LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS
Brendan Smyth MLA (Chair), Mary Porter AM MLA (Deputy Chair), Nicole Lawder MLA, Yvette Berry MLA

Standing Committee on Public Accounts

Review of Auditor-General's Report No. 4 of 2013: *National Partnership Agreement on Homelessness*

Responses to QToN at public hearing of 17 October 2014

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LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

Public Accounts Committee - Review of Auditor-General's Report No. 4 of 2013: National Partnership Agreement on Homelessness

Mr Brendan Smyth (Chair), Ms Mary Porter (Deputy Chair), Ms Nicole Lawder, Ms Yvette Berry

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS
QTON 1

Asked by Ms Nicole Lawder on 17 October 2014: Mr David Matthews took on notice the following question(s):

[Ref: Hansard Transcript 17 October 2014 [PAGE #25-27]]

In relation to: Proposed expenditure for HASI was revised downwards to approximately 66 per cent of the initial expected expenditure. There was some inconsistency between the budget actual and reported expenditure.

What happened to that difference in money? If you only spent 66 per cent, what happened to the remaining 34 per cent of the funding?

MINISTER BARR: The answer to the Member's question is as follows:–

Of the remaining 34 per cent HASI funding:

- $100,000 was allocated for a dedicated HASI Housing Manager (salary expenses)
- $100,000 was transferred to A Place to Call Home Program (support at $10,000 per property for ten properties)
- $204,235 was allocated to the expansion of the Transitional Housing Program

Approved for circulation to the Public Accounts Committee

Signature: Andrew Barr Date: 31.10.2014

By the Minister for Housing, Mr Andrew Barr MLA

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MS LAWDER: Thanks. Minister, I want to ask a few questions about the housing and support initiative, as in the Auditor-General's report from page 53. According to the Auditor-General, the proposed expenditure for HASI was revised downwards to approximately 66 per cent of the initial expected expenditure. There was some inconsistency between the budget actual and reported expenditure; the performance indicators identified and reported on are different from the performance indicators initially envisaged; there was a lack of consistency, completeness and accuracy in the information provided in relation to performance indicators; and the limited capacity to house homeless persons under HASI caused an average delay of six months. I have got a couple of questions, including this: what happened to that difference in money? If you only spent 66 per cent, what happened to the rest of it?

Mr Barr: It was all before my time; I will ask David to answer.

Mr Matthews: Ms Lawder, in term of our overall obligations under the agreement, if we underspend in one area, we have to seek approval from the commonwealth to overspend in another area. Essentially, the total investment is covered by the agreement; the ACT has to report and be accountable to that both by putting in implementation plans and also by doing retrospective reporting which explains what we have actually spent the money on.
In terms of the housing and support initiative, it was one of those really interesting and exciting initiatives for the ACT that we believe has been really successful. It has been very much a learning process as we have gone through that to get that absolutely strong interface between mental health service delivery and the provision of appropriate housing. That is really very much the cornerstone of the initiative. Because of your background, you may well have a background in the New South Wales program, but the difference between HASI and normal housing allocations for people with a mental illness is, firstly, that they get a guaranteed support package with it. So they are not left; they are not housed and then left by support providers to fend for themselves.
The other element of the model is that we look for a very appropriate form of accommodation that suits the need of people with quite acute mental illness. In a lot of cases, of course, that means that housing people in high housing density environments is not appropriate. In terms of the reasons for the delay in actually getting people housed and formally into the program, one was that issue of how we provide the most appropriate form of housing for people. We could have allocated them less suitable properties earlier, but in the spirit of the program, and with recognition of the complex needs of the client group, we took that additional time to find properties in lower density environments, often without close proximity to neighbours or adjoining nature reserves or open spaces, all of which can help support somebody to live their lives with privacy and dignity but also minimise any potential conflict or impact on neighbours, for example.

The housing and support initiative, when it was established, was built very much on the basis of a strong, independent evaluation that was undertaken by New South Wales Health and New South Wales Housing. There was a strong evidence base to support that initiative as it was established. As it got translated into an ACT context, clearly the most important element was us working effectively with ACT Health and also the funded community organisations who were the support providers.

One of the unique elements of HASI at that time, if I can say it again, was that the clients were able to choose the support organisation that would be their support provider. Whilst that might not sound like a big thing to be speaking about today, normally what we would have done with services in the past was allocate people to their support providers and give people with a mental illness less choice in who would be that personal support provider. So HASI also had a part of the model which allowed people to do that.

The other thing that happened very quickly after HASI was established in the ACT was a strong

acknowledgement from ACT Health that it was a very important program, and the bringing in of funding under the national partnership agreement on improving public hospital services. So Health actually became a funder of and financial contributor to the program. That program was called HARI; it is called HASI/HARI now. It gave us the capacity to increase the number of people in the program from, I believe, the 14 that were reported in the Auditor-General's report to a current 50 clients today that are receiving that mixture of accommodation and support.

On the whole, it has been a very successful program. It has been particularly important in continuing to strengthen relationships between mental health services and Housing ACT, in particular, and the support providers that are supporting the HASI/HARI clients.

MS LAWDER: Thank you. I agree that it is another good housing-first sort of approach. I am not sure whether you answered my question about what happened to the remaining 34 per cent of the funding.

Mr Matthews: I would have to take that on notice, Ms Lawder, if you want the specifics. In general, as I said, if we were underspending in a particular area in a particular financial year—

MS LAWDER: I understood that the first time you said it, yes.

Mr Matthews: That is the general answer. If you would like a specific answer about how we reallocated that funding, I can do that.

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

Public Accounts Committee - Review of Auditor-General's Report No. 4 of 2013: National Partnership Agreement on Homelessness

Mr Brendan Smyth (Chair), Ms Mary Porter (Deputy Chair), Ms Nicole Lawder, Ms Yvette Berry

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS
QTON 2

Asked by Ms Nicole Lawder on 17 October 2014: Mr Andrew Barr took on notice the following question(s):

[Ref: Hansard Transcript 17 October 2014 [PAGE #27]]

In relation to: CSD working collaboratively with the Health Directorate to finalise a review of HASI.

Are you able to provide the committee with a copy of that evaluation report?

MINISTER BARR: The answer to the Member's question is as follows:–

A copy of the evaluation report is attached.

Approved for circulation to the Public Accounts Committee

Signature: Andrew Barr Date: 31.10.2014

By the Minister for Housing, Mr Andrew Barr MLA

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MS LAWDER: Thank you. Also, when the government responded to the Auditor-General's report, you said that CSD would work collaboratively with the Health Directorate to finalise a review of HASI. Has that taken place, and is that publicly available?

Mr Matthews: It has not been published, so it is not in the public domain, Ms Lawder, but the review has been completed now. To provide some context, the review was instigated in 2011 originally; it looked at the initial intake of, I believe, eight clients that had come into the program as part of a post-implementation review—having built off the evidence base provided by the New South Wales government, translating that to the ACT. The purpose of that evaluation at that time was to see how it was being "operationalised" in the ACT and to identify any issues.

At that time, seven issues were identified around governance and service delivery criteria. All of those issues were actioned and incorporated as part of the ongoing development of the HASI/HARI document. What was not done was the formalisation or the closing off of the actual evaluation. As I reported previously, that has now been completed, and we have reached agreement with ACT Health around that. We are able to report that we did incorporate the findings of that post-implementation review into the way the program evolved and was implemented.

MS LAWDER: I presume, given that you said that ACT Health found it beneficial and provided some funding for it, it would have been based on some evaluation results. Are you able to provide the committee with a copy of that evaluation report?

Mr Barr: I will check with the Minister for Health to make sure there are no issues, but I cannot imagine that is a problem.

Housing and Support Inititative.

An evaluation.

Charting new territory.

16 Nov 2011

16 Nov 2011

Executive Summary

This review set out to examine three key questions:

1. How effectively has the HASI NSW model been transferred into the ACT context?
2. Are the current governance and partnership arrangements working adequately?
3. Can the current model meet future aspirations?

It is clear from the review that the HASI NSW model has been successfully transferred to the ACT context, insofar as that the program logic and methodology have been closely modelled on the NSW program materials. However it is important to note that the HASI NSW has evolved rapidly to take on a form which is far different to its original iteration. HASI ACT has some way to go if it is to maximise the potential within the model.

Despite the small sample size, 8 clients in HASI, and the short time frame, 1 year of operation, there is sufficient reason to be optimistic about the future of HASI, under the guise of HARI (Housing and Recovery Initiative). The opportunity exists to make a real difference for homeless people with severe mental health issues.

The review has identified a number of issues in the current program and has identified some areas that need to be addressed before HARI is operationalised.

These issues are:

1	Given the significance of the partnership between Mental Health, Justice Health, Alcohol and Drugs (MHJHAD) and HousingACT, it is suggested that the executive committee be regularised to oversee the implementation of HARI, provide strategic direction and receive regular outcome reports.
2	It would be helpful to consider streamlining the eligibility and suitability criteria. This would also assist in clarifying the roles and responsibilities of the partners.
3	Eligibility does not automatically mean suitability, and suitability does not guarantee entry into the program, the decision making for entry into HASI needs to rest more clearly with the Consumer Selection Panel.
4	Consistent with the recovery model it would be useful for support plans to address social inclusion goals.
5	The establishment of a specialist team of at least two housing managers who could work with up to 40 HASI clients. These housing managers could feasibly be managed by a SOG C who would also then be responsible for the co- ordination role as well as developing a quality assurance, monitoring and reporting role.
6	Adequate and robust mechanisms need to be developed to be able to respond flexibly to client needs.
7	Systems should be put in place to measure the impact on the use of mental health services over time.

Introduction.

The National Partnership Agreement on Homelessness (NPAH), established in July 2009, commits the ACT government to continue its 2004 strategic direction of *'Breaking the Cycle - The ACT Homelessness strategy'*. Importantly the ACT Government recognised that beating homelessness is a shared responsibility between government and community, and goes far beyond the provision of a roof. It is seen as a key component of social inclusion, aiming to maximise participation in the economic and social life of the city.

The HASI (housing and support initiative), based closely on the HASI NSW, is one of eight initiatives in the ACT designed to combat homelessness and contribute to the NPAH targets and objectives:

- reduce homelessness;
- reduce rough sleepers;
- reduce repeat instances of homelessness; and
- no exits from mainstream services into homelessness.

