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NSW HEALTH

HOUSING AND ACCOMMODATION SUPPORT INITIATIVE EVALUATION

REPORT III

SPRC Report 2/07

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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
CMH	Centre for Mental Health
DoCS	Department of Community Services
DoH	NSW Department of Housing
GAF	Global Assessment of Functioning Scale
GP	General practitioners
HASI	Housing and Accommodation Support Initiative
HP	Housing provider
MH-OAT	Mental Health Outcomes and Assessment Training
NGO	Non-government organisation
NSW	New South Wales
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 third of four reports on the fieldwork for the evaluation of the Housing and Accommodation Support Initiative Stage One (HASI). HASI is a partnership between NSW Health, NSW Department of Housing (DoH) and non-government organisations (NGOs). The program's objectives are to assist people with mental health problems to acquire and maintain stable housing, to improve community participation and quality of life and to provide a system of supportive stakeholders to work with people with mental illness towards recovery or maintenance (NSW Health and NSW Department of Housing 2005).

This report presents the findings from the final phase of fieldwork (conducted in February and March 2006) and the longitudinal outcomes from Phases 1, 2 and 3. The latter findings are based on over 600 interviews with HASI stakeholders, including 219 client interviews. This report complements the first two evaluation reports (Morris et al 2005, Muir et al 2005). These three reports form the background for the final evaluation report in 2006.

The evaluation found HASI is mediating some of the effects of mental illness for many clients. The program provides an inter-woven system of support from housing providers, Area Mental Health Service (AMHS) and Accommodation Support Provider (ASP) personnel that has enabled people to maintain their tenancies, increase their participation in the community and develop and strengthen social and family networks, among other outcomes. Some of the findings are as follows.

Roles, responsibilities and support plans

- HASI has allowed AMHS case managers to focus on their core activity – the provision of clinical support, which includes the maintenance and monitoring of mental health.
- ASPs provide a range of domestic, emotional, health, employability, educational, advocacy, social and life-based support for clients.
- Client need, interests and willingness, along with the process and approach of the organisations, determine the nature and intensity of support provided.
- Community and public housing providers locate and manage HASI tenancies, working closely with ASP personnel.
- All clients interviewed had a documented support plan with their ASP; a good-practice support plan process is client driven and formulated and implemented in collaboration with AMHS personnel and other stakeholders.

Referral, assessment and client selection

- The majority of ASP and AMHS personnel believe the HASI referral and assessment process is good or excellent.
- When stakeholders question selection decisions, it is usually because they believe a selected client is not making the most of an opportunity in which someone else within the system could be taking advantage.

- Australian born males under 34 years of age with a diagnosis of schizophrenia remained the most prevalent group of people in the HASI program.
- The proportion of Indigenous Australians decreased between evaluation Phase 2 and 3 and culturally and linguistically diverse (CALD) people remained under-representative of the population, as did females.

Tenancies

- Half of the HASI clients accommodated by housing providers live in a unit or an apartment. The proportion living in townhouses, villas, duplexes and houses has increased since the start of the program. Almost all HASI clients live alone in two-bedroom accommodation.
- Clustered accommodation has been successful where the cluster is kept to a maximum number (three or four) of tenants and the tenant mix is carefully considered.
- 70 per cent of people accommodated by a housing provider on entry to HASI were still in the same home by the end of March 2006. In the majority of cases, HASI clients' property care is as good or better than other tenants.
- Co-tenancy has been problematic for some people in terms of exploitation and destabilising HASI tenancies, but also because the model excludes shared leases.
- Only 17 per cent of HASI clients were in rental arrears during the evaluation – most for less than one month. A minority of HASI tenants experienced problems with neighbours (both as complainants and being complained about).

Health

- Global Assessment of Functioning (GAF) scores are a sound indication of change in mental health among clients over time. In Phase 1 only 38 per cent scored over 50 (out of a possible 100), compared to 76 per cent in Phase 3.
- HASI clients continued to have a high level of access to health professionals.
- Between entry to HASI and Phase 3 of the evaluation, 71 per cent of clients reported improved mental health, 60 per cent better physical health, 67 per cent improved diet and 78 per cent felt more positive about themselves.

Living skills

- Living skills improved significantly across the group between entering HASI and Phase 3 of the evaluation. Greatest gains in independence (more than 20 per cent increase) were in banking, medication, diet, exercise and cooking.
- Further key-worker training would clarify the path from support to maximising the attainment of longer-term independence or reliance on mainstream services.

Social inclusion and relationships

- Recreational activities have played an important role for many clients in building social skills, increasing confidence and in turn increasing independence and a pathway to work and education. A variety of social options – ASP-organised, disability and mainstream groups – afford clients the best opportunity for meaningful community participation.

- 83 per cent of clients were participating in at least three of nine community activities measured at Phase 3 (shopping, eating out, library, church, social groups, educational institutions, organised sport, leisure activities or exercise).
- 43 per cent of clients involved in HASI at Phase 1, 2 and 3 were working and/or studying at the time of the last interview, compared to 9 per cent on entry to HASI.
- While 23 per cent of clients did not have any friends when they joined HASI, 94 per cent had established friendships by Phase 3. However, at all evaluation phases, approximately half of all HASI participants reported feeling lonely.

Exits

- 78 per cent of people who started HASI remained in the program in March 2006 (n=113).
- Compared to non-Indigenous people participating in HASI, Indigenous retention rates are low (50 per cent).

Governance

- Approximately 80 per cent of AMHS case managers and ASP key workers reported healthy working relationships with each other. A minority of case managers and key workers are experiencing significantly more difficulty in their collaborative relationship than in the past (Table 8.5 lists factors that facilitate and hinder stakeholder relationships).
- Housing provider and ASP personnel relationships remained stable and overwhelmingly positive throughout the evaluation.
- Housing providers and AMHS personnel have minimal contact at an operational level, but middle and upper management have developed good working relationships. AMHS managers were all positive about these relationships, but some housing providers reflected on the need for a more equitable partnership.
- Open communication with family members and carers has assisted stakeholders to work well together and maintain trust, and may, in turn, help ASP and AMHS personnel to reinforce strategies and to assist clients to reach goals.
- ASP managers reported varying levels of difficulty in regard to recruitment, retention, training and OH&S issues.
- ASPs that provided training, staff development and promotional opportunities reaped the reward of loyal and skilled employees with strong stakeholder relationships.

1 Introduction

This is the third of four reports providing findings from a longitudinal evaluation of HASI Stage One. HASI is a partnership between NSW Health, DoH and NGOs, which is jointly funded by NSW Health and DoH. The program aims 'to assist people with mental health problems and disorders requiring accommodation (disability)[1] support 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 is based on psychosocial rehabilitation principles and has a recovery focus. The program provides permanent housing and long-term support for over 100 people with complex mental health problems and high levels of psychiatric disabilities. It covers nine locations that fall within the following NSW Area Health Services: Greater Western, Hunter/New England, Northern Sydney/Central Coast, South Eastern Sydney/Illawarra, Sydney South West and Sydney West. HASI Stage One is currently supplemented by HASI Stage Two (low support) and Three (high support). This evaluation covers only HASI Stage One.[2]

The Social Policy Research Centre's (SPRC) commissioned evaluation of HASI Stage One examines the implementation, process and effects of HASI over a two-year period.[3] This report focuses on longitudinal client outcomes, service provision and governance issues. Throughout the evaluation, researchers have provided feedback to NSW Health and Housing on a regular basis. Subsequently, modifications to the model have occurred. This document should be read in conjunction with the first two evaluation reports (Morris et al 2005; Muir et al 2005).

1 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.

2 Stage One is for over 100 high support clients. HASI Stage Two is a low support outreach for 460 people who are in established social housing accommodation, but may be at risk of losing this without support. Stage Three has 126 places for individuals with high support needs. This stage is currently being implemented. This evaluation only examines HASI Stage One. From here on, therefore, HASI Stage One will be referred to as HASI.

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

1.1 Overview and Methodology

Summary

- During Phase 3 of fieldwork (February-March 2006) 205 stakeholders were interviewed and surveyed, including 69 clients.
- 55 clients participated in Phase 1, 2 and 3 interviews and the Client Information Database included longitudinal information on 69 clients.

Between February and March 2006, the third and final phase of fieldwork for the HASI evaluation was conducted across all nine sites. Sixty-nine clients were interviewed. Of these clients, 55 had been interviewed in Phase 1 and 2 of the evaluation. Throughout the report, longitudinal client outcomes are based on these 55 people. Table 1.1 lists the number of stakeholders who participated in Phase 1, 2 and 3. Substantial staffing movement (related to changing responsibilities and staff retention) within AMHS and ASPs resulted in a low number of repeat participants across all three phases.

Table 1.1: Evaluation Cohorts at Phase 1, 2 and 3

Stakeholder group	Interviewed Feb/March 2005	Interviewed Sept/Oct 2005*	Interviewed Feb/March 2006	Interviewed all phases
Clients	71	79	69	55
ASP key workers	61	61	52	21
ASP managers	10	11	10	5
AMHS case managers	30	35	36	8
AMHS team leaders and managers	9	10	6	3
Housing provider personnel	11	9	10	6
Family/carers	27	-	13	-
Consumer advocates	2	-	5	-
DOH/CMH personnel	2	-	4	-

Note: * Not all stakeholders were interviewed in Phase 2 of the evaluation. This was agreed within the evaluation plan.

In addition to the interview and survey material collected from the stakeholders listed in Table 1.1, ASP personnel again completed a Client Information Database (CID). This database contains information on 87 HASI clients who were participating in the program in March 2006 (and data on an additional nine people who exited the program between Phase 2 and 3 of the evaluation). Throughout the report, information from this database is drawn upon to examine both what is occurring at Phase 3 and also longitudinally. Longitudinal comparisons are based on the 69 HASI clients

whose details were entered into the database at all three phases of the evaluation and who were still participating in the program during Phase 3.[4]

In cases where longitudinal comparisons are provided, unless otherwise stated, data is only based upon stakeholders who participated in all three phases of the evaluation.[5] Statistics listed throughout the report reflect the number of respondents to each particular question or area, unless otherwise stipulated. In all cases, the proportion and the number are listed.

1.2 Evaluation Progress

This report presents the findings from the fieldwork. The remaining final report will be completed in 2006. In addition to discussing implications from the fieldwork, the final report will include an economic evaluation.

All data collection for the evaluation is now complete except administrative data for the economic evaluation. These data relate to HASI clients and comparison groups, including: MH-OAT, hospitalisation and housing data.

[4] In a few cases, longitudinal comparisons based on CID data include people who had exited the program prior to the fieldwork (n=76).

[5] Only thirteen family members participated quantitatively in Phase 3 of the evaluation. These responses therefore cannot be used as a representation of family perceptions across the cohort. They can, however, be used qualitatively and help us understand how some families interpret and perceive the HASI program.

2 Program Structure

2.1 Partner Roles and Responsibilities

Summary

- Clarity around roles and responsibilities continued to increase over time.

Role of AMHS

Summary

- HASI has continued to allow case managers to focus on their core activity – the provision of clinical support, which includes the maintenance and monitoring of mental health.

During Phase 3 of the evaluation, AMHS personnel reinforced that HASI has enabled them to regain their clinical case management role because they are 'no longer tied up with phone calls, doctors' appointments, … [organising] blood tests [or] social activities [or worrying about] food or tenancy' (case manager). This clinical focus includes medication support, monitoring and maintenance of mental health and referral to psychiatrists and other mental health specialists.

Case manager roles differ depending on qualifications, skills and position descriptions. Occupational therapists, for example, work on activities of daily living, often in conjunction with the ASP. Case managers within a rehabilitation team also have a focus on daily living skills, like budgeting, employment assistance and sleeping patterns, which complement ASP support.

Liaising with ASP personnel is a part of the case managers' roles.[6] By working together, crises are often prevented because key workers report unusual behaviour, changes in wellbeing and elevated symptoms. Assessment and intervention can therefore occur before a client reaches crisis point.

Frequency of AMHS contact with HASI clients differs depending on individual need, from daily support to very infrequent irregular appointments when required. The majority of clients see their case managers once a week, fortnight or month. Throughout the evaluation clients had a total of 1045 contacts with AMHS personnel (Section 4.3). In a number of cases where contact is minimal between clients and case managers, the AMHS expressed an interest to close these cases. ASP requests to keep these people within the case management system was often respected and while they

[6] While most case managers take on this responsibility as part of their role, a few believed that AMHS clinical activity targets did not include liaising with non-health service providers (NSW Health commented that this was not the case; liaisons with non-health service providers are counted towards AMHS case managers' activity targets).

took primary responsibility for supporting these clients, case managers were readily available if required. Maintaining open access to AMHS support is an important component of the program.

Role of ASP

Summary

- ASPs provide a range of domestic, emotional, health, employability, educational, advocacy, social and life-based support for clients.
- Client need, interests and willingness, along with organisational structures, determine the nature and intensity of support provided.
- A minority of ASP workers do not follow the psychosocial rehabilitative principles of the HASI program.
- Thorough induction, training and supervision is/would be beneficial to key workers.

ASP personnel provide a rehabilitation, recovery and disability support role. Support is provided within the home - cleaning, laundry, cooking, diet, personal hygiene, medication and budgeting, for example – and in the community – shopping, banking, exercise, accessing community and government services and transportation to appointments and to access other resources.

One of the primary roles of key workers is to facilitate community participation. As such, key workers provide significant support for clients to access education, work, sport, leisure and community groups and participate in every-day community-based activities, such as eating out, window-shopping, or drinking coffee in a local cafe. Legal, cultural, emotional and relationship support is also provided, along with advocacy and assistance to build or strengthen social networks.

Throughout the evaluation period, some ASP personnel have increasingly based their support on a psychosocial rehabilitation model. Many key workers approach their role as a mentor, teaching living skills and facilitating community participation and independence. Some key workers, however, continue to provide a disability-based 'caring for' and supervisory role. A minority of newly appointed ASP employees also use language and have attitudes that contradict their NGO's practice principles. These problems reinforce the importance of a thorough induction process and training program.

