Active Linking Initiative (ALI) Evaluation Final Report

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Active Linking Initiative (ALI) Evaluation

Final Report

Robyn Edwards and Karen R. Fisher

SPRC Report 1/10

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February 2010

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All names have been changed in the report to protect privacy and confidentiality.

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Abbreviations

ALI	Active Linking Initiative
BHRP	Boarding House Reform Program
BHSU	Boarding House Standards Unit
CASA	Coalition for Appropriate Supported Accommodation
CALD	Culturally and linguistically diverse
DADHC	Department of Ageing, Disability and Home Care NSW
DSP	Disability Support Pension
HACC	Home and Community Care
HASI	Mental Health Housing and Accommodation Support Initiative NSW
ISP	Individual Service Plan
LRC	Licensed Residential Centre
OPC	Office of Protective Commissioner
PWD	People with Disability
PWI	Personal Wellbeing Index
RSP	Resident Support Program
SDS	Service Description Schedule
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive Summary

The NSW Department of Ageing, Disability and Home Care (DADHC) commissioned the Social Policy Research Centre (SPRC) to evaluate the Active Linking Initiative (ALI). The ALI began in 2000 as one part of the NSW Boarding House Reform Program.

ALI aims to link people who live in Licensed Residential Centres (LRC, commonly known as licensed boarding houses) into the community in ways which are meaningful and sustainable. ALI support is a contracted service funded by DADHC and provided by nongovernment organisations (NGO). It aims to facilitate community based activities based on a person's goals, building individual skills to enhance their independence and integration within the community.

The evaluation included process, client outcomes and economic evaluation. Methods included literature review and desk top analysis; data collection through interviews and site visits; and cost effectiveness analysis.

Profile

As at June 2008, NSW had 44 LRCs (40 in 2009). LRCs provided 930 beds with an occupancy rate of 89 per cent. Most residents were aged over 42 years (86 per cent), male (72 per cent) and had a psychiatric disability (60 per cent).

ALI providers are funded $2490 per LRC bed in their location each year. The budget for 2008/09 was $2,435,910. The average cost per person supported was $5,620.

ALI providers report that they provide in-home accommodation support, other accommodation support, learning and life skills development or community access service types. Within the limitations of the data, the number of people receiving support seems stable (453-533 clients p.a.). Clearer definitions and instructions for ALI providers about MDS reporting are required if the MDS data are to be useful for informing program improvements, such as performance against the service agreement.

Consumer experiences and outcomes

Four case study residents who had benefited from participating in ALI were interviewed. Their experiences demonstrate how ALI fosters and builds client outcomes and how outcomes could be strengthened.

- ALI provides positive consumer outcomes for some residents of boarding houses.
- Residents' positive personal wellbeing ratings on life domains and their future may be related in part to their involvement with ALI. Some residents also spoke about having positive relationships with the boarding house manager, who assisted them with their problems.
- The relationship between the ALI worker and residents seems critical to the effectiveness of ALI. Most residents said they liked the ALI workers.
- Residents participated in community access and recreational activities, but had done little formal skills development and generally could not name new skills they had acquired through the ALI activities

- Participation in community based activities increased, consistent with the preferences of the person using ALI, such as recreation in community clubs and going to a café.
- Links to sustained activities with community members increased, such as gardening.
- Individual and group participation in community activities increased, such as attending craft groups, sports and exercise.
- Personal wellbeing tended towards the population norm. For some people it was closer to a norm for people with a mental health condition.
- Social and family relationships improved for some people. For others it remained a long term goal to reconcile with family members and gain friendships outside the LRC.
- Employment and formal education did not increase because of disability, stigma and availability of suitable opportunities.

Cost effectiveness

In the best cases it is likely that the return on investment of $5,620 per person who uses the program per year ($2,490 per LRC bed) includes increased community based activities, linkages and participation for the person; improved personal wellbeing towards the population norm; and increased social contact. For some people it also returns improved relationships with family members and possibly long term reconciliation with family and formation of friendships. The evaluation did not show evidence of impact on participation in employment and education. Other examples of outcomes included successful transition out of hospital based psychiatric care and personal care skill development.

Access to ALI

ALI providers were least likely to engage with people with unmanaged mental health problems or a long history of isolation due to prior institutionalisation. Investment in time to build rapport was necessary to help these people to develop trust so that they can benefit from ALI support. Poverty prevents some people from participating in ALI support because of the cost of the activity, transport and clothing suitable for going out. DADHC could monitor client reach and support ALI providers by assisting them to share good practices about how to engage people with greatest unmet need.

Some LRC managers treat ALI as a recreation service rather than individualised disability support to develop capacity for community participation. At worst, this attitude results in their preference for group activities, in-home activities and punitive action preventing access to ALI support based on behaviour in the LRC seen as noncompliant by the LRC staff.

ALI was less likely to engage with people from Indigenous and culturally and linguistically diverse backgrounds, with the exception of LRCs in the Metropolitan South region which have higher numbers of CALD residents. Partly this is because fewer people are identified as being from these backgrounds. Good practice by ALI providers includes linking people from diverse backgrounds to specialist support workers, interpreter and culturally relevant groups and activities. Individualised responses are most likely to identify and address these needs.

Opportunities for community participation are affected by location, such as availability of activities and community social groups, distance from activities, availability of public transport and cost.

Implications for the effectiveness of the ALI program

Characteristics of effective practice to deliver outcomes for LRC residents include: strong interpersonal relationships between ALI workers and residents based on trust and respect; professional and pragmatic relationships between ALI, LRC manager and staff, DADHC caseworkers and other service providers; active ISP process to build capacity from the person's interests, strengths and abilities of the resident; person-centred and individualised approach; ability to build relationships and link to social networks, community opportunities and other service providers; and partnerships and collaboration between ALI and local community organisations.

Service improvement and development of ALI needs to be guided by contemporary directions in the provision of disability support, related to person-centred support, greater flexibility, individual planning and skills development. Key areas for program development identified by the evaluation include: fostering a stronger network across ALI providers statewide; community education about mental illness; sustainability of community linkages; development of stronger partnerships and collaboration with local community organisations; responding to the characteristics of the resident group within a recovery framework; and responding to diversity within the resident population. ALI skills development could focus on residents learning daily living skills and skills for independent living. This would recognise the possibility of boarding house closure or residents choosing to move to more independent accommodation. Further, the key characteristic and aim of the ALI as a 'linking' initiative lends itself to broadening the focus of linking, to one able to promote partnerships and service integration.

Some concerns regarding the licensed boarding house sector were raised during the evaluation. In particular the way some boarding house managers use the withdrawal of ALI. Adequate legislation and implementation is required to safeguard against practices that breach residents' rights; together with monitoring and review of the LRC sector by DADHC. Many problems faced by the residents that ALI workers become aware of relate to the LRC environment rather than community participation questions.

All providers and stakeholders referred to the low funding levels as a major service constraint. In particular the funding did not allow for adequate individual and person-centred service. Instead the ALI program was used primarily for group and centre based activities, being a more affordable option. Funding levels for the ALI need to be commensurate with other DADHC Programs which are based on individualised support, such as Community Participation and new Day Programs currently in development.

Finally, while development and growth of ALI can be informed by and reflect, the principles outlined in the current day program reform agenda, it is also important for the ALI to retain its own identity, characteristics and strengths. Using these strengths, to move from a linking initiative to a program based on social inclusion for boarding house residents would be a positive development for the program

1 Introduction

1.1 Background

The NSW Department of Ageing, Disability and Home Care (DADHC) commissioned the Social Policy Research Centre (SPRC) to evaluate the Active Linking Initiative (ALI). The ALI began in 2000 as one part of the NSW Boarding House Reform Program.

ALI aims to link people who live in Licensed Residential Centres (LRC, commonly known as licensed boarding houses) into the community in ways which are meaningful and sustainable. ALI services are provided by nongovernment organisations (NGO) and aim to facilitate community based activities based on a person's goals, building individual skills to enhance their independence and integration within the community.

The objectives of the research are to evaluate to what extent the ALI has provided services to people with disability resident in licensed boarding houses as intended and to what extent the program as a whole is achieving its intended outcomes. The purpose is for service development and improvement.

The ALI has three program goals to:

- facilitate access of LRC residents to community based recreation and leisure services and mainstream educational and vocational agencies;
- assist LRC residents to create sustainable community linkages; and
- facilitate activities representing the three components of ALI: skills development; community based recreational/leisure opportunities; and educational and vocational training opportunities.

The participants and stakeholders in an ALI are:

- people who live in the LRC (residents) and use ALI support;
- the owner, manager and staff in the LRC where the residents live;
- the manager and staff in the organisation that provides the ALI support. The providers are an NGO, often a community service provider such as a neighbourhood centre. DADHC funds the ALI program;
- DADHC Boarding House Reform caseworkers who work with LRC residents as part of the wider reform responsibility and liaise with the ALI providers; and
- other service providers such as Home and Community Care (HACC) providers, primary health care providers, disability organisations and advocacy groups, including the Coalition for Appropriate Supported Accommodation (CASA) and People with Disability Australia (PWD).

The evaluation examines to what extent the ALI program goals are being met; how the goals can be better supported; and what options exist for service development and improvement. The evaluation was conducted from December 2008 to April 2009.

The evaluation design was informed by the findings of the Review into ALI conducted by DADHC (2004). The Review found there was a high level of acceptance of ALI by residents and LRC managers and that ALI represented value-for-money. Further, it found that ALI,

> 'supported the broader aims of boarding house reform by enriching the lives of boarding house residents and impacting favourably on the industry.' (DADHC, 2004:4)

Recommendations from the Review included providing a clearer statement of the program's aims, responding to the diversity of the resident population, focusing on individual needs and outcomes rather than prescribed activities, linking expenditure to individual service plans and reducing barriers specific to rural ALI programs. As a result of the Review, DADHC developed an ALI service type description (SDS) which outlines the three key service activities of skills development, community access and integration and leisure and recreation. In light of the changing nature of the boarding house sector, it also recommended there be another review of the ALI program undertaken at a later date, which is this evaluation.

1.2 Policy Context

Current policy developments and reform agendas in the disability support and mental health sectors informed the evaluation. They have implications for the directions of change for ALI.

- *Stronger Together* outlines a new direction for disability services in NSW and promotes a more flexible and innovative system for people with disability, their families and carers – a system that does not assume one size fits all and is not just more of the same (DADHC, 2006).
- A consultation paper on new directions in day programs is in the public domain, Life Choices and Active Ageing (DADHC, 2009).
- NSW Disability Service Standards set out the NSW government's commitment to ensuring the quality of services that people with disabilities receive (Disability Services Act, 1993).
- NSW Framework for Rehabilitation for Mental Health provides a focus for people with mental illness developing and finding supportive environments (NSW Health, 2002).
- The recovery approach to mental illness emphasises a person seeking a valued sense of identity and purpose outside the parameters of mental illness and living a positive life despite any limitations resulting from the illness (Edwards et al, 2009).

1.3 Evaluation Questions

The key evaluation questions are listed below.

a) Has ALI provided services as intended (in relation to the service type description and reasons for variation), including services designed around individual plans?

b) Is the program achieving its intended outcomes:

- To facilitate access of LRC residents to community based recreation and leisure services and mainstream educational and vocational agencies;
- To assist LRC residents to create sustainable community linkages;
- To identify the level of participation and type of activities undertaken, representing the three components of ALI: pre-skilling; community based recreational/leisure opportunities; and educational and vocational training opportunities?

c) How effectively do ALI providers manage funds to ensure equitable outcomes for the LRC resident population (in terms of expenditure against individual plans and access to brokered services)?

d) Does service delivery vary across regions and between services, including consideration of issues specific to rural areas and what are the reasons for the variation?

e) What type of service model (or parts of the service model) is most effective in achieving service outcomes for LRC residents?

f) What other community participation models and approaches (including from other jurisdictions) exist which may inform ALI and the wider Boarding House Reform Program service development?

g) How do services respond to people from an Aboriginal or CALD backgrounds?

h) What are the key barriers and enablers to effective partnerships between DADHC, ALI service providers and LRCs in achieving the intended outcomes?

i) Which LRC residents do not have access to ALI and why?

1.4 Evaluation Methods

The evaluation methodology includes process, client outcomes and economic evaluation (Edwards and Fisher, 2008). Methods include literature review and desk top analysis; data collection through interviews and site visits; and cost effectiveness analysis (Table 1.1). Data collection instruments are modified from existing instruments used to evaluate similar boarding house resident support programs across Australia, including the Personal Wellbeing Index (PWI).

Four consumers participated in case study interviews. ALI providers selected these four consumers as representing people who had benefited significantly from participating in ALI (most significant outcome evaluation approach). An additional two consumers participated in shorter consultations about ALI in the presence of the LRC manager.

Interview schedules were designed for the ALI consumers, ALI providers, LRC managers and DADHC caseworkers (Appendix A).

Table 1.1: Evaluation Samples, February 2009

	Method	Sample
ALI consumers	Case study	4
	Consultation	2
	Service contract data	All participants
ALI providers	Telephone or face to face interview	10
DADHC caseworkers	Face to face interview	3
LRC managers	Face to face interview	3
CASA and PWD	Face to face interview	2
ALI activities and LRC premises	Observation visit	4

Fieldwork was conducted intensively by one researcher over a two week period in February 2009 (Table 1.1). Fieldwork consisted of the following:

- Six interviews with participants of ALI, conducted during the site visits: four in-depth interviews and two consultations with residents in the presence of a boarding house manager;
- Ten one-hour semi-structured interviews with the ALI providers, (seven telephone interviews and three face-to-face conducted during the site visits);
- Two interviews with three DADHC caseworkers, from the Metropolitan South and Western regions;
- Three interviews with boarding house managers, conducted during the site visits;
- Interviews with advocates from the CASA and PWD;
- Three site visits to boarding houses in Inner Sydney, Southwest Sydney and Regional NSW; and
- Participant observation at a regional ALI drop-in centre.

