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

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Executive Summary

The Housing and Accommodation Support Initiative (HASI) aims to provide people with mental illness in New South Wales (NSW) with access to stable housing, accommodation support, and clinical mental health services. HASI is designed to assist people with mental health disorders to participate in the community, to experience improved quality of life, prevent homelessness and, most importantly, to support their recovery from mental illness. Approximately 1167 consumers are currently participating in the program

The Social Policy Research Centre (SPRC) was contracted in 2009 to undertake a mixed method evaluation of the initiative. The evaluation aims to understand the effectiveness of the whole of the HASI program by investigating the support for consumers, benefits and limitations of the service model, and the cost effectiveness of the program. This first report of the evaluation draws on program data and 112 interviews with stakeholders and consumers from three sites in NSW to understand the profile of current clients, the types of services provided by HASI and the framework for service delivery. The report focuses on the processes of HASI and the services provided to clients by ASPs, which are based on the principles of rehabilitation, client centred support and flexibility. While a brief outline of client reported outcomes is included, quantitative client outcomes drawn from administrative data collected from NSW Health and Housing NSW, the HASI Minimum Data Set (MDS), and the MDS Supplement will be included in the next report.

Key findings

Preliminary findings suggest that HASI is successfully attracting its target group. The profile of clients suggests that, with the exception of people from Culturally and Linguistically Diverse backgrounds, there are no substantial gaps in the demographic makeup of HASI clients. Women and people from an Indigenous background are better represented among HASI clients than they were in the evaluation of Stage One, all clients have at least one diagnosed mental illness, and many also have a secondary mental illness or other co-morbidity. Although this preliminary analysis suggests that HASI is attracting the intended target group, more research is needed on the extent to which HASI is attracting people who have insecure tenancy.

Stakeholders reported that the target group is identified and selected through clear referral pathways, which have improved over time due to the growing awareness of, and support for, the program in most Area Mental Health Services (AMHS). In areas where there are multiple Accommodation Support Providers (ASP), however, there was some confusion around referral pathways into the program. Local selection committees have been effective in selecting clients that fit the program's target group. These committees work well because there are common procedures which guide the process but also flexibility to adapt to the local service context. ASPs also work well
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of recovery based practice, and that it can be difficult to strike a balance between providing client centred support and assisting clients to develop the confidence to become more independent from ASP staff.

The HASI model is founded on partnerships between and within NSW Health, Housing NSW and ASPs. Overall, partnerships between and within these groups are generally effective. The AMHS and ASPs have built particularly sound working relationships, and the relationships between the ASPs and housing providers are generally appropriate. Four factors remain important to facilitating effective working relationships: having clear roles and responsibilities, maintaining open communication, having a commitment to work together, and having sound local governance processes.

At a State level, the governance structure appears to be working well. Two issues have been identified that require further investigation: the way ASP funding has been rolled out and the resulting structural rigidity of the program and issues related to how accommodation is accessed under the program. The flexibility of support provided means that when a client's support hours decrease, ASPs reduce the number of hours spent with the client. This has resulted in outstanding support hours and a funding surplus, which was used by evaluation sites to address local needs. Given that the provision of flexible services is crucial to promote an individual's recovery process,

1 Introduction

The Housing and Accommodation Support Initiative (HASI) aims to provide people with mental illness in New South Wales (NSW) with access to stable housing, accommodation support, and clinical mental health services. Initially funded to provide service to 100 people in 2002, the HASI program has since expanded to support over 1000 mental health consumers across NSW. The Social Policy Research Centre (SPRC) was contracted in 2009 to undertake a mixed method evaluation of the initiative. The evaluation aims to understand how well the whole of the HASI program is working by investigating the effectiveness of support for consumers, benefits and limitations of the service model, and the cost effectiveness of the program.

This is the first report of the 2009-2011 whole of the HASI program evaluation. This report presents preliminary analysis about how the program is meeting its objectives in relation to the effectiveness of the service model and partnerships. While it includes a preliminary discussion of how the program is achieving outcomes for clients, this is not a major focus of this report and will be included in future reports. The report provides a demographic and service use profile of current HASI clients. It also draws on 112 interviews with stakeholders and consumers from three sites in NSW to examine emerging issues in relation to the effectiveness of the service model and key partnerships, and the program's governance structure.

1.1 Aims of HASI

HASI is designed to assist people with mental illness to participate in the community, to experience improved quality of life, prevent homelessness and, most importantly, the program assists in the recovery from mental illness. It aims to achieve this by linking people with mental illness to clinical mental health services, secure housing and accommodation support.

The specific aims of the program are to:

- provide people with mental illness ongoing clinical mental health services and rehabilitation within a recovery framework;
- assist people with mental illness to participate in community life and to improve their quality of life;
- assist people with mental illness to access and maintain stable and secure housing; and
- establish, maintain and strengthen housing and support partnerships in the community.

