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Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI)

Evaluation Plan

Shannon McDermott, Jasmine Bruce, Karen R. Fisher and Kristy Muir

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Contents

List of tables and figures ..... **iv**
Abbreviations ..... **iv**
Executive Summary ..... **v**
1 Introduction **1**
1.1 Background 1
1.2 Aims of HASI 2
1.3 Roles and responsibilities of HASI partners 3
NGO partnerships 3
NSW Health 3
Housing NSW 3
Governance arrangements 3
1.4 Framework for service delivery 4
1.5 Evaluation of HASI 7
2 Evaluation Framework **8**
2.1 Program theory 8
2.2 Evaluation parts 9
Formative and summative evaluation 9
Economic evaluation 9
2.3 Evaluation questions 9
3 Methodology **11**
3.1 Rationale 11
3.2 Methods 14
Program data 14
Secondary data 15
Interviews 17
Program observation 21
Policy and program documents 21
Economic evaluation 22
4 Analysis **24**
4.1 Client outcomes 24
Health and mental health outcomes 24
Housing outcomes 25
Interviews 28
4.2 Policy and service system analysis 28
4.3 Economic analysis 28
5 Ethics **29**
6 Project Management **30**
6.1 Deliverables 30
Baseline Report (December 2009) 30
Interim Report (August 2010) 30
Final Report (February 2011) 31
6.2 Reference group 31
6.3 Evaluation timeframe 32
6.4 Data collection timetable 33
References **34**
Appendix A Evaluation Reference Group **36**

List of tables and figures

Table 1.1: Overview of HASI Program Stages....5
Figure 2.1: Evaluation Conceptual Approach....8
Table 3.1: Program Aims, Evaluation Questions and Methods....12
Table 3.2: Description of Evaluation Methods....14
Table 3.3: Longitudinal Interviews....17
Table 3.4: Interviews with Clients....18
Table 3.5: Interviews with Family Members....18
Table 3.6: Stakeholder Interviews....19
Table 3.7: Rural Research Site (Tamworth area)....20
Table 3.8: Regional Research Site (Gosford)....20
Table 3.9: South Eastern Sydney (encompassing Rockdale, St George, Sutherland, Hurstville, Kogarah, Randwick)....20
Table 4.1: Health and Mental Health Indicators....25
Table 4.2: Housing Indicators....26
Table 4.3: Social, Community Participation and Service Access Indicators....27
Table 6.1: Evaluation timeframe....32
Table 6.2: Data Collection Timeframe, Phase 1 2009....33
Table 6.3: Data Collection Timeframe, Phase 2 2010....33

Abbreviations

AHS	Area Health Service
AMHS	Area Mental Health Service
APQ-6	Activity and Participation Questionnaire
ARAFMI	Association of Relatives and Friends of the Mentally Ill
DADHC	NSW Department of Ageing, Disability and Home Care
DSRC	Disability Studies and Research Centre
HASI	Housing Accommodation Support Initiative
HASP	Housing and Support Program
HONOS	Health of the Nation Outcome Scale
IHS	Integrated Housing System
ILP	Independent Living Program
K-10	Kessler-10 Psychological Distress Scale
LSP-16	Life Skills Profile
MHCA	Mental Health Council of Australia
MRN	Medical Record Number
NGO	Non-government organisation
OCH	Office of Community Housing
NGO	Non-government organisation
NOCC	National Outcomes and Casemix Collection
PWI	Personal Well-being Index
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive Summary

NSW Health and Housing NSW have commissioned a research team led by the Social Policy Research Centre (SPRC) to conduct an evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI). The aim of this Evaluation Plan is to provide an overview of the research methodology which will be used to undertake the evaluation.

Background

HASI is a joint initiative between NSW Health and Housing NSW. The aim of the program is to provide stable housing and accommodation support for people with mental health issues in NSW. In 2002, Stage 1 of the program was rolled out in selected areas across NSW. It provided housing and access to high support services for 100 clients. A previous evaluation of HASI Stage 1 found that the initiative had a positive impact on individual clients in terms of improving mental health, providing stable housing and improving community participation (Muir et al. 2007). Since then, new stages of the HASI program have been introduced and the program now supports over 1,000 clients. The initiative has evolved to meet the different support needs of clients ranging from low, medium, high and very high support service levels.

Evaluation objectives and questions

The aim of the evaluation is to assess the effectiveness of HASI as a whole program as well as the effectiveness of each individual stage as the program has evolved. The evaluation questions guiding the research are focused around three key themes: participant outcomes, policy and service delivery model and economic analysis. The overall evaluation questions are:

1. Participant outcomes: To what extent has the initiative met its objectives for individual clients?
2. Policy and service delivery model: How effective is the HASI service delivery model?
3. Economic analysis: What are the costs and benefits of HASI?

A more detailed list of sub-questions is included in Section 2.3 of this report.

Research design and methods

The evaluation framework is based on program theory, which describes the relationship between the service delivery model and individual client outcomes. A mixed method, longitudinal approach will be used to gather data that answer the evaluation questions. This allows for a combination of quantitative and qualitative data to be analysed to measure change over time. Secondary financial and administrative data relevant to the initiative will be analysed, along with additional primary field study data collected in three fieldwork sites (interviews with key stakeholders supplemented by participant observation).

Timeframes

Qualitative data collection is planned to take place in two phases: Phase 1 (September 2009) and Phase 2 (September 2010). Administrative and secondary data will be collected by NSW Health and Housing NSW and transferred to the SPRC in February 2010. The research team will provide a baseline report and an interim report during the evaluation and a final report which will be delivered at the completion of the research.

1 Introduction

NSW Health and Housing NSW have commissioned a research team at the University of New South Wales (UNSW), led by researchers at the Social Policy Research Centre (SPRC), to conduct an evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI). The aim of the evaluation is to review all of the stages of HASI as a whole and individually, taking into account key themes around participant outcomes, policy and service delivery model, and economic analysis. The evaluation will contribute to a growing body of evidence which documents the role that supported housing plays in meeting the health and housing needs of people with a mental illness.

This report explains the methodology underpinning the evaluation. It includes:

- Background information about HASI;
- An overview of roles and responsibilities of program partners;
- Conceptual approach to the evaluation and key questions;
- Evaluation framework and data collection methods;
- Data analysis process;
- Ethical considerations; and
- Project management, including reporting and timeframes.

1.1 Background

Mental health disorders affect an estimated 1 in 5 Australians in any given year (Australian Bureau of Statistics, 2007). While the term *mental health disorder* is often used to cover a wide variety of diagnosed illnesses such as anxiety, depression or schizophrenia, the symptoms and severity of an illness can range from mild to severe impairment (Slade et al. 2009: 9). People with severe mental health disorders can experience detrimental impacts on both their psychological well-being as well as other aspects of their lives, such as housing and social relationships (Browne and Courtney, 2007). Previous research has shown that people with mental health disorders and disability often encounter difficulties 'in accessing and maintaining stable housing' (Bleasdale, 2007: 1) and, as a consequence, many people who are homeless are affected by mental health disorders (Flatau et al. 2008: 2).

