Government of **Western Australia**
Mental Health Commission

Individualised Community Living Strategy (ICLS) Program

Service Program Guidelines

August 2018

Contents

1. Purpose

These guidelines expand on the Mental Health Commission's (MHC) Individualised Community Living Policy and provide an outline of the processes of the Individualised Community Living Strategy (ICLS) service model. The MHC in collaboration with community managed organisations (CMOs) and the Health Service Providers (HSPs) have developed these service model guidelines with the intention of guiding CMOs in the parameters of the program, providing clarity to clinical teams on what the ICLS can provide and informing individuals, families and carers on what to expect if they receive support through the ICLS program.

2. Background

The ICLS was established in 2011 as one of the key initiatives the MHC identified to implement individualised support and funding as a contemporary approach for improving the appropriateness, accessibility and responsiveness, of mental health service delivery in Western Australia. The MHC's strategic policy, Mental Health 2020: Making it personal and everybody's business, and the Economic Audit Committee's Final Report, Putting the Public First (2009), clearly articulate the rationale for individualised support and funding, also known as self-directed supports and services, particularly the positive benefits and outcomes of this approach for individuals, their families and carers and the community as a whole.

The ICLS is an innovative and collaborative partnership approach between the HSPs, CMOs, Community Housing Organisations (CHO) and the Department of Communities – Housing (DoC-H) to provide clinical and psychosocial supports and services, in addition to appropriate housing[1] for individuals to maximise their success in recovery and living in the community.

3. What is ICLS

Purpose and Aim

The purpose of the ICLS is to provide coordinated clinical and psychosocial supports to assist eligible individuals' to achieve their recovery goals and live well in the community. Individuals accessing ICLS can expect to:

1. have an increasing ability to fully participate in their ongoing clinical and psychosocial support needs;
2. develop and sustain meaningful social connections and relationships;
3. participate and contribute to their community and relationships in personally meaningful ways;

[1] Individual packages of support exclusive of housing are also provided to individuals who already have appropriate housing but require additional support to live successfully in community.

4. have an increasing ability to participate in educational, vocational and/or employment activities;
5. develop their skills to self-manage their lifestyle and well-being;
6. demonstrate an increasing ability to maintain and sustain their housing tenancy; and
7. Improve their quality of life.

Individualised Supports

Individualised supports are the various paid and unpaid supports that are identified through a personalised planning process to meet the unique circumstances of individuals, and where relevant, their families and carers. Individualised supports can be created from a vast array of possible sources including personal networks, peers, community and generic supports and services within the mental health sector.

4. Accessing ICLS

4.1 Eligibility

To be eligible for support through the ICLS, individuals will:

4.1.1 have been diagnosed with a severe mental illness;

4.1.2 be an Australian citizen or permanent resident;

4.1.3 be aged 18 – 65 years (individuals under 18 may be considered for a package of support but are unable to access a house);

4.1.4 have agreed to fully participate in a recovery-oriented support initiative to work towards achieving personally identified aims;

4.1.5 be able to provide informed consent or have a formally appointed guardian to agree to share information and participate in all aspects of the program;

4.1.6 be ready and voluntarily want to live in their own home and be committed to engage in support from a mental health service and a community support organisation;

4.1.7 have the capacity to live independently with drop in supports (24/7 support is not available through the ICLS); and

4.1.8 agree to and participate in a range of mental health assessments to confirm eligibility and identify the level of support needed.

Individuals that apply to access a house through the ICLS will be subject to the *Interim Community Disability Housing Program Policy.* This policy outlines the eligibility requirements for access to housing; please refer to the link included in the relevant policies section of this document for further information. The key eligibility criteria for housing, in addition to the above, include that the individual:

- has a low income that matches income support eligibility of Centrelink;
- does not own or part-own property or land or have excess cash assets; and
- Has no outstanding arrears, debts or significant past evictions related to a previous tenancy with the DoC-H.

4.2 Target group

The target group includes individuals that have a range of complexities and challenges and there will be a mix of individuals requiring low, medium, high and very high levels of support. Individuals will have a severe mental illness (such as psychosis or affective disorders) and can only be nominated by a public mental health service Case Manager or Psychiatrist.

4.3 Entry to ICLS

A call for nominations will be sent out to the relevant area health service for individuals to be identified. If the vacancy includes accommodation, prior to interviewing prospective nominees, their details are sent to the MHC to check for DoC-H eligibility.

A panel will be formed by the relevant area health service to short list and review the mental health assessments, the nominee's clinical condition, risks and the level of support and care required to assist in the transition into their individualised accommodation. The panel consists of various stakeholder representatives including, but not limited to, the MHC, Peer Worker, an ICLS CMO and relevant clinical Mental Health Service representatives from North Metropolitan Area Health Service (NMAHS), South Metropolitan Area Health Service (SMAHS), East Metropolitan Area Health Service (EMAHS) and WA Country Area Health Service (WACHS). The panel will also prioritise the nominations based on a range of criteria including; readiness to transition, current living arrangements, willingness to engage in clinical/non-clinical supports and willingness to engage with CMO's. The panel will then recommend successful applicant(s) and the relevant area health representative will advise all applicants of the outcome of their application.

If successful the MHC will provide information to the Consumers of Mental Health WA (CoMHWA) Peer Coordinator who will support the individual to choose a CMO. Once this documentation has been completed, the MHC will inform the CMO that the individual wishes to access their services and to commence working with the individual to develop an individual funding plan, outlining the supports required (please refer to the section on planning for further information).

4.4 Privacy and Confidentiality

The privacy and confidentiality of consumer information is strictly upheld. All nominees into the ICLS are required to sign Consent to Share Information form prior to being accepted into the ICLS program. The CMO will have systems and processes that uphold individuals' rights to privacy and confidentiality, taking into account relevant privacy and other legislative requirements. The CMO will maintain written policies and procedures regarding confidentiality, privacy and consent to share information.

5. Roles and Responsibilities of all Stakeholders

5.1 Individual's Role and Responsibilities

It is the responsibility of the individual to:

5.1.2 respect their own health safety and welfare, and that of others;

5.1.3 engage with clinical and psychosocial supports (these should be flexible, tailored and regularly reviewed to ensure they meet the individual's changing needs);

5.1.4 be a good neighbour;

5.1.5 pay rent on time and look after the property;

5.1.6 not cause serious damage to the property or injure anyone;

5.1.7 advise the CHO when maintenance and repairs are needed; and

5.1.8 advise the CHO Manager when circumstances change, including:

5.1.8.1 income changes;
5.1.8.2 change in the number of people who regularly stay in the house; and
5.1.8.3 Other things that might affect the tenancy.

5.2 Family and Carer Role and Responsibilities

Family/Carers and support persons have the responsibility to:

5.2.1 respect the rights of the individual;

5.2.2 consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services to individuals; and

5.2.3 Engage, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation.

5.3 Community Managed Organisation (CMO) Role and Responsibilities

It is the responsibility of the CMO to:

5.3.1 respect the rights of individuals, families, carers and others;

5.3.2 work in collaboration with the individual, their family, carer's[2], community mental health team and other appropriate stakeholders in planning processes to identify their support needs and aims;

5.3.3 maintain overall management and coordination of supports and activities identified in the individual plan;

5.3.4 provide support to individuals to enable them to live independently in the community, including assisting individuals to comply with their tenancy obligations;

5.3.5 have a planned approach, strategies and safeguards for the person to manage their mental health;

5.3.6 develop and maintain formal and effective partnerships with specialist mental health services;

5.3.7 participate in joint problem solving, at an individual and/or program level;

5.3.8 utilise existing available community based services and add additional value through supports and services provided or brokered through their own organisation;

5.3.9 advise the CHO and the MHC of any changes to the individual that may affect their tenancy or support funding arrangements;

5.3.10 work in partnership with the CHOs to assist the individual in maintaining their tenancy;

5.3.11 meet the MHC Quality Management Framework requirements (as outlined in the Information for CMOs on the Quality Management Framework);

5.3.12 Investigate all complaints in accordance with the CMOs established complaints management policy; and

5.3.13 Develop and maintain effective partnerships with other relevant community services for example, Alcohol and Drug services, Aboriginal mental health services, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Allied (LGBTIQA) services etc.

