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HOUSING AND ACCOMMODATION SUPPORT INITIATIVE EVALUATION

REPORT III

SPRC Report 2/07

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Abbreviations

ABS	Australian Bureau of Statistics
AHS	Area Health Service
AMHS	Area Mental Health Service(s)
AIHW	Australian Institute of Health and Welfare
ASP	Accommodation Support Provider(s)
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CID	

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

Tenancies

- Half of the HASI clients accommodated by housing providers live in a unit or an apartment. The proportion living in townhouses, villas, duplexes and houses has

- 83 per cent of clients were participating in at least three of nine community activities measured at Phase 3 (shopping, eating out, library, church, social groups, educational institutions, organised sport, leisure activities or exercise).
- 43 per cent of clients involved in HASI at Phase 1, 2 and 3 were working and/or studying at the time of the last interview, compared to 9 per cent on entry to HASI.

1 Introduction

This is the third of four reports providing findings from a longitudinal evaluation of HASI Stage One. HASI is a partnership between NSW Health, DoH and NGOs, which is jointly funded by NSW Health and DoH. The program aims 'to assist people with mental health problems and disorders requiring accommodation (disability)[1] support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness' (NSW Health and NSW DoH 2005).

HASI is based on psychosocial rehabilitation principles and has a recovery focus. The program provides permanent housing and long-term support for over 100 people with complex mental health problems and high levels of psychiatric disabilities. It covers nine locations that fall within the following NSW Area Health Services: Greater Western, Hunter/New England, Northern Sydney/Central Coast, South Eastern Sydney/Illawarra, Sydney South West and Sydney West. HASI Stage One is currently supplemented by HASI Stage Two (low support) and Three (high support). This evaluation covers only HASI Stage One.[2]

The Social Policy Research Centre's (SPRC) commissioned evaluation of HASI Stage One examines the implementation, process and effects of HASI over a two-year period.[3]

1 As defined in the 2002 NSW Health Frameworkfor Fd9r6 H -1(i)-2(-hd /P -3(o)-10(r)-1( )(h)-6(i)-6()2(e))-10a

1.1 Overview and Methodology

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

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

1.2 Evaluation Progress

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

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

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

[5] Only thirteen family members participated quantitatively in Phase 3 of the evaluation. These responses therefore cannot be used as a representation of family per

2 Program Structure

2.1 Partner Roles and Responsibilities

Role of AMHS

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

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

Liaising with ASP personnel is a part of the case managers' roles.[6] By working together, crises are often prevented because key workers report unusual behaviour,

Frequency of AMHS contact with HASI clients differs depending on individual need, from daily support to very infrequent irregular appointments when required. The majority of clients see their case managers once a week, fortnight or month. Throughout the evaluation clients had a total of 1045 contacts with AMHS personnel (Section

Summary

x

Role of housing providers

Summary

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

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

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

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

2.2 Support Plans

Summary

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

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

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

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

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

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

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

	Satisfied with key worker(s) (n=47)	Satisfied with case manager(s) (n=48)	Satisfied with housing provider (n=46) 95.28 Tm (91.44 re f*
Phase 1	87	67	72

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

2.4 Referral and Assessment

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

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

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

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

Table 2.3: Client Demographics throughout the Evaluation

	Phase 1 (n=90)

Figure 2.1: Client Cultural Background (n=87)

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

complaints made against them and were less likely to lose their tenancies. As

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

Rent

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

Relationships with neighbours

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

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

Throughout the program, 31 HASI tenants had complaints registered against them. Greater transparency around tenancy problems between housing providers and ASP personnel may furG4(m)-2(a)w the siiew.

