

# Responding to people with multiple and complex needs

Phase one report

Department of Human Services

July 2003

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## Foreword

The management and support of individuals who present as complex and high risk has confronted the health, welfare and criminal justice systems with one of the most significant challenges in recent years. For the past two years in Victoria, stakeholders from across these sectors have called for and participated in a review of the current service system and existing legislation with the aim of improving responses to people with multiple and complex needs.

With the move away from institutionalised care, the provision of successful and sustainable support to this client group has become increasingly problematic. Responding effectively to this population has been an ongoing issue and has often been visited without successful resolution. While the capacity to transcend traditional program boundaries is evident in some cross-program initiatives, further work is required to bring about a more collaborative service model for people with multiple and complex needs.

The *Responding to People with Multiple and Complex Needs* Phase one report is a culmination of the work undertaken by the Department of Human Services since early 2002. This report presents the key findings identified and puts forward the case for an improved service response for people with multiple and complex needs.

Our commitment is to deliver a sustainable and joined up service response to this client group by encompassing the Growing Victoria Together objectives of addressing inequality, improving access to high-quality health and community services and promoting better opportunities for Victorians.

I would like to thank members of the Project Reference Group who have given a significant amount of their time, energy and expertise over the past twelve months. My appreciation is also extended to the Department of Justice whose assistance throughout the project has been invaluable, particularly their contribution to the client profiling exercise. I also wish to thank Department of Human Services' regional and program directions branch staff, funded sector organisations, statewide bodies, individual stakeholders, police, courts and other government departments for their contributions to this project.

The responses and opinions of all stakeholders has allowed us to develop a service delivery framework that will be the benchmark for more appropriate health, housing and support services to people with multiple and complex needs.

The challenge now is to commit to working together to support the implementation of this new service response and its successful integration within the existing service system to improve outcomes for people with multiple and complex needs.



**P M Faulkner**

Secretary



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## **Part one - The case for change**



## Introduction

The Responding to People with Multiple and Complex Needs Project was established in January 2002. It has been a key priority of the Department of Human Services over 2002-03.

The project arose in response to continuing poor service outcomes for a small but significant group of people in Victoria whose complex needs challenge existing policy and legislative frameworks and service systems. This group of people are those adolescents and adults who may experience combinations of mental illness, intellectual disability, acquired brain injury, behavioural difficulties, family dysfunction and drug and alcohol abuse. For many reasons, they often require a service response that is too complex to be met or sustained within existing service frameworks.

When engaged with the service system, these individuals characteristically draw on significant resources - not only from the Department of Human Services, but also from a range of emergency services agencies and other government departments and funded organisations. Frequently, the service response for these individuals is 'crisis-driven', unplanned and uncoordinated. The responses often deliver limited outcomes for the individual, their families or the wider community.

In recent years, concerns have been raised by service providers and support organisations, including the Office of the Public Advocate, Victoria Police and the courts, about the difficulty of providing services to a group of people who have multiple and complex needs and whose behaviours can pose a risk to themselves and others.

The key objective of the project was to develop a framework for the future management, funding, and delivery of improved service responses for this client group. Central to this is the need to deliver a planned response, with better and more efficient use of resources, and a more sustainable approach to the care, support and management of these individuals within a safe community environment.

This publication highlights key findings of the Responding to People with Multiple and Complex Needs project, presents the case for change and outlines a proposed service model to improve responses to the target group. Individual case vignettes are included in this document to highlight common characteristics and features of the target group. The companion document, the *Client profile data and case studies report*, January 2003 presents detailed information about the target group.

## Background

'Complex needs' is a term commonly used across health and welfare sectors. Sometimes used interchangeably with terms such as 'challenging behaviours', 'multiple needs' and 'multi service clients', 'complex needs' is increasingly used by service planners and providers as well as policy makers to refer to people whose needs and behaviours challenge health, human services and criminal justice systems.

This project uses the phrase 'multiple and complex needs' to reflect the cross-sector, cross discipline nature of the presenting problems and concerns of the target client group. If there is a continuum of complexity with regard to individuals presenting to health and welfare services, this project and the service model it proposes are firmly targeted to the extreme end.

The target group criteria established at the outset clearly focused the project objectives on those people:

- who have multiple and complex needs not met or sustained by existing services
- whose challenging behaviours place themselves, staff and community at risk
- who require long term responses from a range of human service areas.

Disability, housing, child protection, juvenile justice, mental health and drug treatment services, as well as components of the criminal justice system, are key service providers to this target group.

While interpretations regarding the definition and conceptualisation of complexity of need vary, there is general agreement that people with behaviours toward the extreme end of the continuum present the greatest challenge to current policy, legislative and service provision frameworks.

A number of common behaviours are associated with this extreme end of the spectrum. The behavioural profile of the target population has been described as including:<sup>1</sup>

- disruptive behaviour that might include violent, threatening, aggressive, antisocial or unpredictable behaviour, inappropriate sexual behaviour and destruction of property
- radically poor living skills and an associated chaotic lifestyle
- repeated crises and excessively demanding behaviour (often leading to exclusion from services)
- an almost total lack of social networks
- violence to self including suicidal and risk taking behaviour and use of alcohol and drugs.

The primary diagnosis or problem ascribed to the individual might be a major mental illness, personality disorder, or it could be an acquired brain injury, intellectual disability, autism spectrum disorder or a long history of substance abuse. Often it is a combination of any of the above, and attempts to identify a primary or major problem will be

the subject of disagreement between service providers. In almost all cases, the presenting difficulties and behaviours are compounded by secondary drug or alcohol use, lack of suitable housing and lack of family or other social supports.

The service response available to the individual will depend on which service sector, if any, is viewed as having the primary responsibility. The length of time the individual will receive a service may depend on the program and funding models developed within that sector, the statutory responsibility, if any, of the provider and the willingness or capacity of the individual to engage with the service.

The degree to which a coordinated response across service sectors is available to the individual will often depend on the capacity of the lead provider to negotiate agreement and commitments from services in other sectors.

While health and welfare service systems have evolved to become highly specialised, they may also be increasingly fragmented. There is a perception that access to services has become more restricted and many agencies are operating in an exclusive or specialist, rather than inclusive, model of care. Some argue that the more complex individuals are screened out and that the option of expelling those considered too challenging is increasingly exercised.

## The imperative for change

### Service system trends

The trend toward specialised targeted service responses delivered from a community base is not new; it began with the sweeping de-institutionalisation reforms of the 1980s and 1990s. For most people, the benefits of the shift to local, community-based services have been universally acknowledged.

However, it is increasingly contended that insufficient consideration was given to planning for community-based options for people with multiple and complex needs. Many within the health and welfare sectors argue that the long term consequences of the move away from institutional care were underestimated and the subsequent impact on demand for appropriate housing, treatment and support services is now emerging. An analysis by the Australian Institute of Health and Welfare (AIHW) found that from 1981 to 1997 there was a reduction of more than 80,000 in the number of people who would have been in health and welfare institutions across Australia had residential care patterns remained constant.<sup>2</sup>

While real advances have been made in specialist interventions such as crisis response, targeted treatment and care models and mobile and home-based services, the benefits have not been realised for the small but significant complex needs population. The service delivery outcomes for

<sup>1</sup> Ecumenical Housing and Thomson Goodall Associates (1999)

<sup>2</sup> Australian Institute of Health and Welfare (2001), Australia's welfare, 2001

people identified within this target group are poor. For this group, contemporary service system models have delivered narrow treatment-oriented assessment; time limited interventions; and a shift away from holistic or comprehensive services.

There is a consistent view across the service system that this problem is escalating. However, many also argue that while the majority of these clients will have long term and high level needs for services, often at greater cost than the majority of clients in the service system, outcomes in relation to health and wellbeing can be significantly improved.

There is a call for the development of new approaches that focus on maintenance, help and support in addition to change-oriented treatment or interventions. For instance, providing a stable environment, order, routine activity, safety and the continuity of care inherent in residential or long term responses may form part of an alternative strategy. An improved response to people with multiple and complex needs requires the innovative translation of these elements of care into legitimate community-based practices.

## **New and emerging health and welfare issues**

Pressures on the service system in relation to the client group are further exacerbated by the emergence of 'new' or increasingly prevalent health and welfare issues. Those attracting increasing attention and featuring strongly in the multiple and complex needs population include:

- increasing recognition and diagnosis of mental health, cognitive and behavioural disorders in children and young people and the lack of clarity around appropriate service system response
- growth in the serious misuse of alcohol and drugs resulting in a marked increase in the presentation of young people with mental illness and or intellectual disability and a co-existing substance abuse problem
- the demand for effective service responses for people seriously disabled with acquired brain injury, including young people, in the context of a community-based service system and limited residential care options.

These issues are examples of new and escalating areas of concern that have added significantly to the stresses on families, carers and the service system. They point to the importance of being able to more effectively link specialist service responses.

## **Over-representation in the criminal justice system**

The need for improved liaison and coordination between health and welfare services and the courts and correctional services in relation to individuals with multiple and complex needs has been recognised for some time. The argument that the number of people with multiple and complex needs in contact with the criminal justice system is increasing and that prisons in some cases are substituting for the institutions of the past gives urgency to the call for new solutions. Frequently, the disruptive and aggressive behaviours and chaotic lifestyle of these individuals lead them to the attention of the police and result in them being brought before the courts for minor matters as well as serious offences.

The client profiling for this project supports these arguments. High rates of past and current contact with the criminal justice system are shown to be characteristic of the client group. Some 93 individuals from the total cohort of 247 are currently involved with correctional services.

## The client group

The client profiling exercise undertaken for this project considered data on 247 individuals who met the target group criteria.<sup>3</sup> Services directly provided and funded by the Department of Human Services identified 208 individuals, while a further 39 were nominated by the corrections service system (prison and community-based). Of the target group, 226 individuals are 16 years and above and will be eligible to be referred to the new service response.

The client group presents many challenges for delivery of an effective service response. Key features include:

- overall, the population is relatively young with 44% of individuals aged between 18 and 35 years
- all have two or more 'presenting characteristics' requiring input from

a range of human services programs

- behaviours prevalent among the client group present significant levels of risk to the community, to staff and to the clients themselves (such as aggressive and assaultive behaviour, self harming, risk taking behaviour)
- 90% had at least one incident of harm to either self, staff or community in the past year and 47% had incidents of harm recorded for all three
- the group are high volume users of emergency services, particularly police, ambulance and hospital emergency services
- 71% have current or past contact with the criminal justice system;
- housing arrangements vary across the client group, but lack of stability

in housing is marked and 35% are reported to be homeless or living in short term or crisis accommodation

- 91% are socially isolated, with few having any regular contact with family
- 55% have chronic health problems, often related to their chaotic and unstable lifestyles.

A brief snapshot of the client group is provided in Part two of this report.

### Case studies - key findings

Six sub-groups comprising specific personal, behavioural and diagnostic characteristics emerged from a cluster analysis<sup>5</sup> carried out on the population. From these clusters, 21 detailed case studies were completed and provide further insights into the client group,

#### Case Study 'Kylie'<sup>4</sup>

Kylie is 18 years old and has been involved with the service system since she was a young child. Kylie has been subjected to abuse, neglect and abandonment and has significant cognitive deficits, learning difficulties, poor impulse control and a reduced understanding of the consequences of her behaviour. She has attended school intermittently and requires constant supervision in an educational/training environment due to her inability to function safely and appropriately.

In the past Kylie has been placed in secure welfare on many occasions, resulting in some success in reducing the immediate and significant risks associated with her behaviours. Many accommodation options have been attempted including foster care, adolescent community placements and supported accommodation, but these have all been unable to successfully manage her behaviours.

Kylie presents with poly-substance abuse, an intellectual disability, behavioural disorders and an acquired brain injury. She has had significant criminal justice involvement and is frequently verbally and physically aggressive and assaultive. She displays indiscriminate sexual behaviour and is known to be involved in prostitution and continually absconds from accommodation placements.

Kylie is currently managed in community-based accommodation with 24-hour staff supervision in order to contain her high risk behaviours. A number of services are involved with her management including mental health services, disability, police and housing and support services. They are of the opinion that due to Kylie's complex needs she will require accommodation in a secure therapeutic environment.

<sup>3</sup> Full report is in the *Client Profile Data and Case Studies Report*, January 2003.

<sup>4</sup> This case study is fictional and based on findings of the profiling and case study exercises.

<sup>5</sup> Methodology is outlined in the *Client profile data and case studies report*, January 2003

their family backgrounds, service utilisation and needs over time, behavioural patterns and key experiences with the service system. Key learnings include:

- Most of these individuals have been involved in the service system in some form since childhood – with the majority of initial contact being with child protection or mental health services.
- More than half of the case study group was reported to have experienced abuse and neglect as children.
- The majority of the case studies described social isolation and in most cases this was reported as consistent over time with little evidence of change – the individuals tended to be isolated in adolescence and remain that way during adulthood.
- Only a quarter of the case studies described stable primary schooling and the majority had left school between the ages of 12 and 16 years.
- The case studies generally described persistent patterns of difficult behaviour, with excessive drug and alcohol use and accommodation breakdown commonly acting as triggers for a period of escalation.
- The most common behavioural characteristic was aggressive behaviour, and for 10 of the case studies this had escalated to violent crime including domestic violence, sexual assault and physical assault.
- There was widespread abuse of alcohol and drugs across the majority of the case studies, with substance abuse problems usually commencing at a young age.
- More than half of the case studies described individuals as leaving or being removed from home at a young age – under 16 years – and going on to experience homelessness, transience or short term and unstable accommodation arrangements throughout adolescence and adulthood.
- Many of the individuals often changed services or used multiple services, usually on a short term basis. The repetitive nature of service responses was often striking, for instance, several different accommodation placements or drug and alcohol counselling services or mental health assessments.
- A key characteristic of the case studies was that many interventions and service responses had been tried, but few with extended, comprehensive case management and support. Only one case study described a relationship with a coordinated support service for an extended period of time – 10 years.
- Average annualised costs of the 21 case studies show that currently each client costs the Department of Human Services and other government agencies (for example, police, courts) around \$248,000 per annum.<sup>6</sup>

## Understanding the issues and problems

A number of key themes emerge from the consultation outcomes and review of the literature.

### Service gaps

There are commonly held views that there are gaps in the service system in relation to this population. Families, carers and services highlighted the following gaps or omissions:

- Lack of targeted responses to individuals with autism spectrum disorders, particularly Asperger's Syndrome. These people are often identified as falling into service gaps, frequently deemed ineligible for both mental health and intellectual disability services.
- No clear service system response for people diagnosed with Borderline Personality Disorder. Individuals with this diagnosis are not always deemed eligible for a specialist mental health response (although mental health services do work with many clients with borderline or severe personality disorders) and there appears to be considerable disagreement and confusion across the broader service system in relation to issues of access and most appropriate service response.
- Lack of 'step-down' forensic mental health or intellectual disability residential services that can enable continued supervised treatment and care following release from hospital-based care, such as Thomas Embling Hospital, prison or other secure environments, such as the Statewide Forensic Service.

<sup>6</sup> Using a cost model of activity level and service usage costs – if extrapolated to the total population it indicates a total cost of \$56 million per annum.

- Lack of appropriate and planned service responses for people with complex needs leaving the custodial system.
- Insufficient drug treatment services with the capacity to proactively and assertively work with clients who have intellectual disabilities, acquired brain injuries and severe mental health issues.
- Lack of effective management of service system transition points – in particular lack of intensive support and treatment services for extremely vulnerable young people moving from systems targeted specifically at children and young people to those designed for adults.
- Absence of safe, contained environments for a small number of clients who pose a severe and immediate risk to themselves.

Growing service system gaps may contribute to an increased reliance on ad hoc service responses developed for individual clients in the absence of other options. These individualised approaches are often unplanned and crisis driven and are usually provided at high cost.

## Comprehensive assessment

The client profiling and case study analysis, along with consultation feedback, underline the importance of comprehensive multidisciplinary assessment that is practical and can support effective service delivery to this population.

Critics of the current service system response identify multiple, repeated

and fragmented assessment and disputed diagnoses as common problems. Associated difficulties include:

- individuals not being able to access an expert assessment as they did not meet the criteria for entry to particular parts of the service system or were difficult to engage in a comprehensive assessment process
- service planning relying on assessments conducted many years earlier (for example, when the person was an adolescent)
- variability in the quality and comprehensiveness of assessments;
- high levels of substance abuse compromising efforts to ensure comprehensive assessment
- tendency for needs analysis and service planning to be crisis driven and reactive
- lack of time and resources to devote to comprehensive assessment.

## Interface with the criminal justice system

Almost three quarters of the profiled population have been involved with the criminal justice system. Representatives of the courts, correctional services staff and post-release service providers have regularly voiced concerns about appropriate health and welfare system responses. The potential criminalisation of people with multiple and complex needs is a growing area of concern. It has been argued that an increasing number of people with multiple and complex needs have been identified as unnecessarily entering the criminal

justice system. If these people are excluded from or not engaged with the broader service system, they may continue to exhibit behaviours that bring them into contact with the criminal justice system.

