NGO Practice Enhancement Program: Working with Complex Clients Initiative

LITERATURE REVIEW AND MEMBER CONSULTATION

JUNE 2011

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW.

NADA's goal is to support non government drug and alcohol organisations in NSW to reduce the alcohol and drug related harm to individuals, families and the community.

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EXECUTIVE SUMMARY

In January 2011, the Network of Alcohol and other Drug Agencies (NADA) engaged Community Sector Consulting to undertake a project investigating how NADA member services were working with clients with complex needs. These complex needs' clients were identified as, but not limited to: people with drug and alcohol issues who present with cognitive disabilities (intellectual disability, acquired brain injury, Fetal Alcohol Spectrum Disorder), mental health issues and involvement with the criminal justice system (including those involved in court ordered treatment).

The consultation process had three parts. First, a limited literature review of governmental policy documents and scholarly articles relating to complex needs was undertaken. Secondly, a scoping and mapping exercise of non-government drug and alcohol service providers' policy and procedure related to complex needs was completed. Lastly, a consultation with NADA members took place. This consultation included a questionnaire distributed to members as well as a number of face to face interviews conducted with NADA members.

Some conclusions drawn from the literature review reported that there is still potential for inquiry into the intersection of complex needs with drug and alcohol service provision, especially as this is described from the clients' perspectives. The scoping and mapping exercise illustrated that a number of services make publicly available their policy and procedure as it relates to clients with complex needs. This is not to say however that other services do not have policy and procedure as it relates to complex needs. Finally, the NADA member consultation revealed that all of the members who participated, currently, or have in the past, worked with clients with complex needs. Recommendations were made by these members in relation to working with clients with complex needs, and areas for future investigation are described. Appended at the very end of this report are five case studies which draw together information about the landscape of service provision as described by NADA members, the scholarly literature, recommendations of the members regarding service provision and recommendations for further investigation.

In sum, as part of this consultation, many NADA members from Sydney metropolitan, regional and rural New South Wales shared their experiences of working with clients with complex needs.

ACKNOWLEDGEMENTS

We would like to acknowledge all of the NADA member services who generously shared their time, expertise and experiences with us in the production of this consultation. We would also like to acknowledge the ongoing, often difficult, work these services undertake with their clients.

CONTENTS

1. Introduction

The Network of Alcohol and other Drug Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW, and is primarily funded through NSW Health. NADA has approximately 100 members providing drug and alcohol health promotion, early intervention, treatment, and after-care programs. These organisations are diverse in their philosophy and approach to drug and alcohol service delivery and structure.

NADA's goal is 'to support non government drug and alcohol agencies in NSW to reduce the alcohol and drug related harm to individuals, families and the community'.

The NADA program consists of sector representation and advocacy, workforce development, information / data management, governance and management support and a range of capacity development initiatives. NADA is governed by a Board of Directors primarily elected from the NADA membership and holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014.

Further information about NADA and its programs is available on the NADA website at www.nada.org.au.

2. Background

NADA was funded by NSW Health Mental Health and Drug and Alcohol Office in July 2010 to roll out a two year Practice Enhancement Program for the NSW non government drug and alcohol sector. This program aims to build capacity within drug and alcohol non government organisations (NGOs) through addressing staff skills, knowledge and confidence, as well as organisational capacity in responding to the needs of clients who present with complex needs.

For the purpose of this project, complex clients are defined as, but not limited to:

People with drug and alcohol issues who present with cognitive disabilities (such as intellectual disability, acquired brain injury, Fetal Alcohol Syndrome Disorder), mental health issues and involvement with the criminal justice system (including those involved in court ordered treatment).

The Practice Enhancement Project objectives are to:

- Identify the service practice development needs and barriers of non-government drug and alcohol services in relation to responding to clients with complex needs.
- Implement projects and activities to build the capacity of the sector to respond to drug and alcohol clients with complex needs as stated above.
- Evaluate the outcome of capacity building projects and related activities to inform ongoing workforce, organisational development and provision of treatment.

- Improve the engagement of drug and alcohol NGOs with complex-needs clients and improve treatment outcomes for this population where service practice grants are provided.

3. List of abbreviations

ABI: acquired brain injury
ARBI: alcohol related brain injury
CI: cognitive impairment
CS NSW: Corrective Services New South Wales
DHS: Victorian Department of Human Services
DoCS: New South Wales Department of Community Services
ID: intellectual disability
NADA: Network of Alcohol and other Drug Agencies
NSW: New South Wales

4. Complex Needs Policy and Practice: A Limited Literature Review

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4.1 Abstract

Introduction: Working with clients with complex needs represents a significant challenge for drug and alcohol services. Many clients presenting to these services have complex needs, associated with, but not limited to, cognitive impairment and / or contact with the criminal justice system.

Aims:

1. To examine the national and international policy contexts in which drug and alcohol services work with clients with complex needs.
2. To examine the literature stemming from programs working with clients with complex needs.

Method: A limited literature review was undertaken of government publications, various databases and scholarly literature related to working with clients with complex needs. Publications were included if they specifically discussed policy or programs associated multiple and complex needs and related to policy or programs post-dating 2000.

Results: In total, 4 policy documents and 7 scholarly articles were reviewed. Largely, government policy in this analysis is directed towards specifically-defined complex needs, such as intellectual disability and contact with the criminal justice system. The scholarly literature around programs working with clients with complex needs suggests that it is often difficult to disentangle complex needs, such as cognitive impairment and offending behaviour.

Conclusion: there is an apparent tension when examining policy and literature related to service provision for clients with complex needs. While government policy is targeted to specific complex needs, at the service provision level, complex needs may be less easily-defined.

4.2 Introduction

Previous research has documented policy frameworks in which services are delivered to clients with complex needs (Thomson Goodall Associates, 2002). In addition, previous research has illustrated that there is an increasing use of the term ‘complex needs’ in Australian and international literature (Keene, 2001). An extensive literature review around

responding to clients with complex needs was undertaken some years ago (Thomson Goodall Associates Pty Ltd, 2002) and used the following measures to describe complex needs:

> ...children, adolescents and adults who may experience various combinations of mental illness and disorders, intellectual disability, acquired brain injury, physical disability, drug and/or alcohol misuse. (2002:1)

Given the extensive nature of the Thomson Goodall (2002) literature review, this description accords well with the aims of the present review, and represents a description here used when discussing complex needs. It is of note too that the Thomson Goodall (2002) literature review fed into the Victorian Multiple and Complex Needs Initiative later evaluated by Hamilton and Elford (2009). In addition, complex needs in the present study may also relate to contact with the criminal justice system in recognition of the apparent increase in representation of people with complex needs in the criminal justice system (Baldry, Dowse and Clarence, 2010).

While there is a vast body of literature devoted to responding to co-occurring issues such as mental health and drug and alcohol issues, or multiple disabilities (Thomson Goodall Associates Pty Ltd, 2002), there is a scarcity of literature around complex needs and drug and alcohol service provision. One such paper that does examine these needs in relation to contact with the criminal justice system concludes that an individual's complex needs such as drug and alcohol issues and intellectual disability may in combination contribute to their offending behaviour (Moore and McGillivray, 2000). Another paper suggests that best-practice drug and alcohol interventions may also be suitable for people with intellectual disability and drug and alcohol issues (Degenhardt, 2000), but questions remain regarding the ethics of this when informed consent may not be readily achieved (Simpson, Martin and Green, 2001).

As such then, there are clear and targeted policies for people with complex needs and contact with the criminal justice system. There is extensive research on complex and multiple needs per se, and there is an emerging body of literature examining responses to complex needs and contact with the criminal justice system. There is a relative paucity of literature in examining the intersection of these multiple and complex needs and drug and alcohol services provision. This review represents a starting point for future research into the intersection of these issues.

4.3 Method

Government websites and policy documents relating to complex needs both nationally and internationally were examined. In addition, a systematic review of the literature published from January 2000 until January 2011 inclusive and limited to the English language was undertaken. The January 2000 delimit was selected as it approximately coincides with the commencement of the extensive literature review undertaken by Thomson Goodall

Associates (2002) and the publication of *The Framework Report* (Simpson, Martin and Green, 2001). Both documents represent highly significant contributions to the field of complex needs in the Australian policy framework context. Later research has focussed in particular on the contribution Simpson, Martin and Green (2001) make to the notion of 'double disadvantage' (Baldry, Dowse and Clarence, 2010) and concedes that, "There is very little published research on those with dual diagnosis and the CJS [criminal justice system] in Australia" (Baldry, Dowse and Clarence, 2010: 5). January 2000 therefore represents a reasonable limit after which to include literature in this review. The literature review was conducted searching the electronic databases available at the University of Sydney. A popular, commercially-available internet search engine was also used. The literature derived from these searches was analysed for content relevant to the interaction of complex issues, such as contact with the criminal justice system and other co-occurring issues.

Data from 4 government policy documents were extracted and analysed for content relating to complex issues. Data from 7 scholarly articles were extracted and synthesised thematically as they related to complex issues, including but not limited to co-occurring drug and alcohol issues, cognitive impairment and contact with the criminal justice system.

4.4 Results

4.4.1 Policy contexts

A total of 4 national and international government policy documents were selected according to their relevance to working with clients with complex needs. The data extracted is summarised below:

1. *NSW Interagency Service Principles and Protocols (2008)*

   In NSW, the *NSW Interagency Service Principles and Protocols (2008)* detail the co-operation between the following agencies in service approaches for clients with the aforementioned complex needs:

   - Department of Justice and Attorney General, Attorney-General's (Attorney-General's)
   - Ageing, Disability and Home Care, Department of Human Services NSW (ADHC)
   - Department of Justice and Attorney-General, Corrective Services (Corrective Services NSW)
   - Department of Education and Training (DET)
   - Housing NSW, Department of Human Services NSW (Housing NSW)
   - NSW Health (NSW Health)
   - Juvenile Justice, Department of Human Services NSW (Juvenile Justice)

- NSW Health, Justice Health (Justice Health)
- Police and Emergency Services, NSW Police Force (Police Force).

