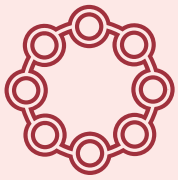

NADA

network of alcohol & other drugs agencies

CRIMINAL JUSTICE CONTACT

DRUG AND ALCOHOL

COGNITIVE IMPAIRMENT

MENTAL HEALTH

COMPLEX NEEDS CAPABLE

A practice resource for drug and alcohol services

ABOUT THIS RESOURCE

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services was developed as part of the Network of Alcohol and Drug Agencies (NADA) Practice Enhancement Program. The program was funded by the Mental Health and Drug and Alcohol Office, NSW Ministry of Health.

The Practice Enhancement Program's aim is to build capacity within the non-government drug and alcohol sector by supporting the development of staff skills, knowledge and confidence, and of organisational capacity in responding to the needs of people with drug and alcohol issues and complex needs such as cognitive impairment and criminal justice system contact. While this resource was developed for use by the drug and alcohol non-government sector, the information in it is relevant for and could be used by all organisations who work with people with drug and alcohol and complex needs.

ACKNOWLEDGEMENTS

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The Working with Complex Needs Resource Advisory Group

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Alison Churchill, Community Restorative Centre NSW

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NADA member services Practice Enhancement Program grant recipients

ABOUT NADA

NADA is the peak organisation for the non-government drug and alcohol sector in NSW. NADA represents over 100 organisational members that provide a broad range of services, including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community-based organisations operate throughout NSW and the ACT. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

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

NADA provides a range of programs and services that focus on sector representation and advocacy, workforce development, information management and data collection, governance and management support plus 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 Healthcare Standards (ACHS) until 2014.

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

NSW GOVERNMENT Health

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NADA acknowledges the traditional custodians of country throughout NSW and the ACT and their continuing connection to land, culture and community. We pay our respects to Elders past, present and future.

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FOREWORD

Larry Pierce

Chief Executive Officer

Network of Alcohol and Drug Agencies

Non-government drug and alcohol services have been at the forefront of meeting client and community demands for more than 30 years. This has included addressing the needs of people with complex issues such as co-existing drug and alcohol and mental health issues, criminal justice contact and diagnosed or undiagnosed cognitive impairment who often fall outside the scope of service funding and delivery structures. NADA and the non-government drug and alcohol sector have welcomed the rollout of the Practice Enhancement Program: Working with Complex Needs Initiative as an opportunity to better support these clients who present with more complex issues and less resource support.

NADA would like to acknowledge the expertise of our membership and the stakeholders who have helped to guide and develop this resource. The expertise and support provided by strong partnerships between members and stakeholders has been vital to the development of *Complex Needs Capable: A Practice Resource for Drug and Alcohol Services. Complex Needs Capable* is an invaluable resource which will support non-government drug and alcohol staff and services to better identify and address the needs of drug and alcohol clients with complex needs.

NADA will continue to build on the work of the Practice Enhancement Program as a means of support for the non-government drug and alcohol sector, and we call on government to continue to identify strategic funding opportunities which will better support the high level of complexity non-government drug and alcohol services work with every day.

David McGrath

Director

Mental Health and Drug and Alcohol Office, NSW Ministry of Health

Along with everyone else in our society, people with complex needs have a right to quality drug and alcohol treatment services. Unfortunately, due to a number of factors, their particular circumstances can act as a barrier to accessing appropriate treatment.

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services is an important step in overcoming the barriers. This resource is intended to be used by frontline drug and alcohol professionals. It contains practical information on what workers need to know when providing services to people with acquired brain injury or intellectual disability, or those in contact with the criminal justice system.

This resource is one element of the NADA NGO Practice Enhancement Program: Working with Complex Needs Initiative, which was funded by the NSW Ministry of Health in 2010. This initiative aims to increase the capacity of drug and alcohol non-government organisations to respond to the needs of people who present to services with complex needs.

I congratulate the Working with Complex Needs Resource Advisory Group on the development of *Complex Needs Capable*. I am confident that it will become a highly valuable tool for frontline workers in drug and alcohol treatment.

Jim Simpson

Senior Advocate

NSW Council of Intellectual Disabilities

This resource will help to bridge a chasm between two challenges. People with complex needs find it very challenging to recognise and get the right help for a problem with alcohol or other drugs. Drug and alcohol services find it very challenging to meet complex needs.

An intellectual disability, for example, tends to make an individual more prone to peer pressure and less able to see the consequences of misuse of drugs and alcohol, therefore needing a high level of engagement and support to see the need for drug and alcohol treatment. The treatment itself may need to be modified to address the person's communication and cognitive impairments. The person may need ongoing support to keep appointments and to follow through on the lessons learnt in treatment.

These challenges will arise all the more if a person has mental health issues and criminal justice system involvement as well as an intellectual disability. Recent research highlights how common it is for this complex interplay of disadvantage to arise.

The United Nations Convention on the Rights of Persons with Disabilities emphasises the right of people with disabilities to "the highest attainable standard of health without discrimination", including "the same range, quality and standard of free or affordable health care and programs as provided to other persons".

Complex Needs Capable: A Practice Resource for Drug and Alcohol Services is aptly named. It should assist drug and alcohol services to provide a steadily growing quality of service to people with disabilities and other complex needs.

Alison Churchill

CEO

Community Restorative Centre NSW

Although the prison population is around 10,000 in NSW, about twice that many people are released back into the community each year. In this population group, people with very complex needs are over-represented. This includes people with mental illness, people with cognitive impairment, people who are homeless, and people with serious drug and alcohol problems. It is clear that the majority of people who spend time in NSW prisons have a problematic relationship with drugs and/or alcohol. In the most recent NSW Corrective Services Drug Use Survey, 72% of male inmates and 67% of female inmates reported that their crime was directly related to their drug use.

For this population it is both the multiplicity of the need and the complexity that arises from the interaction between the various forms of disadvantage that have historically ensured that post-release support (including drug and alcohol support) has been – when it exists – difficult to access and very difficult to sustain.

Finding ways to prevent the cycle of reoffending and imprisonment for complex needs groups is one of the key challenges for both criminal justice organisations and the community agencies in regular contact with these populations. This challenge is not just in attempting to curb the enormous expense (both social and financial) of long-term offending/reimprisonment patterns, but is about recognising that this group have often had insufficient opportunities to make the changes necessary to remove themselves from these entrenched patterns. For drug and alcohol services, developing practical strategies for working effectively with complex needs criminal justice system clients is a fundamental part of a broader movement towards recognising the many barriers to service provision experienced by people with multiple and complex needs. Assisting frontline drug and alcohol services to implement strategies which will ultimately reduce reoffending and relapse for a group who are so often put in the 'too hard basket' is a mighty achievement. CRC congratulates NADA on the development of this important resource.

Rachel Merton

CEO

Brain Injury Association of NSW

Working with people with drug and/or alcohol problems can be challenging and rewarding at the best of times, but both the challenges and the rewards are magnified when the person also has a cognitive disability and is trapped in the cycle of the criminal justice system. At the Brain Injury Association, we are acutely aware of the barriers – systemic, cultural and social – that at best impact on, and at worst exclude, people with an acquired brain injury (ABI) from accessing the support they need from drug and alcohol services.

This is why we have been involved with NADA's Practice Enhancement Program and have sought to develop better links and pathways, and to build the sector's knowledge, skills and confidence around ABI and how it interacts with the other complexities in each individual's story. From this foundation, our partnership with NADA and its member organisations will continue to grow and develop, with our primary aim being to facilitate and support effective practical approaches so that people working in the drug and alcohol sector feel they are well equipped to work with people with a complex array of issues that include ABI.

On behalf of BIA NSW, I warmly congratulate the team at NADA for putting together this resource, which should become an essential tool in the daily work of support workers and organisations working with people with complex needs. We also applaud the level of engagement with external partners, including our Association, which has brought us together around common ground. Complexity can only be addressed through such collaborative approaches, firmly grounded in each individual's experience.

I commend this resource to you, and we welcome you all to contact our Association and to continue to build on the work we have done together to date.

GLOSSARY OF TERMS

Abstract concepts refer to concepts of a higher order derived from the usage and classification of real or concrete objects. For example, the concept of emotions is formed through grouping specific demonstrable feelings such as anger and happiness.

Acquired brain injury (ABI) refers to an injury to the brain that results in deterioration in cognitive, physical, emotional or independent functioning. It can result from traumatic causes such as car accidents, falls and assaults, or from non-traumatic causes such as stroke, hypoxia (insufficient oxygen), infection, tumour, substance misuse and degenerative neurological diseases.

Adaptive behaviour refers to social, conceptual and practical skills that have been learned by a person in order to function in their everyday lives.

Borderline intellectual disability is a term used to refer to people who are assessed as having an IQ between 71 and 80 who do not meet the IQ requirement to be diagnosed with intellectual disability but who still may have difficulties in a number of areas of adaptive functioning.

Cognitive functioning (or 'cognition') refers to the processing of information by the brain, i.e. a person's ability to think, concentrate, formulate ideas, reason and remember. There are several domains of cognitive functioning, including attention, memory, visuo-spatial skills and executive functioning.

Cognitive impairment (or cognitive disability) is a term used to recognise a broad range of disorders that affect cognitive functioning. Each domain of cognitive functioning can be selectively or jointly impaired across a range of developmental, neurological, acquired brain injury, mental illness, substance-related or dementia conditions. The terms 'cognitive impairment' and 'cognitive disability' are interchangeable, and workers in the community service sector are likely to come across both terms depending on the specific sector or service within which they are working.

Comorbidity (and related terms such as 'dual diagnosis', 'co-existing' or 'co-occurring' disorders that are often used interchangeably with 'comorbidity') can have a different meaning depending on the particular health and community sector. In the drug and alcohol sector, this term is often used to refer to a person who presents with a drug and alcohol problem in addition to a diagnosed mental illness or symptoms of a mental health issue. In other sectors, such as the intellectual disability sector, this term is used to refer to a person who has a mental illness in addition to intellectual disability.

Compensatory strategies refer to skills and behaviours that a person learns to improve their functioning in a specific area in which if they have difficulties, e.g. memory, comprehension, attention or vision.

Complex needs refers to needs that a client may present with to a drug and alcohol service in addition to drug and alcohol issues/co-existing drug and alcohol and mental health issues, such as cognitive impairment (including intellectual disability, acquired brain injury and fetal alcohol spectrum disorders) and/or involvement with the criminal justice system. This is the definition used for this resource but it is acknowledged that there are many other areas of complexity in which drug and alcohol organisations may provide support.

Executive functioning is a term used to describe the many tasks the brain performs that are necessary to think, act and solve problems. Executive functioning includes tasks that help people learn new information, remember and retrieve information, plan, make decisions and use information to solve problems.

Fetal alcohol spectrum disorder (FASD) and **fetal alcohol syndrome** and related disorders are terms used to describe a range of conditions and harms emerging from prenatal exposure to alcohol consumption. These conditions include fetal alcohol syndrome, partial fetal alcohol syndrome, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects.

Holistic practice refers to providing care to a person that takes into account all aspects of his or her life, considering physical and mental health, living circumstances and sense of social connectedness.

IQ (intelligence quotient) is a score derived from a set of standardised tests designed to assess intelligence.

Institutionalisation refers to the adverse effects of spending time in highly institutionalised environments such as prison, psychiatric units, large residential units, hospitals and out of home care. These adverse effects impact on a person's psychological and physical health, living skills and patterns of behaviour, and continue long after a person has returned to the community.

Intellectual disability (ID) is a cognitive impairment that is medically defined as consisting of three elements:

- An individual is assessed as having an IQ below 70 (2 standard deviations below the mean)
- An individual displays at least 2 deficits in adaptive functions (such as communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety), and
- An individual acquires the disability before 18 years of age.

Intergenerational trauma refers to the cumulative and lasting impact of trauma over the lifespan and across generations that stems from trauma experiences. Events that damage people, families and communities, particularly processes relating to conflict, sovereignty and cultural identity, can contribute to the development of intergenerational trauma.

Neuropsychological assessment refers to an assessment conducted by a neuropsychologist using a range of standardised tests, including tests of memory and problem-solving, to gather detailed information on how the brain is functioning.

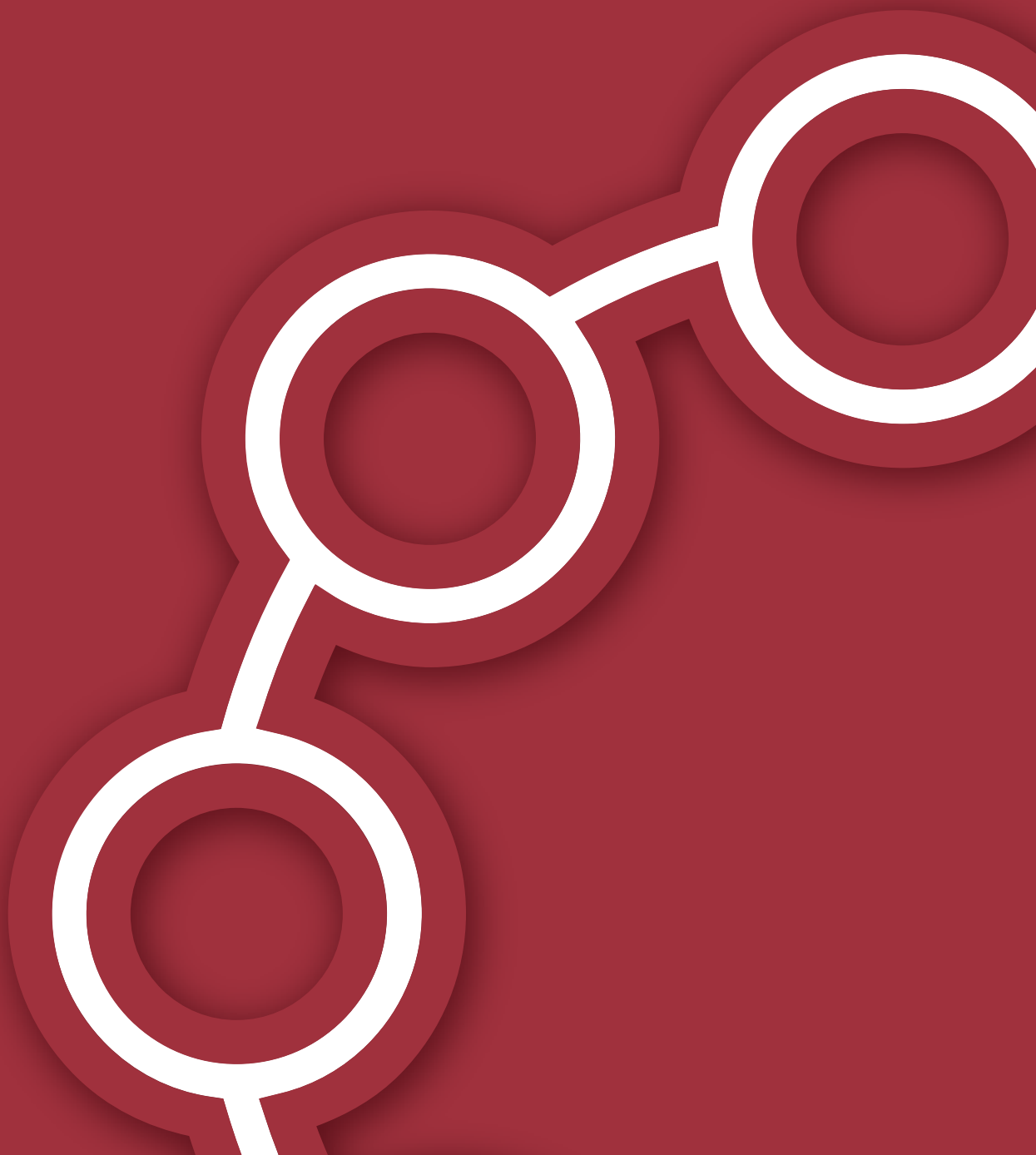
Remand refers to being detained in custody before and during trial having been refused bail, being unable to meet bail conditions or not having applied for bail.

Traumatic brain injury (TBI) is an acquired brain injury caused by an external force, for example as a result of a car accident, fall or assault.

ACRONYMS

ABI	Acquired brain injury
ACE-III	Addenbrooke's Cognitive Examination – III
ADHC	Ageing, Disability and Home Care (part of NSW Family and Community Services)
CALD	Culturally and linguistically diverse
FAS	Fetal alcohol syndrome
FASD	Fetal alcohol spectrum disorder
HASI	Hayes Ability Screening Index (note: HASI can also refer to Housing and Accommodation Support Initiative)
I-CAN	Instrument for the Classification and Assessment of Support Needs
ID	Intellectual disability
IDRS	Intellectual Disability Rights Service (note: IDRS can also refer to Illicit Drug Reporting System)
MoCA	Montreal Cognitive Assessment
NADA	Network of Alcohol and Drug Agencies
NANT	Neuropsychological Assessment Needs Tool
NGO	Non-government organisation
PEP	Practice Enhancement Program
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
SIB-R	Scales of Independent Behaviour – Revised
TBI	Traumatic brain injury

CHAPTER 1
Understanding Complex Needs



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Understanding Complex Needs

Key points

- Every person accessing drug and alcohol services has multiple needs; however, it is the interaction of these multiple needs that leads to complexity.
- There are many pathways to complexity and there's no one model or set of strategies to use when working with clients with complex needs.
- Becoming 'complex needs capable' means moving towards a more inclusive and holistic model of service delivery where you have the knowledge, skills and confidence to support clients with complex needs.
- Most drug and alcohol services already work with clients with complex needs, but there is a high level of 'hidden' disability among people accessing services.
- Each person with complex needs has a different pathway to their current circumstances as a result of their unique life experiences. A common feature of people's experience is marginalisation.

THE AIM OF *COMPLEX NEEDS CAPABLE*

In recent years there's been growing recognition in the drug and alcohol field that clients frequently present with co-existing mental health and drug and alcohol problems at drug and alcohol services, and that drug and alcohol professionals working with clients presenting with these issues need guidance on this issue (Mills et al 2009; NSW Health 2009; NSW Health 2007).

But there's been less attention paid to providing drug and alcohol services to clients with other complex needs, such as intellectual disability, acquired brain injury and involvement in the criminal justice system (Community Sector Consulting 2011).

Although drug and alcohol misuse is the primary presenting need for a person seeking to access drug and alcohol programs, all people present with multiple needs. In a profile of the NSW non-government drug and alcohol workforce commissioned by NADA (Gethin 2008) and the Complex Needs Survey, also commissioned by NADA (Community Sector Consulting, 2011), the additional needs of people accessing drug and alcohol services that were identified included:

- Criminal justice system involvement
- Borderline personality disorder
- Homelessness
- Poor physical health
- Mental illness
- Cognitive impairment
- Child protection issues
- Family breakdown, and
- Unemployment.

Complex Needs Capable aims to help drug and alcohol workers support clients with some of these complex needs. It focuses on people presenting with drug and alcohol issues or co-existing drug and alcohol and mental health issues who have cognitive impairment (including intellectual disability, acquired brain injury and fetal alcohol spectrum disorder) and/or involvement with the criminal justice system.

We acknowledge that having this focus excludes other areas of identified complexity and that some of these areas, such as mental health, have available resources specifically designed to support drug and alcohol services working with clients with mental health issues. Other identified areas of complex needs require further research, resources and training for the drug and alcohol sector.

In focusing on cognitive impairment and criminal justice, we aim to give you practical information to use in your everyday client service delivery. Many of the guiding principles and practice strategies covered in this resource are applicable to working with a wider range of complex needs issues in service settings and can be adapted for use with clients with a range of complex needs.

This resource will help drug and alcohol workers and organisations become 'complex capable'. This means moving towards a more inclusive and holistic model of service delivery where you have the knowledge, skills and confidence to support clients with complex needs. There are many pathways to complexity, and there's no one model or set of strategies to use when working with clients with complex needs. *Complex Needs Capable* provides a range of information, practice tips, service considerations and practical resources to help you work with clients with complex needs.

WHAT'S IN *COMPLEX NEEDS CAPABLE*?

Chapter 1: Understanding Complex Needs
This chapter provides the rationale for the development of *Complex Needs Capable*, distinguishes between multiple needs and complex needs, and considers how issues of equity and access relate to working with people with complex needs. It briefly describes some of the theoretical approaches and principles that underpin working with clients with complex needs, and identifies some of the pathways to complexity and factors that contribute to disadvantage and marginalisation among clients with complex needs accessing drug and alcohol services.

Chapter 2: Cognitive Impairment – What You Need to Know
This chapter covers the common indicators of cognitive impairment as well as specific information on intellectual disability, acquired brain injury and fetal alcohol spectrum disorders.

Chapter 3: Criminal Justice Contact – What You Need to Know
This chapter provides information on people in contact with the criminal justice system. It covers drug and alcohol misuse and offending behaviour, pathways to criminal justice contact, criminal justice clients and other complex needs, barriers to treatment and transition from prison to community.

Chapter 4: Practice Tips for Workers
This chapter provides a range of practice tips for drug and alcohol workers on how to use and adapt current practice techniques when working with clients with complex needs. It also covers case management, counselling and group work.

Chapter 5: Screening and Assessment for Cognitive Impairment
This chapter covers screening and assessment for cognitive impairment. It discusses when to use assessment and screening tools and highlights the advantages and disadvantages of various screening questionnaires, tools and neuropsychological assessments.

Chapter 6: Making Your Service Complex Capable
This chapter provides guidance on implementing organisational change to better support clients with complex needs. Specific areas include quality improvement, adapting policies and procedures, ensuring systems of workplace support (including training, supervision and reflective practice) and establishing and extending service partnerships.

Chapter 7: Further Resources
This chapter contains a list of sources for further information and support, training organisations and suggested reading to support you in working with complex needs clients, and a comprehensive bibliography listing all publications used in developing this resource.

Chapter 8: Supporting Information on the CD-Rom
This chapter lists the many supporting resources and documents on the accompanying CD-Rom, including fact sheets, templates, practice guidelines and other documents as referred to throughout the resource. *Complex Needs Capable* and all accompanying documents are also available on the NADA website at www.nada.org.au/resources/nadapublications/resourcestoolkits/.

NAVIGATING *COMPLEX NEEDS CAPABLE*

To make navigating this resource easier, you'll find the following images directing you to supporting information:

Further information in this resource

Information on the CD-Rom

Further reading suggestions.

If you're already using the electronic version of *Complex Needs Capable*, just click on the text in italics next to the further information icon images and you'll be taken to the related information.

WHY BE *COMPLEX NEEDS CAPABLE*?

Complex needs are not easily defined. They depend on the individual and their situation, and are often referred to as 'multiple unmet needs'.

> **Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services.**

Complex needs can be viewed as a framework for understanding multiple, interlocking needs that span health and social issues. Every person accessing drug and alcohol services has multiple needs; however, it is the interaction of these multiple needs that leads to complexity: "Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services" (Rankin & Regan 2004:1).

In *Complex Needs Capable,* drug and alcohol or co-existing drug and alcohol and mental health and cognitive impairment or involvement in the criminal justice system are defined as complex. These issues are likely to:

- Interact with a client's drug and alcohol use, which may impact on the development of care plans, including how treatment and therapeutic services are delivered
- Have an effect on the way a client participates in drug and alcohol programs
- Result in a client displaying a range of behaviours that may require services to adapt part of their programs.

Complexity is not the same as difficulty, though people with complex needs are commonly labelled as 'challenging' or as 'having challenging behaviour'. Clients with complex needs may challenge your way of working but there are many strategies you can use to enhance your practice to support the different needs of clients.

Best practice in working with people with complex needs involves continually reflecting on your practice and considering new ways to provide support while incorporating the holistic principles of respect, flexibility and engagement. The pathways of clients to treatment services are all different, and it can't be assumed that providing care in the same way to all people will be effective and result in positive client treatment outcomes.

Equity and access

People with complex needs often fall through the gaps of health service provision by encountering cultural, economic or social barriers to accessing health services. They are often further disadvantaged when their support and care needs increase because they cannot access the services they need. It's important to consider particular complex needs issues such as cognitive impairment and criminal justice contact when thinking about the equity and access obligations of your service and of drug and alcohol treatment services more broadly.

Equity is "*concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible*" (Whitehead 1990:7). This definition is based on the idea that everyone should have a fair opportunity to attain their full health potential. Inadequate access to health services contributes to health inequity (Whitehead & Dalgren 2006).

Access concerns the opportunity or ease with which a person or community can use services. A commonly cited barrier to accessing health services in Australia is geography, but issues of economic access (affordability), appropriateness and cultural access also need to be considered. 'Cultural access' refers to the existence of cultural enablers or barriers for people from diverse backgrounds in accessing available services. If there are cultural barriers, a person may consider a service unacceptable and not access it, even if they need it. Cultural barriers include services and/or health workers:

- Not being accommodating enough of language and/or cultural diversity
- Not considering the needs of people with low levels of literacy or education, and
- Lacking awareness of the day-to-day restrictions in the lives of clients (Whitehead & Dalgren 2006).

You should also consider legal obligations relating to equity and access, as specific legislation has been developed to protect human rights and prevent discrimination on the basis of age, disability, race and/or sex. From a human rights perspective, all organisations providing health and social support services should consider equity and access when determining program availability and providing services, to ensure programs are available to people who most need them.

For information and resources on state and federal human rights and anti-discrimination legislation, including the *Disability Discrimination Act 1992* (Cth), *Australian Human Rights Commission Act 1986* (Cth) *and Anti-Discrimination Act 1977* (NSW), go to www.hreoc.gov.au.

THE THEORY BEHIND THE PRACTICE

Good practice is informed by evidence, and most evidence-based practice is informed by theory. You should consider how you work with a person and why you're working in that particular way. There are a number of theoretical approaches that are useful for framing practice strategies when working with clients with complex needs. Here is a brief overview of some of these theories.

Holistic practice

Holistic practice means providing care to a person in a way that considers all aspects of their life, including their physical and mental health, living situation and social networks. It doesn't mean that a drug and alcohol worker or service is expected to provide all services to meet a person's needs. But it does involve identifying areas of need, and potentially modifying the way you provide services to a person and coordinate care with other services. Holistic practice is:

- **Person-centred**. Care is personalised and focused on the specific strengths and needs of the person.
- **Collaborative**. A person participates in making decisions about all aspects of their care. Support is provided to the person if necessary to maximise their ability to make their own decisions.
- **Flexible**. The model of care can be adapted to accommodate a person's needs.
- **Strengths-based**. The care received by a person should recognise and work towards their strengths and capacities.
- **Focused on engagement and rapport**. The model of care recognises that engaging with a person and building a trusted and positive relationship is a key component of fostering personal growth and change.
- **Respectful**. The care provided to a person is free from stigma and discrimination and actively works towards making a person feel accepted by the service, the workers and other clients.
- **Hopeful**. Care is informed by an attitude of optimism and hope. There's an assumption that a person can be supported to make positive changes in their life, whatever their history or current circumstances.

> **Holistic practice means providing care to a person in a way that considers all aspects of their life ... It doesn't mean that a drug and alcohol worker or organisation is expected to provide all services to meet a person's needs.**

Inclusive practice

Inclusive practice occurs independently of any specific model of care. The central idea of inclusive practice is to provide individualised care based on a comprehensive assessment of a person's needs. For individualised care to be possible, the ability to modify program elements to support people with complex needs must be embedded within an organisation's systems as much as possible, so that workers can make use of this ability when required. Adopting a model of inclusive practice should reduce the need for a person with different abilities to highlight their difference when accessing a service.

Consistent with the principles of access and equity, inclusive practice can encompass a range of strategies that aim to ensure that as many people as possible can participate in a program or access a service despite their literacy levels, linguistic preference, cultural background or specific experiences in the past (e.g. certain offending behaviour).

You should consider inclusive practice in all aspects of service delivery, not just intake and assessment. It should particularly be considered in relation to service partnerships, when involving support people (including families and carers) in a person's care, and when planning case management and counselling.

Trauma-informed care

Experiences of trauma have a lasting impact on a person's life. Trauma-informed care is a term used to describe a way of working with people that acknowledges the lasting impact of trauma.

In order to respond empathically to the needs of trauma survivors, ensure their physical and emotional safety, develop realistic treatment goals, and at the very least avoid re-traumatisation, all practices and programming must be provided through the lens of trauma (Guarino et al 2009:i).

There are different views on whether "*trauma refers to an event, a series of events or an environment, to the process of experiencing the event or environment, or to the psychological, emotional and somatic effects of the experience*" (Purdie et al 2010:135). There's wide agreement, however, on the profound and often devastating impact trauma has on many people.

Practice guidelines for the treatment of complex trauma and trauma-informed care and service delivery have recently been developed by Adults Surviving Child Abuse (ASCA). These comprehensive guidelines are located on the CD-Rom.

The guidelines emphasise a recovery orientation approach and identify the following five core principles of trauma-informed care that pose key questions for organisations to consider and contextualise in specific service settings for implementing a service framework that is trauma informed (Kezelman & Stavropulous 2012:23-27) (note that 'consumer' in the following should be understood as 'client' for the purposes of this resource):

- **Safety.** Ensuring physical and emotional safety.
  Key service questions: To what extent do the program's activities and settings ensure the physical and emotional safety of consumers? How can services be modified to ensure this safety more effectively and consistently?
- **Trustworthiness.** Maximising trustworthiness through task clarity, consistency, and interpersonal boundaries.
  Key service questions: To what extent do the program's activities and settings maximise trustworthiness? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximise honesty and transparency?
- **Choice.** Maximising consumer choice and control.
  Key service questions: To what extend do the program's activities and settings maximise consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximised?
- **Collaboration.** Maximising collaboration and sharing power.
  Key service questions: To what extent do the program's activities and settings maximise collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximised?
- **Empowerment.** Prioritising empowerment and skill building.
  Key service questions: To what extent do the program's activities and settings prioritise consumer empowerment and skill building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximised?

These guidelines also identify indicators for service policy review and screening for trauma to support organisational trauma informed care practice.

Good Lives Model

This approach to offender rehabilitation focuses on the person's strengths. The model views offending behaviour as functional, as it is attempting to secure some kind of valued outcome in a person's life. To interrupt the pattern of reoffending, it is necessary to build a person's capabilities and strengths.

The focus of treatment and care is for the worker and the client to work together to establish what a 'good life' might look like. There's an emphasis on establishing respectful and non-judgmental relationships. Activities undertaken as part of a program should add to a person's repertoire of personal functioning, rather than being focused only on managing problems.

> **"The good lives model determines ways of living that are beneficial and fulfilling to the individual in meeting their basic human needs … Importantly, the model emphasises autonomy and a therapeutic alliance to support offenders' conception of a good life (Birgden & Grant 2010:345)."**

Strength-based practice

Clients with complex needs face many challenges in their day-to-day lives and will have learned a range of ways to cope. Using strength-based practice to further support these clients can be of great benefit.

Strength-based practice recognises the resilience of individuals and focuses on their strengths and potential rather than their deficits. A strong emphasis on the relationship between the client and the worker and having genuine belief in the client is of key importance. Workers can then help the client to discover and use their strengths in pursuit of their goals, thereby building empowerment and self-determination (Manthey et al, 2011).

The six key principles of the strength-based approach are (Saint-Jacques et al 2009):

- Every individual, family, group and community has strengths, and the focus is on these strengths rather than pathology.
- The community is a rich source of resources.
- Interventions are based on client self-determination.
- Collaboration is central, with the practitioner/client relationship primary and essential.
- Outreach is a preferred mode of intervention.
- All people have the inherent capacity to learn, grow and change.

Person-centred planning

Person-centred planning is an approach that is philosophical as much as practical. The emphasis is on the idea of including the person in all decision-making and planning for them. It's far too easy for any of us to slip into practices that don't support self-determination, particularly when working with clients with complex needs. This is because some people:

- Face difficulties articulating clearly what they want and need
- Find it harder to engage in a process if there's no attempt to seek out their strengths and adapt to their needs
- Are reliant on others who are significantly challenged in responding to their needs, and within resource limitations.

For person-centred planning to be useful and effective, it needs to make sense to the person and be driven by them as much as possible. By using the key element of inclusion for all client decision-making and planning, you use a person-centred approach and support the client with developing self-determination. To remain genuine in person-centred practice requires the worker to always reflect on their practice.

Positive behaviour support

Positive behaviour support encompasses strategies and methods that aim to help a person reduce challenging behaviours and increase their quality of life through acquiring new skills. It asserts that challenging behaviours serve a purpose and are influenced by a person's social and physical environment. Therefore, in implementing positive behaviour support strategies, a person's wider support network and environment needs to be considered.

Models of positive behaviour support often include:

- Undertaking a comprehensive bio-psychosocial assessment to determine the function of the challenging behaviour
- Using the least restrictive alternative to manage challenging behaviour
- Using positive reinforcement and contingency management to reward and reinforce positive behaviours rather than punishment or negative reinforcement to manage challenging behaviours.

Positive behaviour support strategies are considered effective when interventions result in increases in a person's success and personal satisfaction (Synapse 2011c).

Which theory is the 'right one'?

Just as there is no one generic presentation of a person with complex needs, there is no one theoretical model or set of principles to follow to inform your individual practice or service response to complex needs. However, what does become apparent when reviewing these approaches are the common themes of client self-determination, working from a strengths-based perspective, and the importance of engagement and rapport. The principles of holistic practice reoccur throughout the theories and practice strategies in working with people with complex needs. Many of these are explored further with a practical approach in *Complex Needs Capable*.

Some of the theoretical and practical approaches outlined above are familiar to, and already applied in some drug and alcohol treatment service settings. By including and adapting these approaches in your work with people with complex needs, you will be supporting your clients to achieve the best possible individual treatment outcome and promote access and equity within your service for all people needing drug and alcohol treatment.

WHO IS ENTERING YOUR SERVICE?

Many drug and alcohol services in the non-government sector currently provide individualised care and services to people with a range of complex needs. However, you should be aware that people may have specific needs that are not evident when they first arrive. These needs become apparent as a person progresses through a treatment program and/or adapts to the treatment environment.

A consultation survey with NADA members undertaken in 2011 as part of the NADA Practice Enhancement Program found that over half of the responding organisations had over 50% of clients involved in the criminal justice system. One-third reported that at least 20% of their clients had a cognitive impairment (Community Sector Consulting 2011).

As well as clients having complex needs, there will also be a high degree of 'hidden' disability among people accessing drug and alcohol services. Many clients entering your service presenting with drug and alcohol and mental health concerns will have experienced significant levels of childhood and adult trauma, the effects of which are often unrecognised and the symptoms of which are often seen or labelled as challenging. Often clients won't have

formal records to indicate that they've experienced mental illness or have an intellectual disability or acquired brain injury. Additionally, people with a mild form of cognitive impairment may have developed a range of compensatory strategies that mask their low levels of functioning in some areas. Masking the effects of a disability is often associated with previous experiences of stigma or discrimination.

Due to numerous barriers to access, many clients with complex needs will have failed to access services until they require a high level of support. If they have previously accessed a service or been in an institutionalised setting, such as prison or a mental health facility, don't assume they would have been given the opportunity to receive treatment for a drug or alcohol problem or other physical health or social support issues.

