Pack on Support Needs Assessment

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1. Introduction

1.1. Aim of the *TopHouse Support Needs Assessment* Tool (THSUNA)

This document is part of the TOPHOUSE Erasmus+ project. This document aims to focus on instruments to assess support needs which are separate elements of an individuals' life but are found often intertwined. Once identified and contextualised enable professionals to make up a person centred assessment of support needs. These instruments may include – but are not limited to – looking at individuals needing support in one or more areas of their life, either as separate elements or combined but with a global focus on the following items:

- ✓ Will and preferences of the individual about his/her housing expectations or current needs
- ✓ Kind of accommodation needed & preferred location
- ✓ Eligibility and ability to claim benefits
- ✓ Budget & manage a bank account
- ✓ Cook & store food
- ✓ Keep a property clean, secure & operate services (gas/water/electricity) safely
- ✓ Use local facilities & public transport
- ✓ Mobility or health needs, assistance needed with personal hygiene
- ✓ Mental health or medication issues?
- ✓ Healthy lifestyle
- ✓ Need for education, employment, daytime activities
- ✓ Language, cultural or religious issues
- ✓ Capacity to communicate well with others & understand/read documents or instructions.

The TOPHOUSE Pack on Support Assessment Needs (THSUNA) is conceptualised departing from an innovative nature, being so that it has not before been explicitly underpinned by UNCRPD principles or a Person Centred approach, nor catered for such a wide range of people with different needs, starting from the most basic ones and extending it to more complex situations. It aims to provide an assessment framework on support needs transferable between all delivery partners as described in the process below. There are studies that show that there is a close relationship between not having a stable household and/or appropriate housing conjointly with a psychosocial disability and a general decay of global functioning in everyday basic living skills. That decrease on global social functioning increases the level of support needed by a person on both aspects and, especially the process of assessing housing needs will also depend on a tight analysis of the level of his/her functioning on multiple levels from a social perspective and within a Human Rights approach.

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The capacity to better assess support needs will have positive impact over failure rates of certain groups of people in satisfactorily maintaining a tenancy (e.g. ex-homeless people, people leaving long term institutions etc.). By improving the level and better targeting the nature of the support provided to individuals the assessment can make all the difference between success and failure in a housing placement and a chance to keep a place in society.

In order to deal with this goal, the present document include and extract content from the analysis on best practices collected in assessing support needs. These include the set of necessary skills not only to maintain a tenancy but to develop their independent live. These set of skills explicitly reflect UNCRPD principles and values or a Person Centred approach, based on will and preferences.

This manual will improve professional underpinning knowledge and long-life learning outcomes of professionals' abilities to detect, assess and improve their strategies to provide improved support to individuals with disabilities or complex life situations.

Quantitative-based scales are presented with the aim to provide an individual assessment of a person needs. In addition, qualitative instruments are used to offer a global, flexible and a wide-range scope assessment. The combination of methodologies in the following tools results on a tailor-made assessment on different support needs. For this purpose the methodology of support delivery and the instruments developed include a high degree of user-involvement strategies.

THSUNA's ultimate goal is to provide professionals an assessment framework, understanding the high impact that an accurate assessment has on the quality of service provision to the person also using housing services.

1.2. How to use THSUNA

THSUNA is an assessment tool aimed to professionals that already have some previous background and knowledge on the UNCRPD Principles and work in organisations or services aligned and compromised to further implement UNCRPD. The instrument (THSUNA) described below intends to become an element of empowerment to users through co-production approach. Accordingly, the professional or trainer using THSUNA must take into account the principles of the UNCRPD alongside with the user-involvement strategies described in this guide. The final aim the THSUNA tool is to aid in the decision-making process of a person with disabilities on how they want to be supported and for the professional to provide an individualised assessment framework of the individuals support needs.

THSUNA has been conceptualised and developed with a double methodology, quantitative and qualitative. Chapter 3 describes specific procedures and instruments to be used in the THSUNA support assessment process. THSUNA package deliverable will also be operationalised (e.g. how to use it in the

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different stages of support needs assessment) as described in the chapter 3. Annex I, II, III includes specific templates about different scales and an interview guide.

1.3. Concepts & Vocabulary

Family Group Conferences are conceptualised as a voluntary consultation process in which an independent co-ordinator or supporter facilitates a series of discussions between an individual and her or his key social network. The individual selects friends and/or family, or professionals, to discuss issues of concern and seek solutions, including composing a plan which sets out the steps to be taken. Clinicians and Social Workers may have a background support role, or could have roles in facilitating any outcomes of decisions that involve clinical care decisions or social services decisions.

Open Dialogue (OD) strategies aim to treat disability conditions or situations in the user's home. Open Dialogue Strategies involve the patient's social network and implies a shared responsibility to seek solutions for a condition or situation. Open Dialogue is a practice developed in Finland in which decisions are made in the presence of the individual and his or her wider social networks. Psychotherapeutic approaches are taken with the aim of developing dialogue between the person and their support system as a therapeutic intervention. Service providers aim to facilitate regular 'network meetings' between the person and his/her immediate network of friends, carers and family, and several consistently attending members of the clinical or social team. A strong emphasis is placed on equal hearing of all voices and perspectives as both a means and an objective of treatment in itself.

Peer Support Groups: Peer support are groups in which persons with psychosocial disabilities provide support to one another. Originally conceived for people with psychosocial disabilities (with the already know form of hearing voice groups, perhaps the most internationally known) peer support groups can be used too by people with intellectual disabilities and can take many forms. The composition of the groups can be informal (on homes, institutions or neutral spaces in the community) or formal (where service user consultants assist in hospitals, or respite houses are run by people who experienced mental health crises). The use of peer support groups have shown an impact on the reduction in admissions among those with whom they work, and also shown associated improvements - with sufficient training, supervision and management - to drive through recovery-focused changes in health services. Peer support groups work under the idea that members can share successful strategies with each other in a mutually safe space, sharing key ingredients to succeed reducing distress about particular health and social situations.

Trialogue Group Users: users, friends, supporters and professionals meet regularly in an open forum that is located on neutral terrain – outside therapeutic spaces, family spaces or institutional contexts – aiming to discuss the experiences and consequences of health or social problems searching ways to

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solve them. Trialogue group discussions offer new possibilities for gaining knowledge and insights and developing new ways of communicating beyond role stereotypes.

Introductory Meeting: The introductory meeting aims in the creation of a relationship between the supporter and the service user that is based on trust and cooperation. During this meeting the supporter must understand the needs and wishes of the service user as well as his or her skills. At the same time the service user must understand the subject and the training activities in which he or she will be involved and his/her relevant learning responsibilities. The supporter collaborates with the learner to identify his/her needs and wishes and help him/her to identify his/her personal motivations. A profile of the service user must be developed to function as a baseline data for a later elaboration of Individualised Support Plan which must be agreed with the supported person and the professional.

Individual Support Plan: Work plan that the supporter elaborate for each supported individual setting out the objectives and actions that must be carried out in order to achieve their goals. The initial one is made within an established timeframe agreed with the individual and the professional, being reviewed later on if significant changes in the person's situation occur, or in case the person demands it with a specific reason.

Complex Case: Person with a vital situation or context that makes the intervention more complicated due to various circumstances (i.e. the person or the professional is unable to control them nor comprehend them fully due to the lack of information or due to its nature).

Immediate/Community environment: People, family, friends, professionals or social network with whom the supported person is usually in contact or already has some type of relation on a daily basis.

Unforeseen situations: Unforeseeable situations that affect the protected person in their daily lives and which require immediate intervention.

2. Background

2.1. United Nations Convention on the Rights of People with Disabilities (UNCRPD)

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is a Human Rights Convention written by and for people with disabilities in the wider concept of the term but it is not only addressed to people with disabilities but to general society. It is intended to protect the rights and dignity of persons with a disability. While it does not provide any new rights, it does expand basic Human Rights and became an important reference document that recognises and explicitly states that individuals with disabilities have the same Rights as individuals as what is considered an individual without a disability. Since UNCRPD was ratified by member states, those can only accept that the term

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disability changed its conception to include environmental and social aspects as the main barriers for the inception of any disability without relying exclusively on personal and individual factors. The implementation of this Human Rights Approach in support service delivery has the potential to impact in several areas of an individual's life such as:

- ✓ Housing and the ability to choose where and how you want to live
- ✓ Choosing and deciding on your own support services
- ✓ Access to information
- ✓ Employment and education
- ✓ Health services and the right to the highest attainable standard of health
- ✓ Equal recognition before the law and enjoyment of the Right to Legal Capacity
- ✓ Living Independently and being included in the community
- ✓ Full participation in society

The UNCRPD has now been signed and ratified by all EU countries and THSUNA has been created in line with the principles of the Convention. The Convention intends to protect the rights and dignity of persons with disabilities. State Parties who have signed and ratified to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities. The Convention has served as the major catalyst in the global movement from viewing persons with disabilities as objects of charity, medical treatment and social protection towards viewing them as full and equal members of society, holders of human rights. It is also the only UN human rights instrument with an explicit sustainable development dimension. UNCRPD was the first human rights treaty of the twenty-first century.

