

Housing and Support Program

Resource Manual

June 2016

Housing and Support Program Resource Manual 2016

Published by the State of Queensland (Queensland Health), May 2016



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Contents

Foreword	V
1. Introduction	1
1.1 Purpose of the resource manual	1
1.2 Background	1
1.3 Recovery framework	2
1.4 Eligibility	3
1.5 Outcomes	3
1.6 Collaborative framework	4
1.6.1 Local Coordination Group	4
2. Entry to the program	5
2.1 Pre-application	5
2.2 Application	5
2.3 HHS register of applications	5
2.4 Prioritisation of applications	6
2.4.1 LCG Selection Panel	6
2.4.2 Vacancy management	6
2.5 Establishment of support and housing	7
2.5.1 Support	7
2.5.2 Housing	7
2.6 Transition into community living	8
2.7 Community living	8
2.8 Monitoring and review processes	8
3. Changes of circumstances	9
3.1 Consumer does not wish to engage with HASP	9
3.2 Consumer's support needs increase beyond the capacity of the program	9
3.3 Continued reduction in need for support	10
3.4 Reallocation of surplus funds	10
3.5 Transfers – consumer changes location or service provider	11
3.6 Exit from support	12
3.7 HASP forms	12
4. Roles and responsibilities	13
4.1 People who access HASP services	13
4.2 Community-managed mental health service provider	14
4.3 Housing services (Department of Housing and Public Works)	15
4.4 Hospital and Health Services	16
4.5 Department of Health	19
4.6 Community Services Funding Branch	20
4.7 Definitions	20
4.7.1 An hour of support	20
4.7.2 Recovery plan	20
4.7.3 Individual recovery-orientated support plan	21

5.	Dealing with issues and complaints	21
5.1	Consumer issues	21
5.2	HASP consumer complaints	22
5.3	Tenancy Support and Complaints Management	22
5.4	Refusal of support	23
6.	Glossary.....	24
7.	Appendix.....	26
8.	References.....	27

Foreword

People with mental health disorders or illness often face difficulties when trying to meet their basic needs, in particular having access or maintaining tenure of suitable, sustainable and safe housing. It is known that a high percentage of people who experience homelessness or are living in sub-standard or marginal housing have a mental illness.

People with mental illness can and do recover to live productive and meaningful lives in their community. Recovery emphasises the need for a comprehensive community-based service system that works to address the full impact of mental illness.

The Queensland Government recognises the importance of the roles of the housing, clinical and community-managed mental health service providers in reducing the impact of mental illness or psychiatric disability for both the individual and the community. Supporting people who experience mental illness requires a focus on the potential for growth within the person and acknowledgement that they are active participants in their recovery process.

In 2006 the Housing and Support Program (HASP) was established to enable people with a psychiatric disability to live in the community with stable social housing and enjoy an improved quality of life. Individuals are offered a coordinated package of housing and support. Sustainable housing and independent living support are seen as key elements in supporting a person's recovery and reducing the need for hospital care.

This resource manual has been developed for the three sector support stakeholders who deliver the three key components of HASP: housing options (provided through the Department of Housing and Public Works) clinical mental health support (Queensland Health) and non-clinical lifestyle support (delivered by community-managed mental health service providers).

The Queensland Government remains committed to facilitating access to a comprehensive, recovery-oriented and consumer-focussed mental health system that improves the quality of life and mental health of Queenslanders.

Dr Bill Kingswell

Executive Director

Mental Health, Alcohol and Other Drugs Branch

1. Introduction

1.1 Purpose of the resource manual

The Housing and Support Program (HASP) Resource Manual has been provided by the Mental Health Alcohol and Other Drugs (MHAOD Branch), Department of Health (DoH). It has been developed to provide a shared understanding of the HASP service model and collaborative processes undertaken to support people with a psychiatric disability through HASP.

The manual is a guide for operational procedures and protocols which has been designed to assist staff to work in the efficient coordination, administration and implementation of the HASP. The targeted audience of the manual is:

- community-managed mental health service providers (service providers) approved to deliver HASP services
- Hospital and Health Services (HHS)
- Department of Housing and Public Works (housing services).

With reference to the *National Mental Health Commission's Strategies and Actions 2012-2015* document, the Commission commits to using person centred language in line with a recovery approach, with terms like 'person', 'individual', 'people with a lived experience' and 'people accessing mental health services.'

This package of HASP documentation will refer to people who access mental health services as the individual or consumer.

1.2 Background

HASP was established in 2006 as one of the key initiatives in the Council of Australian Governments *National Action Plan on Mental Health 2006-2011*.

The HASP service model builds on the actions of the *Queensland Plan for Mental Health 2007-2017*, the *Fourth National Mental Health Plan* and the mental health reform agenda, which encourage services to develop programs that support people with a mental illness to live in the community and live full and meaningful lives.

HASP provides assistance to people with a psychiatric disability who are inpatients of Queensland Health mental health facilities, or who are homeless or at risk of homelessness, transition to sustainable community living.

1.3 Recovery framework

The key philosophy underpinning HASP is one of recovery. Recovery has been described as:

- a journey, sometimes lifelong, through which a person achieves independence, self-esteem and a personally meaningful life in the community
- a personal and ongoing process, defined and led by the individual
- something worked towards and experienced by the person with mental illness: it is not something services can do to the person.

The delivery of community-managed mental health services is underpinned by the principles outlined in *A national framework for recovery-oriented mental health services*. The framework defines recovery as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

A detailed description of the domains and associated capabilities can be found in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Other relevant documentation includes the *Mental health statement of rights and responsibilities*.

Service delivery models are underpinned by the values and principles of a recovery-oriented framework of service provision, including (but not limited to):

- fostering hope
- acknowledging the uniqueness of the individual
- promoting an active sense of self including personal responsibility
- fostering discovery of personal strengths and abilities
- recognition and support of the individuals' personal resource base and natural networks
- attaining citizenship and community membership.

