



**Evaluation of the Multiple and Complex
Needs Initiative**

Report 1 - April 2005

This report contains 22 pages
EvalMultipleComplexNeeds050403-MR7

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This report has been prepared as outlined in Section 1 of this report. The procedures outlined in Section 1 constitute neither an audit nor a comprehensive review of operations. The findings in this report are based on a qualitative study and the reported results reflect a perception of the Department of Human Services and associated stakeholders but only to the extent of the sample surveyed, being the Department of Human Services approved representative sample of stakeholders. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, stakeholders consulted as part of the process. KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report. KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form. The findings in this report have been formed on the above basis.

This report is solely for the purpose set out in Section 1 of this report and for the Department of Human Service's information, and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent. This report has been prepared at the request of the Department of Human Services in accordance with the terms of KPMG's contract. Other than our responsibility to the Department of Human Services, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

1 Executive summary

1.1 Evaluation background, governance, framework and methodology

The group of people often considered to have complex needs includes those individuals who may experience various combinations of mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, social isolation, family dysfunction, and drug and/or alcohol misuse. They are often unable to sustain appropriate accommodation and/or require a level of support the current design of services does not readily allow. Services are often unable to maintain involvement over time with individuals with extremely difficult behaviours. Many of these individuals are homeless or at risk of homelessness.

The Multiple and Complex Needs Initiative (**the Initiative**) is a state-wide program providing specialist intervention (including assessment and development of Care Plans) for this target group - the most complex clients in Victoria.

The overall purpose of the evaluation is to:

- determine the success of the Initiative in achieving its stated aims and objectives;
- identify factors that facilitate and inhibit the effective and efficient implementation of the Initiative;
- identify the measurable impacts of the Initiative, including factors relating to changes in service utilisation, resource utilisation, client outcomes, systemic outcomes and cost effectiveness;
- dynamically inform the ongoing operation of the Initiative; and
- develop a strong evidence base on which to develop and refine a future legislative framework and service responses¹.

The key research questions that need to be answered by the evaluation are:

- Is the Initiative leading to better outcomes for clients with multiple and complex needs?
- Is the human services system more coordinated in its service planning and provision for clients with multiple and complex needs?
- Is the legislation adequate to achieve improved service co-ordination and better outcomes for clients with multiple and complex needs?
- Is the Initiative providing cost benefits in relation to service provision for clients with multiple and complex needs?²

¹ Taken from <http://www.dhs.vic.gov.au/complexclients/evaluation.htm> (accessed 29 January 2005)

To oversee the Initiative and the evaluation, the Multiple and Complex Needs Initiative Steering Committee (**the Steering Committee**) has been established.

To support the Steering Committee, the Initiative (and all its components) and the Evaluation Team, the Multiple and Complex Needs Reference Group (**the Reference Group**) has been established.

To facilitate the evaluation methodology, an evaluation framework was developed in consultation with representatives of each of the Initiative components (that is, the Initiative Team, Regional Coordinators, the Panel, the Multidisciplinary Assessment Service and the Intensive Case Management Service), as well as key stakeholders represented on the Reference Group and Steering Committee. Endorsed by the Initiative Steering Committee and approved by the DHS Ethics Committee, the evaluation framework establishes the key outcome indicators for the Initiative at three levels:

- the individual client;
- the Initiative as a whole (including the effectiveness of each of the individual components that comprise the Initiative); and
- the impact/influence of the Initiative on the human services system.

The evaluation methodology has been designed to balance quantitative approaches with qualitative approaches so as to ensure that the incremental changes and impacts that result from the Initiative cannot only be captured but assessed in terms of their merits.

The period of reporting covered by this progress report is from proclamation of the Act on 31st May 2004 up until and including 30th November 2004.

1.2 The Initiative

The Initiative is underpinned by the *Human Services (Complex Needs) Act 2003* (**the 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.

1.2.1 Eligibility criteria

To be eligible to receive assistance and support under the Initiative, individuals must be a person that:

- has attained 16 years of age; **and**
- appears to satisfy two or more of the following criteria:

² Department of Human Services Tender Brief (T2922) The Evaluation of the Multiple and Complex Needs Initiative, November 2003

- has a mental health disorder within the meaning of the *Mental Health Act 1986*;
- has an acquired brain injury;
- has an intellectual impairment;
- 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.

1.2.2 Guiding principles

The Act's guiding principles require that the wellbeing, health, safety and stable housing of the person are of paramount consideration in decision-making, and planning and delivery of services.

