NSW Health
Department of Communities and Justice

Housing and Mental Health Agreement 2022

Governance Framework

CONSULTATION EXPOSURE DRAFT

January 2023

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

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 program
CMO	Community Managed Organisation
DCJ	Department of Communities and Justice
DIP	District Implementation Plan
HASI	Housing and Accommodation Support Initiative
HMHA 22	Housing and Mental Health Agreement 2022
LALC	Local Aboriginal Land Council
LHD	Local Health District
LIACC	Local implementation and coordination committee
LIP	Local Implementation Plan
MH	Mental health
MHS	Mental Health Service
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
TA	Temporary Accommodation

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:

- Lived Experience Framework for NSW produced by the NSW Mental Health Commission
- Recovery Oriented Language Guide produced by the Mental Health Coordinating Council (MHCC) and
- Language Matters resource produced by the Network of alcohol and other drugs agencies (NADA).

Some key terms used in this document are explained below.

People who have experienced a mental health issue and have recovered, or who currently have a personal lived experience of mental health issues and are on their recovery journey, are referred to as ‘people with lived experience of mental health issues’.

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 issues.

1 The Housing and Mental Health Agreement 2022

Introduction

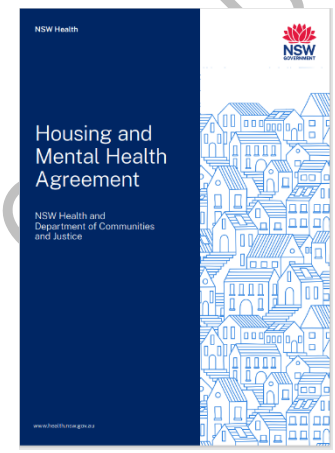
The Housing and Mental Health Agreement 2022 (HMHA 22) is a formal agreement between NSW Health and the Department of Communities and Justice (DCJ).

It is a commitment that all levels of the agencies will work together, and with key stakeholders, to ensure that that people with experience of mental health issues 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 (HMHA 22)

Access to safe, secure, appropriate housing is essential to ensure that people who live with mental health issues can live well in the community. And 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 DCJ entered into the current Housing and Mental Health Agreement in February 2022. It marked a public commitment between the two agencies and established the common objectives, principles, and commitments of the signatories including to:



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

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

We know that safe, secure, appropriate and affordable housing improves wellbeing by allowing people to build independence, social relationships and networks; and is critical for recovery from mental ill-health. And we know that poor and deteriorating mental health directly impact housing stability.

Having this two-way relationship means when we work together, we can amplify our shared clients' wellbeing and minimise their mental ill-health.

But in NSW, like in other states, housing, homelessness and mental health have a history of being separate policy systems with little formal integration. And this can contribute to poor housing and health outcomes for people with lived experience of mental ill-health.

The scope of the Agreement – our shared clients

HMHA 22 relates to the policy, commissioning and delivery of mental health, social housing and homelessness services by all levels of the signatory agencies to a shared client group of:

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 be supported to access broader mental health services.

Two signatory partners working with a broad range of participants

While 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 services and the people supported by these services.

In the Agreement, this group is collectively referred to as the HMHA 22 'participants' and it includes:

- People with a lived experience of mental ill health, housing instability or homelessness, their families, kin, carers, and representative organisations.
- Community Housing Providers (CHPs)
- Community managed organisations (CMOs) providing mental health and psychosocial supports
- Specialist Homelessness Services (SHS)
- Aboriginal owned and community-controlled organisations including Aboriginal Community Housing Providers (ACHPs), Aboriginal Community Controlled Health Organisations (ACCHOs) and Local Aboriginal Land Councils (LALCs)
- 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.

Signatories

NSW Health Local Health Districts
Department of Communities and Justice Districts

Social Housing Management Transfer (SHMT) Program providers

People with lived experience

Specialist mental health supports

Specialist housing supports

Housing supply and management

Specialist homelessness supports

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, 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.