[2] The involvement of family and carers should be encouraged; the individual has the right to refuse the involvement of family. Where a person is recognised as a carer under the Carers Recognition Act 2010, the following applies:

- The role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and the role of carers.
- The views and needs of carers must be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers.
- Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

5.4 Community Housing Organisation (CHO) Role and Responsibilities

It is the responsibility of the CHO to:

5.4.1 respect the rights of individuals, families, carers and others;

5.4.2 manage the property and tenancy, including undertaking maintenance and collecting rent, in accordance with the Residential Tenancies Act;

5.4.3 comply with contractual agreements with the Department of Communities - Housing; and

5.4.4 Maintain effective working relationships with the CMO.

5.5 Health Service Providers (HSP) Role and Responsibilities

It is the responsibility of the HSP to:

5.5.1 respect the rights of individuals, families, carers and others;

5.5.2 provide assertive clinical supports for each individual that is tailored to their individual needs;

5.5.3 allocate each individual to a dedicated clinical case manager. The clinical case manager is responsible for the referral and management of the client (where relevant), input into an individual's funding plan and will be point of contact for the MHC and the CMO for the individual's clinical care;

5.5.4 the Area Health Manager (or delegated authority), is responsible for convening and managing nomination panels for new ICLS referrals with the inclusion of the MHC. The purpose of the panel is to determine the suitability of individuals referred to the program in a timely manner;

5.5.5 participate in joint problem solving, at an individual and/or program level;

5.5.6 work collaboratively with the individual, family, carer, CHO's and CMOs to develop supports and plans to enhance and maintain each individual's health and wellbeing;

5.5.6 consult and collaborate with CMOs personnel in the support of individuals;

5.5.7 manage the provision of agreed clinical services in a timely manner;

5.5.8 participate in reviews and evaluations as agreed by both parties;

5.5.9 inform the MHC of critical program issues in a timely manner;

5.5.10 Ensure a case manager or single point of contact is available and has a replacement, which is familiar with the individual if on leave or away and to ensure the CMO is made aware of any changes to the individual's primary clinical contact. This is to enable CMOs to easily make contact as appropriate in relation to individuals they are supporting;

5.5.11 Following regular review and assessment, the HSP is required to advise the MHC of any individual no longer considered clinically appropriate to remain within the ICLS program, and therefore recommending they be withdrawn; and

5.5.12 In consultation with the CMO and other appropriate stakeholders, explore and secure alternative accommodation, should they recommend or support an individual's withdrawal from the program.

5.6 Department of Communities - Housing Role and Responsibilities

It is the responsibility of the DoC-H to:

5.6.1 receive and manage applications for all new Community Disability Housing Program (CDHP) housing;

5.6.2 assess eligibility for CDHP and liaise with the MHC regarding the individual's housing requirements;

5.6.3 construct or purchase housing for lease to CHOs through the CDHP;

5.6.4 identify and contract manage a suitable CHO; and

5.6.5 Lead the implementation and improvement of the CDHP.

5.7 Mental Health Commission Role and Responsibilities

It is the responsibility of the MHC to:

5.7.1 respect the rights of individuals, families, carers and others;

5.7.2 allocate support packages and housing (based on recommendations from DoH) within program parameters in a timely manner;

5.7.3 contract management of CMOs including negotiating, reviewing, supporting, monitoring and evaluating service agreements in line with outcomes and outputs;

5.7.4 review and approval of individual funding plans;

5.7.5 provide overarching administration of the ICLS, including maintenance of a database of individuals accessing ICLS, State and Commonwealth reporting, the release of funding to CMOs and DoH, etc.;

5.7.6 support service delivery through the provision of policy, guidelines, templates and other resources for the ICLS in collaboration with relevant stakeholders;

5.7.7 maintain effective communication and working relationships with CMOs, DoH and DoC-H, including the facilitation and participation in forums to enhance service delivery and continuous improvement of the ICLS; and

5.7.8 Identify and provide training and development opportunities for CMOs providing ICLS supports.

6. Service Delivery Guidelines

6.1 Recovery Oriented Mental Health Service Provision

The term recovery oriented practice is widely recognised as a core concept that underpins contemporary mental health service delivery. The focus of recovery oriented practice is that support is individualised and centred on the aims of the person and the role of stakeholders is to support a person's recovery journey. The Commonwealth Government's *National Framework for Recovery-oriented Mental Health Services – Guide for Practitioners and Providers* and *The Principles of Recovery Oriented Mental Health Practice* provide guidance to CMOs on the way that mental health services can encapsulate recovery based mental health care and support.

The principles of mental health recovery practice are:

6.1.1 uniqueness of the individual – service providers acknowledge that recovery is a personal journey and is about living a meaningful life with or without the symptoms of mental illness;

6.1.2 real choices – service providers recognise that in order for a person to exercise 'real choice' they are supported to creatively explore choices to enable them to define their recovery goals ;

6.1.3 attitudes and rights – service providers promote an individual's legal, citizen and human rights; this includes commitment to supporting a person;

6.1.4 dignity and respect – service providers treat individuals with compassion and respect regardless of presenting behaviour, and are culturally sensitive at all times;

6.1.5 partnership and communication – service providers believe in a person's recovery and work in partnership with them and their support network to help them realise their hopes, goals and aspirations; and

6.1.6 Evaluating recovery – service providers support individuals to track their own progress and use consumer and carer feedback to inform quality improvement activities.

6.2 Culturally Appropriate Practice

All stakeholders are expected to adopt cultural sensitivity and cultural awareness in all service delivery and should apply non-discriminatory entry criteria with respect to gender, sexual preference/orientation, race, culture, religion and disability.

Service provision and individual recovery plans should appropriately respond to the individual's cultural background and preferences.

6.3 Individualised Planning

In order to access funding and supports through ICLS the following planning process and approval of individualised funding plans needs to occur, please also see **Appendix B** for further clarification:

6.3.1 Prior to any service commencing, the CMO should go through a planning process with the individual and any other relevant parties[3] (the planning process used should be based on person centred planning principles, but can be any tool the CMO chooses). This planning process should continue to be built on and reviewed over time as the CMO develops their relationship with the individual;

6.3.2 The information gathered through the organisations planning process can then be used to populate the relevant areas in the ICLS individual funding plan which is then submitted to the MHC;

6.3.3 The individual funding plan will be reviewed by the MHC to ensure that the support strategies and safeguards are appropriate and that funding requested is within the individual's allocated bandwidth and meets the funding parameters below;

6.3.4 Following approval of the individual funding plan by the MHC's delegated authority, an engagement form will be utilised to modify an existing service agreement with the approved service provider and funding released through a Recipient Created Tax Invoice (RCTI);

6.3.5 If the individual funding plan is not approved, the CMO in conjunction with the individual and any other relevant parties can revise the plan based on the recommendations/feedback received and resubmit the plan to the MHC;

6.3.6 Once an individual funding plan has been approved, CMOs will be required to review plans informally throughout the year and formally at the end of the year against the identified individual outcomes in partnership with the individual and any other relevant parties; and

6.3.7 The information gathered through these reviews can then inform the next year's individual funding plan, to be submitted to the MHC for approval and funding allocation[4]. The steps outlined above for the MHC review and approval process will then occur for the renewed individual funding plan.

6.4 Funding parameters

Funding provided to support individuals who are participating in the ICLS is intended to be flexible to optimise the individuals' opportunity to live successfully in the community of their choice. This is in line with the intentions of the State Government's *Delivering Community Services in Partnership Policy* and the operational guidelines of the National Disability Insurance Scheme.

[3] Relevant parties that may be involved are the individual's family/carers, guardian, treating clinical team and/or community clinical team.

