People with Complex Needs and the Criminal Justice System

Abstract

Efforts to enhance efficiency in service provision have produced increasingly sophisticated targeting in the various human service domains. In the context of changing demographics, the aftermath of de-institutionalisation and governments contracting out services with tight specifications, this has often had an unintended outcome of excluding those with multiple needs, leaving some people in our community especially vulnerable. Some appear to be at increasingly high risk of being 'serviced' in our state run prisons. This paper shares the experience of one endeavour to provide an over-sighting service (under legislation) to people with multiple and complex needs. It describes and reflects on the features of the initiative that have relevance and possible pointers for the criminal justice system suggesting that the service systems themselves are more complex than those needing service.

Introduction – People with Multiple and Complex Needs

Many of the people who come in to the criminal justice system, especially prisons, have multiple unmet needs. These people need significant health, welfare and other community based services when not in custody and services struggle to sustain them. The very services they need are increasingly focused on efficient, specialist service delivery and this evolution of the service sector appears not to respond well to those with multiple needs. Some sub-groups, such as Indigenous people and women in prison, are especially vulnerable.

This paper describes and provides critical reflection on one recent initiative to respond to people with multiple needs. While the initiative was not focused on the criminal justice system specifically, the clients of the program share many of the characteristics typical of those who are imprisoned. The paper is written from the perspective of involvement in the implementation of the Multiple and Complex Needs Initiative (MACNI) in Victoria, Australia, between 2004 and 2009. While some research and evaluation studies have been conducted (Department of Human Services [DHS] 2007a, 2009) and will help inform the paper, it is primarily drawn from the authors' experience as the Chair of the MACNI Panel.

Those referred to as people with multiple and complex needs usually include individuals who experience various combinations of mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, homelessness, social isolation, family dysfunction, and drug and/or alcohol misuse. They have usually been involved with many services, often from early childhood, including child protection and juvenile justice. People with multiple unmet needs struggle to sustain accommodation and require a level and type of support that the contemporary service system does not readily allow. In addition, they are difficult to engage in service provision and many are very socially isolated.

Some of these people exhibit disruptive or aggressive behaviours contributing to the difficulty services face in trying to maintain involvement with them. Based on their historic experience, the mutual perception and disinclination of clients and services to be involved

with one another makes for mutually low expectations. Eligibility criteria are sometimes used to exclude those who are considered 'too difficult' or 'too high risk' to work with.

The behaviours, social situations and often accompanying chaotic lifestyle of people with multiple needs contribute to them coming to the attention of police and can result in them being brought before the courts. At this point their very situations reduce the likelihood of diversion or community based sentencing options. An increasing number of people with multiple and complex needs are unnecessarily entering the criminal justice system having been effectively excluded from the broader service system.

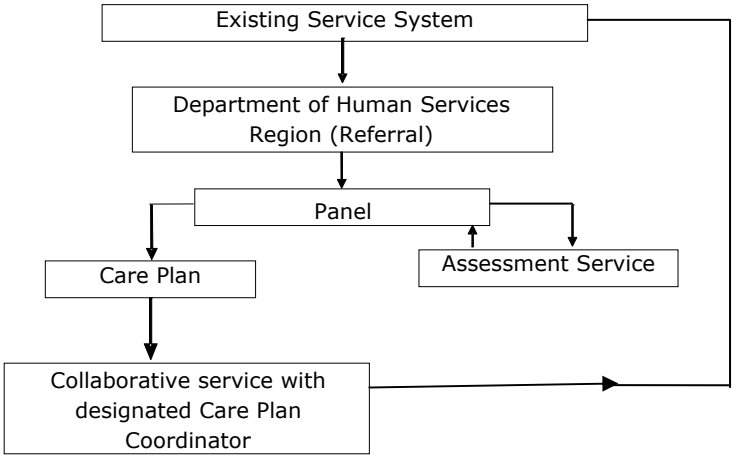
It is the interaction between the individuals with multiple needs and the arrangement of the service systems that contribute to increased difficulty in providing for these most vulnerable people.

Background and Development of the MACNI

In 2002-03, the Victorian Department of Human Services undertook a project, *Responding to People with Multiple and Complex Needs,* that initially involved the identification and profiling of 247 people at the extreme end of the continuum of complexity (DHS 2003).

This found that service responses were provided at high cost: on average, an estimated $248,000 each per annum. Services were often reactive and crisis-based rather than being fully planned and coordinated. Phase Two of this Project involved developing an operational model to deliver an innovative service that included drafting new legislation and the appointment of the MACNI Panel alongside development of the specialist services. The *Human Services (Complex Needs) Act 2003* (Vic), established powers for a time limited, specialist intervention for individuals 16 years and older with multiple and complex needs. It aimed to stabilise housing, health, social connection and safety. It also pursued planned therapeutic goals for each individual with an emphasis on coordination of services and provided a platform for long term engagement in the service system. It established the MACN Panel to decide eligibility, oversee development and implementation of care plans, review progress and allocate brokerage funds where needed.

