

Service Provision Framework: Complex Needs

The Multiple and Complex Needs Initiative, Support for High-Risk Tenancies, and the Assertive Outreach and Support pilot program.

August 2023

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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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 978-1-76130-329-6 (online)

Available at [Service provision framework: Complex needs](https://www.dffh.vic.gov.au/service-provision-framework-complex-needs) <https://www.dffh.vic.gov.au/service-provision-framework-complex-needs >

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Glossary

Term	Definition
Assertive outreach	Assertive outreach is intensive and flexible direct client support, with an emphasis on building rapport and improving engagement with targeted interventions and services
Assertive Outreach and Support (AOS)	AOS is a pilot program to deliver assertive outreach and case management support to people with complex needs experiencing significant service system gaps and who pose unacceptable risk to others. The AOS is time-limited and is only delivered across metropolitan areas.
Brokerage agreement	Brokerage agreements provide detail supplementing the existing service agreement / contract between the department and a service in receipt of brokerage. Brokerage agreements are not used in AOS.
Capacity-building	Capacity-building refers to activities that strengthen and enhance the existing service delivery, care planning and coordination capabilities, skills, and knowledge of community service organisations through training, mentoring and secondary consultation.
Care plan	A plan which documents client needs, goals, support services and interventions, considering the client's best interests, goals and working within a strengths-based framework. Care plans may specify the care, treatment, support, and accommodation recommended for the client.
Care plan coordination	Care plan coordination is a client-centred, assessment-based, interdisciplinary approach to integrating health care and psychosocial support services in which a comprehensive care plan that addresses the client's needs, strengths and goals is developed, implemented, and monitored. The work is performed by a Care Plan Coordinator.
Care plan development	A client determined as eligible for MACNI services under the <i>Human Services (Complex Needs) Act 2009</i> must have a care plan developed within 12 weeks from the date of eligibility. The care plan is based on a comprehensive assessment of the client's needs.
Case management	Case management is direct work with a client focused on achieving their need/s goals as established in their case plan. A service provider is responsible for assessment, planning, referrals/linkage facilitation, implementing the plan's actions, advocacy, monitoring, plan review and case closure. For AOS, case management aims to enhance a client's service access.
Community housing	Community housing is housing owned or managed by community housing providers. Community housing providers are regulated, not-for-profit organisations that specialise in housing a diverse range of renters that require both public and affordable homes.
Complex Needs Coordinator	Departmental staff providing consultation for MACNI, SfHRT, AOS pilot program and broader complex needs cohorts. To support improved client outcomes, these coordinators provide consultation and service coordination support to the existing service system, assisting with service system navigation to identify appropriate service responses for clients, advocacy as required, and support the functions of the Complex Needs Panels. Complex Needs Coordinators do not directly work with people with complex needs.

Term	Definition
Complex Needs Project	The Complex Needs Project drives policy and service initiatives across the Department of Families Fairness and Housing and the Department of Health to improve the service system response for people with complex needs who experience significant service system gaps and pose an unacceptable risk of harm to others.
Complex Needs Panel	Area-based panels provide a formal mechanism for review, consultation and shared decision making for people with complex needs. Complex Needs Panels also assume specific responsibilities for clients eligible for the Multiple and Complex Needs Initiative (MACNI).
Consultation	Consultation is provided to the service system for people with complex support needs. Consultation involves supporting the services to improve and stabilise their capacity to meet the needs of a person with complex needs. Most referrals for consultation are supported by a Complex Needs Coordinator.
Engagement Plan (EP)	Engagement plans are used in AOS. A plan is created by an AOS service provider and identifies creative strategies the provider will use to maintain open communication with the client and encourage their participation in the AOS pilot program.
Formal MACNI	A service phase where the client has been deemed eligible under the <i>Human Services (Complex Needs) Act 2009</i> . The client is supported by a care plan, based on a comprehensive assessment. A care plan coordinator is appointed to support the coordination of the plan.
High-risk tenancy	A tenancy that is at high-risk of failure (breach or eviction) due to the negative impact of the renter's social, health and/or welfare circumstances on their ability to responsibly manage the tenancy.
Hoarding	Hoarding is a behavioural / mental health condition which involves persistent accumulation of, and lack of ability to relinquish, large numbers of objects/animals, resulting in extreme clutter in or around premises.
Individual support plan (ISP)	An individual support plan is a person-centred planning document used in AOS. It includes client's goals, supports needed to achieve goals, implementation strategies, how the service provider will support goal achievement and the next review date.
Person with complex needs	A person with complex needs experiences intersecting health, social, forensic, housing, substance use issues. The person would benefit from enhanced support due to: <ul style="list-style-type: none"> • the presence of complexity and/or multiplicity of support needs • unmet support need (s) • high-risk behaviours or community safety needs for which there are limited, no or fragmented service responses available and <ul style="list-style-type: none"> • a targeted support response is required with additional resourcing, shared problem-solving, risk management, decision-making and /or enhanced service coordination • independent expert input is required to stabilise and continue service provision.
Pre-MACNI	Pre-MACNI is a support phase indicated where:

Term	Definition
	<ul style="list-style-type: none"> • a person appears to meet the <i>Human Services (Complex needs) Act 2009</i> eligibility criteria • the person's support needs /issues were not able to be adequately resolved at the consultation stage • there is evidence to suggest that a particular intervention is likely to positively impact on the person's situation and longer-term outcome and reduce the progression to formal MACNI.
Public housing	Public housing is long-term housing owned and managed by Homes Victoria. It is for people on low incomes that are most in need, especially those who have recently experienced homelessness, family violence or have other special needs.
Service coordination	Service coordination is focused on service system collaboration and integration so that engaged services can more effectively meet the needs of client. It is not direct client support.
Social housing	Social housing is short and long-term housing owned and managed by the government or not-for-profit agencies. Social housing is made up of public housing and community housing. It generally indicates housing that involves rental subsidy.
Statewide Complex Needs Advisory Panel (SCNAP)	SCNAP provides multi-disciplinary clinical consultation and advice, and oversight of service responses for people who have complex needs and/or are subject to the proceedings or <i>Crimes (Mental Impairment and Unfitness to be Tried) Act</i> supervision orders; and people who are within the target cohort for the Complex Needs Project Initiatives, including the AOS pilot program.
Support for High-Risk Tenancies (SfHRT)	SfHRT provides targeted support for people with multiple and complex needs at risk of losing their public housing tenancy.
System navigation	System navigation refers to tasks that enhance the capacity of the client (and the services and programs supporting them) to access available resources across multiple support systems due to service fragmentation. System navigation helps improve integration by enhancing services' knowledge and increasing timely access to support for clients.

1. Introduction

1.1 Purpose of document

The *Service provision framework: complex needs* provides operational guidance to ensure consistent, transparent, and high-quality delivery of complex needs services across Victoria, including the Multiple and Complex Needs Initiative (MACNI), Support for High-Risk Tenancies (SfHRT) and the Assertive Outreach and Support (AOS) pilot program.

The intended audience for this document is any person or service providing a service response for people with complex needs.

1.2 The need for complex service responses

The demand to respond proactively and with flexibility to people with complex needs is ever growing, reflecting the continuing presence, and changing complexity in peoples' presentation, including high-risk behaviours, complex mental health, trauma, substance misuse and greater concern for community safety. MACNI, SfHRT and the AOS pilot program are programmatic elements of this complex needs response.

Complex needs services are delivered through the collaboration of government, Aboriginal community-controlled organisations, health, and community service organisations to provide services to people with complex support and coordination needs.

1.3 Department of Families, Fairness and Housing

The Department of Families, Fairness and Housing (the department) is responsible for the development and delivery of policies, programs and services that support and enhance the wellbeing of all Victorians. We take a broad view of the causes of ill health, the drivers of good health, the social and economic context in which people live, and of the incidence and experience of vulnerability. This allows us to place people at the heart of policymaking, service design and delivery.

The department includes Child Protection, Prevention of Family Violence, Family Safety Victoria Homes Victoria, Housing and Disability and Seniors and Carers. The department is also responsible for the key portfolios of Multicultural Affairs, LGBTIQ+ communities, Equality, Veterans and the Offices of Women and Youth, enhancing the alignment with policy areas and portfolios focusing on the recovery and growth of our diverse communities. The department also supports the Victorian Disability Workers Commission and Respect Victoria.

In addition, the department's *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan* provides an overarching framework for action to improve the health, wellbeing, and safety of Aboriginal Victorians between 2017-2027.

The department provides a range of services to people with complex needs, including inter-departmental initiatives and funded services provided by the sector. Complex needs service responses are aligned with the department's key policies, frameworks, and strategic direction.

Complex needs interventions support the government's objectives in working to improve access to services and outcomes for Aboriginal people, including self-determination. From consultation to care

planning, intervention supports Aboriginal people to strengthen connection to culture and community.

Refer: [The Department of Families, Fairness and Housing 2021 strategic plan](https://www.dffh.vic.gov.au/sites/default/files/documents/202110/DFFH%202021%20strategic%20plan.pdf) <https://www.dffh.vic.gov.au/sites/default/files/documents/202110/DFFH%202021%20strategic%20plan.pdf>

Refer: [Framework for trauma-informed practice](https://www.dffh.vic.gov.au/publications/framework-trauma-informed-practice) <https://www.dffh.vic.gov.au/publications/framework-trauma-informed-practice>

Refer: [Korin Korin Balit-Djak](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>

Refer: [Aboriginal and Torres Strait Islander cultural safety framework](https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework) <https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>

Refer: [Inclusive Victoria: State disability plan \(2022–2026\)](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>

1.3.1 Area based

The department consists of four divisions responsible for oversight and coordination of local areas (see Figure 1).

Consistent with localised service delivery principles, people are supported by the division and area they are most connected to. This is typically determined by the person’s residential address and existing support relationships, or at times of itinerancy or custody, the place the person identifies as preferable. Complex Needs Coordinators are positioned in each local area to support local areas establishment of innovative, localised, and timely responses to people with complex needs.

Figure 1 – The department’s division and area structure



1.3.2 Area Executive Director

The Area Executive Director leads and manages service delivery across their specific area of the department. The role is accountable for client outcomes at a local level across a range of integrated services. Area Executive Directors have responsibility to develop and foster strategic partnerships with the local community and external service providers, local businesses, and other government

agencies to ensure local issues are understood, prioritised, and addressed. Specific responsibilities include:

- chair of the Area Complex Needs Panel (and where unable has an executive level proxy chair)
- financial delegation and oversight of complex needs budget
- escalate cases between other specialist panels for consultation (e.g.: High Risk Youth Panels)
- support problem-solving for complex needs cohorts through participation on panels
- delegated functions and powers of the *Human Services (Complex Needs) Act 2009* (the Act):
 - eligibility determination
 - notifications to client
 - care plan development and review.

1.3.3 Disability, Communities and Emergency Management Division

The Disability, Communities and Emergency Management division delivers on the Victorian Government's policy priorities in the areas of disability, seniors, carers, elder abuse reform, community participation, support for vulnerable community members, and emergency management in support of positive community outcomes. The division is comprised of the Disability, Seniors, Carers and Communities Branch, the Disability Services, Policy and Support Branch, and the Emergency Management Branch.

1.3.4 Disability Services, Policy, and Support Branch

Disability Services, Policy and Support Branch brings together the functions associated with delivery of services to people with disability and complex needs. The Branch is responsible for policy and oversight of disability services and the NDIS, and major policy and legislative initiatives affecting people with disability. The unit also supports the promotion of the social, economic, and civic participation and rights of people with disability through its legislative policy function. The Branch leads the oversight of disability services transferred to the non-government sector, comprising post transfer supports (performance monitoring unit, contract management and quality and safeguards).

1.3.5 Central Complex Needs team

On complex needs issues and system capacity building, the Complex Needs team:

- develops and support the implementation of the Service Provision Framework for state-wide delivery of complex needs responses, including MACNI, SfHRT and AOS
- provides quality assurance, practice compliance and systemic improvement
- develops and reviews policies, professional standards, and operating practices to enhance service delivery, budget effectiveness, efficiency, and improved client outcomes.

There are instances where consultation with the Central Complex Needs team is required regarding service delivery and the implementation of this framework. This is outlined in Section 9: Quality, safeguards, and critical events.

2. Key sector partners and reforms

This section identifies the key service system partners and critical strategic reforms which importantly interface with the delivery of the complex needs service responses for improved client outcomes.

2.1 Partners in service delivery and coordination

2.1.1 Department of Justice and Community Safety

The Department of Justice and Community Safety (DJCS) leads the delivery of justice and community safety services in Victoria by providing policy and organisational management. Its extensive service delivery responsibilities range from managing the State's prison system, to providing consumer protection and enforcing court warrants.

DJCS provides funding for MACNI service provision, and many referred people have previous or current contact with the justice system. Each area based Complex Needs Panel has a DJCS representative who provides advice on services and supports within the state-wide justice system.

Refer: [Department of Justice and Community Safety](https://www.justice.vic.gov.au) <https://www.justice.vic.gov.au>

2.1.2 Homes Victoria

Homes Victoria manages Victoria's social housing portfolio. This includes public housing, community housing, crisis accommodation, transitional accommodation, affordable housing, and other associated essential support services. Homes Victoria provides funding for MACNI and solely funds SfHRT. Homes Victoria has a key role in early identification of potential clients with complex needs and their referral to the complex needs service response.

Refer: [Homes Victoria](https://www.homes.vic.gov.au) <https://www.homes.vic.gov.au>

2.1.3 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is a national scheme for people with disability. The NDIS provides funding to eligible people with disability to gain greater independence, access to new skills, jobs, or volunteering in their community, and an improved quality of life. Once a participant reaches 65, engaged services should consider a person's eligibility and suitability for My Aged Care, noting that supports may only be funded by the NDIS.

National Disability Insurance Agency - Complex Support Needs Pathway

The Complex Support Needs Pathway provides specialised support for participants with a disability who have other challenges impacting their lives such as mental health issues, incarceration, or homelessness, and need a higher level of specialised supports in their plan. There are dedicated planning teams and a network of specialised planners with strong experience in high-level coordination and/or allied health experience.

Refer: [National Disability Insurance Scheme](https://www.ndis.gov.au) <https://www.ndis.gov.au> [email the NDIS](mailto:enquiries@ndis.gov.au) <enquiries@ndis.gov.au> or contact NDIA on 1800 800 110.

Refer: [My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>

2.1.4 Forensic Disability Services

Forensic Disability Services supports people with cognitive impairment involved in the criminal justice system who require specialist support and adapted intervention to address criminogenic needs. The program operates alongside the broader justice and disability service system and other mainstream services to address disability specific factors contributing to a person's risk of offending.

To be eligible, a person must have a cognitive impairment associated with a neurological disability, acquired brain injury or intellectual disability within the definition of the Disability Act. Forensic Disability Services is comprised of:

- Forensic Disability Statewide Access Service - for referrals
- Forensic Residential Services - residential treatment facilities and specialist forensic disability accommodation
- Disability Justice Coordination
- Forensic Clinical Service.

Refer: [Forensic Disability Services](https://www.dffh.vic.gov.au/forensic-disability-services) <<https://www.dffh.vic.gov.au/forensic-disability-services>>

2.1.5 Principal Disability Practice Advisors

The department has Principal Disability Practice Advisor (PDPA) roles in teams in each of the four operational divisions. These operational teams also include two Disability Practice Advisors (DPA). The teams provide oversight of arrangements funded by the Support for Children with Complex Disability Program. The program responds to children who require, or may require in the future, accommodation outside the family home due to their complex disability support needs. PDPAs and DPAs lead the coordination and support to access mainstream services, work with the NDIA to coordinate disability specific supports and identify children in need of early intervention supports to sustain their living arrangements in the family home.

The teams also work with Child Protection Service (CPS) to improve outcomes for children with disability in the statutory system. This includes supporting assessments and decision making about individual children in all phases of CPS involvement, workforce capacity building to ensure that children are receiving optimal disability supports through the NDIS, and escalation of interface and individual client issues to the NDIA as required. Once a young person turns 18, the PDPA transitions tasks to the Intensive Support Team if required.

Division	Email
North	northdisabilitypracticeadvice@dhhs.vic.gov.au
West	westdisability@dhhs.vic.gov.au
South	south.disabilitypracticeadvice@dhhs.vic.gov.au
East	east.disabilitypracticeadvice@dhhs.vic.gov.au

2.1.6 Intensive Support Team

The IST is a state-wide service established in April 2017 by the Victorian Government to provide a targeted intervention to Victorians with disability experiencing significant and critical issues with the disability service system. The IST was set up in response to the systemic issues experienced by people with complex support needs transitioning to the NDIS.

More recently the focus of the IST is on formally developing the capacity of the sector and departmental programs to better navigate and resolve issues with access, planning and plan implementation for people with complex support needs. This work will include formal and informal capacity building activities and targeted to programs with a priority need. These services continue to be delivered by the IST program, alongside a current focus on systems and service level capacity building activities for sector partners and state programs.

In 2021, the Continuity of Support program was absorbed by the IST. This program has been expanded to also support Victorian's Ineligible for NDIS. Both programs offer support for Victorians who are NDIS ineligible respectively due to residency or inability to secure disability specific supports following their NDIS transition. The IST is currently operating up to 30 June 2024.

Refer: [Intensive Support Team](#)

<https://dhhsvicgovau.sharepoint.com/:w:/r/sites/dffh/_layouts/15/Doc.aspx?sourcedoc=%7B97A8F70D-CF23-41B9-B543-8C01CC6E424F%7D&file=Intensive%20Support%20Team%20-%20Factsheet%20outlining%20program%20offerings.docx&action=default&mobileredirect=true&DefaultItemOpen=1>

2.2 Strategic reforms for improved service system

2.2.1 Better, Connected Care

Better Connected Care is a whole-of-Victorian-government reform which brings together government departments, entities, and the community sector to collaboratively deliver more integrated services that meet the needs of people who encounter and use multiple government services. Better, Connected Care aims to deliver a person centred and integrated service system where people can access services that they need to make lasting positive change to their lives. The reform has a focus on building stronger partnerships and earlier intervention, to achieve improved client outcomes and reduce demand on acute systems

For information email [Better Connected Care](mailto:bcc@dffh.vic.gov.au) <bcc@dffh.vic.gov.au>

2.2.2 Royal Commission into Victoria's Mental Health System

The Royal Commission into Victoria's Mental Health System delivered its final report in 2021 which set out a 10-year vision for a balanced, flexible, and responsive system through 65 recommendations, in addition to nine from its interim report. The reforms aim to rebalance the system so that more services will be delivered in community settings and extend beyond an acute health response to a more holistic approach. There will be significant change to the mental health system governance and associated legislation. These structural changes will help drive the long-term improvements needed across the system.

2.2.3 Complex and Forensic Needs Integrated Response

The department is responsible for the delivery and coordination of critical services to respond to people with multiple and complex needs. The Complex and Forensic Needs Integrated Response (the Integrated Response) connects to and complements the Better, Connected Care Framework which is the overarching government reform agenda for people with multiple and complex needs using multiple service systems.

The Integrated Response responds to current challenges in the complex and forensic disability needs service system, including barriers to access and to the effective integration and coordination of services. The aim is to drive improved coordination of supports for people with multiple, complex and/or criminogenic needs, including those supported through MACNI, SfHRT, forensic disability service responses, and initiatives of the Complex Needs Project.

Complex Needs Project

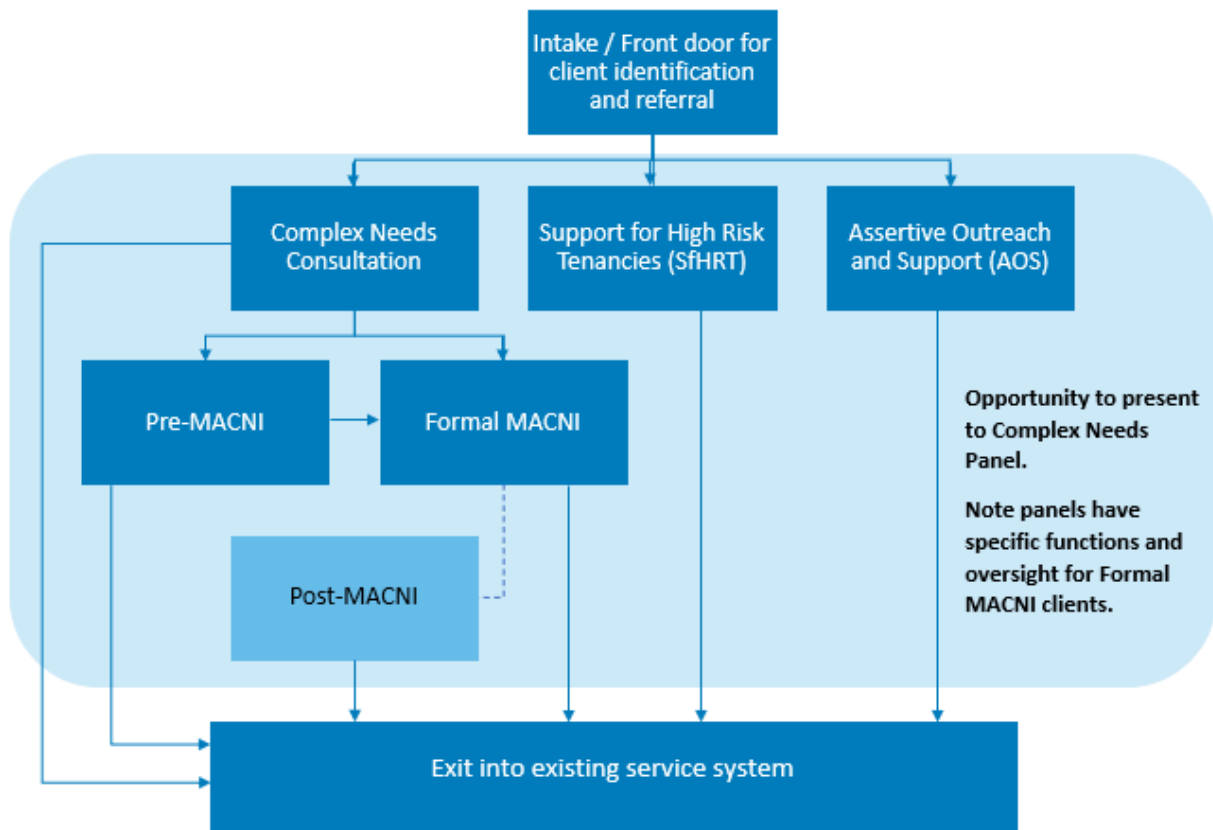
The Complex Needs Project was established, under the Integrated Response, to drive policy and service initiatives across the department and the Department of Health to improve the service response for people with complex needs who experience service gaps and present an unacceptable risk of harm to others. Initiatives of the Complex Needs Project include:

- development of new services, including trialling assertive outreach and case management approaches (the AOS pilot program)
- establishing a multidisciplinary clinical panel to advise on overcoming the most significant service gaps
- new policy, clinical and practice leadership functions to enable both the department and the Department of Health to collaborate and support the target cohort
- improved governance, accountability, and reporting.

