacy services. As discussed earlier, the availability of other State and Commonwealth funded disability support services also varies between sites.

In summary, the referral and assessment process has been refined. This has resulted in stakeholder agreement that suitable clients are entering HASI. ASPs have continued to adapt their support to improve client outcomes. Some ASPs have improved on and others continued to demonstrate their capacity to provide psychosocial rehabilitation. A few areas could benefit from consulting with an occupational therapist, or a similar specialist, to further develop key worker skills in facilitating independence.

3.3 Area Mental Health Services

Stakeholder roles

Since the initial Phase of the evaluation project, the support provided by the AMHS has undergone little change, relative to their ASP counterparts. Managers and case managers from the various sites continue to provide clients with clinical care. This chiefly involves the assessment of mental, physical and social health, the monitoring of medication regimes and the coordination of access to additional health and mental health services. It is important to report that, consequent to HASI, some case managers have greater opportunity to focus on their core business. The supplementary support provided by ASPs has alleviated tasks they would otherwise do. In reference to one client, one case manager stated, ‘I no longer have to provide him with transport.’ Similarly, an AMHS manager from another service remarked, ‘[that] has certainly been a benefit of [the ASP]’s role in providing support. Some of those clients weren’t going to get it – we’re not resourced to provide the services that clients should be entitled to.’

According to some case managers, the auxiliary services of the ASPs reduced the potential for mental heath crises among clients. The regular contact between client and key worker increased the likelihood that changes in wellbeing would be detected promptly. This opinion is reflected by an AMHS manager, who said, ‘instead of the crisis coming with a crash, there is a build up and there are more opportunities to provide intervention before things reach breaking point.’

Professional relationships with clients

While the type of support offered by AMHS may not have undergone significant change since Phase one of the study, the degree of clinical care provided to some clients has. During periods of poor wellbeing, some clients have required clinical care of greater intensity, while those who are relatively well have less frequent contact

with their case manager. Reflecting on the support offered to one client, a case manager remarked, 'I have minimal contact with her now. She comes in for her Depo once a fortnight and we have a long discussion about once a month.' Like their ASP counterparts, most AMHS respond to the changing needs of clients.

Most clients continue to express satisfaction with the supportive efforts of the case manager: 70 per cent of the clients were satisfied or very satisfied with the way respective case managers have supported them, similar to Phase one of the evaluation.

Further to this, three quarters of the clients were satisfied or very satisfied with the treatment received from their respective AMHS. More clients were satisfied or very satisfied with the accessibility of doctors, psychiatrists and mental health professionals (84 per cent) which compares favourably with 51 per cent at first contact.

Concerns about the services provided by case managers were also voiced by key workers. Some said that the approach of some case managers was too rigid. One key worker for instance, spoke of the 'forceful' manner of a case manager, which in turn, caused the client to feel 'powerless' in the management of his mental health – 'He's become distrusting of hospitals and the mental health workers and this is really difficult to rebuild.'

For one client with a primary diagnosis of an autism spectrum disorder, the role of the AMHS was somewhat contentious. Although ASP personnel were under the impression that the local AMHS were supporting this client, case managers suggested otherwise. They felt that the client was inappropriate for the mental heath service because his primary diagnosis is a neurobiological disorder. This situation raises an interesting dilemma, because despite its inclusion in the most current diagnostic manual for psychiatric disorders (First and Tasman, 2004), there remains debate about whether this disorder constitutes a mental illness.

Other key workers observed that case managers only appear when a client experiences an emergency. As noted by one key worker, 'they do more crisis management than anything else.' This might be partly due to the high caseload that some case managers were required to manage. As reported by one ASP manager, 'every case manager's got a million clients; what happens is, when they've got clients in the HASI program, they know that there's workers going there everyday, so the mental health workers automatically go, "whew! That's sorted out. I'll run off and I know that [the key worker] will ring if there's a problem."' While most case managers spoke of caseloads between 20 and 35 clients, one case manager worked with a caseload of approximately 70 clients.