A comprehensive and multidisciplinary assessment is required to form the basis of any Care Plan. It is recognised that planning will be most effective when those services are coordinated, and when service providers share relevant information about the person. The Act therefore requires that the services provided in accordance with a Care Plan are to be delivered in a coordinated manner for a specified period.

Additionally, improved services for individuals with multiple and complex needs are to be planned, individually tailored and occur within a voluntary framework.

1.3 The service model

The new service model developed by the Initiative is based on more effective service planning and coordination that provides a 12-15 month intervention, including assessment and coordinated care planning with lead care coordination. The aim of the new service model is to stabilise the disruptive elements of complex needs clients' lives and create a platform for the long-term engagement of these clients within the service system that can then deliver planned and coordinated services for the clients.

Importantly, services contributing to the Initiative will work in collaboration with the existing service system to enhance longer-term capacity and responsiveness to this group of clients. The findings and outcomes from the evaluation of the Initiative will form part of the evidence base to inform systemic practice.

The key components of the Initiative are as follows:

- *Regional Gateway and Referral Process* –provides the single point of entry (in each Region) to refer complex needs clients into the intervention process. Regional Coordinators undertake a preliminary assessment of whether an individual appears to meet eligibility criteria, whilst ensuring that all available service responses have been considered or tried. The Gateway and Referral Process screens potential clients against a set of eligibility criteria to ensure that only individuals with high level multiple and complex needs are referred to the intervention processes. Evidence of attempts to provide a relevant and coordinated service response to an individual need to be demonstrated before a Regional Director will consider referring an individual to the Multiple and Complex Needs Panel.
- *Multiple and Complex Needs Panel (the Panel)*– whose core role is to determine eligibility under the Act and the coordination of, and exchange of information between, different elements of the services system and specialist services (including the multidisciplinary assessment service (**MAS**)) in the:
 - assessment and determination of client needs; and
 - development, implementation and review of a coordinated Care Plan for that client incorporating coordinated services from disparate services providers.

The Panel may, where necessary, support the implementation of the Care Plan through the allocation of brokerage funds. The Care Plan specifically identifies the nature of the intervention process and the service providers that will work with the individual to maximise the outcomes they are seeking.

- *MAS* – undertakes a comprehensive assessment, which in turn informs the development of a coordinated client Care Plan, including the nomination of a care plan co-ordinator. The key objective of the assessment is to develop a practical and achievable Care Plan that recognises the client’s range of needs, engages the individual, their family and relevant service providers to develop consensus on a planned approach to meeting the support needs of the individual. The assessment may also include, where necessary, specialist reports on the client to assist in better understanding the client’s full range of needs. By its nature, the assessment will require cross-disciplinary expertise from within the MAS, however, responsibility for the development of the assessment and resultant plan will be allocated to a nominated member of the assessment service.
- *Intensive Case Management Service (ICMS)* – under the Care Plans developed by the Assessment Service and approved by the Panel, a lead Care Plan Coordinator is appointed. This responsibility may be either delegated to a provider within the existing service system or the specialist intensive case management service. As a preferred option, coordination responsibility will be delegated to a part of the existing services system that provides services to the client in order to minimise the disruption to the client’s existing care environment. The coordinator will manage the implementation of the Care Plan (including accessing of any services arranged or brokered by the Panel).

1.4 The Initiative Team

To support the implementation of the Initiative, the Initiative Team has been established. The Initiative Team is responsible for the overall strategic planning, operational management of the Initiative and the conduct of the evaluation and for ensuring that the legislative imperatives of the Act are implemented consistent with their intent.

The Initiative Team consists of the following positions:

- Manager, Initiative Team, full time;
- two part time Senior Project Officers; and
- Administration Officer, 0.3EFT.

There are two positions supporting the activities of the Panel that work closely with the Initiative Team. These are:

- Executive Officer Panel, full time³; and
- Executive Office Coordinator Panel, part time.

In establishing the Initiative, the Initiative Team has been required to engage in a broad range of activities. Overall, activities which the Initiative Team have undertaken are much more diverse than was originally anticipated in the original work up of the Initiative. By necessity, there has been a substantial focus on strategy development, the establishment of collaborative partnerships at all levels of the Initiative and change management.

