Making Links Project

Frequent Service User Think Tank 1 Notes

18 August 2016

Facilitator: Kris Honey Minutes: Sarah Langmore

1. Welcome and introductions

Gordon Conochie, Senior Manager, Prevention and Population Health, Co Health

Gordon welcomed all and thanked us for our participation.

Last December about 100 representatives of the Mental Health, Homelessness and AOD Sectors came together to discuss cross sector responses to shared clients. The three Sectors identified key priorities for this work.

Today is the first of three Think Tanks:

- Shared Understandings
- Show and tell
- Putting it together

The focus for this Think Tank is the development of a common definition – how do we define the group of service users who we wish to assist across our sectors. We will consider the privacy implications of this cross sector work.

In the second Think Tank we will be considering learnings from other similar projects/initiatives. In the third we will be developing a shared model. The aim is that participation in each of the Think Tanks is active.

2. Brief Overview of Collective Impact

Grant Liptrot

See attached powerpoint presentation.

Grant proposed that one approach that this group could take to designing a response to Frequent Service Users is to draw on the collective impact approach. We cannot apply collective impact in its true sense as collective impact work traditionally builds from the community up, but utilising collective impact principles will provide a good framework to develop the work.

In some respects collective impact is the 'co-design of 2013-14'. It was very popular at the time, but still has strong positive elements to bring people together from across sectors and perspectives.
Grant is now working for Primary Health Network and was previously the Catchment Based Planner for MHCSS based at cohealth, and prior to that worked in Partners in Recovery in NSW. Collective impact principles were utilised in the planning role and the project management role across Partners in Recovery.

Grant proposed the following variation on collective impact:

- ***Service driven response, not community led***: We are working together to identify strategies in response to a community, rather than responding to a community identified issue.
- ***Not specifically funded***: Collective impact work is generally well funded and projects usually have the backing of a backbone organisation. At this point we have no funding.
- ***Wicked problems***: problems not easily solved by one approach, one sector, one solution. Problems that are best addressed in different ways by different people.
- We can use this approach to people who are constantly re-presenting to our services and whose needs we can't adequately address as individual sectors.
- ***Shared understandings***: at the heart of collective impact is the development of shared understandings across differing perspectives/languages/frameworks.

Bringing collective impact to reality

At its heart, collective impact is **data driven** – with data guiding what will be undertaken and what will be measured. We need to think about what we want to measure, how we build the evidence of success.

Mutually reinforcing activities: we have a great deal of activity underway responding to people with a complex set of needs, who re-present to our services. We need to work out how we all work together to address the headline response that we want.

Continuous communication: once the activity is underway, how do we know that changes have occurred or that activity is occurring in another part of the community?

Backbone organisation: Often this is the funder. Often they are not undertaking the activity but are heavily involved in setting the agenda and monitoring the response.

Case study

Grant provided an example of collective impact in response to specific individuals. A family with four children was identified as being disengaged from the education system and community more generally. They were viewed as very problematic from a range of services and sectors. The family had some engagement with education, justice, child protection, disability, health and mental health sectors. It was identified that the Mother's mental health was a key factor in the issues that the family was experiencing. A number of agencies were investing large amounts of time for little result. Several meetings of all stakeholders were held to develop an action plan to address the range of the family's issues.

The focus shifted from the children to the mother, with agreement from agencies to hold back their activity until the mother was well engaged. The initial action was to assist the mother to engage with the mental health sector. Once the mother engaged with the mental health system, many of the other issues started to resolve.

3. Homelessness Frequent Service User's project:

George Hatvani, Launch Housing

Launch Housing identified a group of people for whom the resolution of homelessness and its associated impacts has not been achieved, even after multiple attempts and many presentations.

George presented on the findings of the Launch Housing Frequent Service User project.

"All of us are aware of those clients who keep coming back to us, their problems unresolved. They are the ones we just can't seem to help. We've all individually and in some case collectively tried to do something about them, for them, with them. We have not succeeded.