Moreover, governments should provide persons with disabilities with any support they might need in their decision-making. Support can be both "formal and informal" and can constitute "arrangements of varying type and intensity". The type and intensity of support should take into account the diversity of people with disabilities. Also, a range of appropriate measures should be available for persons with disabilities to receive adequate support, according to their will and needs. Support could include providing information in plain language or easy-to-read, explaining different options, or, in some exceptional cases, articulating an opinion based on a deep knowledge of the will and wishes of individuals, which stems from a long-lasting trusting relationship. Regardless the domain of their personal life, their opinions and decisions should be taken into account and respected. Implementing UNCRPD requires a shift towards the respect of human rights by replacing substituted decision-making approach with the supported decision making model.

In practical terms, exercising legal capacity means making decisions for oneself in all areas of life including medical treatment, housing, employment, relationships, finances, children, family planning,

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or property, among others. The CRPD recognizes that there are times when persons with disabilities may require support in making decisions and that depending on the course of the disability or illness, varying levels of support may be needed. In order to guarantee equal and full citizens recognition before the law, support provision is central and may vary a lot depending on each person. States must develop supported decision-making arrangements of varying types and intensity, including informal and formal support arrangements. Such arrangements include, for example, support networks, support Agreements, peer and self-support groups, support for self-advocacy, independent advocacy and advance directives.

When the user participates in design, implementation and evaluation of the a service to be received by him/ herself, a double effect appears: first, the service itself is more effective providing the goals to achieve had been addressed to solve actual problem/s expressed by the service users; second, the supported persons are empowered as they are taken into account by the administration and other stakeholders or because the person is placed in an equal power relationship context.

LO: Treat service users with dignity and respect

Supporters must learn the UNCRPD principles as a basic element of professional practice. Any activity described in this tool and implemented in practice must respect UNCRPD principles.

2.2. Person Centred Planning

Person centred planning (PCP) provides a way of helping an individual with psychosocial disabilities to exercise choice and control over the way they want to execute their life project by planning in advance some or all aspects of their life. Thus, support should be delivered taking into account the person expectations and her plan, ensuring that the individual remains central to the creation of any plan which will affect them and consequently receiving the support to execute this plan. Person centred planning is not only an assessment, it's also a methodological approach to develop future support. PCP is applied in THSUNA through the different phases the application of this tool involve.

LO: Work in a Person-Centred way.

Learn what the support approach is according to UNCRP principles and person-centred-principles is a transversal element of TopHouse and THSUNA.

2.3. Definition of Support

Support can take many forms but according to the UN Special Rapporteur on Rights of People with Disabilities, an agreed and universal definition of support is:

"Support is the act of providing help or assistance to someone who requires it to carry out daily activities and participate in society. Support is a practice, deeply embedded in all cultures and communities that

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is at the basis of all our social networks. Everyone needs support from others at some stage, if not throughout their life, to participate in society and live with dignity. Being a recipient of support and offering support to others are roles we all share as part of our human experience, regardless of impairment, age or social status. Support for persons with disabilities encompasses a wide range of formal and informal interventions, including live assistance and intermediaries, mobility aids and assistive devices and technologies. It also includes personal assistance; support in decision-making; communication support, living arrangements services for securing housing and household help; and community services. Persons with disabilities may also need support in accessing and using general services, such as health, education and justice.

For most persons with disabilities, access to quality support is a necessary precondition for living and fully participating in the community on the basis of choices equal to others. Without adequate support, persons with disabilities are at risk of falling into neglect and institutionalization. The provision of appropriate support is necessary to the realization of the full spectrum of human rights and enables persons with disabilities to achieve their full potential, thus contributing to the overall well-being and diversity of the communities in which they live. For many persons with disabilities, support represents an essential precondition for their active and meaningful participation in society, while preserving their dignity, autonomy and independence."[1]

LO: Practice co-production with service users who are 'experts by experience"

LO: Support choice and control by users of services

Learn the definition of Support and how professionals have to integrate it and apply it in daily practice as a key factor to guarantee inclusion and equal participation.

2.4. Co-production and Support

Co-Production in the field of psychosocial disabilities is an approach where the aim for a sustained recovery takes into account involving a wide range of support and service providers, including clinical supports and services, community supports, direct housing support and employment and social integration. Co-Production is the element facilitating that key stakeholders work together with the persons receiving the support to deliver these supports. From a technical perspective, co-production is defined as:

"A process by which are enabled to become actively and genuinely involved in defining the issue that concern them, in making decisions about factors that affect their lives, in formulating and

[1] (A/HRC/34/58) - Report of the Special Rapporteur on the rights of persons with disabilities

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implementing policies, in planning, developing and delivering services and in taking action to achieve change" (WHO; 2002)

There is no single formula for co-production but there are some key features that are present in co-production initiatives: define people who use services as assets with skills; break down the barriers between people who use services and professionals; build on people's existing capabilities; include reciprocity (where people get something back for having done something for others) and mutuality (people working together to achieve their shared interests); work with peer and personal support networks alongside professional networks.

A definition that fits THSUNA tool is:

> *Co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them. [2]*

As key elements of co-production, research on user-involvement strategies showcases that the following elements ought to be included in co-production strategies when conceptualising, designing and developing support services to succeed:

- ✓ Creation of exploratory space → Stakeholders and users work together to create new knowledge
- ✓ Collaboration → All stakeholders and users share their experiences from their perspective to reach desirable outcomes.
- ✓ Power Sharing → Quotas of power between stakeholders, users and professionals ought to be balanced and recognize the importance of different and diverse expertise resulting in shared ownership.
- ✓ Equality → Relationships between stakeholders, users and professionals have to be based on mutual respect.
- ✓ Willingness to implement → Positive involvement at all levels of service to implement co-production strategies.

These elements to succeed on co-production impact positively on the final user and stakeholder self-conception and lack thereof impacts negatively on the following aspects (Beresford; 2013)

- ✓ Distortion of concept of recovery and support

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- ✓ Continuation of the separation between them (professionals) and us (supported individuals) / (otherness)
- ✓ Sustaining social exclusion patterns
- ✓ Perpetuating discrimination
- ✓ Reproducing disempowering models
- ✓ Retaining the role of professionals as the only "experts"
- ✓ Dragging an atmosphere of silence on real issues and invisibilising the user experience.

Co-production is a framework of intervention that involves all stakeholders, users and professionals involved when assessing support needs and the necessary support steps to cover those needs. As a methodological approach, it will be included also in the support needs assessment. It consists of a particularly striking issue since it combines a balance between scientific reliability of the tool and users' inputs. The combination of these complementary evaluation or assessment of needs leads to involve users in the identification of which support best fits with their needs as well as to ensure the reliability of the *THSUNA* tool.

2.5. The Role of the Supporter

The supporter can be a member of the social network of the person, as a friend or a member of the family or a professional of support services. THSUNA targets the case of professional supporters, being able to coordinate resources and services around the person. To facilitate this, the **supporter** will study the decisions the user make and will provide all necessary information to give the user a clear view on all possibilities and their pros and cons. At this point it is up to the person to make her or his own decisions and the supporter to enable the necessary resources to implement their decision.

Skills and values required

- ✓ The supporter respects and values the supported person's autonomy and dignity and knows and respects the supported person's goals, values and preferences.
- ✓ The supporter respects the particular decision-making style of the supported person and recognizes when and how support may be offered.
- ✓ The supporter needs to be able to form a trusting relationship with the supported person and to spend as much time as is required to support a person make each decision.
- ✓ Other soft-skills required are empathy, assertiveness and the ability to speak and communicate in a clear an understandable way.

