Models of Centralised Intake and Waiting List Management Systems: Feasibility Report

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FEASIBILITY REPORT

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Abbreviations

AHS	Area Health Service
AMHS	Area Mental Health Service
CANSAS	Camberwell Assessment of Need Short Appraisal Scale
Department of Housing	New South Wales Department of Health
Department of Health	New South Wales Department of Housing
HASI	Housing and Accommodation Support Initiative
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

1 Introduction

This Report has two main objectives. The first is to review three models of centralised intake and waiting list systems and assess how feasible features of these respective models are for HASI. The three services / programs reviewed are the Victorian Living Options Service, the Access to Community Care and Effective Services and Supports (ACCESS) program and the Assessment and Referral in Homelessness Services Project (A&RHSP). The second objective is to outline the possible benefits and also the potential limitations and challenges a centralised intake and waiting list management system has for HASI. This analysis is informed by the review of three models mentioned and by an in-depth interview with Brendan O'Conner, who was instrumental in setting up the Victorian Living Options Service.

The feasibility report has the following structure:

- The key components of integrated intake systems, the problems they potentially address and the challenges an integrated system possibly creates are outlined.

- The current systems of referral, assessment and allocation utilised in HASI are then described.

- Three relevant examples of centralised intake and waiting list management systems are reviewed and compared.

- Finally we suggest future models that could be adopted by HASI. This includes a discussion of the benefits and challenges of the proposed models. A key point argued is that a model does not have to be taken up in its entirety rather HASI could take on board components of a model and develop a partially integrated rather than a fully integrated model.

2 Methodology and Conceptual Framework

The primary research method utilised was a review of the relevant literature in this highly specialised area. The review allowed us to describe and analyse components of centralised waiting and intake systems, the issues they potentially address and the effects that have been observed in different contexts. The *Living Options Service Evaluation* (Corbo 2001), an evaluation of the *The Victorian Living Options Service*, was the key literature resource utilised. Literature evaluating the *The Statewide Assessment and Referral in Homelessness Services Project* was reviewed as was literature evaluating the *Access to Community Care and Effective Services and Support (ACCESS) Program* in the United States. The *Information Collection Systems in the Housing and Accommodation Support Initiative Issues Paper* (Morris *et al* 2004) guided descriptions of the systems currently operating within HASI.

In addition to the literature review, an interview was conducted with Brendan O'Conner, an integral member of the Victorian Living Option Service development team. The interview was conducted using an electronic question-answer format broadly covering all aspects of the system, its strengths and weaknesses and future directions. Each question was delivered in an open answer format to facilitate information collection, and to allow extended responding where necessary.

2.1 Defining the components of centralised systems

The following six components of centralised intake and waiting list systems in the mental health and housing sector can be identified: common / standardised screening and assessment tool/s; a networked database; an information interface; a common waiting list/reassessment register; a common needs evaluation process and an agreed upon allocation procedure. Each of these components is briefly defined below.

1) Standardised screening and assessment tool/s

In this situation all the service providers will use uniform selection criteria and assess eligibility for potential clients with the same tools.

2) Networked database

A common computer system that allows for the integration of relevant information from all services involved irrespective of physical location.

3) Information interface

This is the 'front door' to the services offered in the network. It can take a couple of forms. It may take the form of a physical location, such as an office where clients may go to acquire information, undertake initial assessment (screening) or be referred on to another more appropriate service. In a large geographical area there could be several 'front doors', however they will all provide uniform information and follow common procedures. The information interface could also include a common web-site describing the service and how it operates. A key feature of system integration is the need to appoint a coordinator to run the information interface (Rosenheck *et al,* 2002; Corbo, 2001). This staff member would play a major role in fielding enquiries, conducting screening and doing external service referrals if necessary.

4) Waiting list/reassessment register

A waiting list can be defined as 'the way information about applicants for housing and their housing needs are recorded, updated and used to ensure equitable allocation of housing' (NSW Federation of Housing Associations 1999: 6). The process and frequency with which it is updated can vary and there are also a range of possibilities as to how individuals on a waiting list or reassessment register are prioritised. A key aspect is that with a centralised system the waiting list is usually processed centrally according to uniform criteria.

5) A uniform needs evaluation process

A uniform needs evaluation process can be defined as utilising ranking criteria to prioritise applications. There are a number of ways this can be achieved. The NSW Federation of Housing Associations recommends a needs based points system (NSW Federation of Housing Associations Inc 1999: 14). This is the process of ranking clients according to the different weightings assigned to each criterion (NSW Federation of Housing Association Inc 1999: 13). This method potentially provides equitable access to limited resources as it takes into account changes in circumstances and needs status of potential clients.

6) Allocation procedure

This is the allocation of resources to priority clients on the register. Ideally, in a centralised system it is undertaken by a selection committee comprised of all partner organisations. This practice has the potential to ensure transparency and that the highest need clients are placed first.

2.2 Issues targeted through centralised systems

Through a review of reports (Corbo 2001; NSW Federation of Housing Associations Inc 1999; Thomson 2001; Coccozza *et al* 2000) describing and evaluating integrated systems in the mental health sector and the housing sector, it is evident that these system components have been adopted to address a range of issues and objectives (summarised in Figure 2.1 below). For example, the literature indicated that common *needs evaluation processes* addressed the aims of achieving transparency, obtaining accurate data on housing needs and endeavouring to ensure equitable access to resources for applicants. A common *information interface* helped address transparency and equitable access issues. Thus it can be seen that the components adopted within a system largely determine which aims of the system are achieved. Figure 2.1 below details the range of issues addressed by each identified component of centralised waiting list and intake systems.

Figure 2.1: Issue grid

COMPONENT / ISSUE/AIM	Standardised Screening and Assessment Tool	Networked Database	Information Interface	Waiting List / Reassessment Register	Need evaluation Process	Allocation Procedure
Transparency	Helps ensure target groups are reached and that all potential clients experience a similar assessment process	Department of Housing and Department of Health will be able to access housing and service provider client records.	Potential clients receive all the relevant information regarding the services offered.	There will be a uniform policy and the criteria will be standard across providers.	A common allocation system would ensure greater transparency of needs assessment and the standardization of allocations.	
Accurate data on housing needs	Clients' characteristics will be accurately and consistently described facilitating comparison and outcome evaluations. Provides an accurate profile of client characteristics.	Provides information on those waiting for services and those who have received assistance. Allows the identification of areas of demand and unmet need. Assists in the evaluation of the quality of service provision.		Clients will only be presenting to one register, rather than to many different registers. It will hopefully provide a more accurate depiction of demand.	Client characteristics will be accurately and consistently described facilitating comparison and outcome evaluations. Provides an accurate profile of client characteristics.	
Autonomy of housing / support providers	Housing and support providers gather only the information requested by Department of Housing and Department of Health. There is no individualised 'back page'.	Department of Housing and Department of Health will be able to access housing and service provider client records.		.	Need is determined by Department of Health and Department of Housing criteria, not by their own. There are no individually determined need hierarchies.	Housing and support providers accept clients according to criteria stipulated by Department of Health and Department of Housing rather than their own.
Equitable access	Evaluations will be based on standardised criteria applying equally to all applicants.		Information received by potential clients will be similar.	Those placed on waiting for services all meet the same entry criteria for entry into HASI as stipulated by Department of Housing and Department of Health.	Those most in need are identified and given priority.	Uniform rather than individual determinations will facilitate objective, needs based resource allocation.

3 Systems Utilised by HASI-1

The process of gaining access into HASI-1 can roughly be broken into five stages - referral, application, assessment, filling a vacancy and finally meeting with the applicant. At present the way HASI is structured gives the support providers and other partner organisations a good deal of discretion as to who will be accepted into HASI and to shape the way each stage operates. There is little standardisation or uniformity.