Support plans

As part of their case management responsibilities, case managers were required to assess the mental health status and needs of their clients using MH-OAT – the Mental Health Outcomes and Assessment Training/Tool. Although known for its comprehensiveness, this feature has also deterred some case managers from using MH-OAT on a regular basis. Many did not administer the tool at the required intervals of 13 weeks. As one case manager stated, 'MH-OAT? You're kidding, right? It simply doesn't get done!' These case managers explained that the tool is 'vastly

time consuming' and they argued that their time was better spent providing direct care to clients. One case manager suggested that the tool lacks the receptiveness required to effectively gauge client change. Further to this, case managers were typically unaware of how the aggregated MH-OAT data were being used. There was thus little motivation to ensure its regular completion.

Management

As Table 3.3 shows, staff recruitment and selection continued to be the main difficulty with managing HASI within AMHS. Vacant positions in effect, means that caseloads are increased among existing case managers. A number of AMHS personnel suggested that the intense and hectic workload contributes to higher staff turnover. Over half of the HASI case managers vacated their position during the six months between contacts or moved to other roles within the AMHS.

Table 3.3: AMHS Managers' Level of Difficulty with Human Resource Management, Phase I and II

	AMHS managers mean score*		
Level of difficulty with	Phase I (n=6)	Phase II (n=8)	Change
Recruitment and selection	4.0	5.0	+1.0
Supervision	1.4	3.2	+1.8
Training	3.2	2.5	-0.7
Staff retention	2.7	2.5	-0.2
Occupational health and safety	2.2	2.2	0

Note: * 0 no difficulty to 10 high difficulty

Local resources

Additional community resources were not always available to supplement the services of the AMHS and alleviate hectic workloads. This was particularly the case in rural sites, where there were fewer mental health services. As one AMHS manager explained, 'the difficulty is the number of private psychiatrists – all their books are closed. We have a visiting psychiatrist, but he's probably going to die in his chair one day from trying to take on too much.'

In summary, most AMHS case managers believe that the support clients receive from the ASP successfully complements their clinical role. Clients are more satisfied with the medical care they are receiving.

3.4 Relationships between Key Stakeholders

Interviewees from the three key stakeholders suggested that their interagency relations have improved since the initial Phase of the study. Overall, they spoke of greater clarity in their distinct roles; a better understanding of client needs; and enhanced awareness of the most effective ways to meet them.

Accommodation Support Providers and Area Mental Health Services

Personnel from both the AMHS and ASPs recognised that initial teething problems in the implementation of HASI had generally eased. Through the course of the program they have acquired a greater appreciation of each other's functions and organisational constraints. As one key worker explained, 'I've got an increased respect for [the case

manager] … now'. Table 3.4 shows the continuing high quality of working relationships between ASP and AMHS personnel.

Table 3.4: Quality of Relationship between ASP Personnel and AMHS Personnel, Phase I and II, mean score

	Excellent or good Phase I		Excellent or good Phase II	
	Per cent	Number	Per cent	Number
AMHS managers	78	9	80	10
AMHS case managers	83	29	88	33
ASP managers	90	10	82	11
ASP key workers	76	46	76	45

A number of ASP personnel had improved insight into the structure of the health system within which case managers operate. Similarly, they recognised the often hectic workloads of case managers. An ASP manager aptly described this, stating, 'I think the relationship probably has improved, but we also need to remember that they are so understaffed … We tend not to ring if there is a minor problem or to have a whinge, because they're very busy.'

Equally, case managers were relatively more familiar with the role of ASPs in facilitating psychosocial rehabilitation among clients. An ASP manager reported, 'One particular case manager … really didn't understand our program and it became very political … But [the case manager] had since come back and apologised.'

According to some of the research participants, improved role clarity was also attributable to greater professional confidence. A number of case managers for example, had noticed reduced telephone contact from key workers who were concerned with client wellbeing. As reported by one case manager, 'I've noticed they don't ring me for the little things anymore. I think they've realised a lot of the behaviours, the negative symptoms; they're things that we just have to work around.'

