

Doorway – Formative evaluation report – November 2013

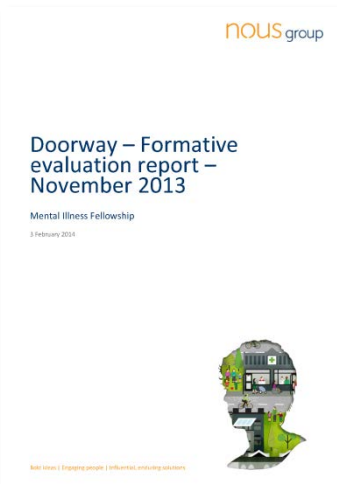
Mental Illness Fellowship

5 February 2014

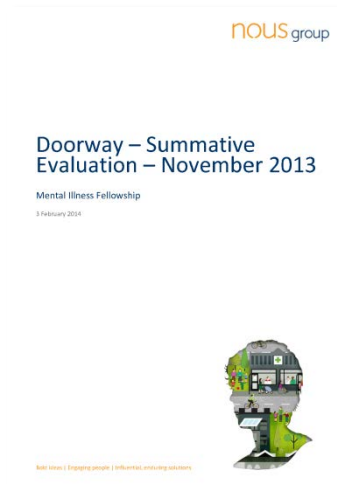


This final *Formative Evaluation Report* for the Doorway program pilot is accompanied by the *Summative Evaluation Report*. The contents of each report are outlined below.

This final *Formative Evaluation Report* also augments and updates the formative evaluation components of the *Doorway – Interim Evaluation Report* that covered the period up to March 2013.



- Evaluation background
- Model design and evolution
- Initial implementation
- Governance
- Housing and Recovery Workers
- Partnerships
- Future implementation considerations



- Evaluation background
- Program model and cohort
- Participant outcomes
- Assessment of continued program need
- Benefits to Government
- Impact of ceasing program
- Overview of program delivery against intended scope, budget, and expected timeframe

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Acronyms and abbreviations

| Acronym/ abbreviation | Explanation |
|-----------------------|---|
| AMHS | Area Mental Health Services |
| Austin | Austin Health |
| BAU | Business as Usual |
| CSU | Client Support Unit |
| DEEWR | Department of Education, Employment and Workplace Relations |
| DES | Disability Employment Services |
| DoH | Victorian Department of Health |
| DHS | Victorian Department of Human Services |
| DSP | Disability Support Pension |
| H&RWs | Housing and Recovery Workers |
| HBOS | Home-Based Outreach Support |
| IPS | Individual Placement and Support |
| ISPs | Individual Support Plans |
| Latrobe | Latrobe Regional Hospital |
| LGAs | Local Government Authorities |
| MDC | Model Development Committee |
| MHCSS | Mental Health Community Support Services |
| MI Fellowship | Mental Illness Fellowship |
| MoU | Memorandum of Understanding |
| Nous | Nous Group |
| REIV | Real Estate Institute of Victoria |
| SEIFA | Socio-economic Indexes for Areas |
| SMI | Serious mental illness |
| St Vincent's | St Vincent's Hospital Melbourne |

Executive summary

Doorway is an innovative three-year pilot program funded by the Victorian Department of Health (DoH) and implemented by Mental Illness Fellowship Victoria (MI Fellowship) that crosses traditional program boundaries of mental health, housing and economic participation. Doorway is designed to enhance the capacity of individuals with a serious mental illness (SMI) who are homeless or at risk of homelessness to lead independent, healthy and meaningful lives in housing and communities of their choice. The program explicitly focuses on addressing social isolation and increasing client confidence and choice – both elements often missing from traditional approaches to housing and recovery.

The Doorway model supports participants to choose, access and sustain their own private rental accommodation by subsidising participants' rental payments where required and building their independent living and tenancy management skills.

Participants in the Doorway pilot are empowered to self-direct their support needs by designing and managing their own integrated support teams. These teams are comprised of core elements – such as family members, friends and AMHS case managers – and flexible elements which may include workers from employment and other health support services. Doorway also supports participants to develop and/or extend their informal social supports, through an intentional approach to developing their natural support networks. The relationships between participants and their integrated teams and natural support networks are initially established, nurtured and mediated by Doorway's Housing and Recovery Workers (H&RWs).

The Doorway pilot is being implemented in partnership with three Area Mental Health Services (AMHS) that span inner city, suburban and regional catchment areas in Victoria. The intended numbers of participants in each of the three AMHS regions and the Local Government Authorities (LGAs) targeted in each region are listed below:

1. **Austin Health (Austin)** – Banyule and Nillumbik (20 participants)
2. **St Vincent's Hospital Melbourne (St Vincents)** – Yarra (10 participants)
3. **Latrobe Regional Hospital (Latrobe)** – Baw Baw and Latrobe (20 participants).

These regions were selected on the basis of a number of factors including the demographics of the region, the type and accessibility of services for people with a mental illness, and the extent to which MI Fellowship had a pre-existing presence in the region and relationships with the local clinical providers.

Participants in the Doorway pilot program have been diagnosed with a wide range of mental health illnesses. Schizophrenia is by far the most prevalent primary mental health diagnosis among Doorway participants, followed by Depression. More than one third of Doorway participants have multiple mental health diagnoses. Approximately half of Doorway participants were classified as experiencing 'secondary homeless' prior to entering the program, based on Chamberlain model of homelessness.¹

¹ Chamberlain, C. and MacKenzie, D. (2003) *Counting the Homeless 2001*, Canberra: Australian Bureau of Statistics, Catalogue No. 2050.0.

The Doorway model adapts Housing First

The Doorway model builds upon and adapts the Housing First model that was pioneered in the United States in the early 1990s. The design of the Doorway and Housing First models are founded upon the assumption that stable housing plays a critical role in the recovery of people with serious mental illness (SMI). Both models also assume that people with a SMI can live successfully in the community throughout their recovery process, including in private rental accommodation.

There are several differences between the Doorway model and other iterations of the original Housing First model – most notably in the way that housing support services are designed and delivered. The primary difference is that participants source and choose properties through the open rental market – rather than through properties owned or managed by preferred Housing First providers. This provides participants with a greater number of options to live in a community and house type of their choosing.

Doorway participants lease their rental properties directly from real estate agents as opposed to sub-leasing through a Housing First provider. This provides participants with their own rental history, which will increase their chances of successfully accessing other rental accommodation after leaving Doorway. Participants also build the skills required to sustain their tenancies as they are progressively supported to deal directly with their Property Managers and landlords.

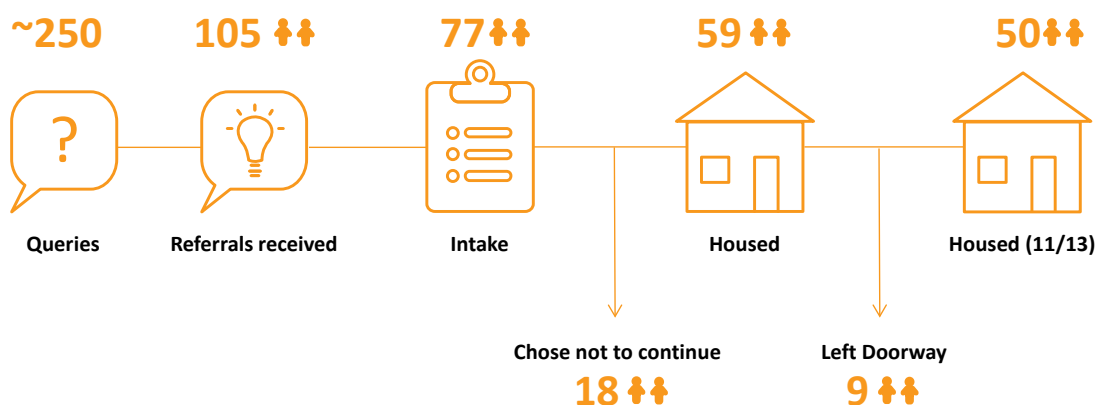
Implementation has been smooth after delays

After a series of delays during the initial implementation phase, the ongoing implementation of Doorway has been relatively smooth. Participant feedback indicates they are very happy with the management of the program to date – particularly the central role played by their H&RWs.

As at November 2013, seventy-seven people had gone through the Doorway intake process and fifty participants are currently living in private rental properties – as shown in Figure 1 below.

Despite the best efforts of the Doorway program and its clinical partners, eighteen individuals who were assessed as suitable for the program through the referral and assessment process did not progress into housing. These participants exited Doorway post-intake for various reasons, including changes in their personal circumstances or a fear of losing their place on the public housing waiting list.

Figure 1: Doorway pilot program throughput (as at November 2013)



The implementation of Doorway was deliberately staggered across the three regions so that program resources would not be over-stretched, and lessons learnt in the first catchment region could inform implementation activities in subsequent regions.

The intended target of all three Doorway regions functioning at full capacity by January 2012 however was not met. The first major milestone in the implementation of Doorway – the commencement of delivery to the first housed participant in the Austin catchment – did not occur until November 2011, three months after the scheduled date.

The delays in housing participants were due largely to the challenges MI Fellowship faced in establishing the operational base for the program and housing participants. Sourcing and securing private rental accommodation in particular took considerably longer than anticipated. On average, it takes participants 51 days from intake and five applications to secure accommodation.

The time and effort taken to secure rental properties for participants subsequently decreased as the pilot program has progressed. This can be attributed to the strengthening of relationships with real estate agents and an increasing awareness about how best to support participants to find appropriate accommodation.

Governance arrangements have evolved

Doorway's governance arrangements have evolved as the pilot moved beyond the initial implementation phase in the first 18 months of the program. Key changes over this period included increased clarity in the roles and accountabilities of the various program committees, a greater decentralisation of day-to-day program management, tighter overall project management, a reduced focus on operational issues and risks related to housing, and increased engagement of participants in formal governance roles.

Housing and Recovery Workers are central

The Doorway H&RWs are responsible for implementing the model on a day-to-day basis in their regular interactions with Doorway participants and have played a critical role in the achievement of many of the pilot program's outcomes to date. Where possible, participants see the same H&RWs on a weekly basis for at least the first four months of their tenancy and provide – on average – 1.6 hours per week of direct face-to-face support to participants. Feedback from Doorway participants about the support provided by their H&RW has been unanimously positive.

Partnerships have been fundamental

The partnerships between MI Fellowship and the clinical partners and real estate agents in each region have been fundamental to the positive outcomes achieved by the Doorway pilot to date. The speed with which these partners engaged with the Doorway pilot and continue to advocate and support the program also far exceeded MI Fellowship's initial expectations. The contributions of employment providers in the Doorway pilot have been less successful by comparison – although strategies are currently in place to remedy this.

After a slow start, Doorway's partnerships with all three clinical partners have reached a state of maturity where they are stable and well-functioning. This can be largely attributed to the decisions to co-locate Doorway staff at each of the AMHS sites. Senior managers at the three AMHS have had

uniformly high levels of support for Doorway. The levels of buy-in have been slightly more variable at a case manager level – which is where the majority of day-to-day interaction occurs between the Doorway team and the AMHS.

To date MI Fellowship has partnered with twenty-seven real estate agents across the three Doorway regions. The levels of interest from agents in the program grew rapidly and organically, and as a result the initial strategy of emphasising financial incentives to agents and landlords was replaced by one based on providing information about the kinds of support that were available to real estate agents and landlords.

The groundswell of support for Doorway from within the real estate sector resulted in agents offering a level of service to Doorway participants well beyond MI Fellowship's expectations. Examples of support provided by Property Managers to participants during the initial stages of locating and securing rental properties included Property Managers contacting participants directly when potentially suitable rental options become available, offering to provide character references and waiving requirements for supporting documentation in a property application. Examples of ongoing support include working with participants to find new properties at the end of their lease or alternate properties if their needs were not being met, forgoing or reducing lease break fees and working with H&RWs to avoid formal lease breach notices being sent to participants.

Real estate agents have also supported Doorway more broadly – with many acting as champions of the program. For example, on several occasions Property Managers have advocated directly to landlords on behalf of a participant during the application process. Real estate agents outside the three regions have also contacted MI Fellowship on several occasions to ask how they could participate in Doorway after hearing about the program from colleagues who are part of program.

Partnerships between Doorway and the employment service providers in each region have been mixed. Feedback from Doorway participants and staff indicates that the services provided by these partners have been of variable quality. MI Fellowship recently revised their approach to working with employment providers in each region to improve the quality of employment support provided to participants. These strategies include seeking a new preferred partner who will be required to use the Individual Placement and Support model in the St Vincent's region. MI Fellowship is also working with other employment providers used by participants – which may not be the preferred provider for their region – through these individual's integrated team.

The pilot can inform future Doorway programs

The Doorway pilot program has highlighted several key areas that should be considered if the model is to be extended beyond the current three AMHS regions in Victoria or interstate.

In light of the lessons learnt through the implementation of the Doorway pilot, future iterations of Doorway may benefit from minor changes to the design of the program model. Firstly, the eligibility criteria used to identify Doorway participants may need to be refined, particularly if future analyses of post-Doorway outcomes data highlight specific characteristics of the Doorway pilot cohort that may increase the likelihood of participant outcomes being sustained post-program. Secondly, geographic restrictions related to housing could be eased to give participants' greater choice in selecting properties outside their AMHS catchment region. This would overcome accessibility challenges posed by suburbs with high median rents within the AMHS catchment regions. It would also give participants the option to be closer to their formal and natural supports if they are located outside the catchment regions.

The Doorway pilot has reinforced the need for a multi-faceted approach to identifying which geographic regions could most benefit from future iterations of the Doorway model. The pilot has demonstrated

that improving and sustaining participant outcomes across multiple domains can be challenging – particularly when they are not mutually compatible. For example, a regional town may offer a large number of affordable rental properties, but employment opportunities may be limited and poor public transport could hamper attempts to grow participants' natural support networks or pursue employment. Conversely an inner urban suburb may offer more employment opportunities, and have better public transport, but rental accommodation may be prohibitively expensive and employment opportunities may be ill-suited to potential Doorway participants.

The faithful replication of the current Doorway model is not enough to guarantee that intended outcomes are achieved by future iterations of Doorway. There are several key lessons learned through the implementation of the current pilot program that should be taken on board by future implementing organisations. These important lessons include:

- **Organisational culture and capabilities are vital** – The right organisational culture and capabilities are fundamental to ensuring that the three core values underpinning the model are adhered to on a day-to-day basis in all interactions with participants and partners.
- **Clinical partnerships take time to build** – MI Fellowship's pre-existing relationships with the three AMHS partners in the Doorway pilot were fundamental to the speed with which they were able to build the productive working relationships in the ongoing implementation of the program.
- **Peer Workers with lived experience add substantial value** – Doorway participants have observed that Doorway's Peer Workers can easily relate to their day-to-day recovery challenges and provide support based on their own personal experiences. H&RWs without lived experience of mental illness have also gained value from advice provided by their Peer Workers colleagues about how best to manage specific challenges in providing support to participants.
- **Participants provide vital input to model design and implementation** – The inclusion of Doorway participant representatives on the Doorway Model Development Committee (MDC) immediately proved beneficial. They were able to provide valuable input into issues such as changes to policies related to furnishing fees and ongoing ownership of furniture packages and the development of a policy related to the management of rental arrears.
- **A single implementing agency has multiple benefits** – The Doorway pilot program is unique in that it is the only Victorian Government funded program where mental health and housing support services are delivered by a single agency. There are demonstrated benefits of the single agency model employed by MI Fellowship to deliver Doorway that should be retained in subsequent iterations of the Doorway model.

1 Evaluation background

MI Fellowship engaged Nous Group (Nous) to conduct a three year formative and summative evaluation of the Doorway pilot program. The aims of the evaluation are to:

- determine the social and economic impacts of the model for individuals
- determine if the Doorway model is being effectively implemented and identify the key challenges/barriers to achieving the intended client and system outcomes
- identify opportunities for further improvement of the Doorway model and its delivery and/or address any weaknesses
- develop a coherent and practical approach to monitoring and continuous improvement of the interventions at the service provider level.