The five stages

1) Referral

For a person to be considered for HASI, they must be referred to the local accommodation support provider. Referrals can be made by clients' family members, friends and carers, but in most cases referrals come from community mental health services and hospital inpatient units.

2) Application

Once a referral has been made, an application form is completed. In sites supported by New Horizons and Richmond Fellowship, the referring agent is responsible for completing the application form and obtaining informed consent. At sites supported by Neami, the referring agent provides Neami with the contact details of the applicant. A Neami staff member then completes the application form in an informal face-to-face interview with the client. The potential client's case manager and / or the referring agent will also attend this meeting.

Once the application form has been completed it is forwarded to the local selection committee. These committees are responsible for assessing the eligibility of applicants for HASI and will usually be comprised of members from both the support provider and the Area Mental Health Service.

Importantly, while there are many similarities in the information gathered during the application process, each support provider has developed their own application forms. For a more detailed account of the commonalities and differences re the application forms and application process of the respective accommodation support providers refer to Morris *et al* (2004: 10).

3) Assessment

HASI requires that for an applicant to be deemed eligible they must be aged between 16 and 65 years; diagnosed with a severe mental illness such as Schizophrenia, Schizoaffective Disorder or Bipolar disorder; be experiencing moderate to severe levels of psychiatric disability; not be in an acute phase of mental illness that requires inpatient treatment; be capable of benefiting from the provision of accommodation support services and be capable of providing informed consent to participate in the program (Deakin 2004 Part B: 11-13; NSW Health and Housing 2003: 42-50).

In addition to these criteria and reporting requirements, Neami and Richmond Fellowship also stipulate that applicants who have drug, alcohol or self-harm issues, must be able to be managed safely within the support levels available.

If they satisfy the eligibility criteria, HASI requires that each client undertakes a relative needs assessment. This includes a life skill profile, an account of the client's present accommodation status and a record of the number of days spent in inpatient care over the previous 12 months. Information is also required regarding the applicant's levels of support needs, levels of ongoing disability and any additional health problems they might be experiencing (Deakin 2004 Part B: 11-13; NSW Health and Housing 2003: 42-50).

Whether an applicant is deemed eligible depends on their assessment results, and on the evaluation of the *local selection committee* in the cases of Neami and Richmond Fellowship, and the *local placement committee* for New Horizons.

4) Filling a Vacancy

Once an applicant has been determined as eligible and their needs assessed, they are placed on a register of applicants in accordance with their relative needs score. People with a greater score are placed at the top of the register and are considered to have the greatest level of need at that time. It would appear that in all the sites the register is frequently reviewed and the order of applicants can change.

The register is known as t*he register of applicants* in sites supported by the Richmond Fellowship and *the contact register* in sites supported by Neami. These assignment lists are consistent with the earlier definition of a *Reassessment Register.*

5) Meeting with applicants

Once a vacancy is available and the applicant has been accepted they are now considered a client of HASI and proceed to a final meeting with their local support provider. At this meeting the service provider provides the applicant with more information regarding the Initiative, determines their support needs, establishes a rapport and finally obtains the applicant's informed consent to participate in HASI.

3.1 Strengths and Weaknesses of the present HASI intake and waiting list systems

The potential strengths and weaknesses of the systems currently employed by HASI are listed below.

Strengths

Autonomy

- Service providers are able to assess and determine the eligibility of those clients who present to their service. This can give service providers a sense of ownership and control over the process and thereby make them more committed to the program.

- Service providers can interact with that client numerous times before they are finally accepted into HASI, facilitating the process of building the rapport with the applicant necessary to facilitate appropriate service provision.

- Service providers are able to accept the clients that they feel they can best assist with their available resources.

Transparency

- The current local committees involved in the selection and placement of HASI applicants allow representatives from partner organisation to contribute to the placement process. Thus, the allocation committees have the potential to act as self-regulating mechanisms to ensure that appropriate (using HASI criteria) placement determinations are made.

Weaknesses

Autonomy

- Service providers are able to reject applicants who do not meet their own additional eligibility criteria but who fit the criteria for acceptance into HASI as defined by the Department of Housing and the Department of Health.

- Service providers are able to accept those applicants who they deem most appropriate independent of their demonstrated level of need.

Transparency

- There is no single source that Department of Health or Department of Housing can access to ascertain whether or not HASI target clients have gained access into HASI or the HASI reassessment registers.

- There is no reliable means by which service providers can be held accountable for their placement decisions. Without a centralised database it is not possible for the relevant Departments to evaluate the appropriateness of the selection decisions of service providers.

Access to accurate data

- At any given time there is no single source that the Department of Health or Department of Housing can access to ascertain who is in HASI, who is waiting for a HASI vacancy or who has been deemed ineligible for HASI;

- There is no reliable mechanism through which to inform statewide planning and allocation of services. That is without a centralised source of reliable data the information available for the purpose of informing funding decisions will probably be inadequate. For example, housing needs across regions will be difficult to ascertain.

- There is no single source from which to obtain and analyse information regarding HASI statistics including demographic details, successes, attrition and progress. This means it is difficult to ascertain whether HASI has achieved its goals.

Equitable access

- There is no way to ensure HASI target clients have equitable access across local support provider sites.

4 Literature and Model Review

In conducting the literature review of centralised intake and waiting list management systems it became apparent that there was a paucity of literature that describes and evaluates these systems. This was compounded by the specific target population of HASI - individuals with a psychiatric disability. In general, the literature on centralised intake and waiting lists tended to refer to generic populations and housing services, and did not focus specifically on supported accommodation and housing services for individuals with a psychiatric disability.

The three evaluations we examine below were selected because they capture in different ways vital features of centralised intake and waiting list management systems. *The Victorian Living Options Service evaluation* was the primary source of information regarding the development of standardised and screening assessment tools, networked databases and waiting list management. Furthermore, it was selected because the population it targeted was comparable to that of HASI.

The second evaluation chosen for inclusion in the literature review was *The Statewide Assessment and Referral in Homelessness Services Project*. Its inclusion was driven by the comparability of the geographical scale on which the HASI and homelessness projects operate. Furthermore, the homelessness project provided a strong conceptual framework for the discussion of centralised intake as it identifies and describes various intake models and the components required in constructing them.

The final evaluation presented in this review is the *Access to Community Care and Effective Services and Support (ACCESS) Program*. This was the only empirical investigation of the systems required to facilitate the operation of centralised intake and waiting list management. It examined the local interagency coordinating bodies, inter-agency management information systems / client tracking systems and standardised application procedures.

4.1 Victorian Living Options Service

The Living Options Service, established in 1998 (it ceased operations in 2002), was a 'centralised information, intake and referral service of Housing and Support Services provided for people with a psychiatric disability' (Corbo 2001: 3). The service covered the Northern region of Melbourne and operated as a single point of entry for all housing and support services in the region. It was funded by the Department of Human Service and managed by Neami. Neami was instrumental in the development of the service, was the fund holder and employed the coordinator (interview with Brendan O'Connor).

Entry to the system was through the central location point of the service, with participating services linked via the Living Options Service Intranet (Corbo 2001: 8). Clients were able to access information such as vacancy and eligibility criteria in each of the eight housing and support providers that participated in the Living Options

Service. A uniform screening tool was developed and, following completion of this, clients could be referred to the most appropriate service within that region. The Living Options service also managed and co-ordinated the regional database and website and clients could access information regarding generic housing options and services.

The evaluation of the Living Options Service Pilot (Corbo, 2001) is summarised below.

