NSW Ombudsman

The implementation of the *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*

A special report to Parliament under section 31 of the *Ombudsman Act 1974.*

November 2009

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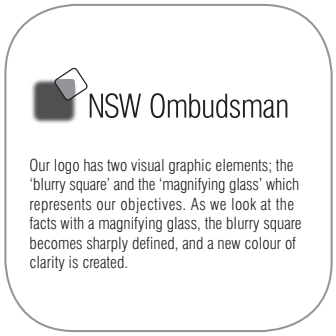

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November 2009

The Hon Peter Primrose MLC
President
Legislative Council
Parliament House
Sydney NSW 2000

The Hon Richard Torbay MP
Speaker
Legislative Assembly
Parliament House
Sydney NSW 2000

Dear Mr President and Mr Speaker

I submit a report pursuant to s.31 of the *Ombudsman Act 1974*. In accordance with the Act, I have provided the Ministers for Housing and Health with a copy of this report.

I draw your attention to the provisions of s.31AA of the *Ombudsman Act 1974* in relation to the tabling of this report and request that you make it public forthwith.

Yours faithfully

Bruce Barbour
Ombudsman

Ombudsman's message

The State Plan commits all government agencies to delivering better services. My office plays a significant role in ensuring services are delivered fairly, efficiently and effectively.

One of the ways my office receives information about the quality of services provided by agencies is through complaints. While complaint-handling will always be a central and important part of the work we do, it is often our pro-active work that is best suited to bringing about systemic and lasting change.

For this reason, it is important that my office from time to time assesses the implementation of key commitments by government agencies – such as those set out in the *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing* (the JGOS).

The JGOS is intended to assist some of the most vulnerable people in our community: people with mental health problems needing assistance to access and sustain social housing. Mental illness has long been recognised as one of the major pathways into homelessness. Both the Federal and NSW governments have recently renewed their commitment to address homelessness, which has far-reaching negative consequences both for the individuals who experience it and for society at large.

In carrying out our investigation into the implementation of the JGOS, my staff worked closely not only with the agencies subject to the investigation – Housing NSW and the Department of Health – but also with other important partners in the JGOS, such as the SAAP sector and Aboriginal health and housing providers.

This report is the culmination of a comprehensive investigative and research process. Our findings and recommendations are informed by extensive consultations, interviews and surveys with over 460 stakeholders. The report focuses on what is needed to make an interagency partnership work effectively in what is undoubtedly one of the most complex and challenging areas facing the human services sector, and proposes a new way forward.

I am pleased with the cooperative approach taken by Housing NSW and the Department of Health to our investigation and their commitment to implement the significant changes we have recommended. I am confident that these changes will enhance the capacity of the social housing system in NSW to better respond to the needs of those members in our community who most depend upon it.

Bruce Barbour
Ombudsman

Contents

Glossary

AH&MRC	Aboriginal Health and Medical Research Council
AHO	Aboriginal Housing Office
AHS	Area Health Service
AHURI	Australian Housing and Urban Research Institute
CAG	NSW Consumer Advisory Group
CHD	Community Housing Division (formerly Office of Community Housing)
CISS	Client Information Sharing Schedule
CLC	Community Legal Centre
COAG	Council of Australian Governments
CPO	Community Programs Officer (DoCS)
CSO	Client Service Officer (Housing NSW)
CTTT	Consumer, Trader and Tenancy Tribunal
DADHC	Department of Ageing, Disability and Home Care
DHASI	Disability Housing and Support Initiative
DHS	Department of Human Services (Vic)
DoCS	Department of Community Services
DPP	Director of Partnerships and Planning (DoCS)
DSP	Disability Support Pension
dual diagnosis	For the purposes of this report, a diagnosis of mental illness and substance abuse, or a diagnosis of mental illness and intellectual disability
HACP	Housing Aboriginal Communities Program
HASI	Housing Accommodation Support Initiative
health worker	A worker employed by an area mental health service
housing worker	A worker employed by Housing NSW or a community housing provider
Housing worker	Capitalised – a worker employed by Housing NSW
HPLS	Homeless Persons' Legal Service
IRG	(JGOS) Implementation Reference Group
JGOS	The Joint Guarantee of Service
JGOS 1	Joint Guarantee of Service – 1st implementation 1997
JGOS 2	Joint Guarantee of Service – 2nd implementation 2003
JHSCC	Justice and Human Service Coordination Committee
MHDAO	Mental Health, Drug and Alcohol Office
MHCC	Mental Health Coordinating Council
MoU	Memorandum of Understanding
NCOSS	NSW Council of Social Services
NGO	Non-government organisation
NOT	Notice of Termination
OCH	Office of Community Housing (now Community Housing Division)
OOH	Office of Housing (Vic)
OPC	Office of Protective Commissioner (now part of NSW Trustee and Public Guardian)
OPG	Office of Public Guardian (now part of NSW Trustee and Public Guardian)
PHaMS	Personal Helpers and Mentors Program
PIAC	Public Interest Advocacy Centre
PRBS	Private Rental Brokerage Scheme
RAHMS	Regional Aboriginal Housing Management Services
RIAG	Rehabilitation Innovation Advisory Group
RCMG	Regional Coordination Management Group
RRSP	Resource and Recovery Services Program
RTRS	Regional Tenant Resource Services

SAAP	Supported Accommodation Assistance Program
SCSO	Senior Client Service Officer (Housing NSW)
SCSOASB	Senior Client Service Officer Antisocial Behaviour (Housing NSW)
SCSOS	Senior Client Service Officer Specialist (Housing NSW)
SEARMS	South Eastern Aboriginal Regional Management Service
SHASP	Social Housing Advocacy and Support Program (Vic)
SIAS	(AHO) Service Improvement and Accreditation System
social housing	An umbrella term that includes public housing, community housing and Aboriginal community housing
SPC	(JGOS) Strategic Partners Committee
SPO	Specific Performance Order
STP	Supported Tenancies Program (SA)
TAAS	Tenants Advice and Advocacy Service
ToR	Terms of Reference
TPRS	Tenant Participation Resource Services

Executive summary

The *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing* (JGOS) was developed in recognition that people with mental health problems frequently experience difficulties accessing housing, disruption to tenancies and reduced capacity to maintain housing. For these reasons, mental illness has been identified as one of the typical pathways into homelessness.[1]

Existing in one form or another since 1997, the JGOS aims to coordinate the delivery of services to people with mental health problems and disorders who have ongoing support needs living in social housing.

This report details the findings of a comprehensive, 18 month investigation into the implementation of the JGOS. The agencies which are the subject of the investigation are Housing NSW (Housing) and the NSW Department of Health (Health), the two original signatories to the JGOS.

The JGOS in context

Currently, there are more than 1.1 million people living with mental health disorders in NSW.[2] In 2006 there were 27,374 homeless people in NSW (42 per 10,000 of population), with the rate of homelessness higher in regional areas than in Sydney.[3] Many homeless people rely on temporary accommodation and assistance provided by the Supported Accommodation Assistance Program (SAAP). Data collected by the Australian Institute of Health and Welfare suggests that, nationally, SAAP services are operating to full capacity. In 2007–2008, there were 1,740 unmet requests for SAAP accommodation in NSW.[4]

While it is difficult to reliably estimate the number of people living in social housing who have a mental health problem, research indicates the concentration is high.[5] Social housing tenants are in a vulnerable position because of the limited housing options they have if they lose their tenancy. In the decade to 2006, average house prices relative to income almost doubled; the proportion of low-rent homes fell by at least 15%; and opportunities to rent public housing fell by at least 30%.[6]

However, it is important to note the significant recent injection of funding for public housing as part of the Federal Government's Nation Building Economic Stimulus Plan and the Social Housing Growth Fund under the National Partnership Agreement on Social Housing.[7] The NSW Government has committed to deliver an extra 9,000 properties – 75% of them by December 2010 – as a result of $2 billion provided under the stimulus plan and an additional $1 billion from state funds.[8]

Recent policy developments

The social housing landscape in NSW has changed considerably since the JGOS was introduced. The 'Reshaping Public Housing' reforms are largely responsible for this change. Introduced in 2005, the reforms established a new public housing allocation model based on the principle of strongest housing need. This has led to an increased number of tenants in public housing with complex support needs.

As a result, the *Housing and Human Services Accord*, a formal agreement between Housing NSW and all human services agencies to assist social housing clients with support needs, was developed in 2007.[9] Housing NSW has also developed a range of additional products aimed at assisting disadvantaged people to find and sustain housing in the private rental market, such as the Private Rental Brokerage Service which is now operating in 15 locations across NSW.

Since the JGOS was introduced, there has also been an increase in the availability of programs designed to provide accommodation support to people with mental illness and delivered by non-government organisations, most notably the Housing Accommodation Support Initiative (HASI).

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1 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
2 NSW Health, *NSW Community Mental Health Strategy 2007–2012*, May 2008, p3.
3 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
4 Australian Institute of Health and Welfare, *Demand for SAAP accommodation by homeless people 2007–08*, May 2009.
5 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p5.
6 National Affordable Housing Forum, *Achieving a National Affordable Housing Agreement, Background Paper 1: A National Approach to a National Problem*, July 2006, p2.
7 The Social Housing Growth Fund 'aims to increase the supply of social housing and provide increased opportunities for people who are homeless or at risk of homelessness to access secure, long-term accommodation'. Housing NSW, response to provisional report, 20 May 2009.
8 Mr Nathan Rees, Premier, NSW Parliament Legislative Assembly, 4 June 2009.
9 The signatories to the Accord are: Aboriginal Housing Office; Attorney General's Department; Department of Ageing, Disability and Home Care; Department of Community Services; Department of Corrective Services; Department of Education and Training; Department of Housing; Department of Juvenile Justice; NSW Health and NSW Police.

Jointly funded by Housing and Health, HASI is a partnership between both agencies and non-government organisations that links stable accommodation with support for people with mental health problems and disorders. At the time of writing, the program has over 1,000 places across NSW.[10] HASI has been found to be successful in reducing the deleterious effects of mental illness for many of its participants and enabling the vast majority of participants to maintain a stable tenancy.[11]

Together with HASI, the introduction of other programs providing support to people with a mental illness, such as the Personal Helpers and Mentors Scheme (PHaMS), has significantly increased the number of non-government agencies active in providing support to people with mental illness in NSW. Although non-government agencies have always played a role, the extent to which these agencies have emerged as key service providers and interagency partners in the area of mental health is unprecedented and one of the most significant changes to have taken place since the JGOS was implemented.

Finally, governments across Australia are increasingly focusing on the community housing sector as an accommodation option for individuals in need of social housing.[12] Currently, there are about 14,000 properties under community housing management in NSW.[13] It is envisaged that an additional 5,000 properties will be transferred to the sector over the next 10 years.[14]

Why we investigated

A number of factors coalesced to inform our decision to investigate the implementation of the JGOS. In 2006 we investigated a complaint in relation to the eviction of a long-term public housing tenant whose lease was terminated due to rental arrears, despite NSW Housing workers being aware of his chronic mental illness. The tenant sustained serious injuries after a struggle ensued when police accompanied Housing staff to his premises to carry out the eviction.

Our investigation found that local Housing staff did not follow appropriate procedures for dealing with tenants who have known mental health problems. In particular, the investigation revealed a limited awareness by staff of the JGOS. Our inquiries also suggested that the JGOS was not being consistently implemented across the state.

While Housing initiated a number of changes aimed at ameliorating the deficiencies we identified through our 2006 investigation, our decision to commence a separate investigation examining the implementation of the JGOS was influenced by other information from complaints and inquiries to our office and representations by the community sector. Most significantly, in 2007, the SAAP sector – in response to a report we commissioned about compliance with the recommendations of our 2004 special report to Parliament, *Assisting homeless people* – expressed significant dissatisfaction with the JGOS, reporting inadequate engagement with and support by mental health services, and little benefit for their clients.

How we investigated

During the course of the investigation we travelled to 25 metropolitan and regional locations throughout the state, consulting over 460 people with experience of working with existing or potential social housing tenants with mental health problems, including managers and frontline staff from the JGOS strategic partner agencies and other local partners. In selecting the locations we visited, we had regard to information provided to us by Housing, Health and peak bodies, which included their observations about areas where the JGOS was functioning well in addition to those that were struggling to implement the JGOS. This allowed us to appreciate the issues and challenges associated with the implementation of the JGOS and to directly assess how it has impacted on the way that people do their work.

Our consultations focused on issues including awareness and knowledge of the JGOS, practical implementation of the JGOS principles at a local level, governance and performance measurement. We were particularly keen to explore the level of involvement in the JGOS by Aboriginal organisations and the SAAP sector, including the efforts made by Housing and Health to engage both sectors, how the sectors responded to these efforts and the sectors' views about their involvement in the JGOS.

We also wanted to test some of the early perceptions of the JGOS reported to us by some stakeholders prior to commencing our investigation. For example, we were told that in the eyes of many people, the JGOS had become 'a tarnished brand' and that the introduction of the *Housing and Human Services Accord* and HASI had diminished

10 NSW Health, 'Housing and Accommodation Support Initiative mental health program extended', media release, 6 March 2008.
11 Kristy Muir, 'Housing support for people with a mental illness', *Social Policy Research Centre Newsletter*, No.98, March 2008, p1.
12 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p4.
13 Australian Institute of Health and Welfare, *Community Housing 2006–07: Commonwealth State Housing Agreement National Data Report*, January 2008.
14 Office of Community Housing, *eNews*, August 2008, p3.

the relevance of the JGOS. In addition, we were keen to explore what changes may be required to better equip workers to deliver responsive services in the context of the changed public housing demographic ushered in by the 'Reshaping Public Housing' reforms.

Based on our review of information we required from Housing and Health, we had concerns early in our investigation that the governance arrangements at each level of the JGOS may not have been operating effectively. During our consultations, we sought to identify what types of strategic direction and support local partners needed from the JGOS strategic partners and how the partners could best support their frontline workers to apply the JGOS principles as part of their everyday work.

Early in our investigation, Housing acknowledged that they were not systematically capturing data in relation to JGOS outcomes for clients. For this reason, we decided to examine how JGOS work was being measured at a local level, both by Housing and other JGOS partners. We were also interested in identifying any systemic issues that were negatively impacting on the implementation of the JGOS at the local level and what steps had been taken to address them.

What we found

While we found evidence of good work to implement the JGOS principles in some areas and a large number of committed individuals who are passionate about improving the social outcomes of people living with mental illness, we found little evidence to demonstrate that the JGOS is achieving systemic improvements and were unable to conclude that the overall implementation of the JGOS has been effective.

Our investigation revealed that the implementation of the JGOS has been patchy and inconsistent. In particular, it revealed a low level of participation by several of the local partners that the JGOS was widened to include in 2003, most notably SAAP and Aboriginal housing and health providers. It was overwhelmingly clear that the JGOS was not meeting their needs.

We identified several weaknesses in the JGOS agreement and governance arrangements, including inconsistencies and a lack of accountability mechanisms and systems to support the effective implementation of the JGOS. We identified four key areas that would need to be addressed should the agencies decide to maintain the JGOS: the JGOS agreement and resources; the practical implementation of the JGOS; systemic issues that have impacted on implementation; and the JGOS governance and accountability arrangements.

What we recommended

We made a number of recommendations in our provisional report aimed at strengthening the JGOS – these are included at Appendix 1.

However, in light of the significant changes to the social housing landscape since the JGOS was introduced, our provisional report to Housing and Health recommended that the *Housing and Human Services Accord* should become the primary governance model by which human service agencies implement their responsibilities to plan, coordinate and deliver services to clients who need support to access and sustain social housing, whilst incorporating the JGOS principles. This will enable a more coherent, systemic response to the range of complex support needs with which social housing applicants and tenants now commonly present.

We stressed the importance of incorporating the JGOS principles into the Accord framework and recommended the adoption of a supportive tenancy management approach, including the development of a risk assessment screening tool, the adoption of an early intervention approach to sustaining tenancies, the provision of a tenancy support program, and the collection of relevant data and performance indicators. This approach requires the support and involvement of the health and human services sectors and needs to be embedded in the social housing system rather than superimposed on an existing way of doing business. Its adoption is required for the Accord to fully realise its aims.

In response, Housing and Health expressed strong support for reviewing the JGOS and building on the Accord.[15] To this end, the agencies have committed to develop a new Housing and Mental Health Agreement under the Accord to 'guide the coordinated delivery of mental health, support and housing services [and] provide a consistent operating framework for each agency to work collaboratively, including the development of consistent governance and accountability frameworks, operating processes and data collection, and reporting and monitoring.'[16] Both Housing and Health expressed support for a supportive tenancy management approach.[17]

15 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.
16 Housing NSW, response to provisional report, 20 May 2009.
17 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.

In developing and implementing the new Agreement, it will be critical that consideration is given to the recommendations made in our provisional report about the changes that would have been required to strengthen the JGOS had the agencies decided to maintain it. These recommendations –which are summarised in the 'key lessons' from the JGOS outlined below – are relevant to any collaborative model which is aimed at supporting clients to access and sustain social housing.

JGOS agreement and resources

One of the weaknesses of the JGOS was that the documentation establishing it did not support effective implementation. The Guidelines to support the agreement did not provide adequate practical guidance for frontline workers or sufficient detail about governance arrangements and therefore generated confusion. While it was envisaged that additional information would be provided in a separate 'resource kit', this did not eventuate until four years after the JGOS was launched. The outcome was a variety of entrenched practices which were not necessarily productive and multiple, inconsistent documents that provided neither clarity nor strategic direction.

The Housing and Mental Health Agreement should be supported by one document that provides clear guidance about how staff from partner agencies should meet the objectives of that approach, the type of results they should be achieving and how they will be held to account. The document must be negotiated between all partners to ensure it meets the needs of all parties. It is also important that the aims and objectives of the new approach are explicitly reflected in each partner agency's internal policies and procedures. This was an area that was lacking in relation to the JGOS. It resulted in the JGOS operating as an isolated policy document rather than as a framework with consequences for how the overall business of the partners should be approached.

Finally, when a significant policy or framework is released with the expectation that this will change the way that staff approach their work, it is critical that it be supported by a timely strategy to promote awareness and training about the practical business implications.

Governance

Like the documentation, the JGOS governance model appeared to unfold over time. For example, the original Guidelines did not refer to the existence of a Strategic Partners Committee (SPC) or Implementation Reference Group (IRG). They were also unclear about how the various types of meetings/committees would function in relation to each other.

While on the surface there does not appear to be anything wrong with the governance arrangements that evolved (local and area committees supported by an IRG and SPC) or the committees' terms of reference, what was lacking was proper consideration of how the committee layers would interact in a practical sense. For example, there was no adequate mechanism for local or area committees to report their work or concerns to the SPC and for the SPC to report back to them. This was due in part because there was no methodical area/regional representation on the IRG. The relevant peak bodies, which are best placed to report on the concerns of their members, were unable to do so effectively because they were represented on the IRG rather than the SPC and these two committees did not, in their view, interact in a productive way.

The governance of the JGOS was also weakened by the lack of strategic direction about what each of the partners should achieve in order to give effect to the JGOS principles, and productive ways to go about doing this. Our investigation revealed that although a number of local and area/regional committees were genuinely trying to meet the JGOS aims, they felt hampered by a lack of guidance about how to do this. These committees wanted to 'benchmark' their work, while ensuring they were not expending unnecessary effort attempting to find solutions to problems that others had already solved.

In developing the Housing and Mental Health Agreement, the partners will need to ensure that the governance arrangements involve all participants having a clear sense of what their responsibilities are – both at a direct service delivery level and in relation to the partnership arrangement itself. In order to achieve this, all partners need to be meaningfully consulted about the type of mechanisms required to facilitate the partnership at each level.

Accountability

It would also appear that inadequate consideration was given at the outset to how the partners would demonstrate they were achieving the JGOS aims, that is, how an evidence base would be built. Our investigation found that neither Housing, nor Health, nor any of the other partners were systematically capturing information about what

results were being achieved through the JGOS process or the nature of any impediments to achieving them. This was because the agencies did not appear to have factored in the systems needed to identify the clients the JGOS aims to assist and monitor results. Moreover, it is not clear that they ascribed responsibility to certain staff positions for making sure it occurred. Therefore, the agencies were not well placed to demonstrate that the implementation of the JGOS was effective.

In the absence of changes to the operational systems and procedures of partner agencies to give effect to any policy – including the Housing and Mental Health Agreement – it will always be difficult to implement it and for people to see the results.

Building on the Accord

The Housing and Human Services Accord has the buy-in of all major human services agencies, recognises the importance of the NGO sector and has designated coordinator positions. It reflects the new circumstances in which social housing is delivered by recognising that social housing clients will have a range of support needs and that all human service agencies have a shared responsibility to assist them to establish and sustain tenancies.

In response to our provisional report, Housing and Health advised us that:

> *The integration of the JGOS and other housing and mental health agreements into the Housing and Mental Health Agreement under the Accord framework will provide an opportunity to utilise and build on the Accord and enhance the provision of housing and support services for people with a mental illness.*[18]

Housing and Health agreed that in developing the Housing and Mental Health Agreement and reviewing the Accord framework, they will take into account our observations and preliminary recommendations about the implementation of the JGOS with particular regard to the JGOS agreement and resources, governance and accountability.

In our view, one of the main reasons the implementation of the JGOS has been largely unsuccessful is because it was imposed on existing organisational structures that were not set up to deliver what the JGOS promised. For the approach we have outlined to be successful, it is critical that this does not happen again.

In this regard, the adoption of a supportive tenancy management approach is vital. However, to assist clients to sustain their tenancies, social housing providers require the help of others within the health and broader human services sectors. Based on our consultations, housing workers often feel they shoulder the burden of vulnerable tenancies. They experience frustration and disillusionment when the assistance they need to carry out their responsibility to sustain tenancies is not forthcoming. Often, they also feel unfairly blamed when tenancies do fail.

Like social housing providers, other agencies and services should be able to demonstrate how they contribute to sustaining tenancies. To do this, an agreed set of indicators should be developed.

Even where support is forthcoming from other agencies and services, however, housing workers can find it difficult to negotiate the service sector. Identifying relevant service providers, making and following-up referrals and coordinating the actual provision of support can be complex and time consuming.

In some jurisdictions, tenancy support programs have been introduced to streamline the provision of support to clients whose tenancies are identified as being at risk. These programs involve housing workers identifying people whose tenancy may be at risk and referring them to a specialist service that can help to develop a plan of action and refer tenants to another service as needed. Under the National Partnership on Homelessness agreed to by COAG, state and territory governments will be encouraged to develop expanded tenancy support models to help people sustain their tenancies.[19] We have suggested that the Department of Health and Department of Human Services consider establishing a tenancy support program as part of a broader supportive tenancy management approach.

Our investigation revealed three major systemic issues that negatively impacted on the effective implementation of the JGOS: discharge planning, training and development and exchanging information. Unless the problems we identified in relation to these issues are addressed, the success of the Housing and Mental Health Agreement will be similarly undermined. We have therefore made recommendations aimed at avoiding this.

In particular, we have recommended changes to promote a more consistent and accountable approach to discharge planning by area health services for mental health clients who have been hospitalised. We have also recommended consideration of legislative amendment to allow for information to be exchanged by agencies without consent in a broader range of circumstances where the well-being, health or safety of a person is at risk.

18 Housing NSW, response to provisional report, 20 May 2009. Health provided similar advice (NSW Department of Health, response to provisional report, 29 May 2009).

19 Australian Government, *The Road Home: A National Approach to Reducing Homelessness*, White Paper, December 2008.

To ensure the success of the approach we have outlined, it is critical that it is implemented in a way that is consistent with the Federal Government's reform agenda to reduce homelessness. The reforms require all states and territories to develop implementation plans setting out how they will achieve the objectives outlined in the December 2008 White Paper. In August 2009 the NSW Government released the NS*W Homelessness Action Plan 2009–2014*, which incorporates NSW's implementation plan.[20] To be effective, the Accord governance arrangements and planning processes will need to be closely aligned with the contribution of NSW to the national response to homelessness. Housing and Health have recognised this.

Finally, it became apparent during our investigation that there are serious implications arising from the significant shortage of supported accommodation for people with mental health problems. In this regard, a consistent theme to emerge from our consultations was strong support for a substantial increase in the number of HASI places across NSW. We note the recent report of the Mental Health Council of Australia which found that while there are still some areas that need to be developed in relation to the delivery of HASI, the quality of the service it provides is 'excellent'. However, it also found that there are not enough places in the program to accommodate existing needs.[21]

About this report

This report is comprised of three parts. Part 1 outlines the background to our investigation and the methods we employed to conduct it. Part 2 summarises the findings of our investigation and outlines the changes that were needed to strengthen the JGOS had the agencies decided to maintain it.

In Part 3 we explain the basis for our recommendation that the Accord become the primary governance model by which agencies implement their responsibilities in relation to clients who need support to access and sustain social housing. We also outline the critical components of the supportive tenancy management approach that we suggest should be adopted.

Our work in this important area will continue after the tabling of this special report. We will closely monitor the development of the Housing and Mental Health Agreement and the implementation of the recommendations we have made.

20 NSW Government, *A Way Home: Reducing Homelessness in NSW*, *NSW Homelessness Action Plan 2009–2014*, August 2009.
21 Mental Health Council of Australia, *Home Truths: Mental Health, Housing and Homelessness in Australia*, March 2009, p44.

Part 1: The JGOS in context

The JGOS was developed because it was recognised that there was a need for a coordinated approach to the provision of social housing and mental health services. In Chapter 1 we discuss the link between housing and mental health and the reasons why people with mental illness may experience housing vulnerability. We then outline what the JGOS involves before moving on to consider the context in which it currently operates and the policy developments that have taken place since the JGOS was introduced.

Chapter 2 outlines the direct background to our investigation and examines the methodology we used to conduct it.

Chapter 1.
Background to our investigation

1.1. The link between housing and mental health

Mental illness has been identified as one of the typical pathways into homelessness.[22] The 1993 Burdekin Report on *Human Rights and Mental Illness* documented the importance of adequate, affordable and secure housing for people with a mental illness, and the consequences when such housing cannot be accessed or sustained.[23] People with a mental illness can manifest a range of psychiatric disabilities[24] that may make it more difficult to access and sustain stable housing.[25] Misunderstanding of mental illness and the resulting discrimination, stigma and fear in the broader community can compound these difficulties.[26]

A distinguishing characteristic of psychiatric disabilities arising from mental illness compared to other disabilities is their tendency to be episodic and to fluctuate in intensity and duration.[27] Maintaining housing can be particularly challenging during very disabling periods, the timing and duration of which are often unpredictable.[28] Nonetheless, there is substantial research which indicates that with appropriate support, people with mental illness can maintain stable housing.[29] The research also demonstrates that stable housing can result in reduction in hospitalisation rates, increased functioning, increased independence and improved quality of life.[30] Conversely, the social and health costs of homelessness, particularly iterative homelessness, are significant.[31]

In addition to, and sometimes as a consequence of, the psychiatric disabilities that can be associated with a mental illness, people can be socially isolated, in poor physical health and living in poverty – factors that may further impede their access to housing and/or their ability to sustain a tenancy.[32] The nature of their psychiatric disability combined with the presence of these indicators of social disadvantage means that for many people, social housing is the only realistic means of obtaining affordable, stable accommodation.

1.2. Access to social housing for people with mental illness

Research and anecdotal evidence suggests that there remain barriers to accessing social housing for people with a mental illness.[33] It is known that people experiencing mental illness may need assistance with the practical aspects of applying for housing, as well as moving and settling in.[34] The mental illness and/or resultant psychiatric disability can affect basic abilities, such as completing an application form.[35] A recent Australian survey of people living with a mental illness found that of 372 respondents, almost 90% had applied for public housing but reported that 'the complexity of applying for public housing had created difficulties for them'.[36]

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22 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
23 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of National Inquiry into the Human Rights of People with Mental Illness* (Burdekin Report), 1993.
24 'Psychiatric disability is a consequence of mental illness; that is, the behavioural changes that can affect daily living' (Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, p5).
25 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, pp5–6; Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, pp5–6.
26 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p6.
27 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, pp9–10.
28 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p6.
29 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p6.
30 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, p4.
31 Australian Government, *Which way home? A new approach to homelessness*, Green Paper, May 2008.
32 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p5.
33 Homeless Persons' Legal Service (Chris Hartley and Elisabeth Baraka), *Housing the homeless a priority? HPLS Submission to the Joint Guarantee of Service inquiry*, July 2008.
34 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, p33.
35 Australian Housing and Urban Research Institute, 'Improving housing and support service coordination for people living with mental illness', *Research and Policy Bulletin*, Issue 7, May 2002.
36 SANE Research, *Housing and mental illness*, Research Bulletin 7, July 2008.

People with a mental illness are known to be over-represented amongst the homeless population.[37] In a submission to us, the Homeless Persons' Legal Service (HPLS) has stated that people who are homeless may experience difficulty responding to an offer of housing from Housing NSW, because the offer is communicated to them in a letter and they are required to respond within two days of the letter's date of issue.[38] The submission also advises that the HPLS:

> *has become aware of numerous cases in which long-term homeless people with severe mental health problems have had their priority housing applications rejected on the basis that they can, according to the assessment by* [NSW Housing]*, resolve their housing needs in the private rental market. All of these clients have significant mental illnesses and Centrelink payments are their only form of income.*[39]

The Office of the Public Guardian also told us that their clients, who can include people with a dual diagnosis of mental illness and intellectual disability, may find it difficult to understand and respond to correspondence.[40]

1.3. What puts the tenancies of people with mental illness at risk?

People with mental illness are recognised as a group particularly vulnerable to tenancy failure.[41] As noted above, the nature of a person's mental illness may cause a range of psychiatric disabilities such as memory loss, anxiety, phobias, depression or hallucinations.[42] These may in turn create difficulties that threaten a person's ability to retain their housing, including:

- inability to perform daily living tasks, such as paying rent
- difficulty interacting with neighbours
- problems with property maintenance
- vulnerability to negative peer influence
- periods of instability due to medication problems or hospitalisation.[43]

While eviction is often regarded as the only way by which tenancies fail, property abandonment may also take place. This may occur because of the presence of psychiatric disabilities, such as delusional behaviour,[44] or in response to the housing provider initiating action in response to a tenancy breach.[45]

Not all people with a mental illness choose to disclose their illness to housing providers. This can limit the ability of providers to respond effectively to any problems that may arise as a result of psychiatric disabilities associated with the illness.[46] There are also individuals who are not able or willing to acknowledge their psychiatric disabilities, or the risk these may present to their ability to sustain a tenancy. These people are unlikely to accept support. This can place real limits on the capacity of housing providers and other services to respond effectively if problems arise that place an individual's tenancy at risk.

Individuals at risk of tenancy failure are vulnerable because of the limited housing options they have if they lose their tenancy, and the other consequences that tenancy loss brings. They may become homeless, or have to move to unsafe or other forms of inappropriate housing. They may lose possessions, and supports previously in place.[47]

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37 Australian Institute of Health and Welfare, *Homeless SAAP clients with mental health and substance use problems 2004–05*, March 2007.

38 The HPLS goes on to state: 'While the Department has indicated in discussions with HPLS that a person may still be able to be placed in accommodation if they contact the Department after the two days have elapsed, this is not communicated by the Department to the recipient of the letter and the likelihood of a homeless person feeling confident enough to pursue the offer after the time limit has elapsed is extremely slim'. Homeless Persons' Legal Service (Chris Hartley and Elisabeth Baraka), *Housing the homeless a priority? HLPS Submission to the Joint Guarantee of Service inquiry*, July 2008, p3.

39 Homeless Persons' Legal Service (Chris Hartley and Elisabeth Baraka), *Housing the homeless a priority? HLPS Submission to the Joint Guarantee of Service inquiry*, July 2008, p1.

40 Meeting with Office of the Public Guardian, September 2008.

41 Daphne Habibis, Rowland Atkinson, Terry Dunbar, Dan Goss, Hazel Easthope and Paul Maginn, for the Australian Housing and Urban Research Institute, *A sustaining tenancies approach to managing demanding behaviour in public housing: a good practice guide*, July 2007, p2; Victorian Department of Human Services, *Support for High-Risk Tenancies Final Report*, October 2006; Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies at risk*, presentation to Housing Futures: National Housing Conference, Adelaide, November 2003.

42 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p10.

43 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, p49; Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p10.

44 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p10.

45 Flatau et al cite research by Beer et al showing that many tenancies end without any recourse to courts or tribunals because tenants tend to pre-empt disputes by leaving when problems arise or are anticipated. (Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p7).

46 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p10.

47 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p7.

Indigenous tenants face a much higher risk of eviction than non-Indigenous tenants.[48] 'Moreover, Indigenous people are more likely to live in regional or remote areas where there may be limited availability of support services to assist people to address the problems placing their tenancies at risk'.[49] In addition to the usually-cited risk factors, research has indicated that Indigenous people may encounter culturally-specific impediments in accessing and sustaining tenancies.[50] Indigenous homelessness has been estimated at three times the rate for other Australians.[51] In 2006, while Indigenous people comprised 2.4% of the national population, they were 9% of the homeless population.[52]

In Australia, research on how best to sustain tenancies at risk has tended to emphasise the importance of social housing providers adopting an explicit 'sustaining tenancies' approach, key elements of which are the identification of risk and early intervention. In Part 3 we discuss this approach in detail, including the implementation of tenancy support programs operating in other states.

1.4. The Joint Guarantee of Service

The JGOS is a collaborative, interagency framework aimed at better assisting and enhancing the wellbeing of existing social housing tenants with a mental health problem whose tenancy may otherwise be at risk, and assisting people with a mental health problem who may be homeless or at risk of homelessness to successfully establish a tenancy.

1.4.1. 'JGOS 1'

The first Joint Guarantee of Service ('JGOS 1') for people with mental illness was signed by the respective Directors General on behalf of the (then) Department of Housing and the Department of Health in September 1997, following the completion of a brief research project commissioned by Health.[53] It was initiated in recognition of the linkages between housing and mental health and the need for both organisations to work together at a local level for the benefit of mutual clients affected by mental illness. JGOS 1 required area health services and housing regions to formally agree to a set of principles aimed at achieving coordinated service provision.

A preliminary review of JGOS 1 was completed by the Department of Health in February 1999. The review found that all area health services and housing regions had commenced the process of implementation, and reached different stages of development. It was also found that there were well-developed partnerships in some areas that included health, housing and non-government agencies providing tenancy support services.[54]

To address issues raised by the review, a Housing and Mental Health Steering Committee was established with members from the (then) Department of Housing and Office of Community Housing, the Department of Health, the Mental Health Coordinating Council and the NSW Consumer Advisory Group. The committee was tasked with developing practical strategies to assist the further implementation of the JGOS, as well as reviewing and advising on local implementation plans as requested. In 2002, Health conducted a further review of JGOS 1, leading to the establishment of a multi-agency working group and the development of a new, expanded JGOS ('JGOS 2').

1.4.2. 'JGOS 2'

The second and current Joint Guarantee of Service ('JGOS 2') for people with mental health problems and disorders living in Aboriginal, community and public housing was signed in April 2003 and included additional government and non-government agencies. At a state-wide level, the Aboriginal Housing Office (AHO), the Aboriginal Health and Medical Research Council (AH&MRC) and the Department of Community Services (DoCS – on behalf of the Supported Accommodation Assistance Program – SAAP) became JGOS strategic partners in addition to Housing and Health. The AHO works in partnership with Aboriginal community housing providers and Housing NSW to deliver housing and develop housing policies and standards. The AH&MRC is the peak body for Aboriginal community controlled health services (hereafter referred to as 'Aboriginal medical services') in NSW. DoCS administers the SAAP in NSW.

48 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p4.
49 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p8.
50 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p9.
51 Australian Government, *Which Way Home? A New Approach To Homelessness*, Green Paper, May 2008, p21.
52 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
53 Wendy Weir, *Housing and Supported Accommodation Strategies for People Seriously Affected by Mental Illness*, report on project commissioned by the Centre for Mental Health, NSW Department of Health, September 1997.
54 NSW Department of Housing and Centre for Mental Health, NSW Department of Health, *Preliminary Review of the Housing and Health Joint Guarantee of Service for People with a Mental Illness*, February 1999.

At a local level, individual SAAP service providers, community and Aboriginal housing providers, Aboriginal medical services and other non-government organisations were invited to become party to the JGOS by signing local memoranda of understanding.

JGOS 2 describes itself variously as 'a broad inclusive strategy', 'a framework' and 'a synthesis of best practice'.[55] Essentially, it outlines the roles and responsibilities of the participating agencies in maintaining the coordination of planning, evaluation and services to people with mental health problems and disorders who need social housing and have ongoing support needs. Agencies are expected to commit 'adequate resources … from those available'[56] to achieve this, and to do so based on a shared understanding of their respective roles and responsibilities.

At a local level, the JGOS commits representatives from social housing providers, DoCS' Area Partnerships and Planning Team, SAAP service providers, the Area Mental Health Service and individual Aboriginal medical services to meet 'as needed', and at a minimum of once every three months, to address common issues; maintain an effective working relationship; exchange information; and plan joint action on issues requiring a coordinated service approach.

In addition, housing workers should attempt to resolve any tenancy problems that arise. If in the course of doing so, a mental health problem is identified as a contributing factor, assistance should be sought from the individual's health provider or the area mental health service and where appropriate, a 'joint service meeting' convened. For housing applicants or those individuals needing SAAP assistance in circumstances where an area mental health service supports the application, the JGOS requires the mental health service to provide sufficient information to enable the housing/SAAP worker to effectively assess the individual's support needs. The JGOS also requires the mental health service to endeavour to support the individual through the application process.

In addition to a formal Memorandum of Understanding (MoU) between the signatories (Part 1), JGOS 2 includes supporting Guidelines (Part 2) and resources to support local implementation; these are described in Chapter 3. To oversee the implementation and review of JGOS 2, a Strategic Partners Committee (SPC) and an Implementation Reference Group (IRG) were established. The SPC includes representatives of the statewide signatories to the JGOS, while the IRG has a broader membership including representatives from relevant peak bodies. Secretariat support is provided to the SPC and IRG by an officer within the Homelessness Unit of Housing NSW. The SPC and IRG are discussed in more detail in Chapter 5.