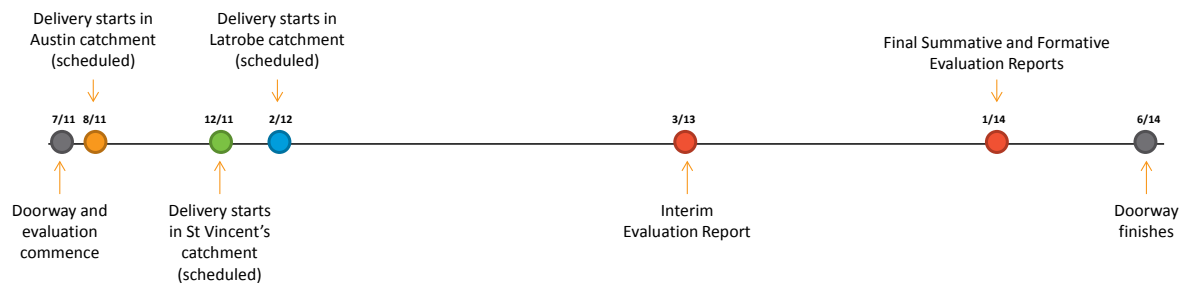
The lines of inquiry that underpin this summative evaluation can be found in Appendix A.1.

1.1 Evaluation timeframes

Nous commenced work on the evaluation of Doorway in mid-2011, prior to the official start date for the pilot program. Nous released the *Interim Evaluation Report* which addressed both formative and summative lines of inquiry and covered the period up to March 2013. **This final *Formative Evaluation Report* augments and updates the formative evaluation components of the *Interim Evaluation Report*.**

Key program implementation and evaluation milestones for Doorway are shown in Figure 2 below.

Figure 2: Scheduled Doorway and evaluation milestones



It should be noted that this final *Formative Evaluation Report* was **brought forward by six months** relative to the original timeframe for this evaluation, at the requirement of the DoH. The final formative and summative evaluation reports covers the period up to November 2013 – which is seven months prior to the scheduled end of the pilot program on 30 June 2014.

1.2 Formative and summative evaluations

The differing focuses of the final summative and formative evaluation reports for Doorway are illustrated in Table 1 below.

Table 1: Contents of Doorway formative and summative evaluation reports

| Formative evaluation report | Summative evaluation report |
|---|---|
| <ul style="list-style-type: none"> • Evaluation background • Model design and evolution • Initial implementation • Governance • Housing and Recovery Workers • Partnerships • Future implementation considerations | <ul style="list-style-type: none"> • Evaluation background • Program model and cohort • Participant outcomes • Assessment of continued program need • Benefits to Government • Impact of ceasing program • Overview of program delivery against intended scope, budget, and expected timeframe |

1.3 Evaluation data sources

Table 2 below provides an overview of the key sources of quantitative and qualitative data that underpin the analysis in the summative and formative evaluations. More information about the qualitative data collection processes for the evaluation can be found in Appendix A.2.

Table 2: Primary sources of evaluation data

| Quantitative data | Qualitative data |
|---|--|
| <ul style="list-style-type: none"> • Six monthly data collection by Doorway staff • Outcomes measurement tools • Department of Health (Vic) datasets | <ul style="list-style-type: none"> • Six monthly data collection by Doorway staff • Participant and carer focus groups • Key stakeholder interviews |

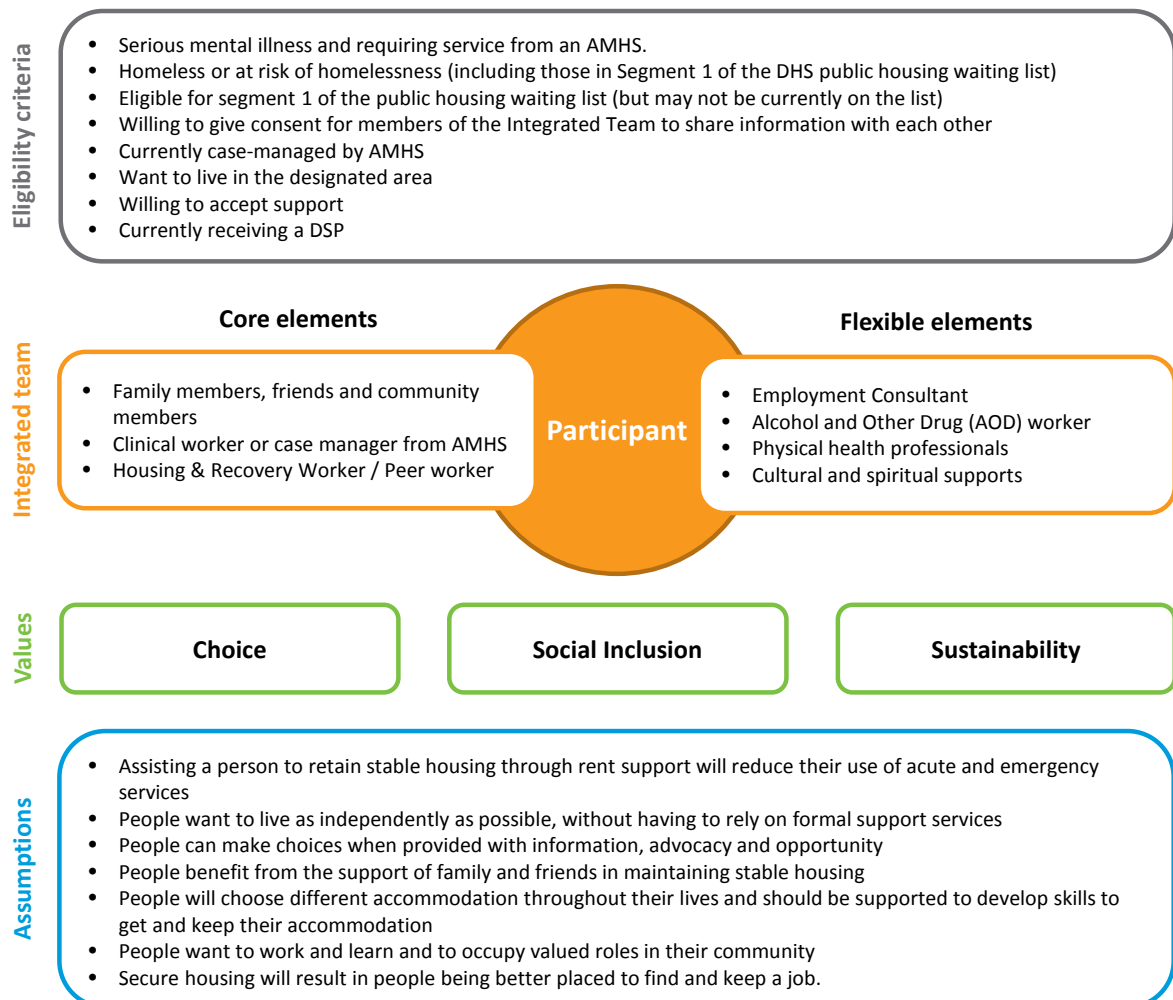
2 The Doorway model builds on Housing First

The Doorway model was developed gradually by MI Fellowship over a period of several years as a response to a key program delivery challenge in the human services sector – the provision of housing and support for people with SMI who are homeless or at risk of homelessness.

The design of the Doorway model builds upon and adapts the Housing First model that was pioneered in America in the early 1990s. The design of the Doorway and Housing First models are built upon the assumption that stable housing plays a critical in the recovery of people with SMI. Both models also assume that people with a SMI can live successfully in the community throughout their recovery process, including in private rental accommodation.

This section of the *Formative Evaluation Report* explores the core elements of the Doorway model shown in Figure 3 below, and discusses how and why it builds upon various iterations of the Housing First model.

Figure 3: Core elements of the Doorway model



2.1 Housing First assumes that housing is a primary need

The Housing First model of homelessness reduction was developed in 1992 by Dr Sam Tsemberis and the New York City Pathways to Housing organisation. The aim of the Housing First approach is to provide rapid access to permanent, supported housing for chronically homeless people.² The Housing First approach is based on the assumptions that housing is a human right and that the provision of housing is not contingent upon behavioural changes or anything other than abiding by standard tenancy obligations.³

The Housing First model presumes that a homeless individual’s first and primary need is to obtain stable housing, and that other issues impacting a household should be addressed once permanent housing is obtained. This approach differs fundamentally from a ‘continuum of care’ model, which makes progress to permanent housing contingent upon an individual committing to address issues such as addictions and managing their mental health.

The core tenets of Housing First which distinguish the model from the continuum approach include:

1. rapid access to permanent housing
2. consumer choice
3. separation of housing and services
4. recovery as an ongoing process
5. community integration.⁴

2.2 The Doorway model retains core Housing First elements

The Housing First model has effectively demonstrated that people with a mental illness who are homeless are able to successfully sustain tenancies when provided with housing and personalised support.⁵ It has also demonstrated reduced incidences of hospitalisation and acute treatment.⁶

Doorway retains core elements of the Housing First model design, which are listed in Table 3 below.

Table 3: Housing First and the Doorway Enhanced Housing First Model

| Design element | Housing First Model | Doorway Model |
|---|---------------------|---------------|
| Targets those not well-served by traditional housing support services | ✓ | ✓ |
| Independent, non-congregate housing | ✓ | ✓ |

² Tsemberis, S., Gulcur, L. & Nakae, M. (2004) Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651–656.

³ Stefanic, A. & Tsemberis, S. (2007) Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *Journal of Primary Prevention*, 28(3-4), 265–279.

⁴ Tsemberis, S. (2010) Housing First: Ending homelessness, promoting recovery and reducing cost. In Ellen, I. & O’Flaherty, B. (2010) (eds) *How to House the Homeless*. New York: Russell Sage Foundation.

⁵ Gulcur, L., et al. (2003) Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. *Journal of Community & Applied Social Psychology*, 13, 171-186.

Gulcur, L., et al. (2007) Community integration of adults with psychiatric disabilities and histories of homelessness. *Community Mental Health Journal*, 43, 211-228.

⁶ Sadowski, L. S., Kee, R. A., VanderWeele, T. J. and Buchanan, D. (2009) Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *Journal of the American Medical Association*, 301, 1771-1778.

| Design element | Housing First Model | Doorway Model |
|---|---------------------|---------------|
| No requirement regarding “housing readiness” | ✓ | ✓ |
| Harm reduction approach to substance use | ✓ | ✓ |
| Provision of permanent housing and support that is conditional on engagement with weekly support visits | ✓ | ✓ |

2.1 Doorway adapts the Housing First model

2.1.1 The rationale for Doorway is different

The design of the Doorway model differs from the Housing First model as it was originally applied in the Pathways to Housing program in New York by incorporating new or adapted design elements. The rationale for these changes to the original Housing First model stem from two sets of drivers:

1. Differences in the operating context between New York and Victoria
2. A desire to improve upon the social inclusion and employment outcomes of Housing First programs.

These two drivers are explored in more detail below.

2.1.1.1 Differences in operating context

Many of the contextual drivers for the original Housing First model as applied in the Pathways to Housing program in New York are not present in Victoria’s contemporary service delivery landscape.⁷ The key differences in the operating context of Pathways to Housing in New York in the 1990s and present day Victoria include:

- **Non–conditional housing support** – Providing housing support that is not conditional on an individual receiving treatment or changing behaviours is a fundamental element of the Housing First model. In contrast to US services at the time, current specialist homelessness services in Australia (including the former Supported Accommodation Assistance Program (SAAP)) do not require individuals to receive treatment or make behavioural changes prior to the allocation of housing.
- **Integrated support teams** – The multidisciplinary team of support services that is the core of the Housing First model already operate in Australia in a range of service settings. However, whether these multidisciplinary teams are fully and effectively integrated in practice is debatable.
- **Voluntary engagement** – Notions of voluntary engagement are already embedded in homelessness services in Australia.
- **Government support** – Australia has a comprehensive social security system with ongoing unemployment benefits and disability pensions. For example, many Doorway participants are receiving a Disability Support Pension (DSP).

⁷ Johnson, G.; Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia*. AHURI Final Report No. 184 AHURI: Melbourne.

2.1.1.2 Questions about social inclusion and employment outcomes

While the housing outcomes of the Housing First approach have been demonstrated,⁸ questions remain about the magnitude and longevity of outcomes for participants in other domains. Recent studies of the Housing First programs have raised concerns about the social outcomes of the program. Yanos et al. (2007) found that the Housing First program participants, although in stable housing, appeared to have “lives without any involving pursuits or set of meaningful connections”⁹. Another study noted that “other core elements of psychiatric recovery such as hope for the future, having a job, enjoying the company and support of others, and being involved in society ...have only been partially attained.”¹⁰

2.1.2 The Doorway model incorporates new elements

There are several key points of differentiation between the original Housing First and Doorway models, which are outlined below.

Adaptations that reflect Doorway’s local operating context

1. **Integrated teams** – Participants co–design a personalised, integrated support team that is intended to improve collaboration across service providers external to Doorway which are already providing services to participants. This differs from the Pathways to Housing model of providing a suite of services through special Assertive Community Treatment (ACT) teams, comprising social workers, nurses, psychiatrists, and vocational and substance abuse counsellors, who are permanently on call.¹¹ Integrated teams are explored in more detail in Section 2.1.3 below.
2. **Emphasis on psychosocial support** – The design of Doorway assumes that individuals who require intensive treatment for their mental illness are already receiving voluntary or involuntary clinical interventions through their local AMHS. The efforts of Doorway program staff are focused on providing psychosocial support.

Adaptations intended to improve non–housing outcomes

3. **Natural support networks** – The social inclusion needs of participants are specifically addressed through the development and resourcing of personal natural support networks.¹² Natural support networks are explored in more detail in Section 2.1.4 on page 14.
4. **Specialist employment assistance** – Participants are provided with access to specialist employment assistance providers – many of which utilise the Individual Placement and Support (IPS) model (see Section 6.3.1 below for more details).

Adaptations intended to enhance sustainability

5. **Open rental market** – Participants source and choose properties through the open rental market – rather than through properties owned or managed by preferred Housing First providers. This

⁸ Tsemberis, S., Gulcur, L. & Nakae, M. (2004) Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651–656.

⁹ Yanos, P. T., Felton, B. J., Tsemberis, S. and Frye, V. F. (2007) Exploring the role of housing type, neighbourhood characteristics, and lifestyle factors in the community integration of formerly homeless persons diagnosed with mental illness. *Journal of Mental Health*, 16, 703–717.

¹⁰ Padgett, D. K. (2007) There’s no place like (a) home: ontological security among persons with SMI in the United States. *Social Science and Medicine*, 64, 1925–1936.

¹¹ Tsemberis, S., Gulcur, L. & Nakae, M. (2004) *Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis*. American Journal of Public Health, 94(4), 651–656.

¹² NOTE: The concept of Circles of Support later became re–framed as natural support networks for participants.

supported process enables both choice and an opportunity to develop property search and lease establishment skills.

6. **Participants hold the lease** – Doorway participants are required to lease rental properties directly. This contrasts with the Pathways to Housing model, which sub-lets accommodation to individuals based on pre-existing relationships with the landlords or housing providers. The rationale for Doorway’s approach is two-fold:
 - a. From a sustainability perspective, enabling someone to lease a property themselves will provide them with a rental history that will make it considerably easier for them to gain rental accommodation post-program. Doorway also intends for participants to build tenancy management skills as they are progressively supported to deal directly with their real estate agents and landlords
 - b. From an organisational risk-management perspective, MI Fellowship is able to minimise the financial risks associated with maintaining properties, or managing sub-tenants who break a lease or are evicted.
7. **Combined housing and recovery role** – The H&RW role that is fundamental to the Doorway model combines two roles that were split in the original Pathways to Housing model. These roles have also been split historically in housing and support programs delivered in Victoria. The decision to combine the roles and not use an external tenancy management agency was based on the following rationale:
 - a. The development of tenancy management skills is a key outcome of the program that should be overseen by Doorway staff.
 - b. Having the H&RW play a housing role encourages Doorway staff to have conversations about rent with participants – which can often be confronting and challenging – rather than leaving such discussions to a third party that can be portrayed as bearers of difficult news.
 - c. The H&RWs are easily able to ascertain why a participant may be unable to pay their rent on time. Similarly, they are also well-placed to work with participants to develop and action any plans to overcome rental arrears.
 - d. By keeping tenancy management in-house Doorway staff are more likely to be alerted to tenancy related risks and issues in a timely fashion.

