

**HOUSING AND
ACCOMMODATION
SUPPORT PARTNERSHIP
(HASP) PROGRAM**

**PROGRAM
GUIDELINES**

**Stepping Up
South Australian
Mental Health Reform**



**Government
of South Australia**

SA Health

CONTENTS

ACKNOWLEDGEMENTS	4
1. INTRODUCTION	4
2. HASP PROGRAM OBJECTIVES.....	5
3. THE HASP PROGRAM.....	5
3.1 METROPOLITAN HASP PROGRAM	
3.2 HASP PROGRAM – LARGE CLUSTER	
3.3 HASP PROGRAM HOUSING	
4. THE PARTNERSHIP	7
4.1 CONSUMERS	
4.2 PSYCHOSOCIAL REHABILITATION SUPPORT SERVICES	
4.2.1 PROVISION OF PSYCHOSOCIAL SUPPORT	
4.2.2 PROVISION OF AFTER HOURS SUPPORT	
4.2.3 NGO KEYWORKER	
4.2.4 INDIVIDUAL SERVICE PLAN	
4.3 HOUSING PROVIDERS	
4.4 COMMUNITY MENTAL HEALTH SERVICES	
4.4.1 ASSESSMENT, TREATMENT AND REHABILITATION	
4.4.2 CRISIS INTERVENTION	
4.4.3 CARE COORDINATION	
4.4.4 CARE PLAN	
4.5 RELATIONSHIPS WITH OTHER SERVICES	
5. CONSUMER JOURNEY.....	12
5.1 ELIGIBILITY	
5.2 REFERRAL	
5.2.1 IDENTIFICATION OF A POTENTIAL CLIENT	
5.2.2 REFERRAL OF A POTENTIAL CLIENT	
5.3 ASSESSMENT AND ALLOCATION OF HASP PLACE	
5.4 SERVICE ENTRY PLANNING	
5.5 REVIEW	
5.6 TRANSFER	
5.7 EXIT	
5.8 TIMELINESS OF NOTIFICATION OF VACANCIES AND REFERRALS	
5.9 TRANSITIONAL VS LONG-TERM	
6. GOVERNANCE	18
6.1 PROJECT MANAGEMENT COMMITTEE	
6.2 ALLOCATION COMMITTEE	
6.3 LOCAL PARTNERSHIP COMMITTEES	
6.4 CONTRACTING ARRANGEMENTS	
7. DISPUTE RESOLUTION AND APPEALS	21
7.1 CLIENT DISPUTES	
7.2 NEIGHBOURHOOD DISPUTES	
7.3 PARTNER DISPUTES	
7.4 APPEALS PROCESS	
7.4.1 CLIENT APPEALS	
7.4.2 SECOND TIER APPEALS	

8. RISK MANAGEMENT.....	24
9. SPECIFIC ISSUES	27
9.1 PROVISION AND REPAIR / REPLACEMENT OF HOUSEHOLD FURNITURE AND WHITEGOODS.	
9.2 FLEXIFUND	
9.3 BROKERAGE FUNDING	
9.4 EXCESS HOURS	
10. MONITORING AND EVALUATION.....	28
10.1 MINIMUM DATA SET	
10.2 EVALUATION	
APPENDIX A – REFERENCES.....	30

Acknowledgements

SA Health would like to thank consumers, carers and their families, Non-Government Organisation psychosocial rehabilitation and support providers, Non-Government Organisation housing providers, South Australian Mental Health Services and Housing SA for their work in the development of the HASP program.

SA Health would also like to acknowledge the NSW Department of Health's 2006 *Housing and Accommodation Support Initiative (HASI) for people with mental illness*, and the Victorian Department of Human Services 1990s initiative the Housing and Support Program, which have been used in the formulation of this document.

1. INTRODUCTION

People with mental illness or psychiatric disability often experience major challenges in accessing and maintaining ongoing individualised accommodation. It is difficult for a person to engage in a process of recovery without having a place they can call home, from where they can rebuild their skills and re-engage with the community. To this end, the Housing and Accommodation Support Partnership (HASP) Program has been established between consumers, Psychosocial Rehabilitation Support Services (PRSS), non-government housing providers and mental health services (MHS), to provide housing and psychosocial rehabilitation and support for individuals in a community setting.

In February 2007 the Social Inclusion Board released its report *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*. The Government of South Australia endorsed the direction of all the report's recommendations and committed \$107.9 million to a reform program that includes service development, capital works and collaborative partnerships to build an integrated community-based stepped system of care. The HASP Program will be funded as part of the recommendations from the Stepping Up report.

1.1 Vision

To provide linked housing, support and clinical services to enable individuals with severe and enduring mental illness or psychiatric disability to live in the community and re-engage with the domestic, social, vocational and recreational aspects of their lives.

1.2 The HASP Program Guidelines

The HASP Program guidelines are intended to assist in the development of strong and effective partnerships between mental health services and the non government sector in supporting the recovery of people with mental illness. The HASP Program Guidelines will provide Mental Health Services, Non Government Organisations and Housing Providers with clear information designed to improve state-wide consistency in the delivery of Housing and Accommodation support services. The HASP Program Guidelines sit under the HASP Program Service model which provides further detail about the model.

The content of the document will be reviewed regularly to ensure its applicability.

1.3 The Recovery Approach

The HASP Program will reflect recovery principles and support people's engagement in their recovery process.

Recovery is a deeply personal, unique process of changing one's attributes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effect of psychiatric disability.

– Australian Health Ministers, *National Mental Health Plan 2003-2008*.

1.4 Rehabilitation Framework

The HASP Program will be delivered in a rehabilitation framework.

Rehabilitation is a philosophy and a specialist service which requires a particular skill set. Rehabilitation services aim to provide individually targeted interventions to assist people to regain, build or develop skills which enable consumers to engage in their recovery process.

Rehabilitation should commence at the earliest opportunity and be holistic and connected with the community. Rehabilitation services should use evidence based interventions and an assessment and treatment planning approach which identifies and builds on a person's strengths. Rehabilitation services promote recovery and aim to reduce the disability associated with mental illness.

2 HASP PROGRAM OBJECTIVES

The objectives of the HASP Program are to support consumers to enjoy the full benefits of citizenship and community membership by:

- Providing safe, secure and affordable housing with security of tenure.
- Providing psychosocial rehabilitation and support services that are flexible and responsive to the person's needs, including up to 24-hour support if and when required.
- Providing clinical mental health care and rehabilitation services which are individualised, flexible, responsive and recovery focussed.
- Supporting consumers to improve their skills and capacity to live as independently as possible in the community.
- Improving consumers' quality of life, health and well-being.
- Avoiding or reducing hospital admissions and crisis service usage.
- To evaluate the program and to use the lessons from HASP to develop other options that link housing and support services for people with mental health problems and disorders;

3 THE HASP PROGRAM

3.1 Metropolitan HASP Program

Housing will be individualised self-contained accommodation in the eastern, northern, southern and western metropolitan regions of Adelaide. Accommodation will consist of a range of housing types including stand-alone housing, virtual clusters within

reasonable proximity and co-located clusters of dwellings (no more than 5 per site). Support provided into this range of accommodation will be flexible and tailored to needs, including on-call 24 hours, if needed. Funding from the Stepping Up report provided funding for 73 + places, 20 of those places are co-located in the large Cluster (See 3.2)

Tenancy services, psychosocial rehabilitation and support and clinical support will be provided as separate services.

