**Victorian Department of Human Services**

# Evaluation of the Multiple and Complex Needs (MACN) Initiative

## Evaluation Progress Report 2
## Preliminary Case Studies
## APPENDIX 3

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Government
This report contains 26 pages

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# A Introduction

Clients selected for case study are listed in Table 1, which also illustrates the extent of their interaction with the Initiative which has been examined[1].

## *Table 1 Case study cohort*

| Regional Gateway | | | Panel | CPAV | Indigo |
|---|---|---|---|---|---|
| **Inquiry** | **Consultation** | **Referral** | | | |
| | | | | | **"Ben"** |
| | | | | **"Andrea"** | |
| | | | | **"Carl"** | |
| | | | | **"Dana"** | |
| | | | | **"Eric"** | |
| | | **"Frank"** | | | |
| | | **"Greg"** | | | |
| | **"Gina"** | | | | |
| | **"Harry"** | | | | |
| | **"Ian"** | | | | |
| | **"James"**[2] | | | | |
| **"Ingrid"** | | | | | |
| **"John"** | | | | | |
| **"Kyle"** | | | | | |

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The purpose of preparing these preliminary case studies is to outline the result of the experience of clients at each stage of the Initiative and to determine the reasoning behind why some clients did not proceed. The learnings from the case studies have informed the conclusions in the substantive report and the areas for future investigation. The case studies will also inform the individualised cost effectiveness analysis which will also commence in the next reporting period. It is also intended that these case studies provide a foundation for more in-depth case studies, which will be undertaken in future reporting periods. As the Initiative continues to be implemented, there is growth in the client population and an increasing number have a designated care plan, the benefits of the Initiative to those clients engaged in it will be able to be discerned.

The sources of information to inform the development of the case studies has been drawn primarily from documentation provided by Indigo (response to survey), CPAV (draft care plans, referral documentation and assessment reports), the Panel (Panel session reports) and data extracts from the Referral Gateway database. Regional

[1] The client cohort was initially selected to enable analysis of clients who did not proceed beyond certain stages in the Initiative, however since the selection of the client cohort was made and the extraction of data (as at 31 May 2005), it has been identified that in fact "John" is currently being considered at the referral stage.
[2] There is no record of this client at the inquiry stage.



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Coordinators of clients who did not proceed beyond referral were also contacted. They were asked two questions:

- Why didn't the client proceed beyond referral/inquiry/consultation stage?
- Did that person's case management change as a result of interaction with the initiative?

Where Regional Coordinators provided a response, this is indicated for each case study. Regional Coordinators were also contacted to provide insight into the reasons why referrals did proceed; this information is provided under the heading "Regional Gateway" for each case study.

As far as possible (given available data and the length of time clients have been engaged in the Initiative), client case study information presented is consistent with the categories of information provided in the DHS report *Responding to people with complex needs project – client profile data and case studies report* (January 2003). Thus, information provided includes both background and the current circumstances pertaining to:

- demographics;
- social issues (including accommodation, employment, education and training);
- behavioural issues;
- health issues (including disability and mental health);
- interaction with emergency services;
- interaction with the child protection system;
- interaction with the juvenile justice system;
- interaction with the criminal justice system (including legal orders);
- substance misuse and abuse; and
- interaction with the support system.

Where available, information regarding the result or experience of the client with Initiative components is presented, specifically:

- inquiry;
- consultation;
- referral;
- Panel – determination of eligibility;
- CPAV – assessment and care plan development;
- Panel – care plan determination;
- Indigo – care plan coordination; and
- Panel – care plan review.

A much greater level of detail is presented for those clients who proceeded beyond referral (given more data is available for analysis). Basic data, extracted from the

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Regional Gateway database, is presented for clients who did not proceed beyond this stage.

It should be noted that the case studies are preliminary and will form the basis for more in-depth case studies in the next reporting period. At that time, the following questions will be answered:

- How did the service providers and each of the Initiative components experience the processes of the Initiative in relation to the individual client?
- What was the client's experience of the process (as reported by services)?
- How did CPAV undertake the assessment and planning processes in relation to the client and services required for the client's care plan?
- Who participated in the Panel meeting? What was their experience of it?
- Was there acceptance of care plan goals and agency responsibilities by parties to the case plan?
- How did Indigo find the process of implementing and coordinating the care plan?

To enable this level of detail, interviews with Initiative components and service providers specifically in relation to the case study cohort will be undertaken as each case's progresses through the Initiative.

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# B Client selection for engagement with Indigo

## B.1 Case Study 1

*"Ben's" motivation for participation in the Initiative was his desire to obtain stable long-term accommodation. He was aged between 20 and 25 years.*

### B.1.1 Case history

Ben's childhood years were characterised by marital breakdowns between his parents and his father's subsequent partners, conflict between he and subsequent step-parents, and parental absence due to mental illness and death. In his adolescent years, Ben was diagnosed with an intellectual impairment as well as neurological and psychological conditions. He also frequently moved between out-of-home care placements (including placement breakdown) and has engaged in criminal behaviour.