1.5. The context in which the JGOS currently operates

It is useful to understand the environment in which the JGOS operates, including the prevalence of mental illness and homelessness and their impact on the SAAP sector, and the availability of affordable accommodation and supported housing.

1.5.1. Prevalence of mental illness

Currently, NSW has over 1.1 million people living with mental health disorders. An estimated 250,000 are children and adolescents, while another 120,000 are aged 65 years and over. People aged between 18 and 64 years constitute the majority (760,000) living with mental disorders.[57] It is estimated that over half of all new presentations to mental health services have substance abuse problems as well as mental illness.[58]

It is difficult to reliably estimate the proportion of people living in social housing who have a mental illness. However, research indicates there are high concentrations in social housing.[59] In 2006–2007 there were 120,516 public housing tenancies in NSW. Of these, 30% of tenants received the Disability Support Pension (DSP), the most common source of income for tenants overall.[60] Nationally, in 2005, psychological or psychiatric conditions were the second most common reason for people receiving the DSP (26%).[61]

The available data indicate that Indigenous Australians suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community.[62]

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55 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, pp3–4.
56 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p9.
57 NSW Health, *NSW Community Mental Health Strategy 2007–2012*, May 2008, p3.
58 NSW Health, *NSW Community Mental Health Strategy 2007–2012*, May 2008, p3.
59 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p5.
60 Housing NSW, *2006–07 Annual Report*, 2007.
61 Australian Government Department of Employment and Workplace Relations, *Characteristics of Disability Support Pension Recipients*, June 2005.
62 Australian Institute of Health and Welfare, www.aihw.gov.au/indigenous/health/mental.cfm. Accessed 16 September 2008; NSW Health, *Aboriginal Mental Health and Well Being Policy 2006–2010*, July 2007.

1.5.2. Availability of affordable housing and supported accommodation

Social housing tenants are in a vulnerable position because of the limited housing options they have if they lose their tenancy. At the time of writing, this vulnerability is heightened due to a well documented shortage of affordable housing. In the decade to 2006 average house prices relative to income almost doubled; the proportion of low-rent homes fell by at least 15%, and opportunities to rent public housing fell by at least 30%.[63] In 2005–2006, NSW had the highest average weekly housing costs, with housing in Sydney costing 64% more than in the rest of the state.[64] High housing costs are both a partial result of and compounded by a low rental vacancy rate. In June 2008 for example, the rental vacancy rate for Sydney was estimated to be approximately 2.9%. A healthy rental market would usually have a vacancy rate of 5–6%.[65]

The recent Senate inquiry into mental health services in Australia noted that together with affordable housing, supported accommodation is a 'keystone' to furthering efforts towards improving mental health outcomes.[66] Based on evidence provided to the Senate Committee, it found there is a significant shortage of supported accommodation for people with a mental illness, concluding that this shortage is 'a major gap in the community-based care currently available'.[67] As a result the committee recommended that all state and territory governments 'substantially increase funding to establish more long-term, step-up and step-down community-based accommodation for people with mental illness that is linked with clinical and psycho-social supports'.[68]

1.5.3. Prevalence of homelessness

The rate of homelessness in Australia has remained more or less consistent since 2001, with some changes in the different sections of the homeless population. For example, there has been a significant increase (17%) in the number of homeless families, and a decrease (21%) in the number of young homeless people. In 2006 single people over the age of 19 were the largest sub-group of the homeless population, and 56% were male. In 2006 there were 27,374 homeless people in NSW (42 per 10,000 of population), with the rate of homelessness higher in regional areas than in Sydney. On Census night, 40% were staying with friends or family, 28% were living in boarding houses, and 19% were in SAAP accommodation.[69]

1.5.4. Increased support provided by SAAP services

In 2003–2004, SAAP services in NSW provided support to 25,050 clients.[70] By 2006–2007 this number had increased by almost 28% to 31,850 clients.[71] The Australian Bureau of Statistics attributes this increase to an increase in SAAP services.[72] Regardless of the reason, data collected by the Australian Institute of Health and Welfare suggests that, nationally, SAAP services are operating to full capacity. In 2007–2008, there were 1,740 unmet requests for SAAP accommodation in NSW.[73]

SAAP services have reported an increase in the complex mix of health, behavioural, social and psychological problems with which their clients present.[74] In 2004, around 12% of SAAP clients nationally reported a mental health problem, and approximately 19% reported a substance abuse problem. About 5% of clients reported have both a mental health and substance abuse problem ('co-morbidity').[75]

The current SAAP funding agreement (SAAP V) commenced in October 2005. DoCS, which administers the SAAP program in NSW, criticised the (then) Federal Government's decision not to provide any growth funding under SAAP V, citing an independent evaluation of SAAP IV which found that a minimum 15% increase in funding was required to maintain existing services in their current form.[76] The SAAP sector in NSW has argued that services are operating under high pressure and are unable to meet demand as a result of:

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63 National Affordable Housing Forum, *Achieving a National Affordable Housing Agreement, Background Paper 1*: *A National Approach to a National Problem*, July 2006, p2.
64 Australian Bureau of Statistics, *Housing Occupancy and Costs Australia 2005–06*, October 2007.
65 Sunanda Creagh, 'Rental shortage hyped up: researcher', *Sydney Morning Herald*, 7 June 2008.
66 Australian Parliament, Senate Standing Committee on Community Affairs, *Towards recovery: mental health services in Australia*, September 2008, pxii.
67 Australian Parliament, Senate Standing Committee on Community Affairs, *Towards recovery: mental health services in Australia*, September 2008, p113.
68 Australian Parliament, Senate Standing Committee on Community Affairs, *Towards recovery: mental health services in Australia*, September 2008, p116 (Recommendation 16).
69 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
70 Australian Institute of Health and Welfare, *Homeless people in SAAP: SAAP National Data Collection Annual Report 2003–04*, 2005.
71 Australian Institute of Health and Welfare, *Homeless people in SAAP: SAAP National Data Collection Annual Report 2006–07,* 2008.
72 Australian Bureau of Statistics, *Counting the Homeless 2006*, September 2008.
73 Australian Institute of Health and Welfare, *Demand for SAAP accommodation by homeless people 2007–08*, May 2009.
74 NSW Health, *NSW Community Mental Health Strategy 2007–2012*, May 2008, p3. See also Homelessness Australia, *Homelessness Service Delivery – Survey factsheet*, October 2008.
75 Australian Institute of Health and Welfare, *Homeless SAAP clients with mental health and substance use problems 2004–05,* March 2007, p2. During our consultations, SAAP providers suggested the true numbers are much higher.
76 NSW Department of Community Services, *Annual Report 2006/07*, p21.

- the increasing complexity of client need
- the lack of growth funding
- the requirement under SAAP V for services to provide early intervention and post-crisis support in addition to meeting the immediate and short-term housing needs of clients.[77]

1.6. Recent policy developments

Since the JGOS 2 was launched there have been a number of significant social housing and mental health policy developments. These are outlined below.

1.6.1. 'Reshaping public housing'

There has been a significant recent injection of funding for public housing as part of the Federal Government's Nation Building Economic Stimulus Plan and the Social Housing Growth Fund under the National Partnership Agreement on Social Housing.[78] The NSW Government has committed to deliver an extra 9,000 properties – 75% of them by December 2010 – as a result of $2 billion provided under the stimulus plan and an additional $1 billion from State funds.[79]

However, between 1990–1991 and 2000–2001 real capital funding for public housing across Australia fell by 25%, accompanied by sustained demand.[80] The increased targeting of public housing to those most disadvantaged in the mainstream housing market was a significant and lasting outcome of this situation. In NSW, a critical policy change was enacted in 2005 with the announcement of the 'Reshaping Public Housing' reforms. As a result of these reforms, public housing is now allocated on the principle of strongest housing need, and the proportion of tenants with complex support needs has increased.[81] This is reflected nationally, with the number of priority and special needs allocations into public housing increasing from 17% to 49% since 1996.[82]

1.6.2. Priority housing and the Accord

Housing NSW's priority housing policy reflects the 'Reshaping Public Housing' reforms. Applicants approved for priority housing are housed ahead of most other applicants on the waiting list. To be eligible, they must be in urgent need of housing and unable to resolve that need in the private rental market. Homelessness or imminent risk of homelessness and the presence of other risk factors (including a severe or ongoing medical condition or disability) may be assessed as relevant to the need for urgent housing.

The *Housing and Human Services Accord* (the Accord) was developed in response to the reforms. The Accord is a formal agreement between Housing NSW and all human services agencies to assist social housing clients with support needs.[83] It:

> *aims to more clearly define the different roles of human service agencies in providing supported social housing and assisting low income people with support needs to sustain their tenancies …* [and] *seeks to encompass existing arrangements and to facilitate new partnerships, service guarantees and integrated delivery models for priority client groups.*[84]

Schedules to the Accord, consisting of specific partnerships or agreements, will be progressively developed. At the time of our investigation, the JGOS had been designated as one such schedule. Two other schedules – Shared Access and Client Information Sharing – are being trialled in a number of locations across the state. The Shared Access schedule involves new partnership approaches to meeting the complex housing and support needs of nominated client groups, while the Client Information Sharing schedule aims to enable the appropriate sharing of personal information about common clients between agencies with the client's consent.

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77 Consultations with SAAP services, March–June 2008.
78 The Social Housing Growth fund 'aims to increase the supply of social housing and provide increased opportunities for people who are homeless or at risk of homelessness to access secure, long term accommodation'. Housing NSW, response to provisional report, 20 May 2009.
79 Mr Nathan Rees, Premier, NSW Parliament Legislative Assembly, 4 June 2009.
80 Australian Housing and Urban Research Institute, 'Housing management practice and support', *Research and Policy Bulletin*, Issue 71, January 2006, p2.
81 Housing NSW, *Corporate Plan 2007/08 – 2009/10*, 2008, p8.
82 Daphne Habibis, Rowland Atkinson, Terry Dunbar, Dan Goss, Hazel Easthope and Paul Maginn, for the Australian Housing and Urban Research Institute, *A sustaining tenancies approach to managing demanding behaviour in public housing: a good practice guide*, July 2007, p3.
83 The signatories to the Accord are: Aboriginal Housing Office; Attorney General's Department; Department of Ageing, Disability and Home Care; Department of Community Services; Department of Corrective Services; Department of Education and Training; Department of Housing; Department of Juvenile Justice; NSW Health and NSW Police.
84 *NSW Housing and Human Services Accord Between the Department of Housing and NSW Human Service Agencies*, n.d. p2.

1.6.3. Housing NSW initiatives

Housing NSW has developed a range of additional products aimed at assisting people with support needs to obtain housing. The Private Rental Brokerage Service began as a pilot and is now operating in 15 locations across NSW. It assists people who have a physical or mental illness, drug or alcohol problems, a physical or intellectual disability or other complex needs, to find and sustain accommodation in the private rental market. A specialist worker assists the client and support providers to develop a plan to live independently in private rental housing, to find suitable housing, and to help if something goes wrong that might affect the tenancy.

The Tenancy Guarantee program encourages private sector landlords and agents to rent properties to people who are having difficulty entering the private rental market because of a poor tenancy history or discrimination. Under the Guarantee, up to $1,000 is available to landlords/agents to cover rental arrears and/or property damage over and above the rental bond. The program aims to help people establish a satisfactory tenancy record and make it easier for them to rent in the private market in the future.

1.6.4. Expanding the community housing sector

Governments across Australia are increasingly focusing on the community housing sector as an accommodation option for individuals in need of social housing.[85] In 1996, the year before JGOS 1 began, there were 6,000 properties under community housing management in NSW.[86] Currently, there are about 14,000.[87] As at 30 June 2008, 2,427 properties had been transferred from public to community housing management under the stock transfer program that forms part of the NSW Government's current social housing strategy. It is envisaged that an additional 5,000 properties will be transferred over the next 10 years.[88]

The government plans to expand the community housing sector to provide 30,000 homes within the next decade. Seven high-performing community housing organisations have been designated as 'growth providers'. They will be supported by the government to take on a large-scale housing development role and be equipped to leverage private investment.[89] The NSW Government has also indicated that the bulk of the 6,000 new properties to be built in NSW under the Federal Government's Nation Building Economic Stimulus Plan will be transferred to community housing organisations to manage.[90]

As a result of these plans, the number of tenants accommodated in community housing has and will continue to increase significantly. Many of these tenants will have complex needs.

1.6.5. Housing Accommodation Support Initiative and COAG initiatives

Mental health services are provided cross-jurisdictionally and across the public, private and community sectors. In NSW, the role of public mental health services is to support people with severe illness or acute needs. Access is prioritised according to clinical need, as guided by the *Mental Health Act 2007*. Both the NSW and Federal governments also fund the non-government sector to provide a range of specialist mental health services.

A key change since the launch of JGOS 2 in 2003 is the implementation in NSW of the Housing Accommodation Support Initiative (HASI), which commenced in the same year, initially providing 100 places of support across nine locations. Jointly funded by Housing and Health, HASI is a partnership between both agencies and non-government organisations that links stable accommodation with support for people with mental health problems and disorders. HASI comprises a number of stages, with each stage involving a different level of support.[91] The management and coordination of HASI involves the social housing provider, which supplies housing; the area mental health service, which provides clinical mental health support; and the non-government organisation, which provides the accommodation support and psychosocial rehabilitation.[92] At the time of writing, the program has over 1,000 places across NSW.[93] In 2008, a new HASI pilot – 'HASI for Kooris' – addressing the needs of Aboriginal people, commenced in western Sydney.

85 Paul Flatau, Michele Slatter, Jo Baulderstone, Anne Coleman, Stephen Long, Paul Memmott and Lee Shepard, for the Australian Housing and Urban Research Institute, *Sustaining at-risk Indigenous tenancies*, April 2008, p4.
86 Housing NSW, *Planning for the Future: New directions for community housing in NSW*, December 2007.
87 Australian Institute of Health and Welfare, *Community Housing 2006–07: Commonwealth State Housing Agreement national data report*, January 2008.
88 Office of Community Housing, *eNews*, August 2008, p3.
89 Housing NSW, *Planning for the Future: New directions for community housing in NSW*, December 2007.
90 Mr David Borger, Minister for Housing, 'New regulations for community housing', media release, 13 May 2009.
91 Ann Dadich and Karen Fisher, *Housing and Accommodation Support Initiative I Evaluation, Care Planning Report*, SPRC Report 13/8, August 2008. p1.
92 The exceptions to this are HASI Stage 4b, 'HASI in the Home', and 'HASI for Kooris', for which clients are not required to reside in social housing.
93 NSW Health, 'Housing and Accommodation Support Initiative mental health program extended', media release, 6 March 2008.

An independent evaluation of stage 1 of HASI found that it was successful in reducing the deleterious effects of mental illness for many of its participants. Hospitalisation rates for psychiatric and emergency admissions dropped in frequency and duration, and community participation increased. By the end of the evaluation, the vast majority of participants had maintained a stable tenancy. This was attributed to the intensive support that was provided to participants.[94]

Our consultations indicated that HASI is viewed by many individuals and organisations working in housing and mental health as the most tangible expression of commitment to interagency collaboration in these areas. This is reflected by the statement of one person we interviewed that 'JGOS is the theory, HASI is the real thing'.[95] Others said that it is difficult to imagine that HASI would exist had the JGOS not come before it.

NSW Health has acknowledged that there are not enough HASI places to meet demand. Recently, the NSW Government announced funding to further enhance and expand the HASI program and to review and scope a service model that is more culturally appropriate for Aboriginal people.[96]

In addition to HASI, there has been an increase in other support initiatives for people with mental illness in NSW as a result of significant commitments under the Council of Australian Governments' (COAG) *National Action Plan on Mental Health*. The community program with the largest budget in the COAG plan is the Commonwealth funded Personal Helpers and Mentors program (PHaMS). Commencing in 2006–2007, PHaMS provides funding to non-government organisations to engage personal helpers and mentors to assist people with mental illness who are living in the community to better manage their activities. The program has the capacity to assist up to 10,000 people, but at the time of writing it had not yet achieved full capacity.[97]

The NSW Health funded Recovery and Resource Service Program (RRSP) is another addition to the community mental health service sector. Commencing in 2007–2008, the program is aimed at improving outcomes for people who experience mental health problems or disorders by offering them opportunities to be engaged in mainstream community activities. RRSP is operating in 19 sites identified as areas of need due to a limited existing range of community based mental health services. Like PHaMS, it is delivered by non-government organisations.[98]

In addition to these programs, there are a number of other supports provided by NGOs that help to sustain tenancies by assisting people with living skills (eg budgeting and property maintenance).

Together with HASI, the introduction of PHaMS and RRSP has significantly increased the number of non-government agencies active in providing support to people with mental illness in NSW. Although non-government agencies have always played a role, the extent to which these agencies have emerged as key service providers and interagency partners in the area of mental health is unprecedented and one of the most significant changes to have taken place since the JGOS was implemented.

94 Kristy Muir, 'Housing support for people with a mental illness', *Social Policy Research Centre Newsletter*, No. 98, March 2008, p1.
95 Mental health worker, consultation April 2008.
96 NSW Department of Health, correspondence 11 June 2009.
97 Australian Parliament, Senate Committee on Community Affairs, *Towards recovery: mental health services in Australia*, September 2008, p53.
98 Information supplied by NSW Health, 27 October 2008.

Chapter 2.
NSW Ombudsman investigation

A number of factors coalesced to inform our decision to investigate the implementation of the JGOS. In 2006 we investigated a complaint in relation to the eviction of a long term public housing tenant whose lease was terminated due to rental arrears. The tenant sustained serious injuries after a struggle ensued when police accompanied Housing staff to his premises to carry out the eviction. Our investigation found that local Housing staff did not follow appropriate procedures for dealing with tenants who have known mental health problems, despite their awareness of the man's chronic mental illness. In particular, the investigation revealed a limited awareness by staff of the JGOS. Our inquiries also suggested that the JGOS was not being consistently implemented across the state. In reporting our findings and recommendations in relation to this complaint, we foreshadowed the possibility of undertaking a systemic investigation into the implementation of the JGOS in the future.

While Housing initiated a number of changes aimed at ameliorating the deficiencies we identified through our 2006 investigation, our decision to commence a separate investigation examining the implementation of the JGOS was influenced by other information from complaints and enquiries to our office and representations by the community sector. Most significantly, in 2007, the Supported Accommodation Assistance Program (SAAP) sector – in response to a report we commissioned about compliance with the recommendations of our 2004 special report to Parliament, *Assisting homeless people* – expressed significant dissatisfaction with the JGOS, reporting inadequate engagement with and support by mental health services, and little benefit for their clients.

Prior to commencing our investigation we also noted the findings of the Auditor-General's May 2007 performance audit report, *Responding to Homelessness*, which observed that agencies did not appear to be implementing the JGOS with any consistency across the state. From the Auditor-General's report, we became aware that the JGOS SPC had in 2006 commissioned a formative evaluation of the JGOS consistent with the review period specified when the expanded JGOS ('JGOS 2') was launched in 2003. We closely considered the unpublished evaluation report.[99] The report examined the JGOS governance arrangements and this included an audit of JGOS committees (while the JGOS Guidelines use the language of 'as needed' and 'joint service meetings', what has evolved in practice is a governance structure comprised of local and area committees). The report noted that these committees were not operating in all areas and identified a low level of participation on the committees by both SAAP services and Aboriginal housing and health providers. We determined that there would be value in examining in detail the specific issues faced by the SAAP and Aboriginal sectors in order to identify why their participation in the JGOS was limited and practical ways to increase it.

The significant environmental and policy changes that have taken place in relation to the provision of social housing since JGOS 1 and 2 were introduced, together with the available data regarding the prevalence of mental illness and homelessness, contributed to our view that an investigation into the implementation of the JGOS was timely.

Against this background, in October 2007 we commenced an investigation pursuant to section 13 of the *Ombudsman Act 1974* into the implementation of the JGOS. The agencies which are the subject of the investigation are Housing NSW[100] (Housing) and the NSW Department of Health (Health), the signatories to the original JGOS ('JGOS 1') signed in 1997. While there is no designated 'lead' agency responsible for the JGOS, there could not be a JGOS without Housing and Health driving it. Our investigation has focused on identifying the steps taken by both these agencies to meet the objectives of the JGOS.

As the other JGOS strategic partners – DOCS, the AHO and the AH&MRC – are not agencies the subject of investigation, this report does not direct any recommendations to them. However, on a number of occasions we recommend that Housing and/or Health pursue with these agencies certain issues we have identified as a result of our investigation.

2.1. Our methodology

Our investigation was informed by what we already knew about the JGOS from our earlier work (detailed above). Our investigative strategy also took into account initial information provided by the agencies the subject of our investigation and other information obtained from preliminary discussions with these agencies and other stakeholders.

99 Susan Johnston and Margo Moore, *Joint Guarantee of Service Formative Evaluation*, April 2007.

100 At the time of issuing our investigation notice, we referred to the Department of Housing, the name by which Housing NSW was previously (and is still widely) known.

Prior to developing our investigative framework, we explored with Housing and Health how the JGOS strategic partners planned to respond to the recommendations resulting from the independent evaluation. The strategic partners recognised the need for additional analysis of a number of broad policy and structural issues prior to fully implementing certain recommendations made in the evaluation report. It was agreed that our investigation would help to inform this analysis.

The primary aim of our investigation was to determine whether the implementation of the JGOS was effective in achieving the JGOS objectives, which are to better assist and enhance the well being of existing social housing tenants with a mental health problem whose tenancy may be otherwise at risk, and assist housing applicants with a mental health problem who may be homeless or at risk of homelessness to successfully establish a tenancy. In order to examine the implementation of the JGOS, our investigation examined the following key issues:

1. Whether the JGOS is being effectively implemented across the state, including examining barriers to implementation and solutions to these.
2. The appropriateness and effectiveness of JGOS governance structures at a statewide, area and local level.
3. The adequacy of the support and direction provided by the strategic partners for the local implementation and sustainability of the JGOS.
4. The level of awareness and knowledge of the JGOS among key stakeholders.
5. The strength and effectiveness of relationships at each level between workers from participating agencies.
6. The arrangements in place to provide ongoing monitoring of the JGOS and the related data collection requirements to allow key outputs and outcomes to be reported.
7. Whether the JGOS agreement and resources provide adequate information to enable frontline workers to effectively implement the JGOS.
8. The experiences of frontline workers and their views about 'what works' and why.
9. Examples of good practice and potential opportunities to promote these 'successes'.
10. The level of consumer participation.
11. The reasons for the apparent limited engagement with the JGOS of the SAAP sector and Aboriginal housing and health services.
12. How the JGOS intersects with other relevant frameworks/programs/policies such as the *Housing and Human Services Accord* and the Housing Accommodation Support Initiative (HASI).

In conducting our investigation we employed a number of methods and these are outlined below.

2.1.1. Requirement to provide information

On 15 October 2007, we issued Housing NSW and the Department of Health with formal notices of investigation. We required both agencies to provide us with JGOS related information and documents about:

- tenant assessment and information management
- governance, monitoring and evaluation
- policies, procedures and training
- area and local JGOS committees
- roles and responsibilities
- statistical information.

Responses were provided on 3 December (Housing) and 21 December 2007 (Health). By agreement, Housing provided some supplementary material on 1 February 2008. In addition, between February and December 2008, both agencies provided us with further specific information on an informal basis.

In March 2009 we provided Housing and Health with a provisional report outlining our preliminary findings and recommendations. We also provided the report to the other JGOS strategic partners – AHO, the AH&MRC and DoCS. Given the relevance of our report to the Department of Ageing, Disability and Home Care (DADHC), it was also provided to that department.

Between May and June 2009 we received responses from all agencies except the AH&MRC. In addition to providing a written response, the Department of Health requested a meeting to discuss certain recommendations. This meeting took place on 3 June 2009. Health provided us with further updated advice on 23 September 2009. Housing also requested a meeting to provide us with additional information. This meeting was held on 28 September 2009.

Housing and Health expressed support for our preliminary findings and recommendations. In particular, they were strongly supportive of our recommendation that – in light of the significant changes to the social housing landscape since the JGOS was introduced and currently unfolding developments such as the Federal Government's strategy to reduce homelessness – the *Housing and Human Services Accord* should, whilst incorporating the JGOS principles, become the primary governance model by which human services agencies implement their responsibilities in relation to clients who need support to access and sustain social housing.

In response to our provisional report, Housing and Health advised us of their commitment to develop a new Housing and Mental Health Agreement under the Accord, to be 'underpinned by a new governance, accountability and reporting structure' and 'to assist in engaging a broader range of Accord agencies beyond the JGOS partners to work in partnership to coordinate and deliver sustainable housing and support services to people with a mental illness'.[101]

Although they commented only on the sections of the report relevant to their agencies, the AHO and DoCS also supported our observations and the recommendations affecting them. DADHC agreed there would be a benefit in becoming a signatory to the JGOS should it be maintained. They also endorsed our recommendation that the separate JGOS governance arrangements be reviewed.

In formulating our recommendations, we have taken into account the advice received from agencies in response to our provisional report. Our preliminary recommendations are outlined in Part 2 of this report and reproduced in full at Appendix 1. Both Housing and Health have acknowledged that these preliminary recommendations will need to be considered in the context of the development of the Housing and Mental Health Agreement.

2.1.2. Review of JGOS documentation

The key JGOS documents consist of a Memorandum of Understanding between the strategic partners, Guidelines for local implementation and the following additional resources:

- *Making JGOS Work: Operations Manual* – explains the JGOS and provides information about its partners and clients and includes tips and strategies for local committees
- *JGOS Reference Guide* – provides information about mental health issues, housing needs of people with mental health problems, relevant legislation, and includes a 'troubleshooting' section
- *JGOS Templates* – provides examples of a local Memorandum of Understanding, individual service plans, authority to disclose personal and/or health information forms and JGOS meeting agenda
- *JGOS Quicklinks* – provides a list of links to relevant websites.

2.1.3. Review of independent evaluation of the JGOS

As previously noted, we also reviewed the findings from the 2007 independent evaluation of the JGOS.

2.1.4. Consultations with strategic partners

In order to gain a detailed understanding of the role of the JGOS strategic partners, we met with senior representatives from these agencies. During the meetings we explored with these representatives what they expected from their staff in implementing the JGOS at the local level. We also used the meetings to explain the purpose of our field audits (see below) and to negotiate where and how we would conduct these.

Following an initial meeting with Housing and Health to brief them on our investigation, we agreed to regular liaison meetings with both agencies for the purpose of communicating our progress and discussing emerging issues.

As the other signatories to the JGOS, we contacted DoCS, the AHO and AH&MRC to inform them of our investigation and to request meetings. We subsequently met with DoCS. Despite our repeated efforts, we were unable to arrange meetings with the AHO and AH&MRC at a corporate level. However, we were able to meet with regional AHO staff and a number of Aboriginal medical services during our field audits.

We also met with the Community Housing Division (CHD), formerly the Office of Community Housing, which is a signatory to the JGOS as a separate business unit of Housing NSW.

Towards the conclusion of our investigation, we met with Housing and Health to brief them on our findings. We also met with the CHD, DoCS and the AHO (our efforts to arrange a meeting at this time with the AH&MRC were again unsuccessful).

101 Housing NSW, response to provisional report, 20 May 2009.

2.1.5. Consultations with peak bodies and other organisations

Peak bodies are an important source of information about what is happening 'on the ground' in relation to initiatives such as the JGOS. This is because they have a direct line of communication to their many member organisations across the state. For this reason, we met with the peak bodies for SAAP services (Homelessness NSW, Youth Accommodation Association and Women's Refuge Resource Centre), mental health non-government organisations (Mental Health Coordinating Council), community housing providers (Federation of Community Housing Associations), tenants' advice and advocacy services (Tenants' Union) and mental health consumers (NSW Consumer Advisory Group). All of these bodies are directly involved in the implementation of the JGOS through their membership of the IRG. We also spoke with the Aboriginal tenant advocates' network and a representative of the National Tenants Support Network.

In addition to the peak bodies already mentioned, we had discussions with the NSW Council of Social Services, the peak body for the community and social services sector, and the Combined Community Legal Centres Group, the peak body for community legal centres. We also met with the Public Interest Advocacy Centre (PIAC), Legal Aid NSW, the Office of the Protective Commissioner, the Office of the Public Guardian, Shelter NSW and the Law and Justice Foundation of NSW. A description of the role of each of these organisations is included at Appendix 2.

A number of the organisations disseminated information about the investigation to their members, inviting people to contact us should they wish to contribute. As a result, a number of people asked to meet with us during our audits. The Homeless Persons' Legal Service (auspiced by PIAC) and the Aboriginal tenant advocates' network made written submissions to us.

2.1.6. Field audits

Between March and June 2008, we conducted field audits in 25 metropolitan and regional locations across the state. A list of these locations is included at Appendix 3. The purpose of these audits was to collect qualitative information about how the JGOS is operating at a local level. The audits gave us access to a large number of 'frontline' workers who were able to inform us of their direct experience of the JGOS in practice. Many workers were also keen to share their view on how an initiative of this kind could be made more effective.

Following consultation with Housing and Health, we selected the locations for our field audits on the basis of several criteria, including:

- geographic and demographic spread
- density of public, Aboriginal and community housing
- information about functioning JGOS committees
- relative availability of mental health, SAAP and other resources.

We also planned to visit at least two locations within each area health service (AHS). (Apart from the North Coast AHS, where we travelled to Lismore and Coffs Harbour, we were able to visit a minimum of three locations in each AHS.)

We targeted locations which already had functioning JGOS committees, as well as a number which did not. As at 30 June 2007, there were 33 local JGOS committees across the state, one more than at the time the independent evaluation of the JGOS was conducted. However, three of these committees had reportedly lapsed. Sixteen of the locations we audited had local JGOS committees. Therefore, we were able to gather information about the operations of approximately half of all local committees. At 30 June 2007 there were two functioning area JGOS committees, the same number identified by the independent evaluation. We conducted audits in both of the areas where these committees were located. We also audited four of the five areas where, according to information provided by Housing NSW in February 2008, 'regional' JGOS committees[102] were operating (during our audits we discovered that the fifth committee had folded).

During each visit, we interviewed local Housing NSW and area mental health service staff, as well as CHD regional staff and community housing providers, AHO regional staff, DoCS Community Programs Officers, SAAP services, Aboriginal medical services, mental health non-government organisations, and tenant and consumer advocates. Appendix 4 shows the number and range of people we met within the regions covered by each area health service. Altogether, we met with over 460 individuals over the course of more than 250 meetings.

102 These committees tend to operate according to area health service clusters.

2.1.7. Survey of Client Service Officers

Client Service Officers (CSOs) are the 'frontline' workers employed by Housing NSW. We originally planned to hold focus groups with CSOs during our field audits. Housing expressed the view that this would create an unreasonable operational burden. Therefore, we decided to distribute written surveys to CSOs working in the locations where we conducted our field audits. We sent written surveys to 317 CSOs and received 108 completed responses. The survey responses were analysed for information about the level of knowledge and experience of the JGOS held by frontline housing workers. The results have been incorporated into Chapter 4.

2.1.8. Audit of inquiries and complaints

During our investigation, we monitored inquiries and complaints to our office that raised issues relevant to the application of the JGOS. We reviewed a total of 30 inquiries and complaints and, where appropriate, have taken these into account in forming our findings and recommendations.

2.1.9. Literature review

We undertook a comprehensive review of literature addressing mental health and housing policies and procedures; linkages between housing and mental illness; housing and support service coordination; approaches to sustaining tenancies 'at risk'; and managing complex needs and demanding behaviour. Our literature review has informed a number of our recommendations, particularly those contained in Part 3.

2.1.10. Other sources of information

The Ombudsman is responsible for monitoring and reviewing the delivery of community services, including SAAP services. In exercising this responsibility and carrying out other work, particularly in the policing area, we also focus on the provision of services to Aboriginal people. As a result, we have considerable experience consulting the SAAP and Aboriginal sectors. Over many years, this work has enabled us to make a number of observations about the challenges these sectors face and possible ways to address them. These observations inform our report.

2.2. Methodological limitations

One of the limitations from the methodology we have adopted relates to the selection of Housing and Health staff for consultation during our field audits. There are variations in the way that Housing NSW and area mental health services assign responsibilities to staff in different areas. In some cases, positions also vary from area to area. As a result, it would have been difficult for us to accurately identify the most relevant staff members to consult. Therefore, we relied on advice provided by the area directors from Housing NSW and area mental health services. However, we were able to speak to a large number and variety of staff, and our impression was that they spoke candidly about their views and experiences.

Because we learned early on that data was not being systematically collected about the outcomes for JGOS clients, we could not justify expending our resources or those of Housing and Health to review client files.

Our field audits enabled us to draw observations based on consultations with a diverse range of people in both metropolitan and regional locations across the state. While we are confident that our sample is representative, we were unable to universally assess the implementation of the JGOS and our findings and recommendations have been drawn on this basis.

Part 2: What we found

This part summarises the findings of our investigation. The various investigative methods we used provided us with comprehensive information which enabled us to assess whether the JGOS has been effectively implemented.

Our consultations revealed a high level of support for the JGOS principles and examples of them being put to good effect in some areas. While a number of people we consulted said that Housing generated some early momentum around the release of JGOS 2, there was a consensus that this fell away reasonably early. Overall, our investigation revealed that the implementation of the JGOS has been patchy and inconsistent. In particular, it revealed a low level of participation by several of the local partners that JGOS 2 was established to include, most notably SAAP and Aboriginal housing and health providers. While it is clear that there are many individuals working to improve housing outcomes for people with mental health issues, we found little evidence to demonstrate that the JGOS is achieving systemic improvements.

Our consultations revealed that while there was a general awareness of the existence of the JGOS, there was virtually no awareness of the resources that were released in the second half of 2007 to support its implementation. Having reviewed the JGOS documents, we also identified several weaknesses in the JGOS agreement and inconsistencies between the agreement and resources. Similarly, through our consultations and review of the information provided to us by the agencies subject to investigation, we identified weaknesses with the JGOS governance arrangements, including a lack of accountability mechanisms and systems to support the effective implementation of the JGOS.

As a result of our investigation we are unable to conclude that the implementation of the JGOS has been effective. We identified four key areas that would need to be addressed should the agencies decide to maintain the JGOS: the JGOS agreement and resources; the practical implementation of the JGOS; systemic issues that have impacted on implementation; and the JGOS governance and accountability arrangements. We made a number of recommendations in our provisional report aimed at strengthening the JGOS – these are included at Appendix 1.

However, in light of additional issues arising from our investigation, our provisional report also recommended that further consideration should be given to the future role of the JGOS.

While the concept behind the JGOS was in many ways innovative for its time, the social housing landscape has changed considerably since the JGOS was introduced. In Chapter 1 we outlined some of the main changes that have occurred and how they have been reflected in social housing policy. The 'Reshaping public housing' reforms articulated a new public housing allocation model based on the principle of strongest housing need. This has led to an increased number of tenants with complex support needs. In recognition of this, the *Housing and Human Services Accord* was developed to formalise a joint commitment from all human services agencies to assist social housing clients who have a range of support needs to establish and sustain tenancies. The Accord functions as an overarching framework for a suite of partnership initiatives.

Our provisional report recommended that the JGOS should be reconsidered against the changed landscape brought about by the 'Reshaping public housing' reforms, the Accord and more recent developments such as the Federal Government's strategy to reduce homelessness. We further recommended that consideration should be given to making the Accord the primary governance model by which human services agencies implement their responsibilities to plan, coordinate and deliver services to clients who need support to access and sustain social housing, whilst embedding a commitment to the JGOS principles. Finally, we recommended the adoption of a supportive tenancy management approach aimed at making the social housing system more responsive to the range of complex needs with which clients now commonly present.

In response to our provisional report, Housing and Health agreed with utilising and building on the Accord to develop more streamlined formal partnership arrangements that support the accommodation needs of people with mental health problems, and advised us of their intention to develop a new Housing and Mental Health Agreement under the Accord. The aim of the Agreement will be 'to ensure a collaborative working relationship between key agencies to improve the housing outcomes for people with a mental illness'. It will engage a broader range of agencies beyond the JGOS partners. Like the JGOS, 'it is intended that agencies will endeavour to provide adequate resources to supporting improved housing outcomes'. However, it is not a funded program.[103]

Housing NSW has proposed the preparation of an options paper to inform the development of the Agreement. As part of this process, it will be critical that the agencies consider the lessons from the JGOS outlined in this part of the report and ensure that the weaknesses which undermined the effective implementation of the JGOS are not duplicated. In later chapters in this report we make a number of suggestions relating to incorporating relevant preliminary recommendations that were originally formulated to strengthen the JGOS into the development and implementation of the Housing and Mental Health Agreement.

103 Housing NSW, response to provisional report, 20 May 2009.

Chapter 3.
JGOS agreement and resources

The JGOS framework is established and communicated by an agreement (MoU), Guidelines for local implementation and several resources that have been developed over time (these resources are described at 2.1.2 and below). This evolving policy landscape, combined with weaknesses in the original agreement and Guidelines developed by the SPC,[104] has led to a number of deficiencies in the documents and inconsistencies between these documents.[105] It would appear that these deficiencies and inconsistencies have contributed to the ineffective implementation of the JGOS.

3.1. The JGOS documents

The JGOS consists of a Memorandum of Understanding (MoU) between the strategic partners and Guidelines for local implementation. The Guidelines contain a sample local MoU. In 2007, some four years after the MoU and Guidelines became operational, the SPC released additional resources consisting of:

- *Making JGOS Work: Operations Manual* – explains the JGOS and provides information about its partners and clients and includes tips and strategies for local committees
- *JGOS Reference Guide* – provides information about mental health issues, housing needs of people with mental health problems, relevant legislation, and includes a 'troubleshooting' section
- *JGOS Templates* – provides examples of a local Memorandum of Understanding, individual service plans, authority to disclose personal and/or health information forms and JGOS meeting agenda
- *JGOS Quicklinks* – provides a list of links to relevant websites.