Main tasks to be undertaken by the supporter

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- ✓ To assess the skills of the person in relation to the specific areas included in THSUNA scales.
- ✓ To build and help the person implement an Individualized Support Plan.
- ✓ To search materials and resources to help the person to understand the information needed to take their own decisions.
- ✓ To assist the supported person to obtain advice from different sources.
- ✓ To join the supported person at meetings with outside organizations set up to obtain information and explore options.
- ✓ To help the person to analyse the different options.
- ✓ To verify the person has understood the pros and cons of the options involved in a decision or in an Individual Support Plan.
- ✓ To help the person to communicate the decisions to his/her family and to the support network for the good implementation of the person's choice. When necessary the supporter will advocate for the person.
- ✓ To facilitate the progress through interviews and specific measurement tools.
- ✓ To keep an accurate log/record of all the activity made with the person, if possible.

LO: Practice co-production with service users who are 'experts by experience"

LO: Support choice and control by users of services

Learn what is understood as co-production in the frame of this manual in order to establish the suitable links and procedures to achieve real participation of users and stakeholders during the assessment process.

3. Support Needs Assessment Tool (THSUNA)

3.1. Barriers & Obstacles in Support

Support, conceptualized as a global service can take many forms, both in terms of length and intensity and is often variable depending on the target population whom benefit from it depending on their social context, personal situations and characteristic personality traits or derived from its particular disability, taking into account that disability according to the Human Rights model the Professionals need further guidance on different types of support.

As a reference, support systems should ensure the availability of an adequate number services to provide the fullest possible range of support, including communication support, support in decision-making, mobility support, personal assistance, support in living arrangements and other types of support based on the community. Ensuring the availability of a reliable, skilled and trained workforce to deliver support is a critical component of ensuring the availability and quality of support, hence the need for harmonizing professional formation regarding support to boost in a substantial manner the

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professionals' abilities and skills at the same time that enabling individuals to improve the support they receive and, ultimately, their quality of life. While the existence of strong non-discrimination legal frameworks and fully accessible general environments significantly facilitate the participation of persons with disabilities, many of them may still require support measures to be able to participate in the community on an equal basis with others.

LO: Enable service users to keep themselves and other safe

LO: Enable service users to positive risks

The professional must know specific difficulties of the individual that may influence in the type of support to be provided in order to plan the assessment and improve its quality.

3.2. Steps to determine Support Needs

3.2.1. Initial Considerations

Assessing support needs in the field of disability has been traditionally done by professionals, ranging from an initial clinical or medical point of view based on a biological model focusing on individual deficiencies and progressively moving towards a biosocial (more holistic approach) taking into consideration social aspects of the individual's life leaving aside the co-production aspect (e.g. the opinion or shared vision of the user individual needs). Acknowledging this, it is of the utmost necessity balance both visions and to determine support needs shifting into a Human Rights model. A comprehensive individualised support plan is essentially an articulation of a community's shared vision for its future growth and modern development to contribute to the promotion of social and economic inclusion, in particular of minorities and vulnerable groups, including persons with disabilities. An individualised support plan should assess the needs of the individual from different perspectives but taking always into consideration that the user perspective is the ground base for further professional intervention or support without excluding the professional knowledge accumulated by certain disciplines traditionally assessing support needs such as social workers or psychologists. This disciplines exercise their professional role knowing a wide range of administrative and bureaucratic procedures and documentation required to activate resources from the Welfare State or the Social Service System so THSUNA offers a mixture of tools to assess support needs from the user perspective and from a professional's point of view, but not mutually exclusive, in a collaborative fashion and with a co-production methodology. The aim of THSUNA is to provide quality support which can be defined as:

- ✓ Support is offered within a community-environment.
- ✓ Support from professionals aims to maximize positive interaction of the person supported with the local community (neighbours, shops, services, et al.)
- ✓ Support ought to respect personal space, privacy and property of the individual.

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✓ Support is delivered according to individual needs and with flexible scalability.

LO: Build trusting relationship with service users

LO: Communicate effectively and openly

LO: Work in a multi-disciplinary way

LO: Develop networks and collaborate with other service providers

Assessment has to be provided following Person-Centred Planning, using Co-Production methodologies and with a flexible and tailored base. Both, the vision and expertise of professionals in contrast with the individual perspective and experience are essential to reach a satisfactory assessment. In this scenario, successfully bonding and interviewing the person is a key element to succeed.

3.2.2. Specific Instruments

THSUNA uses different tools to identify, detect and assess individual needs according to the user's own assessment and according to the professional assessment. Taking into consideration the existence of different assessment scales such as: *Basic Everyday Living Skills (BELS)*, which aims to assess the close relationship between people with psychosocial disabilities and the decay/impairment of global functioning assuming that the level of support required by the individual will also depend closely of the level of his or her functioning. *BELS* is an assessment instrument with adequate reliability properties for the purpose for which it was conceived: to assess the basic abilities for the everyday living. Another assessment scale, from a professional perspective, is the *Global Assessment of Functioning / Modified Global Assessment of Functioning (GAF/mGAF)*. The Global Assessment of Functioning assigns a clinical judgment in numerical fashion to the individual's overall functioning level. Impairments in psychological, social and occupational/school functioning are considered, but those related to physical or environmental limitations are not. The scale ranges from 0 (inadequate information) to 100 (superior functioning). Apart from these scales, proprietary scales exist to assess comprehensively the needs of people with disabilities – not specifically targeting people with psychosocial disabilities – but as a whole such as the *Housing First Model (proprietary model)*, *MyLife Scale (proprietary scale)*, *ENAR-TMG Scale (Assessment Scale of the Attention Levels required for people with Severe Psychosocial Disabilities)* and the *Outcome Star Scale/s (proprietary scale; e.g. recovery star).*

THSUNA tools develop a framework of support assessment by using two specific tools: *THSUNA Scale* (See Annex I *HAS+THSUNA Integrated Scale) and THSUNA Data Gathering Tool* (See Annex II) and uses an inter-sectoral approach by using the following methodology / process.

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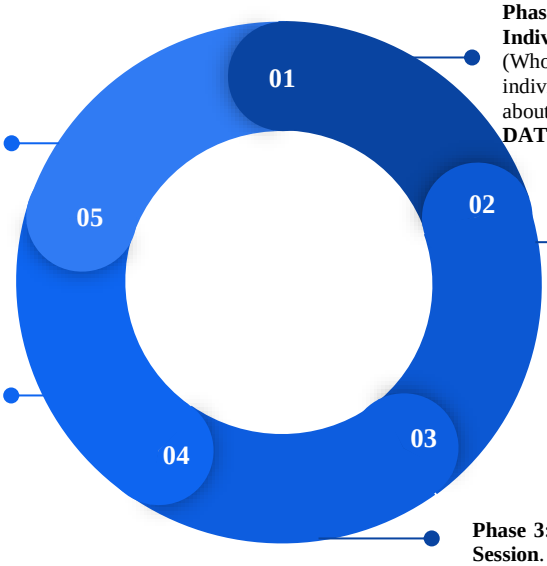
3.2.3. Five Phases / Stages Assessment Methodology

THSUNA instruments must be used following a circular process mode developed in a continuum



Phase 1: Identify the Supported Individual & Professionals Involved (Who will be involved in supporting the individual?) (Ask and help the individual about his/her support needs) – **THSUNA DATA GATHERING TOOL**

Phase 2: First Joint Assessment Session. Semi structured interview (Professional/s conjointly with the Individual) using **THSUNA Scale**. Bonding with the individual & Defining support needs. **First Assessment Report**

Phase 3: Joint Professional Contrasting Session. Shared analysis about service & support options. **Second Assessment Report**

Phase 4: Final Joint Assessment Session. Inform the individual about the different options to provide support. **Final Assessment Report & Individualised Support Plan**

Phase 5: Support Delivery & Refinement of the Support

A profile of the service user must be developed during all the process to function as a baseline data for a later elaboration of Individualised Support Plan which must be agreed with the supported person and the professional.

