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Social Policy Research Centre

NSW DEPARTMENT OF HOUSING
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HOUSING AND ACCOMMODATION SUPPORT INITIATIVE

REPORT I: SUMMARY

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Key Points

The Housing and Accommodation Support Initiative (HASI) is a jointly funded NSW Department of Health and NSW Department of Housing (DOH) program, which aims to improve housing stability and community participation for people with mental illness through community based accommodation and coordinated support services. HASI Stage One provides accommodation support places to over 100 people with complex mental health problems and high levels of psychiatric disability. The Social Policy Research Centre (SPRC) is evaluating this program. The following are some of the key findings from the first evaluation report:

Target Group

- HASI Stage One clients have high levels of psychiatric disability and histories of long term hospitalisations, tenancy instability, limited social networks and family connectedness and minimal levels of community participation.
- 71.9 per cent of clients have schizophrenia as a primary diagnosis.
- Clients spent 12,486 days in hospital or residential rehabilitation centres in the year prior to joining HASI.

Partnership Model

- Housing provision by community housing providers and the DOH is well linked to clinical support from the Area Mental Health Services (AMHSs) and accommodation/disability support from non-government organisations (NGOs).
- Three NGOs, Neami, Richmond Fellowship of NSW and New Horizons, fulfil the role of the Accommodation Support Providers (ASPs). They provide a range of support to clients - domestic, emotional, physical health, education and employment, advocacy, social and leisure.
- Clients are independently accommodated in units, townhouses, villas or separate houses, which usually have two-bedrooms.

Initial Outcomes

- 93.1 per cent of clients were satisfied with their homes.
- Community participation levels had improved for most HASI Stage One clients. 72.2 per cent had made new friends since joining the program and 65.6 per cent were participating in social and community activities.
- 85 per cent of clients have successfully maintained their tenancy under HASI.
- 69 per cent of AMHS case managers reported an improvement in their clients' mental health.
- Projected over twelve months, HASI clients spent 1,377 days in hospital, which represents a 90 per cent fall in hospitalisation/residential rehabilitation trends.
- Most clients were regularly seeing a case manager (92.2 per cent), psychiatrist (88.9 per cent) and general practitioner (85.4 per cent); and 42.4 per cent had consulted an allied health professional.
- Over half of the clients reported improvement in their cooking, shopping and budgeting skills, along with improved diet and use of public transport.
- 9 per cent of individuals had exited the program at the time of the evaluation.

Initial Analysis of Issues

- Effective governance was instrumental in successful program outcomes.
- Relationships between the AMHS, ASPs and housing providers were generally sound, but some tensions persisted around issues such as the style of support provided, training, response times and clients with dual diagnosis.

- ASP support has enabled some case managers to redirect their focus back to clinical support and provided a preventative and interventionist role for housing providers.

Background

This report presents the first phase of evaluation findings of HASI Stage One. HASI is a three-way partnership between NSW Health, DOH and NGOs, which is jointly funded by NSW Health and DOH. It aims to assist people with mental health problems requiring accommodation (disability) support to participate in community life, maintain successful tenancies and improve their quality of life. HASI incorporates a range of support levels from low to high.[1]

HASI Stage One offers accommodation support places to over 100 people with complex mental health problems and high levels of psychiatric disability. The program is currently operating in nine sites across NSW, which previously had no or few housing and accommodation support services available for people with mental illness - the Far West, South Western Sydney, Western Sydney, Wentworth, South Eastern Sydney, New England, Greater Murray, Illawarra and the Central Coast.

The program targets individuals with long-term recurrent hospitalisations who have the ability and desire to live in the community and a capacity to maintain a mainstream tenancy with appropriate support. Thus two primary objectives of HASI are to decrease hospitalisations and improve quality of life.

The Social Policy Research Centre (SPRC) from the University of New South Wales was commissioned by NSW Health and DOH to longitudinally evaluate HASI Stage One over two-years. The implementation, process and effects of HASI are being evaluated with a specific focus on client outcomes (such as hospitalisation rates, tenancy stability and community participation), service provision and governance framework.[2]

This is a summary from the first of three reports, which was based upon fieldwork with over 200 HASI stakeholders. Between February and April 2005 71 HASI clients were interviewed and surveyed,[3] along with 57 individuals working for the three NGO Accommodation Support Providers (ASPs), 46 employees from the various Area Mental Health Services (AMHS), 11 housing provider staff members and 27 clients' families.

This summary is divided into four parts, defined by the aims of HASI – to target appropriate individuals for the program, provide high level accommodation support and attain client and governance objectives.

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1 HASI currently has three stages. Stage One is for over 100 high support clients. HASI Stage Two is a low support outreach for 460 people who are in established accommodation, but may be at risk of losing this without support. Stage Three has 126 places for individuals with high support needs. This stage is still in the tendering process.

2 This first report is a baseline descriptive one. The evaluation is longitudinal and thus assesses change over time. This report does not draw on a control group because of a number of complexities and limitations, but, given the availability of the data, hospitalisation rates and clinical data on HASI Stage One clients will be compared to those on the waiting list in the following reports. Ethics approval has been granted for the project from UNSW and NSW Health.

3 At the time of field work, there were 92 HASI clients. Aggregated non-identified data was collated to determine a comprehensive picture of these clients.

1.1 HASI Client Demographics

HASI clients participating in the evaluation closely matched the group targeted. They had high levels of psychiatric disability, were on low incomes, had a history of hospitalisations and tenancy instability, limited social networks and family connectedness and minimal levels of community participation.

Almost all of the HASI clients were born in Australia. Four HASI clients are Indigenous Australians and five clients identified their first language as other than English. The latter are underrepresented as a proportion of the Australian population; 5.6 per cent of HASI clients identified their first language as other than English, compared to 20 per cent of the population.[4] Most clients were 35 years or younger (61.2 per cent) and the majority were male (70 per cent).

Mental illness

Schizophrenia is the primary diagnosis for 71.9 per cent of clients. Eleven per cent have been diagnosed with schizoaffective disorder, 3.4 per cent with bipolar disorder, 2.2 per cent with depression and 11.2 per cent with other diagnoses.[5] Many HASI clients suffer from comorbidities. All but six clients drink alcohol, use tobacco and/or take other recreational drugs. Alcohol abuse and other comorbidities will be further explored in the following reports.