3.1.1. MoU and Guidelines

The MoU is a brief, clearly expressed document that commits the JGOS strategic partners to operate according to a number of principles. The Guidelines 'may be used as they are or may be adapted to better suit local requirements, as far as possible'.[106] This provides local participants with a significant degree of latitude, although the introduction to the MoU does state that 'any amendments must … be consistent with the JGOS's principles'.[107] An advantage of this latitude is that partners are not forced to adopt arrangements that do not suit local conditions. A disadvantage is that it may result in inconsistent application of the JGOS principles that in turn may lead to inequitable outcomes from one location to the next for the people the JGOS is designed to assist.

However, aside from these considerations, the Guidelines lack clarity in a number of important areas:

1. Meetings

Most references are to 'joint service' and 'as needed' meetings, which are defined (see 1.4.2), but there is also a reference to 'local' and 'area' meetings, which are not – the use of this different terminology is confusing. Readers have to navigate three different and at times contradictory sections of the document to find out the purpose of joint service meetings and who should attend them. The link between joint service and as needed meetings, if any, is unclear.

2. Local action plans

The Guidelines state that 'indicators for individual, service and strategic community planning outcomes will be developed as part of the local action plan'.[108] However, no guidance is provided about what should be the broad indicators and outcomes which need to be pursued or who is responsible for developing and monitoring the local action plan.

3. The role of SAAP services, advocates and NGOs

The Guidelines lack clarity about the role of these participants. For example, although their participation is listed in the JGOS principles, it is not clear how mental health NGOs can participate in practice.

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104 As previously noted at 1.4.2, the role of the Strategic Partners Committee (SPC) is to oversee the implementation and review of the JGOS.
105 Housing NSW acknowledged these weaknesses in their response to our provisional report.
106 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p15.
107 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p4.
108 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p22.

3.1.2. Operations Manual and Reference Guide

As noted earlier, the JGOS Operations Manual and Reference Guide were not released until the second half of 2007. Our consultations in early to mid 2008 revealed that although there was a general awareness of the existence of the JGOS, there was virtually no awareness of these documents despite their availability on the Housing NSW website.

3.1.2.1. Operations Manual

The Operations Manual (the Manual) attempts to address some of the Guidelines' deficiencies and to make the JGOS more 'user-friendly'. Unfortunately, in attempting to do so, it creates further confusion because the Manual and Guidelines provide inconsistent information about some important areas of the JGOS. For example:

- The Manual appears to add a new, third JGOS 'aim'. In addition to assisting existing social housing tenants and housing applicants to maintain or establish a tenancy, the Manual states that another focus of the JGOS is to 'assist clients with mental health problems, who may be homeless or at risk of homelessness, to establish and maintain SAAP accommodation'.[109] This aim is not reflected in either the MoU or Guidelines.
- The Guidelines imply that the role of SAAP providers in relation to JGOS is limited to providing emergency accommodation. However the Manual states that SAAP clients are 'suitable to be referred to a local JGOS committee for assistance'.[110] While this is appropriate and appears to be an attempt to provide greater clarity in relation to who can be a 'JGOS client' and how they can be assisted, the description of the joint service meetings in the Guidelines does not reflect that SAAPs can refer clients for discussion with the aim of helping them to establish more permanent accommodation.
- The governance structure outlined in the Manual is not the same as that described in the Guidelines due to the way JGOS committees have evolved over time. For example, the Manual refers to 'regional/area committees'. There is no reference to joint service or as needed meetings, only to local JGOS committees. The role of these committees is not clearly articulated and their membership, as stated by the Manual, is much broader than the list of participants for either the joint service or as needed meetings described in the Guidelines.

The lack of consistency between the JGOS Guidelines and the Operations Manual is marked. If the governance structure and interpretation of the JGOS aims set out in the Manual is the preferred description, it would have been preferable for the document to supercede the Guidelines. Clearly, having two sets of inconsistent documentation is unhelpful.

Aside from this, the Manual represents a missed opportunity in several respects. For example, whilst detailed information is provided about the JGOS partners, it does not focus on their practical role in relation to the operation of the JGOS.

In Chapter 7 we discuss the concern and confusion about client confidentiality and the exchange of information that has preoccupied many JGOS participants at the local level, particularly where consent is not provided and the client's wellbeing is a serious concern. The Manual contains a brief section addressing this issue, but does not provide clear guidance beyond stating that 'confidentiality and privacy should be fully respected in accordance with applicable law and policy' and that 'working out common policy that everyone can agree on can help'.[111] In fact, based on our consultations, reaching a common agreement on this issue appears to be the sticking point. This section of the Manual could have provided clearer direction about client consent and what to do when consent is not provided.

The Manual provides useful information about ensuring consumer and carer participation generally. It states that 'consumers and carers … have an important role in providing feedback and evaluation of service delivery'.[112] Some valid suggestions are also made about how to obtain feedback from consumers about their satisfaction with services. However, the Manual does not emphasise and clarify the role that consumer advocates can play in the JGOS.

Finally, the Manual includes a section on 'Troubleshooting commonly experienced problems'. Much of the information here does not relate specifically to the JGOS. For example, there are two sub-sections that deal with general staff welfare issues. The section also attempts to deal with the question of what to do if a JGOS partner will not respond. The advice provided is generic, in that it could apply to any interagency arrangement, and unfortunately does not provide clear guidance about how to escalate an issue if necessary; for example, to a more senior level within an agency or organisation or to the SPC.

109 JGOS Strategic Partners, *Making JGOS Work: Operations Manual*, 2007, p4.
110 JGOS Strategic Partners, *Making JGOS Work: Operations Manual*, 2007, p5.
111 JGOS Strategic Partners, *Making JGOS Work: Operations Manual*, 2007, p19.
112 JGOS Strategic Partners, *Making JGOS Work: Operations Manual*, 2007, p22.

3.1.2.2. Reference Guide

The Reference Guide (the Guide) repeats some of the information provided in the Operations Manual. It also provides definitions of terms, references to relevant legislation and background information about mental illness, including types and incidence and the housing circumstances and needs of people with a mental illness. The section 'Differing perceptions' attempts to address some contentious issues, such as what mental health services are mandated and resourced to do, as opposed to what others may expect them to do, and why SAAP services cannot always accommodate certain homeless people. This section includes an acknowledgement that there can be disagreement about some issues between JGOS partners.

The Guide also provides advice about how to work effectively with Aboriginal people and homeless people, being sensitive to cultural diversity, responding to challenging people and the role of the OPG. Some of these sections provide practical advice for frontline workers to assist them to implement the JGOS. While bringing all of this information together in this form is a good initiative, it is unclear why a separate Guide was created rather than consolidating the existing Manual or Guidelines.

3.2. Final observations

Our provisional report contained a recommendation about the need to review and rationalise the JGOS documentation to make it more 'user-friendly' and to strengthen overall accountability for the JGOS. Housing NSW has advised us that the new Housing and Mental Health Agreement 'will be supported by the development of operational guidelines'.[113] It will be important that these guidelines clearly and consistently describe how the Agreement should work in practice, outline responsibilities for implementation at a strategic and local level and provide practical advice to frontline workers. To this end, in developing the guidelines, the partner agencies should have regard to the observations contained in this chapter as well as preliminary recommendation 1.[114]

113 Housing NSW, response to provisional report, 20 May 2009.
114 See Appendix 1.

Chapter 4.
Local implementation

In order to gain an understanding of how the JGOS has been practically implemented, we consulted managers and frontline staff from the JGOS strategic partner agencies. We also consulted other local partners who have a role in assisting people with support needs to access and sustain social housing.

We spoke to a large number of people occupying different roles and with varying levels of knowledge and experience of the JGOS and expectations about what the JGOS should deliver. This allowed us to appreciate the issues and challenges associated with the implementation of the JGOS and to directly assess how it has impacted on the way that people do their work.

Regional differences determined by geography, infrastructure, demography and the availability of human and other resources can significantly impact on both direct service provision and the implementation and success of interagency initiatives. For this reason, visiting a significant number of diverse areas across the state was critical in enabling us to make informed findings about the overall implementation of the JGOS.

Overwhelmingly, we found that people welcomed the opportunity to meet with us to express their views. Participants commented that the process had provided them with a good opportunity to reflect on practice issues including 'what works' and how challenges could be approached differently.

4.1. Background

As previously noted in Chapter 1, the JGOS outlines the roles and responsibilities of the strategic partners – NSW Health, Housing NSW, AHO, AH&MRC and DoCS (on behalf of SAAP services) – to coordinate the delivery of services to people with mental health problems and disorders who have ongoing support needs living in social housing. The JGOS also provides a framework for participation by Aboriginal and community housing providers, Aboriginal and non-government mental health service providers, SAAP services and advocates in the JGOS partnership framework.

The JGOS aims to:

- better assist and enhance the wellbeing of existing social housing tenants with mental health problems and disorders whose tenancy may otherwise be at risk
- assist housing applicants with mental health problems or disorders who may be homeless or at risk of homelessness to successfully establish and maintain a tenancy.

4.1.1. JGOS committees

In Chapter 3 we noted that the JGOS governance arrangements have evolved over time and that this is reflected in the resources that were released in 2007. At the time of our investigation, a JGOS Strategic Partners Committee (SPC) and Implementation Reference Group (IRG) had been operating for some time. The SPC is chaired by Housing NSW. Its purpose is to provide strategic coordination for the JGOS, including developing an implementation plan, monitoring the ongoing application of the JGOS across NSW and identifying policy, practice and systemic issues associated with implementation. The IRG was established to provide advice to the SPC on action required to implement the expanded JGOS ('JGOS 2'). The members of the group are drawn from the strategic partner agencies, peak bodies representing local partners and regional representatives. A key focus for the IRG is to develop strategies to facilitate the participation of all local stakeholders, particularly new partners.

There are eight area health services in NSW. Before commencing our investigation, Housing NSW advised us that there were two area JGOS committees in North Sydney Central Coast AHS and North Coast AHS. There were also five 'regional' JGOS committees (committees that are generally based in AHS clusters[115]) operating in parts of the Sydney South West, Sydney West and Greater Southern area health services (during our audits we found out that one of the regional committees had lapsed). Area/regional committees are responsible for identifying where local committees should be established, providing a mechanism to escalate issues from local JGOS committees to the IRG and addressing issues of area-wide significance.

115 For administrative purposes, each area health service is divided into a number of geographical clusters.

Prior to conducting our field audits, we were informed by Housing NSW that there were 33 local JGOS committees across the state, of which three had lapsed. There were only two local committees in Greater Western AHS and one of these had been recently formed. There were no local committees north or west of Orange. In addition, there were no local committees in the Hunter region (north of Newcastle) of the Hunter New England AHS. Both Greater Western and Hunter New England area health services have significant Aboriginal populations. Of the 33 local committees in total, 19 did not have a local MoU registered with Housing NSW as at 30 June 2007.

The JGOS Operations Manual envisages that local committees will have members from the local area mental health service, Housing NSW service division, Community Housing Division (CHD) regional staff, Aboriginal Housing Office (AHO) regional staff, DoCS regional staff, Aboriginal housing provider(s), Aboriginal community controlled health service(s), non-government mental health service providers, community housing providers, local Tenants' Advice and Advocacy Program services, SAAP services and consumers advocates.

The JGOS Operations Manual allows local areas to decide the best way to establish local committees and suggests that linking in with an existing mechanism such as a HASI committee or social housing forum may be appropriate. Regardless of the local structure adopted, there is an expectation that local committees will jointly plan responses where a coordinated service approach is required and develop housing and support options to meet the needs of shared clients.

4.1.2. The role of local partners

In relation to new housing applicants or individuals needing SAAP assistance, the JGOS expects that where the area mental health service supports the individual's application, the service will provide the social housing and/or SAAP workers with sufficient information to effectively assess the individual's housing needs and/or other support needs. If appropriate and the individual consents, a health worker should try to attend an initial interview for housing assistance.

While the JGOS agreement envisages that joint service planning will take place at a local committee level, it also expects that on a practical, day-to-day level, housing workers will attempt to resolve tenancy problems (such as arrears, property damage or nuisance and annoyance) as part of their normal duties. If during this process the housing worker identifies that an individual has or is thought to have a mental health problem, and their difficulties are associated with this problem, then a referral should be made to the individual's health worker, Aboriginal health worker or to the area mental health service if the health worker is not known. As appropriate, the housing and health worker will jointly problem solve the issues in a cooperative manner.

If these steps have been taken and the tenancy remains at risk, the individual's situation should be referred to a joint service meeting where consideration will be given to developing a coordinated service plan if one is not already in place. When it is identified that an individual may be at risk of homelessness, this meeting may include the relevant SAAP provider. If possible, the meeting will include the individual who may also have an advocate present. An advocate can be any person the individual chooses, such as a tenant advocate, mental health consumer advocate, or a representative from any organisation that provides support to the individual.

Aboriginal health and housing providers have the same responsibilities as area health services and other social housing providers to support individuals to access and maintain tenancies. The AHO has a role to promote the JGOS principles to Aboriginal housing providers and to participate in joint service planning at a local level.

The principles underpinning the JGOS agreement commit SAAP services to provide support to people with mental health problems and disorders who are identified as homeless or are at risk of homelessness and require and are prepared to accept a support service from SAAP. The principles make clear that the transitional support provided by SAAPs does not replace the area mental health service's responsibility to ensure an appropriate service response for the individual. While the JGOS anticipates that SAAP providers will 'develop referrals and joint case management processes with the area mental health service', it is less clear what SAAP services can expect from other JGOS partners when they are assisting clients to obtain more stable housing. At a local level, DOCS has a role to promote the JGOS principles to SAAP services and to participate in joint service planning.

While the JGOS envisages a role for mental health non-government organisations at the local level, it provides limited guidance about how NGOs should participate in practice.

All local JGOS partners are expected to work cooperatively and promptly to resolve situations in the best interest of the individual concerned.

4.2. What we looked for in our consultations

In Chapter 2 we outlined the key issues our investigation sought to examine. In addition to these, during the course of the investigation we identified other significant issues relevant to the implementation of the JGOS. For example, workers identified that although the JGOS provides a guarantee of service in relation to clients with mental health problems, many of these clients also have a range of other support needs requiring a service response that the JGOS does not cover. The workers commented that the 'Reshaping Public Housing' reforms (described in Chapter 1) have resulted in an increasingly complex social housing client demographic.

During our interviews with stakeholders, we were keen to explore what changes may be required to better equip workers to cater for this demographic. In order to do this, we needed to understand the specific challenges that workers currently face in carrying out their responsibilities under the JGOS.

In addition to ensuring a representative sample, in selecting the locations we audited we had regard to information provided to us by the agencies the subject of investigation and peak bodies, which included their observations about areas where JGOS committees were functioning as well as those struggling to implement the JGOS. We were also keen to explore the lack of engagement with the Aboriginal and SAAP sectors identified by the independent evaluation. We wanted to know what efforts had been made by Housing and Health to engage both sectors, how the sectors responded to these efforts and the sectors' views about their involvement in the JGOS.

At the outset of our investigation, Housing acknowledged that it was not systematically capturing data in relation to JGOS outcomes for clients. For this reason, we decided to examine how JGOS work was being measured at a local level, both by Housing and other JGOS partners.

We also wanted to test some of the early perceptions of the JGOS reported to us by some stakeholders prior to commencing our investigation. For example, we were told that in the eyes of many people, the JGOS had become 'a tarnished brand' and that the introduction of the *Housing and Human Services Accord* and HASI had diminished the relevance of the JGOS.

Based on our review of information we received about how the SPC and IRG were monitoring the implementation of the JGOS, we had concerns early in our investigation that the governance arrangements at each level may not have been operating effectively. We wanted to know what types of strategic direction and support local partners needed from the SPC and IRG in order to run effective local/area committees and in turn, how committees could best support frontline workers to apply the JGOS principles as part of their everyday work. We were also interested in identifying any systemic issues that were negatively impacting on the implementation of the JGOS at the local level and what steps had been taken to address them.

Against this background, the interviews we conducted during our field audits were aimed at examining the following areas in order to assess the implementation of the JGOS:

- awareness of the JGOS agreement, resources and governance arrangements, including the role of the SPC and IRG
- the level of understanding about individual roles and responsibilities in relation to the JGOS
- whether and how local and area JGOS committees were functioning
- participation in local and area JGOS committees
- the link between local committees and frontline staff
- the link between local and area committees, whether there were clear processes for escalating issues that could not be locally resolved, and whether systemic issues were identified and addressed
- the outcomes achieved for clients through the JGOS
- processes for recording activities and outcomes connected with the JGOS
- relationships between local partners
- whether and how good practice was being identified and shared
- whether the broader operational systems of each partner organisation facilitated the JGOS objectives

In the first section of this chapter we outline the views of staff from Housing NSW (including the Community Housing Division – CHD) and Health (area mental health services) as the original signatories and two main agencies involved in the JGOS. Since community housing providers are regulated by the CHD as a business unit of Housing NSW, we have also included the views of their staff in this section. The chapter then reports on the findings of our consultations with the other stakeholder groups, including, where relevant, the peak bodies and other organisations outlined in Chapter 2.

4.3. Housing providers and mental health services

During our audits, we interviewed 89 Housing NSW staff (including six area directors) and 96 staff employed by area mental health services (including three area directors). Because of variations in the responsibilities assigned to staff between different Housing areas and area health services, it was necessary to ask relevant housing and mental health area directors to nominate the most appropriate staff members to consult in each area.

The health workers occupied diverse positions, ranging from community mental health team leaders to clinical nurse consultants, recovery services managers and social workers. Most of the people we interviewed occupied senior positions involving supervisory and/or coordination responsibilities. However, we also met with a number of frontline community and inpatient mental health workers. In addition, we met with three area directors.

The Housing staff we interviewed were mainly those employed as team leaders or in the Senior Client Service Officer Specialist or Antisocial Behaviour role. Team leaders are responsible for either access teams, which assess new applications for housing and allocate properties, or tenancy management teams, which handle all aspects of tenancy and property management, such as rent and maintenance. Team leaders supervise a number of Client Service Officers (CSOs) and Senior Client Service Officers.

Senior Client Service Officers may be located in either access or tenancy teams. Some Senior Client Service Officers are specialists. Senior Client Service Officer Specialist (SCSOS) positions have an advocacy and consultancy role. They provide specialised advice to CSOs about clients with complex support and housing needs. They also provide support service 'brokerage' for such clients. SCSOSs are expected to develop and manage relationships and partnerships between Housing NSW and other agencies and services to improve communication on and access to services for clients, and to support sustainable tenancies. There are 60 SCSOS positions throughout the state.

In addition to SCSOSs, there are also Senior Client Service Officer Antisocial Behaviour (SCSOASB) positions which are responsible for providing advice and support to client service teams in their management of matters involving nuisance and annoyance and antisocial behaviour. SCSOASBs also assist in planning the implementation of initiatives and strategies for improving the way that Housing NSW manages antisocial behaviour. There are 19 SCSOAB positions across the state.

At the commencement of our investigation, CHD explained that information about the JGOS is disseminated by their representatives on the JGOS SPC and IRG to regional CHD staff, and that regional staff may be able to provide us with information about the engagement of community housing providers with the JGOS at a local level.[116] For this reason we sought to meet with CHD staff in all four regions to gain a better understanding of how information about the JGOS is filtered between the corporate and regional levels of CHD, as well as the extent to which CHD regions are involved in encouraging and assisting community housing providers to engage with the JGOS. We were able to meet with CHD staff in three regions.

The JGOS envisages community housing providers as local JGOS partners, so it was important that we meet with those located in the areas we audited. We met with workers from 19 community housing providers to gauge their level of awareness and knowledge of the JGOS, hear about their experiences of participating in the JGOS, or the reasons for not participating, and seek their views about the overall operation of the JGOS. We also wanted to know whether they had received any guidance or support to engage with the JGOS, particularly by CHD.

4.3.1. Key challenges

Housing and Health staff were keen to tell us at the outset of our interviews about the challenges they face in carrying out their work. They felt it was important for us to appreciate these challenges in order to understand the broader context in which the JGOS operates. To this end, the most frequently cited challenge was the increasing complexity of client need resulting from the way that housing is now allocated (ie on the basis of greatest need). Workers also spoke of the specific challenges that come with working in particular locations (eg vast distances and limited services in rural areas).

For housing workers, the increasingly complex client base means that both applicants and tenants are likely to require significant support to enable them to live independently. Staff expressed the view that a lack of available support services too often impedes successful tenancies, and that this leads them to spend significant time and resources trying to prevent tenancies from failing and dealing with those that do fail. Housing staff said that at times they felt unsupported by their organisation to undertake the work necessitated by an increasingly complex tenant demographic.

Some specific challenges reported by housing workers were:

- a lack of suitable housing options, particularly transitional and supported accommodation, to accommodate individuals with high needs

116 Meeting with Community Housing Division, 10 March 2008.

- 'privacy' requirements hampering the exchange of information when it was necessary to exchange information in the interests of tenants
- balancing their responsibility to support the tenancies of individuals with high needs with their responsibilities for sound property management practices and the rights of all tenants
- support services, and tenants themselves, withdrawing from support agreements they had entered into after a tenancy is established
- mental health services failing to inform them when a tenant is admitted or discharged from inpatient care
- the high turnover of CSOs in a number of areas and some CSOs lacking the capacity to provide quality tenancy management
- the large portfolios (up to 1,200 properties) that many CSOs manage representing a significant challenge in providing quality tenancy management
- being unclear about how to escalate matters when they are unable to be resolved locally
- not receiving adequate information about tenants' histories and support needs when housing stock is transferred from Housing NSW to community housing providers.

For mental health workers, complexity increasingly relates to co-morbidity and the intensity of symptoms. Dual diagnoses of mental illness and substance abuse or intellectual disability, acquired brain injury or dementia were reported to present challenges. The prevalence of the use of the drug 'ice' was said by many practitioners to have led to an increase in the incidence and severity of psychotic illness. A number of health workers also expressed frustration about attempting to secure appropriate housing and support services for clients with a dual diagnosis of mental illness and intellectual disability/acquired brain injury. We were told that at times, some people could not be discharged from hospital because health workers were unable to secure appropriate, supported accommodation for them. This leads to beds being 'blocked' for periods of up to 12 months. Workers were concerned that on other occasions, people are discharged too early without appropriate support measures in place. Many of the health workers we spoke to believed that better support could be provided to clients with a dual diagnosis of mental illness and intellectual disability if the Department of Ageing, Disability and Home Care (DADHC) was a JGOS partner.

Health workers frequently acknowledged that they are responding to 'the tip of the iceberg'[117] because the level of demand combined with limited resources means they are restricted to providing acute or crisis care, which even then may be variable in consistency and quality. They stated that this can and often does lead to strained relationships with other agencies and services that are reliant on them.

For mental health workers, other specific challenges included:

- understaffing, including difficulty recruiting and/or retaining staff, particularly Aboriginal mental health workers
- managing the expectations of other agencies and services – for example, many of the behaviours that can place tenancies at risk may appear to stem from mental illness but are in fact the result of complex disorders or issues (eg personality disorder, substance abuse) that mental health services are not necessarily mandated or resourced to address
- a lack of suitable housing options, particularly transitional and supported accommodation, to accommodate people with high needs.

4.3.2. Implementation of the JGOS

Our consultations indicated that, while there is evidence of good work by many individuals to give effect to the JGOS principles, practice associated with the JGOS implementation is clearly ad hoc in nature when the overall picture is considered. For example, we did not see many examples of good practice duplicated across the state or even consistently in one area. Generally, there was confusion about how the JGOS should operate and uncertainty as to what outcomes it should achieve. This reflected a limited awareness of the purpose of the JGOS. While it was pleasing that virtually all housing and health workers knew that the JGOS requires Housing and Health to work together to assist people with mental illness, their focus appeared to be very much on existing tenants rather than people in need of social housing as well. This reflected an apparent lack of attention to the JGOS aim of assisting those who are homeless or at risk of homelessness to access social housing.

Whilst there was awareness that JGOS 2 envisages the involvement of partners beyond Housing and Health, few staff could articulate the role of these partners. There was a notable lack of understanding about the role of SAAP providers and the Aboriginal sector in relation to the JGOS (as opposed to the services they provide) and of meaningful engagement with them. There was also disagreement about who can or should participate on JGOS committees. Additionally, there was almost no awareness of the JGOS resources published in 2007.

117 Mental health social worker, consultation May 2008.

Not surprisingly, workers in areas where JGOS committees were operating had more to say about the JGOS. However, with some exceptions, even they struggled to demonstrate what outcomes the committees are pursuing and/or achieving. It was our observation that many had spent a significant amount of time discussing matters relating to the internal functioning of the committee, such as MoUs and the exchange of client information. There was little evidence that issues unable to be resolved locally were being escalated by committees to a higher level; with a handful of exceptions, neither health nor housing workers were aware of the existence or purpose of the IRG or SPC, and the purpose of area committees was not well understood.

In the majority of cases there also appeared to be a 'disconnect' between committees and the day-to-day work of the partner organisations. For example, there was limited evidence that information was being consistently conveyed between committees and local partners. The majority of Client Service Officers[118] we surveyed were unable to report any results achieved by committees. It appeared that items for discussion were not being forwarded by workers to committees or that meeting outcomes were not communicated.

Despite this, there were a number of Senior Client Service Officer Specialists (SCSOSs) who spoke about the benefits of a regular forum where they could discuss individual cases with health workers. These included getting to know local staff, obtaining advice and sharing tips about dealing with problematic cases, and identifying and responding to training needs.

Interestingly, when we asked staff about how the JGOS was being implemented in their local area, they spoke almost exclusively about whether or not they had a local committee, and, if there was a committee, its work and their experience of participating on it. While those we interviewed felt that much of the everyday work they undertake to sustain tenancies was occurring regardless of whether there was a local JGOS committee operating, they did not initially refer to this work as an important part of implementing the JGOS principles. It was not uncommon for people to tell us that the JGOS wasn't 'happening' in their area, only to go on to describe examples of such work; for example, conducting joint Housing/Health client visits and case conferences or developing partnerships with SAAP services to provide transitional housing.

It appears that the JGOS has been interpreted in a way that emphasises the role of committees without adequate consideration also being given to the type of systems and work practices needed to facilitate the JGOS aims and the role of committees in ensuring that this takes place.

While it may be seen as positive that good practice does not need to be consciously underpinned by policy or a JGOS committee in order to take place, the disadvantage of this is that the JGOS misses out on much needed 'marketing'. The JGOS is seen by many as 'a tarnished brand',[119] and this is largely because there is inadequate identification or promotion of work that is attempting to achieve its aims.

It was notable that many workers – including senior staff – communicated the view that 'HASI is the new JGOS'. Indeed, we were told on a number of occasions that the JGOS is no longer needed now that HASI has been implemented. However, staff also acknowledged that, while HASI is a valuable program, there are not enough packages to meet demand. The notion that HASI has superceded JGOS is understandable given the successful marketing of HASI and the fact that it is also aimed at sustaining the tenancies of social housing tenants with mental health problems. However, the notion is misplaced because HASI is a specific program designed to support a limited number of people, whereas the JGOS brings together a set of principles and work practices to guide the way that partner organisations respond to the support needs of all social housing applicants or tenants with a mental health problem.

An assumption was often made that, because HASI is funded, it is of greater value than the JGOS. This does not recognise the potential broader reach of the JGOS framework. On the other hand, there were many who advocated the need for the JGOS principles to remain explicitly documented and to be reflected in the procedures and operations of partner organisations. They pointed to the danger of over-reliance on a single program to achieve what should be embedded in the system more generally: 'It's important for us to have a policy that we can rely on so we can say to other workers, "you have to try to help"'.[120]

4.3.3. JGOS committees

As we have already indicated, the JGOS is generally viewed by practitioners as being 'about' committees and their work. Discussion of committees during our audits tended to focus on the experience of local committees, occasionally on area committees, and very rarely on the IRG and SPC, as few staff (apart from some area directors) were aware of the existence or purpose of the latter. This lack of awareness was demonstrated by the fact that many of those we spoke to were quick to advocate the need for a higher layer of governance to coordinate and oversight the local operation of the JGOS.

118 As previously noted in Chapter 2, Client Service Officers are the 'frontline' staff employed by Housing NSW.
119 Peak body consultation, February 2008.
120 Housing NSW SCSOS, consultation May 2008.

4.3.3.1. Local committees

We found considerable variation in the way local JGOS committees were operating, something that was also noted by the independent evaluation of the JGOS. Broadly, there are three types of local committees: client focused; strategic; and a mix of the two. Client focused committees tend to discuss individuals already in housing whose tenancies are at risk: in a few cases, they also discuss housing applicants. Strategic committees do not discuss individual clients but rather focus on networking, exchanging general information and discussing systemic issues. At times they may discuss case studies for educative purposes. Mixed committees perform the functions of both client focused and strategic committees with these meetings generally divided into two parts.

There tended to be strong views held by different staff about the most effective and appropriate style of meeting. Proponents of client focused meetings argued that, unless committees discuss actual clients, meetings become no more than 'a talkfest' and the focus of the JGOS on better outcomes for individuals can become lost.[121] On the other hand, those in favour of strategic committees spoke of the need to address systemic issues impacting on housing outcomes in order to benefit all potential JGOS clients. They were concerned that focusing on individuals alone would prevent this from occurring. Many also raised the issue of client confidentiality as a reason why client focused committees are not appropriate. Additionally, they suggested that client focused meetings are really about case coordination and that this process should occur as part of normal daily work. Not surprisingly, those who thought mixed committees were the best approach saw benefits in both client focused and strategic meetings and sought to combine both elements.

Example

A 'client focused' meeting

In Wollongong, Housing NSW SCSOSs, community housing and mental health social workers attend a fortnightly client driven case meeting. This meeting reports to the local JGOS committee, which meets quarterly. Chaired by the local Housing NSW Team Leader (Access and Demand), the client focused meeting is also open to SAAP providers who attend when they have an individual they wish to discuss. Participants report: *'We have a real sense that we're preventing terminations'*. The advantages of this approach are that the meetings have a clear, practical purpose, involve key specialist staff, and offer SAAP providers a flexible way of participating. While SAAP and NGO participants were pleased to have the opportunity to discuss particular cases with the agency staff directly responsible for them, they agreed that the meeting could be strengthened if agency staff also took on the role of escalating other cases and issues at a higher level within their organisations.

Housing NSW appeared to facilitate most committees, although there were examples of strong leadership by Health. It was not uncommon for there to be a rotating secretariat between the two organisations. In a number of locations, we heard that the main driver for JGOS had alternated back and forth over the years. In one location, an NGO chaired the meeting. From Housing NSW, attendance at committees was generally by team leaders and/or SCSOSs. Area mental health services were generally represented by community mental health team managers (or equivalent) and in a few instances, social workers. Community housing providers participated in most functional local committees and were generally represented by housing managers. In one area, a worker from the regional CHD office also attended local committee meetings. Participation by other local partners varied considerably (we discuss this in the stakeholder sections to follow).

There is no specified number of local JGOS committees that should exist in any one region and it is the role of area committees to determine where they should exist. Various reasons were provided by those we consulted in locations that did not have local committees as to why they did not exist. In some locations, committees had previously existed in one form or another and had lapsed. In others, workers said there was no need for a local committee as implementing the JGOS principles was part of their everyday work, or other forums (such as HASI meetings, social housing forums or mental health interagency meetings) were adequate for the purposes envisaged by the JGOS. In several areas, workers could provide no reason apart from inertia, lack of time or resources, or 'competing priorities'.

121 Housing NSW SCSOS, consultation April 2008.

In those areas where committees were operating, staff described the benefits as including:

- greater access to other agencies and services – getting to know local staff
- increased awareness of other organisations' policies and procedures
- a way of holding other agencies and services to account
- sharing strategies and tips for working with complex clients
- provides a mechanism to identify and address systemic problems.

Staff also identified a number of frustrations:

- no, or inconsistent, attendance by other partners, particularly from within the Aboriginal sector
- too many housing workers attend who are at a junior level, with their focus tending to be on their own cases rather than taking responsibility for addressing broader issues
- the lack of concrete outcomes for individuals
- impediments to exchanging client information due to privacy concerns
- repetitive discussion about issues without achieving any resolution
- the failure to improve overall service delivery.

4.3.3.2. Area committees

During our consultations we obtained information about both area and regional JGOS committees that were operating. The style of these meetings followed a similar pattern, in that all involved a mixture of general information exchange and discussion about systemic issues. Attendance was broad, though generally dominated by more senior Housing and Health staff.

The two area committees in operation were well organised and had the support of area directors. The North Sydney Central Coast committee had developed links with the local committees in the AHS and processes for recording their work and results. There was also good work being done by some regional committees, but this was mostly focused on specific supported housing projects rather than overall implementation of the JGOS.

The work of some other committees appeared limited to networking and greater awareness of other services. We were told of only a handful of local issues that were escalated by local committees to area/regional committees, and the results achieved through escalation did not appear to be significant.

There also did not appear to be a link between area/regional committees and the IRG/SPC or evidence that some of the common systemic issues we identified, or issues unable to be resolved locally, were being escalated by the area/regional committees to the IRG/SPC.

Overall, while it was clear that committed individuals were involved, it was difficult to assess what the area/regional committees saw as their purpose and what they had achieved or were trying to achieve.

4.3.3.3. Other forums

The JGOS Operations Manual notes that it may be appropriate for local JGOS partners to link in with an existing mechanism rather than establish a separate JGOS committee. During our consultations we asked about the existence of other local interagency forums in an attempt to ascertain whether JGOS type work was being carried out under alternative banners in areas without local JGOS committees. In a number of cases we were advised that forums including HASI committees, social housing forums, care coordination meetings, Accord meetings and mental health interagency groups were being used to facilitate JGOS work. However, in only one such case (see 'the RIAG in Dubbo' below) was it clear that the JGOS had been specifically incorporated into a committee's terms of reference. In the other cases, we were unable to determine what JGOS type work was being undertaken. Despite this, a number of people claimed that the existence of alternative mechanisms rendered the establishment of a separate JGOS committee redundant (we observed a link between this second suggestion and the view that HASI has replaced the JGOS).

We appreciate the need to draw on existing structures so as to avoid duplication. However, alternative forums can only be effective in facilitating JGOS work if this is clearly identified within the terms of reference of the alternative forum and the JGOS related outcomes are monitored.

Example

The RIAG in Dubbo

In Dubbo, Health has taken the lead in establishing a Rehabilitation Innovation Advisory Group (RIAG). Meeting bimonthly, the RIAG seeks to cover issues connected with the JGOS, the *Housing and Human Services Accord* and the Framework for Rehabilitation for Mental Health. It has three working parties – carers and consumers, Aboriginal and rehabilitation – which meet separately. Membership includes Housing NSW, the AHO, community housing providers, NGOs, the local Aboriginal medical service, some SAAP services and DoCS. The RIAG represents an attempt to meet local needs in a streamlined way. An advantage of this approach is that it brings together the main players to achieve the objectives of three interrelated policies in a flexible way. It is also notable for placing a specific focus on the needs of Aboriginal clients. The group was in its early stages at the time of our audit, and some participants said one potential risk is that, in attempting to achieve several things, the group may lose focus and lack cohesion.

4.3.3.4. The IRG and SPC

We have already noted that, with the exception of a few Housing and Health area directors, there was virtually no awareness or understanding of the existence and/or role of the IRG and SPC among frontline workers and local JGOS participants. There was general agreement however that a layer of governance is required to ensure the JGOS is being effectively and consistently implemented across the state. Staff identified a number of issues that they would like this layer to address:

- direction about what the JGOS should look like on the ground and what practical results staff are expected to achieve
- a reporting framework to record their activities and results achieved
- endorsement of local initiatives
- guidance about issues impacting on day-to-day work, eg exchanging client information
- dissemination of good practice examples and tips for working with complex clients, eg dealing with hoarding[122]
- a clear process by which issues can be escalated when they cannot be locally resolved.

While there was a strongly held view that a strategic layer of governance is needed to provide leadership at a statewide level, many IRG members questioned whether two committees with a strategic focus (ie the IRG and SPC) are necessary.

What makes an effective committee?

At our prompting, the staff we consulted made a number of suggestions about what is required for a committee to be effective:

- a clear purpose for the meeting and agreed rules
- documentation (terms of reference, action plan, agenda, minutes)
- an agreed process for recording activities and results and measuring performance
- consistent attendance, and representatives who have authority to make decisions
- identification of training needs for local partners
- a clear process for escalating issues that cannot be resolved
- a focus on identifying 'local solutions to local problems'
- feedback from the strategic committee to ensure broader systemic issues are addressed
- strong links between frontline staff and committee representatives

122 Several workers we consulted reported becoming individually aware of guidelines about better responding to and managing hoarding, produced under the auspices of Partnership Against Homelessness. They were critical that they had not been made aware of these guidelines in a more strategic way by the JGOS partners.

4.3.4. Relationships and responsibilities

4.3.4.1. Relationships

Staff reported that the introduction of the JGOS has led to greater understanding and acceptance of the notion that Housing and Health have a responsibility to work together. In some areas we were told that this had merely formalised good relationships that existed prior to the JGOS. In others, however, staff reported the JGOS had made a big difference in terms of 'getting people to talk to each other'.[123] There was considerable variability in the strength and quality of relationships between housing providers and health services.

Generally, there were good relationships between Housing NSW and community housing providers. Mental health workers often reported having a better relationship with community housing providers than with Housing NSW. In part, this appeared due to a perception that community housing providers are 'by nature less bureaucratic and more flexible'.[124] Some community housing providers reported feeling that Housing NSW has a tendency to refer to them the most difficult clients before assessing whether these clients can be accommodated in public housing. Not surprisingly, relationships were reported to be stronger where there was a perception that workers were honest about their capacity and limitations and demonstrating a willingness to share information and resources.