Figure 1: MACN Initiative Service Model



The MACNI eligibility criteria included satisfaction of at least two of the four defined diagnostic criteria—mental disorder, drug and/or alcohol dependence, intellectual impairment and acquired brain injury—and being at risk to self or others, and that the person would derive benefit from involvement in the initiative. It was established as a joint initiative of the Department of Human Services (DHS) and Department of Justice (Corrections) in Victoria, and administered through DHS. Regional offices established processes to facilitate access through formal referral and assisted with development of local capacity to manage many of the potential clients.

Over the first five years of the initiative regional offices had contact or consultation with 688 people, considering 167 appropriate for referral. Of these, 84 were referred to the MACN Panel and 79 were formally declared eligible.

Multiple Needs of People in Prisons and Those Identified in the Community

Reflecting on the profile of prison populations in Australia, there are clear similarities to the MACNI clients and the issues that arose during implementation of the MACNI response bear consideration in managing transitions for many of those in the corrections domain.

Of the 79 people eligible for MACNI, 27 (34 per cent) were women and 52 (66 per cent) were men. Ages ranged from 17 to 65, with most under the age of 35. Criteria for eligibility meant that these people were much more likely to have a diagnosed problem than either the general population or those in prisons.

It is noteworthy that there was a small cluster of young people (aged 17-19 yrs); almost half of them were young women who were usually referred by youth-specific services at the time when they were having to transition to the adult service system. Duty of care concern for young people and the particular risk management approach of governments might in part explain these referrals, since services with primary responsibility for young clients make every effort to 'retain' them. The adult service system, especially when pressed with high demand, generally relies on clients to seek help. For some young people this change in service stance alone poses significant risks as they move into adulthood and in the corrections domain this shift can be dramatic; especially if it involves incarceration.

What follows will draw on parallels between those in prison and MACNI clients.

Diagnostic Classifications and Complexity

Studies have found that rates for all mental health disorders are much higher among those who have been incarcerated than the general population (for example ABS 2009) and generally rates of the major mental illnesses, such as schizophrenia and depression, have been found to be between three and five times higher in prisons than that expected in the general population (Ogloff et al 2007:1). 37 per cent of prison entrants report having a mental health disorder at some time and 18 per cent report currently taking medication for a mental health related condition (AIHW 2010:25).

The national census of prison entrants (AIHW 2010:27) reports that 50 per cent of all female prisoners report high or very high levels of stress compared with only 14 per cent of

the general female adult population. For males, this was over a quarter (27 per cent) compared with 10 per cent in the general population.

Among MACNI clients, mental disorders were even more common and present in 69 of the 79 eligible clients (87 per cent). With regard to risky or very risky alcohol and other drug use/dependence**,** 59 people (76 per cent) of MACNI clients were identified with alcohol and/or drug misuse or dependence. These rates are more similar to the prison population than the general population (AIHW 2008). Among Australian prisoners, 51 per cent of men and 52 per cent of women are reported to have been drinking alcohol at levels that put them at risk of alcohol related harm prior to their time in prison (AIHW 2010:106). Using more specific diagnostic criteria, alcohol dependency is reported in 34.5 per cent of the adult men in custody in NSW and 15.7 per cent of their female counterparts (Indig et al 2010:103).

Illicit drug use is about five times higher among prisoners (with 71 per cent reporting using in the past year) than the 13 per cent of the general community over the age of 18 (AIHW 2008). Women inmates are more likely to have used all classes of drugs than men, with the exception of ecstasy. Among women, 56 per cent have used cannabis, 38 per cent have used heroin and 10 per cent have used ecstasy, compared to men where 51 per cent, 17 per cent and 19 per cent of them have used cannabis, heroin and ecstasy respectively (AIHW 2010:60).

The extremely high reported use of heroin by women in the year prior to prison entrance raises concern about injecting practices in custodial settings and associated risks. The 'principle of equivalence'[1] should apply to allow inmates to protect themselves from further harms; including access to safe injecting equipment. 52 per cent of women and 40 per cent of men in custody in NSW report that they had injected drugs at some time (Indig et al 2010); while precise data is not available, sharing of injecting equipment in custody carries a high risk of spreading infections including Hepatitis C and HIV.

There are other reasons to be concerned about these levels of heroin (and likely other opiates) histories, particularly among female prisoners. Studies have shown that women are at even greater risk of overdose death following release from custody than men (Davies and Cook 2000:3).