PATHWAYS TO COMPLEXITY

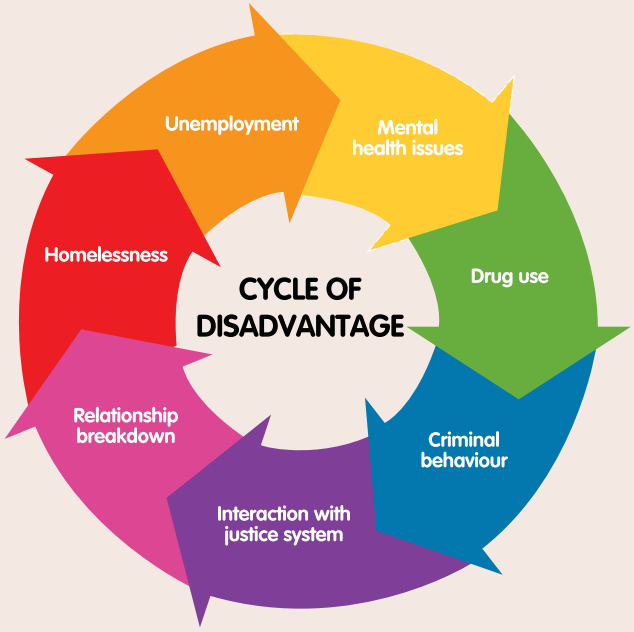
> **Often for people who are marginalised, what is essentially a social or historical phenomenon ... is presented as a biological or psychological characteristic ... A person is then perceived as not deserving of support because it is their 'fault' they are in their present situation.**

People with complex needs accessing drug and alcohol services will all have different pathways to their current circumstances as a result of their unique life experiences. A common feature for many clients who present with complex needs is a history of marginalisation and disadvantage, trauma (including childhood and/or adult sexual, physical and/or emotional abuse), dysfunctional family relationships, low educational attainment, low or no employment, and stigmatisation.

Often for people who are marginalised, what is essentially a social or historical phenomenon (the result of factors external to the person) is presented as a biological or psychological characteristic (the result of factors internal to the person). The person is then perceived as not deserving of support because it is their 'fault' they are in their present situation (Burton & Kagan 2004).

This type of approach produces further barriers to accessing support for a person, creating a cycle of marginalisation and compounding the disadvantage, as illustrated in Figure 1.1.

Figure 1.1: Cycle of disadvantage

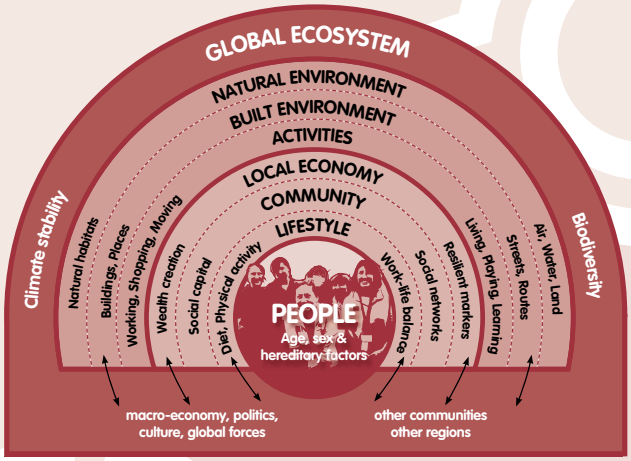


Source: Adaptation of Department of Families, Housing, Community Services and Indigenous Affairs, 2009.

SOCIAL DETERMINANTS OF HEALTH

It is widely recognised that higher rates of ill health result from the influence of social and environmental factors such as being poor, experiencing unemployment, and living in unsafe housing situations (Whitehead 1990; Wilkinson & Marmot 2003). These factors, depicted in Figure 1.2, are often referred to as the social determinants of health. These types of factors tend to cluster and reinforce each other to make some groups, including clients accessing drug and alcohol services, marginalised and vulnerable to a range of health and social problems (Whitehead 1990).

Figure 1.2: The layers of the determinants of health



Source: UN Economic Commission for Europe (2007), from Barton & Grant (2006), drawing on Whitehead & Dahlgren (1991) and Barton (2005).

According to Saggers and Gray (2007) socioeconomic positioning is often cited as the main determinant of health, but gender, ethnicity, social and emotional wellbeing, cultural differences and disempowerment are all contributing factors in determining health outcomes. The longer a person lives in disadvantaged circumstances, the more likely they are to suffer from a range of health problems. (Wilkinson & Marmot 2003).

> **...health is not dependent on the physical wellbeing of individuals. It is also dependent on key indicators such as education, financial status, adequate housing, sanitation, diet, and access to a range of goods and services. When considering health, you need a model that has a focus on structural inequalities, not just a focus on personal stories of misfortune. Also you need a model that acknowledges a history of oppression and dispossession, and a history of systemic racism (O'Donoghue 2007, cited in Kratzman et al 2011:6).**

TRAUMA

Experiences of trauma can have a lasting impact on a person's life. Certain experiences and behaviour can trigger traumatic memories, causing a person to experience severe emotional distress and other symptoms.

Traumatic experiences include child abuse, physical abuse and assault, emotional or psychological abuse, rape or other sexual assault, neglect, family separation (particularly forced separation), domestic violence, witnessing conflict, and migration. Often people accessing drug and alcohol services have experienced one or more traumatic events, particularly those who've experienced mental health and drug and alcohol issues and have cycled between out of home care, homelessness and institutionalised settings such as prison.

Intergenerational trauma and Indigenous people

It's vital to take into account the effects of intergenerational trauma when working with Aboriginal people and communities. The impact of colonisation on Indigenous Australians continues to directly and significantly contribute to the health and social inequalities experienced by Aboriginal people today (see Figure 1.3).

Aboriginal people experience significantly poor health outcomes compared to non-Aboriginal Australians, including an average life expectancy for males that is 21 years less and for females almost 20 years less than the total population (Australian Indigenous HealthInfoNet 2005, in Carson et al 2007).

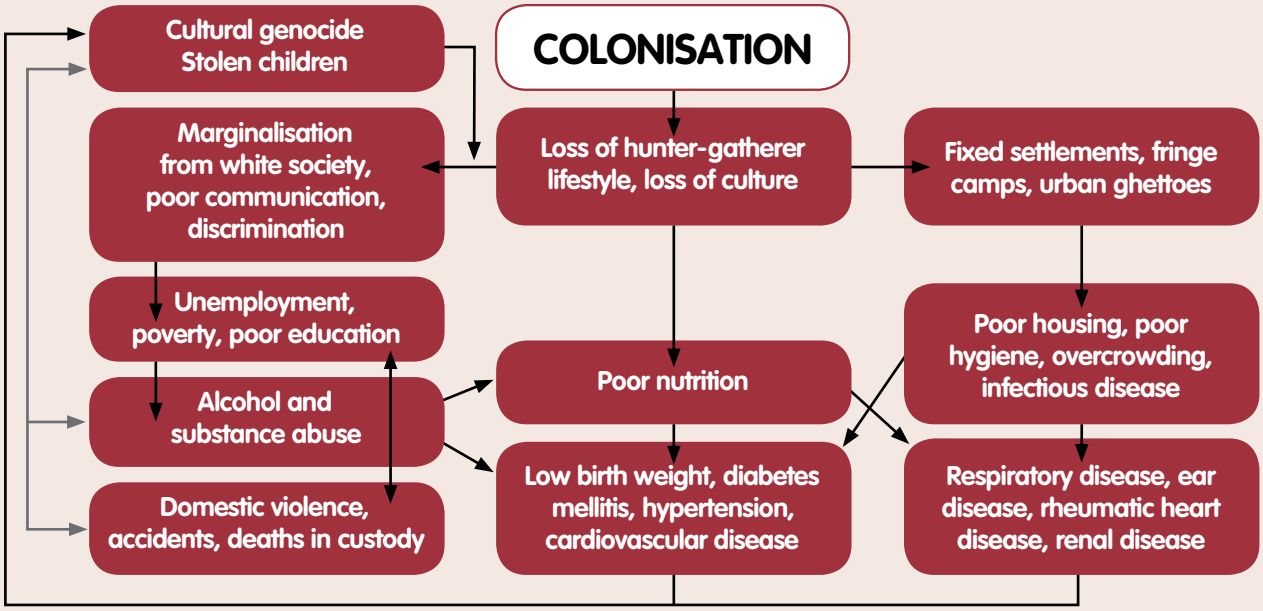
Aboriginal people also experience significantly higher rates of incarceration. Indigenous adults are 14 times more likely to be imprisoned than non-Indigenous adults (ABS 2011, in NIDAC 2013), and almost half the young people in juvenile corrective institutions aged between 10 and 17 (between 2010-2011) were Indigenous (Australian Institute of Health and Welfare 2012, in NIDAC 2013).

Past Australian government policy and practices enabled the destruction of Indigenous kinship groups, languages and cultural rituals through the forcible removal and separation of Aboriginal and Torres Strait Islander children from their families and kinship networks over some five generations (Ranzijn et el 2010). The *Bringing Them Home* report (HEROC 1997) concluded that the forcible removal of children was an act of genocide and that the consequences for Indigenous peoples continue to reverberate today.

Indigenous Australians have been affected by extreme personal, collective and cultural trauma, with the effects of trauma in one generation being the causes of trauma in the next. The effects of past traumatic events are compounded by further traumas, lack of self-determination and other negative reoccurring events. This creates a continuous cycle of trauma that is difficult to break and is exacerbated by ongoing individual and institutional racism experienced daily by Aboriginal people (Purdie et el 2010).

> **The trauma and suffering that Indigenous people have experienced over generations have contributed to the burden of disease, substance misuse and incarceration (NIDAC 2009 & 2013:1).**

Figure 1.3: Effects of colonisation on Aboriginal people and communities



Source: Cunningham & Stanley 2003.

Trauma and people from a CALD background

People from culturally and linguistically diverse (CALD) backgrounds, particularly migrants, refugees and humanitarian entrants, can also experience the lasting impact of trauma across generations, and this may be a risk factor for mental health and drug and alcohol issues (Donato-Hunt, Munot & Copeland 2012). Pre-migration stressors may include torture, trauma, conflict and loss of loved ones. Post-migration stressors may include feelings of grief and loss, economic and social disadvantage, discrimination and racism, and issues with cultural adjustment.

Children of migrants, refugees and humanitarian entrants may also experience a range of stressors that make them vulnerable to substance misuse, mental health issues and other complex needs, including involvement in the criminal justice system. They may also have conflict with family due to stark differences in upbringing and experiences, peer culture, and feelings of marginalisation and social isolation.

> **“The majority of the research … suggests that resettled refugees are at risk of developing significant psychological and substance-use disorders as a result of accumulated stress before, during and after migration (Posselt et al. 2013).”**

INSTITUTIONALISATION

Spending time in highly institutionalised environments – including prison, mental health facilities, large residential units, hospitals, refugee camps, detention centres, boarding houses and out of home care – deprives a person of responsibility, autonomy and control over their lives. They may have few life skills and social supports, and this can result in:

- Few employment opportunities
- Poor family relationships, and
- Difficulty in coping with stressful situations (this may be exacerbated by mental health problems).

These factors interact with and reinforce each other. As a result, a person may struggle to manage regular aspects of life such as maintaining housing and finances, and may find it difficult to access services (UK Social Exclusion Unit 2002). This leaves them vulnerable to inadequate housing situations or homelessness, lack of social support, and developing health problems such as drug and alcohol and mental health issues.

Many people with complex needs have experienced living in institutional settings, often more than one. People with an intellectual disability who’ve spent their childhoods in institutions (e.g. large residential facilities, out of home care) may experience lifelong difficulties managing daily life.

People who've been institutionalised may display behaviours that are contrary to the expectations of drug and alcohol workers. For example, people who have been to prison may be reluctant to openly express personal information, thoughts and feelings with others in a group setting in a drug and alcohol service, due to the prison culture of not sharing any information to maintain personal safety.

People released from institutionalised environments often lack adequate connections to health and social support services and regularly face an array of decisions to make. This can be overwhelming, and a person who's finding it difficult to cope may slide back into previous, known patterns of behaviour (UK Social Exclusion Unit 2002) which may include offending behaviour and drug and alcohol misuse. As noted by Baldry, Dowse and Clarence (2011), these adjustment difficulties may be exacerbated for people with cognitive impairment, particularly those with a co-existing drug and alcohol or mental health issue.

For more information on working with clients who've had contact with the criminal justice system, see *Chapter 3: Criminal Justice Contact – What You Need to Know.*

DISCRIMINATION AND STIGMA

Experiences of discrimination and social exclusion can have long-lasting impacts on a person's health and emotional wellbeing and may increase their vulnerability to drug and alcohol misuse.

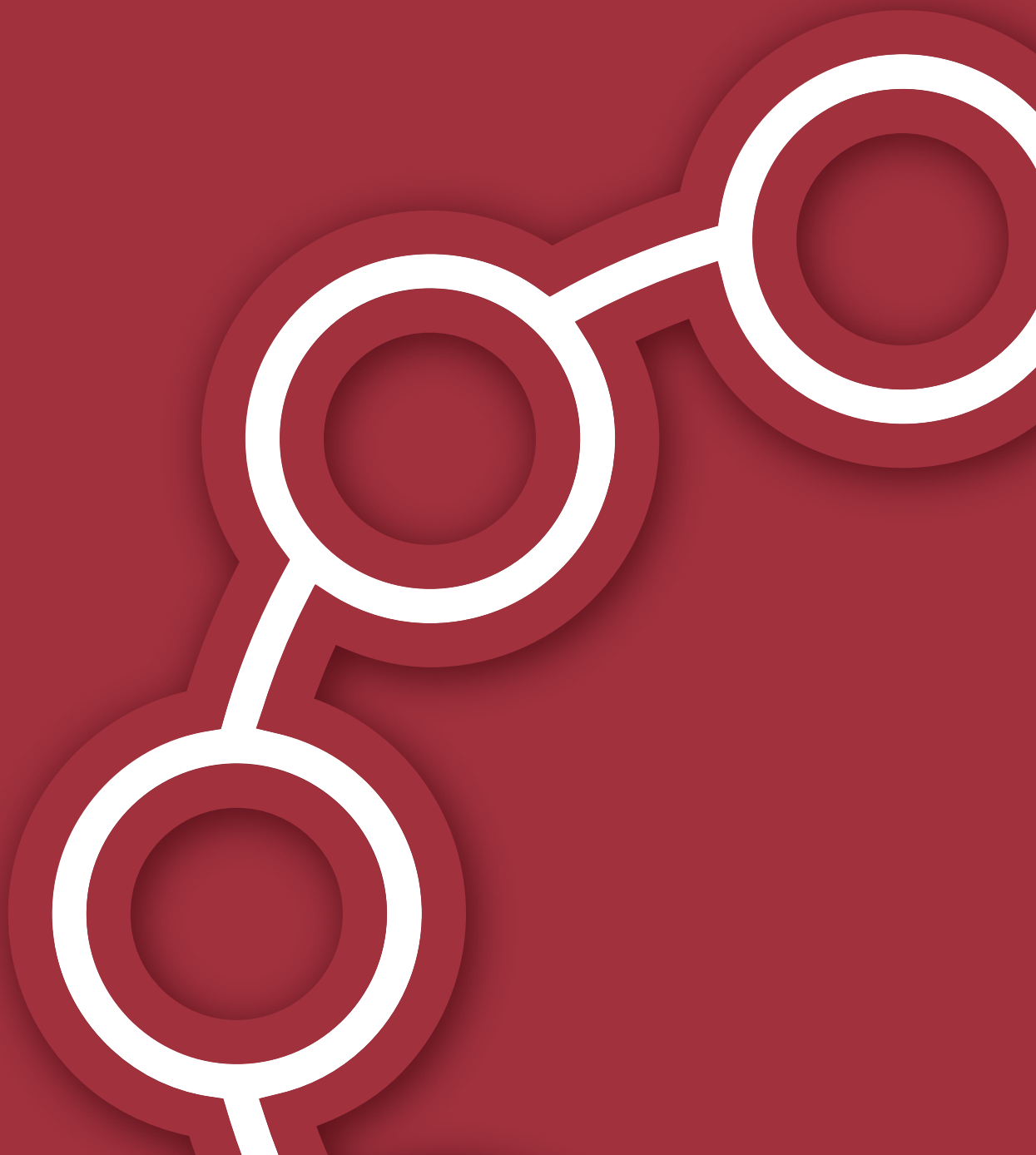
Many Aboriginal people and people from CALD backgrounds experience discrimination as a result of racism. And people with cognitive impairment, physical disabilities or mental illness also frequently experience discrimination. Another group that commonly reports experiences of stigma and discrimination are people who identify as gay, lesbian, bisexual, transgender, intersex or queer. This discrimination may be experienced through social exclusion, verbal abuse, physical attacks or other forms of violence.

As a minimum standard, your service should have policies to ensure service access and provision is free of discrimination and promotes equity. Workers and other clients need to be aware of their responsibilities in respecting others and practising empathy. Systems need to be in place to recognise the indicators of past stigma and discrimination and provide support to reduce the negative impacts on a person's mental health and functioning.

For more information on the various pathways to complexity see these further reading suggestions (full titles in *Chapter 7: Further Resources*):

- Atkinson (2008)
- Baldry, Dowse, and Clarence (2011)
- Carson et al (2007)
- Community Sector Consulting (2011)
- Donaghy, Becker and Flaherty (2012)
- Human Rights and Equal Opportunity Commission (1997)
- IDRS and NSW CID (2001)
- National Indigenous Drug and Alcohol Committee (2009, 2013)
- Ranzijn et al (2010)
- Wilkinson and Marmot (2003).

CHAPTER 2
Cognitive Impairment
What You Need to Know



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Fetal alcohol spectrum disorder 17

Cognitive Impairment – What You Need to Know

Key points

- Cognitive impairment is a term used to recognise a broad range of disorders that affect cognitive functioning, including intellectual disability, acquired brain injury and fetal alcohol spectrum disorder.
- People with cognitive impairment experience difficulties with a range of adaptive behaviours, including social, conceptual and practical skills they've learned in order to function in their everyday lives.
- Workers in drug and alcohol organisations are most likely to come into contact with people who have a mild impairment and who are generally able to live relatively independently but require some support, particularly if problems arise.
- Cognitive impairment can often be hidden. It's likely that you already work with people who have an undetected cognitive impairment.

The three specific types of cognitive impairment covered in this chapter are intellectual disability, acquired brain injury and fetal alcohol spectrum disorder.

However, the practical strategies covered in *Chapter 4: Practice Tips for Workers* and *Chapter 6: Making Your Service Complex Capable* can be broadly applied to other areas of complex need, not just cognitive impairment.

COGNITIVE IMPAIRMENT

Cognitive functioning or cognition refers to the processing of information by the brain, and can be described as a person's ability to think, concentrate, formulate ideas, reason and remember (Gray, Forell & Clarke 2009). There are several domains of cognitive functioning, including:

- Attention
- Memory
- Visuo-spatial skills (which allow us to visually perceive objects and the spatial relationships among them), and
- Executive functioning (which includes tasks that help people learn new information, remember and retrieve information, plan, make decisions, and use information to solve problems).

Table 2.1: Common causes of cognitive impairment

COMMON CAUSES OF COGNITIVE IMPAIRMENT	
Developmental	• Fetal alcohol syndrome and related disorders • Learning disorder • Attention deficit hyperactivity disorder • Autism Spectrum Disorder • Intellectual disability
Acquired brain injury	• Traumatic brain injury • Stroke • Hypoxic brain injury • Alcohol and other drug-related brain injury
Neurological	• Multiple sclerosis • Huntington's disease • Parkinson's disease
Mental illness	• Depression/anxiety • Psychosis/schizophrenia
Dementia	• Alzheimer's dementia • Vascular dementia • Fronto-temporal dementia

Each of these domains can be selectively or jointly impaired across a range of developmental, neurological, acquired brain injury, mental illness, substance-related or dementia conditions. The term 'cognitive impairment' is used to recognise a broad range of disorders that affect cognitive functioning. Cognitive impairment may be hidden from a worker when a person first enters a program, especially if the person has a mild impairment. Common causes of cognitive impairment are listed in Table 2.1.

Common indicators of people with cognitive impairment

The indicators of a person with cognitive impairment are highly varied. They may have difficulties engaging with other people or services, identifying and maintaining suitable work or study, driving a car, carrying out daily activities (e.g. paying bills) or managing basic aspects of self-care. Cognitive impairment rarely occurs in isolation, i.e. without affecting both emotional and behavioural functioning. In fact, behavioural and emotional disturbances often reveal the presence of cognitive impairment.

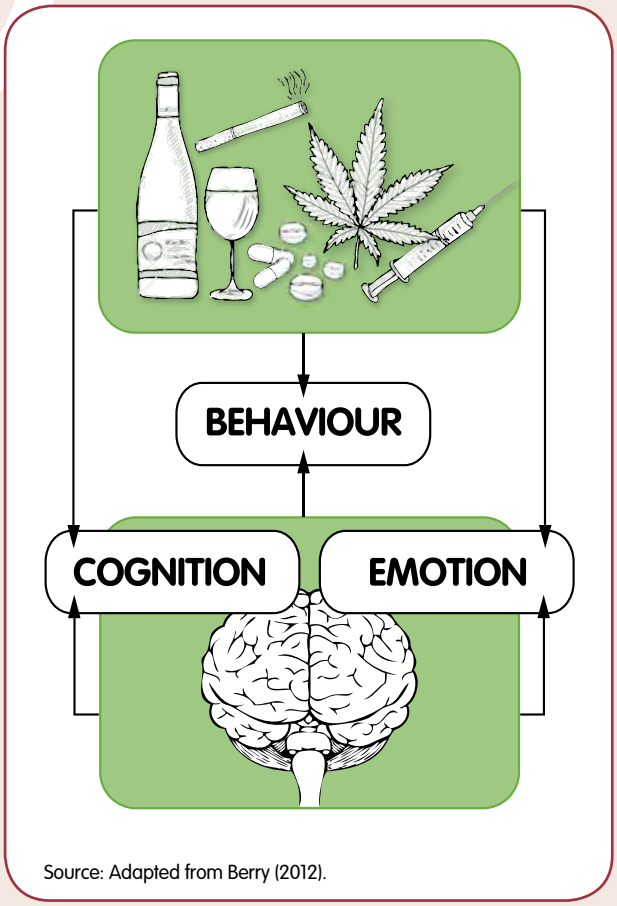
Addressing the cognitive impairment through compensatory or remedial approaches may reduce challenging behaviour and emotional distress. Some people lack the knowledge or resources to cope with their cognitive, behavioural and/or emotional difficulties and use alcohol or other drugs to cope, which often further impairs functioning in these domains. All three factors – cognition (thinking), behaviour (acting) and emotions (feeling) – affect a person's ability to get by in the world.

At a broad level, people with cognitive impairment will experience difficulties with adaptive behaviours. These include social, conceptual and practical skills they have learned in order to function in their daily lives (The Arc 2011).

A person with impaired conceptual skills, for example, receptive and expressive language, reading and writing, money concepts and self-direction, may present with:

- A low literacy level
- Comprehension difficulties, including with abstract concepts and complex instructions
- Problems planning and organising daily activities
- Problems with budgeting and managing money.

Figure 2.1: Neuropsychological Cognitive Behavioural Model



Source: Adapted from Berry (2012).

A person with impaired social skills, for example, relating to other people and the external social environment, as well as self-esteem, personal sense of responsibility, may:

- Have difficulties following rules (including laws)
- Respond inappropriately in some social settings
- Have low self-esteem
- Be vulnerable to victimisation.

A person with impaired practical skills, for example, personal daily activities such as eating, dressing and mobility, may have difficulties with:

- Preparing meals
- Using transport
- Using the telephone
- Maintaining a safe living environment.

Hiding, masking or denying disability

Cognitive impairment is often masked. For most people who come into contact with drug and alcohol services, their cognitive impairment is in no way visible. It's only through observing their behaviour in the assessment process or while they're receiving treatment that we may get clues that they may have a cognitive impairment.

Many people with a cognitive impairment are very good at hiding their disability. This may be because they want to fit in with everyone else or because they might be very high functioning in some areas of their lives or have very good expressive communication yet have very poor receptive communication. Also, people will have typically experienced discrimination, shame and humiliation as a consequence of being labelled due to their disability. Often if a person is aware they have a cognitive impairment, they won't readily admit to it.

What does this mean for people accessing drug and alcohol treatment services?

Having a cognitive disability can often result in a person not being able to access or maintain the drug and alcohol treatment they require. People with a cognitive impairment often:

- Don't receive the services they need
- Are unable to maintain waiting list protocols
- Fall through services gaps and experience a 'referral merry-go-round'
- Are screened out of entry to services
- Are perceived to have no or low motivation
- Are put in the 'too hard basket'
- Are said to have 'challenging/problem behaviours' when they in fact have a cognitive impairment
- Are exited from services early
- Are unable to access services because they don't have a diagnosis
- Are told that disability services should address their drug and alcohol issues.

When armed with the knowledge of how cognitive impairment can affect a person and the practical strategies to support a person combined with some adjustments in service provision, drug and alcohol services can successfully support people with intellectual disability, acquired brain injury and fetal alcohol spectrum disorder to receive the expert drug and alcohol treatment they need.

For more information on strategies for working better with people with cognitive impairment see *Chapter 4: Practice Tips for Workers*.

INTELLECTUAL DISABILITY

As a worker in a drug and alcohol service, you're most likely to come into contact with people with borderline (IQ 70 to 80) or mild intellectual disability (IQ 55 to 70). About 85% of people who have an intellectual disability are classified as having a mild disability (IDRS 2011) and make up approximately 2% of the general population. Most people with a borderline or mild intellectual disability are able to, with support, learn the many skills necessary to live in the community relatively independently (IDRS 2011).

People with moderate (IQ 40 to 55) and severe (IQ 25 to 40) levels of disability are less likely to present to drug and alcohol services due to their high support needs and their reliance on carers to support many daily functions.

The Diagnostic and Statistical Manual of Mental Disorders V defines intellectual disability as consisting of three elements:

- A person has an IQ below 70 (2 standard deviations below the mean)
- A person displays at least 2 deficits in adaptive functions (such as communication, self-care, home living, social/interpersonal skills, self-direction, functional academic skills, health and safety), and
- A person acquires the disability before 18 years of age.

These criteria are used by Ageing Disability and Home Care (ADHC) to determine NSW government disability service eligibility for people with intellectual disability. As such, people with borderline intellectual disability are not eligible for ADHC services, but they face many of the same disadvantages and struggles as those who are eligible for services and support.

> **"In drug and alcohol services, adjusting the environment and the supports for the person can increase their capacity to participate in treatment and reduce the effect of intellectual disability (IDRS 2009)."**

The medical or diagnostic definition of intellectual disability focuses on the deficits of a person and does not take account of the level of support available to a person in their environment. A social perspective considers intellectual disability to reflect the interaction between the capabilities of a person and the structure of their environment.

In drug and alcohol services, adjusting a person's environment and support can increase their capacity to participate in treatment and reduce the effect of intellectual disability (IDRS 2009).

What to consider when working with a person with an intellectual disability

Intellectual disability affects the way that a person learns. This includes:

- The time taken to learn something
- The ability to read and write
- Communication and understanding
- The ability to plan and solve problems
- The ability to adapt to new and/or unfamiliar situations (IDRS 2009).

Stigma (negative social attitudes about people with intellectual disability)

Social stigma has a big impact on the lives of people with intellectual disability. Historically speaking, this has meant being socially shunned, segregated from the rest of society, and institutionalised. The reasons for these practices have focused on ideas of difference, deficits, and deviation from what is considered 'normal'. This has had extremely negative effects for people with intellectual disability.

While supports and services are moving away from former beliefs and practices like institutionalisation, and towards inclusive, human rights-based approaches, the social stigma attached to intellectual disability is still acutely felt. "Susan", a woman with intellectual disability, commented: "It's a label, written in permanent marker. You are written off!"

Little or none of the right kind of support

People with mild or borderline intellectual disability may not be eligible for the support they need, depending on their IQ and the scope of support currently available. An absence of formal diagnosis, or no evidence that there has ever been diagnosis (e.g. evidence of having had a diagnosis would be available if a person had received services in the past from ADHC), are also barriers to accessing specific support. This group is at high risk of falling through the gaps in service delivery. There is an increased risk of imprisonment due to the lack of access to support services, including access to drug and alcohol treatment services.

> **"Successfully supporting a person with an intellectual disability to complete treatment will often rely not only on the person's motivation but on the ongoing support offered by workers."**

Other reasons for lack of support include:

- Natural supportive relationships having broken down
- Being unlikely or unable to form and maintain a range of positive supportive relationships without facilitation
- Gravitating towards, or attracting, those who may influence, manipulate and take advantage of their vulnerability.

Avoiding support

There are people who may avoid services and support because they fear that past uncomfortable or shameful experiences will be repeated. These may include when the person has:

- Not understood what's been said or written down
- Had minimal say in shaping or controlling plans and support
- Been unable to comply with service agreements and therefore exited from programs
- Been belittled, bullied and/or abused by staff or other service users
- Felt uncomfortable grouped with other people of similar disadvantage.

Emotional, social and health effects

Without suitable life options and individualised, flexible and adaptable supports that promote a feeling of some authority over their own lives, people are likely to experience:

- Lack of self-determination
- Poor self-esteem
- Loneliness
- Boredom
- Anxiety and depression
- Poverty.

These stressors can affect the mental and physical health of individuals. There are, for example, higher occurrences of mental and physical illness among people with intellectual disability than in the general population. People with intellectual disability, including borderline intellectual disability, are also overrepresented in the criminal justice system. In 2001, 18% of women and 27% of men in NSW prisons scored below the pass rate on an intellectual disability screening test (Butler & Milner 2003).

What does this mean for drug and alcohol services?

Successfully supporting a person with an intellectual disability to complete treatment will often rely not only on the person's motivation but on the ongoing support offered by workers. Your expertise in being able to support clients to generalise treatment program learnings to everyday life situations and address multiple life issues is key to improving and maintaining their health outcomes. The focus should be on engagement, individual strengths and self-determination.

Focus on strengths

A functional assessment of a person's strengths and limitations will allow you to develop a profile of the supports they need to complete the treatment program. If the appropriate supports are in place, their level of functioning, and therefore success in treatment, will generally improve.

Masking of disability

When you're working with a person with intellectual disability or a person who displays indicators of intellectual disability, don't make assumptions about their level of disability. Some people develop strategies to mask the effects of their disability, due to stigma and discrimination. For example, even if they appear to give all the right responses to your questions, it may not mean they understand what you've asked them.

To improve communication with people with intellectual disability:

- Build rapport
- Allow plenty of time – don't rush your interaction
- Ask open questions, requiring more than a yes or no response
- Deal with one piece of information at a time
- Don't pretend you understand them if you don't.

For more information on functional assessment see *Chapter 5: Screening and Assessment for Cognitive Impairment*. For information on practical strategies in working with people with intellectual disability and people with other cognitive impairment conditions see *Chapter 4: Practice Tips for Workers*.

CD-Rom resources

- Introduction to Intellectual Disability (IDRS 2009)
- What is Intellectual Disability? (NSW CID 2006)

ACQUIRED BRAIN INJURY

Acquired brain injury (ABI) refers to an injury to the brain resulting in deterioration in cognitive, physical, emotional or independent functioning. It can result from traumatic causes such as car accidents, falls and assaults, or from non-traumatic causes such as stroke, hypoxia (insufficient oxygen), infection, tumour, substance misuse (including overdose) and degenerative neurological diseases.

People who misuse alcohol or other drugs have an increased likelihood of developing an ABI due to their alcohol and/or drug intake and their risk-taking lifestyle.

What to consider when working with a person with an ABI

The nature and severity of an ABI

Cognitive, physical and sensory disabilities vary in their severity, may be temporary or permanent, and often exist in combination. The nature and severity of disability will be influenced not only by the type and level of damage to the brain but also by other medical, personal and social factors (Fortune & Wen 1999). It's important to remember that, although a person may be experiencing cognitive and communication difficulties, they may not have necessarily lost their inherent intellectual capacity or IQ.

The hidden disability

ABI is often referred to as a 'silent' or 'hidden' disability, and can involve long-term problems with thinking and behaviour that are not always easy to identify and are often misunderstood by other people.

Even close family and friends can often find it hard to understand and accept cognitive problems or changed behaviour in a person with an ABI, and they may regard them (unfairly) as lazy or hard to get along with. Someone who's confused, frustrated or apathetic as a result of their ABI may be misunderstood as belligerent, antisocial or lazy.

Typical cognitive (thinking) changes after brain injury can include (but are not limited to):

- Being easily confused and overwhelmed
- Difficulty paying attention – short attention span
- Difficulties with learning and storing new information
- Problems with memory – short term or long term
- Being stuck on ideas and having fixed patterns of thinking
- Reduced levels of initiative, and difficulty starting activities
- Being slower at processing information.

Typical emotional changes after brain injury can include (but are not limited to):

- Sadness and/or grief
- Depression and/or anxiety
- Loss of self-esteem
- Changes in personality, including difficulties in emotional control
- Irritability.

Typical physical changes after brain injury can include (but are not limited to):

- Overwhelming fatigue
- Headaches
- Changes in smell, taste, hearing, and/or vision
- Weakness or paralysis, often in one side of the body
- Difficulties with speech and communication
- Sensitivity to light and/or noise
- Seizures and epilepsy.

The level of cognitive, emotional and physical changes depends on a number of factors, including:

- The seriousness or severity of the brain injury
- The location of the brain damage
- How well the person has integrated back into the community.

For some people who sustain an ABI, some or all of these changes may gradually improve, but it's impossible to predict how this will happen or how long it will take. For many people these changes will be lifelong.

Grief and loss

Depression is common following an ABI, leading to further isolation and additional complex issues such as drug and alcohol misuse, other mental health conditions, or involvement with the criminal justice system. This may be due to the person experiencing prolonged and unresolved grief when they compare how they were before and after their injury. It's also extremely common for people with an ABI to lose some, many or all of their important family and personal relationships. Combine this with other factors such as loss of accommodation, employment or financial security and the impact can be overwhelmingly devastating.

What does this mean for drug and alcohol services?

When working with someone with an ABI who has problems with drugs and/or alcohol, different and individualised approaches may be needed, as their executive functions may be affected i.e. the ability to:

- Be proactive
- Plan and organise
- Make judgements and decisions
- Problem solve
- Learn from their mistakes
- See the consequences of behaviour.

Therefore, for many people with an ABI, a commitment to change should be regarded as a treatment goal rather than as a prerequisite for entering drug and alcohol services. Drug and alcohol workers should focus on engagement and person-centred motivational strategies to address individual needs.

For practical strategies for working with people with an ABI see *Chapter 4: Practice Tips for Workers*. For screening and assessment considerations see *Chapter 5: Screening and Assessment for Cognitive Impairment*.

CD-Rom resources

- *Acquired Brain Injury: The Facts* (3rd ed, Synapse Association of Queensland 2011)
- *Understanding and Living with Brain Injury – for Service Providers* (Brain Injury Association of NSW 1999)
- *Looking Forward: Acquired Brain Injury* (4th ed, arbias 2011)
- *Looking Forward: Information and Specialist Advice on Alcohol Related Brain Impairment* (4th ed, arbias 2011)
- *Our Health Our Way* (3rd ed, arbias 2012)

FETAL ALCOHOL SPECTRUM DISORDER

Fetal alcohol spectrum disorder (FASD) is an umbrella term used to describe a range of conditions and harms which have emerged as a result of prenatal alcohol consumption. It's also referred to as 'fetal alcohol syndrome and related disorders'.

You may be familiar with FASD when considering infant and maternal health, but there's less awareness of adolescents and adults with FASD who are presenting at drug and alcohol services for treatment.

There are four diagnoses under the umbrella of FASD, as shown in Table 2.2.