Ben was placed on a Guardianship to the Secretary Order until he was 18 years of age. Ben currently resides in a secure structured environment; however, due to legislative constraints, he is not eligible for support at this placement (which is designed for adults with an intellectual disability) and hence his placement is unfunded. In Victoria one of Ben's psychological conditions is not recognised under legislation as a mental illness or a disability.

### B.1.2 Engagement with the initiative

#### *B.1.2.1 Regional Gateway*

Regional Gateway referral data indicated that Ben met the eligibility criteria given he had attained 16 years of age, had a mental disorder and an intellectual impairment. He had also exhibited violent or dangerous behaviour that caused serious harm to some other person and had exhibited behaviour which was reasonably likely to place him or some other person at risk of serious harm. He was also in need of intensive supervision and support and would derive benefit from receiving coordinated services.

Ben's referral was made because his service provider had experienced a recent deterioration in ability to support him, and no alternative supports were available. At the time the referral was made, Ben was experiencing secondary homelessness, and his mental health was unstable. He was also known to occasionally harm others. It was noted that Ben had a Guardian and financial administrator. Ben's level of service provider engagement and social connection was erratic.

The Regional Coordinator advised that Ben's referral was endorsed by the Regional Panel primarily because he was not eligible for any supports that could be offered by the Region (given he did not appear to meet the necessary diagnostic criteria for eligibility

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for mental health services or disability support services). At the time of referral, Ben was accommodated in a service for individuals with an intellectual disability; however, his placement was unfunded due to not meeting the service's eligibility criteria. He was thus referred to the Panel given their broad approach to the Initiative's diagnostic criteria. His engagement with the Initiative ultimately legitimised his existing accommodation placement.

#### *B.1.2.2 Panel – determination of eligibility*

The Panel determined in November 2004 that Ben was an eligible person in accordance with the criteria described in Section 15, *Human Services (Complex Needs) Act 2003,* having been referred by DHS Disability Client Services and the referral being endorsed by the relevant DHS Regional Director. The rationale for eligibility is listed below.

- Ben was older than sixteen years of age.
- Ben appeared to have a mental disorder given he was reported to have mood and thought disorders. He is currently prescribed psychotropic medication for the management of these mood and thought disorders. Child and Adolescent Mental Health Services have reportedly provided a diagnosis of Aspergers Syndrome. Ben appears to have an intellectual impairment as he has displayed significant and lifelong deficits in his adaptive behaviour that require daily assistance to enable him to function within his living environment that may be attributed to the interaction between a mental disorder and cognitive deficits.
- Ben has exhibited violent or dangerous behaviour that has caused serious harm to others, particularly in his living environment.
- Ben would derive benefit from receiving co-ordinated services and is in need of intensive supervision and support as indicated by the following factors:
  - he experienced extreme difficulty in accessing appropriate supports due to his inability to meet the respective eligibility criteria for current programmatic service responses; and
  - Ben has a critical need for an integrated assessment and service response that is facilitated beyond current program boundaries and enables his accommodation and personal support needs to be met within his rural community.

The Panel made the following observations during the session:

- the learning from an integrated assessment based on a full understanding of Ben's individual needs, an associated review of current service system capacity and the identification of opportunities to reduce barriers to service access will be fundamental to the development of a comprehensive and co-ordinated service response;
- the significant systemic issues associated with the provision of support and the need to strengthen capacity and authority to develop creative approaches that urge and

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support local services to appropriately 'stretch' boundaries to enable an integrated service response is noted; and
- it is noted that undertaking an assessment of Ben's capacity for community based living, whilst he is residing in a highly structured institutional setting, may require confirmation of his previous experience and history in the community.

Ben was referred to Care Plan Assessments Victoria (CPAV) for an assessment and the development of a draft care plan.

### *B.1.2.3 CPAV – assessment and care plan development*

During the development of Ben's assessment and care plan, CPAV undertook consultations with between 21 and 40 stakeholders, including the person Ben had a personal relationship with, DHS Disability Client Services, and Ben's Guardian. They also met with Ben on four occasions. Ben was an active participant in the assessment process and carefully considered what he would like to gain from participating in the Initiative. He found the assessment and draft care plan process somewhat stressful as he was asked to consider for a range of issues the outcomes he would like for himself within these areas. Throughout the assessment and draft care plan process, Ben remained friendly and cooperative with CPAV.

Psychometric tests were also administered for assessment purposes; these included the Wechsler Adult Intelligence Scale Version 3 (WAIS-III), State Trait Anger Expression Inventory and a Clinical Interview.

The draft care plan for Ben developed by CPAV identified goals in relation to housing, health and wellbeing, social connectedness, safety, service system responsiveness, care plan coordination, case management, brokerage, and care plan duration and review.

Regarding Ben's housing needs, it was recommended he continue to reside at his existing location; that all decision's regarding Ben's accommodation be made in consultation with, and have the approval of, his Guardian; that his Guardian continue in the role and that Ben continues to have an Administrator appointed through State Trustees.

In regard to Ben's health and wellbeing, the care plan recommended that Ben's medication be reviewed and that he undergo a neurology assessment. It also suggested he be provided with regular medical health checks and be referred to a dietician and an optometrist. It was recommended that Ben's presentation of Aspergers Syndrome be monitored and consistently managed.