1.4.1 Progress on Initiative Team's activities

At the time of reporting, the Initiative was in the early stages of implementation; however, a substantial amount of activity has been undertaken, and many of the required planning and support activities have been completed or are well progressed. To date, the Initiative Team has:

- established guidelines, policies and procedures to support implementation and operation of the Initiative and the individual components;
- commenced the development and establishment of budget and reporting systems and procedures for individual components and the Initiative as a whole;
- established and given effect to the Regional Gateway and Referral Process. As the entry point to the Initiative, it is reasonable to expect that this is the most progressed element of the Initiative. Consequently, a formal review of Regional Gateway and Referral Process operations is scheduled for early 2005⁴;

³ As from 1 January 2005, this position will now be counted as part of the resources available to the Panel and not as part of the Initiative Team.

⁴ This has been initiated by the Initiative Team.

- the Panel has been established and is now operational, having commenced the consideration of referrals, with a number of clients referred to Care Plan Assessment Victoria (CPAV) for assessment;
- meeting schedules, agenda and reporting frameworks are in place across the Initiative (including for the Panel, Steering Committee, Reference Group, CPAV, Intensive Case Management Service (Indigo), Regional Coordinators, regional management and program management);
- assessment processes are in place, with referrals being provided to CPAV for assessment; and
- development of the Initiative database is well progressed.

1.4.2 Preliminary findings for the Initiative Team

Considering the scale of the establishment task, and in recognition of the additional activities undertaken by the Initiative Team during this phase, the Initiative Team has been very effective in ensuring that the infrastructure needed to support the Initiative is not only established in a timely manner but that the policies and protocols to support the work of the Initiative are effective and responsive to the to day-to-day operational requirements and challenges of each component.

The Initiative Team has taken on a strong leadership role in ensuring that the establishment phase of the Initiative has not only run smoothly but has built on the opportunities to build collaborative partnerships between each of the individual components. To encourage such behaviours, the Initiative Team has employed a collaborative, community development approach, which has been enthusiastically supported by the majority of stakeholders.

The intensive induction and development work undertaken by the Initiative Team with the Regional Coordinators in establishing the Regional Gateway and Referral Process has been extremely beneficial for the Initiative. The heightened awareness and understanding of this group has enabled Regions to embrace the Initiative. Importantly, Regions have begun to use the Initiative to start to examine their local practices in seeking out ways to better respond to people with multiple and complex needs⁵. These early indicators of change suggest there is potential for wider benefits (not only for clients with multiple and complex needs) to be realised through improvements in service coordination and planning.

The Initiative Team has assisted in enhancing lines of communication between and within Departments, in particular across programs within DHS. The Team has promoted collaboration and cooperation across key stakeholder groups. For example, externally there has been enhanced and positive communication channels developed with the Justice Department. These links have been established at both the Initiative Team and regional levels.

The strategic partnerships that the Initiative Team have been able to develop have ensured that each component has not only been able to be established in a manner consistent with the

⁵ Refer to Section 4 Regional Gateway and Referral Process

original design of the service model but that the ‘value add’ of sharing the knowledge and skills across each component has begun to be realised and is informing the further development of the service model.

The Initiative Team’s role, though underestimated in the original design of the service model, is crucial to the success of the Initiative as it provides the linking mechanism between each component of the Initiative and the key stakeholder groups.

1.5 Regional Gateway and Referral Process

The core functions of the Regional Gateway and Referral Process are to:

- develop an understanding and working knowledge of the Initiative amongst key stakeholders;
- establish a single point of access to the Initiative in each DHS Region;
- provide an initial contact point for people (agencies or individuals) considering making a referral to the Initiative;
- provide advice and support to potential referrers in ensuring that all possible alternate support options have been investigated prior to referrals being made;
- distribute referral forms to referrers and provide support and advice in filling these out;
- provide advice on eligibility criteria;
- identify appropriate candidates and make referrals to the Panel for consideration and assessment; and
- provide feedback and advice to referees and candidates on the outcome of referral processes.

The Regional Gateway and Referral Process provides an opportunity to explore the current service response for individuals and to make an initial assessment in relation to eligibility criteria and potential courses of action.

The Initiative service model originally proposed that the structure of the Regional Gateway and Referral Process in each DHS Region includes:

- a Regional Coordinator – providing a focal point for support, referrals, information and advice regarding the Initiative; and
- the DHS Regional Director – with formal responsibility for endorsing referrals to the Panel.

