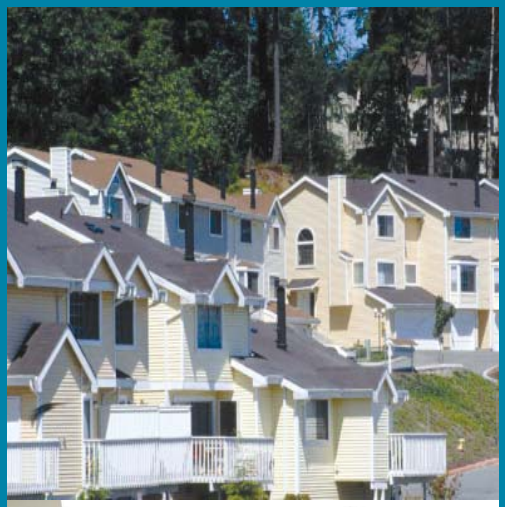
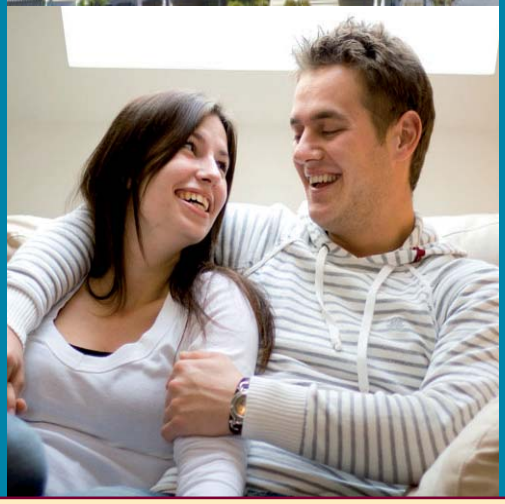
Stage 1 Evaluation report





Housing and Accommodation Support Initiative (HASI)

HASI Housing and Accommodation Support Initiative
NSW Government initiative

NSW DEPARTMENT OF HOUSING

SPRC Social Policy Research Centre

NSW HEALTH

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September 2007

FOREWORD

Mental health services in NSW are changing direction to create a comprehensive service system with both a hospital and community focus of care. The Premier has pledged to help people who live with a mental illness and has made this one of his highest priorities.

To ensure this occurs, the NSW Government is investing millions of dollars under the *NSW: A new direction for Mental Health (2006)* and the *NSW State Plan*, in developing new services to improve outcomes for people with a mental illness, their families and carers.

These reforms of the service system will ensure that for people living with a mental illness, there is:

- Improved early intervention and continuity of care
- Reduced unnecessary hospital admissions
- Increased employment and education opportunities
- Increased community participation, including stable and supported accommodation.

The Housing and Accommodation Support Initiative (HASI) is already demonstrating these benefits for its participants. HASI is an innovative program funded by the NSW Government that ensures stable housing linked to a range of levels of specialist support for people with a mental illness.

The Social Policy Research Centre (SPRC) of the University of NSW has recently completed a two-year longitudinal evaluation of the first stage of HASI. This report details the outcomes of HASI Stage One, which was implemented in 2003 with 100 places of high-level support in nine locations across NSW. The evaluation by the SPRC has helped to guide the further development of HASI.

From its inauguration in 2003, HASI will, by the end of 2007, be providing over 1,000 places of differing levels of accommodation support across NSW.

HASI is displaying outstanding success in providing a stable, consistent and integrated hospital to community care system for people with a mental illness and associated psychiatric disability. For this group of people, HASI is helping to avert homelessness and to reduce the need for hospitalisation.

Winner of the Gold 2006 NSW Premier's Public Sector award, HASI is based on a three-way partnership between NSW Health, the Department of Housing and the non-government organisation (NGO) sector. HASI provides practical assistance, intensive psychosocial rehabilitation, clinical care, and secure housing, along with opportunities, options and hope to people who have a mental illness.

Recognition by the Government of the role of NGOs as valuable partners in mental health service delivery has led to further investment in this sector. The Government is helping to build the sector's capacity through mental health NGO infrastructure grants and the development of improved training programs, under the auspice of the Mental Health Coordinating Council, the mental health NGO peak body for NSW.

An evaluation of the overall HASI program will be initiated in 2007 and again, should provide HASI partners with further information to guide expansion of the HASI model.

Different models of accommodation support, which fit under the HASI umbrella, are being developed. An example of one of these new models is HASI in the Home, which will provide accommodation and clinical support for people living in a variety of housing situations. This more flexible model of HASI will engage a range of communities including people from culturally and linguistically diverse backgrounds. A culturally appropriate HASI model for Indigenous people is being developed and in the future it is anticipated that HASI will target specific populations of need across NSW.

The HASI program will continue to strive to ensure people with a mental illness are given the support to build resilience, and have the strength to make choices about their recovery, to develop the skills and competence necessary to enjoy a full and rich life.

The Hon Paul Lynch MP
Minister assisting the Minister for Health (Mental Health)

The Hon Matt Brown MP
Minister for Housing

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TABLES AND FIGURES

ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHS	Area Health Service
AMHS	Area Mental Health Service(s)
AIHW	Australian Institute of Health and Welfare
ASP	Accommodation Support Provider(s)
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CID	Client Information Database
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
HoNOS	Health of the Nation Outcome Scale
HP	Housing provider
K10	Kessler 10
LSP	Life Skills Profile
MH-OAT	Mental Health Outcomes and Assessment Tools and Training
NGO	Non-Government Organisation
NSW	New South Wales
OCH	Office of Community Housing
OH&S	Occupational Health and Safety
PWI	Personal Wellbeing Index
SPRC	Social Policy Research Centre
TAFE	Technical and Further Education
UNSW	University of New South Wales

EXECUTIVE SUMMARY

This is the final Housing and Accommodation Support Initiative (HASI) Stage One evaluation report. HASI is a partnership between NSW Health, the Department of Housing (DoH) and non-government organisations (NGOs), and is jointly funded by NSW Health and DoH.[1] The program follows psychosocial rehabilitation principles and has a recovery focus. It aims 'to assist people with mental health problems and disorders requiring accommodation (disability) support[2] to participate in the community, maintain successful tenancies, improve quality of life and most importantly, to assist in the recovery from mental illness' (NSW Health and NSW DoH 2005).

HASI Stage One began in 2002/2003. It provides permanent social housing, long-term accommodation and community participation support and active mental health case management for over 100 people with complex mental health problems and high levels of psychiatric disabilities. It is a coordinated approach, with non-government organisation (NGO) accommodation support workers, Area Mental Health Service (AMHS) mental health case managers, housing providers and HASI participants working together. Funded by NSW Health and the NSW Department of Housing, HASI Stage One is offered in nine locations, and is situated in six NSW Area Health Services: Greater Western, Hunter/New England, Northern Sydney/Central Coast, South Eastern Sydney/ Illawarra, Sydney South West and Sydney West.

The two-year longitudinal study of HASI Stage One, conducted by researchers from the Social Policy Research Centre (SPRC) of the University of NSW and the Disability Research and Studies Institute (DSaRI), outlines some remarkable outcomes, including:

- The provision of secure, affordable housing. Eighty-five per cent of all participants remained with the same housing provider.
- An increase in community participation. Ninety-four per cent had established friendships and 73 per cent were participating in social and community activities. Fourty three per cent were working and or studying.
- Improved physical health. Over 50 per cent of participants reported improved physical health from regular access to general practitioners and specialists, as well as improved diet and increased physical exercise.
- Improvement in psychological wellness with 68 per cent of participants reporting improvement in symptoms, social and living skills and a decrease in psychological distress.
- Reduced hospitalisation rates, frequency and duration for 84 per cent of participants. Time spent in hospital and emergency departments decreased by 81 per cent.
- Increased connection with commmunity mental health services. Ninety-two per cent of participants regularly saw their case managers and 89 per cent of participants were still in contact with their psychiatrists.
- A high rate of improved family connectedness. Eighty-one per cent of participants said they were satisfied or more than satisfied with their family relationships since participating in the HASI program.

"Without them [HASI Accommodation Support Provider] I wouldn't be in as good a place as I'm in now, not just physically but having achieved some of the things I wanted to achieve – like my independence in living and in running my own life and stability in housing." (HASI participant).

1 The Office of Community Housing (OCH) is a business unit of the Department of Housing. As its role is to fund and regulate community housing providers (as compared to the service delivery function of the Department of Housing) it is referred to separately in this report.

2 As defined in the 2002 NSW Health *Framework for Housing and Accommodation Support 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.

The study included 633 interviews and surveys with all HASI stakeholders as well as family members, consumer advocates and people involved in the governance of the program at Area, Regional and State levels. These interviews and surveys enabled two years of invaluable feedback that is guiding HASI forward. This has enabled the new stages of HASI to focus on the development of specific service directions for Indigenous peoples and models of care to address the specific needs of women with mental illness, people from culturally and linguistically diverse (CALD) backgrounds and people from rural and remote areas of NSW.

The HASI Stage One objectives are:

- Engage people with a mental illness and high levels of psychiatric disability
- Enable the sustaining of successful tenancies with appropriate support
- Maximise participation in the community
- Improve mental health
- Increase access to specialist and generalist community services.

The evaluation plan is summarised in Appendix A.

The participants in HASI Stage One are people with a mental illness and high levels of psychiatric disability. They have histories of long term hospitalisations, unstable tenancies, limited social networks and have largely been excluded from standard spheres of societal participation – community, recreation, work and study; for some there have been periods in prison. HASI has provided these people with the opportunity for stable housing; intense support for living skills, community participation and service referral; and the regular monitoring and maintenance of mental health. By providing a stable, consistent and integrated support system, HASI is mediating the effects of mental illness for most participants.

Since joining HASI and receiving a network of psychosocial support from Accommodation Support Providers (ASPs), AMHS and housing providers, many participants' lives have changed dramatically. The partnerships between the three stakeholders are integral to the success of the model and the numerous examples of good practice, strong relationships and lessons learnt can inform future collaborations. The positive effect from collaborating on individual support plans is merely one of these lessons. If ASP and AMHS personnel are working closely together, the psychosocial model of support can be beneficial for smooth working relationships and participant outcomes.

As the evaluation reports have demonstrated, through strong partnerships between health, housing and NGO personnel, the foundation of stable social housing, the regular monitoring and maintenance of mental health and support within the home and community, the majority of HASI participants are combating the debilitating effects of mental illness. HASI has performed outstandingly in meeting its objectives.

The principal outcomes of HASI are outlined below.

Tenancies

One of the strongest outcomes of HASI is the provision of secure, affordable housing. Most HASI participants had come from vulnerable housing situations. They were living in hospitals, boarding houses, refuges, crisis and other temporary accommodation or in housing situations that were unstable and unsuitable. Since joining HASI, people involved in the program had affordable and secure social housing. Mental health, personal preference and access to resources and social and family networks were well considered in matching appropriate housing to peoples needs. Consequently, 70 per cent of people housed with a HASI housing provider remained in the property they were first placed in at the end of the evaluation. While some people moved during the evaluation, or left the program, almost all participants (85 per cent) remained with the same housing provider. Therefore HASI has provided positive rental histories for the majority of participants.

"I went through a pretty bad stage with both my kids where I didn't see them at all. ... When I first moved in [to the HASI property] I was alone and my daughter was too scared to have anything to do with me. ... Over a period of time the kids have got used to the fact that I'm not so whacko anymore and ... relaxed and started coming back around. And this one [grandson], he's warmed up himself to the fact that "I just want to spend time with Nanny."... I love it." (HASI participant).

Community participation

Community participation has also increased for the HASI participants. Peoples social networks have grown and participation in community, recreational and social activities and in work and education has increased substantially. A consistent finding was the importance of recreational activities organised by the ASP in strengthening participant and worker rapport, increasing participant confidence and social skills and providing a pathway to mainstream participation. As loneliness and isolation are common problems for people with a mental illness, facilitating access to community is an important issue for all HASI participants. While this is especially the case for people in rural areas, who in many cases were required to move away from family and social networks to be involved in the program, it is an issue that is not restricted to geographic boundaries. Although loneliness persisted for approximately half of the people involved in the program at each phase of the evaluation, significant increases in community participation was largely facilitated by ASP workers supporting people to meet their goals. This participation was linked to improvements in mental health and decreases in hospitalisation.

Access to specialist and generalist community services

HASI participants access a range of health, specialist and general community services. Regular contact with general practitioners and appointments with specialists, improved diet and increased physical activity, resulted in over half of HASI participants reporting improved physical health. While many HASI participants have ongoing comorbid physical health problems, HASI has facilitated recognition, identification and appropriate treatment of these problems.