Phase / Stage 1a: Inform the individual on the *THSUNA Scale and methodology.* The methodology comprises the use of individualised scales and interviews with professionals and other relevant stakeholders so the individual is aware of the whole process. In this early stage, the professionals will ask the individual to come with a mindset focused on self-reflection about the difficulties, issues, context and personal needs alongside with useful documentation to validate his needs and proceed with further support intervention. ***THSUNA Data Gathering Tool*** is a tool aimed at compiling basic documentation about an individual to proceed with further support actions, it is primarily aimed at professionals delivering support but it also can be relevant as a template to share at this stage with the person for the individual to collect all the information prior to the *First Joint Assessment Work session.*

Phase / Stage 1b: Identify and select the user/s, stakeholder/s and professional/s to be involved in the assessment. Prior to further proceed, the person / final user should be asked if there's a specific person that does not want to be present during the assessment and this decision must be respected. However, the crucial role of an initial assessment should not overlook inputs from professionals, family members or other stakeholders that can have a different point of view or a piece of information whom

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the user might specifically hide or retain that can be useful to understand the person's context as a whole in a comprehensive manner. This initially excluded stakeholders should be included and consulted although not directly during later phases to contribute with their knowledge and experience on the context and situation of the individual. During the first meeting between the supporter and the person, the bond should consolidate and grow. Only when a trust relationship appears, the supporter can ask the person about his/her wishes, will and preferences or assess the skills of the person through THSUNA Scale. It is highly recommended to avoid any assessment during the first contact with the person.

Inform, Promote Self-Reflection & Data Gathering to:

- ✓ Guaranteeing access to information (bidirectional)
- ✓ Better Assessment efficiency (time & focus)
- ✓ Promote user involvement and co-production

Phase / Stage 2: First Joint Assessment session. Arrange a meeting where ***THSUNA Scale*** ought to be undertaken by the individual and complemented by professional/stakeholder observations in a positive fashion and with evidence, leaving questions unanswered if the person doesn't feel comfortable sharing personal information at this stage.. The session is conducted using semi-structured interviews to extract qualitative elements about the individual's' situation. In parallel, the documentation brought by the individual is compiled using the ***THSUNA Data Gathering Tool*** guidelines. The collection of all types of information (economic, legal and social) required in administrative and practical terms should be the strictly necessary and relevant according to the user's demand and can vary from country to country (structure of social services, health system, etc...).

The number of interviews to complete accurately ***THSUNA Scale*** is not defined and is determined by the person's volition. Moreover, completing the initial assessment will require more than one visit, contacts by phone or by email to the different professionals who already support the person so it is not contingent on the person and the professional applying ***THSUNA Scale.***

THSUNA Scale **is** conceptualised as a flexible instrument and not conceptualised nor intended to be a finalistic resource but the starting point to develop support in a continuum since needs of individuals are constantly changing due to personal growth, experience, changes in the sociocultural context of the individual or due to unforeseen situations.

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First Joint Assessment Session

- ✓ Carried out guaranteeing an equal distribution of power between all participants (Family Group Conferences, Open Dialogue Strategies, Trialogue are encouraged).
- ✓ Professionals define their respective scope and limits within its professional assignments.
- ✓ Bonding and Temporality as key elements (more than one session will be needed in complex cases).
- ✓ Create a climate of security, confidence, respect and collaboration.
- ✓ Initial Documentation Gathered.

Phase / Stage 3: Joint Professional Contrasting Session. During this third phase professionals work collaboratively to determine the tasks to be undertaken by each professional depending on its area of expertise, institutional assignment and possibilities of intervention within realistic parameters (i.e. financial situation of the individual, welfare state structure, social services resources, community services, social housing and/or direct or indirect support schemes in different areas provided by the state or by NGO's in the local territory, etc.). In this stage, *TSHUNA Data Gathering Tool* and the information compiled became crucial to determine potential options and possibilities to support the individual. In case of not having enough information or lacking documentation to further proceed, it is necessary for professionals to start the proceedings to expedite that documentation as soon as possible (e.g. national id card, census registration, disability certificate, etc..). This collaborative work intends to avoid overlapping of tasks and to determine with accuracy what services, resources or benefits the user has the Right (universal or concurrent) to enjoy.

Joint Professional Contrasting Session

- ✓ To know and list "real" options for service provision.
- ✓ To avoid professional overlapping and duplicities and to miss resources to be offered and/or available to the individual

Phase / Stage 4: Final Joint Assessment Session. This work session intends to inform the user of all the available resources, benefits, services within the Social and Health Service System whom he might have access or Right to access. Communication is a key aspect of this phase since it enables an individual to exercise choice and control over the option most suitable for his/her needs. The professional ability

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and skills to explain with details each and every option and its consequences is important for the final user's informed choice. Temporality also plays a key role in this phase since the individual needs to understand comprehensively what support entails and the temporality of its provision. In this phase it is important for the professional to confront expectations of the individual since bureaucratic procedures and administrative formalities entail complex processes and timelines, often confronted with the perceived reality or expectations of the user.

Final Assessment Report: Elaboration of a report to determine the support that the person needs on an individualised basis. It is important to keep in touch with the real situation of the individual and the plausible options that every professional / stakeholder has to deliver support. The report should contain the different options available (resources, service, benefits, programmes...) to the end user. The final assessment report is the principal input for the professional supporter to design an Individualised Support Plan to be agreed with the person.

Final Joint Assessment Session & Individualised Support Plan

- ✓ To make sure the individual understands available options and chooses which option suits his/her needs within a range of options presented by the professional. The individual is able to accept, modify or reject the proposed objectives and actions. It is necessary to record the agreements that are established with the person.
- ✓ Define a list of actions to do with a concrete temporality both for the user and for the professional.
- ✓ Define a frequency and tracking channel – face to face visit, in-home visit, office visit, call, email, etc. – by consensus with the person. The individual can change his preference at any time. Detecting new needs or redefine existing ones.

Individualized Support Plan. Once the assessment phases are over, the supporter and the person will have a comprehensive idea about the needs of the person, his/her will and preferences and information about his/her wishes, goals or lifestyle. The supporter's duty is to elaborate an Individualised Support Plan with a list of issues, including the actions to be carried out for each issue according to the resources/services/programmes available in the territory. The individualised support plan includes searching sources of information; coordinate actions to enjoy support of other support services; do the necessary steps to communicate the individual's decision to the support services, social services or social network or actions to help the implementation of the plan with external supports.

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Individualised Support Plan – General

The needs and actions to do in Individualised Support Plan are specified, but not limited to, these aspects, if agreed with the person and with an agreed intensity and frequency.

- ✓ Purchasing of products: personal use, hygiene, clothing, tobacco, leisure products, and food.
- ✓ Agreement on pocket money and its management, which will serve to determine the economic tool adapted to the need of the person.
- ✓ Vehicle management (taxes, insurance, fuel, repairs).
- ✓ Debt Management (negotiation of the payment of the individual's debts).
- ✓ Monthly payments (services, mortgages, loans, rents or residential facilities, day centres, deeds, supplies, etc.).
- ✓ Support for processing documentation: National ID, Health Insurance, Health Card, Passport, Disability Certificate, Benefits from the Welfare System, Certificate of Residence and other type of administrative/legal documentation.
- ✓ Management and coordination of external supports.
- ✓ Management and support if a change of centre / place of residence occurs.
- ✓ Management of bank accounts (checking account, investment funds, pension plan, etc.).
- ✓ Supervision of medical visits and pharmacology assuming the accompaniment directly or managing an external support and / or trip service, in the case of medical visits, hospital emergencies and surgical interventions, with all the actions that are derived thereafter (monitoring of the evolution of the person, information to families and / or centres, signature of informed consent, hospital monitoring, etc.).
- ✓ Supervision of personal hygiene.
- ✓ Supervision of place of residence, support and maintenance (i.e. pest control, external support cleaning, etc.).
- ✓ Promotion of leisure and cultural activities (links to centres, services, activities, etc.)
- ✓ Pet management (food, veterinarian, etc.)
- ✓ Community Support: Search, coordinate and manage the different supports of the community environment and specialized services in the different areas (health, work or occupational, leisure, social services, external services, housing, volunteering, etc...).
- ✓ Community Support: Encourage the integration of the person in the community, showing the resources of their environment and encouraging them to use them. Promoting autonomy.

Phase / Stage 5: Support Delivery & Refinement of the Support

<u>Not to be covered by this Intellectual Output</u>

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3.3. Main Support Areas' Needs Assessment

THSUNA instrument aims to provide an assessment of support needs for independent living in the community and as such it needs to further define the areas whether the individual need support to develop independent life. This can be assessed by inventorying life skills of and individual in a subset of items to assess the level that individuals have at a specific point in their life or when in the process of receiving support. The use of exploratory tools and scales could be done in the form of a checklist and is comprised of different categories, The categories can be divided into money, daily life habits and routines, health-care related skills, consumer awareness, food management, personal appearance and hygiene, housekeeping, housing, transportation, educational planning, job seeking skills, job maintenance skills, emergency and safety skills, knowledge of community resources, interpersonal skills, legal issues, and others.