1. Development of the screening tool

The development of the screening tool was undertaken by a subgroup of the Northern Residential Mental Health Services Reference Group (NRMHSRG). In order to ensure that their understanding of housing, support, assessment and referrals had a common framework, the services worked together to develop the screening tool (Corbo 2001: 15). This involved the coordinator of Living Options meeting with each of the participating services and noting what questions were desired and what the concerns were. Ultimately the final screening tool was made up only of those questions agreed to by all the participating providers (interview with Brendan O'Connor).

The screening tool developed did not, however, alter the internal assessment procedure of participating housing and support providers as they maintained a 'back page'. Maintenance of individual 'back pages' allowed for further assessment of suitability by service providers using their own criteria (Corbo 2001: 15). The evaluation found that agreement on the content of the common screening tool would probably not have occurred if service providers were told that they were not able to have their own 'back pages'.

2. Ownership of the Living Options Service

As mentioned above, Neami managed the Living Options Service and held the funds for the service, employed the coordinator, and managed the website and database. The evaluation reported that a number of housing and support services felt that the service operated for the primary benefit of Neami and that they received little or no benefit from their involvement and did not feel that they were equal stakeholders. For example, three housing and support services saw the Living Options network as a program designed by Neami to manage their own housing system (Corbo 2001: 14).

Furthermore, Corbo (2001: 14) noted that as participation was on a voluntary basis, services/organisations could exit Living Options at any time. In the two years proceeding its establishment one organisation did leave the network, demonstrating the dilemma of forming voluntary partnerships. The evaluation concluded that if any more services exited Living Options, the whole program could be threatened (Corbo 2001: 14).

3. Management support and workload change

The evaluation highlighted issues regarding managerial support, organisational arrangements, and workload changes. One concern was that 'workers reported they were expected to juggle the Living Options Service commitments around their existing support work' (Corbo 2001: 15). This was resented by some workers.

Furthermore, there were cases where management had failed to inform workers of their participation in Living Options. In these cases resentment was also evident (Corbo 2001: 15).

On the other hand, service providers reported that in some areas their workload had decreased as a result of Living Options. Many reported a reduction in their workloads due to all initial queries and screening being redirected to Living Options (Corbo 2001: 19). Furthermore, services indicated that their intake process had become less time consuming due to Living Options collecting the initial information. Clinical services also reported a reduction in workload as all their housing and support queries could be directed to one central point. They no longer had to contact individual service providers (Corbo 2001: 20).

4. Costs/Funding

A number of agencies expressed their disappointment that the lead agency (Neami) received the funding despite the fact that all incurred some costs for participation in the Living Options service. Other issues identified were the lack of funding for computing resources (reducing the capacity for involvement by some organisations), cost of staff training and meeting times.

There were costs involved with the development of the database, its installation and associated training and support. The developer of Living Options revealed that there were some initial difficulties in developing a secure web-based database however these were overcome through the support of the company contracted to develop the information technology system.

The interview with Brendan O'Connor also highlighted problems regarding the ongoing funding of the project. When pilot funding from the Victorian Department of Human Services ceased after 2 years, North Central Primary Care Partnerships then took up funding for a period of 6 months, with the remaining 6 months of operation funded by NEAMI. However, attempts to secure further ongoing funding from the Department of Human Services were unsuccessful and Living Options was eventually forced to close its doors.

5. Data collection / Planning tool

A benefit highlighted by many of the services was the potential use of data collected via the centralised database for planning purposes. The Department of Human Services indicated that data collected would have an application as a planning tool for the area's housing needs. This view was reiterated in the interview with Brendan O'Connor who highlighted the additional benefit of eradicating double counting for clients on multiple waiting lists. Furthermore, he noted that service gaps could be identified with greater ease

However, the evaluation by Corbo (2001: 18) indicated that three housing and support services indicated that they were not enthusiastic about the idea of data collection as this had the potential to increase service accountability. The evaluation suggested that they found this threatening as it could expose inefficiencies.

6. Waiting lists

Although the Living Options Service was not utilised as a central waiting list by most of the of services, some indicated that they would eventually do so as a way to eradicate the duplication of client information and administrative effort (Corbo 2001: 20). There was, however, some scepticism about having one waiting list. Several of the services felt that 'if a consumer was on only one list their chances of getting a service was reduced, and it could make their wait seem longer' (Corbo 2001: 20).

Summary and Conclusions

The evaluation of the Living Options Service and the interview with a key developer of the service indicated benefits, both actual and potential, and challenges of a centralised intake and waiting list system. Five clear potential benefits could be identified:

a) increased access to and reliability of data to inform funding and planning for future housing needs of the target population;

b) potential for increased accountability of housing and support services;

c) potential for a single waiting list that negates the need for individual providers to maintain and update their own lists;

d) reduction in workloads for clinical, housing and support service staff relating to information collection and accessing services;

e) potential for such a service to expand to include additional services and catchments areas.

The challenges identified included

a) the need for agreement among multiple housing and support providers regarding the content of an initial common screening tool;

b) dissatisfaction and resentment among several service providers that management, funding and co-ordination of the Living Options service sat solely with one participating service provider (Neami);

c) whether such a service could be self-sufficient (which remains unknown) and its dependency in the initial stages on ongoing funding beyond the pilot phase;

d) potential ongoing viability concerns when individual service providers cease their participation;

e) need for management / organisational support and recognition for the value of the service and the impact of participating on existing workloads for staff.

It is important to acknowledge the differences between the Living Options Service and HASI when considering the evaluation offered by Corbo (2001). Firstly, the Living Option Service included a range of housing support services for individuals with a psychiatric disability, offering long-term, shared, gender specific and permanent accommodation across a small region of Melbourne. In contrast HASI currently involves one housing and one accommodation support organisation in each local government area and covers most of New South Wales.

Secondly, the target populations differ. HASI 1 focuses specifically on clients with high support needs, while Living Options also involved a referral service for all individuals with a psychiatric disability and hence provided a systematic referral component and follow-up. It is unclear if such a comprehensive service is feasible for HASI at this stage.

Based on the Living Options evaluation, it appears that any centralised intake and waiting list management model proposed for HASI would ideally not involve one support provider managing the centralised system. This issue has also been recognised by other housing services, such as the NSW Federation of Housing Associations, that suggest it is inappropriate for a dominant service provider to manage a database and refer to services within the network that they are a part of.

A further issue concerns determining the funding body and the period for which resources are provided, as inadequate funding can undermine the contributions made by partner organisations to developing centralised intake and waiting list systems.

In regards to developing a common screening tool, agreement would probably be necessary among the support providers currently funded by HASI as to the content of this. A related issue concerns the appropriateness or desirability for the separate services to retain a 'back page' as the HASI funded services are all targeting the same population i.e. clients with high support needs. Thus a balance needs to be determined between autonomy for service providers including what they are equipped to offer clients, and equitable access to housing and support for HASI clients regardless of location.

4.2 The Statewide Assessment and Referral in Homelessness Services Project

The Assessment and Referral in Homelessness Services Project (A&RHSP) was funded and managed by the Community Programs Group of the Department of Human Services in Victoria during 2001. It was established to address the issue identified by the Victorian Homelessness Strategy that

> a lack of clearly visible entry points to the homelessness system, a lack of readily available information about service options, and poor co-ordination between existing services, made clients' experience of seeking assistance complicated and stressful. (Thomson 2001: 1)

The A&RHSP concentrated on the 'front door' of the homelessness service system. In the process they focused on the following aspects:

- The identification of appropriate entry points and pathways to assessments and referral for homeless people requiring access to support, accommodation and information. This relates to the appropriateness of systems incorporating a single information interface rather than those which require contact directly with the service provider as in the case of HASI.