Within the ACT, HASI was established as a tri-parte program to assist and support adults with mental ental illness in need of accommodation support:

- to participate in the community;
- maintain successful tenancies;
- improve quality of life; and,
- Recover from mental illness.

This review will focus on the **implementation** and **operation** of HASI ACT.

The review will examine the degree to which the model has been implemented in the ACT. This review will be through an analysis of the current processes, policies and procedures and measure these against the aims and objectives of the HASI program.

Although this review will not replicate the findings of the SPRC review of the NSW HASI it will, as far as is possible, be aligned with that review. This will allow, where appropriate, some comparison of findings across the two programs.

The three key questions to be considered are:

4. How effectively has the HASI NSW model been transferred into the ACT context?
5. Are the current governance and partnership arrangements working adequately?
6. Can the current model meet future aspirations?

Methodology

This evaluation will combine both qualitative and quantitative methodology to address the three key questions, and to understand the contribution of the program to the NPAH targets and outcomes.

The Review will consider the following activities:

- Decision Making;
- Accountability;
- Roles and Responsibilities;
- Documentation;
- Record keeping;
- Administration;
- Governance; and,
- Funding.

These activities will be examined across the following domains.

1. **Referral pathways** – e.g. Are these appropriate and effective? Easy to navigate and reaching the right people?
2. **Eligibility criteria** – e.g . Are these fair and transparent and not exclude people unintentionally.
3. **Assessment methodologies** – e.g. is a strengths based holistic methodology being employed, including user participation? Do the assessments gather the right information, meaningful and avoids duplication of information.
4. **Role, composition and function of the CSP**. e.g. Is the CSP working effectively? What does it do and why?
5. **Partnership working** – e.g. Are the partners working effectively? What is the nature of the partnerships, information sharing, communication and coordination?
6. **Stakeholder involvement** – e.g. To what extent are stakeholders involved in the process that affect their lives?
7. **Practice Ideology.** e.g. What are the theoretical perspectives of the support and intervention and how closely do these align with 'recovery models' as opposed to 'supervision models' .

Underpinning the Clinical approach to the HASI model of intervention are the following principals:

- Consumer participation
- Recovery model of support
- Client rights
- Normalisation

The review will examine the extent to which these principals are manifest across all aspects of the program.

Background

The HASI ACT was implemented in the ACT in 2010 following the considerable success of a similar program in NSW. The NSW HASI was established in 2004 and has been enhanced and developed over time, now providing services to approximately 1000 consumers. The NSW HASI has matured over time and provides a sophisticated differentiated service which can cater for people with very low to very high mental health needs and behaviours, resulting in low level outreach support to some consumers to very high level and intensive support to others.

HASI NSW

2002/3 commenced with 100 high support packages – (5hours support per day, 7 days a week)

2005 – an additional 460 packages of care, 5 hours support per week - people requiring lower level outreach accommodation support

2005/6 – a further 126 high support packages made available

2006/7 – further 50 very high support packages – up to 8 hours support per day, 7 days a week. – Mental health with high levels of disability

2007 – an additional 240 low support packages, and 80 medium support packages (2-3 hours a day, 7 days a week - available anywhere and not linked to tenure..

Package name	No of packages	No of hours
Low	700	5 hours a week
Medium	80	2-3 hours a day
High	136	5 hours a day
Very High	50	8 hours a day

HASI NSW findings

Having gone through numerous iterations, HASI NSW appears to be a robust, evidenced based program which provides services to around 1000 people with mental health issues of varying degrees housing assistance and psychosocial support.

The second review of the NSW HASI, undertaken by the SPRC (social policy research council) in 2011 concluded:

> **'that the majority of HASI consumers are successfully maintaining their tenancies, are regularly using appropriate services in the community, and have a high degree of independence in activities of daily living.'** (Evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI) Second Report . Shannon McDermott, Jasmine Bruce, Ioana Oprea, Karen R. Fisher and Kristy Muir Report for NSW Health and Housing NSW)

Housing stability

Most HASI consumers were living in a range of stable accommodation options including public housing, community housing and private housing. Consumers seldom moved house and, when they did, it was usually for positive reasons (e.g. they moved to accommodation more appropriate to their needs). Only a small proportion of consumers living in public housing were in rental arrears or had caused damage to their properties, which compares favourably to the broader population of people in public housing.

Mental and Physical Health

The majority of HASI consumers (96 percent) used health and mental health services more than once each year. People receiving high and very high support were more likely to use community mental health and psychiatric services more than once a month than people in low and medium support, but were less likely to go to a general practitioner (GP) or use allied health services. Participation in HASI appears to have had a positive impact on consumers' levels of hospitalisation. Data from NSW Health show a statistically significant decrease in the average number of hospital admissions each year (24 per cent decrease), the mean number of days spent in hospital per person per year (60 per cent decrease), and the average number of days hospitalised per admission (68 per cent decrease). Longitudinal analysis conducted over a four year period shows that people joined the program at a time when their rates of hospitalisation were high, and that the amount of time spent in hospital decreases the longer consumers are in the program. Men and women had different patterns of hospital service use. The data show that women are admitted to hospital more regularly and spend more time in hospital per admission than men, but that men spend more days in hospital per person per year.

Social and community participation

The majority of HASI consumers have a high degree of independence in their daily living skills, particularly in relation to personal hygiene, cooking, taking medication and transport. The area in which consumers required the most assistance was financial management (budgeting and paying bills).

Consumers were participating in community activities, such as social and recreational activities. More than half of consumers (54 per cent) were independently participating in social and recreational activities, but many consumers receiving high support continued to require the support and assistance of their support workers to be able to participate in the community in a meaningful way.

While most consumers enjoyed regular social contact (daily or weekly) with at least one of the following people – a family member, friend, spouse or partner (86 per cent) – around one in seven (14 per cent) continued to be socially isolated and have no form of regular contact. The findings show that some HASI consumers (19 per cent) were actively involved in education and training, and participation in paid or unpaid work was another way that consumers were spending their time (31 per cent).

Who needs HASI?

AHURI research paper issue 13, published in March 2004, based on interviews and surveys of homeless people with mental illness suggested that at any one time, around 75% of homeless people may have a mental health disorder.

This is a particularly vulnerable group who become trapped in an 'iterative' cycle of homelessness punctuated with periods of well being and hospitalisation.

In addition to mental illness with the most common diagnosis being Schizophrenia, most of the participants in their research had some or all of the following:

- low education levels;
- general health problems;
- low or no income;
- poor employment opportunities;
- high rate of Hep C infections.

Furthermore, just under 50% of the sample had been in prison or juvenile detention, over half of whom had been re-offenders. Drugs, alcohol and self harm compounded many of the presenting issues for the sample.

This AHURI research clearly describes the target group for a program such as HASI.

Mental Health and Homelessness in the ACT.

During the reporting period 2009-2010, approximately 3,600 people in the ACT were supported by homelessness services. Of these, 56% (2000) were clients and 44% (1600) were accompanying children. The majority of clients receiving support were female and the average age of clients was 29y. There was an over representation of Aboriginal and Torres Strait Islander people, 15% of the total, compared with 1% of the population.

The primary reason given for seeking support from specialist homelessness services was to do with relationship or family breakdown. However there is no way of knowing, from the data, what were the precipitating factors that contributed to the family or relationship breakdown.

The national and international evidence identifies mental health issues as a key risk factor for homelessness (Park et al. 2012; Busch-Geertsema et al. 2010; Chamberlain et al. 2007; Johnson and Chamberlain 2011; Bleasdale 2007). In Australia it is has been estimated that that 50–75 per cent of homeless youth have some experience of mental illness (Chamberlain et al. 2007; MHCA 2009; Pryor 2011).

Other evidence has shown that approximately 75% of people utilising homelessness services will have a serious mental health issue, either as a casual factor or as a consequential factor. The high correlation between homelessness and mental health is clear from the research.

Given the above, it would be safe to assume that in the ACT there are at any time around 1500 clients within specialist homelessness services with a mental health issue, and furthermore a significant proportion of this group will have a serious mental health disability impacting considerably on their ability to obtain and sustain a tenancy.

Furthermore, there will be a number of people not in homelessness services, but in institutional settings such as prison, youth detention or psychiatric units or psychiatric services who, without adequate planning, are at risk of entering the homelessness system once released or discharged.

Interestingly, of the 1913 applications received by Gateway services for public housing during the period 2010-2011 only 13 (less than 1%) disclosed a mental health issue on their application.

Who is in HASI ACT?

Currently, there are 8 clients in the HASI program, (five others have recently been accepted), all of whom are single, and the majority of whom are aged in their mid to late 30's

- Average age = 39.5.
- Oldest age = 60.
- Youngest age = 34.

Six of the clients are female and two are men. None are indigenous, and two identify as being from a culturally and linguistically diverse background, although no additional linguistic or cultural supports were requested by the client.

All eight consumers have a diagnosis of Schizophrenia, and all had additional mental health issues as well, such as paranoid ideation, anxiety or depression.

Of these consumers, three were new to public housing (i.e never having had a public housing tenancy before,) and three were in mental health service. The remaining two were existing tenants of HousingACT identified as needing support and being at risk of losing their tenancy.

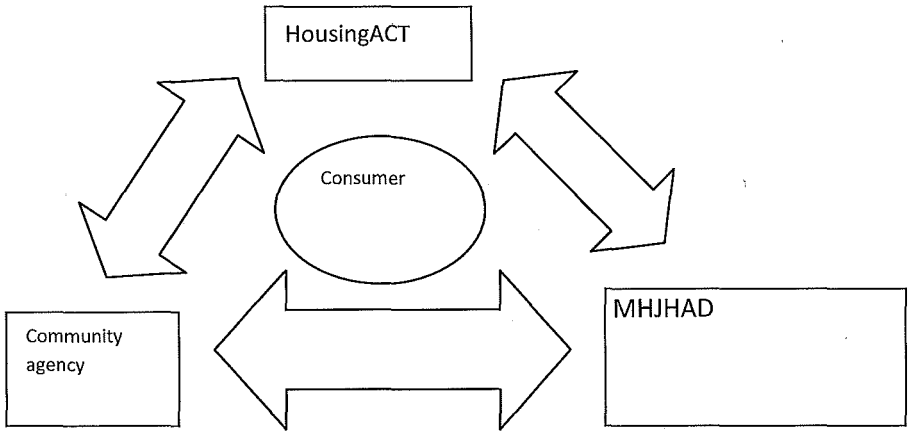
Although each of the consumers had a unique history and background, typically these backgrounds were characterised by cycling between hospitalisation and homelessness. Even for those consumers who had previously held public housing tenancies, these had been vacated due to mental health, either hospitalisation or related issues.

