

Doorway – Summative Evaluation – November 2013

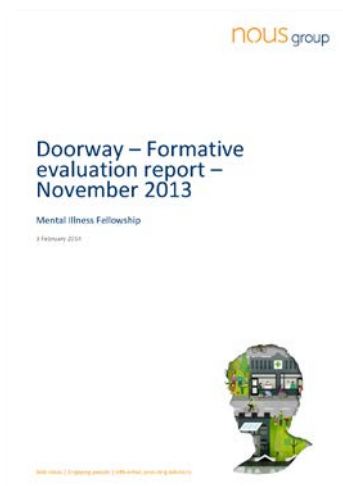
Mental Illness Fellowship

3 February 2014

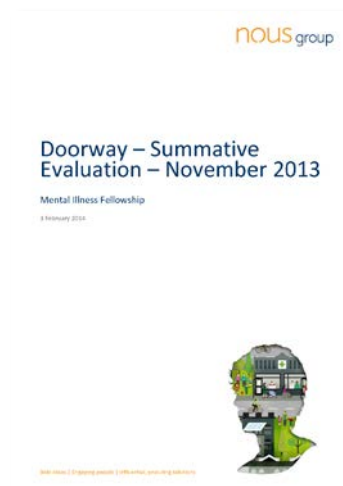


This final *Summative Evaluation Report* for the Doorway program pilot is accompanied by the *Formative Evaluation Report*. The contents of each report are outlined below.

This final *Summative Evaluation Report* also augments and updates the summative 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	Explanation	Acronym	Explanation
AMHS	Area Mental Health Services	MDC	Model Development Committee
ARR	Adult Residential Rehabilitation	MHCA	Mental Health Council of Australia
Austin	Austin Health	MHCSS	Mental Health Community Support Services
BASIS-32	Behaviour and System Identification Scale	MI Fellowship	Mental Illness Fellowship
CCU	Community Care Unit	MISHA	Michael's Intensive Supported Housing Accord
CRA	Commonwealth Rental Assistance	NDIS	National Disability Insurance Scheme
CTO	Community Treatment Order	Nous	Nous Group
DES	Disability Employment Services	NPA	National Partnership Agreement
DoH	Victorian Department of Health	NRAS	National Rental Affordability Scheme
DHS	Victorian Department of Human Services	PDRSS	Psychiatric Disability Rehabilitation and Support Services
DSP	Disability Support Pension	PARC	Prevention and Recovery Centre
DTF	Victorian Department of Treasury and Finance	PDRSS	Psychiatric Disability Rehabilitation and Support Services
ED	Emergency Department	PRAP	Private Rental Access Program
EOI	Expression of Interest	PRBP	Private Rental Brokerage
FVOP	Family Violence Outreach Program	RTA	Residential Tenancies Act (Vic.) 1997
H&RWs	Housing and Recovery Workers	SAAP	Supported Accommodation Assistance Program
HASI	Housing and Accommodation Support Initiative	SASHS	Salvation Army Social Housing Service
HASP	Housing and Support Program	SECU	Secure Extended Care Unit
HBOS	Home-Based Outreach Support	SECU	Secure Extended Care Unit
HEF	Housing Establishment Fund	SEIFA	Socio-economic Indexes for Areas
HoNOS	Health of the Nation Outcome Scales	SMI	Serious mental illness
IPS	Individual Placement and Support	St Vincent's	St Vincent's Hospital Melbourne
ISPs	Individual Support Plans	TUV	Tenants Union of Victoria
J2SI	Journey to Social Inclusion	VAED	Victorian Admitted Episodes Dataset
Latrobe	Latrobe Regional Hospital	VCAT	Victorian Civil and Administrative Tribunal
LGA	Local Government Authority	VEMD	Victorian Emergency Minimum Dataset

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 AHMS regions areas 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).

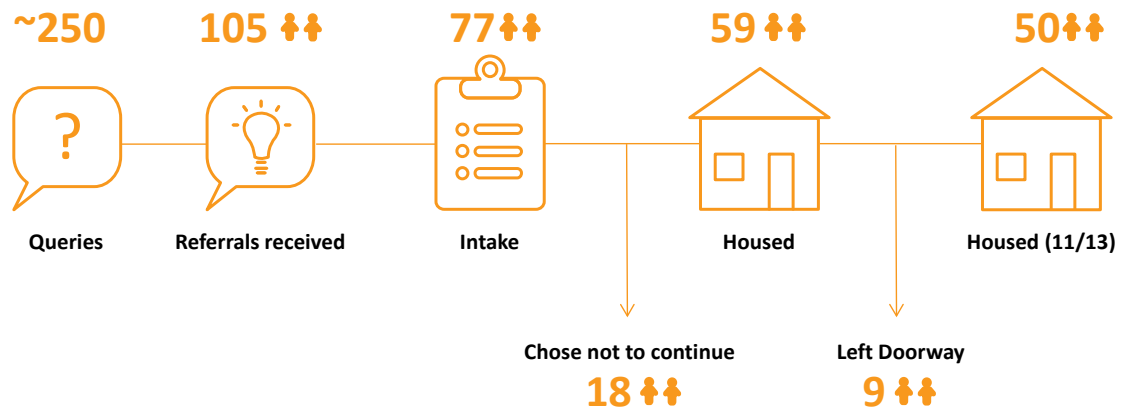
These regions were selected on the basis of a number of factors including the demographics of the region, the type and accessibility of services for people with a mental illness, and the extent to which MI Fellowship had a pre-existing presence in the region and relationships with the local clinical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

As at November 2013, 77 people had gone through the Doorway intake process and 50 participants are currently living in private rental properties. The throughput of individuals through the program is shown in Figure 1 below.

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



Participants have achieved positive outcomes

The primary participant-focused objective of the Doorway pilot program was to “broker/provide support for clients that is transitional in nature and enhances the ability of clients to develop skills to maintain a tenancy, meet their financial commitments independently of the program, meet their personal needs and link with the community for recreational, educational and or employment opportunities.”²

The outcomes for participants - with seven months remaining in the three year pilot program - have been largely positive when compared against the original objectives of the program. Health and housing outcomes have seen the greatest gains – even for participants that have been in the program for a short period of time. Social inclusion and employment outcomes have seen modest gains, as participants have tended to prioritise improvements in their overall wellbeing and housing stability first over other outcome areas.

Mental health outcomes are very positive

Qualitative feedback, quantitative service utilisation and outcomes measurement data indicates significant improvements in the mental health of Doorway participants. Key changes in mental health outcomes include:

- The average time in bed-based clinical mental health services per participant per year has decreased from 20.4 to 7.5 days in the 12 months pre and post-housing³ – with the biggest decrease occurring with acute inpatient services (13.9 to 6.6 days)

² Department of Health (2011), *Housing Support and Brokerage Demonstration Project - Funding and Service Agreement (Draft)*, p. 1

³ This data excludes three participants that were in CCU beds at Latrobe Regional Hospital for most of the year prior to Doorway. If these three participants are included in the analysis, average time in bed-based clinical mental health services per participant changes from changes 38.1 to 8.2 days in the 12 months pre and post-housing.

- Doorway has provided a viable housing alternative to three participants who were long-term residents of Community Care Units (CCUs) prior to joining the program due to a lack of identified housing and support options before to the introduction of Doorway
- Data suggests that visits to bed-based mental health services are more likely to be planned than unplanned, and H&RWs noted that participants are now likely to pro-actively seek ways to manage their mental health treatment needs
- Participants are having less contact on average with ambulatory mental health clinical services since entering Doorway. The biggest decreases in average usage hours are for services provided by Mobile Support and Treatment Teams (MSTT) and Continuing Care Teams (CCT)
- The mental health of one-third of current participants has improved to the point of their being able to be discharged from their AMHS
- Doorway participants are less reliant on specialised mental health supports and are increasingly utilising the support of GPs and Alcohol and Drug Workers to manage their health and wellbeing
- Changes in mean scores across three of the five BASIS-32 sub-scales (Relation to self/others, Depression/anxiety and Daily living/role function) and changes in the total overall score show statistically significant improvements
- Participants largely attributed their improved mental health outcomes to having stable accommodation and an integrated support team – two firsts for many participants.

Participants are better at managing their overall health

The majority of Doorway participants have become more actively engaged with managing their overall health and wellbeing. Stable accommodation has made it easier for participants to attend appointments with clinicians, and for their formal supports, including clinicians, to stay in touch with their clients. Key changes in overall health outcomes include:

- H&RWs report that participants are more engaged in the development and management of their support plans and with their primary health providers
- The total number of estimated Emergency Department presentations across all participants in the 12 months pre and post-housing decreased from 93 to 63 based on annualised averages. The decreases in urgent presentations (41 to 22) suggests that participants may be managing their health more pro-actively and taking preventative steps
- The total number of estimated hospital admissions across all Doorway participants decreased from 22 to 6 pre and post-housing based on annualised averages
- There was a statistically significant ($P < 0.05$) improvement in mean scores for the *Emotional and mental health* recovery ladder of the Homelessness Star from 6.0 at the point of program intake to 7.0 in November 2013 (out of a maximum of ten).

Housing outcomes have improved substantially

Since entering Doorway, the majority of participants have achieved stable and secure private rental accommodation for the first time in their lives. The positive effects of this from a wellbeing, health and social inclusion perspective have been profound in many instances. Key changes in housing outcomes include:

- Most participants reported feeling more independent, having greater levels of self-respect and pride and finding greater meaning in their lives as a direct result of having more stable and secure accommodation
- Thirty one participants have been offered and accepted 12 month lease extensions. An additional three participants have elected to renew their lease on a monthly basis.
- The number of tenancy related incidents has been relatively low with six lease breaks by participants (excluding those leaving the program), ten breach of duty notices and no evictions
- There was a statistically significant ($P < 0.05$) improvement in mean scores for the *Managing money* recovery ladder of the Homelessness Star from 6.5 at the point of program intake to 8.0 in November 2013 (out of a maximum of ten)
- Most participants are able to manage their rents with only eleven people falling into rental arrears. H&RWs have negotiated re-payment plans with participants in all instances of arrears
- Only one participant has had their utilities disconnected due to the late payment of a bill
- Ten people currently pay their own rent in full - five of whom have done so since entering the program. The other five participants have attained self-sufficiency with their rental payments for a variety of reasons – including acquiring housemates, having family members move in and re-establishing stable relationships with an employed partner. Two of these five participants also commenced employment after joining Doorway – although this was not the primary contributing factor to their no longer requiring rental subsidies
- The mean rental gap paid by Doorway to participants is \$194 per fortnight – which remained static over the 12 months prior to November 2013.

Economic outcomes are encouraging

Positive progress has been made against economic indicators – albeit at a slower rate than other outcome domains. This is to be expected given the long lead times that are normally required for improved economic outcomes to eventuate.

As health and housing outcomes have generally become more stable there has been a natural shift in focus for many Doorway participants towards strategies to sustain these gains – with a particular focus on paid employment. Recent feedback from the H&RW suggests that in the lead up to the end of the Doorway pilot, participants are more proactively engaged in conversations with their H&RW about economic outcomes and are meeting more regularly with their employment consultants - where they have one.

Key changes in economic outcomes to date include:

- The percentage of participants engaged in paid and unpaid work has increased from 16% at the point of intake to 27% in November 2013
- Doorway employment outcomes compare well against other Victorian and interstate programs that have sought to increase economic participation rates for people who are at risk of homelessness at similar points in their implementation timeframes

- Current workforce participation levels are in line with national rates for people with a SMI – which are estimated to be between 22-30%
- There were statistically significant ($P < 0.05$) improvements in mean scores for the *Motivation and taking responsibility* and *Meaningful use of time* recovery ladders of the Homelessness Star from 6.1 to 8.0 and from 5.6 to 6.8 respectively - from the point of program intake to November 2013
- The proportions of Doorway participants accessing education and vocational training opportunities and receiving qualifications whilst in the program has increased.

Challenges in increasing workforce participation rates among Doorway participants include the different stages of recovery across participants, variable levels in the quality of support provided by employment providers in each region and issues related to transport access for many participants

Levels of social inclusion have improved

Social inclusion outcomes have improved for many participants. Many of the improvements that have occurred in social inclusion outcomes since the start of Doorway have been attributed by participants and H&RWs to greater housing stability. Having their own house has also brought a new set of opportunities and challenges for participants as they have sought to build or re-build their social networks. Key changes in social inclusion outcomes include:

- The composition of participants' natural support networks have evolved over time and are now playing a more active role in supporting the recovery of participants
- Many participants have been able to re-connect with family and friends – in some cases for the first time in many years – and develop new relationships
- Social isolation remains an ongoing challenge for some participants
- Levels of anti-social behaviour have decreased among several participants who were challenged by the transition out of congregate living environments into their own rental accommodation
- Participant interactions with the justice system have often resulted in positive outcomes, such as family reunifications or orders being lifted.

Post-Doorway participant outcomes are varied

To date, nine participants have formally left the Doorway pilot program – two in the Austin catchment, four in the St Vincent's catchment and three in Latrobe. The period of time these participants were housed in rental accommodation ranged from 3 to 21 months – with an average of 11.5 months. The reasons why participants chose to leave Doorway and their post-program outcomes are varied, and have reflected both positive steps and recovery challenges.

Doorway has provided support for families and carers

The families and carers that were consulted as part of this evaluation indicated that the greater stability provided by Doorway has positively impacted their relationships with the individuals they care for. Families and carers also reported that their ongoing interaction with H&RW has made them feel less isolated and more supported about decisions they make related to the welfare and wellbeing of the relevant Doorway participant.

There is an ongoing need for Doorway

There is a clear and compelling case for an ongoing role for Government in funding the Doorway program. This case is based around the arguments outlined below.

Integrated, flexible and person-centred services are becoming the norm

The delivery of community-based services for people with mental health issues has shifted fundamentally in recent years both in Victoria, nationally and internationally. There has been an explicit move towards more client-directed, person-centred and family-inclusive support services with a broader focus on improving health, social and economic outcomes. This evolution aligns directly with the Victorian Government's Priorities for mental health reform 2013-15⁴ and the aims of the Victorian Mental Health Community Support Services (MHCSS) program.⁵ The shift to more client-directed and person-centred services also reflects the broader Services Connect and Community Services Sector reforms in Victoria, and the introduction of the National Disability Insurance Scheme (NDIS). The design of the Doorway model aligns with many of the intended outcomes of these major reforms.

Demand for equivalent Doorway services will increase

Government investment in community-based mental health services recently increased under the current MHCSS reforms. This increase recognises the role of these services in supporting people with mental illness in their recovery journey, including building the individual's resilience and creating their capacity for self-management, and also freeing up valuable upstream service capacity in acute mental health services.

Demand for housing support services for people with a serious mental illness will remain high as this cohort is vulnerable to homelessness and remains over-represented in populations of homeless Australians. The attainment of stable housing is critical as a pathway out of homelessness and a basis for ongoing recovery for people with a serious mental illness.

The integrated delivery of both mental health and housing services is crucial if the Government is to fully realise the system-wide benefits of its investment in community based mental health services, as people with severe and enduring mental illness require access to secure and stable housing to sustain any positive recovery outcomes.

Standalone housing options for people with a mental illness remain limited

Suitable, stable and sustainable housing options for those Victorians with a SMI are currently very limited. For those individuals who may be able to live independently with community mental health outreach support but do not own a home or live with family or friends, the housing options most likely to support stable and long recovery are public housing, community housing and private rental accommodation.

Public housing in Victoria remains notoriously difficult to access as a result of decades of underinvestment and decreasing stock levels. The number of applicants on the general waiting list for

⁴ Department of Health (2013), *Victoria's priorities for mental health reform 2013 – 2015*

⁵ Currently operating as the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program.

public housing has remained relatively steady at around 40,000 people over the past seven years.⁶ This has resulted in lengthy waiting periods for people wanting to access public housing. In 2010-11, individuals at risk of homelessness who were deemed the highest priority on the waiting list waited an average of more than nine months for a dwelling – up from an average of three months in 1998-99. Non-priority applicants in 2010-2011 could wait several years to be allocated public housing.⁷

Community housing can also be hard to access - despite the recent growth in community housing stock. Access to community housing for socially and economically disadvantaged Victorians with high needs for social housing also remains an issue. A 2010 report by the Auditor-General found that despite the requirement for up to 50% of new vacancies in housing association properties to be filled from the public housing waiting list, there were “no clear guidelines to deliver equity of access for applicants from the public housing waiting list”.⁸

Those individuals with a mental illness who choose to access private rental accommodation will face substantial financial and non-financial barriers. Financial barriers include the paucity of affordable rentals – particularly in metropolitan regions, a lack of access to employment in locations where rent is affordable and low levels of Government rental subsidies. Non-financial barriers to renting can include a poor or non-existent rental record and a lack of general awareness about how to access private rental properties and live independently in mainstream community settings.

If a person with a mental illness is able to overcome the various barriers to accessing private rental accommodation, they will only be able to access very limited forms of financial and non-financial support to seek and sustain their tenancies. For example, the current design of Commonwealth Rent Assistance payments have long been recognised by successive Government reviews as inadequate given current national rental markets. State-funded rent assistance programs also provide limited levels of support that are in no way comparable with the duration and type of financial and non-financial support provided by Doorway.

Comparable programs do not exist in Victoria

Doorway is currently the only Government funded program targeting Victorians with a SMI who are homeless or at risk of homelessness that provides the type of integrated, comprehensive and long-term support required for people to access and sustain private rental accommodation. To this end, the program goes a long way to addressing the fundamental inconsistencies and inequities in the types of housing assistance offered to tenants in social housing and the private rental market noted in the Government’s 2012 discussion paper on social housing.⁹

The historical shortfall of integrated mental health and housing programs was recognised in the recent introduction of two new National Partnership Agreement (NPA) funded programs - *Mental Health Support for Secure Tenancies* (*‘Secure Tenancies’*) and *Breaking the cycle: reducing homelessness* (*‘Breaking the Cycle’*). These two programs are designed to improve long-term housing security for people with serious mental illness, and to break the cycle of homelessness they experience.

Despite their intended housing outcomes, the housing components of both *Secure Tenancies* and *Breaking the Cycle* do not provide the same level of sustained housing and tenancy management support offered under the Doorway service model. Client choice regarding housing options is also

⁶ Department of Human Services (2007-2013), *Summary of Housing Assistance Programs*

⁷ Victorian Government (2010), *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. xxii.

⁸ Victorian Auditor-General (2010), *Access to Social Housing*, p. ix.

⁹ Department of Human Services (2012), *Pathways to a fair and sustainable social housing system - Public consultation discussion paper*, p. 20.

constrained to specific housing types and access to private rental accommodation appears limited under both models. Furthermore, neither program offers the integrated mental health and housing support provided by H&RWs under the Doorway model – with delivery of both service by a single agency.

It is important to note that the type of supported rental assistance offered by Doorway is likely to become even scarcer once the current Psychiatric Disability Rehabilitation and Support Services (PDRSS) services are replaced by Mental Health Community Support Services (MHCSS) under the current sector-wide reforms in July 2014. In recent years, some PDRSS providers have offered limited brokerage support to clients under DoH's current brokerage guidelines. This type of limited support will cease once the current service delivery reforms are complete. The service specifications for the delivery of the new MHCSS services explicitly state that Government funding for individualised client support packages "cannot be used to subsidise a client's rent".¹⁰

Doorway has unique features and benefits

The design of the Doorway service model has several unique features relative to other services currently funded or delivered by the Victorian Government – particularly the two NPA-funded programs *Secure Tenancies* and *Breaking the Cycle*.

The housing component of the Doorway model is unique in that it supports participants to rapidly access stable private rental housing in a community of their choice beyond existing social housing stock. Participants are the sole lease holder for the property– which builds their own rental history and develops their tenancy management skills (with support from H&RWs). Doorway also removes financial barriers to stable rental accommodation by providing rental subsidies that are linked to participant income levels. Longer-term housing outcomes are facilitated by the creation of strong partnerships with real estate agents and landlords to raise their awareness about the program's objectives and how they can best support tenants with a serious mental illness to sustain their tenancy.

The way in which Doorway is delivered is unique to the program - with a single agency providing both mental health and housing support services. This approach has several benefits which include a more holistic approach to recovery as H&RW have conversations with participants about issues related to their tenancies in the context of broader discussions about the progress of other non-housing outcomes. The single agency model decreases the likelihood of rental default given that potential financial stresses experienced by participants are more likely to be identified earlier. From a participant point of view, a single point of contact for all health and housing issues is more consistent and efficient. The model of a single agency delivering multiple support services also makes it easier for rapid interventions in times of crisis, relative to programs delivered by multiple providers.

Aspects of Doorway's delivery of community mental health support may also be unique. These include the extent to which service delivery is closely integrated with clinical service partners and local real estate agents, the number of Peer Workers with declared lived experience who perform the H&RW role, and the inclusion of Doorway participants in formal governance roles on the Model Development Committee which oversees the design and implementation of the Doorway model.

¹⁰ Department of Health (2013), *Service Specification for the Delivery of Mental Health Community Support Services*, p. 10.

Doorway delivers benefits to Government

Doorway was originally budgeted at \$19,300 per annum per participant – excluding one-off staff and marketing costs relating to the establishment of the pilot.

This evaluation estimates that Doorway saves the Victorian Department of Health an estimated \$11,050 in avoided costs per annum per participant through reduced usage of bed-based mental and ambulatory mental health services, presentations to EDs and hospital admissions. This estimate may be higher if changes in usage patterns for other State Government funded services such as ambulances, drug and alcohol services and community health services were included in the analysis.

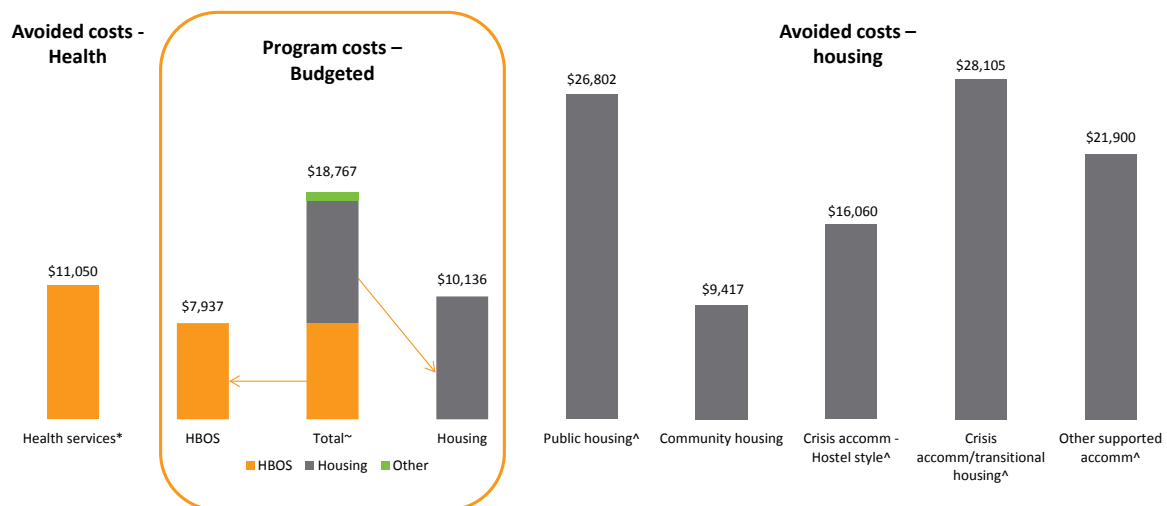
If just the Department’s investment in the mental health Home-Based Outreach Support (HBOS) component of Doorway is taken into account, the changes in health system utilisation result in a **net saving** of approximately \$3,100 per participant per annum – a return of \$1.39 per dollar invested. If Doorway’s full costs (excluding one-off costs) are assessed against benefits related to health outcomes only, the **net cost** of the program is approximately \$7,717 per participant per annum.

Approximately one-third of Doorway participants resided in some form of Government funded social housing prior to joining the program, and it is feasible that an even larger proportion of participants would be residing in social housing if they were not living in private rental accommodation provided through Doorway.

The budgeted housing cost - \$10,136 per participant per annum - is lower than the annual costs of all social housing options when the cost of capital to Government for each option is available and included. The program’s full program costs of \$19,300 per participant per annum (excluding establishment costs) are also lower than the annual costs of public housing, hostel style crisis accommodation and other supported accommodation – when the cost of capital to Government is included.

Doorway’s budgeted costs and the estimated avoided costs for health and housing services per participant per annum after joining the program are shown in Figure 2 below.

Figure 2: Program costs and avoided costs per participant per annum (2010-2011 costs where available)



~ Total program costs exclude one-off program establishment costs *Health avoided costs include changes in participant utilisation of bed-based mental and ambulatory mental health services, presentations to EDs and hospital admissions. ^ All social housing options include the cost of capital to Government – with the exception of community housing given that data is not available. The ‘Other’ category of costs includes program management costs that cannot be attributed to the specific delivery of HBOS or housing services.

Doorway's cessation will have varied impacts

The impacts of Doorway's cessation on current program participants will be varied.

Participants will be impacted in different ways

The Doorway participants who are most likely to sustain the gains made while participating in Doorway are typically those who are currently employed and have been discharged from their AMHS to their GP. Conversely, there are participants who may well experience a backwards step in their recovery at the end of Doorway.

The varied outcomes of participants post-Doorway are largely due to each individual being at very different points in their recovery journey. This variance can also be attributed in part to the different durations of support received by Doorway participants because of the staggered implementation of Doorway across the three regions and the continued throughput of participants in the program.¹¹

It is important to note that the true impact of ceasing the program will likely remain unknown until at least six to twelve months after the program has finished. This is related to the lead times for particular strategies being put in place to sustain improved outcomes made under Doorway.

Different strategies have been put in place to minimise the impacts on participants of the current program ceasing. H&RWs are engaged in ongoing planning with Doorway participants about their intended post-program housing arrangements. Some participants are looking at more sustainable housing arrangements, such as moving to cheaper properties or suburbs and sub-letting their property to family members, friends or other tenants. Participants are also being actively encouraged by their H&RW to more independently manage relationships with members of their formal and informal support networks. Finally, Doorway participants are working with their H&RW to identify how their ongoing needs post-Doorway could be met by alternate formal or informal supports in local area.

MI Fellowship will not provide any direct and ongoing support to Doorway participants under the auspices of Doorway after the completion of the pilot program in June 2014 – with the possible exception of three additional months of support for a handful of selected participants who would benefit from the additional support for a short period of time.

Existing momentum with partnerships could be lost

There is a risk that existing momentum with Doorway's clinical services and real estate partners could be lost if the program did not continue. The partnerships built with real estate agents are particularly unique to the Doorway program in a local context. The close working relationships between Doorway and the two groups of partners have resulted in changes in attitudes about how people with a serious mental illness can access and sustain rental accommodation if the right supports are provided. The program has raised awareness levels about the direct roles that partners can bring in supporting private rental tenancies under the Doorway model. The continuation of the Doorway model will embed these changes in attitude and awareness, and also provide the opportunity for new partners to be exposed to the Doorway model of support – particularly in the property sector among real estate agents and landlords.

¹¹ The entry of new participants continues as at November 2013.

Doorway is being delivered according to plan

The intended scope of the Doorway project – as outlined in the draft Funding and Service Agreement (FASA) in Appendix F.2.¹² – has largely been met. The original program objectives have been fully met as have those intended outcomes which can be measured within the timeframe for this evaluation. The design and implementation of the Doorway model has incorporated all of the original participant eligibility criteria – where practical - and all four of the original model components outlined in the original FASA.

MI Fellowship has forecast that the Doorway pilot program will be delivered within the original budget figure of \$3.1 million.

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 activities. 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 – was delayed by three months.

Delays in providing housing for participants were largely due to the challenges MI Fellowship faced in establishing the operational base for the program and building the relationships and expertise required to support participants to source and secure rental properties.

Due to the initial delays in implementing the program the initial target of providing support to fifty Doorway participants over a period of three years (36 months) will not be met at the completion of the pilot program. Once the ongoing throughput of Doorway participants is taken into account, at the end of the three years, the program will have provided 59 participants with an average of 22 months of support.¹³

MI Fellowship has employed appropriate governance and risk management practices since the inception of the Doorway pilot. Doorway's governance arrangements evolved over the first 18 months of Doorway, as the program moved beyond the initial implementation phase.

¹² This draft Doorway FASA was not finalised or signed by the Department of Health and MI Fellowship.

¹³ This is calculated based on the assumptions that as at November 2013, there will be no further participants join the program and all currently participants will remain in their housing until 20 June 2014.

1 Evaluation background

Mental Illness Fellowship Victoria (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.

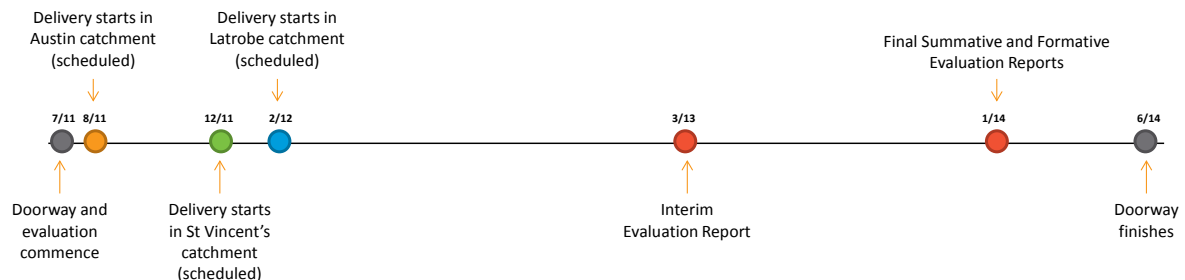
The program logic framework and lines of inquiry that underpin this summative evaluation can be found in Appendices A.1 and A.2.

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 *Summative Evaluation Report* augments and updates the summative evaluation components of the *Interim Evaluation Report*.**

Key program implementation and evaluation milestones for Doorway are shown in Figure 3 below.

Figure 3: Scheduled Doorway and evaluation milestones



It should be noted that this final *Summative Evaluation Report* was **brought forward by six months** relative to the original timeframe for this evaluation, at the requirement of DoH. The final formative and summative evaluation reports cover 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

It should be noted that this *Summative Evaluation Report* is structured to respond to the five key questions contained in the Victorian Department of Treasury and Finance's (DTF) minimum standards for evaluations of lapsing programs with total funding less than \$5 million.¹⁴

The relevant sections of this *Summative Evaluation Report* that respond directly to the questions in the current DTF guidelines are outlined in Table 2 below.

Table 2: Report responses to DTF Evaluation policy and standards for lapsing programs

Evaluation question	Reference
1. What is the evidence of a continued need for the program and role for Government in delivering this program?	Section 4
2. What is the evidence of the program's progress toward its stated objectives and expected outcomes, including alignment between the program, its output (as outlined in Budget Paper No. 3), Departmental objectives and any stated Government priorities?	Section 3
3. If ongoing funding was provided, what level of efficiencies could be realised?	Section 5
4. Has the program been delivered within its scope, budget, within the expected timeframe, and in line with appropriate governance and risk management practices? (Funding/Delivery) Has the Department demonstrated efficiency and economy in relation to the delivery of the program?	Section 7
5. What would be the impact of ceasing the program (for example, service impact, jobs, community) and what strategies have been identified to minimise negative impacts?	Section 6

¹⁴ Department of Treasury and Finance (2013), *Evaluation policy and standards for lapsing programs - Attachment 1*.
<<http://www.dtf.vic.gov.au/files/fdd29cbf-367d-4a4e-9137-a1cd0100e819/Evaluation-Policy-and-Standards-for-Lapsing-Programs-2013-14.doc>>

1.3 Evaluation data sources

Table 3 below provides an overview of the key sources of quantitative and qualitative data that underpin the analysis in the summative and formative evaluations. These data sources are explored in more detail in Appendix A.

Table 3: 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 (see Appendix A.3)• Department of Health (Vic) datasets (see Appendix A.4)	<ul style="list-style-type: none">• Six monthly data collection by Doorway staff• Participant and carer focus groups (see Appendix A.5)• Key stakeholder interviews

2 Doorway provides integrated mental health and housing support

NOTE: Further information about the design and evolution of the Doorway model can found in Section 2 of the *Formative Evaluation Report*.

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 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 that are 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 initially established, nurtured and mediated by Doorway's Housing and Recovery Workers (H&RWs).

MI Fellowship and its three AMHS partners selected participants for the Doorway pilot program based on the following eligibility criteria:

- Severe mental illness requiring service from an AMHS
- Homeless or at risk of imminent homelessness (including those in Segment 1 of the DHS public housing segmented waiting list)
- Willing to give consent for members of the Integrated Team to share information with each other
- Currently case-managed by an AMHS
- Want to live in the designated area
- Willing to accept support
- Currently receiving a DSP (a requirement that was subsequently relaxed following the tightening of DSP eligibility criteria and the referral and acceptance of several participants on Newstart).¹⁵

In late 2011, the participant referral process was clarified further to include the following guidelines:¹⁶

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

2.1 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.¹⁷ The design of the Doorway and Housing First models are built upon the assumption that stable housing plays a critical role in the recovery of people with serious mental illness. 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 first key 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 post-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.

¹⁵ 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. These changes subsequently passed through parliament in November 2011. It was estimated at the time of the Government's announcement that up to forty per-cent of individuals receiving DSP payments would no longer be eligible under the proposed reforms. 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 suffering from episodic mental health conditions.

¹⁶ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - December 2011*.

¹⁷ 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.

2.2 Doorway spans three diverse Victorian regions

The Doorway pilot is being implemented with three clinical partners across inner city, suburban and regional catchment areas. The intended number of participants in partner catchment areas and the LGAs they encompass are listed below:

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

To minimise the geographic spread of participants, Doorway does not cover all of the LGAs within each catchment area of each pilot site. The number of participants targeted in the St Vincent’s catchment area is lower than the other two Doorway regions, due to the significantly higher levels of average rents in the City of Yarra which require higher rental subsidies.

The demographic, social and economic disadvantage, rental affordability and mental health indicators differ considerably across each region. These differences presented unique program delivery challenges for MI Fellowships in each region and LGA. For example, the relative emphasis on housing or employment outcomes differed depending on the affordability of rental properties or the availability of suitable employment in each region.

The LGAs across the three Doorway regions are profiled in Figure 4, Figure 5 and Table 4.

Figure 4: Profile of metropolitan Doorway LGAs

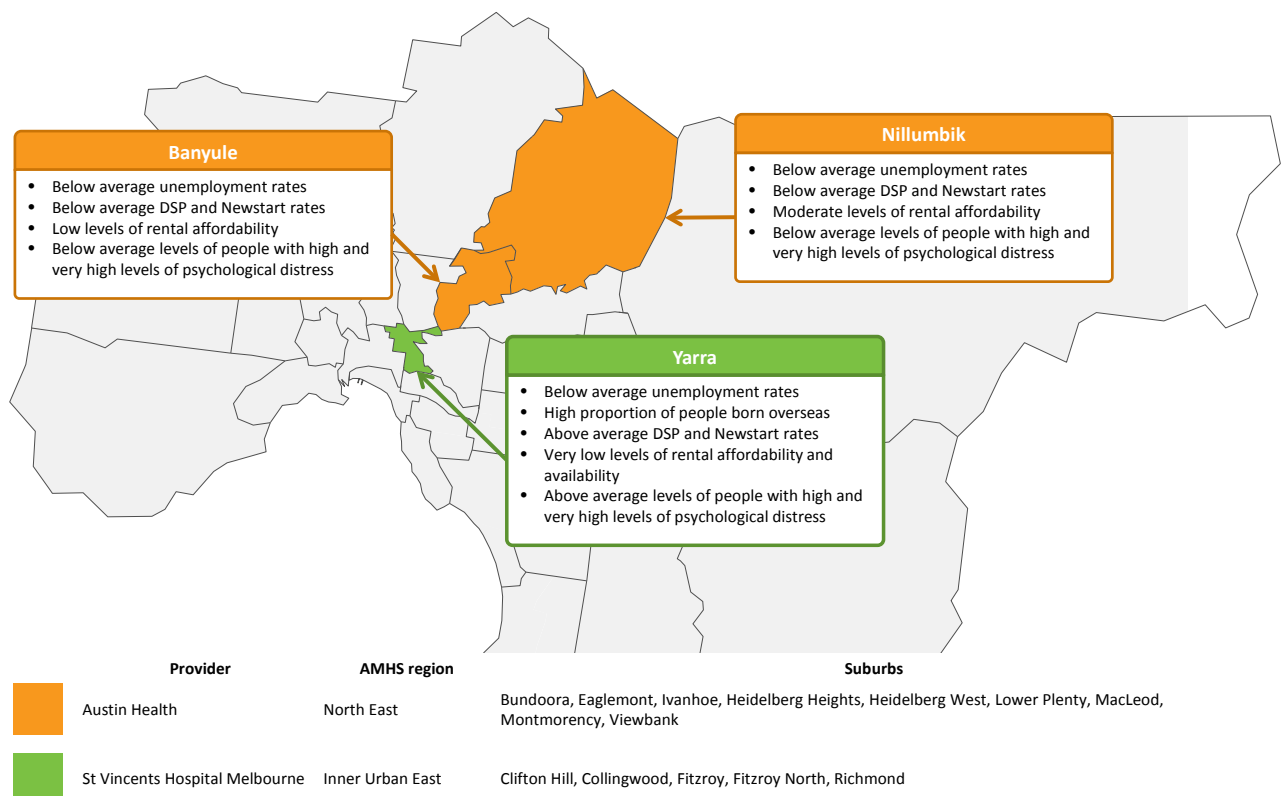


Figure 5: Profile of regional Doorway LGAs

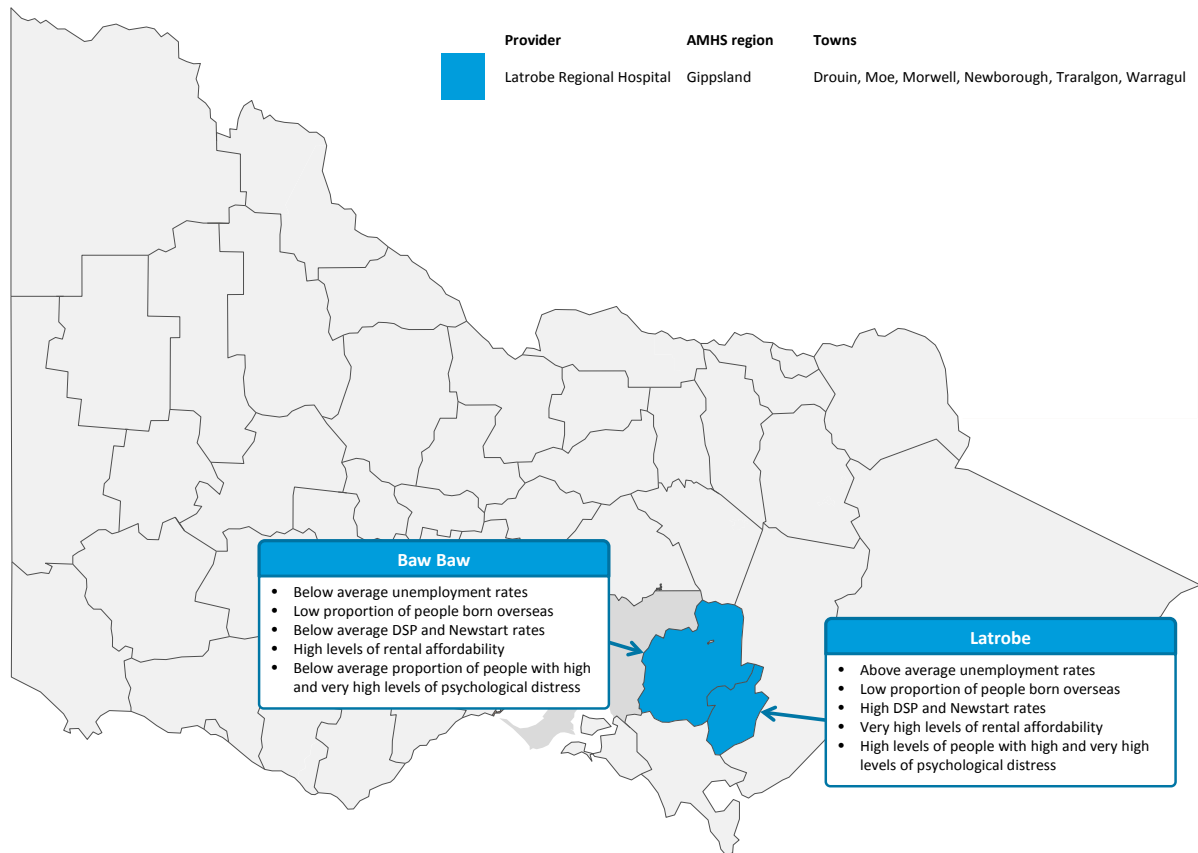


Table 4: Key indicators for Doorway LGAs by region

	St. Vincent's	Austin		Latrobe		
	Yarra	Banyule	Nillumbik	Baw Baw	Latrobe	Victoria
Demographics						
Population (2010)	79,540	124,249	64,184	42,921	76,144	5,545,932
Total born overseas (2006)	31%	21%	15%	10%	14%	25%
Average taxable income (2009)	\$67,201	\$59,183	\$61,071	\$48,820	\$41,184	\$55,986
Social and economic disadvantage						
Unemployment rate (2010)	5%	3%	2%	4%	7%	6%
SEIFA ranking in Victoria (2006)	72	69	75	41	16	
Disability Support Pension recipients (2010)	3.6%	2.9%	1.5%	3.5%	6.0%	3.5%
Newstart Allowance recipients (2010)	3.3%	1.7%	1.0%	1.9%	3.5%	2.3%
Newstart recipients for > 1 year (2010)	61%	57%	52%	50%	69%	61%
Rental affordability						

	St. Vincent's	Austin		Latrobe		
Average value of private sector houses (2010)	\$363,300	\$309,600	\$345,700	\$204,400	\$233,500	\$240,100
Quarterly median rents (June 2012)						
1 bedroom flat	\$340	\$273	\$190	\$150	\$118	\$290
2 bedroom flat	\$480	\$320	\$315	\$220	\$161	\$340
Quarterly affordable rental (June 2012)						
1 bedroom	0.0%	1.3%	40.0%	25.0%	75.0%	3.8%
2 bedroom	0.2%	2.4%	10.8%	59.4%	87.4%	12.4%
Mental health						
People with high and very high levels of psychological distress (2008)*	11.9%	12.4%	8.8%	10.4%	14.3%	11.4%
Persons who sought professional help for a mental health problem in last year (2008)	15.2%	13.2%	11.7%	10.3%	13.3%	11.4%

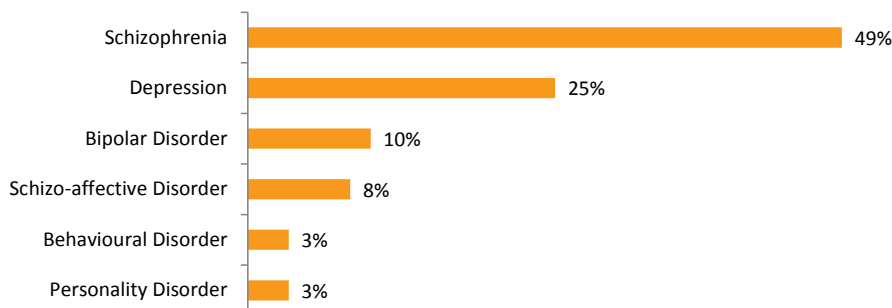
* Based on Kessler 10 Psychological Distress Scale (K10). High is 22–29 and very high is 30–50.