Attention to the interface between the human services system and corrections system, particularly in relation to diversionary strategies, pre-release planning and post-release engagement and service delivery is critical. While specialist forensic mental health or disability services will often have an important role to play, broader engagement of the service system in both planning and service delivery will be central to improving outcomes for this client group.

## Service delivery and funding models

In the wake of the move from institutional care to community-based responses, there is concern that client management frameworks and funding models that promote throughput and short term interventions are increasingly prevalent. There is a sense this has occurred at the expense of therapeutic programs with longer term treatment and care options.

While governments require mechanisms to ensure services are targeted to those most in need, critics of the existing service system characterise elements of it as:

- having a culture of exclusion rather than inclusion
- increasingly offering specialised models of care
- constrained by funding and

accountability imperatives, for example, in relation to throughput

- deploying inappropriate gatekeeping practices in relation to clients perceived to be high cost/high burden
- banning client access to services due to difficult behaviours (usually aggressive, confrontational).

Increasingly, in the absence of appropriate service provision models, ad hoc accommodation and intensive support/supervision responses are developed for individual clients, usually at very high cost. In addition, these responses often result in the isolation of individual clients and high turnover of staff. The sustainability and appropriateness of such ad hoc models of care, support and supervision are increasingly being questioned.

### **Service system coordination and integration**

The failure of the service system to deliver sustainable, joined-up service responses to this client group has been consistently highlighted throughout the consultation process and is underlined by the profiling and case study analysis.

The need for an overarching responsibility and capacity to direct resources in relation to this client group has been raised by a number of stakeholders. The issue of identifying and agreeing on lead case management responsibility as well as specific contributions from other providers is central to achieving a sustained service response to those with exceptional needs.

The consultation process revealed significant goodwill in the service sector. However, there is no ‘umpire’ to resolve disputes and individual agencies feel they cannot rely on other services to work with them to enable delivery of an effective service response. Without assurances of that support, providers can be reluctant to take these clients on.

### **Stability - housing and social connection**

Individuals within the target group have often exhausted available accommodation and support options. Many are homeless or rely on funding packages that house them in single rented accommodation with intensive levels of supervision to minimise risk to self or others. Such approaches have been criticised for effectively imposing containment and isolation on individuals via an intensive supervision model.

Social connectedness is intrinsically linked to stable housing and, not surprisingly, the level of ‘disconnection’ among this client group is marked. Indicators of social exclusion are often highlighted - many within the group exhibit behaviours that deviate markedly from mainstream norms, there is little regular contact with family and few are involved with any sort of training, education or rehabilitation. A significant number have chronic health problems that go untreated and many are only on the fringe of the formal human services system.

### **Workforce issues**

There is considerable concern that staff are not sufficiently trained, supported or experienced across the service system to work effectively with many clients in this target group. Skill gaps, as well as occupational health and safety issues, are perceived as a barrier to the development of more flexible and multidisciplinary treatment and support models. It has often been difficult for intensive service responses to be sustained over time, due to the excessive pressure this places on staff and the services’ capacity to respond to the needs of other clients. Worker burnout was consistently identified as a major problem.

### **Legislative reform**

There are widespread views that the existing legislative framework has significant limitations in relation to ensuring access to services and enabling appropriate secure care and containment options. These concerns are based on current service system responses to individuals with very complex needs and the level of risk to the community. In discussion of these issues the underlying tension between individual and community rights is widely acknowledged. Further to this, consideration must be given to the work being undertaken by the Victorian Law Reform Commission in regard to the examination of the current framework for the compulsory treatment and care of people with an intellectual disability and other cognitive impairments who are at risk to themselves and the community.

## The service system - current responses

### Existing service responses and planned initiatives

There is a growing awareness of the demands for and associated costs of service delivery to individuals with multiple and complex needs.

Effectively responding to the client group has been an issue for several years and has often been visited without successful resolution. Program areas within the Department of Human Services have attempted to address the issues from the perspective of their individual programs and through various coordination mechanisms with other programs (for example, the Drug Treatment Services Program worked with Mental Health to address dual diagnosis issues). The very nature of the various individual program structures - from their individual legislative and policy frameworks through to their funding mechanisms and service delivery models - has often inhibited the formation of an appropriate and sustainable response for people with multiple and complex needs.

Where new initiatives have been tried, they have been essentially 'two dimensional', targeting dual presentations such as mental health and substance abuse or intellectual disability and mental health.

Most strategies have been within program boundaries, with limited mechanisms or capacity for cross-program coordination. Initiatives that

have tried to go further, for example, the *Working Together Strategy* and the *Multi Service Clients Project* have recommended strategies to address some identified systemic problems. Both initiatives found that services need to be better coordinated at the local level and individual practitioners and services need to work more cooperatively. The initiatives have resulted in improved local capacity and enhancements to specific service responses. However, their ability to respond to the high level cross-sectoral needs of this population has been limited.

Currently, there are few strategies planned (or in place) within any department or departmental division to address the level of need associated with the target population. There are, however, strategies underway to support initiatives that target the escalating needs of individuals within specific groups, such as the department's *Integrated Strategy for Child Protection and Placement Services* (2002), undertaken in part to identify better responses to complex and chronic problems within some families.

Across the department's program areas there are a range of initiatives - planned or already underway - that aim to build on the current capacity of the department and its funded agencies to manage complexity. A range of important initiatives are noted below:

### Victorian Homelessness Strategy

The Victorian Homelessness Strategy recognises the importance of providing services to people with complex needs. It also emphasises the provision of a whole of government response to homelessness and proposes several directions for change, including the establishment of an interdepartmental committee on homelessness.

The Victorian Homelessness Strategy also identifies a series of sub-strategies developed to improve the way support is provided to people who are either homeless or at risk of homelessness by linking up government assistance and increasing cooperation and collaboration between homelessness services and other community and health services.

A range of specific initiatives has been designed to assist people leaving custodial, rehabilitative and treatment facilities who are at high risk of homelessness. These 'Pathways' initiatives link individuals on drug treatment orders or with significant drug abuse issues, those with mental health problems, young people leaving State care, adults exiting prisons and young people leaving juvenile justice facilities with transitional housing support and supervision specific to their needs.

## Disability Services

The Disability Services State Plan (2002-2012) emphasises tailoring approaches to individual needs and forging stronger links between disability supports and generic services in local communities. In terms of improving responses to people with complex or potentially complex needs, the State Plan identifies a range of strategies including:

- establishing a central resource of practice expertise to develop support strategies and prevent the development of complex behaviours
- working with Community Care to develop a method for the early identification of risk factors for adolescents with a disability who are at risk of becoming involved with the criminal justice system
- establishing a partnership with Mental Health to improve access to mental health services for people who have a dual disability
- working with Community Care to develop early intervention, diversion and management strategies for young people who come into contact with the juvenile justice system
- working with the Department of Justice and agencies to enhance support for people with a disability in contact with the criminal justice system, including those in custody, on community orders or needing planning and support post-release.

## Mental health

Priorities outlined for the next five years (*New directions for Victoria's mental health services 2002*) include initiatives targeted to clients with multiple or complex levels of need, including:

- strengthening services to young people aged 16-25 through two dual diagnosis (mental health and drug and alcohol) pilot programs
- providing integrated clinical, support and residential rehabilitation services to enable people with high needs to access these specialist residential services.

## Community Care

Community Care Division will introduce an Intensive Therapeutic Service (ITS), acknowledging the need for improved responses to children and young people who exhibit, or are at risk of developing, severe emotional and behavioural disturbance as a result of abuse or neglect. The ITS will provide specialist intensive therapeutic and treatment services. It is intended that the ITS establish strong working relationships with a range of cross-sector agencies and develop a tool and other aids to assist with early detection and assessment of children and young people at risk of developing severe emotional and behavioural disturbance.

## Drug Treatment Services

In collaboration with other key program areas including mental health, disability and child protection, Drug Treatment Services has emphasised the establishment of cross-program initiatives. These include the creation of:

- alcohol and drug acquired brain injury (ABI) resource workers
- specialist therapeutic workers for young people in the child protection area
- a dual diagnosis team
- alcohol and drug supported accommodation with some houses designated for women with dependent children
- a brokerage system which purchases alcohol and drug assessment and treatment for offenders on treatment orders and post release intensive treatment support programs
- police and court diversion programs
- a rural outreach program targeting young people in rural areas
- a trial drug dependency unit within housing.

## Achieving change - what else has been tried?

The Victorian service system is not unique. In other jurisdictions in Australia and overseas it is common practice for separate policies and programs to be established for the range of human service areas such as mental health, housing, disability, juvenile justice, child protection and drug and alcohol services. Within the different programs, separate developments are targeted to young people and adults. As specialisation has increased, the service system has become more fragmented and coordinated service responses have become harder to deliver. Tight funding environments and the dominance of throughput models have exacerbated these difficulties.

As recognition grows of the service system challenges posed by clients with multiple and complex needs, policy makers, service planners and those delivering services on the ground have had to consider new responses. Specific new initiatives have made incremental gains, but rather than delivering systemic change they have focused on particular elements of the multiple and complex needs problem.

Efforts have included:

- improved two dimensional strategies, such as treatment approaches targeting dual mental health and drug or alcohol abuse, or improving assessment and interventions for individuals with an intellectual disability within the juvenile justice system
- policies encouraging collaborative efforts and improved links between service sectors, such as joint funding models and co-located programs
- localised regional service planning and network development
- joint assessments.

More systemic efforts have included the establishment of formal panels with representatives from different sectors or program areas. These panels monitor and encourage coordinated service delivery to challenging or complex clients. Examples include the work of the Multi Agency Risk panels established in the UK in the 1990s or the Management Assessment Panels operating currently in South Australia and the ACT. However, there is little evidence of structural service system change occurring in conjunction with these initiatives.

## Towards an improved service response - key challenges

Key stakeholders and service providers recognise the urgent need for new solutions to deliver improved outcomes for individuals with multiple and complex needs. A multifaceted approach is required to respond effectively to the multi-layered issues associated with the failings of the current service system response. A better response needs to be founded on a systemic view of the problem and the need for structural, legislative and cultural change.

A number of key factors that need to be addressed have been identified:

- Individuals with multiple and complex needs require access to accommodation, care and treatment appropriate to their needs. Threshold issues of complexity, rather than program-specific eligibility requirements, should determine a person's access to a service response.
- Clear leadership by the Department of Human Services, with involvement of all aspects of its directly-delivered and funded sector services, is necessary to ensure an improved response for the population.

- A forum and process with formal authority and mandate is required to bring together relevant providers and experts to plan for an appropriate individualised service response.
- Comprehensive and multidisciplinary assessment of need should inform this process. Residential support may be required to facilitate this process.
- The long-term responsibility for service delivery to this client group will remain with the existing service system – building capacity to work more effectively with the population needs to be an ongoing priority.
- Immediate enhancement of the existing service system should include further intensive case management resources, accommodation options and the availability of brokerage funds.

An improved understanding of the client profile, stakeholder perspectives and efforts in other jurisdictions to tackle the challenges provides the opportunity to develop a comprehensive strategy for a new and improved response, which can:

- **Drive change into the existing service system** rather than establish a parallel service system that would be costly, easily marginalised and act as a disincentive to improvements in collaboration and shared approaches more generally.
- **Focus on individual needs as well as consequences of behaviour.** While one of the most striking characteristics of the client group is the disruptive behavioural profile, any new strategy must also consider therapeutic objectives and be founded on developing improved ways of responding to basic needs for housing, stability, health care and safety. Careful assessment of need should be a central component of the strategy.
- **Develop new and innovative practices.** Acknowledging the critique of deinstitutionalisation policies in relation to this client group is not an argument for the re-introduction of institutional care. Rather, a new approach needs to promote the development of new practice approaches and technologies that

draw on what appear to have been important elements of institutional care for this client group. Maintenance models, continuity of care and stable environments are likely to be as important to this client group as any necessary clinical interventions.

- **Providing a multifaceted response to a multifaceted problem.** As essential as improved coordination across systems and sectors is, it is not, on its own, enough to deliver real change for this client group. There is a need for structural change as well as a formal mandate with legislative backing to drive improvement within and between service system components.



## Part two - Project findings

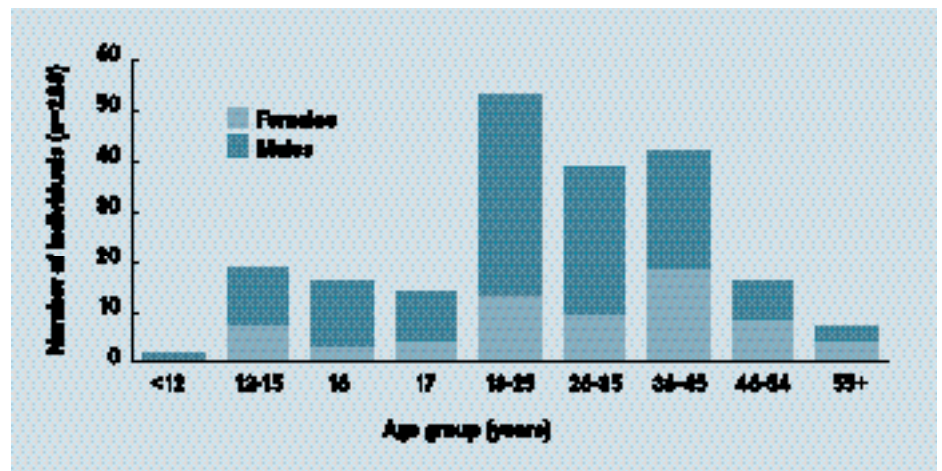


## Client profiling and case studies

The Responding to People with Multiple and Complex Needs Project developed a comprehensive profile of the target group across Victoria. This information is included in full in the companion document *Client profile data and case studies report* (January 2003).

The brief profile outlined below draws on the data collected on the 208 individuals nominated by the Department's directly provided or funded services. While information on the identified corrections population (39 people) is less detailed, it suggests a very similar client profile.<sup>7</sup>

Figure 1: Department of Human Services and funded sector population - age and gender (n=208)



### Key features

Overall, the population is relatively young, with most individuals aged between 18 and 35 years and a significant group (24%) aged under 18. There are twice as many men as women, and the majority of the population live in metropolitan Melbourne.

While not a homogenous group, there are common characteristics, including:

- combinations of mental health issues, disability and substance abuse
- high level of contact with juvenile and adult criminal justice systems
- high volume use of emergency services

- extreme problematic and high risk behaviours causing considerable risk to self, staff and community
- lack of access to secure and stable housing
- chronic health problems
- extreme social isolation.

Individuals were reported to have two or more of intellectual or physical disability, acquired brain injury, mental health issue or substance abuse problem. Most individuals have some combination of these presenting characteristics, reinforcing the cross-sector nature of the problem.

<sup>7</sup> Details on the Corrections population is available in the *Client Profile and Case Studies Report*, January 2003, p 79

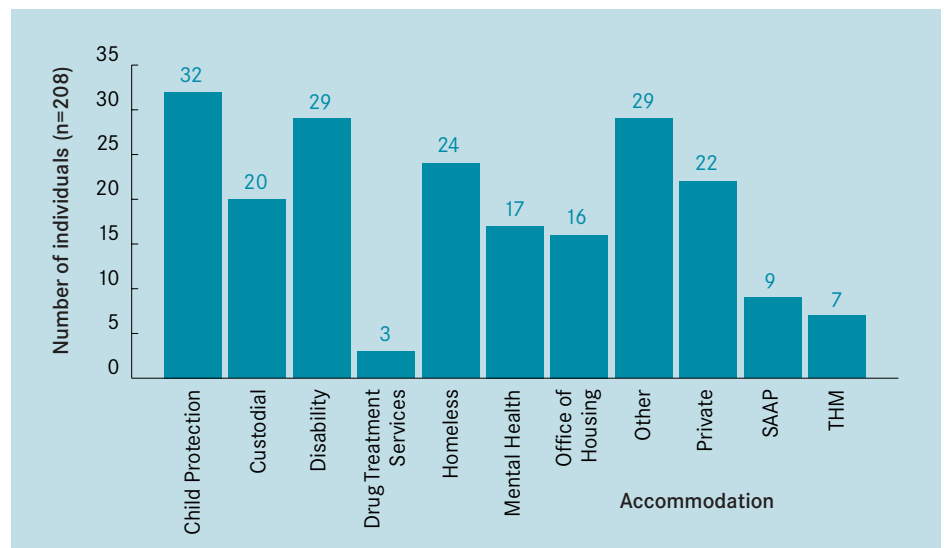
The following matrix (figure 2) is a two dimensional representation of clients by presentation. Each client shows evidence of two or more presenting characteristics. For example, the matrix shows the number of individuals in the total Department of Human Services population (208) with mental health issues (175) who also have a disability (82), who frequently abuse substances (103), have current involvement with adult corrections (42), have current involvement with juvenile justice (23) and with child protection (38). This analysis considers those individuals who are reported to present with these characteristics, but who are not necessarily involved directly with the program area.<sup>8</sup> For example, 175 individuals were reported to have mental health issues, but not all were involved with mental health services.