Four supporting frameworks

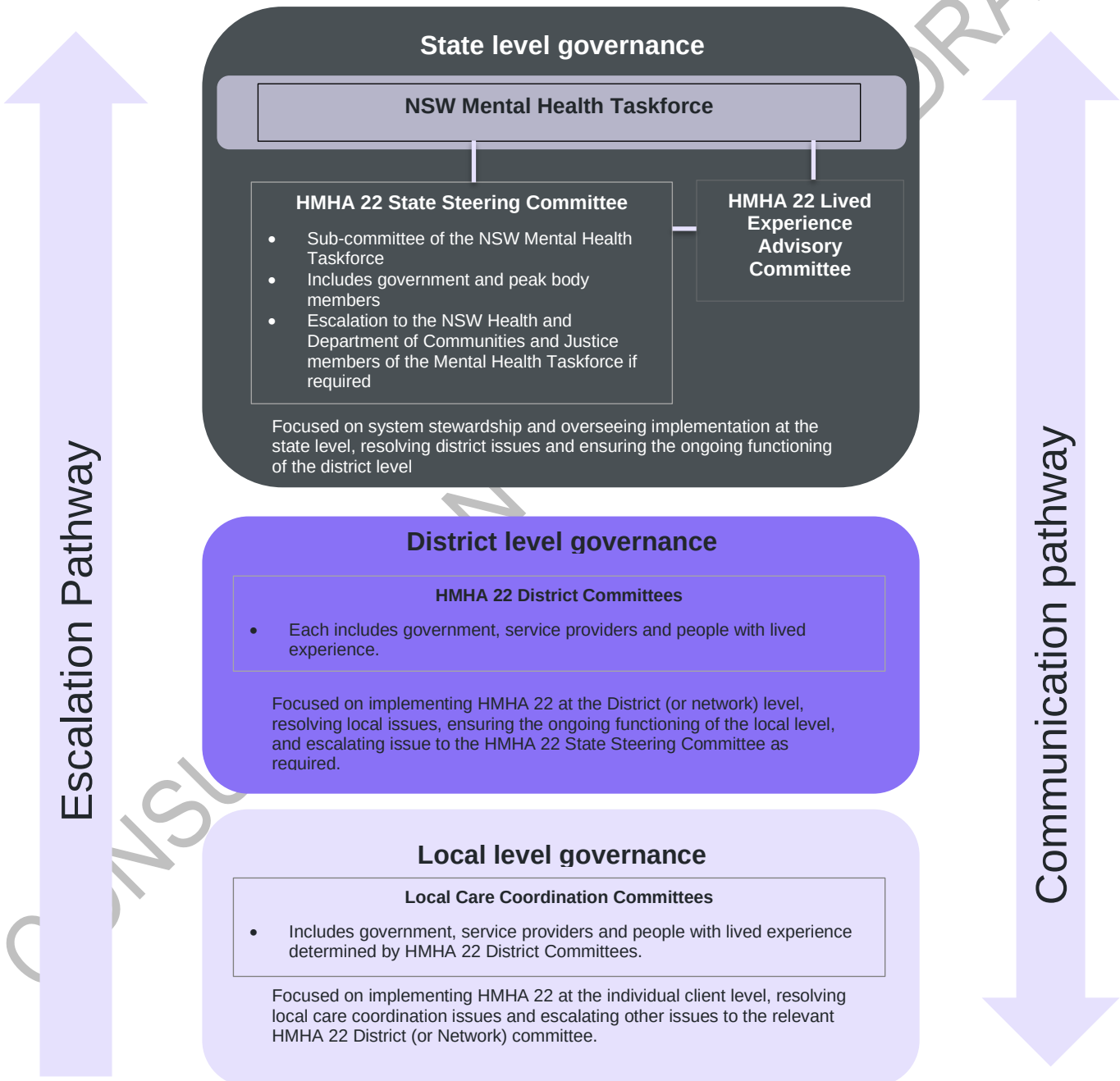
HMHA 22 outlines the overarching aims, objectives and commitments for DCJ and NSW Health as the signatories to support the shared client group. The Agreement is underpinned by this Governance Framework along with three other related supporting frameworks:

	Service Delivery Framework [LINKED ONCE PUBLISHED]
	Monitoring and Reporting Framework [LINKED ONCE PUBLISHED]
	Information sharing framework [LINKED ONCE PUBLISHED]

2 The Governance Framework

The Framework at a Glance

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



The principles

In developing HMHA 22 all stakeholders called for multi-tiered formal governance with clear guidelines. The overarching principles to ensure this Governance Framework is effective are set out below.

The Principles

Support the aim, objectives, and principles of the HMHA.

Engage with people with lived experience and their families and carers in planning, commissioning, and delivery of services.

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 and NGOs and the Aboriginal Community Controlled Sector.

Resource effective coordination at the relevant governance tier (state, district and local).

Promote awareness of HMHA 22 among a broader range of stakeholders.

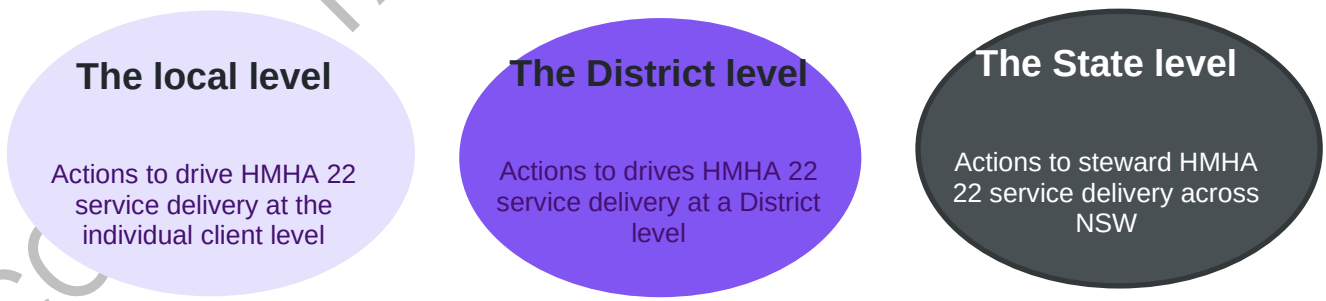
Promote good practice in delivering coordinated services when responding to people in the target group.