3. Complex needs service elements

This section describes the elements of the department’s complex needs service responses. Figure 2 shows the service response pathway.

Figure 2 – Complex Needs service responses



3.1 Complex Needs Coordinators

There are Complex Needs Coordinators in each of the department’s seventeen areas who provide a single point of contact (a ‘front-door’) for service providers, clinicians or people seeking information about complex needs service responses or to discuss a potential referral.

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 (MACNI, SfHRT and AOS pilot program)
- 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.

3.2 Intake: referral, eligibility, and consent

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.

3.2.1 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.



Documentation required

- 1 Complex Needs Referral Form
- 1a Complex Needs Intake Form



Coordinator tasks

- ensure person's consent is obtained/renewed
- reinforce that complex needs interventions are not crisis response but an option of service coordination when a client's support needs are high and facilitated multi-service responses are required
- determine the service system's capacity to effectively respond to the client's support needs through exploration of available support and service options
- provide information and advice on support that can be provided, alternate options and/or next steps
- use information on the Complex Needs Referral Form (1)
- if needed follow-up the referrer to complete the Complex Needs Intake Form (1a).

3.2.2 Consent

The referrer is responsible for obtaining consent prior to the referral or consultation unless duty of care overrides this (see Section 3.3). For clients under 18 years of age, consent must also be renewed when the client turns 18.

There is no fixed age rule at which a person aged under 18 years is deemed to be capable of giving legally effective consent to receipt of services or sharing of personal or health information. A young person can provide consent to participate in and receive services, and to the disclosure of their personal or health information, if the department is satisfied that the young person has sufficient maturity and capacity to make an intelligent choice, involving the ability to consider different options and their consequences.

For persons aged over 18 years, the department must also be satisfied that the person has capacity to provide consent if the person has an intellectual disability, acquired brain injury, is substance affected or has a mental illness.



Documentation required

- 1 Complex Needs Referral Form
- 5b Duty of Care Referral Form (as required)



Coordinator tasks

- ensure consent is obtained/renewed:
 - upon referral to complex needs services
 - upon recommencing complex needs services after a period of suspension
 - on engagement of a new service provider from whom the client's personal or health information will be sought in developing or amending their care plan
 - when the client reaches 18 years of age (noting that upon reaching the age of 18, a client may still not have capacity to consent).

3.2.3 Duty of care referrals

Where a potential referrer holds significant concern for the welfare or wellbeing of a client or the community, a duty of care referral may be actioned. Duty of care referrals allow for the disclosure of

client information pursuant to the department's *Privacy policy* without prior consent and without breaching the Information Privacy Principles under the *Privacy and Data Protection Act 2004*.

A duty of care referral is recommended where a referrer:

- reasonably believes that the use or disclosure is necessary to lessen or prevent:
 - a serious threat to an individual's life, health, safety, or welfare; or
 - a serious threat to public health, public safety or public welfare.
- the referrer is a health service provider and the Complex Needs Coordinator, and their line manager reasonably believes that the collection, use or disclosure of that individual's health information is necessary to prevent or lessen a serious threat to:
 - any individual's life, health, safety, or welfare; or
 - the public health, public safety, or public welfare.¹

Refer: [Privacy Policy](#)

<https://dhhs.vic.gov.au.sharepoint.com/:w:/r/sites/dffh/_layouts/15/Doc.aspx?sourcedoc=%7B2C14437E-01E0-4508-9E9E-7135C3E6F2A8%7D&action=View>

Refer: [Information Privacy Principles](#) <<https://ovic.vic.gov.au/privacy/for-agencies/information-privacy-principles>>



Documentation required

- 5b Duty of Care Referral Form



Coordinator tasks

- on receiving a duty of care referral, provide the referrer with the additional consent for Duty of Care Referral Form
- ensure the duty of care referral is endorsed by:
 - supervisor / team leader / manager of the referrer
 - Manager Client Support and Housing Services.
- review duty of care regularly and ensure the Information Privacy Principles are considered in care team planning / decisions.

3.3 Complex Needs Panels

Each departmental area operates a Complex Needs Panel that meets on a regular schedule according to their local needs. These panels provide a formal mechanism to collaboratively discuss and address service delivery options and issues for clients with complex needs. The panels consider and provide advice and direction on broader policy or service delivery matters relating to each member's service/program area and undertake systems and trend analysis to influence strategic thinking regarding clients with complex needs.

¹ HPP1.1(f), 1.2, 1.3, 1.5, 2.1 and 2.2(h).

The Complex Needs Panels have in scope all the complex needs service responses provided via the Complex Needs teams in the areas – complex needs consultation, SfHRT, Pre-MACNI, MACNI and the AOS pilot program.

The panels are not limited to Formal MACNI client matters only and this is reflected in the 6f Panel Agenda Template which opens panels up to valuable expert input on all the service responses.

3.3.1 Responsibilities

The key roles and responsibilities of a panel are:

- problem solve client and service system issues through robust discussion and critical reflection
- enhance the service system capacity through cross-program / service partnership and collaborative practice, reflection, and learning
- consider, recommend, and review the activity and brokerage for clients with complex needs
- support culturally safe service delivery in the review and recommendation of service delivery
- escalate systemic issues and trend analysis findings to the Central Complex Needs Team.

Panels have specific responsibilities depending on the complex needs response being used. These specific responsibilities are outlined in relevant sections below.

3.3.2 Membership

The specific make-up of each panel will depend on the local area needs, member availability and the required subject matter expertise as associated with the presenting clients. Panels may also invite independent expert advisers to participate in meetings on a case-by-case basis and as determined necessary according to subject expertise. Panels are typically comprised of:

- Executive Director, Area, DFFH (Chair, and where unavailable an executive level proxy chair)
- Assistant Director Child Protection Operations / Operations Manager, Child Protection / Principal Practitioner, Child Protection, Area / Division, DFFH
- Manager, Complex Needs, Disability Services Policy Branch, Disability, Communities and Emergency Division, DFFH
- Manager, Client Support and Housing Services, Area, DFFH
- Senior Advisor/Manager, Population Health and Community Wellbeing, Area, DH
- Principal Disability Practice Adviser, Division, DFFH
- Manager, Agency Performance and System Support, Area, DFFH
- Senior Advisor, Aboriginal Engagement, Area, DFFH and/or a local Aboriginal organisation
- senior staff from Department of Justice and Community Safety / other departments as required
- representative from the Intensive Support Team, DFFH
- representation from Orange Door or other peak family violence service in the local area
- representation from an appropriate cultural service relevant to the local area/client matters
- Director/senior manager, area mental health service
- Director/senior manager, drug, and alcohol service
- Director/senior manager, youth and/or family service
- 1 - 3 senior representatives of sector organisations (e.g.: homelessness, community mental health, offender support, neuropsychology, and/or culturally specific services/workers).

Panel members with lived/living experienced are encouraged.

3.3.3 Panel member onboarding and ongoing support

The Complex Needs Coordinator, with the Client Services and Housing Support Manager, maintain engagement with new and regular panel members to ensure they are supported with their role and functions.

Prior to panel member commencing

When panel members are first invited to consider joining the panel, they should be briefed on the panel and member roles to assist their decision about their capacity to meet panel requirements. This may include a meeting to describe the panel purpose and functions. In some cases, senior staff and/or the chair may prefer to initiate and undertake this engagement, and who will take this responsibility must be clarified locally to ensure it occurs.

For commencement

Complex Needs Coordinators need to ensure that all panel members have received the panel induction pack on their role commencement to support them to perform effectively. The pack is:

- copy of the Service provision framework: complex needs
- 6a Complex Needs Panel information pack checklist
- 6b Complex Needs Panel Manual
- 6c Complex Needs Panel Terms of Reference
- 6d Complex Needs Panel member prompt sheet.

Any new panel members must be provided and return the (6e) Complex Needs Panel Deed of Confidentiality (only non-VPS employees are required to sign this document) prior to panel commencement.

The Complex Needs Coordinator, with the Client Services and Housing Support Manager should also ensure there is a focused meeting with a single or group of new panel members to introduce the panel pack, including discussion on the:

- complex needs service responses in scope of the Complex Needs Team and panel
- role and functions of panels and panel members, including the subject matter deliberations and brokerage request recommendations required
- panel processes.

Ongoing support

Complex Needs Coordinators ensure the panel pack (the set of documents) are available as standing attachments to the agenda for the panel members. This can be in the form of a link on the agenda, actual attachments to the agenda and/or meeting invitation, or as documents in the meeting Teams chat as relevant.

Should panel members request or appear to need support to perform their functions, any of the Complex Needs Coordinator, the Client Services and Housing Support Manager, and/or the Area Executive Director can provide additional information and direction as is needed. Who will take on this responsibility must be clarified locally to ensure it occurs.

3.3.4 Panel meeting procedures, quorum, and accountability

Each panel has established local terms of reference which detail their operation, including dispute resolution, quorum, accountability, and reporting procedures.

On quorum, it is anticipated that the quorum determination will be eight panel members, irrespective of whether internal or external members.

Panel members will prior receive an agenda with associated client related papers and panel member guiding documents.

Panels meetings are recorded in minutes, including client-related decisions and actions and the allocation of brokerage.

The Complex Needs Coordinator reports to the panel on client activity and brokerage budget updates, including the tabling of 7d brokerage Notification Form and the Monthly Snapshot Report provided to the division from the Central Complex Needs Team.

Documentation required

Standing documents

- attach or link to the *Service provision framework: complex needs*
- 6a Complex Needs Panel Information Pack Checklist
- 6b Complex Needs Panel Manual
- 6c Complex Needs Panel Terms of Reference
- 6d Complex Needs Panel Member Prompt Sheet



Before each panel

- 6f Complex Needs Panel Agenda
- Monthly Snapshot Report (for the division)
- 7d brokerage Notification Form
- supporting brokerage documentation (e.g., quotes, brokerage requests).

Following each panel

- 6g Complex Needs Panel Minutes
- 6h Complex Needs Panel Session Report
- brokerage documentation (e.g.: Brokerage Agreement, SAMS variation)
- memorandums for Formal MACNI clients (if required by the area).

Coordinator tasks



- facilitate Complex Needs Panel induction sessions for panel members (may be supported by CSHSM and/or Area Executive Director)
- circulate all panel documentation (including client documentation) to panel members securely. This includes use of protective markings, password protected documents (password sent separately) and ensuring emails are marked PROTECTED to prevent forwarding/copying.
- review panel documentation (i.e.: terms of reference and manual) annually or on change of membership.
- refer to [Help on protective markings](https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Protective-markings.aspx)
<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Protective-markings.aspx>

Annual tasks

- renew all panel documentation and membership agreements as required
- review all panel documentation with each change of membership.

Before each panel

- schedule panel dates, send invitations to panel members and care team members
- prepare and circulate the panel agenda (minimum 3 business days prior) and panel member prompt document
- send (securely) brokerage and client documentation to members (minimum 3 business days prior) using protective markings
- assist in the preparation of care plan
- prepare brokerage requests and notifications (Pre-MACNI and consultation)
- prepare Care Plan Coordinators, AOS providers and care team members to present to panels as relevant
- meet with Area Executive Director to confirm brokerage requests are in budget
- ensure the Deed of Confidentiality is signed by all non-VPS panel members.

Following each panel

- prepare and circulate minutes and session report to members and care teams
- prepare memorandums as required
- prepare brokerage agreements as required
- update the SharePoint databases with the relevant care plan dates and brokerage
- ensure panel recommendations are implemented/addressed in care plans.

3.3.5 Out of session panel requests

Out of session requests relate are matters that could not be presented to a panel meeting as they have arisen between scheduled meetings. Out of session requests may seek:

- advice and decisions on new emergent risks or service delivery (or other) issues
- recommend for the appointment of a care plan developer / coordinator
- views and recommend on care plans (new, variations or closure)
- consider and recommend brokerage requests
- (AOS specific) endorse proposed response to clients who have not consented to receive services after 6 weeks of attempted engagement (to ensure appropriate balance between privacy/right to refuse services and risk of harm considerations)
- (AOS specific) endorse proposed case closure for clients who continue to pose high risk of harm to others but no longer require or will benefit from AOS.

The Complex Needs Coordinator is responsible for preparing out of session information and requests with the endorsement of their line management.



Documentation required

- 6m Complex Needs Panel Out of Session Request Form
- documentation relevant to the request (i.e.: MACNI Eligibility Consideration Request Form, Care Plan, Brokerage Request Form, Complex Needs Client

Presentation Template, Complex Needs Recommendations and Closure Summary).



Coordinator tasks

- ensure completion of the Out of Session Request Form
- consult with the Area Executive Director to ensure brokerage requests are within the allocated area / divisional complex needs budget
- email the request to the Panel members with a due date for responses
- seek Area Executive Director approval as relevant.

3.4 Brokerage

The complex needs service response allows for the provision of discretionary client-attached brokerage to purchase items such as specialist assessments, services, and interventions to support the implementation and delivery of the care plan or to improve client outcomes. The availability and use of brokerage varies according to the service response type.

Eligibility, principles, and processes for the use of brokerage are provided in Section 8.

4. Consultation

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

4.1 Consultation work

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.

4.2 Complex Needs Panel

Consultation clients may be presented to panels by the Complex Needs Coordinator for expert advice on service planning, monitoring and the identification of systemic issues. Not all consultation clients are required to be presented; however, the panel should be consulted where there are:

- particularly challenging or unusual circumstances
- systemic issues
- concerns around risk management.

Consultation activity and brokerage expenditure information is provided to panel members on 7d Brokerage Notification Form at each panel meeting. The Monthly Snapshot Report forwarded to divisions from the Central Complex Needs team is also recommended for panel to note.

4.3 Consultation closure

Closure is required when:

- the matter is believed to be resolved, and/or
- the involved services have not required further consultation support for 3 months
- no further tasks have been generated for the Complex Needs Coordinator for 3 months
- the service response has escalated to Pre-MACNI or formal MACNI
- the client decides to withdraw.

The client can be re-referred if the need arises. If the client is re-referred, the Complex Needs Coordinator opens a new consultation record (ensuring client details are updated), reflecting the current reason/goal of consultation, service system issues and service involvement.



Documentation required

- 1c Complex needs recommendations/closure form



Coordinator tasks

- complete and provide complex needs recommendations/closure form to the referrer
- contact referrer to advise of the closure
- update the SharePoint client database, ensuring the closure date is recorded.

5. Support for High-Risk Tenancies (SfHRT)

SfHRT provides targeted supports for people with complex needs who are at risk of losing their tenancy. This support includes information, consultation, service coordination and/or provision of brokerage to maintain a tenancy.

5.1 Eligibility

Eligible clients are predominantly public housing renters, although services are also offered to renters in community housing when:

- the tenancy is at imminent risk of failure
- the renter is not responding to multiple intervention attempts from housing support services or the tenancy support service provider
- circumstances make it difficult for them to establish their tenancy and there are no other service options. These renters will have complex behaviours that prevent them from engaging with support services.
- the renter has complex support needs including but not limited to mental health, drug and alcohol and behavioural issues require intensive support from a range of programs and services to assist them to maintain their tenancy.

5.2 Response

SfHRT offers a variety of responses to a referral, these include:

- consultation, information and advice
- advocacy or liaison within the department
- brokerage to assist in ways that will maintain the tenancy
- coordinating care teams to establish supports and/or a care plan.

SfHRT is not a case management or direct service delivery response. SfHRT eligible renters may already be receiving support from a range of service providers, and a referral to SfHRT aims to enhance service coordination and the development of a shared care plan for a limited period.

Note: Renters in community housing are offered all SfHRT service responses excluding brokerage.

Templates are provided in the appendices to assist areas to implement SfHRT. The templates used by Complex Needs Coordinators to enhance consistency and promote adherence to legislation and operational guidelines.

5.3 Collaboration

SfHRT is a collaborative practice with departmental property and tenancy staff, Tenancy Plus providers and other housing support services is crucial in the understanding and relationship with the tenant.

SfHRT also complements the integrated community services system model, family violence initiatives and broader reform agenda.

It is expected that a renter's lead service provider/key worker will continue to maintain the role as primary contact/liaison for the client throughout the involvement of the Complex Needs Coordinator.

The Complex Needs Coordinator involvement is only active if the referrer or lead support organisation remains in contact.

There are various services that should be accessed for tenancy assistance prior to referral to SfHRT services. As such, it is anticipated that other tenancy management options have been attempted or explored prior to a referral to SfHRT, and the referring program has tried to resolve the tenancy issue through active communication with the relevant support links.

The primary provider of support to social housing renters is the department funded Tenancy Plus. Support providers offering Tenancy Plus provide early intervention and work in partnership with the department's housing program, other department program areas, community housing agencies and the general service sector.

5.4 Identification and referral

Common reasons for referral to SfHRT are hoarding, antisocial behaviour (mental health or substance misuse), environmental neglect and/or family violence. In some cases, the department may have already breached the client or are indicating that legal action is imminent.

SfHRT has the capacity to provide prompt advice and consultation to referrers in time pressured situations via phone, email or in person. This initial contact will determine if the client is eligible for SfHRT and if a more detailed referral form is required. This function aims to support the early identification of tenancies at-risk and focus on prevention, whilst providing capacity building to housing services.

Where it is determined during initial contact that a more intensive advocacy, brokerage or service coordination may be required, a completed Complex Needs referral form is required. This referral form also enables requests for brokerage to be documented.

Any contact or correspondence that requires the Complex Needs Coordinator to provide information, practice advice, system navigation, problem solving, referral or coordination is regarded as a consultation.



Documentation required

- 1 Complex needs Referral Form
- 5b Duty of Care Referral Form (as required)
- 1c Complex needs recommendations / closure form.



Coordinator tasks

- ensure the Complex Needs Referral Form is completed
- provide referral advice and consultation as required
- record the contact under the renter's client number in HiiP and note the advice provided
- update the SharePoint SfHRT client database.

5.5 Consultation

Where the department's housing staff or community organisations, including the tenancy support service providers, need advice regarding a public housing renter with complex behaviours/needs, the Complex Needs Coordinator should be consulted.

SfHRT consultation includes advice on:

- best practice
- service coordination
- system navigation
- care planning
- capacity building.



Coordinator tasks

- provide services as specified
- convene and chair care team meetings as required
- identify staff member / agency to take the lead post SfHRT intervention.

5.5.1 Duration of SfHRT consultation

The duration of a SfHRT consultation is flexible and may vary between referrals. Some consultations entail a single interaction while others require longer-term support and oversight. SfHRT interventions are considered short, medium, or long-term as outlined below.

Duration	Description and examples
Short-term Less than 2 weeks	Brokerage referrals only (e.g., property clean, rubbish removal, skip hire). Referrers seeking information, advice or referrals to specialist services.
Medium Less than 3 months	Requirement for multiple case conferences and service coordination. Care team requires support/guidance/leadership to develop and implement a multidisciplinary plan. E.g., clients who reside in a property that requires multiple or staged cleans with or without therapeutic intervention.
Long-term More than 3 months	Requirement for multiple case conferences and extended service coordination. Client may present with significant hoarding behaviours and require a staged cleaning process supported by therapeutic intervention. May involve a significant transition to social housing (e.g., client with history of arson/fire-setting who is returning to public housing in the community from prison or other secure facility).

5.6 Interface with Tenancy Plus

The Tenancy Plus support program assists social housing renters by providing early intervention when a tenancy is at risk to sustain their tenancy and reduce the risk of homelessness. This program offers assertive outreach, case management, local area referral and interim intervention

support to assist renters to maintain housing and prevent homelessness. Tenancy Plus should commence when a housing issue is identified, rather than when the tenancy is at the point of failure.

Tenancy Plus providers intervene where a social housing tenancy is at risk to identify and assist the tenant to address and resolve the underlying factors that are placing the tenancies at risk, including:

- developing a client support plan with the tenant
- providing direct support to the tenant
- actively engaging with appropriate organisations or department program areas to address the underlying issues that are causing the tenancy to be at risk
- convening a meeting with support providers to determine who will be responsible for actions listed in the plan
- oversight, coordination, and implementation of the plan.

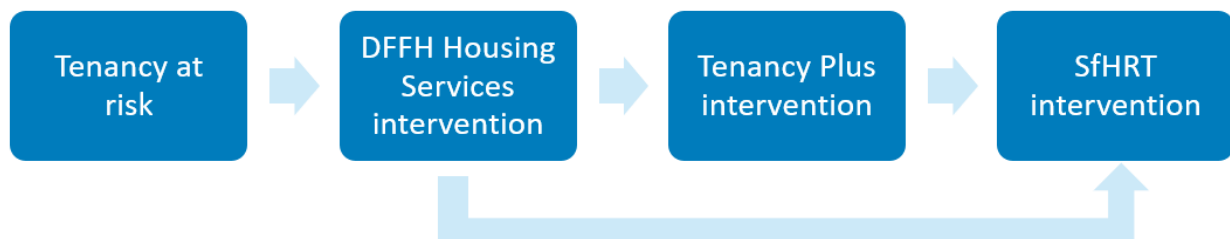
Tenancy Plus service locations align with the department's areas and have a close relationship with local housing offices, community housing providers and SfHRT.

At any stage of Tenancy Plus support, it may become apparent that the tenant's needs cannot be effectively met without a higher level of coordination or intervention. SfHRT provides this escalated service response.

Refer: [Tenancy Plus – Tenancy support program operational guidelines](https://providers.dhhs.vic.gov.au/tenancy-plus-tenancy-support-operational-guidelines)

<<https://providers.dhhs.vic.gov.au/tenancy-plus-tenancy-support-operational-guidelines>>

Figure 4 – The escalation of service response when a tenancy becomes at risk



Coordinator tasks

- maintain a collaborative relationship with Tenancy Plus, encourage referrals and provide capacity building as required/requested
- support departmental housing staff to engage and collaborate with Tenancy Plus
- provide specific advice, referral, and service coordination for cases where hoarding and squalor are prominent/present.

