New and innovative approaches to supporting people with complex needs

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For Dad – who would have ploughed through this report, all 78 pages of it!

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A shared problem

Since the turn of the millennia in both Australia and the United Kingdom there has been a growing awareness of a shared problem: poor responses from health, welfare and justice services to a small but significant group of people with multiple and complex needs.

These needs exacerbate and reinforce one another and include health, behavioural, practical, emotional and skills-based needs in addition to both victimisation from and perpetration of crime (Anderson, 2010). These people tend to have multiple and confused diagnoses, experience repeated episodes of crisis that are demanding of services, have poor living skills and a chaotic lifestyle, a lack of social networks and exhibit behaviour which is at the least disruptive and at worst a risk to themselves or others (Department of Human Services, 2003).

"Our emergency services and criminal justice system are forced to respond because our mainstream services do not. Our health and welfare systems, designed to tackle one problem at a time, or to focus on more serious conditions, are simply not geared up to provide the sort of help people need to avoid or escape this trap. The result is that people are caught in a downward spiral as one problem exacerbates another, causing damage to themselves and communities, generating huge costs to the public purse." (Revolving Doors Agency, 2010, p.3)

In the United Kingdom government responses include the development of the Adults facing Chronic Exclusion pilots instigated under the previous New Labour government (Cattell, Hitchins & Mackie, 2010), the Scottish Multiple and Complex Needs Initiative (Hirst et al, 2009) and the coalition government's current cross-departmental Social Justice strategy (HM Government, 2012). Importantly, at the time of writing government policy across a range of departments acknowledges the impact of multiple and complex needs and highlights the need for a whole person approach (Ministry of Justice, 2010a; HM Government, 2010; HM Government, 2011).

Nevertheless, despite considerable progress of late the problem remains. This Churchill Fellowship was undertaken in recognition of the fact that a poor response to complexity is by no means a uniquely British problem and that we may be supported in developing better responses by looking further afield.

Emerging responses

In Victoria and New South Wales a range of initiatives and programmes have been developed which provide support for people with multiple and complex needs. Both Victoria and New South Wales have established cross-government projects targeted specifically at improving responses to complexity and challenging behaviours.

In other cases, services have developed in response to specific combinations of needs but which frequently provide a comprehensive and personalised response. A number of such responses are situated across the criminal justice pathway reflecting the fact that many individuals with multiple and complex needs are involved in offending behaviour and find themselves being brought into this system. Responses have also emerged from the homelessness and the health and disability fields.

Finally, in the case of the Medically Supervised Injecting Centre, the service is targeted at one specific need but its usage suggests that it is particularly acceptable to clients who live chaotic lives and have complex problems (MSIC Evaluation Committee, 2003).

The table below outlines the projects discussed in this report:

		Victoria	*New South Wales*
Cross-government		• Multiple and Complex Needs Initiative (MACNI)	• Integrated Services Project (ISP)
Criminal justice	Police	• Police and Community Triage (PACT)	
	Courts	• Courts integrated services program (CISP) • Assessment and Referral Court List • Dandenong Drug Court • Neighbourhood Justice Centre	• Parramatta Drug Court
	Prison	• Marrmak Unit, Dame Phyllis Frost Centre • Marlborough Unit, Port Phillip Prison	
Homelessness			• Homelessness Interventions Project • Complex Needs Coordination Project
Health & disability		• Alcohol related brain injury assessment service (ARBIAS)	• Sydney Medically Supervised Injecting Centre (MSIC)

In addition, there were a number of other projects that I visited as part of this Fellowship which respond to people with multiple and complex needs but which are not covered in this report. All of these provided useful insights into supporting this group but were omitted due to significant similarities with existing and well-established programmes in the United Kingdom. They nevertheless inform my thinking in this chapter and throughout this report.

Main impressions

Recognition of the problem

One catalyst for my visit, reinforced on the Fellowship itself, was the clear recognition of both the necessity and challenges of improving responses to individuals with multiple and complex needs in Australia. This was not just recognition by practitioners who are usually all too aware of the complexities of some of their most intractable clients. In both Victoria and New South Wales there was evidence that members of the government, senior members of the civil service and other public service leaders recognised the problem as well.

In Victoria, the 'Responding to People with Multiple and Complex Needs Project' was established in 2002 and was a key priority of the Department of Human Services over the following year, leading ultimately to the development of the Multiple and Complex Needs Initiative (Department of Human Services, 2003). During my visit it was reported that the Secretary of State was a champion for this initiative and that there was a clear consensus among the different departments that they need to work better together. This consensus was attributed partly to a number of high profile negative cases highlighted in the media that preceded and were a catalyst for the initiative.

The Complex Needs Coordination Project in the City of Sydney was reportedly established following a multi-agency forum involving federal, state and local government and local non-governmental organisations (McDermott & Bruce, 2010). The Integrated Services Project also grew out of recognition at state government level that people with multiple and complex needs were not being well-served and was one of a number of other initiatives including the Homelessness Interventions Project and others which are not covered within this report.

Pragmatic responses to identified need

An overwhelming sense of pragmatism appeared to lie behind every new and innovative response to need that I saw during my Fellowship, whether that was local community need, professional need or client need.

During my visit to the Sydney Medically Supervised Injecting Centre it was described emphatically as *"a local solution to a local problem".* In the period leading up to the opening of the MSIC, the Kings Cross area of Sydney had a problem with discarded needles, public injecting, the operation of illegal 'shooting galleries' and a high number of overdoses. The centre continues to receive high levels of support from local residents and businesses as it is perceived as contributing to the reduction of these unwanted activities.

The Police and Community Triage (PACT) and the Courts integrated services program (CISP) simply respond to those who are likely to come in front of criminal justice professionals, the police and magistrates, time and again. In other words, those people who are likely to be 'problematic' for these professionals. There are no complicated or detailed eligibility criteria. In turn, both of these services respond pragmatically to the needs and goals identified by these clients without being restricted by diagnosis or any range of predetermined interventions that the service offers.

A number of services (MACNI, CNCP, ISP) spend significant time comprehensively assessing the client and thinking about what has worked previously and what has failed and adopting their approach accordingly. Conversely PACT does not undertake systematic assessment at all. Instead PACT responds to a hard to engage client group by working towards the client's own identified goals with assessment undertaken concurrently to this work as client trust increases.

Finally, putting aside the debate about whether those with significant mental health problems or learning disabilities should ever be in the prison system, the Marrmak unit and the Marlborough unit both start from the premise that there are such people within the system and look for the best way that they can be supported.

Taking a "whole system" approach to complexity

Conceptualisations of complexity have frequently focused on multiple diagnoses or needs. This diagnosis focused approach to complexity has serious limitations since it excludes the impact of the service and social systems within which the person is based. This system is complex at the best of times but multiple needs bring in multiple professionals and services (multiple 'players') alongside a range of other complicating factors (system components).

The services targeting complexity visited as part of this Churchill Fellowship frequently included the presence of multiple diagnoses as part of eligibility. Nevertheless, implementation of this appeared flexible (diagnoses could be suspected or confused) and eligibility criteria included other potentially emergent characteristics (e.g. challenging behaviour and intractability of problems). In addition, services frequently took a "whole system" approach to understanding the person's presentation (with contextual assessments that took account of social and service history) and to approaching solutions.

MACNI in particular takes a whole system approach to complex needs. It is a state wide initiative involving civil servants from a range of government departments and agencies at both state and regional level. As well as providing an intensive assessment, care planning and coordination service, MACNI includes both a process for developing responses at a local level and as such distilling those people in need of the intensive service. Unusually, civil servants from state government are directly involved in decisions regarding acceptance onto the scheme and individual client care which develops their understanding of the challenges of complexity that can support policy making.

Those involved in MACNI from both state and regional government agencies are able to take steps to overcome systemic barriers to meeting the needs of people with multiple and complex problems. Similarly, the CNCP was structured to have both a strategic and an operational group so that the latter could work to negotiate systemic barriers while the former concentrated on individual care planning.

Valuing and resourcing the coordination function

Coordination of services and departments needs to be undertaken at both the systemic and the individual level. One interviewee emphasised the challenge that this poses with a need to harmonize different philosophies, service models and staff skills and training, reporting that although possible and valuable *"partnership is a huge amount of work".*

The evaluation of the CNCP identified that dedicated resources are an important contributing factor to achieving successful coordination and a Project Coordinator was recruited mid-way through the project. In MACNI, the care coordination function was separated from the case management function with an independent care coordinator identified and funded. This enabled the care coordinator to escape from the day-to-day 'fire fighting' that is characteristic of work with complex and challenging clients and instead develop a long-term and systemic perspective. Much of the role was focused on the agencies working with the client as opposed to the client themselves and this role was seen as a core component of the model.

Sufficient and flexible funding to broker creative solutions

Leaders from government and other public services had demonstrated a willingness to invest in innovation in response to people with multiple and complex needs. Cross-government funding had been secured for MACNI demonstrating and sustaining engagement and buy-in while in the case of ISP funding came direct from the Treasury again reflective of cross-departmental and ministerial interest. Both projects require high level of per capita funding. PACT had reportedly received strong support from Victoria Police Deputy Commissioner Lucinda Nolan and Victoria Police provided pilot funding for the project. In addition the Courts service in Victoria had provided funding for a range of pilot projects implementing principles of therapeutic jurisprudence or otherwise providing support, on the back of strong support from the previous Attorney General, Rob Hulls.

A number of the services including MACNI, ISP and CISP had access to brokerage funding in order to procure goods and services that were not available (or at least not available to that client) within the existing service system. A number of interviewees emphasised that the support provided to clients

often had more to do with what the services provide rather than what the client needs. One interviewee emphasised that *"Brokerage is about client need and not service need."*

Many of those involved in the development and implementation of these services recognised that clients with multiple and complex needs often use significant levels of public funding through unplanned, uncoordinated and often inappropriate use of a range of services, notably crisis and emergency services. In many cases those developing and implementing services had taken a leap of faith to invest in something different. For example, MACNI brokerage funding had been used to secure family therapy and facilitating family contact, top-up support towards rent, counselling, staff training and an out-of-hours response to support the client to achieve their Care Plan goals (Department of Human Services, 2007b). The flexibility of the funding allowed those developing and coordinating care plans to be creative in response to identified need. This approach is supported by the principles of personalisation outlined in the New Labour government's vision for adult social care with a move towards person-centred planning and the use of individual budgets (HM Government, 2007).

Using criminal justice services as agents for change

The high number of criminal justice services visited during my trip is reflective of my professional and organisational interest in offenders with multiple and complex needs. Nevertheless, the experience of MACNI and ISP suggests that offending behaviour and experience of imprisonment is common among people who present with risky or challenging behaviour and have multiple and complex needs; only 11% of eligible individuals for MACNI were reported as not known to offend by referrers (Hamilton, 2010). Additionally, research from New South Wales suggests that police effectively become the front line managers of people with complex needs, usually at a fairly young age, but have great difficulty knowing what to do with this group (Baldry & Dowse, in press).

The services that I visited across the criminal justice pathway – from the PACT service which can become involved with a client from the point of contact with the police right through to the prison-based services – demonstrated that criminal justice services can be used as agents for change.

This includes criminal courts themselves. Far from exclusively acting as agencies of punishment, courts were able to provide an access point for mental health, disability and substance abuse support services. Additionally, they were a means for developing motivation and self-belief, crucial factors in both desistance from crime and recovery. This was not perceived to be in conflict with the rights of victims to see justice served since the courts had an important role in challenging clients and holding them accountable for offending behaviour and other behaviour likely to lead to re-offending. In doing so they were indirect agents of change in the lives of victims as well.

In the case of the PACT service, the police were able to refer both offenders and victims to the service so that in this case the service was able to act as a direct change agent as well as an indirect one. This was identified as an important feature of the service by its stakeholders.

Thinking about hidden disabilities

High prevalence of mental health problems and substance misuse within the criminal justice system has been recognised as an issue for many years in England and Wales and internationally. This was confirmed by a prison survey undertaken by the Office of National Statistics published in 1997 (Singleton et al, 1997).

The profile of those with learning disabilities and difficulties within the criminal justice system has also been raised significantly, in large part due to the No One Knows campaign by the Prison Reform Trust and subsequent government focus on the issue within Offender Health. Nevertheless, there remains limited tailored provision for those with learning disabilities within the English and Welsh

prison system. In contrast, the Marlborough Unit within Port Phillip prison is a pilot partnership programme between Disability Services (Department of Human Services), Corrections Victoria and Port Phillip prison that seeks to provide a more appropriate environment with tailored offending behaviour and other programmes for prisoners with learning disabilities.

In England and Wales, the issue of Acquired Brain Injury among prisoner and other offender populations has had far less prominence than both mental health problems and learning disabilities among policy makers and campaigners in the field of criminal justice. In both New South Wales and in particular Victoria, the issue of Acquired Brain Injury was a frequent feature of discussions with those working in the criminal justice field in service delivery, service design and in policy. Corrections Victoria had commissioned research to establish prevalence levels of Acquired Brain Injury within the state's prison system. The research, undertaken by Arbias and La Trobe University (2010) suggested that 42% of males and 33% of females in the Victorian Correctional (prison) system have evidence of an ABI following formal neuropsychological assessment.

Although policy makers were still considering how best to respond to this at the time of my visit, the issue was quite clearly on the agenda and there were examples of improved criminal justice responses to this group. Corrections Victoria had employed a dedicated ABI clinican to provide a primary and secondary consultancy service to the correctional estate. The ARC List included Acquired Brain Injury as one of the diagnoses for acceptance on to the list. CISP had a dedicated ABI worker and it was suggested that brokerage funding was used to procure neuropsychological assessments where an ABI was suspected. Improving responses to this group is likely to be important; since brain injuries can be associated with impulsivity, reactivity and aggression there are clear implications for criminal justice agencies.

Barriers to innovation

Throughout my trip I met with inspirational people who had developed and implemented innovative solutions despite a number of common barriers to this process. Barriers to innovation are likely to be problematic for any transfer of models to the United Kingdom. Barriers included:

Meeting client needs, not service needs

It was clear that in many cases these clients needed services that were simply not on offer at all or were only on offer for insufficient time periods. In other cases clients were excluded from these services due to not meeting eligibility criteria. One interviewee suggested that such criteria were frequently manifestations of service philosophies rather than based on what was right for the client(s). There was a persistent sense from a number of interviewees that service responses were shaped around the needs of services rather than the needs of clients; square pegs hammered determinedly but unsuccessfully into round holes. Although innovative responses were frequently designed to overcome this through the development of tailored care plans, attempts were still impeded by the limitations of the existing service system since responses were usually based within this system or attempted ultimately to transfer care back to this system.

Old habits die hard

A significant barrier to innovation was that professionals and services were heavily embedded in these old ways of working and could struggle to adequately adapt practices to provide a qualitatively different approach. This was identified as an issue for the implementation of Housing First models whereby independent housing is given to complex individuals without any conditions on their tenancy relating to engaging with support. It was suggested that although such approaches were

theoretically being embraced, conditions surrounding engagement were still being applied in a number of cases. Many of the services that I visited identified problems around finding the right staff with the willingness and ability to work in new ways with a complex client group.

Service reluctance to work with this group

The interviews and the literature suggested reluctance on the part of services to work with this extremely complex group as a barrier to innovation. The evaluation of the Complex Needs Coordination Project identified the unwillingness of organisations to take ownership over clients with multiple needs and diagnoses. An article by the former Chair of the MACNI Statewide Panel highlighted service concerns about risk of actual harm but more importantly reputational risk when working with this group of clients. The time involved in successfully engaging and working with complex clients was also a deterrent to some services to respond to this group.

Mainstreaming

I visited a variety of innovative responses to this group however for the most part services had or more often still languished in pilot phase. Although there was a willingness to try new things on a smaller scale, it was rare for services to have achieved state wide coverage (MACNI was the exception). In one case continuation funding had not been received and other services expressed concern that political change meant that such funding would not be given after pilot status.

Overcoming these barriers

In order to overcome these barriers, those involved in developing and implementing these new responses to multiple and complex needs had clearly demonstrated creativity, tenacity and above all strong leadership. This leadership was necessary to secure involvement from a wide range of agencies at both a strategic and an operational level. In many cases initiatives had buy-in from across government which in turn was crucial for overcoming barriers within the existing system. Where services had been mainstreamed, support from government and from other influential champions was influential in achieving this. Finally flexible funding enabled the brokerage of services for clients that were simply not on offer within the existing system.

2

Introduction to Australia, the Fellowship and this report

What is the problem?

I started my professional career as a prison resettlement worker, providing housing support for prisoners on short sentences approaching the end of their sentence. Day in day out conducting assessments with these prisoners I was struck by the sheer multiplicity of their problems. Alongside homelessness and offending histories, they were frequently poly-drug users, most described poor mental health, almost all were unemployed with little education history, most had at least some debt, many had experienced periods in care, childhoods characterised by neglect and abuse and all too often they had little contact with families. Perhaps unsurprisingly many of those I saw kept coming back, in one notable case the very same day as he had been released.

Revolving Doors Agency[1], who I subsequently started working for, look specifically at this multiplicity of need of so-called 'revolving door' prisoners and at how public services currently respond to this:

"Our emergency services and criminal justice system are forced to respond because our mainstream services do not. Our health and welfare systems, designed to tackle one problem at a time, or to focus on more serious conditions, are simply not geared up to provide the sort of help people need to avoid or escape this trap. The result is that people are caught in a downward spiral as one problem exacerbates another, causing damage to themselves and communities, generating huge costs to the public purse." (Revolving Doors Agency, 2010, p.3)

The key question then is how can services across both the public and independent sectors improve their response to people with multiple and complex needs?

Why Australia?

The main reason for visiting Australia (and Victoria in particular) for my Churchill Fellowship was that the Victorian government had identified a significant problem in relation to the service response to people with multiple and complex needs and in 2002 had initiated a programme of work to improve responses to this group:

"With the move away from institutionalised care, the provision of successful and sustainable support to this client group has become increasingly problematic. Responding effectively to this population has been an ongoing issue and has often been visited without successful resolution. While the capacity to transcend traditional program boundaries is evident in some cross-program initiatives, further work is required to bring about a more collaborative service model for people with multiple and complex needs." (Department of Human Services, 2003, p.iii)

[1] Revolving Doors is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in contact with the criminal justice system.

The service system within Australia bears similarities to that in the United Kingdom and the 'case for change' described appeared to me equally true of the situation in the United Kingdom:

- The service response depends on which service sector, if any, is viewed as having primary responsibility for the individual
- The length of service received may depend on the program and funding models developed within that sector, the statutory responsibility, if any, of the provider and the willingness or capacity of the individual to engage with the service
- The degree to which a coordinated response is provided often depends on the capacity of the lead provider to negotiate agreement and commitments from services in other sectors
- Highly specialised health and welfare service systems have become increasingly fragmented
- Access to services is perceived to be more restricted. Some argue that more complex individuals are screened out and those considered too challenging are increasingly expelled altogether (Department of Human Services, 2003).

The considered result was that service improvements up to 2003 had not resulted in benefits for a small group of individuals with complex needs who were more likely to have negative outcomes, notably over representation in the criminal justice system.

This programme of work led to a review of the current service system and existing legislation and ultimately to the development of the Multiple and Complex Needs Initiative (MACNI) which was implemented in August 2004 (Department of Human Services, 2011b). During my visit I was fortunate enough to meet with a number of people involved in the (latest iteration of the) MACNI programme as well as speaking to a small number of community stakeholders in the programme to hear perspectives on what progress had been made both in terms of improving client outcomes and improving local service responses.

The MACNI programme was by no means the only Australian programme designed to improve responses to individuals with multiple and complex needs. The state government in New South Wales and local government in Sydney had established a number of initiatives including the Integrated Services Project (ISP) and the Complex Needs Coordination Project (CNCP; now concluded) and I was again able to meet with key people involved in the development and operation of these services.