Should an individual recover to the extent where they no longer require HASP support it is the intent of all partners involved that the consumer will be able to remain in their home and that the partners will work together to access another property. In these instances the supported accommodation component of the program will transition rather than the consumer, so that the dwelling will become part of the normal accommodation supplied by the Housing Provider and the HASP Program will need to acquire a new property. In this way, additional properties may be required from time to time and the HASP Program partners will work together to access these.

3.2 HASP Program – large cluster

There will be a large cluster of 20 units which will provide self-contained individual dwellings for 20 people, located in the LGA of Burnside. The housing will consist of 1 bedroom dwellings, built to be indistinguishable from other housing and fronting onto 4 roads. Each house will have access to car parking, have its own address and be completely self contained. There will be an additional building (2 houses internally modified to provide office type facilities) which the PRSS will use as its on site facility. This facility will be indistinguishable from the residential houses and will be designed to be flexible as the needs of the consumers or the program changes. There will be a shared common garden in the middle of the properties which consumers will have access to from their backyards.

This development will offer a very high level of support catering to the needs of consumers with psychiatric disability. Clinical services will be able and accessible 24 hours a day, 7 days a week and initially, the PRSS will also provide intensive support up to 24 hours a day, 7 days a week. It is acknowledged that many of these consumers may need support for life or until ageing issues become predominant.

Clinical support will be provided by the local community mental health service in a manner consistent with the service they provide to other consumers living in their catchment area.

It is anticipated that some consumer's support needs may diminish significantly and no longer require such high levels of support. In this circumstance, the consumer may be assisted to relocate to other more independent accommodation with whatever level of support is needed.

3.3 HASP Program Housing

Housing in the HASP Program will:

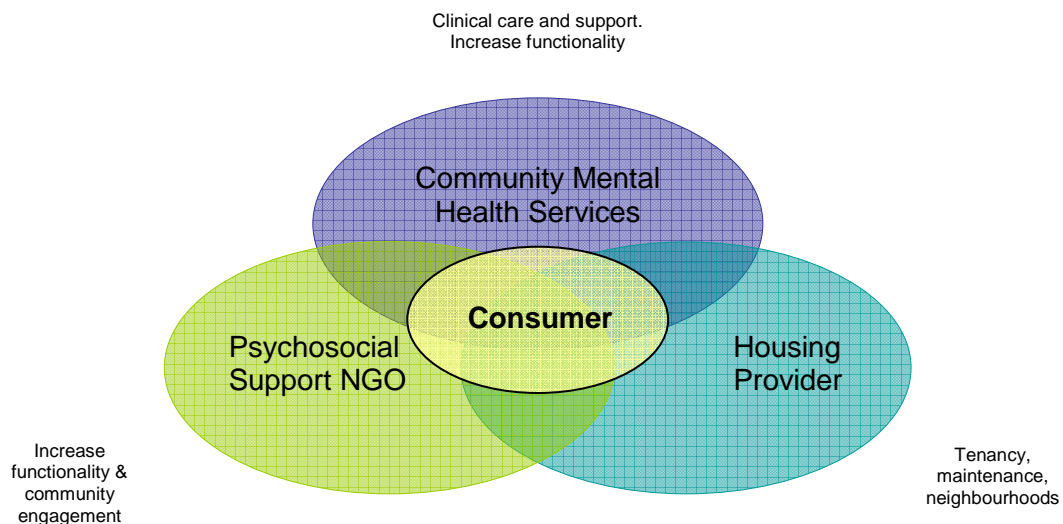
- be self contained and individual
- have capacity for consumers to share with other people if this should be their choice
- be located close to transport, shopping facilities and health services.

- be indistinguishable from other housing within the community in terms of design.
- Have internal finish which is aesthetically pleasing and easy to maintain
- Be single level and easily accessible
- be fitted out with some window dressings; built in wardrobes to at least one bedroom and general storage; telephone line; television antenna; floor coverings; light fittings; fenced yard; washing line.

4. THE PARTNERSHIP

There are four core partners in the HASP Program – the consumer, the PRSS, the housing and tenancy support provider, and CMHS. Additional partners will sometimes participate, including carers, community organisations and employment agencies. The HASP Program is a partnership program. It is based on a commitment by all agencies involved to work in partnership to improve consumer outcomes through coordinated service delivery.

Each partner in the HASP Program has their own roles and responsibilities.



4.1 Consumers

HASP is a voluntary program. Consumers who participate in the HASP Program are expected to be an equal partner in the collaboration. Each consumer will support their own journey of recovery by, to the degree they are able, participating in:

- The self-management of their mental illness.
- Partnership with their housing provider, PRSS and community mental health service.
- Engagement with the domestic, social, vocational and recreational aspects of their lives.
- Development of aspirations, goals and milestones.
- Regular review of HASP and other supports to better meet their recovery needs.

Carers and family members are encouraged and supported, where the consumer is in agreement, to be involved with plans for the care of their family member.

4.2 Psychosocial Rehabilitation and Support Services (PRSS)

4.2.1 Provision of PRSS

Non-government organisations who specialise in providing psychosocial rehabilitation and support to people living with a mental illness or severe and enduring psychiatric disability will be funded to provide intensive 'in-home' and community non clinical psychosocial rehabilitation, support and coordination services.

PRSS provide structured, goal focused, strengths based and individually tailored non clinical rehabilitation and support services at a level of intensity and duration appropriate to the consumers needs. The range of needs consumers may be across the spectrum of:

- Self maintenance needs – self care, home management, shopping, cooking, cleaning, medication management and physical and dental health care needs, eg diabetes management.
- Provision of support to assist with maintaining secure tenure
- Providing services based on the philosophy of recovery through fostering hope and supporting consumer empowerment and self determination.
- Productivity needs – education, employment, meaningful occupation of time.
- Leisure needs – social and recreational.
- Community connection – assisting consumers to connect with their community. Ensure that intervention strategies connect with mainstream community services.
- Meet the needs of people from Culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander people, people with physical impairment and intellectual disability.

These services will be available up to 7 days a week, within extended hours depending on the personal needs of the consumers in the HASP Program. It is expected that consumers' needs will vary and change over time. These specialist NGOs will work with the other partners in the HASP Program to provide a holistic and recovery focussed program of support.

