NSW Health

Housing and Mental Health Agreement 2022

Monitoring and Reporting Framework

NSW Health and
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
AHO	Aboriginal Housing Office
AOD	Alcohol and Other drugs
CHPs	Community Housing Providers
CMO	Community Managed Organisation
DCJ	Department of Communities and Justice
HMHA 22	Housing and Mental Health Agreement 2022
LALC	Local Aboriginal Land Council
LHD	Local Health District
LIP	Local Implementation Plan
MHS	Mental Health Service
NGOs	Non-government organisations
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NSW	New South Wales
PHN	Primary Health Network
SHS	Specialist Homelessness Services
SHMT	Social Housing Management Transfer program
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

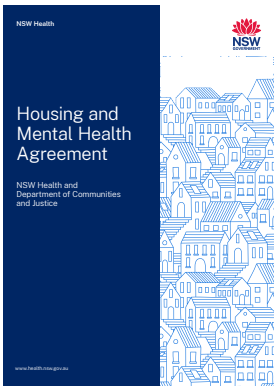
The Housing and Mental Health Agreement 2022 is a formal agreement between NSW Health and the Department of Communities and Justice.

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

Governance Framework

Service Delivery Framework

HMHA 22 Monitoring and Reporting Framework

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The Framework at a Glance

The HMHA 22 Monitoring and Reporting Framework:

The HMHA 22 Monitoring and Reporting Framework:

- helps all signatories and participants **understand progress** towards the Agreement's vision by **reporting** key output, outcome and evaluation information
- supports the signatories to be **accountable** for their commitments in the Agreement
- provides **structure for evaluating** the implementation and effectiveness of the Agreement
- encourages and facilitates **data driven decision making and targeted interventions** at a state, district and local level.

Monitoring the implementation of the Agreement

1	**Annual HMHA 22 Communique**	Reporting progress on the three core objectives (Refer to page 12 of this document). Reporting progress on the 15 signatory commitments (Refer to page 13 and 14 of this document).
2	**District Implementation Plan Report**	HMHA 22 District Committees provide an annual District Implementation Plan Report to the HMHA 22 State Steering Committee.
3	**Local Implementation Plan Report**	HMHA 22 Local Committees provide an annual Local Implementation Plan Report to the HMHA 22 State Steering Committee (endorsed by district committee).

Monitoring the key outcomes: HMHA 22 Linked Data Set

A commitment by both signatory agencies to work with district and local partners to develop linked data sets for the purpose of monitoring and reporting on the HMHA 22.

Purpose and Principles

Purpose

The HMHA 22 Monitoring and Reporting Framework:

- helps signatories and participants understand progress towards the Agreement's vision by transparent reporting of key performance and evaluation information
- supports the signatories to be accountable for their commitments in the Agreement
- provides structure for evaluating the implementation and effectiveness of the Agreement
- encourages and facilitates data driven decision making and targeted interventions that ensure resources are targeted to the areas and people in most need.

Principles

The following principles underpin the Monitoring and Reporting Framework:

- support participation of people with lived experience, their families, carers and kinship networks to understand their experience of the systems
- support participation of Aboriginal people, their communities and kinships networks to understand their experience of the systems
- understand our progress on the shared agenda (as outlined in the Service Delivery Framework)
- include information from, and make information available to, HMHA 22 signatories and participants
- embrace innovative data linkages as a key building block for HMHA 22 integration
- draw from existing data, where possible, to minimise administrative burdens
- protect client privacy at the three tiers of governance – local, district and state – by disaggregating data.

Monitoring the Implementation of the Agreement

The Monitoring and Reporting Framework ensures that the signatories, and all tiers of governance, are accountable for their commitments, as outlined in the Agreement and supporting frameworks.

Agreement objectives

The HMHA 22 includes three broad objectives. The below table sets out how the commitments will be delivered and monitored.

Broad objectives in the Agreement	How will we know it is achieved?
1. Re-invigorate effective, accountable, and sustainable governance at the interface of mental health, housing, and homelessness services.	• The HMHA 22 Governance Framework is implemented at state, district and local levels.
2. Deliver on our shared agenda through strategic actions in partnership with funded services and other key stakeholders.	• The shared agenda is delivered as set out in the Service Delivery Framework. • The HMHA 22 vision is localised through District and Local Implementation Plans. • The strategic actions are monitored through the Annual HMHA 22 Communique, and District and Local Implementation Plan Reports.
3. Embed the HMHA 22 common principles in policy, commissioning and service delivery.	• The HMHA 22 common principles are reflected in policy, commissioning and service delivery, where appropriate. • The implementation of the HMHA 22 common principles are monitored through Annual HMHA 22 Communique, and District and Local Implementation Plan Reports.