This report represents the findings of the evaluation from the following sources:

- Primary data collected during the fieldwork;
- Information provided by DADHC on the ALI Program and Service Description Schedule;
- MDS and demographic data on the LRC resident population in NSW, provided by DADHC;
- Input from members of the Evaluation Steering Committee;
- Literature about disability support, mental illness and recovery programs and other mental health and disability support programs.

The structure of the report is:

- a description of the people using ALI, their experiences and outcomes;
- the support services used, the effectiveness of the program and information from similar programs; and
- implications for the future of the program.

2 LRC Resident Profile and ALI Service Use

2.1 LRC Resident Profile

DADHC maintains statistics on the size of the licensed residential centre sector. As at June 2008, NSW had 44 LRCs (40 in 2009). LRCs provided 930 beds with an occupancy rate of 89 per cent (Table 2.1). Most residents were aged over 42 years (86 per cent), male (72 per cent) and had a psychiatric disability (60 per cent).

Table 2.1: Licensed Residential Centre Residents Profile, 2008

		Metro south	Metro north	Western	Hunter	Total	Per cent
Number of beds		458	64	154	254	930	
Number of people currently residing		418	47	132	233	830	89[a]
Age	18-22	0	0	2	0	2	0.2
	23-27	2	1	1	0	4	0.5
	28-32	8	0	0	0	8	1
	33-37	21	3	2	16	42	5
	38-42	31	6	12	13	62	7
	43-47	41	5	20	20	86	10
	48-52	61	8	6	33	108	13
	53-57	70	4	10	41	125	15
	58-62	73	6	8	42	129	16
	63-67	54	5	15	31	105	13
	68-72	27	4	5	21	57	7
	73+	30	5	6	16	57	7
	Not identified	0		45	0	45	5
	Total	418	47	132	233	830	
Sex	Male	282	37	57	190	566	72
	Female	136	10	30	43	219	28
	Not identified					45	
	Total					830	
Background	Aboriginal	3	1	2	3	9	
	Torres Strait Islander	0	0	0	0	0	
	CALD	58	0	3	19	80	
	Not identified					741	
	Total					830	
Primary Diagnosis	Psychiatric	243	36	60	155	494	60
	Intellectual Disability	54	6	47	41	148	18
	ARBD	29	5	3	0	37	4
	Acquired Brain Injury	6	0	1	29	36	4
	Physical Disability	5	0	0	1	6	1
	Other	34	0	4	3	41	5
	Not identified	47	0	17	4	68	8
	Total	418	47	132	233	830	

Source: DADHC
Notes: a. Occupancy rate.

ALI providers are funded $2,490 per LRC bed in their location each year. The budget for 2008/09 was $2,435,910 (Table 2.2). The average cost per person supported was $5,620.

Table 2.2: Annual ALI Funding, 2006/07

	LRC beds	Annual funding ($)	People supported (Table 2.3)	Average cost per person supported
Sydney metropolitan				
1	270	361,983	32	11,312
2	59	154,005	73	2,110
3	93	231,162	N/A	N/A
Other locations				
4	165	438,422	142	3,087
5	56	148,796	39	3,815
6	50	132,854	8	16,607
7	102	271,024	94	2,883
8	50	137,854	46	2,997
9	93	212,563	99	2,147
10	101	270,077	N/A	N/A
11	24	77,170	N/A	N/A
Total	961	1,688,760	533	
Average				5,620

Source: DADHC 2006/07
Notes: Cost per person is not calculated for the locations with missing MDS data (N/A). Average cost is based on 8 locations.

ALI providers are asked to report on the annual number of units of support provided to clients by service type (Table 2.3). They reported in-home accommodation support, other accommodation support, learning and life skills development or community access service types. No location reported providing more than one support type in each year, which probably only reflects limits to the way they used the reporting system. Clearer definitions and instructions for ALI providers about MDS reporting are required if the MDS data are to be useful for informing program improvements. Within the limitations of the data, the number of people receiving support seems stable (453-533 clients p.a.)

Table 2.3: Annual ALI Clients by ALI Support Type 2004-2007

	2004/05	2005/06	2006/07
Sydney metropolitan			
1	N/A	N/A	32
2	56	78	73
3	N/A	N/A	N/A
Other locations			
4	139	157	142
5	N/A	N/A	39
6	N/A	N/A	8
7	87	83	94
8	105	51	46
9	103	84	99
10	N/A	N/A	N/A
11	N/A	N/A	N/A
Total	490	453	533

Source: CSTDA MDS 2004/05, 2005/06 and 2006/07

Notes: Data missing from locations indicated by 'N/A'. All data is missing from three locations. The figures are at service level, not provider level. By using the linkage between service ID and outlet ID from which the CSTDA data is based on, service level figures were derived. Due to the data quality problem regarding the start and end dates and the way the number of quarters is calculated, this table is indicative only and should be used with caution.

2.2 Profile of the Residents who Participated in the Research

Six residents participated in research activities, including four case studies and two shorter consultations (Table 2.4). The residents were diverse in gender, age, location and disability type.

Table 2.4: Resident Profile, Interview Sample (n=6)

	Characteristic	Number
Gender	Male	4
	Female	2
Age	30-35 years	3
	50-55 years	3
Background	Aboriginal	0
	CALD - Lebanese	1
	Anglo-Australian	5
Place of residence	Sydney – inner west	2
	Sydney – south west	2
	Regional NSW	2
Primary disability type	Psychiatric	4
	Intellectual	1
	Multiple	1
Employment and education	Employment	0
	Education/vocational courses	0

Gender

Of the six residents, four were male and two female. The population of LRC residents has a greater proportion of men to women.

Age

Three residents were aged in their mid-fifties and three in their thirties. While the population of LRC residents is ageing (Table 2.1), an emerging group of residents in some LRCs are younger people. The research group included two men from the LRC in south western Sydney, which has a predominantly younger resident group.

Cultural background

Five residents were Anglo-Australian and one resident was from a Lebanese background. No Indigenous residents participated, which reflected the low number of people identified as Indigenous in the LRC population (Table 2.1).

Location

Two residents lived in Sydney's inner west, two in south western Sydney and two in a regional location.

Disability type

Four residents had mental illness (schizophrenia), one resident had intellectual disability and one resident had multiple disabilities related to serious abuse, abandonment and neglect during her earlier life.

Employment and vocational courses

None of the residents were employed. One was seeking supported employment through a local business service. Another had been employed at a business service, but had been asked to leave due to challenging behaviour and arguing with the manager. None of the residents were undertaking vocational courses or educational courses.

The findings in later sections also include researcher observations from the three LRC site visits and the ALI drop-in centre, to provide a broader context beyond the six residents. Names are changed to protect confidentiality.

3 People's Experiences Using ALI

This section discusses the findings about people's experiences using ALI from interviews with them.

3.1 Case Studies

The case studies illustrate how the ALI fosters and builds client outcomes. The studies also identify areas where the outcomes could be strengthened. Names and identifying features have been changed in order to protect confidentiality.

Ruth

Ruth is a middle aged, a long-term resident of a boarding house in the city. Her case study demonstrates significant outcomes and improvements in her life, in part due to ALI, as well as the assistance provided her by the LRC manager.

Ruth had come to the boarding house nearly 30 years ago, after being subjected to significant abuse and neglect. On arrival at the boarding house, she was in very poor physical and mental health. With the assistance first of the boarding house manager and then ALI, her life has been transformed.

She has been involved with ALI since its beginning 8 years ago. She is very active in the art and craft program, her main interest and hobby. This has resulted in her showing her art in an exhibition of art works by boarding house residents. She has been able to demonstrate her art to others in the wider community and sell work at a local festival. A profile of Ruth and her work has been featured in a community magazine. Her ALI worker said that Ruth had introduced ALI to arts and crafts (not the other way around), which is evidence of ALI responding to the interests of individuals, rather than prescribing set activities for residents.

Ruth has a good relationship with the ALI workers, who have helped her to use public transport and make use of resources and social groups at a local community centre. Following Ruth's decision to meet with some of her family, the ALI worker is providing assistance to link Ruth with family members. She has benefited from the volunteer program which ALI runs, where she is linked with a local volunteer who provides one-on-one support and regular outings and visits. The volunteer program is able to offer individualised support, as well as facilitate community integration. Ruth has benefited from the primary health service provided in-house at the boarding house. She has a number of health problems and is in urgent need of dental care.

Her self-rating of the Personal Wellbeing Index shows that she is very happy with her life as a whole. Reflecting satisfaction with her arts and crafts, she said she was 'completely happy' with the things which she makes. She also indicated that she felt very safe in the boarding house and wider community. She said she did not know the future.

Jenny

Jenny is aged in her fifties and she has lived at a boarding house in the city for two years. Previously she had lived in a shared household, supported by an organisation which works with people with mental illness. Her case study demonstrates how the ALI provides a mix of activities to facilitate participation in a range of community

activities. Importantly for Jenny, ALI enabled her to get out of the boarding house and spend time in the community. She did not like to spend time at the boarding house as 'there is nothing to do there' and residents were always annoying her for cigarettes or her lighter. She said all the conversation you get from other residents is, 'Can I use your lighter.' She found living at the boarding house depressing and felt that she did not belong there as people had a lot of problems. She shares a room with two women, one of whom 'screams, shouts and smokes in the room.'

Jenny engages in as many of the ALI activities as possible. This includes attending a weekly social club at the local neighbourhood centre, a regular women's group and BBQs at the local park. Describing the ALI she said,

> ALI helps you get out of the house. I couldn't stand it if I had to stay there all the time … you get given cigarettes [from staff], you go out the back to smoke them, all the other residents are out there smoking, then you get tired because you're on medication, so then you go to your room and lie down till lunch. So with ALI I can get out of the place.

She said that the ALI provides options to residents about what they would like to do and asks for resident feedback. ALI is important for her because it provides the possibility for socialising and friendships. She says, 'I don't have any friends. I don't know why. I wish I did. It would be nice to have a friend I could go out with and have a meal.' The ALI worker indicated they are assisting Jenny develop a friendship group. ALI provides transport for her to attend community activities, as she lacks confidence to use public transport, is fearful of going out by herself and fears getting lost.

Jenny's money is held by the Office of Protective Commissioner (OPC), something not uncommon for residents of boarding houses. She has been frustrated by not having access to her money and said she enjoyed more independence when she lived with a mental health provider and was able to access money from an ATM. The ALI and PWD are currently involved in advocacy work with OPC regarding residents' access to money. Jenny works in the LRC kitchen every morning, for which she is paid $5.00.

Jenny used to be married and has two adult children, with whom she has lost contact due to her mental health problems. While she has attempted to re-establish a connection, her children did not respond. This led her to realise that she needed to build up her own life and ALI has been assisting with this.

She is worried about her loss of independence at the boarding house. Previously she did her own shopping, cooking and banking but now this was all done for her. She gave an example of where the previous LRC manager did not allow her to go out independently with another resident for coffee. Of her future she said,

> I hope I won't have to stay at the boarding house all my life. I don't know where I can go. I'd like to get a flat. I'd like to be more independent.

Her self-rating of the Personal Wellbeing Index showed that while she is very happy with many aspects of her life, she is less happy about getting on with the people she

knows. This reflects her comments about not having friends and wanting more opportunities for socialising.

Mohammad

Mohammad is a young man in his early thirties from a Lebanese background, resident at a boarding house in Sydney for 2 years. Previously he was hospitalised in a psychiatric ward of a large hospital. Mohammad said the important thing about ALI was that it kept him 'occupied' and that if it was not for [the ALI worker] 'I wouldn't be doing anything.' He spoke of having problems with lack of motivation and that ALI was helping him do more things with his time.

With the support of ALI, he has been able to access the two local community centres, where he enjoys playing pool and enters into the pool competitions. He is a regular at one of the centres, but says he does not like the other centre which is for people with mental health problems. Mohammad also participates in monthly bus outings and BBQs at the national park.

Mohammad clearly likes the ALI worker, who he describes as 'young at heart ... easy going ... communicates properly ... and encourages me to go out.' The worker often transports him to the local community centres, even though there is a local bus and centres are within walking distance. He said that if he was not driven there, he probably would not go. However, he does catch public transport every weekend to visit his mother. This involves catching two buses and one train. He enjoys the visits very much and often sleeps over at his mother's place on Saturday.

He said that his main interest is music. He writes his own songs, plays keyboard and has produced a CD of his work. Like other men his age, he said that the songs he likes 'are about girls.' It appears the ALI has not acted on his interest in music, by including it in his ISP or linking him into a local group of songwriters and musicians. He said he would like ALI to approach a local paper to write an article about his music and CD.

The boarding house has a very pleasant outdoor garden area, where Mohammad enjoys sitting, relaxing and mixing with the other residents. This is how he engages with the ALI worker informally and often plays cards with her. Despite the attractive and home-like environment the boarding house manager has worked hard to create, Mohammad said the boarding house was 'just like a mini-hospital.' He described meal time routines, 'lunch at midday, dinner at 4 pm.' He thinks there is a microwave in the kitchen if he wanted to eat later, but he does not use it. He referred to other residents of the boarding house as 'patients', because 'they have a lot of problems.' Mohammad spoke of problems he experienced due to being on medication, saying that he got 'mind blocks.'

Mohammad's assessment of his wellbeing was possibly more realistic than other people in the case studies. He said he was unhappy about his life as a whole, however was very positive about his future life, which may be related to his age and belief that things can get better. He said he was very happy about the things he owned, referring to his prized music collection. He said he did not have enough money as he lived on the Disability Support Pension and most of this went to the boarding house. He felt unsafe at the boarding house, because 'people are out to get me ... some people want me dead,' and he had mixed feelings about doing things outside his home. He said he

would feel safer if he could move out of the boarding house and that he hoped to get another flat through the Housing Department. He had lost his previous Housing Department tenancy when he was hospitalised.

