



Never Stand Still

Faculty of Arts and Social Sciences

# **Evaluation of the Housing and Accommodation Support Initiative (HASI)**

## **Final Report**

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Bullen and Karen R. Fisher**

**For NSW Health and Housing NSW**

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## Abbreviations and glossary

APQ-6	Activity and Participation Questionnaire
ASP	Accommodation Support Provider
CALD	Culturally and linguistically diverse
CTTT	Consumer Trader and Tenancy Tribunal
DEC	Departmental Executive Committee
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
HoNOS	Health of the Nation Outcome Scale
IHS	Integrated Housing System
ISP	Individual Service Plan
JGOS	Joint Guarantee of Service (now replaced by the Housing and Mental Health Agreement, 2011)
K10	Kessler Psychological Distress Scale
LHD	Local Health District
LSP16	Life Skills Profile
MDS	Minimum Data Set
MRN	Medical Record Number
MH-AMB	Mental Health Ambulatory Data Collection
MHDAO	Mental Health and Drug and Alcohol Office
MH-OAT	Mental Health Outcomes and Assessment Tools
MHS	Mental Health Service
NGO	Non-government organisation
NOCC	National Outcomes and Casemix Collection
NSW	New South Wales
OT	Occupational therapy
PHaMs	Personal Helpers and Mentors Program
PWI	Personal Wellbeing Index
RAFT	Recovery and Assertive Follow-up Team
RRSP	Recovery and Resource Services Program
SLA	Service Level Agreement
Social housing	Public and community housing
SPRC	Social Policy Research Centre
State HIE	State Health Information Exchange
SUPI	State Unique Personal Identifier
UNSW	University of New South Wales

*Allied health services* – clinical health care services other than dentistry, nursing and medicine, eg physiotherapists, occupational therapists, psychologists, dieticians, podiatrists, exercise physiologists, speech pathologists, audiologists, pharmacists, optometrists and social workers.

*Ambulatory care services* – community mental health care, comprising government-operated specialised mental health care provided by community mental health services and hospital-based outpatient and day clinics.



*Comparison time periods* – quantitative analysis in this report includes three time comparisons: the two years before consumers enter HASI compared with their first two years during HASI; a measure in 2009 compared with 2010; or current 2009-10 evaluation compared to the 2005 Stage 1 evaluation (Muir et al., 2007).

*Homelessness* – The cultural definition of homelessness developed by Chamberlain and MacKenzie and used by the Australian Bureau of Statistics (Chamberlain and MacKenzie, 2003) identifies ‘primary’, ‘secondary’ and ‘tertiary’ homelessness:

- *Primary homelessness* accords with the common sense assumption that homelessness is the same as ‘rooflessness’. It includes all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.
- *Secondary homelessness* includes people who move frequently from one form of temporary shelter to another, including all people staying in emergency or transitional accommodation; people residing temporarily with other households because they have no accommodation of their own; people staying in boarding houses short-term (12 weeks or less).
- *Tertiary homelessness* refers to people who live in boarding houses on a medium to long-term basis (13 weeks or longer). Residents of private boarding houses do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have security of tenure provided by a lease. They are homeless because their accommodation situation is below the minimum community standard.

*Housing stability* – housing stability is described in the literature in terms of the consistency of living in a residence, and may be measured by the number of days living continuously in a dwelling or the number of moves over a period (Dickey et al., 1997; Hurlburt et al., 1996; Rosenthal et al., 2007). Housing stability may also be defined as living in an apartment or other long term housing situation as opposed to being homeless (Tsemberis et al., 2004). Consistent with this, where housing stability for consumers at entry to HASI is measured, stable housing includes public or community housing, private rental and home ownership, while unstable housing includes hospital, temporary situations such as living with family or friends, boarding houses and primary homelessness (HASI MDS). Without support, illness can disrupt tenancies and the ability of an individual to maintain their housing (NSW Health, 2002).

*Housing security, security of tenure* – housing security may be achieved through home ownership or, for tenants, through security of tenure. Security of tenure refers to private or public tenant households with a lease, and could also incorporate factors such as availability of rental bond boards, appeal procedures and notice periods for evictions (Flood, 1993). Chamberlain and MacKenzie’s (2003) definition of homelessness described above also refers to security of tenure provided by a lease, and lists the following situations as lacking security of tenure: moving between the residences of friends or

relatives, living in squats, caravans or improvised dwellings, or living in boarding houses.

*Priority housing assistance* – for clients assessed as having urgent housing needs including unstable housing circumstances (including homelessness and imminent homelessness), at risk factors including domestic or other violence and sexual assault, existing accommodation that is inappropriate for basic housing requirements; and are unable to resolve their urgent housing need in the private rental market.

*Social and community participation* – formation and engagement in meaningful social relationships and networks and social, community, education and paid and unpaid work

*Social housing* - secure, affordable housing for eligible people on low to moderate incomes. Social housing properties are owned or managed by Housing NSW, community housing providers (NGOs) or the Aboriginal Housing Office.

*Tenancy risk factors* – unstable housing experiences before HASI that might indicate risk to future stable housing, including periods of homelessness, high housing turnover, nuisance and annoyance complaints and applications for orders to CTTT. ASP staff collected the data. The data should be interpreted with caution because the collection was inconsistent and probably underreported risk factors. For example, some ASPs reported tenancy risk as minimal if consumers had access to support services.

## **1 Executive summary**

### **1.1 Brief summary**

The Housing and Accommodation Support Initiative (HASI) in New South Wales (NSW) aims to provide adults with a mental health diagnosis with access to stable housing, clinical mental health services and accommodation support. HASI supports over 1000 mental health consumers across NSW living in social and private housing and ranging from very high support (8 hours per day) to low support (5 hours per week) levels.

It is a partnership program between Housing NSW, NSW Health, NGO Accommodation Support Providers (ASPs) and community housing providers. The annual cost of HASI per person ranged between \$11,000 and \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit cost.

#### *Consumer outcomes*

The most common diagnosis of HASI consumers' was schizophrenia (65 per cent). One quarter of consumers had a secondary diagnosis and more than half had a co-existing condition, such as alcohol or drug dependency, physical health problems and intellectual disability. Nearly half the consumers were in hospital or had unstable housing when they entered HASI and most consumers who did have housing were referred to HASI at least partly with the aim of supporting them to sustain their tenancies.

Consumer outcomes were positive for mental health hospital admissions (reduction in admissions and length of stay), mental health (clinically significant change in K10, HoNOS and LSP16 scores), stable tenancies, independence in daily living, social participation, community activities and involvement in education and voluntary or paid work. Physical health remained lower than the general population. While there was no single measure of quality of life, most consumers believed that HASI contributed to improving their quality of life compared to before joining the program.

#### *HASI model and partnerships*

The process evaluation examined the effectiveness of the referral and selection process; the type and quality of HASI support provided to current consumers through tenancy management services, clinical support and accommodation support; exiting from HASI and transitioning between levels of support; and partnership arrangements. Overall, the HASI service model operated well to provide an integrated response to its target group. The partners have established effective mechanisms for coordination at the state and local levels.

Some HASI partners were unclear or disagreed about the aims of the HASI model and the recovery based framework for service delivery, and many thought that the aims of the HASI program had changed over time. A number of factors could be addressed to improve the implementation of the HASI

model, including clarifying the aims of the model and recovery framework to provide ongoing support for as long as a consumer needs it; regular training and information for staff and managers of the HASI partners to share good practice; better coordination with related services to facilitate transitions and integration; and clearer articulation of effective pathways to secure housing, including social housing and private rental..

## **1.2 Introduction to the full summary**

The Housing and Accommodation Support Initiative (HASI) in NSW aims to provide people with mental illness with access to stable housing, clinical mental health services and accommodation support. Initially funded to support 100 people in 2002/03, the HASI program has expanded to support over 1000 mental health consumers across NSW.

In 2009, the University of New South Wales (UNSW), led by the Social Policy Research Centre (SPRC), was contracted to undertake a longitudinal, mixed method evaluation of the initiative.<sup>1</sup> This is the final evaluation report across all stages of HASI support including low, medium, high and very high support (Stages 1-4B). It does not specifically include Aboriginal HASI, which is being evaluated separately, but it does include the experiences of some Aboriginal HASI consumers both in the mainstream program and in Aboriginal HASI.

The purpose of the evaluation was to understand how well the HASI program is working by investigating the effectiveness of support for consumers; benefits and limitations of the service model; and the cost of the program. The data analysed in the evaluation were interviews with consumers, families and HASI partners in three evaluation sites (Section 4); and data from secondary sources (including mental health scores, hospital visits, housing indicators, monitoring data from accommodation support services and selected consumer outcomes, such as community participation). Outcomes data are analysed against three comparisons: normative population data; the two years before a consumer enters HASI compared with the first two years during HASI; and a measure in 2009 compared with 2010.

## **1.3 Program description**

HASI is designed to support people with mental illness to participate in the community, to improve their quality of life, maintain successful tenancies and, most importantly, assist people in their recovery from mental illness. It aims to achieve this by facilitating access to housing, accommodation support and clinical mental health services. The specific aims of the program are to:

- provide to 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;

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<sup>1</sup> HASI Stage 1 was evaluated by the SPRC in 2005 (Muir et al., 2007).

- 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 mental health diagnosis who require support services to maintain a tenancy and live independently in the community.

HASI is a partnership program between Housing NSW, NSW Health, NGO Accommodation Support Providers (ASPs) and community housing providers. Social housing is provided by Housing NSW and community housing providers. Consumers living in properties which they own or rent privately can also receive HASI support through HASI Stage 4B (HASI in the Home), which offers support wherever the consumer is currently living. NSW Health is responsible for providing ongoing clinical care to consumers through Local Health Districts (LHDs) and funding accommodation support provided by NGOs.

HASI commenced in 2002-03 for mental health consumers with high support needs. From 2003 to 2010, the HASI program expanded significantly. Different stages of HASI were targeted to meet the different needs of mental health consumers, providing a range of support, from low support (up to 5 hours a week) to very high support (up to 8 hours a day), and rolled out in places of need across NSW.

#### **1.4 Profile of HASI consumers**

To be eligible for HASI, a person must be aged more than 16 years old, have a mental health diagnosis,<sup>2</sup> require support services, in many cases require housing (72 per cent of higher support consumers and 26 per cent of lower support consumers), and have the ability and desire to live in the community. There is no specified upper age limit, as consumers are considered to be eligible until frailty is determined to inhibit ongoing involvement in the program.

Eligibility for the program varies between lower and higher support level packages depending on consumers' level of functioning (Section 3.3). Higher support HASI is for consumers with a moderate or severe level of psychiatric disability. Priority for higher support HASI is given to: consumers who are in hospital because it has been difficult to access high levels of accommodation support; are homeless, at risk of homelessness, inappropriately housed or whose current housing is at risk due to lack of care and support; or who are unlikely to be able to maintain a mainstream tenancy agreement without HASI type support. Lower support HASI is for consumers with a mental health diagnosis who can function at a high level most of the time; who would

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<sup>2</sup> Or in the case of a young person where formal diagnosis is absent, functional impairment that has been identified by a mental health professional.

generally be already established in social or other housing; and whose support needs could be ongoing or time-limited (NSW Department of Health, 2006: 17, 21).

The profile of consumers shows that slightly more men (53 per cent) than women (47 per cent) were in the HASI program and the median age of current consumers was 40 years old. Nine per cent of consumers identified as Aboriginal or Torres Strait Islander. This is higher than the NSW population and people with mental illness in the community, which indicates that HASI has successfully recruited them into the program. Eight per cent of consumers spoke a language other than English as their main language at home, which is still lower than in the NSW population and people with mental illness in the community and might suggest that HASI delivery could be improved in this area.

The most common diagnosis of HASI consumers' was schizophrenia (65 per cent). One quarter (26 per cent) of consumers had a secondary diagnosis, of which the most prevalent was depression and anxiety. More than half (54 per cent) of current consumers had a co-existing condition. The most common condition for current consumers was alcohol or drug dependency (28 per cent), followed by physical health problems (12 per cent) and intellectual disability (10 per cent)..

More than one third (43 per cent) of consumers were in hospital or had insecure housing when they entered HASI and most consumers who had housing were referred to HASI at least partly with the aim of supporting them to sustain their tenancies. A greater proportion of higher support consumers had insecure housing when they entered HASI (72 per cent), than lower support consumers (26 per cent), which is consistent with the eligibility criteria.

## **1.5 Consumer outcomes**

Consumer outcomes were positive for mental health hospital admissions, mental health, stable tenancies, independence in daily living, social participation, community activities and involvement in education and voluntary or paid work. Physical health had not moved towards the levels in the general population. While there is no single measure of quality of life, most consumers believed that HASI has contributed to improving their quality of life compared to before joining the program.

The evaluation measured mental and physical health outcomes through use of hospital services, mental health clinical measures (K10, HoNOS and LSP16), consumer and worker perceptions and the use of other health services, including community mental health. The general results were improvements in mental health for most HASI consumers.

### *Mental health hospitalisations*

The use of hospital services decreased in terms of average number of admissions, average length of stay per year and average length of stay per

admission in mental health inpatient care, other inpatient care and emergency department presentations.

Overall, HASI consumers had significantly fewer and shorter mental health hospital admissions after joining HASI: improvements included a 59 per cent decrease in the average number of days spent in a mental health inpatient hospital per year; and a 24 per cent drop in the number of admissions to hospital per year. Among consumers who were admitted to hospital at least once both before and during HASI, the average number of days hospitalised per admission decreased by 68 per cent. Over \$30 million per year has potentially been avoided on the hospitalisation of HASI consumers (estimated in 2009/10 dollars), thereby increasing capacity for other patients. Similar improvements were experienced in other inpatient admissions and days and emergency presentations and hours.

Longitudinal analysis of hospital use by gender shows that women were admitted to hospital more often than men and spent more days in hospital per admission, but that men spent more days in hospital per person before joining the program. The inpatient rate and length of stay improved for both men and women once they entered HASI and improved further during their second year in the program.

The greatest improvements in admissions were for men, lower HASI support and younger consumers. Changes were sustained over the first two years in HASI and hospitalisation rates in the second year were lower than two years before HASI, except for higher support HASI consumers. Greatest improvements for days in mental health inpatient services were for higher support HASI consumers.

#### *Psychological distress, life skills and behavioural issues*

Analysis of the MH-OAT measures (K10, LSP16 and HoNOS) shows significant improvements in consumers' mental health since joining the program. The absolute change in mean scores was first assessed, then consumers who were most likely to experience change (positive and negative) were identified through the Effect Size approach (clinical significance).

More women, lower support consumers and younger consumers experienced improvement in all three mental health assessment scores. Although less often than their counterparts, men, higher support or older consumers were more likely to experience greater improvements in absolute scores (i.e. the difference between the mental health score during and before HASI was larger for these consumers). Most important, after joining HASI, the K10, LSP16 or HoNOS scores between lower and higher support consumers were not significantly different, indicating that HASI was successful in reaching most consumers.

HASI consumers' life skills increased and behaviour issues decreased (both statistically significant) compared with before consumers became involved in the program (LSP16 and HoNOS outcome measures).

Consumers K10 scores decreased overall, flagging a general improvement in their mental health. During HASI K10 scores were not significantly different between consumers of different ages or support levels. Women had higher levels of distress both before and during HASI and both men and women relatively improved in this respect when before-during HASI scores are compared.

#### *Consumer and worker perceptions of mental and physical health*

Most consumers said that they had experienced improvements in their mental health and attributed part of this change to regular contact with ASPs. ASP staff rated over half of current consumers as having excellent, very good or good physical health, but this was still lower than the general population. This is consistent with the consensus in the international and national literature that the physical health of people with a mental illness is poor because of many factors. The results may also be influenced by a focus by ASPs on health issues, better identification and treatment of pre-existing problems and other physical health needs related to the mental illness and medication.

#### *Use of other mental and physical health services*

Almost all consumers used health, allied health and community mental health services. Changes in service use over time showed more frequent use of psychiatrists and allied health and less frequent use of community mental health services after an initial increase, consistent with appropriate use of services. Women used GP and allied health services more frequently than men. Consumers receiving higher HASI support services used community mental health and psychiatric services more frequently than those on lower support, but used GP or allied health services less frequently.

HASI consumers used a range of community mental health services (ambulatory care), such as care planning, counselling and education, carer support or referral. Community mental health service use increased during the first year in HASI then dropped to levels below 2 years before HASI. All HASI consumers, regardless of age and gender, followed this pattern. Before HASI lower and higher support consumers had similar use of ambulatory services, and lower support consumers decreased their use significantly, well below their initial levels of use, and below the higher support consumers' use.

#### *Housing*

The HASI program has achieved its aim of stable housing for most HASI consumers. Most people enter the program with a history of unstable housing, including almost half with no home immediately prior to entering HASI, for example, from hospital, prison, living with friends or family, living in a boarding house, in other unstable or temporary housing or primary homelessness. Many consumers who were already housed before joining HASI had also experienced unstable housing in the past.

The HASI stages have different eligibility for housing, with the expectation that consumers referred to higher support HASI might require housing and that consumers referred to lower support HASI might have housing that could be



at risk because of their mental health. Most higher support consumers (72 per cent) lacked stable housing and required housing. In addition, over one quarter (26 per cent) of HASI Stage 2 (lower support) also lacked stable housing and required housing.

HASI consumers live in a range of housing types, including social (public and community) housing and private housing. Almost nine out of 10 (88 per cent) HASI public housing residents live alone, compared to one in two public housing tenants (51 per cent) in the general population.

HASI operates within an extremely tight housing market that has affordability pressures. Social housing is an increasingly scarce resource, with demand for housing assistance far exceeding supply. While some stages of HASI had funds specifically allocated to provide housing, the costs of providing housing for new consumers and ongoing housing for consumers whose housing was originally funded through leasing subsidies are absorbed by the housing provider (Section 7.1).

New HASI consumers who require social housing apply through Housing Pathways for public or community housing. They are prioritised according to relative need and may be assessed as eligible for priority assistance because of urgent housing needs. They are housed in existing social housing stock, when a suitable property becomes available. Waiting times to access priority housing assistance varied depending on the location and needs, ranging up to many months.

Most HASI consumers were satisfied with their housing and the support they receive from the housing provider. If consumers had moved, it was usually for planned reasons to more suitable accommodation. Most HASI consumers successfully maintained their tenancies (90 per cent).

With the support of the ASP and housing provider, almost all HASI consumers met their tenancy obligations – they paid rent on time, maintained their property and were good neighbours. Interviews with consumers and their family members found that overall they were satisfied with the housing and tenancy management that they received.

The number of Consumer Trader and Tenancy Tribunal (CTTT) actions against HASI tenants was low, as was the incidence of damage caused by tenants. Both these results were similar to other people living in social housing. Housing managers were generally satisfied that, with support, HASI tenants were reliable and paid their rent on time.

### *Participation*

Consumers developed daily living skills, increased social connections and participated in the community, education and employment according to their preferences. Consumers overall reported benefits in these activities and feeling positive about living independently in the community. Some consumers expressed concern that they still felt marginalised and stigmatised in the community because of their mental illness. Other consumers had limited family support or no contact with family members and some said they

did not have any friends. Consumers reported developing supportive relationships with ASP staff and other consumers. They wanted greater participation in mainstream services and activities with other community members.

*Daily living skills.* At least 60 per cent of consumers were reported to be independent or supported less than half the time in all activities of daily living including personal care, cooking, taking medication and transport, cleaning and exercise. Approximately one in three consumers required support more than half of the time with shopping, managing their finances, cleaning and exercising. Consumers on lower support were more independent than consumers receiving higher support in the activities of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ( $p < 0.05$ ).

*Relationships and social connections.* Most current HASI consumers (86 per cent) had some form of regular social contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner. One in seven consumers (14 per cent) did not have any regular contact (daily or weekly) with other people, such as a family member, friend or partner. Men and consumers with higher support were less likely to have regular social contact with a family member, friend or partner.

*Community participation.* Most HASI consumers (83 per cent) were participating in at least one kind of community activity (including supported and unsupported group activities, supported individual activities and day programs). Most consumers enjoy regular social contact, which has improved over time. One in seven continue to be socially isolated. Many consumers receiving higher support continue to require the support and assistance of their ASP support workers to be able to access and participate in the community in a meaningful way. ASPs continue to rely on participation in activities targeted to people with a mental illness rather than mainstream activities. A greater emphasis on access to mainstream activities would be more consistent with HASI goals and with the aspirations of many consumers.

*Work, training and education.* HASI consumers were continuing to participate in education and work, with 31 per cent currently involved in some type of activity (paid or voluntary work, education and training). They were encouraged and supported in these activities by ASPs.

#### *Consumers most likely and least likely to benefit from HASI*

Most people using HASI support experienced improved quality of life and wellbeing since participating in the program. A small number of people reported that their wellbeing had decreased or remained the same. Consumers attributed improvements in their mental health to regular contact with ASPs. Most consumers from every group benefit from the program, including men and women, consumers on higher and lower support packages, all age groups, consumers with and without prior contact with families and friends and consumers with and without prior stable housing.

Some consumers initially had difficulty engaging with HASI but subsequently did so and gained considerable benefit from the program. For example, some consumers with drug or alcohol problems ceased or reduced their substance use with support from HASI.

The expansion of HASI to include multiple stages with flexible support has addressed many of the program rigidities in HASI Stage 1. The availability of different housing options and levels of support in a geographical location enables the HASI partners to be more responsive to the various needs of mental health consumers at risk of unstable housing, irrespective of their mental health support needs, other conditions and life circumstances. This has meant that HASI has been able to benefit a wider range of consumers and to respond to their changing needs, including people with higher and lower support needs. Training and information for HASI partners would assist them to respond effectively to consumers with complex needs who meet the eligibility criteria, whenever consumers are ready for the next step of their recovery. With appropriate housing, clinical and support services and encouragement to engage with the program, all groups have been shown to benefit.

## **1.6 HASI service model**

The HASI model aims to support personal recovery by providing housing assistance, clinical mental health services and accommodation support services through a three-way partnership in service delivery. The process evaluation examined the effectiveness of the referral and selection process and the type and quality of HASI support provided to current consumers through tenancy management services, clinical support and accommodation support. Overall, the HASI service model operates well to provide an integrated response to its target group. A number of factors could be addressed to improve the implementation of the HASI model.

### *Referral and selection processes*

Most HASI referrals are made by mental health clinicians. Housing providers and others also informally refer people with mental illness to clinicians, who then make the formal referral to the ASP. Waiting lists for HASI support packages are active in all three evaluation sites.

The processes for referring and selecting consumers into HASI generally conform with the procedures set out in the HASI Resource Manual. Most HASI partners thought that these processes worked well and appreciated that the procedures allowed them to adapt the process to suit the local context. Some ASPs report that referral pathways are confusing for clinicians, particularly in locations that have more than one ASP and with multiple levels of support. Locations with multiple referral forms create confusion and obstacles to referral, and it would be worthwhile reviewing whether to standardise the referral processes within the location.

Factors contributing to effective selection meetings were regularity of meetings, joint agreement by local partners about the role of housing

providers in selection processes and discussion about the needs of current consumers. In some locations HASI partners co-ordinate selection committee meetings with JGOS<sup>3</sup> meetings that are also attended by organisations who provide other services such as PHaMs and RRSP that work with a similar target group. This approach has the potential to enable co-ordinated consideration of which mental health support program would be most suitable for individual consumers.

The consumer profile (above) shows that HASI is reaching its intended target group. Stakeholders raised some problems about access to the program. Some ASPs expressed concern that clinicians sometimes referred people who required housing but did not wish to receive support. The different priorities of the higher and lower support HASI packages, means that HASI appears inconsistent to some referrers, consumers and families, as well as disadvantageous to some low support HASI consumers, who need to find housing.

HASI partners' interpretations of consumers' capacity to participate in rehabilitation also differed in the selection processes. Some HASI partners referred to the practices of selection committees and ASPs that prioritise consumers who they think have a greater capacity to develop independent living skills in a shorter timeframe. These practices suggest that contrary to the program design, some mental health consumers may be excluded from the program.

The selection process and entry to HASI support is sometimes limited by a shortage of HASI support packages, clinical services and social housing in most locations. The waiting lists for consumers applying for HASI reflect an obstacle for people eligible for the program. HASI partners' are inconsistent between sites about how they respond to these shortages. Most HASI partners reported that consumers were accepted into a support level that was appropriate to meet their need, rather than an available package that was not suitable. A small number of ASP and MHS staff were aware of instances where consumers were provided with packages that were lower than required due to a shortage of higher support packages. One ASP reported that they had used a combination of PHaMs and HASI to provide extra support when suitable packages were not available. These practices indicate that selection committees are sometimes forced to compromise the intention of the program when consumer needs are greater than the resources available.

Selection into HASI ensures access to ASP support and assistance to find and/or maintain housing. Where applicants to HASI do not have housing they need to apply for social housing, which may take some time. Some ASPs provide support while HASI consumers are living in temporary accommodation and waiting for housing. Other ASPs insist that housing is a prerequisite to receiving accommodation support. Some selection committees actively seek alternative support (e.g. PHaMs) while consumers wait for

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<sup>3</sup> JGOS has now been replaced by the Housing and Mental Health Agreement, 2011.

housing and HASI support. In locations where there is a shortage of social housing and the ASPs do not provide support until a person is housed, people can wait many months for both housing and support.

Demand exceeds supply in all areas of the service model because of the finite number of HASI packages and the limited availability of clinical mental health services and social housing. This highlights two broad considerations to address:

- The on-going impact of resource constraints on service providers' ability to implement the service model as it was intended; and
- The inconsistencies across the state in the way that service providers are responding to these constraints.

### *HASI services*

The HASI program aims to support each consumer's recovery by providing stable housing, clinical services and accommodation support. The way the aims of the HASI Program are interpreted varies by location, reflecting how the recovery oriented framework is implemented locally.

Tenancy management services are provided by public, community and private providers. Most housing managers view HASI consumers as reliable tenants. HASI consumers are generally satisfied with the tenancy management of their dwellings, although they criticised the maintenance processes. The delivery of quality tenancy management required timely handling of maintenance and repairs and involving consumers in resolving tenancy management problems. Strong partnerships with ASPs and clinicians assist both the housing provider and the consumer with tenancy management issues.

Community mental health teams provide essential clinical services to HASI consumers. HASI partners in all locations raised concerns about the impact of limited resources and capacity of community mental health teams. The delivery of quality clinical mental health services required the provision of appropriate treatment, clinical supervision, manageable clinical workloads, open communication and information sharing with ASPs, involvement of clinical staff in ISPs and liaison with housing providers. Community mental health teams are providing essential clinical services to HASI consumers. Further clarification is needed at the local LHD level about how the local HASI partnership can manage support for consumers' continued mental health after clinical support is withdrawn.

The most common activities ASP staff assisted consumers with were accessing the community, developing skills in personal self care, counselling and advocacy. ASPs provide rehabilitation focused services to support each person's recovery and they work with consumers to identify and achieve goals. The support provided by ASPs is structured around the goals that consumers set for themselves in their Individual Service Plans. The goal most frequently identified by consumers was to engage in social and community activities, followed by engaging in community tasks and carrying out activities

of self care. The support provided by ASP staff closely matches the goals set by consumers.

ASP services work within a recovery framework applying the principles of rehabilitation, consumer centred support and flexibility. The way some ASP staff interpret the process of rehabilitation varies. Contrary to the HASI Manual (NSW Department of Health, 2006), some staff stated that consumers who continue to need disability or maintenance support over a long time are a less suitable consumer group for HASI than prioritising support for people who have the capacity to become independent within a shorter time.

ASP services are tailored to the person, involve consumers in decision-making, respect their choices and provide consistency of support. Some HASI partners were concerned that some consumers become too reliant on ASP staff members. This highlights the important role of ASP staff in facilitating consumer's to achieve their goals.

The level of support is flexible to meet changing consumer needs. Consumers can be transferred to lower support packages when their support needs decrease, which releases support resources for other consumers with higher support needs. It can be problematic, however, if ASPs have only one level of support and do not have strong partnerships with other ASPs in the local area.

The provision of accommodation support works well when staff are highly professional, understand the personal recovery approach and have the opportunity to continually develop new skills. HASI partners and consumers were overwhelmingly positive about the quality of the support provided by most ASP staff. They raised concerns about the qualitative differences between ASPs, skills and knowledge of some staff, attention to confidentiality, the need for good communication between staff and the availability of sufficient staff.

Key issues for quality support include recruitment of qualified and experienced staff, supervision, training and development opportunities and retention of skilled staff to ensure continuity of care. ASPs recognise the importance of staff training and prioritise training about working with mental health consumers, the support implications of consumers' co-existing conditions, risk management and occupational health and safety. The effectiveness of HASI support is also assisted by strong internal risk assessment and management processes, good communication and coordination strategies, and confidentiality procedures. Some ASPs regularly seek consumer feedback, without disadvantaging consumers who raise these issues. These professional requirements suggest a continuing need to develop the capacity of ASP management and staff.

## **1.7 Exiting HASI**

The level of support and time in the HASI program depends on consumers' individual needs. The evaluation examined the process and support for consumers who exited HASI or changed their level of support. Exiting HASI

means that the consumer no longer received accommodation support. They did not necessarily leave the housing or stop receiving support from clinical mental health or other community services. For some people, a period of accommodation support was sufficient for them to stabilise their lives and set up other community and clinical support to successfully maintain their tenancies and mental health. This included people who had started with higher support, changed to lower support and finally exited HASI. Good practices for supporting consumers to exit from lower support packages could be shared between the HASI partners across the State to learn about successful transition planning and support.

HASI consumers exited the program for a variety of reasons. These include planned exits where people were assessed as no longer requiring HASI assistance, or moving to a more suitable form of higher or lower support from a different HASI provider or another organisation. Some consumers left the program for other reasons, such as moving from the location. In general, a planned exit involved the ASP working with the consumer to support the consumer in developing an exit plan.

Some people no longer needed support services from ASPs and were successfully living independently and maintaining their tenancies and mental health. This included people who had started with higher support, changed to lower support and finally exited HASI.

Some people leave HASI without alternative support or independence for maintaining mental health and housing. Examples were consumers who refused ASP support so they left the program because they no longer consented to participate; and consumers whose abusive or other behaviour was too difficult for HASI to manage. The circumstances in which these people left raise questions about appropriate processes to support people with complex needs who have not developed the independent living skills to maintain their tenancy and mental health. Improved processes to re-engage consumers or refer them to alternative support could prevent some of the problems that arise in these circumstances.

Factors supporting the effective transition of people out of the HASI program included: planned exits between HASI partners, consumers, family and other organisations; coordination of HASI services with other community services during this transition; and flexible support by ASPs during the transition.

Given the fluctuating nature of some mental illness and the positive relationships that ASPs had often developed with consumers, these services were well-positioned to provide effective occasional support to consumers who were no longer receiving a regular support package. While some ASPs had adopted a flexible open door policy, the ASP funding model does not lend itself to providing one off or discrete support to consumers who have left the program.

## 1.8 Partnerships and governance

The relationships between local partners are generally effective. This is particularly the case between MHS and ASP providers, ASP and housing providers and ASP staff from different organisations. The local partnerships between housing providers and MHS is less intensive, and require less frequent communication than their respective relationships with ASPs who provide consumers with both accommodation support and disability rehabilitation.

With the expansion of the program, multiple ASPs now provide services across NSW and many in overlapping geographical areas. The competitive funding model may have compromised the collaboration between some ASPs during the retendering, but the ASP staff appear to be working together well in the interests of consumers in most areas.

HASI is now an established program and relationships between partners seem to be working relatively well due to four factors:

1. Clear roles and responsibilities. The clear delineation of clinical and non-clinical roles and responsibilities was crucial to developing positive working relationships with HASI partners. Where roles and responsibilities were not clear, tensions emerged and the partnerships were compromised.
2. Open communication. It is crucial that HASI partners promptly share information that could be relevant to staff and consumer risk management. This is the usual practice in most locations, but in some instances information sharing was delayed, especially where HASI partners did not have regular meetings. While open communication is important, not all partners require detailed personal information about consumers. For example, housing providers require information about the HASI program, risks and consumer needs, but they do not require other details that potentially compromise consumer confidentiality. The type of information that needs to be shared promptly should be defined in the HASI manual.
3. Commitment to working together. Effective partnerships require a substantial investment of time and energy, so organisational and staff commitment to HASI is essential to working together. This commitment requires recognising and respecting the recovery oriented approach of the HASI program and the differences in organisational values of HASI partners.
4. Sound governance processes. 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 processes, including selection of new consumers, planning and risk management, transitioning of consumers between support packages, and any other consumer related issues; and service level agreements.

Local governance processes were potentially hampered in some areas by the tension between the two different roles that Local Health Districts (LHD) have with the ASPs: the HASI partnership role and the operational role as contract



manager for NSW Health. This created confusion for some HASI partners about how ASPs are accountable to LHDs in relation to HASI.

The State governance structure of HASI is working well and has addressed different policy priorities of NSW Health and Housing NSW, which need to continue to be recognised and managed. Factors that supported the State level partnership included regular meetings between NSW Health and Housing NSW, and wider stakeholder meetings.

The effectiveness of HASI will continue to depend on program resources and management. In addition to resource pressures on community mental health services, the two other resource questions identified in the evaluation were the funding of accommodation support and pathways into secure housing:

- Since the redistribution of funding for accommodation support in 2010, ASPs have had more flexibility to respond to consumers' changing needs by transferring consumers between funding packages and changing the number of hours spent with the consumer. A key challenge for HASI in this context is how to promote a funding model that builds accountability for ASPs but also allows for flexible service delivery to support consumer recovery.
- HASI partners including Housing NSW acknowledged the shortage of appropriate housing stock across the state and particularly in some locations. The social housing shortage impacts on the provision of effective pathways into secure housing for those consumers who require housing. This impact needs to be further considered in the design and costing of the HASI program.

## **1.9 Costs of HASI**

The final part of the evaluation was a cost analysis. It analysed the budgeted costs of HASI services between 1 July 2006 and 30 June 2010. The per consumer costs are calculated on the basis of the 1076 HASI packages (allocated between 2006-June 2010).

The allocated budget for the program over the last four years was \$118 million for accommodation support costs and \$1 million for project management costs.

The annual cost of HASI per person ranges between \$11,000 and \$58,000, plus project management costs of between \$200 to \$500 (depending on the level of accommodation support and the method of calculating the annual unit cost). These figures do not include the cost of clinical mental health services or the costs to social housing providers of housing HASI consumers in some stages of the program. Nor does it include social housing capital investment from 2002-07 of \$26 million. These costs were excluded because clinical mental health services and social housing assistance are available to all mental health consumers, regardless of whether they were receiving HASI support. As the costs of providing these services were likely to be incurred anyway, they have not been included as a direct cost of the program.

### **1.10 Improvements to the HASI program**

The success of the program into the future will not only depend on recurrent funding for ASPs to deliver accommodation support services but also on effective program resourcing and management – flexibility and accountability of funding for ASPs and the facilitation of effective pathways into secure housing through the program. The evaluation identified four questions requiring review for the effectiveness of HASI.

#### *Clarification of the aims of the HASI model and recovery framework*

The HASI program provides ongoing and flexible support services. For some HASI consumers this may mean ongoing and indefinite support services; whereas for other people this may mean short to medium term support. Both of these options are complementary to a recovery based approach. Not all HASI partners recognise this and some of them think HASI had shifted to a time-limited support model, which limits referral to mental health consumers who could be expected to eventually leave HASI. The published Program guidelines need to be updated to clarify program priorities and procedures for all stakeholders.

#### *Improvements to support processes for transitions*

The processes for supporting people transitioning between packages and exiting the program needs further development. Considerations include integration with other support services in the community, and pathways back into the HASI program or alternative support should consumers require crisis or short term assistance should be agreed. Distinctions between rehabilitation and dependency needs to be addressed in training and information to workers, such as the ASP role in providing this support, organising alternative support from other sources or building the confidence of consumers to act independently would address their uncertainty. Good practices for supporting consumers to exit from low support packages could be shared between the HASI partners across the state to learn about successful transition planning and support.

Clarification is also needed in situations where higher support HASI consumers are discharged from LHD but still require ASP support. For example, in some sites ASPs were refusing to support consumers without a clinical case manager.

#### *Appropriate accommodation support services*

Since 2010, all ASPs are funded to provide more than a single support level to support consumers who have a range of needs and provide flexibility so that if a consumer's needs increase or decrease they can be transitioned between HASI packages.

In some locations the high demand for HASI support at the local level was putting pressure on some consumers and ASPs to transition people out of the program. An implication is that HASI will need to increase the support services available if it is to address the community demand. Additionally, it will

need to develop better integration with other support services in the community to support consumers who decide to exit the program.

*Pathways into secure housing*

As the various HASI stages were established, housing has been provided in a range of ways. This has catered for consumers in a diversity of situations, but it has also created confusion about housing arrangements in the HASI program. Access to secure housing includes social housing, HASI in the Home packages for people in privately owned housing and private rental properties. Pathways into a range of secure housing options need to be investigated to meet the housing needs of people referred to the program and to avoid blockages. Clarification for ASPs about whether to start support while consumers are on housing waiting lists would remove inconsistencies.

## 2 Introduction

The Housing and Accommodation Support Initiative (HASI) New South Wales (NSW) aims to provide stable housing, clinical mental health services and accommodation support to people with mental illness. Initially funded to support 100 people in 2002/03, the HASI program has since expanded to support over 1100 mental health consumers across NSW.

In 2009, the University of New South Wales (UNSW), led by the Social Policy Research Centre (SPRC), was contracted to undertake a mixed method evaluation of the initiative. This followed an evaluation by SPRC of HASI Stage 1 (Muir et al., 2007). The purpose of the current evaluation is to understand how well the HASI program is working by investigating the effectiveness of support for consumers, the benefits and limitations of the service model, and the cost of the program.

This is the final evaluation report for the HASI program, across the stages of HASI support, including low, medium, high and very high support and HASI in the Home (Stage 1-4B). It does not specifically include Aboriginal HASI, which is being evaluated separately, but it does include experiences of some Aboriginal HASI consumers.

The evaluation compares the objectives of the HASI program with how the service model is operating, and the outcomes for consumers who are participating in the program. For HASI to meet its objectives it needs to reach the intended target group (of adults with a mental illness, who are at risk of homelessness, and require accommodation support services to live independently in the community); ensure that the three-part service model is appropriate (housing and tenancy management, clinical services and accommodation support); and that the key partnerships are effectively operating to support quality service delivery and outcomes for consumers.

This report presents key findings from repeat interviews with consumers, families and HASI partners (October 2009 and October 2010) about the effectiveness of the HASI program across the different stages of the program (low, medium, high and very high); as well as key findings on consumer outcomes, such as hospital admissions, mental health outcome measures, housing stability and satisfaction, social connections and community participation, from a range of secondary data sources; process evaluation about the implementation of the program; and a cost analysis.

The report includes an overview of the key aims of HASI (Section 3) and a description of the methodology (Section 4) before presenting the main findings. The outcomes evaluation findings are presented in Sections 5 and 6. Section 5 examines the profile of HASI consumers to assess whether HASI is reaching its intended target group. Section 6 presents the consumer outcomes of HASI by comparing measures before and during HASI or changes over the two years of the evaluation.

The process evaluation findings are presented in Sections 7 to 9. Section 7 describes the components of the service model that constitute the HASI program, including referral and selection; and housing, mental health and accommodation support services. Section 8 discusses the processes for exiting HASI and transitioning between different levels of support. Section 9

finishes the process evaluation by analysing the factors contributing to effective partnerships and program governance arrangements. Section 10 presents the analysis of program costs. Section 11 concludes the evaluation by drawing together the key implications in relation to the evaluation aims.

### **3 Key aims of HASI**

HASI is designed to support people with mental illness to participate in the community, to improve their quality of life, maintain successful tenancies and, most importantly, assist people in their recovery from mental illness. It aims to achieve this by providing mental health consumers with secure housing, accommodation support and clinical mental health services. The specific aims of the program are to:

- provide people with mental illness ongoing clinical mental health services and rehabilitation within a recovery framework
- support people with mental illness to participate in community life and to improve their quality of life
- support 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 mental health diagnosis who require support services to maintain a tenancy and live independently in the community.

#### **3.1 Background**

Mental health disorders affect an estimated one in five Australians in any given year (Australian Bureau of Statistics, 2007). The term mental health disorder is often used to cover a wide variety of diagnoses such as anxiety, depression or schizophrenia, and the symptoms and severity of an illness can range from mild to severe impairment (Slade et al., 2009: 9). People with severe mental health disorders can experience detrimental impacts on both their psychological wellbeing as well as other aspects of their lives, such as housing and social relationships (Browne and Courtney, 2007). Previous research has shown that people with mental health disorders and disability often encounter difficulties in accessing and maintaining stable housing (Bleasdale, 2007) and many people who are homeless are affected by mental health disorders (Flatau et al., 2008).

Several factors can support recovery from the impact of mental illness (Lysaker and Buck, 2008; Torrey and Wyzik, 2000). There is evidence that providing appropriate housing, clinical services and flexible support assists people with mental health problems to maintain stable housing and that stable and secure housing contributes to positive benefits to people's mental health and general wellbeing (Reynolds and Inglis, 2001).

NSW is not alone in delivering integrated services to people with mental health disorders. Programs that are similar to HASI currently operate in most other Australian States and Territories (Carter, 2008; Meehan et al., 2001; Smith and Williams, 2006; Smith and Williams, 2008).

### **3.2 Recovery orientated services**

The NSW HASI Program is underpinned by principles of recovery. It provides housing, accommodation support services provided by non-government organisations (NGOs), and is linked to clinical care and rehabilitation provided by specialist mental health services (NSW Department of Health, 2006). This approach is consistent with the NSW Community Mental Health Strategy 2007-2012 aim to ensure that rehabilitation services in both the public sector mental health program and in the mental health NGO sector promote a recovery oriented process defined and led by the consumer (NSW Health, 2008).

HASI draws on the work of William Anthony to define mental health recovery as, 'a journey, sometimes lifelong, through which a mental health consumer achieves independence, self-esteem and a meaningful life in the community (Anthony 2000, cited in NSW Department of Health, 2006: 2). The concept of recovery does not refer to a cure, but to '... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness' (Anthony, 1993: 15).

In Australia, consumer defined recovery is now used in policy documents such as the National Mental Health Policy (Commonwealth of Australia, 2009) and a number of State/Territory government policies (eg. NSW Consumer Advisory Group - Mental Health Inc and Mental Health Coordinating Council, 2009; NSW Health, 2008). Recovery is, however, used in several different but related ways in Australia: for consumers, it conveys personal recovery as a continuing process involving empowerment, hope, choice, self-defined goals, reclaiming meaning and purpose, healing, wellbeing and control of symptoms; for public mental health services the meanings may range from consumer defined recovery to clinical recovery; and in the NGO sector recovery can also be related to functional and social recovery (Deegan, 1995; Mental Health Coordinating Council, 2008; NSW Consumer Advisory Group - Mental Health Inc., 2009; Ramon et al., 2009).

Recovery-focused rehabilitation aims to enhance the capabilities of people with serious and persistent mental health disorders to meet their own goals to maximise independence. Rehabilitation includes a range of social, educational, occupational, behavioural, and cognitive interventions that can take place in four domains: skills training; peer support; vocational services; and consumer-community resource development of an array of community support (Barton, 1999: 526).

Recovery thus refers not only to processes and conditions of the person but also to external conditions and social processes (Jacobson and Greenley, 2001; Schon et al., 2009) At the level of service provision, the shift from hospital or similar accommodation to having a home and support in the community is a key feature of the shift to a recovery model (NSW Consumer Advisory Group - Mental Health Inc., 2009). A home-like environment is usually a necessary precondition for recovery: it not only provides shelter but supports social and economic participation, a sense of belonging and control

over one's environment and an opportunity to develop skills and responsibility and thus a greater sense of self-worth (Mental Illness Fellowship of Victoria, 2008; Psychiatric Disability Services of Victoria, 2008).

### **3.3 HASI service delivery framework**

HASI is a partnership program between Housing NSW, NSW Health, NGO Accommodation Support Providers (ASPs) and community housing providers. Social housing is provided by Housing NSW and community housing providers. NSW Health is responsible for providing ongoing clinical care to consumers through Local Health Districts (LHDs) and funding accommodation support provided by NGOs. The Housing and Mental Health Senior Executive Meeting and the Departmental Executive Committee (DEC) have strategic oversight of HASI (Figure 9.1). The Senior Executive Meeting manages the strategic development, governance arrangements and future planning of the initiative and the DEC focuses on interagency policy and operational effectiveness issues.

HASI stakeholder groups are also involved in the program governance. NSW Health hosts regular HASI forums attended by representatives from all HASI funded ASPs, Mental Health Services, and Housing NSW and community housing providers as required. These meetings support the ongoing planning, development and delivery of HASI. If specific development work is required for the program (such as reviewing changes to the way in which data are collected) a smaller working group is formed from the membership of this meeting. At the local level, HASI is managed by local coordination groups, which foster partnerships between the MHS, housing providers and the ASPs in each location.

HASI commenced in 2002-03 for mental health consumers with high support needs. From 2003 to 2010, the HASI program expanded considerably. Each stage of HASI was targeted to meet the different needs of mental health consumers, providing a range of support, from low support (up to 5 hours a week) to very high support (up to 8 hours a day), and rolled out in places of need across NSW.

- HASI Stage 1 commenced in 2002/03 with 100 high support packages (up to 5 hours of support per day, 7 days per week). This stage targeted people with high support needs who were at risk of homelessness, inappropriately housed, or unable to exit an inpatient facility due to difficulty accessing the level of accommodation support they require. Housing was provided by Housing NSW and community housing providers.
- HASI Stage 2 commenced in 2005 with the provision of 460 low support packages (up to 5 hours of support per week) targeted to people who were already living in social housing but who were at risk of being unable to sustain their tenancy.
- HASI Stage 3 commenced in 2005/06, expanding on HASI 1. This stage of HASI provided an additional 126 high support packages (up to 5 hours of



support per day, 7 days per week). Housing for Stage 3 was provided by Housing NSW and community housing providers from existing stock.

- HASI Stage 3B commenced in 2006/07, and provided 50 very high support packages (up to 8 hours of support per day, 7 days per week), targeted to people who have a mental illness and associated very high levels of disability. Housing NSW was funded to acquire 50 properties to house consumers accepted into very high support packages.
- HASI Stage 4A commenced in 2006/07 and building on HASI 1 and 3 and provided another 100 high support packages. Community housing providers were funded for a period of three years to head lease properties for people accepted into HASI 4A packages with an expectation that these costs would be absorbed after that.
- HASI Stage 4B (HASI in the Home) commenced in 2007 and provided 160 low support packages and 80 medium support packages (2-3 hours of support per day, 7 days per week). HASI 4B is a flexible model of HASI where consumers can receive HASI accommodation support wherever they are currently living. While consumers could be living in or accessing social housing, this was not a requirement. As Stage 4B was targeted at consumers who were already housed, the expectation was that no additional housing was required for consumers in this Stage.
- Aboriginal HASI was implemented throughout 2009/2011 with the provision of 58 new packages and the transfer of 42 existing packages. This HASI stage has a mix of low, medium and high support. There are no additional funds for housing. Aboriginal HASI is being evaluated separately.

NGOs are funded by NSW Health to provide 1135 packages of accommodation support across the state as at March 2011. The analysis of HASI packages in this report focuses on the cohort of consumers for whom information was available (n=895, from a total of 1076 consumers funded at June 2010; Table 3.1).

Most consumers in the program were receiving low or medium accommodation support services (62 per cent, n=552) in 2009, which is less frequent and intensive support than high and very high support services (Table 3.1).<sup>4</sup> Lower support packages are also aimed at eligible people who are already living in social housing (HASI Stage 2), private housing, or who live with family (HASI Stage 4B).

Thirty eight per cent of consumers (n=376) received high or very high support services, meaning that they are provided with social housing, as well as more

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<sup>4</sup> Low level support services are normally provided five hours per week, one to two days per week as appropriate for each consumer, while medium support services are funded at a higher rate, and provide consumers with approximately two to three hours per day, seven days per week. Low and medium support HASI packages are referred to as lower support HASI in this evaluation.

accommodation support hours.<sup>5</sup> Interviews with ASP staff indicated that the level of support provided to consumers varies depending on individual need, which can change over time.

**Table 3.1: Types of HASI support packages by current consumers 2009**

Support level	Support packages		Current consumers <sup>1</sup>		
	Funding	HASI package	Funded packages	Consumers	Per cent
Low <sup>2</sup>	\$11,000	HASI 2	460	397	44.7
		Low HASI in Home 4B	160	99	11.1
Medium <sup>2</sup>	\$35,000	Medium HASI in the Home 4B	80	56	6.3
		Total low and medium	700	552	62.2
High <sup>3</sup>	\$50,000	HASI 1	100	85	9.6
		HASI 3	126	121	13.6
		HASI 4A	100	75	8.4
		Total high	326	281	31.6
Very high <sup>3</sup>	\$70,000	HASI 3B	50	55	6.2
Total			1076	888*	100

Source: HASI MDS September 2009 n=895

Note: 1. Although 1076 packages were funded through the HASI program to June 2010, complete administrative data were only available for 895.

2. In this evaluation low and medium support are referred to as lower support.

3. In this evaluation high and very high support are referred to as higher support.

\* Data on the level of support received for the April-June 2009 monitoring period were missing for 7 consumers.

Higher support HASI aims to assist people with mental illness and high levels of psychiatric disability who are homeless, at risk of homelessness or inappropriately housed, including those who are residing in a hospital bed because it has been difficult to access appropriate housing and support elsewhere. Consumers receiving high level support need to have the ability and desire to live in the community and the capacity to maintain a mainstream tenancy agreement (with appropriate support). Lower support HASI is aimed at providing assistance to people who are already housed and who may be at risk of being unable to maintain their housing without support.

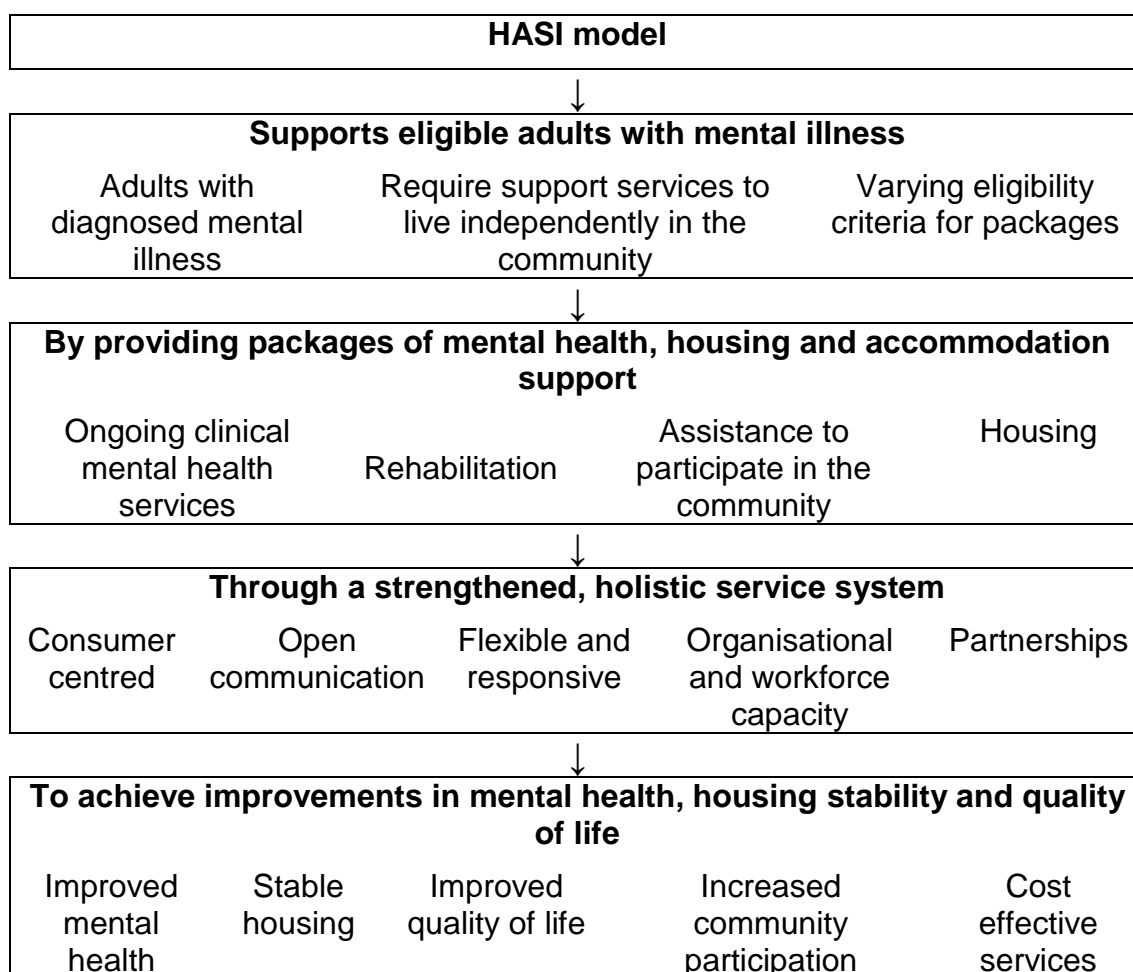
<sup>5</sup> Normally high support services are up to five hours of support per day, seven days per week and very high services are provided up to eight hours per day, seven days per week. Very high and high support HASI packages are referred to as higher support HASI in this evaluation.

### 3.4 HASI logic model

The premise of HASI is that some people who have a mental health diagnosis require support services tailored to their individual needs to live independently in the community. The logic model of the program is illustrated in Figure 3.1. It follows three key assumptions:

- If people with a mental illness receive appropriate services and support such as housing, rehabilitation services, assistance to participate in community networks and activities, and clinical mental health services;
- And those services are provided in a co-ordinated and collaborative way that is defined by organisational capacity, strong partnerships and is consumer centred, features open communication, is flexible and responsive
- Then it is likely that the service model will achieve beneficial outcomes for consumers, such as improvements in mental health, access and maintenance of secure housing, improved quality of life and increased community participation.

**Figure 3.1: HASI program logic model**



### **3.5 Summary**

This report draws on the logic model of HASI described above to evaluate whether the program is supporting the people it intends to; whether the consumers benefit from receiving this model of support; how the program is operating across the range of support packages (low, medium, high and very high); and how well the partnerships between housing providers, clinical services and ASPs are working. It also discusses the cost of the program.

## 4 Methodology

The evaluation applies longitudinal, mixed methods to address the 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 consumers in the domains of housing stability and satisfaction, 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 and
- contribute to ongoing improvements in the support provided to HASI consumers and to partnership arrangements.

As described in the previous section, the logic model is the framework for understanding how the inputs, activities and outputs of the program impact on consumer outcomes. The process evaluation focuses on how services operate to support consumers and foster partnerships between Housing NSW, NSW Health and ASP service providers in each location as well as at the State level.

The evaluation report applies data from a range of sources, including quantitative and qualitative data collected specifically for the evaluation. More details about the evaluation framework and the methods used to address the evaluation questions are provided in the full evaluation plan (McDermott et al., 2009). The research received ethics approval from the UNSW Human Research Ethics Committee and the NSW Population and Health Services Research Ethics Committee in 2009.

Two main types of data were analysed in the evaluation:<sup>6</sup>

- interviews with consumers, families and HASI partners in three evaluation sites (metropolitan, regional and rural) (Table 4.1) and

data from secondary sources (including mental health scores, hospital visits, housing indicators, monitoring data from accommodation support services and selected consumer outcomes such as community participation) (

Table 4.2).

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<sup>6</sup> Further information on the methods used in this evaluation, in particular details of how interview and quantitative data were collected, is at Appendix 3.

**Table 4.1: Number of interviews by stakeholder group 2009-10**

Stakeholder group	2009	2010	Total
Accommodation support providers	29	15	44
Mental health professionals	11	10	21
Housing (public and community)	10	9	19
Other service providers	2	0	2
Family or carers	1	6	7
Consumers	59	48	107
Total	112	88	200

Note: See the evaluation plan (McDermott et al 2009) for the sampling framework (Appendix 3)

**Table 4.2: HASI evaluation sample consumer characteristics**

	Number of consumers	Average age (years)	Average time in HASI (months)	Gender (per cent)		Support level (per cent)	
				Men	Women	Lower	Higher
HASI MDS	895	41	23	53.2	46.7	61.7	38.3
MDS supplement 2009	639	43	24	53.6	46.4	62.4	37.6
MDS supplement 2009-10	403	41	21	54.8	45.3	62.8	37.2
Housing NSW (public housing)	163	45	29	51.8	48.1	79	21
Mental health inpatient admissions	197	38	30	58.9	41.1	44.7	55.3
All inpatient admissions	222	39	29	57.2	42.8	45.5	54.5
Emergency department presentations	353	39	19	54.4	45.6	57.2	42.8
Ambulatory (community) services	496	41	23	54.4	45.6	59.1	40.9
K10	242	42	24	56.2	43.8	48.3	51.7
HoNOS	204	42	24	53.4	46.6	49.8	50.2
LSP	291	41	22	52.9	47.1	52.6	47.4
Evaluation interviews 2009-10	66	37	-	59	41	-	-

Note: 1. Total HASI packages = 1076 at June 2010

\* MHOAT measures – see glossary and Appendix 1

Details of the data, samples, evaluation sites, methods and analysis are described in Appendix 1.

The quantitative analysis in this evaluation compares: evaluation results to normative population data; the two years before consumers enter HASI compared with their first two years during HASI; a measure in 2009 compared with 2010; and current 2009-10 evaluation compared to the 2005 Stage 1 evaluation (Muir et al., 2007).

## 5 Profile of HASI consumers

To be eligible for HASI, a person must be aged more than 16 years old, have a mental health diagnosis (or in the case of a young person where formal diagnosis is absent, functional impairment that has been identified by a mental health professional), require support services, have difficulty accessing or maintaining stable housing and have the ability and desire to live in the community. While there is no upper age limit, consumers are considered to be eligible until frailty is determined to inhibit ongoing involvement in the program.

Eligibility for the program varies between lower and higher support level packages depending on consumers' level of functioning (Section 3.3). The higher 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, while the lower support packages are focused on people with low levels of psychiatric disability who are already living in social housing or the private housing market but whose housing might be at risk because of mental health support needs (NSW Department of Health, 2006: 17, 21).

This section describes the characteristics of current HASI consumers, their mental health and their housing status upon entry into the program.<sup>7</sup>

### 5.1 Consumer characteristics

An important element of the program effectiveness is whether HASI supports consumers who match the intended target group. This section examines the characteristics of consumers when they entered the program. HASI MDS data collected from 895 consumers who were in the program in 2009 was analysed.<sup>8</sup> Consumers were almost evenly men and women (53 per cent men and 47 per cent women).<sup>9</sup> The average age was 41 years (Table 5.1; Figure 5.2).