These services will build on consumers' strengths and ensure access to and engagement with support and resources including financial, professional, housing and social to enhance independent living skills, social and community connectedness, mental health, general health and well-being and quality of life.

4.2.2 Provision of After-Hours Non-Clinical On-Call Support

PRSS are expected to provide appropriate support during and outside business hours, weekends and public holidays. It is expected that PRSS services will operate on call support between 8am – 10pm, 7 days a week. The type of support will range from on call to on-site depending on the needs of the consumers, which are expected to change over time.

4.2.3 NGO Worker

The PRSS NGO worker is qualified as a rehabilitation worker from a variety of backgrounds with a minimum qualification of Certificate IV. The NGO worker is responsible for coordinating the care and support provided to an individual HASP consumer, and is responsible for:

- Coordinating services (from the PRSS or organised by the PRSS) to be received by the consumer
- Negotiate the Individual Support Plan with the consumer.
- Regularly liaising with the other HASP providers both individually and through the Allocation Committee particularly when there are changes which need to be made and new issues are emerging.
- Monitoring changes in the consumer's situation that may affect their mental health care plan, support contract or services provided by other agencies.
- Participating in joint reviews of the mental health care plan with the mental health care provider and the consumer and carer.
- Being the first contact point for the consumer and carer, where appropriate when there is a problem or change is happening.

4.2.4 Individual Support Plan

Each HASP Program consumer has an Individual Support Plan (ISP) which documents the service and approach the PRSS will provide to the consumer. It is negotiated between the consumer and the PRSS support worker. The ISP is reflected in the Mental Health Care Plan and contains information on:

- Consumer identified goals.
- The level and type of support to be provided through the PRSS.
- Details of other agencies who will provide services.
- What happens if the consumer's needs decrease or increase.
- What happens if the consumer loses the legal ability to give consent.
- Contact information about carer and / or guardian and next of kin and acknowledgement of care and support provided now and in the future.
- Provision for quarterly meetings and reviews.
- Addresses significant lifestyle issues eg alcohol misuse that may need to be addressed by the consumer. It may also list strategies to assist the consumer to manage these issues eg attending alcohol counselling.
- Any specific supports which may assist the consumer to better manage their tenancy.
- Any special consumer needs eg using an interpreter.

4.3 Housing Providers

Housing management providers will provide housing and tenancy management services. Housing management services will be provided by a non-government organisation experienced in providing housing and tenancy management services to people who have high levels of psychiatric disability and complex needs.

Housing Providers are responsible for housing and tenancy management of the HASP Program properties.

Managing the tenancy involves the following:

- Signing with the consumer a Residential Tenancy Agreement. The Tenancy agreements should be the same for HASP Program consumers as for any tenant of the housing provider. The Residential Tenancy Agreement is a standard leasing

document which defines the terms and conditions of the landlord – tenant relationship.

- Ensuring that the properties are maintained and repaired according the *Residential Tenancies Act (1995)*.
- Collect rent from the consumer in line with the Housing Provider's rental policy.
- Monitoring of all rental payments and managing rental arrears. This includes negotiating schedules of repayments and monitoring arrangements. Provision of rental receipts.
- Providing the consumer with appropriate documentation regarding their accommodation and its management, including policies and processes for disputes and complaints.
- Nominating a person as Housing Manager or Landlord Agent as a contact point.

In undertaking these roles it is expected that the housing provider will engage with the consumer in sensitive and responsive way. They will also ensure the consumer understands what is required of them as part of their Tenancy Agreement.

In the case of tenant damage, the housing provider will negotiate repairs and payment with the tenant according to their internal policies and in line with the provisions of the *Residential Tenancies Act*.

Consumers may wish to move from their accommodation, either due to no longer needing the level of support provided by the HASP Program, or because they wish to move locations. Housing providers will work with consumers and the other HASP partner agencies where possible to assist consumers to access secure long term housing.

4.4 Community Mental Health Service

Consumers of the HASP Program are also consumers of the community mental health service. In many cases HASP Program consumers will be long time consumers of Inpatient facilities or be connected to community mental health services.

Clinical services generally focus on assisting people to manage the effects of severe mental illness. Community mental health services are usually multi disciplinary in nature and include registered nurses, occupational therapists, social workers, psychologists and psychiatrists. The Community Mental health team is the central and coordinating service on the mental health services continuum. They provide a care coordinator for every mental health consumer who is responsible for coordinating care which includes after hours support. They also work in partnership with GPs, non government agencies and other government providers as well as the consumer, carers and their families.

The Community Mental Health Services are to provide:

4.4.1 Assessment, Treatment and Rehabilitation

The mental health care coordinator, along with their mental health colleagues are to provide each HASP Program consumer with a full range of mental health services responding to the consumer's specific needs. These services could include assessment of specific needs, including assessment of mental state, individual goal planning, therapeutic treatment and interventions, rehabilitation, crisis intervention and referrals.

Treatment provided should be firmly rooted in the recovery framework and aim to support consumers to achieve their maximum potential and lead a more satisfying life.

4.4.2 Crisis Intervention

Where required the mental health provider will ensure that the consumer is able to access crisis intervention when required. Mental health staff will undertake assessment of mental state and determine risk status and arrange for follow up psychiatric assessment where required. Mental health staff will also arrange admissions to inpatient facilities as per their usual protocols.

4.4.3 Care coordinator

The Mental Health care coordinator is the designated person from the Community Mental Health Service who is responsible for coordinating and providing mental health care to the HASP Program consumer. They are qualified clinicians from the disciplines of nursing, occupational therapy, social work and psychology.

The Mental Health care coordinator is responsible for working closely with the consumer, carers and other HASP Program partners to enable the consumer to reach the goals identified in the mental health care plan. This process will include:

- Responding to any new developments or changes in the consumer's situation and amending the care plan where necessary.
- Regularly reviewing the rehabilitation process with the consumer and other parties.
- Working closely with HASP Program partners to ensure services provided are integrated and targeted.

The mental health care coordinator needs to work flexibly with all partners of the HASP Program. Should the consumer be admitted to an inpatient facility (whether acute or rehabilitation) or to a CRC or ICC, the mental health care coordinator will remain in contact with the consumer. They will also renegotiate the care plan and facilitate discharge when required.

4.4.4 Care Plan

Each consumer will have a mental health Care Plan (the Plan) which is the document which underpins the consumer's mental health care. The development of the Plan is a collaborative and joint process between the consumer, carer, care coordinator and other relevant services. A Care Plan has three broad sections – the Consumer's Plan, Carer's Plan and Service Plan – and incorporates the information previously contained in Crisis Intervention Plans and Relapse Prevention Plans. A mental health Care Plan contains information about: Demographics, Socio-cultural Considerations, Legal Considerations, Advance Directives, Wellbeing Matrix, Recovery Plan, Collaborative Therapy, Physical Wellness and Wellbeing, Medication, Carer's/Family Plan, Service Plan and Shared Care Agreements. The consumers Individual Service Plan should be reflected in the consumers Care Plan.