Sources: Department of Health (2008), Victorian Population Health Survey report 2008; ABS (2011), 1379.0.55.001 National Regional Profile, Banyule (C), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Baw Baw (S), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Latrobe (C), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Nillumbik (S), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Yarra (C), 2006-2010; Department of Human Services (2012), Affordable Lettings by LGA June 2012; Department of Human Services (2012), Quarterly Median Rents by LGA June 2012

2.3 Participants have a serious mental illness

Participants in Doorway have been diagnosed with a wide range of mental health illnesses. Figure 6 below illustrates that Schizophrenia is by far the most common primary mental health diagnosis among Doorway participants, followed by Depression.

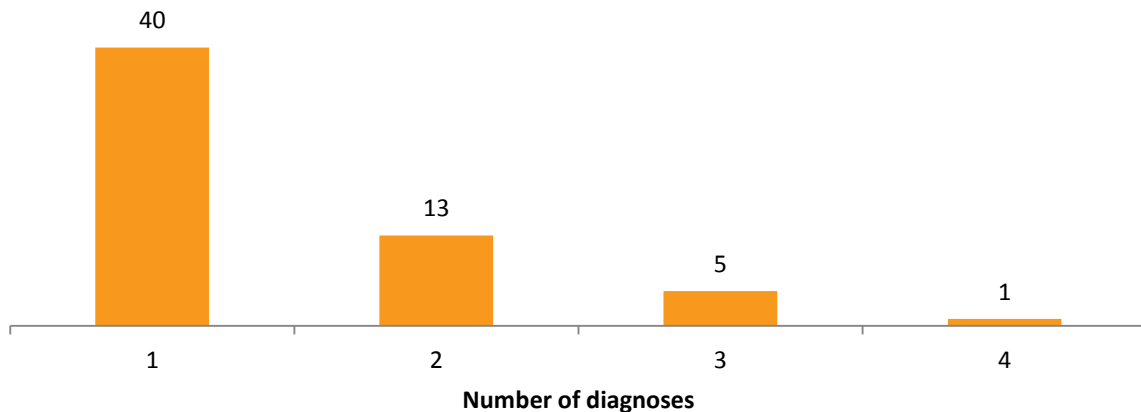
Figure 6: Primary mental health diagnoses of Doorway participants (n=59)



Source: AMHS case notes and Doorway case notes

More than one third of Doorway participants have multiple mental health diagnoses, as shown in Figure 7 below. For some Doorway participants, these additional diagnoses occurred after they entered the program. Doorway staff note that there are significantly greater challenges associated with supporting individuals with co-morbid conditions.

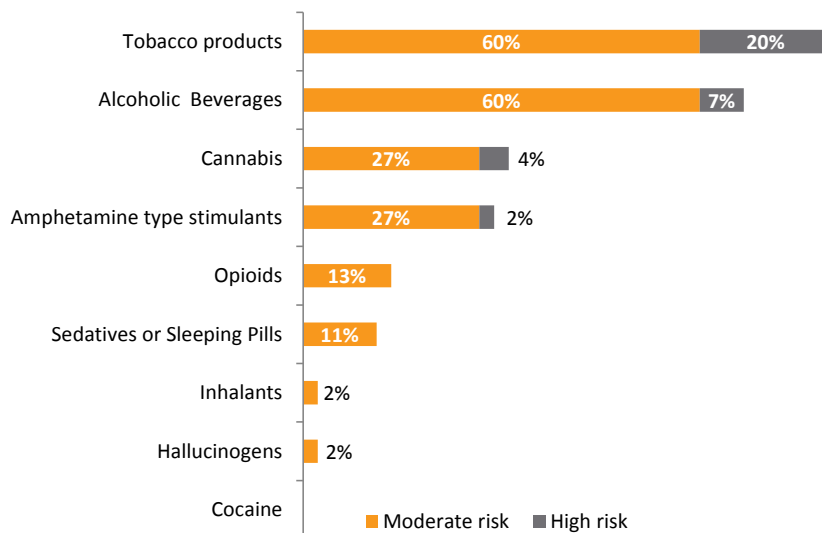
Figure 7: Number of diagnoses per participant (n=59)



Source: AMHS case notes and Doorway case notes

One of the key contributing factors to the mental health of Doorway participants is the problematic use of Alcohol and other drugs. Figure 8 illustrates that the most common problems among participants are with tobacco products and alcoholic beverages.

Figure 8: Baseline ASSIST score (n=45)



Source: Doorway case notes

NOTE: Participants with moderate risk levels (score of 4 – 26) are at risk of health and other problems from their current pattern of substance use. Participants with high risk levels (score of 27+) are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of their current pattern of use and are likely to be dependent

2.4 Participants were at risk of homelessness

Approximately half of Doorway participants were classified as experiencing ‘secondary homeless’ prior to entering the program, based on the Chamberlain definition of homelessness.¹⁸ The next most common categorisation was ‘tertiary homelessness’ at 21%. Table 5 below illustrates the regional variations in homelessness status across participants prior to joining Doorway. Sixty-seven per-cent of participants were classified as primary or secondary homeless prior to entering Doorway.

Table 5: Homelessness status of participants at point of referral (n=52)

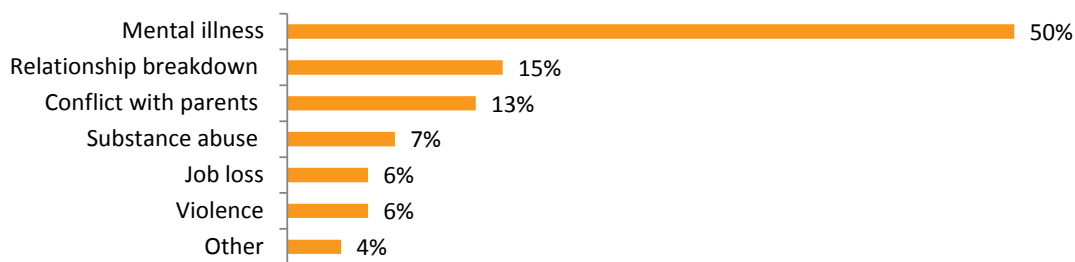
Homelessness status	Austin	St Vincent's	Latrobe	Total
Primary homelessness	25%	10%	18%	17%
Secondary homelessness ¹⁹	55%	57%	27%	50%
Marginally housed ²⁰	5%	14%	9%	10%
Tertiary homelessness	15%	19%	45%	23%

Several key issues are worth noting about the housing status of participants prior to joining Doorway:

- Doorway participants had moved an average of 2.6 times in the three years prior to their intake into the program. This average was similar across all three regions
- Twenty-eight per cent of participants were on the public housing waiting list prior to intake
- The most common primary cause for Doorway participants' homelessness was their mental illness (50%), followed by relationship breakdowns (15%).

The primary causes of homelessness among Doorway participants are shown in full in Figure 9 below.

Figure 9: Primary factor leading to homelessness at point of referral (n=52)



Sources: Doorway referral forms

¹⁸ Chamberlain, C. and MacKenzie, D. (2003) *Counting the Homeless 2001*, Canberra: ABS, Catalogue No. 2050.0.

¹⁹ Participants that were previously staying in beds within Community Care Units (CCU) in the La Trobe were classified as Secondary homelessness. Despite some of these participants spending extended periods of time in CCU, their stay in the CCU was viewed as temporary, and only prolonged due to the lack of suitable alternate housing options available to these participants in Gippsland.

²⁰ Examples of participants classified as marginally housed include a mother who was living with her ex-partner who was at risk of eviction due to illegal sub-letting and a single male with history of Alcohol and Other Drug abuse who was living with his elderly mother.

2.5 Participants come from similar backgrounds

The typical Doorway participant is male, middle-aged, born in Australia, receiving DSP payments and unemployed. The overall demographic profile of Doorway participants is shown in Table 6 below.

Table 6: Demographic indicators for participants (n=47)

Indicators	Data
Demographic	
Male/ Female	68% / 32%
Average age (mean)	39
Born in Australia	91%
Identify as Aboriginal or Torres Strait Islander	2%
Family background	
Has an identified carer (as at point of referral)	30%
Single parent or couple with children	8%
Social and economic disadvantage	
Receiving DSP payments (as at January 2013)	78%
Average fortnightly income (as at January 2013)	\$956

NOTE: Excludes participants who have left the program prior to March 2013.

There are significant variations in the profiles of participants across the three Doorway regions, as shown in Figure 10 below. These variations reflect the diverse characteristics of each region (see Section 2.2 above) as well as differences in the referral and intake practices in each region.

Figure 10: Characteristics of participants by region (as at March 2013)

Austin (n=20)	St Vincents (n=9)	La Trobe (n=18)
<ul style="list-style-type: none"> Highest proportion of females at 41% Lowest proportion participants who completed Year 12 or equivalent at 5% 	<ul style="list-style-type: none"> Highest average age for participants of 45 (with ages ranging from 38 to 66) Lowest proportion of females at 25% Highest proportion of participants born overseas (11%) Highest proportion participants who completed Year 12 or equivalent at 33% Highest average monthly income at \$909 Highest proportion of participants doing paid or unpaid work at 44% No participants on NewStart allowances 	<ul style="list-style-type: none"> Lowest average age for participants of 36 (with ages ranging from 20 to 53) Lowest average monthly income at \$783 Highest proportion of participants on DSP at 84% Lowest proportion of participants doing paid or unpaid work at 6%

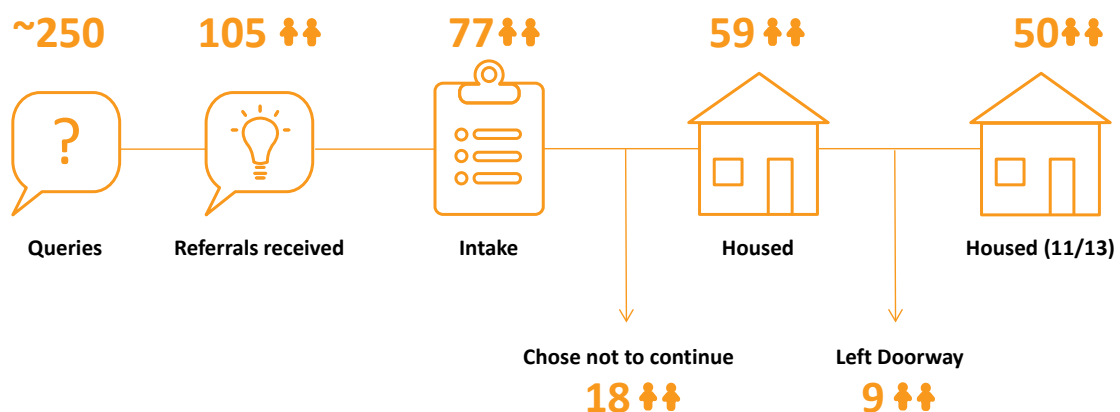
3 Participants have achieved positive outcomes

The primary participant-focused objective of the Doorway pilot program was to “broker/provide support for clients that is transitional in nature and enhances the ability of clients to develop skills to maintain tenancy, meet their financial commitments independently of the program, meet their personal needs and link with the community for recreational, educational and or employment opportunities.”²¹

With seven months remaining in the three year pilot program, the outcomes for participants have been largely positive when compared against the original objective of the program. Health and housing outcomes have seen the greatest gains – even for participants that have been in the program for a short period of time. Social inclusion and employment outcomes have seen modest gains, as participants have taken time to start making the most of their improved wellbeing and housing stability. The latter outcome areas in particular will be a key focus between now and the end of the Doorway pilot in June 2014.

As at November 2013, 77 people had gone through the Doorway intake process and 50 participants are currently living in private rental properties. The throughput of individuals through the program is shown in Figure 11 below.

Figure 11: Doorway pilot program throughput



Source: Doorway Statistics (11 November 2013)

²¹ Department of Health (2011), *Housing Support and Brokerage Demonstration Project - Funding and Service Agreement (Draft)*, p. 1

This section of the *Summative Evaluation Report* explores the outcomes to date of Doorway participants across five main outcome domains. Key changes across each outcome domain are summarised below.

Mental health outcomes are very positive

- The average time in bed-based clinical mental health services per participant per year has decreased from 20.4 to 7.5 days in the 12 months pre and post-housing²² – with the biggest decrease occurring with acute in-patient services (13.9 to 6.6 days)
- Doorway has provided viable housing alternative to three participants who were long-term residents of Community Care Units (CCUs) prior to joining the program (due to a lack of identified housing and support options prior to the introduction of Doorway)
- Data suggests that visits to bed-based mental health services are more likely to be planned than unplanned, and H&RWs have noted that participants are now more likely to pro-actively seek ways to manage their mental health treatment needs
- Participants are having less contact on average with ambulatory mental health clinical services since entering Doorway. The biggest decreases in average usage hours are for services provided by Mobile Support and Treatment Teams (MSTT) and Continuing Care Teams (CCT)
- The mental health of one third of current participants has improved to the point of their being able to be discharged from their AMHS
- Doorway participants are less reliant on specialised mental health supports and are increasingly utilising the support of GPs and Alcohol and Drug Workers to manage their health and wellbeing
- Changes in mean scores across three of the five BASIS-32 sub-scales (Relation to self/others, Depression/anxiety and Daily living/role function) and changes in the total overall score show statistically significant improvements
- Participants largely attributed their improved mental health outcomes to having stable accommodation and an integrated support team – two firsts for many participants.

Participants are better at managing their overall health

- H&RWs report that participants are more engaged in the development and management of their support plans and with their primary health providers
- Having more stable accommodation has made it easier for participants to attend appointments with clinicians, and for their formal supports, including clinicians, to stay in touch with or seek out their clients if need be
- The total number of estimated Emergency Department presentations across all participants in the 12 months pre and post-housing decreased from 93 to 63 based on annualised averages. The decreases in urgent presentations (41 to 22) suggests that participants may be managing their health more pro-actively and taking preventative steps
- The total number of estimated hospital admissions across all Doorway participants decreased from 22 to 6 pre and post-housing based on annualised averages.
- There was a statistically significant ($P < 0.05$) improvement in mean scores for the *Emotional and mental health recovery* ladder of the Homelessness Star from 6.0 at the point of program intake to 7.0 in November 2013 (out of a maximum of ten).

²² This data excludes three participants that were in CCU beds at Latrobe Regional Hospital for most of the year prior to Doorway.

Housing outcomes have improved substantially

- Most participants reported feeling more independent, having greater levels of self-respect and pride and finding greater meaning in their lives as a direct result of having more stable and secure accommodation
- Thirty-one participants have been offered and accepted 12-month lease extensions. An additional three participants have elected to renew their lease on a monthly basis.
- The number of tenancy related incidents has been relatively low with six lease breaks by participants (excluding those leaving the program), ten breach of duty notices and no evictions
- There was a statistically significant ($P<0.05$) improvement in mean scores for the *Managing money* recovery ladder of the Homelessness Star from 6.5 at the point of program intake to 8.0 in November 2013 (out of a maximum of ten)
- Most participants are able to manage their rents with only eleven people falling into rental arrears. H&RWs have negotiated re-payment plans with participants in all instances of arrears
- Only one participant has had their utilities disconnected due to the late payment of a bill
- Ten people currently pay their own rent in full - five of whom have done so since entering the program. The other five participants have attained self-sufficiency with their rental payments for a variety of reasons – including acquiring housemates, having family members move in and re-establishing stable relationships with an employed partner. Two of these five participants also commenced employment after joining Doorway – although this was not the primary contributing factor to their no longer requiring rental subsidies
- The mean rental gap paid by Doorway to participants is \$194 per fortnight – which remained static over the 12 months prior to November 2013.

Economic outcomes are encouraging

- The percentage of participants engaged in paid and unpaid work has increased from 16% at the point of intake to 27% in November 2013
- Doorway employment outcomes compare well against other Victorian and inter-state programs that have sought to increase economic participation rates for people who are at risk of homelessness at similar points in their implementation timeframes Current workforce participation levels are in line with national rates for people with a SMI– which are estimated to be between 22-30%
- Challenges in increasing workforce participation rates among Doorway participants include the different stages of recovery across participants, variable levels in the quality of support provided by employment providers in each region and issues related to transport access for many participants
- There were statistically significant ($P<0.05$) improvements in mean scores for the *Motivation and taking responsibility* and *Meaningful use of time* recovery ladders of the Homelessness Star from 6.1 to 8.0 and from 5.6 to 6.8 respectively - from the point of program intake to November 2013
- The proportions of Doorway participants accessing education and vocational training opportunities and receiving qualification whilst in the program have increased.

Levels of social inclusion have improved

- The composition of participants' natural support networks have evolved over time and are now playing a more active role in supporting the recovery of participants

- Having a home has enabled many participants to re-connect with family and friends – in some cases for the first time in many years – and develop new relationships
- Social isolation remains an ongoing challenge for some participants
- Levels of anti-social behaviour have decreased among several participants that were challenged by the transition out of congregate living environments into their own rental accommodation
- Participant interactions with the justice system have often resulted in positive outcomes such as family reunifications or orders being lifted.

3.1 Several caveats should be noted

The analysis and interpretation of outcome data in this *Summative Evaluation Report* comes with several caveats:

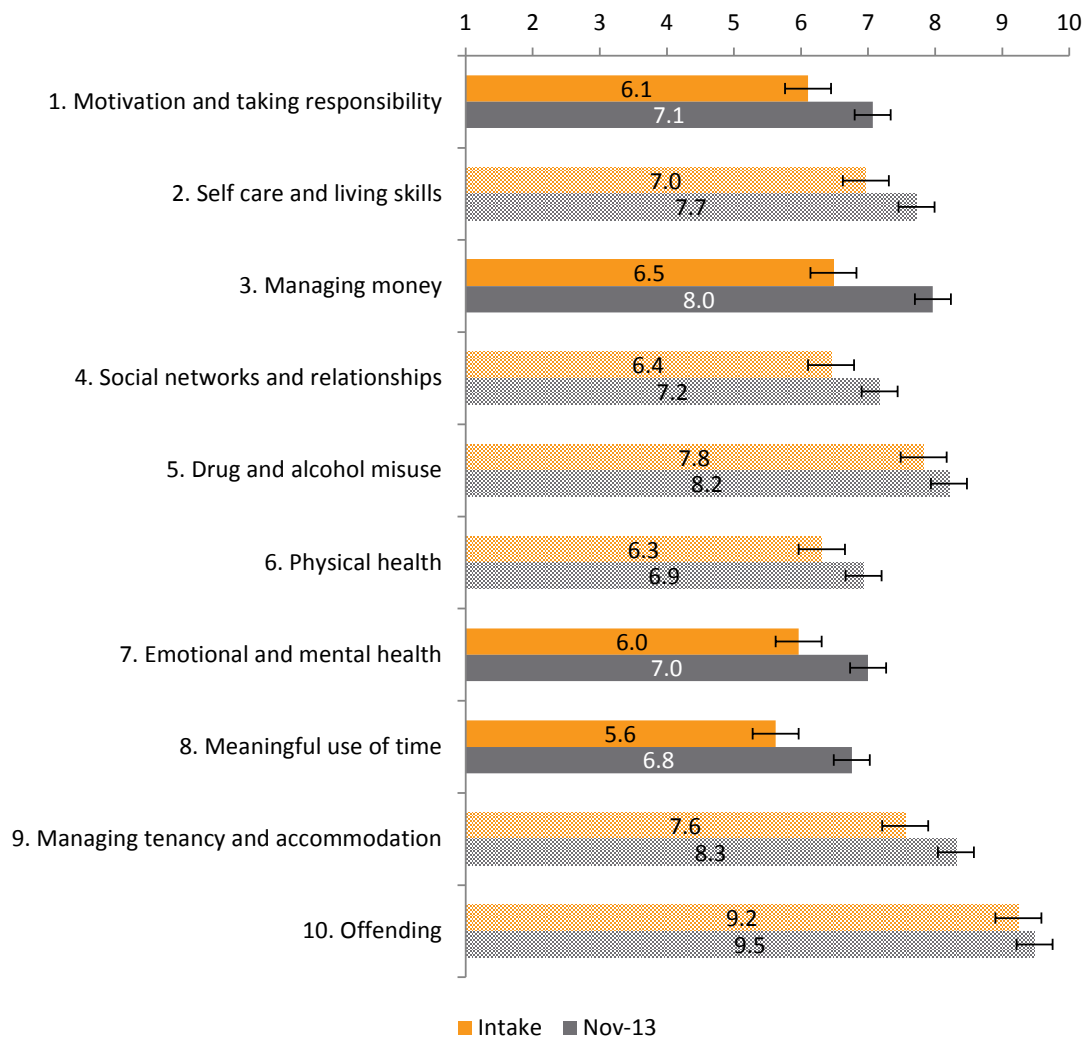
- **Participants vary in length of time in Doorway** – There is significant variation in the amount of time that participants have spent in Doorway to date. This is due to the staggered implementation across the three regions, delays in finding rental accommodation, and the arrival of new participants to fill the places vacated by those who have exited Doorway. Where possible, consistent point-in-time comparisons have been made of participants' outcome data (e.g. 18 months pre and post each individual's intake or housing date).
- **Outcome scores are subjective and context dependent** – Participants themselves have noted that self-assessed scores in outcome measurement tools are strongly influenced by how they are feeling at the particular time on a particular day when they are completing the measurement tool. This is also indicative of the non-linear nature of most participants' recovery journey.
- **The process of recovery is lengthy and highly individualised** – The attainment of positive outcomes related to health and wellbeing, and social inclusion can take many years to attain. Attainment can depend on the participant's life stage, severity and/or continuity of conditions experienced.
- **Low outcome measurement scores are not necessarily a bad thing** – Several H&RWs noted that a decrease in scores for outcome measurement tools such as the Homelessness Star can sometimes indicate a participant being well enough to openly acknowledge and assess some of the less positive things that they want to change in their own lives.
- **Participants are receiving additional attention** – It is possible that some form of 'Hawthorne effect'²³ may be skewing some of the outcome data, given the higher than usual levels of attention that Doorway participants are receiving due to this evaluation and the program's pilot status. This bias may also be compounded by several of the participants knowing that decisions about the continued funding of Doorway are likely to be based on the results of this evaluation.
- **Quantitative and qualitative data may tell slightly different stories** - Generally speaking the qualitative data gathered for this evaluation has been more positive than quantitative outcomes measures. This may be due to the former type of data being better at capturing the nuances of participants' gradual progress along the multiple stages of the recovery journey.

²³ The 'Hawthorne effect' refers to the tendency of some people to work harder and perform better when they are participants in an experiment or study. This changed behaviour may be due to the attention they are receiving from researchers rather than due to any manipulation of independent variables.

3.2 Changes in Homelessness Star scores are encouraging

The graph in Figure 12 below shows that average Homelessness Star scores have improved in all domains since Doorway participants have entered rental accommodation and started receiving support. It should be noted though that these increases are only statistically significant ($P < 0.05$) across four of the Star's ten domains: 1. *Motivation and taking responsibility*; 3. *Managing money*; 7. *Emotional and mental health*; and 8. *Meaningful use of time*. An increase in scores across each of the ten Star domains represents a positive step in a participant's recovery journey.

Figure 12: Mean Homelessness Star scores (n=29)



Source: Doorway six-monthly participant data collection

NOTE: Shaded sub-scales have changes in means that are not statistically significant ($P > 0.05$). An increase in a score represents improvement. Data is presented as the mean \pm standard error. The sample for both measurement periods is drawn from a matched cohort (i.e. participants that have completed Stars at the point of intake and in November 2013). The average time that elapsed between these the point of intake and November 2013 across all participants in the matched cohort was 16 months.

3.3 Mental health outcomes are very positive

Qualitative feedback, changes in service utilisation and outcomes measurement data all indicate significant improvements in the mental health of Doorway participants. Across all Doorway participants, the average number of days in bed-based clinical services has decreased substantially post-housing, and average total contact hours with ambulatory services per participant have also decreased albeit less substantially. There has been a small increase in average usage of crisis-based ambulatory services provided by Crisis Assessment and Treatment (CAT) teams, but this can be viewed as a positive outcome in the instances of participants who continue to have higher levels of support needs, but whose use of inpatient services has decreased, as it means their support needs are being met in the community.

One third of participants who are still enrolled in the Doorway program have been formally discharged from their AMHS. Six of the nine current Doorway participants who were subject to a Community Treatment Order (CTO) at the point of program intake have had these CTOs lifted.

Doorway participants are also becoming less reliant on specialist mental health supports. Participants are increasingly connected to and utilising the support of GPs and Alcohol and Drug Workers to manage their health and wellbeing.

3.3.1 Qualitative data support significantly improved outcomes

Participants who attended the series of focus groups in all three regions almost unanimously indicated that their mental health had improved significantly since joining Doorway. Most participants attributed this improvement to having stable accommodation and an integrated support team – a first for many participants.

“I wasn’t able to get better when I was couch-surfing – I had no base for recovery. Having my own place has made a world of difference. My recovery began as soon as I moved in. I have come such a long way in just seven months. Doorway has saved my life”.

Doorway participant

Participants also discussed the positive effects of Doorway giving them the time and space in their own accommodation to reflect upon their own mental health and seek the necessary treatment.

“My mental health has improved a lot - I feel more at ease. Having a house has given me time to take a deep breath and collect my thoughts.”

Doorway participant

3.3.2 Doorway has provided pathways out of Community Care Units

Doorway has provided viable housing alternatives and pathways out of CCUs to three participants who were long-term residents of CCUs prior to joining the program. Two participants were in Latrobe Regional Hospital’s CCU for 1.5 years and 1.75 years respectively prior to being housed through Doorway. The third participant was from the Austin catchment and in a CCU for two years before their lease commenced.

In the case of all three participants, the long periods of time that they spent in CCU beds pre-Doorway were largely due to an inability to access suitable alternate housing arrangements and support, rather than the complexity of their ongoing support needs.

For example, one participant - who had resided in a CCU for two years – made over ten unsuccessful applications for rental properties in the six months prior to joining Doorway. This resulted in the participant feeling a sense of hopelessness about their ability to transition to independent living. In the

case of another CCU resident, the resident and the CCU staff members did not have the capacity to source private rental accommodation by themselves without the initial support provided by Doorway staff.

3.3.3 Use of bed-based mental health services has decreased

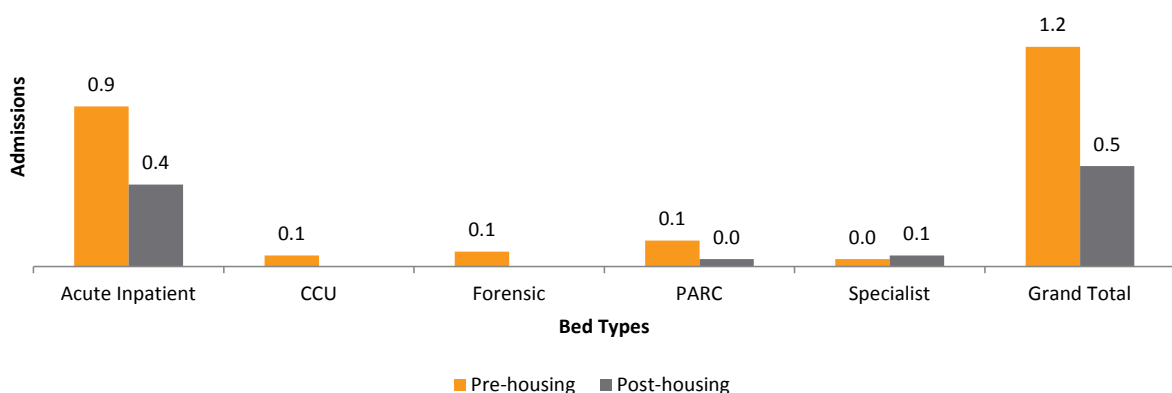
The use of bed-based mental health services has decreased substantially across Doorway participants. Figure 13 below shows the average admissions per participant for the period before and after the start of their Doorway rental accommodation across the bed types shown in Table 7 below.

Table 7: Types of bed-based mental health services

Bed type	Overview
Clinical based services	
Acute inpatient	<ul style="list-style-type: none"> Units that provide voluntary and involuntary short-term inpatient management and treatment during an acute phase of mental illness located within acute general hospitals
Forensic	<ul style="list-style-type: none"> Secure hospital inpatient services provided by Forensicare to mentally ill offenders in Victoria at Thomas Embling Hospital
Specialist	<ul style="list-style-type: none"> Specialist services that provide an additional level of expertise or service response for people with particular clinical conditions or high level needs
Community-based services	
Community Care Unit (CCU)	<ul style="list-style-type: none"> Medium to long-term residential clinical care and rehabilitation services located in residential areas with a 'home like' environment
Prevention and Recovery Centre (PARC)	<ul style="list-style-type: none"> Sub-acute clinical units that provide a short term acute supported residential option in partnership with Psychiatric Disability Rehabilitation and Support Services (PDRSS) providers

Source: Department of Health (2005), *Specialist mental health service components*

Figure 13: Average admissions per year per participant (n=53)

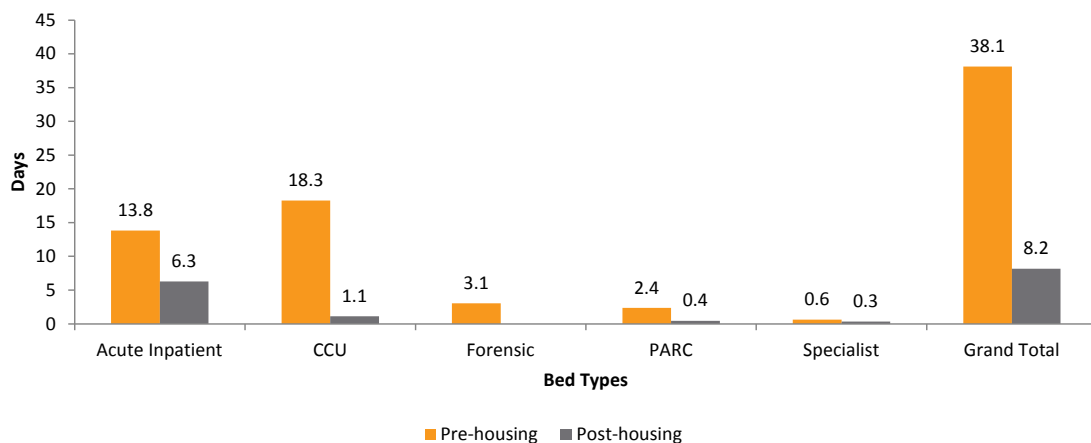


Sources: Department of Health, CMI/ODS dataset (13 October 2013), data provided by the Manager of Service Development - Mental Health at St Vincent's (18 December 2013)

NOTE: Admission data was not available for twelve participants. It is assumed that these participants were not admitted to beds during the 12 months pre or the period post housing with Doorway. Admissions are shown as means. Participants who left Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 13 October 2013 have also been excluded from this analysis. Total admissions for the pre-housing period exclude admissions that occurred more than 365 days before the date of house occupation or any period after housing occupation (admissions that occurred <365 days before housing for the same admission have been counted). If a participant was admitted to a bed at the point of housing occupation, the total days admitted were allocated between the pre and post period. The admissions for the post-housing period are based on annualised average admissions per participant. These annualised calculations are based on average of 10.3 months of post-housing data. For participants who are currently in a bed, the numbers of days in the post-housing period were counted up to the date that the CMI/ODS data was received from the Department of Health (13 October 2013).

Doorway participants showed a reduced length of stay across all bed types, increasing accessibility for clients requiring a bed based service in each of the three regions. Figure 14 below shows the average bed days per participant for the period before and after the start of their Doorway accommodation.

Figure 14: Average bed days per year per participant (n=53)



The largest decreases were in the average bed days for CCU and acute inpatient services. It should be noted that the reduction is skewed by three participants who were long term residents of CCU beds pre-Doorway (see section 3.3.2, page 28). When these three participants are excluded from the sample (n=51), there is still a substantial decrease in total average bed days from 21.3 days pre-housing to 4.0 days post housing – as shown in Figure 15 below.

Figure 15: Average bed days per year per participant – Latrobe CCU participants excluded (n=51)



Sources: Department of Health, CMI/ODS dataset (13 October 2013), data provided by the Manager of Service Development - Mental Health at St Vincent's (18 December 2013)

NOTE: Admission data was not available for twelve participants. It is assumed that these participants were not admitted to beds during the 12 months pre or the period post housing with Doorway. Days are shown as means. Participants who left Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 13 October 2013 have also been excluded from this analysis. Total bed days for the pre-housing period exclude bed days that occurred more than 365 days before the date of house occupation or any period after housing occupation (bed days that occurred <365 days before housing for the same admission have been counted). If a participant was admitted to a bed at the point of housing occupation, the total days admitted were allocated between the pre and post period. The bed days for the post-housing period are based on annualised average bed days per participant. These annualised calculations are based on average of 10.3 months of post-housing. For participants that are currently in a bed, the numbers of days in the post-housing period were counted up to the date that the CMI/ODS data was received from the Department of Health (13 October 2013).

One H&RW noted that Doorway participants are now able to more pro-actively manage their mental health treatment needs, and that visits to bed-based mental health services are more likely to be planned than unplanned. Furthermore, Doorway has mitigated the need for participants to be admitted to in-patient facility primarily because they have no other viable form of accommodation (see Section 3.3.2 above), or alternatively, for discharge to be delayed due to a lack of suitable accommodation, or for a participant to worry about their accommodation following discharge.

"The creation of a stable environment has meant clients are able to reintegrate and not have the troughs. Housing stability has meant treatment has continued and we are now treating at a higher level. This is the first time in the seven years of the CCU that we have had vacancies. We also have fewer admissions and re-admissions to the inpatient unit. For the client group we have had a decrease in presentations because of Doorway and breaking the crisis loop."

Manager, AMHS

Outcomes for Doorway participants related to bed-based mental health service admissions compare favourably with other similar programs in Victoria and nationally.²⁴ Table 8 below shows how these outcomes compare relative to comparable indicators for those individuals that participated in two comparable programs - *Housing and Accommodation Support Initiative* (HASI) and *Journey to Social Inclusion* (J2SI). Further details about these and other comparable programs can be found in Appendix D.

Table 8: Comparison of bed-based mental health service outcomes

Indicator	Program	Sample	Baseline	During program	Change
Average number of admissions per person per year	Doorway [^]	n=53	1.18	0.54	-54.2%
	HASI ^{25*}	n=197	1.7	1.3	-24.0%
Average number of admitted days per person per year	Doorway [^]	n=51 ²⁶	20	7	-63.3%
	HASI [*]	n=197	54.7	22.5	-58.9%
	J2SI ^{27~}	n=33/ 36	5.8	2.8	-51.7%

[^] Admission data were not available for twelve participants. It is assumed that these participants were not admitted to beds during the 12 months pre or the period post housing with Doorway. Admissions and bed days are shown as means. Participants who exited Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 13 October 2013 have also been excluded from this analysis. Total admissions and bed days for the baseline pre-housing period exclude admissions that occurred more than 365 days before the date of house occupation or any period after housing occupation (admissions that occurred <365 days before housing for the same admission have been counted). If a participant was admitted to a bed at the point of housing occupation, the total days admitted were allocated between the pre and post period. The admissions and bed days for the post-housing period are based on annualised average admissions and bed days per participant. These annualised calculations are based on average of 10.3 months of post-housing 'during program' data. For participants that are currently in a bed, the numbers of days in the post-housing period were counted up to the date that the CMI/ODS data was received from the Department of Health (13 October 2013).

^{*}The HASI baseline period covers average number of mental health inpatient hospital admissions and days per person in their two years prior to joining HASI. The 'during program' period covers average number of admissions and days per person in their first two years in HASI. The computation of the average number of admissions per person per year and the average number of days in hospital per person per year counted all consumers with valid inpatient data, including consumers who did not have a hospital admission in the respective period but recorded valid zero admissions. When calculating the average number of days per admission, only consumers who had at least one admission in the respective period were counted, hence the average number of days per admission is not the result of the mathematical division of the average number of days per year spent in hospital by the average number of admissions per person. Data is sourced from NSW Health, Admitted Patient Data Collection in the State HIE July 1999-June 2009

²⁴ It should be noted that comparable outcomes data is not publicly available for other programs funded by the Victorian Government under the rubric of Standard or Moderate levels of Home-Based Outreach Support.

²⁵ Bruce J., S. McDermott, J. Ramia, J. Bullen and K. Fisher (2012), *Evaluation of the Housing and Accommodation Support Initiative (HASI): Final Report*, Social Policy Research Centre UNSW, p. 47.

²⁶ Latrobe CCU participants excluded from this calculation.

²⁷ Johnson, G., Kuehnle, D., Parkinson, S. & Tseng, Y. (2012) *Meeting the Challenge? Transitions out of long-term homelessness. A randomised controlled trial examining the 24 month costs, benefits and social outcomes from the Journey to Social Inclusion pilot program*. Sacred Heart Mission, p. 48.

~The J2SI calculation of average days covers admissions to psychiatric units (excluding days in psychiatric wards) and includes participants that were not admitted to these units. The baseline period (n=33) covers admissions in the six month period prior to the start of the program. The 'during program' period (n=36) includes admissions that occurred in the first 24 months of the J2SI program.