Mental health and hospitalisation

> "She thinks the accommodation is the bee's knees. She's never had anything new in her life, not even a new kettle – she loved it ... And it's doing wonders for her mental health."
> (AMHS case manager)

While data from HASI participants' baseline and in-program NSW Health data reports (MH-OAT) were limited, at least two-thirds of the group with completed data experienced improvements in behaviour, impairment, symptoms and social areas, an increase in living skills and a decrease in psychological distress. This is testimony to the program, because people with MH-OAT data had lower levels of occupational, social and psychological functioning, than their counterparts. The regular monitoring and maintenance of mental health and consistent access to mental health professionals is likely to have played an important role in the widespread reporting of improved participant mental health. It is unsurprising that improvements in mental health were accompanied by substantial decreases in hospitalisation. Hospitalisation rates not only dropped in frequency, but also duration. For 84 per cent of HASI participants, the proportion of time spent in hospital in psychiatric units and emergency departments decreased by 81 per cent, an average of 70 days per person per year.[3]

Program cost-effectiveness

HASI Stage One cost $5,752,962 to support 100 people each year. This cost includes recurrent funding to ASP NGOs for accommodation support, program management and housing costs (leasing, rental arrears, housing vacancies, appeals and locating new properties). In addition, one-off setup costs were $11,033,786, including $9,700,000 for DoH capital costs.

The cost-effectiveness analysis demonstrates that for the recurrent annual program costs ($57,530 per person), the returns were not only decreased hospitalisation rates for these clients, but also stabilised tenancies; improved mental and physical health; increased life skills and social, educational and workforce participation; and decreased imprisonment.

Family connectedness

> "With the drugs and me being so sick it caused a bit of problems in the family, but now we're working through that. Things are going good with mum; I'm getting closer to me sister and brother-in-law now."
> (HASI participant)

Another notable outcome of HASI was the change in a number of participants' relationships with their families. HASI eased tensions, reconnected some individuals with estranged family, and improved family dynamics for others. For many participants, frequency and quality of contact with family had improved since starting HASI. Eighty-one per cent of participants reported being satisfied or very satisfied with family relationships. This satisfaction resulted from individuals having more functional

3 Comparing equivalised hospitalisation data for 67 participants before entering HASI (1 July 2000 to day prior to HASI accommodation) and since entering HASI (in accommodation to 30 June 2005).

relationships with their families. Greater stability in mental health coupled with independent living has assisted some clients to more effectively engage with family members.

HASI good practice

The evaluation process identified a number of practices that were most associated with positive participant outcomes.

- Effective partnerships in local areas
- Sound communication between partners at both managerial and direct support levels
- ASP and AMHS personnel having a well developed understanding of the HASI model and the roles and responsibilities of various stakeholders
- Local stakeholders having a primary role in the referral and assessment process
- Stable case managers
- Ongoing training for key workers
- ASP personnel actively working within a rehabilitative, rather than a supervisory, framework
- Key workers and clients having a strong rapport, which is often established through social interaction
- ASPs organising social activities, which enhance confidence and social skills and help to facilitate community participation
- The provision of relevant information about HASI participants to housing providers to assist in allocating the most appropriate housing
- Client choice and active involvement in the selection of available accommodation
- Active involvement of family or carers
- Increased linkage – using outside consultants to facilitate good practice, eg Department of Ageing, Disability and Home Care (DADHC) and Drug and Alcohol Services.

ONE

INTRODUCTION

The Social Policy Research Centre, University of New South Wales, was commissioned to evaluate HASI Stage One.[7] The evaluation was longitudinal over a two-year period with three data collection stages (Appendix A).[8] This included 633 interviews and surveys with HASI stakeholders: participants, AMHS, ASP and housing provider personnel, as well as family members, consumer advocates and people involved in the governance of the program at Area, Regional and State levels. A series of assessment tools were incorporated into the design and used throughout the fieldwork. In addition, NSW Health hospitalisation records and data from NSW Health Mental Health Outcomes and Assessment Tools (MH-OAT) were accessed and analysed.[9]

HASI Stage Two, (lower level support), and Stage Three A (high support) have now also been implemented. At the time of this report, HASI Stage 3B (very high support) and HASI Stage Four A (high support) is underway. HASI Stage Four B or HASI in the Home, which is the first stage of HASI where people do not necessarily live in social housing, will become available in 2007/08.[6]

For HASI Stage One the research evaluated the following HASI objectives:

- Engage people with a mental illness and high levels of psychiatric disability
- Enable the sustaining of successful tenancies with appropriate support
- Maximise participation in the community
- Improve mental health
- Increase access to specialist and generalist community services.

> "I am living a life now. I was suicidal; I was in so much emotional pain in the past, I didn't want to live anymore. And it wasn't until now that these people have got me into a lifestyle, which I enjoy. I am living a life and I enjoy it. I never had that before...I wouldn't socialise, I would still be 122 kilos, I wouldn't have the door open like it is now. It would be closed and bolted. And I would be chain smoking and arguing with the radio. That would be my life." (HASI participant).

The HASI model, the effectiveness of stakeholder partnerships and governance structures and operational issues were also examined throughout the evaluation. The research was a formative evaluation so that the program could incrementally respond to the findings during the evaluation period.

It is within this framework that this report is set out. Sections 2 and 3 present the participant outcomes and model and partnership outcomes, along with lessons learnt throughout the evaluation. The final part of the report, Section 4, is a cost-effectiveness analysis.

This report, and the earlier evaluation reports (Morris et al., 2006a-d; Muir et al., 2006; Muir et al. 2007), demonstrate that HASI is meeting its objectives and producing some remarkable outcomes.

4 The Office of Community Housing (OCH) is a business unit of the Department of Housing, but throughout this report DoH refers to the operational arm of the Department of Housing only (public housing and supporting business units) and does not include OCH, which is identified separately given the independent nature of its administration of housing providers.

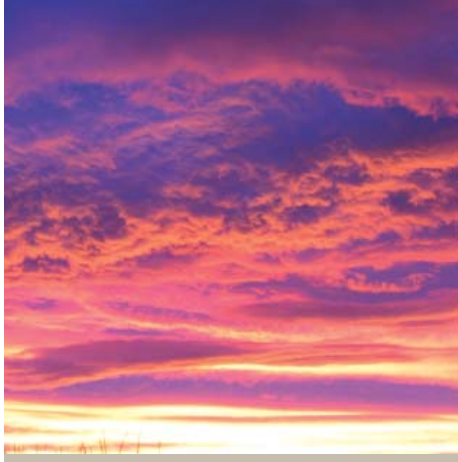
5 As defined in the 2002 NSW *Health Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders* 'accommodation support' is a component of disability support that specifically assists an individual to maintain their role functioning, skills and independence in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

6 Stage One is for over 100 high support clients. HASI Stage Two is a lower support outreach for 460 people who are in established social housing, but may be at risk of losing this without support. Stage Three has 126 places for individuals with high support needs, this stage has been implemented. Stage 3B is 50 places of very high support (up to eight hours a day) and Stage 4A is a further 100 places of high support. HASI in the Home will provide over 120 places of support to people to assist them to remain living independently. This evaluation only examines HASI Stage One.

7 From here on HASI Stage One is referred to as HASI.

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

9 This data was only received for HASI participants who consented to participate in the evaluation.



TWO

PARTICIPANT OUTCOMES

This section examines whether HASI has met its participant objectives. It uses the histories and demographic details of HASI participants to assess whether HASI is engaging people with a mental illness and high levels of psychiatric disability; tenancy data is used to understand whether HASI participants have sustained successful tenancies; and NSW Health's hospitalisation and Mental Health Outcomes and Assessment Tools data are explored to assess improvements in mental health. Interviews with program stakeholders – participants and ASP, AMHS and housing provider personnel – are also used to elicit participant outcomes, such as community participation levels and access to services.

2.1 Engage people with a mental illness and high levels of psychiatric disability

HASI is aimed at people with a mental illness and related psychiatric disability. It's core goal is to assist people to live in the community with appropriate support.

Summary of participant engagement

- People with mental illness and high levels of psychiatric disability were engaged in the program throughout the HASI evaluation.
- HASI participants are typically men born in Indigenous with a primary diagnosis of schizophrenia and a secondary diagnosis.
- Women are under-represented in HASI and more likely to leave the program than men.
- People who identify as Indigenous are well represented in recruitment, but the program has had difficulty retaining them.
- People from CALD backgrounds are under-represented in terms of recruitment, but once in the program are no more likely to leave than their counterparts.

People with a mental illness and high levels of psychiatric disability were engaged in HASI throughout the evaluation. This section examines the demographics of people involved in HASI, whether participants are representative of the population and retention rates (in terms of the characteristics of people who remain in HASI or have exited the program).

The AMHS and ASP are the principle drivers for recruitment to the program. Most people selected for HASI are referred by the AMHS (85.5 per cent, n=110) and chosen by a selection committee. The committee members include AMHS, ASP and housing provider representatives.

The objective of engaging people with mental illness and high levels of psychiatric disability who require accommodation support has been met, as indicated by HASI participants' psychiatric hospitalisation rates (NSW Health data), high levels of psychiatric distress (Kessler 10), minimal living skills (Living Skill Profile), low levels of occupational, social and psychological functioning (Global Assessment of Functioning – GAF) and significant behaviour, impairment, symptoms and social problems (Health of the Nation Outcome Scale – HONOS) among the people involved in HASI.[10]

HASI participants present with a typical profile; they are usually male (67 per cent) and born in Australia (93 per cent), with English as their first language (94 per cent). The majority of participants have a primary diagnosis of schizophrenia (74 per cent) and many also have a history of a substance use disorder (46 per cent).

Recruitment and group representation in the mental health community

It is difficult to determine whether people selected for HASI reflect the demographics of people within the community requiring such support. This is because while national demographic data is available regarding the prevalence of mental health problems, hospitalisation and mental health service use, the data does not include levels of psychiatric disability by demographic details.

According to the prevalence of mental illness and hospitalisation rates, women and people from culturally and linguistically diverse backgrounds are under-represented in HASI.

10 The results for each of these assessment tools are discussed throughout this report.

Table 2.1 Characteristics of HASI participants (Phases 1–3 of the evaluation)

	Description	Per cent
Primary diagnosis (n=109)	Schizophrenia	74.3
	Schizoaffective disorder	11.9
	Bipolar	2.8
	Depression	1.8
	Other	9.2
Gender (n=110)	Male	67.3
	Female	32.7
Age (n=106)	Under 35 years	55.7
	35–39 years	7.5
	40+	36.8
Multiple diagnoses (n=98)	At least a dual diagnosis	64.3
	History of substance use disorder	45.9
	Substance use disorder	29.6
	Physical disability	17.3
	Intellectual or cognitive disability	31.6
	Secondary mental illness	11.2
Birthplace (n=110)	Australian born	93.6
	Born overseas – English speaking	1.8
	Born overseas – non-English speaking country	4.5
Aboriginal (n=109)	Aboriginal	6.4
	Non- Aboriginal	93.6
First language (n=109)	English	94.2
	Other than English	5.8

Women

Women remained under-represented in HASI throughout the two-year evaluation, but the number slightly increased across time (30 per cent in Phase 1 to 33 per cent in Phase 3). While only one-third of HASI participants were women in Phase 3, the same proportion of men and women experience mental illness. The prevalence of certain types of mental illness differs by gender, but the most common diagnosis among HASI participants is schizophrenia and men and women are equally likely to experience this condition (albeit at different ages; AIHW, 2005). Women are also more likely to have a mental health related hospital admission than their male counterparts (AIHW, 2005: 84).[11]

Some ASP and AMHS stakeholders believed women are under-represented because men generally had less support from family and/or friends and poorer living skills, and were therefore more likely to need HASI. While this may be the case, the prevalence of mental health problems, the hospitalisation rates and the fact that women face other barriers in regard to the access and provision of mental health services (Mowbray, Nicholson and Bellamy, 2003:106) suggest that the under-representation of women in HASI requires further consideration.

People from culturally and linguistically diverse backgrounds

People from culturally and linguistically diverse backgrounds also remained under-represented in HASI, when compared to the Australian and mental health populations. Six per cent of HASI participants spoke a language other than English at Phase 3 of the evaluation, compared to 20 per cent of the population (ABS, 2003) and 14.5 per cent of people with mental and behavioural problems (ABS, 2001).

People born outside of Australia are slightly less likely than Australian born people to experience mental disorders. Andrews et al. (1999: 10) attributes this to the 'healthy migrant effect' – people with poor mental health are less likely to migrate. Overall, however, people from culturally and linguistically diverse backgrounds account for 19.8 per cent of mental health care service contacts (AIHW 2005: 72).

11 Women accounted for 62 per cent of all mental health related hospital admissions in Australia in 2003–04.

Indigenous people

The proportion of Indigenous people differs across the nine sites, but overall, Indigenous Australians are well represented in HASI in terms of recruitment. In Phase 1 of the evaluation 8 per cent of the group identified as Indigenous Australians. While recruitment of Indigenous people was strong, the proportion of Indigenous Australians in the program decreased significantly from 8 to 4 per cent (discussed in Section 2.6).

Although 4 per cent remains above the proportion of Indigenous people across the population, it is lower than the proportion of Indigenous people hospitalised for mental illness and using mental health services (6.8 per cent; AIHW 2005: 70; Australian Indigenous Health*Info*Net, 2005).[12] If schizophrenia remains a prevalent diagnosis among people involved in HASI, the proportion of Indigenous people included in the program should exceed their representation in the general population. This is because the rate of schizophrenia (along with schizotypal and delusional disorders) is twice as high among Indigenous people compared to non-Indigenous Australians (Australian Indigenous Health*Info*Net, 2005).