2.1.3 Integrated support teams are a core element of the model

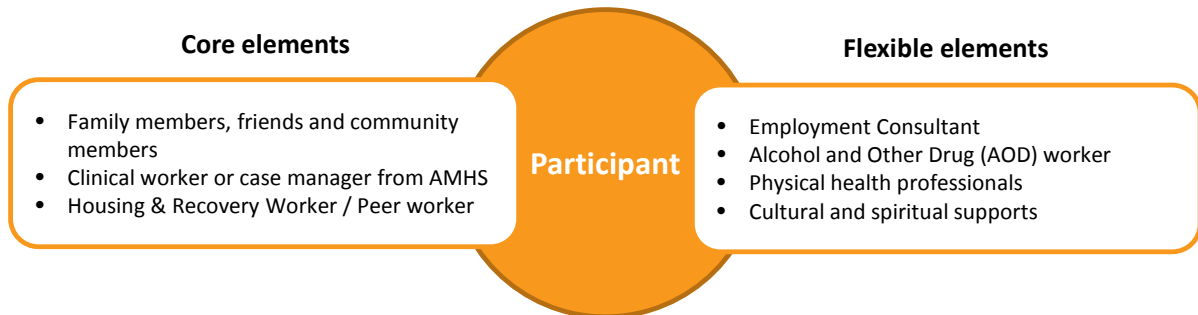
The various support services that are provided in Australia to people with a SMI and at risk of homelessness are often fragmented and poorly coordinated. The Doorway program’s integrated support team model is intended to overcome this fragmentation. It aims to improve the historically poor performance of collaboration across multi-disciplinary teams from the mental health and housing sectors.

In the Doorway model, integrated teams are established around each participant for the duration of the program to help them maintain their tenancy and improve their quality of life. Participants meet with their integrated team on a quarterly or as needed basis to review progress made and determine any necessary changes to the composition of the team. The integrated team meetings also draw upon the results of the outcome assessment tool data collected by members of the integrated team to inform collaborative assessment and planning to identify the areas of focus for a participant over the coming period.

2.1.3.1 Composition

Wherever possible, Doorway participants are given the opportunity to direct the creation of their integrated team that best meets their needs at a given time. The team may expand or contract and members may change, depending on the needs and priorities of the person. The participant may be supported by family members or friends in the establishment and ongoing development of their support team. Integrated teams are comprised of core and flexible elements, as shown in in Figure 4 below.

Figure 4: Integrated team elements



The members within the core and flexible elements of the integrated team have clearly defined roles and responsibilities. The roles of the *core* component of the integrated team are outlined in Table 4.

Table 4: Roles and responsibilities of the core integrated team

| Team member | Roles and responsibilities |
|---|---|
| Housing and Recovery Worker | <p><i>Ongoing support</i></p> <ul style="list-style-type: none"> Conduct weekly support visits (for at least the first four months) Regularly review the integrated team with the person to ensure support is well-matched to current need and goals Support and facilitate the development and maintenance of natural support networks <p><i>Tenancy management</i></p> <ul style="list-style-type: none"> Monitor and offer support around any tenancy related issues Liaise with landlords and real estate agents and be responsive to any concerns Support participants to ensure that rent is paid on time and progressively supporting participants to take leadership in this area Ensure participants address any issues around damage to properties <p><i>Integrated team support</i></p> <ul style="list-style-type: none"> Support communication between all members of the integrated team, including leading and coordinating shared plans |
| Clinical worker or case manager from AMHS | <ul style="list-style-type: none"> Manage participant referrals and eligibility assessments Participate in assessment, planning and direct advocacy and support if and when the person becomes unwell |
| Family members, friends and community members | <ul style="list-style-type: none"> Participate in assessment, planning and service co-design Assist in the management and allocation of support budget (optional) |

The roles of the *flexible* component of the integrated team are to provide Doorway participants with:

- Specialised services
- Culturally–appropriate assessment and support
- Family peer support and education
- Family advocacy
- Interpreter services (where appropriate).

2.1.4 Natural support networks support sustainable recovery

Loneliness and social isolation are significant issues for people even once stable housing is achieved.¹³ The development of natural support networks provides a structured approach to the development of a person’s informal, unpaid support network. This model has also shown promise as an adjunct to supported employment services in supporting people with psychiatric disabilities to get and keep a job.¹⁴

The development of natural support networks is an intentional process of inviting others to be part of a supportive, reciprocal network in which people are able to share resources, knowledge and practical assistance in working toward an agreed goal. Natural support networks differ from Doorway’s integrated teams, in that they are less formal, not structured around case or care coordination and more focused on supporting participant wellbeing in a holistic sense.

People who may be invited to join a participant’s natural support networks include:

- people who know the Doorway participant well and want to be involved (e.g. close family members or friends)
- people with relevant skills, knowledge or connections with others in the community
- peers who are currently working on or want to work on a similar goal
- workers who are connected to formal support systems and who have access to relevant resources and information.

In the Doorway model, H&RWs initially support and facilitate the development and maintenance of natural support networks.

¹³ Franklin, A. & Tranter, B. (2011) *Housing, loneliness and health, AHURI Final Report No. 164*. Melbourne: Australian Housing and Urban Research Institute.

¹⁴ Spagnolo, A., et al. (2011) A study of the perceived barriers to the implementation of circles of support. *Psychiatric Rehabilitation Journal*, 34 (3), pp 233-42.

Roberts, M., et al. (2010) A study of the impact of social support development on job acquisition and retention amongst people with psychiatric disabilities. *Journal of Vocational Rehabilitation*, 33 (3), pp 203-207.

2.2 Doorway is informed by key assumptions and core values

2.2.1 The model is based on key assumptions

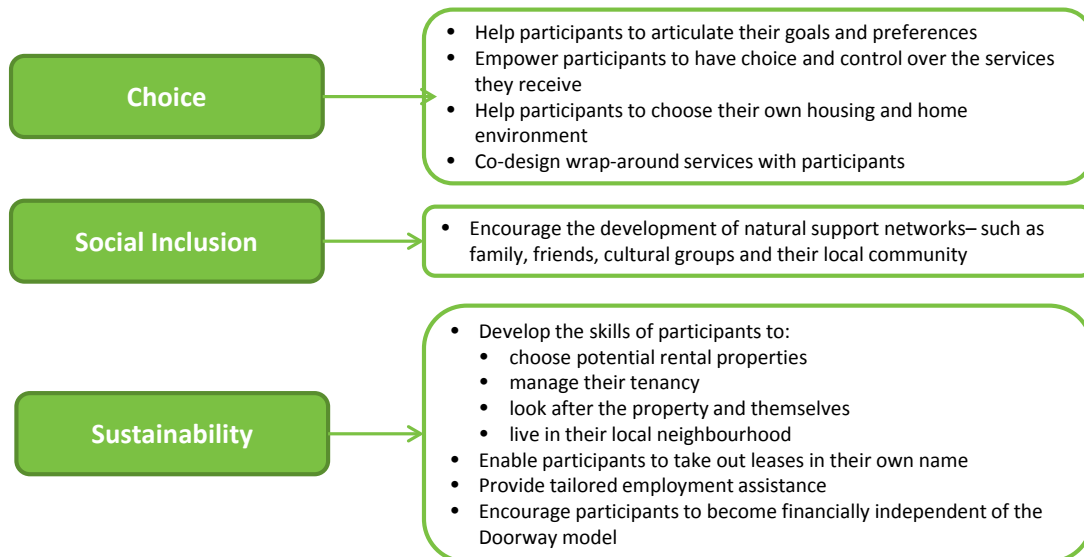
The design of the Doorway program model is based on several key assumptions:¹⁵

- Assisting a person to retain stable housing through rent support will reduce their use of acute and emergency services
- People want to live as independently as possible, without having to rely on formal support services
- People can make choices when provided with information, advocacy and opportunity
- People benefit from the support of family and friends in maintaining stable housing
- People will choose different accommodation throughout their lives and should be supported to develop skills to get and keep their accommodation
- People want to work and learn and to occupy valued roles in their community
- Secure housing will result in people being better placed to find and keep a job.

2.2.2 Doorway is underpinned by three core values

The design and implementation of Doorway is underpinned by three core values: choice, social inclusion and sustainability. These core values were formally articulated just prior to the start of the program pilot in mid-2011, and were informed by Michael Kendrick's value and person-centric approaches to care.¹⁶ The intended applications of these values in practice through the Doorway model are outlined below.

Figure 5: Doorway values and application



¹⁵ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - July 2011*

¹⁶ Kendrick, M (2008) How Genuinely Supportive Persons, Agencies And Systems Can Enable People To Have Real Homes Of Their Own. *Crucial Times*, 40, pp 13-15.

2.2.3 Engagement with participants is recovery focused

The notion of recovery as an ongoing process is a critical element of the Housing First model and is also embedded in Doorway. The recovery model used by Doorway staff is based on the MI Fellowship's Community Recovery Model.

The Community Recovery Model integrates a number of established, evidence-based models within a Recovery-oriented framework: the Boston University Model of Psychiatric Rehabilitation, Intentional Peer Support, Family Education, Individual Placement and Support, Housing First and the Biopsychosocial models. These approaches share a theoretical framework that combines evidence from research with the evidence and expertise of lived experience.¹⁷

The Community Recovery Model underpinning Doorway incorporates the following principles:

- Hope and self-determination
- Personhood and the right for each person to develop his or her own potential in each of the dimensions of life
- Citizenship and social inclusion
- Self-perception and a sense of being valued and respected by others
- Relationships and belonging
- Meaningful participation including through work and education
- Economic participation and financial stability – freedom from poverty
- Appropriate housing – a home.

2.3 Doorway eligibility criteria have evolved

2.3.1 Criteria has become more prescriptive

The eligibility criteria for individuals to enter Doorway have evolved to reflect lessons learnt during the intake and referral process as well as changes in the program's operating environment. Table 5 below illustrates the progressive evolution of Doorway's eligibility criteria for participants from the criteria originally defined by the Department of Health in the pilot program's draft Funding and Service Agreement (FASA).

¹⁷ The Boston Model is generally understood to be closely aligned with the Strengths Model, with both approaches based on the same core values and principles: hope and belief in the person's capacity for growth and change; a focus on developing and building on the person's strengths, resources and expertise; a preference for community-based and naturally occurring supports over formal ones; a belief that skills and resources are best developed in the environments where they will be used – workplaces, schools, and community spaces – rather than learnt in institutional environments; and a commitment to the development of a collaborative relationship where the person is able to direct their own support and to make real choices about where and how they want to live, work, connect with others and maintain their wellbeing. The Boston Model addresses four life domains: living, learning, working and socialising. This model works with individual participants to identify strengths and resources, assess needs and set goals to develop the specific skills and resources required for individual recovery. The Boston model has a strong focus on housing, employment, education and social connection; as an organisation, the primary measure of effectiveness is whether the people worked with experience real and lasting changes in these areas.

Table 5: Evolution of the Doorway eligibility criteria

| | 2010 ¹⁸ | Mid-2011 ¹⁹ | Late 2011 ²⁰ |
|--|--------------------|------------------------|-------------------------|
| • SMI or requiring service from an AMHS. | ✓ | ✓ | ✓ |
| • Homeless or at risk of homelessness (including those in Segment 1 of the DHS public housing waiting list) | ✓ | ✓ | ✓ |
| • Eligible for segment 1 of the public housing waiting list (but may not be currently on the list) | | ✓ | |
| • Willing to give consent for members of the Integrated Team to share information with each other | | ✓ | ✓ |
| • Currently case-managed by AMHS | | ✓ | ✓ |
| • Want to live in the designated area | | ✓ | ✓ |
| • Willing to accept support | | ✓ | ✓ |
| • Have support needs or preferences not well-served by traditional services | | ✓ | |
| • Currently receiving a DSP (see Box 1 below for an overview as to why this criteria was added and subsequently relaxed) | | | ✓ |
| • Demonstrate a commitment to private rental as a long term housing options | ✓ | | |
| • Demonstrate awareness of their rights and responsibilities under the Residential Tenancies Act | ✓ | | |
| • Capable of sustaining private rental ²¹ | ✓ | | |

The definition of homelessness used in Doorway’s eligibility criteria draw on the four categories articulated by Chamberlain:²²

1. **Primary homelessness** – people without conventional accommodation (living in the streets, in deserted buildings, improvised dwellings, under bridges, in parks, etc.)
2. **Secondary homelessness** – people moving between various forms of temporary shelter including friends, emergency accommodation, youth refuges, hostels and boarding houses
3. **Tertiary homelessness** – people living in single rooms in private boarding houses without their own bathroom, kitchen or security of tenure
4. **Marginally housed** – people in housing situations close to the minimum standard.

¹⁸ Department of Health (2011), *Funding and Service Agreement - Housing Support and Brokerage Demonstration Project - DRAFT ONLY*

¹⁹ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - May 2011*

²⁰ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - December 2011*

²¹ This criteria was later removed on the grounds that any implied references to daily living skills or related assessment of skills by Occupational Therapists ran contrary to the rehabilitation and skills development focus of the Doorway model.

²² Chamberlain, C. and MacKenzie, D. (2003) *Counting the Homeless 2001*, Canberra: Australian Bureau of Statistics, Catalogue No. 2050.0.

In late 2011, the participant referral process was clarified further to include the following guidelines:²³

- referrals of people who have been chronically and persistently homeless may be declined and alternative services suggested
- referrals should come from a mix of the four categories of homelessness or risk of homelessness.

The rationale for these changes stemmed from MI Fellowship's wish to:

- clarify that Doorway was not a 'Street to Home' program
- ensure that the Doorway pilot project encompassed participants from across the four categories of homelessness.

The prioritisation of individuals that met the Doorway eligibility criteria was guided by an additional set of criteria:

- person is connected to the area
- person has key social supports in the area
- person's needs and preferences are well-matched to the property on offer.

Box 1: Changes to DSP eligibility criteria

On 30 July 2011, within a month of the Doorway pilot commencing, the Federal Government announced the first major changes since 1993 to the impairment guidelines that inform eligibility for the Disability Support Pension (DSP). These changes subsequently passed through parliament in November 2011. It was estimated at the time of the Government's announcement that up to 40% of individuals receiving DSP payments would no longer be eligible under the proposed reforms.²⁴ The Government intended that changes in eligibility for people with mental disorders, the fastest-growing category of new DSP recipients, would result in a greater focus on rehabilitation for individuals diagnosed with episodic mental health conditions, including obtaining employment or accessing education and training courses.

In response to these changes, the Doorway management team made a decision in November 2011 to limit entry into the program to individuals still eligible to receive DSP payments under the new impairment guidelines. This decision was made on the basis that those remaining on DSP were among the most severe cases, and eligibility criteria should reflect severity of need. This decision was the subject of considerable internal debate, and provoked some discomfort among members of the Implementation Committees in each of the three regions.

A second rationale for not considering individuals receiving NewStart payments (which made up approximately 20% of the initial referrals) was that they would be receiving approximately \$200 less per fortnight on average in income support, relative to individuals eligible on a DSP. This in turn would significantly limit their capacity to sustain suitable rental accommodation within the original parameters of Doorway's rental subsidies.²⁵ The financial implications for Doorway of the changes to DSP were compounded by the higher than expected proportion of referrals in the first few months of the program from people only receiving NewStart payments (approximately forty per-cent).

The Doorway guidelines restricting referrals from individuals not receiving DSP payments were not applied consistently across the three regions. In one region, the criteria was relaxed almost as soon as it was introduced in response to the referral of a number of individuals with exceptional needs who were only receiving NewStart. As at March 2013, six of the housed Doorway participants are only receiving NewStart payments.

²³ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - December 2011*

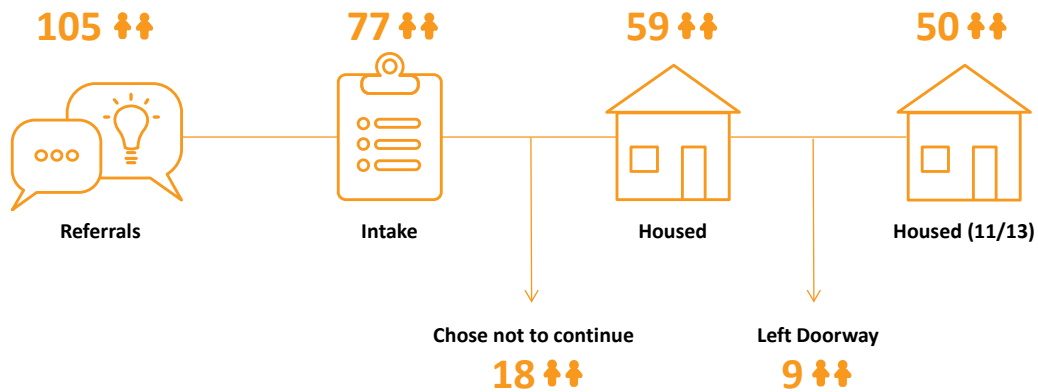
²⁴ Lunn S. (2011), Gillard tightens disability pension, *The Australian*, 30 July 2011.