High levels of psychiatric disability – hospital admissions and high support needs

The high level of psychiatric disability is evident by the number of hospitalisations prior to HASI and the daily living support required by many clients when they first joined the program. Almost all clients (86.4 per cent) had been hospitalised at some stage in the year prior to joining HASI. Just under one third (32 per cent) had spent 260 or more days of the year before they started HASI in hospital.

The majority of clients entered the program with very high support needs. Client dependency on the ASPs varied, but almost all clients relied on ASP support for fundamental daily living skills: shopping (87.8 per cent), medication (84.4 per cent), budgeting (81.1 per cent), making appointments (78.9 per cent); cleaning (75.6 per cent); diet (71.9 per cent); and accessing community services (66.7 per cent).[6]

Difficultly sustaining mainstream tenancies

At least one in ten clients had been living in very vulnerable housing situations prior to HASI.[7] They were accommodated in boarding houses, refuge or crisis accommodation, living in a car, tent, park or squatting or in other temporary housing. A further 34.4 per cent had been living in hospital before joining HASI. While 18.9 per cent were still residing in the family home, the interviews revealed that many of these situations were unstable and unsuitable.

Some of those who had been renting public or private housing had difficulties maintaining tenancies. One client, for example, had two DOH properties terminated prior to joining HASI because of his 'drug and alcohol problems' and failure to 'pay the rent'.

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

5 See Figure 2. All figures and tables, except figure 1, are in the appendix.

6 See Figure 3.

7 See Table 1 for a breakdown of accommodation types.

Limited social networks and family connectedness

At the time of joining the HASI program, only 8.9 per cent of clients were married or in a de facto relationship and a further 5.6 per cent were involved in an intimate relationship. Parental contact was the most common social network among clients – 53.3 per cent had contact with a parent or parents at least once a week. Yet almost one in four clients (24.4 per cent) had either no contact with their parent(s) or only saw them once a year or less.[8] Over one in five clients (21.3 per cent) have children, but 31.6 per cent of this group never see them. Over one in four clients (25.6 per cent) were in contact with a carer. Of all the clients, nine had very limited, if any, family or carer connectedness. Seven of these clients were only in contact with relative(s) once a year or less and the other two had no social contacts, neither with a relative, friend nor carer. Many HASI clients reported having very few or no friends.

1.2 High-level support linked to supported housing

HASI provides support in three areas - housing, accommodation/disability and clinical. Community housing providers and DOH supply accommodation for all HASI clients. Housing provision is well linked to clinical and disability support. Case managers within the local Area Mental Health Services assist clinically, while three NGOs, Neami, Richmond Fellowship of NSW and New Horizons, provide a range of psychosocial rehabilitation interventions that include domestic, emotional and community support.

The level of case manager and ASP support was generally high, but varied depending on client need and discretion. ASP support was most beneficial when life-based support was coupled with social interaction, enabling a rapport to develop between workers and clients. Healthy client and case manager relationships were often founded upon long-term interaction.

ASP support

ASPs provide a range of domestic, emotional, health, employability, advocacy, social and life-based support for clients. Organisational policies and procedures and client need shape the nature and intensity of support provided, but client willingness also plays a key role.

Overall, clients were positive about the support they received from their key workers.[9] Ninety-three per cent felt the ASP had helped them either ‘a lot’ (60.3 per cent) or ‘a bit’ (32.8 per cent). For many clients, domestic support and life skills training dominated the time key workers spent with them. While this type of support is required, many clients perceived emotional and social support as most beneficial.

Participating in social activities with clients was instrumental in developing a strong rapport between key workers and clients. Without this, some clients felt confined by the support provided and were disgruntled with the supervisory nature of the support and what they thought was an intrusion of their space. Rigid ASP visiting times sometimes further exacerbated this disgruntlement.

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[8] This includes 11.1 per cent of clients whose parents were deceased or not known.

[9] See Table 2.

AMHS Support

Case managers also played an important role in clients' lives. The majority of clients (78.9 per cent) stated that the AMHS had helped them and 69 per cent were satisfied or very satisfied with their case manager.[10] Relationships between clients and case managers were particularly strong when case managers had worked with clients over a long period of time. Clients in these situations placed significant trust in the case manager to look out for their interests in HASI.

Most family members interviewed perceived individual case managers positively, but the AMHS had developed a negative reputation among some families. This was largely because of a history of staff turnover and families' frustrating attempts to get support from the mental health system.

Supported housing

Community housing providers locate and manage accommodation for HASI clients in seven sites. In the two remaining locations, the Department of Housing provides accommodation. Clients were housed in units, townhouses, villas or separate houses, which usually had two-bedrooms. Properties were either leased or capitally owned by the housing providers. While leaseholds provide clients with greater choice, housing stability remains 'at the mercy of the landlords' (key worker). Contrarily, capital properties offer security of tenure if Tenancy Agreements are upheld.

Although most housing providers accommodated HASI clients in separate homes, unit or townhouse complexes, there were two exceptions. In one area, five clients were living in the same block of units, and in the other location, four clients resided in a newly built block of townhouses. These providers believed that clients offered each other 'a sense of support'. The evaluation found that if the appropriate clients lived in this situation, it was beneficial for developing social networks. However, an unsuited client could be detrimental to others.

Almost all of the HASI clients were positive about their accommodation, with 93.1 per cent either satisfied or very satisfied with the condition of their homes. Only three clients said that overall they were dissatisfied. Dissatisfaction was based on space and/or inadequate temperature control within the home. The latter was a prevalent problem in winter in one of the rural locations. While there were complaints about inadequate heating, 91.2 per cent of clients were satisfied or very satisfied with the furnishings they received.[11]

Client enthusiasm for their homes is understandable. Many had never had stable, decent accommodation surrounded by their own, new items, and many had spent long periods in institutions with minimal privacy. A case manager of a client, who had spent most of her life in and out of hospital and gaols, commented, 'She thinks the accommodation is the bee's knees. She's never had anything new in her life, not even a new kettle – she loved it … And it's doing wonders for her mental health'.

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10 See Table 3.

11 See Table 4 for client satisfaction with various aspects of their accommodation.

1.3 Client objectives

The evaluation revealed some remarkable outcomes for many of the clients participating in HASI. Clients, case managers, key workers and family members told of changes in relation to clients' community participation, ability to sustain tenancies, their physical and mental health, life skills, independence and relationships.