Further to this, some key workers have demonstrated a willingness to learn more about the mental health issues experienced by clients. As one case manager observed, 'They're knowledgeable to a point, but they're not scared to ask questions.' Others concurred with this sentiment: 'They use us as a resource and ask for advice.' However, the exercise of these skills was not always welcomed. One key worker felt that case managers 'don't like it when you correct them … or when you ask for an assessment.'

In addition to greater role clarity, several case managers and key workers said that the interagency relationships have developed more respect. Relationships were relatively more amicable and cordial as there was an enhanced understanding of the most appropriate way to approach and work with the other stakeholder. Recollecting experiences with a case manager, one key worker stated:

> [It's] good because I know them … [One of the case managers] goes from being frustrated with [the client] to being overly supportive, so I've been cautious about what I say in the past. But that's changed. I've been liaising quite a bit so I feel that relationship is much better now. We can achieve a lot more and I feel I can speak more freely about my views.

Comparable sentiments were expressed by a number of case managers, as the following quote demonstrates:

> I think, as two organisations, we're working better. Before, I thought we couldn't say anything because we might have upset them. Now we're having monthly meetings and we're bringing things up before they fester.

Some key workers continue to experience difficulty in liaising with AMHS personnel. In reference to one case manager, a key worker recalled, 'I found her very, very frustrating. I never met her once. I made appointments for meetings and she'd just fob me off.' Equally, a few of the case managers said that the consumer-focus of key workers sometimes blinkered them from the advice of clinicians.

A number of AMHS or ASP personnel identified the features that had facilitated successful working alliances. Of particular value was the opportunity for regular communication. Reflecting on the working relationship with the AMHS, one key worker said, 'We've formed a pretty good partnership. We have regular [monthly] meetings with case managers. The communication has been excellent'. Similarly, a case manager stated,

> I've been able to negotiate with them to have group meetings; we exchange information; everyone feels free to call me if something is happening with the clients, which is helpful because I can't be there everyday. They all have my mobile number.

As shown in Table 3.5, most AMHS case managers were satisfied or very satisfied with the level of communication they maintained with their respective ASP key workers – a sentiment that was mirrored by most ASP key workers.

Table 3.5: Satisfaction with Quality of Communication between ASP and AMHS Staff, Phase I and II, mean score

	Satisfied or very satisfied Phase I		Satisfied or very satisfied Phase II	
	Per cent	Number	Per cent	Number
AMHS case managers	82	28	94	33
ASP key workers	67	46	76	45

The regularity of communication between the AMHS and ASP is influenced by the rostered nature of key work, differences in management structure of ASP ('sometimes I get lost in the hierarchy of [the ASP]', said one case manager) and geographical distance (one ASP is about 40 kilometres from its AMHS).

In an attempt to rectify the problem of 'telephone tag', a key worker and case manager from one site have adopted a communication diary. This is permanently located in the home of the client that they cooperatively support. It ensures that both parties are aware of each other's efforts and thus reduces the likelihood of service duplication. According to the key worker, it is also a useful way to ensure that the client does not continue to 'play one worker off against the other.'

Another vital feature that facilitated successful working alliances was responsiveness. It was important that case managers and key workers alike responded to each other's

concerns. This does not necessarily imply complete acquiescence, but a willingness to engage with the other and a demonstration of sincere interest in those matters identified by the other.

Responsiveness was particularly important to ASP personnel given the disciplinary divide separating the two services. Despite their different skills and expertise, responsiveness from case managers demonstrated that the AMHS took the concerns of ASP personnel seriously. To exemplify this, a key worker stated, '[The case manager] is really responsive. Even with this issue with the citizen advocate, [she] has organised to get a psychologist to spend an hour with this woman and to explain the way we work.' Similarly, a case manager remarked, '[ASP personnel] are very receptive to our comments in the care plan meetings.' Conversely, one key worker felt that a slow or non-existent response suggested arrogance or condescension.