- The development of principles for best practice in assessment and referral and the construction of a model assessment tool so as to address the necessity for standardised intake and assessment tools in centralised systems.

- The development of IT systems for assessment and referral across key entry points.

The evaluation of A&RHSP focused on comparing different models of integrated, coordinated service systems in order to evaluate the system approach which best supported improved assessment and referral. In doing so the evaluators identified two kinds of systems integration approaches which differed in their approach to system entry.

The first model incorporates all those models which adopt single or limited points of intake, assessment and or referral: 'Such models involve a designated service or a small number of services that undertake key access, assessment and referral roles on behalf of the broader service system' (Thomson Goodall Associates 2001: 16). Services in this category have a designated entry point which applicants seeking to enter the service must contact. If contact is attempted at some other location in the network, this location will refer the applicant back to the 'front door' for assistance.

The second model maintains multiple entry points. This model 'incorporate[s] multiple agencies within a network or cluster working consistently to provide a complementary approach to access or intake, assessment and referral' (Thomson 2001: 14). When contact is made with any service network with an 'any door' structure the applicant will be assisted at the point of contact rather than at a central hub. Each of these 'doors' or contact points will give the client access to the full range of available services within the network.

Although the evaluation stops short of concluding that one model is superior to the other, it does describe what components are required for a model to be successful. The evaluation recommended that the Victorian Department of Human Services do the following in order to optimise the service:

1. Develop a process to finalise, ratify and operationalise *common* tools, principles, guidelines and processes across the different homelessness services.

This recommendation was premised on the argument that there is a need to ensure consistency in the implementation of assessment and referral systems within the homelessness network. Common tools and processes would also increase the possibility that individuals would be directed to the most appropriate service for their

requirements and not be 'bounced' from one service to the next. In order to achieve consistency, projects to develop common tools and guidelines would need to be coordinated centrally (Thomson Goodall Associates 2001: 69).

2. Develop agreed standards for assessment and referral in all homelessness services

This suggests that standards should be supported by a quality improvement strategy and a compliance framework linked to funding (Thomson Goodall Associates 2001: 70). That is, in order for services to continue to receive funding they must meet the standards agreed to by the funding body and partner organizations regarding appropriate service provision.

3. Implement a training strategy for assessment and referral including joint training across services (Thomson Goodall Associates 2001:71).

It was argued that that this would facilitate the development and implementation of standardised assessment and application tools and this will help ensure that access to services are consistent and equitable.

4. Develop, implement and resource an Information Technology (IT) strategy

It was argued that improved IT systems are required to 'support the assessment and referral frameworks' (Thomson Goodall Associates 2001: 71). The evaluation argued that there needs to be a compliance framework so as to 'to ensure all homelessness services participate'(Thomson Goodall Associates 2001: 71). The IT system would ensure that there was up-to-date data on vacancies and support available.

5. Develop standardised data collection for homelessness services. This would need to be linked to the IT strategy (Thomson Goodall Associates 2001: 71).

This relates to the need for accumulation of accurate data at a centralised location in order to inform planning and resource allocation decisions.

Although the state-wide scale of the A&HRSP evaluation exceeds that of HASI and its partner organizations, this evaluation has the potential to inform decisions regarding the structure and components of a potential HASI centralised intake system. The evaluation suggests that while the entry category, be it single or any door, to a system is not crucial, it is vital that the system incorporates standardised assessment and application tools, guidelines and interagency agreements regarding standardised and equitable assessment and considers and implements an appropriate information technology strategy, which adheres to privacy principles and has the capacity for an accurate and comprehensive collection of data and analysis thereof.

4.3 Access to Community Care and Effective Services and Supports (ACCESS) program

In 1993, the ACCESS demonstration program was established by the U.S. Centre for Mental Health Services with the aim of improving the life outcomes of homeless individuals with severe mental illness through the integration of support services.

These included intensive mental health, substance abuse, housing, primary care and income maintenance services (Randolph, *et al* 2002). By the end of 1999, approximately 400 clients had passed through each of the 18 ACCESS sites. Each site was given $US500,000 per year to provide intensive outreach and assertive community treatment to homeless persons. An additional $US250,000 was provided to nine of the eighteen sites each year for four years to implement strategies of systems integration (Rosenheck, *et al* 2002: 958).

The ACCESS evaluation sought to investigate the 'extent to which a higher level of systems integration of the services needed by people who are homeless and mentally ill results in improvements in clients' functioning, quality of life, and housing outcomes' (Coccozza, *et* al 2000: 397). It also focused on the actual process of integrating these services, that is the strategies adopted, the amount of time involved and its overall success. It is this aspect of the ACCESS evaluation which has the potential to inform decisions regarding the feasibility of centralised intake and waiting list management systems for HASI.

The evaluation defined 'systems integration' as a process involving 'the development of interagency partnerships that establish linkages within systems and across multiple systems to facilitate the delivery of services to individuals at the local level to improve treatment outcomes' (Randolph *et al* 2002: 946). The authors of the ACCESS evaluation identified 12 separate integration strategies employed across the nine integration sites. While all of these approaches are not relevant to centralised intake and waiting list management, three of the components correspond closely to those described earlier in this report. These are discussed in turn:

- Local-interagency coordinating body

This component is similar to the *Allocation Committee* and is defined as 'a group composed of representatives from multiple agencies who are brought together to address common concerns' (Coccozza *et al* 2001: 401).

- Interagency Management Information Systems/Client tracking systems

Akin to the *Database*, this strategy describes a 'computer tracking and management information system that links participating agencies, promotes interagency sharing of information, simplifies interagency referrals, minimises paperwork, reduces duplication of services and facilitates access to services by clients' (Coccozza *et al* 2001: 401).

- Uniform applications, eligibility criteria and intake assessments

This approach parallels the *Standardised screening and assessment tool* and is defined as 'a standard process or form containing information used by participating agencies that an individual completes only once to apply for or receive services' (Coccozza *et al* 2001: 401).

Relating to these components then, the ACCESS evaluation found that the investment of $US250000 per year for nine sites, with the purpose of supporting integration strategies yielded mixed results. Most successfully, the *Local-Interagency coordinating body* was fully implemented at all nine sites within the five-year trial,

while *interagency management information systems/client tracking systems* were in their initial stages at seven sites by trial completion. Finally, *uniform applications, eligibility criteria and intake assessments* were utilised at less than half of the nine sites and even then were still only in their initial stages. These findings led evaluators to conclude that some strategies have a higher probability of being successfully implemented than others, however they were unable to definitively explain why this is so (Coccozza *et al* 2000: 405). It was further concluded that systems integration strategies could be implemented, but only with significant additional technical assistance (Goldman *et al* 2002: 967).

The implications of this research for HASI is that centralised intake and waiting list management systems are costly in terms of both time and money, and that the investment of both of these resources does not necessarily mean that all aspects of the system will become operational or that investment in systems integration will produce the desired outcomes (Goldman *et al* 2002: 968). The evaluation of the ACCESS program also suggested that some strategies like uniform application eligibility criteria and intake assessment are more challenging to establish than other integration strategies like the local-interagency coordinating body. It is important to note that the integration attempted through ACCESS required the contribution of more diverse services than those participating in HASI, a difference which could have increased the difficulty and cost associated with integration.

4.4 Summary of general and HASI specific benefits and challenges identified through the review of the three models

1. Standardised screening and assessment tool

Benefits - General

- Potential clients across many catchment areas are compared against the same eligibility criteria. This hopefully ensures that uniform criteria for admission are used irrespective of which service the client is applying to and that there is equitable access for all target individuals.

- Where a standardised screening and assessment tool is used it also has implications for the needs evaluation process. It facilitates the development of fair, efficient and consistent priority determinations and definitions of housing need.