Improve/maximise community participation

Increased community participation is evident in regard to clients' social interaction and use of local facilities and resources. Approximately four in ten clients (41.4 per cent) reported developing friendships with neighbours. Key workers maintained that 72.2 per cent of clients had made new friends since joining HASI; and 65.6 per cent were reported to be actively participating in social and community activities. Most clients participated in leisure activities (62.3 per cent) or day programs (65.6 per cent), 50 per cent utilised local parks and about one-third (35.6 per cent) attended church.[12]

Further indicative of clients socially participating in the community were the one in five (21.8 per cent) who attended an education facility. Those who were successful in re-engaging in education tackled short courses with a part-time status either at TAFE or community colleges. At the time of the evaluation 21.1 per cent were in paid or voluntary work (all part-time or casual and many supported) and one in five (20.9 per cent) remaining clients were looking to re-enter the workforce.

Health, history and social skills largely determined the degree to which clients participated in the community. ASP workers, however, also played an instrumental role in facilitating community participation. Areas where clients were well integrated into the community, relative to their HASI counterparts in other locations, were those where the ASP not only motivated clients, but also provided organised activities where clients could build their confidence and develop their social skills. Through ASP organised group outings, a number of clients had moved from social isolation to independently pursuing and participating in activities of interest. For some other clients, organised activities remained their only social contact outside of service provision.

One of the three ASPs does not organise internally run activities for HASI clients, but rather endeavours to connect clients with existing disability support groups and/or day programs in their respective communities. While some clients have benefited from such an approach, others disliked attending 'disability' labelled groups. As a number of these clients were not ready for mainstream community involvement, internally organised group activities may assist to maximise participation.

The research material suggests that it is difficult to achieve a balance between clients becoming dependent on ASP social activities and independently integrating into the community, however there is no doubt that some clients involved in ASP group activities have benefited significantly. ASP organised activities have played an important role in developing social skills and fostering confidence among some clients, enabling them to participate independently. A client explained the difference these activities have made to his life:

> I've got a social life now and I enjoy it, whereas before I was too scared to leave the premises. I would barricade myself in. … It wasn't much of a life

[12] See Table 5 for client use of neighbourhood resources and proportion accessing services with support.

> really. All the worries that were overwhelming before, now they're easier to deal with because of the medication and because of the support of these people [ASP]. And I can get out, I don't always have to rely on them, I can go and do something off my own bat.

To improve housing stability and sustain successful tenancies

Almost 85 per cent of clients (62 out of the 73 who we received tenancy information on) have successfully maintained their tenancy since joining HASI. Housing providers partly attributed this success to the support provided by the ASP and AMHS, along with the Centrepay system, which ensures most clients' rent is paid on time.

Despite the support provided by the ASP and AMHS, a minority (15.1 percent) of clients had difficulty maintaining their tenancies. While some clients opted to move locations (30.8 per cent of the thirteen clients), others had their tenancies terminated because neighbours complained about 'noise and nuisance' (46.2 per cent). Behaviour was an issue, but some of these clients were also inappropriately housed because once they were moved from a unit to a stand-alone house complaints stopped. The majority of client tenancies have thus far proven successful and housing providers and AMHS personnel attributed this to ASP support. This support provided both a preventative and interventionist role in regard to property damage and conflict with neighbours. Very few clients (10.3 per cent) reported tensions with their neighbours and only thirteen HASI residents (18.3 per cent) had complaints made about them to their housing providers.

Further testament to the benefits stable housing afforded clients, was their sense of safety within and around their home, and future security. Just under three-quarters of clients (74.6 per cent) felt safe walking around their neighbourhood during the day and 77.8 per cent mostly or always feel safe in their homes.

The Personal Well-being Index (PWI) reaffirmed the important role housing played in client outcomes. Despite the PWI indicating clients felt less satisfied with most aspects of their lives compared to the normative population, clients felt as secure as the normative population about their future.

To improve mental health

The qualitative and quantitative data indicates stakeholders believed most clients' mental health had improved. Over 70 per cent of clients self-reported an improvement in their mental health since starting HASI. In addition, 64.9 per cent felt better about themselves and 50 per cent were also sleeping better since moving into their HASI property.[13]

Case managers within the various AMHSs corroborated client perceptions. Sixty-nine per cent of case managers thought their client(s)' mental health had improved.[14] While perceptions are important, the greatest testament to improved mental health among HASI clients is the dramatic decrease in hospitalisations.

Compared to the year prior to joining HASI, clients are having fewer and shorter admissions to hospital or health funded residential rehabilitation centres. The client research cohort spent a total of 12,486 days in hospital or residential rehabilitation centres in the year prior to joining the program, compared with 1,461 days since. Figure 1 illustrates the decrease by comparing hospitalisation trends based on the ratio of days clients spent in hospital before and after HASI.

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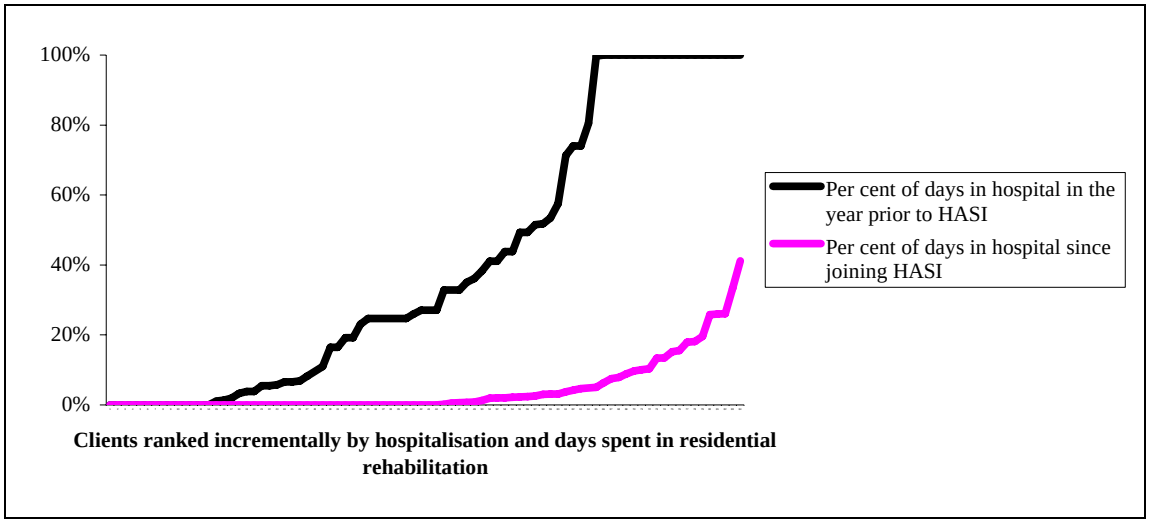
[13] See Table 6.