**Table 5.1: Consumers by age group**

	Consumers	Per cent
Less than 20 years	36	4.6
20-29 years	137	17.3
30-39 years	214	27.1
40-49 years	216	27.3
50-59 years	149	18.9
60 or over	38	4.8
Total	790	100.0

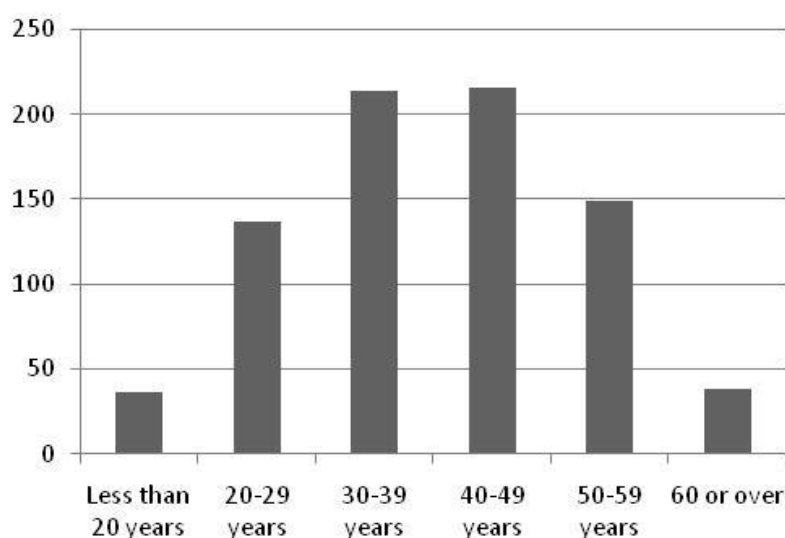
Source: HASI MDS September 2009 n=895

Note: Data missing for 105 consumers from incomplete administrative data collection

<sup>7</sup> The information is from the HASI MDS 2009 and fieldwork (Appendix 1).

<sup>8</sup> Due to missing data, totals do not always equal 895.

<sup>9</sup> 852 consumers due to missing data (452 men and 400 women).

**Figure 5.2: Number of consumers by age group**

Source: HASI MDS September 2009 n=895

This profile is different to the Stage 1 evaluation, when women made up only 33 per cent of all consumers and the average age of consumers was 34 years (Muir et al., 2007). It is likely that the reason the average age has increased since the evaluation of HASI Stage 1 is that the program has expanded to include people with a variety of support needs and diagnoses.

Nine per cent of current consumers in the program were identified as Aboriginal or Torres Strait Islanders (Table 5.3). They were well represented in the HASI sample compared to the general population and compared with other mental health services (Muir et al., 2007). The higher representation of Aboriginal and Torres Strait Islander consumers in HASI is also consistent with research findings that Aboriginal and Torres Strait Islander Australians have higher levels of psychological distress and poorer social and emotional wellbeing than non-Indigenous Australians (Australian Institute of Health and Welfare, 2010: 236-237).

**Table 5.3: Consumers by Aboriginal or Torres Strait Islander status**

	Consumers	Per cent
Aboriginal or Torres Strait Islander	63	8.8
Non-Aboriginal or Torres Strait Islander	656	91.2
Total	719	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 176 consumers

The proportion of Aboriginal and Torres Strait Islander HASI participants has increased since the Stage 1 evaluation, when only four per cent of consumers were Aboriginal or Torres Strait Islanders and their exit rate from HASI was higher than other consumers. All five Aboriginal people interviewed for the current evaluation remained in the program from 2009 to 2010. Exit data showed that 27.1 per cent of the Aboriginal or Torres Strait Islander



consumers exited HASI between January 2007 and June 2009. This exit rate is still higher than that of other consumers (17.7 per cent,  $p < 0.05$ ) (Section 8).

Eight per cent of HASI consumers spoke a language other than English at home (Table 5.4), which is an under-representation compared to the Australian population with mental health and behavioural problems. For example, the prevalence of mental health disorders among people born in non-English speaking countries was 12.6 per cent (Slade et al., 2009: 7).<sup>10</sup> The under-representation has not improved since the Stage 1 evaluation.

**Table 5.4: Language spoken at home by HASI consumers**

	Consumers	Per cent
Language other than English at home	56	7.7
English spoken at home	673	92.3
Total	729	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 166 consumers. Of the 56 consumers who speak a language other than English at home, one was also of Aboriginal and Torres Strait origin.

## 5.2 Mental health diagnosis and other co-existing conditions

All HASI consumers had at least one mental health diagnosis, the most common of which was schizophrenia (65 per cent), followed by schizo-affective disorder (11 per cent), depression/anxiety (10 per cent), and bipolar disorder (nine per cent) (Table 5.5).

**Table 5.5: Consumers' primary mental health diagnoses**

Primary mental health diagnosis	Consumers	Per cent
Schizophrenia	548	64.9
Schizo-affective disorder	91	10.8
Depression/ anxiety	83	9.8
Bipolar disorder	75	8.9
Personality disorder	19	2.2
Other	29	3.4
Total	845	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 50 consumers

The mental health diagnoses have changed slightly since the Stage 1 evaluation, which recorded a higher proportion of people with schizophrenia (75 per cent), and a lower incidence of bipolar disorder (three per cent) and

<sup>10</sup> Speaking a language other than English at home and being born in non-English speaking countries do not measure the same diversity and might partly account for the discrepancy.

depression (two per cent) (Muir et al., 2007).<sup>11</sup> This change is probably because HASI now also offers lower and medium support. In addition to the primary mental health diagnoses, more than a quarter of HASI consumers (26 per cent) had a secondary mental health diagnosis, of which the most common was depression or anxiety (Table 5.6).

**Table 5.6: Consumers' secondary mental health diagnosis**

Secondary mental health diagnosis	Consumers	Per cent
Depression/ anxiety	98	11.6
Other	61	7.2
Personality disorder	30	3.6
Schizo-affective disorder	17	2.0
Bipolar disorder	11	1.3
Schizophrenia	4	0.5
No secondary mental health diagnosis	624	73.8
Total	845	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 50 consumers

In combination with a mental health diagnosis, more than half (54 per cent) the consumers had a co-existing condition (Table 5.7). The most prevalent co-existing condition was alcohol or drug dependency (28 per cent), followed by physical health problems (12 per cent), intellectual disability (10 per cent), physical disability (five per cent), and acquired brain injury (three per cent). Some HASI consumers had more than one co-existing condition.

**Table 5.7: Consumers' co-existing conditions**

Co-existing condition	Consumers	Per cent (n=845)
Alcohol or drug dependency	238	28.2
Physical health	104	12.3
Intellectual disability	85	10.1
Other	53	6.3
Physical disability	45	5.3
Acquired brain injury	24	2.8
Total conditions <sup>1</sup>	549	-
Total consumers with at least one co-existing factor	460	54.4
Total consumers with no co-existing factors	385	45.6
Total consumers	845	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 50 consumers

1. Some consumers reported more than one condition

<sup>11</sup> It is likely that this change has occurred because of the increase in the number of people with low and medium level support requirements.

These conditions have an impact on the type of accommodation support and other services that HASI consumers need, including drug and alcohol services and specialist disability support (Section 7).

Some housing managers were concerned that they could not refer existing tenants who were at risk of eviction or who exhibited troubled or disturbing behaviour in their housing setting, but who were not linked to mental health services. They suggested that HASI-like services would be of great value for a wider group of their existing tenants who appeared to have undiagnosed mental health problems.

### 5.3 Housing at entry to HASI

When they entered the HASI program, almost half of consumers (43 per cent) did not have stable housing and were experiencing primary, secondary or tertiary homelessness.<sup>12</sup> These consumers were living in hospital or in unstable housing: living with family or friends, without shelter or living in a boarding house (Table 5.8). Consumers and their family members said that many consumers had a longer history of homelessness and insecure housing prior to entering the program (Section 7.3).

The remaining 57 per cent of consumers had stable housing when they entered HASI (Table 5.8). They lived in public housing (41 per cent), community housing (nine per cent) or private rental (seven per cent). In addition to their housing status at entry, one quarter of all HASI consumers had a tenancy risk factor when they entered the program, as described in Table 5.10.

**Table 5.8: Consumers' type of housing at entry to HASI**

	Consumers	Per cent
Stable housing at entry to HASI		
Public housing	348	41.2
Community housing	76	9.0
Private housing	58	6.9
Total stable housing	482	57.0
Unstable housing at entry to HASI		
Hospital	138	16.3
Living with family or friends	91	10.8
Primary homelessness	22	2.6
Boarding house	18	2.1
Other	94	11.1
Total unstable housing	363	43.0
Total	845	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 50 consumers

<sup>12</sup> As defined by Chamberlain and Mackenzie (2003), who refer to primary homelessness (people who do not have access to shelter including people living on the street), secondary homelessness (people who are living in temporary accommodation such as with family or friends), and tertiary homelessness (people who have access to accommodation with insecure tenure and shared facilities, eg boarding houses) – see glossary.

The housing at entry to HASI differs between consumers who joined HASI with a higher support level and those with lower support (Table 5.9). These differences reflect the HASI eligibility criteria set out in the HASI Manual (NSW Health, 2006) (Section 7.1).

**Table 5.9: Consumers' type of housing at entry to HASI by support level**

	Lower support		Higher support	
	Consumers	Per cent	Consumers	Per cent
Stable housing at entry to HASI				
Public housing	302	56.4	46	14.8
Community housing	51	9.5	25	8.1
Private housing	42	7.9	16	5.2
Total stable housing	395	73.8	87	28.1
Unstable housing at entry to HASI				
Hospital	25	4.7	113	36.5
Living with family or friends	56	10.5	35	11.3
Primary homelessness	12	2.2	10	3.2
Boarding house	7	1.3	11	3.5
Other	40	7.5	54	17.4
Total unstable housing	140	26.2	223	71.9
Total	535	100.0	310	100.0

Source: HASI MDS September 2009 total n=895;

Note: Data missing for 50 consumers (17 lower support, 33 higher support)

Higher support HASI focuses on consumers who are experiencing moderate to severe levels of psychiatric disability, and who are homeless or at risk of homelessness. It includes consumers who are inappropriately housed or unable to leave a hospital because they have nowhere else to go or whose current housing is at risk due to lack of support, and consumers who are unlikely to be able to maintain a tenancy without HASI type support. Consistent with these criteria, 72 per cent of consumers in higher support were living in unstable housing conditions at the time of entry to HASI. Of these higher support HASI consumers in unstable housing (n=223), approximately half (50.7 per cent) lived in hospitals, and the remainder (49 per cent) lived in other unstable housing situations. Nearly a quarter (23 per cent) of higher support HASI consumers lived in social housing (public or community) before entering HASI.

Lower support HASI is targeted to consumers with a mental illness who can function at a high level most of the time, and who would generally already have housing, but who may be at risk of being unable to maintain their housing without support. At entry to HASI, 74 per cent of lower support HASI consumers fit the expectation that they would already have a home, with 89 per cent of these living in social housing. However, over one quarter (26 per cent) of all lower support HASI consumers did not fit these criteria and were experiencing primary, secondary or tertiary homelessness<sup>13</sup> at entry to HASI. The process for accessing stable housing for higher and lower support consumers without housing, is discussed in Section 7.1.

<sup>13</sup> Ibid

When consumers enter HASI, ASP workers record past housing experiences that might indicate a risk to future stable housing for each consumer.<sup>14</sup> One quarter (25 per cent) of HASI consumers had a tenancy risk factor when they entered the program (Table 5.10). The greater incidence of tenancy risk factors was for consumers on higher HASI support – almost a third had at least one tenancy risk factor (28 per cent).

**Table 5.10: Tenancy risk factors at entry to HASI by HASI support level**

	Support level (per cent)		
	Lower (n=546)	Higher (n=339)	Total (n=885)
No tenancy risk factor	76.7	71.7	74.8
At least one tenancy risk factor	23.3	28.3	25.2
Total	100.0	100.0	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 10 consumers. Difference between groups is statistically significant ( $p < .05$ )

It is surprising that the assessed incidence of tenancy risk<sup>15</sup> factors at entry to HASI was not higher, given that one of the primary aims of HASI is to support people to maintain or move into secure housing. This suggests that the assessment data are incomplete (footnote 13), as 43 per cent of consumers did not have stable housing at the time they entered HASI (Table 5.8), as confirmed in consumer interviews. In addition, 50.2 per cent of consumers were already in public or community housing at the time they entered HASI. A primary focus of HASI for existing social housing tenants was to assist consumers who were at risk of being unable to sustain their tenancies, and consumers were referred to HASI on this basis. In these circumstances, it is likely that the tenancy risk data underreported the actual risk faced by HASI consumers. It suggests that reviewing how the ASP staff collect HASI assessment data, with greater involvement from NSW Housing and Health staff could improve data quality.

The most common risk factor was homelessness (12 per cent of consumers) (Table 5.11). Other risk factors included previous instances of high housing turnover (10 per cent), complaints from neighbours (8 per cent), and previous applications by the tenancy manager to the Consumer Trader and Tenancy Tribunal (CTTT, 2 per cent).

<sup>14</sup> Tenancy risk factors – Consumers' unstable housing experiences before HASI that might indicate risk to future stable housing, including periods of homelessness, high housing turnover, complaints from neighbours or other community members and applications for orders to CTTT.

<sup>15</sup> Some ASP staff said the way these data were collected was inconsistent and probably underreported risk factors. The data should therefore be interpreted with caution. For example, some ASPs reported tenancy risk as minimal if consumers had access to support services.

**Table 5.11: Type of tenancy risk factor at entry to HASI**

	Number of people with each risk factor	Per cent (n=885)
Periods of homelessness	107	12.1
High housing turnover	88	9.9
Complaints from neighbours or others	75	8.5
Applications for orders to CTTT	14	1.6
Total incidence of risk factors <sup>1</sup>	284	
Total consumers with at least one tenancy risk factor <sup>1</sup>	223	25.2
Total consumers with no tenancy risk factor	662	74.8
Total consumers	885	100.0

Source: HASI MDS September 2009 n=895

Note: 1. Some consumers had more than one risk factor. The 223 consumers who had a tenancy risk factor experienced a total of 284 risk factors.  
Data missing for 10 consumers

#### 5.4 Discussion about the findings

HASI is assisting its intended target group of people with mental health problems who require accommodation support to participate in the community. With the possible exception of people from culturally and linguistically diverse backgrounds, HASI consumers are representative of mental health consumers in key demographic characteristics. Women and Aboriginal and Torres Strait Islander people are better represented among current HASI consumers than they were at the time of the evaluation of Stage 1. All consumers have at least one mental health diagnosis, and many also have a secondary diagnosis or other co-existing condition.

At least one quarter of consumers had a history of tenancy risk factors including homelessness and high housing turnover. However it is likely that the level of housing difficulty for consumers using HASI is higher than this suggests. Almost half (43 per cent) of consumers did not have stable housing when they entered HASI, and most consumers who did have housing were referred to HASI at least partly with the aim of supporting them to sustain their tenancies.

Consistent with the differences in eligibility criteria for higher and lower support HASI, most higher support consumers (72 per cent) had been living in unstable housing situations when they entered HASI, and most lower support consumers (74 per cent) had stable housing. Most lower support consumers (66 per cent) lived in social housing. However, over one quarter (26 per cent) of all consumers entering lower support did not fit these program expectations and were experiencing primary, secondary or tertiary homelessness at the time they entered HASI (discussed further in Section 7.1).

## 5.5 Summary of profile of HASI consumers

- The profile of consumers shows that slightly more men than women were in the HASI program and the median age of current consumers was 40 years old.
- Nine per cent of consumers identified as Aboriginal or Torres Strait Islander. This is higher than in the NSW population and people with mental health problems in the community, which indicates that HASI has succeeded in recruiting to the program.
- Eight per cent of consumers spoke a language other than English as their main language at home, which is still lower than in the NSW population and people with mental ill health in the community. It might be a focus for improving the way HASI is delivered.
- The most common HASI consumers' mental health diagnosis was schizophrenia (65 per cent). One quarter (26 per cent) of consumers had a secondary diagnosis of which the most prevalent was depression and anxiety.
- More than half (54 per cent) of current consumers had a co-existing condition. The most prevalent condition was alcohol or drug dependency (28 per cent), followed by physical health problems (12 per cent) and intellectual disability (10 per cent).
- More than one third (43 per cent) of consumers were in hospital or had unstable housing when they entered HASI. A greater proportion of higher support consumers had unstable housing when they entered (72 per cent), than lower support consumers (26 per cent), which is consistent with the eligibility criteria.

## 6 Consumer outcomes

The HASI program aims to assist consumers to improve mental and physical health, achieve stable housing and improve social connections and community participation. This section examines the extent to which the HASI program meets these objectives.<sup>16</sup>

### 6.1 Mental and physical health

The evaluation analysed specific measures of change in mental and physical health: mental health hospital admissions; mental health outcomes and assessment measures (MH-OAT) (psychological distress – K10; life skills – LSP16; and behaviour – HoNOS); non-clinical measures of consumers' and workers' views of physical and mental health status; and use of other health services, including community mental health. The results of each of these measures are presented below and summarised at the end of the section.

Foremost, HASI aims to assist people to improve their quality of life through addressing their mental and physical health needs. A high support HASI consumer summed up the impact of the HASI program on her life:

I can't really explain how much [the ASP] have done for me. I was everyday trying to think of ways to kill myself. Now, I don't want to die. It's just a really big difference.

#### Mental health hospital admissions

The change in consumers' mental health hospital admissions since joining the program is an important mental health outcome measure. This was the strongest positive indicator of the impact of the program in the HASI Stage 1 evaluation in 2007.

Data were available for HASI consumers two years prior to joining HASI and who had been in the program for approximately two years (n=197).<sup>17,18</sup> The results discussed here start with analysing the before and during HASI change in the number of admissions and days in hospital (length of stay) and differences between women and men, consumers receiving higher and lower HASI support and from various age groups. This before and during HASI change analysis illustrates the overall impact of the HASI intervention on hospitalisation.

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<sup>16</sup> The information in this section is from the sources described in Appendix 1. The samples are compared in Table 4.2.

<sup>17</sup> Data were available for a subset of consumers who had been in HASI between one and two years (n=197). We annualised their data to create consistent comparison periods between consumers.

<sup>18</sup> Analysis was conducted about all people who had at least one mental health inpatient admission over the four year period. Consumers who did not have an admission were excluded from the analysis because we could not verify whether these data were missing or whether the consumers had no admissions.



Second, the section discusses a longitudinal analysis over the two years before consumers enter HASI and their first two years during HASI of the number of admissions and days in hospital and differences between women and men, HASI support levels and age groups. This longitudinal analysis demonstrates the different patterns of hospitalisation in the lead up to entry to HASI and the changes during the first and second year in HASI. Appendix 3 includes detailed results about length of stay, all hospital admissions and emergency department presentations (Appendix 3, Sections D, E and F respectively).<sup>19</sup>

#### *Change in mental health hospitalisation since joining HASI*

HASI consumers had significantly fewer mental health inpatient hospital admissions after joining HASI (24 per cent decrease; Table 6.1). The average number of days spent in hospital per year also decreased (59 per cent), and the average number of days hospitalised per admission decreased (68 per cent).

**Table 6.1: Comparison of change in mental health inpatient hospitalisations between Whole of HASI 2009 and HASI Stage 1 Evaluation 2007**

	Whole of HASI		Per cent change since joining HASI	
	Before HASI <sup>1</sup>	During HASI <sup>2</sup>	Whole of HASI	Stage 1 (n=67)
Average number of admissions per person per year	1.7	1.3	-24.0**	-17
Average number of days in hospital per person per year	54.7	22.5	-58.9***	-81
Average number of days per admission <sup>3</sup>	6.3	2.1	-68.0***	-78

Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009 n=197; (Muir et al., 2007)

Notes: \*\* p<0.05, \*\*\*p<0.001 Sig. 2-tailed, from paired sample t-test of means across two periods

1. Average number of admissions and days per person in their two years prior to joining HASI

2. Average number of admissions and days per person in their first two years in HASI

3. The averages do not sum to the same total because the computation of the average number of admissions per person per year and the average number of days in hospital per person per year counted all consumers with valid inpatient data, including consumers who did not have a hospital admission in the respective period but recorded 'valid zero admissions.' When calculating the average number of days per admission, only consumers who had at least one admission in the respective period were counted, hence the average number of days per admission is not the result of the mathematical division of the average number of days per year spent in hospital by the average number of admissions per person.

<sup>19</sup> Analysis of data about all hospital admissions, which includes all emergency department presentations, acute admissions, general admissions and mental health admissions are included in Appendix 3. They show similar trends to those described in this section. This section focuses on inpatient admissions to hospital in which the reason for admission was mental health.

These decreased mental health inpatient admissions and days in hospital are overwhelmingly positive. They differ slightly from the HASI Stage 1 2007 evaluation – the current sample had a larger decrease in the number of hospital admissions per year, but smaller decreases in the days in hospital per person and the days in hospital per admission. Explanations for the smaller decrease in days in hospital include: consumers with lower support needs are now in HASI; hospitalisations during the program are more likely to be short admissions; and it could also be due simply to the more reliable larger sample size.

The decrease in the time HASI consumers spent in hospital resulted in a drop in hospital expenditure on these consumers. An estimate of the change in the mental health inpatient hospitalisation cost to the NSW government on all HASI consumers is a decrease from over \$51 million per year before they entered HASI to just under \$21 million while they were in HASI (Table 6.2; annualised days per person in the two years before and during HASI and applying 2009/10 mental health acute inpatient hospitalisation costs).

In 2009/10 dollars, the estimate reflects hospital dollars avoided for HASI consumers by participating in the program. If these figures are estimated across the total HASI consumers, over \$30 million per year has potentially been avoided on the hospitalisation of HASI consumers, thereby increasing capacity for other patients. These are costs avoided for these consumers rather than costs saved by NSW Health.

**Table 6.2: Estimated cost of mental health inpatient hospitalisations annualised for 2 years before and during HASI applying 2009/10 costs (\$)**

	Before HASI	During HASI	Cost avoided
Average cost per person per year	47,425	19,508	27,917
Average cost per admission	5,462	1,821	3,641
Total cost per year for all HASI consumers (1076)	51,029,192	20,990,070	30,039,122

Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009  
n=197

Notes: Estimated from mental health inpatient hospitalisation data Table 6.1. Cost data from NSW Health: acute admissions adjusted average bed day cost \$867 2009/10 (adjusted to include overhead and indirect costs) average length of stay 15.2 days

The decreases in mental health inpatient days and admissions are similar for all consumers, but with some variations, when analysed by gender, support level<sup>20</sup> and age<sup>21</sup> (inpatient days: Table 6.3 and Figure 6.5; admissions: Table 6.4 and Figure 6.6).

<sup>20</sup> Lower support includes HASI low and medium support packages; and higher support includes HASI high and very high support packages.

<sup>21</sup> Age was calculated as at each consumer's HASI start date, which was the date when they first received an intervention.

Greater decreases in the average number of mental health inpatient days were experienced by men (70.4 per cent decrease; women 38.1 per cent decrease); higher support consumers (62.1 per cent decrease; lower support consumers 52.4 per cent decrease), and younger consumers aged 18-44 years (18-29 years old 72.2 per cent decrease; 30-44 years old 64.5 per cent decrease; and consumers aged 45-64 years the change was not statistically significant) (Table 6.3 and Figure 6.5).

**Table 6.3: Change in average number of mental health inpatient days per person per year before and during HASI, by gender, level of support and age**

Consumers	Mental health inpatient days		Change in mental health inpatient days									
			Before HASI	During HASI	Sig. <sup>b</sup>	Mean change (days)	Mean change (%)	Standard deviation	95% confidence interval for mean		Sig.	
Number	Per cent								Lower bound	Upper bound		
All	197					-32.2		70.9				
Men	116	58.9	59.2	17.5	0.000	-41.7	-70.4	73.7	-43.4	-3.3		
Women	81	41.1	48.3	29.8	0.012	-18.4	-38.1	64.7	-42.9	-3.7		.023 <sup>a</sup>
Sig. <sup>a</sup>			.288	.036								
Higher support	109	55.3	65.5	24.8	0.000	-40.7	-62.1	74.5	-38.9	1.0		
Lower support	88	44.7	41.4	19.7	0.002	-21.7	-52.4	65.1	-38.6	0.7		.062 <sup>a</sup>
Sig. <sup>a</sup>			0.017	0.386								
18-29 years	47	23.9	68.4	19.0	0.000	-49.4	-72.2	71.2	-70.3	-28.5		
30-44 years	87	44.2	58.9	20.9	0.000	-38.0	-64.5	76.8	-54.4	-21.6		
45-64 years	58	29.4	39.4	25.8	0.075	-13.6	-34.5	57.2	-28.6	1.4		.021 <sup>b</sup>
65+ years*	5	2.5	31.3	46.9	0.518	15.6	+49.8	49.4	-45.7	77.0		
Sig. <sup>c</sup>			0.148	0.455								

Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009 n=197

Notes: a: Independent sample t-test; b: Paired sample t-test; c: One way ANOVA

\*The 65+ years age group sample is small so the statistics obtained from this group are not reliable. This group is not included in the Figures of the mental health hospitalisations.

Greater decreases in the average number of mental health inpatient admissions were experienced by men (40 per cent decrease; women, the decrease was not significant); lower support consumers (33.3 per cent decrease; 17.6 per cent decrease higher support consumers); and younger consumers aged 18-44 years (42.9 and 23.5 per cent decrease for 18-29 and 30-44 year olds respectively; consumers aged 45-64 years the decrease was not significant) (Table 6.4 and Figure 6.6).

**Table 6.4: Change in average number of mental health inpatient admissions per person per year before and during HASI, by gender, level of support and age**

Consumers	Mental health inpatient admissions		Change in mental health inpatient admissions								
	Number	Per cent	Before HASI	During HASI	Sig. <sup>2</sup>	Mean change (admissions)	Mean change (%)	Std. dev.	95% confidence interval for mean		Sig.
									Lower bound	Upper bound	
All	197					-0.4		1.9			
Men	116	58.9	1.5	0.9	0.000	-0.6	-40.0	1.5	-1.0	0.1	0.110 <sup>1</sup>
Women	81	41.1	2.0	1.9	0.477	-0.2	-10.0	2.4	-1.0	0.1	
			0.048	0.001							
Higher support	109	55.3	1.7	1.4	0.089	-0.3	-17.6	1.8	-0.2	0.9	0.225 <sup>1</sup>
Lower support	88	44.7	1.8	1.2	0.005	-0.6	-33.3	2.0	-0.2	0.9	
			0.777	0.357							
18-29 years	47	23.9	2.1	1.2	0.003	-0.9	-42.9	2.0	-1.5	-0.3	0.152 <sup>2,4</sup>
30-44 years	87	44.2	1.7	1.3	0.024	-0.4	-23.5	1.6	-0.7	-0.1	
45-64 years	58	29.4	1.6	1.5	0.753	-0.1	-6.3	2.3	-0.7	0.5	
65+ years*	5	2.5	1.7	0.8	0.298	-0.4	23.5	1.7	-3.0	1.2	
			0.417	0.845							

Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009.

Notes: 1: Independent sample t-test; 2: Paired sample t-test; 3: One way ANOVA; 4: effect size .026

\*The 65+ age group is under represented and the statistics obtained from this group are not reliable; this group is not included in the graphic representation of mental health hospitalisations

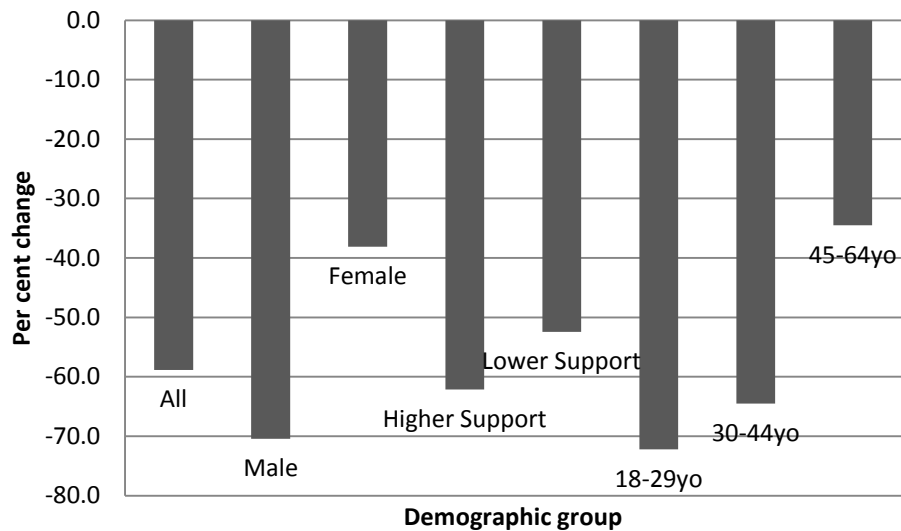
Before joining HASI, men had more mental health inpatient days per year on average than women, which reversed after joining HASI, when men used fewer days than women (Table 6.3). The women's number of admissions remained slightly higher than men (Table 6.4).

The decrease in days per year was greater for higher support consumers than lower support consumers (Table 6.3), yet the decrease in number of admissions per year was greatest for lower support consumers (Table 6.4).<sup>22</sup>

<sup>22</sup> While the change in the average number of days spent in mental health units is statistically significant for the two groups of higher and lower support consumers, and the change in the average number of admissions is statistically significant for consumers in lower support, the differences between groups both in terms of average number of

These differences between lower and higher support consumers are consistent with less mental health complexity for lower support consumers and more frequent, short hospital stays for higher support consumers. The difference between the number of days and admissions by age group was not significant before or during HASI, although the decrease during HASI for younger consumers was significant.

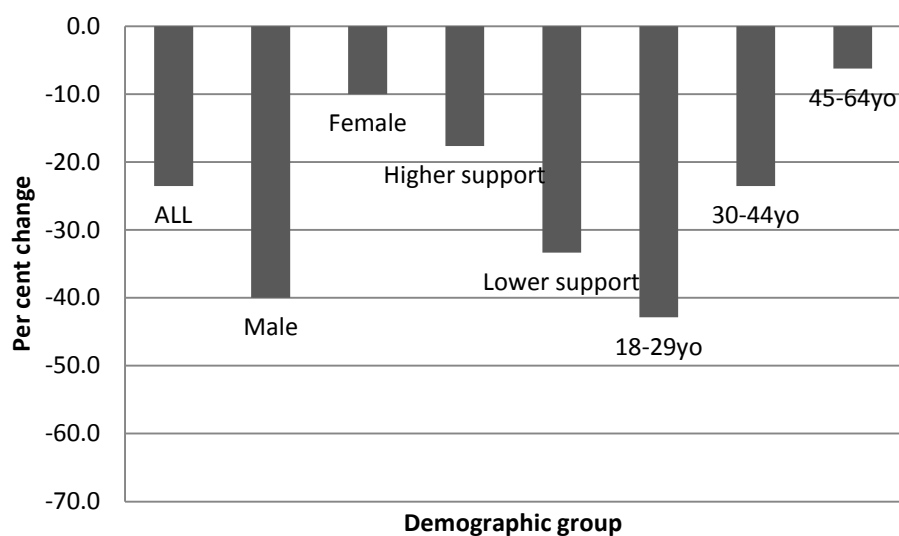
**Figure 6.5: Percentage change in the average number of mental health inpatient days per person per year before and during HASI**



Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009 n=197. Note: Age was calculated as at each consumer's HASI start date, which was the date when they first received an intervention.

admissions per year and the average number of days spent in mental health units are not statistically significant, except days per year before HASI.

**Figure 6.6: Percentage change in average number of mental health inpatient admissions per person per year before and during HASI, by gender, level of support and age**



Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009.

#### *Longitudinal analysis of mental health hospitalisation 2 years before HASI and first 2 years during HASI*

The decrease in number of admissions and length of stay are also sustained over time.<sup>23</sup> The longitudinal analysis of mental health hospital admissions showed that people experienced an increase in the mean number of hospital admissions during the 2 years before HASI (Years 1-2) (Table 6.7). For example, the average number of hospital admissions per year increased from about 1.5 admissions in the 12 to 24 months prior to joining HASI to two admissions in the year before. The number of admissions per year began to decrease after consumers entered HASI so that, in the first year in HASI, the number of admissions was lower than 2 years before HASI and stabilised during the second year during HASI.

<sup>23</sup> We used unit-record data to examine the average yearly use of mental health admissions across a four year period. The four years include annualised data for the two years immediately prior to joining HASI (13-24 months before HASI and 0-12 months before HASI) and two years immediately after joining HASI (0-12 months in HASI and 13-24 months in HASI). To simplify the explanations in this section, 13-24 months prior to joining HASI is referred to as Year 1, 0-12 months prior to joining HASI is referred to as Year 2, 0-12 months in HASI is labelled Year 3, and 13-24 months in HASI is described as Year 4.

**Table 6.7: Mean number of mental health inpatient admissions for two years prior and first two years of HASI per person per year by gender, level of support and age**

	Consumers	Last 2 years before HASI		First 2 years during HASI		Sig. <sup>1</sup>	Effect size <sup>2</sup>
		13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4		
Men	116	1.4	1.6	0.9	0.9	0.000	0.194
Women	81	1.6	2.5	1.9	1.9	0.027	0.110
Sig.		0.655	0.009	0.003	0.006		
Higher support	109	1.5	1.9	1.3	1.5	0.011	0.100
Lower support	88	1.5	2.1	1.4	1.0	0.008	0.129
Sig.		0.988	0.678	0.845	0.119		
18-29 years	47	2.1	2.2	1.4	1.0	0.008	0.233
30-44 years	87	1.2	2.1	1.3	1.2	0.007	0.133
45-64 years	58	1.5	1.6	1.3	1.6	0.594	0.034
65+ years	5	1.0	2.4	0.8	0.8	0.534	0.601
Sig. <sup>3</sup>		0.162	0.555	0.954	0.675		
Total	197	1.5	2.0	1.3	1.3	0.000	0.103

Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data July 1999-June 2009 n=197

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA  
2. Partial eta squared  
3. One-way between-groups ANOVA

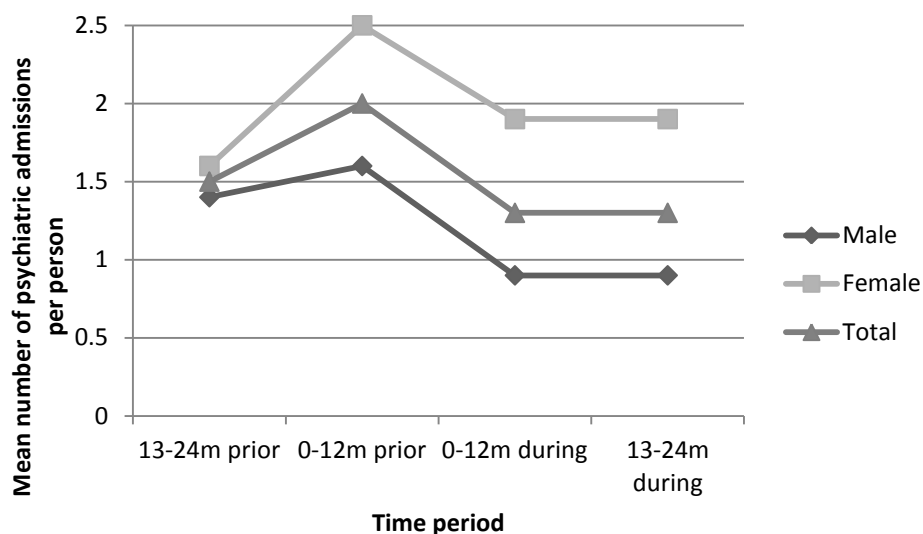
This suggests that many consumers enter HASI when they reach a crisis. For some consumers, hospitalisation facilitates the referral to HASI, when some consumers are open to participating in HASI. One inpatient clinician who referred consumers to HASI explained these factors:

... what we do here, we often identify people who would benefit from HASI ... it's all about timing, often when people are first in the unit for example, they're acutely unwell and they're not in any position to talk about making plans or decisions, so we often wait 'til they're on the way to recovery, chat with them about whether they see a bit of help as being helpful, they often say yes ... we make a referral to HASI ...

The analysis of changes in mental health inpatient admissions and length of stay by gender, level of support and age over the two years prior and first two years during HASI shows similar reductions for all groups, although the effect size varies within groups (Table 6.7 to Figure 6.10).

Men and women had different patterns of mental health inpatient use over time. Women were admitted to hospital more regularly than men over all four years and after joining HASI, women continued to be admitted to hospital more often than they did two years before HASI (Table 6.7). Nonetheless, both men and women reached a stable level of annual hospital admissions during HASI and used mental health inpatient services significantly less often than the year prior to HASI (Table 6.7; Figure 6.8).

**Figure 6.8: Mean number of mental health admissions for two years prior and first two years of HASI per person, per year by gender**



Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data July 1999-June 2009 n=197

Note: The effect size for men was largest, while the overall effect size and the effect size for women are medium-high. According to Cohen (1988) a .01 eta squared indicates a small effect size, .06 a medium effect size and more than 0.14 a large effect size.

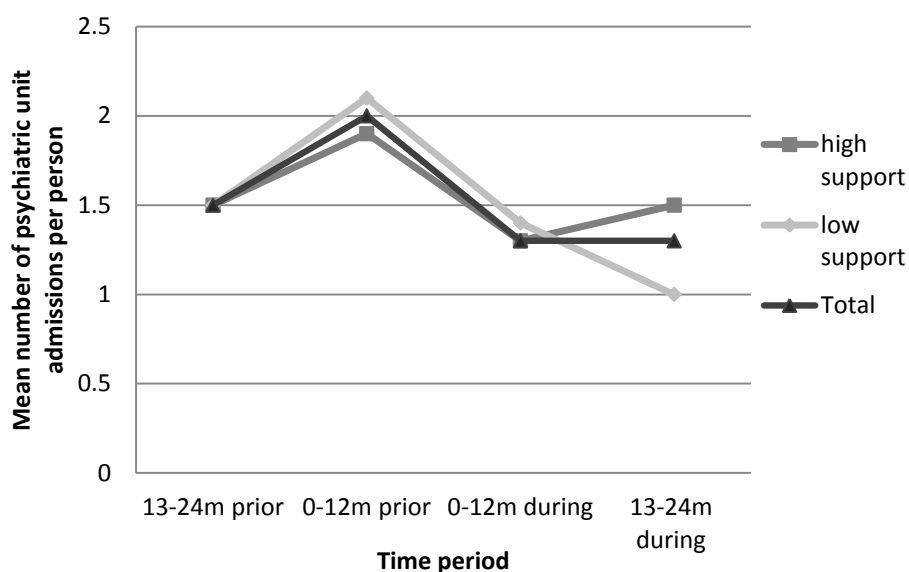
Women spent less time (fewer days) in hospital than men in the two years prior to joining HASI (Appendix 3, Table E.4). This trend reverses once consumers enter HASI and women begin to spend slightly more time in hospital than men in the first year of HASI. The number of days per admission increased during the year prior to HASI for both men and women. Both men and women experienced a sharp decrease in the number of days per admission after entering the program. This indicates that people continue to spend fewer days in hospital while in the program (Appendix 3, Table E.7).

The change in hospitalisation also differs between consumers receiving higher and lower support (Table 6.7; Figure 6.9). They had similar mental health inpatient admissions in the two years prior to HASI and the first year in HASI; that is, an initial increase in the number of admissions per person, followed by a steep decrease in admissions.

After the first year in HASI the two groups diverged. The average number of admissions for both groups remained below the rates of admission prior to HASI, but continued to decrease for consumers with lower support in the second year in HASI and slightly increased for consumers with higher support. Higher support consumers' use of hospital services climbed back to the level two years prior to joining HASI. Nevertheless, this level is less than that immediately prior to HASI and could indicate their relatively higher clinical support needs.

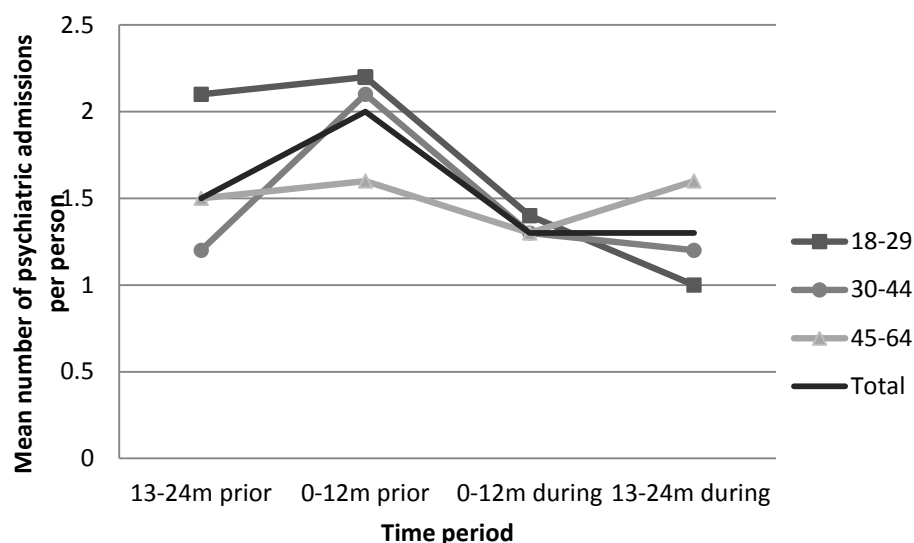


**Figure 6.9: Mean number of mental health admissions for two years prior and first two years of HASI per person per year by support level**



Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data, July 1999-June 2009 n=197.

A longitudinal analysis of the number of mental health admissions per person by age revealed changes for the four age groups (Table 6.7). Although admissions increased prior to HASI, then decreased during the first and second year of HASI for all consumers, the intensity of change varied by age (Figure 6.10). Younger consumers (aged 18-29 and 30-44 years) continued to decrease their hospital use during their second year in HASI. The number of admissions possibly increased during the second year in HASI for one age group (45-64 years) although it is not statistically significant. Hospital use for this older age group is most constant throughout the four years in terms of admissions but the age group is too small for this to be a reliable finding.

**Figure 6.10: Mean number of mental health admissions per person by age group**

Source: NSW Health, Inpatient Admissions Database July 1999-June 2009 n=197

Sustained changes in number of mental health inpatient days by support level were also similar to these admission results, showing a statistically significant decrease in the number of days spent in hospital per person (Appendix 3, Table E.6).<sup>24</sup> On average, consumers experienced a sharp increase in the number of days spent in hospital during the year prior to entering HASI. However, the change between years was not always significant.

Without a comparison group, it is not possible to know what the trajectory in length of stay days would have been for these HASI consumers had they not been accepted into the program. A longer term comparison is needed to assess this trend over time and to determine whether the spikes in the amount of time spent in hospital, which are likely to continue to happen to HASI consumers throughout their lives, are less severe than before they joined HASI.<sup>25</sup>

#### *Emergency department presentations*

Emergency department presentations are an important measure of mental health because they generally indicate use of hospital services at times of crisis. For mental health consumers, presentations to emergency departments are likely to occur more frequently if their mental health status is poor or mental health support is absent or unsuitable. The emergency presentations

<sup>24</sup> One-way repeated measures ANOVA test of change in yearly averages across the four year period.

<sup>25</sup> Using the SUPI, it would be possible to follow consumers over time to explore this question.

data were analysed in the same ways as the above mental health inpatient data (before and during HASI; longitudinal analysis of two years before HASI and two years during; number of presentations; number of hours; variation by gender, level of support and age).

The findings about emergency presentations were similar to the inpatient findings – the mean annual number of presentations per person and the total hours per year spent in the emergency department were highest in the year prior to joining HASI and decreased during the first and second year during HASI (Appendix 3, Tables F.4, F.5).<sup>26</sup>

#### *Other hospitalisation results*

Consumer comments reinforced the results from the hospital admission and length of stay data analysis. Most consumers said they had experienced improvements in their mental health and they attributed part of this change to the fact that ASP support workers were in regular contact with them, which helped them to manage their health and to stay out of hospital. For example, the following comments were made by four consumers of various support levels:

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.

They've been saying I've been doing good. I haven't been in hospital for about four years now.

Since I've been in HASI? No, I haven't been in a hospital for nearly two years.

I go up and down but especially with their support there's definitely been less admissions. There's still being dragged off by police or by ambulance to ED but there's been less admissions and if there is an admission it's less time. It's been the three of them, HASI, my psychologist and RAFT.<sup>27</sup> About HASI, because I don't have family support and friends nearby, it's that having those three days when I'm going to see someone that helps.

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<sup>26</sup> The mean number of hours per presentation followed a similar pattern for the two years prior to HASI and the first year during HASI and slightly increased during the second year in HASI. The increase is likely to be due only to the methodological approach – hours per admission includes only the consumers with an admission in the 12-month period, and in their second year of HASI only 25 per cent of consumers still had any emergency department presentations (Appendix 3, Table F.6).

<sup>27</sup> Recovery and Assertive Follow-up Team

## Psychological distress

Three clinical measures of mental health were analysed for mental health outcomes (K10, HoNOS and LSP16).<sup>28</sup> All measures were taken from 13 week review data.<sup>29</sup>

Consumers' level of psychological distress decreased on average after joining the program, as measured by the Kessler 10 score, for consumers with available data (K10; Appendix 1) (Table 6.11; Table 6.12).<sup>30</sup> A lower K10 score indicates improvement.

**Table 6.11: K10 psychological distress scores before and during HASI**

Distress level	K10 scores <sup>a</sup>	Mean score		Per cent		Sig <sup>b</sup>
		Before HASI	During HASI	Before HASI	During HASI	
None	10-19	14.1	13.6	44.6	48.3	.402
Mild	20-24	22.2	22.1	14.5	22.3	.037
Moderate	25-29	27.1	27.3	13.6	9.5	.184
Severe	30-50	36.5	37.3	27.3	19.8	.027

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=242

Notes: Consumers were included in this analysis if they had at least two valid scores at a 13 week review (one before and during HASI). Consumers who met this criterion had an average of nine scores available per person.

a. Levels of distress are those defined by AMHOCN <http://amhocn.org/>

b. McNemar Test

c. Repeated sample t-test for equality of means

<sup>28</sup> Details of the samples and limitations are described in Appendix 1. Valid data on HoNOS, LSP 16 and K10 was available for 204, 291 and 242 consumers respectively, summing to a total of 337 consumers with some mental health evaluation data. K10 and LSP 16 data were available for 199 (59.1 per cent) consumers, K10 and HoNOS for 152 (45.1 per cent) and LSP 16 and HoNOS for 201 (59.6 per cent) consumers. Overall, for 138 consumers (or 59.1 per cent of the sample with some mental health evaluation data) all three measures were valid. A K10 item score from 1 to 5 is considered valid, and a valid total K10 score is a score from 10 to 50 for which at least 9 out of 10 items have valid item scores. At the item level a valid HoNOS score is from 0 to 4, and at least 10 out of 12 items must have valid item scores for the total HoNOS score to be considered valid. 14 out of 16 LSP item scores must be valid (0 to 3) for a valid total LSP-16 score.

<sup>29</sup> This is the standard mandatory review to be conducted at intervals of 13 weeks (three months) in all mental health service settings as identified under Standard 11.3.17 in the National Standards for Mental Health Services as the routine clinical review interval. It is also the standard interval for the collection of outcomes and casemix data identified under the National Information Strategies and Priorities. (Your guide to MH-OAT. Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools, NSW Health 2001).

<sup>30</sup> The sample of consumers with valid K10 scores both before and during HASI (n=242) is relatively small when analysed by level of distress, for some groups (medium distress and high distress before HASI) the size of the sample falls under 60, reducing the statistical significance of tests.

Before joining HASI, almost a third of the consumers had mild and moderate psychological distress, and about the same percentage had severe levels of psychological distress (Table 6.11).<sup>31</sup> Fewer consumers had high levels of psychological distress after joining HASI and more consumers had low or no distress.

The reduction in psychological distress is reflected in the small but statistically significant decrease in average scores after consumers entered the program (Table 6.12).<sup>32</sup>

**Table 6.12: Mean and median K10 scores before HASI and during HASI**

	Before HASI	During HASI	Change in score
Mean score***	23.2	21.5	-1.7
Median score	22.0	20.0	-2.0

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=242

Note: \*\*\* p<0.001, Paired sample t-test of equality of means

Changes in mean scores within and between demographic groups (by gender, support package and age group) were analysed for statistically significant change. Consumers who improved, deteriorated or did not change were then flagged through the Effect Size (ES) approach (AMHOCN, 2008; Eisen et al., 2007) and results are summarized in Table 6.12.

Men and women's distress improved (decreased) during HASI as measured by K10 (Table 6.13). Women had higher distress than men and men's improvement was slightly larger and almost statistically significant (men's mean K10 score before HASI was 21.5 and women 25.2; and during HASI – men 19.7 and women 23.8; within group differences were statistically significant).<sup>33</sup> This gender difference is consistent with the inpatient results.

Consumers in lower support packages improved (lower K10 scores) more than higher support consumers (change and difference were statistically significant); as was the change for consumers aged 30-44 years and 45-64 years.

<sup>31</sup> Each K10 item is rated 1-5 with 1 being least severe and 5 most severe resulting into a total K10 score of 10 to 50. The ABS acknowledges various cut-off points for levels of psychological distress using the K10 score. The cut-off points used in this study follow the model provided by in the ABS 2001 Victorian Population Health Survey and AMHOCN to estimate the prevalence of levels of psychological distress: 10-19 Likely to be well; 20-24 Likely to have a mild disorder; 25-29 Likely to have a moderate mental disorder; 30-50 Likely to have a severe mental disorder. (<http://amhocn.org/>)

<sup>32</sup> The change is smaller than in the evaluation of HASI Stage 1, but that is to be expected given lower reliability of the small sample size in the first evaluation (12 consumers in Stage 1; 242 in this evaluation) and because HASI now includes a mix of support levels whereas Stage 1 was only HASI high support.

<sup>33</sup> The mean scores both before and during HASI are not different for groups of consumers by support level or age.

**Table 6.13: Mean K10 score and clinical change in scores before and during HASI by gender, level of support and age**

	Consumers		Mean K10 score		Sig <sup>1</sup>	Change in K10 (per cent) <sup>4</sup>		
	Number	Per cent	Before	During		Improve	Worse	No change
All	242		23.2	21.5		37.2	23.1	39.7
Men	136	56.2	21.5	19.7	0.051	35.3	21.3	43.4
Women	106	43.8	25.2	23.8	0.191	39.6	25.2	34.9
Sig <sup>2</sup>			0.004	0.001				
Higher support	125	51.7	22.9	21.4	0.172	36.8	26.4	36.8
Lower support	117	48.3	23.5	21.6	0.050	37.6	19.7	42.7
Sig <sup>2</sup>			0.652	0.937				
18-29 years	55	22.7	21.5	22.7	0.377	34.5	32.7	32.7
30-44 years	100	41.3	23.9	21.5	0.037	40.0	23.0	37.0
45-64 years	82	33.9	23.4	20.6	0.022	35.4	17.1	47.6
65+ years*	5	2.1	23.2	22	0.822	40.0	20.0	40.0
Sig <sup>3</sup>			0.54	0.657				
Effect size			0.009	0.006				

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=242

Notes: 1. paired sample t-test; 2. independent sample t-test; 3. One Way ANOVA; 4. Change in K10 scores was assessed using the Effect Size approach (MH-OAT); the effect size of change (small, medium or large) was assessed at an individual level, then grouped by representative demographics. Effect sizes larger than 0.5 and smaller than -0.5 are considered high enough for significant change in mental health measures such as K10 (Eisen et.al, 2007).

\*The 65+ age group is under represented and the statistics obtained from this group are not reliable; however the size of the sample is not important within the effect size approach, hence the identified change is reliable even for the small sample of 5 consumers aged 65 or more.

Using the ES approach the individual changes in K10 scores for each consumer were analysed (Table 6.13). It was then possible to create a demographic profile of consumers for whom HASI has been more beneficial.<sup>34</sup> We differentiated between consumers that improved, worsened, and did not

<sup>34</sup> The group statistics above inform general variations within a group of consumers before and during HASI, but not all consumers changed at the same pace. Three methods to assess change following mental health support are: reliable change index (RCI), effect size (ES) and standard error of measurement (SEM). For the purpose of this analysis the effect size approach was applied to the sample of consumers who participated in HASI, making results comparable to similar populations discussed in general MH-OAT reports. Effect size is based on the ratio of the difference between baseline and follow-up scores to the standard deviation of the baseline score. Unlike significance test, effect size is independent of sample size; [...] Because they provide standardized measures of change, effect sizes can be used as benchmarks for understanding changes in health status' (Eisen et al., 2007:273-274). The change in psychological distress was assessed at individual level as the difference in score before and during HASI divided by the standard deviation for the entire sample in the period of measurement prior to intervention (i.e. before joining HASI). These differences were also analysed at group level by gender, support level and age.

change in terms of mental health status as measured through K10. The psychological distress of more than one third (37.2 per cent) of HASI consumers improved during HASI, 23.1 per cent were slightly worse than before HASI and 39.7 did not change.

Between 35 and 40 per cent of consumers improved when analysed by demographics using the ES approach: slightly more women (39.6 per cent) than men (35.3 per cent) improved; similar results for consumers in lower support (37.6 per cent) and higher support (36.8 per cent); more improvement for 30-44 year olds (40 per cent) and 65 plus year olds (40 per cent) compared to younger and middle aged consumers (35 per cent). Interestingly, ratios of 'no change' had wider gaps by age than by any other demographic. HASI seems to have been less successful in changing the K10 scores of 45-64 year olds (almost half of this demographic group did not change). Nevertheless, the group with the biggest better and worse variations was the 18-29 year olds: 34.5 per cent improved, 32.7 per cent became worse in terms of K10 scores, indicating that the younger group of consumers was also the most sensitive to change.

Consumers receiving higher support packages also seem slightly more sensitive to becoming worse off in terms of K10 score, although not as much as the young HASI participants. These results indicate that higher support consumers and younger consumers need more focus on their support to avoid risk of psychological distress.

### **Behaviour (HoNOS)**

The second clinical measure of change in mental health was information on the severity of problems faced by consumers in 12 common aspects of their life<sup>35</sup> using the Health of the Nation Outcome Score (HoNOS). A lower HoNOS score indicates improvement. HASI consumers improved in the 12 aspects during HASI (that is, scores decreased, Appendix 1)(Table 6.14).<sup>36</sup>

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<sup>35</sup> These problems are: aggressive behaviour, self injury, problem drinking or drug taking, cognitive problems, physical illness or disability, hallucinations or delusions, depressed mood, other mental and behavioural problems, problems with relationships, problems with activities of daily living, problems with living conditions, and problems with occupation and activities.

<sup>36</sup> The severity of each problem over the past two weeks is rated on a five point scale, and higher scores indicate that consumers have more severe problems across a broader range. The number of consumers with valid HoNOS scores both before and during HASI is 204; while the measure is reliable for the group analysed, when investigated by behavioural difficulty level the sample in each category reduces, limiting the possibilities of statistical significance test computations.

**Table 6.14: HoNOS score descriptive statistics before HASI and during HASI**

	Before HASI	During HASI	Change
Mean score***	10.8	9.8	-1.0
Median score	10.4	9.7	-0.7

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=204  
Notes: \*\*\* p<0.01, Paired sample t-test of equality of means

Some groups of consumers improved more than others (Table 6.15, statistically significant within-group changes). For example the HoNOS scores during HASI moved towards a common mean value (8.8) for both men and women, implying a greater (and statistically significant) change for women than for men. Women, lower support consumers and consumers aged 18-29 years had the greatest HoNOS improvements (statistically significant within-group changes of before and during HASI scores). None of the other groups deteriorated and change was smaller and lacked statistical significance.

**Table 6.15: Mean HoNOS score and clinical change in scores before and during HASI by gender, support level and age group**

	Consumers	Mean HoNOS score		Sig. <sup>1</sup>	Change in HoNOS (per cent) <sup>4</sup>		
		Before	During		Improve	Worse	No change
All	204				34.3	22.5	43.1
Men	109	10.6	9.8	0.126	27.5	25.7	46.8
Women	95	11.0	9.8	0.031	42.1	18.9	38.9
Sig. <sup>2</sup>	-	0.685	0.793	-			
Higher support	102	10.6	9.8	0.103	29.4	21.6	49.0
Lower support	101	11.0	9.8	0.037	39.6	22.8	37.6
Sig. <sup>2</sup>	-	0.670	0.919	-			
18-29 years	34	10.5	8.7	0.027	35.3	17.6	47.1
30-44 years	85	11.1	10.1	0.099	36.5	23.5	40.0
45-64 years	79	10.7	10.0	0.264	31.6	22.8	45.6
65+ years	6	9.3	9.5	0.924	33.3	33.3	33.3
Sig. <sup>3</sup>	-	0.808	0.563	-			

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=204

Notes: 1. Paired sample t-test of equality of means

2. Independent sample t-test of equality of means

3. One way ANOVA

4. Individual effect size was calculated for all individuals, then by demographic characteristics; a negative significant change was identified if the effect size was -0.5 or less, no significant change if the effect size was between -0.49 and 0.49 and a positive change was flagged if the effect size was 0.5 or greater.

While mental health measures like K10 and LSP-16 (discussed later) identified between-gender differences, gender differences were not noticeable in the HoNOS scale (Table 6.15). This is different from the Eager et al (2005) study, which found a significant difference in the HoNOS scores of men and women. However, women's scores improved more than men's. HoNOS



scores were not different by demographic characteristics before or during HASI.<sup>37</sup>

Analysis of change for each consumer<sup>38</sup> showed that the percentage of consumers who improved varied by demographic groups from just under 30 per cent (consumers in higher support) to over 40 per cent (women) (Table 6.15). Surprisingly, while the difference in mean HoNOS scores of the groups of men and women were not statistically different, a greater proportion of individual women than men improved in terms of this mental health measure (42.1 per cent of women as compared to only 27.5 per cent of men). The differences between consumers who worsened by support level was only slight. More men than women became worse off (25.7 per cent of men compared to only 18.9 per cent of women). Similarly, more consumers with lower support HASI improved during HASI than higher support HASI consumers. Slightly more younger consumers also had improved HoNOS scores.

### **Life skills**

The final clinical measure was the life skills of HASI consumers, which also improved since joining the program, as measured by LSP16 (Appendix 1) (Table 6.16) and interview data.<sup>39</sup> A lower LSP16 score indicates improved life skills.<sup>40</sup> Analysis of LSP16 scores for 291 people before and during HASI shows a small drop, which indicates that consumers' life skills increased since joining the program. Some consumers experienced significant changes, as analysed by change in mean scores (Table 6.16 and Table 6.16).<sup>41</sup>

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<sup>37</sup> The independent sample t-test generated p-values greater than 0.05.

<sup>38</sup> The significance of individual changes in HoNOS scores was investigated with the effect size approach (see footnote 34). The individual level effect size was calculated as the difference between the individual HoNOS scores before and during HASI.

<sup>39</sup> The number of consumers with valid LSP16 scores is relatively high compared to consumers with valid K10 or HoNOS scores. However LSP16 is a scale of 16 questions, where each question is ranked from 0 to 3, a higher number indicating a higher level of difficulty in the respective life skill. A total score is computed as the average of the 16 questions and it may range between 0 and 48. To assess the reliability of the scale for the current population, and the clinically significant change it is necessary to analyse the 16 question with respect to each other and the total score. However detailed scores by question are not available in the data set provided, hence thresholds of clinically significant changes cannot be computed and only statistical change was analysed.

<sup>40</sup> The LSP16 is designed to capture deficits in life skills and, therefore, higher scores indicate lower levels of functioning in MH-OAT data but the LSP16 can also be scored to capture consumers' strengths, in which case higher scores equate to higher levels of functioning. The extent to which these scores could be compared to the broader literature on LSP16 is limited as a consequence. See Appendix 1.