The individual and the supporter (here, all the social and healthcare agents) together should use TSHUNA tool and methodology to answer the questions to determine the level of support required by the individual. The individuals' level (complete dependency, partial dependency, partial autonomy and full autonomy) is determined based upon the completion of certain items specified in the checklist for each category and each question. Individuals must be able to complete or know a certain amount of items, determined by the inventory, at least partially – ideally completely over time – to at least start enjoying of support even if it is on a very basic level. *THSUNA* tool should be undertaken with the help of supporters, peers, parents, relatives, professionals or other adults involved with the individual and can help the individual "plan…on filling gaps" that exceed their knowledge on a given time, context or area.

LO: Practice co-production with service users who are 'experts by experience'
LO: Develop networks and collaborate with other service providers

4. Key success factors to put THSUNA into practice

There are several factors influencing a good assessment. Some have a personal component, affected by cultural elements and biography of the person while other have a strong organizational component which conditions the relationship quality between the supported person and the supporter. Below you can find a list of identified factors that helps to obtain a good support.

4.1. Bonding between the supporter and the supported person

The emotional bond between the supporter and the accompanying person is one of the main factors that favour the positive change that is sought in the intervention (Escudero 2009).

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The bond is a living state, which as a relationship, requires attention to continue provoking positive changes. Thus, professionals have to know the characteristics of the link. According to the model proposed by Friedlander and collaborators (2010) the link has four elements that must be taken into account:

- ✓ Adherence to the accompaniment process. The intervention has a sense for the person. She feels involved and works with the professional. He considers that the objectives and tasks of the evaluation can be discussed and that he can express his opinion.
- ✓ Security during the process. You have to get the person to perceive the context as a space where you can take risks and in which you can openly show your opinions and be sensitive. In conclusion, it is very effective that the person feels comfortable and in no case on the defensive.
- ✓ Emotional connection. The person sees the professional as someone important at a particular time in their lives. It is important that the relationship passes familiarly, although it is also advisable to avoid the treatment of "colleagues". The relationship must be based on trust, affection, interest and sentiment of relevance.
- ✓ Commitment to the objectives. It is effective to encourage the collaborative spirit and agree the objectives with the person accompanied.

LO: Treat service users with dignity and respect
LO: Build trusting relationship with service users
LO: Communicate effectively and openly

4.2. Interview as a key instrument

The support based on a good bond uses the personal interview as a fundamental tool for such purpose. The interview must possess a series of characteristics to be effective, among which the following ones stand out: Flexibility in the approach, Integral approach - in the sense of collect information about the net and specialized resources that the person has experienced,

A good practice included in this guide is a joint interview in which participate all professionals services involved in support. During the interview available resources are shown to the person in order to see the matching with his/her will and preferences. Special attention is paid also to non-verbal communication. A shared template is used by professionals in order to collect of the information it may arise.

LO: Communicate effectively and openly

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4.3. Temporality and respect versus communication style

Each meeting or interview must be planned with enough time to allow the professional and the person to express their points of view. It is also important to design a program of interviews in which the first meeting serve the purpose to create a bond with the individual since professional experience shows that it will not be until the third or fourth meeting (may be more depending on the person) that a climate of trust has already been created so that the supported person "opens up" and expresses their interests and true needs.

To achieve the above, it is also very important that the professional shows respect towards the way the person expresses their interests and needs. There are persons that take decisions about their needs very quickly, without much reflection about. Other take time to think about before to say that they want to do or need and will ask you for some support before to express a clear will. And more, one person could express opinions and plans without much words, just using non-verbal communication whereas other are inexpressive and use mainly words as communication way. The supporter must accept the style of communication of the person and work together the person to catch what the person needs and will.

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6. Annexes

ANNEX I – HAS / THSUNA Integrated Scale - To be fulfilled always with the user and **the professional**

HAS – HOUSING ALLOCATION SYSTEM

Name / Surname:
National ID or Passport Number:
Date of birth & Birthplace:
Current Address:
Telephone:

FIRST I WOULD LIKE TO KNOW ABOUT YOUR PRESENT LIVING SITUATION

1. WHERE ARE YOU LIVING RIGHT NOW? (Check one answer. If the answer is not clear, ask the participant to choose one).

a. _____ in a general hospital
b. _____ on a psychiatric ward in a hospital
c. _____ in a rehabilitation unit run by a support service
d. _____ in a high support hostel or house run by a support service
e. _____ in a group home run by a support service
f. _____ in other accommodation run by a support service
g. _____ in a homeless hostel
h. _____ in a homeless B+B
i. _____ in other accommodation run by the homeless services
j. _____ in transitional accommodation
k. _____ in prison or other custodial institution
l. _____ sleeping rough/on the street
m. _____ temporarily with friend or relative
n. _____ in the family home
o. _____ local authority housing
p. _____ supported / voluntary housing
q. _____ private rented housing

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r. _____ housing association

2. DO YOU LIVE ALONE OR WITH OTHER PEOPLE?

a. _____ alone

b. _____ with other people

3. HOW LONG HAVE YOU LIVED THERE?

_____ _____

Years Months

(If less than a year, ask # 3a and # 3b; if more than a year, skip to # 4)

3a. IN THE PAST YEAR HOW MANY TIMES HAVE YOU MOVED?

# of times _____

3b. IN THE PAST YEAR, HAVE YOU EVER BEEN HOMELESS?

► _____ yes b. _____ no

4. DURING THE PAST YEAR, WHERE DID YOU GET YOUR MONEY FROM? (Check all that apply)

a. _____ employment

b. _____ social welfare (name of payment _____)

c. _____ support from family

d. _____ other (specify) _____

e. _____ I have no income (skip to 6e)

4a. HOW MUCH A WEEK WAS THIS? (Record the answer here:)

_____

4b. HOW MUCH A WEEK DO YOU PAY IN RENT? (if not paying rent skip to # 6). (record answer here:) _____

4c. DOES THIS AMOUNT INCLUDE HOUSING RELATED UTILITIES? (electricity, rubbish, heating etc)

a_____ yes

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b_____ no

4d. ABOUT HOW MUCH MONEY DO YOU SPEND A WEEK ON UTILITIES? (record answer here:) _____

4e. DO YOU GET HELP WITH YOUR RENT? E.g. rent supplement / housing benefit?

a. _____ yes
b. _____ no (if no skip to # 5)

4f. WHO HELPS YOU WITH YOUR RENT?

a. _____ support service provider
b. _____ community welfare officer
c. _____ family, spouse
d. _____ Other (specify :) _____

5. I'D LIKE TO KNOW HOW SATISFIED YOU ARE WITH WHERE YOU ARE LIVING RIGHT NOW. WOULD YOU SAY THAT YOU ARE: (Read these out loud and check the one that applies).

a. _____ VERY SATISFIED
b. _____ SOMEWHAT SATISFIED
c. _____ NEITHER SATISFIED OR DISSATISFIED
d. _____ SOMEWHAT DISSATISFIED
e. _____ VERY DISSATISFIED

6. WHAT IS THE ONE THING YOU LIKE BEST ABOUT YOUR PRESENT LIVING SITUATION? (Record the answer here:) _____
_____
_____

7. WHAT IS THE ONE THING YOU LIKE LEAST ABOUT YOUR PRESENT LIVING SITUATION? (Record the answer here:) _____
_____
_____

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8. THE LIST BELOW (A TO K) CONTAINS 11 OF THE THINGS THAT PEOPLE SAY THEY LIKE OR DISLIKE ABOUT THEIR LIVING SITUATION. TELL ME HOW YOU FEEL ABOUT EACH OF THESE THINGS IN YOUR PRESENT LIVING SITUATION. DO YOU:

LIKE IT A LOT (5)
LIKE IT SOMEWHAT (4)
NOT CARE ABOUT IT (3)
DISLIKE IT (2)
DISLIKE IT A LOT (1)
IT DOES NOT APPLY (0)

(Read the list out loud and circle the number which applies).