The Department of Health and Ageing has requested the FASD Collaboration, led by the *Telethon Institute for Child Health Research,* to prepare Australian clinical guidelines for the diagnosis of FASD. These should be available in 2013.

What to consider when thinking about FASD

People with FASD have an organic brain injury and, as a result, think and learn differently and are unable to make sense of information the way others do. People with FASD often have a hard time understanding that actions have consequences, and they can't always apply what they learn in one situation to another. Other challenges include:

- Poor short-term memory
- Lower IQ (although only 25% of people with FASD will have an IQ lower than 70)
- Developmental delay
- Difficulty setting goals and/or knowing if they're on track.

Many people will see examples of these behaviours and difficulties every day but may not realise they're the result of a brain injury. Without understanding this condition it's easy to view each behaviour as an isolated problem rather than as a group of symptoms indicating a syndrome. In formal environments such as drug and alcohol or mental health programs (particularly when pressure is placed on the person), these challenges become even more evident.

Table 2.2: Conditions resulting from prenatal alcohol exposure

CONDITIONS RESULTING FROM PRENATAL ALCOHOL EXPOSURE	
CONDITION	**CRITERIA**
Fetal alcohol syndrome (FAS)	• Confirmed exposure to alcohol in utero • Facial dysmorphology, including the following (which may become less obvious over time): – Flat midface – Small head circumference – Low-set ears – Flat philtrum (the area between the mouth and the nose) – Thin upper lip – Short epicanthal folds (the points of the eye next to the nose). • Growth retardation • Central nervous system dysfunction
Partial FAS (pFAS)	• Confirmed exposure to alcohol in utero • Some but not all of the facial dysmorphology above • Either growth retardation or central nervous system dysfunction
Alcohol-related neuro-developmental disorder (ARND)	• Confirmed exposure to alcohol in utero • Central nervous system dysfunction
Alcohol-related birth defects	• Presence of congenital anomalies (e.g. cardiac, skeletal, renal, ocular), all of which are known to be linked to prenatal alcohol exposure

Source: Adubato & Cohen, 2011

FASD is difficult to identify at birth unless the condition is severe and the facial features of full FAS are evident. As a result, many people are not identified or diagnosed until they reach puberty. Many more live their whole lives without knowing they have a significant disability. By the time they reach their teenage years, the behaviours have become entrenched and secondary issues have often emerged, such as drug and alcohol and mental health issues.

It's these secondary issues that are often presented as the primary issue/diagnosis and typically are what will cause people to enter programs. As a result, insufficient account may be taken of a person's cognitive abilities, such as:

- Linking cause and effect
- Generalising learning, and
- Working independently.

A person may then be vulnerable to experiencing extra stress and/or program failure due to the unrealistic requirements placed on them by the worker, service provider or program.

Secondary issues are often framed as being the problem. They are often seen to be intrinsic to the condition rather than a symptom or pattern of behaviours reflecting chronic frustration and failure. People with FASD experience poor fit for programs, services, employment and training because the cognitive impairment isn't always apparent at first meeting, so the person with FASD is placed in what seems to be appropriate treatment situations but which in fact can exacerbate their problems.

If a client has a history which includes some or all of the following and a history of prenatal alcohol exposure, consider FASD as the possible cause of their situation:

- Problematic alcohol and/or drug use
- Contact with the criminal justice system
- Mental health problems from a young age
- Disrupted school experience, including expulsion or suspension
- As an adult, regular contact with multiple social services such as housing, drug and alcohol, mental health, disability, employment and corrections
- Jobs which do not last longer than six months
- Poor academic results, especially in mathematics
- Diagnoses such as autism spectrum disorders, attention deficit hyperactivity disorder, oppositional defiance disorder and personality spectrum disorders.

For practical strategies for working with people with complex needs including FASD see *Chapter 4: Practice Tips for Workers*.

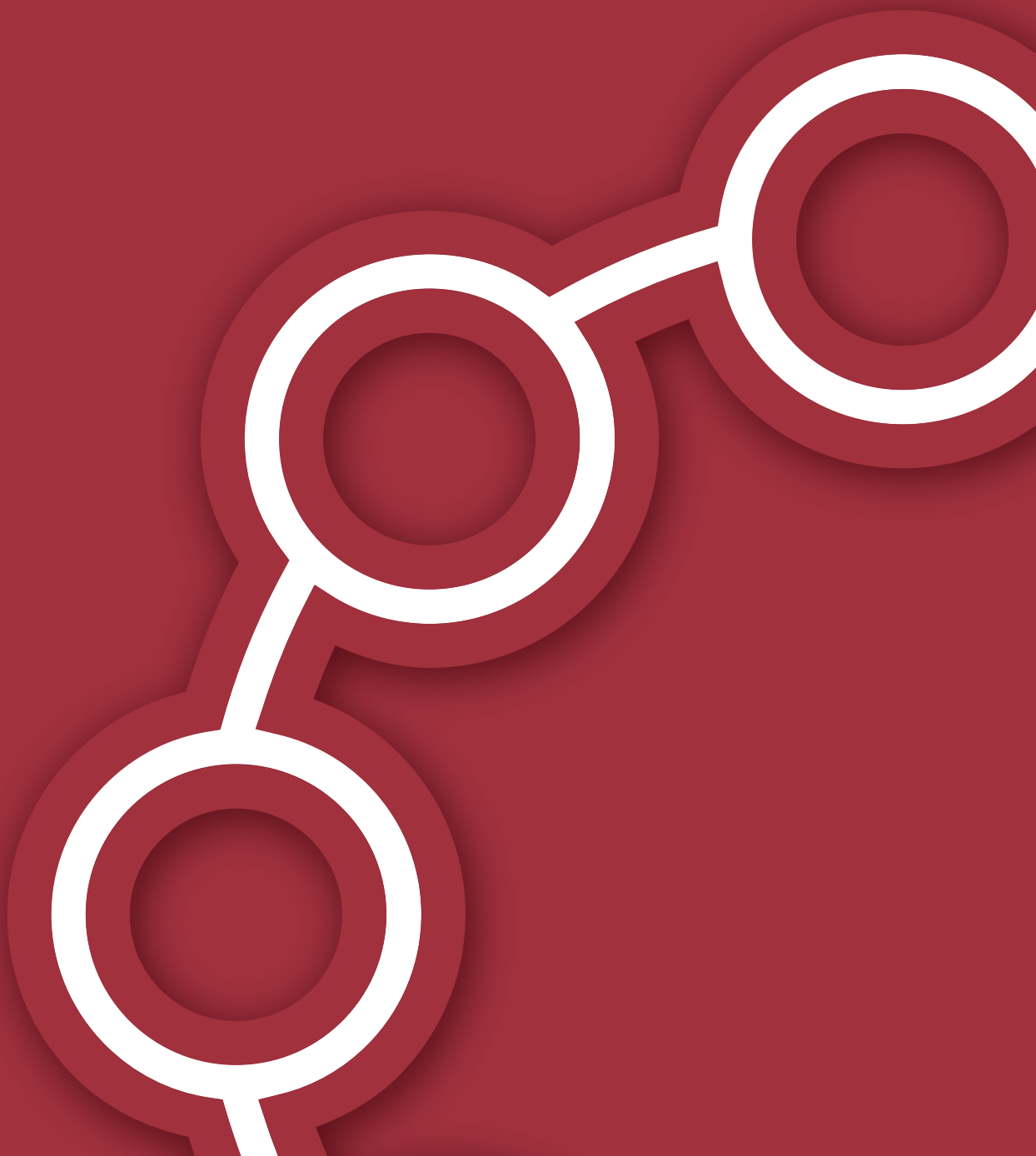
CD-Rom resources

- *Fetal Alcohol Spectrum Disorder (FASD): A Framework for Action* (Public Health Agency of Canada 2005)
- *Fetal Alcohol Spectrum Disorder Factsheet* (Health Canada)

Further reading

- National Indigenous Drug and Alcohol Committee (2012) *Addressing Fetal Alcohol Spectrum Disorder in Australia*
- Russell Family Fetal Alcohol Disorders Association (rffada) *Compilation of Links to Resources in FASD*

CHAPTER 3
Criminal Justice Contact
What You Need to Know



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Criminal Justice Contact – What You Need to Know

Key points

- Drug and alcohol use is often a contributing factor for people in the cycle of offending and imprisonment.
- The risk factors for relapse are similar to the risk factors for offending behaviour.
- People who have been in prison may display behaviours associated with surviving in a custodial setting when they enter your service. By understanding the meaning behind the behaviour, you can support them to feel safe and to successfully adjust to a treatment setting.
- Treatment outcomes for people mandated into treatment are no different to those who are not mandated.
- Giving a person time, acknowledgement and emotional safety are key to working with clients who've had contact with the criminal justice system.

People may come into contact with your service at a number of points in the criminal justice system. They may self-refer before their offending matters come to the attention of the police or courts, be referred by the court as part of their bail or sentencing conditions, be on a diversion program, or have finished their sentence and be exiting prison.

PEOPLE IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

There are many health and social factors that are overrepresented in people involved in the criminal justice system compared to the general population. These include higher levels of drug and alcohol problems, mental health issues and cognitive impairment.

The 2009 Inmate Health Survey found that many prison inmates experience disadvantage as a result of histories of:

> abuse, neglect and trauma; poor educational attainment and consequent limited employment opportunities; unstable housing; parental incarceration; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment. (Indig et al 2010a:151)

There are approximately 10,000 people in prison on any one day in NSW, with up to 30,000 cycling through the NSW prison system each year (Corrective Services 2012). Nearly half of these people will be back in prison within two years.

On average over 17,000 people are under the supervision of Community Offender Services (formerly Probation and Parole) through community orders, home detention, bail and/or parole on any given day (Corrective Services 2012). Drug and alcohol use is often a factor in the cycle of offending and imprisonment.

DISADVANTAGED BACKGROUNDS

Like the majority of drug and alcohol clients, criminal justice clients, according to research both in Australia and overseas, are highly disadvantaged.

> **"The similarities between drug and alcohol clients and people in contact with the criminal justice system outweigh the differences. The risk factors for relapse of a drug and alcohol problem are similar to the risk factors for offending behaviour."**

When disadvantaged people come in contact with the criminal justice system, their disadvantaged situation often 'tips' them towards prison. Conversely, a person from a more advantaged background who commits the same offence may be steered away from prison due to more comprehensive legal and financial support.

Key social determinants of prisoners in NSW identified in the 2009 NSW Inmate Health Survey (Indig et al 2010a) include the following:

- **Not completing Year 10**. Approximately half of participants did not finish Year 10.
- **Accommodation**. One in 10 (11%) were living in unsettled accommodation or had no fixed abode prior to their current incarceration, and approximately 30% noted they had accommodation problems in the six months prior to incarceration.

- **Unemployment**. 50% of men and 67% of women were unemployed in the six months prior to their imprisonment, with 30% of men and 44% of women being unemployed for five years or longer.
- **Out of home care before the age of 16**. 22% of non-Aboriginal male prisoners and 27% of non-Aboriginal female prisoners, and 46% of Aboriginal male prisoners and 45% of Aboriginal female prisoners, had been placed in out of home care as a child.
- **Parental incarceration**. Approximately one in five prisoners (18% of men and 17% of women) have had a parent in prison.

It is important to remember that the similarities between drug and alcohol clients and people in contact with the criminal justice system outweigh the differences. The risk factors for relapse of a drug and alcohol problem are similar to the risk factors for offending behaviour. And the underlying social determinants of crime are similar to the social determinants of health.

Working holistically with a person to address their drug and alcohol use can therefore assist in reducing the likelihood of the cycle of crime, relapse and reoffending.

For more information see www.nobars.org.au 'About Criminal Justice Clients'.

DRUG AND ALCOHOL USE AND OFFENDING BEHAVIOUR

The NSW Inmate Health Survey (Indig et al 2010a) demonstrates the strong link between offending behaviour and alcohol and drug use. While most offences were not, strictly speaking, 'drug related' by definition (11% were convicted of drug offences), a large proportion of prisoners were intoxicated at the time of their offence (61%), believed their substance use was related to their current sentence (54%) and had high rates of illicit drug use and problematic drinking.

Figures 3.1 and 3.2 show the high rates of illicit drug use and hazardous or harmful drinking in the NSW prison population.

Figure 3.1: Illicit drug trends

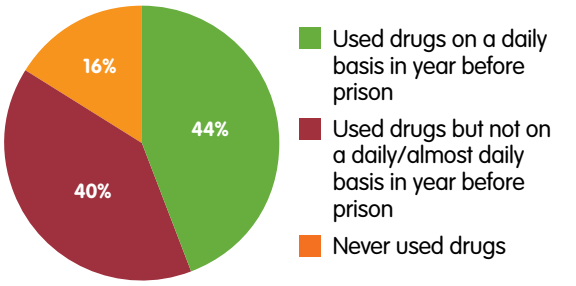
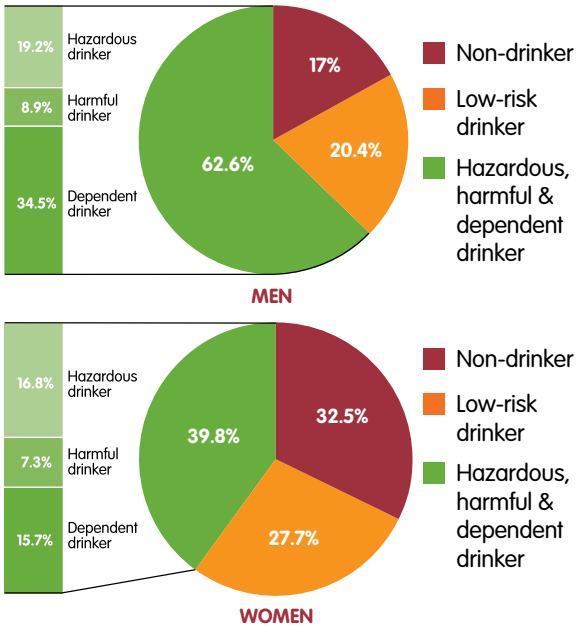


Figure 3.2: Alcohol use trends



Source: Indig et al (2010a).

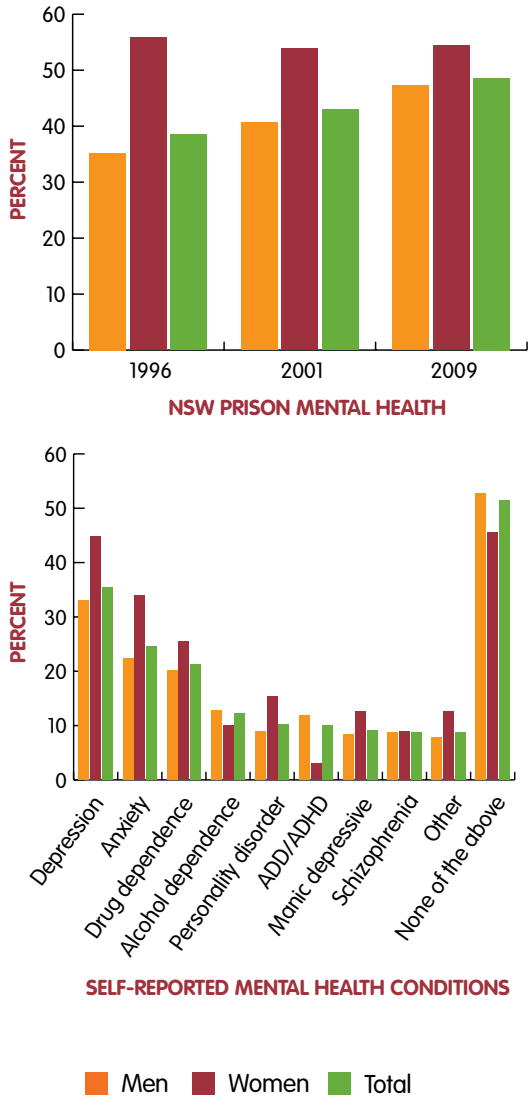
MENTAL HEALTH OF CRIMINAL JUSTICE CLIENTS

Psychiatric disorders identified in the Australian prison population are substantially higher than in the general community. In 2006, the 12-month prevalence of any psychiatric illness in the last year was 80% in prisoners compared with 31% in the community (Butler et al, 2006).

The 2009 Inmate Health Survey noted that almost half of participants reported they'd been assessed or had received treatment for a mental health problem, with approximately one-fifth of participants currently on psychiatric medication.

Figure 3.3 shows the mental health disorders in the NSW prison population, which range from serious mental illness to chronic depression, with the most common diagnosis for both sexes being depression (Indig et al 2010a).

Figure 3.3: Mental health disorders in the NSW prison population



Source: Indig et al (2010a).

CRIMINAL JUSTICE CLIENTS AND COGNITIVE IMPAIRMENT

People with a cognitive impairment are significantly more likely to have contact with the criminal justice system from an earlier age, and those with a cognitive impairment or mental health issue are also more likely to have a co-existing substance use disorder (Baldry et el 2010).

People with an intellectual disability are overrepresented in the criminal justice system and are more likely to:

- Be arrested
- Be questioned and detained for minor public offences
- Receive harsher penalties
- Have less access to sentencing options
- Experience disadvantage when interviewed by police or when in court because they may not understand what's happening and what's being said
- Be highly vulnerable in prisons because of their disability
- Have higher rates of reoffending than the general population.

While limited research is available, people with other forms of cognitive impairment may experience similar higher contact with the criminal justice system.

You should be aware that people entering your service with a long history of contact with the criminal justice system may have a cognitive impairment and that a formal diagnosis or assessment history is not necessarily going to be available.

The Criminal Justice Support Network of the Intellectual Disability Rights Service can show you how to support people with intellectual disability (diagnosed or suspected) who are in contact with the criminal justice system. Visit www.idrs.org.au.

Further reading

- NSW Ombudsman (2008) *Supporting People with an Intellectual Disability in the Criminal Justice System: Progress Report*, Sydney.
- Intellectual Disability Rights Council (IDRS) (2012) *Step By Step Guide to Making a Section 32 Application for a Person With an Intellectual Disability*, Sydney.
- arbias & La Trobe University (2010) *Acquired Brain Injury: Screening, Identification and Validation in the Victorian Correctional System*, La Trobe University.

ABORIGINAL PEOPLE AND THE CRIMINAL JUSTICE SYSTEM

It's well documented that Aboriginal people are grossly overrepresented in both the Australian and NSW criminal justice systems. The 2011 NSW Inmate Census found that 22.9% of the NSW prison population identified as Indigenous (Corben 2011), compared with only 2.1% of the general population. There's been a 71% increase in overall Aboriginal prisoner rates in Australia, compared with a 25% increase in non-Aboriginal prisoners, between 2001 and 2009 (Indig et al 2010b).

> **Indigenous offenders with an existing substance use, mental health, or physical health problem often have complex needs. Separation from family and culture, together with a previous history of an undiagnosed or unrelated health condition, places an indigenous offender at great risk while in the correctional system (NIDAC 2013:2).**

The long-term factors impacting on the overrepresentation of Aboriginal people in prison are complex, interconnected and intergenerational. They include (CRC & NADA 2011):

- Heavy surveillance by criminal justice agencies such as the police, and scrutiny by government departments such as child protection agencies
- Inability to afford or access legal help
- Coming from some of the most disadvantaged geographical areas in Australia
- High levels of family breakdown in Aboriginal communities due to the fragmentation of traditional structures, cultural disconnection and social isolation
- Lack of access to appropriate services due to remote location, history of strained and conflicted relationships with services, or services that aren't Aboriginal specific or sensitive in their service delivery
- The experience of intergenerational and historic trauma that continues with the ongoing experience of grief from being removed from families, traditional lands and culture
- The ongoing effects of colonisation and assimilation on Aboriginal people that have resulted in negative outcomes in health, housing, employment and education.

In NSW there's been a 48% increase in Aboriginal people incarcerated over the last 10 years. Yet this increase does not correlate with an increase in offending behaviour. Evidence suggests the reason for the growth is an increased severity in the criminal justice system's treatment of Aboriginal offenders. Compared with non-Indigenous offenders, Aboriginal people are refused bail more often, are detained for longer periods on remand, receive prison sentences more often, and are being sentenced for longer (Fitzgerald 2009).

MOTIVATION AND CRIMINAL JUSTICE CLIENTS

People who have a drug and alcohol issue and are in contact with the criminal justice system often have their motivation to change questioned when accessing treatment. Whether they are appearing at court for bail or sentencing, or applying for parole, there can be an assumption by service providers that a request to access treatment is a 'get out of jail free card' that can result in a person being denied treatment. However, research has identified that treatment outcomes for people mandated into treatment are no different to those who are not mandated (Ip et al 2008).

Institutionalised behaviours from time in custody can sometimes support a worker's belief that the person isn't motivated or doesn't have the 'right' motivation. This can influence a worker's decision not to allocate places in treatment to people who may be perceived as not committed to treatment. Coercion into treatment through the criminal justice system is just one factor among many that motivate people to decide to access drug and alcohol treatment.

A key role of drug and alcohol workers is to build clients' motivation. As motivation is a product of the relationship the person has with you as a worker, and with their family and community, you should build on any element of motivation that exists to support them in their process of change.

Access to treatment in prison

Often a person's motivation can be questioned if they haven't accessed drug and alcohol treatment programs while in prison. But this is not always a question of motivation, as a range of factors influence access to treatment services while in prison.

For some, prison can provide an opportunity to address their physical, mental and drug and alcohol needs. A range of drug and alcohol programs exist in NSW prisons, including Getting SMART, SMART Recovery maintenance groups, a pre-release three-month residential therapeutic program (Ngara Nura), POISE for women and Narcotics and Alcoholics Anonymous.

However, for many people accessing the appropriate program for their drug and alcohol issue/s is limited by the following factors (CRC & NADA, 2011):

- The availability of drug and alcohol programs and drug and alcohol workers differs across prisons in NSW.

- Not all programs are available in all prisons.
- Caseloads for welfare and drug and alcohol workers in prison are very high (sometimes up to 150 inmates per worker), making it difficult for even initial casework sessions to identify and facilitate client needs.
- The security classification of a prisoner determines which prison they are housed in, in turn determining what type of programs may be available to them (every prison has differing levels of prisoner classification).
- Rehabilitation programs are usually available only for longer-term prisoners (six months plus) and are not available in all prisons.
- People on remand (over 25% of prisoners) cannot access any prison programs.
- With up to 30,000 receptions (people being received into prison) each year, waiting lists to access drug and alcohol programs can be long. Prisoners can be moved to a different prison before their name comes up or can be moved before they complete a program.

For more information on prison programs and issues affecting program availability visit www.nobars.org.au/criminal-justice-system.html (go to the 'Prisons and Community Offender Management' page under 'About the Criminal Justice System').

Access to treatment on release from prison

Access to treatment on release from prison is critical for people with problematic alcohol and drug use:

- The **first 72 hours** after leaving prison is the **danger time for relapse and overdose**. People often don't realise their tolerance has dropped so they can fatally overdose on amounts they formerly would have handled.
- The **first two weeks** after leaving prison is the **critical period for relapsing into drug and alcohol use**. This can quickly lead to reoffending (e.g. petty theft, arrest for drunken behaviour) and a return to the criminal justice system.
- The **first three months** after leaving prison are **critical for transitioning back to living in the community**. In this period, a key issue is finding accommodation, as this provides a base from which people can get work, start to deal with their drug and alcohol issues and reconnect with society. For some people who have left prison, the transition back to society can be even harder than serving time.

Challenges on release – Getting out and getting treatment

There are many practical challenges faced by people on exit from prison. Many of these are beyond the person's immediate control and can affect their ability to access drug and alcohol treatment services in the community. Service flexibility in making small adjustments in intake, waiting list and admission procedures will support access to treatment, lower instances of relapse and save lives of people seeking treatment on release from prison.

These challenges include (CRC & NADA 2011):

- **Inability to plan for release when on remand.** Over 25% of prisoners in NSW are on remand, meaning they're awaiting trial or sentencing and have no identified fixed term of imprisonment (Corben 2011). People can be on remand for many months. When their matter is heard at court, they may be released directly from court back into the community (because of a finding of not guilty or time already served) and not transported back to prison to collect any personal belongings and money. Not knowing a release date poses many problems in planning for transition to the community, including not being able to advise a drug and alcohol rehabilitation service of a treatment start date.
- **Limited phone access.** A range of factors affect a person's ability to access a phone and therefore maintain a place on a treatment service waiting list. Prisoners have phone cards limited to a few programmed numbers that need to be prepaid to use. It's unlikely that a prisoner will be able to call a service on a specific day, at a specific time, to maintain a spot on a waiting list, due to prison lock down, lack of phones, and lack of access to phone money despite their motivation to access treatment on release.
- **Lack of personal identification.** People released from custody often have no identification other than their MIN (Master Index Number) and prison discharge certificate. Any personal belongings not with them when taken into custody may have been lost or destroyed. Prison discharge papers are accepted as forms of valid identification by Centrelink and Housing NSW, but generally not by drug and alcohol treatment services. Gaining other forms of ID is costly and can take time.
- **Limited finances and accrued debt.** On release, a person will be given any money left in their prison bank account. If they've been in prison for 14 days or more, they'll be eligible for a Centrelink crisis payment. This payment can provide some immediate financial relief, but it's issued as a one-week advance payment of the regular fortnightly payment. This means in the next fortnight the person will receive only one week of their Centrelink payment to cover a two-week period.

Many people coming out of prison have accrued debt through ongoing direct debits, account fees, contract fees (e.g. phone, bank, credit card) or rental payments while in prison. This can make it difficult to afford basic needs before budgeting for the cost of upfront fees to enter drug and alcohol treatment.

- **Challenges getting from prison to drug and alcohol services.** Most NSW prisons are in regional areas with minimal and infrequent transport options. People can wait up to 24 hours in some areas for public transport after release. When a person leaves prison, Corrective Services will give them a ticket for direct travel back to the place of arrest only. These issues can often impact on a person being able to arrive at a treatment service by the cut-off date or time for admission.
- **Getting released directly from court.** Prisoners can be released directly from court into the community. They're released in their prison 'greens' (clothing) with no belongings, no money and no identification. It's likely that nothing is in place for release, including accommodation, transport or medication. Emergency assistance can often be required for food, clothing, transport and accommodation.
- **Getting released from a correctional centre.** On release from prison, a person will be given back any belongings they entered with and any money remaining in their prison bank account. Some people may have had an opportunity to discuss and plan for their release with prison welfare staff. However, even when a release date is known, effective post-release and transition planning are not always possible.

TRANSITIONING FROM PRISON TO TREATMENT

The transition from prison to a drug and alcohol residential treatment setting can be challenging for the client, and can impact on staff and other clients in the service. These issues (referred to as the 'culture clash' and explored in more detail in *Chapter 4: Practice Tips for Workers*) often stem from the institutionalisation experienced by the person while in prison.

The behaviours required to survive and stay safe in prison are contradictory to the behaviours required to receive treatment in a residential rehabilitation setting. For example, in prison a person doesn't share any personal information, thoughts or feelings, so that they can survive emotionally and physically. In a treatment setting, sharing information and feelings is an essential part of the therapeutic process and not doing so can lead to the person being described as unmotivated or non-compliant.

For service staff, the key is to understand the impact of time in prison on the person's behaviour and to help them make the cultural shift so they can experience a positive treatment outcome. The challenge for you as a worker is to not make assumptions that a person is unmotivated or non-compliant and that they can't change their prison behaviour. There are several small but important adjustments in your practice you can make to help clients remain in treatment and have successful treatment outcomes:

- **Time.** Give the person support and time to make the cultural shift.
- **Acknowledgement.** Identify and acknowledge with the client the difference in environments.
- **Emotional safety.** Help them feel safe to share in your program.
- **Motivation.** Be conscious of how easy it is to interpret the 'culture clash' as a lack of motivation to participate in the program, rather than the process of adjustment to a setting with different expectations and rules.

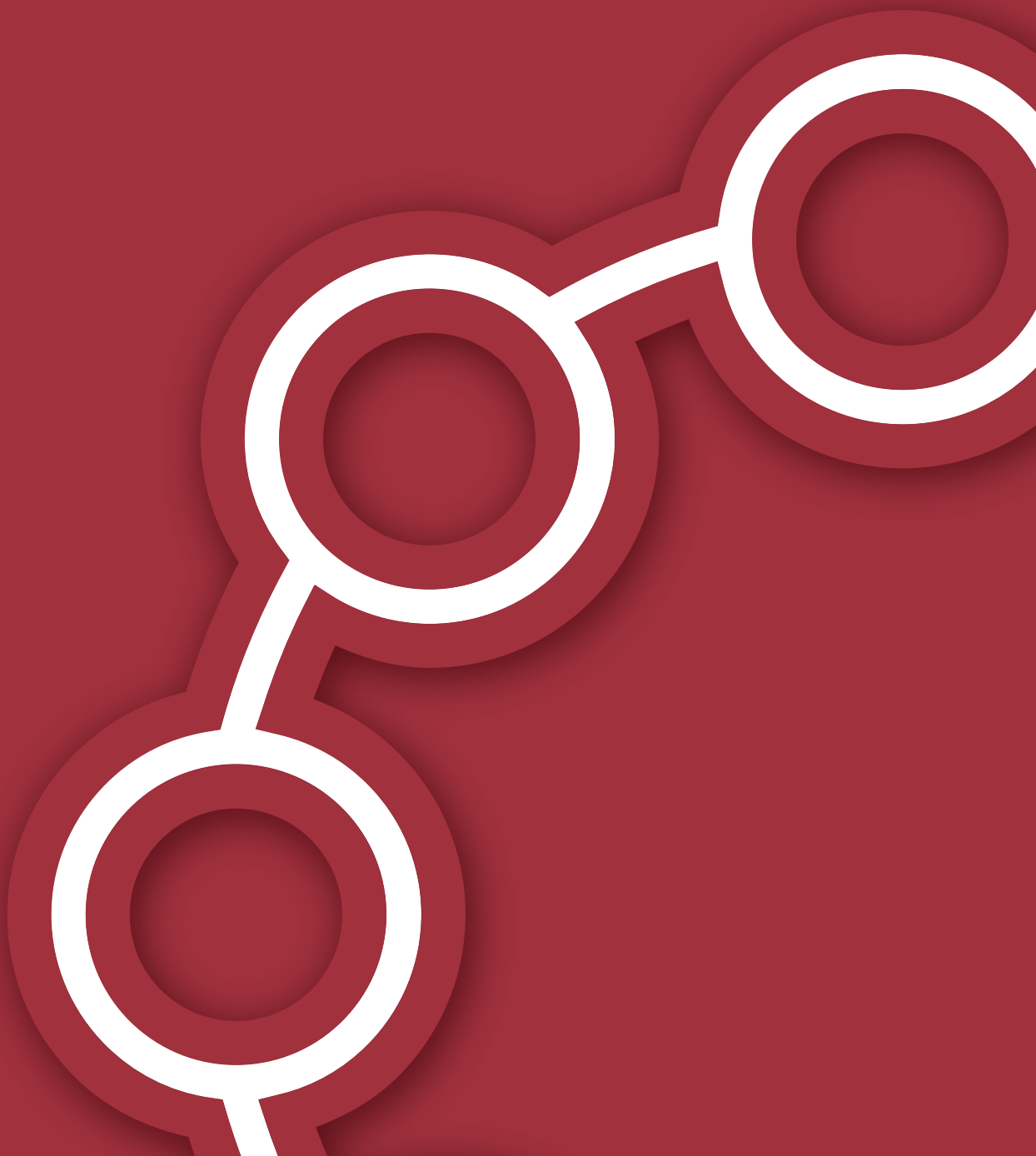
For ways to best support clients who've had criminal justice contact see *Chapter 4: Practice Tips for Workers* and *Chapter 6: Making Your Service Complex Capable*.

For more information on criminal justice clients and the criminal justice system visit www.nobars.org.au. This website has a range of information on the criminal justice system, including about working people in prison and people who've left prison, as well as links to research and other resources.

Further reading. The Community Restorative Centre and NSW Department of Corrective Services resources, *Planning Your Release: NSW Exit Checklist (2005)* and *Getting Out: Your Guide to Surviving on the Outside* (2007) were designed for people exiting prison in NSW, but you may find them useful when working with people who've recently exited prison or are planning to go from prison to your service.

CD-Rom resources. For more information on supporting clients at court refer to the *Court Support Information Booklet* (CRC 2012) and the *Supporting Your Client in Court: Quick* Tips for Alcohol and Drug Workers Booklet (NADA & Legal Aid NSW 2012).

CHAPTER 4
Practice Tips for Workers



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Practice Tips for Workers

Key points

- Having a holistic approach is the foundation for working with clients with complex needs.
- Minor adaptations to your core practice strategies will better support clients with complex needs and will benefit all clients.
- Using universal communication strategies will assist clients with complex needs.
- Understand behaviour as a communication strategy to increase your awareness and response to what are often perceived as challenging behaviours.
- Increasing your knowledge and understanding of complex needs issues is the key to increasing your skills and confidence in working with people with complex needs.

There's a range of practice considerations and modifications that can be implemented to better support clients with complex needs. This chapter describes strategies for working with clients in the areas of building rapport and engagement, applying principles of universal communication, responding to behaviour, care planning and case management, counselling, group work and referrals. This chapter also provides information on supporting clients in your service who have had contact with the criminal justice system.

GENUINE, HOPEFUL AND EMPATHETIC RELATIONSHIPS

Having a genuine, hopeful and empathetic client/worker relationship makes a difference to the lives of clients. When you're working with people with complex needs, this relationship is particularly important as it's likely the person will have experienced 'service system fatigue' and feel that services they've been involved with in the past have given up on them. Developing solid engagement and rapport and developing and maintaining boundaries are key components of developing this relationship.

Establishing solid engagement and rapport with your client cuts across all theoretical approaches and is one of the most important tools in successfully supporting someone to participate in a drug and alcohol program. When supporting a person with complex needs, use the following engagement strategies:

> **As we gradually get an understanding of the person we are able to have a much more personalised approach (Staff member, Karralika Programs Inc, April 2012).**

- **Get to know them.** Learning information about a person, such as what they like or what they're interested in, can help you develop engagement and rapport. The better you know the person, the easier you'll find it to identify when they need additional support and how to help them work through particular impulses or challenging behaviours.
- **Time and patience.** It may take more time and perseverance than usual to develop a solid level of engagement with a person with complex needs. Don't give up!
- **Be present.** Focusing on being emotionally present is particularly powerful and effective and essential to a genuine, empathetic and hopeful worker/client relationship.
- **Focus on the positive.** Use a strengths-based approach, focusing on achievements and acknowledging that setbacks are part of the change process. People with complex needs may take longer to achieve their goals. It's likely they'll have more setbacks on their path to change than other clients. Celebrate all the effort and small achievements and allow the person time to learn from their mistakes.

Boundaries

Developing and maintaining professional boundaries is an important part of a genuine, hopeful and empathetic relationship between worker and client. Consider the following points when working with people with complex needs:

- **Understanding boundaries.** People with complex needs are likely to have difficulty understanding, setting and maintaining personal boundaries. This may be because of a cognitive impairment or may be in response to having personal boundaries damaged or violated during their life.

- **Time to learn.** Knowing what boundaries are appropriate and acting accordingly is something we learn over time. Some people with complex needs may need support and time to learn what is appropriate in your service, in the community and in their personal relationships. This may mean resetting the boundaries every day, sometimes more than once a day, and being consistent with what the boundaries are.
- **Modelling boundary-setting.** Modelling effective boundary-setting is a useful tool in helping people see how they can respectfully deal with situations where their personal boundaries are being threatened. This can mean showing a person how to set limits, demonstrating that you're able to say, for example, "No thanks. I don't feel like doing that now", or "Would you mind stepping back a little bit – you're standing a little bit close", or "I'm not sure about that – I'll think about it and get back to you".
- **Feedback.** Give the person clear and straightforward feedback on inappropriate behaviour and your service's behavioural expectations. Help the client to identify the consequences of their actions for themselves and for other people.