²⁵ The original Doorway budget for total rental subsidies across the life of the program was based on agreed rental ceilings within each region and the assumption that participants would be eligible for DSP.

3 Implementation has been smooth after delays

As at November 2013, seventy seven people had gone through the Doorway intake process program and fifty participants are currently living in private rental properties. The throughput of individuals through the program is shown in Figure 6 below.

Figure 6: Doorway pilot program throughput

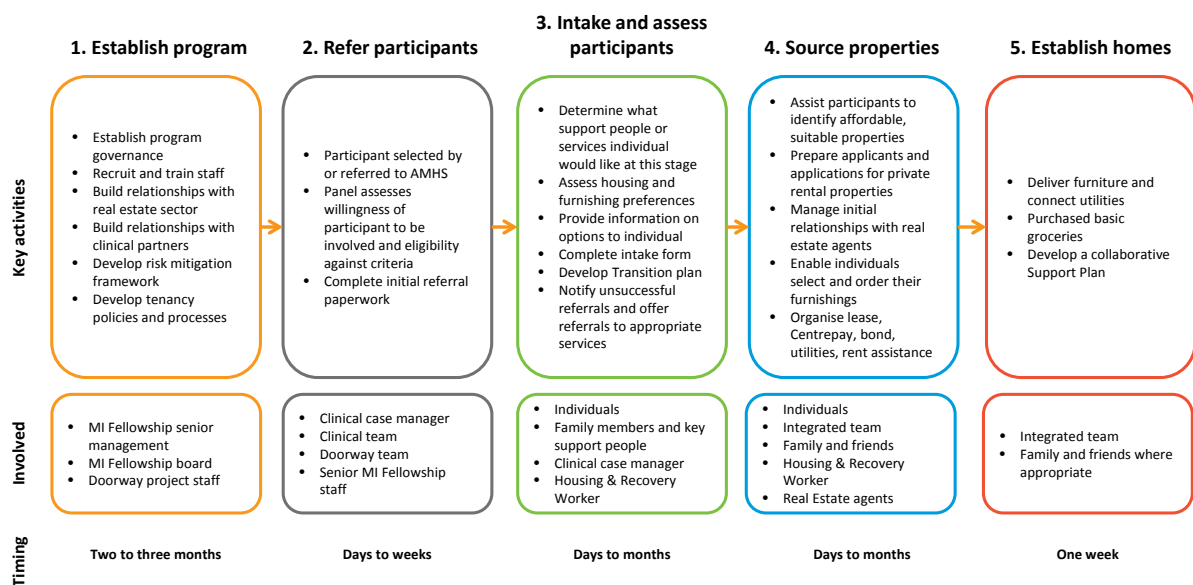


Source: Doorway Statistics (11 November 2013)

To achieve these milestones, a considerable amount of time and effort was needed in the first year of the program as MI Fellowship learnt how best to put the Doorway model into practice.

The initial implementation phase of the Doorway program focused on activities associated with establishing the operational base for the program, referring and assessing potential participants, and working with selected participants to identify properties and establish a home. The activities associated with each of these initial implementation stages are outlined in Figure 7 below.

Figure 7: Initial implementation stages



This section assesses the challenges and opportunities that were encountered in each of these initial implementation stages.

Key performance metrics associated with the stages of the initial implementation phase are shown in Table 6 below.

Table 6: Initial implementation performance metrics (as at November 2013)

| Indicator | Average |
|--|-----------|
| Number of MI Fellowship contacts with participant from referral to point of intake | 1.8 times |
| Total time spent with participant from referral to point of intake | 1.9 hours |
| Elapsed time from program intake to occupy a house | 7.9 weeks |
| Time taken to complete transitional plan | 3.2 weeks |
| Time taken to complete Individual recovery and treatment plan | 8.2 weeks |

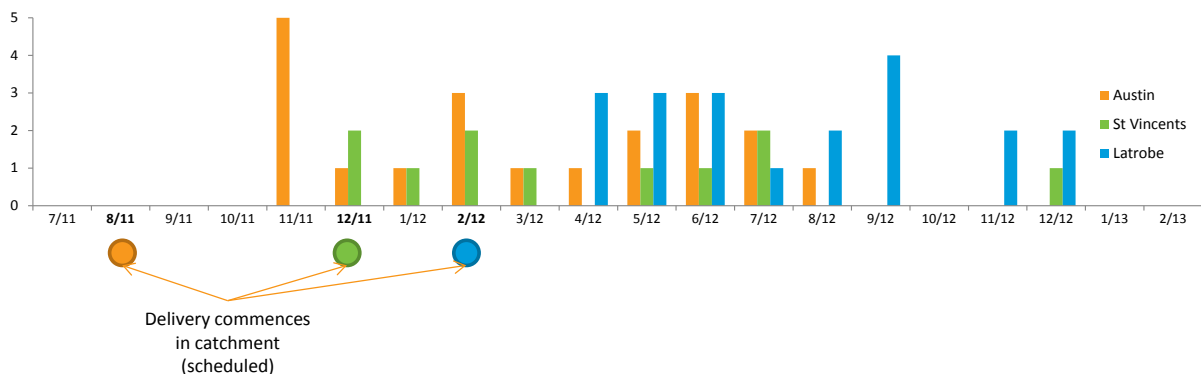
Source: Doorway program records

3.1 Doorway’s initial implementation was delayed

The implementation of Doorway was deliberately staggered across the three regions to reduce the likelihood of over-extending program resources and to ensure that lessons learnt in the first catchment region would inform implementation activities in subsequent regions. Despite the staggered start dates, the intended target of all three Doorway regions functioning at full capacity by January 2012²⁶ was not met.

The first major milestone in the implementation of Doorway – the commencement of delivery in the Austin catchment – was delayed. As illustrated in Figure 8 below, the first participants in Austin were not housed until November 2011 – three months after the scheduled commencement of Doorway in the catchment area.

Figure 8: Number of participants housed by region during initial implementation (as at February 2013)



²⁶ Department of Health (2011), *Funding and Service Agreement - Housing Support and Brokerage Demonstration Project - DRAFT ONLY*

The delays in housing participants were due largely to the challenges MI Fellowship faced in establishing the operational base for the program (see Section 3.2 below) and building the relationships and know-how required to support participants to source and secure rental properties (see Section 3.5 below).

3.2 Internal challenges to program establishment

The initial timeframes for establishing the operational foundations for the program were exceeded by at least three months. Several interrelated factors within MI Fellowship contributed to these delays:

- **Lack of housing experience** – As an organisation, MI Fellowship had no experience in sourcing private rental accommodation and engaging with the real estate sector. As a result, the senior management of the organisation underestimated the amount of time to develop the external relationships and systems and processes to support the housing component of the program.
- **High-profile internally** – The Doorway pilot project had a high-profile within MI Fellowship due largely to the time invested in designing the model and securing funding for the project and high levels of interest from external stakeholders. This resulted in higher levels of scrutiny from MI Fellowship's board and senior management relative to existing Business as Usual programs.

3.3 Referral and selection practices varied

Responsibility for managing the referral and selection of participants rested with the case managers or other clinical staff in the AMHS in each region, with varying levels of input from Doorway staff, other AMHS staff, other service providers, the potential participants and their family members and friends.

In practice, the referral and selection of Doorway participants differed across the three regions – which in turn influenced the type of participants who were accepted into the program. Differences occurred in who participated in the referral and assessment process, application of the eligibility criteria (see section 2.3 above), and how long it took for suitable participants to be identified. Referral and assessment practices also matured in each region as the number of participants entering Doorway increased.

The variance in referral and assessment practices across the three regions was due to several factors:

- **The availability of suitable individuals** – The pool of suitable candidates differed across each region depending on the size and density of their populations of people with a SMI who were homeless or at risk of homelessness. These variations influenced the relative weightings given to each eligibility criteria during the assessment process.
- **Relative maturity of MI Fellowship's relationships with each AMHS** – Where Doorway staff were able to build upon existing MI Fellowship relationships with AMHS providers, it was typically easier to create awareness of the Doorway program and generate buy-in from the case managers who would be referring potential participants
- **Internal culture of AMHS** – The working practices and relationships of each AMHS informed the extent to which internal teams collaborated to refer potential Doorway participants. For example, staff at the Austin initially intended referrals to be drawn equally from their various teams.²⁷ In practice though, the majority of Austin referrals came from the Continuing Care Service team. The internal culture of each AMHS also dictated the extent to which Doorway staff were encouraged to take a greater role in the referral and assessment process.

²⁷ The Austin's AMHS teams include Crisis Assessment and Treatment Service, Continuing Care Service, Mobile Support and Treatment Service and Primary Mental Health.

- **Presence of a homelessness team** – Whether or not each AMHS had a dedicated homelessness team affected the volume and type of referrals. For example, St Vincent's Homeless Outreach Psychiatric Service played an active role in referring individuals for assessment. Neither of the other two partner AMHS had a similar dedicated homelessness team.
- **Existing AMHS capacity to support potential participants** – The capacity of each AMHS to support existing clients who were suitable for the program influenced the types of individuals who were referred. For example, pressure on beds at Latrobe's Community Care Unit (CCU) meant that Latrobe staff were keen to refer participants who were currently in or might otherwise be admitted to the CCU. This meant that many of the individuals referred to Doorway in the Latrobe catchment had very complex needs, which in turn led to the process of engagement with these individuals by Doorway staff being deliberately slower.

The development and ongoing maintenance of MI Fellowship's partnerships with each AMHS are explored in more detail in Section 6.1.

3.4 There were some barriers to participation

Despite the best efforts of the Doorway program and its clinical partners, several individuals who were assessed as suitable for the program through the referral and assessment process did not progress into housing. As at November 2013, 28 individuals had been referred to the program, but withdrew pre-intake, and eighteen withdrew post-intake, but prior to securing private rental accommodation.

Several of these participants exited Doorway post-intake for personal reasons, such as giving birth, being sentenced to a jail term and not receiving the support of financial guardians to live independently in private rental. Another barrier that prevented several individuals from progressing into housing was fear of losing their place on the Public Housing Waiting List – for further detail on this issue see Box 2 below.

In the first half of 2012, two individuals who were primarily homeless withdrew from the intake process. The H&RWs experienced great difficulties in contacting these two individuals to arrange times to find suitable rental properties. The key lesson for Doorway staff from these two cases was that individuals who are primarily homeless are better able to engage with the early stages of the program if they are provided with emergency accommodation, such as a hotel room, immediately after the point of intake.

Box 2: Doorway and the Public Housing Waiting List

The Doorway management team were advised by the Department of Housing in late 2011 that participants who gained privately rented accommodation through Doorway would lose their position on the priority Segment 1 Public Housing Waiting List. Doorway staff subsequently communicated the potential Public Housing Waiting List implications of the program to potential participants during the referral process. This resulted in a small number of individuals withdrawing from the search for private rental accommodation.

This issue was subsequently raised by MI Fellowship with the Ministerial Committee on Homelessness in mid-2012. The Chief Executive of MI Fellowship also lodged a formal request in October 2012 with the Director of Housing seeking exemption for Doorway participants to retain their position on the Public Housing Waiting List on the grounds that the current pilot project was not guaranteed continued funding at the end of three years.

The Director of Housing granted an exemption for Doorway participants for "Doorway Project clients' public housing applications to be reinstated to the priority waiting list (with the same effective date) if their private rental tenancy breaks down or is at risk of breaking down within the initial six months (with some flexibility to extend this to 12 months)".²⁸

To date, this exemption has not been tested in practice with any Doorway participants who left the program within 6–12

²⁸ Email dated 4 December 2012 from Arthur Rogers (A/Director of Housing & Executive Director Housing & Community Building), Department of Human Services to Elizabeth Crowther, CE, Mental Illness Fellowship Victoria.

months of being housed.

3.5 Participants had varied experiences in securing properties

Sourcing and securing private rental accommodation took considerably longer than anticipated. These delays occurred despite some of the major property related risks identified early on in the planning phase not materialising. For example, the stock of suitable properties within the pre-determined price range was generally better than expected, and the speed and depth of real estate agent engagement with the project surpassed initial expectations.

On average, it took participants 51 days and five applications to secure accommodation. In some extreme cases the time and resources required to find a property were significantly greater than this, as demonstrated in Table 7 below.

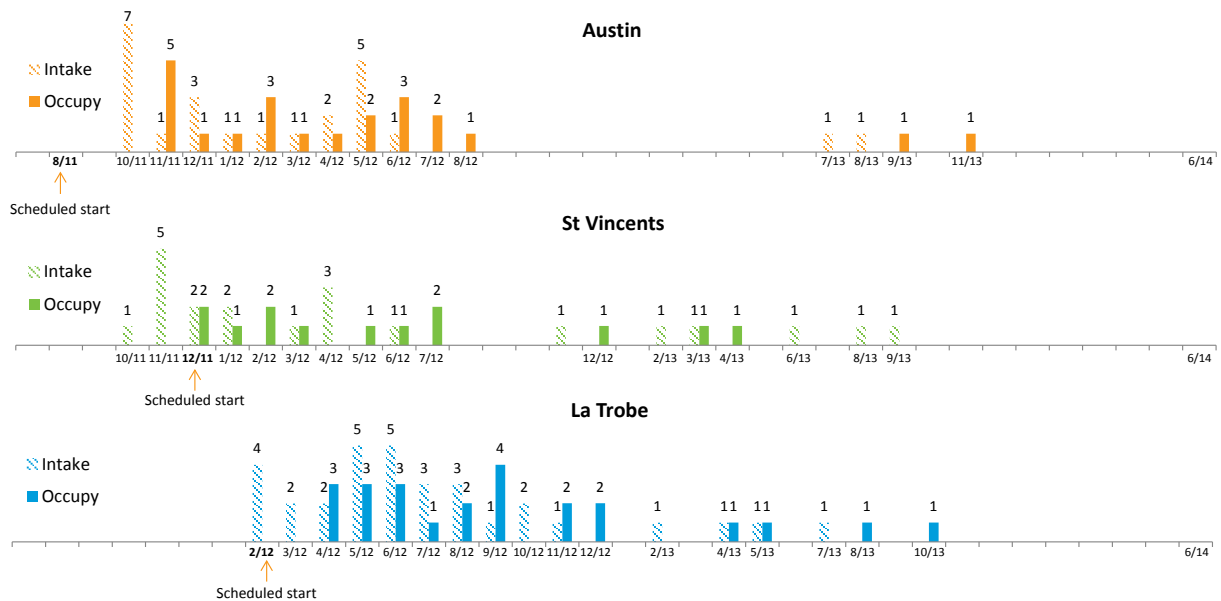
Table 7: Indicators related to sourcing rental properties (as at November 2013)

| Indicator | Average | Minimum | Maximum |
|--|---------|---------|---------|
| Number of inspections | 6 | 1 | 25 |
| Number of applications | 6 | 1 | 19 |
| Number of applications until successful | 5 | 1 | 13 |
| Days from program intake to occupy a house | 51 | 10 | 191 |

Source: Doorway Statistics (11 November 2013)

The longer than anticipated timeframes for securing private rental accommodation has meant that many participants will be spending less time than anticipated in the Doorway program. The graphs in Figure 9 below illustrate that most participants moved into their accommodation around six months after the original scheduled delivery date in each region. The challenges in finding housing for participants were compounded by the delays in establishing the program and sourcing suitable participants, as discussed in Sections 3.3 above.