2.2 Enable sustaining of successful tenancies with appropriate support

Housing plays a fundamental role in peoples lives. A decent, stable and affordable place to call home underpins our health, safety, security, family life and participation in the workforce. Good housing also contributes to healthy neighbourhoods and in doing so shapes our communities, lifestyles and aspirations (DoH 2002: 1).

Summary of tenancy outcomes

- The majority of HASI tenancies have remained stable (70 per cent of people still live in their first HASI property and 85 per cent remain with the housing provider).
- Stable tenancies are attributed to: housing provider and ASP personnel striving to match available accommodation to individual need and choice, relocation when housing did not match requirements, high levels of participant satisfaction, good property care, consistent rental payments, amicable neighbour relations, and ongoing support from housing providers and ASP personnel.
- All housing, clustered or not, requires forethought about the type of housing; the social setting at block, street and suburb levels; and accessibility to social networks (family, friends and carers), services and resources (such as shopping facilities, doctors and hospitals).
- The housing component of HASI has worked well as both a reactive program for people with poor rental histories and as a preventive/interventionist program for people who were depending (unsustainably) on family and/or friends for accommodation.
- Capital properties provide stability, while head-lease properties offer greater choice and flexibility.

Most HASI participants had come from vulnerable housing situations. They were living in hospitals, boarding houses, refuges, crisis and other temporary accommodation or in housing situations that were unstable and unsuitable. The role of social housing, funded and organised by DoH, OCH and community housing providers, is instrumental to the program meeting its objectives.

With appropriate support, HASI has enabled the sustainability of successful tenancies for the majority of people participating in the program. Successful tenancies are defined as people maintaining stable accommodation since starting HASI (70 per cent of the 105 people about whom we received tenancy data), remaining with the housing provider (85 per cent) or obtaining a positive tenancy record that enables them to move from a social housing property into the private rental market (with financial support from a housing provider), or from one housing provider to another (in the case of people who have left the program and moved to another area).[13] Table 2.2 highlights the tenancy outcomes achieved through the program.[14]

12 Data is not available on the overall prevalence of mental illness among Indigenous people (Australian Indigenous Health*Info*Net, 2005).

13 It was difficult to get accurate statistics for people within the latter category, but anecdotal evidence provided by the ASP and housing providers on where people moved after leaving HASI suggests that a number of people left the program with positive rental histories that has, or will, assist them to obtain public or private rental accommodation in the future.

14 For a more detailed discussion of tenancy issues, see earlier reports.

Table 2.2 Sustained tenancy (entry to Phase 3, n=105)

	Explanation	HASI participants
Sustained tenancy	Remained in same home (12 months or more)	70%
	Remained with housing provider in or out of HASI	85%
Rental arrears	Proportion of tenants without rental arrears	83%
Relations with neighbours	Proportion of tenants with no complaints from neighbours throughout the program	70%
Satisfaction with tenancy	Self-reported participant satisfaction measured with a Likert scale	94%
Vacancy rate	Average number of days property remained vacant after tenant moved out (compared to 19.2 for OCH clients) [a]	6.4
Property care	Housing provider managers reported property care by the majority of HASI participants were equal to or better than general tenants	

Notes: a. Office of Community Housing. Only vacancy rates are compared with normative data. This was because data was either unavailable or not appropriate for comparison. The low vacancy rate may be due to the responsive nature of the program and the intent to meet the individual needs of each tenant. Some vacant HASI designated properties are transferred to general housing stock and another property provided to meet HASI participants' needs. This also reduces vacancy rates and rent loss.

The sustainability of tenancies also reflects high levels of participant satisfaction with their housing and consequent good property care, consistent rental payments (assisted by the use of Centre Pay)[15] and amicable neighbour relations, coupled with ongoing support, intervention, prevention strategies from housing providers and ASP personnel.

Half of the HASI participants accommodated by housing providers live in a unit or an apartment (52 per cent), with the remainder accommodated in townhouses, villas, duplexes (31 per cent) and houses (18 per cent). This distribution is converse to the types of accommodation occupied by NSW public housing tenants, where 70 per cent live in separate houses, 18 per cent in a flat, unit or apartment and 9 per cent in a semi-detached terrace or townhouse (ABS 2001 in DoH 2002: 1). By Phase 3 of the evaluation, housing providers were slightly less likely to place HASI participants in units or apartments, than they were earlier in the program. Interviews with stakeholders suggest that close living within units may increase the potential for conflict with neighbours, but targeted support and resident matching can lessen this risk. Stand alone houses have also presented some problems with regards to the responsibility for ground maintenance. While a couple of HASI participants have avoided this burden by moving to smaller complex properties, such as townhouses or villas, the problem has also been addressed through support strategies and subsidising gardeners.

Stakeholders have discussed at length the appropriateness of clustered accommodation for people with a mental illness. Clustered accommodation is perceived by some stakeholders to be stigmatising and negating the aim of independent, integrated, community living. However, it has proven beneficial in fostering social relations between tenants where a maximum of three or four properties are grouped and people are carefully selected.

Accommodation options require significant forethought in regard to the type of housing; the social setting within the complex, street and suburb; and accessibility to social networks (family, friends and carers), services and resources (such as shopping facilities, doctors and hospitals).

HASI properties are either leased or owned by the housing providers. Leasehold properties provide a level of flexibility and choice for program participants that capital properties do not. Conversely, capital properties offer reliable tenancy security, which is not available from leaseholds.

"When I saw it, when I got inside, I was like ... this is home, this is definitely home ... you know how you just feel at home some place, where you feel comfortable, things are right? The sun was shining ... and it just sort of made it look cool and ... I looked through the place and the balcony was cool ... When I moved in, I was like, yeah this is cool...I loved the fact that I felt secure." (HASI participant).

15 An automatic rent payment system where rent is electronically directed from CentreLink payments straight to the housing provider. This is a voluntary system that can be suspended at any time.

Finding housing that incorporates access to social networks with access to services and resources has been difficult in situations where the two are geographically distant, or where a person has been required to relocate to participate in the program (HASI One is only provided in nine locations around NSW). These issues are particularly problematic for HASI participants in rural locations. In most cases, effort was made to match people's needs and requests to available accommodation, ensuring a balance between accessibility of networks and resources. Consequently, 94 per cent of HASI participants were satisfied or very satisfied with their homes, tenancy retention rates remained high and, according to some stakeholders, stable housing contributed to improved health.

At this stage, the HASI model does not allow for shared tenancies. For some clients who would prefer to share accommodation with a friend, relative, partner and/or flatmate this restriction can cause concern. Forty-two per cent of HASI clients indicated a preference for shared accommodation in the future. This desire was primarily based on sharing tenancies with people who are trusted and where there is a meaningful relationship, rather than with strangers or acquaint-ances. In a small number of circumstances (less than one in each area) there were examples of exploitative, unauthorised co-tenancies. While these could destabilise the HASI participant's tenancy, ASP and housing provider support provided some protection.

2.3 Maximise community participation

One of the main goals of HASI is to assist consumers to connect with their community and to enable community participation.

Summary of community participation

- Since joining HASI, most people have increased their social networks and almost half (43 per cent) were participating in work and/or education by Phase 3 of the evaluation.
- Accessing employment agencies and disability workers within educational institutions has been important for many HASI participants who are working or studying.
- Recreational activities played an important role for many people in building social skills, increasing confidence and in turn increasing independence and a pathway to work and education.
- ASP organised social activities, provided a pathway to community participation (offering an alternative between disability based and mainstream programs) and assisted in building worker/participant rapport.
- The meaningfulness of an activity was more important than mere participation. In some circumstances, eg a recreational activity could be more beneficial than supported work.
- In Phase 3, HASI participant trust levels were close to population norms for Australians of a similar age.

Many people have increased their participation in the community since joining the program. Statistically significant increases in participation span paid and voluntary work, training and education, as well as social and community activities. Consequently, 'HASI has enabled a shift from social exclusion towards social inclusion' for many participants (Muir et al., 2006: 29).

HASI participants started the program with limited social networks (23 per cent had no friends) and almost all were excluded from work (8 per cent were working, most of whom were engaged in supported employment) and education (only 2 per cent were involved in study or training).

By Phase 3 of the evaluation, the majority of HASI participants had increased their social networks (94 per cent had established friendships) and 83 per cent were actively participating in their communities in at least three ways. Participation was defined to include shopping, eating out, accessing the library, attending social groups or church, studying, working, playing sport, doing leisure activities and/or exercising. Seven in ten HASI participants (73 per cent) were participating in social and community activities and 43 per cent were working and/or studying (Table 2.3).

Work included open paid positions (50 per cent of those working), supported employment (33 per cent) and volunteer roles (22 per cent). These positions ranged from cleaning, factory work and gardening to mental health training. Of those studying, the majority of people (57 per cent) were attending TAFE, 29 per cent a community college or education centre and 14 per cent university. Employment agencies played an important role in relation to some HASI participants' workforce participation. Similarly, disability support personnel within educational institutions assisted some HASI participants in their re-engagement with education.

As earlier reports reinforced, recreational activities were important for many participants in building social skills, increasing confidence and in turn increasing independence and a pathway to work and education. People with access to ASP organised, disability and mainstream groups had an enhanced opportunity for meaningful community participation. The importance of meaningful participation – where people feel like they belong, have an opportunity to increase social and other skills, along with confidence, and where a process of reintegration and community engagement can occur – for HASI participants should not be underestimated. The scope of the activity was not necessarily found to be important, but rather the purpose and opportunity the activity afforded, such as skill development, socialisation, interaction in the broader community, and/or working towards goal achievement.

Table 2.3 Longitudinal indicators of social inclusion of HASI participants (per cent)

	No friends (n=69)*	Social and community activities (n=69)*	Work (paid, voluntary, supported or open; n=55)**	Education or training (n=55)**	Work and/or study (n=55)**
Entry to HASI	23	–	8	2	9
Phase 1	15	73	18	22	37
Phase 2	7	84	31	18	41
Phase 3	6	73	26	20	43

Source: Muir et al., 2006: 29.

Notes: *Based on longitudinal data from the Client Information Database – 69 people had participated in the program from the outset through to Phase 3 of the evaluation.

** Based on longitudinal interviews with people who participated in the evaluation from the outset of the program through to Phase 3. All longitudinal differences in frequency (between entry and Phase 3) are statistically significant at p←0.05.

The level of community participation may have assisted to build trust, along with the relationships HASI participants have formed between each other and with ASP, AMHS and housing provider stakeholders:

> "'I don't trust people very much. [But] I've got to know them [ASP workers and other participants] and feel comfortable with them' (participant). Another participant reported that her key worker taught her to 'trust again'."

In Phase 3 HASI participants had similar levels of trust to the comparative age group in the Australian population. The Australian Social Attitudes survey (2003: 126) found 36 per cent of 18–34 year olds believed most people could be trusted, compared to 32 per cent of HASI participants interviewed. Fluctuating trust levels at an individual level ($p<0.05$) reveal that some HASI participants have been and remain vulnerable to exploitation. Participation in HASI, however, has assisted in increasing participant awareness of exploitation, the likelihood of preventing such exploitation from occurring (through implementing strategies and occasional relocation) and intervention from key workers when exploitation occurs.

Facilitating meaningful access to community is an important issue for social inclusion, building relationships and trust and overcoming feelings of loneliness. While community participation has increased, feelings of loneliness have persisted for approximately half of the group throughout the evaluation. Historically, most HASI participants have been isolated from their communities irrespective of their geographic location. Isolation and feelings of loneliness were further compounded for some people who were required to move away from family and/or social networks to join the program (usually the case for people from rural and regional areas).

One of the most profound outcomes from HASI is the improvement in peoples connection with their communities and families. Many participants increased their participation in local activities and events, work and education. Through meaningful activities and ongoing support, many HASI participants also improved their social skills, developed new friendships and strengthened their relationships with family and friends.

HASI has eased tensions, reconnected some individuals with estranged family, and improved family dynamics for others. For many clients, frequency and quality of contact with family had improved since starting HASI. At the third phase of the evaluation, 81 per cent of clients reported being satisfied or very satisfied with family 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.

> "If it wasn't for [the ASP] I would have just barricaded myself inside everyday and not gone anywhere; and because I have got good medication now and I have had the support from the HASI people, I can actually start to function a bit and get out and about in public and realise that there is a world out there and I should be a part of it." (HASI participant).

"Since joining HASI, one woman reported significant improvements in her relationships with her family and friends. She now has regular contact with her previously estranged daughter, son and grandson. Her daughter lives with her and her son frequently brings her grandson to visit. The ASP corroborated the marked changes that have occurred in this woman's life. As her key worker stated:

'Previously it was hard to get her out of the house. Her anxiety levels have decreased. ... She is also participating more in the community and now goes out on her own. She has fulfilled a lot of the goals she set for herself.'

One of the biggest was to live happily with her daughter."

2.4 Improved mental health

As earlier evaluation reports showed, most participants, ASP and AMHS personnel and family members reported improvements in HASI participants' mental health. The strongest indicator supporting this is hospitalisation data. Improvement in mental health across the majority of HASI participants is also supported by data contained within MH-OAT. The pre-HASI and in-program hospitalisation and MH-OAT outcomes are detailed below.