a. AMOUNT OF ROOM / SPACE	(0) (1) (2) (3) (4) (5)
b. THE REPAIR AND CONDITION	(0) (1) (2) (3) (4) (5)
c. IT'S LOCATION	(0) (1) (2) (3) (4) (5)
d. THE PEOPLE YOU LIVE WITH	(0) (1) (2) (3) (4) (5)
e. THE NEIGHBOURS	(0) (1) (2) (3) (4) (5)
f. LIVING ALONE	(0) (1) (2) (3) (4) (5)
g. THE LANDLORD	(0) (1) (2) (3) (4) (5)
h. SUPPORT STAFF VISITING	(0) (1) (2) (3) (4) (5)
i. THE AMOUNT OF PRIVACY	(0) (1) (2) (3) (4) (5)
j. THE PRICE OR COST	(0) (1) (2) (3) (4) (5)
k. ANY OTHER THING	(0) (1) (2) (3) (4) (5)

(Specify). _____

9. ARE PETS ALLOWED WHERE YOU CURRENTLY LIVE?

a. _____ yes
b. _____ no

10. DO SUPPORT STAFF COME INTO YOUR HOME TO PROVIDE SERVICES ON A REGULAR BASIS?

a. _____ no (if no, skip to # 12)

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b. _____ yes (continue)

11. IF YOU RECEIVE SUPPORT SERVICES WHERE YOU LIVE ON A REGULAR BASIS COULD YOU DESCRIBE WHAT THEY ARE AND HOW OFTEN YOU GET THEM? (Record the answer here:)

_____

_____

_____

12. HOW SATISFIED ARE YOU WITH THIS SITUATION? (Read out loud and check the one that applies).

a. _____ VERY SATISFIED
b. _____ SOMEWHAT SATISFIED
c. _____ NEITHER SATISFIED OR DISSATISFIED
d. _____ SOMEWHAT DISSATISFIED
e. _____ VERY DISSATISFIED

13. CAN YOU CONTINUE LIVING WHERE YOU ARE AS LONG AS YOU WANT TO OR WILL YOU HAVE TO MOVE?

a. _____ yes, I can stay as long as I want to (if yes, skip to # 14)
b. _____ no, I will have to move (continue)

13a. WHY WILL YOU HAVE TO MOVE? (Record the answer here:)

_____

_____

_____

14. WOULD YOU LIKE TO CONTINUE TO LIVE WHERE YOU ARE RIGHT NOW OR WOULD YOU LIKE TO MOVE SOMEWHERE ELSE?

a. _____ stay (skip to # 15)
b. _____ move elsewhere (continue)

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14a. WHY WOULD YOU LIKE TO MOVE? (Record the answer here:)

_____

_____

_____

15 IS THERE ANY OTHER SIGNIFICANT ISSUE YOU WOULD LIKE TO MENTION ABOUT YOUR CURRENT LIVING SITUATION THAT WOULD HELP YOU TO EXPLAIN YOUR HOUSING NEED?

_____

_____

_____

_____

==========

GO TO SUMMARY 1 TO SUMMARISE THE HOUSING NEEDS

==========

16. IDEALLY, WHAT KIND OF PLACE WOULD YOU LIKE TO LIVE IN?

(Check one answer. If the answer is not clear, ask the participant to choose one).

a. _____ in a group home run by a support service
b. _____ in a nursing home
c. _____ in a homeless hostel
d. _____ in a homeless B+B
e. _____ in other accommodation run by the homeless services
f. _____ in transitional accommodation
g. _____ on the streets/sleeping rough
h. _____ independently in an apartment
i. _____ independently in a house
j. _____ in my family's home
k. _____ with a friend or relative,
l. _____ other (specify) _____

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17. WHAT IS IT ABOUT THAT PLACE THAT WOULD BE MOST IMPORTANT TO YOU?

(Record the answer here:) _____

_____

_____

18. WOULD YOU LIKE TO LIVE:(Read out loud and tick the one that applies).

a. _____ WITHIN THE AREA YOU CURRENTLY LIVE
b. _____ OUT OF THIS AREA BUT STILL IN [name of city]
c. _____ OUT OF [name of city]
d. _____ IT DOESN'T MATTER

19. WHAT IS IT ABOUT THAT LOCATION THAT WOULD BE MOST IMPORTANT TO YOU?

(Record the answer here:)_____

_____

_____

20. IF YOU HAD TO LIVE WITH SOMEONE, WOULD YOU PREFER TO LIVE WITH OTHER SUPPORT SERVICE USERS OR NOT? (Read the 3 choices out aloud and ask person to choose the one that suits most)

a. _____ yes, I would prefer to live with other support service users
b. _____ no, I would rather not
c. _____ it doesn't matter

20a. WHY DO YOU FEEL THIS WAY?

(Record the answer here:) _____

_____

_____

21. IF YOU HAD THE CHOICE, WOULD YOU RATHER LIVE ALONE OR WITH OTHER PEOPLE?

a. _____ I would rather live alone (skip to # 23)

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b. _____ I would rather live with others (continue)

22. WHO WOULD YOU MOST LIKE TO LIVE WITH? (Check one answer. If the answer is not clear, ask the participant to choose one).

a. _____ my relatives
b. _____ my friends
c. _____ my spouse
d. _____ support staff
e. _____ homeless staff
f. _____ any other person? (Specify) _____

23. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD ABOUT YOUR CHOICE OF HOUSING AND WHO YOU WOULD LIKE TO LIVE WITH?

_____
_____
_____

==========

GO TO SUMMARY 2 TO SUMMARISE PREFERRED HOUSING

==========

NOW THAT WE'VE TALKED ABOUT WHERE YOU WOULD LIKE TO LIVE, I'D LIKE TO ASK ABOUT WHAT KINDS OF SUPPORTS OR SERVICES YOU FEEL YOU WOULD NEED IN ORDER TO LIVE THERE

24. WHAT KINDS OF SUPPORTS OR SERVICES DO YOU THINK YOU MIGHT NEED IN ORDER TO BE ABLE TO LIVE WHERE YOU WANT TO?
(Record the answer here:) _____
_____
_____

25. DO YOU HAVE ANY PARTICULAR DIFFICULTY OR NEED WHICH INFLUENCES YOUR CURRENT CHOICE OF HOUSING? (Circle)

A. MEDICAL (heart, breathing, etc) yes / no

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B. PHYSICAL (difficulty with stairs etc) yes / no

C. LEARNING (mild learning difficulty etc) yes / no

D. SENSORY (hearing, sight difficulties) yes / no

E. FINANCIAL (cannot pay rent, bills etc) yes / no

F. LEGAL (separation, barring order, will etc) yes / no

G. Other yes / no If 'other' specify _____

25a. IF 'YES' TO ANY PARTICULAR DIFFICULTY, DO YOU WANT TO TELL ME MORE?

(Record answer here) _____

_____

_____

26. IN GENERAL, HOW URGENT DO YOU THINK YOUR HOUSING AND SUPPORT NEEDS ARE?

High _____

Medium _____

Low _____

27. DO YOU CONSIDER YOURSELF TO BE AT RISK OF ANY OF THE FOLLOWING; (circle - no, high, med, or low risk)

a. Homelessness	no	High	Medium	Low
b. Abuse	no	High	Medium	Low

(If yes circle whether: emotional, physical, sexual, neglect or financial)

c. Deteriorating Mental Health	no	High	Medium	Low
d. Deteriorating Physical Health	no	High	Medium	Low
e. A Risk to Self	no	High	Medium	Low
f. A Risk to Others	no	High	Medium	Low
g. Any other risk	no	High	Medium	Low

If 'other' specify _____

28. ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO MENTION IN RELATION TO YOUR HOUSING AND SUPPORT NEEDS?

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_____

_____

29. WHAT KINDS OF SUPPORTS OR SERVICES DO YOU THINK YOU MIGHT NEED IN ORDER TO BE ABLE TO LIVE WHERE YOU WANT TO?

(Record the answer here:) _____

_____

_____

30. I'M GOING TO READ YOU A LIST OF SUPPORTS THAT PEOPLE OFTEN MENTION. PLEASE SAY WHICH OF THESE ADDITIONAL SUPPORTS YOU THINK YOU MIGHT NEED IN ORDER TO LIVE WHERE YOU WANT TO LIVE.

(Read the list aloud and check yes or no for each item).