As to social connectedness, suggestions were made as to maintaining boundaries regarding his existing relationships; that he be encouraged and supported to maintain his relationship with his father; that he continue to receive Interchange services as per current arrangements; and that education and vocational training activities be sought for



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him. The care plan also recommended that Ben attend anger management (which was also mentioned in relation to safety) and social skills training sessions.

In regard to safety, the recommendation included Ben to attend stress management interventions, that those with whom he has an existing relationship be made aware of the potential danger he presents and that contact be structured and supervised. The creation of a behaviour management plan was also suggested, as well as putting in place environmental controls and supports. It was also suggested that female staff working with Ben be made aware of the potential risks to them.

As to service system responsiveness, it was recommended that Ben's current care team be provided with support and assistance, including professional development. It was also suggested that DHS Disability Services review his support annually and that he continued to be case managed by his existing service. In addition, it was recommended that a single point of contact be established for the person that Ben had a personal relationship with and that this person not have contact or involvement in services providing direct support to Ben.

It was recommended that Indigo be appointed as Ben's Care Plan Coordinator and to provide support for the current service system and be responsible for all communication with the person Ben had an existing personal relationship with. (given the disruption and difficulty this person had caused previous service providers). Indigo was also to provide opportunities for capacity building and professional development for Ben's care team.

The care plan suggested that Ben's existing service provide case management and that decisions made by the case manager occur in consultation with Ben's care team and with the consent of the plenary guardian.

Regarding brokerage, the draft care plan recommended that $5 000 be allocated for the purpose of staff training and $3 600 be allocated for the purpose of facilitating family contact. It was suggested that the care plan be implemented for an initial period of 12 months and be reviewed initially after three months.

#### *B.1.2.4 Panel – care plan determination*

The Panel received an Assessment Report in March 2005 and Ben's draft care plan in April 2005. The Panel met in May 2005 to determine recommendations in Ben's draft care plan, the appointment of a Care Plan Coordinator and expenditure of any funds recommended within his draft care plan.

The Panel determined that the draft care plan provided sufficient information and an appropriate system of care for Ben. The Panel also determined that Indigo be the Care



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Plan Coordinator. The Panel allocated $8 600 for brokerage for staff training and facilitating family contact.

In addition, the Panel determined that the care plan should remain in place for one year from the date of determination and that it review the care plan in three months, as was suggested in the draft care plan.

#### *B.1.2.5 Indigo – care plan coordination*

The main focus of the Care Plan Coordination role with this client was to assist the case management service to enhance their capacity to support Ben and his support services so he could receive the level of care he required. In line with the recommendations of the care plan, Indigo has arranged specialised training for the staff working with Ben at his accommodation unit. Indigo has weekly telephone contact with at least one member of Ben's support network and has successfully established itself as a facilitator – enabling information to be shared and clear communication paths between different services to be established.

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# C Client selection for engagement with CPAV and the Panel

## C.1 Case Study 2

*"Andrea" felt that the initiative would help her and her family develop a better way of life by providing her with suitable accommodation and supporting her to reconnect with the community. Andrea was aged between 35 and 40 years of age.*

### C.1.1 Case history

Throughout her life, Andrea has experienced trauma and loss as a result of the deaths of her child and immediate and extended family members and the separation from her sibling. Andrea has a history of self-harm, she has been diagnosed with a range of physical and mental health conditions and has substance abuse issues. Andrea has engaged in serious criminal activity, experiences a significant level of isolation, both from the community and her family, and has frequently moved residences. Andrea and her family have had interaction with the Child Protection Services and support systems.

### C.1.2 Engagement with the Initiative

#### *C.1.2.1 Regional Gateway*

Andrea was referred to the Regional Gateway by mental health services. Her referral data indicated that Andrea met the eligibility criteria given she had attained 16 years of age; had a mental disorder and was an alcoholic or drug-dependent person. Further, it indicated that Andrea had exhibited violent or dangerous behaviour that caused serious harm herself or some other person and had exhibited behaviour which was reasonably likely to place herself or some other person at risk of serious harm. Andrea was also deemed to be in need of intensive supervision and support and would derive benefit from receiving coordinated services.

Andrea was socially excluded and had limited service provider engagement, although an advocate was assisting her. Andrea had made previous suicide attempts and also had chronic health issues. At the time of referral, Andrea was experiencing secondary homelessness.

The Regional Coordinator advised that Andrea was referred to the Panel for consideration given the view that the high level of support she was receiving from mental health services was unsustainably high, although essential. The rationale behind the referral was to ensure the high level of support was continued, the Regional Panel was concerned that if the level of support was not maintained that this would impact on Andrea's accommodation, parenting, and family relationships and would result in an escalation of self harming behaviour. Alternative supports had been previously



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considered (eg Psychiatric Disability Rehabilitation and Support Services), but the referrals to these services had not been accepted given Andrea's complexity.

#### *C.1.2.2 Panel – determination of eligibility*

The Panel determined in December 2004 that Andrea was an eligible person in accordance with the criteria described in Section 15, *Human Services (Complex Needs) Act 2003,* having been referred by a Community Mental Health Service and the referral being endorsed by the relevant DHS Regional Director. The rationale for eligibility is listed below.