Housing arrangements vary across the client group but lack of stability in housing is marked. More than a third of the population is reported to be homeless or living in short term or crisis accommodation. Where accommodation arrangements appear more stable, the client is often residing in a Department of Human Services provided or funded housing program, for example within the child protection or disability service system.

Figure 2: Matrix of cross-program presentations (n=208)

	Mental Health	Disability	Frequent Substance Abuse	Adult Corrections	Juvenile Justice	Child Protection
Mental Health	175 (84%)	82 (39%)	103 (50%)	42 (20%)	23 (11%)	38 (18%)
Disability		104 (50%)	58 (28%)	29 (14%)	13 (6%)	21 (10%)
Frequent Substance Abuse			132 (63%)	42 (20%)	20 (10%)	25 (12%)
Adult Corrections				54 (26%)	3 (1%)	-
Juvenile Justice					29 (14%)	22 (11%)
Child Protection						45 (22%)

Figure 3: Department of Human Services and funded sector population - accommodation types (n=208)



<sup>8</sup> Of the 175 individuals reported to have mental health issues, 104 with disabilities and 132 with frequent substance abuse, not all were in receipt of current services from those program areas. In contrast, all individuals identified in adult corrections, juvenile justice and child protection were known to have current program involvement.

The behavioural profile of the client group is significant for the prevalence of high risk behaviours. Aggressive, risk taking, self-harming, assaultive and inappropriate sexualised behaviour were common. For almost all individuals, the behaviours were not associated with ‘one off’ incidents but occurred on five or more occasions over a 12-month period.

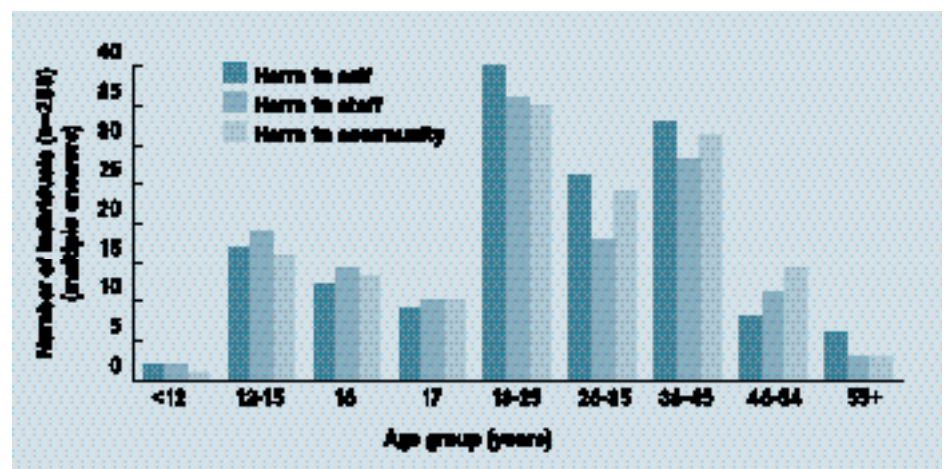
High rates of actual harm were also reported - for instance more than half of the population harmed staff on more than four occasions in a 12-month period.

The population are high volume users of emergency services - police, ambulance and hospital emergency departments in particular. Over the previous 12-month period, 64% of the group had four or more contacts with police; 30% had four or more ambulance services contacts and 43% had four or more contacts with hospital emergency departments. These were known contacts and likely to be an underestimate.

Figure 4: Department of Human Services and funded sector population - problematic and high risk behaviours (n=208)

Behaviour	Number of individuals displaying this behaviour	Percentage of population (n=208)
Aggressive behaviours	194	93.3
Inappropriate sexualised behaviours	114	54.8
Antisocial behaviours	180	86.5
Limited ability to understand consequences	189	90.9
Deliberate self harming	126	60.6
Suicide attempts	106	51.0
Risk taking	163	78.4
Violent crime	92	44.2
Assaultive behaviour	175	84.1
Arson	42	20.2
Under-age prostitution	21	10.1
Other	34	16.3

Figure 5: Department of Human Services and funded sector - individuals with incidences of harm towards self, staff and/or community - age groups (n=208)



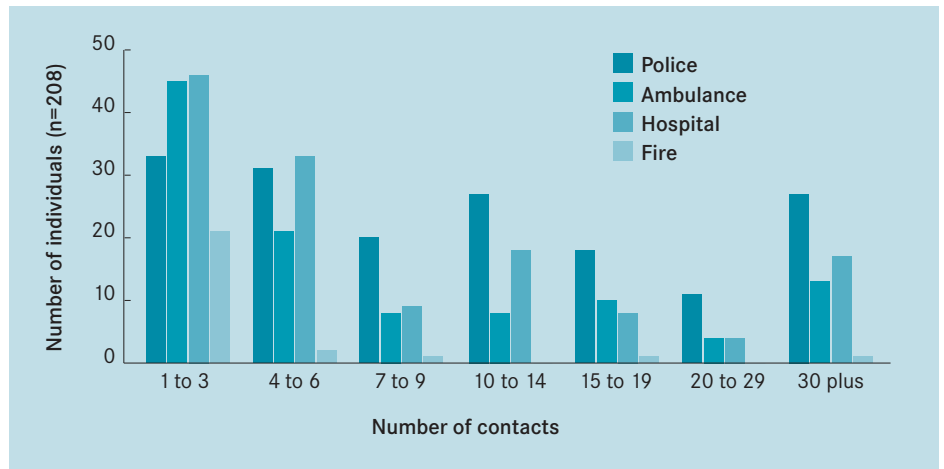
There is also a smaller group using emergency services on an intensive and frequent basis. For example, 27 individuals had 30 or more known contacts each with police in the 12-month period.

High rates of past and current contact with the criminal justice system are also characteristic of the client group - 71% having had past or current contact with juvenile justice or adult correctional services.

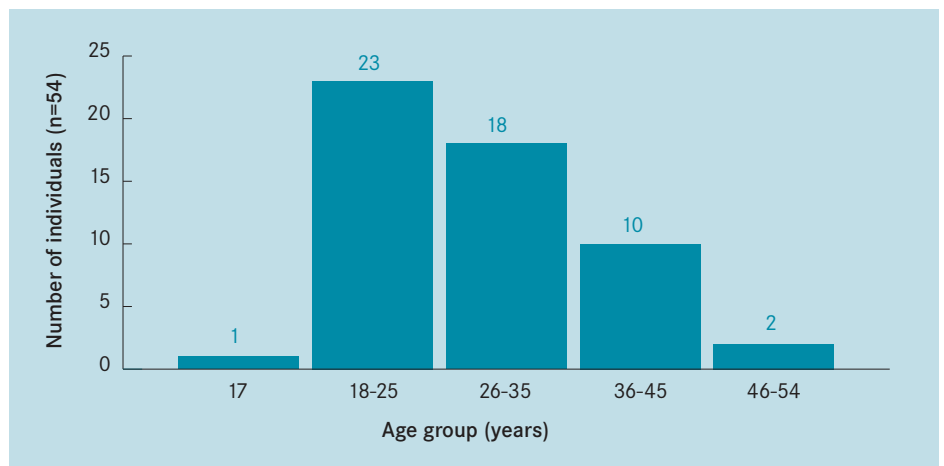
There were 54 individuals or 26% of the population reported to be currently involved with adult corrections - prison or community corrections<sup>9</sup>. All but four of these individuals had previous criminal justice involvement.

Current involvement with juvenile justice services was reported for 29 individuals or 14% of the population. A total of 80 individuals or 38% were reported as having previous involvement with juvenile justice services.

**Figure 6: Department of Human Services and funded sector population - use of emergency services, last 12 months (n=208)**



**Figure 7: Department of Human Services and funded sector - adult criminal justice sub-population - age distribution (n=54)**



<sup>9</sup> A further 39 individuals meeting the target group criteria were identified by Corrections services making a total of 93 individuals from the total cohort of 247 with current adult Corrections involvement.

The vast majority of the population are socially isolated (190 individuals) with most individuals extremely isolated. Only around one third of the population was known by service providers to have some form of regular contact with family.

Figure 8: Department of Human Services and funded sector - juvenile justice sub-population - age distribution (n=29)

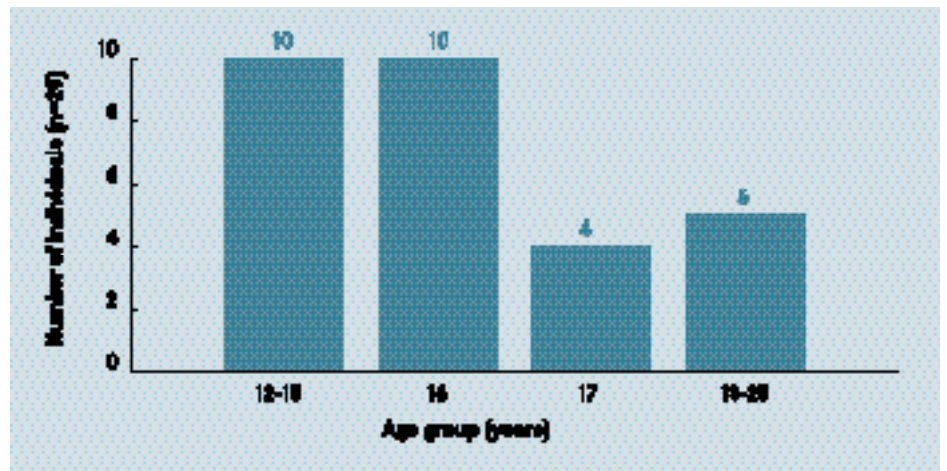


Figure 9: Department of Human Services and funded sector population - level of social isolation (n=208)

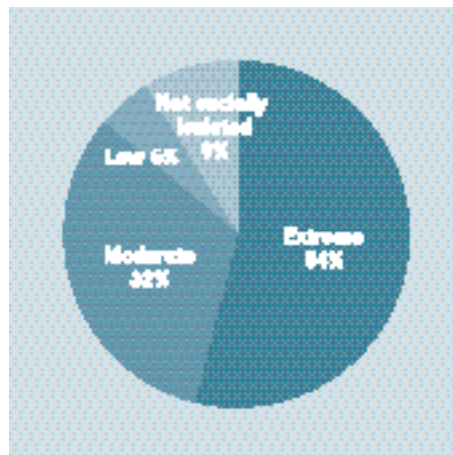
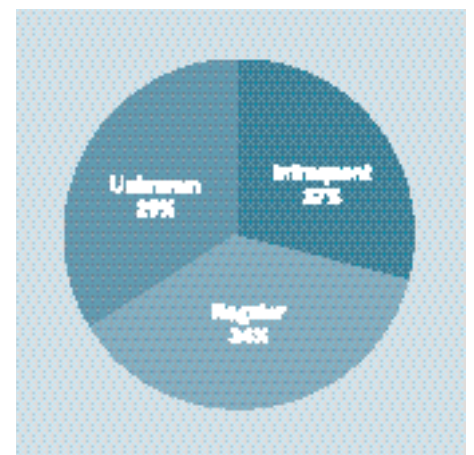
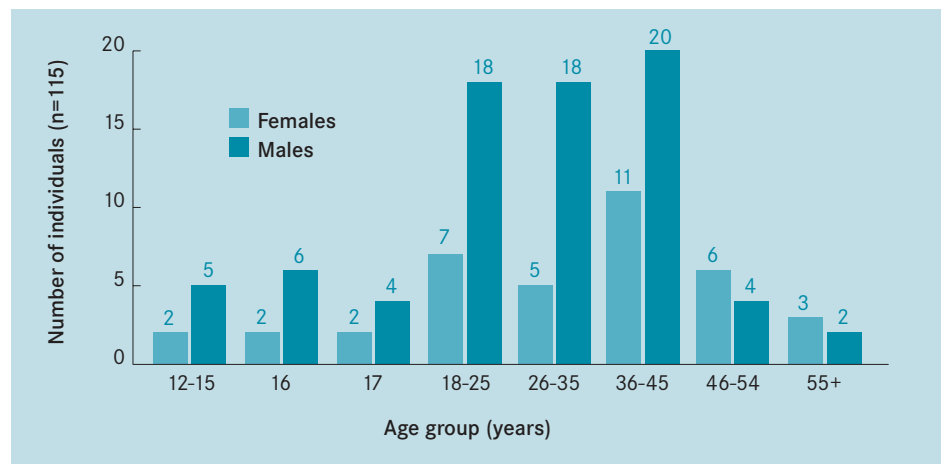


Figure 10: Department of Human Services and funded sector population - family involvement (n=208)



Not unexpectedly, given their often chaotic and unstable lifestyles, 115 individuals (55%) were identified as having a chronic health problem, such as hepatitis C and B, liver disease, unstable diabetes, cardiac and respiratory diseases, sexually transmitted diseases and epilepsy. In most cases the conditions went untreated and were often exacerbated by substance abuse.

**Figure 11: Department of Human Services and funded sector - chronic health (n=115)**



### Case study 'Kevin'<sup>10</sup>

Kevin lives on the outskirts of the metropolitan area and is 20 years old. From early childhood he displayed dangerous and aggressive behaviours and was diagnosed with Conduct and Attention Deficit Hyperactivity Disorders.

From the age of four and throughout his life, Kevin has been involved with the mental health service system and has had many psychiatric assessments, diagnoses and intervention.

From approximately 12 years of age Kevin began to display a fascination with knives and other weapons. He was considered a risk to his peers and at one stage seriously assaulted another child and became involved with Child Protection services after assaulting family members.

At this time Kevin commenced a lifelong pattern of significant alcohol and poly substance abuse, including the use of intravenous drugs. He was noted to have a learning disability and by age 15 was assessed as having a borderline intellectual

disability. School attendance was erratic and there were periods when he was banned from school in response to his violent behaviour.

In adolescence Kevin was diagnosed with Aspergers Syndrome and a personality disorder although there was disagreement among health professionals as to his primary problem and therefore the most appropriate intervention.

Kevin has always been noted to have extremely poor social skills and has usually been very isolated with few if any friends. He could be extremely paranoid in every day situations and the possibility of an emerging paranoid psychosis was noted. At one point, at age 17, he was diagnosed with a drug induced psychosis.

Kevin has had significant police and corrections involvement throughout his late teens and has been charged with offences such as physical assault, possession of drugs and weapons and burglary.

Throughout Kevin's life his family have sought help with his behaviours, however,

they have also struggled with significant and chronic mental health and health problems that have affected their ability to effectively support him.

Kevin requires intensive support to manage his life and behaviours. He has been aggressive and violent towards support staff and members of the community, but with intensive support and supervision these behaviours lessen and become more manageable. However, Kevin has often 'dropped out' of services or has been referred on after short term interventions. A new service arrangement is set up following another crisis event.

A broad range of agencies and service sectors have been involved with Kevin for most of his life, including mental health, child protection, juvenile justice, disability and drug treatment services, housing agencies, police and the court system. However, continuity of care remains a problem and there is a lack of agreement about the type of care and support required in the longer term and which service sector or sectors is responsible for this.

<sup>10</sup> This case study is fictional and based on findings of the profiling and case study exercises.

## Literature review

There is a vast amount of literature about co-occurring and multiple disorders or disabilities, particularly where these are accompanied by behaviours and needs that challenge the service system and the communities in which people live. Although broader than the focus of this project, much of this literature is relevant in identifying and understanding some of the key issues and service system challenges specifically associated with effective responses to people deemed to be at the extreme end of the continuum.

The literature review was prepared by Thomson Goodall Associates and presented to the project team in September 2002. The literature review is available at [www.dhs.vic.gov.au/complexclients](http://www.dhs.vic.gov.au/complexclients). The major findings of the literature review follow.

### Defining and understanding complex needs

This section of the literature review examines definitions of ‘complex needs’, placing complexity on a continuum of need. Reference is made to theoretical frameworks or professional orientations and perspectives influencing understanding of complexity of need.

The range of terms used to describe people with complex needs are examined. Over the last two decades in Australian and international literature terms such as ‘complex needs’, ‘high complex behaviours’, ‘multi-

service clients’, ‘complex clients’, and ‘people whose needs require a high level and complexity of service provision’ have been used. The terms appear to be used interchangeably.

The review describes Keene’s identification of five categories of co-occurring problems (co-morbidity) as a basis for defining complex needs. The categories are:

- psychological, mental health, and other problems
- learning and developmental difficulties and other problems
- social problems, homelessness, and other problems
- crimes and other problems
- drug and alcohol misuse and other problems.

Keene also proposes a continuum of need, where a significant minority at one end preoccupy policy makers, planners and services, and are time consuming and resource intensive<sup>11</sup>.

This section of the review also discusses the dual disability and dual disorder perspective. Dual disability is described in terms of mental disorders co-occurring with substance abuse; mental health issues co-occurring with intellectual disability; and intellectual disability co-occurring with substance abuse. Much of the literature focuses on mental illness and substance abuse co-occurring. Another focus is the relationship between dual disability and the criminal justice system. Cupitt et al. associated several other

factors with substance misuse and severe mental illness:

- heavy use of emergency services
- increased suicidal or violent behaviour as inpatients, thereby prolonging hospital stays
- poor clinical and social outcomes
- violent behaviour
- high rates of offending and imprisonment
- homelessness<sup>12</sup>.