Brad

Brad is in his early thirties and has lived at the boarding house for six months. He has schizophrenia. Previously he lived in private rental accommodation. Speaking of ALI, Brad said, 'It's a great program, gives us the opportunity to get into the community.' ALI supports Brad attend a local community centre for people with mental health problems, where he participates in cooking and art groups and attends social outings. The ALI worker drives Brad to the centre twice a week and sometimes spends time at the centre with participants. Brad said the ALI needed its own small bus, as the worker could only transport two residents in her small car. He participated in the ALI BBQs and day trips once a month, which were dependent on ALI securing a bus from the local Community Transport organisation. Brad also uses public transport, for example he catches a bus to the local shopping centre. He travels further afield on public transport to visit his ex-wife.

Brad was very positive about his life. He said he liked living at the boarding house, where he has made friends and can talk with the manager. He said the manager was very supportive and that 'if I have any problems I always talk with [the manager].' He also clearly had a good rapport with the ALI worker, who he said was very supportive and worked with him once a week, sometimes more.

Brad was the only consumer interviewed who knew he had an Individual Plan. He recalled his doing the plan but not what it contained. He said his interests included ten-pin bowling, going to the movies and walking. Some of these activities were difficult to do because the cost was prohibitive for people living on the DSP. He also said he enjoyed cooking, but that he could not cook at the boarding house, even though there were small kitchens attached to the residents' units.

Brad has many interests outside ALI and the boarding house, including attending church, reading and visiting his family. These interests may account for his positive attitude to life. He considers the boarding house as his home at the moment, however he did not think he would remain there all his life.

Speaking of the changes ALI has made in his life over the last six months, Brad said 'I've got more independent ... I'm more confident going into the community.' He said he was very happy with ALI, 'There's no negatives. There can only be more positives.' His goals for 2009 included becoming more involved in the community and finding employment to provide more financial security. Brad rated he was 'completely happy' with his life as a whole, for each part of his life and future.

3.2 Consultation with Residents

Resident consultation included short interviews with two male residents at a boarding house in a regional location, in the presence of the manager and researcher observation at an ALI drop in centre.

One resident participated in a wide range of ALI supported activities, including the music and art program located at the neighbourhood centre auspicing the ALI, a

fitness program at the local gym, regular bus outings and bush walks. The other resident voiced disappointment at missing out on activities and not being on the list of residents for the bus outing. He gave the view that ALI was 'not doing the right programs' because what was needed were activities on the weekend.

The ALI drop-in centre for residents of a boarding house provided an informal, unstructured and supportive environment where residents could relax, make themselves tea or coffee, watch TV, play pool, do artwork and engage with the ALI worker. While this activity may support residents to go out of the boarding house, it does not assist them to link or engage with other people in the community; rather it was separate from the wider community. This community has two other local community centres within walking distance of the boarding house, both of which offer drop-in facilities as well as a wide program of activities to other people.

3.3 Summary about Consumer Experiences of ALI

The case studies demonstrate how the ALI fosters and builds client outcomes. They also suggest how outcomes could be strengthened.

- ALI provides positive consumer outcomes for some residents of boarding houses.
- Residents' positive personal wellbeing ratings on life domains and their future may be related in part to their involvement with ALI. Some residents also spoke about having positive relationships with the boarding house manager, who assisted them with their problems.
- The relationship between the ALI worker and residents seems critical to the effectiveness of ALI. Most residents said they liked the ALI workers.
- Residents participated in community access and recreational activities, but had done little formal skills development and generally could not name new skills they had acquired through the ALI activities.
- ALI often provides private transport to activities even though some residents demonstrated they used public transport at other times, such as to visit their families and engage in non-ALI activities.

4 Outcomes for People Using ALI

This section details the outcomes for people using ALI support according to the outcome goals of ALI – activities in the community, community linkages and participation.

The evaluation data paints a picture of a vulnerable group of people with few opportunities and a history of isolation from other members of the community. ALI focuses on addressing that isolation by linking LRC residents into their community. In the words of one provider,

> ALI is the only opportunity people in boarding houses have for social inclusion and skills development. If it wasn't for ALI, they would lead very isolated and lonely lives and their mental health would deteriorate.

Seen from this perspective, ALI can both promote mental health recovery and contribute to preventing extreme events such as hospitalisation. The following examples illustrate how the program achieves its intended outcomes.

4.1 Community Based Activities

ALI is intended to facilitate access of LRC residents to community based recreation and leisure services and mainstream educational and vocational agencies. One consumer identified in his ISP that he wanted to play darts and join a darts competition. The ALI worker took him to the local pub and introduced the resident to the local darts team. He started playing in the weekly competition, became the team's best player, travelled to different pubs and clubs, saved his money so he could buy a beer after the game, had meals with the darts group and became friends with the members. His ALI worker said, 'It's all about being included, now he's one of the boys.' One early barrier to the community activities was the boarding house manager said the resident could not go out at night. The ALI worker responded by initially transporting the resident to and from the darts events. The club members then took over this transport role. The resident has participated in the darts club for 3 years.

Some ALI providers indicated facilitating access to mainstream educational and vocational agencies was difficult. Reasons for the difficulty related to the residents' level of disability and a lack of TAFE and adult education courses in some locations. ALI support is generally only provided during the day and cannot support the small number of LRC residents who work in mainstream or supported employment.

4.2 Community Linkages

ALI assists LRC residents to create sustained community linkages. In one example, ALI set up a community vegetable garden on a vacant block of land next to a boarding house in a small rural location. The boarding house residents planted vegetables, maintained the garden and sold the vegetables at a community market stall. Community members also participated in the garden and offered gardening advice to the residents. The experience has allowed residents to have a visible and ongoing presence in the community. Further, residents have gained a range of skills related to gardening and the environment, vegetables and good nutrition. As in many

of the ALI examples, elements of each of the three SDS activities can be found in the vegetable garden experience.

In another example, ALI formed a partnership with a local Council based in Sydney's inner west and developed a work program for residents of boarding houses, involving graffiti removal and gardening projects. The residents have experienced many benefits. The work is done outside in the community, allowing for a level of social inclusion for residents. They are paid for their work giving them some much needed additional income. The work is physical and contributes to making the local area more attractive, which means the activities are meaningful for the residents. The residents mix with other community members, for example at the railway station where they are engaged in maintaining garden beds. Importantly, they are contributing to the life of the community. The supported work program was initiated seven years ago. It is now a sustainable linkage with the community.

One barrier to community linkages and sustainability experienced by some ALI providers is poor community acceptance of people with mental illness, including discrimination and stigma. In contrast, some ALI providers spoke of parts of their community and local organisations where people with mental illness were accepted. They attributed that change to community education programs, breaking down stereotypes and greater visibility of the consumer group. ALI has helped to promote community acceptance and address social isolation and stigma, through its program of active linking, for example through visits to local shopping centres, cafes, parks and restaurants. Advocacy groups pointed out that this approach worked better if the approach was individualised and normalised, rather than group outings which may serve to foster prejudice and stereotypes.

One advocacy group noted that facilitating community integration sometimes meant going back to basics and providing people with decent clothes and walking shoes, so they did not 'stand out' in the crowd. They spoke about how boarding house residents were sometimes desperately poor and could not afford to pay for activities like going to the movies. They supported the practice of some ALIs where residents were provided with vouchers, such as to access their local hairdresser or cinema.

4.3 Participation

A third goal of ALI is to facilitate participation in a broad range of activities. In one example, an ALI in a small isolated community successfully supported an older male resident to participate in a range of activities, both in the community and at the boarding house. This included his participation at a local community centre where he engaged in sports, gym activities and creative writing; participation in a craft class run in-house; swimming activities with the aim to lose weight; and participation in the ALI day trips.

The type of activities undertaken varied widely, from active to passive, from individual to group, from community based to centre-based and from ongoing to one-off. Many activities were developed through planning and consideration of specific resident goals. Other activities seemed to be more about filling in time, getting residents on to a bus and taking them to another disability program such as a day centre. Stakeholders to the program argued that providers needed to be more purposeful in planning how to achieve the program goals and 'think outside the square' when developing a mix of appropriate activities.

ALIs located in inner Sydney or large regional centres benefited from a larger number of community services and activities to link residents to, compared with ALIs located in outer western Sydney or small rural communities which had little or no public transport and few community services. Despite the lack of support services in rural areas, one rural provider indicated they have made use of extensive networks across the local area and that their ALI is well-known and has a positive profile.

Some ALI providers raised concerns that some of the expectations around consumer outcomes were not realistic, given the characteristics of the consumer group. This particularly related to skills development and use of educational and vocational training opportunities. They said that TAFE courses are not appropriate for some residents due to their psychiatric disability.

ALI providers also emphasised the need for what was often a long process of engaging with residents and relationship building, to gain trust. Often, one-on-one support at the boarding house was required to establish rapport before development goals could be established and acted upon.

Providers who had worked in the ALI program for over the 8 years were able to identify significant and positive changes in the target group. For example one provider said residents,

> are much more social now. Before they were very introverted. ALI's developed rapport with the residents, to help the residents develop rapport in the community.

They also observed residents now communicated with each other, whereas previously they were isolated in their own rooms. Another ALI provider reported that clients used to be institutionalised and while the boarding house mentality and culture may have continued, with ALI,

> clients have been de-institutionalised, they have become freer, more open, more trusting of people. They walk the streets of their community. You can see people's personality.

4.4 Personal Wellbeing

The case studies showed that most people were reasonably satisfied with their lives, which in part could be attributed to the positive contribution of ALI support (Table 4.1). Wellbeing in three of the four case studies was similar to the Australian population norm and one was closer to a similar mental health cohort (Muir et al, 2007). The results are not surprising because the case studies were chosen as examples of successful outcomes from the ALI intervention. The results are therefore an indication that in the best cases, ALI can contribute to improving personal wellbeing towards a population norm. It is likely that other residents who receive ALI support would have lower personal wellbeing scores.

Table 4.1: Personal Wellbeing of Case Study Residents

	Person					Comparison groups	
How happy do you feel about:	1	2	3	4	Average	HASI baseline[1]	Australian norm[2]
Your life as a whole	100	100	30	100	82.5	59.4	77.6
Things you have	100	100	10	100	77.5	65.2	77.3
How healthy you are	70	100	50	100	80.0	56.0	75.1
Things you make or things you learn	100	N/A	50	100	50.0	64.2	74.2
Getting on with the people you know	60	50	50	100	65.0	63.2	79.8
How safe you feel	100	100	33	100	83.2	70.4	77.6
Doing things outside your home	90	N/A	50	100	50.0	57.7	70.5
How things will be later in your life	Don't know	N/A	100	100	100.0	68.0	70.5

Notes: Personal Wellbeing Index (PWI). Scale 0-100 where 0=completely unsatisfied, 100=completely satisfied (IWG 2006).
1. People with mental health conditions, Muir et al, 2007: 20.
2. Cummins, 2005: 39.
N/A = no answer

5 Cost Effectiveness

The cost effectiveness analysis identifies the expenditure and outcomes associated with ALI. The focus is what is the ALI recurrent cost and what are the benefits to the person, government and community of ALI.

The unit cost of ALI is the contract price of $2,490 per LRC bed. Average annual cost per person actually supported is $5,620 (Table 2.2). This cost presumably covers all costs specific to each person supported, including case planning, arranging and providing support. It also covers the administrative and management cost to the ALI provider to run the program. Other data about management costs to ALI providers to run the program not covered by the contract price, costs to the person supported and program and policy costs to DADHC were not available to the evaluation.

Outcome data were gathered from the interviews and case studies. No ALI program management data about outcomes were available. The data were compared to before and during ALI or to population norms and people with mental health conditions. (Table 5.1).

Table 5.1: Measures of Effectiveness for People Successfully Supported by ALI

Outcome	Explanation
Community based activities	Participation in community based activities consistent with the preferences of the person using ALI increased, such as recreation in community clubs and going to a café
Community linkages	Links to sustained activities with community members increased, such as gardening
Community participation	Individual and group participation in community activities increased, such as attending craft groups, sports and exercise
Personal well-being	Personal wellbeing tended towards the population norm. For some people it was closer to a norm for people with a mental health condition
Social and family relationships	Social and family relationships improved for some people. For others it remained a long term goal to reconcile with family members and gain friendships outside the LRC.
Employment and education	Employment and formal education did not increase because of disability, stigma and availability of suitable opportunities. Some people who already work do not use ALI support.

Note: Data are not available for all people supported by ALI. The case study sample included people with significant outcomes from using ALI. Comparison is between before and during ALI or a population norm.

In summary, in the best cases it is likely that the return on investment of $5,620 per person who uses the program per year includes increased community based activities, linkages and participation for the person; improved personal wellbeing towards the population norm; and increased social contact. For some people it also returns improved relationships with family members and possibly long term reconciliation with family and formation of friendships. The evaluation did not show evidence of impact on participation in employment and education. Other examples of outcomes included successful transition out of hospital based psychiatric care and personal care skill development.

6 Access to ALI

The ALI is intended to be available to all residents in the LRC who want to participate. The findings below describe the variation in the amount of support some people receive, support for Indigenous people and people from diverse cultural and language backgrounds and which residents do not have access to ALI.

6.1 Client Reach

ALI providers acknowledged that some residents received many support hours per week, while other residents received a small number or none. One reason suggested for this was that some people with chronic mental health problems and a history of institutionalisation 'stand in the shadows.' The respondents said that ALI needs to reach out to this group and not just work with those people who are more active and ask for support. DADHC caseworkers reported that ALI had its regular consumers and that some residents missed out. Boarding house managers pointed out that ALI often just took out 2-3 residents, leaving over 20 residents behind at the boarding house. This approach could be justified on the grounds of individualising support.