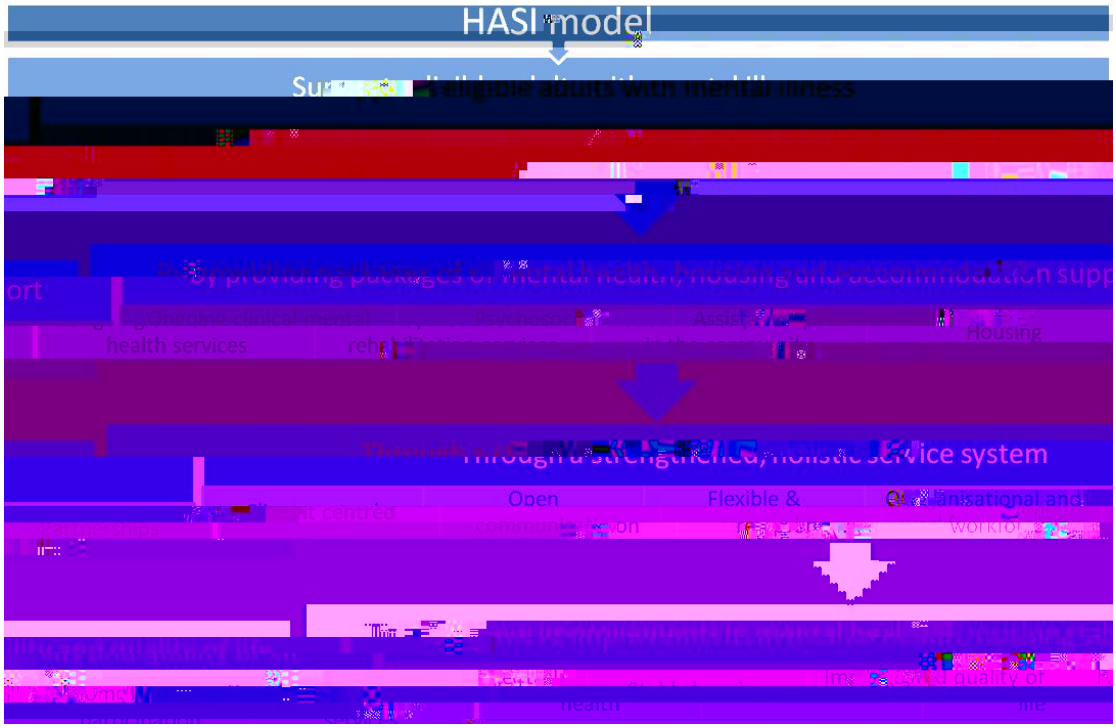
The program is available to adults with a diagnosed mental illness who require support services (and, in most cases, housing) to live independently in the community. Since the implementation of Stage One in 2002, which funded high level support services, HASI has expanded to provide low to very high levels of support to people with mental illness across NSW. Although the core objectives of HASI have remained the same since the program's inception, the service delivery system has evolved and

different groups of mental health consumers have been targeted. All stages of HASI provide some level of accommodation support services, and most (with the exception of 4B or HASI in the Home) provide services to people who are eligible for, or who are currently living in social housing.

1.2 Service delivery framework

HASI is a partnership model between NSW Health, Housing NSW, and non-

Figure 1.1: HASI Logic Model



1.4 Conclusion

This report provides a preliminary analysis of the profile of clients who are currently accessing HASI, and some early findings from the qualitative data regarding the changes experienced by clients of the program. The report also flags emerging issues around the supports provided to clients, partnerships, and governance.

2 Methodology

This is the first report of the 2009-2011 evaluation of the HASI program. The evaluation draws on a longitudinal, mixed methods approach to meet the three key aims of the evaluation, which are to:

- Review the effectiveness and efficiency of the program as a whole in meeting its aims and objectives for clients around the areas of tenancy, service access, mental and physical health, social connections, community participation, and quality of life;
- Assess the effectiveness and efficiency of the HASI stages individually and collectively including the operational effectiveness of service delivery and partnership models, as well as the costs and benefits of the model.
- Contribute to ongoing improvements in the support provided to HASI clients and to partnership arrangements.

As described in the previous section, a logic model theoretical approach is used to provide the basis for understanding how the inputs, activities and outputs of the program impact on the outcomes experienced by clients. In addition, a process evaluation which focuses on how services operate to provide support to clients and foster partnerships between the Housing NSW, NSW Health and ASP service providers in each area as well as at the state level, is being conducted.

This report draws on demographic and service use data from the HASI Minimum Data Set (MDS) and 112 interviews with clients and other stakeholders in three sites across the state. This section provides the details of these methods and also discusses how this report fits in with the broader evaluation. More detail about the evaluation framework and the methods used to address the evaluation questions can be found in the evaluation plan (McDermott et al., 2009). This research received ethics approval from the UNSW Human Research Ethics Committee and the NSW Population and Health Services Research Ethics Committee in 2009.

2.1 Program data

The ASPs complete quarterly reports on each client's service use as part of the monitoring requirements of the program. During the first quarter that a client enters the program, an initial applicant form is completed which includes questions about their gender, age, mental health status and tenancy history. Each quarter thereafter, ASP staff complete a report on each client detailing the services received in areas such as housing and health.[1]

The HASI program monitoring data was first collected in July 2006, and the first two monitoring periods (July-September and October-December, 2006) were pilot

[1] This information is completed by NGOs and is compiled by InforMH, which is a unit within NSW Health responsible for data management. The HASI MDS was previously managed by ARTD consultants.

periods. There are significant gaps in the data for these pilot periods so reliable data cover the period from 1 January 2007 to 30 June 2009.

The MDS was analysed in this report to understand the demographic characteristics and service profile of current clients. The analysis draws on a snapshot of current clients (n=895) in the April to June 2009 reporting period for whom demographic and service use data was available and for whom this data could be linked.[2] It is important to note that Section 3 includes additional data on a larger cohort of clients who exited the program between January 2007 and June 2009.

