NSW GOVERNMENT

Together Home

Housing and support for people street sleeping during the COVID-19 pandemic and beyond

May 2022

Program Guidelines

Contents

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1. Introduction

1.1. Purpose

The Together Home program is a $122.1 investment by the NSW Government that aims to support people street sleeping across NSW into stable accommodation, linked to wraparound supports.

Together Home is a key initiative to support the Premier's Priority to halve street homelessness by 2025. The program aims to transition people onto a trajectory away from homelessness and into long-term, stable housing, while improving overall personal wellbeing. Housing and support is provided through the program, which aims to address people's support needs, build individual capability and capacity, and foster connections to community.

The program was first established in 2020 to ensure that the spread of COVID-19 was minimised as Public Health Order restrictions were implemented across NSW, by supporting people into affordable, sustainable and supported accommodation.

Together Home is an extension of the Community Housing Leasing Program (CHLP). Community Housing Providers (CHP) across NSW are engaged to head lease properties in the private rental market and house people who currently street sleeping, or have a history of street sleeping.

Together Home uses Housing First principles and is premised on a distinct separation between housing and support functions. This means that a participant receives tenancy supports and will also receive trauma-informed, wrap-around support to address underlying risk factors associated with homelessness.

The purpose of these Program Guidelines is to provide departmental staff, CHPs and other funded services with information regarding the aims, objectives, operational requirements and expectations of the Together Home program. These Guidelines specify the outcomes to be achieved and the mechanisms for achieving them.

These Guidelines provide broad parameters and requirements for service planning and delivery. CHPs, support providers and DCJ Districts are encouraged to work collaboratively and localise program delivery and governance structures.

1.2. Context

People who are experiencing homelessness and especially people who experience street homelessness often face a range of complex and compounding issues, including:

- historical and/or current trauma
- abuse
- physical and mental health issues (including Post Traumatic Stress Disorder)
- substance use
- cognitive impairment
- discrimination and racism
- distrust of authorities or services as a result of institutional or custodial experiences
- limited or non-existent history of successful tenancies

- financial difficulties
- other barriers associated with systemic issues that perpetuate homelessness.

People who are entrenched in street sleeping often require intensive, proactive and long-term responses. This group often remain homeless, disengaged from support services and not accessing the assistance they require for long periods. There is often diminished levels of individual capability, which requires intensive, ongoing supports. Evidence demonstrates that providing stable, affordable housing and intensive wraparound supports can help to sustain tenancies and address the underlying causes that led to the person experiencing homelessness[1].

People who are street sleeping are generally unable to access private rental accommodation independently, due to the perceived barrier of high support needs. However, the high degree of specialisation within the housing and homelessness service system, including the effective coordination of housing and support services, provides a strong basis on which to build robust strategies to assist people who are street sleeping via the private rental market.

1.2.1 Impact of COVID-19 on people experiencing homelessness

At the beginning of 2020, Public Health Orders commenced in Australia to minimise the impact of the coronavirus disease (COVID-19). COVID-19 was declared a pandemic in March 2020 by the World Health Organisation (WHO) due to its widespread prevalence around the world.

The COVID-19 pandemic has had wide ranging impacts on the broader community in NSW; and people experiencing or at risk of homelessness have been impacted significantly.

To support the sector, the NSW Government's second Health and Economic stimulus package announced on 27 March 2020, included $34 million in funding to prevent people from experiencing homelessness (to June 2021). This included $14 million for emergency Temporary Accommodation (TA) and $20 million for additional private rental subsidies.

Since March 2020, the NSW Government has supported people experiencing homelessness by:

1. Accelerating its expansion of Assertive Outreach patrols within existing resources;
2. Supporting larger crisis accommodation centres to improve their capacity for physical distancing and self-isolation options; and
3. Bulk booking a large number of hotel and motel rooms across NSW to provide accommodation for people who were street sleeping during this period.

During the COVID-19 response there were more than 15,000 people since 1 April 2020 in emergency TA, including over 1,500 people who had been street sleeping (as at July 2020).

The Together Home program responded to the needs of the target group by providing a supportive longer term housing solution. The healthiest and safest place for people street sleeping is in stable accommodation with support networks in place. The Together Home program (Tranche 1) commenced on 1 July 2020 and was eligible for people who were assisted into Temporary Accommodation due to COVID-19.

[1] Policy shift or program shift? Implementing Housing First in Australia, March 2012, https://www.ahuri.edu.au/__data/assets/pdf_file/0012/2064/AHURI_Final_Report_No184_Policy_shift_or_program_drift_Implementing_Housing_First_in_Australia.pdf

2. Program Description

In June 2020, the NSW Government committed $36.1m to establish the Together Home program. Tranche 1 will operate for two years from 1 July 2020 to 30 June 2022.

In November 2020, a further $29m was committed as part of the NSW 2020/21 Budget. Tranche 2 will commence operations incrementally from 1 April 2021.

The 2021-22 NSW Budget (June) included $57 million over two years to expand the Together Home program by another 250 households. Tranche 3 includes funding towards 100 new dwellings for people who require long-term housing support at the end of the program.

This program will make available properties leased from the private rental market linked to wrap-around, flexible supports. Some of the housing and support packages are High Needs Support packages assessed by the High Needs Assessment Panel (see section 5.6, 7.4 and 7.5).

The program will operate as a partnership between the Department of Communities and Justice (DCJ) and Community Housing Providers (CHP). The program is an extension to the Community Housing Leasing Program (CHLP).

Tranche 1 funding was allocated to CHPs in June 2020 to deliver the program. Tranche 2 funding was allocated to CHPs between March 2021 and September 2021. Tranche 3 packages were allocated in late 2021 and take into account low rental vacancy rates, high demand and CHP capacity in the final CHP allocations.

CHPs engage appropriate support providers, such as Specialist Homelessness Services (SHS), to deliver wrap-around support that is tailored to the person's needs.

A key component of each person's support plan will be identifying a long-term, sustainable housing pathway following, participation in the program. This may include pathways into social housing, such as CHPs assisting participants into their community housing capital supply. Based on an assessment of their capacity, some participants will receive support at the end of the program to remain in the private rental market through the use of private rental products such as Rent Choice.

The Together Home program expanded in the Hunter Central Coast District to deliver a $1.3m Aboriginal-led model. This part of the program is outlined in more detail at Appendix 3.

An evaluation of the Together Home program will be undertaken, with involvement from key stakeholders including CHPs, DCJ Districts and support providers.

2.1 Evidence-informed program design

Using evidence-based interventions, the program presents an opportunity to both manage immediate public health risks and create a lasting change to address street sleeping, in line with the Premier's Priority to reduce street homelessness.

2.1.1. Supported Transitions and Engagement Program (STEP)

The Together Home program has been designed using the principles of the Supported Transitions and Engagement Program (STEP), which delivers a rapid rehousing response, premised on a Housing First philosophy.

This approach prioritises housing people as quickly as possible and linking them with wrap-around, person-centred support, so that issues contributing to their homelessness can be addressed.

Core principles underpinning the approach include:

- **Equitable and rapid access to housing** – provide rapid access to safe accommodation with no readiness conditions.
- **Informed choice** – commitment to individual choice and self-determination, wherever possible.
- **Recovery** – recovery oriented approach to service delivery.
- **Intensive support** – wrap-around supports will be strengths based, person centred and trauma informed.
- **Continuity of care** – the program recognises the importance of continuity of care as a key factor in creating trusting, respectful and positive relationships between the person and the service.
- **Community** – the program has a strong focus on social and community integration.
- **Culture** – service delivery will be culturally appropriate and the cultural needs of the person will be considered as part of the overall support planning approach.
- **Stabilisation and sustainabilit**y – long-term housing and wellbeing outcomes will be identified upon entry into the service and worked towards throughout.

2.1.2. Housing First

Housing First is an internationally recognised model that prescribes safe and permanent housing as the first priority for people experiencing homelessness. While models can vary, the key foundational principle of the Housing First model is that safe and secure housing is provided prior to participation in addressing other support needs[2]. Once housing is secured, the support needs can be addressed with support workers. Safe and secure housing is provided quickly and is not conditional upon the person addressing issues they may have.

Housing First models were implemented in the USA almost 30 years ago and since then numerous programs around the world have worked to implement the model. The Together Home program incorporates many Housing First principles.

2.1.3. Australian Housing First principles

The following are the Housing First principles in an Australian context:

1. People have a right to a home
2. Flexible support for as long as it is needed
3. Housing and support are separated

[2] What is the housing first model and how does it help those experiencing homelessness? 25 May 2018, AHURI https://www.ahuri.edu.au/policy/ahuri-briefs/what-is-the-housing-first-model

4. Choice and self-determination
5. Active engagement without coercion
6. Recovery oriented practice
7. Social and community inclusion
8. Harm Reduction approach

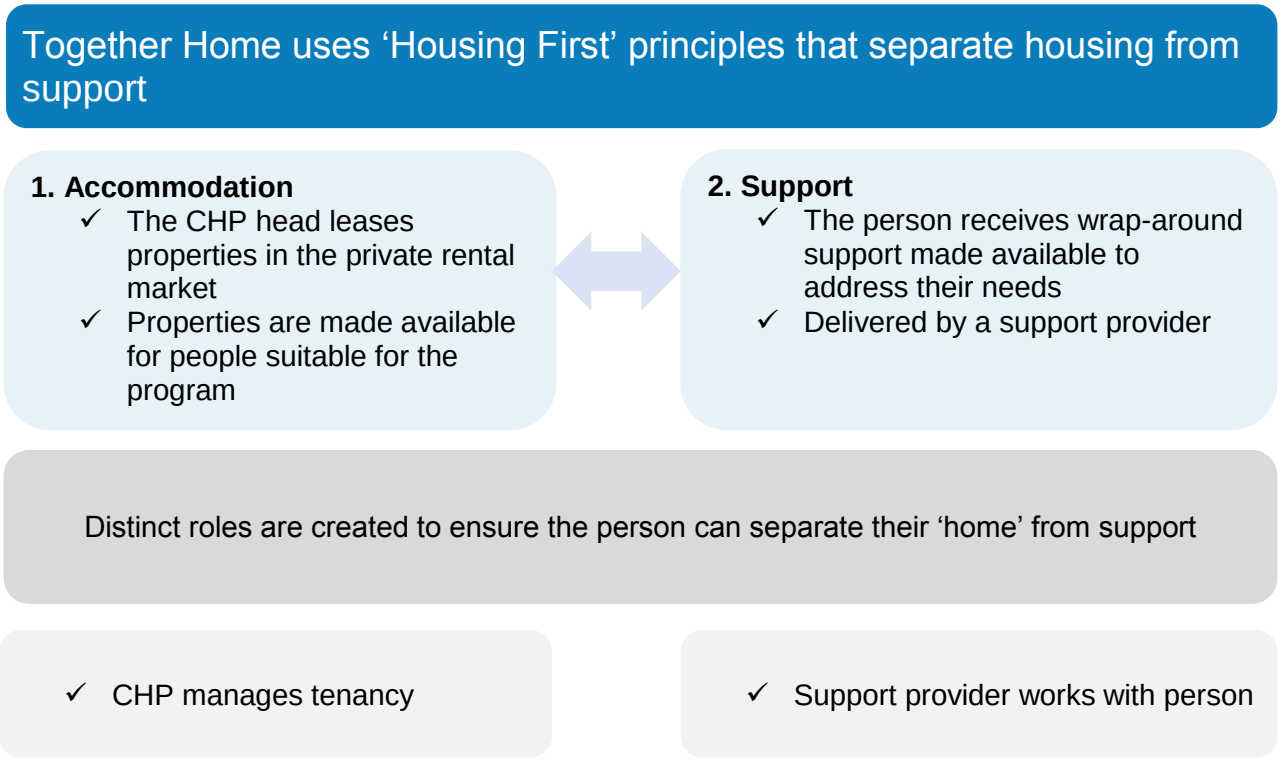
In practice, the evidence demonstrates that when implementing Housing First to a 'high-fidelity' model, there can be better outcomes for people.

For more information on Australian Housing First principles go to:
https://www.homelessnessaustralia.org.au/campaigns/housing-first-australia

2.1.4. Separating housing support from wraparound support

In line with Housing First principles, when delivering Together Home, 'housing' must be separated from 'support'. This is to ensure that a participant can raise issues to their support worker that they may not be able to raise with their tenancy manager. See Fig. 1. Where a CHP also has a support provider function, these must be distinct roles to ensure that the support is separated.

Figure 1. Separating housing from support



2.2. Community Housing Leasing Program (CHLP)

The Community Housing Leasing Program (CHLP) has been in operation since 2000 and is designed to give CHPs increased flexibility in accommodating eligible people in housing that suits their needs. The program is a core part of the community housing sector's supply of social housing.