Recovery models:

- are person-centred (responsive to and driven by the expressed rights of the person and are respectful of rights, dignity and confidentiality) with the aim to develop independence
- include consumer perspectives and input in the development, implementation, monitoring, evaluation and review of the services
- are flexible, coordinated, integrated and not duplicating other services. Services should actively engage the individual, collaborate and/or partner with local care coordination networks and other relevant stakeholders, to improve coordinated support for individuals and reduce their need for acute services.

The Queensland Government is committed to ensuring that mental health services operate within a recovery-oriented framework, as outlined in *Sharing Responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health*.

The collaborative contributions of clinicians, service providers and housing services aim to support each person accessing HASP in their recovery journey.

1.4 Eligibility

To be eligible for HASP, an individual must meet all of the following criteria:

- be aged between 18 to 64 years
- be an Australian citizen or permanent resident
- live in Queensland
- have a diagnosed mental illness that results in a primary psychiatric disability
- a) be an inpatient of a Queensland Health mental health facility who is unable to be discharged due to being homeless or at risk of homelessness
 - or**
 - reside in the community and are homeless or at risk of homelessness and have a history of frequent admissions to Queensland acute inpatient facilities
 - or**
 - have had repeated admissions to Queensland Health acute inpatient facilities
 - and**
- b) be unable to be discharged to their usual place of residence without support, or be at risk of losing or being evicted from their usual place of residence without support
- be ready, to transition to full community living, with appropriate levels of support, within the next three months
- be committed to maintaining stable housing
- have clinical needs that can be met by a community mental health team, or by clinicians in private practice, which may include conditions of leave under the *Mental Health Act 2000*
- provide informed consent (or appointed guardian / attorney where required) to agree to share information and participate in all aspects of the program
- meet the eligibility criteria for social housing. If social housing is required, an application has been lodged.

1.5 Outcomes

Outcomes or benefits resulting from the support through HASP are that individuals would expect to have:

- an increasing ability to maintain and sustain their housing tenancies
- an increasing ability to fully participate in and determine their ongoing clinical and lifestyle support needs
- improved quality of life, a greater sense of self-determination and increased valued roles, with benefits including that the individual:
 - be able to create and sustain meaningful social connections and relationships and as a result be less dependent on paid support solutions

- participate and contribute to their community in meaningful ways
- have an increasing ability to participate in educational, vocational and/or employment activities
- be provided with opportunities to realise more of their self-management ability. This will be evident by a reduced number (or shorter duration) of unplanned admissions to mental health facilities.

Consumers accessing HASP support identified what really made a difference:

“Somebody told me that the future was in my hands”

“Somebody believed in me”

1.6 Collaborative framework

The provision of HASP is underpinned by collaborative partnership which includes:

- psychosocial support delivered by service providers (funded by Department of Health)
- clinical care provided by specialist mental health services (as the individual recovers this may be through private services or general practitioner)
- long term, secure and affordable housing provided by housing services.

The collaborative approach should deliver tangible benefits for HASP consumers. This should be demonstrated through:

- the Local Coordination Group (LCG) regularly discussing and reviewing strategies to ensure that referral and prioritisation processes are effectively managed
- a holistic approach to service delivery
- consistency of service within and across sectors, organisations and initiatives providing supports
- seamless service provision.

1.6.1 Local Coordination Group

The HHS facilitates an LCG consisting of representatives from each of the local key stakeholders. The aim of the coordination group is to foster the collaborative approach across all stakeholders. The core roles of the group are to:

- develop and review local processes
- identify:
 - local issues impacting upon consumers
 - barriers to the local partnerships
- reach agreement on what can be done to overcome barriers or make improvements
- identify opportunities to forge links with other agencies that could assist HASP consumers
- review individual consumer’s progress in HASP annually, as a minimum, or as required.

The LCG can be utilised as the selection panel for additional individuals to enter HASP during the management of localised HASP vacancies.

In recognition that many HASP consumers link with a range of services providers, LCG can invite Primary Health Networks, private clinical networks, employment or other relevant organisations to participate in the meetings—with the aim of collaborating to support local consumers to achieve improved outcomes.

2. Entry to the program

Entry to HASP and the application process is managed by the HHS.

2.1 Pre-application

- **Identify** - the clinical team identifies individuals who could benefit from HASP
- **Check** - the clinical team checks:
 - eligibility
 - if the individual has an appointed guardian/attorney, to endorse the process of completing an *HASP Application form (form 1.1)*
 - that clinical endorsement has been provided for a HASP application, and
 - if the individual is under an order of the *Mental Health Act 2000*, approval will be provided for community access (within three months) to enable commencement of transition.
- **Provide** - the clinical team will provide **information and discuss**:
 - HASP with the individual (and their family or appointed guardian/attorney, if relevant) and confirm their willingness to participate in HASP.

2.2 Application

The HHS clinical team supports the individual to:

- **apply for HASP** by completing the *HASP Application form (form 1.1)*. The clinician sources additional reports and information to include in the application (for example, relevant information from the occupational therapist report, support worker, a risk assessment and management plan, the psychiatric report, Mental Health Review Tribunal report)
- **apply for housing** by submitting an application for social housing through housing services as required
- **submit** the application and the associated reports to the HHS HASP coordinator (typically the Service Integration Coordinator) who registers the application via the *HHS HASP Application register*.

2.3 HHS register of applications

If the application meets the eligibility criteria, applicants are recorded on a *HASP Application register (example template 2.1)* held by the HHS. This is a formal list of all

local HASP applications maintained by the HHS HASP coordinator. When a permanent HASP vacancy occurs the applicants on the list are considered by the LCG.