Figure 9: Timing of participant intake and housing occupation by region (as at November 2013)



The delays in sourcing and securing private rental accommodation were due to a range of factors:

- **Finding a house can be very challenging** – The majority of Doorway participants were not used to competing for rental properties on the open market and the need to attend multiple inspections. This required additional time to adapt to the new processes.
- **Some participants required additional support** – The challenges and stresses associated with looking for rental properties adversely impacted the wellbeing of some participants. In these cases, Doorway staff were required to delay the search for properties and work with these individuals’ case managers to arrange additional support.
- **Real estate agents had differing levels of engagement** – In the initial stages of working with agents in each region to find rental accommodation, agent level of awareness of, and buy-in to, Doorway was uneven. This affected the extent to which they were willing to be flexible to accommodate the particular needs of Doorway participants, or the speed with which they responded to queries or applications from participants.
- **MI Fellowship originally anticipated inspecting properties outside scheduled open inspections**– Doorway staff initially envisaged that real estate agents would be willing and able to arrange inspections for participants outside of scheduled open inspections. It quickly became apparent this would not be feasible in the vast majority of cases, and that Doorway staff and participants would need to attend scheduled inspections to view properties. This entailed a large amount of after-hours and weekend work by Doorway staff to accompany participants to open inspections.
- **There were various logistical challenges** – Managing the logistics of seeking rental accommodation also proved time consuming for Doorway staff. The key logistical tasks included contacting participants to arrange inspections, ensuring that they had all requisite identification documents, coordinating the inspections and assisting with applications. These challenges were compounded by HR&Ws experiencing difficulties with contacting clients, an issue that was rectified in some instances by purchasing mobile phones for participants.
- **Participant expectations need to be managed** – In a handful of cases, participants invested time in looking at properties that exceeded the budget caps set for each region. Doorway staff were

required to carefully manage the expectations of these participants so that they were looking for accommodation within budget limits.

In addition to the above issues, there was a set of unique Gippsland-specific challenges that hindered the search for rental accommodation in the Latrobe catchment region:

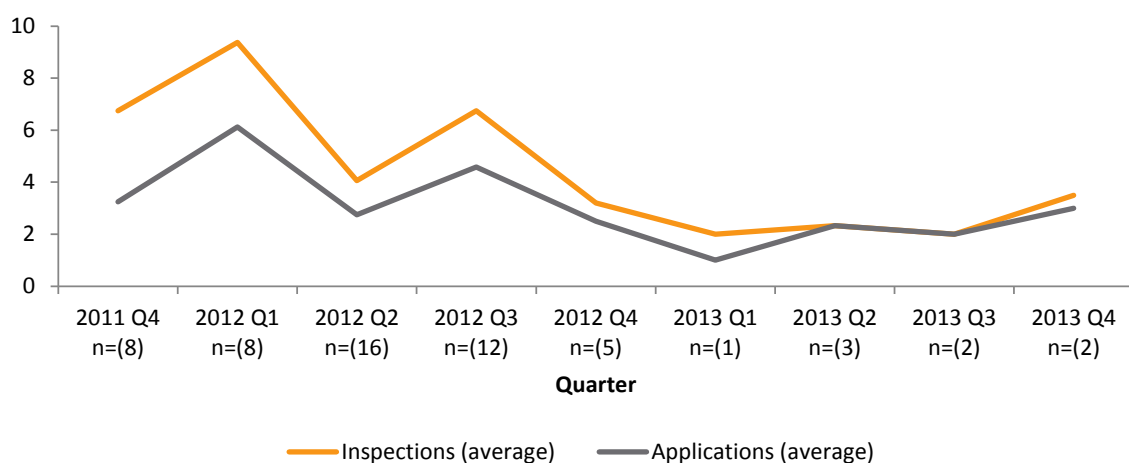
- **Participants had higher needs** – Compared to the two metropolitan regions, Latrobe participants tended to have higher levels of complexity and support needs. Doorway staff required a longer transition time to meet and engage with these participants and commence the process of finding a property.
- **Fewer properties were available** – The smaller size of Gippsland towns and the lower density of housing limited the number of rental options in particular towns at particular times. This posed challenges in seeking properties, given that the majority of participants were not willing or able to move to other towns in the region.
- **Local communities are smaller and more inter-connected** – The smaller and more closely knit communities in Gippsland significantly increased the likelihood of real estate agents being familiar with the family or friends of participants. In some cases, agents refused or were hesitant to work with certain participants given their familiarity with their family's history in the area.

Over time, the Doorway team in Gippsland were able to overcome these particular challenges as they grew their engagement and relationships with the local real estate agents.

3.6 Securing properties become easier

The time and effort taken to secure rental properties for participants has decreased as the pilot program has progressed. Figure 10 below shows that the average number of rental inspections and applications for housed participants have decreased over time. This can be attributed to the strengthening of relationships with real estate agents and the H&RWs increasing familiarity with how best to support participants to locate and secure rental accommodation.

Figure 10: Average numbers of rental inspections and application for housed participants



3.7 Incident levels have been low

There have been lower than expected levels of reported incidents since the start of the Doorway pilot. As at November, there have been single occasions of DoH Category 1 and 2 incidents and six Category 3 incidents reported – as outlined in Table 8 below.

Feedback from participants indicates incidents have been managed well from their perspective.

Table 8: Officially reported Doorway incidents by DoH category (as at November 2013)

| Type | Incidents | Details | Category definition ²⁹ |
|------------|-----------|---|---|
| Category 1 | 1 | <ul style="list-style-type: none">• Possible overdose³⁰ | <ul style="list-style-type: none">• Incidents that result in a catastrophic outcome, such as death or severe trauma |
| Category 2 | 1 | <ul style="list-style-type: none">• Participant self-harm | <ul style="list-style-type: none">• Incidents that seriously threaten, clients or staff, but do not meet the category one definition |
| Category 3 | 6 | <ul style="list-style-type: none">• Medical concerns, physical assault, anti-social behaviour | <ul style="list-style-type: none">• Incidents that disrupt normal work and routine but do not extend in significance beyond the workplace |

Source: Doorway program records (November 2013)

4 Governance arrangements have evolved

Doorway's governance arrangements have evolved as the pilot moved beyond the initial implementation phase in the first 18 months of the program. Key changes over this period included increased clarity in the roles and accountabilities of the various program committees, a greater decentralisation of day-to-day program management, tighter overall project management, a reduced focus on operational issues and risks related to housing and increased engagement of participants in formal governance roles.

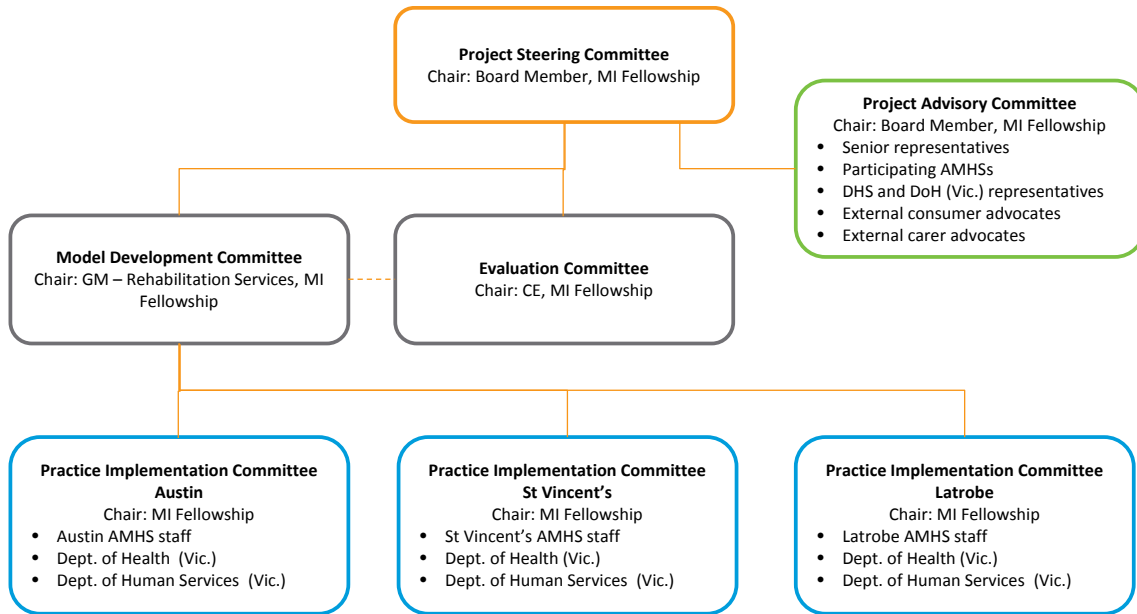
4.1 The roles of program committees have evolved

After an initial flurry of meetings and engagement with external stakeholders during the initial design and implementation phases, the functioning of Doorway's various committees (shown in Figure 11 below) became more bedded down.

²⁹ Department of Health (2013), *Incident reporting instruction*, pp. 7-9. <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/680662/incident-reporting-instruction-updated-may-2013.pdf>

³⁰ In this particular case the Doorway participant made a full recovery and came back into the program. They later decided to leave Doorway in positive circumstance.

Figure 11: Doorway program committee roles and accountabilities



The consensus among MI Fellowship’s senior management and external stakeholder representatives is that Doorway’s various governance committees have largely fulfilled their originally stated purposes. During the first 18 months of the program, the composition and roles of some of the Doorway committees evolved – as outlined in Table 9 below.

Table 9: Key changes in governance committees

| Committee | Key changes |
|------------------------------------|--|
| Model Development Committee (MDC) | <ul style="list-style-type: none"> Initially very resource intensive Meetings moved from fortnightly to weekly in mid-2012 Have become less operationally focused – a shift which coincided with H&RWs no longer attending the meetings Three participant representatives were elected and joined the MDC in December 2012 Chair role transitioned from GM – Rehabilitation Services to Regional Manager – Southern and Gippsland |
| Steering committee | <ul style="list-style-type: none"> Initially very active and focused on overall risk management |
| Evaluation Committee | <ul style="list-style-type: none"> Met only once formally Has evolved into monthly evaluation meetings with Nous which are also attended by Department of Health central office representatives Chair role transferred to Nous |
| Practice Implementation Committees | <ul style="list-style-type: none"> Still active across all regions but meeting less frequently |

4.2 The composition of the Doorway team has evolved

The composition, capabilities and overall approach of the Doorway team changed during the initial implementation phase as the program model evolved and new issues have come to light. Key changes to the composition of the team included:

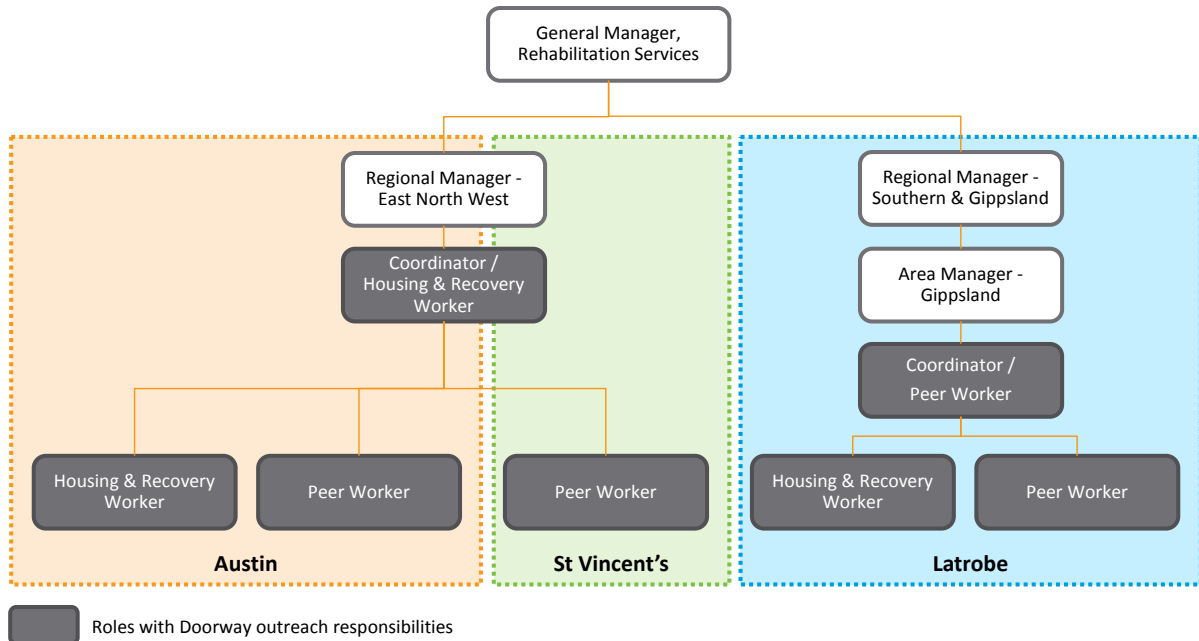
- The phasing out of two Project Officer roles in asset management and an increase in the number of H&RWs in the Doorway team. These changes shifted the focus of control in the Doorway team and resulted in a more rehabilitation-centric approach being taken to the management of day-to-day operational issues.
- A shift in emphasis by Doorway management from being directive and operationally focused towards the maintenance of the programs core values of choice, social inclusion and sustainability.
- An increase in the number of Peer Workers over the course of the program as MI Fellowship gained more experience in how to best utilise workers with lived experience.

The current structure of the Doorway team across the three catchment regions is shown in Figure 12 below. The Doorway team currently includes four staff with declared lived experience with mental illness. These include three Peer Workers, who perform the same support role as Housing and Recovery Workers with an additional component of peer support responsibilities.³¹

It should be noted that the two Coordinators also have additional housing and recovery responsibilities.

³¹ For the purposes in this report, references to H&RW include Peer Workers given that the responsibilities of both roles are the same.

Figure 12: Structure of the Doorway team



4.3 Culture and capabilities have been key enablers

Feedback from Doorway participants and staff indicate that the culture of the Doorway team and MI Fellowship more broadly have contributed to the successful management of the project thus far and the high levels of engagement between the Doorway team and participants and partners.

Doorway staff who joined MI Fellowship from other organisations have described the culture as open, inclusive, inviting and friendly – for both employees and consumers. H&RWs have described the Doorway team as collegiate, supportive, open and united around a shared sense of purpose. The introduction of the three core Doorway program values – choice, sustainability, inclusion – has been acknowledged as a key contributor to the last attribute – a shared purpose.

“It was very easy to join the Doorway team – it has structure but they still care about your opinions – there is an open floor.”

Doorway team member

Peer Workers with lived experience have also felt fully supported to talk with clients and colleagues about their own lived experiences with mental illness.

“This the first job I have had where I can disclose my own mental health issues with participants – it’s very liberating.”

“MI Fellowship allows people to be more open about their own experiences – I can talk about being a drug addict in the past and there isn’t a risk of being judged like there is in other organisations.”

Peer Workers

4.4 Consumer representation has deliberately evolved

During the design and initial implementation of the Doorway model, consumer input was provided by MI Fellowship’s internal Consumer Participation Service Consultant – who sat on the Advisory Committee and Model Development Committee. The Consumer Participation Service Consultant provided input during the initial phases of Doorway into issues related to the promotion social inclusion, optimal ways to engage with participants, and the appropriateness of certain language in Doorway documentation and communications.

MI Fellowship identified an opportunity in early 2012 to further enhance the levels of consumer engagement in Doorway by formally inviting Doorway participants to sit on the Doorway Model Development Committee (MDC). The processes of selecting and defining the precise responsibilities and functions of the participant representative roles on the MDC were subject to lengthy internal debate over a period of several months. The first two Doorway participant representatives were eventually inducted to the MDC in late 2012 with support from the Consumer Consultant.

Feedback from MI Fellowship staff indicates that participant representation on the MDC provided invaluable input within a short period of time, and that Doorway would have benefited greatly had these roles been formalised much earlier in the pilot program. Within the first few months of joining the MDC, the participant representatives provided valuable input into day-to-day program management issues such as the changes to policies related furnishing fees and ongoing ownership of furniture packages and the development of a policy related to the management of rental arrears.

The input of the participant representatives has subsequently focused less on operational issues and more on advocacy and providing strategic advice on issues such as transitional planning and how best to sustain participant outcomes. The level of peer support among the two participant representatives has also increased. After intentional support from the Consumer Consultant when they first joined the MDC, the participant representatives now meet by themselves before each MDC meeting to discuss the agenda and their role in the meeting and then again afterwards to debrief the meeting outcomes.