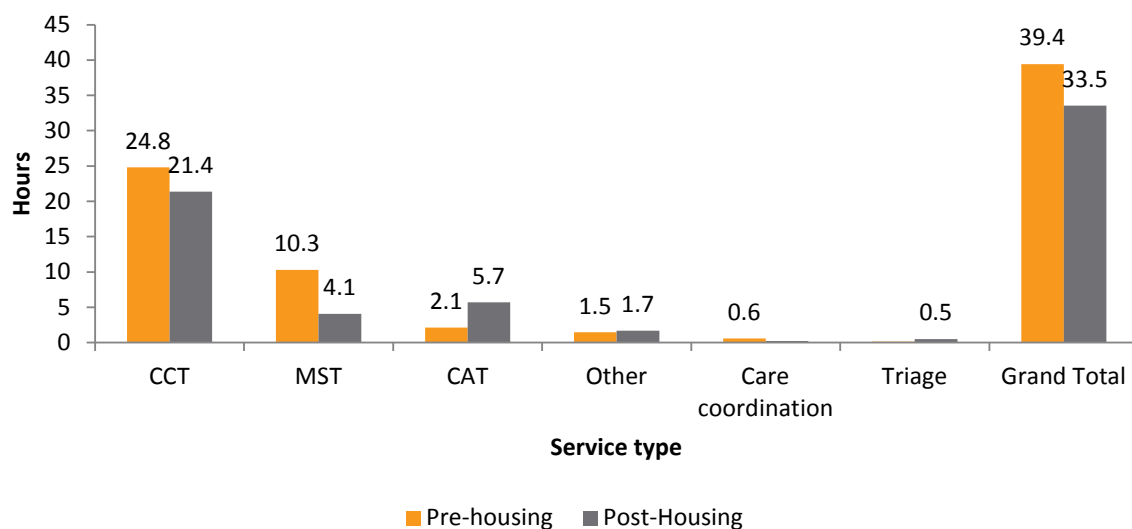
3.3.4 Participants are making marginally less use of ambulatory mental health clinical services

On average, participants are having marginally less contact with ambulatory mental health clinical services since entering Doorway.

Figure 16 below illustrates the average hours of contact per participant for the 12-month period prior to and after being housed in rental accommodation across a range of ambulatory services.

The biggest decreases in average usage patterns are across the planned intervention services provided by MST and CCT. There has been a very small increase in average usage of crisis-based ambulatory services provided by CAT teams. An increase in CAT team interventions can be viewed as a positive outcome in light of the decrease in admissions to bed-based mental health services (see 3.3.3, page 29) for those participants that continue to have higher levels of support needs. This indicates that despite increasing ill health participants did not require bed-based hospital services.

Figure 16: Average hours of contact per year per participant (n=40*)



Source: CMI/ODS (13 October 2013)

* Data for participants from the St Vincent's catchment region was not available in the CMI/ODS.

NOTE: Hours are shown as means. Participants who exited Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 13 October 2013 have also been excluded from this analysis. The pre-housing period covers from the date of housing occupation to 365 days before this date. The annual contact hours for the post-housing period are based on annualised average hours per participant. These annualised calculations are based on an average of 10.3 months of post-housing data (i.e. the average period that Austin and Latrobe participants have been housed).

3.3.5 One third of participants have been discharged from their AMHS

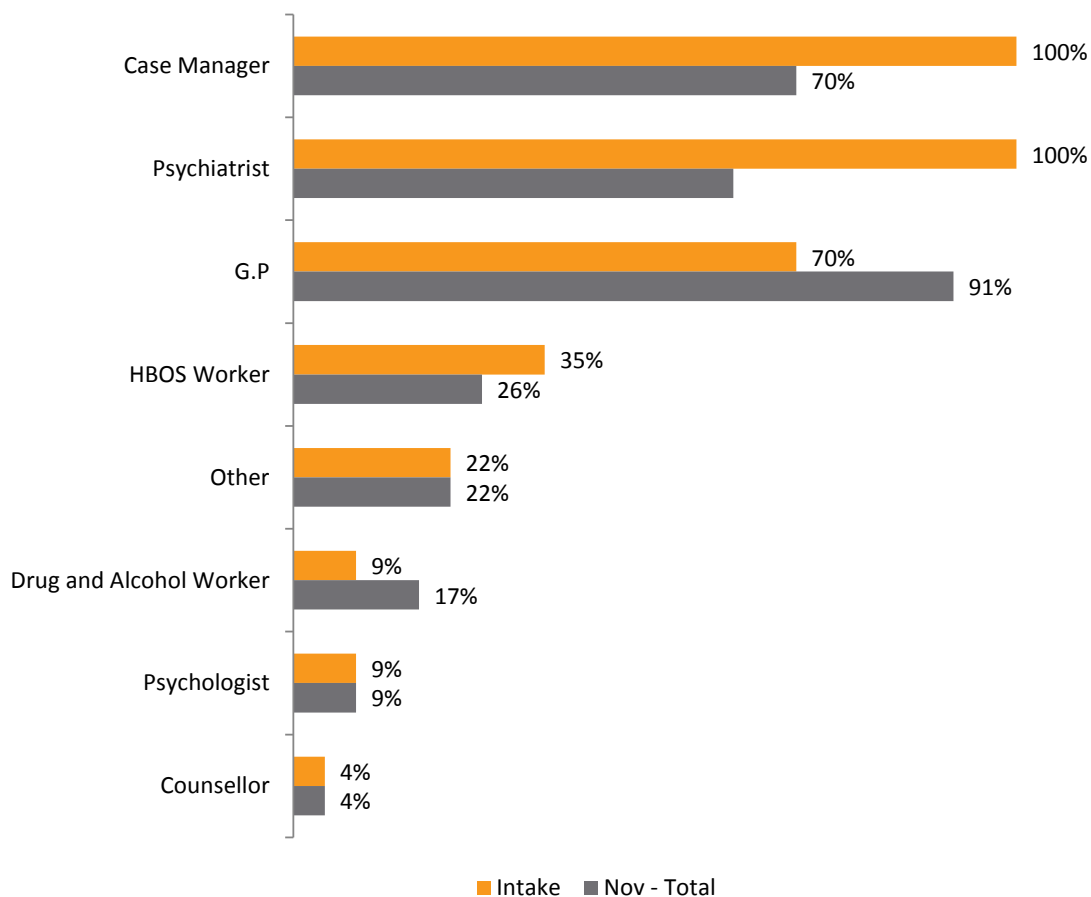
As at November 2013, 16 of the participants still enrolled in the Doorway program (n=48) have been formally discharged from their AMHS. Discharge indicates that their mental health has improved to the point that further clinical care could be provided by a GP or other health practitioner, rather than a specialist public mental health service. An additional two participants who have left Doorway were discharged from their AMHS prior to leaving the program. Feedback from these participants indicates that this represents a significant milestone in their recovery.

In addition, six of the nine current Doorway participants subject to a Community Treatment Order at the point of program intake have had these CTOs lifted.

3.3.6 Participants are less reliant on specialist mental health supports

Doorway participants' use of specialised mental health supports has decreased over time. Figure 17 below illustrates that participants are increasingly connected to and utilising the support of GPs and Alcohol and Drug Workers to manage their health and wellbeing. The decreased use of case managers and psychiatrists as formal supports reflects that one third of Doorway participants have been discharged from their AMHS (see section 3.3.5 above).

Figure 17: Formal health supports over time (matched cohort of n=23)



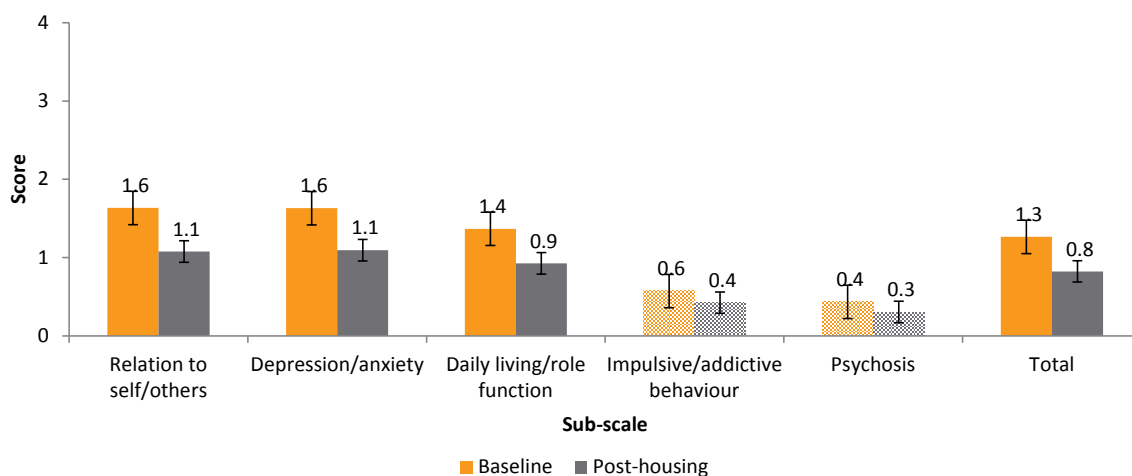
Source: Doorway six-monthly participant data collection

3.3.7 Standard outcomes measurement tools indicate positive changes

The pre and post-housing results for participants are not conclusive across Behaviour and Symptom Identification Scales (BASIS-32) and Health of the Nation Outcome Scales (HoNOS) - two of the widely used mental health outcomes measurement tools. This is primarily due to insufficient data being available across both measurement periods available for matched cohort comparisons of changes in mean scores across the Doorway participants. The limitations of standard outcomes measurement tools such as BASIS-32 and HoNOS - which are explored in Table 9 on page 36 - should also be noted.

Figure 18 below shows that average baseline and post-housing scores across the five BASIS-32 sub-scales have improved. It should be noted that **the changes in mean scores for the two of the sub-scales - impulsive/addictive behaviour and psychosis - are not statistically significant** ($P > 0.05$).

Figure 18: Mean BASIS-32 sub-scale scores for participants pre and post Doorway housing (n=29)

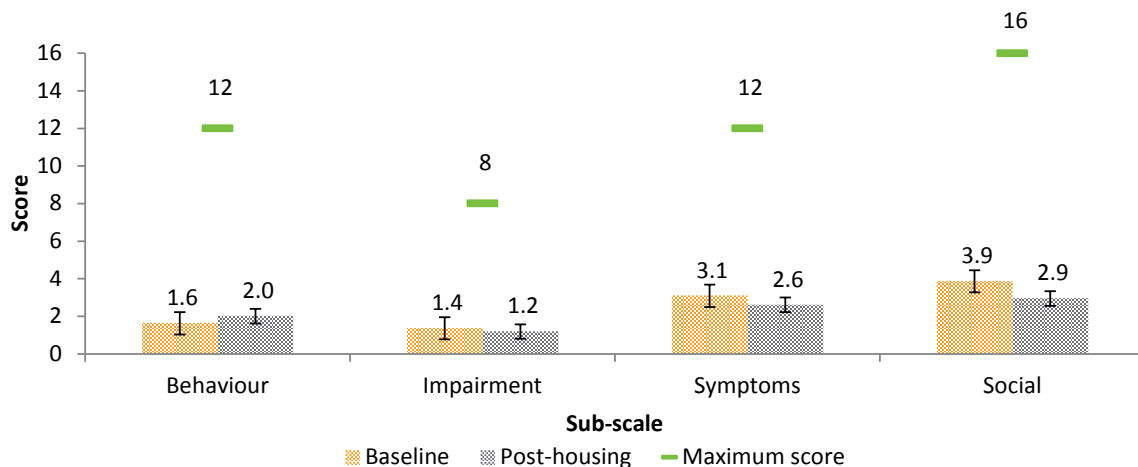


Source: CMI/ODS (13 October 2013); Doorway six-monthly participant data collection

NOTE: Shaded sub-scales have changes in means that are not statistically significant ($P > 0.05$). A decrease in a sub-scale score represents improvement. Data are presented as the mean \pm standard error. The sample for both measurement periods is drawn from a matched cohort (i.e. participants that have baseline and post-housing BASIS-32 scores). The baseline period corresponds with the quarter in which a participant occupied their first house, or ± 3 months from this date if BASIS-32 scores were not available. The post-housing period corresponds with the 15 months after the housing occupation date, or ± 3 months from this date if BASIS-32 scores were not available. Where a participant had multiple BASIS-32 sub-scale scores in the same quarter, the mean of these scores was used as the basis of the averages for the Doorway cohort. Null values for selected sub-scale scores in the source data have been assumed to correspond with 0 ratings.

Figure 19 below shows the average pre-housing baseline and post-housing scores across the four HoNOS sub-scales. Although Figure 19 shows that mean scores have improved across all domains (with exception of the Behaviour sub-scale), it should be noted that **none of the changes in sub-scale mean scores are statistically significant** ($P > 0.05$). The **change in mean total HoNOS scores** from 10.0 pre to 8.8 post-housing (out of a maximum score of 48) **is statistically significant** ($P < 0.05$).

Figure 19: Mean HoNOS sub-scale scores for participants pre and post-housing (n=20)



Source: CMI/ODS (13 October 2013); Doorway six-monthly participant data collection

NOTE: Shaded sub-scales have changes in means that are not statistically significant ($P > 0.05$). A decrease in a sub-scale score represents improvement. Data are presented as the mean \pm standard error. The sample for both measurement periods is drawn from a matched cohort (i.e. participants that have baseline and post-housing HoNOS scores). The baseline period corresponds with the quarter in which a participant occupied their first house, or ± 3 months from this date if HoNOS scores were not available. The post-housing period corresponds with the 15 months after the housing occupation date, or ± 3 months from this date if HoNOS scores were not available. Where a participant had multiple HoNOS sub-scale scores in the same quarter, the mean of these scores was used as the basis of the averages for the Doorway cohort. Null values for selected sub-scale scores in the source data have been assumed to correspond with 0 ratings.

Table 9: Limitations with HoNOS and BASIS-32

The utility of HoNOS and BASIS-32 in measuring recovery and assessing individual change (particularly over short time frames) has received considerable attention in literature related to mental health outcomes. Despite their widespread deployment in Australia and acknowledged usefulness, there are several limitations should be taken into account when interpreting HoNOS and BASIS-32 outcomes data:

- HoNOS and other routine outcome measurements have been criticised as failing to capture the subtlety of individual differences and of “having a limited capacity to capture the richness of people’s recovery journeys or provide information that can usefully inform care”²⁸
- The ability of HoNOS and BASIS-32 to meaningfully assess change has also been questioned. This is on the basis that the tools focus on a consumer’s health status and severity of symptoms, at a specific point in time over the previous two weeks. They do not directly ask for assessments of change, and instead change is to be extrapolated from consecutive ratings of mental health status²⁹
- It has been argued that it is easier to administer HoNOS in settings where large improvements are the norm (i.e. acute inpatient) and that HoNOS is less viable in community settings like the Doorway program where the process of recovery may be much slower and not as dramatic³⁰
- Due to a limited range of measurement, these tools can be subject to a ‘floor’ and ‘ceiling’ effect – meaning that there are distinct upper and lower limits of potential.

²⁸ Lakeman, R. (2004). Standardised routine outcome measurement: pot hole in the road to recovery. International Journal of Mental Health Nursing, 13, 210-15, cited in T. Trauer, *Outcome measurement in mental health: theory and practice*, Cambridge UP, 2010.

²⁹ Stedman, T., Yellowlees, P., Mellsop, G., Clarke, R., and Drake, S. (1997), *Measuring Consumer Outcomes in Mental Health*, Department of Health and Family Services.

³⁰ Developing an indicator of effectiveness: the HoNOS Working Party (2010)

3.4 Participants are better at managing their overall health

The majority of Doorway participants have become more actively engaged with managing their overall health and wellbeing. This is demonstrated by the decrease in Emergency Department (ED) presentations and hospital admissions after Doorway participants have been housed, and the increased use of GPs.

H&RWs have observed that living in rental accommodation has made it easier for participants to attend appointments with their formal supports, including clinicians, and for these supports to stay in touch with or make appointments with participants. H&RWs have also reported that participants are attending meetings with their AMHS case managers more frequently and are visiting their GPs on a more regular basis.

The General Manager of one of the partner AMHS also observed that, “Doorway has improved relationships with case managers. People are seeing that they can get more out of their support services and that the visits are not just about compliance.”

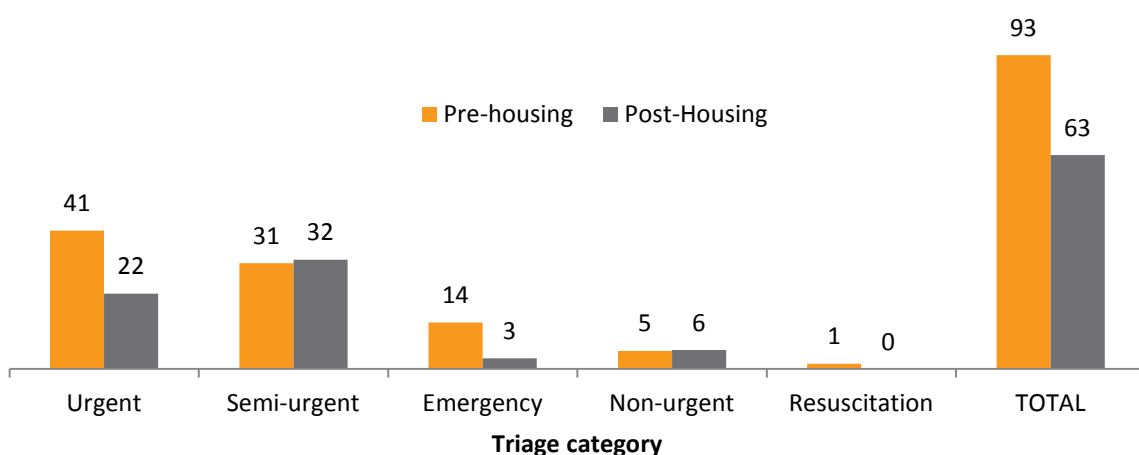
3.4.1 Hospital presentations and admission are decreasing

The total number of Emergency Department (ED) presentations and hospital admissions across all Doorway participants are lower in the period post-housing for each participant relative to the period pre-housing.

Figure 20 below shows that total ED presentations have decreased across all triage categories. The decreases in urgent and semi-urgent presentations may indicate that participants are managing their health more pro-actively, and therefore require less urgent treatment for medical issues.

The impact of reduced ED presentations is particularly significant for hospitals located in regional areas. As one staff member at Latrobe Regional Hospital’s AMHS noted, “a reduction in ED presentations has a big impact in country areas where EDs are not open 24 hours a day and practitioners have to be called out in the middle of the night.”

Figure 20: Presentations to Emergency Departments by triage category across all participants (n=50)

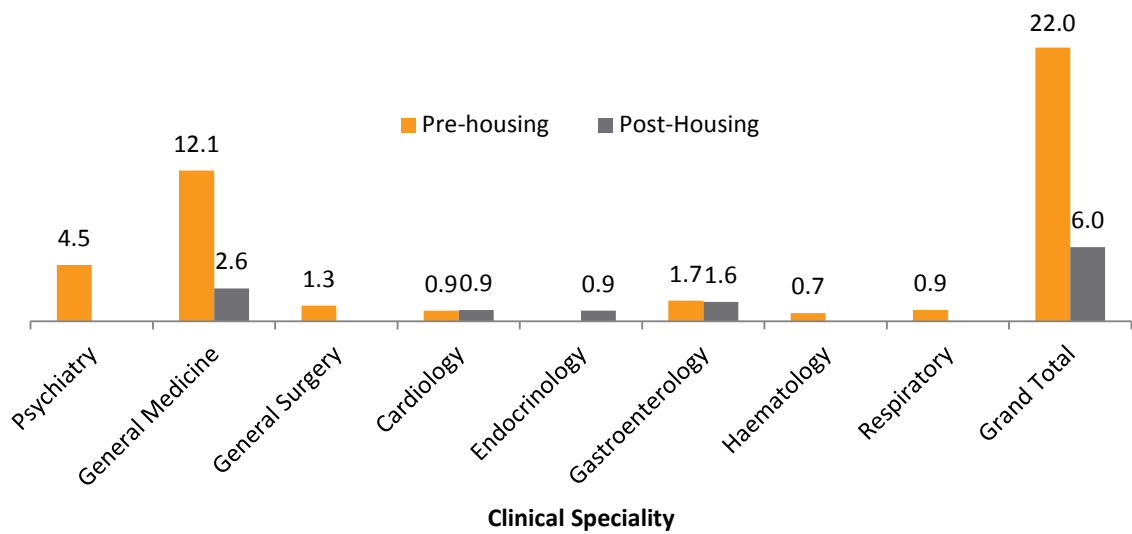


Source: Department of Health, Victorian Emergency Minimum Dataset (VEMD) dataset (data to 30 June 2013)

NOTE: Participants who exited Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 30 June 2013 have also been excluded from this analysis. The pre-housing period covers from the date of housing occupation to 365 days before this date. The annual admissions for the post-housing period are based on annualised admissions per participant. These annualised calculations are based on an average of 13.9 months of post-housing data (i.e. the average period that all participants have been housed for).

Similarly, Figure 21 illustrates a decrease in the total number of admissions to hospitals across the majority of clinical specialties, which may also indicate a more pro-active approach to preventative health management.

Figure 21: Total admissions to hospitals by clinical specialty across all participants (n=50)



Source: Department of Health, Victorian Admitted Episodes Dataset (VAED) (data to 30 June 2013)

NOTE: Participants who exited Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 30 June 2013 have also been excluded from this analysis. The pre-housing period covers from the date of housing occupation to 365 days before this date. The annual admissions for the post-housing period are based on annualised admissions per participant. These annualised calculations are based on an average of 13.9 months of post-housing data (i.e. the average period that Austin and Latrobe participants have been housed). Admissions classified under Acute Adult Mental Health Service and Acute Specialist Mental Health Service care types have been excluded to avoid double counting the bed-based mental health services utilisation data shown in Figure 14 on page 30. Psychiatric admissions under Alcohol and Drug Program and Other Care (Acute) including Qualified Newborn were included. Admission for following clinical specialties have been excluded on the grounds that they are one off episodes and independent of the intended health outcomes of Doorway: Gynaecology; Plastics; and Obstetrics & Ante-natal.

3.5 Housing outcomes have improved substantially

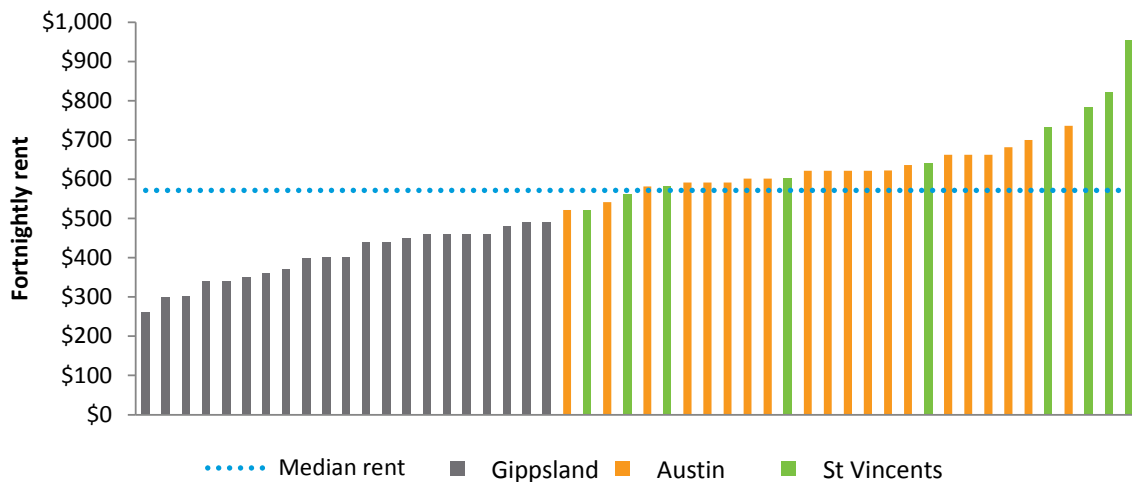
Since entering Doorway, many participants have achieved stable and secure private rental accommodation for the first time in their lives. The positive knock-on effects of this from a wellbeing, health and social inclusion perspective have already been profound in many instances. There have been relatively few incidents related to housing, and the majority of participants have been able to pay their rents on time. The average level of rental subsidies have yet to decrease substantially though– which will present dilemmas for some participants at the completion of the program in June 2014 (see Section 6.1.2 on page 98 for a discussion of this issue). Section 6.1.1 on page 97 provides an overview of the various strategies that are currently in place to ensure that participants' housing outcomes are sustained once support under the current Doorway pilot ceases in June 2014.

3.5.1 Participants established diverse living arrangements

The majority of current Doorway participants live in two bedroom properties –a choice dictated for many participants in the two metropolitan regions by the paucity of one bedroom properties. Most participants in the two metropolitan catchment regions are living in flats or units, whereas most Gippsland participants currently live in free-standing houses.

The median fortnightly rental amount is \$542. Rental payments range considerably from \$260 per fortnight in Morwell to \$953 per fortnight in Fitzroy. The disparate level of rents across the three regions is highlighted by the twenty lowest rent properties all being located in Gippsland. The distribution of fortnightly rental payments is shown in Figure 22 below.

Figure 22: Fortnightly rental payments

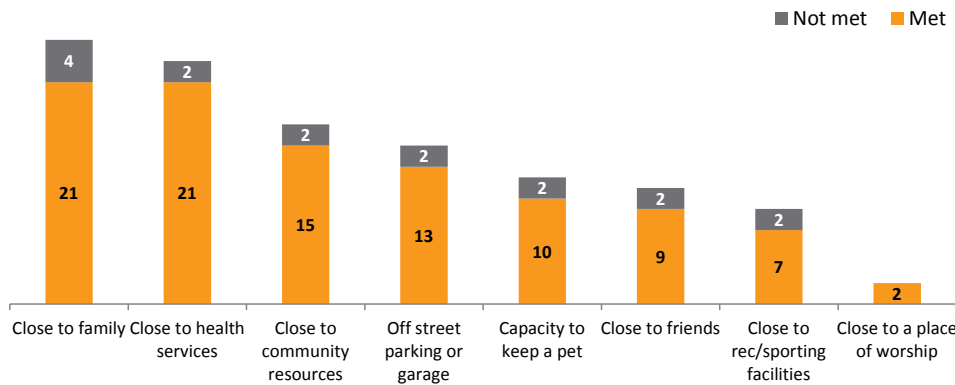


Source: Doorway Stats (November 2013)

3.5.1.1 Specific housing preferences were mostly met

The desired attributes of participants' rental accommodation were ascertained by H&RWs during the intake process. The most commonly expressed preferences were for proximity to family, health services and community resources. Figure 23 below illustrates that the majority of participants' housing preferences were met in the rental accommodation that they eventually occupied.

Figure 23: Met and unmet housing preferences of participants



Source: Doorway program records

3.5.2 The process of finding properties was more important than anticipated

Doorway staff have acknowledged that they initially under-estimated the importance of time spent actually looking for accommodation given the stage in the recovery journey of each participant. Two key lessons were learnt in the process of looking for accommodation:

- **The importance of choice was affirmed** – For many participants, Doorway was the first time ever, or in a long time, that they were able to choose their own type of accommodation. Therefore it was critical for participants to have enough choices to be able to exercise their preferences in what was a momentous decision for most people.
- **External support was invaluable** - Several participants had family members, friend or advocates accompany them to inspections or assist with rental applications. Those participants who received this type of support benefited greatly.

The process of finding rental properties also had a number of positive and unexpected outcomes:

- **The process of finding properties accelerated H&RWs relationships** – One positive effect of the lengthy process of finding suitable properties, was that participants spent a lot of time with their H&RW during the housing process. One H&RW noted that this provided a very good opportunity to properly engage with their clients for the first time.
- **Participants provided peer support**– The Doorway team observed multiple instances of participants helping each other during the process of finding rental accommodation. In one case, one participant who had been looking for a property for three months discussed the rejections he had received with other participants and also provided advice about tenancy applications.
- **Some participants were willing and able to seek housing independently** – In some instances, participants began to source their own means of transport to attend open inspections by themselves, and independently contact Property Managers to make applications.

3.5.3 The initial creation of homes was critical

The first few weeks of turning participants' newly rented houses into homes were critical in the recovery process. H&RWs observed that the majority of participants were initially euphoric about finally having their own house which resulted in a 'honeymoon' period.

For many participants the 'honeymoon' period ended as they started to comprehend the responsibilities associated with managing their own home. The challenges faced by participants ranged from administrative (connecting utilities, updating Government benefits, paying bonds etc.) and daily living skills (learning to cook and operate a washing machine etc.) to more profound issues such as dealing with isolation, re-connecting with family, or reducing their drug use.

"It was a little bit overwhelming for the first couple of days. I didn't realise where I actually was and what I had achieved. I had this renewed sense of responsibility – I had something now that I had to take care of."

Doorway participant

The speed with which participants were able to settle into their homes depended largely on the stage in their recovery. Many participants experienced a significant drop in their moods, while others became anxious about the number of changes they were dealing with. This necessitated additional levels of support from their H&RW, which proved challenging at times for the Doorway team.

3.5.4 Most participants have maintained stable housing arrangements

Based on the range of indicators in Table 10 below, the majority of Doorway participants have had stable, trouble-free tenancies since joining Doorway. These indicators are explored in more detail below.

Table 10: Stability of housing indicators

Indicator	Number
Current participants who have moved into different rental accommodation	9
Lease breaks by participants who have remained in Doorway	6
Notice to vacate instigated by real estate agents	1
Breach of duty notices ³¹	10
Evictions	0

3.5.4.1 Several participants have moved to different properties

As at November 2013, nine current Doorway participants have moved into different rental accommodation. These moves have occurred for a variety of reasons including lease breaks (due to breach of duty notices in one case and the property being sold in another), rental affordability and a desire to move to different suburb or town

Only three of these nine participants have moved more than once. One participant moved three times due to a combination of feeling socially isolated in one home and wanting to re-unite with their partner in another instance. This particular participant observed that "Doorway staff and the landlords have

³¹ A breach of duty notices is a formal warning that can be issued to any party to a lease that is not meeting their obligations under the terms of their rental agreement and the *Residential Tenancies Act 1997* (Vic).

been really supportive each time and made it really easy for me - I now know all about the Tenancy Act and having to give notice and how to pay my bills”.

“I was in a place initially through Doorway – it was good and I’m eternally grateful, but it was a bit small and overpriced. After 12 months, I found a new place to live, I applied for it on my own – it was good to have Doorway to back me up”.

Doorway participant

3.5.4.2 Leases have been broken for several reasons

There have been six instances of lease breaks instigated by either participants or real estate agents. The characteristics of these cases are outlined below:

- All cases resulted in participants moving to more appropriate accommodation
- Three cases involved bullying or threatening behaviour by neighbours
- In most cases real estate agents were generally very understanding of the participants’ needs, and assisted them to find alternate properties and to release the leased property

No or minimal lease break fines were incurred in the majority of the above cases.³² This can be attributed to the strong relationships between Doorway staff and the local Property Managers and ongoing communication between the Property Managers and Doorway tenants – which was typically facilitated by H&RW’s.

3.5.4.3 Breach notices, evictions and property damage remain minimal

As at November 2013, there have been ten breach of duty notices issued across the three catchment regions since the start of Doorway. There has also been one case where a third breach of duty notice resulted in a notice to vacate for one participant.

The reasons for these breach of duty notices include noise disturbances, alleged theft by an associate of one participant, an unkempt garden, harassment of other neighbours and sub-letting against the terms of the lease. In the case of Doorway participants in the Latrobe catchment region, all issues that may have led to breach of duty notices were resolved with real estate agents before they might have escalated.

In addition to the formal breach of duty notices, MI Fellowship have also been notified by Property Managers of numerous verbal warnings and some complaints from neighbours made against Doorway participants.

To date there have only been three instances of property damage. These instances include one case where police entered the unit to conduct a welfare check, another related to an attempted burglary and the third where violence resulted in damage.

3.5.4.4 Incidents have been significantly fewer than anticipated

The number of officially recorded incidents related to Doorway participants has been far lower than originally anticipated by MI Fellowship at the start of the pilot program. To date, there have been single occasions of DoH Category 1 and 2 incidents and six Category 3 incidents reported – as outlined in Table 11 below.

³² In one case the lease fees incurred were paid by MI Fellowship for a participant that subsequently left Doorway and found new employment in WA. This person continues to re-pay the fee amount to MI Fellowship via Centrepay.

Table 11: Officially reported Doorway incidents by DoH category (as at November 2013)

Category	Incidents	Details	Category definition ³³
1	1	<ul style="list-style-type: none"> Possible overdose³⁴ 	<ul style="list-style-type: none"> Incidents that result in a catastrophic outcome, such as death or severe trauma
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 1 definition.
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)

3.5.5 Participants' quality of life has improved due to housing

Participants consulted for this evaluation unanimously cited many positive impacts from having their own stable and secure accommodation. Participants talked about feeling more independent and self-confident, having greater levels of self-respect and finding greater meaning in their lives. Others described the sense of pride that comes from having their own home and the change in status that this has conferred upon them in their local communities.

The feedback from participants in Table 12 below provides an overview of the profound impacts that stable accommodation have had on their quality of life.

Table 12: Participant quotes about Doorway's impact on their quality of life

- “Before Doorway my life was in the gutter. My mental health is under control for the first time and I have gone from being a psych ward patient to not needing my medication and only seeing my shrink once a month. Doorway has allowed me to get away from the wrong influences. I haven't touched drugs and I have got healthy again – which is simply because my life is stable and I have my own place for the first time in 15 years.”
- “I am now like everybody else - I have my own place, on equal terms, on equal footing. I have an address. I have a home to go to in the evening. I can cook my own meals, I'm not different. I may have a mental illness but I can lead a normal life. I have a home, a job. I can move into the community, move into my own place, manage finances, day-to-day living. I don't worry about people dropping me off – they think he's normal, he's no different.”
- “Being homeless – when I look back it was something that wasn't necessarily a choice. But when I really think back to the lowest time in terms of not having a roof over my head, not being able to cook for myself, not being able to have family members know where I was, not being able to care for myself. All those little one per-centers you don't take for granted if you have been [homeless]. Going through what I have been through might just add a little bit to how I look after my place now.”
- “Where I was living before was only short-term. My health was never going to get better there. Moving here is like starting from scratch. I go for walks. I'm learning to cook more things. I'm getting used to being independent.”
- “There hasn't been one day since I've been here that I've felt funny. I've felt sad - but that's not Depression. In the right environment, even with a mental issue, you can get around it. The best thing about the program is that you are given independence. Financially it's been good as well - it hasn't put me under pressure to pay the rent. It's not always a lot of money but at least you have money. So independence and financial stability are the top two things – they are interrelated as well.”

³³ 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>

³⁴ 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.

- “The most valuable thing has been having a secure house –a roof over my head and a place that is clean. Being able to be close to everything helps with the stress of trying to get to appointments – it’s been good not having to stress over things like that.”
- “I’m a lot better if in stable accommodation and taking my meds - I’m able to look after myself. With Doorway I can stay away from bad influences and I haven’t touched drugs since Doorway. I am now independent and can come and go as I please and do things when I want to do them. I am hoping to get work and I have recently enrolled in a self- esteem course. I am feeling hopeful.”

Individuals who had previously resided in group living arrangements also talked about the increased freedom and reduced stress through not having to worry about the permanence and security of their possessions. Moving out of group living also provided a greater sense of personal safety for some participants.

“For the first time I am able to leave my wallet on the table and leave my toiletries in the bathroom.”

“In the boarding house I had people always walking past my room, knocking on my door, the police were coming all the time... not having to worry (about that), and people giving me grief, is really good.”

Doorway participants

Some participants also talked about having more time and space to reflect on their lives, and assess the point that they had reached in their journey of recovery. Others reflected that being in Doorway had highlighted daily living skills that they did not know that they had.

“I have learnt that I can clean!”

“I have learnt that I can manage my own bills.”

Doorway participants

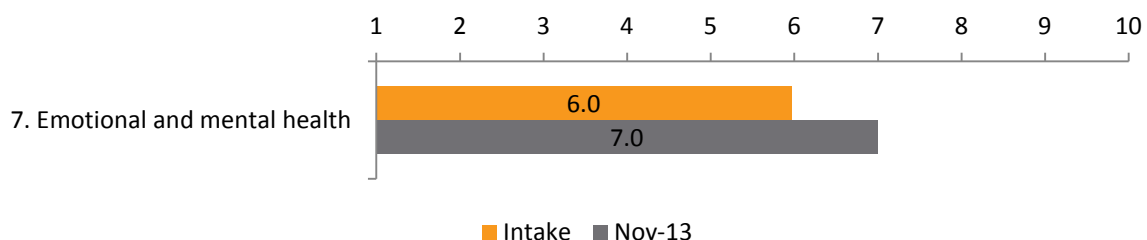
For several participants, having their own house has provided them with the opportunity to make a break from their past. In these cases, choosing accommodation that is away from people with whom they wish to have less contact has been just as important as proximity to their support networks.

*“Choosing where not to live has been as important as choosing where to live.
I wanted a house that was not near my local drug dealers.”*

Doorway participant

Qualitative feedback about improvements to overall wellbeing for participants is supported by quantitative data from outcomes measurement tools. Figure 24 below shows the statistically significant ($P < 0.05$) increase in means scores in the Emotional and mental health ladder of the Homelessness Star.

Figure 24: Mean Homelessness Star scores (n=29)

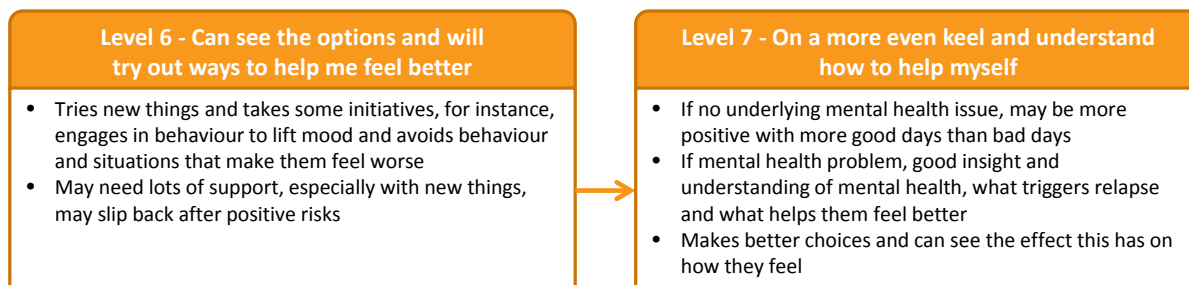


Source: Doorway six-monthly participant data collection

NOTE: An increase in a score represents improvement. Data is presented as the mean \pm standard error. The sample for both measurement periods is drawn from a matched cohort (i.e. participants that have completed Stars at the point of intake and in November 2013). The average time that elapsed between these two measurement periods was 16 months.

The changes associated with stages six and seven in the *Star's Emotional and mental health* ladder of recovery are outlined in Figure 25 below.

Figure 25: Stages in the *Emotional and mental health* ladder of recovery of the Homelessness Star



3.5.6 Participants are developing tenancy management skills

Many Doorway participants have developed the skills required to sustain their own private rental tenancies. This broad suite of skills includes finding suitable properties, communicating and negotiating with real estate agents, maintaining their housing to an acceptable standard, purchasing household supplies, abiding with body corporate rules (where applicable), interacting with neighbours, paying rent on time, and managing tenancy-related paperwork.

Some participants have found it challenging to develop or strengthen the above skills, and for others the transition from having their H&RWs act as a tenancy advocate and conduit to external parties has taken longer than expected.

As at November 2013, thirty one participants have received 12 month lease extensions by their Property Managers. A further three participants were offered another 12 month lease extension, but chose to continue their tenancy on a month to month basis instead. In many of these cases, the participants independently managed the lease extensions with the Property Managers.

As an indicator of one critical tenancy management skill – paying bills on time – only one participant had any utilities disconnected during the first measurement period for this evaluation – with no disconnections in the subsequent three measurement periods.