The guiding principles of this document are:

- identifying and addressing all factors which have contributed to the involvement of people with intellectual disability with the criminal justice system;
- working collectively to promote an environment that enables people with intellectual disability to succeed in the community without offending;
- early intervention services for people with an intellectual disability to strengthen families, promote community inclusion and valued roles;
- early identification of intellectual disability and joint agency approaches for people when they first come into contact with the criminal justice system;
- facilitating the delivery of appropriate support and services for people with an intellectual disability, including borderline intellectual disability;
- co-ordinating service delivery and reducing duplication;
- identifying and responding to gaps within and across agency programs;
- facilitating the delivery of an appropriate range of services to people with intellectual disability with co-morbidities (eg: mental health disorder or illness, alcohol or other drug misuse);
- improving the responsiveness of services for Aboriginal people and people from culturally and linguistically diverse communities;
- improving responsiveness to clients needs through better provision and management of information. This includes fostering where possible informal support and self advocacy; and,
- better targeting available resources to achieving the overarching cross-agency goal and outcomes.

As will be examined further in the discussion, these principles rest largely on ensuring services are provided from the basis of a *person-centred* approach. Upon this foundation, the following outcomes are anticipated for clients with an intellectual disability:

- having reduced contact with the criminal justice system through improved assessment, early intervention and triage;
- are less prevalent in the criminal justice system because they succeed in the community and are able to live there;
- having improved access to appropriate services and support to assist in meeting their day-to-day needs, particularly at key life transitions;

- are treated fairly when they come in contact with the criminal justice system, with appropriate recognition of and response to the fact that they have a disability;
- having improved access to a variety of accessible diversion options to allow them to stay out of custody;
- are only incarcerated when they should be (if their crime justifies it); and,
- are reintegrated into the community with stable accommodation, support and case management, including interventions, designed to reduce the risk of recidivism.

How these principles are achieved is the subject for further investigation and will form part of the consultation process of this project. For now, it is important to recognise that within NSW, there are guiding principles for working with clients with complex needs, especially those who have had contact with the criminal justice system. How these principles are engaged in everyday service provision, especially among non-government service providers will be the subject of further investigation.

2. Victorian Department of Human Services:

   The Department of Human Services (DHS) takes several different approaches to supporting clients with an intellectual disability who have had, or at risk of, contact with the criminal justice system (Simpson, Martin and Green, 2001):

   - Each region of the DHS has a specialist team that provides service to people with disabilities, including client service workers who may act as case managers when a client has contact with the criminal justice. Their role includes but is not limited to: developing plans in collaboration with the client and all stakeholders for achieving the client's goals (Victorian Disability Services Criminal Justice Programme, 1992), ensuring that the client has had legal advice, monitoring the implementation of a Justice Plan where this so happens, and developing a pre-release plan if the client receives a custodial sentence.
   - The Disability Forensic Assessment and Treatment Service (DFATS): this service is made up of multiple teams. The Forensic Assessment and Intervention Team (FAIT) for example, consists of psychologists and psycho-educational trainers who provide services to regional workers and conduct assessments, therapy and relapse prevention with individual clients. Interestingly, research is also core business for this team. The Client Services Coordination and Evaluation Team develops and monitors service agreements between regions, Justice Plans and individual service plans.
   - The DFATS also has an Intensive Residential Treatment program comprising four stages of security, supervision, program intensity and community access.

The clients of this program are largely those charged with, or convicted of, serious sexual offending behaviour and assault.

- The DHS also provides emergency accommodation for up to three months for people with an intellectual disability who are in crisis associated with offending behaviour. Usually, the accommodation is provided while the clients are on bail.
- In addition to the state-provided services, two non-government organisations provide short and long term accommodation for clients post-release. One such service is based upon the supported-living model and provides short-term accommodation for up to one year. This service also provides permanent accommodation support in conjunction with the Department of Housing. This service also provides a non-residential sex offenders service.
- A second non-government service provides a twelve month residential and outreach programme for clients aged between 17 and 21 years. The focus of this service is to reduce the frequency of the clients' offending behaviour and increase the clients' independent living skills.

Largely then, the Victorian model for providing service to people with intellectual disabilities, complex needs and contact with the criminal justice system is based upon individualised case management by specialist human services teams from the commencement of the risk of, or actual contact with, the criminal justice system. There are also accommodation options for these clients while they are on bail and post-release. The focus of these programs is centred upon relapse prevention and development of independent living skills.

3. Law Reform Commission of Western Australia :

In June 2009, the Law Reform Commission of Western Australia (LRCWA) released its final report on *Court Intervention Programs*. Of particular significance was the following:

> The review of programs and relevant literature outlined in the Commission's Consultation paper highlighted the difference between the management needs of mentally ill offenders and cognitively impaired offenders. For example, it became apparent that cognitively impaired offenders require far more intensive hands-on case management and often longer-term supervision or support than mentally ill offenders. While many mentally ill offenders may be treated effectively in the short term by medication and counselling, cognitively impaired offenders must learn skills to manage a lifelong disability. Cognitively impaired offenders also present more often with severe functional disabilities (especially those people who have degenerative brain injury or acquired brain injury) and sometimes require supported

accommodation with assistance in all aspects of daily living from toileting to decision making (LRCWA, 2009: 82).

Western Australia has an existing Intellectual Disability Diversion Program (IDDP) and the LRCWA recommended that the program be retained as a specialist list and expanded; and, to include offenders with all types of cognitive impairment including acquired or organic brain injury, intellectual disability, dementia and other degenerative brain disorders. The level of cognitive impairment that a participant must have is a matter of policy for the court (LRCWA, 2009: 83).

The Commission also recommended:

For the reasons set out in its Consultation Paper, and with which the submissions agreed, the Commission recommends that the program should have inclusive psychiatric diagnostic criteria that include personality disorders and dual diagnosis substance abuse. However, the Commission recommends that offenders with a primary diagnosis of intellectual disability or other recognised cognitive dysfunction be dealt with under an expanded version of the existing IDDP and therefore should not be specified in the diagnostic criteria of the proposed mental impairment court intervention program. Nonetheless, those offenders whose primary diagnosis is of a mental illness or personality disorder with a secondary diagnosis of intellectual disability or other cognitive dysfunction may apply to participate in the mental impairment court intervention program (LRCWA, 2009: 84).

According to the Commission's report then, 'best practice' in WA when working with clients with an intellectual disability who have had contact with the criminal justice system means separating programs for these clients from those programs for clients who have a primary diagnosis of a psychiatric disorder. Such a 'best practice' model has implications for individualised service provision which will be further expanded in the discussion.

4. Texas (USA) Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI):

   The mission statement of this office is:

   To provide a formal structure for criminal justice, health and human service, and other affected organizations to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. Special needs include offenders with serious mental illnesses, mental

retardation, terminal or serious medical conditions, physical disabilities and those who are elderly. (TCOOMMI, 2010)

The Council is a state-funded program for offenders with the needs identified above. There are three program areas: community-based programs, continuity of care and special needs parole. The program takes a collaborative approach, funding community-based programs including case management, psychiatric treatment, rehabilitative services, medications support, substance issue treatment and residential and vocational training (Simpson, Martin and Green, 2001).

Community-based continuity of care workers are contracted by TCOOMMI to devise and implement post-release plans. In this way, TCOOMMI focuses its efforts on "revising regulatory, procedural or statutory practices that served as impediments to an integrated service delivery system" (Simpson, Martin and Green, 2001: 109).

4.4.2 Themes from scholarly literature around services for clients with complex needs

Data were extracted from 7 scholarly articles. Several key themes emerged and are listed below:

1. Cognitive impairment and contact with the criminal justice system:

   In a recent cohort study of people with mental health disorders and cognitive disabilities in the criminal justice system in New South Wales (Baldry, Dowse and Clarence, 2010), the following findings were reported:

   - People with complex cognitive disability are significantly more likely to have earlier contact with the police and more lifetime police contacts, and are more likely to be clients of the juvenile justice system;
   - People with diagnoses of either/or borderline cognitive disability, intellectual disability or mental health issues who have had contact with the criminal justice system also have significantly increased rates of substance use disorder when compared with the general population;
   - It is likely that the people in this cohort "become locked, early in their lives, into cycling around in a liminal, marginalised community/criminal justice space" (Baldry, Dowse and Clarence, 2010: 27).

   As such then, Baldry, Dowse and Clarence (2010) recommend recognising the different disability and rehabilitative interventions and supports that may be required at different time points across the life courses of these individuals.

Despite the overrepresentation of this client group within the criminal justice system, little is known about the prevalence of cognitive impairment among accused within the local courts system in New South Wales (Vanny et al., 2009). Further, little is known about the personal, health and mental health characteristics and their service provision needs in the community (Vanny et al., 2009: 289). Vanny and colleagues conclude that this dearth of knowledge has implications for people with cognitive impairment both within, and outside of, the criminal justice system:

> Accused persons with ID [intellectual disability] and/or CI [cognitive impairment] may not be identified in the Magistrates Court as having a disability and therefore may be unable to access the legal safeguards which exist for their protection within the criminal justice system and/or may fail to receive appropriate community health and welfare services (Vanny et al., 2009: 289).

Earlier research from the United Kingdom pointed to a similar finding: little is known about people with intellectual disabilities who have had contact with the criminal justice system and are now living in the community. Mason and Murphy found for example, that:

> It seems likely that the probation service contains a significant minority of people with ID. Despite the fact that no difference was found to exist in terms of outcome, people with ID or borderline ID are likely to have a number of support needs which could affect the success of their time on probation (Mason and Murphy, 2002: 230).

