

Multiple and Complex Needs Panel

Multiple  
and  
Complex Needs  
Panel

*Working with complexity –  
clients and silo like services*

Outside In conference  
Sydney  
May 2009

Prof. Margaret Hamilton (Chair)

## Outline

- Background to MACN initiative (Vic)
- Model of care/response
- Profile of clients / service response
- What seems to work? Learning (so far)
  1. Assessment & formulation
  2. Care Planning
  3. Care Plan Coordination
  4. Review
- Reflections on mental health & AOD services part in this

### ▪ **History**

Department of Human Services, January. 2003

‘Responding to people with multiple and complex needs project’. Client profile and case studies report.

[www.dhs.vic.gov.au/complexclients/](http://www.dhs.vic.gov.au/complexclients/)

Behaviours present significant levels of risk to community, staff and self (90% past incidents; 47% risk of harm to all 3)

High volume users of emergency services.

Significant accommodation issues – 35% homeless, short term or crisis accommodation.

91% are socially isolated, few have regular contact with family.

55% have chronic health problems

- History of concerns raised by service providers, clinicians, carers, OPA, police, magistrates and others – internal and external over several years.
- Varying attempts to deal with the problem over the years including development of specialist service responses and a number of different projects
- High cost individualised and tailored service responses provided on a case by case basis. Such methods of funding and providing service responses are not sustainable.
- Meetings held in early 2001 at instigation of Magistrates involved wide range of above people.

## Background: MACN Multiple & Complex Needs Initiative (Vic)

- History of concern (service providers, carers, OPA, Police, Magistrates & others)
- Stage 1 research 2002-03  
[www.dhs.vic.gov.au/complexclients/](http://www.dhs.vic.gov.au/complexclients/)
- Poor service outcomes - group with complex needs that challenged existing policy and legislative frameworks
- Service responses - lacking or inadequate - people refused services or excluded (eligibility requirements)

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## Legislation (2003)

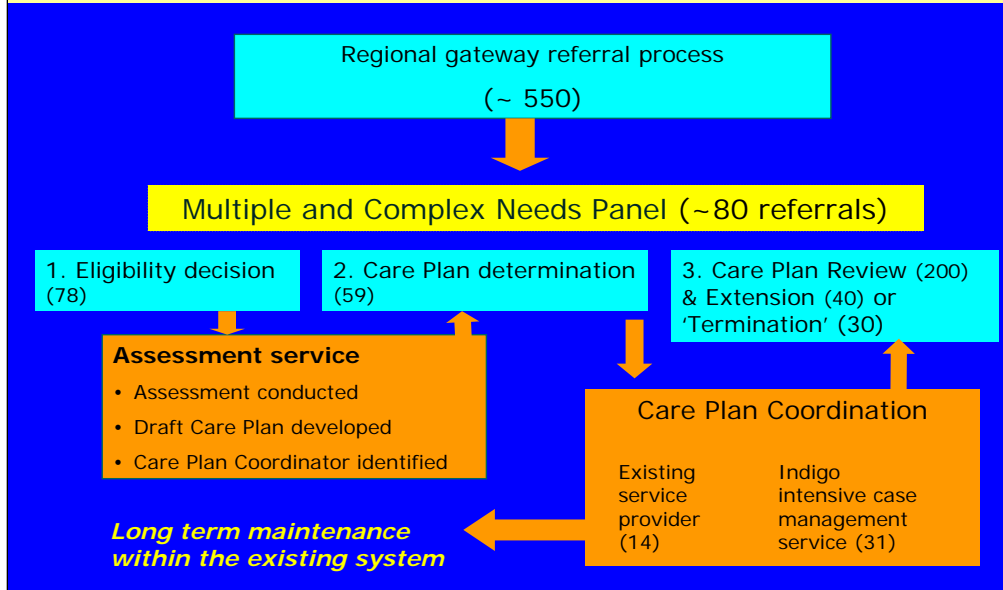
### **Human Service (Complex Needs) Act 2003:**

- established MACN Panel &
  - eligibility criteria
  - Multidisciplinary Assessment Service
  - Requirements for determination, oversight & termination of a Care Plan for each person
  - Appointment of Care Plan Coordinator
- Provision for information sharing

Not a preventative program but as a remedial response to an existing configuration of service challenges.