Rates of intellectual impairment (43 per cent) and those diagnosed with acquired brain injury (28 per cent) among the MACNI clients were lower than the other diagnostic categories. Both of these, particularly acquired brain injury, are likely to be under-reported and are subject to ongoing research in many settings. A comprehensive report on acquired brain injury among those in corrections services in Victoria is understood to support an earlier exploratory study suggesting over-representation of acquired brain injury in the prison population (Famularo-Doyle 2010:18).

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[1] A term adapted from physics and used in international law, rights discourse and medical ethics. In this context specifically referring to 'equivalence of care' in prison medicine, where it has been defined as 'a principle by which prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public in the same country' (Niveau 2007:610).

The most common combination of co-occurring problems among the MACNI clients included mental disorders, and alcohol and drug dependence (present in 60 per cent); some of these with additional diagnoses or multi-morbidities.

Risk to Self and Others

The MACNI client profiling exercise undertaken as part of the earlier exploratory study noted that the behaviours of the client group surveyed presented significant levels of risk; 90 per cent had at least one incident of harm to either self, staff or community in the past year and 47 per cent had incidents of harm recorded for all three (DHS 2003:6). It should be noted that the use of risk assessment tools and their gendered effects has been subject to criticism (Hannah-Moffat 2005:38). Within MACNI, risk was assessed by reference to the person's history of offending and self-harm, and considered in the context of a preliminary assessment of their perceived needs based on professional judgements. In the MACNI context, interpretation of risk when deciding eligibility was framed in a manner that was more likely to allow inclusion in the initiative than exclusion, akin to the stance taken regarding disorders or diagnoses. It was seen as an advantage to the client to be eligible and thus allow access to services that might not otherwise be available. Actuarial assessment tools were not used at this point although they were occasionally 'sighted' in correctional histories. In the immediate, practical situation where the person was usually already in the community or had an end of custody date it was necessary to develop a plan for care; whatever the person's assessed risk. The impact of levels of risk related then to the degree of specificity of management and resource allocation (such as double staffing for some for a period).

The most common evidence of risk, provided in referrals, was related to risk to self, and included suicide attempts, self harming or putting oneself in danger. Women were more likely to have self-harmed than men. This is generally consistent with data from prison populations. The proportion of Australia's prison entrants with a history of self-harm is 18 per cent (31 per cent among females) and similar to that reported overseas (AIHW 2010:31).

Many MACNI clients had a history of convictions for significant crimes; only 11 per cent of the 79 eligible individuals could be described by the referring agencies as not being known to offend. 58 per cent of the eligible individuals had known custodial histories (DHS 2007a). At the extreme end, this included clients with convictions for assault, rape, manslaughter and murder. Most however had multiple convictions for what can be described as nuisance offences. Some included clients who persistently engaged in crimes where the only motivation appeared to be inviting emergency service responses. One example was a young man who broke into a number of cars in the central city area then sat in front of CCTV cameras until police arrived. He had been diagnosed with having a serious mental illness with a history of absconding from community based group living facilities soon after release from custody with repeat similar offences.

Overall, comparison of the situation of Indigenous Australian prisoners and the MACNI population is not possible given the small numbers in MACNI. The over-representation of Indigenous people in Australian prisons has been well documented and lamented. Indigenous prisoners account for 25 per cent of all prisoners in Australia and Indigenous people are 14 times more likely to be imprisoned than non-Indigenous people (Australian Bureau of Statistics 2009:8). Evidence suggests that this over-representation is due to high rates of violent offences and re-offending with no evidence of racial bias in sentencing of Indigenous people (Snowball and Weatherburn 2006:14) The proportion of Indigenous

women in prisons is rising and it is recognised that they have higher rates of mental health disorders than either their male counterparts or non-Indigenous women. Many of them enter prison following a history of sexual or physical abuse (Johnson 2004:76). Although Aboriginal people were over-represented in the MACNI population, their numbers do not allow any more detailed examination and only one of the eligible women was Indigenous.

Reflection on the Implementation Phase of the MACNI

The remainder of this paper will reflect on lessons learned in implementing the MACNI and possible parallels of particular relevance to the criminal justice system, as it shares responsibility for many of these clients. It will include other descriptive data about these populations as relevant.

Legislation and Ethical Issues in this Context

The legislative context of the *Human Services (Complex Needs) Act 2003* (Vic) Act was important. It provided an authoritative umbrella in the early development of the MACNI. It facilitated a capacity to urge or even insist on certain processes; not with clients but with services. This legislation had no power to insist that a client do anything. It's perceived authority acted as a lever in getting services to cooperate. It became important to use the perceived authority of a statutory body (the MACN Panel) to ensure service access for people who had too often been denied service.

