Leadership Gathering on Complex Service Delivery

Agenda-Building Webinars
Webinar 4: Wednesday, June 30th – Noon to 12:30 pm Pacific Time (Canada)
"Working Across Sectors to Focus on the Person: International Examples"

SUMMARY

The inaugural *Leadership Gathering on Complex Service Delivery*, to be scheduled June 6-7, 2022, contingent on health guidelines, will engage decision-makers, thought leaders, and service providers in British Columbia on key policy issues directly impacting services to those with complex needs. To build the agenda for the event during the pandemic, the organizers have arranged a series of focused web-based discussions on several core themes.

Previous discussions have focused on the theme of complex service delivery and the path to holistic, person-centered service; the reality of seeking services according to those with lived experience in British Columbia; and issues around substance use, service delivery, and service eligibility. Video and summaries of these discussions may be found here.

On June 30th, the discussion moved from the operational realities of complex service delivery to the question of bridging differing mandates and structures within the health, justice, and social sectors to bring the person's holistic needs and outcomes into focus. The webinar focused on two examples: the **Mental Health Crisis Care Concordat** in the United Kingdom, a national agreement between services and agencies involved in the care and support of people in crisis; and the **Multiple and Complex Needs Initiative** (MACNI) in the Australian state of Victoria, which provides targeted, time-limited, and flexible interventions for people aged over 16 years who have complex needs and who pose a risk to themselves and/or others. The discussion was facilitated by Jonny Morris, CEO of the Canadian Mental Health Association BC, and featured a panel of experts closely associated to these initiatives:

- The Rt. Hon. Sir Norman Lamb, former Minister of Care for the UK Government, 2010-15
- Sophie Corlett, Director of External Relations – Mind mental health charity, United Kingdom
- Shane Beaumont, Manager, Complex Needs, Department of Fairness, Families and Housing, Government of Victoria, Australia
- Katherine Hlasko, Principal Program Officer, Complex Clients, Department of Fairness, Families and Housing, Government of Victoria, Australia

THE MACNI APPROACH

MACNI is operated in the state of Victoria which has a population of 6.5 million. The capital city Melbourne has a population of five million, including a population of 24,000 Indigenous people, who are significantly overrepresented amongst those with complex needs. MACNI provides targeted, time-limited, and flexible interventions to a small number of people aged 16-years and over living with combinations of mental health conditions, problematic

substance use, developmental disabilities, acquired brain injury, and who pose a risk to themselves and/or others. MACNI provides for an individually tailored response based on a comprehensive assessment of need, service system capacity, and case-by-case considerations. MACNI is not a crisis response service, rather it aims to develop a planned wrap-around response for clients where all other service responses have been exhausted. MACNI is underpinned by the *Human Services (Complex Needs) Act 2009* which outlines specific eligibility criteria.

The Department of Fairness, Families and Housing (DFFH) and the Department of Health operate mental health services, alcohol, and drugs treatment, housing, disability, and child protection services. Together with the Department of Justice and Community Safety, these departments contain most of the relevant services for those with complex needs.

Prior to the early 2000s, the Government's approach was siloed. Several crises led to the decision to pool resources and come up with a new approach to complex clients, articulated in the 2004 *Human Services Complex Needs Act*. The Act provided for an independent person managing a statewide panel of different departments and programs, coming together on regular basis to consider complex needs client's eligibility for MACNI. In 2009, further legislation moved the model to a single statewide panel chaired by department staff; in 2014, it was decided to decentralize the approach allowing people to get services at their local geographical area without a bureaucratic central panel.

Under the Act, MACNI gives service providers the ability to share information with other service providers in the best interests of the client. This includes child protection, justice, mental health, drug and alcohol services, hospitals, and disability services. It is a voluntary program that is rarely refused by prospective clients. It is based on client consent, or family consent if the client is held to lack the mental capacity to consent. In some cases, formal guardians are appointed.

MACNI has 28 staff (known as Complex Needs Coordinators) across the state working in 17 geographical areas, each with its own Complex Needs Panel. Staff principally provide problem solving and service system navigation for clients. It is not a crisis response service. MACNI allocates 12 weeks to assessment and development of the care plan, which is the key element. The legislation does not require formal diagnoses of disorders, but only that the client "appears to" meet eligibility criteria, which provides greater flexibility. The Complex Needs Panels involves representation from mental health, drug and alcohol treatment, the criminal justice system, homelessness, child protection, and disability services, as well as Indigenous liaison personnel. Panels run monthly for two to three-hour sessions and are also attended by MACNI program management.

In the last year, 454 clients engaged with MACNI, of whom 39 become full formal clients; others were provided more partial, short-term services (consultation and system navigation over a period of approximately 3-6 months). Many clients are impacted by the criminal justice system.

The program continues to grow and attract resources, due in part to the attention brought by significant crises, and also by recent Royal Commissions into mental health and disability services. Cultural safety has been identified as an ongoing challenge, related directly to Indigenous peoples' access to services and to the many diverse and immigrant cultures in Melbourne.

