NSW Health

Housing and Mental Health Agreement

NSW Health and
Department of Communities
and Justice

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Acknowledgements

NSW Health and the Department of Communities and Justice acknowledge and respect Aboriginal people as the traditional custodians of the lands and waters of NSW and pay respect to Elders past, present and emerging.

We acknowledge all people with lived experience. The voice of people with lived experience is essential in guiding the work we do.

We acknowledge the families, carers and support networks for all people with lived experience. We recognise the commitment and contribution of family and carers in supporting people living with a mental health condition.

We also acknowledge the valuable contributions and input made by our partners across the housing, homelessness and mental health sectors in the design, development and implementation of this Agreement.

1. Vision

People who live with mental illness have timely access to safe, secure, appropriate housing; and mental health supports in place when needed, to sustain housing, live well in the community and lead their recovery.

2. Summary

The 2022 *Housing and Mental Health Agreement* (HMHA 22) outlines how the Department of Communities and Justice (DCJ) and NSW Health (the signatories) work together and engage key stakeholders (the participants) to achieve this vision and improve outcomes for a shared client group defined as below.

HMHA 22 Shared Client Group

The shared client group are people aged 16 years and over who:

- are living in social housing, experiencing homelessness, or are at risk of experiencing homelessness, and
- may require mental health services funded by NSW Health or be supported to access broader mental health services.

HMHA 22 outlines the common objectives, principles and commitments of the signatories. This Agreement is underpinned by:

- a Service Delivery Framework
- a Governance Framework
- monitoring and reporting mechanisms.

3. Background

Housing and mental health have a two-way relationship.[1] Having a safe and secure place to call home is a fundamental foundation for health and wellbeing. In turn, having good health and wellbeing helps people to sustain housing and access housing supports.

Housing instability and homelessness can harm people's health and act as a barrier to accessing the right health supports at the right time. People experiencing homelessness or experiencing housing issues are at a higher risk of health conditions, including mental ill health, alcohol and other drug issues, and physical health issues.[2] This impact can be even greater for Aboriginal and Torres Strait Islander communities who may face multiple barriers to sustaining tenancies over time.[3]

Poor mental health can act as a barrier to accessing safe and secure housing.[4] People with a lived experience of mental ill health often face stigma and exclusion from the housing market. Poor mental health is also linked to other risk factors contributing to homelessness, including domestic and family violence, unemployment, financial hardship, and alcohol and other drug use. Mental ill health can impact on the capacity of people to sustain and maintain housing.[5]

Overall, there is significant opportunity for the housing, homelessness and mental health service systems to improve how they collaborate and integrate their services, to deliver better outcomes for the shared client group. Services that are well integrated can assist people to maintain and access the supports they need, when they need them, and enable people to live well in the community.[6]

This Agreement is consistent with commitments made by the signatories under the *No Exits from Government Services into Homelessness: A framework for multi-agency action 2020*.[7]

1 Australian Housing and Urban Research Institute (AHURI) Brief, *Understanding the links between mental health, housing and homelessness*, updated 8 July 2019
2 Australian Institute of Health and Welfare (AIHW) Snapshot (2021), *Health of people experiencing homelessness*, released 7 December 2021
3 Australian Institute of Health and Welfare (AIHW) (2019). *Aboriginal and Torres Strait Islander people: a focus report on housing and homelessness*, AIHW, Canberra. Updated 29 March 2019.
4 Brackertz, N., Borrowman, L., Roggenbuck, C. Pollock, S. and Davis, E. (2020). *Trajectories: the interplay between mental health and housing pathways. Final research report*, Australian Housing and Urban Research Institute (AHURI) Limited and Mind Australia, Melbourne.
5 Brackertz, N. et al. AHURI, February 2020
6 Brackertz, N. et al. AHURI, February 2020
7 NSW Government (2020), *No Exits from Government Services into Homelessness: A framework for multi-agency action 2020*

Implementing a new HMHA

In 2019, DCJ and NSW Health commissioned an independent review of the 2011 HMHA, which was overseen by the cross-agency NSW Mental Health Taskforce.[8] Building on the review, this new Agreement replaces the 2011 HMHA and seeks to:

- Reinstate a state-wide governance mechanism for district oversight and to monitor progress against objectives.
- Re-invigorate district and local level governance structures as operational forums with key service providers.
- Establish senior executive accountability for the performance of the HMHA and monitor against outcomes and objectives.
- Reflect the contemporary service environment including:
  - strengthening integration with NSW Government funded mental health services
  - connecting with housing and homelessness supports delivered by non-government organisations
  - recognising the important role of Commonwealth funded supports including the National Disability Insurance Scheme (NDIS) and through Primary Health Networks (PHNs)
  - the expanded role of Community Housing Providers (CHPs) in provision and planning of social housing.
- Embed the HMHA objectives through commissioning mechanisms with the role of DCJ and NSW Health as market stewards.
- Involve people with lived experience in the design, implementation and evaluation of the HMHA, and in the design and delivery of services to the shared client group.
- Respond to vulnerable groups and people with complex needs.
- Address barriers to service coordination and collaboration, such as promoting effective practices for information sharing, privacy and consent.

4. Signatories

HMHA 22 is a formal agreement between DCJ and NSW Health as the signatories. This emphasises the key role and special responsibilities of the signatories for ensuring the operation and governance of the Agreement. The signatories have responsibility to ensure HMHA 22 principles and commitments are embedded across the service system through agreements with funded services.

5. Shared client group

HMHA 22 relates to the policy, commissioning and delivery of mental health, social housing and homelessness services by the signatories to a shared client group.

The shared client group are people aged 16 years and over who:

- are living in social housing, experiencing homelessness, or are at risk of experiencing homelessness, and
- may require mental health services funded by NSW Health or be supported to access broader mental health services.

Services provided to the shared client group include the following funded by the signatory agencies:

DCJ: the provision of social housing, homelessness services and private rental assistance for people aged 16 years or over.[9]

NSW Health: the provision of specialist clinical services in hospital and community settings for people with severe mental illness, a sub-set of the significantly larger group of people in NSW with mental health support needs.

In addition, in recognition of the complex and diverse needs within the shared client group, including for vulnerable groups and people with coexisting conditions, HMHA 22 also acts to facilitate interaction with a broader range of services including:

- other housing, mental health and psychosocial support services not funded by DCJ or NSW Health, for example supports provided through PHNs, the NDIS or private providers
- physical health, alcohol and other drugs, domestic and family violence, refugee and migrant services, justice networks, Aboriginal community-controlled services and disability supports.

8 The NSW Mental Health Taskforce is a group of cross agency senior executives convened to consider key Government priorities and cross-portfolio matters related to mental health and suicide prevention, including the significance of regional challenges and implementation. See NSW Health (2019) *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022: Implementation Plan*

9 This is the age at which the law assumes capacity to take on the legal responsibilities associated with living independently

Under HMHA 22, signatory agencies commit to collaborate and work towards integration with these broader service networks to improve outcomes for the shared client group.

6. Objectives

The objectives of HMHA 22 include the following key commitments by the signatories:

- Re-invigorate effective, accountable, and sustainable governance at the interface of mental health, housing, and homelessness services.
- Deliver on a common agenda through shared goals in partnership with funded services and other key stakeholders.
- Embed agreed principles in policy, commissioning and service delivery.

7. HMHA 22 partners and participants

Partners

The signatories acknowledge the following as key partners in leading the implementation of HMHA 22:

- Senior Executives within the Ministry of Health and DCJ, who are responsible for ensuring the ongoing operation and progress against outcomes.
- Policy and commissioning staff in both the Ministry of Health and DCJ.
- Local health districts, specialty health networks and DCJ districts.
- Community Housing Providers (CHPs) from the Social Housing Management Transfer (SHMT) program.[10] SHMT CHPs take on responsibilities similar to DCJ Housing and in locations where they are the lead housing representatives, with responsibilities for service system coordination, HMHA state-wide governance and for engaging with senior executives from SHMT CHPs and involving them in decisions regarding implementation.

Participants

The following stakeholders are considered key participants for the effective implementation of HMHA 22, and may be encouraged to join in district and local level governance groups:

- People with a lived experience of mental ill health, housing instability or homelessness, their families, kin, carers, and representative organisations.
- Non-government organisations (NGOs) providing DCJ and NSW Health funded housing, homelessness and mental health services to the shared client group and their peak organisations.
- Non-SHMT Community Housing Providers.
- Community managed organisations (CMOs) providing mental health and psychosocial supports and Specialist Homelessness Services (SHS).
- NSW Government agencies outside DCJ and NSW Health with policy or operational responsibility for housing, homelessness, mental health or psychosocial support services. This includes:
  - Land and Housing Corporation (LAHC) and the Aboriginal Housing Office (AHO) which own social housing properties managed by DCJ and CHPs and Aboriginal Community Housing Providers (ACHPs)
  - the National Disability Insurance Agency (NDIA)
  - NDIS funded providers as it relates to case level responses
  - PHNs funding health and psychosocial supports
  - Local Government.