Role of housing providers

Summary

- Community and public housing providers locate and manage HASI tenancies, working closely with ASP personnel.

Community and public housing providers are tenancy managers for the majority of HASI clients.[7] Community housing providers locate and manage accommodation for HASI clients in seven of the nine sites; the Department of Housing (DoH) is responsible for tenancy management in the remaining two locations. Housing providers focus on locating appropriate properties, tenancy rights and responsibilities (including tenancy laws) and property maintenance.

Clients are housed in units, townhouses, villas or separate houses. Most properties have two-bedrooms and were carefully matched to individual clients. The involvement of ASP personnel in this process helped to ensure that housing was matched to personal and mental health needs. Properties are either leased or owned by the housing providers. Leasehold properties continue to provide flexibility and widespread choice, but they lack the tenancy security of a capital property.

Housing providers work closely with clients and ASP personnel in relation to locating appropriate housing, property maintenance, rental arrears, neighbour relationships and property related problem solving.

2.2 Support Plans

Summary

- All clients interviewed had a documented support plan with their ASP.
- The planning process is often client driven and in collaboration with AMHS personnel and other stakeholders. The review of these plans is inconsistent and infrequent for some clients. Goal setting can also be problematic for some clients in terms of timeframe, breakdown of tasks and not being client driven.

In most cases, the clinical, property related and community-based support HASI clients receive is determined by a collaborative support plan process. These meetings are largely driven by the clients and attended by key workers, ASP managers, case managers and occasionally family members or carers and housing providers.

While some case managers continue to update MH-OAT-based care plans, the majority do not review these plans with any frequency. Many case managers,

[7] A few HASI clients have their own home or are in private accommodation.

however, actively contribute to and reinforce support plans developed in a collaborative environment with clients and ASP personnel.

A collaborative approach towards care plans has been successful for consumer outcomes and relationship building between stakeholders. Allowing clients to drive the support plan process has enabled some clients to take greater responsibility in their recovery. As an AMHS manager explained, 'People have learnt to become more assertive and increase in confidence in contributing to their program'. This approach has enabled key workers and case managers to brainstorm, share skills and work strategically and cooperatively to assist clients to achieve their goals. It has also assisted stakeholders to understand and respect each other's roles and responsibilities and prevent clients from 'playing off' support personnel.

While the process for establishing support plans is similar between and within sites, there is little consistency in reviewing these plans; with ASP personnel scheduling them between 3 and 12 months. Whether these reviews occur is dependent on ASP and client willingness. Six monthly reviews are fairly standard, but they are more likely to occur approximately every 12 months if this willingness wanes or other priorities emerge for the ASP.

According to most clients, these reviews are likely to occur infrequently. Less than half of the clients (45.5 per cent) interviewed longitudinally recalled setting any short or long-term goals with their key worker or case manager in the six months prior to the final interview. Many of these clients, however, had set goals between evaluation phases one and two. One in five respondents could not recall setting goals with their key worker or case manager in the previous 12 months (that is, in either evaluation Phase 2 or 3).[8] Clients were most likely to report setting large goals, such as participation in work, education, leisure activities and exercise, as well as improved diet, relationships and property maintenance. Some clients who did not recall goal setting may have still participated in this process.[9]

Some case managers and key workers reported that 'concrete and specific' goals were set by many clients in the support plan process. Goals were generally considered to be 'achievable and practical' and were broken down into realistic steps (case manager). In some areas, however, AMHS personnel and consumer advocates expressed concern that goals were prescribed by ASP workers or family members or were not sufficiently broken down or realistic. In these cases, the goal setting process could probably be improved; but it also must be recognised that some clients have great difficulty identifying goals. Most clients can articulate goals when they first join the program because they are based on tangible, basic needs, such as secure accommodation and developing living skills to maintain that accommodation. In time, however, goal articulation can be more challenging for some clients. An ASP manager admitted that because some clients have difficulty deciding on and setting goals, the onus can shift and agreement is based on 'our goals, such as stabilising and

[8] 51 clients responded to this question in Phase 2 and 3. In the second interview 56 per cent of the group reported setting goals and 46 per cent in the third interview. Eleven people could not recall setting goals in either of the interviews.

[9] Poor recall or a misunderstanding of the question may have affected client responses.

engaging, rather than their goals'. Even if goals are consumer driven, achieving these goals can be difficult because like AMHS support, ASP work can become 'crisis driven' making 'the reality of the ISP [individual support plan] different to people's day to day traumas' (ASP Manager).

2.3 Client Perceptions of Support Provided

Summary

- Throughout the evaluation period, the majority of clients remained satisfied with the support they received from the ASP, AMHS and housing provider.
- Many clients experienced change(s) in their key worker and/or case manager. Consequently, fluctuations in satisfaction with case managers occurred at an individual level. The structure of ASP support prevented such fluctuations in regard to key workers.

Client satisfaction with ASP, AMHS and housing provider support remained high throughout the evaluation, despite changes in case managers and/or key workers between interviews.

Although most clients have fairly infrequent contact with their housing provider, clients who felt informed enough to comment on the support housing providers offered were generally positive. Of the 46 clients who definitively answered this question in the first and third interview, satisfaction increased from 72 to 82 per cent.

In Phase 3 of the evaluation, 91 per cent of clients were satisfied or very satisfied with the support provided by their ASP and 87 per cent were content with the time ASP workers spent with them. Frequency of key worker and client contact differed depending on individual needs. It varied from face-to-face and/or telephone contact numerous times a day to fortnightly meetings. Flexibility with support times was important so contact hours could be shifted where most required and so support remained as unobtrusive as possible. For clients who no longer require intensive daily ASP support, these organisations remain an important safety net. Consequently, some clients are anxious that increasing periods of wellness and stability could result in withdrawal of ASP support.

Of clients interviewed at Phase 3 (n=69), 80 per cent were satisfied or very satisfied with their case manager. Client satisfaction with their relationships with case managers and key workers remained high when compared longitudinally, as can be seen in Table 2.1.

Table 2.1: Longitudinal Client Satisfaction with ASP, AMHS and Housing Provider Primary Support Personnel (per cent)

	Satisfied with key worker(s) (n=47)	Satisfied with case manager(s) (n=48)	Satisfied with housing provider (n=46)
Phase 1	87	67	72
Phase 2	92	69	80
Phase 3	92	77	82

Almost all people who responded to questions in all three phases about their relationships with support workers remained consistently positive (Table 2.1).[10] That is, they did not change their opinions between interviews. This is especially telling because of the number of changes among support workers. Just under a quarter of clients had the same key worker and case manager throughout the evaluation.[11] Thus given the fluctuations in trust among the group as a whole (Section 6.7), relationships with ASP personnel are important examples of consistent, trusting, reliable and largely unconditional support.

While the majority of HASI participants perceived their relationships with their case managers positively (Table 2.1), there was less consistency in the responses over time. Just under half of the positive responses changed between interviews one, two or three. This was primarily because of a change in case managers throughout the period. When a change in case manager occurs, clients do not usually have a pre-existing relationship with the new case manager. While key workers also changed for numerous clients, client perceptions did not fluctuate to the same degree because of the organisational structure within each ASP. All three ASPs structure their support so all workers have contact with each client; therefore when a change in staffing occurs, support workers and HASI participants already have an established relationship and new key worker/client matches can be based on rapport. This model is also beneficial because if a key worker is unavailable, the client still receives support.

Although most clients were satisfied with their support worker relationships, a minority reported relationship problems. In Phase 3 of the evaluation just over one in ten (12 per cent) stated that they did not get on with some ASP workers. This reflects a difference in staff approach, for example clients interpreting support as supervisory, 'bossy', too intrusive or directive. In areas where key worker and clients interacted socially in the community together (either at a one-on-one level or as a part of ASP-organised activities) rapport was often strong and satisfaction high.

While the proportion of clients who do not get on with some ASP workers is small, respecting client choice in contact with key workers is important for both clients and staff. A few clients, for example, dislike working with males. While meeting this

[10] Between the first and second interview 81 per cent of respondents (n=47) remained positive about their relationship with their key workers; that is they did not change their mind. Similar consistency occurred when the other interview responses are compared (79 per cent of respondents in interviews 1 and 3 and 82 per cent in interviews 2 and 3).

[11] 13 of the 55 clients who responded to this question in Phase 1, 2 and 3 reported having the same key worker. The same proportion reported having a consistent case manager.

request may cause ASP roster difficulties, it can be important for both client and worker wellbeing.

2.4 Referral and Assessment

Summary

- Awareness about HASI within the AMHS has increased. This, coupled with the rollout of HASI, has resulted in an increase in referrals.
- The majority of ASP and AMHS personnel believe the HASI referral and assessment process is good or excellent.
- When stakeholders question selection decisions, it is usually a result of their belief that the selected clients are not making the most of an opportunity in which someone else within the system could be taking advantage.

HASI is increasingly being promoted within the AMHS. This greater awareness of the program and a further rollout of HASI has increased referrals from within the AMHS.

The majority of key workers and case managers are not directly involved in the HASI referral process. Approximately two-thirds of key workers and case managers who felt informed enough to provide an opinion on the referral process within their area felt it was good or excellent (Table 2.2).

Table 2.2: Stakeholder Perceptions of the Referral Process (number)

	Excellent	Good	Average	Weak	Don't know	Total
ASP managers	5	2	1	1	0	9
Key workers	3	22	11	1	12	49
AMHS managers	5	2	1	1	0	9
Case managers	5	8	5	2	16	36

Four of the nine ASP managers interviewed rated the referral process as average or below. The referral and assessment process was criticised for a lack of transparency in the decision-making process, limited feedback to referrers and insufficient clinical and dual diagnoses measures in the assessment process. With the rollout of HASI, the latter concern is being addressed.

While key workers made suggestions for further improving the referral process, their satisfaction with this process has increased over time. There was a statistically significant ($p<0.01$) increase in individuals rating the referral process as good or excellent when perceptions were compared longitudinally. The referral and selection process is also well regarded by most AMHS personnel.

The majority of stakeholders agreed that people participating in HASI were appropriate for the program. When suitability was questioned, it was often because of the limited size of the program, rather than clients in the program being

inappropriately placed. Some AMHS personnel believed that other clients within their caseloads would benefit from the program more than some currently within it.

In a number of sites, some AMHS and ASP personnel agreed that some clients were not appropriately matched to the program, but were involved because of a lack of other options. One ASP manager believed that initial enthusiasm and the appearance of adequate resources resulted in the acceptance of a couple of very high support clients whose needs have turned out to be greater than the capacity of the program. Some key workers across two sites believed the acceptance of these clients was a result of pressure from AMHS personnel and hospital staff, along with pressure and desperation from family members who had exhausted other support services and programs.

2.5 Client Demographics

Summary

- Australian born males under 34 years of age with a diagnosis of schizophrenia remained the most prevalent group of people in the HASI program throughout the evaluation.
- The proportion of Indigenous Australians decreased between evaluation Phase 2 and 3.
- Females and people from culturally and linguistically diverse (CALD) backgrounds remained under-representative of the population.

Despite some client turnover throughout the evaluation (Section 7), client demographics remained similar. People participating in HASI at Phase 3 were most likely to be born in Australia, have a diagnosis of schizophrenia, be male, under 34 years of age and have at least dual diagnoses (Table 2.3 and Figure 2.1).

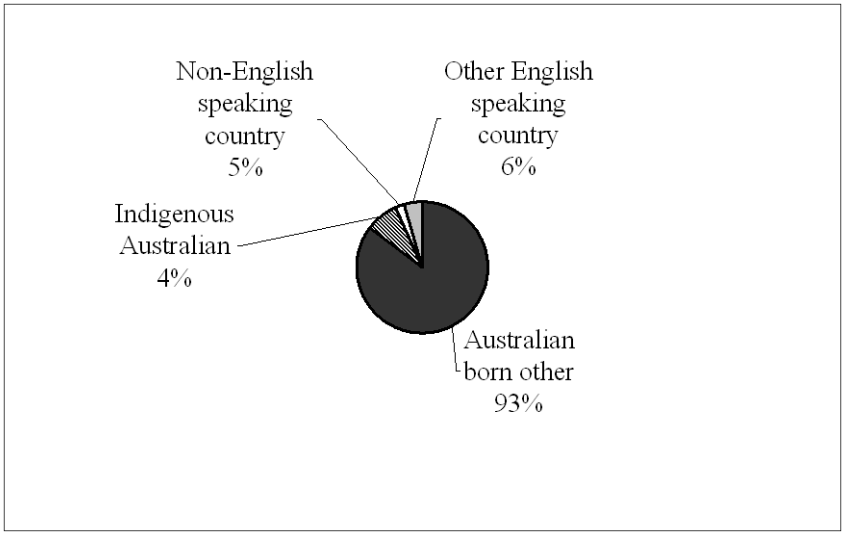
Table 2.3: Client Demographics throughout the Evaluation

	Phase 1 (n=90)	Phase 2 (n=92)	Phase 3 (n=87)
Primary diagnosis of schizophrenia*	72 per cent	72 per cent	72 per cent
Gender	70 per cent male	69 per cent male	67 per cent male
Age	61.2 per cent 35 yrs or younger	59 per cent were under 34 years of age	59 per cent were under 34 years of age
Multiple diagnoses	63 per cent had at least a dual diagnosis when they started the program (intellectual disability: 26 per cent; substance use disorder: 37 per cent; 12 clients experienced mental illness, intellectual and physical disability and substance use disorder)	46 per cent of clients who started the program with a substance use disorder were reported to no longer experience substance use issues by Phase 2 of the evaluation.	58 per cent at least a dual diagnosis (intellectual disability: 29 per cent, substance use disorder: 26 per cent; physical disability: 14 per cent; 9 clients experienced at least two other diagnosis)

Note: *Other diagnosis include schizoaffective disorder (14 per cent), bipolar disorder (5 per cent), depression (1 per cent), and other.

The proportion of Indigenous Australians participating in the program decreased significantly from 8 to 4 per cent as a result of four people who identify as Indigenous Australians exiting the program. Despite this decrease, Indigenous Australians remained representative of the population at Phase 3. The proportion of people from CALD backgrounds, however, was under-representative of the Australian population. 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).