4.4.5 Relationships with other Services

HASP Program consumers will have and create links to other local services and it may be appropriate for representatives of these services to be invited to HASP Program Local Partnership Groups whether on a temporary or permanent basis. One of the objectives of the HASP Program is to assist consumers to integrate and become part of their community. Liaising with local organisations could prove beneficial in achieving this aim.

All providers, in addition to working in partnership with each other will work in partnership with consumers, families, other government services (including drug and alcohol services, Department for Families and Communities) and non-government services (including social, recreational and employment) and other community services (including General Practice, Neighbourhood Houses).

5. CONSUMER JOURNEY

5.1 Eligibility

The HASP Program is intended to house and support adults between 18 and 65. However, on occasion, younger people, older people or adults with early onset dementia may be considered for the program.

The Criteria for the HASP Program are for individuals who:

- Are diagnosed with a mental illness and experience significant functional disability as a result of their mental illness.
- Have non-existent, lost or limited independent living skills and require significant support to develop skills in the management of housing, finances, relationships, activities of daily living, social integration and / or parenting.
- Are eligible for housing with the housing provider.
- Have an identified mental health contact person (commonly a care coordinator from a Community Mental Health Service) or are in the process of being allocated one.
- Are homeless or at risk of homelessness, which includes being housed in inadequate, unsustainable or inappropriate housing (for example: being housed in a facility, living with elderly carers who are unable to continue caring for their family member and a range of other potentially unacceptable situations.)
- Have the capacity to benefit from the provision of accommodation and support services.
- Give informed consent to participate in the program.

People being considered for referral to the program may also share some or all of the following characteristics and these should be taken in account when prioritising referrals:

- History of harm to self and/or others including due to personal neglect.
- Refusal or difficulty in engaging with services creating risk to self and/or others.
- Have a substantial history of extended hospital admissions
- Have failed at independent community living previously
- Risk factors including complex health (medical and allied health), lifestyle and/or behavioural needs.
- Unstable mental state and unremitting symptoms.
- Lack of natural support from family/friends and/or connectedness with the community.
- Significant grief and loss issues impacting on long term mental health.

- Subject to legal orders including Mental Health Act, Guardianship and Administration Act and Criminal Law Consolidation Act: Mental Impairment Provisions.
- Frequent use of ACIS and other emergency services and/or attendance at Emergency Departments.
- Are cycling through the criminal justice system, often for low tariff offences that may be associated with their mental or functional impairment.

5.1.1 Additional Eligibility

On occasion younger people, older people or adults with early onset dementia may be considered for the program.

People under 18 years of age may be considered for HASP when they:

- **Fulfil the criteria for the program**
- Are in transition to adult mental health services or are highly likely to require adult mental health services in the future.
- Have developmental needs likely to require ongoing psychosocial rehabilitation and support/disability support.

People over 65 or with early onset dementia may be considered for HASP when they:

- **Fulfil the criteria for the program.**
- Do not yet require intensive support for their age-related vulnerabilities, or have in place strategies to manage their age-related vulnerabilities.

5.2 Referral

All consumers who participate in the HASP Program are expected to be a consumer of a Community Mental Health Service, and to have a Care coordinator and a Care Plan, or that there is a process in place to acquire same. Whilst it is anticipated that most referrals will come from public mental health services, anyone is able to refer to the HASP Program.

HASP is the most intensively supported mainstream community living program for persons with serious mental illness. It is therefore targeted to consumers whose need for psychosocial rehabilitation and support cannot readily be met by less intensive options (for example, IPRSS) or those for whom an emergency housing or supported mainstream supported social housing options would be more appropriate

5.2.1 Identification of a Potential Consumer

Most potential clients of the HASP Program will be identified by Community Mental Health Services. Occasionally, other services such as an Acute Inpatient Service, Community Residential Service or a non-government organisation may identify an individual who could benefit from HASP.

5.2.2 Referral of a Potential Consumer

Before a potential consumer of the HASP Program can be considered by the Regional Allocation Committee, the referrer will coordinate a number of assessments and documentation to produce a referral package.

- Consent form – consumer consent to information sharing between CMHS, PRSS, Housing NGO and Allocation Committee
- Application for resources – complete the HASP Section.

- Care Plan– standard Mental Health Care Plan,
- Risk Assessment– standard assessment of risk by CMHS.
- OT Assessment– standard Occupational Therapy assessment by CMHS.
- Current outcome measure scores – including Health of the Nation Outcome Scale (HoNOS), Life Skills Profile (LSP) and Kessler 10 (K10).

When formally interviewing or negotiating with a consumer the CMHS, PRSS NGO or Housing NGO will ensure that the consumer:

- Knows what the meeting is about and who will be attending.
- Is invited to have an advocate or carer attend, if the consumer wants.
- Can negotiate a place where they feel comfortable carrying out the interview.

Once the referral pack is completed it will be sent to the Regional Allocation Committee.

5.3 Assessment and Allocation of a HASP Place

When a vacancy in the HASP Program occurs the following process will be undertaken:

1. A referrer who is assessing a consumer's needs should determine what programs will best be able to meet those needs. Should the consumer have a need for housing and require medium, high or 24/7 psychosocial rehabilitation and support they should be referred to the HASP Program.
2. This is accomplished by filling out the HASP section of the Application for resources form.
3. A referral to HASP can be initiated from a number of sources such as CMHS, Child and Adolescent MHS (CAMHS), Mental Health for older persons services (MHOPS), Inpatient services, GPs, private psychiatrists and other sources.
4. The Local Allocation Committee (LAC) will consider HASP referrals and members should include: Local CMHS Manager, CMHS Team Leaders, PRSS Managers, Housing NGO Managers and AC Secretariat. When individuals cannot attend, proxies or phone contact outside the meeting is essential.
5. A psychosocial rehabilitation support service (PRSS) provider will carry out an assessment jointly with the CMHS representative to determine appropriateness for the HASP program.
6. The joint assessment will be fed back to the Local Allocation Committee for consideration and approval. If the members of the Local Allocation Committee do not agree on the outcome of the referral, further discussion and/or assessment will need to take place.
7. A period of notice is required when a vacancy occurs in order to give the allocation committee time to respond and identify an appropriate consumer.
8. The AC secretariat will collate a shortlist of consumers potentially suitable for HASP from referrals entered into the database and consult with the appropriate CMHS team(s) and PRSS.