5.7 Interface with Indigenous Tenants at Risk

The Indigenous Tenants at Risk (ITAR) program, also referred to as Aboriginal Renters at Risk (ATAR), uses an intensive case management and support service model to assist Indigenous people living in mainstream, public housing, community housing or Aboriginal Housing Victoria (AHV) properties whose tenancies are at risk because of issues such as financial difficulty, neighbourhood disputes, drug and alcohol and mental health issues. Households are supported to stabilise their housing and retain their tenancies rather than leave the property or risk eviction.

An ITAR support worker intervenes where a public housing tenancy is breaking down to resolve factors placing the tenancy at risk. The intervention also involves the provision of intensive individual support to tenancies identified at risk. It is expected that where the issues relate to non-housing issues that referrals will be made to those programs.

Flexible brokerage is available through this program and its primary uses include:

- household expenses, e.g.: electricity, gas and water bills, repairs to whitegoods
- life skills e.g.: financial services, cooking courses, cleaning skills
- recreation activities, e.g.: sporting and fitness, join in community groups, cultural events, children holiday clubs, camps, after school activities
- education and training, e.g.: language classes, literacy and numeracy, job coaching
- material aid, e.g.: food, travel, clothing expenses
- medical, e.g.: GP, dentist, optometrist, podiatrist
- pharmaceutical requirements as indicated for use by a prescriber, e.g.: glasses, prescriptions
- therapeutic interventions, e.g.: counselling, life skills or personal development courses, speech therapy, AOD support.

SfHRT can provide an escalated service response if at any stage of ITAR/ATAR support, it appears that the renter's needs cannot be effectively met without higher level of coordination or intervention.

Refer: [Homelessness services guidelines and conditions of funding](https://www.dhhs.vic.gov.au/sites/default/files/documents/201705/Homelessness-Services-Guidelines-and-Conditions-of-Funding-May-2014.pdf)

<<https://www.dhhs.vic.gov.au/sites/default/files/documents/201705/Homelessness-Services-Guidelines-and-Conditions-of-Funding-May-2014.pdf>>

5.8 Public housing and the NDIS

There are a range of scenarios where public housing clients will interface with the NDIS, which may impact the SfHRT service response. This includes public housing applicants and renters who have a disability or are carers or a family member of a person with disability, who:

- has NDIS transitioned but need to remain connected with access and planning processes
- has not accessed services before or are not yet an NDIS participant and may need assistance to engage with the NDIS application process
- is an NDIS participant but not accessing support, and either needing assistance to re-engage with the NDIS and implement their plan, or to seek a review if their plan is no longer meeting their needs
- has an active NDIS plan and is accessing NDIS funded services and may need help coordinating between NDIS and other mainstream supports (such as health)
- is not likely to meet the NDIS access requirements - a Local Area Coordinator may connect the person to services, supports and activities in the community and other government services.

Refer: [Public Housing and the National Disability Insurance Scheme: Roles and responsibilities operational guidelines](https://providers.dhhs.vic.gov.au/public-housing-and-national-disability-insurance-scheme-roles-and-responsibilities-operational) <<https://providers.dhhs.vic.gov.au/public-housing-and-national-disability-insurance-scheme-roles-and-responsibilities-operational>>

5.9 Complex Needs Panel

SfHRT clients may be presented to panels by the Complex Needs Coordinator for expert advice on service planning, problem-solving and the identification of systemic issues. Not all SfHRT clients are required to be presented; however, the panel should be consulted where there are:

- particularly challenging or unusual circumstances
- systemic issues
- concerns around risk management.

SfHRT activity and brokerage expenditure information is provided to panel members on 7d Brokerage Notification Form at each panel meeting. The Monthly Snapshot Report forwarded to divisions from the Central Complex Needs team is also recommended for panel to note.

5.10 SfHRT consultation closure

A SfHRT consultation should be considered for closure in the following circumstances:

- the matter is believed to be resolved
- the involved services have not required further consultation support for 3 months
- no further tasks have been generated for the Complex Needs Coordinator for 3 months
- the referring/lead service has withdrawn
- the client decides to withdraw.

The client can be re-referred if the need arises. If the client is re-referred, a new consultation record is opened (ensuring client details are updated), reflecting the current reason/goal of consultation, current service system issues and current service involvement.



Documentation required

- 1c Complex Needs Recommendations/Closure Form.



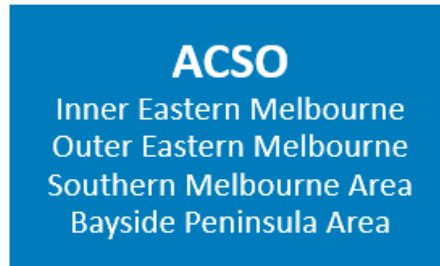
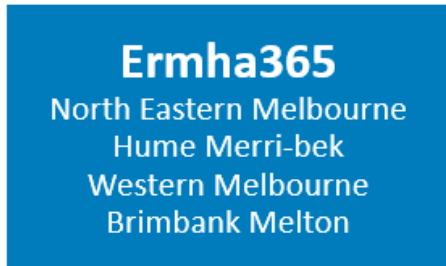
Coordinator tasks

- complete and provide Complex Needs Recommendations/Closure Form to the referrer
- update HiiP, uploading the Complex Needs Recommendations/Closure Form.
- update the SharePoint SfHRT client database, ensuring the closure date is recorded.

6. Assertive Outreach and Support

The Assertive Outreach and Support (AOS) is a pilot program which will operate until 30 June 2024 in metropolitan areas only.

The AOS is delivered by two funded providers:



6.1 Service model

The AOS delivers assertive outreach and case management support to people with complex needs who experience significant service gaps and present an unacceptable risk of harm to others.

Assertive outreach will support people to overcome barriers to accessing services and is provided flexibly in the place of residence or community, to build capacity for people with complex needs and improve their engagement with targeted interventions and services. Assertive outreach will provide:

- intervention at the time a person needs it to address barriers to access, including service refusal and avoidance
- intensive and flexible support addressing barriers to accessing services, including environmental, social, and criminogenic barriers
- recognition of the potentially difficult, chaotic, and challenging life circumstances which make it difficult for people to engage in conventional treatment settings
- proactive approaches and acknowledgement that for some people it is not simple to access relevant services required to address their needs.

Case management will enhance a person's access to services through a collaborative, structured process of assessment, planning, intervention, and review of services delivered, that responds to the risk and needs of a person with complex needs.

The AOS process workflow outlines the key process steps for AOS (Appendix 1).


AOS providers will deliver assertive outreach and case management support to the person. It is not expected that AOS providers will be the primary service delivery agency but will facilitate the persons' access to existing mainstream and specialist services through warm and facilitated referrals; and through identifying and resolving any barriers preventing their access.

Where existing services are not available to the person, AOS providers will manage a flexible brokerage allocation to support people to achieve their goals.



Coordinator tasks

- receive referrals and screen/assess eligibility for AOS
- allocate AOS eligible referrals to the relevant AOS provider

- 
- provide consultation support as the person is receiving services from the provider
 - prepare AOS matters for presentation at Complex Needs Panels in collaboration with the AOS provider.

6.2 Service delivery principles

AOS service delivery will align with the following principles:

- human rights focus
- person-centered, including peer-led design and delivery
- trauma-informed
- evidence-based and outcomes focus
- family and carer-inclusive
- responsive to diversity.

6.3 AOS provider service delivery frameworks

AOS providers have developed service delivery frameworks that outline how they will deliver AOS to clients. The frameworks include:

- initial engagement and service delivery
- assessment of client needs and risk
- development of a tailored engagement plan and/or individual support plan
- interaction with Complex Needs teams, including the area Complex Needs Panel
- exit planning and transitioning to AOS closure
- service response, duration, and environment
- risk management approach.

6.4 Operational Management Group

The primary purpose of the Operational Management Group (OMG) is to support consistent and timely implementation of the AOS Pilot Program, particularly in the early stages of AOS service delivery to clients.

The relevant department area is responsible for determining a person's eligibility for AOS, noting the determination will consider the input of the OMG and be consistent with application of eligibility criteria across other areas with the AOS pilot program.

OMG members representing the AOS provider are responsible for providing updates on current allocated clients and escalating current risk and issues for discussion as required.

The OMG terms of reference will be reviewed after eight weeks of service delivery.

The purpose of the OMG is to:

- provide a forum for discussion of incoming referrals' eligibility assessment outcomes and allocation to the provider
- support consistent and timely decision-making across the pilot areas
- receive progress updates on clients previously allocated to the provider, including brokerage expenditure, discussion of risks, issues, and mitigation strategies

- provide advice and feedback on referrals, eligibility considerations and specific issues raised at meetings to ensure consistent and timely implementation of AOS and services to AOS clients
- facilitate local resolution of risk and issues if needed (Complex Needs Coordinators can provide support via information/practice advice, system navigation, problem-solving, capacity building)
- identify AOS clients that should be escalated to the relevant Complex Needs Panel and/or the Statewide Complex Needs Advisory Panel (SCNAP) - cases where there is high level of risk and a clear purpose for the escalation
- escalate issues to the Central Complex Needs Team if there is a procedural or practice issue to be resolved
- provide advice when products to support implementation of the AOS Pilot Program are developed or reviewed.



Documentation required

- 1 Complex Needs Referral Form
- 1a Complex Needs Intake Form
- AOS Engagement Plan (provider's own), where present
- AOS Individual Support Plan (provider's own), where present



Coordinator tasks

- prepare AOS matters for presentation at the OMG
- present the AOS referral
- finalise service response recommendations for the person considering OMG input.

6.5 Complex Needs Panel

The AOS provider can request to escalate matters to area Complex Needs Panels via Complex Needs Coordinators.

Complex Needs Panels will receive an AOS progress summary in the form of a tabled document on AOS clients for the relevant pilot area, including the number of referrals, allocations, closures, high/critical risks, and issues). Panels will also consider individual cases escalated by the OMG if risks/issues have been unable to be resolved.

Escalated cases will include scenarios where:

- individuals have not consented to receive AOS services after 6 weeks of attempted engagement. The purpose is to ensure an appropriate balance between privacy/right to refuse services and risk of harm considerations.
- access to / cooperation between specific local services is unable to be resolved
- appropriate awareness and oversight within the area is required due to escalation or level of risk
- closure is proposed for clients who continue to pose high risk of harm to others but no longer require or will derive benefit from AOS.



Documentation required

- 1 Complex Needs Referral Form
- 1a Complex Needs Intake Form

- 6n Complex Needs Case Presentation Template
- AOS Progress Summary (provider's own)
- AOS Engagement Plan (provider's own), where present
- AOS Individual Support Plan (provider's own), where present
- 1e AOS Closure Report



Coordinator tasks

- provide Complex Needs Case Presentation Template to the AOS provider to complete
- support the AOS provider for presentation at Complex Needs Panels
- discuss outcome of panel deliberation with AOS provider and any actions arising, where needed.

6.6 Eligibility for AOS

The AOS target cohort is people aged 16 years and over who appear to have all the following:

- complex functional needs that are causally linked to mental illness, psychological distress, cognitive impairment, neurodiversity, substance use or trauma
- pose an unacceptable risk of harm to others, and
- are experiencing significant service gaps such that the current service system is not addressing their needs or reducing the risk to community safety.

The Complex Needs Intake Form should be used to determine if a person meets the criteria for AOS based on information provided in the Complex Needs Referral Form. Complex Needs Coordinators will consider factors outlined below when determining a person's eligibility for AOS.

6.6.1 Complex functional needs

A person may meet the eligibility criteria for AOS if they appear to have at least one of the following:

- mental illness, including personality disorder
- psychological distress
- cognitive impairment, including acquired brain injury and intellectual disability
- neurodiversity, i.e.: autism spectrum disorder
- problematic substance use
- experience of trauma.

And they have complex functional needs causally linked to their mental illness, psychological distress, cognitive impairment, neurodiversity, substance use or trauma, i.e.:

- behavioural challenges, including behaviours of concern, socially inappropriate behaviours and difficulty coping with change
- social challenges, including having difficulty maintaining relationships with family and friends
- challenges making decisions and organising tasks (i.e.: taking medication or attending appointments)
- challenges with communicating, learning or memory
- challenges maintaining a healthy lifestyle, including eating a healthy diet, getting exercise, and avoiding harmful use of alcohol and other drugs

- physical health needs, including chronic conditions
- housing needs, including being homeless or lacking stable housing, poverty, social isolation, or loneliness.

6.6.2 Unacceptable risk of harm to others

A person may meet the eligibility criteria for AOS if they appear to pose an unacceptable risk of harm to others based on their:

- presentation
- unique circumstances and environment
- diagnoses or clinical assessments.

Unless therapeutic interventions to reduce the risk are put in place (e.g.: treatment, secure accommodation, or behavioural supports).

The *AOS risk assessment and management framework* provides guidance to Complex Needs Coordinators, AOS service providers and other key stakeholders on the screening, assessment, monitoring, and management of risk for AOS clients.

Determining if a risk is unacceptable involves considering the gravity of the consequences of potential actions against community standards, and the probability of those actions occurring. An unacceptable risk of harm may exist even where the likelihood of the harm occurring is low.

Complex Needs Coordinators are required to consider risk to determine if a person meets the 'unacceptable risk of harm to others' criteria based on information provided by the referrer.

When considering the information, particular attention should be given to information that indicates the presence of personal characteristics and environmental factors that are most strongly associated with violence. A history of violence, combined with indicators that the trajectory of violent behaviour is increasing are particularly important. Questions for Complex Needs Coordinators to consider when reviewing the referral information and during follow-up conversations with the referrer are included in the Complex Needs Referral and Intake Forms. More information is available in the *AOS risk assessment and management framework*.

6.3.4 Experiencing significant service gaps

This criterion is likely to be the one that most often determines if AOS is the recommended complex needs response. AOS is not intended to divert people from services for which they are eligible and should be able to access including existing mainstream or specialist service responses and other complex needs responses offered by the department.

A significant service gap means that the person is not receiving services that are meeting their complex needs or appropriately managing their unacceptable risk of harm to others. This could be due to a range of factors, including:

- appropriate services aren't available because the person's needs fall outside existing service responses
- the person doesn't meet eligibility criteria for existing services
- providers refuse to offer/provide services to the person because of perceived risk
- the person refuses to access services
- there are behavioural barriers to accessing appropriate services, including motivation, communication, or lack of organisational skills to attend appointments

- the services the person is receiving are demonstrably ineffective or unsustainable, or don't have the capacity to meet the persons needs or manage the risk of harm to others, perhaps due to a lack of clinical treatment or evidence-based models of care
- the person is receiving appropriate services, but they are not effective due to a lack of coordination and collaborative planning (and they are not consenting to or eligible for MACNI).

It is intended the AOS provider will support the person to overcome those barriers to improve the persons access to existing mainstream or specialist service responses.

It is only when there are significant barriers in accessing those services, or a significant service gap, that a person should be considered as being eligible for AOS. Complex Needs Coordinators should also consider other less intensive measures for addressing service barriers or gaps that should be investigated before a person is recommended for AOS. This may determine for example, if a person should receive consultation support as first response, and only be recommended for AOS if attempts to address service barriers and gaps has been unsuccessful.

6.7 Referral process

People will be identified in the community and can be referred to Complex Needs teams via self-referral, family, friends, health, community, or emergency services. As with all complex needs' referrals, the referrer is responsible for obtaining the person's consent to collect and use their personal information for the purpose of making a referral and providing their information to a service provider who will deliver the recommended complex needs response (Refer section 3.2 and 3.3).

Complex Needs teams in the AOS pilot areas will manage incoming enquiries about the AOS response and will screen enquiries and referrals for AOS eligibility.

Step 1 Assess eligibility

Referrers may directly contact a Complex Needs Coordinator to discuss a potential referral for complex needs support. The Complex Needs Coordinator will request the referrer to complete a Complex Needs Referral Form. This form includes questions that assist to identify eligibility for AOS, including questions about violence towards others. Equally, some referrers directly submit a referral for a complex needs service response. In this scenario, the Complex Needs Coordinator will follow-up with the referrer to discuss the information submitted as per usual practice.

The Complex Needs Coordinator subsequently completes the Complex Needs Intake Form to consider make recommendation on the service response best suited to the person.

If the person is eligible for other complex needs responses such as Complex Needs Consultation, this should be considered for recommendation before AOS eligibility is considered. AOS is not intended to replace existing service responses the person should be able to access, including mainstream, specialist and other complex needs responses offered by the department.

Where the Complex Needs Referral Form indicates that the person presents an unacceptable risk to others or more information is required to make this decision, the Complex Needs Coordinator will seek further information from the referrer using the Complex Needs Intake Form's Attachment 1 AOS Additional Risk Questions. This will assist the Complex Needs Coordinator to confirm if the person is eligible for AOS and will provide critical information for the AOS service provider.

Step 2 Operational Management Group and recommendation to AOS

The pilot area is responsible for determining if a person will be recommended for AOS. However, prior to confirmation that a person will be referred to AOS, the recommendation should be discussed with members of the Operational Management Group (OMG). The purpose of this is to identify if the recommendation is consistent with decision-making across other areas in the pilot and if there is a need for further information. If no consent has been provided, i.e.: it was a duty of care referral, the presentation should be de-identified and remain de-identified until it is confirmed that the person will be recommended for AOS.

Following consideration of the OMG, the Complex Needs Intake Form is finalised, including the final recommendation and line manager approval.

If the person is not recommended to receive AOS following the OMG, Complex Needs Coordinators will provide advice and support to the referrer in line with their consultation role.

Step 3 Notify the referrer of outcome

The Complex Needs Coordinator is responsible for informing the referrer of the outcome. If the referral was a duty of care referral, the referrer should again seek the person's consent and let them know that their information has been provided to the AOS provider, excluding the provision of sensitive information if consent was not provided, who will be in contact with them to explain supports available through AOS.

Once the person is allocated to an AOS provider, the provider will contact the referrer to confirm that the client has been informed, confirm if consent has been provided and to plan for initial engagement with the person.



Documentation required

- 1 Complex Needs Referral Form
- 1a Complex Needs Intake Form, including Attachment 1 AOS Additional Risk Questions.



Coordinator tasks

- provide referral advice and consultation as required
- receive referral and seek further information if required to determine AOS eligibility
- complete the Complex Needs Intake Form with line manager approval for AOS
- present at the next OMG for discussion, and if there is no consent, present as de-identified and without sensitive information
- allocate to the pilot area AOS provider
- update the referrer on the outcome and next steps for contacting the client
- request referrer to make further attempt to obtain consent
- update the SharePoint client database.

6.8 Allocation to an AOS provider

Allocation will include provision of the Complex Needs Referral Form, evidence provided by the referrer to support the referral, and the Complex Needs Intake Form, including the completed Attachment 1 AOS Additional Risk Questions.

Prior to sharing client information with an AOS provider, Complex Needs Coordinators review the referral and intake documents to ensure any sensitive information has been removed if consent has not been provided by the client.

Complex Needs Coordinators will notify the AOS provider when they can access SharePoint.

AOS providers will acknowledge receipt of a referral with the Complex Needs team within one business day and make initial contact with the referrer within two business days.

The purpose of the contact is to confirm the person has been informed that they have been recommended to AOS and that the AOS provider will contact them. The AOS provider will also gather information from the referrer to support planning for the initial engagement.



Documentation required

- 1 Complex Needs Referral Form and evidence provided to support referral
- 1a Complex Needs Intake Form



Coordinator tasks

- review information provided by the referrer and remove any sensitive information that may have been shared without consent
- notify AOS provider that client information is available in SharePoint
- update the SharePoint client database.

6.9 Individual Support Plan

For clients who have provided consent, AOS providers will work with each client to develop an Individual Support Plan (ISP). An ISP is a person-centred planning document used in AOS. It includes:

- client's goals
- supports needed to achieve goals (e.g.: to address service gaps and barriers or to increase protective factors)
- implementation strategies
- how the service provider will support goal achievement
- the next review date.

Central to the development of an effective ISP is a strong understanding of the client's needs and goals. Assessments including clinical assessments and past interventions should inform future planning and service delivery.

Provision of consent to receive AOS services also includes consent for a risk assessment to be undertaken by the AOS provider. This risk assessment will inform the development of risk planning and management strategies, inform the client's ISP, and establish key risk factors that should be monitored during service provision. The *AOS Risk Assessment and Management Framework* to guide how they assess risk for this purpose.

ISPs should be completed within six weeks of the person providing consent to AOS. The person must receive a copy of their ISP in the format and language they are most likely to understand. AOS providers use their own ISP templates and may refer to the ISP by a different name if preferred.

While the ISP is being developed and implemented, AOS providers update Complex Needs Coordinators on the progress of AOS clients, including regular check-ins, risks relating to the client and any other presenting issues.

Where issues are escalating and/or there are barriers to accessing services, the Complex Needs Coordinator may provide information and practice advice, system navigation, problem solving and capacity building. This support may be sought on a one to one basis between the AOS provider and the Complex Needs Coordinator, or as part of the broader discussion and regular updates at the OMG.

Where any emerging risks or issues are unable to be resolved through the OMG or the informal methods, escalation to Area Panel may be determined to be the most appropriate response. The Complex Needs Coordinator will support the AOS provider to access forms and templates required for panel presentations, and if required additional guidance to prepare and support the AOS client presentation at the Panel.



Documentation required

- Individual Support Plan Template – AOS provider specific
- 6n Complex Needs Case Presentation Template (if escalated to Complex Needs Panel)



Coordinator tasks

- monitor completion of ISPs within six weeks of a client having provided consent
- update SharePoint client database, ensuring the initial ISP date is recorded
- supply AOS provider with required panel documents
- support the AOS provider to prepare for panel if/when required.

6.10 Engagement Plan

Where a person has not provided consent for AOS, but is recommended for the AOS, the AOS provider will create an Engagement Plan (EP) within two weeks of allocation. This plan details tailored, creative strategies for communication and engagement for each client of AOS. A copy of the EP will be provided to the Complex Needs Coordinator.

EPs are a 'live' document for the engagement/assertive outreach phase of AOS service provision until the client provides consent. Following consent provision, the AOS provider can commence individual support planning. Where the engagement strategies set out in the EP have not resulted in client consent, the AOS provider will review, refine, and adjust the EP as necessary. The AOS provider may seek advice from within their organisation and use the Complex Needs Coordinator and/or OMG to discuss.

During the EP implementation, AOS providers will update the Complex Needs Coordinator on the progress of AOS clients, including regular check-ins, risks relating to the person and any other presenting issues. AOS providers may seek information and practice advice, system navigation,

problem solving and capacity building through this period. This support may be sought on a one to one basis between the AOS provider and the Complex Needs Coordinator, or as part of the broader discussion and regular updates at the OMG. AOS providers will update the OMG on the progress of active EPs with a view to review and refine the engagement strategy.