Overall, the JGOS appears to have helped strengthen the relationship between Housing and Health. However, it appears to have been unsuccessful in terms of building effective relationships between these two agencies and the other partners that 'JGOS 2' was established to include (Aboriginal housing providers and health services, SAAP providers and advocates). There was little evidence of meaningful effort to engage these stakeholders at an organisation-to-organisation level. We discuss this issue further in the stakeholder sections that follow.

4.3.4.2. Responsibilities

Based on our consultations, JGOS responsibilities do not generally appear to be specifically assigned to particular positions within Housing and Health. A notable exception is the North Sydney Central Coast AHS which employs a part-time Housing Coordinator who is responsible for developing policies and standards, and a management system for the 214 properties owned by NSW Health within the area and mostly managed by Housing NSW or community housing providers. The position, which is unique within NSW Health, is also responsible for 'ensuring leadership of the JGOS'.[125] Importantly, the position holder acts as a link between the local committees and the area committee.

In addition, as part of NSW Health's Clinical Mental Health Partnership Program, every AHS has a 'clinical partnership' position. The program is designed to better coordinate the delivery of mental health services by working with other agencies and the JGOS falls within these parameters. In at least two AHSs, clinical partnership positions are actively involved in the JGOS.

During our consultations we also observed that in some locations, mental health social workers are actively involved in JGOS committees and assisting people who need support to access or sustain social housing or SAAP services.

Good practice

Social workers

In Wollongong, mental health social workers identified the JGOS as one of their core responsibilities. They ensure that case management staff refer to them clients who need to be discussed at the fortnightly client focused JGOS meeting, where solutions are negotiated with Housing NSW, the local community housing provider and SAAP services. Such clients may be homeless or have an existing tenancy at risk. The social workers also assist clients by helping with applications and providing support and advocacy at priority housing assessments and CTTT hearings.

4.3.5. Views about the JGOS

Staff expressed a range of views about the benefits of the JGOS and frustrations associated with it. The most commonly cited benefit was that it recognises the need for Health and Housing to share responsibility for assisting people with mental illness to access and sustain housing. Housing workers in particular said the JGOS gives them additional leverage when attempting to engage other services. The reported frustrations were:

123 Housing NSW manager, consultation May 2008.
124 Mental health social worker, consultation May 2008.
125 Area Mental Health Housing Coordinator position description, provided by incumbent August 2008.

- a lack of clearly outlined roles and responsibilities of partners
- confusion about the intersection of JGOS with other programs and frameworks eg HASI and the Accord
- a lack of resources attached to JGOS (compared, for instance, to HASI) makes it difficult to meet its objectives
- the specific focus of the JGOS on mental illness does not assist workers when dealing with clients with a range of complex needs
- the absence from the partnership of DADHC and drug and alcohol services makes it harder to engage supports for dual diagnosis clients
- 'privacy' requirements impeding the exchange of information and the provision of the best possible service to clients
- for Housing staff, work undertaken in service of the JGOS principles not being recognised – staff attribute this to there being no requirement to record this type of information on the current Housing database
- weaknesses with the existing accountability and reporting mechanisms.

4.4. Engaging the SAAP sector

DoCS administers the SAAP in NSW and is a strategic JGOS partner on behalf of SAAP services. SAAP services become partners to the JGOS at a local level. From the meetings we had at the beginning of our investigation with SAAP peak bodies as well as from our ongoing work with the sector, we knew that many SAAP services reported feeling that the JGOS was delivering little benefit to their clients. The independent evaluation of the JGOS also found a low rate of participation by SAAPs on local JGOS committees. We met with workers from a total of 62 SAAP services, including women's, men's and youth refuges, to hear about SAAPs' experiences of participating in the JGOS or their reasons for not being involved, and to find out what guidance or support is provided to SAAP services to engage with the JGOS, particularly by DoCS.

The JGOS Guidelines state that DoCS staff should be involved in joint service planning at a local level. At the beginning of our investigation DoCS advised us that Community Programs Officers (CPOs) are encouraged to support SAAP services that want to become involved in the JGOS.[126] CPOs are regionally based and are supervised by Directors of Partnership and Planning (DPPs). We met with 11 CPOs and two DPPs in order to examine the extent of DoCS' involvement in the JGOS at a local level and in particular, what guidance and support they provide to SAAP services to participate.

4.4.1. DoCS

There was very limited awareness on the part of CPOs and DPPs of the JGOS or DoCS' responsibilities in relation to it. Without exception, those we interviewed stated that they had been provided with little or no corporate guidance or support in this regard. CPOs told us they were not required to report on any aspect of the JGOS as part of their performance management processes. One CPO who regularly attends her local JGOS committee advised that she had only found out about the JGOS through her Housing NSW colleagues when they requested DoCS representation. The CPO then undertook her own research in order to establish her responsibilities. Another CPO had the JGOS incorporated into her performance agreement only after raising the matter with her supervisor.

CPO attendance at JGOS committees was very limited. One CPO said that following a request by the local committee in her area for DoCS to send a representative, she attended, only to be told that the committee wanted 'a child protection person'.[127] This is indicative of a broader misunderstanding by some local JGOS partners, which we encountered on several occasions, of DoCS' role in relation to the JGOS, which is as a strategic partner on behalf of the SAAP sector. The few CPOs who were attending JGOS meetings were able to demonstrate that they had made an effort to encourage the participation of SAAP providers in the JGOS by providing information about local committees. Our consultations revealed little evidence that SAAP providers were raising JGOS related issues with their CPO, or that CPOs were raising issues specific to SAAP providers at JGOS committee meetings.

Overall, substantial confusion was apparent both among DoCS workers and other partner agencies and services as to the actual role of DoCS in relation to the JGOS. In addition to the misunderstanding cited above, there was evidence that some partner organisations regard DoCS as a 'gatekeeper' to the SAAP sector. At times, when asked about SAAP involvement, committee participants replied by saying they had been unable to engage with DoCS. They did not seem to think they could approach SAAP providers directly. In fact, while the JGOS Guidelines state that DoCS should be involved in local joint service planning, it is our view that the time of CPOs is not well spent attending local committees. Rather, their role should be to facilitate the participation of individual SAAP services in

126 Meeting with DoCS, 11 February 2008.
127 DoCS CPO, consultation June 2008.

the JGOS. This would appear to be the role that DoCS also evisaged. However, to perform this role effectively, CPOs need to have a better understanding of what is expected of them.

Towards the end of our investigation DoCS advised us that, due to a funding review, there has been no formal recruitment for the past two years to the CPO or Director of Partnerships and Planning (DPP) positions. Because of this, all CPOs are acting in their positions and the more experienced CPOs are acting in DPP roles. As a result, the workforce in this area is and has for some time been unstable. This is likely to have had an impact on the limited involvement of CPOs in the JGOS.

DoCS' strategic involvement in the JGOS is through their membership on the SPC. DoCS expressed some concerns about the appropriateness of participating on the SPC on behalf of SAAP services. When we put to DoCS the idea of expanding the SPC to include the SAAP peak bodies, DoCS agreed this would be potentially beneficial because in their view, peak bodies are better placed to represent SAAP providers.

4.4.2. SAAP providers

SAAP workers reiterated several of the major challenges that housing and health staff spoke to us about, namely increasing complexity of client need, a lack of available support services and for some, understaffing. In Chapter 1 we noted that the use of SAAP services has increased significantly in recent years. SAAP workers said the acute lack of affordable housing in many areas meant that more and more people – including a large number of families – were seeking their services. They also referred to the current SAAP funding agreement, which requires the SAAP sector to demonstrate that they are undertaking early intervention and post-crisis work in addition to their traditional function of providing emergency accommodation and case management. At the same time, services reported that their funding had not increased in real terms for several years. As a result, SAAP services commonly expressed the view that they are being required 'to do more with less' and that the sector is stretched to capacity with workers experiencing considerable stress.

Within this context, the two most common complaints by SAAP services were inadequate support by mental health services and a lack of suitable exit accommodation for clients. Workers spoke about the risks and stress involved when they are attempting to accommodate a person with a mental illness. With some exceptions, they said they felt unsupported by mental health services to do so. Workers spoke primarily of being unable to get assessments and case management support for clients, or of case management being inadequate. Many offered the view that the case management offered by Health does not adequately meet the needs of SAAP clients who have a mental illness.

Workers also reported feeling immense frustration when, after describing client behaviours to mental health services, they are told that the behaviours do not constitute evidence of a mental illness and therefore no assistance can be provided. SAAP staff also complained about ringing for assistance during a crisis and being told to transport their client to hospital or ring the police. This was felt to be inappropriate for a number of reasons, including the time and resources consumed when having to transport a client to hospital and accompany them while they wait to be assessed (this was particularly an issue for small services and those in rural and regional areas) and the likelihood of police involvement escalating a crisis situation by aggravating and alienating the client (this was particularly an issue in relation to Aboriginal and young clients).

Whilst there was acknowledgement of the pressures under which mental health services operate, and often sympathy for and goodwill towards mental health workers, the majority of SAAP providers we consulted were clearly of the view that they are not getting what they need to do their job properly and safely. Several indicated they felt they were viewed as 'a dumping ground' for the people no one else is prepared to assist. One SAAP worker said her service was 'a pseudo hospital wing'[128] and similar sentiments were expressed by others. A senior mental health worker with whom we spoke acknowledged that the SAAP sector would be likely to be critical of Health due to the large gap between the number of people and type of situations they can respond to, and the relative need of SAAP clients:

> *The SAAP sector will always say they're not getting enough* [from us] *and I don't blame them. By the very nature of homelessness, they have the people who've reached the end of the line. Inevitably, we won't be able to provide services when they want us to.*[129]

Lack of exit accommodation for clients was frequently cited by SAAP providers as a major source of frustration. In particular, they were critical of the lack of transitional and supported housing options. Many SAAP clients are unable to demonstrate capacity to live independently in social housing even with support provided. With case management, some will achieve readiness but the issue is how to accommodate them in the meantime. Others may never be able to sustain a tenancy and allocating social housing to these people may be 'setting them up to fail'. This may also be true for SAAP clients who have demonstrated the capacity to sustain a tenancy with support but then fail to receive this support.

128 SAAP worker, consultation April 2008.
129 Mental health manager, consultation May 2008.

Some SAAPs reported being approached by housing providers to provide outreach support to clients as a condition of allocating housing. However, SAAP services are generally not funded or resourced to carry out this work. Some SAAPs also reported that they had hoped the advent of HASI would benefit their clients in a way the JGOS has not. However, there was a general view that the SAAP sector has been excluded from HASI, with workers reporting little or no success in having client referrals accepted and expressing the opinion that HASI is 'a closed shop' between Health, Housing and the participating NGOs.

The housing and support needs of young people with mental illness featured consistently throughout our consultations with SAAP services. Concern was expressed that there are very few options for this group. The JGOS does not have a specific focus on young people as it is not common for those under the age of 18 to come to the attention of the social housing sector as applicants or tenants in their own right. The opposite is the case for SAAP providers. In 2005–2006, 35% of people accessing SAAP nationally were young people, with young females aged 15–19 years the most likely group to become a SAAP client.[130]

SAAP services require the support of mental health services to accommodate young people with mental illness. Based on our consultations, many feel they are not receiving this support.[131] The trial of a specialised youth mental health 'one stop shop' model in the North Sydney Central Coast AHS may, if the model is implemented across the state, provide SAAP services with a resource that assists them to meet the needs of this client group.[132]

4.4.2.1. Relationships

Overall, SAAP services appeared to have better relationships with Housing NSW and community housing providers than with mental health services. One SAAP worker commented that there are more opportunities for engagement with housing providers and that they share more in common (ie accommodating people) than do SAAPs and mental health services. While SAAP providers were sometimes critical of individual housing workers, particularly CSOs, their frustrations tended to be about a lack of adequate housing stock, waiting lists and administrative processes associated with applying for housing. A number of housing workers told us they would be lost without SAAP providers, as the case management they provide to clients is invaluable in terms of assisting people to become ready to sustain an independent tenancy.

Generally, relationships between SAAP providers and mental health services could be described as strained. SAAPs often reported feeling that despite the fact that the JGOS envisages SAAP providers as local partners, mental health workers do not respect SAAP workers' knowledge, experience and judgments. SAAPs also believed that mental health workers do not have a real appreciation of the challenges they face in trying to work with high needs clients, including the high-risk working environment that this can and does create. As an illustration of this, workers reported multiple instances of health workers referring clients to their services, often on discharge from inpatient care, without providing them with important information about the client's behaviours or needs. The JGOS states that area health services will provide sufficient information to SAAP services to enable them to assess a client's support needs. However, services reported accepting referrals from mental health services on the basis of information provided, only to find once they had done so that the clients' behaviours posed unacceptable risks to workers and fellow residents.

SAAP workers said that when they raised this issue with health staff, the common response was that they had been unable to pass on the information due to privacy considerations. SAAPs interpret this as an excuse, and suggested that the real motivation for withholding the information is fear that SAAP providers will not accept referrals if they have all the facts, leaving mental health workers 'holding the baby'. This alleged practice appears to be a source of considerable distrust and resentment on the part of SAAP providers, something that would appear to undermine the capacity for good relationships with mental health services and the effective implementation of the JGOS.

Overall, our consultations suggested that there is a structural 'disconnect' between the SAAP sector and mental health services, with limited evidence of strategic collaboration between them to achieve the JGOS aims. However, we did come across a number of examples of good partnerships between local SAAP providers and mental health services in relation to specific projects to meet local needs – see the example below.

130 Australian Institute of Health and Welfare, *Homeless people in SAAP: SAAP National Data Collection annual report 2005–06*, May 2007.
131 The report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals singled out mental health services for children and young people as being 'grossly under-resourced'. (*Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals*, Vol.1, November 2008, p99).
132 NSW Health, 'Youth Mental Health Service model piloted on the Central Coast', media release, 9 October 2008.

Good practice

Collaboration between mental health and SAAP

In Liverpool, the Youth Accommodation Service (YAS) described a productive collaboration with the Early Psychosis Intervention Program at Liverpool Hospital, NEAMI (a local NGO HASI provider) and the local Housing NSW SCSOSs. The partnership is formalised by memoranda of understanding. It involves the YAS providing crisis, medium-term and long-term (up to two years) accommodation with outreach support to young people aged 16–24 years. Health provides clinical case management and clients are transitioned into either mainstream social housing or a HASI package.

In some areas, SAAP providers were very complimentary about the approach taken by local mental health workers; for example, preparedness to attend SAAP facilities to conduct assessments, providing assistance to SAAP workers to ensure clients take their medication, and involving SAAP providers in discharge planning.

Good practice

Outreach health care for homeless people

St Vincent's Hospital in Darlinghurst has developed the Community Outreach Medical Emergency Team (COMET), an acute care outreach service for homeless and disadvantaged people. COMET treats homeless people where they live, rather than having them attend a hospital. The program also links people to other community support groups and services, including crisis housing. Staffed by a doctor and registered nurse and resourced with two cars equipped with diagnostic equipment, COMET has helped to reduce the amount of time spent by homeless people in emergency departments and hospitals, and enhanced the management of drug and alcohol and mental health issues.

4.4.2.2. JGOS involvement

SAAP awareness of the JGOS varied considerably, with some providers demonstrating familiarity and others none. This variation was also reflected in SAAP involvement. There was limited or occasional participation by a SAAP service/s in seven of the 16 local committees operating in the locations we audited. Where JGOS committees were functioning but SAAPs did not attend, they typically advised that they were unaware of the meetings, 'excluded', or had attended in the past and found the meetings not useful or relevant. Overwhelmingly, the view of most SAAPs who were aware of the JGOS is that it does not offer any benefits to them or their clients. It was noted that the guarantee is 'weighted' towards the potential contribution of SAAP providers without a concomitant acknowledgement of what they require in order to do their job, and of what SAAP clients need to enhance their wellbeing: stable housing and support.

In other words, the JGOS is not seen to facilitate mutual obligation and collaboration. As one worker put it, 'I stopped attending as it was a one-sided affair. Housing NSW and Mental Health just wanted SAAPs to guarantee they would take clients but they wouldn't guarantee they would house or case manage any SAAP clients'.[133] Another reported that when she raised the JGOS with a mental health worker in relation to difficulty accessing mental health services, the worker claimed not to know it existed (a similar experience with a Housing NSW CSO was also reported to us).

SAAPs also felt the JGOS was limited in that it specifically focuses on mental illness rather than complex needs. Workers spoke of the number of clients who present with multiple needs and of the difficulty involved in engaging support and finding housing solutions for this group. They felt the JGOS does not facilitate this and that it is therefore of limited value. SAAP providers who do participate on committees were also concerned that agencies too often say they cannot discuss individual clients due to privacy reasons and that this stands in the way of meeting the needs of the most vulnerable clients.

SAAPs reported that, in an environment where their resources are limited and there are a number of competing priorities, they need to see a clear benefit to their involvement in the JGOS. Currently, many cannot see any benefit and so choose not to participate. The clear exception which we identified during our consultations was that SAAP services in the Wollongong area welcomed the opportunity to attend the client focused meeting which we described in the previous section. SAAPs attend these meetings as needed to discuss individual clients. They felt this was an effective way of participating and achieving results for their clients.

133 SAAP worker, consultation March 2008.

4.4.3. Peak bodies

The SAAP peak bodies felt strongly that, as a brand, the JGOS has become irreparably tarnished. They suggested that JGOS 2 got off to a bad start because there was insufficient consultation with the SAAP sector prior to DoCS signing the MoU on their behalf. This created a lack of 'buy in' and also resulted in a lack of clarity about the role of SAAP providers and DoCS. According to one peak, the JGOS is 'too theoretical' and the lack of consultation meant that inadequate consideration was given to how the involvement of DoCS and the participation of SAAPs would work in practice.

Unsurprisingly, the peaks shared the view of SAAP providers that in its current form, the JGOS offers limited value to the SAAP sector. They reported that some SAAPs do not want to sign local MoUs because of a perception that the JGOS is not 'joint' and they will merely be expected to accommodate clients without receiving any assistance to enable them to do so: 'SAAPs are the poor partner in the [JGOS] relationship. When you say 'JGOS' to them, you get the groan response'.[134] The peaks' view was that what SAAP providers want from the JGOS is essentially better access to mental health services and housing for their clients, and the vast majority do not think it has delivered this. It is easy to understand why, given the data showing that half of all SAAP clients with a mental illness remain homeless after their period of support with SAAP ends.[135] The message conveyed by the peaks was that given the considerable strain that the SAAP sector is already under, 'unless the benefits to SAAP services are demonstrated, they are not going to get involved'.[136]

The peaks' direct involvement with the JGOS is through the membership of Homelessness NSW and the Youth Accommodation Association on the IRG. They expressed the view that the JGOS governance arrangements would need to be reviewed in order to promote increased participation by SAAPs and more effective implementation of the JGOS overall. Specifically, the SAAP peaks were in favour of reviewing the membership of the SPC and expanding it to include them as well as the other peak bodies that currently sit on the IRG. They argued that this would reduce duplication and lead to improved efficiency, planning and coordination. However, they stressed that including the SAAP peak bodies on the SPC would need to go beyond a symbolic gesture and result in the JGOS achieving more meaningful, demonstrable outcomes for SAAP clients.

What the SAAP sector wants

- A clear statement about what SAAP providers can expect from JGOS and what they are expected to provide, accompanied by genuine collaborative efforts to assist homeless people to access social housing
- Better access to mental health services for advice, assessment of clients and clinical case management
- More flexible approaches by mental health services in assessing clients, such as preparedness to attend SAAP facilities – sole worker services in particular experience difficulty when having to transport clients to hospital
- Meaningful consultation as part of discharge planning, including the provision of full information regarding clients' behaviours and needs
- Practical information and training to assist their work with clients who have complex needs, eg how to respond when clients resist taking their medication
- More transitional supported accommodation for their clients, especially young people
- Recognition of their knowledge, skills and experience
- Recording and monitoring of outcomes against the JGOS aims.

The peaks also suggested that there is a need to review how existing policies, programs and frameworks can be rationalised, including through consideration of how other interagency structures can be used to drive the JGOS at a regional level. They indicated that there is great scope for the strategic partners to utilise the existing SAAP regional networks to promote the JGOS and to work collaboratively to ensure it operates in a way that confers mutual benefit for all partners. There is also a recognised need for better recording and reporting of JGOS results by local partners, particularly in relation to homeless people assisted to access social housing and tenancy failures prevented. The peaks have also acknowledged that SAAP providers need to collect better data on the requests they make for mental health assistance and the occasions these are unmet. This will assist to substantiate the level of demand, and promote an honest, factual dialogue about the problems SAAPs encounter.

134 SAAP peak consultation, December 2007.
135 National Youth Commission, *Australia's Homeless Youth: A Report of the National Youth Commission Inquiry into Youth Homelessness*, 2008, p154.
136 SAAP peak consultation, December 2007.

Finally, the peaks see a greater role for DoCS and Health in assisting SAAP providers to better meet the challenges associated with working with clients who have complex needs. They advocate for more training to be provided to SAAPs with a focus on managing the practical issues that arise for workers on a day-to-day basis and skilling them to navigate the mental health system on behalf of clients.

4.5. Engaging the Aboriginal sector

The AHO is a strategic JGOS partner and, with the other strategic partners, is responsible for participating in the local coordination and monitoring of service provision. Aboriginal housing providers and medical services can become partners to the JGOS at a local level. As we have already noted, the independent evaluation of the JGOS found limited participation in JGOS committees by Aboriginal representatives. In addition, the baseline data collected for the purpose of the evaluation provided no information to suggest that the JGOS is achieving outcomes for Aboriginal clients. The evaluation found that there were no JGOS committees operating in Western NSW or the New England region, both of which have large Aboriginal populations.[137] At the outset of our investigation we recognised the importance of consulting with the Aboriginal sector in order to identify effective strategies to increase their participation in the JGOS.

We were particularly interested in meeting with Aboriginal medical services because of the critical role they play in identifying and responding to the needs of Aboriginal people with health problems. Many Aboriginal people are reluctant to use mainstream health services and it is reasonable to assume that many Aboriginal people whom the JGOS is designed to assist are known to, and/or regularly present to, Aboriginal medical services rather than area mental health services. We met with 13 Aboriginal medical services to examine the reasons for the apparent low level of engagement of the Aboriginal service sector with the JGOS, better understand the needs of Aboriginal clients with mental health issues, and find out how the JGOS or other initiatives might effectively address these issues.

One of the roles of the AHO's regional offices is to build capacity in the Aboriginal community housing sector. They undertake this work by providing training and support to the sector and carrying out compliance assessment and performance monitoring of Aboriginal community housing providers.[138] It was important that we also met with AHO regional staff to assess the level of their involvement with the JGOS at both the strategic and local level. In particular, we wanted to know what guidance and support they provided to Aboriginal community housing providers to engage with the JGOS. We also wanted to hear the AHO's views about the nature of any barriers to the participation of Aboriginal community housing providers. We met with AHO staff at four of the AHO's six regional offices.

In Chapter 6, we outline the significant reforms currently being considered to improve the capacity, governance and sustainability of the Aboriginal community housing sector. On the basis of information provided to us by the AHO, we decided to explore with the AHO how the proposed establishment of Regional Aboriginal Housing Management Services (RAHMS) could strengthen the Aboriginal community housing sector's capacity to engage with the JGOS at a local level. We interviewed South Eastern Aboriginal Regional Management Services (SEARMS), the only RAHMS – a coalition of 10 Aboriginal community housing providers – currently operating.[139]

4.5.1. Key challenges

Aboriginal people experience more disadvantage than non-Aboriginal people against a range of indicators. As we noted earlier in this report, they suffer a higher burden of emotional distress and possible mental illness. Despite this, research and anecdotal evidence has indicated they do not access mental health services at a commensurate rate.[140] There may be a number of reasons for this. The western concept of mental illness may not be relevant to Aboriginal people, who are more likely to view health as a continuum of physical, mental, emotional, spiritual and cultural states of being.[141]

In addition, for Aboriginal people there can be great shame attached to behaviours attributed to mental health conditions. Often, families will seek to care for the individual themselves rather than risk exposure to this shame as well as to interventions that may not be culturally sensitive to the individual's needs. Although in NSW most Aboriginal people live in urban areas, compared with the population as a whole they are more likely to live in regional or remote areas where there may be a limited availability of support services. In addition to emotional distress, substance

137 Susan Johnston and Margo Moore, *Joint Guarantee of Service Formative Evaluation*, April 2007.
138 Aboriginal Housing Office, *Annual Report 2006/2007*, 2007. p20.
139 The AHO has since advised us that the creation of RAHMS is only one of several options being considered (AHO, response to provisional report, 1 May 2009).
140 Tracy Westerman, 'Engagement of Indigenous clients in mental health services: What role do cultural differences play?', Guest Editorial, *Australian e-Journal for the Advancement of Mental Health*, Vol.3, Issue 3, 2004, p1. www.auseinet.com/journal/vol3iss3/westermaneditorial.pdf. Accessed 12 December 2008.
141 Tracy Westerman, 'Engagement of Indigenous clients in mental health services: What role do cultural differences play?', Guest Editorial, *Australian e-Journal for the Advancement of Mental Health*, Vol.3, Issue 3, 2004, p3. www.auseinet.com/journal/vol3iss3/westermaneditorial.pdf. Accessed 12 December 2008.

abuse[142] and disability[143] are over-represented in Aboriginal communities, meaning there are comparatively high numbers of individuals presenting with complex needs. Research commissioned by the AHO in 2004 found that 50% of Aboriginal homeless people presented with a dual diagnosis or three or more complex issues.[144]

Housing is another area of disadvantage for Aboriginal people. Over one-third of all Aboriginal households in NSW live in social housing, compared with 6% of the total population. As we have already noted, Aboriginal people are at greater risk of eviction and are more likely to be homeless than non-Aboriginal people, although the extent of homelessness tends to be hidden:

> *Due to the nature of our culture, you may never know the true homelessness figure because we have family members living with us and we do not usually notify people. People turn up on your doorstep, you have an obligation to feed them, house them, give them money and send them on their way the next morning.*[145]

Aboriginal households are almost three times more likely than non-Aboriginal households to live in overcrowded conditions.[146] At 3.2 persons, the average size of Aboriginal households is also larger than non-Aboriginal households (2.6).[147] The Aboriginal population in NSW is rapidly growing, meaning that demand for housing is increasing and will continue to grow well into the future. In 2006, 38% of the Aboriginal population was aged less than 15 years.[148] It has been estimated that the total Indigenous population will grow from 148,178 in 2006 to 199,775 in 2021, resulting in an increase in the number of households from 57,709 to 77,178 in 2021. This is an increase of 19,933 households or 35% (averaging 2.3% per year), implying over 1,300 new demands for housing annually during the next 15 years.[149]

Aboriginal services operate in the context of these and other challenges for their communities. The desire of many Aboriginal people to use Aboriginal-specific rather than mainstream services means the resources of the former are in high demand. Like other organisations, Aboriginal services have to contend with often limited resources and competing priorities. In rural and remote areas, the tyranny of distance can present obstacles to the provision of services. Recruiting and retaining appropriately skilled staff can be an issue, and the desire by other agencies and organisations to have Aboriginal representation at various committees and events can place considerable demand on workers' time. The six regional AHO offices cover large and diverse geographic areas and most employ less than five staff. Staff reported that these factors impact on their ability to participate in local interagency work.

In terms of assisting their clients to access and maintain social housing, Aboriginal services nominated the following specific difficulties:

- identification of Aboriginality – to be eligible for Aboriginal housing, applicants must have a signed Aboriginal identity form. There are often delays obtaining these signatures from the AHO or local Aboriginal land council[150]
- lack of regular and flexible communication by agencies with Aboriginal organisations to identify potential clients who need housing and support
- complex application processes – completing lengthy and detailed forms is often difficult for Aboriginal people, and assisting them to do so consumes a significant amount of services' resources
- inadequate communication and planning by Corrective Services and inpatient facilities prior to releasing or discharging people
- lack of available emergency and transitional accommodation.

4.5.2. JGOS involvement

Our consultations revealed minimal awareness and understanding of the JGOS by AHO workers and Aboriginal medical services. Some Aboriginal medical services had never heard of the JGOS. Neither AHO nor Aboriginal health workers reported receiving information or guidance from the AHO or AH&MRC about the JGOS. They also advised that this had not been provided by other partner organisations at a local level, even though they may have sought the involvement of Aboriginal organisations. Workers from Aboriginal organisations reported not understanding what their role should be in relation to the JGOS. One AHO worker who had been attending a JGOS committee meeting for some time told us she did not know what she should be contributing. This had never been

142 NSW Parliament Legislative Council, *Overcoming Indigenous Disadvantage in NSW*: *Interim Report*, June 2008, p130.
143 Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, August 2005.
144 Meeting with Jenny Brown, Regional Manager Sydney and South Eastern Region, AHO, 24 September 2008.
145 Mr David Lee, Aboriginal Housing Office, quoted in NSW Parliament Legislative Council, *Overcoming Indigenous Disadvantage in NSW*: *Interim Report*, June 2008, p221.
146 NSW Parliament Legislative Council, *Overcoming Indigenous Disadvantage in NSW*: *Interim Report*, June 2008, p28.
147 Noor A Khalidi, *Indicative NSW Indigenous Population Projections 2006 to 2021*, Aboriginal Housing Office, March 2008, p14.
148 Noor A Khalidi, *Indicative NSW Indigenous Population Projections 2006 to 2021*, Aboriginal Housing Office, March 2008, p12.
149 Noor A Khalidi, *Indicative NSW Indigenous Population Projections 2006 to 2021*, Aboriginal Housing Office, March 2008, pvi.
150 The AHO has advised us that they are currently reviewing the process for confirmation of Aboriginality in order to simplify it and minimise the time involved (AHO, response to provisional report, 1 May 2009).

explained to her, either by her own organisation or by the other participants, and she was embarrassed to ask. She was relieved when we spent time exploring with her the purpose of the JGOS and how she could make a productive, practical contribution both to the committee and implementing the JGOS principles more broadly.

Overall, Aboriginal services were the least likely of all the JGOS partners to participate on committees. Only one Aboriginal housing provider, SEARMS, attended a local committee on a regular basis. Regional AHO staff reported sometimes attending meetings of a small number of local and area/regional committees. Only three local committees were regularly attended by staff from an Aboriginal medical service. One worker from an Aboriginal medical service initially attended local committee meetings but stopped doing so because she could not see their relevance – Aboriginal clients and issues were not discussed. Other staff echoed this point and some also raised concerns about their participation being 'tokenistic'. Frequently, the need for a framework addressing complex needs, rather than just mental illness, was specified.

The AHO also questioned the value of their participation at meetings given they do not directly manage tenancies. They agreed with our observation that it would be more appropriate for Aboriginal community housing providers to attend local meetings, and for the AHO to play a role in encouraging this involvement as well as continuing to contribute to the JGOS at a strategic level through their participation on the SPC. It would seem that, because the AHO is a signatory to the JGOS, the other partners have sought to involve them at a local/area level rather than individual Aboriginal housing providers. This may reflect a lack of understanding of the AHO's role generally and/or a failure to strategically consider how JGOS committees might best identify and meet the needs of Aboriginal people.

We identified that the funding and service agreements for Aboriginal health services and community housing providers do not require them to report on their involvement in the JGOS or against measures such as the number of clients provided with support to access and sustain social housing. Regionally, the AHO also has no responsibility to report on its involvement with the JGOS, such as committee participation or work undertaken to support Aboriginal community housing providers to implement the JGOS principles. The AHO staff we spoke to advised that Aboriginal community housing providers are not required to report on JGOS participation or against measures such as the number of people with a mental illness housed, or support provided to tenants to assist them to sustain their tenancy. We reviewed the relevant registration documents and service provision guidelines and confirmed this. In response to our provisional report, the AHO also confirmed this. They advised that many Aboriginal community housing providers do not presently have the capacity to report against the JGOS in any detailed way, noting that the reforms to Aboriginal housing currently being considered would change this. The AHO agreed that it would be appropriate for Aboriginal community housing providers to report on the provision of assistance to clients to access support services.[151]

The AHO staff we consulted acknowledged there is more the organisation could and should do to promote the JGOS to Aboriginal community housing providers and to support them to implement the JGOS principles. They believe sector reform involving the consolidation of Aboriginal housing provision and more stringent accreditation processes for providers is likely to enable this. We discuss the reform of the Aboriginal housing sector in more detail in Chapter 6.

Both housing and health workers in locations where JGOS committees were operating reported having difficulty securing the involvement of the Aboriginal sector. They often complained that they had extended invitations to participate but that these had been ignored or refused, or that attendance at meetings occurred on a sporadic basis. Few workers were able to say what attempts had been made to explore or address the reasons for this. Housing and health workers were also unclear about the nature of the contribution they were seeking from Aboriginal organisations. In some areas there appeared to be a view that engaging the Aboriginal sector is simply too difficult. Some committees said they had stopped trying to secure Aboriginal involvement. Several Aboriginal organisations noted that a more effective way for agencies to engage them is to establish regular, informal contact to encourage client referrals and seek feedback about their service delivery.

As strategic partners, the AHO and AH&MRC have seats on the SPC. The AHO is also represented on the IRG. The AH&MRC attended only two of eight SPC meetings during 2006 and 2007,[152] while the AHO was absent from all but one of the five IRG meetings that took place during the same period. As neither the AHO nor AH&MRC have made themselves available to meet with us at a corporate level during our investigation, we are unable to offer a possible explanation for this. It has been suggested to us that the resources of both organisations are stretched and that, in the context of competing priorities, their focus has not been on the JGOS. It may also be the case that they question the relevance of the JGOS to their work; some Aboriginal staff who have participated at the strategic level said they were disappointed because they thought the JGOS would focus on better case management of clients, and this was not their experience.

151 AHO, response to provisional report, 1 May 2009.

152 We were told by Housing NSW that the SPC met on nine occasions during this period, however we only received minutes for eight meetings.

4.5.3. Relationships

Housing NSW, area health services and some community housing providers employ people in Aboriginal-identified positions. During our audits, we gained the impression that the organisations tend to greatly rely on the staff in these positions to 'access' Aboriginal communities and respond to their needs. It was our observation that much of the work undertaken by these staff is not adequately recorded. While it is clear that Aboriginal workers tend to have good connections in their communities and are a valuable resource, the over-reliance on them by the agencies they work for can be problematic. Their time, energy and capacity are limited, and being Aboriginal does not mean they will automatically have positive and constructive interactions with all members of the Aboriginal community. For this reason, it is important to ensure that outcomes for Aboriginal clients are being systematically tracked and measured, rather than assuming that informal connections between Aboriginal workers and their community contacts are adequately identifying and meeting community need. Another risk for agencies in relying solely on their Aboriginal workers to develop relationships with Aboriginal organisations is the loss of community connection and corporate knowledge that can occur when individual staff members move on.

While senior Housing and Health staff acknowledged the important role that Aboriginal medical services play and saw collaboration with them as desirable, we were concerned by the apparently low level of meaningful engagement occurring on the ground in many areas. The majority of Aboriginal medical services did not report close relationships or collaboration with either housing providers or area mental health services. Their interagency partnerships tended to be with SAAP services and NGOs. There was evidence of poor communication between Aboriginal medical services, area mental health services and housing providers. For example, based on our consultations, it appears that Aboriginal medical services' knowledge and understanding of programs such as HASI and the Private Rental Brokerage Service was often limited, confused or inaccurate. Services also reported that housing providers were not informing them about tenancies of Aboriginal people at risk, despite the likelihood that most would be known to the Aboriginal medical service and the service could be in a position to assist.

Aboriginal medical services function as a sort of 'one stop shop' for many Aboriginal people, who access them to obtain a range of information and services apart from health care. Staff often assist clients with applications for housing and have a good understanding of their support needs as well as issues more generally for Aboriginal people. Aboriginal medical services are therefore an extremely valuable community resource. The failure of mainstream agencies to pursue good relationships and to seek to collaborate with them on specific strategies represents a wasted opportunity to improve the provision of services to Aboriginal people. One Aboriginal medical service described feeling frustrated and disappointed when they approached Housing NSW with the idea of setting up a housing shopfront from the service for three hours each fortnight, staffed by Aboriginal workers.[153] The service believed this would be a practical way of assisting Aboriginal people to access Housing's services and of therefore meeting the JGOS aim of assisting people with mental health problems to establish social housing tenancies. Housing reportedly said they were unable to accommodate the suggestion. We note that the arrangement suggested by the Aboriginal medical service has been implemented in other areas with considerable success.

Our extensive ongoing work with Aboriginal communities has confirmed that it is the willingness of mainstream agencies to explore practical and flexible measures in collaboration with Aboriginal services that leads to the development of trusting relationships, which in turn facilitates greater involvement on their part and ultimately, better service provision to Aboriginal people. An example of good practice is included below. In Chapters 5 and 6 we discuss what additional measures are needed to increase participation in the JGOS by Aboriginal community housing providers and medical services.

Good practice

Engaging Aboriginal organisations

In one area we visited, a Housing team leader told us he rings the coordinator of the local Aboriginal medical service every fortnight 'to have a yarn' about any individual matters or issues that may have recently arisen. He uses these conversations to exchange information and to ensure matters are followed up as required. The team leader told us he recognises that the resources of the medical service are thinly stretched and that, as they are often unable to attend committee meetings, regular phone calls are the most effective way of getting things done. He said that reaching out consistently is the key to building a trusting relationship.

153 AMS consultation, April 2008.

4.5.4. What Aboriginal services want

- a clear understanding of their role and what is expected of them
- a specific focus on meeting the needs of Aboriginal people
- a focus on complex needs rather than just mental illness
- to be approached to be involved in committees on an 'as needed' basis (eg to participate in case conferences or joint client visits) or to play an advisory role in the development of Aboriginal specific programs or initiatives
- regular, informal contact from agency staff to identify problems and who may need assistance
- for Aboriginal medical services to be utilised as a resource for early intervention when tenancy problems are identified
- Housing NSW to provide outreach services at Aboriginal organisations
- simpler housing application processes
- involvement of family members when Aboriginal clients are unwell and/or experiencing problems with their tenancy
- mental health services to visit people in their own homes (at least for initial assessment)
- information about specific outcomes achieved for Aboriginal people
- more transitional and supported accommodation specifically for Aboriginal people.