The Regional Gateway and Referral Process is supported by a set of business rules and protocols to guide its operation⁶. The business rules and processes were developed in consultation with a range of internal and external stakeholders, including Regional Coordinators, Regional Directors, potential gateway users such as DHS program branches, Office of the Public Advocate, Corrections and the Courts. These rules comprehensively set out functions, roles and activities to be undertaken by Regional Gateway and Referral Process staff and outline protocols established with other jurisdictions.

1.5.1 Implementing the Regional Gateway and referral process in each Region

While there are consistent processes established for the Regional Gateway and Referral Process, DHS Regions have some flexibility in the structures and supports they establish to undertake the Initiative.

Establishment of the Regional Gateway and Referral Process has occurred within the existing DHS service framework. Responsibility for the establishment of the Regional Gateway and Referral Process has been managed utilising expertise and resources from both the Regions and the Initiative Team. Key activities in the establishment stage have included:

- development of position requirements and appointment of Regional Coordinators;
- recruitment of all Regional Coordinators in early 2004;
- establishment of the Regional Coordinator network, including weekly coordinator meetings with the Initiative Team to provide training and develop consistent application of business procedures, information and advice;
- establishment of business rules and protocols for operation of the Regional Gateway and Referral Process, including specific consideration of referrals through courts, prisons, child protection units, community corrections and juvenile justice;
- development of a demand management strategy and regional service allocation response schedule to provide guidance on anticipated regional referral levels; and
- database development – a Regional Gateway and Referral Process database has been developed to collect information for ongoing demand and trend analysis of the Regional Gateway and Referral Process.

Appropriate steps have been taken to establish local operational guidelines and supports for Regional Gateway and Referral Process in all DHS Regions. The intensive training and development of the Regional Coordinator role has facilitated a common understanding and has supported a consistency in approach across all Regions.

⁶ Ibid.

1.5.2 Preliminary analysis of data available on the Regional Gateway and Referral Process activities

Data obtained from the Regional Gateway and Referral Process database was analysed for the period 31st May 2004 to 30th November 2004⁷. The information captured encompasses activities undertaken in relation to the following processes:

- Inquiries – involving initial queries, informational provision, assessments for service options, eligibility and progression to consultations;
- Consultations – a more in depth assessment of eligibility and service options informing a decision on whether to progress to the regional referral process;
- Referrals – involving the final assessment processes and recommendations to the Regional Director; and
- Endorsed Referrals – involving all referrals endorsed by the Regional Director.

1.5.3 Inquiries

Regional Coordinators responded to a total of 101 inquiries during the reporting period. Details on 67 of these inquiries were available for analysis.⁸

Organisations making contact with Regional Coordinators included DHS, family members and significant others and a range of other service provider organisations.

Most inquiries made were with a view to making a potential referral (54 of 67), with a small number of inquiries (10) made generally in relation to the nature of the Initiative.

Common reasons provided for making the inquiry included a lack of clarity on how to proceed with the case (32), deterioration in ability to support (19) and a lack of available supports (9) for the individual.

Initial assessments at the inquiry stage included 32 cases that appeared to meet eligibility criteria.

Of the 67 inquiries received, 14 inquiries did not meet eligibility criteria.

Common outcomes at the inquiry phase involved encouragement to explore other service options through referral to identified services providers (13) and program specific intakes (6). There was also strong focus on providing information at the inquiry level (54 instances recorded).

⁷ Data was downloaded from the Regional Gateway and Referral Process database and provided to the Evaluation Team in an Excel spreadsheet. In addition, a preliminary analysis of the data was provided to the Evaluation Team by the Initiative Team in order to allow cross checking and accuracy of data provided.

⁸ The remaining 34 records relate to inquiries related to the Initiative but do not refer to specific individuals.

1.5.4 Consultations

A total of 77 consultations were conducted across the Regional Gateway and Referral Process up until 30 November 2004.

As is expected, there is a strong concentration of consultations conducted in Metropolitan Regions (74.4 per cent).

Methods of consultation employed at the regional level have included face-to-face meetings, telephone meetings or a combination of both. In 63 of 77 cases, face-to-face meetings took place; in 30 of these cases, telephone consultations were also used.

Client characteristics in relation to consultations conducted at Regional Gateway and Referral Process show a strong trend toward age groups at or below 39 years. This included a substantial number of clients in the 16-19 years age category, who were largely identified by Juvenile Justice (6), and Child Protection services (2). Consultations across other age groups were spread across a range of service types.