Strengthening integrated service planning, delivering coordinated person-centred services.

Work towards the shared agenda as outlined in the Service Delivery Framework

Measuring progress against performance indicators that support HMHA 22 outcomes.

The three tiers



The participants

While 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 services and the people with of these services. This group, referred to in the Agreement as the HMHA 22 'participants', includes the following.

People with lived experience of social housing, homelessness and mental health issues, their families, carers, and/or their representative organisations.

People with lived experience, their families, carers and/or representatives should be empowered in directing individual care needs and goals. They are experts through experience, as such they should be included in the planning, design and delivery of programs, services and policies.

The Agreement signatories - Department of Communities and Justice (DCJ) and NSW Health

The **Department of Communities and Justice (DCJ)** has a dual role in the commissioning and provision of social housing and homelessness outreach services. In its provision of social housing (public housing), DCJ undertake tenancy management/maintenance services through an agreement with the Land and Housing Corporation (LAHC). DCJ also commissions several housing assistance programs and homelessness services including specialist homelessness services, private rental assistance and community housing providers.

NSW Health plans the provision of comprehensive, balanced and coordinated health services to promote, protect, develop, maintain and improve the health and wellbeing of the residents of NSW. Local Health Districts (LHDs) and Specialty Health Networks, funded by NSW Health, provide a range of specialist mental health services and deliver hospital and community-based care to those with high levels of need. NSW Health also commissions community managed organisations to partner with LHDs for service delivery.

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

DCJ and NSW Health have their own statewide, 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 State Steering Committee.

Other related government agencies (non-signatory)

The **Aboriginal Housing Office (AHO)** is a statutory body established under the Aboriginal Housing Act 1998 (NSW) that is responsible for Aboriginal and Torres Strait Islander people having access to affordable quality housing. The AHO provides funding support to registered Aboriginal Community Housing Providers (ACHPs) for the purpose of carrying out operational and management services, including the acquisition and construction of properties. The AHO also supports programs to build culturally appropriate service coordination, support and capacity building for Aboriginal people experiencing vulnerability.

Land and Housing Corporation (LAHC) is responsible for the NSW Government's social housing portfolio, managing more than 125,000 properties. LAHC supports the priorities of the Government's social housing policy *Future Directions for Social Housing in NSW*, including the priorities of more social housing, more support and opportunities to avoid and/or leave social housing and a better social housing experience. LAHC also delivers maintenance services to public housing residents (social housing provided by DCJ) through several local contractors.

Funded Non-Government Organisation (NGO) services

Non-Government Organisation (NGOs) are funded to deliver services across the mental health, housing and homelessness sectors, their roles are diverse and flexible (and in the mental health sector they are often referred to as community managed organisations or CMOs).

The importance of their role has significantly increased in the past decade due to the shift to commissioning in NSW. These organisations can receive funding from both Commonwealth and State governments and through private philanthropy. NGOs are essential contributors to policy and program development at each level of the Governance Framework.

At the State level NGO services are represented by their peak bodies. Peak bodies engage in policy reform, reviews and inquiries and the development of best practice initiatives and resources to build capacity and capability across the service sectors.

Sector	Examples of NGOs/CMOs relevant to HMHA 22
Health	• NSW Mental Health Community Living Program providers funded by NSW Health such as the Housing and Accommodation Support Initiative (HASI) and the Community Living Supports (CLS) program • Psychosocial support providers funded and commissioned by the NSW Primary Health Networks (PHNs) • Some organisations providing psychosocial supports to people funded under the National Disability Insurance Scheme (NDIS)
Social Housing and Homelessness	• Community Housing Providers (CHPs) and Specialist Homelessness Services (SHSs) funded by DCJ • Asset operators
Aboriginal Community Controlled Sector	• Aboriginal Community Controlled Health Organisations (ACCHOs) • Aboriginal Community Housing Providers (ACHPs)

Primary Health Networks (PHNs)

Primary Health Networks (PHNs) are funded by the Commonwealth Government to undertake planning, coordination and commissioning of primary health services, including but not limited to psychosocial support programs, clinical and non-clinical mental health wellbeing services and suicide prevention and aftercare services. There are 10 PHNs in NSW and they each have mental health as well as Aboriginal and Torres Strait Islander health and alcohol and other drugs as priorities. PHNs are also empowered to set local priority areas.

The National Disability Insurance Scheme (NDIS)

The National Disability Insurance Scheme (NDIS) is the national scheme for people with disability, including psychosocial disability, which is jointly funded by the Commonwealth and state and territory governments.

Aboriginal organisations

Improved engagement and partnership with Aboriginal stakeholders is a key objective for the new HMHA 22 at all three levels of governance.

The Local Decision Making initiative of OCHRE, the NSW Government's community focused plan for Aboriginal affairs, establishes important contemporary context for the Aboriginal organisations with a critical stake in HMHA 22 and its objectives. These will typically include Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Housing Providers (ACHPs) as noted above, as well as:

- Aboriginal Regional Alliances (and the representative NSW Coalition of Aboriginal Regional Alliances - NCARA)
- NSW Aboriginal Land Councils (and the representative elects arm New South Wales Aboriginal Land Council's - NSWALC).