[4] Funding requested through the individual funding plan should be reflective of the individual's current support needs and may be reduced in line with their support needs (refer to Duration and Level of Support for further details).

The ICLS funds reasonable and necessary supports that help an individual reach their recovery goals and aspirations. Funding provided through this initiative must purchase supports that are clearly linked to the achievement of outcomes related to the personal support needs identified in the individual's plan (please also see **Appendix B** for further clarification) these may include:

6.4.1 supporting the individual to build their capacity and skills to live independently (including budgeting and tenancy management skills);

6.4.2 supporting an individual with opportunities to develop social relationships and to engage in active community participation; and

6.4.3 supporting the individual to build on their skills to further their opportunities to participate in educational/vocational and/or volunteer work or employment.

There are circumstances where supports will not be funded through this initiative. A support will not be funded if it:

6.4.4 is not related to the individuals mental illness and recovery goals as documented in their individual funding plan;

6.4.5 duplicates other supports already funded by another government department or agency;

6.4.6 relates to day-to-day living costs that are not related to an individual's support needs (for example, rent and other household bills);

6.4.7 relates to the provision of services for daily personal self-care;

6.4.8 relates to the provision of services for ensuring medication compliance, particularly if an individual is on a community treatment order;

6.4.9 is likely to cause harm to the individual or pose a risk to others;

6.4.10 is for illegal activities or gambling; or

6.4.11 Is considered income supplement for the individual, family members or carers.

It is recognised that individuals may wish to change some of the outcomes and activities stipulated in their individual funding plan. Stakeholders are encouraged to work flexibly with individuals to meet their changing needs working within the above parameters. It is expected that the CMO or HSP will contact the MHC for advice only when significant changes to an individual's plan is warranted.

6.5 Duration and Level of Support

The duration and level of support an individual receives will be different for everyone based on their individual needs. The intention of the ICLS is to be as flexible as a possible to support these changes as and when they occur by working in partnership with the individual and their family/carer (as appropriate).

For example, individuals may have a reduction in support needs due to successful recovery and transition into community life. This should be discussed with the service provider when reviewing their individual funding plan so that a reduced level of support reflective of the individual's needs is outlined in the revised individual funding plan. Reducing the level of support provided can occur at any time based on the individual's needs. The CMO will report to the MHC on these changes to support at the end of the current plan.

Alternatively individuals may experience increased support needs that require a more intensive level of support than is within the provision of the current funding allocation. If this occurs it is essential that the MHC is notified as soon as practicable so they can work in partnership with the service provider to determine the best solution for all parties involved. If the circumstances warrant an increase in supports and funding to meet the individual's changed needs, there will be a requirement for the involvement of the treating clinical team and the MHC approval of an interim or revised support plan. The MHC will not back date any increased funding levels without prior notification and agreement of the individual's changed circumstances.

Where an individual refuses support (clinical and/or CMO supports) that is offered through the ICLS, but clearly requires some form of assistance to live independently in the community, the MHC will work with both the clinical treating team and the CMO to review the individuals needs and their suitability for ongoing access to the ICLS program.

6.6 Accommodation and Tenancy

Having a stable form of accommodation is widely recognised as one of the most significant factors in achieving recovery for a person with mental health difficulties. Safe, secure, stable housing helps people keep in touch with family and friends and form new relationships with neighbours and local communities. It provides a basis for other areas of a person's life to fall into place, such as getting back to work, finding a new job, or taking up sport, education and other activities.

Individuals that access housing through the ICLS program are required to meet all relevant DoC-H policies and guidelines (please refer to the references at the end of this document for links to the relevant policies and guidelines) in addition to the terms and conditions set out in the lease agreement between the individual and the CHO.

The DoC-H reserves the right to refuse assistance to any applicant with substantiated breaches of their tenancy agreement or the *Residential Tenancies Act, 1987*. This means the MHC may not be able to offer an alternative house for individuals whose tenancy is terminated.

Additionally, due to the limited number of houses available and the high demand for housing, alternative properties are unlikely to be available. The responsibilities of individuals accessing a house through the ICLS are described in the responsibilities section. Ongoing engagement with supports provided through the CMO and clinical treating team is important to assist with understanding and meeting these responsibilities.

6.7 Housemates and Live in Supports

The MHC recognises the potential benefits a supportive housemate may provide for some individuals experiencing severe and persistent mental illness, living independently in the community.

A supportive housemate can assertively assist individuals to develop independent living skills, maintain their tenancy and develop community connectedness. For some individuals, having a supportive housemate may reduce (though not necessarily replace) the necessity of more formal supports.

Where appropriate, ICLS funds may be used to assist the implementation of a supportive housemate model and CMO's are asked to discuss individual proposals with the MHC ICLS team prior to submission of a formal funding request (if there is a guardian involved with an individual, the guardian would need to be involved in this process).

Though the individual circumstances will govern the specific model employed, the following aims to provide service providers with information about some of the logistics in implementing a supportive housemate model.

6.8 Clarifying the role of a supportive housemate

The CMO should assist the individual and their supporters to identify the specific types of support they require from a housemate. Clarifying the proposed role of the housemate along with the desirable competencies and qualities of an ideal candidate will assist the individual to develop a set of selection criteria.

6.8.1 Selection of a housemate

There are numerous avenues for sourcing potential housemates. Current ICLS individuals have found supportive housemates via online community classified websites; through posting *housemates wanted* notices on community billboards in public locations and via recommendations from friends, family members or other contacts. In some instances an individual has invited an existing friend to take on the role of supportive housemate. The CMOs are encouraged to work closely with the individual to implement staged interview processes with potential housemates. Typically this may include phone interviews and initial face to face meetings in the community, prior to inviting potential candidates to view the property. A supportive housemate should be subject to a successful police clearance along with any other formal requirements of the CHO.

6.8.2 Supporting the co-tenancy

Following the selection of an appropriate housemate, individuals may require assistance to work with the supportive housemate to establish house rules, in which roles and responsibilities, grievance processes and so on are clearly outlined and formally agreed to by all parties (with input from CMO and CHO). In some existing co-tenancy arrangements, a regular house-meeting is convened on a weekly or

fortnightly basis. Depending on the specific situation, the CMO may participate in these meetings.

6.8.3 Rent

The supportive housemate will be subject to standard tenancy requirements as outlined in the *WA Residential Tenancy Act, 1987*. This includes the payment of rent. The MHC encourages service providers to discuss the proposed logistics of a particular housemate model with both the allocated CHO managing the tenancy and with the MHC, prior to implementation.

6.8.4 Lease

The specifics of the supportive housemate's lease will need to be determined prior to the commencement of tenancy, in line with the *WA Residential Tenancy Act, 1987* and subject to approval of the CHO. The CMO's and individuals are encouraged to be cognisant of the various rights, responsibilities and legal ramifications of tenancy contracting arrangements such as sub-letting prior to implementing a supportive housemate model.

6.9 Safeguarding

Safeguards are precautions and measures that are put in place to ensure an individual has the best possible chance of succeeding in their recovery. Safeguards may protect a person from exploitation and harm, and foreseeable unintended events. Importantly, safeguards should enhance and protect a person's human rights, and enable a person to make choices and decisions, take considered risks, and live a life as an active and equal citizen in the community.

The identification and establishment of appropriate safeguards is viewed as a fundamental component of person centred planning and practice. When safeguards are understood in this way, there is a need to develop an appreciation of what safeguards are, and how they can be implemented to have maximum positive impact on the lives of individuals.

One perspective in looking at safeguards is to consider the extent of 'citizen capital' that each person has in order to identify areas of strength, possible areas of vulnerability, potential threats and hazards, and level of risk.

This concept provides a way of understanding the range of resources that everyone needs in their lives to enable them to live safely and well in their communities. The key aspects of citizen capital are:

6.9.1 personal capital (who I am) – for example a person's ability to assert themselves, their resilience, self-esteem and a person's key roles

6.9.2 knowledge capital (what I know) – for example, a person's skills, knowledge, education experiences

6.9.3 social capital (who I know and who knows me) – for example a person's relationships and connections, membership to groups, sources of support, informal and formal advocates

6.9.4 Material capital (what I have) – a person's income and investments, employment/occupation, safe and stable home and other community resources that a person can readily access.