The interviews demonstrated that not all residents are participating in ALI and that some groups of residents miss out. LRC residents who commonly do not have access to ALI include: people who work; people who declined offers of ALI assistance; and people who did not want to leave the boarding house. ALI providers indicated that residents who were unwell, residents with paranoia, or older and less mobile residents may choose not to participate in ALI activities outside of the boarding house. In-house activities were developed as a direct response to ALI's experience that not all residents wanted to participate in regular activities away from the boarding house.

Some ALI providers use additional strategies to engage women, because more men than women live in LRCs. Some examples were women-only activities and outings, 'pamper days' aimed to build self-esteem and personal care and one-on-one support. Stakeholders said that women's safety at the boarding house and in the wider community could also be a focus for ALI.

One boarding house manager was critical of the ALI for not providing any weekend activities, especially for residents who worked. A few ALI providers were inclusive of people who worked during the day by organising a regular night out once a month. This activity was generally funded from other sources within the organisation. This offered an outlet for socialising and something which most people in the community expect, 'a night out.' Residents decided where they would like to go for the evening.

DADHC caseworkers assist in ensuring residents do not slip through service gaps and that they receive a response from ALI. The caseworker facilitates interagency cooperation, by holding case management reviews with agencies to ensure the needs of residents are being met.

ALI providers and stakeholders repeatedly pointed out the financial disadvantages faced by residents, many of whom lived in poverty after their board and lodging was deducted from their pension by the boarding house. They said that while ALI providers subsidised many activities, or provided free activities, some residents could not participate in ALI activities which required a cost contribution. They gave

examples of boarding houses that take the residents' entire pension for board and lodging; or where residents had no cash left after cigarettes. ALI activities which are cost neutral are likely to provide the best access and/or activities where a voucher system is used.

In some instances, boarding house managers and staff also prevent residents from participating in ALI. An ALI provider told of an example where a LRC manager stopped residents from using ALI services. ALI providers indicated that if they had a disagreement or conflict with boarding house staff, the manager sometimes simply said no residents wanted to go out, acting as a gatekeeper to ALI, deciding which residents could participate. As one ALI provider said, 'They can close the door to us and we get nowhere.' This is contrary to the legislation (*Youth and Community Services Act 1973*) which states,

> Opportunities shall be provided for each person with a disability to participate in activities in the community when such participation is consistent with the requirements that the person's individual needs are met. (Section 5.5.4)
>
> The licensee, licensed manager and staff shall allow residents to have access to independent advocacy support in relation to the residents' dealing with the centre and otherwise. To this end, the said people shall foster the relationship between any available advocacy service...and the residents. (Section 7.1)

6.2 People with Indigenous or Culturally and Linguistically Diverse Backgrounds

Most LRCs and ALI programs do not have large numbers of Indigenous people or people from culturally or linguistically diverse (CALD) backgrounds. Part of the explanation might be that LRC and ALI workers are not identifying the cultural background of the residents. Some boarding houses in the Metropolitan South region have a higher number of CALD residents, which was evident to the researcher during the visit to the boarding house in south west Sydney.

This apparently low rate of Indigenous residents in LRCs is despite a general shortage of affordable housing for Indigenous people (although the rate of Indigenous homelessness and residency in licensed and unlicensed boarding houses is similar, 9 and 7 per cent; Chamberlain and MacKenzie 2003). Aboriginal people may be more likely to be resident at unlicensed than licensed boarding houses. The state wide summary of LRC residents profile showed that only 9 residents, out of a resident total of 830, were Aboriginal (Table 2.1).

Examples of ALI workers responding to Indigenous background are to link a resident with Aboriginal art exhibitions and cultural pursuits. Other providers have held culture days for boarding house residents, which may involve linking them into cultural activities and festivals held in the community. In one small rural location, the local Aboriginal caseworker is invited to provide individual support to Aboriginal residents of the boarding house. In the large well-serviced regional centre of Dubbo, ALI facilitates links with the various Aboriginal cultural activities and services, as well as with Aboriginal health workers who visit the boarding house and engage with

Aboriginal residents. Some Aboriginal residents have drug and alcohol problems and resultant brain injury.

According to ALI providers, people who speak little English may require a greater use of interpreters than currently occurs. This may be a group who miss out on ALI services if ALI workers do not facilitate means to communicate about what they would like to be doing. Stakeholders suggested that ALI providers could use interpreters and bilingual workers from Multicultural Resource Centres to assist residents from diverse language backgrounds engage with the ALI. ALI providers are required to provide significant levels of disability support to enable other people with communication support needs to participate in ALI, for example a resident at a boarding house who was deaf.

Stakeholders suggested that Aboriginal and CALD residents in particular would benefit from a more individualised response from ALI and that ALI could be doing more to link Aboriginal and CALD residents into culturally appropriate activities. An individualised response needs to be coupled with a holistic approach to the person in their community (NATSIHC, 2004). Health is viewed in a holistic context, encompassing mental health and physical, cultural and spiritual health according to the first guiding principle of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being.

The complexity of needs faced by Aboriginal people and communities is evident when understanding that problems associated with social and emotional wellbeing result from a systemic history of dislocation, loss, racism and social disadvantage. Recognition of family and kinship is important, alongside the broader concepts of family and bonds of reciprocal affection, responsibility and sharing (NATSIHC, 2004). Multi-dimensional approaches responding to the person's whole of life needs are required, together with community based healing processes.

Stigma, often resulting in isolation, was the most common problem raised in a series of national consultations to better understand the needs, concerns and aspirations of people from culturally and linguistically diverse backgrounds with mental illness (MMHA, 2004). Stigma led to feelings of shame, resulting in significant barriers for people seeking support. As reported by participants, 'Mental illness is a taboo subject, it is very sensitive and people are embarrassed so they don't go to mental health services.' (MMHA, 2004) CALD participants spoke about how mental illness was a private and personal matter, compounded by a range of cultural beliefs and norms,

> We come from cultures and countries where if you have a mental illness, you end up being locked up and the keys are thrown away … [mental illness] is seen as a price for past sins or a family curse and the family has to cop it without outside help. (MMHA, 2004)

6.3 Location

Access to ALI varies considerably between regions, LRCs and ALI providers. Licensing of LRC in remote locations without public transport or facilities accentuates this problem. ALI cannot solve problems related to the geographic isolation of an LRC.

Geography and location both play a part in the way ALI operates. For example ALI providers are often required to transport residents to and from activities, particularly where public transport options are not available. If a boarding house was located close to services, transport and networks, community access and integration were more likely to occur. Boarding houses in small rural or regional locations may be isolated and lack transport and services. An absence, or lack of local services, can hamper ALI's goals of community access and sustainability. Location in a regional hub such as Dubbo is less vulnerable to this access barrier.

In small rural locations with no TAFE or adult education facilities, the goal of vocational training was not considered to be realistic. Some rural LRCs solve this problem by transporting residents to a regional centre, with the support of the LRC, ALI and DADHC workers.

Access to ALI support also varies according to the quality of the relationship between the ALI and LRC, for example restrictions from the LRC on ALI access to residents described above. Another example was demonstrated by the experience of two ALI providers. They were each able to offer a positive program to residents of one of the boarding houses in their area due to good relationships with the LRC. However, the ALI providers could not implement a similar program at a second boarding house in their area due to restrictions on resident access from the LRC manager.

6.4 Summary about Access

ALI providers are least likely to engage people with unmanaged mental health problems or a long history of isolation due to prior institutionalisation. Investment in time to build rapport was necessary to help residents develop trust so that they can benefit from ALI support. Poverty prevents some people from participating in ALI support because of the cost of the activity, transport and clothing suitable for going out. DADHC could monitor client reach and support ALI providers by assisting them to share good practices about how to engage people with greatest unmet need.

Some LRC managers treat ALI as a recreation service rather than individualised disability support to develop capacity for community participation. At worst, this attitude results in their preference for group activities, in-home activities and punitive action preventing access to ALI support based on unrelated behaviour in the LRC.

ALI was less likely to engage with people from Indigenous and culturally and linguistically diverse backgrounds, with the exception of LRCs in the Metropolitan South region which have higher numbers of CALD residents. Partly this is because fewer people are identified as being from these backgrounds. Good practice by ALI providers includes linking people from diverse backgrounds to specialist support workers, interpreter and culturally relevant groups and activities. Individualised responses are most likely to identify these needs.

Opportunities for community participation are affected by location, such as availability of activities and community social groups, distance from activities, availability of public transport, cost.

7 ALI Support Services

This section presents findings about how ALI support services are organised. It describes the services provided, how providers work together and respondents' suggestions for change.

ALI providers assist people who live in LRCs develop skills to participate in the community. They do this by linking residents with activities in the community. The program is planned through individual service plans (ISP) and activities relate to the services contracted by DADHC listed in the Service Description Schedule (SDS). ALI providers raised some considerations about how they organise the activities including building relationships, group and individual activities, transport, funding and advocacy.

7.1 Individual Service Plans

ALI providers use ISPs to engage residents in discussions about what they would like to do with ALI and to respond to their individual needs. Providers also use the ISPs to develop their regular weekly program of activities for residents. Plans are reviewed at least once a year and provide the opportunity to celebrate the person's achievements.

A DADHC caseworker, advocating a more individualised response to clients, said that ISPs need to tap into, build and foster people's own interests. Generally, the ALI participants interviewed were not aware they had an ISP. The one respondent who recalled doing a plan could not remember what was in it. The importance of respecting the residents' state of mental health, rather than imposing an ISP on them, was emphasised by one provider,

> The ISP might look good on paper; in reality the resident may not be able to participate in many of the activities because of the state of their mind.

Stakeholders argued that the focus of the ISP and wider program needed to be on improved consumer outcomes, such as greater use of community resources, improved confidence and sense of identity and enhanced interpersonal skills. In contrast many plans focus on busyness and traditional centre based activities with the use of a bus and transportation to a centre. Further, they said ISPs should have more accountability and reporting, for example the proportion of individualised activities compared with group activities.

Individual plans need to include more than just activities. DADHC's new directions in day programs state that individual plans need to include the participant's long-term plans, directions and aspirations; goals; skills and competencies; support needs; activities and strategies; and outcomes measurement (DADHC, 2009:10).

7.2 Service Description Schedule

ALI providers base their program around the DADHC Service Description Schedule (SDS), which includes the three activities of skills development, community access and integration and leisure and recreation. Examples of skills development were accessing adult literacy classes at the local TAFE and travel training. Examples of community access and integration were regular visits to local clubs, coffee shops and

community centres and volunteering. Examples of leisure and recreation were day trips, arts and crafts.

Providers indicated that their program was often focused more on leisure and recreation and community access, than on skills development and vocational and educational activities. However they also noted that skills development, for example social and interpersonal skills, occurred informally with each of the activities offered to residents. Indeed, some of good practice examples demonstrated that some activities were able to incorporate elements of the three SDS activities. DADHC could facilitate discussion between ALI providers about the intention of the service descriptions to share good practice about strategies for skill development towards maximising independence.

Some providers suggested that the SDS was too prescriptive and formulaic. The SDS needed to be more flexible to respond to people with mental illness, many of whom had been institutionalised in the past and had a high level of need. In particular, providers felt that skills development was generally not what consumers wanted or needed, especially when that activity was focused on educational or vocational activities. One provider suggested that the SDS was more attuned to the needs of people with intellectual disability, than people with mental illness.

The SDS stipulates that ALI services should not be:

- Centred based programs, including programs operated from within a LRC and programs operated within a 'closed' setting that does not promote the inclusion of other community members; and
- Group activities, unless the activity and measurable outcomes are identified in each individual's plan.

Interviews with ALI providers and a DADHC caseworker confirmed many activities are centre based and group activities. These practices raise questions about the extent that centre-based activities facilitate community integration, particularly where an ALI centre-based activity operates separate from similar centre-based services for other people in the community.

Some stakeholders, though not all, suggested they would like to see assistance to access other support services recognised within the SDS. This could include assisting residents to navigate their way through service provision, such as Centrelink, Office of Protective Commissioner (OPC), banks and community mental health services.

7.3 Activities in the Community

The intention of the ALI when it was introduced over eight years ago was to provide the opportunity for residents to get out of their boarding house and participate in activities in the wider community. This aim responded to the concern that residents were spending all their time in the boarding house, possibly isolated in their own room. In the words of one provider,

> When ALI started, residents were a forgotten group and were quite happy to stay in their bedrooms. Now, because of ALI, they are happy to go out.

Getting people out of the boarding house and into the community was seen as an underlying key activity for ALI providers. As reported by a DADHC caseworker, 'ALI's got people out of their armchairs and into the community.'

ALI providers link residents to a wide range of activities which are run outside the boarding house, including activities run at local community centres, sporting venues and Sport and Recreation, TAFE and adult education, arts and crafts, pubs and clubs, church groups, cafes and shops and local parks. Providers themselves also run some activities for residents, for example day trips on buses. While the main form of activity is usually group based, providers also offer individual activities to residents. Providers use the activities to facilitate community linkages, community integration and where possible, sustainability. ALI workers discussed examples such as fostering connections with family members and supporting visits to the family.

Interviews with ALI participants revealed they engaged in many activities organised for them outside the boarding house. For example one person participated in a range of art and craft groups at the local community centre; another person went on BBQs and bush walks. These activities in the community and others like them, are an affirmation of the Disability Service Standard 'Participation and Integration', where 'each person with a disability is supported and encouraged to participate and be involved in the life of the community' (Disability Services Act, 1993).

7.4 In-house Activities

The SDS indicates in-house activities are acceptable if they are: within an individual's plan with meaningful, measurable outcomes; an inclusive activity that would normally be engaged in at home with friends and is part of a wider program of linking to the community; or is a time-limited preparation for active linking to the community. The program intention is for in-house support to be used to engage people sufficiently to be able to make referrals to support or activities, such as occupational therapy, HACC support, case management, equipment or accessible transport.