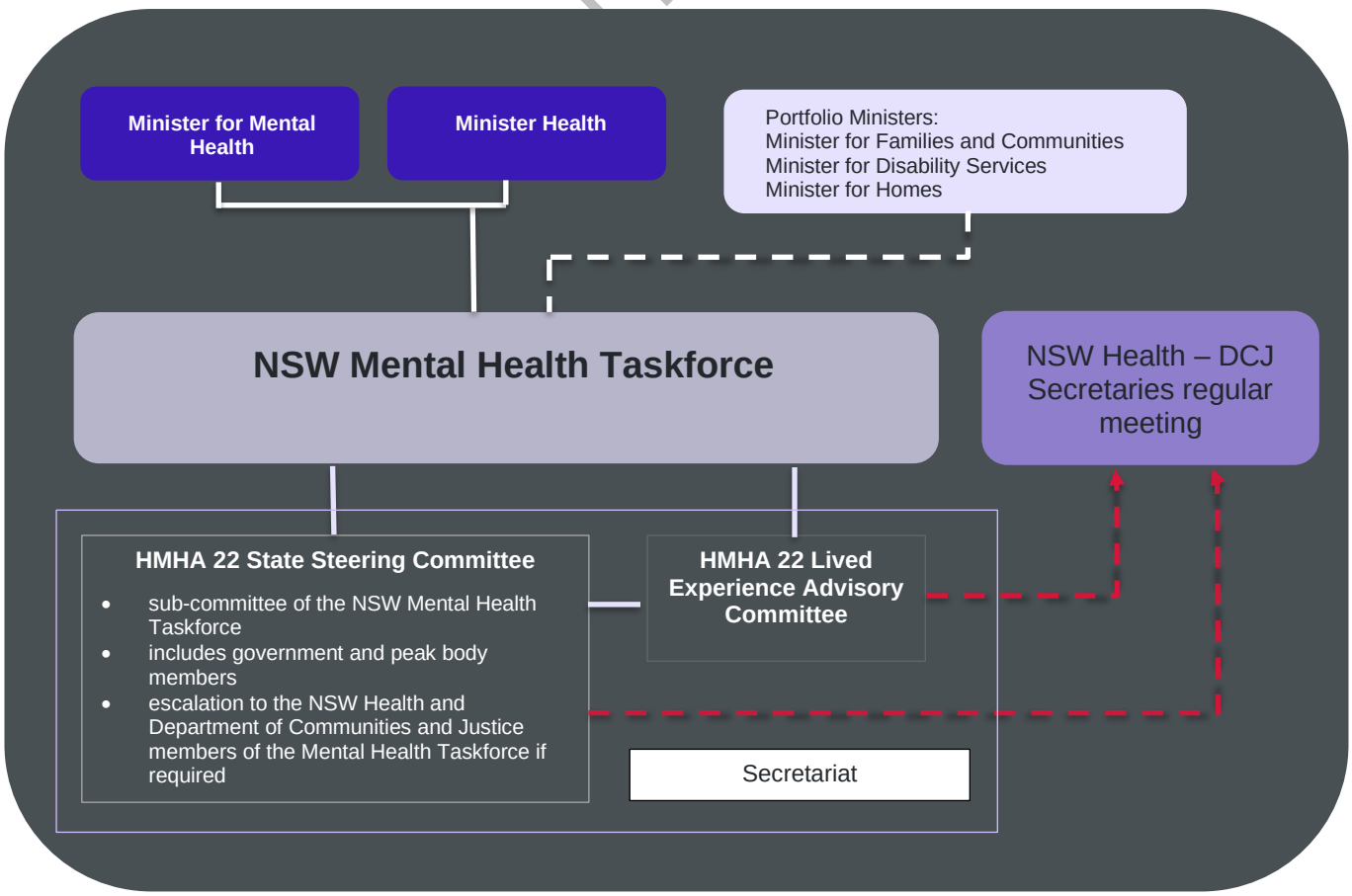
State governance

The governance structures at state level are responsible for:

- Stewardship of the overall implementation of HMHA 22
- Developing strategies to resolve implementation issues
- Facilitating improvements to state-wide service planning, commissioning, access and outcomes.

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

As illustrated below state governance tier components includes the NSW Mental Health Taskforce, meetings of the NSW Health and DCJ Secretaries, the HMHA 22 State Steering Committee, Lived Experience Advisory Committee; and a Secretariat function.



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.[1]

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.

NSW Health and DCJ Secretaries regular meeting

The Secretaries of NSW Health and DCJ are the HMHA 22 signatories. They meet on a regular basis (currently bi-monthly) to discuss key strategic issues that impact on both agencies and cannot be resolved elsewhere. This is not a HMHA specific meeting but is a regular opportunity to raise HMHA issues at the highest levels of DCJ and NSW Health.