The signatories also recognise the role of private sector stakeholders in supporting the shared client group, including the role of General Practitioners, private psychiatrists, landlords and real estate agents.

10 This is part of the transfer of government owned dwellings from DCJ to select CHPs under the *Future Directions for Social Housing* reforms to 2025. Key responsibilities include tenancy management and delivery of private rental assistance products. Currently, there are nine CHPs under the program across select Local Government Areas

8. Principles underpinning HMHA 22

The signatories commit to the following principles:

	**Empowering and respecting the rights of people with lived experience**, including the right to participate in decisions about their care, to decline services and to respect their confidentiality and privacy in accordance with relevant laws.
	**Adopting a trauma-informed approach** through actions that promote safety, choice, collaboration and empowerment to build trust.
	**Placing the person at the centre of services** so that a high standard of care is achieved for each individual.
	**Adopting a holistic approach** to consider physical, emotional, social, cultural and spiritual wellbeing and provide culturally responsive services.
	**Respecting differences between and across the signatory agencies** at all levels of governance, including differing structures, priorities and constraints. Staff are listened to as the experts in their own field.
	**Involving people with lived experience**, their families, carers and kinship at all levels of service delivery and policy development.
	**Sharing information** between services to facilitate individual client outcomes and to inform policy, planning and service design.

9. Commitments

As part of HMHA 22, the signatories are jointly responsible and committed to the following:

1. Senior Executive leadership (Ministry of Health and DCJ) has leadership and oversight of the Agreement. This ensures delivery against HMHA 22 intended objectives and outcomes.
2. The statewide governance provides bi-annual reports to the Secretaries on HMHA 22 progress and escalates issues that cannot be resolved at the state-wide governance level as needed.
3. Both agencies commit to establish, re-invigorate, and actively participate in HMHA 22 governance at the statewide, district and local levels to implement the agreement and intended objectives.
4. Resource the secretariat function across state, district and local governance tiers, to ensure accountability and ongoing operation of HMHA 22.
5. Establish and resource a lived experience advisory panel and engage people with lived experience, their families, carers and representative organisations in the operation and evaluation of HMHA 22.
6. Engage with other NSW Government agencies, relevant Commonwealth Government agencies, and NGOs who play an important role in supporting positive outcomes for the shared client group. This includes proactively engaging mental health services and psychosocial support services outside the funded remit of the signatories.
7. Implement the *No Exits from Government Services into Homelessness: A framework for multi-agency action 2020*.[11]
8. Lead the development and ongoing operation of a HMHA 22 Service Delivery Framework and ensure transparent reporting against outcomes and indicators in the framework. This includes working towards shared goals that reflect the key focus areas across the housing, homelessness and mental health interface.
9. Establish and maintain performance monitoring mechanisms for shared goals to support client level and service delivery outcomes.
10. Develop and embed principles for collaboration and service principles in the planning, delivery and evaluation of policies, programs and services.
11. Embed HMHA 22 through commissioning mechanisms.

11 NSW Government (2020), *No Exits from Government Services into Homelessness: A framework for multi-agency action 2020*

12. Enable solutions to effective practices which address requirements for privacy and consent to promote legal, appropriate and consistent information sharing across HMHA 22 participants, to support collaboration and outcomes for the shared client group.
13. Consult and collaborate early on policy, programs and initiatives that impact the shared client group.
14. Collaborate to improve service coordination and integration, encouraging flexibility and innovative responses, while acknowledging business as usual processes within each agency for client eligibility, service access and prioritisation.

10. Structure

Agreement

This Agreement forms the basis of implementation and governance mechanisms and outlines the overarching aims, objectives and commitments for DCJ and NSW Health as the signatories to support the shared client group.

This Agreement is underpinned by:

- a Service Delivery Framework
- a Governance Framework
- monitoring and reporting mechanisms, and
- guidance to promote effective information sharing.

