NSW Health

Housing and Mental Health Agreement 2022

Governance Framework

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Department of Communities
and Justice

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The NSW Ministry of 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.

Further copies of this document can be downloaded from the NSW Health webpage www.health.nsw.gov.au

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Contents

"The national and international evidence indicates the importance of having a home for an individual's ability to lead a contributing life. We know that generally, for people who are living with a mental health difficulty, getting and keeping their own home is hard to achieve compared to the general community... For the most vulnerable and unwell, cycles of homelessness, unstable housing and poor mental health can become their total life experience. Housing is a critical foundation for an individual's journey to recovery."

Professor Allan Fels AO and Dr Peggy Brown
Housing, Homelessness and Mental Health Consultation
National Mental Health Commission, 2017

A guiding note on language

Language has a profound impact on people and the use of inclusive and contemporary language empowers people, minimises stigma and changes culture over time.

The language used in this document is intended to be respectful, inclusive, recovery oriented and reflect the **Recovery Oriented Language Guide and Resources** produced by the Mental Health Coordinating Council (MHCC). The terminology of "person with a mental health condition" is used to refer to people with lived experience.

The framework also uses language which acknowledges the lived experience of carers, families, kinship groups and friends supporting people with lived experience of mental health conditions.

Further resources on language can be found here:

- **Lived Experience Framework for NSW** produced by the NSW Mental Health Commission
- **Language Matters** resource produced by the Network of Alcohol and Other Drugs Agencies (NADA).

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACHP	Aboriginal Community Housing Provider
ACI	Agency for Clinical Innovation
AHO	Aboriginal Housing Office
AOD	Alcohol and Other Drugs
CHP	Community Housing Provider
CLS	Community Living Supports
CMO	Community Managed Organisation
DCJ	Department of Communities and Justice
DIP	District Implementation Plan
HASI	Housing and Accommodation Support Initiative
HASI Plus	Housing and Accommodation Support Initiative Plus
HMHA 22	Housing and Mental Health Agreement 2022
LALC	Local Aboriginal Land Council
LEC	Lived Experience Committee
LHD	Local Health District
LIACC	Local Implementation and Coordination Committee
LIP	Local Implementation Plan
MHS	Mental Health Service
MH-CLSR	Mental Health Community Living Supports for Refugees
NGO	Non-Government Organisation
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NSW	New South Wales
PHN	Primary Health Network
SHS	Specialist Homelessness Service
SHMT	Social Housing Management Transfer program

The Housing and Mental Health Agreement 2022

01

Introduction

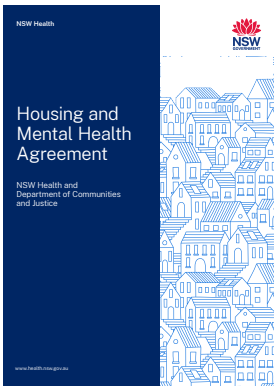
The Housing and Mental Health Agreement 2022 is a formal agreement between NSW Health and the Department of Communities and Justice.

It is a commitment that all levels of the agencies will work together, and with key stakeholders, to ensure that people with lived experience of a mental health condition have timely access to safe, secure, appropriate housing; and mental health supports in place when needed, to sustain their housing, live well in the community and lead their recovery.

The Agreement

Access to safe, secure, appropriate housing is essential to ensure that people who live with a mental health condition can live well in the community. Timely access to appropriate mental health supports enhances wellbeing, helps people sustain their tenancy, and creates pathways into housing for people experiencing homelessness.

NSW Health and the Department of Communities and Justice (DCJ) entered into the current **Housing and Mental Health Agreement (HMHA 22)** in February 2022. It marks a commitment between the two agencies to deliver the following key objectives:



- **Objective 1:** Re-invigorate effective, accountable and sustainable governance between mental health, housing, and homelessness services.
- **Objective 2:** Deliver on a common cross-agency agenda through shared goals in partnership with mental health, housing, and homelessness services and other key stakeholders.
- **Objective 3:** Embed agreed principles in policy, commissioning and service delivery.

The case for collaboration: a two-way relationship between housing and mental health

Housing and mental health have a two-way relationship. 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.

In NSW, like in other states, housing, homelessness and mental health have a history of being separate policy systems with little formal integration.

Acknowledging this two-way relationship and strengthening how we work together can amplify our efforts to improve our shared clients' wellbeing and mental health.

The HMHA 22 Shared Client Group

The HMHA 22 relates to the policy, commissioning and delivery of mental health, social housing and homelessness services by the signatory agencies 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 at risk of experiencing homelessness, and
- require mental health services funded by NSW Health or support to access broader mental health services.

The HMHA 22 Participants

While the HMHA 22 is a formal agreement between DCJ and NSW Health, it cannot achieve its objectives without the two agencies working in close partnership with a broader range of service providers and the people who use these services. In the Agreement, this group is collectively referred to as the HMHA 22 'participants', and includes:

- people with a lived experience of a mental health condition, housing instability or homelessness, their families, kin, carers, and representative organisations
- NSW Health local health districts (LHDs)
- DCJ Districts
- Social Housing Management Transfer Program (SHMT) providers
- specialist mental health supports
- specialist housing supports
- specialist homelessness supports
- specialist Aboriginal providers
- housing supply and management
- other 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.

These stakeholders are considered key participants for the effective implementation of HMHA 22, and are encouraged to join in district and local level governance groups.

The signatories also recognise the role of private sector stakeholders in supporting the shared client group, including the role of general practitioners, private psychiatrists, allied health professionals, landlords and real estate agents.

Signatories

NSW Health Local Health Districts
Department of Communities and Justice Districts

Social Housing Management Transfer (SHMT) Program providers

Specialist mental health supports

Specialist housing supports

Housing supply and management

Specialist homelessness supports

People with lived experience

Specialist Aboriginal providers

Local supports

Specialist mental health supports

- Community Managed Organisations funded by NSW Government
- Community Managed Organisations funded by Primary Health Networks
- Psychosocial disability support providers funded under the National Disability Insurance Scheme
- Private sector providers – General Practitioners and private psychiatrists

Housing supply and management

- Land and Housing Corporation
- Aboriginal Housing Office
- Aboriginal Land Councils
- Real estate agents and landlords

Specialist Aboriginal providers

- Aboriginal Community Controlled Organisations
- Specialist Aboriginal Services funded by Primary Health Networks

Specialist housing supports

- Community Housing Providers
- Aboriginal Community Housing Providers

Specialist homelessness supports

- Specialist Homelessness Services

Local supports

- Local Government

A key program for the HMHA 22 shared clients

The Social Housing Management Transfer (SHMT) Program

The Department of Communities and Justice has transferred the tenancy management of around 14,000 social housing tenancies to community housing providers (CHPs), including the delivery of private rental assistance products as part of the **Social Housing Management Transfer (SHMT) Program**. This reflects the NSW Government support for a diverse community housing provider sector, and recognition of positive impact CHPs can have on people's lives.

Where a community housing provider has responsibility for tenancy management under the SHMT, it takes on responsibilities like DCJ Housing. This includes HMHA 22 district level governance.