### Government policy frameworks

This section of the literature review examines government responses to people with multiple and complex needs, specifically through enacting legislation and through policy and program development.

The impact of deinstitutionalisation is considered and, while the rationale is generally supported and seen to have resulted in significantly improved outcomes for most clients, concerns persist about the impact it has had on a small group with multiple and complex needs. Overall, the review finds insufficient planning and resourcing occurred in relation to community-based services following deinstitutionalisation. This resulted in clients with multiple and complex needs receiving inadequate responses.

The literature review also discusses the national policy context in Australia for people with complex needs, including mental health, disability and drug strategies.

11 Keene, J. (2001) *Clients with complex needs – interprofessional practice*. Blackwell Science Ltd, UK.

12 Cupitt, L., Morgan, E., Challeley, M. (1999) *Dual diagnosis – stopping the merry-go-round*. ACT.

Policy and program development in Victoria is also discussed. Initiatives relating to mental health, child and adolescent mental health, disability, protection and care, juvenile justice, drug treatment services, the Working Together Strategy, the Multi Service Client Project, and the Victorian Homelessness Strategy are canvassed. The policy contexts of selected other states and territories (Western Australia, South Australia, and the Australian Capital Territory) are also summarised.

### Legislative context relating to people with multiple and complex needs

This section of the literature review concerns the range of legislation covering people with multiple and complex needs. The review has found that in most Western countries, the important provisions are found in mental health, disability and criminal justice legislation, and that most of the relevant legislation is enacted at the state or provincial level rather than at the federal level.

The Victorian context is also examined, noting that several acts provide the legislative basis for both mandating and circumscribing a response to people with complex needs, including the *Mental Health Act 1986*, the *Intellectually Disabled Persons' Services Act 1986*, and the *Guardianship and Administration Act 1986*.

Other relevant Victorian legislation includes the *Community Protection (Violent Offenders) Act 1993*, the

*Sentencing Act 1991*, the *Children and Young Persons Act 1989*, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, and the *Alcoholics and Drug-dependent Persons Act 1968*.

The literature review also examines selected other jurisdictions, notably the Australian Capital Territory, New South Wales and the United Kingdom. The review notes little comparative literature.

### Service system issues, barriers and gaps

This section of the review notes that for people who require a high level and complexity of service provision, effective responses involve multiple services spanning several disciplines, program areas and service organisations. This is particularly so for people with dual disability, people with mental disorder and/or intellectual disability, including those involved in the criminal/juvenile justice systems, or people with personality disorder for whom it is often not clear which services are the most appropriate.

The review finds that while a number of initiatives have been developed in some departmental areas to more effectively respond to complex need, specific gaps and barriers still exist.

The review finds that many authors have documented barriers to effective responses to people with complex needs and there is remarkable congruence about these barriers.

The US based Taskforce on Dual Disability noted incongruity and

incompatibility across a number of dimensions. Barriers identified included:

- separate organisational and financial structures/separate systems
- inconsistent administrative rule requirements
- differing record keeping and data systems
- unrelated performance measurement objectives
- uncoordinated funding mechanisms.<sup>13</sup>

The review also collates a number of issues identified as barriers to multidisciplinary coordination:

- lack of sharing information about overlapping populations and shared patients/clients
- lack of common information systems
- lack of principles to underpin shared data, and shared agreed practice models
- insufficient central guidelines
- funding constraints and accountability imperatives (throughput measures) that can result in including less demanding clients and excluding people with complex needs from service provision
- exclusive rather than inclusive criteria and cultures in specialist services
- misidentification of symptoms
- absence of a shared case management approach and holistic approaches to support
- levels of resourcing required.

Other gaps reported in the literature include:

- the conceptualization of complexity of

<sup>13</sup> Oregon Department of Human Services (2000) *Report of the Statewide Taskforce on Dual Diagnosis*.

need has only recently occurred at a public policy level

- amount and allocation of resources dedicated to this area
- inappropriate policy and legislative contexts
- lack of attention to culturally appropriate service provision
- insufficient collaboration among corrections, courts, mental health, substance abuse, social service agencies, housing, employment services
- lack of an agreed model(s), partly due to the diversity of needs and debate over appropriate responses
- lack of quality (longitudinal) research in the area to inform practice
- lack of support by the service system for comprehensive long-term case management
- limited training/understanding amongst professional and clinical staff of the complexities of dual disability – particularly in terms of appropriate cultures, attitudes and practices.

The review also canvasses system gaps and barriers relating to specific program areas: mental health services; forensic mental health services; disability services; criminal justice; child protection services; juvenile justice; child and adolescent mental health; housing and homelessness; and drug treatment services.

## Towards improved responses

The literature review finds a range of proposed improved responses to

people with multiple and complex needs. Some literature focuses on the need for legislative reform. Several authors highlight the importance of improved responses that integrate criminal justice and human services responses. The review discusses improved responses at the system-wide level, including consideration of program coordination and planning, principles, collaborative responses and the role of specialist services. The review also discusses improvements at a service level, including principles and practices and service models.

Regarding system-based responses, the literature suggests that approaches to improve outcomes for people with complex needs must encompass improvements in policy and program frameworks; legislation dealing directly or indirectly with people with multiple and complex needs; design and resourcing of the relevant government departments (including criminal justice, health, welfare, other); and collaborative and joint responses involving several departments and program areas.

Most texts proposing improved systems and models argue for agreed governing principles. Examples from the literature of governing principles include:

- access to all population groups experiencing complex, multiple, chronic and disabling conditions
- access to a full range of services in which clients and families have some choice of services suitable to their needs, and potentially reduce the

necessity for hospitalisation or institutionalisation

- coordination and management of care and interventions with transfer of clients to assistance more appropriate to their current needs
- community-based networks using the least restrictive environment
- consumer involvement in decisions
- a continuum of care.

The review discusses collaborative approaches. Panels comprising representatives from several program areas have been established in a number of jurisdictions to improve responses to people with complex needs and to manage associated risks.

The review notes that the value of specialist responses as part of an integrated response to people with severe co-morbid disorders has been recognised by many authors.

Regarding service-specific principles and practices, the review notes that required improvements relate to governing principles, practice models, approaches and elements, resourcing, governance and management.

The literature indicates that good practice approaches identified for people with complex needs will take into account:

- the quality of relationships between workers and clients
- the engagement of clients
- long-term commitment
- holistic approaches.

The literature review discusses suggested service models and

## Consultation outcomes

notes that there are several model components required by people with complex needs to be used on an as-required basis. These model components are:

- A range of graded residential and community-based treatment and support models – specialised inpatient treatment, short and long term inpatient residential and community-based care, supported housing, integrated treatment teams, and a range of treatment options and interventions.
- Client interventions – cognitive behavioural training, intensive therapy, relapse prevention training, therapeutic communities, group treatments, simultaneous psychosocial education and substance use education, and ongoing outpatient follow-up.
- Accommodation – inpatient treatment units, short and long stay hospital and community-based residential units, community-based beds, home-based residential options, community-based shared/independent supported accommodation.
- Outreach – assertive outreach, detached outreach support. These approaches are described by flexibility to respond to multiple needs and increased ability to ‘track’ people across service boundaries and geographical locations.
- Service delivery components – crisis intervention, assessment, clinical interventions, case management, psychosocial interventions and ongoing support.

Stakeholders identified a range of key themes and elements missing from the existing service system. Some of these themes were presented in Part one and are repeated here along with additional issues raised through the consultations. An outline of the consultation strategy is at Appendix Four.

### Service gaps

It appears that most individuals have benefited significantly from the move from institutional care to local, specialist and community-based service responses. Stakeholders suggested that although this transition has been positive there is now a lack of therapeutic residential and community-based programs that enable longer term treatment and care options for some people within the target group.

There were commonly held views among stakeholders that a number of very specific service gaps are contributing to broad-ranging difficulties in the provision of adequate support to the target population. In the absence of appropriate service provision models, ad hoc accommodation and intensive support/supervision responses are developed for individuals, usually at a very high cost. Specific service gaps were identified by stakeholders in relation to:

- People with Asperger’s Syndrome and those with Borderline Personality Disorder. These people are often identified as falling between service gaps due to ineligibility and/or a lack of available service options. Stakeholders often remarked that

people with these diagnoses are frequently deemed ineligible for intellectual disability and mental health services.

- Residential care programs. A particular need was identified for programs that enable an effective service response in a safe environment, particularly in relation to young people with multiple and complex needs.
- ‘Step down’ forensic mental health or intellectual disability residential facilities. Stakeholders stressed that ‘step-down’ services were essential to enable continued supervised treatment and care following release from hospital-based care such as Thomas Embling Hospital, prison or other secure environments such as the Statewide Forensic Service.
- Vulnerability at system transition points. In particular, service providers emphasised the lack of intensive support and treatment services available for extremely vulnerable young people moving from systems targeted at children and young people to those designed for adults. Examples were given of young people moving between child and adolescent and adult mental health services and young people moving out of the child protection system at 18 years of age.
- Transition from custodial services. Stakeholders identified the need for access to appropriate and planned service responses for people with complex needs leaving the custodial system, and more effective collaboration between health, welfare and criminal justice systems.

- **Mental health services.** The need for ongoing therapeutic support was identified by a number of stakeholders as a critical feature of any service response to complex clients. In this context, feedback from service providers indicates that the crisis response nature of many mental health services is inadequate for addressing the ongoing mental health support requirements of many people with multiple and complex needs.
- **Drug treatment services.** Alcohol and other substance abuse was identified as an issue for many individuals with multiple and complex needs. Comments from stakeholders indicated that drug treatment services are (usually) designed for people with a certain level of cognitive functioning. Service providers suggested that this has limited the accessibility of drug treatment services to individuals with intellectual disabilities, acquired brain injuries and/or severe mental health issues, and that proactive and assertive outreach often required for people with multiple and complex needs is, therefore, difficult to access.
- **People with multiple and complex needs from Koori and culturally and linguistically diverse (CALD) backgrounds.** Service providers identified the need to ensure that service responses adequately address the needs of people with Koori or CALD backgrounds.
- **Sex offenders.** Service providers identified the need for access to suitable placement/accommodation options and treatment services for

people with multiple and complex needs who are also sex offenders. This has been noted as a particular problem in rural regions.

### Service delivery issues

- **Sustainability.** Where services do provide intensive support for the target population, forum participants said they believed this support could not be sustained over time due to the excessive pressure such individuals place on the capacity of services to respond to the needs of other people.
- **Funding.** Regions reported that tailored individualised service ‘packages’ involve funds being accessed from multiple program and regional sources on an ad hoc basis.
- **Containment/secure environment.** The majority of those consulted identified a lack of available options to provide secure or contained environments for a small number of individuals who pose a severe and immediate risk to themselves and the community.

### Rural services

A number of rural service providers indicated that their ability to respond to people with multiple and complex needs is affected by the availability of specific services, that is, more specialist services tend to be located in metropolitan regions. Some rural regions indicated that a number of individuals who might otherwise have been ‘managed’ locally were at risk of becoming ‘complex’ because rural organisations do not have the client numbers to inform their practice and

assist the development of expertise in addressing complex needs.

### Workforce issues

Many of those consulted argued that staff support, like staff supervision and training, is intrinsic to the provision of quality services to people with highly complex needs. Skill gaps, occupational health and safety and industrial issues were perceived to act as a barrier to the development of more flexible and multidisciplinary treatment and support models within the current service system. It has often been difficult for intensive service responses to be sustained over time due to the excessive pressure working with such individuals places on staff and the service capacity to respond to the needs of other clients.

### Legislation

There are widespread views among stakeholders that the existing legislative framework has significant limitations. In particular, the Mental Health Act 1986, the Intellectually Disabled Persons’ Services Act 1986 and the Children and Young Persons Act 1989 have been criticised for the limitations they place on both service accessibility for people with highly complex needs, including those with mental disorders as distinct from mental illness, and therapeutic containment for people who are a high risk to themselves or others. In discussion of these issues the underlying tension between individual and community rights was widely acknowledged.

Further to this, consideration must be given to the work undertaken by the Victorian Law Reform Commission in regard to the examination of the current framework for the compulsory treatment and care of people with an intellectual disability who are at risk to themselves and the community.

### **Lack of early intervention options**

The consistent lack of appropriate early intervention and case management with people who are now described as having multiple and complex needs was identified as a significant concern to stakeholders. A greater focus on early intervention and prevention strategies across the range of program areas was seen as critical to improving overall service responses and preventing people developing needs that cannot be met by the service system.

### **Lack of engagement with the education system**

A lack of engagement with, or exclusion from, the education system was consistently identified as having a significant impact on young people. Without access to education, these young people not only lose opportunities to develop learning and employment skills but also life and social skills, friendships and community links. An absence of these skills and community connections is a consistent characteristic of people identified as having multiple and complex needs.

### **Service system exclusion on the basis of perceived difficulty**

A number of respondents expressed concern about service provider organisations using perceived difficulty as a mechanism to exclude individuals known to have multiple and complex needs.

### **Reluctance to work with the individual in the broader context of their families**

The lack of ability of some service providers, including mental health providers, to work with both the individual and their family was identified as a problem by respondents. This approach was seen as limiting the potential long-term gains that might be made for the individual.

### **'Criminalisation' of people with multiple and complex needs**

An increasing number of people with multiple and complex needs have been identified as entering the criminal justice system unnecessarily. These people are seen by stakeholders to be excluded from or not engaged by the broader service system and, in the absence of more suitable service responses, continue to exhibit behaviours that eventually bring them into contact with the criminal justice system.

## **Summary of possible solutions**

### **Guiding principles**

Stakeholders argued strongly that service responses must be underpinned by a framework or set of principles that address an individualised needs-based assessment, intervention and management, and leadership incentives to ensure the long-term engagement of the client. It was also argued that principles should emphasise the importance of viewing individual need in the context of family/social and community supports, and that measures of service provision success should include the individual's wellbeing.

### **Service response system structure**

Stakeholders agreed that service response systems should have a single entry point with a definition of complexity that enables appropriate gatekeeping. The establishment of an umbrella panel that spans program and regional boundaries and has the capacity to direct funding and resources was also proposed by a range of respondents. It was broadly agreed that service response systems should have the capacity to work with a range of disorders and ages or transitional life stages. A number of stakeholders favoured the establishment of 'hub and spoke' models of service provision, with the hub taking responsibility for establishing a centre of excellence, training and

education, research and service development. It was highlighted that there should be a single point of accountability for government and non-government clients and a centralised cross-service database.

### Legislative reform

Stakeholders emphasised the need for a consistent legislative framework that would overarch program areas. The framework must address the need for long-term secure accommodation with different service models. Stakeholders were strongly of the view that legislation must balance community and individual interests and contain appropriate review and accountability mechanisms.

### Containment

Many of those consulted stressed that service responses to people with multiple and complex needs must include the capacity for secure containment options that balance rights and needs.

### Individually tailored supports

Service responses must be sufficiently flexible to ensure individualised responses with accommodation options to provide long-term support.

### Workforce

The building of resilient agencies and staff was seen as crucial to ensuring ongoing assessment, diagnosis and management of people with multiple

and complex needs. Training and staff supervision were identified as key elements of an overall human resources strategy for service providers responsible for managing the target population. Stakeholders stressed that industrial and occupational health and safety issues must be examined to prevent worker burnout and increase flexibility of service responses through mechanisms such as revised staffing rosters and multidisciplinary teams. Stakeholders indicated that consideration should be given to funding universities to conduct practical, evidence-based research, program development and planning and evaluation of treatment options.

### Case study 'Mary'<sup>14</sup>

Mary lives in a metropolitan area and is in her late thirties. Her childhood was characterised by physical abuse, neglect and alleged sexual abuse. Her contact with the service system was as a result of an escalation in high risk and extreme behaviours including significant self-harm, assaultive and aggressive behaviours and extensive criminal behaviour.

Mary has been diagnosed with a severe personality disorder with possible psychotic features, cognitive impairment requiring ongoing review and management and a significant medical condition that requires medication and continued monitoring. Her behaviours include assault, theft, stand over tactics to obtain money, trespass and extreme self-harming behaviours. Because of her intimidating, manipulative and anti-social behaviours, Mary is extremely isolated, self-absorbed and has significant difficulty in engaging with other people.

Mary is non-compliant with services and has a history of extremely assaultive behaviours toward service staff. She has a significant criminal history and has been charged with many offences and been imprisoned on a number of occasions. During periods of extremely disturbed behaviours, emergency services have been known to attend Mary on several occasions within a 24-hour period.

Mary currently resides in accommodation with intensive support provided seven days a week in order to maintain her own safety and the safety of others in the community. Her living skills and social skills are extremely poor and, combined with her high risk behaviours, it is necessary for two staff to manage her.

