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| Getting it together |
| A guide for individuals, carers, and services on accessing the Multiple and Complex Needs Initiative (MACNI). |
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| Getting it togetherA guide for individuals, carers, and services on accessing the Multiple and Complex Needs Initiative (MACNI). |
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| To receive this document in another format, email Central Complex Needs <Central.ComplexNeeds@dffh.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Australia, Department of Families, Fairness and Housing, August 2023.Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.ISBN 978-1-76130-330-2 (online)Available at [Complex Needs Services](file:///%5C%5Cinternal.vic.gov.au%5CDHHS%5CHomeDirs2%5Ckhla1407%5CDesktop%5CCYAN%5CComplex%20Needs%20Services) <https://providers.dhhs.vic.gov.au/multiple-and-complex-needs-initiative> |
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Contents

[What is the Multiple and Complex Needs Initiative? 6](#_Toc144299816)

[Key elements of MACNI 6](#_Toc144299817)

[The legislation 6](#_Toc144299818)

[Eligibility for MACNI 6](#_Toc144299819)

[Who can make referrals? 7](#_Toc144299820)

[Operating model 7](#_Toc144299821)

[How do you access MACNI? 8](#_Toc144299822)

[Complex Needs Coordinators 8](#_Toc144299823)

[Intake 8](#_Toc144299824)

[Referral and eligibility 9](#_Toc144299825)

[Consultation 9](#_Toc144299826)

[Pre-MACNI 10](#_Toc144299827)

[Making a referral to formal MACNI 10](#_Toc144299828)

[Complex Needs Panels 10](#_Toc144299829)

[What happens if the person is eligible? 11](#_Toc144299830)

[Care plan 11](#_Toc144299831)

[What is the role of the care plan coordinator? 11](#_Toc144299832)

[Reviewing and closing a care plan 12](#_Toc144299833)

[Post-MACNI support 12](#_Toc144299834)

[Making a complaint 12](#_Toc144299835)

[Enquiries 13](#_Toc144299836)

[Appendix 1: Potential referrer self-assessment 14](#_Toc144299837)

# What is the Multiple and Complex Needs Initiative?

The Multiple and Complex Needs Initiative (MACNI) is a time-limited service response for people aged 16 years and older with multiple and complex needs.

People will have a combination of mental illness, substance use, intellectual impairment, and acquired brain injury, and will benefit from a coordinated service response to meet their needs and goals.

MACNI is funded by the Department of Families Fairness and Housing, the Department of Justice and Community Safety, and the Director of Housing.

MACNI involves the partnership of the two departments and numerous service providers who provide both specialist and generic services to clients, such as:

* Aboriginal community-controlled organisations
* mental health services
* housing services
* justice and correctional services
* drug and alcohol services
* disability and health services.

Focusing on a more effective and coordinated approach to support, MACNI aims to:

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

Participation in MACNI is voluntary. A person can decide to discontinue MACNI services at any time during the process.

## Key elements of MACNI

* *Human Services (Complex Needs) Act 2009*
* information, consultation and referral
* care plan development and coordination
* *Service Provision Framework: Complex Needs*
* The Complex Needs team.

## The legislation

MACNI is underpinned by the *Human Services (Complex Needs) Act 2009*. This Act establishes the authority for a collaborative and coordinated approach to planning service delivery for people with multiple and complex needs.

# Eligibility for MACNI

For a person to be eligible for MACNI, they must meet the eligibility criteria in section 7 of the Act.

An eligible person is a person who:

1. has attained 16 years of age; and
2. appears to satisfy two or more of the following criteria—
	1. has a mental disorder within the meaning of the *Mental Health Act 2014*
	2. has an acquired brain injury
	3. has an intellectual impairment
	4. has a severe substance dependence within the meaning of section 5 of the *Severe Substance Dependence Treatment Act 2010*, and
3. has exhibited violent or dangerous behaviour that 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
4. is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

# Who can make referrals?

Anyone can make a referral to MACNI, for example:

* referrals from individuals for themselves
* family members or significant others
* existing service providers working with the person
* court support services
* correctional services
* mental health services
* Aboriginal community-controlled organisations
* community service organisations.

Appendix 1 is a brief referral checklist that gives potential referrers an indication of the information needed for a MACNI referral.

# Operating model

MACNI provides a range of targeted supports for people with multiple and complex needs ranging from information, consultation, coordination and referral through to care plan development and coordination for those determined eligible under the Act.