In this Framework, where a DCJ District Executive Director has responsibility for an action, this is transferred to the Chief Executive of the relevant SHMT provider, if a transfer has occurred.

The Supporting Frameworks

The HMHA 22 outlines the overarching aims, objectives and commitments for DCJ and NSW Health as the signatories to support the shared client group.

The Governance Framework guides how the three levels of the HMHA 22 – local, district, state – interact and support each other, including escalation pathways for resolving systemic issues.

The Agreement is underpinned by this Framework along with other supporting frameworks:

Service Delivery Framework

Monitoring and Reporting Framework

The Governance Framework

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The Framework at a Glance

The Housing and Mental Health Agreement 2022 (HMHA 22) is implemented through a three-tiered governance model at local, district and state levels. The model is mutually reinforcing, in that each level supports and interacts with the other levels through information, communication, and escalation pathways, and organisational structures in the signatory agencies.

Escalation Pathway

Communication Pathway

State level governance

NSW Mental Health Taskforce

HMHA 22 State Steering Committee
- sub-committee of the NSW Mental Health Taskforce
- includes government and peak body members
- oversees implementation of the HMHA 22 across NSW and works to resolve issues escalated by the district tier.

HMHA 22 Lived Experience Committee

Key functions for the HMHA 22 State Steering Committee are:
- stewarding the implementation of the Agreement
- developing strategies to resolve implementation issues and facilitate improvements to state-wide service planning, commissioning, access and outcomes
- escalating issues to the NSW Health and DCJ members of the Mental Health Taskforce, if required.

District level governance

HMHA 22 District Committees
- includes government, service providers and people with lived experience
- implements the HMHA 22 at the district level and works to resolve issues escalated by the local tier.

Key functions:
- enabling decisions on district wide service delivery issues
- facilitating joint service and workforce planning
- improving cross agency coordination to improve service access and outcomes.

Local level governance

HMHA 22 Local Committees
- includes government, service providers and people with lived experience, determined by the local service context
- implements the HMHA 22 Service Delivery Framework at the local level.

Key functions:
- coordinating consistent service provision for individual shared clients
- building relationships for HMHA 22 local alliances
- identifying systemic issues and innovative practices that should be escalated to the district committee.

A note on HMHA 22 governance and other DCJ and NSW Health policies

DCJ and NSW Health have their own state wide, district and local organisational structures, policies, escalation pathways and reporting requirements. The HMHA 22 Governance Framework does not affect these.

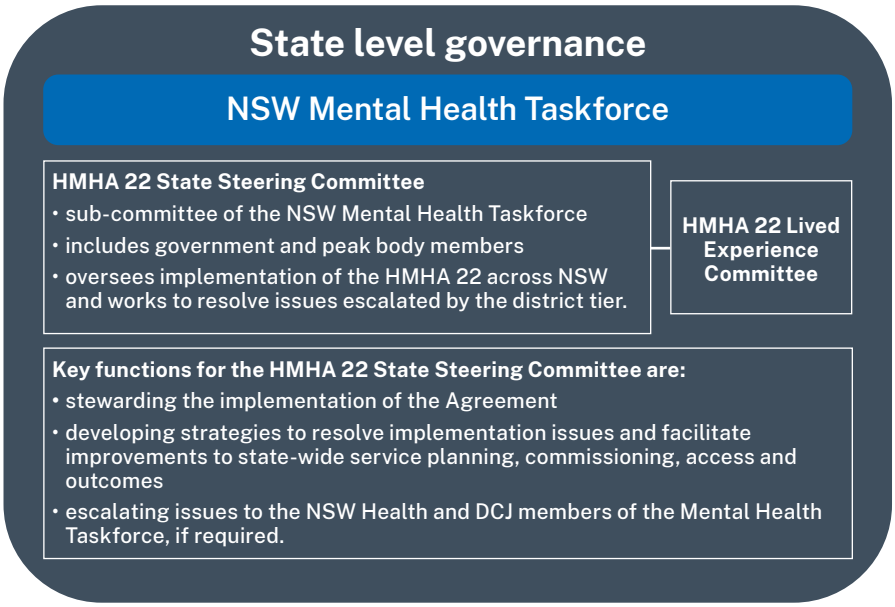
Where there may be an inconsistency between the HMHA 22 governance and other organisational requirements, the issue should be escalated to the HMHA 22 State Steering Committee.

The Governance Principles

Through consultation on the HMHA 22, participants and stakeholders called for formal, consistent, multi-tiered governance arrangements, with clear guidelines.
The overarching principles to ensure this Governance Framework is effective are set out below.

The HMHA 22 Governance Principles
Support the aim, objectives, and principles of the HMHA 22.
Partner with people with lived experience, their families and carers in the planning, com-missioning, and delivery of services.
Partner with Aboriginal people, their communities and kinships networks to understand their experience of the systems
Participate actively and professionally in governance at relevant levels.
Recognise and involve all HMHA 22 participants as equal partners, where appropriate, including NSW government agencies, NGOs, CMOs and the Aboriginal Community Con-trolled Sector.
Ensure effective coordination at the relevant governance tiers.
Promote awareness of the HMHA 22 to a broader range of stakeholders.
Promote good practice in delivering coordinated services to people in the shared client group.
Strengthen integrated service planning, to deliver coordinated person-centred services.
Work towards the shared agenda and goals as outlined in the Service Delivery Framework
Measure progress against performance indicators that support the HMHA 22 outcomes through partnering with people with lived experience.

State Level Governance



The state level provides support and the authorising environment for the HMHA 22 district and local governance tiers.

As a subcommittee of the NSW Mental Health Taskforce, the HMHA 22 State Steering Committee, in partnership with the Lived Experience Committee, is responsible for state level governance and oversight for the HMHA 22.

NSW Mental Health Taskforce

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.

The Taskforce recognises that good mental health is a whole of government concern and works to drive senior executive level discussion of key Government priorities and cross-portfolio matters related to mental health.

The HMHA 22 State Steering Committee is a sub-committee of the NSW Mental Health Taskforce.

Membership

The membership of the HMHA 22 State Steering Committee consists of **Executive Director or equivalent level representatives** and assumes a leadership, stewardship, and approval and endorsement function.

Co-Chairs

- NSW Ministry of Health - Mental Health Branch
- NSW Department of Communities and Justice

Members include:

- NSW Ministry of Health - Centre for Alcohol and Other Drugs
- NSW Ministry of Health – Centre for Aboriginal Health

- NSW Department of Communities and Justice – Corrective Services
- NSW Department of Planning and Environment - NSW Aboriginal Housing Office
- NSW Department of Planning and Environment - NSW Land and Housing Corporation
- NSW Health - Justice Health Forensic and Mental Health Network (Justice Health NSW)
- National Disability Insurance Agency (NDIA)
- Peak representative organisations of key HMHA 22 participants:
  - Mental Health Coordinating Council (MHCC)
  - Mental Health Carers NSW (MHCN)
  - Aboriginal Health and Medical Research Council (AH&MRC)
  - Community Housing Industry Association of NSW (CHIA NSW)
  - Aboriginal Community Housing Industry Association (ACHIA)
  - Homelessness NSW
  - Network of Alcohol and other Drugs Agencies (NADA)
  - NSW Coalition of Aboriginal Alliances (NCARA)
  - NSW Aboriginal Land Council
  - Yfoundations
  - Domestic Violence NSW (DVNSW)
  - BEING – Mental Health Consumers NSW.
- NSW PHN representative nominated by the NSW PHN-NSW Health Statewide Committee
- HMHA 22 District Committee representative (on a rolling schedule with one District representative at each meeting)

Guest invitation (or periodic time limited representation) from other HMHA 22 participants is likely to be beneficial and may include representatives from:

- local government and its peak bodies
- aged care peak bodies
- disability Services
- child protection and out-of-home care agencies
- other organisations or individuals as recommended and agreed to by members of the HMHA 22 State Steering Committee.