4 Health

4.1 Mental Health

Client, case manager, ASP perceived change

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

Key workers believed that 59 per cent of clients had improved mental health since the last interview (n=59). Case managers (n=40) reported mental health improvement in 45 per cent of cases.[14]

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

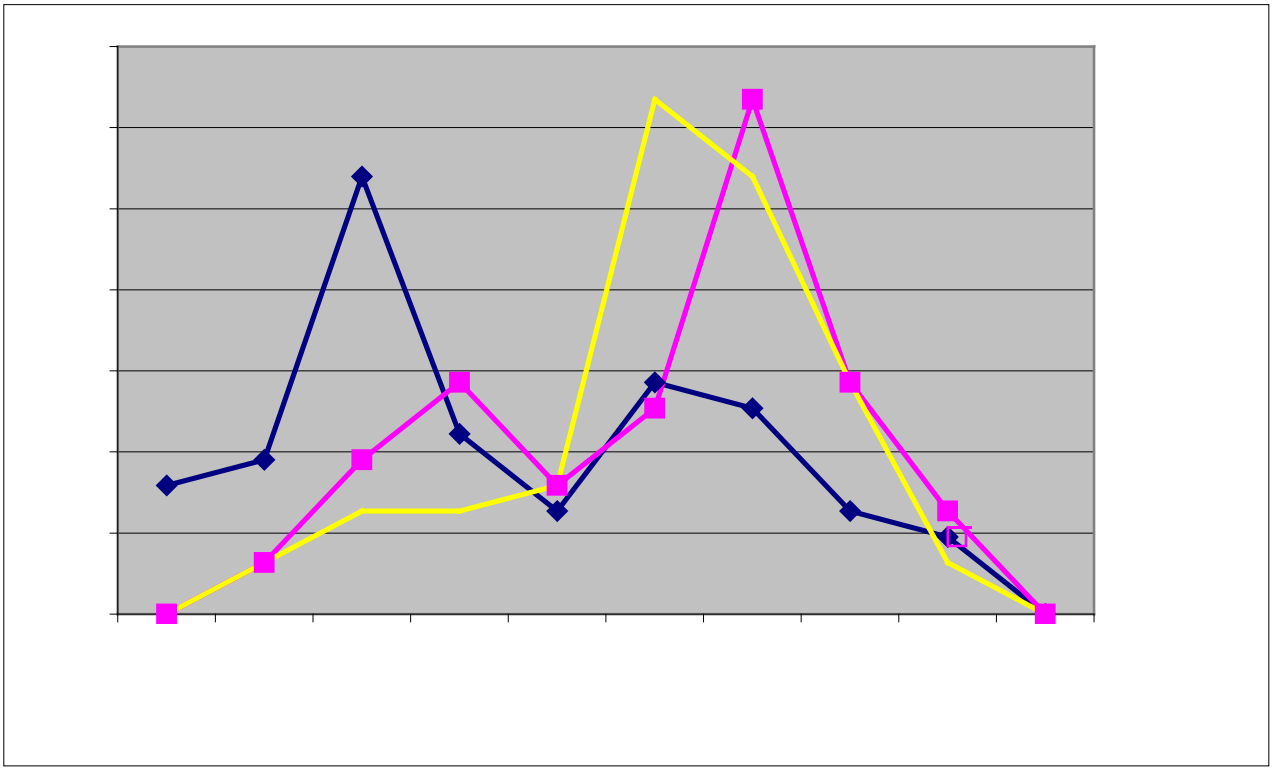
very good mental health (100) and relates to the level of independence and efficacy in psychological, social and occupational functioning. It is a useful clinical tool to measure change across a group (Söderberg, Tungström et al. 2005).