The concentration of matters being resolved at the regional level at this early stage of the Initiative is encouraging. This trend highlights that the Regional Gateway and Referral Process has begun to have a positive local impact for clients with complex needs.

1.5.5 Referrals

A total of 37 referrals had been initiated by the Regional Gateway and Referral Process at the time of reporting.

Referral processes were underway within five Regions, with North and West and Southern Regions accounting for four out of five (80 per cent) of the total number of referrals conducted. Southern Region appears to account for a large number of referrals.

A wide variety of organisations made referrals. Of particular interest is the high number of regionally based referrals from mental health services, particularly Adult Mental Health (7) and Psychiatric Disability Rehabilitation Services (3). Juvenile justice and disability based support services are also strongly represented.

Most commonly, clients at the referral stage were identified as having erratic or limited engagement with service providers. Small numbers of clients were identified as engaged with the service system

The client group at the referral stage shows greater representation of males (70 per cent of the referred group), with 65 per cent of this client group being below 40 years of age.

The highest numbers of referrals were received from clients in the 25-39, 20-24 and 16-19 years age groupings. Despite a tendency for higher representation amongst younger adult age groups, it is also important to recognise that there are referrals occurring across all age categories up to the 65-69 years age grouping.

Three people engaged at the referrals stage identified as Aboriginal and Torres Strait Islanders. Four of the group (11 per cent) required assistance with communication throughout the Regional Gateway and Referral Process, although none required an interpreter.

More than 60 per cent of referred clients had chronic health problems. The status of health problems varied evenly Unstable (8), Managed (8) and Poor (7) classifications. A minority of clients were ranked as healthy, with no known chronic health problems.

Accommodation status and stabilisation is likely to be an important factor in outcomes for clients engaged in the Initiative. The current accommodation status of clients at the referral stage show a strong tendency for clients to be homeless (Primary – 14 per cent; Secondary – 46 per cent), with only 16 per cent of the group in stable housing situations (Table 25).

Four clients (11 per cent) were in prison or other custody at the time of the referral. These clients accessed the assessment processes through Prisons (one female client aged 40-44 years), DHS Juvenile Justice services (two males aged 16-19 years) and Disability Services (one male aged 25-39 years).

1.5.6 Endorsed referrals

Of the 37 referrals undertaken or in progress at the time of reporting, there were 14 referrals to the Panel that had been endorsed by Regional Directors⁹. For the majority of clients (23 of 35), referrals were yet to be completed or submitted for the Regional Director's consideration. In four cases, the referral was not endorsed by the Regional Panel (North and West – 2; Hume – 1; Southern – 1).

1.5.7 Preliminary findings on those coming into contact with the Regional Gateway and Referral Process

Overall, the initial profile of the individuals coming into contact with the Initiative is in keeping with the intent of the Initiative. Individuals identified have a range of diagnoses and issues that are likely to require responses across a range of support areas (eg social support; health; disability; mental health). The group is commonly difficult to engage and exhibit high risk behaviours, a high degree of social disconnection and unstable accommodation experiences.

The inquiry, consultation, referral and endorsed referral stages of the Regional Gateway and Referral Process appears to be identifying clients who appropriately meet the criteria for referral to the Panel. Further confirmation of the effectiveness of these processes will be available as the Panel provides feedback on the suitability of individuals referred.

The phased process for consideration at the regional level appears to be providing ample opportunity to focus resolution of client needs through the development of local responses.

⁹ Recording of endorsement by the Regional Director in the Regional Gateway and Referral Process database occurs prior to establishment of the client's refusal status for the Initiative. As a result, the level of endorsed referrals and actual referrals to the Panel may differ over time.

1.5.8 Emerging themes and trends

Early perceptions of the impact of the Initiative are positive. The overwhelming view of those interviewed in relation to the Regional Gateway and Referral Process and associated processes is that it is, at the very least, establishing a need for Regions to reflect on their responses to clients with multiple and complex needs. Generally, the regional response is positive, with a common focus on increased awareness and shared responsibility for coordinated and planned responses to clients with multiple and complex needs.

Local stakeholders consistently indicated that the Initiative will have a positive impact from a system and practice perspective. This is being achieved through direct engagement in regional capacity building, network development and the common ownership of issues relating to individual clients. Early examples of this were identified across a number of Regions in relation to the overall level and willingness to participate in case conferencing.