The Chair of the HMHA 22 State Steering Committee

The Chair or Co-Chairs is appointed by the signatories for a 2-year rotation.

Chair responsibilities include:

- providing leadership to the HMHA 22 State Steering Committee and serving as its spokesperson or representative if required, especially in liaison with the Secretaries of the signatory agencies
- preparing agendas in consultation with the Secretariat
- effectively and rigorously Chairing regular meetings of the HMHA 22 State Steering Committee
- monitoring and ensuring participation and engagement of members at appropriate levels
- writing correspondence and signing off on reports of the HMHA 22 State Steering Committee as required.

Responsibilities of the HMHA 22 State Steering Committee

The HMHA 22 State Steering Committee leads and stewards the system wide delivery of the commitments and accountabilities of the Agreement according to the HMHA 22 principles.

Specific responsibilities include:

- sponsoring a supportive authorising environment for the implementation of the HMHA 22 at the district and local levels
- providing a biannual report to the Secretaries DCJ and NSW Health on HMHA 22 progress
- identifying and promoting good practice examples by facilitating and collaborating on state-wide research, relevant policy and program reviews and supporting the sharing of information between agencies and stakeholders
- sharing service gap assessments and planning for coordinated service delivery
- identifying needs and facilitating joint workforce capability enhancements
- developing, monitoring and implementing the HMHA 22 Monitoring and Evaluation Framework with key performance indicators as agreed by sector stakeholders
- developing, implementing and reporting the HMHA 22 Service Delivery Framework every two years
- raising and addressing issues and opportunities to improve the implementation of HMHA 22 including issues escalated from the district tier
- reviewing, monitoring and endorsing the work of the district tiers to implement the Agreement (including endorsing the l District Implementation Plans developed by the district tiers)
- proactively engaging and developing relationships with HMHA 22 participants including Non Government / Community Managed Organisations, local government, State government agencies, services funded by the Commonwealth Government including those providing supports under the National Disability Insurance Scheme and through the Primary Health Networks
- ensuring a commitment to a trauma informed approach through actions that promote safety, choice, collaboration and empowerment to build trust.

Meeting frequency

The HMHA 22 State Steering Committee meets quarterly.

Where practicable, the meeting schedule will relate to the NSW Mental Health Taskforce and NSW Health – DCJ Secretaries schedules so issues requiring escalation can be managed promptly.

Escalation pathways

If required, the HMHA 22 State Steering Committee can escalate issues via two paths:

- NSW Mental Health Taskforce

  Where an issue requires multi agency consideration (i.e., beyond NSW Health and DCJ), the HMHA 22 State Steering Committee can escalate the matter to the NSW Mental Health Taskforce (via the Chair)

- NSW Health and DCJ Secretaries Regular Meeting

  Where an issue is within the remit of NSW Health and DCJ the HMHA 22 Steering Committee can escalate the matter to the Secretaries regular meeting.

Secretariat Function

The secretariat function for the HMHA 22 State Steering Committee ensures the stability, efficiency and effectiveness of the HMHA 22 Governance Framework. It alternates between NSW Health and DCJ on a yearly basis.

The secretariat function:

- supports the Chairs (or Co-Chairs) to exercise their functions including preparing agendas and papers for the regular meetings
- arranges members and guests to attend meetings and monitors attendance of members
- minutes all meetings and circulates minutes and action points to all members within a reasonable timeframe and maintains other records
- monitors actions out of session to ensure they are progressed according to timeframes.

The HMHA 22 Lived Experience Committee

The HMHA 22 Lived Experience Committee (LEC) is a new element of the HMHA 22 governance arrangements and functions as an advisory body and member of the HMHA 22 State Steering Committee.

The LEC provides a voice for people with mental health conditions and experience of the social housing and homelessness systems to influence important changes for the shared client group.

Membership

The LEC is made up of 10-12 representative service users who bring insights from their own unique experiences of the housing and mental health service system, and aims to include:

- a person from the NSW Mental Health Consumer Subcommittee, the group that provides the NSW Ministry of Health with advice on policy, planning and strategic issues relating to mental health consumers in NSW public mental health services
- a representative from Yfoundations, the NSW peak body representing young people at risk of, and experiencing, homelessness, and the services that provide direct support to those young people
- a person accessing the Housing Accommodation Support Initiative (HASI) or Community Living Supports (CLS) program
- two Aboriginal people living in Aboriginal Community Housing or Aboriginal Housing with lived experience as a person or carer of a person with mental health conditions
- a person representing the family or carers of people with lived experience of mental health conditions or homelessness.

Where possible, the members of the LEC represent the diversity of the shared client group and includes people from regional, rural or remote areas, older people, younger people (under 25 years old), Aboriginal people, Culturally and Linguistically Diverse communities, the Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) community; and people with lived experience of disability, including a psychosocial disability.

Responsibilities of the Lived Experience Committee

The responsibilities of the LEC include:

- facilitate quarterly working groups to comment on State Steering Committee agenda items, ensuring that the interests of people with lived experience are represented in decision making
- provide additional advice to the State Steering Committee on strategy, policy, planning, implementation and review of the HMHA 22 as it impacts service users
- contribute to the implementation of the HMHA 22 Supporting Frameworks
- participate in additional consultations and working groups to develop and review HMHA 22 policies, plans, projects and programs, as required.

People sitting on the committee with lived experience - who are not employed to represent an organisation - are paid to participate according to the NSW Mental Health Commission *Consumer and Carer Paid Participation* policy in recognition of their valuable, specialised and expert contribution.

District Level Governance

Establishing a HMHA 22 District Committee

The HMHA 22 Governance Framework reflects stakeholders calling for clear and consistent governance at local, district and state levels across NSW. However, the HMHA 22 governance arrangements also allow flexibility for district committees to invite representatives as they see fit, to best respond to the local needs and service contexts of their area.

At the district level, this requires participants to first determine if a new HMHA 22 District Committee needs to be established, or whether an existing committee, such as a HMHA District Implementation and Coordination Committee (DIACC) or District Homelessness Implementation Group (DHIG), may be adapted to provide appropriate HMHA 22 district level governance.