Consent

A significant difference for MACNI clients is that they were voluntary; although some advocates voiced concern about the consent procedures. After considerable parliamentary debate, the MACNI legislation provided for passive consent where people had to be given an opportunity to actively refuse rather than actively consent. Verbal reports from regions suggested that refusal was rare, with only two reported during the five year period. Clients were not required or explicitly obliged to undergo any treatment or respond to any plan except and unless it was in conjunction with legal orders under other legislation.

During implementation this required liaison with other bodies including the Office of the Public Advocate, the Adult Parole Board, the Victorian Civil and Administrative Appeals Tribunal, the Mental Health Review Board, and various professional Boards and Associations. It was sometimes necessary to clarify the hierarchy of authority associated with orders to facilitate collaboration with guardians, administrators, clinical psychiatrists and police.

A MACNI client who had spent the two previous years in an acute, high security, forensic hospital and who had a history of disruption, aggression toward others and service refusal was managed for two years in a community setting under the MACNI (and continues at the time of writing). He periodically withdrew consent to his involvement when unhappy with some aspect of his care. This required balancing his right to choose and refuse with an ongoing duty of care toward him and toward community members. Recognising that he usually changed his mind within 24 hours, asking for re-instatement of arrangements, his withdrawal of consent was usually managed by a willingness to listen and, if necessary, to renegotiate elements of his care plan in consultation with his legal representative.

The Use of 'Apparent' Diagnostic Eligibility Criteria:

The Panel interpreted the intent of the legislation to be inclusive and used the phrasing of the legislation '… appears to have …' as a means of making an independent judgment about the *apparent* nature of the person's condition to achieve this (*Human Services [Complex Needs] Act 2003* (Vic) s 15). Most of these clients had a history of multiple assessments and some had a range of specific diagnoses.

Client histories suggested that assessments had sometimes been used as a reason to refuse service, declaring people ineligible or not a priority. Assessments based on IQ scores had sometimes excluded people from intellectual disability services. In the mental health services, clients with predominantly 'axis one' diagnoses—such as schizophrenia and bipolar disorder—were more likely to be in receipt of active mental health treatment than those with diagnoses of anxiety or depression, perhaps related to their perceived higher risk to the community. Women, among whom diagnoses such as personality disorder were more common, had often only been provided with service during a crisis. Across all of the diagnostic criteria, those with diagnoses that were contested—such as some of the autism spectrum disorders—were often assumed to be more appropriately dealt with by other services. As a consequence of the interaction between diagnosis and service access, some of these clients had not received services in any systematic or sustained manner for some time, if ever.

Assessment and stabilisation of health, including treatments while in prison, sometimes resulted in significant changes to treatment and facilitated eligibility for needed services on release. The failure to use a period of incarceration to achieve this for many people in prison was frustrating; the frequent movement of prisoners made this difficult. The administrative and functional separation of health services for prisoners (contracted out and run by the Justice Department), hospitals and community health services (run by state DHS) and primary care delivered by GPs (largely funded by the federal government through Medicare) is wasteful and dysfunctional.

Thus the role of legislation was especially useful in bringing services to the care plan table; rather than dealing with reluctant clients, it allowed for dealing with reluctant services. It was recognised that legislation can be used to urge services to respond and support people's rights to service and that this could then occur in supportive rather than coercive relationships.

Client Related Observations

Other characteristics in the histories of the MACNI clients have likely parallels with those in custody; a high proportion had experienced early childhood trauma, including significant reports of abuse, loss, grief and/or neglect, poor general health and high levels of homelessness. In addition, it was apparent that among those with alcohol and/or drug misuse, it was episodes of intoxication specifically that were the most destabilising.

General Health (Especially Physical Health)

25 per cent of prison entrants report that they have a current chronic health condition—asthma, arthritis, cardiovascular disease, diabetes or cancer (AIHW 2010:40). They are reported to be less likely to attend to their health, with over 40 per cent reporting that they needed to consult a health professional in the community during the 12 months prior to going in to prison, but did not. Almost one-quarter (24 per cent) needed to see a doctor or

GP but did not attend, and 17 per cent needed to see a dentist but did not (AIHW 2010:68). Detailed data is not available for MACNI clients but many had chronic health conditions including diabetes, respiratory illness and hypertension; one woman required surgery related to a long standing under-treated condition that had previously been ascribed to her mental illness.

The lack of consistent health related information in the MACNI client histories and difficulty accessing health records even when privacy concerns were addressed, was an impediment to integrated care. This is linked to the complexity and fragmentation of health care in Australia. Client histories revealed that many services had ignored physical and dental health, assuming this was dealt with 'elsewhere' or by another service.