HASI stakeholders have generally demonstrated flexibility, according to client need, and function within the constraints of challenging workloads and extraneous demands.

Accommodation Support Providers and Housing Providers

In contrast to the communication levels between ASPs and AMHS, the housing providers across the nine sites appeared to have intermittent contact with their fellow key stakeholders. This is not to suggest that housing providers operated in isolation of the remaining two stakeholders. In fact, as the following section illustrates, the successful continuation of HASI tenancies was very much influenced by interagency partnership.

An examination of the quantitative data indicates that ASP personnel were generally satisfied with the alliance they had established with respective housing providers. Most deemed the working relationship as good or excellent, which is depicted in Table 3.6.

Table 3.6: Relationship between ASP Personnel and Housing Provider, Phase II, per cent

	Excellent	Good	Average	Poor	Very poor
ASP managers (n=11)	55	45	0	0	0
Key workers (n=45)	33	53	9	2	2

Although five of the six housing provider respondents were satisfied or very satisfied with the communication they shared with respective ASPs, they collectively had little to report about this working alliance. For some, it was a case of, 'no news is good news'. One housing provider said that the nominal change in the partnership with the local ASP was evidence of sound planning at the initial Phase of the program, as well as ongoing communication.

Some housing providers suggested that their working relationship with the ASP had steadily improved. For some, it was initially difficult to implement the HASI model with great haste, particularly when the working alliance with the ASP was in its infancy. However, the time and effort expended on the implementation of the program appears to have been quite a fruitful investment. One housing provider conceded:

> [The time HASI takes up] is not an issue now, [but] it was a difficulty in the early stages because clients were coming on quickly. … We did try and take a lot of care in finding the right properties for each person at the time and I think that's paid off. We knew that any old property wouldn't do … [HASI consumed much of our resources] in the early stages, but now it has saved us a lot of time and effort because the support is there. They're our clients … and it's about being flexible.

Akin to the partnership between ASPs and AMHS, some sites appear to have greater clarity around the functions of the ASP and housing provider. One housing provider remarked, 'I think we're really lucky. We've got a blend where everyone knows their job and does it'. Greater role clarity between ASPs and housing providers was often a result of good communication. Some sites had witnessed regular interaction between the two parties, providing opportunities for information sharing and the development of an effective working relationship. ASP personnel were generally content with the communication they shared with respective housing providers, with most indicating that they were satisfied or very satisfied.

A couple of housing providers, however, were disappointed with key worker responses to poor property care among a few of the HASI tenants. And on a few occasions, key workers were critical of housing providers sometimes losing 'the consumer focus'. In one situation, this was apparent in the allegedly 'inappropriate' selection of accommodation for clients who have recently joined the initiative.

Not all sites had effective communication between the ASPs and housing providers. One housing provider for instance, was disappointed that key workers no longer attended property inspections. Their initial presence was of great value to the housing provider, for it facilitated greater insight into the issues and problems experienced by the client. But in light of their absence, the housing provider was concerned about the potential for OHandS issues for staff, should a client be unwell at time of inspection.

Another housing provider was frustrated by the dearth of client information provided by the ASP. She criticised such secrecy, arguing that it thwarted amicable working relationships:

> Unless we request information, we don't actually get anything. We work in partnership with other agencies and we expect to work with those agencies and to be in touch with them. We don't have that sort of contact with [the ASP]. I think they like to keep things close to themselves. I don't think they see it as a joint venture.

Area Mental Health Services and Housing Providers

An analysis of the research material collected through the course of Phase II of the study suggests that the contact between the AMHS and housing providers is negligible. As one housing provider reports, 'we don't talk to Health at all with HASI.' This relationship is comparable to that found during Phase one of the study. Unlike their ASP counterparts, the core business of the AMHS is the clinical management of the mental health issues experienced by clients. For this reason, case managers have marginal involvement in clients' accommodation and the continuance

of their tenancies. As suggested by an AMHS manager, 'Personally, I haven't had a need to have a strong relationship with them, but as a team it's good. We contact them when needed and they bring up issues at the advisory committee meeting.' Among those from AMHS and housing providers who did share mutual interaction, it appears that their working relationship was satisfactory. Five of the six housing providers consulted were very satisfied with the alliance they had formed with respective AMHS.