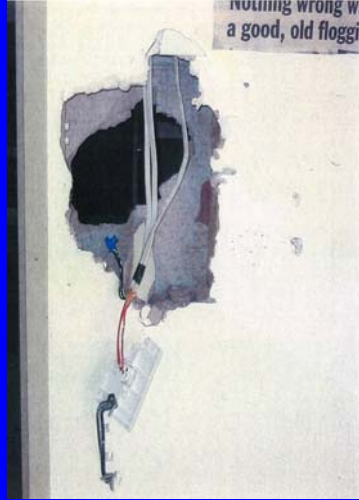
We now have five years of focused experience to guide the next stage - knowledge and practice emerging from this

# How People Currently Access MACN Initiative (#= ~)

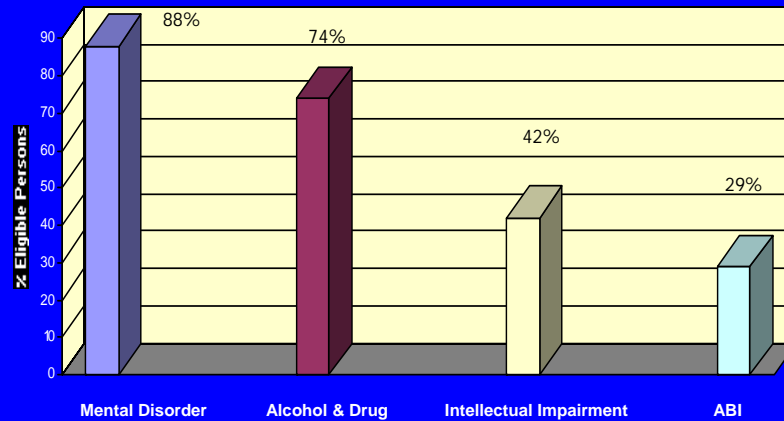


## ELIGIBILITY .... each AND....

1. 'Consent'
2. Age
3. Diagnostic criteria
4. Risk or danger
5. Need for support & supervision  
and could derive benefit ...



## Panel – Diagnostic criteria (65 individuals)



### 04-08 Data

Blue = mental disorder = 57

Burgundy = Alcohol & Drug = 49

Yellow = Intellectual impairment = 27

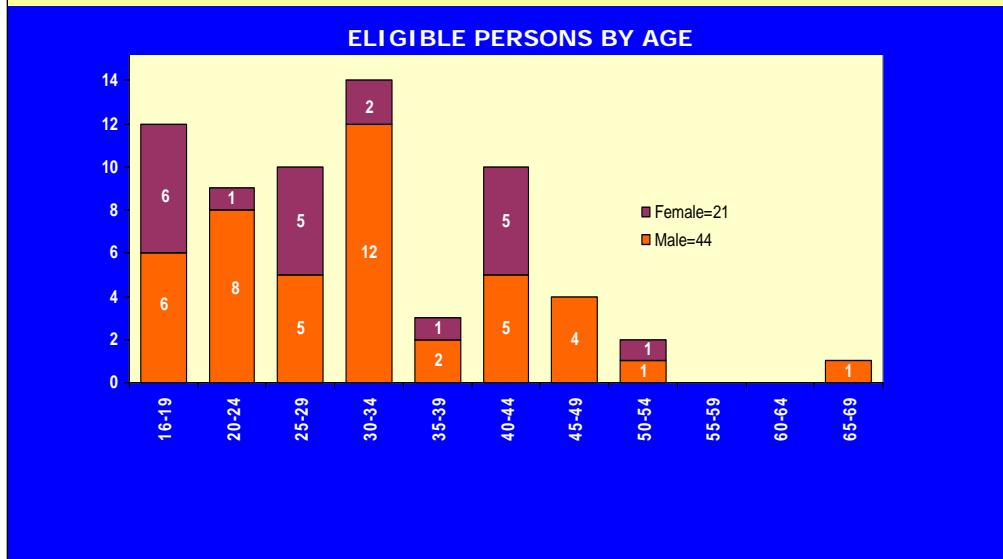
Aqua = ABI = 20

- Note also following further assessment under MACNI evidence of pre-existing ABI and other diagnoses sometimes emerge

- reports and trend analyses suggest increasing numbers of adults with dual diagnosis, dual disability and co-morbidities (or perhaps now more properly termed multi-morbidity).