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

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

	Phase 1	Phase 2	Phase 3
Average score	41	56	58
Median	35	61	60

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



4.3 Service Use

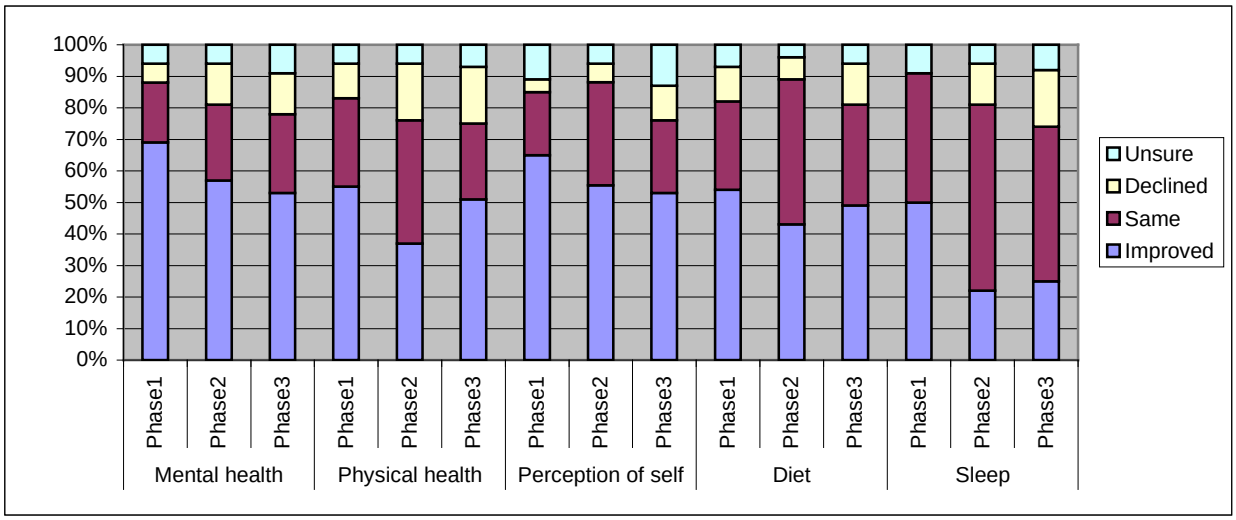
Client health service use remained high between Phase 2 and 3 of the evaluation (Table 4.4). The majority of clients consulted with health professionals in regard to

Table 4.5

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

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

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



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

Table 4.7: Client Perception of Change in Mental Health between Entering HASI and Phase 3 (n=55) 7

Score	Per cent	Cumulative per cent
6	4	4
5	7	11
4		

5 Living Skills

5.1 Changes in Living Skills

Summary

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

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

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

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

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

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

Living skill (n=69)	Independent when entered HASI (per cent)	Independent at Phase 2 (per cent)	Independent at Phase 3 (per cent)	Shift in proportion independent between entering HASI and Phase 3 (percentage points)
Banking	30	52	59	29
Medication	16	39	42	26
Diet	25	50		