In summary, interagency relationships between the ASPs, AMHS and housing providers have continued to develop. Clarity about stakeholder roles and how they complement each other has increased. Understanding client needs and the most appropriate ways to meet these needs through interagency collaboration has also developed. While the clinical services from AMHS personnel have not changed, AMHS case managers have greater opportunity to focus on their core business. Both NSW DoH and NSW Health reported benefits from the enhanced working relations between key HASI stakeholders to support people who experience chronic mental health issues to reside in the community.

3.5 Mutually Beneficial Partnerships

Notwithstanding some of the aforementioned difficulties in the implementation and management of the program, HASI appears to be functioning successfully. In fact, most managers from both the AMHS and ASPs (55 per cent and 90 per cent, respectively) conferred an overall effectiveness rating of seven or above on a ten-point Likert Scale, where a rating of one signifies unsuccessful, and a rating of ten denotes very successful.

HASI is mutually beneficial for many of the stakeholders. In addition to facilitating enhanced working relations between AMHS, housing providers and ASPs, the partnership is able to support a cohort of people with chronic mental health issues in the community.

The advantages offered by HASI have been recognised by both housing providers and AMHS personnel. Housing Providers for example, are generally content to know that they are effectively contributing to the wellbeing of clients. As one housing provider stated, 'I'm enjoying the program … I'm excited that we can help people who couldn't just walk into a real estate agent.'

Some of the housing providers were all too familiar with the tenancy issues often experienced by people with chronic mental health issues. Within their pool of general tenants were those who fared poorly because of poor wellbeing. These tenants typically struggled with their lease contracts because of property damage or complaints from neighbours. This in turn, was a financial drain to the organisation. HASI somewhat alleviated this issue by providing a small number of clients with the accommodation support they require. Consequent to such support, most clients have successfully maintained their tenancies without property damage and complaints from neighbours.

Further to this, involvement in HASI has provided some of the housing providers with greater insight into the mental health sector. Through engagement with AHMS and ASPs, they have become increasingly familiar with community support systems

available for people with a mental illness. As articulated by one housing provider, 'I can actually now look at my clients and [know who to contact] … It's given us another avenue to refer people that possibly need support because we think they have mental health problems.' The one housing provider who did not concur with these positive sentiments recommended that additional funds be provided specifically for property maintenance.

The HASI tenancies have not proven to be decidedly different from general tenancies and therefore significant policy changes have not been warranted. However, experience has provided the housing providers with greater insight into appropriate ways to liaise with the clients. For instance, as one housing provider warned, it is not always preferable to send a standardised letter of warning to the clients, but rather, to work in collaboration with the other key stakeholders.

Like many of the housing providers, AMHS staff have also recognised the benefits of HASI. Of principal importance is the impact of the program on case management practices. The model has shifted many of the psychosocial rehabilitation tasks from AMHS case managers to other parts of HASI, complementing the AMHS case plans. In light of current NSW Health (2002) policy, encouraging its mental health services to adopt a clinical focus, this is particularly significant. As an AMHS manager suggested:

> We were dealing with people with a lot of personal crisis, trauma, grief and loss and comorbidities. That put a lot of pressure on our service to adopt a broader approach. That meant we were providing case management to fewer of our population. I think we tended to lose a case management model. The [ASP] has helped to rekindle that [by] establishing a rapport, doing assessment, monitoring programs and compliance.

Another AMHS manager said that the easing of superfluous responsibilities also helps case managers manage their mounting caseloads.