Figure 2.1: Client Cultural Background (n=87)



Females also remained under-represented in HASI. Yet the same proportion of men and women experience mental illness (even though the prevalence of certain types of mental illness differs). In addition, the most common diagnosis of HASI clients is schizophrenia and men and women are equally likely to experience this condition (albeit at different ages; AIHW, 2005). Some ASP and AMHS stakeholders argued that women with mental illness are under-represented in the program because they have more support structures in place than their male counterparts. However, if one of the main objectives of HASI is to decrease hospitalisations, support should be equally extended to women because they accounted for 62 per cent of all mental health related hospital admissions in 2003-04 (AIHW, 2005: 84).

3 Tenancies

3.1 Accommodation Type

Summary

- Half of the HASI clients accommodated by housing providers live in a unit or an apartment. The proportion living in townhouses, villas, duplexes and houses has increased since the start of the program.
- Clustered accommodation has been successful where the cluster is kept to a maximum number (three or four) of tenants and the tenant mix is carefully considered.
- Almost all clients were satisfied with their accommodation (94 per cent).

At the time of the third interview, the largest proportion of HASI clients, about whom we received tenancy data (n=85), resided in units or apartments (52 per cent). A further 31 per cent were in townhouses, villas or duplexes and 18 per cent in houses. Housing providers were slightly less likely to place clients in units or apartments by the third interview than they were 12 months earlier (7 per cent decrease), and more likely to place people in townhouses, villas or duplexes (5 per cent increase) or houses (2 per cent increase). Anecdotally, this increase can be accounted for because townhouse, villa, duplex and especially house residencies are less likely to result in noise and nuisance complaints from neighbours.

While standalone properties can be advantageous, they can also prove stressful because of ground maintenance. Between evaluation Phases 2 and 3, two people moved from houses into smaller properties within strata complexes after requesting more manageable homes.

Eight clients are in clustered accommodation in two sites. Four are in a block of townhouses and the remaining in a block of units. As noted in previous reports, in both cases, clustered accommodation has worked to foster a supportive community among these participants, increase socialisation and improve accessibility and save time for case managers and key workers. However, the evaluation also found that if the wrong clients are selected to live in clustered settings, more than four tenancies are clustered, or the location of the clusters is inappropriate, this type of supported accommodation can place people at risk of stigmatisation, exploitation, minimised community integration and/or heightened stress, which can affect mental health. This reinforces the importance of having a range of accommodation choices available to HASI participants.

An ASP manager explained the importance of a range of choices:

> We've got a group set up, individual houses, capital and rental. It's about providing options. It's not about cluster housing being your only option; it's about clients who prefer to live that way. … They still have their own house. They're free to mix and/or not to mix.

Whether in clustered or other types of housing, satisfaction with accommodation remained high throughout the evaluation. At the third interview, 94 per cent of people supported by housing providers were satisfied or very satisfied with their accommodation (n=68) and 84 per cent felt safe within their homes (n=69). The people who were not satisfied with their accommodation were disgruntled with poor access to services and facilities, social problems in the housing location (such as drug and alcohol problems and anti-social behaviour) and/or felt geographically too far from family and social networks.

Accessible social networks (family, friends and carers) and resources (such as shopping facilities, doctors and hospitals) significantly affected people's satisfaction with their accommodation. Accessibility was especially important for independence and community participation because walking was the most common form of transportation, with two-thirds using it to get around their local area.[12] Thus for people living on the outskirts of their local community or town centre, location added to isolation and loneliness and decreased the likelihood of independent social participation. Clients in this situation were in the minority because in most cases housing providers strived to match individual need to accommodation. Consequently, property retention rates remained high throughout the program.

3.2 Tenancy Turnover

Summary

- 70 per cent of people accommodated by a housing provider on entry to HASI were still in the same home by the end of March 2006.
- The time invested into finding appropriate accommodation, support provided by ASPs and systems such as Centre Pay, have worked together to produce a high level of successful, stable tenancies.

Since the last interview, ten HASI clients (of the 84 for whom we received tenancy data) had their tenancy agreements terminated. The housing provider rehoused three of these people (two requested to move and one was transferred because of property damage and for causing nuisance and annoyance); the remaining seven exited the program (two were rehoused by the provider, two were incarcerated, two left by choice and moved to locations of choice and the final person was hospitalised long-term).

Property retention rates remained high from entry into HASI through to the final phase of the evaluation (Table 3.1). In total, 70 per cent of people accommodated by a housing provider on entry to HASI (and who we were given data on, n=105) were still in the same home at the end of March 2006. Thirty-one people had moved – 16 exited the program and were not rehoused, 3 exited and stayed with the housing provider, 9 were rehoused once and stayed in the program and the final 3 were rehoused on two occasions and remained in HASI. Of the clients who moved out of the property in

[12] Almost half use the bus (42 per cent), nearly one-third (32 per cent) use the train, a small proportion ride a bicycle and the majority still rely on the ASP for car transportation.

which they were first placed, only one exited the program and this person progressed to HASI Stage Two.

The time invested into finding appropriate accommodation, the intensive support provided by ASPs (which has assisted in property care, good neighbour relations and prevented problems from escalating) and systems such as Centre Pay,[13] have worked together to produce a high level of successful, stable tenancies.

Table 3.1: Tenancy Changes Among HASI Clients Accommodated in Housing Provider Properties (from entry to Phase 3, n=105)

	Total number	As a proportion of people who moved	Proportion of all HASI clients housed by providers
People rehoused once and remained in HASI	9	29%	9%
People rehoused twice and remained in HASI	3	10%	3%
People exited HASI and rehoused by provider*	3	10%	3%
People exited HASI and not rehoused*	16	51%	15%
Total people moved after starting HASI	31	100%	30%
Total tenancies turned over throughout program	34	-	32%

Note: *These figures do not match the exits in Section 7 because not all HASI clients were in housing provider managed properties and these figures are based only on data provided by housing providers. Most people who exited the program and left the provider moved from the area served by HASI and the housing provider.

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3.3 Tenancy Issues

Summary

- In the majority of cases, HASI clients' property care is as good or better than other tenants.
- Co-tenancy has been problematic for some people in terms of exploitation and destabilising HASI tenancies, but also because the model excludes shared leases.
- Only 17 per cent of HASI clients were in rental arrears during the evaluation – most for less than one month.
- A minority of HASI tenants experienced problems with neighbours (both as complainants and being complained about).

The majority of housing providers (six of the seven who completed surveys) reported that HASI tenants kept their accommodation in good order. All agreed that HASI clients were not more 'difficult' to manage than other clients, were less likely to have

[13] An automatic rent payment system where rent is electronically directed straight from Centre Link payments to the housing provider. People using this system can request for its suspension at any time.

complaints made against them and were less likely to lose their tenancies. As expected, however, some tenancy problems persisted.

Property care

Housing providers indicated that the level of support provided by the ASP resulted in the care and maintenance of properties and that this standard was equal to or, in many cases, above that of other tenants. A small number of isolated cases of very poor internal property care, but the most common problem was insufficient management of lawns and gardens by the people living in houses. One site has overcome this problem by introducing a $5 a fortnight gardening fee, which funds a contracted gardener to mow lawns and help maintain gardens.

Co-tenancy

Co-tenancy problems are ongoing. This is both in relation to people who cause tenancy problems for HASI clients and those who do not. It is problematic in terms of the co-tenancy restrictions in the model and the problems caused by some unauthorised co-tenants. 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. Some ASP personnel also saw this as a limitation of HASI:

> There is little flexibility in the HASI model to tailor accommodation to individual preference and need. The benefits of a peer approach [that is, mental health consumers as peers] are lost in this model, not being able to use shared accommodation as an option.

Forty-two per cent of HASI clients indicated a preference for shared accommodation in the future. This desire was based on meaningful and trusting shared tenancies, not those of exploitation. The latter, however, was perceived to be happening in a small number of circumstances (less than one in each area). Exploitation and problematic co-tenancies can destabilise tenancies.

With the tenants' permission, ASP personnel locked the second bedroom of two HASI clients' homes to decrease 'uninvited guests staying all the time'. In other situations, 'freeloaders' moved on after ASP personnel intervened. Housing providers appreciated ASP intervention because they are largely powerless to rectify these situations themselves. In one case, a HASI tenant moved away from an area of high social disadvantage in an effort to prevent people exploiting his stable tenancy. He is happy with his current accommodation, including his new neighbours, and was content to have moved away from people who exploited him in the past: 'I'm not seeing those people now. They were using me. They took things and borrowed money and never paid me back. I have some good friends now and they support me.'

HASI tenants do not always perceive these co-tenancy situations negatively because of the 'barter system' that operates; that is, accommodation in exchange for alcohol and drugs. Yet, after some time these unstable relationships become unsettled: 'Mates come and visit and stay a couple of weeks then I tell them to piss off. They give me alcohol when they're there. [But] there are holes in the walls from … them.'

Clients who are housed in areas of high disadvantage and anti-social behaviour continue to be more vulnerable to exploitation. In some circumstances, HASI clients are discontent with their location because there are 'too many needy people' exploiting them for their resources, but for other less vulnerable people, their social networks are in these areas and they do not wish to move.

Rent

Eight clients were in rental arrears between evaluation Phase 2 and 3. Half of these people owed two weeks rent, two were behind by three weeks and the other two by four and seven weeks. Throughout the program only 18 clients (17 per cent, n=105) reportedly fell behind with their rent. These arrears ranged from 1 to 18 weeks with most (8) falling behind by two weeks.

Relationships with neighbours

Twelve people (14 per cent) had formal complaints made against them between Phase 2 and 3 of the evaluation. While the majority of this group had one or two complaints registered, four were complained about on three or more occasions. Complaints were all in relation to property care (damage or maintenance issues) and nuisance or annoyance (such as noise levels, substance use and disruptive 'uninvited guests'). Alleged property care issues ranged from a pest problem as a result of poor hygiene, removing smoke detectors (largely unit-based complaints) to failing to mow the grass regularly (house-based complaints).

A minority of HASI clients also reported difficulties with neighbours. Just over one in ten (12 per cent, n=69) were not getting on with their neighbours at the time of the third interview.

Throughout the program, 31 HASI tenants had complaints registered against them. Greater transparency around tenancy problems between housing providers and ASP personnel may further prevent some neighbour complaints and property care issues. While tenancy problems occur with some HASI clients, property retention rates (Table 3.1) are testimony to the effectiveness of the program in providing people with secure, stable accommodation.

4 Health

4.1 Mental Health

Summary

- Approximately half of all clients, key workers and case managers interviewed in Phase 3 of the evaluation self-reported improvement in client mental health since the last interview.
- Global Assessment of Functioning (GAF) scores are a sound indication of change in mental health among clients over time. In Phase 1 only 38 per cent scored over 50, compared to 76 per cent in Phase 3.

Client, case manager, ASP perceived change

Significant improvement in most clients' mental health was reported by clients, case managers and key workers when they reflected on current mental health states compared to when clients entered HASI. Much of this improvement occurred between entering HASI and Phase 2 of the evaluation, however, positive improvement continued between Phase 2 and 3 for 56 per cent of the clients interviewed. The same proportion stated they felt better about themselves than they had in the previous interview.

Key workers believed that 59 per cent of clients had improved mental health since the last interview (n=59). Case managers (n=40) reported mental health improvement in 45 per cent of cases.[14] Perceived improvement in mental health was based on a decline in hospital admissions; increase in independence from key worker/case manager support; increased medication compliance; less confusion, stress and depression; decline in substance use and a subsequent decrease in certain symptoms; and improvement in functioning and/or fewer or no crises.

A quarter of the clients interviewed reported stability in their mental health between evaluation phases. Just over one in ten (12 per cent) reported a decline. Key worker and case manager comments were consistent with these reports. The precipitating factors that were identified for poor mental health included stressful family law issues, problems with neighbours, excessive social use of drugs and/or alcohol, physical illness, severe symptoms of mental illness, exploitation, social disadvantage and an increased dependence on key workers and case managers. While there were some relapses in mental illness among some clients, the periods of unwellness were perceived as relatively less severe and chronic than prior to the program.

Global Assessment of Functioning scores

At each phase in the evaluation, ASP personnel attributed a GAF score to the HASI participants. The GAF employs a scale of 0-100 indicating very serious illness (0) to

[14] Where case managers and key workers reported on the same clients (n=38), there was much similarity. The only two deviations were case managers stating no change in mental health and key workers reporting a slight improvement.

very good mental health (100) and relates to the level of independence and efficacy in psychological, social and occupational functioning. It is a useful clinical tool to measure change across a group (Söderberg, Tungström et al. 2005).

There were significant changes in client GAF scores when the first and last evaluation phases are compared. For the group of clients with GAF scores in all three phases of the evaluation (n=63), the average score increased by 17 points, from 41 to 58 (see Table 4.1). Over two-thirds of clients' (68 per cent) GAF scores increased between the first and last phase of the evaluation (see Table 4.2). For 17 clients (27 per cent), GAF scores decreased, while the remaining three people experienced no change. While much of this increase occurred between phases one and two, Figure 4.1 and Table 4.3 demonstrate that compared to Phase 1 and 2, by Phase 3 very few clients scored less than 50, which is indicative of improved psychological functioning.