Preventative health and basic screening measures—such as pap smears and breast screens for women, comprehensive health checks and basic ancillary services, such as optometry and audiology, with accompanying provision of aids—had rarely been included in care. This is consistent with data on women prisoners, where only 46 per cent are reported to have undertaken cervical screening in comparison with 62 per cent of women in the general community (AIHW 2009:47).

Accommodation / Homelessness

It is clear to all who work in the corrections, health and community care sectors that the achievement of safe, secure accommodation is fundamental for people's stability. The report of the NSW Prison Health Survey (Indig et al 2010:37) noted that in the 6 months prior to custody, many prisoners were homeless (living in unsettled accommodation or sleeping rough).

Many of the people subject to the MACNI had an itinerant or chaotic lifestyle history. 41 per cent were experiencing primary or secondary homelessness; higher among women than men). 15 per cent were accommodated in a mental health or disability facility—or some other supported residential service; 13 per cent were accommodated in some form of government assisted housing; and 6 per cent lived with family members. 20 per cent of referrals were individuals in custody or prison (DHS 2007b).

The group nature of much of the available community based accommodation such as boarding houses, made it difficult to find suitable long term housing for some MACNI clients who were not able to be housed with others. However, there were examples of clients who continued to 'sleep rough' but agreed to receive active outreach and over time moved to stable accommodation, which then allowed for the provision and use of a range of other services.

Too often, people leave custody with no place to go, making them extremely vulnerable to further problems including offending. A survey of NSW prison entrants (Indig et al 2010) revealed that approximately half of all women who enter prison in NSW report that they had experienced housing problems in the first six months after the last time they were released with this slightly more likely among Aboriginal women (52 per cent compared to 50 per cent of non-Aboriginal women). This was not as likely among men (33 per cent of Aboriginal men and 21 per cent of non-Aboriginal men). This association of a lack of appropriate accommodation on release with re-offending appears to be significant. It is akin to the experience of MACNI where the provision of housing emerged as a necessary priority in all care plans.

In recognition of this, the current national policy on homelessness includes a laudable but hard to achieve goal; a policy of 'no exits into homelessness' from statutory, custodial care and hospital, mental health, and drug and alcohol services (Commonwealth of Australia 2008:27)

It is likely that the mix of inadequate or inappropriate housing—together with exclusion from services—significantly increases the likelihood of re-offending and for women this is especially true.[2]

Intoxication

Given the high frequency of alcohol and/or drug misuse among both the MACNI and custodial clients, this issue remains one of major significance. Between 41 per cent and 70 per cent of violent crimes in Australia are committed under the influence of alcohol (Drugs and Crime Prevention Committee 2006:156-62). In a six year period, nearly half (47 per cent) of recorded homicides in Australia were classified as alcohol-related, and of those, over half involved both victim and offender consuming alcohol prior to the incident (Adams et al, cited in Dearden and Payne 2009:1). Further, in the ten-year period between 1996 and 2005, it was estimated that 813,072 Australians were hospitalised for alcohol-attributable injury and disease, with assault the third most common reason for hospitalisation (Pascal et al 2009:4).

The association of intoxication, in particular, with violence increases the likelihood of being apprehended. This is linked to laws relating to public drunkenness or intoxication in many jurisdictions. It is noted that among NSW inmates surveyed, 74 per cent of Aboriginal men (60 per cent of non-Aboriginal men) and 69 per cent of Aboriginal women (44 per cent of non-Aboriginal women) were intoxicated at the time of their offence (Indig et al 2010:118, and further discussed in Grace et al 2010:1-15). Studies have shown that Indigenous offenders are more likely to report being under the influence of alcohol at the time of the offence or arrest (Juodo 2008:10-11) and Indigenous male offenders are more likely to be dependent on alcohol than non-Indigenous male offenders (Putt et al 2005:3).

The MACNI experience suggests that the pursuit of a goal of abstinence can be counterproductive. Instead, focusing on the prevention of acute intoxication can be more useful. It requires the development of knowledge and skills aimed at supporting people to avoid acute intoxication, even when they choose to continue using alcohol and drugs.

Service System Issues

Over the past twenty years, there has been a significant increase in the focus on efficiency in the delivery of human services to community members. This has been informed and facilitated by a set of managerial imperatives characterised by targeting and contracting of specific services. This, in turn, has contributed to an increase in specialist or niche services in many private, public and not-for-profit services. Arrangements for service delivery have become increasingly complex and fragmented. Many human services including health, juvenile justice, child and family services, housing and homelessness, mental health and

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[2] See for example, Baldry et al 2003 and 2004, who studied the bearing of different forms of housing on social reintegration for ex-prisoners.

disability services as well as some prisons have been contracted out with governments relying on other providers.