2.2 Qualitative data

Qualitative interviews with clients and stakeholders were conducted in three locations in NSW in October 2009 to understand the strengths and weakness of the program, the perspectives of clients on the support model, and the impact it has had on clients. Table 2.1 outlines the number of people interviewed in each stakeholder group. It shows that more ASPs were interviewed in this first round of data collection than was originally intended (see McDermott et al., 2009). This is due in part to the instrumental role that ASP staff members play in the program as well as the variety of ASPs in the program. In addition, few family members or carers were interviewed in 2009 because many clients did not have regular contact with family members and some could not be contacted in this round. In the next round of data collection, which will take place in September 2010, researchers will focus on increasing the numbers of family and carers, housing and mental health professionals, and other stakeholders in the sample (e.g. those from relevant peak bodies and advocacy groups).

Table 2.1: Interviews by Stakeholder Group

Stakeholder group	n	Per cent
Mental health professionals	11	10
Housing (public and community)	10	9
Accommodation support providers	29	26
Other stakeholders	2	2
Family or carers	1	1
Client interviews	59	53
Total	112	100

Interviews took place in a metropolitan, regional and rural location in NSW. These locations were chosen to maximise learning outcomes around the way the model operates in areas with a different mix of accommodation support providers, public and community housing providers, and local governance structures. Table 2.2 outlines the spread of interviewees across the three sites and at the state level. It shows that

with the opportunity to compare the differences between how HASI operates in a rural, regional and metropolitan area.

Table 2.2: Interviews by Area

Stakeholder group	n	Per cent
Client interviews by area		
Metropolitan	24	41
Regional	20	34
Rural	15	25
Total client interviews	59	100
All interviews by area		
Metropolitan	39	35
Regional	30	27
Rural	26	23
NSW	17	15
Total interviews	112	100

In addition to clients and stakeholders involved at the local service level, interviews were conducted with state level stakeholders (Table 2.3). This included representatives from NSW Health and Housing NSW as well as personnel who hold upper level management positions in NGOs and advocacy groups.

Table 2.3: Interviews by Local and State Level

Stakeholder group	n	Per cent
Local level		
Clients	59	-
Other interviews	36	-
Total local level interviews	95	85
State level		
Total state level interviews	17	15
Total interviews	112	100

Characteristics of client interview sample

An important element of this evaluation are interviews with HASI clients, which assist the evaluation to understand clients' experiences and perceptions of HASI and any changes experienced in their lives while involved in the program. A total of 59 clients were interviewed and this sample is closely representative of HASI clients more broadly. The average age of the interview sample was 39 years, and 8 per cent (n=5) identified as Aboriginal or Torres Strait Islander. Most clients who were

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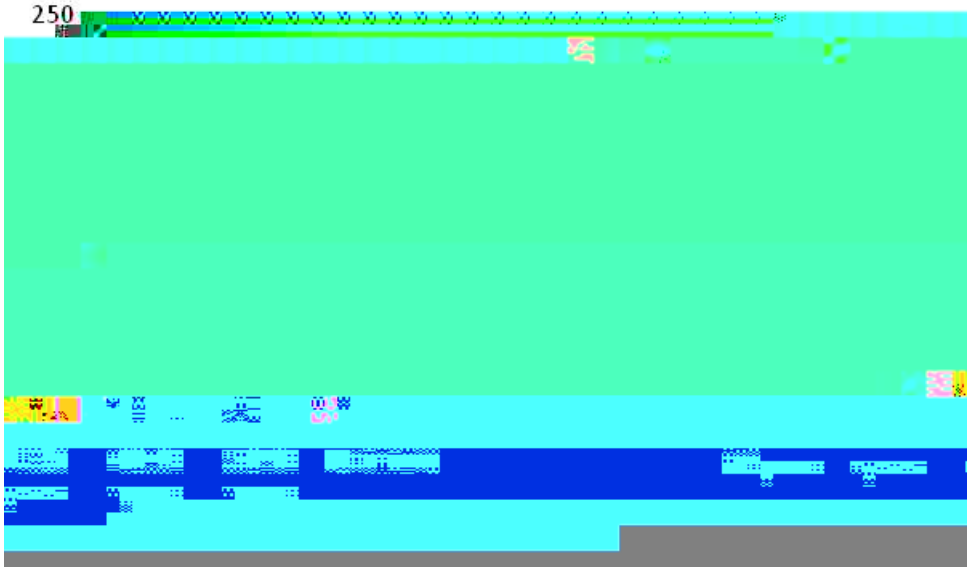
3 Client Profile

To be eligible for HASI, a person must be 16+ years of age, have a diagnosed mental illness, require support services (and in most cases housing), and have the ability and desire to live in the community. While there is no upper age limit, individuals are considered to be eligible until frailty is determined to inhibit ongoing involvement in the program. Eligibility for the program varies slightly between lower and higher support level packages depending on clients' level of functioning and whether housing is required. Furthermore, the higher level support packages prioritise people who are in hospital, homeless or at risk of homelessness, and who find it difficult to maintain their tenancy without support (NSW Health, 2006: 17). This section describes the effectiveness of referral processes and the extent to which the program has accessed its intended target group by examining the demographic profile of current clients.