Table 4.1: Comparing the Average, Median and Range of GAF scores at Phase 1, 2 and 3 (n=63)

	Phase 1	Phase 2	Phase 3
Average score	41	56	58
Median	35	61	60
Range	0 to 87	12 to 89	13 to 90

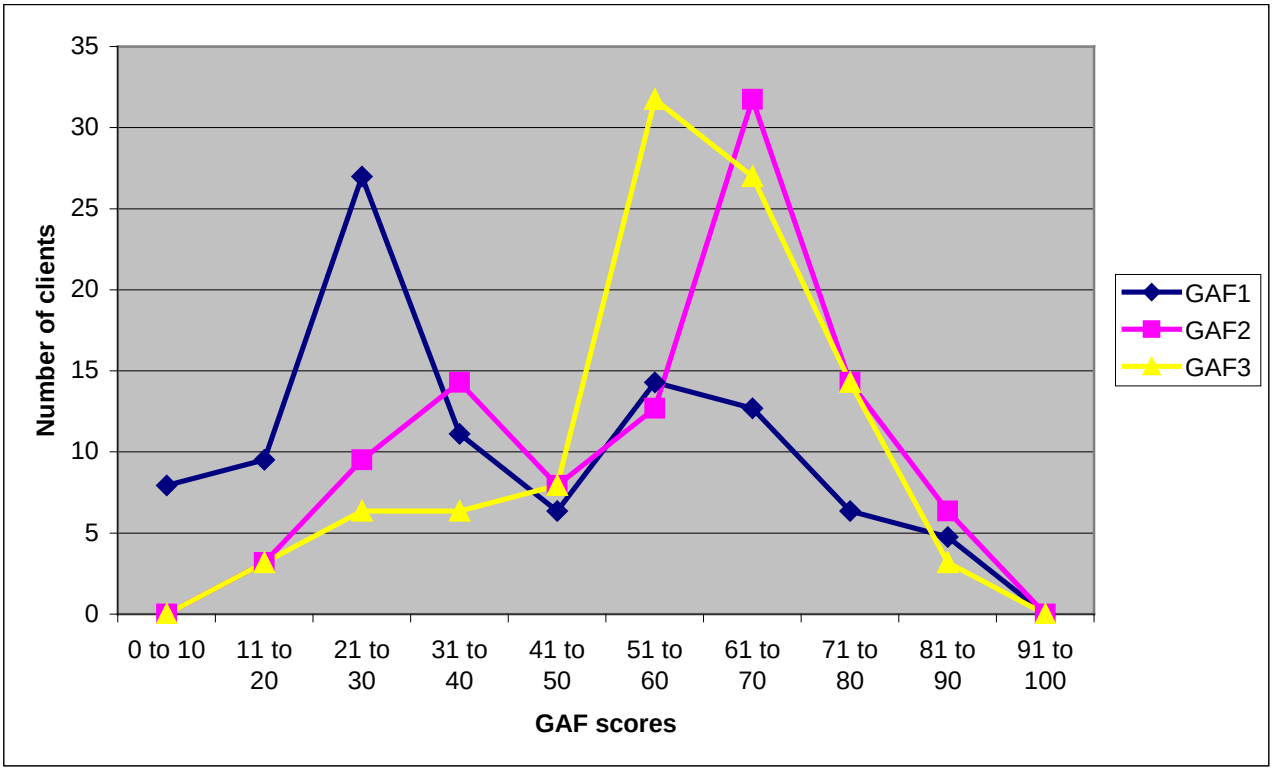
Table 4.2: Degree of Change in GAF Scores for Clients with Increased and Decreased Scores (n=63)

	Increased score Phase 1 and Phase 3	Decreased score Phase 1 and Phase 3
Number of cases*	43	17
Range of change	2 to 67 points	1 to 28 points
Average change	28 points	9 points
Note: *GAF unchanged in 3 cases		

Table 4.3: Longitudinal GAF Scores (per cent, n=63)

	GAF1	GAF2	GAF3
0 to 10	8	0	0
11 to 20	10	3	3
21 to 30	27	10	6
31 to 40	11	14	6
41 to 50	6	8	8
51 to 60	14	13	32
61 to 70	13	32	27
71 to 80	6	14	14
81 to 90	5	6	3
91 to 100	0	0	0

Figure 4.1: Client GAF Score Ranges in Phase 1, 2 and 3 (n=63)



4.2 Physical Health

Summary

- The majority of HASI clients reported improvement in their physical health since the last interview.
- While there are some serious physical health problems among participants, ASP and AMHS support continued to facilitate recognition, identification and appropriate treatment of these problems.

Of all health measures, physical health was most likely to be reported as declining. Almost one in five (18 per cent) clients interviewed in Phase 3 of the evaluation (n=69) stated their physical health had declined since the last interview (Table 4.6). Some of the common physical health problems reported included obesity, liver functioning problems (such as Hepatitis C), asthma and other respiratory problems, incontinence and arthritis.

Just over half of the clients (56 per cent) reported improved physical health. This may be due to increased use of health services and the identification and treatment of physical health problems.

4.3 Service Use

Summary

- HASI clients continued to have a high level of access to health professionals. This may have contributed to the reported improvements in mental and physical health.

Client health service use remained high between Phase 2 and 3 of the evaluation (Table 4.4). The majority of clients consulted with health professionals in regard to their mental and physical health: 91 per cent with the AMHS, 85 per cent with a psychiatrist and 76 per cent with a general medical practitioner. Twenty-eight clients used emergency services in this period. Few clients (20 per cent) consulted with a psychologist or counsellor between Phase 2 and 3. The inclusion of Medicare rebates for clinical psychologist consultations in the 2006-07 budget (Abbott & Pyne, 2006) may assist to overcome financial barriers to accessing counselling.

Table 4.4: Health Service Use between Phase 2 and 3 (n=87)

	GP contacts	Psychiatrist	Psychologist /counsellor	Specialists, other	AMHS	Emergency services
Number of clients who had a consultation	66	74	17	30	79	28
Proportion of clients who had a consultation	76%	85%	20%	34%	91%	32%
Total visits	377	328	46	76	1045	335
Average contact per client	4	4	0	1	11	3
Range of contacts	0 to 85	0 to 20	0 to 18	0 to 8	0 to 91	0 to 91

Throughout the evaluation almost all HASI clients have accessed AMHS health professionals (96 percent), psychiatrists (94 per cent) and general practitioners (94 per cent). Just over half also consulted with other types of health specialists (

Table 4.5). HASI participants' access to mental health professionals is substantially higher than the general population. The Western Australian Mental Health Survey (ABS 1999), for example, found 39 per cent of people with mental disorders had accessed a health service within a twelve-month period and 32 per cent a general practitioner. While those with severe levels of psychiatric disability were more likely to have used health services (59 per cent of women and 56 per cent of men) than other Western Australians with more moderate or mild levels of psychiatric disability, HASI clients' were 39 per cent more likely to have accessed a health service (with 96 per cent using at least one health service). These high levels of access to appropriate health care are likely to have been instrumental to the reported improvements in mental and physical health among HASI clients, as Section 4.4 demonstrates.

Table 4.5: Health Service Use between Entering HASI and Phase 3 (n=109)

	GP	Psychiatrist	Psychologist/ counsellor	Specialist, other	AMHS health professional
Number of clients who had a consultation	102	102	35	56	105
Proportion who had a consultation	94%	94%	32%	51%	96%
Total visits	2251	1564	373	294	3746
Median number of visits (of those who had at least one consultation)	8	12	4	3	18
Average number of visits (of those who had at least one consultation)	22	15	11	5	36

4.4 Longitudinal Health Change

Summary

- Between entry to HASI and Phase 3 of the evaluation, 71 per cent of clients reported improved mental health, 60 per cent better physical health, 67 per cent improved diet and 78 per cent felt more positive about themselves.
- Reported improvements in mental and physical health peaked between entry to HASI and Phase 1. Many clients continued to report improvement, but at a slower rate.
- The health of some clients stabilised and it declined for a minority of people.

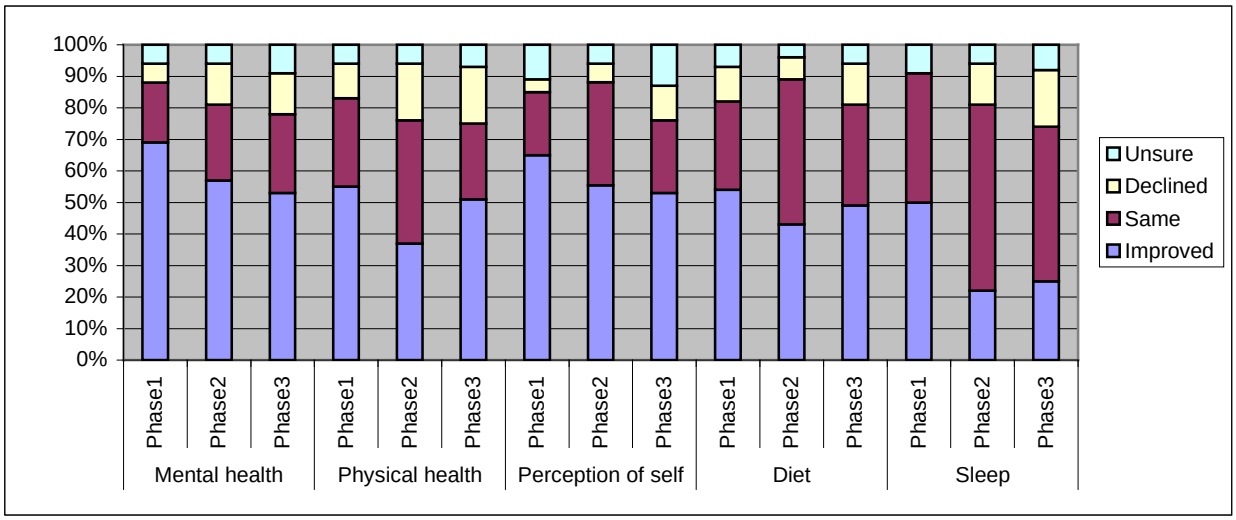
For the greatest proportion of HASI clients, perceptions of physical and mental health continued to improve over time (Table 4.6 and Figure 4.2). The rate of positive change, however, slowed over time. In Phase 1, the majority of participants experienced an improvement across all health measures – mental, physical, diet and sleep. Mental health improved to the greatest extent, with 69 per cent reporting some gain. Change between phases one and two continued for a number of participants, but there were many who perceived no health changes. Surprisingly, in the third interview the majority of people again reported improved mental and physical health.

A minority of people experienced declines in mental health and perception of self (between 6-13 per cent), while up to 18 per cent experienced poorer physical health and sleeping patterns between interviews.

Table 4.6: Client Perception of Health Changes between Phases (n=55, per cent)

	Mental health			Physical health			Self perception			Diet			Sleep		
	P1	P2	P3	P1	P2	P3	P1	P2	P3	P1	P2	P3	P1	P2	P3
Improved	69	57	53	55	37	51	65	56	53	54	43	49	50	22	25
Same	19	24	25	28	39	24	20	33	23	28	46	32	41	59	49
Declined	6	13	13	11	18	18	4	6	11	11	7	13	0	13	18
Unsure	6	6	9	6	6	7	11	6	13	7	4	6	9	6	8

Figure 4.2: Client Perception of Health Changes Over Time (n=55, per cent)



When health changes are compared over time at an individual level, most people perceived some positive gain since joining the program. By scoring responses to health questions (much worse = -2; a bit worse = -1; same = 0; a bit better = 1 and much better = 2) across all three interviews, 71 per cent of people involved in the evaluation longitudinally (n=55) reported improved mental health (see Table 4.7), 60 per cent better physical health, 67 per cent improved diet and 78 per cent felt more positive themselves since joining the program. A minority believed their mental and physical health had declined (11 and 13 per cent respectively) since joining the program, yet their scores were never lower than –2 in total. Thus most HASI participants perceived significant gains in relation to their mental and physical health, as well as their diet and self-confidence.

Table 4.7: Client Perception of Change in Mental Health between Entering HASI and Phase 3 (n=55)

Score	Per cent	Cumulative per cent
6	4	4
5	7	11
4	16	27
3	16	44
2	16	60
1	11	71
0	18	89
-1	9	98
-2	2	100

5 Living Skills

5.1 Changes in Living Skills

Summary

- Living skills improved significantly across the group between entering HASI and Phase 3 of the evaluation.
- Further key-worker training would clarify for workers the path from support to maximising the attainment of longer-term independence or reliance on mainstream services.

One of the main aims of HASI is to assist people to build living skills through accommodation support. All ASP personnel work with this primary objective. Key workers train, motivate, prompt and/or support clients in regard to a range of living skills within and outside of the home (such as cleaning, cooking, laundry, banking and budgeting). How key workers approach this at a practical level, however, differs. While all three ASPs advocate a psychosocial rehabilitation model, this is not always followed. Using a psychosocial model, workers teach living skills or assist people to build these skills.

Overall, living skills significantly improved between entering HASI and Phase 3 of the evaluation in bathing/showing, dressing, cooking, cleaning, transport, banking, budgeting, accessing community services and making appointments ($p<0.05$) (Table 5.1 and Table 5.2). Clients who became more dependent on service providers over time either experienced a decrease in mental or physical health and therefore required greater assistance, or became increasingly willing to accept support from providers. As expected, many clients continue to be either fully dependent on the ASP or supported more than half the time for living skills such as budgeting (48 per cent); shopping (46 per cent); making appointments (35 per cent); medication, cleaning, banking and accessing community services (c. 30 per cent); laundry, diet and accessing transportation (c. 20 per cent); and exercise (24 per cent).[15]

The proportion of people who were completely independent with a range of living skills peaked during Phase 2 of the evaluation (Figure 5.1 and Table 5.1). The number of HASI clients who were fully independent across most living skills dropped between Phase 2 and 3 (transport, shopping, budgeting, exercise, accessing community services, laundry, diet, cleaning, making appointments and cooking). When client independence is compared between entering HASI and phase 3, however, all measures increased (Table 5.2). Therefore while some clients failed to maintain high levels of independence at Phase 2, the majority were still more independent during Phase 3 than they had been on entering the program. The proportion of clients who were fully independent in banking, medication and personal hygiene skills increased at each evaluation phase.

[15] Cooking (15 per cent), bathing/showering (9 per cent) and dressing 6 per cent.