Although the impact of mental health disorders can be detrimental, several factors can support a recovery process (Torrey and Wyzik, 2000; Lysaker and Buck, 2008). An important aspect of recovery is psychosocial rehabilitation, which works to enhance the capabilities of people with serious and persistent mental health disorders in order to maximise independence. Rehabilitation includes a range of social, educational, occupational, behavioural, and cognitive interventions that usually take place in four domains: skills training; peer support; vocational services; and consumer-community resource development of an array of community supports. Rehabilitation can be viewed as one particular type of program within a range of services, or as a template for all mental health services (Barton, 1999: 526).

The key philosophy that underpins the HASI program is one of recovery. The HASI program recognises that secure, safe and stable housing is an essential requirement for health and well-being. The program recognises that many people with mental health disorders have difficulty accessing or maintaining housing because of their illness and other factors such as poverty and social stigma. HASI aims to increase access to recovery services and to services that assist people with mental health disorders to maintain secure housing. This is done through the provision of integrated services which work in partnership across the health, housing, and NGO sectors (NSW Health, 2006a).

NSW is not alone in delivering integrated services to people with mental health disorders. Programs that are similar to HASI currently operate in most other Australian states and territories. For example, the Housing and Support Programs (HASP) in Victoria and Queensland have provided supported housing to people with mental illness for over ten years (Carter, 2008; Meehan et al. 2001). Western Australia's Independent Living Program (ILP), which is managed by WA Health and the WA Department of Housing and Works, provides 650 houses and accommodation services to people with a mental illness (Smith and Williams, 2006; Smith and Williams, 2008). Finally, South Australia's Returning Home Program offers support for people leaving hospital to live independently in the community (Carter et al. 2008).

1.2 Aims of HASI

HASI is designed to assist people with mental health disorders to participate in the community, to experience improved quality of life, prevent homelessness and, most importantly, the program assists in the recovery from mental illness. It aims to achieve this by linking people with mental health disorders with clinical mental health services, secure housing and accommodation support.

The specific aims of the program are to:

- Provide people with mental illness ongoing clinical mental health services and rehabilitation within a recovery framework;
- Assist people with mental illness to participate in community life and to improve their quality of life;
- Assist people with mental illness to access and maintain stable and secure housing; and
- Establish, maintain and strengthen housing and support partnerships in the community.

Since the implementation of Stage 1 in 2002, which funded high level support services, HASI has been expanded to provide low to very high levels of support to people with mental health disorders across NSW. Although the core objectives of the program have remained essentially the same since the inception of the program, the service delivery system has evolved as new stages of the initiative have been established. The different stages of the program are described in the next section of the report.

1.3 Roles and responsibilities of HASI partners

HASI is a joint initiative between NSW Health and Housing NSW with NGOs playing a central role in the HASI partnership model. The roles and responsibilities of each of the partners are described below.

NGO partnerships

Accommodation support is provided by NGO service providers with funding from NSW Health. NGO service providers that are responsible for delivering accommodation support packages include organisations such as Mission Australia, New Horizons, Neami and Uniting Care. The type of accommodation support provided varies depending on the stage in HASI in which the packages were awarded: some NGOs provide high levels of support to clients, while others provide medium to low support or a combination of support levels. NGOs work with local Area Mental Health Services (AMHS) to provide client focused care planning and access to appropriate services (NSW Health, 2006a: 25).

NSW Health

NSW Health funds the accommodation support provided by NGOs to HASI clients. In addition, NSW Health provides clinical mental health services to HASI clients from AMHS. Mental Health clinicians provide ongoing clinical support to HASI clients such as assessments, care coordination, treatment and rehabilitation (NSW Health, 2006a: 41).

Housing NSW

The provision of stable housing is one of the key objectives of HASI. To meet this objective, Housing NSW provides a mix of public and community housing properties to people with mental health disorders who are accepted into the HASI program. Key responsibilities of the public and community housing providers include:

- Allocate accommodation;
- Provide tenancy management services;
- Monitor rental payments and rental arrears; and
- Assist clients to manage their tenancies (NSW HASI, 2006a: 28-31).

Governance arrangements

The sponsor agencies, NSW Health and Housing NSW, are each represented on the Housing and Mental Health Partnerships Senior Officers Meeting and the Departmental Executive Committee (DEC). The Senior Officers Meeting oversees the HASI program from a strategic development, governance and future planning perspective. The DEC focuses on policy and operational effectiveness issues. HASI is managed on the local level by Local Coordination Groups, which aim to foster partnerships between the Area Mental Health Service, housing provider and the accommodation support provider in each area.

NSW Health hosts HASI stakeholder meetings regularly throughout the year where all the non-government organisations (NGOs) and the Area Health Services (AHS) are represented. A representative from Housing NSW is also invited to attend.

This model has been recognised as a successful way to support people with mental health problems and, in 2006, was awarded the Premier's Public Sector Gold Award for service delivery (NSW Premier's Department, 2006).

1.4 Framework for service delivery

The program is available to adults with a diagnosed mental illness who require support services (and in most cases housing) to assist them to live in the community. Commonly, people accessing support have been diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder, however, some people also have a dual diagnosis which may include depressive, anxiety, personality, intellectual, substance use, or brain injury disorders (NSW Health, 2006a: 21).

The HASI program has developed over time and, through the release of different stages, provides low to very high levels of support for people with mental health disorders. Most stages of HASI involve the provision of:

- Some level of accommodation support services; and
- A place in public or community housing.

A limited number of packages released in Stage 4B provide accommodation support to people who live in private housing (also called *HASI in the Home*). Table 1.1 describes the packages in each HASI stage.

Table 1.1: Overview of HASI Program Stages

Stage	Start date	No. of packages	Description of packages delivered
Stage 1	2002/03	100	• Access to high level accommodation support services • Access to public or community housing
Stage 2	2005/06	460	• Access to lower level accommodation support for people who are already living in public and community housing
Stage 3A	2005/06	126	• Access to high level accommodation support services • Access to public or community housing
Stage 3B	2006/07	50	• Access to very high level accommodation support services • Access to public or community housing
Stage 4A	2006/07	100	• Access to high level accommodation support services • Access to public or community housing
Stage 4B – (HASI in the Home)	2007/08	240	• Access to lower level accommodation support services for people who have private housing and/or are already living in public and community housing.
Total packages		1076	

Higher support packages

Participation in the high support program is available for people who meet the following eligibility criteria:

- Aged 16-65 years;
- Diagnosed with a severe mental illness;
- Have moderate to severe levels of psychiatric disability;
- Are eligible for social housing;
- Have the ability and desire to live in the community;
- Have the capacity to benefit from accommodation support services;
- Have submitted an application with a HASI accommodation service provider; and
- Have consented (or had their guardian consent) to participate in the program (NSW Health 2006a: 17).

Within the high level support program, priority is given to participants who are:

- In hospital because high level support has been difficult to access;
- Homeless, at risk of homelessness, or live in inappropriate housing; and
- Find it difficult to maintain stable tenancy without high level support (NSW Health 2006a: 17).

People are not eligible for high level support in the HASI program if they:

- Are not eligible for social housing;
- Require long-term hospital care;
- Receive support through other programs provided through NSW Department of Ageing, Disability and Home Care (DADHC) or the Department of Community Services;
- Require lower levels of support; or
- Are older and receive support through a nursing home or hostel (NSW Health, 2006a: 17).