3.1 Client profile

An important element of the referral and selection process is whether the HASI program is accepting clients who match its target group. This section assesses that question by examining the demographic profile of current clients upon entry into the program, which is drawn from the HASI MDS on 895 clients.[3]

Figure 3.1: Current Clients by Age Group



Around 9 per cent of current clients in the program identify as Aboriginal or Torres Strait Islander, which demonstrates that

Table 3.3: Clients by Language Spoken at Home

	n	Per cent
Language other than English at home	57	8
English spoken at home	672	92
Total	729	100

Note: Data missing for 166 clients

Mental health diagnosis and other co-existing factors

Consistent with the aim of HASI, all clients were reported to have

In combination with a diagnosed mental health illness, more than half (54%; n=460) of current clients reported having a co-existing condition such as a physical or cognitive disability and/or a dependence on alcohol or drugs. Table 3.6 shows that the most prevalent co-morbidity was substance abuse (28%, n=238) followed by physical health problems (12%), intellectual disabilities (10%), physical disability (5%), and acquired brain injury (3%).

Table 3.6: Client Co-existing Conditions

Type of co-existing factor	n	Per cent*
Substance abuse	238	28
Physical health	104	12
Intellectual disabilities	85	10
Other	53	6
Physical disability	45	5
Acquired brain injury	24	3
Total conditions	549**	-
Total clients with at least one co-existing factor	460	54

Table 3.7: Clients by Type of Accommodation at Entry

	N	Per cent
Public housing	348	41
Hospital	137	16
Living with family or friends	91	11
Community housing	75	9
Private rental	58	7
Homeless	20	2
Boarding house	18	2
Other	92	11
Total	839	100

Note: Data missing for 56 clients

There are a variety of reasons why people with a mental illness may find it difficult to maintain their tenancy and may experience loss of tenancy. Some of the associated risk factors related to tenancy breakdown were identified when clients' entered the program. Preliminary results show that one in four (25%, n=223) current clients accepted into the program had an identified tenancy risk factor. Nearly half of clients receiving very high support had at least one identified tenancy risk factor (48%). Tenancy risk factors, however, were less of an issue for clients receiving other levels of support packages: 24 per cent of low support; 29 per cent of medium support; and 23 per cent of low support. Given that one of the primary aims of HASI is to support people to maintain or access secure housing, it is surprising that these figures were not higher, and indeed site/client interviews have identified that only half of clients interviewed had access to housing prior to HASI (see section 6) The lower than

Table 3.11: Average Months in HASI for Current (n=887) and Exited Clients (n=224)

Support level	Current clients	Exited clients
Low	11.6	8.7
Medium	5.4	3.5
High	13.1	8.9
Very high	13.4	15.3
Total	11.6	9.0

Note: Data missing for 8 current clients and 307 exited clients

Clients left the program for a variety of reasons (Table 3.12). Forty five per cent (n=222) had a planned exit from the program, meaning that the client, AMHS and the ASPs agreed that the client no longer needed support, required a higher frequency of support, or needed another type of support. Planned exits, in which clients had achieved their rehabilitation goals and no longer needed support from ASPs, were considered by stakeholders to be successful exits:

> What we try and do is 'planned exits' if possible, where we recognise that a consumer is actually doing really well, and they don't particularly want us out of their lives, they just don't want us in their lives. So the way we kind of deal with that is go, "Okay, well let's try and go a week without seeing you, see how that goes. You know, give us a call if you need to but otherwise good luck, let's see how you work it."

Table 3.12: Reasons for Exiting HASI by Level of Support

Reason for exiting HASI	n	Per cent
Client no longer needed support	181	37
Client decided to discontinue support	103	21
Failure to meet tenancy obligation	36	7
Move to higher support accommodation	22	4
Move to other long term housing	19	4
Other	132	27
Total	493*	100

*Note: Data missing for 38 clients

Close to 30 per cent of the exits from HASI were unplanned, meaning that clients decided to discontinue the support (including those who refused contact with ASPs) (21%;n=103), or did not meet their tenancy obligations (7%;n=36). There were a range of other reasons that clients left the program (27%; n=132) which included admissions to hospital or psychiatric units; moving from the service area; connecting with a more appropriate service; and, in

suggests that HASI is attracting the intended target group, more research is needed on tenancy to investigate whether the data is accurately capturing risk of tenancy and to further understand the tenancy risk experienced by clients.

Referral pathways

HASI is accessing its target group through the development of strong referral pathways. Potential HASI clients are initially referred to ASPs; referrals most commonly come from mental health clinicians – including Community Mental Health Service teams (60%) and hospital staff (18%) – rather than from social housing or other organisations (Table 3.13). This ensures that people with mental illness are targeted in the referral process. Clinicians suggested that their decision to refer a person to HASI is influenced by a range of factors including the person's current level of functioning, potential to benefit from the program, capacity to live independently, as well as considerations of the service context such as whether vacancies are available in the local area.

Table 3.13: Referrals to the HASI Program

	n	Per cent
Community Mental Health Service	512	60
Hospital	149	18
Public Housing Client Service Team	46	5
Community Housing Provider	21	2
Other HASI provider	14	2
Other	107	13
Total	849*	100

*Note: Data missing for 46 clients

The referral rates for each organisation vary depending on the level of support clients are currently receiving (Table 3.14). It is unsurprising that referrals to high and very high levels of support come primarily from Community Mental Health and hospital services, as these packages intend to serve people with the highest support needs and the most housing vulnerability. Conversely, the rates of referral from housing organisations for low and

some ASPs. Other ASPs, however, were clearly more inclusive of clients with more complex needs.

Additionally, some ASPs indicated that they often set their own conditions as part of client's acceptance into the program, as demonstrated in the following quote:

> I make contact with the person or referrer and say they're accepted based on these conditions – basically it can be conditions like they go on a three month probation cause we're worried they're not going to work out – not gonna want to work with us.