UNIVERSAL COMMUNICATION STRATEGIES

Universal communication strategies are beneficial to all service users and are particularly valuable when working with people with complex needs. They support service access and participation for all people using your service, and many of these strategies cost little or nothing to implement.

Strategies include modifying language, establishing rapport and involving clients in their care and service planning. Having universal communication strategies in place helps you and your service comply with legislation and accreditation standards relating to access and equity.

> **"With this approach [universal design] there doesn't have to be a separate program or special testing or treatment for people with cognitive impairment – programs are already suitable (Staff member, The Lyndon Community 2012)."**

Communication

Face-to-face communication is the most effective way of communicating with someone. If it's not possible to communicate face to face and you have to rely on phone or email communication, be aware of the communication challenges that present when cues like body language and facial expressions are not available.

For example, if you know or suspect someone has specific cognitive functioning difficulties related to communication and comprehension and you have to speak to them over the phone, use strategies to make sure they've understood what you've said. This may include having a support person or advocate for the client involved in the phone conversation. Also, be aware of how you're communicating, including your use of complex words, or long sentences in which multiple pieces of information are included.

Verbal communication tips

- Keep your language simple by using short sentences and avoiding jargon. This will increase the likelihood that the person will understand directions or questions.
- Raise only one topic at a time. Clearly signpost changes in topic to avoid confusion.
- When explaining tasks, make sure you break the task into a step-by-step process, as these are easier to both understand and remember.
- Ask the person to explain in their own words the information you're giving them – don't just ask "Do you understand?" (If you do this, they may automatically say "yes" because they think this is the "right" response and/or what you want to hear.)
- Allow more time than usual for a response.
- Encourage the person to ask for information to be repeated if they haven't understood fully.
- Minimise distractions in the immediate environment.
- When language is a barrier, use action-based strategies to help the person understand, such as demonstrating what needs to be done or asking them to demonstrate their understanding of a direction or question.
- Support verbal communication with audiovisual, written and pictorial resources where possible.

CD Rom resources

- *Introduction to Intellectual Disability* (IDRS 2009)
- *Maximise People's Ability to Make Their Own Decisions* (IDRS 2004)

Written and visual materials

Many people find it difficult to understand complex text, so it's essential to consider the literacy needs of your client group.

The Australian Bureau of Statistics (ABS) has identified that almost half of Australian adults have literacy skills considered inadequate to meet the demands of common daily activities. This includes understanding narrative texts and completing forms. See Figure 4.1 for the results of the 2006 Adult Literacy and Life Skills Survey conducted by the ABS.

Literacy levels are affected by a range of factors, including school leaving age, quality of education, having English as a second language, and learning disabilities or cognitive impairments. People with a disadvantaged background are more likely to have literacy problems.

Preparing written materials that are easy to understand will ensure they're accessible to a wider audience and will lessen disputes or difficulties that can occur through misunderstandings. 'Plain English' and 'Easy English' (see below) can both be used to make written material more accessible.

What is plain English and when should I use it?

Plain English is a flexible and efficient writing style that readers can understand in one reading. It combines clear, concise expression, an effective structure and good document design (Plain English Foundation 2012).

Plain English should be used for any information that's in the public domain and that the public uses to make decisions.

What is Easy English and when should I use it?

Easy English (also known as 'easy read' or 'easy to read') is a simple and controlled writing style developed for people who have difficulty reading and understanding information. Easy English identifies the key points a person needs to know, and the most direct and concise way to say it, and includes the use of relevant images.

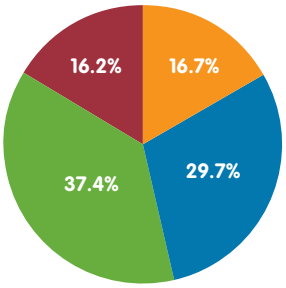
Easy English documents are usually developed for a specific target audience. Documents that provide essential information that helps a person make an informed decision or where action is required should be developed using Easy English.

There are a number of resources available to help people develop documents that use plain English and Easy English. The types of written materials that may need to be modified in a drug and alcohol service are:

- Forms
- Information sheets
- Brochures
- Booklets
- Reports
- Policies and procedures
- Signage
- Websites.

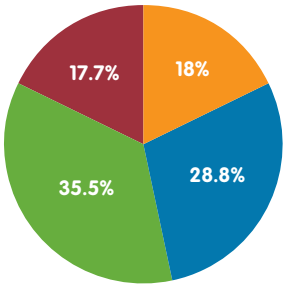
Services often already use signage that incorporates plain or Easy English, usually for health and safety. For examples of signs to promote fire exits, handwashing and cough etiquette refer to figure 4.2.

Figure 4.1: Adult literacy in Australia



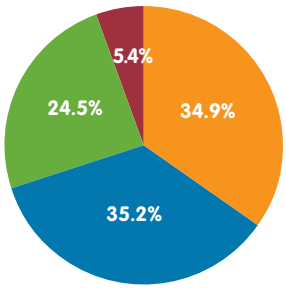
ADULTS (15-74) PROSE LITERACY

Knowledge and skills needed to understand and use various kinds of information from text, including editorials, news stories, brochures and instructional manuals.



ADULTS (15-74) DOCUMENT LITERACY

Knowledge and skills required to locate and use information contained in various formats, including job applications, payroll forms, transportation schedules, maps, tables and charts.



ADULTS (15-74) PROBLEM SOLVING SCALE

Understanding the problem situation and its step-by-step transformation, based on planning and reasoning, constitute the process of problem solving.

Level 1
Level 2
Level 3
Level 4/5

Note: *Level 3 is considered the equivalent of High School years 8-10 which the survey developers regard as the minimum required for individuals to meet the complex demands of everyday life and work in the emerging knowledge base.*

Level 4/5 includes those education post High School Year 10

Source: Australian Bureau of Statistics (2006, reissue 2008), Adult Literacy and Life Skills Survey, Summary Results, Australia.

Figure 4.2: Easy English signage examples

These examples can be accessed on the CD-Rom.

You should make sure all materials meet plain English requirements at a minimum, and consider when Easy English should be used. All clients will benefit from the use of both plain and Easy English, whether or not they have literacy problems.

Staff may feel uncomfortable using Easy English, thinking they are being condescending or patronising. But anecdotal evidence shows this is not the case, and people are happy to receive materials in this format. By developing materials in consultation with the target audience, and being sensitive and responsive to their needs, you will ensure this doesn't happen.

The NSW Council of Intellectual Disability (NSW CID) partners with Scope Victoria to facilitate Easy English writing courses in NSW. These courses cover the essential skills to develop written information for people with limited literacy. For more information contact NSW CID: info@nswcid.org.au.

Written materials tips

- Use plain English.
- Consult with the target audience when developing materials to ensure appropriate content and design.
- Consider people's literacy levels when distributing written materials in your service.
- Supplement written materials with a face-to-face explanation to ensure key messages are easily understood.
- Use images or audiovisual materials to support written materials.
- Get ongoing feedback from the target audience when using written materials, and adapt as needed.

Using visual aids to support written materials

The use of visual aids (images, symbols, illustrations) and audiovisual materials can help the reader understand and remember key information. Incorporating images into text can be done for minimal or no cost and commercial software is available to assist you to develop visual aids, including:

- CHANGE Picture Bank©
- Valuing People ClipArt, from Inspired Services Publishing Pty Ltd©, and
- Bonnington Symbols.

A wide range of stock images can be sourced from a number of websites such as Shutterstock. Microsoft Office software also includes a searchable range of ClipArt images. You can also use images relevant to your service by creating photos or drawings.

When using visual aids:

- Consider how relevant the image is to what you're trying to represent and whether it could be confused with something else.
- Make sure images are not overused, or used inconsistently, in a document (e.g. the same image being used to refer to multiple concepts).
- Consider the acceptability of the image for the target audience (e.g. in terms of culture, age and life experience).
- Consider getting staff and clients involved and using real images from your service to complement stock and ClipArt images.

Further information

For further information on what written materials and information may suit your service, see *Chapter 6: Making Your Service Complex Capable*.

CD-Rom resources

- *Easy English Writing Style Guide* (Scope 2007)
- *Images for Easy English* (Scope 2008)
- *How to Write Plain English* (Plain English Foundation)

THE LYNDON COMMUNITY CASE STUDY

Cognitive impairment (CI) is one factor known to affect people's ability to participate in substance misuse treatment because of the range of cognitive, behavioural and emotional problems such impairment can cause. Some of the behaviours described as common features of cognitive impairment (such as impaired self-monitoring and self-regulation and lack of initiative) are interpreted in some treatment modalities as the causes and consequences of addiction. This can result in workers prescribing a moral rationale to a person's behaviour that may have a physical cause.

The Lyndon Community undertook to investigate the scope of, and responses to, cognitive impairment within its residential treatment programs. A staff survey conducted in July 2011 across the agency's programs found that employees had little or no knowledge about the characteristics of CI, could not easily identify CI in clients and did not perceive CI to be common in those clients they were working with. With the assistance of a PEP grant from NADA, Lyndon employed a person (Annette) to skill up and support staff in working with CI. This case study highlights the benefits of this approach.

Joe is a 31-year-old man who completed detox with the Lyndon Withdrawal Unit and was transferred to the Lyndon Therapeutic Community. He had an extensive history of poly-substance use and had entered treatment on this occasion to withdraw from alcohol and pain-killers.

Medical history

- History of seizures (doctor determined that these may be withdrawal seizures)
- Motor vehicle accident at 12 years of age – hit by a car fractured left and right femurs: 2 steel plates (L) and 1 steel plate (R). Has not had them removed … should have been removed at age 16 … typically experiences constant leg pain and foot pain and numbness in both feet.
- Diabetes, diagnosed at 16-17 years, untreated
- Enlarged heart
- Hepatitis C positive
- Diagnosed with depression
- Reported on admission assessment Mini-Mental State examination states cognition: orientated to time, place and person.
- Client states that memory is 'shot' both long and short term.
- Client's principle substances of concern: current – alcohol, cannabis, previous – crystal meth/ speed and oxycontin.

Substance use history

- Alcohol – wine daily: 3L/day
- Amphetamines/ice – speed/ice daily: 1g/day IV
- Cannabis – smoked daily: 2g/day
- Opiates/analgesics – oxycontin 80mg x 1 – IV daily, heroin at times
- Started alcohol and cannabis use at approximately 15 years of age; heroin at the age of 18 then moved on to speed/ice.

Joe stated both his parents were alcoholics and his mother had died at age 49 from alcohol-related illness.

Joe initially settled in well to the rehabilitation program. However, after 3 or 4 weeks his case notes began to record lack of motivation, failure to complete tasks and attend scheduled group sessions.

Continued over page

When these concerns were discussed with Joe, he agreed he had not done what was expected of him and that he would do better.

The case notes at the time record the following entries:

> **2/6/11** – Resident's participation in group is fragmented and bears little or no relation to the group topic. I have had to assist him in filling out questionnaires for groups requiring responses to written information. He often experiences trouble understanding the instructions for filling these response sheets out and needs it to be explained a few times and/or be shown. This resident is observed to take a longer time to complete the response sheets than the majority of the group.
>
> **16/6/11** – The resident was confronted by staff and other community members regarding behaviours which the majority of the house had raised as issues in regard to the rules and participation in the community. These issues included being lazy, moody, isolated, accumulating a lot of 'hours' (consequences for not adhering to community rules and participation in aspects of the program). The resident was placed on a 'pre-contract' (or re-commitment contract) where residents agree to make a greater effort to improve in the areas of concern.

Joe's behaviour failed to improve. He continued to be late for group, not complete his kitchen duty, not turn up to undertake other tasks or attend doctor's appointments. He did not complete journal tasks or group tasks on time or sometimes not at all. He was described as lazy, having a bad attitude and displaying addict irresponsibility. The case notes record that Joe could not identify goals or describe what he might get out of the program. His constant infringement of the rules and routines of the program meant he was very likely to be asked to leave.

Annette could see from Joe's history and behaviour that he was highly likely to have a cognitive impairment and proposed screening him with the Addenbrooke's Cognitive Examination Revised (ACE-R) cognitive screening tool. During the screening interview Annette found out that as a result of the car accident when he was 12 he had been in a coma for some weeks and had no recollection of any support or assistance in recovering from that event.

Joe also reported experiencing increased difficulty with concentrating, motivation, following instructions, communicating, fatigue, regulating emotions, controlling anger, and a number of physical limitations related to his legs and feet. Joe's ACE-R scores indicated he was highly likely to have a cognitive impairment.

Annette believed that Joe was unable to comply with the program's expectations for participation without some assistance for his cognitive functioning. With Joe's permission, Annette reported the results of Joe's screen and her discussions with him to the program staff. Annette provided a short (2 hour) training program on the causes and consequences of cognitive impairment and listed a range of strategies that could be used in the residential setting to support people with cognition problems. This way of viewing Joe's situation made a substantial difference to the way his behaviour was interpreted and how he participated in the program. Staff used a simple diary and watch with multiple alarms to help Joe move through the day. Joe revised and checked the daily diary with a staff member twice a day. Extra time and practice sessions were used if Joe moved to a new role or tasks in the program and the tasks Joe was expected to complete during group were reduced or he was given extra time and assistance.

Joe completed the six-month program at the Lyndon Therapeutic Community and moved into a half-way house. Cognitive impairment was an explanation for Joe's behaviour that was not previously considered in the treatment program. When it was, it became easy for the staff to adapt the program for Joe's needs.

STRATEGIES TO SUPPORT MEMORY AND ATTENTION

A person who has difficulty remembering, concentrating or paying attention may use specific compensatory strategies to improve their functioning. You should support the use of these positive compensatory strategies and, if the person hasn't developed their own strategies, work with them to test a range of strategies they could use.

Compensatory strategies include (Synapse 2011a, 2011b):

- Using **external memory aids**, including writing lists, keeping a diary or wall calendar, using a mobile phone alarm or alarm clock for reminders, and using a dictaphone or an electronic organiser.
- Using **specific memory techniques** such as repeating and rehearsing key information and using visual or verbal associations to help recall information and categorise information into groups.
- **Organising the environment** to reduce the demand on the person's memory; this may include having noticeboards with tasks and reminders, labelling or colour-coding cupboards and tying objects to things (e.g. tying a pen to the phone).
- Developing a **structured daily routine**.

UNDERSTANDING BEHAVIOUR AS COMMUNICATION

Behaviour is a means of communication, and all behaviour has a functional element. 'Challenging' behaviour is often described as communicating unmet needs. People with complex needs have many unmet needs and often find it difficult to express them. This can result in a person being perceived as having challenging behaviour. People can then find themselves being labelled by service providers as unmotivated, antisocial, offensive, treatment resistant, having a borderline personality disorder, or being aggressive or passive aggressive.

When people behave in a way that challenges us, we need to question why they're behaving in this way. Consider the origins of the behaviour and what the message behind the behaviour might be. This will help you to understand the meaning behind the actions and help avoid attaching labels to a person.

All clients who are part of a drug and alcohol program, including those with complex needs, at times will display behaviours perceived as challenging.

Behaviours perceived by services as challenging may include showing up late (or not at all) to group or other compulsory activities, not sticking to or participating in parts of the program, or breaking program rules (see Table 4.1).

For you, these behaviours can impact on the running of the service or a program, or the dynamics and interactions of a group. This can be one of the biggest challenges facing workers, as it can be hard to find effective strategies to address the person's behaviour while managing the effect these behaviours have on other clients and staff.

Some of these behaviours can be interpreted as 'resistant' and/or 'unmotivated', that is, indicating an unwillingness to participate in or cooperate with the program. However, we need to examine the possibility that the behaviours are a way of the client expressing an unmet need or a communication misunderstanding. For you as a worker, finding out what this unmet need is may provide clues to how to respond to the behaviour and help the person remain in treatment and experience a successful treatment outcome.

It's also important to separate behaviours that can be challenging in an individual from behaviours that can be challenging because you're working in a complex environment, such as a residential treatment setting.

Understanding behaviour – three approaches

There are three approaches to understanding behaviour:

- The **internal approach** views the behaviour as originating from the individual, including mood, mental health and character.
- The **external approach** views the behaviour as a result of the environment, including the physical environment (such as noise levels) and the systemic environmental (such as policy and procedures, staff-to-client ratio, work culture and level of freedom for clients).
- The **interactional approach** considers the interaction of both internal and external factors. This approach looks at the interactions among staff, clients and the environment and tends to prioritise an examination of the function of the behaviour.

Using an interactional approach will help you understand the internal and external factors influencing a person's behaviour, and help you identify the factors influencing both negative and positive behaviour. Taking the time to work with the person will help you identify what it is that's causing the problem and if it's caused by underlying complexity.

The following table lists behaviours identified as challenging by drug and alcohol services through the consultation process of the NADA and CRC No Bars Project. It identifies a possible alternative reason for the behaviour to non-compliance or non-motivation, linked to the possibility of an underlying complex issue, and suggests effective strategies to address these behaviours.

Table 4.1: Possible causes and strategies for challenging behaviours

BEHAVIOUR	POSSIBLE REASON	POSSIBLE UNDERLYING COMPLEX ISSUES	SUGGESTED RESPONSE
Being late to group or other activities	Difficulty getting organised for group or remembering how long it takes to get ready and get to the room.	Problems with executive functioning as a result of cognitive impairment.	Talk to the person to check what's happening. Help the person set a routine to arrive on time. Implement a buddy system.
Not following program rules	Not understanding what they're meant to be doing.	Problems with memory and/or executive functioning as a result of cognitive impairment.	Check that they understand the program rules. Get clients involved in identifying why the rules are important. Go over the rules using specific, simple and concrete language where possible. Have written rules with the least amount of text possible. Use corresponding pictures with text and make the pictures larger than the text. Using colour is best. Discuss strategies with the person to help with program compliance, e.g. using reminders, having a buddy.
Not participating in activities required by the program (e.g. household duties)	Difficulty getting organised or may be fatigued or confused, especially if there's lots of activity and noise in the environment.	Problems with executive functioning as a result of cognitive impairment. High level of fatigue is a common physical change after a brain injury.	Ask the person what's happening for them. If they find it difficult to get organised, help them set a routine using memory aids and reminders. If it is fatigue, consider their program schedule and ensure there are adequate breaks for them.
Not sharing personal information	Difficulty displaying or articulating their feelings. Not trusting others. The environment may not be conducive to disclosing personal information.	Consequence of history of institutionalisation, e.g. prison or out of home care. Never having experienced a trusting environment/ having trust violated.	Recognise that personal information might be very difficult for some people to share. Be positive and offer encouragement when a person does share information (even if it's only a small amount).

Table 4.1 continued

BEHAVIOUR	POSSIBLE REASON	POSSIBLE UNDERLYING COMPLEX ISSUES	SUGGESTED RESPONSE
Not relating well to other clients	Difficulties interpreting the emotions of others or responding to an interaction in a socially expected way. Fear of other people.	Difficulty in reading social cues may indicate FASD or mild or borderline ID. Previous traumatic experience/s. If they have few social networks, they may not have well-developed skills in communicating and interacting with others.	Support the person to develop social interaction skills by offering tips, encouragement and role-modelling behaviour. Sometimes one-to-one teaching by a case manager to address a particular area is needed. Role plays may assist in this process.
Sharing information that contradicts what they said previously or that later turns out to be false	Difficulties with memory and comprehension so they could be: • Responding to what they thought the question was • 'Filling in the blanks' in their memory • Trying to be compliant and thinking they're telling you what you want to hear.	Problems with comprehension and memory may be indicators of a cognitive impairment. Confabulation (i.e. to fill in memory gaps with fabrications that they believe to be fact) is a common indicator of FASD.	Make sure you ask questions clearly, using specific, simple and concrete language. Ensure they have adequate time to respond. Allow them to give open-ended responses rather than yes/no answers where possible. If this information is important to treatment, gently raise with the person one on one that this information is contradictory. Explore why, and explain why it is important to have the right information.
Repeatedly smoking in the wrong areas after you've shown them the designated areas	Difficulty learning consequences from past behaviour, or may be impulsive.	Difficulty in memory, impulse control and learning from past behaviour may be indicators of ID, ABI or FASD.	Advise the person again where the smoking areas are (try not to get irritated). Ensure that smoking areas are clearly marked. Discuss strategies that may help a person to remember, e.g. additional signs.
Taking another person's possessions	Not understanding the concept of ownership or may have trouble predicting the consequences of their actions. May have come from an impoverished environment and have survived this way.	Difficulty in memory, impulse control and learning consequences of behaviour may be indicators of ID, ABI or FASD. Difficulty adjusting to new circumstances.	Explain that it's polite to ask a person for something before taking it (but don't assume the explanation will generalise to other situations). Ensure property is labelled, where possible. Teach the person one on one the communication skill of how to ask for what they need and how to respond.

Table 4.1 continued

BEHAVIOUR	POSSIBLE REASON	POSSIBLE UNDERLYING COMPLEX ISSUES	SUGGESTED RESPONSE
Being disruptive (including speaking over others) or disrupting the harmony of the group	Becoming overexcited, having difficulty paying attention, or failing to correctly interpret the reactions of others. Group sessions may be too long. The environment may be too distracting, with outside noise or overstimulation from posters, etc, in the room.	Difficulties in attention and regulating behaviour and emotions may be indicators of a cognitive impairment.	Reiterate the rules of the group and why it's important to allow everyone to have a turn to speak at the beginning of and during each group work session. Use an implement (such as a 'talking stick') to give people permission to speak only when they're holding it. Ensure group sessions have adequate breaks. Make sure there's minimal internal and external distraction. Be aware there may be times when group work is not the best environment. This could change depending on if they are well or ill.
Being defensive when challenged by staff or others	Difficulty regulating emotions such as anger. Being hypervigilant, i.e. nearly always in an anxious, aroused state.	Difficulties in regulating emotions may be an indicator of cognitive impairment, previous trauma or abuse.	Help them use alternate strategies when challenged or frustrated, such as taking time to respond or taking deep breaths. Use appropriate trauma-informed practice strategies when working with all clients. Recognise that the behaviour may have been useful prior to the program, but work towards new strategies.

Source: Developed by the Complex Needs Resource Advisory Group

The spiral of negativity

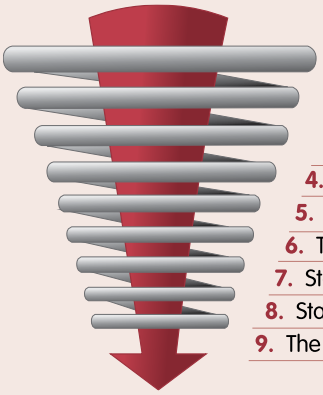
The 'spiral of negativity' was identified in care staff working in residential settings with older people who had an alcohol related brain injury (ABRI). It refers to the impact of negative perceptions, views and labelling of challenging behaviours on both the client and the caregiver in a service setting (Smith 2006, in Rota-Bartelink 2012) and can occur in any care giving situation.

If staff don't have the appropriate knowledge and skills required, they may perceive the way a person with complex needs communicates or behaves as personally hurtful or offensive, and may behave negatively (subtly or overtly) towards the person. For example, staff may tell colleagues the person is 'unappreciative' or 'manipulative', or may simply avoid contact with the person.

By recognising that negative perceptions, views and labelling of people with complex needs contribute to developing a cycle of mutual distress (the client continues to have unmet needs that cause underlying stress impacting on their treatment, and the worker also suffers from anger, resentment, ineffectiveness and frustration), drug and alcohol workers can become attuned to how their perceptions and reactions can have an effect on the treatment and care a person receives (Rota-Bartelink 2012).

Figure 4.3 shows the consequences of the downward spiral in a drug and alcohol treatment environment when perceived challenging behaviours are misunderstood, leading to staff frustration and client expulsion.

Figure 4.3: Downward spiral of negativity



1. The person living with the complex needs is seen as 'difficult', 'hard to manage' or 'aggressive'.
2. Staff work with the person to change their behaviour.
3. If they're not successful, the person may be labelled as unmotivated, resistant to change, a 'pain', a problem, difficult and manipulative.
4. No new interventions are tried because the person is seen as the problem.
5. Staff 'cope' by imposing penalties on the person.
6. The person is not comforted or assisted, and behaviours become more intense.
7. Staff feel even more distressed and frustrated by the behaviours.
8. Staff 'cope' by exiting the person due to multiple penalties, or incompatibility with the service.
9. The person's behaviour continues and often intensifies; they may relapse.

CARE PLANNING AND CASE MANAGEMENT

Many drug and alcohol and community services use a variation of case management or care planning approaches. These approaches allow for "a process that coordinates the acquisition and delivery of services to meet individual client needs" (Marsh et al, 2007:55). As a case manager in a drug and alcohol setting you are not expected to provide all the necessary services to support a person's needs, but you are expected to work with staff from appropriate agencies to provide holistic care.

Care planning and case management is an effective approach to working with clients with complex needs. Case management may at times require a high level of coordination with external services, depending on the individual's needs. Having close partnerships with relevant service providers will assist you in facilitating this process.

Your case management approach when working with clients with complex needs may require a more proactive or assertive approach to maintain client engagement. Both approaches draw significantly from the strength-based model of care and have been shown to be highly beneficial in mental health service provision.

A **proactive** style of case management promotes strong client engagement and close follow-up of new or fragile clients (Mental Health Services 2008). This includes people who have complex needs and people who shift between the stages of change in alcohol or drug treatment.

An **assertive** approach to case management focuses on ensuring the person doesn't 'fall through the cracks' by providing service support but knowing when to stand back and give support when invited. The assertive approach supports not intervening so as to abuse a person's human rights, but not passively neglecting them either. This approach requires a good and often long-term relationship with the client that fosters engagement and collaboration (Mental Health Services 2008).

There are advantages and disadvantages to these approaches in terms of accountability, coordination of services and funding models for providing services. Whatever the approach your organisation uses, the following considerations, developed to inform case management for working with people with FASD (Gelb & Rutman 2011), are a useful guide for working with all clients:

- Establish a trusting relationship with the person.
- Establish close and frequent communication with them (e.g. check-ins and regularly scheduled meetings).
- Develop a care plan based on their goals, strengths and needs.
- Facilitate transportation for important appointments.
- Liaise with other service providers with consent.
- Assist the development of life skills and/or the person's participation in healthy, safe activities.
- Establish close communication with supportive significant others in the person's life.
- Advocate for improved communication among service providers, continuity of care and access to care/services.

For further guidance on case management and case planning, see the following resources on the CD-Rom:

- *A Counsellor's Guide to Working with Alcohol and Drug Users* (Marsh et al 2007)
- *The Multiple and Complex Needs Initiative: Care Plan Coordination* (MACNI 2005)
- *Resource Manual: Assertive Case Management A Proactive Approach* (Mental Health Services 2008)

Case management for a person with FASD

People with FASD learn and behave differently. They are usually expected to change and adapt to the world, when in fact they can't change. Changes to the environment (both physical and social) should be considered to better support a person with FASD. Additionally, a change to more appropriate assumptions and expectations will create a better working/living/learning environment and produce successes instead of failures (Sood et al 2001).

If FASD is referenced in previous documentation or suspected, then treatment planning needs to reflect the adjustments, strategies and interventions that might be made in support of the person, examples of which are provided in Table 4.2. Similar adjustments may be useful for a person with another form of mild cognitive impairment.

Table 4.2: Examples of adjustments for FASD-related problems

PROBLEM	REASON FOR PROBLEM	ADJUSTMENTS
Not remembering to attend appointments	Poor short-term memory. Easily distracted.	Provide reminders via SMS, phone, email. Enlist friends and family members as reminders. Facilitate transport and/or accompany the client to appointments.
Issues when participating in programs	People with FASD think differently and have usually felt like 'failures' at school and in previous programs. Because of this they'll often have difficulty participating in a program where it's likely these issues will crop up again.	Provide programs that are suitable for a client with a cognitive impairment.
Nothing is making a difference	Inappropriate strategies, communication and/or intervention model for a person with an organic brain-based disability.	Strategies must be appropriate for a cognitive impairment. Workers need to consider that the person may be unable to work independently as planning and organising can be very difficult for a person with FASD. Therapeutic interventions such as cognitive behaviour therapy may be effective. Spoken communication: Make sure language is concrete – don't use idioms or jargon (e.g. 'bitten off more than you can chew' may be interpreted literally). Written communication: Make sure any documents, reading material or resources have lots of white space and contain only one point at a time.

Source: rffada (2012).

COUNSELLING

Counsellors in drug and alcohol settings work from a variety of models. When counselling people with cognitive impairment, it's essential you have strategies to tailor sessions to their needs. A person requires numerous cognitive functions (verbal skills, memory, attention, problem-solving and abstract reasoning) to benefit from the many strategies used in drug and alcohol counselling (Teichner et al 2002 in Marsh et al 2007b).

If the person's level of cognitive functioning is not taken into account, they'll experience poorer treatment outcomes. For people with attention/concentration difficulties, Aharonovich et al (2003) recommend shortening the length of sessions and frequently rehearsing session content and feedback with the client (Marsh et al 2007b). Modifying content to include more concrete language and offering greater counselling support to assist the person in identifying and changing problematic beliefs and thought patterns are essential.

Similarly, narrative techniques that require a high degree of verbal competency and comprehension will need to be modified to include simplified language and diagrams or pictorial representations. Motivational interviewing has been highlighted by a number of authors as a particularly useful technique in working with people with complex needs (Taggart et al 2008; Gelb & Rutman 2011).

> **"... it is important for counsellors to consider the impact of cognitive deficits upon client engagement behaviours (e.g. irregular attendance, non-compliance with homework completion) rather than automatically assuming these behaviours are the consequence of more typically salient explanations (e.g. resistance, ambivalence to change etc) ... (Marsh et al 2007b:45)."**

Cognitive behaviour therapy and cognitive impairment

Evidence suggests that people with ABI or another cognitive impairment are more likely to display maladaptive coping styles due to impaired executive functioning (Arundine 2009). Cognitive behaviour therapy (CBT) has been suggested as an appropriate therapeutic intervention for people with ABI or other cognitive impairment because of its structured format, flexibility and extensive range of therapeutic techniques that can be employed and potentially adapted (Arundine 2009; Kahn-Bourne & Brown 2003).

The following list of techniques, as described by Kahn-Bourne and Brown (2003), may help in delivering CBT to people with an ABI or cognitive impairment:

- Use memory aids such as written notes, cue cards, digital recorders or audiotapes
- Shorten the length of individual sessions
- Increase the frequency of sessions
- Involve a family member or support person to help remind or reinforce therapy strategies and to assist with work outside of the counselling session
- Use techniques such as summarising, or even agreeing on hand signals, to refocus clients.

No matter what counselling technique you use, it's important to remember that non-compliance with homework, being late or not attending sessions does not automatically translate into a person being ambivalent or unmotivated. Rather, this may be due to the impact of their cognitive deficits.

For further information consider talking to a specialist service such as the Brain Injury Association NSW about how to adapt CBT when a cognitive impairment has been identified or is suspected. Contact details can be found in *Chapter 7: Further Resources*.

GROUP WORK

A key consideration when facilitating a group that includes people with complex needs is that group situations are often overwhelming. This can be due to the level of information provided in a group, and the depth and speed of discussion. Other factors which may contribute to this include communication barriers, tiredness and negative past experiences of group work or sharing personal information.

A person with complex needs may find any group or education-like setting confronting. People who had difficulty at school may have had negative group experiences, resulting in shame and humiliation, and so may become anxious about participating in groups as it may lead to failure or embarrassment.

A person with a cognitive impairment may have difficulties in understanding the subtleties in communication in a group setting. For example, they may interrupt at inappropriate times, such as a powerful silent moment after somebody has shared some information. Making these subtle communication messages explicit in a non-confronting way is a useful starting point.

GROUP WORK TIPS

To facilitate understanding:

- Recap on the previous session
- Repeat the group rules at each session
- Repeat key questions and ideas
- Check regularly for understanding.

To build a supportive group culture:

- Let people know from the start that groups are hard work for some people
- Provide positive feedback for people who are struggling but making some attempts at participation
- Make explicit that lots of people feel like they're going to say the wrong thing, but that group work is, instead of a test of knowledge, a way of learning and growing together
- Allow people to express themselves in the way they're most comfortable with
- Recognise that, although a person may not seem engaged, they may still be taking the information in and participating at their level.

For session duration and amount of material covered:

- Take short breaks to improve people's attention and concentration
- Cover no more than two concepts in each session
- If possible, limit the duration of group sessions and introduce strategies to extend the learning experience outside the session – preferably one on one.

Additional group work strategies to support understanding and participation include:

- Using physical and visual activities
- Providing revision sessions outside of the group session
- Letting people use their own terminology to assist in understanding concepts
- Writing strategies on (laminated) cards that people can take with them
- Checking in with people one on one after the group to gauge their understanding and the level of support they require.

People who have been in prison may also find a therapeutic group environment difficult due to their experience of the prison environment, where sharing intimate information with others can be dangerous. Learning to trust others and trust the environment will take time. Allowing people to take time to feel safe and build trust in the group environment is an important aspect of managing this. It may take a few sessions before some people feel comfortable to participate in group situations.

Tiredness is a common challenge when working in drug and alcohol settings. It may result from the intense nature of participating in a rehabilitation treatment setting, or it may be a feature of a cognitive impairment. Taking regular short breaks (in groups, counselling and casework sessions) and allowing people the recovery time they need to be able to concentrate properly is important.

Checking in one on one with individuals after each group session will give you, as a group facilitator or case manager, the chance to check for understanding, clarify any aspects of the session that may have been misunderstood, and provide positive feedback on group participation.

Some people with cognitive impairment such as FASD may not understand the confidentiality and privacy obligations of working in a group. It's important to reiterate confidentiality and privacy at each group session. If a person is disregarding the privacy and confidentiality of others when outside of the group, don't assume this is in malice. Check they understand the concepts of privacy and confidentiality, as they may not fully understand the consequences of their actions. Work with them to implement strategies to help them maintain the confidentiality of others.

See the CD-Rom for an example and case study of modifying group work in a correctional setting for people with a cognitive impairment.

PROGRAM PARTICIPATION

Across both individual and group-based components of a drug and alcohol program, there are a number of practice tips that will increase the engagement and participation of clients with complex needs:

- Use aids to help people with low literacy. Use a digital recorder or voice recognition software installed on a computer instead of a journal. Include pictures with homework that people can use to explain their thoughts to the worker/group, instead of written content only.
- Change activities frequently to support those people who have short attention spans or who are easily distracted.
- Use strategies that have lower literacy demands, such as those involving art and music.
- Use movement-based activities, including outdoor activities such as walking and other forms of exercise.
- Make sure the physical environment is not cluttered or overstimulating.
- Explicitly teach generalisations. Don't assume a lesson learned or information applied in one context will automatically transfer to another.
- Implement a mentoring or buddy system to help people participate in the program.

Continually reflecting on your practice and regularly seeking client feedback will ensure you develop a strong rapport with clients and maximise their participation in program activities. Don't assume people know what interventions involve or what the terminology means. Take the time to explain what the interventions will involve, whether they will be one on one or group work, how frequent they will be, and what the expectations are during the session.