The program allows CHPs to increase and decrease their supply by location, source suitable property types and/or other factors to respond to the needs and priorities of the person.

CHPs also deliver the Community Housing Leasing Program – Homelessness Housing where funding is used to support the leasing of rental properties from the private rental market to accommodate people who are eligible for Crisis Housing or Transitional Housing. Some CHPs have partnered with SHS to deliver programs which involve head leasing and wrap-around support services, similar to what is being proposed under the Together Home program.

2.3. Supporting Aboriginal people through Together Home

People identifying as Aboriginal access Specialist Homelessness Services (SHS) at a significantly higher rate than non-Aboriginal people. In 2019-20, 30% of people accessing NSW's SHS were Aboriginal[3]. Further to this, while Aboriginal people represent 3.5% of the NSW population, they represented 7.3% of the people who were experiencing homelessness in NSW on Census night in 2016.

Understanding homelessness within Aboriginal communities requires an understanding of the legacy of colonization and dispossession. Histories of both cultural and physical displacement increases homelessness risks amongst Indigenous Australians.

People who are Aboriginal are a priority group for the Together Home program. Service practice under Together Home should reflect culturally safe, supportive and inclusive approaches for indigenous people. Aboriginal specific support planning should be adopted and mechanisms put in place to support and assist Aboriginal staff and program participants to resolve issues in a culturally appropriate way.

It will be necessary for providers to prioritise referrals of people who are Aboriginal into the program. Where there are limited numbers of Aboriginal people being referred to the program, the Aboriginal representative on the Client Referral Assessment Group (CRAG) may be called upon to bring referrals of people street sleeping or with a history of street sleeping to the group. A partnership like this can be used to provide cultural context, networks and local knowledge.

For the High Needs Support packages, a program level target of 30% has been set for any referrals to the High Needs Assessment Panel (see sections 5.6, 7.4 and 7.5).

2.4. Delivering a culturally appropriate service

Culturally specific strategies are required to support people who identify as Aboriginal when implementing this program. Approaches used for non-Aboriginal people may not necessarily be appropriate or effective for people who identify as Aboriginal. The support provider will identify cultural needs, be culturally sensitive and appropriate in their response. The support provider will undertake research and consult with Aboriginal stakeholders to ensure the service approach is culturally appropriate.

[3] AIHW Specialist homelessness services annual report, Dec 2020, https://www.aihw.gov.au/getmedia/c1ce917d-9812-459d-967d-0d2a027f70c0/aihw-hou-322-nsw-factsheet.pdf.aspx and https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/indigenous-clients

Further, the support provider will have policies in place that proactively seek the recruitment and retention of Aboriginal staff, where possible.

The service provider must make cultural competence training available to their staff.

The Support Provider will provide people from Culturally and Linguistically Diverse (CALD) backgrounds with linkages to services to meet their cultural and language needs and engage interpreters as required.

3. Program principles and objectives

The objectives of the program are to:

Objectives

- Rapidly rehouse people who are street sleeping or with a history of street sleeping with a plan for longer term housing
- Provide access to culturally appropriate health, mental health and wellbeing services (where appropriate)
- Rebuild family, community and cultural connections (where appropriate)
- Support the development of daily living and self-management skills (where appropriate)
- Facilitate engagement with positive structured activities such as social groups, education and/or employment (where appropriate)

Longer term housing

- Support for the participant will be available for two years where possible.
- During the two year lease period, the CHP will make available to the program participant a reasonable offer of long-term accommodation/private rental options while they are in the head-lease property. The two offer policy will apply when allocating social housing.
- DCJ and SHMT CHPs will assist in offers of properties (and other Private Rental Assistance products such as Rent Choice where appropriate) to non-SHMT CHPs during the two year period (outside SHMT areas) for the longer-term housing solution.

Principles

- Focus service delivery on stabilisation and sustainable outcomes
- Ensure a commitment to individual choice and self-determination, where possible (in particular for property & location selection, health management & goal setting)
- Provide support using a strength based, person centred approach that leads to independence and growth of capability
- Enable continuity of care for the program participant which makes assistance seamless and where possible enables the principle of ‘one-person-one-plan’
- Require both accommodation and support providers to take a hope-inspiring, recovery-oriented approach to service delivery

3.1 One-person-one-plan

One person one plan is a part of the principle: 'Enable continuity of care for the program participant which makes assistance seamless'.

One person one plan is person centred as it aims to ensure that a person has continuity of care in the program.

One person one plan seeks, wherever possible, to keep established support workers involved with the program participant following a referral to Together Home. This is important because it:

- Reduces transition points between agencies, which can create disengagement risks.
- Allows existing relationships between clients and support services to continue. This approach can assist with a person's continuity of care and assist the person in the service system.
- Aims to avoid scenarios where an existing support arrangement is cut off too early for a participant.

One person one plan can be operationalised depending on the program participant's needs and the delivery models for CHPs, where it is possible. In many cases some CHPs may already be delivering under this model. Examples of how one person one plan can be operationalised:

- **Person-centred transition planning** – providing a coordinated transition period for the participant, such as 3 – 6 months (or a time that is suitable for the participant), to help the participant transition from the current support worker and build rapport with a new support worker, where appropriate.

- **Co-case management with support workers** – an arrangement where all or part of the person's support in the program includes existing support workers and new support workers where appropriate. This could also be a transition arrangement where one support worker helps the participant work with a new support worker (see person-centred transition planning).

- **Continued case management** - the participant continues to work with their existing support workers or an SHS with whom they have a rapport throughout the program.

- **Coordinated case planning** – this includes in the case plan all of the other service providers that a participant is currently receiving and may receive, such as NDIS and health services.

Depending on the arrangement, a subcontract or fee for service model may be required to engage with the existing support service.

If the client is not yet engaged with support when they are accepted to the program, the support service should be advised immediately. To enable this, support providers should attend CRAG meetings, or be advised of accepted clients immediately if they cannot attend a session.

3.1.1. Identifying participant needs

Implementing the principle will require early, collaborative planning to understand the participant's needs and current support services. The lead CHP will need to work with DCJ and existing supports, such as SHS, to identify participant needs and where existing relationships need to be maintained.

This may also require the participant to identify whether they would like the existing relationship to continue with their current support worker.

To ensure that CHPs can begin to plan their service delivery models effectively, after the CHP understands the client base, then they can budget their models.

This planning can take place at the referral and assessment stage (see section 5):

- **Referral form:** All referrals coming into the CRAG will be required to use the Together Home Referral Form, which will have a section that identifies any existing support arrangements already in place.
- **CRAG:** The Client Referral and Assessment Group (CRAG) will then work to understand when a person is referred to the program what the current support services and arrangements are, and how to continue or transition to new support services in a way that supports the participant.
- **VI-SPDAT: The Vulnerability Index -** Service Prioritisation Decision Assistance Tool (VI-SPDAT) is a survey that gathers information about the housing and support needs of people. It is a screening / triage tool for matching people to services and supports.

If a participant has a high degree of complexity, a referral can be made to the High Needs Assessment Panel for a High Needs package (see section 7.4 and 7.5).

3.1.2. Support agencies in scope and requirements

Support providers in scope for this approach include:

- Support providers already known to DCJ through funded programs e.g. SHS or other homelessness services
- Other specialist support providers that are integrated into the local service system, such as NDIS providers, HASI support providers and mental health providers

Support providers will need to meet key program requirements/expectations, including:

- Participate in program governance including the CRAG
- Support providers will need to fulfil all data and reporting requirements including reporting on the Together Home Outcomes Framework and using CIMS (or an approved alternative)

3.1.3. Seeking approval for support providers and delivery models

As per the Letter of Variation - Annexure 1, CHPs will need to seek approval for each support provider and the delivery model. This is also to ensure that the Together Home project team can support CHPs to meet the requirements in 3.1.2. DCJ will review and approve support providers within 48 hours.

When seeking approval for a support provider, CHPs should:

1. Contact their local Commissioning and Planning lead contact to discuss the support provider, due to their local knowledge and expertise.

2. Commissioning and Planning will liaise with the Together Home project team.
3. The Together Home project team will make a decision to accept the support provider and inform the CHP and local Commissioning and Planning contact.

CHPs will need to notify DCJ partners, including the CRAG of each support provider and the delivery model.

3.1.4. Feasibility of one person one plan

For some CHPs one person one plan may not be a sustainable approach, as many CHP's subcontract an SHS provider to deliver the support for the program. CHPs may be required to coordinate more support providers when using a one person one plan approach.

Funding per participant may also not be feasible for the support provider. Some support providers may require a minimum number of participants to generate an appropriate scale to support the program, such as having the resources to meet reporting requirements. Some homelessness service providers may also not be able to retain this participant due to BAU targets.

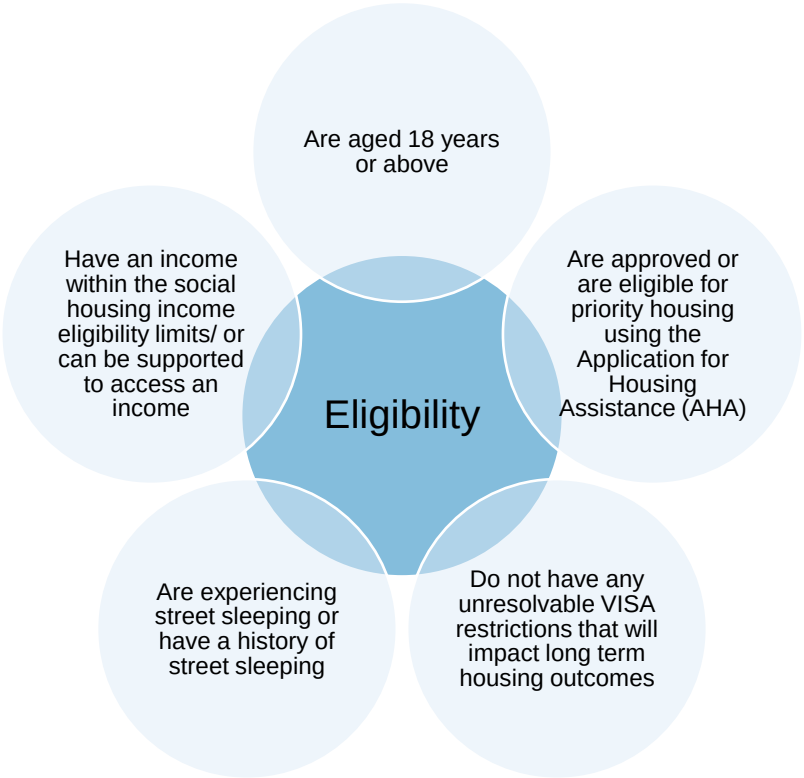
4. Program target group and eligibility criteria

The primary target group for this program is people who are street sleeping or have a history of street sleeping, that are:

- Being supported in Temporary Accommodation
- Clients of SHS providers who are currently in crisis or transitional accommodation, or
- Clients known to Assertive Outreach services across NSW.

People who are Aboriginal are a priority group for this program.

Packages will be provided to people who:



Program participants with accompanying children are eligible for the program provided they meet other eligibility criteria.

Applicants under the age of 18 years should be managed within existing provider's policies.

In locations where there are relatively low numbers of people sleeping rough, but large numbers of people at risk of experiencing rough sleeping, including Aboriginal families living in overcrowded dwellings and couch surfing, flexibility will be provided to the target cohort. An example of where this flexibility may be required is Murrumbidgee, Far West and Western NSW District.

5. Referrals, assessment and prioritisation

5.1. Client Referral Assessment Group (CRAG)

Referrals into the program require a transparent assessment and prioritisation process. Each CHP is required to be part of a Client Referral Assessment Group (CRAG) to manage referrals. The CRAG is led by the SHMT CHP in SHMT locations, and by DCJ in non-SHMT locations.

The CRAG will include:

- DCJ or SHMT CHPs
- CHP delivering the program
- Local support provider/s
- Local Aboriginal representation
- Additional members as required, including representatives from the local health district, if possible.

The CRAG will assess all referrals that come into the program.

The CRAG will collaboratively decide whether the person referred into the program is suitable for the program (see 5.3); if a referral needs to be made to the High Needs Assessment Panel for a High Needs Support package (see 5.6); or a referral to another DCJ product is needed (5.7). The panel will also explore whether a participant will use the one-person-one-plan principle (see 3.1).

If the client is not yet engaged with support when they are accepted to the program, the support service should be advised immediately. To enable this, support providers should attend CRAG meetings, or be advised of accepted clients immediately if they cannot attend a session .