As will be discussed further, the findings of Vanny et al. (2009) and Mason and Murphy (2002) have implications for service delivery for people with complex issues around cognitive impairment when involved with the criminal justice system.

2. Drug and alcohol issues and intellectual disability and cognitive impairment:

There is limited research on drug and alcohol use and misuse among people with intellectual disabilities (Taggart et al., 2007). In a qualitative study in Northern Ireland, Taggart et al. (2007) sought to gain the insight into the experiences of a group of people with intellectual disabilities who had alcohol and drug issues. Taggart et al. (2007) also explored the services that this group receives. In narrating their own experiences, this group generally described the reason for drug and alcohol misuse as “self-medicating against life’s negative experiences” (Taggart et al., 2007: 360). Taggart et al. identified two sub-themes within this broader theme: “psychological trauma” and “social distance from the community” (2007: 360).

A majority of participants in Taggart et al.'s (2007) study had been referred to mainstream drug and alcohol services, although this experience was viewed negatively. Taggart et al. concluded that, in order to meet the needs of people with intellectual disabilities, better access to specialist services is required. In addition, mainstream intellectual disability and drug and alcohol services need to be more effective in the treatment and prevention of substance misuse (2007: 367). One way of achieving this may be by using motivational interviewing (Taggart et al., 2007).

3. Mainstream versus specialist services for clients with complex needs:

There is considerable ongoing debate regarding the capacity of mainstream drug and alcohol and mental health services to provide effective service to clients with complex needs. On the one hand, for example, Chaplin (2009) found that in the first instance, people with intellectual disability, especially those with more complex disability, had reduced access to general psychiatric services. Chaplin (2009) also found that accumulating evidence suggests that provision of general psychiatric services may not be effective for people with intellectual disability without additional supports such as outreach from specialised community intellectual disability services. Largely however, Chaplin found that further investigation by way of large-scale qualitative studies was warranted in order to assess relative effectiveness of mainstream versus specialised mental health services for people with intellectual disability (2009: 197).

An earlier study (Hall et al., 2006b), referenced by Chaplin (2009), found that, "Working with mainstream mental health services and across health and social service boundaries delivers effective mental health care for people with intellectual disabilities" (Hall et al., 2006b: 598). Hall et al. studied the Mental Health Service for People with Learning Disabilities in North London. This service has a specialist inpatient service and a "community 'virtual team'" (2006b: 599). In effect, this service is a combination of specialist and mainstream services:

> The specialist inpatient service was designed to allow people with IDs [intellectual disabilities] to access mainstream mental health inpatient services, while still benefiting from the specialist expertise available from ID professionals (Hall et al., 2006b: 599).

The weight of evidence suggests therefore, that mainstream services alone may not necessarily be effective in providing service for clients with complex needs.

4. Health inequities more broadly:

Individuals with intellectual disabilities, among other complex needs, are particularly vulnerable to health inequities (Ouellette-Kuntz, 2005). Drug and alcohol issues lie

within this vulnerability to health inequities. Ouellette-Kuntz (2005) identifies a number of factors that may be associated with these inequities. These "modifiable" factors include: lifestyle and behavioural factors, social networks and living and working conditions (2005: 118). Wider structural determinants of health, economic and social policies for example, may also contribute to these inequities (Ouellette-Kuntz, 2005). In her framework for the study of health inequities based on intellectual impairment, Ouellette-Kuntz emphasises the need to examine the experiences of people with intellectual disabilities and uncover the causal pathways to health inequities more than continuing to describe health disparities:

> Furthering our understanding of health inequities faced by individuals with intellectual disabilities will require that we target specific health outcomes/indicators as causal pathways that are likely to differ for different outcomes/ indicators (Forbes & Wainwright, 2001) and that we shift our efforts towards shedding light on the experience of individuals with intellectual disabilities in relation to avoidable determinants of health differentials rather than continuing to describe disparities. In order to reduce health inequities, we must first develop explanatory models for inequities observed which recognize the multiple layers of modifiable factors and their interrelatedness (2005: 118).

One way of achieving this, Ouellette-Kuntz (2005) suggests, is by 'nesting' epidemiological research within social science. This suggestion has broad implications for the ways in which we seek to research and overcome health inequities for clients with complex needs.

4.5 Discussion

Several significant discussion points arise from an overview of some of the policy and practice relating to supporting clients with complex needs including cognitive disability and contact with the criminal justice system. Firstly, there is general agreement that a continuum of services results in improved outcomes for the clients (Simpson, Martin and Green, 2001), but exactly how this is to be achieved requires further analysis and evaluation of the models of service provision currently engaged.

Secondly, largely the direction of policy in NSW, for example, is towards a *person-centred* approach (O'Brien, 1989). Such an approach recognises community presence, community participation, valued social roles, promotion of choice and support for contribution for the clients. The concrete details of this participatory discourse however remain an area for further investigation.

Thirdly, discussion around normalisation discourses is elemental to policy and practice that improves outcomes for the clients. So, for example, there is a general consensus in the literature that there should be separate facilities for youth and adults and also clients with intellectual disabilities and non-disabled clients. On the one hand, however, many clients with mild intellectual disability in a custodial setting, may not wish to be singled out for special programs for a variety of reasons, within the custodial setting, but there is some evidence that specialised programs may yield better outcomes in the community setting (Petersilia, 1997). Some of the custodial clients may feel the need to mask their disability for fear of victimisation and disruption of routines, hence the reluctance to participate in specialised programs in the custodial setting (Reynolds, 1999).

In light of this, the consensus in the literature is that outcomes for the clients are improved when there are comprehensive individual programs that are:

- individually designed and based on a comprehensive assessment;
- highly structured and accountable, for example, movement through accommodation being based on measurable progress;
- inclusive of recreational and vocational skill building;
- inclusive of regular monitoring of outcomes and review of the program;
- inclusive of both behavioural and therapeutic components to address both offence- related and offence-specific behaviours;
- consistent in programming and intervention strategies;
- multi-disciplinary in approach; and,
- inclusive of a system of monitoring an individual's progress for up to five years after leaving a service.

Under this rubric then, two further questions need to be asked, especially as they relate to the models in WA and NSW. As previously outlined, the WA model suggests that there should be separate programs for people whose primary diagnosis is either of a psychiatric or intellectual disability. Certainly such a separation may improve outcomes for all clients with a disability in so far as it may overcome the conflation of psychiatric disorder and intellectual disability that sometimes occurs in the juridical process at large. A paper by the Intellectual Disability Rights Service (IDRS: 2008) problematises even further the idea that jurisprudence can dispense therapeutic justice without consideration of the environmental and social features associated with an individual's offending behaviour:

> Whilst therapeutic jurisprudence offers some positive ways to address the issues faced by offenders with intellectual disability in the criminal justice system, it also has limitations that should be considered carefully before incorporating it into approaches to addressing intellectual disability criminal justice matters. These can be summarized in three points. If not applied carefully it could be inconsistent with the interactional model of disability adopted by this report because in some circumstances "therapeutic jurisprudence" is focussed on "therapeutic", that is on health-based, interventions which concentrate on the internal, psychological causes

of offending to the detriment of a thorough consideration of the role of environmental factors. Second, therapeutic jurisprudence sees the law as a positive, therapeutic tool and hence can fail to consider how the law itself can be a source of disempowerment. Third, it has the potential to have a "net widening" effect of drawing people with intellectual disability into and maintaining them in the criminal justice system insofar as it sees court as the moment for addressing an offender's issues. For example, there is a risk that the creation of specialist courts and diversionary mechanisms translates a social issue which should be the responsibility of the community and be addressed through human services into an individualised, legal and criminal issue (IDRS, 2008: 18).

So, for example, how do we separate offending behaviour associated with an intellectual disability from offending behaviour that arose from criminality? How does therapeutic jurisprudence manage these potentially conflicting episodes? Further investigation is required in order to address the social and environmental aspects of offending behaviour associated with intellectual disability.

In light of the literature examined in this review, further investigation may include, for example, as recommended by Taggart et al. (2007) an investigation into motivational interviewing for people with complex needs and drug and alcohol issues. Vanny et al.'s (2009) study leads to several potential questions: How much do we know about the history of our clients with complex needs? Could knowledge around a client's intellectual disability or cognitive impairment result in enhanced practice especially if that client has also had contact with the criminal justice system? In addition Vanny et al. (2009) and Mason and Murphy (2002) point to the probability that clients with cognitive impairment require specialist support if and when they come in contact with the criminal justice system. In examining the tension between mainstream and specialised services, Chaplin (2009) points to the need for appropriate networks for complex-needs clients when accessing specialist services. Similarly, Hall et al. (2006) suggest that outcomes for clients with complex needs may be improved if specialised service is delivered within a mainstream context. Finally, in light of Ouellette-Kuntz's (2005) discussion of 'modifiable factors', how might an examination of the lifestyle factors/behaviours, social networks (particularly the critical role of caregivers in facilitating access to care and lifestyle choices), living and working conditions (including community attitudes and access to services and facilities) of clients with complex needs, as well as the wider structural determinants of health (economics, policies) inform and enhance practice?

4.6 Conclusion

Discussion around complex needs is, quite literally, complex. In this review, complex needs have been described as, but not limited to, a range of cognitive impairments co-occurring with drug and alcohol issues and, in some instances, contact with the criminal justice

system. Policy in New South Wales around intellectual disability and contact with the criminal justice system is very clear. What is less clear however, is how a whole range of complex needs can be framed within a policy context. A limited review of the scholarly literature on complex needs reveals that there is an abundance of literature on, for example, co-occurring mental health and drug and alcohol issues, or drug and alcohol issues and contact with the criminal justice system. Where further work is required is in examining the interaction of all of these complex needs, in order to further enhance capacity to meet these needs.