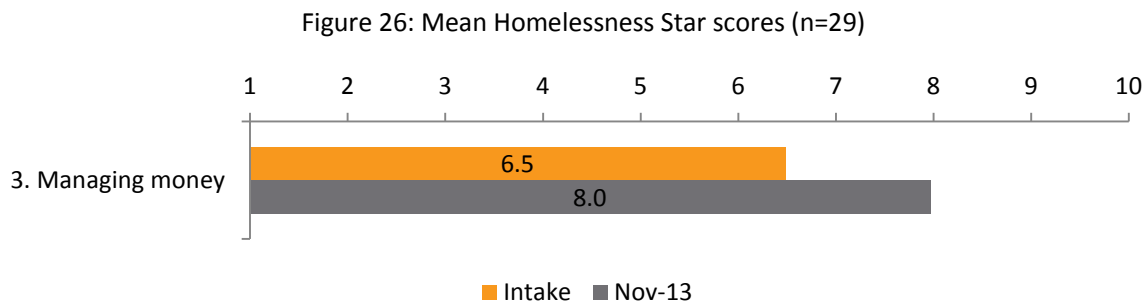
Another critical indicator of sustainable housing is the ability of participants to pay their rent on time. As at November 2013, seven Doorway participants have fallen into rental arrears on one occasion, and four participants have had issues with arrears on more than one occasion. As shown in Table 13 below, arrears were repaid in full to MI Fellowship for almost half of these participants. In the majority of cases, H&RWs have worked with participants to develop plans to better manage future rental payments.

Table 13: Number of participants that have fallen into rental arrears across Doorway

Region	Participants	Arrears paid in full	Agreement to re-pay in effect	Exited Doorway *
Austin	4	2	2	
St Vincent's	5	2	2	1
Latrobe	2	1		1
TOTAL	11	5	4	2

*Agreements are in place with these participants to re-pay arrears to MI Fellowship via Centrepay.

Feedback from participants about improvements in their basic financial management skills is supported by the statistically significant ($P < 0.05$) increase in means scores in the *Managing money* ladder of recovery in the Homelessness Star – as shown in Figure 26 below.

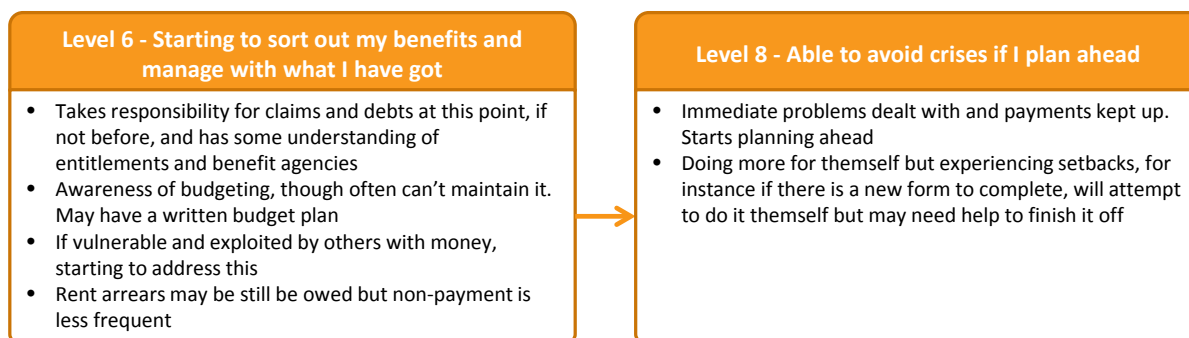


Source: Doorway six-monthly participant data collection

NOTE: An increase in a score represents improvement. Data is presented as the mean \pm standard error. The sample for both measurement periods is drawn from a matched cohort (i.e. participants that have completed Stars at the point of intake and in November 2013). The average time that elapsed between these two measurement periods was 16 months.

The changes associated with stages six and eight in the Star's Managing Money ladder of recovery are outlined in Figure 27 below.

Figure 27: Stages in the Managing Money ladder of recovery of the Homelessness Star



3.5.7 The majority of participants have renewed their leases

Thirty four Doorway participants have been offered and accepted a lease renewal as at November 2013. Of these thirty four, thirty one accepted 12 month lease extensions with three electing to renew their leases on a monthly basis.

3.5.8 Progress towards rental self-sufficiency has been slower than hoped

3.5.8.1 One in five Doorway participants do not require rental subsidies

Ten of the current fifty Doorway participants pay their own rent in full without any rental subsidies from Doorway as at November 2013. Of these ten, five participants in the Latrobe catchment area were already in a position to pay their own rents when they joined Doorway and not in need of any subsidies. The additional five participants received initial subsidies that ranged from \$53 to \$395 per fortnight. The current rents of these participants range from \$400 to \$682 per fortnight.

There are various factors that enabled these five participants to transition towards paying their rent directly to their real estate agents without Doorway subsidies. Two participants began sub-letting their property to a housemate. Other individual cases include one participant who started sharing costs with family members who moved into their property, another participant who has started using their single-parenting-payments to cover rental payments, and another participant who re-established a more stable relationship with their employed partner.

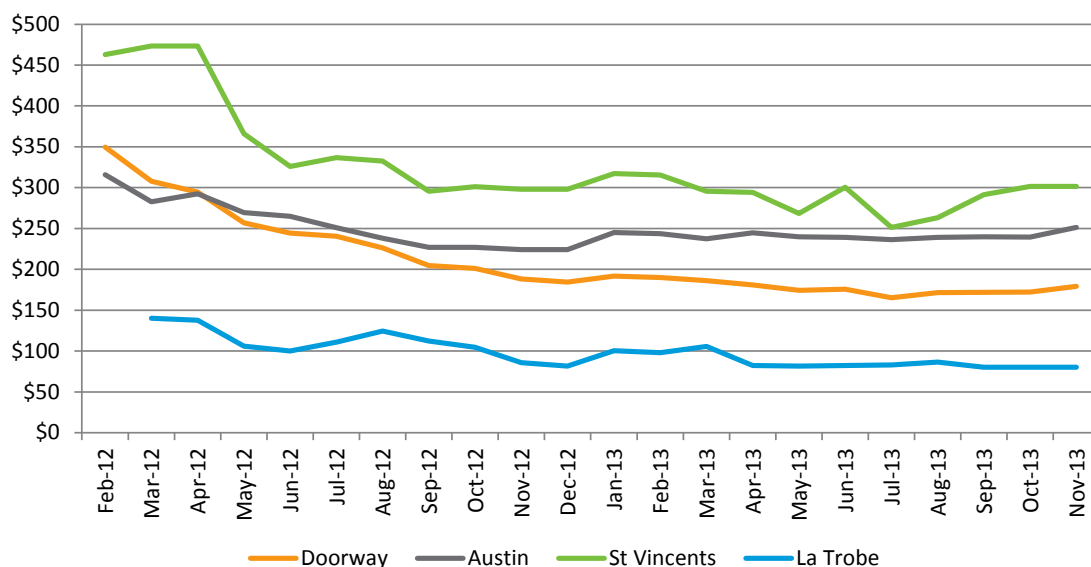
It is worth noting that two of these five participants began working after entering Doorway. These changes in employment status did not directly contribute to these two participants being able to achieve self-sufficiency with their rental payments.

3.5.8.2 Rental subsidies remain static after an initial decrease

As at November 2013, the mean rental gap paid by Doorway to participants was \$194 per fortnight. As demonstrated in Figure 28 below, the mean rental gap across all three regions has remained relatively static for the last 12 months.

Issues of rental affordability have been compounded by the continued increase in rental rates in Melbourne's inner-city areas. For example, in the City of Yarra (the sole St Vincent's Doorway LGA), median rental rates increased by 10% in the first year of the program.³⁵

Figure 28: Mean fortnightly rental subsidies by region



³⁵ Department of Human Services, *Quarterly Median Rents by LGA June 2012*.

Case study 1: Doorway participant

Rob is in his mid-sixties and divorced father of four. He has been an AMHS client since October 2010. He has a history of major Depression and Bipolar Disorder, and is currently on a Community Treatment Order.

Rob has owned his own homes in the past, however following two divorces and significant Depression was homeless. Prior to Doorway, Rob was staying at a local Supported Residential Service (SRS) – a place that he described as “terrible” to live in due to the poor hygiene standards and lack of qualified staff. Rob felt highly stigmatized living at the SRS and he avoided telling people where he lived, visiting old friends, or entering into relationships. He also describes the feeling of disempowerment that comes with institutionalised living arrangements, such as having to organise his work roster around meal times.

Rob entered Doorway in early 2011 and secured a property within a few weeks of joining the program. Rob describes his house as more than just a house— he has a place he can call a home that is a source of great confidence and normality. Having stable accommodation that he is proud of has enabled Rob to re-connect with family and friends. Soon after joining Doorway, Rob spoke with his children for the first time in eight years and later invited them around to his home for dinner.

Rob has also recently entered into a relationship, and has been on a self-described “milestone” holiday in regional Victoria with his new partner to stay with old friends – something he was previously too ashamed to do. At the end of Doorway, Rob will seek to move into a larger unit. “Now that my recovery is going well, I’m cooking again, and I’m in a relationship so I need some more space...I have a good job and my hours are up, so I’m financially stable”. He is now working as a cleaner and earning an independent income.

He is also engaged with his recovery planning and is working with his integrated team to address his issues. Rob describes his support worker as “making an indelible mark”. Rob regularly uses the results from his Homelessness Star surveys as a way of measuring his progress.

In Rob’s words, Doorway has meant that “I am now like everybody else - I have my own place, on equal terms, on equal footing. I have an address. I have a home to go to in the evening. I can cook my own meals, I’m not different. I may have a mental illness but I can lead a normal life. I have a home, a job. I can move into the community, move into my own place, manage finances, day to day living.”

*** Participant name has been changed**

Case study 2: Doorway participant

Ben* is a single middle aged male who has who has experienced long-term Depression. Prior to joining Doorway, Ben had been living in a Supported Residential Service (SRS) facility. Within this environment he felt institutionalised and unable to make his own decisions – “it was like being in a prison”. Doorway has provided Ben with an opportunity to live in an environment with more freedom and choice.

Ben has enjoyed the responsibilities of living alone and attributes the major improvements in his mental health to having a home of his own and “enjoying life again”. Doorway has given Ben a “sense of self-respect... the right to make decisions, to have your privacy. You get your self-respect back. When people ask you where you live you can answer them.”

In the past 12 months he has been discharged from his AMHS and is managing his medication to ensure his recovery is sustained. Ben states that “I don’t see myself as suffering from Depression anymore – I have it but I don’t suffer from it”

Ben has also developed and maintained strong relationships with Doorway staff – whom he has found friendly, approachable and always willing to help. Losing this support will be one of the most difficult things for Ben when Doorway ends. Ben notes that this support is particularly important for participants who are socially isolated themselves.

Ben recognises that the end of the program will be difficult because of his current level of rent he will not be able to maintain his current accommodation after Doorway but is confident about staying in private rental. He is planning ahead. Ben considers a key element of Doorway that “they give you the tools to go out and do stuff yourself – they don’t hold your hand the whole time...they help you, without it being so much that you become reliant... that goes to sustainability once you exit the program.” Ben does have some concerns about how other Doorway participants with more severe mental illness will maintain the transition out of Doorway.

In Ben’s words, “Prior to Doorway I had suicidal thoughts every day – this is now no longer an issue. I’ve been suffering from mental health issues for almost fifty years and my biggest improvement has been the last two years with Doorway - – it all started with getting a house and a good network of support. The best outcome for me is that people don’t think I have a mental illness when they first meet me. People sit next to me on the tram now – they don’t move away.”

*** Participant name has been changed**

3.6 Economic outcomes are slow but encouraging

Positive progress has been made against economic indicators – albeit at a slower rate than other outcome domains. This is to be expected given the long lead times that are normally required for improved economic outcomes to eventuate.

The proportion of participants engaged in paid and unpaid employment increased from 16% at the point of intake to 27% as at November 2013. Doorway's current employment outcomes compare well against other Victorian and interstate programs which seek to reduce homelessness at similar points in time. Outcomes for Doorway participants are also in line with national workforce participation rates for people with a SMI – which are estimated to be between 22-30%. The proportion of Doorway participants accessing education and vocational training opportunities and gaining qualifications whilst in the program has also increased.

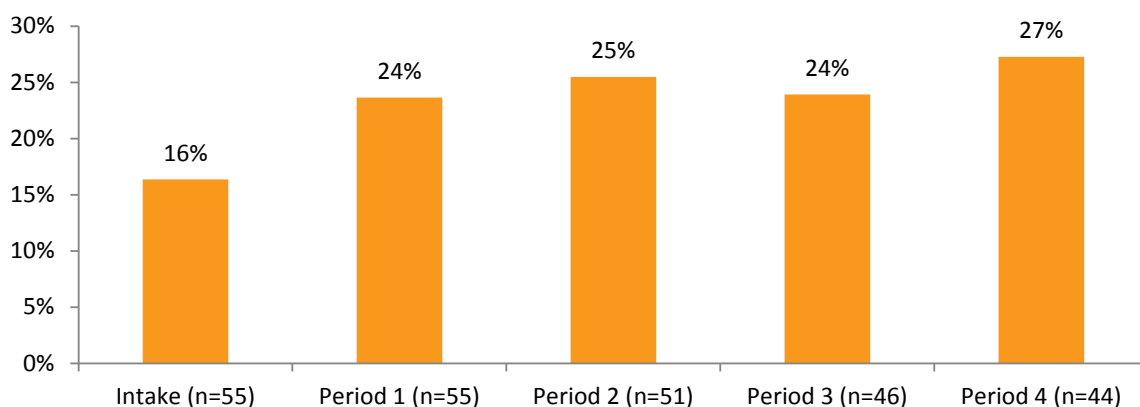
As health and housing outcomes have generally become more stable there has been a natural shift in focus for many Doorway participants towards strategies to sustain these gains – with a particular focus on looking for paid employment. Recent feedback from H&RW's suggests that in the lead up to the end of the Doorway pilot, participants are more proactively engaged in conversations with their H&RW about economic outcomes and meeting more regularly with their employment consultants.

Despite the best efforts of the Doorway team and many participants, further progress against key economic outcome indicators is likely to remain slow. Challenges in increasing workforce participation rates among Doorway participants include the slow pace of recovery for some participants, a soft labour market across the three regions, variable levels in the quality of support provided by employment providers in each region and issues related to accessing transport for many participants.

3.6.1 Accessing employment remains challenging

Sixteen per-cent of Doorway participants were engaged in paid or unpaid work at the point of intake into Doorway. As shown in Figure 29 the proportion of employed participants increased to 27% in the most recent measurement period (Period 4) in November 2013.

Figure 29: Percentage of employed Doorway participants (paid and unpaid work)



Source: Doorway six monthly data collection

The current workforce participation rates for Doorway participants are in line with national rates for people with a SMI– which are estimated to be between 22-30%.³⁶ Increasing workforce participation rates for people with SMI is challenging. This is reflected in the fact that workforce non-participation rates for this cohort have remained stable nationally despite historically low national unemployment rates and an increased policy focus on promoting employment opportunities for people with SMI.³⁷

Box 1: Examples of positive employment outcomes

- Rachel* had not worked for over four years. After entering Doorway and securing stable housing Rachel increased engagement with her employment consultant. Before returning to the workforce Rachel wanted to build her confidence by volunteering which she does two days a week. After approximately three months Rachel successfully applied for a paid position working as a personal care assistant. Rachel has told her H&RW that she is very excited about entering back in to the workforce as well as being able to continue volunteer work.
- Karen* is a parent and had not worked for over five years before entering Doorway. Five months ago, Karen started working two days a week as a kitchen hand at a cafe. Karen enjoys her new job and has received positive feedback.
- Jimmy* has been unemployed for several years. Prior to joining Doorway, Jimmy was living in very basic temporary accommodation on a farm. Jimmy was still very isolated when he first joined Doorway, and it took over six months for him to fully engage in one of MI Fellowship’s local Day programs. After attending classes on cooking and re-learning social skills at the Day program for five months, Jimmy gained enough confidence to join a job support network. Shortly afterwards, Jimmy started volunteering with a local catering company where he helps out in their warehouse and with food deliveries. Jimmy plans to remain in this role while he continues to look for paid employment.

* Participant names have been changed

Doorway’s current employment outcomes compare well against other Victorian and interstate programs seek to reduce homelessness – as shown in Table 14 below. Further details about these and other programs can be found in Appendix D.1.

An analysis of employment outcomes data for J2SI, HASI and other programs similar to Doorway all illustrated the lengthy lead times to achieve even modest economic outcomes.

Table 14: Comparison of employment outcomes with other programs

Program	Indicator	Measurement period	Sample	Participation rate
Doorway	Engaged in <i>paid or unpaid</i> work	November 2013	44	27%
HASI ³⁸	Engaged in <i>paid or unpaid</i> work	September 2009	639	19.2%
J2SI ³⁹	Engaged in <i>paid</i> work	24 months	36	8.3%
	Looking for <i>paid</i> work	24 months	36	36.1%
Way2Home ⁴⁰	Engaged in <i>paid or voluntary</i> work	12 months	31	6.4%

³⁶ Waghorn G. and C. Lloyd (2005), “The employment of people with mental illness,” *Australian e-Journal for the Advancement of Mental Health*, 4, pp. 1–43.

³⁷ Waghorn G., D. Chant, C. Lloyd, and M. Harris (2011), “Earning and learning among Australian community residents with psychiatric disorders,” *Psychiatry Research*, 186 (1), pp. 109–116.

³⁸ Bruce J., S. McDermott, J. Ramia, J. Bullen and K. Fisher (2012), *Evaluation of the Housing and Accommodation Support Initiative (HASI): Final Report*, Social Policy Research Centre UNSW, p. 99.

³⁹ Johnson, G., Kuehnle, D., Parkinson, S. & Tseng, Y. (2012) *Meeting the Challenge? Transitions out of long-term homelessness. A randomised controlled trial examining the 24 month costs, benefits and social outcomes from the Journey to Social Inclusion pilot program*. Sacred Heart Mission, p. 51-52.

Indicators for participants that remain unemployed show slow but positive progress over time towards better employment outcomes – as shown in Table 15 below.

Table 15: Unemployed Doorway Participants (matched cohort of n=34)

Indicator	Intake	November 2013
Unemployed participants taking appropriate steps to find work	24%	38%
Unemployed participants seeing an Employment consultant	26%	35%

Despite these changes, there continue to be multiple barriers impacting on people's ability to work:

- **Ongoing recovery challenges** – Many participants do not feel that they are currently well enough to work or look for employment
- **Discouragement from natural support network members** - In a handful of instances participants have been discouraged from seeking employment by family members who do not want them to work for reasons related to their recovery
- **Soft labour market** – Unemployment rates have increased since the start of the Doorway pilot, and labour market conditions remain particularly challenging in Gippsland
- **Variable support by employment providers** – The quality, frequency and appropriateness of the support offered by the various employment providers across the three regions has been variable (as discussed in Section 6.3 of the *Formative Evaluation Report*)
- **Transport accessibility is a challenge** – Despite being able to afford to live closer to public transport, many participants in the Austin and St Vincent's catchments are only offered employment opportunities in outer suburban areas or at times of the day that require a car to access (which the majority of participants do not have). These difficulties are even greater in Gippsland, where appropriate employment opportunities are more geographically dispersed.

Figure 30 below shows that half of the Doorway participants that were not employed as at October 2013 cited their disability as the primary reason why they were not working.

Figure 30: Primary reason for not working as at October 2013 (n=31)

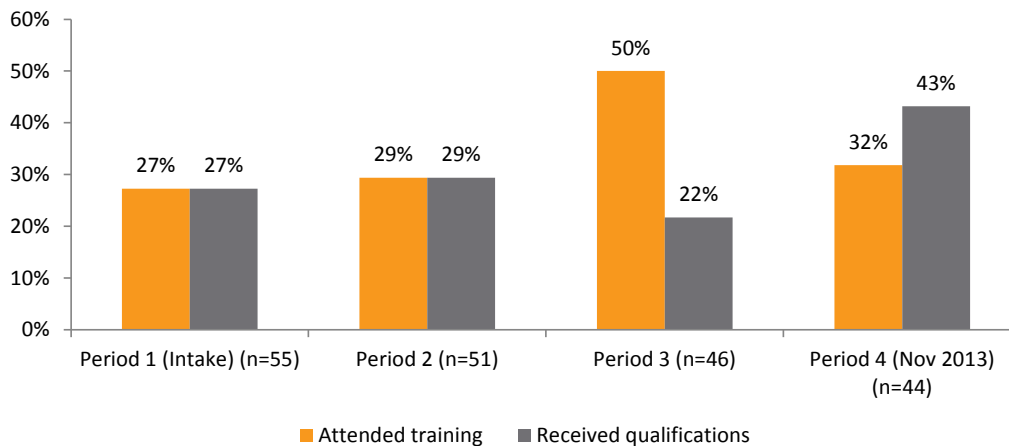


⁴⁰ Parsell, C., W. Tomaszewski and A. Jones (2013), *An Evaluation of Sydney Way2Home: Final Report*, Institute for Social Science Research, the University of Queensland, p. 41.

3.6.2 Access to training has improved

The proportion of Doorway participants accessing education and vocational training opportunities and receiving qualifications whilst in the program has increased – as shown in Figure 31 below.

Figure 31: Access to education and vocational training



3.7 Levels of social inclusion have improved

Social inclusion outcomes have improved for many participants; however several of the H&RWs have noted that progress for some has been slower than in other outcome areas. Most of the discussions to date between H&RWs and participants related to improving social inclusion outcomes have occurred in the context of the Homelessness Star.

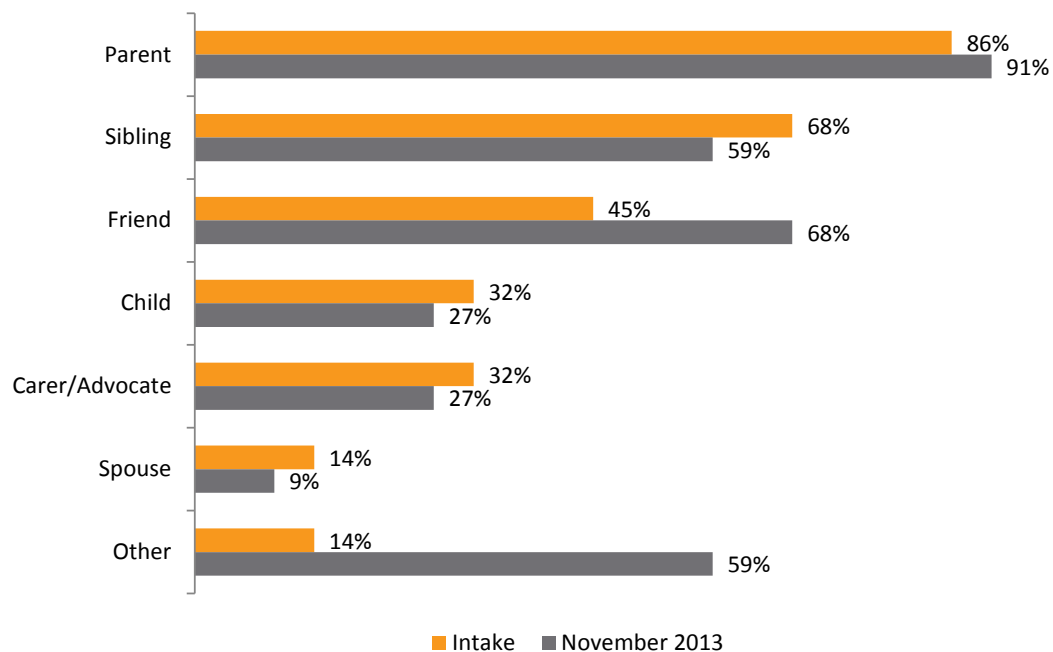
Many of the improvements that have occurred in social inclusion outcomes since the start of Doorway have been attributed by participants and H&RWs to greater housing stability. Having their own house has also brought a new set of opportunities and challenges for participants as they have sought to build or rebuild their social networks.

3.7.1 The composition of natural support networks has changed

The composition of participants' natural support networks have evolved over time. Figure 32 below shows that friends in particular are playing a more active role in supporting the recovery of participants. The growth in the 'other' category includes natural supports such as participants' neighbours, work colleagues, members of their religious/spiritual group and local shop and café owners.

Feedback from H&RW suggests that the current composition of participants' natural support networks will remain the same post-Doorway for the majority of individuals (84%).

Figure 32: Natural support network composition over time (matched cohort of n=22)



Source: Doorway six monthly data collection

3.7.2 Participants are rekindling old and developing new relationships

Qualitative feedback indicates that the newfound stability created by Doorway has enabled many participants to reconnect with family and friends and to develop new friendships and relationships. Examples of these new relationships are provided in Box 2 below.

Box 2: Examples of social inclusion outcomes

- Stephen* has been reunited with his two adult children following his period of homelessness. They are now in regular contact
- With improvements in her mental health, Kylie* is now looking after her sons for a few days every fortnight, which was something she'd been hoping for and working towards
- Leanne* can now see her children three times a week. She has set up outdoor play equipment for their visits
- Andrew* reflected on how he used to hate going home when he was in a boarding house. His father recently stayed for the weekend in his second bedroom
- Simon* has got a new mobile phone plan so he called his sister in Perth and spoke for 2 hours – which was their first conversation in a long time. He's recently become involved with Yarra Men's Shed and is friendly with a nearby Doorway participant
- Sally* has had her mother and grandmother move into her unit with her. By sharing, they can pay their rent independently and provide regular support to each other
- Craig* was keen to find a place close to his mother. He is now settled in nearby and is seeing his mother on a more regular basis
- Keith* has formed a friendship with his neighbour who has given him pre-cooked meals
- Harrison* reconnected with friends to have a garage sale.

* Participant names have been changed

Source: Model Development Committee Minutes, Doorway 2012 Project Update

The stability provided by Doorway has also enabled some participants to attend Family Court hearings related to their children. Examples where participants have attended Family Court hearings since joining Doorway include:

- One participant attended a hearing to determine ongoing care arrangements for their child. The resulting decision ruled that the child would remain in the care of its grandparent, but that the participant could now visit their child without DHS interventions and involvement
- One participant attended a hearing to negotiate custody of their children which resulted in the participant being granted increased supervised accesses to their children with one overnight stay
- One participant is currently attending ongoing hearings related to custody of their children with support of DHS staff.

Other examples of participants being able to manage ongoing domestic issues since joining Doorway include three instances where participants attended or were scheduled to attend court hearings related to intervention orders (IVO) against abusive ex-partners. In two of these cases, the IVOs were upheld.

3.7.3 Social isolation remains a challenge for some

Some of the participants consulted as part of this evaluation spoke about the varying levels of loneliness that they experienced when they first moved into their own rental accommodation. Most participants experienced a period of prolonged adjustment as they learnt to manage long days alone and establish new daily routines in a completely new environment. This transition was especially stark for participants who had moved from boarding houses or bed-based treatment facilities such as CCUs where they were constantly surrounded by other people. It should be noted that all people, regardless of mental illness, take time to adjust to new surroundings and engage with new communities, so the challenges experienced by participants are not out of the ordinary.

“The loneliness is tough - you have to pull yourself out of bed.”

“Being lonely sometimes means you need company.”

Doorway participants

Despite these initial challenges, quite a few of the participants reported that they had got better at managing their initial feelings of being alone. The speed with which participants were able to make this transition successfully depended largely on the stage of their recovery, the proximity of social networks, their familiarity with the local area, and their ability to have someone else move in with them.

“Once I got used to being on my own it was good.”

“I would have preferred to be sharing with someone else.”

Doorway participants

For some participants, feelings of social isolation remain a challenge. These challenges are typically compounded by an absence of social support for these participants. One H&RW noted that many of their clients lacked satisfying intimate relationships and that attempts to establish deeper friendships with acquaintances at places such as their local pub or gym were often mixed.

Given that the void of meaningful relationships for many Doorway participants is currently being filled in part by their H&RW, improving the levels of social inclusion for these participants in a sustainable manner remains a key goal ahead of the pilot ending June 2014.

“In the last 12 months my Depression has improved. I’m regularly seeing my H&RW – normally weekly. We usually just talk about my health, how I’m feeling. I’ve been provided resources for employment agencies, but mainly it’s just comforting to have someone visit me. I don’t have many people visit me – I’ve pushed a lot of people out of my life.”

"I see my H&RW once a fortnight. It's nice to just know that someone is there. If it wasn't for Doorway I'd still be in a rooming house – just me and my suitcase. It's not just about the rent subsidy – it's the support, having my H&RW to back me up with problems."

Doorway participants

3.7.4 Anti-social behaviour has decreased over time

3.7.4.1 The initial transition from congregate living was a challenge for some participants

For some participants, adapting to private rental was an initial challenge after entering the program - particularly for those participants that were living in boarding houses prior to Doorway. One of the key determinants of how well these individuals have been able to transition out of supported group living is the extent to which they have been able to make a break from the culture of boarding houses and establish new behavioural norms and expectations.

Managing relationships with boarding house associates who might engage in theft or substance abuse also proved challenging for some participants. As one H&RW noted, the higher number of complaints from neighbours about those participants who formerly lived in boarding houses could be due to these participants having become desensitised to the impact of their behaviour on others due to prolonged periods in boarding house accommodation.

Box 3 below outlines several examples of participants that have struggled with the transition from a boarding house environment to private rental accommodation.

Box 3: Selected cases of participants who left group living and boarding houses

- Before Doorway, Joe* lived in a boarding house and had spent time being primarily homeless. Joe is diagnosed with Schizophrenia and has an addiction to alcohol and methamphetamines. Before he joined Doorway, Joe stated that he would likely be dead if he stayed in a boarding house any longer. Joe has lived in his house for seven months and has had serious challenges with personalising his own space and creating a home, and with mastering daily living skills such as cooking, cleaning and managing his finances. He has also found it difficult to engage with his local community. Coming from a long history of temporary accommodation, Joe has had an "open-house" culture at his rental property. This has resulted in Joe engaging in risky behaviour and having people coming into his house uninvited or leaving his house unlocked when he is not there.
- Dave* lived in boarding houses for 18 months prior to entering Doorway. Dave would occasionally go back to the boarding house to see friends and spend time there for the first few months after entering his own accommodation. After a period of about 3 months, Dave stopped going to the boarding house and instead chose to have friends and acquaintances visit him at home. This resulted in people often coming around to his unit that he did not know, and Dave suspected that people had been using his home as a safe and secure place to use substances. This led to a number of complaints by neighbours that he was subletting to different people as well as complaints of noise disturbance. The Doorway team subsequently worked with Dave to move to a new property with another real estate agent.
- Tim* lived in boarding houses prior to entering Doorway. Shortly after securing private rental accommodation, Tim's neighbours started to complain about noise disturbances, Tim climbing up his balcony to get in to his property, and urinating in public. Tim was subsequently supported to break his tenancy and move to a new property that was more suitable. Tim has now been living in a new unit for 6 months. However, similar complaints from neighbours have arisen, as well as additional complaints about harassing other neighbours and asking for money. Tim is now on a second breach notice.
- Shortly after moving out of a boarding house and into his own rental accommodation, Bob* started to experience overwhelming feelings of loneliness and ended up spending the majority of his time back at the boarding house. Bob subsequently became unwell and developed acute paranoia in relation to his unit and living within the private rental market. As a consequence Bob exited Doorway and moved back into the boarding house.

*** Participant names have been changed**

Source: Emails from Doorway staff

3.7.4.2 Interactions with the justice system have typically been positive

As at November 2013, there have been nineteen reported instances of interaction with the courts system related to criminal or civil matters by eleven Doorway participants. Five of these participants had two or more interactions with courts since the start of Doorway and one participant is currently attending a series of ongoing hearings related to a family matter.

The reasons for these interactions have varied from determining custody and ongoing care arrangements for children, applying for or being the subject of Intervention Violence Orders (IVO), reviews or breaches of Community Based Orders (CBOs) and suspended sentences and Community Corrections Orders that were issued prior to Doorway. The majority of interactions have resulted in positive outcomes such as intervention orders not being placed or lifted. Examples of cases with positive outcomes are provided in Box 4 below.

Box 4: Examples of positive interactions with the judicial system

- Jeff* attended a hearing related to a resisting arrest charge that was placed prior to the participant entering Doorway. The charge was subsequently dismissed due to Jeff's ill mental health at the time of the incident as well as the letters of support that were provided - including ones from Doorway staff
 - Larry* attended a hearing related to breaking and entering charges that were made while the participant was in Doorway. Larry received a good behaviour bond as a result of the hearing
 - Paul* attended a hearing to review a CBO which was subsequently lifted
 - Jim* broke a corrections order but escaped a custodial sentence due to meetings with correctional officers and having a good care team in place
 - Nathan* attended a hearing related to a breach of their CBO. The fact that Nathan had secured stable accommodation through Doorway met a key condition imposed by the judge and the Order was lifted
 - Rohan* attended hearing to successfully appeal suspension of his driver's license due to drink driving
 - Hamish* successfully applied to court to have his traffic fines dismissed.
- * Participant names have been changed**

Source: Emails from Doorway staff

There have also been cases of participants who had contact with the justice system or committed offences prior to joining Doorway, who have not had subsequent contacts or committed further offences since joining Doorway. These cases include:

- One participant who was charged with armed robbery and was incarcerated in Melbourne Assessment Prison (MAP) for six months prior to entering Doorway who has not had any further contact with criminal justice system whilst continuing to comply with their Non-Custodial Supervision Order (NCSO)
- One participant who reported vandalising public areas and breaking into houses whilst under the influence of drugs and alcohol has since become abstinent since securing stable housing.

3.7.4.3 Participants have interacted with police for a variety of reasons

As at November 2013, there have been twenty-one reported instances of interaction with the police related to eleven Doorway participants. Four participants have had interactions with police on more than one occasion. These interactions occurred for a wide variety of reasons – which are outlined in Appendix C.1. These interactions with police have resulted in charges being laid in only one case, where a participant was arrested for breaking and entering, and subsequently placed on a good behaviour bond.

3.8 Post-Doorway participant outcomes are varied

To date, nine participants have formally left the Doorway pilot program – two in the Austin catchment, four in the St Vincent’s catchment and three in Latrobe. The period of time that these participants were housed in rental accommodation ranged from 3 to 21 months – with an average of 11.5 months.

There have also been several other instances where participants have come close to exiting the program – usually due to financial pressures – but plans were made for participants to remain housed in a sustainable manner.

The reasons why participants chose to leave Doorway and their post-program outcomes are varied, and have reflected both positive steps and recovery challenges. The individual cases of each of the nine participants who have left Doorway are outlined in more detail in Table 16 below. It is important to note from the perspective of future implementation of the model that participants who have experienced ongoing recovery challenges after leaving Doorway all have complex support needs. Further investigation is required to determine whether the complexity of these participants’ needs was greater than those of other participants who have remained in the program – which could lead to changes in the design of the Doorway model.

Table 16: Overview of participants that have left Doorway

Positive steps to recovery	Ongoing recovery challenges
<ol style="list-style-type: none"> Participant moved into a house purchased by their grandparents in a neighbourhood close to their rental property. At the time of the transition out of Doorway this participant had recently moved from a volunteer role at an aged care facility to a paid job as a cleaner at a high school. Their supports post -Doorway include a drug and alcohol counsellor. Participant is paying their rent and has strong natural supports and completed a detox program. Participant chose to move out of their neighbourhood and into a flat with a friend. Doorway staff were recently informed that this participant had started a full-time job and that their recovery was going well. Participant chose to move to Western Australia to re-connect with their family. At the time of the move this participant had been working as a cleaner for several months and was supported to secure this employment whilst receiving support from Doorway. The participant is now working in WA and continues to pay back rental arrears to the program. Participant chose to move in with their partner in a new neighbourhood and start a family. 	<ol style="list-style-type: none"> Participant chose to break their lease and exit Doorway due to committing to a long term (12-18 month) detox and rehabilitation program. This participant subsequently exited the program within 24 hours of entry and moved into a rooming house. Prior to entering Doorway this participant was primarily homeless Participant was hospitalised twice during their time in Doorway due to deterioration in their mental health. This participant was taking positive steps in their recovery but did not enjoy living independently and chose to break their lease after six months to move back into their previous supported accommodation Participant exited after receiving three Breach notices and a Notice to vacate, due to numerous complaints from neighbours alleging verbal abuse, threats and harassment. After leaving Doorway the participant was accepted into a short-term women’s crisis accommodation program. They were subsequently evicted from this facility after assaulting a staff member. The participant later presented at mental health services in NSW, and current reports indicate that the participant is hospitalised in Brisbane. Offers of support by Doorway during this period were not utilised Participant exited Doorway after leaving two rental properties due to Breach notices related to neighbour complaints about noise, numerous police attendances, and public acts of indecency. This participant still has significant mental health and drug dependence issues and moved into a boarding house Participant chose move back in with their partner after one month. The participant was also concerned about having insufficient funds to sustain their rent post housing.

3.9 Doorway has provided support for families and carers

The families and carers consulted as part of this evaluation⁴¹ indicated that the greater stability provided by Doorway has had positive impact on their relationships with the individuals they are involved with. Families and carers also reported that their ongoing interaction with H&RW has made them feel less isolated and more supported about decisions they make related to the welfare and wellbeing of the Doorway participants they care for.

Feedback from H&RWs also suggests that Doorway may have had a positive impact on carer attitudes about the extent to which the Doorway participants can live successfully outside a supported accommodation setting.

Case study 3: Doorway carer

Mary's* daughter Sarah* has been part of Doorway for the past 18 months. Sarah is in her late forties and following two marriages and separations has been living at home since 2009. Before Doorway, "it wasn't easy having her here, with all the problems, you didn't know from day to day what was going to happen... It caused friction between Sarah and I, between myself and my husband. Her other siblings were also upset— there was a lot of disharmony".

Mary reflects that since entering Doorway, "Sarah has managed very well living on her own, which we didn't think was going to happen. Doorway has given her the independence that she needed – which is something she hasn't had for a long time. She is motivated to find work – it has been slow and there have been some hiccups, but she has a trial shift and hopefully something will come of that." Most importantly, Mary's relationship with Sarah has "improved 100%" since she entered Doorway.

Following Doorway Sarah will move to a cheaper unit. Sarah and Mary are both optimistic about Sarah staying in private rental, and they are proactively looking for more affordable accommodation. Sarah will still need some assistance from her family to arrange the rental, but she is not anxious about moving.

Doorway has also positively impacted on Mary, as she feels that Sarah's H&RW is "there if I need to speak to her".

*** Names have been changed**

Case study 4: Doorway carer

Lynne's* nephew Tony* has had a long history of involvement with mental health and housing services. As a result of his mental illness, Tony has been admitted to in-patient beds multiple times, spent time been in residential rehabilitation facilities and lived in transitional housing.

From Lynne's perspective, it was important for Tony to move out of a "circular environment, where you are surrounded by others with mental illness". Doorway has enabled Tony to be "quarantined from the negative influences in shared residential and can get on with thinking positive – it's so important for Tony to see a future".

Since joining Doorway, Lynne has observed that Tony has started taking more care in his appearance and presentation, is seeking budgeting advice and beginning to form a social relationship with his landlord. Through these changes Lynne has seen a "gentle confidence slowly starting to re-emerge" in Tony.

For Lynne personally, she has been able to get personal support and direction by talking to Doorway staff. This has provided her with "affirmation that I'm making the right decisions in respect of Tony."

Lynne acknowledges that Tony still has a long way to go in his recovery journey, and that he will struggle to maintain his current rental accommodation if he continues to live by himself. Tony is currently talking to Lynne about seeking a housemate to help with the rent, "but on his terms". In Lynne's words, "while Tony still has a significant journey, it [Doorway] has given him security and a safe place that is his own."

*** Names have been changed**

⁴¹ Details of consultations undertaken throughout the evaluation are contained in Appendix A.5.

4 There is an ongoing need for Doorway

There is a clear and compelling case for an ongoing role for Government in funding the Doorway program. This case is based around the following:

- **Doorway addresses historical service delivery challenges** - Doorway responds to a historic absence of coordinated, collaborative and reliable recovery-based mental health services and counters prevailing wisdom about the separate delivery of mental health and housing supports.
- **Integrated, flexible and person-centred services are becoming the norm** - In recent years there has been a clear and rapid move towards delivery of programs like Doorway that are client-directed, person-centred and family-inclusive support services and have a broad focus on improving health, social and economic outcomes.
- **Demand for equivalent Doorway services will increase** – Based on current demographic and population health data, and trends towards integrated service delivery, demand for the types of community-based mental health and housing support services provided by Doorway is projected to increase.
- **Stand-alone housing options for people with a serious mental illness remain limited** - Suitable, stable and sustainable housing options are currently very limited for those Victorians with a serious mental illness. For those individuals who may be able to live independently with psycho-social outreach support but do not own a home or live with family or friends, the two main available housing options are social housing and private rental accommodation.
- **Comparable programs do not exist in Victoria** - Doorway is currently the only Government funded program targeting Victorians with a serious mental illness who are homeless or at risk of homelessness that provides the type of comprehensive and long-term support required for people to access and sustain private rental accommodation.
- **Doorway has unique features and benefits**– Despite the introduction of similar Government funded programs since the inception of the Doorway pilot, the Doorway service model continues to provide unique benefits.