In addition, although ISP and MACNI in particular focused on the most complex cases of all, there were also a wide range of other initiatives that looked to provide a safe space for, engage with, provide coordinated support to and reduce the challenging behaviour of those people with multiple needs of varying degrees of complexity.

Introduction to Victoria and New South Wales

Geography and Population

Victoria is located in the South East of Australia and is roughly the size of England, Wales and Scotland combined with a total area of around 240,000km^2. It has an estimated population of 5.6 million which is equivalent to the population of the West Midlands, despite being 18 times bigger. Australia has a very low total population density of 2.9/km^2 compared to England and Wales, whose population density stands at 371/km^2 (Office of National Statistics, 2011; Australian Bureau of Statistics, 2012). Victoria is highly urbanised; 75% of Victoria's population live in Melbourne, Victoria's capital, which has an estimated population of 4.17 million (ibid).

New South Wales is situated in the South East of Australia, north of Victoria. With an area of just over 800,000km^2, New South Wales is bigger than France, although it has an estimated population of

7.3 million, which is about one million fewer than London. New South Wales has a population density of just 9.12/km^2 (ibid), and like Victoria it is highly urbanised. 62.9% of the population live in Sydney, the state capital of New South Wales, which is the most populated city in Australia with a population of 4.63 million people (ibid). The capital of Australia is Canberra, which has a population of 358,000 (ibid) and is located in the Northern Capital Territory, which is enclosed within New South Wales.

According to the 2011 census, 70% of Australia's population was born in Australia while 24.6% were born overseas. Of those from overseas, the biggest groups come from the United Kingdom, New Zealand, China, India and Italy and Vietnam. A significant proportion of those born overseas therefore are from English speaking countries. Victoria has a slightly higher proportion of people born overseas from non-English speaking countries than NSW; 19.6% compared o 18.6%. Although if we compared Sydney and Melbourne, 26.5% of Sydney's population were born in non-English speaking countries compared to 24.3% in Melbourne (ibid).

Indigenous Population

Under government policies of forced assimilation, by the late 1880s the majority of the indigenous population had joined white communities. An economically marginalised group, the indigenous peoples were not recognised as citizens of Australia until a referendum in 1967. Conflict over land and property rights gave rise to the civil rights movement in the 1970s, and the Aboriginal Land Rights Act was passed in 1976, which enabled indigenous people to claim rights to land based on traditional occupation (Siasoco, 2007).

The 2011 census shows that 548,370 people identified as being of Aboriginal and/or Torres Strait Islander origin, or 2.5% of the total Australian population (Australian Bureau of Statistics, 2012). Around 32% live in major cities, 43% in regional areas and 25% in remote areas. 31.5% of the indigenous population live in NSW, where they account for 2.5% of the population. 6.9% of the indigenous population live in Victoria, where they account for 0.7% of the population in Victoria (Australian Bureau of Statistics, 2012).

Politics and Government

The Commonwealth of Australia was formed in 1901. Its Constitution created a federal system of government. Powers are divided between a central federal government, six individual states and two major mainland territories. States and territories have their own parliament and can create their own laws, although federal government retains legislative power in certain policy areas including education, policing and local government among others (Australian Government Website, 2012).

The Federal government is divided into three arms; parliament, executive and judiciary. Parliament consists of two chambers; the House of Representatives and the Senate. The members of both chambers are democratically elected and represent geographical areas. The Executive is made up of government employees working across multiple departments, while the judiciary is the legal arm of the government. Elections for both chambers are usually held every three years, and throughout most of Australia, with the exception of the state of South Australia, voting is compulsory. In order for a party to form a government it must gain a majority in the House of Representatives, at which point its leader will become Prime Minister. The federal political landscape comprises of two major political groups; the Australian Labor Party, largely considered to be centre-left, and the Coalition which consists of the Liberal Party and the National Party, usually considered to be centre-right.

The Australian Labor Party has been in government since the 2007 federal election, with Julia Gillard as Prime Minister. In state parliament however, both Victoria and New South Wales are governed by a Coalition between the Liberal and National Parties. In the last half century, New South Wales has

been more likely to vote Labor than Victoria, which has tended to vote for the Liberals. Between 1937 and 1973, fourteen state elections were held in Victoria, and in eight of those elections Labor won 40% or less of the vote (Blainey, 2006, p.230).

Crime rates and prison population

International comparisons of crime are difficult to make because of international differences pertaining to the definition, reporting and recording of incidents of crime. The following table compares crime rates in England and Wales with Australia. The data comes from the UN Survey of Crime Trends which is based on police recorded crime in 2006 (United Nations Office on Drugs and Crime, 2006).

	Police Recorded Cases per 100,000 population	
	Australia	England and Wales
Intentional Homicide	1.2	1.1
Rape	91.9	27.7
Robbery	18	137
Assault	327	730
Burglary	1017	986

These figures suggest that there Australia has a much higher rate of rape while England and Wales have much higher rates if assault. Overall the evidence is ambiguous. According to the International Crime Victim Survey (ICVS) conducted in 2000, Australia has a higher rate of victimization than England and Wales (which is the percentage of the population that report being victims of crime). According to the ICVS, 26 % of people in England and Wales reported being a victim of crime, compared to 30% in Australia (Kesteren, Mayhew & Nieuwbeerta, 2000).

Data from the International Centre for Prison Studies (ICPS; 2012) demonstrate that Australia and England and Wales are characterised by high imprisonment rates. In England and Wales we imprison more of our population than any other Western European country. We have an imprisonment rate of 152 per 100,000, compared to 99 per 100,000 in Northern Ireland, 83 in Germany, and 75 in Finland (ICPS, 2012). Australia has a similarly high imprisonment rate of 165 per 100,000. As is the case in all developed countries, women constitute only a minority of the prison population. In England and Wales women account for 4.8% of the prison population while in Australia this is slightly higher at 7%.

	Australia	Victoria	New South Wales	England and Wales
Total prison population	28,404[2]	4,737	11,338	85,454[3]
Imprisonment rate[4]	165	105	179	152
Proportion of prison population that is female	7%			4.9%

Within Australia, New South Wales has a higher imprisonment rate than Victoria; 179 compared to 105 per hundred thousand (Australian Bureau of Statistics, 2011), and 165 in the UK. While NSW has historically had a much higher imprisonment rate than Victoria, both states are currently headed in different directions in terms of penal policy. In Victoria, law and order was a key theme in the last election campaign which resulted in the now Coalition government between the Liberal and National Parties. The prison population is rising in Victoria. In the past decade it has risen by 44% (Smart Justice, 2010, p.1). In contrast, the prison population in NSW has declined by 8% over the last decade (Australian Bureau of Statistics, 2011). This is consistent with NSW's coalition government's recent plans to close three prisons.

Currently however it remains the case the NSW has a much higher imprisonment rate. This is not attributable to any single factor, but to a combination of factors relating to both crime rates and also differences in policing and penal policy. For example, the higher number of convictions for armed robbery in NSW compared to Victoria is likely to be at least in part because of higher rates of armed robbery in NSW (Weatherburn et al 2010, p.5). The recorded rate of armed robbery in NSW was 1.9 times higher than that of Victoria in 2005 However, the higher numbers of convictions for drink driving in NSW compared to Victoria are more likely to be a result of greater levels of enforcement in New South Wales (Weatherburn et al 2010, p.5). Offenders in NSW are more likely to receive a prison sentence than their counterparts in Victoria. It is unclear however whether this reflects more punitive sentencing within NSW or rather differences in the severity of crimes that come before the courts, for example a greater proportion of crime in NSW could be violent crime. In both states, the Indigenous population is over-represented in the prison population. While 2.5% of Australia's population is Indigenous, 21% of the prison population in NSW and 6% of the prison population in Victoria are indigenous (Weatherburn et al 2010 p.5).

Homelessness, mental illness and substance misuse

Issues such as homelessness, mental illness and substance misuse often co-occur. This is particularly evident when one considers the profile of offenders. According to Australia's National Survey of Mental Health and Wellbeing, just under one in five Australian adults (17.7%) suffered from a mental disorder in the last 12 months (Australian Bureau of Statistics, 1997). This is comparable to findings from European studies; a review of which found that one in four adults was affected by at least one mental disorder in the past 12 months (Wittchen and Jacobi, 2005). Mental health issues are

[2] Australian Bureau of Statistics (2011)
[3] Ministry of Justice (2011)
[4] The Imprisonment Rate is the number of people in prison per 100, 000 population

particularly widespread among the prison population. According to the Australian National Survey of Mental Health and Wellbeing 42% of the prison population has experienced mental illness in the last 12 months (Australian Bureau of Statistics, 1997). In England and Wales, 2% of men and 5% of women in the general population will suffer from two or more mental disorders. When we look at the prison population however we see that 72% of men and 70% of women suffer from at least two mental disorders (Prison Reform Trust, 2012, p.27).

Similarly, people who end up in prison are much more likely than the general population to be homeless. According to the Australian Bureau of Statistics, on any given night at least 100 000 Australians are homeless. The majority of homeless people live in large cities including Sydney, Melbourne, Perth and Brisbane. 75% of homeless Australians are male and 20% are under 18.

In England, around 15% of men and 8% of women have used an illicit drug in the last 12 months (NHS Information Centre for Health and Social Care, 2011), for adults in Australia this figure is also 15% (Australian Institute of Health and Welfare, 2006). Among the prison population however, drug use is much higher. For example, 65% of the male prison population and 55% of the female prison population in England have used drugs in the last year (Prison Reform Trust, 2012) while 66% of the Australian prison population have used drugs within the last year (Australian Institute of Health and Welfare, 2006).

Overview of the trip and this report

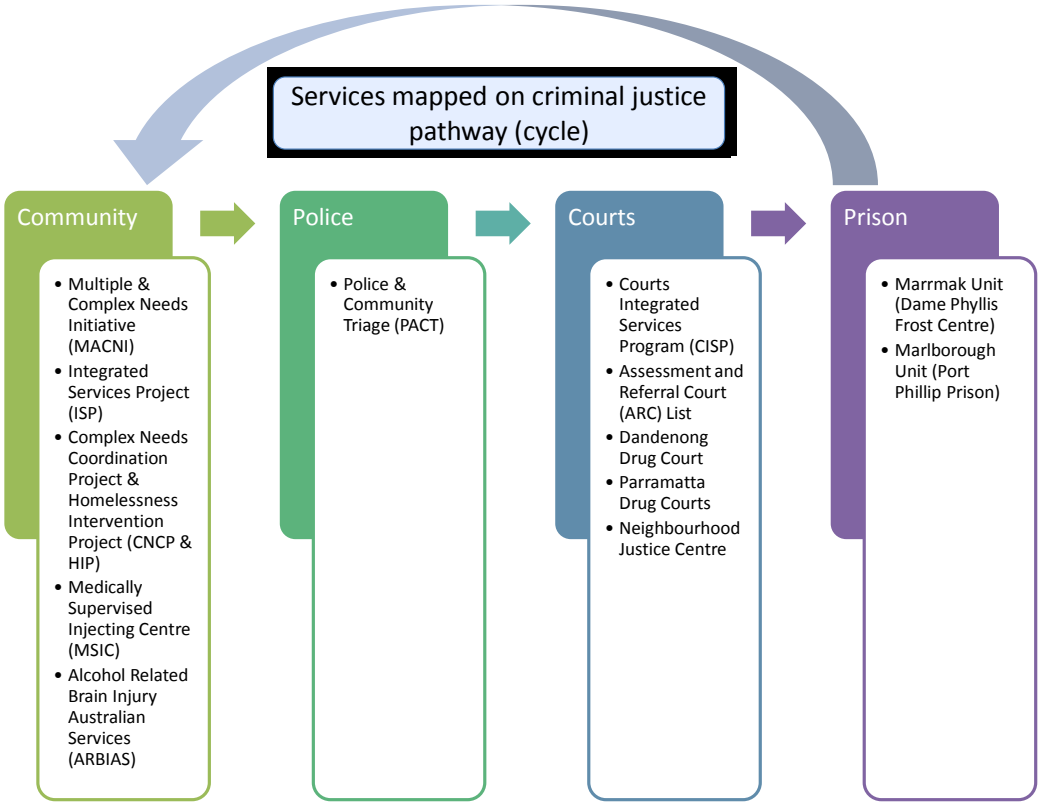
My Churchill Fellowship took place between the 25th September and the 22nd October 2012. I met with over 100 people from a range of services, universities and organisations. The initial focus of the trip was the Multiple and Complex Needs Initiative and the manager, Anne Leonard, was approached directly to facilitate a visit. In turn, Anne Leonard identified the Integrated Services Project in New South Wales as another example of a service addressing a similar target group. Further services were identified through UK based and Australian professional contacts in a snowballing approach whereby each new contact was asked to suggest further relevant services. A preference was given to services operating from central bases in Melbourne and Sydney which either directly targeted complexity or worked within the criminal justice system.

The trip and this report aims to raise awareness of a number of innovative service models for people with multiple and complex needs, to compare these models with those in use in England and Wales and to think about possibilities for and challenges of introducing such systems in this country. These service models include:

- Models for the most complex (Chapter 3)
- Diversionary case management interventions (Chapter 4)
- Responses to mental health needs and learning disabilities in the prison estate (Chapter 5)
- Problem-solving courts (Chapter 6)
- Medically Supervised Injecting Centre (Chapter 7)

This report also hopes to raise a number of other issues that became apparent on my trip that I am keen to bring back to the United Kingdom, notably the prevalence of Acquired Brain Injury within the Victorian prison estate and implications for service responses (Chapter 8).

The services covered in this report can be mapped across the criminal justice pathway as follows:


Services mapped on criminal justice pathway (cycle)
Community
• Multiple & Complex Needs Initiative (MACNI)
• Integrated Services Project (ISP)
• Complex Needs Coordination Project & Homelessness Intervention Project (CNCP & HIP)
• Medically Supervised Injecting Centre (MSIC)
• Alcohol Related Brain Injury Australian Services (ARBIAS)
Police
• Police & Community Triage (PACT)
Courts
• Courts Integrated Services Program (CISP)
• Assessment and Referral Court (ARC) List
• Dandenong Drug Court
• Parramatta Drug Courts
• Neighbourhood Justice Centre
Prison
• Marrmak Unit (Dame Phyllis Frost Centre)
• Marlborough Unit (Port Phillip Prison)

Constraints

With only four weeks in which to cover two states, time and distance were significant constraints. Inevitably, there were a number of important people and services that I did not get around to seeing. All of the interviews and visits were conducted in or around the metropolitan areas of Melbourne and Sydney. This was largely for time reasons although was also in recognition of the vastly different nature of 'rurality' in Australia to the United Kingdom (see population densities above).

The larger part of my trip was in – and so the focus of this report is – Melbourne, Victoria. This was in part due to my initial interest in MACNI and also partly due to the fact that I established stronger contacts in Victoria prior to my trip. Some of the provision in New South Wales in particular did not become apparent until late on in my stay, by which point it was unfortunately too late to make arrangements to visit some services. This report is in no way intended to provide a comprehensive overview of service provision for this group within the states of Victoria and New South Wales. I left feeling that I had only just touched the surface.

The same reasons constrained my examination of gender specific approaches with women who have complex needs although the section on Dame Phyllis Frost Centre highlights innovative practice with women in a custodial setting.

The primary focus of my trip was on services for adults and service responses to children and young people are not considered within this report (although MACNI works with those aged 16+).

The introduction to Australia outlined earlier on in this chapter highlights some of the historical context regarding the indigenous population in Australia as well as highlighting their over-representation in the justice system. While these are important issues, the context is highly specific to Australia and it was decided that addressing these issues was not directly related to the problems concerning people with complex needs in the UK.

I began the trip with aspirations to meet people with direct experience of multiple and complex needs and to seek the service user perspective on the services visited and on the overall services within the states visited. I was unsuccessful in this aspiration. Many of the services visited worked on an outreach basis in the community or provided interventions at points of crisis. The complexity of the clients also acted as a barrier to undertaking client interviews without significant preparation and time allowance. Due to these considerations, I was unable to make contact with those who use services.

In addition to the services and programmes detailed in this report I was fortunate enough to visit a number of other interesting services providing a range of support to people with complex needs. These have been omitted from this report due to significant similarities with existing and well-established programmes in the United Kingdom. Nevertheless, their omission does not detract from the important support that they provide to this group. Visiting these services has helped inform my thinking about complexity and responding to this and has provided invaluable insights to use in my daily work.

3

Models for the most complex

Conceptualising complexity

A significant number of people struggle with difficulties across a range of life areas and might be described as having 'multiple problems'. This might include financial, marital and other relationship and substance abuse problems alongside a diagnosis of mental ill-health. These problems are likely to interact with one another and may reduce a person's resilience to other life problems; their needs 'exacerbate and reinforce one another' (Anderson, 2010, p.4). However, this person may also have other factors in their life that increase their resilience e.g. a supportive relationship with a close family member, a passion and opportunity for gardening, the possibility and capacity to engage with support services to address their issues.

One of my early tasks at Revolving Doors was to undertake a review of the agency's learning. *Summing Up* reflected on the findings from 16 years' research and practice at Revolving Doors and found clear evidence of the existence of a group of people with multiple unmet interrelated needs, including health, behavioural, practical, emotional and skills-based needs who are both victims as well as perpetrators of crime (Anderson, 2010). The report highlights the sheer multiplicity of need. Almost half of the clients from Revolving Doors' pioneering Link Worker services needed help from between six and ten services; a further 10% required help from 11 services or more.

In seeking to understand the inter-relationship between these needs it is sometimes emphasised that the sum is greater than the individual parts. Rankin & Regan (2004) use the term 'complex needs':

"a framework for understanding multiple interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to stable housing or meaningful daily activity... [T]here is no generic complex needs case....People's complex needs can have breadth (range of need) and/or depth (severity of need). It is valuable shorthand to describe multiple interlocking problems where the total represents more than the sum." (Rankin & Regan, 2004, p.i)

Nevertheless, the interlocking nature of this complexity can be difficult to conceptualise and too often it appears easier to avoid explicitly articulating the problem that is being addressed. A failure to develop such a conceptual understanding is likely to act as an impediment to improving responses to this group of people since the group themselves are not clearly identified and the nature of their needs is therefore poorly understood.

During my Churchill Fellowship I met with a research team from the School of Social Sciences at the University of New South Wales who were considering this problem, led by Professor Eileen Baldry and Dr Leanne Dowse. The team were looking to gain insights into the nature of this complexity considering research and theory from other disciplines including intersectionality, game theory,

wicked problems and complexity science (Baldry, Dowse & Clarence, 2011). Although their work is still in progress, this approach already suggests some critical insights into complexity.

These theories have a common focus on the interdependence between elements. They highlight the non-additive nature of the elements within a complex system, the dynamic nature of this system, the need to consider the whole system and not the individual elements in isolation and they highlight that intervening in one area of the system on the basis of partial information can have unforeseen consequences elsewhere in the system. In turn, such consequences can negate or reinforce the initial intervention (Baldry, Dowse & Clarence, 2011).

The person's 'complex needs' form an interdependent system where the sum of need is more than its parts and problems are compounded by each other. However, crucially this is only a sub-system of a much wider system. Too often concepts of complex health and social care needs ignore the significant role played by the service and social system within which the person finds themselves in exacerbating a person's needs and entrenching their problems.

"The underpinning assumption is that the presence of a particular characteristic, impairment or dysfunction or combinations of these is attributed primarily to the individual...Their problems are individualized (she or he is the person with complex needs) and any social and structural factors that have created and maintained the need or dysfunction are written out of an understanding of the person's immediate situation and out of a criminal justice response." (Baldry & Dowse, in press)

The review *Complex Responses* was an attempt to understand the many and complex reasons behind poor frontline service responses to adults with multiple needs, with a particular focus on those in contact with the criminal justice system (Anderson 2011). The work unearthed a wide range of interpersonal, professional, organisational and structural factors which contributed to these poor responses. More than this, they contribute to the very complexity of the person's needs.