At any stage of MACNI intervention where a critical need arises, the Complex Needs Coordinator will work with the involved services and Panel to determine the most appropriate level of support. Similarly, a case may be closed at any stage or duration of involvement and are not required to progress through stages before closure is recommended.

The MACNI model is not strictly linear; at any stage, it may become apparent that the client’s needs cannot be effectively met without a higher level of coordination or intervention. At this point, the Complex Needs Coordinator will work with the involved services to determine the next steps of either a referral for:

* Pre-MACNI
* MACNI eligibility determination to receive care plan coordination under the Act.

Standardised templates are provided in the appendix to assist Areas implement MACNI at a local level. These templates are to be used by all Complex Needs Coordinators to enhance consistency and promote adherence to legislation and operational guidelines. Where appropriate, templates can be adjusted to each client’s communication capacity and may benefit from pictorial representations and/or translation.

# How do you access MACNI?

The Department of Families Fairness and Housing consists of 17 area across four divisions responsible for oversight and coordination of local areas that provide direct services across Victoria.

Each area has at least one Complex Needs Coordinator, who is the first point of contact to discuss a potential referral to MACNI. Complex Needs Coordinator contacts are listed at the end of this booklet.

# Complex Needs Coordinators

The Complex Needs Coordinators provide support to referrers and care teams in localised problem-solving and assistance in navigating systemic issues for improved service responses to people with complex needs. The range of responsibilities are:

* provide a contact point for enquiries, information provision and eligibility screening for complex needs responses
* provide consultation and facilitate improved planning by services as a diversionary approach
* identify systems gaps and systemic risks for people with complex needs
* provide capacity building to assist the service system’s support for people with complex needs
* facilitate relationships between departmental program areas and external services,
* facilitate integrated responses with service providers and promote practice excellence
* support the functions of the Complex Needs Panel and perform the administrative functions required by legislation for MACNI under the Act
* action/support the implementation of Area Complex Needs panel decisions with care plan coordinators and/or care team members
* manage brokerage processes in line with procurement guidelines.

Complex Needs Coordinators do not provide:

* case management
* crisis response
* direct client work.

# Intake

At intake the Complex Needs Coordinator provides a tailored response based on the initial identification of client need, eligibility consideration, care team functionality, the service system’s capacity to effectively respond to the client’s support needs, (reflecting on the success of interventions and service responses used to this point), and other case-by-case considerations. For incoming client referrals, the pathway options will be:

* consultation with the Complex Needs Coordinator, which may progress to Pre-MACNI and/or formal MACNI
* Assertive Outreach and Support (AOS)
* Support for High-Risk Tenancies (SfHRT)
* non-acceptance and referral to alternate existing service system response.

# Referral and eligibility

A referral to a Complex Needs team is made for a person who would benefit from a service response due to:

* the person needing support with their multiple and/or complex health or social needs. This can include individuals with medical conditions, mental health issues, disabilities, high-risk behaviours, or social issues, such as homelessness or substance use
* the person may be experiencing significant service gaps and/or barriers to service access
* existing services needing additional resourcing, service coordination, expert input, and/or shared problem-solving, decision-making, planning to stabilise and continue service provision for improved client outcomes.

On contact, the referrer will be asked to complete a referral form to enable the Complex Needs Coordinator to initially assess eligibility and identify the client’s support needs. Intake allows for the referral to progress to the most suitable complex needs services response.

# Consultation

Complex Needs Coordinators’ work is predominantly in the consultation support phase.

Including intake, consultation services are provided for clients who have complex support needs which are not being suitably supported within the existing service system. Consultation is intended to complement and enhance the sustainability of the existing service system, rather than replace or duplicate specific service responses. The primary function is to improve client outcomes through support and guidance to engaged services to maximise flexibility and responsiveness of support options in the standard service system.

The Complex Needs Coordinator’s tasks at this stage are:

* information and practice advice
* system navigation and problem-solving
* capacity-building
* facilitate assessment for diagnostic clarity and to drive required service responses
* service coordination (time-limited and less than 4 hours per week).

The Complex Needs Coordinator does not directly engage with, provide direct support, or case management with individuals and families. There may be contact if people self-refer/families refer or are in a care team.