<sup>41</sup> Although some researchers argue that such a small drop is unlikely to be clinically significant (Eagar et al., 2005). Individual item results were not available within the data set provided for the purpose of this evaluation and the reliability of the scale could not be tested. However, the LSP16 scale is described in the literature to have a good consistency and reliability. Furthermore, good correlations with scores and indicators of wellness and

**Table 6.16: LSP16 score descriptive statistics before HASI and during HASI**

	Before HASI	During HASI	Change
Mean score***	11.5	10.0	-1.5
Median score	11.0	9.3	-1.7

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and during HASI n=291

Notes: \*\*\* p<0.001, Paired sample t-test of equality of means, standard deviation 6.6

Life skills for men and women improved and the difference between men and women's LSP scores before HASI disappeared during HASI (both statistically significant) (Table 6.16). Men recorded poorer scores than women, both before and during HASI on the LSP16. This experience was opposite to the K10 results – women had more psychological distress and better life skills than men.<sup>42</sup>

Life skills improvements were greatest for consumers on lower HASI support and the 30-44 year age group. Before HASI, consumers from lower and higher support groups had similar LSP16 scores (not statistically different) and during HASI the difference widened but remained not statistically significant. The improvement for lower support consumers was statistically significant.

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illness suggested the validity of the scale as a mental health measure (Network of Alcohol and Other Drugs Agencies, 2009).

<sup>42</sup> A similar finding was noted by Eagar et al (2005) in their analysis of HoNOS and LSP16 data collected by clinicians in New Zealand over a six-month period.

**Table 6.17: Mean LSP16 score and clinical change in scores before and during HASI by gender, support level and age group**

	Consumer s	Mean LSP16 score			Change in LSP16 (per cent) <sup>5</sup>		
		Before	During	Sig. <sup>1</sup>	Improve	Worse	No change
All	291				40.9	19.6	39.5
Men	154	12.3	10.4	0.002	40.3	18.8	40.9
Women	137	10.6	9.5	0.041	41.6	20.4	38.0
Sig. <sup>2</sup>	-	0.023	0.323	-			
Higher support	137	11.4	10.6	0.189	36.5	22.6	40.9
Lower support	152	11.7	9.4	0.000	45.4	16.4	38.2
Sig. <sup>2</sup>	-	0.659	0.147	-			
18-29 years	58	10.9	9.5	0.241	46.6	22.4	31.0
30-44 years	123	11.7	9.4	0.000	43.1	14.6	42.3
45-64 years	101	11.5	10.6	0.151	35.6	23.8	40.6
65+ years <sup>3</sup>	7	16.0	14.7	0.564	42.9	14.3	42.9
Sig. <sup>4</sup>	-	0.290	0.220	-			

Source: NSW Health, MH-OAT Collection in the State HIE June 2001-July 2009 annualised for the 2 years prior and 2 years during HASI n=291

Notes: 1. Paired sample t-test of equality of means

2. Independent sample t-test of equality of means

3. Sample of consumer 65 years and older is small and results are not statistically reliable

4. One way ANOVA

5. Individual effect size was calculated for all individuals, then by demographic characteristics; a negative significant change was identified if the effect size was -0.5 or less, no significant change if the effect size was between -0.49 and 0.49 and a positive change was flagged if the effect size was 0.5 or greater.

Analysis of individual LSP16 change before and during HASI showed that very high percentages of consumers – overall and by demographic groups – have improved in terms of social skills (ES approach). Except for 45-64 year olds and consumers in higher support, more 40 per cent of consumers improved and only around 20 per cent deteriorated in all groups (Table 6.16).

The life-skills of most consumers improved while they were in HASI, with only small differences for men and women or by age (least change for 45 to 64 year olds). The biggest gap in the difference in change was between consumers in lower and higher support (improvement for lower support consumers 45.5 per cent and higher support consumers 36.5).

The qualitative data supported the LSP16 evidence about improved life skills during HASI. The life skills varied among consumers. Some younger consumers were learning skills for the first time with ASP support workers and some older consumers, including some who had exited HASI, were still continuing to develop skills such as basic cooking. A consumer said, 'I'm not much of a cook yet ... I need to learn a bit more so I can start eating a bit more healthier food... [the HASI worker] tried to help me.' Some consumers learned or re-learned new skills, such as this consumer receiving lower support:

Five years in a psych hospital, then come out – without them [ASP], I wouldn't have made it ... I'm a lot better than I was ... HASI had to teach me things like shopping and how to cook again.

Some other consumers reported that these improvements persisted only while HASI workers were providing help. For example one consumer whose support had reduced, reported he had improved his shopping and cleaning skills while receiving support, but he had not been able to maintain them without someone to support him. Others said they had managed to sustain life skills despite episodes of mental ill health and hospitalisations. In summary, the interview and LSP16 data indicates that consumers' life skills increased during HASI and that gains were maintained for most consumers, at least while they continued to receive support.

### Consumer and worker perceptions of mental and physical health

The remaining measures of mental health are non-clinical. HASI consumers' self perception of their mental and physical health was low compared to the general public (Table 6.18) and this self-perception is consistent with the evidence, discussed below, that the physical health of many people with a mental illness is poor.

**Table 6.18: Mean self reported mental and physical health satisfaction**

	2009		2010		Australian population norm
	Consumers	Mean	Consumers	Mean	
Mental health <sup>a</sup>	45	68.4	43	65.6	-
Physical health <sup>b</sup>	43	57.9	43	58.7	75.1

Source: Consumer interviews September 2009, 2010 n=59 (caution small sample)

Notes: a. 66.9 and 64.1 for repeated sample (n=29), p=0.479 (change is not statistically significant)

b. 60.0 and 57.0 for repeated sample (n=28), p=0.498 (change is not statistically significant)

Consumers were less satisfied with their physical health than their mental health. Comparison of change from 2009 to 2010 was not significant and the sample was too small compared to the total HASI population to be meaningful.

Higher support consumers were more likely to have improved their self-assessed health, indicating that consumers from both support level groups merged towards a similar health level.<sup>43</sup> In the cases where consumers' self-

<sup>43</sup> The percentage of lower support consumers who ranked their mental health as fair or poor decreased from 56.0 to 42.3 per cent (p<0.001) and the percentage of those ranking their mental health as good increased from 30.6 to 44.3 (p<0.001). The within-group changes for consumers receiving higher levels of support were not statistically significant but between group changes were significant. In 2009 there was a significant difference between individuals that ranked their satisfaction with mental health as good (30.6 per cent of lower support consumers and 50.7 per cent of higher support consumers,

assessed mental and physical health was very good or excellent, their support level was not a factor. Some changes for good and fair or poor ratings by higher and lower support consumers were statistically significant (Appendix 3, Table C.8).

ASP staff reported that over half the consumers had good or very good mental and physical health (Table 6.19). Comparison between 2009 to 2010 showed that ASP staff thought consumers' mental health had improved and physical health had remained the same or possibly slightly improved. Physical health had not moved towards the Australian population norm.

**Table 6.19: ASP perceptions of consumer physical and mental health**

	Mental health (per cent)			Physical Health (per cent)			Australian population
	Current consumers (n=397)			Current consumers (n=399)			
	2009	2010	Sig. <sup>a</sup>	2009	2010	Sig. <sup>a</sup>	
Very good or excellent	14.4	15.4	0.664	15.0	14.8	1.000	36
Good	37.8	45.8	0.028	37.3	39.8	0.474	29
Fair or poor	47.9	38.8	0.006	47.6	45.4	0.494	15

Source: HASI MDS 2009, 2010; n=403; ABS National Health Survey 2007-08

Notes: Stage 1 Evaluation mental health comparison data were not available

a. McNemar test

ASPs rated men as having slightly better physical health than women (54 per cent were reported as good, very good or excellent health, compared to 48 per cent of women) but this difference was not statistically significant.

In addition to the multiple measures of mental and physical health outcomes discussed in the sections above, most consumers believed that HASI contributed to their better quality of life in total compared to before the program. Most consumers said that before HASI they had been struggling with difficult circumstances including: temporary housing or homelessness; social isolation; hospitalisation; drug and alcohol abuse; psychosis, anxiety and depression; and self harm. During the consumer interviews most people across all HASI support levels, spoke of very difficult times prior to joining the program. Consumers on high and low HASI support said:

Psychologically I was stressed – [living in a] small house ... I'd get outside as much as I could. The stress that was involved – had to keep my illness separate from the family 'cause we were all struggling in different ways. I know if I wasn't coping it would have an effect on the family.

p<0.001), the difference between consumers from the two groups ranking their mental health as good in 2010 reduced and was no longer statistically significant. Rather surprisingly, more consumers receiving lower support (42.3 per cent) than consumers receiving higher support (32.7) ranked their mental health as fair or poor in 2010 and the difference was statistically significant (p<0.05). Consumers who had been in HASI for one to two years as of September 2009 were most likely to report better mental and physical health in 2010.

It was very lonely – I have very little family in [name of location]. My dad just passed away. All of a sudden there was just nobody there. I guess it was pretty depressing too.

Most consumers said that, since being in the program, their life had improved, and some said they felt that their life had improved greatly, even while they may still struggle with some of the effects of their illness. They reported feeling more confident and happier, and had a sense of hope for the future or were less depressed or anxious. A high support consumer said, 'I feel better, I have more self esteem, I'm more relaxed.' Another said:

I've got lots of support, I'm well, the welllest I've been in years, I'm contented living where I live, I'm busy so I don't live in my head at home on my own, we're out doing things every day. Coming from a background of drug and alcohol abuse where it made me suicidal many times, I've now got a good quality of life, I'm now 98 per cent clean and sober, and I enjoy my life now. It's because of having somewhere good to live, with the support. The medication also helps ... I've lost weight too – when I was at [mental health facility] I ballooned, it's the medication. Now I've been with [ASP], going to the swimming pool and walking every day, going to squash and the gym, I've lost 27.5 kilos.

A small minority of consumers had experienced increased difficulties with their mental health during the previous year in HASI and felt that they were deteriorating. A low support consumer said, 'I spend a lot of time in bed with depression. It hasn't been very good the last 12 months. I seem to be losing confidence not gaining it.'

A small number of consumers, expressed ambivalence, and their wellbeing seemed to have neither greatly improved nor deteriorated. Even in this group of consumers, most of them were able to reflect on being better able to cope when they were not feeling well. Comments from two consumers in this situation (one receiving high support and one receiving a low support) were:

They're very supportive even if you're having a bad day ... Without them I wouldn't be here. I am better than I was.

They [HASI] helped me out .... I do go out on my own now ... But sometimes I go into a lull, periods of depression, like the last couple of weeks, has been bad ... I don't think HASI has really improved my life, on the whole.

Family members agreed that HASI had helped consumers meet their goals and improve their quality of life. A parent commented that the HASI support had been 'a big help to him, somebody to talk to, improved his health' and another family member said that the consumer's life had changed because although, 'she still has the up and downs ... when she's down they help by trying to get her out of it ... I can't always be around.'

The physical health of current consumers (Table 6.18 and Table 6.19) was worse than in the evaluation of HASI Stage 1,<sup>44</sup> which also found that physical health declined over the course of the evaluation. Current consumers' physical health problems persisted despite most consumers regularly accessing health services (see service use below). This persistence could reflect increased identification and treatment of physical health problems once consumers are in HASI. It is consistent with research that the physical health of people with a mental illness can be poor as a result of factors including smoking, alcohol and other drug use, use of psychotropic medication, high risk behaviours and reduced access to appropriate assessment and treatment (Australian Institute of Health and Welfare, 2011; NSW Health, 2009).

Identifying poor physical health could be because of a focus within LHD and ASPs on the physical health needs of people with mental illness. ASP staff and clinicians in some evaluation sites stressed that they had a greater focus on assessing the physical health needs of consumers during the last 12 months. For example, some ASPs reported regularly undertaking a physical health check list with consumers and ensuring they had regular appointments booked with allied health professionals.

Analysis of interviews with consumers indicated that they experienced a range of physical health needs such as dental hygiene and tooth decay; diabetes; back, knee, shoulder pain; stroke effects; thyroid problems; podiatry (feet) problems; post surgical care (eg hand and spinal surgery); liver problems; multi-organ failure; hysterectomy; and severely reduced mobility. Medications commonly prescribed for mental ill health are associated with weight gain, diabetes and other health problems (Mauer, 2006).

The physical health problems directly related to some consumers' mental health problems. For example, one consumer has significant and ongoing internal injuries resulting from having jumped from a height on a number of occasions. Another high support consumer explained that he had recently been diagnosed with liver damage and was not allowed to drink any more, but that:

Sometimes I just want to escape, I can't stand reality, but I can't do it now, dope's the only thing, but I want to stay away from it because I get thrown back in the loony bin.

Several consumers indicated that they had gained weight – which was commonly attributed to the medication they were taking – and had identified weight loss as a goal. A consumers receiving lower support said:

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<sup>44</sup> The only large source of quantitative data available on consumers' physical health status was the MDS supplement, where ASPs answered a standard ABS question about their perceptions of the consumers' physical health. These data need to be interpreted with caution because the supplement was not a standardised operational measure and does not reflect consumer perceptions of their own health.

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.

Most consumers did not report any improvements in their physical health conditions since entering the program, although some said that they had given up or reduced smoking or drinking, had increased their exercise or were eating better than in the past. Many, however, spoke about the contact they had with GPs and other allied health services, meaning that consumers were receiving treatment.

Both ASP workers and consumers reported that the HASI support included a variety of activities related to promoting consumers' physical health. These included nutritional training and advice, including shopping; healthy cooking classes and providing healthy food at barbecues; diabetes education; and a variety of exercise based activities including swimming, tennis, walking, yoga and squash. Some consumers admitted that aspects of their lifestyle were unhealthy but that they had not changed them yet, despite encouragement from ASP staff. On the other hand, one consumer with a serious illness felt that he had not had adequate support from the ASP concerning this. He acknowledged that he found it difficult to ask for more help.

### **Use of mental and physical health services**

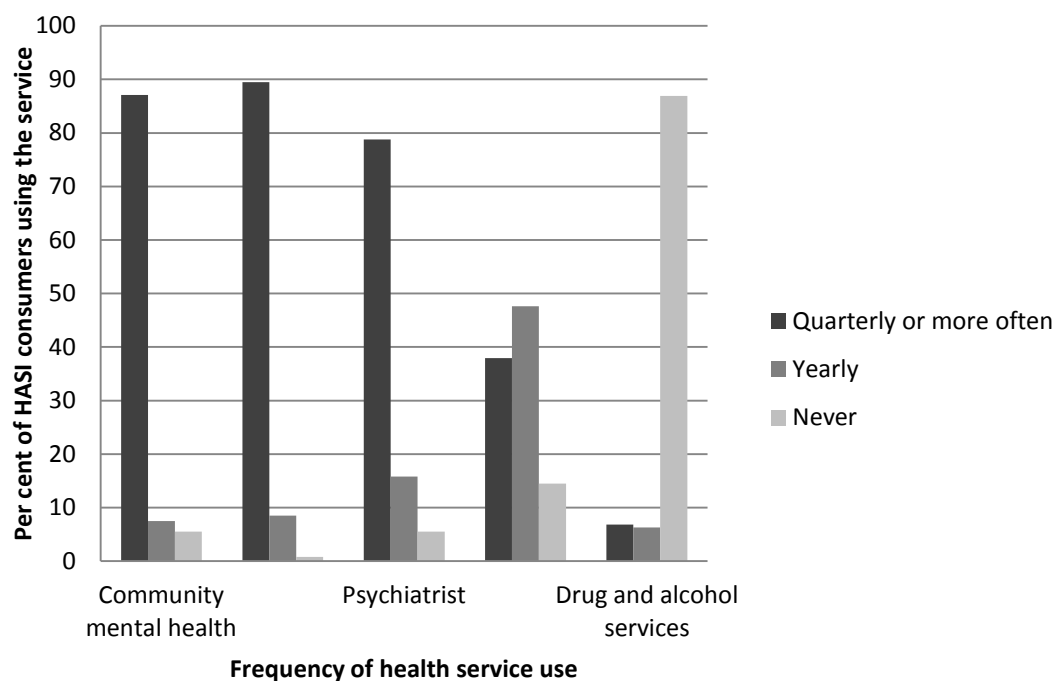
HASI provides support for consumers to use the specialist and general services they need to improve and maintain their mental and physical health. The results indicate that it is achieving that goal. Most consumers (96 per cent, n=611) regularly used community mental health, general practitioner and allied health services, and about 86 per cent had used allied health services (Figure 6.20 (2009); and Figure 6.20 (2010)).<sup>45</sup>

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<sup>45</sup> MDS Supplement data were recorded by ASP staff about consumers' access to health and mental health services and is therefore a subjective measure from the staff, which is unlikely to be a complete record of all occasions of service.

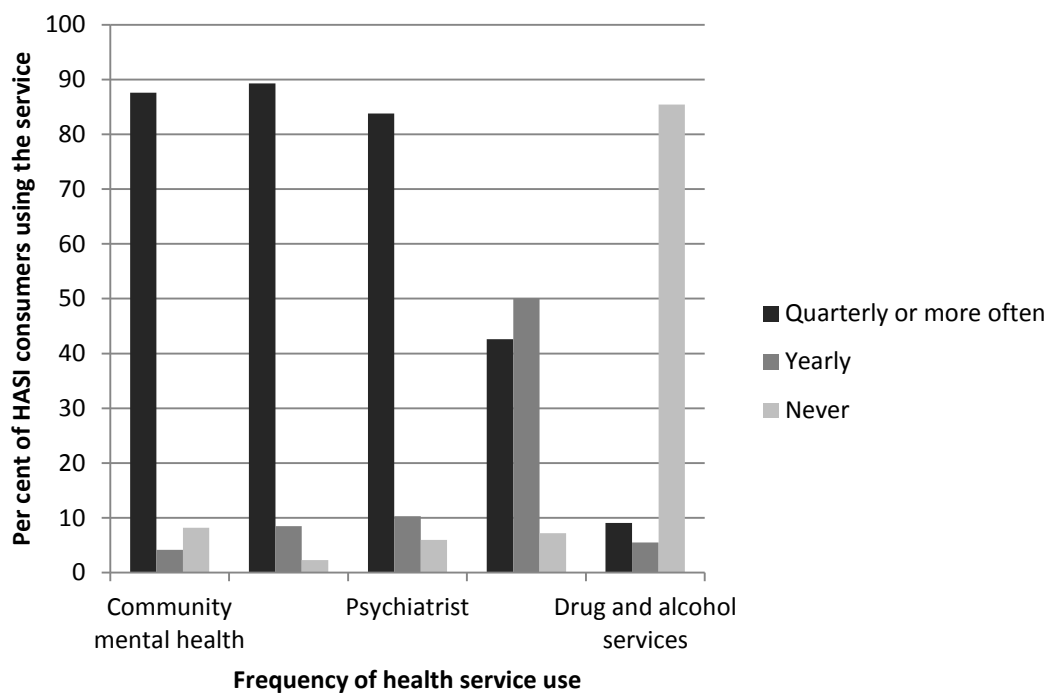


**Figure 6.20: Frequency of health service use**



Source: MDS supplement, 2009, n=403

**Figure 6.21: Frequency of health service use**



Source: MDS supplement, 2010, n=403

Use of health and allied services remained stable in the two measures in September 2009 and 2010 (Table 6.22). Using community mental health services became slightly less frequent and seeing a psychiatrist slightly more frequent, which is consistent with the aims of HASI. More consumers used allied health over time – the proportion of consumers who never used allied health halved.

**Table 6.22: Change in frequency of health service use**

		Monthly or less	Quarterly	Yearly	Never	Consumers
Community mental health	2009	76.9	10.2	7.5	5.5	402
	2010	68.9	18.7	4.2	8.2	
	Sig <sup>a</sup>	0.006	0.001	0.067	0.136	
General Practitioner	2009	59.0	30.5	8.5	0.8	400
	2010	59.8	29.5	8.5	2.3	
	Sig <sup>a</sup>	0.862	0.792	-	0.109	
Psychiatrist	2009	47.5	31.3	15.8	5.5	400
	2010	48.8	35.0	10.3	6.0	
	Sig <sup>a</sup>	0.745	0.261	0.012	0.871	
Allied health	2009	13.0	24.9	47.6	14.5	401
	2010	15.7	26.9	50.1	7.2	
	Sig <sup>a</sup>	0.215	0.557	0.493	0.001	
Drug and alcohol services	2009	5.0	1.8	6.3	86.9	398
	2010	7.8	1.3	5.5	85.4	
	Sig	0.072	0.754	0.742	0.519	

Source: HASI MDS supplement September 2009, 2010; n=403

a. McNemar test for equality of means

Women used some services more frequently than men (GPs  $p < 0.01$  and allied health services  $p < 0.05$ ). Consumers receiving higher support were significantly more likely than those in lower support to use community mental health ( $p < 0.001$ ), psychiatric services ( $p < 0.01$ ) and drug and alcohol services ( $p < 0.05$ ) more than once a month, but were less likely to see a GP or use allied health services (Appendix 3, Table C11a, b)

People receiving HASI support reported that HASI workers took them to appointments with doctors or other health services. One consumer receiving high support was particularly appreciative that the ASP had agreed that a woman worker accompany her to the city for a series of medical tests. Another consumer receiving medium support explained that:

Times that because I felt down or don't want to leave the house, I wouldn't be able to go out to get medication, I wouldn't have gone without the HASI [worker].

Consumers spoke of no longer using drugs through the assistance of the ASP supporting them to access drug and alcohol services and related support programs.

## Community mental health services

In addition to the specialist and general services analysed above, HASI consumers also used a range of ambulatory care services, which are the government-operated specialised mental health care provided by community mental health services and hospital-based ambulatory mental health services, such as outpatient and day clinics.<sup>46</sup>

Change in the use of community mental health services was analysed by comparing the two years before and first two years during HASI for each consumer.<sup>47</sup> The analysis showed a slight increase in the average annual number of contacts from 50.8 to 53.2 contacts per year (Table 6.23).

**Table 6.23: Average community mental health contacts per year two years before and two years during HASI**

	Consumers	Before HASI	During HASI	Sig. <sup>1</sup>
All consumers	496	50.8	53.2	0.553
Men	261	48.1	50.4	0.632
Women	219	52.9	57.6	0.530
Sig <sup>2</sup>		0.517	0.397	
Lower support	291	47.3	39.4	0.131
Higher support	201	55.9	73.4	0.012
Sig <sup>2</sup>		0.249	0.000	
18-29 years	70	60.1	48.9	0.286
30-44 years	183	51.0	55.4	0.537
45-64 years	202	42.4	53.4	0.055
65+ years	10	52.5	43.1	0.574
Sig <sup>3</sup>		0.250	0.947	

Source: InforMH, MH-AMB data set, 1999-2009, n=496

Notes: 1. Paired sample t-test 2. Independent sample t-test 3. One-way ANOVA

The longitudinal analysis of use of ambulatory services reveals an inverted U-shape use of ambulatory services along the four periods investigated (Table 6.24 to Figure 6.27). The number of contacts increased in the year prior to joining HASI, and during the first year in HASI and sharply decreased in the second year of HASI.

<sup>46</sup> 496 consumers from the Ambulatory data set were linked to corresponding demographic data. The analysis was carried out at two levels: contacts and activities. A contact (or service event identifier) "is a unique identifier within the source system of the event (contact, attendance, or non-consumer contact event) that links together activities performed at the same time" (MHOAT). More than one contact per day is possible for same consumer and during each contact various activities are recorded. The number of contacts per person per year prior to HASI was calculated as the average of the number of contacts two year and one year prior to the HASI start date. Similarly, the number of contacts per person per year during HASI was calculated as the average of the number of contacts in the first year and the second year of being in HASI. Where the consumer had been in the program for less than two years the number of contacts was annualised.

<sup>47</sup> Given the longitudinal nature of the data set, the change across the four years was investigated (2 years before and two years during HASI). See footnote 23.

This pattern is also observed in the longitudinal analysis by gender, support level and age group. However, the intensity of change and statistical significance vary. All yearly changes (between two years and one year before HASI, the year before HASI and the first year in HASI, and the first and second year in HASI respectively) are statistically significant, but the difference between the first and last period (two years prior to HASI and two years during HASI) is not statistically significant (Table 6.24).

These findings indicate that although in the year before HASI and the first year during HASI the number of community mental health contacts was high, during the second year this number decreased (statistically significant change) at or below the initial level (two years prior to HASI) to the extent that the difference between the first and last stage of the longitudinal analysis was no longer statistically significant. The average annual number of community mental health contacts in the second year in HASI is however lower than two years prior to HASI for most consumer groups (except aged 45-64 year olds and consumers in higher support who had slightly higher number of contacts after having received HASI intervention for two years) (Table 6.24).

**Table 6.24: Longitudinal analysis of the number of community mental health contacts per year in the two years before and two years during HASI**

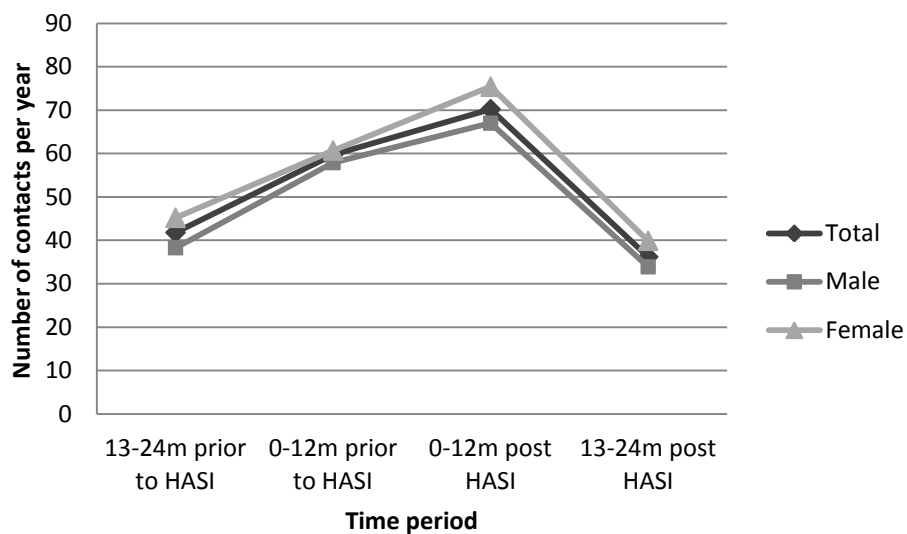
	Consumers	2 years before HASI		First 2 years during HASI		Sig. <sup>1</sup>	Effect size <sup>2</sup>
		13-24m prior	0-12m prior	0-12m during	13-24m during		
All consumers	496	41.8	59.7	70.2	36.2	0.000	0.135
Men	261	38.3	57.9	67.0	33.9	0.000	0.131
Women	219	45.2	60.7	75.4	39.9	0.000	0.144
Sig <sup>3</sup>		0.353	0.758	0.421	0.488		
Lower support	291	40.3	54.3	58.9	19.9	0.000	0.181
Higher support	201	44.1	67.7	86.6	60.3	0.000	0.101
Sig <sup>3</sup>		0.607	0.131	0.007	0.000		
18-29years	70	43.2	77.1	67.7	30.1	0.000	0.366
30-44years	183	42.1	59.9	74.1	36.6	0.000	0.144
45-64years	202	36.2	48.5	66.1	40.8	0.000	0.093
65+ years	10	35.8	69.1	65.0	21.2	0.087	0.586
Sig <sup>4</sup>		0.776	0.106	0.910	0.811		

Source: InforMH, MH-AMB data set, 1999-2009, n=496

Note: 1. Wilks' Lambda 2. Partial Eta Squared 3. Independent sample t-test of equality of means 4. One-way ANOVA

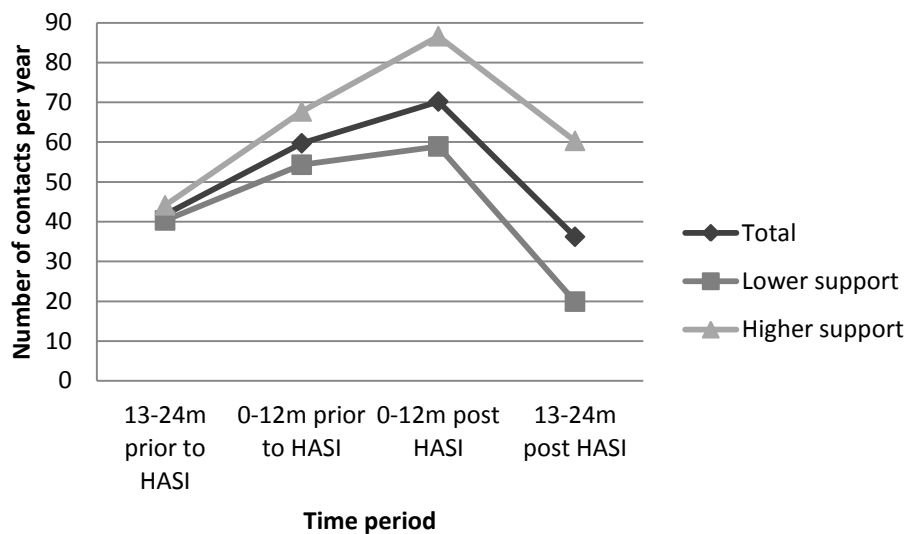
Cross-sectional analysis of each of the 12-month periods found no statistical differences between genders or by age group, indicating that both men and women of all ages had similar use of community mental health services within the four years. However, lower and higher support consumers had significant differences in the frequency of annual contacts, both in the first and second year during HASI. The use of community mental health services by consumers in higher support was three times higher than that of consumers in lower support during the second year in HASI, which is consistent with the higher clinical support needs of these consumers.

**Figure 6.25: Longitudinal analysis of community mental health contacts per year by gender**

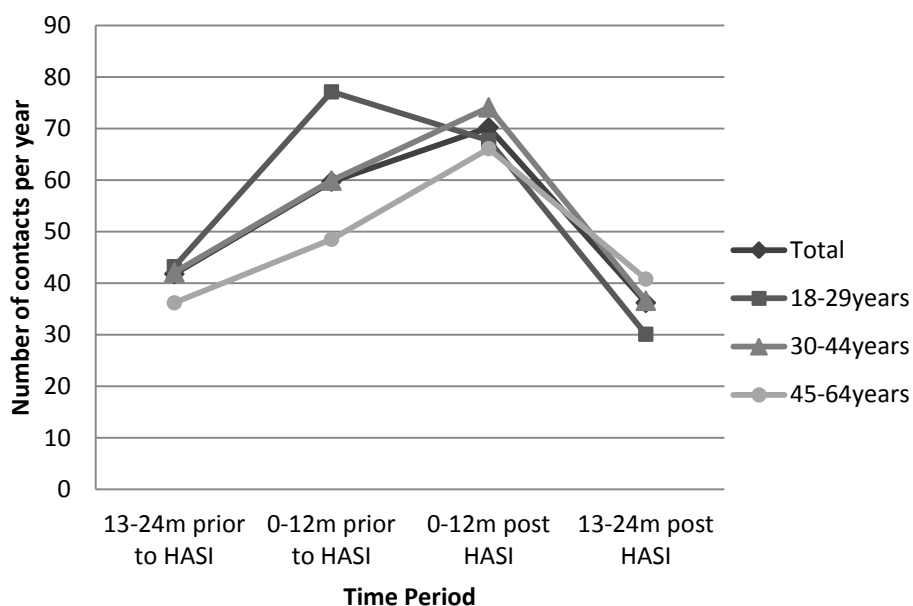


Source: InforMH, MH-AMB data set, 1999-2009, n=496

**Figure 6.26: Longitudinal analysis of community mental health contacts by support level**



Source: InforMH, MH-AMB data set, 1999-2009, n=496

**Figure 6.27: Longitudinal analysis of community mental health contacts by age group**

Source: InforMH, MH-AMB data set, 1999-2009, n=496

In addition to changes in the number of contacts with community mental health services, the type and frequency of ambulatory activities per year was analysed and compared before and during HASI (Table 6.28).<sup>48</sup> The most frequent activity was care planning, which increased in mean annual frequency after consumers joined HASI from an average of 10.6 to 12.1 times per year. The other activity that became more frequent during HASI was medication activity. All other activities either decreased in frequency or remained same.

<sup>48</sup> 15 types of activities were identified: 1. Assessment (AS); 2. Carer support (CA); 3. Care planning (CC, CM, CP); 4. Counselling and education (CE, CO, ED); 5. Other – assistance with activity (AW); 6. Other – Admin (ACT, AD, CS, DC, LR, MS, RP, SK, SM, SR, SU, TC, WT); 7. Legal activity (LE, MH); 8. Psychotherapies (PT); 9. Referral (RF); 10. Clinical review (RV); 11. Medication activity (RX); 12. Service coordination (SC); 13. Transport or accompany consumer (TP); 14. Triage (TR); 15. Travel (TRV, TR) Source: InforMH

**Table 6.28: Frequency of community mental health activities per year descriptive statistics in the two years before and two years during HASI**

Ambulatory activity		Mean	Median	Maximum
Care planning	Before	10.6	3.5	214.5
	During	12.1	6	202
Other admin	Before	6.2	2	89.5
	During	6.2	2.5	119.5
Medication activity	Before	3.3	0	114
	During	5.3	0	317.5
Counselling and education	Before	2.1	0	65
	During	1.9	0	59
Clinical review	Before	1.9	0.5	50.5
	During	1.8	0.5	42
Assessment	Before	1.5	0.5	34.5
	During	1.4	0.5	40
Service coordination	Before	0.9	0	54.5
	During	0.8	0	21
Other assistance	Before	0.9	0	83.5
	During	0.7	0	37.5
Carer support	Before	0.8	0	16.5
	During	0.6	0	20.5
Travel	Before	0.7	0	93
	During	0.7	0	93
Psychotherapies	Before	0.5	0	39.5
	During	0.4	0	21.07
Transport or accompany consumer	Before	0.5	0	31.5
	During	0.3	0	19.5
Triage	Before	0.4	0	18.5
	During	0.3	0	17.5
Legal activity	Before	0.2	0	9
	During	0.2	0	6.5
Referral	Before	0.1	0	2
	During	0.1	0	2.01

Source: InforMH, MH-AMB data set, 1999-2009.

Note: Minimum number of possible activities per person per year is zero (Data includes consumers with zero activities of the respective type)

### Summary of mental and physical health outcomes

The evaluation measured mental and physical health outcomes through use of hospital services, mental health clinical measures (K10, HoNOS and LSP16), consumer and worker perceptions and the use of other health services, including community mental health.

The general results were improvements in mental health for most HASI consumers. The use of hospital services decreased in terms of average number of admissions, average length of stay per year and average length of

stay per admission in mental health admissions, other admissions and emergency department presentations.

Using MH-OAT measures of mental health (K10, LSP16 and HoNOS), the changes experienced by consumers since joining HASI were explored. The absolute change in mean scores was first assessed, then consumers who were most likely to experience change (positive and negative) were identified through the Effect Size approach. More women, lower support and younger consumers experienced improvement in all three mental health assessment scores. Although less often than their counterparts, men, higher support or older consumers were more likely to experience greater improvements in absolute scores (i.e. the difference between the mental health score during and before HASI was larger for these consumers). Most important, after joining HASI, the K10, LSP16 or HoNOS scores between lower and higher support consumers were not significantly different, indicating that HASI was successful in reaching most consumers.

Almost all consumers used health, allied health and community mental health services. Changes in service use over time showed more frequent use of psychiatrists and allied health and less frequent use of community mental health services after an initial increase, consistent with appropriate use of services.

## 6.2 Housing

A core aim of the HASI program is to support people to maintain stable housing.<sup>49,50</sup> Support to maintain housing is an important component of the program given that people with mental illness often experience difficulty maintaining stable housing which in turn can be correlated with continuing poor mental health outcomes (Bleasdale, 2006; Flatau et al., 2008).

The successive HASI Stages had different eligibility in relation to housing, so HASI consumers live in a range of housing types, including public, community and private housing. Higher support HASI packages (Stages 1, 3, 3B very high support and 4A) targeted people with a mental illness who were homeless or at risk of homelessness or inappropriately housed, whereas lower support HASI (HASI Stages 2 and 4B HASI in the Home) targeted people with mental illness who were already housed in social housing (Stage 2) or in private rental, privately owned or other housing. Consumers accepted

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<sup>49</sup> As detailed in the glossary, secure housing refers to housing with the protection of a lease, notice periods for evictions and other safeguards. Stable housing is a housing outcome that is continuous and consistent rather than disrupted and transient. Illness risks disruption to tenancies and ability to maintain housing.

<sup>50</sup> This section examines the housing profile and outcomes of three samples. The interviews (n=69) and HASI MDS (n=895) describe the housing profile and outcomes for all HASI consumers. A housing profile and outcomes are from a sub-sample of HASI consumers who are public housing tenants and who could be identified in the Housing NSW dataset (n=163), described in Appendix 1.



into higher support HASI (high and very high support) were allocated social housing as required (Section 3.3).

The expectation was that most consumers referred for higher support HASI would require housing and that most consumers who were referred for lower support HASI would already be housed but their housing could be at risk because of their mental illness. When consumers entered HASI, 43 per cent did not have stable housing (Section 5.3). As expected, most higher support consumers (71 per cent) lacked stable housing and did require housing. However, a higher proportion than expected of people accessing HASI Stage 2 (low support) lacked stable housing (26.2 per cent) and these people also required support to find housing.

Many of the consumers interviewed had previously experienced insecure housing and expressed relief about the permanence of the housing they now had. Most HASI consumers and their family members said they were satisfied with the type of housing they were now living in and the tenancy management services they received (Section 7.1).

### **Gaining housing stability: consumers without stable housing**

For consumers without housing before HASI, or in temporary housing such as caravan parks, HASI supported them to access stable housing. Most of these consumers entered higher support HASI, but they also include some lower support HASI consumers (Section 5.3). Most HASI clients who require housing are assessed as eligible for priority assistance (Section 7.1). Many consumers who had previously lacked stable housing stated how much it meant to them to have obtained stable housing and a sense of home.

HASI operates within an extremely tight housing market. Rising rents and falling vacancy rates in the private rental market have reduced the ability of lower income households to find affordable accommodation that meets their needs. Social housing is an increasingly scarce resource with demand for housing assistance far exceeding supply<sup>51</sup>. The most recent State of Supply Report (National Housing Supply Council, 2011) estimates that the gap in the supply of affordable housing in NSW was 73,700 in 2010 and is expected to increase in future years. It also finds that housing affordability remains stretched, with Sydney households facing the greatest affordability pressures.

While some Stages of HASI had funds specifically allocated to provide housing, the cost of providing housing for new consumers and ongoing housing for those consumers whose housing is funded through leasing subsidies is absorbed by the housing provider (Section 7.1). New HASI

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<sup>51</sup> Housing NSW advises that in 2010-11, the Housing Pathways system received 60,176 applications for housing assistance. 21,567 of these applications were assessed as eligible for social housing and added to the NSW Housing Register. 3997 applications were assessed as eligible for priority housing assistance, and 17,750 for general wait turn housing. During this same time period, 14,438 households were housed by public, community and Aboriginal providers. Of these, 8915 or 61% were priority applicants. The number of applicants on the NSW Housing Register as at 30 October 2011 was 56,000.

consumers are therefore housed out of existing stock, when a suitable property becomes available.

Waiting times for priority housing assistance for HASI applicants varied depending on the location and their requirements. The interview data found that commonly, eligible consumers had to wait for many months, although one housing provider interviewed gave an example of a consumer who had been allocated a property within weeks (discussed in Section 7.1). One high support consumer was referred to HASI from hospital, after experiencing homelessness: '[The mental health worker] did the [housing] application, it took about 16 months. I was homeless.' Some consumers, who were new to HASI at the time of the evaluation, indicated that they were still on a waiting list and did not yet have access to stable housing. For example, one consumer was living in a homeless men's shelter while he waited for housing.

Some consumers lived with their parents to avoid primary homelessness.<sup>52</sup> One clinician from an inpatient mental health unit described how, on discharging patients, he often had to ask elderly parents to care for their unwell adult children. A high support HASI consumer, who had previously been staying with her parents, explained how much she appreciated having her own home:

... the fact that they have something like that [community housing] so that we can afford to live within the community and not with our family is great, because it gives us our independence and our freedom to make our own decisions. If you are living with your parents you just have very little freedom, I know how my parents are and they're getting older, it just wouldn't be right for them to have me there.

### **Maintaining housing stability: already housed consumers**

Approximately half of the consumer group were already housed when they joined the program, according to the consumer profile from the MDS. This is consistent with the majority of HASI packages being low support or HASI in the Home packages (Section 3.3). It is likely that this data under reports the proportion of consumers living in unstable tenancies prior to joining the program (discussed in Section 5.3).

The consumers who were already housed were in public housing, community housing or, for a smaller group of consumers, in private rental (or rarely, private ownership). For these consumers, a key aim was to support them to maintain housing stability.

Consumers said in interviews that even when they had found stable housing immediately prior to entering HASI, many of them had experienced a long history of prior housing instability. The experiences reported by HASI consumers are consistent with research that people with mental illness often

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<sup>52</sup> See glossary

encounter difficulties accessing and maintaining stable housing (Bleasdale, 2007; Robinson, 2003). For example, a higher support consumer was referred to HASI from hospital, but had experienced periods of homelessness. He said:

I was homeless and I went into hospital and the staff at the hospital helped me get [housing] – my father put in the application for Housing NSW. And that's how I got my apartment.

A small group of consumers (6.9 per cent) were renting privately or owned their home when they joined HASI. For consumers in private rental, their own home or living with family, Stage 4B HASI in the Home has a similar role to other HASI Stages. In the case of homeowner consumers HASI may also assist with home maintenance and safety issues that are the responsibility of landlords in rental properties. HASI enables homeowner consumers to maintain and live safely in their homes despite fluctuating mental health. For example, one consumer in Stage 4B HASI in the Home said:

I own my house. They [HASI] helped me cut a tree down that was growing onto my roof, and they got new guttering for me. Electrical work, they helped me get that fixed up.

Some consumers and their families who were renting privately were concerned about the lack of long term security of tenure combined with uncertainty about future access to housing. For example a parent of a medium support HASI consumer in private rental wanted to know what would happen if the property was no longer available, and whether he could receive help to access social or other housing, 'Well if [consumer] ever had to move out of his place, would they [HASI] sort of help find him a place? I think he has got his name down.'

### **Satisfaction with housing**

Most consumers interviewed for the evaluation were satisfied and appreciated the housing security they had gained while in HASI. Some were enthusiastic and appreciative of their housing and housing provider. Two women in community housing said, 'I love where I am, it's safe and secure' and '[community housing provider staff] are wonderful.' A consumer in public housing said, 'The house is Department of Housing. It's good, I like the location ... I got a really nice place.' Similarly, the staff and managers from housing, mental health and ASPs recognised the value of stable housing for HASI consumers, even after clinical and ASP support finished for any reason.

### **Public housing arrangements**

Public housing HASI consumers were more likely than other public housing residents to live alone, according to Housing NSW data (Table 6.29).<sup>53</sup> Almost

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<sup>53</sup> The section is only about HASI consumers in public housing because similar data were not available about consumers living in other forms of housing.

nine out of 10 (88 per cent) HASI public housing residents live alone, compared to one in two public housing tenants (51 per cent). This may be because HASI Stage 1 tenancies were all single tenant households, and therefore this first cohort were required to live alone (the requirement changed after HASI Stage 1). The high rate of living alone may also be influenced by the fact many HASI consumers have little or no contact with family (14 per cent), a partner (28 per cent) or friends (21 per cent) (Section 6.3). People with mental illness are slightly more likely to be living alone than others (15 per cent compared with 13 per cent), (Australian Bureau of Statistics, 2009: 16).

**Table 6.29: People per household, public housing subgroups**

People per household	Per cent	
	HASI consumers in public housing (n=163)	All public housing residents in NSW (n=121,120) <sup>1</sup>
1	87.7	51
2	6.7	25
3	4.3	11
4	0.6	7
5	-	4
6	0.6	2
7	-	1
Total <sup>2</sup>	100.0	100

Source: Housing NSW, IHS database June 2009

Notes: 1. Data missing for 147 people

2. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents

A higher proportion of HASI consumers lived in one bedroom apartments than other public housing tenants (53 per cent compared with 25 per cent; Table 6.30).

**Table 6.30: Number of bedrooms, public housing subgroups**

Number of bedrooms	Per cent	
	HASI consumers in public housing (n=163)	All public housing residents in NSW (n=121,120)
1 <sup>1</sup>	52.7	25
2	31.3	28
3	14.1	39
4	1.8	8
Total <sup>2</sup>	100	100

Source: Housing NSW, IHS database June 2009

Notes: 1. Includes studio apartments

2. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

Interviews with HASI consumers found that although consumers were generally happy with their housing, living alone was not something that all consumers enjoyed. If their house was larger, some people had family living with them to address this preference, for example, a consumer receiving low support commented:

I got me grandson with me at the moment - staying with me. Yeah I'm going through a trauma with him at the moment but he'll get over that. My son comes and stays with me too. I don't think I could live on my own, I like having the company.

### Housing stability

Most consumers successfully maintained their tenancies during their time in HASI – 90 per cent (n=806) of consumers had not ended a tenancy since joining the program. Most of the tenancies that ended were for planned reasons, such as moving to more appropriate or other long term housing (86 per cent; Table 6.31).

**Table 6.31: Reasons for tenancy completion current consumers from entry in HASI to 2009**

Reasons for tenancy completion <sup>1</sup>	Number of completions <sup>2</sup>	Per cent
Planned		
Consumer moving to other long-term housing	33	41.3
Housing inappropriate for consumer's needs	26	32.5
Planned end of tenancy	5	6.3
Consumer moving to higher-support accommodation	5	6.3
Unplanned		
Eviction	8	10.0
Abandoned property	2	2.5
Non-renewal of tenancy due to failure to meet tenancy obligations	1	1.3
<b>Total reasons for tenancy completion</b>	<b>80</b>	<b>100</b>

Source: HASI MDS September 2009 n=895

Notes: 1. Includes HASI consumers living in public housing, community housing, and private housing. Most consumers did not move (806; 90 per cent).

2. n=80 is the total number of completed tenancies where a reason for the completion is known. 89 people moved (completed a tenancy) at least once and some of the 89 people moved more than once since starting HASI equalling a total of 103 completed tenancies. Reasons for 23 of the 103 moves are missing, therefore n=80.

A small number of consumers indicated that they had moved house since joining the program, usually because they were provided with more appropriate housing or had moved closer to family and friends. Other reasons that consumers gave for relocating or applying to be relocated included their private rental unit being sold; harassment from neighbours, in one case allegedly because of the consumer's mental illness; and other tenants frequently breaking into the consumer's house. One low support consumer left his housing to serve time in prison, but was able to resume participation in HASI upon release, including moving to another flat.

Most consumers transferred to properties within the same service location, but those seeking to transfer outside the service location had to wait for a HASI package to be available in the new location as well as for an available property.

Housing providers and ASPs raised concerns about inconsistencies in approach to situations where housing changes had an impact on HASI

consumers. Although the HASI model envisages that ASPs provide continued support during periods of housing change, some ASPs had a policy of not offering support during times when the consumer was unable to live in a property connected to HASI. Suspending support in these circumstances does not acknowledge the benefits to consumers of having support during periods of change, as intended in the HASI design. For example, a housing provider spoke about problems getting ASP support for consumers who had to leave their property because of feeling unsafe due to, for example, domestic violence or a break-in. In that location the ASP withdrew its support from the consumer until they returned to social housing. Another ASP was concerned about a HASI consumer who was waiting on the housing register after their community housing tenancy ended due to the house being sold and alternative community housing was unavailable. Unlike the first case, during this time, the ASP continued to support the consumer.

### **Rental payments**

Housing managers were generally satisfied that, with appropriate support, HASI consumers were reliable tenants who paid their rent on time. Many consumers receive financial and budgeting support from ASPs, which assists them to manage their finances. Consumers were assisted to pay their rent on time by arrangements for automated rental payments, often as a result of ASPs working with them to develop budgeting skills and set up payments from their bank accounts, or for some consumers by automated payments through a guardian such as the Office of the Protective Commissioner (OPC).

Most HASI consumers living in public housing properties paid their rent on time, and only a small proportion (3 per cent, n=5) were in rent arrears of two weeks or more (Table 6.32), which is comparable to residents who received priority housing assistance<sup>54</sup> and all public housing residents.

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<sup>54</sup> HASI consumers were compared to people in public housing who had been provided with priority housing assistance because these groups may have more comparable characteristics to HASI consumers. People are eligible for priority housing assistance if they are eligible for social housing, in urgent need of housing and unable to access housing in the private rental market. People are in urgent need of housing if they are living in unstable housing, at risk of harm, or living in very inadequate accommodation (Housing NSW, 2008, fact sheet on priority housing, <http://www.housing.nsw.gov.au/NR/rdonlyres/6E8E2485-29B4-4BB3-A8A9-381138374582/0/PriorityHousingDec2006.pdf>, accessed 5 October 2010).

**Table 6.32: Rent arrears of two or more weeks of rent by public housing subgroups**

	Per cent		
	HASI consumers in public housing (n=163)	All public housing residents in NSW (n=121,273)	Priority housing residents in NSW (n=17,455)
People not in arrears	97.5	97	96
People with two or more weeks in arrears	2.5	3	4
Total <sup>1</sup>	100.0	100	100

Source: Housing NSW, IHS database June 2009

Notes: 1. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents

### Tenancy complaints

The vast majority of HASI consumers were successfully maintaining their tenancies. The number of Consumer Trader and Tenancy Tribunal (CTTT) actions (which occur when tenancy agreements are breached or complaints are made against tenants) against them was low, indicating that consumers were maintaining their tenancy agreements (Table 6.33).<sup>55</sup> Only one per cent (n=6) of all consumers were recorded in the MDS as having a CTTT action in the June 2009 quarter. Similarly, very few consumers (only four per cent (n=27)) had complaints made against them. The number of CTTT and complaints did not vary by the consumers' support level.

**Table 6.33: CTTT actions and complaints against HASI consumers by support level**

	HASI support level					
	Lower		Higher		Total <sup>1</sup>	
	Consumers	Per cent	Consumers	Per cent	Consumers	Per cent
One or more CTTT actions <sup>2</sup>	2	0.5	4	1.4	6	0.9
One or more complaints <sup>3</sup>	13	33	14	5	27	4.7

Source: HASI MDS June 2009 n=895

Notes: 1. Includes HASI consumers living in public, community and private housing

2. n=686, missing = 209 people

3. n=690, missing = 205 people

The number of CTTT actions remained low over time according to longitudinal analysis of the MDS (Table 6.34). MDS data from the first four quarters that consumers were in HASI demonstrate that consumers had a low number of CTTT reports from the time they started in the program. Only two per cent (n=6) of consumers had a CTTT hearing in their first two quarters in HASI, and only one per cent (n=1) in the third and fourth quarters in the program.

<sup>55</sup> These figures may be underreported because CTTT actions and complaints may not always come to the attention of ASPs. Alternative data from Housing NSW were not available.

**Table 6.34: Longitudinal analysis of CTTT actions against HASI consumers**

	Time in HASI (per cent) <sup>1</sup>	
	0-6 months	7-12 months
No CTTT action	98	99
One or more CTTT action	2	1
Total <sup>2</sup>	100	100

Source: HASI MDS June 2009 n=895

Notes: 1. Only 289 consumers had complete data on this item during their first 12 months in the program.  
2. Includes HASI consumers living in public, community and private housing

The proportion of HASI consumers who had other complaints made against them also remained low over time, as measured by the MDS subset of consumers who had been in the program for 12 months or more (Table 6.35).

**Table 6.35: Longitudinal analysis of nuisance and annoyance complaints against HASI consumers**

	Time in HASI (per cent) <sup>1</sup>	
	0-6 months	7-12 months
No complaints	92	93
One or more complaints	8	7
Total <sup>2</sup>	100	100

Source: HASI MDS June 2009 n=895

Notes: 1. Only 294 consumers had data consistently reported on this item during their first 12 months in the program.  
2. Includes HASI consumers living in public, community and private housing.

Housing providers reported that few complaints are made against HASI consumers. When complaints were made, the housing providers said that these were often minor problems that could usually be resolved by contacting the ASP and setting up a joint meeting with the tenant. HASI consumers also suggested a similarly low level of problems because they were aware of the importance of maintaining their tenancy. A low support consumer said:

I haven't had any complaints yet. Before I went to jail the girl I was living with and I had noise complaints, parties. So this time [in his new place] I just keep quiet. If I have drinks I just have 2 or 3 – turn the music down. If I upset someone I apologise straight away.

Some housing providers indicated that hoarding was a problem for some HASI consumers. However, with support from the ASP, these consumers had been able to address the hoarding problem and maintain their tenancies.

Harassment from other tenants and neighbours was a problem raised by some HASI higher and lower support consumers. In some cases ASPs had assisted them to put in a transfer application. Consumers who had moved said this took several months. Some consumers said housing providers had



been as helpful as possible in the circumstances. A medium support HASI consumer said:

The dispute with the neighbours just got to the point where ... I wouldn't leave the house unless HASI [ASP] came to get me to take me somewhere. I wouldn't take the bins out, I wouldn't go to the letterbox or do the shopping and if it wasn't for HASI I would have starved to death. Every time I left the house, next door would threaten me that they were going to get me ... I went and stayed with a friend and [the community housing provider] got me this [house]. It's still big enough if the boys come over. This is only temporary until they can find something bigger. They [community housing provider] have been really supportive.

### Repairs and maintenance

Most HASI consumers were maintaining their property well. According to data from Housing NSW's Rechargeable Repairs account (RRP) (Table 6.36) only a very small proportion (4 per cent; n=7) owed more than \$100 to Housing NSW for damage caused by the tenant. This result is comparable to all public housing tenants and the subsample of tenants housed through the priority housing assistance list.

**Table 6.36 Damage to public housing properties (people with an RRP balance of \$100 or more) by public housing tenant subgroups**

	Per cent		
	HASI consumers in public housing (n=163)	All public housing residents in NSW (n=121,273)	Priority housing residents in NSW (n=17,455)
No balance or balance less than \$100	96	97	96
Balance greater than \$100	4.3	3	4
Total <sup>1</sup>	100.0	100	100

Source: Housing NSW, IHS database June 2009

Notes: 1. Includes people living in public housing and housed through the Aboriginal Housing Office but excludes community housing residents.

The main housing problem mentioned by HASI consumers who were interviewed for the evaluation was the length of time it sometimes took for maintenance and repairs to be completed (see Support model).

### Summary of housing outcomes

The HASI program has achieved its aim of stable housing for most HASI consumers. Most people enter the program with a history of unstable housing, including no home immediately prior to entering HASI, for example, they enter the program from hospital, prison, living with friends or family, living in a boarding house, in other unstable or temporary housing or primary homelessness (Section 5.3). Most HASI consumers are satisfied with their

housing and the support they receive from the housing provider. If consumers have moved, it is usually for planned reasons to more suitable accommodation.

With the support of the ASP and housing provider, almost all HASI consumers meet their tenancy obligations – they pay rent on time, maintain their property and are good neighbours.

### 6.3 Social and community participation

HASI aims to help participants develop meaningful relationships and participate in their communities. One of the underpinning assumptions of HASI is that the provision of stable housing and appropriate clinical and accommodation support assists consumers to become more independent in their daily life, develop or maintain social connections, participate in recreational activities, and find pathways into education and work (Muir et al., 2008; 2010).

#### Daily living skills

HASI consumers are supported by ASPs to develop daily living skills across a range of activities such as cooking, cleaning and taking medication. At least 60 per cent of consumers were independent or supported less than half the time in all activities of daily living, including personal hygiene, cooking, taking medication and transport, cleaning and exercise. At least one third of consumers required support more than half of the time with shopping, managing their finances, cleaning and exercising (Table 6.37; Table 6.38).

**Table 6.37: Independence in activities of daily living**

	Time supported in the activity		Total consumers
	Less than half of the time <sup>1</sup> Per cent	More than half of the time <sup>2</sup> Per cent	
Personal hygiene	84.9	15.1	634
Cooking	81.4	18.6	604
Taking medication	71.0	29	631
Transport	70.0	30	631
Cleaning	66.9	33.1	635
Exercise	66.6	33.1	629
Shopping	63.6	36.4	635
Paying bills	60.3	39.7	633
Budgeting	59.8	40.2	635

Source: HASI MDS supplement September 2009 n= 639

Notes: 1. Fully independent or supported less than half the time

2. Fully dependent or supported more than half the time

The improvements in daily living skills demonstrate a small but consistent increase in independence over time, but only statistically significant for cooking and cleaning (Table 6.38).

**Table 6.38: Change in independence in activities of daily living**

	Time supported in the activity (per cent)				Sig.	Total consumers
	Less than half the time <sup>a</sup>		More than half the time <sup>b</sup>			
	2009	2010	2009	2010		
Personal hygiene	84.8	85.1	15.2	14.9	1.00	396
Cooking	83.4	83.9	16.6	16.1	0.014	397
Taking medication	70.7	72.8	29.3	27.8	0.488	393
Transport	67.4	72.5	32.6	27.5	0.080	393
Cleaning	67.3	73.0	32.8	27.0	0.044	400
Exercise	64.6	67.3	35.4	32.7	0.351	395
Shopping	66.3	69.6	33.7	30.4	0.263	398
Paying bills	61.9	66.8	38.1	33.2	0.110	394
Budgeting	61.3	65.3	38.8	34.8	0.171	400

Source: MDS supplement September 2009, 2010 matched sample n=403.

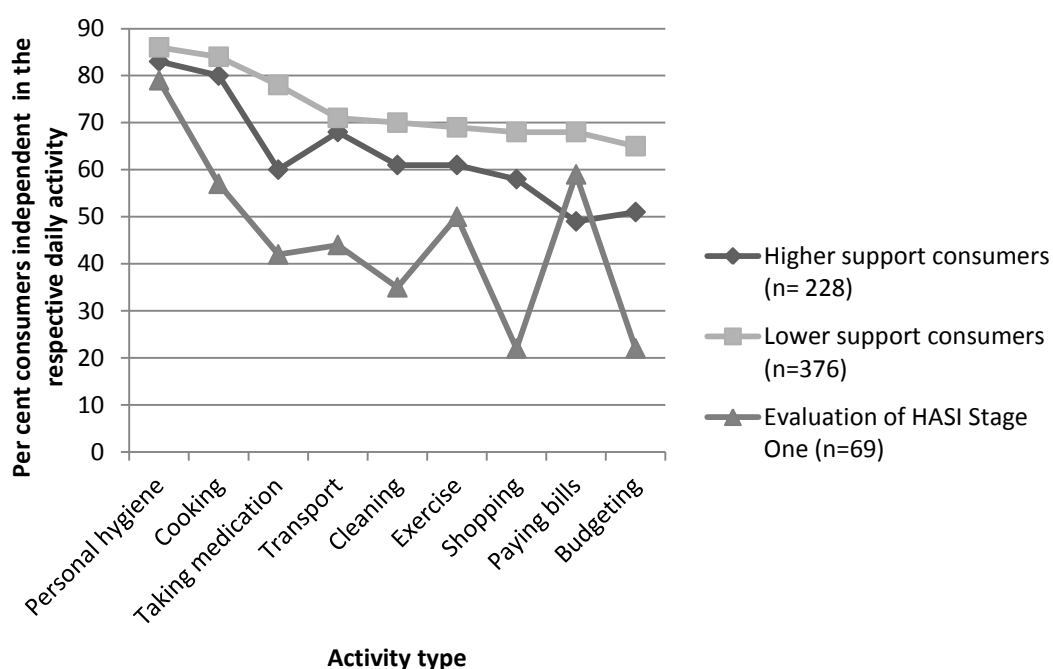
Notes: McNemar Test non-parametric test applied to dichotomous variable to trace the change in outcome

a. Fully independent or supported less than half the time

b. Fully dependent or supported more than half the time

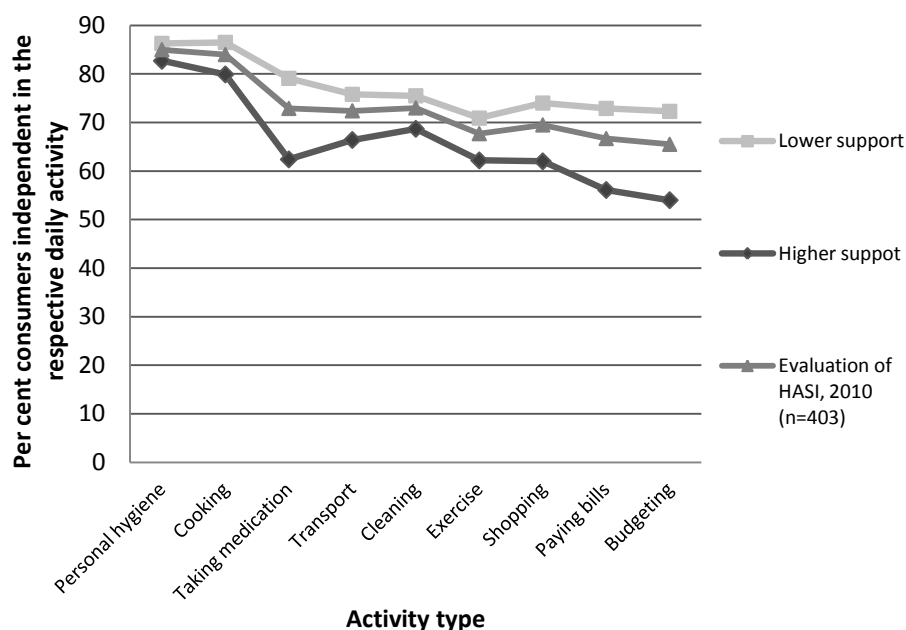
The level of independence in daily activities differed slightly between consumers on lower and higher HASI support (Figure 6.39; Figure 6.40). As expected, consumers on lower HASI support were significantly more independent than consumers receiving high HASI support in the activities of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ( $p < 0.05$ ).