Agreement

A formal Agreement between DCJ and NSW Health that outlines how DCJ and NSW Health will work together and engage key stakeholders, to improve outcomes for the shared client group

Service Delivery Framework

The mechanism to engage people with lived experience and support collaboration amongst housing, homelessness, mental health and other partner services

Governance Framework

A three-tiered model to set out the roles and responsibilities of stakeholders, including accountabilities, escalation and communication pathways

Monitoring and reporting mechanisms

Mechanisms to measure the HMHA's progress against key deliverables outlined in the Service Delivery Framework

Guidance for information sharing

Guidelines to promote effective information sharing across services and support collaboration

Service Delivery Framework

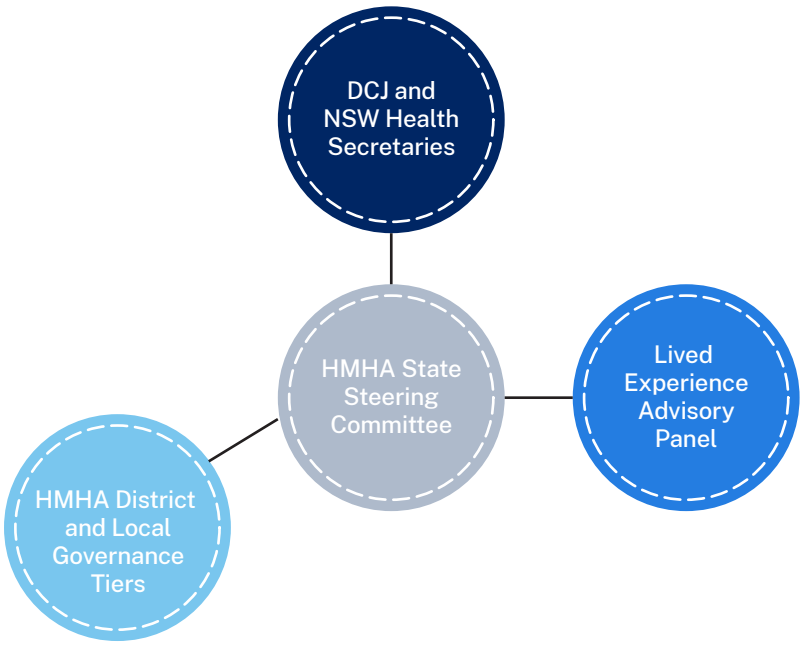
The HMHA 22 Service Delivery Framework supports collaboration amongst housing, homelessness, mental health and other partner services to implement this Agreement. It is expected to be flexible and adaptable over time.

The primary components of the Service Delivery Framework may include:

- specific shared goals within the housing, homelessness and mental health service delivery context
- actions to address key interface issues, such as solutions to requirements for privacy and consent to promote legal, appropriate and consistent information sharing across services to support collaboration
- principles for collaboration for HMHA participants and principles to guide service delivery for the shared client group
- organisation, service and client level outcomes to be achieved that relate to the shared goals
- sector level objectives and targets that are relevant (such as the Premier's Priorities).

Governance

Establishing effective and sustainable governance at the interface of mental health, housing and homelessness is fundamental to successful implementation of the HMHA. Governance mechanisms incorporated from this Agreement will be outlined in the supporting Governance Framework. The governance model comprises three tiers: state, district and local, with clear accountability, escalation and communication pathways embedded throughout.



State Level Governance

The state tier of governance will focus on system stewardship and overseeing state-wide implementation, resolving issues escalated from districts and ensuring ongoing functioning of the district level. This includes:

- a State Steering Committee with government and peak body members with escalation pathways to DCJ and NSW Health Secretaries.
- an advisory panel of people with lived experience.

District and Local Level Governance

The district tier of governance will focus on district-wide implementation, overseeing local level governance, resolving issues escalated from the local level, ensuring ongoing functioning at the local level and escalating unresolved issues to the statewide level.

The district level may include District Implementation Committees with DCJ district, local health district and specialty health network senior staff, Aboriginal housing and mental health staff, service providers and people with lived experience. In districts where there is no DCJ Housing presence, SHMT CHPs will be the lead for housing.

The local tier of governance will focus on the individual client service level. Local governance may include members from government, service providers, local Aboriginal organisations and people with lived experience.