Assessing whether an existing governance structure is suitable for the HMHA 22

When district participants are considering whether to use an existing district structure for HMHA 22 governance, or establish a new one, the following factors may support decision-making:

- Does the membership of the existing group include the members required for the HMHA 22 district governance tier?
- Is the overall intent of existing governance structures sufficiently aligned with the HMHA 22 vision and shared client group to effectively implement the Agreement in line with the requirements of the Service Delivery Framework?
- Can the existing meetings provide sufficient time for proper consideration of HMHA 22 standing items as well as address their original intent?
- Can the existing structure properly deliver the specific responsibilities of the HMHA 22 district tier, as outlined below?

If the answer to any of these questions is ‘no’, it is likely that a new HMHA 22 District Committee will need to be established.

Where an existing committee is to be used, this committee should review and update its Terms of Reference to ensure that they are aligned to HMHA 22 and this Governance Framework.

Model Terms of Reference for HMHA 22 District Committees are included in the Appendix of this Governance Framework. These should be completed by each district committee and provided to the HMHA 22 State Steering Committee secretariat. If an existing group is being used, an updated terms of reference should be provided, outlining how it will be aligned to the HMHA 22.

A note on DCJ and NSW Health District Structures

DCJ and NSW Health have district structures. The geographical boundaries of their districts are broadly aligned to facilitate greater collaboration and service coordination for initiatives like the HMHA 22.

These districts manage, plan and fund a range of services for populations within defined boundaries. They have strong relationships with the NGO sector through funding arrangements and other strategic partnerships, both formal and informal.

Broadly, the HMHA 22 District Committees will reflect NSW Health and DCJ districts, with some variations due to local contexts.

Requirements for the HMHA 22 District Committees

The following section details the requirements for HMHA 22 District Committees, including membership, key responsibilities, as well as the roles of chairs and secretariat functions.

Membership

The list of representatives below specify the minimum required membership for district committees. Members will generally be senior staff with appropriate delegation to make decisions on behalf of their organisation.

The district will determine the membership from each of the following categories:

Minimum Required Membership
Representative - People with lived experience of social housing, homelessness and mental health and/or their families and carers or representatives (this may include a Peer Worker or other person engaged through consumer consultation committees in NSW Health and DCJ).
Representative – local health district mental health services
Representative – local health district alcohol and other drug services
Representative – DCJ district housing services, Commissioning and Planning Teams, and Social Housing Management Transfer Community Housing Providers
Representative - District Community Housing Providers (with all Community Housing Providers to be invited in the first instance)
Representative – NSW Mental Health Community Living Programs (e.g. HASI, CLS) provider(s)
Representative – Aboriginal Housing Office, Aboriginal Community Housing provider(s) and Land Councils
Representative – Aboriginal Community Controlled Health Services
Representative – Other Aboriginal Organisations such as Aboriginal Regional Alliances
Representative – Primary Health Network

Committees may invite other members to tailor the committee to meet their local needs and service context.

Guest Representatives – at the discretion of district committees

Examples of guest representatives that district committees may wish to consider, include:

- local councils
- district NDIS providers
- local PHN funded mental health, alcohol and other drug services, and Aboriginal health providers
- aged care providers
- organisations supporting refugees or asylum seekers
- emergency departments, ambulance and police
- domestic violence organisations
- culturally and linguistically diverse organisations.

The Chair of the HMHA 22 District Committee

This role will be appointed by the committee for a 2-year rotation and/or be shared by two co-chairs who alternate chairing meetings.

Chair/co-chair responsibilities include:

- leading the HMHA 22 District Committee and serving as its spokesperson or representative, when required
- preparing agendas in consultation with the secretariat
- Chairing regular meetings of the HMHA 22 District Committee and ensuring effective function and respectful deliberations
- writing correspondence and signing off on reports of the HMHA 22 District Committee

Responsibilities of the HMHA 22 District Committees, include:

- taking a district wide leadership approach to improve the coordination of service delivery between social housing, homelessness service and mental health providers to meet the diverse needs of the target group
- developing and implementing a HMHA 22 District Implementation Plan every two years according to the requirements of the HMHA 22 Service Delivery Framework (including establishing working groups as may be required)
- reporting on progress as per the HMHA 22 Monitoring and Evaluation Framework
- raising and addressing issues and opportunities to improve the implementation of the HMHA 22 including issues escalated from the local tier committees
- addressing the HMHA 22 Service Delivery Framework priorities by collaborating on relevant policy and program reviews and implementation and supporting the sharing of information between agencies and stakeholders
- understanding the district service delivery landscape and identifying areas of under and over utilisation and capacity
- identifying and resolving district service delivery and workforce planning issues which impact on how services are provided or escalate issues to the HMHA 22 state governance tier
- providing a forum for reporting issues, distributing information related to policies, new developments and partnerships related to the HMHA 22 shared clients
- communicating to the local tier about issues resolved and the work of the district and state governance tiers
- identifying, promoting and sharing good practice examples or local innovations
- engaging with people with lived experience including Aboriginal stakeholders and people from culturally and linguistically diverse communities and LGBTIQ+ communities to ensure that services are responsive, inclusive, culturally safe, non-discriminatory and appropriate
- strengthening (where required) the processes and mechanisms for:
  - Prevention and early intervention approaches
  - Undertaking joint client care planning
  - Providing a trauma-informed recovery-oriented practice approach
  - Linkages with other agencies and other interagency committees.
- endorsing the Terms of Reference of the local tiers
- monitoring the work of and ensuring the functioning of any local tiers
- managing any other issues delegated by the HMHA 22 State Steering Committee
- engaging and informing district level representatives of partner organisations outside the funded remit of DCJ and NSW Heath such as:
  - Local government or local government peak organisations
  - Land and Housing Corporation
  - Primary Health Networks
  - The National Disability Insurance Agency.

In addition to these specific responsibilities the district level is also required to meet the HMHA 22 Principles and Commitments.

Secretariat Function

The secretariat function for the HMHA 22 District Committee ensures the stability, efficiency and effectiveness of the HMHA 22 governance. It is shared between NSW Health and DCJ.

The secretariat:

- supports the chair (or co-chairs) to exercise their functions including preparing agendas and papers for the regular meetings
- arranges members and guests to attend meetings and monitors attendance of members
- minutes all meetings and circulates minutes and action points to all members within a reasonable timeframe and maintains other records
- monitors actions out of session to ensure they are progressed according to timeframes.

Meeting Frequency

HMHA 22 District Committees meet quarterly at minimum.

Where reasonably practicable, the meeting schedule should relate to the meetings of the HMHA 22 State Steering Committee, so that issues can be escalated promptly if required

Representatives from the local tiers

The HMHA 22 District Committees should include (or regularly engage with) representatives from the local governance tier(s).

Relationship to Existing Interagency Forums and District Management Structures

DCJ and NSW Health Districts have their own internal organisational management structures, policies, escalation pathways and reporting requirements. The Governance Framework does not affect these.

A locality may also have other interagency forums that it would be beneficial to link to. To be relevant to the operational and organisational context, significant relationships such as these should be acknowledged and made clear in the Terms of Reference.

District Implementation Plans

All HMHA 22 District Committees must develop plans setting out how the Agreement will be implemented in the local context, called District Implementation Plans (DIPs).