Both game theory and complexity theory highlight the role of agents (in this case people, services and other organisations) in driving change within the system in an attempt to achieve their own shared or divergent goals. Nevertheless, in a complex system such changes are likely to based on (at best) only partial information about the state of the system and other agents within it, giving rise to the likelihood that changes will lead to unanticipated outcomes. Complexity increases with the number of agents (eg. clients, professionals, carers and services) and leads to an overwhelming sense of unpredictability within the system (Allen, Griffiths & Lyne, 2004; Ramalingam et al, 2008).

The relationship between the person with multiple and complex needs, their family and wider social circle and the professionals and services that work with them is one of mutual interdependence and interaction. Nevertheless, this tendency to resort to an individualised diagnosis-based understanding is entrenched within the thinking of many of those working to address complexity. Frequently I found myself falling back upon such conceptualisations of complexity. Meeting with Professor Eileen Baldry, Dr Leanne Dowse and colleagues played an important role in challenging these entrenched concepts.

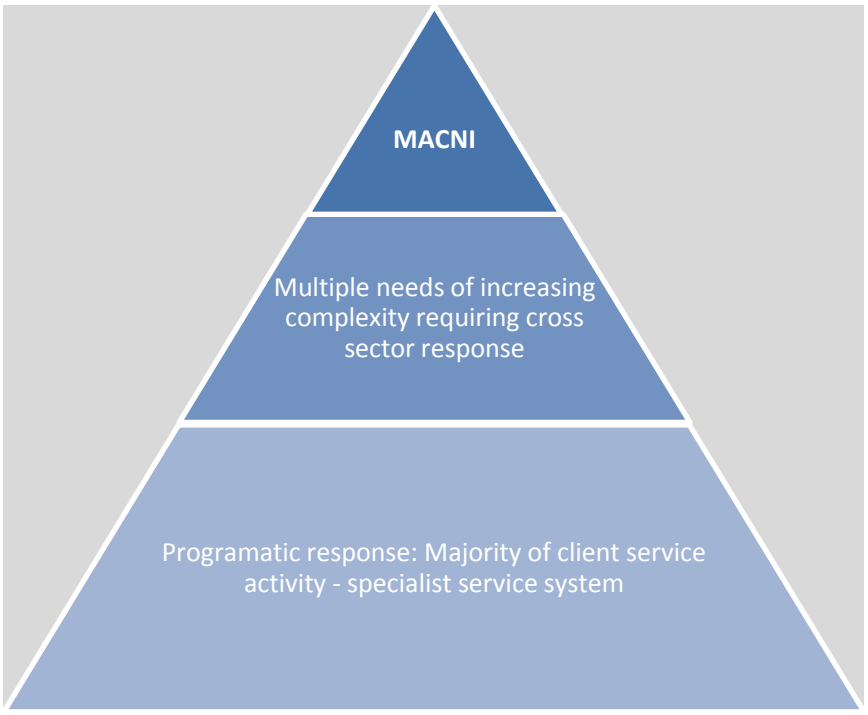
This move away from a diagnosis focused approach to complexity is a key factor for the services outlined in this chapter. Although a range of diagnoses are included within the eligibility criteria for these services, it was clear that a largely flexible approach to this was adopted allowing for the inclusion of those with apparent or confused diagnoses. The focus was on complexity itself. In addition to this the services in this chapter (in particular the Multiple and Complex Needs Initiative and the Complex Needs Coordination Project) implicitly acknowledge the role of and actively seek to influence the system within which the person with multiple and complex needs is only one component part.

Multiple and Complex Needs Initiative (MACNI)

Targeting the most complex

Victoria's Multiple and Complex Needs Initiative (MACNI) targets the very small number of individuals described as being at the 'extreme end of the spectrum'. These individuals were reported to present with a number of common behaviours including:

- disruptive behaviour that might include violent, threatening, aggressive, antisocial or unpredictable behaviour, inappropriate sexual behaviour and destruction of property
- radically poor living skills and an associated chaotic lifestyle
- repeated crises and excessively demanding behaviour (often leading to exclusion from services)
- an almost total lack of social networks
- violence to self including suicidal and risk taking behaviour and use of alcohol and drugs



Reproduced from Department of Human Services, 2007a, p.18 (Department of Human Services, 2003)

Eligibility for MACNI (initially enshrined in legislation[5]) adopts a combined diagnosis-, behavioural- and system-based approach to complexity.

Those accepted onto the programme must have at least two of a number of identified diagnoses.[6] Of the sixteen case studies reviewed as part of the final evaluation, the most common diagnosis was mental disorder with 13 out of 16 clients having such a diagnosis. That said, Marilyn Kramer, Senior Program Advisor for MACNI, reported that there was sufficient flexibility to allow those with 'the

[5] Human Services (Complex Needs) Act 2003, Part 3, Section 15 (KPMG, 2007)

[6] A mental disorder (within the meaning of the Mental Health Act 1986); an intellectual impairment; an acquired brain injury; or a drug or alcohol dependency (within the meaning of the Alcoholics and Drug-dependent Persons Act 1968)

appearance of' a diagnosis to be included who may not have had the opportunity to be formally diagnosed or who may have highly confused diagnoses.

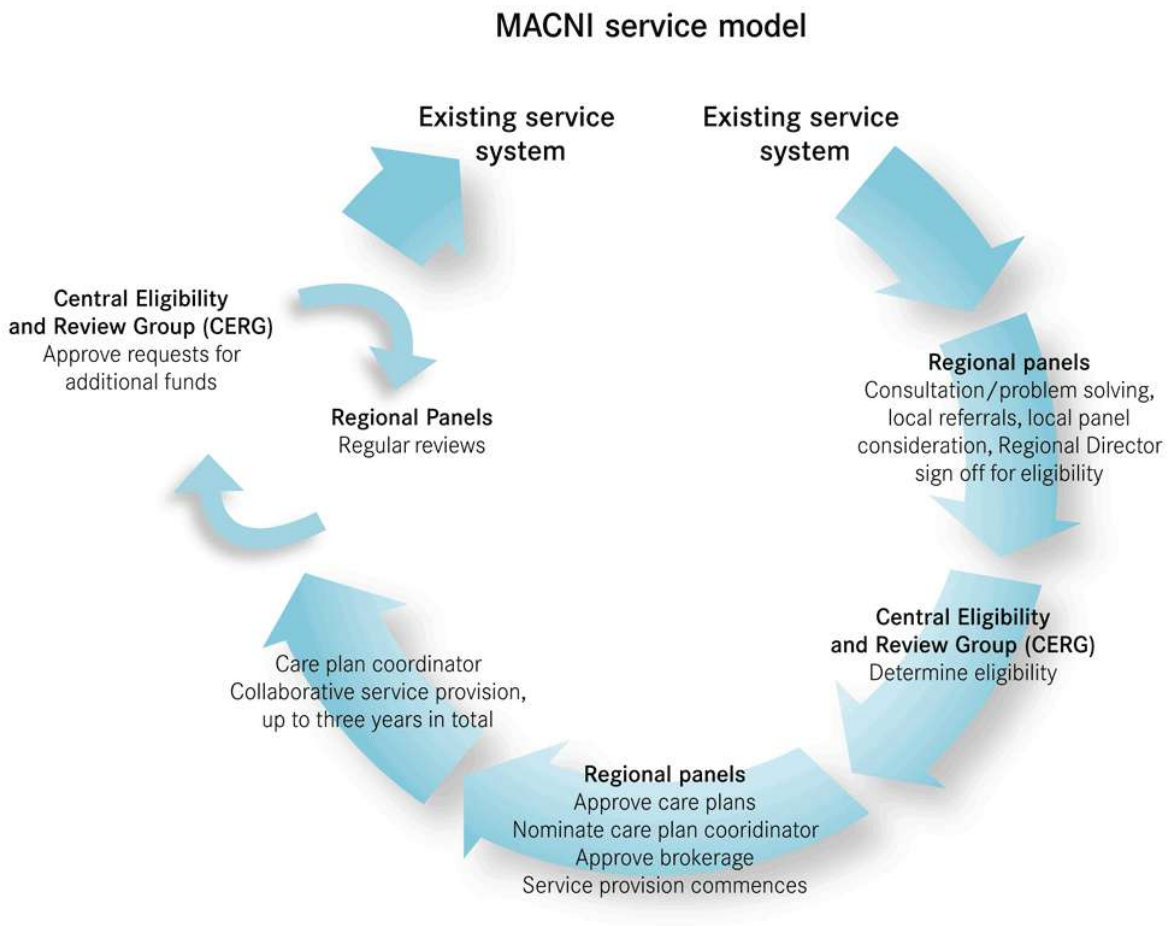
Eligible clients must also have exhibited violent or otherwise dangerous behaviour that has caused serious harm to themselves or others or be exhibiting behaviour which is reasonably likely to put themselves or others at risk of serious harm. However, although some MACNI clients were reported to have committed serious offences including rape, manslaughter and murder it appears from interviews and other evidence that there is a broad interpretation of what constitutes 'serious harm'. Professor Margaret Hamilton, formerly Chair of the MACNI Statewide Panel writes that *"Most [clients] however had multiple convictions for what can be described as nuisance offences. Some included clients who persistently engaged in crimes where the only motivation appeared to be inviting emergency service responses."* (Hamilton, 2010, p. 311)

The person must also be seen to need and be likely to derive benefit from the programme, in particular the care coordination aspect. Finally and crucially entrance onto the programme is further restricted since regional areas must be able to demonstrate that they have already exhausted all local options. These latter requirements comprise the system-based eligibility components in that it is the system (and not the person) which requires coordination as well as an external impetus for change. There are at most 40 clients per year on MACNI across the whole of Victoria.

MACNI is both a process for bringing agencies together to provide support for people with multiple and complex needs and itself a service providing assessment, care planning and care coordination.

Application to the programme is through regions with each region having a Regional Coordinator (an employee of the Department of Human Services) who gate keeps referrals. Regional Panels consisting of senior managers from the regional departments of Human Services, Health and Justice (along with the managers of other service providers such as NGOs) meet regularly to provide support to the Regional Coordinator. Originally referrals to the initiative were made to a Statewide Panel. This has now been disbanded and a Central Eligibility Review Group (CERG) with similar but reduced functions manages referrals. The CERG is departmental, held by the Department of Human Services and is attended by senior bureaucrats and clinicians from the departments as well as two expert advisors who are independent of government and whose role is to ensure that decisions are made in the best interest of the client and are not driven by policy or funding considerations. They play an important role in challenging decisions.

Once accepted onto the programme, MACNI offers an extensive assessment of need, a tailored care plan and independent coordination of a range of support for up to three years.



MACNI service model reproduced from website of the Department of Human Services, Victoria (Department of Human Services, 2011a)

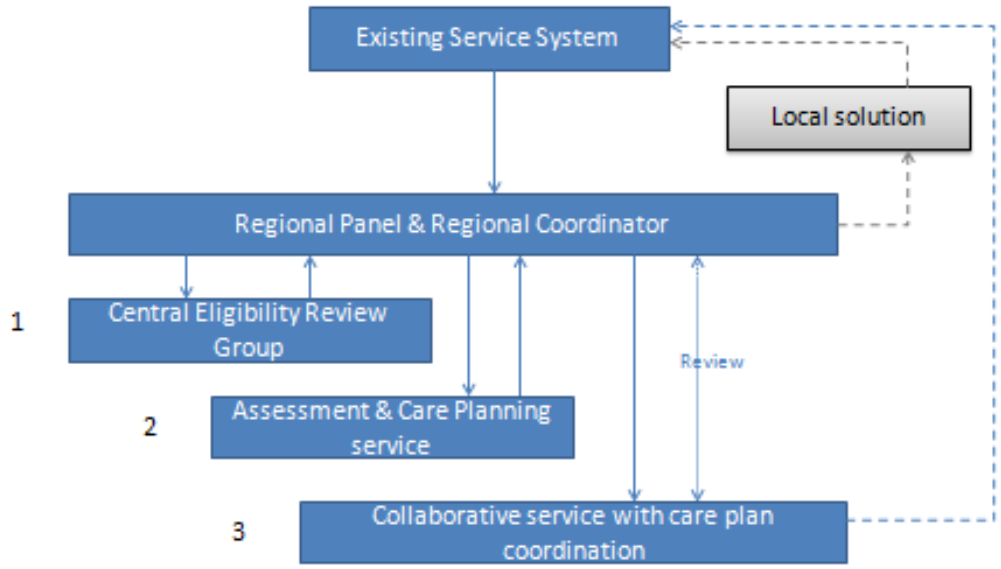


Diagram to demonstrate MACNI process, adapted from Hamilton, 2010

Indigo Assessment and Care Plan Coordination service is contracted by the Department of Human Services to undertake comprehensive psychosocial assessment and care plan development for clients accepted onto MACNI. In addition, they undertake the independent care coordinator role for a majority of MACNI clients. Indigo is part of the Western Region Health Centre Ltd, a not-for-profit company, managed by a Board of Directors committed to improving the health and well being of the people who live and work in the Western Region by providing an accessible range of comprehensive, high quality and integrated health and welfare services. Although the Western Region Health Centre is focused on the Western Region of Victoria, the Indigo service is statewide. Indigo staff are highly skilled with at least a tertiary qualification in a relevant discipline (for example social work or nursing) and extensive experience working with clients with complex needs and multi-agency working.

Key features (MACNI)

1) **Welfare led:** The central team is based within the Department of Human Services (DHS) which includes housing and disability services. It appears to have a similar remit to the Department of Communities and Local Government in England. Initially the programme sat within the integrated Department of Health and Human Services. This Department was then split for unrelated reasons which may have an impact on the Initiative. When asked, Marilyn Kramer (Senior Programme Advisor for MACNI, DHS) clearly expressed the view that the programme could not have been a justice-led initiative and still received buy-in from all government departments.

2) **Direct government involvement:** As well as developing the initial model and associated legislation; the central team in the DHS ensure the continuing development of the model. Senior bureaucrats and clinicians from a range of government departments sit on the Central Eligibility Review Group and so determine access to the programme. The central team also adopt a 'hands-on' approach with those on the programme; liaising closely with Indigo over individual care plans and coming up with innovative solutions to meet client needs. This is highly unusual for those working within a central government department.

3) **Cross-Departmental Buy-In:** There is reportedly a clear consensus among the different government departments that they need to work better together. Finding and engaging other champions for the initiative, including strong support from the Secretary of State, was also felt to have secured cross-departmental buy-in. A significant amount of work was undertaken at the outset engaging like-minded people to promote the benefit of getting together and talking. There is no independent funding from the Treasury for the initiative. Instead, funding comes from the various programme areas whose existing complex clients are likely to fall within the MACNI remit, i.e. disability services, mental health, justice. Pooling of resources to provide funding for the initiative is reflective of and has helped to sustain this buy-in.

4) **Regional Buy-In:** Regional buy-in was also identified as crucial. It was felt that participation on the Regional Panels offers the valuable opportunity to strategically engage with other programme areas. Attendance of other senior managers on Regional Panels was felt to reinforce the importance of representation of other departments on the panel at a senior level. These panels were not part of the original model but a later development.

5) **Up-skilling local areas:** There is the expectation that all clients accepted onto MACNI have had a range of solutions tested and exhausted locally. A significant focus of the Regional Coordinator role is in the pre-MACNI work which involves bringing services together to problem-solve. It was reported that the regions' capacity to manage complex clients has increased significantly through the lifetime of the programme and that the service sector as a whole had improved their response to complexity. This view was supported by the KPMG evaluation that reported that the eligibility criteria requiring regions to demonstrate that local solutions had been exhausted had been "a major impetus to regions developing the processes and capacity to identify local solutions for managing people with complex needs" (Department of Human Services, 2007a, p.6). As a consequence, it was suggested that there had been an up tariffing of client complexity with those now presented to the CERG being far more complex and chaotic than those before the Statewide Panel at the outset. In particular it was felt that responses to serious self-harm and Borderline Personality Disorder had improved.

6) **Managing and sharing risk:** In her analysis of the MACNI programme, Professor Margaret Hamilton, former Chair of the MACNI Statewide Panel, identified the management and sharing of risk as a key feature in the success of the programme. She reports that *"Achieving service cooperation and coordination to ensure integration was the most difficult aspect of the MACNI implementation. It proved more demanding of all resources...One underlying aspect of this was the issue of managing risk."* (Hamilton, 2010, p.316) Hamilton makes clear that although risk management at the individual level was a concern, it was comparatively straightforward compared to concern regarding risk to organisational reputation. She reports that the perceived authority of the original Statewide Panel *"facilitated a level of comfort on the part of participating services that allowed for negotiated risk sharing. Care Plans had to be agreed by Senior Management of all services and the sharing of risk was often crucial in achieving agreement."* (Hamilton, 2010, p.317)

7) **Legislation:** MACNI was introduced and is governed through specific legislation.[7] Successive phases of the evaluation have identified the value of this legislative underpinning. The final evaluation reported that the legislation *"is perceived as adequate to improve service coordination and achieve client outcomes through: providing the imprimatur for sharing information and engaging stakeholders; conferring authority for Regional Directors to prioritise complex clients; imposing a timeframe requiring a focussed response; and creating a process for coordination and collaboration."* (Department of Human Services, 2007a, p.13) In addition, Professor Hamilton has emphasised the legislation's use as a vehicle for bringing *"reluctant"* services together (Hamilton, 2010, p.313). The legislation's value in clarifying what information could be shared was perceived as a benefit by interviewees on my visit. It was reported that although existing legislation in place prior to MACNI did not always legally stop professionals sharing information with each other, in practice this was the result as there was a general misunderstanding regarding what information could be shared and in what circumstances. The importance of legislation in compelling multiple agencies to work together and share information to support clients with complex needs is an interesting issue for consideration. During my visit I was able to meet with Professor Bernadette McSherry from Monash University who was hoping to embark on a programme of research to consider just this issue, looking also at the UK's Multi-Agency Public Protection Arrangements. These findings will be important in considering government approaches to meeting complex needs.

[7] The Human Service (Complex Needs) Act 2003 later amended by the Human Services (Complex Needs) Act 2009)

8) **Brokerage funds:** There is $1.4 million AUS (approximately £900,000[8]) in brokerage funding available for the clients on the programme. Clients do not have a set budget but it was reported that most clients cost between $40-50,000 AUS per annum (approximately £25-32,000). However, individual brokerage costs can be much higher. It was reported that one very dangerous client was on a programme of support that cost $360,000 AUS per annum in top-up funds (approximately £230,000). Regional Panels have the authority to attach a budget of up to $50,000 AUS (approximately £32,000) for six months. Funding in excess of this has to be agreed by the CERG. Brokerage funds acknowledge that some mainstream services often fund only very specific and time limited activities. The aim of the funding is to top-up services that are already available; it is not to pay for activities and support that should be being provided anyway. *"Brokerage is about client need and not service need."* (Marilyn Kramer). It was clear from talking to other people during my trip that the large amount of funds available is perceived as one of the attractions of the programme by professionals.

9) **Extensive and contextual approach to assessment & resulting care plan:** An extensive process of assessment is undertaken to inform the development of the care plan. As well as meeting with the client, their family and other support services involved in the client's care, a dedicated worker collates and reviews all other assessments undertaken on the client and all current and historic service use, including school records and child protection records. Despite the care planning agency Indigo having 9 frontline staff and 2 team leaders at the time of my visit, around only 15 care plans are developed a year due to the time-consuming nature of this process. Interviewees from Indigo explained that a contextual approach is taken to the client's problems, with a key purpose of the assessment being to establish how their personal and service-use history have led to their current situation. The approach assumes that the policy environment and service systems have themselves had a direct influence on the client's behaviour. The assessment process and the care plan development are undertaken in tandem with the worker using this information to formulate hypotheses of what might work throughout the assessment process and canvassing the views of people who are currently involved in the client's care.