We started off calling them 'frequent flyers' but quickly adjusted, it was disrespectful.

The closer we looked at each of these individuals the more they come into focus as the complex, vulnerable people they are. The more we find out about them, the more we realise the length and tragedy of their experience.

They are not stories, these are our fellow citizens and our services see only a tiny fraction of their lives. They are people we have had some responsibility for.

We decided to start our journey by calling them 'frequent service users' and seeing what the world had to teach us about them, in the hope that it would prove instructive.

This presentation is about the results of that work and the things that have flowed from it."

This project identifies one way of prioritising resources. Numerous approaches have been developed to prioritise access to our resources: risk, distress, deserving/undeserving. This project identifies one approach based on service impact or frequency of service use.

Rational for the project:

Launch has identified people for whom the service system was unable to successfully house long term. The service identified this as a service failure, beyond the impact of a lack of affordable housing. It was also identified as a failure of adjoining systems.

Purpose:

1: To identify the clients who most appear in the homelessness access point data since 2000. What are the characteristics of these people? What are their issues? Are some groups over represented? What can we do? What intervention strategies will better assist this group?

2. The project aims to develop intervention strategies in advance of people in this group re-presenting.

3. The service undertook a literature review and a data analysis of over 100,000 clients and prepared an annotated bibliography (currently 180 pages) examining definitions and international approaches.

Launch Housing has recently been able to access some philanthropic funding to provide responses to the 25 most frequent service users.

What emerges from the literature?

- **Homelessness is bad for you:** In 2007, Chamberlain, Johnson and Theobold analysed the experiences of 4,252 homeless people and 934 people who were at risk of homelessness at HomeGround and the Salvation Army Crisis Service, among their many findings; 30% of the sample experienced mental health issues but just over half (53%) developed these issues as a result of homelessness. Similarly 66% of people who were homeless had developed AOD issues after becoming homelessness.
- **Homelessness is a killer:** Numerous international studies have shown that people who are homeless are between 4 and 9 times more likely than the general population to die earlier and younger. People who experience homelessness are much more likely to experience violence and to be murdered. In the USA during 2015 and 2016 there were at least 58 murders of homeless people.
- **Prior experience of homelessness can predict future experiences:** Analysis of the Journey's Home Data in 2015, looking at a stratified random sample of 2719 individuals across 36 distinct locations Australia found that a prior experience of homelessness has a 'strong and highly statistically significant' impact on the chances of homelessness later on, mainly driven by increasing the likelihood of entering homelessness.
- **The longer you are homeless the harder it is to get out.** The longer someone is homeless the more likely they are to develop AOD and mental health issues and to become part of a homelessness sub culture. This is supported by (among others) research in Australia (Chamberlain, Johnson and Theobold, 2007; and Cob-Clark et al 2014) and the USA (McQuiston et al, 2014)
- **Risk factors**
    - Early onset of homelessness
    - Presence of alcohol or other drugs
    - Mental health issues
    - Identification with a homeless sub culture

- **Homelessness is more expensive than the solutions**: Research from the USA (Evaluation of NY/NY Supportive Housing program, Culhane, Metraux and Hadley 2002), analysed the activities of 4,000 homeless men with mental health issues 2 years before placement and 2 years after. After placement in NY/NY housing, **95% of public expenditure costs were offset.**

Results were also compared between NY/NY participants and a control group not in the program.

Initial and ongoing costs of NY/NY Supportive Housing Unit	$17,277
Savings in reduced costs for: • Hospital admissions • Mental health inpatient admissions • Incarceration	$16,282
Actual cost of NY/NY Supportive Housing Unit	**$955**

The benefits to the individual of the model were enormous.

Pathways into homelessness provide a useful framework

The pathways concept provides a classification lens that uses biography and recognizes context in a way that demography does not. This research adds the perspective of sequencing into and out of homelessness; what came first?