The DIPs are updated every two years. The committees monitor progress at the regular quarterly meetings as a standing agenda item.

The DIPs can draw on relevant commitments made in other mental health and housing/homelessness regional planning requirements, such as:

- joint regional plans developed by LHDs and PHNs as part of the implementation of the National Mental Health and Suicide Prevention Agreement
- local implementation plans developed as a requirement of the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025.

- In the development of these plans, district committees should ensure their DIPs:
  - **Strive for Co-Design:** District committees should strive for co-design of DIPs by partnering with people with lived experience of local mental health and social housing supports, carers, and their families.
  - **Align with the Service Delivery Framework:** The DIPs should reflect the domains, shared agenda and strategic actions of the HMHA 22 Service Delivery Framework.

DIPs are submitted to the HMHA 22 State Steering Committee for endorsement and monitoring.

A 'minimum requirement' DIP template for HMHA 22 District Committees is included in the Appendix of this Governance Framework. The HMHA 22 State Steering Committee secretariat will communicate with district committees in relation to timeframes and reporting requirements for DIPs.

A note on HMHA 22 governance and other DCJ and NSW Health policies

DCJ and NSW Health have their own state wide, district and local organisational structures, policies, escalation pathways and reporting requirements. The HMHA 22 Governance Framework does not affect these.

Where it appears that there may be an inconsistency between the HMHA 22 governance and other formal organisational requirements, the issue should be escalated to the HMHA 22 State Steering Committee.

Escalation and Communication Pathways

District committees can escalate both district and local issues, or examples of innovative practice, to the HMHA 22 State Steering Committee, via the secretariat, where required.

Before escalating issues to the HMHA 22 State Steering Committee, all reasonable attempts must be made to resolve the issue locally.

Once an issue has been considered by the HMHA 22 State Steering Committee, the secretariat will communicate the outcome to the relevant district committee via email.

For more information on escalation and communication pathways, refer to the HMHA 22 Monitoring and Reporting Framework.

Local Level Governance

Establishing a HMHA 22 Local Committee

The HMHA 22 Governance Framework reflects stakeholders calling for clear and consistent governance at local, district and state levels across NSW. However, as with the district level, the HMHA 22 governance arrangements allow flexibility for local committees to invite representatives as they see fit, to best respond to the local needs and service contexts of their area and clients.

At the local level, this requires participants to first determine if a new HMHA 22 Local Committee needs to be established, or whether an existing committee, such as a HMHA Local Implementation and Care Coordination Committee (LIACCs), or other client care coordination structures, may be adapted to provide appropriate HMHA 22 local level governance.

Assessing whether an existing governance structure is suitable for the HMHA 22

When local participants are considering whether to use an existing local committee for HMHA 22 governance, or establish a new one, the following factors may support decision-making:

- Does the membership of the existing committee include the members required for the HMHA 22 local care coordination?
- Is the overall intent of the existing committee sufficiently aligned with the HMHA 22 vision and shared client group to effectively implement the Agreement in line with the requirements of the Service Delivery Framework?
- Can the existing meetings provide sufficient time for proper consideration of HMHA 22 standing items as well as address their original intent?
- Can the existing structure properly deliver the specific responsibilities of the HMHA 22 local care coordination requirements, as outlined below?

If the answer to any of these questions is ‘no’, it is likely that a new HMHA 22 Local Committee will need to be established.

Where an existing committee is to be used, this committee should review and update its Terms of Reference to ensure that they are aligned to HMHA 22 Service Delivery and Governance Frameworks.

Model Terms of Reference for HMHA 22 Local Committees are included in the Appendix of this Governance Framework.

These should be completed by each local committee and provided to their oversighting HMHA 22 District Committee, for forwarding to the HMHA 22 State Steering Committee secretariat.

If an existing group is being used, an updated terms of reference should be provided, outlining how it will be aligned to the HMHA 22.

Requirements for the HMHA 22 Local Committee

The following section details the mandatory requirements for the HMHA 22 Local Committees, including membership and key responsibilities.

Membership

The membership of a HMHA 22 Local Committee is determined locally.

The list of representatives below, specify the minimum required membership for local committees. Members will generally be **senior staff with appropriate delegation to make decisions** on behalf of their organisation in line with the responsibilities of the local tier.

The district will determine the membership from each of the following categories:

Membership – mandatory
1. Representative(s) – NSW Health - Mental health services
2. Representative(s) – DCJ or SHMT - district housing staff and/or Commissioning and Planning staff, and/or SHMT Community Housing Provider
3. Representative(s) – local Community Housing Provider(s) (including Aboriginal Community Housing Providers)
4. Representative(s) – Specialist Homelessness Services(s)
5. Representative(s) – NSW Mental Health Community Living Programs (e.g. HASI, CLS)

Committees may invite other members to meet their local needs and service contexts.

They may also include representation from organisations or people with lived experience, their families or carers for agenda items that do not require discussion of individual shared clients.

Guest Representatives – at the discretion of local committees

Examples of representatives that local committees may wish to consider, include:

- local councils
- district NDIS providers
- local PHN funded mental health, alcohol and other drug services, and Aboriginal health providers
- aged care providers
- organisations supporting refugees or asylum seekers
- emergency departments, ambulance and police
- domestic violence organisations
- culturally and linguistically diverse organisations.

Responsibilities of the HMHA 22 Local Committees

A HMHA 22 Local Committee does three things:

1. It provides the primary forum to build relationships for a robust HMHA 22 local alliance
2. It is responsible for ensuring an agreed and transparent process for local HMHA 22 participants to coordinate care for individual clients
3. It is responsible for developing a HMHA 22 Local Implementation Plan (LIP) and then ensuring its delivery.

1. Building relationships for a HMHA 22 local alliance

- Provide a regular forum for all local HMHA 22 participants to develop the relationships necessary to ensure flexible coordinated services that meet the diverse needs of shared clients.

2. Ensure agreed and functioning processes for participants to coordinate care for individual clients

- Agree, and ensure all local HMHA 22 participants understand the local process and/or protocol for any participant to escalate a shared client for a coordinated response from one or more other local participants.
- Coordinate transitional planning for people exiting mental health inpatient facilities, or shared clients exiting social housing, general health or other government services.

3. Implementing the HMHA 22 Service Delivery Framework at a local level

- Identifying and resolving individual and local issues which impact on how services are provided or escalating issues appropriately to the HMHA 22 District Committee.
- Monitoring, assessing and planning for local service needs, prevention initiatives and implementing early intervention wherever possible.
- Facilitating education and training between services to support collaboration and integrated service delivery and to ensure organisational and staff culture, attitudes, knowledge and skills are complementary.
- Improving understanding of common issues and awareness of services between mental health, social housing, homelessness, government and NGO services including issues often faced by individuals including and not limited to experiences of trauma, domestic and family violence, stigma and discrimination.
- Discussing de-identified practice examples/issues to resolve concerns and identifying systemic issues regarding individual and local service provision.
- Engaging with people with lived experience including Aboriginal and culturally and linguistically diverse people, people with disability, and communities and LGBTIQ+ communities to ensure that services are responsive, inclusive, safe, non-discriminatory and culturally appropriate.