Signatory commitments

The HMHA 22 includes fifteen signatory commitments. The below table sets out how the commitments will be delivered and monitored.

Commitments in the Agreement	How will we know it is achieved?
1. Senior Executive leadership (Ministry of Health and DCJ) has leadership and oversight of the Agreement.	• Regular HMHA 22 updates to the NSW Mental Health Taskforce.
2. The State Steering Committee provides reports to the Secretaries on HMHA 22 progress and escalates issues that cannot be resolved at the state-wide governance level as needed.	• Reports to the Secretaries.
3. Both agencies commit to establish, re-invigorate, and actively participate in HMHA 22 governance at the state, district and local levels to implement the agreement and the intended objectives.	• Governance Framework released. • District and Local Committees meet regularly.
4. Resource the secretariat function across state, district and local governance tiers, to ensure accountability and ongoing operation of HMHA 22.	• Secretariat functions shared and agreed between NSW Health and DCJ at all three levels of HMHA 22 governance.
5. Establish and resource a lived experience panel and engage people with lived experience, their families, carers and representative organisations in the operation and evaluation of HMHA 22.	• Lived Experience Committee established.
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.	• A broad range of HMHA 22 participants are represented at all three levels of HMHA 22 governance.
7. Implement the No Exits from Government Services into Homelessness: A Framework for Multi-agency Action.	• Annual reporting according to the No Exits from Government Services into Homelessness Framework: Agency annual planning and reporting guide (April 2022).

Signatory commitments (cont.)

Commitments in the Agreement	How will we know it is achieved?
8. Lead the development and ongoing operation of the 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.	• Service Delivery Framework released. • Data sources and mechanism for measuring the impact of the HMHA 22 established through the Monitoring and Reporting Framework. • District Implementation Plans developed and submitted to State Steering Committee by date determined by the HMHA 22 State Steering Committee secretariat. • Local Implementation Plans developed and submitted to State Steering Committee by date determined by the HMHA 22 State Steering Committee secretariat.
9. Establish and maintain performance monitoring mechanisms for shared goals to support client level and service delivery outcomes.	• Data sources and mechanism for measuring the impact of the HMHA 22 established through the Monitoring and Reporting Framework. • Annual District and Local Implementation Plan Reports provided to the State Steering Committee.
10. Develop and embed principles for collaboration and service principles in the planning, delivery and evaluation of policies, programs and services.	• Service Delivery Framework released.
11. Incorporate HMHA 22 principles through commissioning mechanisms.	• Annual report – qualitative account of new (and renewed) district mental health and housing services funding agreements, strategies and implementation plans that incorporate the HMHA 22.
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	• Information Sharing Framework released.
13. Consult and collaborate early on policy, programs and initiatives that impact the shared client group.	• Annual report of the number of HMHA 22 partnership projects at state, district and local levels.
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.	• District and local committees established and meeting regularly. • Examples of good practice are shared.
15. Engage authentically and meaningfully with Aboriginal people, communities and their kinship networks for the duration of the development and implementation of the HMHA 22 at the state, district and local level.	• Annual District and Local Implementation Reports include qualitative reports on ongoing engagement with Aboriginal people or community groups.

State commitments

The HMHA 22 signatories will prepare and release an Annual HMHA 22 Communique in partnership with the State Steering Committee. The Communique will:

- report progress on the broad objectives
- report progress on the 15 signatory commitments
- provide best practice examples from District and Local Implementation Plan Reports
- include other content as agreed by the HMHA 22 State Steering Committee.

District commitments

All HMHA 22 District Committees must submit an annual District Implementation Plan Report to the State Steering Committee.

The annual District Implementation Plan Report is a qualitative narrative style report that:

- provides a snapshot of progress towards delivery of the strategic actions in the District Implementation Plan
- provides examples of good practice
- identifies the three main implementation challenges for the district.

Local commitments

All HMHA 22 Local Committees must submit an annual Local Implementation Plan Report, endorsed by the oversighting district committee, to the State Steering Committee.

The annual Local Implementation Plan Report is a qualitative narrative style report that:

- provides an annual snapshot of progress towards delivery of the strategic actions in the Local Implementation Plan
- provides examples of good practice
- identifies the main implementation challenges for the local area.