Each of the above arguments is explored in more detail below.

4.1 Doorway addresses historical service delivery challenges

The Doorway model is an attempt to redress the historic absence of coordinated, collaborative and consistently reliable recovery-based services for people with a mental illness. The model also counters prevailing wisdom in the Government mental health sector about separating the delivery of mental health and housing support across different agencies.

4.1.1 Mental health services have been fragmented and insufficiently responsive to need

Mental health service delivery until recent times in Australia has often been fragmented, poorly coordinated and not integrated with other service systems. This has led to a mental health system that has been heavily reliant on the goodwill and commitment of families and other carers to fund and resource recovery-based care. Results from a 2010 survey by the Mental Health Council of Australia (MHCA) of carers of people with a mental illness found that 77% of respondents were responsible for

organising the majority of care for the person they care for. Clinical staff including case managers organised 10.6% of care, with community workers arranging slightly more at 13.9%.⁴²

Further MHCA research found that carers strongly support the integration of other forms of support with standard mental health treatment and psychosocial rehabilitation services. Carers favour a more holistic approach to recovery for consumers which includes supported work and study opportunities, access to a range of different health professionals, integration with drug and alcohol services, and assistance in building independent living and social interaction skills.⁴³

The case for integrated and recovery based support services is even more compelling from a consumer perspective. As the 2011 Australian Government Budget Paper on national mental health reform⁴⁴ stated, people with serious mental illness have to “deal with fragmented and uncoordinated systems”.⁴⁵ It continued: “despite previous attempts at reform and investment by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don’t know where to find it, and are falling through the cracks in the system. The families and people who care for them struggle with a system which often causes them frustration and even despair.”⁴⁶

In addition to fragmented and uncoordinated services, there has also been the lack of a holistic focus across all domains of recovery for people with a mental illness. A 2010 survey of people living with psychotic illness found that just over half (56%) of respondents reported receiving no or only minimal support in the preceding four weeks to maintain performance across the domains of work, study and activities of daily living.⁴⁷ One in three (31%) were receiving modest or moderate support and only 13% were receiving significant, comprehensive or total support. The same survey also found the main challenges identified by people living with psychotic illness relate to financial, social and employment outcomes.⁴⁸

4.1.2 Mental health and housing services have been delivered separately

PDRSS and housing providers have historically found it difficult to deliver coordinated and effective services to people with a severe mental illness. This is largely due to a historical separation of housing and mental health in different Government portfolios and long-held attitudes about how these services should be delivered to clients.

From the early 1990s, the prevailing wisdom in the mental health sector has been that housing and support should be provided by different agencies. Historically, supported housing in the community (such as group homes) was typically owned or leased by mental health agencies. Staff supervised residents’ behaviour as tenants as well as monitoring their mental health status. In addition, consumers often had to ‘progress’ through different levels of supervised accommodation, called the ‘residential continuum’, before gaining access to independent housing.

In Victoria, this arrangement changed in the early 1990s, with housing management being separated from provision of support. Firstly, in 1991, the independent living requirement for public housing was

⁴² Mental Health Council of Australia (2010), *Mental Health Carers Report*, p. 20.

⁴³ Mental Health Council of Australia (2009), *Adversity to Advocacy - The Lives and Hopes of Mental Health Carers*, p. 27.

⁴⁴ Australian Government (2011), *Budget: National mental health reform*.

⁴⁵ Ibid., p. 5.

⁴⁶ Ibid., p. 12.

⁴⁷ The survey used the Multidimensional Scale of Independent Functioning was used to provide a global measure of the level of formal and/or informal support from any source that participants had received in the four weeks prior to interview. The model took into account the frequency, quality and proximity of support, who provided this support (family, friends or professionals) and consequences if support was absent.

⁴⁸ Department of Health (Cth.) (2010), *People living with psychotic illness*, p. 84.

abolished. Next, a proportion of new public housing was targeted for people with disability, on condition that off-site support would be provided. This pilot was called the Housing and Support Program (HASP).⁴⁹ It built on the work of US experts such as Dr Paul Carling, who showed that, with support, people with psychosocial disability could live in independent housing, which they preferred. He argued against the demeaning and self-defeating ‘residential continuum’.⁵⁰

NSW’s recent Housing and Accommodation Support Initiative (HASI) also separates housing and support, making use of different types of social housing. Doorway takes this ‘normalising’ approach a step further by assisting participants find rental accommodation in the private market rather than through public housing. In line with the principles of housing and support, Doorway does not manage the participants’ rent or their accommodation. Instead, Doorway facilitates access to rental accommodation which is provided by landlords or real estate agents on their behalf.

4.2 Integrated person-centred services are becoming the norm

The delivery of community-based services for people with mental health issues has shifted fundamentally in recent years both in Victoria and nationally. There has been an explicit move towards more client-directed, person-centred and family-inclusive support services with a broader focus on improving health, social and economic outcomes.

This evolution aligns directly with the Victorian Government’s Priorities for mental health reform 2013-15⁵¹ and the Mental Health Community Support Services (MHCSS) program⁵². The shift to more client-directed and person-centred services also reflects the broader Services Connect and Community Services Sector reforms in Victoria, and the introduction of the National Disability Insurance Scheme (NDIS).

The design of the Doorway model aligns with many of the intended outcomes of these major reforms. The extent of this alignment with several of these major policy reforms is explored below.

4.2.1.1 Doorway embodies the core tenets of Services Connect

Doorway embodies many of the core tenets of the Victorian Government’s *Services Connect* reforms - service-integration, capability building and self-management. In practice, Doorway has addressed several of the key systemic problems outlined in *Human Services: The Case for Change* - the policy platform for Services Connect. These problems include:

- A fragmented and poorly coordinated system that largely focuses on particular issues or groups of vulnerable people without a ‘whole of system’ view
- A program focus - where the onus is on people to make sense of services, navigate from door to door and ‘fit’ a program to qualify for support, rather than a client focus
- A system that is crisis oriented and gives priority to immediate support and stabilisation, at the expense of programs that build on a person’s strengths and capabilities.⁵³

⁴⁹ Robson, B (1995) Can I Call This Home? *An evaluation of the Victorian Housing and Support Program for people with psychiatric disabilities*. Melbourne, VICSERV.

⁵⁰ Hogan, M & Carling, P (1992) “Normal Housing: A key element of a supported housing approach for people with psychiatric disabilities”. *Community Mental Health Journal*, 28(3), 215-226.

⁵¹ Department of Health (2013), *Victoria’s priorities for mental health reform 2013 – 2015*

⁵² Currently operating as the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program.

⁵³ Department of Human Services (2011), *Human Services: The case for change*, p. 16.

The level of alignment between Doorway’s service model and the four key elements of the Victorian Services Connect model⁵⁴ are explored in Table 17 below.

Table 17: Core elements of the Victorian Services Connect model

Key element	Extent of Doorway alignment
1. One assessment so that individuals and families only have to tell their story once	HIGH – Doorway works in an integrated way with clinical and community services to establish an integrated team with a single plan.
2. One key worker who works with people most in need	HIGH – H&RWs take a lead role in coordinating support to the individual and their family. A single H&RW provides continuity of care.
3. One plan focused on building people’s strengths and capabilities and helping them move towards greater independence	HIGH – Doorway develops client-centred plans that are built on the individuals’ and their families’ strengths and resources. Individuals are supported to drive decision making and develop self-management skills. Doorway plans are holistic and support greater social and economic independence.
4. Different levels of support to meet people’s needs as they change over time	HIGH – Doorway provides higher intensive support as people establish their lives in the community and in times of stress and mental ill health. The Doorway model intentionally builds skills to provide less intensive support as self-management skills develop.

4.2.1.2 Doorway follows the principles of Service Sector Reform

The principles and values underpinning the design and implementation of the Doorway model closely align with the Statement of Principles outlined in the Final Report for the recent Victorian Service Sector Reform project led by Peter Shergold. The extent of alignment against applicable principles of the Victorian Service Sector Reform is shown in Table 18 below.

Table 18: Doorway alignment with the Victorian Service Sector Reform’s statement of principles

Principle	Extent of Doorway alignment
1. Achieving the best outcomes for clients	HIGH - Doorway has demonstrated high levels of public value and improved quality of life for participants to date
2. A holistic approach	HIGH - Services are delivered in an integrated and holistic way and in accordance with a client plan
3. Partnership	HIGH - There are strong partnerships between Doorway and clinical, real estate, employment services partners and Doorway participants
4. Shared governance	MEDIUM - Government representatives have maintained full participation on governance of Doorway, including through the Advisory Committee and regular evaluation meetings over the full period of the program
5. Provider choice	N/A - Doorway is a pilot program
6. Program flexibility	HIGH – Doorway services are evidence based and tailored to each of the regions where it operates, and to the needs of the people participating in the program

⁵⁴ Department of Human Services (2013), *Services Connect: Better services for Victorians in need* <<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/cross-departmental-projects-and-initiatives/services-connect>>

Principle	Extent of Doorway alignment
7. Citizen control	HIGH – Choice for Doorway participants includes where they live, who is part of their integrated support team, how often and where they see their Housing and Recovery Worker, and when start looking for a job if they are not already employed.
8. Public accountability	HIGH - This evaluation will provide a high level of transparency and accountability, with a focus on outcomes and program management
9. Early intervention	N/A - Doorway is specifically focused on people who are homeless or at risk of homelessness
10. Facilitation	N/A - This principle applies to Government

4.2.1.3 Doorway aligns with the features of MHCSS

The design and implementation of the Doorway service model closely follows the intended direction of the Victorian Government’s current community-based mental health service reforms, which will see the introduction of Mental Health Community Support Services (MHCSS) in place of elements of the current PDRSS program. The levels of alignment between Doorway and the ten features of the new MHCSS delivery system outlined in the reform framework are shown in Table 19 below.

Table 19: Doorway alignment with MHCSS reforms

Key MHCSS feature ⁵⁵	Extent of Doorway alignment
1. Easy to access services and a focus on those most in need	MEDIUM – Doorway focuses on those most in need through prioritising people with serious mental illness who are at risk of homelessness. Doorway’s accessibility is limited by its current eligibility criteria, which requires participants to be an AMHS client in one of the three pilot regions.
2. Client-directed and person-centred support with a focus on improving health, social connectedness and economic participation	<p>HIGH - The design and implementation of Doorway is informed by three core values: <i>Choice, Social Inclusion and Sustainability</i>. In practice this means that Doorway program aims to:</p> <ul style="list-style-type: none"> • help participants to articulate their goals and preferences • empower participants to have choice and control over the services they receive • help participants to choose their own housing and home environment • co-design wrap-around services with participants • encourage participants to develop their own natural support networks– such as family, friends, cultural groups and their local community with the aim of achieving self-management and to decrease reliance on formal supports • encourage participants to pursue employment opportunities and/or undertake relevant training programs <p>Doorway participants are supported to direct the creation of the integrated support 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.</p> <p>Flexible elements of support teams may include the following members: employment consultant; Peer Worker; Alcohol and Other Drug (AOD) worker; physical health professionals; and cultural and spiritual support.</p>
3. Family-inclusive support	HIGH - Doorway encourages participants to be supported by family members or friends in the establishment and ongoing development of their integrated support team.

⁵⁵ Department of Health (2013), *Reforming community support services for people with a mental illness: reform framework for Psychiatric Disability Rehabilitation and Support Services*.

Key MHCSS feature ⁵⁵	Extent of Doorway alignment
4. Responsive to client diversity	HIGH - Doorway participants have diverse support needs and diagnoses. In the Doorway model, integrated teams are established around each participant to help them maintain their tenancy and improve their quality of life for the duration of the program. 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.
5. Community-focused and accountable to local needs	HIGH – Doorway has partnered with AMHS and other local support providers in each of the program’s three regions to ensure that services are tailored to local needs and conditions.
6. Integrated part of the specialist mental health and broader health and community service systems	<p>HIGH - The Doorway program partners closely with AMHS in each of the three regions. In practice this partnership has resulted in:</p> <ul style="list-style-type: none"> • regular involvement by case managers in the integrated team meetings • continued engagement by AMHS staff in the implementation meetings • sharing of standard outcomes measurement data • co-location by Doorway staff at the AMHS sites. <p>Doorway also partners with other support providers through their inclusion in participants integrated teams.</p>
7. Sustainability through efficiency and effectiveness	HIGH – As outlined in Section 5 of this report, Doorway has delivered benefits to Government through reduced health service utilisation and avoided social housing costs.
8. High-quality, evidence based services	HIGH - The design and delivery of Doorway was based on an extensive review of existing peer-reviewed literature as well as existing Housing First programs nationally and internationally and other programs targeting mental health and housing outcomes. Core elements of the Doorway model such as the integrated support teams, natural support networks, intentional peer work and the use of the Individual Placement and Support model for employment support were all designed following a review of existing evidence related to high quality service delivery.
9. Highly skilled and capable workforce	HIGH - MI Fellowship provide ongoing professional development opportunities to the Doorway team members which include Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and <i>Residential Tenancies Act</i> training
10. Strengthened accountability for achieving client outcomes.	HIGH –Outcomes for Doorway participants have been monitored, discussed and shared on an ongoing basis throughout the pilot program.

4.2.1.4 Doorway’s recovery model mirrors the Framework for recovery-oriented practice

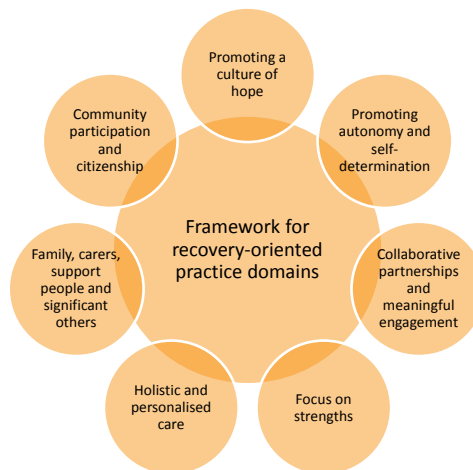
Doorway service design and delivery has an explicit recovery focus. The recovery model used by Doorway staff is based on MI Fellowship’s Community Recovery Model. This model integrates a number of established, evidence-based models within a Recovery-oriented framework: the Boston University Model of 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.

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.

The Community Recovery Model closely aligns with the Department of Health’s recent *Framework for recovery-oriented practice*.⁵⁶ This framework is structured into concurrent domains of recovery-oriented practice which are designed to inform the ongoing provision of mental health care in Victoria. These domains are shown in Figure 33 below.

Figure 33: Framework for recovery-oriented practice domains



Source: Department of Health (Victoria) (2011), *Framework for recovery-oriented practice*

⁵⁶ Department of Health (Victoria) (2011), *Framework for recovery-oriented practice*.

4.3 Demand for equivalent Doorway services will increase

Demand for the type of integrated community mental health and housing support provided by Doorway will continue to grow. One indicator of this latent demand is the volume of inquiries that the MI Fellowship has received over the past two years - approximately 2-3 per week – from AMHS case managers and other health professionals such as psychiatrists and GPs wanting to learn more about Doorway program and potentially refer their clients.

The ongoing importance for the community-based mental health services provided by Doorway is demonstrated by recent increases in the Government's investment in the sector under the MHCSS. This increase recognises the role these services play supporting people with mental illness in their recovery journey, including building the individual's resilience and creating capacity for self-management and also in freeing up valuable upstream service capacity in acute mental health services.

Demand for housing support services for people with a serious mental illness will remain high as this cohort is vulnerable to homelessness and remains over-represented in populations of homeless Australians. The attainment of stable housing is critical as a pathway out of homelessness and a basis for ongoing recovery for people with a serious mental illness.

The integrated delivery of both community based mental health and housing services is critical if the Government is to fully realise the system-wide benefits of its investment in community-based mental health services, as people with severe and enduring mental illness require access to secure and stable housing to sustain any positive recovery outcomes.

4.3.1 Demand for community-based mental service will remain high

4.3.1.1 The use of acute mental health services is increasing

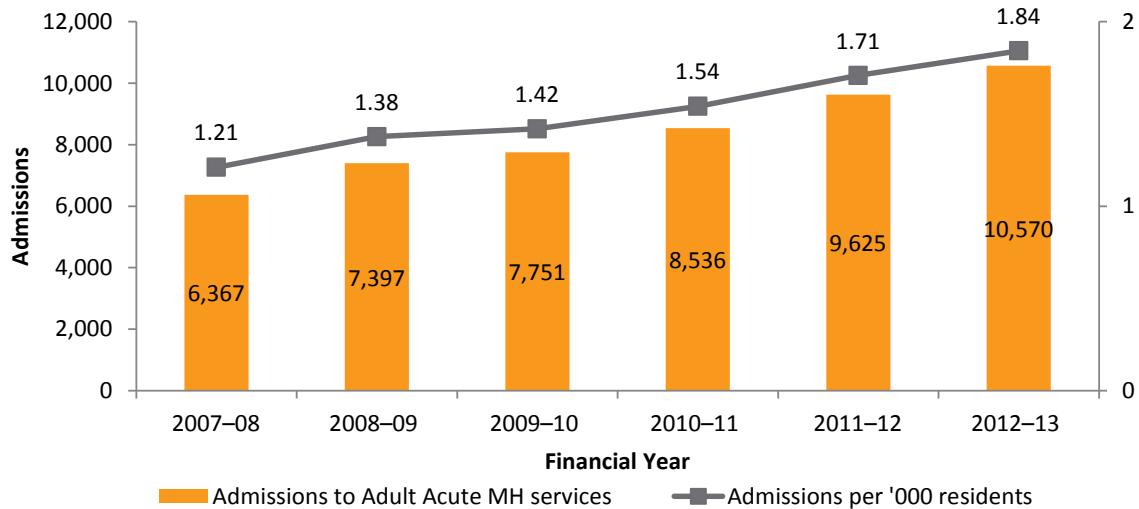
The use of acute inpatient mental health services has increased significantly over the past six years in Victoria – as illustrated in Figure 34. This reflects an increase in people experiencing acute mental illness or crisis, despite recent efforts by the Government to provide more options for earlier intervention and community-based care. The proportion of mental health admissions through hospital EDs has also increased during the same period.⁵⁷

As noted in the Department of Health's current Victorian priorities for mental health reform 2013–15 document, consistently high bed-occupancy levels, high caseloads and blockages in moving people through services reflect pressures [on acute services], making it hard for many people to access timely care". The reform document also notes that "these demand pressures [are for services that] tend to focus predominantly on a person's immediate presenting problems – on achieving stabilisation and risk reduction – rather than on long-term holistic recovery".⁵⁸

⁵⁷ Department of Health (2013), *Victoria's priorities for mental health reform 2013 – 2015*, p. 5.

⁵⁸ Ibid. p. 5.

Figure 34: Total admissions to adult acute inpatient services



Source: Department of Health (2013), *Victoria's priorities for mental health reform 2013 – 2015*, p. 5.; ABS (2013), 3101.0 - Australian Demographic Statistics, Jun 2013

4.3.1.2 Community-based mental health services will continue to play a central role

Community-based mental health services will continue to play a central role in supporting people with mental illness in their recovery journey, including building the individual's resilience and creating capacity for self-management. The effective delivery of community-based services will continue to play a critical role in reducing the burden on other forms of scarce and more resource-intensive mental health services, especially acute inpatient psychiatric care. The estimated service system cost savings generated by the Doorway pilot program are explored in detail in Section 5.3 on page 91 of this report.

The 2006 report by The Boston Consulting Group (BCG) on the reform of mental health services found substantial blockages in long-stay rehabilitation beds due to a lack of supply in the provision of PDRSS services. BCG found that approximately 65% of consumers in a Secure Extended Care Unit (SECU) and 30% of consumers in a CCU were staying for more than 300 days. BCG argued that an increase in PDRSS services would shift consumers to "lower-cost downstream accommodation options, which are also more conducive to recovery and prevent unnecessary hospitalisation".⁵⁹

In recognition of the importance of community based services in increasing individuals' capacity for day-to-day living, the Victorian Government has progressively grown its investment in the PDRSS sector. The Government invested \$93.5 million in PDRSS services in 2010-11 - \$24.1 million of which was directed towards the delivery of Standard HBOS – level of HBOS that Doorway's funding is based upon.⁶⁰ In 2013–14 following the current reforms to the sector, the Government will invest \$117 million in the new MHCSS program in recognition of the increasing demand for community-based mental health services.⁶¹

⁵⁹ Boston Consulting Group (2006), *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform*, p. 66.

⁶⁰ Department of Health (2012), *Psychiatric Disability Rehabilitation and Support Services Reform Framework - Consultation paper*, p. 8.

⁶¹ Department of Health (2013), *Advertised Call for Submission - Delivery of mental health community support services in Victoria*, p. 9.

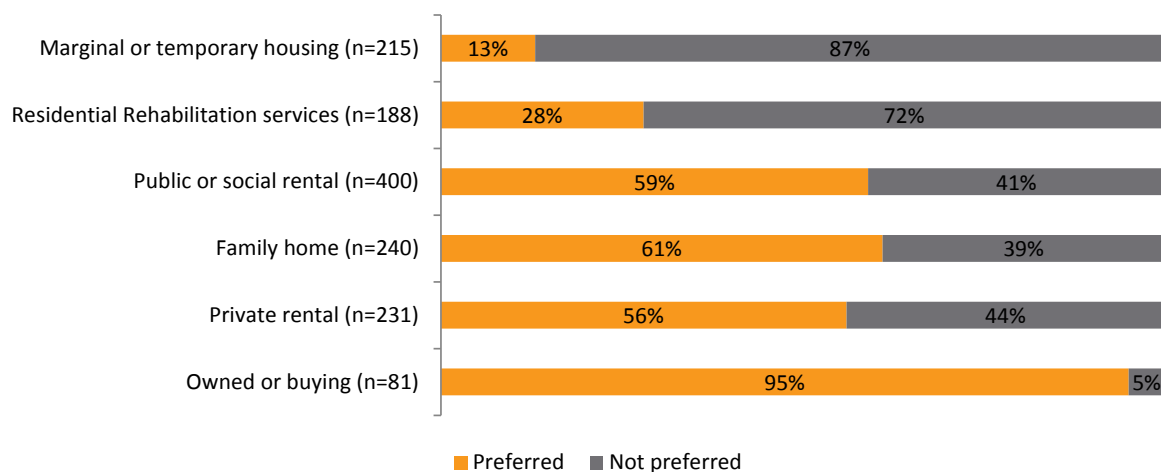
4.3.2 Many people with a mental illness have ongoing housing support needs

4.3.2.1 People with a mental illness have poor housing outcomes

People with a serious mental illness are significantly over-represented in statistics related to homelessness. Current Department of Health data indicate that 6% of registered clients of Victorian public clinical mental health services are homeless (approximately 3,600 individuals), with up to 25% identified at housing risk.⁶² Similarly, a 2009 Victorian Government report estimated that over 40% of people with serious mental illness in Victoria were homeless or housed in tenuous accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.⁶³ These figures compare with overall homelessness levels of just 0.42% among Victoria's total population, based on 2011 census data.⁶⁴

Many people with severe and enduring mental illness would prefer not to be housed in their current form of accommodation. A recent survey of PDRSS clients found that the majority of individuals living in marginal/temporary or residential rehabilitation housing would prefer to live somewhere else – as shown in Figure 35 below.

Figure 35: Whether client's current accommodation is their preferred form of accommodation (n=1355)



Source: Mental Illness Fellowship, Mind and Neami (2010). Housing Needs Survey

4.3.2.2 Stable housing is critical for recovery

In order for the Government to fully realise the system-wide benefits of its investment in community-based mental health services, people with severe and enduring mental illness need to have access to secure and stable housing. Without the foundation provided by stable housing, it is very difficult for people to access and fully benefit from treatment and care, meet basic needs such as nutrition, maintain general good health, obtain and sustain employment and build and retain social networks. Similarly, without appropriate support of adequate intensity and duration, this highly vulnerable and marginalised population group can be difficult to engage with, and their entrenched health, social and economic problems remain hard to address.

⁶² Department of Health (2013), Client Management Interface-Operational Data Set.

⁶³ Department of Human Services (2009), *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019*, p. 106.

⁶⁴ ABS (2012), *Census of Population and Housing: Estimating Homelessness*, p. 8.

“Unless the most basic need for stable and affordable accommodation is met we just stay in an ongoing crisis loop with a person. We have gone around in circles with lot of people because we cannot find safe and secure places for them to live in. Doorway is about addressing fundamental quality of life issues – it’s more than just saving costs through reduced services use.”

General Manager, AMHS

“Doorway participants are given the opportunity to stop, sit and reflect and think about their future and what is important to them. Life for many of them had been chaotic and they were focused on how they would survive each day”.

Case Manager, AMHS

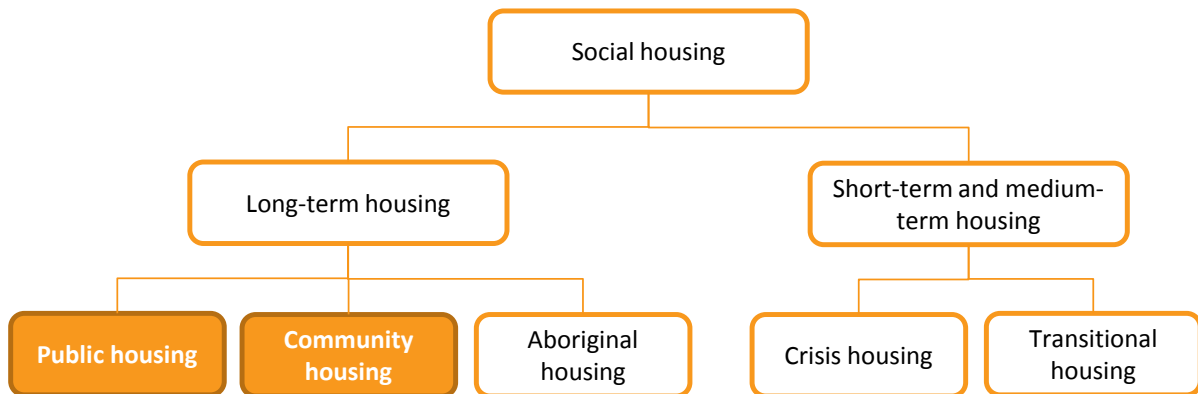
4.4 Stand-alone housing options for people with a serious mental illness remain limited

Suitable, stable and sustainable housing options are currently very limited for those Victorians with a serious mental illness. For those individuals who may be able to live independently with community mental health outreach support but do not own a home or live with family or friends, the most appropriate housing options are various types of social housing – specifically public and community housing - and private rental accommodation.

4.4.1 Social housing is hard to access

Of all the main types of social housing available to Victorians with a serious mental illness, the two options most likely to support stable and long recovery are public housing and community housing – as shown in Figure 36 below.

Figure 36: State Government supported housing options



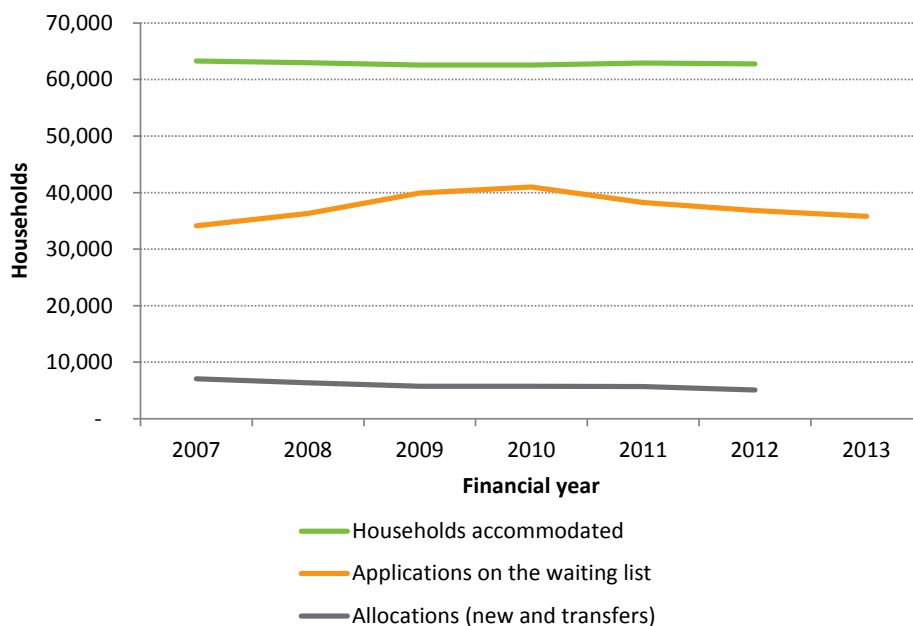
Source: Victorian Auditor-General (2012), *Access to Public Housing*, p. 1

4.4.1.1 Public housing supply remains severely constrained

The 2010 parliamentary inquiry into public housing found that decades of underinvestment and decreasing stock levels have contributed to a large gap between public housing supply and demand. Underinvestment has also created issues relating to the quality of the housing stock and the services that administer it.⁶⁵

Figure 37 below shows that the number of applicants on the general waiting list for public housing has remained relatively steady at around 40,000 people over the past seven years. Figure 37 also illustrates that total allocations to public housing have actually dropped over the past decade. This decrease in allocation is largely due to changing demographics, low turnover of public housing tenancies and only minor increases in public housing stock.

Figure 37: Historical supply and demand for Public Rental Housing



Source: Department of Human Services (2007-2013), *Summary of Housing Assistance Programs*

The lengthy and static nature of the waiting list has resulted in substantial waiting periods. In 2010-11, individuals at risk of homelessness who were deemed the highest priority on the waiting list waited an average of more than nine months for a dwelling – up from an average of three months in 1998-99. Non-priority applicants in 2010-2011 could wait several years to be allocated public housing.⁶⁶

The overall challenges in qualifying for public housing through the segmented waiting list have been particularly difficult for people who are homeless and have a serious mental illness. In their submission to the 2010 parliamentary inquiry, Neami noted that “many people who have been homeless or in unstable accommodation arrangements for extended periods have been unable to satisfy the criteria due to the lack of continuity of care by support providers or their itinerancy.”⁶⁷

⁶⁵ Victorian Government (2010), *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. ix.

⁶⁶ *Ibid.*, p. xxii.

⁶⁷ *Ibid.*, p. 105.

VICSERV also informed the inquiry committee that as a consequence of these barriers, “anecdotal evidence suggests many people do not apply due to the complexity of the assessment process and beliefs about the unlikelihood of ever getting a suitable property”.⁶⁸ A recent survey of PDRSS clients who were identified as needing to apply for public housing asked about the main barriers they experienced in accessing public housing. One of the main barriers identified by 45% of clients (n=170) was a perception that waiting lists are too long. One quarter of clients felt that the application process being too complex was another barrier.⁶⁹

For those individuals with a serious mental illness who are previously homeless that do choose to apply for public housing, the time spent on the waiting list can have negative effects. The 2010 parliamentary inquiry found that the length of time individuals and families are on waiting lists can adversely impact health and wellbeing, create barriers to community participation, provide disincentives to employment, and disrupt children’s social and educational development.⁷⁰ The 2009 evaluation of the Integrated Rehabilitation and Recovery Care Program pilot found some participants in the pilot “went backwards and lost some of the gains they had made” when the wait for permanent housing “slipped from a couple of months to up to two years”.⁷¹

4.4.1.2 Community housing options are limited but improving

Recent Government efforts to increase the supply of different forms of social housing have focused primarily on the growth of the community housing sector – which currently comprises 16,294 tenancies.⁷² These tenancies are managed by not-for-profit registered housing associations and providers which develop, own and manage rental housing for people on low incomes.

Despite the recent growth in community housing, the sector has yet to resolve the issue of having sufficient accessible housing for socially and economically disadvantaged Victorians with high needs for social housing. A 2010 report by the Auditor-General found that even with the requirement for up to 50% of new vacancies in housing association properties to be filled from the public housing waiting list, there were “no clear guidelines to deliver equity of access for applicants from the public housing waiting list.”⁷³

It is also important to note that the design of the community housing sector may implicitly work against the most disadvantaged Victorians in need of housing who are on the priority housing waiting list. The 2010 parliamentary inquiry into public housing found that housing associations tend to target tenants through their individual eligibility requirements who can provide additional rental income that is typically then used to service the housing association’s debts.⁷⁴

4.4.2 Assistance to access private rental accommodation is limited

Victorians who are homeless or at risk of homelessness and have a serious mental illness currently receive limited forms of financial and non-financial support to seek and sustain private rental accommodation. Barriers include the paucity of affordable rentals – particularly in metropolitan regions, a lack of access to employment in locations where rent is affordable and low levels of Government rental

⁶⁸ *Ibid.*, p. 105.

⁶⁹ Mental Illness Fellowship, Mind and Neami (2010). *Housing needs Survey*.

⁷⁰ *Ibid.*, p. xxiii

⁷¹ Abelló D., Fisher K. and Sitek T. (2009), *Evaluation of the Integrated Rehabilitation and Recovery Care Program*, p. 38.

⁷² Housing Registrar (2012), *Housing Registrar Report 2011-12*, p. 36.

⁷³ Victorian Auditor-General (2010), *Access to Social Housing*, p. ix.

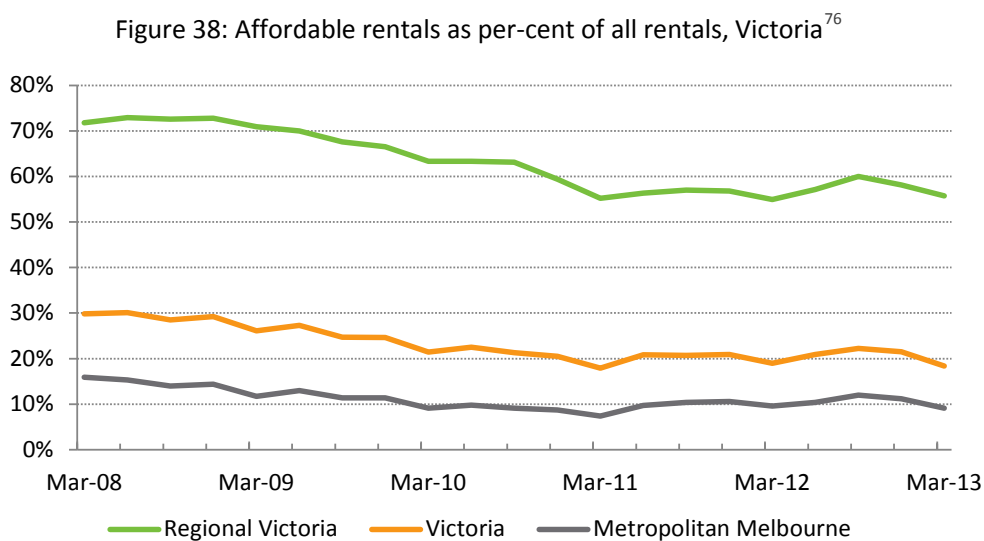
⁷⁴ Victorian Government (2010), *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. 362.

subsidies. Non-financial barriers to renting can include a poor or non-existent rental record and a lack of general awareness about how to access private rental properties. These barriers are explored below in turn.

4.4.2.1 Affordable rental properties in suitable locations are getting harder to find

The supply of private rental properties in Victoria remains under stress due to population growth and relatively high levels of employment. At August 2013, private rental vacancy rates were 3.7% in metropolitan Melbourne and 3.0% in regional Victoria.⁷⁵

Ongoing tightness in the rental market has been combined with a decrease in the proportion of new lettings that are defined as affordable. Figure 38 below clearly demonstrates that the issue of affordability is particularly acute for disadvantaged people who live in metropolitan Melbourne.



Source: Department of Human Services (2013), *Rental Report - March quarter 2013*, p. 13

The latest Rental Report produced by the Victorian Department of Human Services highlighted the dire nature of rental affordability for individuals households dependent on Centrelink incomes. For a single person on a Newstart allowance with a fortnightly income of \$492 (net of Commonwealth Rental Assistance), affordable rental accommodation is defined as a one bedroom property with a fortnightly rent of \$270 per fortnight or less. As at March 2013, there were just 27 affordable rental properties in metropolitan areas (representing 0.3% of total rents). Regional areas fared better, with a total of 189 rental properties defined as affordable for single individuals on Newstart (representing 27.4% of total rents).⁷⁷

⁷⁵ Real Estate Institute of Victoria (2013), *August rental update* <[http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August rental update](http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August%20rental%20update)>.

⁷⁶ The assessment of affordable supply is based on the number of suitably-sized properties that are within 30% of gross income for low income households. The rental thresholds are taken from the household incomes for whom that number of bedrooms is a minimum and may have been rounded up to the nearest \$5 increment. Different income levels were used to calculate the affordability of different sized properties: one bedroom - singles on Newstart allowance; two bedrooms - single parent pensioner with one child aged under 5; three bedrooms - couple on Newstart with two children; four bedrooms - couple on Newstart with four children. The method used in these calculations assumes rent assistance is fully offset against the weekly rent by subtracting rent assistance from the rent and then calculating the resulting rent as a proportion of the Centrelink income. This net-rent method treats rent assistance as a housing payment, not an income supplement.

⁷⁷ Department of Human Services (2013), *Rental Report - March quarter 2013*, p. 17

The parts of Victoria with higher concentrations of affordable housing - suburbs in Melbourne's urban fringe and regional areas – are typically areas with poor access to public transport and fewer employment options. This has resulted in many households on income support having to move further from employment opportunities to be able to access affordable housing. For many Victorians with serious mental illness, finding more affordable private rental accommodation can also mean moving away from their established support networks and treatment relationships– which can impact on their recovery.

4.4.2.2 Subsidies for people seeking private rental accommodation are inequitable

Social housing tenants in Victoria currently receive a higher average level of assistance than tenants in the private rental market, given the current caps on rental payments in the social housing sector. Table 20 below shows that once Commonwealth Rent Assistance (CRA) payments are taken into account, a single person whose only source of income is the Disability Support Pension will use 23% of their weekly income to make rental payments if they are living in public or community housing. The same single person will use 64% of their income on rental payments in the private rental market. This disparity is even greater if the current median rent for units in Melbourne is used – which stood at \$380 per week as at August 2013.⁷⁸

Table 20: Weekly rental costs for a single person receiving a DSP across a range of housing providers

Housing provider	Pension income (per week)	Rent paid	CRA (\$)	Rent paid after CRA	% of Income
Public Housing	\$376	\$86	\$0	\$86	23%
Community Housing	\$376	\$146	\$60	\$86	23%
Private Rental	\$376	\$300	\$60	\$240	64%

Source: Department of Human Services (2012), *Pathways to a fair and sustainable social housing system*, p. 16; Department of Human Services (Vic.) (2013)

The 2010 Henry Review of Australia's taxation system considered that this large difference in assistance levels is inequitable and that the gap in assistance "leads to rationing of access to public housing through queuing and can lead to poor outcomes for tenants in the long-term."⁷⁹ The recent Victorian Government discussion paper on social housing also observed that "housing assistance is inconsistent and unfair for those who may have similar circumstances (and on the public housing waiting list), but may be renting in the private rental market."⁸⁰

4.4.2.3 Commonwealth funded rental support programs are limited

The type and scope of support provided by the two main Commonwealth funded schemes designed to facilitate greater access to private rental accommodation for low income individuals and households – Commonwealth Rental Assistance (CRA) payments and the National Rental Affordability Scheme (NRAS) – are explored below.

⁷⁸ Real Estate Institute of Victoria (2013), *August rental update* <[http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August rental update](http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August%20rental%20update)>

⁷⁹ Henry, K. (2009), *Australia's Future Tax System: Report to the Treasurer - Part One: Overview*, p. 66.

⁸⁰ Department of Human Services (2012), *Pathways to a fair and sustainable social housing system - Public consultation discussion paper*, p. 20.

Commonwealth Rental Assistance

CRA is a non-taxable income supplement payment added on to the pension, allowance or benefit of eligible income support customers who rent in the private rental market. To be eligible to receive CRA, individuals must first qualify for a social security income support payment, more than the base rate of Family Tax Benefit Part A or a service pension.