Remember that counselling, case management and group work are all abstract concepts. This means that clients who've had little or no previous service contact, those who have complex needs and those who come from CALD backgrounds may not know what they mean in the context of a drug and alcohol service.

For further information see *Chapter 6: Making Your Service Complex Capable* for examples of how drug and alcohol services have implemented changes like these at an organisational level.

Visit The Lyndon Community's website, www.lyndoncommunity.org.au/research-training/ to access a training package developed to support their drug and alcohol workers to work with complex needs clients.

SUPPORTING CRIMINAL JUSTICE CLIENTS IN YOUR SERVICE

There's a range of practice considerations that will help your service to work better with criminal justice clients. People who've been in prison are essentially no different to other clients and present with a similar range of issues, but with some specific considerations to take into account.

The transition from prison to a drug and alcohol residential treatment setting can present challenges for the client and impact on staff and other clients in the service. These transitional issues stem from the institutionalisation experienced by people while in prison, and can result in behaviours that appear to be in direct conflict with the behaviours you expect in a drug and alcohol program. This has been identified as a 'culture clash' between prison and the treatment service.

The key is to understand the impact of 'doing time' on a person's behaviour and then make small adjustments in your practice. By acknowledging the differences between the two environments, you can build emotional safety and help the client make the cultural shift. The challenge for workers is not to make quick assumptions that a person is unmotivated, non-compliant and unable to change their prison behaviour.

Figure 4.4 highlights the differences in behavioural expectations and cultural norms in a prison setting versus a drug and alcohol treatment setting. It explains the possible consequences of these differences and offers strategies to support a person to remain in treatment.

For detailed information on what you need to know about criminal justice clients see *Chapter 3: Criminal Justice Contact – What You Need to Know*.

Figure 4.4: The effects of the prison/rehab culture clash

PRISON	REHAB
POWER AND CONTROL	
Custodial power is ultimate.	Staff have the power to determine if a person has access to, and can remain in, a program.
Information is held by staff that can be used against the person at any time.	Information is collected by staff and informs decision-making. Processes may not seem transparent to clients.
Information is power and is traded among inmates and officers for control over others.	Clients are expected to share information about themselves and their feelings with staff and other clients.
Survival requires outward compliance, internal withdrawal and emotional shutdown.	Being able to remain in a program requires outward compliance, emotional openness and ongoing participation.
VALUES AND BELIEFS	
Do not pass on information to staff about another person under any circumstances. This is termed 'dogging' and the penalty can be serious injury or death.	Peer support is a vital part of the treatment process. Clients help other clients by telling staff if other clients are going to use, or break, agency rules in some way. Not doing so may result in sanctions or discharge for the client who has not spoken up.
Do not trust prison staff; they do not care about prisoners.	Trust service staff; they care about clients' wellbeing. Participate in the program, which is designed to help clients.
Keep your head down and do whatever you are told, whether you agree or not.	Openness and communication are vital components of program participation and success.

RESULTS OF THE CULTURE CLASH FOR CLIENTS

- Mistrustful and defensive with workers
- Lack of understanding of rules or expectations
- Fearful that information will be used against them
- Difficulty or inability to participate in group activities
- Ostracised by other clients in the service
- A perceived lack of motivation and/or commitment to the program
- Difficulty in adjusting to routines, structure and rules
- May be asked to leave at an early stage of treatment.

HOW TO SUPPORT CLIENTS EXPERIENCING THE CULTURE CLASH

- **Motivation.** Be conscious of how the cultural clash can be interpreted as lack of motivation by the client to participate in the program rather than the process of adjustment to a setting with different expectations and rules.
- **Time.** Allow the client the time and support to make the cultural shift and take time to build engagement and rapport with the client.
- **Acknowledge.** Identify and acknowledge the difference in environments with the person, e.g. the difficulties in being able to share personal information or stick to rules which require people to tell staff when another client is breaking rules.
- **Emotional Safety.** Support the client to feel safe to share personal information in the program.

Source: Adapted from CRC & NADA (2011)

Tips for addressing barriers to working with people who've been in prison

Drug and alcohol workers have identified a range of barriers to providing services to people who've been in prison, barriers which can be understood in the context of the 'culture clash' – transitioning between the prison setting and the treatment setting. Most of these barriers can be overcome with time and support. Tips on how to address these barriers are given in Table 4.3 below.

Table 4.3: Addressing barriers to working with people who've been in prison

TIPS FOR ADDRESSING BARRIERS TO WORKING WITH PEOPLE WHO'VE BEEN IN PRISON		
	BARRIER TO TREATMENT	**TIPS FOR CLIENT SUPPORT**
Pacing	A typical response to being in a confined space and the need for exercise.	Often people are unaware they're pacing and are prepared to stop when asked; they may need to be reminded a few times. Use the opportunity to walk and talk with the client. Suggest they take a walk outside to reduce excess energy and clear their minds.
Withholding emotions	A survival mechanism in prison is to be outwardly compliant while internally withdrawing and shutting down emotionally. People who've been in prison may take longer than others to feel comfortable expressing emotions during a program, particularly in group work and similar situations.	Acknowledge with the person one-to-one (not in a group setting) about why they appear to be not participating. Letting them know you understand and will support them to feel safe and give them time to adjust. Avoid misinterpreting this behaviour as a perceived lack of motivation to participate in the program. Building rapport and engagement will help the person feel emotionally safe.
Reluctant to share personal information	In prison, other people use a person's personal information against them. Information is power and is traded among inmates and officers for control over others. Divulging personal information makes a person vulnerable to this abuse and at times places the person and their family at risk. To stay safe, people do not share personal information.	Acknowledge with the person one-to-one (not in a group setting) the difficulty they may be having in sharing information due to their experience of being in prison. Give them time to adjust. Avoid misinterpreting this behaviour as a perceived lack of motivation to participate in the program. Building solid engagement and rapport and acknowledging the difference in expectations of the prison setting to the treatment setting will help the person feel emotionally safe and secure to divulge personal information. Clearly identifying privacy and confidentiality rules within the service can help a person feel more confident in sharing personal information. State how any information a person discloses about them or their family will be used, why personal information is needed by the service, who will have access to it and where it will be kept.
Being overwhelmed by the program's expectations	People in prison have a lot of time to themselves in their cells – approximately 20 hours a day. Participating in a treatment program and having to be part of group work, follow rosters and having other responsibilities can initially be overwhelming.	Be aware that the program's expectations can be overwhelming, and acknowledge this with the person. Allowing people time to adjust to the increase in activities and requirements to be fully participate will support them to remain in treatment.

Table 4.3 continued

TIPS FOR ADDRESSING BARRIERS TO WORKING WITH PEOPLE WHO'VE BEEN IN PRISON		
	BARRIER TO TREATMENT	**WORKER TIPS FOR CLIENT SUPPORT**
Not passing on information about other clients	In prison, you don't pass on information to staff about another person under any circumstances. This is considered the worst betrayal. People who are thought to be a 'dog' in prison can be seriously injured or killed.	In a treatment setting, peer support is a vital part of treatment. People are asked to help others by informing staff if someone is going to use drugs or break service rules in some other way. Support a client by acknowledging the different environments and clearly explaining the benefits of the peer support systems in place. Letting them know you understand will support them to feel safe and give them time to adjust. It may be worthwhile discussing these issues in a group setting and allowing people who have reported or been reported on by another person the opportunity to discuss the positives and negatives of the system.
Having restricted family contact	Prisons usually allow frequent family phone contact and visits. When a person's participating in a treatment program, family contact can be more restricted (e.g. having an eligibility wait time) and this can be distressing. Being unable to be in contact with their family when in the community, can feel like a further punishment or sanction and can be confusing and frustrating. A person's family may be geographically closer now than when the person was in prison (they may have been unable to visit because of the prison's location and lack of transport) and restrictions on contact when they are now so close can be difficult, it places continuing treatment at risk.	Recognise that people who've been to prison may be used to having more contact with their family and be aware of the emotional impact and possible confusion of this restriction in a community setting. Your service should consider developing family-inclusive practice strategies and talk with the person about options to include family in their treatment. If restrictions on family contact are a part of the treatment service, you need to clearly explain the reasons behind this to the person and the family in order to prevent the feeling of continued punishment post release and to reduce distress levels. The NADA toolkit *Tools for Change: A New Way of Working with Families and Carers* (NADA 2009) has a range of information which can help drug and alcohol services implement family-inclusive practice strategies.
Current legal concerns	Having a current or outstanding legal concern can often exclude someone from accessing a drug and alcohol residential treatment service. If the person does enter a service with legal concerns, they may be distressed, anxious or distracted as they wait for important advice from their legal service.	Talk to the person about their legal concerns and what you can do to support them. External services may be able to provide legal advice and/or court support when your service is unable to assist. Sometimes just making or receiving a phone call from their lawyer can greatly reduce a person's stress. Acknowledging and addressing these issues can go a long way to helping them feel able to remain and participate fully in treatment. **For information** on providing court support see *Supporting Your Client in Court: Tips for Drug and Alcohol Workers*.

ASSERTIVE OUTREACH AND AFTERCARE

Post-treatment outreach and aftercare services benefit all drug and alcohol clients. They provide the opportunity for transitional support back into the community and to consolidate skills learnt in the treatment setting, including relapse prevention, problem-solving, harm-reduction and self-help skills. People with complex needs have an increased chance of experiencing setbacks, so post-treatment follow-up can be key to helping them maintain healthy treatment outcomes.

Best practice indicates that people who participate in follow-up or aftercare after exiting a service have better long-term outcomes. Structured aftercare programs can help provide additional support for people during the transition from treatment into the community. Assertive follow-up for those who miss appointments can help by providing the opportunity to reschedule, to identify and discuss any problems, and to remain engaged.

People with complex needs such as a cognitive impairment may require more assertive aftercare service provision. Service-directed follow-up can support the person to remain engaged. This may require a person keeping a diary, receiving reminders via phone, and having transport available to get them to their aftercare appointments.

Services that can't provide aftercare or outreach support should refer people with complex needs to other service providers post treatment. When supporting people with complex needs to make this transition, allow time to take them to the new service and have transitional meetings, as people with complex needs may need extra time to feel comfortable with different or multiple service providers. Family, carers or other support people in the person's life should be involved in aftercare planning and treatment where possible.

REFERRALS

As noted above, when working with a person with complex needs you may need to refer them to another service. Recent research suggests that successful engagement with appropriate services largely depends on the person's capacity to navigate the sector, recognise when interventions are not appropriate for their needs, and find more effective services (Flaherty et al 2010). Referrals by workers, and the referral process, therefore, can be particularly influential in facilitating the person's engagement and retention with appropriate care.

Referrals may occur at the initial assessment stage when you and the person determine that another service may be more effective in meeting their needs. It may be while the person is participating in your program and needs specialist support, or it may be at the end of your program as part of their aftercare plan to meet their ongoing needs.

While many people may only be given a service name and number, i.e. a 'cold' referral, "the research suggests that people with complex needs may require more intensive support" (Clarke & Forrell 2007) – in other words, a 'warm' referral.

Cold and warm referrals

Referrals can be categorised as either 'cold' or 'warm':

> 'cold referral' [involves] providing information about another agency or service so that the client can contact them [while a] 'warm referral' involves contacting another service on the client's behalf and may also involve writing a report or case history on the client for the legal service and/or attending the service with the client. (Clarke & Forell 2007)

Turn cold referrals into warm referrals for people with complex needs by:

- Speaking directly to the service you are referring the person to and checking it's appropriate for them
- Introducing yourself and the person to the referring agency and providing a verbal and/or written handover (with the person's consent)
- Developing a referral pathways list for your service that identifies and shares useful contacts
- Developing shared assessment or referral tools and processes for services that you regularly refer to (and those that regularly refer to you)
- Setting up joint meetings with the person and the new service for initial appointments
- Following up with the person to see how the referral is working out
- Getting support from colleagues to help identify appropriate services for referrals in particular locations or for specific issues.

CD-Rom resources

- *Referral Pathways Template* (NADA 2013)
- *A Counsellor's Guide to Working with Alcohol and Drug Users* (Marsh et al 2007)

WORKER WELLBEING

Ensuring your own wellbeing is crucial to helping reduce stress and avoid burnout. It can be particularly important when working with an increase in numbers of people who have more complex or challenging needs. Your wellbeing can be maintained through:

- Organisational support
- Supervision
- Continued professional development
- Peer support
- Mentoring
- Reflective practice, and
- Self-care strategies.

The key consideration when working with people with complex needs is to remember not to personalise challenging or difficult behaviour, and to externalise the possible functions of their behaviour. Exploring professional development opportunities to support working with specific complex needs issues will increase your confidence, skills and capacity – and support your wellbeing.

For more information on systems of workplace support see *Chapter 6: Making Your Service Complex Capable*.

A Counsellor's Guide to Working with Alcohol and Drug Users (Marsh et al 2007) provides a range of information and tips for clinical supervision and stress and burnout.

For more information on worker wellbeing in drug and alcohol services see the National Centre for Education and Training of Addictions (NCETA) *Indigenous Worker Wellbeing Kit and Workforce Development Tips* (particularly Chapter 13: Worker Wellbeing).

TRAINING AND EDUCATION

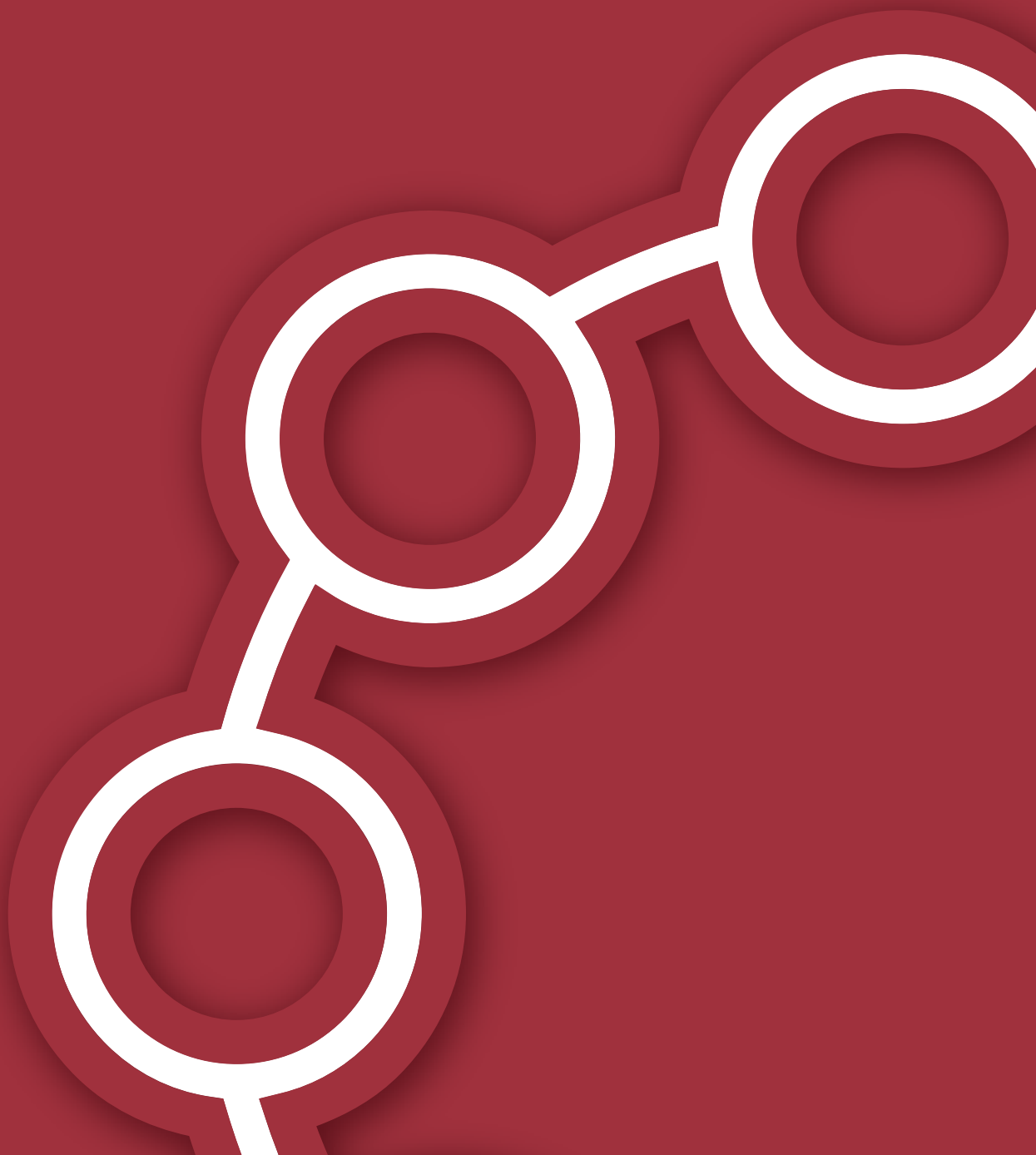
Training and education are not just about learning new skills and gaining knowledge. They allow you to build confidence in your current skills, increase your levels of empathy and understanding, and demystify common beliefs and misconceptions.

When working with people with complex needs, taking opportunities to learn about ABI, for example, may not only help build your skills in identifying common indicators of an ABI but also help identify the core skills you use in everyday work that can be directly transferred and/or adapted in working with a person with an ABI.

A range of training options are available for working with clients with complex needs. For a list of organisations providing training services in complex needs see *Chapter 7: Further Resources*; information on training providers is also available on the NADA online Training Directory at www.nada.org.au.

For more information on training and implementing organisational change, see *Chapter 6: Making Your Service Complex Capable*.

CHAPTER 5
Screening and Assessment for Cognitive Impairment



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Screening and Assessment for Cognitive Impairment

Key points

- Consider what benefit screening and assessment will have for your client.
- Cognitive screening questionnaires and tests can help identify signs of cognitive impairment.
- Identifying indicators of cognitive impairment can help you plan and adapt care and support services, and may indicate if further assessment would be beneficial.
- Functional assessments help identify the level of support, supervision and resources a person needs.
- It's not always practical or necessary to have a person who you think may have cognitive impairment referred to a neuropsychologist for a full neuropsychological evaluation.

This chapter provides information on screening and assessment tools for cognitive impairment that can be used in drug and alcohol service settings and considers a range of issues that may affect the screening and assessment of complex needs. At the end of the chapter you'll also find a brief guide to cognitive impairment screening and assessment tools that covers the time required to administer the tool, cost to your service and availability in community languages. A print-friendly version of the guide is also available on the CD-Rom.

CONSIDERING DIAGNOSIS

Many people in drug and alcohol services have some kind of cognitive impairment and spend their whole lives without a diagnosis. For some people with complex needs, a diagnosis can increase the barriers to the treatment and support they need.

People with complex needs need a service – and individuals within that service – to commit to working with them even if they present with issues that are primary or secondary to their drug and alcohol treatment needs. A drug and alcohol worker does not have to be an expert in all areas of complex need to be able to provide treatment to a person presenting with complex needs issues.

Although getting formal assessments and diagnoses can give you insight into particular kinds of behaviour, this is just one of many factors to consider. Formal assessments are costly, take time and are not always easy to access.

Looking at the whole story for a person with complex needs is the key to unlocking effective strategies to working with them. You can work effectively without a diagnosis by being aware of the potential signs of an underlying issue and adjusting your practice accordingly. In addition to working within a holistic framework, there are a range of brief screening questionnaires and assessment tools that can support you to support your clients effectively.

SCREENING

Using screening tools to identify if a person has indicators of cognitive impairment, such as difficulties in memory, attention, planning and organising activities, can provide information that can be used to plan and adapt care and support services. Screening tools can also indicate whether further assessment would be beneficial.

However, health professionals who can provide further assessment, such as neuropsychologists, may be difficult to access and you should consider exactly how any further assessment information would be useful to inform a person's care and support. Regardless of whether further assessment occurs, the person will still need support for their drug and alcohol use, in addition to a range of health and social factors such as mental and physical health, accommodation, parenting and family and social relationships (Alberta FASD Cross-Ministry Committee 2009).

ASSESSMENT

On entering a drug and alcohol treatment program, people should undergo an assessment interview and complete standardised assessment tools as appropriate. The fundamental purpose of this is to gather comprehensive information that can be used to build up an understanding of the person in order to develop an individualised care plan. The care plan should be reviewed at regular intervals to ensure it remains accurate and to monitor the person's progress towards identified goals.

Assessing cognitive, physical and emotional functioning is important for all clients, but is especially important when working with or identifying a person with complex needs. A functional assessment will provide detailed information on their practical skills and limitations and can inform the development of a personalised care plan.

When further information is needed to understand the deficits that may underlie the practical difficulties, referral for a neuropsychological assessment may be warranted. Neuropsychological and functional assessments are complementary: neuropsychosocial describes the underlying skills or deficits, and functional describes the practical effects of these. For example, a neuropsychological assessment may reveal a deficit in planning and a functional assessment may reveal that this deficit affects the person's ability to do their shopping or manage a budget.

CONDUCTING SCREENING AND ASSESSMENT

Expectations of assessment and delivering assessment results

Before starting the assessment, you need to have a clear understanding of what you, your service and your client expect of the process and the outcomes. This includes considering:

- The assessment process and specific assessment tools used – e.g. explain to the client if you're following a standard process that all clients go through or if a specific assessment is being used because of their presenting issues
- What the results of the assessment process may be and how you'll communicate the results to the client
- The impact of the results for the client and for their treatment
- The treatment or intervention options for the client following the assessment, including the criteria for accessing your drug and alcohol program, waiting lists and possible points of referral.

Client history

The personal, social and cultural history of a person is also important to consider (Morrison 2007). The areas outlined in Table 5.1 should be considered when conducting an assessment.

Table 5.1: Elements of personal, social and cultural history

PERSONAL, SOCIAL AND CULTURAL HISTORY	
Childhood	• Early relationships • Losses and traumatic experiences (including abuse) • Educational experiences
Adult life	• Current living situation • Sexual and relationship life and difficulties • Employment and financial support • Legal involvement
Family history	• Family breakdown and/or separation experiences • Family and cultural history that may contribute to experiences of intergenerational trauma • Family history of mental health and drug and alcohol issues

Considerations of culturally-specific events and experiences should inform assessment practices, such as the effects of intergenerational trauma on Indigenous people or the trauma associated with migrants, refugees and humanitarian entrants.

Consider cultural diversity and the stigma that may be associated with drug and alcohol issues, mental health issues and disability from different cultural perspectives. Additionally, when using standardised screening and assessment tools, ensure they're culturally sensitive and appropriate.

Resources for culturally appropriate screening and assessment include:

- *NSW Health Transcultural Assessment Checklist.*
- *Indigenous Risk Impact Screen (IRIS) and Brief Intervention*

Masking impairment

Some clients will not disclose they have low literacy skills or have an intellectual disability. They may try to hide the effects of their disability. This behaviour is often due to the stigma associated with having an intellectual disability, and the person may have experienced in the past that masking their disability will increase their chances of accessing a service.

The re-traumatising effects of screening and assessment

For some people, assessment will require sharing personal information that is emotionally distressing to recount. Additionally, many people will have tried to access multiple services in the past and have been through many different assessment processes. If the experience and outcomes of these assessment processes are largely negative for them, the process of assessment may produce feelings of stress and anxiety.

Therefore it is important to make sure the person feels that the environment is safe and supportive and that you remain calm, open and approachable (MHCC 2010). Workers conducting assessments should receive education and support on methods to sensitively address these issues and support a person who becomes distressed during the assessment process.

It can be difficult to gain access to previous assessment records for a client (such as previous psychological assessments), and barriers such as cost and time can impact upon a person seeking drug and alcohol treatment. Consider how information contained in past assessment records or a criminal record will be used to inform current treatment and care planning and whether obtaining this information is necessary. There may be ways to find out the information you need when assessing a person for a service without obtaining their previous records.

For information on considering a client's criminal record see the No Bars website: www.nobars.org.au/working-criminal-justice-clients.html

Validity and reliability of standardised screening and assessment tools

Most standardised drug and alcohol assessment tools have not been validated for use with people with an intellectual disability. Measures may also rely on retrospective memory, so the reliability of a person's recall may be an issue (Mendel & Hipkins 2002).

In relation to screening tools for cognitive impairment, the target group that many tools were designed for is older people with dementia, so they may not be suitable for use in drug and alcohol settings.

If you have concerns or questions about the validity and/or reliability of a screening tool you would like to use in your service, talk to a specialist. The Brain Injury Association NSW will be able to help you link to an appropriate specialist. Call BIA NSW on (02) 3868 5261 or free call 1800 802 840.

ASSESSING LEVELS OF FUNCTIONING

Functional assessments help identify the level of support, supervision and resources a person needs. They can be used to determine eligibility, care planning and assessing outcomes. Functional assessment practices consider differences in cognition, communication, sensory abilities (sight, hearing) and mobility.

Rather than simply asking people questions about their educational history or contact with disability-related support services, or whether they can perform a specific skill related to cognitive functioning, it's better to ask them to demonstrate a particular skill. In other words, you assess what a person 'does do', rather than what they 'can do'.

Functional assessment shifts the focus from the cause of disability or cognitive impairment to the impact of the condition. It's important to distinguish between capacity limitations that result directly from a person's health status and those limitations in which a person's participation is restricted due to environmental factors, including their physical environment and social circumstances (World Health Organization 2003).

The World Health Organization lists a number of activity and participation domains in its Checklist for International Classification of Functioning, Disability and Health (World Health Organization 2003) that should be considered in functional assessments.

A person's functioning in the context of their environment also needs to be considered, including available supports such as family, health and support services, medication, and aids for communication and memory.

Examples of functional assessment tools

The **I-CAN (Instrument for Classification and Assessment of Support Needs)** was developed to assess and classify the support needs of adults (16 years plus) with diverse disabilities in residential and respite settings, but its use has been expanded to mental health and rehabilitation programs. It emphasises support needs rather than deficits and considers health, wellbeing and activities of daily life. The assessment produces a written psychological report which can be used to inform, guide and improve the individual support plan. Where an intellectual disability has been identified, the tool takes approximately 70 minutes to administer, but applications in mental health settings show a shorter length of time, and Version 5 (currently under development) will include a brief version which is being trialled at 30 minutes.

Training in the I-CAN is required, and is available through the Centre for Disability Studies, University of Sydney (www.i-can.org.au). The cost to an organisation is $550 sign-up fee plus $22 per assessment.

The **Scales of Independent Behaviour – Revised (SIB-R)** is a comprehensive, norm-referenced assessment of adaptive and maladaptive behaviour designed to establish the type and amount of special assistance needed by people with cognitive disabilities. The short form acts as a brief screening tool and can be administered in 15-20 minutes, and an Individual Plan Recommendation provides a plan for and tracks an individual's support and service needs and goals. The tool, including the manual, interview handbook and 25 forms, can be purchased from ACER for $559 (www.shop.acer.edu.au).

Table 5.2: Functional assessment domains

DOMAIN	SKILLS
Learning and applying knowledge	• Watching • Listening • Reading • Writing • Arithmetic • Solving problems
Communication	• Receiving and producing spoken message • Receiving or producing non-verbal messages • Conversation
Domestic life and mobility	• Shopping • Preparing meals • Self-care/hygiene • Housework • Using transport • Simple exercise (taking stairs, walking short distances)
Interpersonal interactions and relationships	• Forming and maintaining intimate relationships • Forming and maintaining social relationships with family and friends • Relating to strangers

SCREENING QUESTIONNAIRES

Questionnaires may be used to screen for cognitive impairment. There are benefits to this approach in that these questionnaires:

- Can be incorporated into intake or routine assessment processes
- Are more naturalistic in their administration and therefore reduce the anxiety often associated with 'being tested'
- Are generally more familiar and acceptable to clients
- Generally take less time to complete than a cognitive screening test.

Examples of screening questionnaires

The **Cognitive Failures Questionnaire (CFQ)** (Broadbent et al 1982) has been well validated and used extensively as a self-report measure of cognitive impairment. It has good coverage of a wide variety of cognitive difficulties that people experience in everyday situations (e.g. forgetting whether you've turned off the stove or locked the door). There are 25 items that are rated on a 5-point Likert-type scale.

The **Acquired Brain Injury (ABI) Screening Tool** covers eight assessment domains that address the major risk factors for sustaining an ABI. These are history of alcohol use, drug use, assaults, loss of consciousness from motor vehicle accidents, suicide attempts, stroke, psychiatric conditions and amateur/professional boxing. The tool is available from arbias (www.arbias.org.au).

The **Neuropsychological Assessment Need Tool (NANT)** screens for cognitive impairment from a range of both acquired and non-acquired (e.g. developmental) causes. It comprises 31 yes/no items across six categories. A free online version is available at neurotreatment.com.au/neuropsychological-assessment-need-tool.aspx.

Qualifications, training and recommended administration

There is no minimum qualification required to administer these tools: the ABI specialist organisation arbias offers training in the use of the ABI Screening Tool, but training is not required for use of the CFQ or NANT. The recommended time for use of screening questionnaires is on entry to a program or service. It's recommended that all clients of a program or service are given a screening questionnaire.

COGNITIVE SCREENING TESTS

Due to the time required and financial costs of neuropsychological assessment, it's not always practical or necessary to have a person who is thought to have a cognitive impairment referred to a neuropsychologist for a full neuropsychological evaluation.

There's been a prolific development of cognitive screening tests since the middle of the 20th century due to recognised need to identify cognitive impairment, mainly for primary care clinicians and mainly for the purpose of assisting with the diagnosis of dementia in the elderly.

There are a number of **advantages** to using cognitive screening tests:

- They can identify those with cognitive impairment.
- They can identify, at a broad level, cognitive strengths and weaknesses.
- Due to their brevity and simplicity, they are relatively non-demanding for the client.
- They are portable.
- They can assist with management and/or treatment of cognitive impairment.
- They allow a tailored approach to treatment.
- They promote education of the client and their carer/family about their condition.
- Most require no specialised qualifications for administration and require little formal training for appropriate scoring and administration.
- They're not as time consuming, costly or imposing as a full neuropsychological assessment (administration time varies from 5 to 30 minutes).
- They help identify those in need of more detailed neuropsychological investigation.
- Objectivity and quantification allow for comparison between time points.
- They can be used to monitor improvement where this is expected (e.g. with abstinence) or decline where it is suspected (e.g. alcoholic dementia).

There are also **limitations** to using cognitive screening tests:

- Poor sensitivity (see 'psychometric properties') – they may miss some individuals with cognitive impairment.
- Poor specificity (see 'psychometric properties') – they may falsely detect cognitive impairment when there is none.
- Brevity usually compromises reliability.
- Incorrect administration and scoring can significantly skew results.
- Single items or domains are often not very reliable, so are not a good indicator of true strengths and weaknesses.
- Not all domains are assessed in screening tests (e.g. visual memory and executive functioning are not typically covered).
- They often miss non-verbal impairments as most measures are highly verbally loaded.
- They're not good at detecting impairment in previously high-functioning and/or well-educated people.

PSYCHOMETRIC PROPERTIES

The psychometric properties of a test refer to the test's reliability and validity. Reliability refers to the stability of test scores and includes test-retest reliability (the probability of getting the same or similar score at two points in time) and inter-rater reliability (the probability of two examiners independently arriving at the same score). Validity refers to whether a test measures what it's supposed to measure and includes face validity (whether the test appears to measure what it's supposed to) and criterion-related validity (whether the test performs similarly to a gold standard, such as neuropsychological assessment).

In general, the greater the length of a cognitive screening measure and the simpler the administration and scoring, the better the reliability. A valid test has high sensitivity (detects impairment when it's present) and specificity (detects normality when it's present). Generally, the greater the sensitivity the less the specificity, and vice-versa. Cognitive screening measures have lower sensitivity and specificity than neuropsychological assessment when it comes to detecting presence or absence of cognitive impairment.

- They may produce false positive errors in cases of those with:
  - Culturally and linguistically diverse background
  - Low education
  - Poor literacy
  - Low intellect, and
  - Poor motivation/lack of cooperation.
- There's limited generalisability beyond the population for which the tool was developed (e.g. if a tool was developed to detect impairment in dementia, it won't necessarily detect impairment in a drug and alcohol population).
- Lack of sensitivity to executive dysfunction – this is an important limitation because executive dysfunction is common in a range of conditions, including non-Alzheimer's dementias (e.g. vascular dementia, fronto-temporal dementia), traumatic brain injury, stroke, Parkinson's disease, schizophrenia, and alcohol and other drug related brain impairment.

Examples of cognitive screening tests

The following examples have been chosen to demonstrate variability in factors such as administration time, qualifications required, validation in drug and alcohol populations and cost/availability.

The **Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)** has excellent psychometric properties for a screening tool. It includes 12 subtests that factor into five domains: Immediate Memory, Visuo-spatial/Constructional, Language, Attention, and Delayed Memory. There is also a total score. It takes 30 minutes to administer. It includes comprehensive normative data from a large sample, allowing for valid and reliable documentation of cognitive strengths and weaknesses. Some studies have used the RBANS to specifically examine the effect on cognition from substance use disorders (e.g. Green et al 2010). Despite this tool being lengthier than most cognitive screening tools, executive functioning is not adequately sampled; it requires specific user qualifications (allied health or special education professional). The full kit costs in excess of $650 and is available from Pearson PsychCorp (www.pearsonpsychcorp.com.au).

The **Addenbrooke's Cognitive Examination – III (ACE-III)** comprises 19 brief subtests that make up five dimensions: Attention, Memory, Fluency, Language, and Visuo-spatial. It takes 15 minutes to administer. Although its predecessor, the ACE – Revised (ACE-R) was originally developed to detect mild cognitive impairment (a precursor to dementia) and rarer forms of dementia such as fronto-temporal dementia, it has shown utility in detecting cognitive impairment in other populations, such as traumatic brain injury (Gaber 2008). The ACE-III has comparable psychometric properties to the ACE-R, which are good for a test of this length. However, it has not been validated specifically in a drug and alcohol use disorder population. There are no qualification restrictions for use of the test. Pending registration, it's available free of charge from www.neura.edu.au/frontier/research/test-downloads/.

The **Hayes Ability Screening Index (HASI)** is a brief, individually administered screening index of cognitive impairment for people between the age of 13 and late adulthood. The HASI was originally designed to support the identification of potential intellectual disability in criminal justice clients to assist in identifying when an individual may be vulnerable and indicate if further support or assessment is required, but the tool has been administered more broadly in the community sector as a screening tool for cognitive impairment. The tool is not culture or gender biased. It takes 5–10 minutes to administer and requires no minimum qualifications, though half-day training is advised. The HASI can be purchased from the University of Sydney Behavioural Sciences in Medicine Department (www.sydney.edu.au) at $215 for a complete set.

The **Montreal Cognitive Assessment (MoCA)** comprises eight domains: Visuo-spatial/Executive, Naming, Memory, Attention, Language, Abstraction, Delayed Recall, and Orientation. Administration time is 10 minutes. For a test of its brevity, its psychometric properties are very good. It's more sensitive than the Mini Mental Status Examination (MMSE) at detecting cognitive impairment, although it takes the same length of time to administer. Although the MoCA was originally developed to detect mild cognitive impairment, a precursor to dementia, its inclusion of items sensitive to frontal lobe (executive) impairment has made it attractive across a range of populations, on which it has been validated, including substance use disorders (Copersino et al 2009). There are no qualification restrictions for use of the test. It's available free of charge for non-commercial use from www.mocatest.org. This website also includes information about norms and cut-off scores.

Training

Although the ACE-III and MoCA do not require specific qualifications for users, familiarisation of the standard administration and scoring procedures is highly recommended. Two-to-three-hour training workshops for these measures are available (e.g. neurotraining.net.au).