HMHA 22 State Steering Committee

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

The Chair of the HMHA 22 State Steering Committee

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

Chair responsibilities include

- Providing leadership to the HMHA State Steering Committee and serves 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; and,
- Writing correspondence and signing off on reports of the HMHA 22 State Steering Committee as required.

Membership

The membership of the HMHA 22 State Steering Committee consists of **Executive Director or equivalent level** representatives. It intended to have a leadership, stewardship and approval/endorsement function, so members are expected to have sufficient authority to resolve issues (within the scope of the committee responsibilities).

Co-Chairs

- NSW Ministry of Health - Mental Health Branch
- NSW Department of Communities and Justice – Housing, Homelessness and Disability

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

[1] See NSW Health (2019) NSW Strategic Framework and Workforce Plan for Mental Health 2018 – 2022: Implementation Plan

- NSW Department of Planning and Environment - NSW Aboriginal Housing Office
- NSW Department of Planning and Environment - NSW Land and Housing Corporation
- 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)
    - 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
- 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)
- National Disability Insurance Agency (NDIA)

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

- Local Government and its peak bodies
- Aged care peak bodies
- Disability Services
- Child protection and out-of-home care agencies
- ACON.

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 at the district and local levels
- Providing a biannual report to the Secretaries DCJ and NSW Health on HMHA 22 progress
- Facilitating and collaborate on state-wide research, relevant policy and program reviews and support 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 biennial HMHA 22 Service Delivery Framework
- 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 biennial 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.

Meeting frequency

The HMHA 22 State Steering Committee meets quarterly.

Where reasonably practicable, the meeting schedule will relate to the NSW Mental Health Taskforce and NSW Health – DCJ Secretaries meeting schedules so that any issues requiring the further escalation can be managed promptly (as below).

Escalation pathways

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

- 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 NSW Health – DCJ Secretaries regular meeting.

Relationship to Existing Interagency Forums

There are several interagency forums that the HMHA 22 State Steering Committee could informally link to as required through regular communication and/or attendance and presentations.

For example,

- The NSW Premier's Advisory Council on Homelessness
- the Homelessness Interagency Project Working Group
- Housing and Accommodation Support Initiative/Community Living Supports Stakeholder Forum.

Secretariat Function

The secretariat function for the HMHA 22 State Steering Committee and the Lived Experience Advisory Committee ensures the stability, efficiency and effectiveness of the HMHA 22 Governance Framework. It is shared between NSW Health and DCJ (and/or jointly commissioned and funded).

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.

HMHA 22 Lived Experience Advisory Committee

The HMHA 22 Lived Experience Advisory Committee ensures that the voices of people with mental health issues and experience of the social housing and/or homelessness systems are heard by decision makers, service providers, to lead and influence systemic change in services and systems.

Membership

The Lived Experience Advisory Committee is comprised of at least 10 members. Membership should be diverse and include:

- Representative with lived/living experience of mental health issues and emotional distress
- A person from the NSW Mental Health Consumer Sub Committee, the group that provides the NSW Ministry of Health 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 issues
- A person representing the family or carers of people with lived experience of mental health issues or homelessness.

Where possible, the members of the Lived Experience Advisory Committee should represent the diversity of the shared client group include people from a regional, rural or remote district, older people, younger people (under 25 years old), Aboriginal people, Culturally and Linguistically Diverse communities, the Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTI) community; and people with a lived experience of disability including a psychosocial disability.

Responsibilities of the Lived Experience Advisory Committee

The specific responsibilities of the Lived Experience Advisory Committee include:

- Providing advice to the HMHA 22 State Steering Committee on policy, planning and strategic issues relating to the HMHA shared client group
- Providing advice to the HMHA 22 State Steering Committee on the HMHA 22 Service Delivery Framework, Governance Framework, Monitoring and Evaluation Framework, and information sharing protocol
- Supporting the HMHA 22 State Steering Committee to ensure people with lived experience of the issues participate in the development, implementation and review of related HMHA 22 activities
- Participating (or supporting people to participate) in time limited working groups, workshops and consultations to develop and review HMHA 22 policies, plans and programs as required
- Proactively commenting on agenda items to go to the HMHA 22 State Steering Committee to ensure that the interests of people with lived experience and in particular, the HMHA target group are adequately and appropriately reflected in decision-making.

In addition to these specific responsibilities, the HMHA 22 Lived Experience Advisory Committee will take the HMHA Principles and Commitments and Accountabilities into consideration in their work.

Meeting frequency

The Lived Experience Advisory Committee meets quarterly.

Where reasonably practicable, the meeting schedule will relate to the meetings of the NSW HMHA 22 State Steering Committee, so that people with lived experience can provide input on agenda items

before they are considered.

Participation payments

People sitting on the committee with lived experience (who are not employed to represent an organisation) will be 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 governance

The HMHA 22 district level governance is responsible for:

- Deciding district wide service delivery priorities
- Facilitating joint service and workforce planning at a district level
- Improving cross agency/participant coordination at a district level to improve service access and outcomes for shared clients
- Resolving escalated local level issues as required.