Overall, it appears that HASI is mutually beneficial for its two funding bodies. In addition to facilitating interagency relations between the three key stakeholders, the program has contributed to the extended tenancies of its clients. Further to this, its implementation has not necessitated significant new policy development, as existing protocols appear to have the elasticity required to accommodate this innovative program. Although some financial difficulties have been identified by a couple of housing providers, these appear to be idiosyncratic of particular sites and do not reflect experiences across the nine HASI sites.

3.6 Governance

The governance of HASI is directed by the people, policies and processes that provide senior personnel with the framework to make and implement decisions that optimise outcomes. As one housing provider articulated, 'governance doesn't happen at the top; it happens on the ground.'

Collaboration

On the whole, the coordination of HASI was regarded positively by the key stakeholders. For instance, 91 per cent of ASP managers and 80 per cent of AMHS managers were satisfied or very satisfied with the local coordination of the program. Similarly, all six housing provider respondents were satisfied or very satisfied. These levels of satisfaction are consistent with similar levels expressed during Phase one of the evaluation. While management remained positive about coordination of the program, staff of ASP and AMHS showed increased satisfaction since our first contact.

According to some of the key stakeholders, the partnership proposed by the model reflects a bona fide collaboration. Each party has defined roles and responsibilities, directing their degree of involvement in the various facets of HASI – from the initial referral of a client to his/her possible exit.

Admittedly, a number of sites witnessed initial teething troubles as stakeholder roles were defined. This was particularly because of the need to allocate client support needs to the appropriate stakeholder – a process that was not always easy. As one ASP manager explained, 'For years, mental health teams have been involved in the whole thing, so it's much easier to just put your hands around a client and control the whole thing. Whereas now, they can't do that because we're in the middle of it.' Yet, with the increasing longevity of HASI and consequent role clarification, the interagency alliance has shifted. One AMHS manager reported, 'there was a time, a learning path, but a dynamic has appeared. The meetings we're having now tend to be focussing more on relevant issues, rather than the overall issues.'

Others however, expressed concern at the quality of the partnership due to the financial responsibilities within the relationship. One housing provider for example, found it challenging to work effectively with NSW Health because it is a large, complex organisation. An ASP manager expressed similar sentiments. Aware that organisational funds were derived from the AMHS, she felt that this skewed the working relationship. She stated, 'Area Mental Health are partners, but they are also the contract managers or funders. Therefore, there is a contradiction in the partnership. They can pull the purse strings, so that's not actually a partnership'.

Communication

Consultation with the key stakeholders suggests that effective governance requires a number of elements. This includes open communication channels with fellow stakeholders. The importance of effective interagency communication is a theme that seems to permeate the research findings; and its significance should not be understated.

Interagency communication was demonstrated in various ways. During the infancy of HASI, localised HASI committees involving the three key stakeholders occurred in all nine sites. One of the chief purposes of these committees was to articulate and endorse Service Level Agreements between the key stakeholders. In some sites, this process was expeditious, while in other sites, Service Level Agreements are yet to be signed. This delay was primarily attributed to cumbersome bureaucratic process, whereby all minor changes to the agreement would need to be ratified by senior personnel, some of whom were not involved in the committee.

Despite the time and effort invested in the development of Service Level Agreements, it appears that their ongoing use has diminished. A number of research participants indicated that the agreement was 'just a formality' required by the funding bodies. However, the formality did appear to incite discussion and clarify the roles and responsibilities of each key stakeholder at the commencement of the program: 'It says what the protocols are. Who refers, who does what if something goes what, who talks to who' (housing provider).

Since the inception of HASI, the frequency of formal local committee meetings has decreased across a number of sites. This was attributed to a change in local needs, greater familiarity and ease with fellow key stakeholders, and the presence of other relevant committees within the site in which to discuss HASI-related issues. Only two stakeholders described their local committee meetings as ineffective.

Client exits

Despite the articulation of Service Level Agreements and/or guidelines in some sites, there appears to be little clarity around the matter of client exits. When a client leaves the program, there was limited information across the nine sites about the effective and efficient management of the resources initially allocated to the client. One ASP manager stated, 'I know the Service Level Agreement says the furniture should stay with the person, but there is only funding for ten people and how do you take the furniture back if they are allowed to remain in their accommodation?'