Some ALI providers offer in-house activities to residents at the boarding house, in response to consumer need and some residents not wanting to participate in ALI activities away from their home. According to ALI staff, some residents are fearful of leaving their home; older people may have mobility problems; residents who are mentally ill may not be well enough to go out. In-house activities include coffee mornings, gentle exercise classes, one-on-one relationship building and BBQs. One ALI provider has established a small library at the boarding house and runs art and craft sessions for residents, as well as activities based around improving self-esteem. Another provider runs a regular coffee morning at the boarding house to engage with residents who may be too ill to go out.

In-house activities meant that residents who did not want to participate in programs outside the boarding house received alternative ALI support. Regular in-house activities provide the opportunity for ALI to have a positive presence at the boarding house and develop stronger relationships with the LRC.

Two of the LRC managers who were interviewed wanted ALI to run more activities at the boarding house, because most residents in their LRC were not engaged with ALI's community program and they had a strong preference to stay home. However, unless

these activities are for the purpose of moving towards building capacity for community participation, they are not within the intention of ALI. Likewise, a DADHC caseworker emphasised that in-house activities can provide the resident with the confidence and social skills to later participate in community activities. They said in-house activities can be used as part of a progression towards community engagement. Advocates emphasised that in-house activities needed to be clearly based on a person's needs, rather than being offered as an institutional approach.

If the in-house activities are not for the purposes outlined in the SDS principles, it may be better to consider alternative sources of this support such as from the LRC itself, volunteers or HACC services.

7.5 Building a Relationship with the Residents

All ALI providers based their support on a relationship model, where the worker takes time to build rapport and trust with the individual resident over time. They saw this as critical to building confidence for the resident to leave the boarding house and link with their local community. Taking the time to build the relationship was required; and the continuity of positive relationships over the life of the ALI Program has benefited some residents.

Many respondents reported that the relationship between resident and ALI worker is often the foundation which allows residents to build their self-esteem and sense of wellbeing. It provides them with the confidence to engage with the wider community. In the best cases, ALI helps vulnerable people develop their own voice and a sense of their own worth and builds decision making skills. One stakeholder said these were the important things about ALI, not just getting people out of the boarding house. Providers indicated stable staffing, which allowed for relationship building and trust with residents, assisted ALI to deliver improved consumer outcomes. The program has benefited from the stability of ALI providers over the last 8 years and the stable staffing this has brought. It is timely now for ALI providers to critically review how to prioritise engagement with residents with the greatest unmet needs.

Advocates reported that the ALI workers can make a big difference in residents' lives. The ALI worker may be the only person who greets a resident and the only person who provides some fun in their life. Before the ALI program was introduced, residents were isolated, withdrawn and vulnerable; ALI has changed this through building positive relationships with residents.

7.6 Mix of group and one-on-one activities

While many of the activities offered were group activities, ALI providers recognised the importance of offering one-on-one support to residents, especially residents who may be unwell, vulnerable, aged and not wanting to participate in group outings. For example one provider offers group activities in the morning and individual support in the afternoon. Providers indicated that the ALI funding level limited how much the ALI worker providing one-on-one assistance and that the low funding level required workers to base their program around group activities. Providers indicated they were inventive and creative with funding and used it effectively to meet consumer needs. 'One-on-one support is near impossible with the amount of funding we get – but we still do it.' Examples of individual support were fostering connections and visits with siblings and family.

One provider based in metropolitan Sydney had a strong philosophy and practice around providing an individualised response to ALI clients and generally did not support use of group activities or bus trips, particularly if group activities were offered to save costs. The provider worked with individuals to find out their interests and preferences and to foster, support and build on these. Stakeholders to the program argued for individualised and personalised responses, rather than an attitude of 'everyone in the bus and drive them to the local church'.

The growing body of literature on person-centred support also speaks of the need to offer individualised responses to people with disability (see for example www.jrf.org.uk). DADHC's new directions in day programs outline five key elements to a person centred approach, where the person is at the centre, not the service:

- Planning focuses on establishing what the person wants to do and achieve in their life, their abilities and the supports needed;
- The person can choose to involve their wider social network as full partners and the contribution and knowledge of families and local communities are valued;
- A partnership between the person, their family/carer and service provider, where all parties have a shared commitment to action;
- The whole of life is considered, services align with the goals and needs of the person and look beyond traditional constraints; and
- Continued listening, learning and action, where new goals are set as a person's experience and expectations grow (DADHC, 2009).

7.7 Transport

While travel training and use of public transport was encouraged, most ALI providers offered transport to and from activities. This was especially the case in areas not served by good public transport and in the small isolated rural and regional locations. The providers operating in Sydney's inner west were best able to make use of travel training and residents making their way independently to activities, due to the availability of good public transport. However, despite travel training, interviews with residents suggested that some people do not have the confidence to travel independently on public transport. Further, boarding house managers may place restrictions on residents' use of public transport, for example one manager interviewed did not allow residents to catch the local bus into town. Advocates pointed out that residents were sometimes so poor they could not afford to travel on public transport.

Some ALI providers had vehicles to transport residents, including mini-buses and vans. One provider had a vehicle modified for use by aged residents with limited mobility, which had been bought from the organisation's wider funding base. However, not all providers had vehicles. For example, one ALI worker operating at a boarding house in south western Sydney, where there was very limited public transport, uses her own small car to transport residents to services and activities. She could only fit two residents in the car at any one time, limiting her ability to get people out of the boarding house and into the community. The boarding house manager identified this as a limitation of the provider, who was unable to take people on weekly group outings and bus trips as other providers did. Conversely, regular

group outings in private transport are not consistent with a capacity building approach.

7.8 Funding limitations

The ALI providers and stakeholders considered the funding of $2,490 per annum per person restricted the program's effectiveness. Funding allows for approximately 2 hours of support per person per week. In the words of one provider, 'This isn't good enough for that group.' Rather than funding according to the number of beds in the LRC, other options for DADHC to consider are funding based on individual resident need and a loading for locations with higher transport costs.

The 2004 ALI Review identified that the resources available determined the programs that could be offered. 'Funding levels affected whether programs had an individualised focus or were provided as a group activity … as well as in some cases the frequency of the programs.' (DADHC, 2004:8)

Further, limits on the funding and possibly the way organisations roster their staff, has created the problem of sole workers sometimes being responsible for running ALI activities with a boarding house. This may result in Occupational Health and Safety problems, practical problems of staffing when taking a large group on a bus trip and worker isolation.

One stakeholder argued that use of funds by ALI providers to broker services from another organisation (for example a community centre) was sometimes inefficient and defeated the underlying purpose of community access.

7.9 Referral and Advocacy

While referral is not included in the SDS, some providers offer informal referral and advocacy to residents. This sometimes brought them into conflict with boarding house managers. One ALI provider spoke of the opportunity they give ALI clients to 'have a voice', through the organisation's 'My Life My Rights' program. ALI providers typically used Community Visitors and/or the PWD to provide formal advocacy and respond to residents' problems and complaints, for example in the area of their finances and dealings with the Office of Protective Commissioner (OPC).

One LRC manager argued that advocacy should not be part of the job description of ALI workers. He said that workers needed to be, '… watchful of the residents, not watchful of the boarding house', because the government already monitors licensed boarding houses. Other respondents suggested residents have experienced positive outcomes from ALI's informal referral and advocacy role.

7.10 Summary of ALI Support Arrangements

Good practice in ALI individual planning takes an individualised approach to developing capacity for community participation according to the person's preferences and goals. It sets short term, incremental goals to cumulatively work towards attaining long term goals. Planning and reviewing the goals with the person is an active process rather than relegating the ISP to an annual paper record.

The Service Description Schedule sets out the activities and principles for ALI support. Some ALI providers have the skills to implement the SDS in a manner that

addresses the individual needs and preferences of the residents. Their support includes linking residents to other service providers for general and specialist support as needed. Providers could benefit from sharing experiences about how to design ALI support in a way that provides disability support rather than maintenance services.

ALI providers use in-house activities to engage residents who would otherwise not have the trust or motivation to participate in ALI support. Similarly group activities and use of private transport can be justified if they contribute to a participant's goals of building social skills and confidence. Good practice use of in-house, group support and private transport uses these activities as a temporary step towards individualised activities outside the LRC, as specified in the SDS.

The limited funding for ALI support means that ALI providers are forced to choose between prioritising higher levels of support for some residents or spreading a low level of support between a larger number of residents. That decision should be made on the basis of providing disability support to attain individual planning goals rather than recreation to all residents.

Suggestions for how to improve the program include facilitating opportunities for ALI providers to share their practices, such as implementing individualised approaches; methods to engage isolated residents, prioritise residents' needs, recovery and skill development and developing individuals' capacity for community participation; managing service integration between caseworkers, ALI workers, LRC staff and other human service providers.

8 Effectiveness of Service Model

The evaluation examines the effectiveness of the service model to inform future improvements. Findings from the fieldwork have been supplemented with evidence from other programs.

8.1 Effective Model

Generally, providers reported that the service model achieves positive change for the LRC residents who participate in the program. Eight years into the ALI it is important to consider if the model needs to be modified to achieve its aims.

Many ALI providers recognised that boarding house managers were satisfied that residents were leaving home for the day and participating in ALI. However, they said that some LRC managers misinterpret the purpose of ALI. As reported by one ALI worker the manager, '… wants to push people out the door', disregarding that the LRC is their home.

Stakeholders said that the aim to get residents out of their rooms and the boarding house into the community was an important one eight years ago. However, now that ALI has achieved this for some residents, they thought it timely to consider whether some in-house activities are appropriate for those residents who have not engaged with ALI. They said that questions about how ALI can engage isolated residents in the boarding house have not yet been addressed. Some advocates argued against in-house activities as inconsistent with contemporary disability practice unless it was used as a preliminary engagement step to other support (Section 7.4).

The ALI model is flexible in the way it is able to respond to individual needs. Its primary focus on 'linking' residents to a wide range of community organisations, resources and activities gives the ALI a broad scope. For example ALI is able to foster connections and links between the resident and their family; it is able to link CALD people with cultural activities and Aboriginal people with indigenous organisations. The model is able to provide both individual and group activities. ALI is able to offer women's groups or women only activities, which may be important in some boarding houses where most residents are men. The ALI model needs a mix of activities, with the focus kept on community integration.

Stakeholders reported that activities which are more person-centred and link residents into the wider life of the community are better able to provide the potential for sustainable community links, than group activities which are based in a disability centre separate from the community. ALI providers reported they would need more funding if the model was to better incorporate individualised and personalised support.

Many ALI providers have struggled to offer skills development as one of its activities. They have often interpreted it to mean educational and vocational training. Stakeholders said that a focus on daily living skills for more independent living may be more relevant, to prepare residents who may wish to live more independently or leave the boarding house.

ALI providers viewed the variability of ALI services across NSW as a strength of the program, not a weakness. Service variability related to the needs of particular

consumer groups, location issues and geography and the characteristics of LRCs. ALI providers indicated they met the requirements of the SDS; however they interpreted the SDS in different ways to respond to local factors.

8.2 Effective Recovery Service Model

The ALI model can be informed and extended by the national framework for Community Supported Recovery Services (Mental Health Council of Australia, MHCA, 2006). The framework identifies the following components of effective recovery services:

- Partnerships between consumers; family and/or carers; nongovernment agencies, private and government providers; and community-based and clinical services;
- Addresses needs holistically;
- Avoids siloed approaches and thinking;
- Prevention and early intervention approaches at its core;
- Reflects a spectrum of care and offers a range of intensive support options;
- Builds and fosters community understanding and engagement with and around the person;
- Leaves systemic questions to be addressed by the system and providers, not consumers;
- Supports autonomy, independence and freedom of choice while the person is actively engaged in their treatment and support options;
- Incorporates a range of paid non-clinical roles including system advocates and peer support; and
- Treats the person with the same human rights as anyone else (MHCA, 2006: 14).

8.3 Partnerships

The ALI program is a service integration model, relying on partnerships between ALI providers, LRC, DADHC and other human service providers. Some residents also use primary health services, personal care and other HACC services, which complement the ALI functions. Contact with staff of these services has resulted in greater support for residents in the boarding house.

ALI providers emphasised they needed to have good relationships with the boarding house manager and staff in order for ALI to be effective. If ALI had a bad relationship, the boarding house could simply say that no residents wanted to participate in ALI. In this sense, ALI is reliant on the goodwill of the boarding house manager to permit residents to participate. As one ALI provider explained, ALI workers at one boarding house were not able to walk around the house and talk with residents independently. Rather, when the ALI worker arrived at the front door, the manager provided the worker with a list of residents who could go out for the day. Attempts by ALI to change this practice have not been successful. At other boarding houses, ALI workers have more opportunity to engage with clients at their place of residence.

According to DADHC caseworkers, DADHC's regulatory and licensing functions mean that some LRC managers view DADHC officers with cynicism and suspicion. This may occur particularly where the caseworker's role includes both casework with residents and licensing and monitoring the LRC. DADHC officials said that over time relationships between DADHC and LRCs has improved, although this was sometimes dependent on the people involved. In one instance, a DADHC caseworker has been excluded from a LRC. In some regions DADHC holds regional meetings with all stakeholders including LRCs to facilitate regular communication.

A DADHC caseworker reported that over the last 5 years the quality of support in most boarding houses has improved, 'they have been humanised … managers are not so authoritarian, they understand the need to work with other agencies.' They said that this improvement was coupled with residents becoming more aware of their rights and with better medication they are more awake and active.

One boarding house manager interviewed demonstrated considerable goodwill toward the residents and commitment to improve their quality of life, by creating a pleasant outdoor garden environment for residents to enjoy, organising regular annual holidays for the whole resident group and having weekend BBQs and birthday celebrations. Importantly, he communicated with residents in an open and supportive way and residents said they would go to the manager if they had a problem.