The consumer representatives who were interviewed in March 2013 – shortly after their inclusion on the MDC – agreed that there was an opportunity to further extend and formalise their roles as conduits between the management of Doorway and the participants. To this end, two Doorway participants completed a consumer leadership course in early 2013, funded by the Department of Health.

“I try to represent what I feel is a general view rather than personal views. I haven’t met many other participants yet, but I am happy to become a contact person. I would like to see us get more involved with participants. People are more likely to speak to us if they have an issue, because they might fear getting thrown out of their homes.”

“There is a gap – we interact with other participants during social exercises but we need to speak to people on a one-on-one basis to find out their experiences. It would be great if we would be great to represent all the Doorway participants on a more structured basis.

Participant representatives on MDC

4.5 Project management has improved

The project management of the Doorway pilot could have been strengthened during the first 18 months of the program and MI Fellowship. There were several examples of project management slippages during the initial implementation phase of the program including delays related to the:

- Placing participants in accommodation across all three regions
- Developing or finalising key policies and systems (see Section 4.6 below)
- Gaining ethics approval for this evaluation.³²

One of the reasons for these delays is that Doorway did not have a dedicated project manager during the initial implementation phase of the program. Project management responsibilities during implementation sat across three different operational level roles. Although well resourced, this arrangement proved ineffective and resulted in many project management and operational decisions being escalated to MI Fellowship's GM of Rehabilitation Services – the most senior member of the Doorway team .

In recognition of the fact that these arrangements were not sustainable as well as the ongoing evolution of the Doorway model, responsibility for many operational issues shifted in early 2013 to the program's two Regional Managers. Responsibility for chairing the MDC was also transferred from the GM of Rehabilitation Services to a Regional Manager in early 2013.

4.6 The development of some policies and systems lagged

By their own admission, MI Fellowship could have had a greater focus on developing and embedding program policies and systems during the initial implementation phase of the Doorway pilot. Examples of policies and systems that were delayed included those related to ascertaining participant debt levels prior to entering Doorway, recording tenancy related issues such as the timing and outcomes of inspections by Property Managers, managing participant lease breaks, and clarifying whether participants could own or can choose to purchase their furniture package at the end of the program.

A lack of regular and centrally controlled updates to the Tenants Handbook during the first 18 months of the pilot also posed problems – given that it is the primary tool for communicating expectations to Doorway participants. In the absence of official updates, changes were made to the Tenants Handbook at a regional level which resulted in inconsistencies across key parts of the handbook. The official version of the Tenants Handbook was eventually updated in mid-2013 with input from the consumer representatives on the MDC.

³² Responsibility for seeking ethics approval for this evaluation has rested with MI Fellowship. Delays in the initial application process has resulted in the final ethics approval (for Latrobe) not being granted until January 2013 –18 months after the start of the evaluation. It should be noted that the delays in seeking ethics approval were largely due to the requirement to submit unique applications to the Human Research Ethics Committees at each of the three AMHS partner hospitals. MI Fellowship could have proceeded with this evaluation without hospital ethics committee approval by just utilising data collected by Doorway staff to analyse changes in participant outcomes. It was decided though that clinical data would provide valuable insights in changes in health outcomes and that ethics approval to access this data was required.

4.7 Risk management has become less formal

During the initial implementation of Doorway, MI Fellowship devoted a large amount of effort to identifying and assessing possible program risks, seeking legal advice about how best to mitigate these perceived risks, and developing related documentation – particularly those related to potential rental defaults and property damage. This initial focus was largely due to what turned out to be an overly conservative view of how real estate stakeholders would engage with and support Doorway and how well participants would be able to live independently and maintain their tenancies.

This imperative to monitor and manage program risks on a regular basis diminished as the program moved into the ongoing implementation phase and the perceived risks related to procuring and maintaining tenancies did not manifest at the expected levels– as demonstrated by the relatively low levels of housing incidents. As a result of this, the risk register for the program was last updated in August 2012 and reviewed again by the MDC in early 2013. The subsequent six monthly review has been delayed and is scheduled to occur at the time of this evaluation report being written.

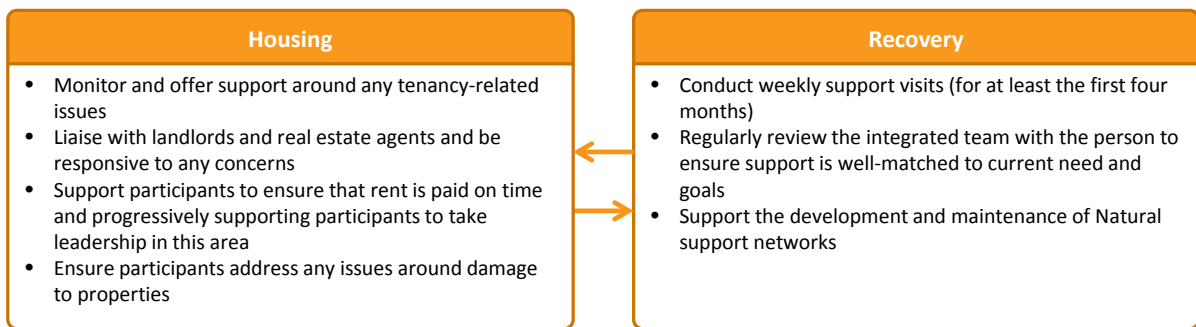
5 Housing and Recovery Workers are central

The Doorway H&RWs are responsible for implementing the model on a day-to-day basis in their regular interactions with the Doorway participants and have played a critical role in the achievement of many of the pilot program’s outcomes of to date. Where possible, participants see the same H&RWs on a weekly basis for at least the first four months of their tenancy and provide – on average – 1.6 hours per week of face-to-face support to participants.³³ Feedback from Doorway participants about the support provided by their H&RW has been unanimously positive.

5.1 H&RW have multiple roles and responsibilities

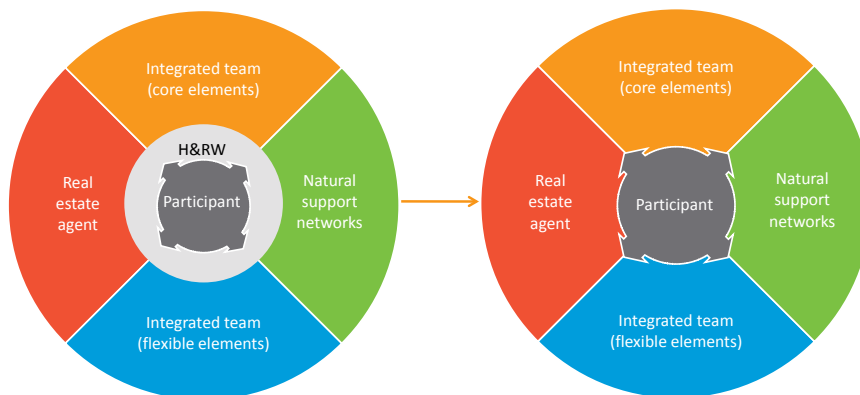
H&RW have dual recovery and housing roles – a key difference from the original Housing First model implemented in Pathways to Housing (see Section 2.1.2 on page 11). The responsibilities of H&RWs across these two roles are shown in Figure 13 below.

Figure 13: The responsibilities of the Housing and Recovery Worker



H&RWs are also responsible for establishing, nurturing and facilitating the relationships between participants and their integrated teams, natural support networks and real estate agents – key elements of the Doorway model. As shown in Figure 14 below. It is intended and intentionally supported that Doorway participants gradually become able and willing to manage these relationships themselves.

Figure 14: Core elements of the initial Doorway model



³³ Calculation based on Doorway program records for the period from July 2011 to December 2012.

The process of encouraging participants to manage these relationships on their own and make independent decisions requires H&RW to strike a delicate balance between motivating and advocating for participants on one hand, and mitigating the risk of dependency by pushing and holding them accountable on the other. In the words of one H&RW, “persistence is the key – but it’s a fine line as you don’t want to push too hard and have the person put up a barrier.” Feedback from Doorway participants in the focus groups indicates the H&RWs have managed this delicate balance well thus far.

“I once asked my H&RW to post a letter for me, but they said ‘I will do it for you this one time, but not again – this is something you can do yourself!’”

“Without my Housing and Recovery Worker’s help I would be stuck in the boarding house because I didn’t have any idea how to do the paperwork and process things”.

Doorway participants

5.2 H&RW engagement with participants was rapid and deep

The H&RWs interviewed for this evaluation were taken aback by the speed with which they were able to establish trust and rapport with many of the participants they support. The depth of the engagement between participants and their H&RW has also surprised staff who have performed similar outreach roles in other programs.

The speed and depth of this engagement fast-tracked the ability of H&RWs to have frank and open conversations with participants. As one Doorway team member noted, “We have gotten straight into people’s lives – rather than just preparing them for real life issues.” Feedback from H&RWs indicates that these conversations have engendered greater levels of self-reflection which in turn have enabled many individuals to move into the next stage of their recovery.

Feedback from Doorway participants about the level of support provided by their H&RW has been unanimously positive. Participants most commonly describe their H&RWs as ‘down to earth and supportive’, ‘caring’ and ‘consistent’.

“They stick by you – whether you are well and when you are not.”

“It’s been overwhelming – but not in a bad way – I am not used to receiving such generosity and support”

Doorway participants

5.3 Peer workers have added great value

The inclusion of Peer Workers – H&RWs with lived experience of mental health issues – in the Doorway team has added great value to the experience of participants and other staff in the pilot program. Peer Workers have the same job description as H&RWs, with additional responsibilities in the form of peer support.

The inclusion of Peer Workers in the Doorway team coincided with an increase in peer workers across all MI Fellowship programs, and the development of the Peer Support Framework and a Peer Hub. The latter is intended to facilitate group reflection and embed principles of intentional peer support across all programs.

“Peer Workers understand certain things others don’t – you know you are both travelling on the same path.”

“Books don’t explain the whole condition. I prefer to talk to people with personal experience.”

Doorway participants

The support provided by Peer Workers to participants has added value to the pilot program. Feedback from participants indicates that Peer Workers can easily relate to their day-to-day recovery challenges and provide support based on their own personal experiences.

H&RW without lived experiences of mental health issues have also gained value from advice provided by their Peer Workers colleagues about how best to manage specific challenges with providing support to participants.

Despite the success of the Peer Worker model, several issues were raised about how it has operated in practice. The first query related to whether it was necessary to explicitly identify Peer Workers as such in their job titles – as opposed to workers with housing and recovery responsibilities who may choose to disclose their own lived experiences. Views on this issue were mixed, as many of the current Peer Workers were happy to have their status as peers openly identified in their job title.

5.4 The H&RW role presents challenges

The majority of the H&RWs in Doorway describe their roles as rewarding and challenging and in equal measures. The H&RWs also report that there have been times when they have felt stressed and overwhelmed, particularly during the initial implementation stages when they were supporting participants to find rental accommodation and settle into their homes.

The day-to-day pressures and stresses felt by H&RWs in supporting participants – many of whom had highly complex needs and had never lived in their own private rental accommodation before – was compounded by a variety of factors:

Program-related factors

- **Workload of dual roles** – Many H&RWs highlighted the high workloads associated with playing their dual housing and recovery roles. They also noted that it could be challenging to balance the two responsibilities and assist participants to achieve housing and recovery goals that at times were in conflict – particularly when participants were struggling to make rental payments.
- **High levels of emotional engagement** – As noted in section 5.2 above, levels of engagement between H&RW and participants have generally been very high, with workers often stepping into the role of friend or confidante. As a result of this emotional investment, H&RWs at times have been personally affected by setbacks experienced by participants. On occasion during times of crisis, H&RWs have also had to resist stepping into a ‘rescue’ type role with participants.
- **Lack of experience** – Several members of the Doorway teams were relatively new to community outreach work at the start of the pilot project. As a result, several of the H&RW may have initially lacked the resilience and ability to deal with secondary trauma, in comparison with older and more experienced outreach workers.
- **Lack of time to debrief** – Despite the regular Doorway team and individual supervision meetings, several H&RWs suggested that these meetings tended to be very operationally focused and task based. This left little time for H&RWs to discuss and debrief challenges they may be experiencing on a day-to-day basis in supporting participants. Steps were taken to rectify this with the introduction of a weekly two hour Recovery meetings with an embedded component of practice reflection. Shortly after this, H&RW also stopped attending the more operationally focused MDC meetings.

Pilot-related factors

- **Uncertainties of a pilot program** – Pilot programs by their nature can be characterised by unpredictable events and outcomes. The rapid evolution of the Doorway model and the ongoing development of associated systems and processes also generated high levels of ambiguity for staff working in the program. As one Doorway team member remarked, “pilot programs are always unpredictable, stressful and uncertain.”
- **Attention and expectations of MI Fellowship senior management and Board** – The majority of H&RWs reported feeling direct and indirect pressure at the start of the project from members of MI Fellowship’s senior management and Board to achieve the best possible outcomes for Doorway participants and minimise the number of incidents that might expose the organisation to financial risk. It was suggested by some H&RWs that this initial pressure may have compromised longer-term outcomes for participants, by not giving participants the space to learn from mistakes that may have resulted in tenancy breaches or in extreme cases, evictions.
- **Evaluation reporting burden** – Several H&RWs highlighted the substantial extra workload involved in collecting and recording data used in the evaluation of Doorway. The burden associated with capturing data over and above the BAU program data was compounded by the absence of electronic systems and the need to manually enter data for this evaluation. H&RWs also reported feeling pressured to complete outcome measures with participants during periods that were not always appropriate for participants in terms of their recovery process. It is also possible that some H&RWs may have initially lacked confidence in completing the outcomes measures.

It should be noted that all H&RWs reported feeling supported by their peers during periods of stress and distress. It has also been acknowledged by MI Fellowship management that the type and level of support offered by MI Fellowship as an organisation to its peer workers has matured significantly since Doorway’s inception.

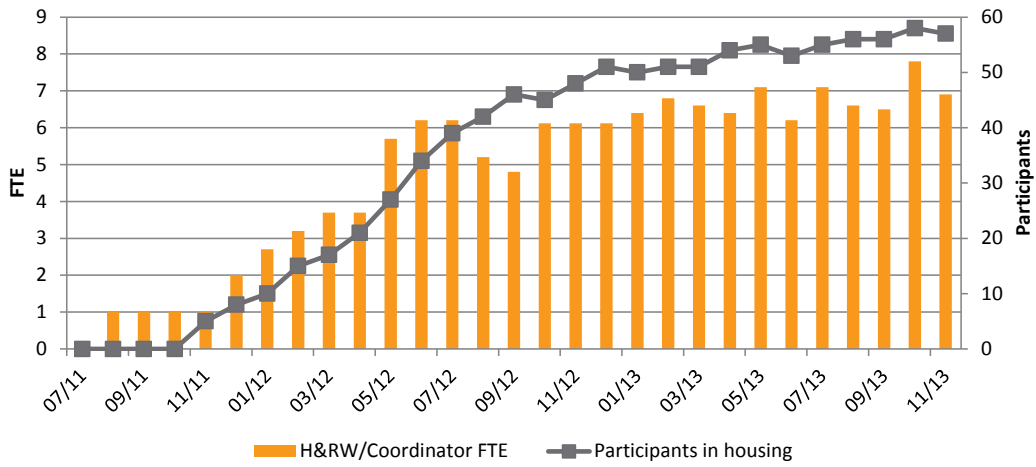
5.5 The H&RW team has become more stable

In the initial stages of the Doorway pilot, MI Fellowship made a concerted effort to attract high-calibre H&RWs through a range of incentives such as above-market salaries. Despite this, the evolution of the H&RW team was slow and protracted.

On average, there have been 6.2 participants per one Doorway H&RW/Coordinator FTE³⁴ since the first participant was housed. Figure 15 below illustrates that there was only one H&RW/Coordinator FTE for the first few months of the program. The graph also shows that the team has generally grown at the same pace as the number of participants who have been housed in Doorway.

³⁴ This FTE total includes H&RW, Peer Workers and the Coordinators who also have H&RW roles.

Figure 15: H&RW/Coordinator FTE and number of participants in housing since Doorway inception



There was some turnover in the Doorway team in the first year of the pilot, – with two staff leaving within six months of joining the project. MI Fellowship’s management team attributed this turnover to poor assessments during the initial selection process of the capabilities, resilience and cultural fit of the individuals who were hired – rather than the demands of the program or a dearth of support and training from MI Fellowship. Several other H&RWs have also moved on to other roles in MI Fellowship or have gone on parental leave.