Some of the conditions of acceptance, such as that described in the quote above, raise a concern around who can be effectively supported. While most stakeholders perceived the aim of service provision to support an individual's recovery process, the way in which this is interpreted can potentially impact on selection processes, particularly if clients with less complex needs were prioritised over others. These tensions are discussed more fully in Section 5.

3.3 Conclusion

HASI appears to be attracting its intended target group and, with the exception of CALD clients, has distributed services reasonably equitably across different groups within the target population. More information is needed about the assessed tenancy risk experienced by clients accepted into HASI, as well as the complexity of HASI clients to determine whether some people are excluded from the program due to some ASPs increasing focus on prioritising people who are perceived to have a greater capacity to develop independent living skills.

The target group is identified and selected through appropriate referral pathways and

- More than half (54%) of current clients had a co-existing condition. The most prevalent condition identified among current clients was substance misuse (28%) followed by physical health problems (12%) and intellectual disability (10%).

- Preliminary analysis of data on clients' associated tenancy risk factors when they entered the program appears to be underreported. One quarter of HASI clients experienced at least one tenancy risk upon entry into the program, which is considerably low given that one of the primary aims of HASI is to support people who have insecure tenancies.

- Further follow up is needed to understand the tenancy risk experienced by clients accepted into HASI, the extent to which HASI targets or excludes people who have complex needs and to understand the capacity of HASI in each area and whether there are waiting lists for the program.

- Most referrals to HASI (78%) came from AMHS and hospitals. The next phase of the evaluation will seek to understand why most referrals come from health organisations and the implications of this for the future of the program.

- Stakeholders reported that referral pathways have improved over time, due to the growing awareness of and support for the program in most AMHS.

- In areas where there are multiple ASPs, there was a perception that this created confusion around referral pathways due to multiplicity of providers and availability of different support levels. As a result, ASPs continue to receive some inappropriate referrals.

- Most stakeholders reported that the process of selecting people to participate in the program generally worked well because there are common procedures which guide the process but also flexibility to adapt to the local context. Further, ASPs are working well together to coordinate the selection process and overcome issues concerning duplication in assessment procedures across ASPs.

- There was, however, some emerging evidence of variation in selection processes according to how ASPs understand the nature of the recovery process and the role of services to promote their recovery.

Table 4.1 shows that most clients in the program (62%, n=716) were receiving low and medium accommodation support services, which provide less frequent and

Table 4.3: Proportion of Clients Who Set Goals in Each Area by Support Level (%)

Identified goal area	Low	Medium	High	Very High	Total
Social/community participation	80	88	82	81	81
Community tasks	70	86	77	87	74
Self-care	66	86	77	88	72
Domestic skills	63	77	76	87	69
Use of health services	63	73	62	76	64
Work, education and/or training	44	40	49	24	44
Other	32	26	28	30	30

The goal most frequently set by HASI clients relates to participating in social and community activities (81%), followed by engaging in community tasks such as going to appointments, doing shopping and using public transportation (74%), and carrying out activities of self care (including learning strategies to manage the symptoms of mental illness, such as exercise classes).

Table 4.3 also highlights that clients set different goals depending on the level of support that is received. A higher proportion of clients receiving very high support, for example, set goals across most areas, with the exception of work, education and training, which only a small proportion of clients set as a goal. The extent to which these goals vary according to support level will be explored in more detail later in the evaluation.

Once clients identify their goals, ASP staff support clients to meet their goals. Clients seemed fairly satisfied with the way ASPs worked with them to achieve their goals. For example, one client explained:

> When I first came – we wrote down goals – one was getting physically well and I've avoided that – we have done a little bit of swimming and weight watchers but nothing much else. I've resisted doing that and she has respected that. She just brought it up out of the blue the other day and I thought 'yeah it's time'. (F, 55, low support)

Clients interviewed for the evaluation emphasised that while they valued the practical support they received from ASP staff with activities such as shopping, cleaning, transport, getting to appointments, and budgeting, what they also valued highly was the human and social contact with ASP staff.

> I value the visits each day… I really value the contact because I'm so isolated. (M, 49, very high support)

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Table 4.4: Proportion of Clients who Party or Fully Attained their Goals by Support Level (%)

Identified goal area	Low	Medium	High	Very High	Total
Social/community participation	95	90	95	95	95
Use of health services	94	90	92	92	93
Self-care	92	81	94	91	92
Community tasks	91	88	90	91	90
Domestic skills	87	88	93	87	89
Work, education and/or training	83	73	82	69	82

An emerging finding from the evaluation is that some ASP staff believe that the program should provide time limited support because, if clients remain in the program over a long period of time and require ongoing disability or maintenance support, they were blocking other people from entering the program. It was perceived to be preferable to accept people who have a greater capacity to become fully independent rather than someone who may require ongoing support.

Preliminary results suggest that some ASPs have altered their expectations of the program and perceive the primary aim of HASI is to support clients to achieve defined outcomes in a set time period. This has implications for the groups of high need clients which may lead to their deprioritisation in the selection process, however, further information about the selection process is needed to confirm this early finding. If this were the case, the initial objective of HASI (to fill a specific gap in the service system) would be partly compromised or changed.

According to stakeholders, HASI continues to successfully provide rehabilitation services to consumers. Yet some ASP staff were interpreting the aim of recovery based services to support clients to develop the capacity to live independently within a limited timeframe. This may influence the types of consumers who are accepted into the program, and may disadvantage people

> lot of referring out to other agencies. There's a lot of resistance from the consumer but we're still [working] quite diligently [referring the client to other services] to break that dependency.