Lower support packages

Eligibility to participate in lower level HASI support is for people who meet the following criteria:

- Are aged 16 years or older;
- Have accommodation in social housing;
- Have a diagnosed mental illness;
- Have low levels of psychiatric disability;
- Have a high level of functioning;
- Have the capacity to benefit from disability support services; and
- Give their consent to participate (NSW Health, 2006a: 21).

People who receive accommodation support services through other State or Commonwealth funded programs are not eligible to participate in HASI (NSW Health, 2006a: 21).

HASI in the Home provides low and medium support packages designed to assist people with a mental illness who are living in a variety of situations to live successfully within the community. Consumers do not have to live in social housing to receive accommodation support and, for this reason, there is no specific housing stock attached to this stage of the program. Consumers eligible for packages in this stage may live in private accommodation or social housing. Support may also be provided to consumers who are living in hospital because of the lack of appropriate supports available in the community.

Exiting the program

While the program aims to support people to live in the community, the decision to leave the program may occur when:

- The client's service needs become too high or too low;
- Long-term hospital care (inpatient care) is required;
- The client is in breach of their tenancy agreement;
- The client's financial position changes and social housing is no longer needed (except if the consumer receives HASI in the Home);

- The client has a new partner and wants to end the housing lease; or
- The client wishes to end the lease for financial reasons (NSW Health, 2006a: 15).

Accessing the HASI program and exit planning for all clients and potential clients is usually discussed and negotiated on an individual basis with the AMHS, the NGO and the housing provider.

1.5 Evaluation of HASI

The first independent evaluation of HASI was conducted on Stage 1 and completed in 2006. The evaluation indicated that HASI was effective in providing people with mental illness secure and affordable housing and regular access to health and mental health services. Clients experienced increased community participation, improved physical health and psychological well-being, reduced rates of hospitalisation and improved social connectedness (Muir et al. 2007).

Following the evaluation of Stage 1, HASI was rolled out in a number of stages across the state and the program is now well established. This evaluation aims to:

1. Review the effectiveness and efficiency of the program as a whole in meeting its aims and objectives for clients around:
    - Secure tenancy;
    - Increased access to health, mental health services and accommodation support services;
    - Improved mental and physical health;
    - Improved social and community connections; and
    - Improved quality of life.
2. Assess the effectiveness and efficiency of the HASI stages individually and collectively including the:
    - Operational effectiveness of the service delivery model;
    - Effectiveness of the partnership model;
    - Policy context;
    - Costs and benefits of the model;
    - Impact on client outcomes; and
    - Sustainability of housing support.
3. Contribute to ongoing improvements in HASI support provided to clients and the partnership arrangements.

This evaluation will be both formative in order to inform policy development in the evolving program, and summative, in that it reports on the outcomes for clients. The following section considers the framework guiding the evaluation and specific evaluation questions.

2 Evaluation Framework

Program theory provides the conceptual basis for the HASI evaluation (Figure 3.1). The conceptual underpinnings of the evaluation and the evaluation questions are described in this section.

2.1 Program theory

Program theory articulates the elements of a program and assists in describing how these elements fit together to meet an identified need. To do this, program theory examines the inputs, activities, outputs and outcomes (short and long term) of a program. Understanding program outcomes requires a synthesis of the inputs, process and context to determine 'for whom, in what circumstances and in what respects a family of programmes work' (Pawson, 2006: 25). In addition to these elements, program theory also draws attention to how the program is influenced by the wider service system, the policy context and other external contextual factors (McLaughlin and Jordan, 1999).

The following logic model will be applied to HASI to understand the relationship between the individual stages of the program and how HASI works as a whole to produce outcomes for HASI clients.

Figure 2.1: Evaluation Conceptual Approach

Inputs ⇨	Activities ⇨	Outputs/Impacts ⇨	Outcomes
HASI policies, plans and infrastructure Resources/funds – housing, health, NGO support Consumers Support staff Housing management staff Other service providers and government programs	HASI management and planning Partnership management – government (health and housing), NGO (support and housing) HASI service delivery – accommodation support, clinical support, other Facilitation and barriers to change	Types and amount of support, services and housing provided Access to services – accommodation support, clinical support, housing, other Consumer satisfaction Support for managers and staff Engage consumers with special needs and specific population groups	Improved housing stability, successful tenancy, community participation, quality of life, physical and mental health and well-being, safety, capacities, life skills, education and employment, social networks and functioning Decreased hospital admissions, community complaints and homelessness

This approach provides a useful framework for understanding the relationship between the service delivery model and outcomes for individual clients.

2.2 Evaluation parts

The evaluation has three interrelated parts: formative, summative and economic evaluation.

Formative and summative evaluation

The evaluation process will generate information about the program throughout the evaluation period to inform progressive policy and program change. This will include outcomes and process evaluation data. In addition, the final evaluation report will draw summative conclusions for the whole of HASI program.

One of the key aims of the evaluation is to assess whether the program has met its objectives for individual clients. To address this aim, the evaluation will analyse the outcomes for HASI participants across a range of health, housing and social indicators (Section 2.3).

Another important aspect of the evaluation is to assess the effectiveness of the service delivery model. To address this aim, the evaluation will analyse the policy context in which HASI operates and how effectively the current service delivery model is operating across each of the HASI stages and as a whole program, including the HASI partnership model which is central to the service delivery framework (Section 2.3).

Economic evaluation

Economic analysis provides information about the value added to the service system by a particular program. The underlying principle of economic analysis is that for the given budget, the government wishes to maximise the total aggregate housing, health and other consumer benefits. This analysis is done by comparing the cost of HASI with its outcomes and making judgments about the benefits of the program as a whole based on this comparison (Section 2.3).

2.3 Evaluation questions

The tender document outlined evaluation questions in five themes: aims and objectives, economic analysis, models, analysis of existing policy and partnerships. The questions under the five original themes have been consolidated into three key themes: client outcomes (aims and objectives), service delivery model (partnerships, policy and models) and economic analysis.

1. **Participant outcomes**: To what extent has the initiative met its objectives for individual clients?

    - Are clients receiving stable and affordable housing?
    - What impact has the initiative had on community participation?
    - Are clients more engaged in activities such as employment, voluntary work and education and training?
    - Is the initiative achieving improved health and mental health outcomes for clients?
    - Is the initiative having an impact on clients' quality of life?

- Is the program facilitating improved access to generalist and specialist services?
- Is the initiative supporting improved social contact?

2. **Policy and service delivery model**: How effective is the HASI service delivery model?

   - What are the strengths and weaknesses of the current service delivery model?
   - How could the service model be improved and strengthened?
   - What are the factors that support good working relationships between HASI partners?
   - Are there any factors which limit the effectiveness of HASI partnerships?
   - How can HASI partnerships be improved and strengthened?
   - Do the current partnership arrangements support appropriate and flexible delivery of services for clients?
   - How effective is the governance of HASI?

3. **Economic analysis**: What are the costs and benefits of HASI?

   - What is the HASI expenditure in terms of establishment and recurrent costs? Which agencies or people incur these costs?
   - What is the average cost per person in HASI compared to the cost prior to HASI?
   - What are the benefits to the person, government and community during HASI compared to prior to HASI?
   - Where these benefits can be quantified in financial or economic terms, what cost savings result from HASI services? What agencies experience the cost savings?

The next section outlines the methods by which these questions will be answered and the rationale behind the research design.