The Lyndon Community, a large non-government drug and alcohol treatment service in regional NSW, incorporated the ACE-R into staff training in 2011. The in-house training workbook is available on their website for download at www.lyndoncommunity.org.au/research-training/publications-and-reports.

Consultation

Due to the brevity of the ACE-III and MoCA, these tools are particularly susceptible to non-specific variables that can potentially significantly skew test results. These include low mood state, reduced motivation, CALD status, history of learning disability and high education level. It's recommended that consultation be sought from a neuropsychologist to assist with interpretation of borderline or unusual results in these cases.

Optimal time to administer cognitive screening tests

In a drug and alcohol service, it's not valid to use these tools during periods of intoxication or withdrawal. As such, a rule of thumb of 2–3 weeks' abstinence is optimal. Furthermore, choosing a time of day when the client feels most alert and rested is important.

Tips when conducting an assessment with a person with cognitive impairment

- Conduct the assessment in person if possible.
- Be aware that a person may need to take breaks during the assessment.
- Address the person directly and use a tone of voice consistent with their age, e.g. speak to an adult as an adult.
- Invite the person to say if they're not sure what you mean, but be aware that, even if you do this, they may not disclose a lack of understanding. You should take responsibility for frequently checking the person's understanding by saying something like "Many people find this information difficult to understand, so can I check that I have explained it clearly?"
- Deal with one question, area or piece of information at a time. Also, 'signpost' when you're about to change conversation topic. For example, say "That's all I need to ask you about ABC. Now I'd like to talk to you about XYZ."
- Ask open questions and encourage the person to respond at their own pace; try not to rush a response or finish their sentences.
- Use plain, everyday language and short, clear sentences and try to minimise use of jargon and abstract concepts.
- Have pictures and visual representations handy to aid in the explanation of assessment questions. If the person agrees they will help, these can be used to aid explanation of concepts.
- People without high verbal skills rely more on body language, so you should be aware of their non-verbal communication such as facial expressions, gesture and posture.
- With the consent of the person, it may be appropriate to involve a family member, carer or support worker during the assessment process.

Source: IDRS (2009); IDRS (2004); Centre for Developmental Disability Health Victoria (2008).

A comprehensive review of cognitive screening tools is beyond the scope of this chapter. For recent reviews see Cullen et al (2007) and Ismail et al (2010).

FORMAL ASSESSMENT OF COGNITION – NEUROPSYCHOLOGICAL ASSESSMENT

Clinical neuropsychological assessment is the gold standard with respect to formally evaluating and documenting the nature and severity of cognitive impairment, together with the relevant behavioural, emotional and psychosocial factors that may be contributing to a clinical profile.

A neuropsychologist is a psychologist who has completed specialist training in acquired brain injury. Neuropsychologists diagnose brain injury and can provide recommendations for ongoing care and rehabilitation needs (arbias 2011).

Contact the Brain Injury Association (BIA) NSW for information on how to access a neuropsychologist or assistance in accessing a neuropsychologist in NSW. BIA NSW also administers a brokerage program to support people to access neuropsychological services. Contact them on 1800 802 840 or visit www.biansw.org.au.

Formal neuropsychological assessment is very time consuming, with the typical assessment lasting 3–4 hours. Included in the assessment is a detailed clinical interview with the person and often, additionally, with a family member, carer or care worker. The clinical history from the interview and any available case notes, medical records or previous medical and psychological reports may assist the clinician to generate hypotheses about the potential causes of cognitive impairment.

The remainder of the assessment time is spent administering standardised tests and questionnaires that comprehensively sample all domains of cognition. The skill of the neuropsychologist is in bringing together the history, test results and client presentation to formulate an opinion about the cause and nature of their cognitive impairments. From this platform, the neuropsychologist can make recommendations about prognosis, treatment and management.

The average neuropsychological assessment involves administering a large number of separate tests (often over 20). Although most tests are multifactorial in what they assess, the following skills within each of the main domains are assessed in a standard neuropsychological assessment:

- Attention
  - Attention span
  - Focused attention
  - Sustained attention
  - Divided attention
  - Complex attention (e.g. working memory)
- Visuo-spatial skills
  - Basic visual and sensory perception and integration
  - Motor skills
  - Constructional skills
- Memory
  - Immediate memory
  - Delayed memory
  - Verbal memory
  - Visual memory
  - Encoding, storage and retrieval
- Executive functioning
  - Initiation/generativity
  - Mental flexibility
  - Planning/organisation
  - Abstract reasoning (verbal and visual)
  - Impulse control/inhibition
  - Problem-solving.

NEUROPSYCHOLOGICAL ASSESSMENT

Psychometric assessment involves test administration. Neuropsychological assessment involves test administration, behavioural observation and integration of available history.

It's often thought that neuropsychologists only administer tests and arrive at their conclusions based purely on test results. This is an inaccurate perspective, as many tests have inherent sources of error, meaning test variability is the norm. There's no single test that can rule in or out a diagnosis of cognitive impairment, because of the various factors that contribute to a test score. Neuropsychologists are trained in test interpretation to derive the greatest meaning from test scores in an individual's psychosocial context.

CASE STUDY: SAM

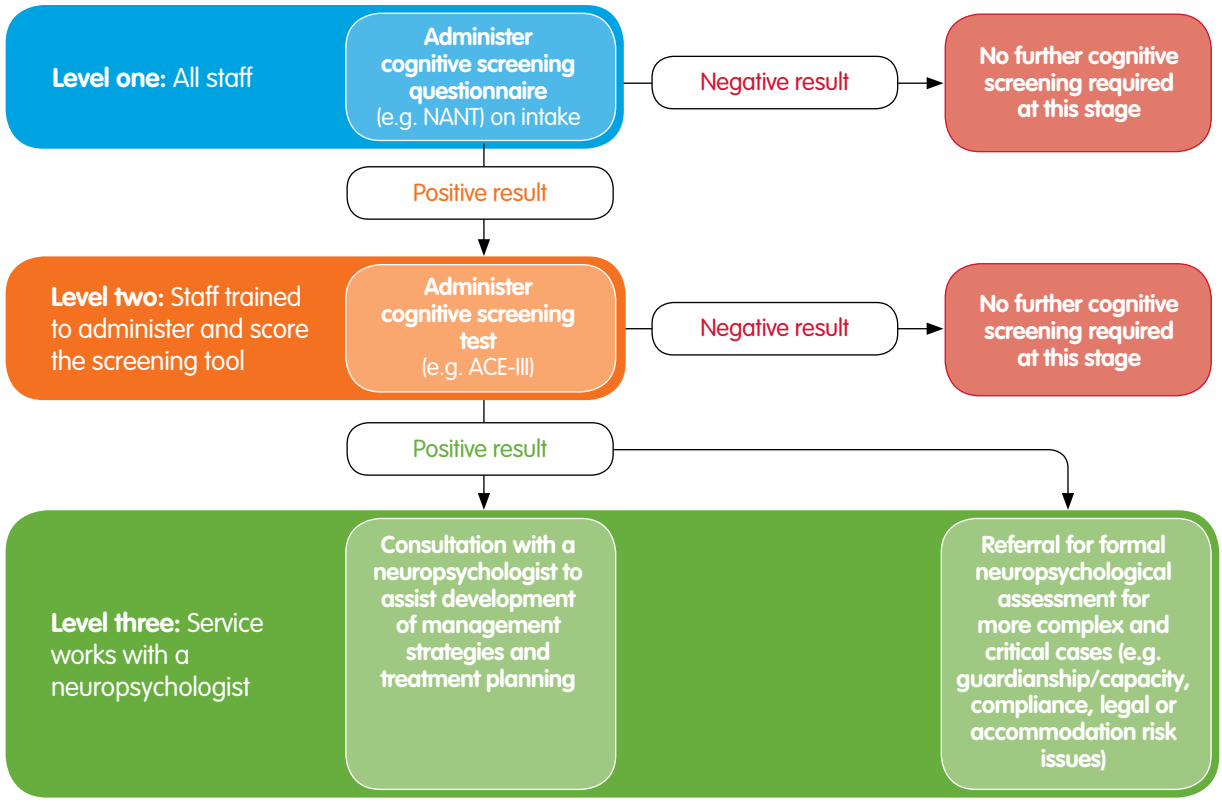
Sam was referred to ABC Drug and Alcohol Service. On intake he completed the Cognitive Failures Questionnaire, upon which he indicated difficulties such as losing his temper, forgetting where items are placed and becoming distracted with other things after starting a task. His total score was 80/100.

As such, the MoCA was administered and he scored 22/30. He experienced particular difficulty in the Visuo-spatial/Executive, Attention and Delayed Recall sections. There was a long waiting list for neuropsychological assessment but, based on phone consultation with a local neuropsychologist, a number of practical strategies were implemented at the service. These included minimisation of distractions, encouragement to work on only one thing at a time, establishing routine times for regular activities (e.g. shower, meals and appointments), maintenance of a tidy and well-organised environment and the provision of prompts and cues to aid recall.

When Sam was seen for his neuropsychological assessment three months later, he was found to demonstrate a cognitive profile consistent with moderate traumatic brain injury, which he had sustained in an assault five years earlier. Following neuropsychological assessment, Sam was given psychoeducation about the effects of the brain injury, and a range of cognitive compensatory strategies were suggested, modelled and employed. His case worker from ABC Drug and Alcohol Service sat in on the feedback session and was able to implement these strategies in the treatment setting and afterwards, when receiving follow-up in the community when working with Sam.

As a result, Sam was better able to consistently attend appointments, bring with him the required materials, understand the content of interventions (through assertively asking the speaker to repeat or re-explain new concepts in more concrete terms and with examples), and to complete the program. Sam was also given strategies to help manage escalations in anger. He and his case worker developed a non-verbal sign to indicate rising agitation, and Sam was able to walk away at these times and return when he felt more relaxed.

Figure 5.1: Screening pathways



PROPOSED SERVICE SCREENING PATHWAY

Various programs and services have used a three-tiered pathway to identify cognitive impairment and/or diagnose neurocognitive disorders (e.g. Robben et al 2010). Such a process is cost effective because only people with self-reported cognitive difficulties proceed to cognitive screening tests, and only those identified as impaired on cognitive screening tests proceed to full neuropsychological assessment if required. The process is shown in Figure 5.1.

The levels of this screening pathway and the screening and assessment tools implemented by your services will depend on a range of factors including program length, staff training.

For more information on considering screening and assessment implementation in your service see *Chapter 6: Making Your Service Complex Capable*. Also in Chapter 6, We Help Ourselves, a NGO drug and alcohol service in NSW and QLD implemented a screening and assessment for cognitive impairment in their service.

CD-Rom resources

- *Guide to Neuropsychological Assessments for Clients and Family Members* (arbias, Brain Foundation Victoria, Headway Victoria, 2005).
- *Brief Guide to Cognitive Impairment Screening and Assessment Tools* (NADA 2013)

THE DIAGNOSTIC FASD PROCESS

There are relatively few medical professionals in Australia currently diagnosing conditions falling under the umbrella of FASD. Due to the complexity and the range of dysfunction related to prenatal alcohol exposure, a multidisciplinary team is needed for accurate and comprehensive diagnosis and treatment recommendations. The assessment process begins with recognising the need for diagnosis and ends with implementing appropriate recommendations.

The core team may vary according to the specific context, but ideally it should consist of the following professionals:

- Coordinator for case management (e.g. nurse, social worker)
- Physician specifically trained in diagnosis
- Psychologist
- Occupational therapist
- Speech/language pathologist.

Additional members may include drug and alcohol counsellors, childcare workers, cultural interpreters, mental health workers, parents or caregivers, probation officers, psychiatrists, teachers, vocational counsellors, nurses, geneticists or dysmorphologists, neuropsychologists and family therapists. Due to the multidisciplinary nature of assessment and diagnosis, team members may be based in different geographic areas, so collaboration via telecommunications mechanisms may be necessary (Chudley et al 2005).

The Department of Health and Ageing has asked the FASD Collaboration, led by the Telethon Institute for Child Health Research, to prepare Australian clinical guidelines for diagnosing FASD. These guidelines should be available in 2013.

The Adult FASD Identification Tool has been developed by the Russell Family Fetal Alcohol Disorders Association (rffada). This is a short non-medical identification tool that provides information on a person's history, signs and symptoms that may indicate FASD. It's important to recognise that screening and assessment for FASD are emerging fields, and it's very difficult to make a definitive diagnosis of FASD in adulthood. Internationally, adult diagnosis of FASD requires the input of a multi-disciplinary team and may still not result in a definitive diagnosis (Gelb & Rutman 2011).

CD-Rom resources

- *FASD Adult Identification Tool* (rffada 2012)

A BRIEF GUIDE TO COGNITIVE IMPAIRMENT SCREENING AND ASSESSMENT TOOLS

This brief guide aims to provide a snapshot of the different types of screening and assessment tools for cognitive impairment, including information on the:

- Time required to administer the tool
- Cost of the tool to your service
- Qualifications required to administer the tool
- Availability in community languages.

Although none of the tools in this list were specifically validated for use with ATSI or CALD populations, careful use of these tools with these populations may still be valid. When unsure about the interpretation of results, it's always best to seek the opinion of a neuropsychologist.

This list is not exhaustive. The cost to services, training required and availability in community languages and validation of tools in CALD and/or Indigenous communities may change over time. Before selecting a tool for implementation in your service, consult a specialist to discuss your service needs. If you're concerned about which tool might best suit your client group, talk to a specialist. BIA NSW will be able to help you link to an appropriate specialist. Call BIA NSW on (02) 3868 5261 or free call 1800 802 840.

Name of tool	Type of tool	Time to administer	Cost to your service	Training required/ qualification required	Available in community languages
Cognitive Failures Questionnaire (CFQ)	Screening questionnaire[1]	5–10 mins	Free www.yorku.ca/rokada/psyctest/cogfail.pdf	No qualifications or specific training	No
Acquired Brain Injury (ABI) Screening Tool www.arbias.org.au	Screening questionnaire[1]	5 mins	Licensing agreement with arbias ($100 per annum)	No minimum qualification but training is required on the use of the tool	No
Neuropsychological Assessment Need Tool (NANT) www.neurotreatment.com.au	Screening questionnaire[1]	5–10 mins	http://neurotreatment.com.au/neuropsychological-assessment-need-tool.aspx	No qualifications or specific training	No
Hayes Ability Screening Index (HASI) http://sydney.edu.au/medicine/bsim/hasi/index.php	Screening questionnaire for intellectual disability[2]	5–10 mins	$215.20 for complete set	No particular qualifications or training required	CALD status is taken into account. The tool is available in Dutch, English and French (Canadian)
Scales of Independent Behaviour – Revised (SIB-R)	Assessment of adaptive and maladaptive behaviour	15–20 mins	Available from $559.00 (includes manual, interview book and 25 short forms) https://shop.acer.edu.au/acer-shop/group/SIB/13;jsessionid=5274462C341CA98D1429F2915BF55B9C	Available to professionals with accredited training in psychology, health sciences, counselling, special education, medicine and other specialist areas	Version available for use with the visually impaired

Name of tool	Type of tool	Time to administer	Cost to your service	Training required/ qualification required	Available in community languages
Instrument for the Classification and Assessment of Support Needs (I-CAN) www.i-can.org.au	Functional assessment of adults with diverse disabilities	70 mins	$550 sign-up fee plus $22 per assessment	Training is required (approx $2,000 per 20 staff)	No
Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) www.rbans.com	Screening test[2]	30 mins	$650 (from Pearson PsychCorp www.pearsonpsychcorp.com.au/productdetails/172)	Allied health or special education professional	Available in: Afrikaans, Bulgarian, Czech, English, Estonian, French, German, Greek, Italian, Korean, Polish, Russian, Spanish
Addenbrooke's Cognitive Examination-III (ACE-III)	Screening test[2]	15 mins	Free http://www.neura.edu.au/frontier/research/test-downloads/	No specific qualification.[3] Administration and scoring guide available at: www.neura.edu.au/frontier/research/test-downloads	No
Montreal Cognitive Assessment (MoCA) www.mocatest.org/	Screening test[2]	10 mins	Free for non-commercial use www.mocatest.org/pdf_files/test/MoCA-Test-English_7_1.pdf	No specific qualifications.[3] Administration and scoring guide available at: www.mocatest.org/pdf_files/instructions/MoCA-Instructions-English_2010.pdf	Available in: English (3 versions), Arabic, Afrikaans, Chinese, Czech, Croatian, Danish, Dutch, Estonian, Filipino, Finnish, French, German, Greek, Hebrew, Italian, Japanese, Korean, Persian, Polish, Portuguese, Russian, Serbian, Sinhalese, Slovak, Spanish. A version is available for use with the visually impaired
Abbreviated Neuropsychological Testing contact Advanced Neuropsychological Treatment Services www.neurotreatment.com.au	Brief neuropsychological testing[4]	1 hour face to face	$275 www.neurotreatment.com.au	Clinical neuropsychologist	CALD status is taken into account

Name of tool	Type of tool	Time to administer	Cost to your service	Training required/ qualification required	Available in community languages
Clinical neuropsychological assessment contact BIA NSW for a list of clinical neuropsychologists in your area www.biansw.org.au	Neuropsychological assessment	3–4 hours face to face	$600–$2,000 (varies depending on the case and the provider)	Clinical neuropsychologist	CALD status is taken into account

Notes

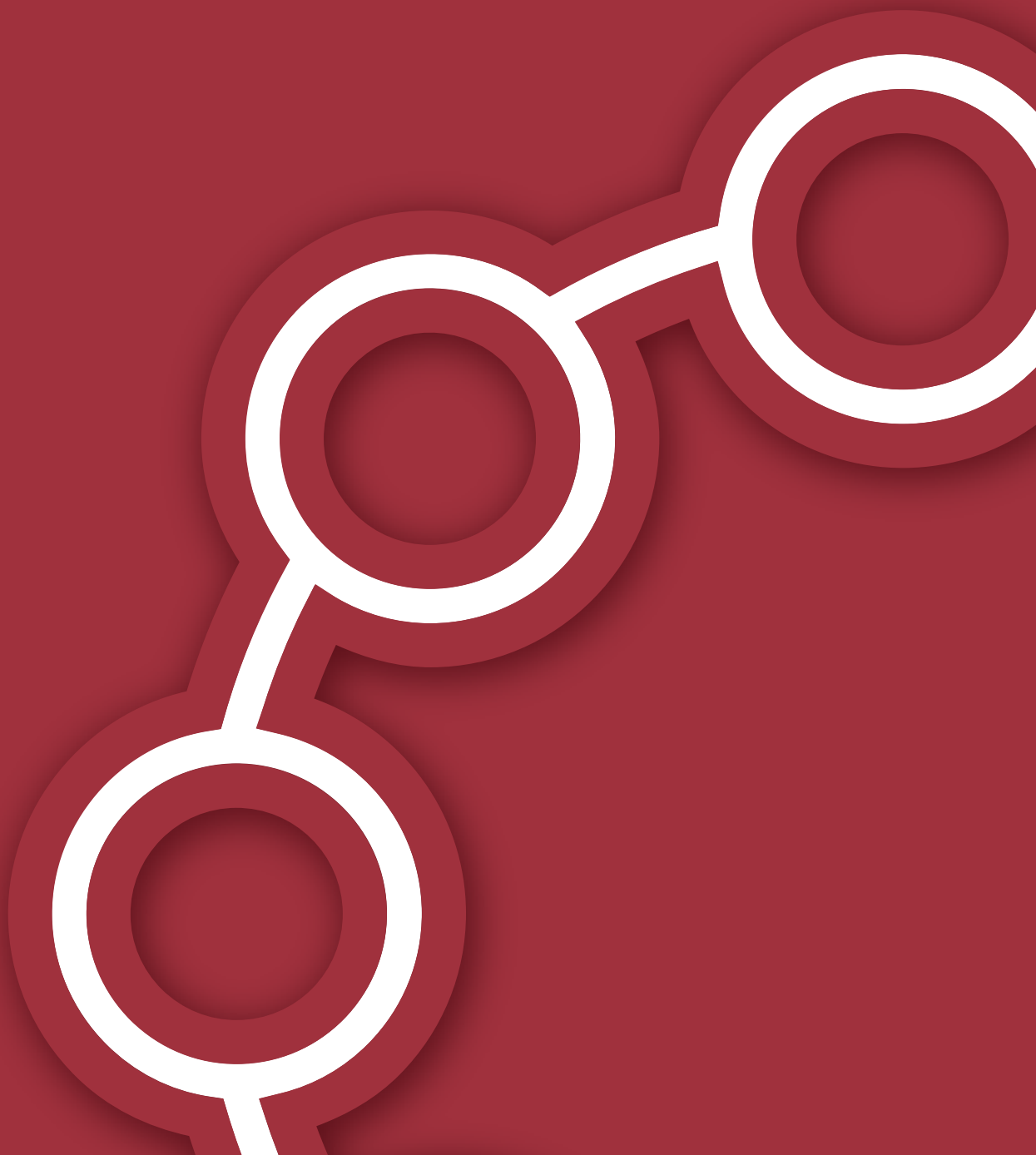
[1] **Screening questionnaires.** The recommended time for use of screening questionnaires is on entry to a program or service. It is recommended that all clients of a program or service are given a screening questionnaire.

[2] **Screening tests.** In a drug and alcohol service it is not valid to use these tools during periods of intoxication or withdrawal. As such, a rule of thumb of 2–3 weeks' abstinence is optimal. It is recommended to choose a time of day when the client feels most alert and rested.

[3] Although the ACE-III and MoCA do not require specific qualifications for users, familiarisation of administration and scoring is highly recommended; 2–3 hour workshops are conducted by Jamie Berry, Senior Clinical Neuropsychologist (www.neurotraining.net.au).

[4] Brief/abbreviated neurological testing may be possible where a comprehensive neuropsychological assessment is impractical or unaffordable. However, this is no substitute for a formal comprehensive neuropsychological assessment.

CHAPTER 6
Making Your Service Complex Capable



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Making Your Service Complex Capable

Key points

- A whole-of-organisation approach to change will ensure consistent practices across your service and improve outcomes for clients with complex needs.
- Small changes in organisational practice will go a long way to improving outcomes for clients with complex needs.
- Elements of organisational change to support complex needs clients can be achieved at minimal or no cost.
- Areas of organisational change to provide holistic support to clients with complex needs include:
  - Adapting policies and procedures
  - Having training and workplace support
  - Establishing and extending service partnerships.

This chapter discusses working with clients with complex needs from an organisational perspective. It covers workforce development, managing organisational change, communication and environmental considerations, specific areas of service practice change, workplace systems of support and worker wellbeing.

Also included in this chapter are practical examples and key learnings from NADA member drug and alcohol organisations that have successfully implemented change management processes to increase their capacity to work with people with complex needs.

WORKFORCE DEVELOPMENT AND CHANGE MANAGEMENT

Training and professional development

Ongoing training and education are a key component of any service's professional development and continuing quality improvement. Training can be used to build up individual and whole-of-staff skill sets. By including complex needs in your mandatory orientation and recurrent refresher training, you'll ensure both consistency and stability of service provision for all clients.

Training on particular complex needs issues will:

- Increase staff understanding, awareness and empathy when working with clients with complex needs
- Reduce the stigma and labelling associated with people with complex needs issues
- Improve staff communication techniques when working with people with complex needs
- Increase staff confidence in managing people with complex needs
- Increase staff skills for working with people with complex needs.

With a small amount of planning, you can implement an organisational staff training needs analysis that will assist to accurately gauge the training needs of individual staff and the organisation cognitive impairment and/or criminal justice.

Before and after training, measure the impact of training by implementing pre- and post-training staff surveys. The pre-training survey will identify specific areas to focus on in training, including identifying workers' self-reported level of knowledge, skills and confidence. The post-training survey will assess change in workers' knowledge, skills and confidence and help identify any further areas of training needed on the topic. You can reduce costs associated with training by:

- Sourcing and accessing free training, training grants and scholarships
- Using free online education and training tools
- Having systems in place for staff who attend training to feedback key learnings (e.g. by developing policy and procedures related to the topic area, providing a presentation and resources to staff in a staff meeting)
- Sourcing in-house training
- Developing training packages tailored to your service
- Partnering with other local organisations.

For a list of organisations that provide training see *Chapter 7: Further Resources*.

The Lyndon Community – Cognitive Impairment and Organisational Change

The Lyndon Community, a large drug and alcohol non-government service in regional NSW, implemented a staff training needs survey across all their program sites (an adapted version of the survey is included on the CD-Rom). At the same time, they screened all current service users for cognitive impairment using the ACE-R screening tool (this project was undertaken as part of the NADA Practice Enhancement Grant Program 2011–2012).

The results from both surveys strongly supported the need for Lyndon to address the management of clients with cognitive impairment across the organisation (Allan et al 2012).

The training needs analysis survey found that:

- The majority of staff believed few people in treatment at Lyndon had a cognitive impairment
- Staff had minimal or no training in recognising or screening for cognitive impairment
- Staff had no strategies to work with people with a cognitive impairment

The cognitive screening tool implementation found that:

- 40% of all current clients screened identified as having a possible mild cognitive impairment
- 12% of people screened identified possible moderate to severe cognitive impairment

These results were used to develop the Lyndon in-house training package *Working with Clients With Complex Needs – Cognitive Impairment – On-Site Training Workbook* for the use of all staff across every site and program.

This package is available for download on The Lyndon Community's website at www.lyndoncommunity.org.au/research-training/publications-and-reports.

For more information on The Lyndon Community's experience of implementing organisational change, see the article 'The prevalence of cognitive impairment in a rural in-patient substance misuse treatment programme' (Allan et al) in *Mental Health Substance Use*, Volume 5, Number 4, November 2012.

For guidance on developing a training needs assessment and staff professional development in the sector, see the *NCETA Workforce Development 'TIPS'* (Theory Into Practice Strategies)*: A Resource Kit for the Alcohol and Other Drugs Field* (particularly Chapter 9: Professional Development).

The following resources can be found on the CD-Rom to help your service take a whole-of-organisation training approach to complex needs:

- *Training Needs Analysis Template* (NADA 2013)
- *Complex Needs Pre-training Survey example* (NADA 2013)
- *Complex Needs Post-training Survey example* (NADA 2013)
- *Cognitive Impairment Survey* (Adapted from Questionnaire on Cognitive Impairment, The Lyndon Community, 2012)

Managing change

It's important to remember that, although training and education are crucial to increasing the capacity of drug and alcohol services in responding to the emerging needs of the community, they are not sufficient on their own to bring about sustained improvement in service delivery and system responses (Roche & Skinner 2005). To bring about sustained improvement through organisational change management, an effective process is essential.

There are three main components of change management outlined by Guarino et al (2009):

1. Setting the scene – creating an atmosphere of change
2. Assessing and evaluating current practice
3. Developing a plan for change and change implementation.

All staff should be involved in assessing and evaluating the current strengths and challenges of the organisation before the change implementation process commences, ensuring all staff have input and take ownership of the change process.

A change management plan should incorporate space for staff to discuss challenges, frustrations and success stories, as implementing change can have a significant impact on organisational culture. Clients should be included in the organisational assessment process. This may involve speaking to current and past clients as well as their family and carers.

The Lyndon Community received a 12 month Practice Enhancement Grant from NADA in 2011 to increase their capacity to work with clients with a cognitive impairment. The following page shows a snapshot of Lyndon's experience in implementing an organisational change management approach to working with clients with a cognitive impairment.

THE LYNDON COMMUNITY'S ORGANISATIONAL CHANGE MANAGEMENT APPROACH

The Lyndon Community is a non-government organisation providing alcohol and other drug treatment through residential and community-based programs. Lyndon provides residential services in Orange and Canowindra and non-residential programs across western NSW, Bega and surrounding communities on the NSW south coast, including the Murdi Paaki Region (from Brewarrina to Dareton). Services include withdrawal, rehabilitation, one-to-one counselling, SMART recovery groups, education programs, women's groups, mental health and drug use groups, family support and kids' programs.

The organisation has a strong commitment to research and has formed close partnerships with peak bodies, other health services and universities. Lyndon has been providing drug and alcohol services for over 30 years and is accredited through the Australasian Council of Healthcare Standards.

What key areas did you cover in your organisational approach to complex needs?

The organisational approach to addressing complex needs was to address the practice context of each of the five programs run by The Lyndon Community so that staff from each program would have information and skills relevant to their role. The Practice Enhancement Program (PEP) grant was used to employ a worker whose specific task was to raise the issue of cognitive impairment in drug and alcohol clients and identify ways of working effectively with these clients. Having a dedicated role for the project and an individualised approach to each program was the key to the project's success.

What were the challenges, and what would you have done differently?

The project highlighted the need for ongoing work in the area of cognitive impairment within substance treatment. We wouldn't have done anything differently but need to find ways to maintain the gains from the PEP project. Now that the funding has ended and the PEP worker role has ceased, it's a significant challenge to continue work in the area.

What are the benefits and key outcomes for the organisation?

The key benefit for the organisation is a new approach to psycho-educational groups and adult learning within our programs. The PEP worker was able to review and adapt the content and structure of many of the groups run with Lyndon's residential programs, making them more suitable for people with a cognitive impairment. The project highlighted simple changes that staff could make to assist people with cognitive impairment to participate in treatment programs. Changes such as wearing nametags, reducing and simplifying signs, repeating instructions and practising/role-playing skills such as drink refusal were implemented.

What cost-effective strategies could you recommend?

The Lyndon Community has taken on an approach of universal design. This is where programs, treatment and resources are designed to be appropriate for people with cognitive impairment as well as others. With this approach there doesn't have to be a separate program or special testing or treatment for people with cognitive impairment – programs are already suitable.

What are your strategies for the long-term implementation of the gains made?

The universal design principles are a long-term strategy for the organisation to support people with cognitive impairment.

What recommendations do you have for services considering becoming complex capable?

A key finding from the PEP project for the Lyndon Community was the lack of staff knowledge about cognitive impairment, its impact and ways to address it. A staff survey found that only staff trained in the disability sector had any knowledge of cognitive impairment causes and effects. Staff skills and knowledge are critical to the way client needs are addressed. As staff change, the collective skills and knowledge change also. The way this affects practice needs to be monitored.

In the following, the staff of Karralika Programs Inc., an NGO therapeutic community in the ACT that has recently undergone organisational change to increase its capacity to work with clients with complex needs, discuss their experience of the implementation process.

How drug and alcohol workers in a therapeutic community responded to an organisational change management approach to working with people with complex needs

Karralika Programs Inc. (KPI) is a therapeutic community which delivers a range of alcohol and other drug treatment programs and services to the ACT region. Its vision is for the reintegration of individuals and families into the community through alcohol and other drug treatments, rehabilitation and transition programs. Karralika has been focused on becoming a more complex needs capable service as a part of the 12-month PEP Grant it received from NADA in 2011. There's an increasing expectation on staff at Karralika to work with people with a range of complex issues beyond drug and alcohol and mental health issues. As part of the evaluation process, staff gave the following responses to the implementation of Karralika's change management approach.

What changes have you seen among staff and clients in the last year in relation to working with people with more complex needs? Would you have felt confident to work with people with a cognitive impairment a year ago?

- Definitely not confident a year ago – much more confident now, and so is the therapeutic community, in working with complex needs.
- We've slowed down, changed the way we do things – come from a one-size-fits-all attitude to working more individually with residents, engaging more with them about their needs (e.g. rest and time out).
- We use the same principles now for all people with complex needs, not just those identified in regards to the grants project.
- Modelling from staff helped the rest of the therapeutic community understand complex needs and those who need additional attention and flexibility, with peers and senior peers being very supportive.
- There's been real growth and understanding in the therapeutic community of complex needs.

What advice would you give to other drug and alcohol services that are becoming complex capable?

- Expect the unexpected!
- Be prepared to not stick to your routine and structure – flexibility is really important, and the need to slow down.
- Have calm and understanding staff. Staff skill mix is important. The health worker role is important and support/backup by external experts (e.g. GPs and mental health). Formal diagnosis of conditions may be important at some stage, especially to the resident.
- Recognise that complex needs are what we have been working with every day anyway.
- In the therapeutic community there are really only minor modifications required – communicate with all staff and residents about what you're doing.
- Draw on the strengths of the person and their previous experience.
- Make sure that your environment supports what you want to do, including special areas for time out.

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Has the training in complex needs areas assisted you in your work?

- The training has been really important.
- Training really verified a lot of what we do anyway in the therapeutic community.
- It was great to be able learn more strategies.
- There's more depth of understanding as a result of the training – we are working better with clients.

What are the main learnings you've gained through the complex needs project?

- We have more tools and strategies to use than before and lots of information we can draw on.
- That we can make small changes which help a lot.
- Small meetings before and after group as a check-in for people with complex needs – how is everyone going?
- Changing language, reframing questions and working with what is presented.
- As we gradually get an understanding of the person, we're able to take a much more personalised approach.
- We can create a much more inclusive environment.

What has impacted on your confidence in relation to working with people with a cognitive impairment?

- That I have improved confidence is probably the main thing.
- Working with the cognitively impaired residents – knowing that I can do it.
- Knowing that in working with people with complex needs I am supported by my team and organisation.
- Improved awareness of other agencies who know what we do.

Have you noticed a change in the level of people with complex needs accessing the service?

- There seems to be increased access – or maybe we're identifying them as such now. We are not excluding now as we might have before.
- We're becoming more tuned in to needs of people with complex needs and more flexible in our approach.
- We have more resources now – increased knowledge and understanding, a supportive environment, more training and information.
- We've made changes in the organisation to cater to current demand.

CD-Rom resources

Change Management Template (NADA 2013).

For guidance on developing a change management workforce development approach see *NCETA Workforce Development 'TIPS' (Theory Into Practice Strategies): A resource Kit for the Alcohol and Other Drugs Field* (Chapter 7: Organisational Change) and *Trauma-Informed Organizational Toolkit for Homeless Services*, developed by the National Centre on Family Homelessness (US).

COMMUNICATING WITHIN YOUR SERVICE

There is overwhelming evidence to support the implementation of universal communication practices in drug and alcohol services. *Chapter 4: Practice Tips for Workers* outlines a range of strategies that can support you with your communication practices. For consistent implementation, and the impact of changes measurable for clients and staff, there needs to be an organisation-wide approach with the support of management.

Auditing organisational communication practices

Many modifications can be implemented at little or no cost. Reviewing all communication practices may seem overwhelming, but breaking down the task into realistic timeframes will make it manageable. Services could consider reviewing one area of communication at a time over 12 months as part of their quality improvement cycle. The following questions provide a brief guide to what to consider when assessing organisational communication practices:

- Is all service information that's available to the public clear, concise and an accurate reflection of the service and its practices?
- Is plain English used in all documents provided to the public and clients?
- Is Easy English used (including images) when appropriate?
- Does the service have clear, concise and appropriate signage?
- Are clients involved in developing resources that are designed for them?
- Is all information provided to clients given both verbally and in written form to maximise opportunities for a person's understanding?
- Are alternative options to written program elements available for clients with cognitive impairment or low literacy?

Chapter 4: Practice Tips for Workers provides information on the difference between Easy English and plain English and can guide you in adapting current communication practices.

A Service Communications Audit Template (NADA 2013) is included on the CD-Rom. The template provides a starting point for reviewing service practice and includes questions relating to three key communication areas.

THE SERVICE ENVIRONMENT

Although service facilities are not often purpose built, minor alterations can be made to the physical environment for little or no cost to support people with complex needs.