Once all program packages are allocated, the frequency of meetings is likely to reduce. The CRAG may be re-formed to:

- plan the longer-term exit housing options for participants
- discuss re-engagement with evicted or exited clients (if raised by CHPs/support providers)
- discuss flexible use of funding or remaining funding after program exits (if raised by CHPs)
- Discussion of other matters as required.

In the first instance, issues should be escalated by the CRAG through the local PDG and to the Steering Committee, if required (e.g. systemic issues). CRAG members may also raise issues through the Together Home Mailbox, if required.

5.2. Referral pathways and referral form

The primary target group for this program is people who are street sleeping or with have a history of street sleeping.

The Together Home program referral form must be completed to make a referral to the CRAG (see 5.1). The referrer must submit the form to the Secretariat of the CRAG.

Informed consent is essential. It will be important to ensure that the person is aware that a referral to the program is being made on their behalf, and their consent is obtained using the Together Home Referral Form.

Referrals to the program will come from:

- Department of Communities and Justice
- Community Housing Providers (SHMT and non-SHMT)
- Specialist homelessness services

Services that work with people who are currently sleeping rough, or have a history of sleeping rough can connect with their local SHS or CHP to discuss the referral process.

5.3. Assessing suitability and prioritising people for the program

It is anticipated that Together Home providers will receive more referrals into the program than packages available.

The program aims to provide equitable and rapid access to housing with no readiness conditions (i.e. sobriety and compliance with health treatment will not be required to obtain housing). This reflects Housing First principles (see section 2 and 3).

While readiness is not required, the CRAG will need to determine if the person is suitable for the program. Suitability for the program will be assessed in part on the potential for the person's existing support needs to be addressed during their tenancy. Informed consent also forms part of participant suitability. The person must be aware that the program can offer intensive support when participating in the program.

To support decision making the assessment process must consider the:

- VI-SPDAT score and content where a survey has been completed (note a person refusing to complete a VI-SPDAT will not exclude them from the program)
- Expert assessment from the support worker
- Priority Housing application and supporting material such as the Independent Living Skills Assessment and Medical Assessment Form
- Person's need for the support component (where a participant only needs housing assistance, an alternative housing product must be sourced).

People who identify as Aboriginal are to be given priority access to this program.

As part of a Housing First response, property matching and choice are also key to improving housing stability for a program participant, as the person must feel comfortable and familiar in their surroundings in an appropriate dwelling. Where possible, participant choice should be taken into consideration.

In instances where people will be priority approved, the CRAG will need to decide whether this can be managed retrospectively to prevent delay.

5.4. Assessment tools

Assessment of program participants must be trauma informed and support the identification of the person's support needs.

Assessment Tool	Purpose	Administered by
Application for Housing Assistance (AHA) - required for referral process Which may include the Independent Living Skills Assessment, Medical Assessment form and Locational Needs Assessment form.	This initial assessment will provide adequate information about the person to help determine their housing and support needs.	DCJ The CHP in non SHMT locations. Support providers, where appropriate.
Together Home Living Skills Assessment	This assessment will provide adequate information about the person to help determine their housing and support needs. The assessment will also help to measure whether individuals have an improved level of daily living skills necessary for long term accommodation and self-management. The assessment is completed at set intervals: • within first 6 months as part to the DCJ Application for Housing Assistance Independent Living Skills Assessment • Within first 9-12 months using the Together Home Living Skills Assessment • Within 12-18 and 18-24 months using the Together Home Living Skills Assessment	Support provider
Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT)	It is strongly encouraged that each program participant has the VI-SPDAT undertaken as part of this program, see section 5.4.1. This tool can help the CRAG understand a person's level of vulnerability and can support program participant prioritisation	Trained support worker
Personal Wellbeing Index (PWI) start survey	The PWI start survey will gather baseline information about a person's wellbeing prior to being successfully housed.	Trained support worker

	This is best completed prior to the person being housed. The PWI is integrated into CIMS. Start survey scores will need to be provided to the allocated support provider for entry into CIMS.	
Personal Wellbeing Index (PWI) - periodic and end surveys	Administered at review points during the program and at exit to assist with outcomes data. The PWI is integrated into CIMS. Note: as part of the Outcomes Framework at Appendix 1, it is not anticipated or required that continual improvement in PWI scores is achieved for your program participant. However, it is anticipated that the program participant will experience improved wellbeing due to their participation in the program. The "improved total wellbeing score" is always measured against the start survey.	Support provider
Together Home program Client Satisfaction Survey	This is an anonymous survey to be completed by program participant at the 18 month point and on exit from the program – this could be where a client chooses to exit, or the point at which the sub-contracted support is ending. CHP/Provider will work to administer this anonymous survey at the 18 month point and when the person exits the program (positive or negative exits) or the THP program ends, whichever comes first.	Managed by DCJ

5.4.1. Role of the VI-SPDAT

The person referred into the program may have a VI-SPDAT completed. The VI-SPDAT can support discussions at the CRAG about prioritisation and support needs. The VI-SPDAT will be considered in conjunction with other supporting information provided by the referring organisation.

The use of the VI-SPDAT at CRAG meetings can be localised to best suit each District. The following points should be considered:

- For areas that have more referrals than lease allocations available, the VI-SPDAT will be a crucial consideration for the CRAG when prioritising participants with higher vulnerabilities into the program.
- For areas that may not have this issue with lease allocations, the VI-SPDAT will provide useful information on the program participant and complexity of support needs.
- The referral form will indicate whether the VI-SPDAT has been completed. Where it has not been completed, the CRAG Secretariat will seek to have the survey completed by a suitably trained person from an appropriate agency. Where a referee does not complete the VI-SPDAT the CRAG Secretariat will seek written advice from the referring agency on the person's circumstances and needs.
- The content of the VI-SPDAT will provide useful information in determining who should be referred to the High Needs Assessment Panel for access to high needs packages.

5.4.2. VI-SPDAT and the By-Name List

The NSW Government has partnered with the End Street Sleeping Collaboration (ESSC) and the many specialist homelessness services in New South Wales to halve street sleeping by 2025. As part of the partnership, we have developed the By-Name List (BNL), which is a case coordination system that holds important information on people street sleeping in NSW and can be used by organisations to match people with the most appropriate housing and support agencies. It also ensures that people street sleeping are not having to repeat their stories to different agencies and service providers. The BNL is being actively used by SHS providers and CHPs throughout NSW. Training on the use of the BNL, including how to conduct the VI-SPDAT is provided by ESSC and can be booked using this link: https://endstreetsleeping.org/training or you can email support@endstreetsleeping.org to request additional training or for help with accessing and using the BNL

The VI-SPDAT and associated consent form can be completed online and entered directly into the BNL using a mobile device, or laptop. Services will need to complete training and be allocated a login by End Street Sleeping Collaboration in order to access the BNL. Only authorised members of DCJ, the CHP and support providers will have access to the BNL.

CHPs or the support provider must ensure that the participant has provided consent before the VI-SPDAT scores are entered into the BNL.

The consent form provides detail about how the information will be used to ensure the participant has informed consent. The consent form also lists services that can access the information including state-wide services and local services. If a participant does not want their information shared with a particular service on the list, this can be indicated.

In addition to the VI SPDAT, ESSC has developed a Housing Needs Assessment, which can be completed by service providers to support the referral process.

5.5. Overview of referral, assessment and offer process

Stages	Description
1. Identification, referral and immediate access to supports	Referrals can be made by SHMT and non-SHMT CHPs, DCJ and SHS for people who were/are street sleeping or with a history of street sleeping, and who currently are or have recently been in TA, are clients of an SHS in crisis or transitional housing, or are known to an Assertive Outreach program. • As part of the referral, discuss with the person that supports form part of the program. • Ensure any pets or dependents are considered and noted in the referral. • Complete the program referral form for the person ensuring that consent is given. • SHMT and non-SHMT CHPs, DCJ and SHS send the referral form to the CRAG Secretariat (if the SHS does not know the CRAG secretariat in their District, please contact the relevant Together Home provider – see section 8 Delivery Locations) • The referring organisation (SHMT and non-SHMT CHPs, DCJ and SHS) should facilitate access to immediate supports for the person (i.e. crisis accommodation or TA). DCJ can consider allocation of TA for this purpose, where alternative arrangements are not available (see 5.3).

	Note: The referral form asks whether the VI-SPDAT and PWI start survey has been completed and a recent Application for Housing Assistance (of any status) has been completed. **Note:** Where STEP-Link operates in the same District, CHP and DCJ should engage with the provider to ensure no duplication of effort, and to coordinate the most appropriate support services according to each potential referee's preferences. **Note:** There may be instances where a person being assessed for the Together Home program has a LIVE housing application on the NSW Housing Register. If there are concerns that this person may be offered social housing before the Together Home assessment is finalised by the Together Home Client Referral Assessment Group (CRAG), the application can be suspended See 7.1 for more information.
2. Preparation for CRAG	**CRAG Secretariat will coordinate:** 1. Where not completed, complete Application for Housing Assistance – including, where relevant, the Independent Living Skills Assessment, the Medical Assessment form and the Locational Needs Assessment form. The Locational Needs Assessment can support the person's self-determination in terms of where they would like to live, noting this must be weighed against housing availability and affordability in the private rental market. 2. Where not completed, complete the VI-SPDAT and PWI start survey to help determine the degree of vulnerability. The VI-SPDAT will help the CRAG triage and prioritise people into the program (see 5.4.1). Where the referring agency has no experience with the VI-SPDAT, the Secretariat must organise for its completion. 3. CRAG Secretariat convenes a meeting as required. **Note:** All referrals and offers are to be de-identified and presented to the governance group. This will include persons not accepted into the program.
4. Program intake determined at CRAG	• The CRAG will collaboratively decide whether the person is suitable for the program, if referral needs to be made to the Together Home High Needs Assessment Panel for more intensive support or a referral to another DCJ product is needed. • The CRAG will complete the referral form for a person accepted into the program, who may benefit from additional mental health support, and send this to the Together Home High Needs Assessment Panel. • If not present at the CRAG, the support provider should be informed of approved referrals immediately after the CRAG session so support can begin. • People accepted into the program will receive follow up from the CHP. • The program participant must be contacted within 48 hours of referral being accepted. • People who are not eligible/suitable for the program must be offered an alternative response.

	• If an applicant is unsuitable for the program, due to longer term needs, and no other responses are available, they will be offered a package until an alternative option becomes available.
5. Support provider works with program participant	• Support provider commences development of support plan in discussion with the program participant (and in coordination with current/ previous support worker if possible). • Support provider completes PWI periodic and end surveys with the program participant as required. • Support provider commences delivery of support. • Support provider makes a referral to NDIS where required. • Support provider can refer program participant to the High Needs Panel if more complex support needs are identified, including mental health needs. • See section 6 for more information on the support component and support activities/requirements.
6. Offer and acceptance	• CHP makes an offer of housing, arranges and conducts interview with the program participant in a location suitable for the program participant. It is recommended that the CHP meet with the person where they are most comfortable. • Program offer meeting includes: o Explaining available option/s to the program participant and confirming understanding of, and commitment to, rights and responsibilities. o Re-visiting any circumstances that may have changed and may need to be returned to the panel. •
7. CHP works with program participant	• Identify housing to meet the person's needs in discussion with the program participant and the support provider. • Ensure Housing Pathways application is approved and entered into HOMES. • Conduct lease sign-up with support provider present (where possible). Undertake sign up in a location where the program participant is comfortable.

5.6. Referrals to the High Needs Assessment Panel

The High Needs Assessment panel will prioritise and allocate the funding for the packages. Therefore it is essential that any individual who is referred to the panel has provided informed consent and a VI-SPDAT has been completed.

The information for a referral will include:

- A copy of the Together Home Referral form
- Completed High Needs Panel referral form
- Completed High Needs Assessment Panel budget template
- Any other supporting documentation

For relevant documentation and for more information on the process and the timeline, please refer to the Homelessness NSW website - https://homelessnessnsw.org.au/project/together-home-high-needs-packages/. Questions can be directed to highneedspackage@homelessnessnsw.org.au.

5.7. Referrals to other DCJ products

For people not accepted into the program who may require housing assistance, there are alternative options available. For example, a referral can be made for Rent Choice by the CRAG.

Rent Choice is a private rental subsidy provided by DCJ to assist individuals and households to access and sustain a tenancy in the private rental market, where private rental housing is appropriate to their housing needs and circumstances, and ultimately to provide opportunities and pathways to independence in the private market. Rent Choice recipients are expected to be linked into employment programs. There are a range of Rent Choice products:

- Rent Choice Assist - is a time limited Rent Choice Product. Suitable people for this product are generally not for people who have been street sleeping. It is more for people who have 'stabilised' and those who are able to secure and maintain private rental accommodation with or without assistance.
- Rent Choice Start Safely – targeting people leaving domestic and family violence
- Rent Choice Youth – targeting young people aged 18 to 24
- Rent Choice Veterans
- Rent Choice Transition – targeting social housing tenants who want to move to the private rental market. This is currently being piloted in Western Sydney, South West Sydney, Murrumbidgee, Illawarra Shoalhaven and Hunter.