	Yes	No	
a.	___	___	Would you like to be able to reach staff by telephone any time of the day or night?
b.	___	___	Would you like to be able to ask staff to come to your home any time of day or night?
c.	___	___	Would you like to have staff come to your home regularly during the day?
d.	___	___	Would you like to have staff live with you?
e.	___	___	Would you need more income/ benefits/rent allowance?
f.	___	___	Would you need money for the deposit?
g.	___	___	Furniture? (like chairs, bed etc)
h.	___	___	Would you need household supplies? (like pots / pans)
i.	___	___	Would you need roommates or housemates?
k.	___	___	Would you need help in finding a place to live?
l.	___	___	Would you need help in finding roommates or housemates?
n.	___	___	Would you need help getting benefits?
o.	___	___	Would you need anything else?

(If yes specify) _____

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DO YOU HAVE ANY QUESTIONS YOU WOULD LIKE TO ASK ME, OR ANY COMMENTS YOU WOULD LIKE TO MAKE THAT WOULD PLAN HOUSING AND SUPPORT OPTIONS IN THIS AREA? (If so record below)

_____

_____

_____

_____

Step 3: Summary of housing and support needs and preferences

The survey that has been conducted with the applicant is lengthy so the next step involves summarising their housing and support needs and preferences. The following summary sheets allow for the key elements of the applicant's needs and preferences to be clearly communicated. It's important to remember that the allocations officer who was present when the survey was carried out may not be involved in making the allocation so it is vitally important that the applicant's needs and preferences are clearly understood.

SUMMARY 1: CURRENT HOUSING

You are living in _____ for the past _____ months/years.

You live with _____.

You are (very / somewhat dis / satisfied) living there because _____

_____

_____.

However / consequently you (want to / have to) move because _____

_____

_____.

Other things you like about where you are living are _____

_____

_____ _____.

And things you dislike about where you are living are _____

_____

_____.

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You recieve your money from _____(name of employment/benefit etc). Your weekly income is _____, and you currently spend _____ per week on rent and _____ per week on utilities.

Summary 2: Preferred Housing

You would prefer to live in (type of housing)_____ as that place would offer you _____.
Your preferred location is _____ because _____.

You would prefer to live (alone or with others) because _____ _____. If you had to live with others your preference is / is not to live with other service users because _____ _____.
The person / people you would most like to live with is / are _____, because _____.

Step 4: Matching an applicant to a suitable property

IHS applicants should be matched with potential units according to the organisation's existing IT system and based on the basic features of the unit – number of bedrooms and location primarily. While a unit may meet all the preferences of an applicant, it should not be considered if basic features of the unit do not match an applicant's needs or preferences, for example, if it is in a different area to where they have expressed a wish to live or if it is the wrong size for their household.

Existing allocations systems should all be capable of categorising applicants according to size of property required and preferred location.

When an HIS applicant is relatively close to the top of the allocations list - through a points system, a system of time spent on the list or another waiting list system – their summarised needs and preferences should be reviewed and allocations officers reminded of them so they can be kept in mind for upcoming vacancies.

If the allocations system was to wait until an IHS applicant was at the very top of the waiting list, there may be undue delays caused to the applicant. The nature of their support needs and preferences may make many properties unsuitable for them. There needs to be some level of flexibility and adaptability to ensure best outcomes for all applicants.

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In such cases, the use of an 'Offer Zone' can be helpful. The housing authority shall contact the individual in writing when they enter the 'Offer Zone' stating that it is likely that the individual will be offered a property within the next 6 months and that they should apply/ensure that the supports that they require to live independently will be in place at that time. Confirmation of the availability of these supports to allow the individual to take up the housing opportunity will be required prior to the offer being made and this requirement will be clearly communicated to the individual and their advocate, as appropriate.

If no supports are available within the 'Offer Zone' timeframe then the client returns to the housing authority when the supports are in place, their place on the Waiting List will not be affected.

In matching an applicant to a property, the following scoring matrix is available to determine suitability:

	Yes	**No**	**Comments / Points** (5 points for yes, 0 for no)
Location of property matches applicant preference			
Size of property matches applicant eligibility			

	Yes	**No**	**Comments / Points** (5 points if both answers match, 0 if they do not)
Is wheelchair accessibility required?			
Is the property wheelchair accessible?			

	Yes	**No**	**Comments / Points** (5 points if both answers match, 0 if they do not)
Are support services required? (Consult results of THSUNA)			
Are supports available to the applicant and in this location?			

	Yes	**No**	**Comments / Points** (3 points if both answers match, 1 if they do not)

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Does the applicant wish to live with others?			
Is this possible in this property?			

	Yes	**No**	**Comments / Points** (3 points if both answers match, 1 if they do not)
Is the property furnished?			
Does the applicant want a furnished property?			

	Yes	**No**	**Comments / Points** (3 points if both answers match, 1 if they do not)
Are pets allowed in the property?			
Does the applicant want or have a pet?			

14 points or fewer: Property is not suitable for this applicant.

15-20 points: This property may be suitable for this applicant. Requires further discussion with applicant and support service.

21-29 points: This property is a likely match for this applicant. An offer or allocation can be made.

THSUNA – TOPHOUSE SUPPORT NEEDS ASSESSMENT

31. I'M GOING TO READ YOU ANOTHER LIST. PLEASE, ASNWER THE QUESTIONS HONESTLY AND THINKING IN YOUR CURRENT SITUATION (Read the list out loud and circle the answer that suit your situation).

a. Budgeting money - Financial

► Do you know how much you earn as income weekly/monthly? (Yes) (No) (With Support) (Comments)

_____

► Do you consider that you administer well financially? (Yes) (No) (With Support) (Comments)

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- With your current financial situation, do you get to the end of the month without issues? (Yes) (No) (With Support) (Comments)

- Do you have savings? (Yes) (No) (Comments)

- Do you borrow money? (Neighbours, friends, bank) (Yes) (No) (Comments)

- Do you understand the economic information that you get? (Yes) (No) (With Support) (Comments)

---

b. Shopping

- Do you know how much things are worth money-wise? Provide examples in comments (Yes) (No) (With Support) (Comments)

- Do you do the basic shopping in the same place every time? (Yes) (No) (With Support) (Comments)

- Do you shop with a shopping list? (Yes) (No) (With Support) (Comments)

- Do you consider that you manage your money to make ends meet at the end of the month with all your basic needs covered? (Yes) (No) (With Support) (Comments)

---

c. Keeping the house

- Are you able to accept and respect rules and norms established when sharing a household? (Yes) (No) (With Support) (Comments)

- Do you do your household chores correctly? (Bedding, order and organization, etc.) (Yes) (No) (With Support) (Comments)

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- Do you do clean the house on a regular basis? (Yes) (No) (With Support) (Comments)

- Do you know how to do basic maintenance tasks on your house? (Purge the radiators, remove pressure from the boiler, fixing the sink, unfreezing a refrigerator, changing a light bulb, etc.) (Yes) (No) (With Support) (Comments)

- In case of experiencing any problem at or with your home, do you know to who and how to ask for help? (Yes) (No) (With Support) (Comments)

---

d. Cooking

- Do you know how to use a microwave / oven / stove / other kitchen appliances? (Yes) (No) (With Support) (Comments)

- Do you cook for yourself on a daily basis? (Yes) (No) (With Support) (Comments)

- Do you buy ready-to-eat meals? Specify how many meals a week (Yes) (No) (Comments)

---

e. Laundry

- Do you know how to use the washing machine? (Yes) (No) (With Support) (Comments)

- Do you know how to dry your clothes properly? (Yes) (No) (With Support) (Comments)

---

f. Family – Social Relations

- Do you maintain contact with your family or relatives? (Yes) (No) (With Support) (Comments)

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► Do you need help to see them or talk to them? (Yes) (No) (With Support) (Comments)

► Would you like to re-connect with them? (Yes) (No) (With Support) (Comments)

► Do you want to inform your family about your situation? (Yes) (No) (With Support) (Comments)

► In case of family conflict, do you know how to solve it or do you want to solve it? (Yes) (No) (With Support) (Comments)

---

g. Making friends / Getting along with people

► Are you satisfied with your network of social relationships? (Yes) (No) (Comments)

► Do you want to keep them? (Yes) (No) (With Support) (Comments)

► If not: Do you want to improve this situation? (Yes) (No) (With Support) (Comments)

► Do you participate in activities in the community where you live? (Yes) (No) (With Support) (Comments)

► If yes: Do you want to keep them? (Yes) (No) (With Support) (Comments)

► If not: Do you want to improve this situation? (Yes) (No) (With Support) (Comments)