9. The AC will use the short-list, and their knowledge of current consumers and their needs, to prioritise consumers for entry and formal referral to HASP for the vacancies that exist, using the HASP Guidelines.
10. The AC secretariat will record the referral, decision, care coordinator, support worker and tenancy manager in their database.
11. The AC secretariat will contact the referrer regarding the success or status of the application for HASP.
12. The care coordinator will work with the consumer, the PRSS worker and the tenancy manager to establish a collaboration for support and engagement.
13. The PRSS worker will work with and assess a consumer's needs over time. Minor changes to support arrangements will be negotiated between the PRSS worker, care coordinator and consumer. Major changes to support arrangements will go back to the AC for consideration.
14. Additional funding through the Flexible Support Fund can be sought for a specific increase in hours. In these cases, the CMHS Team Leader and PRSS Manager should complete the "Flexible Support Fund" form and forward it to the Manager, Rehabilitation and Recovery Services for assessment and approval.
15. Reviews of individual support plans will occur every three months, with the PRSS worker, care coordinator and consumer. Housing partners, carers and other involved parties will be invited to join the review process if required. There will be a major review carried out annually.

5.4 Service Entry Planning

There are a number of steps which need to be undertaken once the consumer has agreed to enter the HASP Program, including:

- PRSS to work with consumer to develop and sign an Individual Support Plan (ISP), assign a worker from the NGO and plan for housing, furniture and utilities needs.
- Housing Provider to work with consumer (and PRSS as required) to develop rental arrangements and sign Residential Tenancy Agreement.
- CMHS Care coordinator to confirm relationship with consumer and other parties, and include PRSS ISP into Care Plan.
- PRSS to liaise with other partners, including carers, employment agencies for planning and support needs.
- Signing of Partnership Agreement between consumer, PRSS, Housing NGO and CMHS, including contact details of Support Coordinator, Landlord and Care Coordinator.

Often people moving into HASP accommodation will be moving from hospital into the community, so the mental health care will be coming from the community rather than inpatient staff. This plan will be made in partnership by the mental health clinician, the

consumer and carer (where the carer provides significant support, and invited by the consumer).

5.5 Review

Review is an essential component of collaborative intervention and will include the consumer, mental health care coordinator, PRSS worker and carers/other agencies where appropriate.

Reviews will be held 3 monthly as a minimum and more often as required, depending upon the complexity of service delivery. The review will still occur, even if all partners are not available.

The NGO worker will convene the review meeting and will record the outcomes of the review on the Review Form which is to be provided to the consumer, filed in the Mental Health file, NGO file and provided to other parties as agreed.

The review meeting will include reviewing the intensity of support and will document the agreed decision relating to any increase or decrease in the intensity of support
The review must be:

- transparent
- inclusive
- collaborative
- structured
- documented.

It is expected that community mental health services and PRSS will have their own internal review processes and that HASP consumers will be reviewed as per these organisations normal review processes.

5.6 Transfer of Consumers between Regions

- The transfer of HASP services will be managed as a parallel process to the transfer of clinical mental health services.
- The transfer will be facilitated by the Local Allocation Committee.
- If resources are available the Local Allocation Committee will approve a continuation of services, if no resources are available the Local Allocation Committee will place the transfer on a waiting list.
- Transfers are a priority and will be allocated according to waiting time.
- The Mental Health care coordinator of the transferring region will meet with the Mental Health care coordinator of the receiving region. This meeting will include the PRSS worker of the transferring region and the PRSS worker of the receiving region.

5.7 Exit

An individual may exit from the HASP Program if:

- They don't want to participate any more.
- Their support needs become too high for the Program to provide.
- Their support needs become too low to meet the Program eligibility criteria and their needs can be better met by another program (if required) such as Individual Psychosocial Rehabilitation Support Services (IPRSS).
- The consumer has breached tenancy conditions and is being evicted.

- They require another form of permanent housing and / or support eg aged care facility.
- They die.

In all cases, the CMHS care coordinator and the PRSS worker will work together to actively support the consumer through the exit process, and provide formal transition to other programs and agencies. A number of possible scenarios are noted below, it is also accepted that other scenarios will arise which are not detailed and any solutions being sought should remain true to the Program's Objectives and Philosophy.

An individual may recover sufficiently to no longer require HASP levels of psychosocial rehabilitation and support but to move them from their HASP-linked housing would be potentially harmful. The care coordinator, support worker and Local Allocation Committee may advocate for the following actions:

- Continue the consumer's tenure in the dwelling under normal social housing arrangements.
- Transfer the dwelling to the usual social housing program of the housing provider and source a replacement property for the HASP Program from Housing SA or the housing provider if available.
- Arrange for appropriate support from another program, possibly IPRSS or CSI.

A consumer may relinquish HASP-linked accommodation (through eviction or preference) but still need daily psychosocial support at HASP levels.

- HASP psychosocial support may be provided in non-HASP housing for a limited period.
- It is expected however that the region (if necessary with the support of PMC) will act to restore the linked housing and high level support package as soon as practicable.
- This may be achieved by sourcing the consumer's future support from IPRSS or another program, or by additional service funding allocation to HASP.

A consumer is unable to maintain their place in the community and requires more support than is available and goes into hospital, a Community Rehabilitation Centre or an Intermediate Care Centre:

- Where possible their place should remain open and connection with the consumer maintained by the NGO worker and CMHS care coordinator.
- Where the admission is likely to be an extended or permanent measure, the HASP Program place should be restored and have someone from the waiting list allocated to it.

If the consumer's support needs have grown beyond the resources of the HASP Program, the PRSS and/or the mental health service and the consumer will explore options to move to accommodation with a higher level of support. Consumers should not leave the HASP Program until appropriate alternative accommodation and support is available.

Consumers should not exit the HASP Program into homelessness or inappropriate housing.

5.8 Timeliness for Notification of Vacancies and Referrals

- It is essential that notification of vacancies and referrals are made in a timely way.

- It is expected that the Housing NGO will know that a property will become available for some time before it is available, for most properties. The Housing NGO will inform the Local Allocation Committee (LAC) secretariat as soon as possible that a property will become available, so the search for a new program participant can begin.
- It is also expected that the LAC and mental health services will maintain a shortlist of consumers suitable if a HASP Program place arises, so that when an upcoming housing vacancy is notified it can be discussed with the consumer and formally referred, assessed and allocated by the LAC before the property is vacated or before it has been vacant for 14 days. This will also allow more time for the consumer to get ready for moving and the services to make agreements.
- The establishment of strong regional partnerships will also enable vacancies and issues to be discussed between agency managers/team leaders to expedite the speedy selection of consumers for properties.

5.9 Transitional vs Long-Term

It is anticipated that consumers who enter the HASP Program will have long term security of tenure except in the following examples:

- they breach their tenancy conditions and are evicted
- they choose to move to another area
- they are being housed in the 20 Unit Cluster located in the LGA of Burnside which is designated as Transitional.

The level of support provided to the consumers living in 20 Unit Cluster is very high. It is anticipated that consumers' needs will change over time and therefore this housing is seen as transitional. There is no time limit on how long the transition may take. Should a consumer's needs change and they require less support than is provided in this part of the HASP Program, they will be assisted to move out into the wider community and receive the more flexible support they need to maintain their mental health, quality of life and tenure.