6. Support component

6.1. Support providers

Support providers in the context of the Together Home program will be required to demonstrate capabilities in working effectively with people with a history of severe homelessness, trauma and with multiple, complex needs, and to have experience with the following practice principles:

- person-centred approaches,
- intervening early to prevent return to homelessness, and
- providing intensive responses for program participants with complex needs.

Suitably qualified support workers will have skills in engaging, building rapport with, and supporting people who are experiencing homelessness, and are experiencing mental health concerns and/or problematic substance use.

The service will know how to use Assertive Outreach techniques to overcome barriers for engagement with people participating in the Together Home program.

The support provider will work to coordinate and strengthen relationships between the various services involved in a person's support plan, including:

- primary health care providers
- alcohol and other drug services
- disability supports

- family supports
- Centrelink and income support
- mental health supports
- training, education and employment
- cultural and community networks
- structured activities
- parenting support and child protection

Support providers should be prepared to offer support outside of usual business hours, if this will assist in engagement and management of issues.

The following table outlines some key criteria and accompanying signposts that would assist in identifying a support provider with the necessary capabilities to offer support as part of the Together Home program.

Table 1: Support Provider Capability Checklist[4]

Person-centred approach A person-centred approach to service design means that each service response is built around the needs of the individual program participant rather than a programmatic or predetermined service offer. A person-centred approach is strengths-based with a focus on building individual and family capacity, skills, resilience, and connections to community.	
Criteria	**Signposts**
Commitment to a person-centred approach	• Person-centred service design and planning that is strengths-based and linked to individual needs
Appropriate feedback and complaints mechanisms	• Robust mechanisms for collecting feedback, both directly from program participants and indirectly from advocates and other service providers that work with program participants • Easy access to mechanisms to lodge complaints and for the prompt resolution of complaints
Systematic policies and procedures to ensure each service response is built around individual the program participant's needs	• Comprehensive policies and procedures for individualised support planning to ensure: o all supported program participants have an individualised support plan o all support plans encourage program participant responsibilities and mutual obligations o all support plans outline how services will be integrated and coordinated o all support plans consider and have specific actions for program participant safety
Having a range of opportunities for program participant input into support plan goals and service responses	• Robust mechanisms for setting and documenting program participant choices and goals • Regular reviews of support plans with evidence of program participant input in reviewing progress and updating goals
Practices in place to ensure target groups	• Comprehensive policies and procedures for planning and delivering evidence-based service responses that consider, for example, cultural background, disability, sexuality, age, and gender.

[4] Source material: Specialist Homelessness Services – Practice Guidelines November 2014

	• Flexible service delivery arrangements that allow support workers to undertake place based support and work cooperatively with specialist support services.
Intervening early to prevent return to homelessness - -	
Criteria	**Signposts**
working with individuals and families who were previously homeless who require support to sustain the new tenancy	Mechanisms that facilitate proactive and ongoing collaboration with the full range of service providers that contribute to addressing individual program participant needs, for example: ○ services to access education and employment opportunities ○ income support services and financial help ○ legal advice ○ health services, particularly mental health and drug and alcohol services ○ specialist DFV support services and systems ○ family support and mediation services ○ community participation and engagement opportunities ○ Aboriginal services ○ services for people from culturally and linguistically diverse backgrounds ○ other specialist services Specific policies and procedures for individualised transition plans for program participants, including: ○ integrated transition planning ○ multi-agency support planning ○ negotiating program participant responsibilities and advocating on behalf of the program participant to help them sustain their new tenancy ○ facilitating access to the above mainstream services needed to sustain their new tenancy ○ putting in place follow-up strategies to respond to ongoing requests from the program participant for information, advice and advocacy (after the end of the transition plan).
Intensive responses for program participants with complex needs Practice responses that include intensive multidisciplinary support are recognised as the best approach for program participants with complex needs such as program participants entrenched in homelessness and people with chronic physical and mental health issues, drug and alcohol related issues, or people at continued risk of domestic and	
Criteria	Signposts
Systems in place for coordinating the service response for individuals and families with complex needs	• Regular contact and robust collaborative arrangements with specialist support services • Establish approaches, such as those used in Assertive Outreach, to engage with program participants who are hard to reach • Mechanisms for establishing intensive, multidisciplinary teams, including establishing the roles and responsibilities of all agencies contributing to the support plan.
Expertise to deliver specialised models of care such as trauma	• Relevant staff training and resources to ensure staff are equipped to manage a range of challenging behaviours and complex situations

informed practice and narrative therapies to work with program participants impacted by mental health problems, drug and alcohol, DFV, and other complex issues	• Specific collaborative arrangements, and policies and procedures to ensure needs are identified and appropriate referrals are made • Having the knowledge base to identify complex needs and building an appropriate referral network.

6.2. Support activities

It is anticipated that the program will deliver a suite of support activities which may include, but is not limited to:

- coordinating entry into secure, safe accommodation aligned to the needs of individuals that is appropriately furnished to include sofa, bed/mattress, kitchen equipment
- assisting people to sustain tenancies through person-centred and trauma-informed risk management planning and positive engagement
- developing a support plan in consultation with the program participant to monitor current needs and identify and implement additional needs as required
- as part of each person's support plan, developing a pathway to long-term housing
- facilitating relationships and linkages with relevant mainstream health services to coordinate care planning and service delivery and help tenants manage their health needs
- working with people to develop a safety plan that identifies individual triggers and effective responses, and connect with relevant support networks and resources if required for additional support
- supporting people escaping domestic and family violence, and ensuring 24-hour access to emergency support is available
- encouraging engagement in the local community and identifying and developing new local networks to promote wellbeing, including support networks and diverse community engagement activities, and reducing the likelihood of their return to the street
- inviting family and other personal supports to participate in support planning and development as appropriate
- consult with individuals to identify and address previous tenancy issues if required
- collaborating with community housing partners, DCJ Housing Services and relevant supports to ensure necessary assistance is provided for people to successfully retain their new tenancy and avoid a return to homelessness
- working with people to identify priority skill development areas and local resources to enhance their daily living skills, including budgeting, shopping, food preparation and storage; assisting with income management and advocacy to social security and service providers
- supporting people to develop interpersonal skills for managing day-to-day relationships
- supporting people to identify vocational goals and skills, and seek suitable employment meeting the individual's requirements and interests
- facilitating linkages to structured support groups and services, including employment initiatives and groups promoting education, self-management and wellbeing
- encouraging and promoting engagement with diverse community engagement activities.

Please refer to Table 2 for the Together Home Program Model.

Table 2: Together Home Program Model

Support Phase 1: Introduction & Participation	**Support Phase 2: Increased Participation and Independent Management**	
0-12 months ⇨	12-18 months ⇨	18-24 months
Assessment: VI-SPDAT Application for Housing Assistance including the DCJ Independent Living Skills Assessment Together Home Living Skills assessment Personal Wellbeing Index – start and periodic surveys	**Assessment:** Personal Wellbeing Index - periodic surveys Together Home Living skills assessment	**Assessment**: Personal Wellbeing Index - periodic surveys and end survey at exit. Together Home Living skills assessment.
Goal setting: Person-led process identifying goals that will assist the program participant to maintain their tenancy and develop independent management. Commence regular support planning reviews.	**Goal setting:** Review of goals incorporated in regular support planning reviews.	**Goal setting:** Review of goals incorporated in regular support planning reviews and identifying specific post-exit goals for the program participant to address with ongoing supports and independently.
Planning: Development of a long term support plan, including long-term housing pathway. In line with the program participants goals. Commence delivery of support. Commence regular support planning reviews	**Reviewing**: Continue delivery of support. Regular, planned case-management reviews with program participant, adjusting support plans as needed.	**Evaluating**: Continue delivery of support. Continued support planning reviews with the program participant, adjusting support plans as needed. The anonymous Client Satisfaction survey (at the 18 month point and on program exit) to facilitate continuous program improvement and for the CHPs and support providers to reflect on the program.
Transition: Include exit-planning and identification of longer term support needs, in support planning.	**Transition**: Review exit-plans. Commence engagement with ongoing support providers as appropriate. Focus on securing long-term, sustainable housing for the program participant post program.	**Transition**: Commence handover with ongoing support providers as appropriate.
Supports:		**Goals:**

Introduction to and participation in understanding a tenancy agreement and their obligations as a tenant and tenancy support available	**Increased understanding** of responsibilities and maintaining a household.	**Independent** management of responsibilities as a tenant	Increase in overall wellbeing Increased independent living skills Decrease in contact with emergency services Decrease in hospital presentation Decrease in arrests and incarceration Decrease in return to homelessness Improved mental and physical health Stronger social connections Increased independence & empowerment Long term housing secured
Introduction to (i.e. developing strategies) and participation in income management	**Increased participation** in income management and decrease in support required	**Independent management** of income without support	
Introduction to and participation in mental health treatment	**Increased** symptom management and confidence in recovery	**Independent management** of symptoms and recovery	
Introduction to and participation in an NDIS assessment as required.	**Access to** additional support as identified through the NDIS assessment	**Independently** managing with or without support NDIS plan.	
Introduction to and participation in physical health treatment	**Increased** participation in health management and self-care	**Independent management** of health management and self-care	
Introduction to and participation in problematic substance use treatment	**Decreased** problematic substance use	**Independent management** of substance use	
Participation and compliance with any community based health treatment orders or other supports to stabilise mental health	**Continued engagement** with community based health treatment orders or other supports to stabilise mental health.	**Independent management** of mental health treatment	
Participation and compliance with any community based Justice orders; barriers to compliance addressed	**Continued compliance** or cessation of any community based Justice orders	**Independent management** of Justice obligations	
Introduction to independent living and psychosocial supports/ meaningful activities (i.e. cultural/community engagement; increased social or familial connection or reconnection; training or employment)	**Increased participation** in independent living and psychosocial supports/ meaningful activities (i.e. cultural/community engagement; increased social or familial connection or reconnection; training or employment)	**Independent management** of daily living and psychosocial supports/ meaningful activities (i.e. cultural/community engagement; increased social or familial connection or reconnection; training or employment)	

7. Program Implementation

7.1 Managing a client with a LIVE housing application on the NSW Housing Register

There may be instances where a person being assessed for the Together Home program has a LIVE housing application on the NSW Housing Register.

If there are concerns that this person may be offered social housing before the Together Home assessment is finalised by the Together Home Client Referral Assessment Group (CRAG), the application can be suspended.

When suspending an application pending a decision by the CRAG use the 'Together Home' suspension code in HOMES.

Once a decision is made by the CRAG, you must:

- un-suspend the application with no action (as the client is not eligible for Together Home), OR
- un-suspend the application and house the client in a Together Home property.

When housing a person in the Together Home program their status in HOMES will be changed to 'housed' using the Housed Other Housing Provider (HOHP) code.

7.2 Managing people who are ineligible or unsatisfactory former tenants

There may be some people that have their Application for Housing Assistance declined or suspended as they have previously been classified as an unsatisfactory former tenant or ineligible to be listed on the NSW Housing Register. This may be as a result of a history of property damage, rental arrears or criminal behaviour.

In many cases these classifications will be a barrier for people who are street sleeping to enter the Together Home program. Districts must consider on a case-by-case basis the contributing factors to the classification, and decide locally any 'out of guidelines' decisions to allow flexibility to support the person into the program.

7.3 Managing registrable persons

There may be instances where a Together Home provider is supporting a person in Temporary Accommodation; and the person has disclosed, or the provider becomes aware that the person may be a registrable person. A registrable person is someone who is on the NSW Child Protection Register convicted of sexual and/or violent offences against young people (under 18 years of age).

Some registrable persons living in the community have specific requirements identified by the NSW Police Force (NSWPF) and/or Corrective Services NSW (CSNSW), particularly in relation to the most appropriate location for them to reside. You can find more information regarding eligibility for housing assistance for a registrable person here.

Where a person has disclosed, or you have received information that a person may be a registrable person, refer to the *Process an application for housing assistance from a registrable person*. If you are

unsure on the approach to take with a potential program participant, please send any queries to Registercheck@facs.nsw.gov.au.

7.4 Supporting people with higher support needs

As many people who are experiencing homelessness also experience mental illness, the Together Home program will specifically allocate high needs packages to people with complex high needs, including severe mental health needs..