- co-morbidity is widely considered so great that it is generally acknowledged to be the rule or expectation rather than the exception (Senate Select Committee on Mental Health 2006)

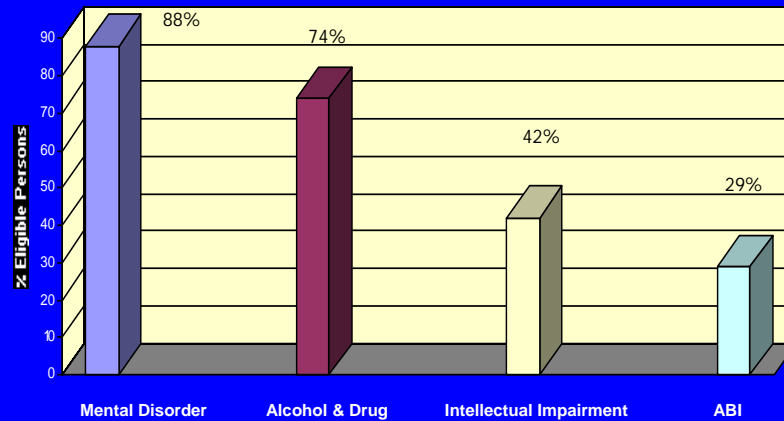
## Panel – operational information (65 individuals)



NB. Earlier operational data

NOTE: mostly in age from 16-35

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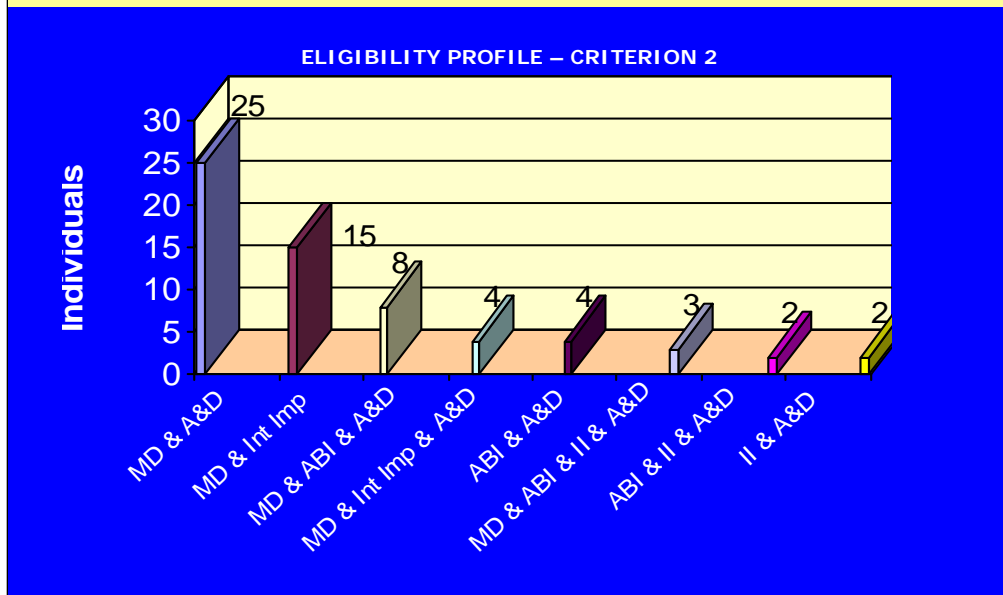
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## 'Diagnostic' Criteria Combinations

(65 individuals)