However, pathways are heuristic devices that allow us to organise a complex reality:

The 5 pathways identified by Johnson, Gronda and Coutts (2008) are 'ideal types' and are not causal accounts.

Two pathways that can be addressed quickly if housing is provided:

- **Housing crisis** – something has meant people have lost housing (loss of job, medical emergency)
- **Family Violence** – lost housing as a result of family violence

- **Youth dissenters** - young people reacting to the restrictions of home. Again, if assisted swiftly, homelessness can be quickly addressed.

The next three groups have a high risk of long term homelessness:

- **Mental health** – most isolated and may a long pathway through homelessness.
- **Youth escapers** – escaping trauma, young people leaving care – longest pathway through homelessness (Discussion: the trauma experienced by young people can also lead to mental health and substance use issues.)
- **Substance use** – can lead to a long pathway through homelessness, often bringing in justice involvement.

Literature on frequent service users

A great deal of literature refers to 'frequent service users', often linking frequent service use of homelessness services to frequent use of health, justice, services. Repeat usage. (Discussion: frequent service users may present at any one of our service systems. How do we decide whom to focus on? For example, the ABS General Social Survey of 2014 identified 70% of people who self-reported experiences of homelessness didn't present to homelessness services for assistance)

The Literature also identified two other groups:

- **Chronic homelessness** – a large number of episodes of homelessness, many definitions, but mainly had long experiences of homelessness.
- **Episodic homeless** – lots of short episodes of homelessness (also referred to in the literature as recurrent, iterative, persistent, repeat), often linked to institutions. These were probably the chronic homeless at a younger age.

All of the 100 Launch Housing most frequent service users were chronically homeless.

A useful typology of homelessness:

Kuhn and Culhane (1998) tested a typology of homelessness (Lovell, Barrow and Struening, 1984). They used administrative data (not self-report and not retrospective) of public shelter utilization by individual homelessness clients (not families) in New York City (1988 - 1995) and Philadelphia (1991-1995) by number of shelter days and number of shelter episodes. IN all they did a cluster analysis on over 80,000 individuals.

They found strong support for the suggested typology in the proportions below.

1. **Transitional homelessness** (80%) – short experience of homelessness, low frequency, short stays – making rapid transitions into stable accommodation (likely pathways: Housing Crisis, Youth dissenters, family violence): find affordable housing was what most mattered for this group.
2. **Episodic** (10%) – repeat experience of homelessness (Do not exit into mainstream housing but into institutions, jails or rough sleeping
3. **Chronic** (10%) – survivors of the episodic group (Long term stays; Likely pathways: Substance use, mental health, youth escapers).

Even though homelessness shelters as they are administered in the USA do not have a direct analogue in Australia, the typology is another useful framework for thinking about homelessness and pathways out.

This research has been very influential in the USA. Ending chronic homelessness is a high focus in US, particularly in relation to veterans.

The other group is the transitional, with a focus on 'rapid rehousing', to reduce the period of homelessness.

From what we could see, the episodic homeless represent a critical and often forgotten cohort, the survivors of which are likely to become our frequent service users.

McQuiston examined this group and discovered the following common characteristics: substance use 30 days period to baseline, personality disorders. We hypothesise that poverty, substance use, incarceration, state care and a youth entrance in to homelessness are major risk factors in episodic homelessness.

Action: Launch is happy to share their annotated bibliography.

What did the Launch Housing data reveal about 'our' Frequent Service Users?

HomeGround initially merged 58,000 client records from our Access Points at St Kilda and Collingwood between 2000 and 2014 and ranked them to create the first list of 'most' to 'least' service users.

We used this list and identified the top 100 most FSU – all were chronically homeless. The average service contact period was 9 years; slightly higher representation of ATSI; most were single people; 59 men, 39 women; age at first presentation was highest in the 18-34 year old group. Only 28 were housed at their last known housing outcome. Many of these service users had been housed at some point but the housing had not been stable.