[14] Table 7 includes case manager perceptions on client mental health and other variables.

When the data is equalised to years, it is possible to estimate the likely number of hospitalisation/residential rehabilitation days 'saved' in the year following the commencement of HASI assistance. Projected as a full year, there are likely to be 1,377 days spent in hospitals or residential rehabilitation centres. This represents a 90 per cent fall in days for the cohort. If a day in hospital for general psychiatric treatment costs $657 (average patient day cost, NSW DOH 2005) and hospitalisation of HASI clients has decreased by 11,109 days over a twelve month period, HASI has saved almost $7.3 million on hospitalisation in one year.[15]

Figure 1: Comparing hospitalisation/ residential rehabilitation trends of HASI clients in the year before and the period since HASI assistance commenced



To increase access to the range of specialist and generalist community services for which they are eligible

With ASP support, clients were accessing various specialists and generalists in their areas. Most clients (88.9 per cent) had seen a psychiatrist since joining HASI and 92.2 per cent attended appointments with case managers or other AMHS personnel. In addition, 85.4 per cent of clients had seen a general practitioner, 42.4 per cent an allied health professional (such as a nutritionist or dietician), 22.1 per cent a psychologist or counsellor and 37.9 per cent had seen other specialists at least once. Many clients have attended multiple appointments with various health professionals.

Increased access to specialists and generalist community services may have contributed to the improvement in some clients' physical health. Appropriate treatment, coupled with an increase in knowledge, improved diet and exercise, may be responsible for the 53.4 per cent of clients who feel that their physical health has improved since starting HASI.[16]

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15 These figures are only indicative of the savings regarding hospitalisations based on ASP records. They should not be further quoted. When hospital data on HASI clients is available and received from the Centre for Mental Health, SPRC will complete a cost-effectiveness analysis. The NSW Centre for Mental Health does not endorse the use of these figures for costing.

16 This is notably because of the correlation between mental illness and poor physical health. See for example, Jones, D., Macias, C., Barreira, P., Fisher, W., Hargraves, W. & Harding C. (2004), 'Prevalence, severity and co-occurrence of chronic physical health problems of persons with serious mental illness', *Psychiatric Services*, vol. 55, no. 11, Nov 2004, pp. 1250-1257; and Lawrence, D. & Coghlan, R. (2002), 'Health inequalities and the health needs of people with mental illness', *NSW Public health Bulletin*, vol. 13, no. 7, pp. 155-158.

To facilitate stability, independence and improved quality of life

The improvement in mental health and community participation may have influenced clients' quality of life. Client perceptions about quality of life, or subjective wellbeing, were measured using the PWI. As a group, HASI clients have a PWI of 63.2, which is approximately ten points lower than the normative population (73.4-76.7).[17] This score indicates that on average clients are satisfied with their life as a whole, as a score over 50 denotes satisfaction.[18]

These perceptions could have been affected by increased living skills, which in turn assist clients to become more independent. Over half of the clients who participated in the evaluation reported an improvement in the following skills – diet (58.2 per cent), cooking (55.6 per cent), shopping (67.9 per cent), using public transportation (50.9 per cent) and budgeting (61.8 per cent). Despite the self-reported improvement, most clients remained dependent to some level on key worker support for many living skill related tasks.

Another notable outcome of HASI, which contributed to subjective wellbeing and the measurement of the PWI, was the change in a number of clients' relationships with their families. HASI eased tensions, reconnected some individuals with estranged family, and improved family dynamics for others. For many clients frequency and quality of contact with family had improved since starting HASI.[19] Four of the six clients who had no contact with their children on entry to HASI have re-established relationships with them. The qualitative data revealed that some clients with violent histories had re-established healthy relationships with children, parents and other relatives. The nature of some clients' relationships with their parents changed from complete dependence to more equitable adult interactions. For a few clients, HASI had granted them the independence and confidence to move away from unhealthy and/or abusive family relationships.

The family dynamics reveal that while changes often occurred at a micro level for clients, these changes often had macro effects. Many family members' lives had been transformed by HASI. This was especially the case for those who had shared housing with a client prior to the program. Besides feeling profound relief that their family member with a mental illness was adequately supported in an independent living situation, some parents were able to embrace working and social lives that had previously been denied to them because of their caring role.

Exits

Parallelling client successes were a few exits. At the time of fieldwork, nine individuals (9 per cent) had exited the program since its implementation. Some left voluntarily because they could not adjust to the program or living situation. Others were forced to exit, largely because of 'noise and nuisance', complaints from neighbours and an unwillingness to cooperate with ASP support. There were some contradictions around exiting policies and whether clients kept their properties and/or their furniture. Some exits were also problematic for housing providers because ASPs withdrew their support, leaving housing providers to manage tenants alone.

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17 International Wellbeing Group (2005), *Personal wellbeing index*, accessed 1 August 2005, http://www.deakin.edu.au/research/acqol/instruments/wellbeing_index.htm.

18 See Figure 4 and Table 8 for further detail on the PWI.

19 See Figure 5 for example.

Case Studies

Client 1
Prior to joining HASI, one man had spent eighteen months in hospital. His mental illness is compounded by a history of drug and alcohol abuse and his paranoia meant he rarely left his home. After 12 months of stable housing and high levels of clinical (which included a change in medication) and ASP support, his case manager believes his mental health is the best it has been in fifteen years. The client agreed, 'This is the wellest I've ever been since I first got sick'. This man has increased his participation in the community through social activities and is starting to look at employment options. He is overjoyed by the changes HASI has brought to his life:

> [In] every aspect of my life that has been trouble [the ASP] helped me. I'm living a life now. I was suicidal; I was in so much emotional pain in the past, I didn't want to live anymore. And it wasn't until now that these people have got me into a lifestyle which I enjoy. I'm living a life and I enjoy it. I never had that before.