2.4 Prioritisation of applications

2.4.1 LCG Selection Panel

- The HHS HASP LCG has established processes to:
 - convene the selection panel when advised by service providers that vacancies are available
 - ensure that the panel consists of a minimum of three people comprising of HHS staff, the relevant service provider/s and a representative from housing services
 - identify the chairperson
 - inform the panel of purpose and documentation processes.
- The panel's tasks include:
 - confirming eligibility
 - checking each applicant's functional ability to transition and willingness to participate in receiving support (as circumstances may have changed since the application was initially completed)
 - checking that any relevant documents are signed, including those that require signing by the appointed guardian/attorney (if applicable)
 - prioritising the HHS applicants.

The HHS forwards the endorsed list of priority applications to MHAOD Branch for consideration. The HHS must include a completed *Panel checklist (form 1.2)* for each applicant to verify eligibility and the selection panel's endorsement for a HASP package of support.

2.4.2 Vacancy management

Permanent vacancy

A permanent vacancy may occur if an individual exits the program or has a permanent reduction in their support needs.

Service providers advise the HHS of permanent vacancy by completing the *Consumer exiting HASP or relinquishing hours form (form 1.5)*.

Once a consumer is identified by the selection panel to fill the vacancy, the completed *New consumer proposal, permanent vacancy (form 1.3)* is submitted to MHAOD Branch.

Temporary capacity

Temporary vacancies occur when permanent HASP individuals do not access their full allocation of hours. These hours may be utilised to assist:

- another current HASP consumer who may require some additional hours for a short period of time, or

- an individual who may require community supports in their own home for a short period of time following discharge up to a maximum period of six months; or
- an individual residing in the community who requires a short period of supports to avoid admission.

Filling of temporary vacancies require LCG endorsement and acceptance by the individual and by the service provider.

The LCG vacancy management panel can endorse temporary support to an eligible individual for a period up to three months. Temporary support can only be provided in the current financial year and must end 30 June of each year.

Initial support will be for a maximum of three months then revised for requirement and availability. All short term vacancies must be closely monitored by the LCG and are not to be considered as an expectation of a permanent package. They should be monitored at a minimum every three months and are not to be extended beyond six months of support for one individual.

Temporary allocation is for the provision of supports only and does not include housing or set-up costs. Temporary hours cannot be subcontracted or transferred to other providers.

Once a consumer is identified to fill the vacancy, the completed *Temporary capacity notification/new consumer proposal (form 1.6)* is submitted to MHAOD Branch.

2.5 Establishment of support and housing

2.5.1 Support

- A HHS mental health case manager provides clinical care and treatment
- The HHS works with the service provider to plan and support the individual to transition to living in the community and to develop a recovery plan
- The service provider commences delivering support and develops a relationship with the individual while they are still an inpatient of a Queensland Health facility (or in other places of residence)
- The service provider, HHS, housing services and other stakeholders work collaboratively with the individual to progress the agreed actions and meet their individual needs.

2.5.2 Housing

- HHS advises housing services that a HASP package has been endorsed - a collaborative approach is used to source and allocate a suitable housing option
- Housing services identifies and allocates social housing to the individual
- The individual enters into a tenancy agreement and signs a State Tenancy Agreement.

2.6 Transition into community living

When implementing the transition to community living:

- the consumer, the HHS and the service provider will develop a *Transition plan (example template 2.2)* detailing the steps required for the smooth transition from the mental health inpatient facility to the consumer's own home in the community
- the duration of the transition depends on the individual's mental health, well-being, daily living skills, informal supports, confidence and capacity
- the individual commences to live full time in their home
- the individual, the clinician and service providers are encouraged to work towards the one set of recovery goals identified by the individual. Early identification of goals during the transition phase will provide the individual with highly effective support during their recovery journey.

A transition plan:

- is required to assist with planning and coordinating a smooth and timely transition for the individual from inpatient mental health facilities to their home in the community
- is developed with the individual (and/or appointed attorney or guardian)
- should be updated regularly to reflect changes as they occur.

2.7 Community living

Support stakeholders work collaboratively to support the individual to:

- maintain independent living and general well-being in their home
- integrate into local community connections
- re-establish or build upon informal supports
- develop self-determination skills
- develop valued roles
- meet tenancy obligations as outlined within their tenancy agreement.

2.8 Monitoring and review processes

It is essential that all agencies work together to regularly monitor and review the consumer's progress to ensure their support needs are being met. A review of support needs should be undertaken every 12 months, at a minimum. The *Review of support needs template (example template 2.4)* was developed to assist with the review process, this can be adapted to suit local needs. A comprehensive review should include all key stakeholders including, the consumer, the HHS, the service provider and housing services.

The roles and responsibilities of the review processes stipulate that:

- The service provider and the individual receiving supports develop a support plan that includes agreed actions with a plan to regularly monitor how the support assists the individual with their recovery aspirations.
- Housing services or the community housing provider manage the tenancy, including the residential tenancy agreement, maintenance of the accommodation and monitoring of rental payments.
- HHS initiates an annual review, as a minimum, of the overall support components with the individual and relevant stakeholders to monitor the individual's progress and outcomes.
- The HHS and service providers collaboratively work together to coordinate their care in situations when an individual's complex needs impact on their progress or capacity to maintain living in the community, engagement with support and/or housing tenure.

3. Changes of circumstances

HASP is a flexible and responsive service model which targets people who may have fluctuating or episodic support needs. The HHS might initiate a review if an individual's circumstances/support needs change significantly, as outlined below.

3.1 Consumer does not wish to engage with HASP

The status of the consumer's ongoing eligibility for the program will be reviewed to identify any unmet need or change of circumstances that has arisen (which is the barrier to engagement with support services). If an individual no longer wishes to engage with the program and has been assessed as no longer requiring supports, HHS and service provider sign the *Consumer exiting HASP or relinquishing hours form (form 1.5)*, with the hours becoming a permanent vacancy with the service provider. It is recommended that the hours are released on a temporary basis for up to 12 months to allow the consumer to re-enter the program if their situation changes.

Consideration should be given to the consumer's ability to sustain their tenancy without ongoing supports. Housing services should be advised if the consumer relinquishes their package and appropriate strategies put in place to ensure housing services are assisted if tenancy issues arise in the future.