The Regional Gateway and Referral Process is operating effectively as the entry point for the Initiative. Regional Coordinators have been pro-active in engaging their local communities, ensuring that service providers and key stakeholders have a solid understanding of the processes and in supporting activities of the various components of the Initiative.

This understanding, along with the effective role Regional Coordinators play in exploring and in identifying alternative options at the regional level, has seen a range of solutions devised for people with multiple and complex needs.

The problem solving approach taken by all Regions and the emphasis on engaging key stakeholders in improved and authoritative service planning and coordination activities is a direct product of the Initiative.

The role of the Regional Coordinators ensures that each Region is now more able to explore capacity building strategies for supporting individuals with complex needs. This work is expected to have long term benefits for each Region and for the service system as a whole.

1.6 The Panel

The Panel is an independent body established by the Act. The Panel's role is to determine eligibility and authorise the referral of individuals to the specialist service to undertake a multidisciplinary assessment and develop a draft Care Plan. The Care Plan identifies a Care Plan Coordinator with responsibility for coordinating the service response. Where necessary, the Panel is able to allocate brokerage funds to support the implementation of an individual's Care Plan.

The Panel formally determines the agreed Care Plan which will direct an individualised service response for a 12 month period that will be subject to at least one review during that time. The Panel may choose to convene a conference where necessary to discuss the progress of the Care Plan. In accordance with the legislation, the Care Plan may be extended for a further period, up to one year.

1.6.1 Constitution of the Panel

The membership of the Panel consists of a Chairperson and five persons who have significant experience in providing welfare, health, mental health, disability, drug and alcohol treatment, offender or housing and support services. The Chairperson (and Alternative Chairperson) is appointed by the Governor in Council on the recommendation of the Minister for Health. The remaining Panel members are appointed by the Minister for Health and the Minister for Community Services. All appointments are for a term of three years.

The Panel is supported by an Executive Officer and a part time Executive Office Coordinator.

1.6.2 Initial Panel members focus and activities

The initial focus for the Panel has been on establishing the operational arrangements to give effect to the Panel's role and responsibilities. Key activities have included:

- developing a clear understanding of the roles and responsibilities of the Panel;
- developing operational guidelines and procedures to guide Panel activities;
- establishing meeting protocols and procedures and scheduling of Panel meetings;
- networking and meetings with other Initiative components,
- establishing communication processes within the Panel, with the Initiative Team, and the other components. For example, this has included establishing terms of reference for meetings between the Panel and CPAV; and
- obtaining a clear perspective on how the Initiative works and the various components fit together, including the need to inform the evaluation.

1.6.3 Preliminary findings

At the time of reporting, the Panel had received eight referrals, one from a rural Region and seven from metropolitan Regions.

It is too early in the operation of the Panel to identify any preliminary findings directly attributable to the Panel's consideration of individual clients referred through the regional Gateway and Referral Process.

Feedback from all stakeholders indicates that the Panel is working productively with the Regional Gateway and Referral Process and other components of the initiative evolving a common understanding of the needs and potential responses required to effectively support people with multiple and complex needs.

1.7 Multidisciplinary Assessment Service – Care Plan Assessment Victoria (CPAV)

The MAS is responsible for undertaking:

- face-to- face consultations with the nominated person and (where appropriate and agreed by the nominated person) with the person’s family;
- consultations with the nominated person’s carers;
- consultations with organisations previously and currently providing services to the individual (includes welfare, health, mental health, disability, drug and alcohol treatment, offender or housing and support services);
- multidisciplinary analysis of the nominated person’s needs; and
- collection and consideration of relevant personal or health information.

1.7.1 Care Plan development and submission

In addition to the conduct of the broad client assessments, the assessment service is responsible for development of draft Care Plans for referred clients and an assessment of the service system. The Act sets out that this plan should specify the ‘*care, treatment, support and housing recommended*’¹⁰ for the individual. The legislation stipulates that Care Plans should:¹¹

- focus upon the ‘*well being, ,health, safety and stable housing of the person*’;
- be based upon a complete multidisciplinary assessment of the person; and
- recognise that delivery of services to the individual will be best achieved through a coordinated approach to service planning.

Under the legislation, plans are subject to a maximum duration of 12 months, with opportunity to extend the plan for a further 12 months (maximum) where deemed necessary by the Panel.

Care Plans are to be submitted to the Panel within the 90 day assessment period. Once submitted, the Panel may accept or reject recommendations and the Care Plan proposed by the MAS. A Care Plan cannot be implemented by the Panel unless an assessment has been undertaken via the MAS.