Reporting – HMHA 22 escalation and communication pathways

A key function of the HMHA 22 State Steering Committee is to consider issues that cannot be resolved at the district governance level.

In such cases, the chair of the HMHA 22 District Committee should contact the HMHA 22 State Steering Committee secretariat.

The HMHA 22 State Steering Committee secretariat will advise if the issue can be considered out-of-session or tabled for discussion at an upcoming HMHA 22 State Steering Committee meeting.

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

1) 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

2) 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.

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.

All reasonable attempts must be made to resolve an issue locally prior to escalating the matter to the HMHA 22 State Steering Committee.

Monitoring the Key Outcomes

"Putting customers at the centre of everything we do requires a connected government where the data and insights we collect and create are used and shared across government, in a manner that is consistent, and compliant with privacy and other legislative requirements and ethical standards...."

– NSW Government Data Strategy

The foundational project - a linked data set

The NSW Government is committed to a collaborative, coordinated, consistent and safe approach to using and sharing data and insights across government. Both DCJ and NSW Health recognise the value of high-quality integrated data to inform well targeted, coordinated, evidence-based interventions.

Housing and mental health are interrelated. Therefore, outcomes for HMHA 22 shared clients should capture multiple data sets used by housing, mental health and specialist homelessness services. Linking the data across these sectors will enable rich and meaningful insights. It also provides an opportunity to develop a de-identified linked data set for wider and ongoing use.

It is important to note the complexities in collecting data on people in the shared client group who are not accessing or engaging with the system. This is a key limitation for data collection that will be considered during the development of a linked data set.

DCJ and NSW Health are committed to exploring opportunities to leverage data from existing systems and working towards a linked data set. Greater linkage of data sets will allow shared accountability and the development of key performance indicators to support the implementation of the HMHA 22 and improved outcomes for the shared client group. The consultation feedback on the HMHA 22 supporting frameworks will guide this foundational project.

The outcome indicators

Outcome indicators will be developed through the foundational project, aligned to the linked data set.

The HMHA 22 vision is that, over the long term:

1. people with a mental health condition have timely access to safe, secure, appropriate housing
2. people with a mental health condition have mental health supports in place when needed, to sustain their housing, live well in the community and lead their recovery.

The HMHA 22 signatories are committed to working with district and local partners to develop linked data sets for the purpose of monitoring and reporting on the delivery of the HMHA 22 vision.

Disaggregation

Any data reported will be disaggregated. For example, data will be broken down by:

- DCJ district/ LHD (and potentially smaller statistical areas as appropriate without impacting privacy)
- gender
- age (or age bracket)
- indigenous status
- cultural and linguistic diversity status
- housing assistance type.

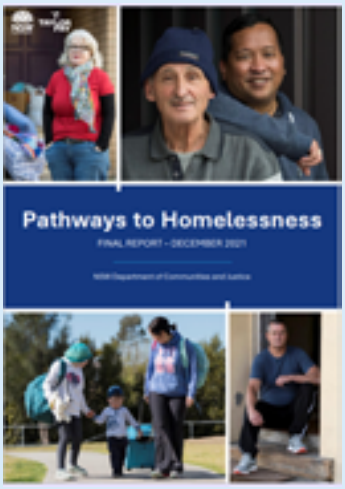
Reporting outcomes

The frequency of outcomes reporting will depend on:

- the collection frequency of the data sources
- the time required for reliable linkage.

Pathways to Homelessness

The **Pathways to Homelessness** project shows the value of a linked dataset for people experiencing or at risk of homelessness, by identifying the key risk factors, service use, and costs across government.



The project's cross-agency linked dataset is one of the most comprehensive datasets related to homelessness in Australia. It captures data of 625,000 people across 19 NSW and Commonwealth services including homelessness, health, housing and Medicare.

The data provides powerful insights for some vulnerable cohorts. For example, the analysis illustrates how support needs such as poor mental health or family and domestic violence correlate with higher likelihood of homelessness, as well as significant future costs across government services.

Glossary

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.
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 health district	The 15 local health 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 local health districts 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.
Outcomes 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.
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	Primary Health Networks (PHNs) are independent organisations that are funded to co-ordinate 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 independent-ly 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.
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.
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 program	DCJ transfer of tenancy management of social housing tenancies to community hous-ing 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.
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.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