Due to confidentiality and privacy reasons it has not been possible to get access to very much background information on the clients' pathways into HASI. However, in addition to a diagnosis of a severe mental illness the following characteristics were consistently found amongst all the clients:

- no stable accommodation for long time periods;
- repeated hospitalisation ;
- financial concerns with varying degree of debts ;
- poor relationship with children and other significant family members;
- isolation with little interest or ability to socialise ;
- limited ability in self care .

Description of HASI ACT

The HASI (ACT) is a partnership between HousingACT, MHJHAD and a number of Community sector agencies.

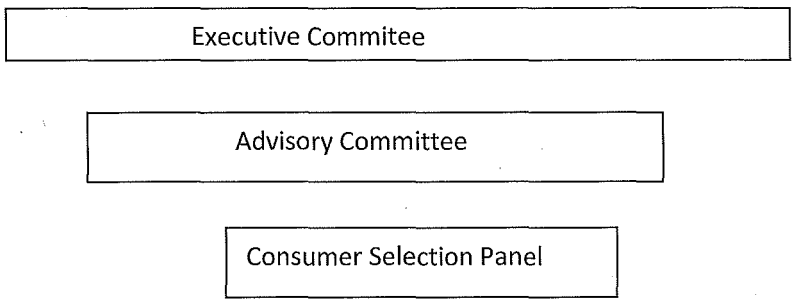


The partners work together to assist people with mental health issues in need of housing to:

- increase their participation in the community,
- sustain successful tenancies and;
- access other services.

Roles and responsibilities

The HASI program has established a layered management and governance system which fits together to ensure the effective operation and delivery of the program.



The Executive committee was established to provide high level governance and strategic direction to the program and was critical during the initiation phase. This executive committee consisted of executive level

membership from both Housing ACT and MHJHAD and ceased to meet. Given the significance of the partnership between MHJHAD and Housing ACT, it is suggested that the executive committee be re-established to oversee the implementation of HARI, provide strategic direction and receive regular outcome reports.

The Advisory Committee continues to meet on a regular basis and includes membership from all the stakeholders, as well as consumer advocacy groups and a peak body. This advisory committee oversees the day to day operations and manages policy development. It also trouble shoots issues and identifies solutions to problems as they arise.

The Consumer Selection Panel meets on a 'needs basis' and is responsible for selecting applicants into the program. The CSP is central to the operation of HASI, in that this is the group that manages the intake process. The membership of the CSP is made up of representatives of Housing ACT, Health, and the community sector organisations.

The CSP meets on a 'as needs' basis when there are potential applicants to consider. The CSP will consider the application, and provide a determination to suitability and make a recommendation to accept into the program. Once accepted, a brief is generated to the Director of Housing to exercise discretion and escalate the client's application to that of priority housing.

Once on the priority housing list, there is a commitment to house the applicant as soon as possible.

Referral

The referral process outlined in the HASI manual is based closely on the NSW HASI, in that it relies on the Consumer Selection Panel (CSP) to establish suitability for the program.

It is unclear, however, how well the referral process has worked in the ACT. Although there are 8 clients in the program, there is little evidence or documentation available in the Housing ACT files to support the decision making process or rationale. Similarly, there is no documentation available about any clients who were not accepted into the program.

The advisory group recently considered and adopted a revised referral process (attachment A) which outlines much more clearly the pathways to HASI.

The previous and the revised referral process is led by the 'expertise' of the mental health professionals, who are responsible for assessing applicants for suitability to the program. However this limits access to HASI to those homeless people who are currently engaged with a clinician. The revised process compensates for this by allowing any one of the three parties to indentify a suitable applicant, but the referral still is cleared by Mental Health Justice health Alcohol& Drug Service (MHJHAD)who will undertake an assessment of mental health, allocate a clinician, (if there is not one currently allocated) and then refer to the CSP panel for consideration.

Eligibility

This is clearly documented in the HASI manual and quite rightly, the eligibility criteria is broad, designed to be inclusive rather than exclusive. The eligibility criteria includes **ALL** of the following:

- Must be over aged 16;
- Have diagnosed severe mental disorder;
- Be experiencing moderate to severe level of psychiatric disability;
- Be eligible for public housing in the ACT;

- Have the ability and desire to live independently;
- Be capable of benefiting from the provision of accommodation support services;
- Have completed and lodged appropriate documentation with MHACT;
- Have provided informed consent to participate in the program.

In other words, all of the above have to be present for a person to be considered eligible.

In addition to the above, HASI prioritises:

- Homeless, at risk of homelessness or inappropriately housed;
- Resident in a hospital bed;
- Unlikely to maintain a tenancy without support; and
- In short term, temporary accommodation.

The above criteron confuses the issue of eligibility with that of suitability. These are different and it would be useful to clarify the meaning of each. Eligibility are those criteria which although necessary, would not be on their own sufficient. For example, being aged 16+ is an eligibility criteria, it is not a suitability criteria. Suitability criteria are those criteria which would make the applicant suitable for the program; often this suitability is ascertained on the basis of an assessment or judgement and is not as clear cut as eligibility. For example' Being capable of benefiting from the provision of accommodation support services' is a suitability criteria and not an eligibility criteria.

Issue 1

Given the significance of the partnership between HealthACT and HousingACT, it is suggested that the executive committee be re-established to oversee the implementation of HARI, provide strategic direction and receive regular outcome reports.

Issue 2

It would be helpful to consider streamlining the eligibility and suitability criteria to the following; this would also assist in clarifying the roles and responsibilities of the partners.

Eligibility –

- Must be over aged 16
- Have diagnosed severe mental disorder
- Be eligible for public housing in the ACT
- Homeless, at risk of homelessness or inappropriately housed

Suitability –

- Be experiencing moderate to severe level of psychiatric disability
- Have the ability and desire to live independently
- Be capable of benefiting from the provision of accommodation support services
- Unlikly to maintain a tenancy without support

Issue 3

If the CSP has the responsibility for establishing suitability, then it is important to clarify that the role of MHACT is related to identification, checking for eligibility and assessment of need and risk.

As eligibility does not automatically mean suitability, and suitability does not guarantee entry into the program, the decision making needs to rest more clearly with the Consumer Selection Panel.

As the current model presupposes that a house is the only missing component, and accessing a house through HASI could be seen as expediency, a suggested process is

1. MHACT identify possible clients, and check eligibility and complete assessment
2. Client application forwarded to HACT, together with supporting documentation
3. HACT coordinate a CSP meeting.
4. CSP consider the following information to establish suitability
    a. Confirm eligibility
    b. Check recovery plan.
    c. Check client is willing and able.
    d. Check support provider is available.
    e. Check that an application for housing is lodged.
5 Make decision.

Assessment and Intervention

Currently, the main assessment tools that are utilised are the mental health tools, CANSAS, HONOS and LSP(attachment B). Like many assessment tools that are utilised as part of a gateway process into a service, these tools appear to focus on an assessment of the clients' suitability into the program, rather than a holistic assessment of the clients' needs – from which decisions can be made about suitability. Furthermore, both the HONOS and the LSP are very clinically orientated, providing clinicians excellent methodology for charting mental health and risk, but failing to provide good assessment of other life domains, and focussing more on 'problem' and less on 'strengths'

In contrast to the Mental Health Clinicians, all of the community partners talked about the importance of the recovery model as an intervention strategy for working with consumers within the HASI program. The Recovery model is a paradigmatic shift in the treatment and management of mental health, shifting the focus from illness and treating symptoms, to supporting a journey of personal recovery through the illness. It looks at supporting the consumer to live with their 'illness' rather than just focusing on an alleviation of symptoms.

The recovery model relies heavily on user identified goals, and is a classic expression of the client centred and self directed ideologies that are currently prevalent within mental health and other social welfare fields.

The recovery model has some important underlying components; these are:

- Creating Hope;
- Choice and Goals;
- Creating Meaning;
- Purpose and Direction;
- Empowerment and Personal Growth, and;
- Ownership of Recovery.

Once accepted into the program, each HASI client is involved in developing a psycho-social support plan based on the recovery model, which includes such things as activities, socialisation and self development. However, an analysis of available plans identified that these lacked clear long term objectives and focused instead on a series of small steps. However, this would be consistent with the debilitating effects of long term serious mental illness and long term homelessness.

The recovery model relies on, and gives primacy, to user identified goals. This can become problematic for users who have had chronic and enduring mental health conditions, compounded by extensive periods of homelessness and hospitalisations.

The model presupposes, that the illness itself is reasonably well controlled, thus allowing the user the cognitive functioning to set 'meaningful goals' unaided.

Furthermore, it is not clear what impact prolonged periods of institutionalisation would have on cognitive ability to set clear and meaningful goals. It is unclear how the chronicity itself can limit aspiration goal setting, when day to day existence is constantly under threat.

This low level of aspirations is reflected in the planning for most of the clients, with only one of the agencies talking about the clients' desires for a job and desire to leave mental health services. Other aspiration goals that were lacking were around home ownership and family relationships.

Developed in Wollongong, the Collaborative Recovery Model is less client focused and recognises that for some mental health consumers with long term and enduring illnesses, a little more structured goal setting will be required. This model enhances the concepts of the recovery model, and introduces the ideas of Coaching, Visioning, Camera and Compass. Coaching is a well established technique used in many fields from sport, to business to education. Visioning actually assists the user to think big and long term, having aspiration goals which create hope and purpose. The Camera is essentially a technique of capturing the current situation and environment and the compass maps a way out, and toward the vision.

Issue 4

Consistent with the recovery model it would be useful for support plans to address such social inclusion goals as:

- Employment;
- Training;
- Education; and
- Relationships.