THE CRISIS CARE CONCORDAT

The Crisis Care Concordat arose in 2014-15 as an initiative of the then-coalition government in the United Kingdom. The activity leading to its creation built significant momentum in setting standards for crisis mental health and for improving the coordination between services, particularly police and mental health services.

The state of crisis mental health care in the UK was held to be unacceptable. Police were heavily involved in mental health crisis responses in the field, though with tools, training, and procedures that were not appropriate and with mental health services commonly absent despite their mandate. Those in mental health crisis were being placed in police cells at the rate of 6,000 people a year. Just 14% of people surveyed who had experienced a mental health crisis reported that they had received good care.

A national multi-sectoral gathering convened by the government led to the creation of a document that set the standards of crisis mental health care very clearly. Created in collaboration with the Mind mental health charity (analogous to the Canadian Mental Health Association), the document was entitled the Crisis Care Concordat. Those with lived experience were central to the process, leading to the document's powerful framing using "I statements" ("What I as someone in a mental health crisis should expect from the system when I face that crisis is…").

Twenty-two national organizations signed it at the national level, including the police and local government representatives. The document contained clear statements about committing to work together, along with specific individual commitments such as reducing the use of police cells by 50 percent by 2015, and an end to the use of marked police cars to attend to people in a mental health crisis.

Given the importance of local government[1] in the UK, it was also necessary to generate parallel commitments at the local level everywhere in the country. It became apparent that the multi-sectoral nature of the work meant that the initiative could not be driven by one national government department (e.g., by the Home Office or by the Department of Health). To do so would result in "territorial issues." Mind, the mental health charity, was asked to set up a project which at a local level would bring the same services around the table to produce the same declaration which had happened nationally.

The process took six months to reach local agreements, with a further three months to create an action plan. A national map available to the public colour-coded each local area. When the declaration was agreed that area's colour went from red to amber; with an action plan it went from amber to green; if the action plan was deemed insufficient the map colour returned to amber until the declaration was revised.

In terms of results, the called-for reduction in the use of police cells by 50% was nearly reached within a year. Legislation has subsequently banned the use of police cells for those under 18, now permitting their use only in exceptional circumstances for adults. In 2019-20, only 128 adults and three youth nationally ended up in a police cell, a dramatic improvement

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[1] In the UK's unitary government structure, local councils provide public services which equate not only to Canadian municipal government services, but also many services which are administered in Canada by provincial and territorial governments.

from over 6,000 six years previously. Substantial investment has been made in health-based places of safety, in appropriate support crisis lines, in a reduction of "out of area places" (where people in a crisis are sent to a hospital bed away from their home area), and in crisis houses and crisis cafes. The use of marked police vehicles has been reduced and a national plan developed to invest in alternative vehicles. Some progress has occurred in reducing the use of restraint physical force in mental health settings, but challenges remain. Overall, the Concordat had several specific impacts, but perhaps as important is how it served to spark collaboration on the ground in local areas.

VIEWER QUESTION PERIOD

For the UK presenters: Of all the levers you've described, what would you say was the most powerful in service of collective impact around crisis care in the UK?

The momentum built and peer pressure from this website allowed people to see that map. Funding was also used as a lever. Every year in the UK the government funds hospitals' acute care services to manage the winter crisis: money only went out across the country if the area signed up to the Crisis Care Concordat.

The Concordat gained power due to its use of "I statements." We required people with lived experience to be involved. At that time there was reluctance to do so but in the end, it was very beneficial.

Once you managed to get people around the table, they felt freer to opt-in, and it was clear that the process resonated with the reasons people had joined their organizations in the first place, whether it was the police or the ambulance service or mental health – because they actually wanted to *do* something.

For the Australian presenters: What experiences would I have as an individual client encountering the MACNI service?

From the client's perspective, it might be that their experience day-to-day doesn't look significantly different, and that is by design. The intention is to not try to introduce a new swathe of people for them to meet. Instead, it's about doing "back of house" work to ensure that everyone is sharing information, that we're all on the same page, and that the services are complementing each other and collaborating effectively. So, it could be that the services that the client directly engages with could be quite minimal.

For the UK presenters: What's your best advice on bringing disparate government actors to the table? Did you experience any political pushback, and if so, how did you remedy that?

Political leadership mattered. This was a coalition government. The Home Secretary understood the issues well and was committed to improving crisis care. Our office (Minister of Care) drove it, but the Home Office cooperated completely.

The focus should now become driving the case for a human rights-based mental health approach, by which is meant de-institutionalized mental health services, supporting people in the community, avoiding crises as much as possible, but also recognizing that crises will happen and that when crises do happen there must be an effective response. On this topic, the World Health Organization has recently issued new guidance on how you deliver a human rights-based, person-centered, community-based mental health approach

More broadly, at first there was no political issue because there was no political interest. This changed during the period of the Concordat's development. By the time we got to the third national meeting, the Secretary of State (under the next government) was coming and speaking to the national meeting. Police were tweeting that they had a child in cells because no mental health service had a bed. Issues such as those got the ear of the media, the public, and the political class. Crisis care was a useful wedge to get the country interested in mental health as the issues are so obvious. The government wants to be part of the success of addressing these issues.