- Andrea was older than sixteen years of age.
- Andrea appeared to have a mental disorder. This was substantiated by reports from psychiatrists, which provided a formal diagnosis of on-going major depression with psychotic features; she was being prescribed psychotropic medication as part of a Community Treatment Order under the *Mental Health Act (198).* Her significant number of psychiatric in-patient admissions in the preceding four years also demonstrated her mental illness.
- The Panel agreed that Andrea appeared to be an alcoholic or drug dependent person within the meaning of the *Alcoholics and Drug-dependent Persons Act 1968* given the apparent synergy between her use of alcohol and prescription drugs and her harmful behaviour towards herself or others.
- Andrea had a history of self-harming behaviours which have intensified since the death of her daughter in 2000, and there were also reports of and a number of criminal charges involving significant threats and violent behaviour towards others, including family, service providers and strangers.
- The Panel also agreed that Andrea would derive benefit from receiving coordinated services and is in need of intensive supervision and support, as indicated by the following factors:
  - during recent years, Andrea has required and been sustained by frequent and sometimes lengthy in-patient psychiatric admissions and intense (daily) community based outreach support;
  - she has required monitoring and oversight of her medication for both her physical and mental health needs;
  - the extensive efforts at co-ordinated care currently being undertaken appear to go beyond the usual expectations and capacity of the existing service system in the long term;
  - Andrea may benefit from further consideration of the interplay between elements, such as her past trauma, inappropriate use of alcohol and prescription medication, her mental state and her physical well being; and
  - it appears there is an opportunity to identify Andrea's potential for engagement in long term counselling and support that utilises her intelligence and history of episodic stability and is directed towards improved resolution of her past loss and trauma.

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The Panel also observed during their deliberations the extensive efforts and commitment of the current key health and welfare professionals. They also suggested that consideration be given to whether there was the potential for family based interventions that would help provide Andrea greater stability. The Panel also observed that a specific focus on her history of alcohol and drug use may be helpful.

### *C.1.2.3 CPAV – assessment and care plan development*

During the development of Andrea's assessment and care plan, CPAV undertook consultations with between 21 and 40 stakeholders, including Andrea and her case workers, as well as a range of services she was engaged with including Psychiatric services at six hospitals; Child Protection Services; Aboriginal Housing Services; her husband and child.

The draft care plan for Andrea developed by CPAV identified goals in relation to housing; health and wellbeing; social connectedness; safety; service system responsiveness; care plan coordination; case management; brokerage; and care plan duration and review.

The care plan suggested that Andrea relocate to a larger home, that this be leased in her and her husband's name, and be specifically geographically located.

In regard to health and wellbeing, the care plan suggested that Indigo visit Andrea three days a week for a couple of hours each visit for socialisation and assisting Andrea to identify activities that she might enjoy. It was suggested that case management for Andrea continue to be provided by her existing Community Mental Health Centre team for all medical and mental health issues. In addition, that Service A remains as secondary consultants and that her existing Community Mental Health Centre and Indigo share joint overall case management and meet regularly.

As to social connectedness, this would be achieved through the three days a week visit from Indigo but that Andrea also receive family and individual counselling for grief and loss and that respite be provided for Andrea's child.

Regarding safety, the draft care plan recommended that, if her safety was at risk, her existing Community Mental Health Centre Treatment Plan be followed. It was also suggested that drug and alcohol counselling be reviewed by her case manager and pursued for Andrea when deemed appropriate. It was also recommended that home visits to Andrea occur in pairs.

The draft care plan provides detailed recommendations for service system responses for services engaged with Andrea or potentially exposed to her. They include: her existing Community Mental Health Centre; Mobile Support Treatment Team; the relevant area



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based Crisis Assessment Team; emergency departments; Psychiatric Unit responses; and police responses. A recommendation is also made that her existing Community Mental Health Centre introduces Indigo to Andrea and her family.

Indigo was recommended to be Andrea's Care Plan Coordinator, given the high workload on her existing case manager; however, case management was recommended to remain with her existing Community Mental Health Centre.

As to brokerage, the draft care plan recommended the following:

- $1 000 to provide counselling as required for Andrea and her husband;
- $1 000 to provide respite to Andrea and her husband;
- $21 000 for respite for Andrea's child;
- $30 000 for 5 workers to assist the Community Mental Health Centre; and
- $5 000 for Community Mental Health Centre for additional resources.

It was suggested that the care plan remain in place for a period of 12 months and be reviewed after three months.

#### *C.1.2.4 Panel – care plan determination*

As at 26 September 2005, the draft care plan for this client had yet to be determined.

## C.2 Case Study 3

*"Carl's" motivation for participating in the Initiative was to obtain alternative accommodation. Carl was aged between 25 and 30 years.*

### C.2.1 Case history

During his childhood and adolescent years, Carl experienced frequent family abuse, had multiple moves in his accommodation (including treatment programs) and attended several schools. Carl has criminal convictions for sexual and violent offending. Carl has been diagnosed with an intellectual disability and psychological conditions. His treatment progress has been minimal and further treatment gains are expected to be negligible.