Impediments to Achieving Service Integration

Considerable work at many levels was required in the MACNI to achieve coherent cooperation. This included overcoming impediments to integrated care created, in part, by the administrative service system divisions that are described by many as 'silos'.

The drive for efficiency has increased targeting through contracts that include carefully worded eligibility criteria; governments are increasingly looking to service contracts with not-for-profit organisations to deliver care, with performance measures that differ between funding sectors. This is the source of much of the complexity. The report of the Productivity Commission relating to the not-for-profit (NFP) sector, for example, concluded that the current regulatory framework is complex, lacks coherence, sufficient transparency and is costly to the around 600,000 NFP organisations (Australian Productivity Commission 2010).

It is not surprising that where diagnostic categories are the basis of systemic 'silos' and, in turn, the specific service contracts they oversee, agencies focus on treating or responding to specific problems of their clients that they are funded to attend to and struggle when they have to meet needs of clients beyond their remit.

The selection of an appropriate mix of services for each client to achieve integrated care under the MACNI proved to be challenging but critical. This required assessment of organisational and workforce competence, as well as an understanding of service contracts, stance and the capacity of services to work together. Some sectors lack consistent quality assurance and transparent accreditation. There are still services in receipt of public, private and charities money that do not have sufficiently robust and comparable standards. As a negotiator and purchaser of services this increased the difficulty of service selection.

At the interface between client and service(s), clarification of goals, roles and sequencing of priorities, as well as attention to the client's interests and desires, was necessary. Finding ways of bringing services together in a timely and consistent manner for a client was the major challenge. Historic responses to this have included developing services to raise their capacity in multiple areas or co-locating. Drug courts are one example of the justice system's attempt to deal with the complexity of responding to drug dependent offenders. There are limits to such arrangements if one is dealing with multi-morbidity or needs that require many specialist services, suggesting that adding extra special courts for newly emerging problems is unlikely to be sustainable into the future.

Much is now written about the need for service integration and holistic care, 'no wrong door' policies and various ways that this might be achieved; there is a promising literature emerging on integration and implementation science (Bammer 2005) but its achievement remains elusive for most people.

Achieving service cooperation and coordination to ensure integration was the most difficult aspect of the MACNI implementation. It proved more demanding of all resources (including time, use of authority, professional skill and brokerage funds) than sorting out the client profile or assessment and planning for what MACNI clients needed and wanted. One underlying aspect of this was the issue of managing risk.

Managing and Sharing Risk

The question of risk was ever present in the MACNI: how risk was manifest, experienced, interpreted and how it was managed. The community more broadly has been increasingly preoccupied with the issue of risk and clearly the topic of risk is fundamental in the criminal justice system. The matter of risk impacted on the development of collaborative working relationships necessary to achieve integration of services.

Agencies raised concern when asked to respond to high risk people who, by their very nature and histories, pose some threat. It became apparent that services were generally familiar with and able to explicitly address containment or management of risk for individual clients and also workers' safety. This included a number of strategies including detailed risk management plans for individuals, sometimes double staffing, clear and detailed specification of roles and responsibilities, supervision for staff and sometimes joint training of personnel involved in direct care, monitoring and review.

Attending to risk management at the level of the individual was comparatively straightforward, even if it sometimes meant considerable shared work in developing detailed plans. However, services were usually more fundamentally, though less explicitly, concerned about the risk to the organisation's reputation, especially in the eyes of the government department that was their main source of program funds. This emerged as the more usual source of reluctance to provide service to people with multiple needs in the context of a complex system of service provision.

The authority conferred on the MACNI Panel, or perhaps more significantly its perceived authority, was important in implementation of care plans involving multiple services. It facilitated a level of comfort on the part of participating services that allowed for negotiated risk sharing. Care Plans had to be agreed to by senior management of all services and the sharing of risk was often crucial in achieving agreement. Government risk shifting to contracted service providers has limits. Thoughtful articulation of risk provisions is needed in the contracts between government and non-government services that recognise services willing to provide for high risk people.

The authority of the MACN Panel was delegated to the Care Plan Coordinator's (CPC) who were appointed under legislation and then responsible for oversight of service delivery. Arrangements between the Panel and the CPC included opportunities for ready access to consult, regular and formal reviews and other less formal, regular meetings.

Care Plan Coordination

Notwithstanding sound agreements, identification of skilled and experienced practitioners and considerable willingness on the part of services to come together, the MACNI experience suggests that the necessary coordination at the direct client level for those with multiple needs is beyond a usual case manager. From this evolved the role of Care Plan Coordination, which proved to be one of the most important elements of the overall success of the MACNI (DHS 2007a).