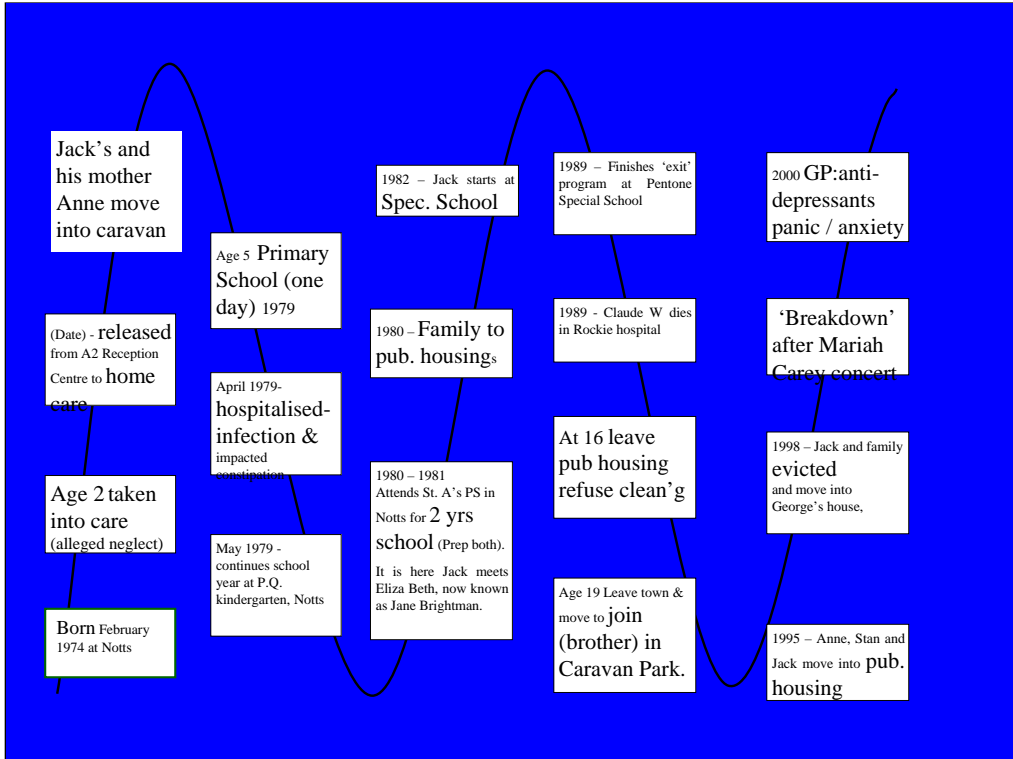
### NOTE:

1. High proportion re mental health  
45 : appear to have a mental disorder  
3 did not
2. Degree of complexity (on diagnostic criteria at least ....)

## *Reflections*

*(especially on Eligibility data)*

- **Accommodation** – from homeless chaos to restrictive /custodial  
*(one example of transitions)*
- **Earl(ier)** life trauma, loss, grief .... Neglect, abuse ...
- **General health** – 'underdone'
- **Lack of diagnostic clarity**
- **Dynamic status of diagnosis** - a slow slide into complexity
- **Service system & carers response(s)**
  - often extensive service histories, especially mental health & AOD
  - fatigue of services, workers, and family/carers
  - some 'extra-ordinary' positive practice



# Complexity practice development

## What seems to work...

### 1. Assessment and Formulation

Person  
Service system

### 2. Care Planning

### 3. Care Plan Coordination

### 4. Review

*Reflections on Assessment (s)  
(person) :*

- *Most people - many assessments over life time*
- *Some areas – lack of precision (eg: A&D)*
- *Focus often been on deficits –need to include resilience / resources*
- *Persons perception of situation/opportunities*
- *Family & carers (some need more attention)*

*Assessment observations -  
service system(s)*

- *Service system assessment / analysis – less systematic than person*
- *Commitment & humane concern – necessary/not sufficient*
- *Service system capacity (??  
Resources; training/experience ..)*

## Case study: LOUISE (say - 40 yrs)



- **Referred** after 2 yrs in acute psych ward (Regional city) following admission incidents of community risk
- Variously diagnosed :
  - Longstanding conversion disorder, Phobic anxiety disorder, factitious disorder, chronic disturbance of thought and perception, intermittent mood disturbance (suicide attempts), extensive disability including blindness,
  - seizures and weakness – early attributed to her mental disorders

## Case study: LOUISE (say - 40 yrs)



- Long history dependence on others (Functionally blind since age 7 & attended Blind School)
- lived all her life with aged parents (now in 80's) – unsustainable
- one brief report of her being 'interested in needlework' while on a ward
- Significant physical health issues - epilepsy with +++ seizures.
- \* Heavy toll on services / significant fatigue including emergency services, local community members and health services.