Over the last two years we have also slowly undertaken detailed client analyses (up to #41) using all contact notes (Support and Access Points) and built up a detailed case history of our interaction with these individuals.

For example, the most frequent service user had over 600 service contacts in 15 years. She first presented as homeless in her early 30's and had 4 children removed from her care already. She was had brief stays in public and transitional housing but both times lost the tenancy due abusive partners. She was also housed in Supportive housing for 38 months but was finally evicted and then

spent a few months in Southbank. Overall she spent 53% of the last 15 years homeless, cycling between sleeping rough, couch surfing, rooming houses and various crisis accommodations. She has concurrent mental health and AOD issues and multiple physical health problems.

FSU 2 was only housed for 13% of the last 15 years.

HomeGround also developed a data warehouse ('The Asset') and this helped us to do this more quickly and efficiently. The merger with Hanover allowed us to bring in that data set and expand it to over 80,000 clients and include all support contact notes. What we found was that the vast majority of people who approach Launch Housing (94%) don't have much contact with the service, 80% had between 1 and 10 case notes with the Access Point.

We also found that:

- 0.35% had more than 90 contact notes - that is 280 people
- 5% had between 30 and 90 contact note - that is 4,000 people

We secured philanthropic funding started a short term project to work with top 25 most frequent service users

Top 25 (based on case notes of what is reported by individuals – these are likely to be under representations of the full experience):

- All single
- 13 women; 12 men
- 77% of the women have lost access to their children
- Women much younger than men, most men over 40(84% > 40), most women under 40 (54% < 34)
- Estimated years of homeless – women (median 13); Men – (median 15 years)
- 92% of men and 100% of women have mental health issues (29% schizophrenia)
- 100 % of women and 75% of men have AOD issues.
- 100% of women and 75% men have a dual diagnosis
- 23% of women and 42% have engaged with a mental health service (largely related to movement between catchments)
- 15% women and 17% men have ABI
- Financial administration 30% women, 33% men
- 38% women, 25% men, cognitive impairment
- 85% of women and 25% of men have reported being victims of violence
- 31% of women and 33% of men report being perpetrators of violence
- 39% of women and 42 % of men identify being victims of childhood abuse, neglect, trauma
- 23% of women and 42% of men report a history of incarceration

Discussion

Early YSAS studies showed that 90% of young people had experienced sexual abuse as children. Studies of prison populations also show high levels of childhood abuse and trauma.

All present recognised this group of people and identified the limitations in our current service system in responding effectively to them. AOD system used to have outreach workers who could work with these people. Recent reform in AOD has moved the focus to the 80% of transitional users.

What interventions work?

Overall what outcomes matter?

The 'What Makes a Difference?' Client Outcomes Literature Synthesis (Gronda et al 2011) showed that only two elements matter when it comes to homelessness: **Getting and Keeping Housing.** The key factors important to **getting housing** include: housing work, case management, specialist health, increased specialist support (especially AOD) and increased housing supply. The factors that contribute to **keeping housing** are homelessness prevention work, economic and social participation and complex health management. The research also found that most service responses are oriented toward 'getting' housing. Almost no-one is focussed on sustaining housing. Keeping housing also requires shared accountability between the homelessness and other specialist systems such as mental health, AOD, education, family violence, health, housing, etc.

Housing

Housing first – the best approach. Housing is a human right. People do not need to be housing ready – housing must be provided so that people can learn housing readiness.

Permanent supportive housing: health and other supports linked to stable housing in an ongoing way. Can be congregate or scattered sites. Support levels are intense and voluntary. Literature lends itself to scattered housing as being of greatest benefit to most but that single site works for some people.

Support

The literature review (all in the annotated bibliography) showed three broad approaches to support that work:

- Onsite – workers onsite.
- In reach – into institutions
- Outreach support - into people's living spaces and homes

Some of the most important evaluations and approaches:

Frequent Service Users Enhancement Initiative (FUSE)

FUSE project focussed on housing frequent service users through permanent housing with onsite support. 84% remained housed. 40% less incarceration. 30% less substance use.