Recovery Model and Life Planning

This is a critical component of the HASI program. As extensive support is provided to ACT Housing Tenants who are in the HASI program, it would be useful to have clearly articulated support plans which go beyond day to day activity and more closely reflect the principals of the recovery model.

There are numerous planning methodologies that have been developed, in particular the Disability Sector is at the forefront of person centred planning, with models such as:

- Essential Lifestyle Planning;
- PATH (Planning Alternative Tomorrows with Hope); and
- Maps and Personal Futures Planning.

It is suggested that a single planning methodology which captures hope and aspirations, as well as social inclusion goals and day to day activity, is developed, agreed and then implemented for all HASI clients. This planning model should then assist to facilitate some enduring change which goes beyond 'just managing' and moves towards 'achieving and thriving', and would sit as an adjunct to the clinical assessments.

Attachment C provides a model planning tool that could be further developed and implemented as part of the planning and intervention process with HASI clients.

Partnership working

The partnerships seem enthusiastic in working together and all share the common goal of achieving good outcomes for people with mental health. The partners appear to be working effectively, although there may be some merit in defining and clarifying roles and responsibilities more clearly.

In particular, the question about the coordination role needs to be examined. Housing ACT is clearly responsible for the allocation of the property and for the provision of tenancy support. As the initiating agency, Housing ACT also took on the role of coordination. However, doing this reinforces the assumption that entry into HASI pre-supposes entry into public housing.

With the onset of HARI, it will be necessary to revisit the overall co-ordination function.

Is the program working?

It is difficult to answer this question with any degree of certitude. From a research point of view, the sample is too small, the time frame is to0 short and there are too many confounding variables to honestly attribute anything to the program. What can be said with certainty is that the framework for a potentially positive program is well established, and although requiring some tweaking, looks set to make a difference in the lives of some of the most vulnerable homeless people in the ACT.

An examination of some of the traditional measures of successful tenancies, rental payments and arrears, property damage and TRM and complaints, shows that this small group of highly support consumers are doing well in all these regards.

Rental payment and arrears

Rental payment is usually an indicator of stability; indeed the HASI NSW review identified this as one area in which consumers needed most assistance. Within the ACT four HASI tenants are under the guardianship of the public trustee, hence rental is paid on time, and they have no previous rental history. The other four have no or minimal rental debt (less than $200). Because of these facts, rental payment and rental debt is currently a very poor indicator of the effectiveness of this program in the ACT. It is not known how many of the HASI NSW consumers are under similar guardianship arrangements.

Property Damage

None of the eight had any TRM (tenant responsible maintenance) listed, other than three consumers who needed replacement keys.

Complaints

None of these tenants had any complaints listed on the system, either by them or against them.

HASI is designed to target the most vulnerable consumers, yet, interestingly, comments by staff in the data section of the Business development unit who extracted the data from Homenet, were 'these are model tenants' . This could indicate that either the accurate selection and intensive support of the consumers is working exceptionally well, or that the wrong clients are in the program.

Most likely, however, it is a combination of the former and the fact that this such a small sample size and time frame that very little inference can actually be drawn.

Discussions with the stakeholders would indicate that the intensive support provided to HASI clients is a significant factor, contributing to these positive and promising indicators.

In addition, apart from one consumer who is currently in hospital with severe burns:

- All have maintained tenancy for 12 months;
- All are engaged in some form of social activity (usually with support worker);
- Some have commenced and completed study at CIT;
- Some have re-established relationships with family; and
- None have had any periods of hospitalisation.

How much effort is required?

If we assume for a moment that these factors are indeed attributable to the HASI program, then it is useful to also look at the extent and intensity of the support provided together with the associated costs.

Although $1.4M dollars has been allocated to this program over three years, this $1.4M is only for additional support hours and is not a true cost. Each consumer is allocated up to $50K for support hours from an community agency per year. This works out to around 10 hours a week support from the community agency.

In addition to this support, the program includes:

- The Housing Manager provides intensive support at least monthly contact, often more, with the option to increase at short notice is needed;
- Mental Health clinical support;
- Coordination and Management undertaken by the Senior Manager of Housing Inititatives;
- Advisory group;
- Consumer Selection Panel; and
- Monthly client coordination meetings involving all partners and the consumer.

Taking all of this into account, it is not surprising that these consumers are doing reasonably well.

Exiting the HASI

Although the HASI manual is very clear in highlighting the entry criteria, there is little discussion or documentation about how and when clients will/can exit from HASI. Some comments from both mental health and from community agencies suggested that the prognosis for these clients exiting the highly supported HASI program was poor. This was based on the long term enduring nature of the mental illness together with the clients' history of being locked into cycles of mental illness and cycles of homelessness.

What is meant by Exit?

Clearly, most if not all of the clients entering HASI will require ongoing support for some considerable periods of time. Due to the enduring nature of the mental health issues as well as traumatic backgrounds punctuated by periods of homelessness, it may be that the support required to maintain tenancies and participate fully in the community will have to be equally enduring. However, this could mean that once the program is full, there will be no room for any new clients entering. In some way that this may not be so problematic, as the incidence of the suitable clients may well be much smaller compared to the prevalence. What this means is that once an adequate program is in place, supporting the current cohort of eligible consumers, the number of new consumers will be small and should match those exiting the program through natural attrition, such as improved and stabilised mental health, leaving public housing, moving interstate, or dying.

However, what is more important is a system which can assess accurately the level of needs of clients so that this can be matched by the level of intervention and the level of funding, to allow for the entry of new clients into the program over time.

For example, if the client is managing well in the areas of Housing, i.e rental payments, no neighbourhood complaints and no TRM damage, then it may be that the Housing support is reduced to a lower level. This would also be the case for the community sector, and for Mental Health.

It is important, however, that there are some clear mechanisms in place to trigger a response if needed from each of the partners to support a client quickly. The current process of "Future planning' (attachment D) is an excellent tool, which would allow the client as well as each partner to know what to do and how to do it, if support needs to be stepped up.

Charting new territory, Introducing HARI

ACT Health is committing Commonwealth funding to enable the HASI program to grow to 40 consumers over a period of three years. Although this new funding is available as HARI (Housing and Recovery Initiative) Mental MHJHAD has confirmed that the current HASI model will be utilised to deliver this service, new in name only.

Although HARI will providing funding for 40 clients, this is similar to the HASI model in that the funding is only for consumer set up and agency support hours. This means that whilst community agencies will have more capacity under HARI, the same is not true for HousingACT.

It is envisaged that the current Housing Manager could possible work with around 20 HARI clients; any more would be unsustainable for any prolonged period of time.

Furthermore, there are some concerns regarding the workload and capacity of the Senior Manager, Housing Initiatives to provide the same level of involvement for up to 40 clients, and in fact this may not be the best use of a Senior Managers time, now that the program has been implemented and appears to be working adequately

It may also be timely to consider the lessons from other initiatives which have involved singleton positions in an area of innovation.

Issue 5

It would be important to consider the establishment of a specialist team of at least two housing managers who could work with up to 40 HASI clients. These housing managers could feasibly be managed by a SOG C who would also then be responsible for the co-ordination role as well as developing a quality assurance, monitoring and reporting role.

An alternative option would still require additional staffing at the Housing manager level, but could be that:

- MHJHAD' s take on the overall coordination role;
- Community Agencies assume responsibility for the case management of the consumers, in their agencies;
- HousingACT assumes responsibility for the management of the Consumer Selection Panel, which in fact could be undertaken by the current MDP panel, thus avoiding the need to write a brief for approval.

Addressing (Changing) Client Needs and funding.

It will be essential going forward with HARI, that there are adequate and robust mechanisms to be able to respond flexibly to client changing needs. This would need to be looked at in relation to the funding model as well; currently the funding is attached to each client, but perhaps a system needs to be considered that can move money between clients as needs change, with an aggregate funding level to agencies based on numbers and levels of need.

For example, under the current model, if agency A has 10 clients, they would be eligible for up to $500,000 funding. However, each client could only access upto a maximum of $50K per annum ($4166 a month) dependent on hours used, equal to around 10 hours support a week.

However, an aggregate funding model might consider procuring services for 10 clients at a total cost of $500,00, with the notion that some of these ten will be higher needs than others and that these needs would vary month by month.

Outcomes

Community Services Directorate has been moving towards a model of outcomes based reporting for some time, and it is clear from this review that there is a need for some clear indicators to be identified in relation to outcomes for clients. Some obvious outcomes could be related to frequency of contact with mental health services, periods of hospitalisation, engagement with other services, employability, as well as the traditional measures of rental payments, and tenancy management.

It is highly recommended that systems be put in place to measure the impact on the use of mental health services over time.

CSP could be responsible for regularly reviewing consumers on a 6 monthly basis to ensure that the resources are being appropriately targeted, that the client is making progress, and that the goals are being met. The long term goal should be to move people to sustainable mainstream tenancy as soon as possible. This review would be separate from the clinical client reviews and part of a formal governance process which would feed into data collection and reporting.

END

Attachment A

Application Process

The HASI program coordinator will call for referrals to the Client Selection Panel 3 months prior to sitting. This enables documentation to be updated (if an existing referral) or prepared and coordinated if a new referral.

All referrals are to be actioned via Mental Health, Justice Health and Alcohol and Drug Services. This ensures eligibility for clinical management and the HASI program. Community agencies can refer consumers for consideration of clinical management with a view to entering the HASI program.

Once accepted for clinical management the clinical manager coordinates the referral process by way of completing the required documents inclusive of the consent form and a covering letter outlining issues and potential benefits of HASI for the consumer and identifying and contacting one of the partner community agencies (if not already engaged). Please see attached flow chart.

If the application is approved the details will be forwarded to:

- Housing ACT Manager for HASI to begin the allocation process
- The clinical manager from MH, JH & ADS
- The identified Community Agency and
- The consumer.