**Figure 6.39: Proportion of consumers independent in activities of daily living, by HASI support level compared to evaluation of HASI Stage 1**



Source: HASI MDS supplement September 2009 n=639; (Muir et al., 2007)

Notes: Fully independent or supported in the activity less than half the time.

**Figure 6.40: Proportion of consumers independent in activities of daily living, by HASI support level**

Source: HASI MDS supplement September 2010 n=403

Notes: Fully independent or supported in the activity less than half the time.

ASPs support consumers in activities such as shopping, attending appointments and other activities, by providing transport. Many HASI consumers said they found it difficult to get out of the house without support from the ASP worker. A medium support consumer said:

Times that because I felt down or don't want to leave the house, I wouldn't be able to go out to get medication etc, I wouldn't have gone without HASI. Times I've just been down and staying in the house all the time, just the support and encouragement to get out of the house and go and do something – go for a walk or go and sit at the beach.

Some consumers and ASPs reported that ASPs had started to review how much transport was provided in order to promote independence. ASPs did this by, for example, restricting transport to visit friends or by introducing travel training where a worker would catch public transport with the consumer on outings such as grocery shopping, with the aim of teaching the skills required for independent travel. Consumers and ASPs indicated that considerations about the extent to which ASPs provided transport included responding to genuine need. Many consumers commented about the level of help in this activity. Withdrawing help with transport was interpreted by some consumers as, '... probably a good thing, it gets you to be more independent.'

In some instances, the property allocated may not be easily accessible by public transport, which can be a barrier to the HASI consumer developing

their independence and achieving goals. An older former HASI consumer who had exited medium HASI support 12 months before and was hoping to commence employment in a physically demanding job illustrates the difficulties experienced by some consumers using public transport. Although this consumer said that the lack of help with travel did not affect her mental health, she expressed concerns about the difficulty of travelling to her prospective workplace:

The unit is great, [pause] put it this way, you've got to be grateful for what you've got [laughs]. Even the location, you know, on a Sunday, buses every two hours, when you don't have a car. It makes it hard when you only have a pushbike or you've got to walk down to the station it's a 25 minute walk ... So if I'm lucky enough to get this job and it starts at 4.30 or 5 o'clock, no problem, I could even ride the bike in, which you don't fancy wanting to do when you've got to go to work ...

Some consumers, however, reported that the withdrawal of transport support had negative effects on their mental health. Their problem was not simply one of transport and travelling independently, but also of overcoming other obstacles to leaving the house, that were related to their mental health. A consumer preparing to leave low support HASI explained that for her, the help with travel was valuable not because she was unable to travel alone, but because she needed someone to push her or to help give an impetus to her to leave the house:

My time is up. I'm up to the program where you travel on your own. I already do travel on my own. But I do need the service again. Since the program stopped I've sort of slid downhill ... I think I need people to push me ... I'd sit there agitated and bored, they'd get me out ... While things were at the maximum, things were running well, now I don't leave home much. I'm sleeping my life away. My physical and mental health are not as good ...

This account shows how the ASPs continuing to support consumers who require longer term assistance with activities of daily living to maintain the gains that they have achieved in HASI would be beneficial. The need for this approach has been reinforced during the expansion of HASI to include short, medium or long term support, depending on the need of the individual consumer. The way some HASI partners interpret this aspect of the HASI model does not meet the needs of some of these consumers, as discussed further in Section 7.2.

### **Relationships and social connections**

Regular contact with family and friends is an important way for people to feel connected to social and community networks. Most consumers (86 per cent; n=548) had regular contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner (Table 6.41 and Table 6.42). One in seven (14 per cent; n=91) do not have any form of regular social

contact. Men and people in higher support are less likely to have any regular form of social contact. Appendix 3 includes the 2010 results and analysis by gender and support level. While this measure is a good indicator of consumers' level of social contact it does not convey whether consumers were satisfied with this level of contact or quality of their relationships with their family members.

**Table 6.41: Contact with family, friends or a partner**

	Per cent (n=639)		Total
	No regular contact <sup>2</sup>	Daily or weekly contact	
Contact with social networks <sup>1</sup>	14.2	85.8	100.0

Source: HASI MDS supplement September 2009 n=639

Notes: 1. Consumers level of contact with family, friends or a spouse or partner  
2. Consumers who did not have daily or weekly contact with family, friends or partner

Some HASI participants lived with a partner or children. More than half the HASI consumers had daily or weekly contact with a family member (64 per cent), but some consumers have minimal contact with family (9 per cent had no contact and 5 per cent had annual contact) (Table 6.42).

**Table 6.42: Frequency of contact with family**

	Consumers	Percent
Daily or weekly	390	63.5
Monthly or quarterly	140	22.8
Yearly	31	5.0
Never	53	8.6
Total	614	100.0

Source: HASI MDS supplement September 2009 n=639

Over time the proportion of consumers with no contact with family decreased significantly (Appendix 3). While the evaluation has not obtained specific data on why this has occurred, it is consistent with the other HASI outcomes for consumers including improved quality of life, mental health and housing stability, and suggests that these factors may support improved family relationships for some consumers.

This suggestion is supported by consumer interview comments reporting that relationships with family and friends had improved as a result of support provided by HASI, although some consumers continued to experience difficult relationships with family. Some consumers said they had increased contact with their family since joining HASI. For example, a consumer receiving low support said:

Before I would see my parents every 3 or 4 months. Now I go every second week, so she [mother] is happy and that so yeah they have helped me out heaps.

Other consumers had positive reasons for seeing less of their family after starting HASI support because they were now more involved in other activities. For example, one consumer saw his mother less frequently because he now attended TAFE.

Some family members described how they felt relieved when their relative started receiving HASI support because they had felt overwhelmed and were happy that their relative received other help. Some families and carers felt HASI had a positive impact on their own lives because it contributed to the quality of their relationship with their family member.

Family members were pleased that HASI had assisted in practical ways by encouraging the consumer in activities such as using public transport, working, cooking, self care, exercise, looking after their house and social interaction, and that this had also helped to lessen their constant worry about their family member. A mother and a daughter of high and medium support consumers said:

She's the type of person who can't be by herself ... it just got too much for me. Just constant support ... they take her out on outings and barbecues, food shopping and all that ... I just need that break.

It's taken a lot off me. It's made it easier, knowing that I don't need to be there and he has someone else to help now.

Other consumers described how they provided support to family members and also received help with their mental health needs. Reciprocity in social relationships is reflected in consumer comments such as the following, by a low support consumer:

My daughter had a baby so [I have been] spending time with her. She is about an hour away. I was with her for about a month – she was helping me too 'cause I was struggling. Just moral support. I've been having a lot of anxiety and depressions. So having company helped.

Some HASI consumers had positive but more distant relationships with family who lived interstate. A low support consumer said, 'My dad's in Melbourne. I ring him up once a month, and send letters.'

For other consumers their relationships with family members were sometimes a source of stress because they felt that their family did not understand their mental illness or because it adds complexity to their daily activities. A medium support consumer explained how HASI had been flexible in assisting him to manage this situation:

I see them [HASI] 3 times a week but at the moment my mum and stepdad are visiting. We all knew this was going to be a hard time so they put in an extra phone call or come out for longer, give extra support.

One fifth of consumers (19 per cent) had a relationship with a spouse or partner (Table 6.43). Of the current consumers who had a partner, two thirds (66 per cent) had regular daily or weekly contact with them, whereas for other consumers, contact with their partner was much less frequent, including a quarter who are estranged from their partners.

Family members and partners who were primary carers of the HASI consumer valued information and support provided by HASI partners. Most felt they were appropriately informed while a small number said they would like to be kept more informed and to have greater recognition of their contribution by HASI partners.

**Table 6.43: Contact with partner**

	Consumers	Per cent <sup>1</sup>
Daily or weekly	78	66.1
Monthly or quarterly	7	5.9
Yearly	4	3.4
Never	29	24.6
Total	118	100.0

Source: MDS supplement September 2009 n=639  
Notes: 1. Per cent of consumers who have a partner (n=118)

Two thirds of HASI consumers had daily or weekly contact with friends (65 per cent), but one fifth (19 per cent) had no contact with friends (Table 6.44). Some HASI consumers had not formed or maintained friendships and HASI workers were the only people they saw other than family. The percentage of HASI consumers who had contact with friends at least once a month (80 per cent) is lower than the overall population with a mental illness who have contact with friends at least once a month (89.9 per cent) (Australian Bureau of Statistics, 2009: 15). This is not surprising because HASI is targeted to consumers with mental illness who require support to participate in community life, maintain a tenancy and live independently in the community. Many of the consumers interviewed indicated that they felt socially isolated and had little contact with family members or friends. On the other hand, consumer interview data confirmed that some consumers felt that since being involved in the program they were less isolated because they had developed new friendships with other consumers and relationships with neighbours and people they had met through social activities in the community.

**Table 6.44: Contact with friends**

	Consumers	Per cent <sup>1</sup>
Daily or weekly	408	64.7
Monthly or quarterly	92	14.6
Yearly	11	1.7
Never	120	19.0
Total	631	100.0

Source: HASI MDS supplement September 2009 n=894  
Notes: 1. Per cent of consumers who have a friend (n=631)



Social isolation is associated with increased risk of mental health problems (Australian Bureau of Statistics, 2007). Further, people living alone, as most HASI consumers do (as described in Section 6.2), are more likely to be lonely and less likely to be able to rely on informal care provision (Franklin and Tranter, 2011).

For those consumers who did not have contact with family members, friends and partners, HASI was effective for improving relationships. Change in contact improved for consumers who previously had no contact with family (8.3 per cent of consumers in 2009 and only 4.3 per cent in 2010 ( $p < 0.01$ ); friends (7.6 per cent of consumers in 2009, only 1.8 lacked contact in 2010 ( $p < 0.001$ ); and a partner (5.4 per cent in 2009 reduced to only 0.8 per cent of consumers in 2010 ( $p < 0.001$ ). Other change in contact between 2009-10 was not significant in the MDS (Appendix 3, Table C.13).

### Community participation

Most HASI consumers (83 per cent) were participating in at least one type of community activity.<sup>56</sup> One fifth of HASI consumers (21.3 per cent) were participating in a disability day program, nearly two-thirds of consumers (62.4 per cent) were supported to participate in individual social and recreational activities – such as mainstream exercise classes – and half of all consumers (54.8 per cent) were supported to attend group activities such as sports or art classes (Table 6.45).

**Table 6.45: Participation in social or recreational activities by type**

	Participating (per cent)	Consumers
Supported group activity	54.8	611
Unsupported group activity	53.7	594
Supported individual activity	62.4	611
Day program	21.3	597

Source: HASI MDS supplement September 2009 n=639

People in lower and higher support had similar levels of participation in supported independent activities, but consumers receiving higher support were significantly more likely to participate in supported group activities ( $p < 0.001$ ) and day programs ( $p < 0.05$ ) than those in lower support. More than half of participants (53.7 per cent) regularly attended activities without their support worker and these activities were more likely to be undertaken by people receiving lower levels of support. The proportion of consumers participating in unsupported group activities increased over one year, although the other types of activities remained similar (Table 6.46).

<sup>56</sup> MDS supplement September 2009

**Table 6.46: Change in participation in social or recreational activities by type**

	Participating (per cent)			Consumers
	2009	2010	Sig. <sup>a</sup>	2009-2010
Supported group activity	60.6	57.4	0.303	383
Unsupported group activity	51.8	60.1	0.016	363
Supported individual activity	66.1	58.7	0.027	383
Day program	24.3	22.4	0.450	362

Source: HASI MDS supplement September 2009, 2010; n=403  
Note: a. McNemar test

Both lower and higher support level consumers increased their independence and decreased their participation in supported activities (Table 6.47). Consumers from both support level groups increased their participation in unsupported group activities, and the increase was greater and statistically significant for lower support level consumers. Furthermore, there was a great decrease in participation in supported individual activity, and the change (improvement) for consumers in higher support level was most significant (while 73 per cent of higher support level consumers participated in supported individual activity in 2009, in 2010 only 57.4 per cent needed such high level of support).

**Table 6.47: Change in participation in social or recreational activities by type and HASI support level**

	HASI support level (per cent)					
	Lower (n=253)			Higher (n=144)		
	2009	2010	Sig. <sup>a</sup>	2009	2010	Sig. <sup>a</sup>
Supported group activity	51.5	51.5	1.000	75.7	67.4	0.059
Unsupported group activity	49.3	61.3	0.008	55.8	58.0	0.779
Supported individual activity	62.0	59.5	0.610	73.0	57.4	0.004
Day program	20.9	19.1	0.596	30.3	28.0	0.719

Source: HASI MDS supplement September 2009, 2010 n=397 consumers the support level could be identified. Missing = 6.  
Notes: a. McNemar test

Similarly, the increased participation in unsupported group activity was greatest for HASI consumers who had been in the program for 1 to 2 years, and those who had been in HASI for more than 2 years (Table 6.48).

**Table 6.48: Change in participation in social or recreational activities by type and length of time in HASI**

	Length of time in HASI <sup>a</sup> (per cent)								
	One year and less (n=140)			1-2 years (n=55)			More than 2 years (n=208)		
	2009	2010	Sig.	2009	2010	Sig. <sup>b</sup>	2009	2010	Sig.
Supported group activity	61.4	55.3	0.280	55.8	59.6	0.791	61.3	58.3	0.511
Unsupported group activity	61.1	55.6	0.360	46.9	69.4	0.035	46.8	60.6	0.005
Supported individual activity	67.9	58.2	0.093	61.5	57.7	0.804	66.0	59.4	0.188
Day program	28.3	18.1	0.011	15.4	21.2	0.453	24.0	25.7	0.728

Source: HASI MDS supplement September 2009,2010 n=404

Notes: McNemar test

a. Time from entry to December 2009;

b. The differences for this group may not be statistically significant because of the small size of the sample (55 consumers in HASI for between one and two years)

Over time, participation in HASI is associated with increased consumer involvement in unsupported social and recreational activities. While many people receiving HASI continued to participate in supported activities, HASI also had success supporting consumers to participate in the community in activities independent of service providers.

Interviews with consumers suggested that many of them were involved in activities run by ASPs or by other services specifically for people with mental health issues. In addition to the types of health-related activities mentioned above, consumers mentioned participating in grocery shopping trips, barbecues, outings to the beach, coffee or meals at restaurants, woodwork classes and craft classes. Some consumers enjoyed and appreciated these activities and said that they met their needs. Others reported that there was not enough variety, for example barbecues or group coffee outings were the most frequent recreational activity for some people. One consumer said that the organisation did not include him in all of the outings because of where he lived. Some consumers also reported that they did not attend group activities because other consumers had threatened them.

Consumers indicated that through HASI they had become involved in day centre activities, such as Day to Day Living Program, which is targeted at people who have mental illness. These programs generally provided consumers with a safe place to socialise, learn new skills and join in on planned activities. The exception was that some consumers said they had withdrawn from these programs because of inappropriate behaviour by other participants.

Day centre activities are targeted to people with mental illness rather than being mainstream, and emphasis on access to mainstream activities for HASI consumers would be more consistent with HASI goals and with the aspirations of many consumers who wish to be 'mixing with people in ordinary society'. On the other hand, as described above, HASI consumers were mostly independent in daily living and participation in HASI is associated over time with increased consumer involvement in unsupported social and recreational activities, such as exercise and fishing.

Participating in mainstream group activities was less common. A low support HASI consumer suggested that HASI should do more to assist consumers with accessing the mainstream community, saying:

Give them more resources to help clients find other things to do with people that are healthy, so they're not just mixing with people like them but mixing with people in ordinary society that have got good values and stuff. How to mix with people that are well – that's something I would like to see. You need help getting into it. Most of us just coop ourselves up in our houses and stay away from things that are bad, and unfortunately we pay the price for that.

An ASP staff member suggested that consumers underestimated the amount of community participation that they achieved, and the diversity of activities involved in participating in the community, saying:

I don't think a lot of the time our guys understand when they are being linked to community. I don't think they understand if they do TAFE, it's a link to the community, and most of them have done TAFE courses. They seem to think being linked to the community means going out and getting a job and working ...

The ASP worker described how the consumers had links in the community such as attending conferences, teaching in NSW Health, appearing on television to speak about mental health stigma, running a craft stall, cleaning at the ASP and the community housing provider, volunteering by returning shopping trolleys and shopping independently in the community.

While some consumers had found participating in mainstream community groups to be a positive experience, for other consumers it was not. For example, one consumer described how she had decided to leave a local art and craft class because the teacher and other participants were not very accepting of her. She has since found a new teacher who had a better understanding of mental health.

## Work, training and education

One third (31.3 per cent) of current HASI consumers participated in employment, education or training (Table 6.49). One fifth of HASI consumers participated in paid or voluntary work (19.2 per cent).

**Table 6.49: Participation in work, training and education**

	Participating (per cent) (n=639)
Work, training or education <sup>1</sup>	31.3
Paid or unpaid work <sup>2</sup>	19.2

Source: HASI MDS supplement September 2009 n=639

Notes: 1. Consumers who are involved in at least one type of work, education or training activity

2. Consumers who are involved in at least one type of paid or unpaid work (part-time, full-time or volunteering)

More consumers were employed in part-time (11.4 per cent) rather than full-time work (1.6 per cent) (Table 6.50). Consumers receiving higher support were more likely to be participating in part-time work in 2009 ( $p < 0.005$ ). The percentage of consumers on lower support and working part-time decreased in 2010 and that of consumers receiving higher support and working part-time increased. However, the 2010 difference between the two groups was not statistically significant (Appendix 3, Table C.20). The numbers are too small to comment on the impact of changes in the employment market.

**Table 6.50: Work, training and education participation categories**

	Participating (per cent of total consumers)	Total consumers
Education or training	17.1	625
Looking for work	15.6	620
Part-time work <sup>1</sup>	11.4	630
Caring for others	11.0	618
Volunteer work	8.1	623
Full-time work <sup>2</sup>	1.6	626

Source: HASI MDS supplement September 2009 n=639

Notes: 1. Less than 30 hours per week

2. More than 30 hours per week

Consumers could be involved in more than one activity

Close to one-fifth of consumers (17.1 per cent) were participating in some type of education and training, with slightly more men (53.3 per cent of people studying) studying than women (46.7 per cent), however, this difference is not statistically significant. While many consumers were not participating in any form of paid employment, 15.6 per cent were currently looking for work and 8.1 per cent were volunteering.

Some HASI consumers undertook voluntary work: a higher proportion of men were involved with volunteering than women (Appendix 3, Table C.20). Consumers indicated that voluntary work was an enjoyable part of their week.

One said, 'I go to work one day a week at Vinnies. And that's voluntary work and I love it. Love it.'

Some consumers (11 per cent) are also involved in caring for children or dependent family members or friends. HASI consumers involved in care work were more likely to be women than men (81 per cent compared to 19 per cent,  $p < 0.05$ ). For example, some women had children living with them or were involved in providing support to other family members such as grandchildren.

A combined measure of economic involvement was defined as consumers involved in at least one of the activities: education or training, looking for work, part-time or full-time work, volunteer work or caring for others. The changes between 2009 and 2010 across the sample were not statistically significant but when analysed by length of time in HASI, 45.7 per cent of consumers who had been in HASI for less than a year in 2009 were involved in some kind of economic activity and this ratio increased to 56.4 per cent by 2010 ( $p < 0.05$ ), emphasising the impact of HASI on economic involvement during the second year of participation.

Comparing consumers in 2010, consumers who had spent longest in HASI were less involved in economic activities and the differences between groups (consumers who had been in HASI in 2010 for 1-2 years, 2-3 years and over 3 years) are statistically significant ( $p < 0.005$ ) (Appendix 3, Table C.20).

Several consumers interviewed for the study expressed an interest in studying or undertaking a training course in the future. Others said they were already participating in education courses:

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.

Participation in education program varied from TAFE courses such as Landcare and veterinary studies to one consumer studying part-time for a bachelor degree. A medium support consumer said:

I'm going to Tech. I'm studying horticulture, mathematics, computers and first aid. [The support worker] encouraged me to do that. I'm enjoying it ... Next month I go to do some work experience through the tech, it's at a factory.

The Australian unemployment rate for people with a mental health disability is 75-78 percent (Frost et al., 2008: 3). Many consumers (45 per cent) identified participation in education or employment as a goal and 82 per cent of these consumers had partially or fully achieved this goal (Table 7.5). Several of the consumers from all support levels who were interviewed for the evaluation stated that the program has helped them to manage their mental health which, in turn, has had a positive impact enabling them to undertake employment, voluntary work or education and training:

They got me under an employment agency to get me some work and I'm really looking forward to that as well.

The help and support I got from HASI was A1 ... I wasn't on my own any more ... As well as being involved in the HASI program I was also involved in the [charity] workshop as a volunteer, I went back to Centrelink and said I need help to get back in the workforce and they put me back into the Jobcentre, and I've been looking for jobs and they've got a job over here doing the cleaning of the common area, they're going to start a training program ... I had the interview yesterday.

Several consumers, particularly those receiving low support HASI, mentioned they were currently looking for work and a number of other consumers confirmed that they were actively engaged in paid employment. One low support consumer described the difference that having a job had made on his life:

I have been working for four and a half years now ... Now I have to be more disciplined – with appointments and going to work and things...

### **Summary of participation outcomes**

Consumers developed daily living skills, increased social connections and participated in the community, education and employment according to their preferences. Consumers overall reported benefits in these activities and feeling positive about living independently in the community. Some consumers expressed concern that they still felt marginalised and stigmatised in the community because of their mental illness. Other consumers had limited family support or no contact with family members and some said they did not have any friends. Consumers reported developing supportive relationships with ASP staff and other consumers. They wanted greater participation in mainstream services and activities with other community members.

### **6.4 Consumers most likely and least likely to benefit from HASI**

The analysis in this consumer outcomes section shows that most consumers from every group benefit from the program, including men and women, consumers on higher and lower support packages, all age groups, consumers with and without prior contact with families and friends and consumers with and without prior stable housing.

The interview research found that some consumers initially had difficulty engaging with HASI but subsequently did so and gained considerable benefit from the program. As described in Section 6.1, some consumers with drug or alcohol problems ceased or reduced their substance use with support from HASI.

The expansion of HASI to include multiple stages with flexible support has addressed many of the program rigidities identified in the 2007 HASI Stage 1 evaluation. The availability of different housing options and levels of support in a geographical location enables the HASI partners to be more responsive to the various needs of mental health consumers at risk of unstable housing, irrespective of their mental health support needs, other conditions and life circumstances. This has meant that HASI has been able to benefit a wider range of consumers and to respond to their changing needs, including people with higher and lower support needs.

This required ASPs to optimise opportunities to engage consumers at the times in their recovery when they were responsive to HASI support (discussed more in Sections 7 and 8). Some workers indicated that consumers who were most willing and motivated to engage with HASI support were most likely to benefit. A clinical mental health worker said, '... some people benefit more and they tend to be the ones that are willing to do the work and really get on board with the care plan ...' Some workers also suggested that when HASI consumers also use drugs and alcohol, their motivation may be reduced and they may benefit less from HASI.

If these support needs are addressed, and recovery oriented practice is used to motivate engagement, consumers with drug and alcohol use need not be excluded from HASI.

Improved training and support for HASI partners (see also Section 7) would assist them to respond effectively to consumers with complex needs who meet the eligibility criteria, whenever consumers are ready for the next step of their recovery. With appropriate housing, clinical and support services and encouragement to engage with the program, all groups have been shown to benefit.

## **6.5 Discussion about the findings**

Qualitative and quantitative evidence from the evaluation is that most people using HASI support experienced improved quality of life and wellbeing since participating in the program. A small number of people reported that their wellbeing had decreased or remained the same. Consumers experienced significantly fewer and shorter mental health hospital admissions after joining HASI, as well as reduced psychological distress, improvements in behaviour difficulties and some improvement in life skills. Consumers attributed improvements in their mental health to regular contact with ASPs.

In addition, the HASI program has provided stable housing for almost all consumers participating in the program, most of whom had experienced unstable housing in the past. However some HASI applicants had to wait for many months to be allocated a property via priority housing assistance. Most HASI consumers are satisfied with their housing and the support they receive from the housing provider. If consumers have moved, it is usually for planned reasons to more suitable accommodation. With the support of the ASP and housing provider, almost all HASI consumers meet the obligations of their



tenancy agreement (they pay their rent on time, maintain their property and are good neighbours).

Most HASI consumers have a high level of independence in their daily living skills, particularly in relation to personal hygiene, cooking, taking medication and transport. Consumers are also participating in social networks and community activities such as recreational activities, education and employment. Most consumers enjoy regular social contact, which has improved over time, however one in seven continue to be socially isolated.

Some consumers were actively involved in some kind of education, training, paid or unpaid work and were encouraged and supported in these activities by ASPs. Most participants independently participate in social and recreational activities, but many consumers receiving higher support continue to require the support and assistance of their ASP support workers to be able to access and participate in the community in a meaningful way. Some ASPs continue to rely on participation in activities targeted to people with a mental illness rather than mainstream activities. A greater emphasis on access to mainstream activities would be more consistent with HASI goals and with the aspirations of many consumers.

**Table 6.51: Summary of HASI outcomes analysis**

Outcome	Explanation	Normative comparison data	Before HASI	During or at entry HASI	Average outcomes measure
<i>Hospitalisation</i>	<i>Hospital admissions and length of stay (2 years before and 2 years during HASI; mental health and other inpatient, emergency presentations)</i>				<i>Decrease in average number of inpatient admissions; average days in hospital per year; average days per inpatient admission; and emergency presentations. Greatest improvements were for men and younger consumers. Changes were sustained over the first two years in HASI and hospitalisation rates in the second year were lower than two years before HASI, except higher support consumers.</i>
	Average no. of mental health inpatient admissions per person per year		1.7	1.3	24% decrease in mental health inpatient admissions per person. Greatest improvements were for lower support consumers.
	Average no. mental health inpatient days per person per year		54.7	22.5	58.9% decrease in days in mental health inpatient use per person per year. Greatest improvements were for higher support consumers.
	Average no. of mental health inpatient days per person per admission		6.3	2.1	68.0% decrease in the number of days mental health inpatient use per person per admission
<i>Mental health</i>	<i>Mental health before and during HASI (13 week reviews K10, LSP16, HoNOS)</i>				<i>Average MH-OAT measures of mental health improved</i>
	Kessler 10 (K10+LM – MH-OAT)	<sup>o</sup> Residential: Ambulatory:	17.5 19.8	23.2 21.5	1.7 point reduction in K10+LM per person (an average decrease in psychological distress). Clinical significant change: 33.9% improved, 42.1% no change; 24.0 deteriorated. Greatest improvement was for men and consumers aged 30-64 years.
	Health of the Nation Outcome Scales (HoNOS – MH-OAT)	<sup>o</sup> Inpatient: Residential: Ambulatory: Total(mean):	11.5 10.5 9.4 10.5	10.8 9.8	1.0 point score reduction in total HoNOS scores per person (an improvement in behaviour, impairment, symptoms and social problems). Clinical significant change: 8.9% improved, 87.7% no change; 2.5 deteriorated. Greatest improvement was for women, lower support and consumers aged 18-29 years.
	Life skills 16-item disability measure (LSP16d- MH-OAT)	<sup>o</sup> Residential: Ambulatory: Total(mean):	14.2 10.8 12.5	11.5 10.0	1.5 point score reduction in life skill related disability (improvement in life skills). Clinical significance analysis was not possible. Greatest improvements were women, lower support and consumers 30-44 years.
<i>Other health service use</i>	<i>Number of community mental health service contacts (2 years before and 2 years during HASI)</i>	-	50.8	53.2	No significant change in community mental health contacts. Significant increase for higher support and 45-64 year old consumers. Increase after immediate entry to HASI and sharp decrease to below pre-HASI use in second year in HASI. Care planning and medication support activities increased significantly.

Outcome	Explanation	Normative comparison data	Before HASI or at entry	During HASI	Average outcomes measure
<i>Tenancies</i>	<i>Secure tenancy</i>				<i>Most people maintained a secure tenancy and uphold the conditions of their tenancy agreements. Most moves are for positive reasons. HASI public housing tenants have similar outcomes to other public housing tenants for rental, complaints and repairs.</i>
	Consumers who maintained tenancy	-	-	90%	90% of consumers sustained their tenancy while in HASI. Where they did change their tenancy, 86% of these changes were planned (more appropriate or long term housing).
	Consumers in public housing who met rental payment requirements	96% <sup>a</sup>	-	97%	97% of consumers in public housing paid rent on time, which is comparable to other priority housing residents.
	Consumers with a CTTT <sup>b</sup> action	-	-	1%	1% of consumers had a CTTT action and this did not differ between higher and lower support consumers or across the first year in HASI.
	Consumers without a nuisance and annoyance complaint	-	-	93%	93% of consumers were living as 'good neighbours' and had no complaints made against them. This was stable over the first year in HASI.
	Consumers without outstanding repairs and maintenance	96% <sup>a</sup>	-	96%	96% of consumers maintained their property to a good standard and did not have outstanding repairs and maintenance, which is comparable to other priority housing residents.
<i>Social and community participation</i>	<i>Meaningful participation</i>				<i>Most consumers improved their life skills, social relations and meaningful participation in social, community and economic activities.</i>
	Independence in daily living (supported less than half the time)	-	-	60%	60% consumers have some independence in daily living skills and many need support for more complex tasks. No statistical improvement in independence was observed. Lower support consumers had the greatest independence and improvement.
	Social network	-	-	86%	86% of consumers had regular social contact with family and friends. Proportion of consumers with no contact decreased.
	Community activities	-	-	83%	83% of consumers participated in social and community activities. Improvement was greatest for lower support consumers. And consumers in HASI for more than 2 years. Higher support consumers were more likely to participate in supported activities.
	Consumers in work, training or education	-	-	31%	31% of consumers participate in education, voluntary and paid work. The proportion in paid work increased and most were in part-time work (11%).

Notes:

- a. Priority housing residents in NSW
- b. Consumer Trader and Tenancy Tribunal action -where a tenancy issue has not been able to be resolved by other means
- c. <http://wdst.amhocn.org/>

## 6.6 Summary of consumer outcomes

The outcomes for HASI consumers makes three types of comparisons: between the HASI consumers and a comparable group, such as the general population, the consumer outcomes from the Stage 1 evaluation in 2007, or another comparison group derived from the secondary data sources; before and during HASI consumer outcome measures; and 2009 to 2010 HASI consumer comparison outcome measures.

The outcomes analysis shows positive results in mental health hospital admissions, mental health, physical health, stable tenancies, independence in daily living, social participation, community activities and involvement in education and voluntary or paid work.

### *Mental health hospital admissions*

- Overall, HASI consumers had significantly fewer and shorter mental health hospital admissions after joining HASI: improvements included a 59 per cent decrease in the average number of days spent in a mental health inpatient hospital per year; and a 24 per cent drop in the number of admissions to hospital per year. Among consumers who were admitted to hospital at least once both before and during HASI, the average number of days hospitalised per admission decreased by 68 per cent. Similar improvements were experienced in other inpatient admissions and days and emergency presentations and hours.
- Longitudinal analysis of hospital use by gender shows that women were admitted to hospital more often than men and spent more days in hospital per admission, but that men spent more days in hospital per person before joining the program. The inpatient rate and length of stay improved for both men and women once they entered HASI and improved further during their second year in the program.
- The greatest improvements in admissions were for men, lower HASI support and younger consumers. Changes were sustained over the first two years in HASI and hospitalisation rates in the second year were lower than two years before HASI, except for higher support HASI consumers. Greatest improvements for days in mental health inpatient services were for higher support HASI consumers.

### *Psychological distress, life skills and behavioural issues*

- Analysis of the MH-OAT measures (K10, LSP16 and HoNOS) shows significant improvements in consumers' mental health since joining the program.
- Overall women, consumers in lower support and younger consumers were more likely to improve while in HASI. However when differences in mean scores before and during HASI are compared, although less often than their counterparts, men, higher support or older consumers were more likely to experience greater improvements in scores.

- HASI consumers' life skills increased and behaviour issues decreased (both statistically significant) compared with before consumers became involved in the program (LSP16 and HoNOS outcome measures).
- Consumers K10 scores decreased overall, flagging a general improvement in their mental health. During HASI K10 scores were not significantly different between consumers of different ages or support levels. Women had higher levels of distress both before and during HASI and both men and women relatively improved in this respect when before-during HASI scores are compared.

#### *Consumer and worker perceptions of mental and physical health*

- Most consumers said that they had experienced improvements in their mental health and attributed part of this change to regular contact with ASPs. ASP staff rated over half of current consumers as having excellent, very good or good physical health, but this was still lower than the general population. Possible explanations are better identification and treatment of pre-existing problems, a focus by ASPs on health issues and other issues related to the mental illness and medication.

#### *Use of mental and physical health services*

- Most consumers (96 per cent) had used health, mental health, and allied health services at least once during the previous year. Women used GP and allied health services more frequently than men. Consumers receiving higher HASI support services used community mental health and psychiatric services more frequently than those on lower support, but used GP or allied health services less frequently.
- HASI consumers used a range of community mental health services (ambulatory care), which increased during the first year in HASI then dropped to levels below 2 years before HASI.

#### *Housing*

- HASI has provided housing stability for almost all consumers participating in the program. Most people had experienced unstable housing before entering HASI.
- HASI operates within an extremely tight housing market with a shortage of affordable housing. Currently new HASI consumers are housed in existing stock when a new property becomes available and the cost is absorbed by the housing provider. Waiting times to access priority housing assistance varied depending on the location, ranging up to many months.

#### *Tenancy*

- Interviews with consumers and their family members found that overall they were satisfied with the housing and tenancy management that they received.

### *Daily living skills*

- At least 60 per cent of consumers were reported to be independent or supported less than half the time in all activities of daily living including personal care, cooking, taking medication and transport, cleaning and exercise.
- Approximately one in three consumers required support more than half of the time with shopping, managing their finances, cleaning and exercising.
- Consumers on lower support were more independent than consumers receiving higher support in the activities of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ( $p < 0.05$ ).

### *Relationships and social connections*

- Most current HASI consumers (86 per cent) had some form of regular social contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner.
- One in seven consumers (14 per cent) did not have any regular contact (daily or weekly) with other people, such as a family member, friend or partner. Men and consumers with higher support were less likely to have regular social contact with a family member, friend or partner.

### *Community participation*

- Most HASI consumers (83 per cent) were participating in at least one kind of community activity (including supported and unsupported group activities, supported individual activities and day programs).

### *Work, training and education*

- HASI consumers were continuing to participate in education and work, with 31 per cent currently involved in some type of activity (paid or voluntary work, education and training).

## 7 HASI service model

The aim of the HASI model is to support a consumer's process of recovery, as defined in the HASI Resource Manual:

a personal and ongoing process, defined and led by the individual. Recovery from mental illness has been described as a journey, sometimes lifelong, through which a mental health consumer achieves independence, self-esteem and a meaningful life in the community (Anthony, 2000; NSW Health, 2006).

The HASI model of supporting personal recovery (Section 3.2) operates by providing housing services, access to clinical services and accommodation support services. This section analyses the effectiveness of the HASI referral and selection processes, type of services provided to consumers and the framework for service delivery.<sup>57</sup>

### 7.1 Referral and selection

This section examines the effectiveness of the way referral pathways were operating at the local service level and how people were selected to participate in the program. Sample application and consumer consent forms and processes are outlined in the HASI Resource Manual (NSW Health, 2006).

#### *Referral and application process*

Referral and application procedures are similar for all stages of HASI. Any person or organisation can refer a consumer to HASI and referrals can be made at any time. The consumer or the person/organisation making the referral completes a HASI application form and submits it to the relevant local ASP. HASI application forms vary according to the requirements of the particular ASP, but must contain a specified set of core information about consumers and their needs. In addition, a consumer seeking a higher support HASI package who needs housing also completes an application for social housing if this has not already been done. Low support packages are targeted to consumers who already have stable housing, but in practice some of these applicants also need to complete an application for social housing (discussed further below). Where an applicant is not known to the local MHS, the applicant is assessed by the MHS as part of the application process.

If the ASP does not have an immediate vacancy, eligible applicants are placed on a waiting list maintained by the ASP. The ASP contacts the referral source or nominated contact when a vacancy occurs. The consumer might appear on more than one waiting list if the location has more than one ASP with multiple levels of support packages, as discussed below. ASPs seek out

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<sup>57</sup> The information sources for this section are the fieldwork interviews and observation in 2009 and 2010 and HASI MDS 2009 (Appendix 1).

applications if a vacancy occurs and no suitable applicant is on the waiting list. All three evaluation sites had waiting lists of people eligible to join HASI.

### *HASI vacancies*

When a HASI vacancy exists, the ASP reviews all eligible applicants on the relevant waiting list. (There is some variation in these processes across the State, and not all ASPs hold a waiting list.) When the ASP identifies suitable consumers, they conduct interviews with the applicants (and carers if appropriate) to confirm their suitability for the timing and nature of the vacancy. The purpose of these interviews is also to gather information about the support needs of the applicants, and provide information about the support available for the package and the subsequent selection process.

The ASP also conducts a needs assessment with these consumers based on established criteria. In some locations this task is performed prior to convening the Selection Panel. In others it is done after the first step of the Selection Panel described below. The purpose of this task is to establish the relative needs of the applicants, in order to prioritise consumers and also to assess the level and types of support they will require.

### **Referral pathways**

The evaluation found that referrals to the HASI program conformed with the procedures described above. Referring agencies made referrals directly to ASPs who managed HASI support packages. Mental health clinicians made the most referrals, including community mental health service teams (60.3 per cent) and hospital staff (17.6 per cent), rather than social housing or other organisations (Table 7.1). Some referrals made by mental health clinicians were initiated by housing or community organisations, as discussed below.

**Table 7.1: Source of referrals to HASI**

Referral source	Consumers	Per cent
Community Mental Health Service	512	60.3
Hospital	149	17.6
Public Housing Consumer Service Team	46	5.4
Community Housing Provider	21	2.5
Other HASI ASP	14	1.6
Other	107	12.6
Total	849*	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 46 consumers

The referral rates from each referral source varied by the level of HASI support required (Table 7.2). It is unsurprising that referrals to higher HASI support primarily came from community mental health and hospitals, as these packages are intended to support people with the highest needs and the greatest housing vulnerability. It is also unsurprising that referrals from housing organisations for medium support packages were low, as these are HASI in the Home packages.



**Table 7.2: Referral source by support level**

Referral source	HASI support level (per cent)				Total (n=849)
	Low (n=475)	Medium (n=54)	High (n=261)	Very high (n=59)	
Community Mental Health	63.4	74.1	58.6	30.5	60.3
Hospital	8.0	18.5	27.2	50.8	17.6
Housing NSW	9.5	0	0.4	0	5.4
Community Housing Provider	4.0	0	0.4	1.7	2.5
Other HASI ASP	1.3	0	2.3	3.4	1.6
Other	13.9	7.4	11.1	13.6	12.6
Total	100.0	100.0	100.0	100.0	100.0

Source: HASI MDS September 2009 n=895

Note: Data missing for 46 consumers

The rates of referral from housing organisations for low support packages, however, were unexpectedly low and only one in ten referrals were received from social housing and other providers. The low proportion of referrals from housing providers and ASPs could be explained by these organisations first directing their referrals to MHS who then formally make the referral to the HASI program. For example, an ASP manager reported that:

[Referrals] might come from housing but general agreement is that housing should contact health and they should agree that that person should be referred, because again they should have a case manager ... we get more referrals from housing ... through HASI 2 because of the focus being on people who are not coping with their tenancies. [But overall] most of our referrals come from health.

ASPs in some locations reported that referrals were, however, increasingly coming directly from other service providers in the community. Indeed, almost 14 per cent of current consumers were referred by other providers, such as temporary accommodation services. This finding was also emphasised in interviews.

Most HASI partners thought the referral processes worked well, although the process varied across the evaluation sites, as permitted in the HASI Manual and described above. They said the referral pathways have improved and strengthened with growing awareness and support for the program in the local mental health services.

As a result of the expansion of HASI, some locations may now have multiple ASPs who offer multiple HASI support levels (low, medium, high and very high support). While many locations co-ordinate well between ASPs, in some locations different ASPs have different application forms and consumers may need to make more than one application to more than one ASP. Some workers reported that some referring agencies in some sites were confused about filling out multiple applications because the process did not have a central place to make HASI referrals. The onus is on the referring agency to identify and refer people to the appropriate ASP and level of support. Some

clinical referrers did not fully understand the differences between ASPs and the packages. This suggests that the referral process would be strengthened by additional information or training about the process and by ASPs in a particular location agreeing on a single entry point and referral process.

One location with multiple ASPs had developed a common referral form used by all ASPs to streamline the referral process. Particularly for metropolitan locations, referral processes worked well if they had designated staff with knowledge and expertise within the LHD and hospitals to coordinate the referrals. This was less of a problem in rural and regional locations because of the small service context and continuity of staffing in the LHD. However, the need to promote information about eligibility criteria to referring agencies and simplify the referral processes in some locations continues.

In some locations ASPs meet directly with referring organisations to discuss each referral. A LHD clinician described the process:

We make a referral to [the ASP, who] arrange to come into the unit and we sit down and we have a chat to the person in question. [The ASP] takes that away ... and we then have our placement meeting.

In some evaluation sites, LHDs or housing providers did not refer consumers with less complex needs to HASI if they were aware of other support services offered by ASPs, such as the Recovery and Resource Services Program (RRSP) or other programs such as Personal Helpers and Mentors Program (PHaMs). Possible explanations for this include that the referrals were more appropriately made to other programs and a finite number of HASI places. A housing provider said:

[HASI] is a last resort in the sense that places are limited and they are for clients who have complexity whereas there are other services like (ASP) offering less intensive services.

A number of ASP managers reported that some clinicians, consumers and family members were under the impression that HASI is a housing provider. One ASP manager reported that they were approached directly every week by people who were homeless and thought the ASP may be able to provide them with housing. Other ASPs were concerned that clinicians were referring and selecting some consumers who have no interest in receiving accommodation support services. Clear information about the program criteria needs to be regularly disseminated to all referring agencies. This misconception was also mentioned by a LHD staff member:

Referrals happened from psych units – as a way of getting out. ‘It’s going to help you get accommodation’ and they don’t realise they are going to have the ASP visiting everyday and they find they don’t want them around. Maybe it was due to a lack of information about what was involved.

The consumer profile analysis showed that HASI is accessing the intended target group through the strong referral pathways (Section 5). Suggested ways that the referral process can be strengthened include:

- Co-ordinating referrals within the LHD if the location has more than one ASP to avoid duplicate referrals
- Promoting information about the eligibility criteria and alternative support services among referring agencies and
- Agreeing on a common ASP referral form in each location.

### **Selection processes**

The selection process is the same for higher and lower support HASI packages and is described below as set out in the HASI Resource Manual (NSW Health, 2006). The ASP is responsible for convening a meeting of the local Client Selection Panel as soon as practicable after an available support package is identified. The Selection Panel is convened locally in each HASI location and is coordinated by the relevant ASP. Each local Selection Panel includes, at a minimum, a representative from the local mental health service and the ASP. Some also include the local housing provider, or other service providers.

HASI partners advised that they use local selection committee meetings for many functions. The functions included reviewing new referral applications; following up reasons why potential consumers had been assessed or not by the ASP; allocating housing to successful applicants; and discussing any concerns about current consumers' wellbeing or tenancy.

The selection process is set out in the HASI Resource Manual (NSW Health, 2006):

1. Eligible applicants from the Register of Applications are considered by the Client Selection Panel, using a short-list generated by the ASP, based on the interview process which assesses suitability.
2. The Selection Panel generates a priority list of applicants for the available support package, based on the assessment and other relevant information.
3. Following the decision of the Selection Panel, the ASP informs the highest priority consumer of the Panel's decision and interviews them to ensure they are still willing and able to enter the Initiative.
4. Where necessary, additional information may be sought from other people prior to accepting the applicant. These checks are required to conform with consumer privacy and confidentiality regulations.
5. The ASP, on behalf of the Selection Panel, informs the applicant interviewed in writing of the outcome. If the applicant is not recommended for acceptance into HASI, the ASP advises the Selection Panel, and notifies the applicant of the reasons for the decision and the appeals procedure.

6. Once a consumer accepts a HASI place, the ASP notifies any unsuccessful applicants considered by the Selection Panel, together with their respective referral agencies. The communication with the unsuccessful applicants and their referring agency may: indicate that their application will remain on the Register of Applications; notify the applicant that their application will immediately be considered when a support package next becomes available; or refer applicants to other support options.

The HASI partners reported that the selection process generally worked well because processes have developed organically in response to local need, and key HASI partners made decisions locally. Common procedures guide the selection process, and partners also adapt these processes to the local service context.

Understanding how the local selection processes operate is important because they prioritise between eligible consumers. The consumer selection was from the target group, in line with eligibility criteria and made in a context of waiting lists for HASI. The committees selected HASI consumers by prioritising among eligible applicants and in some cases, referring consumers who were not selected to alternative forms of support.

Local selection committee meetings were usually attended by representatives from the LHD, ASPs and housing providers. For example, in some sites all HASI partners meet monthly. In one site the meetings included only an ASP and MHS. In this site, housing organisations did not directly participate, which they considered appropriate because the panel did not need additional housing information. In another site, the housing provider did attend, although not as regularly as the panel would have preferred. Regular participation by housing providers at all sites could improve the communication between the HASI partners.

Some HASI partners also used other interagency meetings, such as the Joint Guarantee of Service (JGOS) meetings to discuss potential HASI applicants. A housing staff member said:

And with HASI we meet once a month, which is the same day as we have a JGOS meeting. So pretty well whoever goes to HASI goes to JGOS or maybe two thirds. So there's always bits relating, mental health there, we all know one another.

One of the benefits of coordinated HASI and JGOS meetings is that JGOS is attended by multiple HASI providers or by other support services potentially supporting the same target group (e.g. PHaMs and RRSP).<sup>58</sup> Therefore,

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<sup>58</sup> PHaMs has not been formally evaluated, but submissions to the Senate Standing Committee on Community Affairs (2008) expressed concern that PHaMs and other newer service types may not always be adequately coordinated with other relevant programs such as HASI. Evidence from this evaluation suggest that coordination of programs such as PHaMs and HASI depends on the extent to which interagency meetings are used by local HASI partners to discuss the needs of new consumers and availability of support services across program.

because HASI is now one of a suite of support packages offered by ASPs, consideration is not only given to whether someone is eligible for HASI, but also as to whether another type of support package might better meet their needs. JGOS does not replace or duplicate HASI selection processes because some HASI selection meetings are also used to raise and discuss concerns HASI partners have about consumers who are already in the program.

ASP and LHD staff reported that consumers were generally accepted into an appropriate support level to meet their needs, rather than accepted into an available package not suitable for their needs. Some ASPs indicated that they revise the level of support allocated once the consumer had joined the program as necessary. A small number of ASP and LHD staff stated that sometimes consumers received a lower package than required due to a shortage of packages, and one ASP reported that they had used a combination of PHaMs and HASI to support higher needs consumers when only lower support HASI packages were available.

The HASI waiting lists did not include all levels of support in all sites. During the evaluations all three evaluation sites had waiting lists and one site had a waiting list for lower support and vacancies for higher support. The HASI partners reported that selection processes worked best when ASPs and LHDs worked cooperatively to prioritise eligible consumers if demand was greater than available resources.

Priority across support packages was usually given to consumers who had the greatest need and fewest alternative family or community support options. For example, at one selection meeting the ASP and LHD representatives decided together to prioritise the consumer who did not have family support or community networks and was in transient housing over the other consumer who had family support and was living in the family home. A clinician described another case where:

There is one [consumer] waiting for high support and three waiting for low support. It normally goes on need and that decision is made by the selection committee. We might look at what other supports they have in the community – a couple of people had other NGOs involved and one didn't have any – so very similar needs but that support made a difference [to prioritise the person without any community support].

Some ASPs indicated that they set additional conditions as part of a consumer's acceptance into the program, such as probationary periods, which is contrary to program design.

The prioritisation process differs for selecting consumers depending on their support level. For example, in contrast to the example above, where lack of housing and support were prioritised, a housing provider suggested that for a lower support consumer, maintaining an existing tenancy was a higher priority than housing someone who does not have secure housing:

.. we've got two HASI packages, we've got one [consumer who's] coming through maybe on priority housing and one that's already housed, so we'd probably look at the one that's already been housed to save the tenancy or to support saving the tenancy.

These contrasting opinions about priority arguably reflect the different priorities in the higher and lower support HASI packages, as discussed above. Consistent with the HASI Manual, lower support HASI selections tended to prioritise consumers who already have housing, while higher support HASI selections tended to prioritise consumers without existing housing and support. The different priorities between support levels potentially appear inconsistent to consumers and families. They also potentially disadvantage low support HASI consumers who need to find housing, as discussed in the section on housing access below.

HASI partners' interpretations of people's capacity to participate in rehabilitation (Section 7.2) also differed in the selection processes. Some ASP staff were concerned that the selection processes screened out people with complex needs because they were perceived to have a lower capacity to participate in rehabilitation activities and subsequently develop independent living skills that enable them to exit HASI. There was some evidence that, as a result of this view, some consumers with complex needs may have been screened out of the program by some ASPs, although over half the HASI consumers have a secondary mental health diagnosis or co-existing condition (Table 5.6 and Table 5.7).

Contrary to the eligibility criteria, the suggestion that some people are assessed as too difficult for HASI is supported by comments made by one clinician, who noted that there are a 'hell of a lot of people who would benefit from HASI' but that they tried to 'target people who would be agreeable and accepting of the service because there's not much point if they're not going to.' Other ASPs indicated that they were more inclusive of consumers with more complex needs, as anticipated by the program design.

### **Housing access**

The housing arrangements for each stage of HASI were negotiated between NSW Health and Housing NSW stage by stage as they were rolled out (Section 3.3 and Section 6.2). While HASI Stage 3B (50 very high support packages) and HASI Stage 4A (100 high support packages) had funds specifically allocated either for social housing or for leasing subsidies for the first 3 years, housing for other HASI packages has been drawn from existing social housing stock.

The expectation was that most consumers referred for higher support HASI would require housing and that most consumers who were referred for lower support HASI would already be housed but that their housing could be at risk because of mental health issues. As described in Section 5.3, most (72 per cent) consumers entering HASI at the higher support level required housing as expected, but although additional housing was not expected to be required

for lower support consumers, some of this group (26 per cent) also required housing.

One stage of HASI that provides high support received funding for community head leasing for a limited period of time (3 years), which has now expired. The ongoing cost of housing is now absorbed by the housing provider, with no additional funds to head lease properties for new HASI consumers. In addition, people who exit HASI are not required to leave their social housing property. When high or very high support packages become vacant, no additional funds are available to find housing for 'new' HASI consumers, so they must be housed in existing stock when a suitable property becomes available. HASI consumers assessed as eligible for priority housing assistance compete for housing with other people who have also been assessed as eligible for priority assistance.

The housing arrangements attached to each stage of HASI differ because they were negotiated between NSW Health and Housing NSW stage by stage as they were rolled out (Section 3.3). This has sometimes created confusion among HASI partners about the availability of housing through the HASI program (Section 9.4).

HASI operates in a very tight housing market and housing affordability is stretched, with a scarcity of social housing and demand for housing assistance that far exceeds supply (Section 6.2). For new consumers entering the HASI program, part of the selection process involves assessing their housing needs and assisting them to apply for social housing if they need it. When a person requiring housing (most applicants referred for higher support, and some referred for low support as described above) is referred to HASI, they submit an application for housing assistance to Housing NSW. Most HASI clients who apply for social housing are assessed as eligible for priority assistance, which means they are unlikely to resolve their urgent housing need in the private rental market. These clients are housed as soon as a suitable social housing property is available. Housing NSW also provides a range of services to assist people to overcome difficulties entering or sustaining a private rental tenancy, but most HASI consumers do not rent privately. Housing NSW advises that some HASI providers in NSW are, however, successfully using the private rental market to house HASI consumers, often using Housing NSW services to assist in this process, although data about the extent of private rental use were unavailable.<sup>59</sup>

HASI partners explained that allocation of a social housing property can take some time due to the shortage in many locations. They reported that some consumers had to wait for many months to be housed, even if they were

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<sup>59</sup> Prior to April 2010, consumers applied to Housing NSW for priority housing. Their application would be separately assessed for eligibility for public housing and then eligibility for priority housing. If people wanted to apply for community housing, they also applied to the community housing provider directly. After April 2010, people apply for social housing (public and community housing) through the Housing Pathways using the same application.

eligible for priority housing assistance. The waiting time varies across different locations and can depend on specific consumer requirements such as property size or location. A Housing NSW staff member stated that, 'We don't give a time.' For example, a housing provider referred to a consumer who had been allocated a dwelling within weeks, and explained that, '... if they can take stairs and they're not particularly fussed where they live it can be easy.' Another consumer interviewed had waited 16 months (Section 6.2), and a housing provider said that they had 'never known it to be so bad.'

In some evaluation sites, ASPs supported consumers while they were living in temporary housing and waiting for social housing. However, in one site, a local Housing NSW manager said it was the ASP practice to not provide HASI support until housing became available: '... if they've been assigned for housing and they've been approved [for HASI] and then they're just waiting around ... they can't get their HASI package until they're housed.' At this site, the HASI partners organise that while consumers were homeless, they received other support instead of HASI, such as PHaMs, although a clinician said consumers did not always receive support while they were waiting for housing, which is problematic if it is continuing to occur.

Housing NSW managers reported that in some locations, HASI partners sometimes had unrealistic expectations about the type of housing that could be provided to HASI consumers and the timeframe in which it could be provided, which sometimes created misunderstandings between the partners. HASI partners including Housing NSW acknowledged the lack of appropriate housing stock in some locations across the state.

HASI partners reported that the allocation of appropriate housing to new HASI consumers was working best in sites where ASPs had good working relationships with community housing providers or a key contact with a public housing officer with whom they could liaise directly. For example, one Housing NSW officer reported that when they did not have good communication, the lack of coordination allocating housing and support could later affect tenancy outcomes (Section 7.3):

... it comes to the housing committee and then they say well no, they're not housed yet ... so they get put on the backburner and then they get allocated a house and no one's none the wiser and when they get their tenancies they start to have a few problems, it's up to that specialist in that area or the client service officer to look up the case plan and see that they have been submitted for a HASI package and then they can follow that through.



## 7.2 Interpretations of the HASI model

The HASI design, and the NSW Community Mental Health Strategy more broadly, emphasises recovery as defined and led by consumers themselves and emphasises empowerment and hope (see Section 3.2). Some ASP staff agreed that recovery was 'different for every consumer' with some consumers aiming to move on from HASI and others focusing more on maintaining and developing skills. These staff suggested that recovery oriented services included support for chronically unwell consumers who would need a low level of support for an indefinite period to maintain basic functioning and avoid lengthy stays in hospital.

However, some HASI partners were unclear or disagreed about the aims of the HASI model and the recovery based framework for service delivery. Many HASI partners thought that the aims of the HASI program had changed over time. This confusion could be addressed through information, discussion and training.

Key staff (ASPs, housing providers and LHD clinicians) who work at the local service level felt that the goals of HASI had shifted since the program was first introduced. Local staff described this shift as a new focus on recovery oriented services. Their understanding about the meaning of recovery oriented varied.

HASI was first established to offer consumers ongoing high support. A number of clinical mental health and ASP staff who were interviewed in 2009 and 2010 said that with the expansion of the program goals of HASI had changed, and their interpretation of the expansion to lower levels of support included a new emphasis on reducing the level of support or exiting consumers from the program. Local staff perceptions about the aims of the program ranged from a model where most consumers would exit HASI within a limited timeframe; to a range of consumer outcomes, including exiting, ongoing HASI support and ongoing HASI support at a reduced level (Section 8). This latter description of a range of outcomes is consistent with the HASI design.

Many ASPs envisaged that consumers with higher support HASI would transition to lower support and that consumers in lower support would eventually graduate to no longer needing support from the ASP. Some ASPs reported that a goal of HASI was to support consumers to achieve defined outcomes in a set time period. They emphasised that ongoing support was now 'not what HASI's about.' They reported that they felt pressure from clinical services to achieve a 'flow through' so they could accept new consumers. Some ASP staff described chronically unwell consumers, who might not have recovery and service exit as a goal, as 'exceptions.'

Some HASI partners described the change they perceived in the goals of HASI as setting various objectives: to ensure that consumers moved on to make HASI places available for others; to avoid dependencies between consumers and ASP workers; and that recovery is 'being independent without service involvement.'

Some HASI partners equated the concept of 'recovery' with reduced or no service involvement. For example, one LHD interviewee described HASI support as 'usually 18 months to two years' and suggested that ASPs needed to focus more on exit strategies for consumers to prevent disempowerment, particularly 'for clients who've been there a while, if they're not moving forward they're probably moving backward.' Clinicians and housing providers in other locations were critical of an approach taken by some ASPs that did not offer continued support for consumers who required the ongoing support to maintain their tenancy.

A narrow definition of HASI as short-term support only, is inconsistent with both the original aims of the program as set out in the HASI Manual (NSW Department of Health, 2006) and with subsequent program developments. In contrast to some local staff interpretations, the HASI Manual states that higher support packages are intended to be ongoing, and lower support HASI may be of short, medium or long term duration. The HASI Manual does not recommend any timeframes for support or suggest that exiting the program should be a goal for all consumers, or even all low support consumers. Further, following the expansion of HASI, all HASI packages may be short, medium or long term, depending on the needs of the consumer.

These policy interpretations need to be clarified with service providers at the local level. Some HASI partners knew that the aims of HASI and recovery services include both ongoing and time-limited support, but other staff perceived that the goal of HASI had shifted to only a short-term model of support. Such a definition has negative implications for how the service model is implemented by some of the HASI partners, as discussed below and in the HASI partnership arrangements (Section 9).