Critical Time Intervention

Outreach support such as Critical time intervention that focussed on responding at times of transition i.e. leaving a mental health institution. Transitions between states (housed and homeless, homeless and housed, incarcerated and released, etc.) are critical to be aware of and plan for.

Outreach support linked to housing: J2SI
The J2SI trauma informed approach is highlighted as an exemplar of successful outreach support but man other models exist. The evaluation showed the benefits of long term, voluntary support with low case loads. Data shows a drop in housing outcomes once intensive support is removed.

Inreach
Inreach models of support – i.e. providing support to people while they are in institutions in order to better manage transitions. Not a lot of focus on this in Australia or overseas this and where it does it is poorly coordinated with existing housing and homelessness services. Incarcerated people at risk of homelessness (especially those with histories of homelessness or showing a pattern of episodic homelessness) could be targeted while incarcerated if better coordination existed.

Key features of good interventions

Small case loads, long support periods (indefinite if necessary), focussing on transition periods, providing support where people are, multidisciplinary teams, discharge planning, outreach to where person is.

Key question: How to break connection between those who are episodically homeless from becoming chronically homeless? Features: Housing first, supportive housing, multi-disciplinary workers, persistent, hopeful and well prepared support, inreach to a 'captive audience', prevention once housed, end the war on drugs.

Key question: ending the homelessness of those who are chronically homeless
Features: Housing first, permanent supportive housing, persistence and trust, monitor wellbeing, find out what gives their lives purpose, prevention once housed. We know transition out of chronic homelessness is slow. We need to overcome a lack of appropriate housing. Coordination and co-operation are key.

The question of Priorities: How do we prioritise our resources?

As we know there are a number of ways to assess priority…

- **Risk:** An imminent and serious risk to a person and/or their children
- **Risk:** Prioritization based on known risk factors such as:
    - Young people leaving care
    - Women and children escaping family violence
    - Perpetrators removed from their dwelling
    - People leaving institutional care such as psychiatric inpatient units, hospitals, detention centres and jails
- **Tools:** Prioritization lists based on pre-determined priority such as that which operates in Victoria under the Opening Doors Framework
- **Tools:** Prioritization based on tools such as the Vulnerability Index or the SPDAT; both of which make 'evidence based' claims for their validity

Vulnerability Index
Used to identify those people most likely to die within 5 years if they don't get housing and support. Based on a study conducted by Hwang et al (1998) which identified the demographic and clinical factors associated with an increased risk of death in homeless individuals.

Service Prioritisation Decision Assistance Tool (SPDAT)

- Need to function as a system to end homelessness.
- Need to be objective in determining service.
- Need to move from waiting list mentality to a priority list operation
- Need to move from just who is eligible to who needs the resource the most.
- Need to move away from luck and "first come, first served".
- Need a tool that follows the person/family; not the person/family having to tell their story over and over again.

There are other ways to assess priority

- **Distress and Noise:** People in distress (the 'loudest' and most 'demanding', for example those who make entreaties directly to the Minister)
- **A 'first come - first serve' system**
- **Deserving/undeserving dichotomy** (E.g. The focus on ending veterans homelessness in the USA; the operation of the UK's statutory definition of homelessness)

Frequent service use or service impact is another way to view prioritisation

One thing we are becoming increasingly aware of from the research is the need for differential responses based on quality assessments.

This in itself will be a form of prioritisation.

Discussion:

Our systems work against these types of interventions. We can choose to ignore funding guidelines if we know what will work for someone.

How do we identify who it is we will work with?

Kris Honey checked whether there are other services undertaking the same sort of analytics. AOD in the North West has two years of data that is currently being analysed. We could interrogate the data against some of the lens presented.

The Asset provides the capacity to pull together disparate data sets but data sharing issues may impede this.