Mary has a range of services involved in her care including mental health services, corrections, police, ambulance, disability services and housing and support services.

<sup>14</sup> This case study is fictional and is based on findings of the profiling and case study exercises.

## Assessment, planning and treatment

Those consulted were consistently of the view that cross-sector/cross-discipline expertise is required with holistic mechanisms that consider the engagement of the person. Participants indicated that serious consideration must be given to the management of both client and service provider non-compliance.

## Eligibility

Stakeholders consistently stressed the view that service access must be client driven. It was proposed that the use of a category such as ‘human service’ might overcome rigidity of response to clients who do not ‘fit’ any program.

## ‘Whole of person’ approaches

Those consulted stressed that service responses must encompass a ‘whole of person’ approach and address quality of life issues as well as maintain social and family relationships where possible. It was consistently argued that capacity must exist for long term (potentially life long) engagement, commitment and planning.

In addition to intensive therapeutic options, it was argued that support and care must be provided in therapeutic environments and, to ensure greater accountability, a ‘lead’ case manager must be identified for clients in the target group.

## The development of a service response model

Following the May 2002 statewide forum, areas of change identified by stakeholders through the preceding phases of consultation were grouped into four primary components of a service response system:

- **A central coordination or policy point.** The responsibility for coordinating any new agreed service responses, liaison with the Department of Justice and oversight of any policy or legislative changes, would be located within the Department of Human Services.
- **A panel or board.** This function could be located within, or external to, the Department of Human Services. Such a panel would have the capacity to bring together relevant service providers and other experts to consider individual client needs and plan for a response.
- **Legislative reform.** Key issues raised related to service eligibility requirements and the capacity to provide compulsory treatment and care, when required. It was determined that legislative change would be required to enable the establishment of an appropriate service response.
- **Strengthening service system capacity.** Identified elements of a strengthened service response included intensive multidisciplinary case management, the establishment of central or regional expert teams, improving capacity through workforce

training and change, and establishment of new initiatives targeting a range of service gaps and accommodation options.

Based on these primary components, three service models were constructed that were used for discussion purposes in the third phase of the consultation process, namely the August 2002 regional forums and the statewide stakeholder consultations. [Details of the discussion models and a summary of consultation issues can be found in the document, *Responding to People with High and Complex Needs Project: summary of consultation findings* September 2002.]

The third phase of consultation emphasized a high degree of consistency in views regarding the types of changes that need to be introduced to strengthen service system capacity. There was also consistency of stakeholder views regarding the limitations of the legislative framework, the need to expand service eligibility requirements and the need for broader access to compulsory treatment and care options. However, views varied regarding mechanisms to ensure the protection of individual rights, particularly in relation to compulsory treatment and care options. Finally, the notion of establishing a panel external to the Department of Human Services received broad support from most stakeholders. Again, views varied in relation to the structure of this

component and mechanisms to ensure relevance to individual regions.

In response to feedback obtained through the August regional forums and statewide stakeholder interviews, a proposed service response model was presented to participants at the September 2002 statewide forum.

Essentially, the proposed service model comprised five components. These were:

- **A multiple and complex needs panel**

The panel would be responsible for determining individual need and implementing and reviewing a care plan. It would have the capacity to direct and, if necessary, compel multidisciplinary assessment. It was proposed that the panel would be an independent body with statewide responsibility. It would have a legal mandate with review and appeal provisions.

- **A specialist multidisciplinary assessment service**

The assessment service would be responsible for holistic and comprehensive assessments and drafting of care plans. While the service would have the capacity to undertake assessments on an outreach basis, these could also occur in a residential assessment unit, in circumstances where the individual required stabilisation prior to assessment. Any admissions to a residential assessment unit would vary according to individual need but would not exceed three months. Such a

facility would only be accessible to those aged 18 years or over. The assessment service would work collaboratively with past and present service providers, the family and carers to complete the assessment.

- **Research, development and training**

A research, development and training function was considered an essential secondary role of the assessment service. Objectives of this function include identifying new practice technologies and developing links with tertiary education and training institutions. Provision of a secondary and tertiary consultation capacity was identified as a further objective.

- **Service System Enhancement**

This involved the establishment of a small number of specialist agencies to provide intensive multidisciplinary case management and outreach services for people with multiple and complex needs. It was envisaged that these services would not take on case management for all people referred to the panel, but rather would take on the role when local options were not available. Where possible, existing services would be engaged to assume case management for people within their local environments. The core function of these specialist service providers would be to address the individual's needs in relation to:

- stable housing
- health and wellbeing
- safety
- social connectedness.

The development of effective links and working relationships between specialist agencies and other local and regional services was considered essential. The eventual transfer of support of the individual to existing services would be an objective of all care plans.

- **Building capacity in the existing system**

Existing services would continue to be the primary providers to the target population. The panel and specialist assessment service would enable a coordinated response and specialist intensive case management services would supplement service options currently available.

Stakeholder comments on the proposed model are summarised below according to the model components:

### Multiple and complex needs panel

While an independent, multidisciplinary panel with the legal authority to compel an individual to undergo assessment was broadly supported, stakeholders varied in their views about operational issues and span of authority. The range of views included:

- a panel should be centralised but also have the capacity to convene in regional locations according to demand
- a series of panels should be established in key regional locations
- a panel's authority should not extend

to the under-17 year old age group due to their differing developmental needs

- a panel should have the capacity to compel services to provide specific supports to people with multiple and complex needs
- any attempt to compel services would ultimately undermine the model
- capacity to compel individuals was consistently identified as being critical to a panel's role
- various options for membership of a multiple and complex care panel.

It was broadly agreed that the panel should have an identified budget to supplement existing service responses.

### Specialist multidisciplinary assessment service and assessment unit

There was broad agreement that a specialist multidisciplinary assessment service should have capacity to undertake direct assessments of individuals in their own communities or in a separate residential facility in cases where the individual requires stabilisation pending assessment. It was also broadly agreed that an assessment service should also assume responsibility for research, training and consultation functions.

Other views included:

- service providers should be able to access an assessment service for support and direction prior to application to a panel
- in addition to preparing an holistic assessment of the individual, assessment service staff should also be responsible for drafting a care plan for approval by the panel
- the assessment unit should be smaller than a 20 bed facility
- an assessment unit must never be used for containment only
- the establishment and funding of advocacy options, including legal advocacy, to ensure client-centred focus is essential, particularly if there are involuntary outcomes of referral to a panel.

### Specialist agencies

There was broad agreement that the establishment of services in key regional locations to address individuals' basic needs in terms of housing, health, safety and social connectedness was appropriate.

Other views included:

- support should not be time limited
- longer term intervention with regular structured reviews will be essential for the target population

- a maintenance rather than throughput model of service provision, post-assessment, would be most relevant to the target population.

### Existing service system

A number of stakeholders argued that the success of the service response model will be contingent upon the strength of the existing service system and that any care plan will need to consider a person's needs after a return to the existing system.

There was consistent agreement that the existing system should have access to training and support to improve capacity to respond to the target population.

Some suggested that existing service provider organisations should be used to provide the 'specialist agency' responses as this would affirm their capacity and provide incentives for developing expertise.

While it was understood that the development of early intervention models or strategies would be outside the terms of reference of the current Responding to Victorians with Multiple and Complex Needs project, stakeholders identified the target population's long histories of service system involvement as requiring attention.

## Part three - Towards a new response



## Guiding principles

An improved service response to people with multiple and complex needs requires:

### 1. A joined up service response

Individuals with multiple and complex needs have an entitlement to a 'joined up' service response.

### 2. A way through the barriers

Threshold issues of complexity rather than program specific eligibility requirements need to determine access to a service response.

### 3. Commitment across the service system

Clear leadership by the Department of Human Services is required. Involvement of all aspects of the Department of Human Services and its funded agencies is needed to contribute to an improved service response to this client group.

### 4. Effective assessment and determination of a way forward

A forum and process - with legal

authority and mandate - is required to bring relevant providers and experts together to plan for an appropriate service response for individuals with multiple and complex needs.

Comprehensive and multidisciplinary assessment of need (rather than service eligibility) is critical to the development of an informed and practical service response that is agreed across agencies and sectors.

### 5. Strengthening existing services to lead the way

Overall, and in the longer term, responsibility for service delivery remains with the existing service system - new initiatives must complement work undertaken within specific Department of Human Services program areas to improve capacity to manage complexity.

New service development targeted to this client group will have a medium-term focus with eventual transition to existing services as a key objective.

### 6. New ways of working

Implementation of specialist initiatives must include a feedback loop to ensure learnings and outcomes inform existing services and further develop the capacity to manage complexity across the service system.

Outcomes flowing from this initiative should inform early intervention and prevention strategies that will continue to be pursued across the service system.

### 7. Balancing individual rights and need

There may be occasions when assessment, treatment and care need to be compelled for this client group to activate a service response that they are entitled to and can benefit from.

Appropriate protection of client rights must be built in to any future legislative authority that would restrict individuals in this context.

## Service model

A new, targeted, cross-sector service response is required to more effectively respond to people with multiple and complex needs.

While the literature indicates that jurisdictions across Australia and other parts of the world face the same problem, there are no single best practice solutions. An innovative response is required to a new public policy challenge.

A new service model will aim to develop a system of care that provides for and maintains stable housing,

health and wellbeing, safety and social connectedness.

The new service response is predicated on a specialist 12-15 month intervention (including assessment and care plan) that aims to:

- stabilise housing, health, social connection and safety issues
- provide a platform for long-term engagement in the service system
- pursue planned and consistent therapeutic goals for each client.

The project findings point to a range of service response elements that, in combination, can build a more

effective response to people with multiple and complex needs.

The components are listed below followed by a more detailed explanation.

- A. Regional gateway and referral process
- B. Multiple and Complex Needs Panel
- C. Multidisciplinary assessment service
- D. Intensive case management agencies
- E. Improved capacity in the existing service system
- F. Sustainable housing options

## A. Regional gateway and referral process

### Initial client identification process

The service system, including the Department of Human Services, funded agencies, courts, police and correctional services, can identify clients with multiple and complex needs for whom it has not been possible to provide or sustain an appropriate service response. Clients identified for referral must be adults (18 years and over) or young people aged 16 or 17 years and in transition to adult services.

The relevant Department of Human Services regional office is the initial contact point for assessment of client eligibility for referral to the Multiple and Complex Needs Panel.

The referral process requires regional director endorsement and is designed to provide a small, controlled gateway in each region and ensure 'net widening' does not occur. An effective screening process is critical for the service response to be appropriately targeted to the relatively small group of individuals with high level multiple and complex needs.

Department of Human Services regions will screen referrals against the entry criteria and confirm that all available service responses – including improved coordination between services – have been considered. Referrals will not progress to the panel unless the regional director is satisfied that the existing service system

responses are insufficient. Standardised screening tools and mechanisms will be developed to guide a consistent approach to gatekeeping across regions.

### Children and young people

Individuals 15 years and younger with multiple and complex needs will be excluded from the service model.

Most children and young people profiled as part of the project are or have been clients under the Children and Young Persons Act. Most of these clients are already subject to guardianship and custody orders, which confer on the Secretary, Department of Human Services, a range of powers and duties relating to the care and control of the child or young person.

In addition, the new Intensive Therapeutic Service will provide a targeted response to those children and young people with very high levels of need that has not been previously available. It has been argued that the children and young people identified through the Responding to People with Multiple and Complex Needs project can more appropriately have their needs met through this specialist early intervention response offered within the context of child protection services.

Young people aged 16 and 17 years are included in the service model as they are approaching the end of their involvement with statutory child protection services and are transitioning to adult services.

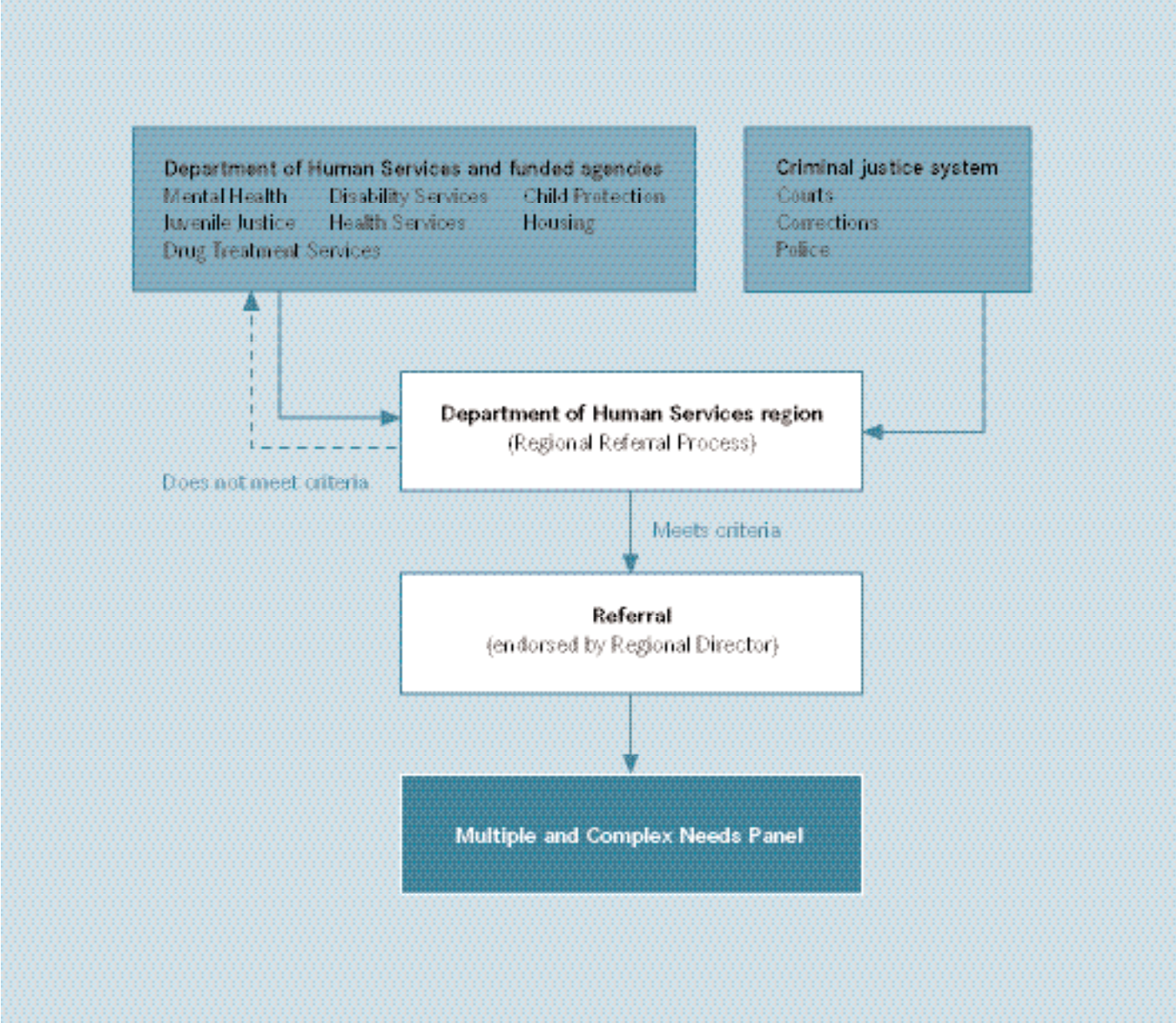
Of the target group, 226 individuals are 16 years and above and will be eligible to be referred to the service model.

### Regional role

The regional role will:

- Provide a single regional point of entry into the complex clients referral process through a designated position.
- Undertake a preliminary client eligibility assessment including an examination of current service responses and the feasibility of continued regional service delivery versus referral to the Multiple and Complex Needs Panel.
- Liaise with relevant services and professionals and regional program managers as part of the assessment of the client's situation for preliminary eligibility purposes.
- Advise the regional director in relation to the client's progression (or otherwise) to a panel referral.
- Marshall regional resources and facilitate a case coordination strategy for the client if no panel referral is necessary.

### Gateway to Multiple and Complex Needs Panel



### Draft eligibility criteria

The draft eligibility criteria will be further considered during the development of legislation to support the model.

Eligible person means a person:

- who has attained at least 16 years of age; and
- Appears to have two or more of the following:
  - a mental disorder
  - an intellectual impairment
  - a disability
  - acquired brain injury
  - current history of serious drug and/or alcohol misuse; and
- Has exhibited or is exhibiting violent or dangerous behaviours, which are reasonably likely to place him, her or others at risk of serious harm; and
- Is assessed by the Secretary as having complex and multiple needs; and
- Appears to be in need of intensive supervision and support.
- And where other options for assessment and care of themselves are insufficient, inappropriate or do not meet the person's needs adequately.

## B. Multiple and Complex Needs Panel

The panel's role is to engage the existing service system and newly developed specialist services in the assessment and determination of client need and subsequent development, implementation and review of a care plan. The care plan will direct an individualised 'joined up' service response for a 12-month period. Where necessary, the panel can allocate brokerage funds to support a care plan.