- Ensuring individuals receive consistent responses when they access mental health and or social housing or homelessness services.
- Identifying, promoting and sharing good practice examples or local innovations.
- Managing any other issues delegated by the HMHA 22 District Committee.

In addition to these specific responsibilities, the local level is also required to meet the HMHA 22 Principles, and Commitments.

Secretariat function

The secretariat function for the HMHA 22 Local Committees ensures the stability, efficiency and effectiveness of the HMHA 22 governance. It is shared between NSW Health and DCJ representatives.

The secretariat:

- supports the chairs (or co-chairs) to exercise their functions including preparing agendas and papers for the regular meetings
- arranges members and guests to attend meetings and monitors attendance of members
- minutes all meetings and circulates minutes and action points to all members within a reasonable timeframe and maintains other records
- monitors actions out of session to ensure they are progressed according to timeframes.

Meeting frequency

HMHA 22 Local Committees meet at least bi-monthly (every two months).

Relationship to Existing Interagency Forums and District Management Structures

A locality may also have other interagency forums that it would be beneficial to link to. To be relevant to the operational and organisational context, significant relationships such as these should be acknowledged and made clear in the Terms of Reference.

Local Implementation Plans

All HMHA 22 Local Committees must develop plans setting out how the Agreement will be implemented in the local context, called Local Implementation Plans (LIPs).

The LIPs are biennial plans, updated every two years. The local committees monitor progress at the regular meetings as a standing agenda item.

As with the district plans, LIPs may draw on relevant commitments made in other mental health and housing/ homelessness regional planning requirements:

- joint regional plans developed by LHDs and PHNs as part of the implementation of the National Mental Health and Suicide Prevention Agreement
- local implementation plans developed as a requirement of the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025.

In the development of these plans, committees should ensure their LIPs:

- **Strive for Co-Design:** Local committees should strive for co-design of LIPs by partnering with people with lived experience of local mental health and social housing supports, carers, and their families

- **Align with the Service Delivery Framework:** The LIPs should reflect the domains, shared agenda and high level strategic actions of the HMHA 22 Service Delivery Framework.

LIPs are submitted to the HMHA 22 State Steering Committee, via the oversighting district committee, which is responsible for endorsement and monitoring.

A 'minimum requirement' LIP template for HMHA 22 Local Committees is included in the Appendix of this Governance Framework.

A note on HMHA 22 governance and other DCJ and NSW Health policies

DCJ and NSW Health have their own state wide, district and local organisational structures, policies, escalation pathways and reporting requirements. The HMHA 22 Governance Framework does not affect these.

Where it appears that there may be an inconsistency between the HMHA 22 governance and other formal organisational requirements, the issue should be escalated to the HMHA 22 State Steering Committee, via the oversighting district committee.

Escalation and Communication Pathways

HMHA 22 Local Committees can escalate local issues, or examples of innovative practice, to their oversighting HMHA 22 District Committee. In cases where district committees are unable to effectively resolve a local issue, district committees can escalate the matter to the HMHA 22 State Steering Committee.

Before escalating issues, all reasonable attempts must be made to resolve the issue locally.

Once an issue has been considered by the HMHA 22 State Steering Committee, the secretariat will communicate the outcome to the relevant district committee via email.

For more information on escalation and communication pathways, refer to the HMHA 22 Monitoring and Reporting Framework.

Glossary

Aboriginal Community Controlled Health Organisation (ACCHO)	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).
Assertive outreach for homelessness	A purposeful, proactive and persistent approach that has the common goal of ending homelessness for those who are sleeping rough. It is conceptualised as part of a broader, integrated and intentional policy response that requires both a multidisciplinary team and the availability of long-term housing. It aims to work with people over the medium to long-term to assist people to access housing and sustain their tenancies post-homelessness
Community Housing Provider (CHP)	Not-for-profit providing housing assistance to eligible people on low incomes who are unable to access appropriate housing in the private market. The housing types provided by community housing providers include social housing, affordable housing and supported housing.
Community Managed Organisation (CMO)	Key non-government provider of mental health, community support and disability support services to people with a lived experience.
Culturally appropriate 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.
High Needs Shared Client	A person who: • had a mental health related admission in the previous 2 years, and • had some SHS or temporary accommodation use in the past 3 years.
Homeless	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. Types of homelessness include: • 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.

HMHA 22 participants

A collective term for the stakeholders considered key participants necessary for the effective implementation of HMHA 22 including:

- people with a lived experience of mental health concerns, 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.

HMHA 22 private sector stakeholders

Private sector stakeholders that also provide relevant support to the shared client group, including general practitioners, private psychiatrists, landlords and real estate agents.

HMHA 22 signatories

Secretaries of the Department of Communities and Justice and NSW Health as the representatives of or on behalf of:

- 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, which take on responsibilities like 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.

Local Implementation and Coordination Committee (LIACC)

A general term used to describe the HMHA 22 local governance tier which is focussed on implementing the agreement locally including coordinating service access and care for individual shared clients.

Local health district (LHD)

The 15 LHDs districts that are responsible for providing health services in a wide range of settings, from primary care posts in the remote outback to metropolitan tertiary health centres. Eight LHDs cover the greater Sydney metropolitan regions, and seven cover rural and regional NSW.

Non-government organisations	Includes organisations operating in the community or private sectors. See also Community Managed Organisations
NSW Health	The collective term for the network of local health districts, specialty networks and non-government affiliated health organisations that operate more than 220 public hospitals, as well as provide community health and other public health services, for the NSW community.
Outcome data	Data that indicates whether, or the degree to which, the intended result or consequence has occurred from a program or activity. An example of an outcome is an increase in a consumer's ability to participate in the community.
Outputs data	Data measuring what has been produced by an activity or group of activities. An example of an output is the number of occasions of service an organisation has delivered.
Peer worker	A mental health peer worker is someone employed based on their personal lived experience of mental health issues and recovery (a consumer peer worker), or their experience of supporting family or friends with mental health issues (carer peer worker). This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.
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.
Primary Health Network (PHNs)	PHNs are independent organisations that are funded to coordinate primary health care in their region. PHNs assess the needs of their community and commission health services so that people in their region can access coordinated health care where and when they need it.
Psychosocial support	Psychosocial supports are non-clinical and recovery-oriented services, delivered in the community primarily by funded CMOs and tailored to individual needs, which support people experiencing moderate to complex mental health challenges to live independently and participate in the community. Examples may include support to sustain a tenancy, build skills to live independently, find fulfilling work, and build social connections. In NSW people with a mental health condition may receive psychosocial supports through NDIS funding and/or programs funded by NSW Health or Primary Health Networks.
Public housing	Long-term, affordable housing for people on low incomes who are unable to rent privately. The properties are managed by Department of Communities and Justice.
Risk of homelessness	A person is at risk of homelessness if they are at risk of losing their accommodation. A person may be at risk of homelessness if they are experiencing one or more of a range of factors or triggers that can contribute to homelessness.
Service integration	Structures and processes that attempt to bring together the participants in human services systems with the aim of achieving goals that cannot be achieved by those participants acting autonomously and separately.