Over its 8 year history, ALI providers have worked hard to develop productive working relationships with the LRCs. Generally, they have been successful. However a small number of examples demonstrate this is not always the case and that bad relationships between the LRC and the ALI have a negative impact on the support to residents.

In Queensland, the closest equivalent of the ALI is the Resident Support Program (RSP). RSP providers adopt a pragmatic approach to the relationship with the boarding house operator, in terms of accepting the residential context of the program, the business nature of the premises and the broader reform context.

> They have had to strike a balance between acting on the interests and rights of residents, while maintaining RSP access to the premises and operators and acknowledging their viability (Abello et al, 2004).

Respondents identified the following barriers to effective partnerships between DADHC, ALI and LRCs.

- Some boarding house managers and staff treat any outsider, including ALI workers, as a 'spy', who is going to tell them what they are doing wrong.
- Some LRCs have a culture and history, where managers feel they have 'ownership' over residents.
- LRCs sometimes prevent residents from using the ALI.
- DADHC's role of licensing and monitoring LRCs sometimes brings the Department into direct conflict with LRCs, particularly if the caseworker for residents also has the licensing role.

- The large caseload of DADHC caseworkers means they focus more on crisis and reactive work, rather than 'whole-of-life' issues for residents.
- Some LRC managers operate in an authoritarian and controlling fashion and do not allow the ALI workers open access to residents. There was an attitude of 'no-one goes in and no-one goes out.'
- Some LRC managers provide the ALI worker with a list of which residents can go out with them, rather than allowing ALI to engage directly with residents and provide residents with the choice of whether or not to participate.

Respondents identified the following enablers to effective partnerships.

- Most boarding house managers and staff are happy for ALI to take the residents out for the day, or part of the day; managers and staff of LRCs can see that this is a significant benefit for the residents and the LRC operators. This mutual benefit provides the basis for building an effective partnership.
- Some ALI workers and LRC managers have open communication, where problems are able to be addressed quickly, for example, regular meetings with LRC staff, DADHC caseworkers and other stakeholders.
- Some LRC managers inform ALI workers when new residents take up lodging, to allow ALI to engage with them and offer support.
- Some ALI workers take great effort to be diplomatic, 'treading a fine line' and building a relationship with the boarding house manager and staff. In some cases it takes a long time for the ALI provider 'to get a foot in the door'.
- Some ALI providers refer problems to Community Visitors and/or PWD, who then act as an advocate. Some ALI providers do less intensive, informal advocacy work.
- Some ALI providers raise problems directly with the LRC manager rather than going to DADHC, to avoid inflaming a problem.

8.4 ALI Program Improvement

The respondents made the following suggestions to improve the ALI program.

- LRC manager and/or DADHC caseworker to provide more information about residents when they first enter ALI program, for example mental health history.
- Boarding house managers and staff to consult with residents over matters affecting their accommodation and wellbeing. They gave the example of consulting with residents regarding how vacancies are filled.
- ALI skills development could include residents learning daily living skills such as cleaning their room, personal hygiene, preparing simple meals and cooking. This would recognise the possibility of boarding house closure or residents choosing to move to more independent accommodation.
- DADHC caseworkers have a role in facilitating interagency cooperation, education and training for all stakeholders.

- Networking and information sharing among ALI providers, with the aim to provide a more collaborative and cohesive program. A state ALI conference was suggested.
- Sharing information about innovative responses among ALI providers across NSW was suggested, for example fund city based ALI providers to travel to the small isolated rural providers and share experiences and practice.
- Women's safety, both in the boarding house and the wider community, could include ALI programs focused on skills building, assertiveness and protective behaviours and women's right to consent.
- The current provision of 3 months ALI support to residents who have exited the boarding house needs to be extended, to better respond to residents' transition to a new and more independent living environment.
- Consideration of a potential role for the ALI in working with residents with disability at unlicensed boarding houses.

Respondents also made comments about the contextual policy environment for the ALI program. In the context of the wider Boarding House Reform Program, they commented on the need for legislation to limit the amount of board and lodging managers are able to deduct from the resident's pension. Stakeholders said it was unacceptable that managers could deduct the entire pension for board and lodging. Similarly, they thought that legislation is required to give boarding house residents a level of security of tenure. They reported that residents have no tenancy rights. Finally, they were dissatisfied with poor implementation of legislative requirements so as to prevent actions such as LRC managers from restricting ALI providers' access to residents and withdrawing ALI support from residents.

9 Other Community Participation Models

This section considers how the experience from other community participation models and approaches from other jurisdictions can inform ALI service development. It includes evidence from the NSW Mental Health Housing and Accommodation Initiative (HASI), Resident Support Program (Qld), recovery approach and developments in NSW Day Programs for people with disability.

9.1 NSW Mental Health Housing and Accommodation Initiative (HASI)

HASI aims to assist people with mental illness to maintain successful housing tenancies, participate in the community, improve quality of life, increase access to specialist and generalist community services and assist their recovery from mental illness. The program began in 2002 and provides permanent social housing, long-term accommodation, community participation support and active case management for people with complex mental health problems and high levels of psychiatric disability (Muir et al, 2007). HASI is a partnership between NSW Health, the Department of Housing (DoH) and nongovernment organisations (NGO). Jointly funded by NSW Health and DoH, HASI operates as a coordinated response with NGO accommodation support workers, Area Mental Health Service case managers, housing providers (primarily community housing) and HASI participants working together.

The HASI evaluation identified the following practices, many of which are relevant to ALI, that resulted in positive participant outcomes:

- Effective partnerships in local areas;
- Sound communication between partners at both managerial and direct support levels;
- Staff from Accommodation Support Providers (ASP) and Area Mental Health Services having a well developed understanding of the HASI model and the roles and responsibilities of various stakeholders;
- Local stakeholders having a primary role in the referral and assessment process;
- Stable case managers and ongoing training for key workers;
- ASP staff actively working within a rehabilitative, rather than a supervisory, framework;
- Key workers and clients having a strong rapport, often established through social interaction;
- ASPs organising social activities that enhance confidence and social skills to facilitate community participation;
- The provision of relevant information about HASI participants to housing providers to assist in allocating the most appropriate housing;
- Client choice and active involvement in the selection of available accommodation;
- Active involvement of family or carers; and
- Increased linkages across and within government agencies.

The way the ALI understands support can be informed by the HASI which applies three combined approaches to support in working with people with mental illness:

- A person-centred rehabilitative approach where support aims to change the person's cognition and behaviour to enhance personal efficacy and wellbeing;
- A person-centred disability support approach that acknowledges the practical difficulties of daily living and community engagement and aims to improve quality of life; and
- An advocacy approach that seeks to help people assert their rights and take greater control of the circumstances of their daily life (Muir et al, 2007: 26).

The evaluation identified the following as good practice approaches to support, within the context of the HASI program:

- Support plans are participant driven and reviewed regularly;
- Participant skills and strengths are identified and goals set with achievable steps;
- Support is flexible and follows routine and structure when required;
- Support is decreased when participants feel the program is too intrusive;
- Daily living skills are an important focus, along with recreation and social activities;
- Boundaries of responsibility are maintained;
- Key workers are trained to understand early warning signs of poor mental health;
- Key workers participate in social and recreational activities with clients to help build rapport and improve social skills;
- Key workers provide a preventive and interventionist role to help avoid mental health crises and failed tenancies; and
- Staff training includes core competencies, including first aid, behaviour management and substance use disorders.

The evaluation concluded that the HASI model has provided people with mental illness and high levels of psychiatric disability with,

> the opportunity for stable housing; intense support for living skills, community participation and service referral; and the regular monitoring and maintenance of mental health. By providing a stable, consistent and integrated support system, HASI is mediating the effects of mental illness for most participants (Muir et al, 2007).

9.2 Resident Support Program (Qld)

The Resident Support Program (RSP) aims to provide support services to residents with a disability living in private residential facilities, including boarding houses. It is a joint Disability Services Queensland and Queensland Health funded initiative.

The RSP has three components: Community Linking Projects (CLP), Disability Support Services (DSS) and Key Support Worker (KSW). The CLP provides a very similar community linking approach as the ALI. It organises and assists residents to

attend social events, supports residents to access community services and supports residents develop skills by attending short part-time courses. The KSW is focused on providing individual support to residents and access to health services; while the DSS focuses on personal care, residents' hygiene, grooming and presentation.

As identified in the evaluation of RSP, Community Linking Projects

> aim to support socially isolated residents to participate in local community activities in order to develop or rebuild sustainable relationships, for example by linking individuals into recreational, social, educational and where appropriate, vocational opportunities (Abello et al, 2004:2).

The RSP evaluation identified benefits for the residents which were of a very similar nature to the ALI. For example, one boarding house operator describes the residents' involvement with RSP,

> they're getting out more, they're not just vegetating in front of the television, they're doing things and they're mixing with other people. I think that's a good thing" (Abello et al, 2004:26).

Much of the work of the KSW focused on provision of transport to and from medical and allied health appointments. The premise operators identified that this had freed up their time, as previously they were providing some transport services for residents. ALI workers also provide transport to and from activities and while this can be seen as supporting residents' mobility and access to the community, it is important that ALI workers not be seen as simply providers of transport.

Similar to the ALI, the RSP has had to develop positive working relationships with proprietors, often based on pragmatism and partnership. In the words of one RSP provider,

> we understand that they have a business to run and they understand we have a role to play in getting their residents active and out. Our staff is very conscious that they are working in an environment which they don't own and where they don't have any privileges. We are very keen to negotiate with owners" (Abello et al, 2004:26).

One interesting difference between the RSP and ALI is the RSP adopted both an individual and a premises approach. In the individual approach, residents were identified for assistance based on their need and vulnerability; RSP followed the person providing continuity of support if they moved accommodation. In the premises approach (also adopted by ALI), specific premises were identified and all eligible residents were offered assistance. In the ALI, when a boarding house closes and residents re-locate, after the three-month transition period, the ALI worker does not continue working with the person.

The RSP final evaluation report concluded that,

> Residents with RSP assistance increased their access to health, welfare and community services. CLP played a major part in

> improved resident satisfaction with social participation, with most people benefiting from increased social contact and the development of broader interests (Fisher et al, 2005: vii).

9.3 Recovery and Principles for Effective Housing and Support

This section considers how the recovery approach can inform the ALI. Recovery is a process of restoring and developing a meaningful sense of belonging and rebuilding a life in the broader community despite or within the limitations imposed by that disability (Davidson, 2004). It is a '...journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness' (Queensland Health, 2005).

Ten principles to effectively achieve sustainable housing with support for people with mental illness or psychiatric disability were identified in 'Housing and Support for People with Mental Illness or Psychiatric Disability' (Edwards & Fisher, 2007), a recent SPRC project involving a literature review and consultations with people with mental illness resident in Queensland. Some of the principles can be applied to the ALI program, in particular principles relating to the recovery approach and person-centred services.

The ten principles are: recovery approach, person-centred support, facilitation of the person's housing needs and preferences, choice in independent living, responsiveness to population needs, separation of housing and support, interagency collaboration and coordination, individual and systemic advocacy, long-term perspective of housing and support needs and preventing homelessness**.** Key findings from the study which are of relevance to the ALI are discussed below.

Person-centred services

Person-centred services aim to plan and implement support around the person's identified needs and preferences. Planning which is person-centred considers the aspirations, interests and capacities expressed by the person, rather than focusing on needs and deficiencies. It is inclusive of the person's family, friends and wider social network. Furthermore, it provides support required to achieve the person's goals, rather than limiting goals to what services typically can manage (Mansell & Beadle-Brown, 2003). Person-centred planning and support can assist the ALI provide more individualized support to residents, rather than relying on traditional centre-based group activities.

Participating in the community

Evidence from the literature shows that one key enabler to recovery in mental health is participation in the community (Muir et al, 2007). Stable housing provides the opportunity for people with mental illness to live and become connected to a local community. Consumer feedback and narratives have identified involvement in meaningful activities in the community as important to their recovery (Davidson, 2004). The social researcher and writer, Hugh McKay, in his address to the National Housing Conference (2008) concluded, 'Home is about belonging, being connected to the wider community.'

The HASI evaluation identified that one of the successes of the program was the increase in community participation. The evaluation showed that of the 100 clients

who had complex mental health problems and high levels of psychiatric disability, 94 per cent had established friendships, 73 per cent were participating in social and community activities and 43 per cent were working or studying. As reported to the evaluation by one of the participants,

> Without them (HASI Support Provider) I wouldn't be in as good a place as I'm in now, not just physically but having achieved some of the things I wanted to achieve – like my independence in living and in running my own life and stability in housing (Muir et al, 2007).

The evaluation found that facilitating meaningful access to community can build a sense of social inclusion, build relationships and overcome feelings of loneliness. One participant said,

> If it wasn't for the [support provider] I would have just barricaded myself inside everyday and not gone anywhere; and because I have got good medication now and I have had the support from the HASI people, I can actually start to function a bit and get out and about in public and realise that there is a world out there and I should be a part of it (Muir et al, 2007).

Multi-dimensional support – whole of life support

ALI provides and links residents of boarding houses to a range of support. This can include formal and informal support services, peer support, support for complex needs, early intervention and mainstream support. Of course, ALI is not responsible for provision of all support, but facilitates a range of supports as required by each individual resident.

Consumers in an Australian study by Reynolds et al (2002), examining effective program linkages for people with mental illness, identified the following areas of support as important:

- Assistance with practical and financial support to access housing;
- Assistance with daily living skills;
- Support to develop and maintain social networks;
- Assistance to manage health and wellbeing;
- Transport and mobility; and
- Assistance to live independently.

The Reynolds study summarised sources of support as including family, friends, co-residents, neighbours and mainstream community resources and services, as well as specialist mental health and disability services. The Mental Health Council of Australia (MHCA) (2006) refers to these supports as 'natural support', to encompass the broad range of people consumers identify as supporting them, for example local shop owners and youth mentors.