## Practice development... Assessment

### What seems to work. . .

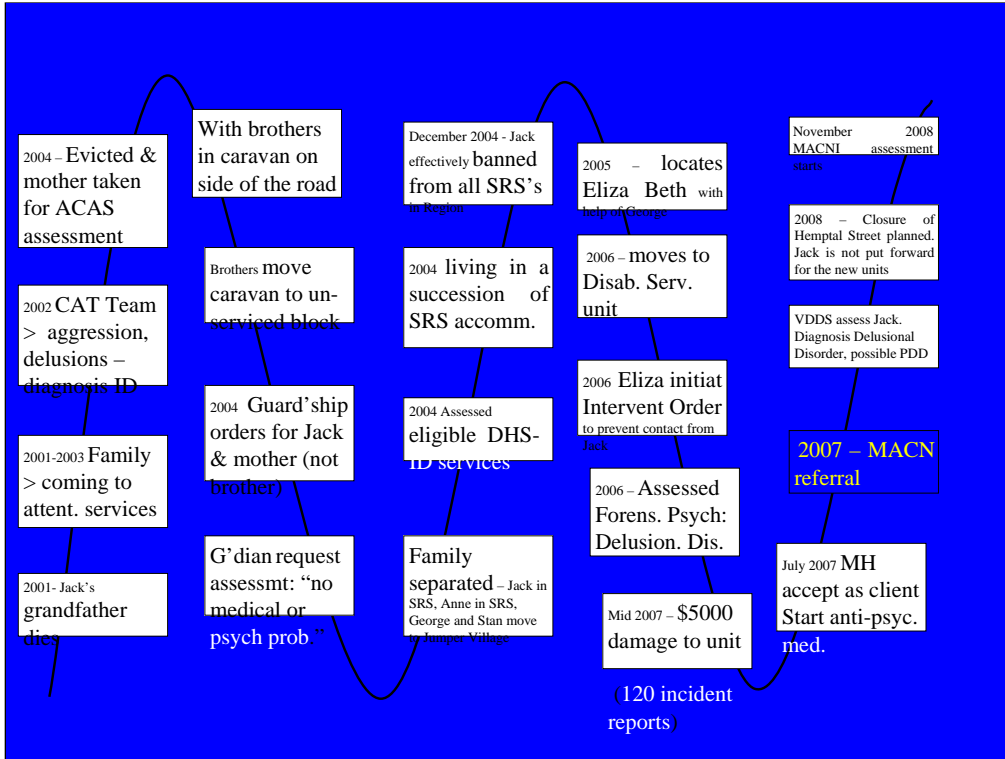
#### Assessments that include:

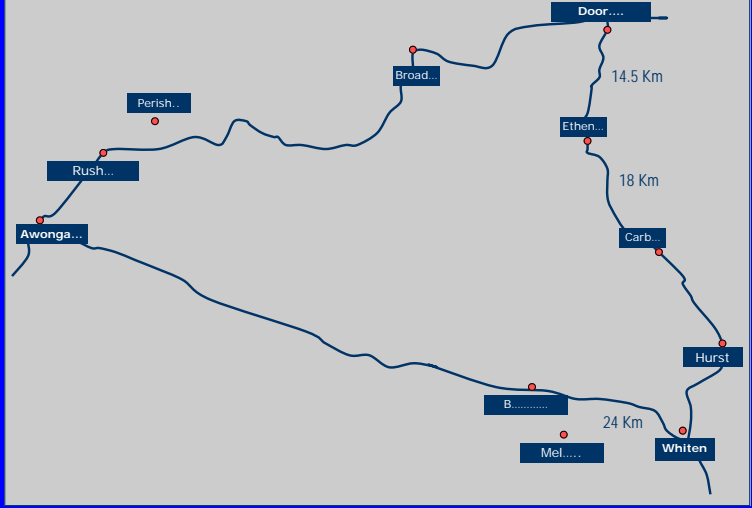
- a person-centred assessment
- expert/specialist knowledge
- analysis of the **service system** & the history of the person's experience of services
- knowledge of service eligibility and access
- Functional meaning of 'diagnoses' or expert assessments