The district level governance provides support, legitimacy and the authority necessary for the local committee(s) to fulfil its responsibilities.

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 such as 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 governance will reflect the aligned NSW Health and DCJ districts with some variation due to local contexts.

State level governance

District level governance

HMHA 22 District Committees

- each includes government, service providers and people with lived experience
- focused on implementing HMHA 22 at the district (or network) level, resolving local issues, ensuring the ongoing functioning of the local level, and escalating issue to the HMHA 22 State Steering Committee as required.

District governance flexibility

The HMHA 22 Governance Framework reflects stakeholders calling for clear and consistent governance at all levels of the agencies and across NSW. This needs to be balanced, however, with related stakeholder feedback that district level governance needs to provide some flexibility to accommodate district service contexts. This includes district participants considering how any existing governance structures, such as the previous HMHA District Implementation and Coordination Committees (DIACCs) or District Homelessness Implementation Groups (DHIGs), may be adapted to provide appropriate HMHA 22 district level governance.

Assessing whether existing governance is suitable for 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 the governance sufficiently aligned with the HMHA 22 vision and shared client group to provide effective and concerted attention to the implementation of the Agreement in line with the Principles, Commitments and Accountabilities and 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 specific HMHA 22 district governance structure will need to be established.

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

HMHA 22 District Committee

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 if and when required
- Preparing agendas in consultation with the Secretariat
- Chairing regular meetings of the HMHA District structure and ensuring effective and respectful deliberations
- Writing correspondence and signing off on reports of the HMHA District Committee as and when required.

Membership

The membership is to be determined by the District and consist of senior staff with appropriate delegation to make decisions on behalf of their organisation in line with the responsibilities of the district tier.

Membership – mandatory
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 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 – Specialist Homelessness Services(s)
Representative - District Community Housing Providers (with all Community Housing Providers to be invited in the first instance)
Representative – NSW Mental Health Community Living Programs (HASI, CLS) provider(s)
Representative - Aboriginal Housing Office, Aboriginal Community Housing provider(s), Land Councils and Aboriginal Community Controlled Health Services
Representative - Aboriginal Community Controlled Health Services
Representative – Other Aboriginal Organisations such as district Aboriginal Land Councils and the applicable Aboriginal Regional Alliance
Representative – Primary Health Network

Typical regular guests
Representative – Local council(s)
Representative – District NDIS providers
Representative – local PHN funded mental health, alcohol and other drug services, and aboriginal health providers
Representative – Aged care providers
Representative - Organisations supporting refugees or people seeking asylum

Responsibilities of the HMHA 22 District governance groups 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 biennial HMHA 22 District Implementation Plan according to the requirements of the HMHA 22 Service Delivery Plan (including establishing working groups as may be required)
- Reporting on progress as per the HMHA 22 Monitoring and Evaluation Framework including agreed Key Performance Indicators or shared goals
- Raising and addressing issues and opportunities to improve the implementation of the HMHA including issues escalated from the local tier
- 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
- 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 LGBTI 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 discussed 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 ensure 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 Principles and Commitments and Accountabilities.

Representatives from the local tiers

The HMHA 22 District Committees should include (or regularly engage with) representatives from the

local governance tier(s).

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 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 District Committees meet quarterly.

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

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 HMHA 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 districts must develop plans setting out how the Agreement will be implemented in the local context, called District Implementation Plans (DIPs). These should be:

- co-designed with the key HMHA 22 district participants including consumers, carers, those with lived experience and families
- reflect the domains, shared priorities and mandatory actions of the HMHA 22 Service Delivery Framework.

The HMHA 22 DIPs are biennial plans, updated every two years. The District Committee's monitor progress at the regular quarterly meetings as a standing agenda item.

The district plans can 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 Fifth National Mental Health and Suicide Prevention Plan
- Local implementation plans developed as a requirement of the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025

District Implementation Plans are submitted to the HMHA 22 State Steering Committee for endorsement and monitoring.

The first of these plans must be developed and submitted to the State Steering Committee by July 2023.

A 'minimum requirement' templates for the plan is provided as part of the Framework Appendices.

Local governance

The HMHA 22 local governance tier is responsible for:

- providing a forum for developing the local provider relationships among HMHA 22 participants
- developing processes and protocols necessary to ensure coordinated service provision for individual shared clients in that area
- ensuring cross agency/participant awareness of local services and access pathways
- escalating systemic issues as required.

Flexibility for local governance

The HMHA 22 Governance Framework reflects stakeholders calling for clear and consistent governance at all levels of the agencies and across NSW. However, as with the district level, this needs to be balanced with allowing enough flexibility for local governance to respond to the service contexts of the area.

The local signatory representatives should consider how any existing governance structures, such as the previous HMHA Local Implementation Agency Coordination Committees (LIACCs) or other client care coordination structures may be adapted to provide appropriate HMHA 22 local level governance.

Assessing whether existing care coordination structures are suitable for 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 group include the members required for the HMHA 22 local care coordination?
- Is the overall intent of the group sufficiently aligned with the HMHA 22 vision and shared client group to provide effective and concerted attention to the implementation of the Agreement in line with the Principles, Commitments and Accountabilities and 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 Implementation and Coordination Committee, as outlined below?