### C.2.2 Engagement with the initiative

#### *C.2.2.1 Regional Gateway*

The Regional Gateway data indicated that Carl was in custody and referred by disability client services. Carl also had poor mental health and was frequently violent to him and others. Carl required communication assistance and was supported by an advocate. The



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referral data noted that Carl had been involved with the most intensive residential treatment program in the state of Victoria, but had ceased to derive any benefit from the intervention. Carl was residing in a secure environment under legal bind of a Good Behaviour Bond. Carl's level of service provider engagement was erratic, and he was socially excluded. Carl frequently engaged in behaviour that harmed others and was a known offender. He was also a risk to himself (not suicide) and engaged in occasional high-risk behaviour.

In terms of the eligibility criteria, the referral data indicated that Carl had attained 16 years of age; had a mental disorder and an Acquired Brain Injury; and that he had exhibited violent or dangerous behaviour that caused serious harm to some other person. He had also exhibited behaviour which was reasonably likely to place some other person at risk of serious harm. Carl was also in need of intensive supervision and support and would derive benefit from receiving coordinated services.

The Regional Coordinator advised that the referral was made to the Panel given there were no other service responses available.

#### *C.2.2.2 Panel engagement*

The Panel determined in September 2004 that Carl was an eligible person in accordance with the criteria described in Section 15, *Human Services (Complex Needs) Act 2003,* having been referred by DHS Disability Client Services and the referral being endorsed by the relevant DHS Regional Director. The rationale for eligibility is listed below.

- Carl was older than sixteen years of age.
- Carl had an intellectual impairment as evidenced by his Declaration of Eligibility, (dating from1994) for services under the Intellectually Disabled Persons' Services Act 1986.
- Carl also appeared to have a mental disorder. Carl had a history of sustained sexual abuse since two years of age which was deemed to be a powerful indicator of the potential for mental disorder. Further, his psychological history, his problems with impulse control, his apparent lack of affective response and other difficulties, are sufficient to indicate an appearance of mental disorder.
- Carl had exhibited violent or dangerous behaviour that has caused serious harm to others.
- The Panel agreed that Carl would derive benefit from receiving coordinated services. They agreed that he was in need of intensive supervision and support as he required a coordinated and creative approach to establishing a service response that is built on his fundamental need for stable and secure accommodation that provides on-going structure and routine and recognises the apparent need to protect other members of the community.

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CPAV commenced an assessment and development of a draft care plan for Carl in response to the Panel's determination.

On 31 March 2005, the Panel determined to request further exploration within the relevant DHS Region regarding the appointment of an appropriate Care Plan Coordinator for Carl.

Having sought this clarification, the Panel was formally advised, in writing on 11 July 2005, the Regional Director that the "issues in relation to this particular client have been resolved at a regional level" and that the referral is withdrawn. The Panel Chairperson responded in writing on 28 July 2005 and has asked that the Region ensure that Carl was advised in an appropriate and timely manner of the change to the oversight of his ongoing care. This concluded Carl's current involvement with the Initiative.

The Regional Coordinator has advised that the referrer withdrew the referral because a service option which had not been previously available became available (specifically, an accommodation placement which was deemed to be the only suitable placement). Reportedly, the draft care plan which had been developed by CPAV was also a consideration in withdrawing the referral. It was felt that the care plan affirmed the approach that was already being taken; therefore there was not a pressing need to pursue the referral.

## C.3 Case Study 4

*"Dana" was referred to the Initiative in advance of her transition from the child protection system to the adult service system. This was to ensure she would continue to receive intensive outreach case management services after she turned eighteen.*

### C.3.1 Case history

Dana's early years were characterised by involvement with the child protection system, unstable and broken down placements. Dana operates at a level consistent with a person who has an intellectual disability. The times when Dana absconds from placement, she has exposed herself to risks, including violence (both as victim and perpetrator), criminal activity, serious health issues and risk of serious injury or death, and substance abuse.

### C.3.2 Engagement with the Initiative

#### *C.3.2.1 Regional Gateway*

Dana was referred to the Initiative by Child and Adolescent Family Welfare Services. Dana is identified as being of Aboriginal Torres Strait Islander descent. Dana

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experienced poor mental health and had a history of offending. At the time of referral, Dana was in stable accommodation, and her family was prepared for her involvement in the Initiative.

In terms of the eligibility criteria, Dana had attained 16 years of age; she also had an acquired brain injury, intellectual impairment and was an alcoholic or drug-dependent person. Dana had exhibited violent or dangerous behaviour that caused serious harm to her or some other person. Dana had exhibited behaviour which was reasonably likely to place her or some other person at risk of serious harm. It was identified that Dana was in need of intensive supervision and support and would derive benefit from receiving coordinated services.

The Regional Coordinator indicated that Dana's referral proceeded to the Panel given the significant risk of her dropping away from support provided by the services system due to her moving out of the Child Protection system. The Regional also saw that Dana met the eligibility criteria given her ABI, intellectual disability, drug taking behaviour and the risk of harm she continually placed herself in. The Region was also seeking to provide some continuity in service support – Dana moved from being supported by Child Protection Intensive Case Managements services at the NGO she was receiving support from, to their adult support services.