1.7.2 CPAV

CPAV was appointed to undertake the role of the MAS, a component of the Initiative, early in 2004.

¹⁰ Human Services (Complex Needs) Act 2003.

¹¹ Ibid

CPAV was established under a consortium of two pre-existing organisations, the Australian Community Support Organisation (ACSO) and the Victorian Institute of Forensic Mental Health (Forensicare). These organisations provide management and infrastructure support and policy guidance to CPAV. The support functions of the two auspice organisations are divided according to the areas of expertise within these organisations.

CPAV has funding for six staff. At the time of this progress report, recruitment to positions has been undertaken for all except one position.

Policies and procedures for CPAV have largely been sourced from existing policy frameworks within both ACSO and Forensicare. Policies and procedures are adopted in line with the split of services provided by the two parent organisations.

1.7.2.1 CPAV activities and strategies since establishment

Activities of the CPAV service to date have included Initiative establishment and client related activities. Initiative establishment activities relate to the set up a of the CPAV infrastructure, including the office, equipment and staff resources. Client activities are those related to assessment of clients referred from the Panel, including development of draft Care Plans.

Initiative related activities have included establishment of the office and working environment, purchasing equipment, IT infrastructure, recruitment, policy and procedural development. Communication to service providers and other stakeholders across the State has also been a large component of set up activities undertaken by CPAV.

The use of a consortium of two existing service providers to form the MAS is consistent with the identified preference to promote collaboration and partnership development. This has allowed development of a culture within CPAV that has been developed to specifically meet the needs of the assessment service. However, the result of this model is that there has been a requirement to spend longer in set up and establishment of CPAV than would have been expected in the case of an existing, single auspice model.

1.7.3 Client contact, visits and assessment

At the time of this report, the CPAV team had been referred six clients by the Panel. Of these, direct contact had been made with five clients. In one case, the Care Planning process had been undertaken and a Care Plan submitted to the Panel for consideration. In all other cases, the processes of information and evidence gathering, assessments and development of Care Plans was underway. To date, client meetings have taken place in a variety of settings and circumstances. Clients are provided with the option of nominating the location of meetings.

1.7.4 Contact with the Panel, Indigo, the Initiative Team and Regional Coordinators

From the onset of referral, regular fortnightly meetings are held between CPAV and the Panel. At these meetings, progress on Care Plan development is communicated, including a general outline of issues and specific flagging of important issues arising from the process.

An agenda and terms of reference have been established for these meetings. Attendance includes: Panel representatives; the Panel Chair; CPAV staff; and an Initiative Team representative.

CPAV has been in regular contact with Indigo via meetings and other less formal contacts. CPAV staff report that the relationship with Indigo is being developed, and CPAV has been able to seek input and advice from Indigo in care planning processes.

CPAV reports that it has established an open and positive relationship with the Initiative Team. CPAV staff felt confident in approaching DHS contacts for information, advice and guidance on Initiative issues.

In the original outline of the Initiative, the role of the Regional Coordinators ends once a referral leaves the Regional Gateway and Referral Process.

CPAV has questioned the appropriateness of this as they identify a need for local engagement and knowledge to be available during Care Plan development. Areas where such contact has proved invaluable to date include knowledge of local issues, communities and cultural requirements.

1.7.5 Preliminary findings

Whilst it is still early in the life of the Initiative, the work of CPAV has highlighted that the multidisciplinary assessment strategy allows a variety of possible interpretations and viewpoints to be expressed and considered in determining the needs of an individual. Consideration via a centralised assessment is helping a full picture to be developed, with clear themes emerging from diverse information sources that may not have been viewed as important when previously viewed in isolation.

Engagement of a range of stakeholders in care planning is exposing these groups to issues and service possibilities that they have not previously considered. As a result of comprehensive assessments, appropriate interventions are easier to identify. This is allowing a positive focus on achieving actions that are most likely to address the critical, high priority areas of need for clients. For example, development of crisis response strategies in Care Plans has been positively received by service providers as an area they had not previously considered. In addition, the existence of brokerage funds is reassuring for service providers and is an important element in establishing service provider acceptance of the Initiative and minimising resistance.

The independence of CPAV from direct provision of service responses allows the CPAV team to look holistically at, and concentrate on, establishing responses that meet the specific needs of the individual.