During consultation, it may become apparent that the client or care team’s needs cannot be effectively supported without a more specific response or higher level of service or care coordination. If so, the Complex Needs Coordinator will work with involved services to determine the next steps of either a referral for:

* Pre-MACNI
* MACNI eligibility determination to receive formal care plan coordination under the Act.

# Pre-MACNI

Pre-MACNI is indicated where:

* a client appears to meet the *Human Services (Complex Needs) Act 2009* eligibility criteria (does not require to be confirmed by formal assessment)
* the client’s presenting issues were not able to be adequately resolved through consultation, local problem-solving and collaboration
* the client and care team would benefit from time limited care coordination (<4 hours per week)
* there is evidence to suggest that a particular support intervention is likely to positively impact on the client’s situation and longer-term outcome and can only be achieved through the use of Pre-MACNI brokerage funding.

Based on the above, a Pre-MACNI response may be considered by the Complex Needs Coordinator.

# Making a referral to formal MACNI

Referrals to formal MACNI must be made through the Complex Needs Coordinator, the single access point to the MACNI referral process. All referrals commence in the consultation phase and are only escalated for consideration for formal MACNI once all other options have been exhausted. The Complex Needs Coordinator decides if and when a client should be considered eligibility under the Act and this decision needs to be endorsed by the Complex Needs Panel and Area Executive Director. This process can be lengthy, however many referrals can be resolved at the consultation stage without needing further escalation.

If a referral to formal MACNI is appropriate, the Complex Needs Coordinator is available to help a referrer complete the eligibility request form and ensure all of the requirements are met. Once completed, the Complex Needs Coordinator will review and present the eligibility request to the local area panel for its assessment and recommendation of eligibility.

# Complex Needs Panels

The key roles and responsibilities of the panel are:

* evaluate the effectiveness of care plans intended to promote holistic, innovative, flexible, client-centred and value-for-money service responses
* consider eligibility, recommend, vary and terminate care plans for the Multiple & Complex Needs Initiative according to the Act
* consider, recommend and review brokerage for clients with complex needs, including SfHRT consultations (for requests over $15,000 only), MACNI consultations, Pre-MACNI and formal MACNI clients
* escalate systemic issues and trend analysis findings to the Disability and Complex Clients Practice Advice and Support unit.
* enhance the service system capacity through cross-program and service partnership and collaborative practice
* empower and support practitioners to problem solve client and service system issues through robust discussion and critical reflection.

## What happens if the person is eligible?

If the person is determined to be eligible for MACNI, the Complex Needs Coordinator will notify the person and the referrer of the eligibility determination outcome.

A Complex Needs Panel will meet to arrange for a service to develop a draft care plan for that person. This plan will be based on a thorough understanding of the person’s needs, goals and best interests, including cultural identity and safety, cultural planning and self-determination.

# Care plan

The care plan enables a coordinated response to the needs of the person. It seeks to promote stabilisation in housing, health and wellbeing, safety and social connectedness, including the promotion of cultural identity.

A care plan is initially developed for a 12-month period and may be extended to a maximum of 36-months.

The care plan outlines the:

* areas of the person’s life which have been identified as a priority
* priority goals for the person
* strategies to engage the person
* services and supports required and their roles and responsibilities
* crisis intervention and contingency plans specific to the person.

The *Human Services (Complex Needs) Act 2009* permits services to share an eligible person’s personal, sensitive or health information if it is in the best interests of that person.

The care plan will identify a care plan coordinator. This will be either an existing service provider to the person or an alternate service, depending on which is best placed to provide care plan coordination.

# What is the role of the care plan coordinator?

A care plan coordinator is appointed by an area panel when a care plan for a person is approved.

Key responsibilities of the care plan coordinator are to:

* schedule and chair care team meetings, including responsibility for meeting agenda and minutes
* monitor the care plan’s implementation and progress of the client
* coordinate the services provided to the client as per the care plan
* conduct six-monthly reviews of the care plan including funding acquittals
* provide a report to the department on client progress when requested
* provide a transition / exit plan six months prior to closure
* provide a closure report at the point of closure.

# Reviewing and closing a care plan

Care plan review is the key mechanism for the care plan coordinator, the services involved in delivering the plan and the area panel to monitor the progress and effectiveness of the care plan. Reviews are held every six months and additionally upon request.

Area panels can seek to change and close a care plan based on the input of the care plan coordinator, with the approval of the relevant departmental director.