In some cases, the individual may still require supports but does not wish to continue to engage with their current service provider. In this case, the HHS will work with the individual to engage a new service provider, and complete the relevant transfer of service provider forms (for more information see section 3.5 transfer of provider).

3.2 Consumer's support needs increase beyond the capacity of the program

If the individual requires complex supports, the HHS care coordination process would review the circumstances and consider if the individual needs to transition into more appropriate supports, for example:

- As individuals age, their increasing support needs may no longer be related to their psychiatric disability but are rather age-related. In this case, the consumer is supported to move to more appropriate aged care services. The HASP package then becomes a permanent vacancy and is managed as per the vacancy protocols.
- If an individual's psychiatric disability becomes increasingly complex and they require additional support hours, a comprehensive assessment will be required, and where possible, additional supports should be sought through temporary or permanent HASP capacity processes.

3.3 Continued reduction in need for support

If the individual recovers to a point where they require reduced support (typically four hours or less per week), consideration should be given as to whether HASP is the most appropriate program. In many cases, individuals will be assessed and assisted to transition to more appropriate programs such as Personal Helpers and Mentors Program (PHaMS) or time limited community managed mental health support. They would then be required to relinquish their HASP package, creating a permanent vacancy within the program.

If a consumer's needs reduce from the original allocated hours they can relinquish part of their package, to a minimum of four hours per week. The relinquished hours can then be allocated to another individual as a permanent package. The consumer will need to complete a *Consumer exiting HASP or relinquishing hours form (form 1.5)* noting the hours they are maintaining and the hours they are relinquishing.

3.4 Reallocation of surplus funds

Occasionally the consumer may require assistance that is not part of direct service delivery. A form has been developed to assist organisations who wish to utilise funding for any purpose other than direct service delivery. In many cases this will be using the funding to assist with the purchase of goods for new consumers entering the program.

If the consumer does not have the capacity to pay for goods and services then all parties must agree at a local level, including the HHS, to complete the *Request to reallocate surplus funds form (form 1.10)* and submit to MHAOD Branch for endorsement and approval by Community Services Funding Branch (CSFB), Department of Health. Funding for anything other than direct service delivery is not to be progressed without approval. Endorsement by the HHS does not constitute approval. All requests to reallocate are considered carefully prior to endorsement by MHAOD Branch and CSFB.

Funding is not to be transferred directly into consumer bank accounts or given directly to anyone but the provider of the service or goods. All receipts for purchase are to be kept by the service provider for audit purposes.

NB: Assisting consumers to manage their money should be considered as part of their community supports. Ongoing reallocation of funds for anything other than service provision will only be considered if the request is submitted with appropriate supporting documentation linking the purchase to recovery goals.

3.5 Transfers – consumer changes location or service provider

HASP consumers are able to change their service provider, either within their current HHS or through a move to a new HHS.

If the consumer requests a change of service provider within their current HHS:

- The consumer completes a *Consumer request to transfer service provider form (form 1.7)* and submits to the HHS. The HHS assists the consumer to identify a new service provider, if they have not already done so.
- The current service provider provides information to the new service provider on the consumer's support plan and ensures that appropriate consents have been undertaken for the sharing of information.
- The consumer and their mental health case manager are included in all discussions pertaining to transfer of service provider.
- A *Transfer of service provider - relinquishment of funds form (form 1.8)* is completed by the relinquishing service provider and the accepting service provider completes a *Transfer of service provider - acceptance of funds form (form 1.9)*. These are to be submitted to MHAOD Branch.
- The transfer is formalised by executing a variation to both service agreements.
- A subcontract arrangement can be put in place between the two organisations until variations to contacts are executed.
- As an interim measure for funding to the new service provider a *Request to subcontract form (form 1.11)* is completed and submitted to MHAOD Branch. No service provision can commence with the new provider until the approval for the subcontract is given.
- If the individual resides in social housing, the housing service centre should be advised of any changes to the service provider.

If the consumer is changing service provider within a different location or HHS the following steps should be undertaken in readiness for the individual's relocation. The referring HHS ensures that:

- the individual is supported to liaise with the local housing service to secure housing options in the new location (if they are currently residing in public/social housing)
- liaison between the existing and the accepting HHS take place regarding the transfer of mental health care
- negotiations are held with the HHS HASP coordinator regarding the options of appropriate HASP service providers
- all relevant forms listed above must be completed and submitted to the MHAOD Branch.

As per the transfer of service provider within a HHS, it is necessary for the original service provider to subcontract the support services to the new service provider until contract variations can be finalised.

3.6 Exit from support

HASP is delivered within a recovery framework with positive outcomes for consumers who access the program. Many individuals recover to a point where they no longer require the community-based supports from HASP. If this occurs then:

- the service provider notifies the HHS HASP coordinator that the individual no longer requires support or are assessed as no longer requiring psychosocial support in the community
- it is recommended that the individual's package is suspended for 12 months
- the individual's package of support is recorded as a temporary vacancy for up to 12 months (which provides the individual the opportunity to re-enter the program if required)
- if the consumer is residing in social housing, the local housing service centre should be advised of the ceasing of supports and appropriate contingency plans put in place to address any tenancy issues that may arise into the future
- if the individual does not require the HASP package after 12 months, the service provider formally advises the consumer of their exit from the program and the *Consumer exiting HASP or relinquishing hours form (form 1.5)* is signed relinquishing the package and thereby creating a permanent vacancy within the program
- the *Consumer exiting HASP or relinquishing hours form (form 1.5)* is completed within one week of the package becoming available and a copy is submitted to the HHS HASP coordinator and MHAOD Branch for processing
- the individual continues to reside in their current accommodation as a tenant of social housing.

Other reasons for exit from HASP include:

- **a change in financial status** - which results in the individual no longer meeting the eligibility requirements for social housing, and therefore HASP
- **death of a consumer** - when a HASP consumer passes away, the service provider informs relevant stakeholders (HHS, housing services or community housing provider) and completes *Consumer exiting HASP or relinquishing hours form (form 1.5)*, which is submitted to MHAOD Branch for processing.