Hospitalisation

Summary of mental health – hospitalisation

- Eighty-four per cent of HASI participants have spent less time in psychiatric units or emergency departments since joining HASI.
- The average time participants spent in psychiatric units or emergency departments as a proportion of total time decreased by 81 per cent: from 88.7 hospital days per person per year (prior to HASI) to 18.9 days (since joining HASI).
- The average number of days people were hospitalised per admission dropped by 77.6 per cent (an average of 23.2 fewer days per admission).
- Twelve per cent of HASI participants experienced an increase in hospital admissions since joining HASI (the remaining 4 per cent did not experience any change).
- When 2004–05 costs are used to standardise dollars spent on hospitalising HASI participants between 2000 and 2005, $49,654 was spent per HASI participant per year prior to their joining the program. Since joining HASI, the hospitalisation of HASI participants costs an average of $8,065 per person per year. This is an 84 per cent decrease, which equates to a potential of over $4 million hospital spending on HASI participants avoided per year (based on 100 HASI participants).[16]

"After being in and out of institutions for long periods for the past seventeen years, a middle-aged man has finally regained his independence through HASI. He was unable to live in supported accommodation previously because of his mental health problems; and poor living skills and his history of aggression meant he could not access community services such as Home Care. Over the last six months the ASP has spent time developing this client's social skills and according to his key worker he is now 'more independent'.

'He has begun a one-on-one TAFE course on computers and has reconnected with his family after seven years of separation. At Easter 2005 he caught an interstate bus to visit family and he now speaks with them once a week. The six months he has remained in his home 'is the longest period of time he has had out of hospital since 1988'. (ASP Key worker)"

16 For a more detailed discussion of program costs and benefits, see Section 4.

17 This only included participants who consented to have their hospitalisation records accessed by SPRC evaluators and whose details could be matched with NSW Health hospital data. As NSW Health hospital data became available in July 2006, HASI Evaluation Reports 1 and 2 used ASP records to calculate the number of hospital days per person. Their data were based on records received in referral forms (predominately from AMHS personnel) and their own records. There is some discrepancy between ASP and NSW Health data because the ASP records included days spent within residential rehabilitation facilities, as well as hospital admissions. To ensure data accurately reflects the hospitalisation of HASI participants, this report only analyses NSW Health data.

Method

NSW Health provided hospital data for approximately 67 HASI participants.[17] Data received covered five financial years – from 2000/2001 to 2004/2005. The data included the dates of admission and discharge, unit type on admission and facility. Data was divided into two categories: status prior to joining the program (pre-HASI) and status since joining the program (in-HASI).[18] The analysis for each period was conducted on the proportion of days hospitalised compared to the total days in the period.[19] To accurately reflect the change in psychiatric based hospitalisations since joining HASI, all general, surgical and medical admissions were omitted from the analysis. Hospitalisations included psychiatric unit (acute and non-acute) and emergency department admissions.

Outcomes

Eighty-four per cent of HASI participants (n=56 of 67; Table 2.4) spent less time in hospital since joining HASI, compared to the immediate years prior to HASI. Only 12 per cent (eight participants) spent a greater proportion of their time in hospital since participating in the program (the additional three participants had no hospital data recorded before or after joining HASI).

Overall, the average time participants spent in hospital as a proportion of total time decreased from 24.3 per cent prior to joining HASI to 4.6 per cent since starting the program. When equalised over a year this equates to 88.7 hospital days per person per year prior to joining HASI and 18.9 days since; an 81 per cent reduction (Figure 2.1 and Table 2.4).

The average number of days people were hospitalised per admission also dropped substantially by 77.6 per cent (an average of 23.2 fewer days per admission). The average length of stay in hospital for HASI participants (6.8 days) is half the average of all mental health related hospitalisations 2003-04 (AIHW 2005:102).

Table 2.4 Pre-HASI and in-HASI participant hospitalisations in psychiatric units and Emergency Departments (n=67)*

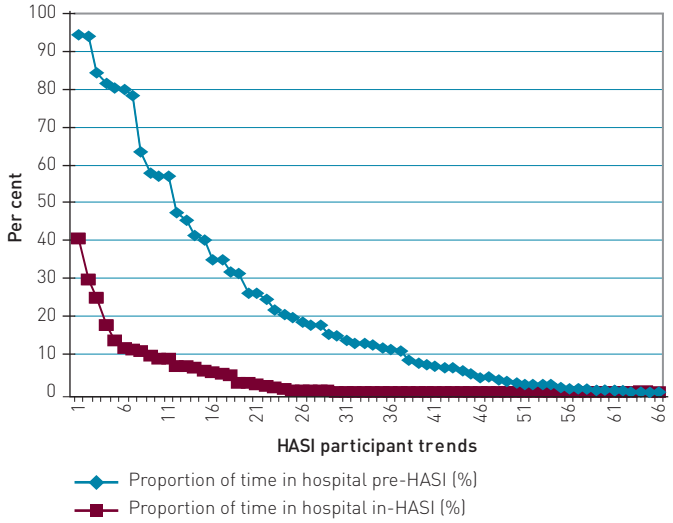
	Pre-HASI (based on days from first admission occurring after 1 July 2000 to day prior to HASI entry, inclusive)	In-HASI (from day entered HASI to 30 July 2005, inclusive)	Change since joining HASI
Time participants spent in hospital as a proportion of total time (per cent)	24.3%	4.6%	–19.7 percentage points
Average number of days spent hospitalised per person per year	88.7	16.8	81.1% reduction
Average number of admissions per person per year	3.0	2.5	–0.5 days** (16.7% reduction)
Median number of admissions per person per year	1.7	0	–1.7 less admissions (100% reduction)
Average number of days hospitalised per admission	29.9	6.7	–23.2 (77.6 % reduction)

Notes: Based on data received from NSW Department of Health hospitalisation records (data provided for financial years 2000/2001–2004/2005). Total hospital admission days pre-HASI= 15,449 over 63,606 days and in-HASI = 1267 admission days over 27,554 days in the program. Total number of admissions pre-HASI = 516 and in-HASI = 189.
**This drop is small because one person had 38.6 per cent of all in-HASI admissions (n=73 of 189).

18 The former includes data from the first hospital admission after or on 1 July 2000 and the latter from the date housed in the HASI property. To compare the number of hospital days prior to and since joining the HASI program a proportion of days was used. The number of days spent in hospital prior to the program was divided by the total number of days between the first hospital admission on or after 1 July 2000 and the day before being housed as a HASI participant; this was compared to the number of days hospitalised after joining the program divided by the total number of days between the date housed as a HASI participant and 30 June 2005 (the most recent hospital data provided by NSW Health)

19 Each HASI participant started the program at a different time and therefore standard comparison dates cannot be used. Comparing a 12-month period prior to HASI with 12-months involvement in the program was considered but rejected because of the episodic nature of mental illness, changes to peoples accommodation situation immediately prior to HASI to assist in the transitioning process and the likelihood of a 'honeymoon' period immediately after joining HASI. A proportion of time was the preferred method because it increased the period analysed and maximised the sample size.

Figure 2.1 Psychiatric unit and Emergency Department hospitalisation trends as a proportion of time, pre-HASI and in-HASI (n=67)



At an individual level some HASI participants experienced significant decreases in the proportion of time they spent in hospital (Figure 2.2 and Figure 2.3). One participant's hospitalisation decreased from 94 to 0 per cent. The cost implications of decreased hospital admissions are discussed below.

Figure 2.2 Psychiatric unit and Emergency Department hospitalisations by individual as a proportion of time, pre-HASI and in-HASI (n=67)

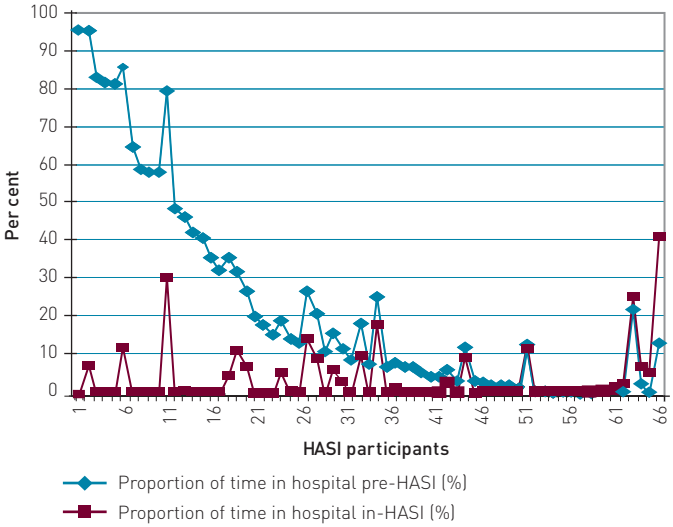
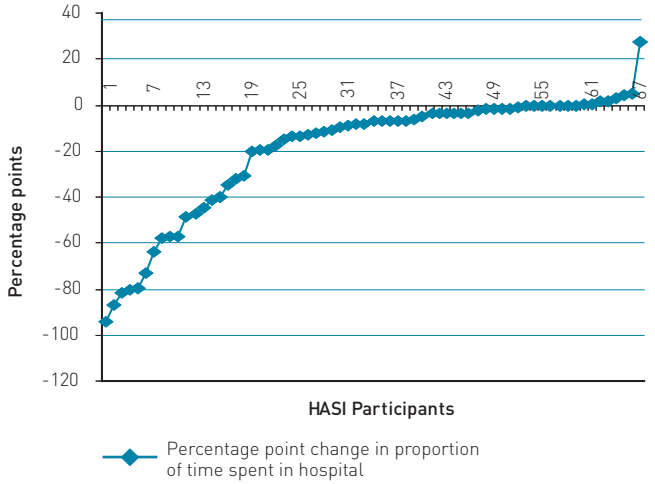


Figure 2.3 Change in time spent in hospital since joining HASI, by individual (percentage points, n=67)



HASI participants experienced a decrease in both the frequency and duration of hospital admissions since joining the program. However, the average length of time people spent in hospital decreased at a greater rate than the average number of occasions they were admitted (duration decreased by 81.1 per cent, while frequency dropped by 16.7 per cent, Table 2.4). This was primarily because one person accounted for 73 of the 189 in-HASI admissions (38.6 per cent).

Change in hospitalisation costs

The substantial decrease in the time participants spent in hospital resulted in a significant drop in hospital expenditure on these individuals. Between 1 July 2000 and peoples entry into the HASI program, the NSW government spent almost $7.5 million on their psychiatric unit and emergency department hospital admissions. When the dollars spent are annualised per person, psychiatric unit and emergency department, admission costs on HASI participants decreased from $42,959 pre-HASI to $7,831 since the program started (Table 2.5 and Figure 2.4).[20]

Table 2.5 Real dollars spent on psychiatric unit and Emergency Department hospitalisations pre-HASI and in-HASI (n=67)

	Pre-HASI	In-HASI	Change
Average $ spent per person per day	$117.70	$21.46	–$96.24
Average $ spent per person per year	$42,959.50	$7,831.64	–$35,127.86

Notes: Based on 15,499 hospital days (NSW Health data) at a cost of $7,486,278.60 (NSW Health Costs of Care Standards) over 63,606 total days pre-HASI (CID); and 1,267 hospital days at a cost of $591,214.00 over 27,554 total days in-HASI.

If hospital expenditure is adjusted to standardise costs between 2000 and 2005, the estimation more closely reflects hospital dollars avoided for HASI participants by participating in the program (Table 2.6). Using 2004/05 costs derived from NSW Health Costs of Care Standards, $49,654 was spent per HASI participant per year prior to the program, compared to $8,065 since joining. This is an 84 per cent decrease; and if these figures are estimated across 100 program participants, over $4 million per year has potentially been avoided on the hospitalisation of HASI participants, thereby increasing capacity for other patients. The costs are costs avoided for these participants rather than costs saved by Health.

Table 2.6 Estimated dollars spent on psychiatric unit and Emergency Department hospitalisations pre-HASI and in-HASI based on financial year 2004/05 costs (n=67)

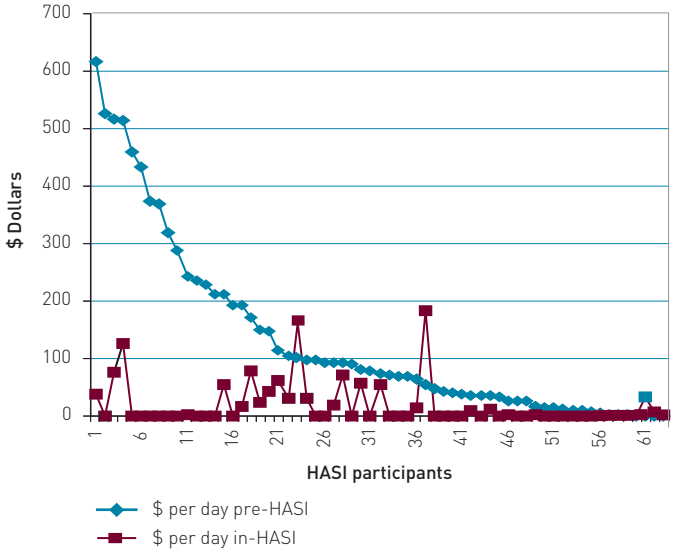
	Pre-HASI	In-HASI	Change
Average $ spent per person per day	$136.04	$22.10	–$114.00
Average $ spent per person per year	$49,654.63	$8,065.65	-$41,588.98
Proportion of pre-HASI cost		16%	84% reduction
Total cost estimated for 100 people per year	$4,965,463.00	$806,565.00	–$4,158,898.00

Source: NSW Health Costs of Care Standards 2004–05.