The panel should be established through legislation. Its authority and status will be a significant factor in its capacity to encourage different elements of the service system to come together and broker agreement about appropriate and achievable care plan objectives. The legislation should also ensure the panel is able to authorise access and sharing of relevant client level information to enable an informed and coordinated service response.

The key objective is to ensure that for clients with multiple and complex needs, a comprehensive multidisciplinary assessment informs development of a care plan that directs a 'joined up' service response in relation to:

- stable housing
- health and wellbeing
- safety
- social connectedness.

### Panel composition

The panel will have a stable (core) membership, made up of:

- a permanent chairperson, who is a person of standing with significant background and experience in human services, and with a respected body of work.
- a small number of other persons with significant background and experience in one or more of the following areas: mental health, disability, drug and alcohol, brain injury, housing, adolescent services or welfare.

In addition, a senior Department of Human Services representative will sit on the panel in an advisory capacity, particularly in relation to service system details and allocation of brokerage funds.

On a case by case basis, the panel will be able to call on a range of 'advisors' with particular clinical or service system expertise.

### Brokerage funds

The panel will manage an identified and fixed budget in relation to brokerage funds. In many cases clients referred to the panel will continue to require some level of flexible, individualised service response. Where the panel determines it necessary, it can authorise allocation of brokerage funds to enable implementation of an appropriate care plan.

## Entry

Referrals to the panel will come through Department of Human Services regional offices and can only proceed with the endorsement of the regional director.

All referrals to the panel will be assessed against the multiple and complex needs eligibility criteria. If eligibility criteria are met, the referral, authorised by the panel chair, is forwarded to the Multidisciplinary Assessment Service and the assessment process commences.

## Information management and exchange

The panel will have authority to enable full exchange of information with and between relevant service providers without breaching the Information Privacy Act 2000 and other legislative restrictions. It is intended that a client register and common client file for retention of all assessment and care planning information will be created.

## Exit

At the end of the 12-month period, it is the intention that the existing (generic) service system resume responsibility for planning, delivery and review of care for the client.

The Multidisciplinary Assessment Service reviews progress and outcomes of the care plan on a regular basis and also approximately six weeks in advance of the 12-month expiry date. A final report prepared for the panel will include:

- Recommendations for ongoing care and management within the existing

service system. In this case, wherever possible, continuity of effective service responses delivered under the care plan will be encouraged.

- Recommendations in relation to the initial six-month transition period. This may involve a period of support and secondary consultation from the specialist intensive case management agencies to the ongoing service provider.

A new (extended) care plan may be considered by the panel if appropriate care and treatment cannot be sustained within the existing service system and the eligibility criteria is met.

## Authority and mandate in relation to Department of Human Services and its funded agencies

While the panel (and Multidisciplinary Assessment Service) will operate independently of the Department of Human Services, it will be strategically linked to the operations of the broad service system via its legally established mandate. In addition, it is proposed that Department of Human Services funding and service agreements:

- recognise this client group as requiring priority access to services
- require the participation of Department of Human Services funded agencies in relevant panel and assessment service proceedings.

## Involuntary assessment and care – future option

A number of stakeholders have expressed concern that the target

group's behavioural profile and history of resistance to service engagement would preclude many from the specialist assessment and service planning process. The power to compel assessment and care, along with suitable residential infrastructure, are potential additions to the service model.

The need for new powers that impact on individual rights through the imposition of involuntary treatment and care remains the subject of considerable debate. Further, the nature of creating residential infrastructure is costly and complex – particularly for an untested service response. Legislation to compel clients to participate in an assessment and care plan and a residential assessment unit will not be considered for inclusion at this time. While there is considerable stakeholder support for these components, some have questioned the evidence base that demonstrates their necessity.

Given this, an evaluation of the first two to three years of operation of the model will be undertaken. An evaluation of the initial service response will explore the potential need for legislative change to enable involuntary assessment and care plan orders and the establishment of suitable infrastructure to support short-term (secure) residential assessment.

The following are possible ways in which compulsory assessment and care plan orders would operate as part of the service model.

## Multiple and Complex Needs Panel – potential involuntary components

### Assessment order

Where the client does not, or is not able to, consent to the assessment, the panel would have the power to authorise an assessment order for the purpose of completing a specialist multidisciplinary assessment and developing a draft care plan.

The assessment order could require:

- a community-based or ‘in-situ’ assessment or
- admission to a secure assessment unit.

To order an assessment, the panel would need to form the view that the client is not currently able to receive a service response appropriate to their needs without a care plan and would not participate in the assessment process on a voluntary basis and that the client would benefit.

### Care plan order

If the client does not consent to the care plan or any particular element of the care plan, the panel could compel the client to comply with specified treatment and care components through a care plan order. The panel could make a care plan order for up to 12 months.

The panel would need to form the view that the client could benefit from enforcing the care plan and would not otherwise comply with the treatment and care arrangements.

### Review and appeal arrangements

Appropriate appeal and review arrangements, involving a separate and independent body, would also be established within the legislative framework.

## C. Multidisciplinary Assessment Service

The requirement for a specialist multidisciplinary assessment recognises the difficulty of planning and providing a service response for clients for whom:

- assessment has been fragmented or incomplete
- assessment has resulted in multiple and/or disputed diagnoses.

The cross-sector needs of many of the clients within the target group underlines the need for a broad and multidisciplinary approach to the assessment and care planning phase. The key objective is to undertake a comprehensive assessment of clients’ needs, seek consensus among relevant service providers in relation to service requirements, and develop a practical and achievable care plan.

All clients accepted by the panel will receive a specialist assessment, however, the complexity and duration of the assessment process may vary on a case by case basis.

### Location

The assessment process will, usually, be best undertaken in the person’s own environment. An ‘in situ’ approach to assessment will generally allow better consideration of environmental factors and local supports. It is expected that, for many of the target population, assessment will occur while the person remains in their usual place of residence. For a small number this may mean a treatment or rehabilitation facility or while in custody.

The assessment service may seek to negotiate access to a program bed-based service (for example, drug treatment, mental health, disability) to enable an assessment where the client consents. However, negotiations with existing services would need to be cooperatively managed in a high demand environment and access to a bed may not always be able to occur in a timely manner.

### Assessment process

Irrespective of the location in which the assessment occurs, its components will be consistent. The assessment will be comprehensive and involve:

- engaging the individual, their family, as appropriate, carers and all other relevant service providers
- collating information relating to the person’s history and contact with the service system
- accessing all relevant or existing reports including specialist reports regarding the person.

One member of the Multidisciplinary Assessment Service team will coordinate each assessment.

This person will have the capacity to draw on the cross-disciplinary expertise of other members of the team and to access other specialist assessment skills as required.

### Development of care plans

The Multidisciplinary Assessment Service will be responsible for developing a draft care plan (for a 12-month period) for all clients

referred by the panel. The draft care plan will need to be comprehensive and address all relevant areas of a person’s life.

The draft care plan will be included in the assessment service’s report to the panel and will be completed according to an established template. Core elements to be addressed include:

- detailed identification of client needs
- objectives
- service response(s) required
- specific role of participating agencies.

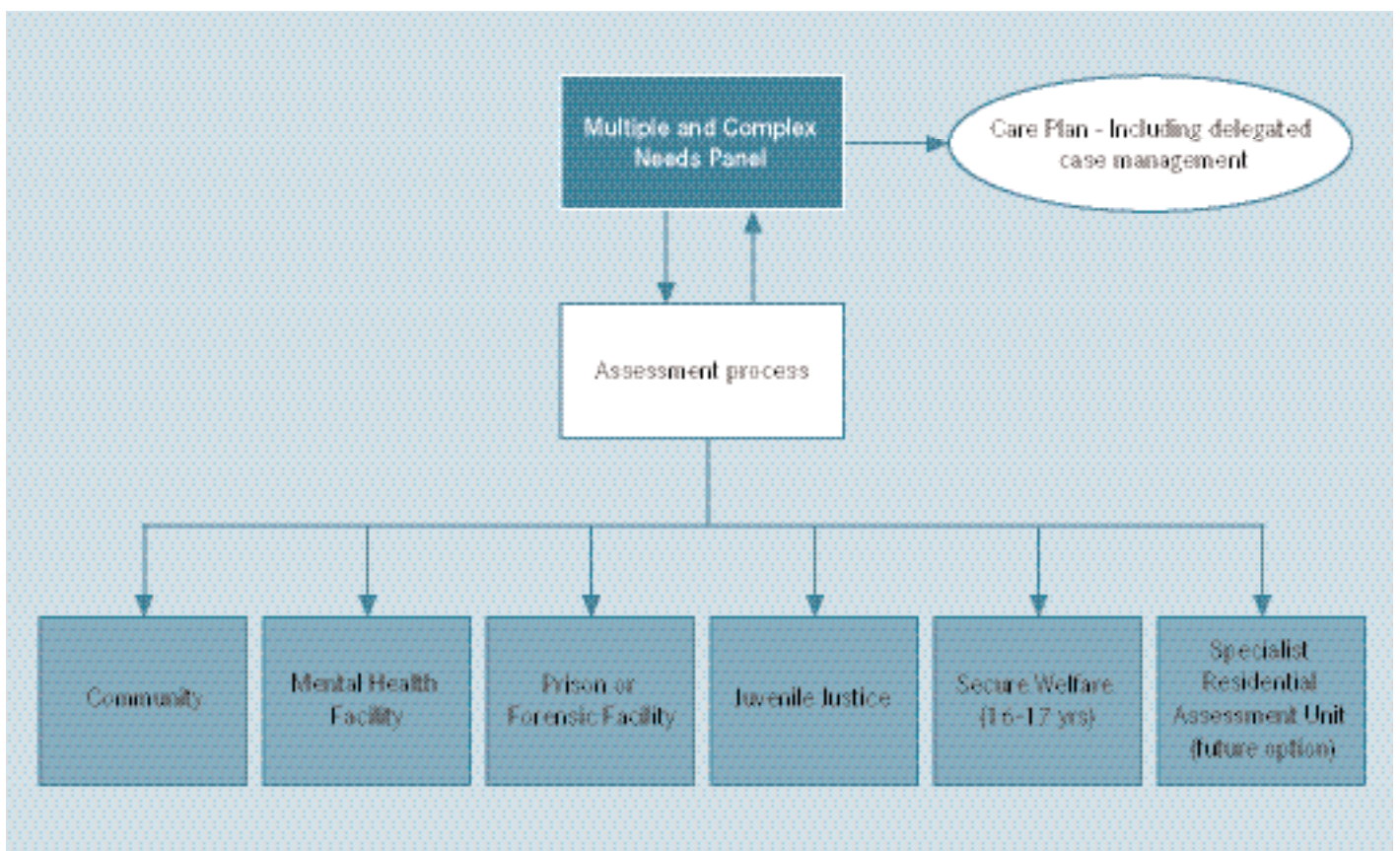
A lead case manager will be identified in all draft care plans. Training and development opportunities will be made available to staff working in Drug Treatment, Mental Health, Disability, Community Care and Housing services to address:

- Rationale and objectives of Care Plans
- Role and function of lead case managers
- Role and function of the Multiple and Complex Needs Panel and Multidisciplinary Assessment Service
- Transfer of skills and knowledge to support ongoing management and care of clients post Care Plan

Individual clients, family and carers will be encouraged and supported to participate in the care plan development process and any subsequent panel hearings.

The assessment team will have responsibility for engaging regional staff, relevant service providers, client, family or carers in the process and must be in a position to advise the panel of levels of agreement between all stakeholders.

### Options for location of assessment



It is anticipated that service responses coordinated through care plans will fall into three broad categories:

#### Care Plan A

- The lead case management responsibility is delegated to a provider within the existing service system. The roles and responsibilities of other providers in the joined up service response are negotiated and documented in the care plan. This category of plan requires no additional funding.

#### Care Plan B

- The lead case management responsibility is delegated to a provider within the existing service system. The roles and responsibilities of other relevant providers are negotiated and documented in the care plan. The care plan includes some additional funds to buy in other resources, such as accommodation. This category of plan requires brokerage funding.

#### Care Plan C

- The lead case management responsibility is delegated to a specialist intensive case management service that will provide accommodation and other resources, such as extended hours support and supervision. Any clinical or treatment services required will, in most cases, be negotiated as part of the care plan and provided by existing services. This category of care plan requires brokerage funding.

### Residential assessment unit – future option

For a proportion of the target population, circumstances may prohibit assessments being completed in the person's own environment. Development of a small residential assessment facility may ensure that the resources and capability exist to enable a specialist assessment to be completed for all clients referred to the program. This is an option to be considered as an enhancement to the service model if supported by evaluation outcomes.

An outline of how a residential assessment unit would operate if included in the future as part of the service model is provided.

#### Secure residential assessment

A residential assessment would be required where:

- the client does not consent to the assessment; and
- the panel determines that a community-based assessment order is not viable or appropriate; or
- the client has breached a community-based assessment order.

#### Assessment unit

A small secure assessment unit with up to 10 beds would admit clients referred by the Multiple and Complex Needs Panel for the purpose of completing a comprehensive multidisciplinary assessment and development of a draft care plan.

Admission could only take place on referral from the panel. Involuntary admission could only occur when an assessment order is in place.

The maximum length of any single stay in the facility would not exceed three months.

Admission to the unit would generally be targeted to adults aged 18 years or more. However, where the panel considers it appropriate, it would also be available to young people aged 16 and 17.

## Research and development

The role of the Multidisciplinary Assessment Service will include a small research and development focus to ensure outcomes and learnings from the panel, assessment and service delivery components are analysed and promulgated effectively across the service system.

In particular, the assessment service will initiate or work in partnership on projects aimed at identifying and evaluating new practice technologies and service response models as well as those that can inform early intervention and prevention approaches.

Links with tertiary education and training institutions will be sought to support and further develop this focus.

## D. Intensive case management agencies

A small number of existing agencies specialising in outreach and support services will be invited to work with the target group within an intensive case management model. This enhancement will be built on existing expertise rather than creating a new service from the ground up.

It is not the intention that the agencies take on management and care for all clients coming to the attention of the panel. Wherever possible, care plans will be designed to be implemented by existing services and within the client's region – thereby minimising disruption to continuity of care and the clients' connection to existing service providers. The specialist agencies will take on the delegated case management role when appropriate local options are not available or not able to meet the client's current level of need.

The intensive case management agency must focus the service response on the four key objectives of:

- social connectedness
- housing
- health and wellbeing
- safety.

Additional therapeutic, clinical or treatment functions will be provided (where identified and agreed in the care plan) by existing services (such as drug treatment, mental health, disability services) working in collaboration with

the specialist agencies. Where access to such expertise is required, this will be made explicit in the care plan and the panel will negotiate a commitment of resources from the relevant agency.

Where appropriate, the panel can commit additional brokerage funds to the specialist agencies to buy in additional resources, such as extended hours supervision and support.

The enhanced services provided by the specialist agencies will only be available to clients referred by the Multiple and Complex Needs Panel and will be provided on a medium-term basis. A client's transition back to existing services will generally occur, in line with the care plan, after 12 months.

### Agency profile

The identified agencies should have:

- an established record and expertise in intensive case management and outreach work in the human services sector
- a reputation for pursuing innovative and practical outcomes for clients with high levels of need
- a collaborative and participatory service model that is inclusive of both the client and families or carers
- proven capacity to work collaboratively with other service providers
- a staffing group with a mix of skills, backgrounds and expertise
- access to accommodation models or housing stock.

## E. Improved capacity in the existing service system

Existing services within the disability, mental health, drug treatment, housing, child protection and juvenile justice sectors will continue to be the primary service providers to this target group.

Feedback from these programs indicate increasing demand from clients with multiple and complex needs.

A key element of the strategic response must be to continue to build capacity to work effectively with this client group across the service system. New initiatives developed as part of this response need to operate alongside and complement service development currently being pursued across the department.

Examples of current commitments across the Department of Human Services to improve services to people with complex or exceptional needs include:

- Intensive Therapeutic Service - Community Care
- Complex Clients Project - Disability Services
- Expanded intensive services for people with high needs - Mental Health
- Victorian Homelessness Strategy - Housing.

## New practice technologies and workforce development

The work of the research and development component of the Multidisciplinary Assessment Service is intended to develop and refine new practice models and technologies in relation to this client group and, in turn, strengthen and build on existing capacity across the service system.

In addition, feedback and learnings flowing from outcomes from the panel and assessment process and implemented care plans need to inform ongoing service delivery and facilitate earlier intervention in the 'cycle' of complexity for many clients within this target group.

## F. Sustainable housing

Longer term and more sustainable alternatives to existing housing options have been identified as a clear need for this target group.

Clients within the target group have often exhausted available accommodation and support options. Many are homeless or rely on crisis accommodation. Others rely on funding packages that house them in single rented accommodation with intensive levels of supervision to minimise risk to self or others. Such approaches have been criticised for effectively imposing containment and isolation on individuals via an intensive supervision model.

The development of individual and cluster housing models with appropriate supervision and support targeted to the needs of this population is an important part of the overall response.