- It provides information regarding clients in a standardised format that facilitates data comparison and analysis across services as all characteristics will be assessed and categorised in a standard fashion. This removes the potential for mis/multiple classification of client information.

- The use of a standardised screening and assessment tool limits the extent to which hidden criteria can inform and direct determinations of eligibility as all decisions are guided by the tools rather than the assessor or service provider.

Benefits - HASI

- Clients applying for housing and support services will be compared against the same eligibility criteria, irrespective of the identity of their local support provider.

- All local service providers will use the same screening and assessment tool. This will ensure that the HASI program will be client driven rather than service driven - the clients' characteristics rather than the service provider will determine eligibility.

- The standardised screening and assessment tool should provide a means of collating statewide data on HASI client profiles and levels of need. This will indicate what the current HASI service system is capable of providing and where changes need to be made.

- The use of a standardised tool should limit the extent to which the staff of various local area accommodation support providers are able to influence eligibility determinations beyond the scope of the selection and assessment criteria.

Challenges - General

- Services attempting to develop a standardised application and/or assessment form have found it difficult to satisfy the requirements of all partner organizations in one document.

- Developers of this component of the system must be careful that the tool is not so broad that it leads to too many people meeting the eligibility criteria as this could lead to the inappropriate inflation of waiting lists/registers (NSW Federation of Housing Association Inc, 1999: 11). It also may give those waiting the mistaken impression that they may be housed at some point when the reality is that only a small percentage will be housed (NSW Federation of Housing Association, 1999: 12).

- Standardised measures may limit the extent to which service providers are able to match client eligibility with their own specific service aims, workers' skills and service resources. This means, that service providers utilising a standardised tool may find themselves obliged to accept clients that they do not have the resources to manage. Ultimately this may lead to poorer quality service provision for a subset of the target population.

- The use of a standardised screening and assessment tool limits the extent to which professional judgment can inform and direct determinations of eligibility as all decisions are guided by the tools rather than the intuitive knowledge and experience of the individuals involved in client selection.

Challenges - HASI

- Agreement among all the stakeholders as to the content of a standardised screening and assessment tool may lead to the broadening of the eligibility criteria in order to accommodate the differences of each service. This may lead to inflated waiting lists.

- The service providers may not all have the skill capacity to gather certain information. Such differences between local service providers may result in the adoption of individualized 'back pages' which ultimately may undermine the benefits gained from the implementation of standardised tools.

- The removal of the autonomy of local area support providers is potentially a contentious and delicate matter. It could be responded to with hostility and has the potential to undermine the partnerships formed.

- A possible implication of a standardised client-centred approach is that service providers may find themselves ill-equipped to meet the needs of their clients.

- By removing the role of intuitive professional experience from eligibility determinations, the potential exists for valuable skill and judgment to be lost. It could also have an impact on the skill development of staff members by limiting the areas of expertise they may explore.

2. Networked data base

Benefits - General

- The database allows reporting and monitoring of application processes and outcomes and thus assists in maintaining the accountability of the selection decisions made by all partner organizations. This is achieved by the adequate and appropriate reporting of required information into the database.

- A centralised repository for all data gathered from client applications and assessment allows for the collection of a range of accessible, useful data - the identification of client characteristics; clients' progress and outcomes; estimates of waiting times; estimates of housing needs within regions; advocacy for service provision and funding allocations; identification of service gaps (e.g. where one type of client is consistently found ineligible for available services) and for ensuring that service providers are held accountable for any mismatch between stated and demonstrated target populations.

- Where appropriate consent has been obtained all partner organizations contributing to the networked database may access and gain up-to-date information at any time. Thus the status of every client on the database can be accessed at any given time in order to assist the tracking of client outcomes.

- Streamlining of information transfer through the introduction of electronic processes should reduce the amount of time involved in processing a client's application and providing the relevant data to those who require it to tailor service provision.

- Individual service providers no longer have to provide different information to each of the interested partner organizations. This could translate into greater service efficiency and increased long-term cost effectiveness.

Benefits - HASI

- The centralised database will enable the Department of Housing and the Department of Health to view the status of the HASI project at any given time. This means they will be able to see who has applied, who has been accepted / rejected, on what grounds and by which local accommodation support service. Thus it should be possible to assess the extent to which HASI eligibility criteria determine entry into the HASI system.

- A database should facilitate the decision-making process by informing the relevant Departments of the development or tailoring of services in response to the gaps that have been identified in the provision of services to individuals with a severe psychiatric disability. It will also allow more informed decision-making regarding ongoing and future funding requirements appropriate to the maintenance of the current level of service provision and possible service expansion across regions and providers.

- The database will allow service providers and the Departments (Health and Housing) to view the status of HASI at any given moment. This means that they should be able to more efficiently fill vacancies, gather information regarding client outcomes and analyse the profiles of clients who benefit most from the services offered within HASI.

- The data gathered through the screening and application process could be readily transferred to relevant allocation committees to facilitate speedy determinations regarding eligibility.

- Accommodation support providers are currently required to fill out many documents regarding their dealings with HASI and its clients. The process of completing and submitting these reports should be easier and probably more efficient when electronic transfer is possible.

Challenges - General

- Confidentiality and privacy of applicants in the way that their personal information is collected, stored, verified and employed presents a significant challenge. Sophisticated monitoring mechanisms will have to be developed to ensure compliance with privacy and consent legislation.

- The use of a centralised database would require applicants' consent to place their information on this database and allow for it to be transferred electronically. If many clients refuse to give their consent there is the potential for the networked database to be significantly undermined in terms of the benefits it will be able to deliver.

- There needs to be managerial support of the time investments required of staff in order to establish and learn the data collection system. As mentioned this has been found to be a time-consuming and challenging process that is often undervalued. Effective operation of the database requires that all staff members display competency in the procedural skill set necessitated by information technology systems. The database may be undermined by a lack of training, support or time investment on both staff and managerial levels.

- There would be a substantial cost involved in designing, implementing, staffing and supporting the improved information technology system required to underpin a centralised intake and waiting list management system. As discussed the ACCESS program in the United States provided $250,000 per year over four years to nine sites to facilitate systems integration and found levels of component integration across sites ranging from low to complete. Thus, even when substantial funds are forthcoming there is no guarantee a successful information technology network will result even in the long term.

- Staff member trained in IT development, maintenance and support would be required to facilitate the systems establishment, conceptualisation and day-to-day running of the system.

Challenges - HASI

- A specific system addressing privacy regulation would need to be developed for HASI to protect client information contained on a centralised database. This database also requires detailed consideration of who will have access and to what specific data. Further, it raises questions regarding the means by which compliance with privacy and consent regulation is monitored.

- Due to the time costs associated with database operation it may be necessary to develop an incentive based system to encourage staff compliance with data entry. Conversely, it may also be necessary to introduce some penalty for persistent lack of compliance with database maintenance. Either way it could induce staff resentment.

- Although the current HASI network of partner organizations is quite small, the introduction of a centralised database will undoubtedly be costly. It will require the employment of IT staff and the contracting of software design and support services. Thus it must be established that the costs of this network are outweighed by the benefits when the current and potential scale of HASI is considered.

- It has been noted in the course of the HASI evaluation that some accommodation and support providers do not currently employ any computerised records of their clients' status. Accordingly a great deal of hardware, training and support will be required to ensure that these services become familiar with the HASI database and the associated reporting requirements.

3. Information interface

Benefits - General

- There could be a reduction in the workload experienced by partner organizations as a result of a drop in the number of preliminary enquiries received by individual services.

- Clients who contact an information interface which offers referral will be put in touch with an appropriate service provider, rather than being told that they are not

suited to the service that they have contacted. This has the potential to streamline the process of accessing services.