For example, some people with cognitive impairment can be overstimulated by the environment, impacting on the way they're able to engage and interact in activities, such as group work and counselling. People who've recently exited prison may feel uncomfortable in surroundings that replicate the prison environment (e.g. bars on windows). Reviewing the surroundings, adapting them to reduce the possibility of distractions and decrease the feeling of being institutionalised will help provide a more conducive environment for treatment for people with complex needs.

The following questions provide a brief guide to what to consider when reviewing your service environment:

- How many and what types of images, information, posters and resources are on the walls and doors? Do these hide important signs (e.g. room numbers or names)?
- Is there a computer on in the background during group, assessment, intake or counselling sessions? Is the screensaver visible to clients and potentially distracting?
- Is there any excess noise that may be distracting or frustrating?
- Is the lighting appropriate?
- Is there a quiet, calm, safe space available for clients who may need time out from an intensive program activity?
- Is there an outdoor space where clients can spend time?
- Does the environment feel institutionalised (e.g. ex-hospital building)? If so, how can this be addressed for all clients and particularly for those with a history of contact with institutions?

KARRALIKA PROGRAMS INC.
ORGANISATIONAL CHANGE MANAGEMENT APPROACH

Karralika Programs Inc. is a non-government organisation providing drug and alcohol treatment to people in the ACT and the surrounding NSW region and is accredited by the Quality Improvement Council. Karralika supports people to address their alcohol and drug dependence, lead productive lives and positively contribute to their communities through the provision of residential and community-based programs. These include the Karralika Therapeutic Community Adult Program, the Child and Family Services Karralika Family program, the Karuna Short-stay and Nexus programs, the Solaris Therapeutic Community program at the Alexander Maconochie Centre, outreach programs, and the Sober Driving program.

Karralika received a 12-month PEP Grant from NADA in 2011 to increase its capacity to work with clients with complex needs/cognitive impairment. The following is a snapshot of Karralika's experience in implementing an organisational change management approach to working with clients with a cognitive impairment.

What key areas did you cover in your organisational approach to complex needs?

Key areas covered as part of the Karralika Programs Inc. PEP project included:

- Development of complex needs policy and procedures
- ABI-targeted staff training
- Review and modification of assessment tools
- Review and modification of program delivery and support mechanisms
- Modification of treatment environment to incorporate quiet time/time out spaces
- Updated service information, including: website, pamphlets and program information.

What were the challenges, and what would you have done differently?

During the initial phases staff were somewhat daunted by the project proposal. There were particular reservations with regard to our capacity to work with clients, specifically those with ABI conditions. There was not a clear understanding that (as there had not been clear identification of risk of ABI previously) this work was not significantly separate or different to that which was already occurring.

The training component of the project had a significant impact in reducing anxiety and improving confidence in working with clients with complex needs, specifically ABI conditions. In this regard the training, while delivered in the first six months of the project, may have been better delivered earlier in this period, given the positive outcome that this achieved in terms of attitude change and confidence building for workers.

What are the benefits/key outcomes for the organisation?

The enhanced capacity of staff, at each program point (including through our assessment processes), to work with clients with specified complex needs is the most significant outcome of the project. This has occurred through:

- Modification of our assessment form, which is now a comprehensive tool that identifies risk of ABI for all clients accessing our residential services
- Upskilling of clinical staff through the provision of targeted training relating to ABI; training packages delivered during the project period included Working with ABI, Fetal Alcohol Spectrum Disorder and the Triple Comorbidities (AOD, mental health and acquired brain injury)
- Whole-of-organisation support for the project as well as access to and/or provision of supporting information and resources for clients and workers.

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What are your strategies for the long-term implementation of the gains made?

In order to build on the gains already achieved as a result of this project, KPI will:

- Ensure access to ongoing training for workers
- Complete an ongoing review of policy and practice, maintaining currency in terms of developments in the field through the NADA Complex Needs Capable resource and those achieved by other grant recipients which will support and inform good practice
- Develop partnerships with other community agencies and specialist providers to assist clients and support program delivery within the therapeutic community and our other residential programs further enhancing our capacity.

What cost-effective strategies could you recommend?

One cost-effective strategy is to develop effective working relationships with other community agencies and/or specialist service providers that can support and assist service delivery. This is also an area of ongoing work for KPI.

What recommendations do you have for services considering becoming complex capable?

Recommendations would be for services to determine their capacity to become complex capable and what their specific requirements might be for that to occur in terms of policy development, training requirements, program modifications, etc. It is also important to ensure that there is whole-of-organisation support for the initiative through the inclusion of management and staff in planning and development activities, and that a staged approach is undertaken with regard to project implementation.

ELIGIBILITY, INTAKE AND ASSESSMENT

A review of your service's eligibility, intake and assessment policy and practice will identify if people with complex needs are inadvertently screened out at any of these stages when trying to access drug and alcohol treatment at your service.

The following questions provide a brief guide to what to consider when reviewing organisational practice:

- What are your service's requirements for eligibility, to remain on the waiting list, intake and assessment? What is the rationale behind these requirements?
- What documents and supporting information are required to access your service?
- Does the eligibility criteria and assessment process communicated to the public reflect your service's practice?
- What referral practices are in place across your service for those who don't meet the entry criteria?

The following table gives examples of common service eligibility criteria and assessment practice that may inadvertently screen people with complex needs out of receiving drug and alcohol treatment. It offers improved practice strategies founded on a strength-based approach, universal communication practices and the principles of access and equity.

Table 6.1: Improving eligibility, intake and assessment practice

COMMON PRACTICE	IMPROVED PRACTICE
People calling at a set time on nominated days to show motivation and maintain a waiting list place. This can be problematic for: • People in prison preparing for release. Consistent access to a phone is difficult and is beyond the control of the person. • People with a cognitive impairment who may have memory issues. • People who live in disadvantaged circumstances.	Be flexible about how potential clients can maintain a place on a waiting list. If the person indicates that they're in prison, you could place them on a waiting list, or allow for flexibility in when they can contact you/how often they are required to contact you. If the person has contact with formal or informal supports you could take any details provided as a possible point for assertive follow-up. A quick phone call may help you find out, for example, that the prison has been in lockdown or that they had no phone money to make the call. For people with a suspected or confirmed cognitive impairment, check with the person (each time you talk to them) that they have a reminder in place to make their next appointment or call. Their support person may also be able to help with reminders and appointments.
People having to participate in (face-to-face or phone) intake and assessment processes without a support person. This can be problematic for people with a cognitive impairment who may not understand the questions and/or have memory issues.	Consider if the person will benefit from having a formal support person involved, and ask them if they'd like this. This may be a case worker or support worker from another service. Partnerships and co-case management with other support services can be key to supporting a person with complex needs in treatment.
Identification (ID) requirements including requiring multiple forms of ID This can be problematic because: • Many people don't have access to ID, or it may carry a significant financial cost. • A person's inability to source/afford ID can sometimes be interpreted as the person not showing enough motivation to be allowed to access and receive drug and alcohol treatment.	Think about the type and amount of ID your service asks for, why it is needed, and how this is communicated to the public. Be mindful of what is reasonable to expect a person to supply for ID requirements to access drug and alcohol treatment services. Often service ID requirements can exceed those required to access public services such as Centrelink. Consider the following when revising ID requirements: • The cost of obtaining the ID you're requesting and implementing low or no cost ID solutions to assist access. • The amount of time it may take to obtain ID and how long this may delay access to treatment. Timely access to treatment can be a key aspect of engaging a person successfully. • Alternative forms of ID that a person may be able to access easily without significant cost or time. • How your service advises people on how to access the different types of ID.
Providing a criminal history/record. Many services ask for a person's criminal history when considering eligibility for programs. This may only apply to those who disclose a criminal history or to all clients accessing the service.	Think of other ways of gaining the information you may require that is relevant to your service or the person's treatment. Review why your service requires knowledge of a person's whole criminal record/history, how it will be used and interpreted, and whether the specific information required can be obtained another way. For example, your services' policy may be to exclude people convicted of arson. Can you find out this specific information without needing a person to obtain their whole criminal history and having information not relevant to a person's treatment on file? Consider the financial cost of obtaining a criminal record for the individual or service and check if the information required can be obtained another way. If a criminal record is used, think about who is interpreting the information, if they are trained to do so, if the context of any situation of concern is known by or discussed directly with the client, and if this information could be obtained another way.

SCREENING AND ASSESSMENT FOR COGNITIVE IMPAIRMENT

The 2009 Department of Health and Ageing Guidelines for Treatment of Alcohol Problems recommend as a standard of care that screening for cognitive dysfunction is carried out when a clinician suspects a cognitive impairment and that a referral to a clinical psychologist or neuropsychologist may also be required (Haber et al 2009).

The following questions provide a brief guide for reviewing cognitive impairment screening and assessment tools:

- What tools are right for our service? (e.g. cultural safety and appropriateness, level of detail required, and treatment planning benefits)
- What staff training is required to administer and/or interpret the results of the screening tools?
- When should the tools be administered? (e.g. some cognitive screening tools are not recommended until several weeks of abstinence has been maintained)
- How will screening and assessing for cognitive impairment assist in the client's treatment?
- Do clients understand why they're being asked the screening questions? Have they given consent?
- How will the results be delivered to the client and how will they be supported?
- Is there an implementation plan to incorporate new tools into current practices? (e.g. policy, procedures, use of or integration into client management systems, timeline, cost of implementation).

The organisational benefits of implementing cognitive screening questionnaires or assessments include the following:

- The results can be used to tailor treatment to a person's needs and support successful treatment outcomes.
- Periodic screening (of some tools, e.g. MoCA) can show improvement (if any) in the person's cognitive functioning. This can be used as a tool in their treatment and to build confidence among staff that change is possible.
- Data on the number of people accessing your service with cognitive impairment indicators can be used to support funding applications, identify areas for staff development, and support research and long-term service planning.

We Help Ourselves (WHOS) is a non-government drug and alcohol service provider in NSW and Queensland engaged in an organisational change management approach which incorporated the selection and implementation of a screening and assessment tool to help identify cognitive impairment. A snapshot of their approach can be found on the next page.

For detailed information on screening and assessment of cognitive impairment, including information on training and the cost of a range of screening tools, see *Chapter 5: Screening and Assessment for Cognitive Impairment*.

The WHOS review of complex needs assessment and treatment options data (*WHOS Complex Needs Client Data Survey: Assessment and Treatment Options* (Community Sector Consulting 2011)), can be found on the CD-Rom.

INVOLVING FAMILIES, CARERS AND FORMAL SUPPORTS

Recently there's been a move towards incorporating family-inclusive practice into drug and alcohol service provision. Best practice recommendations are that services "more routinely: (a) assess the strengths and needs of the substance misuser's current familial and social networks; and (b) implement one or more of the range of evidence-based approaches which impact either the substance misuse in their familial/social context or the affected family members" (Copello et al 2006 in NADA 2009).

When working with people with complex needs, involving family or support workers in treatment planning can be beneficial. Support workers, advocates or family members may be able to support you to better address the client's needs (NSW CID 2011). Establishing and maintaining solid social supports can be an essential element in preventing lapse and relapse post treatment.

Family contact for people who've had contact with the criminal justice system can have a stabilising influence on release from prison. Working with the person and their family to enhance or maintain a functional family relationship can help prevent reoffending (Borzycki 2005) or relapse into other problematic behaviour patterns.

WE HELP OURSELVES (WHOS) ORGANISATIONAL CHANGE MANAGEMENT APPROACH

About We Help Ourselves

WHOS currently operates seven residential therapeutic community projects across NSW and Queensland with the aim of fostering personal growth within alcohol and other drug therapeutic programs incorporating harm minimisation and co-existing mental health initiatives. Its change management strategy, outlined below, was employed as part of the NADA Practice Enhancement Project (PEP). For more information on WHOS visit www.whos.com.au.

What key areas did you cover in your organisational approach to complex needs?

The PEP project was designed around organisational change management principles. In summary, it's essential to first determine (through gathering evidence and data collection – see below) what changes are required, to determine whether staff and management perceive change to be necessary. Ensure that an implementation process is adopted that links policy and procedure change with training to support staff skills and ensure the organisation's resources are equipped to adopt the change. It's also essential to look at how evidence of change within the organisation will be evaluated.

1. Gathering evidence/data collection

The literature review conducted by NADA suggested that cognitive impairment would be an issue for the client group accessing WHOS. However, the exact extent of the problem was unknown prior to the PEP project commencing. To rectify this, a literature review was commissioned to determine if there was an existing assessment that would be an appropriate assessment tool for WHOS. 'Appropriate' meant that it would be quick to administer and score (staff are already under enormous administration pressure), would not require special qualifications to administer (e.g. a psychology degree) and would not have any costs (e.g. copyright).

A number of tools were identified, with the Montreal Cognitive Assessment (MoCA) tool most closely suiting the needs of the organisation. However, this tool had been designed to detect early signs of dementia, with only one study using it for an alcohol and other drugs population. To validate this assessment within this population, the University of Wollongong was approached and an honours research student was engaged to validate the tool as part of her research.

In addition, WHOS modified the client treatment outcome data collection to screen for traumatic head injury resulting in a loss of consciousness, learning difficulties and, or diagnoses. This data was collected/readministered with all clients across WHOS and, as such, that data will now be available not only for individual treatment planning but for research and long-term service planning to improve service to people with cognitive impairment.

2. Policy and procedure review

The WHOS Assessment and Admissions Policy was reviewed and client assessment procedures modified to make sure appropriate data was being collected. Further modifications were made to the Discharge Policy to make sure that staff were aware of the importance of ensuring safe discharge for people with cognitive impairment.

Staff were also encouraged to review issues of cognitive impairment for people who tended to have difficulty fitting into the therapeutic community and following instructions. It was recommended that, if these issues were present, trained staff were to administer the MoCA to determine if the issue was one of either engagement/motivation or capacity.

3. Training

A training needs analysis was conducted to determine if staff viewed cognitive impairment as something they wanted to understand better. It was found that the vast majority of staff viewed the issue of alcohol and other drugs clients and the impact of cognitive impairment as important and something they'd want to be trained in.

Continued over page

This meant we could engage in training to provide information, rather than try to motivate them to view this client group as a core part of their work. A specialist trainer was engaged to provide all staff with one full-day training session and a half-day booster session. The focus of the training was common causes of cognitive impairment, symptoms of cognitive impairment, and key strategies for working with people with cognitive impairment.

A number of key staff were also trained to administer the MoCA so that, if staff identified potential issues, this tool could be administered to screen for cognitive impairment.

What were the challenges and what would you have done differently?

The biggest challenge was the short length of the project. It's really important to make sure that, even though many new projects arise as a knee-jerk reaction when funding becomes available, comprehensive planning is done to ensure the viability of project outcomes in the long term. We wouldn't have done anything differently for this project.

What are the benefits and key outcomes for the organisation?

The benefits for the organisation and for our clients is that there's now an awareness of causes, impacts and strategies for working with people with cognitive impairment. Of key benefit to the industry is the existence of a useful screening tool for people with cognitive impairment.

What cost-effective strategies could you recommend?

Services should incorporate basic screening questions for cognitive impairment into their standard assessment, as these can provide strong indications of potential cognitive damage even if a service doesn't have formal assessment for cognitive impairment. It's good to incorporate training for working with cognitive impairment into the staff training calendar or, if a service doesn't have training funds, to apply to NADA's training grant scheme to access training funds.

What are your strategies for the long-term implementation of the gains made?

WHOS has the advantage of being successful in obtaining ongoing funding for what was originally the Improved Services Initiatives (ISI) project. In our new funding submission, we've incorporated clients with cognitive impairment into the definition of clients with multiple and complex needs. This has ensured that we'll be able to focus on the needs of this group over the next three years.

What recommendations do you have for services considering becoming complex needs capable?

If the service is already working with a drug and alcohol population, it's already working with incredibly complex clients. Our most important recommendation is to adopt an organisational change management approach incorporating the following approaches:

1. Gather the evidence for how your service currently operates. What does your service's data suggest and what does the research literature suggest? What are your staff's views about suggested changes?
2. Identify what's required and plan how the changes will be implemented into your service, focusing on organisational systems such as policy and procedure, targeted staff training and linkages and partnerships.
3. Evaluate in multiple ways the outcome of the changes.
4. Most importantly, persevere and continue to learn from people who may have been badly managed by your service or who you were unable to assist. Each service needs to know its limitations but also needs to continually explore how to improve service delivery to clients.

Organisation-wide systems need to be in place to allow for the involvement of families, carers and formal supports. These systems should incorporate policies and procedures, training and workforce development, and partnerships with external organisations that provide formal supports to the person or can assist in providing specialist support to families and carers.

The following questions provide a brief guide to what to consider when developing organisation-wide strategies to involve carer and formal supports:

- What systems are in place to cater for the organisation-wide impact of involving informal supports? (e.g. What information and organisational support is provided to staff about the involvement of family or carers in a support role for a client?)
- What systems are in place to cater for the organisation-wide impact of involving formal supports? (e.g. How will staff communicate to the broader client group about the role of an external support person's involvement in an individual's treatment?)
- What consent is needed to engage formal and informal supports?
- What support can our service offer to formal and informal supports?
- At what point in treatment should you engage these supports with the person?

Further information on family-inclusive practice see NADA's *Tools for Change: A New Way of Working with Families and Carers* (2009).

From Individuals to Families Single Session Family Consultations (Bouverie Centre & NADA 2012) provides practical examples from alcohol and drug services on how you might implement and sustain family-inclusive practice.

Information on all NADA resources can be found at www.nada.org.au/resources.

AFTERCARE, OUTREACH AND REFERRAL PRACTICES

When working with people with complex needs, a continuum of care is vital to ensure people do not fall through the cracks of service provision and to prevent relapse into alcohol or drug misuse or other risky behaviours.

The following questions provide a brief guide to what to consider when developing an organisational approach to post treatment service:

- Are assertive outreach, aftercare and referral practices used in our service?
- What level of outreach, aftercare or detail of referral can we provide?
- Are agreements in place with external service providers to support provision of service outside of our own resources or geographical constraints?
- Are transition plans (as part of a care or exit plan) made with the client when they're moving from our service to another provider? At what point is the transition plan implemented?
- What level of staff facilitation is involved in this transition plan? (e.g. do we accompany the person to the first few meetings? Is the new service involved in the care plan while the person's still in treatment?)
- Are aftercare and referral practices used for all clients exiting our service?
- Is there active follow-up with the person and/or the relevant service provider to check the person's level of engagement with a new service?
- Is there a system in place to address any problems with a referral?

Chapter 4: Practice Tips for Workers includes a range of information on aftercare, outreach and referral that can be used to review your service's current practices, policies and procedures.

CD-Rom resources

- *Referral Pathways Template (NADA 2013)*
- *A Counsellor's Guide to Working with Alcohol and Drug Users* (Marsh et al 2007)

PARTNERSHIPS WITH OTHER SERVICES

Establishing partnerships will allow your service to work with a person with more complex needs on their drug and alcohol misuse while they simultaneously receive support for other health and social issues. Partnership benefits include the following:

- The person receives the most appropriate care for their needs.
- The person connects with services that can continue to support them once they've completed a drug and alcohol program.
- Better support for you in working with people with complex needs.

It's important to have a good working knowledge of support services available in your area. Allocating resources to researching potential service partnerships and undertaking activities to establish partnerships is essential. This initial investment will pay off at a later date when your service has access to additional supports or points of referral. Services that are geographically isolated could explore opportunities for accessing additional services using teleconferencing or web-based technologies.

Providing coordinated care that involves a number of different workers and services working in partnership is generally regarded as best practice, but it's important that all parties are clear about the specific responsibilities of their service and that mechanisms are established for regular communication between services.

CD-Rom resources

- *External Relationships Policy Template* (NADA 2010)
- *Memorandum of Understanding Template* (NADA 2010)
- *Contractual Relationship Procedure* (NADA 2010)
- *Intention to Collaborate document* (NADA 2010)

The NADA website partnerships webpage www.nada.org.au/resources/partnerships lists a range of resources and links to further information that may help you in developing effective partnerships.

SYSTEMS OF SUPPORT AND WORKER WELLBEING

Systems of workplace support are of key importance when working in a drug and alcohol setting. Stress, burnout and staff retention are all challenges to the drug and alcohol workforce, so having practices and actions in place to support a worker's effectiveness and wellbeing is essential (Roche & Skinner 2005).

When working with people with complex needs and/or when implementing change management in your service, these systems are essential to ensure staff are not overwhelmed and feel supported by the service to carry out their role.

Workplace supports fall into two categories:

1. **Social/emotional support** is "focused on meeting workers' needs to feel valued, cared for, respected and liked" (Roche & Skinner 2005, Ch14, p2).
2. **Instrumental support** refers to "support that provides workers with practical assistance in terms of their roles, responsibilities and tasks" (Roche & Skinner 2005, Ch 14, p2).

All levels of the service can be engaged in a supportive workplace system, and services should investigate the types of strategies that can be implemented by co-workers, managers/supervisors and the service as a whole to facilitate a highly supportive workplace. Table 6.2 highlights the strategies services can implement to provide workplace support.

Worker wellbeing is recognised as a major area of concern for workers in the human services industry, who often experience high levels of stress and burnout. The drug and alcohol workforce faces many challenges in meeting the demands of responding to the ever-changing and often increasing complex needs of the community, including stigmatisation, heavy workloads and increased expectations.

The Indigenous drug and alcohol workforce faces additional challenges, including, but not limited to, a lack of culturally appropriate support and understanding, racism, and difficulties setting appropriate boundaries, particularly when working in small communities where workers are likely to know clients personally (Gleadle et al 2010).

Table 6.2: Workplace support

	SOCIAL/EMOTIONAL SUPPORT	INSTRUMENTAL SUPPORT
Organisation	• Ensuring fairness of treatment • Providing valued rewards • Ensuring supportive supervision	• Ensuring good job conditions (physical safety, job security, promotion paths, autonomy) • Addressing work overload • Addressing role ambiguity or conflict • Providing access to high-quality resources and equipment
Managers/supervisors	• Channelling/facilitating organisational support • Providing positive social interaction praise, encouragement, caring, respect) • Recognising and rewarding good work • Involving workers in decision-making	
Co-workers	• Providing positive social interaction (praise, encouragement, caring, respect)	• Providing help and advice • Filling in when others are absent • Assisting with heavy workloads • Providing constructive feedback • Appreciation and recognition • Sharing duties and responsibilities

Source: Roche & Skinner (2005), Ch14, p2.

The National Centre for Education and Training on Addiction (NCETA) suggests a two-pronged approach to addressing stress and burnout in drug and alcohol services (Roche & Skinner 2005):

1. There should be organisational strategies which focus on altering the work environment and/or the conditions causing the stress and burnout.
2. The individual worker should focus on developing coping strategies and stress management techniques.

Organisations should ensure effective workplace support systems are in place to avoid or reduce the chance of stress and burnout occurring. Organisations should also consider how workers are supported to develop their own coping strategies, including regular formal and informal supervision sessions, promoting the use of reflective practice, and ensuring staff are aware of and have access to an employee assistance scheme.

Further reading

For guidance on assessing your service's current workplace support systems (including a checklist and survey tool) and implementing effective systems, see *NCETA Workforce Development 'TIPS' (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field* 2005 (Chapter 14: Workplace Support).

For guidance on supporting worker wellbeing, including checklists and survey instruments, see Chapter 13: Worker Wellbeing from the same resource. This contains a range of information specific to the wellbeing of the Indigenous alcohol and other drug workforce.

Further information

Chapter 4: Practice Tips for Workers has information for workers to consider in relation to addressing their own wellbeing.

QUALITY IMPROVEMENT

Quality improvement is the ongoing process of a service self-reflecting and developing systems and service delivery.

With a focus on outcomes, processes and people-based improvement, the objective is to improve the quality of care for clients. Improvements can be made by:

- Systematically reviewing current practice
- Devising strategies to improve the services provided
- Implementing strategies through organisational change
- Monitoring and evaluating strategies to assess the impact they have had on service provision and client outcomes.

Quality improvement programs

Quality improvement also refers to formal programs that services can become members of via an external provider. These external providers offer a range of quality improvement products, some of which have the goal of gaining accreditation. All quality improvement programs have standards which services can measure and improve themselves against. These standards generally focus on functions such as service delivery, human resources, work health and safety, governance and management, and information management.

All these functions will contain elements where improving practice and service delivery in working with people with complex needs can be undertaken. For example, elements and criteria in the human resources function that relate to professional development may prompt your service to implement complex needs training for all staff. Or elements and criteria in the service delivery function that relate to coordinated care may require your service to develop formal partnerships with other service providers so that people's needs are better responded to.

Policies and procedures

Policies provide governing principles or frameworks that guide what is to be achieved across a particular function or subject (e.g. human resources or client diversity). Policies can align with relevant state and federal legislation such as antidiscrimination legislation applicable to both human resources and client access policies. Procedures detail how a policy is to be achieved, and generally include process steps and responsibilities.

Policies and procedures that relate to how services are provided for clients may need to be reviewed and adapted to improve how your service responds to people with complex needs. Areas for consideration include service/program access criteria, referral processes, and how programs can be modified to be more inclusive and appropriate for this group.

NADA Policy Toolkit

The NADA Policy Toolkit contains template policies, procedures and checklists to guide many aspects of service delivery. The templates can be adapted to reflect your organisation's needs.

CD-Rom resources

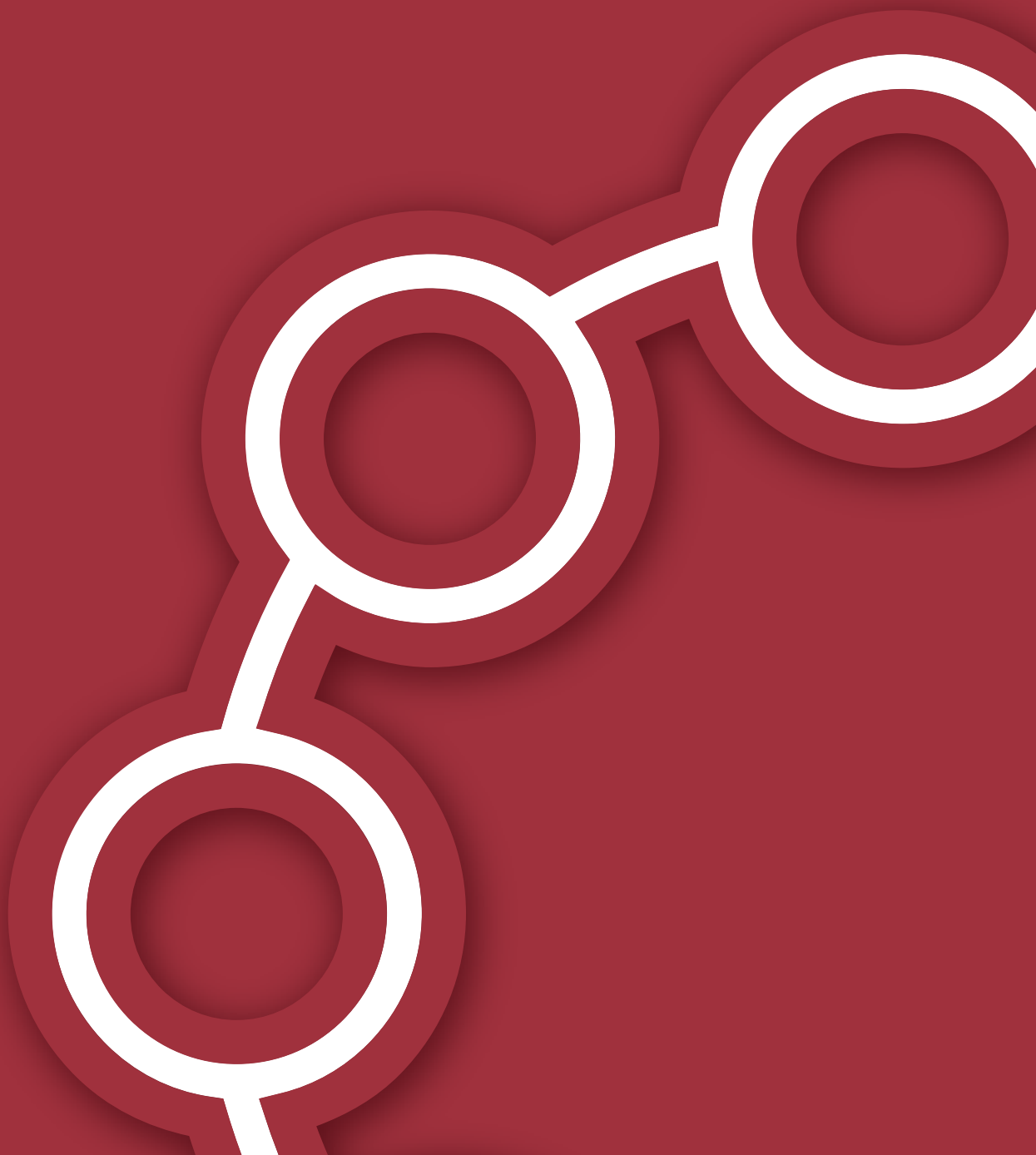
- *Inclusive Practice Policy Template* (NADA 2013)
- *Karralika Complex Needs Policy and Procedure* (Karralika Programs Inc. 2012)
- *Quality Improvement Policy Template* (NADA 2010)
- *Quality Improvement Action Plan Template* (NADA 2010)

Further reading

Further support for quality improvement can be found in the NADA Quality Improvement Resource Tool. *ACHS EQuIP5 Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations* (NADA 2013)

All NADA publications can be accessed at www.nada.org.au/resources/publications.

CHAPTER 7
Further Resources



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Further Resources

This chapter includes:

- Information and resource sources
- Training services
- NADA resources
- Further reading suggestions
- Bibliography

INFORMATION AND SUPPORT

Acquired brain injury

Acquired Brain Injury Services NSW Inc.

Acquired Brain Injury Services is a not-for-profit specialist service for people with an ABI. Its aim is to enhance people's lifestyle by maintaining and promoting independence and providing opportunities for socialisation and community integration with appropriate and quality service provision.

Web: www.abis.org.au
Phone: (02) 9649 7299
Email: info@abis.org.au

Ageing Disability and Homecare ABI Web Resource

A webpage dedicated to ABI on the Family and Community Services Ageing Disability & Home Care website provides information on care and support pathways for people with an ABI, as well as information on the new ADHC training resource (web-based and face-to-face training options available).

Web: www.abistafftraining.info/Content/

arbias

arbias provides support to people with an acquired brain injury, specialising in alcohol and other drug related brain injury in NSW and Victoria. arbias is a case management, specialist assessment and intervention service targeted at people living with an alcohol-related acquired brain injury aged 16 to 65. arbias also provides a comprehensive range of training package options. Its training program provides practical strategies for working with people with acquired brain impairment and associated complex support needs.

Web: www.arbias.org.au
Phone: (02) 9708 0027 or (03) 8388 1222
Email: enquiriesNSW@arbias.com.au

Brain Injury Association NSW (BIA NSW)

The Brain Injury Association of NSW is the peak advocacy organisation for people affected by ABI in NSW – including people with acquired brain injury, family members, friends, professionals, and the broader community. The website includes a range of useful links and resources, including fact sheets in community languages and links to services in your region. BIA NSW also provides tailored training for drug and alcohol services.

Web: www.biansw.org.au
Phone: (02) 9868 5261 or freecall 1800 802 840
Email: mail@biansw.org.au

Brain Injury Australia

Brain Injury Australia is the peak ABI advocacy body representing, through its state and territory member organisations, the needs of people with an ABI, their families and carers. It works at a national level to make sure all people living with ABI have access to the supports and resources they need to optimise their social and economic participation in the community.

Web: www.braininjuryaustralia.org.au
Phone: (02) 9808 9390 or freecall 1800 BRAIN1 (1800 272 461)
Email: admin@braininjuryaustralia.org.au

Synapse – Brain Injury Association of Queensland

Synapse (formerly the Brain Injury Association of Queensland Inc.) is the peak disability organisation providing specialist services to Queenslanders living with ABI or behaviours that challenge our understanding. A range of useful publications, fact sheets and posters are available on the website.

Web: www.synapse.org.au
Phone: (07) 3137 7400
Email: info@synapse.org.au

Criminal justice support

Community Restorative Centre (CRC) NSW

CRC is a NSW community organisation dedicated to supporting people affected by the criminal justice system, particularly prisoners, ex-prisoners and their families and friends. Staff offer personal and practical assistance such as counselling, accommodation, a subsidised transport service, a court support service, outreach to prisons, information, advice and referrals. CRC also provide a range of training package options.

Web: www.crcnsw.org.au
Phone: (02) 9288 8700 (Monday, Tuesday, Thursday, Friday)
Email: info@crcnsw.org.au

Criminal Justice Support Network (CJSN)

The CJSN is a service of the Intellectual Disability Rights Service Inc. (IDRS) that provides volunteer support workers for people with an intellectual disability who are in contact with the criminal justice system. The CJSN also provides education and training to staff in the criminal justice system, including police and court workers, lawyers and service agency workers, carers and people with an intellectual disability.

Web: www.idrs.org.au
Phone: (02) 9318 0144
Email: info@idrs.org.au

NO BARS: Supporting drug and alcohol service to work with criminal justice clients

This web resource provides a wide range of information on prisoners, ex-prisoners and the criminal justice system in NSW. Visit the resources section for listings of useful contacts, research and publications.

Web: www.nobars.org.au

Fetal Alcohol Spectrum Disorder and Justice Website

This Canadian based site is designed for justice system professionals and others who want to understand more about FASD. It provides information and resources about FASD, including background information, case law, legal resources and strategies for effective intervention.

Web: www.fasdjustice.on.ca

The Good Lives Model website

Information and examples of application of the Good Lives Model, a strength-based approach to offender rehabilitation.

Web: www.goodlivesmodel.com

WISE Employment

WISE Employment is a not-for-profit organisation which supports the most disadvantaged in our community to find meaningful employment, including people with disability, people with mental illness, youth, ex-offenders, refugees and Indigenous communities.

Web: www.wiseemployment.com.au
Phone: 1800 685 105

Cultural and linguistic diversity

Mental Health in Multicultural Australia

Mental Health in Multicultural Australia (previously Multicultural Mental Health Australia) has produced a range of services to support service providers working with people from CALD communities, including:

- Making a Difference: Service Provider Checklists
- Providing information and services for culturally diverse communities
- Planning and evaluating services for culturally diverse consumers
- Cultural Awareness Questions and Language Competency Tips.

Web: www.mhima.org.au

NSW Multicultural Health Communication Service

The NSW Multicultural Health Communication Service develops and distributes health publications in a wide range of languages. The service also provides advice and information related to multicultural communication.

Web: www.mhcs.health.nsw.gov.au/index.asp

Transcultural Mental Health Centre (TMHC)

A NSW-wide service providing clinical consultation and assessment, transcultural mental health promotion, prevention and early intervention, publication and resource development, and education and training.

Web: www.dhi.gov.au/tmhc/default.aspx

Disability

Disability Advocacy (DA) NSW

Disability Advocacy provides information and advocacy services for persons with any disability in the Hunter, New England and Mid-North Coast regions of NSW. DA also provides advocacy workshops for workers, families and carers.

Web: www.da.org.au
Phone: 1300 365 085
Email: da@da.org.au

JobAccess

JobAccess is an information and advice service funded by the Australian Government to support the employment of people with disability. It offers help and workplace solutions for people with disability and their employers.

Web: http://jobaccess.gov.au
Phone: 1800 464 800

Indigenous Disability Advocacy Service (IDAS)

IDAS is funded to service Indigenous persons with a disability in western Sydney and regional centres in areas of high need in NSW, in consultation with Family and Community Services and Ageing, Disability and Home Care.