It is the intention that these people will receive intensive assistance, which may include support with:

- daily living skills like shopping, looking after finances, cooking or catching public transport
- remembering mental and physical health appointments, medications and other treatments
- meeting people in the local community and participating in social, leisure or sporting activities
- learning new skills
- accessing education or help to get a job
- moving from a hospital or a prison back to home
- accessing other supports like drug or alcohol services and the National Disability Insurance Scheme (NDIS).

The CHP will receive additional support funding to engage a service that can deliver this intensive support to the person. The CHP should also establish relationships with the Local Health District (LHD) should a referral to the local mental health team be required.

Program participants should be supported with a referral to the NDIS, if appropriate.

7.5 Administration of High Needs packages

Homelessness NSW will administer the High Needs packages for the Together Home program.

This will be done by:

- Informing and promoting awareness of the program
- Developing a fair and transparent criteria and application process in consultation with DCJ
- Overseeing the application process and providing information sessions and support to organisations in completing applications
- Establishing and supporting an independent High Needs Assessment Panel (HNAP) to assess and agree the recipients of the packages that include a Clinical Health expert, a Housing expert, an Aboriginal representative with expertise in homelessness, a representative with support expertise in homelessness and a representative from DCJ
- Supporting the liaison with the Community Housing Provider who will receive the funds and the support provider who will be delivering the support service
- Managing reallocation of packages and unspent funding from closed packages

The following parameters will form part of the allocation of High Needs Support packages:

- A cap on the number of inner-city applications to ensure that there is distribution across NSW
- Where possible, 30% of packages will be allocated to Aboriginal people referred to the High Needs Assessment panel

- Identification of support providers based on experience in supporting high needs people in this work and includes organisations with clearly demonstrated expertise in delivering culturally safe services to people who are Aboriginal
- That allocation of funding is made as flexibly as possible, to reflect current practice in the Housing and Accommodation Support Initiative (HASI) service delivery
- That a relationship is established with the NDIA to understand how these packages align with or support NDIS packages and that consideration is given to how the NDIS could be used for any applicants who may be unsuccessful

When a decision is made to allocate a High Needs Support package to a program participant, Homelessness NSW (HNSW) will authorise funding to be transferred to the CHP, to subcontract the high needs support component.

CHPs should report monthly on High Needs package expenditure via CHIMES. Reporting of High Needs Package expenditure is further outlined in the Together Home Program Reporting and Data Collections Document for Community Housing Providers. In the case of unspent HN Package funding from a closed package that has been issued to the CHP the CHP should advise the TH Project Team via the TH mailbox. The TH project team will advise the CHP in writing how to deal with these unspent funds (and where necessary consult with HNAP).

The support provider is responsible for updating the High Needs Assessment Panel on client progress and/or changes of circumstances, primarily through the 6-monthly review process, or on a needs basis. These reviews should include information on:

- Progress the client has made, including engagement with support funded through early High Needs Assessment Panel (HNAP) funding approvals
- Any ongoing or newly identified support needs, with a relevant funding request if needed
- NDIS package received and proposed transition to allow the High Needs Package (HNP) to be closed
- Other reasons for the HNP to be closed, including exit from TH program

To ensure the flexibility of the support funding is available under a HNP, a client can continue to access their full 2 years of HNP funding even if this is beyond the life of their THP tenancy. CHPs should be able to continue to provide or subcontract the high needs support component after the end of the THP tenancy.

Case by case decisions will be made by the HNAP to determine whether to keep a package open and/or transfer the support funding for a client who has a period of absence from the program. HNAP meetings may include discussion of relevant information provided by the CHP and support services (who may attend sessions if required). Any decisions will be documented.

HNSW should escalate issues relating to support provision to the TH Program team via the TH mailbox for consideration in a timely manner.

7.6. NDIS support and packages

CHPs and their support providers may work with people who have a disability and are eligible for the National Disability Insurance Scheme (NDIS). The NDIS provides all Australians under the age of 65 who have a permanent and significant disability with necessary supports.

CHPs and their support providers are encouraged to assist participants to access the NDIS, where appropriate. As part of program reporting requirements, CHPs and support providers will report on:

- The number of participants that have an NDIS plan
- The number of participants referred for assessment within 2 months.

For more information on program reporting and monitoring requirements, see Appendix 1.

Homelessness NSW has developed Practice Guidelines for NSW, in consultation with the NDIA and SHS providers. The guidelines include NSW case studies, as well as information on working with the NDIA and NDIS processes to support people accessing the NDIS. These Practice Guidelines are to be read in conjunction with NDIS material where possible for the most current information. For more information:

- How the NDIS works - https://www.ndis.gov.au/understanding/how-ndis-works
- NDIS Operational Guidelines - https://www.ndis.gov.au/about-us/operational-guidelines
- Practice Guidelines for Specialist Homelessness Services regarding their interface with the NDIS - https://www.homelessnessnsw.org.au/news/practice-guidelines-specialist-homelessness-services-shss-regarding-their-interface-national

When a participant commences receiving an NDIS package:

- If there are surplus Together Home support funds – the CHP should manage any unspent funds flexibly as per section 10.4 of this document.
- If there is a High Needs Package in place – you will need to inform the High Needs Assessment Panel to determine if these funds or degree of funds are still required. HNP support should be tailored to include support types not offered by NDIS and to support the client to successfully apply for NDIS support. Any support types that will be provided by the NDIS should taper off once the NDIS support is received to support the individual and NDIS service in this transition.

7.7. Managing rental bond requirements

It will be a requirement of the program that the CHP ensures the bond and advance rent for the property is paid to the landlord. The CHP should refer to their internal policy in order to recoup any funds outlaid for the bond and advance rent on behalf the program participant. Any repayment plan should be reasonable and not act as a deterrent for the person to enter the program.

7.8. Using capital supply to house program participants

There may be instances where the most suitable immediate housing option for a program participant is in a social housing dwelling managed by the Together Home provider, rather than in the private market. In these instances, a property must still be leased from the private market to ensure the provider is meeting the contracted housing component. The allocation of this lease may go to an

additional Together Home program participant, provided there are sufficient support funds available for this new tenant; or the lease could be provided to a priority approved applicant from the NSW Housing Register. This should be determined locally via the Client Referral Assessment Group (CRAG).

Participants housed in social housing are still considered a participant of the Together Home program and need to be treated as such for support planning, as well as monitoring and reporting purposes to DCJ.

The general costs of housing the client in capital stock (such as council rates, water, strata etc.) should be met through the use of the social housing rent paid by the client (including Commonwealth Rent Assistance (CRA)). Together Home funds should not be used for general costs. If required, Together Home tenancy funds or Rough Sleeper loading can be used for additional tenancy management costs (e.g. excessive tenant damage).

7.8.1. SEPP 5 Properties

Some CHPs may have access to SEPP 5 properties. Eligibility for SEPP 5 properties is guided by the State Environmental Planning Policy (Housing for Seniors or People with a Disability) 2004, formerly known as the State Environmental Planning Policy Number 5. In accordance with this policy, eligibility for SEPP 5 properties is limited to seniors or people living with a disability. This includes:

- People over 55 years of age.
- People who receive a disability support pension (regardless of age).
- Aboriginal and Torres Strait Islander people who are 45 years of age or over.
- People whose partner (married or de facto) is aged over 55 years or receives a disability support pension.

It is anticipated that some people who are accepted into the Together Home program will meet the eligibility criteria for SEPP5 housing, as outlined above. For others who do not meet this criteria, SEPP 5 accommodation is not appropriate.

7.8.2. Private rental market accessibility

Certain locations across NSW continue to experience record low private rental vacancy rates. DCJ recognises the challenges that CHPs operating in these housing markets face and aims to provide as much flexibility to support pathways into long-term housing as possible. In these instances please contact the DCJ contract manager to discuss options.

7.9. Use of brokerage funds

Support providers should use Together Home funding to allocate proportional and flexible brokerage funds to assist with home set up and other needs associated with improved wellbeing and sustaining the tenancy.

As a guide, up to 10% of a program participant’s support dollars could be used as brokerage.

Importantly, use of brokerage funding must be consistent with and supportive of goals outlined in the person’s support plan.

A Together Home program Brokerage policy, in line with other DCJ policies on use of brokerage funds, is provided at Appendix 2.

7.10. Re-engaging participants and managing early exits from the program

In line with Housing First principles, a person's tenure will not be impacted if they refuse supports during the program. In these circumstances, the CHP will continue to provide housing to the person and when appropriate, make efforts to reconnect the person with supports. The CHP will need to understand the person's reason for refusing support, which may include the need to source an alternative support worker.

Where a person is refusing support provided as part of the program, the support provider must demonstrate to the CHP their efforts to re-engage the person in supports. Frequency of effort to re-engage a person must be assessed on a case-by-case basis. The actions the support provider will take should be discussed with the participant as part of the case planning process.

Where a person is withdrawing from the program and leaving the housing, the CHP record the person's reasons for leaving the program, and where they are exiting to. CHP will also send the Client Satisfaction survey link to the participant, to be completed anonymously.

To ensure privacy and confidentiality are maintained, where clients have limited access to technology (e.g. phone or data) or low literacy levels, CHPs and SHS can assist the client to complete the 18 month and exit surveys online. This could include loaning an IPad or tablet with the survey and confirming if client would like to fill in the survey, and answering any questions if needed.

The results will be used for continuous program improvement and to assist CHPs and support providers to reflect on the program.

The CHP should inform the High Needs Assessment Panel (if applicable) when a client exits the program.

7.11. Exits into longer term housing

A key component of each person's support plan will be identifying housing options for the participant at the end of the two year period. This may include:

- The Together Home private rental being absorbed into the provider's CHLP portfolio, and the participant remaining in this accommodation
- Access to the provider's capital supply via a transfer
- Access to another community housing provider or public housing capital supply via a transfer
- Use of private rental products such as Rent Choice, where appropriate

The CHP will make available to the program participant a reasonable offers of long-term accommodation/private rental options while they are in the head-lease property during the 2 year lease period. The two offer policy will apply when allocating social housing.

As part of the program participant's support plan, the CHP and support provider will need to consider the program participant's support needs at the end of the program and how this is managed. For

example, the program participant may remain with an SHS provider as part of their contractual annual intake or be referred to other local support services based on the person's individual needs at the time.

The CRAG may be re-formed to plan the longer-term exit housing options for participants.

7.12. Managing clients evicted and potential evictions from Together Home properties

Where a client is at risk of eviction by a CHP or has been evicted by a landlord/real estate agent, all efforts should be taken to re-engage with and support the tenant to be re-housed and/or sustain the tenancy.

In both scenarios, actions should include:

- Early engagement between CHP and support provider to understand all issues impacting the tenancy and next steps to be taken prior to eviction.
- In the case of clients with a HN package, CHPs/support provider should engage with the High Needs Assessment Panel to assist with re-engaging the client. This can include applying for additional HNP funding for ongoing, increased or newly identified support needs through a regular or urgent review of the package

CHPs can discuss issues with the CRAG (if required) or suggest that the client be transitioned to a different support worker or support provider if this is beneficial to the client sustaining the tenancy.

Support providers can raise concerns about at-risk tenancies with the CHP in the first instance, the CRAG (if further information/suggestions are required), and Homelessness NSW, if required.

If the CHP decides to disengage from the client completely:

- the CRAG should be notified when this has occurred, and
- Homelessness NSW should be informed if the client has a High Needs package.

See clauses 7.4 and 7.5 for further information on the role of the High Needs Assessment Panel.

7.13 Client satisfaction survey

The Client Satisfaction Survey will provide important information on clients' experience of the Together Home Program and enable DCJ and participating CHPs and support providers to make appropriate ongoing adjustments to improve the Program.

CHPs are required to ensure that exiting clients have the opportunity to complete the survey. CHPs are to stress that completion of the Survey is voluntary and that all feedback is to be held in confidence.

The Survey will be administered via Survey Monkey and respondents will remain anonymous. The Survey Monkey link is to be provided to respondents by CHPs at the 18 month point and during the exit process and clients should be encouraged to complete the voluntary survey. The surveys can be found through the following links:

- 18 month client satisfaction survey - https://www.surveymonkey.com/r/SX29TMK
- Exit client satisfaction survey - https://www.surveymonkey.com/r/JTPPN9K

To ensure privacy and confidentiality are maintained for clients who do not have access to a phone it is requested that CHPs and SHS facilitate online completion of the 18 month and exit survey. For example, the CHP or SHS could loan an IPad or tablet to the client with the survey set up.

8. DCJ will collect responses and forward de-identified data to AHURI for analysis. This data will inform the Together Home Program evaluation. Delivery locations

The locations listed below relate to a service provider's delivery footprint. Any significant variation to the locations listed below needs to be considered in consultation with DCJ or the CHP in SHMT locations (or via the local governance group). There will also be the opportunity for flexibility with geographic boundaries to ensure appropriate service coverage and access to a larger pool of private rental accommodation.