3.7 HASP forms

All HASP, where applicable, must be completed in full. Incomplete forms can lead to situations where all aspects of the process have not been authorised. Where two service providers are involved, such as transfers, both service providers must agree on the dates, hours and funding amount or delays can be experienced and payment of funds can be compromised.

4. Roles and responsibilities

The roles and responsibilities of key stakeholders are broadly described below.

4.1 People who access HASP services

People who access HASP services may be defined in a variety of ways depending on the type of support they receive, for example:

- **consumer** by Queensland Health (a person who is or previously has accessed public mental health services)
- **individual, service user, participant or client** by service providers
- or as a **tenant** of a housing services or community housing provider.

Consumer's responsibilities

The consumer considers their:

- housing needs and:
 - provides information about accommodation options
 - identifies their preferred geographical location to live
 - provides assistance to submit a social housing application
 - makes a commitment to maintaining their social housing tenure.
- lifestyle support needs and agrees on engagement with a service provider to access ongoing community-based support
- clinical needs and agrees to access clinical mental health case management when required
- sign the consent form.

Once the HASP package has been endorsed the individual meets with the case manager/clinicians to discuss and identify:

- transitional and ongoing needs - both clinical and community support
- housing needs.

During the transition process the individual, with the support of the case manager/clinician:

- keeps the HHS key contact person and the service provider informed of any changes in circumstances
- makes arrangements with housing services regarding tenancy
- remains involved in all stages of transition planning
- discusses with the service provider any further details about personal vision and aspirations for their recovery plan and their re-establishment back into the community
- works with their transition support team to move into their home.

After moving into their home the individual engages with their three components of support to:

- develop and maintain their social housing tenure

- access their psychosocial support services
- engage with their mental health clinical care services.

When a HASP consumer does not wish to engage with all components of support, the status of their ongoing eligibility for the program may be reviewed.

4.2 Community-managed mental health service provider

The *Queensland Plan for Mental Health 2007-2017* acknowledges that non-government organisations include not-for profit community agencies, consumer, family and carer groups and other community-based services that provide a range of treatment, disability support and care services, which complement both public and private mental health services.

Non-government organisations are the primary providers of psychosocial disability support for people with mental illness and play an important role in supporting individuals in the community to maintain their mental health and wellbeing.

Role and functions of service providers

- Deliver recovery-oriented support services:
 - as specified in their service agreement with Queensland Health
 - to individuals who are currently allocated funded support hours
 - to individuals referred by HHS to receive HASP support
 - predominantly in the individual's home and community as per the individuals recovery-oriented support plan.
- Support HASP consumers to:
 - attain levels of independence during the transition phase from an inpatient mental health facility and sustain living in their community
 - re-establish/establish connections within their community
 - work collaboratively to develop an agreed transition plan so the person and their support stakeholders can work together to enable the individual to achieve their goals.

Responsibilities

- Service providers have defined relationships with:
 - individuals accessing HASP and their family/significant others
 - HHS
 - Department of Health
 - Housing services
 - other HASP service providers via the LCG
 - other relevant service providers.
- Service providers actively participate in:

- LCG meetings
- the development of local processes for the coordination of HASP within the HHS
- HASP vacancy management processes
- working with the HHS during the review and progress of the individual's recovery-oriented support plan.
- The service provider works closely with the individual to:
 - assess support needs
 - involve the individual's support stakeholders within the planning processes
 - develop recovery-oriented individual support plans
 - define roles and responsibilities
 - deliver support as per the agreed plan
 - provide arrangements for after-hours contact (if required)
 - monitor and review progress of a consumer's recovery plans.

Service providers facilitate opportunities that engage an individual's efforts of reclaiming their ability to self-manage and self-direct their lives. Through focusing on assisting an individual address the barriers to achieving and maintaining the things that are important to them, support services will consider the following:

- how an individual names their aspirations, hopes and dreams and the current barriers to achieving them
- how an individual utilises day-to-day skills and abilities to maintain their wellbeing
- what are the barriers to an individual's ability to maintain a high level of wellbeing and social functioning
- how the individual might develop or maintain their natural networks and valued roles.

4.3 Housing services (Department of Housing and Public Works)

Role and functions

Housing services provide and manage housing options for people who meet eligibility criteria for social housing allocation and:

- manage the tenancy, including the residential tenancy agreement, maintenance of the accommodation and monitoring of rental payments
- meet all obligations under the *Residential Tenancies and Rooming Accommodation Act 2008*.

In relation to HASP, housing service centres:

- prioritise housing applications for individuals who are supported through HASP
- work in partnership with the individual and their HASP service provider
- work collaboratively with HHS:

- to assess and prioritise HASP housing applications
- to annually review the individual's progress as required (in partnership with the individual and key stakeholders).

Responsibilities of housing services provided by Housing Delivery Support and Practice

- disseminate information in relation to individuals who have been endorsed by the HASP panel to the housing service centre network
- provide over-arching support to housing service centre staff regarding any issues relating to individuals accessing HASP.

The housing service centre staff:

- participate in HASP selection panels (as required)
- engage in LCG meetings
- participate in stakeholder meetings (as required)
- check the individual's eligibility for social housing and ensure that all documentation to approve an application has been received
- ensure the person's HASP interagency priority status has been applied after receiving notification of an individual's endorsement by the HASP panel
- collaborate with the case manager to coordinate meetings with the individual to develop a shared understanding of the supports and environment required for the person to live in their own home and promote recovery
- conduct an occupational therapy needs assessment (where required)
- collaborate with the individual, appointed guardian/attorney (if applicable) and other agencies to reach agreement on the proposed housing solution
- liaise with all stakeholders and participate in planning for the individual's coordinated transition into community living
- coordinate timely viewing of a proposed property with the individual and other relevant stakeholders and assist the person, and/or appointed guardian/attorney, to sign a tenancy agreement
- provide ongoing tenancy assistance
- participate in annual HASP reviews of each individual's progress of their recovery plan as required (as required).