3 Methodology

This study uses a longitudinal, mixed methods design to address the evaluation questions. The rationale behind the design and the methods chosen to answer the research questions is discussed in this section.

3.1 Rationale

Some studies have used experimental research designs in the evaluation of mental health services. In a US evaluation of the cost-effectiveness of a supported housing program for people with a mental illness, clients were randomly allocated to three treatment groups; the first group of clients received standard care, the second group intensive management care, with the third group receiving intensive management care and rent subsidies (Rosenheck et al. 2003: 940). Even though this approach is considered to be rigorous, it was deemed not to be feasible for the current evaluation for a number of reasons. Aside from the ethical issues associated with limiting access to services for the purpose of evaluation, HASI participants had already been selected to participate in the program from 2002 and so it was not possible to randomly allocate access to HASI support services for the purpose of the evaluation.

The second reason why an experimental design was not chosen is because it is assumed that this type of study can show that a treatment causes an effect by controlling other variables (Pawson and Tilley, 1997). Because the social world is complex, it is impossible to experimentally control all variables and so there is a concern that conclusions about the social world drawn from randomized controlled trials lead to 'artificially closed comparisons' (Pawson, 2006: 18). Furthermore, such studies cannot explain which elements of the program have produced those effects and in what contexts, so process evaluations are needed to distinguish between the failure of the theory guiding the program versus implementation failure (Birckmayer and Weiss, 2000).

Finally, experimental designs are extremely costly and, in most evaluations, impractical due to limitations around the scope, funding and timeframe (Bangert-Drowns and Wells-Parker, 2001).

For these reasons, a longitudinal, mixed method research design was chosen to address the aims of the evaluation and, the use of a longitudinal approach means that outcomes for participants can be tracked over time. The way in which the methods used in this evaluation were selected to match the evaluation questions is outlined in Table 3.1.

Table 3.1: Program Aims, Evaluation Questions and Methods

Theme	Evaluation questions	Evaluation methods						
		Program data	**Secondary data**	**Interviews-clients**	**Interviews-family**	**Interviews-stakeholders**	**Observation**	**Policy and document analysis**
Individual clients	To what extent has the initiative met its objectives for individual clients?	✓	✓	✓	✓	✓		
	Are clients receiving and maintaining stable and affordable housing?	✓	✓	✓	✓	✓	✓	
	Is the program facilitating improved access to generalist and specialist services?	✓	✓	✓	✓	✓		
	Is the initiative achieving improved health and mental health outcomes for clients?	✓	✓	✓	✓	✓		
	What impact has the initiative had on community participation?	✓		✓	✓	✓		
	Are clients more engaged in activities such as employment, voluntary work and education and training?	✓		✓	✓	✓		
	Is the initiative supporting improved social contact?	✓		✓	✓	✓		
	Is the initiative having an impact on clients' quality of life?			✓	✓	✓		
Service model	How effective is the HASI service delivery model?	✓		✓	✓	✓	✓	
	What are the strengths and weaknesses of the current service delivery model?	✓		✓		✓	✓	
	How could the service model be improved and strengthened?	✓		✓		✓	✓	

Theme	Evaluation questions	Evaluation methods						
		Program data	**Secondary data**	**Interviews-clients**	**Interviews-family**	**Interviews-stakeholders**	**Observation**	**Policy and document analysis**
	What are the factors that support good working relationships between HASI partners?					✓	✓	
	Are there any factors which limit the effectiveness of the HASI partnership model?					✓	✓	
	How can the HASI partnership model be improved and strengthened?					✓	✓	
	Do the current partnership arrangements support appropriate and flexible delivery of services for clients?					✓	✓	
	How effective is the governance of HASI?					✓	✓	
Costs and benefits	What are the costs and benefits of HASI?					✓		✓
	What is the HASI expenditure in terms of establishment and recurrent costs? Which agencies or people incur these costs?					✓		✓
	What is the average cost per person in HASI compared to the cost prior to HASI?							✓
	What are the benefits to the person, government and community during HASI compared to prior to HASI?	✓	✓	✓	✓	✓	✓	✓
	Where these benefits can be quantified in financial or economic terms, what cost savings result from HASI services? What agencies experience the cost savings?		✓					✓

3.2 Methods

The evaluation methods are summarised in Table 3.2 and discussed below.

Table 3.2: Description of Evaluation Methods

Evaluation methods	Description and explanation
Program data (HASI MDS)	Information collected as part of the HASI Minimum Data Set (MDS) will be analysed as part of the evaluation.
Secondary data (Health, Housing)	Administrative records on client outcomes will be analysed from datasets managed by NSW Health and Housing NSW. This includes: • NSW Health Inpatient care data • NSW Health Mental Health Ambulatory data • NSW Health NOCC data • Housing NSW tenancy data Financial and administrative data on the costs of the program: • NSW Health financial data • Housing NSW financial data
Interviews • Clients • Family members • Other stakeholders	Interviews will be conducted with HASI clients, family and friends of HASI clients, NGO service delivery workers, Housing provider staff, AMHS staff, other stakeholders involved in HASI policy and program implementation. The interviews will provide detailed information to address key evaluation questions specifically in relation to the strengths and weakness of the program, tracking changes for a group of clients over time and will assist with understanding how changes occur over time.
Program observation	The researchers will spend time at each of the three fieldwork sites observing the different contexts in which the HASI program operates.
Policy and program documents	Program and policy documents will be collected and analysed as part of the evaluation.

Program data

The evaluation will analyse information collected in the HASI Minimum Data Set (MDS). This information is collected as part of monitoring of the HASI program for the purpose of quality assurance. The MDS was designed and managed by independent consultants (ARTD) until July 2009, after which NSW Health (InforMH) took over its management.

Information contained in MDS is completed by NGO service providers when clients first join the program and NGOs provide progress reports on each client every quarter. Clients are given a unique identifier by the NGO, meaning that all information in the MDS is de-identified when it is submitted for entry into the system. Clients can be tracked over time so long as they have the same level of support package and remain with the same provider. If clients change provider or package, they are allocated a new identifier by the NGO and so the MDS data cannot be used to track movements between packages or providers.

The MDS provides a uniform way of describing demographic characteristics of consumers in HASI and also contains valuable information about program inputs such as the percentage of time staff spend with clients on certain activities. However, in its current form, the MDS collects limited data on client outcomes such as clients' physical health status, or social and community participation. For example, the information in the MDS on clients' mental health status is based on either the NOCC scores reported to the NGO by the AMHS, or the NGOs assessment of CAN and GAF scores. There are poor completion rates for all measures, which limits their usefulness for the evaluation.

Even though the HASI MDS does contain some information related to clients' participation in community activities, this information only describes program inputs rather than client outcomes. In other words, it can be used to measure whether clients have a goal to participate in social activities, but we do not know whether or in what way they are participating. Therefore, the current data in MDS cannot be used to determine whether clients' participation in community activities has changed over time.

To address this, supplementary questions for MDS have been drafted in order to collect important information on social and community participation (Table 4.3). These measures are currently being considered as supplementary information to be collected twice for use in the evaluation. These questions will provide cross sectional information about community, social and economic participation, service access and mental and physical health status across the HASI population.

Secondary data

In addition to the program data described above, the evaluation will also analyse de-identified secondary data transferred from NSW Health and Housing NSW to address several of the evaluation questions (Table 4.1 and Table 4.2).