6. GOVERNANCE

6.1 HASP Management Committee

At the commencement of the HASP Program the HASP Management Committee will be established. The HASP Management Committee will have representation from all partners who will oversee the successful implementation and operation of the Program and to ensure uniformity with the multiple partners and systems. This Management Committee will be chaired by the Mental Health Unit and will report to the Statewide Supported Accommodation Program Management Committee.

The Aims of the HASP Management Committee are:

- To ensure the implementation of the HASP Program occurs, achieving the aims of the Supported Accommodation model which are:
 - “To provide a supported accommodation program that is individualised, holistic, integrated and flexible for people with mental illness and severe and enduring*

psychiatric disability who initially require intensive support up to 24 hours per day in order to live in the community.”

- To ensure that development and implementation of the HASP program across South Australia grows in a uniform and complementary way. Whilst some parts of the program may differ slightly, the roles of the partners and the goals of the program should remain aligned. The HASP Program and other supported accommodation programs should be firmly connected to the mental health system and provide part of the continuum of care.
- To ensure communication about the HASP Program is coordinated and clear.

6.2 Statewide Supported Accommodation Program Management Committee

Is a state-wide program management committee which involves all stakeholders is responsible for coordinating and developing supported accommodation options for mental health consumers across South Australia. It had the responsibility of developing the HASP Program until the procurement process was completed and the HASP Management Committee was able to be formed with all HASP Stakeholders. It is chaired by the Director, Operations, Mental Health Unit.

Aims

- To ensure the integrated development and implementation of supported accommodation programs, achieving the aims of the Supported Accommodation model which are:
“To provide a supported accommodation program that is individualised, holistic, integrated and flexible for people with mental illness and severe and enduring psychiatric disability who initially require intensive support up to 24 hours per day in order to live in the community.”
- To ensure that development, implementation and integration of supported accommodation programs across South Australia grows in a uniform and complementary way. Whilst programs may differ slightly, the goals of the programs should remain aligned. All supported accommodation programs should be firmly connected to the mental health system and provide part of the continuum of care.
- To develop a State-wide Supported Accommodation and Housing Strategy which brings together the different strands of supported accommodation programs, eg the HASP Program, the Accommodation Support Program, existing supported accommodation programs and the Supported Social housing Program and provides direction about the program developments required to achieve comprehensive, recovery focussed, individualised supported accommodation options across South Australia which meets the needs of consumers.

6.2 Local Allocation Committee (LAC)

It is intended that HASP will join the IPRSS Local Allocation Committees and that referrals will be directed to the chair of the relevant committee. It is expected that there will be one Allocation Committee per area. It is expected that representation from each of the service partners will attend and together will do the following:

- To look at referrals into the HASP Program, organise assessment of consumers referred and maintain a log of referrals and a waiting list where required.

- To review assessment information, consider risks and participate in the consumer selection process
- review consumers already in the program when required, for example, when difficulties arise or when transition to a new stage of support is anticipated, eg, needing more / less support, graduating from the program.
- to plan for exit of consumers where required from the HASP Program into long term secure housing through a comprehensive housing and support needs assessment.

Ensure that there is a written record of the meetings and that this is made available to all participants.

It is anticipated that this will be the forum whereby consumer information is discussed. It is **essential** that:

- **written consumer consent** has been given to share information with the 3 partners. It is an entry requirement that consumers allow discussion of their relevant information between the three partners.
- that there is a signed MOU between the 3 parties and are therefore they are formally partners
- that exchange of consumer information between the three partners is undertaken when it is vital to the consumer's health, well being or ongoing tenancy.

6.3 Local Partnerships Committees

Local Partnership Committees should be established in each area and include team leaders from CMHS and equivalents from PRSS and Housing NGOs and other partner agencies and consumer and carer representatives with knowledge of local consumers, partner agencies, service providers and other parties, who are able to negotiate local systems and personalities to find solutions to problems.

The focus of these Local Partnership Committees should be the following:

- to build close local relationships between the service providers
- review local progress of the HASP Program
- identify barriers impeding the progress of the HASP Program as a whole, or of individual consumers' progress within HASP and develop strategies to overcome barriers.
- Build or extend partnerships with other local agencies which could assist HASP Program consumers'
- Identify ongoing problems or innovations which should be reported to the Allocation Committee and Supported Accommodation PMC. Problems and innovation should be equally recognised and solutions promoted beyond local boundaries
- Engage in problem solving.

It is recommended that Local Partnership Committees also include representatives from other Partnership Programs eg IPRSS, Supported Social Housing, Accommodation Support Programs, local housing initiatives eg Avalon, Supported Housing in the North, The Gables and Catherine House.

Local Partnership Committees may decide to invite other local service providers or client advocacy organisations to participate in their meetings, either on a one-off or ongoing basis. Written consumer consent to share information must be gained prior to

sharing any consumer information with a new agency. This recognises that many HASP Program participants are regular users of other services in the area, and improved coordination with those services will also improve client outcomes.

6.4 Contracting Arrangements

Contracts will be between the Mental Health Unit and the PRSS NGO provider and between the Mental Health Unit and the housing providers. Tendering and procurement processes will be overseen by the Mental Health Unit and will involve relevant partners, for example, the regional health services. Contract management will be the responsibility of the Mental Health Unit.

The program will be underpinned by written partnership agreements called Memoranda of Understanding (MOU) between PRSS, mental health services and housing management services. The MOU describes how each of the three partners will operate and defines the roles and responsibilities of each provider, together with other operating issues. As each partnership is set up, MOUs will be drafted and signed between the three service partners.

Each MOU should be negotiated and signed at a local level. It is a requirement of the HASP Program that an MOU is convened and signed as soon as is practicable and that a signed copy is provided to the Mental Health Unit, SA Health. A template for the MOU is available on the health website.

Service Coordination

It is a core responsibility of all partners involved in the HASP Program that they work in partnership at a local level. This includes:

- Signing the MOU
- Participating in Regional Allocation Committee
- Collecting relevant data as required.

7. DISPUTE RESOLUTION AND APPEALS

There are times in all working relationships when partners disagree. These Guidelines provide strategies for resolving disputes with consumers, neighbours and between service providers.

7.1 Consumer Disputes

Sometimes a consumer will disagree with their treatment or support. The PRSS or CMHS, or both, will use their usual strategies for resolving this type of dispute, including talking through the issue with the consumer, involving a PRSS or CMHS team leader or senior clinician, trialling a modification to treatment or support, formally reviewing treatment or support, and reviewing participation in the HASP Program.

All HASP Program providers should have in place an established complaints and disputes handling policy and procedure. These should be documented in each provider's agreement with the client.