If the AOS provider has been unsuccessful in obtaining consent within six weeks of the EP implementation, or if the AOS provider considers that continued attempts to engage with the client are increasing the risk of harm to others, escalation to the Complex Needs Panel should occur. The purpose of this escalation is to seek advice about whether there is benefit in the AOS provider continuing to attempt engaging with the person or if the case should be closed and the person referred to a different service response.

The Complex Needs Coordinator will support the AOS provider with access to forms and templates required to be presented to panel, and if required additional guidance to prepare and support the AOS presentation at the Panel.



Documentation required

- Engagement Plan Template (supplied by AOS provider)
- 6n Complex Needs Case Presentation Template (if escalated to Complex Needs Area Panel)



Coordinator tasks

- monitor completion of EPs within two weeks of client commencing AOS, where they have not yet provided consent
- consult with AOS provider between implementation and six weeks post implementation
- provide client EP progress updates to OMG
- update SharePoint client database with EP information.

6.11 AOS closure

AOS will close service when the client:

- achieves their ISP goals and is sustainably linked to existing and mainstream services
- is no longer deriving benefit from AOS services and/or a different service response is required (note: transition to the alternate response should occur prior to closure)
- withdraws consent after ISP commenced and repeated attempts to re-engage and panel endorses/recommends closure and an alternate service response
- does not consent after 6 weeks, attempted engagement is increasing risk and panel endorses/recommends closure and an alternate service response.

The AOS provider recommends to the Complex Needs Coordinator the timing of AOS client's transition to closure. In liaison with the Complex Needs Coordinator, the AOS provider develops a closure report to assist with the final review of the AOS period of support.

If a client is continuing to present unacceptable risk to others but no longer requires or will derive benefit from AOS at the time closure is recommended, the closure report will be presented to panel.

The closure report reflects on the role of the AOS service provision in improving the client's outcomes, including enhanced service integration and collaboration. In addition, the closure report forms an assessment and analysis of the AOS service period and the risk present at referral, during service provision and on closure.

Note that movement of AOS clients to a restricted facility such as prison is not a reason for closure if it is still appropriate for the AOS provider to continue to engage and plan with the client. This may include facilitating access to suitable supports within the suite of standard services available to the client (e.g.: a hospital or prison may provide access to therapeutic supports or assessments).

Increased risk of unacceptable harm is not a reason for closure unless the AOS service response is contributing to that increased risk, for example the client is agitated by continuing attempts to engage with them and risk of harm to others is increasing as a result and the risk cannot be managed by modifying how the AOS provider engages with the person such as reducing the frequency of contact for a period.



Documentation required

- 1e AOS Closure Report.



Coordinator tasks

- provide AOS closure report template to AOS provider
- ensure all AOS clients have an AOS closure report
- ensure the AOS provider has completed required documents
- escalate AOS clients to the Complex Needs Area Panel where the AOS provider:
 - recommends closure due to no engagement
 - is recommends closure following AOS service delivery and the client remains an unacceptable risk to others
- ensure all documents are filed in TRIM
- update SharePoint client database, ensuring the closure date is recorded.

7. Multiple and Complex Needs Initiative

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 where a critical need arises, the Complex Needs Coordinator will work with the involved services and the area panel to determine the most appropriate level of support required. Similarly, a client's case may be closed at any stage and are not required to progress through stages before closure is recommended.

MACNI's operating model is not strictly linear, and all clients begin as a consultation. 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 appendices to assist areas implement MACNI. These templates are used by Complex Needs Coordinators to enhance consistency and promote adherence to legislation and operational guidelines. Where appropriate, templates for clients can be adjusted to suit their communication requirements.

7.1 Human Services (Complex Needs) Act 2009

MACNI is underpinned by the *Human Services (Complex Needs) Act 2009* (the Act) which establishes the authority for a coordinated approach to service delivery for people with multiple and complex needs. Appendix 2 is a summary of the MACNI service provision legislative requirements.

The Act outlines specific principles with respect to the determination of eligibility and the development and implementation of a care plan. These principles ensure client wellbeing, highlight the importance of care plan development based on a comprehensive assessment, as well as the benefits of sharing information and a coordinated approach to service delivery.

To allow for the effective implementation of MACNI, the Act enables the Secretary to delegate any of their powers or functions except for the power of delegation. To give practical effect to the operation of MACNI, an instrument of delegation specifies the delegation of powers and functions to nominated departmental officers.

Refer: [Instrument of Delegation](#)

<<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Delegations%20and%20Authorisations.aspx>>

7.1.1 Information sharing provisions under the Act

The Act aims to achieve an appropriate balance between the protection of personal information and the need for disclosure in the best interests of the client. For the MACNI client group much of the existing information available about a client may be sensitive.

The Act specifically allows the Secretary and, if contracted by the Secretary, a service provider to seek information about the client from any person or organisation for the purpose of developing a

care plan. The Act authorises any person or organisation providing services to the eligible client to disclose information about this person for the purpose of care plan development.

The Act also allows service providers identified in the care plan to disclose information about a client to another service provider identified in the care plan when it will assist in giving effect to the care plan (i.e., care plan development, implementation, monitoring and review).

The Act does not compel service providers to exchange information, rather it allows them to make a professional judgement based on what they believe will be in the best interests of the client.

The *Privacy and Data Protection Act 2014* and the *Health Records Act 2001* provide additional obligations to confidentiality and nothing in this Act affects those obligations.

More broadly, there are a range of policies and resources at the department level to guide practice for appropriate information-sharing and privacy protection.

Refer: [Victorian Legislation and Parliamentary Documents <http://www.legislation.vic.gov.au/>](http://www.legislation.vic.gov.au/)



Where the request to share or release information with a third party is declined, the Care Plan Coordinator or Complex Needs Coordinator is required to escalate the issue through the relevant service provider (e.g., hospital, justice health).

7.2 MACNI eligibility criteria

An eligible client is a person who:

- (a) has attained 16 years of age; and
- (b) appears to satisfy 2 or more of the following criteria:
 - (i) has mental illness within the meaning of the Mental Health Act 2022
 - (ii) has an acquired brain injury
 - (iii) has an intellectual impairment
 - (iv) has a severe substance dependence within the meaning of section 5 of the Severe Substance Dependence Treatment Act 2010; and
- (c) 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
- (d) 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.

7.2.1 Interpretation of diagnostic criteria

Since the inception of MACNI, it has been recognised that the interpretation of the eligibility criteria relies on an inclusive position with respect to criterion b) (i) (ii) (iii) (iv) to ensure the intent of the legislation and initiative is met. That is, it is available to those most in need and is used for people where significant effort to assist has been unsuccessfully tried by the current service system. The role of the panel is not to determine eligibility only against formal diagnoses made by a professional.

Many clients have had numerous assessments and diagnoses over their life. These clients may be presented to MACNI with a clear diagnosis and the panel may determine that specific diagnostic eligibility criterion is met, and further assessments are not needed.

In other cases, due to the plethora of assessments and/or diagnoses, a panel may determine that a synthesis of existing information for the purpose of developing tailored interventions is required.

For other clients, evidence of prior assessments and diagnoses may not be available, or the information contains contradictions that necessitate an integrated assessment. Relying on the legislation's wording of 'appears to have' enables the use of judgement about the diagnoses which errs on the side of inclusion.

Mental Health Act 2022 and Severe Substance Dependence Treatment Act 2010

Further supporting less stringent interpretation of eligibility, is the requirement to establish diagnoses consistent with the definitions of 'mental illness' and 'severe substance dependence' in the *Mental Health Act 2022* and *Severe Substance Dependence Treatment Act 2010*. Both Acts provide definitions that narrowly establish the requirements for the compulsory/mandated treatment of persons.

Section 4 of the *Mental Health Act 2022* defines mental illness as '...a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'. The Act establishes a supported decision-making model that will enable and support compulsory patients to make or participate in decisions about their treatment and determine their individual path to recovery.

The *Severe Substance Dependence Treatment Act 2010* targets a very small group of people affected by the most severe substance dependence who urgently require treatment to save their lives or prevent serious damage to their health. Section 5 of the Act defines that a person has a 'severe substance dependence':

- if the person has a tolerance to a substance; and
- the person shows withdrawal symptoms when they stop using or reduce the level of use of the substance; and
- the person is incapable of making decisions about his or her substance use and personal health, welfare, and safety due primarily to the person's dependence on the substance.

The respective definitions enable an Area Complex Needs Panel to use its collective knowledge and experience to consider the available information about the client. Therefore, the Area Complex Needs Panel's role is to establish an 'apparent' presence of diagnostic criteria, even if it is to the extent that the panel notes information deficiencies/contradictions that require attention for clarification during the development of a care plan.

7.3 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 service coordination (time-limited at less than 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 using Pre-MACNI brokerage funding.

Therefore, a Pre-MACNI response may be considered by the Complex Needs Coordinator.



Documentation required

- 1 Complex Needs Referral Form
- 1c Complex Needs Recommendations / Closure Form.



Coordinator tasks

- update the SharePoint client database
- provide services as specified
- provide Complex Needs Recommendations/Closure Form to the referrer.

7.3.1 Complex Needs Panel

Pre-MACNI clients may be presented to the panel by the Complex Needs Coordinator for expert advice on service planning, monitoring and the identification of systemic issues. Not all Pre-MACNI clients are required to be presented, however, the panel should be consulted where there are:

- particularly challenging or unusual circumstances
- systemic issues
- brokerage expenditure that requires noting
- concerns around risk management.

For some people, the use of Pre-MACNI is determined to be an insufficient level of coordination to meet their needs and goals. For some, this will be determined after the approach has been tried; while for others, evidence indicates that a higher level of coordination and care planning is required and a formal referral to MACNI is initiated.

7.3.2 Pre-MACNI brokerage

Up to \$15,000 of Pre-MACNI brokerage is available to purchase specific services / interventions that will avoid further escalation. Refer to section 8 for further information regarding the use of brokerage.

7.3.3 Pre-MACNI closure

Pre-MACNI services should be considered for closure in the following circumstances:

- the matter is believed to be resolved, and/or
- the involved services have not required further consultation support for 3 months
- no further tasks have been generated for the Complex Needs Coordinator for 3 months
- the client decides to withdraw.

The client can be re-referred if the need arises. If the client is re-referred, a new consultation record is opened (ensuring client details are updated), reflecting the current reason/goal of consultation, current service system issues and current service involvement.



Documentation required

- 1c Complex Needs Recommendations/Closure Form.



Coordinator tasks

- contact referral to advise of the closure
- update the SharePoint client database, ensuring the closure date is recorded
- provide Complex Needs Recommendations/Closure Form to the referrer.

7.4 Formal MACNI services

When a referral to formal MACNI is recommended, care planning and processes are subject to the provisions of the *Human Services (Complex Needs) Act 2009*.

Figure 5: Key MACNI process considerations

Clients are required to provide consent at each stage of MACNI
Panels make eligibility, care planning and brokerage recommendations
Approval decisions are made consistent with the Instrument of Delegation and <i>Financial Management Act 1994</i>
Eligibility determination outcomes must be provided to clients in writing
Approved care plans must be provided to the clients
Clients to be informed of their right to cease involvement at any time
Clients to be informed of personal information being shared

7.4.1 Complex Needs Panel

Panels assume specific responsibility for clients eligible for MACNI. In addition to the responsibilities outlines in section 3.3, panels are required to fulfil the following tasks for formal MACNI clients:

- consider eligibility for MACNI in accordance with the Act
- recommend, vary, and terminate care plans for MACNI in accordance with the Act
- evaluate the effectiveness of MACNI care plans intended to promote holistic, innovative, flexible, client-centered, and value-for-money service responses.



The Act does not give panels specific functions or powers. Panels provide authoritative advice, support and recommendations pertaining to client matters to the Area Executive Director who holds delegated functions and powers.

7.4.2 Eligibility

Prior to consideration for eligibility, there are multiple notification requirements under the Act. A standardised eligibility consideration letter is provided/sent to the client to seek their consent for the consideration of eligibility, including a consent for eligibility determination form. Once the panel considers and recommends (as relevant) the referral, Area Executive Director approval is required. A standardised eligibility outcome letter is sent to the eligible client.



Documentation required - prior to Panel

- 8a MACNI Eligibility Consideration Notification – Letter to Client
- 5a Consent for MACNI Referral and Eligibility Consideration – Client
- 6i MACNI Eligibility Consideration Request Form

Documentation required - following Panel

- 8b MACNI Eligibility Decision Notification – Letter to Client.



Coordinator tasks

- obtain client consent (liaise with the key worker)
- complete MACNI Eligibility Consideration Request Form
- ensure the above eligibility notification requirements are satisfied
- prepare notification letters and obtain Area Executive Director signature
- update SharePoint client database, ensuring the start date reflects the date eligibility was recommended at panel and approved by Area Executive Director.

7.4.3 Consent documentation

The client's consent is required at each stage of the MACNI from consultation to formal MACNI. The referrer is responsible for obtaining consent from the client prior to the referral or consultation unless duty of care overrides this (section 3.3). Consent must be renewed when the client turns 18.

On consideration for formal MACNI, a standard eligibility consideration letter is provided to the client to seek their consent for the consideration of eligibility, including a Consent for Eligibility Determination Form.

The client may at any time refuse to be considered for eligibility or to be the subject of a care plan.



Documentation required

- 5a Consent for MACNI Referral and Eligibility Consideration Form.



Coordinator tasks

- ensure consent is obtained/renewed:
 - on referral to Complex Needs services
 - on recommencing Complex Needs services after a period of suspension
 - at each stage of the MACNI process
 - on the engagement of a new service provider from whom the client's personal or health information will be sought in developing or amending their care plan
 - when the client reaches 18 years of age (noting that upon reaching the age of 18, a client may still not have capacity to consent).

7.4.4 Client refusal

A refusal can be made to any provider, the Care Plan Coordinator, or a delegate of the Secretary. It can be made at any stage of involvement in MACNI. Once a care plan is developed and/or is being coordinated, and the client communicates a refusal to participate in MACNI, the Care Plan Coordinator or person being advised must determine if the client's statements of refusal are a true reflection of their wishes. The level of impairment and behavioural profile of some clients results in a changeable willingness to participate from day to day. A process for checking back with the client about the refusal is recommended before MACNI services are formally ceased.

7.4.5 Client participation

Complex Needs and MACNI service responses, including panel deliberations, are designed to assess and review the changing needs and experiences of clients at regular intervals. Client participation in the identification of priority goals and needs for addressing through a care plan is initially established by both the referring service and the care plan developer.

Departmental and/or funded community sector staff meet with the client, their family/carer/guardian and/or the services engaged in the care plan to review the achievement of identified goals. A revised care plan builds on the views, experience and perceived progress of the client and services.

Clients and/or their families/guardian may be invited to participate in regular care team meetings (whole or part) and may be provided with a summary of discussion topics if in their best interests.

7.4.6 Complex needs client information pack

On being considered for formal MACNI services, clients should be provided with documents that contain information regarding privacy, information sharing, making a complaint and the department's *Client services charter*. This client information pack is compliant with the Human Services Standards and ensures information sharing is actively undertaken throughout service provision.

Refer: [Human Services Standards](https://providers.dffh.vic.gov.au/human-services-standards) <<https://providers.dffh.vic.gov.au/human-services-standards>>



Documentation required

- 9 Formal MACNI client information checklist and supplementary documentation.



Coordinator tasks

- provide a client information pack to eligible clients and ensure understanding of its contents and purpose. This task may be better facilitated by the Care Plan Coordinator or key worker.

7.5 Care plan development

It is a requirement under the *Act* that a client determined eligible for services has a MACNI care plan developed within twelve weeks from the date of eligibility. The Instrument of Delegation specifies the roles authorised to make care planning decisions as delegations of the Secretary's powers and functions under the *Act*.

7.5.1 Duration

The *Act* stipulates care plans should not be longer than twelve months and the total duration of MACNI involvement must not exceed thirty-six months. The duration of the MACNI care plan is calculated from the date of the initial care plan approval by the departmental delegate to the date of MACNI closure, less any time for which a suspension of the care plan was approved.

7.5.2 Content

Core to the establishment of an effective care plan is a strong understanding of the client's needs and goals. The care plan makes recommendations about supports and interventions to address the client's needs, considering their best interests and working within a strengths-based framework.

The care plan must be based on a comprehensive assessment of the client's needs. Assessments, including clinical assessments and the service interventions that have been attempted or implemented in the past should assist to inform service delivery into the future. Depending on the amount and quality of previous assessments, a brief synthesis or timeline of events/interventions may be sufficient to understand the client's needs and the systems issues impacting the achievement of desired outcomes. Other times, an in-depth file review and analysis is required.

The service responsible for developing the care plan will be determined based on appropriate matching to the client's needs and the service's expertise and capacity to provide care plan development in a timely and effective manner.

MACNI assessment and care plan development templates are provided to the service developing the care plan. A service may tailor the plan with additional fields as seen relevant while maintaining the template's minimum MACNI information requirements



Documentation required

- 2 MACNI Assessment and Care Plan Development Report
- 3 MACNI Care Plan Template.



Coordinator tasks

- support the care plan developer to access and gather relevant assessments and documentation as required
- identify the need for cultural-specific consultation and arrange as required

- provide assessment/MACNI Care Plan templates to service providers to complete
- ensure 90% of MACNI care plans are recommended by the panel within 12 weeks from the date of eligibility
- ensure MACNI care plans are reviewed and recommended by the panel on a six-monthly basis
- update SharePoint client database, ensuring the initial care plan date is recorded.

NDIS plan and MACNI care plan

Many clients receiving MACNI services may also be eligible to receive a service plan from the NDIS. In many instances, the existing MACNI care plan has been provided in pre-planning meetings with the NDIS to demonstrate the level of complex support and coordination required.

Where a formal MACNI client also has an approved NDIS plan, details regarding NDIS-funded service provision are to be incorporated into the MACNI care plan, specifying the funding source. No plan takes precedence over another, and the two plans exist side-by-side with specific functions.

To avoid duplication of funding, knowledge of what is/can be funded via the NDIS plan is required before brokerage can be committed. For example, the NDIS plan may include provision for assessments or direct staff support and should not be requested from MACNI. MACNI does not fund services that would normally be funded by the NDIS, including psychosocial disability support.



Coordinator tasks

- ensure fund holders (e.g.: DFFH, NDIA) are clearly indicated within the care plan
- obtain consent from the client to have information regarding services in their NDIS plan released to the Complex Needs Coordinator or Care Plan Coordinator.

7.5.3 Care plan development tiers

To help target interventions appropriately, MACNI uses a tiered approach to care plan development based on the client’s need and the availability and accessibility of required information.

At eligibility determination (or later) panels may make a recommendation on care plan development, including the choice of service provider to engage and the care plan level required. In some cases, a draft care plan is presented to panel at the point of eligibility consideration for its recommendation. If this occurs, the further appointment of a care plan development agency is not required, and service provision can progress to care plan coordination.

The panel reaches a decision about the care plan development level required at a point in time. If the client’s needs or circumstances change, the level can be adjusted outside the panel meeting to ensure a timely response. This is initiated through contact with the Complex Needs Coordinator who reviews the request, and if appropriate, seeks approval from a departmental delegate. The decision is reported to panel members at the next scheduled meeting.

Care plan development tiers and descriptions

Tier	Description
Tier 1: 20 hours per week for 4 weeks	Synthesis and analysis of existing and readily accessible information

Tier 2: 20 hours per week for 8 weeks	Sourcing and analysis of new or difficult to access information
Tier 3: 20 hours per week for 12 weeks	Extensive sourcing and analysis of new and difficult to access information

7.5.4 Care plan approval

Following the care plan developer's preparation of a MACNI care plan, the Complex Needs Coordinator ensures the initial care plan is scheduled for an upcoming panel meeting (ensuring that key performance indicators are met (section 9.3 Performance targets)).

The panel considers the initial care plan, the associated brokerage budget and proposed care plan coordination service provider, with a view to making a recommendation to the Area Executive Director for approval.



Coordinator tasks

- communicate the outcomes of a panel meeting to the care plan developer, including feedback and the requirement for any amendment to the plan and/or brokerage request
- update the CSA/SharePoint with the initial care plan approval date (date care plan is approved by the delegate)
- schedule next care plan review date within six months.

7.5.5 Copy of care plan

The Act requires that within 14 days after approving a care plan, the department must:

- give a copy of the MACNI care plan to the client
- give a copy of the whole or any part of the MACNI care plan to service providers identified in the care plan if it is in the best interests of the client and assists service providers to give effect to the care plan.

For some clients, panel recommends eligibility and a proposed care plan at the same meeting. If so, a consolidated letter (eligibility outcome and care plan) is sent/given to the client. Typically, the Complex Needs Coordinator will engage with the Care Plan Coordinator to establish the best approach for providing the care plan to the client and other engaged service providers. A standardised care plan letter, with a copy of the care plan, is prepared for the client.

A copy of the whole or part of the care plan is also given to service providers in the plan.



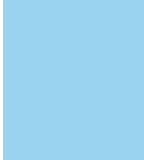
Documentation required

- 8c MACNI Care Plan Notification – Letter To Client
- 3 MACNI Care Plan – to the client (may be modified in accordance with section 20 of the Act)
- 3 MACNI Care Plan (whole or part) – to service providers.



Coordinator tasks

- ensure adherence to care plan template including details of brokerage expenditure
- support the modification of the care plan appropriate to the client's needs/capacity

- 
- prepare care plan notification letter and obtain Area Executive Director signature
 - ensure the letter and an appropriate version of the care plan are sent to the client
 - ensure service providers are provided with a copy of the approved care plan (whole or part).

7.6 Care plan coordination

While a care plan makes recommendations about supports and interventions to address the client's needs, a nominated Care Plan Coordinator has responsibility for the implementation of the care plan through active engagement with the care team.

7.6.1 Appointing a Care Plan Coordinator

The determination of the care plan coordination service is based on the matching of the client's needs and the service's expertise and capacity to provide care plan coordination in a timely and effective manner.

The Instrument of Delegation specifies the departmental roles authorised to make care planning decisions, including the nomination of the care plan coordination service provider. While a Care Plan Coordinator can be nominated from any service, the service provider needs to demonstrate:

- a commitment and expertise integrating clients with complex needs into existing service provision
- an ability to nominate or recruit an experienced, influential, and highly capable person/s to undertake the care plan coordination role
- the capacity to provide appropriate supervision and support to the Care Plan Coordinator
- professional values of open communication, effective networking, and the capacity to provide independent and objective care team governance
- skill sets in establishing and implementing rigorous accountability frameworks, including the financial acquittal of brokerage funding.