The Departments of Health and Housing have advised that some sections of the HASI Manual are outdated, and have provided specific advice to the evaluators about developments in the Program. Amended published Program guidelines need to clarify the program priorities and procedures for all stakeholders.

### **7.3 Tenancy management**

Housing providers manage the tenancy of HASI consumers, whether they are in social housing or renting privately. This includes collecting the rent, ensuring the property is maintained to a suitable standard and ensuring the right to quiet enjoyment of the property. Housing providers conduct property inspections, organise maintenance and repairs, respond to any noise or other complaints, process rent payments and rent arrears notices and handle any Consumer, Trader and Tenancy Tribunal matters (CTTT) as required.

Housing providers expressed a range of views about how HASI consumers compared to other social housing tenants. Some housing providers felt that they were very similar to other social housing tenants (Section 6.2). For example, one provider had been unaware that a woman whose tenancy she had been managing had a mental health problem and was in the HASI

program. Another stated that after receiving HASI, the large differences between these and other tenants disappeared:

... depending on why HASI was brought in, in the first place, it could be that their property care greatly improved, it could be that their general outlook greatly improved. It could be that their arrears have stopped. They're now getting the financial help that they need ... they're able to then sustain the tenancy ... they're good after HASI, there's a great improvement.

While some other providers thought that the tenancies of HASI consumers were sometimes more resource intensive to manage because they were consumers with complex needs, they also thought that, with appropriate accommodation support services, processes were in place to effectively address any tenancy related issues with ASPs. For example, a community housing provider said:

Their [HASI consumers] needs are much more complex. We handle them a bit differently because of their complex needs – maybe we need a support worker for a property inspection or a second person there. Sometimes safety concerns – it is added resources for us but really supported tenancies is what we're about ... that's why we're here.

Nearly all the consumers interviewed for the evaluation were satisfied with the amount of rent they paid. Some consumers said they were unsure how much rent they paid because their finances were managed by the Public Trustee. Other consumers were acutely aware of their rental payments. For example, one consumer was in the process of having his rent readjusted due to income he earned from paid work.

Consumers had few complaints about their housing, with many stating that they were very happy with their property and the housing provider. Where consumers were not satisfied, it was usually in relation to the way repairs and maintenance were handled. Some of these situations related to housing leased through private real estate firms and therefore were not within the control of HASI partners. The main issue raised was the time taken for repairs, such as broken windows and doors, problems with mould, hot water systems and water leaks. Several consumers mentioned that ASPs supported them to deal with these problems, although one consumer wanted HASI to advocate for him with the housing provider and was unhappy that the ASP was encouraging him to do this himself. Two consumers said:

I started getting all these leaks. And they'd send someone – it was like a band aid and no one ever checked their work.

Yeah, my hot water tap in the kitchen is broken. I have to boil the kettle to wash my dishes. At the last inspection, I reported it but they haven't fixed it yet.

The frustration felt by some consumers about the considerable length of time taken for maintenance work was also something that housing staff also felt unhappy about. For example a housing client services officer said:

The only problem I'm having at the moment is trying to get maintenance on these properties – it has to fit into a program and I can't speed it up. That would be the most difficult thing [in the tenancy management of HASI consumers].

Housing providers are able to arrange for the transfer of tenants to other properties if requested by the tenant. Several HASI consumers interviewed indicated that they had put in applications for a tenancy transfer due to difficulties they were experiencing with their housing, in particular problems with neighbours (see Section 6.2). Many consumers indicated that ASPs had assisted them to complete the necessary transfer application.

#### **7.4 Clinical mental health services**

LHD clinical mental health services are central to the HASI model through the public health system. The interviews indicated that relationships between clinicians and other partners were generally positive (Section 9). The HASI partners were frustrated by the lack of adequate resources available for clinical services. Factors that supported good clinical services in the HASI program were: an appropriate range of clinical treatments offered; clinical governance including supervision; involvement of clinical staff in individual support plans; manageable workload for clinical staff; and integration with other health services.

Clinical services staff participated in the development of individual support plans with ASPs and consumers as well as providing direct services to consumers. Their role in relation to HASI consumers includes assessments, the co-ordination of clinical care and treatment including counselling, support, monitoring medication, providing clinical rehabilitation services and crisis intervention. Clinical service staff include staff trained in nursing, occupational therapy and social work.

Active support from the local mental health service is a prerequisite to be eligible for high support HASI packages. Lower support applicants need not have existing clinical support, but must have a mental health diagnosis. Consumers who have not had previous contact with the LHD are required to have a clinical assessment as part of the application process (Section 7.1). The HASI Manual also states that all consumers of HASI will continue as consumers of the MHS, although in practice this does not always happen, as discussed below and Section 9.2.

An ASP interviewed stressed that some consumers receiving low support HASI continued to require ongoing clinical support and questions about the level of clinical care to consumers of particular HASI support levels could not be generalised. MHDAO agreed with this approach and endorsed partnership negotiation and agreement on the need for ongoing clinical support. This

issue will be further clarified in the revised version of the HASI Manual due for completion late 2012.

Clinicians at one site estimated that they provided services to high support HASI consumers every two weeks to a month.<sup>60</sup> Clinicians suggested that they tended to see low support consumers on average about once a month. In addition to these direct services, clinicians reported that they would participate in care planning every three months for HASI consumers regardless of whether they were in higher or lower support, which is consistent with the MH-OAT mandatory review timeframe.

Some clinical staff reported that the pressure on resources for community mental health teams forces them to cease maintenance support when HASI consumers are relatively well. A clinician for example referred to the:

... need to be pushing people through because there's always new clients coming, so we don't have a never-ending ability to manage people on an ongoing basis when they're well.

In the face of this pressure, mental health teams sometimes need to stringently prioritise their workloads and service delivery. Consumers with a community treatment order (CTO) are consequently often prioritised over others. Some clinicians impression was that this this had two effects for HASI consumers. First, some consumers did not receive treatment as frequently as required if they were not on a CTO. Second, some consumers were presented to the Mental Health Tribunal to apply for a CTO to ensure they would be prioritised to receive treatment. A clinician also reports that the increasing pressure on community mental health teams has meant that HASI consumers are:

... referred into the mental health team if they needed a review of their medication or to be restabilised and then ... the majority of consumers could be discharged back to the care of their GP.

In most cases, when HASI consumers' mental health becomes stable, they continued as MHS consumers with contact on an as needs basis, ranging from regular to occasional,<sup>61</sup> with an agreement to provide more intensive support immediately if consumers became unwell and were re-referred. Some MHS interviewees said the agreement that the MHS would increase support or re-engage with a previously discharged consumer in response to deterioration of a consumer's mental health, might not be acted upon in the context of the recent introduction of waiting lists (and the need to prioritise people on these lists) through LHD policies in some locations.

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<sup>60</sup> Which is consistent with the MDS data of increased and high levels of support (Section 6.1).

<sup>61</sup> Ibid.

ASPs stressed the importance of fast track access to clinical care for HASI consumers who became unwell. They explained that it made a difference if early intervention and access to medication was available in this situation. The qualitative data indicates that resource and workload issues in LHDs impacts on their ability to respond quickly to HASI consumers in some local areas, particularly if the consumer has been well for some time and has not required recent clinical care. ASP and Housing partners expressed concern about the need for flexibility from LHDs in this situation.

In addition, ASP staff said that in some locations ASPs were now interpreting the HASI Manual more strictly for the consumers who were not receiving MHS clinical support. For consumers receiving high (and in some cases medium) level HASI support, MHS clinical involvement is required. For consumers receiving lower support, ASPs were able to continue providing accommodation support without clinical involvement.<sup>62</sup>

ASPs continued to provide lower level support for former higher support consumers once they were discharged from the MHS. They reduced their support level to meet the HASI guidelines. They did not report exiting higher support consumers because they no longer had clinical support, although they described several situations where they had considered doing so. In one case an ASP reported meeting with the MHS about a high support consumer who was to be discharged from clinical care. The ASP stated that MHS agreed to continue clinical support for this consumer.

Where lower support HASI consumers did not receive clinical care, ASPs also reviewed their status as HASI consumers, and exited some who they assessed as already moving toward exiting HASI. In other cases consumers refused to discontinue HASI support and were maintained in the program. One of these consumers was reported as having become unwell (Section 8.6). At the time of the evaluation fieldwork HASI partners at this site stated they were hoping to negotiate a solution to this situation. The issue arises from workload problems within the LHDs combined with a lack of clarity between the HASI partners about their respective responsibilities. Addressing these problems could lead to improved responses for consumers.

## **7.5 Accommodation support**

ASPs provide non-clinical support to HASI consumers in the form of accommodation support and rehabilitation. ASPs are NGOs that are contracted by NSW Health to provide low, medium, high and very high levels of support to consumers (Section 3.3).

HASI aims to provide accommodation support that is consumer focused, based on respect and open communication, is flexible and responsive to consumer needs and is provided in partnership across the health, housing

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<sup>62</sup> Although there was initially some confusion about whether this was possible.

and NGO sectors (NSW Health, 2006: 7). This section discusses the key aspects of ASP services and how services are provided within this framework.

### Consumer goals and support types

The HASI approach to accommodation support is underpinned by the recovery framework, which starts from the consumer's current situation, perspective and self-defined goals. It encourages consumers' confidence and self-belief, including belief in their capacity to live more independently, with support as required. Consumers and family members emphasised the value of this approach to service provision. For example, one consumer spoke of how her self-esteem had increased since HASI participation; another described how he had 'got back my independence'; and another how with HASI she can 'be myself.'

ASP support is structured around the goals that consumers set for themselves through the development of an Individual Service Plan (ISP), consistent with the recovery approach. In most cases, HASI partners agreed that these plans are based on consumer goals and are developed together with consumers, the ASP and MHS clinicians, and if appropriate their family and carers, after consumers are accepted into the program. In some cases, HASI partners found the focus on consumer goal-setting challenging and at times introduced their own beliefs and attitudes into expectations and goal definition. It is not known to what extent this occurs. Additional training for all HASI partners about this topic could be valuable.

Common goals identified by HASI consumers were participating in social and community activities; engaging in community tasks such as going to appointments; doing shopping and using public transport; and carrying out activities of self care (including both personal care activities and learning strategies to manage their mental health symptoms, such as through exercise classes) (Table 7.3).

**Table 7.3: Proportion of consumers who set goals by goal type by support level**

Goal type	HASI support level		Total (n=895)	Sig. <sup>1</sup>
	Lower (n=552)	Higher (n=343)		
Social and community participation	80.3	81.8	80.9	0.548
Community tasks	71.0	79.0	74.1	0.084
Self-care	62.8	78.4	72.3	0.005
Domestic skills	64.5	76.5	69.1	0.001
Use of health services	63.0	63.0	63.0	0.315
Work, education and/or training	42.9	46.4	44.3	0.484
Other	30.2	28.7	29.7	0.689

Source: HASI MDS 2009 n=895

Note: Consumers commonly have more than one goal; 1. Pearson Chi-square

Some of the common goals identified by consumers varied according to the level of support they received. Only a small proportion of consumers receiving very high support set goals about work, education and training.

Consumers interviewed were satisfied with the way ASPs worked with them to achieve their goals, including sensitive handling of following up on those goals that many people find challenging or requiring extra willpower. For example, one low support consumer 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.’

ASPs provide support to consumers across a range of types of support (Table 7.4). The most common types of support ASPs provided to consumers were community access, counselling, personal self care and advocacy. The average proportion of time ASPs provide to HASI consumers differs slightly across the two support levels.

**Table 7.4: Average per cent of ASP support time spent by type of support and HASI support level**

ASP type of support	HASI support level		Total (n=895)	Sig. <sup>1</sup>
	Lower (n=552)	Higher (n=343)		
Community access	23.4	20.2	22.1	0.040
Counselling	21.1	20.9	21.0	0.853
Personal self care	17.7	17.1	17.4	0.631
Advocacy	17.3	16.0	16.7	0.406
Domestic skills	11.7	15.9	13.4	0.000
Vocational support	6.2	5.1	5.7	0.271
Income management	4.9	6.0	5.3	0.090
Links with family and friends	5.8	4.2	5.2	0.001

Source: HASI MDS 2009 n=895

Note: In the MDS, ASPs are asked to indicate the percentage of their time spent supporting each consumer in these activities during the reporting period. This provides some indication of how ASPs are spending their time with HASI consumers, however, the proportions reported were inexact and the totals do not equal 100 per cent.

Most of the ASP support time was spent assisting HASI consumers with community access, counselling and personal self care. Consumers in lower support received more assistance with community access than consumers receiving higher support and consumers receiving higher support were assisted more frequently with domestic skills. Other major differences between the two groups of consumers with respect to the assistance received from ASPs are not statistically significant.

Interviews with staff and consumers suggest that, while it is difficult to generalise, the ASP support for higher support consumers tended to focus more on self care, basic living skills and other challenges experienced by this group, such as the major effects of mental and physical health problems (see Section 6.1). ASP support for lower HASI support consumers focused more



on maintaining stability and accessing activities in the community, for example, use of public transport.

ASPs spent only a small proportion of support time on income management and vocational support, perhaps because of the immediacy of consumers' support needs for community access and personal self care and the time consuming nature of assisting consumers with these activities. The proportion of time spent assisting consumers to build relationships with family and friends was also small, although improvements in relationships were evident (Section 6.3). The support provided to consumers mirrors the priority goals set by consumers (Table 7.3). ASP staff reported that they spend the largest proportion of time facilitating community access; equally this is the most frequently selected goal across the consumer group.

Consumers 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, they also highly valued the social contact with ASP staff and the opportunity to get out of the house.

Some clinicians and consumers were concerned that many of the activities were with the ASP and other HASI consumers, such as outings and barbecues, rather than activities in the wider community. On the other hand, some ASP staff suggested that some consumers underestimated the amount of community participation that they achieved. The evidence overall is that participation in mainstream, particularly social activities was limited and that participation in activities specifically for people with mental illness was emphasised (Section 6.3).

Most consumers were progressing towards their goals and this did not vary widely by HASI support level (Table 7.5). The high proportions of consumers who partially or fully met their goals across most goal types indicate that ASPs are supporting consumers to set achievable and meaningful goals. The longer term goals for consumers appeared to be work, education and training. Some consumers said they would like to set future education and training goals and this was something they felt they had to work towards.

**Table 7.5: Proportion of consumers who partially or fully attained their goals by support level**

Goal type	HASI support level		Total (n=895)	Sig. <sup>1</sup>
	Lower (n=552)	Higher (n=343)		
Social/community participation	95.3	95.4	95.3	0.397
Use of health services	94.8	92.4	93.8	0.170
Self-care	91.3	94.8	92.9	0.270
Community tasks	91.2	91.2	91.2	0.902
Domestic skills	87.9	92.9	90.0	0.153
Work, education and/or training	84.0	81.1	82.9	0.483
Other	65.1	73.2	67.7	0.499

Source: HASI MDS 2009 n=895

Note: Consumers commonly have more than one goal; 1. Pearson Chi-square

## **Key components of ASP support services**

The key aspects of the rehabilitation approach of ASP services are consumer centred<sup>63</sup> flexible service delivery to meet consumers' individual priorities for recovery.

### *Rehabilitation*

ASP staff reported that they prioritise the provision of person-centred rehabilitation activities over other types of support.<sup>64</sup> Accordingly some consumers, particularly those receiving lower support, reported that the services they receive from HASI are more oriented to achieving their personal goals since they started the program. A low support consumer said:

A yeah it's just got more rehab – we used to go for a swim and have a chat. I probably would have preferred a bit more notification that things were changing but you hear one thing and all that. Since the new manager came it all changed.

Interpretations of rehabilitation support vary between ASPs and individual staff. These interpretations were influenced by the values of the ASPs and how staff members interpreted their roles. For example, one ASP staff member was less concerned about consumers achieving goals within a short time than her other colleagues.

Many clinicians were very positive about the support provided by ASPs, with one clinician emphasising that 'there are incredible success stories, miracles.' On the other hand, a small number of clinicians were critical of the goal oriented approach for high support HASI consumers with severe mental illness, suggesting that some consumers were unable to set goals, even with support. The approach of these clinicians was not consistent with the HASI design and indicates a need for additional skills development and information to the partners about this topic.

### *Consumer centred services*

The model of support delivered by ASPs is designed to work with the strengths of each consumer. Staff reported that to accomplish this, the types and amount of support are tailored to the needs of individual consumers. Consumers said that their experiences of the personal approach to service provision were generally good.

Most of the consumers were exceedingly positive about the quality of service they received from ASP staff. They particularly appreciated the personalised

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<sup>63</sup> Consumer centred (or person-centred) services are defined in the section below on this aspect of support.

<sup>64</sup> The evaluation of Stage 1 found that the activities undertaken by ASPs varied between four different approaches: person-centred rehabilitative, person-centred disability, advocacy, and non-person centred directive (Muir et al, 2007). The findings in this new evaluation show greater commitment to the person-centred rehabilitation approach.

support, inclusion in decision-making and respect they received. A small number of consumers were dissatisfied with aspects of ASP support, such as unreliable staff and reduced hours of support over time. A low support HASI consumer described that she appreciates the support because she receives respect, rather than just defined by her mental health, 'They [ASPs] don't treat you like a number, they treat you like a person.'

Most consumers reported that they felt included in decision-making. It was a new experience for many consumers, who were used to being told what to do. A low support consumer commented: 'It's not like they are watching you all the time.' Most consumers agreed that they felt included in decision-making, but one consumer said that he sometimes felt 'bossed around.'

Along with respecting consumer choices, regular contact assisted ASP staff to develop trust and rapport with consumers. ASP workers were generally enthusiastic about the program, but some staff were concerned about the potential for consumers to become dependent on the ASP. Dependency in the sense of relying on a service is not in itself a negative result, but may be detrimental for consumers if the ASP is not promoting their efficacy and working towards building quality social networks and links with mainstream activities and services. Dependency may be caused both by structural factors, such as a lack of transportation, leading to reliance on ASP workers to access the community, and by interpersonal factors, such as a lack of social connections, causing dependency on the service for emotional support.

Most ASP staff were aware that their supportive relationships should facilitate goals for social interdependence. With an intensive program like HASI, relationship building with the support worker is an important part of developing trust and recovery. ASPs may need to continue to provide training to workers about quality support relationships that encourage consumer confidence towards building other friendships.

Some HASI partners address the potential for reliance on individual workers by setting professional boundaries with consumers, rotating workers, and referring consumers to other organisations. The aim of this is to also expand support networks and skills. Some ASPs adopted a team approach to support consumers. This promoted continuity of care and opportunities for more than one support worker to contribute new ideas and solve problems, while also reducing the risks of relying on one staff member.

Some consumers appreciated receiving assistance from workers with a range of perspectives, while others found the unpredictability and need to relate to multiple workers difficult, disrupting the coherence of the support. Some consumers reported that where multiple workers delivered the support, the workers sometimes had problems coordinating so that important information was lost or consumers had to repeat information already provided.

Most consumers' family members were very satisfied with the support provided by ASPs. Some family members indicated that the ASP had been a source of support for consumers and also for the family, as explained by this relative of a consumer receiving high support:

If I have a problem I call the support worker. So I have that support too. And they are great to talk to. The manager is very fair and [the support worker] is terrific. She has helped [my daughter] heaps – when other people have given up on her, she hasn't. I've never seen anyone like it.

In contrast, a small number of families were dissatisfied that they were not included in decision making in the way they would like to be:

... my impression of HASI is when I've tried to get in touch with them and they say well we'll talk about it with [consumer], not you, sort of thing ... the consumer doesn't always know what's in their best interests ... That is a complaint I could make, that they don't talk to us about what's happening.

### *Flexibility of support*

Because HASI accommodation support intends to assist consumers to become more independent, flexibility is a key element of support. Even though services are delivered through a range of support packages, ASP staff stated that support hours remain flexible depending on consumer needs, so that, for example, ASPs can respond to crises by spending additional hours with consumers who need more support at a particular time. Many of the ASP staff believed they were flexible in how they deliver support to individual consumers, and many consumers appreciated how adaptable ASP staff were in meeting their individual needs. A consumer receiving a low support package explained:

I have been up and down with my illness. They have been really good – contacting me and making sure I'm ok, doing more visits than normal. They are ringing me all the time. They are making sure the crisis team know about it. So they were really good when I was unwell. Then I got better and I [only] see them twice a week.

When ASPs spent extra time with consumers in crisis, the needs of other consumers were not prioritised and they sometimes felt that they didn't always receive as much support as they needed. Some consumers said that some staff were not always available or reliable. In follow up interviews in 2010 some consumers were unhappy with the reduced number of support hours they received.

Several HASI consumers felt they would like more time with ASP staff. Reasons for this included that some consumers wanted more contact with ASPs on weekends in addition to existing weekday contact; others wanted ASPs to spend more time with them on each occasion that they visited; and other consumers expressed concern that they missed out on receiving support if ASP staff were absent from work.

The need for flexibility of ASPs as consumers transition to new services was also emphasised by ASP staff. Some consumers transition between HASI

packages either within the same ASP or to another type of support program delivered by the ASP, or in some cases to another HASI provider. ASP staff suggested that it took several months for some consumers to transition to new support services in the community. Some ASPs and MHSs felt the need for a more consistent approach for consumers who had left the program and who required some follow up support after they had left or who wished to rejoin the program (discussed in more detail in Section 8).

### **Workforce and organisational capacity**

The provision of effective ASP services within a recovery framework relies on the quality of the workforce and organisational capacity. Staff and managers from the HASI partners stated that promoting staff skills, workforce development and developing strong internal processes in ASPs were central to ensuring appropriate and effective HASI support.

ASP services are provided by a diverse range of NGOs. Services and working relationships vary even within one location. Both clinicians and housing providers in locations with more than one ASP commented on the variable type and quality of support provided. Additional training for ASP staff and managers could address this variation.

#### *Staff skills and workforce development*

To effectively apply the HASI model, ASP staff require relevant qualifications and skills. Staff must be able to develop rapport with HASI consumers, respect consumer decisions and facilitate, rather than direct, them to learn new skills and participate in the community. Staff also require understanding about different mental health problems and co-existing conditions.

The ASPs strive to recruit highly skilled staff. The majority of HASI consumers spoke highly of the staff, although some few consumers criticised the attitudes, skills or knowledge of some ASP staff (see below). Some locations had trouble recruiting staff with the knowledge to work with mental health consumers and how to provide recovery focused support. Several ASP managers, for example, stated that staff with a background in disability services have good skills in maintenance support, but require additional training to implement the principles of rehabilitation in their practice with HASI consumers.

The ASPs recognised the importance of staff development and offered training (e.g. risk management and Occupational Health and Safety) and opportunities for staff to perform management roles. During the last round of evaluation interviews (2010), it was apparent that staff in some ASPs had moved into more senior positions and several had been promoted during the course of the evaluation. Training and development opportunities for staff are essential to build a skilled workforce that can deliver consistent support within and between providers.

HASI consumers suggested topics they thought that some staff required additional training to ensure appropriate and consistent support. Some consumers were concerned that some ASP staff were not skilled in how to

work with people with specific mental health problems and some also suggested additional training to assist staff to better understand their other needs, related to or in addition to their mental health (e.g. abuse, trauma, drug and alcohol and Hepatitis B). A small number of consumers viewed some workers as patronising, and did not feel respected. Respect is central to consumer centred services, and needs to be addressed in recruitment as well as staff development.

One site assisted ASP staff to become aware of consumer needs by including consumers in staff induction training. Most ASPs did not do this and the practice requires an emphasis on the effect of this role on individual consumers. In some locations clinicians also suggested that some ASP staff were working in roles that were 'above their experience and training'. In particular some clinicians and a small number of consumers were concerned about whether some ASP staff had sufficiently clear boundaries in their work with consumers. These concerns covered a range of areas, such as ASP staff hugging them and what one consumer referred to as 'slight invasions of privacy.' These are issues which could be addressed in staff training. A consumer said:

They want to know where I am all the time, what I've done, who I've spoken to, where I'm going, what I'm doing. I know they're trying to help, they've got my best interests at heart, but sometimes they're like pseudo parents.

Other clinicians questioned the capacity of some ASP workers to make judgements about supporting consumers. For example they said that some ASP staff were manipulated by consumers, particularly about providing transport, and that ASP staff sometimes contacted clinicians because the consumer was 'not appearing well and they're questioning our treatment modality and where we're up to and whether we are attending to this and that ...' Further discussions between HASI partners at local level would be appropriate to address these criticisms.

ASP staff reported that, while their work is rewarding, it can also be challenging and isolating. Most staff work individually with consumers and were sometimes required to spend a lot of time travelling each day. They sometimes found it difficult to support and empower consumers to make decisions, set goals and take action to achieve the goals, particularly because consumer needs can change daily.

Management support, such as team case reviews, team meetings, professional development and training could address these questions in locations that do not already use these practices. Structured supervision and support from management are also crucial in maintaining quality and consistency of staff. The emphasis on these mechanisms differed across the ASPs that participated in the evaluation. Strategies to support staff also included informal activities, such as monthly barbeques and weekly afternoon teas to give staff opportunities to be reflective as a group in a relaxed environment.

Retention of staff is important in maintaining quality of services provided across ASPs. The retendering of the HASI packages in 2010 caused some employment insecurities for some ASP staff who had many years of experience and had completed diploma training specific to the support worker position. The job insecurity affected staff, ASP morale and consumers during the transition to new ASP providers. This issue raises questions for future tendering about how information is shared between NSW Health, ASP management and staff during tender processes.

#### *ASP management processes*

HASI partners suggested that the provision of quality services also depended on ASPs having strong internal management processes to promote open communication between workers at all levels and the development of a support network among staff to facilitate information sharing and collective problem solving. Good record keeping procedures and communication between support workers were important in providing consistent support to consumers. HASI partners also emphasised the need for policies and strategies to assess and manage risk.

Consumers receiving support from some ASPs reported that breakdowns in communication between ASP staff had led to workers failing to arrive for prearranged appointments at the agreed time, or failing to arrive at all. Some consumers also reported that staff had failed to telephone at agreed times, so that consumers were left waiting and unable to leave the house or complete other activities. Some consumers reported that they had missed appointments or other activities because of these problems. Where these problems had occurred, consumers reported feeling frustrated and distressed. Some consumers and ASP staff attributed these problems to the growth in size of ASP organisations, reliance on casual staff and staff shortages, sometimes not addressed by ASP management.

The quality of the management, leadership and consumer feedback processes varied between ASPs. In some locations, staff and consumers said the ASP management was approachable, supportive and had on-site management, which was important for sustaining good practice and consistency in approach between workers. These ASPs regularly emphasise to consumers that the service wishes to hear consumer concerns and complaints, and that consumers will not be disadvantaged by raising them. Some consumers felt confident raising problems with ASP staff or management, while others were not prepared to raise problems, fearing retaliation.

Practices to protect consumer confidentiality also varied between locations. ASP staff need to discuss consumer progress in order to provide appropriate support to consumers. The physical layout of some ASP premises means that when consumers are at the premises they may be able to overhear workers' conversations, as observed by the researchers. In these situations, workers need to be particularly vigilant about confidentiality. Some ASPs need to change practices to improve consumer confidentiality in these situations.

Risk assessment, planning and management to ensure the safety of consumers, staff and others worked well in some locations. In order for this process to work well, ASPs developed a collaborative individualised risk management plan and the MHS continued to communicate with the ASP about the consumer's mental health status, behaviour and risks. This level of information sharing did not occur in all sites, which raised concerns that ASP staff were occasionally exposed to avoidable risks. To ensure the safety of all, ASPs need to regularly review and update their risk management strategies. The last evaluation interviews suggested that some locations had a renewed focus on risk management and risk assessment training was being carried out with ASPs and MHS. Risk management is a responsibility which involves all HASI partners and which requires regular updating.

## **7.6 Discussion of the findings**

This section examined the effectiveness of the referral and selection process and the type and quality of HASI support provided to current consumers through tenancy management services, clinical support and accommodation support. The evaluation found that, overall, the HASI service model operates well to provide an integrated response to its target group. A number of factors, described below, could be addressed to improve the implementation of the HASI model.

The processes for referring and selecting consumers into HASI generally conform with the procedures set out in the HASI Resource Manual. Most HASI partners thought that these processes worked well and appreciated that the procedures allowed them to adapt the process to suit the local context. Mental health clinicians make the majority of referrals to HASI. Some ASPs report that referral pathways are confusing for clinicians, particularly in locations that have more than one ASP and with multiple levels of support. Locations with multiple referral forms create confusion and obstacles to referral, and it would be worthwhile reviewing whether to standardise the referral processes within each location.

Factors contributing to effective selection meetings were regularity of meetings, joint agreement by local partners about the role of housing providers in selection processes and discussion about the needs of current consumers. In some locations HASI partners co-ordinate selection committee meetings with JGOS meetings that are also attended by organisations who provide other services such as PHaMs and RRSP that work with a similar target group. This approach has the potential to enable co-ordinated consideration of which mental health support program would be most suitable for individual consumers.

The consumer profile (Section 5) shows that HASI is reaching its intended target group. Stakeholders raised some problems about access to the program. Some ASPs expressed concern that clinicians sometimes referred people who required housing but did not wish to receive support. The different priorities of the higher and lower support HASI packages, means that HASI appears inconsistent to some referrers, consumers and families, as well as



disadvantageous to some low support HASI consumers, who need to find housing, as discussed below.

HASI partners' interpretations of consumers' capacity to participate in rehabilitation also differed in the selection processes. Some HASI partners referred to the practices of selection committees and ASPs that prioritise consumers who they think have a greater capacity to develop independent living skills in a shorter timeframe. These practices suggest that contrary to the program design, some mental health consumers may be excluded from the program.

The selection process and entry to HASI support is sometimes limited by a shortage of social housing, clinical services and HASI support packages in most locations. The waiting lists for consumers applying for HASI reflect an obstacle for people eligible for the program. HASI partners' are inconsistent between sites about how they respond to these shortages. Most HASI partners reported that consumers were accepted into a support level that was appropriate to meet their need, rather than an available package that was not suitable. A small number of ASP and MHS staff were aware of instances where consumers were provided with packages that were lower than required due to a shortage of higher support packages. One ASP reported that they had used a combination of PHaMs and HASI to provide extra support when suitable packages were not available. While combining resources does not necessarily involve a compromise to the intention of the program, the comments of these interviewees suggest that selection committees are sometimes forced to place consumers in arrangements that they considered less than optimal when consumer needs are greater than the resources available.

Where applicants to HASI do not have housing they need to apply for social housing. Some ASPs provide support while HASI consumers wait for housing, and other ASPs insist that housing is a prerequisite to receiving accommodation support. Some selection committees actively seek alternative support (e.g. PHaMs) while consumers wait for housing and HASI support. In particular, the long waiting time for social housing in some locations means that some people who require HASI assistance wait for many months before entering HASI. This shortfall in the HASI model is in the context of a very tight housing market, pressure on housing affordability and a demand for social housing and housing assistance that far exceeds supply. The context undermines the coherence of HASI as a service model that aims to include housing linked to services for people with mental illness.

The HASI program aims to support each consumer's recovery by providing stable housing, clinical services and accommodation support. The way the aims of the HASI Program are interpreted varies by location, reflecting how the recovery oriented framework is implemented locally. Some HASI partners applied the HASI recovery approach with ongoing and short term support as described in the HASI Manual. Other HASI partners thought the aims of the HASI program had changed. They understood that they were now expected to interpret the focus on recovery as a transition through the program from high to low support towards exit from the program.

Factors that support the delivery of effective services across the three service types were identified in the evaluation. For tenancy management the delivery of quality services included timely handling of maintenance and repairs, strong partnerships with ASPs and clinicians, and including consumers in resolving tenancy management problems.

For clinical mental health services the delivery of quality services included the provision of appropriate treatment, clinical supervision, manageable clinical workloads, open communication and information sharing with ASPs, involvement of clinical staff in ISPs and liaison with housing providers. Community mental health teams are providing essential clinical services to HASI consumers. Further clarification is needed at the local LHD level about how the local HASI partnership can manage support for consumers' continued mental health after clinical support is withdrawn.

For ASP services the delivery of quality support within a recovery framework is dependent upon the principles of rehabilitation, consumer centred support, flexibility, a skilled workforce and ASP organisational capacity. HASI partners and consumers were overwhelmingly positive about the quality of the support provided by most ASP staff. They raised concerns about the qualitative differences between ASPs, skills and knowledge of some staff, attention to confidentiality, the need for good communication between staff and the availability of sufficient staff. ASPs recognise the importance of staff training and prioritise training about working with mental health consumers, the support implications of consumers' co-existing conditions, risk management and occupational health and safety. Some ASPs regularly seek consumer feedback, without disadvantaging consumers who raise these issues. These professional requirements suggest a continuing need to develop the capacity of ASP management and staff.

## 7.7 Summary of the service model

### *Referral and selection processes*

- Most HASI referrals are made by mental health clinicians. Housing providers and others also informally refer people with mental illness to clinicians, who then make the formal referral to the ASP.
- Waiting lists for HASI support packages are active in all three evaluation sites.
- Selection into HASI ensures access to ASP support to find and/or maintain housing, through the priority housing assistance list, a process which may take some time.
- Some new HASI consumers receive ASP support while they are living in temporary accommodation. In other locations, ASPs did not provide support until consumers have housing.

### *Understanding the model*

- HASI aims to support consumers in their recovery process by providing stable housing, access to clinical services, and accommodation support services.
- The aims of HASI and recovery based services are interpreted in different ways by local HASI partners. The main tension is between ASPs that understand HASI as offering a spectrum of ongoing and short-term support services and ASPs that aim to provide time limited services.

### *HASI services*

- Tenancy management services are provided by public, community and private providers. Most housing managers view HASI consumers as reliable tenants. HASI consumers are generally satisfied with the tenancy management of their dwellings, although they criticised the maintenance processes.
- Community mental health teams provide essential clinical services to HASI consumers. HASI partners in all locations raised concerns about the impact of limited resources and capacity of community mental health teams.
- The most common activities ASP staff assisted consumers with were accessing the community, developing skills in personal self care, counselling and advocacy.
- ASPs provide rehabilitation focused services to support each person's recovery and they work with consumers to identify and achieve goals. The support provided by ASPs is structured around the goals that consumers set for themselves in their Individual Service Plans.

- The goal most frequently identified by consumers was to engage in social and community activities, followed by engaging in community tasks and carrying out activities of self care. The support provided by ASP staff closely matches the goals set by consumers.
- The way some ASP staff interpret the process of rehabilitation varies. Contrary to the HASI Manual (NSW Department of Health, 2006), some staff stated that consumers who continue to need disability or maintenance support over a long time are a less suitable consumer group for HASI than prioritising support for people who have the capacity to become independent within a shorter time.
- ASP services are tailored to the person, involve consumers in decision-making, respect their choices and provide consistency of support. Some HASI partners were concerned that some consumers become too reliant on ASP staff members. This highlights the important role of ASP staff in facilitating consumer's to achieve their goals.
- The level of support is flexible to meet changing consumer needs. Consumers can be transferred to lower support packages when their support needs decrease, which releases support resources for other consumers with higher support needs. It can be problematic, however, if ASPs have only one level of support and do not have strong partnerships with other ASPs in the local area.
- The provision of accommodation support works well when staff are highly professional, understand the personal recovery approach and have the opportunity to continually develop new skills. Key issues for quality support include recruitment of qualified and experienced staff, supervision, training and development opportunities and retention of skilled staff to ensure continuity of care. The effectiveness of HASI support is also assisted by strong internal risk assessment and management processes, good communication and coordination strategies, and confidentiality procedures. Good mechanisms to enable consumer feedback are important to ensuring quality services.

## 8 Exiting HASI

As consumers' needs change over time HASI offers ongoing or time-limited support depending on the individual needs of each consumer (NSW Health, 2006). This section discusses the support in place for consumers who exit the program or change their level of support and the main reasons they do so. The analysis informs understanding about the reasons and circumstances surrounding when and why consumers exit HASI or transfer to different support levels.<sup>65</sup>

Exiting HASI means that a person no longer receives accommodation support; it does not necessarily mean that the consumer vacated the housing provided through the program. Consumers who exit HASI generally still remain in their house and may still be engaged with clinical services.

HASI Program data provides information on consumers at the time of exiting HASI but data are not available on their subsequent wellbeing and housing situations. Some information is, however, available from twelve consumers within the qualitative sample who exited HASI between 2009 and 2010. Some case study material about the exit circumstances of these consumers is presented in Sections below.

### 8.1 Profile of consumers exiting HASI

Analysis of the program data collected found that 531 consumers exited the program between January 2007 and June 2009; proportionally more consumers exited the program when they were receiving lower support services (26 per cent) compared to those who were receiving higher support (15 per cent), although this is not statistically significant (Table 8.1).<sup>66</sup>

**Table 8.1: Proportion of consumers who left HASI by level of support, January 2007 – June 2009**

	Lower (n=1412)	Per cent Higher (n=756)	Total (n=2222)
Not exited	74	85	76
Exited	26	15	24
Total	100	100	100

Source: HASI MDS 2009 n=2222  
Note: Data missing for 40 consumers; Differences are not statistically significant (p>0.05)

<sup>65</sup> The information in this section is from interviews conducted with consumers and HASI partners in October 2009 and repeat interviews in October 2010, as well as secondary data from the HASI MDS program data (Appendix 1).

<sup>66</sup> The data on exits are based on all consumers of the HASI program between January 2007 and June 2009.

On average, consumers who left HASI spent about nine months in the program before exiting, although time in the program varied by support level (Table 8.2). For example, high support HASI consumers spent on average thirteen months in HASI, compared with about nine months for low support HASI consumers (Table 8.2).

**Table 8.2: Average months in HASI for current and exited consumers, January 2007 – June 2009**

Support level	Months	
	Current consumers (n=887)	Exited consumers (n=224)
Lower	8.5	6.1
Higher	13.3	12.1
All consumers	11.6	9.0

Source: HASI MDS 2009 n=1423 (Consumers with data about both support level and length in HASI)

Note: Data missing for 8 current consumers and 307 exited consumers; not statistically significant ( $p>0.05$ )

Consumers left the program for a variety of reasons (Table 8.3). Forty five per cent (n=222) had a planned exit from the program, meaning that the consumer, MHS and the ASPs agreed that the consumer either: no longer needed support, required a higher level of support, or needed another type of support. Consumers who exited HASI did not differ in terms of support level, age, gender or Aboriginality.

**Table 8.3: Reasons for leaving HASI, January 2007 – June 2009**

Reason for leaving HASI	Consumers	Per cent
Planned exit		
Consumer no longer needed support	181	36.7
Move to higher support accommodation	22	4.5
Move to other long term housing	19	3.9
Total planned exits	222	45.0
Unplanned exit		
Consumer decided to discontinue support	103	20.9
Failure to meet tenancy obligation	36	7.3
Total unplanned exits	139	28.2
Other <sup>1</sup>	132	26.8
Total exits	493*	100

Source: HASI MDS 2009 n=2222

Note: Data missing for 38 consumers

\*This probably underestimates the number of exits because the data are incomplete

1. Includes long term admissions to hospital or mental health units; moving from the service area; connecting with a more appropriate service; or the person died.

Planned exits, in which consumers had achieved their rehabilitation goals and no longer needed support from ASPs, were considered by HASI partners to

be successful exits. An ASP staff member described how their service worked with consumers to plan their exit:

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."

More than a quarter of the exits from HASI (28 per cent) were unplanned, meaning that consumers decided to discontinue the support (such as those who refused contact with ASPs) or did not meet their tenancy obligations (Table 8.3). The range of other reasons that consumers left the program (27 per cent) included long term admissions to hospital or mental health units; moving from the service area; connecting with a more appropriate service; and, in a few circumstances, the consumer had died.

Most consumers interviewed had remained in the program (80 per cent; n=47). Some of the consumers who had left were interviewed, or where this was not possible, their former ASP support workers were interviewed to find out the reasons for exit. The following section presents a series of case studies to show in more detail how people experienced their transition out of HASI.

## **8.2 Transitions to independent living**

Three of the twelve former HASI consumers within the qualitative sample who exited HASI between 2009 and 2010 had left the program because they felt they had achieved a high level of independence and no longer needed support. Two of these consumers had been receiving low support packages and one medium support. Two had initiated the process of leaving because they felt confident that they could live independently in the community. The HASI support worker assessed the other consumer as no longer requiring HASI support and he agreed that he was 'able to stand on my own two feet.' All three consumers had remained in the same housing as when they were in HASI.

One consumer had started in the program in a high support package, subsequently transferred to a low support package with another ASP before deciding he no longer required the support of the ASP. This consumer was interviewed after he had left the program. He described his experience of moving between support levels and leaving the program in the following way:

I decided to leave the program cause I was well enough ... We found out that after their work [the ASP] – they made me more independent – to be able to do things for me self. I've got a support network at [the day centre] and now I worked out I do shopping with Dad. I do everything myself now.

This consumer had achieved a level of independence that enabled him to maintain his tenancy and live independently in the community. He felt this was possible because the ASP staff had worked with him to develop his daily living skills and also because he had other forms of support in the community and through his family networks.

### **8.3 Transitions to low HASI support**

One consumer had left the ASP provider because he no longer needed the level of support offered. During this transition process the consumer had remained in his house. As the ASP was not funded to provide low support he decided to transition to another ASP which could offer him lower support. He said:

I was one of the first to be in and out of the organisation the quickest. I was on my two feet at the [day centre] for a while, I was holding down a job. I think it was the factors of just being ready to move on. Just reaching that maturity – that independence ... There were a few of us [who left together and joined a new ASP]. We had been through a transitional period, sort of like less supervision, more freedom.

Some high support consumers reduced the levels of support they required over time. In these situations, the consumers, ASPs and mental health service providers all agreed that it was appropriate for some consumers to transition to a lower level of support. In a small number of cases, the interviews showed that some consumers may have prematurely transitioned to lower support to alleviate the pressure of waiting lists for high support packages. Some low support HASI consumers also thought that they would have to leave HASI so that other people with unmet needs in the community could be selected for HASI (Section 7.2).

### **8.4 Transitions to an aged care service**

Two consumers with very high support needs who were interviewed in 2009 had exited HASI by 2010 because they needed even higher support than that available in HASI. HASI could not meet their range of physical and mental health needs, which included depression, diabetes and memory loss.

According to his key support worker, one of the consumers required a more intensive 'carer model' of support. The clinical case manager instigated the transition to an aged care service that had 24 hour care and housing. According to the ASP worker who had regular contact with the consumer during a 4-6 month transition period with the new service, the consumer was enjoying having more regular social contact with other residents. Other benefits included having more regular meals, intensive support to manage his medication and assistance with monitoring his blood sugar levels.

A similar scenario occurred for another man who was receiving very high HASI support. According to his former ASP support worker, the transition was initiated by his public guardian who felt that the very high HASI support and



the type of housing provided were no longer adequate to support his needs. His condition was deteriorating, adding to his frailty and other health conditions, such as asthma and motor skills. The planned transition process took about 4-5 months from assessment to moving to an aged care facility. According to his former ASP support worker, when this consumer was with HASI he stated that he needed a carer rather than developing his independent living skills. The ASP staff perceived that the consumer was generally happy with the aged care facility, but that he was not so pleased about some of the conditions, for example, that he was not permitted to go out at night.

### **8.5 Refusal of ASP support**

Two consumers had left the program because they did not wish to continue working with the ASP providers. One man who left the program for this reason was receiving low support. According to his support worker, he was not interested in participating in the community, he did not have any goals he wanted to achieve and he did not like the structure of the ASP support. When he started with HASI he joined a voluntary group but he was not interested in participating in anything else and he started refusing support from ASP staff. He started to refuse to engage with male ASP staff (female staff did not work with him due to previously identified risks). The ASP worker indicated that unfortunately, since he had stopped receiving support, he had experienced difficulties with his mental health and was currently in hospital.

The second example was a woman receiving medium support (HASI in the Home) who had left the program just after the time of the first interview. According to the ASP manager, she was living in a public housing unit when she joined HASI and applied for new housing with the assistance of the ASP. Since she was relocated 'to a better neighbourhood' where she had better access to services she had reportedly started to refuse support from the ASP. The ASP staff said:

Shortly after moving she became more independent by walking everywhere but her hygiene continued to be a problem. She didn't want assistance with housework – she wanted to live in a mess in her house. Several times she verbally abused staff. I had to say I'd like some modification to this type of behaviour and there was no modification so we basically discharged her from the program.

The ASP manager indicated that the consumer was still in contact with the local mental health services and that the clinicians were hopeful that she would rejoin the HASI program. The ASP manager was concerned about her capacity to maintain her tenancy but he felt there was little the ASP could do, although they had attempted to re-engage with her over some time and were prepared to resume support whenever she consented. He said:

[Mental health] would like her to re-engage with us and we could if she was willing to work with us but she is defiant to do that ... [Mental Health clinicians] are helping with clinical

everyday mental illness control, however she is almost like a vagrant even though she has a roof over her head ... Somehow she is managing to maintain her tenancy – everything was set up so it's OPC paid. I would like to have her back in the program but with it being a voluntary program if she is not interested, she is not interested.

One of the aims of HASI is to support people who already have social housing or private rental. If a consumer refuses support from the ASP, and becomes unwell, this may lead to problems for the housing provider because of failure to pay rent or other problems and as a result the consumer's tenancy may be at risk. Questions raised by such situations about the kind of strategies that ASPs might use to reengage with the consumer, and whether alternatives to formally discharging consumers might be devised are discussed in Section 8.7 below.

## **8.6 Other reasons for exiting HASI**

Consumers exited the program for a number of other reasons, positive and negative. Three consumers in the case studies had exited the program for other reasons. In one situation, a woman had moved out of area and was not contactable, although the ASP understood she was not receiving support from another similar service.

Another consumer who was interviewed in 2009 and 2010 did not know that he had left HASI, although this was confirmed by the ASP. The ASP assessed him as no longer requiring the service, although the consumer said that he would like to increase his help again. The ASP advised that he was subsequently referred to PHaMs.

In another case, the consumer had been asked to temporarily leave HASI due to what the ASP staff described as behavioural problems. This consumer was in low support HASI, living in social housing. This consumer remained in his housing and maintained contact with clinical services. Interviews with other key HASI partners suggested that this consumer had not been formally exited from the program and local mental health clinical staff were negotiating with him about re-engaging with the ASP.

Another consumer's family was advised that his HASI support (2 days a week) would not continue as a result of local changes to LHD and ASP policies (described in Section 7.4). This consumer was receiving mental health services through private practitioners rather than through public MHS. The consumer's mother was concerned for his mental health and believed he still needed HASI. She indicated that she had been informed 'the other day' by the ASP that:

... support [would be] terminated from next week because he doesn't have any public [mental] health involvement' ... another program is taking over called PHaMs.

At the time that the 2010 fieldwork was conducted, local HASI partners were seeking to resolve these issues and the ASP advised that consumer remained in the program. The consumer's mental health deteriorated and the ASP responded positively to his needs and continued his support.

### **8.7 Transition or exit?**

At an organisational level, some ASPs grappled with the issue of whether to formally exit consumers from the program or whether to have a transition period whereby the consumer could re-enter the program without needing to formally repeat the selection process. For example, one ASP support worker who worked mainly with low support consumers indicated that this was something senior managers in his organisation were discussing – a new approach to start talking to consumers about exiting, then provide them with a transition period where the package is left open so that if a problem arises they could receive immediate support.

The need for flexibility when consumers leave the program was also raised by support workers working for ASPs in other evaluation sites. Some ASPs had an open door policy after consumers had officially left the program. An ASP staff said:

The transition can take 3 months. We do take that time to step out, reduce [the support] further to fortnightly, then every 3 weeks, then to phone calls. They know they still have us to fall back on. We never leave anyone high and dry without referring them on.

### **8.8 Discussion about the findings**

HASI consumers exited the program for a variety of reasons. These include planned exits where people were assessed as no longer requiring HASI assistance, or moving to a more suitable form of higher or lower support from a different HASI provider or another organisation. Some consumers left the program for other reasons, such as moving from the location. In general, a planned exit involved the ASP working with the consumer to support the consumer in developing an exit plan. The interviews suggest that in a small number of cases the exit planning process was initiated and driven by the ASP rather than the consumer. This is not compatible with the recovery approach.

The evidence from interviews with ASPs is that for consumers to effectively exit from lower support HASI, other support needs to be available in the community, either through other service providers or family support. It is important that ASPs communicate clearly with consumers and housing providers and, where relevant, family members, about ending the ASP support and about their availability after regular ASP support ends. ASP training about effectively exiting HASI consumers could assist them to strengthen their approach.

For those consumers who exited HASI but were not linked to other programs such as PHAMs, there was scope to strengthen exit pathways to support the capacity of consumers to live independently without the intensive contact (Section 7.5). Given the fluctuating nature of some mental health problems and the strong and positive relationships that ASPs had often developed with consumers, these services were well-positioned to provide effective occasional support to consumers who were no longer receiving a regular support package. ASPs needed to be flexible should consumers need to turn to someone they could trust if future problems arose. While some ASPs had adopted a flexible open door policy, the ASP funding model does not lend itself to providing one off or discrete support to consumers who have left the program.

Some high support consumers reduced the levels of support they required over time, which resulted in some of them transitioning to a lower support package. In these situations, the consumers, ASPs and mental health service providers agreed that it was appropriate to transition to a lower level of support. In a small number of cases, the consumers may have been prematurely transitioned to lower support to alleviate the pressure of waiting lists for high support packages. Some lower support HASI consumers also thought they had to leave HASI so that other people with unmet needs in the community could be selected for HASI (Section 7.2). Decisions about when a consumer reduces support or moves to lower support are complex and it is likely that waiting lists create pressure in the program's limited resources. Further training to balance managing limited resources within the recovery approach would be appropriate.

The circumstances under which some consumers left HASI were complex to manage. For example, some consumers refused support from ASPs and were exited because HASI is a voluntary program. The situations of some tenants with unplanned exits raise questions about alternative approaches to supporting mental health consumers with complex needs to maintain their tenancy and live in the community.

An ongoing issue for HASI partners and consumers is the situation where people refused support from an ASP and became unwell, or were already unwell. In this situation, problems arose with the consumer maintaining their tenancy because of failure to pay rent or other issues, and this led to problems for the housing provider when the consumer's tenancy was at risk. This situation raises questions about the strategies that HASI partners could use to reengage with consumers, and whether alternatives to formally discharging consumers could be designed (Section 9). Specific training to HASI partners about approaches to successfully reengage consumers in this situation could be useful.

In other situations ASPs refused to work with consumers who were abusive to staff or whose behaviour was too difficult for the ASP to manage. Some clinicians were concerned that ASPs had different thresholds, strategies and timeframes to respond to challenging behaviour. The way ASPs and other HASI partners work with complex support needs and communicate with each

other about these consumers' needs could also be the subject of further staff development.

The information currently available about the outcomes for people whose needs could not be or were not met by HASI is not comprehensive. The collection of detailed data in this area is challenging because of the difficulties involved in contacting this group when they are not engaging with HASI. The information about these consumers is from interviews, MDS and the case studies.

The interview evidence is about consumers who were not accepted into HASI. The stakeholders referred to a small number of consumers who could potentially benefit from HASI but who were not accepted because they were assessed as too complex, did not want to participate in the service or had less capacity to participate (Section 7.1). Information was not available about how many consumers were not accepted for these reasons or their circumstances and outcomes.

The HASI MDS data also shows that between January 2007 and June 2009, approximately 1 per cent of consumers who entered HASI later exited to higher support accommodation (5 per cent of all exits), and a further 6 per cent of consumers who entered HASI had an unplanned exit involving a decision to discontinue support or a failure to meet tenancy obligations (29 per cent of all exits) (Section 8.1, Table 8.1 and Table 8.3). This demonstrated that a small number of consumers who were initially accepted into the program were later assessed as having higher or more complex needs than could be met within HASI; exhibited behaviour that could not be managed within the constraints of the HASI model; or believed that the program did not meet their needs and chose to leave.

The case study information in Section 8 about exits among those consumers within the qualitative sample indicates the range of reasons for exiting, including moving to higher support and unplanned exits resulting from refusal of support and behavioural problems. In particular the case study information reveals that in some instances unplanned exits are associated with worsening mental health and associated problems such as personal care and maintaining the tenancy. The case studies also describe examples where HASI partners attempted to re-engage and resume support with consumers in these situations. The data do not track the outcomes for this group beyond the 2010 collection.

Unplanned exits from HASI support do not require the consumers to exit their housing, but the HASI MDS shows that 1 per cent of all consumers (14 per cent of tenancy completions) were evicted, abandoned the property or did not have their tenancy renewed due to failure to meet tenancy obligations (Table 6.30). The interview sample did not include any consumers who left their housing in these circumstances and as a result there is no information about outcomes for this group.

Factors supporting the effective transition of people out of the HASI program included: planned exits between HASI partners, consumers, family and other

organisations; coordination of HASI services with other community services during this transition; and flexible support by ASPs during the transition.

### **8.9 Summary of leaving HASI**

- Some people no longer needed support services from ASPs and were successfully living independently and maintaining their tenancies and mental health. This included people who had started with higher support, changed to lower support and finally exited HASI.
- Some people leave HASI without alternative support or independence for maintaining mental health and housing, for example, they refuse support from the ASP. Improved processes to re-engage consumers or refer them to alternative support could prevent some of the problems that arise in these circumstances.
- Good practices for supporting consumers to exit from low support packages could be shared between the HASI partners across the state to learn about successful transition planning and support.

## 9 Partnerships and governance

HASI services are provided within a partnership model at the local level that involves NSW Health, Housing NSW and NGOs for accommodation support and community housing. NSW Health is responsible for delivering clinical services via LHDs as well as funding accommodation support services which are delivered by ASPs, while Housing NSW supplies housing, provides tenancy management services and funds community housing to do the same.

Research indicates that co-ordinating housing and support provision leads to better outcomes for consumers (Reynolds et al., 2002). This section describes the relationships between partners, the extent to which they effectively work together, and the factors that facilitate or hinder effective partnerships. It focuses on the partnership model and factors that contributed to developing strong partnerships.<sup>67</sup>

### 9.1 Partnerships

#### Relationships between local HASI partners

Overall the relationships between local partners are operating effectively in each of the three evaluation sites. Staff reported that relationships between LHD and ASP providers, ASP and housing providers and ASP staff from different organisations were particularly strong. They reported some tensions between stakeholder groups in some sites, discussed below. In addition, a few local partnerships were under stress in 2010 when the ASP support packages were retendered, resulting in some reallocation between existing and new NGOs.

#### *ASPs and LHDs*

ASP staff suggested that positive and inclusive relations between themselves and clinicians had progressed considerably over the life of the HASI program. The relationship between these two partners was reportedly enhanced where LHD staff believed that the ASPs provided a service that supports the MHS to focus on their clinical roles and spend more time on consumers who do not receive HASI or other support in the community. ASP and MHS staff reported that their relationships were usually based on mutual respect, particularly when they perceived that they added value to each other's roles. A mental health clinician, for example, stated that one consumer:

... has an excellent [ASP] worker who knows her really well so if she has concerns about her mental health, she'll call me and she'll offer extra support around those periods. I really trust her opinion in terms of her assessment especially because I have faith in her skills and she's really reliable.

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<sup>67</sup> The information is from interviews with key HASI partners and observation conducted in October 2009 and October 2010 (Appendix 1).

Some MHS staff did not view themselves as part of the HASI partnership but instead primarily identified HASI with the ASP only, frequently referring to the ASP as 'HASI'. Some MHS interviewees were critical of ASP staff contacting them with concerns about the consumers' wellbeing and treatment (Section 7.4 and further discussion below). At worst, some MHS staff associated the development of HASI with a reduction in resources for the MHS and suggested that better service integration would be achieved if the resources allocated to HASI were instead provided to the LHD. On the other hand, some MHS staff who were positive about the HASI accommodation support model, suggested that the quality of support varied between ASPs in their local area.

### *ASPs and housing providers*

Most housing providers and ASPs reported that they work together well to assist consumers to manage their tenancies. Staff from both HASI partners agreed that sustaining tenancies was an important part of HASI's role, with both ASPs and consumers reporting that support to maintain the housing, such as cleaning, maintenance and repairs, was an important activity.

The HASI partnership work between ASPs and housing providers is primarily reactive, driven by consumer need. These two partners work together when consumers experience a problem associated with housing, such as complaints from neighbours, rental arrears, repairs and maintenance requests or if the consumer requires more suitable housing. In these cases, ASPs often advocate on behalf of consumers. ASP and housing staff believed this reactive contact was usually appropriate.<sup>68</sup> Housing staff at the local level generally felt well supported by ASPs, as described by a community housing provider:

We have a tenant who has a lot of issues. We had a number of complaints from neighbours. I rang [the ASP manager] ... and within the hour we had the tenant, the case worker, ASP manager and myself all in the same room ... We developed some strategies, with her involvement, to ensure that this didn't happen again. Now this all happened 6-8 months ago and she is still a tenant of ours.

The HASI program gives housing providers a mechanism for key contacts and support and, as the following housing stakeholder reported, this level of contact is often not achieved for people with a mental illness who live in social housing, and who are not HASI consumers, 'With our other consumers you don't get the support or communication [from the mental health teams]. But with HASI they [ASP] are there all the time.'

Housing NSW and community housing staff valued the important role of ASPs assisting consumers to maintain their tenancies because this allows housing

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<sup>68</sup> They said that more involvement with HASI, further communication and personal relationships would be too time consuming for housing personnel who are often working with multiple ASP organisations in their community.



providers to focus on tenancy management. A local Housing NSW manager said:

When we do something jointly [with the ASP] it works better for everybody. We still need the commitment that both parties would have to put towards the agreement. We feel we're a housing provider and we assist up to a point but we don't ... do the social worker part and unfortunately [the broader community] sees us like that sometimes.

Strong partnerships were also evident between some ASPs and community housing providers. A community housing provider reported:

One of the priority conditions is that people are supported. Now when they come through the HASI program, we can have a lot more faith that that will happen ... I know they'll have that support. Yes they have complex needs but ... I know they won't have any issues that can't be addressed. It gives me that confidence.

A small number of ASPs reported that they had difficulties working with housing providers due to confusion among housing staff about the difference between the roles of clinical and ASP staff, and limits to their knowledge about mental health consumers. To protect the privacy of HASI consumers, some ASPs were hesitant to share too much information with housing providers about individual consumers, which sometimes caused problems from the perspective of the housing provider. There is sometimes disagreement about what personal information is necessary for the housing provider to have access to in order to anticipate risks to tenancy.

Some ASPs also reported that sometimes, managing expectations was an issue for HASI partners. For example, an ASP worker explained that, even with support, it is sometimes difficult for tenants to meet the requirements of housing providers:

With housing [providers] it can be hard to convince people doing inspections that this is the cleanest their house has ever been. But most of time partnership works wonderfully.

Some housing providers were concerned that sometimes they did not have up to date information about whether their tenants were still receiving ASP support services or up to date contacts in the LHD.

Most housing providers believed that HASI benefited mental health consumers already in social housing who were referred to HASI. A Housing NSW manager stated that HASI was 'one of the best services I've come across.' In some instances housing providers had experienced poor responsiveness from ASP workers if they raised tenancy problems. One community housing provider was concerned that sometimes the level of support reduced after HASI consumers were housed, leading to problems managing their tenancy.

### *Relationships between ASPs*

Multiple ASPs provide services across NSW and in overlapping geographical areas to meet consumer needs in the expanding HASI program. This arrangement requires ASPs to work not only with staff from the LHD and Housing NSW, but also with each other. Relationships between multiple ASPs in each location appeared to be based on mutual respect and co-operation, and the ASPs worked well together in the evaluation sites.

