

Multiple and Complex Needs Initiative

Background

Phase one of the Multiple and Complex Needs project was conducted in 2002–2003. It involved consultation with key stakeholders from a range of government and non-government organisations and other significant bodies.

The project findings suggested that an innovative response was required to the challenge of building a more effective response to people with multiple and complex needs.

The new service response targets individuals 16 years and older with multiple and complex needs. It is centred on a time limited specialist intervention that aims to:

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

What are the key elements of the Multiple and Complex Needs (MACN) Initiative?

- *The Human Services (Complex Clients) Act 2003*
- regional gateway referral process
- Multiple and Complex Needs Panel
- multidisciplinary assessment service
- Care Plan
- care plan coordinator
- intensive case management service
- formal evaluation.

The legislation

The MACN Initiative is underpinned by the Human Services (Complex Needs) Act.

This Act establishes necessary and appropriate powers for a new approach to planning service delivery for some of Victoria's most vulnerable community members.

Eligibility for the Multiple and Complex Needs Initiative

For an individual to be eligible for the MACN Initiative they must meet the eligibility criteria outlined in the Act.

An eligible person is a person who:

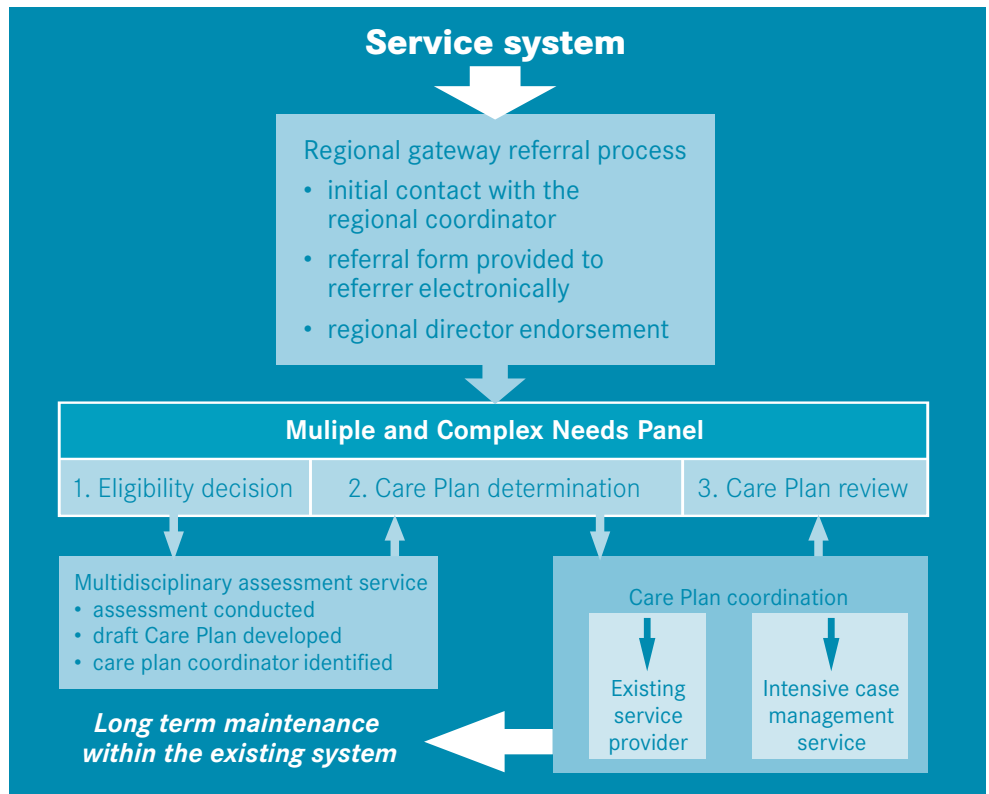
- has attained 16 years of age: **and**
- appears to satisfy two or more of the following criteria:
 - i has a mental disorder within the meaning of the *Mental Health Act 1986*;
 - ii has an acquired brain injury;
 - iii has an intellectual impairment;
 - iv is an alcoholic or drug-dependent person within the meaning of the *Alcoholics and Drug-dependent Persons Act 1968*; **and**
- has exhibited violent and dangerous behaviour that has caused serious harm to himself or herself or some other person or is exhibiting behaviour which is reasonably likely to place himself or herself or some other person at risk of serious harm; **and**
- is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan under this Act that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

How do people access the Multiple and Complex Needs Initiative?