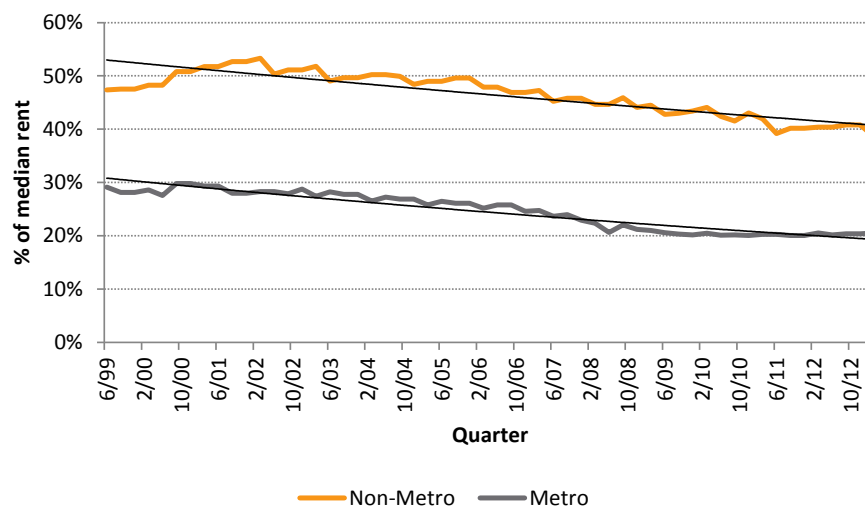
CRA is paid at different levels depending on fortnightly rent amounts, family status and the number of dependents. The current CRA payment for a single person with no children is capped at a flat rate of \$124 per fortnight.

It has been acknowledged in recent years that the adequacy of CRA is variable and declining. Again, the 2010 Henry Review of Australia’s taxation system noted that the CRA’s “current maximum levels of assistance are too low for many people to secure an adequate standard of housing.” It also argued that the “indexation of assistance to the Consumer Price Index means that assistance is not well targeted over time, leaving recipients to bear the risk of rent fluctuations.”⁸¹

The review recommended that CRA payment rates be increased and maximum rates be indexed to move in line with market rents.⁸² To date, none of these recommended reforms have been adopted by the Commonwealth Government.

The difficulties faced by Victorians with a serious mental illness who are homeless or at risk of homelessness and who wish to sustain private rental accommodation using CRA payments is illustrated in Figure 39 below. Figure 39 shows that the proportion of median rental payments covered by maximum CRA payments has steadily declined over the last ten years - leaving people on low incomes with an increasing shortfall that must be met through other means.

Figure 39: Maximum weekly CRA payments for single individuals with no dependents as a proportion of median weekly rents for a one bedroom flat in Victoria



Source: Department of Families, Housing, Community Services and Indigenous Affairs (2013),
Department of Human Services (Vic.) (2013)

⁸¹ Henry, K. (2009), *Australia’s Future Tax System: Report to the Treasurer - Part One: Overview*, p. 66.

⁸² Henry, K. (2009), *Australia’s Future Tax System: Report to the Treasurer - Part Two – Detailed Analysis – Volume 2*, p. 491.

National Rental Affordability Scheme

The National Rental Affordability Scheme, which commenced in 2008, seeks to address the shortage of affordable rental housing by owners of rental properties. NRAS provides an annual subsidy for up to ten years to individuals and entities in return for renting their property to low and moderate income households at a rate that is at least 20 percent below the market value rent. The NRAS aims to stimulate the construction of 50,000 homes and apartments nationally by June 2016.

NRAS incentives are allocated by approved participants – who are usually property developers, not-for-profit organisations and community housing providers.⁸³ The NRAS is not generally available to small-scale, private, individual investors in the rental property market.

As at June 2013, incentives for the construction of 2,469 dwellings had been allocated to Victoria and 4,298 incentives had been reserved – a total of 6,767. An average of 322 incentives have been allocated to a total of twenty-one approved participants in Victoria.⁸⁴

The NRAS is a positive step towards improving access to private rental accommodation for disadvantaged Victorians. The national target of 50,000 new dwellings is still limited though when compared to the number of Australians with low or moderate incomes.

For example, in the context of the three Doorway regions, NRAS will result in 2.6 new dwellings per 1,000 low income Newstart/DSP recipients in Latrobe – as shown in Table 21 below. The number of dwellings is better in the Austin and St Vincents regions – at 13.0 and 34.9 dwellings for 1,000 Newstart/DSP recipients respectively.

The availability of NRAS housing for individuals in each region that may be eligible for the Doorway program – i.e. low income Newstart/DSP recipients with a serious mental illness – is even lower. NRAS housing in these regions may be allocated to the approximately 70 per-cent of income support recipients that do not have a mental illness.⁸⁵

Table 21: NRAS dwelling incentives by Doorway region

	Austin region	St Vincents region	Latrobe region
Active Dwellings	8		25
Proposed Dwellings	87	191	
Total dwellings	95	191	25
Population (2010)	188,433	79,540	119,065
Total dwellings (per '000 persons)	0.5	2.4	0.2
Total dwellings (per '000 DSP or Newstart recipients)	13.0	34.9	2.6

⁸³ Department of Social Services (2013), *About the National Rental Affordability Scheme (NRAS)* <http://www.dss.gov.au/sites/default/files/documents/03_2013/about_nras_-_fact_sheet.pdf>

⁸⁴ Australian Government (2013), National Rental Affordability Scheme Monthly Performance Report - 30 June 2013

⁸⁵ Research from 2003 estimated that 27.7% of income support recipients had an affective, anxiety or substance use disorder. (Source: Commonwealth Department of Family and Community Services (2003), *Estimating the prevalence of mental disorders among income support recipients: Approach, validity and findings*, Policy Research Paper No. 21, p. 36). More recent data estimated that 29% of DSP recipients had 'Psychological / Psychiatric' as their primary medical condition. (Source: FaHCSIA (2011), *Characteristics of Disability Support Payments Recipients*, p. 21.)

Sources: Australian Government (2013), National Rental Affordability Scheme Monthly Performance Report - 30 June 2013; ABS (2011), 1379.0.55.001 National Regional Profile, Banyule (C), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Baw Baw (S), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Latrobe (C), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Nillumbik (S), 2006-2010; ABS (2011), 1379.0.55.001 National Regional Profile, Yarra (C), 2006-2010

4.4.2.4 Core state-funded rent assistance programs provide limited levels of support

Victorian Government rental assistance is delivered through two key programs – the Bond Loan Scheme, and the Housing Establishment Fund (HEF). It is important to note that both programs provide one-off assistance and are designed to support individuals with recurrent rental shortfalls.

The HEF is a grant program provided by homelessness housing and support agencies to people with disabilities who are experiencing housing related hardship. The fund provides up to \$300 per person per year to make rental payments to access and/or to maintain private rental housing, assist with storage and removal costs, or access emergency short term accommodation. Office of Housing eligibility requirements include HEF recipients to be in receipt of the Disability Support Pension (DSP). HEF assisted 36,000 households during 2011-12 with an average level of assistance of \$251 per household.⁸⁶

The Bond Loan Scheme is a demand-driven program that provides interest-free loans to assist low-income earners with bond deposits when entering private rental accommodation. Loan recipients must meet early housing (segments 1 to 3) income limits. The current loan limits for household are \$1,300 (one or two bedroom properties) and \$2,100 (three or more bedroom properties). The Bond Loan Scheme assisted 11,747 households during 2011-12, an increase of 12.3% on the previous year.⁸⁷

In practice, the HEF and Bond Loan Scheme can be hard for some disadvantaged individuals to access. For example, many Doorway participants did not meet HEF eligibility requirements when they entered the program. Those participants who were eligible found that access to the fund was managed tightly by local housing agencies and that local demand far exceeded available supply. Similarly, several Doorway participants also found it difficult to access the Bond Loan Scheme due to a history of payment defaults with the Office of Housing.

4.4.2.5 Standalone state-funded rental assistance programs are limited in scope

The Victorian Department of Human Services currently contributes funding to two similar standalone rental support programs – the Private Rental Access Program (PRAP) and the Private Rental Brokerage (PRBP). Both programs are delivered by housing agencies and local councils and have multiple referral streams. Both programs also provide short-term brokerage services that are limited financially and in geographic coverage.

Although limited in scope, both programs are examples of where the State Government has intervened to overcome market failure for severely disadvantaged groups – an important precedent that supports the potential continuation and/or expansion of the Doorway model.

Private Rental Access Program

The PRAP is designed to assist clients establish and maintain private rental as a long term housing option. PRAP services support clients to find and inspect suitable houses, apply to real estate agents, sign leases, establish their tenancies, and access support including local HEF and brokerage providers.

⁸⁶ Real Estate Institute of Victoria (2013), *August rental update* <[http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August rental update](http://www.reiv.com.au/News_Publications/News-Archive?newsID={5BBA3A04-B8D7-4B0B-A6FE-FF076C7AFBCA}&title=August%20rental%20update)>

⁸⁷ Department of Human Services (2012), *Summary of Housing Assistance Programs 2011-12*, p. 31.

Some PRAP providers also support clients with visits from a support worker during the first few weeks and months of their new tenancy.

The initial PRAP service model was based on the lessons of two Victorian Homelessness Strategy Pilots which ran from 2003-2005– Housing Options for Women and Private Rental Brokerage. The initial PRAP model was implemented in 2006 and specifically targeted women who experienced family violence. The Family Violence Outreach Program (FVOP) PRAP was delivered by the Salvation Army Crisis Services Network and HomeGround Services in St Kilda.⁸⁸

Under the original PRAP service model payments could only be paid up to a maximum period of six months. The service model design document developed by DHS also stated that the PRAP model “is not intended to be an income supplement, or another HEF product - it is a strategic, planned and staged approach, which aims to result in sustainable independent living in private rental accommodation.”⁸⁹

Several iterations of the PRAP beyond the initial FVOP PRAP model now provide assistance to clients. The Youth PRAP (YRAP) program delivered by HomeGround and Salvation Army Crisis Services targets individuals between 16 – 25 years old in Melbourne’s inner and middle south and provides up to \$2,000 in support grants – with an average grant size of \$1,500. This grant can be divided into two packages: tapered rent assistance which provides a maximum of 100% of the grant, or tenancy set-up costs which provide a maximum of 50% of the approved grant amount.⁹⁰

The various Private Rental Access Programs currently operating in Victoria are limited in geographic scope and in the duration of support they provide. These programs in turn also provide support to a relatively small number of individuals. For instance, the YPRAP was designed to provide 38 packages of up to \$1,300 in services to clients in the Inner Middle South Metropolitan Region. Hanover’s PRAP has assisted 50 clients secure rental properties throughout the southern suburbs of Melbourne in the two years preceding mid-2013.⁹¹ The PRAP delivered by the Shire of Melton and Salvation Army Social Housing Service (SASHS) network received an average of 19 referrals per month in the 30 months preceding March 2011. Only half those referred were then housed in private rental accommodation.⁹²

Private Rental Brokerage Program

The Private Rental Brokerage Program (PRBP) provides similar services to the PRAP. The current iteration of PRBP is funded as part of the Government’s response to recommendation 23 of the 2009 Rooming House Standards Taskforce report.⁹³ This program targets rooming house residents, and those at risk of entering rooming houses (single clients, couples, and families), who are identified as able to sustain a tenancy with limited assistance in the form of rental information, brokerage, start-up costs and time-limited support. At present, only a small number of organisations are funded to deliver this iteration of PRBP.⁹⁴

⁸⁸ Coutts, S., D’Arcy, A., Harris, L., and Janicijevic, I. (2009), “Private Rental Access Program: Debunking the Myth of the Impossible Private Rental Market”, *Parity*, 22(3), pp. 40-41.

⁸⁹ Department of Human Services (2005), *Linking to the Private Rental Market - Private Rental Brokerage Program - Service model description*, p. 3.

⁹⁰ HomeGround (2012), *Youth Private Rental Access Program - Program Guidelines - February 2012*, <http://www.homeground.org.au/assets/yprap_guidelines1.pdf>

⁹¹ Hanover (2013), *Hanover news – Spring 2013*, p. 6.

⁹² Viojo-Rodriguez, R. (2011), *Private Rental Access Program Melton*, <<http://www.nwhn.net.au/admin/file/content101/c6/Melton%20Housing%20Service%20PR%20Forum%20Presentation%2031032011.pdf>>

⁹³ A previous iteration of the PRBP – Creating Connections – specifically targeted youth and was funded from 2008 to 2010 under the Youth Homelessness Action Plan.

⁹⁴ Organisations that currently funded to deliver PRBP services include Homeground, Wesley Mission and Unitingcare Harrison.

Like the PRAP, current PRBPs currently provide a limited range of services to a relatively small number of clients. The Northern-PRBP, which is delivered by HomeGround in partnership with North East Housing Service, provides advice and information sessions, advocacy, and limited outreach support (such as attending open inspections and assisting with applications). The program does not provide ongoing support to clients, just referral to other support services if required. The limited brokerage component of the PRBP – Northern provides assistance for rent and/or bond payments, removalist costs and, in some cases, rental arrears, but is generally limited to the first month's rent in advance. In addition, the program only targets clients with rental obligations that it deems sustainable. This precludes clients with rental obligations that exceed 55% of their monthly income.

A lack of resources has limited the coverage of the Northern PRBP. At present, the program is funded for 1 Full Time Equivalent (FTE) worker who is expected to manage service delivery across all Northern metropolitan LGAs.⁹⁵ In the 2011-12 financial year Northern PRBP provided services – largely referrals to other services - to 205 clients⁹⁶

4.5 Comparable programs do not exist in Victoria

Doorway is currently the only Government-funded program for Victorians with a serious mental illness who are homeless or at risk of homelessness providing the type of integrated, comprehensive and long-term support required for people to access and sustain private rental accommodation. To this end, the program goes a long way to addressing the fundamental inconsistencies and inequities in the types of housing assistance offered to tenants in social housing and the private rental market noted in the Government's 2012 discussion paper on social housing.⁹⁷

It is important to note that the type of supported rental assistance offered by Doorway will become even more scarce once the current PDRSS services are replaced by the MHCSS under current Victorian Mental Health sector-wide reforms. In recent years, some PDRSS providers have offered limited brokerage support to clients under DoH's current brokerage guidelines. This type of limited support will cease once the current service delivery reforms are completed in the coming months. The service specifications for the delivery of the new MHCSS services explicitly state that Government funding for individualised client support packages *"cannot be used to subsidise a client's rent"*.⁹⁸

4.5.1 Integrated mental health and housing services have been limited

PDRSS and housing providers have historically found it difficult to deliver coordinated and effective services to people with a serious mental illness. The difficulties experienced by both service provider groups in facilitating access to affordable and stable housing for this cohort has exacerbated the demand on specialist mental health services. At a policy level, the separation of housing and mental health service delivery in different Government portfolios has also posed challenges for coordinated service delivery.

The importance of coordinated service delivery was reinforced by recent research by Nous Group which found that PDRSS providers spend significant amounts of time in assisting consumers to find and maintain stable housing. The providers encounter difficulties in partnering with housing associations to

⁹⁵ These LGAs include Banyule, Darebin, Melbourne, Nillumbik, Whittlesea and Yarra.

⁹⁶ Homeground (2012), *Annual Report 2011/12*, p. 31.

⁹⁷ Department of Human Services (2012), *Pathways to a fair and sustainable social housing system - Public consultation discussion paper*, p. 20.

⁹⁸ Department of Health (2013), *Service Specification for the Delivery of Mental Health Community Support Services*, p. 10.

find suitable and sustainable housing for consumers. Many providers noted these difficulties were mainly due to an overall lack of supply and a perceived absence of transparency in the housing allocation process. Several PDRSS providers also noted that housing associations seem to consider consumers with mental illness too difficult to deal with.⁹⁹

Conversely, PDRSS providers and AMHS are limited in their capacity to provide timely treatment and psychosocial support of the right intensity and duration for many consumers with high levels of need, which places pressure on housing and homelessness agencies. Homelessness services, in the main, struggle to respond to the needs of this population group, as they typically provide short-term assistance, and carry high case loads.¹⁰⁰ This in turn severely limits the ability of individuals receiving this short-term assistance to focus on their recovery in stable and long-term housing.

4.5.2 Current programs provide limited housing support

Since the start of the Doorway pilot, the historical shortfall of integrated mental health and housing programs has been partially addressed with the introduction of two new National Partnership Agreement (NPA) funded programs. Both programs are funded under the NPA on Supporting National Mental Health Reform and began delivery in early 2013, with a scheduled end date of 30 June 2016. Further details about both programs can be found in Appendix D.2.

The first of these programs, *Mental Health Support for Secure Tenancies* ('*Secure Tenancies*'), provides scaled flexible mental health outreach support and proactively links clients to affordable, long-term rental housing options. It is targeted to people aged 16-64 years with serious mental illness who are homeless or at high risk of homelessness. *Secure Tenancies* will support up to 140 clients at any given time and operates across five catchments.¹⁰¹ There is minimal overlap between these five catchments and the three Doorway regions.¹⁰²

The second of these programs, *Breaking the Cycle: reducing homelessness* ('*Breaking the Cycle*'), provides assertive mental health outreach support and care coordination to clients with a severe and enduring mental illness and a history of long-term homelessness or repeated homelessness. The program will particularly target those individuals whose mental illness, and consequent stability and recovery, is impacted by deep set trauma and who require intensive, sustained engagement to achieve and maintain health and social participation outcomes. *Breaking the Cycle* will provide support to up to 100 adults and older people at any one time and will be delivered through consortia of service providers in four service catchments. Each consortium has a core partnership comprised of an AMHS, PDRSS provider and homelessness and housing service.¹⁰³ There is no overlap between the four *Breaking the Cycle* catchments and the three Doorway regions

The housing components of both *Secure Tenancies* and *Breaking the Cycle* do not provide the same level of sustained housing and tenancy management support offered under the Doorway service model. Client choice regarding housing options is constrained to specific housing types and access to private rental accommodation appears very limited under both models.¹⁰⁴

⁹⁹ Nous Group (2011), *Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services*, p. 95.

¹⁰⁰ Department of Health (2012), *Invitation for Submissions - Breaking the cycle: reducing homelessness*, p. 5.

¹⁰¹ Department of Health (2012), *Invitation for Submissions - Mental health support for secure tenancies*.

¹⁰² Banyule (Austin) and Yarra (St Vincents) are two of the four LGAs serviced by the Secure Tenancies consortium led by Homeground.

¹⁰³ Department of Health (2012), *Invitation for Submissions - Breaking the cycle: reducing homelessness*.

¹⁰⁴ Given that both programs have just commenced at the time of writing this report, there is no data available about the housing outcomes of clients for either program.

The type of housing support provided in the *Breaking the Cycle* service model is ill-defined in initial program documentation. The model specifies the inclusion of a homelessness provider as a core delivery partner and the expectation for the program's multi-disciplinary team to provide "housing support" that includes engagement with local social housing providers. The design of the *Breaking the Cycle* service model also excludes references to private rental accommodation.¹⁰⁵

The *Secure Tenancies* service model requires providers to identify and assist clients to secure and maintain affordable, long-term public and private housing options. Providers are expected to do this by working collaboratively with social housing providers, including Housing Associations, DHS regional housing staff and private real estate agents.¹⁰⁶ In practice, it is likely that the majority of *Secure Tenancies* clients will be housed in social housing accommodation – rather than through the private rental market. This is due in part to the restrictive nature of the guidelines under which *Secure Tenancies* providers can offer brokerage funding to support clients with private rental accommodation.¹⁰⁷

It is important to note that *Breaking the Cycle* and *Secure Tenancies* are intended to leverage existing program capacity available in Victoria's homelessness and social housing service systems. For example, housing providers within the program delivery consortia that currently manage community housing are required to link participants to opportunities within their existing portfolio. These providers are not allocated additional properties owned by the Director of Housing to manage or funded through *Breaking the Cycle* or *Secure Tenancies* to purchase or construct other dwellings. This contrasts with the Doorway model, which is designed to increase the supply of accessible housing stock through subsidised private rental accommodation.

4.6 Doorway has unique features and benefits

The design of the Doorway service model has several fundamentally unique features relative to other services currently funded or delivered by the Victorian Government – particularly the two NPA-funded programs *Secure Tenancies* and *Breaking the Cycle*.

The housing component of the Doorway model is unique in that it supports participants to rapidly access stable private rental housing in a community of their choice. Participants lease properties personally – which builds their own rental history and ensures that their tenancy management skills are enhanced with support from H&RWs. Doorway also removes financial barriers to stable rental accommodation by providing rental subsidies that are linked to participant income levels. Longer term housing outcomes are facilitated by creating strong partnerships with real estate agents and landlords.

The way in which Doorway is delivered is unique - with a single agency providing both mental health and housing support services. This approach has several benefits which include a more holistic approach to recovery where H&RWs can have conversations about rent and tenancies with participants in the context of broader discussions about the progress of other non-housing outcomes. The single agency model also decreases the likelihood of rental default as potential financial stresses are more likely to be identified earlier. From the client point of view, a single point of contact for all health and housing issues is more user-friendly and less burdensome. A single agency delivering Doorway's core support services also allows for more rapid intervention in crises, relative to programs delivered by multiple providers.

¹⁰⁵ Department of Health (2012), *Invitation for Submissions - Breaking the cycle: reducing homelessness*.

¹⁰⁶ Department of Health (2012), *Invitation for Submissions - Mental health support for secure tenancies*.

¹⁰⁷ DoH's current interim guidelines (as at September 2012) allow for up to 30% of a funded package of care for a client to be spent on brokerage. Brokerage support is intended as a 'last resort' option in the event of critical episodes or pressing needs. Funding cannot be used to pay rent or bond unless all available sources such as Housing Establishment Fund (HEF) and Office of Housing Bond Loans for private accommodation are exhausted.

4.6.1 All participants are supported to access and maintain private rental

Rapid access to stable housing

People recovering from a mental illness and mental health providers identify access to stable and affordable housing as one of the most important issues affecting their quality of life and capacity for recovery.¹⁰⁸ Most PDRSS consumers also indicate a preference for living in mainstream housing and not with other people with a mental illness. Research from 2010 found that over 80% of PDRSS consumers who live in short-term residential rehabilitation or temporary housing stated that this was not their preference.¹⁰⁹

Disadvantaged Victorians face substantial waiting times to access stable forms of long-term social housing, as discussed in detail in Section 4.4.1 on page 69 above. This can have a detrimental effect on the recovery of individuals with a serious mental illness, if they are living in unstable and transitional forms of accommodation while they wait for a public or community housing allocation.

The average time between program intake and occupying a house is 7.2 weeks for Doorway participants – which is comparable to other Housing First programs internationally. Doorway therefore provides Victorians with a serious mental illness that are homeless or at risk of homelessness with much more rapid access to stable and long-term housing relative to public housing – which has an average waiting period of nine months even for the highest priority individuals on the Segment 1 waiting list.¹¹⁰ Individuals on the segment 3 waiting list are likely to wait between 3-5 years to be allocated public housing in outer metropolitan regions.¹¹¹

Greater opportunities for people to live in their chosen community

Doorway provides people with a serious mental illness with a greater choice of housing type and location - within the boundaries of their AMHS catchment region¹¹² - relative to different forms of long-term social housing. This means that participants can choose to live embedded in mainstream local communities that may be near members of their natural support networks (such as friends and family), or sports clubs and places of worship etc..

Substantial reduction in financial barriers to private rental

As illustrated in Section 4.4.2 on page 71 above, current levels of CRA are not sufficient to support disadvantaged individuals living in rental accommodation – especially for those people who choose to live alone in metropolitan areas. Section 4.4.2 also demonstrates that current state-funded forms of rental assistance are primarily one-off and short term in nature.

As at November 2013, Doorway provided an average (median) of \$96 per week in rental subsidies for each participant – which equates to a median subsidy of approximately 35% of total rent payments. Figure 40 below illustrates that the median level of rental support provided by Doorway is substantially greater in the two metropolitan regions. Doorway subsidies exceed the levels of financial assistance available under other state-funded programs that target disadvantaged Victorians seeking private rental accommodation.

¹⁰⁸ Parliament of Victoria (2009), *Inquiry into Supported Accommodation for Victorians with a Disability and/or Mental Illness*, p. 57.

¹⁰⁹ Mental Illness Fellowship, Mind and Neami (2010). *Housing needs Survey*.

¹¹⁰ Victorian Government (2010), *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, p. xxii.

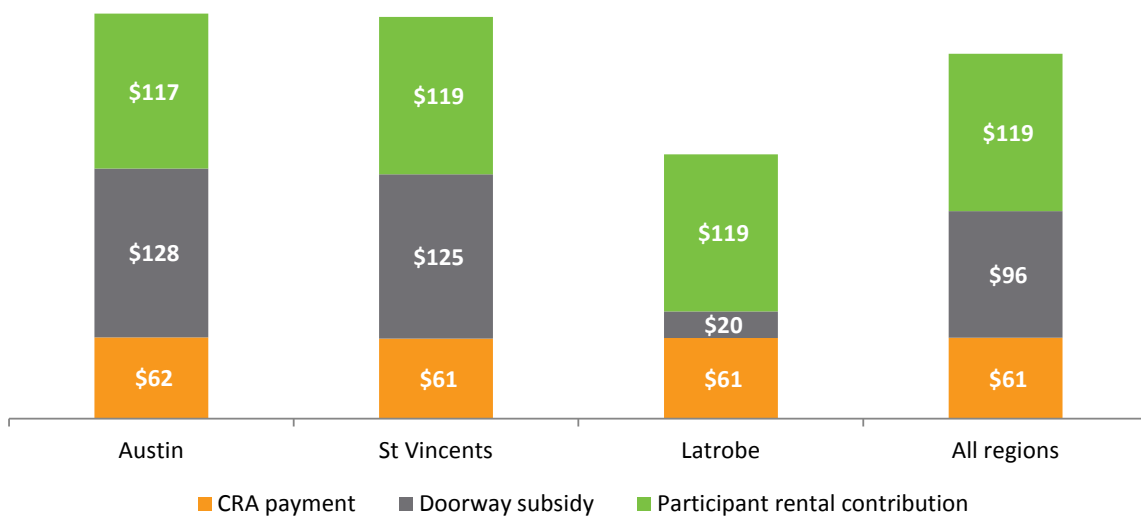
¹¹¹ *Ibid.* pp. 125-6.

¹¹² Under the original design of the Doorway model, participants are required to seek rental accommodation within the catchment region of the AMHS where they are enrolled at the start of the program. It is likely that this requirement will be relaxed in future iterations of the program.

This level of financial support makes accessing and sustaining private rental accommodation much more attainable for Doorway participants. It is intended that these rental subsidies will be reduced to zero by the end of the program (see Section 3.5.7 on page 46 for a discussion of the extent to which this has occurred in practice).

The median level of Doorway subsidy of approximately 35% is less than the level of implicit rental subsidies provided to public housing tenants. The 2012 report into public housing by the Auditor-General noted that public housing rents are significantly below market rates and set and capped at 25% of the tenant's income. Constrained growth rental income and escalating operating costs has resulted in a gap between income and expenses – or implicit subsidy - of 42% in 2011.¹¹³

Figure 40: Median weekly rents, subsidies and gap payment by region (as at November 2013)



Source: Mental Illness Fellowship (2013), Doorway program data

The Doorway program funds additional forms of financial support to participants beyond weekly rental subsidies, such as:

- Four weeks of rental support upfront
- Bond loans for those participants that are not eligible for DHS's Bond Loan Scheme
- Subsidised furnishing package (which includes a bed, bar fridge, couch, kitchen table, cutlery etc.) that is available to participants for a charge of \$6 per week
- Assistance with furniture removalist costs
- Coverage for rental arrears
- Landlord insurance.

¹¹³ Victorian Auditor-General (2012), Access to Public Housing, p. 9.

Provision of skills and track record to support sustainable tenancies

Victorians with a serious mental illness who are homeless or at risk of homelessness can find it very difficult to secure private rental accommodation as the lease holder. As a result, these individuals lack the skills and experience that are necessary to successfully access and sustain tenancies in a highly competitive rental market.

People with a serious mental illness typically face substantial non-financial barriers to accessing and sustaining private rental accommodation. Recent research by the Tenants Union of Victoria (TUV) identified some of the key factors that can dissuade agents and landlords when they are processing tenancy applications. These include:

- Absence of rental history
- Poor work history (indicating instability of income)
- Making a poor first impression based on physical presentation, behaviour, treatment of property, attitude to agency staff, etc.
- Poor literacy skills which impact on ability to complete application forms
- Reliance on Bond Loans or other financial assistance
- Use of Centrepay which is perceived to provide an additional administrative burden and limited flexibility in payment dates/options.

The TUV research noted that the first two barrier factors had the greatest impact on assessments made by real estate agents.¹¹⁴ Doorway seeks to address the barrier to access posed by an absence of rental history by requiring program participants sign the leases for their property in their own right. As a result, Doorway has provided the majority of program participants with their first experience of a positive rental tenancy in their own name. This first step in establishing a positive rental history will make it considerably easier for participants to gain rental accommodation post-program.

Doorway also provides participants with basic tenancy management skills by progressively supporting people to deal directly with their real estate agents and landlords. These skills include finding and attending open inspections, how to communicate appropriately with real estate agents and landlords, completing requisite paperwork, signing leases and lease extensions, managing property inspections, managing co-tenancies, maintaining their property, building relationships with neighbours and day-to-day household budgeting to ensure that payments are met.

Creation of strong partnerships with real estate agents and landlords

The experiences and attitudes of real estate agents and landlords can pose another barrier to private rental accommodation for people with a serious mental illness. TUV research found that agents are often reluctant to lease properties to people with a mental illness. This reluctance can stem from agents lacking information about the specific mental illness conditions of prospective tenants, or about their agreed support arrangements. TUV also found that some agents believe that some individuals with complex and multiple problems (e.g. a combination of mental illness, substance abuse, severe physical disability etc.) cannot afford to pay rent and are therefore not suitable for the private rental market. Agents tend to deal with such individuals by referring them to less expensive areas – an approach that becomes increasingly problematic in outer urban areas.¹¹⁵

¹¹⁴ Tenants Union of Victoria (2009), *Position Paper: Improving Access to the Private Rental Market - Addressing discrimination and other barriers for low-income and disadvantaged households*, p. 5.

¹¹⁵ Tenants Union of Victoria (2008), *Research Report: Access to the Private Rental Market - Industry Practices and Perceptions*, p. 21.

MI Fellowship intentionally built relationships with real estate agents and landlords with a view to overcoming some of the non-financial barriers that people with a mental illness face in accessing private rental accommodation.

In the initial pre-implementation phase of Doorway, MI Fellowship developed a range of marketing collateral that was customised for the particular real estate agency they initially partnered with in each region. Doorway staff also developed a number of incentives to encourage real estates and landlords to support Doorway based on the assumption that they may view the program participants as undesirable tenants due to their mental health status and lack of rental history. These incentives included landlord insurance for each property to protect against rental defaults¹¹⁶ and a surety fund to cover repairs for any wear and tear at the end of each lease.

When the process of searching for properties commenced, the Doorway team worked with each participant to build individual relationships with real estate agents and landlords in each region. Doorway staff also maintained regular contact with real estate agents throughout the pilot program to discuss individual participant circumstances when required and to provide information about the support that they are receiving from the program.

Doorway has attained high levels of buy-in across most of the real estate agents in the three regions which has resulted in these agents supporting Doorway participants in ways that have exceeded MI Fellowship's initial 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 issues¹¹⁷
- Working with H&RWs to avoid sending formal lease breach notices to participants.

Another role played by real estate agents which was not originally anticipated is that of champion and advocate. Doorway staff cite multiple examples of agents advocating directly to landlords on behalf of a participant during the application process. There have also been cases of agents from outside the three Doorway regions expressing interest in participating in any future iterations of the program.

The engagement of landlords with the Doorway pilot has been similarly positive, with few exceptions, although direct contact with landlords occurs less frequently than with real estate agents. Following encouragement from some real estate agents, instances of direct communication between landlords and Doorway staff started to occur early in Doorway's implementation phase. This enabled Doorway staff to

¹¹⁶ In practice very few landlords availed of the option to take out landlords insurance.

¹¹⁷ The Doorway team are currently moving away from this approach towards direct contact between agents and participants when issues arise.

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 buy-in and 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 tenant and her family were supported and given enough time to relocate when their property was sold.

4.6.2 Health and housing services are delivered by a single agency

Doorway is unique in the sense that it is the only Victorian Government funded program where mental health and housing support services are delivered by a single agency. In contrast, both of the new NPA-funded programs are delivered by consortia of mental health and housing/homelessness providers - a model which relies on strong collaboration and referral processes between consortia members.¹¹⁸

There are demonstrated and potential benefits of the single agency model employed by MI Fellowship to deliver both mental health and housing services under the Doorway program:

- **More holistic approach to recovery** – The creation of Doorway H&RW with dual mental health and housing responsibilities can result in a more holistic approach to recovery. The design of the Doorway model requires H&RW 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.

¹¹⁸ *Secure tenancies* is delivered by a core partnership between a state-funded PDRSS providers (the 'lead service provider') and local housing providers. Other partners include specialist clinical mental health services, homelessness, primary health care, social support, Aboriginal community controlled organisations and community welfare services. Similarly, *Breaking the Cycle: reducing homelessness* is delivered and auspiced by either an adult AMHS or state-funded PDRSS provider as the 'lead agency'. The lead provider then works in partnership with an AMHS/PDRSS/homelessness provider, social housing service, primary health (including Aboriginal Community Controlled Health Organisations), social support and community welfare services.

- **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.

“It has been clearer, cleaner and easier with a single provider delivering all the mental health and housing services - there are not the layers of bureaucracies. When there are multiple agencies involved, their needs can sometimes conflict and the priorities of programs can change. It has also been easier for real estate agents having a single point of contact”.

Regional Manager, AMHS

4.6.3 Aspects of Doorway’s delivery of psychosocial support may be unique

Elements of the way Doorway delivers psychosocial support are unique relative to the two NPA-funded programs. These unique elements and associated features are discussed below.

Integrated service delivery with clinical service partners

The partnerships between MI Fellowship and the AMHS hospital site in each of the three regions have been fundamental components of the Doorway model. The success of these partnerships is largely due to the co-location of Doorway staff at the relevant site of each AMHS and governance arrangements that include the involvement of AMHS case managers in integrated support teams, regular meetings between coordinators and clinical team leaders, implementation meetings held at each AMHS, and AMHS representation on the Doorway Advisory Group.

H&RWs and the AMHS staff have noted multiple benefits from co-location and other aspects of their partnership – particularly those related to improved communication and greater involvement by Doorway staff in case reviews and other formal discussions about shared participants. 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 more able to contact clinical staff in person rather than having to rely on the phone.

“There is real familiarity and ease of working and interacting with H&RW that we have not achieved with other PDRSSS providers. Doorway staff are more sharing and caring and less territorial.”

AMHS staff member

All AMHS have provided H&RWs with access to security passes and email accounts which assist with their integration in the clinical team. H&RWs also 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 outcomes for participants.

From a participant perspective there are also benefits to integrated service delivery. As one AMHS staff member noted, “clients seem to really like co-location, they have said to me, ‘I am used to coming here – I can see all my support workers and case manager at the same time’”.

Partnerships with real estate agents

Partnerships between MI Fellowship and local real estate agents in each of the three regions are another fundamental components of the Doorway model. To date MI Fellowship has partnered with twenty-seven real estate agents across the three Doorway regions. The levels of interest from agents in Doorway grew rapidly and organically and resulted in high levels of buy-in and support from all partner agencies.

Real estate agents have offered levels of service to Doorway participants well beyond MI Fellowship's initial 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.

The inclusion of Peer Workers with lived experience

Doorway's H&RW outreach team includes four Peer Workers, who are H&RWs with lived experience of mental health issues, dual diagnosis or homelessness. Peer Workers have the same job description as H&RWs, with additional responsibilities in the form of peer support.

To date, these Peer Workers have added great value to the experience of participants and other staff in the pilot program. Feedback from the Peer Workers suggest that they can relate to participants' struggles more easily than other staff without direct consumer experience, and that disclosing their own experiences can accelerate the process of building trust and credibility with participants.

Participants have also identified the benefits of having a Peer Worker. One person noted that, "Peer Workers understand certain things others don't - you know you are both travelling on the same path". Another remarked that, "Books don't explain the whole condition - I prefer to talk to people with personal experience."

H&RWs without lived experience have also appreciated the different levels of insight and understanding that their Peer Worker colleagues have brought to day-to-day discussions about the experiences and challenges of particular participants.

Participants are formally represented in governance roles

In late 2012, the Doorway Model Development Committee (MDC) added a participant representative from each of the three regions. These participant representatives initially provided 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.

5 Doorway delivers benefits to Government

Doorway was budgeted at \$19,300 per annum per participant – excluding one-off staff and marketing costs relating to the establishment of the pilot.

This evaluation estimates that Doorway saves the Department of Health an estimated \$11,050 in avoided costs per annum per participant through reduced usage of bed-based mental health and ambulatory mental health services, presentations to EDs and hospital admissions. This estimate may be higher if changes in usage patterns for other State Government funded services such as ambulances, drug and alcohol services and community health services were included in the analysis.

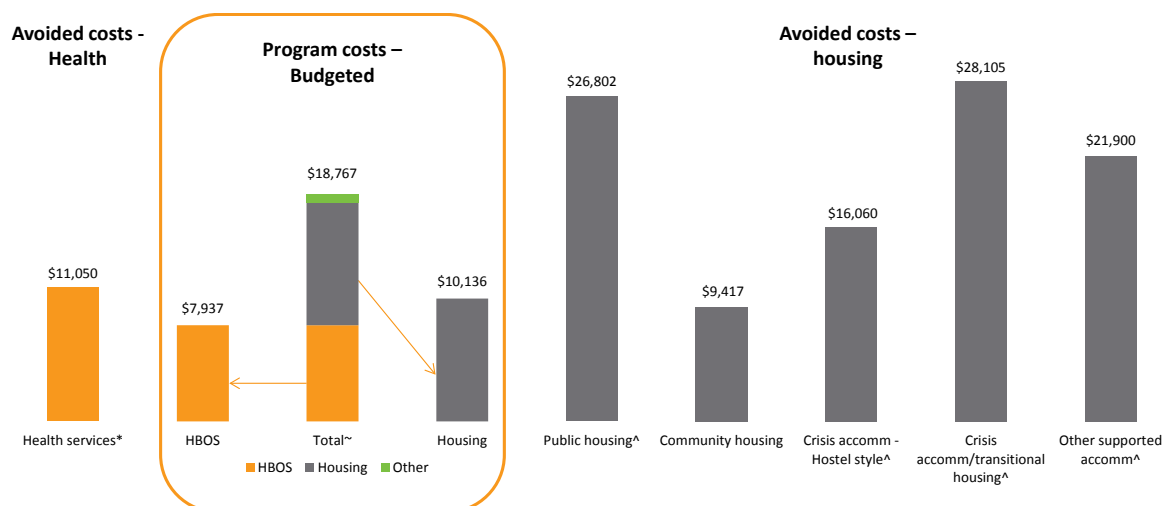
If just the Department’s investment in the mental health Home-Based Outreach Support (HBOS) component of Doorway is taken into account, the changes in health system utilisation result in a **net saving** of approximately \$3,100 per participant per annum – a return of \$1.39 per dollar invested. If Doorway’s full costs (excluding one-off costs) are assessed against benefits related to health outcomes, the **net cost** of the program is approximately \$8,250 participant per annum.

Approximately one-third of Doorway participants resided in some form of social housing prior to joining the program, and it is feasible that an even larger proportion of participants would be residing in social housing if they were not living in private rental accommodation provided through Doorway.

The budgeted housing cost - \$10,136 per participant per annum - is lower than the annual costs of all social housing options when the cost of capital to Government for each option is available and included. The program’s full program costs of \$19,300 per participant per annum (excluding establishment costs) are also lower than the annual costs of public housing, hostel style crisis accommodation and other supported accommodation – when the cost of capital to government is included.

Doorway’s budgeted costs and the estimated avoided costs for health and housing services per participant per annum after joining the program are shown in Figure 41 below.

Figure 41: Program costs and avoided costs per participant per annum (2010-2011 costs where available)



~ Total program costs exclude one-off program establishment costs *Health avoided costs includes changes in participant utilisation of bed-based mental and ambulatory mental health services, presentations to EDs and hospital admissions. ^ All social housing options include the cost of capital to Government – with the exception of community housing given that data is not available. The ‘Other’ category of costs includes program management costs that cannot be attributed to the specific delivery of HBOS or housing services.