Feedback from participants who have been supported by more than one H&RW indicates that the transitions between workers were managed well and that the change had minimal adverse impacts. Where possible, MI Fellowship has facilitated formal handovers that have involved both workers visiting the participant involved.

6 Partnerships have been fundamental

The partnerships between MI Fellowship and the three clinical partners and real estate agents in each region have been fundamental to the positive outcomes achieved by the Doorway pilot to date. The speed with which these partners engaged with the Doorway pilot and continue to advocate and support the program also far exceeded MI Fellowship's initial expectations. The contributions of employment providers in the Doorway pilot have less successful by comparison – although strategies are currently in place to remedy this.

6.1 Clinical partnerships require investment by all

After a slow start, Doorway's partnerships with all three clinical partners have reached a state of maturity where they are stable and well-functioning. The key points of engagement between the Doorway team and the AMHS staff are through the Practice Implementation Committee meetings, the quarterly integrated team meetings to update participants' recovery plans and other interactions dictated by the particular needs of the participants.

6.1.1 Partnerships were initially challenging at times

Senior managers at the three AMHS have been almost uniformly supportive of Doorway since the start of the pilot program. Levels of engagement were initially more variable at a case manager level – which is where the majority of day-to-day interaction occurs between the Doorway team and the AMHS.

The Doorway team encountered several initial challenges in establishing and managing their relationships with the AMHS case managers. These challenges include:

- **Delayed or no communication on critical issues** – There were several instances of participants being hospitalised and their H&RW either not being informed at all or not being informed until well after the admission.
- **Lack of ownership and accountability** – H&RWs noted that most case managers tended not to take responsibility for organising integrated team meetings and that significant time and effort was required to ensure that case managers attend the meetings when they do occur.

The majority of these issues have been resolved – but some continue to pose challenges. Many of these initial challenges have attributed to a range of different factors by MI Fellowship staff:

- **Lack of time and availability** – The majority of case managers have large and demanding case loads, which can limit their ability to engage with Doorway staff and participants at a level greater than the other clients in their case load.
- **Differing approaches to recovery** – Doorway and AMHS staff have noted the differences between the treatment and rehabilitation approaches to recovery and risk management. These differing approaches have at times led to robust discussions between case managers and H&RWs about how best to support a Doorway participant – particularly in times of crisis.

It is important to note that any ongoing cultural tensions between the Doorway team and AMHS staff can also be viewed in a positive light. As one AMHS manager noted, "These tensions show that collaboration between us and MI Fellowship is real". With this type of collaboration, cultural tensions have been openly acknowledged and their impacts discussed.

6.1.2 Partnership outcomes for MI Fellowship are positive

Despite the challenges noted above, the Doorway team are generally satisfied with the health of their relationships with the three AMHS. Several H&RWs stated that the relationships should be viewed in relative terms, and that MI Fellowship's partnerships with the AMHS on the Doorway pilot have been more open and productive than they have experienced with other services providers.

“Coming from a different organisation I have been surprised at how receptive our AMHS have been and how strong the relationship is.”

“There are open doors at our AMHS, we can sit down and have conversations with the case managers. With other clinics I have worked with, I would struggle to get a response.”

H&RWs

Some of the key successes for MI Fellowship from their partnerships with the AMHS include:

- Co-location by Doorway staff at the AMHS sites
- Regular involvement by case managers in the majority of integrated team meetings
- Continued engagement by AMHS staff in the Implementation Committee meetings
- Development of some shared Individual Support Plans (ISPs) being informed by results from the Doorway program's Homelessness Star
- Standard outcomes measurement data (such as BASIS-32 and HoNOS) being shared to reduce the need for duplicate assessments of participants.

6.1.3 Outcomes are also positive for AMHS

Senior staff across all three AMHS were part of the initial intake and referral processes at the outset of Doorway in their region. These staff have also engaged with Doorway on an ongoing basis by sitting on the Implementation Committee meetings and through their day-to-day interaction with the H&RW co-located at the AMHS sites.

Senior staff at the AMHS made the following comments about their partnerships with MI Fellowship through the Doorway pilot:

- **Implementation was smooth** – The H&RW and AMHS staff worked from the outset to plan how the program would operate in the area, including the referral process, eligibility and on-going relationships.

“We were constantly assessing and re-assessing and tweaking as we went and as we learned more. This is the most successful partnership we have had with an NGO because both organisations did the groundwork and worked with one aim”.

Staff member, AMHS

- **AMHS have generally included Doorway staff** – All AMHS provided the majority of H&RWs with access to security passes and email accounts. H&RWs are also usually invited to attend staff meetings to raise awareness of Doorway related issues or other forums (such as St Vincent's weekly Strengths Brainstorming peer supervision meetings and Physical Health Working Party) to discuss specific outcome areas for participants.

“We have been mindful of including the H&RWs – they are an honorary member of our AMHS – they have access to email and supervision with senior clinicians – which has really benefited participants.”

Team Leader, AMHS

- **Client outcomes are being noticed** – AMHS have become increasingly supportive of Doorway as the program has started to show positive outcomes for clients. The biggest successes noted by

AMHS have occurred when their clients are able to be discharged. The relationship and shared responsibility is benefiting clients as well as clinical staff.

“Doorway took the hard clients. The only reason a client was not taken was because the clinical staff made the call. We did not want to set the clients or MI Fellowship up for failure.”

Clinical staff member, AMHS

“The difference with Doorway is that MI Fellowship requires a commitment from the client to take responsibility for the tenancy and for meeting with the support team. Other programs tend to have a take it or leave it approach and this does not provide much of an incentive. Doorway clients own the issue and take responsibility.”

Director of Nursing, Mental Health

“Doorway has been about setting people up to succeed in the future – it’s about normalising the housing process and reducing stigma. Case managers are starting to see good outcomes emerging and we have seen a recent influx of referrals (~forty) – as case managers now know they are not setting their clients up for failure.”

Team Leader, AMHS

- **AMHS have confidence in Doorway staff** – AMHS staff noted the professional and enthusiastic way in which the H&RWs engage with them on an ongoing basis, and that this has had a positive impact on case managers involved with Doorway as well as the participants themselves.

“The H&RWs are very engaged and excited by the project which makes them very good advocates. Their optimism and enthusiasm rubs off on the participants and case managers.”

Team Leader, AMHS

6.1.4 Co-location remains a good decision

The co-location of Doorway staff at the three AMHS sites has been fundamental in facilitating the growth of the partnerships between Doorway and AMHS staff. The co-location of H&RW at Austin, St Vincent’s and Latrobe all occurred during the implementation phases in each region.

H&RWs and AMHS staff have noted multiple benefits from the co-location – particularly those related to improved communication. From the perspective of the H&RWs, working out of the AMHS offices has meant that they are less likely to miss important corridor conversations about participants and better able to contact clinical staff in person rather than over the phone.

“Case managers show me more respect when they see that I have a desk in the office.”

“I spend a lot of time at the offices and I feel like an honorary employee and a part of the team – I have an access pass and I can log on to the AMHS computers.”

H&RWs

H&RWs have also noted that the co-location can be challenging, as they can feel isolated when they are at the AMHS offices and separated from the daily support of their Doorway colleagues in the MI Fellowship offices.

From a participant perspective, co-location has also been beneficial in terms of convenience. As one participant noted about their AMHS clinic, “I am used to coming here – I can see my case manager as well as my housing and employment support workers at the same time”.

6.2 Real estate stakeholders play a critical role

To date MI Fellowship has partnered with twenty–seven real estate agents across the three Doorway regions. Real estate agents have played a fundamental role in some of the positive housing outcomes that Doorway has been achieved to date.

6.2.1 Initial engagement was formal

MI Fellowship’s approach to engaging with the real estate agents in the three Doorway regions has evolved over time as the organisation’s confidence in working with Property Managers has increased.

MI Fellowship’s initial engagement with the real estate sector came through the Real Estate Institute of Victoria (REIV), who provided feedback on how best to initially engage with real estate agents. Based on advice from REIV, the initial approach to real estate agents was highly structured and formal – with REIV sending out an introductory letter endorsing the program to the directors of the large real estate agencies in each region.

MI Fellowship developed a range of marketing collateral that was customised for the one real estate agency they partnered with in each region initially. Doorway staff also developed a range of incentives to encourage real estate agents and landlords to support Doorway. These included landlord insurance for each property to protect against rental defaults³⁵ and a Surety Fund to cover repairs for any wear and tear at the end of each lease. The full list of incentives (see Box 3 below) was formulated and articulated through consultation with real estate agencies on the assumption that real estate agents and landlords may view the Doorway participants as undesirable tenants due to their mental health status and lack of rental history.

“When we [initially] put the application up to prospective owners [to let them know] we’ve found a suitable [Doorway] tenant they’ll ask us, ‘Well what’s the prior rental history, what do they do and where do they come from?’ And we’ll say, ‘Well they’re part of the Mental Illness Fellowship program’. Straight away the alarm bells are switched on. I’ve been able to tell owners of properties that, ‘look there are many checks and balances in this program which would mitigate risk. We feel confident with the organisation that we’re associating with that there are sufficient checks and balances on prospective tenants where you’re guaranteed the rent, the property is to be maintained in a suitable condition and we don’t feel that there is any greater risks in finding somebody [who has a] rental history.’”

Property Manager

Box 3: Real estate agent incentives

- The Doorway project assists tenants with a range of services and subsidies to help them meet their rental obligations and manage their homes
- Doorway tenants are supported by a Housing and Recovery Worker who visit the tenant regularly in their home
- Tenants have access to flexible support from the Housing and Recovery Worker should they find they need additional assistance
- The project covers the cost of furnishing the property for tenants, ensuring that tenants can quickly establish their new homes
- Stringent financial management systems are in place to identify potential rental default before it occurs
- Our tenants and support workers are highly committed to a successful, long–term tenancy

Source: Mental Illness Fellowship Victoria (2011), Real estate agent proposal.

³⁵ In practice very few landlords availed of the option to take out landlords insurance.

Once the incentives and marketing collateral were finalised, the Doorway team and other MI Fellowship staff began a series of meetings and presentations to local agents in each region.

“The introduction to Doorway was well explained and clearly set out. The dealings we had with carers and clients alike were easy to work with”.

Senior Executive Property Manager, Ivanhoe

6.2.2 The depth of engagement from agents was a surprise

After the initial round of formal meetings and presentations, it quickly became apparent to MI Fellowship that the sector was much more willing to engage with Doorway than had originally been anticipated. The levels of interest from agents grew rapidly and organically, and as a result the strategy of emphasising financial incentives to agents and landlords gradually became one based on providing information about the kinds of support that were available to real estate agents and landlords. It has since been acknowledged by MI Fellowship that they could have made a more rapid transition to a more values-based approach to engaging the property sector.

Overall we think Doorway is an extremely worthwhile program and we really want to see things work out for the Doorway tenants.”

Director, Clifton Hill

It also became apparent to MI Fellowship that their original plan of only engaging with one to two companies in each region and offering exclusive agreements with Doorway was not necessary as an incentive to gain their support. The strategy of offering exclusive agreements also limited the number of rental properties that participants could apply for in a local region.

When the process of searching for properties commenced, the H&RW worked with each participant to complete rental applications in a professional manner. The participants’ rental applications also included an endorsement letter from REIV, a letter of support from senior staff in the central office of each agency, a short cover letter that told the story of the participant applying and a letter from the Chief Executive of MI Fellowship. During the house-hunting process, the day-to-day management of the real estate agent relationships shifted away from MI Fellowship’s central office assets team to the H&RWs, as they started to interact with local Property Managers on a more regular basis.

The groundswell of support for Doorway from within the real estate sector resulted in agents offering a level of service to Doorway participants well beyond MI Fellowship’s expectations. Some of the many examples of assistance provided by real estate agents to participants include:

Securing tenancies

- Contacting participants directly when potentially suitable rental options become available
- Driving participants to open houses
- Offering to provide character references
- Waiving the requirement for particular items of paperwork for applications.

Managing tenancies

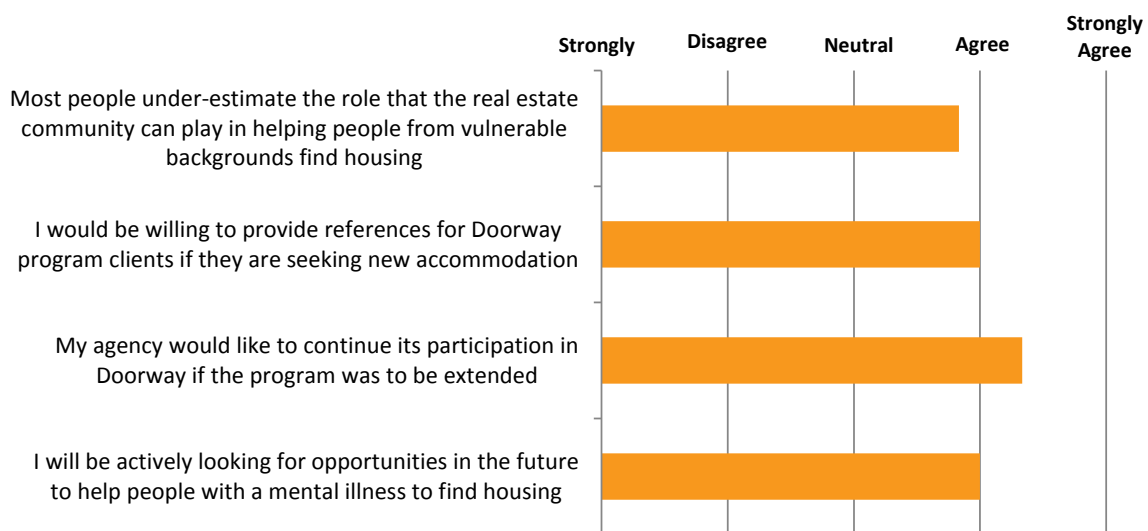
- Working with participants to find new properties at the end of their lease
- Working with participants to find alternate properties if their needs were not being met
- Forgoing or reducing lease break fees

- Contacting MI Fellowship to problem solve a range of tenancy-related issues³⁶
- Working with H&RWs to avoid sending formal lease breach notices to participants
- Meeting with participants to identify suitable cheaper accommodation options ahead of the Doorway pilot program ending in June 2014.

Real estate agents have also supported Doorway more broadly – with many acting as champions of the program. For example, on several occasions Property Managers have advocated directly to landlords on behalf of a participant during the application process. Real estate agents outside the three regions have also contacted MI Fellowship on several occasions to ask how they could participate in Doorway after hearing about the program from colleagues who are part of program.

The results from a survey of real estate agents from March 2013 reinforce their engagement with Doorway. The average levels of agreement with a series of statements related to the future role of their roles post-pilot are shown in Figure 16.

Figure 16: Real estate agent engagement with Doorway (n=6)



Source: Online survey of Doorway real estate agents (February 2013)

6.2.3 Real estate agents have been supported in their role

Real estate agents are satisfied with how their involvement with the Doorway pilot has been supported. The general consensus is that Doorway staff have been professional and easy to communicate with and that their priorities have been taken into account.

“We have good relationships with the Doorway staff. They understand what we need and address any issues quickly. In the time we’ve been involved we’ve had only one unfortunate hiccup which involved a friend of a Doorway participant. The Doorway crew sorted it out. We were keen to see it sorted out quickly for the sake of the tenant as well as the property owner.”

Director, Clifton Hill

Several agents did note that there have been logistical challenges in engaging with some of the Doorway participants.

³⁶ The Doorway team have moved away from this approach towards direct contact between agents and participants when issues arise.

“One of the tenants does not have a phone. I have to send a letter or physically visit the property if I need to contact them.”

Property Manager, Moe

Despite these logistical challenges, Property Managers shared the view that managing the tenancies of Doorway participants did not pose any additional difficulties over and above their usual workload – as noted in the below feedback from Property Managers.

“Two of our tenants we have no concerns with – the rent is paid and there are no damages. One of the tenants is a bit more challenging; there have been a few complaints about things like lawn maintenance...but it’s nothing extreme – we have tenants who are so much worse.”

“We haven’t had a great deal of issues with our Doorway tenants – a couple of small things, but nothing I would say that is more than our dealings with other tenants.”