The opportunity exists to develop such housing options and link them with the intensive case management agencies.

Housing model options that might be developed over time include:

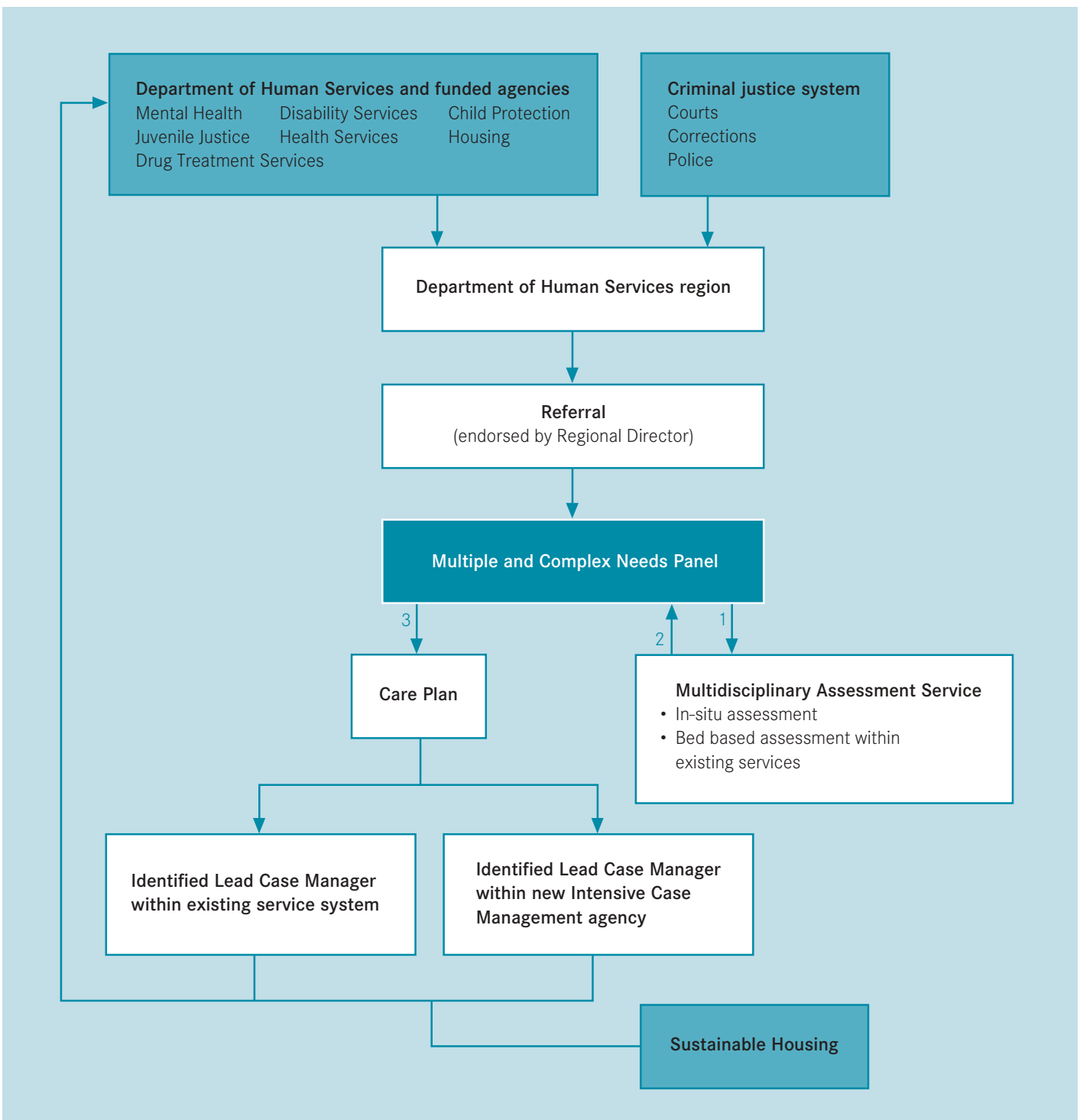
- Cluster housing for adults 25 years and over developed on a medium density, medium volume, medium support basis.
- Cluster housing for young people aged 25 years and under - low density, low volume but high support.
- Dispersed long-term community managed public housing with support attached.

Further project work will be undertaken in 2003-04 to

- Develop a framework for longer term, sustainable accommodation options for people with multiple and complex needs.
- Develop a strategy to integrate and link to the Intensive Case Management Services, the existing transitional and long term community managed housing being utilised by complex need clients together with the base line of support that the Support Accommodation and Assistance Program (SAAP) provides when these clients are homeless.

## Proposed Service Model – Multiple and Complex Needs Program

(Does not include compulsory assessment and care plan orders or secure residential assessment unit)



## Part four - The way forward



## The Multiple and Complex Needs Program

The Multiple and Complex Needs Program will be introduced from January 2004 as a new and innovative response to the needs of individuals with multiple and complex needs.

The program will provide, via an integrated model:

- a regional gateway and referral process
- Multiple and Complex Needs Panel
- Multidisciplinary Assessment Service
- intensive case management agencies
- existing service system options
- sustainable housing options.

The model will offer independent and expert assessment of client need and the formulation of client care plans and enhanced service response options through new intensive case management capacity and flexible brokerage funds. There will be some capacity for (voluntary) bed-based assessment through negotiation with existing services and the model will begin to tackle sustainable housing solutions.

Legislative reform to enable involuntary assessment and care and the secure residential assessment unit will not be included in the first stage of implementation. These important, but costly and controversial, components will be reconsidered for implementation at a later date if supported by evaluation outcomes.

### Implementation - organisation

A small implementation project team will be located within the Operations Division, Department of Human Services. This team will be responsible for developing operational details for each of the program components (such as pathways and processes between program elements, standard assessment frameworks, position descriptions, legislative reform to establish the panel and its functions) and methods for fund allocation.

Considerable consultation will occur with existing programs and services on links and pathways to and from the new program and between components of the new program (such as the assessment service and the intensive case management agencies). This will be essential to avoid the pitfalls of creating a specialist service that operates independently of the existing service system rather than one that adds value through additional expertise.

Development of sustainable housing options for the target population is a critical element of the model. This will be undertaken by the project team in cooperation with the Housing and Community Building Division.

### Scale and timelines

The program will commence in early 2004 on a small scale, targeting up to 50 referrals over a 12-month period.

It is important to note that given the program is being initially introduced on a smaller scale, it will not address all cost and demand pressures in the service system. However, it will provide an opportunity to trial and evaluate an innovative response, and provide an evidence-based rationale for expansion to include a larger number of referrals if supported by favourable evaluation outcomes.

### The evaluation

The literature and experiences in other jurisdictions indicate that there are no established practice models that effectively address the needs of this population. Though the new approach is built on known best practice and the considered views of key stakeholders, there is a clear need for a strong evidence base upon which to develop and refine future service responses. At the outset of this initiative there is a need to develop and implement a comprehensive evaluation framework that can assess the success of the approach and dynamically inform the ongoing operation of the model.

A two to three-year evaluation framework will be established and include success or outcome measures that relate to the key objectives for the project and provide a clearer assessment of the cost benefit of the initiative.

Client outcomes to be monitored and evaluated will include:

- maintenance of stable accommodation
- continuity of care (maintenance of case management)
- engagement in response to health needs
- improved social connection
- reduced incidence of harm (self and others)
- reduced incidence of offending.

Cost benefit evaluation will include analysis of service volume and unit cost measures for:

- the panel
- assessment service
- care plans (with brokerage funds, without brokerage funds)
- intensive case management
- sustainable housing
- program costs (mental health, disability, drug treatment, child protection, housing).

The evaluation will be designed in parallel with the detailed operational design of the service response. It will ensure that the client, service system and cost impacts of the model can be measured and analysed and the assumptions inherent to the model tested. Any consideration of modification or expansion of the program, in particular in relation to mandatory or involuntary elements and residential infrastructure, can then be informed from an evidence base.

## Enabling factors

### Legislative change

It is proposed that the Multiple and Complex Needs Panel is established through enabling legislation to ensure:

- it has sufficient authority, status and capacity to bring different elements of the service system together and broker agreement about appropriate and achievable care plan objectives
- it is able to authorise access and sharing of relevant client level information to enable an informed and coordinated service response.

### Cultural change

Individuals with multiple and complex needs will require time and resource intensive service responses to effectively stabilise their circumstances and to provide opportunity for change and improved outcomes. Individuals in the target population will not necessarily 'flow through' the service system at a rate similar to other, less complex client groups.

The effectiveness of a new approach will depend on recognition across the service system that individuals with multiple and complex needs require a consistent and joined up service response.

The department's objectives in relation to clients with multiple and complex needs will need to be visible, prominent and reinforced through a range of corporate tools, including

divisional plans and funding and service agreements, to ensure a shared, cross-sectoral approach to delivering change.

## Further areas of work

The Responding to People with Multiple and Complex Needs project only addressed those individuals at the extreme end of the continuum of complexity. The Department of Human Services recognises that there are other areas of work that would benefit from being considered by existing program areas such as:

- Achievement of seamless, joined up service responses for other clients with multiple needs accessing services from two or more directly provided or funded services (with less complex needs than this target group).
- Development of early identification and intervention strategies to prevent individuals from progressing to a level of complexity that demands a higher cost service and places themselves, staff and the community at risk.

## For more information

For further information about the Multiple and Complex Needs Program, please contact the implementation team on (03) 9616 7588.

Or visit our website on [www.dhs.vic.gov.au/complexclients](http://www.dhs.vic.gov.au/complexclients)

## Appendix one

### Terms of reference

The purpose of the project is to develop a framework for future management, funding and delivery of service responses. A set of recommendations will inform the development of cross-program policy and future directions in relation to the target group and will form the basis of the implementation strategy.

The project will:

1. Identify, quantify and develop a comprehensive profile of the types of individuals with complex needs (the target group) and the costs/resources associated with service provision to these individuals.
2. Identify strengths and weaknesses of current legislative frameworks that define the provision of services to the target group.
3. Identify strengths and weaknesses of policy frameworks, service responses and any gaps in services.
4. Identify examples of best practice (including anecdotal) and evidence-based research, both locally and internationally, regarding service provision.
5. Develop a service framework and strategic plan for improving responses to the target group, taking into account current resource usage, potential resource demands and future workforce requirements.
6. Define appropriate service responses and propose reconfiguration of resource allocations to provide these.
7. Develop recommendations on how service solutions may be supported by legislative change.

## Appendix two

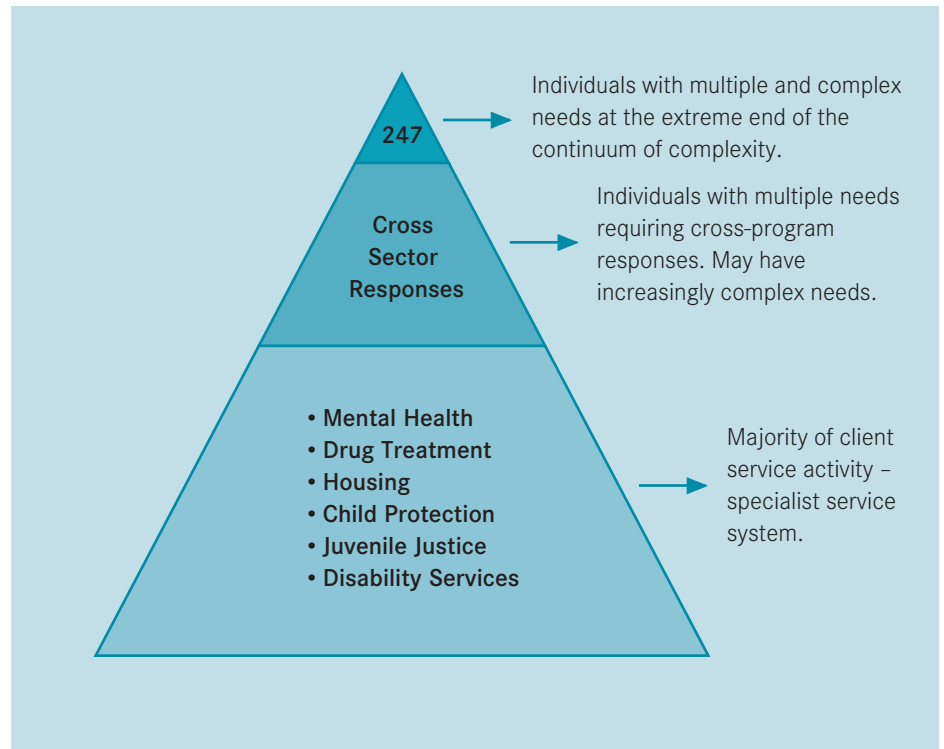
### Target population

Target population criteria were established at the beginning of the project to guide project work and assist in identifying and profiling of the group. The criteria were considered as a guide.

The Complex Clients Project target population was expected to comprise a small number of children, adolescents and adults who have profoundly multiple and complex needs and require a service response that is unable to be met or sustained within existing service frameworks. While there are many clients with complex needs requiring improved service responses, this project only considered those at the extreme end of the continuum of complexity.

The presenting factors that characterise this target group were a combination of all the following:

- having multiple and complex presenting problems
- having multiple and complex needs that are not met or sustained by existing services
- having challenging behaviours that place the individual at high risk to self, service staff and/or the community
- chronic or episodic behaviours and/or conditions that require long-term service responses
- requiring a service response from two or more department of human services program (or criminal justice) areas
- having a specific need for which there is no current service system response and/or require a current tailored funding package (usually at high cost).



Additional characteristics of this target group may include:

- an inability or unwillingness to engage with the service system.
- multiple service usage without resolution of issues.
- being homeless or at risk of homelessness.
- a history of family dysfunction and/or abuse.
- a history of transience.
- contact with the criminal justice system.
- social isolation and/or lack of supports.
- high-level and ongoing supervision required.

## Appendix three

### Reference group

Ms Penny Armytage,  
Executive Director, Operations  
(Chair - to March 2003)

Mr Brian Joyce,  
A/Executive Director, Operations  
(Chair - from March 2003)

Ms Jelena Popovic,  
Deputy Chief Magistrate

Mr Julian Gardner,  
Public Advocate

Ms Beth Wilson,  
Health Services Commissioner

Mr John Lesser,  
President, Mental Health Review Board

Ms Sue Tait,  
President, Intellectual Disability  
Review Panel

Mr Stephen Nash,  
Chief Executive Officer, Outreach  
Victoria (now Homeground Services)

Mr David Brunt,  
Program Director, Drug and Alcohol  
Services, Salvation Army

Ms Pip Wisdom,  
Director, Policy and Standards,  
Office of Correctional Services  
Commissioner, Department of Justice

Mr Greg Byrne,  
A/Director, Legal Policy,  
Department of Justice  
(delegated to Catriona Galbraith,  
Legal Policy, Department of Justice)

Superintendent Rod Norman,  
Statewide Strategic Support,  
Victoria Police

Ms Leonie Colman,  
Latrobe Community Health Centre

Reverend Canon Ray Cleary,  
Chief Executive Officer,  
Anglicare and recent Chair,  
Ministerial Advisory Committee for  
Victorian Homelessness Strategy

Ms Stephanie Lagos,  
Director, North East Region Migrant  
Resource Centre and member of the  
Ministerial Advisory Committee for  
Cultural and Linguistic Diversity  
(MACCALD)

Associate Professor Linda Hancock,  
School of Australian and International  
Study, Deakin University

Ms Helen Riseborough,  
Hanover Welfare Services

Mr Arthur Rogers,  
Executive Director, Disability,  
Department of Human Services

Mr Paul McDonald,  
Director, Drugs Policy and Services,  
Department of Human Services

Dr Ruth Vine,  
Deputy Chief Psychiatrist, Department  
of Human Services (Acting Director,  
Mental Health, Department of Human  
Services from November 2002)

Mr John Leatherland,  
Regional Director, Eastern Metropolitan  
Region, Department of Human Services

Mr Mike Debinski,  
Director,  
Regional Operations Performance,  
Department of Human Services

Ms Tracey O'Halloran,  
Manager, Complex Clients Project,  
Department of Human Services

### Steering committee

Ms Penny Armytage,  
Executive Director,  
Operations Division  
(Project Sponsor/Chair)  
(to March 2003)

Mr Brian Joyce,  
A/Executive Director, Operations  
Division (Chair from March 2003)

Mr Arthur Rogers,  
Executive Director,  
Disability Services

Ms Angela Jurjevic,  
Director, Mental Health  
(to November 2002)

Dr Ruth Vine,  
A/Director, Mental Health  
(from November 2002)

Ms Jane Herington,  
Director, Aged Care

Mr Paul McDonald,  
Director, Drugs Policy and Services

Ms Gill Callister,  
Director, Child Protection  
and Juvenile Justice

Ms Carolyn Gale,  
Manager, Community Programs

Mr John Leatherland,  
Regional Director,  
Eastern Metropolitan Region  
Department of Human Services

Mr Mike Debinski,  
Director,  
Regional Operations Performance

Ms Tracey O'Halloran,  
Manager, Complex Clients Project

## Project team

Ms Tracey O'Halloran, Manager

Ms Jenny Atta

Ms Kate Graham

Ms Jenny McKeagney

Ms Kim O'Shaughnessy

Ms Kathryn Phillips  
(June - December 2002)

Ms Angela Mihalakos,  
Administrative support

Other staff to provide support  
to the project included:

Mr Jonathon Brown,  
Eastern Metropolitan Region  
(June - August 2002)

Ms Britt Pencharz,  
Southern Metropolitan Region  
(July - September 2002)

Ms Ginta Menzies,  
Western Metropolitan Region  
(August 2002)

Ms Julie Shelton,  
Southern Metropolitan Region  
(August 2002)

Ms Bee Mitchell-Dawson,  
Mental Health Branch  
(August 2002)

Ms Willa Longmuir,  
Northern Metropolitan Region  
(August 2002)

Mr Paul Hansen,  
Project support

Mr Cameron Church,  
Administrative support

Additional project support was  
provided by:

Ms Liz Forsyth,  
KPMG (previously from KPMG  
Consulting now Bearing Point) -  
project advice, business case,  
preparation of data report, financial  
modelling and cost benefit analysis

Mr Fred Halliday  
KPMG, Business case and  
financial modelling

Ms Kris Honey,  
KNH Consulting - facilitation of  
statewide and regional forums.