- The introduction of an information interface will provide the scope for the seamless inclusion of additional service providers into an existing network as clients will not need to locate that service individually, or even be aware of its inclusion. All they will have to do is contact the interface which will then refer them to the most appropriate provider.

Benefits - HASI

- In the current HASI system, accommodation support providers receive enquiries about HASI and other programs directly. This can be very time-consuming. The implementation of an information interface would allow them to focus more specifically on the provision of support.

- Applicants who contact the HASI interface will not be turned away simply because they do not meet the specific HASI criteria, rather their need will be acknowledged and they will be assisted to locate the service most appropriate for their situation.

- If HASI were to expand to include more than one accommodation support provider in each local government area, applicants would not need to apply to each of these support providers, rather they could just contact the information interface and be referred to the one most suited to their needs.

Challenges - General

- The success of an information interface appears to hinge a lot on the skill of the coordinator. The coordinator role requires administrative, time management, policy and diplomacy skills (Corbo 2001: 16). Where this information interface takes on the role of a referral service a further skill set including crisis intervention, immediate needs assessment and risk assessment have been identified (Thomson 2001 Appendix D: A19). Finding the right person/s for the job will be a significant challenge.

- The boundaries of the services referral and information capacity must be clearly defined and appropriately resourced. Individuals who do not meet the specific criteria of the services offered will access this information source. Policy must be in place to ensure that paths of appropriate redirection exist.

- The information interface must be able to act responsibly when confronted by inquiries from non-eligible individuals. This means that it is not appropriate to ignore the situation of an inquirer on the basis that they do not meet the criteria of the services available as they may be demonstrating a real need which must be addressed. Thus the information interface must be able to help the inquirer to locate the service appropriate to them.

Challenges - HASI

- The size of HASI may mean that the benefits associated with an information interface may be outweighed by the costs involved with hiring a staff member/s with the skills required to operate it.

4. Centralised waiting list / Reassessment register

Benefits - General

- Service providers are no longer required to manage their own specific waiting lists or other information systems as this is done at the central location.

- How applicants are prioritised should become transparent as the reassessment register will be maintained and updated at a centralised location and can be compared with the allocation decisions made. If high priority clients are continually passed over questions can be asked as to why this has occurred.

- A centralised waiting list should prevent the same client presenting to each of the partner organizations thereby having their name on multiple waiting lists or reassessment registers. Multiple representation by clients may mean that other individuals are turned away from a service appropriate to their needs.

- The waiting list can be updated centrally. This should save time and streamline the reassessment and prioritisation process.

Benefits – HASI

- A common waiting list will eliminate the need for accommodation support providers to maintain, update and follow up the records of applicants waiting to gain access to HASI. This means that time previously spent in this fashion may be more appropriately invested in provision of support services.

- Records of high priority clients will exist external to the accommodation support provider. This should result in the movement of clients on the HASI register being monitored by an independent body perhaps drawn from the Departments of Health and Housing. This independent body could insist that a service provider takes particular clients and that potential clients requiring less support are not favoured over potential clients requiring high support.

- Should HASI expand to include more than one accommodation support provider in each local area, a common waiting list or reassessment register will prevent an applicant from presenting to each service in their area in the hope of expediting their placement. This means that waiting lists will be free from double counting and will accurately reflect the demand for HASI services.

Challenges - General

- Finding the funds to support the development of a common waiting list can be difficult. Communities Scotland allocated £686,462 to develop a common housing register over a two-year period running from 2000-2002 (Reid *et al* 2004: 15).

- Where the waiting list or reassessment register holds the data of clients eligible for many diverse services, there is a possibility that representation on only one list will slow the assignment process compared with the situation where a client presents to each individual service and is accepted on many waiting lists.

Challenges – HASI

- It is unclear what it would cost to develop a common reassessment register for HASI, but it is likely to be an exercise. Its implementation would at least require the development of an associated standardised assessment tool and a centralised database.

5. Needs evaluation process

Benefits - General

- Waiting lists that are prioritised according to need allow for a fair, efficient and consistent process of allocating resources as the sequencing and placing of applicants can be explicitly justified by the level of demonstrated need.

- It has the potential to ensure transparent, non-discriminatory decision-making via the abolition of hidden ranking criteria since all allocations are made on the basis of need alone (NSW Federation of Housing Association Inc 1999: 6 & 11).

- A need evaluation process is less susceptible to forceful or persistent applicants thereby preventing the frequency and forcefulness of requests for assistance influencing priority determinations and allocation decisions.

Challenges - General

- A needs based priority system limits the ability of providers to select applicants using their professional judgement and experience.

- A needs based priority system can only be fair, efficient and consistent where need is defined in the same way by all services contributing to the reassessment register. Inconsistent definitions of need may lead to the artificial prioritisation of applicants coming from a particular service over those assessed at other locations.

- Service specialisation could suffer to some extent from the adoption of a needs based allocation procedure as services will no longer be able to specialise in the support of individuals with a particular subset of characteristics, unless that criteria is shared by all services in the network.

Challenges specific to HASI

- Although HASI already has a needs based allocation system, its benefits are somewhat stifled by the absence of a standardised tool by which to determine an applicant's need, and a centralised database by which to monitor needs assessments. This undermines the fairness and consistency normally attributed to needs based allocation procedures.

6. Allocation procedure (a common placement committee)

Benefits - General

- It can assist in the development and maintenance of inter-agency partnerships (Randolph *et al* 2002: 946).

- Allocation of available resources are not made arbitrarily by one influential individual, rather are made by a group of invested parties. This tends to improve the impartiality and accountability of the allocation procedure.

- The existence of an efficient and impartial allocation committee is not explicitly dependent on any other component of integrated systems.

Benefits – HASI

- HASI currently utilises a committee based allocation procedure.

Challenges - General

- It is often difficult to convene a cohesive and cooperative committee focused on a common goal. The parties involved may be operating with differing agendas, priorities and scopes for compromise. Disunity and incompatibility can influence the extent to which the committee can make informed and appropriate resource allocations.

- Attending committee meeting may be time-consuming and difficult to arrange considering the number of people involved and the demands on workers' time.

Challenges - HASI

- It may be difficult to convene an allocation committee in a timely fashion after the notification of a vacancy as many people need to be contacted and common availability may be difficult to identify.

5 Recommendations

The literature review presented here indicates 'there is not one single approach to developing integrated coordinated service systems' and that many 'system integration initiatives include a combination of different approaches' (Thomson Goodall Associates, 2001: 13). Adoption of whole or part of an integrated system and its components depends upon a number of factors. Key questions are the resources available and the issues that a centralised intake and waiting list management system is intended to address. For HASI the considerations that need to be taken into account would probably include the following:

The resources available to HASI

Setting up an integrated, centralised system is expensive and requires substantial ongoing funding and skilled personnel.

Autonomy of service providers

A centralised HASI system might benefit from the inclusion of a networked database, a standardised screening and assessment tool and waiting list / reassessment register, need evaluation process and allocation procedure. This will remove a good deal of the autonomy and discretion of the local accommodation support providers and could ensure that there is equity as to who is admitted into HASI.

Transparency

A centralised HASI system using standardised screening and assessment tools and a network database would certainly be a lot more transparent. The relevant stakeholders will be able to track what applicants have been successful and who has not and what criteria were used for the making of decisions.

Accessible and accurate data

A centralised and more uniform system should result in the Departments of Health and Housing and other relevant stakeholders having much greater access to pertinent data. The networked database should allow the key stakeholders to easily access information on all relevant issues.

Equitable access

A centralised HASI system will enhance the possibility that intake into HASI is equitable and fair.