Although this can include case management, it is more than this and includes:

> A vision beyond the immediacy of necessary 'client settling' or overcoming a crisis to include systemic change; requiring a commitment to longer time frames and a systemic focus. The main focus ….for the CPC, and one of the practices that differentiates it from case

> management is not with the client but with the services that provide for the client. (Hamilton and Elford 2009:47)

The Panel encouraged the setting and pursuit of goals that included both the person and the service system. Options were identified, operationalised, monitored and reported back to the Panel where subsequent review allowed for refinement and refocusing. This, together with the appointment of a person to ensure coordination, was critical to success.

Considerable time was spent encouraging the Care Plan Coordinators to exercise the authority vested in them by the MACN Panel through these administrative processes since this workforce had come from backgrounds more used to 'passively seeking' cooperation rather than 'assertively expecting' delivery by other services.

The role and capacity of people to provide Care Plan Coordination needs enhancing; from the MACNI experience, post graduate education of Social Workers would seem to be most appropriate given their theoretical background, communication skills training and practice experience that is focused on people in the context of service systems, including the regulatory and legislative context.

Reforming Practice – a Systematic, Inquiring Stance

In part because of the high risk status of many MACNI clients, the overall task with each of them was to establish if a client could be sustained in the community and to discern what services and other resources were needed to achieve this. More simply put: what was the least restrictive, least expensive option for sustaining the person in the community? This task was approached with a stance of enquiry and conceptualised as exploratory 'research' (with an n=1 design). It required a commitment to evidence as the basis of decision making with setting of goals, careful monitoring, review and re-development of plans with interim goals when necessary.

Some effort was made to inculcate this stance in those associated with the work of the MACNI as described in a presentation at a workshop with Care Plan Coordinators:

> (The Panel) is not merely seeking a settled state (for the clients), albeit an exceptional achievement if and when this is possible, but always posing new questions; testing and checking. This is an opportunity to try and test some of the 'what if questions'. Overall, what is the person capable of under different circumstances? (Hamilton 2009)

The Panel asked what might be imagined for a person in five or 10 years time. This involved exploring what resources were needed and then whether the same result could be achieved with fewer or with a different group of services. Generally it was necessary to ensure sufficient resources at the start of a care plan in order to engage clients and stabilise them and then gradually explore the impact and implications of reducing these. The alternative approach: to wait to see if someone can cope and only when they are in crisis, respond with additional 'band-aid' solutions, had been a persistent response to some MACNI clients in the past.

Stabilising clients in the community sometimes involved the use of brokerage resources in addition to accessing usual community based services.

Use of Brokerage

Brokerage funds allowed for flexibility and timely responses. Amounts allocated ranged from $3,500 to $275,000, with an average of $72,740 per client (DHS 2007a:87). The main items of expenditure were for attendant care to support clients to reside in the community, accommodation, Care Plan Coordination, secondary consultation—for specialist assessment, planning and occasionally for direct work with clients–and training and supervision of care team members where necessary. In some cases it included travel costs and occasional capital works to modify housing.

These amounts might seem excessive but it is worth noting the benefits of providing funds to purchase necessary, specific services in a timely manner to take advantage of coordinated effort. The occasional somewhat glib suggestion of providing the dollar amount that a prison stay actually costs the government for services to manage a person instead might be seen as naïve; however the experience of the MACNI suggests it should perhaps be taken more seriously.

What can be Achieved and is it Worth it?

Did the MACNI succeed and what relevance does this have for the criminal justice system? There are significant similarities in the MACNI client group and the population in custody, including the ongoing efforts of justice systems to develop new initiatives to prevent recidivism and stop the increasing numbers in prison. The results of the five year implementation phase of the MACNI suggest that it is likely to be those who are especially disadvantaged who might be better served with a different intensive approach to that usually on offer. People who had previously been deemed to require high security facilities have been managed in general community settings under the MACNI and while it is too early to fully evaluate the cost of doing this, it is important to know that it can be done.

Reports from a commissioned, independent evaluation (DHS 2007a) and a ‘Snapshot Study’ involving careful and detailed case studies (DHS 2009) provide considerable detail about the outcomes of the MACNI work. In summary, the quantitative outputs/outcomes evaluation (DHS 2007a) in response to the questions posed concluded that improvement in individual (client) outcomes, improvement in service coordination and the adequacy of legislation had all been achieved. The question of achievement of cost-benefit was less clear and difficult to assess because there had been insufficient time to draw conclusions and it had been difficult to get appropriate data (especially from central agencies).