NSW Health

Secondary data from National Outcomes and Casemix Collection (NOCC) (mental health measures), Inpatient care collection (hospitalisations data) and Mental health ambulatory care collection (community mental health service use data) will be obtained from NSW Health databases.

NOCC data contains four different mental health measures including the:

- Kessler Psychological Distress Scale (K-10);
- Health of the Nation Outcome Scale (HONOS);
- Life Skills Profile (LSP-16); and
- Activity and Participation Questionnaire (APQ-6).

Inpatient care data includes information on the number of times emergency care was used, the number of inpatient hospital visits, reason for hospitalisation and the length of stay. Mental health ambulatory care data includes information on the number of times clients accessed mental health services in community settings. This data will be included on the proviso that it is available and reliable.

HASI clients will be identified through their Medical Record Number (MRN) and the location of service which will be added to the MDS so that HASI clients can be identified in NSW Health data without accessing any identifying information. The data will be collected on each client from the year 2000 until 2009 in order to track change in mental health status, hospitalisation and service use before, during and after HASI. Analysis of secondary health data is contingent on ethics approval, consistency in identifying MRNs, and completeness of the datasets.

If possible, comparison groups will also be selected so that the changes experienced by HASI clients can be measured against people of similar characteristics who have not had access to HASI support. Ideally, the comparison groups will be as large as the group of HASI clients (up to 1000 people) and would be determined based on the following characteristics: diagnosed mental illness of similar severity to HASI clients; age; and pattern of service use comparable to the matched HASI client.

This data provided by NSW Health is crucial for the evaluation to assess changes in clients' mental and physical health as a result of HASI, however, there are limitations surrounding the completeness and regularity that the NOCC and Mental Health Ambulatory data is collected and entered into the system by AMHS clinical staff. The APQ-6 is a new assessment which has been introduced in 2009. While data from this assessment would be useful to the evaluation, retrospective data will be unavailable and the completeness of the data remains unknown at this stage.

Housing NSW

Administrative data from Housing NSW's Integrated Housing System (IHS) will be used to collect information on the following client outcomes (see Table 4.2 for more detail):

- Tenancy stability;
- Homelessness;
- Housing affordability;
- Housing Assistance; and
- Repairs and maintenance.

HASI clients will be identified in the IHS through a flag that identifies HASI clients under the Housing and Human Service Accord. About 500 HASI clients in public housing can be identified through the flag. Unfortunately, the IHS does not include information on clients in community housing, therefore, the administrative data on housing indicators will be limited to HASI clients who are living in public housing. Even though the delivery of services by community and public housing providers may affect client outcomes, there is no way of measuring this from the IHS. This issue will be explored, however, in interviews with HASI clients. A further limitation of this data is that neighbour complaints can only be collected from hard copy files rather than the IHS, so this data is not available for the evaluation.

Housing NSW has identified a potential comparison group through a review of a selection of people on the priority housing list. The file review identified 59 clients

who had similar characteristics to HASI clients but who were not receiving HASI services.

The researchers aim to link de-identified Housing data with the Health data and MDS by way of client date of birth, gender and postcode. Data will only be able to be linked for the 500 clients in public housing, but it will lead to a more robust analysis of the data overall.

Interviews

Longitudinal interviews will be undertaken with key stakeholders involved in the program. Samples will include: 60 consumers across the HASI stages in three fieldwork sites; forty workers and managers; and nine family and carers related to the 60 consumers will also be interviewed (Table 3.3). Interviews will be conducted with the most recent clients in all six of the HASI stages, equating to approximately 10 consumers per stage.

Table 3.3: Longitudinal Interviews

	Phase 1 2009	Phase 2 2010	Total
Client interviews	60	60	120
Family and carer interviews	9	9	18
Stakeholder interviews	40	40	80
Total interviews	109	109	226

Interviews will be conducted at three fieldwork sites including a metropolitan, regional and rural location in order to include a diversity of experiences in the evaluation. There will be a minimum of two visits to each research site during the course of the evaluation.

Client interviews

Interviews with clients will be conducted to explore their experience and perceptions of HASI and any changes experienced in their lives while involved in the program. Interviews with clients will be conducted at two points in time during the evaluation period to enable changes to be tracked over time. Client interviews will cover topics such as tenancy, service access and social and community participation. Client interviews will also include standard questions from the Personal Well-being Index (PWI). This will enable clients to rate their personal welfare and identify any changes in their well-being over time. If clients leave the program after the first interview, researchers will attempt to interview them to gain a better understanding of why they left the program and how the program fits in with other support services.

Table 3.4: Interviews with Clients

	Phase 1 2009	Phase 2 2010	Total
Metropolitan site	20	20	40
Regional site	20	20	40
Rural site	20	20	40
Total	60	60	120

Family member or carer interviews

With the permission of clients, family, friends and carers of the 60 consumers will also be invited to participate in an interview (Table 3.5). Similar to HASI clients, family and friends will be asked about their experience and perceptions of the program.

Table 3.5: Interviews with Family Members

	Phase 1 2009	Phase 2 2010	Total
Metropolitan site	3	3	6
Regional site	3	3	6
Rural site	3	3	6
All three sites	9	9	18

Other stakeholder interviews

Other stakeholders associated with the three fieldwork sites will also be asked to participate in a face to face interview or phone interview (Table 3.6). Stakeholder interviews will focus on their experience of the service delivery model, partnerships and client outcomes. The following stakeholders will be invited to take part in the evaluation:

- Accommodation support providers: NGO staff who provide essential accommodation services as part of the HASI program;
- Housing providers: Staff involved with HASI who work for community and public housing service providers;
- AMHS service delivery staff and AMHS Managers: mental health clinicians who provide support to HASI clients;
- HASI staff at NSW Health and Housing NSW: Key staff involved in the HASI program at a program and policy level;
- Consumer and provider organisations: Representatives from the Evaluation Reference Group will also be invited to participate in an interview. Additional representatives from consumer and mental health peak bodies may also be asked to participate if appropriate.

Table 3.6: Stakeholder Interviews

	Phase 1 2009	Phase 2 2010	Total
Metropolitan site	10	10	20
Regional site	10	10	20
Rural site	10	10	20
All fieldwork sites	30	30	60

Recruitment strategy

Participants in the study will be recruited in two ways. Clients, family members and carers will not be personally approached by the researchers. HASI clients will initially be invited by a trusted person to participate in the research. If the consumer gives initial consent to the trusted person, the contact details will be passed to the researchers to arrange the fieldwork and to gain full consent to participate. Researchers will ask each clients permission before contacting family members and carers to participate in an interview. This 'arm's length' process aims to avoid real or perceived coercion by the researchers. A similar recruitment process was successfully applied in the HASI Stage 1 evaluation.

The stakeholder interviews will similarly be focused around the 60 clients. Key stakeholders in this research are NGO service providers, such as workers and managers, housing providers, mental health consumer groups and staff from key government agencies such as NSW Health and Housing NSW. Stakeholders will be indirectly approached by the researchers to participate in the study via email invitation. The email will explain to identified stakeholders that participation in the research is voluntary and consent can be withdrawn at any stage of the research process.