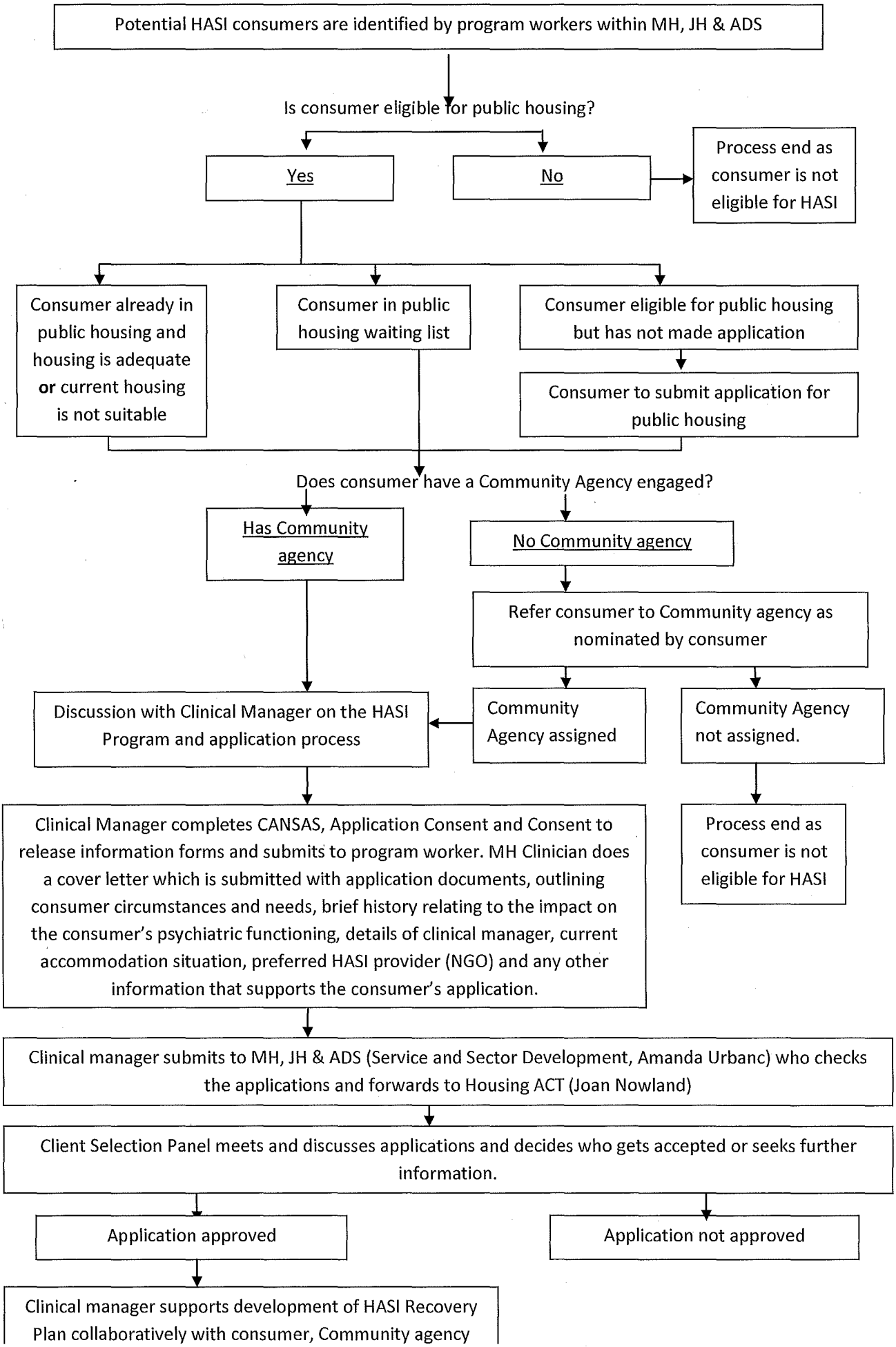
At this point, the MH clinical manager and the Community mental health support organisation collaborate to develop a recovery plan with the client

If there is no current housing vacancy or HASI support package available the application is placed on a HASI Register. This is a formal list of all applicants who have applied for HASI in the ACT. The Register is maintained by the CSP. A representative from the CSP will contact the next applicant on the list when a housing vacancy or package becomes available. If necessary, an update of consumer status will be required.

The CSP will advise the client in writing of the outcome of the CSP decision.

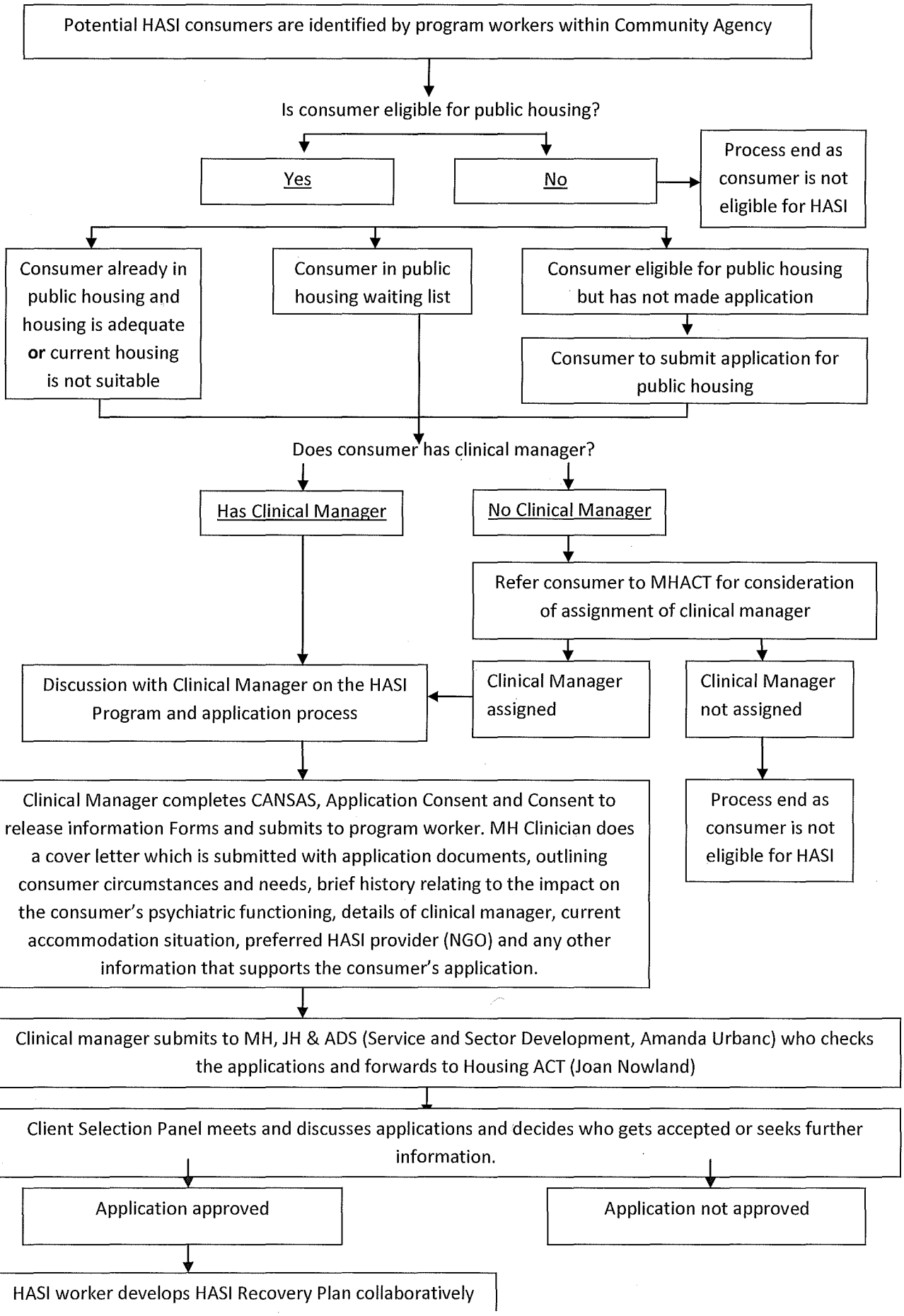
Attachment A

HASI APPLICATION WORKFLOW – Mental Health, Justice Health and Alcohol and Drug Services



Attachment A

HASI APPLICATION WORKFLOW – Community Agency



Attach B

HoNOS

Health of the Nation
Outcome Scales

Summary of rating instructions:

1. **Rate** each scale in order from 1 to 12
2. **Do not** include information rated in an earlier item except for item 10 which is an overall rating
3. **Rate** the MOST SEVERE problem that occurred during the period rated
4. **All scales** follow the format:

   0 = no problem
   1 = minor problem requiring no action
   2 = mild problem but definately present
   3 = moderately severe problem
   4 = severe to very severe problem

1. Overactive, aggressive, disruptive or agitated behaviour

Include such behaviour due to any cause, e.g drugs, alcohol, dementia, psychosis, depression, etc.
Do not include bizarre behaviour, rated at Scale 6

0 No problems of this kind during the period rated

1 Irritability, quarrels, restlessnes etc. not requiring action

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked overactivity or agitation

3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity o

4 At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious behaviour

2. Non-accidental self-injury

Do not include accidental self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.
Do not include illness or injury as a direct consequence of drug/alcohol use rated at Scale 3: (e.g. cirrhosis of the liver or injury resulting from drunk driving are rated at Scale 5.)

0 No problems of this kind during the period rated

1 Irritability, quarrels, restlessnes etc. not requiring action

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked overactivity or agitation

3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity o

4 At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious intimidation or ob behaviour

3. Problem-drinking or drug-taking

Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Scale 1
Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5

0 No problems of this kind during the period rated

1 Some over-indulgence but within social norm

2 Loss of control of drinking or drug-taking, but not seriously addicted

3 Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influen

4 Incapacitated by alcohol/drug problems

4. Cognitive problems

Include problems of memory, orientation and understanding associated with any disorder; learning disability, dementia, schizophrenia, etc.
Do not include temporary problems (e.g. hangovers) resulting from drug/alcohol use, rated at Scale 3

0 No problems of this kind during the period rated

1 Minor problems with memory or understanding, e.g forgets names occasionally

2 Mild but definite problems e.g. has lost the way in a familiar place or failed to recognise a familiar person; so simple decisions

3 Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherer

4 Severe disorientation e.g. unable to recognise relatives, at risk of accidents, speech incomprehensible; cloudin

5. Physical illness or disability problems

Include illness or disability form any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.
Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents of self-harm associated with cognitive problems, drink-driving, etc.
Do not include mental or behavioural problems rated at Scale 4.