Table 5.1: Longitudinal Levels of Client Independence with Living Skills as Determined by ASP

Living skill (n=69)	Independent when entered HASI (per cent)	Independent at Phase 2 (per cent)	Independent at Phase 3 (per cent)	Shift in proportion independent between entering HASI and Phase 3 (percentage points)
Banking	30	52	59	29
Medication	16	39	42	26
Diet	25	50	47	22
Exercise	28	56	50	22
Cooking	35	58	57	22
Making appointments	19	36	34	15
Laundry	45	64	60	15
Accessing community services	30	47	42	12
Shopping	13	33	22	9
Cleaning	26	38	35	9
Bathing/showering	70	78	79	9
Dressing	75	80	80	5
Budgeting	20	33	22	2
Transport	42	62	44	2

Figure 5.1: Proportion of Clients Fully Independent with Living Skills from HASI Entry to Phase 3 (n-=69)

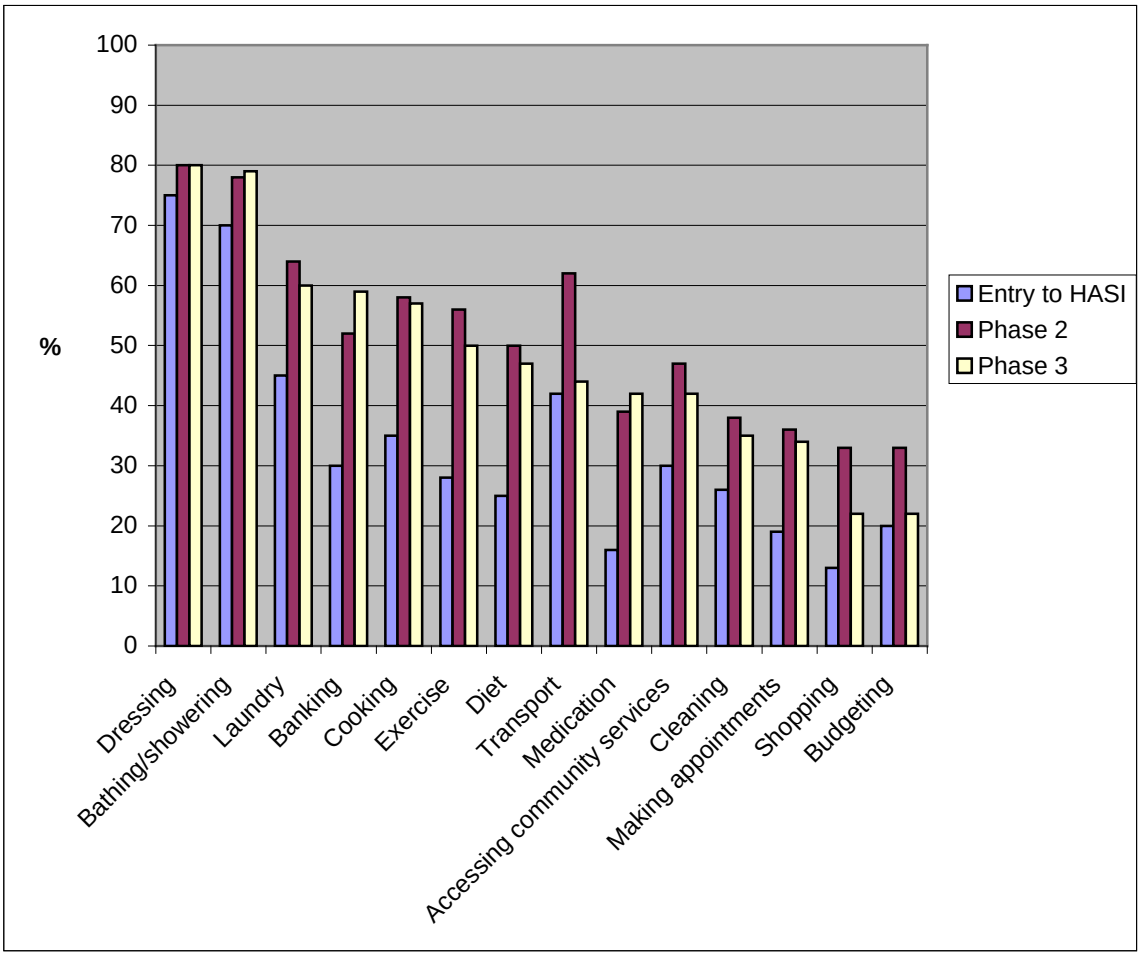


Table 5.2: Change in Client Living Skills between Entering HASI and Phase 3 (number)

	Increased independence	No change	Decreased independence
Medication	34	21	11
Cooking	32	27	6
Diet	30	24	11
Banking	29	28	8
Cleaning	29	24	12
Making appointments	28	24	13
Accessing community services	27	24	13
Exercise	27	25	10
Budgeting	26	13	25
Laundry	23	34	7
Using transportation	23	28	15
Shopping	19	32	14
Bathing/showering	15	48	5
Dressing	10	48	7

5.2 Facilitating Independence or Developing Dependency?

Some key workers still need further training about how to help HASI clients develop living skills. Almost all key workers spoke of completing activities of daily life 'with' clients, rather than 'for them'; although in some cases the contrary is still occurring. Two key workers conceded in the third interview, 'It's easier just to do it [domestic tasks]', rather than try and develop skills in clients. In one site an AHMS commented, 'As a whole things are still getting done for the clients. It's easier to do it for or with the clients than to stand there and prompt them. I doubt staff are taught how to teach living skills'. While this manager was commenting on a whole site, differences in key worker support exist within areas. A standardised approach is important for not only skill development, but also to avoid some HASI clients playing off staff members or exploiting the support of others.

People's capacity for skill development differs. Those who also have an intellectual disability, for example, have made smaller gains in living skills. People involved in HASI started the program with 'high levels of psychiatric disability' and the model was established with an understanding that some people would require ongoing support. Therefore it not surprising that a certain level of dependence may prevail.

Some ASP personnel acknowledged that the regularity of their support had the capacity to foster dependency amongst some clients. They commented that this is the nature of the program and dependence is difficult to avoid 'among the type of client … [eligible] for the program' (AMHS Manager). What is important is not whether some dependency develops, but rather whether a temporary dependency is purposive to achieve longer-term independence goals. Many clients stated that HASI has made them feel 'more independent', even if they still required support in a number of aspects of their lives. Clients who did not participate in work, education or social activities and were restricted in their social contact were more likely to develop a dependency on social contact with key workers. This reinforces the importance of recreational activities. Even if these activities are ASP-organised and may temporarily reinforce dependency, HASI has shown that this process can provide a pathway towards independence.

6 Social Inclusion

6.1 Community Connections, Relationships and Support Networks

Summary

- HASI has enabled a shift from social exclusion towards social inclusion for many clients; friendships have been formed, people are participating in social and community activities, work and education.

A significant indicator of the success of HASI is the shift from social exclusion towards social inclusion. Social inclusion is about feeling a part of the community and it is facilitated by actively participating in social and community activities, work and/or education.

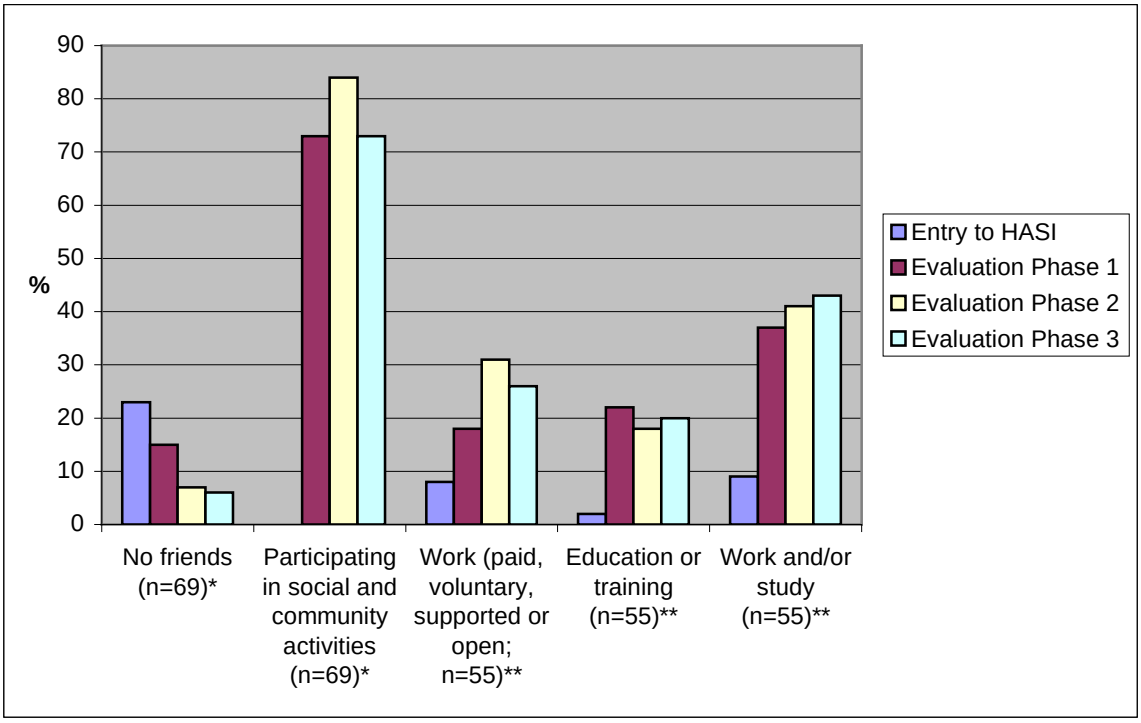
HASI participants started the program with limited social networks and almost all were not participating in work and education and many were excluded from social activities. On entering the program, almost one in four participants did not have any friends, less than 2 per cent were involved in education and fewer than 8 per cent were working (the majority of these were supported employment places). HASI has facilitated a major shift from this situation of social exclusion towards social inclusion. The majority of HASI clients have increased their social networks and become active participants in society. Between entering the program and Phase 3 of the evaluation 94 per cent had established friendships, 73 per cent were participating in social and community activities and 43 per cent were working or studying ($p<0.05$).

Table 6.1: Longitudinal Indicators of Social Inclusion of HASI clients (per cent)

	No friends (n=69)*	Participating in 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

Notes: *Based on longitudinal data from the Client Information Database - 69 clients had participated in the program from the outset through to Phase 3 of the evaluation.
** Based on longitudinal interviews with clients 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 $p<0.05$.

Figure 6.1: Longitudinal Indicators of Social Inclusion (per cent)



6.2 Social and Community Activities

> One thing I've learnt [from HASI] is the importance of recreation and socialisation. … You have a population of people without socialisation, recreation skills – people think what a crock, you're just taking people on group outings – … [but] clients have to learn those skills... All of a sudden we've got people with social skills, happiness, friends, a quality of life. That is the best thing about HASI ... (AMHS Manager)

Summary

- Recreational activities have played an important role for many clients in building social skills, increasing confidence and in turn increasing independence and a pathway to work and education.
- A variety of social options – ASP-organised, disability and mainstream groups – afford clients the best opportunity for meaningful community participation.
- 83 per cent of clients were participating in at least three of nine community activities measured at Phase 3 (shopping, eating out, library, church, social groups, educational institutions, organised sport, leisure activities or exercise).

Community participation is an integral part of HASI. If this participation is meaningful it can increase a person's social skills, confidence, 'provide personal development and a platform for people' to move on to work and education (consumer advocate) and give people a 'sense of belonging' (ASP manager). HASI clients currently participate across three types of activities: disability-based, ASP-organised and mainstream. As reports one and two explained, a mix of these options, including the opportunity to meaningfully integrate into the community is preferred practice because 'we don't all want to participate in one community, such as the mental health community' (ASP Manager).

An AMHS manager explained the importance of facilitating participation through varied options:

> The things they [HASI participants] are doing are in the community setting. A lot of them do community access by themselves and they do it together as a group. I think that's really important for them to feel that today I'm in this group, everyone is the same as me and in today's group I'm the normal one. Community access is great and it's the ultimate goal, but I'm sure hanging around with other people with mental health problems is great because you just fit in. It's about giving people options, a mix. (AMHS Manager)

Through group activities some HASI clients have moved on to participating in work, education and community events and groups. In a program like HASI, group activities can and have provided this type of pathway. This step can take years and caution should be exercised to ensure that the next step is a 'healthy risk' and does not set a person up for failure (key worker). People with poor mental health who have high support needs can face considerable barriers in integrating into the community. Besides often lacking the social skills and confidence, people do not necessarily know what is available in their community. ASP personnel help clients overcome this barrier by organising and subsidising (if necessary) community activities. This ranges from accompanying a group of interested people to a community event or festival to going ten-pin bowling or fishing.

In organising group activities ASPs have become 'mindful that not everyone wants to spend time together'. Smaller groups or one-on-one meaningful community-based activities may help to overcome this problem.

Clients, case managers, consumer advocates and most key workers were supportive of ASP-organised community activities where they occur and eager for their introduction where they do not. A case manager in one site appreciated the social activities because even though her AMHS offers a rehabilitation program 'focusing on getting ready to work, volunteering [and] stress management', it does not provide 'social contact, which is quite often what they need'. Similarly, an AMHS manager in another site emphasised how 'valuable' recreational activities are and, even though they may be difficult to orchestrate, the need for ASPs to facilitate them:

> Fun and play and recreational activities are a critical factor. … Fun and recreation is challenging and finding suitable activities and

> helping people to access them and value that part of their life can be difficult. We [community mental health team] make treatment real and essential. We get cross with people when they aren't compliant and we make it a big deal about it. … I think we leave fun out of people getting well and learning how to get well, and if we do, we tend to brush it off a little bit. Every professional in the group that is involved in psychosocial rehab tends to have a fairly serious bias – daily living skills, treatment compliance, service plans; you don't often talk about fun and laughter and forgetting about yourself. We don't often encourage clients of mental health to do that. … [ASPs] are in a position to do recreational activities because of the power base they share with clients.

The mother of one client was impressed with both the group activities her son participated in and the subsequent involvement in a work experience course once a week because it has not only 'motivated' and 'stimulated' him, it has also 'made him feel worthwhile'.

ASP support (suggesting, encouraging, organising and/or transporting) has assisted people to become involved in a variety of activities. Some HASI participants, for example, attend church, barbeques, parenting courses, swimming pools, gymnasiums, concerts, community events and festivals, go shopping or window-shopping, out for coffee or to a local club, fishing or ten-pin bowling, and/or participate in sporting teams or exercise groups. Across nine indicators – shopping, eating out, attending the library, church, social groups and/or educational institutions or participating in organised sport, leisure activities or exercise – all clients interviewed (n=69) were participating in at least one of these activities. Eighty-three per cent were involved in at least three activities, 59 per cent in at least four and over one-third (36 per cent) participated in five or more. These high rates of participation are testimony to the shift to social inclusion.