Research sites

As described above, interviews will be conducted in three research locations. The sites selected for the evaluation are: Tamworth, Gosford and an area which will be known in this evaluation as South Eastern Sydney but which encompasses areas such as Rockdale, Kogarah, Hurstville, St George, Sutherland, Botany Bay and Randwick. These fieldwork areas were selected in consultation with key staff at NSW Health and Housing NSW on the basis that: all stages of the HASI program were covered in at least one area (Table 1.1); accommodation services provided by singular and multiple NGO providers were included; accommodation provided by both public and community housing providers was included and; a combination of metropolitan, regional and rural contexts were covered. Details of the number and stage of the packages in each site are provided in Table 3.7, Table 3.8 and Table 3.9.

Table 3.7: Rural Research Site (Tamworth area)

NGO providers	HASI Stages	Commencement date	Number of packages
RFNSW	Stage 1	2002/03	10
PRA Tamworth	Stage 2	2005/06	15
		Total packages	25

Source: NSW Health, April 2009

Table 3.8: Regional Research Site (Gosford)

NGO providers	HASI Stage	Commencement date	Number of packages
New Horizons	Stage 1	2002/03	10
Mission Australia	Stage 2	2005/06	27
New Horizons	Stage 3A	2005/06	8
New Horizons	Stage 4A	2006/07	1
Uniting Care	Stage 4B (HASI in the Home)	2007/08	10 (medium)
		Total packages	56

Source: NSW Health, April 2009

Table 3.9: South Eastern Sydney (encompassing Rockdale, St George, Sutherland, Hurstville, Kogarah, Randwick)

NGO providers	HASI Stage	Commencement date	Number of packages
Neami	Stage 1	2002/03	7
Neami	Stage 2	2005/06	33
Neami	Stage 3A	2005/06	7
Neami	Stage 3B	2006/07	18
Neami	Stage 4A	2006/07	8
Neami	Stage 4B	2007/08	22
		Total packages	93

Source: NSW Health, April 2009

Program observation

In addition to undertaking interviews with key stakeholders, the research team will spend time in each of the three fieldwork sites to explore how the program operates in specific contexts. In consultation with NGOs and their staff, researchers will spend time at the NGO offices to understand the environment in which HASI services are managed and delivered.

Participant observation is a method that has been used in previous research on health care service delivery (Fudge et al. 2008: 314). It involves the researchers observing how the service system and partnerships are working (across the individual stages of HASI and as a whole program) and taking detailed notes about their impressions. The benefit of this approach is that it provides researchers with a rich understanding of the service delivery context and provides an additional source of data which can be triangulated with other data sources. For example, program observation data can be contrasted with what is written in policy documents and procedure manuals with interview data, which can strengthen the overall analysis. Participant observation is an important component of the evaluation as it enables researchers to gain a greater understanding of the factors which can enhance and limit the effectiveness of the HASI program. An observation schedule will be used by researchers to guide the program observation.

Policy and program documents

The evaluation aims to examine the broader policy context in which HASI operates. In addition to interviewing key stakeholders who are knowledgeable about HASI and the broader mental health policy context, another method used in the evaluation is policy and program document analysis. The purpose of this method is to understand the relationship between the HASI service model and the broader mental health policy framework. Documents included in this aspect of the evaluation will aim to include but not be limited to:

- NSW: A new direction for mental health (NSW Health, 2006b);
- NSW State Health Plan: A new direction for NSW (NSW Health, 2007a);
- National Standards for Mental Health (Commonwealth of Australia, 1997);
- NSW Disability Service Standards (NSW DADHC 1998);
- NSW Community Health Strategy 2007-2012 (NSW Health, 2008a);
- NSW Multicultural Mental Health Plan 2008-2012 (NSW Health 2008b);
- NSW Aboriginal Mental Health and Well-being Policy 2006-2010 (NSW Health 2007b);
- Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders (NSW Health, 2002);

It will also include documents directly related to HASI. For example:

- HASI Resource Manual (NSW Health, 2006a)

This part of the evaluation requires that relevant policy and program documentation is transferred to the evaluation research team for analysis.

Economic evaluation

The economic analysis will compare the costs of HASI with the benefits clients experience a result of the program, such as changes in service access, physical and mental health, functioning and social, community and economic participation. These benefits will be compared with either the budgeted or, preferably, the actual expenditure on HASI services, including accommodation support (contributed by NSW Health), and central project management costs at the state and AHS levels.

The hypothesis of this analysis is that for a given cost, as a result of HASI, clients experience improvements in service access, health status and participation. A secondary hypothesis based on the experience of the HASI Stage 1 evaluation is that for some clients, the benefits represent a cost saving to government compared to before clients entered HASI and compared to people with mental illness who do not have access to HASI.

The extent to which this hypothesis can be tested depends on the availability and quality of expenditure and benefit data provided by NSW Health and Housing NSW. In addition, not all benefits from HASI can be quantified into a dollar value, which limits the scope of the economic analysis. Costs of the outcomes will be quantified where realistically possible and other outcomes will be discussed in relation to the benefits in more general terms.

Costs

HASI offers low to very high support packages, so the cost of HASI will differ depending on the package received. We will calculate the unit cost of HASI per client as the financial expenditure on each stage divided by the number of clients in each of the stages. A unit cost per client by level of support actually provided will also be calculated where possible from the HASI MDS data to test the relationship between contracted cost and the support cost. The cost will also include the ongoing administrative and service costs of providing HASI services, including the financial costs of managing HASI and the cost of providing accommodation support services. If possible, the following categories of recurrent cost will be collected by HASI to be analysed.

- Program management: These are costs not specific to one client and instead describe the costs of project management positions in NSW Health and Housing NSW and any positions funded in the Area Health Services that are dedicated to HASI;
- Accommodation support services: The cost of providing accommodation support such as care planning, arranging services or providing direct services. This cost is incurred by NSW Health but may also involve costs to the NGOs.

If possible, the costs reported by NSW Health and Housing NSW should include the actual expenditure (if this is not available, the budgeted cost). The cost analysis will exclude:

- One-off costs of establishment and evaluation because these are not comparable to the operational systems in other health, housing and community service systems;
- Costs incurred by other agencies that are not allocated to the HASI budget;
- Indirect costs to clients or other stakeholders; and

- Non-financial costs, such as time, stress and impact on other service providers.

Costs will be taken at the dollar value at the time of measurement because the analysis is a relative comparison of simultaneous service provision over a short evaluation period. We will assume all other costs for HASI clients and other clients are the same, except the financial cost of the HASI project (e.g. criminal justice and drug and alcohol management).

Data on HASI costs will be collected once (February 2010) and will concentrate on costs incurred in the 2007-2008 and 2008-2009 financial years.

Benefits

The cost data described above will be compared with the impact of the program on clients. Data on client impact will be gathered from program and secondary data provided by NSW Health and Housing NSW and will be supplemented with data from the qualitative interviews with clients. Secondary data on HASI will be analysed in relation to comparison groups (see Sections 3.2 and 4.1).

The next section explores how each of the methods will be analysed in relation to the three key research questions.

4 Analysis

Analysis of the various sources of data will be conducted with the aim of answering each of the evaluation questions as set out in Section 2.3. The three key research questions are:

1. To what extent has the initiative met its objectives for individual clients?
2. How effective is the HASI service delivery model?
3. What are the costs and benefits of HASI?