George's ideal model is a data sharing model to help us identify FSUs across our systems in order to approach them individually to find out whether they would like a response.

The people who are most vulnerable may not be frequent service users because they may have opted out from our systems. Sometimes those who are most in need can't navigate/access our services so won't be identified through the data.

Frequency of use is one framework. Level of acuity is another framework.

Who are we talking about?

- Frequent service users
- Most vulnerable
- Chronic
- People who have a high impact on our service system (costly) – those whose needs lead them to rely most intensively on system resources
- People with AOD, mental health issues, homelessness, experience with criminal justice, experience of homelessness. Leading lives with multiple and complex needs. Some focus on a younger cohort who are at risk of becoming chronically homeless.
- People who we have been unable to assist to positive outcomes. Positive outcomes include stable housing and access to services. If we can keep people housed, we can assist them to address other issues in their lives.
- Individuals who have needs in at least two of the participating sectors and who meet the criteria for the participating services.
- People who are not housed, be vulnerable, chronic complexity, high use of service systems, high use of at least two systems, 'too hard basket', current service system responses are failing. Those people who are in the 'too hard' basket.
- Focus on people whom we have failed.
- High use of current services but our responses are failing them. Each of our service systems has a compelling desire to work with them. Business as usual is failing them. People with issues across at least two of our service systems (one of which is homelessness), broad brush eligibility for services. Often the complexity is in the management of the services sitting around them.

We suspect that there are a lot more people in this system who have given up on our service systems. For instance, the proportion of people with chronic AOD issues accessing the AOD system is very low compared to the proportion in the general population.

Once we have defined the group, we have to define at what point we intervene with them. Street to Home developed a vulnerability index. Launch may start using another tool, the SPDAT. (Iain de Jong presenting on this in Melbourne on Friday 26 August).

People with these characteristics present to the mental health system in crisis but for whom there is no currently appropriately mental health response.

Service systems for young people and adults are very different. Wayne from Frontyard identified that if we could access the needed services for young people, they wouldn't become the group who are chronically homeless. Several people have suggested a notion of earlier intervention with a focus on young people.

Mental health services have identified the state-wide mental health access system is problematic. One option is to lower the mental health access bar for people who have the other issues. I.e. take on people who have anxiety and depression.

If we go through these three think tanks and have clarity about 'who' and a model, will we get traction?

The group is very supportive of progressing this thinking but we need to consider how to get 'buy in from the AOD, MH, and Homelessness sectors more broadly. Do we need Departmental involvement? CEO involvement? Leadership in organisations?

Data

Participants suggested that homelessness data is probably more accurate than AOD data. Those who make it through the AOD data are likely to be screened out. People we are interested in may only hit parts of AOD and mental health system, emergency departments, specific services.

Who needs to be in this conversation? CEOs definitely – to negotiate with government and to sign off changes to targets/ways of working.

Can we offer government a pilot to work differently with?

- Young people at risk of becoming chronically homeless?
- People in the identified target group?

4. Information sharing in the Victorian Public Sector

Adriana Latomanski and Emily Minter, Commissioner for Privacy and Data Collection

See attached powerpoint presentation.

This Team has key responsibility for privacy policy. Adriana and Emily spoke about how data sharing is enabled, challenges with information sharing and how they might be overcome. The presentation focused on personal information.

Privacy and Data Protection Act 2014 – only applies to the public sector and led to the establishment of the Commissioner for the Privacy and Data Collection. Victorian Protective Data Security Standards were released recently attached to this Act. Part 5 of the Act relates to law enforcement data security.

Information sharing – we first need consider legislation that is specific to our Sectors as what this legislation says about what can and can't be shared 'trumps' the privacy legislation.

The Privacy legislation includes 10 information privacy principles and are very similar to principles in Health Records Act and Federal legislation. (See website for resources relating to the principles, including an online training module.)

The Privacy Commission is very keen to dispel the myth that privacy issues are a barrier to information sharing in order to working together. Organisations are often reluctant to share information because of the complexity of the legislative environment.