7.6.2 Role of Care Plan Coordinator

The Care Plan Coordinator continuously collects and analyses information to develop, implement and monitor the progress of a set of tailored service responses and interventions as set out in the client's care plan. This is achieved through cross-sector collaboration demonstrated by maintaining regular contact with the care team, including well-structured care team meetings, providing support and guidance at critical points, and monitoring to ensure tasks are completed within agreed timelines. Equally, the Care Plan Coordinator documents care team actions and support interventions, and their efficacy in improving client outcomes.

Key responsibilities of the Care Plan Coordinator are:

- schedule and chair care team meetings, including 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.



Coordinator tasks

- schedule regular meetings with Care Plan Coordinator to discuss emerging concerns/trends, risk management, case direction, care team dynamics, processes, brokerage management, etc.
- ensure care plan coordination tier is reviewed regularly (less than 6 monthly).

7.6.3 Care plan coordination levels

A decision is made about the level of care plan coordination required for each MACNI client at panel meetings. If circumstances change, the care plan coordination tier is be adjusted outside the panel meeting to ensure responsiveness to client need. This is initiated through contact with the Complex Needs Coordinator who reviews the request and if appropriate, seeks approval from a departmental delegate. The decision is also reviewed at the next available panel meeting.

Approval for the care plan coordination tier should not exceed 6 months. This is to ensure an adequate review of tiers. Regular review of care plan coordination tier should be conducted and adjusted as required.

Care plan coordination tier and descriptions

Tier	Considerations
Tier 1: 4 hours p/w	Risk is currently managed; the care team is identified as relatively cohesive and high functioning; interventions are not determined especially urgent, and the client is not at a critical transition point.
Tier 2: 8 hours p/w	Some identified risks have not yet been responded to adequately; the care team is not cohesive and well-functioning; there is some urgency to required interventions, and/or the client is at a critical transition point.
Tier 3: 12 hours p/w	A high level of risk is identified; the care team is not well developed or dysfunctional; interventions are urgent, and/or the client is at a critical transition point.

Existing NDIS Support Coordination

The amount and level of Support Coordination provided as part of an approved NDIS plan needs to be considered when determining tier. For example, a client who may be suitable for tier 3 (12 hours per week) may be reduced to tier 2 (8 hours per week) due to a high level of Support Coordination or Specialist Support Coordination funded by an NDIS plan.

Travel requirements

The amount of travel required from the Care Plan Coordinator's usual place of work to the location of care team meetings, client visits or relevant meetings is to be considered when determining the tier.

7.6.4 Service provider information pack

Upon being appointed to deliver formal MACNI services (care plan coordination), service providers are required to be provided with a suite of documents that contain key information, standards, legislation and policy. This service provider information pack is compliant with the Human Services Standards and its content is evidenced on a checklist.

The checklist is to be completed and returned to the Complex Needs Coordinator three months after commencement of service provision. This checklist will be reviewed annually until MACNI closure.

Refer: [Human Services Standards](https://providers.dffh.vic.gov.au/human-services-standards) <https://providers.dffh.vic.gov.au/human-services-standards>



Documentation required

- 10 Formal MACNI service provider information checklist and supplementary documentation.



Coordinator tasks

- provide a service provider information pack to services offering formal MACNI services and ensure understanding of its contents and purpose
- ensure a representative from the service provider signs the checklist 3 months after commencement of service provision, and annually thereafter.

7.7 Care plan review

Once the first care plan is approved, MACNI care plans are reviewed by the Panel every six months at a minimum.

Preparation for a care plan review enables the Care Plan Coordinator to assess progress in implementing the plan. It also provides an opportunity to consider issues that may be impacting on the implementation of the plan and the outcomes achieved by the client supported.

A review may be requested at any time when there are major changes which occur for the client or when known or emerging significant risks are identified. Any care team member, panel representative or other person listed in the Instrument of Delegation can request a care plan review take place earlier than six-monthly and at any frequency required.



Documentation required

- 3 MACNI Care Plan
- 6j MACNI Care Plan Review Report



Coordinator tasks

- ensure adherence to care plan template including details of brokerage expenditure
- ensure MACNI care plans are reviewed and recommended by the panel on a six-monthly basis
- update the SharePoint client and brokerage databases as required.

7.8 Care plan progress updates

In addition to the six-monthly care plan review, Care Plan Coordinators are required to provide updates on formal MACNI clients at Complex Needs Panels if there are issues, risks and any substantive changes that require the input and/or oversight of the panel.

Care plan progress updates are not required if the client matter is stable, and the care plan implementation is progressing as expected.

A Complex Needs Coordinator will provide a verbal or written update where there is a change to the care plan's progress, any services involved, specific actions or interventions previously recommended by the panel and/or new risks and issues emerging requiring panel decision or oversight.

It is at the discretion of the panel chair as to whether these are verbal or written, noting that the update will be recorded in the panel minutes.



Documentation required

- 6k MACNI progress update



Coordinator tasks

- provide MACNI Progress Update Form to Care Plan Coordinator to complete
- ensure MACNI care plan is updated as required
- update the SharePoint client and brokerage databases as required.

7.9 Suspension of a care plan

A change in a MACNI client's situation may impact the ability to implement the care plan effectively. In these circumstances, it may be appropriate to suspend the care plan until the outcome of the change is known. Suspending the care plan effectively pauses MACNI service provision, preserving it for a point in time where it may be more effective or of greater value to the client.

A suspension may be considered when:

- the client is incarcerated or hospitalised (or equivalent), for a period longer than 3 months or unknown, and the care plan is unlikely to be effectively implemented
- a significant crisis or event (e.g., resulting in a move to another location) gives rise to the need for the existing service providers to be engaged about the viability of service continuity.

Alternatively, a care plan may also be varied to change the number and/or type of service providers engaged. This approach would be used when, despite the change in client circumstance, many elements of the care plan can be continued. For example, an incarcerated client may continue to receive MACNI care planning if service provision remains largely unchanged, and the goals of the plan can continue to be realised while incarcerated.



The total duration of a MACNI care plan may not exceed 36 months

Panels consider and determine the appropriateness of suspending a care plan. The decision should be made with consideration of the following:

- the client's perspective

- opportunities for the client to access suitable supports from the services currently available to them (e.g.: does the hospital/prison provide access to therapeutic supports or assessments?)
- value of continued service provision in the current circumstances (e.g.: is service provision largely unchanged? How effective are services? Are the travel requirements reasonable?)
- the benefit of ‘stopping the clock’, providing continued MACNI care plan coordination while in a restrictive facility versus longer access to MACNI care plan coordination while transitioning / in the community
- the current tier of care plan coordination (may be reduced if not suspended)
- if a suspension is recommended, the panel should establish the circumstances for MACNI service provision to recommence (e.g.: agreed date, when parole or discharge planning commences).

The panel recommendation to suspend a care plan needs to be documented and communicated to the client and engaged services. The Complex Needs Coordinator notifies the Agency Performance and Systems Support (APSS) unit where the funding to a contracted service is to be impacted and/or adjusted in their funding and service agreement.

Where a Care Plan Coordinator is in place and the care plan is suspended, the continued funding for the Care Plan Coordinator may be negotiated by the area in relation to work with other MACNI clients. Alternatively, the Complex Needs Coordinator can vary the service and brokerage agreements and recoup funds accordingly.



Documentation required

- 8d MACNI Care Plan Suspension Notification – Letter to Client
- 8e MACNI Care Plan Suspension Notification – Letter to Services in the Plan.



Coordinator tasks

- prepare notification letters and obtain Area Executive Director signature
- communicate the outcomes of a panel meeting to the care team including terms of the suspension
- notify the APSS where the funding to a contracted service is to be impacted and/or adjusted in their funding and service agreement
- assume the primary liaison role for the client until formal care plan coordination recommences
- provide the panel with updates as requested
- ensure service provider engagement is maintained to enable effective commencement of services once the suspension ends.

7.10 Transition and exit planning

Over the period of MACNI engagement, the Care Plan Coordinator is required to plan for the closure by considering future options and creating sustainable service responses. This planning is undertaken with the existing care team, potential future service providers and the relevant panel.

The transition exit plan describes adjustments to the services to be delivered to meet the needs of the client’s needs from the closure of MACNI. The plan also describes the transition of supports to

sustainable services and supports in the community. The plan ideally involves planned reductions in supports coordinated via the MACNI care plan.

In the last six months of MACNI, a transition exit plan should be created, and implementation commenced. However, if the care team can successfully transition to sustainable services and achieve the care plan objectives within a shorter time, the case can return to panel for closure earlier than the six-month period.



Documentation required

- 4 MACNI Transition / Exit Plan (reflecting transition arrangements and supports upon closure).



Coordinator tasks

- provide guidance and support the Care Plan Coordinator to identify sustainable supports in the community
- ensure MACNI clients have a transition/exit plan recommended by the Complex Needs Panel at least six months prior to expected care plan termination
- ensure the case returns to panel where closure can be endorsed (within a six-month period)
- update SharePoint client database, ensuring the exit/transition plan date is recorded.

7.11 Care plan closure

The panel recommends to the Area Executive Director for care plan closure. There are multiple circumstances in which a care plan is closed:

- at any point in time if requested by the client
- when the Care Plan Coordinator, care team and department, in consultation with the client, agree that the client's needs/goals have been realised through the care plan
- when the Care Plan Coordinator, care team and department, in consultation with the client, it is agreed that the client's needs/goals can no longer be realised through the care plan due to changes in circumstance for the client
- when the care plan's duration has reached the maximum duration of 36 months.

The Care Plan Coordinator is required to prepare a closure report to assist the final review of the care plan. The report is provided to the panel at the time the Care Plan Coordinator is recommending that MACNI cease involvement, or when the maximum three-year involvement in MACNI has been reached.

The report reflects on the role MACNI has played in improving the client's outcomes and enhancing service integration and collaboration. In addition, the closure report forms an assessment and analysis of the formal MACNI service period. There is an important emphasis on the progress of the client throughout the time with MACNI; the learnings gathered; identification of systemic issues; analysis/evaluation of interventions; the client's perspective on what has been achieved; confirmation of continuing support arrangements (as relevant) and, any other future planning considerations.

7.11.1 Care plan closure acquittal

At the termination or closure of a MACNI care plan, areas must ensure the care plan is reviewed, including the formal acquittal of allocated brokerage. In some cases, the use of approved brokerage may continue for a short period of time post-closure while in transition from MACNI to the existing service system. It is the responsibility of the Complex Needs Coordinator to continue to monitor and ensure the appropriate acquittal of MACNI commitments and expenditure is performed.



Documentation required

- 4 MACNI transition/exit plan (reflecting transition arrangements and supports upon closure)
- 6l MACNI Care Plan Closure Report, including funding acquittal
- 8f MACNI Care Plan Closure Notification – letter to client
- 8g MACNI Care Plan Closure Notification – letter to services within the plan.



Coordinator tasks

- ensure MACNI clients have a transition/exit plan recommended by the Complex Needs Panel at least six months prior to care plan termination
- ensure adherence to the closure report template
- ensure all departmental actions are completed for the closure of the care plan:
 - funding acquittal
 - conclusion of funding to the care plan coordination service
 - completion of data and record management requirements
- prepare and send care plan closure notification letter to the client and services identified in the care plan
- ensure a copy of the closure report is sent to the Manager, Complex Needs Team
- update the SharePoint client database, ensuring the closure date is recorded. If required, create a new line reflecting a period of Post-MACNI support (section 7.13).

7.12 Appeal of MACNI service decisions

MACNI clients may appeal or request a review of actions relating to a departmental action that the client believes has/will adversely and directly affect them. The following events in the MACNI service model may result in an appeal by a client:

- eligibility determination
- care plan content and approval
- care plan review
- care plan suspension
- care plan closure.

A client may raise a request for appeal via any service provider engaged in the delivery of support, including the Care Plan Coordinator and/or the Complex Needs Coordinator. The client's appeal may be verbal, in writing or another format that is accessible for them. Where an appeal by a client

is indicated, the right to appeal should be actively supported for a resolution that is transparent and responsive to the issue raised.

The Complex Needs Coordinator should schedule the appeal for an upcoming panel to consider and resolve through the provision of explanation, revised decision, feedback, rationale for decisions and/or apology.

Where a panel cannot resolve an appeal, the matter will be escalated to the relevant Area Executive Director to assist with resolution.

Where an Area Executive Director is unable to resolve an appeal, the matter is escalated to the Manager, Complex Needs team for the Executive Director, Disability Services Policy and Support to review the matter.

7.13 Post-MACNI support

For a small number of MACNI clients, the full transition to sustainable engagement with the existing service system is not able to be achieved by the closure of the MACNI care plan, particularly where the plan has been in place for the maximum period of 36-months.

The department and services engaged in the care plan will continue to be engaged for a limited period (3 months) to ensure the effective integration of the client into the existing service system.

In some cases, the use of approved brokerage may continue for a short period post-closure while in transition from MACNI to the standard service system.

Information sharing provisions under the *Human Services (Complex Needs) Act 2009* do not apply to Post-MACNI clients, so Complex Needs Coordinators may be required to establish new agreements / understanding amongst those services that continue to provide a service to the client.



Coordinator tasks

- continue to monitor and acquit MACNI commitments and expenditure
- update the SharePoint client and brokerage databases as required, ensuring all entries are recorded in the Post-MACNI support type.

7.14 MACNI booklets

In addition to this framework, three booklets target specific audiences external to the department and are used to support client and sector engagement. These are:

- Getting it together: Multiple and Complex Needs Initiative (for service providers and/or carers)
- Care plan coordination: A guide for service providers on the Multiple and Complex Needs Initiative (for Care Plan Coordinators)
- Support for you: How the Multiple and Complex Needs Initiative can assist you (for clients).

8. Brokerage


Section 8.2 refers to the specific brokerage requirements for the AOS pilot program.

8.1 Summary brokerage responsibilities

The following table sets out the responsibilities by role for brokerage tasks and accountabilities.

Roles and responsibilities for the management of complex needs brokerage budget

Position	Responsibilities
Central Complex Needs Team	<ul style="list-style-type: none"> • develop and oversight of compliance to <i>Service provision framework: complex needs</i> (the Framework) • budget allocation to divisions • request mid-year review information • consider requests for additional budget allocation from the divisions • transfer of budget allocated following the mid-year review reconciliation • oversight and management of the trust fund.
Finance Manager, Division	<ul style="list-style-type: none"> • oversight of the division budget allocation and area expenditure • monitor brokerage data reported in the Complex Support Application • ensure the division budget is adhered to • implement area business processes to reconcile brokerage data between Complex Support Application and financial records (SAMS2 and Oracle).
Area Executive Director	<ul style="list-style-type: none"> • oversight of area expenditure and processes to reconcile brokerage data • perform financial delegation for all brokerage expenditure over \$50,000 • ensure brokerage requests presented to Complex Needs Panel are within the allocated divisional complex needs budget • review the Monthly Snapshot Report (developed by central Complex Needs Team for divisions) and the 7d Brokerage notification Form • monitor brokerage data as reported in the Complex Support Application.
Manager, Client Support and Housing Services	<ul style="list-style-type: none"> • support and oversight the Complex Needs Coordinator prior to / at commencement of the new financial year to project an annualised client brokerage requirement • undertake quarterly and mid-year review with the Complex Needs Coordinator on the status of projected/allocated brokerage requirements • ensure that complex needs expenditure is in-line with the Framework and departmental policies and procedures • perform financial delegation for all brokerage expenditure under \$50,000 • ensure that budgets are acquitted, and commitments are processed in a timely way and using appropriate cost codes • monitor brokerage data as reported in the Complex Support Application.
Complex Needs Panels	<ul style="list-style-type: none"> • ensure that complex needs expenditure is in-line with the Framework and departmental policies and procedures • receive notice of complex needs brokerage expenditure of less than \$25,000 and discuss as appropriate (7d Brokerage notification Form)

Position	Responsibilities
	<ul style="list-style-type: none"> • review complex needs brokerage requests over \$25,000 • recommend brokerage requests with consideration of available budget.
Agency Performance and Systems Support (AOS only)	<ul style="list-style-type: none"> • monitor brokerage administration by the AOS service provider in line with their contractual obligations: <ul style="list-style-type: none"> – monthly reporting through Service Delivery Tracking (Funded Agency Channel) on the total brokerage expended – submission of brokerage acquittal (detailed) quarterly • meet with the AOS service provider and the Central Complex Needs Team to discuss adequacy of brokerage, whether the guidelines are fit for purpose and any recommendations around repurpose of unspent funds.
Complex Needs Coordinator 	<ul style="list-style-type: none"> • ensure that complex needs expenditure is in-line with the Framework and departmental policies and procedures • meet with the Area Executive Director prior to panel to confirm all brokerage requests are within budget • provide Complex Needs Panels with an accurate overview of the current complex needs budget (Monthly Snapshot and 7d Brokerage notification Form). • with the support and oversight of the CSHSM, prior to / on the financial year commencement project annualised client brokerage requirements • with the CSHSM, undertake quarterly and mid-year reviews on the status of projected/allocated brokerage requirements to ensure that budgets are acquitted, and commitments are processed using appropriate cost codes • determine the requirement for a service agreement / brokerage agreement • check the current MACNI unit price on SAMS2 and calculate care plan development and care plan coordination accordingly • initiate the timely transfer of approved brokerage funding to contracted service providers via SAMS2 to improve budget management • update all brokerage allocation and expenditure in the SharePoint brokerage database each week (and as needed) • ensure all reasonable projections for the financial year are included in the SharePoint brokerage database. For example, it is reasonable to project care plan coordination for the remainder of the financial year for formal MACNI clients. • undertake local area business processes to reconcile brokerage data as reported in the Complex Support Application (CSA) and DFFH financial records (SAMS2 and Oracle).
MACNI Care Plan Coordinator	<ul style="list-style-type: none"> • seek quotes for service • request quotes and acquittals from service providers • provide acquittal following MACNI closure.
Services within the MACNI care plan	<ul style="list-style-type: none"> • provide quotes as requested • provide invoices within 30 days of the service being provided • clearly indicate whether GST is applicable • enter into Brokerage Agreements and Service Agreements (as applicable).

Position	Responsibilities
AOS providers	<ul style="list-style-type: none"> • ensure that AOS expenditure is in-line with the <i>Assertive outreach and support program guidelines' Attachment 1 brokerage guidelines</i> and departmental policies and procedures • report monthly through Service Delivery Tracking (Funded Agency Channel) on the total brokerage expended • provide a detailed brokerage acquittal quarterly to the Central Complex Needs team and APSS

8.2 AOS pilot program brokerage

For AOS, providers will be allocated brokerage through their service agreement. AOS providers administer the brokerage and have reporting requirements to monitor performance, that the brokerage is being used in line with guidelines and department policies and allowances are adequate. The *Assertive outreach and support program requirements* are on the Funded Agency Channel.

The use of brokerage is to provide practical assistance in engaging clients and to support people achieve goals outlined in the persons ISP. If the underlying issues leading to the need for AOS are not addressed, small changes brought about using brokerage are unlikely to make a sustained difference. Brokerage use will:

- clearly link to the implementation and achievement of the client's goals in the EP and/or ISP
- be focussed on achieving improved client outcomes and enable individuals to make positive and enduring changes, such as increasing meaningful engagement with services
- be used for time-limited, practical supports and services that are not readily accessible/timely/available within the existing service system (e.g.: local, state or Commonwealth government services) or available to other members of the community
- minimise likelihood of the client requiring more intensive intervention
- be prioritised based on an assessment of greatest need, reducing the risk of harm to others, and anticipated positive impacts on the client's daily life
- represent the most cost-effective and relevant option to sufficiently meet the client's needs
- be used to support the individual consistent with their cultural identity, including supporting Aboriginal self-determination.

Brokerage may be used for the following, where there is no other support to access:

- respite costs for the AOS client
- specialist assessments for the individual or specialist interventions where these are not readily accessible, including in a timely way
- assistance to meet dental costs or specific medical interventions for the individual that is the gap which is not covered by Medicare
- one-off payments to address immediate safety, stability, and wellbeing issues in the client's home
- assistance with a utilities bill or purchasing material aid
- assistance with educational assessments, tutors, training, or educational costs.

In the case of funding a clinical assessment or treatment, the service is to be provided by a professional with appropriate qualifications and registration (i.e.: clinical psychologist).

Brokerage expenditure exceeding a cumulative total of \$5,000.00 for any client will require discussion with the Complex Needs Coordinator (and OMG) on the expenditure. Consideration must be given to whether it is a response to a systemic issue whereby the department can provide assistance.

8.3 Complex Needs brokerage - general

This section does not include AOS. Refer to section 8.2 for AOS brokerage requirements.

8.3.1 Delegations for brokerage expenditure

The authority to approve funding for all departmental programs is governed by the *Financial Management Act 1994*. The Secretary's *Financial Authorisation Schedule* outlines the delegations for all employees which must be adhered for approval for allocation of MACNI brokerage funds.

Delegations under the Financial Management Act 1994

Authorised position	Delegation limit per transaction
Complex Needs Coordinator	\$5,000
Manager, Client Support and Housing Services	\$50,000
Area Executive Director	\$500,000

Appendix 3 is a summary of the brokerage approval process described below.

8.3.2 Brokerage principles

The following principles apply to all brokerage allocations to clients with complex needs:

- all requests for brokerage must be prepared using a Brokerage Request Form
- all brokerage allocations less than \$25,000 are reported as a standard agenda item at Panels
- the Complex Needs Panel is required to recommend all brokerage over \$25,000
- client-attached brokerage is available as a last resort when supports or resources in the standard service system are unavailable or are unable to be provided within effective timelines
- the allocation of brokerage is derived from an analysis of the client's needs and the prior effectiveness of other funding support and considers the sustainability of service delivery
- brokerage is strictly for direct purchase of services for the client (only limited essential household items may be purchased).
- brokerage is not an alternative to core funding and cannot be used to duplicate existing services or cover administrative costs
- brokerage is time-limited and non-recurrent and there must be significant effort to integrate the client back into mainstream service provision
- should be managed via invoice or SAMS2
- brokerage funds may be used to purchase secondary consultation, training, specialist clinical staff support or mentoring as per the care plan and to build service capacity. This training should be to enhance support to specific clients and not be used for broad skill development.

8.3.3 Complex needs brokerage exclusions

Complex needs brokerage is not to be used for:

- staff phones, fax, or computer expenses
- purchasing vehicles, vehicle rental, petrol, or vehicle maintenance
- staff-related travel expenses
- office rental, maintenance, utilities, or insurance
- management/infrastructure fees
- standard supervision, training and attendance and conferences
- client debts (including utility bills)
- rent arrears
- retrospective funding requests
- any items or service that can be funded by the existing service system.