10) **Independent care coordinator:** Clients are provided with a care coordinator who is independent of those professionals providing direct services. For the most part care coordination is provided by Indigo but in some cases coordination is provided by a local service involved in the clients care (although not by someone working directly with the client). Where a local service is used some of the brokerage funding is used for training and professional development of that coordinator around care coordination and working with complexity. The ratio of clients to care coordinator at Indigo is exceptionally low (three to four clients for each care coordinator) allowing for stronger engagement with both the client and the service sector. Senior Program Advisor Marilyn Kramer identified that the care coordinator is able to provide leadership and guidance to other services, ensure that risk and responsibility for the client is shared, be future-oriented and are perceived to have authority to bring people together to problem solve. Meanwhile the case managers in other services are free to do the direct work on a daily basis without having to plan and reflect. In addition, former MACNI Panel chair Professor Hamilton has written that the care coordinator must have *"a vision beyond the immediacy of necessary 'client settling' or overcoming a crisis to include systemic change"* (Hamilton, 2010, p.317). The independence of the care coordinator was perceived to be a crucial aspect of the model.

[8] Exchange rates used throughout this report are those current on the 8th October 2012.

11) **Repeated attempts to engage clients:** Participation in the programme is voluntary but signed consent is not sought from the clients. Rather, they look for active refusal since the concept of 'informed consent' only has limited meaning for many of the MACNI clients. If a client refuses to participate in the process, repeated attempts are made to engage the client in the process. It was reported that they have had only one refusal in eight years.

12) **Strategy for transition:** In preparation for exiting MACNI, transitional care plans are put in place in the 6-8 months prior to release. The evaluation identified elements that support a successful transition, including identifying agencies to carry on key elements of care; a clear assessment of need; identifying a new case manager and handing over responsibility; gradually reducing the level of support; and supporting and in some cases training new professionals to work with the client (Department of Human Services, 2007a). Marilyn Kramer, Senior Program Advisor for MACNI, suggested that through identifying a care coordinator based in a local provider and identifying local funding for the required care package, the intention is that the client themselves is not aware of the transition out of the programme at all in terms of the support that they receive.

Brenda (MACNI Case Study)

"Brenda" was referred to MACNI by her Community Mental Health Centre. Although she was receiving support from them, this high level of support was unsustainable. Brenda had experienced a number of significant bereavements (including traumatic bereavement). She suffered from depression with psychotic features and post-natal depression, was dependent on alcohol, diagnosed as having a borderline personality disorder, had thyroid cancer and had an injury that affected her mobility. She had demonstrated violence to others as well as self-harming behaviour. During the assessment and care planning process, consultation was held with over 21 stakeholders.

The Care Plan goals included relocating to a larger home, reducing social isolation, continuing support from services including attending her GP for her physical health, receiving bereavement counselling and addressing her alcohol and substance misuse problems. Brokerage funding was used to secure counselling and an after hours response, cover taxi costs to attend appointments and cover administrative resources, fund a half-time assertive outreach worker post, provide staff training and supervision and other discretionary costs. Indigo undertook the independent care coordination role. Despite slow progress due to inpatient psychiatric stays, the initiative was seen to have been successful as she had a supported accommodation plan in place, had developed social skills and was engaging successfully with support providers.

For full case study and further case study examples see Department of Human Services (2007b).

Evidence of outcomes

MACNI aims to improve client outcomes against four platforms: stable accommodation; health and wellbeing; social connectedness; and safety.

The KPMG (Department of Human Services, 2007a,b) evaluation reviewed 16 case studies and found that as of the time of the evaluation half of those individuals had achieved significant improvement in their functioning and capacity to live in the community or had demonstrated some improvement that is likely to lead to further gains. In addition, another quarter had been maintained at their current level. In 2008 the MACNI team within the Department of Human Services also published a snapshot study of client status post termination of their case. Of the 21 cases that had been terminated 19 were available for analysis. Of those 19, 13 were found to have experienced significant improvements across all the four MACNI platforms when comparing pre and post MACNI

status (Department of Human Services, 2009). This analysis also reports a 63% improvement in the area of stable accommodation post-MACNI, a 69.5% improvement in health and wellbeing; a 51% improvement in social connectedness and a 46% improvement in safety (the number of individuals rated low or no risk).

KPMG's (Department of Human Services, 2007a) analysis also indicates that following involvement in MACNI there are overall and significant reductions in hospital emergency department presentations, hospital admissions and hospital bed days.

Stakeholders interviewed for the evaluation (Department of Human Services, 2007a), the Snapshot study (DHS, 2008) and interviewees during my Fellowship reported that local responses to complex needs had improved as a result of the programme with local services both more willing and more able to respond to complex clients. Consequently, MACNI is highly likely to have led to improved outcomes for other multiple needs clients not deemed eligible for the service. These improvements are not captured in the available data.

Integrated Services Project (ISP)

Targeting the most challenging

In contrast to MACNI which explicitly focuses on *complexit*y, eligibility for New South Wales' Integrated Services Project (ISP) focuses around *challenging behaviour*. Nevertheless, the actual eligibility criteria are very similar to those for MACNI containing behavioural, diagnosis- and system-based factors. The client must exhibit behaviour that places themselves and / or others at risk of harm and as a consequence of this behaviour the client must have significantly impaired access to essential services. It was reported that many ISP clients have a prison history but once again the majority of clients' recorded offence histories constituted of low-level public disorder or 'survival' offences. Additionally, there is another group of clients who have committed very serious offences and present a very serious risk.

The client must have either **one or more** disabilities or diagnoses, or the client's diagnosis must be in dispute. This is in contrast to the minimum of two diagnoses required by MACNI however the evaluation of the project reported that clients had a median number of four presenting disabilities and disorders; only one person had one diagnosis and the rest (n=37) had two or more diagnosed disabilities or disorders. The most common diagnosis was mental illness and of those the most common diagnosis was personality disorder (McDermott et al, 2010).

As with MACNI, referrals are further restricted to clients that are seen to need a coordinated multiple agency response and again, crucially, all other options for support must have been exhausted (the system-based factors). The most notable distinction with MACNI is that ISP clients must also live in insecure accommodation, although in practice this appears to have equally been a feature of MACNI clients.

Nominations to ISP are made by the seven New South Wales Human Services departments: Health; Housing; Ageing, Disability and Home Care (ADHC); Office of the Public Guardian; Corrections; Juvenile Justice; Community Services. Each department nominates four people per round to the multi-agency Project Management Committee, from which eight people are chosen. The Program is administered by ADHC[9] and is overseen by a Program Management Committee consisting of officers from ADHC, Mental Health and Drug and Alcohol Office (MHDAO) within Ministry of Health, Housing

[9] It was originally intended that the program would be administered by Health. It was felt that this may have been more suitable given that the majority of clients have mental health problems and would not meet the criteria for ADHC services.

NSW and advised by a broader Interagency Reference Group (Ageing, Disability and Home Care, 2012).

Once accepted onto ISP, the project offers supported accommodation alongside a combination of case management and clinical support. A client's treatment team consists of the case manager, clinician, house team leader and key worker who meet regularly to review the treatment plan, goals and successful and unsuccessful aspects of the current adopted approach.

Key features (ISP)

1) **Strategic leadership:** The evaluations of the project reported high level and long term commitment within the NSW government which was seen as key to the successful engagement of stakeholders (McDermott et al, 2010). The project is located within the Office of the Senior Practitioner (OSP) business stream of Ageing, Disability and Home Care whose primary role is to provide leadership and coordination of services for people with complex needs and challenging behaviour. The OSP provides supervision and practice leadership and identifies training and professional development across a range of areas of health care practice. It has a particular focus on policy and practice regarding those who have exhibited offending behaviour.

2) **Cross-governmental project:** ISP is a joint initiative between Ageing, Disability, Home Care (ADHC), NSW Health and Housing NSW. It also incorporates a broader range of agencies through nomination rights for all seven Human Services departments and through the inter-agency reference group. However, interviewees during the visit did highlight a number of problems arising from the project being administered within one department, ADHC, for example restrictions on recruiting that inappropriately limited staff to those with disability expertise. The increasing tension to be 'pulled' into the status quo of one department was seen as a risk to this project that needed to be carefully managed.

3) **Supported accommodation:** The ISP provides support to people in insecure accommodation through a supported accommodation model. Accommodation options vary according to the client's individual needs, ranging from drop-in models to group home accommodation with twenty-four hour cover. For the most part, the latter more intensive option is utilised.

4) **Comprehensive assessment and individualised care plan**: in the months preceding entrance onto the project, attempts are made to build a therapeutic relationship with the client, undertake a comprehensive assessment and develop an individualised care plan. This is developed in partnership with the individual and referral agencies and is an individualised response based on symptomatology (i.e. not purely diagnosis-led). Care plans include a range of behavioural and therapeutic interventions.

5) **Consistent approach to managing behaviour:** A primary focus is on managing and reducing challenging client behaviour. Behavioural support plans are developed by clinical staff for support staff within accommodation and the project's clinical team reportedly undertake significant work visiting properties and modelling behaviours to staff to ensure a consistent approach. In addition, Management Plans are developed with key local agencies, notably the police, for each new client on the programme to ensure that local agencies respond in a way that supports the determined approach.

6) **Clinical support and therapeutic interventions:** As well as providing clinical support to the accommodation team, the clinical team have been engaged in developing tailored therapeutic interventions appropriate for the complex client group on the ISP. For example, in conjunction

with the Community Justice Program[10] within the Office of the Senior Practitioner they have developed a programme of Dialectical Behavioural Therapy for people with a cognitive impairment which includes individual sessions, group work and up-skilling other staff involved in a client's care.

Evidence of outcomes

The independent ISP evaluation undertaken by the Social Policy Research Centre at the University of New South Wales considered ISP impact on challenging behaviours, appropriate service use, ability to live safely in the community, health and wellbeing and social connectedness. Although impact on challenging behaviours was mixed, the evaluation reports that *"Clients experienced a decrease in the frequency and impact of their challenging behaviours which contributed to a considerable decrease in the amount of hospital and criminal justice services used by clients."* (McDermott et al, 2010, p.viii). This includes a 90 per cent decrease in the number of days spent as an inpatient in hospital, an 82 per cent decrease in the number of hours spent in emergency, and a 94 per cent decrease in the number of days spent in custody.

Clients also reportedly demonstrated greater independence in some activities of daily living although improvements were relatively small. There were self-reported improvements to health and improvements to well being with increases in standard of living, achievements in life, future security and life as a whole as measured on the personal wellbeing index. There was also evidence of increased involvement in positive activities. However there is some evidence that wellbeing decreases after transition from the ISP based on the small number of clients (18) that had transitioned from the project at the time of the evaluation.

Complex Needs Coordination Project

The Complex Needs Coordination Project was established in the City of Sydney in 2007. Despite receiving a positive evaluation, the project ceased to operate from 2010 due to insufficient resources. During my visit I was able to meet with Liz Giles, Manager of the Homelessness Unit in the City of Sydney to discuss the model used by, and learning from the project. Further information about the project and key learning is drawn from the project evaluation undertaken by the Social Policy Research Centre at the University of New South Wales (McDermott & Bruce, 2010).

Targeting the chronically homeless

The Complex Needs Coordination Project (CNCP) had the joint and related aims of establishing a framework for coordinating service delivery to chronically homeless people based on flexible and collaborative service responses, and facilitating exits from homelessness by linking clients in with appropriate housing and coordinated support (McDermott & Bruce, 2010).

The focus of the CNCP was on coordinate existing services to provide support for chronically homeless people. Chronically homeless people were taken to be those who have been homeless for a year or more or who have had at least four episodes of homelessness in the past three years. Clients had experienced homelessness for an average of 10 years before joining the Project.

In addition to chronic homelessness, clients had to have one or more 'disabling condition'. The evaluation established that 95 per cent had a primary mental illness, three quarters had a physical illness, three quarters had a substance abuse problem, and half had a cognitive impairment. In

[10] The Community Justice Program provides accommodation and support services for people with intellectual disability exiting the criminal justice system.

addition, the evaluation highlighted the complexity of clients who were reported to have *"an array of other issues, including contact with the criminal justice system, a history of abusive relationships, hoarding and squalor, social isolation, challenging behaviours, and difficulty carrying out daily living skills."* (McDermott & Bruce, 2010).

The model

Similarly to MACNI, the CNCP was a process for developing coordinated care plans but unlike MACNI there is no new service providing assessment, care planning and care coordination. These services were provided through the existing service system although with support from the CNCP structures.

The project involved the convening of two multi-agency groups, a strategic Complex Needs Management Group and an operational Care Coordination Group. Members of these groups gave their time and expertise freely and came from a wide range of relevant agencies from both the government and the non-governmental sector. As the project evolved a dedicated Project Coordinator was recruited to assist this process.

The Complex Needs Management Group had oversight of the project, reviewing quarterly reports from the Project Coordinator. The Care Coordination Group on the other hand was comprised of experienced practitioners and clinicians who considered referrals and provided advice and support in the development of coordinated care plans.

Primary responsibility for client assessment rested with the referring key worker who would have to identify disabling conditions, a detailed history of previous interventions and current professional and service involvement. Where the client was not referred by a key worker the Project Coordinator would identify an appropriate professional to undertake this role.

Following review of this assessment by the Care Coordination Group, the key worker would negotiate a coordinated care plan with a range of other agencies with support from the Care Coordination Group.

Key features[11]

- **Strong leadership:** The evaluation identified strong leadership from the lead agencies to involve and engage a wide range of government and non-governmental partners in the project, to develop and commit to shared aims and to encourage partners to give their time freely. The Complex Needs Management Group was also seen to provide an important leadership role.
- **Addressing systemic as well as individual barriers:** The Care Coordination Group shared knowledge and expertise and worked together to creatively problem-solve for individual clients. In addition, one of the primary purposes of the Complex Needs Management Group was to provide support to overcome systemic barriers in appropriate service access and to facilitate coordination between organisations at a strategic level.
- **Multi-agency expertise:** a wide range of agencies were represented at both a strategic and operational level. This includes representation from housing, mental health, substance misuse, disability, criminal justice, non-governmental support providers and primary health care. These agencies brought with them a range of different expertise, knowledge and networks. It was reported that a primary role of the Care Coordination Group was to support

[11] Although these features have also been identified on the basis of discussions during my Churchill Fellowship, I am heavily indebted to the service evaluation (McDermott & Bruce, 2010) which identified components that need to be in place for service coordination to work well.

the key worker to establish what appropriate agencies were out there and to identify and negotiate pathways into these services (*"sometimes workers just don't know the system"*).

- **Willingness to work flexibly:** The evaluation identified that service coordination works well when *"a strong commitment is made by individuals and key organisations and services to participating in CNCP to work flexibly and to prioritise client need over operating guidelines"*. During my visit it was suggested that *"so much [of the activity that services undertake] is about fitting the services' needs and not the clients"*. Overcoming this barrier was a primary focus of the project.
- **Accountability:** The jointly negotiated care plan contained detailed roles, tasks and time frames and the Project Coordinator could act as an independent arbitrator when disputes arose in the implementation of these care plans.
- **Supporting people to live independently:** Links with the newly established Housing First scheme (see box) gave the CNCP priority allocation to thirty properties for clients of the project, with clients supported to live independently where possible. Interviews and the evaluation highlight that the CNCP project built upon the Housing First philosophy that chronically homeless people do not need to be 'housing ready' to access stable accommodation, although the focus of the CNCP itself was on achieving service coordination.

In addition to these key features, the service evaluation found that coordination works well when regular meetings are held and these meetings have clear objectives and there are good systems for communication and information sharing. These will be important if the model is to be replicated.

Outcomes

The evaluation reported that the Community Needs Coordination Project provided coordinated support for all 41 clients, successfully leveraging resources to support this group. In addition it accessed or supported access to appropriate accommodation for 36 of these clients, all of whom had experienced chronic homelessness prior to engagement in the project. During my visit at the end of 2011, it was reported that most of these were still housed.

The evaluation found that the housing and support services contributed to clients feeling less exposed to the elements and safer. They found it easier to access services, and felt they had somewhere to turn to. Most felt that there had been some positive change in their lives although clients continued to experience difficulties with access to children, drugs and alcohol, physical health issues, and social isolation.

In addition, the evaluation found that *"the framework contributed to a better understanding of different organisational priorities, improved communication and networks amongst members, and improved the capacity of the service system to address the needs of individual clients with complex needs."* (McDermott & Bruce, 2010, p.20) Liz Giles also suggested that it had led to an increased understanding of the people within this group and the barriers to supporting them.

Housing First

'Housing First' is a model of providing housing for vulnerable people with complex needs.

"The Housing First model essentially 'bypasses' transitional stages [through tiers of supported housing] characteristic of linear models by placing the most vulnerable homeless people directly from the street or emergency shelters into permanent independent tenancies, with comprehensive yet non-compulsory, support. As the name implies, the model is founded upon a 'housing first' rather than 'treatment first' philosophy, thus marking a paradigm shift in the approach to housing vulnerable people in many countries." (Johnsen & Teixeira, 2010)

First developed in the United States, this model has reportedly been embraced by Housing New South Wales which established the Homelessness Intervention Project (HIP) in 2008. HIP is a cross agency initiative led by Housing NSW and including the Department of Premier and Cabinet (DPC), NSW Health, the Department of Community Services (DoCS), City of Sydney, Homelessness NSW, and the Youth Accommodation Association. As part of this the Homelessness Intervention Team was tasked with housing and supporting chronically homeless people in the area who demonstrate motivation to be housed, and with identifying and resolving impediments to the effective provision of housing and support services to the broader chronically homeless population in the inner city. They were also expected to make recommendations to build the capacity of the existing service system in the longer term (ARTD Consultants, 2010).

One interviewee explained the motivation for Housing First approaches: *"If you are in a hostel you are homeless, that's the point...Housing First gives primacy to autonomy and choice".*

As part of this fellowship I was able to meet with professionals involved in the delivery of the HIP. However, the international evidence base around 'Housing First' and its applicability for the UK has already been explored recently in a University of York and Crisis study (Johnsen & Teixeira, 2010). It is also the subject of a forthcoming Churchill Fellowship, 'Housing First: rapid housing initiatives' by 2012 fellow Samantha Moore. As such, I do not intend to cover Housing First in detail in this report.