The MHCA identified some housing and support factors as important for people with high support needs, including:

- Illness prevention and early intervention support at the initial signs of illness and prevention of relapse;
- Assisting people to live independently in their homes;
- Assisting people to participate in education, employment and the social life of their community; and
- Services to address the complexity of needs affecting people's lives, including dealing with coexisting drug and alcohol problems (MHCA, 2006).

Consumers also considered peer support processes, continuity of support with trusted workers and self-advocacy as important (MHCC, 2006). Queensland ARAFMI & Queensland Health (2004: 15) defined peer support as,

> based on mutuality, equality, shared power and transparent decision making. The uniqueness of people and their life history is respected and through the sharing of stories peer support helps people understand their experiences and attach meaning to them.

Peer support provides a social network based on common experiences and that provides a sense of hope and role models. The ARAFMI (2004) paper reports on an evaluation of a peer support scheme in Victoria and identified the following successful features of the model:

- A sense of community and security that is not about fixing things, but about validation, acceptance, support, non-judgment and witnessing the experiences of others;
- Flexibility where a range of possibilities are explored;
- Potential for learning;
- Respectful mutuality and honesty with self;
- Safety in self-disclosure and a responsibility to ensure the safety of others; and
- Respecting the limits of individuals and the tolerance of the community.

A multidimensional approach to support is also inclusive of clients with complex needs, for example people with mental illness who also have problems related to drug and alcohol abuse, past experiences of violence and sexual assault or a history of involvement with the criminal justice system. Services and workers need to be highly skilled and trained to work across disciplines. A multidimensional approach to support is important when working with Aboriginal and Torres Strait Islander communities. Health needs cannot be individualised or compartmentalised, as health for ATSI people is viewed within a holistic and community lifestyle framework (Brown, 2001).

An example of this broad community-based approach to support is reflected in the Social Health Teams, located within Aboriginal Community Controlled Health Services (ACCHS). The multi-skilled and multi-disciplinary teams provide social health services and support, responding to a wide range of support needs including suicide, mental health crises, substance misuse, grief, loss, trauma and violence. Teams may include mental health professionals, young people and family support workers, drug and alcohol specialists, sexual health workers, traditional healers,

counsellors and mental health promotion workers (National Aboriginal and Torres Strait Islander Health Council, 2004: 30).

Another aspect of multidimensional support is an early intervention approach to mental health problems, as seen in recent government and community responses to young people with mental illness. Headspace is a good example. It is a Federal government early intervention program targeting young people with mental illness and substance use disorders.

Health promotion and improving mental health literacy are both early intervention strategies targeting the younger population, which could be used effectively for younger residents in LRCs. They also support wider community efforts to address the stigma, discrimination and ignorance associated with mental illness.

Finally most people, with or without mental illness, receive support from mainstream services. Consideration of support needs of people with mental illness within these services is therefore necessary so that appropriate responses are embedded in the service system (Department of Human Services, 2006). The aim is to develop 'supportive' systems able to underpin and strengthen local service models and approaches. Systems level support also has the ability to better provide access to mainstream housing and support services, not exclusively specialised (mental health or disability) services.

In summary, the literature review *Housing and Associated Support for People with Mental Illness*, (Edwards & Fisher, 2007), suggest key service characteristics which could be effectively adopted by ALI. These include assertive outreach; time to nurture and build a working relationship between the person and support workers; commitment to ongoing regular support, including periods of intensive support when the person is unwell; ability to provide support outside business hours; consistency in the service providers and workers offering support; clinical intervention when the person is unwell or in crisis; consumer advocacy; and working with the whole person in all their complexity and diversity, including drug and alcohol and criminal justice.

9.4 New Directions in Day Programs: Life Choices and Active Ageing

In its consultation paper on day programs for people with disability (DADHC, 2009) day programs are described as offering a range of supports and activities focusing on the four areas of:

- skills development including daily living, social skills, independent living, personal development and pre-vocation skills;
- community access, participation and integration including peer support and participation in the community and its activities;
- adult education which in some circumstances might also include vocational activities; and
- leisure and recreation activities, including creative expression, social and individual leisure activities and outings.

These areas are consistent with and similar to, the activities outlined in the ALI SDS. Positioning ALI within the wider context of a Day Program may have some benefits. In particular program development and growth in the ALI could be driven by the

developments occurring in day programs, in particular around person-centred and individualized support.

DADHC is introducing two new programs, Life Choices and Active Ageing, described below, that will form part of the growth in adult day programs under *Stronger Together.* Again the ALI could be positioned within, linked to and/or informed by these programs.

Life Choices Program will target people aged 25 – 54, providing:

- purposeful age-appropriate daytime activities matched to skills and interests;
- leisure and recreation activities;
- healthy lifestyles;
- opportunities for community inclusion and participation e.g. volunteering; and
- support to pursue individual interests and age-appropriate social relationships.

Active Ageing Program will respond to the needs and interests of older people aged 55 – 64 (and people with early onset ageing), providing:

- age-appropriate daytime leisure and recreation activities;
- flexible service options to meet increasing/high medical needs;
- case management support to make the transition to an active older life;
- opportunities for community inclusion and participation, including mainstream seniors involvements; and
- support to build and maintain networks of support.

In particular older residents of LRCs could be linked into the Active Ageing Program. One key difference between the new programs and ALI is the funding level for each individual. The new adult day programs will provide for 'a minimum of 18 hours of activities and support per week, for 48 weeks of the year', compared with approximately 2 hours per ALI participant per week.

DADHC has developed operating principles that will inform its future approach and funding of adult day programs for people with disability. The principles are relevant to the ALI Program and could be effectively adopted by ALI. They are: person-centred planning; strengths based; life-stage appropriate and needs based; social inclusion and participation in the community; flexibility and choice; healthy and fulfilling lifestyles; culturally appropriate and accessible; integrated and collaborative practice; evidence-based and continuous improvement; and efficient and cost effective.

As one way forward and to foster consultation and collaboration with ALI providers, it is suggested that DADHC organise a state wide meeting of ALI providers to inform them of developments in day programs and consider how ALI can best respond to the new principles and two new adult day programs.

9.5 Summary

The four approaches discussed above are able to inform further development and growth in the ALI Program. In particular:

- The HASI evaluation emphasised the importance of stable housing, partnerships and service integration; a focus on recovery and prevention of mental health crises; and identifying participants' skills and strengths.
- The RSP's Community Linking Project focused on the use of social and recreational activities with the purpose of fostering residents' inclusion in the wider community; while the RSP developed professional and pragmatic relationships with the managers of private residential facilities.
- The recovery approach works with the whole person to bring a better quality of life, to minimise the impact of the disability. Recovery provides a powerful framework based on the view that people's mental health can be managed.
- The principles outlined for the new DADHC Life Choices and Active Ageing programs are able to inform the development of the ALI program, in particular principles of person-centred and individualised support.

10 Implications of the Findings

The evaluation interviews with people living in LRCs, stakeholders and staff in ALI providers, LRCs and DADHC identified implications for the effectiveness of the ALI program, which were discussed with the evaluation Steering Committee. This section analyses the preliminary findings against the intention of the program from three other sources: as written in the ALI program and contract specifications; from discussions with the evaluation Steering Committee; and from literature about similar and related programs.

10.1 Contemporary Directions in Disability Support

The ALI needs to be considered within the context of the broader disability policy arena and reforms occurring in NSW. They include the directions outlined in *Stronger Together* and community inclusion strategies for adults with disability, which form part of the day program reforms. The ALI program across NSW needs to be consistent with these directions; ALI growth and development can be informed by them. This section discusses key disability support principles for the ALI – person-centred support, flexibility, individual planning and skills development.

Person-centred support – individualising support

The practice of person-centred support has much to offer to social support programs for vulnerable persons, such as the ALI. Person-centred support means service users are at the centre of the service. People with disability have identified the following factors as key to person-centred support: choice and control; setting goals; importance of relationships; listening; information; a positive approach; learning; and flexibility (Glynn et al, 2008).

ALI providers recognised the need for one-on-one, individualised work with residents. However, one-on-one work was limited by the low level of funding and support hours for each individual, which is around 2 hours of support per person per week. In some instances, the support hours funded may only accommodate 1 hour per week of service. In order to offer more individualised responses to residents, funding arrangements need to be reviewed. Options include more funding, prioritising the needs of particular residents, or changing the way activities are arranged.

Greater flexibility

Greater flexibility, both in the model and individual service provision, can better deliver a developmental approach to disability support and integration with other disability and mental health services.

Most ALI providers recognised the need for an individual capacity building approach to implementing the ALI service model, consumer goals and SDS. The approach could accommodate a mix of activities and respond to changing individual consumer needs. For example, as part of an individualised program, at times in-house activities at the boarding house as a first step in a continuum to facilitate community participation and group activities are appropriate for some people as a transition in the mix of activities offered. If these types of activities are needed long term for some residents, caseworkers, LRCs, ALI providers should consider how to secure that support from alternative sources, such as HACC, volunteers and LRC staff.

Individual planning

The process for developing and applying the ISPs, which are the basis for ALI service delivery, could be improved. Practice in other DADHC Programs which use individual plans, for example Community Participation, could inform the ALI individual planning process.

The evaluation found that individual plans could better focus on individual needs and preferences and sustainable client outcomes. Plans will be more effective if they were less focused on activities (as appears to be the case now) and more focused on improving long term outcomes, such as physical and mental health, relationships, self-esteem and confidence.

Skills development

Of the three activities listed in the SDS, skills development was often the one that ALI providers struggled with. While ALI workers offered residents information about local TAFE and adult education classes, for example in the areas of literacy and computer skills, experience over the last 8 years suggests that most residents do not make use of these courses to improve their skills.

Respondents were concerned that some residents actually lost some of their skills when they entered the boarding house, because everything was done for them. One option for ALI may be in the area of development of daily living skills, including cleaning one's room, personal care and cooking. Residents of boarding houses do not have the opportunity to practise these activities because they are done by staff. Some residents, especially younger people, will move out of boarding houses and are likely to need these skills to live more independently in their community. Skills development with a focus on building daily living skills could be one area for ALI to foster.

10.2 ALI Program Development

Key areas for program development identified during the course of the evaluation included: networking among ALI providers; community education about mental illness; sustainability; development of partnerships and collaborative work with local community organisations; and responding to the characteristics of the resident group – mental illness and poverty.

Networking among ALI providers

The ALI state wide program will benefit from networking among ALI providers and workers, to share ideas on programs and activities, support innovation, identify strategies which promote community integration and sustainability, identify ways of resolving problems and build up a better profile for the ALI. An ALI conference was suggested as one way to build an ALI network and share information and approaches.

Community education about mental illness

ALI aims to foster community access and integration. ALI providers spoke of the stigma and discrimination in the community which people with mental illness faced and how this prevented meaningful community acceptance and integration. ALI providers' experiences could inform community education processes to foster acceptance around diversity and a better understanding of mental illness. Government and nongovernment providers of community education about mental health awareness

might be encouraged to consider ALI providers' experience to inform the content and implementation of community education programs.

Sustainability

Sustainability of community linkages is the big challenge of the ALI program. Some excellent examples of where ALI had fostered sustainability, including the examples of the darts player, vegetable garden, supported work program and active linking to other community services were reported.

While ALI providers worked towards the goal of sustained community engagement, they suggested that for some residents ALI would need to continue providing residents with ongoing support to access community activities and resources. This was often related to people's disability and past institutionalisation. They felt independent participation was not realistic for some people and that if ALI withdrew its support the resident may stop engaging with activities and previous gains made may be lost. A refocusing on generating links to other service providers, family and friends, rather than maintenance support, may help providers achieve more sustainable outcomes for residents.

Development of partnerships and collaborative work with local community organisations

A small number of providers gave excellent examples of partnerships and collaborative work with local community organisations. However, other providers seemed to have more passive connections with other services, for example transporting residents to a centre and leaving them there. Creative partnership building, between ALI and the community organisation the resident is linked with, could result in initiatives, innovations and more dynamic responses for the individual resident. In this sense, a 'link' between ALI and the organisation may not be enough; rather a partnership needs to be sought.

A focus on program linkages may be useful to assist the ALI develop. Recent research studies conducted by the Australian Housing and Urban Research Institute rely on the concept of 'linkages' between housing and support services for people with mental illness (Reynolds et al, 2002; Bleasdale, 2007). Reynolds defines linkages:

> The term program linkages encompasses all of the ways that programs, services, sectors, governments and their departments interact, interrelate, work together, cooperate, network and collaborate to achieve coordinated responses for individuals.

Service integration did not feature in many of the interviews or descriptions of ALI work. Partnerships could be one focus for ALI development and would strengthen the ALI aim of community integration and sustainability. The effectiveness of forming partnerships or brokering to organisations to pay for activities could be compared. One ALI provider suggested that strengthening ALI partnerships with local HACC services could be productive.

Responding to the characteristics of the resident group – mental illness and poverty

A recovery approach has much to offer to residents of LRCs, who are often a vulnerable, isolated and forgotten group. The approach is based on the goal for people with mental illness to seek a new and valued sense of identity, role and purpose outside the parameters of mental illness; and have a better quality of life by minimising any limitations of disability. A recovery approach may assist the resident to gain new skills and strengths and enable them to transition to more independent housing options within the community.

All respondents spoke of the poverty of residents. Sometimes all of residents' DSP was taken for board and lodging, in the best cases 85 per cent of the DSP was taken. Most consumers had very little or no money to pay for ALI activities such as trips to the movies, local swimming pool and ten-pin bowling. ALI providers had to subsidise the trips (not covered in their funding), or look to activities which were free of charge. Advocates said that all ALI activities needed to be free of charge, otherwise residents would be excluded.