Ms Dominique Saunders,  
Russell Kennedy Solicitors -  
legal advice

Ms Julie Goodall,  
Thomson Goodall Associates -  
literature review

## Project organisation

The steering committee included  
senior Department of Human Services  
executives with the ability to determine  
future cross-department policy  
frameworks and resource allocations.  
The steering committee met on a  
regular basis to provide guidance to  
the project team in addressing the  
terms of reference.

The reference group was established to  
provide expert opinion and advice and  
met on:

26 March 2002

23 May 2002

18 July 2002

19 August 2002

4 September 2002

16 October 2002

20 November 2002

28 April 2003

The reference group and steering  
committee were also brought  
together with other key stakeholders  
at two forums (15 May 2002 and  
12 September 2002) during the project  
research phase.

## Appendix four

### Consultation strategy

The development of a broad and appropriately targeted consultation strategy was fundamental to the Responding to People with Multiple and Complex Needs project's ability to understand the issues that have an impact on service delivery to the target population and to develop a service response model based on this information. As such, a comprehensive consultation strategy was a vital component of the project's methodology. The strategy comprised five broad phases:

1. The first phase involved preliminary consultations with Department of Human Services' regional and program directions branch staff in March 2002. Interviews with some key stakeholders also commenced at this time. The purpose of these preliminary consultations was to begin to scope issues relevant to the project, and to advise opinion leaders, key stakeholders, regions, head office programs and, through them, their broad funded sector networks, of the existence of the project.
2. A statewide forum, conducted on 15 May 2002, marked the second phase of the strategy. This forum targeted a range of opinion leaders, funded sector organisations, as well as key statewide bodies, senior Department of Human Services' staff and other government departments including the Department of Justice (Victoria

- Police, Community Corrections and Prisons programs). The forum gave participants an opportunity to identify elements missing from an effective service response framework and to begin to consider possible solutions.
3. The third phase of the consultation strategy comprised two separate elements - regional forums and individual statewide stakeholder interviews. The regional forums were conducted throughout August 2002 in each of the nine Department of Human Services regions. These forums allowed regional departmental and funded sector service providers to work together to build on ideas generated at the May 2002 forum regarding components needing to be considered for inclusion in any future service response. In a separate exercise, key statewide bodies and service provider organisations and advocacy and carer organisations were also consulted regarding the possible solutions identified through the earlier phase of consultation.
  4. A second statewide forum on 12 September 2002 marked the fourth phase of consultation. This forum gave participants an opportunity to debate a proposed model based on findings obtained and refined through the preceding phases of consultation. Participants at this forum included those involved in the May statewide forum as well as service providers, advocates and other persons or organisations

identified through phase three consultations as having a critical interest and role in the development of an appropriate service response.

5. The final phase of consultation prior to the development of project recommendations targeted a smaller group of stakeholders identified as having particular expertise or experience to assist in addressing specific issues related to the proposed model and its engagement with the broader service system.

In the developmental phase of the project, it was determined that consultation with every possible stakeholder regarding the identification of issues and the development and refinement of solution options would be an inappropriate use of stakeholder and project resources. As such, the consultation phases of the project were carefully targeted to ensure appropriate representation of stakeholders through the relevant phases of consultation. It was determined that maximum input from all levels of stakeholders needed to occur at the most critical periods of consultation. On this basis, as the purpose of the third phase of consultation was to test possible response framework components arising from the May 2002 statewide forum, it was determined that more extensive stakeholder consultation would occur at this point rather than in preceding phases.

In addition, the Department of Human Services' regions and program branches were actively consulted

regarding the names of individuals and organisations to be involved in the various phases of consultation. The recommendations of other key stakeholders were also considered in this process.

In the case of the May 2002 statewide forum, regions and program branches were asked to nominate individuals or organisations likely to work with people with multiple and complex needs, or those who had a particular interest or perspective about how system responsiveness to this group of people might be improved. A similar process was employed when identifying stakeholders to be targeted for the statewide consultations and the August 2002 regional forums. In terms of the September forum, participants included those who had previously been involved in the May forum and other individuals or organisation representatives identified as having particular expertise or experience in working with the target population.

## Regional forums

Grampians Regional Forum  
29 July 2002

Loddon Mallee -  
Mildura Regional Forum  
31 July 2002

Loddon Mallee -  
Bendigo Regional Forum  
2 August 2002

Barwon South West -  
Geelong Regional Forum  
7 August 2002

Barwon South West -  
Warrnambool Regional Forum  
8 August 2002

Hume Regional Forum  
9 August 2002

Eastern Metropolitan Regional Forum  
12 August 2002

Gippsland Regional Forum  
13 August 2002

Southern Metropolitan Regional Forum  
14 August 2002

Northern Metropolitan Regional Forum  
15 August 2002

Western Metropolitan Regional Forum  
20 August 2002

## Appendix five

### Major stakeholders consulted

This list does not include the significant number of internal Department of Human Services staff who were consulted during the course of the project. This list also does not include the funded sector and departmental staff or other key stakeholders who participated in the August 2002 regional consultations.

Dr Bob Adler,  
Psychiatrist,  
Adolescent Forensic Health Service

Kelvin Anderson,  
Correctional Services Commissioner

Kathy Arentz,  
Manager,  
Disability and Adolescent Program,  
Australian Community Support  
Organisation (ACSO)

Linda Bamblett,  
Chief Executive Officer,  
Victorian Aboriginal Community  
Services Association (VACSA)

Jane Barnes,  
General Manager,  
Adult Services, Salvation Army

Dr Chad Bennett,  
Clinical Director,  
Victorian Dual Disability Services,  
St Vincent's Hospital

Astrid Birgden,  
Project Manager,  
Office of the Correctional Services  
Commissioner, Dept of Justice

Michael Bladen,  
Senior Case Worker,  
Alcohol Related Brain Injury  
Assessment Service (ARBIAS)

Greg Boland,  
Inspector,  
Victoria Police

Jenny Boulton,  
Chief Executive Officer,  
Disability Attendant Support  
Services Inc (DASSI)

Megan Bridgett,  
Project Officer,  
CORE - The Public  
Correctional Enterprise

Michael Burt,  
Chief Executive Officer,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Tony Calabro,  
Chief Executive Officer,  
Australian Community Support  
Organisation (ACSO)

Dr Andrew Carroll,  
Clinical Director,  
Community Forensic Health Service,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Livia Carusi,  
Supported Accommodation  
Rights Service

Ian Clark,  
A/General Manager,  
Aero Medical Services,  
Ambulance Services

Judge Jennifer Coate,  
President,  
Melbourne Children's Court

Isabell Collins,  
Director,  
Victorian Mental Illness  
Awareness Council

Marie Colman,  
Chair, Management Assessment Panel,  
Australian Capital Territory

Anne Condon,  
Disability Coordinator,  
Melbourne Magistrates Court

Dr Neil Coventry,  
Director, Child and Adolescent  
Mental Health Service,  
Austin & Repatriation Medical Centre

Merrilee Cox,  
Executive Officer,  
Headway Victoria

Jenny Cummings,  
Regional Director,  
Gippsland and Southern Services,  
Berry Street Victoria

Dr Bob Davis,  
Chief Executive Officer,  
Centre for Development Disability  
and Health Victoria (CDDH)

Assoc. Professor Julian Davis,  
Psychiatrist,  
Bendigo Health Care Group

Sandy de Wolf,  
Chief Executive Officer,  
Berry Street Victoria

Sophie Delaney,  
Coordinator/Principal Solicitor,  
Mental Health Legal Centre

Mr Bruce Dufty,  
Manager, Accommodation  
Disability Services Commission,  
Western Australia

Phillip Eddy,  
Program Manager, Mental Health,  
St Luke's Family Care

Aiden Fahey,  
Manager, Mental Health Program,  
Australian Community Support  
Organisation (ACSO)

Janet Farrow,  
Executive Director,  
Moreland Hall

Angela Forbes,  
Chief Executive Officer,  
Kildonan Child & Family Services

Alf Francet,  
Eastern Region Mental Health  
Association (ERMHA)

Professor Arie Freiberg,  
Foundation Chair of Criminology,  
Melbourne University

Dr Chris Fyffe,  
Director and Consultant,  
Grimwood Proprietary Limited

Dianne Garner,  
Manager,  
Adolescent Forensic Health Service

Bernie Geary,  
Executive Director,  
Jesuit Social Services

Dr Bill Glasser,  
Consultant Psychiatrist,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Margaret Goding,  
Director of Mental Health, Corrections,  
Drug and Alcohol Services,  
St Vincent's Hospital

Amanda Golding,  
Chief Executive Officer,  
Autism Victoria

Jonathan Goodfellow,  
Coordinator, Disability Discrimination  
Law Advocacy Service

Michael Gourlay,  
Chief Executive Officer,  
Association for Children with  
a Disability

Brett Goynes,  
Executive Officer,  
Management Assessment Panel,  
Office of Community Advocate, ACT

Phil Grano,  
Coordinator,  
Villamanta Legal Service

Ian Gray,  
Chief Magistrate,  
Magistrates Court

Assoc. Professor David Green,  
Social Work and Policy,  
La Trobe University

Lorraine Green,  
Coordinator, Northern Region,  
Yarra Community Housing Ltd

Marilyn Hage,  
Executive Director,  
Alcohol Related Brain Injury  
Assessment Service (ARBIAS)

Professor Margaret Hamilton,  
Chief Executive Officer,  
Turning Point Alcohol &  
Drug Centre Inc

Peter Harmsworth,  
(previously) Secretary,  
Department of Justice

Maria Heenan,  
Senior Policy Officer,  
Department of Education & Training

Keir Henshaw,  
Policy and Law Reform Worker,  
Villamanta Legal Service

Dr Mal Hopwood,  
Director, Veterans Psychiatry Unit  
& Brain Disorders Program

Nettie Horton,  
Chief Executive Officer,  
Council to Homeless Persons

Lou Iaquinto,  
Assistant General Manager,  
Student and Wellbeing Branch,  
Department of Education & Training

Ross Izzard,  
General Manager,  
Community Operations,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Joseph Jilich,  
Personal Support Program Coordinator,  
North East Migrant Resource Centre

Graham Johnstone,  
State Coroner,  
Coroner's Office

Professor Fiona Judd,  
Director,  
Centre for Rural Mental Health,  
Bendigo Healthcare Group

Evi Kadar,  
Chief Executive Officer,  
Melbourne Juvenile Justice Centre

Shane Kelly,  
Director, Sentence Management,  
Office of the Correctional Services  
Commissioner, Dept of Justice

Frank Lambrick,  
Senior Psychologist,  
Statewide Forensic Services,  
Department of Human Services

Felicity Lawrence,  
Manager, Dual Disability Unit,  
St Vincent's Hospital

Jane Longbottom,  
Manager, Exceptional Needs Process,  
Department of Human Services,  
South Australia

Owen Mahoney,  
Legal Officer,  
Mental Health Review Board

Ken Marchingo,  
Chief Executive Officer,  
Loddon Mallee Housing Services

David Marnie,  
General Manager, Western Region,  
Melbourne City Mission

Tim Mathieson,  
Director,  
Eastcare, Salvation Army

Jeannette Maughan,  
Magistrate,  
Melbourne Children's Court

Belinda McDiad,  
Coordinator,  
Outreach Victoria  
(now Homeground Services)

Lynn McDonald,  
Volunteer Coordinator,  
Bear In Mind

John McGrath,  
Immediate Past Chair,  
Mental Health Council of Australia

Peter McLean,  
Manager, Community Support,  
Loddon Mallee Housing Services

Cath McNamara,  
Coordinator,  
Disability Rights Victoria

Cathie Megens,  
Manager, Service Development,  
Victorian Institute of Forensic Mental  
Health, (Forensicare)

John Morkham,  
Executive Officer,  
ACROD Ltd

Jane Morton,  
Spectrum - The Personality  
Disorder Service for Victoria

Professor Paul Mullen,  
Clinical Director,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Helen Mulquinney,  
Program Manager,  
Victorian Institute of Forensic  
Mental Health (Forensicare)

Professor Marcia Neave,  
Chairperson,  
Victorian Law Reform Commission

Paul Newland,  
Manager,  
Youth Substance Abuse Service (YSAS)

Di O'Neil,  
Deputy Chief Executive Officer,  
St Lukes Anglicare (Bendigo)

Bridget Organ,  
Team Manager, Mental Health Service,  
St Vincent's Hospital

Dr Cathy Owen,  
Chief Psychiatrist,  
Australian Capital Territory

Dr Elizabeth Ozanne,  
Social Work Department,  
Melbourne University

Sally Parnell,  
Consultant,  
Salvation Army Consultancy Unit

Tony Parsons,  
Director,  
Victoria Legal Aid

David Petherick,  
Coordinator,  
Community Visitor Program,  
Office of the Public Advocate

Simone Pica,  
Acting Manager,  
Substance Use Mental Illness  
Treatment Team (SUMITT)

Judith Player,  
Association for Relatives and Friends  
of the Emotionally and Mentally Ill  
(ARAFEMI)

Theresa Punshon,  
Chief Conciliator,  
Health Services Commission

Padma Raman,  
Chief Executive Officer,  
Victorian Law Reform Commission

Ann Reilly,  
General Manager,  
Clinical and Offender Services,  
CORE - The Public Correctional  
Enterprise

Dr Colin Riess,  
Director,  
The Bouverie Centre

Dana Saint,  
Projects Manager,  
Community Correctional Services

Marsha Sheridan,  
General Manager,  
Residential and Carer Support Services,  
Yooralla Society of Victoria

Professor Bruce Singh,  
Clinical Director,  
North West Mental Health Program

Rodney Soar,  
Senior Clinician,  
Grampians Area Mental Health Service,  
Substance Use Mental Illness  
Treatment Team

Margaret Stewart,  
Coordinator,  
Burt Williams Centre & Hostel,  
Victorian Aboriginal Community  
Services Association (VACSA)

Kevin Stone,  
Executive Officer,  
Victorian Advocacy League for  
Individuals with a Disability (VALID)

Michael Stone,  
Manager,  
Statewide Forensic Services,  
Dept of Human Services

Gordon Storey,  
Executive Officer,  
Association of Participating  
Service Users

Teresa Swanborough,  
Manager, Homeless Persons Program  
Royal District Nursing Service

David Sykes  
Manager, Policy and Education  
Office of the Public Advocate

Ass. Prof. Amgad Tanaghow,  
Chief Psychiatrist,  
Department of Human Services

Justice Bernard Teague,  
Judge, Supreme Court of Victoria

Vivienne Topp,  
Solicitor,  
Mental Health Legal Centre Inc

Vic Tripp,  
Unit Manager,  
Continuing Care Mobile Support Team,  
John Bomford Centre,  
Bendigo Healthcare Group

Deb Tsorbaris,  
Director, Social Policy,  
Salvation Army

Maria Vasilopoulos,  
General Manager,  
Clinical and Offender Services,  
CORE - The Public Correctional  
Enterprise

Justice Frank Vincent,  
Judge, Court of Appeal,  
Supreme Court of Victoria

David Ware,  
Assistant Director,  
Strategic Economic and Social Policy,  
Department of Premier & Cabinet

Peter Waters,  
Chief Executive Officer,  
Eastern Region Mental Health  
Association (ERMHA)

Christine Watson,  
Director,  
Spectrum - The Personality Disorder  
Service for Victoria

Marilyn Webster,  
Manager, Social Policy Research Unit,  
Good Shepherd

Sue White,  
Team Coordinator,  
Royal District Nursing Service,  
Homeless Persons Program

Rod Wise,  
Director, Prison Services,  
CORE - The Public Correctional  
Enterprise

Fred Wright,  
Office of Public Advocate