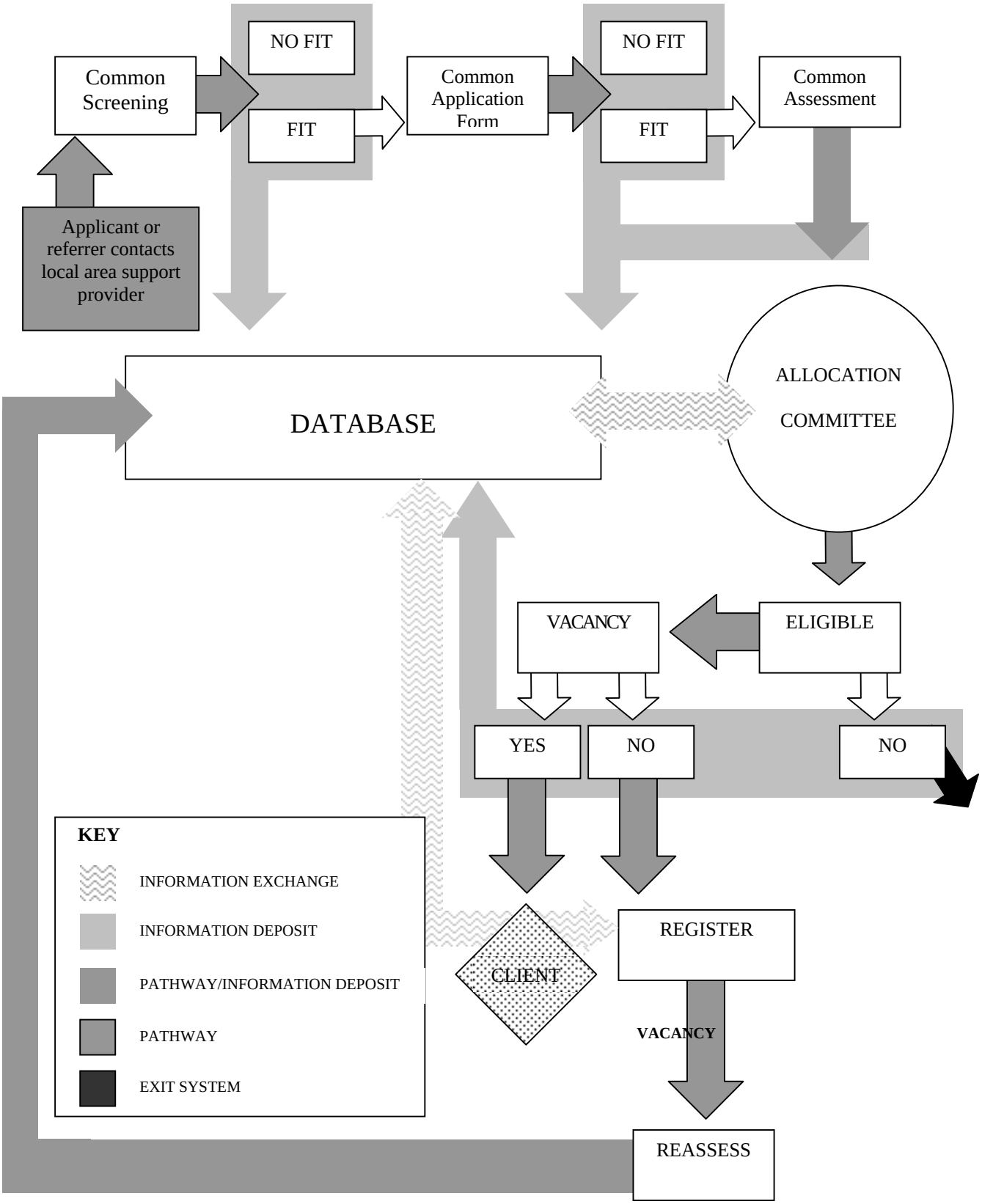
Clearly some parts of a centralised system are easier to put in place than other components. Thus the introduction of a standard assessment system would probably be easier and cheaper to set up than a networked database. The HASI program could contemplate instituting a partial rather than complete centralised intake and and waiting list management system. Some of the components are interrelated, however, and the inclusion of one may necessitate the inclusion of others in order to maximise the benefits resulting from the inclusion of that component. For example, the needs

evaluation process can only provide its full complement of benefits when coupled with both standardised screening and assessment tools and a networked database.

In conclusion it is the resources available and the aims and future directions of HASI that will determine if a centralised system is feasible or necessary and which components would be included in the final model. A significant expansion of HASI in the future may see the long–term benefits of systems integration outweigh its short-term costs. Figure 5.1 summarises how a partially centralised system could work and Figure 5.2 outlines how a fully centralised system would operate.

Appendix A: Intake and waiting list management model

Figure A.1: A partially integrated model for intake and waiting list management



The partially integrated 'any door' model represented by Figure 5.1, incorporates a selection of the components identified in other integrated systems. It utilises a common assessment tool, a networked database, a reassessment register, a reassessment process and an allocation procedure.

Step 1:

To enter this system the applicant or a referring agent contacts the local area service provider to enquire about an admission to HASI. At this first contact the service provider conducts a brief **screening** to ensure that the applicant meets the requirements of HASI.

Step 2:

If the service provider is not satisfied with the fit of the applicant the inquirer is immediately informed of the mismatch and a deidentified record of the outcome is recorded on the **database** by the service provider.

If the service provider is satisfied that the applicant at least superficially meets the criteria for entry into HASI, the service provider together with the referring agent, complete the standardised **application** form. This can be done at the time of screening where the inquirer is also a referrer. If the inquirer is the applicant, informed consent will be obtained at the application stage, which will retrospectively allow individuated information from the screening process to be entered into the database as well as future information regarding their progress through the system.

Step 3:

The model requires that upon completion of the application form the service provider reevaluates the fit of the applicant according to HASI's eligibility criteria. If there is no fit at this stage the applicant and the referrer will be notified of the mismatch.

If there is a fit the applicant will be required to undergo a standardised **assessment** process. This assessment will take the form of a face-to-face informal but structured interview between the applicant and the service provider. Consent will be obtained at this point if not already forthcoming and will retrospectively cover the information gathered at screening and application to allow this and future information to be entered into the database.

Step 4:

The information obtained by the service provider from the assessment is then entered into the database.

Step 5:

This information is forwarded to the **allocation** committee in order that the applicant's eligibility be determined on the basis of the application and assessment information. This committee will be composed of at least one representative from the relevant Area mental health service, the local service provider and the housing provider. In the case of eligibility, all the information regarding the applicant's pending acceptance onto the HASI **reassessment register** is forwarded to the

allocation committee. The eligibility of each applicant is determined by their compliance with HASI criteria. If deemed eligible the applicant is placed on the register and both the referrer and the applicant are notified of the applicant's progress.

If ineligible, the applicant and the referrer are informed of the mismatch and the applicant exits the system.

Step 6:

All information regarding eligibility decisions is entered into the database and is accompanied by a report from the placement committee to justify the decisions made. Accordingly, the decisions of the allocation committee are transparent to all of those on the networked database. Those applicants deemed eligible, but for whom there is no vacancy, are placed on the reassessment register.

Step 7:

When a vacancy becomes available the database generates a list of all the applicants waiting to be placed and forwards it to the appropriate local service provider.

Step 8:

The service provider must then **reassess** each applicant on the register and enter their updated information into the database. The database then prioritises the applicants according to a needs based points system. The information of the highest priority applicant is then forwarded onto the allocation committee to determine eligibility and then housability. If the client is deemed eligible, and also appropriate for the vacancy, the applicant then becomes a HASI client.

