# Housing and Accommodation Support Initiative: Report III Summary

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# HOUSING AND ACCOMMODATION SUPPORT INITIATIVE EVALUATION

## REPORT III SUMMARY

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**Abbreviations**

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| AHS | Area Health Service |
| AMHS | Area Mental Health Service(s) |
| AIHW | Australian Institute of Health and Welfare |
| ASP | Accommodation support provider(s) |
| CANSAS | Camberwell Assessment of Need Short Appraisal Schedule |
| CID | Client Information Database |
| CMH | Centre for Mental Health |
| DoCS | Department of Community Services |
| DoH | NSW Department of Housing |
| GAF | Global Assessment of Functioning Scale |
| GP | General practitioners |
| HASI | Housing and Accommodation Support Initiative |
| HP | Housing provider |
| MH-OAT | Mental Health Outcomes and Assessment Training |
| NGO | Non-government organisation |
| NSW | New South Wales |
| OH&S | Occupational health and safety |
| PWI | Personal Wellbeing Index |
| SPRC | Social Policy Research Centre |
| TAFE | Technical and Further Education |
| UNSW | University of New South Wales |

## Background

This is the summary of the third report on the fieldwork for the evaluation of the Housing and Accommodation Support Initiative Stage One (HASI). HASI is a partnership between NSW Health, NSW Department of Housing (DoH) and non-government organisations (NGOs). The program's objectives are to assist people with mental health problems to acquire and maintain stable housing, to improve community participation and quality of life and to provide a system of supportive stakeholders to work with people with mental illness towards recovery or maintenance (NSW Health & NSW Department of Housing 2005).

This summary presents the findings from the final phase of fieldwork (February and March 2006) and the longitudinal outcomes from Phases 1, 2 and 3. It should be read in conjunction with the full third report (Muir et al, 2007a). The longitudinal findings are based on over 600 interviews with HASI stakeholders, including 219 client interviews (Table 1). The third report complements the other evaluation reports and plan (Morris et al, 2006; Morris et al, 2005; Muir et al, 2005, 2007b). These three reports form the background for the final evaluation report forthcoming in 2006.

**Table 1: Evaluation Cohorts at Phase 1, 2 and 3**

| Stakeholder group | Interviewed Feb/March 2005 | Interviewed Sept/Oct 2005* | Interviewed Feb/March 2006 | Interviewed all phases |
|---|---|---|---|---|
| Clients | 71 | 79 | 69 | 55 |
| ASP key workers | 61 | 61 | 52 | 21 |
| ASP managers | 10 | 11 | 10 | 5 |
| AMHS case managers | 30 | 35 | 36 | 8 |
| AMHS team leaders and managers | 9 | 10 | 6 | 3 |
| Housing provider personnel | 11 | 9 | 10 | 6 |
| Family/carers | 27 | - | 13 | - |
| Consumer advocates | 2 | - | 5 | - |
| DOH/CMH personnel | 2 | - | 4 | - |

Note: * Not all stakeholders were interviewed in Phase 2 of the evaluation as in the evaluation plan.

## Evaluation Findings

The evaluation found HASI is mediating some of the effects of mental illness for many people in the program. The program provides an inter-woven system of support from housing providers, Area Mental Health Services (AMHS) and accommodation support providers (ASP). This enabled people to maintain their tenancies, increase their participation in the community and develop and strengthen social and family networks, among other outcomes. The main findings are as follows.

### Roles, responsibilities and support plans

HASI has allowed AMHS case managers to focus on their core activity – the provision of clinical support, which includes the maintenance and monitoring of mental health.

ASPs provide a range of domestic, emotional, health, employment, educational, advocacy, social and life-based support for clients.

Client need, interests and willingness, along with the process and approach of the organisations, determine the nature and intensity of support provided.

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

All clients interviewed had a documented support plan with their ASP. A good-practice support plan process is client-driven and formulated and implemented in collaboration with AMHS personnel and other stakeholders.