HASI for Kooris

In Penrith, the HASI model has been adapted to better suit the needs of Aboriginal people with a mental illness. Managed by Aftercare with the involvement of two Aboriginal community leaders, the program also employs a full-time Aboriginal worker. While the program is underpinned by the same principles as HASI, its service delivery model has greater flexibility and has been specifically designed to be culturally sensitive to the needs of Aboriginal people and the dynamics of Aboriginal culture by taking into account issues of defining mental illness, locality of the program and family inclusion. Some strategies being explored include considering utilising the 'social and emotional wellbeing' of Aboriginal people as an eligibility criteria, as opposed to a formal clinical diagnosis of mental illness. We understand that Greater Western AHS is also exploring the implementation of a model of HASI that is appropriate for Aboriginal people.

4.6. Involving advocates

The JGOS refers to the role of the 'advocate' as 'a person of the individual's choice, who provides information and/or support on issues of rights and responsibilities'[154] and states that they are responsible for both individual and systemic advocacy at JGOS meetings. Our consultations focused on the two types of advocates that are most likely to have or seek JGOS involvement: mental health consumer advocates and tenant advocates.

In this section we also reflect some of the issues raised during our consultations with Legal Aid, the Office of the Protective Commissioner (OPC) and the Office of the Public Guardian (OPG).[155] With the exception of Legal Aid, these agencies are not strictly advocates, but their clients are often the type of people the JGOS aims to assist and they raised with us some concerns about practices that may detrimentally impact upon their clients' wellbeing.

4.6.1. Tenant advocates

Tenant advocates may work for Tenants Advice and Advocacy Services, Regional Tenant Resource Services or community legal centres.[156] The independent evaluation of the JGOS noted that some tenant advocates reported being excluded from local JGOS committees in some areas. Our consultation with the Tenants' Union also yielded this observation. We were keen to further explore this during our audits. We also wanted to assess the level of tenant advocates' awareness of JGOS, hear about individual cases of tenants/clients with mental illness, and investigate how the participation of tenant advocates in JGOS might be strengthened. We consulted staff from 13 services

154 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, p12.
155 On 1 July 2009, the OPC and OPG merged with the Public Trustee to become the NSW Trustee and Guardian. As they were known separately as the OPC and OPG at the time of our investigation, we reflect this in our report.
156 As of 1 July 2009, Regional Tenant Resource Services have been replaced by nine Tenant Participation Resource Services. We discuss this further in Chapter 8.

providing advocacy for social housing tenants. In addition, the Aboriginal tenant advocates' network made a written submission to us and in February 2009, we met with 15 members of the network to provide them with a further opportunity to discuss their experience of the JGOS and issues specific to Aboriginal clients.

Tenant advocates usually come into contact with social housing tenants when a housing provider has commenced action against a tenant due to a breach of their lease. This action may involve seeking a specific performance order or termination of lease before the Consumer, Trader and Tenancy Tribunal (CTTT). For this reason, the relationship between tenant advocates and housing providers can become adversarial. Some tenancy workers pointed out that their view of housing providers may be coloured because they tend to come into contact with them only in such circumstances. While overall this was evidenced during our consultations, we came across examples of productive relationships that had been developed and sustained, resulting in good outcomes for tenants. Our observation was that these relationships tended to occur when housing providers were willing to actively engage tenant advocates as an early intervention resource and respond positively to their requests for information and documentation when representing clients, and when tenant advocates sought to address problems and concerns in a strategic manner. Poor relationships appeared to be characterised by the absence of these factors.

While Housing NSW SCSOSs generally received praise for good work undertaken in an effort to sustain tenancies, some advocates were concerned about the limited number of these positions and their accessibility. Some advocates also complained about some housing workers displaying negative attitudes towards tenants and tenant advocates. In particular, advocates were concerned that some CSOs may not have been provided with adequate training and guidance to enable them to identify and respond effectively to complex situations. Advocates also thought that the CSO position description should be altered to reflect the need to have skills in dealing sensitively and effectively with clients with complex needs.

Advocates reported that good CSOs are invaluable. We were told, for example, about one CSO who contacted a tenant advocacy service when he identified problems with a tenancy – this action was reported to have ultimately prevented the tenancy from failing. The need for greater guidance and support for CSOs has been recognised by Housing in Parramatta. This office has developed an innovative mentoring program for CSOs whereby they can nominate to be mentored by SCSOSs who assist them to develop skills in managing complex tenancy matters. The mentoring program is for a 12 month period, and CSOs who complete it can then decide if they are interested in applying to become a SCSOS. As a result of the program they are better placed to provide assistance to their peers.

4.6.1.1. Concerns about notices of termination and CTTT proceedings

Many of the tenant advocates we consulted raised concerns about the perceived conduct of Housing NSW in relation to CTTT proceedings. While the scope of our investigation has not allowed us to test these perceptions, it is important that we report them here. This is because the perceptions have the potential to significantly impact on the relationships between tenant advocates and Housing NSW workers and therefore the effective implementation of the JGOS. As such, it is important for Housing NSW to consider the concerns expressed by advocates and the most appropriate way of responding to them.

Tenant advocates commonly expressed concern about housing providers issuing notices of termination (NOTs) to tenants with mental health problems prior to exploring other strategies. Advocates suggested that this practice is used as a way of coercing a tenant to take action to remedy a tenancy breach or to prompt other services to provide support to tenants experiencing difficulties. Some Housing NSW workers we consulted confirmed that they sometimes issue NOTs for the purpose of 'forcing' tenants to take action to remedy tenancy breaches while others said they do so in an attempt to get tenants to realise they may need support. Advocates told us they view this practice as not being in the spirit of the JGOS or consistent with Housing NSW policy. They also complained that tenants experience considerable anxiety when they receive a NOT before other approaches have been made by Housing to resolve problems and that the practice can exacerbate the behaviours that may be associated with a tenant's mental illness.

In 2006 we conducted an investigation into a complaint about the eviction of a tenant with a mental illness who was in rental arrears.[157] In the course of this investigation Housing NSW told us that 'it is common practice for staff to take action at the CTTT to encourage the tenant to seriously consider the consequences of ignoring [Housing NSW's] warnings'. We noted that this position did not sit comfortably with the intention and requirements of Housing's own policies and procedures, or with the JGOS.[158]

Tenant advocates were also concerned about wrong or inadequate information being provided to the CTTT by NSW Housing workers, including the reported failure of some workers to give evidence during proceedings about what steps they had taken to apply the JGOS principles in order to resolve the problem prior to issuing a NOT. Advocates argued that as the JGOS ascribes responsibility for convening joint service meetings to Housing NSW workers, these

157 This investigation is described in Chapter 2.
158 We discuss this issue further in Chapter 8.

workers should provide the CTTT with evidence of what steps were taken to support the tenancy in question and the reasons why they believe the only reasonable course of action is an order for termination and possession. Advocates believe there should be clear protocols for housing workers in this regard.

The adequacy of the information provided to the CTTT was also an issue arising from our 2006 investigation referred to above. In relation to that investigation, we found that the Housing NSW workers involved had not informed the CTTT about the tenant's known mental illness, nor outlined what steps they had taken to negotiate the repayment of the rental arrears with the tenant or to otherwise resolve the problem prior to issuing a NOT. On the basis of a recommendation we made at the conclusion of our investigation, Housing NSW subsequently amended the 'CTTT action sheet' that housing workers must complete before commencing CTTT proceedings. If a tenant has a known current or prior health/medical conditions, Housing must record this on the action sheet. The sheet now also requires staff to advise whether in these circumstances a SCSOS has been consulted and if not, why. This investigation did not explore compliance with the new CTTT action sheet procedures. However, in response to a recommendation contained in our provisional report, Housing has agreed to provide us with advice about the steps taken by the department to ensure housing workers complete the CTTT action sheet.[159]

4.6.1.2. JGOS involvement

There was a good level of awareness of the JGOS agreement and its aims among tenant advocates. However, this awareness did not always extend to knowledge of local JGOS committee arrangements. During our consultations we came across no instances of tenant advocates participating on JGOS committees. However, in early 2009 we were advised by the Aboriginal tenant advocates' network that, after approaching their local Housing office to request involvement, one service is now 'allowed' to attend its local JGOS committee meetings once every six weeks. Some tenant advocacy services reported being actively excluded from attending JGOS meetings, and that their attempts to address this directly with Housing staff had been unsuccessful.[160] No tenant advocates reported being informed about local committees or invited to attend. Dtarawarra, the Aboriginal Resource Unit for the Aboriginal tenant advocacy services, reported difficulty accessing information from Housing NSW about the location of committees and who to contact in order to become involved – when the information was provided, the contact details were out of date or contact people could not be reached. Some tenant advocacy services were aware of committees but had not taken steps to become involved. This could be because it was only in 2007 when the additional JGOS resources were issued that tenant advocates were specifically referred to in the JGOS documentation as potential local JGOS partners.

Advocates often described raising the JGOS with housing workers when dealing with particular situations, reportedly to be told in response 'we have tried the JGOS and it hasn't worked' without being provided with an explanation of the steps taken to sustain the tenancy (Legal Aid also reported being aware of only a handful of cases where the JGOS was successfully applied – these generally involved community housing providers). Advocates reported that they would like more opportunities to advocate on behalf of individual clients at JGOS committee meetings.

Overall, tenant advocates felt there was a lack of clarity and transparency in terms of whether and how the JGOS principles are practically implemented. They were also critical of an apparent lack of knowledge and awareness of the roles and responsibilities of the different JGOS partners. The Tenants' Union, which is represented on the IRG, articulated the view that the JGOS governance structures need to be reorganised. Like the SAAP peak bodies, they were in favour of merging the SPC and IRG, developing strong processes for the recording and reporting of JGOS outcomes and including JGOS responsibilities in the position descriptions of key roles.

4.6.2. Consumer consultants

Area mental health services employ consumer workers, commonly known as 'consumer consultants', who are people that have previously used mental health services. The definitions, job descriptions and roles for these paid and voluntary positions vary, but may include providing peer support, information, education and advocacy.[161] As advocates, consumer consultants can provide individual and systemic advocacy at JGOS committee meetings. The independent evaluation of JGOS found that consumer consultants participated in just under half of the JGOS committees (local and area) operating at the time the evaluation was conducted. We met with nine consumer consultants to hear about their own experience of participating in the JGOS as well as individual cases of tenants/clients with mental illness.

There was strong awareness of the JGOS agreement and aims among consumer consultants. All those we consulted participated on local and some area/regional committees, but most committees in the areas we audited did not have consumer consultant participation. Consultants reported that at JGOS committee meetings their role

159 Housing NSW, response to provisional report, 20 May 2009.
160 We informed Housing NSW of this issue during our investigation. They confirmed the practice should not be occurring and undertook to address it through the IRG.
161 NSW Health, *NSW Community Mental Health Strategy 2007–2012*, May 2008, p15.

was mostly to comment on systemic issues from a consumer perspective. There was limited evidence of consumer consultants providing advocacy for individual clients at JGOS meetings. However, consultants did not see this as a problem and in fact shared a view that for privacy reasons, individual advocacy should take place outside of committee meetings as part of normal 'case management' processes. Outside of committees, consultants were actively engaged in providing individual advocacy as part of a wide range of responsibilities. However, a number of them reported that they would like more opportunities to advocate on behalf of individual JGOS clients.

Overall, consultants reported that while they felt it was important for them to participate on JGOS committees in order to provide a consumer perspective, the experience was often stressful and intimidating because they felt that other participants did not have an adequate understanding of their role.

There were mixed views on the part of housing and health workers about the participation of consumer consultants on JGOS committees. It was generally seen as desirable, with some staff suggesting that the presence and contribution of consultants keeps discussions 'honest' and serves as a reminder of the JGOS aims and the need to place individuals at the centre of service planning. One health worker queried how representative of all consumers a consumer consultant could be, while several housing workers expressed concern about client confidentiality being compromised if individual cases are discussed in the presence of a consumer consultant. It was also recognised that consumer consultants can be a thinly stretched resource.

The NSW Consumer Advisory Group (CAG) sits on the IRG and raised the need for an effective process to enable the escalation of unresolved issues by local committees. They also advocated for better monitoring of JGOS outcomes. In addition, the CAG emphasised the need to more clearly articulate the role of consumer consultants in the JGOS documentation and systematically embed this role in the practices of local committees.

What advocates want

- Acknowledgement and understanding of their respective roles by other JGOS partners
- An agreed process between all JGOS partners by which advocates can refer an individual's circumstances for discussion
- Where possible, consent obtained from clients by housing/health workers prior to discussion of their circumstances at JGOS meetings
- To be more effectively used as a resource for early intervention when tenancy problems are identified
- Appropriate strategies to prevent tenancy failure and transparent processes around this work
- Simpler application processes for priority housing that take into account that applicants often do not possess or cannot supply certain documentation
- Housing NSW CSOs be given adequate training and guidance to enable them to better respond to clients with complex needs
- Housing workers attempt alternative means of resolving tenancy breaches prior to issuing tenants with a mental illness with a notice of termination, and provide adequate information to the CTTT about the steps taken to prevent tenancy failure

4.6.3. Additional issues raised by the OPC and OPG

The Office of the Protective Commissioner (OPC) and the Office of the Public Guardian (OPG) are expected to work with Housing NSW in relation to mutual clients who are vulnerable and at risk of losing their tenancy. Many of these mutual clients have mental health problems and are therefore among the people the JGOS aims to assist. The OPC and OPG need to be a first point of contact for housing workers when tenancy problems and support needs are identified.

Both the OPG and OPC expressed concern that their role is not well understood by housing workers. While the OPG reported receiving good responses from Housing NSW area directors when they raise individual matters with them that have not been well handled, they believe that greater clarity in relation to their role and how and when they should be engaged by housing workers would lead to better handling of individual cases. They also felt that housing workers would benefit from more training about the common reasons why the tenancies of mutual clients become at risk. For example, the OPG noted that squalor and hoarding are the most common problems that put their clients' tenancies at risk. Both organisations also advised that their clients are often vulnerable to manipulation and exploitation by others, and that as a result they may inadvertently breach the conditions of their tenancy (eg through another person moving into the property).

Both the OPG and OPC reported that Housing NSW does not usually inform them of problems with tenancies until the situation has reached the point where CTTT action is commenced. This is despite the fact that the OPC must sign the lease for its clients. Instead, housing workers tend to deal directly with tenants. This is problematic given the functional limitations their clients may have, eg illiteracy or impaired capacity to interpret information. Early contact with the OPC/OPG would enable these agencies to intervene and possibly avoid remedial action being taken against a client.

4.7. The non-government sector

In Chapter 1 we noted the increasing importance of non-government organisations (NGOs) in the mental health service sector. Although NGOs have always played an important role in the delivery of services to people with mental health problems, in more recent times they have become heavily involved as partners in major programs funded by government, such as HASI and PHaMS. Given the growth in the services they provide to people with mental illness, it is not surprising that mental health NGOs are now regarded by both social housing providers and area health services as key partners.

The JGOS envisages mental health NGOs as local partners and in some areas they have become involved in local JGOS committees. We consulted a total of 31 NGOs. While the majority provide mental health services, some provide more general support services to homeless people and people with mental health problems as part of their charitable work. Our consultations with NGOs were aimed at finding out about the extent to which they have become involved with the JGOS at a local level, seeking their views about the JGOS overall, and better understanding how the JGOS intersects with programs such as HASI at a practical level.

NGOs generally reported having good relationships with housing providers and Health. Mental health NGOs who are HASI providers usually have very good access to these partners due to the contractual arrangements they have entered into. Housing and Health workers also have a clear understanding of their role and are well-disposed to working productively with them because they are able to provide much needed support services to clients. The main concern reported by some HASI providers was that some housing workers are not sufficiently aware of HASI's program requirements and limitations. They said housing workers often do not understand why the HASI program cannot accommodate all tenants who have mental health problems and require support in the HASI program and that this can lead to unreasonable expectations being placed on NGOs.

The only significant criticism of NGOs made by the housing workers we consulted was that at times NGOs fail to notify them of concerns with a tenancy or withdrawal of the provision of agreed services. This failure leaves housing workers unaware of a tenancy potentially at risk and precludes them from intervening early to address the situation.

Awareness of the JGOS among those we interviewed was high, and we found that NGOs were participating in all but three of the 16 local committees functioning in the areas we audited. They were also involved in three area/regional committees. There was little awareness of the JGOS or participation on committees of non-mental health NGOs. When we explained to them the aims of the JGOS, a number of these organisations saw their non-involvement as a missed opportunity for housing providers and Health. Such NGOs are usually well embedded in their local communities, come into frequent contact with the people the JGOS aims to assist, and can have substantial knowledge and experience of the issues affecting them. Non-mental health NGOs pointed out that they can often be of assistance in the case of clients who do not acknowledge they have a mental illness or who refuse to engage with mental health support services. Such clients are sometimes willing to accept support (eg social interaction, food, transport) from NGOs that offer more general assistance.

NGOs expressed two main areas of concern about the JGOS. They said that some of the most vulnerable individuals who experience multiple disadvantage as a result of the interaction of a number of complex issues cannot necessarily be assisted through the JGOS because of its primary focus on mental health problems. NGOs also expressed the view that while the aim of the JGOS to provide stable housing is critical, it does not sufficiently emphasise the importance of a holistic approach to supporting clients that takes into consideration all their needs, including general health, independent living skills and social engagement.

The Mental Health Coordinating Council (MHCC) is the peak body for mental health NGOs and is represented on the IRG. They suggested that the primary reason for the limited effectiveness of the JGOS is problematic governance, including a lack of accountability mechanisms. In particular, the MHCC commented that there is a lack of communication between the various committee layers, and insufficient documentation of roles and responsibilities. Furthermore, the MHCC felt there is not enough documentation of the NGO role and what NGOs can expect (this is similar to the point made by the SAAP peaks about the need for 'mutual obligation' to be articulated). The MHCC was critical of the idea that HASI renders the JGOS unnecessary, pointing out that HASI does not have the capacity to meet the level of demand in the community. However, they felt that JGOS could learn from the strong governance model that underpins HASI.

Chapter 5. Governance

The JGOS governance structure, like the JGOS documentation, has evolved over time. Our investigation revealed weaknesses at all levels of governance that have impeded the successful implementation of the JGOS. In this chapter we outline these weaknesses. Our provisional report recommended significant changes to the JGOS governance structure to increase efficiency and maximise performance against the JGOS objectives (see Appendix 1). These changes involved streamlining the JGOS committees and reviewing their terms of reference to provide a greater focus on results rather than processes.[162] In response to our provisional report, Housing acknowledged weaknesses in the JGOS governance structure.[163] Both Housing and Health have agreed to take into account our preliminary recommendations about governance in the development of the new Housing and Mental Health Agreement.

5.1. SPC and IRG

Our consultations revealed a very low level of awareness and understanding of the SPC and IRG and their respective purposes. Where there was some awareness, it was apparent that the existence of two different committees at a statewide level has led to confusion about their roles and responsibilities. A two-tiered model has also required unnecessary deployment of resources and in some respects, duplication of effort. There are a number of changes required to address this.

5.1.1. Strategic Partners Committee

The SPC is chaired by Housing NSW. The stated purpose of the committee is 'to provide strategic coordination for government and non-government action in the implementation of the JGOS'.[164] Its terms of reference are documented as follows:

1. To develop a JGOS Implementation Plan, based on advice from the JGOS Implementation Reference Group, including:
   - JGOS Area Information Workshops across the state
   - Area Implementation Committee meetings and Area MoUs
   - resourcing and training issues.
2. To action the JGOS Implementation Plan and coordinate the engagement of stakeholders, including those represented on the JGOS Implementation Reference Group.
3. To monitor progress of the JGOS Implementation Plan and the ongoing application of the JGOS across NSW.
4. To develop a communication strategy and a framework for dissemination based on advice from the JGOS Implementation Reference Group.
5. To develop and implement an evaluation framework for the JGOS based on advice from the JGOS Implementation Reference Group.
6. To provide briefings to the Partner agencies regarding:
   - priorities and resource development to support the implementation of the JGOS in addressing the needs of identified target groups
   - recommendations in relation to policy and practice and systemic issues.

The terms of reference specify that the SPC will meet bimonthly.

We asked Housing NSW to provide us with copies of any documents developed by or informing the work of the SPC. We were advised that in 2006 and 2007, the SPC met nine times. We received copies of the minutes for eight of these meetings. It is notable that the AH&MRC – the peak body for Aboriginal community controlled health services – were represented at only two of these eight meetings. Although it is clear that there were some attempts to secure more consistent representation from the AH&MRC on the SPC, we were unable to determine what efforts were made by

162 We note that the independent evaluation of the JGOS completed in 2007 recommended that the JGOS governance structure be reviewed through amending the terms of reference of the SPC and IRG to consider the purpose of the committees, membership, role of partner organisations, reporting mechanisms and clearer guidelines for escalating systemic issues (Susan Johnston and Margo Moore, *Joint Guarantee of Service Formative Evaluation*, April 2007, p16).

163 Housing NSW, response to provisional report, 20 May 2009.

164 JGOS Strategic Partners Committee, Terms of Reference, undated, provided by Housing NSW.

the SPC to explore the reasons why this proved so difficult. Based on the minutes, as well as our consultations and other information provided by Housing NSW and the Department of Health, we were able to establish that in relation to the SPC's terms of reference:

- In 2005 Housing NSW conducted 17 information forums across the state 'to stimulate interest in the expanded JGOS and discuss the implementation guidelines'.[165] A total of 461 people attended.
- An Operations Manual, Reference Guide and other resources, including a plain English brochure, were released in 2007 – a communications strategy was developed to guide the promotion of these resources.
- An evaluation framework was developed in 2006, with tenders assessed in September of that year. The resulting formative evaluation of the JGOS was completed in April 2007. The SPC has implemented some recommendations from the evaluation and following consultation with us, has decided not to implement others pending the outcomes of this investigation.
- In 2005, Health commissioned a report about the engagement of the SAAP sector with the JGOS – the report, which contained a number of recommendations, was provided to the SPC in early 2006 and briefly discussed by the SPC in June that year.

Overall, while the SPC achieved some of its objectives, it is difficult to conclude on the basis of the documentation provided to us and information from our consultations that the SPC was successful in guiding and monitoring the effective implementation of the JGOS. The timeliness of actions is one concern given that JGOS 2 commenced in 2003 but the information forums and resources designed to promote it were only held and published in 2005 and 2007 respectively.

The independent evaluation of the JGOS recommended that the SPC develop an annual work plan. In our provisional report, we recommended that the SPC should develop an overarching strategic plan incorporating a revised terms of reference. We further recommended that the strategic plan should be supported by annual plans that identify the work to be undertaken each year in relation to the terms of reference.

We also noted the responsibility of the SPC to escalate certain issues that it identifies, particularly those of a systemic nature that appear to be adversely impacting on the provision of services or the quality of outcomes for the individuals the JGOS aims to assist. In this regard, the independent evaluation also recommended that the SPC develop stronger links with the Housing and Human Services Senior Officers Group which is responsible for the implementation of the Accord. We agreed with this recommendation in our provisional report and expressed the view that there would also be merit in stronger links being developed with other relevant interagency groups, such as the DADHC/NSW Health Senior Officers Group, the Aboriginal Mental Health and Wellbeing Reference Group, and the Human Services and Justice CEOs Forum.

The partners to the Housing and Mental Health Agreement will need to ensure that the implementation of the Agreement is guided by sound strategic planning that is adequately documented. Furthermore, the Agreement will need to be governed in a way that promotes and maintains close links with other relevant interagency groups.

5.1.2. Reviewing the strategic partners

The minutes of the SPC meetings for 2006 and 2007 indicate that discussion took place on more than one occasion about the apparently low level of engagement with the JGOS by the SAAP and Aboriginal sectors. In February 2006, the Housing NSW representative suggested that an implementation strategy be developed targeting these sectors in addition to community housing providers and mental health NGOs. It is not clear what happened following this proposal. It is also unclear what followed from the report commissioned by Health about the engagement of the SAAP sector, apart from it being provided on a confidential basis to the IRG. In September 2007, the AH&MRC representative noted that more promotion of the JGOS to the Aboriginal sector was required; this was agreed by the committee which undertook to give the matter further consideration. A likely reason for the low level of engagement by the SAAP and Aboriginal sectors is that the organisations and/or positions selected to represent the SAAP and Aboriginal sectors at a strategic level are not necessarily well placed to do so. We outline the reasons for this later in this section. Additionally, our consultations revealed support for the Department of Ageing, Disability and Home Care and Health drug and alcohol services becoming signatories to the JGOS.

5.1.2.1. DoCS and the SAAP sector

In September 2007, DoCS' representative on the SPC said that DoCS' participation on behalf of the SAAP sector 'has always been problematic' and should be reviewed; this was agreed to by the committee.[166] DoCS confirmed this view on the two occasions we met with them in 2008. The SAAP peak bodies echoed it during our consultations with them, saying that not enough thought was given when DoCS signed the JGOS on behalf of the SAAP about whether

165 Housing NSW, response to investigation notice, December 2007, p14.
166 Minutes of SPC meeting, September 2007.

or not DoCS would be well placed to represent their views. The issue is primarily that while DoCS administers the SAAP in NSW, they are not 'the representatives' of the service providers. SAAPs are represented by their peak bodies (Homelessness NSW, the Youth Accommodation Association and the Women's Refuge Resource Centre). While DoCS does have a role to play in encouraging and supporting SAAP providers to engage with the JGOS, it cannot be said to effectively represent their views and concerns.

Therefore, our provisional report recommended that while DoCS should remain a strategic partner and a member of the SPC, the SAAP peak bodies should become advisory members of the SPC (whether individually or, should they prefer it, as a coalition). At present, the peak bodies have only an advisory role as members of the IRG. Their participation on the SPC would enable the views and concerns of SAAP providers to be represented, and would provide a direct conduit between them and the strategic partners. In our view, had the agencies decided to maintain the JGOS, this enhanced role for the peak bodies would have been an important practical and symbolic gesture which recognised the critical role that SAAP services play in helping people who are homeless to transition into more permanent accommodation. It would have also been likely to lead to better engagement by the SAAP sector with the JGOS. In response to our provisional report, DoCS indicated support for the inclusion of the peak bodies on the SPC and affirmed their commitment to continuing to engage the SAAP sector in the JGOS.[167] In developing the Housing and Mental Health Agreement, the partners should ensure the SAAP peak bodies are involved in the strategic governance of the Agreement so that the views and concerns of SAAP services are appropriately represented.

5.1.2.2. The AH&MRC and the AHO

The AH&MRC is the peak body for the Aboriginal community controlled health sector in NSW. We have already noted that the AH&MRC attended only two SPC meetings during 2006 and 2007. However, as the organisation did not make themselves available to meet with us during our investigation, we are unable to offer a possible explanation for its low level of attendance. In Chapter 4 we reported that Aboriginal medical services told us the AH&MRC has not provided them with any information about the JGOS nor supported them to engage with it. In this context, our provisional report recommended that the effectiveness of the AH&MRC as a JGOS strategic partner should be reviewed.

We understand that the Department of Health has funded and recruited a new statewide coordinator for Aboriginal mental health. The position, located within the AH&MRC, has been established to improve the provision of mental health services by Aboriginal community controlled health services. We are also aware that, in addition to an Aboriginal Mental Health and Wellbeing Reference Group that has been established to implement and review the *NSW Aboriginal Mental Health and Wellbeing Policy 2006–2010,* area-level reference groups will also be established. The reference groups will include representatives of the Aboriginal community controlled health sector and will report to area mental health services on their progress.

In our provisional report, we recommended that consideration be given to having the Aboriginal mental health coordinator participate on the SPC in an advisory capacity. We suggested the coordinator could work with the area-level reference groups and the AH&MRC to disseminate information, encourage awareness of and participation in the JGOS, and ensure escalation of issues to the SPC when necessary. Health supported this recommendation in principle while noting that the capacity of the position to undertake the requirements would need to be considered and negotiation would need to occur with the AH&MRC.[168]

The AHO attended all but three of the SPC meetings held in 2006 and 2007. Regional AHO staff reported they did not have a good understanding of the SPC's purpose or the AHO's role on it. They also lacked a clear sense of their own JGOS responsibilities, and were not aware of what issues might need to be escalated to them by Aboriginal community housing providers and how they, in turn, should escalate these if required to the SPC. Earlier in the report we noted that significant reform of the Aboriginal housing sector is currently being considered. During our consultations, the AHO agreed with us that this reform process would present them with an excellent opportunity to revisit the JGOS and to put in place improved governance arrangements for facilitating the participation of Aboriginal community housing providers at a local and regional level. We noted that, in turn, this would be likely to strengthen the AHO's role as a JGOS strategic partner.

Both Housing and Health agreed with our preliminary recommendation that the SPC should clarify its expectations about the role of the AH&MRC and AHO in relation to the promotion and implementation of the JGOS in local areas.[169] The engagement of these partners in the Housing and Mental Health Agreement will need to be similarly considered.

167 DoCS, response to provisional report, 7 May 2009.
168 NSW Department of Health, response to provisional report, 29 May 2009.
169 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.

5.1.2.3. Department of Ageing, Disability and Home Care

As we noted in Chapter 4, during our consultations there was a strong consensus that the Department of Ageing, Disability and Home Care (DADHC) should become a local JGOS partner. This reflects the reality that some people with mental illness have a dual diagnosis of intellectual disability. Housing workers in particular reported that securing support for these individuals to enable them to obtain and maintain a successful tenancy can be difficult, largely due to a perceived lack of clarity about the respective responsibilities of DADHC and NSW Health towards this group. We previously raised this concern in our report into reviewable deaths in 2006.[170] In response, DADHC and NSW Health established a working party, reporting to the DADHC/NSW Health Senior Officers Group, to facilitate better coordination of and access to services for people with an intellectual disability and a mental health issue.

DADHC already works in partnership with Housing NSW (through the Office of Community Housing) to deliver the Disability Housing and Support Initiative (DHASI), which commenced in 2006–2007 and is a *Housing and Human Services Accord* Shared Access trial (see 1.6.2). DHASI (modelled on HASI) enables people with a disability to live in community housing by providing the support they need to live independently. DHASI is primarily directed to people with an intellectual disability. By 2010–2011 there will be 40 DHASI places across NSW (in 2007–2008 there were 20 places across South West Sydney, Far North Coast and Mid North Coast). DHASI clients may include individuals with a dual diagnosis. In order to be considered for a DHASI place, clients need to be referred to Regional DADHC Intake and Referral for assessment and placement on the Accommodation Register if appropriate.[171]

Our provisional report recommended that DADHC be invited to become a signatory to the JGOS on the basis of the significant benefits that could flow from this: greater communication between Housing, Health and DADHC and better facilitation of improved joint service planning for people with a dual diagnosis of mental illness and intellectual disability. We also emphasised the importance of the SPC establishing a strong link to the DADHC/NSW Health Senior Officers Group. In response to our provisional report, DADHC agreed that becoming a JGOS signatory would be beneficial.[172] Housing and Health also indicated support for the involvement of DADHC in partnerships at both a strategic and local level.[173] Therefore, in developing the Housing and Mental Health Agreement, Housing and Health should consider DADHC's role.

5.1.2.4. Drug and alcohol services

Many of the people we consulted also felt that Health drug and alcohol services should attend local JGOS meetings given the prevalence of substance abuse among people with mental illness. NSW Health has recognised the prevalence of co-morbidity and has developed a strategic framework that acknowledges the need for a multi-agency response to it. A committee made up of clinical experts and NGO stakeholders has been given responsibility for implementing the framework.

In some locations, we were told that drug and alcohol services had been invited to attend JGOS meetings on an 'as needed' basis. However, we were unable to conclude that this was occurring with any consistency across the state nor determine whether the role of the services was clearly defined. Our provisional report noted that as NSW Health is already a signatory to the JGOS and represented on the SPC, facilitating the involvement and participation of drug and alcohol services should not be complicated in terms of governance. At a strategic level, alcohol and drug health as well as mental health policy both come under the umbrella of the Mental Health, Drug and Alcohol Office (MHDAO).

However, we also noted that should the partners determine local participation of drug and alcohol services is required, the JGOS framework as well as representation on the SPC would need to be adjusted to reflect their participation. Furthermore, in our provisional report we referred to MHDAO staff currently sitting on the SPC but only in relation to their office's role in coordinating mental health policy. In this regard, we said that if drug and alcohol services were required to participate in the JGOS at the local level, MHDAO staff would also need to represent their office on the SPC in relation to their alcohol and drug policy responsibilities. We also noted that it would be necessary for the SPC to develop a link to the NSW Health co-morbidity committee referred to above.

In responding to our provisional report, Health indicated their support for our recommendation that area drug and alcohol services should be included as local JGOS partners, with appropriate representation on the SPC to reflect this.[174] Therefore, it will also be important that this support is reflected in the development of the Housing and Mental Health Agreement.

170 NSW Ombudsman, *Report of Reviewable Deaths 2006 Vol. 1: Deaths of people with disabilities in care*, November 2007.
171 NSW Government, *Disability and Housing Support Initiative (DHASI): NSW Housing and Human Services Accord Project*, January 2008.
172 DADHC, response to provisional report, 26 May 2009.
173 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.
174 NSW Department of Health, response to provisional report, 29 May 2009.

5.1.3. Implementation Reference Group

The IRG is chaired by Housing NSW. The stated purpose of the group is 'to provide advice on government and non-government action required to implement the JGOS'. The members of the group are drawn from government and non-government services with a direct interest in the implementation of the JGOS. Membership 'aims to include workers, consumers and other stakeholders from regional as well as central locations'. [175] The terms of reference are documented as follows:

1. To provide advice to the Strategic Partners Committee about directions for establishing the newly expanded JGOS arrangements, to inform the JGOS Implementation Plan. This advice will focus on:
    - the development of new strategies that facilitate the participation of all local stakeholders, with a particular focus on the needs of new partners
    - the establishment of Area Implementation Committee meetings and Area MoUs
    - the identification of barriers to implementation and options to address these issues
    - communication to and from stakeholders
    - policy and practice and systemic issues arising from implementing the new arrangements
    - mechanisms for local stakeholders to provide feedback on the progress of the JGOS Implementation Plan.
2. To assist the dissemination of information about the new JGOS arrangements with key constituents and to help to facilitate their engagement.
3. To identify priorities and advise on additional training priorities and issues, including:
    - the effective use of the JGOS Operations Manual and Resource Kit
    - specific priorities to address local needs.
4. To assist in and monitor outcomes from the implementation of the evaluation framework for the JGOS.

The terms of reference specify that the IRG will meet bimonthly and that the group will be reviewed in 12 months.[176]

We asked Housing NSW to provide us with copies of any documents developed by or informing the work of the IRG. We were informed that the IRG met six times over a two year period (2006 and 2007). Copies of the minutes for these meetings were provided. Based on these, as well as other information provided by Housing NSW, the Department of Health and from our consultations, we established that:

- the IRG first met in May 2006 when the terms of reference for the group were tabled; the group agreed in November 2006 that these should be reviewed
- the group did not meet for five months between November 2006 and April 2007
- group participants provided advice to the SPC on the Operations Manual and Reference Guide, and promoted the resources to their members
- the group considered recommendations made by the evaluation and how these should be implemented – one participant noted that this process took almost a year.

From the documents we were provided, we could find only one clear example of an issue being escalated from the IRG to the SPC and this related to whether DoCS and the (then) Office of Community Housing (OCH), or SAAP and community housing providers, should sign local JGOS MoU's. After this issue was considered by the SPC, it was clarified that DoCS and the OCH would not sign the MoUs as it was more appropriate that individual service providers do this.

Our consultations revealed that generally, the peak bodies represented on the IRG felt the group brings together a good mix of people, but lacks focus and direction. Several expressed the view that 'there is a lot of talking, but not a lot gets done'. It was also put to us that if the SPC had a different structure and terms of reference, the IRG would not be necessary. It was felt by some that there are inadequate and ineffective linkages between the various committee layers and that this could lead to unnecessary duplication.

Overall, it is difficult to determine how effective the IRG has been in meeting the objectives set out in its terms of reference. All but one of the peak bodies on the IRG proposed that having one strategic committee would be a more effective governance arrangement. We agreed with this proposal and in our provisional report, recommended that the IRG be rescinded and membership of the SPC expanded.

The peak bodies have a direct link to their members, who in turn provide direct services to the people the JGOS aims to assist. Therefore, in our provisional report we noted that they are in a position to provide advice about the practical issues impacting on the implementation and effectiveness of the JGOS. For example, the Tenants' Union

175 JGOS Implementation Reference Group, Terms of Reference, May 2006, provided by Housing NSW.
176 JGOS Implementation Reference Group, Terms of Reference, May 2006, provided by Housing NSW.

have valuable information about how termination decisions are made by social housing providers. It was our view that including the peak bodies as advisory members to the SPC would bring together all the important JGOS players in one forum and thereby promote more efficient and productive communication, identification of problems and more effective planning and monitoring of the implementation of the JGOS. It would also better promote 'ownership' and genuinely shared responsibility. The partners to the Housing and Mental Health Agreement should take this view into account when determining the Agreement's governance arrangements.

Additionally, our provisional report noted that it would be important for a process to exist beyond the SPC to consider issues unable to be addressed or resolved by the SPC or with broader significance for the human services area. For this reason, we recommended that the SPC develop a protocol for escalating issues where appropriate to the Human Services and Justice CEOs Forum. It will be important that an escalation protocol is also developed in the context of the governance of the Housing and Mental Health Agreement.

5.2. Area and local committees

The implementation of the JGOS as envisaged by the Guidelines did not refer to area and local committees in the form they have evolved. While few area committees have been established, as noted by the independent evaluation of the JGOS, local committees have proliferated. However, there is considerable variation across the state in how both types of committees operate.