7.2 Neighbourhood Disputes

On occasion disputes will arise between a consumer of the HASP Program and their neighbours. In these instances all partners will use their usual mechanisms for

resolving neighbourhood disputes, including talking to both parties, negotiating agreed behaviour or actions between the parties, mediating a meeting between parties and more formal processes, including local council or police involvement or a review of tenancy and conditions.

7.3 Partner Disputes

In circumstances where a difference of opinion or dispute arises between local HASP Program providers, it is expected that the parties adopt a staged approach to resolving the dispute amicably and professionally.

Step	Action
1	The individuals directly involved in the care and support of a consumer, usually the PRSS worker and the CMHS care coordinator, will meet to work through the issues and negotiate a solution as a part of the ongoing working partnership. If this is not successful, the issue should be directed to the management of the relevant organisations for a resolution.
2	If a dispute is not resolved in Step 1, the Local Partnership / Coordination Committee will refer the issue to the Allocation Committee, where the broader and more senior group of people from all partner organisations will formally consider the matter, including listening to the individuals involved in the dispute and requesting input from management staff from each organisation. A record of deliberations and actions/outcomes will be kept by the Allocation Committee.

Step	Action
3	<p>If a dispute is not resolved in Step 2, the Allocation Committee will refer the issue in writing to Manager, Rehabilitation and Recovery Services, Mental Health Unit, Operations, SA Health. Correspondence should detail:</p> <ul style="list-style-type: none"> • The issue(s) in dispute between the parties. • A timeline documenting attempts to resolve the dispute to date. • Any agreements or outcomes that have been made to resolve the dispute. <p>The Manager, Rehabilitation and Recovery Services will then take it to the Supported Accommodation PMC. The PMC will deliberate and in doing so they will give special consideration to:</p> <ul style="list-style-type: none"> • Each provider's contractual obligations. • The principles and commitments underpinning the HASP Program, and • The processes and guidelines contained in the HASP Program Guidelines. <p>Once a decision has been made, the parties will be informed in writing of the outcome. The parties have the right to pursue the matter further through any legal avenue available to them.</p>

7.4 Appeals Process

7.4.1 Consumer Appeals

If a consumer, referrer or family/carer wishes to appeal against any HASP Program decision, they must lodge an appeal within two weeks of receiving written notice of the decision from the Allocation Committee. The appeal should state, in writing, the reasons why the application should be reconsidered, and be forwarded to the Allocation Committee.

All appeals will be considered by the Allocation Committee within 10 working days. Should a meeting not be already scheduled during that time, one will be specially convened. All members of the Allocation Committee will declare any conflict of interest or prejudices they hold regarding the appeal. They may exclude themselves from the appeal deliberations. The Allocation Committee may elect to invite an independent person to join the Allocation Committee to hear the appeal.

The Allocation Committee will review all relevant documentation regarding the application and the appeal. If the documentation is insufficient for them to reach an informed decision, then they can elect to reconvene within one week. This allows time for further information to be gathered, or to invite the consumer and his/her support person, or any relevant members of staff from HASP provider agencies, to attend.

The Allocation Committee must then make a decision and immediately inform the applicant in writing of the outcome.

In all of the above scenarios, the applicant will be informed in writing of the decisions and the reasons why. Should the applicant believe that the higher appeals process warrants a formal complaint, then there may be external avenues available to them, for example through the Health Care Complaints Commission.

8. RISK MANAGEMENT

One of the guiding principles of the partnership is that we, the partners, are bound by professional, personal and agency ethics and codes of practice. Staff working within Mental Health Services and the Non Government sector are also bound by statutory requirements (e.g. legislation relating to mandatory notification, firearms notification etc). There is an expectation that partners will undertake formal risk assessments regularly. These vary within different organisations. Staff are responsible for consulting relevant documentation which outlines these requirements.

The delivery of individual psychosocial rehabilitation support services requires effective risk management. Services are to be delivered as a partnership which acknowledges risk with the dignity of risk framework. Services within this area support recovery by developing a shared understanding of the risks associated with any human service domain, developing shared strategies to mitigate unnecessary risk and by adopting a shared responsibility for risk management. The delivery of individual psychosocial rehabilitation support services requires effective risk management. An appropriate risk assessment tool should be used in the initial referral and assessment process.

The following definitions are included for information:

Duty of Care

- > The obligation to take reasonable care to avoid acts or omissions which one can reasonably foresee would be likely to injure another, also, the duty of people in particular circumstances and occupations to protect and control others
- > Mental Health Services and the Non Government Sector owe a duty of care to each other and to their consumers. Professionals working within Mental Health Services and the Non Government Sector are bound by their own professional codes and therefore if a professional departs from accepted professional practice (or if that practice is itself negligent) then a breach of the legal standard of care might be regarded as having occurred.

Duty to Warn

- > The responsibility to report threats made by a consumers, if the Mental Health care coordinator or PRSS worker believes that the consumer will carry out such threats and that they will result in danger, harm or injury to the consumer or others.
- > Where the care coordinator or PRSS worker become aware, in the course of a professional relationship that a risk to public safety exists, they will be excused from breaching confidentiality where they disclose information about the risk in order to protect the public. In this context, 'public safety' includes instances where the risk is to a particular individual. Some of these exemptions are established through statute, others through judicial interpretation of the law.
- > Clinicians should be aware that duty to warn is unlikely to arise in day to day case management and so disclosure on this basis will be a rare occurrence. In circumstances where clinicians/support workers consider that a consumer represents a risk to the public, they should carefully assess the level of risk and,

where possible, discuss the situation with colleagues or superiors before acting.¹

Risk in this context also refers to the risk of loss e.g. the risk of losing accommodation if services are not provided, the risk of losing custody of children if services are not provided.

It must also be recognised that risk is a general term and includes consideration of occupational health and safety risks. Given that HASP services are delivered in a consumer's home and in the community, it is important that consideration is given to the risks associated with the working environment.

Information on occupational health and safety risks will be shared by the partners to ensure that all parties are informed of any identified risks and strategies developed to mitigate such risks.