► Do you often encounter problems when interacting with other individuals (neighbours, colleagues, friends, et al.)? (Yes) (No) (Comments)

► If yes: can you solve them? (Yes) (No) (With Support) (Comments)

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h. Health (Managing medications)

- Do you attend to regularly to the doctor or follow-up visits? (Yes) (No) (With Support) (Comments)
- Do you know when you have visits? (Yes) (No) (With Support) (Comments)
- Do you get the medication correctly prescribed? Do you administer it as prescribed? (Yes) (No) (With Support) (Comments)
- Do you know how to prepare the medication prescribed? (Yes) (No) (With Support) (Comments)
- Do you know how to schedule a doctor appointment? (Yes) (No) (With Support) (Comments)
- In case of a medical urgent situation, can you ask for help? (Yes) (No) (With Support) (Comments)
- Do you maintain a balanced diet or nutrition habit suited for your needs? (Yes) (No) (With Support) (Comments)

i. Hygiene

- Do you shower frequently? (Yes) (No) (With Support) (Comments)
- Do you change your clothes frequently? Specify in the comments section (Yes) (No) (With Support) (Comments)
- Do you spend time doing personal care activities (nails / hair / shaving / hair removal)? (Yes) (No) (With Support) (Comments)

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- Do you know how to make proper use of hygiene products (clean clothes, personal care)? (Yes) (No) (With Support) (Comments)

---

j. Mobility / Transport

Do you have a personal vehicle? (bike, car, motorbike, other) (Yes) (No) (Comments)

Do you know how to use public transport? (metro, train, bus, taxi) (Yes) (No) (With Support) (Comments)

Do you experience problems following map directions or going to places you don't know? (Yes) (No) (Comments)

---

k. Work / Employment

- Do you work? (Yes) (No) (With Support) (Comments)

- Have you experienced difficulties in your work last year (punctuality, etc.?) (Yes) (No) (Comments)

- Do you want to work? (Yes) (No) (With Support) (Comments)

- Do you think you could find a job on your own? (Yes) (No) (With Support) (Comments)

- Do you want to increase your employability or work-related abilities? In which capacity? (Yes) (No) (With Support) (Comments)

---

l. Formation / Education

- Do you have the motivation / want to participate in courses / workshops / educational tasks? (Yes) (No) (With Support) (Comments)

- Do you know the channels to look for specific training courses and/or formation? (Yes) (No) (With Support) (Comments)

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- If you don't want to participate in formation activities: Do you know the purpose/usefulness of the formation activities? Explain yourself in the comments section (Yes) (No) (Comments)

---

m. Juridical / Legal / Administrative

- Do you know how to interpret legal documentation that affects you or is addressed to you? (Yes) (No) (With Support) (Comments)

- Do you understand legal procedures in your country? (Yes) (No) (With Support) (Comments)

- Do you understand administrative procedures in your country? (Yes) (No) (With Support) (Comments)

- Do you understand and do by yourself the administrative/social benefits/bureaucratic procedures related to housing or getting support? (Yes) (No) (With Support) (Comments)

---

n. Leisure / Sport / Culture

- Are you motivated to participate in leisure/cultural/sport and/or other recreation activities? (Yes) (No) (With Support) (Comments)

- Do you know the channels to look for these activities? (Yes) (No) (With Support) (Comments)

---

o. Anything else (please specify)

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32. I'M GOING TO READ YOU ANOTHER LIST. PLEASE TELL ME IF THERE IS ANYTHING ON THIS LIST THAT YOU HAVE DIFFICULTY DOING AND WOULD LIKE HELP WITH. ALSO TELL ME HOW MUCH HELP YOU FEEL YOU NEED WITH EACH OF THESE THINGS: NO HELP, SOME HELP OR A LOT OF HELP. (Read the list out loud and circle the amount of help).

WOULD YOU LIKE HELP WITH;

a. Budgeting money - Financial (no help) (some help) (a lot of help)
b. Shopping (no help) (some help) (a lot of help)
c. Keeping the house clean (no help) (some help) (a lot of help)
d. Cooking (no help) (some help) (a lot of help)
e. Laundry (no help) (some help) (a lot of help)
f. Family – Social Relations (no help) (some help) (a lot of help)
g. Making friends (no help) (some help) (a lot of help)
h. Health (Managing medications) (no help) (some help) (a lot of help)
i. Hygiene (no help) (some help) (a lot of help)
j. Mobility or transport (no help) (some help) (a lot of help
k. Work / Employment (no help) (some help) (a lot of help)
l. Formation / Education (no help) (some help) (a lot of help)
m. Juridical / Legal (no help) (some help) (a lot of help)
n. Leisure / Sport / Culture (no help) (some help) (a lot of help)
o. Anything else (no help) (some help) (a lot of help)
(please specify)

_____

_____

33. IN YOUR OPINION, HAVE YOU BEEN DENIED HOUSING BECAUSE OF YOUR ADDITIONAL SUPPORT NEEDS OR BECAUSE OF A PARTICULAR DIAGNOSIS?

a. _____ no (skip to # 34)
b. _____ yes
c. _____ does not apply (skip to # 34)

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33a IF YOU FEEL THAT YOU HAVE BEEN DENIED HOUSING FOR THESE REASONS WOULD YOU TELL ME ABOUT IT?

(Record the answer here:) _____

_____

_____

34. AND FINALLY, I'M GOING TO READ YOU ANOTHER LIST. PLEASE TELL ME IF YOU HAVE BEEN IN CONTACT WITH THOSE SERVICES WITHIN THE LAST FIVE YEARS. PLEASE SPECIFY THE PROFESSIONAL. (Read the list out loud and write the contact details).

☐ Social Services (Basic, Specialsed)

☐ Primary Health Center:

☐ Mental Health Center:

☐ Residential facility

☐ Hospital / Clinic:

☐ Sociosanitary Center:

☐ Other Professional(s) / Service(s):

WE'RE DONE. DO YOU HAVE ANY QUESTIONS YOU WOULD LIKE TO ASK ME, OR ANY COMMENTS YOU WOULD LIKE TO MAKE THAT WOULD PLAN HOUSING AND SUPPORT OPTIONS IN THIS AREA? (If so record below)

_____

_____

_____

_____

==========

GO TO SUMMARY 3 TO SUMMARISE SUPPORT NEEDS

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Step 3: Summary of housing and support needs and preferences

The following summary sheet allows for the key elements of the applicant's support needs and preferences to be clearly communicated. It's important to remember that the allocations officer or

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support worker who was present when the survey was carried out may not be involved in making the allocation so it is vitally important that the applicant's needs and preferences are clearly understood.

Summary 3: Support Needs

The first person/place you contact for help is _____. When you need to, you also make contact with _____ _____. In general you are (very / somewhat dis/satisfied) with the help you receive. You receive _____ support(s) from _____ services in your home and you are (very / somewhat dis/satisfied) with this.

You (do / do not) think that the money you receive is enough to live on. Your particular difficulties are; medical, physical etc. _____ _____. You have (High / Medium / Low) urgency in relation to your housing and support needs. You consider yourself to be particularly at risk of homelessness/poverty/abuse/deteriorating mental and /or physical health/harm to self/others.

You think the most important support(s) and service(s) that you would need to help you to live in your preferred housing is / are _____ _____. In addition, you think you would also need help with _____ _____. Your preferred supports from the _____ service are _____ _____.

ANNEX II - THSUNA Data Gathering Tool

DOCUMENTATION NEEDED/REQUIRED TO ASSUME THE ROLE OF PROFESSIONAL SUPPORT		
Name:		
Date:		
SOCIAL DOCUMENTATION		
Document	Status (Received/Pending)	Observations
ID Card		

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Passport / Residence Visa		
Disability Certificate		
Health Card		
Social Security Number		
Medical Report		
Pharmacological treatment		
Residential / Facility Contract		
Social Benefits Resolution		
FINANCIAL DOCUMENTATION		
Bank account details (Extracts, others,…)		
Social Benefits Resolution (Economical)		
Labour/Work Contract		
Payslip		
Insurance Contracts (car, home, personal)		
Other Contracts (Mobile Phone, services,..)		
Rental Contract		
Property Scriptures/deeds		
Inheritance Documentation		
Will		
LEGAL DOCUMENTATION		
Criminal Causes		
Civil Causes		
Legal Documentation		
OTHER DOCUMENTATION		

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