ISPs need to consider the financial viability of the plan content. Further, the ALI program design needs to take account of client goals in a context of people in extreme poverty.

10.3 Responding to Diversity within the Resident Population

The evaluation found that ALI needs to take a more proactive approach to engaging with residents, rather than waiting for residents to come to them or only providing the weekly program to a group of 'regulars'. One approach is to develop strategies aimed at including the diversity of the resident population, including younger residents, ageing residents, Aboriginal, CALD and rural residents.

Younger residents

Respondents pointed out that ALI providers need to plan different activities for younger residents, such as a focus on daily living skills and use of public transport. ALI could also assist with transition to more independent and community-based housing and support options by referring them to more intensive case management, if desired by the consumer. Recovery from mental illness could be the focus for a program for younger residents.

Ageing residents

The needs of residents who are ageing in LRCs also require to be addressed by age-appropriate ALI activities. Respondents suggested that this could include the development of in-house programs as a transition step to engage older people with limited mobility, assisting with transition to aged care support programs, referrals to HACC programs and links to age-appropriate activities in the community. ALI could support and promote the aims of Healthy Ageing and link with the new day program Active Ageing.

Aboriginal, CALD and rural residents

People from Aboriginal and CALD backgrounds present an example of the benefits of applying an individualised approach to planning and activities. Opportunities exist in

many local areas to link Aboriginal and CALD residents into culturally appropriate services and activities, including linking residents with Aboriginal health workers and bilingual workers from Multicultural Resource Centres. The ALI could adopt a more proactive approach in this regard.

Rural areas may require a greater focus on provision of transport, building creative partnerships with local community organisations and being part of community development activities within the area.

10.4 Future Development of ALI

Many respondents recognised an opportunity for the evaluation to act as a catalyst for growth and development in the ALI program. It will be critical for ALI providers and stakeholders to be partners in this development, with DADHC. Two key areas for growth emerged from the evaluation. Firstly, that ALI evolve from a linking initiative to a program based on social inclusion. Secondly, that ALI engage with residents' long term housing needs and options, including options to move from boarding houses to more independent housing in the community. We suggest these two areas be examined at a statewide ALI strategy and planning forum, sponsored by DADHC.

11 Conclusions

The conclusions provide a summary of responses to the evaluation questions and a focus on ALI program development and future growth.

Evaluation questions

The evaluation found that ALI has provided services as intended and as outlined in the service type description. While it does use individual plans, the ALI should develop a more robust and comprehensive planning process, focused less on activities and more on consumer strengths and achieving outcomes. Within the constraints of funding, programs need to offer more individualised approaches to residents, rather than reliance on a program based on group activities.

The evaluation found that the ALI is achieving its intended outcomes: access of residents to community based recreation and leisure services and mainstream educational and vocational agencies; sustainable community linkages; and participation across the three areas of skills development, community based activities and educational and vocational opportunities. ALI performs best at linking residents with community based activities, especially those which provide recreation and leisure. It has struggled with linking residents to educational and vocational opportunities; while some ALI providers attributed this to the characteristics of the resident group and their psychiatric disability, it is also an indication of the disabling practices of educational and vocational institutions. One key area for ALI to develop is offering skills development focused on daily living activities and skills for more independent living.

More equitable outcomes for the LRC population will be achieved by ALI adopting a proactive approach to engaging with residents who currently do not use ALI. This includes the development of creative in-house activities as a pathway to future community participation, as well as providing a more individualised and culturally appropriate response to people from Aboriginal or CALD backgrounds.

Service delivery varies considerably across regions and between ALI providers and even within the ALI provider's practice depending on the characteristics and relationships with individual LRCs. While ALI providers met the requirements of the SDS, they implemented the SDS differently across NSW to meet local circumstances. Some themes relating to rural ALIs were consistently raised during the evaluation, in particular the isolation of residents, lack of transport options and limited number of community resources and activities with which to link residents.

Characteristics of effective service models able to deliver outcomes for LRC residents include: strong interpersonal relationships between ALI worker/s and residents based on trust and respect; professional and pragmatic relationships between ALI and the LRC manager and staff; ISPs to build capacity from the person's interests, strengths and abilities of the resident; person-centred and individualised approach; ability to build relationships and link to social networks, community opportunities and other service providers; and partnerships and collaboration between ALI and local community organisations.

HASI, RSP, the recovery approach and day program reforms all point to a broader context with which the ALI can be effectively connected. Themes from these community participation models and approaches, for ALI to utilise, include service integration, assertive outreach, personalised support, recovery from mental illness and individual planning processes.

Program development

Service improvement and development of ALI needs to be guided by contemporary directions in the provision of disability support, related to person-centred support, greater flexibility, individual planning and skills development. Key areas for program development identified by the evaluation include: fostering a stronger network across ALI providers statewide; community education about mental illness; sustainability of community linkages; development of stronger partnerships and collaboration with local community organisations; responding to the characteristics of the resident group within a recovery framework; and responding to diversity within the resident population. The key characteristic and aim of the ALI as a 'linking' initiative lends itself to broadening the focus of linking, to one able to promote partnerships and service integration.

Legislation and monitoring

Some concerns regarding the licensed boarding house sector were raised during the evaluation. In particular the way some boarding house managers use the withdrawal of ALI. Adequate legislation is required to safeguard against practices that breach residents' rights; together with monitoring and review of the LRC sector by DADHC. Many problems faced by the residents that ALI workers become aware of relate to the LRC environment rather than community participation questions.

Funding levels

All providers and stakeholders referred to the low funding levels as a major service constraint. In particular the funding did not allow for adequate individual and person-centred service. Instead the ALI program was used primarily for group and centre based activities, being a more affordable option. Funding levels for the ALI need to be commensurate with other DADHC Programs which are based on individualised support, such as Community Participation and new Day Programs currently in development.

Program based on social inclusion

Finally, while development and growth of ALI can be informed by and reflect, the principles outlined in the current day program reform agenda, it is also important for the ALI to retain its own identity, characteristics and strengths. Using these strengths, to move from a linking initiative to a program based on social inclusion for boarding house residents would be a positive development for the program.

Appendix A. Interview Schedules

INTERVIEW QUESTIONS FOR ALI CONSUMERS

Begin with introductions, purpose of interview, confidentiality and consent.

Questions focusing on ALI

1. How would you describe the ALI, in your own words? (work with response)
2. What do you do with the ALI? Can you describe the things you've done with them over the last year? What was the last thing you did with them? (prompts: social activities, community groups, training, recreation, activities at boarding house)
3. Who is the ALI worker you see? What are they like? How do they support you? Is there anything else you would like them to do that they aren't doing now?
4. What is the best thing about ALI? Why?
5. What about things you don't really like. What's the worst thing about ALI? Why?
6. What else would you like ALI to do for you? How could they help and support you more?
7. We're asking these questions to help ALI improve its support to people living in boarding houses. What are your suggestions and ideas on how ALI can improve the support it gives?
8. We've just started another year. What are your goals for this year? How can ALI help you meet those goals?

Provide a break here if needed and for the consumer to fill out the Personal Wellbeing Index.

Broader context questions about housing, health, friends and family

9. How long have you been living in the boarding house? What's it like living here? (work with response) Where were you living before you came here?
10. What's your health like? Who do you see when you're sick? What about your mental health?
11. What do you do during the day when you aren't doing things with ALI? Do you have any friends? What do you do with them?
12. Do you see your family? What's that like? What do you do with them? Do they give you any help or support? How do they help you?

Conclusion-consumer outcomes

13. What helps you feel part of your local community? (Work with response to this domain in Personal Wellbeing Index). How could ALI help you to feel part of your community?
14. The three goals of ALI are to learn new skills, get access to community things and do more recreational & fun things. Do you get these three things from ALI? Can you give me some examples?

15. What do you think has changed for you over the last year because of ALI?
16. Is there anything else you would like to say about ALI or living here at the boarding house?

Thank you for answering the questions and helping us with the evaluation. Your answers will help ALI to continue supporting people living in boarding houses. Would it be OK if I talk with (ALI worker, family member) about how the ALI is helping you? Provide gift voucher.

Personal wellbeing index

1. Can you tell me how happy you are about these parts of your life at the moment?

How happy do you feel about <u>your life as a whole</u> ?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about the things you have? Like the money you have and the things you own?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about how healthy you are?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about the things you make or the things you learn?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about getting on with the people you know?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about how safe you feel?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about doing things outside your home?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

How happy do you feel about how things will be later on in your life?

0	1	2	3	4	5	6	7	8	9	10
Completely unhappy				Mixed				Completely happy		

INTERVIEW QUESTIONS FOR ALI PROVIDERS

Begin with introductions, purpose of interview, confidentiality and consent.

1. How would you describe the ALI, in your own words?
2. What do you see as the main aims of your ALI service?
3. How do you go about achieving these aims?
4. Can you talk about the ALI consumers? What are some of their needs and problems they may experience? Who misses out on ALI services (and why)? How do you engage with residents of boarding houses?
5. How does the ALI meet consumer needs? How successful do you think you are in meeting people's needs? How could your service better meet the needs of consumers?
6. Can we talk about the program's three main areas of activity, identified in the Service Description Schedule. How does your service facilitate access to and participation in:
    - Skills Development
    - Community access and integration
    - Leisure and recreation.

    Can you provide one example of a person's individual plan which works well and covers these three activities. What were the reasons it was successful?

    Can you provide one example which was not successful? Why do you think it wasn't successful? What would need to change to make it work?
7. Can you describe your relationship with the Licensed Residential Centres? How do they help (or hinder) you in your work with ALI consumers?
8. Would you like to comment on the ALI service model? How do you think the model can best meet the needs of people from particular populations, for example women, Aboriginal, CALD and regional/rural. (*For rural providers*: What do you think should be the main components of a rural ALI model.)
9. What are some of the challenges in creating sustainable community linkages for the target group? What do you see as ALI's role in sustainability? (Do clients move on, do you take new clients into program?)
10. What are the main services you refer ALI clients to? Which services are most helpful? What about barriers to services, would you like to make some comment on that?
11. What do you think are the main priorities for ALI service development and improvement? What strategies should ALI adopt to meet service improvement goals?
12. Would you like to make some comments about the ALI Program in NSW? To what extent do you think it meets the outcomes of skills development, social inclusion and enhanced quality of life?
13. Are there any other comments you would like to make?

14. Can you please email me your most recent Annual Report and any client data you keep which may assist the evaluation. All information will be treated confidentially.

    Thank you for participating in the evaluation.

INTERVIEW QUESTIONS FOR DADHC CASEWORKERS

Begin with introductions, purpose of interview, confidentiality and consent.

1. How would you describe the ALI, in your own words?
2. What do you see as the main aims of the ALI services you are involved with?
3. What is your role in supporting the ALI and ALI consumers and wider role in supporting residents of boarding houses? Can you describe what your work involves and give some examples if that helps.
4. Can you talk about the ALI consumers? What are some of their needs and problems they may experience? Who misses out on ALI services (and why)?
5. How does the ALI meet consumer needs? How successful do you think ALI is in meeting people's needs? How could ALI better meet the needs of consumers?
6. Can we talk about the program's three main areas of activity, identified in the Service Description Schedule. How does ALI facilitate access to and participation in:
    - Skills Development
    - Community access and integration
    - Leisure and recreation.

What do you see as the strengths and weaknesses of ALI in relation to these activities?

7. Can you describe your relationships with Licensed Residential Centres and with ALI providers? How does DADHC develop positive partnerships within the boarding house sector?
8. Would you like to comment on the ALI service model? How do you think the model can best meet the needs of people from particular populations, for example women, Aboriginal, CALD and regional/rural. (*For rural providers*: What do you think should be the main components of a rural ALI model?)
9. What are some of the challenges in creating sustainable community linkages for the target group? What do you see as ALI's role in sustainability? (Do clients move on, are new clients accepted into the program?)
10. What are the main services ALI clients are referred to/access? Which services are most helpful? What about barriers to services, would you like to make some comment on that?
11. What do you consider are the main priorities for ALI service development and improvement? What strategies should ALI adopt to meet service improvement goals?

12. Would you like to make some comments about the ALI Program in NSW? To what extent do you think it meets the outcomes of skills development, social inclusion and enhanced quality of life?
13. Are there any other comments you would like to make?
14. Can you please email me reports and/or service contract data you keep on ALI, which may assist the evaluation. All information will be treated confidentially.

    Thank you for participating in the evaluation.

INTERVIEW QUESTIONS FOR LICENSED RESIDENTIAL CENTRES

Begin with introductions, purpose of interview, confidentiality and consent.

1. How would you describe the ALI, in your own words?
2. What do you see as the main aims of the ALI?
3. Can you describe how ALI operates in your LRC?
4. Can you talk about the ALI consumers? What are some of their needs and problems they may experience? Are there some residents of your boarding house which don't use ALI (why)?
5. We're asking these questions to help ALI improve its support to people living in boarding houses. What are your suggestions and ideas on how ALI can improve the support it gives?
6. The program's three main areas of activity are:
    - Skills Development
    - Community access and integration
    - Leisure and recreation.

    To what extent do you think ALI provides these three things to residents? Can you provide some examples.
7. Can you describe your relationship with the ALI worker/s? How do they help (or hinder) you in your provision of board and lodging to residents? What information do the ALI workers provide you about their program goals and activities? Is there anything you would like to change about how you work with ALI staff?
8. Have you had anything to do with DADHC in relation to the ALI Program (not talking about licensing here!) If you had the opportunity to tell DADHC in person what you think about ALI, what would you say?
9. What do you think are the main priorities for ALI service improvement? What strategies could ALI adopt to meet service improvement goals?
10. To what extent do you think the ALI Program meets outcomes of skills development, being included in the community and improved quality of life? (How would you describe your residents' quality of life?)
11. Are there any other comments you would like to make?

    Thank you for participating in the evaluation.

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