Corrections data was not available for the evaluation. Hospital related data was available for clients and showed:

- 76 per cent reduction in presentations to hospital emergency departments;
- 34 per cent reduction in number of hospital admissions; and
- 57 per cent reduction in hospital bed days. (DHS 2007a:84-124)

The ‘Snapshot Study’ (DHS 2009) of the client’s status pre and post MACNI for 19 out of 22 of the MACNI clients who had exited the initiative reported:

> Improvements across all four MACNI platforms of accommodation, health and well-being, social connectedness and safety for the majority (13) of the 19 individuals; a 63 per cent

> improvement in the area of stable accommodation; a 69.5 per cent improvement in health and well-being; a 51 per cent improvement in social connectedness and a 46 per cent improvement in safety. (DHS 2009:36)

There were other reported outcomes related to integration at the service system level including that 'many providers stated that their experience with MACNI had led to a new or renewed willingness to provide service to individuals with multiple and complex needs' (DHS 2009:37). Clearly the numbers in this study were small and the author notes the need for caution in drawing conclusions from these data. However, this does indicate that it is possible to provide integrated services to people with multiple and complex needs using community based services.

Conclusions and Implications for the Future

Rapidly changing social and economic conditions—and the need to re-structure and target services to meet new demands—compound the problem of the increasing numbers of people with multiple-morbidities (Senate Select Committee on Mental Health 2006:chap 14) who use more public services and are more dependent on welfare benefits than individuals with a single disorder (Goren and Mallick 2007:1).

Changes in the community service systems over the past twenty years are likely to have contributed to the increase in prison numbers as anticipated earlier: 'people with mental illness are consigned to incarceration, rather than treatment, because of the lack of appropriate mental health and associated services' (HREOC 1993:634). This was reiterated more recently in relation to Indigenous Australians (Calma 2008:30).

Without some rearrangement of the way we respond to the most vulnerable people in our community there is a risk that they will effectively be excluded from a range of services and will continue to enter the criminal justice system unnecessarily:

> It is the impression of many… that the population of offenders in community corrections is becoming a more difficult one with more severe problems of personality disorder, more serious substance abuse and more extensive offending. (Howells and Heseltine 2003:326)

This is likely to be even truer of women than male prisoners noting that:

> While both men and women in the Victorian prison system experience a range of complex needs, women tend to present with greater and more complex needs that are more directly linked to their offending behaviour. (Sentencing Advisory Council, 2009:56-57)

Disadvantages and exclusion from services increases the likelihood of (re-)offending and rates of identifiable multi-morbidity among those in prison are increasing. Implementation of the *Human Services (Complex Needs) Act 2003* (Vic) offered a concentrated experiment in responding to people with multiple needs and results suggest that intensive, integrated approaches to people with multiple needs can work and that this might not cost more than current costs of repeated incarceration and may cost less.

The MACNI found that community based services can be found to support people with multiple needs but that the issue of complexity resides more in the service system than inherently in the people it services. Thus, considerable focused attention, planning and sometimes incentives, including brokerage—as well as the responsible use of contracts and authority—are necessary to achieve timely, integrated service provision. This can be

supported with explicit risk sharing and the introduction of care plan coordination; a high level professional role that goes beyond case management.

All people have a need and a right to health and housing. The principle of equivalence should mean that people in prison have access to the same treatment options available in the community, as well as opportunities for self-protection from infections—including safe injecting equipment. Anticipated health reforms—including electronic health records—could facilitate service integration for those who agree to provide access to them and support better assessments and diagnostic clarity, that in turn can enhance care for those with multi-morbid conditions (especially in recognising conditions such as acquired brain injury).

Secure and stable housing is a necessary ingredient to any case plan for a person with multiple needs, especially for women who have children. Women are more vulnerable to being victims of intimidation and violence, making safe accommodation fundamental. For people leaving prison this is crucial, and likely to be a significant factor affecting their capacity to engage with and sustain treatment and programs.

Recognising the value of expanding diversion options, and addressing unmet support and treatment needs, Corrections Victoria implemented a parallel, integrated strategy aimed at reducing women's offending and reoffending known as 'Better Pathways' soon after the MACNI commenced. An initial report noted similar characteristics to the women clients of the MACNI, including higher rates of mental illness and substance abuse than among their male counterparts. It noted the lower frequency and seriousness of women's offending, and that women's crimes are more often motivated by poverty or substance abuse. More women have experienced sexual and physical abuse that can shape their offending, and women's offending is more likely to have been influenced by the complex interaction of mental illness, substance abuse and trauma (Victorian Department of Justice 2005:9).

While this paper has reported on the experience of a population specifically identified under legislation in one jurisdiction in Australia, it has shown that it is a sub-group that shares many characteristics with citizens in prison. With the current projections of the growth of the prison population, perhaps it is time to invest in other services that endeavour to provide integration through professional and specific coordination in an effort to achieve less risky and more sustainable living and service arrangements in the community for those with a complex mix of needs. The evidence from the initial efforts of the MACNI provides a hopeful alternative.

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