0 No problems of this kind during the period rated

1 Irritability, quarrels, restlessnes etc. not requiring action

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked overactivity or agitation

3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity or

4 At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious behaviour

6. Problems associated with hallucinations and delusions

Include hallucinations and delusions irrespective of diagnosis
Include odd and bizarre behaviour associated with hallucinations or delusions

Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1

0 No evidence of hallucinations or delusions during the period rated

1 Somewhat odd or eccentric beliefs not in keeping with cultural norms

2 Delusions of hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestati i.e. clinically present but mild.

3 Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously moderately severe clinical problem

4 Mental state and behaviour is seriously and adversely affected b delusions or hallucinations, with severe impa

7. Problems with depressed mood

Do not include overactivity or agitation, rated at Scale 1
Do not include suicidal ideation or attempts, rated at Scale 2
Do not include delusions or hallucinations, rated at Scale 6

0 No problems associated with depressed mood during the period rated

1 Gloomy; or minor changes in mood

2 Mild but definite depression and distress: e.g. feelings of guilt; loss of self-esteem

3 Depression with inappropriate self-blame, preoccupied with feelings of guilt

4 Severe or very severe depression, with guilt of self-accusation

8. Other mental and behavioural problems

Rate only the most severe clinical problem not considered at items 6 and 7 as follows. Specify the type of problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify

0 No evidence of any of these problems during period rated

1 Minor non-clinical problems

2 A problem is clinically present at a mild level, e/g patient/client has a degree of control

3 Occasional severe attack or distress, with loss of control e.g. has to avoid anxiety provoking situations altogetl help, etc. i.e. moderately severe level of problem

4 Severe problem dominates most activities

9. Problems with relationships

Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships

0 No significant problems during the period

1 Minor non-clinical problem

2 Definite problems in making or sustaining supportive relationships; patient complains and/or problems are evi

3 Persisting major problems due to active or passive withdrawal form social relationships, and/or relationships t comfort or support

4 Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social

10. Problems with activities of daily living

Rate the overall functioning in activities of daily living (ADL): e.g problems with basic activities of self-care such as eating, washing, dressing, toilet; also compex skills such as budgeting, organizing where to live, occupation and recreation, mobility and use of transport, shopping, self-development. etc.
Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.
Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11-12

0 No problems during the period rated; good ability to function in all areas

1 Minor problems only: e.g. untidy, disorganized

2 Self-care adequate but major lack of performance of one or more complex skills (see above)

3 Major problems in one or more area of self-care (eating, washing, dressing, toilet) as well as major inability tc skills

4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills

11. Problems with living conditions

Rate the overall severity of problems with the qualithy of living conditions and daily domestic routine
Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?
Do not rate the level of funcional disability itself, rated at Scale 10
NB: Rate patient's usual accommodation. If in acute ward, rate the home accommodation. If informatioin not available, rate 9

0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the supportive of self-help

1 Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal locati doesn't like the food, etc)

2 Significant problems with one or more aspects of the accommodation and/or regime; e.g. restricted choice; sta understanding of how to limit disability, or how to help use or develop new or intact skills

3 Distressing multiple problems with accommodation; e.g. some basic necessities absent; housing environment facilities to improve patient's independence

4 Accommodation is unacceptable: e.g. lack of basic necessities, patient is at risk of eviction, or 'roofless', or liv otherwise intolerable making patient's problems worse

12. Problems with occupation and activities

Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities, e.g. staffing and equipment of day centres, workshops, social clubs, etc. Do not rate the level of functioinal disability itself, rated at Scale 10
NB Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9

0 Patient's day-time environment is acceptable: helpful in keeping any disability rated at Scale 10 to the lowest l supportive of self-help

1 Minor or temporary problems e.g. late giro cheques; reasonable facilities available but not always at desired ti

2 Limited choice of activities; e.g there is a lack of reasonable tolerance (e.g. unfairly refused entry to public lib handicapped by lack of permanent address; or insufficient carer or professional support; or helpful day setting

limited hours

3 Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills new ones; unskilled care difficult to access

4 Lack of opportunity for daytime activities makes patient's problems worse

HoNOS Score Sheet			
		Rate 9 if not known	Rate
1	Overactive, aggressive, disruptive behaviour	0 1 2 3 4 5	
2	Non-accidental self-injury	0 1 2 3 4 5	
3	Problem-drinking or drug-taking	0 1 2 3 4 5	
4	Cognitive problems	0 1 2 3 4 5	
5	Physical illness or disability problems	0 1 2 3 4 5	
6	Problems with hallucinations and delusions	0 1 2 3 4 5	
7	Problems with depressed mood	0 1 2 3 4 5	
(Specify disorder A,B,C,D,E,F,G,H,I, or J)			
8	Other mental & behavioural problems	0 1 2 3 4 5	
9	Problems with relationships	0 1 2 3 4 5	
10	Problems with activities of daily living	0 1 2 3 4 5	
11	Problems with living conditions	0 1 2 3 4 5	
12	Problems with occupation and activities	0 1 2 3 4 5	

Edited by Gavin Andrews MD, UNSW, Jan 03

THE LIFE SKILLS PROFILE

Background, Items and Scoring for the LSP–39, LSP–20 and the LSP–16

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May 2006

A link to this file can be found at
http://www.blackdoginstitute.org.au/research/tools/index.cfm

The Life Skills Profile(LSP) was developed as a measure of those aspects of functioning ("life skills") which affected how successfully people with schizophrenia lived in the community or hospital (Rosen *et al.* [1989]). As many of the skills are relevant in other major psychiatric disorders and in some organic conditions the LSP has been applied to a broad range of diagnoses.

Versions of the LSP

A number of versions of the LSP have been published or variously reported.

On the basis of psychometric analyses Trauer (1995) suggested some minor re-labelling of the dimensions and a re-arrangement of the items defining them.

The LSP-39 has proved too lengthy for some peoples' needs and so two shortened versions have been described.

LSP-20. This version comprises 20 items and retains the five original dimensions (as re-labelled in Trauer [1995]). It was suggested by Trauer and its properties reported in Rosen *et al.* (2001).

LSP-16. This version with 16 items was constructed by the original authors for an Australian casemix research project — *Mental Health Classification and Service Costs Project* (see `http://www.mhnocc.org`). This version does not have the "communication" subscale which was assessed by other means in the casemix study.

Dimensions of the LSP and their scoring

The philosophy of the LSP was to try and emphasize a person's "life skills" rather than their "lack of life skills." This was seen as being both positive for the person as well as encouraging carers and others to focus on what the person can do, rather than on what they cannot. This philosophy was expressed in the scoring of the items and in the labelling of the subscales.

Scoring of items. Hence the items were meant originally to be scored so that high scores indicate high levels of life skills, just as, for example, high scores on the GAF mean higher levels of functioning. Nevertheless, some users of the LSP have scored items or transformed totals so that high scores indicate low levels of skills (or high levels of deficits), just as, for example, high scores on the HoNOS mean lower levels of functioning.

Labelling of items. Similarly, the subscales had positive labels, such as *self-care*, *non-turbulence* and *social contact*. The emphasis on deficits is seen in labels such as *anti-social* and *withdrawal*.

Subscale	LSP-39	LSP-20	LSP-16
1	Self-care	Self-care	Self-care
2	Non-turbulence	Anti-social	Anti-social
3	Social contact	Withdrawal	Withdrawal
4	Communication	Bizarre	—
5	Responsibility	Compliance	Compliance

The following table shows the items in the three versions and which subscales they form.

Item	Item Descriptor	Subscales of Version LSP–39	LSP–20	LSP–16
1	Does this person generally have any difficulty with initiating and responding to conversation?	Communication	Withdrawal	Withdrawal
2	Does this person generally intrude or burst in on others' conversation (e.g. interrupts you when you are talking)?	Communication	Anti-social	
3	Does this person generally withdraw from social contact?	Social contact	Withdrawal	Withdrawal
4	Does this person generally show warmth to others?	Social contact	Withdrawal	Withdrawal
5	Is this person generally angry or prickly towards others?	Non-turbulence	Anti-social	
6	Does this person generally take offence readily?	Non-turbulence	Anti-social	
7	Does this person generally make eye contact with others when in conversation?	Communication	Withdrawal	
8	Is it generally difficult to understand this person because of the way he or she speaks (e.g. jumbled, garbled or disordered)?	Communication	Bizarre	
9	Does this person generally talk about odd or strange ideas?	Communication	Bizarre	
10	Is this person generally well groomed (e.g., neatly dressed, hair combed)?	Self-care	Self-care	Self-care
11	Is this person's appearance (facial appearance, gestures) generally appropriate to his or her surroundings?	Communication	Bizarre	
12	Does this person wash himself or herself without reminding?	Self-care	Self-care	
13	Does this person generally have an offensive smell (e.g. due to body, breath or clothes)?	Self-care	Self-care	
14	Does this person wear clean clothes generally, or ensure they are cleaned if dirty?	Self-care	Self-care	Self-care
15	Does this person generally neglect his or her physical health?	Self-care	Self-care	Self-care
16	Does this person generally maintain an adequate diet?	Self-care	Self-care	Self-care
17	Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?	Responsibility	Compliance	Compliance
18	Is this person willing to take psychiatric medication when prescribed by a doctor?	Responsibility	Compliance	Compliance
19	Does this person co-operate with health services (e.g. doctors and/or other health workers)?	Responsibility	Compliance	Compliance

Item	Item Descriptor	Subscales of Version LSP–39	LSP–20	LSP–16
20	Is this person generally inactive (e.g. spends most of the time sitting or standing around doing nothing)?	Social contact	Withdrawal	
21	Does this person generally have definite interests (e.g. hobbies, sports, activities) in which he or she is involved regularly?	Social contact	Withdrawal	
22	Does this person attend any social organisation (e.g. church, club or interest group but excluding psychiatric therapy groups)?	Social contact	Withdrawal	
23	Can this person generally prepare (if needed) her or his own food/meals?	Self-care	Self-care	
24	Can this person generally budget (if needed) to live within his or her means?	Self-care	Self-care	
25	Does this person generally have problems (e.g. friction, avoidance) living with others in the household?	Non-turbulence	Anti-social	Anti-social
26	What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?	Self-care	Self-care	Self-care
27	Does this person behave recklessly (e.g. ignoring traffic when crossing the road)?	Non-turbulence	Anti-social	
28	Does this person destroy property?	Non-turbulence	Anti-social	
29	Does this person behave offensively (includes sexual behaviour)?	Non-turbulence	Anti-social	Anti-social
30	Does this person have habits or behaviours that most people find unsociable (e.g. spitting, leaving lighted cigarette butts around, messing up the toilet, messy eating)?	Self-care	Anti-social	
31	Does this person lose personal property?	Responsibility	Self-care	
32	Does this person invade others' space (rooms, personal belongings)?	Non-turbulence	Anti-social	
33	Does this person take things which are not his or hers?	Responsibility	Anti-social	
34	Is this person violent to others?	Non-turbulence	Anti-social	Anti-social
35	Is this person violent to him or her self?	Non-turbulence	Anti-social	
36	Does this person get into trouble with the police?	Non-turbulence	Anti-social	
37	Does this person abuse alcohol or drugs?	Non-turbulence	Anti-social	
38	Does this person behave irresponsibly?	Non-turbulence	Anti-social	Anti-social
39	Does this person generally make and/or keep up friendships?	Social contact	Withdrawal	Withdrawal

Application Referral Form

CANSAS

(Camberwell Assessment of Need Short Appraisal Schedule)

Interviewer:	**Date:**
Consumer:	

CANSAS is a structured interview.
Please circle the rating of consumer, staff and carer that best describes their view of the consumer's needs.
The examples are designed to help with ratings. They will not describe all circumstances.