Some HASI partners were concerned that the HASI competitive funding model threatened the collaboration between ASPs. They reported that partnerships between ASPs were strained in some evaluation sites during the retendering of HASI packages in 2010. Organisations providing existing ASP packages as well as new NGOs wishing to do so were invited to tender to provide services. The re-tendering resulted in some ASPs acquiring or losing a proportion or all of their HASI support packages in some locations.

The impact of the reallocated packages varied across the three evaluation sites. In some sites, the process went smoothly, with no job losses and generally positive responses from ASPs, except for the observation that a little more time would have made the transition easier. In other sites, the reallocation of packages created tensions between ASPs and created uncertainty particularly for ASP staff members who lost their jobs or whose contract was not renewed. In yet other sites, staff whose current position became redundant had been relocated to another office within the ASP. Some ASP staff were also concerned about the impact or future impact on consumers. For example, an ASP staff member suggested that some consumers were initially concerned when they found out they had to move to a new ASP:

The practical stuff of the transition [to a new ASP] was not a hassle ... it was the emotional stuff that comes with it, which was the difficult stuff for the consumers – they felt abandoned, ‘Why me, why do I have to go, why can’t I stay?’ ... so far I haven’t heard that’s anything has gone terribly wrong.

One of the main concerns raised by ASPs and MHS was that the reallocation of packages had created a misperception in the community that some ASPs lost funding due to poor performance. At the local level, some ASPs, housing and MHS staff did not feel they had been appropriately consulted and involved in the decision-making process.

### *Housing providers and LHDs*

Formal relationships between housing providers and MHS staff were less evident, and housing providers reported that they had minimal direct communication with each other. Housing staff felt that, in most cases, this is an effective arrangement. A housing staff member said, ‘When they [consumers] have an ASP case manager – it is easier for us, rather than talking to a health organisation first.’

Even so, it is important that some connection between housing providers and MHS remains, particularly when a consumer exits HASI but remains a consumer of the MHS. In some sites housing providers indicated they had developed good contacts in MHS, whereas in other sites housing staff said they found it difficult to contact MHS staff.

Poor communication between these HASI partners sometimes posed avoidable risks to staff. One housing provider recalled instances where MHS staff had suspended visits to a HASI consumer's house because of safety issues, but failed to advise the other HASI partners. Good communication in the regular HASI meetings was able to resolve this risk, but it was not addressed immediately, so staff from two of the partner services could have been at risk. A housing provider said:

So then we would say to Mental Health at the meeting well have you been going there? Oh no, we didn't go there as they're dangerous. Well thanks for letting us know. So that's where the meetings are really good. Mental Health didn't go. HASI was still going and Housing was still going. Unbeknownst to us there'd been an incident with Mental Health. But I'm not aware that that happens that much now because we've kind of nipped that in the bud ...

This example illustrates the importance of immediate communication between MHS and other partners about changes in consumer mental health and risk status. It also shows the benefit of including housing providers in regular HASI partnership meetings, which does not occur in all sites (Section 7.1; and further discussion below).

### *Other partners*

ASPs emphasised the range of other organisations that they considered to be HASI partners, such as day programs, PHaMs and other community organisations in which consumers were involved. In some evaluation sites, HASI partners also used other forums to discuss the needs of mutual HASI consumers (Section 7.1). For example, a Housing NSW provider commented:

I have face to face contact with [ASP] workers though JGOS ... we have those monthly meetings. I meet also their reps at other interagency meetings such as local mental health interagency ... We've got on board mutual consumers – complex consumers – and all participants [ASP, mental health, housing] present their problems and we discuss as one body the needs of those consumers.

### **Factors impacting on partnership effectiveness**

As HASI is now an established program, relationships between partners appear to be working relatively well due to four factors: clear roles and responsibilities; open communication; a commitment to working together; and sound governance processes.

### *Clear roles and responsibilities*

The clear delineation of roles and responsibilities is crucial to developing positive working relationships. The evaluation of HASI Stage 1 found that clarity of roles and responsibilities increased over time (Muir et al, 2007) and the current evaluation demonstrated that role delineation remained relatively clear. Staff turnover and the program's expansion into new geographical areas means that these processes of clarification and training need to be regularly revisited.

Where roles and responsibilities were not clear, tensions emerged between partners that compromised working relationships. For example, a small number of ASP staff reported that they had difficulties engaging housing providers when they did not understand the HASI model and were confused about the difference between the clinical MHS role and the non-clinical ASP role.

Delineation of roles such as assisting versus supporting consumers with their medication were negotiated at the local level. For example, an ASP staff member described a situation in which her role needed to be clarified:

They [MHS] are wanting us to be more responsible with clinical involvement. We had to really put our foot down and say that's not our role, that's not what we're trained in or qualified in. That's your area.

Similarly, clarifying roles between ASPs and clinical staff who performed similar roles in the MHS was also resolved at a local level. For example, some clinicians specialising in rehabilitation, including occupational therapists and social workers, are involved with how consumers cope at home and engage with the community. Some clinicians suggested that they are easily able to differentiate their role from that of the ASP staff, whereas other clinicians described a situation in which the consumer felt 'over-served' by the rehabilitation support provided by both the clinician and ASP staff.

Some MHS and ASP staff reported tension about different perceptions of consumers' mental health status. For example ASP staff sometimes felt that the MHS were not sufficiently responsive when they reported deterioration in consumers' mental health. An ASP worker said:

The hardest thing we have is trying to convince the clinicians that a consumer is unwell. We see them all the time, when the clinician comes around, they [consumers] may say I'm fine, when they were going to kill themselves yesterday. Also clinicians see things they [ASP workers] don't, so it works both ways.

Some MHS staff viewed some concerns raised by ASPs as an inappropriate questioning of their professional judgement. A clinician said:

Often times we get called about so-and-so doing this and that and whether we're aware of that, we're working on that and

what I find is frustration with HASI [the ASP]. They believe that we should do more, we should be doing something different, they're not aware of all the clinical issues involved.

The same clinician was also concerned that when the MHS decreased their support or withdrew, the ASP sometimes criticised this decision:

You know sometimes we're looking to further their rehab by lessening our service ... We may feel that [remaining in] HASI's still appropriate for them, maintain their housing without active mental health support and that has at times been difficult or challenging for HASI [the ASP] to understand.

A key operational lesson from the evaluation of HASI Stage 1 was that Service Level Agreements (SLAs) strengthened the program by clarifying partner roles and information sharing processes (Muir et al., 2007). During the establishment of HASI, SLAs were important for legitimising HASI partnerships within the organisations. Now that the HASI program is established, the strength of the partnership rests upon informal arrangements and the commitment of the staff involved, rather than a signed document. An ASP manager said:

A lot of SLAs don't get done. It's pretty much word of mouth and the shake of a hand ... an ongoing communication and meetings. We don't have any formal SLAs with local partners – I initiate meetings once a month, in addition to the other interagency meetings and [HASI] selection meetings. I have an individual meeting with those [HASI] partners... I have never signed a piece of paper in the 2 years I've been here.

However, roles and responsibilities were clearest where both formal and informal strategies were implemented. For example, in one site a joint statement by ASPs and the LHD outlined respective roles. Another site established an observation initiative so that both ASPs and MHS staff could appreciate the work contexts in which the other partners operate. An ASP worker explained:

ASPs go to work with mental health and vice versa. They have developed a new respect for the work each other do. NGOs stopped criticising Health for not taking their calls and Health realised that NGOs are professional and do a good job. It created an informal professional relationship and helped staff to call each other and problem solve.

### *Open communication*

HASI partners reported that open communication was a key element of their effective partnership. They stressed the importance of strong communication strategies between partners at all levels, including upper governance, middle managers and frontline workers. When communication channels were weak, particularly between managers and front line workers, partnerships were

undermined. This was particularly the case for frontline Health and Housing staff.

Front-line ASP workers reported that they sometimes struggled to develop effective relationships with front-line staff in health and housing organisations because these staff had a limited understanding of how the HASI partnership model was intended to work. Some ASPs found that staff changes, the expansion of the HASI program and subsequent involvement of more workers had made both communication and the coherence of the program more difficult. Communication was easiest to manage where the HASI partners shared geographical boundaries and had continuity in staffing. A strong organisational focus and training about consumer-focussed services are other factors which support these program priorities.

Some HASI partner staff thought that there was scope for improving communication between the partners. One MHS clinician pointed to an initiative where they invited ASP staff to attend their regular meeting where consumers were discussed. The initiative had lapsed because both partners were busy. Similarly, another suggestion for MHS staff to attend the local ASP's monthly service days was not taken up. Other staff thought that communication between partners was already effective.

While open communication between HASI partners is important, not all partners require detailed information about each consumer's situation. For example, housing providers need to understand how HASI operates and what this means for consumers, but ASP staff said housing providers do not require detailed information about consumer goals or their mental health. An ASP staff discussed the information they share with housing providers:

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 the HASI program remains clinically oriented and that HASI forums focus on recovery and mental health services to the exclusion of discussing housing risks. Some HASI partners suggested it would be useful to bring housing providers together to discuss shared experiences and to network with each other. Some communication problems were also raised between Housing NSW and community housing providers, regarding Housing Pathways and the single social housing waiting list (Section 7.1). Housing Pathways was a major reform and training and change management for community housing and public housing staff in Housing Pathways is ongoing.

Many staff suggested that relationships between ASPs and housing provider staff had improved over time (Section 7.1), although some ASPs indicated that they still experienced ongoing challenges assisting consumers to

navigate the social housing system. The partnership between ASPs and housing providers worked well when there was a designated key contact person at Housing NSW who ASPs could contact directly (for example a senior officer), continuity of staffing in both organisations, and regular contact between ASPs and housing representatives at all levels (management and local staff).

*Commitment to working together and to the program*

Effective partnerships require a substantial investment of time and necessitate an organisational and individual commitment to working together. Good working relationships depended on the commitment from local partners to maintain and develop productive working relationships. ASPs reported that they had built up strong relationships with key partners over time, but that they had ongoing challenges maintaining these relationships due to staff turnover and the expansion of HASI. As discussed above, most HASI partners regularly attended HASI meetings, and those who did not were encouraged to attend. In addition, staff stressed the importance of addressing problems as they arose.

HASI partners reported that problem solving required respecting differences in organisational values and approaches within the overall program philosophy. In some cases, where differences were discussed, they had productive dialogue about how to improve the program, create greater consistency between ASP providers and how to better complement clinical roles. In practice, working together from different organisational cultures could be difficult. As one mental health clinician stated:

[We have] the cultures of the more bureaucratic and hierarchy [based] ... health system versus the more organic and consumer friendly NGO ... I think there's a bit of a clash there ... they [NGO] work from a very consumer-focused perspective ... the mode of our interventions is more directive and we're actually saying to consumers, almost 'you have to do this'... our partner organisation, [NGO], I see that their workers are not pushing and they're much less directive. I actually like that approach ... but for some of my colleagues that's a little bit confronting.

A commitment to working together assisted the HASI partners to overcome challenges that arose from having multiple providers operating in a location, such as co-ordinating referral processes ((Section 7.1). It also helped to decrease duplication in selection processes and increase joint training initiatives and information flow.

Other innovations included an example where community mental health and ASP staff jointly run programs for mental health consumers, such as Healthy Living programs. The benefits described by local partners included pooling resources and increased consumer participation in activities.

## 9.2 Local governance processes

The local governance arrangements centre on the local coordination groups and client selection panels, both of which involve housing providers, MHS and ASPs. In most locations, one group has both functions. Local coordination groups are responsible for the local implementation of HASI, including the Service Level Agreement. HASI partners perceived both groups to be valuable for developing and facilitating effective relationships between local partners, and they viewed the local coordination group as necessary to supplement the operation of selection committees. They said that effective local governance structures were facilitated by the commitment of the people involved; formal and informal communication channels; and regular meetings. The Health Services that had a partnership coordinator position resourced by the LHD had particularly strong local governance structures.

Local governance processes in some sites struggled with the tension between aiming for an equal partnership between the LHD and ASPs and the LHD responsibility to manage the ASP service contracts. The difficulty of the funder-provider relationship was one of the governance lessons from the evaluation of HASI Stage 1 (Muir et al., 2007: 29) and it persists, although to a lesser degree. They continued to express concern about the conflict in managing the current funding model, which ASP staff said pressures them to select referrals from MHS over other agencies. For example, a ASP manager said that:

... the NGOs are funded by the Department [NSW Health] 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.

Another ASP manager also believed that this governance arrangement was affecting the partnership between the ASP and MHS at a broader level. The manager said:

We have a funding and service agreement with the Local Health District, 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.

In this evaluation, most local ASP managers perceived this tension to be a problem at the regional and state level, and less so at the local co-ordination level between clinicians and support workers. They were less concerned about MHS managing ASPs and more concerned that the current governance structure created confusion among the partners about ASP accountability to whom and for what.



Some LHDs have a designated HASI coordinator within the MHS. Other HASI partners thought that having local partnership coordinators could facilitate stronger partnerships between housing providers, clinical services and ASPs.

### 9.3 State governance processes

HASI has a three tiered governance structure at the state level, supplemented with a fourth tier at the local level (Figure 9.1). Partner and stakeholder management structures have evolved over time. The development of these structures reflects the expansion and maturity of the Program.

**Figure 9.1: HASI governance arrangements**



At the top tier, the Senior Executive Meeting, provides a forum for the funding agencies to oversee the Program from a strategic development, governance and future planning perspective.

The second tier, the Departmental Executive Committee, oversees agency responsibilities in relation to policy and operational effectiveness.

The third tier, Stakeholder forums, addresses local level questions that have broader policy implications for the program. These meetings support the ongoing planning, development and delivery of HASI. All HASI funded ASPs and the LHDs are represented at these meetings. Representative(s) from MHD AO and Housing NSW also attend. Housing providers have recently also been invited to attend.

The fourth tier, Local Coordination Groups and Selection Committees, are described above.

HASI partners who were knowledgeable about the governance structure at the state level reported that these arrangements are working relatively well.

An important aspect of the effectiveness of these structures is that HASI continues to receive support and leadership from senior staff in NSW Health and Housing NSW, as well as political support from Ministers.

Lead agencies viewed the DEC as resource intensive, but they reported that meeting regularly was essential for maintaining HASI as a partnership. It encouraged these partners to work together to resolve operational and governance issues. Due to the commitment of the two departments, regular meetings, and strong communication channels, the partnership between NSW Health and Housing NSW has strengthened considerably. A good example of how the partnership works in practice is through the roll out of new stages of the program, where key decisions are made jointly between the two agencies.

The partnership has grown over time and progress to address perceived barriers to the partnership has been made, including how policy priorities of the two organisations are managed. A key priority for NSW Health is to ensure that people with mental illness have access to housing, although it is not their role to provide housing (NSW Health, 2002). Key priorities for Housing NSW include the prevention and reduction of homelessness through the provision of housing solutions for people in need, including a focus on assisting people to maintain their tenancies, although it is not Housing NSW's role to provide the support to people requiring assistance to maintain tenancies (Housing NSW, 2008).

The HASI program has contributed to the coordination and integration of these priorities through rolling out higher and lower support packages for consumers with different needs. For example, the implementation of HASI Stage 1 was for people with complex mental health problems with priority given to those who were in hospital and required housing, whereas Stage Two was introduced to offer services to existing social housing tenants who have a mental illness and required support. For HASI to continue to operate as an effective partnership at the state level, it is important that shared policy priorities of each agency continue to be recognised and managed.

Overall, the evaluation found that the governance arrangements were working well. Communication strategies for retendering accommodation support across the program (higher and lower support) could be improved to protect the quality of local working relationships (Section 9.1). Some local MHS clinicians, ASP staff and managers and some housing providers indicated that they did not feel adequately informed about the process and implications of the funding announcements for ASP services, staff and consumers. They did not think information within and between organisations was circulated effectively to local HASI partner staff in some sites.

Some ASP and MHS staff said that in some locations, the outcomes of the retendering process could not be implemented in the 6 week timeframe set at the central level because of the time to prepare to transition consumers to a new ASP and to set up new ASPs. Although Housing, LHD and ASP managers who attend HASI partnership meetings were consulted and involved in the retendering process, the local staff were not. Communication

to improve the understanding by local staff could improve future coordination of retendering processes.

#### **9.4 Program resourcing**

The effectiveness of HASI depends on the availability of program resources. In addition to the pressures on community mental health services (Sections 7.4 and 9.1), the two other resource questions identified in the evaluation were about accommodation support and pathways into secure housing.

##### **Funding of accommodation support**

Major issues related to accommodation support were approaches to flexibility of support and the pressures of waiting lists and unmet need.

##### *Flexibility of support*

When the HASI program was first implemented in 2002/03, ASPs were contracted to provide high level support services to consumers. Since then, the program has expanded to provide a range of support level packages (low, med, high, very high). The outcome of this was that some locations had a single ASP which could offer a range of support services and others had multiple ASPs offering a mix of support packages. Since 2010, the funding to ASPs has been redistributed so that ASPs are able to provide a range of levels of support where possible. The realignment of ASP funding aims to support consumers who have a range of needs but also aims to provide flexibility so that if a consumer's needs change, they can be transitioned across different funding packages. The evaluation examined whether this movement between HASI packages occurs.

ASPs provide flexible support that is dependent on consumer needs and, as a result of their recovery, some consumers required less support over time even though they continued to be supported in the same HASI package. When consumers required less support, ASPs often reduced the number of hours spent with the consumer. As a result, ASPs sometimes have extra hours to use in other ways to fulfil their funding obligations. Within the three evaluation sites, two strategies were used to address this.

The first practice was splitting higher HASI packages so that more than one consumer received support for fewer hours within the one package. The benefit of this practice is that the original HASI consumer can receive more or less support according to their changing needs. It also has potential drawbacks: if the ASP supports too many consumers and the original consumer is underserved, or consumers with more urgent needs receive extra support at the expense of consumers who have higher levels of functioning but still need support to achieve new goals. The retendering of the HASI packages in 2010 to provide higher and lower accommodation support across the program was designed to partially address these risks.

A second practice employed to use extra support hours was to set up HASI packages that were short term and targeted at people discharged from hospital. The HASI partners welcomed this practice as filling a community

mental health service gap. The risk was that when the community mental health services withdrew or reduced their role in this situation, it changed the responsibilities of the HASI providers.

Given that the provision of flexible services is crucial to promote recovery, a key challenge facing HASI is how to promote a funding model that builds accountability for ASPs and allows for flexible service delivery to effectively support consumers' recovery.

#### *Waiting lists and pressure to transition consumers*

By 2010 all evaluation sites had long HASI waiting lists and high unmet need in the community. This had two impacts on ASPs. First, ASPs felt pressure from other HASI partners to accept new consumers even though they did not have vacant packages (Section 7.1). Second, ASPs and some consumers felt pressure from HASI partners to transition through the program from higher to lower support or to other support services in the community or to live independently (Sections 7.2 and 8).

The ASPs were concerned about organisational pressure to achieve a flow through of consumers as an implicit measure of ASP success. They feared the risk that consumers who need ongoing, perhaps life-long support, would be judged as too dependent and should move to a disability model of support; and that consumers in low support should eventually be independent enough to leave the program. Low support consumers also raised this tension. A consumer said:

One of them [ASP staff] say I got to step away in 6-12 months cause I'm well enough to fend for myself, whereas there could be someone out there doing it rock hard. So I'll step away at some stage and not be selfish - I did without [the ASP] the first 5 years.

This interpretation is not consistent with the HASI Manual which states that high support is ongoing, and lower support HASI may be of short, medium or long term duration. The Manual does not recommend any usual timeframes for support or suggest that exiting the program should be a goal. While ASPs in some evaluation sites recognised that some consumers would need ongoing support, there has been a misinterpretation by some partners of how HASI is intended to operate (Section 7.2). The continuing demand for HASI services in the community has also encouraged this misunderstanding. The situation is potentially compromising the aims of HASI to provide ongoing support to consumers where needed. This difference between policy and practice could be addressed through regular information, discussion and training.

The future of the HASI program depends not only on the provision of ongoing and flexible support services, but also given the continuing demand for HASI services, implies a need to increase the size of the program. Additionally, it emphasises the need to continue to integrate HASI with other support services in the community to support mental health consumers to access

alternatives to HASI and to support HASI consumers who are ready to leave the program.

### **Pathways into secure housing**

HASI operates in a very tight housing market and housing affordability is stretched, with a scarcity of social housing and demand for housing assistance that far exceeds supply (Section 6.2).

The housing arrangements attached to each stage of HASI were negotiated between NSW Health and Housing NSW stage by stage as they were rolled out and differed between the stages (Section 3.3). Most (71.9 per cent) consumers referred for high support and many referred for low support (26.2 per cent) required housing and applied for social housing assistance<sup>69</sup> (Section 7.1).

The expectation was that most consumers referred for higher support HASI would require housing and that most consumers who were referred for lower support HASI would already be housed but that their housing could be at risk because of mental health issues. As described in Section 5.3, most (72 per cent) consumers entering HASI at the higher support level required housing as expected, but although additional housing was not expected to be required for lower support consumers, some of this group (26 per cent) also required housing.

One stage of HASI providing high support received funding for community head leasing for a limited period of time (3 years), which has now expired. The cost of housing ongoing is now absorbed by the housing provider and there are no additional funds to head lease properties for new HASI consumers. A HASI consumer can exit HASI, but stay in their social housing property. This means that the HASI package can then be allocated to someone else, but Housing NSW has no specific funding to secure a replacement house. While most HASI clients are assessed as eligible for priority assistance, it can still take time to be housed as they must wait until a suitable property becomes available from existing stock (Section 7.1).

When a HASI consumer exits a social housing property that was specifically acquired for HASI, most housing providers will notify the ASP in the first instance to see if another HASI consumer is waiting to be housed. The housing provider can keep the property vacant for about 6 weeks, but if no suitable HASI client is found to take over the tenancy during this time, it reverts to general housing stock. This is not, however, the usual means of accessing social housing for HASI consumers.

These nuances in the program about access to social housing for HASI consumers can cause confusion and tension between the HASI partners

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<sup>69</sup> Including consumers who leaving hospital or are experiencing homelessness or insecure housing.

trying to implement the program. It will be important to clarify and regularly communicate these details to all partners.

Availability of social housing stock is likely to remain an ongoing issue for HASI due to the housing needs of consumers. While the Nation Building – Economic Stimulus Plan provided additional properties in the social housing portfolio, which may have benefited HASI consumers applying for social housing at the time these properties were tenanted, there is no indication that an initiative such as this will be repeated in the future. Therefore it is likely that delays for some HASI consumers in accessing secure housing will continue.

## **9.5 Discussion about the findings**

Local partnerships were working well across the evaluation sites. The LHDs and ASPs have built particularly sound working relationships and the relationships between the ASPs and housing providers were generally appropriate. Four factors were identified that have facilitated effective working relationships: clarifying roles and responsibilities, maintaining open communication, having a commitment to work together in the program, and having sound local governance processes.

Local governance processes were generally effective when the people involved were committed, had strong formal and informal communication channels and when regular meetings were held. One of the tensions was between the LHD partnership and contract management roles. More information to local staff about retendering could improve future coordination of the processes.

State partnerships between Health and Housing NSW have strengthened and their joint policy priorities have progressed as a result of working closely together in the HASI partnership. Factors that supported the effectiveness of state level partnerships included:

- Shared policy priorities of each agency continue to be recognised and managed
- Regular meetings and
- Involvement/commitment of senior staff.

At a state level, the governance structure appears to be working well, but two funding questions affect the implementation of the HASI model: practices to manage consumers' fluctuating support and delays entering HASI because of waiting lists for support and housing. First, unmet need for accommodation support has led to some ASPs feeling pressured to transition HASI consumers through the program so that they can accept new applicants. Second, the future of the HASI program depends on consumer access to secure<sup>70</sup> housing, either through social housing, private rental or expanding HASI in the Home packages for people already in housing (privately owned

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<sup>70</sup> See glossary

housing, private rental or social housing). HASI partners including Housing NSW acknowledged the lack of suitable housing stock across the state, particularly in some locations. The social housing shortage impacts on the provision of effective pathways into secure housing for those consumers who require housing. This impact needs to be further considered in the design of the HASI program, particularly in the context of wider NSW Government policies of 'no exits into homelessness' from mental health and other facilities (NSW Government, 2009).

The effectiveness of HASI depends on the availability of sufficient resources for each of the three service types: housing and tenancy management, clinical services and accommodation support. Long waiting lists, unmet community demand, a shortage of alternatives are placing pressure from other HASI partners on ASPs to compromise the HASI service model.

## 9.6 Summary of partnerships and governance

- HASI services are provided within a partnership model at the local level that involves NSW Health, Housing NSW, ASPs and community housing providers.
- The relationships between local partners are generally effective. This is particularly the case between LHD and ASP providers, ASP and housing providers and ASP staff from different organisations. The local partnerships between housing providers and LHD are less intensive, and require less frequent communication than their respective relationships with ASPs.
- With the expansion of the program, multiple ASPs now provide services across NSW and many in overlapping geographical areas. During the retendering process, the competitive funding model may compromise the collaboration between ASPs, however, ASP staff are working together well in the interests of consumers in most locations.
- As HASI is now an established program, relationships between partners appear to work relatively well due to four factors: clear roles and responsibilities; open communication; a commitment to working together; and sound governance processes.
- The clear delineation of clinical and non-clinical roles and responsibilities is crucial to developing positive working relationships with HASI partners. Where roles and responsibilities were not clear, tensions emerged and the partnerships were compromised.
- While open communication is important, not all partners require detailed information. For example, housing providers require information about the HASI program, risks and consumer needs, but they do not require other details that compromise consumer confidentiality.
- It is crucial that HASI partners promptly share information that could be relevant to staff and consumer risk management. This is the usual practice

in most locations, but in some instances information sharing is delayed, especially if HASI partners are not part of the regular meetings.

- Effective partnerships require a substantial investment of time and energy, consequently, organisational and staff commitment are essential to working together. This commitment requires recognising and respecting the recovery oriented approach of the program and the differences in organisational values and priorities.
- 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 processes, including selection of new consumers, planning and risk management, transitioning of consumers between support packages, and any other consumer related issues; and service level agreements.
- Local governance processes are potentially hampered in some locations by the tension between the HASI partnership and contract management roles of LHD in relation to the ASPs. This sometimes creates confusion among the partners about ASP accountability to whom and for what.
- The state governance structure of HASI is working well and has addressed policy priorities of NSW Health and Housing NSW, which need to continue to be recognised. Factors that support the state level partnership include regular meetings between NSW Health and Housing NSW, and wider stakeholder meetings.
- The effectiveness of HASI will continue to depend on program resources and management, including effective pathways into secure housing; access to community mental health services; and flexibility and accountability for ASP funding.



## 10 Costs of HASI

The final part of the evaluation is a cost analysis of HASI. This section includes analysis of the budgeted costs of HASI services between 1 July 2006 and 30 June 2010.<sup>71</sup> The per consumer costs are calculated on the basis of the 1076 HASI packages allocated at the time of the analysis (June 2010).

### 10.1 State level costs

The budget data are an estimated total of central office HASI management costs per year and includes salaries and other costs (Table 10.1). Data collected from Housing NSW and NSW Health show that the state level management cost for 2006-10 was just over \$1 million (\$1,154,765), which is an average of \$208,691 recurrent costs per year (or \$288,691 including establishment costs – evaluation and tendering).

The annual state level cost per consumer is \$200 to \$520 depending on which consumers and costs are included.<sup>72</sup> Most recurrent costs are for project staff whose tasks specifically relate to HASI, such as contract management, tendering, program coordination, policy development.

**Table 10.1: HASI central office budget (\$), 2006-10**

	2006-07	2007-08	2008-09	2009-10	Total	Annual average
<b>Recurrent</b>						
Housing HASI project staff <sup>1</sup>	109,815	58,762	34,996	10,127	213,700	53,425
Health HASI project staff <sup>2</sup>	81,591	84,855	109,113	143,856	419,414	104,854
Training	0	0	0	155,651	155,651	38,913
Meetings, forums (venue, catering, travel)	11,500	11,500	11,500	11,500	46,000	11,500
	202,906	155,117	155,609	321,134	834,765	208,692
<b>Establishment</b>						
Evaluation	0	0	60,000	240,000	300,000	75,000
Tender briefing	5,000	5,000	5,000	5,000	20,000	5,000
<b>Total recurrent and establishment</b>	<b>207,906</b>	<b>160,117</b>	<b>220,609</b>	<b>566,134</b>	<b>1,154,765</b>	<b>288,692</b>

Source: NSW Housing and NSW Health

Notes: 1. Housing Homeless Unit two Senior Officers Grades 2 and 3 60 per cent 2006-7; 30 per cent 2007-8; 15 per cent 2008-09; 0 2009-10. Community Housing Division one Senior Officers Grade 1 and one Clerk Grade 11/12 3 per cent 2006-09; 1 per cent 2009-10.

2. Health Manager and Senior Project Officer excluded because they are not additional roles specific to HASI. One Project Officer Grade 7/8, .5FTE 5A Grade 9/10 to Sep 2011

<sup>71</sup> Expenditure data would have been preferable to use in this analysis but the data were not readily available from NSW Health or Housing NSW.

<sup>72</sup> Total current consumers (1076) by annual recurrent costs (\$208,691) = \$194. Total consumers 2006-2010 (2222) by total recurrent and establishment costs (\$1,154,765) = \$520.

The state level cost per consumer does not include the cost of clinical mental health services or the costs to social housing providers of housing HASI consumers in some stages of the program. Nor does it include social housing capital investment from 2002-07 of \$26 million (Table 10.2). These costs were excluded because clinical mental health services and social housing assistance are available to all mental health consumers, regardless of whether they were receiving HASI support. As the costs of providing these services were likely to be incurred anyway, they have not been included as a direct cost of the program.

Similarly, regional office cost data from NSW Health and Housing NSW and clinical mental health services were not included because these costs of services provided at this level would have been incurred regardless of the operation of HASI.

**Table 10.2: NSW Housing HASI capital acquisitions, 2002-07**

	Cost (\$)
2002/03	4,779,409
2004/05	3,150,511
2005/06	10,781,041
2006/07	7,065,818
Total	25,776,779

Source: NSW Housing  
Note: Purchase of 88 properties

## 10.2 Accommodation support provider and housing provider costs

The cost of funding ASP support was analysed from the contracted budget data. The budget per package varies according to the level of support and is adjusted each year due to Goods and Services Escalations (Table 10.3). The total contracted accommodation support cost 2006-10 for 1076 packages was \$118,278,000, an average of approximately \$31 million per year and nearly \$30,000 per consumer per year.

**Table 10.3: Accommodation Support Provider budget (\$), 2006-10**

HASI stage	2006-07		2007-08		2008-09		2009-10		Total	Total
	Consumers	Per consumer	consumer	Total	consumer	Total	consumer	Total		
		('000)	('000)	('000)	('000)	('000)	('000)	('000)	('000)	('000)
1	100	54	5,379	55	5,524	57	5,663	58	5,781	22,347
2	460	10	4,729	11	4,857	11	5,060	11	5,060	19,706
3a	126	51	6,476	53	6,651	54	6,818	55	6,961	26,906
3b	50	70	3,500	72	3,595	74	3,684	75	3,762	14,541
4a	100	50	5,000	51	5,135	53	5,263	54	5,374	20,772
4b <sup>1</sup>	160	-	-	11	1,760	11	1,804	12	1,842	5,406
4b <sup>2</sup>	80	-	-	35	2,800	34	2,870	37	2,930	8,600
Total	1076	-	25,084	-	30,322	-	31,162	-	31,710	118,278
Average		30	-	28	-	29	-	30	-	-

Source: NSW Health

Notes: 1. Stage 4b included both low and medium support packages. This row refers to the low support packages allocated

2. This row indicates the medium packages allocated in Stage 4b

### **10.3 Summary of the costs of HASI**

- The total budget for the program over the last four years was \$118 million accommodation support costs and \$1 million project management costs.
- The program benefited from the previous housing capital investment 2002-07 of \$26 million. Currently, HASI consumers who require social housing are allocated housing from existing housing stock like all other tenants.
- The annual cost per consumer is \$11,000 to \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit cost.

## 11 Conclusion

This section presents the implications from the evaluation and suggested areas for improvement. The key findings of the evaluation are summarised below in relation to the three aims of the evaluation.

### 11.1 Consumer outcomes

The evaluation of HASI found that most people receiving support through this program are successfully maintaining their tenancies and using relevant mental and physical health services; have improved mental health outcomes, decreased hospitalisations, improved social contact with family and friends and increased participation in community activities, including engagement in work, education and training for some consumers. Most consumers believed that HASI has contributed to their better overall quality of life compared to before they entered the program. Consumers have high levels of satisfaction with housing and tenancy services. Their rental payments, maintenance and repair payments and number of complaints made against them are recorded at similar rates to other tenants in social housing.

Most consumers had used health, mental health, and allied health services as required. Women used GP and allied health services more frequently than men. Consumers receiving higher HASI support used community mental health and psychiatric services more frequently than those on low support, and used GP and allied health services less frequently.

Consumers from every group benefit from the program, including men and women, consumers on higher and lower support packages, all age groups and consumers with and without prior contact with families and friends. The findings show that the assessment of applicants should not exclude consumers on the basis of complex needs or characteristics because, with appropriate housing and support services and encouragement to engage with the program, all groups have been shown to benefit.

#### **Mental and physical health**

##### *Improvements in mental health outcomes*

Consumers, families and workers reported mental health improvements for most consumers in all support level packages. Results show significant clinical and statistical improvements in psychological distress and behaviour since joining HASI (MH-OAT measures – K10, LSP-16 and HoNOS). The size in change in mean scores and the ratios of consumers that improved, worsened and did not change were explored. The purpose was first to understand which groups had the most extreme (largest positive) changes, and then explore the groups of individuals most likely to experience change (improve or worsen). In absolute mean scores, women had more psychological distress (as measured through K10) and better life skills (measured through LSP-16) than men. During HASI, results for men and women were similar in various areas of life (measured through HoNOS).

When the frequency of improvement, rather than the absolute change was explored, women, consumers in lower support, and youngest consumers (age 18-29) more frequently experienced improved K10, LSP-16 and HoNOS scores. However, men and higher support consumers also improved in absolute scores, for example the mean improvement in K10 score before to during HASI was greatest for men. During HASI consumers in higher support recorded HoNOS scores at the same level as those of consumers in lower support, indicating that consumers in the two groups became similar in HASI.

#### *A reduction in hospital admissions and length of stay*

Consumers had significantly fewer mental health hospital admissions after joining HASI. For example, there was a 59 per cent decrease in the average number of days spent in hospital per year, a 68 per cent decrease in the average number of days hospitalised per admission, and a 24 per cent drop in the number of admissions to hospital.

Women were admitted to hospital more often than men and spent more days in hospital per admission after joining the program. The inpatient rate and length of stay improved for both men and women once they entered HASI and improved further during their second year in the program. These reductions were similar for other non-mental health inpatient services and emergency presentations.

#### *Physical health*

Many HASI consumers have poor physical health. Consumers and ASP staff rated physical health worse than mental health and whereas mental health improved over the time of the evaluation, physical health did not. ASPs supported consumers to improve their physical health by developing healthy living practices and using health services. Effects of medication had a negative impact on some consumers' physical health.

### **Participation**

#### *Daily living skills*

Most consumers across all HASI support levels improved their daily living skills. Many consumers (60 per cent) were independent or supported less than half the time in all areas of daily living including personal care, cooking, taking medication, transport, cleaning and exercise. Approximately one in three consumers required support more than half of the time with shopping, managing their finances, cleaning and exercising. Consumers receiving lower levels of support were more independent than consumers receiving higher support in the areas of shopping, cleaning, paying bills, budgeting, exercise, and taking medication ( $p < 0.05$ ). Both groups, however, had higher levels of independence in daily living skills compared to the evaluation of Stage 1 high support consumers.

#### *Most people had social contact with important people in their lives*

Most HASI consumers (86 per cent) had regular social contact with a family member, friend, spouse or partner and many were in the process of re-establishing contact with family members. Social isolation remains a problem

for some HASI consumers with one in seven consumers (14 per cent) not having regular contact with anyone. Men and high support HASI consumers were less likely to have regular social contact.

### *Community participation*

Most people participated in activities in the community. For example, most HASI consumers (83 per cent) participated in at least one kind of community activity (including supported and unsupported group activities, supported individual activities and day programs); which is similar to the Stage 1 evaluation.

### *Some consumers were participating in employment, education and training*

One third (31 per cent) of current HASI consumers participated in employment, education or training.

## **Stable housing**

HASI assisted people to access and maintain stable housing. When consumers entered HASI only 57 per cent already had stable housing, and many of these had previously experienced insecure housing. Consumers expressed relief about having permanent housing and most consumers and their family members were satisfied with the type of housing and tenancy management services that they received. Some consumers commented about the length of time that it sometimes took for repairs and maintenance.

While some Stages of HASI had funds specifically allocated to provide housing, the cost of providing housing for new consumers and ongoing housing for those consumers whose housing is funded through leasing subsidies is absorbed by the housing provider (Section 7.1). New HASI consumers are therefore housed in existing stock, when a suitable property becomes available.

Where consumers do not already have stable housing, they generally need to apply for social housing assistance, and commonly may have to wait several months, depending on the location and type of housing they required.

Most HASI consumers successfully maintained their tenancies and were reliable tenants, paid their rent on time and had few complaints, CCCT actions or debts for property damage.

## **11.2 Program effectiveness**

### **Service access**

HASI is engaging the intended mental health consumers through the development of strong referral pathways and selection processes. Most consumers are referred to the level of support they need rather than only to the support package available. Some concerns were raised about local arrangements to temporarily split some high support packages to be filled by two people on lower support.

With the exception of people from culturally and linguistically diverse backgrounds, HASI consumers are representative of mental health service users. Women and Aboriginal and Torres Strait Islander consumers are better represented among current HASI consumers than in the general mental health community and than they were in the HASI Stage 1 evaluation. All consumers have at least one mental health diagnosis, with many having a secondary mental health diagnosis and co-existing conditions.

All three evaluation sites had a waiting list of applicants to the HASI program. Some ASPs feel pressured by HASI partners to transition consumers through the program to be ready to accept new applicants. If HASI applicants do not already have housing they need to apply for social housing through priority housing assistance. Some ASPs do not provide support until housing is available. The waiting list for social housing in many locations means that some people who require HASI assistance wait for many months before entering HASI. These shortages within the elements of HASI undermine the coherence of HASI as a service model, which aims to link housing, clinical services and accommodation support and prevent or address homelessness for people with mental illness.

Factors that could support the referral process include more HASI packages and stronger pathways into a range of secure housing options, including both social housing and the private rental market. Other ways the referral and selection process could be improved include co-ordinating referrals within the LHD with a single assessment form in the location, especially in locations with more than one ASP; promoting information about the eligibility criteria and available support among referring agencies; regular selection meetings; the use of other interagency meetings to discuss referrals to HASI and referrals to alternative support services such as PHaMs.

### **Service model**

The HASI recovery orientated service model is interpreted differently across and within the HASI partners (housing providers, clinical services and ASPs). The main tension was around how, long-term, ongoing support is consistent with the goals of the HASI program or whether the aims had changed to focus on the provision of time limited support. Another tension was about providing recovery focused, consumer focussed support and about how best to support consumers to engage in their recovery. Further, the different priorities of the higher and lower support HASI packages means that HASI appears inconsistent to some referrers, consumers and families, as well as disadvantaging some HASI consumers who need to find housing, as discussed below.

The evaluation identified factors that support the delivery of effective services across the three service types. For tenancy management services the main problem raised by interviewees regarding delivery of quality services was timely handling of maintenance and repairs.

For clinical services the delivery of quality services included the provision of appropriate clinical services with involvement of clinical staff in the

development of ISPs and a manageable workload for clinical work. Community mental health teams are providing essential clinical services to HASI consumers receiving lower and higher support packages, although further consultation is needed at the local level regarding consumer support after clinical or ASP support are withdrawn.

For ASP support the delivery of quality service is dependent upon implementing the principles of rehabilitation, consumer focussed support and flexibility within the recovery framework. HASI partners and consumers provided overwhelmingly positive feedback about the support provided by ASP staff. However, concerns about the qualitative differences between ASPs, the skills and knowledge of some staff and organisational capacity, suggest a continuing need to support the capacity of the ASP sector through regular training and information sharing.

When consumers are ready to exit the HASI program they usually stop receiving ASP support but are often still engaged with clinical services and tenancy management services and continue to have at least transitional support and irregular contact with the ASP.

The circumstances under which some people exited HASI were complex to manage. The situation of some consumers who had unplanned exits from HASI raise questions about alternative approaches to supporting mental health consumers to maintain their tenancy and live in the community.

Factors supporting the effective transition of people out of the HASI program included: planned exits involving the HASI partners, consumers, family and other organisations; managed transition to coordinate the HASI services with other community services; and flexibility of support by ASPs during the transition.

### **Partnerships and governance**

The HASI model is founded on partnerships between and within housing, mental health and accommodation support services. The partnerships between and within these groups were working well across the three evaluation sites. The LHD and ASPs have built particularly sound working relationships and the communication processes between the ASPs and housing providers are generally effective. Four factors facilitate effective working relationships: having clear roles and responsibilities, maintaining open communication, having a commitment to work together and to the program, and having sound local governance processes.

Local governance processes were generally effective when the staff involved are committed, have strong formal and informal communication channels and when regular meetings are held. One of the perceived barriers to strong local governance was the tension between the partnership versus the contract manager role of the LHD. Limited information from local organisations to their staff regarding the retendering of HASI packages in 2010 was also raised as an issue in some evaluation sites.



At a state level, the governance structure appears to be working well. Two questions remain in development: policies about appropriate ways to effectively manage spare support hours from the fluctuating support needs of higher support consumers; and entry to HASI from delays caused by the shortage of social or other housing.

The effectiveness of the HASI program depends on the availability of resources for each of the three service types: housing and tenancy management, community mental health clinical services and accommodation support. The pressure from long waiting lists and unmet demand in the community compromises the HASI partnership model.

### **Costs of HASI**

The total budget for the program over the last four years was \$118 million accommodation support costs and \$1 million project management costs. The program benefited from the previous housing capital investment 2002-07 of \$26 million.

The annual cost per consumer is \$11,000 to \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit cost.

The cost per consumer does not include the cost of clinical mental health services or of existing social housing stock that was used to house HASI consumers in some stages of the program. Nor does it include social housing capital investment from 2002-07 of \$26 million. These costs were excluded because clinical mental health services and social housing assistance are available to all mental health consumers, regardless of whether they were receiving HASI support. As the costs of providing these services were likely to be incurred anyway, they have not been included as a direct cost of the program.

### **11.3 Improvements to the HASI program**

Even though the HASI program is largely meeting its aims and objectives for consumers who are clearly benefiting from access to support services and housing, several areas could be considered to further strengthen the program.

The success of the program into the future will not only depend on recurrent funding for ASPs to deliver accommodation support services but also on effective program resourcing and management – flexibility and accountability of funding for ASPs and the facilitation of effective pathways into secure housing through the program. The evaluation identified four questions requiring review for the effectiveness of HASI.

#### **1. Clarification of the aims of the HASI model and recovery framework**

Some HASI partners perceive that the aims of HASI have changed since the program has expanded and since it has had a greater focus on recovery. The HASI program provides ongoing and flexible support services. For some HASI consumers this may mean ongoing and indefinite support services; whereas

for other people this may mean short to medium term support. Both of these options are complementary to a recovery based approach. Not all HASI partners recognise this and some of them think HASI had shifted to a time-limited support model, which limits referral to mental health consumers who could be expected to eventually leave HASI.

The ongoing demand for HASI services, and limited resources available in the three evaluation sites, were viewed by some local partners as providing a rationale for understanding HASI as a time-limited model, and for a re-conceptualisation of recovery based services as reducing support over time and moving consumers, particularly those receiving lower support packages, out of the program.

The Departments of Health and Family and Community Services (Housing NSW) have advised that some sections of the HASI Manual are outdated, and have provided specific advice to the evaluators about developments in the Program. The published Program guidelines need to be updated to clarify program priorities and procedures for all stakeholders.

## **2. Improvements to support processes for transitions**

While there was evidence to suggest that people were appropriately transitioned between higher and lower support packages, the processes for supporting people exiting the program needs further development.

If consumers are exiting the program, appropriate processes to support this transition, integration with other support services in the community, and clear pathways back into the HASI program or alternative support should consumers require crisis or short term assistance should be agreed. A greater focus needs to be paid to processes for supporting people who decide to exit or who may exit and decide to return, otherwise the benefits people have gained by participating in HASI may not be sustained in the longer term.

Distinctions between rehabilitation and dependency needs to be addressed in training and information to workers. Some consumers want ongoing support when they have improved their independence and functioning. Clarification, information and training about the ASP role in providing this support, organising alternative support from other sources or building the confidence of consumers to act independently would address their uncertainty.

Alternative processes to engage or support HASI consumers who refuse ASP support need to be developed to ensure that other HASI partners (LHD and housing providers) and alternative service providers are aware of these developments and can respond supportively.

Further clarification is also needed in situations where higher support HASI consumers are discharged from LHD but still require ASP support. For example, in some sites ASPs were refusing to support consumers without a clinical case manager.

### **3. Appropriate accommodation support services**

When the HASI program was first implemented in 2002/03, ASPs were contracted to provide high level support services to consumers. Since then, the program has expanded to provide a range of support level packages (low, medium, high and very high). Since 2010, the funding of ASPs has been redistributed, with ASPs funded to provide more than a single support level, where possible. The realignment of ASP funding aims to support consumers who have a range of needs and also aims to provide flexibility so that if a consumer's needs increase or decrease they can be transitioned between HASI packages.

HASI aims to support consumers for as long or as little as they require and ASPs are delivering services which meet the needs of individual consumers. In some locations the high demand for HASI support at the local level was putting pressure on some consumers and ASPs to transition people out of the program.

HASI aims to provide recovery based services which can include ongoing or time-limited services depending on the needs of individual consumers. The demand for HASI services and limited resources risk creating an expectation that consumers, particularly those in low support packages, should become independent and no longer need the support of ASPs. Some ASPs are committed to ongoing support for consumers who need it. However, the continuing demand for HASI services in the community has the potential to compromise this aspect of the HASI model.

An implication is that HASI will need to increase the support services available if it is to address the community demand. Additionally, it will need to develop better integration with other support services in the community to support consumers who decide to exit the program.

### **4. Pathways into secure housing**

In the implementation of Stage 1, housing for HASI packages was provided by public and community housing providers. Since additional HASI stages were established, the housing arrangements were negotiated between NSW Health and Housing stage by stage, and housing has been provided in a range of ways. While this has catered for consumers in a diversity of situations, it has also created confusion about housing arrangements in the HASI program. Housing NSW staff noted that these nuances in the program regarding access to social housing for HASI consumers had in practice caused some tensions between local HASI partners and difficulties implementing the program.

The future of the HASI program depends on consumers having access to secure housing. Sources include social housing and expanding HASI in the Home packages for people living in privately owned housing, private rental properties or with family.

HASI partners anticipated that the boost to social housing under the Nation Building – Economic Stimulus Plan announced by the Commonwealth in 2009 would benefit new HASI applicants who were waiting for housing at the time

these properties were tenanted. However, this will not offer ongoing resolution to the problems experienced by HASI partners at the local level. Other pathways into secure housing options need to be investigated. In order to meet the housing needs of people referred to the program other pathways into secure housing options need to be investigated and housing could be costed into any future stages.

## Appendix 1. Methods

A full description of the methodology is in the Evaluation Plan (McDermott et al 2009).

### Evaluation sites

The fieldwork was conducted in three evaluation sites. The sites selected for the evaluation were: Tamworth, Gosford and a site known in this evaluation as South Eastern Sydney but which encompasses locations such as Rockdale, Kogarah, Hurstville, St George, Sutherland, Botany Bay and Randwick. These fieldwork sites were selected in consultation with key staff at NSW Health and Housing NSW on the basis that: all stages of the HASI program were covered in at least one site; accommodation services provided by singular and multiple NGO providers were included; accommodation provided by both public and community housing providers was included and; a combination of metropolitan, regional and rural contexts were covered. The evaluation plan details of the number and stage of the packages in each site.

### Interviews with consumers and other stakeholders

Interviews with consumers and other key stakeholders were conducted in three locations in October 2009 and 2010 to understand the strengths and weaknesses of the program, the perspectives of consumers on the support model, and the impact it has had on consumers.

**Table A.1: Number of interviews by stakeholder group by year**

Stakeholder group	2009	2010	Total
Mental health professionals	11	10	21
Housing (public and community)	10	9	19
Accommodation support providers	29	15	44
Other stakeholders	2	0	2
Family or carers	1	6	7
Consumers	59	48	107
Total	112	88	200

In addition to stakeholders involved at the local service level, interviews were also conducted with state level stakeholders. This included representatives from NSW Health and Housing NSW and senior managers in NGOs and advocacy groups.

#### *Characteristics of consumer interview sample*

An important element of the evaluation is interviews with HASI consumers, which inform understanding about consumers' experiences and perceptions of HASI and any changes experienced in their lives while they are involved in the program.

In 2009-10, sixty six consumers were interviewed across the three evaluation sites. Slightly more consumers were available for repeat interviews in the non-metropolitan sites.

**Table A.2: Consumer interviews by evaluation site 2009 and 2010**

Site	Number of first interviews*	Number of repeat interviews	Total interviews	Per cent
Metropolitan	27	11	38	36
Regional	22	18	40	37
Rural	17	12	29	27
Total consumer interviews	66	41	107	100

Note: \*includes 9 first interviews in October 2010 to replace consumers unavailable for repeat interviews

Although the sample was similar to HASI consumers, it included more men (59 per cent, n=39) than women (41 per cent, n= 27), who were slightly underrepresented compared to the gender ratio of current HASI consumers (women 47 per cent).

The average age of people in the interview sample was 38 years with 12 per cent (n=8) of people identifying as Aboriginal and/or Torres Strait Islander. Most consumers who were interviewed were born in Australia (94 per cent) and a smaller proportion indicated that they spoke a language other than English at home (n=5 or 7 per cent).

Consumers interviewed for the evaluation were slightly under representative of consumers receiving low support (47 per cent of sample compared to 56 per cent of all consumers), whereas consumers receiving medium and very high support were slightly over represented, with high support consumers fairly representative of the current consumer cohort. This is due to the service makeup of the rural and regional sites but also to comparatively fewer number of support packages in the program as a whole at these sites.

**Table A.3: Consumer interviews by level of support**

Level of HASI support	Interview sample (n=66)		Current consumers (n=895)*	
	Consumers	Per cent	Consumers	Per cent
Low	31	47.0	496	55.9
Medium	8	12.1	56	6.3
High	20	30.3	281	31.6
Very high	7	10.6	55	6.2
All levels of support	66	100.0	888*	100.0

Source: HASI MDS

Note: \*Data missing for 7 people

Consumers who were interviewed had been in HASI for approximately two years, which is similar to current consumers (Table 4.4).

## Program observation

In addition to undertaking interviews with key stakeholders, the research team spent time in each of the three fieldwork sites to explore how the program operates in specific contexts. In consultation with NGOs and their staff, researchers spent time at the NGO offices to understand the environment in which HASI services are managed and delivered. Both the ASP office environments and client selection panel operation were observed. Some interviews with clinicians and housing providers were also conducted onsite which provided an opportunity for the researchers to see where other HASI partners work.

## Secondary data

This report analyses quantitative data collected from a variety of data sources. Analysis is based on a sample of 895 (77 per cent) HASI consumers who were participating in the program in June 2009 and for whom a start date and demographic data were available.<sup>73</sup> Sample sizes varied across the data sources but all samples were subsamples of the 895 identified in the NSW Health HASI Minimum Data Set (MDS). A comparison of basic demographic characteristics can be found in Table 4.2 and more detail on the demographic differences between the samples can be found in Appendix 3, Section B.

**Table A.4: Sub-sample characteristics**

	Number of consumers	Average age (years)	Average time in HASI (months)	Gender (per cent)		Support level (per cent)	
				Men	Women	Lower	Higher
HASI MDS	895	41	23	53.2	46.7	61.7	38.3
MDS supplement 2009	639	43	24	53.6	46.4	62.4	37.6
MDS supplement 2009-10	403	41	21	54.8	45.3	62.8	37.2
Housing NSW (public housing)	163	45	29	51.8	48.1	79	21
Mental health inpatient admissions	197	38	30	58.9	41.1	44.7	55.3
All inpatient admissions	222	39	29	57.2	42.8	45.5	54.5
Emergency department presentations	353	39	19	54.4	45.6	57.2	42.8
Ambulatory (community) services	496	41	23	54.4	45.6	59.1	40.9
K10	242	42	24	56.2	43.8	48.3	51.7
HoNOS	204	42	24	53.4	46.6	49.8	50.2
LSP	291	41	22	52.9	47.1	52.6	47.4
Evaluation interviews 2009-10	66	37	-	59	41	-	-

Note: 1. Total HASI packages = 1076 at June 2010

\* MHOAT measures – see glossary and Appendix 1

<sup>73</sup> The remaining 272 consumers could not be linked with their demographic data or start date and were therefore excluded from the analysis.

The gender distribution and average length of time spent in the program is similar across all samples, but the average age of consumers and the representativeness of consumers receiving lower and higher levels of HASI support differ in each dataset.

People receiving high support are overrepresented in the data on mental health admissions, inpatient admissions, K10, LSP and HoNOS, with the possible effect that the results are conservative in understating the mental health benefits to other HASI consumers. Consumers receiving low support are overrepresented in the Housing NSW sample, with the possible effect of overstating the housing benefit of HASI to higher support consumers. Support level, therefore, is likely to have the biggest impact on the results presented in this report.

This section describes the data sources that were used in this report. More detail about the evaluation framework and the methods used to address the evaluation questions is in the evaluation plan (McDermott et al., 2009).

### **HASI Minimum Data Set (MDS)**

Data from the HASI MDS are collected by ASPs who complete an application form, which includes questions about gender, age, mental health status and tenancy history, when a referral is received (Appendix 2). Once a person is accepted into the program, ASP staff complete a report detailing the services consumers received such as housing and health at the commencement of service delivery and each quarter thereafter (Appendix 2).<sup>74,75</sup> HASI program data were first collected in July 2006, but there are large gaps in the data for the first two monitoring periods (July-September and October-December 2006) so reliable data are only available from 1 January 2007.

Because ASPs collect some data about housing outcomes, the MDS was analysed in this report to develop an understanding of these outcomes for HASI consumers. In particular, the MDS includes information about how many consumers moved house and why, the number of Consumer, Trader and Tenancy Tribunal (CTTT) actions, as well as the proportion of consumers with complaints made about them to housing providers. The analysis draws on the snapshot of current consumers (n=895) in the April to June 2009 reporting period for whom demographic and service use data were available and for whom these data could be linked.<sup>76</sup>

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<sup>74</sup> This information is completed by ASPs 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.

<sup>75</sup> The MDS forms included in the Appendices were used to collect the data for this report. The forms were extensively revised in 2010.

<sup>76</sup> Due to the way that data are collected, it was not always possible for ARTD or InforMH to link the demographic data collected upon entry to the service use data that are reported quarterly. In the April to June 2009 quarter, service use data were submitted for 1,167 consumers, but could only be linked with the demographic data of 895 consumers (77 per cent).



MDS is intended to collect data for monitoring services provided by ASPs. Its primary purpose is not to monitor housing use, but it does include some data on housing outcomes that can be used to supplement data collected from Housing NSW. Given this context, one of the expected limitations of the MDS is that the housing data are not complete. A substantial amount of missing data for some of the variables, especially in relation to housing indicators, means that it should only be interpreted as supplementary data as it was intended. For example, while the total sample is 895, information about CTTT actions was available for 289 people. This limits the robustness of the analysis to only adding to the interpretation of the other Housing NSW outcomes data and restricts the extent to which analysis of change over time can be conducted.

Other expected limitations about the level of detail available on consumers' housing profile from MDS include that there is no record of whether consumers are living in public housing, community housing, private rental housing or their own homes, which limits the analysis of housing outcomes in relation to different types of housing. A final expected limitation is that information recorded about consumers' housing status and outcomes may be incomplete because it is recorded by ASP staff rather than housing providers. For example, the MDS asks ASPs to record tenancy risk factors when consumers enter the program. The earlier reports found a low proportion of consumers experienced tenancy risks before entry, but interviews with consumers showed that many had long histories of insecure housing. This suggests that housing data from this source may be incomplete and should only be interpreted with the Housing NSW data and in light of the qualitative data.

### **MDS supplement**

At the start of this evaluation it was identified that information about social indicators, such as participation in community activities, employment, education and training, was not routinely collected for the existing datasets.<sup>77</sup> To address this, the researchers included a one page supplementary questionnaire to be completed by ASPs in the July-September 2009 and July-September 2010 MDS reporting period (Appendix 2). The questionnaire was designed so that ASPs could fill out the items on behalf of consumers in relation to living skills, service use, health and mental health status, education, employment, and family relationships. In 2009, there was a 91 per cent response rate for the MDS supplement (1065 forms were returned), but only 639 (55 per cent) could be linked with the consumers' demographic data and HASI start date.

In 2010 MDS supplement data were collected for 1064, of which 403 could be linked to their demographic data (MDS) and corresponding MDS 2009 data.

The primary limitation of the supplement data is that, for most consumers, it was not collected at a baseline. It therefore provides only a repeat point in

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<sup>77</sup> NSW Health has now introduced the APQ-6 which will address this gap in future.

time measurement and cannot be used to understand changes experienced by consumers except over one year. Despite this limitation, some analysis compares outcomes by length of time consumers were in the program.

### **Housing NSW data**

Information about consumers' housing profile and outcomes was also transferred from Housing NSW for a sub-sample of HASI consumers living in public housing properties. Data from Housing NSW were drawn from the Integrated Housing System (IHS) to understand the extent to which HASI consumers are able to maintain their tenancies. The variables included: the number of times people moved house and their reasons for moving, whether people owed money to Housing NSW for damage caused by the tenant, and the number of people in rental arrears.

HASI consumers were identified in the IHS through a flag that was introduced into the system in January 2009. As a result of its recent implementation, the flag does not identify former HASI consumers who are housed in a Housing NSW property but who had left before this time. The data extraction identified 409 people in IHS with a HASI flag, however, it was only possible to confirm the HASI entry date for 163 people. Although this sample is smaller than originally anticipated, it provides a useful snapshot of HASI consumers who are public housing tenants.

Contextual information about tenants who were previously on the priority housing assistance list as well as all tenants in public housing in NSW is included in the analysis to understand how the profile of HASI public housing tenants compares.

One of the main limitations of Housing NSW data is that the sample does not include people living in community housing. Efforts were made to include community housing data early in the evaluation, however, due to decentralised data collection mechanisms across the sector, it was not possible to collect data about people living in these properties. It is, however, likely that people in Housing NSW properties are similar to those who are living in community housing. Eligibility for public and community housing was similar during the period HASI has operated and, since April 2010, all consumers apply for social housing through a common access system called Housing Pathways, regardless of whether they are applying for public or community housing or both.<sup>78</sup> Property allocation policies in terms of location, number of bedrooms, accessibility and transfers are similar in both sectors, and both groups have the same access to long term tenure.

Information about people living in community housing properties is included in the housing data collected as part of the HASI MDS, however, it is not possible to analyse the profile of community housing tenants as a subsample

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<sup>78</sup> When people apply for social housing, they can choose whether they want to live in public housing or community housing. Under Housing Pathways, they can apply for either or both types of housing.

of the main HASI consumer group because the type of housing is not identified in the MDS. It is also important to note that the data taken from both the IHS and the MDS are limited in what they can reveal about long term tenancy outcomes, which makes it difficult to conclusively comment on the impact of HASI on tenancy from quantitative data.