#### *C.3.2.2 Panel – determination of eligibility*

The Panel determined in August 2004 that Dana was an eligible person in accordance with the criteria described in Section 15, *Human Services (Complex Needs) Act 2003,* having been referred by a non-government intensive case management service provider and the referral being endorsed by the relevant DHS Regional Director. The rationale for eligibility is listed below.

- Dana was older than sixteen years of age.
- Dana had an Acquired Brain Injury, as described in the neuropsychological assessment reports and as reflected in the accounts of her early childhood history.
- Dana had an intellectual impairment as evidenced by her Declaration of Eligibility (dated 2000).
- Dana had demonstrated (by her self-report) the daily need for substances (chroming).
- Also, Dana had exhibited behaviour which is reasonably likely to place her at risk of serious harm. Dana's age, established pattern of substance use, sleeping rough, prostitution and sexual encounters with older men also demonstrate her risk of harm.
- The Panel determined that Dana would derive benefit from receiving coordinated services and is in need of intensive supervision and support for the following reasons:
  - o given her age and developmental stage and her impending transition from the children's and young person's service system to adult services;



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- o given that the intensive case management response has been necessary to sustain her and facilitate her connection to relevant support services and it is likely that continuation of this intensive supervision will be necessary; and
- o given the nature of her developmental experiences, cognitive deficits and apparent substance use and the value of an integrated assessment and pro-active case plan at this time in her life.

#### *C.3.2.3 CPAV – assessment and care plan development*[3]

Dana was referred to CPAV in September 2004, and a draft care plan was developed, the aims of which differed for Dana before and after her 18th birthday.

During the development of Dana's assessment and care plan, CPAV undertook consultations with between 40 and 60 stakeholders, including Dana's intensive case management service; secure welfare; Child Protection Services; Disability Client Services; Juvenile Justice; a local Magistrate's court; various non-government organisations; Legal Aid; education services and allied health professionals. Twenty-one contacts were also made with Dana directly, either by face-to-face meetings or by telephone.

Throughout the assessment process, Dana demonstrated a high need for control of the relationship and exercised this by not responding to questions and by making demands of CPAV before agreeing to meet with them. Dana's engagement with CPAV during the assessment and care planning process could be characterised as passive – although in terms of personal interaction, she was initially hostile and aggressive. Dana had difficulty identifying goals and the aspects of her life that she wanted to change and was unwilling to engage in conversation regarding future plans. CPAV felt that Dana's behaviour was an attempt to present as tough, independent and 'street-smart'. In spite of this, Dana appeared vulnerable, with much of her presentation due to her difficulty in trusting and allowing others to help her.

Prior to turning 18, the draft care plan indicated that the aims were to commence the transition of Dana to adult services, introduce the services that will be involved with Dana after she turns 18 to both Dana and her family, introduce service providers to each other, and develop a shared understanding of roles and responsibilities in relation to Dana.

After Dana turns 18, the aims of the care plan were to promote stability for Dana, with the first priority in this area being in her accommodation; avert crises; use the existing service system to provide support to Dana and her family; equip Dana with the knowledge and skills required to access services within the adult system; and encourage

[3] Note, a final version of the draft care plan was not available, the information presented is derived from the draft care plan.



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Dana to reflect on her needs (e.g., medical and sexual health, drug and alcohol services, leisure pursuits, education / employment) and support her in addressing these needs.

### *C.3.2.4 Panel – care plan determination*

The Panel received an assessment report and draft care plan in December 2004. The Panel agreed in principle with the proposed care plan but were unable to make a final determination and requested further clarification. The Panel received a revised draft care plan in January 2005, which included amendments consistent with the Panel's earlier concerns.

The Panel determined that the revised draft care plan provided sufficient information and an appropriate system of care for Dana. In particular, the care plan recognised the need for Dana to transition from youth to adult services.

The Panel also determined to make some further changes to the wording of the care plan and agreed to the Chairperson developing the appropriate wording for this purpose. These changes relate to:

- further analysis and interpretation of Dana's cognitive ability and the extent to which she is able to engage in the measures outlined in the plan; and
- further consideration of any impact of her Aboriginal origins.

The Panel met in February 2005 to determine Dana's care plan. The Panel determined that Dana's existing service provider should be Dana's Care Plan Coordinator. The Panel also agreed to allocate $57 097 in brokerage for the following services:

- 0.5 EFT position for intensive and flexible case management and family therapy ($45 000);
- contribution to Rental Support for 11 months at $827 per month ($9 097); and
- emergency accommodation in central business district for a 12 month period ($3 000).

The Panel determined that the care plan should remain in place for one year from the date of determination. The Panel also determined to review the care plan after four months.

### *C.3.2.5 Panel – care plan review*

The Panel reviewed Dana's Care Plan in July 2005. They noted that Dana had engaged with, and appeared to have developed a positive relationship with her adult services case manager during the three month review period; that her relationship with her mother had improved through the establishment of clear boundaries and strategies to provide



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structured support; but that Dana continued to experience periods of homelessness and transience, with significant associated risks to her health and personal safety.