RATE FOR THE PAST MONTH.

TOPIC (please add comments if necessary)	Example	Consumer	Staff	Carer
1. Accommodation What kind of place do you live in?	Person does have an adequate home.	0	0	0
	Person is living in sheltered accommodation or hostel.	1	1	1
	Person is homeless, precariously housed, or home lacks basic facilities.	2	2	2
	Not known.	9	9	9
2. Food Do you get enough to eat?	Able to buy and prepare meals.	0	0	0
	Unable to prepare food and has meals provided.	1	1	1
	Very restricted diet, culturally inappropriate food.	2	2	2
	Not known.	9	9	9
3. Looking after the home Are you able to look after your home?	Home may be untidy but the person keeps it basically clean.	0	0	0
	Unable to look after home and has regular domestic help.	1	1	1
	Home is dirty and a potential health hazard.	2	2	2
	Not known.	9	9	9
4. Self care Do you have problems keeping clean and tidy?	Appearance may be eccentric or untidy, but basically clean.	0	0	0
	Needs and gets help with self-care.	1	1	1
	Poor personal hygiene.	2	2	2
	Not known.	9	9	9
5. Daytime activities How do you spend your day?	In full time employment or adequately occupied.	0	0	0
	Unable to occupy self, so attending day care.	1	1	1
	No employment of any kind and not adequately occupied.	2	2	2
	Not known.	9	9	9
6. Physical Health How well do you feel physically?	Physically well.	0	0	0
	Physical ailment receiving appropriate treatment.	1	1	1
	Untreated physical ailment, including side effects.	2	2	2
	Not known.	9	9	9
7. Psychotic Symptoms Do you ever hear voices or have problems with your thoughts?	No positive symptoms, not at risk from symptoms and not on medication.	0	0	0
	Symptoms helped by medication or other help.	1	1	1
	Currently has symptoms or at risk.	2	2	2
	Not known.	9	9	9
8. Information on condition and treatment Have you been given clear information?	Has received and understood adequate information.	0	0	0
	Has not received or understood all information.	1	1	1
	Has received no information.	2	2	2
	Not known.	9	9	9
9. Psychological distress Have you recently felt sad or low?	Occasional or mild distress.	0	0	0
	Needs and gets ongoing support.	1	1	1
	Distress affects life significantly, such as preventing person going out.	2	2	2
	Not known	9	9	9
10. Safety to self Do you ever have thoughts of harming yourself?	No suicidal thoughts.	0	0	0
	Suicide risk monitored by staff, receiving counselling.	1	1	1
	Has expressed suicidal ideas or has exposed themselves to serious danger.	2	2	2
	Not known.	9	9	9
11. Safety to others Do you think you could be a danger to other people's safety?	No history of violence or threatening behaviour.	0	0	0
	Under supervision because of potential risk.	1	1	1
	Recent violence or threats.	2	2	2
	Not known.	9	9	9

Application Referral Form

12. Alcohol Does drinking cause you any problems?	No problem with controlled drinking. At risk from alcohol abuse and receiving help. Current drinking harmful or uncontrollable. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
13. Drugs Do you take any drugs that aren't prescribed?	No dependency for abuse of drugs. Receiving help for dependency or abuse. Dependency or abuse of prescribed, non-prescribed or illegal drugs. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
14. Company Are you happy with your social life?	Able to organise enough social contact, has enough friends. Attends appropriate drop-in or day centres. Frequently feels lonely and isolated. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
15. Intimate relationships Do you have a partner?	Satisfactory relationship or happy not having a partner. Receiving couple therapy, which is helpful. Domestic violence or wants partner. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
16. Sexual expression How is your sex life?	Happy with current sex life. Benefiting from sexual therapy. Serious sexual difficulty. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
17. Childcare Do you have any children under 18?	No children under age of 18 or no problem looking after them. Difficulties with parenting and receiving help. Serious difficulty looking after children. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
18. Basic Education Any difficulty in reading, writing or understanding English?	Able to read, write and understand English forms. Difficulties with reading and has help from relatives. Difficulty with basic skills, lack of English fluency. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
19. Telephone Do you know how to use a telephone?	Has working telephone in house or easy access to payphone. Has to request use of telephone. No access to telephone or unable to use telephone. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
20. Transport How do you find using the bus or train?	Able to use public transport or has access to car. Bus pass or other help provided with transport. Unable to use public transport. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
21. Money How do you find budgeting your money?	Able to buy essential items and pay bills. Benefits from help with budgeting. Often has no money for essential items or bills. Not known.	0 1 2 9	0 1 2 9	0 1 2 9
22. Benefits Are you getting all the money you are entitled to?	Receiving full entitlement of benefits. Receiving appropriate help in claiming benefits. Not sure/not receiving full entitlement of benefits. Not known.	0 1 2 9	0 1 2 9	0 1 2 9

A. NUMBER OF MET NEEDS	(the no. of 1's)			
B. NUMBER OF UNMET NEEDS	(the no. of 2's)			
C. TOTAL NUMBER OF NEEDS	(add A + B)			

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HASI ADVANCED AGREEMENT SUMMARY

Advanced Agreements are a written document containing a mental health consumer's preferences regarding future treatment. They are written to inform service providers of consumer preferences in the event of a mental health crisis or period of reduced ability to participate in decisions regarding their mental health.
This document is a summary of the information developed by the consumer and their clinical manager after working through the Advanced Agreement Workbook.
It is intended that mental health professionals will refer to a consumer's Advanced Agreement if the consumer's ability to participate in decisions about treatment is impaired as a result of their illness. The consumer's preferences should be considered and implemented as long as their preferences are in their best interest at the time.

THE TREATING TEAM

(includes the consumer, their clinical manager, psychiatrist, GP, family, support workers, etc)

NAME	POSITION/ ROLE	CONTACT NUMBER	PERMISSION TO CONSULT	SIGNATURE
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No

There is a plan for KEEPING WELL, PREVENTING RELAPSE AND RESPONDING EARLY that should be read in conjunction with this Advanced Agreement Summary (see Recovery Plan)

Yes	No
If yes, review and check that it is up to date	**If no, consider developing this part of the Recovery Plan**

PREFERENCES FOR TREATMENT

Indicate the consumer's preferred strategies for managing mild, moderate and severe symptoms of illness:

Stage	Strategies (e.g. therapies, counselling, relaxation, etc other than medication)	Medications	Dose range	Special Instructions (where, who, how etc)
Mild				

Date:

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HASI ADVANCED AGREEMENT SUMMARY

Moderate				
Severe				

Indicate any consumer preferences to NOT to be given specific medications and/or dosages or specific therapeutic interventions:

Describe Medication, dosage, or other intervention NOT to be used	Reason

PREFERRED TREATMENT FACILITY

The consumer *prefers* to receive treatment at the following facilities:

Stage	Facility	Reason
Mild		
Moderate		
Severe		

The consumer prefers *NOT* to be admitted to the following facilities to receive treatment:

Facility	Reason

Date:

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HASI ADVANCED AGREEMENT SUMMARY

PREFERENCES for EMERGENCY TRANSPORT

Indicate the consumer's preferences for transport to a treatment facility if required:

Transport	Reason	People to assist/ support

PREFERENCES for EMERGENCY INTERVENTIONS

Indicate the consumer's preferences for emergency interventions along with any special instructions that are most helpful when in a treatment facility:

Intervention (e.g. quiet time, talking, medication, sleep, etc)	Special Instructions

PREFERENCES TO *NOT* BE TREATED BY A PARTICULAR MENTAL HEALTH PROFESSIONAL/DOCTOR

This section acknowledges:

- **the importance of the therapeutic relationship in a person's recovery from mental illness**
- **there will be times when a difficulty in the relationship cannot be easily resolved**

NB: The mental health professional/doctor is to be notified that their name is included in this Advanced Agreement

Mental Health Professional/Doctor	Reason
	Unable to establish a therapeutic alliance ☐ gender ☐ cultural concerns ☐ conflict of interest☐ other ☐ :
	Unable to establish a therapeutic alliance ☐ gender ☐ cultural concerns ☐ conflict of interest☐ other ☐ :

SIGNIFICANT OTHERS TO BE NOTIFIED IF UNWELL:

Name	Phone	Relationship (Friend/Family)	Notify (immediately, few days)	Special Tasks (e.g. look after children, feed pet, pay bills)

Date:

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HASI ADVANCED AGREEMENT SUMMARY

There is a CHILDREN AND YOUNG PEOPLE'S SUPPORT PLAN that should be read in conjunction with this Advanced Agreement Summary

Yes	No
If yes, this plan should inform any support required for the consumer's children.	If no, and children and young people are impacted by the consumer's illness, consider developing this part of the plan.