4.1 Client outcomes

A key objective of the evaluation is to analyse the effectiveness of the program for individual participants. The data for this analysis will be drawn from program and secondary data sources for all HASI clients and interviews with clients and their family members in the three fieldwork sites.

The evaluation will analyse baseline data in order to compare change over time across a number of key housing, health and social and community outcomes for HASI clients. Outcomes data analysis will test the hypothesis that participation in HASI:

- Improves mental and general health;
- Improves housing stability;
- Improves social and community connections; and
- Increases access to health, mental health and accommodation services.

Where available a comparison group will be selected in order to measure changes within the HASI population group over time compared to changes within a comparable population group.

Health and mental health outcomes

The evaluation will assess whether there have been improvements for individual clients in terms of their health, mental health and well-being (Table 4.1). It will also analyse how effective the program has been in supporting clients to live independently in the community by analysing whether there has been a decrease in hospital admissions. Where possible the analysis will track changes over time by comparing health outcomes for participants before and during the program and also by comparing outcomes for the HASI population and comparison group. This analysis is dependent on when people start to receive HASI services. While there are different ways of measuring the HASI start date, such as acceptance into the program, start of lease date or move in date, for the purpose of this evaluation the HASI start date will be defined as the date the client was accepted into the program.[1]

[1] Except when analysing selected housing outcomes where the start date will be defined as the date the client's lease commenced.

Analysis of hospitalisation rates, mental health outcomes and other health outcomes for HASI clients as compared to other groups who are not receiving HASI services will provide additional information to understand the nature of change for HASI clients.

Table 4.1: Health and Mental Health Indicators

Outcome type	Variables	Sources	Comparison
Mental health status	K-10 HONOS LSP-16 GAF CAN NGO rating of change in health status	InforMH, MDS, Interviews	Data to be collected from a comparison group of non-HASI clients based on mental health diagnosis, similar hospitalisation history at the same age. Will look at changes over time from 2000-2009 Comparison with HASI Stage 1 evaluation
Physical health status	ABS health questions NGO rating of change in health status	Interviews, MDS	Comparison over time and change toward population norm
Hospitalisation	Number of hospital visits (inpatient and emergency) Reason for hospitalisation Type of treatment Length of stay Cost of hospitalisations	InforMH	Data to be collected from a comparison group of non-HASI clients based on mental health diagnosis, similar hospitalisation history at the same age. Will look at changes over time from 2000-2009 HASI Stage 1 evaluation
Community Mental Health Service Use	Number of units of service Type of service Cost of service	InforMH	Data to be collected from a comparison group of non-HASI clients based on mental health diagnosis, similar hospitalisation history at the same age. Will look at changes over time from 2000-2009

Housing outcomes

The main sources of data used to report on housing outcomes for HASI clients are the HASI MDS and Housing NSW's Integrated Housing System (IHS) database. Five key indicators will be used to report on housing outcomes:

- Tenancy stability;
- Homelessness;
- Housing affordability;

- Housing assistance; and
- Repairs and maintenance.

Table 4.2 describes the variables that will be used to measure each indicator, the source of data and whether a population comparison group has been identified to compare the main findings.

Table 4.2: Housing Indicators

Outcome type	Variables	Sources	Comparison
Tenancy stability	Number of times clients have moved Length of tenancy Reason for tenancy change Number of times clients have changed housing provider Number of times homeless before HASI Number of CTTT actions	IHS, MDS, interviews	To be compared with up to 59 clients on the priority housing list who have mental illness and who have been housed by the first phase of data collection
Homelessness	Whether clients were homeless before they joined HASI	MDS, Interviews	None
Housing affordability	Number of clients in rental arrears Number of times in rental arrears $ owed in arrears	IHS, interviews	To be compared with up to 59 clients on the priority housing list who have mental illness and who have been housed by the first phase of data collection
Housing assistance	Type of assistance Number of times rental assistance requested Value of rental assistance	IHS	To be compared with up to 59 clients on the priority housing list who have mental illness and who have been housed by the first phase of data collection
Repairs and maintenance	Number of repairs and maintenance Cost of repairs	IHS, MDS, interviews	To be compared with up to 59 clients on the priority housing list who have mental illness and who have been housed by the first phase of data collection

An aim of the HASI program is to improve community participation. Table 4.3 describes the outcome types that we would prefer to measure and the potential variables, data sources and sources of comparison data.

Table 4.3: Social, Community Participation and Service Access Indicators

Outcome type	Variables	Sources	Comparison
Community participation	# clients currently participating	MDS supplement, Interview, APQ-6, CAN, LSP-16	Two points in time while in HASI; HASI stage 1 evaluation
Vocational functioning	# clients currently participating in education, training, employment, volunteering	MDS supplement, Interview, APQ-6, CAN, LSP-16	Two points in time while in HASI; HASI stage 1 evaluation
Social contact	Frequency of contact	MDS supplement, Interview, APQ-6, CAN, LSP-16	Two points in time while in HASI; HASI stage 1 evaluation
Functioning	Independence levels	MDS supplement, Interview, LSP-16, CAN	Two points of time while in HASI; HASI stage 1 evaluation
Well-being	Personal well-being index	Interview	Two points in time; population norm; HASI stage 1 evaluation
Access to services	# clients regularly accessing services	MDS supplement, Interview	Two points of time while in HASI

Preliminary definitions of the key indicators of client outcomes as they will be measured in this component of the evaluation are listed below.

- Community participation – participation in social or recreational activities in the community;
- Vocational functioning – participation in employment, education or training, voluntary work or caring work;
- Social contact – interaction that clients have with friends, family members or partners;
- Functioning – the level of independence in daily living activities such as cooking, cleaning, personal hygiene and care;
- Well-being – how clients rate their personal welfare (using the Personal Well-being Index); and

- Access to services – contact with services and professionals including community mental health services, GP, psychiatrists, psychologists, counsellors, allied health services, drug and alcohol services.

Interviews

In addition to secondary data sources, fieldwork data collected through interviews with clients and their family members will be analysed to report on participant experiences, perceptions of the program, reasons for exit, and individual outcomes. The PWI will also be analysed in comparison with data collected in HASI stage 1. Interview transcripts will be analysed in accordance with the evaluation questions concerned with whether the program has met its objectives for individual clients. As with the stakeholder interview transcripts, client interviews transcripts will also be analysed using the NVivo software package.

4.2 Policy and service system analysis

An important aim of the evaluation is to assess the effectiveness of the HASI model of service delivery. It involves analysing the strengths and weakness of the HASI model, the current partnership arrangements and governance issues. The evaluation will consider issues such as the flexibility of the model and whether it supports the transition of clients between packages with different levels of support if their individual support needs change. It will also examine the current pathways available for clients to enter and exit the program, and how the model fits into the wider service system.

The main sources of data used to address this component of the evaluation are interviews with key stakeholders, program observation and program document analysis.

Interviews will be transcribed for the purpose of analysis. Transcripts from interviews with stakeholders will be analysed in accordance with the evaluation questions concerned with effectiveness of the HASI service delivery. Transcripts will be analysed using the NVivo software package.

4.3 Economic analysis

Economic analysis will assess the cost of HASI against the outcomes experienced by HASI clients. Where possible, comparisons will be made between the HASI clients and a comparable group, such as the general population, the client outcomes from the Stage 1 evaluation, or another comparison group derived from the secondary data sources.