1.8 Intensive Case Management Service - Indigo

The role of intensive support and case management in the Initiative is to engage and subsequently work with the individual consistent with their Care Plan to achieve longer term objectives in terms of:

- stable housing;
- social connectedness;
- improved health and well-being; and
- safety, for client, staff and community.

The intensive case management service has been established as a component of the Initiative to enable case management and care plan coordination where appropriate. Local or program based options are not available or are not able to meet the client's current level of need.

Indigo has been established by a consortium of Western Region Health Centre (WRHC), Salvation Army Crisis Services and Home Ground. WRHC is the lead agency in the consortium.

1.8.1 Responsibilities under the Act

The legislation requires that a Care Plan Coordinator must:

- monitor the implementation of the Care Plan and the progress of the person to whom it relates;
- coordinate the services to the client in accordance with the Care Plan; and
- provide a progress report on the client to the Panel every six months or on request from the Panel.

The services to be coordinated are also set out in the Act and are defined as services in the areas of welfare, health including mental health, disability, drug and alcohol treatment and housing and support.

1.8.2 Service staffing structure

Indigo has been designed to have a staffing structure of one co-ordinator and five case co-ordination staff.

Of the 50 clients anticipated to use the Initiative each year, it is expected that 25 will be referred by the Panel to Indigo for intensive case management response. (Alternative case coordinators will be appointed in the remainder of cases.) A staff to client ratio of 1:5 has been planned for Indigo, requiring five staff to support the anticipated client referrals when the Initiative is fully functional.

1.8.3 Indigo - activities and strategies since establishment

To date, priority has been given to establishing the Indigo team and establishing the operating model for Indigo.

Policies and procedures have been developed to support Indigo's activities. As a starting point, Indigo has drawn on WRHC policies to start this process. Indigo have, however, in the development process consulted widely with both specialist and statewide services regarding policy formulation relating to risk management, outreach, out posting and supervision. Policies and procedures that are being developed relate to:

- risk management;
- staff support;
- communication;
- data management; and
- Information Technology.

As the Care Plans will be structured in response to client needs, this has made it hard for Indigo to anticipate and plan for how these will be managed. Consequently, this process will occur as Indigo becomes operational and can draw from practice experience in the Initiative.

Operational policies on how to respond to the needs of clients and services in rural areas are still to be developed. As this needs to be informed by the needs and practical options emerging from 'real life' situations, this work can be expected to progress once referrals commence from the Panel of clients wishing to relocate to or remain in rural areas.

Other activities undertaken to date include liaising with other components within the Initiative and consulting with services.

1.8.4 Preliminary findings

Due to the role of Indigo within the Initiative, the stage of the Initiative's development and the date of reporting, it is not possible to draw any preliminary findings in relation to Indigo's activities apart from to confirm that the activities undertaken to date are appropriate and consistent with the establishment requirements for this component.

1.9 Conclusion

The service models to support each of the supporting components of the Initiative have been developed and established consistently with the objectives and directions of the original strategy underpinning the Initiative.

To date, significant time and resources have been invested by the Initiative Team, and the representatives of each of the components, to ensure that a common understanding is developed about how the individual components link and work in concert in meeting the objectives of the Initiative. With an emphasis on the development of collaborative partnerships at each level of the Initiative, the development work during the establishment phase has provided opportunity to formulate new ways of working.

Traditional program models and service delivery response have been able to be constructively challenged with the introduction of a more person-centred approach to the planning of support responses for people with multiple and complex needs. With this focus, the emphasis for decision making has started to move to an approach based on flexibility and problem solving, tailored to an individual's needs and circumstances, rather than focusing on rigid eligibility criteria for specific services.

In creating this collaborative working environment, both the Initiative Team and Regional Coordinators have been proactive in consulting with, and informing stakeholders about, the Initiative. These activities have been targeted at both DHS provided and funded services as well as other interested stakeholders, such as the Courts, local Magistrates and Corrections.

By engendering a common understanding about the Initiative, its supporting protocols and procedures, agencies referring individuals to the Initiative are increasingly equipped to provide the level of information required to support consideration of individuals with multiple and complex needs.

Initial activity levels of the Initiative have begun to highlight the effectiveness of the Regional Gateway and Referral Process.

Though it is early days, it is clear that the Initiative is already having a positive impact at the local level within each Region.

In the next six month progress report, a more comprehensive analysis of activity levels will be undertaken across all components of the Initiative providing further insight into the impact and influence of the Initiative in responding to people with multiple and complex needs.