Client 2
One client with chronic schizophrenia has spent the previous fifteen years in and out of gaol. She has never had a stable home to live in and has a history of numerous hospitalisations, alcohol problems and very poor nutrition. Her case manager was overwhelmingly positive about the changes he has witnessed since she joined HASI and he reinforced the benefits of a partnership approach:

> [She] is a different girl. The fact that we've had this woman sober for the first time in twenty years and not reaching for a drink is incredible. … I thought we were destined to fail. I really thought it would all come crumbling down, but it didn't. It's only because of the constant support. I know that if I was the sole worker looking after her there would be no way in the world she would have decompensated by now, because I don't have the resources to give that sort of intensive care.

After a long period of separation, this client has also re-established relationships with her children. They now visit regularly and sometimes stay overnight.

Client 3
After years of unstable housing, a period in gaol for assault, drug and alcohol addiction and numerous hospitalisations, one young man's life has turned around since he joined HASI:

> If it wasn't for [the ASP] I probably would have wound up back in gaol or dead by now to be honest. The way I was going with me illness and I started using intravenous drugs when I was sick. I would have wound up dead or back in gaol. They've been supportive and given me other options instead of going back to the partying and all the rest of it. They've talked to me, listened to my side and given me advice (client).

This client feels that his mental health is 'a lot better' and he feels 'more positive about meself [and] I'm positive about the future'. His relationships have also improved. This client has a history of Apprehended Violence Orders established by family and ex-partners. However, he now stays with his mother over the weekends, sees his sister once a week, has re-established a relationship with the mother of his one year old child and is an active father.

1.4 Governance objectives

The benefits of a sound partnership approach are indirectly evident in the client outcomes and were reflected by many stakeholders. Many ASP, AMHS and housing provider personnel have healthy working relationships. While trust and open communication between many stakeholders has developed over time, good working relationships continue to build in areas where tensions and challenges persist.

Open communication, good working relationships and improved outcomes for clients and partner organisations

Most ASP and AMHS personnel reported working well together.[20] Seventy-eight per cent of ASP staff perceived their relationship with AMHS personnel as good or excellent, while 84 per cent of AMHS staff felt the same way about ASP employees. These relationships were shaped to a great extent by whether AMHS staff perceived ASP staff as competent and reliable, and by the responsiveness of AMHS personnel to ASP communication and requests. In areas where the expertise of the key workers was respected, there was usually a very good relationship, but trust took time to develop. Effective partnerships between the ASP and AHMS in each area were also contingent on both a sound relationship between the ASP manager and AMHS team leader and interaction and communication between individual case managers and key workers.

The ASPs and housing providers also generally had good working relationships. Eighty-five per cent of ASP staff said they had a good relationship with the housing provider in their area; and all but one housing provider (91 per cent) was satisfied or very satisfied with their respective ASP. The housing providers were generally overwhelmingly positive about the ASPs because they played an important role in ensuring clients kept their home in a reasonable condition.

The relationship between the AMHS and the housing providers was generally good. Many of the AMHS personnel had minimal contact with the housing provider, as the ASP liaised for the client.

Relationship tensions

Despite generally positive sentiments, there were some tensions between partners. In the minority of areas where case managers were sceptical of key workers' abilities, cooperation was limited. Some case managers expressed concern with the style of support ASP workers provided. In some circumstances they felt support was 'directive', rather than 'encouraging' or 'rehabilitative'. There was also some concern about the training levels of ASP workers.

Some ASP workers were critical of the busyness of some case managers and they felt this affected both their relationship with the AMHS and the frequency of client consultations. There were also some complaints by key workers that case managers were difficult to get hold of and slow to respond to concerns.

Tension between housing providers and ASP personnel sometimes surfaced in relation to competing priorities. While the ASPs' focus is always on the HASI clients, housing providers also have a large number of other tenants to support. Some housing providers felt the ASP failed to appreciate the difficulties and complexities they face. ASP managers commented that the level of commitment to HASI was a key determinant of the how the relationship between the two stakeholders played itself out.

Each partner to participate in the referral, assessment and placement stages

Perceptions of the referral and assessment process varied by area, however, the predominant view was that it was working well. Most partners valued their contribution to the process, including those who chose to have little input.

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[20] See Tables 9 - 13.

In all areas, the referral system is fairly simple. Potential clients are referred to the ASP, sometimes by telephone. When referrals were made to the ASP, it was deemed simple and stress-free – 'It wasn't onerous or difficult', said one case manager.

The selection committees were judged to be generally fair. There was a feeling that most accepted referrals were appropriate choices. A number of case managers were impressed that the ASP in their area supported clients with very high needs. As one case manager enthused, '[The ASP] are housing some of our most difficult clients'.

Almost two-thirds of AMHS team leaders felt the referral and assessment process was good or excellent, and the remaining third rated it as average. Two case managers, however, felt the process was 'weak'. This was largely because they believed their referrals had not been seriously considered and no adequate reason provided. Some case managers also questioned the inclusion of clients who they believed were not high support.

Tensions around the referral and assessment process persist for local service managers and key workers employed by the NGO with a centralised management structure. The considerable weight senior staff members, who do not work directly with HASI clients, hold in the referral and assessment process is of some concern to local employees.

Some ASP staff questioned the appropriateness of accepting dually diagnosed clients into HASI, especially those with drug and alcohol addictions. Yet case managers often held a different position. A case manager who works with perhaps one of the most severe cases of dual diagnosis within the program argued, 'It's probably the only [program] that he [the client] can actually be out in the community'. In the previous five or six years, she reported that the client had spent many more months in hospital than he had at home. This highlights the need for ASP workers to be further trained to support clients with drug and alcohol comorbidities.

Housing providers had little input in the selection process, but this was usually by choice. Only one housing provider expressed a desire to have greater involvement in this process.

Develop mutually beneficial partnerships between housing providers, accommodation support providers and mental health service providers that lead to improved outcomes for people with mental illness

Most ASPs, AMHSs and housing providers are developing mutually beneficial partnerships, which continue to strengthen over time. Almost all ASP staff interviewed (97 per cent) felt the HASI model was effective and working well. When communication was sound between case managers and key workers, the two groups often complemented each other and reinforced support strategies.

The AMHSs were impressed with the effectiveness of the model from both a personal and client outcome perspective. Ninety per cent of case managers believe HASI is an effective program (with 63 per cent ranking the effectiveness of the program with an eight out of ten). At a personal level, HASI enabled case managers to direct their energies back to their core business of clinical support because ASPs took up the day-to-day disability support tasks. ASP reminders and provision of transport also meant clients were more likely to habitually see their case managers; thus mental health was regularly monitored. As noted above, three-quarters of case managers reported improvements in clients' mental health. Over half also saw positive changes in their clients' physical health (56 per cent), general happiness (58 per cent), optimism (62 per cent) and community participation (67 per cent).