5.2.1. Area committees

At the time of the independent evaluation of the JGOS there were two area committees located in the Northern Sydney Central Coast and North Coast AHSs. In February 2008, Housing NSW provided a schedule of JGOS committees which indicated an additional five regional committees (committees that are generally based in AHS clusters) operating in parts of the Sydney South West, Sydney West and Greater Southern area health services (during our audits we found that one of these committees had folded).

The independent evaluation found that the paucity of area committees resulted in the absence of a structural mechanism to escalate issues from local JGOS committees to the IRG. Our consultations confirmed that there is currently no consistent or effective mechanism for the escalation of issues by local committees. It was rare to find examples of local committees raising issues at an area level, or of area/regional committees soliciting information from local committees and providing them with advice about good practice and how to solve specific problems. We did note some good work being done by area/regional committees, particularly regional committees attempting to work within area health service clusters, but this work tended to revolve around specific projects or initiatives rather than addressing broader systems issues. While it was apparent that some individual stakeholders have raised particular issues with members of the IRG, we found no consistent process by which this was occurring. Significantly, there was limited awareness at a local level of the purpose of area JGOS committees.

An inevitable difficulty confronting many interagency initiatives is the different geographical boundaries within which government and non-government organisations operate. On multiple occasions during our audits we were told that this has been an impediment to the implementation and/or effective operation of area JGOS committees. There are eight area health services and 16 Housing areas and their boundaries are not congruent. In this respect, we note that in his report of the Special Commission into Child Protection Services in NSW, the Hon Justice James Wood recommended that the boundaries of key human services and justice agencies be aligned.[177] The NSW Government has supported this recommendation, and committed to monitoring boundary changes on an ongoing basis to improve alignment and governance arrangements. Concern was also expressed during our consultations about senior staff having to attend a number of meetings – often with the same set of attendees and overlapping subject matter – and the time and resource implications of this, particularly in areas where travelling large distances is required. Some stakeholders questioned why existing interagency forums could not be leveraged to progress JGOS-type strategic work.

The independent evaluation of the JGOS recommended the establishment of area committees where they do not currently exist, and of links between area committees and the IRG. However, in our provisional report we expressed the view that there was scope for the JGOS government partners to utilise existing consultation mechanisms to address area/regional issues arising from the JGOS and to increase accountability. Regional Coordination Management Groups (RCMGs), established by the Department of Premier and Cabinet to drive the Regional Coordination Program, operate in 10 regions across the state, bringing together regional managers of government agencies. They are supported by designated coordinators. The role of RCMGs is to:

177 *Report of the Special Commission into Child Protection Services in NSW*, November 2008, Recommendation 24.4.

- identify and prioritise initiatives and issues that require a multi-agency response
- develop and manage regional strategic initiatives
- allocate and monitor resources to support projects
- evaluate and monitor project outcomes
- enhance interagency networks and information exchange.

As part of its response to the recommendations of the Special Commission of Inquiry into Child Protection Services, the NSW Government has released an Action Plan, *Keep them safe: a shared approach to child wellbeing*. As part of the plan, the government will develop and expand the role of RCMGs to facilitate interagency and cross-sectoral work at the local level. A Justice and Human Service Coordination Committee (JHSCC) will be formed in each region to govern the coordinated delivery of services within that region and to oversee implementation of the Action Plan. JHSCCs will have government and non-government representation, including dedicated Aboriginal representation, and will report through a Senior Officers Group to the Justice and Human Services CEOs Forum.

It is not clear from the Action Plan if JHSCCs will replace RCMGs or complement them. Our provisional report noted that regardless, the JGOS could be a standing agenda item for RCMG and/or JHSCC meetings, providing an opportunity for discussion of any matters requiring a regional response by government agencies. In responding to our report, Housing and Health both expressed support for this approach.[178]

Our provisional report also noted that while there was a need for a layer of accountability between local JGOS committees and the IRG/SPC, this did not, in our view, require the establishment of an area committee. We recommended that rather, responsibility for providing this accountability should be attached to the area/regional director position within the JGOS government partner agencies. Our recommendation anticipated that area/regional directors would be required to ensure appropriate consultation with non-government JGOS partners, including SAAP services, tenant advocates and NGOs in carrying out these responsibilities. We also recommended that the SPC give consideration to the benefits of the other JGOS strategic partners identifying which positions within their organisations should have responsibility for the JGOS at the area/regional level.

Under the model we proposed, non-government partners would be able to escalate issues directly from the local level to the SPC through their peak body representatives. Where appropriate, the SPC could then address these issues, or ensure that area/regional directors respond to them at an area level. Our view was that this approach would reduce duplication and increase efficiency.

In responding to our provisional report, Housing and Health agreed that area directors need to fulfil a range of responsibilities associated with key partnerships, including the new Housing and Mental Health Agreement, and that these responsibilities should be reflected in performance management processes. Housing also acknowledged that it will be important that other key agencies to the Agreement clearly determine which positions in their own organisations should share these responsibilities.[179]

5.2.2. Local committees

We want consistent, clear, transparent support for people – not talking.[180]

Overwhelmingly, our consultations revealed that local JGOS committees appear to have focused on processes to the detriment of achieving demonstrable results against the JGOS aims. In large part this can be attributed to the failure of the strategic partners to provide specific guidance about the kind of outcomes local committees should be striving to achieve. It is also likely to be symptomatic of the lack of clarity in the JGOS documentation including the absence of clearly defined responsibilities for particular positions.

In real terms, the success of the JGOS is dependent on what happens at a local level to implement it. This includes the work of committees, which need to support workers in the JGOS partner organisations to implement the JGOS principles. In turn, it is critical that the strategic partners adequately guide and support local committees. To date, as we have noted above, it is clear that this has not occurred in a consistent way. Our provisional report identified an urgent need for the SPC to develop a clear set of objectives for local committees, and to implement processes for monitoring outcomes against these. However, we also noted that local committees should have the flexibility to determine how they go about meeting these objectives. We also expressed the view that whatever the type of meeting structure adopted by local JGOS partners, they would need to demonstrate evidence of working together to:

178 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.
179 Housing NSW, response to provisional report, 20 May 2009; NSW Department of Health, response to provisional report, 29 May 2009.
180 SAAP worker, consultation April 2008.

- identify suitable local partners, including Aboriginal and SAAP organisations
- identify and resolve local and broader issues impacting on service provision
- develop local action plans
- negotiate referral protocols
- undertake joint case planning
- record and measure results for individuals
- develop a local training strategy
- provide relevant service updates
- identify available resources and services to help create innovative housing solutions.

Our provisional report observed that these are just some of the ways that JGOS partners could effect more systemic and sustainable improvements.

Accordingly, we recommended that regardless of how local JGOS committees operate, they should be required by the SPC to document the results they achieve, and the SPC should provide guidance to committees about how to do this. We also recommended that local committees should be required to regularly report their outcomes to the SPC through Health and Housing area directors – noting that this would provide the SPC with valuable information about good practice as well as intelligence about committees that require additional support – and that the SPC should develop a systematic process for reviewing these reports and responding to issues they raise.

We also stressed the need for participants on local JGOS committees to ensure that outcomes are regularly communicated to frontline staff in their organisations, and that adequate processes are in place for the escalation of issues to committees by staff. As we noted in Chapter 4, one of the findings of our survey of CSOs was that while most were aware of the existence of the JGOS, few knew what outcomes the JGOS was actually achieving in their area. This finding is related to one of the main themes to emerge from our consultations, which is that where local JGOS committees exist, their link to the day-to-day work of the partner organisations is generally tenuous at best.

We identified that one of the priority actions for the SPC should be to decide how to measure whether the JGOS is achieving its aims and what indicators to use to do this. Local committees would then be required to report against these. Our provisional report noted that reporting need not be onerous if a simple template with key performance indicators is developed. The value of reporting against performance indicators is twofold. Firstly, the requirement to do so can galvanise activity and assist in providing focus and direction. Secondly, if well designed, the process can provide important and useful information that can be used to monitor performance, identify problems, make comparisons and inform the development of future initiatives. For these reasons, we expressed the view in our provisional report that requiring local committees to report their work to the SPC would benefit both the local and strategic JGOS partners.

In response, Health agreed that 'general information' could be provided by local committees and that a systematic process should be in place for reviewing reports, but expressed the view that 'it would be onerous and inappropriate to collect data on individual outcomes' and that they would not support this as it 'would change the focus of the JGOS to working with individuals rather than fostering collaborative relationships to benefit a broader cohort of residents'.[181] We clarified with Health that our expectation was not that committees should report on individual clients – nor would we expect reporting on individual clients to occur under the Housing and Mental Health Agreement. Rather, local participants in interagency partnerships should be able to demonstrate what practical actions they are implementing to achieve the stated aims of the partnership, and how these actions are benefiting clients. We are of the view that an effective way for the strategic partners to monitor this is to require committees to report against agreed indicators.

We agree with Health that due to 'limited resource availability', the expectations and requirements of committees established to implement interagency partnerships at a local level should not be 'onerous'.[182] However, in our view there is little utility in establishing and maintaining interagency partnerships aimed at assisting particular groups of vulnerable people if the partners cannot demonstrate that the partnership is being implemented and how it is actually benefiting clients.

181 NSW Department of Health, response to provisional report, 29 May 2009
182 NSW Department of Health, response to provisional report, 29 May 2009.

5.3. Final observations

Our provisional report contained detailed recommendations aimed at strengthening the JGOS governance arrangements. These recommendations, which were supported by Housing and Health, were aimed at the strategic (statewide), area and local levels at which the JGOS operates. They addressed the need to:

- streamline overall governance arrangements by reducing duplication and inefficiency and ensuring adequate mechanisms for each 'layer' of governance – strategic, area and local – to link and interact
- ensure all partners have a clear sense of their responsibilities both in relation to the partnership arrangement itself and at a direct service delivery level
- develop a strategic plan outlining specific actions for achieving the aims of the partnership and link this plan to local action plans
- establish a system for monitoring outcomes against these actions and responding to issues that are identified as a result of this monitoring
- ensure all partners task key positions with specific responsibilities for implementing the partnership at a local and area level and ensure workers are provided with adequate guidance about the strategies that should be implemented at a local level to achieve the partnership aims.

At this stage we do not have sufficient information about the proposed Housing and Mental Health Agreement to enable us to make similarly detailed recommendations about the kind of governance arrangements it should have in place. However, the broad observations made in this chapter are relevant to the governance and accountability arrangements which will need to be put in place under the proposed Agreement. In this regard, we were advised that:

> *NSW Health and Housing NSW, in consultation with the other signatory agencies, will establish clear reporting, accountability and performance requirements for the monitoring and reporting on the effectiveness of the Housing and Mental Health Agreement … and will ensure that the reporting, accountability and performance requirements support participating agencies to achieve the goals and objectives of the Housing and Mental Health Agreement.*[183]

183 NSW Department of Health, response to provisional report, 29 May 2009.

Chapter 6. Accountability

> *Housing managers are likely to give greater priority to both planning how their housing service works with support services, and to ensuring sufficient knowledge and resources are available to support tenants to maintain their tenancies, when achievement of stable tenancies is an explicit aim of the service. The importance attached to this is likely to be further reinforced when there are explicit accountability measures around tenant stability in addition to the more standard and predominant financial and asset management measures.*[184]

Those we consulted during our investigation were frequently unable to say what results the JGOS was achieving and acknowledged that this was a problem. We identified that one of the main factors influencing the poor implementation of the JGOS has been the lack of adequate accountability mechanisms in the form of processes for defining, measuring, reporting and monitoring results and designating responsibility for particular tasks. It is therefore difficult to assess the impact of the JGOS, and this has undermined people's perception of its value and potential. In this context, it was important for our provisional report to identify how accountability for the JGOS could be strengthened.

6.1. Data collection

Our provisional report identified a need for the JGOS partner organisations to develop an evidence base to enable them to demonstrate the effectiveness of the partnership. To this end, we emphasised the need for all partners to explore the issue of data collection.

During our consultations, Housing NSW staff were critical of the limitations of their current system for capturing and managing information about applicants and tenants. They indicated that it does not adequately assist them to identify and manage tenancies at risk and does not have the capacity to capture their efforts to sustain them. This was confirmed by Housing NSW at the beginning of our investigation. Housing advised that they were in the process of building a new database. Our provisional report recommended that the new database should enable housing workers to capture data about identified risk factors, early intervention strategies utilised and details of referrals, case conferences and support plans, as well as to have access to an ongoing client review mechanism.

In response, Housing NSW advised us that their new database, 'HOMES' – which will become operational in April 2010 – will include 'a Support Services Module, which will provide greater capacity to record information relating to service provision such as contacts, referrals and support plans. Also included [will be] the capacity to record the related agreement, program or strategy, along with a review mechanism.'[185] These functions would have gone a long way towards addressing our preliminary recommendation. In the context of the development of the Housing and Mental Health Agreement, Housing has advised that, together with key partner agencies, they will consider the data collection requirements that we identified as necessary for the JGOS, when considering the data collection and reporting requirements of the Housing and Mental Health Agreement.

The issue of data collection appeared to be of less concern to health workers. We did identify one area health service that through its area JGOS committee had identified the value of flagging people subject to a case plan between Housing and Health. This was done by creating a 'JGOS' field on the area's database, known as the 'Friendly information system community health' (FISCH). Staff from the area in question noted that it would be helpful to have statewide guidance and expectations around what sort of data should be collected locally and business rules for recording it. As each AHS has their own database, our provisional report recommended that the Department of Health should ensure they have the facility to capture information about clients who need social housing or whose social housing tenancies are at risk.

In response, Health advised that 'reporting and data on social housing needs and social housing tenancies (including those 'at risk') should be vested in the Department of Housing or their contractors who are responsible for addressing the issues of housing need and housing tenancy'.[186] They also requested clarification about whether our preliminary recommendation was aimed at centrally capturing information already recorded in individual client records. At their request, we met with the department to discuss this and related issues.

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184 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, px.
185 Housing NSW, response to provisional report, 20 May 2009.
186 NSW Department of Health, response to provisional report, 29 May 2009.

We explained that we did not have an expectation that area health services should centrally report on 'individual client outcomes', and agreed that it is the role of social housing providers to capture information about existing tenants (including those whose tenancy is 'at risk'). However in our view, it is important for Health to be able to demonstrate how they are implementing the JGOS (or, in future, the Housing and Mental Health Agreement) by capturing and reporting some 'aggregated' information about how area mental health services have assisted clients that they have identified as needing support to access social housing or SAAP accommodation. This information may not be recorded by other agencies or services. Therefore, in developing the Housing and Mental Health Agreement, it will be vital that the participating agencies decide what data needs to be collected to demonstrate how it is being implemented and the outcomes being achieved, and who should be responsible for collecting this information. However, we agree with Health that the type of information and the reasons for collecting it must be clear.

Although a significant number of SAAP providers we consulted complained about unmet requests for assistance by mental health services and to a lesser extent, housing providers, they were unable to provide solid data to support these complaints. This makes it difficult for them to quantify and advocate the need for additional resources, something that was acknowledged by the main SAAP peak bodies. Similarly, tenant advocates were able to provide anecdotes in support of their perceptions but in most cases did not appear to be systematically capturing instances of poor response or practice on the part of housing providers and other agencies. Our provisional report emphasised that it would be important for the peak bodies to obtain consistent information about their members' participation in the JGOS and unmet requests of other agencies for assistance. We noted that this would enable the peak bodies to be more effective in their advisory role to the SPC. To this end, we recommended that the SPC explore with peak bodies the type of data that should be collected by their members to demonstrate their involvement in the JGOS and unmet requests for assistance.

In responding to our provisional report, both Housing and Health commented that while they were committed to negotiating with partner agencies the arrangements for reporting the outcomes and results of the Housing and Mental Health Agreement, data should not be used to demonstrate unmet requests for assistance due to 'the potential to undermine interagency collaboration and create conflict between agencies by focusing on the limitations and gaps in service delivery, rather than opportunities and instances of collaboration'. The agencies further commented that because the Agreement 'is not a funded program, it is likely that there will be instances where agencies cannot meet requests for assistance through the partnership'.[187]

In our view, a critical component of good interagency collaboration is working together to identify gaps and improve service delivery. This depends on shared access to factual information. Our investigation revealed that the circulation of anecdotal information about unmet need has damaged the credibility of the JGOS considerably and therefore undermined its effective implementation. The Housing and Mental Health Agreement will be exposed to the same risk if the partner agencies do not address the need for honest and robust discussion supported by solid data.

6.2. Designating responsibilities

> *The key thing for JGOS is that it needs a champion … it involves great principles but accountability comes through* [incorporating responsibility into] *positions.*[188]
>
> *Ultimately, someone must take responsibility.*[189]

The JGOS framework describes a range of roles and responsibilities in relation to service provision. It does not, however, designate responsibilities in relation to JGOS 'activities' beyond requiring each agency to appoint a liaison officer. Our provisional report pointed out that, while it may be true that 'there is no *top agency* in JGOS',[190] to function effectively the JGOS would need to clearly identify who should be responsible for key activities.

During our consultations we came across very few reported instances of responsibility for JGOS activities being specifically assigned to particular Housing and Health positions, or of these activities being accounted for as part of normal performance management processes. The North Sydney Central Coast AHS (NSCCAHS) Housing Coordinator position, which we outlined in Chapter 4, was a noteable exception in that it was supported by a position description which had responsibility for 'ensuring leadership of the JGOS'. The NSCCAHS area committee stood out for having developed procedures for recording the work of local committees, and this was initiated by the Housing Coordinator who was praised by those involved in these committees. One of the strengths of the Accord remarked on by those we consulted is the regional positions that coordinate Accord projects. The Regional Coordination Program, which we referred to in the previous chapter, is also supported by regional coordinator positions.

187 Housing NSW, response to provisional report, 20 May 2009. Health's response to our provisional report echoed this point.
188 NGO worker, consultation June 2008.
189 DoCS CPO, consultation June 2008.
190 JGOS Strategic Partners, *Making JGOS Work: Operations Manual*, 2007, p20.

One of the main criticisms of the JGOS is that is does not have any additional resources attached to it. Given the already significant demand on the JGOS partner organisations to meet the needs of their clients, many people we consulted felt that the absence of coordinator positions weakened the capacity of the JGOS to function effectively. However, in our provisional report we identified the main issue as being that responsibility for the JGOS has not been appropriately delegated and embedded in operational systems. It was our view that strengthening the JGOS framework in the ways we recommended may render the creation of JGOS coordinator positions unnecessary.

As outlined in Chapter 5, we flagged that there should be a greater role for Housing and Health area directors. In addition, we identified other pivotal positions within Housing and Health that should be given responsibility at a local level for the JGOS. We noted that while positions such as those created under the NSW Health Clinical Mental Health Partnership Program (described in Chapter 4) may appear to be those to which responsibility for the JGOS should be designated within Health, the size of each AHS, the range of other responsibilities that clinical partnership positions have and the fact that they are not responsible for direct service delivery, would make it difficult for the positions to be closely involved in the operation of the JGOS at a local level. While accepting there may be a role for clinical partnership positions to work with area mental health services to facilitate and monitor area-wide implementation of the JGOS, we recommended that Health's responsibility for JGOS at a local level should rest with community mental health team leaders, with appropriate guidance and support provided by area directors. We also noted that mental health social workers play a pivotal role due to their involvement in discharge planning.

Similarly, our provisional report recommended that team leaders (or their equivalent) within Housing NSW should have responsibility for the JGOS at a local level given they manage teams of staff responsible for direct service delivery.

The JGOS Guidelines already ascribe responsibility to team leaders for maintaining consistency in the application of the communication and referral protocol which the Guidelines set out. We emphasised that team leaders need to be responsible for ensuring that frontline staff in their respective organisations are familiar with the existence and purpose of the JGOS, understand how it is relevant to their work and what their responsibilities are in relation to it, and are appropriately supported to carry them out. In practical terms, this might include ensuring that staff know what they are expected to do to uphold the JGOS principles and that they identify and escalate to local committees issues that need to be addressed.

Our provisional report noted that while all team leaders should have these responsibilities, area directors would need to delegate particular responsibility for jointly establishing and/or maintaining local JGOS committees, coordinating their agencies' issues for discussion at committee meetings, and providing feedback as required. As well, we stressed that the role played by frontline agency staff (such as SCSOSs, CSOs, mental health social workers and case managers) in implementing the JGOS would need to be specifically acknowledged. Finally, we recommended that JGOS responsibilities should be built into relevant position descriptions and articulated in the JGOS agreement and resources.

In response, Housing advised that there are a range of positions within their organisation that have specific roles and responsibilities in developing, implementing and monitoring schedules and operating agreements under the Accord. In particular, Accord Coordinator positions in each Housing Division have been established to coordinate Accord partnerships between government and non-government agencies. Housing advised us of their intention to 'utilise and build on existing arrangements under the Accord, relating to the specific responsibilities of staff employed by Housing NSW, in implementing Accord partnerships including the Housing and Mental Health Agreement'.[191]

Health advised that in implementing the Agreement, they intend to use the arrangements under the Accord relating to the specific responsibilities of area mental health service directors. In addition, Health noted that staff responsibilities in relation to implementing and monitoring Accord Operating Agreements, including participating in local partnerships and reporting requirements, are clearly set out in the Agreements.[192]

6.2.1. Aboriginal and community housing providers

Currently, the registration and reporting requirements for Aboriginal and community housing providers do not include JGOS participation and implementation. Our provisional report noted that this has acted as a disincentive for providers to become involved at a local level. We also identified that community and Aboriginal housing providers are not currently required to follow a particular process when seeking to terminate the tenancies of people with mental health problems.[193]

191 Housing NSW, response to provisional report, 20 May 2009.
192 NSW Department of Health, response to provisional report, 29 May 2009.
193 We note that the *National Community Housing Standards Manual* provides (at 1.4) guidance about good practice in relation to ending tenancies, including a brief reference to preventative strategies. (National Community Housing Forum, May 2003).

Earlier, we noted that both sectors are currently undergoing significant reform. During our investigation we discussed with the AHO and CHD the potential benefits of incorporating JGOS participation and implementation into the registration requirements for providers. Our provisional report recommended that to support the JGOS principles, CHD and the AHO should use their respective registration and accreditation processes to provide appropriate guidance to community and Aboriginal housing providers about JGOS participation, and standardised processes for the eviction of people with mental health problems. We also recommended that the SPC explore with the AHO and CHD the type of data that should be collected by Aboriginal and community housing providers to support the effective implementation of the JGOS.

6.2.1.1. Community housing

In Chapter 1 we noted the significant expansion of the community housing sector. In 2007, the *Housing Act 2001* was amended to provide for a number of things, including a new regulatory code and registration system for the sector. During our investigation CHD acknowledged that to date, the registration system for community housing providers has tended to emphasise processes over outcomes – as a result, while there has been good information about who is accessing community housing, less information about 'the qualitative outcomes for them' has been available.[194] The introduction of a new regulatory code and registration system was designed to remedy this.

We were advised by CHD that to be registered, community housing providers would have to comply with the code, which would set out a number of requirements in relation to tenancy and asset management, partnerships and initiatives, financial management and housing development. The code, a draft of which was open for public comment when we provided our provisional report to agencies, would be supported by evidence guidelines setting out indicators. CHD advised us during our investigation that JGOS participation could be included in the evidence guidelines as an indicator in relation to partnerships and initiatives. They also advised that the eviction of people with a mental health problem could potentially be addressed in the evidence guidelines.

The new regulatory code came into effect on 1 May 2009. It sets out a number of requirements in relation to fairness and resident satisfaction, sustainable tenancies and communities, asset management, governance, probity, financial management and housing development. Of particular note is clause six of the code which states that a registered community housing provider must 'develop and maintain arrangements … to ensure residents with support needs receive appropriate support and, if relevant, are able to maintain their tenancies'. These arrangements are subject to scrutiny by the Registrar of Community Housing who must be satisfied as to their adequacy.

The evidence guidelines that have been developed to support the code state that community housing providers must submit to the Registrar a list of all current partnership arrangements in place to support tenants in need, as well as information about individual support arrangements in place and systems for monitoring and maintaining them. Providers must also submit policies and procedures relating to applicant and resident management, including the termination of leases. The evidence guidelines do not refer to JGOS participation as an indicator, nor do they suggest the type of processes that should be in place for the eviction of people with mental health problems. However, the Registrar of Community Housing would appear to have sufficient scope, as part of her scrutiny of arrangements to ensure residents with support needs receive appropriate support and are able to maintain their tenancies, to ensure community housing providers have adequate policies and procedures in this regard.

In response to the recommendation contained in our provisional report that CHD should ensure the evidence guidelines include JGOS participation, including standardised processes for the eviction of people with mental health problems, we were advised by Housing NSW that:

> *the Evidence Guidelines cannot require JGOS participation by community housing providers or provide guidance as to what such participation should involve. It is important to note that it is not generally the function of Housing NSW to establish and/or require standardised operating procedures for community housing providers but instead to monitor compliance with legislation and contract conditions under Community Housing Agreements. At this stage the inclusion of a clause specific to JGOS participation and standardised eviction procedures is not currently proposed.*[195]

Our preliminary recommendation was aimed at creating a positive obligation on community housing providers to become involved in the JGOS and to ensure appropriate safeguards against the termination of tenancies of people with a mental health problem except as a last resort. Based on Housing's more recent advice, it would appear that including guidance for community housing providers in the evidence guidelines about the type of processes that should be in place for the eviction of people with mental health problems – including participation in relevant

194 Meeting with Office of Community Housing, 28 September 2008.
195 Housing NSW, response to provisional report, 20 May 2009.

partnership arrangements under the proposed Housing and Mental Health Agreement – would be appropriate. In this regard, it is necessary for the evidence guidelines to specifically reflect that good practice in supporting tenants with mental health problems involves community housing providers demonstrating compliance with key policies and partnerships (including the Housing and Mental Health Agreement) aimed at assisting clients to access and sustain social housing. This is particularly important given the significant expansion of the community housing sector that is underway and likely to continue into the foreseeable future, meaning that greater numbers of people than ever before will be living in community rather than public housing.

Housing supported our recommendation that the SPC should explore with CHD the type of data that should be collected by community housing providers to support the effective implementation of the JGOS. Similarly, it will be important that the partners to the Housing and Mental Health Agreement explore with CHD the data that community housing providers should collect to support the implementation of the Agreement and to measure its outcomes.

6.2.1.2. Aboriginal housing

The Aboriginal housing sector in NSW is comprised of approximately 4,360 properties owned by the AHO and managed by Housing NSW, and 4,650 properties owned and managed by over 240 Aboriginal community housing providers (of which around 60% are local Aboriginal land council housing assets). The average portfolio size for each of the Aboriginal community housing providers is less than 20 properties.[196] Lack of economies of scale mean their capacity to effectively fulfil the requirements of property and tenancy management is often compromised. Governance of the Aboriginal housing sector is also complex because of the number and mix of providers and different funding arrangements.

In response to this situation, the AHO is considering significant reforms aimed at improving the capacity, governance and sustainability of the Aboriginal housing sector. A new Service Improvement and Accreditation System (SIAS) has been developed to replace the current system of registration. To receive AHO funding, providers will be required to achieve accreditation. We understand that implementation of the SIAS commenced in late 2008. Additionally, we were advised by the AHO during our investigation that between six to eight Regional Aboriginal Housing Management Services (RAHMS) would be established across NSW to undertake property and tenancy management on behalf of Aboriginal community housing providers and enter into service and funding agreements with the AHO, which would monitor their performance. In our provisional report we agreed with the AHO that the establishment of RAHMS would potentially place the Aboriginal community housing sector in a stronger position in terms of capacity to engage with the JGOS.

However, in response to our provisional report, the AHO advised that the RAHMS model will not necessarily be pursued as part of the reforms of the sector currently being considered. The issues related to the reform process are being considered by a working group comprising the AHO, Department of Premier and Cabinet, Department of Aboriginal Affairs, Treasury and Housing NSW. The key aims of sector reform are enhancing the viability and sustainability of Aboriginal community housing and that details will be finalised later in 2009.[197]

Our provisional report recommended that Housing and Health explore with the AHO the inclusion of JGOS participation and standardised processes for the eviction of people with mental health problems in the service/funding agreements for RAHMS. As we have already noted, Housing supported this recommendation. The AHO advised that as the RAHMS model may not proceed, it would be more appropriate for this recommendation to refer to Aboriginal community housing providers. They advised that the reform process will take into consideration registration and reporting requirements for Aboriginal housing providers.[198]

In response to our preliminary recommendation (supported by Housing) that the SPC explore with the AHO the type of data that should be collected by individual housing providers to support the implementation of the JGOS, the AHO commented that it would be important to 'maximise alignment' between the data collected by Aboriginal and community housing providers and the data collected by Housing NSW.[199]

In developing the Housing and Mental Health Agreement it will be important that the partners explore with the AHO the best way to create a positive obligation on Aboriginal community housing providers to implement the Agreement and standardised eviction processes for people with mental health problems, and to ensure providers are collecting data necessary to support the implementation of the Agreement.

196 Russell Taylor, Chief Executive Officer, Aboriginal Housing Office, *Sector strengthening: Towards Sustainability in Aboriginal Community Housing in NSW*, Paper presented at the National Housing Conference, Sydney, February 2008.
197 AHO, response to provisional report, 1 May 2009.
198 AHO, response to provisional report, 1 May 2009.
199 AHO, response to provisional report, 1 May 2009.

6.2.2. DoCS

At the beginning of our investigation, DoCS advised us that CPOs are encouraged to support SAAP services that want to become involved in the JGOS. In Chapter 4, we noted that our consultations revealed a lack of awareness on the part of many CPOs of the JGOS and their responsibilities in relation to it. CPOs also noted that they are not required to demonstrate or report on their performance against their 'JGOS responsibilities'. Without exception, those we interviewed stated that they had been provided with little corporate guidance or support to carry out this function. In October 2008, DoCS told us they are developing a new induction and training package for CPOs, and there is potential to include their JGOS responsibilities in this material.

Like the Aboriginal and community housing sector, there is nothing that compels SAAP providers to participate in the JGOS. In response to the recommendation contained in the independent evaluation, DoCS advised the SPC that participation in the JGOS cannot be prescribed in SAAP funding agreements, which are joint agreements between the Federal Government and the states and territories. However, they suggested there might be scope to highlight the JGOS as an example of partnerships that SAAPs can participate in through other processes. In October 2008, DoCS advised us that they are in the process of developing a new SAAP specific service agreement and that they would consider how the JGOS could be included in it.

As DoCS is not an agency subject to our investigation, we did not make any recommendations to them in our provisional report. However, in light of our observations about the role of DoCS staff in relation to the JGOS and the need to encourage more SAAP providers to participate in the JGOS, we considered that DoCS should review and clarify the responsibilities of their staff in relation to the JGOS and include guidelines for JGOS participation in the new SAAP service agreement. We recommended that Housing and Health pursue this with DoCS. Housing and Health agreed that DoCS should consider these proposals and DoCS advised us that they would do so.[200]

6.3. Final observations

Ensuring adequate accountability measures is a key requirement which the signatories to the Housing and Mental Health Agreement will need to address. It will be important that the partner agencies ensure they have the capacity to capture data, both to support frontline workers in effectively implementing the Agreement, and to enable agencies to measure and report actions and outcomes against the Agreement's aims. To avoid replicating the same weaknesses that undermined the effective implementation of the JGOS, it will also be important that participating agencies ensure that specific responsibilities for the implementation of the Housing and Mental Health Agreement are delegated to appropriate staff members. Finally, the partners to the Agreement will need to consider how best to engage local partners including Aboriginal, community housing and SAAP services. To this end, utilising service agreements to create a positive obligation on these providers to participate in the Agreement and implement practices that give effect to the principles embedded in it should be considered. Having said this, participation and implementation by providers should be treated as a one performance measure only and will need to be examined in the local context.

200 DoCS, response to provisional report, 7 May 2009.

Chapter 7.
Addressing systemic issues

The SPC terms of reference state that the committee will provide briefings to the partner agencies regarding recommendations in relation to policy and practice and systemic issues. During the course of our investigation, we identified a number of systemic issues that do not appear to have been addressed or considered in any great detail by the SPC. A number of these relating to the JGOS framework itself have already been discussed. In this chapter, we outline three broader systemic issues that have impacted on the implementation of the JGOS and which were repeatedly raised during our consultations: discharge planning; training and development; and exchanging information. Our provisional report noted that while the strategic partners may not have the ability to resolve certain aspects of these issues, they do have considerable capacity to advocate for change within their own organisations and a responsibility to provide advice to government about matters that are obstacles to the effective implementation of the JGOS and to the provision of human services more generally.

7.1. Discharge planning

The Federal Government's White Paper on addressing homelessness, *The Road Home*, recognises the importance of discharge planning as a key homelessness prevention strategy.[201] A recent report of the Mental Health Council of Australia reiterated this, noting that discharge planning guidelines developed by public hospitals and health facilities are not always implemented effectively or consistently.[202]

Section 79 of the NSW *Mental Health Act 2007* states that planning for the discharge of a consumer from a mental health facility should involve consultation by Health with agencies involved in providing relevant services to the consumer, and with the their relevant service providers and carers.

The NSW Health policy on discharge planning for adult mental health inpatient services reiterates this, stating that 'discharge planning occurs in collaboration with the consumer, the family/primary carer and other stakeholders to ensure effective transition between inpatient settings and from inpatient services to the community and reduce risk of relapse'.[203] The policy advises that discharge planning 'is part of the continuum of care that starts with the person's admission to hospital'[204] and should include an assessment of the consumer's accommodation needs. Mental health practitioners are advised to determine whether the consumer is in need of housing and should therefore be referred to Housing NSW, and to complete any such referrals prior to discharge. However, the policy does not specifically refer to the JGOS or require Health to notify social housing providers when consumers who are social housing tenants are discharged. Nor does it address the situation in which Health directly refers a client to a SAAP service upon discharge. In Chapter 4, we noted that SAAP services were concerned about Health referring clients to them without also providing full information to enable them to complete an informed risk assessment.

In a number of locations we audited, social housing and SAAP workers told us that a source of major frustration is tenants/clients being discharged from mental health inpatient services without their knowledge or in the absence of any consultation about what supports are needed to ensure the person can sustain their tenancy. The JGOS commits area health services to endeavour to 'develop and action, in consultation with the individual and the relevant social housing agency and other service providers as appropriate, an achievable service plan'.[205] Health and housing workers acknowledged that individuals with mental illness are very vulnerable following discharge from inpatient care. Housing workers in particular reported that tenancies can rapidly become at risk if support services are not in place at the time of discharge. In our view, discharge planning should, as a matter of course, involve notification to and discussion with the social housing provider.

A related problem is tenants being admitted to inpatient facilities without the knowledge of the social housing provider. While the JGOS specifically commits area health services to notify the social housing provider if an individual is hospitalised and to 'negotiate with appropriate agencies so that all [the consumer's] affairs are looked after',[206] a number of Health workers told us they could not do this without the consent of the consumer. We heard of instances where failure to notify the social housing provider led to presumed rental arrears or property abandonment which are both breaches of a lease. Social housing providers emphasised that if they know a person has been admitted to hospital, they can take action to ensure the tenancy is sustained, if appropriate, while the person is being

201 Australian Government, *The Road Home: A National Approach to Reducing Homelessness*, White Paper, December 2008.
202 Mental Health Council of Australia, *Home Truths: Mental Health, Housing and Homelessness in Australia*, March 2009.
203 NSW Health, *Discharge Planning for Adult Mental Health Inpatient Services,* Policy Directive, January 2008, p4.
204 NSW Health, *Discharge Planning for Adult Mental Health Inpatient Services,* Policy Directive, January 2008, p6.
205 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p16.
206 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, April 2003, p16.

cared for. However, in some locations mental health workers were consistently informing social housing providers about admissions and discharges in situations where they were concerned that a person's housing may be at risk. These workers did not feel there was anything to prevent them from doing so. The inconsistency and confusion in relation to this issue is concerning.

Good practice

Discharge planning

In Liverpool, NEAMI, a HASI provider, identified the need for better discharge planning in relation to their clients. They approached treating psychiatrists, nursing unit managers and direct care staff working in the wards to explain their organisation's role and what services they could provide. This led to regular meetings that identified what was working well and what could be improved. A systematic process for discharge planning was then agreed to. Discharge planning now occurs as a staged process rather than 'a single point in time', beginning with combined case meetings, enabling consumers with a chronic mental illness to successfully transition from inpatient care to the community.

Our provisional report recommended that Health amend its policy on discharge planning to:

- refer to Health's role in implementing the JGOS
- require Health to notify social housing providers when consumers who are social housing tenants are admitted to and discharged from hospital, if there is a risk of substantial adverse impact (including loss of housing) if this information is not disclosed
- refer to Health's responsibilities when directly referring clients on discharge to SAAP providers, including providing full information to enable SAAP providers to complete an informed risk assessment.

We also emphasised the role of the SPC in clearly communicating to JGOS partners what constitutes good practice in relation to hospital admission and discharge, and looking for evidence in the reports of local committees that this is being implemented.

In response, Health expressed the view that their statewide discharge policy already adequately addresses the issues raised in our provisional report:

> *Action to maintain a consumer's current social housing is recognised by mental health workers as an important consideration during hospitalisation and is fundamental to early discharge and the consumer's functioning in the community. The policy currently recognises the importance of assessing a consumer's accommodation needs as early as possible during the discharge process and identifies the roles and access pathways to social housing providers … Ideally mental health services will* [also] *advise social housing providers of a consumer's admission in a timely fashion, if the accommodation is understood to be at risk. This can only occur where it is known that the consumer lives in such housing, and with the consumer's agreement.*

The statewide policy requires area mental health services to develop their own local procotols for discharge planning consistent with the policy. Health advised us that 'local area referral arrangements with other agencies' should be included in these local protocols rather than in the statewide policy.[207]

We acknowledge Health's view that it would be problematic to refer to specific partnership agreements (such as the JGOS or proposed Housing and Mental Health Agreement) in the statewide discharge planning policy. However, our primary concern is that discharge planning practice is consistent with the aims of any future initiatives, including the Housing and Mental Health Agreement. Our experience reviewing agency systems has shown us that for strategic policies to be effective, frontline workers need to be given clear guidance about the expectations placed upon them by those policies. For this reason, we believe that Health should take appropriate steps to ensure local discharge planning protocols developed by area mental health services articulate:

- the importance of notifying the social housing provider when a mental health client known to be living in social housing is admitted to or discharged from mental health care and loss of that housing is a risk
- the need to share adequate information with SAAP providers when discharging a client directly to SAAP accommodation, to enable the provider to make an informed risk assessment.