If the applicant's circumstances have changed substantially from the time of their original acceptance onto the register (i.e. the applicant entered an acute phase of their illness while waiting to be placed), that applicant may be deemed ineligible for HASI. If the allocation committee is not satisfied that applicant is suited to the available vacancy, they may place the highest priority applicant back on the reassessment register (notifying both the applicant and the referrer) and request that the information on the next highest priority applicant be provided by the database. Eligibility and housability determinations are made by the allocation committee until a HASI client is located. Again, all the decisions made by the allocation committee must be recorded and made available to all those on the networked database.

A fully integrated model

Important elements of a fully integrated model include

1 That each service operates according to a common set of principles and service philosophy.

2 Common tools, data and definitions

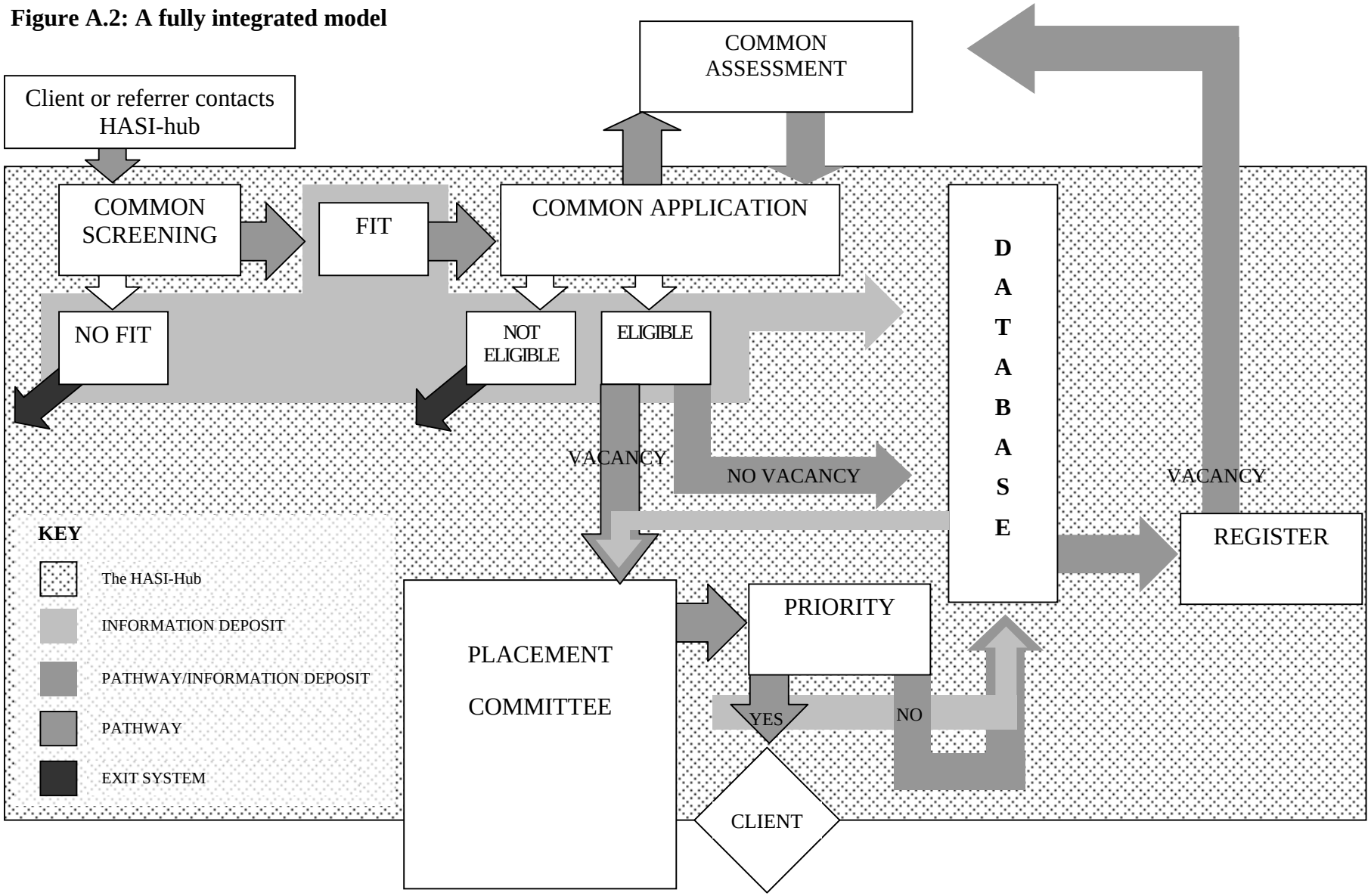
3 Common assessment and intake process

4 Processes for joint decision-making are in place

5 Management structures and resources deployed to ensure service program integration

Source: Thomson Goodall Associates Associates, 2001: 65

Figure A.2: A fully integrated model



A fully integrated 'single entry' model incorporates all of the components of centralised intake and waiting list systems identified in this report. The key component of this fully integrated model is the information interface, referred to here as the HASI-hub.

Step 1:

Entrance into this system is initiated when the client or referrer contacts the **HASI-hub** either in person or over the phone. The HASI-Hub is manned by a system coordinator whose particular skills are comparable to those described by Corbo (2001: 16). The coordinator addresses the enquiry conducting a brief **screening** questionnaire to establish the applicant's compatibility with the HASI criteria.

Step 2:

If the applicant does not fit, their deidentified data is entered into the **database** by the coordinator.

If the inquirer to the HASI-hub is an appropriate referring agent (most likely the applicant's mental health case manager) and the applicant is considered to fit the HASI criteria, the standardised **assessment** tool is issued to the referrer for completion with the applicant. In this case the assessment package also includes a form requesting consent, which will apply retrospectively to the individuated data gathered at screening. If it is the applicant who contacts the HASI-Hub, and they appear to fit the HASI criteria, the coordinator will obtain both informed consent (which will apply retrospectively to individuated data from the screening stage) and information regarding the applicant's mental health case manager. The coordinator will then issue the standardised assessment tool to the referrer for completion with the applicant.

Step 3:

The information gathered by the referrer from the completion of the standardised assessment tool is then returned to the HASI-hub and is used to complete the **application** form. If additional information is required, the coordinator will contact the applicant's referrer. Once the application form is complete the coordinator determines the eligibility of the applicant for HASI.

Step 4:

The coordinator's decisions are entered into the database along with any outstanding information from the assessment and application stages and the applicant and the referrer are notified of the applicant's status. If the client is ineligible the applicant exits the system.

If the applicant is deemed eligible the applicant's information is placed on the reassessment **register**. Both the applicant and the referrer are informed of the applicant's status after the coordinator determines eligibility.

Step 5:

When there is a vacancy all applicants on the reassessment register are reassessed. This updated information is gathered through the reissuing of the standardised assessment tool to each referrer who has a client on the register. This list is generated by the database. If any applicants are deemed ineligible at this stage, the referrer and the applicant are both notified of the change in status.

Step 6:

The coordinator then ascertains that those on the register are still eligible for HASI and then forwards the name of the priority applicant to the **allocation committee**. The allocation committee is composed of the coordinator and a minimum of one representative from the local area mental health service, the local support provider and the housing provider. The allocation committee determines whether or not an applicant can fill the available vacancy. If the applicant is appropriate, they become a HASI client.

If they are not appropriate they return to the register and await reassessment for the next vacancy. The coordinator then provides the allocation committee with the next highest priority applicant and so on until the vacancy is filled.

Step 7:

All of the determinations of the allocation committee are entered into the database by the coordinator to ensure transparency of the allocation procedure. The referrer and the applicant are notified of any decisions made by the allocation committee regarding placement.

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