5.1 This cost-benefit analysis focuses on two outcome domains

This section of the *Summative Evaluation Report* analyses the cost and benefits of Doorway. This analysis focuses on outcomes in two domains – which correspond with two major Government portfolios:

1. **Benefits related to health outcomes** – costs avoided through reductions in the utilisation of health system services by Doorway participants post access to housing.
2. **Benefits related to housing outcomes** – costs avoided by participants gaining access to private rental properties rather than residing in Government-funded types of social housing.

The scope of this cost-benefit analysis is limited by the absence of pre and post-housing data for some indicators within the two in-scope outcomes domains (as shown in Table 22 below). If the likely changes across all of these indicators in Table 22 were able to be measured, **the potential benefits of Doorway across these two domains would likely be greater.**

Indicators and potential costs and benefits related to social outcomes (e.g. days in prison and interactions with courts) and economic outcomes (e.g. change in earnings and use of Job Services Australia) have been excluded from this analysis due to issues of data availability.

Where possible, nominal 2010/11 cost data has been used to calculate program and health and housing service costs. It should also be noted that due to the earlier than scheduled release of this final *Summative Evaluation Report* (see Section 1.1), sufficient longitudinal data was not available to enable the measurement and comparison of changes in health system utilisation outcomes over multiple years.

Table 22: Scope of the cost-benefit analysis

Outcome area and indicator	In-scope	Change post-housing*	Summary
Health outcomes			
Bed-based mental health services	✓	↓ Decrease	Data sourced from CMI/ODS
Ambulatory clinical mental health services	✓	↓ Decrease	Data sourced from CMI/ODS
Presentations to Emergency Departments	✓	↓ Decrease	Data sourced from VEMD
Admissions to hospitals	✓	↓ Decrease	Data sourced from VAED
Ambulance call-outs	×	↓ Decrease	Pre-intake data not available
Use of drug and alcohol services	×	↑ Increase	Pre and post intake data not available
Use of community mental health services	×	↑ Increase	Pre and post intake data not available
GP consultations	×	↑ Increase	Pre and post intake data not available
Housing outcomes			
Use of social housing	✓	↓ Decrease	Costs for social housing provided
Use of homeless support services	×	↓ Decrease	Pre and post intake data not available

**Changes to post-housing indicators that were not officially measured have been estimated based on qualitative feedback from participants and anecdotal data as well as inferences from other data sources that were collected.*

5.2 Doorway is funded for \$3.1m over three years

The total budget for the three year Doorway pilot program is \$3.1 million over mid-2011 to mid-2014.¹¹⁹ This includes \$205,000 in one-off staff and marketing costs relating to the establishment of the pilot program. If these one-off costs are excluded, the delivery of Doorway is budgeted at \$19,300 per participant per annum.

The Doorway pilot program is funded at the Standard rates of Home-Based Outreach Support (HBOS) to program participants through Victoria's community based Psychiatric Disability Rehabilitation and Support Services (PDRSS).¹²⁰ The Standard level of HBOS is explained in more detail in Appendix B.

The components of the program's total budget – excluding the one-off establishment costs – are shown in Table 23 below. It should be noted that the budgeted costs per participant per annum are based on the assumption that Doorway would provide 36 months of support to a total of 50 participants. Due to the initial delays in implementing the program (see Section 3 of the *Formative Evaluation Report* for more details) and the throughput of Doorway participants, the program will in fact provide an average of 22 months of support to 59 participants.¹²¹

Table 23: Program costs

Item	Total	Per participant /annum (budgeted)
HBOS – Standard	\$1,190,475	\$7,937
Housing costs	\$1,520,400	\$10,136
Recurrent (rental subsidy and furniture replacement)	\$1,180,400	\$7,869
One-off (Bond, furnishing and set up costs)	\$340,000	\$2,267
Program management and operations	\$184,125	\$1,228
Sub-total	\$2,895,000	\$19,300
One-off program establishment costs	\$205,000	
Total funded amount	\$3,100,000	\$20,667

Source: Mental Illness Fellowship (2009), *Proposal for Housing Pilot Project – July 2009*; Department of Health (2011), *Housing Support and Brokerage Demonstration Project - DRAFT ONLY*

¹¹⁹ This excludes evaluation costs of \$120,000 which brings the total funded amount to \$3.22 million.

¹²⁰ It should be noted that the model of HBOS that Doorway is based on will be superseded by reforms under the new Mental Health Community Support Services (MHCSS) which will come into effect in July 2014. Once the new model is in place, former PDRSS clients will receive individualised client support packages that will be funded on the basis of a standard, single-price unit to be known as a Client Support Unit (CSU). Under the MHCSS, providers will vary the number of CSUs allocated to an individual client's support package according to the intensity, frequency and duration of their support needs.

¹²¹ This is calculated based on the assumptions that as at November 2013, there will be no further participants join the program and all current participants will remain in their housing until 20 June 2014.

5.3 Reduced health system utilisation delivers benefits

Doorway saves the Department of Health an estimated \$11,050 in avoided costs per annum per participant through reduced health system utilisation by program participants post-housing– as illustrated in Table 24 below.

As outlined in Table 22 above – the analysis of changes in health system utilisation patterns excludes other Victorian Government funded services such as ambulances, drug and alcohol services and community health services.

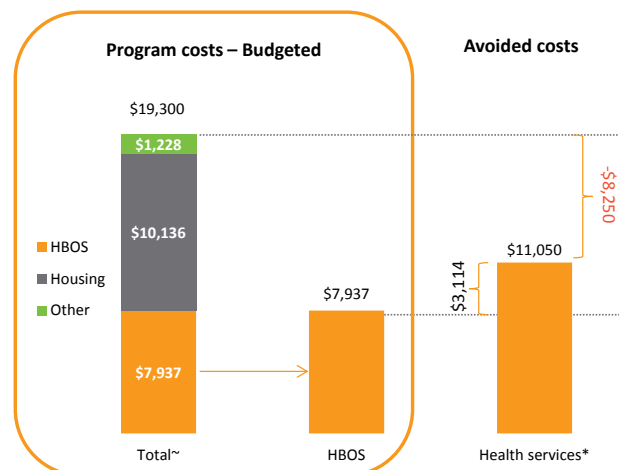
Table 24: Avoided costs related to reduced health system utilisation post-housing (in-scope services)

Service type	Estimated avoided costs per participant /annum
Bed-based mental health services	\$7,400
Ambulatory clinical mental health services	\$1,900
Hospital separation	\$1,400
ED presentation	\$350
TOTAL	\$11,050

NOTE: The cost inputs and estimated avoided cost calculations are outlined in more detail in Appendix E.1.

If just the Department of Health’s investment in the HBOS component of Doorway is taken into account, the measurable changes in health system utilisation result in a **net saving** of approximately \$3,100 per participant per annum – a return of \$1.39 per dollar invested. If Doorway’s full costs (excluding establishment costs) are assessed against just the benefits related to health outcomes, the **net cost** of is approximately \$8,250 participant per annum. These figures are illustrated in Figure 42 below.

Figure 42: Budgeted Doorway costs and avoided health system costs



~ Total program costs exclude one-off establishment costs *Health costs includes changes in participant utilisation of bed-based mental and ambulatory mental health services, presentations to EDs and hospital admissions. The 'Other' category of costs includes program management costs that cannot be attributed to the specific delivery of HBOS or housing services.

5.4 Doorway's housing costs are less than social housing

To calculate the benefits related to housing outcomes for Doorway participants, it is necessary to assume that Doorway participants would otherwise be residing in Government-funded forms of social housing if they were not housed in private rental accommodation subsidised by Doorway. Approximately one-third of Doorway participants resided in some form of social housing prior to joining the program.

Table 25 below compares the annual housing costs per Doorway participant against the costs of a variety of different types of social housing. Where the cost of capital to Government is available and included – the total housing cost per Doorway participant per annum of \$10,136 (see Table 23 above) is lower than the annual costs of all types of social housing. The program's full costs per participant per annum (excluding establishment costs) of \$19,300 are also lower than the annual costs of public housing, hostel style crisis accommodation and other supported accommodation – when the cost of capital is included. Further detail about how social housing costs were sourced can be found in Appendix E.2.

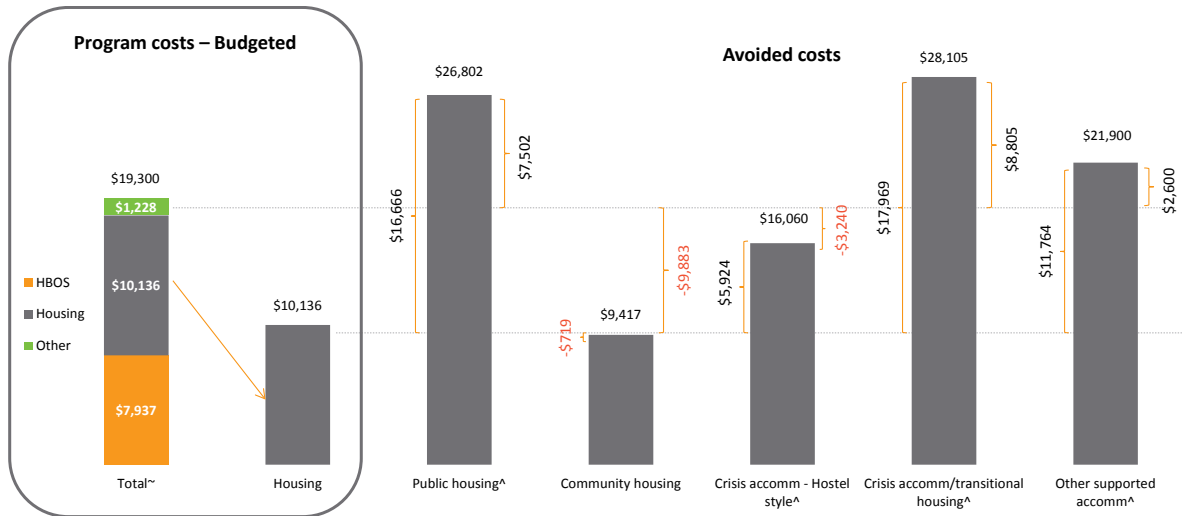
Table 25: Potential net savings per housing type p/a (2010–11)

Social housing type	Cost /annum	Doorway housing costs / annum	Potential net saving / annum^
Public housing (per dwelling)*	\$26,802	\$10,136	\$16,666
Community housing (per dwelling)	\$9,417	\$10,136	-\$719
Crisis accommodation - Hostel style (per bed)*	\$16,060	\$10,136	\$5,924
Crisis accommodation/transitional housing - Non-hostel style (per 2–3 bedroom unit)*	\$28,105	\$10,136	\$17,969
Other supported accommodation (per apartment)*	\$21,900	\$10,136	\$11,764

**All social housing costs include recurrent costs plus the cost of Government capital invested in properties available for client accommodation – with the exception of community housing given that data is not available.*

The net benefits and costs for avoided social housing costs compared to Doorway's housing and total program costs per participant per annum are also shown in Figure 43 below.

Figure 43: Budgeted Doorway costs and avoided social housing costs



~ Total program costs exclude one-off program establishment costs ^ All social housing options include the cost of capital to Government – with the exception of community housing given that data is not available. The 'Other' category of costs includes program management costs that cannot be attributed to the specific delivery of HBOS or housing services.

The cost to participants to access private rental accommodation through Doorway also compares favourably with other alternate housing options. Table 26 illustrates the percentage of income that a single person receiving a DSP pay to access various forms of housing. Under the scenario outlined below - based on a weekly rent of \$300 in private rental accommodation - a Doorway participant's rental costs as a proportion of their income after Commonwealth Rental Assistance payments are actually lower than that of a public or community housing tenant with the same pension income.

Table 26: Weekly rental costs for a single person receiving the Disability Support Pension

Housing provider	Pension income	Rent paid	CRA (\$)	Rent paid after CRA	% of Income
Public Housing	\$376	\$86	\$0	\$86	23%
Community Housing	\$376	\$146	\$60	\$86	23%
Private Rental	\$376	\$300	\$60	\$240	64%
Doorway participant in private rental	\$376	\$113*	\$60	\$53	14%

Source: Department of Human Services (2012), Pathways to a fair and sustainable social housing system, p. 16

*Assumes that the Doorway participant contributes 30% of their income (pre-CRA payments) to their rent and that the residual gap post-CRA would be subsidised by Doorway.

5.5 Potential health and housing benefits are substantial

Through savings related to reduced health system utilisation and the potential avoided costs of social housing the Doorway program can deliver substantial savings to Government across the Health and Human Services portfolios.

Benefits related to measurable health and housing avoided costs net the full costs of the Doorway program (excluding establishment costs) are shown per participant per annum across various forms of social housing in Table 27 below. This table illustrates that the greatest savings from the Doorway program are attainable where, as a result of the program, participants longer need to access public housing and crisis accommodation/transitional housing.

Table 27: Potential benefits post-housing across in-scope health and housing outcomes

Type of social housing	Net benefit per participant /annum*	Benefit per \$ invested
Public housing (per dwelling)	\$19,085	\$2.02
Community housing (per dwelling) - excludes cost of capital	\$1,700	\$1.09
Crisis accommodation - Hostel style (per bed)	\$8,343	\$1.44
Crisis accommodation/transitional housing - Non-hostel style (per 2–3 bedroom unit)	\$20,388	\$2.09
Other supported accommodation (per apartment)	\$14,183	\$1.76

*Net benefit is calculated as follows: avoided social housing costs (including the cost of capital to Government where available) + avoided health system costs per participant – program costs per participant.

5.6 Participant costs compare well to other programs

The budgeted cost for Doorway participants per annum is lower than several other programs that also provide mental health and housing support. Table 28 below shows that Doorway costs are lower than the NPA funded *Breaking the Cycle* program and *Journey to Social Inclusion* (J2SI).

It is important to note that all of the programs included in Table 28 provide services of varying intensity to different client groups with varying rates of throughput. Further details about each of these programs can be found in Appendix D.

In the context of *Secure Tenancies* and *Breaking the Cycle*, it is worth noting that neither the housing components of both programs do not provide the same level of sustained housing and tenancy management support offered under the Doorway service model. Furthermore, *Secure Tenancies* and *Breaking the Cycle* are intended to leverage existing program capacity available in Victoria's homelessness and social housing service systems. For example, housing providers within the program delivery consortia that currently manage community housing are required to link participants to opportunities within their existing portfolio. These providers are not allocated additional properties owned by the Director of Housing to manage or funded through *Breaking the Cycle* or *Secure Tenancies* to purchase or construct other dwellings.

Table 28: Comparison of budgeted participant costs per annum

	Doorway (Total costs)	Secure Tenancies ¹²²	Breaking the Cycle ¹²³	J2SI ¹²⁴
Total budget	\$3.1m^	\$9.9m^	\$12.2m	\$3.92m
Project years	3	5	4	4
Service delivery years	3	4	4	3
Participants (forecast)	50	140	100	40
Budgeted cost per participant p/a	\$20,667	\$17,679*	\$30,500	\$32,667

[^]Program budgets sourced from Appendix 1 of the NPA on Supporting National Mental Health Reform.

^{*} Secure Tenancies participant cost is an average based on 100 participants receiving an indicative total of 3 hours per week of Standard HBOS support (at a cost of \$13,750 per annum) and 40 participants receiving an indicative total of 6 hours per week of Moderate HBOS support (at a cost of \$27,500 per annum).

¹²² Department of Health (2012), *Invitation for Submissions - Mental health support for secure tenancies*.

¹²³ Department of Health (2012), *Invitation for Submissions - Breaking the cycle: reducing homelessness*.

¹²⁴ S Parkinson (2012) *The Journey to Social Inclusion Project in Practice: A Process Evaluation of the first 18 months*..

6 Doorway's cessation will have varied impacts

The impacts of Doorway's cessation on current program participants will be varied. Participants who are currently employed and have been discharged from their AMHS to their GP will be most likely to sustain the gains made while participating in Doorway. Conversely, there are other participants who may well experience a backwards step in their recovery at the end of Doorway.

Different strategies have been put in place to minimise the impacts on participants of the current program ceasing. H&RW are engaged in ongoing conversations with Doorway participants about their intended post-program housing arrangements. Some participants are talking to their real estate agency looking at more sustainable housing arrangements, such as moving to cheaper properties or suburbs and sub-letting their property to family members, friends or other tenants. Participants are being actively encouraged by H&RW to independently manage relationships with members of their formal and informal support networks. Finally, Doorway participants are working with their H&RW to identify how their ongoing needs post-Doorway could be met by alternate formal or informal supports in their region.

Doorway's cessation will also impact the community sector more broadly. There is a possibility that valuable lessons that have been learnt through the pilot project about the design and implementation of the Doorway model could be lost if the current program were not extended in some form. One particularly important and unique aspect of the Doorway model is the integrated delivery of mental health and housing and support services by a single agency.

Finally, there is a risk that existing momentum with key Doorway partners could be lost if the program did not continue. The close working relationships between Doorway and its clinical and real estate partners have resulted in changes in attitudes about how people with a serious mental illness to access and sustain rental accommodation if the right supports are provided. The program has raised awareness levels about the direct roles that partners can bring in supporting private rental tenancies under the Doorway model. The continuation of the Doorway model will embed these changes in attitude and awareness, and also provide the opportunity for new partners to be exposed to the Doorway model of support – particularly in the property sector among real estate agents and landlords.

6.1 Participants will be impacted in different ways

Outcomes for many Doorway participants may still be sustainable if funding for the program ceases in June 2014 as originally intended. The Doorway participants that are most likely to sustain the gains made while participating in Doorway are typically the ones that are currently employed and have been discharged from their AMHS to their GP. Conversely, there are participants that will likely take a backwards step in their recovery at the end of Doorway.

The likelihood of varied outcomes post Doorway is largely due to participants being at very different points in their recovery journey. This variance can also be attributed in part to the different durations of support received by Doorway participants – which is due to the staggered implementation across the three regions at the start of Doorway and the continued throughput of participants in the program.¹²⁵

It is important to note that the true impact of ceasing the program will likely not be known until at least six to twelve months after the program has ceased, given the lead time involved with some of the strategies that are being put in place to sustain improved outcomes made under Doorway.

¹²⁵ The entry of new participants continues as at November 2013.

MI Fellowship does not have the resources to provide any direct and ongoing support to Doorway participants under the auspices of Doorway after the completion of the pilot program in June 2014 – with the possible exception of three additional months of support for selected participants.

This section explores the likelihood of participant outcomes being sustained post-Doorway and several of the key strategies put in place by MI Fellowship to mitigate the potential impacts of the Doorway program ceasing in 2014.

6.1.1 Different strategies are in place to sustain housing outcomes

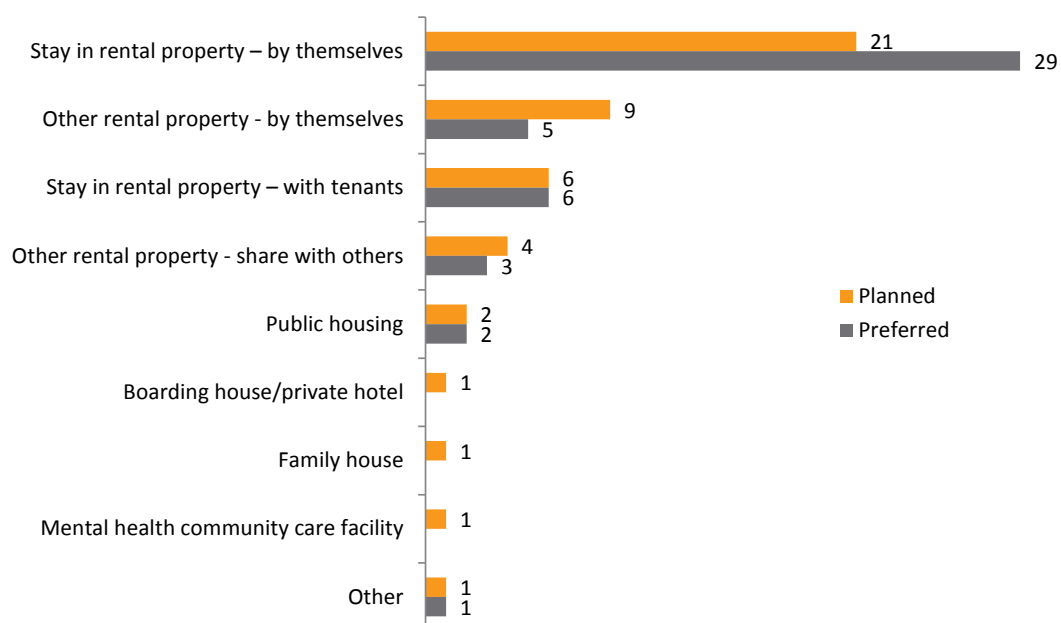
Feedback from participants indicates that the progress of their recovery journey post-Doorway is highly contingent on their ability to sustain stable and suitable accommodation. At present, Doorway participants have identified a number of different strategies to achieve this goal.

With the official end of Doorway pilot only seven months away, all current participants are currently engaged in conversations with their H&RW about their intended post-program housing arrangements. There are a variety of strategies that participants plan to enact to sustain their housing outcomes post Doorway – as shown in Figure 44 below.

In November 2013, seven months prior to the end of the pilot program, all bar six of the forty-six current Doorway participants who nominated their intended post Doorway housing arrangement plan to stay in rental accommodation of some sort – as shown in Figure 44. Half of these forty participants plan to continue living alone in their current accommodation. Of the nineteen participants who plan to move from their current rental property, twelve specified rental affordability as their primary reason for moving. The next most commonly cited reason for planning to move was to seek greater proximity to natural supports (three participants).

Figure 44 also shows the discrepancy between participants who would prefer to stay in their current property by themselves, versus those who actually plan to do this. Of the nine participants whose planned and preferred housing arrangements do not align, seven will not be enacting their preferred housing for affordability reasons.

Figure 44: Planned and preferred post-Doorway housing arrangements as at November 2013 (n=45)



Qualitative feedback collected from participants in the past month indicates that some participants are not feeling confident about their ability to enact their planned post-Doorway housing arrangements. The sources of concern and anxiety for these participants include the need to find a new rental property and predicting how well they will cope if they are moving away from their natural supports or place of current employment. Doorway staff are currently discussing these issues with participants ahead of the June 2014 program end date.

The varied feedback from participants about how they are feeling about their post-Doorway housing and support transitions are represented by the quotations in Box 5 below.

Box 5: Selected participant quotes about their post-Doorway housing arrangements

- “I won’t be able to stay on in my current place after Doorway. There is just no way I could afford it. I can’t share with someone else as my kids stay with me two nights a week. Even if I had a one bedroom flat and my kids slept on the floor – there is just nothing in this area I can afford. I really don’t know what I’m going to do”.
- “At the end of Doorway I’ll need to leave my current place. I need to find somewhere that will be sustainable without the rental subsidies. I’m planning to move to Gippsland where it’s more affordable and MI Fellowship has services there. I’ve been meeting with my support worker - they are helping me out a fair bit, talking to Gippsland about finding me a house there. I don’t want to leave it too late. If you leave it too late can get stuck with nowhere to live.”
- “I need to stay in this area to be near my mental health workers and private rental is just too expensive. I have applied for public housing - but I can’t go on the priority list until I’m actually homeless. I have also applied for co-op housing. I’m pretty anxious about the end of the program - going back to public or co-op housing will be a big change. Living in the flats would be a big change as they are so small – I’ve got pets now and I wouldn’t have a garden. The people around public housing also worry me – I wouldn’t feel safe.”
- “I would prefer to live in this area, even in a shared household, rather than alone somewhere I can’t afford. Moving is not the end of the world. Worse things have happened to me - I’m pretty relaxed and not too fussed about moving.”
- “I haven’t really spoken to anyone about the end of the program. I can afford to stay where I am without Doorway’s help no worries. I’m not too worried in my current circumstances.”
- “We have been talking about what will happen next. I’ve been pretty anxious about what will happen to me and where I’ll be living. Where I am now will be too expensive. Moving means I would lose my Doorway support as I would be out of the area. I would also need to find new doctors.”

It is worth noting that there several participants have reunited with family members after being housed, which has led to a decreased reliance on rent subsidies - which may continue post Doorway. H&RWs cited examples where family members had moved into a participant’s house, enabling them to share living expenses and reduce their reliance on rent subsidies.

The economic independence achieved by participants sharing living expenses is contingent on the relationship between the participant and their co-tenants, and does not directly translate into ongoing economic independence.

6.1.2 Some participants may face difficult choices post-Doorway

The financial capacity for some participants to enact and sustain their planned post-program housing arrangements may be limited – particularly given the current levels of available State and Commonwealth private rental support programs (see section 4.4.2 on page 71 above).

Figure 45 below shows that there are twenty participants who are planning on staying in their current rental accommodation by themselves who will have post-housing incomes under or close to the poverty line¹²⁶ once the rental subsidies provided by Doorway cease. Of these seventeen participants, Figure 45 illustrates that only five of them are currently employed.

Figure 45: Fortnightly pre-tax income after housing costs for current Doorway participants



Source: Doorway housing statistics (November 2013)

NOTE: Poverty line is based on post-tax income threshold and participant incomes are presented pre-tax.

The Poverty line is set at \$474.52 in fortnightly post-tax income after housing costs. The definition is based on current definitions from the Melbourne Institute of Applied Economic and Social Research for a single person household where the main income unit is not in the workforce.¹²⁷

Those participants who plan to remain by themselves in their current accommodation with their post Doorway housing income below or close to the poverty line are likely to face some serious difficulties at the conclusion of the current program. This dilemma will be particularly acute for participants and their carers who do not wish to seek alternate and more financially sustainable forms of accommodation.

Several participants consulted for this evaluation explained how their mental illness makes living with others very difficult, or how moving to a more affordable location would severely hamper their ability to access their formal and natural support networks.

"I have Schizophrenia and can't live with anyone else – I need to be by myself. I can't afford to live in place after Doorway and I need ongoing support. Every time start to think about end of program anxiety levels go up".

Doorway participant

¹²⁶ Defined as <\$300 in post-housing income per fortnight.

¹²⁷ Melbourne Institute of Applied Economic and Social Research (2013), *Poverty Lines: Australia - June Quarter 2013*.
<<http://melbourneinstitute.com/downloads/publications/Poverty%20Lines/Poverty-lines-Australia-June2013.pdf>>

In the cases of some participants – particularly those with serious mental health conditions and complex care needs - there is a **risk that some of the positive outcomes achieved in Doorway will be lost** if they are not in a position at the end of the program to enact their planned housing arrangements.

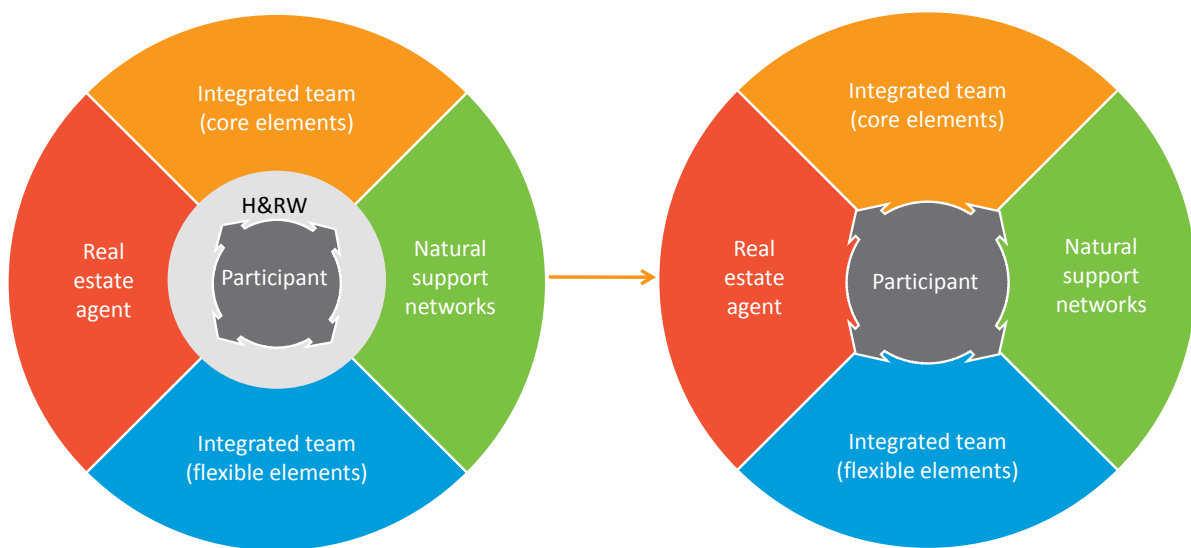
“If the program ends tomorrow and I lost my accommodation, I will be homeless and in a downward spiral. I will also end up costing the Government 3-5 times more than the subsidies I am receiving now.”

Doorway participant

6.1.3 Participants are encouraged to manage relationships independently

One of Doorway’s key goals is for all participants to reach the point where they are well enough and willing to manage the key relationships by themselves - as shown in Figure 46 below.

Figure 46: Core elements of the initial Doorway model



At present, many participants are still in the process of being able to independently manage the relationships with their integrated team, real estate agents and natural support networks. Given the complexity of the needs of many Doorway participants it was always anticipated that these transitions could take time.

Some of the strategies currently being enacted to increase participant’s ability to self-manage their formal and natural support networks include:

- Assisting Property Managers and tenants to resolve issues together without the involvement of H&RW staff
- Encouraging participants to start paying their rent directly to real estate agents rather than through MI Fellowship
- H&RWs and participants agreeing to a gradual reduction in meeting frequencies
- Participants relying more on their natural support networks for help and guidance.

6.1.4 Some participants are linking to alternate forms of support

Doorway participants are currently in discussions with their H&RW about their ongoing needs post-Doorway and identifying whether these are to be met by formal or informal supports. Doorway staff are also working closely with other services in each region to identify what support they can provide to participants. Alternate formal supports that participants are already accessing or planning to access include local community mental health and Alcohol and other Drug (AOD) providers, local community groups, and employment and education providers. Real estate agents are also assisting some participants to obtain more affordable properties within their local areas.

Where formal support needs have been identified, H&RW's are making efforts to ensure that services are delivered jointly with other providers where possible and relevant formal and informal supports are included in integrated team meetings over the next seven months to ensure that structured handovers take place.

It is important to note the planned changes to PDRSS and AOD service delivery that will come into effect as the Doorway pilot program is ending. This may impact the capacity of some of the identified alternate support providers to provide post-Doorway support to participants.

6.1.5 Property managers will support continued tenancies

The Property Managers consulted for this evaluation all expressed a desire to support the continued tenancies of Doorway participants wherever possible – as evidenced by the feedback in Table 29 below. Property managers did acknowledge the challenges associated with participants being able to maintain their rental payments. Most Property Managers though remain relatively optimistic about the capacity of many of the Doorway tenants to sustain their tenancies at the end of the pilot program.

Table 29: Selected feedback from Property Managers about post-Doorway tenancies

- "The agency is planning to stay involved at the end of Doorway. One of the clients we will have no issues with keeping on, one we may be more concerned about but will give it a go. At the end of Doorway we will contact the tenants and put them on Centrepay. We would [also] be willing to provide references."
- "Obviously now the rent is guaranteed there is some security for us and the landlord – but I think [after Doorway] we would all be willing to give it a go and see what happens."
- "At the end of Doorway we should be able to keep our tenants on - we will definitely give it a go. As long as they are paying their rent there is no reason not to."
- "In terms of keeping [the Doorway] tenants on, there is one we would have no issues with. It is difficult to say with the other tenant – they are really not well (they have been hospitalised during the year) and I would be concerned for their health and wellbeing. We would do everything we could to try and keep them going but without extra support it would be hard."

6.1.6 Selected participants may receive three months of additional support

MI Fellowship is currently assessing the feasibility of offering an additional three months of support for a small number of Doorway participants following the official completion of the pilot in June 2014. Decisions about which participants may receive additional support will be based on the extent to which this extended support will increase the likelihood of their Doorway related outcomes being sustained. MI Fellowship will consider a number of factors, which include each participant's:

- Current point in their recovery journey
- Current support needs

- Time to date in Doorway
- Timing of current lease expiration
- Current capacity to enact planned post-program housing arrangements.

6.2 Existing momentum with partnerships could be lost

One of the significant achievements of the Doorway pilot – as outlined in Section 6 of the *Formative Evaluation Report* – has been the program’s strong and effective engagement with clinical and real estate partners. Doorway’s existing clinical and real estate partners have seen the first-hand benefits for clients that can be achieved and partners consulted for the evaluation expressed a desire for Doorway to continue. MI Fellowship has also been contacted throughout the pilot program by real estate agents outside the three catchment regions wanting to participate in Doorway after learning about the program from colleagues in other offices.

The close working relationships between Doorway and these two groups of partners have resulted in changes in attitudes about how people with a serious mental illness can access and sustain rental accommodation if the right supports are provided. The program has raised awareness levels about the direct roles that partners can contribute in supporting private rental tenancies under the Doorway model. The continuation of the Doorway model will embed these changes in attitude and awareness, and also provide the opportunity for new partners to be exposed to the Doorway model of support.

Real estate agents and landlords in particular can continue to play a critical role in facilitating and sustaining access to private rental accommodations for Victorians with a serious mental illness – even outside the scope of formal Government funded projects. It would be a significant lost opportunity if Doorway did not continue to play a facilitation and awareness-raising role in the property sector. This would deny greater numbers of real estate agents and landlords the opportunity to work with Doorway staff to understand how they can best work with prospective tenants with a serious mental illness.

7 Doorway is being delivered according to plan

NOTE: Further information about the extent to which Doorway has been delivered within its intended budget and scope can be found in the accompanying *Doorway – Formative Evaluation* report.

7.1 The Doorway pilot is being delivered within scope

The intended scope of the Doorway project – as outlined in the draft Funding and Service Agreement (FASA) in Appendix F.2.¹²⁸ – has largely been met. The original program objectives have been fully met as have those intended outcomes which can be measured within the timeframe for this evaluation. All of the original participant eligibility criteria - where practical - and all four of the original model components were incorporated in the design and implementation of the Doorway model.

7.1.1 Objectives have been met

The original program objectives stated in Appendix F.2.1 have been fully met in the design and implementation of the Doorway pilot.

7.1.2 Eligibility criteria reflect intended participant characteristics

The eligibility criteria for the Doorway pilot program largely incorporated the participant characteristics outlined in Appendix F.2.2. The eligibility criteria for the Doorway – as articulated in December 2011¹²⁹ – target participants that are:

- Living with a serious mental illness or requiring service from an AMHS
- Homeless or at risk of imminent homelessness (including those in Segment 1 of the DHS public housing segmented waiting list)
- Willing to give consent for members of the Integrated Team to share information with each other
- Currently case-managed by an AMHS
- Want to live in the designated area
- Willing to accept support
- Currently receiving a DSP.

In practice, it was not practical to preclude potential participants during the intake and referral process based on the second of the three criteria outlined in Appendix F.2.2 – participant awareness of their rights and responsibilities under the Residential Tenancies Act (RTA). It was more important for all prospective Doorway participants to be made aware of their obligations under the RTA prior to joining the program. This process led to some participants withdrawing from the intake process after learning about and not wanting to assume the responsibilities associated with leasing a private rental property.

¹²⁸ This draft Doorway FASA was not finalised or signed by the Department of Health and MI Fellowship.

¹²⁹ Mental Illness Fellowship (2011), *Doorway: Enhanced Housing First Demonstration Project - Model Development - December 2011*

7.1.3 The Doorway model reflects its intended design

The design Doorway model incorporates the four model components outlined in Appendix F.2.3. The design and evolution of the Doorway model is explored in further detail in Section 2 of the *Formative Evaluation Report*.

7.1.4 Short-term outcomes have been achieved

The intended outcomes of the Doorway pilot listed in Appendix F.2.4 which can be measured at this point in time have largely been met. Progress against post-Doorway participant outcome indicators cannot be measured until at least late 2014 or early 2015. Progress to date against each of the intended pilot program outcomes is assessed in Table 30 below.

Table 30: Progress to date against intended outcomes

Intended outcome	Extent to which achieved
<ul style="list-style-type: none"> • Clients accepted into program are offered private rental opportunities and support to maintain their tenancy 	<p>Fully met – All prospective program participants that went through the intake process were supported to access private rental accommodation – with the exception of those individuals that chose to exit the program prior to this occurring. All Doorway participants that were successfully housed in rental accommodation have been offered ongoing support to maintain their tenancy.</p>
<ul style="list-style-type: none"> • Clients maintain their tenancy when program financial support ceases 	<p>N/A – The extent to which this outcome has been met will not be known until after the completion of the pilot program in June 2014. As discussed in Section 6.1.1 on page 97, Doorway staff have ensured that different strategies are in place to sustain housing outcomes for participants following the completion of the program. Some participants may find it challenging to maintain their current tenancies though – as highlighted in Section 6.1.2 on page 98</p>
<ul style="list-style-type: none"> • Clients maintain their tenancy when program specific support ceases. 	<p>N/A – see above.</p>
<ul style="list-style-type: none"> • Client outcome measures indicate an improvement in level of functioning during program, which is sustained after transition from the program 	<p>Positive signs to date – The majority of Doorway participants have achieved substantial gains in their mental health and overall wellbeing since the start of the pilot program – as discussed in Section 3.3. Qualitative feedback indicates that gains for many participants are likely to be sustained after the completion of the program.</p>
<ul style="list-style-type: none"> • Real estate agents in the catchment have confidence in the capacity of: <ul style="list-style-type: none"> ◦ people with a mental illness to engage in private rental ◦ the program to enhance the opportunities of people with mental illness ◦ to succeed in private rental 	<p>Fully met – See Section 6.2 of the <i>Formative Evaluation Report</i>.</p>
<ul style="list-style-type: none"> • Local PDRSS and clinical providers are engaged in joint management of clients 	<p>Fully met – All three clinical partners for the pilot program have been involved in jointly managing Doorway participants. MI Fellowship’ engagement with other PDRSS and providers has been more selective.</p>

Intended outcome	Extent to which achieved
<ul style="list-style-type: none"> The mental health sector in catchment demonstrates increased knowledge of how to link clients with housing and private rental 	<p>Partially met – Representatives from the three AMHS partners for the Doorway pilot program have had some involvement with the management of relationships with real estate agents and the ongoing process of supporting participants to sustain their tenancies through their involvement in Doorway’s various committees and advisory groups. It is not clear at this point in time whether the AMHS’ increased knowledge around supporting people with a mental illness access private rental accommodation could be applied in practice in the future without the additional support of Doorway staff.</p>

7.2 Doorway is forecast to be delivered within budget

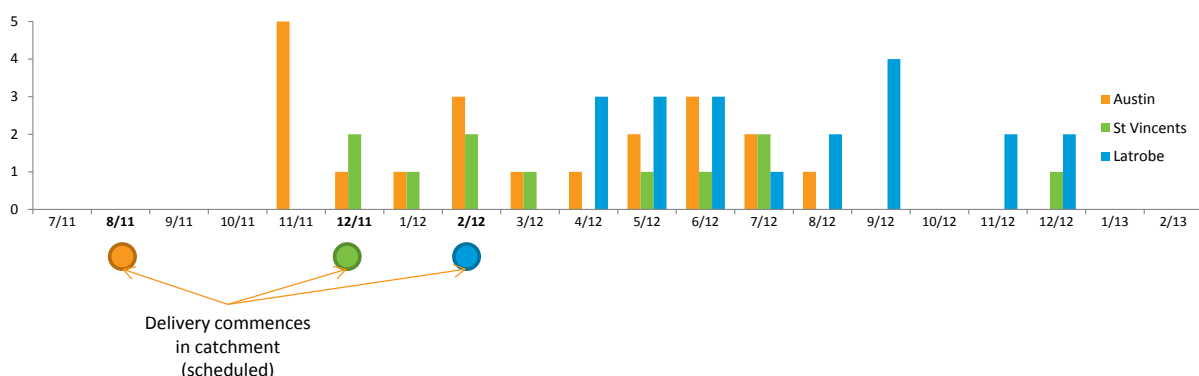
MI Fellowship has forecast that the Doorway pilot program will be delivered within the original budget figure of \$3.1 million specified in Appendix F.2.5.