5.2 Facilitating Independence or Developing Dependency?

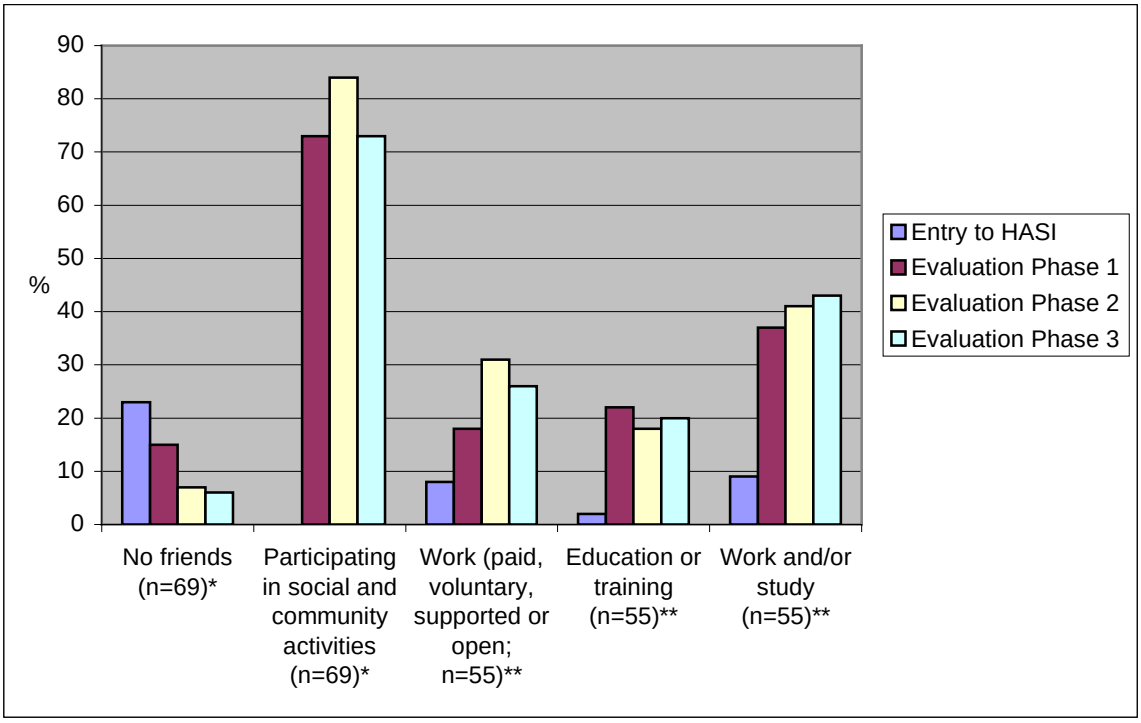
6 Social Inclusion

6.1 Community Connections, Relationships and Support Networks

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

HASI participants started the program with limited social networks and almost all were not participating in work and education and many were excluded from social

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



6.2 Social and Community Activities

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

Summary

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

Many visited or were visited by their friends in the week prior to being interviewed.[18] ASP-organised activities had resulted

A minority of clients interviewed in Phase 3 were struggling to make or maintain friendships. One in four respondents were dissatisfied or very dissatisfied with their friendships either because they did not have any friends or were unhappy with current friendships (

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

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

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

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

	Phase 3	
	Most people can be trusted	You can't be too

7 Exits

Between evaluation Phase 2 and 3, eight people left HASI. A woman was

Table 7.1: HASI Stage One Exits

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

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

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

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

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

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

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

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

Table 8.5: Factors Hindering and Facilitating Stakeholder Relationships

Facilitating factors	Hindering factors
Governance issues (non-HASI related)	
x Effective, constructive and supportive team leadership within the AMHS and ASPs.	x Leadership capacities questioned internally and externally
x Stakeholders historically working together and/or working together on more than on project.	x No previous contact between stakeholders
x Previous AMHS experience working in partnership with the NGO sector.	x No previous AMHS experience working with the NGO sector
Governance issues (HASI related)	
x Shared understanding about and commitment to HASI as a model and program by management and ground staff.	x Micro impact of the program because of the small number included in the program. Limitations placed on program referrals because of small numbers.
x Clarity regarding the roles and responsibilities of each stakeholder (including an understanding of how partners spend their time) and a perception that roles complement each other: 'People know what their role is.	

Facilitating factors	Hindering factors
x Consumer advocates proactively involved in HASI at a local level.	x A lack of involvement of consumer advocates (at local committee levels and in daily operations) potentially jeopardises client interest and outcomes. Some case managers currently act in an advocacy role, but if this does not also include good communication between all parties, then it has the potential to fuel divisions between the AMHS and ASP.
Practical and pragmatic factors	
x Frequent, regular, open and constructive communication through formal and informal meetings: 'The thing that works for us is the relationship with the services. Things go wrong, but there is no blame. There is extreme goodwill to communicate' (AMHS manager).	x Regular and effective communication lines not established at the beginning of the working relationship: 'Initially the communication wasn't set up very well and we've got to a point where when difficulties have arisen we don't know how to manage them together' (AMHS manager).

Facilitating factors	Hindering factors
x AMHS personnel are accessible, supportive and encouraging of ASP personnel (for example, willing to be contacted and some willingness to assist in key worker skill development; this is especially important in rural areas where training is difficult to access). ASP personnel are cognisant of AMHS resource limitations.	x Case managers not returning ASP phone calls. ASP personnel having unrealistic expectations around case managers' capacity. Client caseloads can be such that case managers are often already overburdened and therefore there can be limited opportunity for them to work with fellow stakeholders.

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

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

8.2 Organisational Issues

Staff

All but one ASP manager reported staff recruitment and retention as causing some difficulty. Four reported having moderate difficulty with recruitment and selection and two substantial difficulties. All three rural sites reported moderate difficulty.

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

ASPs also have OH&S policies and protocols and officers are often appointed to take responsibility for identifying risks and raising OH&S matters regularly at team

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