Sleeping rough	Sleeping in uncomfortable conditions without housing and without shelter, often on the streets, in parks or in a car.
Social Housing Management Transfer (SHMT) program	DCJ transfer of tenancy management of social housing tenancies to community housing providers, including the delivery of private rental assistance products under Housing Pathways.
Specialist homelessness services (SHS)	Assistance provided by a specialist homelessness agency to a person aimed at responding to or preventing homelessness. Support includes accommodation provision, assistance to sustain housing, domestic/family violence services, mental health services, family/relationship assistance, disability services, drug/alcohol counselling, legal/financial services, immigration/cultural services, other specialist services and general assistance and support.
Specialty Health Networks (SHN)	Two specialist state wide health networks that focus on children's and paediatric services (Sydney Children's Hospital Network), and justice health and forensic mental health (Justice Health and Forensic Mental Health Network); and the St Vincent's Health Network in Sydney.
Supportive housing	Housing which incorporates additional supports, such as case management and psychosocial supports.
Social housing	Rental housing provided by not-for-profit, NGO or government organisations to assist people who are unable to access suitable accommodation in the private rental market. It includes public, Aboriginal and community housing.
Trauma-informed care	An approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage. It incorporates principles of safety, choice, collaboration, trust and empowerment.

Appendices

Housing and Mental Health Agreement 2022 - District Implementation Plan (2023 – 2025)

[District / Network]

Signatories and participants

In [District / Speciality Health Network] the service organisations represented on the District Committee are:

1.

2. ...

Plan outline: The first two years 2023 – 2025

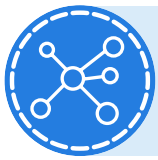
(Refer to the HMHA 22 Service Delivery Framework for information about domains, shared agenda priorities and strategic actions)

Domain 1:
How we work with our shared clients

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

Domain 2:
How we work with each other

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...



Domain 3:
How we promote the Agreement and work together to innovate

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

Actions to progress one or more of the shared agenda priorities

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

The District Committee should strive for co-design of these plans with people with lived experience of mental health, social housing and homelessness services.

- [insert details of engagement with people with lived experience in developing, implementing and/or monitoring the plans where possible]

Approved / endorsed by: (name, signature, date)

Chief Executive Local Health District

Executive District Director – DCJ

Housing and Mental Health Agreement 2022 - Local Implementation Plan (2023 – 2025)

[Local area]

Signatories and participants

In [local area] a Local Committee has been formed with the following organisations as key participants:

1.

2. ...

Plan outline: The first two years 2023 – 2025

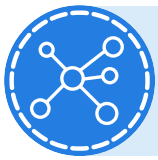
(Refer to the HMHA 22 Service Delivery Framework for information about domains, shared agenda priorities and strategic actions)

Domain 1:
How we work with our shared clients

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

Domain 2:
How we work with each other

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...



Domain 3:
How we promote the Agreement and work together to innovate

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

Actions to progress one or more of the shared agenda priorities

- [Action. Milestones. Milestone dates]
- [Action. Milestones. Milestone dates]
- ...

The Local Committee should strive for co-design of these plans with people with lived experience of mental health, social housing and homelessness services.

- [Summary of co-design process and ongoing involvement of people with lived experience etc]
-

The local process and/or protocol for any participant to escalate a shared client for a coordinated response from one or more other local participants is attached or summarised as:

- [Summary of coordinated care referral process / protocol]

Approved / endorsed by: (name, signature, date)

_____

Chair – HMHA 22 District tier governance committee

Model Terms of Reference - HMHA 22 District Committee

Vision

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

Purpose

The HMHA 22 District Committee is responsible for enabling decisions on district wide service delivery issues, facilitating joint service and workforce planning, and improving cross agency coordination to improve service access and outcomes. It gives effect to and implements HMHA 22 at the district level and works to resolve issues escalated by the local tier.

Key responsibilities include:

1. Taking a district wide leadership approach to improve the coordination of service delivery between social housing, homelessness service and mental health providers to meet the diverse needs of the target group
2. Developing and implementing a HMHA 22 District Implementation Plan every two years according to the requirements of the HMHA 22 Service Delivery Framework (including establishing working groups as may be required)
3. Reporting on progress as per the HMHA 22 Monitoring and Evaluation Framework including Signatory Commitments.
4. Raising and addressing issues and opportunities to improve the implementation of the HMHA 22 including issues escalated from the local tier
5. Addressing the Service Delivery Framework priorities by collaborating on relevant policy and program reviews and implementation and supporting the sharing of information between agencies and stakeholders
6. Understanding the district service delivery landscape and identifying areas of under and over utilisation and capacity
7. Identifying and resolving district service delivery and workforce planning issues which impact on how services are provided or escalate issues to the HMHA 22 state governance tier
8. Providing a forum for reporting issues, distributing information related to policies, new developments and partnerships related to the HMHA 22 shared clients
9. Communicating to the local tier about issues resolved and the work of the district and state governance tiers
10. Identifying, promoting and sharing good practice examples or local innovations
11. Engaging with people with lived experience including Aboriginal people, people from culturally and linguistically diverse communities and LGBTIQ+ communities to ensure that services are responsive, inclusive, culturally safe, non-discriminatory and appropriate
12. Strengthening (where required) the processes and mechanisms for:
    - Prevention and early intervention approaches
    - Undertaking joint client discussed planning
    - Providing a trauma-informed recovery-oriented practice approach
    - Linkages with other agencies and other interagency committees.

Purpose (cont.)

13. Endorsing the Terms of Reference of the local tiers
14. Monitoring the work of and ensuring the functioning of any local tiers
15. Managing any other issues delegated by the HMHA 22 State Steering Committee
16. Regularly updating HMHA 22 SharePoint site
17. Engaging and informing district level representatives of partner organisations outside the funded remit of DCJ and NSW Heath such as:
    - Local government or local government peak organisations
    - Land and Housing Corporation
    - Primary Health Networks
    - The National Disability Insurance Agency.
18. In addition to these specific responsibilities the district level is also required to meet the HMHA 22 Principles and Commitments.

Membership

The membership of up to a set number of people is to be determined by the District.

A quorum for a meeting will be half the membership plus one. (E.g., if there are 10 members, then quorum is 6.)

Members include:

- People with lived experience of social housing, homelessness and mental health and/or their families and carers or representatives (this may include a Peer Worker or other person engaged through consumer consultation committees in NSW Health and DCJ).
- Senior Executive representatives from the local health district:
  - mental health services (as determined by the District's Mental Health Director), and
  - alcohol and other drug services.
- Senior Executive representatives from the:
  - DCJ district housing services
  - Commissioning and Planning Teams, and
  - Social Housing Management Transfer Community Housing Providers.
- District Community Housing Providers (with all Community Housing Providers to be invited in the first instance)
- District NGO service providers (including community managed mental health organisations, specialist homelessness services)
- District Aboriginal organisations and service providers (e.g., Aboriginal Housing Office, Aboriginal Housing providers, Land Councils and Aboriginal Medical Services)
- Representative(s) from one or more of the HMHA 22 local governance tier committee(s)

It is expected that any organisational representatives attending the district tier will have the approved delegation to make decisions on behalf of their organisation.