Most of the clients interviewed as part of the evaluation were exceedingly positive about the quality of service they received from ASPs; they particularly appreciated the client centred support, inclusion in decision-making and respect. ASPs were aware, however, that one of the downsides of providing client centred support is that clients have the potential to become overly dependent on ASP staff, which may detract from their individual process of recovery, and some ASPs had implemented a number of strategies to address this concern. It is also important to acknowledge that in an intensive program like HASI, client dependency will be an ongoing concern and, for some clients, it will be an important part of building trust and undertaking the recovery process. Reliance on a support service is not in itself a negative

the support, the potential downside of flexible support for clients was that some perceived that some staff were not always available or reliable.

> Like when they're busy and they need to do something or like they give you a time, they should be on [time]. When they come, sometimes they're late. (M, 26, high support)

Several clients felt they would like more time

internal processes as important contributors to carrying out HASI support appropriately and effectively.

Staff skills and workforce development

ASP staff who work with clients on a daily basis are central to the HASI model, because their daily interactions with clients are rehabilitation focused. To apply the theory of rehabilitation to daily practice, ASP staff require the skills to develop rapport with clients, respect client decisions, support them to learn new skills, and to access the community without being too directive. Staff also require a good understanding and awareness of different types of mental illnesses and co-morbidities. ASPs strive to recruit highly skilled staff and, as a result, many clients spoke highly of the staff:

> I like all the staff. They are well chosen whoever does the choosing. They are caring professionals – they are good at what they do. (M, 49, very high support)

A few clients suggested that ASP staff could benefit from additional training in mental health so that they develop a greater understanding of other issues clients may face in addition to their mental illness (e.g. abuse, trauma, drug and alcohol issues). One site assisted staff to become aware of client needs by including consumers in staff training.

Some areas had trouble recruiting staff who have the knowledge to work with people with mental illness and who understand how to provide recovery focused support. Several ASP managers, for example, stated that people with a background in disability services have strong skills in maintenance support, but require upskilling to implement the principles of rehabilitation in their practice with HASI clients. ASPs recognised the importance of contributing to staff development, and did so by offering training opportunities (e.g. risk management and Occupational Health and Safety) and providing opportunities for staff to perform management roles.

ASP staff reported that, while their work is rewarding, it can also be challenging and isolating. Most staff work individually with clients and sometimes are required to spend a substantial amount of time travelling to see clients each day. They sometimes found it difficult to support and empower clients to make decisions, set goals and take action to achieve them, particularly because client needs can change can change from day to day. In the words of two frontline workers:

> Unless people [clients] are well the rehabilitation is very hard to do. That's the struggle for myself – you have got to set people with the whole thing.

> You can't take anything for granted in this line of work. Just because someone has been going really well doesn't mean you won't open the door and things crash. Particularly the end of the

Some ASPs utilised a defined team approach to supporting clients; this enabled continuity of care and the opportunity for different staff to contribute new ideas and solve problems, while also reducing the potential for reliance on one staff member. Yet a related challenge for support workers who work as part of a team is that workers may have different styles of working with clients which create inconsistencies in the support:

> I guess the biggest challenge is we all have different ideas on how to work with someone, we all have different approaches, but we try and do it the best we can to create the minimalist disruption I guess to the service users

Strong supervision structures and support from manageme

> If you got a complex client – clinical services won't pass on all the history with the fear that agencies will knock the client back, but not providing the facts is creating a problem for us because we don't know how to react to situations. We are better off knowing all the facts and talking about how to address these issues because the reality is we've probably heard it all before.

While most ASPs have developed risk management strategies, these need to be reviewed and updated on a regular basis in order to remain relevant to the organisation. Otherwise there is a danger that ASPs are compromising the safety of their workforce.

Partnerships

The final key element of HASI services is the relationships between HASI partners. This is discussed in more detail in the next section (Section 6).

4.3 Conclusion

HASI services aim to support each individual's recovery process, and the program aims to achieve this through the provision of stable housing, access to clinical services, and accommodation support services. This section focused on the services provided to 1167 clients, which are based on the principles of rehabilitation, client centred support, flexibility, and improving workforce and organisational capacity. Stakeholders and clients provided overwhelmingly positive feedback about the support provided by ASP staff. Nevertheless, the preliminary data also suggests that ASPs have different interpretations of recovery based practice. There remains tension around providing client centred support and ensuring that clients do not become overly reliant on this support.

4.4 Summary

- HASI aims to support clients in their recovery process through the provision of stable housing, access to clinical services, and accommodation support services.
- This section focused on support services provided to clients by ASPs; access to housing and clinical services will be

5 Partnerships and Governance

HASI services are provided through a partnership model at the local level that involves NSW Health, Housing NSW and NGOs: NSW Health is responsible for delivering clinical services through AMHS as well as funding accommodation support services which are delivered by ASPs, while Housing NSW supplies accommodation, provides tenancy management services and funds community housing. As described in the previous section, ASPs provide daily rehabilitation support to clients. This section of the report draws on the qualitative fieldwork with stakeholders to describe the relationships between partners, the extent to which they are working together, and factors that facilitate and/or hi

While open communication between HASI partners is important, not all partners require detailed information about each client's situation. For example, Housing providers need to understand how HASI operates and what this means for their clients, but these providers do not require detailed information about client goals or their mental illness. One ASP stated that the information they share with housing providers includes:

> Of course we provide risk information, we don't want anyone getting hurt, we want to make sure [Housing knows], if there's going to be noise and nuisance issues. It's not about sharing that information – it's about the fact we don't believe the housing provider needs to know the ins and outs of every aspect of someone's life to be able to provide them with an appropriate house.