### **NSW Health data**

De-identified data about hospitalisations, community mental health services and clinical mental health measures were provided by NSW Health and extracted for the evaluation by InforMH, which is responsible for collecting, analysing and reporting information on mental health services in NSW.<sup>79</sup> InforMH identified 810 HASI consumers in the data, but demographic details and HASI entry dates could only be matched for 604 consumers.

#### *Mental health hospital admissions*

Data about hospitalisations were analysed to test whether the time spent by HASI consumers in hospital changed after they joined the program. The evaluation of HASI Stage 1, which focused on people receiving high levels of support, found that the number of hospital admissions and the number of days per admission decreased after people entered HASI (Muir et al., 2007).

Data for the current report were extracted for all inpatient admissions, including mental health and other hospital admissions, and emergency department presentations from July 2001 to June 2009.<sup>80</sup> The collection of continuous data made it possible to analyse changes in hospital service use for a sample of people who had been in HASI for two years to understand changes in hospitalisation over time before and during HASI. Given this criterion, data about all inpatient admissions were available for 222 people and mental health hospital admissions data were available for 197 people.

#### *Mental Health Outcomes and Assessment Tools (MH-OAT)*

To examine whether consumers experienced changes in their mental health since starting HASI, the evaluation examined data about consumers' levels of psychological distress, living skills and behaviour gathered as part the National Outcomes and Casemix Collection (NOCC). This information is collected by LHD staff when consumers are in hospital or receive community mental health services. NOCC data contains four different mental health measures including the:

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<sup>79</sup> HASI consumers were identified in Health datasets through their Medical Record Number (MRN) which was collected from Area Health Services by HASI ASPs during the July-September 2009 quarter of data collection for the HASI MDS. MRNs were supplied to InforMH which then matched records with the relevant encrypted State Unique Personal Identifier (SUPI), which is a unique number that can be used to link consumers of public mental health services in various NSW Health datasets. The final dataset as provided to SPRC was completely deidentified, it was not possible for the researchers to be able to identify actual individuals from the data provided.

<sup>80</sup> Data were compiled by InforMH from the NSW Health Admitted Patient Data Collection in the State Health Information Exchange (HIE).

- Kessler Psychological Distress Scale (K10)
- Health of the Nation Outcome Scale (HoNOS)
- Life Skills Profile (LSP16) and
- Activity and Participation Questionnaire (APQ-6).

The K10 is a ten-item consumer self-report questionnaire designed to measure psychological distress. It includes questions about levels of nervousness, agitation, fatigue and depression and whether consumers have experienced aspects of distress over the last four weeks. Each item in the K10 is scored from one (none of the time) to five (all of the time). This evaluation includes the data for a sample of 242 people who had valid scores both before and during their participation in HASI. A total K10 score is considered valid if at least nine out of the ten items were assessed.

**Table A.5: Kessler 10 scores**

Likely to be well	10-19
Likely to have a mild disorder	20-24
Likely to have a moderate mental disorder	25-29
Likely to have a severe mental disorder	30-50

Source: ABS, K10 cut-off scores used in 2001 Victorian Population Health Survey to estimate the prevalence of levels of psychological distress

Unlike the K10, which measures levels of distress among the general population, the clinician-rated LSP16 is designed to measure the life skills of people with schizophrenia and other major mental health disorders. A shorter version of the original LSP39, the LSP16, is collected by clinicians as part of MH-OAT. This measure is deficit based rather than strengths based: it focuses on self care, anti-social behaviour, withdrawal and compliance (Alan Rosen et al., 2006).<sup>81</sup> A higher score on the LSP16 indicates poorer functioning (A. Rosen et al., 2001). Potential scores on this measure range from 0 to 48 and a total LSP16 score is considered valid if at least 14 of the 16 items were correspondingly ranked from 0 to 3. LSP16 data were available for 291 consumers before and during their involvement with HASI.

The Health of the National Outcome Scale (HoNOS) is a clinician rated mental health measurement tool used to track changes in behaviour problem areas that are commonly associated with mental illness.<sup>82,83</sup> HoNOS (Wing et

<sup>81</sup> The domains in LSP-39 are labelled: self-care, non-turbulence, social contact, communication and responsibility.

<sup>82</sup> HoNOS65+ is used for people over the age of 65 years.

<sup>83</sup> These include: aggressive behaviour, self injury, problem drinking or drug taking, cognitive problems, physical illness or disability, problems with hallucinations or delusions, problems with depressed mood, other mental and behavioural problems, problems with relationships, problems with activities of daily living, problems with living conditions, and problems with occupation and activities.

al., 1998) assesses individuals with mental health problems in terms of their general health and social functioning in twelve aspects of life: overactive, aggressive, disruptive or agitated behaviour; suicidal thoughts or behaviour; problem-drinking or drug-taking; cognitive problems involving memory, orientation, understanding; physical illness or disability; hallucinations or delusions; depressed mood; other mental and behavioural problems; supportive social relationships; activities of daily living; overall disability; accommodation; and occupational and recreational activities. All items were ranked from 0 to 4

The severity of each problem over the past two weeks is rated by clinicians on a five point scale from zero (no problem within the period rated) to four (severe or very severe)<sup>84</sup>, such that a higher the score indicates more problems experienced by consumers. A total HoNOS score is considered valid if at least 10 out of the 12 items assessed had valid item scores. Valid scores before and during consumer involvement with HASI were available for a sample of 341 consumers.

A non-clinical, self-report measure of social and community participation, the Activity and Participation Questionnaire (APQ6), was introduced by NSW Health in June 2009. It asks consumers to indicate whether they have work or are looking for work, enrolled in any courses, and whether they are participating in any social activities. The questionnaire also includes a section asking whether consumers would like to become involved in any activities in the future. While this measure has the potential to provide valuable information on the level of social activities and community engagement, it is not analysed for this report due to the small number of consumers for whom information was available. At the time data were collected, scores were only available for 49 HASI consumers, and only one person had more than one APQ6 score. If the APQ6 becomes a widely used tool, it has the potential to be useful for both clinicians and evaluators to understand social outcomes that may be experienced by mental health consumers. The data have not been analysed for the evaluation.

#### *Mental Health Ambulatory (MH-AMB) data collection*

The Mental Health Ambulatory (MH-AMB) data collection includes information about the type of community mental health services that HASI consumers have used. This includes services such as general community mental health services, allied health and rehabilitation appointments. These data were analysed to understand whether there was a change in the use of community mental health services after consumers entered HASI. 496 consumers were identified in the MH-AMB data collection, representing 376,801 occasions of community mental health service use (unique days, July 2001- June 2009).

The primary limitation of this analysis is the lack of a comparison or control group, which means that the evaluation is unable to confirm that the changes

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<sup>84</sup> 0= no problem within the period rated; 1= sub-threshold problem; 2=mild but definitely present; 3=moderately severe; 4=severe to very severe. Source: CRUfAD.

experienced by HASI consumers would not have otherwise been experienced by other people with mental illness not in HASI. In the early stages of the evaluation it was intended that data would also be collected on a group of people with comparable characteristics from the NSW Health data to compare against HASI consumers but, given that these datasets do not include a variable indicating the type of support people receive, it was not possible to draw an accurate comparison group using de-identified data. Therefore, while the analysis demonstrates changes for this group of consumers over time, caution needs to be taken when attributing these changes to HASI. In future, it would be important to explore alternative methods of including a comparison or control group to address this limitation.

The source of comparison most frequently used in this report is results from the evaluation of HASI Stage 1. It is important to note, however, that the samples in the current and previous evaluation have different characteristics. The evaluation of Stage 1 involved consumers who were provided with social housing and received high levels of support, whereas consumers in the current evaluation range from receiving low to very high levels of support. Furthermore, although most current consumers are eligible for social housing, not all consumers are living in either public or community housing as some of them live in private rental properties, own home or with family. Comparing results against the HASI Stage 1 evaluation is therefore limited.

The second limitation relates to the interpretation of results from the K10, LSP16 and the HoNOS. Results in these sections were calculated by taking the average of scores before and during HASI, but it is important to note that data were not collected from consumers at regular intervals (e.g. every three months), meaning that the averages are based on a different number of scores for each consumer collected at different times. The averages may therefore hide broader changes or fluctuations in consumers' mental health over time. The limitation was addressed by using the 13 week review data only.

**Table A.6: Summary of data sources and samples**

Data source	Description of the sample	Time period collected	Potential number of consumers	Number of consumers identified and linked to their demographic data and start date	Notes
HASI MDS	Consumers who have participated in HASI since March 2007	Quarterly (Mar, June, Sept, Dec)  2007 – 2009	n=2222	n=895	These are consumers of the program at June 2009 who had demographic data available. This sample of 895 people is the basis for all analysis in this report
MDS supplement	Point in time survey of all consumers who were participating in HASI during the Sept 2009 and Sept 2010 reporting periods	Two points in time - Sept 2009, Sept 2010	n=1065	n=639	1065 forms were returned but only 639 could be linked with their demographic data and start date.
Admitted Patient Data Collection NSW State HIE	Data on all hospital admissions, including general, mental health and emergency. Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period	Continuous Data (2000 – 2009)	n=1107	SUPIs could be identified for 810 people  604 could be linked with their demographic data and start date	Of these 604 consumers:  415 people had inpatient data; 222 had complete data and had been in HASI for at least two years  372 had psych data; 197 had complete data and had been in HASI for at least two years  353 people had ED data; 82 had complete data and had been in HASI for at least two years
Mental Health Outcomes and Assessment Tools (MH-OAT) Collection NSW State HIE	Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period	Continuous data (2000 – 2009)	n=1107	SUPIs could be identified for 810 current consumers  604 could be linked with their demographic data and start date	Of these 604 consumers:  K10: 414 with some data; 242 had scores available both before and after their HASI start date  Honos: 518 with some data; 339 had scores available both before and after their HASI start date  LSP: 409 with some data; 268 had scores available both before and after their

					HASI start date  APQ6: 49 with some data; 1 had scores available both before and after their HASI start date. This measure was not used due to the small sample size
Mental Health Ambulatory Data Collection (MH-AMB) NSW State HIE	Sample is drawn from consumers who were participating in HASI during the Sept 2009 reporting period	Continuous Data (2000 – 2009)	n=1107	SUPIs could be identified for 810 people  604 could be linked with their demographic data and start date	Of these 604 consumers:  400 had ambulatory data. These data will be analysed in the final report.
NSW Housing – Integration Housing System dataset	Sample drawn from public housing tenants who have been in HASI from about 2002.	Different types depending on variable. Data collected between 1999 – 2009	Unknown	409 current and former HASI consumers identified in IHS by the HASI flag	164 consumers could be linked to their demographic data and start date.

Australian Institute of Health and Welfare (2011), *Comorbidity of mental disorders and physical conditions 2007*, AIHW, Canberra.

Franklin, A. and Tranter, B. (2011), *AHURI Essay: Housing, Loneliness and Health*, Australian Housing and Research Institute, Melbourne.

NSW Health (2009), *Physical Health Care of Mental Health Consumers: Guidelines*, NSW Department of Health, North Sydney, NSW.



## Appendix 2. Minimum Data Set (MDS) forms

Version 10 – 2009

### HASI Monitoring Form 1: Applicant profile

A separate form is to be completed for each HASI application received in the reporting period where a decision about the application outcome has been made.

Pilot forms: Submission to ARTD by MAIL (PO Box 1167, Queen Victoria Building, NSW 1230) or EMAIL: [hasi.monitoring@artd.com.au](mailto:hasi.monitoring@artd.com.au)

1. Service name: \_\_\_\_\_

2. Service outlet: \_\_\_\_\_

3. Applicant/ client code

--	--	--	--	--	--

4. Reporting period

- <sub>1</sub> January – March 2009  
<sub>2</sub> April – June 2009  
<sub>3</sub> July – September 2009  
<sub>4</sub> October – December 2009

5. Informed consent

- <sub>1</sub> Yes <sub>2</sub> No

#### Application and referral

6. Date application received: \_\_\_\_\_

7. Referral source

- <sub>1</sub> Public Housing Client Service Team  
<sub>2</sub> Community Mental Health Service  
<sub>3</sub> Hospital  
<sub>4</sub> Community Housing Provider  
<sub>5</sub> Referral from other HASI program  
<sub>6</sub> Other, specify: \_\_\_\_\_

8. Name of referring organisation: \_\_\_\_\_

9. Date application processed by selection committee: \_\_\_\_\_

#### Eligibility

10. Applicant date of birth (16 years or older): \_\_\_\_\_

11. Accommodation at time of application

- <sub>1</sub> Public housing  
<sub>2</sub> Hospital, date of admission: \_\_\_\_\_  
<sub>3</sub> Community housing  
<sub>4</sub> Private rental  
<sub>5</sub> Homeless  
<sub>6</sub> Boarding house  
<sub>7</sub> Living with family or friends  
<sub>8</sub> Unknown  
<sub>9</sub> Other, specify: \_\_\_\_\_

Specify name and location of accommodation: \_\_\_\_\_

12. Primary and secondary diagnosed mental illness (tick one primary and one secondary only)

	Primary	Secondary
a) Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
b) Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
c) Schizo-affective	<input type="checkbox"/>	<input type="checkbox"/>
d) Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
e) Depression/ anxiety	<input type="checkbox"/>	<input type="checkbox"/>
f) Other diagnosed mental illness	<input type="checkbox"/>	<input type="checkbox"/>

Specify other: \_\_\_\_\_

13. Co-existing factors impacting on mental illness (tick all that apply)

- <sub>1</sub> Intellectual disability  
<sub>2</sub> Substance abuse  
<sub>3</sub> Physical disability  
<sub>4</sub> Physical health issues  
<sub>5</sub> Acquired brain injury  
<sub>6</sub> Other, specify: \_\_\_\_\_

14. Predicted support hours per month: \_\_\_\_\_

#### Applicant characteristics

15. Gender

- <sub>1</sub> Male <sub>2</sub> Female

16. Cultural/ language background

	Yes	No	Not known
a) ATSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Language other than English spoken at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify language: _____			
c) Need interpreter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Country of birth: \_\_\_\_\_

1

**18. Tenancy risk factors**

1 High turnover in housing/ accommodation  
Number of tenancies/ houses in last 2 years:  
\_\_\_\_\_

2 Periods of homelessness  
Number of days homeless in last 2 years:  
\_\_\_\_\_

3 Nuisance and annoyance complaints related to tenancy  
Number of nuisance and annoyance complaints for tenancy in last 2 years:  
\_\_\_\_\_

4 Applications for orders to CTTT  
Number CTTT applications for tenancy in last 2 years:  
\_\_\_\_\_

**19. Other relevant information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**20. Application outcome**

- 1 Approved - placed on register
- 2 Approved - support package allocated
- 3 Rejected, state reason for rejection:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HASI Monitoring Form 2: Clients with Individual Service Plan

*A separate form is to be completed for each HASI client who has an ISP during the reporting period.*

Pilot forms: Submission to ARTD by MAIL (PO Box 1167, Queen Victoria Building, NSW 1230) or  
EMAIL: [hasi.monitoring@artd.com.au](mailto:hasi.monitoring@artd.com.au)

1. Service provider: \_\_\_\_\_
2. Service area/ office: \_\_\_\_\_
3. Applicant/ client code  

--	--	--	--	--	--
4. Reporting period  
 11 January – March 2009  
 12 April – June 2009  
 13 July – September 2009  
 14 October – December 2009
5. Client status (tick one only)  
 1 Current client throughout reporting period  
 2 New client during reporting period  
     Specify date: \_\_\_\_\_  
 3 Support for client finished during reporting period  
     Specify date: \_\_\_\_\_
6. Type of Support Package  
 1 HASI 1 (high support \$50,000)  
 2 HASI 2 (lower support \$10,000)  
 3 HASI 3 (high support \$50,000)  
 4 HASI 3B (very high support \$70,000)  
 5 HASI 4A (high support \$50,000)  
 6 HASI in the Home 4B (medium \$35,000)  
 7 HASI in the Home 4B (lower \$11,000)
7. Area Health Service:  

<input type="checkbox"/> 1 NSCCAHS	<input type="checkbox"/> 5 NCAHS
<input type="checkbox"/> 2 SWAHS	<input type="checkbox"/> 6 HNEAHS
<input type="checkbox"/> 3 SSWAHS	<input type="checkbox"/> 7 GWAHS
<input type="checkbox"/> 4 SESIAHS	<input type="checkbox"/> 8 GSAHS
8. Suburb/ town of residence: \_\_\_\_\_
9. Postcode: \_\_\_\_\_

### Services provided - ISP

10. Support hours provided by the Support Coordinator to the client under the agreed ISP
 

a) Total number of face-to-face support hours agreed in the ISP in reporting period	
b) Total number of face-to-face support hours actually delivered in reporting period	
c) Total number of non-face-to-face support provided in reporting period (eg advocacy)	
d) Largest number of direct support hours in any single week in reporting period	
e) Smallest number of direct support hours in any single week in reporting period	
f) Number of weeks in reporting period where client was in the service but no direct support was provided	
11. Main support activities/ services during the reporting period (estimate % of total time spent on each)
 

a) Domestic skills	
b) Personal and health self-care	
c) Pre-vocational and vocational support	
d) Advocacy	
e) Income management	
f) Counselling/ psychosocial support	
g) Links with family and friends	
h) Community access/ socialisation	
12. Please provide details of main support activities: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**13. Further details of other direct support:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**14. Referrals (if no referrals, write "0")**

a) ...to other support services

b) ...to community or recreation activities

**Assessments**

**15. Have the following assessments been completed for the first time or updated during the reporting period?**

a) Global Assessment of Functioning

1 Yes, first assessment

2 Yes, assessment update

3 No

If yes, indicate GAF score:

b) Camberwell Assessment of Needs

1 Yes, first assessment

2 Yes, assessment update

3 No

If yes, indicate CAN score:

**16. Do you have access to MH-OAT data from the Area Health Service for this client?**

1 Yes  2 No → if no, go to Q17

**17. If you have access to MH-OAT data, are the following scores available**

	Unavailable	Available	Score
a) HONOS	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>
b) LSP-16	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>
c) K-10	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/>

**Support details – goal attainment**

**18. Has the client attained their individual (ISP) goals in the reporting period in relation to ...**

	Yes	Partly	No	Not a goal
a) Self-care (personal hygiene, diet, taking medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Domestic skills (cooking, cleaning, shopping, laundry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Community tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(transport, income mgt, making appointments)

d) Use of health and allied services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Social and community participation (family, friends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Work and education/training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify other goal(s): \_\_\_\_\_

**19. If no, provide details of main strategies in place to improve goal attainment:**

\_\_\_\_\_

\_\_\_\_\_

**20. Inpatient admissions in reporting period (number and stay in days, acute & non-acute. If no admissions, write "0". Do not leave blank)**

	No of adm.	Acute days	Non-acute days
a) Unplanned admissions in reporting period	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Planned admissions in reporting period	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Tenancy details**

**21. Did the tenancy end during the reporting period?**

1 Yes

2 No → if no, go to question 24

**22. Date client exited tenancy:** \_\_\_\_\_

**23. Reason for exiting tenancy**

- 1 Eviction
- 2 Abandoned property
- 3 Non-renewal of tenancy due to failure of tenant to meet RTA obligations
- 4 Housing inappropriate for client's needs
- 5 Client moving to other long-term housing
- 6 Client moving back to higher-support accommodation
- 7 Planned end of tenancy due to end of individual support plan

**24. Details of tenancy exit:** \_\_\_\_\_

\_\_\_\_\_

**25. Details for ongoing tenancy**

- a) Duration of current tenancy (in months)
- b) Number of nuisance and annoyance complaints for tenancy in reporting period
- c) Number CTTT applications for tenancy in reporting period
- d) Number of weeks in rental arrears at end of reporting period

**26. Factors that put the tenancy at risk over the reporting period:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**27. Strategies in place to address risk factors:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Closed ISP**

**28. Was the client's Individual Service Plan closed during the reporting period?**

- 1 Yes
- 2 No → if no, there are no more questions

**29. Reason for ISP closure**

- 1 Client no longer needed support (planned closure)
- 2 Client decided to discontinue support (unplanned closure)
- 3 Non-renewal of ISP due to failure of tenant to meet their obligations
- 4 Client moving to other long-term housing
- 5 Client moving back to higher-support accommodation
- 6 Other, specify: \_\_\_\_\_

**30. Other relevant information about ISP closure:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MDS supplement form

### MDS Supplement: September 2009

Date: MRN: Service area:  
 MDS identifier: DOB: Gender: Postcode:

**1. Thinking about the client now, how would you rate his/her level of independence in each of the following:**

	Fully independent	Supported less than half the time	Supported more than half the time	Fully dependent
Personal hygiene and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paying bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. Thinking about the client now, how would you rate the his or her health status:**

	Excellent	Very good	Good	Fair	Poor
Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. How often does the client usually have appointments with the following (approximately):**

	Daily	Weekly	Monthly	Quarterly	Yearly	Never
Community mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist, psychologist and/or counsellor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health services (e.g. dental, optometrist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. How often does the client usually have contact with the following (approximately):**

	Daily	Weekly	Monthly	Quarterly	Yearly	Never	NA
Family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Thinking about the client now, does the client participate in:**

	Yes	No	Don't know
Unsupported social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported <b>individual</b> social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported <b>group</b> social and/or recreational activity in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. Thinking about the client now, is the client involved in any of the following activities?**

	Yes	No	Don't know
Paid work – part time (less than 30 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid work – full time (more than 30 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking for work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education or training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring (for children or other dependent family members/friends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 3. Tables of results

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## A. MDS SAMPLE CHARACTERISTICS

This report focuses on a sample of 895 current HASI consumers.<sup>85</sup> This sample was chosen because demographic information was available on these consumers in the April – June 2009 quarter of data collection from the HASI MDS. This section provides an overview of the characteristics of this sample. A more detailed discussion of this sample can be found in the first evaluation report (McDermott et al., 2010).

**Table A.1: Gender**

	Consumers	Per cent
Men	452	53
Women	400	47
Total	852	100

Note: Data missing for 43 consumers

**Table A.2: Age**

	Consumers	Per cent
Less than 20 years	36	5
20-29 years	137	17
30-39 years	214	27
40-49 years	216	27
50-59 years	149	19
60 or over	38	5
Total	790	100

Note: Data missing for 105 consumers

**Table A.3: Support level**

	Consumers	Per cent
Lower support	552	62
Higher support	343	38
Total	895	100

**Table A.4: Aboriginal or Torres Strait Islander status**

	Consumers	Per cent
Aboriginal or Torres Strait Islander	62	9
Non-Aboriginal or Torres Strait Islander	657	91
Total	719	100

Note: Data missing for 176 consumers

<sup>85</sup> Due to missing data, totals do not always equal 895.

**Table A.5: Language spoken at home**

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

Note: Data missing for 166 consumers

**Table A.6: Consumers by primary mental health diagnosis**

Primary mental illness	Consumers	Per cent
Schizophrenia	548	65
Schizo-affective disorder	91	11
Depression/ anxiety	83	10
Bipolar disorder	75	9
Personality disorder	19	2
Other	29	3
Total	845	100

Note: Data missing for 50 consumers

**Table A.7: Secondary mental health diagnosis**

Secondary mental illness	Consumers	Per cent
Depression/ anxiety	98	12
Other	61	7
Personality disorder	30	4
Schizo-affective disorder	17	2
Bipolar disorder	11	1
Schizophrenia	4	0.5
No secondary mental illness	624	74
Total	845	100

Note: Data missing for 50 consumers

**Table A.8: Co-existing conditions**

Type of co-existing factor	Consumers	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
<b>Total conditions</b>	<b>549**</b>	<b>-</b>
Total consumers with at least one co-existing factor	460	54
Total consumers with no co-existing factors	385	46
<b>Total consumers</b>	<b>845</b>	<b>100</b>

Note: Data missing for 50 consumers

\*Based on a total of 845 consumers

\*\*Some consumers reported more than one condition

**Table A.9: Support level by gender**

	Low (n=477)	Medium (n=54)	High (262)	Very High (n=59)	Total (n=852)
Men	47	48	60	71	53
Women	53	52	40	29	47
Total	100	100	100	100	100

**Table A.20: Proportion of consumers who exited HASI by level of support (per cent)**

	Low (n=1313)	Medium (n=99)	High (n=693)	Very High (n=117)	Total (n=2222)
Consumers	1313	99	693	117	2222
Not exited	73	89	79	83	76
Exited	27	11	21	17	24
Total	100	100	100	100	100

Note: Data missing for 40 consumers

**Table A.31: Reasons for exiting HASI**

Reason for exiting HASI	Consumers	Per cent
Consumer no longer needed support	181	37
Consumer 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

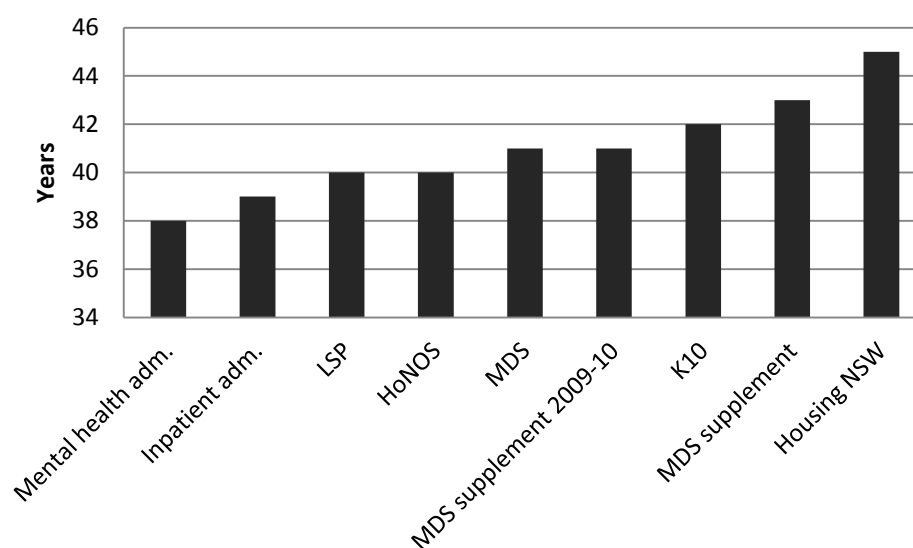
\*Note: Data missing for 38 consumers

## B. MATCHED MDS SUB-SAMPLE CHARACTERISTICS

**Table B.1: Average age, by subsample**

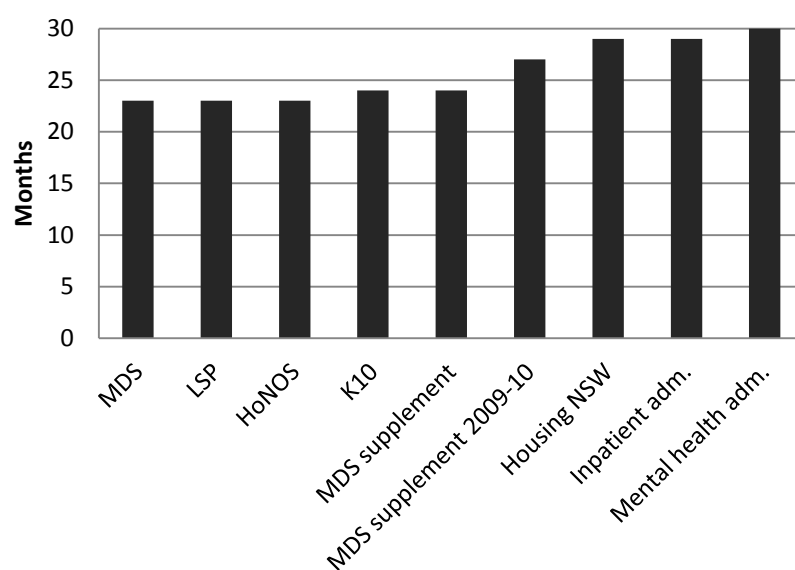
	Consumers	Average age (years)
MDS	895	41
Housing NSW	163	45
Mental health admission	197	38
Inpatient admission	222	39
K10	242	42
LSP	268	40
HoNOS	339	40
MDS supplement	639	43
MDS supplement 2009-10	403	41

**Figure B.1: Average age, by subsample**

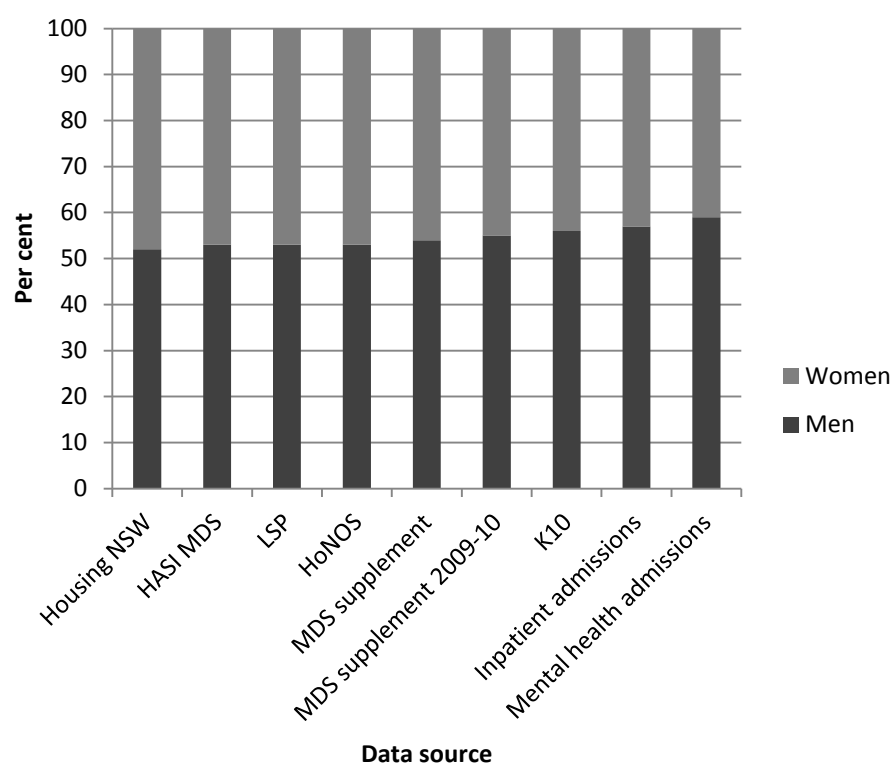


**Table B.2: Average time in HASI, by subsample**

	Consumers	Average time in HASI (months)
MDS	895	23
Housing NSW	163	29
Mental health admission	197	30
Inpatient admission	222	29
K10	242	24
LSP	268	23
HoNOS	339	23
MDS supplement	639	24
MDS supplement 2009-10	403	27

**Figure B. 2: Length of time in the program, by subsample****Table B.3: Gender distribution, by subsample (per cent)**

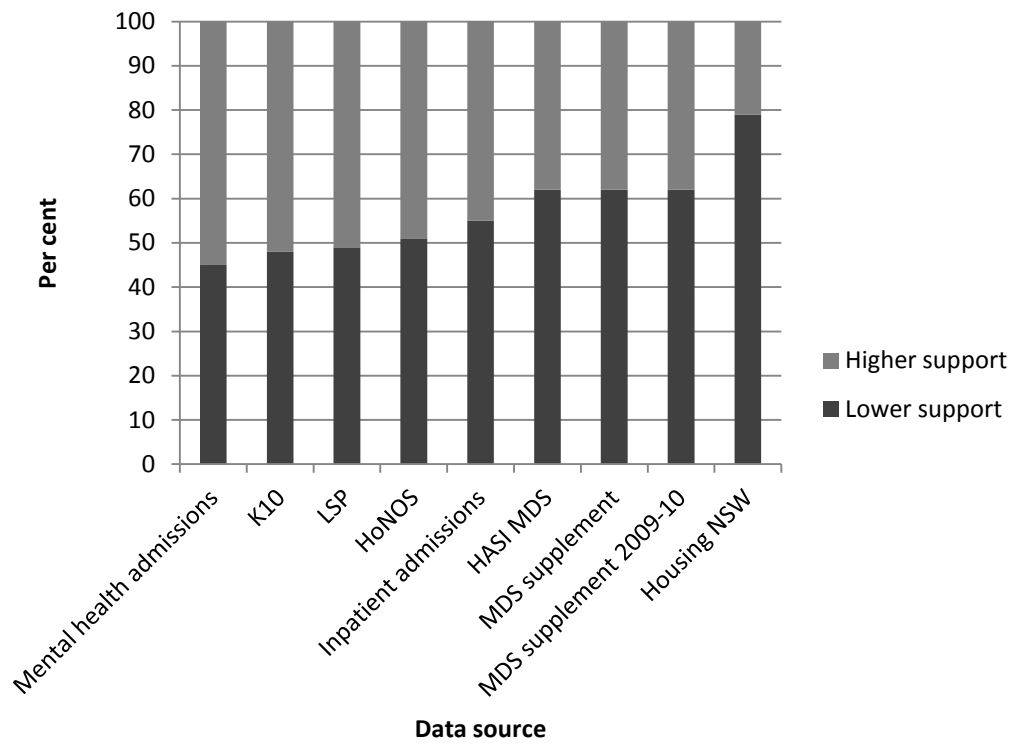
	Consumers	Gender (per cent)	
		Men	Women
HASI MDS	895	53	47
Housing NSW	163	52	48
Mental health admissions	197	59	41
Inpatient admissions	222	57	43
K10	242	56	44
LSP	268	53	47
HoNOS	339	53	47
MDS supplement	639	54	46
MDS supplement 2009-10	403	55	45

**Figure B. 3: Gender distribution, by subsample (per cent)****Table B.4: Support level, by subsample (per cent)**

	Consumers	Support level (per cent)	
		Lower support	Higher support
HASI MDS	895	62	38
Housing NSW	163	79	21
Mental health admissions	197	45	55
Inpatient admissions	222	55	46
K10	242	48	52
LSP	268	49	51
HoNOS	339	51	49
MDS supplement	639	62	38
MDS supplement 2009-10	403	62	38



**Figure B.4: Support level, by subsample**



## C. MDS SUPPLEMENT 2009 – 2010 DATA ANALYSIS (n=403)

**Table C.1 Demographic characteristics of the 2009-2010 MDS supplement sample (per cent)**

	Consumers	Per cent
Men	219	54.8
Women	181	45.3
Higher Support	150	37.2
Lower Support	253	62.8
Less than a year in HASI	140	34.7
1-2 years in HASI	55	13.6
More than 2 years in HASI	208	51.6
N=403		

**Table C.2: Change in independence in activities of daily living, 2009-10 (per cent)**

	Time supported in the activity (per cent)					Total consumers
	Less than half the time <sup>a</sup>		More than half the time <sup>b</sup>			
	2009	2010	2009	2010	Sig.	
Personal hygiene	84.8	85.1	15.2	14.9	1.00	396
Cooking	83.4	83.9	16.6	16.1	0.014	397
Taking medication	70.7	72.8	29.3	27.8	0.488	393
Transport	67.4	72.5	32.6	27.5	0.080	393
Cleaning	67.3	73.0	32.8	27.0	0.044	400
Exercise	64.6	67.3	35.4	32.7	0.351	395
Shopping	66.3	69.6	33.7	30.4	0.263	398
Paying bills	61.9	66.8	38.1	33.2	0.110	394
Budgeting	61.3	65.3	38.8	34.8	0.171	400

Source: MDS supplement September 2009, 2010 matched sample n=403.

Notes: McNemar Test non-parametric test applied to dichotomous variable to trace the change in outcome

a. Fully independent or supported less than half the time

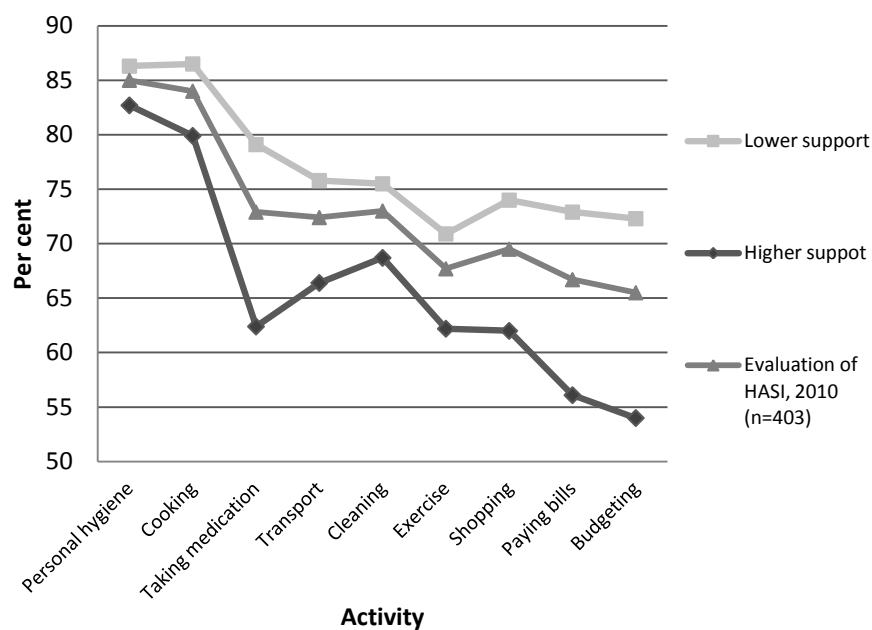
b. Fully dependent or supported more than half the time

**Table C.3: Proportion of consumers independent (more than half of the time) in activities of daily living, by HASI support level, September 2010 (per cent)**

	Lower support	Higher support	Evaluation of HASI, 2010 (n=403)
Personal hygiene	86.3	82.7	85.0
Cooking	86.5	79.9	84.0
Taking medication	79.1	62.4	72.9
Transport	75.8	66.4	72.4
Cleaning	75.5	68.7	73.0
Exercise	70.9	62.2	67.7

Shopping	74	62	69.5
Paying bills	72.9	56.1	66.7
Budgeting	72.3	54	65.5

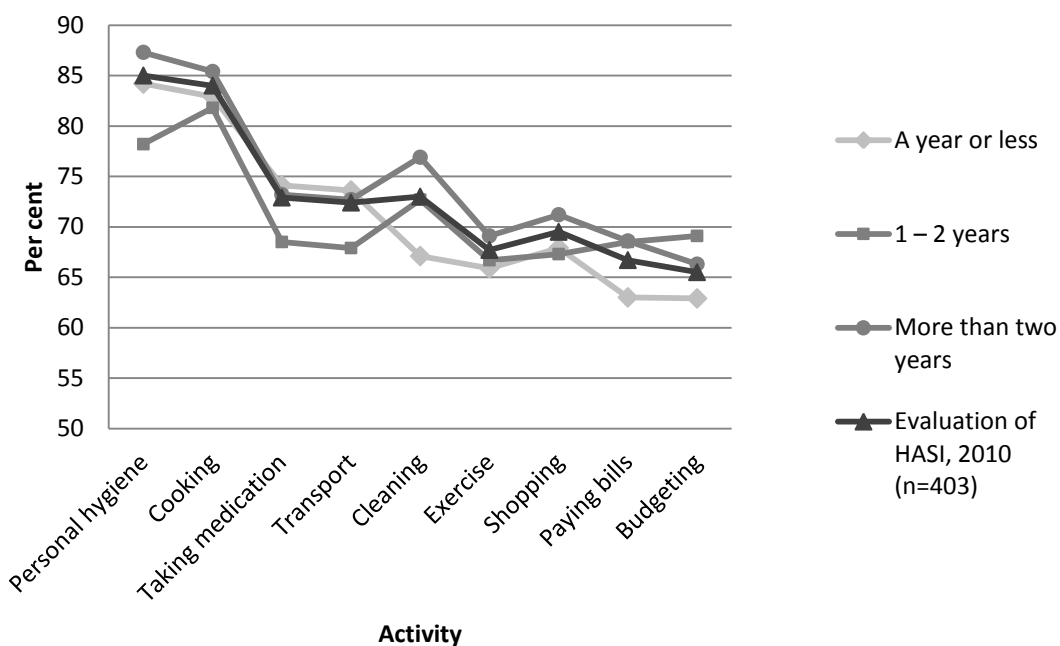
**Figure C1: Consumers independent more than half of the time in activities of daily living, by support level, 2010 (per cent)**



**Table C.4: Proportion of consumers independent (more than half of the time) in activities of daily living, by HASI support level, September 2010 (per cent)**

	A year or less	1 – 2 years	More than two years	Evaluation of HASI, 2010 (n=403)
Personal hygiene	84.2	78.2	87.3	85.0
Cooking	82.9	81.8	85.4	84.0
Taking medication	74.1	68.5	73.2	72.9
Transport	73.6	67.9	72.7	72.4
Cleaning	67.1	72.7	76.9	73.0
Exercise	65.9	66.7	69.1	67.7
Shopping	67.9	67.3	71.2	69.5
Paying bills	63.0	68.5	68.6	66.7
Budgeting	62.9	69.1	66.3	65.5

**Fig. C.2: Consumers independent more than half of the time in activities of daily living, by length of time in HASI, 2010**



**Table C.5: Mean self reported mental and physical health satisfaction, 2009-2010 (per cent)**

		Very good or excellent	Good	Fair or poor
Physical health	2009	14.7	54.9	45.1
	2010	15.0	37.4	47.6
	Sig <sup>1</sup>	1.000	0.431	0.444
Mental health	2009	15.5	45.8	38.8
	2010	14.3	38.0	47.8
	Sig <sup>1</sup>	0.664	0.028	0.006

Note: N=403; missing data for 2 and 3 consumers in physical health and mental health data respectively

1. McNemar test

**Table C.6: Mean self reported mental health and physical health satisfaction, 2009-2010, by gender (per cent)**

		Physical health			Mental health		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Very good or excellent	Men	18.8	16.1	0.496	18.9	17.9	0.892
	Women	9.4	13.3	0.248	11.7	10.1	0.719
	Sig <sup>2</sup>	0.445	0.008		0.025	0.05	
Good	Men	38.1	40.6	0.675	44.2	42.7	0.848
	Women	42.2	33.7	0.092	46.7	31.8	0.003
	Sig <sup>2</sup>	0.182	0.405		0.024	0.607	
Fair or poor	Men	43.1	43.3	1	36.9	39.4	0.59
	Women	48.3	53	0.313	41.7	58.1	0.001
	Sig <sup>2</sup>	0.044	0.304		0	0.316	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square

**Table C.7: Mean self reported mental and physical health satisfaction, 2009-2010, by support level (per cent)**

	Support level	Physical health			Mental health		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Very good or excellent	Lower	14.2	13.4	0.892	13.5	13.4	1
	Higher	16.2	16.9	1	15.5	19	0.499
	Sig	0.629	0.376		0.598	0.160	
Good	Lower	36	42.3	0.156	30.6	44.3	0.001
	Higher	39.9	36.5	0.568	50.7	48.3	0.731
	Sig	0.499	0.213		0.000	0.55	
Fair or poor	Lower	49.8	44.3	0.18	56	42.3	0.001
	Higher	43.9	46.6	0.651	33.8	32.7	0.896
	Sig	0.209	0.736		0.000	0.040	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square

**Table C.8: Mean self reported mental and physical health satisfaction, 2009-2010, by length of time in HASI (per cent)**

Self-reported level satisfaction	Length of time in HASI	Physical health			Mental health		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Very good or excellent	Under 1 year	9.4	7.9	0.832	7.2	9.4	0.664
	1 - 2 years	16.4	18.2	1	14.5	20	0.508
	More than 2 years	18.3	18.4	1	18.3	18.4	1
	Sig <sup>2</sup>	0.066	0.019		0.01	0.044	
Good	Under 1 year	39.9	40.3	1	33.1	37	0.614
	1 - 2 years	32.7	43.6	0.286	40	52.7	0.248
	More than 2 years	37	39.1	0.743	37	49.8	0.068
	Sig <sup>2</sup>	0.693	0.819		0.34	0.028	
Fair or poor	Under 1 year	50.7	51.8	0.883	59.7	53.6	0.281
	1 - 2 years	50.9	38.2	0.189	45.5	27.3	0.064
	More than 2 years	44.7	42.5	0.635	44.7	42.5	0.075
	Sig <sup>2</sup>	0.534	0.137		0.002	0.000	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square

**Table C.9: Frequency of health service use, 2009 – 2010 (per cent)**

		Monthly or less	Quarterly	Yearly	Never	Consumers
Community mental health	2009	76.9	10.2	7.5	5.5	402
	2010	68.9	18.7	4.2	8.2	
	Sig <sup>a</sup>	0.006	0.001	0.067	0.136	
General Practitioner	2009	59.0	30.5	8.5	0.8	400
	2010	59.8	29.5	8.5	2.3	
	Sig <sup>a</sup>	0.862	0.792	-	0.109	
Psychiatrist	2009	47.5	31.3	15.8	5.5	400
	2010	48.8	35.0	10.3	6.0	
	Sig <sup>a</sup>	0.745	0.261	0.012	0.871	
Allied health	2009	13.0	24.9	47.6	14.5	401
	2010	15.7	26.9	50.1	7.2	
	Sig <sup>a</sup>	0.215	0.557	0.493	0.001	
Drug and alcohol services	2009	5.0	1.8	6.3	86.9	398
	2010	7.8	1.3	5.5	85.4	
	Sig	0.072	0.754	0.742	0.519	

Source: HASI MDS supplement September 2009, 2010; n=403

1. McNemar test for equality of means

**Table C.10a: Frequency of health service use by gender, 2009-2010 (per cent)**

		Community mental health			General Practitioner			Psychiatrist		
		2009	2010	Sig <sup>a</sup>	2009	2010	Sig <sup>a</sup>	2009	2010	Sig <sup>a</sup>
Monthly or less	Men	80.3	72	0.036	53.2	57.3	0.32	50.2	52.1	0.74
	Women	74.7	65.6	0.068	68.7	64	0.321	44.7	45.8	0.903
	Sig <sup>2</sup>	0.128	0.163		0.002	0.231		0.266	0.21	
Quarterly	Men	10.6	17.4	0.041	33.8	30.7	0.561	30.9	32.7	0.746
	Women	10.1	20	0.01	26.8	27	1	34.1	36.9	0.63
	Sig <sup>2</sup>	0.855	0.515		0.14	0.37		0.507	0.396	
Yearly	Men	6	3.7	0.359	11.6	9.2	0.486	16.6	10.1	0.035
	Women	9	4.4	0.134	4.5	7.3	0.359	14	10.6	0.361
	Sig <sup>2</sup>	0.265	0.697		0.011	0.48		0.467	0.882	
Never	Men	3.2	6.9	0.096	1.4	2.8	0.453	2.3	5.1	0.146
	Women	6.2	10	0.21	0	1.7	0.25	7.3	6.7	1
	Sig <sup>2</sup>	0.167	0.263		0.114	0.468		0.019	0.492	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square

**Table C.10b: Frequency of health service use by gender, 2009-2010 (continued) (per cent)**

		Allied health			Drug and alcohol services		
		2009	2010	Sig <sup>a</sup>	2009	2010	Sig <sup>a</sup>
Monthly or less	Men	9.3	12.9	0.201	6.9	8.3	0.648
	Women	17.8	19.4	0.735	2.8	7.3	0.039
	Sig	0.011	0.073		0.062	0.699	
Quarterly	Men	21	25.8	0.242	2.8	0.9	0.289
	Women	30.6	28.3	0.716	0.6	1.7	0.5
	Sig	0.024	0.558		0.097	0.505	
Yearly	Men	54.2	53.9	1	6	7.9	0.523
	Women	40.6	45	0.416	6.7	2.2	0.057
	Sig	0.012	0.084		0.775	0.013	
Never	Men	15.4	7.4	0.015	84.3	82.9	0.766
	Women	11.1	7.2	0.248	90	88.8	0.523
	Sig	0.238	0.962		0.066	0.129	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square; n=403

**Table C.11a: Frequency of health service use, by support level (per cent)**

		Community mental health			General Practitioner			Psychiatrist		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Monthly or less	Lower	70.3	62.3	0.08	65.5	56.4	0.03	43	42.2	1
	Higher	90	79.9	0.008	51	65.8	0.004	56	60.1	0.575
Quarterly	Sig <sup>2</sup>	0.000	0.000		0.007	0.058		0.008	0.001	
	Lower	12.4	21.8	0.005	27.3	30.4	0.434	32.5	37.5	0.237
Yearly	Higher	7.3	13.4	0.093	36.2	27.5	0.093	31.3	30.4	0.892
	Sig <sup>2</sup>	0.118	0.036		0.054	0.563		0.887	0.144	
Never	Lower	11.2	5.2	0.021	6.4	10.4	0.123	18.1	12.7	0.086
	Higher	0.7	2.7	0.375	12.1	5.4	0.031	11.3	6.1	0.115
	Sig <sup>2</sup>	0.000	0.233		0.048	0.084		0.083	0.033	
	Lower	6	10.7	0.059	0.8	2.8	0.125	6.4	7.6	0.71
	Higher	2	4	0.453	0.7	1.3	1	1.3	3.4	0.453
	Sig <sup>2</sup>	0.065	0.018		0.889	0.346		0.019	0.087	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square; n=403

**Table C.11b: Frequency of health service use, by support level (per cent) (continued)**

		Allied health			Drug and alcohol services		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Monthly or less	Lower	15.3	17.1	0.551	5.2	5.6	1
	Higher	9.4	13.5	0.263	4.8	11.6	0.021
Quarterly	Sig <sup>2</sup>	0.1	0.328		0.833	0.035	
	Lower	20.2	24.6	0.207	1.6	0.8	0.687
Yearly	Higher	34.9	30.4	0.464	2	2.1	1
	Sig <sup>2</sup>	0.001	0.227		0.756	0.289	
Never	Lower	52.4	49.6	0.682	4	5.6	0.503
	Higher	40.3	51.4	0.085	10.2	5.5	0.143
	Sig <sup>2</sup>	0.027	0.807		0.015	0.932	
	Lower	12.1	8.7	0.291	89.3	88	0.635
	Higher	15.4	4.7	0.003	83	80.8	0.571
	Sig <sup>2</sup>	0.318	0.13		0.033	0.021	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1: McNemar test; 2. Pearson Chi-square; n=403



**Table C.12a: Frequency of health service use, by length in HASI (per cent)**

		Community mental health			General Practitioner			Psychiatrist		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Monthly or less	Under 1 year	82	70.3	0.012	72.1	58	0.009	53.6	50.7	0.583
	1-2 years	92.7	74.5	0.021	57.4	70.4	0.118	56.4	44.4	0.23
	More than 2 years	70.7	66.3	0.47	52.5	58.5	0.131	41.7	48.8	0.081
	Sig <sup>2</sup>	0	0.492		0.001	0.277		0.024	0.724	
Quarterly	Under 1 year	10.1	17.4	0.123	22.9	34.1	0.037	32.1	31.9	1
	1-2 years	3.6	18.2	0.021	33.3	20.4	0.118	29.1	44.4	0.115
	More than 2 years	12.7	19.7	0.041	35.3	28.5	0.154	32.8	34.3	0.737
	Sig <sup>2</sup>	0.157	0.83		0.059	0.163		0.9	0.269	
Yearly	Under 1 year	4.3	6.5	0.581	5	5.8	1	10.7	11.6	1
	1-2 years	0	3.6	0.5	7.4	7.4	1	9.1	7.4	1
	More than 2 years	11.2	2.9	0.002	11.3	10.6	1	20.6	10.1	0.002
	Sig <sup>2</sup>	0.005	0.265		0.13	0.263		0.021	0.688	
Never	Under 1 year	3.6	5.8	0.508	0	2.2	0.25	3.6	5.8	0.508
	1-2 years	3.6	3.6	1	1.9	1.9	1	5.5	3.7	1
	More than 2 years	5.4	11.1	0.038	1	2.4	0.375	4.9	6.8	0.523
	Sig <sup>2</sup>	0.711	0.085		0.36	0.963		0.8	0.682	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square; n=403

**Table C.12b: Frequency of health service use, by length in HASI (per cent) continued**

		Allied health			Drug and alcohol services		
		2009	2010	Sig <sup>1</sup>	2009	2010	Sig <sup>1</sup>
Monthly or less	Under 1 year	11.5	16.7	0.21	4.3	8.7	0.146
	1-2 years	11.1	12.7	1	1.8	7.4	0.25
	More than 2 years	14.7	15.9	0.742	6.3	7.3	0.804
		Sig <sup>2</sup>	0.64	0.807	0.364	0.89	
Quarterly	Under 1 year	28.8	22.5	0.272	1.4	0.7	1
	1-2 years	29.6	25.5	0.832	0	3.7	0.5
	More than 2 years	22.5	30	0.069	2.4	1	0.375
		Sig <sup>2</sup>	0.312	0.278	0.451	0.22	
Yearly	Under 1 year	48.2	51.4	0.699	5.1	3.6	0.774
	1-2 years	40.7	47.3	0.571	9.1	9.3	1
	More than 2 years	49.5	50.2	0.826	6.3	5.9	1
		Sig <sup>2</sup>	0.516	0.909	0.566	0.3	
Never	Under 1 year	11.5	9.4	0.7	89.1	87	0.69
	1-2 years	18.5	14.5	0.791	89.1	79.6	0.109
	More than 2 years	13.2	3.9	0.001	85	85.9	1
		Sig <sup>2</sup>	0.542	0.012	0.486	0.416	

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test; 2. Pearson Chi-square; n=403

**Table C.13: Contact with family members, partner and friends**

	Relationship (per cent)								
	Family (n=396)			Partner (n=392)			Friends (n=394)		
	2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>
Daily or weekly	60.9	62.6	0.550	12.2	14.0	0.391	64.7	66.8	0.519
Monthly or quarterly	22.2	18.2	0.110	1.5	0.8	0.250	14.2	17.8	0.161
Yearly	5.3	5.3	1.000	0.8	0.0	0.508	1.5	0.8	0.453
Never	8.3	4.3	0.008	5.4	0.8	0.000	7.6	1.8	0.000
N/A	3.3	9.6	0.000	80.1	84.4	0.068	11.9	12.9	0.716

Source: HASI MDS supplement September 2009, 2010 n=403  
Notes: 1. McNemar test

**Table C.14: Contact with family members, partner and friends by support level**

	Support level	Relationship (per cent)								
		Family			Partner			Friends		
		2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>
Daily or weekly	Lower	63.1	64.8	0.649	16.5	19.1	0.360	67.6	68.8	0.817
	Higher	56.6	58.4	0.441	5.4	4.7	1.000	58.8	61.7	0.551
	Sig <sup>2</sup>	0.105	0.172		0.001	0.000		0.076	0.175	
Monthly or quarterly	Lower	21.4	15.4	0.064	1.6	0.8	0.687	15.6	17.2	0.688
	Higher	24.1	23.5	1.000	1.4	0.7	1.000	12.2	19.5	0.082
	Sig <sup>2</sup>	0.642	0.047		0.843	0.889		0.342	0.554	
Yearly	Lower	5.2	4.7	1.000	0.8	0.0	0.500	0.8	0.4	1.000
	Higher	5.5	6.7	0.774	0.7	0.0	1.000	3.4	1.3	0.453
	Sig <sup>2</sup>	0.932	0.411		0.889	-		0.059	0.290	
Never	Lower	7.1	4.7	0.263	4.8	1.2	0.035	7.2	2.8	0.013
	Higher	10.3	3.4	0.006	6.1	0.0	0.004	8.1	1.3	0.013
	Sig <sup>2</sup>	0.307	0.496		0.583	0.181		0.061	0.346	
N/A	Lower	3.2	10.3	0.001	76.3	78.9	0.396	8.8	10.8	0.499
	Higher	3.4	8.1	0.039	86.4	94.6	0.004	17.6	16.1	0.864
	Sig <sup>2</sup>	0.066	0.450		0.023	0.000		0.024	0.120	

Source: HASI MDS supplement September 2009, 2010 n=403  
Notes: 1. McNemar test; 2. Pearson Chi-square

**Table C.15: Contact with family members, partner and friends by length of time in HASI**

Length in HASI				Relationship (per cent)								
				Family			Partner			Friends		
				2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>
Daily or weekly	Less than 1			65.5	62.1	0.596	16.5	18.7	0.629	67.9	62.1	0.256
	1 – 2 years			60.0	54.5	0.607	9.3	14.5	0.375	49.1	64.8	0.134
	More than 2			57.6	64.7	0.034	10.3	10.2	1.000	66.0	69.3	0.366
				Sig <sup>2</sup>	0.264	0.405		0.157	0.076		0.046	0.475
Monthly or quarterly	Less than 1			17.3	15.0	0.690	0.7	0.7	1.000	12.9	22.9	0.026
	1 – 2 years			20.0	25.5	0.607	1.9	1.8	1.000	18.2	27.8	0.227
	More than 2			26.2	18.8	0.050	2.0	0.5	0.375	14.3	12.2	0.651
				Sig <sup>2</sup>	0.139	0.232		0.644	0.590		0.626	0.005
Yearly	Less than 1			5.0	5.7	1.000	0.7	0.0	1.000	1.4	0.7	1.000
	1 – 2 years			9.1	10.9	1.000	0.0	0.0	-	7.3	1.9	0.375
	More than 2			4.4	3.9	1.000	1.0	0.0	0.500	0.5	0.5	1.000
				Sig <sup>2</sup>	0.365	0.121		0.761	-		0.003	0.590
Never	Less than 1			10.1	4.3	0.057	5.0	1.4	0.180	6.4	0.7	0.008
	1 – 2 years			10.9	5.5	0.375	1.9	0.0	1.000	12.7		0.016
	More than 2			6.4	3.9	0.267	6.4	0.5	0.002	6.9	3.9	0.210
				Sig <sup>2</sup>	0.334	0.869		0.417	0.474		0.369	0.074
N/A	Less than 1			2.2	12.9	0.001	77.0	79.1	0.710	11.4	13.6	0.678
	1 – 2 years			0.0	3.6	0.500	87.0	83.6	1.000	12.7	5.6	0.344
	More than 2			4.9	8.7	0.077	80.3	88.8	0.012	12.3	14.1	0.617
				Sig <sup>2</sup>	0.815	0.120		0.379	0.085		0.761	0.223

Source: HASI MDS supplement September 2009, 2010 n=403

Notes: 1. McNemar test; 2. Pearson Chi-square

**Table C.16: Change in participation in social or recreational activities by type, 2009-10**

	Participating (per cent)			Consumers 2009-2010
	2009	2010	Sig. <sup>1</sup>	
Supported group activity	60.6	57.4	0.303	383
Unsupported group activity	51.8	60.1	0.016	363
Supported individual activity	66.1	58.7	0.027	383
Day program	24.3	22.4	0.450	362

Source: HASI MDS supplement September 2009; n=403; Notes: 1. McNemar test

**Table C.17: Change in participation in social or recreational activities by type and HASI support level, September 2009-2010**

	HASI support level (per cent)					
	Low and medium (n=253)			High and very high (n=144)		
	2009	2010	Sig. <sup>1</sup>	2009	2010	Sig. <sup>1</sup>
Supported group activity	51.5	51.5	1.000	75.7	67.4	0.059
Unsupported group activity	49.3	61.3	0.008	55.8	58.0	0.779
Supported individual activity	62.0	59.5	0.610	73.0	57.4	0.004
Day program	20.9	19.1	0.596	30.3	28.0	0.719

Source: HASI MDS supplement September 2009, 2010 n=403; for 397 consumers the support level could be identified

Notes: 1. McNemar test

**Table C.18: Change in participation in social or recreational activities by type and length of time in HASI, 2009-10**

	Length of time in HASI <sup>1</sup> (per cent)								
	One year and less (n=140)			1-2 years (n=55)			More than 2 years (n=208)		
	2009	2010	Sig.	2009	2010	Sig. <sup>2</sup>	2009	2010	Sig.
Supported group activity	61.4	55.3	0.280	55.8	59.6	0.791	61.3	58.3	0.511
Unsupported group activity	61.1	55.6	0.360	46.9	69.4	0.035	46.8	60.6	0.005
Supported individual activity	67.9	58.2	0.093	61.5	57.7	0.804	66.0	59.4	0.188
Day program	28.3	18.1	0.011	15.4	21.2	0.453	24.0	25.7	0.728

Source: HASI MDS supplement September 2009,2010 n=403;

Notes:

1. Time from entry to December 2009;

2. The differences for this group may not be statistically significant because of the small size of the sample (55 consumers in HASI for between one and two years); McNemar test

**Table C.19: Involvement in work and education by type of activity**

	2009	2010	Sig. <sup>1</sup>
Part time work	11.7	11.7	1.000
Full time work	1.0	2.2	0.227
Volunteering	7.7	7.9	1.000
Looking for work	14.4	14.6	0.899
Education or training	18.4	18.6	0.916
Care	10.4	11.2	0.749
Total involved in some social activity	41.9	46.6	0.151

Source: HASI MDS supplement September 2009, 2010; n=403

Note: 1. McNemar test

**Table C.20: Involvement in work and education by type of activity, by gender, support level and length of time in HASI**

Activity type		2009	2010	Sig. <sup>1</sup>
Part time work	All	11.7	11.7	1.000
	Men	13.7	13.8	1.000
	Women	9.5	9.4	1.000
	Sig <sup>2</sup>	0.179	0.196	
	Lower support	10.4	8.0	0.361
	Higher support	14.0	18.1	0.238
	Sig <sup>2</sup>	0.002	0.273	
	Less than a year in HASI	12.9	10.7	0.648
	1-2years in HASI	12.7	16.4	0.687
	More than 2 years in HASI	10.6	11.1	1.000
	Sig <sup>2</sup>	0.514	0.781	
Full time work	All	1.0	2.2	0.227
	Men	0.9	2.8	0.219
	Women	1.1	1.7	1.000
	Sig <sup>2</sup>	0.465	0.883	
	Lower support	0.8	2.0	0.453
	Higher support	1.4	2.7	0.625
	Sig <sup>2</sup>	0.649	0.591	
	Less than a year in HASI	0	3.6	0.063
	1-2years in HASI	0	1.8	1.000
	More than 2 years in HASI	1.9	1.4	1.000
	Sig <sup>2</sup>	0.426	0.154	
Volunteering	All	7.7	7.9	1.000
	Men	6.5	9.3	0.571
	Women	9.6	6.7	0.405
	Sig <sup>2</sup>	0.363	0.266	
	Lower support	10.0	9.2	0.871
	Higher support	4.1	6.1	1.000
	Sig <sup>2</sup>	0.277	0.033	
	Less than a year in HASI	7.9	11.4	0.503
	1-2years in HASI	5.5	10.9	0.687
	More than 2 years in HASI	8.2	4.8	0.230
	Sig <sup>2</sup>	0.064	0.794	
Looking for work	All	14.4	14.6	0.899
	Men	16.1	16.7	0.877
	Women	12.8	12.5	1.000
	Sig <sup>2</sup>	0.240	0.368	
	Lower support	12.7	16.1	0.268
	Higher support	17.4	13.0	0.286
	Sig <sup>2</sup>	0.403	0.197	
	Less than a year in HASI	15.7	18.6	0.405
	1-2years in HASI	20.0	20.0	1.000
	More than 2 years in HASI	12.0	10.6	0.710
	Sig <sup>2</sup>	0.058	0.291	

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Activity type		2009	2010	Sig. <sup>1</sup>
Education or training	All	18.4	18.6	0.916
	Men	17.6	17.1	1.000
	Women	20.2	21.3	0.874
	Sig <sup>2</sup>	0.288	0.506	
	Lower support	20.0	18.9	0.791
	Higher support	16.3	18.9	0.486
	Sig <sup>2</sup>	0.991	0.364	
	Less than a year in HASI	20.7	22.9	0.735
	1-2years in HASI	14.5	27.3	0.118
	More than 2 years in HASI	17.8	13.5	0.268
Care	Sig <sup>2</sup>	0.021	0.540	
	All	10.4	11.2	0.749
	Men	6.1	3.7	0.267
	Women	16.4	21.1	0.170
	Sig <sup>2</sup>	0.000	0.001	
	Lower support	12.5	14.6	0.472
	Higher support	7.5	6.1	0.727
	Sig <sup>2</sup>	0.011	0.123	
	Less than a year in HASI	15.0	15.0	1.000
	1-2years in HASI	5.5	7.3	1.000
Total involved in some social activity	More than 2 years in HASI	8.7	9.6	0.832
	Sig <sup>2</sup>	0.181	0.065	
	All	41.9	46.6	0.151
	Men	41.1	43.4	0.644
	Women	43.6	50.3	0.169
	Sig <sup>2</sup>	0.607	0.169	
	Lower support	40.3	45.8	0.175
	Higher support	44.7	47.3	0.665
	Sig <sup>2</sup>	0.392	0.773	
	Less than a year in HASI	45.7	56.4	0.033
1-2years in HASI	40.0	52.7	0.167	
More than 2 years in HASI	39.9	38.0	0.734	
Sig <sup>2</sup>	0.533	0.002		

Source: HASI MDS supplement September 2009, 2010; n=403

1: McNemar test; 2: Pearson Chi-square; n=403



## D. INPATIENT ADMISSIONS DATA

As in the evaluation of Stage One, this evaluation found considerable decreases in hospitalisation of HASI consumers after entering the program.<sup>86</sup> The data show statistically significant decreases ( $p < 0.05$ ) in the average number of mental health hospital admissions each year (23 per cent decrease), the mean number of days spent in hospital per person per year (61 per cent decrease), and the average number of days hospitalised per admission (66 per cent decrease). Of the 222 people for whom there was complete inpatient data over a four year period, 197 people (89 per cent) had had an admission at some point over the four year period.