Furthermore, guidance should be given about why a client's social housing may be placed at risk if a social housing provider does not know they have been admitted to or discharged from mental health care. In saying this, we acknowledge that there will be circumstances in which mental health workers will be unaware that a client resides in social housing.

207 NSW Department of Health, response to provisional report, 29 May 2009.

Given that problems with this aspect of discharge planning were repeatedly raised during our consultations, we are concerned that a failure to provide the type of detailed guidance outlined above will result in problems continuing to occur, leading to negative consequences for clients and undermining the aims of the Housing and Mental Health Agreement.

NSW Health has recently advised us that they are planning to review the implementation of the statewide discharge planning policy. As part of this review, compliance with the policy will be assessed. In addition, area discharge planning protocols will be assessed in relation to the issues we have raised and, if necessary, modifications to local protocols will be suggested to address these issues. Health also advised us that:

> *Reviews of critical incidents where discharge planning has been identified as a contributing factor provide further information to the Department and Area Health Services on local compliance and opportunities for local practice improvements. At the local level, file audits for the quality and completeness of Mental Health Documentation modules also help local improvement initiatives including those relating to the discharge planning process.*[208]

We have asked Health to provide us with advice about the outcome of their review.

7.2. Training and development

A key theme to emerge from our consultations is the need for practical rather than theoretical training. In particular, housing workers and SAAP providers repeatedly spoke of the need for more training about mental illness and the mental health system. The 'Mental Health First Aid' course was highly spoken of by many. However, workers want more than just training about what mental illness is, how to recognise it and how to respond to people who have it. They want practical training about things like handling crisis situations, getting access to mental health services and working with mental health services to achieve better results for clients:

> *We need* [mental health services] *to support us to assist clients by providing us with information, strategies and training, for example how to work with clients who are reluctant to take their medication. We understand that mental health workers can't always be there to assist, but they need to do more to support us to develop the skills we need to help these clients.*[209]

Many Housing SCSOSs expressed the view that all CSOs need to be regularly trained in how to identify and respond to indicators of mental illness:

> *We need our staff to conduct more informed* [client] *visits. They need to know what to look for … to better understand symptoms. For example, what does a person stashing heaps of bottles in a corner mean? Is this hoarding? Is this a sign of broader problems? There is a difference between expecting housing workers to become social workers and housing workers being educated about detecting signs of someone struggling early and referring them to experts for assistance. DoH is often the first to detect problems.*[210]

In addition, or as part of more general mental health training, we identified a need for the practical implementation of the JGOS to be incorporated into regular training for workers employed by partner agencies. In response to our survey of CSOs, only one-third of respondents said they had received any training or guidance about the JGOS. Given they are often in a position to identify early 'warning signs' that the tenancy of a person with mental illness is at risk, and given the role that the JGOS Guidelines envisage for them in attempting to resolve such situations, this was of concern.

As more tenants increasingly present with complex needs, there is a need for CSOs to become skilled in recognising and responding to them. This is because there are simply too few SCSOSs to directly handle cases involving clients with complex needs. SCSOSs need to rely on CSOs to appropriately identify, respond and where necessary escalate matters to them. In this regard, initiatives such as the CSO mentoring program in Parramatta which we referred to in Chapter 4 are a positive step.

In addition to recognising indicators of mental illness, training for housing workers needs to incorporate early intervention strategies to sustain tenancies and information about the role of other organisations who also have a role in helping clients whose tenancies are at risk.

Many health workers said they would like to know more about how to 'navigate' their local Housing office, for example knowing who to contact about particular problems and having a better understanding of Housing's needs in relation to applications for priority housing. In one location we visited we heard about the positive impact of training provided by the local Housing office to the community mental health service. The training focused on the needs of Housing when assessing applications for priority housing from people with mental health issues. Housing workers explained to health workers the sorts of things that should be included in letters of support for priority housing. This

208 NSW Health, correspondence 21 September 2009.
209 SAAP worker, consultation May 2008.
210 Housing NSW manager, consultation March 2008.

simple measure was reported by both parties to have assisted greatly in improving access to housing for individuals with mental illness. While mental health workers did not express a similar desire for training about SAAP, a number of housing workers and SAAP services believed that mental health workers would benefit from such training as it would provide them with a better understanding of the requirements of services when assessing and managing clients. In our view this has merit.

Our provisional report recommended that the SPC develop a training strategy to support the effective implementation of the JGOS. We also emphasised the need for the SPC to support local JGOS committees to implement training, and to look for evidence in the reports of local JGOS committees that training needs have been considered and acted on. In response, Housing NSW affirmed its commitment to the provision of training and development. They advised us that they provide a range of training, including specialist courses about dealing with challenging clients, Mental Health First Aid training, and training and development strategies for the implementation of the Accord, including equipping client service staff to develop, implement and maintain partnerships with other agencies. Housing is also developing an agreement with the Office of the Public Guardian and the Office of the Protective Commissioner (now the NSW Trustee and Guardian) that will be a Schedule to the Accord. The Schedule will provide guidance to staff about the management of mutual clients with impaired decision making abilities. While Housing expressed support for our recommendation that the SPC develop a training strategy to support the effective implementation of the JGOS, they noted that this would have 'significant resource implications for key partner agencies'. [211] Health did not support the recommendation on the basis that 'the training components for the implementation of the JGOS would best be managed locally because of the operational differences across area health services and local regions'.[212]

We agree with Health that the implementation of training needs to be managed locally. However, strategic guidance and oversight is required to ensure this is done adequately. It will be important that the new Housing and Mental Health Agreement is supported by a training strategy that covers the various areas outlined in our preliminary recommendation. The strategy need not comprise a formal, stand-alone training 'package', but may draw on existing methods used by agencies such as the inclusion of specific content in operating manuals, informal presentations by local practitioners, team meetings, supervision, etc. What is important is that practical information is made available to frontline workers in a way that reinforces their specific responsibilities in relation to the Agreement.

7.3. Exchanging information

The sample local MoU included in the JGOS Guidelines states that in relation to the sharing of personal information about clients between JGOS partners, 'no information will be provided without the written consent of the individual or their legal guardian'.[213] The exceptions to this are:

- where a social housing provider has referred the issue of a particular individual to health workers for action, health staff are able to indicate whether the individual is a consumer of the area health service or Aboriginal medical service
- in an emergency situation, where the health worker has reasonable grounds to believe that the physical or mental health of an individual or members of the public is at serious risk, duty of care will be prioritised over confidentiality
- there is otherwise a lawful excuse to provide confidential information in that is for the welfare of the tenant or the public to divulge any such confidential information.

Despite the provision of this guidance, the independent evaluation of the JGOS found that one of the main barriers to the effectiveness of local JGOS committees is concern associated with the exchange of personal information about clients. Our consultations confirmed this. The key issues raised with us were:

- a lack of clear and concise corporate guidance and training about privacy and the sharing of information generally
- complex requirements that may or may not apply to different agencies working together with respect to the one client. For example, there is a separate regime for health information.

The current legislative and administrative framework governing the exchange of personal information is overly complex. The key pieces of legislation are:

- The NSW *Privacy and Personal Information Protection Act 1998*. This Act applies to the sharing of personal information about individuals by NSW public sector organisations.
- The Commonwealth *Privacy Act 1988*, which applies to the sharing of personal information (including health

211 Housing NSW, response to provisional report, 20 May 2009.
212 NSW Department of Health, response to provisional report, 29 May 2009.
213 *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing*, p26.

information), by both public and private organisations

- The NSW *Health Records and Information Privacy Act 2002* which applies to the sharing of health information about individuals by both public and private organisations.

There is also the Privacy Code of Practice (General) 2003 and the Health Records and Information Privacy Code of Practice 2005, as well as sections 248 and 254 of the NSW *Children and Young Persons (Care and Protection) Act 1998*, which is relevant to matters involving young people. In addition, public sector agencies are required to have a privacy management plan in place which outlines the business rules of that individual agency relating to privacy matters. NSW Health's Privacy Management Plan runs to 44 pages and lists a further three pieces of legislation (the *Health Administration Act 1982*, *Mental Health Act 1990*, and the *Public Health Act 1991*) as applying to 'any information acquired in the course of duty' by a Health worker. A number of pieces of legislation, including the *Mental Health Act*, provide for a $5000 penalty for the unauthorised disclosure of information. Finally, the establishing acts relating to government agencies such as Housing NSW create an offence to disclose information obtained without lawful excuse.[214]

The result of this complexity is 'an inconsistency and fragmentation in privacy laws'[215] that tend to stifle the sharing of information by agencies rather than encourage it. The lack of clarity that it creates means that agency staff can struggle to balance the individual's right to privacy with the provision of the best possible service to that person. Our observation is that in this context, there is a tendency to adopt a risk-averse approach to the sharing of information, even when failure to do so may well lead to a negative impact on the well-being of the client.

There are two distinct areas relating to the interagency sharing of personal information. The first involves the sharing of information between agencies with the consent of the individual whom the information is about. The second, and most perplexing to those we consulted, involves cases where the individual refuses or is unable to provide consent.

7.3.1. Client Information Sharing Schedule

Excluding the NSW Police Force, the partners to the *Housing and Human Services Accord* have developed a Client Information Sharing Schedule (CISS) with the aim of enabling 'the appropriate sharing of information between agencies with the client's consent to improve pathways for clients with complex housing needs into the social housing and support systems, as well as to other appropriate housing and supports systems as needed.'[216] Under the CISS, the client is informed that only information needed (including health information) to make the best decisions to obtain and maintain their accommodation and support will be shared. Consent can be partial and can be withdrawn by the client at any time. In 2008, the CISS was trialled in a number of locations involving government and non-government organisations. We understand the CISS will be rolled out pending completion of an evaluation of the trial.

During our consultations we were told that local JGOS committees were often caught up in discussions about appropriate ways of exchanging information even in situations where consent was obtained. We note that the JGOS Templates released in 2007 include a pro forma authority to disclose information. However, there appeared to be limited awareness of this and several committees appeared to be struggling to reach agreement on protocols for exchanging information. The CISS is clearly a positive development. Our provisional report recommended that as part of reviewing the JGOS documentation, there would be merit in incorporating reference to the CISS to facilitate a consistent approach to the sharing of client information where consent has been provided. Housing and Health agreed in principle with this recommendation, with Housing proposing that the key partner agencies consider incorporating the CISS into the new Housing and Mental Health Agreement and resources.[217] We support this.

7.3.2. The issue of non-consent

The perceived inability to exchange information in the absence of client consent was a dominant theme during our consultations. Housing workers were especially frustrated by circumstances where a tenancy is likely to fail unless support services are engaged, but they do not have the client's consent to provide information to those services to facilitate contact with the client. We were provided with a range of examples where housing staff and SAAP workers had contacted mental health workers in an effort to obtain services for a particular tenant but were informed by them that no discussion about the client could take place without the client's consent.

Housing and SAAP workers reported that often the only way they can get mental health services to intervene when they have serious concerns for a person's welfare is to contact police or the ambulance service to take the person to hospital. Under the *Mental Health Act 2007*, a police or ambulance officer can convey a person to a mental health

214 For example section 71, NSW *Housing Act 2001.*
215 Australian Law Reform Commission, *For Your Information, Australian Privacy Law and Practice:* Report 108, Vol. 1, May 2008, p510.
216 *Aims and objectives of the Client Information Sharing Schedule*, at point 1. While it is a signatory to the Accord, the NSW Police Force is not a signatory to the schedule.
217 Housing NSW, response to provisional report, 20 May 2009.

facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed. This approach is often unsuccessful. The test for involuntary admission involves a person being clinically assessed as mentally ill or disordered, and there being reasonable grounds to believe that admission is necessary for the person's 'own protection from serious harm or for the protection of others from serious harm'.[218] Although they may have a range of complex needs, people often do not meet this threshold. Moreover, even if they are involuntarily admitted to hospital and discharged with a care plan, this does not necessarily lead to the outcome that housing or SAAP workers want, that is, an ongoing case management plan aimed at helping the client to sustain their accommodation or tenancy.

The CISS acknowledges that while in most circumstances agencies are obliged to obtain client consent before they use or disclose personal information about the client, there are circumstances when the client's consent is not required. The guide for practitioners that accompanies the CISS includes broad advice about the nature of these circumstances and states that workers should be aware of certain legislative provisions providing specific exemptions to client consent, including the Health Records and Information Privacy Code of Practice 2005 and the Privacy Code of Practice (General) 2003. In circumstances where consent is not given, workers are advised to discuss the need for consent with the client, refer to agency policy directives and seek support from internal agency privacy staff.

The Health Records and Information Privacy Code of Practice 2005 (Health Privacy Code) permits the exchange of information without consent in limited circumstances and provides that:

> *Despite the Health Privacy Principles, a human services agency (the authorised agency) may collect and use health information about an individual, and may disclose health information about the individual to another human services agency or an allied agency, if the collection, use or disclosure is in accordance with a written authorisation given by a senior officer of the authorised agency.*[219]

'Senior officer' means a senior member of staff of a human services agency who has been nominated in writing by the head of that agency to perform this function. A senior officer may make an authorisation only if the officer is satisfied that:

- the individual to whom the specified information relates is a person to whom services are provided or proposed to be provided by a human services agency or an allied agency; and
- the individual (or if the individual is incapable within the meaning of s.7(1) of the Act, of giving consent, the individual's authorised representative) has failed to consent to the agency collecting or using the specified information, or disclosing the specified information to the specified agencies; and
- there are reasonable grounds to believe that there is a risk of substantial adverse impact on the individual or some other person if collection or use of the specified information or disclosure of the specified information to the specified agencies, does not occur; and
- the collection or use of the specified information, or disclosure of the specified information to the specified agencies, is likely to assist in developing or giving effect to a case management plan or service delivery plan that relates to the individual; and
- reasonable steps have been taken to ensure that the individual has been notified by the agency of each of the following: the specified information, the specified agencies, the period for which the authorisation is proposed to be sought to have effect.[220]

Substantial adverse impact includes, but is not limited to, serious physical or mental harm, significant loss of benefits or other income, imprisonment, loss of housing, or the loss of a carer. An authorisation can have effect for up to 12 months.

The Privacy Code of Practice (General) 2003 contains almost identical provisions enabling the disclosure of non-health related personal information about an individual by a human services agency to another human services agency or allied agency.

Of concern to us is the apparent wide spread lack of awareness or understanding among those we consulted about the provisions in the Privacy Code of Practice (General) and Health Privacy Code that allow for the exchange of information in certain circumstances where consent has not been given. Because of this lack of awareness or understanding, we could not assess the effectiveness of the codes in addressing the situations of non-consent that workers described.

The issue of non-consent and the processes for exchanging information in the context of child protection were considered in detail by the Hon James Wood in his report of the Special Commission of Inquiry into Child Protection Services in NSW. The report highlighted the general consensus between agencies, including the Australian

218 Section 15 *Mental Health Act 2007.*
219 Section 4(2).
220 Section 4.

Law Reform Commission, of the 'need for a revision and simplification of the laws relating to the exchange of information.[221] The report by Justice Wood recommended that the *Children and Young Persons Care and Protection Act 1998* be amended to permit:

> *the exchange of information between human service and justice agencies, and between such agencies and the NGO sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child…*[222]

In responding to the report, the NSW Government has agreed to amend the *Children and Young Persons Care and Protection Act 1998* to provide that in all actions and decisions concerning a particular child or young person that are made under the Act, the safety, welfare and wellbeing of the child or young person must be the paramount consideration.

One example of legislation being enacted to permit the exchange of information without consent in relation to people with multiple and complex needs which the health, welfare and emergency services sectors struggle to meet is the *Human Services (Complex Clients) Act 2003*, underpinning the Victorian Multiple and Complex Needs Initiative. The Initiative is a multidisciplinary approach to supporting up to 50 individuals per year identified to have multiple complex needs, including those associated with combinations of mental illness, substance abuse, intellectual impairment, acquired brain injury and forensic issues. One of the aims of the Initiative is to stabilise housing, health, social connection and provide a platform for long-term engagement in the service system. Participation in a service response under the Initiative is voluntary. The Act allows service providers to exchange information by making a professional judgment based on what they believe will be in the best interests of the individual.

7.3.3. The need for a simplified system

As we have previously argued, there needs to be a simple and practical system in place that enables the exchange of information between relevant government and non-government human service providers when there are real risks to a person's safety, welfare and wellbeing associated with the failure to appropriately share that information.[223] This is especially important where the wellbeing of the most vulnerable in the community is the purpose of the communication. While the Victorian legislation only relates to a specific complex needs initiative, its guiding principles require that the 'well-being, health, safety and stable housing of the person are of paramount consideration'.[224] In this regard, given the current focus on simplifying the existing system for exchanging information to promote the safety, wellbeing and welfare of children in this state and the critical link between stable housing and wellbeing, it is timely for consideration to also be given to other vulnerable people, particularly those at risk of homelessness.

Our provisional report identified a clear role for the JGOS strategic partners in advocating for this to occur by highlighting the limitations of the current system and ensuring that staff who work in partner agencies have an understanding of the current system, including what it does and does not enable them to do. In 2006, the Human Services and Justice CEOs Forum issued *Information sharing for effective human service delivery: A guide for practitioners*.[225] The guide provides general advice and includes a decision-making process flowchart. While this document is useful, it does not include detailed advice or guidance about sharing information without client consent. While the guide for practitioners that accompanies the CISS does provide some guidance about when consent is not required and what to do if a client withdraws consent, the advice is general in nature. This is acknowledged in the schedule.

Our provisional report recommended that more practical guidelines about the exchange of information be developed and incorporated into the revised JGOS agreement and resources. In response, Housing NSW advised that in their view, the CISS already provides practical guidance.[226] However, in light of the apparent widespread confusion about when information can be exchanged, we believe there is still scope to provide workers with 'real-life' examples of situations in which non-consent is at issue and how various provisions (such as those outlined in the general and health privacy codes) addressing non-consent might apply in these situations. Scenario-based learning is helpful for creating situational-based awareness and judgment that workers can then apply in the context of their own work. NSW Health has also suggested that targeted education and resources directed at frontline workers in human service agencies about the implementation of privacy codes would resolve many issues around the poor sharing of information.[227]

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221 *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, p997.
222 *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, p1000 (Recommendation 24.6).
223 NSW Ombudsman Privacy and exchange of information, Submission to Special Commission of Inquiry (etc), April 2008.
224 Section 49(a) *Human Services (Complex Needs) Act 2003*.
225 www.community.nsw.gov.au/docswr/_assets/main/documents/iag_infosharing.pdf. Accessed 1 December 2008.
226 Housing NSW, response to provisional report, 20 May 2009.
227 NSW Health, correspondence 21 September 2009.

Having said this, in our view the solution ultimately lies in legislative change. In the child protection context, this has been recognised by the government's decision to amend the *Children and Young Persons (Care and Protection) Act 1998.* However, our work in the broader human services area has shown that in certain circumstances, agencies require the capacity to quickly and simply exchange information about any client when their wellbeing, health or safety is at risk. As the current privacy codes recognise, loss of stable housing is a relevant consideration in this regard.

For this reason, we have recommended that Housing and Health provide a copy of our report to the Human Services and Justice CEOs Forum, and that the Forum consider whether there is a need for legislative amendment to allow for a more streamlined framework for exchanging information in circumstances where the wellbeing, health or safety of a person are at risk.

7.4. Final observations

The systemic issues discussed in this chapter negatively impacted on the effective implementation on the JGOS. Unless the problems we identified in relation to discharge planning, training and the exchange of information are addressed, the success of the Housing and Mental Health Agreement will be similarly undermined.

Part 3: The way forward

Based on our investigation findings, we recommended that the future role of the JGOS be reconsidered in light of the changed landscape brought about by the 'Reshaping public housing' reforms, the introduction of the *Housing and Human Services Accord* and more recent developments such as the Federal Government's strategy to reduce homelessness.

We recommended that the Accord should become the primary governance model by which human service agencies implement their responsibilities to plan, coordinate and deliver services to clients who need support to access and sustain social housing. This will enable a more coherent, systemic response to the range of complex support needs with which social housing applicants and tenants now commonly present. We stressed the importance of incorporating the JGOS principles into the Accord framework and suggested that a supportive tenancy management approach be adopted not only in relation to clients with mental health problems, but to all clients with support needs. This approach is required for the Accord to fully realise its aims.

Given that a supportive tenancy management approach is not the responsibility of Housing NSW alone and must involve the commitment and support of the health and broader human services sectors (including the non-government sector), we have recommended that Housing NSW consult the Department of Health and Department of Human Services[228] about adopting such an approach for clients with support needs, and provide us with advice about the outcome of these consultations.

Both Housing and Health have agreed that the Accord should become the primary governance model and have identified as a key priority the development under the Accord framework of a Housing and Mental Health Agreement that will be closely aligned and integrated with the directions and actions of the NSW Implementation Plan for the National Partnership on Homelessness.

In this chapter, we discuss why the Accord should become the primary governance model. We also outline the critical elements of the supportive tenancy management approach that we have recommended. Finally, we reiterate the important lessons to be learned from the implementation of the JGOS and how these will need to be taken into account in the development and implementation of the new Housing and Mental Health Agreement. Our recommendations in this chapter are aimed at ensuring that the Agreement can be effectively implemented and that the Accord governance model facilitates a more responsive social housing system.

228 Since 1 July 2009 Housing NSW has been part of the Department of Human Services which also includes Ageing, Disability and Home Care and Community Services in addition to several other agencies and bodies.

Chapter 8.
A more responsive social housing system

> *The challenge of responding to tenants with high and complex needs calls for more than an extension or modification of existing practices; it calls for a comprehensive attempt to integrate a responsive support structure into housing service delivery.*[229]
>
> *It's time to start pulling all of the different pieces of the puzzle together in relation to supporting people with complex problems to sustain or obtain housing –– there should be one overarching system that workers can understand.*[230]

The major theme that emerged from our consultations was the enormous challenge facing the human services system in responding adequately to individuals with multiple complex needs. The increased targeting of public housing to people who need support services to help them live independently means that housing workers are coming into contact more frequently than ever with such individuals.

As we pointed out in Chapter 4, during our consultations many workers complained that the JGOS does not adequately cater for people with complex needs that are not solely related to a mental health problem. As the JGOS was never expressly envisaged to do so, this perception is indicative of a limitation rather than a failure. This limitation may be responsible for some of the scepticism expressed about the purpose and benefits of the JGOS. It may also contribute to a misdirected resentment on the part of some JGOS participants towards area mental health services, which are neither mandated nor resourced to respond to the range of potential factors underpinning complex needs that may undermine the ability of some individuals to access and maintain social housing.

The majority of people we consulted felt that while the JGOS principles are worthwhile and should be preserved, there is now a pressing need for a 'guarantee of service' that applies to people who may need support to access and maintain social housing for a range of reasons. We agree with this assessment. While the concept behind the JGOS was in many ways innovative for its time, the social and policy climate have changed dramatically in recent years.

The Accord, a joint commitment from all human service agencies, represents a response to this changed environment and in our view, provides a strong foundation for a broader guarantee of service. It recognises that social housing clients will have a range of support needs and that all human service agencies have a shared responsibility to assist them to establish and sustain tenancies. The Accord functions as an overarching framework for a range of initiatives, including a series of 'Shared Access' trials. These trials involve social housing providers supplying housing and tenancy management resources, and other government agencies providing support packages, to mutually agreed clients who are disadvantaged and need support for a range of reasons to live independently, such as people who are homeless or at risk of homelessness, young people and people with a disability. There are several trials underway and others have been proposed.

Our consultations revealed strong support for the Shared Access trials and a 'joined up' service delivery approach. However, concerns were raised that the trials would not necessarily translate into a broader supportive tenancy management approach but would be limited to those individuals receiving a support package as part of a specific Accord program. For the Accord to fully realise its aims, a broader supportive tenancy management approach needs to be embedded in the social housing system rather than superimposed on an existing way of doing business.

In response to our provisional report, Housing expressed their commitment to a supportive tenancy management approach while emphasising that it is not the responsibility of Housing alone to implement such an approach.[231] We have recommended that Housing consult with the Department of Health and the Department of Human Services about adopting a supportive tenancy management approach and provide us with advice about the outcome of these consultations. Health has expressed in principle support for the development of such an approach.[232]

In the remainder of this section we outline what are, in our view, the necessary components of a supportive tenancy management approach.

8.1. Supportive tenancy management

> *One of the main cultural difficulties for* [Housing NSW] *is that it has overlaid social welfare priorities on top of an existing landlord culture.*[233]

229 Australian Housing and Urban Research Institute, 'Housing management practice and support', *Research and Policy Bulletin*, Issue 71, January 2006, p2.
230 Housing NSW team leader, consultation April 2008.
231 Housing NSW, response to provisional report, 20 May 2009.
232 NSW Department of Health, response to provisional report, 29 May 2009.
233 Housing NSW manager, consultation March 2008.

Housing NSW has already recognised that in the current operating environment, they must adopt a 'client centred' approach to their business. Both the Corporate Plan and the Accord reflect this ideological shift from the traditional 'property management centred' approach.

Such a shift does not require housing workers to become social workers or case managers. However, they do have a clear role to play in helping their clients to achieve successful housing outcomes.[234] Housing NSW's current organisational aims of 'reducing the cycle of disadvantage for social housing tenants' and making 'a sustainable difference to social outcomes' reflect this.[235]

In order to practice a client centred approach, housing workers need to work within an operational system that facilitates supportive tenancy management.[236] This presents significant challenges in a context of strong pressure for more cost-efficient management of social housing. However, from a whole-of-government perspective, there are cost-effectiveness arguments that support sustaining tenancies, as tenancy failure and eviction may result in higher demand being placed on other public services in both the short and longer term.[237]

Housing cannot implement a supportive tenancy management approach alone. While initiative and commitment on the part of Housing is critical, the involvement and support of the health and broader human service sectors – including the non-government sector – is needed if such an approach is to be effective.

8.1.1. Critical elements of a sustaining tenancies approach

Broadly, a 'sustaining tenancies' approach is one that encompasses policies, programs and practices aimed at supporting social housing tenants in order to prevent tenancy failure and homelessness.[238] It must be clearly articulated and built into every stage of service provision, from an initial approach by an individual to obtain housing, to assessing an application and allocating property, and ongoing management of the tenancy. It requires recognition that tenants need certain skills and competencies to sustain a tenancy.[239] It is necessary for housing workers to have an understanding of what these skills and competencies comprise, and why, for some tenants, they may be deficient or compromised at certain times. We note that Housing NSW has committed to a targeted learning and development strategy that focuses on the capabilities and skills required within the organisation to implement new business policies and procedures.[240] In this regard, training and guidance for staff about high-risk tenancies and a sustaining tenancies approach should be part of any plan developed.

For a sustaining tenancies approach to be effective, all workers must see themselves as having a role to play. It is not adequate for the work involved to be considered the business of 'specialist' staff members alone. Responsibilities in relation to sustaining tenancies need to be clearly spelt out in position descriptions, training and reference materials. Performance against these responsibilities should be evaluated and reinforced as part of normal performance management processes.

The lynchpin of a sustaining tenancies approach is the adoption of a rigorous risk management framework. The framework should clearly identify what constitutes tenancy failure and tenancy success. It should also identify:

- pre-existing factors and precipitating 'life events' that make tenancies vulnerable to failure
- early intervention strategies
- appropriate reactive interventions when problems occur, and
- remedial interventions when tenancies ultimately fail.[241]

To ensure its effectiveness, the involvement of the health and broader human services sectors in developing and implementing a risk assessment framework for the purpose of sustaining tenancies is vital.

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234 Tim Seelig and Andrew Jones, quoted by Rowland Atkinson, Daphne Habibis, Hazel Easthope and Dan Goss, for the Australian Housing and Urban Research Institute, *Sustaining tenants with demanding behaviour: a review of the research evidence*, May 2007, p6.
235 Housing NSW, *Corporate Plan 2007/08–2009/10*, 2008.
236 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies at risk*, Presentation to Housing Futures: National Housing Conference, Adelaide, November 2003, p2.
237 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies at risk*, Presentation to Housing Futures: National Housing Conference, Adelaide, November 2003, p2.
238 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies at risk*, Presentation to Housing Futures: National Housing Conference, Adelaide, November 2003, p1.
239 Rowland Atkinson, Daphne Habibis, Hazel Easthope and Dan Goss, for the Australian Housing and Urban Research Institute, *Sustaining tenants with demanding behaviour: a review of the research evidence*, May 2007, p7.
240 Housing NSW, *Corporate Plan 2007/08–2009/10*, 2008.
241 This description is based on a model of risk and intervention proposed in Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies-at-risk in Queensland*, Final report, unpublished, August 2004, p3.

8.1.1.1. Identifying tenancies at risk

The early identification of risk is a crucial component of sustaining tenancies.[242] In order to be able to identify risk, housing workers need to understand the impact that certain factors can have on achieving housing stability, and the specific forms this can take.[243]

Research has supported the use by housing providers of a 'systematic and reliable process for early identification of vulnerable tenancies' that would include:[244]

> *the collection of key information about a person's current housing attributes; their level of satisfaction and the existence of things that might make it difficult for a person to stay housed; and the level of assistance a person requires with daily living activities, so that those factors that may jeopardise a person maintaining their housing are understood, analysed for the potential level of risk, and strategies planned to manage those risks.*[245]

In 2006, the Victorian Department of Human Services recommended that its Office of Housing develop a client risk assessment tool, a 'risk register' and associated processes to flag tenancies at risk and enable monitoring and review of client progress.[246] A number of the housing workers we consulted were assessing risk factors, however, to our knowledge, any screening processes currently utilised by social housing providers in NSW are ad hoc, varying between organisations and in some cases, between different areas within Housing NSW. A standardised tool would help provide for structured, accountable decision-making and enhance the capacity for monitoring and reporting data. In this way it could also be used to promote intelligence-driven practice, for example by providing an indication of the issues that clients at risk are commonly presenting with in a particular area. This information could then be used to inform the development of relationships with key services, or of specific programs.

The use of a standardised tool would also minimise guesswork or over-reliance on particular strategies to the exclusion of others, and enhance the confidence of staff required to make decisions about the appropriate course of action that should be taken. Importantly, it would enable periodic re-assessment that is consistent and able to clearly indicate any changes that may have occurred since the previous assessment. This goes to the importance of ensuring that within a risk management framework, risk is assessed in an ongoing way rather than simply at one point in time such as at the outset of a tenancy. From our discussions with housing workers, it is clear that the effort involved in employing a risk management approach aimed at preventing tenancies from failing would not necessarily be greater than that routinely spent by workers in responding to tenancies in imminent crisis.

Clearly, there are some limitations to the use of a standardised risk assessment tool. There are inherent complexities 'in linking risk assessment models to practical decision-making'.[247] A tool is only useful if it is used properly. Further, it should not be used as a substitute for the exercise of professional judgement and experience, or in a rigid, over-reliant manner. A risk assessment tool will never predict with absolute certainty risks associated with human behaviour, nor prescribe fail-safe interventions. However, the benefits of using a standardised tool, as outlined above, may be considerable 'both as a basis for early intervention … and as an explanatory tool for decision makers'.[248]

In 2007-2008, the Australian Housing and Urban Research Institute (AHURI) conducted a pilot project examining factors impacting on public rental tenancy outcomes in Queensland and South Australia. An aim of the project was to facilitate the development of client needs assessment tools and processes, and to identify options for early or proactive interventions which could be applied to support tenancies, including possibly the further development of risk assessment models.[249]

As part of the Accord, Housing NSW has committed to develop a complex housing needs screening tool. We understand this work is still at a preliminary stage. Our provisional report noted that in the absence to date of substantial data or theory that validates a preferable model, the findings of the AHURI research, when available, should be carefully considered by Housing.

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242 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, p73. Habibis et al provide the following definition of 'sustaining tenancies': 'Housing management policies and practices designed to assist social housing tenants to manage their tenancy successfully and to achieve improvements in their lives' (Daphne Habibis, Rowland Atkinson, Terry Dunbar, Dan Goss, Hazel Easthope and Paul Maginn, for the Australian Housing and Urban Research Institute, *A sustaining tenancies approach to managing demanding behaviour in public housing: a good practice guide*, July 2007, p2).

243 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002, p9.

244 Rowland Atkinson, Daphne Habibis, Hazel Easthope and Dan Goss, for the Australian Housing and Urban Research Institute, *Sustaining tenants with demanding behaviour: a review of the research evidence*, May 2007, p6; see also research cited by Atkinson et al at p9.

245 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002, pxi.

246 Victorian Department of Human Services, *Support for High-Risk Tenancies Final Report*, October 2006. In October 2008 the Department of Human Services advised that these initiatives have been regionally implemented.

247 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies-at-risk in Queensland*, Final report, unpublished, August 2004, p22.

248 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies-at-risk in Queensland*, Final report, unpublished, August 2004, p24.

249 www.ahuri.edu.au/publications/projects/p20290/. Accessed 30 September 2008. As at 14 October 2009 the findings of the pilot project were unpublished.

In response to our provisional report, Health advised us that they while they support the use of a risk assessment screening tool by Housing, they have some concerns about the size of the 'target population' that the tool under development will be used to screen and the business rules for the administration of the tool. Health has written to Housing about these and related issues, including the need to consult with mental health consumers in developing the tool and the importance of ensuring that staff administering the tool are appropriately trained.[250]

Clearly, the proposed risk assessment screening tool requires the input and support of other key partners in the health and human services sectors and should have a 'cross-agency' focus. While Housing must manage certain risks, other agencies also have responsibilities for responding to specific risk factors identified in relation to clients with support needs.

8.1.1.2. Early intervention strategies

A risk assessment framework should support early intervention approaches to high-risk tenancies. There is a need to ensure that early intervention strategies are built into tenancy management plans where potential risks are identified at the assessment stage. Housing NSW does require staff to ensure that support arrangements are in place for new applicants who are assessed as needing assistance to sustain a tenancy, and many community housing providers report also using this approach; 15% of all community housing tenancies have formal support agreements in place, with the figure rising to approximately 30% if informal agreements are included.[251] However, the extent to which the implementation and monitoring of support arrangements is occurring consistently or with rigour is unclear, and determining this was not a specific aim of our investigation.

Based on our consultations, there also appears to be an ad hoc approach across Housing areas and between different community housing providers to the employment of other early intervention strategies, such as sensitive property allocation, targeted client visits, referrals to other agencies or support services and case conferences/plans. Most of these strategies appear to have been initiated locally rather than as a result of corporate endorsement. We note that Housing NSW has committed to implement a model for early intervention to support and sustain high-risk social housing tenancies. This is a positive initiative. What is needed is a systematic approach to identifying, promoting and implementing early intervention strategies that work.

Good practice

Preventing eviction

In a remote country town, an Aboriginal woman residing in a Housing NSW property was in substantial rental arrears. There were grounds to apply for a termination of the lease. Rather than send a letter notifying her of this, a Client Service Officer visited the woman and found that her three adult children and partner were all living in the property but not contributing any rent. The CSO organised a family meeting, explained the situation and the potential consequences, and arranged for each family member to make direct rental deduction payments. As a result, the tenancy was sustained.

8.1.1.3. Reactive interventions

When early intervention strategies fail, we recognise that invoking disciplinary measures may be the only option available to housing workers. In most circumstances the appropriate initial measure is an application for a specific performance order (SPO) to be made by the Consumer, Trade and Tenancy Tribunal (CTTT). An SPO makes continuation of a tenancy conditional on compliance with one or more directives, such as entering into a rental arrears payment plan or maintaining the cleanliness of the property. A breach of an SPO can be grounds for the issue of a notice of termination (NOT).

Because of the potentially serious consequences that can flow from failing to comply with an SPO, the stress associated with CTTT proceedings for tenants, and the resources involved in preparing matters for the tribunal, SPOs should not be used as a substitute for more supportive early intervention strategies. These strategies should be exhausted before taking action at the tribunal. Housing providers should also take steps to see that vulnerable tenants are provided with the support they require to meet the requirements of any SPO that is granted. Otherwise, the SPO is likely to place the tenancy at additional risk of failure. For example, if a tenant has been hoarding and an SPO is granted requiring the property to be cleaned, they are likely to need assistance to make the necessary arrangements.

250 NSW Department of Health, response to provisional report, 2009.
251 Figure provided during meeting with Community Housing Division, 24 September 2008.

In Chapter 4, we reported the concerns expressed to us by tenant advocates about the issuing of NOTs prior to other attempts being made to resolve tenancy problems. We noted Housing's earlier acknowledgement that it is common practice for a NOT to be issued, even when there is no intention to take steps to evict a tenant, in order to encourage the tenant to seriously consider the consequences of not complying with the conditions of their tenancy agreement. As we advised Housing NSW in 2007, it is our view that this position does not sit comfortably with the requirements and intentions of Housing's own policies and procedures. It is also inconsistent with a supportive tenancy management approach.

It is also our view that if issuing a NOT does become necessary, housing workers should inform the CTTT of a tenant's known current or prior mental health condition and provide information about the steps taken to support the tenancy in question and the reasons why they believe the only reasonable course of action is an order for termination and possession.