Organisations are expected to utilise a holistic approach to developing multiple safeguarding strategies to support an individual to succeed in their recovery on their own terms.

Further information on the safeguards and citizen capital can be located in the MHC Safeguards Framework for Individualised Support and Funding document which is available on the MHC website. For examples of safeguarding in practice please refer to Appendix A of this document.

6.10 Grievances and Complaints

The MHC is committed to purchasing high quality services for people with mental illness and recognises that complaints and feedback provide information to improve the quality of services.

CMOs should ensure that individuals supported through the ICLS are advised of their organisation's complaints procedure. Many complaints can be resolved quickly and effectively at a local level. Complaints should be dealt with in a confidential manner and will only be discussed with the people directly involved. Where a complaint cannot be satisfactorily resolved with the service provider the issue can be raised with the ICLS team or alternatively by contacting the Health and Disability Services Complaints Office (HaDSCO).

The service provider will document all complaints in accordance with the organisation's formal procedures.

In instances where individual advocacy support is required to assist an individual and their family or carer in resolving a complaint, information about services will be provided. These include Consumers of Mental Health WA (CoMHWA), Carers WA and Helping Minds (previously ARAFMI).

6.11 Portability of funding

Individuals choose their CMO and can transfer/move between CMOs subject to the following conditions:

6.11.1 A reasonable time[5] accessing a particular CMO is required before individuals change CMOs. This is to allow a plan to be established, developed and implemented effectively. The timeframe is negotiable based on the circumstances surrounding the request.

6.11.2 The negotiated timeframe is required prior to the implementation of a transfer. The timeframe must be mutually acceptable to all parties to ensure appropriate administration tasks have been undertaken and allow

[5] In most cases, a reasonable time is considered to be six months; however each case must be discussed with the MHC.

for a smooth transition with minimal disruption to the individual. The principle of choice for individuals is paramount and every effort will be made to accommodate an individual's choice and resolve any issues quickly.

6.11.3 Services transferred during the course of a year will involve a pro-rata transfer (or based on an acquittal of funds to date) of the allocated funding for that year and the full allocation thereafter, unless otherwise negotiated between the MHC and the CMO.

6.11.4 The MHC will formally notify the outgoing CMO via mail with a Variation to Contract letter when the individual has ceased accessing supports and fully transferred to the new provider.

6.11.5 The MHC will not incur additional recurrent costs as a result of individuals transferring between service providers.

6.11.6 Where services are being terminated by the CMO, three (3) months written notice is required to the MHC and to the individual(s) who is/are receiving the service, to enable appropriate transition arrangements.

6.11.7 The services of the CoMHWA Peer Coordinator can be accessed to support the individual to choose another CMO. This may include over the phone or face-to-face meetings with the prospective CMO's.

6.12 Exiting the ICLS program

Individuals will exit the ICLS for a variety of reasons including when the person:

6.12.1 achieves their recovery goals[6] and no longer requires support of the program in a planned and agreed upon manner[7];

6.12.2 no longer wishes to participate in the program;

6.12.3 has moved interstate or has left Australia for an indefinite period of time.

To ensure that the individual exiting the program transitions safely to alternative supports the individual's CMO and clinical treating team will liaise to develop an appropriate exit plan from the service.

The clinical treating team is required to formerly notify the MHC, in writing, that they support the individual's exit from the ICLS program

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[6] Should an individual's circumstances change and supports are needed to be reintroduced, this will be possible by contacting the MHC.

[7] The individual will be required to continue meeting the Department of Communities - Housing eligibility criteria i.e. low income level and not owing property, etc.

6.13 Withdrawal from the ICLS program

Individuals may be withdrawn from the ICLS for a variety of reasons including when the person:

6.13.1 no longer wishes to participate in the program;

6.13.2 has moved interstate or has left Australia for an indefinite period of time;

6.13.3 is admitted to inpatient care or alternative supported residence (e.g. rehabilitation centre), for an extended period of time;[8]

6.13.4 enters mainstream aged residential care;

6.13.5 has support needs which are outside the scope of the ICLS; or

6.13.6 Is incarcerated for an extended period of time.

An individual is exited/withdrawn from the ICLS program in consultation with all key stakeholders and based on the clinical team's recommendation. The clinical team must discuss this recommendation with the individual in consultation with other key stakeholders.

The clinical treating team is required to notify the MHC, in writing, that they recommend an individual is withdrawn from the ICLS program. Once this is received the MHC will send a formal letter of withdrawal to the individual with a CC to key stakeholders.

To ensure that the individual exiting the program transitions safely to alternative supports the individual's CMO and clinical treating team will liaise to develop an appropriate exit plan from the service. In consultation with the CMO and other appropriate stakeholders, the individual's clinical treating team is required to explore and secure alternative accommodation.

[8] This is in line with the Department of Communities-Housing Community Disability Housing Program policy, which includes all ICLS properties, that if individuals are in hospital or alternative supported accommodation for an extended period, their personal circumstances no longer align with the strategic intent of the program which is to support individuals to live independently in the community.

7. Relevant policies and strategies

The ICLS is guided by the following polices and strategies:

- Delivering Community Services in Partnership Policy, which applies to all Public Authorities that provide funding for, or purchase community services from, not for profit organisations
- National Standards for Mental Health Services 2010
- Australian Government 2013 *A National Framework for Recovery-Oriented Mental Health Services – Guide for Practitioners and Providers*
- Australian Government 2010 *Principles of Recovery Oriented Mental Health Practice*
- Australian Government *Carers Recognition Act 2010*
- Community Disability Housing Program Guidelines: http://www.dhw.wa.gov.au/HousingDocuments/CDHP_Guidelines.pdf
- Interim Community Disability Housing Program Policy: http://www.dhw.wa.gov.au/HousingDocuments/CDHP%20Policy.pdf

The following MHC documents also provide guidance:

- Mental Health 2020: Making It Personal and Everybody's Business
- The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
- Safeguards Framework for Individualised Support and Funding
- Notifiable Incident Reporting Policy
- Quality Assurance Framework

8. Glossary

This Glossary contains terms that are common to some of the related documents, such as the Individualised Support Policy Framework.

Carer: In line with the *Carers Recognition Act 2010*[9], a carer is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:
(a) Has a disability; or
(b) Has a medical condition (including a terminal or chronic
Illness); or
(c) Has a mental illness; or
(d) is frail and aged.

Community Managed Organisations (CMOs): This is another term that is used for non-government organisations.

Individualised funding and self-directed funding: Are both funding mechanisms that promote person-centred approaches where the funding is based on the support needs and identified solutions for individuals, families and carers. It is based on the principle that individuals and families are best placed to determine their own needs and solutions to those needs, and therefore have control over the purchasing of services and supports that they require. In some self-directed models, the funding is provided directly to the person with a mental health problem and/or mental illness or his or her family.

Individualised supports: Are the supports that have been identified to meeting the support needs and solutions of individuals with mental health problems and/or mental illness, and their families and carers. Individualised supports include paid supports, as well as freely given supports through organisations and members of the community.

Mental health services[10]: Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

Mental illness[11]: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness

[9] The explanation of the word 'carer' is adapted from Section 5 of the Act.
[10] Department of Health and Ageing, *Fourth National Mental Health Plan*, Australia
[11] Australian Government, National Standards for Mental Health Services 2010, p.42.

is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

The **person-centred approach:** Puts individuals with mental health problems and/or mental illness at the centre of planning and decision making on how they would like to see their lives unfold. Supports and services provided to individuals are based on their unique wishes, interests, strengths, goals and needs.

Person-centred approach to planning: Is planning that is tailored to the unique circumstances of each person with a mental health problem and/or mental illness and distinguishes between what is important "to the person" as well as "for the person".

