



**Housing and Accommodation
Support Initiative and
Community Living Supports**

Evaluation of NSW Community-based Mental Health Programs: HASI and CLS (overview)

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Acknowledgements

The Ministry of Health pays our respects to the Cammeraygal people of the Eora Nation, the traditional owners of the lands on which the NSW Mental Health Branch is located. We acknowledge the ongoing connection that Aboriginal people have to this land and recognise Aboriginal people as the original custodians of this land. We pay our respects to the Elders, past, present and emerging throughout NSW and are thankful for their continued contributions and guidance in the Supported Living Programs.

Summary

What are the HASI and CLS Programs?

The Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) are community-based programs that support people with severe mental illness to live and participate in the community, the way that they want to. The programs offer psychosocial support, tenancy support in partnership with clinical mental health services. Many consumers are also supported to access secure housing.

HASI/CLS are statewide programs funded by the NSW Ministry of Health (Ministry) and delivered locally through partnerships between local health district (LHD) mental health services and specialist mental health Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

The programs are underpinned by rigorous independent evaluation

The Ministry commissioned the Social Policy Research Centre (SPRC) to evaluate the HASI/CLS programs. The evaluation involved two rounds of qualitative interviews and focus groups, as well as the analysis of quantitative program data and statewide outcomes data about consumers. It ran from November 2017 to January 2020, with final analysis completed in 2021.

HASI/CLS supported 5,533 consumers in the study period from 2015 to 2019. Most consumers were in the programs for only part of this period. The average time in HASI and CLS during this period was 10.7 months. Overall, the evaluation shows that HASI/CLS is generally working well, achieving its goals and is cost effective.

At a broad summary level:

- Consumers liked the programs, and most experienced positive outcomes – overall the programs improved wellbeing, helped people better manage their mental health, enhanced aspects of consumers' physical health and increased opportunities for social inclusion.
- Consumer contact with community mental health services decreased by 10% in the first year in HASI/CLS and was 63.7% less if they remained in the programs for more than one year.
- Hospital admissions due to mental health decreased by 74% following program entry, and the average length of stay decreased by 74.8% over two years. This improvement was sustained after consumers exited the programs.
- Consumers with a new charge in the criminal justice system and with community corrections orders dropped to almost zero in the year after program entry.
- The programs are generating more in cost offsets than the cost of the programs, with a net cost saving per person of about \$86,000 over 5 years. Over 90% of the cost offsets were for reduced inpatient hospital admissions and lower lengths of stay.
- As the NDIS became established during the evaluation period, more consumers gained access to the NDIS before, during or to support exit from CLS or HASI.

The factors identified as most important for the success of HASI/CLS were:

- strong local partnerships between CMOs and LHDs
- a person-centred, responsive approach to service provision
- focus on early intervention when consumers became unwell
- an increasing focus from CMOs on consumer choice.

The main areas where HASI/CLS was not operating as successfully were:

- local and state level partnerships beyond the CMO and LHD
- diversity of referrals into the programs
- responsiveness to the needs of some priority groups
- remaining questions on implementation of the hours of support structure.

Good practice was evident throughout the evaluation, enabled by a range of facilitators

Program partners should consider how these facilitators could be used to continue to improve the programs further, including:

Facilitators of effective implementation of HASI/CLS

1. Dedicate time towards fostering and widening **program partnerships** at the local and state levels
2. Review the functions of HASI/CLS **governance structures** and monitor their implementation
3. Clarify **referral** processes into HASI/CLS and address barriers
4. Fill gaps in **staff capacity** by using the specialised expertise of Aboriginal and culturally diverse staff and of staff with lived experience of mental health issues
5. Review how staff apply personal **recovery approaches** to maximise consumer choice and autonomy
6. Clarify with CMOs any remaining questions about how the **hours of support** structure was intended to work on a day-to-day basis
7. Align **support services** with individual consumer preferences
8. Increase the focus on HASI/CLS **priority groups**, by connecting with relevant local community groups and local providers, and with relevant state agencies
9. Involve a consumer's **family and carers**, consistent with consumer preferences, wherever possible and support their ongoing involvement
10. Support relationships between local HASI/CLS agencies and **NDIS** providers and improve knowledge about each other's services
11. Discuss the goal to **exit** HASI/CLS with all consumers at or near entry
12. Continually review the content, usefulness and accuracy of **program data** collected by CMOs

Facilitators of positive outcomes for HASI/CLS consumers

13. Clarify respective roles of program partners in improving consumers' **mental health and wellbeing**
14. Find ways to enable consumers to make sustained changes to benefit their **physical health**
15. Improve **social inclusion** of consumers by addressing each consumer's individual preferences and barriers
16. Further reduce consumer **hospital stays** by maintaining contact with consumers while they are in hospital
17. Build on staff knowledge and local partnerships to support consumers accessing **safe and secure housing** when needed.

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