How do we overcome challenges?

- Do the work ahead of time so that we are ready prior to the need to share information
- 'privacy by design' – (see resources on website)

- investing in resources and training for staff so that staff are empowered to make information sharing decisions when they need to
- Develop information sharing agreements

The Commission wants to have a cross government perspective and wants to assist cross sector work. Other Government Acts have their own privacy legislation that takes priority and this legislation takes second line. Enacted only where own legislation is silent. (I.e. Housing Act, Disability Act).
1st step – check that we have the legal authority to share information. (The Commissioner can override our Acts). Obligations under each Act will be different so all parties need to check their responsibilities. Conduct a Privacy Impact Assessment.

IPP 2: Use and disclosure
See slide
One way to manage this is to ensure broad coverage when we provide notice to clients about the purpose of collecting data i.e. to respond holistically to their needs. This could then enable later cross sector sharing of information.
Exception: for a reasonably expected secondary related purpose or where sharing of information is in response to a serious or imminent threat to someone's safety or to community safety.

First consider whether we have the authority to share and then whether we have the imperative to share. Undertake a privacy impact statement (copies online) and a security risk assessment.

- Could the same purpose be achieved without the personal information?
- Is the sharing proportionate to the purpose and desired outcome? Have other public interests been considered?
- Will the disclosure be made at the time the information is needed?

If we do not have the legal authority to share, consider flexibility mechanism in new the new Act, where there is a countervailing community interest. The first such exemption is the Family Violence Risk Assessment and Management Panels Information Usage Arrangement (RAMPs IUA) – is a stop gap measure until Family Violence legislation is changed.

We could request an IUA for our purposes and then consent would not be required for the identification of frequent service users. The process of developing the RAMPS IUA took one year and 4,000 pages of documentation. The Commission found that the public interest in sharing information overrides the public interest of privacy.

DHHS were the lead party in creation of the RAMPs IUA.

There is talk of removing 'imminent' from the Privacy Act. It is easy to prove that a threat is serious but it's very hard to provide that it's imminent. This question of imminence is addressed through the Reforming Victoria's privacy legislation: Consultation questions. (Q.14?)

If imminence is removed it is likely that we would not need an IUA for information sharing with current clients. We may still need an IUA for information sharing on past clients. The definition of 'serious threat' is unclear at present. 'At risk of homelessness' could be considered a serious threat. NZ and the Commonwealth have dropped 'imminent'.

Once we have decided to share information and clarified that we can, we need to put procedures in place to ensure secure sharing. We need to apply the appropriate security controls across organisations.

Resources on the website:

- Guidelines for sharing personal information
- Flow chart – things to consider before you share information
- Interactive pdf – before you decide the share.
- Guidelines for applying for an IUA.

Implications
The RAMPS IUA does not cover issues covered by the Health Records Act.

We could probably address privacy issues with current clients by having an MOU about what information we would share, how and why, so we can be clear with clients who can then consent or otherwise.

Action: Agencies to considering responding to the Reforming Victoria's privacy legislation: Consultation questions, address the removal of the term 'imminent' from 'imminent and serious' risk in the exemptions; available at:
http://www.bswhn.org.au/attachments/article/1082/Consultation Paper - Reforming Victoria s privacy legislation.pdf

5. Wrap up

Should anyone else be invited to participate?
NW Mental Health, Orygen Youth, Homelessness Access Points.

Kris summarised that there seems to be adequate support in the room to continue with this process.

Other linked projects:
HOMS
Wodonga WIllum? NEAMI is lead
Frontyard – management of partnerships
People in the room to speak about collaborative work
More work on collective impact G21 Corio project, Monash Uni
Lifeline and other telephone services
Share bibliography
Criminal justice - CISP, Assessment and referral court, (Melbourne Magistrates Court) ex HOPS worker doing MH work there now; MAP
New remand prison