Notes: Based on $8,652,965.50 on 67 people over 63,606 days pre-HASI ($129,148.74 per person) and $608,874.00 on 67 people over 27,554 days in-HASI ($9,087.67 per person).

20 The evaluation plan proposed comparing MH-OAT data from HASI participants to those on a waiting list. The waiting list data was not available to the Mental Health and Drug and Alcohol Office.

Figure 2.4 Dollars spent on psychiatric unit and Emergency Department hospital admissions pre-HASI and in-HASI per person per day (n=67)



Mental health outcomes and assessment tools

MH-OAT provided further baseline and comparison data to evaluate changes in mental health among HASI participants.[21]

Summary of mental health – MH-OAT and PWI

- Completed MH-OAT data sets from 2002–2006 were provided by NSW Health for one-quarter of the HASI participants. These people have a greater frequency of hospitalisation and lower GAF scores than the other HASI participants.
- When MH-OAT data for participants is compared, pre-HASI and in-HASI, the majority of people experienced improved mental health:
  - 68.4 per cent of peoples HoNOS data, which measures behaviour, impairment, symptoms and social areas, improved since joining HASI
  - 68.8 per cent experienced an overall drop in their level of withdrawal and anti-social behaviour and an improvement in their self-care and compliance (LSP 16d)
  - 75 per cent were less psychologically distressed (K10+LM).
- HASI participants were more likely to be dissatisfied with their physical, rather than their mental, health.
- Overall satisfaction in wellbeing between Phase 1 and 3 of the evaluation slightly decreased. High PWI scores in Phase 1 were a reflection on the dramatic change in peoples lives since joining HASI – acquiring a new home, new furniture and new opportunities. With stability and routine, these feelings of wellbeing subdued. By Phase 3, despite improvements in mental health, increases in community participation and other positive outcomes, more people reflected on missed opportunities and unachieved aspirations.
- While average PWI scores decreased slightly, median PWI scores closely reflected normative population scores for standards of living, feelings of safety and future security. This is testimony to the important role stable housing and accommodation support has played in HASI participants' lives.

21 The evaluation plan proposed comparing MH-OAT data from HASI participants to those on a waiting list. The waiting list data was not available to the Mental Health and Drug and Alcohol Office.

Method

NSW Health provided data from three assessment tools within MH-OAT: the Health of the Nation Outcome Scales (HoNOS), Life Skills Profile (LSP) and Kessler 10 psychological distress (K10). Of the 71 people who made their MH-OAT data available for the evaluation, 41 had some completed datasets. Only 25 of these people had data entered prior to HASI and since joining the program. Therefore only one-quarter of the HASI participants' MH-OAT could be analysed.

According to NSW Health (2002), MH-OAT is to be updated every thirteen weeks. However, the majority of data entry for HASI participants occurred when people were admitted or discharged from hospital (192 of the 297 MH-OAT entries). Just over one-third (35 per cent) of entries were standard reviews. As data was not completed at regular intervals for the HASI participants, there were insufficient numbers of standard 13-week reviews to only analyse this data. Therefore all of the measures completed for each person were averaged prior to and after they joined the HASI program. Collection dates span from January 2002 to June 2006.[22]

As the majority of MH-OAT data entries occurred in relation to hospitalisations (65 per cent), the following analysis is based on a specific group of HASI participants. The majority had been admitted to hospital prior to and since joining the HASI program. As a group, these individuals had higher levels of psychiatric disability than other HASI participants before and after joining the program. They were not only more likely to have hospital admissions, they also had lower GAF scores. GAF scores for the group were lower on average at entry into HASI and at evaluation Phases 2 and 3 (Table 2.7).

Table 2.7 Average GAF scores for people with MH-OAT data and without

	Phase 1	Phase 2	Phase 3
Participants with MH-OAT data (n=19)	37.0	45.9	49.2
Participants without MH-OAT data (n=74)	42.7	56.4	56.6
HASI participants (involved Phases 1, 2 and 3 (n=63)	41.0	56.0	58.0

The following sections reveal similar patterns across all three assessment tools; the majority of participants with complete MH-OAT data experienced improved mental health.

Health of the nation outcome scales (HoNOS)

HoNOS, an instrument developed in the United Kingdom, measures twelve item outcomes across four areas – Behaviour, Impairment, Symptoms and Social Functioning – on a scale of 0 (no problem present) to 4 (with 2 or more indicating a problem of clinical significance). Data provided by NSW Health included the total score for each person (based on 10, rather than 12, items). These total scores were averaged pre-HASI and in-HASI to measure change since joining the program. Nineteen HASI participants had completed pre-HASI and in-HASI scores.

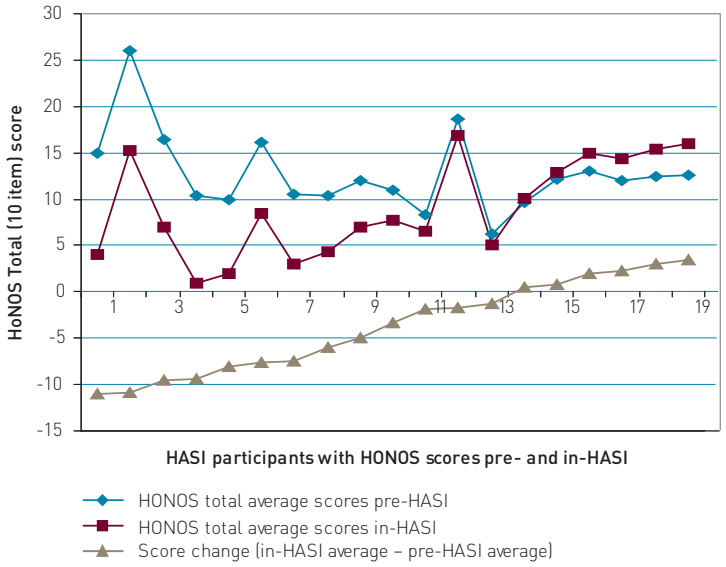
Most people (68.4 per cent of those with completed HoNOS scores) experienced improvement in behaviour, impairment, symptoms and social areas (Table 2.8 and Figure 2.5). This improvement (indicated by a lower HoNOS score in-HASI) ranged from a decrease of 1.3 to 11 points. Six HASI participants experienced more problems after joining the program, but this shift was slight, ranging from an additional 0.05 to 3.4 points. On average, HoNOS scores improved from 12.8 pre-program to 9.0 since joining HASI.

22 Similar to the hospitalisation data, pre-program data included measures entered between 1 January 2002 (earliest data provided by NSW Health, inclusive) and the day before moving into a HASI property, and in-program included measures entered between the day of moving into a HASI property and 30 June 2006 (latest MH-OAT data received by NSW Health, inclusive).

Table 2.8 Participant HoNOS scores pre-HASI and in-HASI

HASI participant	HoNOS Total average scores pre-HASI	HoNOS Total average scores in-HASI	Score Change
1	15.0	4.0	-11.0
2	26.0	15.2	-10.8
3	16.5	7.0	-9.5
4	10.4	1.0	-9.4
5	10.0	2.0	-8.0
6	16.1	8.5	-7.6
7	10.5	3.0	-7.5
8	10.3	4.4	-5.9
9	12.0	7.0	-5.0
10	11.0	7.7	-3.3
11	8.3	6.5	-1.8
12	18.6	16.8	-1.8
13	6.3	5.0	-1.3
14	9.6	10.1	0.5
15	12.1	12.9	0.8
16	13.0	15.0	2.0
17	12.0	14.3	2.3
18	12.4	15.4	3.0
19	12.6	16.0	3.4
Average	12.8	9.0	-3.8

Figure 2.5 Change in HoNOS scores pre-HASI and in-HASI



Life skills profile

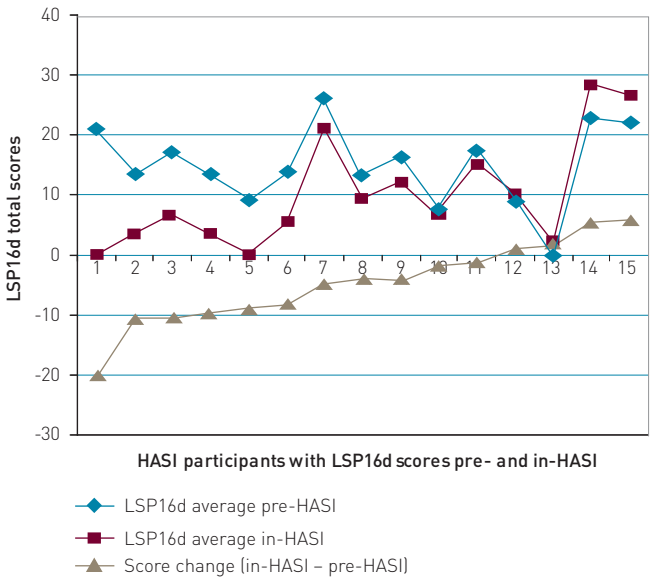
LSP measures life skills in terms of ability level. NSW Health requires the regular collection of the brief 16-item disability version (LSP16d). This measures withdrawal, anti-social behaviour, self-care and compliance. A high score means a person is highly disabled in the area measured. Fifteen HASI participants had LSP16d measures completed prior to and since joining HASI. Total scores (with a possible range of 0 to 48) were averaged pre-HASI and in-HASI to measure change since joining the program.

Life skills had improved for 68.8 per cent of participants (11 of the 15 with available measures). Ability increased significantly for some people, with scores decreasing between 1.25 and 20.5 points (Table 2.9 and Figure 2.6). On average scores decreased per person by 4.8 points.

Table 2.9 LSP16d average total scores pre-HASI and in-HASI

HASI participant	LSP16d average pre-HASI	LSP16d average in-HASI	Score change (In-HASI to Pre-HASI)
1	20.50	0.00	-20.50
2	13.80	3.00	-10.80
3	17.00	6.60	-10.40
4	13.50	3.75	-9.80
5	9.30	0.00	-9.30
6	13.80	5.50	-8.30
7	26.00	21.00	-5.00
8	13.50	9.50	-4.00
9	16.00	12.00	-4.00
10	8.90	7.00	-1.90
11	16.70	15.40	-1.30
12	9.50	10.30	0.80
13	0.00	2.00	2.00
14	23.20	28.30	5.10
15	21.00	26.80	5.80
Average	14.85	10.07	-4.78

Figure 2.6 LSP16d average total scores pre-HASI and in-HASI



Kessler 10

NSW Health also provided data from the Kessler 10, a self-completed ten item questionnaire rating psychological distress (based on restlessness, anxiety and depressive symptoms). The Kessler 10+LM total scores were used to compare baseline (pre-HASI) and in-program data. The K10+LM includes an additional four questions and people rate their psychological distress over the last four weeks. The total score is between zero (no distress) and 50 (extreme distress). The K10+LM is only completed on inpatient admission to hospital. Therefore the scores compare levels of distress immediately prior to hospital admission before and since joining HASI.

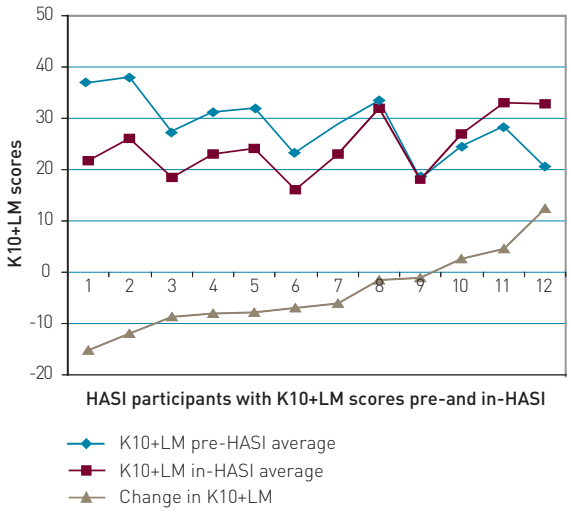
Twelve HASI participants completed K10+LM scores prior to and since joining the HASI program. Three quarters of these participants experienced less psychological distress since their involvement with the program (ranging from a one point to a 15.2 point drop), while three people experienced greater distress (Table 2.10 and Figure 2.8). Therefore, even when HASI participants were unwell enough to require inpatient hospital admission, the majority were less distressed when they were in the program than they had been before participating. This is consistent with the decrease in the duration of hospital admissions.

Table 2.10 Kessler 10+LM scores pre-HASI and in-HASI

HASI participant	k10lm pre-HASI average	k10lm in-HASI average	Change in k10lm
1	37.0	21.8	-15.2
2	38.0	26.0	-12.0
3	27.3	18.5	-8.8
4	31.0	23.0	-8.0
5	32.0	24.2	-7.8
6	23.0	16.0.	-7.0
7	29.0	23.0	-6.0
8	33.5	32.0	-1.5
9	19.0	18.0	-1.0
10	24.3	27.0	2.7
11	28.4	33.0	4.6
12	20.5	32.8*	12.3
Average	28.6	24.6	-4.0

Note: *Score reported immediately after a distressing incident.