Note

This review is being prepared for publication.

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5. Practice Enhancement Project: service mapping and member consultation

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5.1 Abstract

Introduction: In January 2011, the Network of Alcohol and other Drug Agencies (NADA) commissioned Community Sector Consulting to undertake a service mapping exercise and member consultation. NADA is the peak body for non-government drug and alcohol services in New South Wales (NSW). In particular, this exercise was to focus on complex needs.

Aims:

1. Map the ways in which drug and alcohol non-government services in NSW work with clients with complex needs.
2. Consult with NADA members regarding their experiences of working with clients with complex needs.

Methods: The websites of drug and alcohol services in NSW were examined, and policy and procedures around working with complex needs were identified. This exercise was complemented with interviews with workers in a cross-section of these services. Questionnaires sent to services augmented this consultation process.

Results: In total, policy and procedure around complex needs from 6 services were closely examined. In addition, 22 workers in 22 services were interviewed regarding their experiences in working with clients with complex needs. Policy and procedure largely centred around individualised approaches to clients with complex needs. Common themes derived from the worker interviews included stretched resources, assessment and planning for clients with complex needs and challenges in cross-agency communication.

Conclusion: in many ways, challenges around working with clients with complex needs are associated with stretched resources. Many workers spoke however of the advantages and successes of service networks and specialist support.

5.2 Introduction

In January 2011, the Network of Alcohol and other Drug Agencies (NADA) commissioned Community Sector Consulting to undertake a service mapping exercise and member consultation. NADA is the peak body for non-government drug and alcohol services in New South Wales (NSW). The service mapping and member consultation was part of a broader *Practice Enhancement Project: Working with Complex Needs Initiative*. This part of the

broader project aimed to contribute to further research on best practice in working with people with drug and alcohol issues who also present with complex needs. In addition, the consultation with the NADA membership aimed to identify gaps and barriers for the drug and alcohol non-government organisation (NGO) sector in providing services for people with drug and alcohol issues who also present with complex needs. For the purposes of this part of the consultation, a guide for the description of 'complex needs' is as follows:

> ...children, adolescents and adults who may experience various combinations of mental illness and disorders, intellectual disability, acquired brain injury, physical disability, drug and/or alcohol misuse (Thomson Goodall Associates, 2002:1).

In addition to using this description as a guide, the consultation brief defined complex needs as:

> People with drug and alcohol issues who present with cognitive disabilities (intellectual disability, acquired brain injury, Fetal Alcohol Syndrome Disorder), mental health issues and involvement with the criminal justice system (including those involved in court ordered treatment)(Consultant Briefing Paper, 2011: 2).

Complex needs may also include, but are not limited to: trauma, homelessness and involvement with the NSW Department of Community Services (DoCS).

5.3 Methods

There were four elements to the methodology of this service mapping and member consultation:

1. The websites of drug and alcohol services in NSW were scoured for policy and procedure related to clients with complex needs. This information was then distilled by taking a cross-section of policy and procedure from services that were either generalist or had a target client group. While generalisable conclusions cannot be drawn from this sampling for all drug and alcohol services within NSW, cross-sectional data may provide an accurate snapshot of the variety and diversity of services that exist.

2. A member questionnaire was designed to enquire about key elements to service provision for clients with complex needs. This questionnaire was emailed and sent by post to all NADA member services, and was made available on the NADA website. 24 of the 100 or so questionnaires sent out were returned. With the exception of 4, all questionnaires were returned anonymously.

3. An interview schedule was devised that closely replicated the questionnaire. It was thought that, as it would be unrealistic to speak face-to-face to all 100 NADA members, at least the field-notes from the face-to-face interviews would approximate the returned questionnaires. Face-to-face interviews were undertaken with NADA members in the Sydney metropolitan, Greater Sydney and regional areas. In total, 22 member services were interviewed. The interview schedule was used as a guide

for open-ended questions in all the interviews. Extensive field-notes were taken during the course of the interviews. 19 of the 22 interviews were recorded for future reference when examining the field notes. The remaining 3 interviews were not recorded due to technical issues with the recorder. All interviewees were de-identified.

4. Data analysis of questionnaires and interviews:

    - Statistical analysis: A small component of both the questionnaires and the interview schedule asked respondents to describe several statistical measures of their service. While the relative number of member respondents was high (c. 25%), the absolute number of respondents was low (40-50 of potentially hundreds of respondents in drug and alcohol services, both government and non government, across New South Wales). In addition, this may not necessarily be 40-50 individual respondents (see 'Limitations'). Descriptive statistics were therefore used in this analysis as it seemed unlikely that regression analysis would produce any meaningful statistics.

    - Qualitative analysis: Purposive maximum variation sampling was used to reveal common themes of interest in both the questionnaires and the field notes from the interviews. Data saturation occurred on approximately the 20th interview, although a further two interviews were conducted to affirm this. Thematic-based analysis was conducted, in order to analyse naturally occurring text to discover semantic information and patterns. In addition, the interviewees' responses were analysed using Muller's (1999) five over-lapping stages of narrative analysis:

        > …entering the text (reading and preliminary coding to gain familiarity), interpreting (finding connections in the data through successive readings and reflection), verifying, searching the text and other sources for alternative explanations and confirmatory and disconfirming data), representing (writing up an account of what has been learned) and illustrating (selecting representative quotes) (Greenhalgh et al., 2006: 1175).

    By using this approach, we were able to gain access not only to the individual narratives but also the wider context framing the respondents' experiences. From this analysis, we uncovered "patterns and inconsistencies that emerged from multiple stories about comparable events" (Greenhalgh et al., 2006: 1175).

5.4 Results

The results section is divided into three parts: service mapping, descriptive statistics and qualitative analysis.

5.4.1 Service mapping:

In total, 40 NGO drug and alcohol service websites were consulted. The following describes a small cross-section of all of these. This list is by no means exhaustive, *nor* does it imply that other services *do not* have policy and procedure that specifically discuss access and service provision for clients with complex needs. It merely describes a small cross-section of services who have made explicit on their websites their policy and procedure around clients with complex needs.

- Mercy Community Services (MCS), Newcastle:

Equity of access, regardless of disability is key policy directive of this service:

Policy Statement
Services provided by MCS will be promoted in a manner which ensures equity of access. MCS services are not denied any person on the grounds of their gender, marital status, religious or cultural beliefs, political affiliation, particular disability, ethnic background, sexual preference, inability to pay, or circumstances of their carer (Mercy Community Services, 2011: 1).

Further, their drug and alcohol services arm, McCauley Outreach Service states clearly in their eligibility criteria that, "Families with children under 12 years where parental drug or alcohol use has affected the family functioning" (Mercy Community Services, 2011: 8) are all eligible. The implication is that service access policy guarantees equity of access for clients with complex needs, including needs around family services.

- Triple Care Farm, Robertson:

Triple Care Farm has a factsheet available on their website. The factsheet mentions clients with complex needs as part of the target group for whom the service is directed:

Target Groups:

- Males and females aged 16-24 years inclusive
- From Australia wide
- Young people with an alcohol and or other drug issue that they would like to change
- Young people are referred from a range of sources like doctors, counsellors, schools, juvenile justice, probation and parole, other community organisations (Triple Care Farm, 2010).

More detail about their program appears on the Triple Care Factsheet, much of which implies the service approach is individualised and addresses complex needs. Triple Care Farm offers:

A range of services in case management, counselling, GP and psychiatric clinics, welfare, vocational and education training, residential and life skills, sport and recreation, and aftercare; TCF has been successful in engaging young people in all aspects of the program and providing assistance with alcohol and other drugs issues, physical and mental health, family issues, legal issues, employment, education and training, life skills, accommodation, and social contact and support (Triple Care Farm, 2010).

- The Haymarket Centre, Chippendale:

This service specifically states on its website that it provides services for clients with complex needs:

The newly opened Haymarket Centre, previously operating as the Albion Street Lodge, provides accommodation for homeless men and women who have complex issues, including intoxication, addictions, mental illness and/or challenging behaviours (Haymarket Foundation Limited, 2011).

The Centre provides a variety of services in addressing complex needs, on an individualised basis:

Clients are case managed, provided with group sessions and individual counselling by the psychologist, and referred on to housing, health & AOD services. Length of stay varies according to the client's needs (Haymarket Foundation Limited, 2011).

- Rekindling the Spirit, Lismore:

While not specifically a drug and alcohol service, Rekindling the Spirit has built into its aims and objectives meeting the needs of clients with complex needs. For example, the services states as its vision, "a world where Aboriginal Communities are free from social injustice, substance misuse, family violence and child abuse" (Rekindling the Spirit, 2009). In order to achieve this vision, the service:

...will offer services directly to Aboriginal men, women and families that relieve poverty, distress, sickness, destitution, trans-generation trauma and other misfortunes. Our counselling, assistance, education and supplementary services will focus on reducing the occurrence of domestic and family violence and child abuse and on promoting healing and wellbeing within families and the community (Rekindling the Spirit, 2009).

Rekindling the Spirit's service delivery aims encompass complex needs associated with homelessness and violence in addition to drug and alcohol and criminal justice issues.

- Women's and Girls Emergency Centre (WAGEC), Surry Hills:

The specific brief of this service is working with homeless and at risk of homelessness women (including transgender women) and their children:

> The women we support are predominantly long term homeless women, who have little family and community support. Many of the women have lived transient lifestyles impacted by issues such as domestic violence; history of sexual assault; mental health; drug and alcohol use, and come from a variety of diverse backgrounds (WAGEC, 2011).

As is stated on their website, WAGEC provides service to women and their children who have a range of complex needs which may include homelessness and cognitive impairment in some cases associated with long-term drug and alcohol use.