Monitoring and reporting mechanisms

Performance monitoring and reporting mechanisms will be established to measure the impact of HMHA 22 against key priorities outlined in the Service Delivery Framework. This may include:

- measurable targets that relate to the shared goals in the Service Delivery Framework
- detail on the reporting mechanisms, format and frequency that will be used to monitor progress
- data sources for reporting.

Reporting progress against Key Performance Indicators (KPIs) will be a critical element in maintaining accountability and providing transparency to the broader sector. KPIs will be jointly agreed and monitored through the HMHA 22 governance structures.

Guidance to promote effective information sharing

Development of guidance addressing requirements for privacy and consent in relation to the legal, appropriate and consistent sharing of personal information across services to support collaboration and improve outcomes for the shared client group will be a key priority of the Service Delivery Framework. Guidance may include information about when consent is needed, when consent is not needed, and the legal rules for information sharing with and without consent.

11. Terms

This agreement may be reviewed as required and may be terminated in writing by mutual agreement and by each signatory Department. Either Department may withdraw from the agreement by providing six months' written notice to the other signatory Agency.

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12. Definitions

Coexisting conditions – means that someone has more than one condition or illness at the same time. Other terms used, but meaning the same thing, include co-morbidities, dual diagnosis and co-occurring disorders.

Community Housing Provider – a not for profit, non-government, community organisation that provides long-term rental accommodation to people on a very low, low or moderate income or people with additional needs. Community Housing organisations receive assistance from the Government in the form of grants, loans, dwellings, or current operation funding. Community housing and public housing are both forms of social housing, but the latter are government owned.

Culturally responsive service delivery - delivery of programs and services so that they are consistent with the cultural identity, communication styles, meaning and value or normative systems and social contexts of clients, program participants and other stakeholders.

Homelessness – where a person does not have suitable accommodation, which meets basic needs including a sense of security, stability, privacy, safety and the ability to control living space. May be:

- Primary: no conventional accommodation or shelter;
- Secondary: living in shelters, emergency accommodation, refuges and couch surfing;
- Tertiary: living in accommodation that falls below minimum community standards.

Local health district (LHD) – organisations which manage public hospitals and provide health services to communities within a specific geographic area.

Non-government organisation (NGO) – includes organisations operating in the community or private sectors.

National Disability Insurance Scheme – the National Disability Insurance Scheme (NDIS) is an Australia-wide scheme for people with disability, including psychosocial disability. People may be eligible for NDIS funded support if they have a disability that is likely to be lifelong and substantially impacts their life.

Person-centred – placing a person at the centre of service delivery to ensure a high standard of customer service and the best outcomes are achieved for each individual.

Psychosocial disability – psychosocial disability is the term used to describe disabilities that may arise from mental health issues. Psychosocial disability is different for each person, but often impacts capacity to live independently. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage.

Psychosocial supports – psychosocial supports are non-clinical interventions that can assist people with severe mental illness to live independently, participate in their community, manage daily tasks, undertake work or study, find housing, get involved in activities, and make connections with family and friends. Psychosocial supports are specific to the person and their needs.

Recovery – being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.

Social housing – rental housing provided by not-for-profit, non-government or government organisations to assist people who are unable to access suitable accommodation in the private rental market. Social housing includes public, Aboriginal and community housing, as well as other services and products.

Social Housing Management Transfer Program – includes the transfer of the management of government owned dwellings from DCJ to select community housing providers (CHPs). The transfer is an initiative under *Future Directions for Social Housing in NSW*, a 10 year plan spanning until 2025. Currently there are nine CHPs in the program across select local government areas. The SHMT CHPs have responsibilities equivalent to DCJ Housing offices including tenancy management and the delivery of private rental assistance products. Aboriginal Housing Office tenancies are not affected.

Specialty health network – two specialist networks operate across NSW with a focus on children's and paediatric services (Sydney Children's Hospitals Network) and forensic mental health (Justice and Forensic Mental Health Network). A third network operates across the public health services provided by three Sydney facilities operated by St Vincent's Health Australia (St Vincent's Health Network).

Trauma-informed care – provides a framework for service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.

Effective date and Signatories

The Housing and Mental Health Agreement will be effective from 24 February 2022.

Signed:

Elizabeth Koff
Secretary
NSW Health

Date: 

Michael Tidball
Secretary
Department of Communities and Justice

Date: 24 February 2022


NSW
GOVERNMENT