It is essential that where there is a boundary overlap between providers that there is no competition between providers for rental accommodation. This will ensure that the program has no adverse effects on market value. It will be necessary to form relationships with other providers where this overlap exists.

DCJ District	Community Housing Provider	Primary Delivery Locations (LGAs)
South Western Sydney (SWS)	Argyle Community Housing Ltd	Campbelltown, Wingecarribee.
	Evolve Housing Limited	Liverpool/Fairfield (Not Cumberland or Canterbury/ Bankstown)
	Hume Community Housing Association Co Ltd	Liverpool/Fairfield Hunter
Murrumbidgee, Far West, Western NSW (MFWWNSW)	Argyle Community Housing Ltd	Murrumbidgee, Wagga Wagga
	Housing Plus	Bathurst, Cabonne, Dubbo
	Homes Out West (HOW)	Albury, Greater Hume
Northern NSW, Mid North Coast & New England (NNSWMNC & NE)	North Coast Community Housing Company Ltd (NCCH)	Lismore, Tweed, Byron, Clarence Valley
	Community Housing Limited (CHL)	Port Macquarie, Kempsey, Mid Coast
	Mission Australia Housing (MAH)	Coffs Harbour
	Homes North Community Housing Company Ltd	Tamworth, Armidale, Moree Plains
Hunter Central Coast (HCC)	Compass Housing Services Co Ltd	Newcastle, Lake Macquarie, Port Stephens, Maitland, Cessnock, Muswellbrook, Singleton, Upper Hunter, Dungog Aboriginal Together Home - Central Coast
	Pacific Link Housing Limited	Central Coast
	Hume Community Housing	Maitland, Port Stephens
	Bridge Housing Limited	Sydney, Randwick, Woollahra

Sydney, South Eastern Sydney, Northern Sydney (SSESNS)	Link Wentworth	Hornsby, Northern Beaches, Willoughby
	Metro Community Housing Co-operative Ltd	Sydney
	St George Community Housing Limited	Bayside, Georges River, Sutherland
	Women's Housing Company Ltd	Sydney and the broader SSESNS District as required.
Illawarra Shoalhaven. Southern NSW (ISSNSW)	The Illawarra Community Housing Trust Ltd	Wollongong, Shellharbour
	Southern Cross Community Housing Ltd	Shoalhaven, Eurobodalla, Bega
Western Sydney Nepean Blue Mountains (WSNBM)	Evolve Housing Limited	Parramatta, Penrith, Blacktown
	Link Wentworth	Penrith, Blacktown, Hawkesbury, Blue Mountains

9. Program Roles and Responsibilities

9.1 Roles and responsibilities matrix

The following roles and responsibilities cover program design, implementation and ongoing program management.

Role	Responsibility
DCJ Together Home Project Team	**Program design and implementation** • Lead program establishment including program design and implementation • Lead program communications including with CHPs, sector peaks and DCJ, through Implementation Progress Notes, Implementation Forum meetings and other consultation methods • Develop program-level documentation, including Program Guidelines, Reporting templates, Program logic • Coordination of all relevant program-level approvals • Program level risk assessment and management • Manage Program Evaluation **Governance** • Convene and provide secretariat for the Program Steering Committee • Escalate issues raised by the Program Delivery Group to the Steering Committee • Provide advice to the Minister, DCJ Executive and other senior stakeholders. **Contract management and program reporting** • Determine the resource implications for CHPs in managing the program • Lead contract management relationship with CHPs and allocations of funds as part of the CHLP, for the duration of the program • Approve subcontracting arrangements for support providers • Manage incoming fortnightly and quarterly reports through CHIMES, and input into Treasury and Ministerial reporting as required • Develop Quarterly Reports and dashboards **Systems and reporting** • Support CHPs and support providers with access to relevant systems such as CHIMES and CIMS Implementation/program issues escalation: TH Steering Committee
DCJ Housing	• Provide referrals to program where engaged with people street sleeping or people who have a history of street sleeping • Member of the Client Referral and Assessment Group (CRAG). Lead of group to be determined locally with DCJ Commissioning and Planning. • Participate in local governance to oversight implementation and delivery of the program • Along with CHPs, provides options for long-term housing pathways for program participants Implementation issues escalation: CRAG and/or PDG.
DCJ District – Commissioning and Planning	• Participate in program governance • Member of the Client Referral and Assessment Group (CRAG) – Lead of group to be determined locally with DCJ Housing.

	• Escalation of risks to program management, where appropriate • Escalation of issues that cannot be resolved at District-level • Lead variations to service design and planning at a District-level • Participate in local collaborative service planning with key stakeholders • Local stakeholder management • Relevant briefings to District Directors • Resolution of District-level issues within program parameters • District/local-level risk management Implementation issues escalation: CRAG and/or PDG.

Homelessness NSW	• Homelessness NSW will administer the High Needs packages for the Together Home program, by:
	  ○ Informing and promoting awareness of the program
	  ○ Developing a fair and transparent criteria and application process in consultation with DCJ
	  ○ Overseeing the application process and support organisations in completing applications
	  ○ Establishing and supporting an independent High Needs Assessment panel to make a range of decisions relevant to High Needs packages, including;
	  ▪ Assessment and approval of referrals and reviews of packages, as well as one-off funding decisions
	  ▪ Case by case decisions to determine whether to keep a package open and/or transfer the support funding for a client who has left the TH program permanently or has a period of absence from the program
	  ○ Supporting the liaison with the CHP who will receive the funds and the support provider who will be delivering the support service
	  ○ Managing reallocation of packages and unspent funding from closed packages
	
	Implementation issues escalation: TH Project Team

Community Housing Provider in Social Housing Management Transfer (SHMT) sites	• Provide referrals to program where engaged with people street sleeping or a history of street sleeping • Participate in local governance to oversight implementation and delivery of the program • Along with CHPs, provides options for long-term housing pathways for program participants • Lead Client Referral and Assessment Group (CRAG) Implementation issues escalation: PDG
Contracted Community Housing Provider (CHP) as part of Community Housing Leasing Program (CHLP)	• Identify and let appropriate head-lease • Maintain urgency in the response for the person • Participate in program governance • Participate in the CRAG • Tenancy management • Deliver an individualised package of support for the person • Establish and maintain a relationship with local health district for people with mental health issues, as required • As this is time limited program, identify alternative housing solutions in partnership with the person and support provider before the end of the program • Allocate funding to support provider for support planning and delivery of wraparound support • Manage sub-contract with support provider/s and ensure that appropriate and culturally safe support is delivered by qualified staff.

	• Work with the support provider/s to ensure that support expenditure is linked to support provided to engaged clients. In the case of High Needs Packages, CHPs should ensure that client is receiving approved support and that the High Needs Assessment Panel is informed of changes of circumstances. • Program reporting that include details and frequency as specified by DCJ • Provide referrals to program where engaged with people street sleeping or a history of street sleeping • Manage program funding as per these Guidelines, including flexible use of remaining funding after client exits etc. Implementation issues escalation: PDG
Contracted Support Provider	• Partnership with CHP in program delivery • Participate in program governance • Undertake assessment of the person's support needs • Participate in referral and exit assessment group • Provide referrals to program where engaged with people street sleeping or a history of street sleeping • Deliver individualised wraparound support and tenancy sustainment over approximately two years • Develop a support plan with the program participant to include long-term housing planning from commencement of support • As this is time limited program, identify alternative housing solutions in partnership with the program participant and the CHP before the end of the program • Referral to other supports as required • Maintain reporting requirements to the CHP • Data reporting in CIMS or equivalent data reporting system, which includes reporting to provide direct visibility on the progress for each program participant • Provide 6-monthly updates to the High Needs Assessment Panel (e.g. NDIS package has been approved, client disengaging from support, client requires different support to the approved support in their High Needs package etc.). • Establish and maintain a relationship with Local Health District for people with mental health issues as required Implementation issues escalation: CHP and/or PDG
Specialist homelessness service providers	• Provide referrals to program where engaged with people street sleeping or with a history of street sleeping

9.2 Issues management and escalation

Where there are issues relating to performance of a provider or operation of a decision making group, the following process should be followed.

Issues escalation categories:

- Issues in relation to CRAG operation, decision making or membership should be raised with the PDG in the first instance and then the DCJ TH Project team if the PDG cannot resolve the issue.
- Issues in relation to support provider performance should be raised with the CHP (as their contract manager) in the first instance and if not resolved, then this can be escalated to the Project team via the mailbox.

- Issues in relation to CHP performance should be raised with the DCJ TH Project team via the mailbox.
- Issues in relation to Homelessness NSW or High Needs Assessment Panel operation/performance should be raised with the DCJ TH Project team via the mailbox.
- Tenancy management issues raised by clients should be managed through CHP complaints policies, and support provision issues raised by clients should be raised with the support provider in the first instance and escalated to the CHP, if not resolved.
- Program level issues can be discussed at the PDG meetings and escalated to Program Steering Committee, if required
- Issues with PDG operation, decision making or membership (that are unable to be resolved locally) should be escalated to the DCJ TH Project team via the mailbox.

10. Program funding

In June 2020, the NSW Government committed $36.1m to establish the Together Home program. Tranche 1 to operate for two years from 1 July 2020 to 30 June 2022.

In November 2020, a further $29m was committed as part of the NSW 2020/21 Budget. Tranche 2 for operation from 1 July 2021 to 30 June 2023. A further $3.5m was repurposed from the NSW Homelessness Strategy to contribute to wraparound supports.

The 2021-22 NSW Budget (June) included $57 million over two years to expand the Together Home program by another 250 households. Tranche 3 includes funding towards 100 new dwellings for people who require long-term housing support at the end of the program.

The program will use the existing CHLP payment mechanism, with contracts varied to include funding for wraparound support.

Adequate funding is provided for a full two years of leasing, with staggered exits where some people may require continued support for a short period at the end of the lease.

Please refer to your Letter of Variation for more information on the funding split between the housing and support component.

10.1. Distribution model

DCJ will allocate funds to CHPs. CHPs will engage support providers in a sub-contracting or fee-for-service arrangement to deliver wraparound supports.

10.2. Payment mechanism

This program will use the a block funding approach using the existing CHLP payment mechanism, with contracts varied to include funding for wrap-around support.

10.3. Accountability

Accountability is in built in the *Community Housing Assistance Agreement - Community Housing Leasing Program.* The agreement has been developed in accordance with legislation, and in addition to all reporting requirements in the Common Terms and the Community Housing Providers (Adoption

of National Law) Act 2012 (NSW). The Provider must also provide the DCJ with the following reports in the format and within the time period specified:

- all reports in respect of the Project;
- all information reasonably requested by the DCJ including, but not limited to, information which will enable DCJ to determine whether the Provider is complying with the terms and conditions of this Agreement;
- all information required under the contract compliance and performance management framework/s and related documentation;
- all disclosures and all information required by DCJ to comply with its reporting or other obligations to the Minister, Parliament or Government Agencies; and
- access to, and copies of, all records relevant to the performance of the Provider's obligations under this Agreement.

10.4 Flexible use of funding

Unspent funds and Flexible use of unspent funding are outlined in the Letter of Variation (LOV) issued to CHPs from November 2021 (SUB21/229074).

The LOV indicates that funding should now be used for a defined number of months from when the client is accepted into Together Home (i.e. Program Duration by tranche as defined in the LOV). Previously funding was used within a fixed time period for all clients in a Tranche from the tranche start date.

CHP Responsibilities: The CHP is the decision maker for:

- Flexible use of unspent funding after client exits or early transition to long term/permanent housing
- Use of unspent support or tenancy funding due to a lower cost per client
- Use of unspent funding for a tranche that is nearing completion
- Examples of decisions that can be made include (and are not limited to):
    - Use of unspent funding to extend clients for a few months until they can be transferred to social housing (where remaining funding is not sufficient for a new client)
    - Use of unspent funds provision of extended or higher intensity support for clients in need
    - Swapping clients between tranches, as determined by varying levels of support needed
    - Use of combined unspent funding after a client exit/s to house another client

The CHP must ensure (to the best of their ability) that clients are not disadvantaged by any decisions and that each accepted client will get the necessary support and housing they require.

CHPs can use unspent funds flexibly as long as the considerations in the Letter of Variation issued from November 2021 and this document are met.

See Appendix 1 for reporting requirements in relation to Flexible use of funding.

The CHP may discuss flexible use of funding with the CRAG in the local area or the High Needs Assessment Panel (to align THP support with HNP support timelines etc.) if they choose.