Like the AMHSs, housing providers perceived HASI as beneficial from a business and community perspective. Some managers admitted that they had fewer problems with HASI residents than their general tenants because of the support the ASP and AMHS provide: 'The positive thing about the HASI program is that they have been diagnosed, they have these supports around them so that if [there is a problem] you can deal with it quickly' (community housing provider). A DOH manager similarly commented, 'There are ten clients that we can manage much more easily because the supports are there ... in some ways these are our easiest tenancies'. For him, HASI has enabled his organisation to 'house people with complex needs and have it work'.

This housing provider also sees HASI partnerships as advantageous from a 'vested business interest':

> Increasingly these are the clients we're going to work with in the future. Over time Housing is going to become much more targeted to people with complex needs and if we don't have these kind of partnerships in place, we're going to really struggle with that.

Barriers and challenges for housing providers, ASP and mental health clinical care

In addition to those mentioned above, HASI partners face a number of barriers and challenges. One major challenge for ASPs is human resources. In some areas, both rural and urban, recruitment and retention present problems. Closely tied to this is the experience and skills of key workers. The training of staff was a major issue that arose in the evaluation. While one ASP ensures all of its staff members receive various forms of training, another ASP, although committed to training, did not appear to have a training program in place. Key workers employed by this ASP were eager to receive ongoing training. They argued that the effectiveness of HASI was hindered by training and resource limitations. AMHS personnel also echoed this sentiment.

Some key workers and case managers also shared concerns about the social isolation of some clients supported by ASPs with no organised social activities. The potential of some clients to become dependent on key worker support is another challenge ASPs face.

The ASPs have different organisational cultures and modes of operation. Some ASPs are characterised by a centralised management system, which limits the autonomy of the local area manager. This system was sometimes a source of frustration at the local level and may present ongoing challenges.

Besides issues around exiting clients, housing providers reported difficulties providing appropriate housing when ASPs withheld relevant information about clients and their mental illness. Some housing providers were also concerned that HASI was drawing accommodation resources away from the general community. This was particularly problematic in areas where housing providers contributed further subsidies to ensure clients were housed in suitable areas and homes.

Some HASI success factors

- Effective partnerships in local areas;
- Sound communication between partners at both managerial and direct support levels;
- ASP and AMHS personnel having a well developed understanding of the HASI model and the roles and responsibilities of various stakeholders;
- Local stakeholders having a primary role in the referral and assessment process;
- Stable case managers;
- Ongoing training for key workers;
- ASP personnel actively working within a rehabilitative, rather than a supervisory, framework;
- Key workers and clients having a strong rapport, which is often established through social interaction;
- ASPs organising social activities, which enhance confidence and social skills and help to facilitate community participation;
- The provision of relevant client information to housing providers to assist in locating the most appropriate housing;
- Client choice and active involvement in the selection of accommodation;
- Active involvement of family or carers

Further learnings

- Culturally and linguistically diverse individuals are underrepresented as a proportion of the population in HASI Stage One.
- Client throughput limited accommodation choice for some new HASI clients where housing providers strongly encouraged them to accept the accommodation of the exited client.
- Mismatched housing (such as inappropriate size or proximity and demographics of neighbours) affected housing stability in some cases.
- Clients and ASP personnel sometimes had unmet expectations about the accommodation housing providers could offer.
- To secure suitable accommodation located within accessible reach of services and resources, housing providers (particularly one in a rural area) sometimes contributed extra rent.
- Furnishing costs were not always sufficient to cover adequate cooling and heating; this was problematic in areas of extreme temperatures.
- Levels of key worker training seem to affect not only client support, but also relationships between partners. There is a need for ongoing training on various topics, including working with clients with dual diagnoses (such as coexisting mental health, substance use, physical health and cognitive issues).
- Client satisfaction with HASI and their personal outcomes may be affected by rigid ASP visiting/support times, especially on weekends.
- ASPs should be wary of client dependence.
- There was some distress among housing providers about exited HASI clients remaining in their accommodation without ASP or AMHS support.
- Clients who were familiar with the area, had access to suitable resources and services and were supported by local family networks were faring particularly well. These were challenges for some clients in rural areas who were required to move to other country towns to be a part of the program.
- While very positive about the HASI model, some families felt insecure about the longevity of the program.

1.5 Conclusion

This is the first phase of a longitudinal evaluation of HASI Stage One. Further changes will be closely monitored over the next twelve months. The preliminary findings from this report suggest HASI is achieving most of its aims and working towards others. HASI clients are those with high levels of psychiatric disability and high support needs. Many have histories of long-term hospitalisations, tenancy instability, minimal community participation and limited social networks. In the vast majority of cases HASI has succeeded in providing high levels of support and appropriate housing.

Although it is difficult to directly attribute client outcomes to HASI, clients, case managers, key workers and family members reported changes in relation to clients' mental and physical health, life skills, independence, relationships and community participation. The majority of clients have sustained successful tenancies and hospitalisation rates have decreased dramatically. Over time, AMHSs, ASPs and housing providers have demonstrated the benefits of a partnership approach and services are increasingly co-ordinated. If partners address barriers and challenges currently persisting, HASI will continue to improve outcomes for people with mental illness and high levels of psychiatric disability.