Where social activities are not organised, a number of clients, consumer advocates, key workers, case managers and family members expressed concerns of loneliness and dependence on key worker home visits. Some ASPs do not organise activities because of a perception that ASPs are 'not responsible for entertaining people' and group activities can be 'stigmatising' (key workers). Community participation in one area has declined after group outings to a local Returned Services League's Club were discontinued. While most HASI participants in this site let their memberships lapse, had group activities persisted over a longer period of time, it might have resulted in independent participation. This has occurred in another area where after a couple of years a few people regularly, independently go to their local club together.

Consumer advocates were also eager for ASPs to not only network widely and link clients with existing forms of community participation, but to also create social and recreational opportunities. This approach was seen to be imperative because of the dwindling availability of community-based support programs and the difficulties clients might experience in engaging with mainstream networks.

6.3 Work and Education

Summary

- 26 per cent of those interviewed at Phase 3 had worked in the past six months in a paid or voluntary capacity, and 20 per cent had studied.
- 43 per cent of clients involved in HASI at Phase 1, 2 and 3 were working and/or studying at the last interview.

At the time of the third interview, 26 per cent of clients (18 of 69) reported working in the previous six months. Six of these 18 clients were in low pay disability-based supported employment, four were volunteering and nine were in paid open employment positions.[16] The latter included three cleaners, two consumer advocates/trainers, two meat workers, a gardener and a singer.

One in five (14 of 69) clients interviewed at Phase 3 had studied in a formal capacity in the past six months. Four were participating in community courses (including art, yoga and English), eight were attending TAFE (completing computer, art, hospitality and literacy courses), two had discontinued TAFE courses and an additional two were studying at university (completing a Bachelor of Arts and a Bachelor of Science).

Of the clients who participated in all three interviews (n=55), by the third phase 43 per cent were either working and/or studying. This had increased from 9 per cent at entry to HASI ($p<0.01$) (Table 6.1 and Figure 6.1). Although the proportion working declined slightly between Phase 2 and 3, the percentage working and/or studying peaked at the third interview.[17]

6.4 Friendships and Partnerships

Summary

- While 23 per cent of clients did not have any friends when they joined HASI, 94 per cent had established friendships by Phase 3.
- 72 per cent were satisfied or very satisfied with their friendships.

While only a small number of HASI clients interviewed in Phase 3 (n=69) reported having a spouse or partner (15 per cent), 94 per cent reported having friends and almost half (43 per cent) had made friends with people living in their neighbourhood.

[16] Note one person was both volunteering and involved in some paid cleaning work.

[17] Between phases 2 and 3 of the evaluation, 12 continued to work, while 5 did not. An additional two people started working in this period. Of those who discontinued working, 3 stopped working because employment/voluntary opportunities were short term, 2 stopped volunteering because they had developed enough confidence and skills to move into training (both are now studying at TAFE) and 2 were not well enough to continue working.

Many visited or were visited by their friends in the week prior to being interviewed.[18] ASP-organised activities had resulted in some HASI participants forming friendships and spending time together independently of key workers. Participation in other social groups, work and study had also resulted in some people forming new relationships.

A minority of clients interviewed in Phase 3 were struggling to make or maintain friendships. One in four respondents were dissatisfied or very dissatisfied with their friendships either because they did not have any friends or were unhappy with current friendships (Table 6.2 and Figure 6.2). One HASI client, for example, stated, 'I hang out with heaps of drugos [sic]. I don't like em, but it's someone to talk to'. Some people are still reluctant to form friendships because of past experiences or poor mental health. Others would like friends but have had difficulty forming these relationships. The latter group is especially prevalent in rural areas where people have moved away from family and social networks to join the program. Many people interviewed also expressed a desire for a partner.

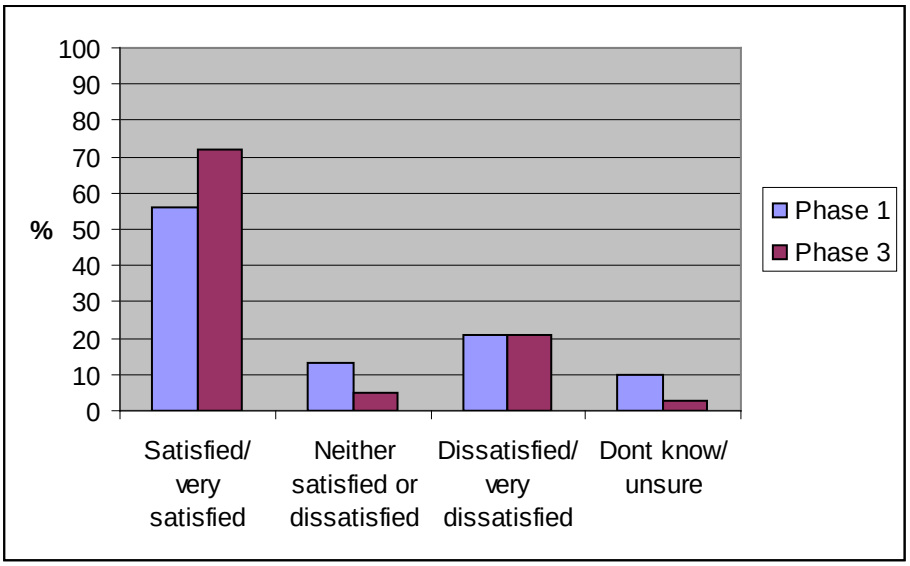
Relationships with ASP workers play an important role in the lives of most HASI participants, especially for those who do not have close friendships. This is corroborated by the 74 per cent of clients interviewed who perceive ASP workers as companions.

Table 6.2: Longitudinal Satisfaction with Friendships (n=39, per cent)

	Phase 1	Phase 3
Satisfied/ very satisfied	56	72
Neither satisfied or dissatisfied	13	5
Dissatisfied/ very dissatisfied	21	21
Don't know/ unsure	10	3

[18] 45 and 49 per cent respectively. These statistics are higher because some individuals already had established relationships in the neighbourhood prior to the program.

Figure 6.2: Longitudinal Satisfaction with Friendships (n=39, per cent)



6.5 Family

Summary

- Satisfaction with family relationships was high at Phase 3 (81 per cent), but individual satisfaction levels significantly fluctuated throughout the evaluation indicating that these relationships were at times complex and difficult.
- ASP (and often AMHS) personnel play an important supportive role for many clients in regard to their family relationships.

Many clients report good or improved relationships with family members throughout the HASI evaluation, especially where family members live locally. When family members are distant, expense becomes an issue in maintaining the relationships, and frequency of contact usually decreased after the HASI participant moved from the family's home town.

Mothers were the most frequently contacted family members. Over three-quarters (77 per cent) of clients interviewed at Phase 3 had contact with their mother. Of this group, 72 per cent were in contact at least weekly. Contact with fathers was less likely, with only 39 per cent of the group reporting contact.[19] Other relatives also played a role in most of the participants' lives, with 80 per cent having some contact. Seven people (10 per cent) who were interviewed in Phase 3 reported no contact with any relatives. Four of these people also reported dissatisfaction with their friendships.

[19] 53 per cent of the group answered that this question was not applicable, indicating that their father was either deceased or in an unknown location.

Twelve people interviewed in Phase 3 have children and eleven of these people are in contact with them. One client has had a setback in his wellbeing following denied access to his children. His key worker is helping him negotiate the legal process, but he is having difficulty coping with the situation: 'Losing access to my kids has affected everything, including my health.'

The proportion of HASI clients satisfied with family relationships remained high between evaluation phases – 83, 86 and 81 per cent respectively. Yet there were statistically significant changes between Phase 1 and 3 ($p<0.01$). Although proportions remained fairly static, there was shift in opinion at an individual level. Three people who were dissatisfied with their family relationships during the first interview were satisfied or very satisfied with these relationships by Phase 3 of the evaluation and five who were satisfied in the first interview were not by interview three. Corroborated by the qualitative data, this indicates that relationships continue to be complex and difficult for some people at some periods in their lives. Some clients have long-term volatile relationships with family members and HASI has assisted these clients to have greater insight into their family dynamics. Others continue to have problems with their family relationships, but key worker and case manager support has helped stabilise some of these relationships and to assist clients to build the capacity to deal and cope with problems.

A number of relationships between HASI clients and family members have shifted from one of a dependent child-to-adult relationship to a healthier adult-to-adult relationship. This has occurred with both parent and sibling relationships in some cases. The shift in the nature of these relationships has enabled family members to re-focus their lives away from their family member's mental illness as a dominating concern. 'It does free me up. I can get on with my life now', commented one mother. Other parents reported that with ASP and AMHS support for their adult child, they could go on holidays and/or increase their working hours. It has resolved their previous problems from the shortage of respite services. As mentioned in previous reports, HASI has also provided relief as the mental health system is offering effective long-term support for their family member.

6.6 Loneliness

Summary

- At all evaluation phases approximately half of all HASI participants reported feeling lonely.

Despite some improved relationships and increased social, work and educational participation, loneliness continues to be a persistent problem for approximately half of all HASI participants. In the third interview, 56 per cent of clients (n=69) reported being lonely. Among those who have participated from Phase 1 to 3, loneliness has remained proportionately high (49, 57 and 54 per cent respectively). While the percentage of people reporting loneliness has barely shifted between evaluation phases, at an individual level, feelings of loneliness fluctuated ($p<0.05$). Seven people who were lonely in Phase 2 were not in Phase 3, yet five people had changed from not being lonely to feeling lonely at Phase 3 of the evaluation. These fluctuations may be associated with changes in health, increased insight and complex relationships.

Loneliness was further reinforced by some clients' reliance on key workers for social contact and some people's preference for co-tenancy. Nineteen clients wanted more time with ASP workers, despite the admission by 14 people in this group that support workers spent enough time with them. While 72 per cent of clients interviewed in Phase 3 enjoy living alone, 42 per cent, if given the choice, would prefer to have someone else to live with. Feeling 'isolated and alienated' was more common in rural areas where people had moved away from family and social networks to join the program. Co-tenancies or increased support for HASI clients may or may not be the solution to clients feeling lonely. This is an area that requires further exploration.

6.7 Trust

Summary

- Trust levels have remained low among evaluation participants, but they have also fluctuated over time. This could be a reflection of insight into past exploitation and persisting vulnerabilities.

While many relationships have strengthened, a minority of clients experienced feelings of generalised trust throughout the evaluation. Over two-thirds of the cohort either believed 'you can't be too careful' in trusting people or were uncertain about trusting people at Phase 1, 2 and 3 of the evaluation.[20] While trust decreased slightly as a proportion between evaluation phases one and three (from 29 to 27 per cent), this is not statistically significant. What is significant ($p<0.05$) is the fluctuation in trust levels at an individual level. As Table 6.3 and Table 6.4 demonstrate, among this group trust is not constant. Eight people who believed most people could be trusted at the time of the first interview no longer trusted people at Phase 3. Yet six people who did not trust at the time of the first interview were trusting by Phase 3. Between Phase 2 and 3 of the evaluation, personal trust levels also fluctuated (Table 6.4). Ten people's trust levels changed at both Phase 2 and 3.

The minimal levels of trust and the personal fluctuation in these levels reflect historical and/or contemporary relationship problems and vulnerabilities. A decrease in trust does not necessarily have negative connotations for people in the HASI program. A number of HASI clients have learnt that some of their relationships were exploitive and they were being 'ripped off' by 'friends' and acquaintances. This is especially the case for some people with intellectual disabilities. Some HASI participants may always remain vulnerable to exploitation, but what has changed is an increase in awareness of possible exploitation, key workers intervening when exploitation occurs, and relocation to areas where there is less exposure to people who may take advantage of this vulnerability. Despite poor levels of trust, the majority of people interviewed longitudinally were positive about their relationships with their key workers and case managers (Section 2.3). This reinforces the important role key workers and case managers play in these consumers' lives.

[20] Phase 1 = 29 per cent (14 people) trusted; Phase 2 = 31% (15 people) and Phase 3 = 27 per cent (13 people).

Table 6.3: Longitudinal Trust Levels at Evaluation Phase 2 and 3 (number)

		Phase 3			
		Most people can be trusted	You can't be too careful	Don't know/unsure	Total
Phase 2	Most people can be trusted	9	5	3	17
	You can't be too careful	5	20	2	27
	Don't know/unsure	1	5	3	9
	Total	15	30	8	53

Table 6.4: Longitudinal Trust Levels at Evaluation Phase 1 and 3 (number)

		Phase 3			
		Most people can be trusted	You can't be too careful	Don't know/unsure	Total
Phase 1	Most people can be trusted	7	4	4	15
	You can't be too careful	3	22	1	26
	Don't know/unsure	3	2	2	7
	Total	13	28	7	48

7 Exits

Summary

- 78 per cent of people who started HASI remained in the program in March 2006 (n=113)
- Compared to non-Indigenous people in HASI, Indigenous retention rates are very low (50 per cent).

Between evaluation Phase 2 and 3, eight people left HASI. A woman was successfully transitioned into HASI Stage Two (and stayed with the housing provider);[21] four people left by choice to regain their independence (one was rehoused by the HASI housing provider, the second remained in public housing, the third returned to live with family, and the fourth moved interstate, was 'kicked-out' of a boarding house and hospitalised); two were incarcerated, and the final person was deemed too unwell for the program and was admitted for long-term hospitalisation.

Four of those who exited by Phase 3 were Indigenous Australians. This accounts for half of all those who exited the program (p=0.001). It reinforces the need to review how to improve the cultural appropriateness of the program for people who identify as Indigenous Australians.

Program retention rates were high throughout the evaluation. As Table 7.1 indicates, of the 113 HASI participants identified by ASP managers, 25 exited the program.[22] Therefore 78 per cent of people who joined HASI continued to be involved in the program in March 2006. For such an historically unwell, vulnerable and transient group, these retention rates reflect the high quality of the program and the success of the model.