Personalised Plan: Refers to the individual support plan completed by the CMO in conjunction with the individual and any other related parties, which will be submitted to the MHC and reviewed by an Independent Panel.

Recovery: Gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self[12].

Safeguards: Are individualised precautions and safety measures that are put in place to protect the person with a mental health condition from exploitation and harm, and provide protection against foreseeable unintended events, while at the same time enabling the person to make choices, take considered risks and live a life that reflects their personal preferences. An important safeguard is the building and supporting of relationships in a person's life as this increases the number of people who care about the safety and wellbeing of the person.

Service Agreement (for Panel of Preferred Service Providers): The Service Agreement comprises:

(i) General Provisions for the Purchase of Community Services by Government Agencies – 2008 Edition (superseded by the General Provisions for the Purchase of Community Services by Public Authorities – February 2012 Edition);

(ii) Request for Individualised Community Living Strategy;

(iii) Response Form; and

(iv) Acceptance of Offer.

Social Inclusion: Is a sense of belonging, sharing responsibility, contributing, having one's differences respected, and being seen to be of value regardless of one's circumstance. Social inclusion also refers to policies and practices which lead to the experience of being socially included for people who may otherwise be excluded because of disability, mental illness or disadvantage.

[12] Australian Government, National Standards for Mental Health Services 2010, p.42.

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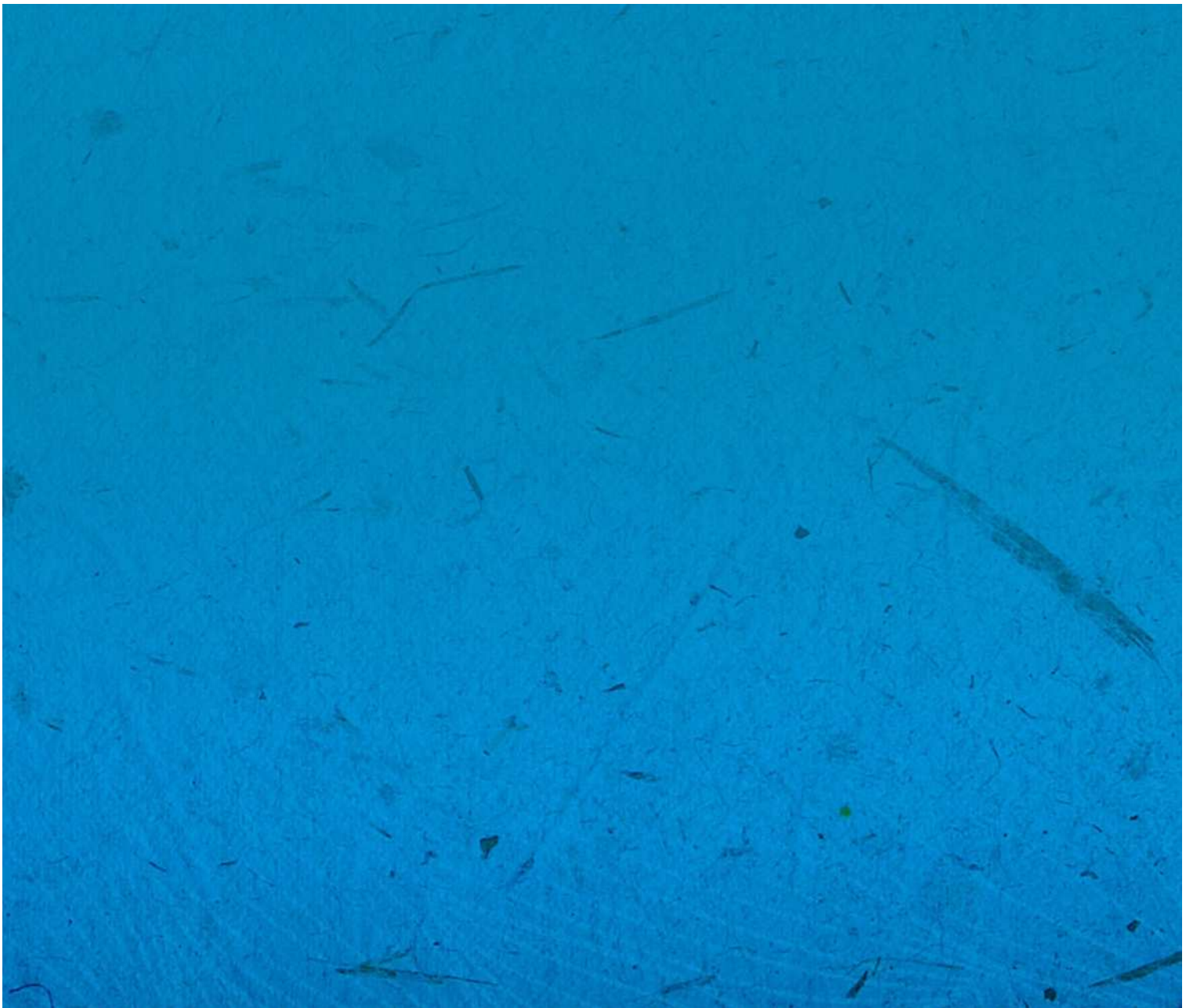
Individualised Community Living Strategy (ICLS) - Appendices



Safeguarding differs from risk management in that it is highly individualised and tailored to an individual's specific support needs. Inherent in safeguarding principles are the concepts of formal and informal supports. Safeguarding works best when it is within a partnership framework and involves contingencies of both a formal and informal nature.

Informal safeguards include: relationships with family, friends, personal networks and wider members of the community. These relationships and connections often need to be intentionally developed, as some people have become socially isolated over time, and have lost these natural connections.

Comprehensive safeguarding involves conceptualising, planning and action to ensure situations of risk are addressed from multiple angles by multiple stakeholders with an individual's unique circumstances and narrative at the forefront.

Example A

John lives alone in a two bedroom house in the community. While he is pleased to be living in the community, he is socially isolated and regularly experiences feelings of loneliness in the evenings. John engages in excessive drug and alcohol usage and is vulnerable to the predatory behaviour of others – including people staying at his house against his wishes. John and his clinical team are concerned at the heightened level of risk and equate John's isolation with an increase in behaviours that compromise his safety and wellbeing.

A safeguarding approach would ensure that John is supported to manage his social isolation in ways that are supportive of his recovery. The CMO would work with John and his formal (clinical, any other service providers involved) and informal (family members, neighbours) supports to devise a safeguarding strategy to assist John to manage his social isolation, recognising that evenings are a time of heightened risk for John.

Examples of actions the CMO might[13] facilitate/support include to:

a) Work with John to identify his motivation for change, including assisting him to articulate his recovery vision.

b) Work with John and the clinical team to devise a clear graduated plan outlining steps John is taking to manage his recovery and maintain independent living, including an outline of formal and informal support roles and responsibilities.

c) Support John to identify key informal support people and clarify roles these people will play in his recovery. The CMO may need to take an intentional

[13] This is not exhaustive and is meant as a guide only.

approach to supporting John to build relationships and networks to increase his connectedness in the community.

d) Provide increased support visits in the evenings to assist John to establish evening routines.

e) Assist John to identify and participate in regular evening-based activities consistent with John's recovery vision. These might include social, fitness and education activities.

f) Ensure phone contact is made with John each evening via a coordinated schedule, involving a combination of CMO staff, family, friends and neighbours.

g) Support John to maintain and regularly update a list of people and services he can contact when feeling socially isolated. These might include clinical contacts, crisis support such as Lifeline, phone numbers of supportive friends and family members.

h) Explore with John the possibility of a housemate moving in with him (refer to guidelines on housemates for things to consider).

i) Support John to develop assertiveness skills, through participation in community education programs

j) Work with Alcohol and Other Drug (AOD) specific services to implement a tailored approach to support John to manage AOD use including the possibility of an AOD peer worker.