Figure 2.7 Kessler 10+LM scores pre-HASI and in-HASI



When compared to people with a mental illness in the general population who have at least moderate levels of psychological distress, HASI participants continue to have higher levels of psychological distress but there has been a substantial improvement over time (Table 2.11).

Table 2.11 Kessler 10 scores of HASI participants (n=12) compared to the general population with mental illness (per cent)

	Pre-HASI	In-HASI	National Health Survey*
Low (10–15)	0	0	64
Moderate (16–21)	17	33	23
High (22–29)	42	42	9
Very high (30–50)	42	25	4

Note: *National Health Survey 2001

The MH-OAT measures show similar trends across time: on average, the majority of participants experienced increased functioning across their living skills (LSP16d); improvement regarding their behaviour, impairment, symptoms and social lives (HoNOS); and a decrease in psychological distress (K10+LM). These are important outcomes, especially because the group of HASI participants who these measures are based on are more likely to have experienced and continue to experience greater psychiatric disability than their HASI counterparts.

Personal wellbeing index (PWI)

Despite the findings of decreased hospitalisation and improved mental health, the PWI scores of people who participated in all three phases of the evaluation (n=55) indicate that there was a slight decrease in overall satisfaction in wellbeing between the first and third interviews (Table 2.12). These decreases are unsurprising. The initial scores were high because the program was new; people's lives were considerably changed by their participation in HASI – acquiring a new home and new furniture was accompanied by a renewed sense of security and safety and an opportunity to re-establish, re-build or strengthen personal relationships.

By the second phase of the evaluation, the feelings of elation and excitement were more subdued because individuals had moved from the 'honeymoon' period to one of stability and routine. The third drop in satisfaction was largely a reflection on participants' increasing awareness of life's possibilities, which may have been coupled with feelings of disappointment, frustration or helplessness about the ability to attain those possibilities – such as the ability to purchase new furniture, attain aspirations of paid mainstream work and/or education, and access mainstream social activities outside of their budget. Time has demonstrated that life's complexities, such as relationship problems, continue even with improved mental health and independence.

Importantly, dissatisfaction with health was more likely to be in relation to poor physical, rather than mental health problems. While there has been some drop in satisfaction on average across all domains, the median scores have remained fairly stable and for every measure, except health, people were more satisfied than not (scores remained over 50). Median scores also closely reflect normative population data (Table 2.12). This indicates the important role HASI has played in some people's wellbeing in relation to their standard of living, what they have achieved in life and their feelings of safety and future security. Satisfaction in these domains among a group of people, who were historically disadvantaged, unwell, vulnerable and living in unstable accommodation, is testimony to the success of the program.

Table 2.12 Personal wellbeing index scores for people who participated in Phases 1, 2 and 3 of the evaluation (n=55) and normative scores*

Satisfaction with:		Phase 1	Phase 2	Phase 3
Life as a whole	Mean	59.4	58.0	54.40
	Median	60.0	70.0	60.00
	Normative mean			71.53
Standard of Living	Mean	65.2	63.2	58.70
	Median	70.0	65.0	70.00
	Normative mean			71.71
Health	Mean	56.0	53.7	49.20
	Median	60.0	60.0	60.00
	Normative mean			68.16
Achieved in life	Mean	64.2	56.6	58.10
	Median	60.0	70.0	70.00
	Normative mean			71.19
Personal relationships	Mean	63.2	60.4	54.20
	Median	70.0	70.0	70.00
	Normative mean			75.57
Feeling safe	Mean	70.4	68.2	60.90
	Median	70.0	75.0	80.00
	Normative mean			75.31
Part of the community	Mean	57.7	64.3	55.80
	Median	60.0	70.0	70.00
	Normative mean			70.68
Future security	Mean	68.0	61.2	57.00
	Median	70.0	70.0	70.00
	Normative mean			68.09
Mental health	Mean**	66.7	56.1	58.20
	Median	70.0	60.0	70.00
Physical health	Mean**	56.9	51.4	53.40
	Median	60.0	60.0	60.00

Notes: * Based on normative data from combined survey mean scores (n=13) (Cummins 2005: 39).

** No normative means available. These are not part of the PWI, but were added in this evaluation to separate people's perceptions of their mental and physical health.

2.5 Increase access to specialist and generalist community services

Being supported to access health services is vital to maintain physical and mental health. Evaluation results show HASI participants accessed a wide range of health services.

Summary of access to specialist and generalist community services

- Since joining HASI 96 per cent of people have accessed AMHS health professionals and 94 per cent psychiatrists and general practitioners.
- Ongoing monitoring of mental and physical health and consistent access to appropriate health professionals is likely to have influenced reports of improved heath.
- While 60 per cent of people reported improved physical health throughout the evaluation, physical health problems are common among HASI participants and their perceptions of general health are poorer than the general population.
- Access to community, welfare, educational and social services has steadily increased throughout the program.

Access to medical services

HASI participants access a range of health, specialist and generalist community services. Almost all HASI participants (96 per cent) have accessed AMHS health professionals, psychiatrists (94 per cent) and general practitioners (94 per cent; Table 2.13). Consistent access to health professionals and ongoing monitoring of mental and physical health are a valued part of the program and are likely to have influenced reports of improved health.

It is difficult to directly compare HASI participant service contacts with contacts made by people with mental health problems in the general Australian population because of variations in data collection.[23] However, HASI participant access rates are high when compared to Western Australians with mental disorders (ABS 1999). Within a 12-month period, 39 per cent of Western Australians with a mental disorder had accessed a health service and 32 per cent a General Practitioner. People with severe levels of psychiatric disability had higher levels of health service access (59 per cent of women and 56 per cent of men) than other Western Australians with more moderate or mild levels of psychiatric disability. Comparatively, 96 per cent of HASI participants had used at least one health service. Throughout the HASI evaluation, participants who saw a general practitioner (94 per cent) had an average of 22 consultations, equating to 1.2 visits a month (Table 2.13).

Table 2.13 Health service use between entering HASI and Phase 3 (n=109)

	GP	Psychiatrist	Psychologist/ counsellor	Specialist, other	AMHS health professional
Proportion who had a consultation	94%	94%	32%	51%	96%
Median number of visits (of people who had at least one consultation)	8	12	4	3	18
Average number of visits (of people who had at least one consultation)	22	15	11	5	36

Perception of general health

This regular medical service contact, coupled with appointments to other specialists where required, along with improved diet and increased physical activity and participation in general, resulted in 60 per cent of people reporting improved physical health. However, numerous participants had ongoing comorbid physical health problems (such as Hepatitis C, asthma and other respiratory problems, incontinence and arthritis).

Almost one in five reported declining physical health in Phase 3 of the evaluation and, as Section 2.4 discussed, HASI participants were more dissatisfied with their physical health than their mental health. It is therefore not surprising that HASI participants' perception of their general health is poorer than the general population. HASI participants were more than twice as likely to describe their general health as fair or poor (ABS 2006: 16; Table 2.14). Despite physical health problems, HASI has continued to facilitate recognition, identification and appropriate treatment of these problems.

> "... because of them [ASP] I discovered I have diabetes, which was caused by the medication, and I've had to cut out loads. I've had to cut out saturated fats and sugars... I used to eat meat pies, I love meat pies, and I don't buy meat pies anymore, they're full of fat. So the pies are out, and peaches are in."
> (HASI participant).

23 The ABS collects data based on the two weeks prior to data collection, while data collected throughout the HASI evaluation was based on a six-month period. The data was entered into a database by ASP personnel in all nine sites and had large discrepancies. Consequently, a two-week collection period could not be accurately estimated across all HASI participants. The ABS National Health Survey: Mental Health (2001) found 29.2 per cent of people with mental and behavioural problems consulted a health professional within the two weeks prior to completing the survey and 36.9 per cent, a doctor.

Table 2.14 HASI Participant and national population (18-64 years) perceptions of general health

	National Health Survey (n=12,523,000)	HASI participants (Phase 3, n=51)
Excellent/very good	58.6	27.5
Good	28.0	37.3
Fair/poor	13.4	35.3

Access to other services

Access to non-medical, general community services varied across sites and between individuals. The services HASI participants accessed can be categorised into four types:

- Work and financial services: employment agencies, government income support, Centre Pay and Office of the Protective Commissioner for financial management and non-government organisations for welfare relief
- Domestic services: such as home care cleaning, meal services and garden/lawn maintenance
- Social/community services: eg day programs, psychosocial support and community support groups for people with mental illness, gymnasiums, sporting organisations, leisure centres and art groups
- Educational services: such as, TAFE, universities, community colleges and public libraries.

2.6 Retention rates and exits

HASI was shown to have high retention rates throughout the evaluation. Reasons for consumers leaving the program were examined in detail.

Summary of retention rates and exits

- Three factors were found to be statistically significant in increasing a person's likelihood of leaving HASI: Indigenous status, time in prison in the year prior to HASI and having children.
- Multiple diagnoses are prevalent in HASI participants and result in complex needs. While the retention rates among this group are high, people with substance use disorders are slightly more likely to exit the program than those without. Staff training on working with people with substance use problems is critical.

The success of the model and quality of the program across the sites are evident in the high retention rates. Seventy-eight per cent of people who joined HASI were still involved at Phase 3 of the evaluation (March 2006; n=113). Twenty-five people exited the program. A certain level of throughput is expected in such an intense program with people who have histories of high levels of psychiatric disability, vulnerability and transience. Program exits can be categorised into people who left the program with the support of ASP and/or AMHS stakeholders – because the program is not, or no longer, believed to be appropriate – and people who left of their own volition. At an individual, descriptive level people have exited the program for a range of reasons – some required a higher level of support than the program could offer, others moved to a non-HASI area, one shifted to HASI Stage Two, two were incarcerated and some sought to regain their independence.[24]

People who left the program to regain their independence were not necessarily leaving because of improved mental health. HASI is a highly interventionist program because of the level of support provided by ASP, AMHS and housing provider personnel. Therefore a key factor in regard to remaining in the program is not only a person's willingness to be involved at the outset, but also an ongoing engagement with the program. AMHS and ASP personnel believed some people who left the program were not ready to embrace the opportunity for change. One AMHS manager explained,

24 It is difficult to determine the number of people who exited HASI and were rehoused in social housing because many left the geographic area and data could only be obtained when a person exited HASI and stayed with the same provider (Section 2.2). For a more detailed discussion of people who exited HASI Stage One, see Muir et al., 2007.

> "[Some people are] restrained from changing ... because of the chronicity [of their illness and] ... a lot of the social factors ... So, even though they may dream up the idea of getting well, to actually tread that path is a fairly hard journey because to do so means taking more responsibility, doing these things, and it could mean at some stage losing their social connections and sometimes the fallbacks they have might not be very supportive, things like alcohol abuse, cannabis, gambling, [and] sitting around doing nothing."

As the number of people who exited HASI is small, it is important to also look at exits from a statistical perspective to inform management of likely exit trends when HASI expands. Three individual factors were found to significantly predict a person's exit from the program: Indigenous status ($p<0.05$), time in prison in the year prior to joining the program ($p<0.05$) and having children ($p<0.1$).

Indigenous people were much more likely to exit the program, with 57 per cent having left by Phase 3 of the evaluation (n=4 of 7), compared to 18 per cent of non-Indigenous participants (n=18 of 102). The poor retention rate of Indigenous people was not only statistically significant as an independent variable ($p<0.05$), but also the strongest indicator of a person exiting the program when regressed across time and other factors are controlled (Table 2.15).

Table 2.15 Retention rates by demographic factors (linear regression)

	Affect	Std. error	Beta	t.	Sig.
Constant	1.98	0.03		68.14	0.00
Identifies as Indigenous Australian	–0.46	0.10	-0.46	-4.74	0.00
Has children	–0.08	0.06	-0.12	-1.20	0.23
Participant spent time in prison year prior to HASI	–0.03	0.05	-0.06	-0.63	0.53

Dependent Variable: Exited the program

Half of all HASI participants who had spent time incarcerated in the year before joining the program had exited by Phase 3 (n=2 of 4), compared to only 6 per cent of people who had not spent time in gaol in the previous 12-months (n=5 of 81). The disparity in the retention rates of people with and without children was not as great, but was significant nonetheless.

Almost one-third of people with children had left the program by Phase 3 (n=7 of 22), compared to 16 per cent of people without children (n=14 of 86).

When these three factors – Indigenous status, prison and children – are examined together, Indigenous status is the only factor that remains significant in predicting program exits (Table 2.15). The fact that Indigenous status alone (when controlling for other factors) is sufficient to increase the likelihood of exiting the program, suggests that HASI is not necessarily successfully supporting Indigenous people. Interestingly, people from culturally and linguistically diverse backgrounds were not anymore likely to exit the program, which indicates that HASI may be responding to the cultural needs of culturally and linguistically diverse people in the program.