- Community Restorative Centre Inc. (Parolee Support Initiative) (CRC PSI), Parramatta/Liverpool/Fairfield:

As the name of the service suggests, the CRC PSI works specifically with clients with complex needs associated with contact with the criminal justice system, intellectual disability and issues around drugs and alcohol and mental health:

> The Parolee Support Initiative (PSI) provides comprehensive support to parolees with an intellectual disability and/or mental health issues throughout their period of transition from custody back into the community, with the explicit aim of successful community integration (CRC, 2011).

Again, it must be re-iterated that this list is not exhaustive. As will be examined in the third section of the results, all of the services who participated in the face to face interviews reported working with clients with complex needs, as did all of the questionnaire respondents. This list serves merely as a small cross-section of a diverse range of services that explicitly state, on publicly available materials, either policy documents or websites, that they work with clients with complex needs, or imply complex needs engagement in their mode of service provision. The high prevalence of working with clients with complex needs will be examined in the third section of the results.

5.4.2 Quantitative measures:

Questionnaire respondents were asked to estimate the number of clients their service saw annually, and what proportion of these clients had complex needs, the proportion of clients who had contact with the criminal justice system (CJS) and the proportion of clients who had cognitive impairment. Respondents were also asked to give the proportion of clients who had both criminal justice contact and cognitive impairment and other complex needs. Where other complex needs were identified, respondents were asked to specify. In total, 24 NADA members returned the questionnaires. The same questions were asked in the face to face interviews. As the questionnaires, with the exception of 4, were returned anonymously, the quantitative data from the interviews was excluded, as it could potentially confound results from the questionnaires given that a service may have returned a questionnaire as well as participated in an interview. Table 1 summarises the quantitative data from the questionnaires.

Table 1

Service characteristics	Range		Mean
Annual number of clients	28000	18	2084
% of clients with CJS contact	100	4	62
% of clients with cognitive impairment (CI)	50	1	15
% of clients with both CJS contact and CI	95	0.5	28
% of clients with other complex needs*	100	10	60

* Other complex needs identified included homelessness, mental health issues, pregnancy, pharmacotherapies, dual diagnosis, trauma, child abuse, behavioural issues, physical health, DoCS involvement, sexual abuse.

Some caution is required when interpreting these results. Data was missing from some fields. There was also a significant disparity between the average number of clients some services saw annually. One member reported seeing 18 clients annually, while another service reported seeing 28,000 clients annually. A more realistic mean number of clients per service sits somewhere around the median of 180 clients seen annually. It would be expected too that the mean number of clients with both CJS and cognitive impairment would be lower than that of cognitive impairment alone. Of note, however, is that every service reported seeing clients with complex needs as outlined in the questionnaire. 13 of the 24 services reported having a CJS client case load of 50% or more, while one third of the services who responded reported at least 20% of their clients had cognitive impairment. The most commonly specified ‘other’ complex need was mental health issues, with trauma, homelessness, abuse and DoCS involvement specified in equal measure.

5.4.3 Qualitative results:

Qualitative data were drawn from the 21 face to face and one telephone interview that took place as part of this consultation. Thematic analysis was conducted and the results are summarised below:

- Stretched and limited resources:

The theme of stretched resources emerged in several different guises. Some services expressed the observation that there are simply not sufficient resources to meet community need around the intersection of complex needs and drug and alcohol issues. Several regional services expressed this observation as a function of their geographical location. Other services reported that, due to their location in regional NSW, there was a dearth of specialist services for clients with complex needs.

Stretched and limited resources were also discussed in the context of organisational constraints. The literature suggests, for example, that more individual and longer-duration service may produce better outcomes for clients with complex needs, especially clients with cognitive impairment. Many services reported that due to their funding, this model of service provision was unavailable to them. Often, this was due to staffing arrangements. Some services reported that their model of service provision, cognitive behavioural therapy for example, may not have suited the best interests of all potential clients. This was always contextualised within the aims of 'not setting the client up to fail.' Other services also mentioned the challenges of working with clients who are on pharmacotherapies in the context that it is considerably more labour-intensive to work with these clients in a residential rehabilitation setting, although one service was able to work around this issue as they were in very close proximity to a local pharmacotherapy clinic.

- The need for functional assessment:

This theme emerged from almost all of the interviews. Often services characterised this as contributing to better intervention strategies, especially for clients with alcohol related brain injury (ARBI). Services reported that instruments to measure cognitive impairment would be useful in their intake procedure, not for the purposes of excluding clients on the basis of the results, but for more effectively individualising service for the client. One service, for example, reported that a short questionnaire at intake to determine cognitive impairment would aid in understanding the extent to which client based resources such as emotional regulation, anger management and memory techniques could be accessed. In addition, this service suggested that this

kind of assessment could aid in avoiding the 'revolving door' of drug and alcohol service that so many long-term clients experience.

Another service reported that they conduct a global assessment of functioning upon intake and this is reviewed every three months. One service also suggested that such an assessment and diagnosis would help the client to better understand their own situation and why they have certain experiences, for example inability to manage aggression. This observation was reported however by only one service. Largely, discussion around assessment centred upon the outcome of aiding individualised service provision.

- The importance of cross-agency collaboration:

Services described the significance of cross-agency collaboration, and the challenges and advantages associated therewith. One service reported, for example, that they had at one point, had an understanding with Corrective Services New South Wales (CS NSW) that parolees requiring drug and alcohol rehabilitation could be directly transported to their service in order to avoid the potentially risky period immediately after release from prison. In order for this to happen, this residential rehabilitation service would require information from Justice Health in order to manage their own risks in accepting a certain parolee. This service was unable to obtain these records so were unable to accept parolees on the grounds that it may constitute immitigable risk. This risk was associated with the service's duty of care to its other clients. This service contextualised this risk within questions about the offender's history, if it included violence, and the medications that this offender may require. On the other hand, another regional drug and alcohol residential rehabilitation service reported a collaborative relationship with CS NSW in their area. Part of this service's model was to go into prisons to inform soon to be released offenders about the realities of drug and alcohol rehabilitation so that should the offender upon release choose to enter rehabilitation, their expectations of this process would be realistic.

In addition, many services reported the vital importance of having close, collaborative relationships with local community mental health services. In some contexts, this relationship was characterised as challenging, in others, as extremely successful. Regional NSW appeared to fair better in this respect than metropolitan Sydney. Other valuable networks described by the services included local general practitioners and psychiatrists.

- Challenges of working with clients with alcohol related and acquired brain injury in the residential rehabilitation setting:

Some services spoke of specific challenges associated with working with clients with alcohol related and acquired brain injury in the residential rehabilitation setting. The challenges arose from the increased support needs of these clients relative to the rest of the client group and the capacity of these clients to participate fully in group settings. One service was working with a client with significant physical and mental health issues associated with their alcohol related brain injury (ARBI). To augment the support provided by the residential rehabilitation service, an external support service came in to assist this client with activities of daily living. Without this support, it was reported that this residential rehabilitation service would not have been able to meet the needs of this particular client.

One service described the changes of behavioural support needs of clients in the residential setting. This service suggested that the brain injury may not be obvious so it is difficult to assess how to manage the behavioural issues that often accompany these brain injuries. This service went on to suggest a further complication included not being able to give clients with brain injuries responsibilities which are part of the therapeutic setting.

- Physical health complications:

The challenges of generalist drug and alcohol services, especially residential rehabilitation services, in meeting physical health complications emerged as a theme in the responses. Among these physical health complications were insulin-dependent diabetes, renal failure, dental issues, eating disorders and pregnancy. While pregnancy itself was not described as a health complication, it was discussed in the context of the added health considerations required when a client is pregnant.

One service however described how they were supporting a client with end-stage cancer. This service reported that this had been challenging, but with collaborative support networks it had been made possible. Access to local health practitioners, especially for the regional services emerged as a challenge when working with clients with complicated physical health needs.

- The significance of complex needs such as mental health issues, homelessness and DoCS involvement:

Overwhelmingly, mental health issues emerged as the primary concern when services were asked to describe complex needs. The literature around the co-occurrence of mental health and drug and alcohol issues is vast. As a consequence, services were questioned further about other complex needs. As described in the quantitative results, a significant number of services reported significant proportions of clients with complex needs around criminal justice contact and cognitive impairment. Most services reported that clients with criminal justice contact came

with a raft of support needs that other clients may not necessarily have, including transport difficulties when first released, drug-testing upon release and access to appropriate medical care upon release from prison.

In addition to the complex needs mentioned above, homelessness and unstable accommodation emerged as issues that can adversely affect client outcomes. This was an especially important theme in the context of discussing those clients who had recently been released from prison. DoCS involvement was frequently discussed by the services. One service, for example, reported supporting many clients who were parents, and both they and their partners had, among many complex needs, drug and alcohol issues. For one service in particular, family and personal history issues around drug and alcohol misuse contributed heavily to the model of their service provision.

- The importance of training around complex needs such as alcohol-related brain injury and intellectual disability:

Other services discussed the training needs of staff in working with clients with these brain injuries. In particular, services spoke of the need for comprehensive training around the presentation of these brain injuries, including impulsivity and anger-management. There appeared to be an agreement among services that generalist drug and alcohol workers would be much better skilled to work with clients with brain injury were there easily accessible training, and in the regional areas, it became apparent that this training would potentially be most successful as an in-service.

Additional training needs identified by services included training around intellectual disability. Some services expressed a seeming apprehension about their capacity to meet the needs of clients with intellectual disability and drug and alcohol issues. Largely, this was framed as a best fit model for service provision, that is; clients with intellectual disability may have better outcomes if they are supported by intellectual disability services. Nonetheless, many services reported that training around intellectual disability could be of benefit.