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

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

HMHA 22 Local Implementation and Coordination Committee

The Chair

The Chair of the HMHA 22 Local Implementation and Coordination Committee will be appointed by the committee for a 1-year rotation. The Chair position can be shared by two co-Chairs who alternate chairing meetings.

Chair/Co-Chair responsibilities include:

- Leading the HMHA 22 local committee and serving as its spokesperson or representative if required
- Preparing agendas in consultation with the Secretariat
- Chairing the HMHA 22 local committee meetings and ensuring effective and respectful deliberations
- Writing correspondence and signing off on reports of the HMHA District Committee as and when required.

Membership

The membership of a Local Implementation and Coordination Committee is determined locally.

Members should be senior staff with appropriate experience and delegation to make decisions on behalf of their organisation/service in line with the responsibilities of the local tier.

	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 (HASI, CLS)

Typical other members
Representative(s) – NSW Health – Local alcohol and other drug services e.g. Assertive Community Management team representative.
Representative(s) – Local NDIS providers
Representative(s) – local Aboriginal Community Controlled Health Organisation
Representative(s) – local PHN funded mental health, alcohol and other drug services, and aboriginal health providers

Depending on their service context local tiers may also include representation from other organisations or people with lived experience, their families or carers for agenda items that do not require discussion of individual clients.

Responsibilities of the HMHA 22 local committees

A HMHA 22 Local Implementation and Coordination Committee does three things:

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

Building relationships for a HMHA 22 local alliance

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

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

2. 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
3. Ensuring coordinated transitional planning for people exiting mental health inpatient facilities, or shared clients existing social housing, general health or other government services

Implementing the HMHA 22 Service Delivery Framework at a local level

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 LGBTI 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

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

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 Local Implementation and Coordination Committee must develop plans setting out how the Agreement will be implemented in the local context, called Local Implementation Plans. These should be:

- co-designed with the key HMHA 22 district participants including consumers, carers, those with lived experience and families
- reflect the domains, shared priorities and mandatory actions of the HMHA 22 Service Delivery Framework.

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

As with the district plans, Local Implementation Plans 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 Fifth National Mental Health and Suicide Prevention Plan
- Local implementation plans developed as a requirement of the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025

Local Implementation Plans are submitted to the HMHA 22 State Steering Committee for noting, via the District Committees, which are responsible for endorsement and monitoring.

The first of these plans must be developed and submitted to the State Steering Committee by September 2023.

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 TA 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. May be: • Primary: no conventional accommodation or shelter; • Secondary: living in shelters, emergency accommodation, refuges and couch surfing; • Tertiary: living in accommodation that falls below minimum community standards.
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 ill health, housing instability or homelessness, their families, kin, carers, and representative organisations. • Non-government organisations (NGOs) providing DCJ and NSW Health funded housing, homelessness and mental health services to the shared client group and their peak organisations. • Non-SHMT Community Housing Providers. • Community managed organisations (CMOs) providing mental health and psychosocial supports and Specialist Homelessness Services (SHS). • NSW Government agencies outside DCJ and NSW Health with policy or operational responsibility for housing, homelessness, mental health or psychosocial support services. This includes: • Land and Housing Corporation (LAHC) and the Aboriginal Housing Office (AHO) which own social housing properties managed by DCJ and CHPs and Aboriginal Community Housing Providers (ACHPs) • the National Disability Insurance Agency (NDIA) • NDIS funded providers as it relates to case level responses • PHNs funding health and psychosocial supports • Local Government.
HMHA 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 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	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.
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	Primary Health Networks (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	A range of supports which may include mental health treatment and counselling, education, social support and group support. It aims to address ongoing psychological and social problems experienced by individuals which may increase the risk of homelessness. In NSW people with a mental illness 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	Two specialist statewide 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.
Supported Independent Living	A National Disability Insurance Scheme (NDIS) term describing when a person receives funding to help with and/or supervision of daily tasks to develop their skills of to live as independently as possible. Assistance is provided to the person as part of their NDIS plan depending on the level of support they need to live independently in the housing option of their choice.
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 mandatory actions)	
DOMAIN 1 **How we work with our shared clients**	• [Action] • [Action] • …
DOMAIN 2 **How we work with each other**	• [Action] • [Action] • …
DOMAIN 3 **How we promote the Agreement and work together to innovate**	• [Action] • [Action] • …
Actions to progress one or more of the shared agenda priorities	• [Action] • [Action] • …

People with lived experience of mental health, social housing and homelessness services are involved in developing, implementing, and monitoring this plan through:

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

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

Chief Executive Local Health District **Executive Director – DCJ District**

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

[Local area]

Signatories and participants
In [local area] a Local implementation and Care Coordination Committee (LIACC) 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 mandatory actions)	
 **DOMAIN 1** **How we work with our shared clients**	• [Action] • [Action] • …
 **DOMAIN 2** **How we work with each other**	• [Action] • [Action] • …
 **DOMAIN 3** **How we promote the Agreement and work together to innovate**	• [Action] • [Action] • …
 **Actions to progress one or more of the shared agenda priorities**	• [Action] • [Action] • …