8.4 Brokerage use by each complex needs response

This section does not include AOS. Refer to section 8.2 for AOS brokerage requirements.

Brokerage requirements apply to the operation of each complex needs service response.

8.4.1 Brokerage use summary

The following table provides summary information on brokerage by service response, which is detailed in the subsequent sections.

Summary of brokerage allocation for complex needs service responses

Response	Limit	Purpose	Services/items
Consultation (any client with complex needs)	Up to \$25,000 per client per 12-month period	Assessments to assist with service planning or access	Assessment only, e.g.: psychiatric, neuro-cognitive, occupational therapy, other allied health, risk assessment.
Support for High-Risk Tenancies (Public housing renters only)	Expendable within budget	To maintain or establish at-risk tenancy	Services that support the renter to maintain/establish a tenancy. e.g.: cleaning services, specialist services (behavioural intervention), capacity building.
Pre-MACNI (pre-MACNI clients only)	Up to \$15,000 per client per 12-month period	Interrupt a significant crisis, trial an intervention and/or prevent further escalation of need at a local level	<ul style="list-style-type: none"> • accommodation (limited - see below) • allied health services (e.g.: OT, speech pathology, neuro-cognitive) • assessments (allied health, risk, psychological, OT) • bridging finance that will have a significant impact on treatment • care plan development

Response	Limit	Purpose	Services/items
			<ul style="list-style-type: none"> • care plan coordination • direct support provision/worker • other specific items upon approval • psychological/psychiatric treatment secondary consultation / clinical guidance / staff training.
Formal MACNI (Formal MACNI clients only)	Expendable within area / division budget and in-line with the approved care plan	Support the delivery of the care plan	<ul style="list-style-type: none"> • accommodation (limited - see below) • allied health services (e.g.: OT, speech pathology, neuro-cognitive) • assessments (allied health, risk, psychological, OT) • bridging finance that will have a significant impact on treatment • care plan development • care plan coordination • direct support provision/worker • other specific items upon approval • psychological/psychiatric treatment secondary consultation / clinical guidance / staff training.

Note: Brokerage can be used for short-term accommodation where there are no appropriate options available within the service system. An allocation of brokerage for accommodation must have an end date; funding is time-limited and reviewed monthly. Where appropriate, clients will be required to contribute up to 25% of their income to the cost of accommodation.

8.4.2 Consultation

Consultation support includes the capacity to use assessment brokerage funding of up to \$25,000 in a 12-month period. This brokerage can only be used to purchase specific assessments that are needed to assist with service planning or service system access. All requests for brokerage must be recorded on a 7b Brokerage Request Form and approved by the appropriate financial delegate.

All consultation brokerage allocations are reported as a standard item at Complex Needs Panels using 7d Brokerage Notification Form. The Monthly Snapshot Report forwarded to divisions from the Central Complex Needs team is also recommended for panel to note.

Consultation brokerage approval requirements

Amount	Documentation	Role of Panel	Financial delegate	Procurement & Probity requirements
Less than \$5,000	7b Brokerage Request Form	Notify only	Complex Needs Coordinator (\$5,000)	Minimum of 1 quote

Amount	Documentation	Role of Panel	Financial delegate	Procurement & Probity requirements
Between \$5,000 and \$25,000	7b Brokerage Request Form	Notify only	Manager CSHS (\$50,000)	Minimum of 1 quote



Documentation required

- 7b Brokerage Request Form
- 7d Brokerage Notification Form – for Complex Needs Panel.



Coordinator tasks

- ensure the 7b Brokerage Request Form is prepared
- notify the panel of all consultation brokerage expenditure at the next panel (7d)
- seek approval for consultation brokerage from the appropriate financial delegate
- update the SharePoint brokerage database.

8.4.3 SfHRT

Brokerage funding is used when flexible responses are required that are not available within the existing service system. Consistent with eligibility for SfHRT, it is expected that all other funding options have been explored prior to any requests for SfHRT brokerage funds. If other funded program areas are involved with the renter, it is also expected that costs are shared.

SfHRT brokerage is only available for renters in public housing, not community housing.

Quotes from contractors or retailers are required for all brokerage requests, and following the receipt of quotations, the Complex Needs Coordinator seeks approval from a suitable delegate and provide written confirmation of acceptance or rejection of the request to the applicant. Where a total will exceed the original quote, an updated quote must be provided to the Complex Needs Coordinator for additional approval from a delegate (prior to the service being provided).

Recurrent requests for similar supports for the same renter, or to address similar themes regardless of the amount, will require separate approval from the appropriate financial delegate.

Items to establish a tenancy are inclusive of essential items only, e.g., bed, seating, basic kitchen appliances/cookware, not non-essential items, i.e.: TVs. There are other options where non-essential items can be sourced prior to using complex needs funds.

It is not expected that every tenant referred to SfHRT will require funding, however, some referrals to SfHRT only require financial intervention (i.e.: industrial cleaning, rubbish removal, skip hire, etc).

All requests for brokerage must be recorded on a Brokerage Request Form, can be completed at the point of referral, and must be approved by the appropriate financial delegate.

SfHRT brokerage allocations are reported as a standard item at the Area Complex Needs Panel on form 7d Brokerage Notification Form. The Monthly Snapshot Report forwarded to divisions from the Central Complex Needs team is also recommended for panel to note.

SfHRT brokerage approval requirements

Amount	Documentation	Role of Panel	Financial delegate	Procurement & Probity requirements
Less than \$5,000	1 Complex Needs Referral form 7b Brokerage Request Form	Notify only	Complex Needs Coordinator (\$5,000)	Minimum of 1 quote
Between \$5,000 and \$25,000	7b Brokerage Request Form 7c Brokerage Agreement	Notify only	Manager CSHS (\$50,000)	Minimum of 1 quote



Documentation required

- 1 Complex Needs Referral form (Section 4.1 Question 7 SfHRT brokerage request completed)
- 7b Brokerage Request Form
- 7d Brokerage Notification Form – for Complex Needs Panel.



Coordinator tasks

- ensure other funding options have been explored
- consider SfHRT brokerage as a contribution to funds required, rather than funding the full amount requested.
- ensure the brokerage request is prepared
- seek approval for brokerage expenditure from the appropriate financial delegate
- notify the panel of SfHRT brokerage expenditure at the next scheduled panel date
- update the SharePoint brokerage database.

8.4.4 Pre-MACNI

Pre-MACNI support can include the use of client-attached brokerage funding of up to \$15,000 in a 12-month period. This brokerage can be used to enhance support by increasing service or assessment options and can enable the development of an intervention/approach that may effectively resolve the matter. The brokerage funding can be used to purchase time-limited care plan coordination and supports to interrupt a significant crisis, trial a new intervention/approach or prevent further escalation of need at a local level. Examples of services items that may be purchased with Pre-MACNI brokerage includes:

- accommodation (restrictions apply, see below)
- allied health services (occupational therapy, speech pathology, neuro-cognitive, etc)
- assessments (including allied health)
- bridging finance that will have a significant impact on treatment (e.g.: less than 8 weeks accommodation)
- care plan development
- care plan coordination

- direct support provision/worker allocation
- other specific items upon approval
- psychological/psychiatric assessment and treatment services
- risk assessments
- secondary consultation / clinical guidance / staff training (capacity building).

All requests for brokerage must be recorded on a Brokerage Request Form and approved by the appropriate financial delegate.

Notification of Pre-MACNI expenditure is required to be provided to the panel at the next scheduled meeting date using 7d Brokerage Notification Form. The Monthly Snapshot Report forwarded to divisions from the Central Complex Needs team is also recommended for panel to note.

The use of brokerage must be documented in the care plan, including the service provider and dates of service provision. If there is no suitable care plan (developed by another service provider), Complex Needs Coordinators ensure a care plan is developed using the Complex Needs Care Plan Form.

Pre-MACNI brokerage approval requirements

Amount	Documentation	Role of Panel	Financial Delegate	Procurement of Probity requirements
Less than \$5,000	7b Brokerage Request Form	Notify only	Complex Needs Coordinator (\$5,000)	Minimum of 1 quote
Between \$5,000 and \$15,000	7b Brokerage Request Form 7c Brokerage Agreement Form	Notify only	Manager CSHS (\$50,000)	Minimum of 1 quote



Documentation required

- 7b Brokerage Request Form
- 7d Brokerage Notification Form – for Complex Needs Panel
- reflect brokerage expenditure in the care plan
- 7c Brokerage Agreement.



Coordinator tasks

- ensure a care plan is developed to reflect the use of brokerage using the 3 Complex Needs Care Plan Form if no care plan exists.
- ensure the care plan is updated to reflect the use of brokerage if a care plan exists
- ensure the Brokerage Request Form is prepared
- follow appropriate brokerage approval procedure, ensuring all other avenues for funding have been explored e.g., NDIS
- notify the Complex Needs Panel of Pre-MACNI brokerage expenditure (7d)
- update the SharePoint brokerage database.

8.4.5 Formal MACNI

MACNI brokerage may be allocated to formal MACNI clients to support the delivery of the care plan. The brokerage is considered and recommended by the Panel at the time of in-principle approval of the care plan, and then approved by the financial delegate. Amounts of less than \$25,000 do not require Panel recommendation, however, the Panel must be notified of the expenditure.

The use of brokerage for Formal MACNI clients requires that:

- any services must be delivered by providers who have a service agreement with the department and are registered under the *Disability Act 2006*
- financial acquittals are provided and processed within 30 days of the MACNI care plan closure
- risk assessments are encouraged at key transition points and should inform service changeover. This risk assessment may be undertaken by the care team or Care Plan Coordinator and does not refer to a clinical risk assessment from an additional external provider
- care plans that cross financial years will require the brokerage to be acquitted and processed within the same financial year that the service is provided. This may require 'in principle' payments for services provided in May/June. E.g.: where a care plan includes services from 1 March - 30 September 2024, the services are acquitted across two financial years:
 - Financial Year 2023-24: Service provision from 1 March - 30 June
 - Financial Year 2024-25: Service provision from 1 July - 30 September.

Formal MACNI brokerage approval requirements

Amount	Documentation	Role of Panel	Financial Delegate	Procurement & Probity requirements
Less than \$5,000	7b Brokerage Request Form	Notify only	Complex Needs Coordinator (\$5,000)	Minimum of 1 quote
Between \$5,000 and \$25,000	7b Brokerage Request Form 7c Brokerage Agreement [^]	Notify only	Manager CSHS (\$50,000)	Minimum of 1 quote
Between \$25,000 and \$50,000	7b Brokerage Request Form 7c Brokerage Agreement Service Agreement (Consult With APSS)	Recommend	Manager CSHS (\$50,000)	Minimum of 1 quote
Between \$50,000 and \$100,000	7b Brokerage Request Form 7c Brokerage Agreement Service agreement (consult with APSS)	Recommend	Area Executive Director (\$500,000)	Seek a minimum of 3* written quotes (see exceptions below)
Over \$100,000	Seek quote /tender or as advised by Procurement Services 7b Brokerage Request Form	Recommend	Area Executive Director (\$500,000)	Seek Quote / Tender or as advised by Procurement Services

Amount	Documentation	Role of Panel	Financial Delegate	Procurement & Probity requirements
	7c Brokerage Agreement Service agreement (consult with APSS)			

^ Unless for assessments.

* In cases where a specialist service is required, this rule does not apply and 1 quote from a provider is acceptable. Brokerage requests must clearly indicate that procurement requirements were waived due to the nature of specialist support provision.



Documentation required

- 7b Brokerage Request Form
- 7d Brokerage Notification Form – for Complex Needs Panel
- 3 MACNI Care Plan must reflect brokerage expenditure
- 7c Brokerage Agreement.



Coordinator tasks

- ensure the Brokerage Request Form and table is prepared for the panel
- prepare SAMS Variation Form (as required)
- notify the panel of all brokerage expenditure at the next scheduled panel date using 7d Brokerage Notification Form
- present brokerage requests over \$25,000 to the panel for recommendation
- seek approval for brokerage expenditure from the appropriate financial delegate
- consult with the Area Executive Director prior to panel to ensure brokerage requests are within the allocated area/division complex needs budget
- prepare brokerage agreements
- consult with APSS on the status of the provider's service agreement as all formal MACNI services require *Disability Act 2006* registration and a service agreement
- update the SharePoint brokerage database, ensuring all reasonable projections for the financial year are included.

8.5 Formal MACNI capacity building schedule

Complex Needs Coordinators are required to facilitate relationships between program areas and services, as well as provide capacity building regarding support provision for clients with complex needs. This aims to enhance the service system capacity through cross-program and service partnerships and collaborative practice, thereby ensuring the client can receive adequate support from the existing service system.

Capacity-building refers to activities that strengthen and extend the existing care planning and coordination capabilities, skills, and knowledge of external service providers through training, mentoring and secondary consultation. This includes service integration and capacity building activities, i.e.:

- secondary consultation

- job shadowing
- targeted training or skill development
- mentoring
- use of brokerage to purchase secondary consultation, specific training, specialist clinical staff support or mentoring consistent with the care plan and build longer term service capacity.

Capacity building is provided in two forms:

- develop a service provider's capacity/expertise to deliver services for clients with complex needs
- develop a care team's skill/expertise to work with a particular complex client presentation.

Under this arrangement, a package of funding aligned with the MACNI unit price is approved, in negotiation with the Central Complex Needs Team, which is used flexibly over an agreed period, typically ranging from 3-6 months.

Capacity building hours are intended to be flexible and responsive. Providers may agree to commence with higher hours initially, which may gradually reduce. It is recommended support hours are increased in line with panel preparation, key transition points or as the need arises.

The new provider receiving capacity building is allocated a Formal MACNI client and receives on-the-job training, support, and mentoring. The provider will be remunerated as per the existing hourly rate and care plan coordination structure of Tier 1, 2 or 3. In addition, the provider will receive an incentive nominal fee to cover the cost of travel and accommodation (where relevant) as included in the reasonable travel allowance rate on the [ATO website](https://www.ato.gov.au/Business/PAYG-withholding/Payments-you-need-to-withhold-from/Payments-to-employees/Allowances-and-reimbursements/Travel-allowances/). <<https://www.ato.gov.au/Business/PAYG-withholding/Payments-you-need-to-withhold-from/Payments-to-employees/Allowances-and-reimbursements/Travel-allowances/>>

If required, capacity building activities may be extended upon request. In these cases, requests must return to panel and the Central Complex Needs Team for endorsement.

Details of the capacity building activity are required in a brokerage agreement. These may include the number and type of panel documentations, number of training/mentoring (face-to-face/online) sessions and panel attendance. Importantly, the new provider must agree on the transition of oversight to the provider's internal management structures. For example, once capacity building activity ends, the organisation must have established mechanisms for ongoing supervision and document review. Complex Needs Coordinators will only review final drafts.

Following the initial period of intensive capacity building, responsibility for ad hoc capacity building, including secondary consultation and mentoring, is provided by the Complex Needs Coordinator.



Documentation required

- 12 Capacity Building Request
- 7c Brokerage Agreement



Coordinator tasks

- analyse data on SharePoint/CSA to identify systemic issues and/or service gaps
- provide or recommend targeted training in response to systemic issues or service gaps e.g., hoarding, implementing behavioural interventions
- ensure capacity building activities are recommended by the Complex Needs Panel

- prepare brokerage agreement to reflective capacity building activity
- notify the Central Complex Needs Team of capacity building activities and seek advice on the provider who will provide capacity building and funding amount.

8.6 Divisional and area allocation and oversight

Please note Section 8.2 refers to the specific brokerage requirements for the AOS pilot program.

At the commencement of each financial year, the Manager, Complex Needs arranges the transfer of complex needs brokerage funding to each division.

8.6.1 Brokerage recording and review

Complex Needs Coordinators and Client Support and Housing Services Managers are encouraged to project annualised brokerage needs early in the financial year to identify potential demand on brokerage. This should be provided to the Area Executive Director to assist with area and divisional resource planning.

Complex Needs Coordinators record all expenditure approved by the appropriate financial delegates and monitor and acquit the allocation against each client supported. This should occur at a minimum weekly, or more often in line with individual changes in client circumstances.

Each area and division is responsible to perform quarterly reviews to ensure that brokerage is recorded and acquitted correctly, including ensuring that payments to providers are performed in a timely way.

At mid-year, the Manager, Complex Needs requests a review and reconciliation of divisional brokerage use and projections. Areas are required to maintain local information to report on funds approved and projected for the remainder of the financial year.

Where a division is unable to use their funding allocation within the financial year, the funding may be redirected to meet high priority needs of clients supported in other divisions. Divisions will be engaged and advised throughout this process of any brokerage allocation adjustments.

8.6.2 Brokerage oversight

For panel meetings, the Monthly Snapshot Report (developed by central Complex Needs Team for divisions) and the 7d Brokerage notification Form are tabled for panel to note and discuss (as relevant).

These documents are made prior available to the Area Executive Director as part of the prior panel briefing process performed by the Client Support and Housing Services Manager and Complex Needs Coordinator.

It is also recommended that the complex needs brokerage budget status be routinely tabled and discussed at regular Division Executive meetings to ensure both divisional oversight and for Area Executive Directors have opportunity to speak to local area demands, challenges and resource requirements.

8.7 Service agreements

The department works in partnership with organisations who directly provide services to clients, families, and communities on behalf of the government. The service agreement sets out the key

obligations, objectives, rights, and responsibilities of both the organisation delivering services and the department.

Complex Needs (MACNI and SfHRT) services are typically delivered by organisations providing services against the complex needs activity numbers. These organisations are subject to a service agreement and service plan and must with comply with the department's service agreement requirements and all relevant policy and funding guidelines. The activity numbers are:

- MACNI services against activity 17250 Multiple and Complex Needs Initiative
- SfHRT services against activity 91417 Support for High-Risk Tenancies
- Assertive Outreach and Support services activity 17085 Assertive Outreach and Support.

Where an organisation is new to delivering services against complex needs activities, the contracting division, through the Complex Needs Coordinator and the local Agency Performance and System Support ensure the organisation is oriented to MACNI legislative obligations, Service framework, contract, and performance requirements.



All formal MACNI services (MACNI assessment, care plan development and care plan coordination) must be delivered by providers who have a Service Agreement with the department and are registered under the *Disability Act 2006*

8.7.1 Brokerage transfer

It is the responsibility of areas to transfer approved brokerage funding to the contracted service providers through funding and service agreements. Where this is not applicable, a contract consistent with the department's procurement policy is required. The transfer of brokerage funding includes the transfer of funds for care plan development and coordination services.

Refer: [Department's service agreements](#)

<<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Funded-agencies.aspx> >

Refer: [Service agreement requirements](#) < <https://fac.dffh.vic.gov.au/service-agreement-requirements> >



Coordinator tasks

- consult with APSS to determine the status of the provider's service agreement
- initiate the request for a service agreement as required.

8.8 Brokerage agreements

Brokerage agreements provide further detail supplementing the service agreement between the department and a service in receipt of brokerage against activity 17250 or 91417. The brokerage agreement complements rather than replaces a funding and service agreement or contract.

Requirements for brokerage agreements are outlined below (not used for AOS pilot program).



Documentation required

- 7c Brokerage Agreement.



Coordinator tasks

- prepare 7c Brokerage Agreement and seek approval from the financial delegate.

8.8.1 Requirements for brokerage agreements and service agreements

All one-off assessments listed below do not require a brokerage agreement if the cost is less than \$25,000 per assessment. However, the quote must meet minimum requirements (section 8.8.2).

Approved types of assessments include neuro-cognitive, occupational therapy, psychological/psychiatric, risk assessment, and speech pathology.

Requirements for all other services are subject to the thresholds in the following table.

Requirements for brokerage agreements and service agreements

Service provision funding amount	Brokerage agreement required	Service agreement required
Assessments up to \$25,000	No	No
Care plan development	Yes	Yes
Care plan coordination	Yes	Yes
All other services less than \$5,000	No	No, however, a service agreement may already exist
All other services between \$5,000 and \$25,000	Yes	Consult with APSS
All other services greater than \$25,000	Yes	Consult with APSS

8.8.2 Minimum quote requirements

When providing quotes for service, services are required to include:

- business details – including contact details and ABN
- details of qualifications, registration with their respective authorising body and relevant experience
- insurance provider – including insurance type and amount of cover
- schedule for work
- payment details, terms, and conditions
- breakdown of costs – including client items and hourly rates e.g.: travel, report writing.
- variations
- registration for GST
- total cost
- reference number.

8.9 Provider reimbursement

Complex Needs Coordinators can use brokerage to reimburse organisations for goods and services that require up-front payment, but appropriate line/financial delegate approval must be confirmed prior to the goods or services being purchased.

Reimbursements completed via SAMS2 will likely be delayed as variation windows are generally live in the first two weeks of the month. Any delay in the reimbursement process should be clearly communicated to the organisation. Where a service provider without a service agreement is used, the contracting division must ensure the department's procurement and contract requirements are met. Invoices may be paid via Oracle or using a departmental credit card. Contact your local area finance services to clarify the preferred method.

8.10 Procurement and probity

Government business must be fair, open and must demonstrate the highest levels of integrity consistent with the public interest. When undertaking funding or procurement activities on behalf of the department, staff and contractors have responsibility to maintain and address procurement and probity requirements at all stages of the funding or procurement cycle. All staff must ensure familiarity and compliance with the relevant procurement policies and guidelines prescribed by the *Financial Management Act 1994*, the Victorian Government Purchasing Board and the department's Procurement Committee (or equivalent).

The Complex Needs Coordinator (and their line and financial delegates as appropriate) must ensure that the development of the care plan, the associated brokerage budget, review, and acquittal of care plan budgets meet the department's probity and procurement requirements.

Refer: [Procurement governance](#)

<<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Procurement-governance.aspx>>

Refer: [Procurement](#) <<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Buying-goods-and-services.aspx?web=1>>



Coordinator tasks

- ensure procurement and probity policies are adhered to
- use the Brokerage Checklist as a prompt.

8.11 Goods and Services Tax

When purchasing services or entering into a service agreement with an organisation, Complex Needs Coordinators check whether GST is payable to an organisation. GST is not payable where:

- the organisation is not registered for GST or does not have an ABN. Organisations are not required to be registered for GST if their annual turnover is below the ATO threshold of \$75,000 (for commercial organisations) or \$150,000 (for non-profit organisations)
- the service agreement is with a government entity (e.g.: local government, government schools, public hospitals) provided that the non-commerciality test is met by the entity receiving funds
- the services being supplied are not taxable supplies (applies to disability client support funding managed through a financial intermediary arrangement).