Depending on their service context, districts may also include representation from other organisations including and not limited to:

- Primary Health Networks
- Local Councils
- Aged care service providers
- National disability service providers
- Organisations supporting refugees or people seeking asylum.

Scope and procedure

Shared clients	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.
Referral and catchment area	*[Insert the relevant geographical area]*
Agenda referral criteria	*[Insert relevant local referral criteria here]* • Issues raised by the [Insert any local lived experience committee] • Any other issues raised by members of the District Committee in alignment with HMHA 22 and its Objectives and Commitments
Client consent	In considering privacy issues best practice is to seek the client's informed consent to the sharing of information between organisations. *[In the absence of consent insert available provisions and relevant existing policies for exchanging information here.]*
Information sharing	Information sharing in these meetings will be governed by [insert relevant policy/ guideline]
Confidentiality	Member's agreement to privacy undertaking as part of these meetings is confirmed by their signature to this Terms of Reference. *[Insert relevant policy/guideline or principles here]*
Escalation pathway	Issues are to be escalated as needed to HMHA 22 State Steering Committee.
Monitoring and reporting	[Subject to HMHA 22 Monitoring and Reporting Framework] *[Insert relevant reporting criteria in the Monitoring & Reporting Framework]*
Review	This Terms of Reference should be reviewed every 12 months to ensure it remains relevant and accurate. Revised Terms of Reference must be approved by a majority of members of the HMHA 22 State Steering Committee. *[Insert here the review date and/or the date endorsed]*
Chair	*[Insert person and organisation responsible and the duration]*
Secretariat	*[Insert person and organisation responsible here]*
Advance Schedule – Venue, Date, Time	*[Insert here if regularly the same time and place, otherwise delete and include logistical information in the meeting agenda]*
Frequency	At least quarterly [insert here]
Recording	*[Insert here if the meeting will be recorded for the purpose of minute taking]*

Member signatories

Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**

Model Terms of Reference - HMHA 22 Local Committee

Vision

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

Purpose

The HMHA 22 Local Committee is responsible for enabling decisions on district wide service delivery issues, facilitating joint service and workforce planning, and improving cross agency coordination to improve service access and outcomes. It gives effect to and implements HMHA 22 at the district level and works to resolve issues escalated by the local tier.

Key responsibilities include:

1. Delivering flexible coordinated services that meet the diverse needs of shared clients
2. Ensuring coordinated transitional planning for people exiting health or other government services
3. Discussing, coordinating and, where necessary, prioritising service availability for people with multiple and complex needs
4. Identifying and resolving individual and local issues which impact on how services are provided or escalating issues appropriately to the HMHA 22 District Committee
5. Monitoring, assessing and planning for local service needs, prevention initiatives and implementing early intervention wherever possible
6. Facilitating education and training between services to support collaboration and integrated service delivery and to ensure organisational and staff culture, attitudes, knowledge and skills are complementary
7. Improving understanding of common issues and awareness of services between mental health, social housing, homelessness, government and NGO services including issues often faced by individuals including and not limited to experiences of trauma, domestic and family violence, stigma and discrimination
8. Discussing de-identified practice examples/issues to resolve concerns and identify systemic issues regarding individual and local service provision
9. Engaging with people with lived experience including Aboriginal and culturally and linguistically diverse people, people with disability, and communities and LGBTIQ+ communities to ensure that services are responsive, inclusive, safe, non-discriminatory and culturally appropriate
10. Ensuring individuals receive consistent responses when they access mental health and or social housing or homelessness services
11. Identifying, promoting and sharing good practice examples or local innovations
12. Managing any other issues delegated by the HMHA 22 District Committee
13. Regularly updating HMHA 22 SharePoint site
14. Engaging and informing partner organisations outside the funded remit of DCJ and NSW Health, particularly the National Disability Insurance Agency and Primary Health Networks to progress solutions for mental health support access and referrals.

In addition to these specific responsibilities, the local level is also required to meet the HMHA 22 Principles and Commitments.

Membership

The membership of up to a set number of people is to be determined at the local level and reflect the main service delivery participants for that area.

A quorum for a meeting will be half the membership plus one. (E.g., if there are 10 members, then quorum is 6.)

It is expected that any representatives attending the local tier will have the approved delegation to make decisions on behalf of their organisation in line with the responsibilities of the local tier.

Members are to consist of senior service delivery staff representing:

- local health district mental health services and other health services relevant for the shared client group (for example this could include alcohol and other drug service staff)
- DCJ district housing staff and/or Commissioning and Planning staff, and/or Social Housing Management Transfer Community Housing Providers
- Local Community Housing Providers (including Aboriginal Community Housing Providers)
- Local NGO service providers (for example community managed mental health organisations, specialist homelessness services and alcohol and other drug services)
- Local Aboriginal organisations and service providers.
- Depending on their service context, local tiers may also include representation from other organisations, including unfunded NGOs, people with lived experience, their families or carers for agenda items that do not require discussion of individual clients.

Scope and procedure

Shared clients	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.
Referral and catchment area	*[Insert the relevant geographical area]*
Agenda referral criteria	• Any HMHA 22 Local Committee member may request the committee to consider coordinating care of a HMHA 22 shared client according to [Insert relevant local care co-ordination process protocol here]
Client consent	In considering privacy issues best practice is to seek the client's informed consent to the sharing of information between organisations. *[In the absence of consent insert available provisions and relevant existing policies for exchanging information here.]*
Information sharing	*Information sharing in these meetings will be governed by [insert relevant policy/ guideline]*
Confidentiality	Member's agreement to privacy undertaking as part of these meetings is confirmed by their signature to this Terms of Reference. *[Insert relevant policy/guideline or principles here]*
Escalation pathway	Issues are to be escalated as needed to HMHA 22 State Steering Committee.
Monitoring and reporting	[Subject to HMHA 22 Monitoring and Reporting Framework] *[Insert relevant reporting criteria in the Monitoring & Reporting Framework]*
Review	This Terms of Reference should be reviewed every 12 months to ensure it remains relevant and accurate. Revised Terms of Reference must be approved by a majority of members of the HMHA 22 State Steering Committee. *[Insert here the review date and/or the date endorsed]*
Chair	*[Insert person and organisation responsible and the duration]*
Secretariat	*[Insert person and organisation responsible here]*
Advance Schedule – Venue, Date, Time	*[Insert here if regularly the same time and place, otherwise delete and include logistical information in the meeting agenda]*
Frequency	At least quarterly [insert here]
Recording	*[Insert here if the meeting will be recorded for the purpose of minute taking]*
Relationship to existing interagency care coordination forums	A locality may have other interagency forums that it would be beneficial to link to. To be relevant to the operational and organisational context, significant relationships such as these should be acknowledged and made clear in the Terms of Reference.

Member signatories

Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**
Name	**Name**
Position/Title	**Position/Title**
Organisation	**Organisation**
Signature	**Signature**
Date	**Date**


NSW
GOVERNMENT