Web: www.idas.org.au
Phone: (02) 4722 3524
Email: idas@idas.org.au

Multicultural Disability Advocacy Association (MDAA) NSW

MDAA is the peak organisation for people from non-English-speaking backgrounds with disability, their families and carers in NSW. MDAA is the only advocacy service in NSW available specifically to people from non-English-speaking backgrounds with disability.

Web: www.mdaa.org.au
Phone: (02) 9891 6400 or freecall 1800 629 072
Email: mdaa@mdaa.org.au

People with a Disability (PWD)

PWD is a national peak disability rights and advocacy organisation which seeks to provide people with disability with a voice of their own. PWD provides information and advocacy services as well as disability awareness training.

Web: www.pwd.org.au
Phone: (02) 9370 3100 or freecall 1800 422 015
Email: pwd@pwd.org.au

WISE Employment

WISE employment is a not-for-profit organisation which supports the most disadvantaged in our community to find meaningful employment, including people with disability, people with mental illness, youth, ex-offenders, refugees and Indigenous communities.

Web: www.wiseemployment.com.au
Phone: 1800 685 105

Drug and alcohol

Alcohol and Drug Council of Australia (ADCA)

ADCA is the peak national non-government organisation representing the interests of the Australian alcohol and other drugs sector.

Web: www.adca.org.au
Phone: (02) 6215 9800
Email: adca@adca.org.au

Alcohol and Drug Information Network (ADIN)

ADIN provides a comprehensive search directory where information on alcohol and drugs and mental health can be found, including links to treatment services, research, statistics, guidelines, professional development and more.

Web: www.adin.com.au
Phone: (03) 9611 6100
Email: adin@adf.org.au

Alcohol and Drug Information Service (ADIS)

ADIS is a 24-hour helpline which provides information, support, crisis counselling and referrals to services in NSW.

Web: www.yourroom.com.au
Phone: 02 9361 800 or 1800 422 599

Alcohol, Tobacco and other Drugs Association of ACT (ATODA)

ATODA is the peak body representing the non-government and government alcohol, tobacco and other drug (ATOD) sector in the ACT. ATODA seeks to promote health through the prevention and reduction of the harms associated with ATOD.

Web: www.atoda.org.au
Phone: (02) 6255 4070
Email: info@atoda.org.au

Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC)

The ATDC is the peak body representing the interests of the community service organisations that provide services to people with substance misuse issues in Tasmania.

Web: www.atdc.org.au
Phone: (03) 6231 5002

Association of Alcohol and other Drugs Agencies in Northern Territory (AADANT)

AADANT is the peak body for alcohol and other drug service providers in NT, currently auspiced by the Northern Territory Council of Social Service.

Web: www.ntcoss.org.au/node/821
Phone: (08) 8948 2665
Email: russell@ntcoss.org.au

Drug and Alcohol Specialist Advisory Service (DASAS)

DASAS is a free telephone service for doctors, nurses, and other health professionals. Specialist medical consultants are on-call 24 hours to provide advice on diagnosis and management of patients. DASAS is especially designed to support regional and rural areas in NSW, but is available to any health professional.

Phone: 02 9361 8006 or 1800 023 687

Drugfields

Drugfields aims to support the Australian alcohol and drug workforce through a professional development service and website which provide assistance to individuals and organisations.

Web: www.drugfields.org.au

National Indigenous Drug and Alcohol Committee (NIDAC)

NIDAC provides advice to government on Indigenous drug and alcohol policy based on its collective expertise and knowledge from those working in the field, health professionals and other relevant experts.

Web: www.nidac.org.au
Phone: (02) 9266 9600

NSW Users & AIDS Association (NUAA)

NUAA is the peak drug user organisation in NSW. It is a not-for-profit organisation advocating for people who use drugs, particularly those who inject drugs. NUAA provides education, practical support, information and advocacy to users of illicit drugs and their friends and allies.

Web: www.nuaa.org.au
Phone: 02 8354 7300 or 1800 644 413
Email: nuaa@nuaa.org.au

Queensland Network of Alcohol and Drug Agencies (QNADA)

QNADA is the peak organisation representing the views of the non-government alcohol and other drug sector in Queensland. QNADA's purpose is to support member services to deliver high-quality, evidence-based services.

Web: www.qnada.org.au
Phone: (07) 3010 6500
Email: info@qnada.org.au

South Australian Network of Drug and Alcohol Agencies (SANDAS)

SANDAS is the peak body providing independent, statewide representation, advocacy and support for non-government organisations working in the South Australian alcohol and other drug sector, through networking and policy development.

Web: www.sandas.org.au
Phone: (08) 8231 8818
Email: sandasinfo@sandas.org.au

Victorian Alcohol and Drug Association (VAADA)

VAADA is the peak body representing drug and alcohol services in Victoria; it provides leadership, representation, advocacy and information to both drug and alcohol and non-drug and alcohol-related sectors.

Website: www.vaada.org.au
Phone: (03) 9412 5600
Email: vaada@infoxchange.net.au

Western Australian Network of Alcohol and other Drug Agencies (WANADA)

WANADA is the peak body for the drug and alcohol education, prevention, treatment and support sector in Western Australia. WANADA's vision is to lead and support development of the alcohol and other drug sector to deliver best possible outcomes for the community of Western Australia.

Web: www.wanada.org.au
Phone: (08) 6365 6365

Fetal alcohol spectrum disorder

National Organisation for Fetal Alcohol Syndrome and Related Disorders (NOFASARD)

NOFASARD is Australia's peak body representing parents, carers and others interested in or affected by fetal alcohol spectrum disorder (FASD). NOFASARD provides information, advocacy services and training services.

Web: www.nofasard.org
Phone: 1300 306 238
Email: admin@nofasard.org.au

Russell Family Fetal Alcohol Disorders Association (rffada)

rffada is a charity dedicated to ensuring that people affected prenatally by alcohol have access to diagnostic services, support and multidisciplinary management planning in Australia, and that carers and parents are supported with a 'no blame no shame' ethos.

Web: www.rffada.org
Phone: 1800 733 232 or 0412 550 540
Email: elizabeth@rffada.org

Compilation of links to resources in fetal alcohol spectrum disorder

The Russell Family Fetal Alcohol Disorders Association (rffada) and Training Connections Australia (TCA) have developed this resource for the public. Links are categorised as:

Research | Journal Articles and Reports | Intervention Strategies | Criminal Justice | Prevention | Allied Health | Health Practitioners | Employment and FASD | Teachers and Educators | Parents and Carers | Support Groups | Australia FASD Training | General Interest.

Web: www.rffada.org

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)

MOFAS has listings on a range of resources, including print materials, books and videos.

Web: www.mofas.org/resources/

Intellectual disability

Intellectual Disability Rights Service (IDRS)

IDRS is a specialist legal information and advocacy service for people with intellectual disability. They work with and for people with intellectual disability to exercise and advance their rights. They provide legal advice, casework and support; advocate for improvements to laws and policies affecting people with intellectual disability; provide assistance to legal and other professionals supporting people with intellectual disability and provide information to service providers and the community about the rights and needs of people with intellectual disability.

Web: www.idrs.org.au
Phone: (02) 9318 0144
Email: info@idrs.org.au

NSW Council for Intellectual Disability (NSW CID)

The NSW CID is the peak body representing the rights and interests of people with intellectual disability in NSW. It provides information and advocacy services and provides expertise in developing resources, modifications and Easy English formats. NSW CID has an information service and resource centre that provides information to people with intellectual disability, their families, carers, advocates and service providers.

Web: www.nswcid.org.au
Phone: (02) 9211 1611
Email: mail@nswcid.org.au

Mental health

Mental Health Association NSW

The Mental Health Association runs both the Mental Health Information Service and the Anxiety Disorders Information Line. These lines provide information, telephone support and referral for issues relating to mental health.

Web: www.mentalhealth.asn.au
Phone: (02) 9339 6000 or 1300 794 991
Email: mha@mentalhealth.asn.au

Mental Health Coordinating Council (MHCC)

The MHCC is the peak body for community mental health organisations in NSW. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services for the community. MHCC provides a range of training and education through its Learning and Development Unit.

Web: www.mhcc.org.au
Phone: (02) 9555 8388
Email: info@mhcc.org.au

NADA Mental Health webpage

This section of the NADA website contains information on the Improved Services Initiatives, trauma informed care and practice and comprehensive listings of resources and training organisations.

Web: www.nada.org.au/sectordevelopment/mentalhealth

Dual Diagnosis Australia & New Zealand

Dual Diagnosis Australia & New Zealand is a resource repository created to contribute to better outcomes for persons with co-existing substance use and mental health disorders.

Web: www.dualdiagnosis.org.au/home

Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings (2009)

Available from: www.ndarc.med.unsw.edu.au/

Mental Health Reference Resource for Drug and Alcohol Workers (2007)

Available from NSW Ministry of Health: www.health.nsw.gov.au

MHCC Trauma Informed Care and Practice webpage

This website contains a range of resources and events listings and a network on trauma-informed care and practice.

Web: www.mhcc.org.au/TICP/

NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (2009)

Available from NSW Ministry Health: www.health.nsw.gov.au

Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings

Available from: www.nada.org.au/sectordevelopment/coms

Trauma

Adults Surviving Child Abuse (ASCA)

ASCA is a national organisation that works to improve the lives of adult survivors of child abuse throughout Australia. ASCA offers a number of training courses and has resources suitable for professionals working with adult survivors of child abuse.

Web: www.asca.org.au
Phone: (02) 8920 3611
Email: admin@asca.org.au

Education Centre Against Violence (ECAV)

ECAV is a state-wide unit responsible for training programs in the specialised areas of adult and child sexual assault, domestic and Aboriginal family violence and physical and emotional abuse and neglect of children across NSW. ECAV provides the mandated training for specialist child protection, sexual assault and Aboriginal family health workers, as well as targeted training for mental health and drug and alcohol workers in government and non-government organisations.

Web: www.ecav.health.nsw.gov.au
Phone: (02) 9840 3737
Email: ecav@wsahs.nsw.gov.au

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

STARTTS supports refugees to recover from their experiences and build a new life in Australia. STARTTS is committed to assisting and resourcing people and organisations to provide appropriate and culturally sensitive services to refugee survivors of torture and trauma. Additionally, STARTTS provides a range of counselling and therapeutic services.

Web: www.startts.org.au
Phone: (02) 9794 1900
Email: startts@sswahs.nsw.gov.au

TRAINING SERVICES

This section lists organisations providing education and training services on some of the specific areas discussed in *Complex Needs Capable*. The NADA website training directory also maintains a comprehensive list of training organisations and workforce development opportunities that is regularly updated.

Acquired brain injury

- arbias: www.arbias.org.au
- Brain Injury Association of NSW (BIA NSW): www.biansw.org.au
- ADHC Working with People with ABI: www.abistafftraining.info

Criminal justice and legal

- Community Restorative Centre (CRC): www.crcnsw.org.au
- Legal Aid NSW Community Legal Education: www.legalaid.nsw.gov.au/what-we-do/workshops
- Public Interest Advocacy Centre (PIAC): www.piac.asn.au
- Intellectual Disability Rights Service (IDRS): www.idrs.org.au

Disability

- Centre for Community Welfare Training (CCWT): www.acwa.asn.au/CCWT
- Education Centre Against Violence (ECAV): www.ecav.health.nsw.gov.au
- Family Worker Training & Development Program Inc: www.fwtdp.org.au
- Intellectual Disability Rights Service (IDRS): www.idrs.org.au
- NSW Ombudsman: www.ombo.nsw.gov.au/trainingworkshops/index.html
- People With Disability (PWD): www.pwd.org.au/training.html
- Uniting Care Institute of Family Practice: www.ifp.nsw.edu.au

Easy and plain English writing

- Plain English Foundation www.plainenglishfoundation.com/index.php/trainingmenu
- Scope Victoria provides Easy English workshops in NSW in partnership with NSW CID. Visit www.scopevic.org.au/index.php/site/whatweoffer/communicationresourcecentre/educationtraining/trainingworkshops/introductiontoeasyenglish for training package information. Contact: mail@nswcid.org.au or crc@scopevic.org.au about NSW workshops.

Fetal alcohol spectrum disorder

- National Organisation for Fetal Alcohol Syndrome and Related Disorders (NOFASARD): www.nofasard.org.au/educators.html
- Training Connections Australia (TCA) in collaboration with Russell Family Fetal Alcohol Spectrum and Related Disorders (rffada): www.rffada.org/training

Mental health and trauma

- Adults Surviving Child Abuse (ASCA): www.asca.org.au
- Centre for Community Welfare Training (CCWT): www.acwa.asn.au/CCWT
- Education Centre Against Violence (ECAV): www.ecav.health.nsw.gov.au
- Mental Health Coordinating Council (MHCC), Learning & Development Unit: www.mhcc.org.au/learning-and-training/default.aspx
- NSW Institute of Psychiatry (NSWIOP): www.nswiop.nsw.edu.au
- Uniting Care Institute of Family Practice: www.ifp.nsw.edu.au

NADA RESOURCES

For information about NADA resources or to access the publications listed below, visit www.nada.org.au/resources

NADA publications

- *ACHS EQuIP5 Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations* (NADA 2013)
- *From Individuals to Families Single Session Family Consultations* (The Bouverie Centre & NADA 2012)
- *NADA Policy Toolkit* (2010)
- *NADA Governance Toolkit* (2011)
- *No Bars: Supporting Drug and Alcohol Services to Work with Criminal Justice Clients* (2011) (CRC & NADA) www.nobars.org.au
- *Supporting Your Client in Court: Quick Tips for Alcohol and Drug Workers Booklet* (NADA & Legal Aid NSW 2012)
- *NGO Practice Enhancement Program: Working with Complex Needs Initiative Literature Review and Member Consultation* (Community Sector Consulting 2011). Report prepared for NADA.
- *Supporting Your Client in Court: Quick Tips for Alcohol and Drug Workers Booklet* (NADA & Legal Aid NSW 2012)
- *Take Note! A Practice Guide to Writing Case Notes: A Comparison with the NSW Jurisdiction* (Legal Aid NSW, NADA & Turning Point Drug and Alcohol Centre). To be read in conjunction with *Take Note! A Practice Guide to Writing Case Notes,* developed by Turning Point Alcohol and Drug Centre.
- *Tools for Change: A New Way of Working with Families and Carers* (NADA 2009)

FURTHER READING SUGGESTIONS

A range of resources are referred to as suggested further readings throughout *Complex Needs Capable* (web addresses up to date as of September 2012). For full details of publications see the bibliography.

Chapter 1: Understanding Complex Needs

- For information and resources on state and federal human rights and anti-discrimination legislation, including the *Disabilities Discrimination Act 1992* (Cth), *Australian Human Rights Commission Act 1986* (Cth) and *Anti-Discrimination Act 1977* (NSW) go to www.hreoc.gov.au.
- *Acquired Brain Injury: Screening, Identification and Validation in the Victorian Correctional System* (arbias & La Trobe University 2010).
- *An Examination of Drug and Alcohol Services Engaging with Complex Needs in New South Wales, Australia, Mental Health and Substance Use Journal* (Donaghy, Becker & Flaherty 2012).
- *Background Paper: People with Mental Health and Cognitive Disability: Pathways Into and Out of the Criminal Justice System* (Baldry, Dowse & Clarence 2011).
- *Bridges and Barriers: Addressing Indigenous Incarceration and Health* (National Indigenous Drug and Alcohol Committee 2009)
- *Bridges and Barriers: Addressing Indigenous Incarceration and Health Revised Edition* (National Indigenous Drug and Alcohol Committee 2013)
- *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Straits Islander Children from their Families* (Human Rights and Equal Opportunity Commission 1997).
- *NGO Practice Enhancement Program: Working with Complex Needs Initiative Literature Review and Member Consultation* (Community Sector Consulting 2011). Report prepared for NADA.
- *Psychology and Indigenous Australians, Foundations of Culture Competence* (Ranzijn et al 2010).
- *Social Determinants of Health: The Solid Facts,* 2nd edition (Wilkinson & Marmot 2003).
- *Social Determinants of Indigenous Health* (Carson et al 2007).
- *The Framework Report* (IDRS & NSW CID 2001). A review of current service provision. The report provides a framework and recommendations for the provision of appropriate community services in NSW for offenders with intellectual disabilities and those at risk of offending.
- *Trauma Trails, Recreating Song Lines: The Transgenerational Effects of Trauma on Indigenous Australia* (Atkinson 2008).

Chapter 2: Cognitive Impairment – What You Need to Know

- *Addressing Fetal Alcohol Spectrum Disorder In Australia* (National Indigenous Drug and Alcohol Committee 2012).
- *Compilation of Links to Resources in FASD,* Russell Family Fetal Alcohol Disorders Association (rffada) www.rffada.org/partners/resources
- *Enabling Justice Report* (2008). A report on problems and solutions in relation to diversion of alleged offenders with intellectual disability from the NSW local courts system with particular reference to the practical operation of s32 of the *Mental Health (Forensic Provisions) Act 1990 No 10* (NSW).

- IDRS Fact Sheets. A range of fact sheets available at www.idrs.org.au.
- NSW CID Fact Sheets. A range of regularly updated health-related (including drug and alcohol) and general factsheets available at www.nswcid.org.au.
- *NSW CID Living Stories*. The Living Stories publication is a collection of stories told by people with intellectual disability, or a family member when the person was unable to speak for themselves. Developed by NSW CID, www.nswcid.org.au.
- *Step by Step Guide to Making a Section 32 Application for a Person with Intellectual Disability* (IDRS). This publication is aimed primarily at those seeking the dismissal of summary criminal charges against their client under the legislative diversionary mechanism; this is so frequently sought that it's known simply as a 'Section 32 application'.

Chapter 3: Criminal Justice Contact – What You Need to Know

- *Getting Out: Your Guide to Surviving on the Outside* (Community Restorative Centre & NSW Department of Corrective Services 2007) www.crcnsw.org.au/publications/booklets
- No Bars: Supporting Drug and Alcohol Services to Work with Criminal Justice Clients www.nobars.org.au (go to 'About Criminal Justice Clients: Challenges Facing Criminal Justice Clients').
- *Planning Your Release: NSW Exit Checklist* (Community Restorative Centre & NSW Department of Corrective Services 2005) www.crcnsw.org.au/publications/checklist
- *Step by Step Guide to Making a Section 32 Application for a Person with Intellectual Disability* (IDRS 2011). This publication is aimed primarily at those seeking the dismissal of summary criminal charges against their client under the legislative diversionary mechanism, known simply as a 'Section 32 application'.
- *Supporting People with an Intellectual Disability in the Criminal Justice System: Progress Report* (NSW Ombudsman 2008).
- *Acquired Brain Injury: Screening, Identification and Validation in the Victorian Correctional System* (arbias & La Trobe University 2010)

Chapter 4: Practice Tips for Workers

- Chapter 13: Worker Wellbeing in *Workforce Development Tips: A Resource Kit for the Alcohol and Other Drugs Field* (National Centre for Education and Training of Addictions 2005) www.nceta.flinders.edu.au/index.php?cID=111
- *Indigenous Worker Wellbeing Kit* (National Centre for Education and Training of Addictions 2011) www.nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources
- *NSW Drug and Alcohol Clinical Supervision Guidelines* (NSW Health 2006) www.health.nsw.gov.au
- *Working with Clients with Complex Needs – Cognitive Impairment: Training Workbook* (The Lyndon Community 2012) www.lyndoncommunity.org.au/research-training/publications-and-reports

Chapter 5: Screening and Assessment for Cognitive Impairment

- 'A review of screening tests for cognitive impairment', *Journal of Neurology, Neurosurgery & Psychiatry*, 78, 790–799 (Cullen et al 2007).
- 'Brief cognitive screening instruments: An update', *International Journal of Geriatric Psychiatry*, 25, 111–120 (Ismail et al 2010).
- *Working with Clients with Complex Needs – Cognitive Impairment, On-site Training Workbook* (The Lyndon Community 2012) www.lyndoncommunity.org.au/research-training/publications-and-reports
- *NSW Health Transcultural Mental Health Assessment*
- *Indigenous Risk Impact Screening (IRIS) Tool*

Chapter 6: Making Your Service Complex Capable

- Chapter 7: Organisational Change in *Workforce Development Tips: A Resource Kit for the Alcohol and Other Drugs Field* (National Centre for Education and Training of Addictions 2005) www.nceta.flinders.edu.au/index.php?cID=111
- Chapter 9: Professional Development in *Workforce Development Tips: A Resource Kit for the Alcohol and Other Drugs Field* (National Centre for Education and Training of Addictions 2005) www.nceta.flinders.edu.au/index.php?cID=111
- Chapter 13, Worker Wellbeing in *Workforce Development Tips: A Resource Kit for the Alcohol and Other Drugs Field* (National Centre for Education and Training of Addictions 2005) www.nceta.flinders.edu.au/index.php?cID=111
- Chapter 14: Workplace Support in *Workforce Development Tips: A Resource Kit for the Alcohol and Other Drugs Field* (National Centre for Education and Training of Addictions 2005) www.nceta.flinders.edu.au/index.php?cID=111

- *From Individuals to Families: Single Session Family Consultations* (Bouverie Centre & NADA 2012) www.nada.org.au/resources
- *Indigenous Worker Wellbeing Kit* (National Centre for Education and Training of Addictions 2011) www.nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources
- *ACHS EQuIP5 Quality Improvement Resource Tool for Non Government Drug and Alcohol Organisations* (NADA 2013). All NADA publications can be accessed at www.nada.org.au/resources/publications.
- *NSW Drug and Alcohol Clinical Supervision Guidelines* (NSW Health 2006) www.health.nsw.gov.au
- NADA website partnerships webpage www.nada.org.au/resources/partnerships
- *Working with Clients with Complex Needs – Cognitive Impairment, On-site Training Workbook* (The Lyndon Community 2012) www.lyndoncommunity.org.au/research-training/publications-and-reports
- *Tools for Change: A New Way of Working with Families and Carers* (NADA 2009) www.nada.org.au/resources
- *NADA Policy Toolkit* (NADA 2010)
- *Trauma-Informed Organizational Toolkit for Homeless Services* (National Centre on Family Homelessness (US) 2009) www.familyhomelessness.org/media/90.pdf

Other useful resources

- *Handbook for Aboriginal Alcohol and Drug Work* (Lee et al 2012).
- *Mary G Gets the Message Out about FASD video,* www.laterallloveaustralia.com/in-the-media/mary-g-gets-the-message-out-about-fasd
- Multiple and Complex Needs Initiative (MACNI) Victoria (Victoria Human Services Department) www.dhs.vic.gov.au
- *State Debt Recovery Office (SDRO) Work and Development Orders* www.sdro.nsw.gov.au
- Substance Using Women with FASD Preventing FASD Project (University of Victoria, BC, Canada) http://socialwork.uvic.ca/research/projects.php
- The Wicking Project: Wintringham & arbias Victoria. A project exploring models of care for elderly people with complex care needs arising from alcohol-related dementia and brain injury, www.wintringham.org.au
- *We CARES Facilitators' Manual* (Anne Wright et al 2004, Canada). Practical skills for frontline workers working with adults affected by fetal alcohol spectrum disorder, specially designed for those working with people who are homeless or at risk of homelessness www.annewright.ca/workshops_training/documents/weCARESFacilitatorsManual September3.pdf
- *Working with Aboriginal People and Communities: A Practice Resource* (2009). For further information on working with Aboriginal and Torres Strait Islander people, including a deeper historical overview and conducting consultations with communities and organisations, go to www.community.nsw.gov.au
- *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Purdie, Dudgeon & Walker 2010) www.ichr.uwa.edu.au

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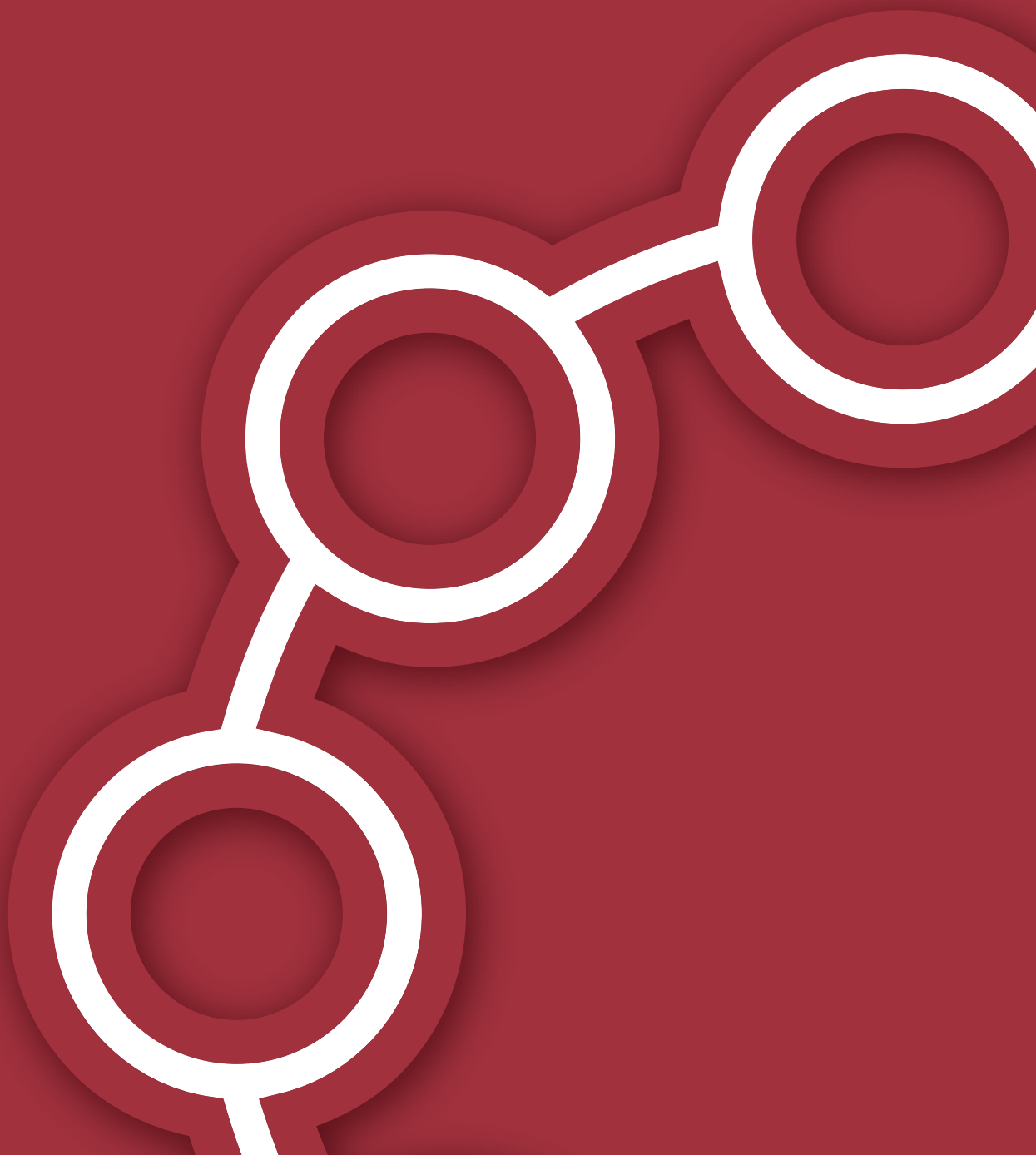
CHAPTER 8
Supporting Information on the CD-Rom



Supporting Information on the CD-Rom

The enclosed CD-Rom contains a range of resources to support you in working with people with complex needs. Included are all the resources with the CD-Rom symbol as referenced throughout the document. It also contains a CD-Rom map that includes the below list and is hyperlinked to each resource for easy navigation.

CHAPTER 2: COGNITIVE IMPAIRMENT – WHAT YOU NEED TO KNOW

- *Introduction to Intellectual Disability* (IDRS 2009)
- *What is Intellectual Disability?* (NSW CID 2006)
- *Acquired Brain Injury: The Facts* (3rd edition, Synapse Association of Queensland)
- *Understanding and Living with Brain Injury – For Service Providers* (Brain Injury Association of NSW 1999)
- *Looking Forward: Acquired Brain Injury* (4th ed, arbias, 2011)
- *Looking Forward: Information and Specialist Advice on Alcohol Related Brain Impairment* (4th ed, arbias, 2011)
- *Our Health Our Way* (3rd ed, arbias, 2012)
- *Fetal Alcohol Spectrum Disorder (FASD): A Framework for Action* (Public Health Agency of Canada 2005)
- *Fetal Alcohol Spectrum Disorder Factsheet* (Health Canada)

CHAPTER 3: CRIMINAL JUSTICE SYSTEM CONTACT – WHAT YOU NEED TO KNOW

- *Court Support Information Booklet* (CRC 2012)
- *Supporting Your Client in Court: Quick Tips for Alcohol and Drug Workers Booklet* (NADA & Legal Aid NSW 2012)

CHAPTER 4: PRACTICE TIPS FOR WORKERS

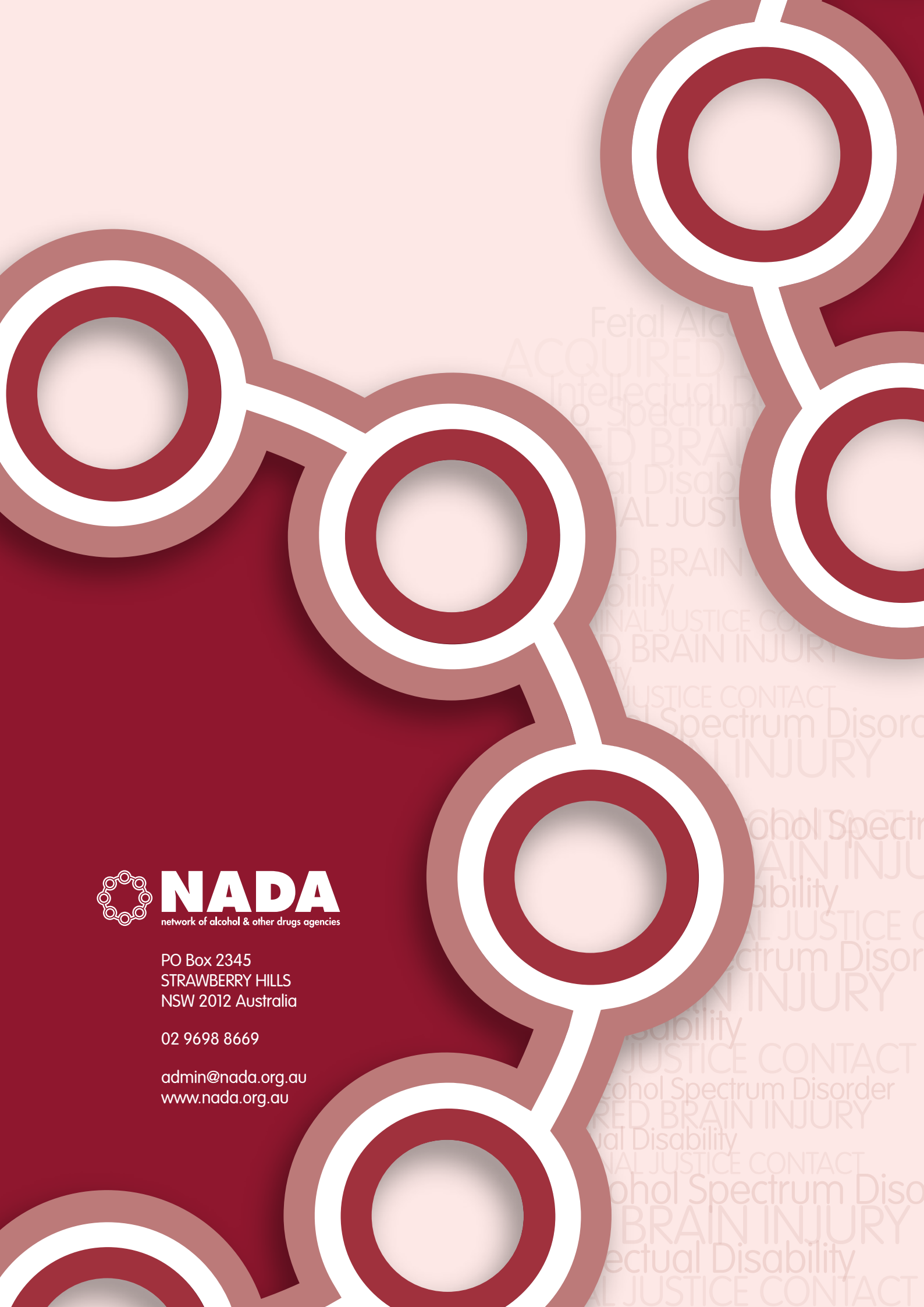
- *Introduction to Intellectual Disability* (IDRS 2009)
- *Maximise People's Ability to Make Their Own Decisions* (IDRS 2004)
- *Easy English Writing Style Guide* (Scope 2007)
- *Images for Easy English* (Scope 2008)
- *How to Write Plain English* (Plain English Foundation)
- *Cover Your Cough* (Minnesota Department of Health)
- *Wash Your Hands* (WHO 2009)
- *Referral Pathways Template* (NADA, Complex Needs Capable 2013)
- *A Counsellor's Guide to Working with Alcohol and Drug Users* (2nd Ed., Marsh et al, Drug and Alcohol Office, Western Australia, 2007)
- *Modifying Group Work in a Correctional Setting for People with a Cognitive Impairment* (NADA 2013)
- *MACNI: Care Plan Coordination* (The Multiple and Complex Needs Initiative State of Victoria, Department of Human Services, 2005)
- *Resource Manual: Assertive Case Management A Proactive Approach* (Version 1 Mental Health Services, 2008, Department of Health & Human Services Tasmania).

CHAPTER 5: SCREENING AND ASSESSMENT FOR COGNITIVE IMPAIRMENT

- *Brief Guide to Cognitive Impairment Screening and Assessment Tools* (NADA, Complex Needs Capable 2013)
- *Guide to Neuropsychological Assessments for Clients and Family Members* (arbias, Brain Foundation Victoria & Headway Victoria 2005).
- *FASD Adult Identification Tool* (rffada 2012)

CHAPTER 6: CONSIDERATIONS FOR SERVICES

- *Training Needs Analysis Template* (NADA 2013)
- *Complex Needs Pre-training Survey example* (NADA 2013)
- *Complex Needs Post-training Survey example* (NADA 2013)
- *Cognitive Impairment Survey* (Adapted from Questionnaire on Cognitive Impairment, The Lyndon Community, 2012)
- *Change Management Template* (NADA, Complex Needs Capable 2013)
- *Service Communications Audit Template* (NADA, Complex Needs Capable 2013)
- *External Relationships Policy Template* (NADA, Policy Toolkit 2010)
- *Memorandum of Understanding Template* (NADA, Policy Toolkit 2010)
- *Contractual Relationship Procedure* (NADA, Policy Toolkit 2010)
- *Intention to Collaborate Document* (NADA, Policy Toolkit 2010)
- *Referral Pathways Template* (NADA, Complex Needs Capable 2012)
- *Inclusive Practice Policy Template* (NADA, Complex Needs Capable 2013)
- *Karralika Complex Needs Policy and Procedure* (Karralika Programs Inc 2012)
- *Quality Improvement Policy Template* (NADA, Policy Toolkit 2010)
- *Improvement Action Plan Template* (NADA, Policy Toolkit 2010)
- *WHOS Complex Needs Clients Data Survey: Assessment and Treatment Options* (Community Sector Consulting, 2011)



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