Example B

Mary lives by herself in her home in the community. She engages with her CMO on a daily basis. This includes contacting the CMO office by phone on average 5-10 times per day, with requests to speak to management staff, often to complain about the service and specific staff members. Mary is regularly verbally aggressive towards staff members, family and community members. The verbal aggression is often personalised and of a sexualised or racial nature. Mary regularly exhausts her mobile phone credit and is sometimes unable to make phone calls for days at a time. Mary's family are highly concerned by Mary's social isolation. Mary has sustained physical injuries in her home and been unable to contact services, during occasions when her phone credit has been expended.

A comprehensive safeguarding approach would seek to address the risks associated with Mary's aggressive behaviour and her social isolation, recognising the link between these two issues.

Examples of actions the CMO might[14] facilitate/support include to:

a) Recognise the link between Mary's social isolation and her excessive phone calls to the CMO and endeavouring to support her engagement in socially appropriate activities in the community.

b) Explore multiple mobile phone and landline phone plans and options with Mary and her family.

c) Explore other options such as a personal alarm system/alerting device that can be activated by Mary in crisis situations should she have insufficient phone credit.

d) Engage Mary in specific budgeting supports.

e) Engage Mary in assertive behaviour training.

f) Engage Mary with activities during the day and evening to reduce social isolation utilising a variety of engagement methods to support Mary's participation.

g) Recognise the risk to staff by Mary's aggressive behaviour and implementing two person visits where appropriate. This may include ensuring male staff members are accompanied by female staff members on support visits following incidents of sexualised comments.

h) Regularly remind Mary of the CMOs formal internal consumer complaints process and encouraging her to utilise this process in preference to contacting the office repeatedly.

i) Establish regular weekly scheduled phone contact between Mary and the manager of the CMO at a mutually agreed time.

j) Work with the clinical team to identify a comprehensive risk management plan.

k) Work with Mary and her family to develop a phone contact/visit schedule to ensure she is receiving regular phone calls and visits at coordinated times to so that she is not socially isolated.

l) Discuss with Mary potential involvement with neighbours to reduce social isolation and develop strategies for appropriate engagement with them.

[14] This is not exhaustive and is meant as a guide only.

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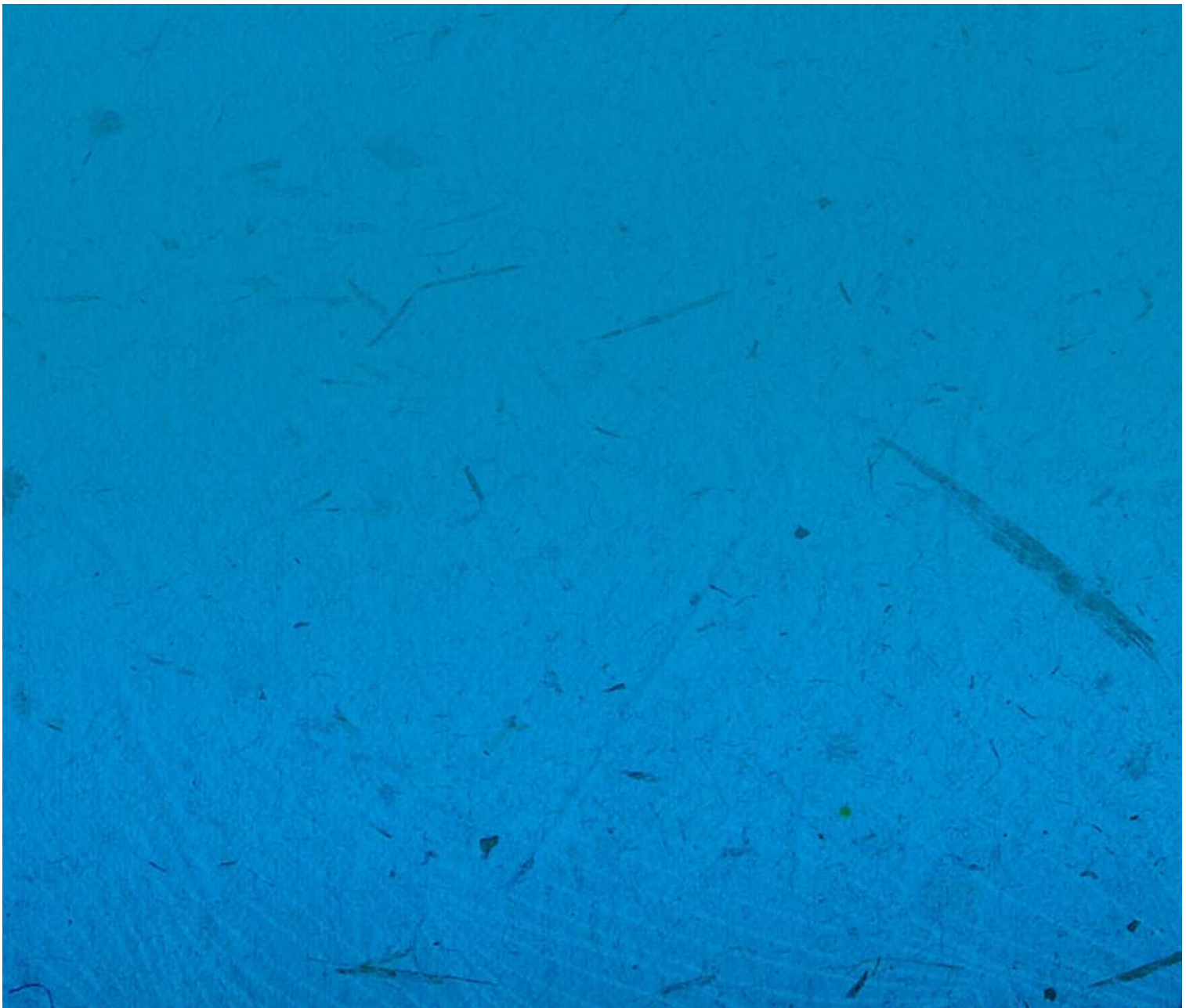
Use of ICLS Funding

Appendix B



Each individual participating in the Individualised Community Living Strategy (ICLS) Program is provided with an allocated maximum amount of funding for each 12 month plan period. The amount of funding relates to the recommended bandwidths of support ranging from Low, Medium, High and Very High.

The bandwidth of support and the maximum amount of funding available is determined by the clinical nomination panel when the individual is successful in their referral to the ICLS program. The funding is paid to the Community Managed Organisation (CMO) to provide recovery focussed supports (see Section 6 of the ICLS Guidelines for Portability of Funding).

The CMO should:

1. Developing and Submitting a Plan:

1.1 Use the MHC provided ICLS Plan templates (full 12 month and Interim funding templates);

1.2 This initial plan should be submitted no longer than 4 weeks after the initial payment or for the 1st day of the following month. An initial $3,000 is paid to the CMO for the development of the first 12 month plan;

1.3 If the individual is assigned an ICLS property, they are eligible for $3,000 to contribute towards furnishings for their property. This is provided through the CMO and the full amount should be utilised for furnishings for the individual's property;

1.4 The hours of direct support and subsequent funding need to be entered on the funding sheet on a weekly basis (not annually) and then the total costing's (not hours) for the year entered;

1.5 The plan should have the input of all stakeholders. The relevant clinical team needs to contribute to the plan with particular reference to safeguarding. All stakeholders (clinical team, individual, Guardian, CMO) need to sign the relevant sections in the plan in order for it to be processed;

1.6 The start date of all plans should be clearly stated on each plan document; and;

1.7 An update on the individual's progress, against the previous year's goals, is captured within the MHC's, Outcome Measurement and Reporting Tool template. This is to be submitted on an annual basis with the new individual funding plan.

2. Discretionary Costs:

2.1 The discretionary funding is based on *up to* 3% of the total funding allocation. So, if the allocated funding is a High bandwidth, the discretionary funding would be 3% of $113,860 (Metro) which is $3,416 leaving $110,444 available for direct supports (based on 2018/19 figures);

2.2 The discretionary funding is not an automatic payment. The funding is *up to* a maximum of 3% of the total funding allocation and should be relevant to the individuals identified recovery aims (i.e. the individual may not wish/need to utilise discretionary funds).