4.4 Hospital and Health Services

Roles and functions

The HHS provides:

- HASP operational and capacity management
- HASP nominations
- clinical mental health care services
- care coordination.

Responsibilities

The HHS HASP key contact include:

- maintaining the HHS HASP application register
- collaborate with new HASP consumers to develop transition plans with service providers and housing services
- coordinating annual HASP reviews
- assisting with the care coordination when an individual's complex needs impact on their progress or capacity to maintain living in the community
- seeking feedback from consumers regarding the supports they receive
- negotiating transitions between HHS and service providers (where required)
- raising local coordination issues to HHS management and/or to the MHAOD Branch.

The service providers are funded to deliver HASP services under the Department of Health's service agreement that is managed directly by CSFB (and as such the HHS does not purchase or manage the funding/packages)

HHS are provided with the names of consumers and hours of support approved to be delivered in their area.

Vacancy management of HASP

The HHS will:

- maintain a focus ensuring that the individual's needs are being met
- liaise with the service provider to manage local capacity (but not contract management)
- support the referral processes as required
- support local coordination through LCG meetings
- work in partnership with the HASP funded service providers to develop vacancy management processes for use
- work with the LCG to develop a vacancy management process
- initiate a vacancy management panel involving representatives from the HHS, service providers and the housing service centre
- work collaboratively with service providers to ensure local capacity management which enables permanent packages of support to be delivered to additional HASP eligible consumers

HHS provide clinical mental health services and have the responsibility to provide a full clinical assessment to consumers and provide:

- treatment and rehabilitation (a care coordination approach to consumer care is adopted in partnership with the consumer and relevant services)
- crisis intervention as required.

Community case managers provide:

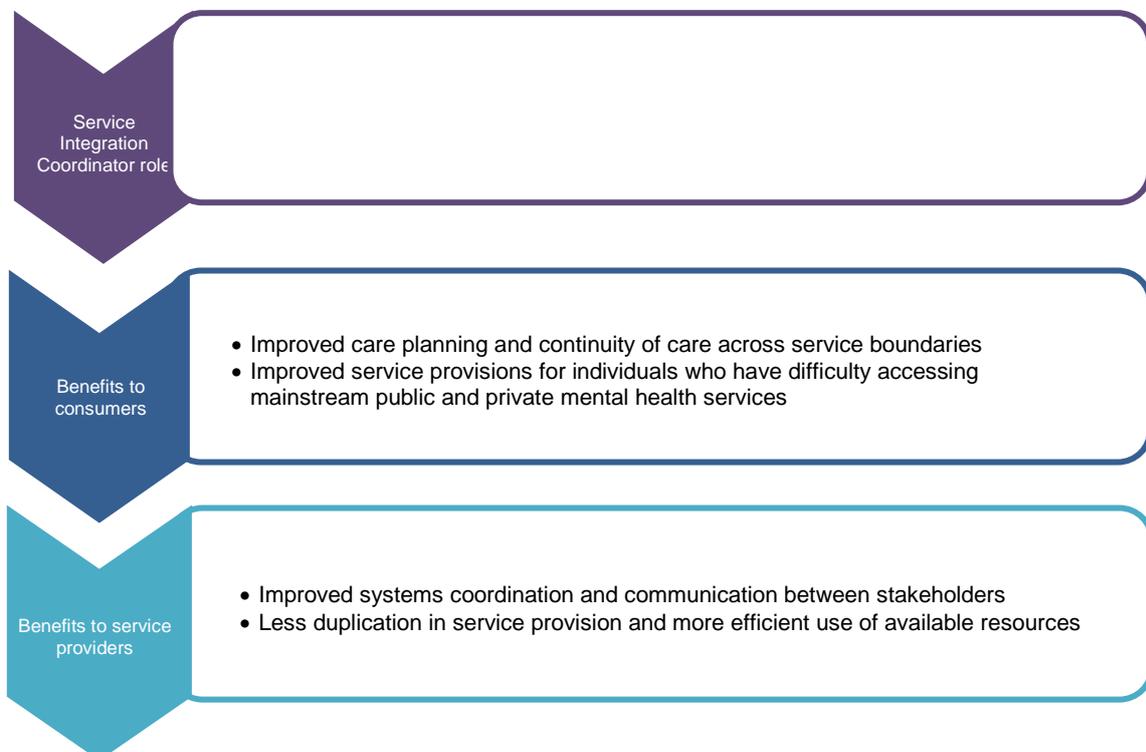
- proactive community case management to ensure the consumer has access to ongoing clinical treatment and support to maximise their mental health and wellbeing when required

- liaison support between the HHS HASP key contact person and the service provider regarding provision of support to the individual in the community
- advice to the service provider and the HHS HASP key contact person if a HASP consumer is readmitted to a mental health facility.

HHS HASP coordinators (typically the HHS Service Integration Coordinator):

- support clinical and community service providers to meet the individual needs of people with complex mental health needs to assist them to live meaningful lives in the community
- coordinate the development, implementation and review of a comprehensive care coordination recovery plan for HASP consumers
- assist service providers to locate and navigate suitable clinical services for individuals
- coordinate case conferences between clinical and service providers to review consumer progress with achieving goals identified in their recovery-oriented support plan
- facilitate the LCG
- convene HASP panels to assess and prioritise applications as soon as practicable after a vacancy is identified or notification from MHAOD Branch that new funds are available
- link with their local housing service/s on a regular basis.

Figure 1: Benefits of the service coordination



4.5 Department of Health

Mental Health Alcohol and Other Drugs (MHAOD) Branch, Clinical Excellence Division

Role and functions

The MHAOD Branch guides the development and implementation of statewide HASP service planning frameworks.