Throughout the life of the care plan, and particularly in its last six months, the care plan coordinator also ensures transition planning is in place for the provision of services to meet the needs of the person beyond the life of the MACNI care plan. This planning will need liaison and negotiation with the relevant departmental area and the services to remain involved with the person.

# Post-MACNI support

A small number of people supported by MACNI may not be able to fully transition to sustainable engagement with the existing service system by the time their MACNI care plan is closed. This applies in particular to people whose care plan has been in place for the maximum period.

The department and services engaged in the care plan can continue to provide coordinated care for an agreed time-limited period to ensure the person’s needs can be effectively met by the existing service system.

# Making a complaint

The department wants our services to work for people who need and use them. We can always do better and we listen to people using our services, their advocates and representatives.

We want to know if you:

* feel a service is unsatisfactory
* did not receive enough information or choice
* were denied respect, dignity or privacy.

Take the following steps to get your complaint resolved:

**Step 1.** Discuss your complaint with your worker or another staff member, including the Complex Needs Coordinator at your local office.

**Step 2.** If you have tried to resolve your concerns but you are still dissatisfied with the outcome, you can refer your complaint to the Manager, Client Support and Housing Services or another senior manager at the local office.

**Step 3**. If your complaint cannot be resolved at Step 1 or Step 2, the department’s Complaints and Privacy unit will assist you and can be contacted on 1300 884 706.

# Enquiries

Contact the Complex Needs Coordinator in your area for MACNI enquiries. If you are unsure who to contact email Central.ComplexNeeds@dffh.vic.gov.au .

### North Division

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| --- | --- | --- |
| Area | Office | Contact |
| North East Melbourne | Preston | NEMAComplexClients@dffh.vic.gov.au |
| Hume Merri-bek | Broadmeadows | HumeMoreland.ComplexNeeds@dffh.vic.gov.au |
| Loddon | Bendigo | Loddon.ComplexNeeds@dffh.vic.gov.au |
| Mallee | Mildura | MalleeComplexNeeds@dffh.vic.gov.au |

### East Division

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| --- | --- | --- |
| Area | Office | Contact |
| Inner Eastern Melbourne | Box Hill | IEMAComplexNeeds@dffh.vic.gov.au |
| Outer Eastern Melbourne | Ringwood | OEMA.ComplexNeeds@dffh.vic.gov.au |
| Goulburn | Shepparton | Goulburn.ComplexNeeds@dffh.vic.gov.au |
| Ovens Murray | Wangaratta | OvensMurray.ComplexNeeds@dffh.vic.gov.au |

### South Division

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| --- | --- | --- |
| Area | Office | Contact |
| Southern Melbourne | Dandenong | complex.clientsSM@dffh.vic.gov.au |
| Bayside Peninsula | Dandenong | Complex.ClientsBP@dffh.vic.gov.au |
| Inner Gippsland | Morwell | complex.clientsIG@dffh.vic.gov.au |
| Outer Gippsland | Bairnsdale | complex.clients.oga@dffh.vic.gov.au  |

### West Division

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| Area | Office | Contact |
| Western Melbourne & Brimbank Melton | Footscray | WMBM.ComplexNeeds@dffh.vic.gov.au  |
| Sunshine |
| Central Highlands | Ballarat | CHA.ComplexClientsReferrals@dffh.vic.gov.au |
| Barwon | Geelong | ComplexNeeds.Barwon@dffh.vic.gov.au  |
| Wimmera South West | Warrnambool | WSWA.ComplexNeeds@dffh.vic.gov.au  |

# Appendix 1: Potential referrer self-assessment

This list of questions gives potential referrers an indication of:

* what questions the Complex Needs Coordinator will ask during the initial consultation, and
* what will need to be answered on the Complex Needs referral form.

### Eligibility criteria

* Does the person appear to meet the eligibility criteria?

### Service response

* Has there been, or is there, a current coordinated service response or case plan for the person? Can you describe what has worked and not worked for the person?
* What are you expecting MACNI to achieve with and for the person?
* Does the person have involvement with other services?
* Have you made contact with these services?
* Has a case plan meeting been conducted with the existing service providers to establish the nature of the issues, or to identify alternative response options?
* Does your program manager support this potential referral?

### Confidentiality and privacy

* Has the person been informed of the potential referral?
* Does the person agree to the referral?
* Does the person have a parent, carer or guardian?
* Have you discussed the potential referral with the parent, carer or guardian?
* Does the person know that the information about them will be shared with the area panel and among other involved service providers?