Some housing providers at the local level felt that HASI remains clinically oriented and that HASI forums focus on recovery and mental health services to the exclusion of discussing housing related issues. Some stakeholders suggested it would be useful to bring housing providers together to discuss these issues and to network with each other.

Commitment to working together and to the program

Effective partnerships require a significant investment of time and, therefore, necessitate an organisational and individual commitment to working together. Good working relationships were premised on a commitment from the partners to maintain and develop productive working relationships. ASPs reported that they had built up strong relationships with key partners over time, but that there were ongoing challenges with maintaining these relationships due to staff turnover.

Part of this commitment includes recognising and respecting the recovery oriented philosophy of the program and respecting differences in organisational values and approach. In some cases, where differences in organisational values and philosophies were discussed, productive dialogue occurred around how to maintain

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helped to decrease duplication in selection processes and increase joint training initiatives and information flow.

5.2 Local governance processes

The local governance arrangements revolve around the Local Coordination and Selection Groups, which involve AMHS, housing providers and ASPs, which were perceived to be valuable in developing and facilitating effective relationships between local partners. In particular, the local coordination group was reported to be necessary to facilitate effective operation of selection committees. Effective local governance structures were facilitated by: the commitment of the people involved, formal and informal communication channels, and regular meetings. These arrangements were particularly strong in areas that had created a partnership coordinator position that was resourced by the AMHS.

Local governance processes were hampered in some areas by the tension between the idea of an equal 'partnership' between the AMHS and ASP when the AHS funds the ASP. The equity of the funder-provider relationships between the AMHS and ASPs was one of the governance lessons that emerged from the evaluation of HASI Stage One (Muir et al., 2007a: 29) and it persists. While this emerged as less of an issue for stakeholders than in the first evaluation of HASI, stakeholders continued to express concern about the potential conflict in the current funding model which pressures ASPs to accept referrals from AMHS over other agencies. For example, one interviewee felt that:

> ...the NGOs are funded by the Department so they have to work within parameters of that Department, so you have to take referrals from Health because you are dependent on them for your future funding. That can often – not intentionally or directly – but it can override things like assessments based on need. I think it's got to be based on need, not just on unblocking hospital beds and getting rid of people who are too difficult out of the hospital system.

Another interviewee also expressed this concern and believed that this governance arrangement was affecting the partnership between the ASP and AMHS more broadly:

> We have a funding and service agreement with the Area Health Service which then means that they believe that they are our boss. That's not conducive to having a good partnership because if they think they can tell us what to do then that's not a partnership.

This was perceived to be an issue for ASPs in their relationship with AMHS at the regional and state level, whereas at the local co-ordination level the perceived tension between clinicians and support workers seemed less apparent. The emerging issue is less about ASPs being 'managed' by AMHS and more that the current governance structure creates confusion among the partners about to whom, and in what ways, ASPs are accountable.

5.3 State governance processes

HASI has a three tiered governance structure at the state level. At the top tier, the Housing and Mental Health

> We've got an allocation of 25 packages, and we're supporting 38 to 42 consumers at the moment. [The extra clients] are supported in an outreach capacity because we are not providing all those hours to the people in existing packages because of their recovery journeys.

There are also potential drawbacks to this practice: the ASP may end up supporting too many clients so that the original client is underserviced, or clients with more urgent needs end up receiving support at the expense of clients who have higher levels of functioning even though they may have several goals they would like to achieve with ongoing support.

A second strategy employed to address the issue of unused support hours was to set up HASI packages that were short term and targeted at people who were being discharged after being an inpatient in hospital. The new program was approved by NSW Health, and is explained in the following quote:

> We ended with a surplus in HASI high support and we allocated the hours to clients without accommodation support. We were limited by the contract – had to spend money within 18 months time, so we offered temporary packages first for people moving out of group homes or hospital into housing. We weren't able to use the surplus doing this so we set up a completely new hospital to community transition service. It provides intensive six week service for people leaving inpatient [hospital] to return to their own homes but will be a different target group to HASI clients because they shouldn't need it [the support] after six weeks.

Given that the provision of flexible services is crucial to promote recovery, one of the key challenges facing HASI in future is how to establish a flexible funding model that also builds in accountability for ASPs. Some interviewees thought that block grant funding would be more effective than the current model of package based funding. Another idea proposed was that people could be allocated places in the program and then allowed to move between levels of support as needed on a case by case basis. This would solve the difficulties around moving clients to higher or lower packages, but would make accountability more difficult.

Accommodation

Further investigation is required into the accommodation component of HASI. In the implementation of Stage One, Housing NSW provided accommodation for HASI packages through public and community housing providers. Since additional HASI packages were established, accommodation was attached to most of the packages and some packages are designed to rely on other housing sources. A range of issues related to this requires further investigation, including the way in which accommodation is allocated through the program and ongoing access and type of accommodation for new clients.