¹ Australian Association of Social Workers, Code of Ethics: November 1999 (2nd Edition – 2002)

Process	Actions Expected	Responsibility
Needs Identification	<ul style="list-style-type: none"> > Risk assessment is an ongoing process that is initiated at the assessment stage but continues during care planning, review and exit planning 	<ul style="list-style-type: none"> > Consumer > Carer as appropriate > Mental Health care coordinator > NGO worker
Eligibility, Priority of Access and Allocation	<ul style="list-style-type: none"> > An up to date Mental Health risk assessment must accompany the Application for Resources and include consideration of the risk of loss. 	<ul style="list-style-type: none"> > Mental Health care coordinator / referrer
Partnership Planning	<ul style="list-style-type: none"> > The initial meeting will include a discussion of the Mental Health risk assessment and where appropriate information is shared and strategies agreed to manage the identified risk > The non government provider of HASP Program services will have their own requirements in relation to risk assessment and documentation > Where possible Ulysses agreements will be used to ensure that the consumer participates in developing and agreeing to strategies required when intervention is required to manage behaviours of concern and associated risks 	<ul style="list-style-type: none"> > Consumer > Carer as appropriate > Mental Health care coordinator > NGO worker
Review	<ul style="list-style-type: none"> > The review of HASP Program support will include a review of identified risks and agreed strategies to manage these risks > Information on risk will be shared appropriately and management strategies documented to ensure that risk is managed as a partnership and in a way that is clear and agreed by all parties 	<ul style="list-style-type: none"> > Consumer > Carer as appropriate > Mental Health care coordinator > NGO worker
Transfer	<ul style="list-style-type: none"> > The transfer of HASP Program services will be managed as a parallel process to the transfer of clinical mental health services (also refer to section 5.6 Transfer) > The transfer of information relating to risk is integral to the transfer of care and will be included in transfers in and transfers out of region <p>Information on risk and risk management will be documented on the Mental Health care plan and on the review documentation.</p>	<ul style="list-style-type: none"> > Consumer > Carer as appropriate > Mental Health care coordinator > NGO worker

Process	Actions Expected	Responsibility
Exit Planning	<ul style="list-style-type: none"> > The exit of a consumer from the HASP Program will occur as a planned process and is a partnership decision including the consumer, Mental Health care coordinator and non government worker > Exit planning will include consideration of risk and in circumstances where risk issues exist post discharge information will be transferred as appropriate > Risks to psychosocial well being and strategies to manage these risks will also be considered in exit planning. 	<ul style="list-style-type: none"> > Consumer > Carer as appropriate > Mental Health care coordinator > NGO worker

9. SPECIFIC ISSUES

9.1 Provision and repair / replacement of household furniture and whitegoods

It is an expectation of the HASP Program that consumers are able to choose their furniture and that this is provided to them as part of the Program. It is an expectation that NGOs assist consumers to access funding for furniture through their normal processes eg assisting them to access funding from the Wyatt Foundation etc. It is expected that the furniture will belong to the consumers and that repair and replacement of furniture is carried out by the consumer eg should a washing machine break down it is the consumer's responsibility to pay for its repair.

There is funding provided through brokerage funding which can be used to assist with repair of household items where no other funds are available.

9.2 Flexifund

SA Health will retain program funding to enable the rapid and temporary extension of HASP service contracts to enable increased hours of support for consumers when required and unable to be met with awarded contract funding. This funding will not be included in the base contract (s).

This Flexifund will support increased hours of support, including, where required, up to 24 hour support for short periods of time, when this course of action is agreed to by the consumer, the support NGO and the Community Mental Health Service.

The Flexifund will be administered by the Mental Health Unit and will be easily accessible. It is expected that NGOs will be able to meet short term / emergency increase in hours to cover weekends or overnight support. The Flexifund is available when hours of support need to be increased over an extended period, or when 24 hour support is required for more than 48 hours.

9.3 Brokerage Allowance

A Brokerage Allowance will be provided annually for each support place at the rate of 3% of average per consumer service funding (eg in 2009/10, for High support: 3% of \$64,000 = \$1,920). This Allowance may be used for a range of direct consumer-related uses to facilitate the achievement of the consumer's goals. Goals may be related to vocational, recreational or educational realms, they also may be connected to physical health needs.

HASP service providers will separately account for the Brokerage Allowance expenditure in quarterly and annual financial reports. Mental Health Unit Management will need to be consulted regarding use of unexpended funds.

9.4 Excess

HASP places are funded for a specified amount of money and for a specified amount of hours. Average hours are specified in both daily and weekly terms as people's daily and weekly routines vary and support programs need to be able to accommodate this. It is expected, based on the experience of similar programs that once consumers are settled in their new homes and have established routines that their support needs may well decrease. Should this be the case, then the Support NGO should tailor support to the consumer's needs. Therefore NGOs may well find that they have "left-over" funds.

There are a number of acceptable ways for Support NGOs to spend this money and they are listed as follows:

- Mental health consumers who are already housed may be identified as needing extra support, and therefore may be able to be supported by HASP NGOs when funds are available. These consumers need to fulfil the criteria of the HASP Program and activity needs to be recorded in the CARS system.
- HASP consumer may need extra support (beyond that provided by their current support package) and extra support can be provided through expenditure of the "left-over" money.
- Bolster brokerage funds
- To meet the needs of consumers through research or a specific project around mental health issues (in consultation with the Mental Health Unit).
- Fund short term contracted workers.

Should an NGO have other ideas about ways to spend "left-over" money then they need to approach the Mental Health Unit with their ideas. These strategies should be discussed at the HASP Management Committee and decided in consultation with the Mental Health Unit.

10. MONITORING AND EVALUATION

10.1 Minimum Data Set

Currently, the Mental Health Unit collects monthly information from NGOs on NGO services through the Consumer Activity Reporting System (CARS).

The HASP Program will link into CARS and will collect information monthly from NGOs. This information is then collated into reports and sent back to the NGOs as well as to the regions for their information.

Monthly reports in a simple format compatible with entry into the MHS information system, providing essential minimum data in relation to client characteristics, the nature of services delivered and service delivery outputs will be collected from NGOs.

Examples of information collected:

- hours of service provided
- type of service provided
- consumer numbers
- date of referral
- date services commence
- date of exit
- accommodation type prior to HASP Program
- Accommodation type post HASP Program
- admissions into inpatient facilities - planned and unplanned
- use of flexifund to increase hours of service
- informal use of excess hours used to increase service
- expenditure of brokerage funds

(Please note the above list is not a full list of all data which will be collected by CARS)

Information will also be collected from the Allocation Committees regarding waiting list information, numbers of consumers referred to HASP Program etc.

10.2 Evaluation

There will be an evaluation of the HASP Program. Evaluation will be carried out by the Mental Health Unit and will be overseen by the Supported Accommodation Project Management Committee.

APPENDIX A – REFERENCES

A number of sources were used in the development of these Guidelines.

NSW Department of Health. (2006) *Housing and Accommodation Support Initiative (HASI) for people with mental illness*. Government of New South Wales.

O'Brien A, Inglis S, Herbert T & Reynolds A. (2002) *Linkages between housing and support – what is important from the perspective of people living with a mental illness*. Australian Housing and Urban Research Institute (AHURI), Swinburne/Monash Research Centre.

SA Health. (2008) *24 Hour Supported Accommodation – Summary Service Model*. Government of South Australia.

SA Health. (2008) *Statewide Operational Protocol – Individual Psychosocial Rehabilitation Support Services (IPRSS)*. Government of South Australia.

Victorian Department of Human Services. (2007) *An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability*. Government of Victoria.

Victorian Department of Human Services. (2003) *Psychiatric Disability Rehabilitation and Support Services (PDRSS) – Guidelines for Service Delivery*. Government of Victoria.