Comparing the models

MACNI[12]	ISP[13]	CNCP[14]
Process for coordinating support and assessment, care planning & coordination service	Service providing direct support	Process for coordinating support
State-wide	Only available to those people in the Sydney Metropolitan Area	Only available to those in City of Sydney
16+	18+	
Referral through Regional Coordinator & multi-agency Regional Panel to Central Eligibility Review Group	7 NSW Human Services departments nominate people to the multi-agency Project Management Committee	Referral through Project Coordinator and Care Coordination Group
Client must have exhibited violent or otherwise dangerous behaviour that has caused (or is likely to cause) serious harm to him/herself or others	Client must exhibit behaviour that places themselves and / or others at risk of harm	
Client must have **at least two** of a number of identified diagnoses[15]	Client must have either **one or more** disability or diagnoses or the client's diagnosis must be in dispute	Clients must have **one or more** disabling conditions
Client must need and be likely to derive benefit from the programme, in particular the care coordination aspect	Client must require a high level of coordinated multiple agency response	
	Client must live in insecure accommodation	Clients must have been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years
	Client must have significantly impaired access to essential services due to their behaviour	
Regional areas must have already exhausted all local support options	All other options for support must have been exhausted	People with a history of failed interventions are a particular focus of the Project
Approx 40 clients on MACNI at any one time	Approx 25 people on ISP per year	41 clients over three years
Care coordination model	Supported accommodation model	Care coordination and independent living (Housing First) model
Comprehensive assessment with contextual focus	Comprehensive assessment with clinical focus	Comprehensive assessment undertaken by referring key worker
Person-centred care plan developed by care planning service	Person-centred care plan developed by treatment team	Coordinated care plan 'owned by client'; negotiated by key worker with support agencies, with support and review from Care Coordination Group
Brokerage of a range of interventions	In-house behavioural & therapeutic interventions	Negotiation of support from a range of agencies on basis of client need not operating guidelines
Significant brokerage funding	Brokerage funding	No brokerage funding
	Development of Behavioural Support plan for support staff and Management plans with	

[12] Information from interviews and Department of Human Services (2007a)
[13] Information from interviews and McDermott et al (2010)
[14] Information from interviews and McDermott & Bruce (2010)
[15] A mental disorder (within the meaning of the Mental Health Act 1986); an intellectual impairment; an acquired brain injury; or a drug or alcohol dependency (within the meaning of the Alcoholics and Drug-dependent Persons Act 1968)

	other agencies e.g. police	
Care plan coordinated by independent care coordinator with support provided by a range of identified services	Care plan implemented by residential & clinical staff with focus on improving & coordinating access to a range of identified services	Coordinated care plan implemented by agencies with independent dispute resolution from Project Coordinator
Care Plan can last up to three years	18 months support (in practice many clients have remained on the project for significantly longer)	
Governance from Central Eligibility Review Group	Governance from Project Management Committee	Governance from Complex Needs Management Group
Department of Human Services lead agency	Office of the Senior Practitioner (Ageing, Disability & Home Care) lead agency	City of Sydney and Community Services lead agencies
Cross-government funded	Direct funding from the Treasury	State and local government funding (initially no dedicated funding, however model developed to include Project Coordinator funded by City of Sydney & Housing New South Wales; evaluation funding from Ageing, Disability and Home Care)
Average $216,000 AUS per client, $172,000 excluding start-up costs (approx £135,000 and £110,000 respectively)	Average $207,000 AUS per client (approx £130,000)	Largely within existing resources; cost of dedicated Project Coordinator

Comparison with England and Wales

The approaches adopted by MACNI, ISP and the CNCP are in many senses unique although there are some similarities with a number of programmes in England and Wales. Notably, MACNI shares some similarities with Multi-Agency Public Protection Arrangements (MAPPA) for violent or sexual offenders. MAPPA is a justice-led initiative (local area Police, Probation and Prison Services) that focuses on the multi-agency assessment and management of risk. It brings these justice agencies together with a range of other agencies including Children's Services, Adult Social Services, Health Trusts and Authorities, Youth Offending Teams, local housing authorities and certain registered social landlords, Jobcentre Plus, and electronic monitoring providers. A statutory duty is placed on these organisations to co-operate, notably through the sharing of information. For those perceived to present the highest risk (level 3) the involvement of senior staff from those agencies is required to authorise the use of special resources, such as specialised accommodation (Ministry of Justice, 2010b).

In England and Wales there are also a number of supported accommodation projects (including care homes) and other interventions for those with mental health problems or learning disabilities, including some provision for those with more complex diagnoses including dual diagnosis of a mental health problem and learning disability.

Challenges for transferring services to the UK

MACNI & ISP

- **Very high levels of funding:** MACNI and ISP both respond to a very small number of the most complex and challenging clients to whom they provide an intensive service. The project evaluations report that for ISP the cost is $207,000 AUS per client (approximately £130,000 per client) while for MACNI the cost of the Initiative was $216,000 AUS per client (approximately £135,000 per client; McDermott et al, 2010; Department of Human Services, 2007a). For MACNI this reduces to $172,000 AUS per client (approximately £110,000 per client) when only a

selection of cost components are included to reflect the costs of an ongoing program (these include the Statewide Panel, Brokerage, Multidisciplinary Assessment Service, Intensive Case Management Service and Regional Coordinators[16]). As part of the MACNI evaluation, a cost-benefit analysis was undertaken but did not establish any cost-benefit associated with the programme. However the central team are apparently not satisfied that this analysis adequately captured client costs to the system. Subsequent attempts to improve on this have proved unsuccessful and doing so was seen as a considerable challenge for such a complex client group. The cost of providing services to clients who had exited ISP was reduced compared to the cost while on the ISP. However, the evaluation does not determine whether overall there has been a cost benefit to the system and there is insufficient evidence to determine whether this reduction is sustained. It was reported by interviewees that producing a cost saving to the system was perceived to be less of an issue than perceived value for money in terms of individual and systemic benefits. This may not be the case in the current economic climate in England and Wales.

- **Challenge of transition:** Transition from the programme was identified as a particular challenge for the ISP. Although involvement with the project is supposed to be for 18 months, it was reported during my visit that many clients had in practice been with the project for significantly longer (it was suggested that some had been there longer than five years). This negatively impacts upon the project's capacity to accept new clients. The evaluation reported that this challenge resulted from limitations in the broader service system's support models, limited knowledge of how to manage clients with challenging behaviour, and limited resources to support this group of clients effectively. It suggested that the project's transitional housing model may simply not be appropriate for some clients, a view supported by interviews during my visit. Although MACNI appears to have established a clearer process around transition, concerns were raised around sustainability for those subject to very expensive care plans.
- **Resistant clients:** Despite intensive and high cost interventions, evaluations of and interviews regarding both projects indicate that some clients still fail to demonstrate improvements. Out of the sixteen MACNI case studies reviewed as part of the evaluation, the MACNI initiative appears to have had little success for four individuals.[17] Marilyn Kramer, Senior Program Advisor for MACNI reported that the programme has had huge success with some clients but acknowledged that in some cases the client remains unstable even after the full three years' participation. Similarly, the ISP evaluation reports that a small number of clients did not engage effectively with ISP services and will continue to be problematic for the service system. It recommends that further analysis is required to help determine the characteristics of these clients. During my visit, Caroline Dodson, Support Services Manager for ISP, suggested that there is a group of complex clients with Acquired Brain Injuries or Personality Disorders that require multiple agency involvement, tight clinical support and strong case management and nevertheless remain challenging. Although improvements are seen, the level of support needed to maintain this improvement is very high. This failure among a minority of clients to improve or sustain improvements is perhaps unsurprising given that both MACNI and ISP only work with those clients for whom all other solutions have failed. Nevertheless, given the high costs of interventions and the intensive levels of support this lack of improvement may be a deterrent to implementation.

[16] There has been considerable restructuring of the program following the KPMG evaluation, in part to stream line processes and increase efficiency. This is likely to have an impact on the costs associated with the Initiative.

[17] It should be noted that of the sixteen only six of these clients had transitioned from the Initiative at the time of the evaluation.

MACNI & CNCP

- **Timeframe for responses:** The process of comprehensive assessment and negotiating care plans appeared to take a number of months in both MACNI and CNCP. For CNCP this partly rested on the infrequency of the meetings of the Care Coordination Group (monthly). For MACNI this was partly due to the nature of the referral process which involved the testing of local solutions. However, for both services it is also partly a reflection of the time consuming nature of gathering evidence for a comprehensive client assessment that maps previous involvement with services. In addition, for CNCP the evaluation reported that there were often delays accessing accommodation which some stakeholders identified as being in conflict with a housing first approach. In some cases this related to difficulties contacting and engaging the client group. However, in other cases these difficulties related to the service system including difficulties finding support services that were configured to providing comprehensive support to high needs clients in a tenancy, locating appropriate housing and negotiating debt clients had accumulated as previous tenants of Housing NSW. Nevertheless, when responding to an extremely complex client group it is arguable that the time taken to put care plans in place is less important than getting it right.

CNCP

- **Need for dedicated resources:** One motivation for the CNCP was to develop a framework for coordinating support to chronically homeless individuals within existing resources. Professionals were asked to give their time and expertise to the strategic and operational groups and organisations were asked to work flexibly with individuals, without being restrained by operational guidelines. Nevertheless, developing partnerships, sustaining professional engagement and coordinating support was time-consuming and involved significant work. Consequently funding for a dedicated Project Coordinator was obtained during the lifetime of the project and this post was seen to have been a valuable development. It was reported to me that *"The Complex Needs project did work but it was hard work and you had to keep partners invested, starting again when leadership changed or roles changed. Partnership is a huge amount of work."* In addition, although services committed to working flexibly in response to this group of clients, the evaluation reported that *"many support providers expressed frustration at the amount of effort required to engage this group, which indicates that relying on coordinating existing services to engage this group would not be sustainable over time without dedicated resources" (*McDermott & Bruce, 2010, p.5).

All

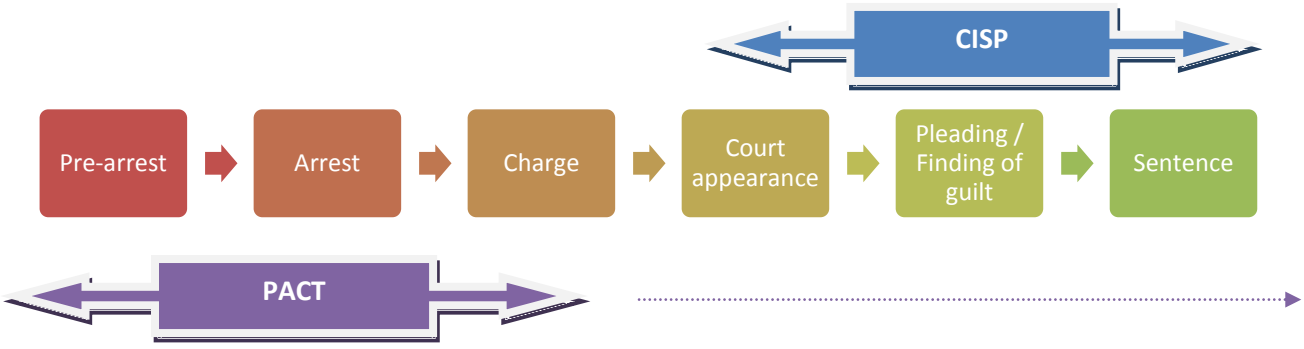
- **Limited evidence of client outcomes:** Other than the KPMG (Department of Human Services, 2007a) analysis of changes in service use and a Snapshot study from 2008 there is little quantitative measure of outcomes or client change during participation on MACNI. Data that is available for MACNI clients is based on a small number of cases and care has to be taken when generalising from such small numbers. Data from the ISP shows mixed improvements to challenging behaviours (although a positive impact on appropriate service use) and there is limited evidence that well being gains may not be sustained after transitioning from the project. Both MACNI and ISP could benefit from more rigorous and systematic longitudinal studies and embedded follow-up mechanisms for clients. The data available for MACNI also fails to capture outcomes for those whose cases were successfully resolved at a local level as a consequence of the initiative. With regards to the CNCP, there is evidence that stable housing was obtained and maintained by many clients who had previously been chronically homeless, although the number of clients seen is fairly small. However, although positive improvements

were reported in other life areas there was evidence that clients continued to face significant challenges. More robust data is likely to be needed when arguing for transfer to the UK.

4

Diversionary case management interventions

During my Churchill Fellowship I visited two projects located at early stages of the justice system (pre-sentence) providing case management and support to those with multiple unmet needs; the **Police and Community Triage (PACT)** project and **Court Integrated Services Project (CISP)** both in Victoria.



Police and Community Triage (PACT)

PACT was established to work with those who are in repeat contact with the police, with the aim of reducing such contact. Referrals come only from the police and the only referral criteria is that the person is or is likely to be in repeat contact with the police as a victim or as an offender. Consequently the service is also able to support victims of crime (in particular victims of domestic violence who are likely to be in repeat contact) and those who are repeatedly subject to police mental health interventions.

The PACT clinician works with the client on an outreach basis in community locations with a significant focus on engaging the client with the PACT service and facilitating engagement to other services. Formal assessments are not undertaken since this may be off-putting to clients; instead a client-directed goal-focused approach is adopted. The service provides case management, advocacy, liaison and linkage with other agencies, pro-social modelling and informal therapeutic support. Support is not time-limited and there is an open door policy if clients wish to reengage with the service.

Courts Integrated Services Program (CISP)

CISP was established in order to reduce the number of offenders being remanded into custody. It aims to do this through the provision of case management, a range of support services and where necessary housing provision so that bail is a viable option for Magistrates in cases where bail might not otherwise have been considered. Clients are referred to the project (by Magistrates and legal advisors) when bail is being considered or immediately after bail has been granted and their psychosocial needs are assessed. The project provides four months intervention during which time the Magistrate can either

adjourn proceedings until after involvement with CISP is completed or request that the defendant returns regularly to the court to report on their progress.

The service links clients in with a range of support to meet both immediate needs (e.g. benefits and bail accommodation) and longer term needs (e.g. training and offending behaviour programmes). The service has access to 50 furnished transitional housing properties managed by Home Ground. These are usually two-bed properties however in most circumstances only one client will be placed in each property. The manager of CISP observed that clients really looked after these properties since it was often the first time that they had ever had their own home. In addition CISP builds engagement, provides pro-social modelling and challenges behaviour. This may include discussion of issues such as how the client presents to others in terms of dress, body language and behaviour.

Comparing the models

PACT	CISP
Aims to reduce contact with police	Aims to reduce use of custodial remand
Works with *anyone* in / likely to be in repeat contact with police (e.g. victims, those in contact for mental health reasons)	Works with defendants on bail
Not diagnosis led / specific-need led	Not diagnosis led / specific-need led (although particular focus on securing housing where necessary)
Operates pre-charge	Operates during court bail
No time limit on involvement / open-door policy on client return	Limited to 4 months involvement (repeat referrals accepted)
Referrals solely from police	Referrals mainly from Magistrates
No formal assessment but works across range of needs	Psychosocial assessment to identify range of needs
Outreach model	All appointments held at the court
Client work undertaken by clinicians (currently psychologists) with two police officers for policy work	Multi-disciplinary team
Caseload approximately 30 clients	Caseload 20 – 25 clients
Client-directed support (goal-focused)	Client-directed support
Case management model	Case management model
Links in with community services	Links in with community & targeted services, including training and offending behaviour programmes
Reliant on in-house clinicians (psychologists) and mainstream psychiatric and neuropsychological services	Access to psychiatrists, psychologists and neuropsychologists for assessment where necessary
Some informal therapeutic support	
Minimal brokerage funds	Brokerage funds ($1,000 - $5,000 per client) and access to transitional housing
Focus on engagement	Focus on engagement
Pro-social modelling and developing client skills at self-support	Pro-social modelling and developing client skills at self-support
	Philosophy of 'challenge with respect' and strengths-based approach (clients are never referred to as 'offenders')
Feedback to referring police officer at first contact and case closure	Monthly reports to Magistrate

Voluntary	Voluntary at outset but engagement with programme then made condition of bail
Non-punitive approach (not linked in to criminal justice proceedings)	Non-punitive approach (breach of bail is not a criminal offence in Victoria)
Harm minimisation approach to substance misuse (willing to work with those who are under the influence)	Harm minimisation approach to substance misuse (does not insist on abstinence nor that the client addresses drug use)

Key features

1) Aim to reduce the use of criminal justice services

Both services have the primary aim of reducing the use of criminal justice services. PACT targets those likely to be at risk of repeat contact, of any kind, with the police. As well as offenders, this includes victims, witnesses and other types of contact (such as mental health contacts). In a domestic violence incident for example, both the offender and the victim could be supported by the service. The police officer who designed the service felt that this was a key element of the service, protecting it from the criticism that resources were being targeted at offenders while leaving victims unsupported. CISP targets those accused persons who have a medium to high risk of offending. The model is designed to reduce the use of custodial remand by making bail in the community a viable option.

2) Minimal eligibility criteria, not diagnosis-based / need specific

PACT's only eligibility criteria is that the person is (or is likely to be) in repeat contact with the police and police must obtain the consent of the person that they are referring. It is not reliant on having, or being suspected of having, any particular diagnosis or other specific need. The police officer who had designed the service felt strongly that simple criteria were needed to avoid exclusion of clients who already 'fall through the gaps' in eligibility for existing service provision. It was also suggested that police officers are more likely to refer to a service with easy to understand and apply criteria. This recognises that services with a large proportion of unsuccessful referrals cause frustration and confusion among referring officers. Eligibility for the CISP scheme is determined by a slightly greater number of restrictions.[18] However, again these criteria are not strict and do not rely on the client having a particular diagnosis or need.

3) Psychosocial assessment

CISP clients undergo a detailed psychosocial assessment to identify the range of emotional, health and social care needs. Although no such assessment is undertaken with PACT clients (as formal assessment is considered to be detrimental to client engagement), case managers attempt to identify the full gamut of psychosocial needs through their ongoing one-to-one work with clients. Both services are able to facilitate access to specialist mental health and neuropsychological assessment where this is deemed appropriate.

4) Case management model

Both CISP and PACT operate on a case management model which involves a lead professional responsible for identifying needs, accessing and coordinating support by appropriate services, and providing one-to-one motivational, emotional and practical support on an ongoing basis.

[18] (i) You must have been charged with an offence; (ii) You must require support and/or treatment to reduce your risk of reoffending and address your needs; (iii) Mental health issues, drug/alcohol dependency and misuse, or lack of social, family and economic support have contributed to your offending; (iv) You must give your consent to be involved in the program.

5) Client-directed support

Both services allow their clients to determine what support they receive allowing them to identify their own goals during their involvement with the service. Neither service insists that clients address issues such as substance misuse which they may not be willing or feel able to address at this stage. Instead, both services will work to build motivation to address these issues where possible and focus on client strengths.

6) Focus on engagement

Both of the services have a clear focus on facilitating engagement with mainstream community-based services although the two services adopt different approaches to achieving this. PACT operates an outreach model with no appointments held in the office at the police station; instead, the case managers utilise offices in other community services to familiarise clients with community provision. The case manager will also accompany clients to appointments where necessary. Conversely, all CISP appointments are held at the court with an increasing focus on punctuality over the course of engagement with the programme to prepare the client for potential Community Corrections appointments. CISP case managers will not accompany clients to appointments, although they may provide text reminders.

7) Feedback to criminal justice agencies

PACT provides limited feedback to the referring police officer at first contact and case closure. Although the information provided to the officer is minimal in order to protect client confidentiality (unless the client requests otherwise), the police officer who designed the service emphasised that this feedback was crucial in retaining police engagement with the service. Where more detailed information is provided to police or courts on the client's request, this information can support criminal justice decision-making although such information would not be provided without the client's consent. CISP on the other hand provides reports to the Magistrate on a monthly basis to keep the Magistrate updated with client progress within the programme, culminating with a final report summing up all the work undertaken. This ensures Magistrates have comprehensive, accurate and current information to inform sentencing decisions.

8) Funding from justice agencies

Although both the PACT and CISP services provide a range of health and social interventions, they are both aimed at reducing use of and therefore cost to criminal justice agencies. It is therefore appropriate that at the time of my visit both services were funded through criminal justice routes; the CISP programme through the Department of Justice (Courts and Tribunals Service) and the PACT programme by Victoria Police and, for historic reasons, the Victorian Police Law Enforcement Drug Funds. However, at the time of my visit PACT was still in the pilot phase and it was reported that they were trying to gather evidence to support a business case to the central Budget Expenditure Review Committee since Victoria Police are unwilling to provide the funding on an ongoing basis.