Contrary to some stakeholder expectations, the severity of psychiatric impairment and having a dual diagnosis did not predict exiting the program. The relationship between exiting the program and the following variables were not statistically significant: intellectual or cognitive disability, physical disability, level of psychiatric impairment, level of impairment from drug or alcohol use, secondary mental illness, occasions admitted to hospital pre-program, GAF at entry, level of living skills when entered the program,[1] region or support provider, country of birth or language.

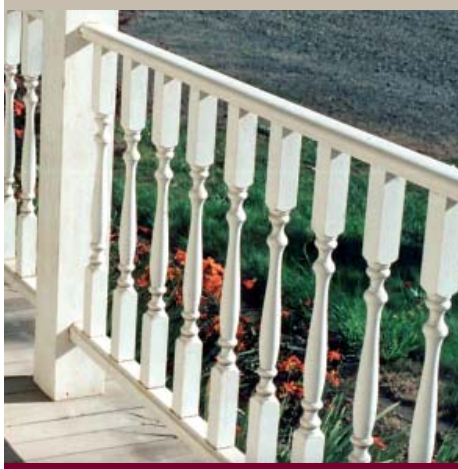
A minority of people (12 per cent) with a history of substance use disorder had exited HASI by Phase 3. These people were slightly more likely (although not statistically significant) to exit the program than people who had no such history (5 per cent). Similarly, 14 per cent of people with a substance use disorder while in HASI left the program, compared to 6 per cent of their counterparts. The high retention rates of people with multiple diagnoses suggest HASI can be a successful model and program for people with complex needs.

25 ASP personnel assessed living skills. These skills included cooking, cleaning, diet, budgeting, banking, making appointments, using community services, laundry, using public transportation, shopping, exercise, bathing/showering and dressing.

> "One case manager believed HASI is 'the only [program] that [enables her client who has a primary diagnosis of schizophrenia and a dual substance use disorder] to actually be out in the community'. Interviews with ASP key workers indicate that staff training on working with people with substance use problems is critical."

Although also not statistically significant, women were slightly more likely to exit HASI (22 per cent) than their male counterparts (19 per cent). The under-representation of women in HASI, women's increased likelihood of exiting the program and having children as a predictor of exiting, indicates that further thought may be required regarding the gendered nature of HASI. This is supported by the literature, which shows that women can be disadvantaged in accessing mental health support services and that community mental health services for women with a severe mental illness 'often do not focus on the needs of women as spouses, mothers, or family members' (Mowbray, 2003: 6).

Finally, the place of residence was found to increase the likelihood of exiting the program (again not statistically significant, which could be a result of the small sample). Almost one in five (19 per cent) people who had lived in a group home or residential–rehabilitation facility prior to the program had left HASI by Phase 3, compared to 7 per cent of people who had lived elsewhere. The severity of psychiatric disability or the level of living skills when entering the program were not likely to increase a person's chances of leaving HASI. Therefore, to ensure HASI is appropriately tailored to people who previously lived in a group home or residential–rehabilitation facility, the transitioning period, the person's willingness to accept a different support model and the effects of moving from shared accommodation to living alone could be further explored. As this section of the report has shown, the evaluation found correlations between certain demographic factors and exiting HASI. To further strengthen the program's ability to successfully support people from a range of backgrounds, relevant services and bodies (such as the NSW Department of Corrective Services, drug and alcohol and disability services and Indigenous and culturally specific peak bodies) could be further consulted.



THREE

MODEL AND PARTNERSHIP OUTCOMES AND LESSONS

3.1 Support practices

Principles shaping HASI support practices reflect the partnership structures of the program (particularly its interdisciplinary characteristics), organisational cultures, workers' experience and skill levels and the complexity of the circumstances of individual participants. These support practices can loosely be categorised as:

- A person centred 'rehabilitative' approach where support aims to change the cognition and behaviour of participants to enhance personal efficacy and wellbeing through psychosocial training
- A person centred disability services approach that acknowledges the practical difficulties of daily living and community engagement and aims to improve the quality of life
- An advocacy approach that seeks to help people assert their rights and take more control of the circumstances of their daily life – this was particularly evident in situations where people require support in family or legal matters, or where there is violence or exploitation by others
- A non-person centred directive approach, usually driven by poor individual practice, expedience or the interests of other parties (while this approach was adopted by a minority of workers, it was not an approach enshrined in the principles, objectives and/or policies of the program or HASI provider organisations).

The first three approaches are broadly compatible in the way they support individual participants in the various domains and aspects of their daily lives. Participants can benefit from psychosocial training, the provision of disability supports and a focus on empowerment to defend their citizenship rights. These approaches are complementary, not contradictory.

Overall, a psychosocial rehabilitation approach appears to work well as a model for HASI. Yet, the evaluation has shown that key workers require training, supervision and ongoing skill development to learn and implement this type of approach. It also found that support for HASI participants should be tailored to individual need, and therefore, practical support may cross various approaches at different times and in different circumstances.

Many ASP key workers demonstrated examples of good practice support. The following is a list of some of the techniques used by key workers, as well as good practice ASP organisational policies, that were identified in the evaluation:

- Support plans are participant driven, in collaboration with AMHS personnel and other stakeholders and reviewed regularly
- Participant skills and strengths are identified and goals are set with achievable steps
- Individual goals are set relative to participant requests, needs and abilities
- Support is flexible where necessary and follows routine and structure when required
- Support is minimised/decreased when participants feel the program is too intrusive
- While daily living skills are an important focus, so too are recreation and social activities
- Boundaries of responsibility are maintained
- Key workers are trained to understand the difference between early warning signs of poor mental health and behavioural problems or loneliness
- Key workers participate in social/recreational activities with clients to help build rapport, develop worker insight, enhance participants' feelings of safety and security and improve social skills
- Key workers provide a preventive and interventionist role to help avoid mental health crises and failed tenancies
- ASP is committed to training staff in core competencies, such as mental health first aid, behaviour management, substance use disorders and facilitating independence/skills training
- At least one key worker has a mental health background to increase the intellectual capital within the ASP and assist in rapport building with AMHS personnel
- ASPs provide staff development and promotional opportunities.

3.2 Mutually beneficial partnerships

The foundation of the HASI model is collaboration. It is a coordinated approach that brings together accommodation support workers from the NGO sector, case managers from Community Mental Health Services, housing providers from both DoH and Community Housing agencies, as well as participants of the initiative. Peak bodies that represent the users of mental health services are also involved in the implementation and monitoring of the program.

The benefits of sound collaboration between the partners are indirectly evident in the client outcomes and were reflected by most stakeholders. Many ASP, AMHS and housing provider personnel have healthy working relationships and mutually beneficial partnerships. Although a minority of partner relationships remain tense, most have taken time to develop the coordination to work together effectively. Stakeholder partners continue to strengthen, deal with, and overcome, persisting challenges.[26]

> "[The ASP] has decreased my workload and provided [my client] with a lot of extra support. I wouldn't have the time to do the things they do. We can't be there as often as they'd [clients] like us to be and we'd like to be. ... Having them on board really helps. (AMHS Case manager)"

AMHS and housing providers

As previous reports have discussed, for many AMHS and housing provider personnel involved in the program, HASI has been mutually beneficial. HASI has enabled case managers to reclaim their 'case management' focus and move away from providing disability and 'survival' maintenance support. The following comments reflect the sentiment shared by many of the AMHS personnel interviewed:

> "Before the [HASI] program I was so busy running around with [a client], I never got to do the work I needed to do with him. ... I was band aiding day by day before, but with [the ASP's] support, that's not the case. And because of the accommodation side of things, I don't have to worry about them getting kicked out of their places or that they don't have enough money to pay the rent because it's at a reasonable rate." (AMHS Case manager)

The majority of housing providers also spoke of the benefits HASI afforded their organisations. As a result of HASI, these organisations have successfully provided housing to individuals with high levels of mental illness:

> "I'm excited that we can help people who couldn't just walk into a real estate agent and get another place. It's given us an avenue to be able to support mental health. ... Before we'd be floundering and their tenancy would be going out the window because they could no longer live in that community and it would be the horrible tribunal and witnesses for things like noise and nuisance." (Housing provider)

This program is an important example for housing providers beyond the nine HASI sites, especially at a time when almost one-third of new public housing households are for people with 'complex priority needs' (DoH 2005: 21).[27]

26 For a more detailed discussion of the challenges and progress during the implementation see the prior three reports: Morris et al. 2006d; Muir et al. 2006, 2007.

27 This includes the elderly, people with a disability or mental illness, homeless people and young people without family support.

Good practice partnerships between AMHS, ASP and housing provider personnel

The evaluation identified numerous factors that strengthen and challenge interagency working relationships and the HASI program (Muir et al. 2006: 47–49). Through the study, many of these factors have received the attention of the Mental Health and Drug and Alcohol Office and the Department of Housing. As partnerships are instrumental to the effective operation of HASI, some of the facilitating factors are repeated below (the antithesis of these factors hindered partnerships):

- Management and ground staff share an understanding about, and commitment to, HASI as a model and program
- Stakeholders have a clear understanding of the roles and responsibilities of each other, which in turn encourages informed and realistic expectations
- Varying stakeholder opinions, skills and experiences are respected and valued
- Stakeholders perceive HASI as mutually beneficial
- Consumer advocates are proactively involved in HASI at a local level
- Stakeholders at all levels have frequent, regular, open and constructive communication through formal and informal meetings (established at the beginning of the partnership and maintained throughout)
- Partners freely share information (with a commitment to confidentiality within the group)
- Stakeholders are transparent with each other when problems arise and work together to solve problems
- Varying approaches are shared and respected and the best option for participant outcomes is jointly decided upon
- Support plans are jointly developed and other formal interactions occur between participant, case manager, key worker and other service providers making the partnership transparent and effective
- AMHS and ASP personnel are accessible, supportive and encouraging of each other, as well as understanding of each other's role limitations
- Case managers and key workers appreciate the different type of relationship they have with participants
- HASI participants, ASP and housing provider personnel work together to understand, minimise and manage tenancy risks
- Community mental health teams have a structure that incorporates a recovery/rehabilitation team, which can support people when they are moving towards recovery, rather than only providing support when they are in crisis
- While some turnover occurs naturally, key worker and case manager retention rates are high.

Most areas were working towards implementing these practices. While some conflict inevitably occurred between the partners, successful areas had introduced mechanisms to resolve problems as they arise.

3.3 Operational and governance lessons from HASI

In addition to key success factors for strong partnerships, the evaluation identified areas of governance that could be further looked at to strengthen HASI. These are summarised as follows:

- Service level agreements could be formulated and signed early in the program to help individuals understand their roles and responsibilities. Flexibility to later revise, add and amend these agreements could also be considered.
- The Area Health Services are the contract providers to the ASP. Therefore AMHS and ASP stakeholders need to be cognisant about the potential for relationships to be skewed and inequitable.
- Communication between key workers (not just management) across organisations could be very beneficial for building skills, sharing ideas and problem solving.
- OH&S for ASP personnel is a major consideration for the planning, budgeting and implementation of stages.
- Confidential, free access to psychologist/clinical supervisors for key workers, coupled with work related reflective practice, may decrease staff burnout.
- Transitioning protocols are required for smooth exits from the program and/or to another stage of the program.
- Further clarification and communication about housing exit policies may assist to overcome some confusion about what happens to housing and furniture once a person exits the program.
- Some stakeholders are concerned that the growth of HASI may compromise the quality of the service or curtail flexibility in the model.
- Further consideration may be needed about how the HASI stages work together: flow-through of participants and inclusion in social and recreational activities.
- ASPs who have funding for various HASI stages have greater flexibility of shifting support hours based on participant requirements. The fluctuating nature of mental illness means that ASPs who have support packages at lower, medium and high levels are better able to flexibly provide support where needed.
- Moving a participant from HASI Stage One to HASI Stage Two could potentially destabilise the person if the ASP changes. Most participants have considerable rapport and trust with their ASP and consistency is relied upon. This stability is seen as especially important as case managers are likely to change (through either turn over or the need to utilise the skills of a different case manager).
- Various HASI stages in one location have in some instances presented referral problems. Many AMHS staff are still not aware of HASI; AMHS, ASP and housing providers sometimes conflict over the appropriateness of different people for the varying levels of HASI; and, because places are still limited, people may still be hesitant to refer to HASI (referring could give a person and carer/family members a sense of false hope).

FOUR

COST-EFFECTIVENESS ANALYSIS

Cost-effectiveness analysis provides information about the value added by HASI.[28] The cost of the program per HASI participant is calculated and the change in outcomes per HASI participant are examined. The costs included and outcomes measured are based on the evaluation plan and discussions with DoH, NSW Health and housing providers during the design and throughout the evaluation.

4.1 Costs

The cost-effectiveness analysis includes direct costs to NSW Health and DoH and individual housing providers. Expenditure reports most closely reflect direct cost. These were received from housing providers and DoH in relation to leasing and recurrent program management costs. Other expenditure data, however, was not available from NSW Health or DoH. Therefore other costs are based on budget data.