**Table D.1: Pre-HASI and in-HASI participant hospital admissions, all types (n=222)**

	Before HASI <sup>1</sup>	While in HASI <sup>2</sup>	Per cent change since joining HASI
Average annual hospital admissions per person per year <sup>3</sup>	1.6	1.2	-23**
Average number of days spent hospitalised per person per year <sup>3</sup>	55.1	21.4	-61**
Average number of days hospitalised per admission <sup>3</sup>	6.3	2.1	-66**

Notes: 1. Based on the average number of admissions per person in the two years prior to joining HASI

2. Based on the average number of admissions per person over each consumers' first two years in HASI

3. Includes consumers that had no hospital admissions in the respective period

4. Only refers to consumers that had at least one visit in the respective period

\*\*  $p < 0.05$ , Sig. 2-tailed, from paired sample t-test of means across two periods

**Table D.2: Longitudinal analysis of mean annual hospital admissions, all types, per person, per year (n=222)**

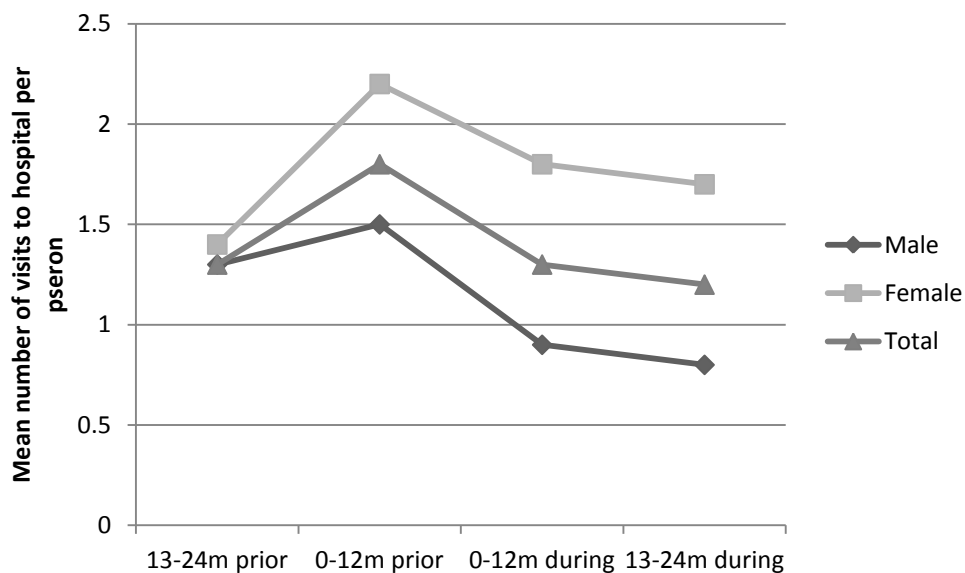
	Consumers	13-24m prior (Year 1)	0-12m prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig <sub>1</sub>	Effect size <sup>2</sup>
Men	127	1.3	1.5	0.9	0.8	.000	.180
Women	95	1.4	2.2	1.8	1.7	.030	.092
Total	222	1.3	1.8	1.3	1.2	.000	.086

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

<sup>86</sup> Hospitalisation in this section includes emergency department visits, general hospital admissions, acute admissions, and psychiatric admissions.

2. Partial eta squared

**Figure D.1: Mean annual hospital admissions, all types, by gender (n=222)**

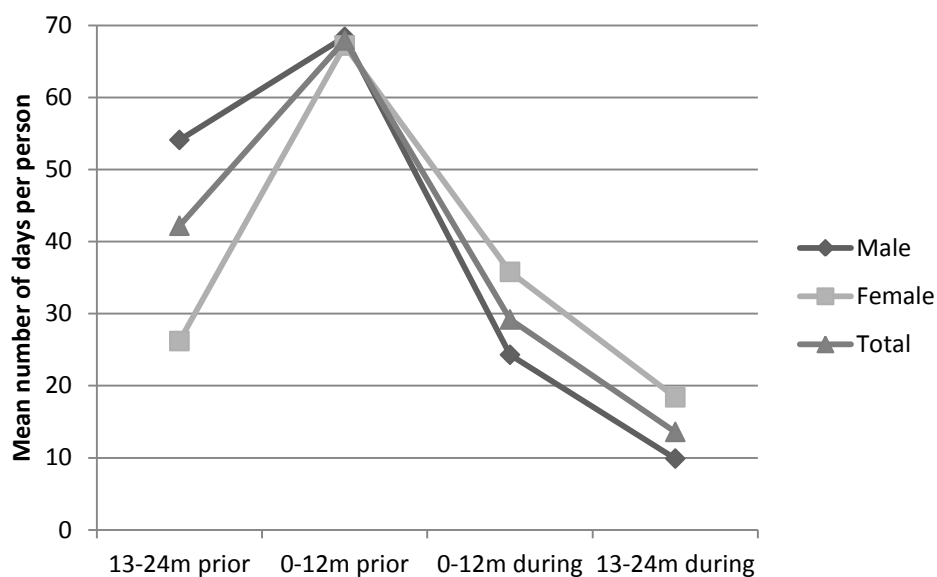


**Table D.3: Longitudinal analysis of mean days in hospital per person, per year, all types of admissions (n=222)**

	n	13-24m prior (Year 1)	0-12m prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. <sub>1</sub>	Effect size <sup>2</sup>
Men	127	54.1	68.4	24.3	9.9	.000	.282
Women	95	26.2	67.2	35.8	18.4	.000	.216
Total	222	42.2	67.9	29.2	13.6	.000	.243

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA  
 2. Partial eta squared

**Figure D.2: Mean number of days spent in hospital per person, per year, by gender, all types of admissions (n=222)**

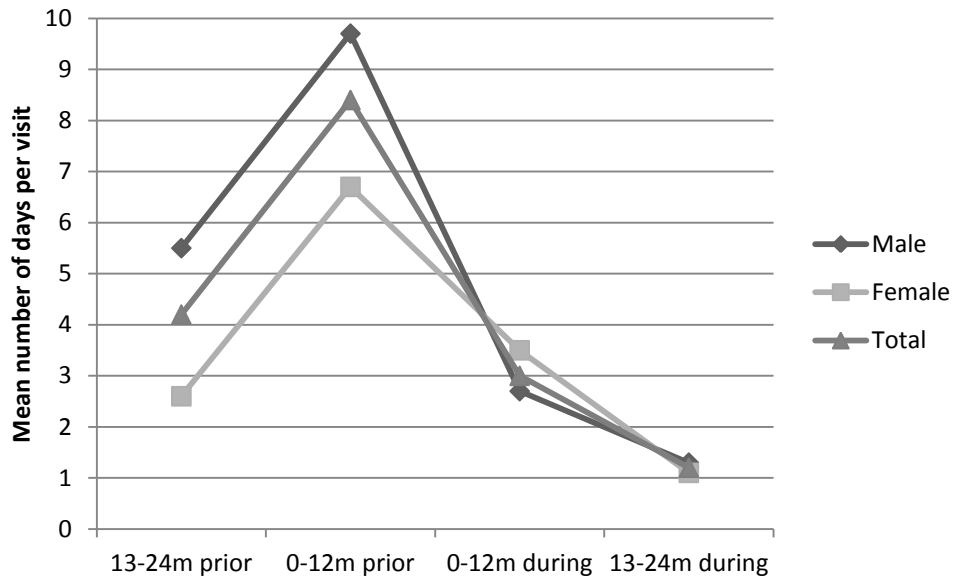


**Table D.4: Longitudinal analysis of mean days in hospital per admission per year, all types, by gender (n=222)**

	n	13-24m Prior (Year 1)	0-12m Prior (Year 2)	0-12m during (Year 3)	13-24m during (Year 4)	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Men	127	5.5	9.7	2.7	1.3	.000	.188
Women	95	2.6	6.7	3.4	1.1	.000	.207
Total	222	4.2	8.4	3.0	1.2	.000	.177

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA  
2. Partial eta squared

**Fig. D.3: Mean number of days per admission, pear year, by gender, all types (n=222)**



## E. INPATIENT MENTAL HEALTH ADMISSIONS (N=197)

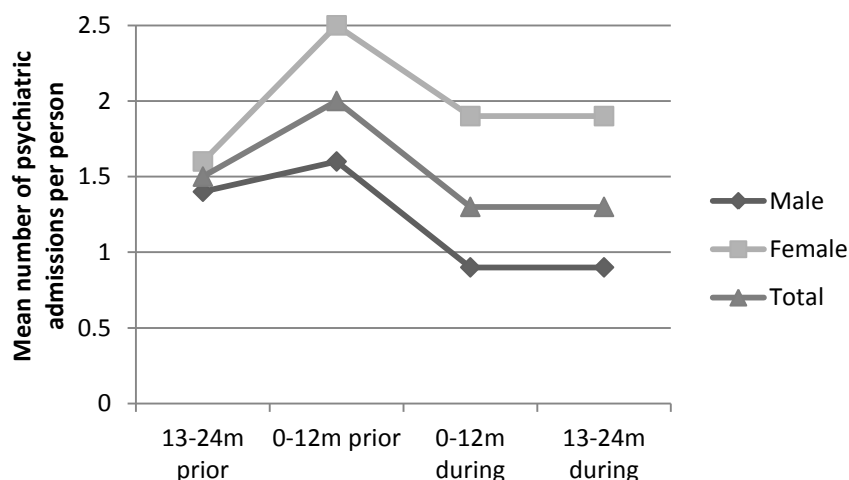
**Table E.1 Longitudinal analysis of mean number of psychiatric unit admissions by gender**

	Consumers	13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total	197	1.5	2.0	1.3	1.3	0.000	0.103
Men	116	1.4	1.6	0.9	0.9	0.000	0.194
Women	81	1.6	2.5	1.9	1.9	0.027	0.110
Sig.		0.655	0.009	0.003	0.006		

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

2. Partial eta squared

**Fig. E.1: Mean number of mental health admissions for two years prior and first two years of HASI per person, per year by gender**



Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data July 1999-June 2009 n=197

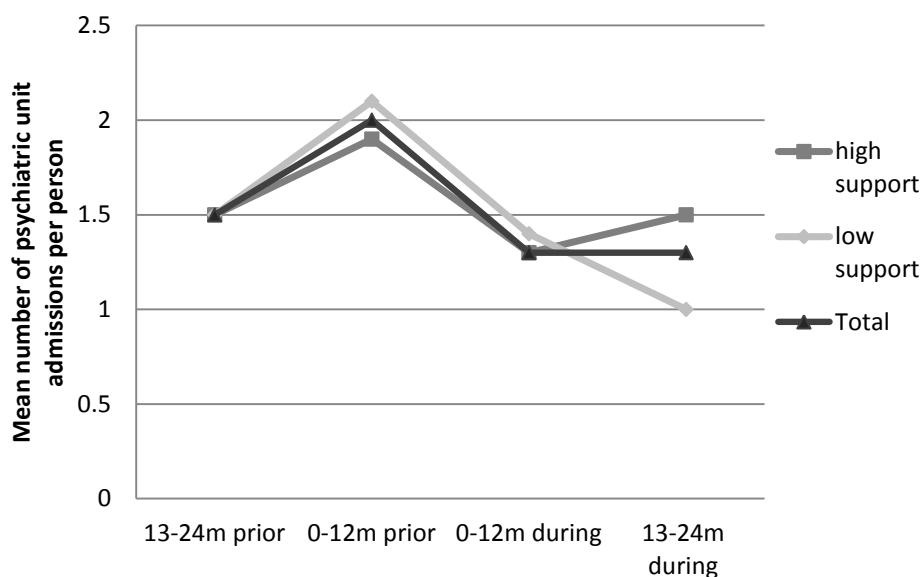
Note: According to Cohen (1988) a .01 eta squared indicates a small effect size, .06 a medium effect size and more than 0.14 a large effect size. The effect size for men was largest, while the overall effect size and the effect size for women are medium-high.

**Table E.2 Longitudinal analysis of mean number of psychiatric unit admissions by level of support**

Consumer s	13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4	Sig. <sup>1</sup>	Effect size <sup>2</sup>	
Total	197	1.5	2.0	1.3	1.3	0.000	0.103
Higher support	109	1.5	1.9	1.3	1.5	0.011	0.100
Lower support	88	1.5	2.1	1.4	1.0	0.008	0.129
Sig.		0.988	0.678	0.845	0.119		

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA  
 2. Partial eta squared

**Fig. E.2: Mean number of mental health admissions for two years prior and first two years of HASI per person per year by support level**



Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data, July 1999-June 2009 n=197.

**Table E.3 Longitudinal analysis of mean number of psychiatric unit admissions by age group**

Consumers	13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4	Sig. <sup>1</sup>	Effect size <sup>2</sup>
18-29 years	47	2.1	2.2	1.4	1	0.233
30-44 years	87	1.2	2.1	1.3	1.2	0.133
45-64 years	58	1.5	1.6	1.3	1.6	0.034
65+ years	5	1.0	2.4	0.8	0.8	0.601
Sig. <sup>3</sup>		0.162	0.555	0.954	0.675	
Total	197	1.5	2.0	1.3	1.3	0.103

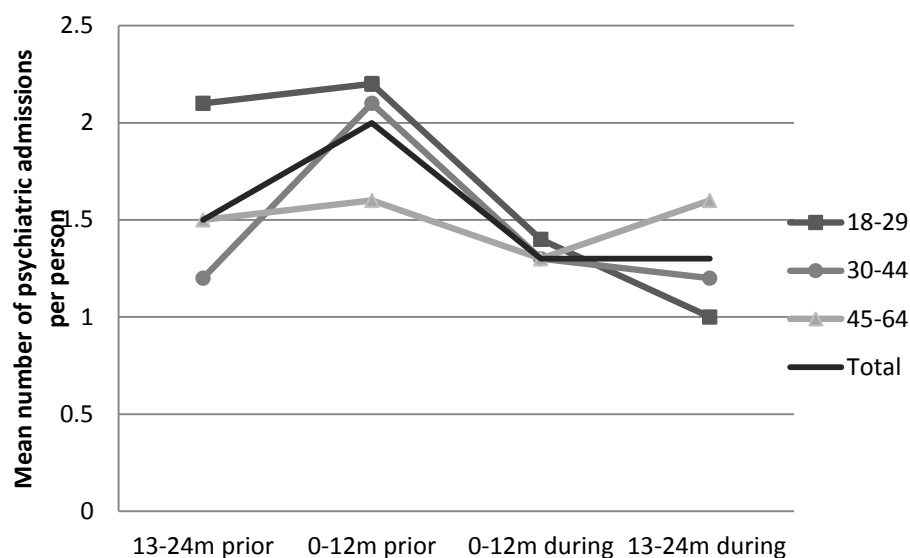
Source: NSW Health, Admitted Patient Data Collection in the State HIE. Annualised data July 1999-June 2009 n=197

Notes: 1. Wilks' Lambda, one-way repeated measures ANOVA

2. Partial eta squared

3. One-way between-groups ANOVA

**Fig E.3: Mean number of mental health admissions per person by age group**



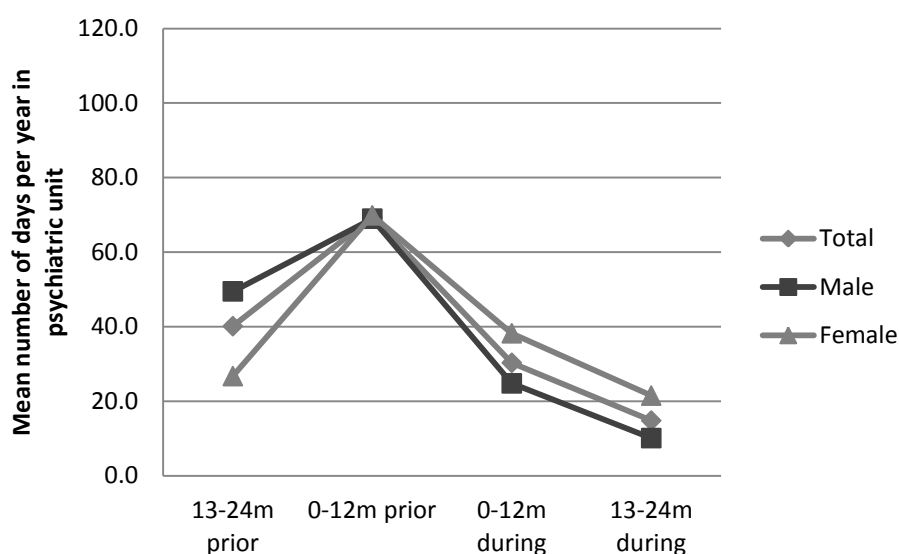
Source: NSW Health, Inpatient Admissions Database July 1999-June 2009 n=197

**Table E.4 Longitudinal analysis of the mean number of days per year spent in mental health ward by gender**

	Consumers	13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total	197	40.1	69.3	30.3	14.8	0.000	0.247
Men	116	49.5	69.0	24.8	10.1	0.000	0.304
Women	81	26.7	69.9	38.2	21.5	0.000	0.218
Sig.		.056	.951	.164	.025		



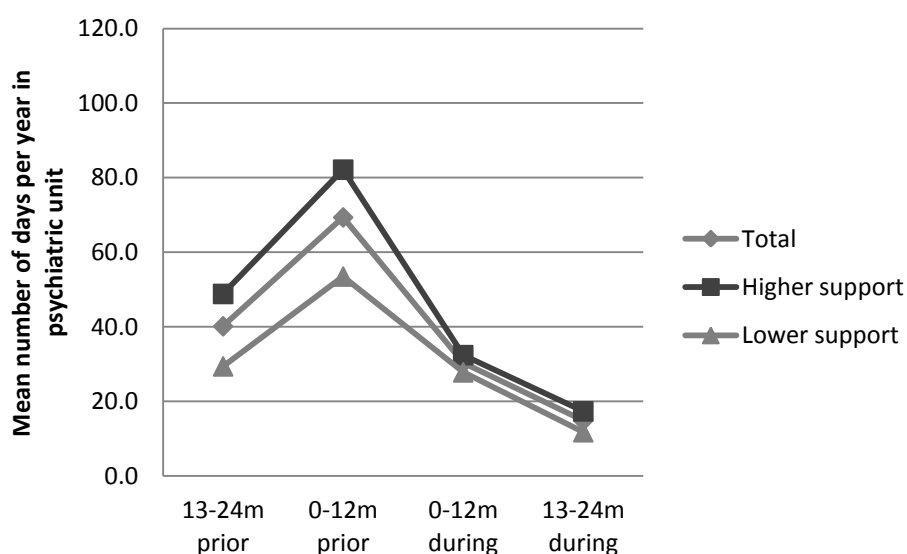
**Fig E.4: Mean number of days per year in mental health ward by gender**



**Table E.5 Longitudinal analysis of the mean number of days per year spent in mental health ward by support level**

	Consumers	13-24m prior Year 1	0-12m prior Year 2	0-12m during Year 3	13-24m during Year 4	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total	197	40.1	69.3	30.3	14.8	0.000	0.247
Higher support	109	48.8	82.1	32.4	17.3	0.000	0.289
Lower support	88	29.4	53.5	27.8	11.7	0.000	0.218
Sig.		.099	.045	.629	.381		

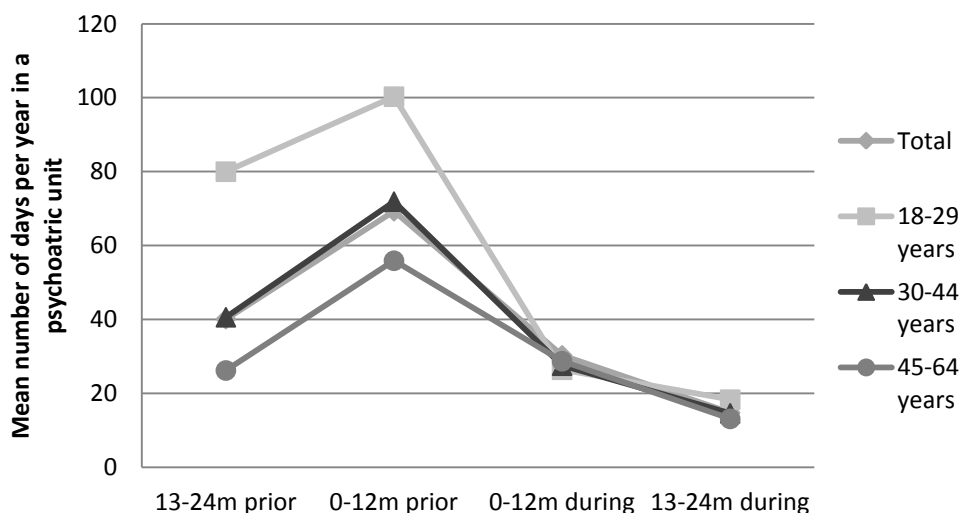
**Fig E.5: Mean number of days per year in mental health ward by support level**



**Table E.6 Longitudinal analysis of the mean number of days per year spent in mental health ward by age**

Consumers		13-24m prior	0-12m prior	0-12m during	13-24m during	Sig. <sup>1</sup>	Effect size <sup>2</sup>
		Year 1	Year 2	Year 3	Year 4		
Total	197	40.1	69.3	30.3	14.8	0.000	0.247
18-29 years	29	80.0	100.3	26.4	18.3	0.000	0.533
30-44 years	84	40.6	71.9	27.5	14.6	0.000	0.218
45-64 years	78	26.2	55.9	28.7	13.1	0.000	0.217
65+	6	20.8	58.7	109.8	22.4	0.714	0.329

**Fig E.6: Mean number of days per year in mental health ward by age group**

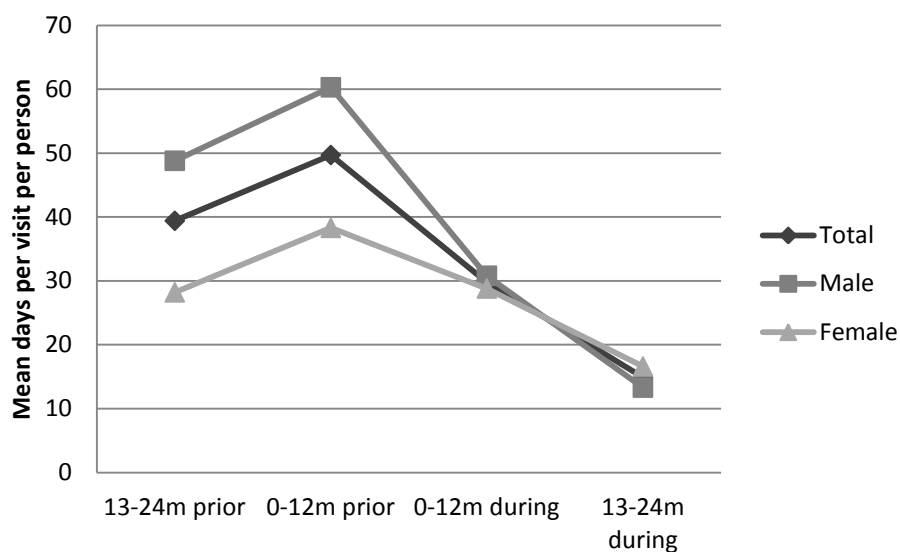


**Table E.7: Longitudinal analysis of the mean number of days per admission, by gender**

	13-24m prior Year 1 (n=109)	0-12m prior Year 2 (n=139)	0-12m during Year 3 (n=94)	13-24m during Year 4 (n=77)	Sig. <sup>2</sup>	Effect size <sup>3</sup>
Total <sup>1</sup>	39.4	49.7	29.8	14.9	0.001	0.040
Men	48.8	60.3	30.8	13.3	0.003	0.063
Women	28.2	38.3	28.8	16.6	0.086	0.020
Sig. <sup>4</sup>	0.124	0.070	0.851	0.519		

Note: 1. this analysis investigates the time spent at each admission and only consumers that had at least a visit both prior to and during HASI are included. 2. One-way ANOVA 3. Between groups sum of squares / Total sum of squares (ANOVA) 4. Independent sample t-test

**Figure E.7: Mean number of days per visit, mental health admissions, by gender**

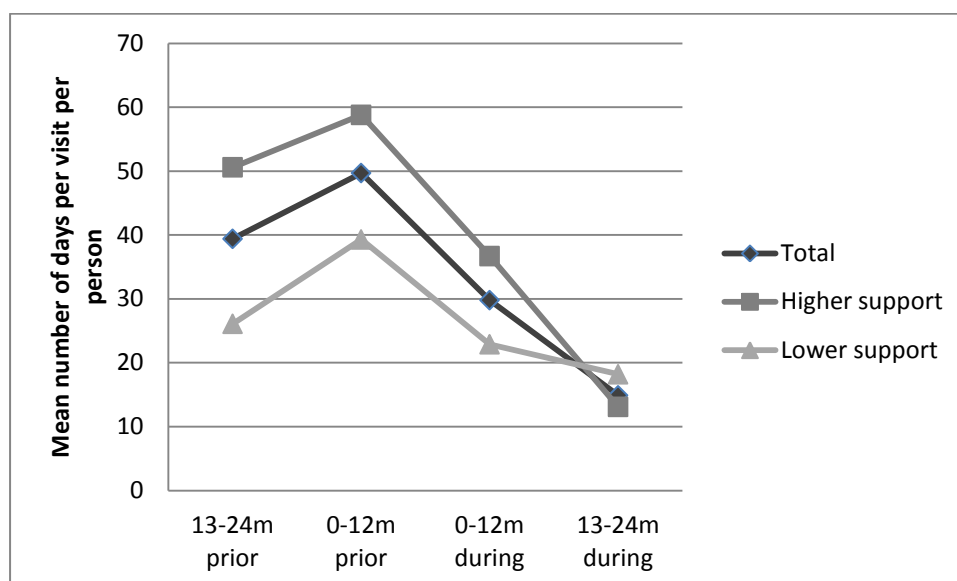


**Table E.8: Longitudinal analysis of the mean number of days per admission, by support level**

	13-24m prior Year 1 (n=109)	0-12m prior Year 2 (n=139)	0-12m during Year 3 (n=94)	13-24m during Year 4 (n=77)	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total <sup>1</sup>	39.4	49.7	29.8	14.9	0.02 <sub>3</sub>	0.040
Higher support	50.6	58.8	36.7	13.1	0.00 <sub>1</sub>	0.067
Lower support	26.1	39.3	22.9	18.2	0.25 <sub>4</sub>	0.021
Sig. <sup>4</sup>	0.067	0.107	0.208	0.334		

Note: 1. this analysis investigates the time spent at each admission and only consumers that had at least a visit both prior to and during HASI are included. 2. One-way ANOVA 3. Between groups sum of squares / Total sum of squares (ANOVA) 4. Independent sample t-test

**Figure E.8: Mean number of days per visit, mental health admissions, by support level**

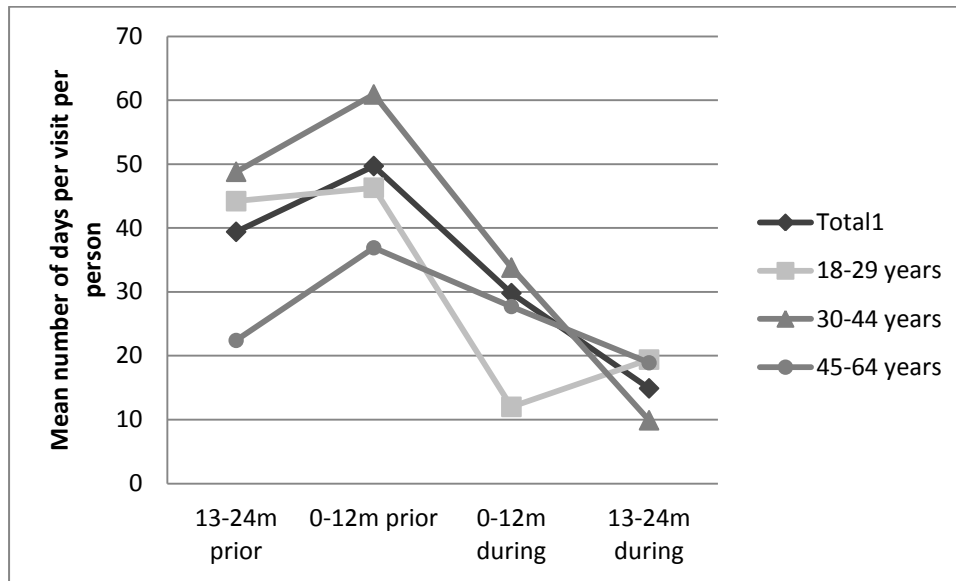


**Table E.9: Longitudinal analysis of the mean number of days per admission, by age**

	13-24m prior Year 1 (n=109)	0-12m prior Year 2 (n=139)	0-12m during Year 3 (n=94)	13-24m during Year 4 (n=77)	Sig. <sup>2</sup>	Effect size <sup>3</sup>
Total <sup>1</sup>	39.4	49.7	29.8	14.9	0.001	0.040
18-29 years	44.2	46.3	12.0	19.4	0.015	0.103
30-44 years	48.8	60.9	33.8	9.9	0.011	0.058
45-64 years	22.4	36.9	27.7	18.9	0.199	0.039
65+ <sup>4</sup>	23.4	19.4	182.5	19.0	0.206	0.417
Sig. <sup>2</sup>	0.400	0.288	0.000	0.352		
Effect size <sup>3</sup>	0.027	0.027	0.212	0.043		

Note: 1. this analysis investigates the time spent at each admission and only consumers that had at least a visit both prior to and during HASI are included. 2. One-way ANOVA 3. Between groups sum of squares / Total sum of squares (ANOVA) 4. Sample size smaller than 5, results statistically not reliable

**Figure E.9: Mean number of days per visit, mental health admissions, by age group**



## F. EMERGENCY DEPARTMENT ADMISSIONS

**Table F.1 Mean number of emergency department contacts per person per year (n=318)**

	13-24 months prior to HASI	0-12months prior to HASI	0-12months during HASI	13-24months during HASI
Mean	2.3	2.8	1.7	0.7
Median	1.0	1.0	0	0
Minimum	0	0	0	0
Maximum	69.0	53.0	25.0	18

**Table F.2 Total hours per year in the emergency department (n=318)**

	13-24 months prior to HASI	0-12months prior to HASI	0-12months during HASI	13-24months during HASI
Mean	13.2	18.7	8.3	3.9
Median	1.6	3.8	0	0
Minimum	0	0	0	0
Maximum	460.0	404.1	202.7	112.5

**Table F.3 Mean number of hours per contact, only consumers with at least one contact in that respective period (does not include consumers that had 'zero' or 'missing data')**

	13-24 months prior to HASI	0-12months prior to HASI	0-12months during HASI	13-24months during HASI
Mean	6.2	7.6	4.9	5.6
Median	3.9	4.3	3.8	4.1
Minimum	0.17	0.2	0.17	0.5
Maximum	70.1	77.4	31.0	27.6
N	203	221	152	82

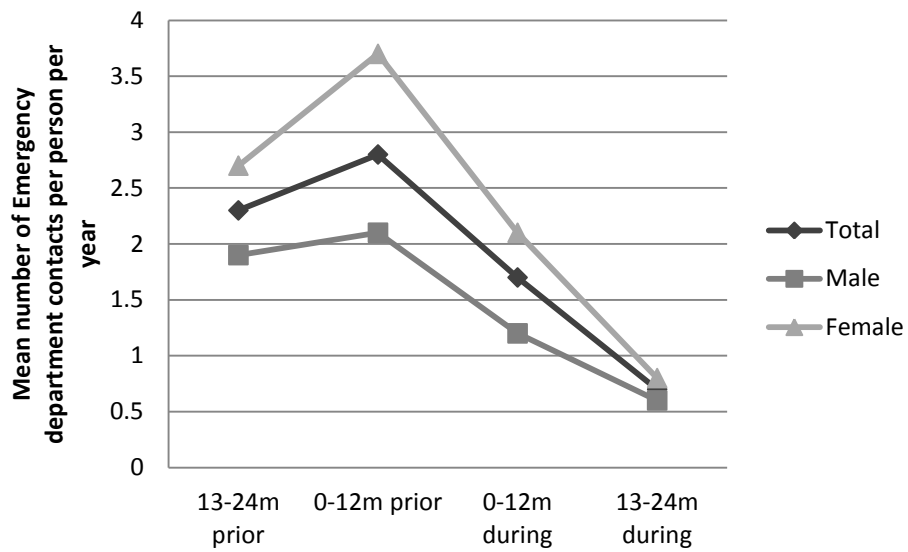
**Table F.4 Longitudinal analysis of the annual number of emergency department contacts, by gender, support level and age group**

Consumers	13-24 months prior to HASI	0-12 months prior to HASI	0-12 months during HASI	13-24 months during HASI	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total	318	2.3	2.8	1.7	0.7	0.000
Men	169	1.9	2.1	1.2	0.6	0.000
Women	149	2.7	3.7	2.1	0.8	0.000
Sig. <sup>3</sup>	0.306	0.061	0.009	0.307		0.166
Lower support	178	2.6	3.1	1.8	0.4	0.000
Higher support	140	1.9	2.5	1.5	1.0	0.012
Sig. <sup>3</sup>	0.284	0.729	0.561	0.004		0.076
18-29 years	72	2.5	3.2	1.7	0.7	0.001
30-44 years	115	2.3	3.5	2.4	0.9	0.000
45-64 years	95	2.3	2.4	1.1	0.5	0.000
Sig. <sup>4</sup>	0.970	0.362	0.023	0.204		0.227
Effect size <sup>5</sup>	0.0002	0.007	0.026	0.011		

## Note:

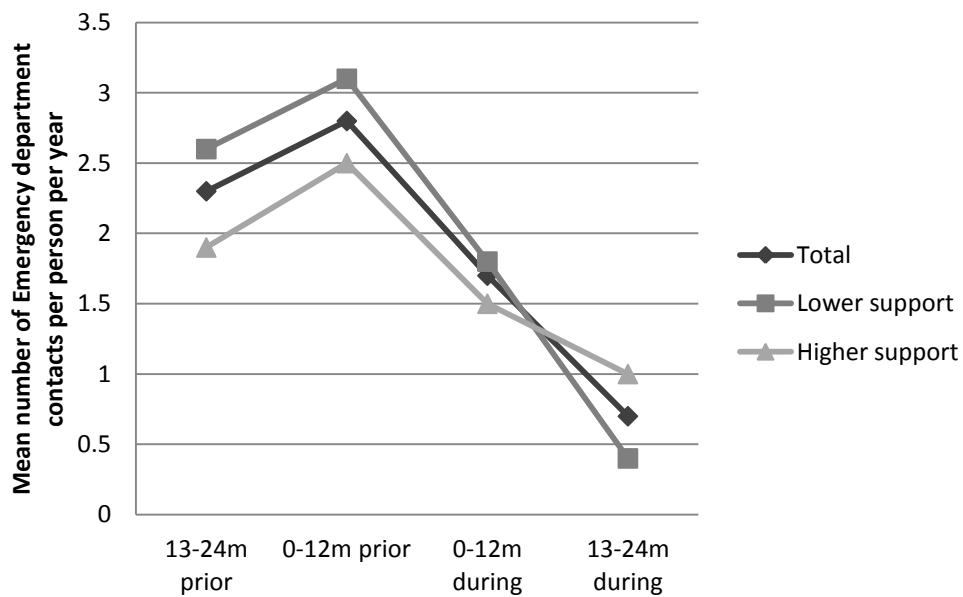
1. Wilks' Lambda
2. Partial eta square
3. Independent sample t-test
4. One-way ANOVA
5. Effect size= Between sum of squares/Total sum of squares; small:0.01; medium:0.059; large: 0.138 (Cohen, 1988)

**Figure F.1: Mean number of Emergency department contacts per person per year, by gender**



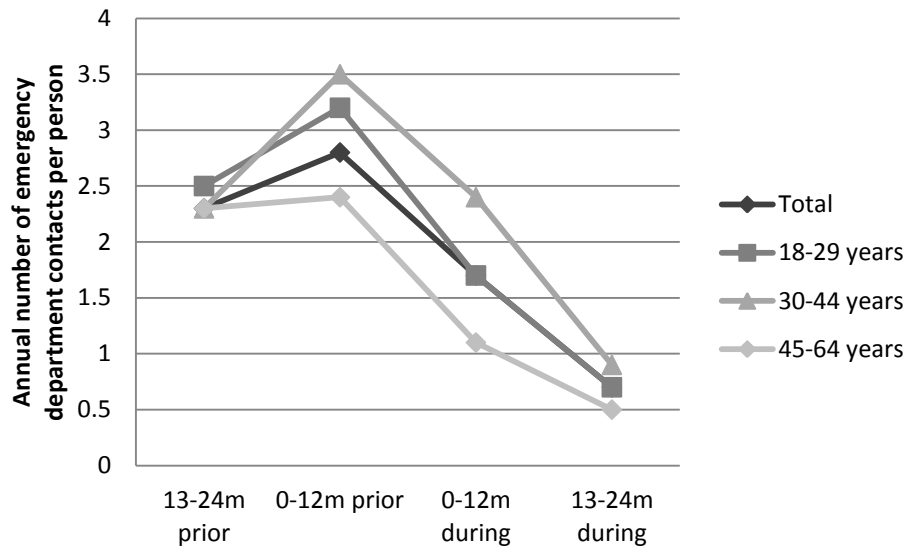
**Figure F.2: Mean number of Emergency department contacts per person per year,**

**by support level**





**Figure F.3: Mean number of Emergency department contacts per person per year, by age group**



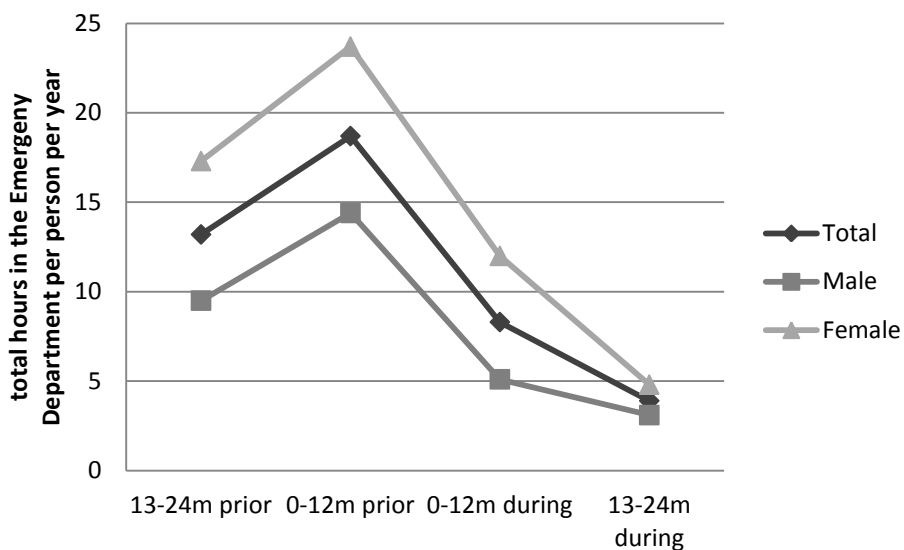
**Table F.5 Longitudinal analysis of the total hours spent in the emergency department by gender, support level and age group**

Consumers		13-24 months prior to HASI	0-12 months prior to HASI	0-12 months during HASI	13- 24months during HASI	Sig. <sup>1</sup>	Effect size <sup>2</sup>
Total	31 8	13.2	18.7	8.3	3.9	0.00 0	0.123
Men	16 9	9.5	14.4	5.1	3.1	0.00 0	0.197
Women	14 9	17.3	23.7	12.0	4.8	0.00 0	0.126
Sig <sup>3</sup>		0.058	0.040	0.002	0.217		
Lower	17 8	13.7	19.3	9.0	1.9	0.00 0	0.192
Higher	14 0	12.5	18.0	7.4	6.5	0.01 8	0.071
Sig <sup>3</sup>		0.764	0.762	0.485	0.001		
18-29 years	72	14.1	21.7	6.5	3.4	0.00 7	0.159
30-44 years	11 5	10.9	21.9	13.5	5.2	0.00 1	0.140
45-64 years	95	16.2	16.0	5.3	2.2	0.00 1	0.171
Sig. <sup>4</sup>		0.599	0.542	0.013	0.191		
Effect Size <sup>5</sup>		0.003	0.004	0.030	0.011		

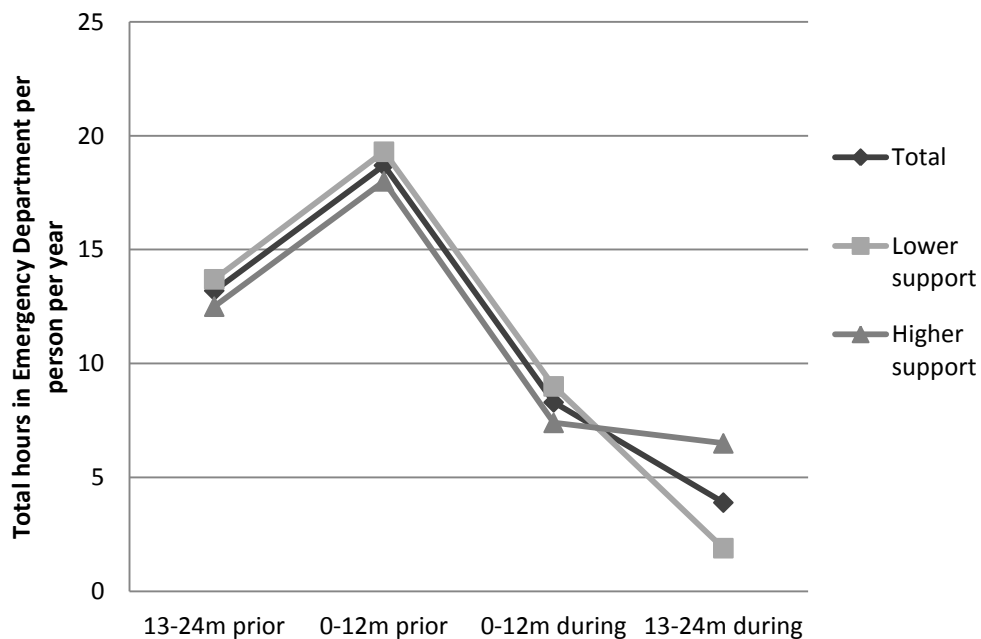
Note:

1. Repeated sample ANOVA
2. Partial eta squared
3. Independent sample t-test
4. One-way ANOVA
5. Effect size= Between sum of squares/Total sum of squares; small:0.01; medium:0.059; large: 0.138 (Cohen, 1988)

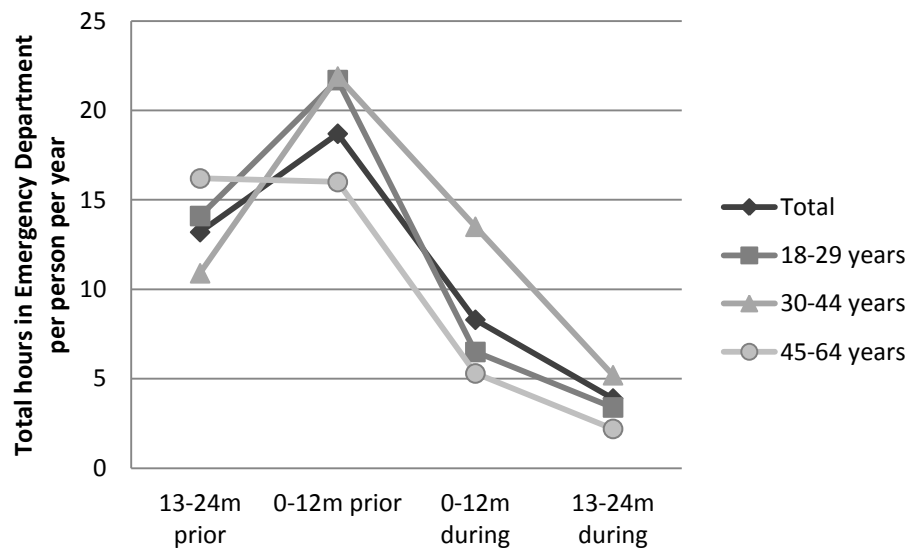
**Figure F.4: Total hours in Emergency department, per person, per year, by gender**



**Figure F.5: Total hours in Emergency department, per person, per year, by support level**



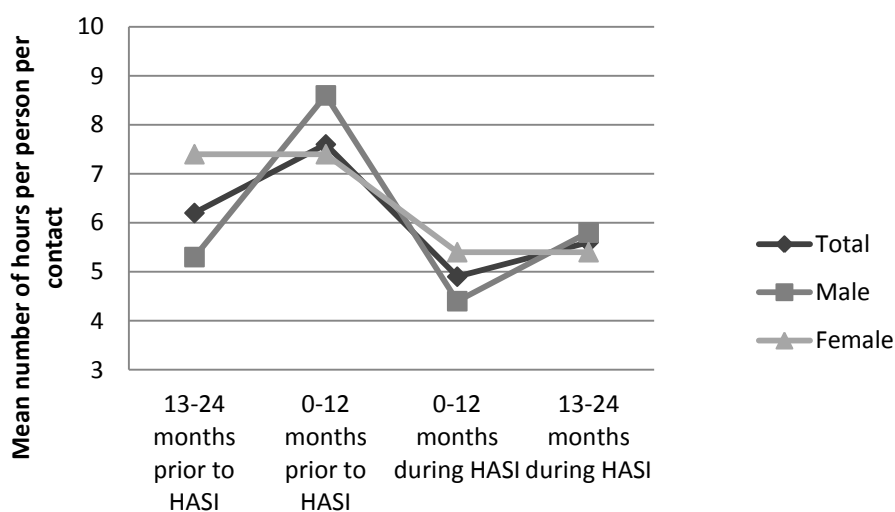
**Figure F.6: Total hours in Emergency department, per person, per year, by age group**



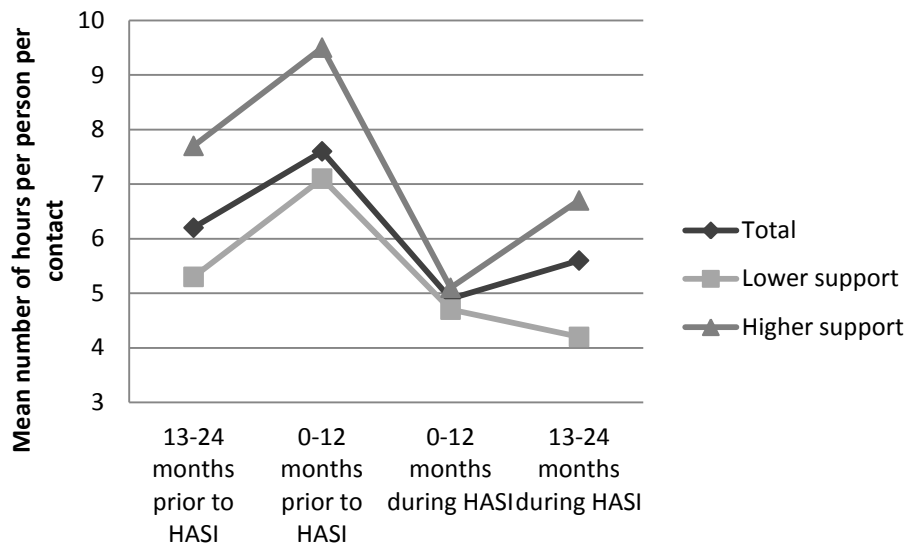
**Table F.6 Longitudinal analysis of the mean number of hours per contact, by gender, support level and age group**

	13-24 months prior to HASI	N	0-12 months prior to HASI	N	0-12 months during HASI	N	13-24 months during HASI	N
Men	5.3	96	8.6	99	4.4	83	5.8	46
Total	6.2	203	7.6	221	4.9	152	5.6	82
Women	7.4	82	7.4	101	5.4	69	5.4	36
Lower support	5.3	105	7.1	121	4.7	91	4.2	34
Higher support	7.7	73	9.5	79	5.1	61	6.7	48
18-29 years	5.8	41	8.5	50	4.1	38	5.3	17
30-44 years	5.6	65	8.8	65	5.3	60	4.9	31
45-64 years	7.6	53	6.6	66	4.4	40	4.4	25
65+	-	-	-	-	-	-	-	-

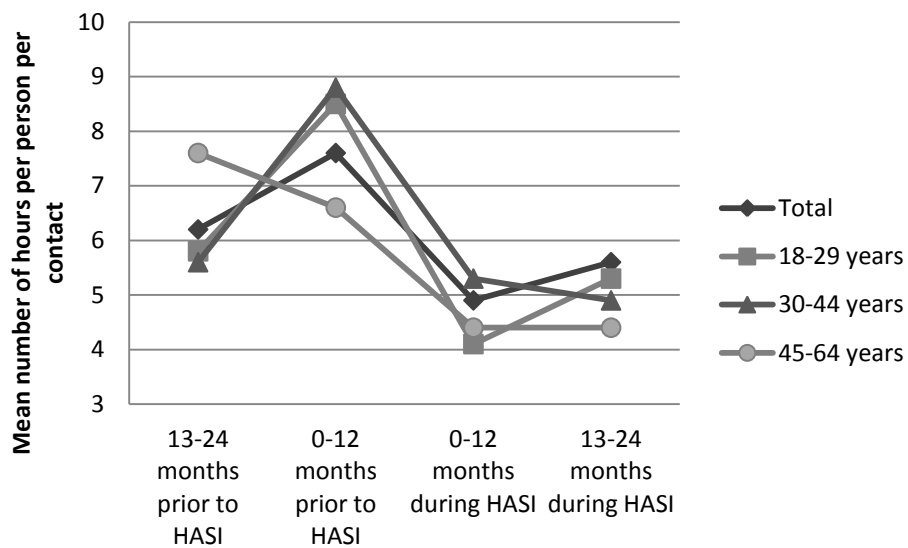
**Figure F7: Longitudinal analysis of the mean number of hours per contact, by gender**



**Figure F8: Longitudinal analysis of the mean number of hours per contact, by support level**



**Figure F9: Longitudinal analysis of the mean number of hours per contact, by age group**



## G. PERSONAL WELLBEING INDEX

Consumers rated their personal wellbeing lower than the population norm and the average wellbeing did not change during the evaluation (Table xxx). The personal wellbeing index is a standardised self-rating scale of aspects of wellbeing. Consumers interviewed for the evaluation completed the scale in 2009 and 2010 (Appendix 1).

In 2009 (n=59) consumers reported feeling more satisfied with their life overall compared with consumers in the evaluation of HASI stage one (62.6 compared with 54.4 in Stage One) but lower than the Australian population norm (tablexxx). Analysis by level of HASI support was not available, but the increase in life satisfaction over this period is consistent with the expansion of HASI to include consumers receiving lower level support who were likely to have less severe mental health problems.

**Table G.1: Mean personal wellbeing compared to Australian population, 2009, 2010**

	2009		2010		Australian population norm <sup>a</sup>
	Consumers	Mean	Consumers	Mean	
Total Personal Wellbeing Index	59	67.5	44	65.3	75.9
Life as whole	55	62.6	44	62.7	78.6
Standard of living	20	69.0	44	68.4	78.7
Health	54	57.6	44	61.5	75.1
Achievements	20	72.3	44	61.3	73.6
Relationships	55	65.9	42	67.0	80.2
Safety	58	74.3	44	72.6	81.3
Community	57	71.6	43	63.4	73.0
Security	20	73.5	42	61.9	70.5

Source: Consumer interviews September 2009, 2010 n=66

a. Australian Unity Wellbeing Index, Report 20.1, 2009.

Average personal wellbeing scores were lower for the smaller sample of consumers who completed the PWI in 2010 and the scores did not change one year later (Table G.2).<sup>87</sup>

<sup>87</sup> Analysis of change in personal wellbeing for consumers with scores in both years.

**Table G.2: Change in Personal Wellbeing, 2009, 2010**

	Consumers	2009	2010	Sig. <sup>1</sup>
Total PWI	37	68.4	64.5	0.093
Life as whole	35	63.6	62.7	0.810
Standard of living	17	68.2	68.5	0.959
Health	35	61.3	59.7	0.694
Achievements	17	70.3	56.5	0.047
Relationships	34	65.1	64.7	0.922
Safety	36	75.7	72.6	0.410
Community	35	69.7	63.6	0.058
Security	16	68.8	63.1	0.378

Source: Consumer interviews September 2009, 2010 n=37

Notes: 1. Significance paired sample t-test. The significance tests are not reliable because of the small number of consumers to have completed a PWI is small. Furthermore, not all 37 consumers for whom the PWI score was calculated answered all seven items of the index, reducing the reliability of the measure.

The means for the total personal wellbeing index in the two years are very similar and the median has decreased, but the standard deviation and variance have reduced by approximately one third indicating that the groups of consumers became more homogenous (Table G.3)

**Table G.3: Total Personal Wellbeing Index descriptive statistics 2009, 2010 for repeated sample**

	2009	2010
Mean	68.4	64.5
Median	70.0	67.1
Standard deviation	17.0	15.8

Source: Consumer interviews September 2009, 2010 n=37

Notes: Correlation PWI 1-2: 0.646, Sig.=0.000; Paired sample t-test of equivalence of means: 0.093 The significance tests are not reliable due to the small number of consumers to have completed a PWI. Furthermore not all consumers answered all items of the PWI leading to a further reduction in the reliability of the index for statistical purposes.

Explanations for the change in personal wellbeing index could include the sample (small sample and incomplete responses); a temporary decrease in wellbeing, reflecting the particular time the measures were taken, or a longer term decrease in wellbeing, reflecting more difficult life responsibilities the consumers were now facing having been in the program for a longer time. The qualitative interview data did not show a decrease in wellbeing so the most likely explanation is that the PWI analysis is a measurement error.



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