Innovative uses of IT

Facilitating instant client referrals: Both PACT and CISP can receive police referrals via a system called SupportLink. SupportLink (run by a not for profit organisation) is an electronic referral system and referral management framework. It provides a single referral gateway for police to refer those that they come into contact with who appear to have support needs to a wide range of services, with secure electronic transfer of referral information. This can be done 'on the beat' through the use of smart phones. Those referred to services receive a text to say that the referral has been made. There is also a feedback loop to keep referring officers informed. Services must attempt to contact the potential client within 48 hours and must try a minimum of three attempts followed by a letter. This is monitored by SupportLink staff who chase services where this has not happened. At the time of my visit in 2011, in the pilot areas of Victoria the system offered the opportunity for client referral for 38 different support needs as diverse as council notifications of abandoned cars, victim services, domestic violence services, homelessness, parenting and immigration services. Up to two support needs can initially be identified for any client and incident information can be added as context. Inappropriate referrals can be re-referred on via SupportLink and the system comes with a twenty-four hour helpline. The system can be tailored to the local area in terms of both need and service structure. The system also allows the monitoring of the need profile of referral for strategic planning purposes. The system reportedly costs $86 AUS (approx £55) per registered officer.

Facilitating information sharing on clients: Those involved in the design and development of PACT are focusing on developing new information systems with an aim of improving information sharing and avoiding duplication of data entry. At the time of my visit, IT consultants (providing pro bono support) were developing a portal based system whereby other professionals working with the client can be invited to access the system via a password to obtain information on the client. All the information is encrypted and clients can determine which professionals have access to which information. It is recorded who has accessed the system and when so it is clear if another professional has viewed the information sent. There is also an outcomes page so that other professionals can feed the outcome of a referral/appointment into the computer and enter in follow up appointment dates so that PACT workers can help to remind clients of appointments. The PACT team can determine the level of feedback that they receive about each client – clients who really struggle to engage can have high levels of feedback so that PACT workers are informed about appointments etc.

Evidence of Outcomes

An evaluation of CISP, undertaken by the University of Melbourne, was published in 2009 (Ross, 2009). This evaluation found significant improvements in clients' reported physical and mental wellbeing (as measured on the SF-12 survey) and reduced alcohol use (as measured by case manager assessments). There was little change in housing status across the period of engagement due to the length of waiting lists for housing. Although data was not available for all CISP clients, a sample of two hundred CISP clients indicated reduced reoffending rates among the CISP sample (50%; 40% with proven charges) than the control group (64%; 50% with proven charges). The divergence between proven reoffending of the two groups continued to grow, peaking at a difference of 10% at seven hundred days after the commencement of "time at risk" (exit from CISP or sentence date; excluding time served in prison). Bail completion rates and community order compliance rates were also higher but this was not statistically significant.

An economic evaluation undertaken by Pricewaterhouse Coopers (Department of Justice, 2009) at the request of the Department of Justice identified significant potential benefits associated with CISP. It suggested that if CISP reduces the recidivism rate for two years, after which the participants' propensity to reoffend returns to the benchmark rate, the benefit to cost ratio (presented in net present value terms) is 1.7 (so for every $1 AUS of cost, there is a return of $1.7 AUS). This rises to 2.6 if gains are

sustained for five years. This analysis does not consider the indirect costs of crime (Department of Justice, 2009).

At the time of my visit in 2011 no evaluation of the PACT programme had been undertaken although funding for such an evaluation had been secured.

Comparison with England and Wales

The projects share similarities with a number of previous and current projects and programmes in England and Wales, including:

- **Arrest referral, Drug Interventions Programme (DIP):** The drug interventions programme aims to provide end-to-end case management of drug-misusing offenders across the criminal justice pathway. Suspected drug-misusing offenders are identified in the police station by arrest referral workers who then link these clients into drug services. Similar support for alcohol-misusing offenders has also been introduced in many areas of the country.
- **Criminal Justice Liaison and Diversion Services (CJLD):** Current government policy is to roll-out liaison and diversion services in police stations and courts across the country by 2014. Although there is currently no agreed model of what these services should look like, liaison and diversion services aim to identify mental health problems or learning disabilities among (suspected) offenders and divert those who have these conditions from or within the justice system to more appropriate criminal justice disposals.
- **Manchester MO:DEL project:** The Manchester MO:DEL project is a particular model of liaison and diversion service developed in Manchester that, in addition to identification of need and diversion to other services, provides interim case management support to these offenders until they are taken on by another service.
- **New Directions (previously Revolving Doors) Service, Warrington:** The New Directions Service in Warrington is a scheme based within mental health services for those with significant unmet needs and moderate or common mental health services within the community. It takes referrals from the Neighbourhood Policing Team and Public Protection Unit, proactively tries to engage with clients and links them in with a full range of community services.
- **Bail Accommodation and Support Service (BASS):** BASS is a government-commissioned service providing accommodation (shared housing) with some in-reach support to those who are on bail or on Home Detention Curfew ('tag') in the community who would not otherwise have anywhere to live.

These English and Welsh programmes vary in the extent to which they share features of the CISP and PACT programmes, with none of these English and Welsh programmes sharing all of the key features identified above.

Challenges for transferring services to the UK

- **Integration of services:** The PACT and CISP projects operate at different stages of the criminal justice system but in different geographical areas; PACT operates across the police division of Moorabbin (the area covered by Moorabbin Magistrates Court) while CISP operates at La Trobe, Melbourne and Sunshine Magistrates Courts. Although the services do have some noticeable differences, they also share key features and are likely to have considerable client cross-over if operating across a similar geographical area. Consideration needs to be given to how the services could be integrated to provide comprehensive coverage across the pathway without losing some of the individual features, such as the victim aspect of the PACT service.
- **Delays to the justice process:** Following on from the Labour government's 2006 initiative for 'Simple, Speedy, Summary' justice, the coalition government in Britain have recently released

their white paper for reform of the criminal justice system, *Swift and Sure Justice*. In this they state that *"Justice needs to be swift if it is to be effective. Offenders need to be made to face the consequences of their actions quickly, using effective, locally-based solutions."* (Ministry of Justice, 2012b, p.6). Unfortunately, such policy emphasis on processing offenders quickly, is at odds with the CISP approach that involves adjournment of the case to allow for the CISP intervention to take place and in some cases a return to court for reviews by Magistrates. It also may impact on the financial benefits of the programme since custodial remand might not otherwise have been used.

- **Brokerage funds:** The CISP programme has access to considerable brokerage funds ($1,000 - $,5000 per client) to secure access to appropriate services for their clients. Funding can be used to fund a GP or psychiatric appointment, the dispensing fee for methadone maintenance, emergency accommodation, securing parenting classes, offending behaviour programmes, accredited drug treatment programmes or positive lifestyle programmes. In the current economic client in the United Kingdom it is unlikely that consideration will be given to providing such high levels of brokerage funding for offenders despite the merit of any arguments around investment to save. However, many of the services accessed through this funding can be secured through mainstream routes and so this may not be a prohibitive barrier.
- **Client-directed nature of court support:** Support provided by CISP is client-directed, despite the fact that clients are on bail from the court and that the criminal justice process has been adjourned to allow them to participate in the programme. This means that clients do not have to address substance misuse and can continue to use substances even where this has been a causal factor in their offending. There may be resistance to such an approach in the UK.

5

Responses to mental health needs and learning disabilities in the prison estate

Mental health care at the Dame Phyllis Frost Centre (Marrmak Integrated Mental Health Unit)

Health Care in Victorian Prisons

Prisoners with health problems fall within the remit of two business units of the Department of Justice. Corrections Victoria operate the adult prison estate and are responsible for ensuring that prisoners are held safely and securely and that attempts are made to rehabilitate these prisoners through addressing the causes of offending behaviour. Justice Health has responsibility for healthcare for those who are held within prisons in Victoria, setting policy and standards and contract managing healthcare providers.

Health care within the Victorian prison system is provided at three different levels primary, secondary and tertiary although tertiary care is only provided in specialist hospitals. In mental health care primary services include GP services, mental health nursing, pharmacotherapy and health promotion. Secondary mental health services include specialist outpatient services and voluntary acute and sub-acute mental inpatient care. Tertiary mental health services include involuntary acute and sub-acute inpatient care and all such services for those in the prison system is provided in one location, Thomas Embling Hospital in Melbourne.[19] Thomas Embling predominantly provides high secure care with a small number of low secure units.

Health care is provided by a range of independent providers (such as G4S and GEO) and by Forensicare, a statutory body that provide forensic mental health services including healthcare at Thomas Embling Hospital.

All male prisoners in Victoria go first to the Melbourne Assessment Prison (MAP) where their health and other needs are assessed before they are moved on to another prison. Services include a 16-bed short stay Acute Assessment Unit (for those thought to be mentally ill or at risk, or those referred by the court for a psychiatric report), outpatient services and an After Hours Crisis Intervention Service.[20] All these services are provided by Forensicare with Pacific Shores Health Care providing primary health care services (both general and mental health). In addition, Port Phillip Prison has a specialist psycho-social unit providing multi-disciplinary care, treatment and rehabilitation for male prisoners requiring assistance and integration to the mainstream prison or the community on release.

Female prisoners are held at one of two prisons for women; Dame Phyllis Frost Centre in Melbourne which contains both maximum and medium security provision, or the minimum security Tarrengower prison in Maldon.

[19] http://www.justice.vic.gov.au/home/prisons/prisoner+services+programs/health/ (accessed 08.08.12)
[20] http://www.forensicare.vic.gov.au/page.aspx?o=prison (accessed 08.08.12)

Dame Phyllis Frost Centre (DPFC)

The Dame Phyllis Frost Centre is one of only two women's prisons in Victoria, and the only maximum security prison. In 2005, following concern about the increasing number of women entering the state's prison system, the Department of Justice published their four year strategy, *Better Pathways*: *an integrated response to women's offending and reoffending.* This strategy included investment in both programs and infrastructure and included a large renovation and building program at the Dame Phyllis Frost Centre. This included a new multi-purpose programs building, a multi-faith chapel, the refurbishment and expansion of the visits centre, the expansion of the education centre and the industries building (Department of Justice, 2005).

The atmosphere of the whole building felt very different to a British prison and gave the impression of greater freedom and self-determination for prisoners and a greater semblance of 'normality'. This may partly have been due to the different weather in Victoria which meant that there was greater use of outdoor space; there was a swimming pool, a garden designed by and for indigenous prisoners and outdoor seating space. The expansion of the visits centre also included an extended garden area, basketball ring and barbecue. Prisoners in medium secure facilities who have earned privileges were housed in shared flats (of 8 prisoners) with en-suite showers and shared kitchen and dining room facilities and activity space. Women cook for themselves and do their own washing. Finally, children under school age are allowed to remain with their mothers if it is considered to be in the child's best interests and so, as well as mother and child accommodation units, one noticeable feature in the centre of the prison is a well-equipped children's play area.

In addition there are two prison cell-blocks dedicated to protection prisoners and those who present with challenging behaviour. I was unable to visit these units but it is likely that these provide a more traditional and restrictive prison environment. The occasional use of restraints on women within this accommodation was reported.

Within DPFC, every prisoner has an individual management plan and a prison officer who acts as a case manager. Probation officers (or 'Community Corrections' officers) do not have a role in Victorian prisons. Offending behaviour programs are frequently run by clinical psychologists employed directly by Corrections Victoria.

Mental health care at DPFC (the Marrmak Unit)

Health care facilities at Dame Phyllis Frost Centre include a health care centre, a drug treatment unit that acts as a therapeutic community and the Marrmak flexible intensive support unit.

The health care centre acts in a similar role to such a centre in the community, providing primary care, health promotion and education activities, an observation room for those who may require hospitalisation and pharmacy provision including the Opioid Substitution Therapy Program. It was recently upgraded as part of the *Better Pathways* rebuilding program. Primary care at the centre is provided by the independent provider Pacific Shores Health. As well as general nurses, they employ psychiatric nurses who undertake an initial screen on those entering the prison and provide primary mental health care. Nevertheless, it was suggested that more could be done to improve the response to those with mild mental health problems, for example through access to general counselling.

The Marrmak Unit which was introduced as part of the *Better Pathways* strategy is a specialist mental health unit within the DPFC. As well as inpatient facilities it provides an outpatient program for those housed in normal accommodation; an outreach service for those held in the Observation & Management or Protection Units who are unable to attend Marrmak; and an intensive day program for women with a personality disorder.[21]

[21] http://www.forensicare.vic.gov.au/page.aspx?o=prison (accessed 08.08.12)

Inpatient facilities are provided for those in the acute phase of a serious mental illness who require ongoing, intensive care and treatment to promote full recovery; those assessed as high risk of suicide / self-harm linked to serious mental illness; and those with age-related mental illness requiring specialist mental health inpatient care and treatment. A flexible mix of beds is provided including acute care beds, sub-acute care beds for those in the recovery phase, psychosocial beds for severe personality disorder, crisis care beds for those at risk of suicide and age-care beds.

Healthcare services at Marrmak are provided by Forensicare and the Unit has a range of staff including a unit manager, a consultant psychiatrist and psychiatric registrar, registered psychiatric nurses, a senior psychologist and psychologist, a social worker, an occupational therapist and a ward clerk, as well as a supervisor prison officer, senior and other prison officers.[22]

Within Marrmak there is one observation unit which does not have access to a kitchen but another unit does have access to cooking facilities (equipped with knives on a chain and electric hot plates) with the aim being for the patient to progress through to this second unit where possible. Both units have social space although this is heavily monitored. Custodial staff participate in a range of social activities provided for patients throughout the day in order to improve relationships and develop trust.[23]

Key features of DPFC provision

- **General facilities:** During my visit I was struck by the high standard of general facilities (for medium security prisoners) and in particular the relatively high levels of self-determination for prisoners, for example being able to cook their own meals. In addition, I was struck by the ability for some prisoners to live with their children and improved visiting facilities (including play and social areas) for those who do not. Such provision may go some way to reducing the detrimental impact of imprisonment on women's psychological health although I was not able to talk with any prisoners about their experience at the centre.
- **Primary care psychiatric provision:** In contrast to the situation in many English and Welsh prisons, there is a clear role for psychiatric nurses within the prison's primary care provision. Alongside general practitioners, they are responsible for providing primary mental health care as well as undertaking an initial reception assessment for prisoners. As such, this is likely to free up secondary mental health care services within the prison (outpatient and inpatient services provided through the Marrmak Unit).
- **Specialist inpatient facilities:** These facilities provide a flexible mix of mental health beds (including crisis and age-care) which are staffed by those with a range of mental health and social care expertise, able to provide assessment, treatment and comprehensive release planning. As well as providing holding beds or step-down care for those returning from or awaiting transfer to Thomas Embling hospital, the Marrmak Unit is able to provide mental health care on a voluntary basis for those in the acute phase of their illness without necessitating a transfer to hospital.
- **Personality Disorder programme:** Case managers can refer women to clinical services for a personality disorder assessment. A six month day-programme is provided (through the Marrmak Unit) for women prisoners with a borderline personality disorder. This uses a range of behavioural treatment programmes, notably Dialectical Behavioural Therapy. This programme is also open to women held in a Management Unit. For those with severe personality disorder who are approaching release, referrals are also made to SPECTRUM, a state wide personality disorder service for those who are being treated by Victorian State Government funded Area Mental Health Services.

[22] http://www.justice.vic.gov.au/resources/845df330-d0e2-4100-a13d-03e4c24d2cfe/mistry_1145_wed.pdf (accessed 09.08.12)
[23] Ibid.

- **Clinical conferences:** These are held once a week to discuss complex presentations with unit managers and to understand what work is being undertaken by different professionals within the prison. Clinical managers are then able to advise operational managers (governors) around the management of these clients and risk management plans are developed for those who are considered to present a risk.
- **Strategic role bringing together services:** The Clinical and Offender Services Manager has responsibility for liaison with the Department of Justice and health service providers as well as having a role managing sport and recreation services with a focus around physical and psychological health. The role also involves bringing together drugs and mental health services to coordinate working and look for overlaps in activity.

Evidence of Outcomes

I am not aware of any evaluation of the Marrmak Unit.

Intellectual Disabilities Unit at Port Phillip Prison

Support for disabilities in Victorian prisons

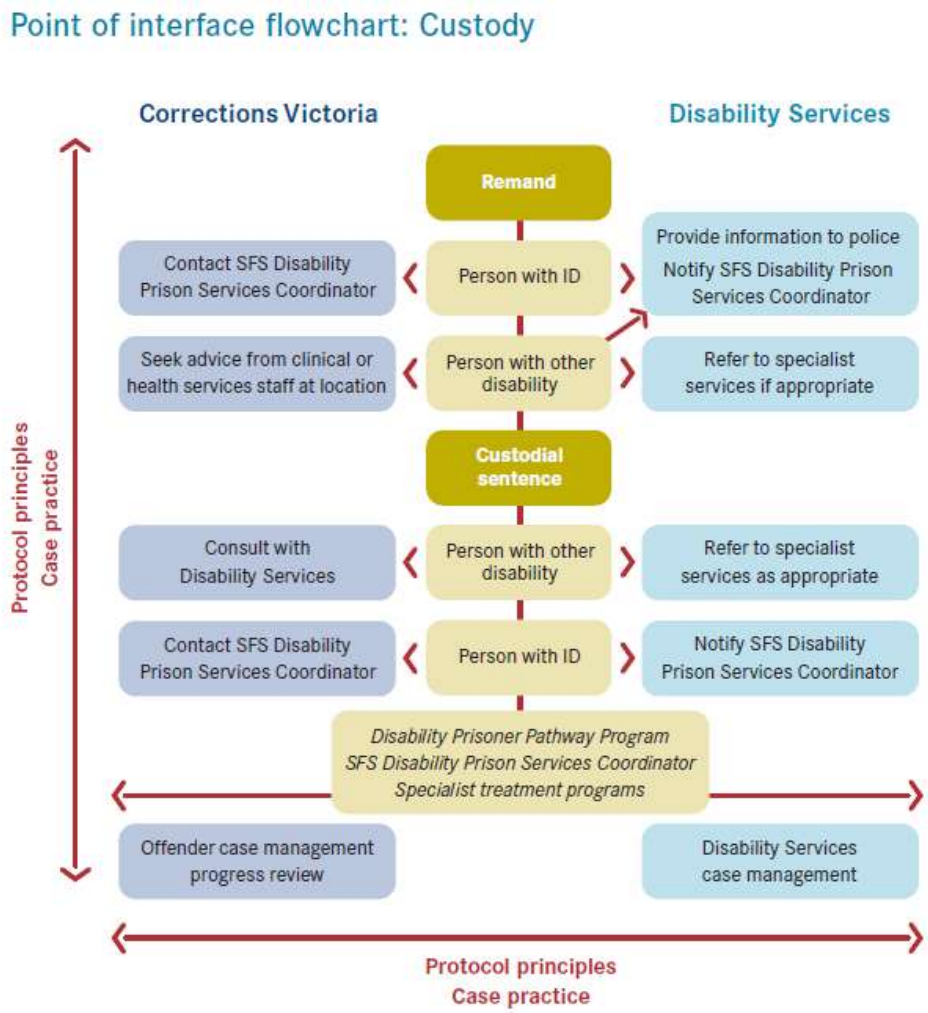
Corrections Victoria (Department of Justice) shares responsibility for providing services to adult prisoners with a disability with Disability Services within the Department of Human Services. Disability Services is responsible for funding and providing a range of support and services for people in the state with intellectual, physical and sensory disabilities, neurological impairments and Acquired Brain Injury (Department of Justice & Department of Human Services, 2008).