Assessment as an ongoing process

### Formulation

•The concept of formulation (A formulation can be defined as a hypothesis about the person's difficulties, which draws on data from the biological, psychological and social domains, and uses a stated theory or theories in its development. It has been described as a story constructed rather than discovered). “The concept of formulation might usefully be thought of as a piece of creative curiosity posing interventions worth trying to avert escalating chaos” (Smith, 2008).





Complexity  
practice development

## What seems to work...

1. Assessment and Formulation

## 2. Care Planning

3. Care Plan Coordination

4. Review

## 2. Care Planning – (Legislated):

- Stable housing
- Health and wellbeing
- Social connectedness
- Safety
  
- Service system responsiveness
- Agreements (Individual and Service Provider/s)
- Brokerage (\$\$) [\$3,000 - \$860,000 a year]
- Notification(s)

Early articulation of what might need to be covered in these.

## Case study: LOUISE (Continued)

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### Under Care Plan (Indigo CPC):

- relocated to private cluster housing with 24 hr care (X2 initially staff)
- Found to be higher functioning than fellow residents.
- Specialist clinical psychiatrist (Priv) & liaison (Epilepsy + psych. + AMHS + GP facilitated by CPC).
- Alternative accom. – hi level support initially...gradual reduction
- Return w/end visit to parents - return of dysfunctional behaviours & hi anxiety
- Guardianship initiated

### Significant achievements at 'termination':

- She was blind and now sees
- Stable mental health (fragile but under careful management)
- Stable epilepsy (few seizures in 2 years under MACN cf. multiple seizures/pseudo seizures before)
- States happy to be settled in Melbourne
- Now clear assessments (including ID of significant capacity in some areas)

**Challenge:** COST / Sustainability (?)

## Practice development... Care Planning

### **Effective Care Planning requires:**

- a clear assessment process leading to formulation
- consistency of purpose (& hope)
- respectful collaborations
- clarity about roles and functions (CPC/CM)
- sharing (info., risk, learning/training, thinking including hunches, feedback, indicators of change)
- legitimated authority

## *Reflections on Implementation of Care Plans:*

- **Engagement** ..... Necessary & sometimes most difficult
- **Continuous assessment** informing plans
- **Goals & expectations / Time**  
*Long service system histories so what's achievable? (maximum of 2 [3] years)*
- *Positive framing & opportunity*
- *Need to keep the usual services involved*
- **Sustainability** (?)

## Care Plan "Termination" – the task

To have explored, understood (?), tested and trialed options, followed (including in and out of prison), discovered, established;

through dialogue & discussion and sharing risk, what :

- The persons **interests** are and
- their **capacity** (or likely capacity), .... & what's
- The **least restrictive**,
- **Least expensive**
- Way in which this can be achieved.

## Case study: LOUISE (Continued)



### **Dilemma at termination:**

– cost of accommodation & care relatively high  
[if compare with standard community housing  
option but not if compared with cost of acute  
psych bed].

.....