Appendix

Figure 2: Mental illness diagnosis of HASI clients (n=89)

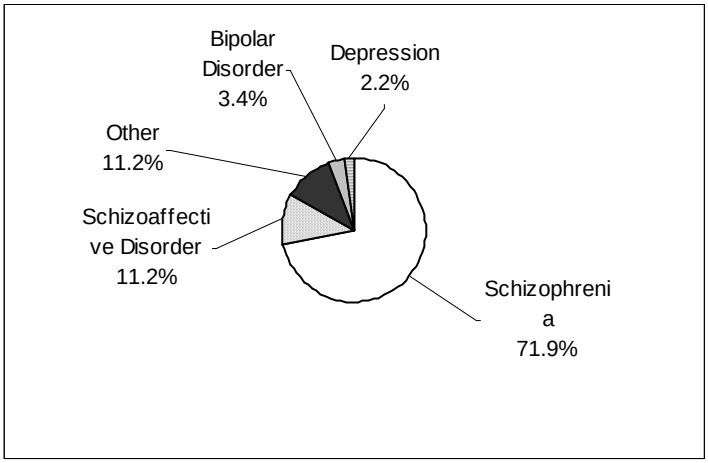


Figure 3: Client support needs on entry to HASI (n=90)

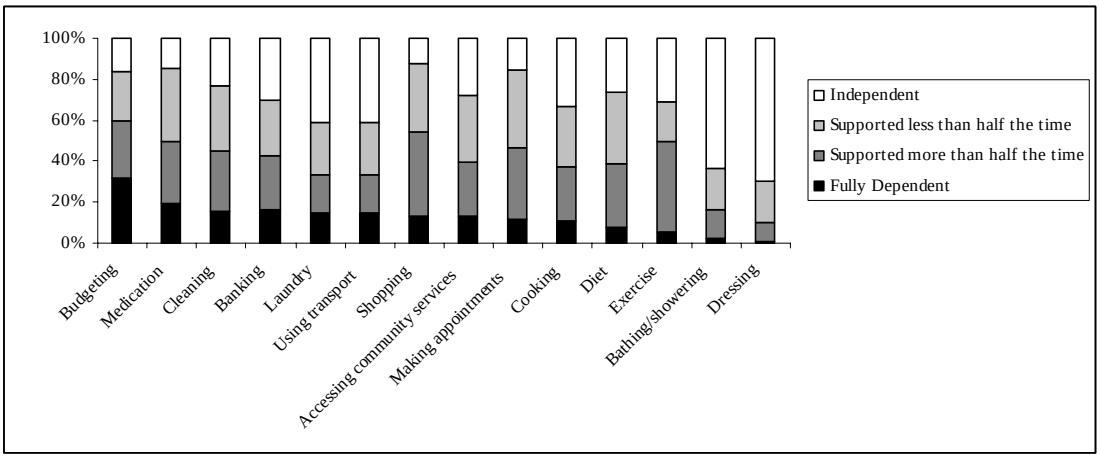


Table 1: Client accommodation immediately prior to HASI (per cent, n=90)

Accommodation situation	**Per cent**
Hospital	34.4
Public housing	21.1
Family / parents' home	19
Private rental	10
Temporary accommodation	4.4
Other	4.4
Boarding house	2.2
Refuge or crisis accommodation	2.2
Car, tent, street, park or squat	1.1
Total	100

Table 2: Client satisfaction with ASPs by number

Level of satisfaction	Neami (n=23)	New Horizons (n=6)	Richmond Fellowship of NSW (n=30)	Overall (n=59)
Very dissatisfied	1	0	1	2
Dissatisfied	0	0	0	0
Neither satisfied or dissatisfied	1	0	0	1
Satisfied	7	2	18	27
Very satisfied	14	4	10	28
Don't know/unsure	0	0	1	1

Table 3: Client satisfaction with AMHSs (per cent)

Level of satisfaction	Support from case manager (n=56)	Support and treatment from AMHS (n=57)	Ease of access to doctors, psychiatrists and mental health workers (n=54)
Very satisfied	25.9	26.8	20.4
Satisfied	43.1	41.1	25.9
Neither satisfied or dissatisfied	8.6	10.7	11.1
Dissatisfied	12.1	12.5	14.8
Very dissatisfied	0	0	5.6
Don't know / unsure	10.3	9.0	22.2

Table 4: Per cent of client satisfaction with accommodation (n=58)

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Don't Know
General condition	48.3	44.8	1.7	5.2	0	0
Cleanliness	50.0	41.4	5.2	3.4	0	0
Space available	57.9	24.6	5.3	12.3	0	0
Furniture provided	54.4	36.8	3.5	3.5	1.8	0
Temperature control	13.6	54.2	8.5	11.9	1.7	10.2
Overall satisfaction	34.5	58.6	1.7	1.7	1.7	1.7

Table 5: Client use of neighbourhood resources

Community resource ‡	Frequency of use (per cent)					Per cent accessing resources with support*
	More than once a week	About once a week	Less than once a week	Never	Don't know	
Shopping facilities	20	49.2	29.2	1.5	0	71.2
Eating facilities	9.5	28.6	38.1	20.6	3.2	58.5
Libraries	1.6	8.2	27.9	60.7	1.6	14.3
Parks	11.7	10	28.3	48.3	1.7	44.0
Cinema	0.0	1.7	48.3	48.3	1.7	58.3
Churches	6.8	15.3	13.6	62.7	1.7	29.4
Leisure facilities	27.9	14.8	19.7	36.1	1.6	48.3
Social groups or day programs	19.7	19.7	24.6	34.4	1.6	54.5
Medical or health services	4.9	11.5	77	6.6	0	62.2
Educational services	14.5	5.5	1.8	78.2	0.0	25

*These are percentages of those clients using the community resource.

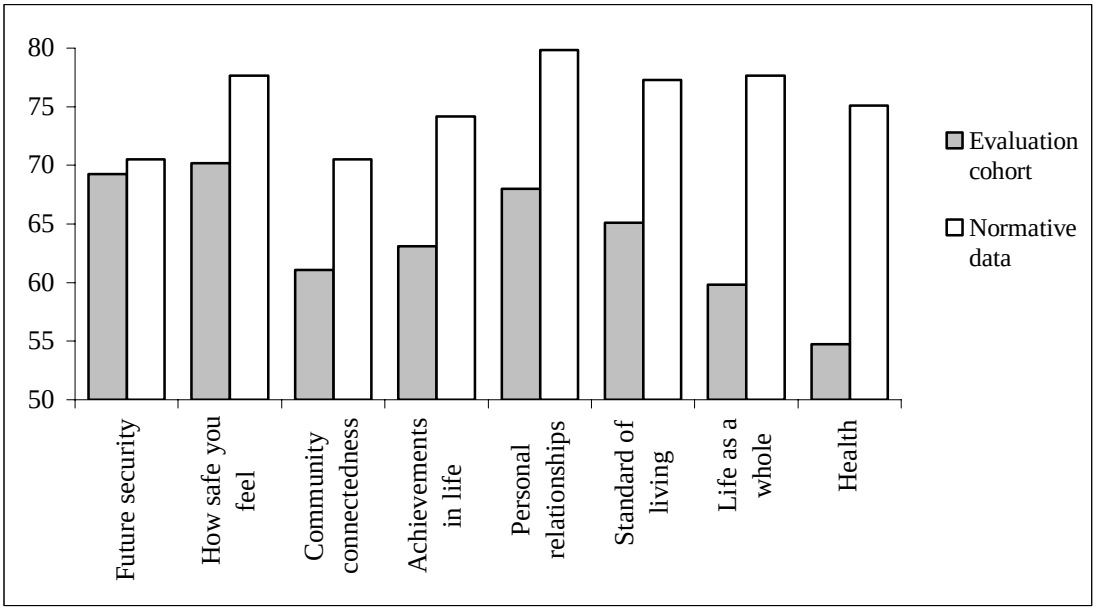
Table 6: Client perceptions of the impact of HASI on their health (per cent, n=57)