2.3 If the discretionary funding is requested, it must be clearly stated what the funding will be used for, relating it to recovery focussed supports in the individuals funding plan. It is not to acquire items; rather it is available for activities that are recovery focussed and will aid the individual to connect to their community, gain employment, learn relevant skills etc. For costs associated with training courses, driving lessons etc. the individual should be encouraged to contribute a 50/50 split, to motivate them to save money towards their recovery aims. However, please discuss with your ICLS Contract Manager if there is any uncertainty around the appropriateness of how these funds can be utilised; and

2.4 ICLS funding cannot be utilised for activities or items that can be funded through other sources.

3. Acquittals:

3.1 The total of ALL funding provided by the MHC must be acquitted at the end of the funding cycle. This includes funds for direct support, discretionary and the initial start-up funding ($3,000) for plan development (this does not include the $3,000 released for furniture if allocated an ICLS property). As per the Tender request, funding should be reconciled and acquitted on a monthly basis and may be requested at contract monitoring meetings;

3.2 When a new funding plan is submitted, the CMO must also provide a preliminary acquittal, showing funding spent to date;

3.3 The end of a 12 month plan, acquittal and reconciliation should be submitted no later than 1 month after the end of the plan; and

3.4 There is an acceptable 5% ‘slippage’ in acquittals on each individuals funding plan. Funds that are surplus (i.e. over and above 5%) at the end of a funding period, will be offset against funds owing in the next period for that individual if they are continuing in the ICLS. In other circumstances, the surplus will be offset against funds to be paid by the MHC to the CMO for

another ICLS participant. Details of offsets are described in the Agreements for each individual when payments are released.

4. Change in Needs (including accommodation):

4.1 If an individual is supported to temporarily access other MHC funded accommodation/residential services, e.g. Step Up/Step Down (excluding hospital admissions), the CMO is required to communicate with the MHC as early as possible to ensure flexibility and accountability of the MHC funds and resources can be maintained. It is anticipated that ICLS funds will not be stopped during this period but will be reduced so as to maintain relationships and continuity of service provision; and

4.2 Any change to the level of funding (e.g.an interim increase for a specific period of time due to need for more intensive supports; an increase in bandwidth whether temporary or permanent) will need to be requested with written endorsement from the individual's clinical team.

4.3 Requests for additional brokered services must be submitted and approved by the MHC prior to the service commencing. Such requests must include written endorsement from the individual's clinical team and timeline.

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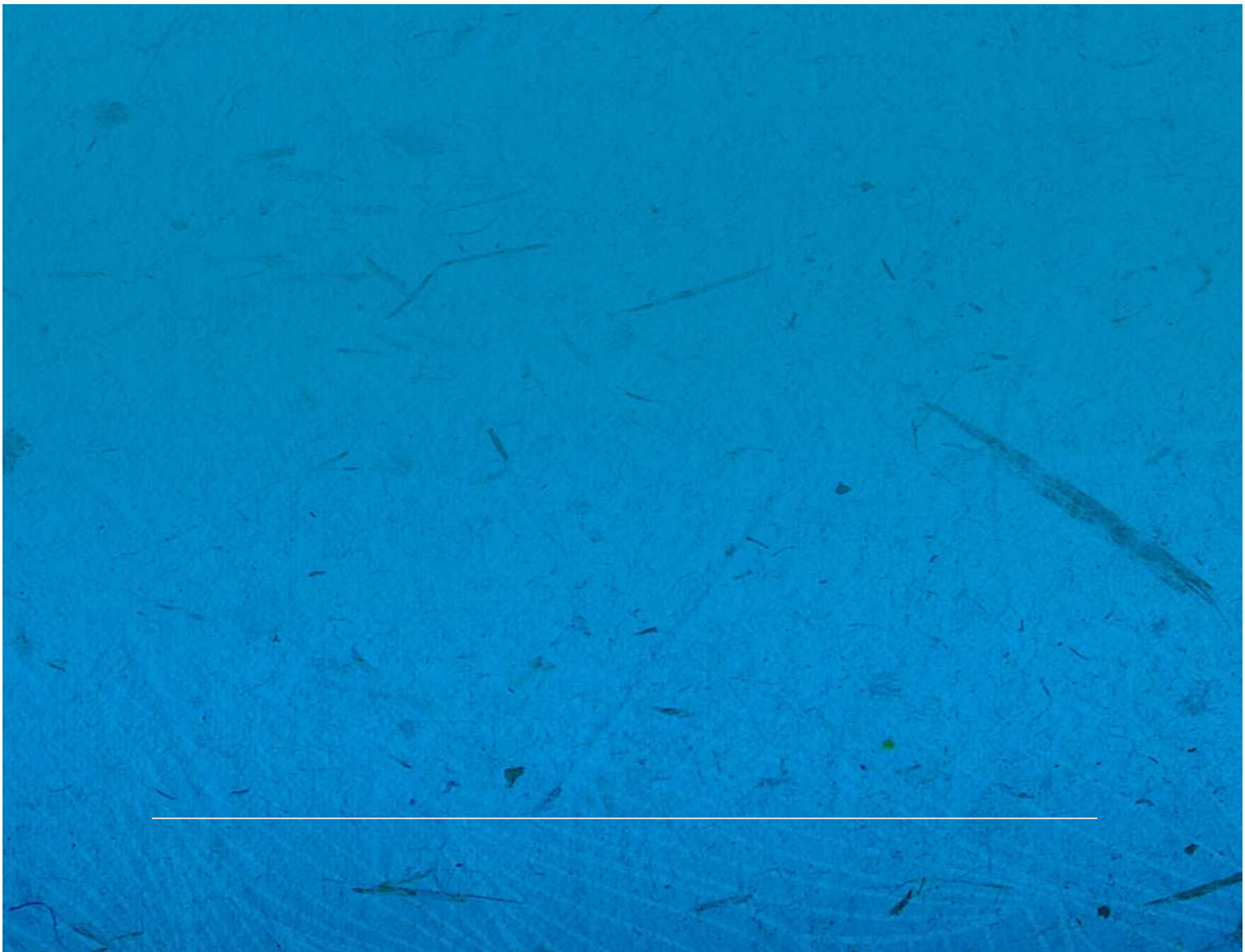
Communication and Information Sharing by the Community Managed Organisation to the Mental Health Commission

Appendix C



To support and maintain effective communication and working relationships with Community Managed Organisation (CMOs), the MHC requires the following notifications to ensure suitable support and advice can be provided, as appropriate. The CMOs should notify the MHC of the following when:

a) An individual is admitted to hospital via a **'Hospital Admission Form[15]'** as soon as is practicable. These forms should be emailed to the MHC ICLS Contract Officer;

b) the CMO is concerned that an individual has been/or is going to be discharged via a **'Discharge Hospital Form'** from the community clinical team;

c) There is a Notifiable Incident[16] relating to an individual in the ICLS. This should be done via the MHC general submission of NI forms – please see MHC website for further details and to access the updated NI form. These forms should be emailed to the MHC via the appropriate email address;

d) An individual does not engage with their supports via a **'Limited or Non Engagement Form'** – when there have been three consecutive unsuccessful scheduled engagements[17]. These forms should be emailed to the MHC Contract Officer;

e) there are any significant safeguarding concerns associated with specific individuals;

f) the individual signs the tenancy agreement and moves into their home or if there is a delay in them taking up full-time residence in their home, notify the MHC via the **'Tenancy Alert Form'**;

g) the individual receives consecutive breaches and/or an eviction notice (this should include the date of termination), notify the MHC via the **'Tenancy Alert Form'**;

h) there are ongoing difficulties with a tenancy (individuals should be supported to maintain their tenancy to an acceptable standard) , notify the MHC via the **'Tenancy Alert Form'**;