### Referral, assessment and client selection

The majority of ASP and AMHS personnel believe the HASI referral and assessment process is good or excellent.

When stakeholders question selection decisions, it is usually because they believe a selected client is not making the most of an opportunity in which someone else within the system could be taking advantage.

Australian born men under 34 years of age with a diagnosis of schizophrenia remained the most prevalent group of people in HASI.

The proportion of Indigenous Australians decreased between evaluation Phase 2 and 3 and culturally and linguistically diverse (CALD) people remained under-representative of the population, as did females.

### Tenancies

Half of the HASI clients accommodated by housing providers live in a unit or an apartment. The proportion living in townhouses, villas, duplexes and houses has increased since the start of the program. Almost all HASI clients live alone in two-bedroom accommodation.

Clustered accommodation has been successful where the cluster is kept to a maximum number of three or four tenants and the tenant mix is carefully considered.

70 per cent of people accommodated by a housing provider on entry to HASI were still in the same home by the end of March 2006. In the majority of cases, HASI clients' property care is as good as or better than other tenants.

Co-tenancy has been problematic for some people in terms of exploiting and destabilising HASI tenancies, but also because the model excludes shared leases.

Only 17 per cent of HASI clients were in rental arrears during the evaluation – most for less than one month. A minority of HASI tenants experienced problems with neighbours (both as complainants and being complained about).

### Health

Global Assessment of Functioning (GAF) scores are a sound indication of change in mental health among clients over time. In Phase 1, only 38 per cent scored over 50 (out of a possible 100), compared to 76 per cent in Phase 3.

HASI clients continued to have a high level of access to health professionals.

Between entry to HASI and Phase 3 of the evaluation, 71 per cent of clients reported improved mental health, 60 per cent better physical health, 67 per cent improved diet and 78 per cent felt more positive about themselves.

### Living skills

Living skills improved significantly across the group between entering HASI and Phase 3 of the evaluation. The greatest gains in independence (more than a 20 per cent increase) were in banking, medication, diet, exercise and cooking.

Further key worker training would clarify the path from support to maximising the attainment of longer-term independence or reliance on mainstream services.

### Social inclusion and relationships

Recreational activities have played an important role for many clients in building social skills, increasing confidence and in turn, increasing independence and a pathway to work and education. A variety of social options – ASP-organised, disability and mainstream groups – afford clients the best opportunity for meaningful community participation.

83 per cent of clients were participating in at least three of nine community activities measured at Phase 3 (shopping, eating out, library, church, social groups, educational institutions, organised sport, leisure activities or exercise).

43 per cent of clients involved in HASI at Phase 1, 2 and 3 were working and/or studying at the time of the last interview, compared to 9 per cent on entry to HASI.

While 23 per cent of clients did not have any friends when they joined HASI, 94 per cent had established friendships by Phase 3. However, at all evaluation phases, approximately half of all HASI participants reported feeling lonely.

**Exits**

78 per cent of people who started HASI remained in the program in March 2006 (n=113).

Compared to non-Indigenous people participating in HASI, Indigenous retention rates are low (50 per cent).

**Governance**

Approximately 80 per cent of AMHS case managers and ASP key workers reported healthy working relationships with each other. A minority of case managers and key workers are experiencing significantly more difficulty in their collaborative relationship than in the past.

Housing provider and ASP personnel relationships remained stable and overwhelmingly positive throughout the evaluation.

Housing providers and AMHS personnel have minimal contact at an operational level, but middle and upper management have developed good working relationships. AMHS managers were all positive about these relationships, but some housing providers reflected on the need for a more equitable partnership.

Open communication with family members and carers has assisted stakeholders to work well together and maintain trust, and may, in turn, help ASP and AMHS personnel to reinforce strategies and to assist clients to reach goals.

ASP managers reported varying levels of difficulty in regard to recruitment, retention, training and OH&S issues.

ASPs that provided staff training and development, as well as promotional opportunities reaped the reward of loyal and skilled employees with strong stakeholder relationships.

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