- Policy, procedure and data recording:

Most services reported that they had specific policy and procedure for assessing and working with clients with criminal justice contact. Most residential services reported that they excluded clients with a history of serious violence or sexual assault in order to meet their duty of care to the other clients. These services reported that accepting such clients constituted an unconscionable risk. Other services situated their exclusion criteria within their risk assessment procedures. Policy and procedure related to cognitive impairment were less clearly defined, again often discussed in

the context of the potential for individual prospective clients' capacity to successfully complete the program, again with the aim of 'not setting people up to fail.'

The forms in which client outcomes were recorded varied among services. Many services reported that they undertook an exit interview, while other services reported monitoring retention rates. Of the participating services, none reported monitoring retention rates for clients with complex needs such as cognitive impairment or criminal justice contact. Rather, most services reported a general retention rate monitoring procedure. One service had an extensive data recording and monitoring system that did record a range of complex needs. Another service reported that as long as clients were working towards defined goals, in most cases, the clients were retained within the service.

5.5 Discussion

The overarching aim of this consultation was to examine the experiences of non government drug and alcohol services in New South Wales in working with clients with complex needs.

In almost all the interviews with workers in these services, an interconnectedness of issues around complex needs emerged. This interconnectedness comprised elements including housing, family and sometimes contact with the criminal justice system. In some ways too, this interconnectedness had had an effect on the ways in which the workers observed clients had experienced service access.

Many of the workers identified issues around organisational structures and practices that both assisted and impeded clients in accessing service for complex needs. The valuable input of individual workers was contrasted in these interviews with service separation and challenges in system access, particularly for complex needs, and especially clients in contact with the criminal justice system (CJS). In some ways too, the perception of accommodating complex needs had an effect on how services were delivered. In the experiences of some respondents, accommodation of complex needs took place as a result of individual workers manipulating the system (or bending the rules), while in others' experiences, complex needs were accommodated by putting the system to work, in the case of strong relationships and memoranda of understanding with local community mental health services for example. The accommodation of complex needs was, as described by the workers, facilitated by services having flexible and sensitive approaches. In combination with appropriate training, collaborative partnership networks, and specialist support, many respondents in this consultation felt empowered to support clients with complex needs.

5.6 Recommendations

The following represents an aggregation of recommendations made by NADA members in relation to working with clients with complex needs:

Assessment and individualised client service:

- Employ a short questionnaire to estimate cognitive impairment at intake for drug and alcohol services;
- Employ holistic service models that recognise the impact and role of family and personal history issues in drug and alcohol misuse;
- Employ service models that are inclusive of therapies better suited to clients who have literacy challenges, for example, art therapies and spoken, rather than written homework;
- Recognise that some modes of therapy, Dialectical Behaviour Therapy, for example, may not be suited to clients with alcohol related brain injury, acquired brain injury or intellectual disability;
- Use a strengths based focus in treatment planning;

Organisational and network attributes:

- Ensure smooth transitions between custody and drug and alcohol rehabilitation where so required using open lines of communication between CS NSW, Justice Health and the non government service providers;
- Upgrade existing drug and alcohol rehabilitation facilities so that they offer more privacy and are less institutional;
- Ensure smooth transitions between drug and alcohol rehabilitation and housing to avoid relapse during periods of unstable accommodation;
- Dedicate placements for clients with cognitive impairment and monitor progress through the program;
- Attempt as far as possible to maintain relationships with clients beyond the context of residency period to retain clients within the therapeutic community;
- As an organisation, be willing to be flexible in whole of service approaches;

Staff training:

- Ensure training in mental health, alcohol related brain injury, acquired brain injury and intellectual disability is accessible, and in regional areas, provide this training as in service.

5.7 Limitations

The limitations of this consultation, as with all qualitative investigation, centre upon representativeness and generalisability. All NADA members were not consulted, nor all non

government drug and alcohol services in New South Wales. While an estimated 30% (given past NADA consultation experiences) of members provided feedback either in the form of a returned questionnaire or interview, it was impossible to disentangle, with the exception of four questionnaires, which services had replied by questionnaire, and which were involved in both the questionnaire and the interview. It is likely that there may have been some overlap. The aggregated response included 46 questionnaires and interviews. This aggregate should not be taken to necessarily represent 46% of the 100-strong NADA membership.

Nonetheless, this scatter gun approach yielded data saturation after approximately 20 interviews. A further limitation relates to transcriptions of the interviews. While extensive field notes were taken during the interviews, and for the large majority of interviews, recordings took place, re-confirming interview data with verbatim transcripts may have yielded differing results. Lastly, further investigation could include talking to those who access services who see clients with complex needs. This however would need ethics review, obtaining which was beyond the scope of this consultation, due to time allocation.

5.8 Conclusion

This consultation revealed that all of the NADA members involved currently work with clients with complex needs. These complex needs may include, but are not limited to, mental health issues, contact with the criminal justice system, domestic violence, trauma, alcohol related and acquired brain injury, involvement with DoCS and intellectual disability. Recurring themes in the information provided by NADA members included stretched resources, the potential benefits of specific assessment for cognitive impairment, the importance of cross-agency collaboration and the multi-faceted nature of complex needs themselves. Largely, these findings accord with the relatively scant literature on the intersection of *complex needs per se* and drug and alcohol service provision. Cognitive impairment also emerged as a significant theme on its own. Most discussion around cognitive impairment centred upon services' capacity to meet the needs of clients with cognitive impairment given current service delivery models. The avoidance of a process of 'setting the client up to fail' resonated in the discussion around cognitive impairment. Further investigation is therefore warranted in service delivery model adaptation for clients with complex needs and, accordant with the literature, how best to ensure a continuum of integrated services given resources available.

Note

This consultation is being prepared for publication.

5.9 References

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6. Appendix 1

PRACTICE ENHANCEMENT PROGRAM
WORKING WITH COMPLEX NEEDS QUESTIONNAIRE

The following questionnaire is part of the member consultation for the Practice Enhancement Program under NADA's Working with Complex Needs Initiative. The questionnaire seeks to explore your service's experience in order to better support NADA members in working with clients with complex needs, including, but not limited to, cognitive impairment and contact with the criminal justice system.

All data arising from the questionnaire will be de-identified and anonymous.

Questionnaire can either be:

a) Completed as a Word document and returned as an email attachment to ciara@nada.org.au.
(If completing on screen simply click on check boxes ☐) OR;

b) Printed out, completed manually, and posted or faxed (please contact us to confirm receipt of fax) to NADA at the address on page 2. OR;

c) Fill in the questionnaire and post to NADA in reply paid envelope provided in the mail.

PLEASE FORWARD YOUR COMPLETED QUESTIONNAIRE BY COB FRIDAY 25 MARCH 2011

1. Which of the following best describes your service type? *(You may select more than one option)*

☐ **AOD Treatment**	☐ **Additional Services**
☐ Pharmacotherapies	☐ Family support
☐ Detoxification	☐ Policy
☐ Residential rehabilitation	☐ Primary Health Care
☐ Therapeutic community	☐ Living skills programs
☐ Outpatient counselling	☐ Workplace AOD
☐ Case management	☐ Research
☐ Day programs	☐ Needle & syringe program
☐ **Prevention programs**	☐ Other
☐ AOD specific community education	*Please specify*
☐ School based AOD programs	

2. Approximately how many clients does your service see annually? ☐

3. Approximately what percentage of your clients do you think have complex needs such as...

i. Contact with the criminal justice system ☐
ii. Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury) ☐
ii. Both contact with the criminal justice system and a cognitive impairment ☐

v. Other complex needs. *please specify*

4. How many full time staff / part time staff work in your service?

FT	PT

5. a) How many staff (equivalent of) have expertise or specialist training in working with clients who have...

i. Contact with the criminal justice system

ii. Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury)

ii. Other complex needs *please specify*

b) How many staff have qualifications in working with clients who have...

i. Contact with the criminal justice system

ii. Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury)

ii. Other complex needs *please specify*

6. Does your service: *(please tick the appropriate box)*		***Yes***	***No***	***Don't Know***
a)	Have policy around assessment and intake for clients with: i. Contact with the criminal justice system ii. Cognitive Impairment			
b)	Have specialised policies and procedures for working clients with: i. Contact with the criminal justice system ii. Cognitive Impairment			
c)	Monitor retention rates for clients with: i. Contact with the criminal justice system ii. Cognitive Impairment			
d)	Have local networks of specialist support for clients with: i. Contact with the criminal justice system ii. Cognitive Impairment			
e)	Feel adequately supported by specialist services to meet complex needs associated with: i. Contact with the criminal justice system ii. Cognitive Impairment			
f)	Does your service undertake specific training in relation to complex needs?			
	i. *If yes* please describe:			

	ii. *If no*, does your service have future plans to participate in specialist training in complex needs areas?			
	iii. *If yes*, please describe/ *if no,* why not?			

7. Would your service be open to looking at service model adaptation for complex needs clients?

☐ Yes definitely ☐ Yes possibly ☐ No, not at this stage

8. Would your service be open to reviewing current policy and practice as it relates to complex needs clients?

☐ Yes definitely ☐ Yes possibly ☐ No, not at this stage

9. Can you give examples of how your service has supported clients with complex needs in addition to addressing drug and alcohol issues?