[21] There were a few people in different sites who were in the process of considering a move to HASI Stage Two. In all cases the housing providers indicated they would continue to support these tenants.

[22] There may have been further exits prior to the evaluation that previous management was involved in and evaluators were not informed about. The exits listed within the housing turnover section are lower than total program retention rates. This is because not all those who exited the program were provided with housing by HASI based providers – some exited before being housed, others were living in their own or private rental accommodation. There may also be some minor discrepancies in the data because it is based on two different sources – housing providers and ASP managers.

Table 7.1: HASI Stage One Exits

	Exits (number)
Phase 1	10*
Phase 2	7
Phase 3	8
Total exits	25
Program retention rate (n=113)	78%

Note: *Report 1 listed nine people as having exited the program between entry and the first phase of the evaluation. SPRC fieldworkers were since informed about an additional person who exited during this period.

There are broadly two types of exiting clients – people who are supported by ASP and/or AMHS personnel in their move from HASI and those who are not. Support to leave can be based on a person not requiring HASI Stage One's level of support any longer; recognition that the program is not appropriate to the person's needs or willingness to be involved; or acknowledgement that the client is using the program for its tangible resources without reciprocity in accepting support. Clients who were not supported were usually given at least three warnings and stakeholders, including the client, worked together to try to address problems before resulting in an exit.

Clients who leave the program unsupported leave by either choice or are forced to leave through circumstances, such as incarceration. Three HASI participants were placed in gaol between Phase 2 and 3 of the program – one breached parole conditions by consuming alcohol and two were involved in criminal activities. AMHS and ASP personnel believed the first person was not 'prepared enough' for the program in terms of substance use rehabilitation and required a 'higher level' of support than the program could provide. The second person incarcerated was believed, by her case manager, to commit a criminal act because of an 'inability to cope with the day to day stuff … By going to gaol she's got structure, companionship, someone to look after her; we did work hard at trying to get that for her, but she still struggled despite our attempts'. The other person incarcerated had made significant gains in his community participation. However, perhaps increased socialisation resulted in this impressionable, vulnerable person being involved in an isolated criminal activity.

The former two people incarcerated have exited the program, while the latter has remained in HASI. ASPs are open to supporting the two people who exited should they be willing and eligible for support when they are on parole. Respective ASPs supported all three clients in the legal process following their arrest. Despite the outcome for these three people, their participation in HASI was perceived to be beneficial to a certain extent. The ASP and AMHS thought that two of these three clients had made significant progress since entering the program. One woman had moved from a situation of very poor personal hygiene and prostitution to becoming 'settled' and learning the 'ability to have self-protective behaviour' (ASP manager). Her case manager noted stability in her mental health, continuity and regularity with health appointments, an improvement in her daily living skills, such as shopping, cleaning and budgeting, and a 'better quality of life'.

Most AMHS and ASP stakeholders conceded that HASI had been positive for most people who have exited, despite the nature of their departure. One AMHS manager

believed some people who joined HASI failed to recognise the 'opportunities' the program could offer, but he still perceived their involvement as positive:

> An important factor is that they entered the program and gave it a go and it provided them with some beneficial return for some time. It sustained them for some time. It enabled them to realise that things could be different, that they weren't entirely stuck. It made some difference in their life. That becomes part of their history now and it depends on how much they valued it and if they want to do it again. At least it shows they were able to engage to some degree. Then they were also in a position to make the decision to leave.

Similarly, even though HASI was unable to provide adequate support to one client, her key worker believed it 'show[ed] her options' and gave her stability for a substantial period of time. While in the program she had the 'least number of hospitalisations since she was 12 years of age' and it gave her a stable place to live when she had 'nowhere else to go' (ASP manager). This person became 'sicker and sicker and sicker' as her time in the program progressed (case manager). Her case manager believed 'she's too ill for the program' and requires 'a lot more assistance' than HASI Stage One can offer. In addition to this person's illness, her case manager and ASP personnel believed her position in the program was undermined by her inability to cope with living alone, the few other young people in the program and her family dynamics.

HASI exits have demonstrated a number of lessons from which the program can be improved: people with severe levels of disability can work towards recovery and transition from high level support; the program requires greater cultural appropriateness for Indigenous Australians; and it is not a suitable program for all people with high levels of psychiatric disability.

8 Program and Governance Issues

8.1 Relationships between the Stakeholders and Making Partnerships work

ASP and AMHS

Summary

- Approximately 80 per cent of case managers and key workers reported healthy working relationships with each other.
- A minority of case managers and key workers are experiencing significantly more difficulty in their collaborative relationship than in the past (see Table 8.5 for factors that facilitate and hinder stakeholder relationships).

The majority of AMHS and ASP personnel continued to report healthy relationships with each other in the third interview (Table 8.1). Over 80 per cent of case managers reported their relationship with the ASP as good or excellent; 78 per cent of key workers stated similarly. Only 14 per cent of key workers and case managers perceived their relationship with the AMHS as either weak or average.

Three of the five AMHS managers reported their relationship with the ASP in their area as good or excellent at Phase 3. The remaining two rated their relationship as average. A similar proportion of APS managers reported problems in the relationships with the AMHS (two average and one weak). Levels of satisfaction in each evaluation phase must be interpreted independently because few people were involved in all three interviews (Table 1.1). Of concern, however, is the rising tension between some stakeholder groups within and across sites between Phase 2 and 3.

Table 8.1: Quality of Relationship between ASP personnel and AMHS Personnel at Phase 3 (per cent, mean score)

	Excellent or good at Phase 1	Excellent or good at Phase 2	Excellent or good at Phase 3
AMHS managers	78 (n=9)	80 (n=10)	60 (n=5)
AMHS case managers	83 (n=29)	88 (n=33)	81 (n=36)
ASP managers	90 (n=10)	82 (n=11)	66 (n=9)
ASP key workers	76 (n=46)	76 (n=45)	78 (n=50)

As a group, workers who participated in Phase 2 and 3 of the evaluation (case managers n=16 and key workers n=20) had higher levels of satisfaction in their relationships with other stakeholders compared to people only involved in the program for a shorter time (compare Table 8.1 with Table 8.2 and Table 8.3). This is expected because time assists in building rapport and relationships. What was not anticipated was a drop in relationship satisfaction among workers involved in the program for over six months.

Table 8.2 illustrates that across all governance measures AMHS satisfaction with the ASP decreased between Phase 2 and 3. These changes are not statistically significant

because the drop is slight and the sample size small. Yet when case manager satisfaction with the support provided by the ASP is compared across sites the difference is statistically significant ($p<0.05$). This is because dissatisfaction is primarily concentrated within certain sites. Case managers who perceive their relationships with ASP personnel as unsatisfactory are also contained within particular locations. ASP personnel's satisfaction with AMHS personnel also slightly declined between Phase 2 and 3 (Table 8.3). In two of the three sites where case manager dissatisfaction was reported, ASP personnel also reported communication and relationship problems.[23] While problems persist in certain sites, there are examples of strong and improving relationships between some case managers and key workers within these sites.

Table 8.2: Longitudinal AMHS Satisfaction with the ASP at Phase 2 and 3 (n=16, per cent)

	Satisfied or very satisfied at Phase 2	Satisfied or very satisfied at Phase 3
Support provided by ASP	100	88
Relationship with ASP	100	81
Communication with ASP	100	88
Co-ordination of HASI	79	64

Table 8.3: Longitudinal ASP Satisfaction with the AMHS at Phase 2 and 3 (n=20, per cent)

	Satisfied or very satisfied at Phase 2	Satisfied or very satisfied at Phase 3
Relationship with AMHS	95	80
Communication with AMHS	90	70
Co-ordination of HASI*	90	60
Note: * This is the only one of the three measures which is statistically significant at $p<0.01$.		

According to ASP managers, poor communication was one of the primary determinants of relationship problems. Only five of the nine ASP managers interviewed were satisfied with the communication between their ASP and the AMHS.[24] As seen in Table 8.4, key workers and case managers were more likely to be satisfied with their communication (68 and 78 per cent respectively) than managers, but communication problems persist between some of these stakeholders.

Although three-quarters of case managers interviewed in Phase 3 were satisfied (19 per cent) or very satisfied (56 per cent) with the support the ASP in their area provided, the remaining were neither satisfied nor dissatisfied (11 per cent) or dissatisfied (6 per cent). Case manager dissatisfaction with ASP support was low (6

[23] The number of AMHS and ASP Managers who were involved in repeat interviews throughout the evaluation (Table 1.1) is too small for statistical comparison.

[24] Only five AMHS managers completed the survey. Four of these managers were satisfied with the communication between their team and the ASP.

per cent), but an additional 11 per cent were neither satisfied nor dissatisfied.[25] One of the AMHS managers was also neither satisfied nor dissatisfied with the support provided by the ASP in their area. This indecisiveness demonstrates that some HASI stakeholder relationships are at a crossroad and will either further deteriorate if problems are not addressed, or quickly improve.

Table 8.4: Satisfaction with the Quality of Communications between ASP and AMHS Staff at Phase 1, 2 and 3 (per cent, mean score)

	Satisfied or very satisfied at Phase 1	Satisfied or very satisfied at Phase 2	Satisfied or very satisfied at Phase 3
AMHS case managers	82 (n=28)	94 (n=33)	78 (n=36)
ASP key workers	67 (n=46)	76 (n=45)	68 (n=50)
AMHS managers	67 (n=9)	80 (n=10)	80 (n=5)
ASP managers	90 (n=10)	73 (n=11)	56 (n=9)

The interviews with the workers and managers reinforced the drop in satisfaction and the need to rebuild and/or strengthen relationships across and within many of the sites. The evaluation found numerous factors affecting the relationships between HASI stakeholders; these are summarised in Table 8.5.

[25] The remaining 8 per cent were unsure.

Table 8.5: Factors Hindering and Facilitating Stakeholder Relationships

Facilitating factors	Hindering factors
Governance issues (non-HASI related)	
• Effective, constructive and supportive team leadership within the AMHS and ASPs.	• Leadership capacities questioned internally and externally
• Stakeholders historically working together and/or working together on more than on project.	• No previous contact between stakeholders
• Previous AMHS experience working in partnership with the NGO sector.	• No previous AMHS experience working with the NGO sector
Governance issues (HASI related)	
• Shared understanding about and commitment to HASI as a model and program by management and ground staff.	• Micro impact of the program because of the small number included in the program. Limitations placed on program referrals because of small numbers.
• Clarity regarding the roles and responsibilities of each stakeholder (including an understanding of how partners spend their time) and a perception that roles complement each other: 'People know what their role is. They're very happy about [the ASP] doing the non-clinical support stuff. I don't think you'd find a clinician here that doesn't say, "HASI has been a wonderful thing"' (AMHS Mgr).	• Roles and responsibilities not fully understood or explained. This can be a continual problem if staff changes occur without education around HASI. Case managers and key workers can consequently have unrealistic and ill-informed expectations of each other's roles.
• Perception that stakeholder input into HASI is equitable. Strong relationships between managers and effective local committee meetings where each stakeholder's opinion is respected and valued. AMHS management perceive local ASP management as skilled and capable.	• In some situations the ASP is considered the junior partner; this is a result of both personnel attitudes, dominance at meetings and it is reinforced by governance structures, which make the Area Health Services contract managers via the funding delineation. Dominance of one partner was believed by one stakeholder to hinder the potential contribution of other relevant bodies, like the NSW Department of Corrective Services, drug and alcohol services, disability services and culturally specific peak bodies.
• Shared perception that HASI is mutually beneficial for all stakeholders. Most AMHS personnel were positive about ASP support because it had 'freed up a lot of clinical time', 'prevented crises' (AMHS Manager) and helped them 'provide a high-level of care' (case manager); most housing providers believe HASI is enabling them to successfully support complex clients.	• AMHS personnel believing ASP support threatens sustainability and maintenance of AMHS services. Model perceived as cost cutting rather than a community-centred partnership approach. Perception that AMHS and ASP roles are duplicated.

Facilitating factors	Hindering factors
• Consumer advocates proactively involved in HASI at a local level.	• A lack of involvement of consumer advocates (at local committee levels and in daily operations) potentially jeopardises client interest and outcomes. Some case managers currently act in an advocacy role, but if this does not also include good communication between all parties, then it has the potential to fuel divisions between the AMHS and ASP.
Practical and pragmatic factors	
• Frequent, regular, open and constructive communication through formal and informal meetings: 'The thing that works for us is the relationship with the services. Things go wrong, but there is no blame. There is extreme goodwill to communicate' (AMHS manager).	• Regular and effective communication lines not established at the beginning of the working relationship: 'Initially the communication wasn't set up very well and we've got to a point where when difficulties have arisen we don't know how to manage them together' (AMHS manager).
• Partners freely sharing information (with consumers' permission and a commitment to confidentiality within the group). This is important not only between AMHS and ASP personnel, but also with housing providers where information is relevant to people's tenancy (for example, informing housing providers of symptoms and/or behaviours that may affect their tenancy).	• Case managers believing that clinical information should not be shared with ASP personnel because of confidentiality. Similarly, ASP personnel withholding information from housing providers about clients that may or has affected their tenancy.
• Transparency between stakeholders when problems arise and subsequent joint problem solving.	• ASP personnel withholding tenancy problems from housing providers because of a fear (mostly unfounded) that clients will be evicted if problems are disclosed.
• Varying approaches are shared and respected and the best option for client outcomes is jointly decided upon. This is not only effective for relationship building, but also client outcomes.	• Disagreements between ASP and AMHS personnel about what constitutes the most empowering strategy for a client (for example, having a client placed under the Office of the Protective Commissioner may be seen as positive - by reducing money available for drugs/alcohol, reducing vulnerability to exploitation, forcing budgeting - or as negative - by taking away self-determination or their responsibility to care for themselves).
• Joint development of support plans and other formal interactions between client, case manager, key worker and other service providers making the partnership more transparent and effective.	• Lack of joint strategising has resulted in some disgruntlement with the type of support provided to clients and client goal achievement. Where support plans are not a shared process and communication between partners is limited, there have also been examples of clients playing off stakeholders and creating tension and suspicion between the two.