- **Timing – can't push (possible ongoing improvement ?)**
- **Some terminate with standard services; some with extra package; all need case management**

Complexity  
practice development

## What seems to work...

1. Assessment and Formulation

2. Care Planning

**3. Care Plan Coordination**

4. Review

## Care Plan Coordination:

- Not crisis management & not just settled state – need vision (short, med., long term)
- What can be learned? Test hypotheses (n=1)
- Systemic focus

### Skills needed in a CPC include:

- Communication
- Coordination and administration
- Use of persuasive authority
- Creativity / innovation

Practice development...  
Care Plan Coordination

**The main focus of activity  
for the Care Plan Coordinator is not  
with the client but with the services  
that provide for the client**

## Practice Development Care Plan Coordination

### Characteristics needed for *Agency* providing Care Plan Coordination:

- Acknowledge specific skill set required in CPC
- Commitment to integration: clients with service provision framework(s)
- Capacity & interest in:
  - provision of **supervision**
  - understanding of a stance of **constant inquiry**
  - **monitoring** and assessment of achievement (or learning through failure)
  - **analysing**, considering and providing feedback and developing new options or approaches
  - oversight of the implementation of care plan including **managing relationships with other services**
- Accounting practices (necessary part of monitoring and discovery)

Complexity  
practice development

## What seems to work...

1. Assessment and Formulation
2. Care Planning
3. Care Plan Coordination

## 4. Review

## Review

- Collaborative reflective opportunity
- Problem solving
- Monitoring & feedback
- Maintenance of focus on testing & trialling in limited time
- Involvement of Care Team
- Strategic use of authority
- Review of \$ / options

## Where to from here?

- Review and evaluation (NB: pm paper)
- Ongoing development / reflection
- New legislation (2009)
- Next phase – no independent statutory body
- Regional focus
- Retention of assessment/care plan coordination
- ?Training

## Reflections: alcohol and drug issues

- Factor most likely to destabilise care plan
- Intoxication – community stance ambiguous
- Too ready use of the term “harm minimisation”
  - often little understanding
  - lack of focussed, individualised, selective application
  - sometimes inappropriate
- Insufficient use of A&D **expertise**
  - A&D agencies – mixed experience
  - Ready use of standard formula phrases (& insufficient detail)
  - Inadequate assessment - physical health implications
  - Can be perceived to be a closed system / difficulty with partnerships and integrated care



## insufficient use of some intervention options

Alcohol and drug agencies –

- often in a fixed pattern of treatment response
  - Standard responses to all comers
- Some insular - loathe to use other services
- unclear outcome measures  
(arising from funding bodies, community expectations, other services, etc)
- Unfairly and inappropriately perceived as failing even when treatment episode is satisfactorily completed

*eg: " ..... this person has had 4 detox episodes in the past six years, has spent 3 months in an AOD resi rehab unit. & then had two years drug-free but A&D treatment has failed as they are now persistently seeking drugs and frequently intoxicated."*

## Eg's - measures (rarely?) considered:

- support attendance community-based self-help groups
- environmental contingency management strategies. Eg:
  - consider administration order (income in small/frequent amounts not fortnightly)
  - active and assertive time structuring programs (day and evening)
  - involvement of significant others (family, colleagues, etc ... )
  - possible replacement of substances with less potent/harmful alternatives (including possible change of routes of or means of administration)
- Possible +ive use of other community-based orders (mental health, guardianship, protective, correction ...etc)

## Reflections re mental health services:

- Pressed in era of risk management + consumer rights
- Crisis and major mental illness focus as consequence
- Medication – benefits
- Non-medication treatments (difficult)
- Some mental disorders – esp. difficult (who = expert?)

## Reflections re mental health services:

- Multi-morbidities (physical, Int. Impair; ABI;... subtle / extreme)
- Case management (limited)
- Probably insufficient residential options
- Training and support / mentorship & supervision (?)

## Reflections:

- Acknowledge some controversial
- ... but might be necessary for survival
  
- The balancing of individual rights, risks to self and to others in the community and the responsibility that we hold for fellow citizens requires judgment(s)



## Case study



- Peter, Male, 46 years, ABI, Mental Disorder, Alcohol and Drug
- Stabilised in service -private accommodation provider
- Family carer included in care team, compared with previous exclusion
- Access to disability Case Management
- Transition to carer's home with strong mental health links, Disability Case Management, Home First package to support structured activities, carer support & modification of home
- *Care Plan Coordinator - objective meta-view – build on strengths (including family)*

## Use of diagrams eg: Family genogram