10. What training / resources could support your service in working with complex needs clients?

11. Do you have any other comments?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

Contact Ciára on 02 8113 1306 with any queries

7. Appendix 2

PEP Interview Schedule

1. Approximately what percentage of your clients do you think have complex needs such as...

v.	Contact with the criminal justice system	
v.	Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury)	
/i.	Both contact with the criminal justice system and a cognitive impairment	
ii.	Other complex needs	

Please specify:

2. How many full time staff / part time staff work in your service?

FT	PT

3. a) How many staff (equivalent of) have expertise or specialist training in working with clients who have...

i.	Contact with the criminal justice system	
ii.	Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury)	
ii.	Other complex needs	

Please specify:

b) How many staff have qualifications in working with clients who have...

v.	Contact with the criminal justice system	
v.	Cognitive Impairment (e.g. Intellectual disability, Acquired Brain Injury)	
/i.	Other complex needs	

Please specify:

	4. Does your service:	*Yes*	*No*	*Don't Know*
a)	Have policy around assessment and intake for clients with: iii. Contact with the criminal justice system iv. Cognitive Impairment v. If yes, could you please provide some detail:			
b)	Have specialised policies and procedures for working clients with: iii. Contact with the criminal justice system iv. Cognitive Impairment v. If yes, could you please provide some detail:			
c)	Monitor retention rates for clients with: iii. Contact with the criminal justice system iv. Cognitive Impairment v. If yes, could you please provide some detail:			
d)	Have local networks of specialist support for clients with: iii. Contact with the criminal justice system iv. Cognitive Impairment v. If yes, what are they?			
e)	Feel adequately supported by specialist services to meet complex needs associated with: iii. Contact with the criminal justice system iv. Cognitive Impairment			
f)	Does your service undertake specific training in relation to complex needs?			
	iv. *If yes* please describe:			

	v. *If no*, does your service have future plans to participate in specialist training in complex needs areas?			
	vi. *If yes*, please describe/ *if no,* what are the challenges you face in meeting this potential need?			

5. Would your service be open to looking at service model adaptation for complex needs clients?

☐ Yes definitely ☐ Yes possibly ☐ No, not at this stage

If so, are you aware of any models of service delivery which may be helpfully adapted to meet the needs of the clients of your service?

6. Would your service be open to reviewing current policy and practice as it relates to complex needs clients?

☐ Yes definitely ☐ Yes possibly ☐ No, not at this stage

If so, how do you see that this review could take place and what sort of resources might be required to undertake this review?

7. Can you give examples of how your service has supported clients with complex needs in addition to addressing drug and alcohol issues?

8. What training / resources could support your service in working with complex needs clients?

9. If a practice enhancement seeding grant were available to your service, how do you think this could be implemented, eg: model adaptation, aftercare service model design, research and evaluation, continuity of care programs, inter-agency agreements?

We really appreciate your time in completing this consultation

8. Appendix 3

NGO Service Practice Enhancement Program:

Working with Complex Clients Initiative

NADA Member Consultation March – April 2011

Workforce Development and Training Needs Identified by NADA Members

Introduction

During March and April 2011, members of the Network of Alcohol and other Drugs Agencies (NADA) were consulted both by questionnaire and face-to-face interview on perceived workforce development and training needs within the drug and alcohol sector, in particular as they relate to working with clients with complex needs. When aggregated, the total number of questionnaires and face-to-face interviews amounted to 46 responses. All but 4 of the questionnaires were returned anonymously. It is of note therefore, that the following list of training needs is defined by the number of times the individual themes arose in the 46 responses. This may or may not relate to 46 individual responses as it is not possible to distinguish, with the exception of 4 responses returned by name, which response corresponds to services who participated in the questionnaire, the face-to face interview, or both. Nonetheless, weight may be attributed to the frequency with which the following list of themes arose, the maximum purposive sampling nature of the investigation notwithstanding. This consultation was part of a broader project investigating how these services work with clients with complex needs more broadly. The following is a summary of the services' responses in these areas:

Training Needs Identified by Services:

1. Free training. 1 of the 46 responses specifically reported that free training would be of benefit. This needs to be contextualised within the discussion of subsidised training, mentioned by 40 of the 46 responses. Some of the areas in which free or subsidised training was reported as needed included: working with people affected by drugs, both licit and illicit, and in particular, working with people affected by methamphetamine.

2. Other training. Suggestions for training around working with clients with complex needs included training in eating disorders and working with clients with experience of childhood sexual abuse and trauma. Further training areas identified included crisis-management (implicitly, the management of client personal crises) and in the area of the 'accidental counsellor.'

3. Co-existing issues. The most commonly reported area where training has been, and would still be, of great benefit was in working with clients with co-existing mental health and drug and alcohol issues.

4. Models of support. 2 of 46 responses indicated training around care planning and case management would be of benefit. This needs to be contextualised within the majority of responses indicating that these functions were already being served. 3 of 46 responses services suggested training around motivational interviewing would also be of benefit. One response suggested a toolkit for integrating people with intellectual disability into the mainstream drug and alcohol therapeutic community.

5. Contact with the criminal justice system. 2 of the 46 responses indicated that, as they increasingly see clients with past or current contact with the criminal justice system, training in this area would be of benefit. This needs to be contextualised within the 6 responses indicating *No Bars* training had been undertaken and was found to be of great benefit.

6. Cultural competence. Cultural competence training was viewed in two responses as potentially of benefit. This was especially pertinent in the responses provided by services whose client group is largely Aboriginal.

7. Networked training. One service reported that they could potentially provide their in-service training packages to other services. This service also said they undertook Dialectical Behaviour Therapy training with their staff.

8. Funding. Reflecting point 1. above, 3 of 46 responses indicated that the release of additional, training-specific funding would facilitate some of their training needs. This need was largely contextualised within an environment in which constraints such as back-filling of staff and continued service provision hampered efforts to facilitate staff training.

9. Piloting programs. One service suggested piloting a pregnancy-specific residential rehabilitation service with in-house pharmacotherapy. While this points perhaps more to structural issues, this comment does perhaps reflect workforce development issues around skill sets required for an in-house pharmacotherapy program to be piloted.

10. Services for youth. One service reported that training specific to youth issues would be of benefit.

11. Specialist intervention. 3 of 46 responses indicated that training around 'speaking the same language' in terms of specialist intervention would be of benefit. They said that sometimes communication in specialist intervention was impeded due to different registers of speech and language use specific to the discipline from where the intervention came, psychiatry or psychology for example. It might be surmised that these services were essentially advocating for training around the language of specialist intervention.

12. Peer support for workers. 2 of 46 responses indicated that one-day workshops may assist with peer-support and professional development. It is difficult to ascertain whether these support recommendations relate to generalised support for staff or for further knowledge acquisition.

13. Cognitive impairment. 7 of 46 responses indicated that training around acquired brain injury, alcohol related brain injury and intellectual disability would be of benefit. Specific areas of training associated with cognitive impairment were identified as anger management and impulse control.

14. Assessments. While not directly related to training needs or workforce development, 7 of 46 responses indicated that valuable beneficial resources may include neuropsychological assessment, functional living skills assessment, and screening for cognitive impairment.

15. Interagency collaboration. Again, while not directly related to training or workforce development, many services reported interagency collaboration as a valuable but often underemployed resource due to structural issues.

16. Training fatigue. One service reported training fatigue as a significant issue for their workforce, but this was contextualised within a framework of multiple training opportunities occurring simultaneously.

17. Grief counselling. 2 of 46 responses indicated acting as grief counselling services, particularly to those clients from whom children had been removed by the State. As a consequence, these services identified the need for grief counselling training.

18. Medication issues. One response indicated there was a need to train staff in medication issues, particularly around the use of benzodiazepines in the treatment setting. This service also reported that more time and resources for staff mentoring around medication issues would be of benefit.

19. Fetal Alcohol Spectrum and Related Disorders. 3 of 46 responses indicated that this would be an area around which training would be beneficial. One service in particular contextualised this within the issues the parent may experience as a result of having a child or children diagnosed with this complex of disorders.

20. Literacy and numeracy training for the clients. 2 of 46 responses identified this as a valuable resource in being better able to meet the needs of their clients.

Conclusion

This document summarises mainly training, but also some workforce development, needs identified by the services who participated in this consultation. As the training needs relate to working with clients with complex needs, the most commonly identified areas in which training would be beneficial was in cognitive impairment and contact with the criminal justice system. Largely, discussion around cognitive impairment centred upon access to

assessment tools in order to better tailor the service for clients who may present with cognitive impairment. Discussion around contact with the criminal justice system centred largely upon more effective referral patterns and exchange of information. Alongside these issues, other areas commonly identified where training could be of benefit were in working with clients who have experienced trauma, clients with co-existing mental health issues and clients who were involved with the Department of Community Services. In sum, almost all services involved in the consultation identified at least one, but often several, of the aforementioned areas in which training would be of benefit.

9. Appendix 4

Case Study One: leaving custody

A residential rehabilitation service in regional New South Wales works closely with Corrective Services New South Wales. This service provides education sessions to individuals in prison who are soon to be released and who are contemplating entering a drug and alcohol rehabilitation service to meet the conditions of their release. These education sessions are conducted in the context of providing prospective clients information regarding the realities of the residential drug and alcohol rehabilitation setting. A large majority, in the region of 85%, of the past and current clients of this service report contact with the criminal justice system as the reason for referral to the service. A mix of treatment modalities is employed at this service, including cognitive behaviour therapy-based sessions and peer education. Life-skills programs also form a key component of the larger rehabilitation process. The overall approach is 'step-down' in nature. The program starts with a six week residential period, moving over the course of the next twelve months to less intensive support, and eventuating in six counselling sessions.

Several key intersections between the literature and this service's practice emerge in this case study. Firstly, the large majority of clients with complex needs such as contact with the criminal justice system points to Baldry, Dowse and Clarence's (2010) finding that individuals with diagnoses of either/or borderline cognitive disability, intellectual disability or mental health issues who have had contact with the criminal justice system also have significantly increased rates of substance use disorder when compared with the general population. Secondly, the experiences of this service point to the Simpson, Martin and Green (2001) finding that a continuum of services may deliver better outcomes for clients with complex needs, especially as this continuum of care may begin while the individual is in custody and last until restoration of full participation in the community.