The Panel therefore requested that Dana's care plan be further developed in the context of her transience and risk taking behaviour. The Panel also noted areas for future care plan development and requested that the care plan be reviewed again in November 2005.

## C.4 Case Study 5

*"Eric" is motivated to participate in the Initiative so that he can receive support to overcome alcohol dependency and to help him get back to work and engage more meaningfully with the community. Eric was aged between 40 and 45 years.*

### C.4.1 Case history

Eric has psychological and neurological conditions. His early years involved parental abandonment, being the victim and perpetrator of sexual abuse, and the death of an immediate family member. Later in life, Eric engaged in criminal behaviour. Eric also has a history of self-harm. Eric currently experiences substance abuse issues and has limited contact with family

### C.4.2 Engagement with the Initiative

#### *C.4.2.1 Regional Gateway*

Eric was referred by a service supporting people with Acquired Brain Injury. He was identified as engaging in high-risk behaviours and was likely to harm himself (including possible suicide). Eric was disengaged from the service system and has poor mental health and chronic health issues. He was not known to offend and was in stable accommodation.

In terms of meeting the eligibility criteria, Eric is of eligible age; he also had a mental disorder, acquired brain injury and intellectual impairment. Eric is alcohol dependant and had exhibited behaviour which was reasonably likely to place him at risk of serious harm. He was also in need of intensive supervision and support and would derive benefit from receiving coordinated services.

Eric's referral proceeded beyond the Regional Gateway in light of the difficulties his local community had in providing him with adequate support. Given his rural location, supports were not available, and public transport was not available to enable him to access support. The community had 'tolerated' Eric's behaviour which had for some time been disruptive and confronting, the community itself was beginning to wear, and its capacity to support him (the local hospital, police and General Practitioner) had

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declined. The Regional Coordinator felt that, if Eric resided in Melbourne, where more supports were available and there was access to public transport, there may not have been a need to refer him to the Initiative, also, that in an urban location, his behaviour (as perceived by the community) may not have been so confronting. To enable his support needs to be met, Eric was relocating (as a part of his care plan) to a regional centre where he would have access to support, such as day programs and other psychosocial supports.

#### *C.4.2.2 Panel – determination of eligibility*[4]

The Panel considered Eric's eligibility first in December 2004, having been referred by a community health service and having the referral endorsed by the relevant DHS Regional Director. The Panel determined that Eric met the criteria described in Section 15 (a), (b) and (d) of the *Human Services (Complex Needs) Act 2003*. The Panel sought additional information in accordance with Section 16 (c) of the Act to assist in making a decision about eligibility under Section 15 (c). With the provision of additional information, the Panel determined in February 2005 that Eric was an eligible person. The rationale for the decision is referred to below.

- Eric was older than sixteen years of age.
- Eric appeared to have an Acquired Brain Injury as evidenced by a neurological report from linking his brain functioning to his long-term heavy alcohol intake; suggesting that this, together with a previous brain injury, is diagnostic of an acquired brain injury.
- Eric appeared to be an alcoholic, as evidenced by his long and persistent history of alcohol dependence that has required treatment.
- The referral documentation suggested that Eric also appeared to have a mental disorder and an intellectual impairment; however, the Panel did not share this view.
- On the basis of the additional material provided, the Panel determined that Eric exhibited behaviour which was likely to place him or others at risk of serious harm. The evidence consisted of Police reports and concern regarding the apparent escalation of Eric's inappropriate behaviour; at least one report of a significant indecent sexual incident; pending assault charges; and concern on the part of the referring service providers regarding Eric's risk to himself through a mix of suicide ideation and incapacity associated with intoxication.
- The Panel agreed that Eric required supportive supervision to protect his own health and safety and possibly that of others. The Panel noted Eric's rural town circumstances and the care and supervision fatigue experienced by the community and service providers. The Panel also noted the suggestion of re-location to another region for this person.

[4] Remaining data provided to inform the preparation of this case study was provided in draft format that was not suitable to draw on for information regarding the draft care plan.



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- At the time of reporting Eric had been referred to CPAV for assessment and the development of a care plan.

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# D Client selection for engagement with Regional Gateway

## D.1 Referral – Case Study 6

At the time of being referred to the Initiative, Frank was experiencing secondary homelessness; had mental health issues and intellectual impairment; was disengaged from his family; had exhibited high-risk behaviours (including risk of harm to others); and was known to offend.

Referral information noted that there was no agreement by service providers on service options and, although service options were available, they had not been explored.

### D.1.1 Feedback from Regional Coordinator

Frank's application did proceed beyond referral because the Regional Coordinator was able to facilitate meetings between various local service providers and a coordinated care package was developed for Frank that included ongoing case management.

## D.2 Referral – Case Study 7

"Greg" was referred by a drug treatment service. Greg had stable accommodation; he had limited engagement with the service system; had an acquired brain injury; had substance abuse issues; was known to frequently harm others and was a known offender. He was also described as engaging in frequent high-risk behaviour but was not a risk to himself. Greg was deemed to be ineligible and was not referred to the Panel because exploration of alternate service options had not occurred.

The referral data noted that Greg was in need of intensive supervision and support and would derive benefit from receiving coordinated services.