11. Contracts

11.1 Contract variation

The *Community Housing Assistance Agreement - Community Housing Leasing Program* – Homelessness Housing contract will be amended specifically for this program to include:

- Support-side outputs and outcomes monitoring plus reporting framework
- Requirements for engaging support services (see 10.1)
- THP participant privacy and confidentiality
- High-level principles for local governance
- Overview of intake approach and referrals from DCJ
- Consultation approach with homelessness peaks, DCJ districts, and other potential service providers
- Agreed funding allocation with CHAP, including housing and support
- Agreed approach on supporting people with mental illness, as required

11.2 Requirements for engaging support providers

The *Community Housing Assistance Agreement* incorporating the Together Home program includes clauses about subcontracting. For the purpose of this Agreement, "subcontract" includes entering into a joint venture, partnership or agency relationship. CHPs may engage a support provider to provide wraparound support for those housed through the Program.

It is encouraged that support services are delivered via sub-contract with a support provider. If supports are delivered by the CHP they must be able to demonstrate there is a clear separation between tenancy and the support component, and the support component is delivered to the requirements noted in these guidelines.

Subcontracting clauses are applicable to CHPs engaging with a support provider to provide wrap-around support. Subcontracting is not applicable for the Property and Tenancy Management component, as this is the CHP's responsibility.

Subcontracted support services are expected to:

- Partner with CHP in program delivery
- Participate in program governance
- Undertake assessment, including use of the Personal Wellbeing Index (PWI)
- Participate in Client Referral and Assessment group (CRAG)
- Deliver wraparound person centred support and tenancy sustainment over approximately 2 years
- Refer the person to other supports as required
- Undertake data capture in CIMS or equivalent system as agreed to by DCJ
- Maintain reporting requirements to the CHP
- Maintain a relationship with local health district as required

Support providers engaged through this process must meet the following parameters:

- Have a track record of delivering outcomes for the target group (noting: the target group is people street sleeping).
- Have experience in providing trauma-informed casework support to people experiencing multiple, complex needs. This case work must include assessment of a person's vulnerability and suitability for the program and tenancy sustainment.
- Have an existing footprint in the delivery location
- Have the capacity to quickly implement the support service, with minimal lead in time, and ability use either existing staff or increase service capacity quickly.
- Experience and systems in place for delivering brokerage to support casework.
- Established partnerships in place

Also refer to the Support Provider Capability checklist (section 6).
For more guidance on subcontracting, please use the DCJ guidance and resources: www.facs.nsw.gov.au/providers/funded/resources/subcontracting.

These include:

- What is subcontracting?
- You have additional responsibilities and obligations when subcontracting
- What to do if you want to change agree subcontracting arrangements
- Support and assistance

DCJ may at any time require the CHP to immediately cease using any subcontractor on reasonable grounds by notice in writing to the Provider and the Provider agrees to comply with any such notice. This may include, but is not limited to, fraud, other illegal activity, inappropriate use of funds, significant and sustained performance issues, etc. This list should not be considered exhaustive.

11.3 Contract management

Contract managers will be engage with CHPs on a quarterly basis to discuss program implementation and performance against KPIs. Discussions about the Together Home program will become a subset of the existing Community Housing Leasing Program contract management discussions already in place.

The contract manager will be in regular contact with CHPs for reporting and to discuss any local operational issues concerning the contract.

12. Monitoring and reporting framework

The overall aim of the program is to provide stable accommodation and wrap-around support to people street sleeping during the COVID-19 pandemic, and to provide ongoing linkages with support services to reduce a program participant's return to homelessness.

CHPs are only to report on outcomes achieved for people who are supported as part of this program. It is acknowledged that CHPs house people who are street sleeping from the NSW Housing Register

in the delivery of their standard business, however these clients should not be included in the Together Home data reporting. This approach will ensure the fidelity of the data for the program.

The program seeks to achieve the following outcomes for people who are experiencing homelessness:

- Increased number of individuals are safely housed in long term/ permanent housing (including, but not limited to: social housing, community housing and private rental properties)
- Increased number of individuals successfully referred to health and wellbeing services
- Increased number of individuals are connected to supportive family, cultural or community networks
- Individuals have improved level of daily living skills necessary for long term accommodation and self-management
- Increased number of individuals are positively engaged with structured activities (i.e. support groups, education and employment).
- Individuals have improved subjective wellbeing.

A Monitoring and Reporting Framework for the Together Home program has been developed, and captures the high level objectives, linked outcomes, output and outcome indicators and the correlating key performance indicators (KPIs), as well as the reporting cycle and corresponding report templates for use by CHPs and support providers.

The Monitoring and Reporting Framework is provided at **Appendix 1,** and should be reviewed carefully to ensure a complete understanding of program requirements.

CHPs should note that DCJ will also provide further reporting detail and instructions via the Together Home Program Reporting and Data Collection Process Document for Community Housing Providers, which will be supplied directly to participating CHPs.

12.1 Record Keeping and Privacy and Confidentiality

The records of people who receive a service from a CHP or support provider fall within the parameters of the Health Records and Information Privacy Act 2002 (NSW), Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 (NSW), Part 13A of the Crimes (Domestic and Family Violence) Act 2007 (NSW), and the Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth).

For referrals into the program and for access to different supports, agencies are required to take reasonable steps to ensure people seeking assistance understand why their information will be shared and with whom, and to seek their consent for that. Information about consent should be provided in an appropriate format that can be understood by the person seeking assistance. Participants should also be provided with information about their rights and responsibilities, and support to exercise those rights.

The support provider must have documented systems and procedures for maintaining program participant records that also ensure personal and service-related information is recorded promptly and confidentially.

In circumstances where it is suspected a person is at risk of significant harm or domestic and family violence, providers must comply with relevant legislation, including:

- Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 that allows agencies who work with at risk children to exchange information related to their safety, welfare or well-being to facilitate better coordination of services
- Part 13A of the Crimes (Domestic and Family Violence) Act 2007 that allows sharing of victims' and perpetrators' information in specific circumstances. These are outlined in the Domestic Violence Information Sharing Protocol.

All providers need to understand their responsibilities and compliance requirements in line with Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 and Part 13A of the Crimes (Domestic and Family Violence) Act 2007. Providers should also ensure that participants have these legal obligations explained to them during entry to the program.

Further information can be found at:

- Privacy and Personal Information Act 1998 (NSW)
- Government Information (Public Access) Act 2009 (NSW)
- www.domesticviolence.justice.nsw.gov.au
- www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm

13. Governance Structure

Governance is critical for the implementation of the program and to escalate implementation issues.

Please note that there is a distinction between the below Governance groups and the referral groups into the program - the Client Referral Assessment Group (CRAG) and High Needs Assessment Panel. The Governance groups will work to understand implementation of these referral groups. See Figure 1 below.

Pre-existing governance structures/arrangements can be used where appropriate.

13.1. Program Management

The program management function within DCJ will be performed by Strategy, Policy and Commissioning (SPC). The Directorate will report into the DCJ Housing and Homelessness Steering Committee, which is chaired at Executive Director level.

As with other programs initiated in response to COVID-19, funding will be reported to NSW Treasury.

13.2. Program Steering Committee

DCJ will convene a Program Steering Committee to oversee all locations and ensure a continuous improvement approach to the delivery of the program.

This group will include, but is not limited to:

- Executive Director, Strategy, Policy and Commissioning (or nominated representative)
- Deputy Secretary, Southern HDDSEM (or nominate representative)
- Directors, Commissioning and Planning DCJ/Directors Housing
- CHP representative – Community Housing Industry Association (CHIA)
- ACHP representative – Aboriginal Community Housing Industry Association (ACHIA)

- Peak representative/s – Homelessness NSW
- NDIA representative – National Disability Insurance Agency (NDIA)
- Director, Community Housing
- Evaluation representative

This group will work collaboratively to resolve issues that may escalate from the local Program Delivery Groups, identify pathways into long term housing for the program participants that require it (e.g. social housing) as well as pathways towards independence (e.g. private rental).

13.3. Program Delivery Group

The structure of this group may look different across NSW, it should be developed for the local context.

Community Housing Providers are expected to participate in a quarterly Program Delivery Group. DCJ will convene and provide secretariat support for this group. Meetings will be held quarterly, or more frequently as required.

The group will focus on program implementation issues and aim to resolve these issues collaboratively. Issues which require further strategic input and consideration should be escalated to the Program Steering Committee.

Membership of the group should comprise the following, but is not limited to:

- A senior level representative from each Together Home Provider (CHP)
- A senior level representative from the SHS sector
- DCJ, Commissioning and Planning
- DCJ, Housing
- A local Aboriginal representative

Figure 1: Governance Structure

14. Program Evaluation

To understand the effectiveness of this approach to assisting people street sleeping, DCJ will undertake an evaluation supported by DCJ Strategy, Housing and Homelessness, as this program links to the Premier's Priority to end street sleeping by 2025.

The evaluation will review all tranches and will include process, outcome and economic evaluation components.

Deliverables include (and are not limited to):

- Evaluation Framework and Implementation Plan
- Baseline Evaluation Report
- Partial findings report
- Interim Report
- Final report

These deliverables will also include an evaluation of the Yerin Aboriginal led model, and a process evaluation of the Tranche 3 Transition Program (or new supply).

Evaluation findings from these components will be included in the interim and final report.

Appendix 1. Together Home Program Monitoring and Reporting Framework

1. Overview

A range of providers play an important role in the ongoing and collective effort of governments, NGOs and communities to address the complex problem of homelessness.

Although factors outside of the funded homelessness program may impact on achievement of the program's objectives, data must still be collected from providers awarded program funding to demonstrate the contribution of that service to the difference that the program is making to peoples' lives, and to support continuous improvement of the homelessness service system.

The CHP and support provider will be required to report quarterly on their performance against the THP Outcomes Framework. A reporting template will be provided to track outputs and outcomes relevant to the short, intermediate and long term stages of support, and identify sources of data and responsibility of reporting for each output and outcome (see Outcomes Report template - sample). The finalised Quarterly Outcomes Report template will be made available to providers shortly after program commencement, and is likely to be in an Excel format for ease of use.

1.1. CHP Program Reporting in CHIMES

The CHP will also be required to report against the following data more frequently:

- Number of people referred to the program
- Number of people accepted in the program
- Number of properties leased through the program
- Number of people with support provider in place
- Number of tenants with exits to stable housing
- Number of tenants with exit to unstable housing.
- Any identified roadblocks, issues, obstacles and successes.

This reporting is to fulfil accountability to NSW Treasury. Reporting will be on a weekly basis initially until December 2020 unless otherwise specified. The reporting may reduce in frequency as the program continues. CHPs will be able to enter this data via a newly developed tab in the Community Housing Information Management E-System (CHIMES) database.

1.2. CHP Financial Reporting in CHIMES

As well as the above housing and support related data, CHPs will be required to report on financial expenditure related to these areas. This information will also be able to be uploaded into CHIMES.

1.3. Support providers reporting requirements

Support providers will be required to maintain program participant records and report to the CHP using the Client Information Management System (CIMS) or equivalent data system / reporting program that will enable Australian Institute of Health and Welfare (AIHW) reporting.

Support providers are responsible for ensuring they can electronically collect and collate this required data. For providers that will not be using CIMS, they will need to establish contact with DCJ for further instructions on the minimum data set for reporting. Providers can request information about the software licenses that support this data collection, from DCJ.

2. Reporting cycle

Reporting will include but is not limited to:

Report name	Content of report / report requirements	Responsibility	Frequency of report	Form and method of delivery of report	Details of recipient
NSW Treasury reporting	• No. of properties leased • No. of people referred/accepted • Support provider in place • + and - exits	CHP	Weekly to end of December 2020, then fortnightly. Monthly from September 2021 Quarterly from May 2022	CHIMES THP data tab.	DCJ CH
CIMS Data Collection or equivalent	• BAU program participant data collection – support period information and status updates	Support Provider	Status updates end of each month	No external report. Status updates completed within CIMS or equivalent.	CIMS or equivalent
CHIMES Financial reporting	• Complete data collection related to expenditure	CHP	Monthly	CHIMES	DCJ CH
CHIMES Financial reporting	• Annual reconciliation of flexible use of THP funding	CHP	Annual	CHIMES	DCJ CH
CHIMES Data Collection	• Complete data collection related to tenant demographic information as required by CHLP.	CHP	Quarterly	Electronic submission	Per BAU
Program outcomes and outputs	• Report on the outcomes framework as relevant to the stage of support	CHP and Support Provider	Quarterly	• Update relevant CHIMES data. • Support providers using CIMS - complete Status Updates in CIMS. DCJ to extract information to Outcomes Report Template to upload to CHIMES. • Providers using non-CIMS systems - complete Outcomes Report	DCJ – Together Home mailbox/ CHIMES

				template and provide to CHIMES to upload. • CHP to approve final data as it appears in CHIMES. • Email manual data to DCJ.	