People with lived experience of mental health, social housing and homelessness services are involved in developing, implementing, and monitoring this plan through:

- [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 State Steering Committee

Vision
People with mental health issues 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 State Steering Committee is responsible for stewarding the implementation of the Agreement; developing strategies to resolve implementation issues and facilitate improvements to state-wide service planning, commissioning, access and outcomes. Key responsibilities include: 1. Sponsoring a supportive authorising environment for the implementation of the HMHA at the district and local levels 2. Facilitating and collaborate on state-wide research, relevant policy and program reviews and support the sharing of information between agencies and stakeholders 3. Sharing service gap assessments and planning for coordinated service delivery 4. Identifying needs and facilitating joint workforce capability enhancements 5. Developing, monitoring and implementing the HMHA 22 Monitoring and Evaluation Framework with key performance indicators as agreed by sector stakeholders 6. Developing, implementing and reporting the biennial HMHA 22 Service Delivery Framework 7. Raising and addressing issues and opportunities to improve the implementation of HMHA 22 including issues escalated from the district tier 8. Reviewing, monitoring and endorsing the work of the district tiers to implement the Agreement (including endorsing the biennial District Plans developed by the district tiers) 9. 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.

Membership

The membership of the HMHA 22 State Steering Committee consists of **Executive Director or equivalent level representation**. The committee has a leadership, stewardship and approval/endorsement function, so members are expected to have sufficient authority to resolve issues (within the scope of the committee responsibilities).

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

Co-Chairs

- NSW Ministry of Health - Mental Health Branch
- NSW Department of Communities and Justice – Housing, Homelessness and Disability

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
- 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)
    - 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
- 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)
- National Disability Insurance Agency (NDIA)

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

- Local Government and its peak bodies
- Aged care peak bodies
- Disability Services
- Child protection and out-of-home care agencies
- ACON.

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	NSW wide
Agenda referral criteria	• Issues raised by the Lived Experience Advisory Committee • Issues raised from the HMHA 22 District Committees for discussion and resolution • Issues that impact more than one District • Issues relating to the interface between the NSW and Commonwealth government • Any other issues raised by members of the Steering Committee consistent with HMHA 22 and its Objectives and Commitments
Confidentiality	Member's agreement to privacy undertaking as part of these meetings is confirmed by their signature to this Terms of Reference. Members agree not to disclose or use any material deemed to be confidential or to communicate discussions held in confidence to parties outside the membership.
Escalation pathway	If required, the HMHA 22 State Steering Committee can escalate issues via two paths as may be appropriate: • 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) • where an issue is within the remit of NSW Health and DCJ the HMHA 22 Steering Committee can escalate the matter to the NSW Health – DCJ Secretaries regular meeting.
Monitoring and reporting	[TBC - Subject to Monitoring and Reporting Framework – Under Development]
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 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]*

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 District Committee

Vision
People with mental health issues 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 biennial HMHA 22 District Implementation Plan according to the requirements of the HMHA 22 Service Delivery Plan (including establishing working groups as may be required) 3. Reporting on progress as per the HMHA 22 Monitoring and Evaluation Framework including agreed Key Performance Indicators or shared goals 4. Raising and addressing issues and opportunities to improve the implementation of the HMHA 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 stakeholders and people from culturally and linguistically diverse communities and LGBTI 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.

13. Endorsing the Terms of Reference of the local tiers
14. Monitoring the work of and ensure the functioning of any local tiers
15. Managing any other issues delegated by the HMHA 22 State Steering Committee
16. 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.
17. In addition to these specific responsibilities the district level is also required to meet the HMHA Principles and Commitments and Accountabilities.

Membership

The membership of up to 12 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 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 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]*

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 Implementation and Coordination Committee

Vision
People with mental health issues 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 Implementation and Care Coordination Committee (LIACC) coordinates service provision for individual shared clients and identify systemic issues that should be escalated to the district committee. 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 LGBTI 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. Engaging and inform partner organisations outside the funded remit of DCJ and NSW Heath, 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 Principles, and Commitments and Accountabilities.

Membership
The membership of up to 12 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 district 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 treatment 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 or 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 local geographical area]*
Agenda referral criteria	Any Local Implementation and Care Coordination Committee (LIACC) 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 District Committee.

Monitoring and reporting	[Subject to 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 State Steering Committee. *[Insert here the review date and/or the date endorsed]*
Chair	This role will be appointed by the committee for a 1-year rotation and/or be shared by two co-Chairs who alternate chairing meetings. *[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	HMHA 22 Local Care Coordination Committees meet at least monthly.
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 Health

Department of Communities and Justice

Department of Communities and Justice

Locked Bag 5000
Parramatta NSW 2124

T: (02) 9377 6000
W: www.health.nsw.gov.au

NSW Health

Locked Bag 2030
St Leonards NSW 1590

T: (02) 9391 9000
W: www.health.nsw.gov.au

NSW GOVERNMENT