The program set-up costs were $11,033,786.72. The majority of these costs were NSW DoH capital costs of $9,700,000. The remainder were NSW Health costs for ASP NGO establishment and program evaluation (Table 4.1).[29] Recurrent costs are presented in Table 4.2. An estimate of recurrent program costs per participant per year is $57,530 (Table 4.3). This includes the funding provided to ASP NGOs for accommodation support, program management and housing costs (leasing, rental arrears, housing vacancies, appeals and locating new properties).[30] When these costs are based on supporting 100 people, the program costs $5,752,962 per year.[31]

Table 4.1 Total start-up costs by agency and type ($, excluding GST)

	NSW Health	DoH	Total
Establishment costs for ASP	960,151.72	N/A	960,151.72
Program management	N/P	N/A	–
Social housing – capital	N/A	9,700,000.00	9,700,000.00
Evaluation cost	373,635.00		373,635.00
Total	1,333,786.72	9,700,000.00	11,033,786.72
Total per person (based on 100 places)	13,337.87	97,000.0.0	110,337.88.00

Notes: N/A – not applicable; N/P – not provided

Table 4.2 Raw recurrent program costs by agency and type ($, excluding GST)

	NSW Health	DoH	Office of Community Housing	Housing providers	Total
ASP recurrent funding (per year)	5,000,000*	N/A	N/A	N/A	5,000,000
Program management (per year)	N/P	31,893	47,840		79,733
Leasing	N/A	104,990	551,200		656,190
Rental arrears				3,900	3,900
Appeals				2,700	2,700
Property vacancy				11,861	11,861
Locating new property				4,830	4,830

Notes: N/A – not applicable; N/P – not available
*Based on $50,000 per person with 100 people in the program.

28 Whereas cost-benefit analysis requires dollar figures to be placed on all components of the analysis (costs and benefits), cost-effectiveness analysis allows the assessment of the benefits of the program in physical and social terms (eg quality of life gained) and is therefore more appropriate for the purposes of human service program evaluation (Schmaedick, 1993). The underlying principle of cost effectiveness is that for the given budget, the government wishes to maximise benefits conferred (or for a given goal the government wishes to minimise the cost of achieving it).

29 NSW Health did not provide any program management costs. DoH advised that its set-up program management costs were an in-kind contribution to the program.

30 NSW Health did not provide any recurrent program management costs. Costs to the HASI participant, family and other service providers such as GPs were unavailable. Economic costs – that is the costs foregone because resources (such as management time or housing stock) were spent in HASI, rather than elsewhere – were also unavailable.

31 NSW Health and DOH costs are based on the program supporting 100 people and aggregated and divided by the number of people in the program based on the program supporting 100 people (as neither NSW Health nor DOH could provide records of the total number of people in the program relating to the relevant financial years). As the data is limited, this analysis does not capture variation per person or per location.

Table 4.3 Estimated recurrent program costs by agency and type per HASI place* per year ($, excluding GST)

	NSW Health*	DoH	Office of Community housing*	Housing providers**	Total
ASP funding	50,000	N/A	N/A	N/A	50,000.00
Program management	N/P	318.93	478.40		797.33
Housing – leasing	N/A	1,049.90	5,512.00		6,561.90
Housing – rental arrears				28.00	28.00
Housing – appeals	N/A	N/A	N/A	19.40	19.40
Housing – property vacant	N/A	N/A	N/A	85.27	85.27
Housing – locating new	N/A	N/A	N/A	37.72	37.72
Total	50,000	1368.83	5,990.40	170.39	57,529.62

Notes: N/A – not applicable; N/P – not provided
*Based on 100 places in the program (as agreed by NSW Health and Housing).
**Based on 93 tenancies lasting for a total of 50,770 total days (includes only the 93 people whose tenancy dates were received for date housed and date left property – this includes some people who exited HASI but remained with the housing provider – or, if still housed, up to 1 March 2006).

4.2 Outcomes

The evaluation plan was that the cost effectiveness analysis would quantify changes by comparing pre-HASI and in-HASI outcomes for HASI participants and by comparing HASI participants to a similar population group of people who were assessed as eligible for HASI and were on a waiting list. For ethical and cost reasons, researchers planned to compare to non-identified data from NSW Health and DoH about people on the HASI eligibility list. This data was not available. The analysis instead relies on baseline and in-program data collected by the evaluators about HASI participants.

All measures for this analysis are presented as per participant and, where possible, annualised. Effectiveness was measured in terms of the following outcomes due to the availability and reliability of comparison data.[32] On average, improvements were measured across all areas – tenancies, hospitalisation, life skills, mental health, physical health, participation, social network and incarceration (Table 4.4).[33]

4.3 Summary

HASI cost $5,752,962 per year for 100 places (this includes funding provided to ASPs for accommodation support, program management and housing costs – leasing, rental arrears, housing vacancies, appeals and locating new properties). It excludes one-off set-up costs of $11,033,786; the majority of which were DoH capital costs. HASI provided people who have a mental illness and high levels of psychiatric disability with affordable, decent housing, daily support from ASP personnel, regular access to mental health professionals and increased access to other specialist and community services.

At an average cost of $57,530 per person per year, the measured outcomes are summarised as follows and quantified in Table 4.4.

- Stabilised tenancies
- Decreased hospital admissions and days spent in hospital per admission
- Improved mental health: decreased psychological distress (K10+LM); improved behaviour and reduced impairment, symptoms and social problems (HoNOS); and increased occupational, social and educational functioning (GAF)
- Improved life skills
- Increased social, economic and educational participation
- Decreased imprisonment rates.

32 Comparison data on length of tenancy and number of evictions for similar social housing tenants were not available from DOH or OCH. Tenancy turnover, number of evictions, proportion of people with rental arrears and number of complaints by neighbours were collected throughout the evaluation. As DOH or the OCH did not provide comparable data, only vacancy rates are compared with normative data.

33 The evaluation plan also proposed measuring change in people's substance use. This was not included in the report because of the poor reliability of data (self-reported measures, missing data and variations in reporting, making standardisation difficult and unreliable).

Table 4.4 Measures of cost-effectiveness

Outcome	Explanation	Normative comparison data	HASI participant pre-program or entry data	HASI participant in-program data (mean results throughout evaluation or Phase 3)	Average cost-effectiveness measure
Tenancies	Remained in same home (12 months or more)		–*	70%	70% of HASI participants (who we received tenancy data on) remained in the same home for 12 months or more
	Remained with housing provider in or out of HASI		–*	85%	85% of HASI participants remained with the housing provider whether still participating in HASI or having exited the program (therefore, at least 85% have achieved stable accommodation)
	Average no. days property remained vacant after tenant moved out	19.2[4]		6.4[7]	Vacancy rates for HASI designated OCH properties three times lower than OCH norms (per property)
Hospitalisation	Average no. hospital days per participant per year (pre-HASI: 1 July 2000-entry; in-HASI: joining the program – 30 June 2005)		88.7[1]	16.8[7]	81% reduction in time spent in hospital for psychiatric and/or emergency admissions per person per year
	Average no. hospital days per person per admission		29.9[1]	6.7[7]	77.6% reduction in the number of days spent in hospital per person per admission
Life skills	Life skills 16-item disability measure (LSP16d- MH-OAT)[3]		14.9[1]	10.1[7]	4.8 point score reduction in life skill related disability
Mental health	Health of the Nation Outcome Scales (HoNOS – MH-OAT)[3]		12.8[1]	9.0[7]	3.8 point score reduction in total HoNOS scores per person (an overall improvement in behaviour, impairment, symptoms and social problems)
	Kessler 10 (K10+LM – MH-OAT)[3]		28.6[1]	24.6[7]	4 point reduction in K10+LM per person (an average decrease in psychological distress)
	Global Assessment of Functioning (GAF)	52.4[6]	41[2]	58[7]	GAF score increased by 17 points per person (occupational, social and educational functioning improvement)
Physical health	Responded excellent, very good or good to ABS general health question	86.6%[5]		64.8%[8]	HASI participants report poorer physical health than the general population. By Phase 3, however, almost 65% reported their physical health as excellent, very good or good.
Participation	Proportion working in a paid or voluntary capacity		8%[2]	26%[8]	Increase in proportion participating in the paid and voluntary workforce
	Education and training		2%[2]	20%[8]	A ten-fold increase in the proportion participating in education or training. 43% of all HASI participants at Phase 3 were working and/or studying (a 34% increase in these types of participation)
Social network	Proportion of HASI participants reporting no friends		23%	6%	Increase in social networks
Imprisonment	Proportion of HASI participants incarcerated		29.9	6.7	77.6% decrease in imprisonment

Notes: *No specific comparative data are available (see footnote 17), but a history of tenancy instability is one of the eligibility criteria for HASI.
[1] Prior to joining the HASI program.
[2] On entry to HASI.
[3] MH-OAT outcomes are based on pre-program: 1 January 2002 to day before being housed in HASI property; and in-program: first day housed in HASI property to 30 June 2006.
[4] Office of Community Housing population data.
[5] ABS 2006.
[6] Mean GAF scores averaged over a 6-month period for 103 people with psychiatric diagnoses similar to HASI cohort (that is, 75 per cent have a primary diagnosis of schizophrenia, Jones, Thorncroft, Dunn and Coffey, 1995).
[7] Average results in-HASI. The low vacancy rate may be due to the responsive nature of the program and the intent to meet the individual needs of each tenant. Some vacant HASI designated properties are transferred to general housing stock and another property provided to meet HASI participants' needs. This also reduces vacancy rates and rent loss.
[8] Results from Phase 3 of the evaluation.

FIVE

FUTURE CONSIDERATIONS

Future considerations

- Australian born men under 35 years of age with at least a dual diagnosis predominate in HASI. The majority of participants have a primary diagnosis of schizophrenia and substance use disorders are the most common secondary diagnosis. It is difficult to assess the representative nature of people selected for HASI according to the population experiencing mental illness. Eligibility for the program is based not only upon long-term hospitalisation rates and tenancy instability among other selection criteria, but also the level of disability experienced as a result of the mental illness. It is this latter factor that is difficult to gauge when comparing the demographics of people in the community with a mental illness and HASI participants. However, women and people from culturally and linguistically diverse backgrounds appear to be under-represented. Contrarily, Indigenous Australians are well represented with regard to recruitment. Yet the program has had difficulty in retaining Indigenous Australians.
- Coordination between each of the partners – Health, Housing and the housing and accommodation support NGOs – is instrumental to the success of the model. Ongoing formal and informal structures, such as regular meetings, improve the effectiveness of the partnership model. Early indications are that where further stages of HASI are implemented with the same providers, there is greater flexibility to meet participant needs and the quality of partnerships improved.
- Future HASI models could consider shared living arrangements for people in relationships or for people who prefer to live with a friend.
- Further stages of HASI should consider the viability questions for DoH and OCH in providing social housing, such as capital and recurrent costs.
- A sense of place is not necessarily determined by geographical location. Therefore facilitating access to community is important for HASI participants, irrespective of whether they live in urban, regional or rural areas.
- Improving access to resources and opportunity for community participation requires careful balance with ensuring connection to family and social networks.
- ASP and AMHS personnel linked some HASI participants to community and general services. In some situations, however, resources and direction may be required to overcome barriers to service access that participants face. For example, accessing some drug and alcohol rehabilitation services is restricted to people with a mental illness who are on certain medication.
- Further consultation with relevant services (such as corrective/justice; drug and alcohol, disability and women's services) and peak bodies (eg Indigenous and culturally specific) may assist HASI participants.
- Participant retention is partly tied to their willingness to engage with the program.
- Three factors were found to be statistically significant in predicting a person's exit from the program – Indigenous status, time in prison in the year prior to the program and having children. Identifying as Indigenous was such a strong predictor of exiting the program, that when indigenous status, prison time and having children were grouped in a regression analysis, only indigenous status remained statistically significant.
- Implementing a psychosocial rehabilitation model requires quality training of staff to address quality of care, application of the HASI principles, burnout and other issues.

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APPENDIX A: EVALUATION PLAN

Key evaluation questions

- Does HASI enable clients to maximise their participation in the community and sustain successful tenancies and access other services?
- Are appropriate and effective governance arrangements in place to support the establishment and ongoing development of HASI?
- Does HASI enhance access to specialist and generalist support services including housing, mental health, disability and other human services through processes of partnership and planning?

The evaluation of HASI was longitudinal and multi-method in design. It incorporated:

1. Three phases of data collection and analysis at six-month intervals:
   - February to April 2005
   - September to November 2005
   - February to April 2006.
2. Interviews with all key stakeholders:
   - Participants
   - Family members or carers (where appropriate)
   - Key workers from the ASPs
   - Managers within the ASPs
   - Case managers from the AMHSs
   - Managers within the AMHSs
   - Housing providers
   - Representatives of relevant peak bodies
   - Senior personnel within the Centre for Mental Health and DoH
   - Members of the HASI Evaluation Advisory Committee.
3. Qualitative data:
   - Collected through interviews with key stakeholders
   - Observation of HASI-related processes, activities and planning.
4. Quantitative data:
   - Key stakeholder surveys
   - Client Information Database
   - Participant hospitalisation data
   - Participant Mental Health Outcomes and Assessment Tools data
   - Global Assessment of Functioning scores.

The full evaluation plan is available (Morris et al., 2006).

APPENDIX B: HASI EVALUATION REFERENCE GROUP

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