The MHAOD Branch provides overarching program administration of HASP and is responsible for:

- supporting the statewide performance management of HASP
- maintaining the integrity of the HASP service model
- maintaining a register of consumers supported by HASP and their hours of support
- act as a conduit between HHS and CSFB for vacancy management and delegation processes.

Maintaining contact with:

- service providers re: HASP program information
- HHS HASP key contacts regarding planning activities within a statewide context.

Responsibilities

The MHAOD Branch provides:

- collaborative planning processes with cross-government agencies, for example:
 - liaising with relevant Commonwealth Government department and agencies units in relation to planning and funding recommendations
 - statewide reporting internally to Queensland Health and the Commonwealth Government (as required)
 - liaising with housing services to align with joint commitments to the program.
- support for service delivery planning through provision of quality processes to the HHS and service provider with the following resources:
 - HASP resource manual
 - suite of HASP forms
 - resources, such as examples of process templates
 - support to sustain and improve statewide service provision.
- a communication plan to provide key stakeholders with:
 - information
 - forums to enhance care coordination efforts and continuous improvement practices.
- operational processes which include:
 - maintaining a register of HASP outputs compiled from information provided by CSFB and HHS
 - identifying key contacts, protocols, forms register and review process of statewide processes
 - liaison with CSFB to align processes and develop procedures.

4.6 Community Services Funding Branch

Role and function

- CSFB, Healthcare Purchasing and System Performance Division, has the role of contract manager.

Responsibilities

- CSFB is responsible for the implementation and on-going management of the service agreements and funding with non-government service providers for a variety of Queensland Health programs, including HASP. In managing compliance with, or changes to, service agreements, CSFB must ensure that Queensland Health's policies, procedures and delegation frameworks are followed. Similarly, CSFB must ensure payment of funds and changes of funding allocations to either individuals or organisations must be made in line with the terms and conditions of the service agreement and comply the Department of Health's procedures.

4.7 Definitions

4.7.1 An hour of support

The time that is counted towards hours of services or outputs delivered includes:

- the time spent with consumers in the community
- the time spent undertaking tasks on behalf of consumers
- the time that is made available for provision of services and support, for example, any direct support with the consumer in their home plus any additional time taken to write case notes or attend meetings relating to the individual.

The time that is not counted in hours of service include activities that cannot be attributed to consumers/service provision, such as:

- team meetings
- non-consumer/service provision related travel
- attending staff training
- receiving supervision, supervising staff
- administrative tasks.

4.7.2 Recovery plan

The development of a recovery plan is led by the HHS and the individual in partnership with clinicians and other from the mental health service and staff from relevant non-government organisations. Information that relates to the external agencies, for example, housing services and others that play a role in supporting the consumer.

The recovery plan will outline the individual's strengths, goals, needs, hopes and desires. It will cover all areas of their life, including:

- social (housing needs, social activities, living skills)
- emotional (relationships with family/friend support networks)
- physical (health and wellbeing, personal care)

- intellectual (work, study, volunteering)
- spiritual (meditation, prayer, practices).

As part of an annual review, an individual's recovery plan can be updated or amended to reflect changes with the individual's wishes and circumstances.

4.7.3 Individual recovery-orientated support plan

An individual recovery-oriented support plan:

- aligns with the recovery plan goals
- is a process to manage how services will be used to support achievement of the goals
- is a shared document negotiated between the service provider, mental health service and the individual
- identifies service details:
 - to support the HHS HASP Coordinator
 - nature and range of services
 - average number of hours of service to be provided
 - lists of contacts and contact details relevant to housing services, the service provider and clinical care.
- identifies needs and background to be considered including:
 - the need for interpreters or cultural brokers
 - sensitivities relevant to religious or cultural beliefs
 - existing links to family and significant others
 - personal strengths, skills and interests
 - any further information regarding support needs and aspirations that has not already been captured.
- identifies monitoring/review processes:
 - the recover-orientated support plans is reviewed annually with the HHS leading review with the individual and their support stakeholders to monitor progress in achieving their goals.

5. Dealing with issues and complaints

5.1 Consumer issues

To remain consumer-focused, it is essential that HASP stakeholders make all attempts necessary to resolve issues that are identified by HASP consumers, and where required, refer the issue to relevant agencies that can assist.

HASP consumers may require additional assistance from an advocate and/or support person to progress issues.

Contact details and processes undertaken in relation to working through the issues should be documented in the HASP consumer files.

5.2 HASP consumer complaints

All HASP support agencies should have an established complaints policy. HASP consumers are provided with this information as part of the recover-orientated support plan process.

All complaints regarding the various providers should initially be managed by the service provider. If required the consumer may seek the support of someone they trust to assist and advocate on their behalf.

If a satisfactory outcome is not reached, the consumer may wish to undertake the following:

- for housing - follow the housing service's complaints process
- for mental health services - follow the local HHS complaints procedure
- for service providers - follow their service procedures.

Any significant changes in the individual's situation should be referred to the HHS HASP coordinator for monitoring.

5.3 Tenancy Support and Complaints Management

All parties supporting the individual, particularly the housing providers, should endeavor to ensure that tenancy issues are dealt with in a timely manner. As outlined in the [State Tenancy Agreement](#) individuals are required to:

- pay the rent as stated in their tenancy agreement
- keep the property clean, as it was at the start of the tenancy
- not maliciously damage, or allow someone else to maliciously damage the property
- not use the property for illegal purposes
- not cause a nuisance whilst in the property
- not interfere with the reasonable peace, comfort and privacy of your neighbours.

The Department of Housing and Public Works introduced the *Fair expectations of behaviour policy in February 2016*. The key to the new behaviour policy is fairness. It balances the rights of tenants, neighbours, service partners, departmental staff and the community. The policy identifies three categories of disruptive behaviour:

1. Minor (general or nuisance) behaviours - these are activities that could reasonably happen occasionally in a household, but which disturb the peace, comfort or privacy of other tenants or neighbours. For example, excessive noise from televisions or stereos or a loud party.
2. Serious behaviours - these are activities that intentionally or recklessly disturb neighbours, or could reasonably cause concern for the safety or security of a tenant, household member, neighbour or their property, or damage to the public housing property. For example, harassing neighbours, intentional disturbances including using aggressive or obscene language, or damaging departmental property.