Degree of impact	Mental health	Feelings about self	Sleeping	Physical health
Much better	41.4	28.1	25.9	17.2
A bit better	29.3	36.8	24.1	36.2
The same	17.2	21.1	42.6	31
A bit worse	3.4	3.5	0	5.2
Much worse	3.4	1.8	0	5.2
Don’t know / unsure	5.2	8.8	7.4	5.2

Table 7: Case manager perceptions of the impact of HASI on clients (per cent)

	Declined	Stayed the same	Improved a bit	Improved a lot	Very uneven	Don’t know / unsure
Physical health (n=28)	10.7	28.6	28.6	25	0	7.1
Mental health (n=29)	3.4	24.1	34.5	34.5	0	3.4
Relationship with family (n=29)	0	41.4	27.6	17.2	6.9	6.9
Other relationships (n=30)	10	26.7	33.3	13.3	10	6.7
General happiness (n=29)	6.9	10.3	31.0	27.6	10.3	13.8
Optimism about the future (n=29)	3.4	20.7	34.5	27.6	3.4	10.3
Level of community participation (n=29)	10.3	10.3	41.4	24.1	6.9	6.9
Ability to sustain a tenancy (n=30)	3.3	10.0	20.0	53.3	3.3	10.0

Figure 4: Comparison of client PWI scores with normative data*



*The data for the evaluation cohort has not been weighted for age because there are minimal variations in the normative data for age group.

Table 8: Variations in strength of satisfaction in life domains by location

Domain	Mean satisfaction for clients living in Metropolitan area (n=32)	Regional or rural area (n=29)	Difference
How safe you feel	75.00	65.86	-9.14
Future security	73.08	65.86	-7.22
Life as a whole	62.69	57.24	-5.45
Standard of living	66.15	64.14	-2.01
Health	55.77	53.79	-1.98
Achievements in life	60.00	65.86	+5.86
Personal relationships	63.85	71.72	+7.87
Community connectedness	56.15	65.52	+9.37

Figure 5: Frequency of contact with parents pre- and post-HASI (n=90)

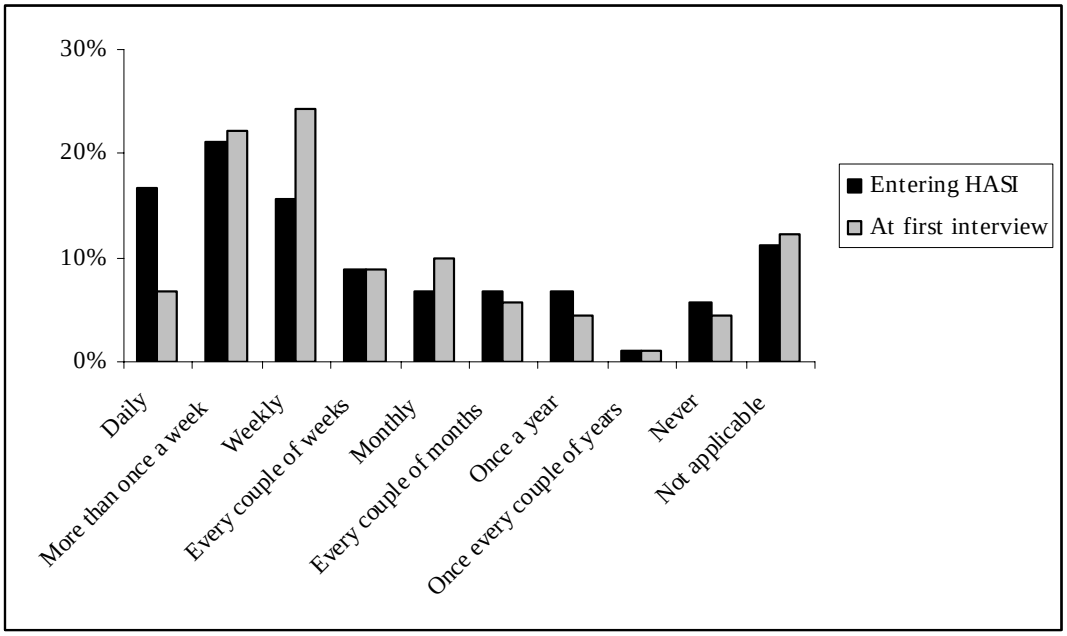


Table 9: ASP manager and key worker descriptions of their relationship with the AMHS (n=56)

	ASP Managers (per cent, n=10)	Key Workers (per cent, n=46)
Excellent	50.0	17.4
Good	40.0	58.7
Average	10.0	21.7
Weak	0.0	2.2

Table 10: AMHS manager and case manager relationships with the ASP (per cent)

	Managers (n=9)	Case managers (n=30)
Excellent	44.4	36.7
Good	33.3	46.7
Average	0.0	10.0
Weak	22.2	0.0
Very poor	0.0	3.3
Unsure	0.0	3.3

Table 11: ASP manager and key worker descriptions of their relationship with the housing provider (per cent)

	ASP managers (n=10)	Key workers (n=46)
Excellent	30.0	17.4
Good	70.0	63.0
Average	0.0	15.2
Weak	0.0	2.2
Unsure	0.0	2.2

Table 12: Housing providers' satisfaction with level of communication with Accommodation Support Provider (n=12)

	Number
Very satisfied	5
Satisfied	6
Very dissatisfied	1

Table 13: AMHS perceptions of the relationship with Housing Providers

	Case managers (per cent)	AMHS leaders & managers (per cent)
Excellent	11.1	10.0
Good	55.6	26.7
Average	22.2	16.7
Very poor	11.1	6.7
Unsure	0.0	40.0