Among several, two key considerations arise from examining the experiences of this service specifically. Firstly, meeting and educating prospective clients while they are still in custody may have beneficial outcomes, including a smoother transition from custody to the residential rehabilitation setting, and ensuring that prospective clients have realistic expectations of the drug and alcohol service. Secondly, the aftercare model employed by this service involves maintaining a therapeutic relationship with clients for as long is as practicable. It is understood that not all services have the organisational capacity to do this, but in the experience of this service, this model is highly recommended.

Further investigation may be warranted here. A deeper understanding of exactly which models yield beneficial outcomes for clients transitioning from custody to residential rehabilitation could inform service practice. In the first instance, a qualitative study involving this client group, followed up by a randomised controlled trial, could lead to this understanding.

Case Study Two: extra supports in mainstream settings

A relatively small residential rehabilitation service in rural New South Wales had a client whom they observed had extensive functional limitations associated with alcohol-related brain injury. Like many similar services, this service's program was based upon group sessions and life-skills development. This service observed that the client mentioned above often had difficulty in meeting the requirements of group sessions and life-skills programs, and this was especially apparent when it came to self-care skills, impulse control and anger management. The client had been referred to the service via the New South Wales Trustee and Guardian (NSW T&G) with the understanding that the service could provide short to medium-term accommodation until more suitable accommodation could be located for this client. In the context of this service's organisational capacity, rehabilitation for this client posed an enormous challenge. Due to the personal care needs of this client, funding was successfully tendered in order to have an external agency come into the service and provide personal care support for this client, as well as provide support in the other rehabilitative aspects of the service. This support was provided by a non-government agency funded by the local area health network, and brokered through the NSW T&G.

The experiences of this service in working with a client with considerable cognitive impairment associated with alcohol-related brain injury intersect with several previous studies. Hall et al.'s (2006b) study, while not specifically related to alcohol-related brain injury, did examine a model of care for people with cognitive impairment in a mainstream healthcare setting. Under this model, additional supports were provided to individuals with cognitive impairment so that they could move through a mainstream inpatient mental health service. It is possible that this finding could also relate to mainstream residential drug and alcohol rehabilitation settings. On a broader level too, the experience of this service may point to Chaplin's (2009) finding that mainstream services alone, without additional supports, may not necessarily meet the needs of individuals with cognitive impairment.

Many recommendations were made by this service as their organisational capacity related to the needs of the client with considerable cognitive impairment. Firstly, the service was certain that without the additional supports from an external agency, they would have been unable to meet the needs of this client. The service characterised the additional funding as unusual and largely related to exceptional circumstances. Additionally this service said that

further staff training in issues especially related to clients with cognitive impairment would be required for the service to meet the needs of this client group in the future. All of this was contextualised within a recognition that the service was a specialised residential drug and alcohol rehabilitation service. As such, further investigation may be warranted in how to secure additional funds to meet the care needs of clients with cognitive impairment associated with alcohol-related brain injury. Furthermore, adaptation of current program models within the residential rehabilitation setting could be investigated in order to give insight into working with clients with considerable cognitive impairment.

Case Study Three: assessment for cognitive impairment

A large service in the metropolitan Sydney region provides a range of options for clients with past or current opiate dependence. These options include a large residential detoxification and rehabilitation service, community-based rehabilitation services and an outreach and aftercare service. This service reported an ageing cohort of clients, with longer histories of injection drug use and chronic relapse into injection drug use. This service characterised this cohort of clients as experiencing the "revolving door" of service provision. For this cohort of clients, independent living was characterised as extremely challenging in the context of their experience of issues additional to their drug and alcohol use. Many of these issues related to the perceived cognitive impairments of this cohort of clients and their capacity to manage without extra supports in the community. This service advocated for longer-term accommodation options for this ageing cohort of clients, as well as the availability of extra supports for this client group when they do leave supported accommodation. In addition, this service reported that an assessment of the individual clients' cognitive impairment would assist in tailoring service provision for improved outcomes for this client group.

That the cohort of people who inject drugs is an ageing cohort is well documented in the literature (Darke et al., 2009). In addition, in one study, the vast majority of a sample of heroin users in Sydney had witnessed a heroin overdose (Darke, Ross and Hall, 1996). Heroin overdose may lead to reduced oxygen supply to the brain (Warner-Smith, Darke and Day, 2002), meaning that early intervention in an overdose is critical to averting potential brain damage (van Beek et al., 2004). Another study pointed to a more complex degree of cognitive impairment among people on methadone maintenance when compared with a control group (Darke et al., 2000). This study concluded that, among other causes not tested, alcohol dependence and exposure to overdose could be contributing factors in this client group's cognitive impairment. In sum then, among the client group in this case study, cognitive impairment at least in part as a result of opiate overdose is highly likely, given their longer history of opiate dependence. Remarkably however, the literature around specific assessments for cognitive impairment in this cohort is relatively scant. As discussed by Chaplin (2009), studies investigating appropriate assessment tools and interventions in a

client group with cognitive impairment of one form or another are too diverse and contradictory to draw any firm conclusions. Chaplin (2009) advocated wide ranging qualitative studies as a good starting point for further investigation.

In light of the experiences of the service in this case study, recommendations were made around assessment for cognitive impairment. This service suggested that a short questionnaire would aid in assessing the degree of an individual client's cognitive impairment, and could guide the service in assessing to which degree client-based resources such as memory techniques, emotional regulation and anger management for example, could be accessed. This service contextualised such an assessment wholly within better tailoring the service provision for improved client outcomes. Further investigation may therefore be warranted in reliability and appropriateness of a compact tool to assess for cognitive impairment, and how this assessment may inform treatment planning.

Case Study Four: training issues

In a large regional centre in New South Wales, a community-based service provides drug and alcohol counselling services for clients and their families. This service receives clients via Corrective Services NSW, the Department of Community Services, family court, the Magistrates Early Referral into Treatment service and self-referral. This service reported that the majority of their clients present with many complex issues in addition to their drug and alcohol issues. Examples of these complex issues related to family breakdown, removal of children and the general challenges of independent living, budgeting on limited income and accommodation for example. This service reported working with approximately 50 families at any one time. Extensive training was reported as being undertaken by this service. Training included *No Bars*, a training package relating to working with clients with a history of criminal justice contact, and training packages around Fetal Alcohol Spectrum Disorder, pharmacotherapies, *Psycheck*, adult survivors of child abuse, self-harm, group work, motivational interviewing, mental health and multiple needs of parents. The list of training undertaken by this service was extensive. Training specifically around cognitive impairment was not reported. This service reported a current "training fatigue", but this was contextualised within many training opportunities occurring simultaneously.

The report of the service in this case study points to two important issues. Firstly, the importance of knowledge transfer among researchers, practitioners and the community more broadly when working with clients with drug and alcohol issues has long been the subject of investigation (Lamb et al., 1998). This knowledge transfer as reported by this service was effectively mediated through extensive training. Secondly, this service's report of "training fatigue" has implications for how training is managed, both at a service level, as well as at the level of organisations advocating for, and facilitating training.

Again, it should be noted that this service's reported "training fatigue" occurred in the context of many training opportunities occurring simultaneously. Several recommendations were made by this service in relation to training. In-services were characterised by this service as the most effective way to deliver training. This service also commended the way in which training had been delivered regionally, with a variety of services attending. These two positions are not necessarily contradictory. In the report of this service, when co-ordinated effectively, both modes of training delivery could be effective, but that this relies on interagency communication regarding upcoming training opportunities, so that full advantage can be taken of training opportunities, especially those that are provided outside of the Sydney metropolitan region.

Case Study Five: care planning and interagency collaboration

In a rural setting, a service provides a three month program for young people who have drug and alcohol and mental health issues. The service model is based largely upon life-skills development and intensive counselling and therapy. This service reported that they had excellent communication with local mental health services and primary health care providers. The profile of the client group indicated an upward trend in recent times of younger clients presenting with acquired brain injury and, in some cases, Fetal Alcohol Spectrum Disorder. 84-92% of the client group presented with mental health issues, of whom 50% presented with a diagnosis of major depressive disorder. As such then, this service viewed their relationships with local mental health and primary health care providers as critical to their own service provision. This service also reported that the effectiveness of these relationships was bolstered by the fact that their staff "spoke the same language" as the local mental health service providers, and knew the "ins and outs" of the mental health services system. This service did report however that there were still challenges in working with the local mental health service providers, often related to availability of response in acute situations. Of great concern for this service was maintaining these client-mental health service relationships once the client had completed their program. An aftercare service was provided, but this service implied that it may not always be sufficient to ensure continued client-mental health service contact.

Several important issues arise from the report of this service. Firstly, the significance of continued care once the program had been completed. This largely reflects the findings of the five-year report on the Multiple and Complex Needs Panel (Hamilton and Elford, 2009). Within this care planning process, the report suggested that the main areas for attention are: stable housing, health and well-being (mental and physical health), safety, social connectedness, service system responsiveness, agreements between individuals and service providers, brokerage and notifications as they may relate to accessing personal information (Hamilton and Elford, 2009: 36). Further, both the report of the service and the

Hamilton and Elford (2009) report reflect upon the significance of interagency collaboration in this care planning process. Hamilton and Elford report that the ingredients for effective service and co-ordinated care planning partnerships are: consistency of purpose, respectful, collaborative processes built on trust, capacity for flexibility, sharing of risk, information and feedback, and a clarity of roles (2009: 37).

Recommendations therefore, flowing from both the report of the service in this case study and the Hamilton and Elford (2009) report are clear: effective case planning is built upon a foundation of interagency collaboration. This service reported that one effective method for facilitating this collaboration was regular case meetings with relevant agencies in preparation for an individual client completing the program. Further investigation is warranted in the context of New South Wales in how exactly this approach to care planning can be instituted.