Another community housing provider spoke of difficulties that emerged at an interagency level when dealing with exiting clients. The Service Level Agreement in this area originally stipulated that if a client exits the program they could maintain their tenancy. Limited housing resources meant this housing provider 'disagreed' with such a clause in the case of capital properties. The agreement was subsequently amended: 'We [housing provider] said they could still be a tenant, but they couldn't stay in the capital properties. We're not in a position to just pick up more properties'.

While client exits have been relatively few to date, with increasing recovery, a number of clients may leave the program in the future. Clear policy should be developed around tenancies to assist clients to successfully transition from the program. One housing provider suggested designating 'exit properties' for HASI clients where they could remain until they are ready to transition into general housing: 'If you think about it, if they're on the program for four years and spend one year on an exit list, then that's five years on the list and they'd be ready for generalist housing'.

Further amendments to HASI policy may be required to ensure transitions out of the program can be both smooth and secure and that additional clientele can be provided with accommodation.

Contact with funding bodies

Other management practices were also deemed problematic. A few housing providers for instance, were concerned with the recent introduction of financial reporting mechanisms at the request of the Office of Community Housing. In addition to conventional accountability practices, which include financial information on HASI, community housing providers are now required to submit the same information in a

different form. One community housing provider reported, 'it's a real nuisance … We report on them as HASI and we report on them within the program … So we have to create a cost centre to track the rents and the expenses and then … add it in.'

Another housing provider suggested that there is little ongoing contact with the Department of Housing. This was not regarded favourably, as he preferred to remain informed about the progress of HASI. He stated, '[the coordination of HASI] was fine at the start, as they provided a lot of information … [but] we haven't received anything since … I'm not in the information loop and this effects our ability to progress.'

These NGO staff wanted opportunities for ongoing contact with funding bodies, not only for the purpose of accountability, but also to provide pragmatic feedback about the continuation of HASI.

In summary, most agencies involved in HASI were satisfied with the governance structure for the program. However, they made suggestions to improve its effectiveness. These included regular opportunities to exchange information about the development of the program; recognition of the unequal relationships due to financial accountability between partners; and facilitated activities at a local level to build collaborative relations between organisation, professionals and practitioners.

4 Conclusion

Phase II of the three-part evaluation found outcomes continued to improve for the majority of HASI clients. In some areas improvements slowed, but nonetheless continued. The demographics of the group remained stable – HASI continues to be dominated by males, people less than 35 years of age and people with a primary diagnosis of schizophrenia. Multiple diagnoses are prevalent among the majority of the group. According to client, case manager and ASP perceptions, client mental health continued to improve for approximately three-quarters of the cohort. These perceptions were corroborated by increased Global Assessment of Functioning scores and decreases in the proportion of clients hospitalised between the first and second evaluation phases. Clients had high levels of mental health service contact and physical health problems continued to be identified, consulted about and treated by appropriate health professionals.

While a number of clients remained fully or partially dependent on ASP support for daily living skills within and outside the home, on average, independence levels improved across all fourteen areas measured. Many clients continued to show increasing community and social connectedness, evident in both personal relationships and areas such as work and study. Almost all clients, 88 per cent, successfully maintained their tenancy. Despite these positive gains, loneliness was reported by just over half of the clients; a minority experienced tenancy problems, such as poor property care, noise and nuisance complaints, rental arrears and unauthorised co-tenancies; and seven clients exited the program between the evaluation phases.

Partnerships between the stakeholders continued to strengthen in most areas. ASP and AMHS personnel generally showed increased understanding and clarity around each other's roles and responsibilities, and consequently, respect, communication and collaboration developed and/or improved. Tensions remain between some individual ASP, AMHS and housing stakeholders around the referral and selection of clients, property maintenance and the nature and style of support provided by key workers. The evaluation found that overall HASI is mutually beneficial for clients, their families, DOH and community housing providers and the AMHS.

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