Our provisional report recommended that Housing NSW should provide us with advice about whether it is still common practice for NOTs to be issued in the circumstances described above, and if so, whether they consider it to be appropriate in light of the observations made in this report. In response, Housing advised that they supported the recommendation and are 'currently reviewing the management of rent and water arrears processes and compliance and monitoring processes and will give careful consideration to these issues and [our] recommended actions as part of the review process'.[252]

8.1.1.4. Remedial interventions

When tenancies do fail despite best efforts to ensure otherwise, there is a need for the supportive tenancy management actions to continue in order to promote the best possible outcome in the circumstances for the individual concerned. This involves planning to minimise the adverse implications of what is intrinsically a traumatic event. Planning may involve giving consideration to the timing of the actual eviction, and the provision of assistance in accessing private rental housing. It may also involve referral to housing and other support agencies who can provide temporary accommodation and/or assistance to re-enter social housing. Like other supportive tenancy management interventions, those concerning eviction need to be documented clearly in organisational procedures and monitored.

8.1.1.5. Data collection

To be effective, a risk management framework needs to be supported by reliable data collection. In Chapter 6 we discussed the type of data about tenants and tenancy management that needs to be recorded in order to support the identification of risk and the implementation of early intervention strategies. Essentially, the same data needs to be collected to facilitate a broader sustaining tenancies approach. The system for collecting data also needs to support decision-making by housing workers and reporting processes.[253]

8.1.1.6. Relevant performance indicators

> *There is not enough recognition about what's involved in saving a tenancy.*[254]

It is important that performance indicators measure and acknowledge the responsibilities associated with sustaining tenancies.

An outcome of the Victorian Department of Human Services' Support for High Risk Tenancies Project in 2006 was a recommendation that the Office of Housing develop performance indicators that relate to their work with people in high-risk tenancies.[255] An unpublished research report undertaken for the Queensland Department of Housing also noted that 'the development of performance indicators for [housing] offices relating to proactive intervention strategies as well as reactive responses' may be one way of institutionalising a commitment to sustaining tenancies.[256]

Housing NSW has advised that they are currently analysing the work performed by staff to support clients with complex needs and the best way to measure this.

252 Housing NSW, response to provisional report, 20 May 2009.
253 Daphne Habibis, Roland Atkinson, Terry Dunbar, Dan Goss, Hazel Easthope and Paul Maginn, for the Australian Housing and Urban Research Institute, *A sustaining tenancies approach to managing demanding behaviour in public housing: a good practice guide*, July 2007, p23.
254 Housing NSW area director, consultation June 2008.
255 Victorian Department of Human Services, *Support for High Risk Tenancies Final Report*, October 2006, p8.
256 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies-at-risk in Queensland*, Final report, unpublished, August 2004, p36.

8.1.1.7. Monitoring and evaluation

Monitoring tenancy failure and tenancy success is a critical component of a sustaining tenancies approach and is dependent on the existence of relevant performance indicators. One of the objectives of doing so should be to enable the evaluation of strategies adopted by housing workers in an effort to sustain tenancies. In a context of limited resources and pressure on housing providers to demonstrate cost efficiencies, evaluation is imperative. Where particular strategies are found to yield positive results, the ability to objectively document this is likely to increase the extent to which housing workers are prepared to utilise them in the future. In the absence of such documentation, workers may be sceptical about doing so.

8.2. Coordinating support

> *The problem facing public housing management is complex and requires the skills and resource support of other parts of the health and welfare service sector.*[257]

Appropriate support for people with complex needs can assist them to sustain their tenancies.[258] Research has established that the provision of housing and support should be separate, but coordinated.[259] In particular, the transfer of information between housing providers and services delivering this support has been found to be critical to achieving good outcomes for individuals.[260]

To meet their responsibility to sustain tenancies, social housing providers require the assistance of others within the broad human services sector. Based on our consultations, housing workers often feel they shoulder the burden of vulnerable tenancies. They experience frustration and disillusionment when the assistance they need to carry out their responsibility to sustain tenancies is not forthcoming. Often, they also feel unfairly blamed when tenancies do fail.

A range of agencies and services have a supporting role in sustaining the social housing tenancies of people with complex needs, and this is recognised by the Accord. The Accord requires signatory agencies to make specific commitments of core business resources which are articulated in relation to specific initiatives. However, what is less clear is the nature of their responsibility to provide support to clients generally, that is, regardless of whether a client is receiving support as part of a specific initiative. Agencies and services have a responsibility at both a strategic and local level to identify what support they can provide and commit to providing it. This helps to identify local service gaps and can inform future planning. Agencies and services should also ensure they negotiate clear protocols for communication and referral with social housing providers.

Like social housing providers, other agencies and services should be able to demonstrate how they contribute to sustaining tenancies. To do this, an agreed set of indicators should be developed. These might include:

- the number of referrals received from social housing providers and SAAP services
- the outcomes of these referrals (eg health assessment, admission to inpatient care, temporary/transitional accommodation, case management or advocacy provided, referral to another service, no further action)
- the number of tenancy related case conferences and joint targeted client visits attended.

Other measures may be appropriate, depending on, for instance, specific programs or initiatives in the area, eg HASI, or other partnerships that link the provision of housing to support.

As discussed above (at 8.1.1.1) the development of a 'cross-agency' risk assessment screening tool is also integral to the coordination of support for people with complex needs.

8.2.1. Tenancy support programs

Even where support is forthcoming from other agencies and services, housing workers can find it difficult to negotiate the service sector. Identifying relevant service providers, making and following-up referrals and coordinating the actual provision of support can be complex and time consuming. In some jurisdictions, tenancy support programs have been introduced to streamline the provision of support to clients whose tenancies are identified as being at risk.

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257 Victorian Department of Human Services, *Support for High Risk Tenancies Final Report*, October 2006, p66.
258 Anne O'Brien, Susan Inglis, Tania Herbert and Astrid Reynolds, for the Australian Housing and Urban Research Institute, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, September 2002.
259 Michael Bleasdale, for the Australian Housing and Urban Research Institute, AHURI Positioning Paper No.89, *Supporting the housing of people with complex needs*, May 2006.
260 Astrid Reynolds, Susan Inglis and Anne O'Brien, for the Australian Housing and Urban Research Institute, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, January 2002.

Tenancy support programs involve housing workers identifying people whose tenancy may be at risk and referring them to a specialist service that can help to develop a plan of action and refer tenants to another service as needed. Under the National Partnership on Homelessness agreed to by COAG, state and territory governments will be encouraged to develop expanded tenancy support models to help people sustain their tenancies.[261]

In Victoria, the Social Housing Advocacy and Support Program (SHASP) has been delivered regionally since 2006 by 11 non-government organisations (it is currently being evaluated). Each year, SHASP provides support to over 2,000 public housing tenants on referral from the Office of Housing (OOH). Individuals and other agencies can also make referrals to SHASP through the OOH. The SHASP provides:

- assistance to applicants in establishing eligibility for housing where support is required to do this
- support to tenants who have a high risk of tenancy failure to establish their tenancy
- intervention when a tenancy is breaking down.

The SHASP is complemented by the Housing Support for Indigenous Tenants initiative. The initiative was implemented in 2006 and provides intensive support to Indigenous tenants whose public, Aboriginal or community housing tenancies are at risk.

South Australia and Western Australia have been running similar programs for some time. In Western Australia, participation in the program may become a condition of tenancy where there has been a prior poor tenancy history.

Research has indicated that a key feature of successful programs that specialise in supporting tenants is that they are commissioned by social landlords, yet are delivered independently of them.[262] The main benefit in implementing tenancy support programs is that housing providers are able to draw on the existing skill base of the NGO sector whose experience is identifying the necessary supports and navigating the service system. The NGO sector is arguably better placed than housing workers to perform this type of social welfare role. In saying this, there is still a critical role for specialist housing workers to play. A tenancy support program would free these specialist workers to focus on the early identification of risk and monitoring the implementation of support plans. Against a background of projected shortfalls in Housing NSW's workforce capacity due to changing skill requirements, it makes sense to consider what existing resources are available to the social housing sector to support them in carrying out their responsibilities, and how these resources can be shared by providers.

In September 2008 Housing NSW announced that a new program, the Tenant Participation Resource Services Program, would commence from July 2009. The program funds nine Tenant Participation Resource Services (TPRS) across the state to deliver activities previously funded under the Regional Tenant Resource Services and Public Tenant Councils programs. The program aims to ensure social housing tenants are engaged in communities; have their needs and priorities identified in planning and service delivery; are informed about their rights and responsibilities and are supported with their housing needs; have skills and resources to participate in community life; and receive services that are coordinated, flexible and responsive to their needs.[263] Providing advice, referral and tenant advocacy constitutes one of five core areas under which TPRS are required to deliver outcomes.

In this way, and unlike the SHASP in Victoria, the provision of tenancy support with a specific focus on assisting clients to establish and sustain tenancies is not the sole aim of the program. While it provides an avenue for social housing tenants to receive some assistance in relation to 'issues or decisions regarding their social housing situation' and/or 'issues related to their physical, social and economic circumstances', providers will have to balance their capacity to provide advice, referral and advocacy with the roles and responsibilities covered by the other four core areas.[264]

In our view, there is merit in considering the benefits of establishing a tenancy support program in NSW that has the capacity and specific responsibility to provide the type of services delivered by the SHASP in Victoria. However, this should be done with reference to the experience of other jurisdictions, and in particular, the evaluation of the SHASP which is currently underway.

8.3. Building on the Accord

Currently, policies and practices aimed at supporting and sustaining tenancies are somewhat disjointed and ad hoc. There are many valuable programs and practices but they are not linked together in a comprehensive policy and strategy.[265]

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261 Australian Government, *The Road Home: A National Approach to Reducing Homelessness*, White Paper, December 2008.
262 Research cited by Rowland Atkinson, Daphne Habibis, Hazel Easthope and Dan Goss, for the Australian Housing and Urban Research Institute, *Sustaining tenants with demanding behaviour: a review of the research evidence*, May 2007, p13.
263 Housing NSW, *Tenant Participation Resource Services 2009–2011 Program Guidelines*, October 2008, p2.
264 Housing NSW, *Tenant Participation Resource Services 2009–2011 Program Guidelines*, October 2008, p6.
265 Andrew Jones, Donna McAuliffe, Tim Reddel, Greg Marston, Alice Thompson, *Sustaining tenancies in public housing: understanding and supporting tenancies-at-risk in Queensland*, Final report, unpublished, August 2004, px.

Both Housing and Health have agreed that it makes sense to review and build on the Accord. The Accord has the buy-in of all major human services agencies, recognises the importance of the NGO sector and has designated coordinator positions. It reflects the new circumstances in which social housing is delivered and the increasing complexity of client need.

8.3.1. Learning from the JGOS

In response to our provisional report, Housing and Health advised us that:

> *The integration of the JGOS and other housing and mental health agreements into the Housing and Mental Health Agreement under the Accord framework will provide an opportunity to utilise and build on the Accord and enhance the provision of housing and support services for people with a mental illness.*[266]

Housing and Health agreed that in developing the Housing and Mental Health Agreement and reviewing the Accord framework, they will take into account our observations and preliminary recommendations about the implementation of the JGOS with particular regard to the JGOS agreement and resources, governance and accountability. In this regard, we note that Housing has proposed the development of an 'options paper' in consultation with Health and other key agencies.[267]

8.3.1.1. JGOS agreement and resources

One of the weaknesses of the JGOS was that the documentation establishing it did not support effective implementation. As stated previously, while the MoU and principles are sound, the Guidelines released alongside them did not provide adequate practical guidance for frontline workers or sufficient detail about governance arrangements and therefore generated confusion. While it was envisaged that additional information would be provided in a separate 'resource kit', this did not eventuate until four years after the JGOS was launched. The outcome was a variety of entrenched practices which were not necessarily productive and multiple, inconsistent documents that provided neither clarity nor strategic direction.

The Housing and Mental Health Agreement will need to be supported by one document that provides clear guidance about how staff from partner agencies should meet the objectives of that approach, the type of results they should be achieving and how they will be held to account. The document must be negotiated between all partners to ensure it meets the needs of all parties. It is also important that the aims and objectives of the new approach are explicitly reflected in each partner agency's internal policies and procedures. This was an area that was lacking in relation to the JGOS. It resulted in the JGOS operating as an isolated policy document rather than as a framework with consequences for how the overall business of the partners should be approached.

Finally, when a significant policy or framework is released with the expectation that this will change the way that staff approach their work, it is critical that this is supported by a timely strategy to promote awareness, together with training about the practical business implications.

8.3.1.2. Governance

Like the documentation, the JGOS governance model appeared to unfold over time. For example, the original Guidelines did not refer to the existence of a Strategic Partners Committee (SPC) or Implementation Reference Group (IRG). They were also unclear about how the various types of meetings/committees would function in relation to each other.

While on the surface there does not appear to be anything wrong with the governance arrangements that evolved (local and area committees supported by an IRG and SPC) or the committees' terms of reference, what was lacking was proper consideration of how the committee layers would interact in a practical sense. For example, there has been no adequate mechanism for local or area committees to report their work or concerns to the SPC and for the SPC to report back to them. This was due in part because there was no methodical area/regional representation on the IRG. The relevant peak bodies, who are best placed to report on the concerns of their members, were unable to do so effectively because they were represented on the IRG rather than the SPC and these two committees did not, in their view, interact in a productive way. In fact, the peaks believe the JGOS governance arrangements have failed to ensure a responsive approach to their concerns and those of their members.

266 Housing NSW, response to provisional report, 20 May 2009. Health provided similar advice (NSW Department of Health, response to provisional report, 29 May 2009).
267 NSW Department of Health, response to provisional report, 29 May 2009.

The governance of the JGOS was also weakened by the lack of strategic direction about what each of the partners should achieve in order to give effect to the JGOS principles, and productive ways to go about doing this. Our investigation revealed that although a number of local and area/regional committees were genuinely trying to meet the JGOS aims, they felt hampered by a lack of guidance about how to do this. These committees wanted to 'benchmark' their work, while ensuring they were not expending unnecessary effort attempting to find solutions to problems that others had already solved.

In developing the Housing and Mental Health Agreement, the partners will need to ensure that the governance arrangements involve all participants having a clear sense of what their responsibilities are – both at a direct service delivery level and in relation to the partnership arrangement itself. In order to achieve this, all partners need to be meaningfully consulted about the type of mechanisms required to facilitate the partnership at each level.

8.3.1.3. Accountability

It would also appear that inadequate consideration was given at the outset to how the partners would demonstrate they were achieving the JGOS aims, that is, how an evidence base would be built. Our investigation found that neither Housing, Health nor any of the other partners were systematically capturing information about what results were being achieved through the JGOS process or the nature of any impediments to achieving them. This was because the agencies did not appear to have factored in the systems needed to identify the clients the JGOS aims to assist and monitor results. Moreover, it is not clear that they ascribed responsibility to certain positions for making sure it occurred. Therefore, the agencies were not well placed to demonstrate that the implementation of the JGOS was effective.

In the absence of changes to the operational systems and procedures of partner agencies to give effect to any policy – including the Housing and Mental Health Agreement – it will always be difficult to implement it and for people to see the results.

8.3.2. The way forward

In our view, one of the main reasons the implementation of the JGOS has been largely unsuccessful is because it was imposed on existing organisational structures that were not set up to deliver what the JGOS promised. For the approach we have outlined to be successful, it is critical that this does not happen again.

Another critical factor in ensuring the success of the approach we have outlined is that it is implemented in a way that is consistent with the Federal Government's reform agenda to reduce homelessness. The reforms require all states and territories to develop implementation plans setting out how they will achieve the objectives outlined in the December 2008 White Paper. In August 2009 the NSW Government released the *NSW Homelessness Action Plan 2009–2014*, which incorporates NSW's implementation plan.[268] The national response to homelessness will be implemented through three strategies:

1. *Turning off the tap*: services will intervene early to prevent homelessness
2. *Improving and expanding services*: services will be more connected and responsive to achieve sustainable housing, improve economic and social participation and end homelessness for their clients
3. *Breaking the cycle*: people who become homeless will move quickly through the crisis system to stable housing with the support they need, so that homelessness does not recur.[269]

In order to implement these strategies effectively, the Accord governance arrangements and planning processes will need to be closely aligned with the contribution of NSW to the national response to homelessness. Housing and Health have recognised this.

Finally, it became apparent during our investigation that there are serious implications arising from the significant shortage of supported accommodation for people with mental health problems. In this regard, a consistent theme to emerge from our consultations was strong support for a significant increase in the number of HASI places across NSW. In this regard we note the recent report of the Mental Health Council of Australia which found that while there are still some areas that need to be developed in relation to the delivery of HASI, the quality of the service it provides is 'excellent'. However, it also found that there are not enough places in the program to accommodate existing needs.[270]

268 NSW Government, *A Way Home: Reducing Homelessness in NSW*, *NSW Homelessness Action Plan 2009–2014*, August 2009.
269 Australian Government, *The Road Home: A National Approach to Reducing Homelessness*, White Paper, December 2008, pix.
270 Mental Health Council of Australia, *Home Truths: Mental Health, Housing and Homelessness in Australia*, March 2009, p44.

Recommendations:

1. Within three months, Housing NSW and the Department of Health should provide advice to this office about how they will:

   a) rescind the JGOS and make the Accord the primary governance model by which human services agencies implement their responsibilities to plan, coordinate and deliver services to those clients with mental health problems who need support to access and sustain social housing

   b) ensure the Accord governance arrangements and planning processes are aligned with the National Response to Homelessness

   c) ensure the Accord commits partners to implement the Housing and Mental Health Agreement

   d) ensure that the Housing and Mental Health Agreement explicitly outlines how agencies will plan, coordinate and deliver services to those clients with mental health problems and support needs in a way that adequately addresses the shortcomings that impacted on the successful implementation of the JGOS

   e) ensure that the Housing and Mental Health Agreement clearly articulates and addresses the support needs of people with a dual diagnosis of a mental health problem and intellectual disability or a mental health problem and substance abuse.

2. Housing NSW and the Department of Health should ensure that in responding to recommendations 1a)–e) above, consideration is given to the relevant policy and practice issues which underpinned our preliminary recommendations and our final observations in chapters 3, 5, 6 and 7 of this report.

3. Housing NSW should consult with the Department of Health and the Department of Human Services about adopting a supportive tenancy management approach, including the:

   a) development of a standardised risk assessment screening tool

   b) adoption of an early intervention approach to sustaining tenancies

   c) provision of adequate guidance for housing workers on the use of reactive and remedial interventions

   d) collection of data and performance indicators to facilitate and measure supportive tenancy management

   e) provision of a tenancy support program

   f) establishment of an ongoing monitoring and evaluation strategy

   and within three months of this report, provide advice to this office about the outcome of these consultations.

4. Housing NSW should recommend to the Registrar for Community Housing that the community housing evidence guidelines be amended to:

   a) include guidance for community housing providers about the type of processes that should be in place for the eviction of people with mental health problems

   b) reflect that good practice in supporting tenants with mental health problems involves community housing providers demonstrating compliance with key policies and partnerships, including the Housing and Mental Health Agreement, aimed at assisting clients to access and sustain social housing.

5. The Department of Health should ensure that the local protocols developed by area mental health services to guide discharge planning should articulate:
   a) the reasons why the social housing of a mental health client may be placed at risk if a social housing provider does not know the client has been admitted to or discharged from mental health care
   b) the importance of notifying the social housing provider when a mental health client known to be living in social housing is admitted to or discharged from mental health care, and loss of that housing is a risk
   c) the need to share adequate information with SAAP providers when discharging a client directly to SAAP accommodation, to enable the provider to make an informed risk assessment.
6. The Department of Health should provide advice to this office about the outcome of its review of the implementation of the statewide policy directive on discharge planning for adult mental health inpatient services, including its findings about compliance with the policy and whether changes to local protocols are required.
7. Housing NSW should review the Client Information Sharing Schedule to ensure it provides practical examples for staff about the application of relevant legislative provisions to situations in which consent is not provided for the sharing of information about clients between agencies.
8. Housing NSW and the Department of Health should provide a copy of this report to the Human Services and Justice CEOs Forum for the Forum to consider the adequacy of the Privacy Code of Practice (General) 2003 and the Health Records and Information Privacy Code of Practice 2005, including whether there is a need for amendments to allow for information to be exchanged without consent in a broader range of circumstances where the wellbeing, health or safety of a person are at risk.
9. Housing NSW should provide this office with advice about the outcome of its review of compliance with rent and water arrears processes.
10. The Department of Health should provide this office with advice about plans to further expand the HASI program.

Appendix 1
Summary of preliminary recommendations

1. Housing NSW and the Department of Health should ensure the SPC reviews and rationalises the JGOS agreement and resources, taking into account the issues raised in this chapter, such that the JGOS agreement is supported by one set of guidelines. The guidelines should include:
   a) a clear statement about the aims of the JGOS
   b) the role of local partners and what is expected of them
   c) the role of other organisations such as the OPG and how they are expected to work together in relation to mutual clients
   d) the role of consumer consultants and tenant advocates
   e) what is expected of local committees and staff in implementing the JGOS (including what reporting is required)
   f) what local committees expect from the SPC
   g) how the work of frontline staff should connect with committees
   h) good practice guidelines and advice for dealing with common problems
   i) links to relevant organisational policies and procedures.
2. Housing NSW and the Department of Health should recommend to the SPC that the IRG be rescinded and the SPC be expanded to include:
   a) the SAAP peak bodies – Homelessness NSW, Youth Accommodation Association and Women's Refuge Resource Centre
   b) the community housing peak body – the NSW Federation of Community Housing Associations
   c) the mental health non-government organisation peak body – the Mental Health Coordinating Council
   d) the representative body of TAAS – NSW Tenants' Union
   e) the peak body representing mental health consumers – NSW Consumer Advisory Group.
3. Housing NSW and the Department of Health should ensure the SPC clarifies the roles of each of the members of the expanded SPC in relation to the promotion and implementation of the JGOS.
4. Housing NSW and the Department of Health should recommend to the SPC that the Department of Ageing, Disability and Home Care (DADHC) be invited to become a signatory to the JGOS.
5. The Department of Health should include area drug and alcohol services as local JGOS partners, with appropriate representation on the SPC to reflect this.
6. The Department of Health should recommend to the SPC the inclusion of the statewide Aboriginal mental health coordinator as an advisory member to the SPC.
7. Housing NSW and the Department of Health should ensure the SPC clarifies its expectations about the role of the AH&MRC and AHO in relation to the promotion and implementation of the JGOS in local areas.
8. Housing NSW and the Department of Health should ensure the SPC develops:
   a) a strategic plan incorporating a revised terms of reference, taking into account the issues raised in this report and related recommendations
   b) annual plans that identify the work to be undertaken by the SPC each year in relation to the revised terms of reference
   c) links with appropriate senior officer groups, including the Housing and Human Services senior officer group
   d) a protocol for escalating issues that cannot be resolved by the SPC or that have broader significance for the human services area to the Human Services and Justice CEOs Forum.
9. Housing NSW and the Department of Health should recommend to the SPC that Area JGOS committees be rescinded.

10. Housing NSW and the Department of Health should recommend to the SPC that they formalise the use of existing regional consultation mechanisms such as RCMGs/JHSCCs to address area and regional issues that cannot be resolved at the local level.
11. Area directors employed by Housing NSW and NSW Health area mental health services should be given specific responsibility for the following:
    a) in consultation with government and non-government partners, ensuring that local JGOS committees are established where required
    b) delegating to local managers joint responsibility for establishing and/or maintaining these committees and actively supporting them to carry out this work
    c) identifying issues that cannot be resolved at a local level, ensure they are referred to existing forums such as the RCMGs/JHSCCs, or if necessary, to the SPC, and report action taken to address them to local committees
    d) ensuring that local committees report to the SPC on their implementation of the JGOS against clear performance indicators and that local committees receive feedback from the SPC about their performance
    e) disseminating to local committees examples of good practice and other useful resources identified by the SPC
    f) identifying the operational systems and procedures needed to support the JGOS objectives and communicate these to the SPC. Such systems and procedures might include: training, provision of administrative support to local committees, implementing agency performance measures, and establishing agency rules for the capturing and recording of relevant data.
12. Housing NSW and the Department of Health should ensure the responsibilities of area directors in relation to JGOS are reflected in their position descriptions and performance management processes.
13. Housing NSW and the Department of Health should ensure the SPC considers the benefits of the other strategic partners identifying which positions within their organisations should have responsibility for the JGOS at the area/regional level.
14. Housing NSW and the Department of Health should ensure the SPC requires local committees to regularly report through Housing and Health area directors their progress as to:
    a) what they have done to assist existing social housing tenants with a mental illness whose tenancy may be at risk to maintain their housing, the outcome of the assistance provided, and if assistance could not be provided, the reasons why
    b) what they have done to assist applicants with a mental illness who are homeless or at risk of homelessness to establish a tenancy, the source of referral where relevant (eg SAAP or Aboriginal medical service), the outcome of the assistance provided, and if assistance could not be provided, the reasons why.

    In relation to a) and b) above, wherever possible data relating to Aboriginality should be captured.
15. Housing NSW and the Department of Health ensure the SPC determines and communicates a range of strategies that should be locally implemented to achieve the above aims, including:
    a) identifying suitable local partners
    b) processes for meaningful engagement between local partners using flexible and consultative mechanisms
    c) annual local committee action plans
    d) referral and joint case planning protocols
    e) processes to ensure that individual cases or issues needing to be addressed by local JGOS committees are routinely identified and brought forward by frontline staff within partner organisations
    f) ensuring that appropriate feedback about JGOS meeting outcomes are fed back to frontline staff within partner organisations
    g) ensuring that matters which require escalation are identified and actioned by local JGOS committees.
16. Housing NSW and the Department of Health should ensure the SPC develops a standardised reporting template for local JGOS committees.

17. Housing NSW and the Department of Health should ensure the SPC develops a systematic process for reviewing local committee reports and responding to issues they raise. Ideally, the SPC will also use such a process to:
    a) identify issues that may be impacting on the delivery of services and the work of committees, eg discharge planning and sharing client information
    b) gather 'intelligence' about committees that require support
    c) identify examples of good or innovative practice and communicate this to all committees
    d) provide feedback to committees about what they are doing well and any opportunities for improvement
    e) inform briefings to partner agencies about relevant themes and issues highlighted through reports
    f) promote the success of the JGOS framework.
18. Housing NSW should ensure that Project Meridian addresses the data collection requirements needed to support the effective implementation of the JGOS. These could include:
    a) risk factors identified
    b) early intervention strategies utilised
    c) details of referrals, case conferences and support plans
    d) an ongoing review mechanism.
19. Housing NSW and the Department of Health should ensure the SPC explores with the AHO and OCH the type of data that should be collected by individual housing providers to support the effective implementation of the JGOS.
20. The Department of Health should ensure that area health services have the facility to capture information about clients who need social housing or whose social housing tenancies are at risk.
21. Housing NSW and Health should ensure the SPC explores with peak bodies the type of data that should be collected by their members to demonstrate their involvement in the JGOS and unmet requests for assistance.
22. Housing NSW and the Department of Health should determine which positions have specific JGOS responsibilities and the nature of these.
23. Housing NSW and the Department of Health should ensure the responsibilities of these staff in relation to JGOS are specifically included in their position descriptions, that they are supported to meet these responsibilities, and that their performance in relation to them is monitored.
24. Housing NSW and the Department of Health should articulate these responsibilities in the revised JGOS agreement and resources.
25. Housing NSW should ensure that the Office of Community Housing includes JGOS participation, including standardised processes for the eviction of people with mental health problems, as an indicator in the evidence guidelines which support the new community housing regulatory code and registration system, and provide guidance as to what such participation should involve.
26. Housing NSW and the Department of Health should recommend to the Aboriginal Housing Office that they include JGOS participation, including standardised processes for the eviction of people with mental health problems, in the service/funding agreements for RAHMS, and provide guidance as to what such participation should involve.
27. Housing NSW and the Department of Health should discuss with DoCS the benefits of:
    a) reviewing and clarifying the responsibilities of CPOs and DPPs with regard to JGOS and ensuring these are documented and communicated, both internally and externally
    b) including guidelines for JGOS participation in the new SAAP service agreement.
28. The Department of Health should amend its policy on discharge planning for adult mental health inpatient services to refer to:
    a) Health's role in implementing the JGOS and to require Health to notify social housing providers when consumers who are social housing tenants are admitted to and discharged from hospital, if there are reasonable grounds to believe there is a risk of substantial adverse impact, including loss of housing, if this information is not disclosed
    b) Health's responsibilities when directly referring clients on discharge to SAAP providers, including providing full information to enable providers to complete an informed risk assessment.

29. The Department of Health should ensure the SPC considers:
    a) providing appropriate guidance to local JGOS partners about the application of the amended discharge planning policy
    b) monitoring the local implementation of the amended discharge planning policy insofar as the policy relates to Health notifications to social housing and SAAP providers.
30. Housing NSW and the Department of Health should ensure the SPC considers developing a training strategy to support the effective implementation of the JGOS, including but not limited to the following components:
    a) identifying indicators of mental illness
    b) communicating with people with mental illness
    c) responding to crisis situations effectively
    d) accessing and working with the local area mental health service
    e) accessing and working with local SAAP providers
    f) accessing and working with local social housing providers
    g) the role of tenant advocates and consumer consultants
    h) the role of the Office of the Public Guardian in relation to mutual clients
    i) good practice in sustaining tenancies.
31. Housing NSW and the Department of Health should recommend to the SPC that:
    a) the Client Information Sharing Schedule be incorporated into the revised JGOS agreement and resources
    b) practical guidelines about the exchange of information be developed, with specific reference to the provisions of the Health Records and Information Privacy Code of Practice 2005 and how these provisions should be applied locally, and incorporated into the revised JGOS agreement and resources.
32. Housing NSW and the Department of Health should provide a copy of this report to the Human Services and Justice CEOs Forum, and that the Forum considers the adequacy of the Health Records and Information Privacy Code of Practice 2005 and whether there is a need for legislative amendment to allow for a more streamlined framework for exchanging information in circumstances where the well0being, health, safety and stable housing of a person are at risk.
33. Housing NSW and the Department of Health should recommend to the SPC that, in light of the observations and recommendations in this report, the separate JGOS governance arrangements be reviewed and consideration be given to adopting the approach outlined in this chapter. This approach should include the following:
    a) making the Accord the primary governance model by which human services agencies implement their responsibilities to plan, coordinate and deliver services to all clients who need support to access and sustain social housing
    b) ensuring that the Accord explicitly outlines how agencies will plan, coordinate and deliver services to all clients with support needs in addition to their responsibilities in relation to participation in specific Accord programs
    c) ensuring the Accord commits partners to implement the JGOS principles as well as other policies and initiatives relating to specific vulnerable groups designed to assist clients who need support to access and sustain social housing.
34. Housing NSW should implement a supportive tenancy management approach including the following:
    a) a standardised risk assessment screening tool
    b) the adoption of an early intervention approach to sustaining tenancies
    c) adequate guidance for housing workers on the use of reactive and remedial interventions
    d) data collection and performance indicators to facilitate and measure supportive tenancy management
    e) a tenancy support program
    f) an ongoing monitoring and evaluation strategy.

    If recommendation 34 is accepted, Housing NSW should ensure that consideration is given to reflecting the critical elements of a supportive tenancy management approach in the Accord.

35. Should the SPC accept recommendation 33, Housing NSW and the Department of Health refer the recommendation to the Human Services and Justice CEOs Forum for their consideration.
36. Housing NSW and the Department of Health should provide this office with advice about how the shortcomings identified in relation to the implementation of the JGOS and described in Part 2 of this report will be addressed.
37. Housing NSW should provide advice to this office in relation to:
    a) the steps taken to monitor compliance by housing workers with the requirement to complete the CTTT action sheet
    b) whether it is still common practice for housing workers to take action at the CTTT to 'encourage tenants to seriously consider the consequences of ignoring the Department's warnings in relation to tenancy breaches' and if so, whether Housing NSW considers this practice to be appropriate in light of the observations made in this report.
38. Housing NSW should recommend to the Human Services and Justice CEOs Forum that regardless of whether recommendation 33 is accepted, any arrangements governing the provision of assistance by government and non-government partners to people requiring support to access or sustain social housing are aligned with those overseeing the contribution of NSW to the national response to homelessness.

Appendix 2
Other organisations consulted

Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, not-for-profit legal and policy centre. It advocates for individuals and groups affected by significant public interest issues. PIAC is currently undertaking the Mental Health Legal Services Project, funded by Legal Aid NSW. The project is exploring the unmet legal needs of people with mental illness and will pilot innovative strategies, enabling those needs to be better met. Housing and social welfare are among the justice issues being targeted.[271] We met with PIAC to hear about the project's progress, and to discuss other housing-related issues that have come to the attention of PIAC. The Homeless Persons Legal Service, which is auspiced by PIAC, subsequently made a submission to our investigation.

Legal Aid NSW

Some social housing tenants who have action taken against them by Housing NSW or a community housing provider before the Consumer, Trader and Tenancy Tribunal (CTTT) may be represented by Legal Aid. More generally, Legal Aid sees a large proportion of clients who live in public housing. A 'disproportionate amount' of these people have mental health issues or other disabilities.[272] For these reasons, we were keen to consult with Legal Aid, particularly to hear about individual cases.

NSW Office of the Protective Commissioner[273]

The Protective Commissioner is an independent public official legally appointed by a tribunal or court to protect and administer the financial affairs and property of people with a disability who are unable to make financial decisions for themselves, where there is no other suitable person willing to assist. Clients include individuals with a mental illness which affects their capacity to make financial decisions. We met with the Office of the Protective Commissioner to inform them of our investigation and to provide them with the opportunity to tell us about any relevant individual or systemic issues or concerns.

NSW Office of the Public Guardian[274]

The Public Guardian is a public official who can be appointed by the NSW Guardianship Tribunal to be the guardian of a person (16 years or over) with a disability, when there is no other person suitable or able to be the guardian. The Public Guardian may make decisions on behalf of the person as directed by the Tribunal. The Public Guardian is the guardian for many people with a disability who have a decision making incapacity, including a number of individuals with a mental illness, intellectual disability or dual diagnosis. We met with the Office of the Public Guardian to inform them of our investigation and to provide them with the opportunity to tell us about any relevant individual or systemic issues or concerns.

Shelter NSW

Shelter NSW is a non-government, not-for-profit organisation that advocates for the housing interests of low-income and disadvantaged people, and provides community education to build the capacity of non-profit organisations to provide housing and housing-related services. We contacted Shelter to invite them to provide feedback to us about the operation of the JGOS, and issues affecting social housing tenants with mental illness or other high needs more generally.

Law and Justice Foundation of NSW

In 2006 the Law and Justice Foundation of NSW published *On the edge of justice: the legal needs of people with a mental illness in NSW*. That report identified housing-related legal issues, including problems relating to public housing, as a key area of concern for people with mental illness. Issues raised included eligibility, eviction and debt, neighbourhood disputes and acceptable behaviour agreements. We contacted the Law and Justice Foundation to learn more about their research.

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271 Public Interest Advocacy Centre, *Mental Health Legal Services Project Factsheet*, undated, www.communitybuilders.nsw.gov.au/download/MHLSFlyer.pdf. Accessed 15 October 2008.

272 Meeting with Legal Aid NSW, 20 March 2008.

273 On 1 July 2009 the Office of the Protective Commissioner merged with the Office of the Public Guardian and the Public Trustee to become the NSW Trustee and Guardian.

274 On 1 July 2009 the Office of the Public Guardian merged with the Office of the Protective Commissioner and the Public Trustee to become the NSW Trustee and Guardian.

Appendix 3
Table of audited locations

Area health service	Audited locations
South East Sydney	Wollongong, Nowra, Hurstville
Sydney South West	Redfern, Campbelltown, Liverpool
Sydney West	Parramatta, Penrith, Lithgow
North Sydney Central Coast	Dee Why, Gosford, Ryde
Greater Southern	Queanbeyan, Goulburn, Wagga Wagga, Deniliquin, Far South Coast (including Moruya, Bega and Pambula)
Greater Western	Dubbo, Orange, Broken Hill
Hunter New England	Armidale, Tamworth, Newcastle
North Coast	Lismore, Coffs Harbour

Appendix 4
Who we consulted

The following table lists the number and type of people we consulted during our field audits. The information is organised by area health service and agency type. The figures for Housing NSW, NSW Health, Community Housing Division and Department of Community Services represent the number of staff members interviewed during our consultations. All other figures represent the number of service providers (or for the Aboriginal Housing Office, regional offices) with whom we met.

Agency type	South East Sydney AHS	Sydney South West AHS	Sydney West AHS	North Sydney Central Coast AHS	Greater Southern AHS	Greater Western AHS	Hunter New England AHS	North Coast AHS	Total
Housing NSW	14	7	15	8	13	9	16	7	**89**
Area directors	1	nil	1	nil	1	1	1	1	**6**
Health NSW	17	12	12	8	13	13	8	13	**96**
Area directors	nil	1	nil	1	nil	nil	nil	1	**3**
Community Housing Division	1	nil	nil	nil	nil	1	nil	1	**3**
Department of Community Services	2	nil	2	2	2	2	2	1	**13**
Aboriginal Housing Office	nil	nil	1	nil	nil	1	1	1	**4**
Community/ Aboriginal housing providers	4	2	2	4	3 (incl. 1 RAHMS representing 10 providers)	2	1	2	**20**
Aboriginal medical services	1	1	1	1	2	3	2	2	**13**
Non-government organisations	2	1	5	6	5	3	5	5	**32**
Tenant advocates	4	2	1	1	2	1	2	1	**14**
Consumer advocates	1	3	2	1	1	nil	1	nil	**9**
SAAP services	8	2	5	5	14	10	9	9	**62**

Other consultations

Aboriginal tenant advocates' network; Combined Community Legal Centres Group (NSW); NSW Consumer Advisory Group; NSW Council of Social Services; NSW Department of Community Services; NSW Department of Health; NSW Federation of Housing Associations; Homelessness NSW; Housing NSW; Law and Justice Foundation of NSW; NSW Legal Aid Commission; Mental Health Coordinating Council; National Tenant Support Network; NSW Office of Community Housing; NSW Office of the Protective Commissioner; NSW Office of the Public Guardian; Public Interest and Advocacy Centre; Shelter NSW; Tenants' Union of NSW; Women's Refuge Resource Centre; Youth Accommodation Association.

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