Property manager

6.2.4 Landlords have been mostly supportive

The engagement of landlords with the Doorway pilot has been mostly positive. Direct contact between participants with landlords has been less frequent than with Property Managers. Following encouragement from some real estate agents, instances of direct communication between landlords and H&RWs started to occur early on in Doorway’s implementation phase. This enabled H&RWs to explain the recovery aspects of the program and assuage any fears and concerns that the landlords may have had. The most common concerns among landlords related to the perceived risk of Doorway participants engaging in drug-taking or violent behaviour.

Over time, the levels of engagement from landlords have grown to a point where many of them are active supporters of Doorway. Examples of positive landlord engagement with the program include:

- contacting Doorway staff to express their interest in the program
- contacting participants to discuss their interest prior to a formal application being lodged
- offering other properties in their portfolio to participants
- making an exception to a no pets rule for a participant with a dog
- ensuring that a participant with children was given a longer than usual notice period when their property was being sold to give them sufficient time to find suitable alternate accommodation.

6.3 Support from employment services has been variable

MI Fellowship has engaged with a wide range of employment service providers across the three Doorway regions since the start of the pilot program. Participant engagement with these providers has been supported by the Doorway team, whose roles have a major focus on social inclusion as well as housing support.

In the Austin and St Vincent’s catchments, MI Fellowship initially engaged its own specialist Disability Employment Services (DES) program (My Recruitment), which was co-located with Doorway staff at the AMHS clinics in these regions. In the Latrobe region, MI Fellowship engaged with a local, external DES provider, as MI Fellowship did not have an employment program in that area. Doorway participants were also supported to choose any employment provider they preferred, regardless of this original approach.

6.3.1 Quality has been inconsistent

Feedback from Doorway participants and staff suggests indicates that the support provided by the employment service providers across the Doorway regions has been varied. This in turn has resulted in low satisfaction levels with some of the services provided, with some participants feeling that their opportunities to achieve their desired employment outcomes have been hampered. The variance in the quality of support for Doorway participants is due to a range of factors:

- **The appropriateness of the model they employ** – Only one provider, My Recruitment (the not-for-profit recruitment service operated by MI Fellowship) employed a model specifically designed for people with a SMI – the Individual Placement and Support (IPS) model. The latter model is the form of supported employment found to be the most successful in assisting people with a mental illness to gain permanent paid work in the open employment market.³⁷ Other providers accessed by Doorway participants do not have experience or expertise in this model.
- **Lack of prior experience delivering tailored interventions to clients with a serious mental illness** – Some of the providers that began working with Doorway participants had limited or no prior experience in working with people with a SMI. For example, one Gippsland provider had previously specialised in working with ex-offenders – a cohort with very different support needs.
- **Employment providers have not been uniformly involved in integrated teams** – The participation and contribution levels of employment provider consultants in integrated team meetings have varied. This is despite the H&RWs efforts to engage with them in order to support them to participate in these meetings.

The above challenges were compounded by the Department of Education, Employment and Workplace Relations' (DEEWR) decision in October 2012 to not renew MI Fellowship's funding to deliver My Recruitment as a DES provider as of March 2013. As the only provider to employ the IPS model – and with staff who were co-located at the Austin's AMHS and St Vincent's AMHS and to have had a close working relationship with Doorway staff – DEEWR's decision had a significant impact on several Doorway participants. Arrangements to transition the ten participants who were being supported by My Recruitment to work with other providers were put in place by Doorway staff starting after the DEEWR decision was announced.

³⁷ Kinoshita Y, T. Furukawa, K. Kinoshita, M. Honyashiki, I. Omori, M. Marshall, G. Bond, P. Huxley, N. Amano and D. Kingdon (2013). 'Supported employment for adults with severe mental illness', *Cochrane Database of Systematic Reviews* 9:CD008297.

6.3.2 Steps are being taken to improve the quality of employment assistance

MI Fellowship has enacted strategies to improve the quality of employment support provided to Doorway participants. At the time of writing, MI Fellowship is in the final stages of selecting a new preferred partner in the St Vincents catchment region who will provide utilise the Individual Placement and Support model of support. MI Fellowship is also working with other employment providers used by participants – which may not be the preferred provider for their region – through these individual’s integrated team. Finally, Doorway participants are able to attend peer–facilitated Ready for Employment workshops, which provide opportunities for individuals to explore suitable employment and study options based around MI Fellowship’s Community Recovery Model (see Section 2.2.3 on page 16).

6.4 Attitudes changed through the partnerships

A notable – but not entirely intended – consequence of Doorway’s partnerships has been a change in their attitudes and perceptions towards the participants among some partners. Doorway staff have observed shifts among some of the real estate agents they have worked with, and to a lesser extent the AMHS staff and Government representatives, in how they judge the ability of people with a SMI to live independently. Ongoing attitudinal changes such as this will be critical if the outcomes of the Doorway pilot are to be sustained in the years following the formal end of the program.

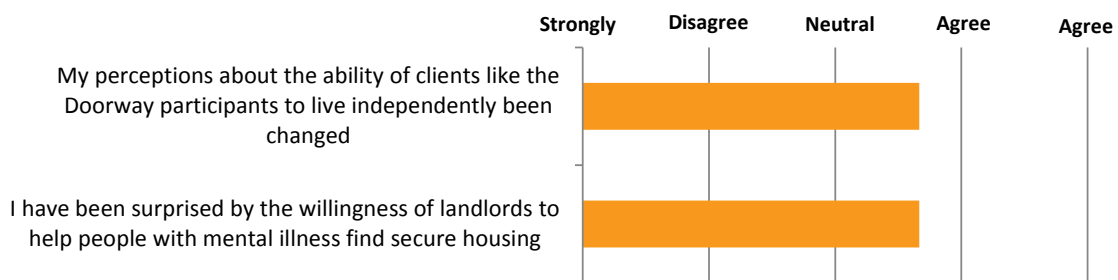
“Doorway has absolutely changed my view of the ability of people with mental illness to live independently in private rental. We were initially cautious but interested in the program, and it has really worked out.”

“My perception of tenants living independently would depend on each individual circumstance, but in general I have now realised that people with a mental illness are capable to live alone successfully”.

Property Managers

The results from the survey of real estate agents lend some weight to the observations of Doorway staff about attitudinal changes among the staff they have worked with.

Figure 17: Changes in real estate agent attitudes (n=6)



Source: Online survey of Doorway real estate agents (February 2013)

7 The pilot can inform future Doorway programs

The Doorway pilot program has highlighted several key areas that should be considered if the model is to be extended beyond the current three AMHS regions in Victoria or interstate. These areas include possible changes to the design of the Doorway model, how future program sites are selected, the timing of initial implementation activities and the benefits of having a single provider deliver the program.

7.1 The design of Doorway could be refined

In light of the lessons learnt through the implementation of the Doorway pilot, there are two key refinements to the design of the Doorway model:

- **Longer-term outcomes data may help to refine participant eligibility criteria** – The criteria used to identify suitable Doorway participants may need to be refined, particularly if future analyses of post-Doorway outcomes data highlight specific characteristics of the Doorway pilot cohort that may increase the likelihood of participant outcomes being sustained post-program.
- **Geographic restrictions on housing could be eased** – The leadership of the Doorway pilot program acknowledge that it may have been beneficial to relax the requirement for participants to secure a rental property in their AMHS catchment area. This original requirement was based on the assumption – which was subsequently disproven – that participants' formal and natural support networks are based in the same area as their AMHS clinic. This would overcome accessibility challenges posed by suburbs with high median rents within the AMHS catchment regions. It would also give participants the option to be closer to their formal and natural supports – if they are located outside the catchment regions. The main drawback of this approach for any organisation implementing the Doorway model is the need to build and sustain relationships with real estate agents across a greater number of regions. Increased travel requirements for H&RWs would also need to be managed.

7.2 Multiple factors will inform the selection of future sites

The Doorway pilot has reinforced the need for a multi-faceted approach to identifying which geographic regions could most benefit from future iterations of the Doorway model. The pilot has demonstrated that improving and sustaining participant outcomes across multiple domains can be challenging – particularly when they are not mutually compatible. For example, a regional town may offer a large number of affordable rental properties, but employment opportunities may be limited and poor public transport could hamper attempts to grow participants' natural support networks. Conversely an inner urban suburb may offer more employment opportunities, and have better public transport, but rental accommodation may be prohibitively expensive and employment opportunities may be ill-suited to potential Doorway participants.

Factors that will need to be considered in the selection of the possible sites for future iterations of the Doorway program include:

Regional demographics

- Relative prevalence of residents with a SMI who are at risk of homelessness
- Relative socioeconomic disadvantage

Regional economy

- Availability of affordable rental accommodation
- Availability and type of employment opportunities

Regional service capacity

- Number of programs already serving the Doorway target group
- Capacity of AMHS and hospitals to serve the needs of local residents with a mental illness
- Current supply of public housing and community housing
- Availability of public transport

Regional partners

- Availability of suitable and willing AMHS and real estate partners.

7.3 Changes to initial implementation

The initial establishment and implementation phases of the Doorway pilot program provided some useful lessons for future iterations of the Doorway model. Future programs may benefit from the following changes in approach during these initial phases:

- **Memorandums of Understanding (MoU) with clinical partners**– Organisations that implement future iterations of Doorway may benefit from formalising their partnerships with clinical partners through the signing of MoUs. The MoUs could articulate key issues such as shared goals, governance, responsibilities and accountabilities, reporting and ongoing communication.
- **Longer lead times for start-up phase** – As discussed in Section 3.1 of this report, there were fairly significant delays in the initial start-up and implementation of the Doorway pilot program. Future iterations of the Doorway model should therefore allow sufficient time to establish project resources and systems and to develop strong relationships with local clinical and real estate partners.
- **Non-staggered implementation across regions** – Assuming that sufficient lead time is allowed for the initial start-up phase, future iterations of Doorway may benefit from a uniform start date across all geographic regions. In cases where funding for these future projects is for a fixed period, this will ensure that participants across multiple regions are able to received support under the Doorway model for equal periods of time.
- **Participant involvement in furnishing their house is critical** – On moving into their housing, Doorway participants were offered the option of paying a small weekly furnishing fee to access a range of furnishing (couches, beds, fridges, cutlery etc.). Due to time and budget constraints, participants were only able to choose their furnishings from a fixed catalogue of items with limited variations in colour. Issues later arose related to the selection, quality and ownership of these furnishings. Many participants complained about not being given the option to choose

their own furniture or about being given furnishings that were inadequate (e.g. bar fridges with one star energy efficiency ratings) or feeling a little ‘institutionalised’ (despite the efforts of MI Fellowship to avoid this). Allowing sufficient time and resources to give participants greater choice in selecting furniture for their house would be beneficial. The degree of choice provided to participants could also be expanded by linking individuals to external community organisations that specialise in providing access to low or no cost house furnishings.

7.4 Critical success factors

The faithful replication of the current Doorway model is not enough to guarantee that intended outcomes are achieved by future iterations of Doorway. There are several key lessons learned through the implementation of the current pilot program that should be taken on board by future implementing organisations. These important lessons include:

- **Organisational culture and capabilities are vital** – The right organisational culture and capabilities are fundamental to ensuring that the three core values underpinning the model are adhered to on a day-to-day basis in all interactions with participants and partners – as discussed in Section 4.3.
- **Clinical partnerships take time to build** – MI Fellowship’s pre-existing relationships with three AMHS partners in the Doorway pilot were fundamental to the speed with which they were able to build the productive working relationships in the ongoing implementation of the program.
- **Peer Workers with lived experience add substantial value** – Doorway participants have observed that Doorway’s Peer Workers can easily relate to their day-to-day recovery challenges and provide support based on their own personal experiences. H&RW without lived experiences of mental health issues have also gained value from advice provided by their Peer Workers colleagues about how best to manage specific challenges with providing support to participants.
- **Participants provide vital input to model design and implementation** – The inclusion of Doorway participant representatives on the Doorway Model Development Committee (MDC) immediately proved beneficial – as discussed in Section 4.4. The consumer representatives on the MDC were able to provide valuable input into issues such as changes to policies related to furnishing fees and ongoing ownership of furniture packages and the development of a policy related to the management of rental arrears.

7.5 A single implementing agency has multiple benefits

The Doorway pilot program is unique in that it is the only Victorian Government funded program where mental health and housing support services are delivered by a single agency. There are demonstrated and potential benefits of the single agency model employed by MI Fellowship to deliver Doorway that should be retained in subsequent implementations of the Doorway model. These benefits include:

- **More holistic approach to recovery** – The creation of Doorway H&RWs with dual mental health and housing responsibilities can result in a more holistic approach to recovery. The design of the Doorway model requires H&RWs to have conversations about rent and tenancies with participants in the context of broader discussions of the progress of other non-housing outcomes, such as mental and physical health. These conversations can also be confronting and challenging – and the dual role removes the temptation for H&RW to leave such discussions to a third party at a housing provider or portraying them as the bearers of difficult news.

- **Decreased likelihood of rental default** – In their dual role, H&RWs are easily able to ascertain why a participant may have been unable to pay their rent on time. Similarly, they are also well-placed to work with participants to develop and action any plans to overcome rental arrears.
- **More user friendly** – Having a H&RW as a single point of contact for all health and housing issues is more user friendly and less burdensome for Doorway participants and key external partners such as Property Managers, landlords and State Trustees.
- **Lesser chance of critical issues getting missed** – A single point of contact also means that issues are less likely to get lost through a failure to communicate about the day-to-day case management of participants across mental health and housing providers.
- **Greater potential for more rapid intervention** – Having a single agency deliver Doorway’s core support services allows for more rapid intervention in times of crisis, relative to programs delivered by multiple providers.

Appendix A Evaluation methodology

A.1 Formative evaluation lines of enquiry

| Domain | Line of enquiry |
|----------------------|--|
| Program model | <ul style="list-style-type: none"> Is the participant eligibility criteria appropriate given the program’s intended outcomes? |
| | <ul style="list-style-type: none"> Do participants experience any barriers to their ongoing participation in the program? |
| | <ul style="list-style-type: none"> Do participants consider they are sufficiently involved in the design and management of their care? |
| | <ul style="list-style-type: none"> Do participants/families/carers consider that their quality of care has improved? |
| | <ul style="list-style-type: none"> How easily can the model be replicated? |
| Program management | <ul style="list-style-type: none"> Are the program’s policies and processes effectively and efficiently enabling the intended participant outcomes? |
| | <ul style="list-style-type: none"> Are participants/families/carers sufficiently informed about program related activities and decisions? |
| | <ul style="list-style-type: none"> Do program staff have the right skills, knowledge and attitudes to effectively and efficiently enable the intended participant outcomes? |
| | <ul style="list-style-type: none"> Are participants/families/carer needs and preferences understood and respected by program staff? |
| | <ul style="list-style-type: none"> Does the program have sufficient financial resources to effectively and efficiently enable the intended participant outcomes? |
| | <ul style="list-style-type: none"> How effectively do the integrated team collaborate to deliver the intended participant outcomes? |
| | <ul style="list-style-type: none"> Are feedback and complaints identified, managed and resolved appropriate and efficiently? |
| | <ul style="list-style-type: none"> Does the program enable the effective and efficient collection of appropriate data? |
| Program governance | <ul style="list-style-type: none"> How appropriate and effective are the program governance arrangements? |
| Program partnerships | <ul style="list-style-type: none"> Has the program identified appropriate partners? |
| | <ul style="list-style-type: none"> Has the program developed partnerships effectively? |
| | <ul style="list-style-type: none"> Has the program effectively maintained partnerships? |
| | <ul style="list-style-type: none"> Has the program effectively facilitated collaboration between partners? |
| | <ul style="list-style-type: none"> What are the key factors that have enabled successful working relationships between MI Fellowship and its partners? |
| | <ul style="list-style-type: none"> Are there any factors which limit the effectiveness of partnerships? |

A.2 Qualitative data collection

Table 10 outlines the number of participants and carers consulted throughout the evaluation process.

Table 10: Participants and carers consulted by region

| | Austin | St Vincent's | Latrobe |
|----------------|--------|--------------|---------|
| Round 1 – 2012 | | | |
| Participants | 5 | 4 | – |
| Carer | 1 | 1 | – |
| Round 2 – 2013 | | | |
| Participants | 5 | 7 | 3 |
| Carers | 3 | 1 | |