To check if GST registered, refer: [Australian Business Register](#) <<https://abr.gov.au>>



Coordinator tasks

- if unsure, check with the service provider whether GST is payable (some invoices may be GST-free as they do not meet ATO thresholds)
- ensure the correct account strings are used in Oracle to reflect non-GST and GST applicable services.

8.12 Transfer of brokerage with clients across areas

Where a client supported by the complex needs team transfers between areas during the period of an approved care plan with attached brokerage, the funding commitment for the approved period is transferred from the exiting to the receiving area. The specific timeframes for transfer should be 6-12 weeks or as agreed between the relevant areas. Any subsequent care plans are subject to the approval processes of the receiving area.

8.13 Brokerage recording and reporting

Areas record complex needs brokerage expenditure approved by the Area Executive Director or Divisional Deputy Secretary and acquit the allocation against each client in the SharePoint brokerage database. This data is then able to be analysed using the CSA provided by the Central Complex Needs Team.

The CSA enables divisions and areas, to monitor and acquit commitments and expenditure by client within their brokerage budget. Standardised reports are within the application for ease of access.



Coordinator tasks

- enter data on SharePoint for all brokerage requests and acquittals
- record and review brokerage projections, updating as required
- update data weekly (at minimum)
- review (weekly) the Complex Support Application to monitor progress against allocations and division/area budgets.

9. Program administration

This section describes records management, data collection and performance reporting for all complex needs service responses.

9.1 Records management

The department's records management policy is to ensure that comprehensive and accurate records of all activities and decisions of departmental staff are created, managed, and kept in accordance with relevant legislation. The department owns all records created by organisations in the delivery of services funded by the department.

Refer: [Records](https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Records.aspx) <https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Records.aspx>

9.1.1 Client related records and TRIM EDRM

A record is any information that provides evidence of a business activity or decision. A record of each complex needs referral, any case notes, attachments, panel papers, legal documents (for example, but not limited to) is maintained in accordance with department policy and procedure for identifiable clients for whom services are provided. Complex Needs Coordinators ensure all records are kept secure using TRIM EDRM.

TRIM Electronic Document and Records Management (TRIM EDRM) is the recordkeeping system used by the department where all records must be saved. It allows staff to create, edit, share, search and restrict file access. The *Complex Needs TRIM EDRM Guide* establishes the requirements that Complex Needs Coordinators must use, including:

- Complex needs consultations (1 per financial year)
- SfHRT consultations (1 per financial year)
- MACNI eligible clients (1 folder each)
- AOS pilot program (1 for pilot period)
- Complex Needs Panels (suggested 1 folder for every 2 years – areas to decide)
- Finance (only required for Complex Needs Coordinators who process invoices via Oracle)

Complex needs consultations may at times be brief and not reveal the client identity. In these instances, a record is kept of the work of the Coordinator to ensure a record of activity is maintained. A separate client file is not practical, and records may be filed with multiple records in one file titled 'Consultations'.

Refer: [TRIM EDRM guides](https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/TRIM-EDRM-how-to-guides.aspx) <https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/TRIM-EDRM-how-to-guides.aspx>



Coordinator tasks

- request and renew TRIM EDRM folders as required
- ensure client files are maintained and securely stored in accordance with departmental policy and procedure and the Complex Needs TRIM EDRM Guide
- ensure accurate case notes are documented in appropriate systems, including HiiP and TRIM EDRM



Documentation required

- 1c Complex Needs Case Note Form
- all client documentation e.g.: assessments, Complex Needs Panel reports.

9.2 Data collection

Complex Needs Coordinators collect data and report on:

- referral targets (contacts)
- client demographics
- brokerage expenditure
- activity across consultation and SfHRT eligible client services.

This information is recorded and analysed in two systems: SharePoint and the CSA.

The Housing Integrated Information Program (HiIP) also provides a platform to document activity which can be readily accessed by housing staff.

Complex Needs Coordinators record and edit data in SharePoint. This data is visible at both its source (SharePoint) and/or can be exported to Excel and is visible via the CSA (an interactive data analysis and reporting tool) for MACNI. The has these capabilities:

- data analysis using graphs, tables, and charts
- workload oversight and management
- budget oversight and management
- target monitoring
- reporting to meet the needs of multiple audiences.

9.2.1 Data analysis for service planning

Central Complex Needs Team regularly reviews the CSA to identify:

- trends in client demographics/service profile
- service access barriers
- area and division performance against the MACNI key performance indicators
- the use of brokerage funding, including expenditure and implications for resource requirements.

9.2.2 What is a 'contact'?

For data recording purposes and to ensure consistency, a contact is defined as:

"A period of service (consultation / Pre-MACNI / Formal MACNI / Post-MACNI/AOS) in which there is regular contact and consultation with the Complex Needs Coordinator. This contact is confined by a start and end date."

The contact may involve the Complex Needs Coordinator undertaking a variety of tasks including:

- facilitate assessment
- information and practice advice
- system navigation and problem-solving
- capacity-building

- service coordination (time-limited, less than 4 hours per week)
- providing brokerage.

A new contact is counted when:

- any period of service commences (including those that only request brokerage)
- a client transitions from one support to another (e.g., SfHRT to Pre-MACNI, Consultation to Formal MACNI)

If closure is indicated, a closure/recommendations form is completed, and the end date is recorded in the CSA/SharePoint. If the client is re-referred, a new line of data is created, with the new commencement date entered. That is, each contact is a new line of data, even if it is for the same client within the same financial year.

One client may have numerous contacts over a financial year. E.g.: initially a contact for brokerage assistance only, then a second contact for 3-months, then a third contact for 1-month consultation. Whereas, a Formal MACNI client will have one contact over several months / years, up to three years in total. This may be recorded as one contact each financial year.

What does not constitute a contact?

- quick, one-off questions regarding service provision
- brief conversations held in passing
- client details / information exchange that is insufficient to populate a client registration form.

9.2.3 Data sources

- The SharePoint database as recorded by Complex Needs Coordinators
 - client databases (MACNI, SfHRT and AOS)
 - brokerage database
- Complex Support Application (CSA; QlikView Application)
- reporting as agreed with funded service agencies
- relevant qualitative data should be included in case file notes in HiiP and SharePoint.



Coordinator tasks

- record client demographics and brokerage using SharePoint databases
- update HiiP with relevant data, including qualitative content where appropriate
- ensure SfHRT referral box is selected in HiiP
- use report functions to view activity, client and area-specific information.

9.3 Performance reporting

9.3.1 Complex needs consultation targets

Complex needs referral targets are set by the Central Complex Needs team each year. They are allocated at a division level and are based on two-year rolling targets.

Information regarding how the client and service providers are supported (including hours per week) is recorded on the SharePoint database.

There are no key performance indicators.

9.3.2 SfHRT performance targets

SfHRT referral targets are set by the Central Complex Needs team each year. They are allocated at a division level and are based on two-year rolling targets. There are no key performance indicators.

Information regarding how the client and service providers are supported (including hours per week) is recorded on HiiP and the SharePoint database.

9.3.3 AOS pilot program key performance indicators and targets

The areas are required to collect and maintain data on:

- performance targets
- number of referrals
- client demographics
- related activity.

Performance indicators must be adhered to by funded services providing AOS against activity 17085.

The service targets that apply to the AOS are:

- number of clients (new clients allocated to an AOS provider)
- brokerage expenditure: monthly acquittal of total brokerage administered by an AOS provider and a detailed quarterly acquittal.

Reporting against performance indicators will be managed throughout the pilot by the Central Complex Needs team. Overall management of performance against the service agreement will be managed by Agency Performance and Systems Support.

9.3.4 MACNI key performance indicators and targets

The following are MACNI targets:

- 90% of care plans are recommended by the Panel within twelve weeks from the date of eligibility
- 100% of clients have an exit transition plan recommended at least six months prior to care plan termination.

Performance indicators are to be adhered to by all funded services providing MACNI care plan development and coordination against activity 17250. The indicators are:

- the client has an assessment and recommended care plan within 12 weeks of eligibility
- the client has a recommended transition plan at least six months prior to the expected MACNI care plan termination (noting closure may occur earlier).

Complex Needs Coordinators monitor care plan development and coordination services' adherence to these indicators and consider the indicators when developing panel schedules. These services may reasonably request Complex Needs Coordinators consider panel rescheduling if key performance indicator achievement is likely to be negatively impacted by maintaining the schedule already in place.

It is the responsibility of Complex Needs Coordinators and funded services to manage panel demands effectively in line with the key performance indicators. Achievement of key performance

indicators is based on the dates on which a panel consideration occurs, not the date a service submits the care planning documents to the Complex Needs Coordinators.

10. Quality, safeguards, and critical events

The department's standard quality safeguards and critical event instructions apply to the delivery of Complex Needs services.

10.1 Human Rights Charter

The *Charter of Human Rights and Responsibilities Act 2006* (the Charter) is a Victorian law that sets out the basic rights, freedoms, and responsibilities of all people in Victoria. The Charter requires public authorities, such as Victorian state and local government departments and agencies, and people delivering services on behalf of the government, to act consistently with the human rights in the Charter.

Twenty fundamental human rights are protected in the Charter because the Victorian Parliament recognises that we all have basic rights. In certain circumstances, some rights may be limited but this must be necessary and reasonable, with clear reasons for the decision.

Refer: [Victorian Human Rights Charter](https://www.humanrights.vic.gov.au/legal-and-policy/victorias-human-rights-laws/the-charter) <<https://www.humanrights.vic.gov.au/legal-and-policy/victorias-human-rights-laws/the-charter>>

10.2 Child safe standards

Victoria's Child Safe Standards are a set of mandatory requirements to protect children and young people from harm and abuse by requiring organisations to put policies, procedures, and processes in place to prevent and respond to abuse. All Victorian organisations that provide services or facilities to children are required to comply with the 11 Child Safe Standards.

The Commission for Children and Young People provides key guidance for organisations on the Child Safe Standards and has range of resources available.

Refer: [Child Safe Standards](https://ccyp.vic.gov.au/child-safe-standards/) <<https://ccyp.vic.gov.au/child-safe-standards/>>

10.3 Privacy and confidentiality

The department and its funded and contracted service providers have access to personal and health information about clients. All are obliged to protect the privacy of this personal and health information. Information can only be shared in accordance with the law.

Sharing information about clients is a legitimate part of providing services and keeping people safe. In sharing information, staff have responsibility to protect the interests of clients, to respect their privacy and share information appropriately when it is in a client's best interests.

Complex Needs service responses operate in accordance with privacy and confidentiality requirements under relevant legislation: Human Services (Complex Needs) Act 2009; Information Privacy Act 2000; Health Records Act 2001; Disability Act 2006; Housing Act 1983, Children, Youth & Families Act 2005; Mental Health Act 2022, Corrections Act 1986, and Severe Substance Dependence Treatment Act 2010.

Refer: [Privacy policy](https://www.dffh.vic.gov.au/publications/privacy-policy) <<https://www.dffh.vic.gov.au/publications/privacy-policy>>

10.4 Human Services Standards

The Human Services Standards represent a single set of service quality standards for department funded service providers and department-managed services.

Organisations funded to provide services to clients are required via the service agreement to meet the Standards and can be monitored against their compliance with the standards.

Services purchased using complex needs brokerage are typically delivered by organisations through a service agreement with the department against activity number 17250.

Refer: [Funded agencies service agreement information](https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Funded-agencies.aspx)

<<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Funded-agencies.aspx>>

Refer: [Human Services Standards](https://providers.dffh.vic.gov.au/human-services-standards) <<https://providers.dffh.vic.gov.au/human-services-standards>>

10.5 Client feedback and complaints

The department's *Feedback policy* and associated procedures provide the framework for how the department manages compliments, complaints and the role and responsibilities in relation to these matters. All clients receiving service support from the Complex Needs teams receive information about how to make a complaint.

Where a client raises a complaint, they should be supported to seek to resolve the matter directly in the first instance. Where the matter is unable to be resolved, the complaint should be referred to the department's Complaints Unit.

Refer: [Making a complaint](https://www.dffh.vic.gov.au/making-complaint) <<https://www.dffh.vic.gov.au/making-complaint>>

Refer: [Feedback \(including compliments and complaints\) management policy](https://dhhsvicgovau.sharepoint.com/:w:/r/sites/dffh/_layouts/15/Doc.aspx?sourcedoc=%7B1F9F7D0A-0933-4062-AD7B-323CC847591F%7D&file=Feedback-including-compliments-and-complaints-management-policy.docx&action=default&mobileredirect=true&DefaultItemOpen=1)

<https://dhhsvicgovau.sharepoint.com/:w:/r/sites/dffh/_layouts/15/Doc.aspx?sourcedoc=%7B1F9F7D0A-0933-4062-AD7B-323CC847591F%7D&file=Feedback-including-compliments-and-complaints-management-policy.docx&action=default&mobileredirect=true&DefaultItemOpen=1>

10.6 Accessing records and Freedom of Information

A client can ask for access to their personal, health and sensitive information held by the department by contacting:

- their nominated case manager/worker (including a Complex Needs Coordinator)
- the department area that has the information
- the Freedom of Information Unit via 1300 151 883 or email foi@dffh.vic.gov.au

Clients receiving services from Aboriginal community-controlled and community service organisations should approach their worker or staff to understand the policy and process for accessing their records held by that organisation.

Refer: [Making a Freedom of Information request](https://www.dffh.vic.gov.au/making-freedom-information-request) <<https://www.dffh.vic.gov.au/making-freedom-information-request>>

10.7 Client Incident Management System

The client incident management system (CIMS) is a reporting system focused on the safety and wellbeing of the department's clients and it outlines key actions service providers are required to

undertake to manage client incidents. Complex Needs Coordinators do not have requirements to report incidents as their role is not in direct client work. This responsibility is with services within a care plan and AOS providers. These services should have their own incident management reporting systems.

AOS service delivery is in scope for CIMS and both AOS service providers are registered for CIMS and are obliged to report in-scope incidents through CIMS.

Refer: [Client incident management system](https://providers.dffh.vic.gov.au/cims) <https://providers.dffh.vic.gov.au/cims>

[Client incident management guide](https://providers.dffh.vic.gov.au/client-incident-management-guide-cims-word) <https://providers.dffh.vic.gov.au/client-incident-management-guide-cims-word>

[Client incident management guide Addendum: Out-of-home-care](https://providers.dffh.vic.gov.au/client-incident-management-guide-addendum-out-home-care-word)
<https://providers.dffh.vic.gov.au/client-incident-management-guide-addendum-out-home-care-word>

10.8 Reporting client deaths

When a client dies, irrespective of the circumstances, Complex Needs Coordinators are required to provide a notification only of the death.

Refer: [Coroner's Court website](http://www.coronerscourt.vic.gov.au/) <http://www.coronerscourt.vic.gov.au/>



Documentation required

Formal MACNI clients

- Divisional Deputy Secretary brief template
- 1c Closure Report, including
 - brief review / key learnings of MACNI intervention
 - Service engagement at time of death

Other support types (SfHRT, Pre-MACNI, AOS pilot program, Consultations)

- 1c Closure / recommendation form (if appropriate)



Coordinator tasks

Formal MACNI clients

- escalate to the Client Support and Housing Services Manager and prepare a brief for Divisional Deputy Secretary with 5 days
- request the Care Plan Coordinator complete the closure report
- advise the Complex Needs Panel of the death at the next panel and if possible, present the closure report for discussion
- arrange for the recoup of brokerage funds.

Other support types (SfHRT, Pre-MACNI, Consultations)

- assist with respective notification processes (where required)
- complete the Closure/Recommendation Form (if appropriate).

10.9 Escalation to the Central Complex Needs Team

There are instances where consultation with the Central Complex Needs team is required. This includes any action that is non-compliant with the *Service provision framework: Complex needs*. The Manager Complex Needs is required to be contacted:

- where clarification is required regarding the *Service provision framework: Complex needs* or supporting documentation (e.g.: the Act)
- requests to vary a standard procedure as in the *Service provision framework: Complex needs*
- any proposal to exceed set brokerage limits (e.g.: more than \$15,000 for a Pre-MACNI client)
- requests for funded capacity building activities
- brokerage requests for items not included in the *sService provision framework: complex needs*
- brokerage funding where the expenditure would result in an area / division overspending its allocated brokerage budget
- requests to remunerate an expert adviser to participate in a Complex Needs Panel if unavailable from the standard service system.

10.10 Aboriginal and Torres Strait Islander cultural safety framework

The *Aboriginal and Torres Strait Islander cultural safety framework* has been developed to help mainstream Victorian health, human and community services and the department to create culturally safe environments, services, and workplaces. Cultural safety is about creating an environment that is safe for Aboriginal and Torres Strait Islander people.

The framework provides a continuous quality improvement model to strengthen the cultural safety of individuals and organisations. It aims to help the department and mainstream health, human and community services to strengthen their cultural safety by participating in a process of continuous learning and practice improvement.

The development of the framework is a key commitment in the department's *Aboriginal employment strategy 2016–2021* and in *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017– 2027*. The framework will support *Korin Korin Balit-Djak* to achieve the Victorian Government's vision of 'self-determining, healthy and safe Aboriginal communities'.

Refer: [Aboriginal and Torres Strait Islander cultural safety framework](https://dhhs.vic.gov.au/sites/default/files/2022-04/Aboriginal_and_Torres_Strait_Islander_cultural_safety_framework.pdf) <https://dhhs.vic.gov.au/sites/default/files/2022-04/Aboriginal_and_Torres_Strait_Islander_cultural_safety_framework.pdf>

10.11 NDIS Quality and Safeguards Commission

The NDIS Quality and Safeguards Commission (the NDIS Commission) is an independent government body that works to improve the quality and safety of NDIS services and supports, investigates, and resolves problems, and strengthens the skills and knowledge of providers and participants. The NDIS Commission provides a single, national registration and regulatory system for NDIS providers setting a nationally consistent approach to regulation of NDIS supports and services.

Refer: [The NDIS Commission](https://www.ndiscommission.gov.au) <https://www.ndiscommission.gov.au>

10.12 Community services quality governance framework

Effective quality governance is fundamental to consistently delivering safe, effective, connected, and person-centred community services. The *Community services quality governance framework* sets the objective of safe, effective, connected, and person-centred community services for everybody, every time. The framework aligns with existing quality and safety accreditation and frameworks that organisations currently have in place.

Refer: [Community services quality governance framework](#)

<<https://www.dffh.vic.gov.au/publications/community-services-quality-governance-framework>>

10.13 Family violence multi agency risk assessment and management framework

The Family Violence Multi Agency Risk Assessment and Management Framework (MARAM) is designed to increase the safety and wellbeing of Victorians by supporting relevant services to effectively identify, assess and manage family violence risk. MARAM is established in law under Part 11 of the *Family Violence Protection Act 2008*.

MARAM describes best practice for family violence risk assessment and management, based on current evidence and research. It sets out principles to guide the service system response to family violence, policies, procedures, practice guidance and tools, and staff responsibilities for family violence risk assessment and management.

Refer: [Family Violence Multi Agency Risk Assessment and Management Framework](#)

<<https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>>

Refer: [Information sharing guides, templates and tools page](#) <<https://www.vic.gov.au/guides-templates-tools-for-information-sharing>>

10.13.1 Complex Needs Coordinator responsibilities

Complex Needs Coordinators are prescribed by regulations made under the *Family Violence Protection Act*. All Complex Needs Coordinators must understand the spectrum of family violence, the evidence-based risk factors used to determine risk, and the complexity of experiences across the community.

Complex Needs Coordinators are aligned to the identification (universal) level of family violence risk assessment and risk management. The table below displays the six practice responsibilities that make up the MARAM responsibilities for Complex Needs Coordinators.

Complex Needs Coordinators MARAM practice responsibilities

Responsibility	Complex Needs Coordinators
1: Engage respectfully, sensitively, and safely	Yes
2: Identify family violence risk	Yes
5: Seek consultation with family violence specialists	Yes
6: Contribute to sharing of information with other services (through the Family Violence Information Sharing Scheme or other mechanism)	Yes

Responsibility	Complex Needs Coordinators
9: Contribute to coordinated risk management	Yes
10: Collaborate for ongoing risk assessment and risk management purposes	Yes

Refer: [Family Violence Multi Agency Risk Assessment and Management Framework Part C Pillars](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars#pillar-3-responsibilities-for-risk-assessment-and-management)

<<https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/part-c-pillars#pillar-3-responsibilities-for-risk-assessment-and-management>>

10.13.2 Training for Complex Needs Coordinators

The department has three training programs that Complex Needs Coordinators must undertake for their MARAM (and Information Sharing) responsibilities, these are:

- Recognising and responding to family violence in Housing eLearn
- Child and Family Violence Information Sharing Schemes eLearn
- MARAM Screening and Identification for Housing webinar.

10.13.3 Tools to support identification of family violence risk

There are tools designed to assist with family violence identification and basic safety planning at

[Family violence practice: MARAM and information sharing](https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Family-violence-practice-better-outcomes-for-individuals-and-families.aspx)

<<https://dhhsvicgovau.sharepoint.com/sites/dffh/SitePages/Family-violence-practice-better-outcomes-for-individuals-and-families.aspx>>.

These tools include the Adult Victim Survivor Screening and Identification Tool and the Observable Signs of Trauma tool that may indicate family violence, response options and a safety planning.

Refer: [Guidance on the Using the Screening and Identification Tool:](https://www.vic.gov.au/sites/default/files/2020-06/APPENDIX%202_0_0.docx)

<https://www.vic.gov.au/sites/default/files/2020-06/APPENDIX%202_0_0.docx>.

10.14 Supervision and support

The *Supervision and support framework* outlines required practices in detail and is a reference for supervision. Prompts for supervision are in the Complex Needs supervision record.

Effective supervision supports good working relationships, helps staff address issues, celebrates achievements, provides opportunity to discuss learning and development needs, and promotes effective complex needs service responses. Supervision can:

- confirm shared expectations about staff and a line manager responsibilities and accountabilities
- enhance supervisee well-being, learning and professional development
- provide a regular opportunity for coaching and reflective practice
- establish and monitor compliance with legislation, the VPS Code of Conduct, and best practice.

Complex Needs Coordinators may seek supplementary support and capacity building through:

- “buddy” with another area (or Coordinator) for ad-hoc or regular scheduled supervision
- case presentations at statewide meetings to discuss complex cases
- existing departmental and DJCS practice advisors
- Peer Support Network; employee wellbeing support service in the DH and DFFH.

- Central Complex Needs Team
- departmental mentors
- use existing relationships with external service providers/stakeholders
- (EAP) Converge International Employee Wellbeing and Support Program.