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[15] ***Hospital Admission Forms*** *should be submitted when an individual in the ICLS is admitted to hospital. This form should be utilised when a serious or notifiable incident has not preceded the admission, i.e. a planned admission by the clinical team due to a decline in wellness or change in medication – even if the police are called to escort the individual to the hospital.*

[16] ***Notifiable Incident Forms*** *should only be submitted if a serious or notifiable incident has occurred (and/or resulted in a hospital admission) as outlined in the General Provisions (examples are also available on the MHC website).*

[17] *If an individual is not engaging in the program this does not mean that the individual will be withdrawn from the program. People disengage for a variety of reasons and early notification of this allows the MHC to provide support to the CMO as appropriate, and to ensure that the clinical team is also aware so that appropriate strategies can be developed to ensure the individual's needs are met.*

i) The CMO must ensure the house is secure and visit it from time to time to ensure it remains safe; and

j) The CMO must support the individual to maintain their tenancy to an acceptable standard.

k) The individual is not in their home for any length of time longer than 4 weeks i.e. if they are admitted to hospital, if they go on holiday, if they go to a residential rehab. In these circumstances it is appropriate and encouraged that CMOs visit the house from time to time to ensure it remains safe and secure. However, if the property is at risk of inappropriate and uninvited guests, the CMO must notify the Community Housing Organisation (CHO) as soon as is practicable as well as, notifying the MHC via the **'Tenancy Alert Form'** or the **'Accessing Residential Services Form'.**

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Clinical Teams Responsibilities – Appendix D

When necessary, each individual in the ICLS receives dedicated clinical support from the relevant community clinical team.

The Community Clinical Team should provide assertive community clinical outreach to individuals in the relevant area in the ICLS:

(a) Act as the Case Manager for identified individuals in the ICLS;

(b) Act as the primary contact for all stakeholders – individual, family, carer, CMO in relation to identified ICLS participants;

(c) each individual is required to have a dedicated clinical case manager. The clinical case manager is responsible for the referral of the client (where relevant), input into an individual's funding plan and will be point of contact for the MHC and the CMO for the individual's clinical care;

(d) Support all newly nominated individuals entering the ICLS to make contact with the Independent Peer Coordinator from CoMHWA to choose a CMO;

(e) Support existing ICLS individuals who would like to change providers, to utilise the services of the Independent Peer Coordinator from CoMHWA;

(f) Provide clinical input into each ICLS plan with particular emphasis on relapse prevention, safeguarding and discharge planning strategies;

(g) Provide written endorsement (via email) to the MHC if a request is made for an increase in support, whether permanently or as an interim funding package;

(h) Meet with all identified stakeholders at least quarterly for individuals on a Low/Medium bandwidth and at least monthly for individuals on High or Very High bandwidths;

(i) In collaboration with the chosen CMO, support each individual to be linked with a General Practitioner (GP) in the community for their general health needs and encourage them to attend the GP at least three times per year;

(j) Ensure a case manager or single point of contact is available and has a replacement, which is familiar with the individual if on leave or away, for each individual and to ensure the CMO is made aware of any changes to the individual's primary clinical contact. This is to enable CMOs to easily make contact as appropriate in relation to individuals they are supporting;

(k) Following regular review and assessment, the clinical team is required to advise the MHC of any individual no longer considered clinically appropriate to remain within the ICLS program, and therefore recommending they be withdrawn;

(l) In consultation with the CMO and other appropriate stakeholders, explore and secure alternative accommodation, should they recommend or support an individual's withdrawal from the program.

(m) Provide a referral back into clinical case management if needed after deactivation; and

(n) Ensure integration of care between clinical and CMO services reflect the ICLS Service Model Guidelines.

Meetings and reporting:

(a) Participate in nomination panels for new referrals into the ICLS;

(b) Attend meetings with the CMO's and MHC as agreed;

(c) Notify the MHC when an individual is deactivated; and

(d) To provide detailed reporting every six months in line with the current year's Commission Service Agreement.

NB: The MHC has been working with the Department of Communities - Housing to devise a suitable exit strategy for those individuals who have gained independence and no longer need ICLS supports. Unfortunately, this is not completed at this time. As a result, if an individual is able to live independently with minimal support, in consultation with the Community Clinical Team and where appropriate, the CMO will support the individual to seek alternative accommodation.

Suite of Forms

HOSPITAL ADMISSION FORM

Use this form for hospital admissions and email to your contract manager

Please inform your contract manager when the individual has been discharged

Please continue to use the Notifiable Incident Form when appropriate.

Date:	
Individual Name:	
Support Organisation:	
Date of Hospital Admission:	
Name of Hospital:	
Anticipated Length of Stay:	
How Referred: I.e., Police, MHERL, Self, Other	
Reason for Referral:	

Levels 1 and 2 Work zone, 1 Nash Street, Perth, Western Australia 6000
Letters GPO Box X2299, Perth Business Centre, Western Australia 6847
Telephone (08) 6553 0600 Facsimile (08) 6553 0400
Website: www.mhc.wa.gov.au

HOSPITAL DISCHARGE FORM

Use this form for hospital discharges and email to your contract manager

Please continue to use the Notifiable Incident Form when appropriate.

Date:	
Individual Name:	
Support Organisation:	
Date of Hospital Discharge:	
Name of Hospital:	
Length of Stay:	
Plan on Discharge:	

Levels 1 and 2 Workzone, 1 Nash Street, Perth, Western Australia 6000
Letters GPO Box X2299, Perth Business Centre, Western Australia 6847
Telephone (08) 6553 0600 Facsimile (08) 6553 0400
Website: www.mhc.wa.gov.au

ACCESSING/EXITING RESIDENTIAL SERVICES FORM

Use this form when individuals are accessing residential services for longer than 28 days and on discharge. This could include Rehabilitation Facilities, and Recovery House etc.

Date:	
Individual Name:	
Support Organisation:	
Name of Additional Service:	
Anticipated Length of Stay:	
Admission Date:	
Discharge Date:	
Reason for referral:	

Levels 1 and 2 Workzone, 1 Nash Street, Perth, Western Australia 6000
Letters GPO Box X2299, Perth Business Centre, Western Australia 6847
Telephone (08) 6553 0600 Facsimile (08) 6553 0400
Website: www.mhc.wa.gov.au

TENANCY ALERT FORM

Please email this form to your contract manager regarding any of the matters below pertaining to an individual's tenancy.

Please continue to use the Notifiable Incident Form when appropriate.

Date:	
Individual Name:	
Support Organisation:	
Community Housing Organisation:	
Date of signing of lease :	
Date of moving into house full time:	
Date of housemate move in and departure date:	
Notification and detail of breach:	
Notification and detail of eviction:	

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Telephone (08) 6553 0600 Facsimile (08) 6553 0400
Website: www.mhc.wa.gov.au

LIMITED OR NON-ENGAGEMENT

Use this form for concerns[18] relating to limited or non-engagement[19] email to your Contract Manager

Date:	
Individual Name:	
Bandwidth:	
Support Organisation:	
Date organisation last had contact with the individual:	
Details of issues/barriers to engagement experienced (include details on time lines, events and actions leading to disengagement):	
Strategies for Engagement and proposed next steps:	

[18] *Please note this form is not required for individuals who are living well in the community and no longer require the previous level of support. This can be captured at the end of plan reporting.*

[19] *Limited or non-engagement is considered when there has been three consecutive scheduled appointments missed*

REQUESTS FORM

Use this form for any ad hoc requests such as, request to move house, extra ordinary funding requests that fall outside of the ICLS guidelines. Requests will be reviewed and approved on a case by case basis.

Date:	
Individual Name:	
Support Organisation:	
Type of Funding:	
Funding Amount:	
Reason for request:	

Approved Not Approved

X

Becki Cheetham
A/Senior Program Officer

Date:

Levels 1 and 2 Workzone, 1 Nash Street, Perth, Western Australia 6000
Letters GPO Box X2299, Perth Business Centre, Western Australia 6847
Telephone (08) 6553 0600 Facsimile (08) 6553 0400
Website: www.mhc.wa.gov.au