For the Australian presenters: Was the MACNI legislation driven by elected officials there or was it driven by the bureaucracy? How long did it take from the genesis of the idea until it was realized?

In about 2000, a series of events happened to generate media attention about a small group of complex clients who were not getting access to services yet had a significant impact on the community. The government committed to act and it took about two years to have the legislation ready. In 2003 the legislation passed with broad support from government and opposition members.

For the Australian presenters: How does MACNI dovetail with individuals with complex needs in conflict with the law and involved in the criminal justice system? Do you have data that would indicate your program has led to diversion away from the formal justice system?

Part of MACNI's involvement can also be around key transitions, so it's not unusual for us to receive referrals from prisons directly. We often get people who are going through the revolving door of remand, where within days of being released they may find themselves back on remand.

The goals for justice clients can vary greatly. Sometimes it can be about getting them out into the community. For other clients, for an array of reasons they may seek the containment and predictability of a cell which for them it's the safest place; those clients can be very challenging to work with.

The management of clients with justice intersection is no different; it's simply another silo for us to integrate into a care plan and collaborate effectively with.

For the UK presenters: Has the crisis care concordat helped with diversion activity? Is police time is being better deployed for traditional policing activities?

The answer is yes, in that they are now able to take people to places of safety. However, while police are to take them if necessary to Accidents and Emergency (AE) or to a mental health setting, because of bed shortages or because of AE queues we end up with police episodes of restraint that can end in death.

These have included some very high-profile incidents. We haven't solved the problem. Sometimes the fate of people picked up by police without sufficient training is not acceptable.

For the Australian presenters: Is it accurate to say the challenge of privacy and information sharing was overcome, so that consumer groups were happy, legislators were happy, and civil rights groups were happy?

Some issues do arise. For formal MACNI, when consent by the client is given, information can be shared readily, with the caveat that such sharing must be in the best interest of the client. Occasionally we have hospitals where a client may be on a mental health ward, the hospital is not sharing information, and MACNI is told to use Freedom Of Information laws. In these cases, it is important to recall that the legislation *allows* the sharing of information, but it doesn't compel. The answer lies in communication. Demanding information is usually not productive. If the other agency has been included on the area-based Complex Needs Panel as a partner, issues can be solved with a phone call. The situation is not perfect, but it functions reasonably well.

For the UK presenters: Under the Concordat, is there any requirement for connecting the client to longer-term supports and services once the immediate crisis has been resolved?

Alongside the work we did were other initiatives. There is a long-term plan for the National Health Service which commits to extra investment in mental health.

The original Concordat had four sections:

1. Access to support before a crisis (informal support when people are approaching crisis).
2. Urgent and emergency support in a crisis.
3. The quality of crisis care.
4. Recovery and staying well - how to support somebody post-crisis to make sure that that crisis wasn't repeated.

Most of the focus was on the second section. A lot of the energy for this came from the police who were interested in the operational impact on their time. The third stage received less attention at the time as mental health inpatient services were less engaged.

The Concordat has eventually been wrapped up into a 10-year plan for the National Health Service in England covering all aspects of mental health. By 2022-23 the plan has also now committed to spending one billion pounds a year on community services, for mental health, which are being very widely defined. Strategically in England, starting with the crisis was a way to get everybody interested in mental health services overall, because “debt advice” and “voluntary sector services” don't sound very exciting to most people as a starting point.

For the UK presenters: One of the frustrations for police in Canada is that when things really go off the rails in a crisis response, they become the lightning rod for everything bad that has happened, and as they rightly point out it is often other links in the chain which have failed. Are there particular champions of this work in UK police forces to whom we might reach out?

There were brilliant champions at the time including in the Metropolitan Police, though we have not maintained that momentum across the board.

For all presenters: *In hindsight what is one thing that you wished you could have done differently, or which could be done differently, and/or one area of impact that you really want to have going forward?*

Australian presenters:

- To invest in capacity building in our local service sector is important. It may be intensive, but beneficial in the longer term to ensure that clients with complex support needs can be supported in their local area.
- It's also important for us to improve cultural safety for Indigenous peoples but also for diverse populations in general.

UK presenters:

- The biggest thing that those with lived experience of crisis care said was missing was humanity in terms of the services. People are vulnerable in crisis, and services are often harsh and unfriendly. We need to build humanity back in, tapping into the humanity that people bring to work when they start their careers and may lose as they go along.
- This work should confront the racial dimension of mental health care and of policing. Many countries face this same structural racism, and it must be confronted.
- There is a global campaign that must be fought for the rights of people living with mental health conditions to be treated as equal citizens. In too many countries they still face discrimination inbuilt in the law, affecting the right to marry, to own property, to enter a contract, etc. So, this is a human rights campaign.

The complete video of this event is available here.

The next Agenda-Building Webinar is scheduled for Wednesday, October 27th from 11:00 am to 12:30 pm PDT, and will focus on "Working Across Sectors to Focus on the Person: North American Examples." For more information, please contact events@connective.ca with the subject line "Webinar".