Documentation required

- 13 Supervision record

Refer: [Supervision and support framework in housing](#)

<https://dhhsvicgovau.sharepoint.com/:w:/r/sites/Publichousingresources/_layouts/15/Doc.aspx?sourcedoc=%7B4A84DECE-A10A-4955-8448-BCFA0CA0000B%7D&file=FINAL-Supervision-and-support-framework-in-housing-June-2021-.docx&action=default&mobileredirect=true>

11. Complex needs contacts

Complex Needs Coordinators in local areas are first point of contact for all complex needs queries.

General enquiries

Area	Office	Contact
Statewide	Melbourne CBD	Central.ComplexNeeds@dffh.vic.gov.au

North division

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

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

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	Sale	complex.clients.oga@dffh.vic.gov.au

West division

Area	Office	Contact
Western Melbourne	Footscray	WMBM.ComplexNeeds@dffh.vic.gov.au
Brimbank Melton	Sunshine	WMBM.ComplexNeeds@dffh.vic.gov.au
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

12. Complex needs forms and templates

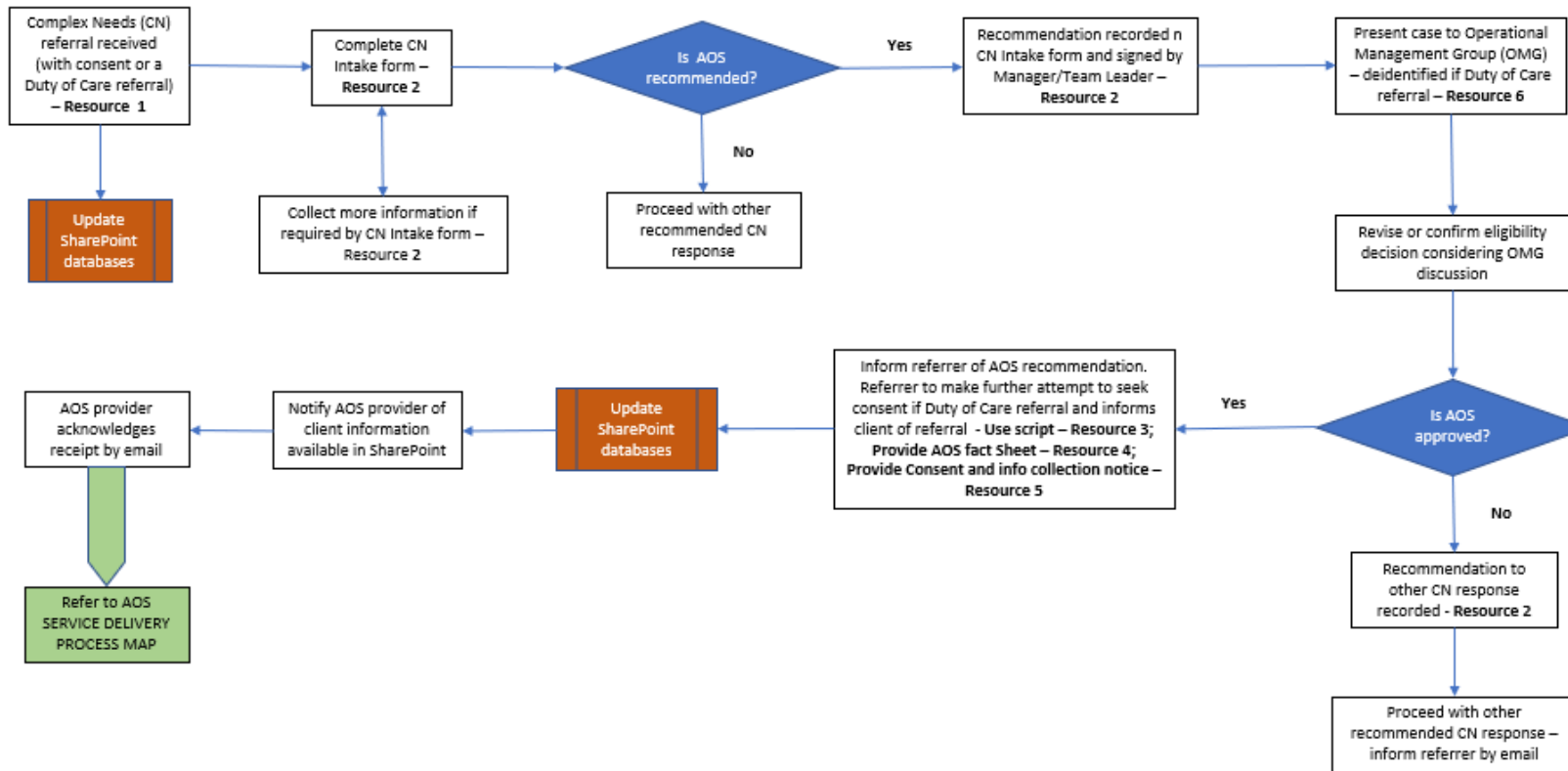
The following templates are available from the Complex Needs Coordinators for areas and divisions to support the delivery of services consistent with this framework. Some templates have been modified to integrate the Assertive Outreach and Support (AOS) pilot program for metropolitan areas.

1	Complex Needs Referral Form
1a	Complex Needs Intake Form
1b	Complex Needs Care Plan
1c	Complex Needs Recommendations and Closure Form
1d	Complex Needs Case Note
1e	Assertive Outreach and Support (AOS) Closure Report
2	MACNI Assessment and Care Plan Development Report
3	MACNI Care Plan
3a	Department of Families Fairness and Housing Cultural Plan
4	MACNI Transition/Exit Plan
5a	Consent for MACNI Referral and Eligibility Consideration
5b	Consent for Duty of Care Referral
6a	Complex Needs Panel Information Pack Checklist
6b	Complex Needs Panel Manual
6c	Complex Needs Panel Terms of Reference
6d	Complex Needs Panel Member Prompt Sheet
6e	Complex Needs Panel Deed of Confidentiality (For non-VPS Panel Members)
6f	Complex Needs Panel Agenda
6g	Complex Needs Panel Minutes – to Panel Members
6h	Complex Needs Panel Session Report – to a Specific Care Team
6i	MACNI Eligibility Consideration Request Form
6j	MACNI Care Plan Review Report
6k	MACNI Progress Update
6l	MACNI Care Plan Closure Report
6m	Complex Needs Panel Out Of Session Request Form
7a	Brokerage Checklist
7b	Brokerage Request Form
7c	Brokerage Agreement
7d	Brokerage Notification Template – For Complex Needs Panel

8a	MACNI Eligibility Consideration Notification – Letter to Client, Parent/Guardian
8b	MACNI Eligibility Decision Notification – Letter to Client, Parent/Guardian
8c	MACNI Care Plan Notification – Letter to Client, Parent/Guardian with Care Plan (or a version of)
8d	MACNI Care Plan Suspension Notification – Letter to Client, Parent/Guardian
8e	MACNI Care Plan Suspension Notification – Letter to Services within the Care Plan
8f	MACNI Care Plan Closure Notification – Letter to Client, Parent/Guardian
8g	MACNI Care Plan Closure Notification – Letter to Services within the Care Plan
9	Formal MACNI Client Information Checklist
10	Formal MACNI Service Provider Checklist
11	New Staff Orientation Checklist
12	Capacity Building Request
13	Supervision Record

Appendix 1 AOS process flow

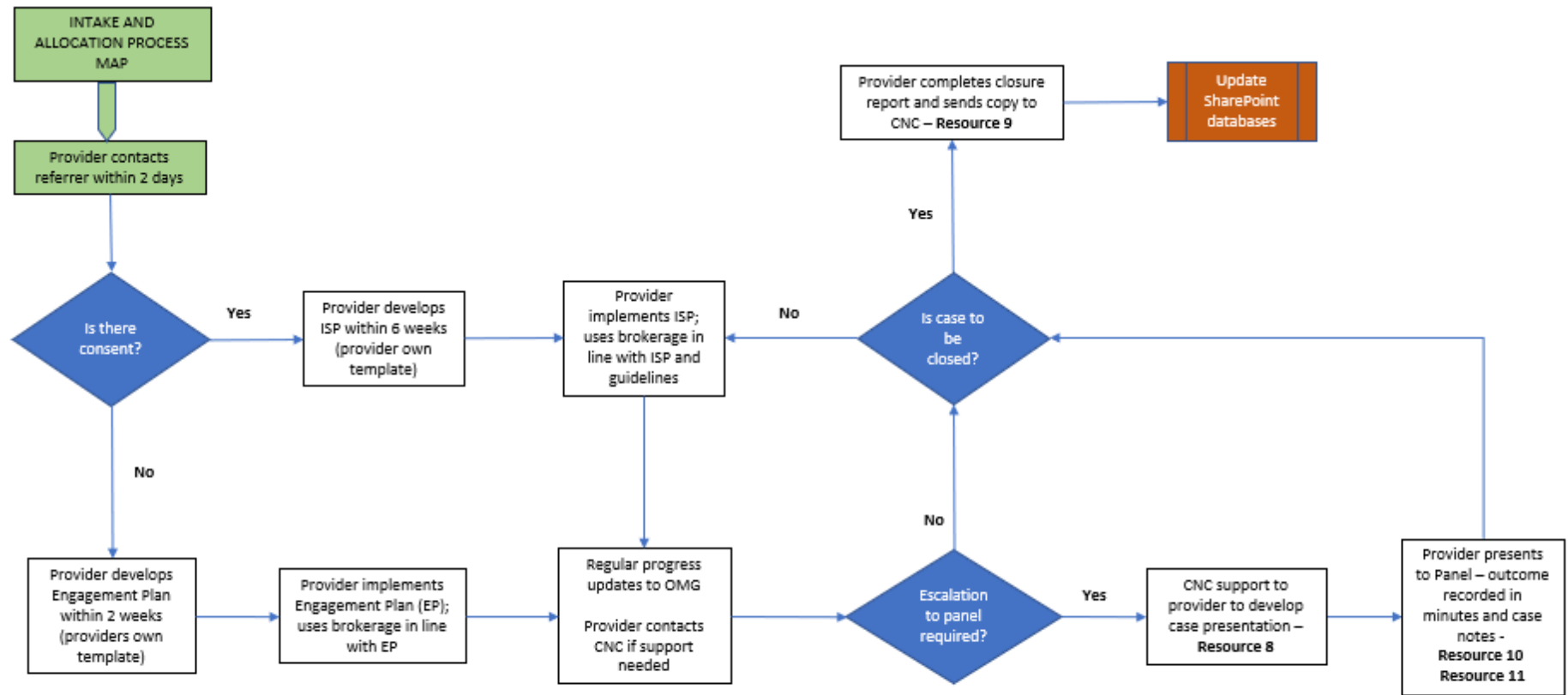
Figure 1: Intake and Allocation



- Resources and tools**
- 1 – Complex Needs Referral form
 - 2 – Complex Needs Intake form
 - 3 - Script for AOS conversation with referrer
 - 4 – AOS Fact sheet
 - 5 – AOS specific Consent/information collection statement

- Resources and tools**
- 6 –OMG Terms of reference
 - 7 – Template email to referrer re. AOS recommendation
 - 8 - Panel case presentation template (incl rationale for escalation to panel)
 - 9 - Closure report template
 - 10 – Complex Needs Area Panel minutes
 - 11 – Client case notes template

Figure 2: AOS Service Delivery



Resources and tools
 1 – Complex Needs Referral form
 2 – Complex Needs Decision Tool
 3 - Script for AOS conversation with referrer
 4 – AOS Fact sheet
 5 – AOS specific Consent/information collection statement

Resources and tools
 6 –OMG Terms of reference
 7 – Template email to referrer re. AOS recommendation
 8 - Panel case presentation template (incl rationale for escalation to panel)
 9 - Closure report template
 10 – Complex Needs Area Panel minutes
 11 – Client case notes template

Appendix 2 MACNI legislative requirements

MACNI Service	<i>Human Services (Complex Needs) Act 2009</i> Section	Legislative requirement
Eligibility	9 Notice to be given to persons before determination is made	<p>The Act requires that a person is not considered for the determination of eligibility if the person refuses to be considered and that the person may at any time refuse to be considered for eligibility or to be the subject of a care plan.</p> <p>The Act requires that before a person can be considered, the department must notify the person in writing that the department:</p> <ul style="list-style-type: none"> • may consider whether the person appears to be eligible unless the person refuses to be considered for eligibility • will ensure a care plan is developed if eligible unless the person refuses to be the subject of a care plan • may seek to obtain from any person or organisation health and/or personal information about the person for the purpose of considering whether the person is eligible or developing them a care plan • may disclose health and/or personal information about the person to a service provider identified their care plan if the department is satisfied that the disclosure is in the best interests of the person and would assist the service provider in giving effect to the care plan, and of how to contact the relevant department contact. <p>At the same time, the person is notified that a Care Plan Coordinator:</p> <ul style="list-style-type: none"> • may seek to obtain from any person or organisation health and/or personal information about the person for the purpose of developing their care plan • may disclose personal information or health information about the person to another service provider identified in the care plan if the first-mentioned service provider is satisfied that the disclosure is in the best interests of the person and would assist the second-mentioned service provider in giving effect to the care plan.
Eligibility	10 Secretary to notify person of determination of eligibility	<p>The department must notify in writing a person whose eligibility has been considered whether or not the department has determined that the person is eligible.</p> <p>The Complex Needs Coordinator ensures that the above notification requirements are satisfied. A standardised <i>Eligibility consideration letter</i> is provided/sent to the person to seek their consent for the consideration of eligibility, including a <i>Consent for eligibility determination form</i>.</p> <p>The Complex Needs Coordinator then schedules the referral consideration for a Panel meeting, providing the panel with the <i>Request for eligibility determination to panel form</i>. The</p>

MACNI Service	<i>Human Services (Complex Needs) Act 2009</i> Section	Legislative requirement
		<p>panel may also provide advice on service responses and identify systemic issues to be addressed through service planning. In particular, the Panel ensures that Aboriginal community-controlled organisations have been engaged for Aboriginal clients.</p> <p>The panel considers and recommends (as relevant) the referral which requires Executive Director approval. A standardised <i>Eligibility outcome letter</i> is then sent to the eligible client.</p>
Care plans	11 - 18	<p>In summary, the Act requires the:</p> <ul style="list-style-type: none"> • department to ensure that a care plan is developed, based on a comprehensive assessment of the person's needs after a person has been determined as eligible • care plan to specify the care, treatment and support strategies recommended for the person taking into account their best interests • care plan is initially not for longer than 12 months but thereafter may be extended with the total duration of a care plan not exceeding 36 months.
Care plan development	13 What does development of a care plan involve?	<p>The Act requires that the department or an appointed care plan development service provider must ensure that:</p> <ul style="list-style-type: none"> • the client is consulted in person and if deemed necessary and the client agrees, their family and carers are consulted • the persons and organisations currently providing welfare, health, mental health, disability, drug and alcohol treatment, offender or housing and support services to the client are consulted • a comprehensive assessment of the person's needs is carried out • relevant health/personal information in relation to the client is obtained and considered. <p>Following the determination of a client's eligibility, a care plan developer is appointed by a Panel to assess the client's needs and develop the care plan. The Panel ensures a care plan is developed as a partnership between a range of services, the client, family members and significant others.</p>
Care plan development	14 Seeking and disclosing information for purposes of developing a care plan	<p>The Act enables the department and a service provider appointed by the department for the development of the care plan, to seek to obtain health/personal information about the client from any person or organisation for the purposes of developing a care plan that relates to the client.</p> <p>The Act also indicates that the following are authorised to disclose health/personal information about the client to the department or a service provider developing a care plan, the:</p> <ul style="list-style-type: none"> • department, in the case of a service provider requesting information

MACNI Service	<i>Human Services (Complex Needs) Act 2009</i> Section	Legislative requirement
		<ul style="list-style-type: none"> • Public Advocate • Mental Health Tribunal • any person or organisation that provides or has provided welfare, health, mental health, disability, drug and alcohol treatment, offender, emergency, or housing and support services to the client.
Copy of care plan	15 Copy of care plan and notice to be given to eligible persons	<p>The Act requires that within 14 days after approving a care plan, the department must:</p> <ul style="list-style-type: none"> • give a copy of the care plan to the person • give a copy of the whole or any part of the care plan to service providers identified in the care plan if it is in the best interests of the client and assists service providers to give effect to the care plan. <p>The department must notify the person in writing:</p> <ul style="list-style-type: none"> • that a care plan has been approved • that the department, the Care Plan Coordinator and service providers identified in the care plan may share and use health and/or personal information about the client if in the best interests of the client and would assist service providers to give effect to the care plan • of how to contact the department representative • that the person may at any time refuse to be the subject of the care plan • that the person may request the department to vary or terminate the care plan. <p>Typically, the Complex Needs Coordinator will engage with the Care Plan Coordinator to establish the best approach for providing the care plan to the client and other engaged service providers. A standardised <i>Care plan letter</i>, with a copy of the care plan, is given/sent to the client. A standardised <i>Care plan letter (services)</i> or email is also sent to the services engaged in the care plan, including the whole or relevant part of the care plan.</p> <p>For some clients, a Panel approves eligibility and a proposed care plan at the same meeting and a consolidated letter (eligibility outcome and care plan) is sent/given to the client. A copy of the whole or part of the care plan is also given to service providers in the plan.</p>

MACNI Service	<i>Human Services (Complex Needs) Act 2009</i> Section	Legislative requirement
Care plan coordination	16 Care Plan Coordinator	<p>The Act requires the department to appoint a Care Plan Coordinator for a person eligible under the Act to:</p> <ul style="list-style-type: none"> • monitor the care plan implementation and progress of the client • coordinate the services provided to the client as per the care plan • provide a report to the department on client progress when requested. <p>The determination of the care plan coordination service is based on the matching of the person's needs and the service's expertise and capacity to provide care plan coordination in a timely and effective manner. As indicated, the care plan coordination service provider is typically recommended in the care plan approved by the department.</p> <p>While a Care Plan Coordinator can be nominated from any service or program, the service provider needs to demonstrate the following:</p> <ul style="list-style-type: none"> • a commitment and expertise integrating clients with complex needs into existing service provision • experience in advocating for service options that best meet clients' needs • an ability to nominate or recruit experienced, influential and highly capable person/s to undertake the care plan coordination role • the capacity to provide appropriate supervision and support to the Care Plan Coordinator • professional values of open communication, effective networking and the capacity to provide independent and objective care team governance • skill sets in establishing and implementing rigorous accountability frameworks, including the financial acquittal of brokerage funding. <p>The Care Plan Coordinator continuously collects and analyses information to develop and implement a set of service responses and interventions. This is achieved through cross-sector collaboration and the documentation of clear actions required to achieve client outcomes. Critical to effective care plan coordination is maintaining regular contact with the care team, including well-structured care team meetings, providing support and guidance at critical points and monitoring to ensure tasks are completed within agreed timelines. The Care Plan Coordinator works to assess and document the effectiveness of agreed service responses.</p>
Care plan coordination	17 Service providers may share personal and health	The Act authorises a service provider identified in a care plan to disclose personal information or health information about the eligible person to another service provider in the care

MACNI Service	<i>Human Services (Complex Needs) Act 2009</i> Section	Legislative requirement
	information to give effect to care plan	<p>plan if the first service provider is satisfied that the disclosure of the information</p> <ul style="list-style-type: none"> • is in the best interests of the person to whom the information relates • would assist the second service provider in giving effect to the care plan. <p>The Act authorises a service provider identified in a care plan to use personal information or health information about the person to whom the care plan relates that is obtained from another service provider identified in the care plan if the use of the information -</p> <ul style="list-style-type: none"> • is in the best interests of the person to whom the information relates; and • would assist the first-mentioned service provider in giving effect to the care plan. <p>The Act specifies the limited purpose for which information can be exchanged as when it will assist in giving effect to the care plan. This relates to the development of a care plan and the implementation, monitoring and review of the care plan.</p> <p>The Act does not compel service providers to exchange information, rather it allows them to make a professional judgement based on what they believe will be in the best interests of the client.</p>
Care plan review	16 Care Plan Coordinator	<p>In summary, the Act requires the Care Plan Coordinator to:</p> <ul style="list-style-type: none"> • monitor the care plan implementation and progress of the client • coordinate the services provided to the client as per the care plan • provide a report to the department on client progress when requested. <p>To achieve this, the Care Plan Coordinator may seek health and/or personal information from the department or any provider in the care plan.</p>
Care plan variation	18 Variation and termination of care plan	<p>The Act allows the department to vary a care plan, including the extension of a care plan (to a maximum of 36 months).</p> <p>Following a review, the Panel's recommended adjustments are made to the care plan and the plan is approved by the Executive Director.</p>
Care plan closure	18 Variation and termination of care plan	<p>The Act allows the Secretary (or delegate) to terminate a care plan. If a care plan is terminated, the person and any service provider under the care plan must be notified by the Secretary (or delegate) in writing.</p> <p>The Panel recommends to the Executive Director to close a care plan. The care plan is closed:</p>

MACNI Service	<i>Human Services (Complex Needs) Act 2009 Section</i>	Legislative requirement
		<ul style="list-style-type: none"> • at any point in time if requested by the client • when the Care Plan Coordinator, care team and department, in consultation with the client, agree that the client's needs/goals have been realised through the care plan • when the care plan's duration has reached the maximum duration of 36 months. <p>A Panel may request the Care Plan Coordinator to prepare a closure report to assist with the final review of the care plan. The report is provided to the panel at the time the Care Plan Coordinator is recommending that MACNI cease involvement with the client, or when the maximum three-year involvement in MACNI has been reached.</p> <p>The report reflects on the role MACNI has played in improving the client's outcomes and enhancing service integration and collaboration. There is an important emphasis on the progress of the client throughout the time with MACNI; the learnings gathered; the client's perspective on what has been achieved; confirmation of continuing support arrangements (as relevant) and, any other future planning considerations.</p> <p>The Complex Needs Coordinator ensures a letter is provided to the client and services identified in the care plan which explains that the MACNI care plan has ended, identifying any continuing supports and a contact person for questions and the continuing supports. Further, the Complex Needs Coordinator ensures all departmental actions are taken in relation to the closure of the care plan, including:</p> <ul style="list-style-type: none"> • funding acquittal • conclusion of funding to the care plan coordination service • completion of data and record management requirements. <p>A standard Care plan closure notification - letter to person, parent/guardian and a Care plan closure notification - letter to care plan coordination service is sent by the Complex Needs Coordinator.</p>

Appendix 3 Summary: brokerage approval process

Reminder: Complex Needs Coordinators are required to engage with the Area Executive Director prior to each panel to ensure brokerage requests are within the division's complex needs budget.