### D.2.1 Feedback from Regional Coordinator

The Regional Coordinator indicated that Greg did not proceed beyond referral because the referrer was able to locate an alternative service option, thus obviating the need for Greg to engage in the Initiative further.

## D.3 Consultation – Case Study 8

"Gina" was a teenager when referred the Initiative by drug treatment services. As well as having mental health issues identified, Gina was also a risk to herself and engaged in frequent high-risk behaviour. The referral data indicated that a case conference was held, and her support issues were addressed at the regional level.



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In terms of the eligibility criteria, Gina was of eligible age, had a mental disorder and intellectual impairment, and exhibited violent or dangerous behaviour.

### D.3.1 Feedback from Regional Coordinator

Gina has been through the consultation process twice. At first contact, the Regional Coordinator recommended service options that had not been tried previously. Responsibility for implementation of these alternative support options was allocated to the Gina's existing case manager. Eventually, the service options were exhausted and her case was resubmitted to the Initiative. Gina is again at the consultation phase of the Initiative.

## D.4 Consultation – Case Study 9

"Harry" was referred to the Initiative from an Acquired Brain Injury service when he was middle-aged. Harry experienced social isolation, was known to offend, engaged in occasional high-risk behaviour and was a risk to himself. The regional data indicated that the issues facing Harry were resolved at the regional level following engagement of service providers.

In terms of meeting the eligibility criteria, Harry was of eligible age, had an Acquired Brain Injury, had substance abuse issues, and exhibited violent or dangerous behaviour that caused serious harm to himself or some other person and exhibited behaviour which was reasonably likely to place him or some other person at risk of serious harm. Harry was also judged to be in need of intensive supervision and support and would derive benefit from receiving coordinated services.

At the time of reporting Harry was still in the consultation stage with a decision yet to be made as to whether a referral to the Initiative would proceed.

## D.5 Consultation – Case Study 10

"Ian" was referred to the Initiative as a result of his unstable and poor mental health. Ian had erratic engagement with service providers, was socially excluded and was known to offend. He engaged in frequent high-risk behaviour and was at risk of harming himself.

Ian has a mental disorder, intellectual impairment and had exhibited violent or dangerous behaviour that caused him serious harm. He has also exhibited behaviour which was reasonably likely to place him at risk of serious harm.

### D.5.1 Feedback from Regional Coordinator

Even though Ian met the eligibility criteria, he was already in receipt of a substantial care package managed by DHS which involved intensive daily individual care. The

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Regional Coordinator decided that Ian would not derive any substantial benefit from the Initiative in light of his existing support arrangements. Ian's did not proceed past the consultation phase of the Initiative.

## D.6 Consultation – Case Study 11

"James" was referred by a mental health unit. At the time of referral, James was experiencing secondary homelessness, had erratic service provider engagement and poor mental and emotional health. James was also socially disengaged.

James has a mental disorder, intellectual impairment and was a drug or alcohol dependant person. He was in need of intensive supervision and support and would derive benefit from receiving coordinated services.

### D.6.1 Feedback from Regional Coordinator

This case did not proceed beyond the consultation stage of the Initiative because James' case manager had not exhausted all local service options, and the case was referred back to the local level to pursue alternative support options. The involvement of the Regional Coordinator helped resolve some of the challenges faced by James' case manager.

## D.7 Inquiry – Case Study 12

"Ingrid" lived in a remote area when referred by a mental health service provider. Ingrid was reportedly suicidal and was sensitive to stressors.

In terms of meeting the eligibility criteria, Ingrid had a mental disorder and intellectual impairment. She had also exhibited violent or dangerous behaviour that caused serious harm to her, and had exhibited behaviour which was reasonably likely to place her at risk of serious harm. It was also identified that she was in need of intensive supervision and support and would derive benefit from receiving coordinated services.

### D.7.1 Feedback from Regional Coordinator

Ingrid lived in a small, remote community with a network of informal supports and was already being case managed by both mental health and disability services. Ingrid did not proceed beyond inquiry stage because it was identified by the Regional Coordinator that Ingrid would not derive a substantive benefit from involvement in the Initiative and was therefore ineligible.

## D.8 Inquiry – Case Study 13

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"John" was referred by a drug treatment service because there were no other available supports. In terms of meeting the eligibility criteria, John was of the eligible age; had an Acquired Brain Injury and had substance abuse issues. John had also exhibited behaviour that was violent or dangerous and had caused serious harm to him and was likely to harm others. He was also in need of intensive supervision and support and would derive benefit from receiving coordinated services.

### D.8.1 Feedback from Regional Coordinator

The Regional Coordinator advised that, since this data was extracted, John's case had proceeded to the referral stage within the Regional Gateway.

## D.9 Inquiry – Case Study 14

The Regional Partnership Team made an inquiry on behalf of "Kyle". His referral was made due to his service providers' deterioration in ability to support him. Kyle did not proceed through the Initiative because he did not meet any eligibility criteria.

### D.9.1 Feedback from Regional Coordinator

Kyle had minimal interaction with the Regional Coordinator, and there was no substantial inquiry undertaken for this case; however, it was redirected to another DHS Region Regional Coordinator. This Regional Coordinator was not able to provide additional information regarding this case study.

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