7.3 The initial implementation of Doorway 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. The intended target of all three Doorway regions functioning at full capacity by January 2012 (see Appendix F.3) 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 – was delayed. As illustrated in Figure 47 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 47: Number of participants housed by region (as at February 2013)



Delays in providing housing for participants were largely due to the challenges MI Fellowship faced in establishing the operational base for the program and building the relationships and expertise required to support participants to source and secure rental properties. The factors that contributed to the challenges are explored in more detail in Section 3 of the *Formative Evaluation Report*.

Due to the initial delays in implementing the program the initial target of providing support to fifty Doorway participants over a period of three years will not be met at the completion of the pilot program. Once the ongoing throughput of Doorway participants is taken into account, the program will provide an average of 22 months of support to 59 participants at the end of the three years..¹³⁰

7.4 Governance and risk management practices are appropriate

MI Fellowship has employed appropriate governance and risk management practices since the inception of the Doorway pilot. Doorway's governance arrangements evolved over the first 18 months of Doorway, as the program moved beyond the initial implementation phase. In the initial enthusiasm to house and support participants the development of several policies and systems lagged behind during this period. These issues have since been rectified.

The program's risk management practices have also become fit-for-purpose over time - after a very strong initial focus on risk management during the initial set-up phase. There have been lower than expected levels of reported incidents since the start of the Doorway pilot. To date, there have been single occasions of DoH Category 1¹³¹ and 2 incidents and six Category 3 incidents reported.

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.

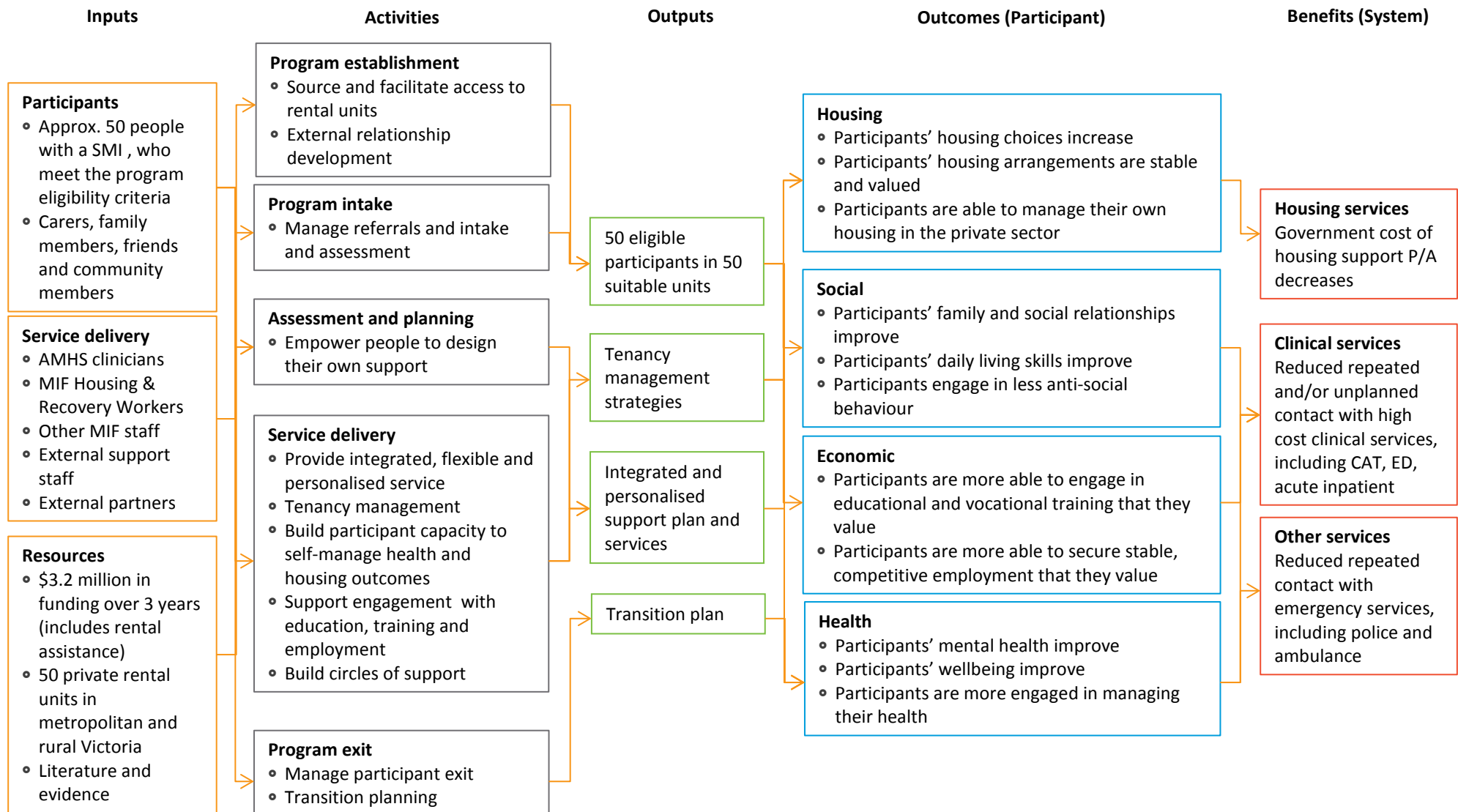
Doorway's governance and risk management practices are discussed in further detail in Section 4 of the *Formative Evaluation Report*

¹³⁰ This is calculated based on the assumptions that as at November 2013, there will be no further participants join the program and all currently participants will remain in their housing until 20 June 2014.

¹³¹ 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.

Appendix A Evaluation methodology

A.1 Program logic framework



A.2 Summative evaluation lines of enquiry

Domain	Outcome	Line of enquiry
Housing	Participants' housing choices increase	<ul style="list-style-type: none"> Do participants have choice in what housing arrangements they have?
	Participants' housing arrangements are stable and valued	<ul style="list-style-type: none"> Are housing arrangements and surrounding amenities fit for purpose? Are the participants' housing arrangements more stable? Are participants able to afford their housing? Are participants satisfied with their new housing arrangements?
	Participants are able to manage their own housing in the private sector	<ul style="list-style-type: none"> Are participants better able to manage their own housing arrangements? Are participants better able to source their own housing accommodation?
Social	Participants' family and social relationships improve	<ul style="list-style-type: none"> Have participants' family and social relationships and networks improved?
	Participants' daily living skills improve	<ul style="list-style-type: none"> Are participants better able to manage day-to-day activities?
	Participants engage in less anti-social behaviour	<ul style="list-style-type: none"> Are participants less likely to engage in anti-social behaviour? Are participants less likely to come into contact with the legal system?
Economic	Participants are more able to engage in educational and vocational training that they value	<ul style="list-style-type: none"> Are participants better able to access education and training? Are participants better able to participate in education and training?
	Participants are more able to secure stable, competitive employment that they value	<ul style="list-style-type: none"> Are participants better able and willing to access competitive and valued employment? Are participants better able to maintain competitive employment that they value?
Health	Participants' mental health improve	<ul style="list-style-type: none"> Have participants mental health improved?
	Participants' wellbeing improve	<ul style="list-style-type: none"> Do participants feel that their wellbeing has improved?
	Participants are more engaged in managing their own health	<ul style="list-style-type: none"> Are participants more engaged in managing their own health? Do participants feel that they are engaging in healthier behaviours? Have the participants built stable relationships with local health providers?

A.3 Outcomes measurement tools

Tool	Overview	Subscales
Primary tools		
Homelessness Outcomes Star	<p>The Homelessness Outcomes Star is the lead instrument used to measure change in the summative component of this evaluation.</p> <p>The Outcomes Star for the homelessness sector is completed by participants in conjunction with program staff.</p> <p>The Outcomes Star is a recovery focused tool that measures a person's progress across ten dimensions and any difficulties they may be facing on their journey of recovery.</p> <p>The tool is based on the assumption that people make changes across five stages in areas of their life where they are experiencing problems: stuck, accepting help, believing, learning and self-reliance.</p> <p>The Star was developed by the London Housing Foundation and Triangle Consulting.</p>	<ul style="list-style-type: none"> • Motivation and taking responsibility • Self-care and living skills • Managing money and personal administration • Social networks and relationships • Drug and alcohol misuse • Physical health • Emotional and mental health • Meaningful use of time • Managing tenancy and accommodation • Offending
Secondary tools		
ASSIST	<p>The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a clinician completed survey designed to detect and manage substance use and related problems in primary and general medical care settings.</p> <p>It was developed for the World Health Organization (WHO) by an international group of substance abuse researchers.</p>	<ul style="list-style-type: none"> • Tobacco products • Alcoholic Beverages • Cannabis • Cocaine • Amphetamine type stimulants • Inhalants • Sedatives or Sleeping Pills • Hallucinogens • Opioids • Other
HoNOS	<p>The Health of the Nation Outcome Scales (HoNOS) is a clinician completed measure which assesses a client's health status and the severity of their mental disorder over the previous two weeks.</p> <p>It is used as a standard outcome measure for specialist mental health services across Australia, as well as internationally.</p>	<ul style="list-style-type: none"> • Behavioural problems • Impairment • Symptomatic problems • Social problems
BASIS-32	<p>The Behaviour and Symptom Identification Scale (BASIS-32) is a client completed measure of the major symptoms and functioning difficulties experienced by people as a result of a mental illness.</p> <p>It is designed to be completed by clients with reference to their experience over the previous two weeks, but can be used as a structured interview if required.</p>	<ul style="list-style-type: none"> • Relation to self and others • Daily living and role functioning • Depression and anxiety • Impulsive and addictive behaviour • Psychosis

A.4 Department of Health datasets

Table 31 below provides an overview of the three Department of Health datasets that were used to measure changes in service utilisation and mental health outcomes tool scores (HoNOS and BASIS-32) for Doorway participants over time. De-identified data from these datasets was provided for this evaluation using unique and randomly generated IDs that were used specifically for the purposes of this evaluation.

Table 31: Overview of Department of Health datasets

Dataset	Overview
Victorian Admitted Episodes Dataset (VAED)	The VAED comprises demographic, clinical and administrative details for every admitted episode of care occurring in Victorian hospitals, rehabilitation centres, extended care facilities and day procedure centres.
Victorian Emergency Minimum Dataset (VEMD)	The VEMD contains de-identified demographic, administrative and clinical data detailing presentations at Victorian public hospitals with 24-hour Emergency Departments.
Client Management Interface (CMI)/ Operational Data Store (ODS)	CMI/ODS is the Victorian public mental health client information management system and comprises the local client information system and data store used by Victorian public area mental health services (AMHS) to support continuity of treatment and care.

A.5 Qualitative data collection

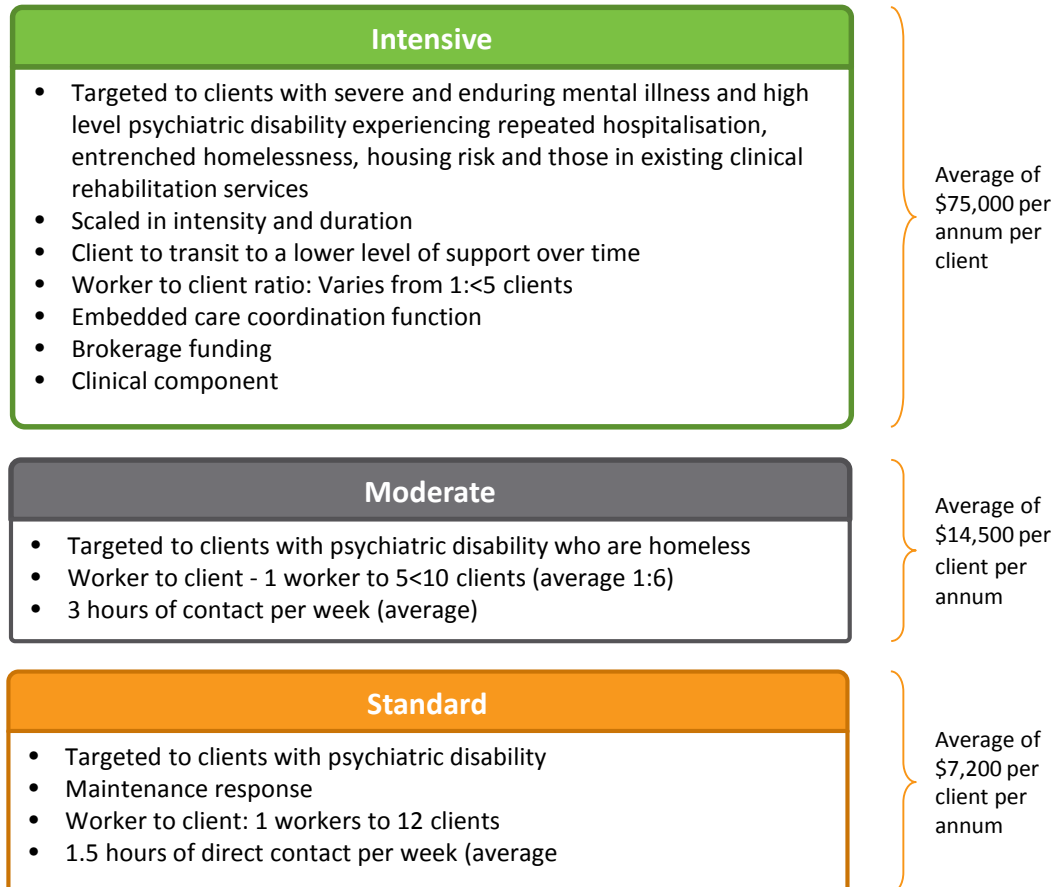
Table 32 outlines the number of participants and carers consulted throughout the evaluation process.

Table 32: 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	

Appendix B Home Based Outreach Support

Figure 48: Overview of Levels of the PDRSS Home Based Outreach Program (2010-2011 costs)



Source: Nous Group (2011), *Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services*

Appendix C Outcomes data

C.1 Participant interactions with police

Table 33: Reasons for police contact

Reason for police contact	Instances
Participant as perpetrator – No charges	
Noise complaint	2
Approached while under the influence of alcohol	1
Verbal harassment of neighbours	1
Domestic dispute	1
Participant as perpetrator – Charges resulted	
Arrested for breaking and entering	1
Participant as victim	
Domestic violence	2
Procedural	
Welfare check	5
Escorted participant to hospital	4
Mental health episode	2
Participant as bystander	
House was raided due to activities of housemate	1
Housemate passed away	1

Appendix D Overview of other programs

D.1 Similar national projects

This premise of the Doorway model is that stable housing can play a fundamental role in the recovery of people with serious mental illness. This model builds upon and adapts the Housing First model.¹³² A number of other programs within Victoria and New South Wales have adopted a similar premise, although cohort groups are not necessarily restricted to people with a mental illness. Table 34 below provides an overview of five similar programs, the targeted cohort group, and the high level objectives of each.¹³³

While each of these models has unique elements, in evaluating Doorway it is valuable to compare the outcomes across these programs. This comparative analysis enables identification of areas where the broad service model is consistently successful, and where there are opportunities for improvement.

Table 34: Overview of comparable programs

Program	Target group	Objectives	Based on Housing First	Timing	Coverage	Implemented by
Doorway	Individuals with a serious mental illness who are at risk of homelessness	To assist consumers to access private rental housing; manage tenancy, engage with local community & access education, training and/or work.	✓	Mid 2011- mid 2014	Austin, St Vincents and Latrobe AMHS catchment regions	Mental Illness Fellowship
Housing and Accommodation Support Initiative (HASI)	Consumers with serious mental illness	To provide people with mental illness with access to stable housing, clinical mental health services and accommodation support.		2002 – ongoing	NSW	NSW Government
Journey to Social Inclusion (J2SI)	People who had slept rough continuously for 12 months or who had been in and out of homelessness for at least 3 yrs.	To stabilise housing and improve health, mental health, quality of life and social participation and inclusion.		2009-2012	St Kilda	Sacred Heart Mission

¹³² The origins of the Doorway program are discussed in detail in the Formative Evaluation Report.

¹³³ Note this is a selection of comparable programs and not a comprehensive list of all existing programs in Australia that target a similar cohort to Doorway.

Program	Target group	Objectives	Based on Housing First	Timing	Coverage	Implemented by
Melbourne Street to Home	Chronically homeless rough sleepers	To assist participants to achieve permanent accommodation; provide support for 12 months to maintain accommodation; provide assistance to improve physical and mental health; and link them in to support services to maintain their housing after the program.	✓	2010 – current	Inner Melbourne	HomeGround
Michael’s Intensive Supported Housing Accord (MISHA)	Chronically homeless men	To provide immediate access to housing and the right mix of support services, tailored to the individual to “solve” homelessness.	✓	2012 – 2015	Paramatta, NSW	Mission Australia
Way2Home	Consumers who have been ‘rough sleeping’ and who also report health, social problems and exclusion.	To help people experiencing homelessness move into long-term housing and re-engage with the community. Involves assertive outreach and homeless health teams	✓	2010 - current	Sydney	Neami

D.2 NPA funded projects

Table 33: Overview of current NPA-funded mental health and housing programs

Program	Breaking the Cycle	Mental health support for secure tenancies
Funding	\$12.2m	\$9.9m
Participants	100	140
Delivery model	<ul style="list-style-type: none"> Core providers: AMHS, PDRSS provider, lead homelessness provider¹³⁴ Partners: Local social housing, primary health and social support services 	<ul style="list-style-type: none"> Core provider: PDRSS provider Partners: Social housing providers, DHS regional housing staff and private real estate agents

¹³⁴ These teams will be dual diagnosis and trauma competent

Program	Breaking the Cycle	Mental health support for secure tenancies
Lead Provider and LGA coverage	<ul style="list-style-type: none"> • Neami - Darebin and Whittlesea • Doutta Galla Community Health - Melbourne and Moonee Valley • Peninsula Support Services - Frankston and Mornington Peninsula • ERMHA - Dandenong, Casey and Cardinia 	<ul style="list-style-type: none"> • HomeGround Services- Yarra, Darebin, Banyule and Whittlesea • SNAP Gippsland - East Gippsland, Wellington, South Gippsland and Bass Coast. • Pathways - Barwon sub-region • EACH - Knox, Maroondah and Yarra Ranges • ERMHA - Greater Dandenong, Casey and Cardinia
Eligibility criteria	<ul style="list-style-type: none"> • Adults with severe and enduring mental illness • History of long-term or repeated homelessness from young age (<25 years) • High users of emergency department and acute inpatient mental health services • High users of crisis accommodation and other homelessness services • Aboriginal people are a priority 	<ul style="list-style-type: none"> • Adults with a severe and enduring mental illness and associated psychiatric disability, including people with co-existing disability and co-occurring problematic substance use and/or physical health conditions • History of long-term homelessness or high risk of homelessness¹³⁵ • Aboriginal people are a priority
Service model	<ul style="list-style-type: none"> • Sustained case management with an embedded care coordination function • Multi-disciplinary team who provide integrated clinical treatment, psychosocial rehabilitation support, housing support and care coordination • Multidisciplinary teams who are dual diagnosis and trauma competent. • Delivered on assertive outreach basis wherever the individual is living • Culturally appropriate care for Aboriginal people¹³⁶ 	<ul style="list-style-type: none"> • Proactively identify and link the target client group to affordable, long-term public and private housing options, augmented by flexible, scaled mental health outreach support tailored to the needs of the individual¹³⁷
Service activities	<ul style="list-style-type: none"> • Comprehensive assessment • Individual service plans • Integrated clinical treatment • Psychosocial rehabilitation support on an outreach basis • Intensive care coordination/case management • Housing support 	<ul style="list-style-type: none"> • Individual service plans • Assistance to secure suitable housing and maintain stable tenancy • Psychosocial rehabilitation support on an outreach basis • Active support/care coordination • Support to address physical health needs • Support to access vocational training and employment opportunities.

¹³⁵ High risk of homelessness includes those whose current tenancy arrangement is failing, eligible individuals exiting bed-based clinical services and correctional services, or where the informal care relationship has changed

¹³⁶ Department of Health (Vic), *Invitations for Submissions Breaking the cycle: reducing homelessness*, August 2012

¹³⁷ Department of Health (Vic), *Invitations for Submissions Mental health support for secure tenancies*, August 2012

Appendix E Service system costs

E.1 Health outcomes

E.1.1 Bed-based mental health services

Table 35 below show the changes in total days in per bed-based mental health services for Doorway participants in the 12 months before and after they were housed in private rental accommodation.

Table 35: Days per year in bed-based mental health services (n=51*)

Bed type	Total bed days p/a (n=40)		Average bed days per participant p/a		
	Pre-housing	Post-housing	Pre-housing	Post-housing	Days made available
Acute Inpatient	733	332	13.8	6.3	7.6
CCU	967	60	18.3	1.1	17.1
Forensic	162	0	3.1	0.0	3.1
PARC	125	24	2.4	0.4	1.9
Specialist	34	18	0.6	0.3	0.3
Total	2,021	433	38.1	8.2	30.0
Total (excluding CCU)¹³⁸	1,018	374	20.4	7.5	12.9

Source: Department of Health, CMI/ODS dataset (13 October 2013)

NOTE: Admissions data was not available for twelve participants. It is assumed that these participants were not admitted to beds during the 12 months pre or the period post housing with Doorway. Days are shown as means. Participants who exited Doorway within 90 days of being housed or who had been in housing for less than 90 days prior to 13 October 2013 have also been excluded from this analysis. Total bed days for the pre-housing period exclude bed days that occurred more than 365 days before the date of house occupation or any period after housing occupation (bed days that occurred <365 before housing for the same admission have been counted). If a participant was admitted to a bed at the point of housing occupation, the total days admitted were allocated between the pre and post period. The bed days for the post-housing period are based on annualised average bed days per participant. These annualised calculations are based on average of 10.3 months of post-housing. For participants that are currently in a bed, the numbers of days in the post-housing period were counted up to the date that the CMI/ODS data was received from the Department of Health (13 October 2013).

The daily funding estimate for each type of bed-based mental health services are shown in Table 36 below.

¹³⁸ Note that the reduction in CCU days is skewed by three participants that were in CCU beds at Latrobe Regional Hospital for most of the year prior to Doorway. When these three participants are excluded from the sample (n=37), the total average bed days are 20.8 days pre-housing and 5.9 days post housing. Average days made available are 14.9.

Table 36: Funding estimates of bed types used in cost savings calculations

Bed type	Funding estimate (\$/day)	Rationale
Acute inpatient	\$572	Average of rural and metro for Adult acute, Aged acute, CAMHS acute, Youth acute
SECU	\$491	Metro unit price
CCU	\$339	Average of rural and metro
PARC	\$407	Weighted average of Adult (90%) and Youth (10%) PARC
Forensic	\$796	Not available in funding guidelines document. Rate based on advice from DoH Finance
Specialist	\$677	Average of rural and metro Acute Specialist rate
Other residential	\$86	Aged Persons Nursing Home Supplement

Source: All estimates based on Victorian health services policy and funding guidelines 2010-11 - Highlights unless otherwise noted

The estimated savings per participant based on the average days made available per annum are shown in Table 37 below based on the inputs from Table 35 and Table 36.

Table 37: Savings in bed-based mental health services days made available per participant per annum

Bed type	Average bed days made available	Cost per day	Estimated cost saving
Acute Inpatient	7.6	\$572	\$4,323
CCU	17.1	\$339	\$5,807
Forensic	3.1	\$796	\$2,437
PARC	1.9	\$407	\$778
Specialist	0.3	\$677	\$203
TOTAL	30.0		\$13,548
TOTAL (excluding CCU)¹³⁹	12.9		\$7,355

Source: Department of Health, CMI/ODS dataset (13 October 2013) and Victorian health services policy and funding guidelines 2010-11 - Highlights

¹³⁹ Note that the reduction in CCU days is skewed by three participants that were in CCU beds at Latrobe Regional Hospital for most of the year prior to Doorway. When these three participants are excluded from the sample (n=37), the average days made available are 13.7 and the estimated cost savings per participant per annum reduce by \$7,300.

E.1.2 Ambulatory clinical mental health services

Table 38 below shows the changes in total contact hours with ambulatory clinical mental health services for Doorway participants in the 12 months before and after they were housed in private rental accommodation.

Table 38: Average hours of contact per year per participant (n=43*)

Service type	Total hours per year (n=40*)		Average hours per year (per participant)		
	Pre-housing	Post-Housing	Pre-housing	Post-Housing	Difference
CCT	1,066	919	24.8	21.4	3.4
MST	442	174	10.3	4.1	6.2
CAT	92	245	2.1	5.7	-3.6
Other	62	73	1.5	1.7	-0.2
Care coordination	25	9	0.6	0.2	0.4
Triage	7	22	0.2	0.5	-0.3
Grand Total	1,694	1,442	39.4	33.5	5.9

Source: CMI/ODS (13 October 2013)

* Data for participants from the St Vincent's catchment region were not available in the CMI/ODS.

NOTE: Hours are shown as means. Participants who have exited the program within three months have been excluded. The pre-housing period covers from the date of housing occupation to 365 days before this date. The annual contact hours for the post-housing period are based on annualised average hours per participant. These annualised calculations are based on an average of 10.3 months of post-housing data (i.e. the average period that Austin and Latrobe participants have been housed for).

Ambulatory clinical mental health services are all assumed to have an hourly funding cost of \$320/hour.¹⁴⁰ This results in an estimated saving of \$1,882 per participant per year in reduced use of ambulatory clinical mental health services.

¹⁴⁰ The Department of Health advised Nous of this figure for use in the current evaluation of selected Adult Mental Health Reform Initiatives.

E.1.3 Hospital admissions

The total hospital admissions and average per Doorway participant for the pre and post-housing periods are shown in Table 39 below.

Table 39: Total hospital admissions

Clinical speciality	Total admissions p/a for all participants (n=50)		Average admissions per participant p/a	
	Pre-housing	Post-housing	Pre-housing	Post-housing
Psychiatry	4.5		0.09	
General Medicine	12.1	2.6	0.24	0.05
General Surgery	1.3		0.03	
Cardiology	0.9	0.9	0.02	0.02
Endocrinology		0.9		0.02
Gastroenterology	1.7	1.6	0.03	0.03
Haematology	0.7		0.01	
Respiratory	0.9		0.02	
Grand Total	22.0	6.0	0.44	0.12

Source: Department of Health, Victorian Admitted Episodes Dataset (VAED) (data up to 30 June 2013)

NOTE: Participants who have exited the program within three months have been excluded. Participants who had been in the program for less than 90 days prior to 30 June 2013 have also been excluded from this analysis. The pre-housing period covers from the date of housing occupation to 365 days before this date. The annual admissions for the post-housing period are based on annualised admissions per participant. These annualised calculations are based on an average of 10.3 months of post-housing data (i.e. the average period that Austin and Latrobe participants have been housed for). Admissions classified under Acute Adult Mental Health Service and Acute Specialist Mental Health Service care types have been excluded to avoid double counting the bed-based mental health services utilisation data shown in Appendix E.1.1. Admission for following clinical specialties have also been excluded on the grounds that they are one off episodes and independent of the intended health outcomes of Doorway: Gynaecology; Plastics; and Obstetrics & Ante-natal.

The estimated cost per hospital admission is based on data sourced from the Australian Institute of Health and Welfare (AIHW) shown in Table 40 below.

Table 40: Cost per casemix-adjusted separation (excluding depreciation) for selected public hospitals in Victoria, 2010–11

Item	Cost
Medical labour costs	\$834
Non-medical labour costs	\$2,383
Nursing	\$1,158
Other staff (includes superannuation)	\$1,225
Other recurrent costs (excludes depreciation)	\$1,291
Depreciation	\$294
Total (excludes depreciation)	\$4,508

NOTE: Psychiatric hospitals, Drug and alcohol services, Mothercraft hospitals, Unpeered and other, Hospices, Rehabilitation facilities, Small non-acute hospitals and Multi-purpose services are excluded from this table. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.

Source: AIHW (2012), Australian hospital statistics 2010–11, pp. 53

The formula used to calculate the cost per case-mix-adjusted separation is:

$$\frac{\text{Recurrent expenditure} \times \text{IFRAC}}{\text{Total separations} \times \text{Average cost weight}}$$

where:

- recurrent expenditure is as defined by the recurrent expenditure data elements in the *National health data dictionary* (HDSC 2008)
- IFRAC (admitted patient cost proportion) is the estimated proportion of total hospital expenditure that relates to admitted patients
- total separations excludes *Newborns* (without qualified days) and records that do not relate to admitted patients (*Hospital boarders* and *Posthumous organ procurement*)
- average cost weight is a single number representing the relative expected resource use for the separations (see above).

The estimated saving in reduced hospital admissions for the post-housing period per participant per annum is shown in Table 41, based on inputs from Table 39 and Table 40.

Table 41: Savings in reduced hospital admissions per participant per annum (n=50)

	Average admissions per person p/a	Total cost per separation
Pre-housing	0.44	\$1,986
Post-housing	0.12	\$539
Estimated savings per person p/a		\$1,447

E.1.4 Emergency Department presentations

The total ED presentations admissions and average per Doorway participant for the pre and post-housing periods are shown in Table 42 below.

Table 42: Total ED presentations

Presentation type	Total Presentations		Presentations per person	
	Pre-housing	Post-housing	Pre-housing	Post-housing
Triaged - admitted	25.0	10.6	0.50	0.21
Triaged - non-admitted	74.0	61.4	1.48	1.23
Total	99.0	72.0	1.98	1.44

Source: Department of Health, Victorian Emergency Minimum Dataset (VEMD) and Victorian Admitted Episodes Dataset (VAED) (data up to 30 June 2013)

The average annual costs per ED presentation in 2010-11 are shown in Table 43 below.

Table 43: Average national costs per presentation (2010-2011 data collection)

Type of presentation	Cost
Triaged - admitted	\$865
Triaged - non-admitted	\$395

NOTE: All ED presentations by Doorway participants that are recorded in the VEMD were triaged

Source: Independent Hospital Pricing Authority (2013), National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2010-2011, Round 15, p 30-35.

The estimated saving in reduced ED presentations the post-housing period per participant per annum is shown in Table 44 below, based on inputs from Table 42 and Table 43.

Table 44: Savings in reduced ED presentations per participant per annum (n=50)

	Average presentations per person p/a		Cost per presentations		
	Admitted	Non-admitted	Admitted	Non-admitted	Total
Pre-housing	0.50	1.48	\$433	\$585	\$1,017
Post-housing	0.21	1.23	\$183	\$485	\$668
Estimated savings per person p/a			\$250	\$99	\$349

E.2 Housing outcomes

This appendix provides a summary of the annual costs associated with a range of different types of social housing provided by the Victorian Government.

E.2.1 Public housing

Victorian Government expenditure on public housing per dwelling per annum is shown in Table 45 below. The ‘net recurrent cost per dwelling’ is defined as the cost of providing assistance per dwelling — total recurrent administration¹⁴¹ and operating¹⁴² expenses, divided by the total number of dwellings. Public housing is defined as dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.

Table 45: Nominal Victorian Government expenditure on public housing, 2010-11 (per dwelling)

Item	Cost p/a
Net recurrent administration and operating costs per dwelling (including payroll tax)	\$5,658
Depreciation	\$2,190
Indicative user cost of capital	
Land	\$10,236
Other assets	\$8,766
Total assets	\$19,003
Total capital costs	\$21,193
Net recurrent cost per dwelling - including the cost of capital (excluding payroll tax)	\$26,802

Source: Productivity Commission (2013), *Report on Government Services 2013 - Chapter 16 Housing Attachment tables, Table 16A.19*

E.2.2 Community housing

The net recurrent cost per tenancy of community housing in 2010-11 in Victoria was \$9,417 per dwelling in nominal terms. This figure excludes the capital cost of community housing.¹⁴³

¹⁴¹ Administration costs include the costs of the administration offices of the Property Manager and tenancy manager.

¹⁴² Operating costs include the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses.

¹⁴³ Productivity Commission (2013), *Report on Government Services 2013 - Chapter 16 Housing Attachment tables, Table 16A.22*

E.2.3 Other types of social housing

The estimated recurrent and capital costs of other forms of social housing utilised by Doorway participants prior to joining the program are shown in Table 46 below.

Table 46: Costs of other forms of social housing (2010–11)

Social housing type	Cost per room p/a
Crisis accommodation - Hostel style (per bed)	\$16,060*
Crisis accommodation/transitional housing - Non-hostel style (per 2–3 bedroom unit)	\$28,105*
Other supported accommodation (per apartment)	\$21,900*

**Costs includes recurrent costs plus the cost of Government capital invested in properties available for client accommodation.*

Source: Department of Human Services and cited in Zaretsky, K P. Flatau, P. (2013), The cost of homelessness and the net benefit of homelessness programs: a national study, AHURI, p. 168

Appendix F Funding and Service Agreement

NOTE: this draft Funding and Service Agreement (FASA) was not finalised or signed by the Department of Health and MI Fellowship.

This document outlines the scope of activities to be undertaken by Mental Illness Fellowship in relation to the Housing Support and Brokerage Demonstration project - sometimes referred to as the innovative housing model.

F.1 Background

When the Liberal Nationals Coalition was elected in 2010 it committed to identifying mental illness early and seeking to reduce its impact through providing timely acute services and appropriate longer-term accommodation and support for those living with a mental illness.

At election the Government committed to provide \$3.2 million to the Mental Illness Fellowship over three years to demonstrate a new approach to housing people with a mental illness. The purpose of the pilot will be to secure housing for 50 people with a severe mental illness in the private rental market and to support them to maintain tenancy and link with the community.

Mental Illness Fellowship will receive \$1.3 million 2011-2012, \$0.96 million 2012-13, 0.96 million 2013-14 to provide 50 places of HBO- Standard (T3) and rental support brokerage to clients in identified catchment/s. The amount includes an allocation of \$120,000 for an evaluation.

Given that funds were directly allocated to MIF, the Fellowship has proactively initiated and developed the key tenants of the model. MIF has identified that the program will target clients being discharged from acute mental health facilities to the following Local Government Areas:

- Yarra (St Vincent's catchment)
- Banyule and Nillumbik (Austin catchment)
- Moe and Morwell (Latrobe Regional Hospital catchment).

F.2 Scope of activity

F.2.1 Objectives

- To identify people with severe mental illness and who are homeless or at risk of homelessness who can be supported to access private rental
- To ensure equitable access to the program for target clients in the identified catchment
- To broker/provide support for clients that is transitional in nature and enhances the ability of clients to develop skills to maintain tenancy, meet their financial commitments independently of the program, meet their personal needs and link with the community for recreational, educational and or employment opportunities

- To collaborate with other initiatives in the catchment including other mental health and community programs that can provide additional and or ongoing support to clients
- To identify a range of flexible financial brokerage opportunities that complement existing related forms of assistance such as the Commonwealth Housing establishment Fund and Bond Assistance programs
- Develop and document approaches that enhance private rental opportunities for the target group at a systemic and individual level and disseminate these to the broader sector
- To engage strategies for capacity building in specialist mental health service to access the private rental market for clients.

F.2.2 Consumers targeted

Clients with severe mental illness who are homeless or at risk of homelessness and demonstrate:

- a commitment to private rental as a long term housing option
- awareness of their rights and responsibilities under the *Residential Tenancies Act*
- that they are capable of sustaining private rental.

F.2.3 Model

The model has the following components:

- Building confidence with private real estate agents
- Transitional time limited support to clients to achieve goals in maintaining tenancy, self-care and establishing links with the community
- Financial packages that provide support for tenancy establishment, property enhancement and interim budgeting incentives
- Capacity building to enhance the capacity of specialist mental health services to support clients to access private rental.

F.2.4 Intended outcomes

- Clients accepted into program are offered private rental opportunities and support to maintain their tenancy
- Clients maintain their tenancy when program financial support ceases
- Clients maintain their tenancy when program specific support ceases
- Client outcome measures indicate an improvement in level of functioning during program, which is sustained after transition from the program
- Real estate agents in the catchment have confidence in the capacity of:

- people with a mental illness to engage in private rental
- the program to enhance the opportunities of people with mental illness
- to succeed in private rental
- Local PDRSS and clinical providers are engaged in joint management of clients
- The mental health sector in catchment demonstrates increased knowledge of how to link clients with housing and private rental.

F.2.5 Funding

Mental Illness Fellowship will receive the following funds over three years (GST not included). Funds will not incur indexation:

2011-12	2012-13	2013-14	Total
\$1,300,000 (approximately)	\$960,000 (approximately)	\$960,000 (approximately)	\$3.1 million (approximately)

This will include funding for:

- 50 places for Home Based Outreach - Standard (T3)
- Evaluation of the pilot outcomes- \$120,000
- Financial assistance packages and make good payment.

MIF will develop a mutually agreeable plan to direct unspent funds from 2011-12 due to delayed start to subsequent years of the pilot.

PDRSS activities such as Home Based Outreach are funded according to an output based funding model.

PDRSS places are funded on the basis of provision of service on an annual basis. Each place is counted as one regardless of the level of throughput. This approach is similar to a bed based service where the number of places (or beds) refers to the capacity of the program at any point in time. With throughput one place may be accessed by several people in any quarter or year.

A relevant document, *A New PDRSS Pricing Model: Implementation Guidelines for Agencies*, is available on the DHS website at <http://www.health.vic.gov.au/mentalhealth/pdrss/pdrss-pricing-implementation.pdf>

The base price build up was based on the expenditure data provided by agencies and includes

- staff salary and on costs
- corporate overheads including the proportion related to rent
- an allowance for car (based on leasing a vehicle)
- annual provisions and minor capital works.

The prices for Psychiatric Disability Rehabilitation Support Services are indexed annually and published each year in the Victorian -public hospitals and mental health services. Policy and funding guidelines are available at <http://www.health.vic.gov.au/pfg/mental.htm>

F.2.6 Reporting and accountability

Services should report Home Based Outreach - Standard (T3) under activity number 15062.

Outputs will be as follows:

- Number of clients
- Number of hours direct service
- Number of new clients.

Table 47: HBO Standard (T3) PACKAGES

Proposed outputs IHBOS	Funding 2011-12	Funding 2011-12
Number of places	1	50
Funding per place	\$7,936.5	\$396,825
Rate per hour (2010-11)	\$101.75	\$101.75
Minimum number of hours of direct service per place per year	78	3900
Minimum number of hours of direct service per quarter	19.5	975
Minimum average number of hours of service per week	1.5	75

Note: Home Based Outreach is funded on the basis that for every hour of direct service provision that is reported, an additional hour of indirect service is expected to be provided. For all PDRSS Home Based Outreach only direct hours of service are reported on.

F.2.7 Brokerage Reporting

There will be additional data reporting requirements during the evaluation period.

F.2.8 Responsibilities

The Department of Health will:

- Coordinate a regular Departmental meeting (quarterly initially) to monitor the development of the model
- Provide funding of \$3.2 million over 3 years (including indexation) for 50 places of transitional Home Based Outreach -Standard (T3), a budget for brokerage for financial assistance packages and an evaluation of outcomes
- Consider whether to conduct an evaluation that assesses the systemic impact of the initiative

- Participate in the Mental Illness Fellowship Program Advisory Group and Program Evaluation Group
- Have access to evaluation data and all associated materials arising from the evaluation as negotiated and according to legal advice
- Regional offices at pilot sites will work with the service provider, as indicated, to implement the initiative at a regional level.

MIF will be expected to:

- Participate in and contribute to quarterly meetings as requested by MHD&R
- Develop a timeline and milestones for program implementation
- Provide the pilot program at locations identified by MIF; City of Yarra, Banyule & Nillumbik, Moe & Morwell
- Participate in any external evaluation facilitated by the Department of Health
- Monitor consumer outcomes by collecting qualitative and quantitative data against an agreed set of performance measures
- Collect outcome measurement data using standard outcome measurement tools
- Provide raw data and associated materials relating to the evaluation to Department of Health as negotiated and dependent on legal advice
- Share experiences and findings with other sectors and agencies within the catchment and broader service system to increase capacity to respond to the housing needs of this group
- Develop a set of resources that will support other clinical and PDRSS services to enable clients to secure private rental opportunities and maintain tenancy.

F.3 Initial Implementation

The model will be implemented concurrently at each of the three nominated locations; City of Yarra, Banyule & Nillumbik, Moe & Morwell. Each site will be expected to be functioning at full capacity by January 2012.

MIF has established a comprehensive governance structure with project Advisory Committee, Model Development Committee, Evaluation Committee and Practice Implementation Committee at each location (3).

Department of Health is represented on the Project Advisory Committee, and each of the Practice Implementation Committees. Mental Health Drugs and Regions will hold regular meetings with MIF, at least quarterly initially, to monitor progress.