5.5 Conclusion

The HASI model is founded on partnerships between and within health, housing and accommodation support services. Overall, partnerships between and within these groups are generally effective. The AMHS and ASPs have built particularly sound

- Effective local governance structures are facilitated by: the commitment of people involved; strong formal and informal communication channels; the use of the regular meetings to discuss a range of i

6 Preliminary Client Outcomes

The aim of HASI is to assist clients to achieve secure tenancies, improve their mental and physical health, improve social and community connections and enhance their quality of life. While the main analysis regarding whether the program has achieved its objectives in improving client outcomes will be undertaken in the next phase of the evaluation, this section presents some preliminary analysis of client outcomes based on qualitative interviews with clients (n=59). These findings will be clarified in relation to analysis of other client outcomes data collected as part of the evaluation (for example, secondary data collected by Housing NSW and NSW Health).

6.1 Tenancies

One of the principle aims of the HASI program is to support people with a mental illness to access and maintain secure tenancies. As described in Section 3, approximately half of the client group had access to housing when they joined the program. For this group of clients, the aim of the program is to support them to maintain their tenancy. Interviews with clients uncovered that even if clients reported living in stable housing immediately prior to entering HASI, most had experienced a long history of housing instability. For example, the following client was referred to HASI from hospital, but had experienced periods of homelessness:

> No, I was homeless and I went into hospital and the staff at the hospital helped me get – my father put in the application for Housing NSW. And that's how I got my apartment. I was sort of homeless because they sold the place I was in. (M, 30, high support)

Other clients were living in temporary accommodation such as caravan parks before they were accepted into the program. Therefore, the demographic details within the MDS may underreport the propor

6.2 Mental and physical health

One of the main aims of the program is to improve clients' mental and physical health. The qualitative data gathered in this round of the evaluation indicates that people have experienced improvements in their mental health since becoming HASI clients. Most clients attributed part of this change to the fact that ASPs were in regular contact with them which helped them to manage their illness and to stay out of hospital:

> I like that they are very orientated in keeping me out of hospital. Usually I spend four months a year in hospital. This year I have spent two months...I won't go to hospital this Christmas and that will be due partly to me, partly my doctor and partly the [NGO] as well. (F, 55, low support)

> They been saying I've been doing good. I haven't been in hospital for about four years now. (M, 32, low support)

> Since I've been in HASI? No, I haven't been in a hospital for nearly two years. (M, 26, high support)

The positive changes experienced by clients were echoed in their responses to the Personal Wellbeing Index (PWI), which showed that participants were more satisfied with their mental health than people who participated in the evaluation of Stage One (67.7 % compared with 58.2% in Stage One; Muir et al., 2007b). Further analysis of PW315her ana]TJ.dg.05TD.(o).9edhemeafoieafo

Several clients indicated that they had gained weight – which was commonly attributed to the medication they were taking – and had identified weight loss as a goal:

> It took me three months to put weight on - here are the meds and they're going to make you fat. 'Fat and well or skinny and sick'. I didn't realise when I was seven and a half stone that they [clinical staff] meant this fat. (F, 49, low support)

> I got a bit of weight on, I'm not real happy with my weight. (M, 46, high support)

Clients did not report any improvements in these health conditions since entering the program, but many did talk about the contact they have with GPs and other allied health services, meaning that clients were receiving treatment for their ailments.

Clients who needed and asked for it had access to drug and alcohol services, and several clients who were interviewed said that being in the program had assisted them to overcome AOD issues.

> [The] biggest change in my life is that I've quit smoking marijuana – I feel a heap better for doing that. Support has helped me get off that. Between [HASI NGO] and [Day centre]. Yeah it was those two that got me off marijuana been off it nearly two years now. (M, 28, low support)

Clients reported improvements in their mental health but less satisfied with their physical health, which is consistent with findings with the evaluation of HASI Stage One (see Muir et al., 2007b). The findings presented here are only preliminary and suggestive of broader trends. Further analysis will be undertaken in the next stage of the evaluation on mental health and physical health outcomes. Further analysis will be conducted during the next phase of the evaluation into clients' rates of hospitalisation, before, during and if possible for some clients after they left the program.

6.3

HASI, although some clients continued to experience difficult relationships with family.

> But now I've started a course in TAFE at home. Yeah it's good. It's a real basic get started – attainment certificate. When you finish you post 'em in and they send you out more. I've got one at the moment about work environment. (M, 41, low support)

Even though clients overall reported feeling positive about living independently in the community, some clients expressed concern that they still felt marginalised and stigmatised in the community because of their mental illness. Other clients had limited family support or no contact with family members and some said they didn't have any friends. While clients reported developing supportive relationships with ASP staff and other consumers, few clients participated in mainstream services or

Since being in the program, many clients said they felt that their life had improved. They reported feeling more confident, happier, a sense of hope for the future or less depressed or anxious. Further analysis is needed regarding PWI scores and length of time clients have been in the program.

6.5 Conclusion

Clients interviewed for the evaluation overwhelmingly reported that their lives had improved since they began receiving HASI services. Most clients had a history of insecure housing and, while this improved while they were in HASI, some newer clients remained on waiting lists for accommodation due to shortages in their local area. Clients spoke of substantial improvements in their mental health since becoming HASI clients and, while clients were less satisfied with their physical health than their mental health, all were receiving treatment from General Practitioners (GPs) and other health services. Some clients also spoke of experiencing improved social relationships and increased involvement in community activities, education and employment, although many clients continued to feel isolated and lonely at times.

6.6 Summary

- Interviews with clients found that most had experienced a history of housing instability throughout their lives, although this history was not adequately captured in the MDS dataset.

- While the preliminary results suggest clients continue to gain access to housing

7 Conclusion

HASI is an established program that provides accommodation support, access to clinical mental health services and social

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