Who can make referrals?

Referrals to the MACN Initiative may come from any source including the following:

- existing service providers working with the individual
- self referrals
- family members or significant others
- court support services through established protocols, or
- Correctional Services through established protocols.



Pre referral discussion

Each region has a MACN regional coordinator. The regional coordinator can be contacted to discuss potential referrals and can provide advice about whether the individual appears to meet the eligibility criteria for the MACN Initiative.

Completing a referral

Referrals to the Panel must be made through the regional coordinator. This is the single access point to the regional referral process.

What does the referrer need to think about prior to making a referral?

- Does the individual appear to meet the eligibility criteria?
- Have all available/possible support options for the individual have been exhausted?

Before completing the referral form forwarded by the regional coordinator, the referrer must ensure that the individual is aware that the referral is being made.

Endorsement of the referral

The regional director determines whether a referral appears to meet the eligibility and priority criteria for the purpose of forwarding it to the Multiple and Complex Needs Panel.

The regional coordinator will notify the individual and the referrer of this decision.

What is the Multiple and Complex Needs Panel?

The Multiple and Complex Needs Panel (MACN Panel) is a statutory body established under the Human Services (Complex Needs) Act.

The Panel is made up of a chairperson, five members and the Department of Human Services secretary's delegate. Members of the Panel have been appointed who have extensive expertise and experience in relevant fields such as mental health, disability, and drug and alcohol dependency

The MACN Panel has a number of responsibilities under the Act. These include:

- determining eligibility of the individual for a Multiple and Complex Needs service response
- authorising a referral to the specialist multidisciplinary service to undertake a comprehensive individual assessment and the development of a draft Care Plan
- considering the recommendations made in the draft Care Plan prepared by the multidisciplinary assessment service
- determining a Care Plan
- appointing a care plan coordinator
- allocating brokerage funds where appropriate
- reviewing Care Plans as required.

For the purposes of making any of the above decisions the Panel will consist of the chairperson and two panel members.

How is information provided to the Multiple and Complex Needs Panel?

Information is provided to the Panel via the Multiple and Complex Needs Panel referral form. However there may be situations where the Panel requires additional information to assist in its decision making.

The MACN Panel has the power, under the Human Services (Complex Needs) Act, to give permission to services to release information related to the individual's personal or health details, if they believe that it is in the best interests of the individual.

What happens if the Panel decides that the individual is eligible and a priority for service through the MACN Initiative?

If the Panel decides that the individual is eligible and a priority for service through the MACN Initiative, it will refer the person to the multidisciplinary assessment service for a comprehensive individualised assessment and the development of a draft Care Plan.

What is the multidisciplinary assessment service and how does it work?

The multidisciplinary assessment service will conduct a comprehensive individualised assessment to provide a holistic picture of the individual and their specific needs.

The multidisciplinary assessment service will then use this information to work with the individual and relevant services to develop a draft Care Plan.

What is the Care Plan?

The Care Plan outlines the following:

- areas of the individual's life which have been identified as a priority
- priority goals for the individual
- strategies to engage the individual
- identification of the services and supports and their roles and responsibilities
- a crisis intervention plan specific to the individual
- when and how the Care Plan will be monitored and reviewed.

The Care Plan will also identify a care plan coordinator either from the existing service system or, in some cases, from the new intensive case management service funded under the MACN Initiative.

What is the role of the care plan coordinator?

The care plan coordinator works in partnership with the individual and the services identified in the Care Plan to achieve the aims documented in the plan.

What is the intensive case management service?

The objectives of this service component are to undertake the role of the care plan coordinator and to provide a time limited intensive case management response where no other service option exists at that time.

Evaluation

A three-year evaluation process will be undertaken to document and measure the impact and outcomes of the Initiative.

There will be opportunities for all parties involved in the MACN service response to provide feedback to the evaluation.

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www.dhs.vic.gov.au/complexclients