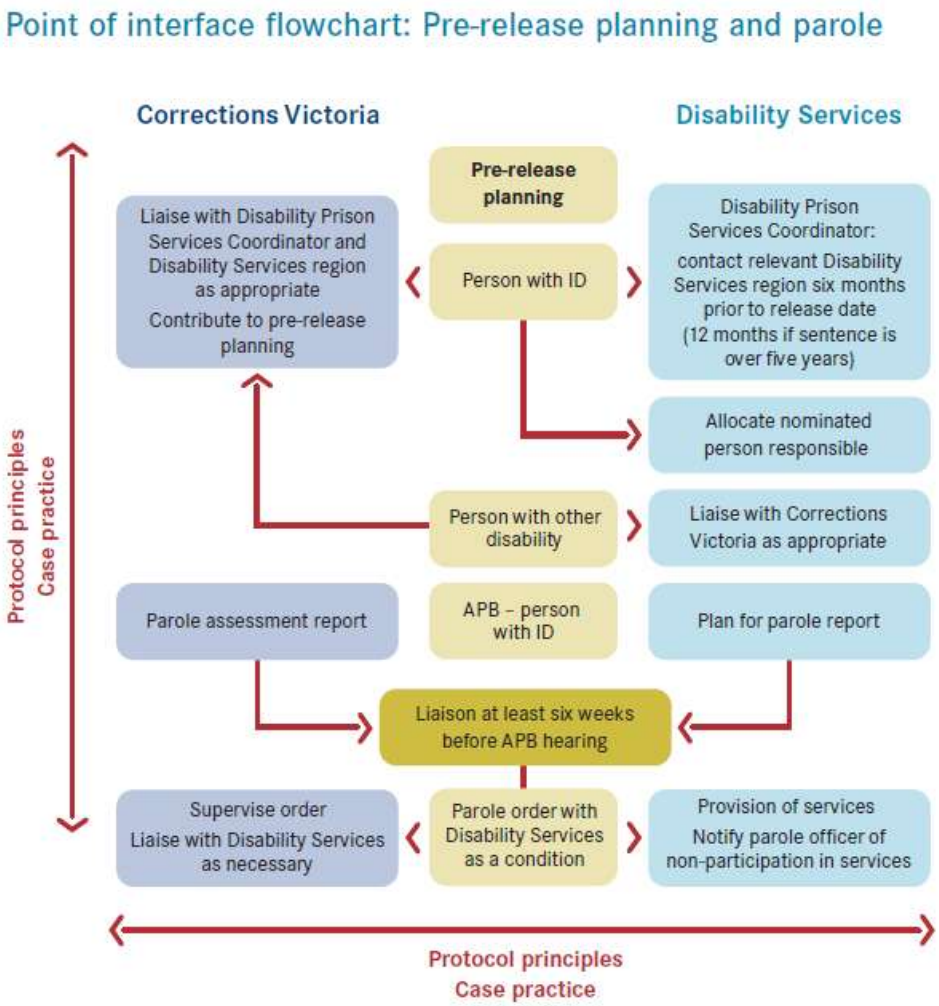
In 2008, the Corrections Victoria and Disability Services published a joint protocol outlining their shared responsibilities for providing services to adult offenders and prisoners with a disability, based upon the following 'practice principles':

i. People with a disability are citizens who have the right to be respected and the right to have equal opportunities to participate in the social, economic, cultural, political and spiritual life of society. As citizens, people with a disability also have equal responsibilities towards Victorian society and should be supported to exercise these.
ii. All offenders with a disability have the same rights as other offenders to access and participate in services and programs that are appropriate to their needs. They should also have the same opportunities for a range of support, advocacy and sentencing options.
iii. Every attempt will be made to reduce the barriers that prevent participation in services and programs and for additional measures to be provided that ensure all people have access to services and programs.
iv. Equality of opportunity for offenders with a disability will be actively promoted, and unlawful discrimination will not be tolerated.
v. Close partnerships between disability and correctional systems are integral to providing better outcomes for offenders with a disability in addressing reoffending and enhancing community safety.

This protocol and accompanying documents outline the points of interface between the services as the offender passes through the criminal justice system, detailing responsibilities at the court stage, on community orders, through imprisonment and in preparation for release.

Within custody and on release the following joint responsibilities apply (diagrams from Department of Justice & Department of Human Services, 2008):





The responsibilities outlined for Disability Services include sharing information with criminal justice agencies necessary to ensure the health and wellbeing of the individual. This includes a proactive responsibility for Disability Services (including case managers and accommodation services) to inform the Statewide Forensic Services Disability Prison Services Coordinator if they are aware that someone with a disability has entered the prison system.

It is also possible that the prison service become aware of a disability through the initial assessment processes undertaken at the Melbourne Assessment Prison (or DPFC for women) although as far as I am aware there is no process for screening for hidden disabilities such as learning disabilities, instead relying on custodial and health staff to identify potential cases.

The Disability Prison Pathway Program

Victorian research undertaken between 2003-2006 by the Department of Justice found that prisoners with an intellectual disability had significant prior involvement with the criminal justice system, a high risk of re-offending, and difficulties moving to minimum security while in prison and obtaining parole (Department of Justice, 2011). Following on from this, a range of programs and services were developed that take account of the needs of prisoners with an intellectual disability, including the Joint Treatment Programme within the dedicated Marlborough Unit at (high security) Port Phillip Prison and the provision of targeted support within the medium security Loddon Prison (Department of Justice & Department of Human Services, 2008).

The Marlborough Unit, Port Phillip Prison

During my Churchill Fellowship I was able to visit and meet with a range of staff at the Marlborough Unit based at Port Phillip prison, a 33-bed unit dedicated to male prisoners with intellectual disabilities. I was also lucky enough to be allowed to attend the Disability Program Governance group which manages disability programmes across Marlborough, Loddon and other parts of the prison estate.[24]

The mission of the Marlborough unit is to address the offending behaviours of offenders with a cognitive impairment through a holistic approach including programmes and transitional support into the community to reduce the risk of reoffending and enhance community safety. Provision is based on a 'treatment community' approach combined with a strengths based approach (that considers all aspects of an offender's life) and a commitment to a 'continuum of care' (Department of Justice & Department of Human Services, 2008). The unit is not a hospital and prisoners on the unit cannot be forced to comply with medication requirements. Length of stay on the unit can be anything from 2-3 months to a couple of years.

The unit is a partnership project between Corrections Victoria, the Department of Human Services (DHS) and Port Phillip Prison which is run by the private security provider G4S. The latter provide the control element to the unit, the unit coordinator and provision for employment, education and training. Custodial officers also undertake a case management role in Victorian prisons. In addition, there is a clinical team attached to the unit during office hours which includes two psychologists, a social worker and a psycho-educational trainer. There is also a DHS-funded position to coordinate joint-working which was perceived by those interviewed as part of the visit to be really helpful. Loddon prison has 1.6 FTE clinicians to support the programme.

At the time of my visit in October 2011 all but one of those at the unit was already registered with the Department of Human Services in the community. At that time there were 114 intellectually disabled prisoners flagged on their prisoner information and management system across the whole prison estate. However, the unit only has a limited capacity and offenders have to have a specific vulnerability to get a place on Marlborough (approximately half are reportedly there for "placement and management". It was reported that of those resident on the unit, the vast majority had substance misuse problems and there was also high levels of co-occurring mental health need. IQ levels reportedly ranged from around 50-70 and offences included significant numbers of violent offences, drug offences and sexual offences. Although the unit would take someone with an acquired brain injury, this is not routinely identified within the system.

In addition the unit has a small number of non-intellectually disabled prisoners who are resident on the unit. They provide a mentoring role to the prisoners with an intellectual disability and are known as 'stabilisers'. However, at the time of my visit there appeared to be a number of problems with recruitment since these prisoners had to be carefully selected to prevent bullying, violence (notably towards sex offenders) or other problems.

The regime was similar to other areas of the prison in terms of timings (lock down etc) but reportedly with greater levels of activity on the Marlborough unit including therapeutic programmes and socio-recreational activities such as street soccer. At the time of my visit a positive lifestyle programme and employment programme was about to start at Marlborough and an art programme was commencing at Loddon. There was also a beautiful mural that had been painted by some of the prisoners on the unit. Nevertheless, my impression was that in atmosphere the unit felt much like other prisons I had visited although perhaps those in a lower security category. Unfortunately I was not able to compare this with other areas of Port Phillip prison.

[24] Representatives included those from G4S; DHS (Disability Forensic Treatment Service); the Policy Manager from Corrections Disability (Peter); the Programme Manager from Corrections Disability; the Loddon clinician; Director of Prison Services at Corrections Victoria.

Key features of Victorian provision

- **Dedicated unit within Port Phillip prison:** The Marlborough unit is an innovative unit providing tailored and holistic support (including therapeutic, socio-recreational and correctional activities) for those vulnerable prisoners with an intellectual disability in the Victorian prison estate. As far as I am aware there is nothing similar within the English/Welsh prison system.
- **Step-down care at Loddon prison:** Apart from those who have committed sexual offences, prisoners can be 'stepped-down' to the medium secure Loddon prison which also has dedicated clinicians. The two prisons work closely together; as part of the Disability Pathways programme the two services have joint governance arrangements and client review meetings are also held with clinicians from Lodden to discuss any problems. Other transitional support includes referral to a DHS case manager or for DHS assessment (if not previously known) six months prior to release. However, it was acknowledged to be a challenge to engage parole boards to impose appropriate conditions that can be managed and there was perceived to be a need to increase the skill of case managers of parole orders. They are providing training to all new Community Corrections Officers.
- **Tailored offending behaviour programmes within prison estate:** The initial aim of the unit was to establish a place to undertake specially tailored offending behaviour programmes as it appeared that those with an intellectual disability may be excluded elsewhere. Offending Behaviour programmes have been locally adapted from existing programmes in order to develop offence-specific work for this group. Programmes include those around sex offending, violent offending, shorter non offence-specific programmes, change motivation and emotional regulation. They run for ten months for four hours a week and use visual models (such as 'old me: new me'). Developed programmes are currently being evaluated by Deakin University. In addition there is existing knowledge around delivering the sex offenders' treatment programme for clients with an intellectual disability and the external service Morland Hall developed a specific drug and alcohol programme for this group. Other prisoners with an intellectual disability resident elsewhere within Port Phillip prison are also able to attend the targeted offending behaviour programmes on the unit (14 at the time of my visit).
- **Clinical staff based on unit:** The Marlborough Unit aims to operate on a therapeutic community model with clinical staff based on the unit during office hours. The role of the clinical team is to provide reactionary work, one-to-one support, tailored offending behaviour programmes, assessments (such as those for induction purposes, forensic assessments and those for the parole board). Being based on the unit reportedly meant that clinical staff were able to observe more and to develop a better relationship with custodial staff.

Evidence of Outcomes

During my visit it was reported that there had been a reduction in prison incidents involving prisoners with an intellectual disability since the start of the programme. At the time of my visit it appeared that only very limited data was being collected about the programme but there were plans in place to expand this to increase the evidence base for the programme. An evaluation of the unit is currently underway with the evaluation report anticipated in March 2013.

Comparison with England and Wales

All prisoners are screened on reception for health problems, including mental health problems, although there are some concerns that implementation problems mean that some people with mental health problems still slip through the net. This tool does not routinely include a learning disability element (Anderson, 2011b). A national licence has been obtained for prisons to use the Learning Disability Screening Questionnaire (LDSQ; Mackenzie & Paxton, 2006) but although some prisons have

adopted this tool, plans for a national roll-out with accompanying training and support appear to have stalled.

All prisons in England and Wales have access to general health care services with around half having 24-hour on site provision which includes enhanced care facilities (inpatient-type provision). Primary health care services are managed by the prison health care managers as part of their general healthcare remit; however research suggests that primary care services may not be well-equipped to support those with mental health needs (Durcan, 2008). There are examples of good practice though, for example HMP Manchester where there is a primary mental health care team, a therapy service offering individual and group work and twenty-four hour coverage by a mental health nurse (HMIP, 2012b).

Most prisons have access to 'inreach' teams who provide secondary mental health care to those with a severe and enduring mental illness. These teams are broadly based along the Community Mental Health Team model with the prison wings acting as the community. In some areas there is reportedly tension between the primary care provider and the inreach teams (managed by local NHS mental health trusts) regarding responsibilities for primary mental health care.

Inpatient healthcare provision is not usually targeted at prisoners with mental health problems however in practice much of this care is provided to this group. The Centre for Mental Health have expressed concern that such provision offers *"little of therapeutic value beyond containment and observation*" with more restrictive regimes and reduced social contact and activities (Durcan, 2008, p.37). Although some psychiatric nurses are employed within these settings, for the most part these nurses are employed within a general role with little opportunity for any therapeutic work to be undertaken.

These inpatient facilities are not mental health facilities and in his 2009 report, Lord Bradley called on the Department of Health to *"develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting"* (Bradley, 2009, p.106). This concurs with Department of Health guidance but has not yet been made a requirement of the NHS. Involuntary mental health treatment cannot be provided within prisons (Centre for Mental Health & National Mental Health Development Unit, 2011).

One exception to the approach that largely prefers hospital treatment for those with the most severe presentations is in the case of clients with a severe personality disorder. The Dangerous and Severe Personality Disorder (DSPD) programme established a number of treatment units within NHS high secure and medium secure provision as well as a number of treatment units within the prison estate. However, the direction of travel (as outlined in a recent DH consultation) now appears to be towards increasing the availability of places for treatment in prison and phasing out the units within the high secure hospital estate (Department of Health & National Offender Management Service, 2011).

One such unit is the Primrose project for women at HMP Low Newton staffed by both prison officers and clinical psychologists. This currently provides 12 residential beds within a 40-bed prison unit which otherwise houses lifer and other long-term prisoners. A range of assessment services and therapies are provided in a purpose built unit attached to the prison wing including Dialectical Behavioural Therapy, trauma-focused work, motivational work and offending behaviour work (the Life Minus Violence program). The remainder of daily activities is delivered by the mainstream prison services (HMIP, 2012a).

Responses to learning disabilities are provided largely through education and Her Majesty's Inspectorate of Prisons have highlighted that *"Crucial social care support was difficult to secure in prisons, and to plan for after release...Prisons [are not] helped by the dislocation between health and social care, with limited engagement by local authorities currently responsible for the latter."* (HMIP, 2009, p.5)

There is evidence of exclusion of those with learning disabilities from access to offending behaviour programmes, often because conventional programmes were not deemed suitable for offenders with

learning disabilities and alternatives were not available. Only a small number of respondents said that their prison ran adapted offending behaviour programmes (Talbot, 2007). Nevertheless, a number of adapted offending behaviour programmes have been developed for those within secure hospital care, for example sex offender treatment programmes (for example, Rotherham, Doncaster and South Humber NHS Foundation Trust, 2012) and cognitive behavioural anger treatment (for example, Taylor, 2011).

Challenges for transfer to the UK

- **Prison v hospital:** The Marrmak Unit is treatment-focused and well-resourced in terms of facilities and staff in comparison with generic prison healthcare units within England and Wales. It seeks to provide a safe, therapeutic hospital-style environment inside the prison walls for clients facing a range of mental health issues, including those at risk of suicide and self-harm, those awaiting transfer to hospital and those who have age-related needs. However, a key component of the model is that it provides ongoing care for those in the acute stage of a mental illness. The question remains whether prison is ever the appropriate place for this group of individuals. Similarly, although there is some support for sanctions of some form in response to offending behaviour by people with learning disabilities, it is a matter of debate whether prison is an appropriate response to this group. It is possible that such an approach may meet with resistance from advocacy groups.
- **Sustaining gains and step-down care:** A small number of expert interviewees in Victoria and England have highlighted that improvements in life skills and offending behaviour made whilst in custody may not be sustained on release. It was suggested that there are limitations with treating offenders with learning disabilities in an artificial environment since such people may have problems generalising skills across environments. These skills may need to be practiced in day to day life. It will be important to ensure that any prison unit is part of a pathway approach. In Victoria, as part of their Disability Framework, Corrections Victoria commit to the development of transitional accommodation and support options to assist the transition and integration of prisoners with a cognitive impairment into the community. Additionally, although some participants in research by the Centre for Mental Health & NMHDU (2011) supported the notion of developing specialist mental health treatment units within prisons, it was felt that this did not ameliorate the considerable problems with step down care.
- **Difference in numbers:** When the *Better Pathways* strategy was published there were around 260 women prisoners in the whole of Victoria (Department of Justice, 2005). At the time of writing the adult women's prison population in England and Wales sat at 4,165 prisoners (Ministry of Justice, 2012a). Planned expansion work to DPFC following my visit will extend its capacity to 344 beds[25] which is comparable with the English women's prison HMP Low Newton (operational capacity of 336) but significantly less than HMP Bronzefield which has an operational capacity of 527 (HMIP, 2012a; HMIP, 2011). There is some evidence that levels of severe mental disorder[26], in particular psychotic disorders and PTSD, may be higher among the women's prison population in Victoria than in England and Wales (Tye & Mullen, 2006; Singleton et al, 1997; Stewart, 2008). However, there is still likely to be considerably greater demand on treatment services within the prison estate in England and Wales than in Victoria with cost and operational implications for the provision of high quality treatment units. Similarly, at the time of my visit there were 114 people with a learning disability flagged within the Victorian prison system. Using an estimate of 6.7% of the prison population having a learning disability[27] and a prison population of 86,000 suggests that there are almost 5,800

[25] http://www.premier.vic.gov.au/media-centre/media-releases/1785-new-buildings-to-accommodate-female-prisoners-.html (accessed 09.08.12)
[26] Excluding personality disorder and drug dependency
[27] Based on findings from research undertaken by Mottram, 2007

prisoners with a learning disability in England and Wales. In addition, research suggests a further 25.4% have a borderline learning disability which equates to almost 22,000 further prisoners. A dedicated unit for all of these prisoners is unlikely to be feasible and there are strong arguments for up-skilling of staff and greater access to tailored offending behaviour programmes throughout the prison system.

- **No evidence of outcomes:** As yet there has not been an evaluation of either the Marrmak or Marlborough Unit to support transfer of this approach to the United Kingdom.

6

Revisiting an existing approach: problem-solving courts

The origins of problem-solving courts

Problem-solving courts attempt to address the underlying causes of criminal behaviour (Berman & Feinblatt, 2005). They are based on the principles of 'therapeutic jurisprudence', an approach which *"seeks to address the therapeutic and counter-therapeutic consequences of the law and how it is applied and to effect legal change designed to increase the former and diminish the latter."* (Winick, 2000 as cited in Freiberg, 2002, p.7). In other words, therapeutic jurisprudence is based on the belief that the law itself and legal processes can be agents for positive change. Problem-solving courts aim to apply the law in a way that improves the health and wellbeing of offenders as well as supporting their rehabilitation and reintegration.

Problem-solving courts originate from the United States. The drug court model was developed there in the late 1980s (Kerr et al, 2011) while the first Mental Health Court was established in 1997 in Broward County, Florida (Ryan & Whelan, 2012).

The American drug court model provides early, continuous, and intensive judicially supervised treatment for drug-dependent offenders accompanied by community supervision and mandatory periodic drug testing. There are appropriate sanctions for failure to comply with treatment or supervision requirements. Access is also facilitated to a range of other rehabilitation services (National Association of Drug Court Professionals website, cited in Kerr et al, 2011).

The 'essential elements' of the American mental health court model (as outlined by Taylor, 2007 as cited in Ryan & Whelan, 2012) similarly include timely assessment of need and links to treatment and support services, along with monitoring of and adherence to court requirements. There should be a clear target group with courts focusing on those where crime has been committed due to mental health problems. The court has a core team to include a judicial officer, treatment provider or case manager, defence lawyer and potentially also a probation officer and information must be shared in a way that safeguards the defendant's confidentiality. Participation should be voluntary. In the early generations of these courts, participation occurred prior to plea with the possibility of charges being dropped altogether following successful completion. However, later generations of American mental health courts have adopted a post-plea adjudication model.

Such courts have since expanded into Canada, Europe and Australia although the model used has varied.