3. Dangerous or severe behaviours - these are activities that pose a risk to the safety or security of residents or property and may result in Police charges, and/or conviction, or significant damage to the public housing property. For example, illegal or alleged illegal activity at the property such as drug production, supply or trafficking, domestic and family violence or physical assault or acts of violence against other tenants, neighbours or departmental staff, or extensive malicious damage to departmental property.

Housing services will only investigate complaints about disruptive behaviour that may be a breach of the State Tenancy Agreement or obligations under the *Residential Tenancies and Rooming Accommodation Act 2008*. Housing services will enable the individual and their supports to tell their side of the story and gather relevant information and evidence about the complaint from other sources including Police, mental health services, neighbours and witnesses.

When a confirmed incident of disruptive behaviour occurs, housing services may issue a warning about the incident. Depending on the circumstances and severity of the incident, impact on neighbours and any other contributing factors, the warning can also be issued with a *Residential Tenancies and Rooming Accommodation Act 2008* [Form 11—Notice to Remedy Breach](#) .

Following each warning, housing services will contact the individual to ensure they are aware of the consequences of the behaviour and reconfirm obligations under the tenancy agreement. Housing services will work with support agencies and HHS, where appropriate to discuss strategies to reduce the behaviours placing the tenancy at risk. A Tenancy Management Plan or Acceptable Behaviour Agreement may also be developed to support the tenancy.

All tenancy issues which are not behaviour-related (for example, rent arrears, keeping an animal without approval) will continue to be managed under existing legislation, policy and procedures with the tenant being issued a Notice to remedy breach (form 11) under the *Residential Tenancies and Rooming Accommodation Act 2008* giving 10 days to remedy the breach. If the tenant does not remedy the breach they may then be issued with a Notice to leave (form 12).

5.4 Refusal of support

Individuals must provide consent for any party to be involved in their support and care. Where consent is not provided, HASP services will be unable to be delivered. In addition, where an individual refuses support that is offered through HASP, the mental health service and the service provider will not be able to provide HASP services. If the individual does not provide consent or refuses support but clearly requires some form of assistance to live independently in the community, the mental health service will work alongside the service provider and undertake a review of the consumer's needs within three months of the consumer withdrawing their consent.

6. Glossary

Appointed guardian or attorney	<p>Can include:</p> <ul style="list-style-type: none">• a person appointed by the Queensland Civil and Administrative Tribunal as guardian for the consumer• a person appointed by the consumer to make decisions on behalf of the consumer.
Capacity	<p>Capacity (also known as vacancy) in HASP is defined as any hours of support that are available from a service provider. If the service provider has capacity, it may be for a temporary or permanent vacancy.</p>
Carer	<p>A carer is a person who voluntarily provides ongoing care and assistance to another person who, because of disability, age, frailty, chronic illness or pain requires assistance with everyday tasks.</p>
Community-managed mental health service providers	<p>Community-managed mental health organisations provide community support services for people affected by mental health problems and mental illness. These organisations provide “valuable community based support options that are flexible, cost effective and essential to prevention and recovery”.</p>
Consumer	<p>A consumer is a person who is accessing or has previously accessed a public mental health service.</p>
Hospital and Health Service	<p>Hospital and Health Services (HHS) were once known as Health Service Districts; they are now statutory bodies governed by a Hospital and Health Board. The 16 HHS are accountable to the local community and the Queensland Parliament.</p>
Psychiatric disability	<p>Disability refers to the restriction, lack or loss of the ability (as a result of the illness and impairment) to perform an activity or task, for instance, the tasks of everyday living, tasks at work, study or activities in the community.</p> <p>Psychiatric disabilities are significantly different from many other disabilities in that they can fluctuate and are a result of an intermittent and episodic process. Not all people who have a mental illness will develop a psychiatric disability.</p>

Queensland Health	<p>Collectively, the public health care system is known as Queensland Health. The implementation of the National Health Reform Agreement on 1 July 2012, resulted in the separation of Queensland’s single health organisation into 17 separate legal entities:</p> <ul style="list-style-type: none"> • Department of Health • 16 HHSs – governed by Hospital and Health Boards.
Support needs	<p>Support needs are defined in HASP based on a recovery approach and all non-clinical supports noted are driven by training and education rather than the service provider actually delivering many of the service needs, for example domestic assistance is defined as assistance to learn domestic tasks.</p> <p>Personalised support—linked to housing are flexible services tailored to a mental health consumer’s individual and changing needs. They include a range of one-on-one activities provided by a support worker supporting individuals in their homes or local communities.</p>

7. Appendix

HASP toolkit

The attached toolkit provides three sets of resources to guide operational processes:

- Mandatory forms for funding procedures
- Example templates example process templates for HHS to consider.

1. Mandatory forms

- 1.1 [HASP Application form](#)
- 1.2 [Panel checklist](#)
- 1.3 [New consumer proposal, permanent vacancy](#)
- 1.4 [Permanent consumer, increase in hours](#)
- 1.5 [Consumer exiting HASP or relinquishing hours](#)
- 1.6 [Temporary capacity notification/ new consumer proposal](#)
- 1.7 [Consumer request to transfer service provider](#)
- 1.8 [Transfer of service provider, relinquishment of funds](#)
- 1.9 [Transfer of service provider, acceptance of funds](#)
- 1.10 [Request to reallocate surplus funds](#)
- 1.11 [Request to subcontract](#)

2. Templates

- 2.1 [Example application register](#)
- 2.2 [Example transition plan](#)
- 2.3 [Example stakeholder information](#)
- 2.4 [Example review of support](#)
- 2.5 [Example satisfaction survey](#)

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