CHPs should ensure that the support providers also submit a quarterly report to the CHP on funds expended. The format for this reporting will be determined by agreement between the CHP and support provider.

Note: Quarterly reports on sustaining of tenancy and supports will be point in time, not linked to an individual person's date of entry. This is due to the expected majority of people coming in at roughly the same time. It would also create undue complexity of calculations linked to differing dates of entry. Data reports will contain the following disclaimer - It is important to note that the aggregated retention rate may include data for some people who have only recently been housed and thus does not necessarily represent one's ability to sustain a tenancy. If needed, this data could still be sourced on a person by person basis for evaluation purposes.

Annual reconciliation of flexible spending of THP funding will become part of the annual CHLP CHIMES reporting.

3. Together Home Program - Outcomes Framework

Key

R = Reportable KPIs

Objective	Outcome	Output	Outcome Indicator	Outcome KPI
1. Rapidly rehouse people who were street sleeping during the COVID-19 pandemic with a plan for long term housing	Increased number of individuals are safely housed in long term/ permanent housing (including social housing, community housing and private rental properties)	• Number of accepted referrals • Number of people housed. • Number of people housed within 4 weeks of referral. KPI = 80% of clients to be housed within 4 weeks of client referred and accepted into the program **R.** Remaining (20%) to be housed within 6 weeks of referral and acceptance into the program. • Number of people with a support provider support plan. • Number of people that have a long term housing plan **R**	Short term (0-12mths) • % of people that remain housed at 3, 6, 9, 12mths. • % of people that remain engaged with a support provider at 3, 6, 9, 12mths. Intermediate (12-18mths) • % of people that remain housed at 15, 18mths. • % of people that remain engaged with a support provider at 15, 18mths. Long term (18-24mths) • % of people that remain housed at 21, 24mths. • % of people that remain engaged with a support provider at 21, 24mths. • % of people street sleeping at entry, in stable housing at exit. **R**	• 100 % • 80 % • 80 % • 70 % • 70 % • 60 % • 60 % • 60 %
2. Provide access to culturally appropriate health, mental health and wellbeing services	Increased number of individuals successfully engage with health and wellbeing services	• Number of people with support plans that address health and wellbeing services for primary physical and/or mental health care and/or substance use support (if required) within 3 months. KPI = 80% of those who require this. • Number of people who have been referred for assessment for NDIS eligibility within 2mths (if required). KPI = 80% of those who require this.	Short term (0-12mths) • % of people that remain engaged with any health and wellbeing services at 6, 9, 12mths. Intermediate (12-18mths) • % of people that remain engaged with any health and wellbeing services at 15, 18mths. Long term (18-24mths) • % of people that remain engaged with any health and wellbeing services at 21, 24mths. • % of people requiring support with health and wellbeing services at entry, who have actively engaged with those services during support. **R**	• 70 % • 60 % • 50 % • 80 %
3. Rebuild family, community and cultural connections	Increased number of individuals are connected to supportive family, cultural or community networks	• Number of people with support plans that address connection to family, cultural and community networks, established within 3mths. KPI = 90% • Number of people who are supported to engage with family/cultural/community networks (if required).	Short term (0-12mths) • % of people that engage with family, cultural and community connection supports at 6, 9, 12mths. Intermediate (12-18mths) • % of people that remain engaged with family, cultural and community connection supports at 15, 18mths. Long term (18-24mths)	• 70 % • 60 %

Objective	Outcome	Output	Outcome Indicator	Outcome KPI
			• % of people that remain engaged with family, cultural and community connection supports at 21, 24mths. • % of people requiring support with family, cultural and community networks at entry, who engaged with supports to reconnect during support.	• 50 % • 80 %
4. Support the development of daily living and self-management skills including skills to sustain a tenancy	Individuals have improved level of daily living skills necessary for long term accommodation and self-management	• Number of people with positive tenancy exits. • Number of people with negative tenancy exits. • Number of people with support plans that address living skills and tenancy management (and/or income management, and/or legal or court support), established within 6mths. KPI = 100% **R** • Number of people with living skills assessment completed within 6mths. KPI = 100% **R** (as part of DCJ Application for Housing Assistance using the Independent Living Skills Assessment)	Short term (0-12mths) • % of people that remain engaged in living skills or tenancy management supports at 9, 12mths. • % of people with improved living skills assessment at 12mths (using the Together Home Living Skills Assessment compared to initial DCJ Application for Housing Assistance Independent Living Skills assessment)	• 80 % • 60 %
			Intermediate (12-18mths) • % of people that remain engaged in living skills or tenancy management supports at 15, 18mths. • % of people that maintain improvement in living skills at 15, 18mths (compared to initial assessment using the Together Home Living Skills Assessment)	• 70 % • 70 %
			Long term (18-24mths) • % of people that remain engaged in living skills or tenancy management supports at 21, 24mths. • % of people that maintain improvement in living skills at 21, 24mths (compared to initial assessment using the Together Home Living Skills Assessment)	• 60 % • 80 %
. Facilitate engagement with positive structured activities such as social groups, education and/or employment	Increased number of individuals are positively engaged with structured activities (i.e. support groups, education and employment).	• Number of people with support plans that address engagement with positive structured activities, established within 6mths. KPI = 80% **R** • Number of people who enter education/training or employment (can include ongoing voluntary work)	Short term (0-12mths) • % of people that engage with positive structured activities at 9, 12mths.	• 70 %
			Intermediate (12-18mths) • % of people that remain engaged with positive structured activities at 15, 18mths.	• 60 %
			Long term (18-24mths) • % of people that remain engaged in structured activities at 21, 24mths. • % of people with requiring support with positive structured activities at entry that have actively engaged with those activities during support. **R**	• 50 % • 70 %
Whole of Program Impact =	Individuals have improved personal wellbeing	• Number of people with completed PWI start survey. KPI = 80% **R** • Number of people with complete PWI data collection (start, periodic surveys, exit survey). KPI = 80% **R**	Short term (0-12mths) • % of people with **improved total wellbeing score** at 3mths (*compared to start survey total score) • % of people with an improved wellbeing score at 6, 9, 12mths (*compared to start survey total score)	• 70 % • 70 %

Objective	Outcome	Output	Outcome Indicator	Outcome KPI
		• Number or people that achieve (part or full) their support plan goals (only answered at end of support period)	Intermediate (12-18mths)	
			• % of people with **an improved total wellbeing score** at 15, 18mths (compared to start survey total score)	• 70%
			Long term (18-24mths)	
			• % of people with **an improved total wellbeing score** at 21, 24mths (*compared to start survey total score)	• 80%
			• % of people with **an improved total wellbeing at exit** (*compared to start survey total score) **R**	• 80 %

**The PWI is not expected to generate continual improvement. We do not anticipate or require continual improvement in PWI scores, however we anticipate an experience of improved wellbeing due to participation in the program. Therefore "Improved total wellbeing score" is always measured against the start survey.*

Quarterly Together Home Program Outcomes Reporting Template Sample				
Service Provider:				**Quarter:**
Objective	**Rapidly rehouse people who were street sleeping during the COVID-19 pandemic with a plan for long term housing**			
Outcome	Increased number of individuals are safely housed in long term/ permanent housing (including social housing, community housing and private rental properties)			
		Result		**Provider comment on outputs**
Output	Number of accepted referrals			
	Number of people housed			
	Number of people housed within X weeks of referral. KPI = X%			
	Number of people with a support provider support plan			
	Number of people who exit into long term housing*			
	Number of people who exit into unstable housing*			
Outcome Indicator	**Short term (0-12mths)**	KPI/**Result**		**Provider comment on outcomes**
	% of people s that remain housed at 3, 6, 9, 12mths.	X %		
	% of people that remain engaged with a support provider at 3, 6, 9, 12mths.	X %		
	Intermediate (12-18mths)			
	% of people that remain housed at 15, 18mths.	X %		
	% of people that remain engaged with a support provider at 15, 18mths.	X %		
	Long term (18-24mths)			
	% of people that remain housed at 21, 24mths.	X %		
	% of people that remain engaged with a support provider at 21, 24mths.	X %		
	% of people street sleeping at entry, in stable housing at exit.*	X %		
	= CHP data * = use PH codes for Termination & Where next housed			= SHS data

Appendix 2. Together Home Program (THP) Brokerage Policy

Brokerage can be an important tool for achieving positive housing outcomes for people in the THP program.

Brokerage assistance is managed at an individual provider level, and that Provider is responsible for record keeping and acquittal of any expenditure related to the brokerage assistance.

Brokerage assistance from THP funds can only be provided to a person who:

- Is currently accessing THP
- Has a current and formal written case-plan
- Is also receiving non-brokerage support from the provider.

Brokerage assistance can only be provided where:

- funds are used for goals directly related to sustaining housing and/or preventing homelessness
- Implementing the agreed case-plan actions requires particular goods and services which:
  - The program participant is unable to directly access
  - The service is unable to provide from other program resources
  - The service is unable to access from other services/agencies
  - And where the cost for the program participant of these good and services within the timeframe required is not affordable

Brokerage assistance is not available for:

- A goods or service that is provided free as part of a service or program the program participant is eligible for with another organisation or agency (e.g. Medicare bulk billing, DCJ rental housing assistance products, employment service supports, etc.)
- Rental arrears for social housing, which can be addressed through a payment plan
- Ongoing assistance with debts
- Personal debts repayable through a Work Development Order (WDO)
- Discretionary items not essential to achieving support plan goals.

Money is not to be issued directly as part of a brokerage or emergency assistance response. The provider must organise payment for goods or services directly with the relevant supplier.

All Providers should consider the following issues in determining their agency's brokerage policies, procedures and brokerage budgets:

- The target number of program participants to be supported over the contract period
- Mechanisms to equitably manage brokerage across the program participant portfolio through agency determined:
  - Limitations on the range of goods and services that may be supported
  - Assistance 'caps' with respect to each request or number or requests to assist in rationing funds

- The availability of goods and services in the local area which can be procured without the use of brokerage funding
- The availability of goods and services in the local area which have consistently required the use of brokerage funding to achieve sustainable program participant outcomes
- The capacity of individual program participants to repay part or all brokerage funding received.

It is a Together Home program requirement that providers keep records of all brokerage approvals, expenditure, and funds recoveries, including:

- Auditable documentation of the brokerage approval process, which includes:
- The identity of the worker who requisitioned the brokerage and the approver
- Identification of the program participant who received the brokerage
- The case-plan activity and goal being supported
- The goods or services to be purchased
- Support-plan records of the contribution brokerage expenditure made to achieving the relevant support plan goal
- Auditable records of purchase orders, invoices, receipts, remittance advices, credit card statements, or vouchers linked to each brokerage approval
- An itemised statement of all brokerage assistance received by an individual program participant is available for audit
- Auditable records of any brokerage expenditure recovered through repayments, refunds, re-sale of items purchased, etc.
- An itemised statement of overall brokerage expenditure or receipts in a financial year that can be reported as part of acquittal reporting through the DCJ Funded Contract Management Framework (FCMF).

Appendix 3. Aboriginal led model Central Coast District

An Aboriginal led model of the Together Home program is being delivered on the Central Coast in the DCJ Hunter Central Coast District. The program will operate for two years between 2020-2021 and 2021-2022, with an investment of $1.3m under the NSW Homelessness Strategy. Discussions are underway in relation to extending the Aboriginal led model for Tranche 3.

Target group

The Aboriginal Together Home program will deliver housing and support to Aboriginal and/or Torres Strait Islander people who are currently or have a history of street sleeping in the Central Coast LGA.

Procurement approach

The Hunter Central Coast District consulted with the Barang Regional Alliance, under the NSW Government Local Decision Making Accord process, on the design of the Aboriginal Together Home service model, and the commissioning approach, with the Alliance confirming their support.

The Barang Regional Alliance is a Local Decision Making body, established under the NSW Government's *OCHRE* strategy. Local Decision Making is underpinned by the principle of self-determination and aims to ensure that Aboriginal communities have a genuine voice in deciding what and how services are delivered to their communities. Local Decision Making places Aboriginal people at the centre of service design, planning and delivery.

Yerin Aboriginal Health Service (Yerin) has been engaged as the lead provider for the program, and will deliver the support component as part of a consortium with Gudjagan Ngara li-dhi Aboriginal Corporation (GNL) and Mingaletta Aboriginal Corporation (Mingaletta).

As part of this model, there is a requirement for Yerin to partner with a Community Housing Provider. Yerin will partner with Compass Housing to access properties from the private rental market.

Delivery and contracting model

Yerin deliver the program as the lead provider contracted with a Human Services Agreement with DCJ for the support component.

Yerin will partner with Compass Housing under an MOU for access to properties in the private rental market.

Compass Housing will deliver the housing component under a Letter of Variation to the CHLP with DCJ.