PEOPLE TO BE ALLOWED CONTACT/VISITS WHILE IN A TREATMENT FACILITY:

Name	Relationship

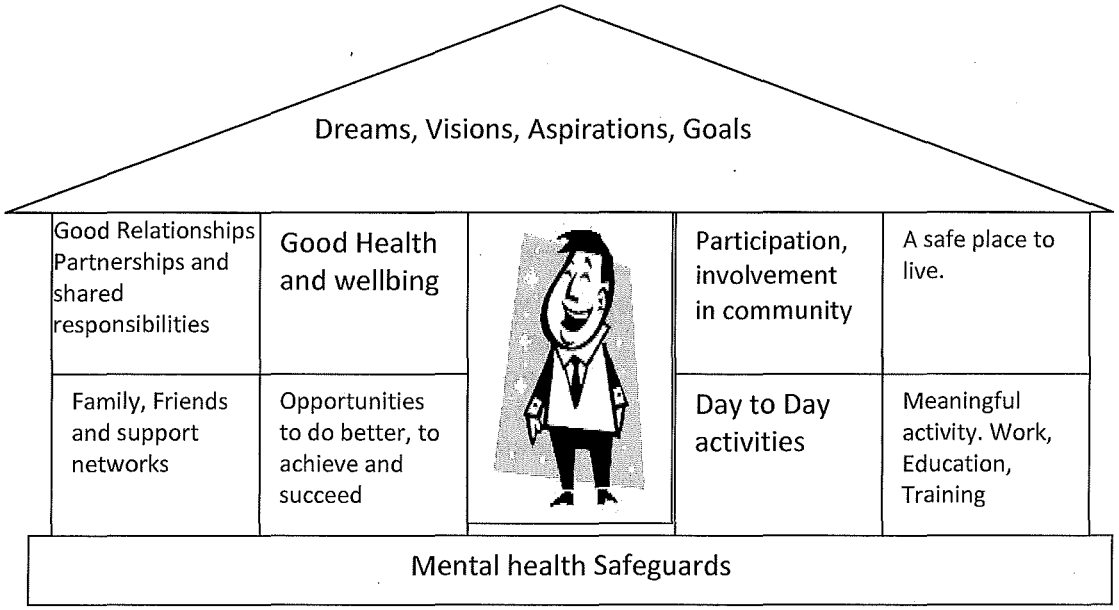
PEOPLE *NOT* TO BE NOTIFIED IF UNWELL OR ALLOWED CONTACT/VISITS WHILE IN A TREATMENT FACILITY:

Name	Relationship

Date:

Attachment 4
Futures planning for HASI Clients in the ACT

(adapted from Disability ACT – Futures Planning Framework)



The above model, clearly locates the person at the centre and identifies a range of domains that need to be considered in developing a plan.

- Underpinning the plan are a range of safeguards
- Overarching the plan are the aspirational dreams and visions which create hope, purpose and opportunity.
- Surrounding the person are the various domains that should be developed into a plan.

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

Public Accounts Committee - Review of Auditor-General's Report No. 4 of 2013: National Partnership Agreement on Homelessness

Mr Brendan Smyth (Chair), Ms Mary Porter (Deputy Chair), Ms Nicole Lawder, Ms Yvette Berry

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS
QTON 3

Asked by Ms Nicole Lawder on 17 October 2014: Ms Maureen Sheehan took on notice the following question(s):

[Ref: Hansard Transcript 17 October 2014 [PAGE #32-34]]

In relation to: Table 2.1 on page 18 of the Auditor-General's report shows a significant increase in the number of persons living in 'severely' crowded dwellings.

a) What does the Government attribute this increase to and what is being done about it?;
b) in addition, Ms Sheehan took on notice to provide the committee with the definition of severely overcrowded and when the definition changed.

MINISTER BARR: The answer to the Member's question is as follows:–

a) The improvement in ACT figures for people in improvised dwellings, or sleeping rough, is primarily attributed to the Streets To Home Program funded under the National Partnership Agreement on Homelessness (NPAH).

b) In 2012, the Australian Bureau of Statistics (ABS) revised its method of counting severely crowded dwellings. The ABS now defines severely crowded dwellings as those requiring 4 or more additional bedrooms in order to meet the Canadian National Occupancy Standard (CNOS) for housing appropriateness. The ABS retrospectively applied the revised definition to the 2011 Census count.

Approved for circulation to the Public Accounts Committee

Signature: Andrew Barr Date: 31.10.2014

By the Minister for Housing, Mr Andrew Barr MLA

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MS LAWDER: On page 18 of the Auditor-General's report, there is a table with information from the censuses in 2006 and 2011.

Mr Barr: Censi. What is the plural? Censi or is it census?

MS LAWDER: Censuses, it says here.

Mr Barr: Perhaps the committee could make a recommendation on the standard definition of the plural of census.

MS LAWDER: Notwithstanding whether you agree with the definition or not—

Mr Barr: Sorry.

MS LAWDER: people in improvised dwellings, or sleeping out or sleeping rough, as it used to be generally called, represent the largest, and in fact only, improvement in the ACT figures, a change of 43 per cent. That is excellent and reflects, I guess, the headline goal of the white paper about focusing on rough sleepers.
I have got two questions. My first one is about what you attribute that very positive change to. I know it is a negative, but it is a positive change. Secondly, the one near the bottom is about people living in overcrowded dwellings. The term "severely overcrowded" generally means you may need four or more additional bedrooms to adequately house those in the household. It has the largest percentage change of any. Whilst we focused quite a bit on the supported accommodation, severely overcrowded dwellings are the largest change. I am wondering what the ACT government may be doing to focus on or improve that situation, and to what you attribute such change.

Ms Sheehan: I am happy to start with that, Ms Lawder. The drop in rough sleepers we would attribute to one of the programs funded under the national partnership on homelessness, the street to home program. That was a great example of adding value to some existing programs. St Vincent de Paul was funded under the street to home program to work with chronic rough sleepers, many of whom might have previously been resistant to moving out of rough sleeping into housing. They were taking a very active approach with those rough sleepers, going out to where you would find them sleeping in a park or on Mount Ainslie, working to get their confidence, working with another St Vincent de Paul program, the food van, the night patrol van, working with other workers who would come in contact with rough sleepers, such as park rangers and so on, working with mental health workers, and then getting their confidence and trust to the point where they would be prepared to move into housing options which were provided by Housing ACT. If the figures could speak, I think that those figures would speak.
With the persons living in severely overcrowded dwellings, there was one change in the definition of overcrowding which was used by ROGS, the report on government services. That was until the point in time of change. I might have to defer to Mr Matthews or take on notice the point of time in which the definition of overcrowding changed, but we moved to adopt the Canadian definition of overcrowding. The overcrowding used to be people who required two extra bedrooms; the definition changed to requiring one extra bedroom. It might be simply a definitional change, but we can certainly look into that and provide the committee with some information.

MS LAWDER: I guess I should point out that people living in severely overcrowded dwellings did increase Australia wide. Mr Matthews might prefer to—

Mr Matthews: I was just supporting your commentary, Ms Lawder. Indeed, that was part of the national trend. The ACT does report on overcrowding in public housing, and on underutilisation, as

part of the report on government services. That is the comment that Ms Sheehan was making. On a household-by-household basis, there is an element of both overcrowding and underutilisation.
In terms of the particular characteristics of homeless people where there are large families involved, one of the key objectives of the government's response to the nation building and stimulus package was to support older people to downsize from their family homes to appropriate older persons accommodation. That had a very specific and deliberate policy goal of freeing up properties for larger families that required them. That was a wonderfully successful initiative in meeting both of those dual outcomes.
Today the minister has been speaking about housing supply issues. We recognise that there are limited stocks available at the very high bedroom number. The ones that are owned by Housing ACT or made available to homelessness services to use are very precious and rare. We need to make sure that we can utilise them in the best possible way. You will continue to see that emphasis in our upcoming construction program, supporting people to have that appropriate form of housing so that we can continue to either transfer people or allocate people to dwellings that are right for their family composition.

MS LAWDER: It is a really interesting area. Potentially with some component of it, though certainly not all of it, there are theories that it could be a sort of cultural thing, with extended families, for example

LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

Public Accounts Committee - Review of Auditor-General's Report No. 4 of 2013: National Partnership Agreement on Homelessness

Mr Brendan Smyth (Chair), Ms Mary Porter (Deputy Chair), Ms Nicole Lawder, Ms Yvette Berry

ANSWER TO QUESTION TAKEN ON NOTICE
DURING PUBLIC HEARINGS
QTON 4

Asked by Ms Yvette Berry on 17 October 2014: Mr Andrew Barr took on notice the following question(s):

[Ref: Hansard Transcript 17 October 2014 [PAGE #36-37]]

In relation to: "A place to call home" initiative.

How do we measure the outcomes post the program to know if the program has worked?

MINISTER BARR: The answer to the Member's question is as follows:–

The most practical way to measure outcomes post the program is to determine the number of tenancies sustained. Of the twenty people engaged in A Place to Call Home (APTCH):

- 17 have sustained their tenancy at the APTCH property;
- 2 have ended their tenancy (1 relocated interstate and the other went to private rental);
- 1 continues to receive support to remain in their APTCH property.

On this basis, the program has resulted in a positive outcome for 95% of participants.

Approved for circulation to the Public Accounts Committee

Signature: Andrew Barr Date: 31.10.14

By the Minister for Housing, Mr Andrew Barr MLA

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MS BERRY: I was looking at the "A place to call home" initiative. It seems, with small numbers in the ACT, that we should know what is going on with these people that we have been providing some support to. That goes to what I think the minister said earlier about how we measure outcomes as well as inputs. How do we measure the outcomes?

Mr Matthews: My memory—and I have to find the reference in the report—is that within this evidence-gathering stage of this report it does provide some guidance about what the status of the outcomes were for the people in "A place to call home".

MS BERRY: But I was thinking that was 2011 and now it is the end of 2014. I was after what has happened now with those people. If you do not have it now—

Mr Matthews: That information would not be readily available in that there is no data source that would be able to identify those 20 people automatically. We would obviously know who those people are because they have been largely allocated public housing, but it would take some effort to get that material together.

MS BERRY: I just wonder how we then know if these programs have worked if we do not know where these people are now. That is my question. It would be good to know.

Mr Barr: It is a good question. As long as it does not involve huge amounts of time or any invasion of privacy, we will see what we can do to provide the committee with some general information about outcomes post the program.