Facilitating factors	Hindering factors
• AMHS personnel are accessible, supportive and encouraging of ASP personnel (for example, willing to be contacted and some willingness to assist in key worker skill development; this is especially important in rural areas where training is difficult to access). ASP personnel are cognisant of AMHS resource limitations.	• Case managers not returning ASP phone calls. ASP personnel having unrealistic expectations around case managers' capacity. Client caseloads can be such that case managers are often already overburdened and therefore there can be limited opportunity for them to work with fellow stakeholders.
• Trained/skilled/experienced key workers. ASP committed to training staff in core competencies.	• Inexperienced, untrained key workers relying heavily on case managers and/or working in ways that are perceived to reinforce client dependence or stymie skill development.
• Having a key worker with a mental health service background increases the intellectual capital within the ASP and assists in rapport building with AMHS personnel.	• Inappropriate cultural matches between key workers and clients.
• Where ASPs adopt a psychosocial rehabilitation focus and have leisure/ recreation as a core component of support.	• ASP support being perceived as hindering client skill development and clients not engaged in recreational activities (outside of those organised by the AMHS).
• Case managers understanding the differences between their relationship with clients and key worker's relationship with clients. There is an appreciation between both parties that boundaries differ in these relationships.	• Stakeholders failing to appreciate the essential differences in the ethical and professional boundaries of client/key worker and client/case manager relationships (some case managers believe that if clients perceive key workers as 'companions', then the worker's capacity to be 'directive' is reduced; others were concerned with the key worker being 'too nice', while they played the 'law enforcer').
• 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 when they are in crisis.	• Where health services have limited structure to support people who are stable and have a high level of efficacy, there is some tension between crisis management and case management. There can be some confusion as to case managers' roles within HASI in these situations and these case managers typically want to remove these clients from their books. This can create tension between the AMHS and ASP.
• Ethical/moral issues are upheld.	• Breaches of, or perceived breaches of, client confidentiality.
• Stability in key workers and case managers to enable relationship to strengthen over time.	• Staff movement or turnover. This affects the continuity of key worker staffing and undermines gains in partnership effectiveness and client outcomes.

Over time most program stakeholder relationships strengthened. This was not always the case between Phase 2 and 3 for some AMHS and ASP personnel; not only have some existing tensions persisted, but new relationship problems have arisen. Despite these problems, there is good will among most stakeholders to overcome tensions and strengthen relationships.

Housing providers and ASP

Summary

- Housing provider and ASP personnel relationships remained stable and overwhelmingly positive throughout the evaluation.

Unlike AMHS and ASP relationships, housing provider and ASP relationships remained fairly static over time. All but one of the housing providers was satisfied or very satisfied with their relationship with the ASP at Phase 1, 2 and 3 of the evaluation. ASP manager perceptions of their relationship with the housing provider also remained strong at Phase 3. All ASP managers interviewed were satisfied or very satisfied with the way housing providers have worked with HASI clients between Phase 2 and 3, as were the majority of key workers (76 per cent, n= 50). Eight of the nine ASP managers interviewed reported their relationship with the housing provider as good or excellent and the same proportion was satisfied or very satisfied with their communication with the provider (Table 8.6).

Table 8.6: Relationship between ASP Personnel and Housing Providers at Phase 3 (per cent)

	Excellent	Good	Average	Poor	Very Poor	Unsure
ASP managers (n=9)	44	44	11	0	0	0
Key workers (n=50)	18	48	12	6	2	14
Housing providers (n=7)	57	29	0	14	0	0

While little changed in overall satisfaction occurred, housing providers and key workers discussed issues that helped to strengthen and/or compromise their relationships in the past six months. Many of these factors are listed in Table 8.5. In one area the relationship 'has grown a lot' (housing provider) because of increased contact and more transparent communication and ASP personnel increasingly understanding the complexities housing providers work within, especially when properties are head leased. Consequently, both organisations have 'greater respect for each other' (housing provider).

In other sites, ASP anxieties continued around privacy and confidentiality in regard to the type and detail of client information to share with housing providers. This created tension within the partnership when information affecting tenancies was not disclosed until a crisis or an inspection occurred, or neighbours complained:

> They're not honest with us; that makes it difficult to work with clients. I don't know if they think we'll evict their clients. But our relationship won't improve until that [dishonesty] changes. We're working on different philosophies and we're not given much information. … We're really only interested in the stuff that impacts on the tenancy. We don't need to know anything else. It's not our business (housing provider manager).

While conscious of the importance of confidentiality, at least three other housing providers believed their relationship with ASP personnel was stymied by limited knowledge of clients' mental health symptoms, problems and histories that could affect their tenancy. They were most concerned about legal issues, occupational health and safety (OH&S) and a duty of care to their employees and other tenants.

Housing providers and AMHS

Summary

- Housing providers and AMHS personnel have minimal contact at an operational level, but middle and upper management have developed good working relationships. AMHS managers were all positive about these relationships, but some housing providers reflected on the need for a more equitable partnership.

Housing providers and case managers generally have little direct contact and therefore many could not comment on their relationship with each other or on the type or quality of support provided. AMHS managers and housing providers, however, were in contact as a result of HASI committee meetings and other programs. All AMHS managers reported their relationship with housing providers as good or excellent. One housing provider was disgruntled with the communication between themselves and their AMHS. Similarly, one AMHS staff member believed the HASI housing provider had misunderstood the needs of one client; alleging the client had been treated poorly, and that the type of housing and its location had contributed to his lack of success in the program. In two other cases, AMHS personnel expressed dissatisfaction with the housing provided to their clients because of its isolated and run-down nature.

At an upper governance level, managers also had some concerns about the equitable nature of the partnership between health and housing. While the structure of governance by the Department of Housing and Centre for Mental Health is well articulated by contractual obligations, a housing provider representative felt that at an operational level the relationship was unequal. Increased consultation, effective, regular communication and transparency around program management, implementation and service delivery were felt to be important in strengthening the partnership. HASI has enabled a well-considered, defined and resourced partnership between health and housing.

AHMS/ASP personnel and family members/carers

Summary

- Open communication with family members and/or carers has assisted them to work together well and maintain trust, and may, in turn, help ASP and AMHS personnel to reinforce strategies and to assist clients to reach goals.

Family members and carers interviewed were generally positive about HASI, but a number were disgruntled with the communication between themselves and the ASP and AMHS. This is a difficult issue because HASI participants are adults and

communication between ASP, AMHS and family members only need occur when HASI participants have requested this or a family member is acting as a legal guardian. Nonetheless, where open communication between HASI stakeholders - especially the ASPs - and family members has occurred, families trusted the program and were supportive and helped to reinforce ASP and AMHS strategies and assisted clients to reach goals.

Disgruntled family members were in the minority.[26] In two cases family members have continued to protest that their family member was not appropriate to participate in HASI. In a small number of cases, family members created barriers to positive client outcomes. Relationships with family members worked best where concerns were taken seriously, discussed and debated (using functionality assessments, for example) where possible. In situations when clients consent, the inclusion of family members or carers in the support plan process could help to overcome some problems.

8.2 Organisational Issues

Summary

- Some ASP managers reported varying levels of difficulty in regard to recruitment, retention, training and OH&S issues.
- ASPs that provided training, staff development and promotional opportunities reaped the reward of loyal and skilled employees with strong stakeholder relationships.

Staff

All but one ASP manager reported staff recruitment and retention as causing some difficulty. Four reported having moderate difficulty with recruitment and selection and two substantial difficulties. All three rural sites reported moderate difficulty. Recruitment difficulties were largely a result of ASP expansion within a short period of time, not a consequence of staff retention. Only two sites (one rural and one metropolitan) perceived staff retention as problematic.

In rural areas attracting suitable staff – those with mental health experience and an understanding of the 'empowering' aspects of a support role – has proven to be challenging. People with relevant qualifications have little incentive to work for ASPs in rural areas because recruitment opportunities are often readily available in the higher paying AMHS or other organisations.

Without incentives, such as training, staff development and promotion opportunities, staff members who are or become increasingly skilled in mental health service delivery are likely to move on in rural, regional and metropolitan areas. ASPs who have offered staff these incentives have reaped the reward of loyal, long-term staff

[26] The number interviewed is too small to be statistically significant.

members who are entrenched in organisational culture and have strong relationships with other HASI stakeholders.

Training

Since the start of the evaluation, ASPs have increasingly pursued training opportunities for their staff members. Two ASPs have financially supported staff participating in mental health-related TAFE courses. Staff completing mental health based university degrees were provided with study leave. One ASP is currently contracting a university to compile seven core training modules, which all staff will be required to complete. Topics such as promoting recovery, understanding consumers' experiences (including working with people with difficult behaviours and people with drug and alcohol issues), working within the psychosocial principles, symptomology, dignity of risk versus duty of care and the role of the support worker, as well as OH&S, reflective practice and supervision will be included. Once completed, staff will have a Certificate III in Mental Health.

Another ASP sends staff members to what are usually single day training courses; internally runs in-services; and endeavours to access AMHS training opportunities. Despite these changes, three of the nine ASP local managers reported moderate to high levels of difficulty with staff training; two of these sites were in rural locations.

Rural locations face particular difficulties, especially since TAFE courses are yet to be financially supported by the organisation. Local consultancy-based training resources are limited, establishing the credentials and ensuring a quality product from out-of-area training consultants is difficult and transporting staff to capital cities for training is outside of the capacity of the training budget. The local AMHS is the most readily available source of training and two of the three sites actively invite and welcome ASP personnel. Consulting AMHS staff to run core competency training sessions could be an option for rural sites to explore.

Training has been important for client and governance outcomes. As one key worker expressed, 'I think getting everyone to do a Certificate IV in Mental Health is a good idea because you're letting people loose on very vulnerable people's lives. You have to know what you're doing'. In one site where training is limited, a consumer advocate recommended a 'structured, thought out and targeted' program.

Managers and staff generally considered training opportunities within AMHS to be readily available and accessed. One site currently conducts inter-agency training to educate HASI stakeholders about each other's roles.

Occupational health and safety

OH&S standards are clear and stringent within Area Health Services. Risks are identified and protocols implemented to protect staff members. An AMHS manager explained some of these protocols:

> After 4pm all home visits are dual visits. … We've got certain streets that have been identified as risky by police; they're two person visits at anytime. Every client has a risk assessment and if there is a risk then that is also a two-person visit. In some houses the

> client is no risk but they might live in a high-risk street. So that client would be a two-person visit too.

ASPs also have OH&S policies and protocols and officers are often appointed to take responsibility for identifying risks and raising OH&S matters regularly at team meetings. In two sites, however, ASP managers reported moderate to high levels of difficulty in dealing with OH&S issues. Interviews with key workers indicate that this problem may be widespread. Some key workers from varying sites felt that their safety is compromised by management and budgetary decisions. Key workers reported that they expressed these concerns to their managers, but they did not believe their comments were always taken seriously or addressed.

There may be a need for ASPs to review OH&S policies against standards set within the AMHS, especially since key workers have less training to identify risk than case managers. ASPs take OH&S seriously in terms of policies, but are sufficient resources invested to ensure these policies are carried out? ASPs complete risk assessments, but it is unclear to the evaluation whether policies are based on clients, people who may be in their home, the block they live in, the street they live in and the time of day.

Staff supervision

Staff supervision was perceived as a problem for managers in four locations. Geography is a determining factor with all three rural sites reporting problems with supervision. Regular staff supervision may help prevent staff burnout, as well as complacency or paternalism. One ASP actively incorporates 'reflective practice' into their work, which also improves service delivery and provides debriefing opportunities. Reflecting on support provision both formally (staff meetings) and informally (on the office couches) is perceived as important by managers and key workers: 'That's really important in mental health, especially when the changes are so minimal … [and] we're working with people with difficult behaviours' (key worker).

AMHS staff members have debriefing sessions and daily meetings as part of their working day. This is a confidential environment for staff to reflect on the working day, problems with clients and strategies to solve these problems. Not all ASPs follow this practice, despite the stress in their daily work.

8.3 Cost-Effective Analysis

The cost effectiveness analysis will be completed in the final report. Administrative data for the HASI clients and comparison groups is not yet available.

9 Conclusion

With a foundation of stable housing, the regular monitoring and maintenance of mental health and a support system within the home and in the community, HASI is mediating the effects of mental illness for many participants. The model has not only brought together DoH, NSW Health and NGOs in a contractual agreement, in many sites, it has also become a unique partnership at an operational level with housing providers, AMHS and ASP personnel and clients working strategically together. The results have been remarkable.

Matching housing to client needs, providing adequate space and locating clients near family networks and community resources, coupled with a preventive, interventionist and supportive approach from housing providers and ASP personnel, has resulted in 70 per cent of clients maintaining their first tenancy and very few cases of rental arrears, poor property care or complaints from neighbours.

Regular contact with AMHS case managers and access to other mental health professionals coupled with ASP monitoring, prompting and transporting have contributed to the reported improvements in client mental health and a drop in hospital admissions. With support networks in place, many clients have a greater capacity to cope with problems and intervention often takes place before crises occur.

The psychosocial rehabilitation approach taken by ASP workers has assisted many clients to improve their living skills, develop new friendships and social networks, strengthen family relationships and meaningfully engage in the community. Participation in social and recreational activities has provided a pathway for some clients to mainstream work and education. This shift towards social inclusion has improved self-confidence and wellbeing with 78 per cent of clients feeling more positive about themselves since joining the program.

Despite the positive gains, loneliness has remained a problem for approximately half of all clients, CALD individuals and women are under-represented in the program and Indigenous Australians are much more likely to have exited HASI than their counterparts. Stakeholder relationships could also be strengthened in some areas.

Overall, HASI is mediating some of the effects of mental illness for many clients. The program provides a matrix system of consistent support that allows people to maintain their tenancies and re-engage, develop and strengthen other spheres of their lives – work, education, community participation and relationships – despite their mental illness. HASI has also demonstrated that a partnership between NSW Health, DoH and NGOs can be effective in minimising the effects of mental illness for some people.

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