If the cost of the outcome can be clearly quantified (such as hospital care) the cost will be calculated. Costs will be analysed for the period before clients entered the program, during the program and after clients left the program. These costs will be compared with the unit cost of HASI. The outcome of this analysis will be discussed in relation to the costs of a comparison group of similar characteristics. Other outcomes that cannot be easily quantified, such as well-being, social contact and functioning will not be costed but will rather be discussed in general terms in relation to the unit cost of HASI services.

5 Ethics

The UNSW has high standards of ethical practice in all of its research projects. The project is currently being reviewed by the UNSW Human Research Ethics Committee (HREC) and the NSW Population and Health Services Research Ethics Committee.

The fieldwork component of the evaluation raises a number of ethical issues including informed consent and anonymity and confidentiality. Participation in the study is purely voluntary and informed consent will be sought from participants prior to their participation in the study. Participants will also be informed that they can decide at any time to withdraw from the study by revoking their consent. Informed consent will be obtained from clients to participate in interviews and access named administrative data collected by the HASI program (HASI MDS). Permission to interview clients' family members or carers will also be requested from clients.

The interviews with clients will cover topics related to their experience of housing and accommodation support services. Interviews with clients might induce some anxiety because of the multiple issues that clients in this program are dealing with. If this occurs we will cease the interview. In all cases, clients will be able to choose if they would like to have somebody with them at the interview and we will have the details of the family, carers and service providers available so that they can be called if there is a problem.

The research team have significant experience in conducting research with people with a mental illness or disability. Researchers responsible for carrying out the fieldwork component of the study have undertaken research with vulnerable population groups such as young people, elderly people, people with complex mental health issues and disabilities. The researchers will also attend refresher training course as part of the Mental Health First Aid course series in preparation for the current evaluation.

All sources of program and secondary data sources used in the evaluation related to individuals will be de-identified. It will not be possible to identify individual people.

6 Project Management

6.1 Deliverables

The reports will include a Baseline Report; Interim Report; and a Final Report, as outlined in the tender. The expected delivery and content of the reports is outlined below.

Baseline Report (December 2009)

Background: program aims, stakeholder roles

Methods

Client outcomes

- Program data (MDS): client profile
- Preliminary findings from interviews and observation

Service system

- Preliminary findings from interviews, observation, policy analysis in three sites

Discussion and data limitations

Implications for evaluation

To complete this report, SPRC requires assistance to complete fieldwork from the three sites selected. The following must be transferred to the SPRC by the end of August 2009:

- MDS profile until end of June 2009.

Interim Report (August 2010)

Background

Methods

Client outcomes

- Program data (MDS): Inputs and outcomes, supplement
- Secondary data (NSW Health)
- Secondary data (Housing NSW)

Economic analysis

- Analysis of program costs

Project management issues

To complete this report, the following must be transferred to the SPRC by February 2010:

- Cleaned Inpatient care, Ambulatory Care and NOCC data from 30 June 2000 until 30 June 2009 for HASI clients and comparison group. This requires that the MRN of all HASI clients is available;
- Cleaned IHS data from August 1998 until end of August 2009 for HASI clients and comparison group;
- MDS data items and first round MDS supplement data; and
- Cost data from NSW Health (Central office and AHS) and Housing NSW.

Final Report (February 2011)

Background: program aims, stakeholder roles

Methods

Client outcomes

- Program data (MDS)
- Secondary data: Change over time of IHS and Health data
- Findings from interviews and observation

Service system

- Findings from interviews, observation, policy analysis in three sites

Economic analysis

- Analysis of program costs versus client outcomes

Discussion

Implications

To complete this report, we need the following to be transferred to the SPRC by the end of August 2010:

- Cleaned IHS data from 1 July 2009 - 30 June 2010 for the comparison group; and up to date data on rent arrears (Aug 2010).
- MDS data items and second round MDS supplement data.

6.2 Reference group

The design phase of the research involved the establishment of an evaluation Reference Group. The role of the Reference Group is to provide advice to the research team during all stages of the research process including feedback on interim and final reports. Membership includes representatives from consumer organisations, service

providers, NSW Health and Housing NSW such as the: NSW Consumer Advisory Group, Uniting Care Mental Health, Richmond Fellowship of NSW, Hunter New England Area Health Service, ARAFMI NSW, Chief Psychiatrist (NSW Health), InforMH (NSW Health), Mental Health and Drug and Alcohol Office (NSW Health), Social Housing (Housing NSW), and Community Housing providers (NGOs). For a list of committee members see Appendix A.

6.3 Evaluation timeframe

Following delay in the commencement of the project due to negotiations around the funding contract, the initial timetable presented in the research evaluation proposal has been revised. The following table outlines the revised timetable proposed for the evaluation. This is conditional on ethics approval being granted, MRNs collected for all HASI clients, and fieldwork completed by September 2009.

Table 6.1: Evaluation timeframe

Phase and deliverable	Tasks	Output	Month
Baseline report	Recruitment and planning		Aug 2009
	Transfer program data		Aug 2009
	Interviews and fieldwork visits		Sept 2009
	Secondary data test run		Sept 2009
	Analysis and write up		Oct-Nov 2009
	Report and presentation	**Baseline report**	**Dec 2009**
Interim report	Transfer program data		Feb 2010
	Transfer MDS supplement		Feb 2010
	Transfer cleaned secondary data on HASI clients and comparison		Feb 2010
	Transfer HASI cost data		Feb 2010
	Analysis and write up		Mar-Jul 2010
	Report on project management		Jul 2010
	Report and presentation	**Interim report**	**Aug 2010**
Final Evaluation Report	Recruitment and planning		Aug 2010
	Transfer program data		Aug 2010
	Transfer MDS supplement		Aug 2010
	Transfer additional secondary data		Aug 2010
	Analysis and write up		Oct-Dec 2010
	Report and presentation	**Final report**	**Feb 2011**

6.4 Data collection timetable

Described below is the data collection timeframe for Phase 1, Phase 2 and Phase 3 of the evaluation. Commencement of data collection is contingent upon ethics approval. If fieldwork has not been approved to commence by October/November 2009 then it will be deferred to commence in February 2010.

Table 6.2: Data Collection Timeframe, Phase 1 2009

Data Collection Phase 1	Tasks	April	May	June	July	Aug	Sept	Oct
UNSW Ethics Committee	Submit ethics application	✓			✓	✓		
NSW Health Ethics process	Submit ethics application			✓	✓	✓		
Policy documents	From NSW Health & Housing NSW			✓	✓	✓	✓	
Stakeholder interviews	Finalise instruments				✓	✓		
	Recruit participants					✓	✓	
	Conduct interviews					✓	✓	
Program observation	Visit fieldwork sites					✓	✓	
Program data	HASI MDS					✓		

Table 6.3: Data Collection Timeframe, Phase 2 2010

Data Collection Phase 2	Tasks	Feb	July	Aug	Sept	Oct	Nov	Dec
Stakeholder interviews	Follow up contact			✓	✓			
	Data collection				✓	✓		
Program observation	Site visits				✓	✓		
Program and secondary data	HASI MDS	✓		✓				
	HASI MDS supplement	✓			✓			
	NSW Health database	✓						
	Housing NSW database	✓		✓				
Financial data	NSW Health	✓						
	Housing NSW	✓						

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Appendix A: Evaluation Reference Group

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