Why revisit an existing approach

A number of examples of problem-solving courts have been piloted in England and Wales, a Dedicated Drug Courts (DDC) pilot programme ran from 2005 onwards, initially with two magistrates' courts in Leeds and West London that expanded to a further four courts in Barnsley, Bristol, Cardiff and Salford. Also, in 2009 a Mental Health Courts pilot programme was started in Magistrates courts in Brighton and Stratford, East London. In addition, the North Liverpool Community Justice Centre opened in 2005

which acted as a one-stop shop to tackle offending in the local area and included a range of problem-solving agencies (Booth et al, 2012).

Nevertheless, despite this activity there appears to have been a shift away from such approaches with a number of the pilot projects closing and a re-focusing on other mainstream initiatives such as liaison and diversion services. This is in part due to concerns about their time and resource implications, however, such approaches also seem to have fallen out of fashion. It is worth revisiting such approaches to think about aspects that can be retained and transferred to new initiatives. In addition there is a concern that problem-solving courts may have been dismissed on the basis of projects that did not ensure complete model fidelity.

Problem-solving courts in Victoria and New South Wales

There are a range of problem-solving court initiatives in Victoria and New South Wales. The first Australian drug court was established in New South Wales in 1998 which now sits at Parramatta and Toronto. There has been a drug court in Victoria, Australia since 2002 which is based at Dandenong Magistrates' Court in an outer suburb of Melbourne. Since 2007, Victoria has also had a Neighbourhood Justice Centre for the inner Melbourne, City of Yarra. In addition, it has been piloting a mental health court based at Melbourne Magistrates Court known as the Assessment and Referral Court (ARC) List since 2010. Other examples of problem-solving courts in the state include domestic violence courts and the Koori court for indigenous offenders.

This discussion is based on a number of courts that were visited as part of this Churchill Fellowship and which are outlined below.

Parramatta (NSW) and Dandenong (Victoria) drug courts

Involvement with both drug courts begins at the point of sentencing, following a guilty plea. In New South Wales, the participant is given a suspended sentence which is revisited after successful completion or premature termination of the order. The judge can confirm the initial sentence or vary it, taking into account any time spent in custody (as sanctions) and progress on the programme. A tailored program of support is offered and progress against this is reviewed by the court on a regular basis. The Victorian drug court does not build on an existing order available to the Magistrates court. Instead, eligible offenders are sentenced to a two-year Drug Treatment Order introduced specifically for the court. This order includes both a custodial sentence (that is not activated but remains in force) as well as a treatment component. Participants in both courts progress through three phases: (1) Stabilisation; (2) Consolidation; and (3) Reintegration.

The Assessment, Referral and Court (ARC) List (Victoria)

The Assessment and Referral Court (ARC) List is a separate court list that operates within the main Melbourne Magistrates court. Eligibility for the list includes those with a mental illness (using the definition in the Victorian Mental Health Act 1986 which excludes stand-alone anti-social personality disorder although not other personality disorders); Acquired Brain Injury; neurological impairment; intellectual disability (including borderline cases); or an autistic spectrum disorder. Engagement with the ARC List occurs for up to 12 months and, in contrast to the drug courts and the British model, involvement occurs both pre-sentence and pre-finding of guilt. Following acceptance on the list, finding of guilt is deferred until the participant's involvement with the court is concluded. In the meantime, a care plan is developed and the ARC List team and the client meet together on a monthly basis to discuss progress against the agreed care plan. If a participant is 'exited' (i.e. asked or chooses to leave the ARC list prematurely) they will plead and be sentenced within the mainstream system and their progress or otherwise on the ARC List should <u>not</u> be taken into account. In contrast, if the participant is 'finalised'

(i.e. they complete their time under the ARC List) they are sentenced within ARC and this sentence should take into account their progress on the ARC List.

Key features of the courts:

- **Judicial supervision with a multi-agency team approach:** Unlike the Brighton mental health court pilot in the UK where progress reviews were led by probation, in all three Australian examples visited, reviews are led by the presiding magistrate or judge. All three courts adopt a multi-agency team approach which involves the judge / magistrate, the registrar or Project Coordinator, the police prosecutor and the participant's legal representative as well as clinical staff. Community corrections (probation) officers are also members of the drug court teams, reflecting the fact that the intervention occurs post-sentence. The team provides a cohesive response although members of the team maintain their individual roles. Maintaining roles was seen as a way of ensuring that the process is fair and justice is served.
- **Providing a diversionary intervention:** To be supervised by the Drug Court in Dandenong, the Magistrate must consider that a sentence of imprisonment is appropriate and that the court would not have otherwise ordered the sentence to be served by a Community Corrections Order or a suspended sentence. Similarly, to be supervised by Parramatta Drug Court a custodial sentence must otherwise have been highly likely. As a genuine 'alternative to imprisonment' then it is likely that the court attracts offenders who have committed more serious offences or have lengthier offence histories than the English pilots (although caution is required in making offence comparisons across jurisdictions). Findings from the respective process evaluations tentatively support this conclusion (Kerr et al, 2011; King et al, 2004)[28]. For the ARC List, intervention occurs both pre-finding of guilt and pre sentence.
  Following successful engagement it is possible for participants to receive a lower sentence, a discharge or even for the case to be concluded without a finding of guilt.
- **Continuity of judiciary:** In the English/Welsh dedicated drug court (DDC) pilot magistrates and district judges volunteered to sit on an exclusive DDC Panel. However, although continuity of the bench was identified as an important part of the model (Kerr et al, 2011), only partial continuity was achieved. Continuity became harder to achieve the greater the number of reviews and there was variation in the degree of continuity between sentencing and breach hearings. In the Dandenong drug court, there was one magistrate dedicated to the drug court and when I visited in October 2011, the same magistrate had been assigned to the drug court since shortly after the commencement of the pilot in 2002. The Parramatta drug court also had consistency of judiciary. Similarly, although four magistrates sit regularly on the ARC List, each magistrate has their own caseload to avoid changeover of magistrates on cases as this was reportedly found to be less effective. Interviewees identified this as an important factor for the development of the relationship between the offender and the judiciary. Stability of other team members including legal representatives was also perceived to be important.
- **A different relationship with the defendant/offender:** In the two drug courts, many of the traditional formalities of a court setting had been retained. For example, the magistrate / judge did not sit at the table with the other professionals but at the bench and first names were not

[28] The process evaluation of the English and Welsh pilots reported that theft was the most commonly reported offence with 40% of the analysed sample reportedly on a DRR for the offence of theft, followed by 24% for the possession of drugs of all categories or the cultivation of cannabis (Kerr et al, 2011). In contrast, the evaluation of the Victorian drug court pilot found that 39% of major offences were burglary followed by theft and trafficking[28] at 14% and 'shopsteal' at 8%. On average, offenders who participated in the Victorian drug court pilot also had a higher number of previous convictions than those who participated in the English/Welsh dedicated drug court pilots. Participants had an average of 40 previous convictions compared to only 16 previous convictions for participants in the English/Welsh pilots (although this varied from 12 to 24 across the sites). In addition to caution regarding comparison across jurisdictions, there are concerns about the quality of the data from England and Wales (King et al, 2004).

used. However, there were noticeable differences in both atmosphere and process when compared to a normal court. The relationship between the magistrate / judge and the defendant/offender was noticeably different. The participant was spoken to directly (not through their legal advisor) and decisions were explained to the participant. Participants were also given the opportunity to speak about their own progress. During the day I spent at the Dandenong court, several participants shared stories about their young children, with one participant bringing their baby into the court to show the magistrate. In Parramatta, a former participant in the court 'dropped in' to the court during proceedings to let them know the progress he had made since finishing his sentence. There was a clear emphasis on building motivation and positive reinforcement, with significant care taken to identify successes and achievements of those who had failed to comply with the programme. One interviewee explained, *"the aim is to set up a mutually respectful and accountable relationship using the authority of the court, but it is about talking to them and asking their opinion."* The environment encouraged open discussion and honesty about drug use in a non-adversarial setting. For the ARC List a more informal approach was adopted with all parties, including the Magistrate sitting around the same table alongside the client and their support worker or family. There is a direct dialogue between the magistrate and the participant. One interviewee highlighted that in the ARC List, "*court is a place where they are connecting and not just judging"'*. This set-up was seen by those involved to be integral to the processes success.

- **Reward and sanction system:** As post-sentence interventions, both drug courts operate a system of sanctions and rewards for (non-) compliance. Non-compliance includes not attending appointments, not providing a sample and positive drug tests. Honesty is encouraged with lesser sanctions given where clients admit to drug use before the test result is revealed. Possible sanctions for non-compliance in Dandenong include verbal warnings; variations to the order; curfews; unpaid community work and custodial time. In Parramatta there appears to be a greater focus on custodial days as sanction. Custodial days are accrued and served when the total reached fourteen days. This is distinct to the situation in England/Wales where imprisonment can only be given where breach proceedings are taken and/or where further offences are committed. Rewards can include the removal of previously accrued community work days or custodial days, as well as verbal praise. Graduation from the programme is also celebrated. Professor Arie Freiberg reports that such a use of rewards and sanctions *"is regarded as essential to achieve the purposes of the program because it applies both* positive *(cf traditional courts) and negative reinforcement techniques quickly, consistently and publicly on persons who require a great deal of external motivation to successfully complete their programs."* (Freiberg, 2002, p.15)
- **Meeting multiple needs:** Treatment and care plans cover a wide range of support needs and are not limited to substance misuse and mental health treatment in the respective courts. Both drug courts had developed arrangements to address housing need among their participants. In New South Wales, the housing department had agreed to house a small number of the court clients. In Victoria, the Department of Justice (through the Courts Service) purchased housing support from existing community providers through the Department of Human Service's Support Accommodation Assistance Programme (SAAP). A full-time programme coordinator and three full-time housing and support case workers are dedicated to assisting drug court clients who are placed in dedicated Transitional Housing Management properties and helped to access long-term housing. In addition they will directly provide emotional and motivational support, help develop life skills (including budgeting, cooking and parenting) and will facilitate access into a range of other health and support services[29]. Low caseloads of community corrections officers also increased the capacity to respond to a wide range of needs. In Dandenong, as well as an ongoing photography course for participants, a range of one-off classes in cooking, fitness, yoga, IT and managing anxiety and depression had been provided.

[29] http://www.waysltd.org.au/prog_drug_court_homelessness.html accessed 22.06.12

Moving from an adversarial model of justice

During my visit I met with Professor Arie Freiberg, Chair of the Victorian Sentencing Advisory Council and an expert of therapeutic jurisprudence. He has previously argued that *"therapeutic jurisprudence and restorative justice have in common a recognition of the importance of factors such as trust, procedural fairness, emotional intelligence and relational interaction which, if applied more broadly, can provide a constructive alternative to the flawed adversarial paradigm which presently dominates the criminal justice system."* (Freiberg, 2002, p.1).

Interestingly, this argument that therapeutic jurisprudence can recognise and in fact support procedural justice was at odds with a slight discomfort that I felt during my visit that problem-solving courts could be perceived as leading to procedural injustice. Police prosecutors and the judiciary could be seen to develop a relationship, of sorts, with the offender. In the ARC List, police prosecutors sat around the table with defendants discussing their histories and their progress in attempts to change. Although this had clear benefits in personal terms, it was at odds with my perception of what a court *should* look like and raised concerns about upsetting the balance of justice.

These instincts arise from my grounding in an adversarial system of justice as opposed to an investigative system. Problem-solving courts however seek to find a new way of justice which does not pit improved therapeutic outcomes for offenders against the interests of justice (or indeed victims).

Frieberg highlights the stark contrast with a traditional court setting: *"In the context of problem-oriented courts, narrative competence requires that the judicial officer, case workers, therapists and others be able to listen to, and understand, the offender's view of the world. This is not a matter of determining 'the facts', but comprehending motivation and action...a rights-oriented approach is replaced by a trust-oriented approach"* (Freiberg, 2002, p.16). Through allowing each person to be heard and forcing them to listen to others it is suggested that this can in fact support the perception of procedural fairness.

The distinction with an ordinary adversarial and impersonal court was symbolised by a large tapestry that decorated the adjacent building where the treatment aspects were offered. This had been produced by the drug court participants and each participant had created a square to describe their struggles with drug use and their hopes for the future.

A final thought on areas of concern

Nevertheless, there are a number of well-versed criticisms to therapeutic jurisprudence (see for example Ryan & Whelan, 2012). During my trip I identified concerns about magistrates making final treatment decisions (as opposed to clinicians), a risk of developing dependency on the court and reducing the capability of other magistrates. In most cases the areas of concern are also directly entangled with the positive features that have been identified throughout this work and consideration will need to be given to how the latter can be incorporated without the former.

7

Extending an existing approach: Medically Supervised Injecting Centre

Medically Supervised Injecting Centre

The Medically Supervised Injecting Centre (MSIC) in the King's Cross area of Sydney started as a pilot in May 2001 and was the first supervised injecting centre in the English-speaking world (Royal Australasian College of Physicians, 2012). The original pilot period was due to last between May 2001 and October 2002, however this pilot period was significantly extended. The NSW government finally lifted the centre's trial status in October 2010 as I was applying for my Churchill fellowship.

The first Supervised Injecting Centre opened in Switzerland in the 1980s and there are now over 90 around the world (Sydney MSIC, 2011). Although differing in implementation, the premise of Supervised Injecting Centres is that they allow illicit substances to be injected legally on site with supervision from volunteers or professionals who monitor for signs of overdose. For the most part they also provide safer injecting advice and equipment.

They adopt a harm minimisation approach to drug use, i.e. with a focus on reducing and preventing drug related harm rather than focusing primarily or exclusively on the cessation of drug use. In an article in the British Medical Journal, two senior doctors from the National Addiction Centre describe harm minimisation as *"the triumph of pragmatism over purism: the acceptance that second best may be best first"* (Strang & Farrell, 1992, p.1127).

Reflecting this pragmatic approach, the MSIC states that *"The Sydney Medically Supervised Injecting Centre (MSIC) recognises that drug addiction is a chronic, relapsing condition and that it is complex and difficult to treat. MSIC does not support or promote drug use; it simply acknowledges that it is a fact of life."* (Sydney MSIC, 2010)

Harm minimisation is well-established and has been widely adopted in England and Wales through the provision of needle exchange schemes providing injecting equipment, increased health education activities, methadone maintenance therapy and other related activities such as the supply of condoms (Monaghan, 2012). As well as methadone and buprenorphine maintenance and detoxification programmes, a medical trial of supervised administration of injectable 'medical' grade heroin (diamorphine) has also been conducted (Strang et al, 2010).

However, the adoption of harm minimisation has been implemented alongside other complementary, and in cases contradictory approaches, such as a convergence between drug and criminal justice policy.

The Model

The Sydney MSIC is staffed by medical professionals (nurses overseen by a Medical Director) alongside trained counsellors and health education staff who support clients to adopt safer injecting practices.

The MSIC has a three stage approach.

- **Stage 1** is registration and assessment that is undertaken in the reception area. As well as ensuring that the client does not meet any of the exclusion criteria, assessment includes discussion of treatment history, past overdose and any referral requirements.
- **Stage 2** is the injecting room with eight open booths for drug injection, each with space for two people. There is a wide range of drug preparation and injecting equipment, including filtration equipment to reflect the high illicit injected use of oxycodone tablets locally. Attached to the injecting room is the resuscitation area where oxygen is administered to those whose oxygen blood level drops suggesting the beginning of overdose. Naloxone can also be administered where necessary although oxygen was usually considered sufficient.
- **Stage 3** is the aftercare room where clients are observed following use.

The MSIC operates a one-way system through the building and clients are encouraged to move through the stages as soon as appropriate so that the building does not become a social space. On site there is also counselling and facilities for testing blood borne viruses and opportunities for clients to be referred into treatment on request. There is no case management or key working undertaken at the centre but proactive steps are taken to follow up with clients where treatment appointments are arranged and provide reminders.

A legislated amendment to the Drug Misuse and Trafficking Act 1985[30] provides the basis for the MSIC to operate, allowing the possession and legal consumption of otherwise illicit substances on site. However, although possession of these substances on site is permitted, legislation does not protect those who are en route to the injecting centre and have drugs on their possession. Since there is no dealing of drugs on site clients necessarily have to have illegal possession of drugs up until the point when they enter the building. Significant and ongoing negotiation with police has been required to allow people to access the centre without being apprehended.

The centre excludes those who are intoxicated, first time users, those who are pregnant and those who are under the age of eighteen. For the most part these exclusions appear to be made for political and legal reasons since for the most part they are not consistent with harm minimisation philosophies; risk of overdose exists for injectors aged under eighteen and while the injection of heroin while pregnant is not advisable, neither is abrupt withdrawal for those who are dependent (Bhuvaneswar et al, 2008).

Evidence of Outcomes

In the first eleven years of its operation, the MSIC had overseen 735,311 supervised visits; an average of 225 visits per day. They have seen 700-750 individuals per month (Royal Australasian College of Physicians, 2012).

In their position statement in support of the MSIC, the Royal Australasian College of Physicians (ibid) conclude that the available evidence on the MSIC (including two evaluations) suggest that the MSIC saves lives, supports the health of clients and promotes treatment. The evidence of the MSIC's impact (particularly from the first evaluation) has been clouded by an unanticipated reduction in the availability of heroin that coincided with the opening of the MSIC. Nevertheless, during its first eleven years of operation, the MSIC has managed 4,376 incidents of overdose without a single fatality on site. Although not all such overdoses would have proved fatal if they had occurred elsewhere, a prompt response to overdose reduces the risk of injury through hypoxia. The first evaluation of the centre (MSIC Evaluation Committee, 2003) found that one in four visits included the provision of health care services – usually safer injecting advice – in addition to the supervision of injecting. In addition, one in 41 visits resulted in a referral for further assistance with drug treatment or other health related needs,

[30] Initially via Schedule 1 of the Drug Summit Legislative Response Act 1999) and then through the Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Act 2010 (Sydney MSIC, 2010)

with frequent attendees significantly more likely to be referred. 20% of referrals led to clients making contact (ibid). The Royal Australasian College of Physicians rightly highlights that saving lives is not the only benefit; nevertheless, during my visit it was emphasised to me that saving lives is the primary purpose. Hope for change remains while someone remains alive.

In addition on the basis of this evidence the Royal Australasian College of Physicians suggest that the MSIC does not attract drug users to the area and is largely supported by local residents and businesses. The 2010 evaluation (KPMG, 2010) found that 70% of local businesses and 78% of local residents support the MSIC. This is likely to be due to improvements in unwanted local activity such as public injecting and discarded needles.

Challenges to extending the model

It was emphasised throughout my visit that the centre was *"a local response to a local problem"*. The Wood Royal Commission (1997) proposed the introduction of such a centre in response to a local situation which was a cause of both public and political concern, including illegal shooting galleries, discarded needles, public injecting and high levels of overdose. It is also clear from the Sydney example that the centre is utilised by those already in the local area; intravenous drug users are unlikely to travel far after picking up drugs to inject. As such, it is likely that such a centre would only be appropriate in a small number of urban areas in the UK and would be likely to have only a localised impact.

Unfortunately, despite support for other harm minimisation approaches and significant evidence of the positive impact of Supervised Injecting Centres from Sydney and worldwide, there is unlikely to be a political appetite for opening such a centre in England and Wales. If anything, there appears to be a push politically towards abstinence based approaches. During my visit I was told that even in Victoria, where such a centre has reportedly been discussed for over a decade, there has never been sufficient political will or public appetite for it to go-ahead despite the Sydney centre being widely perceived as a success.

8

Acquired Brain Injury

The primary focus of my visit was to consider new approaches to supporting people with multiple and complex needs, including mental health, learning disability, substance misuse, homelessness and offending. This list of needs is by no means exclusive; at the beginning of this report I acknowledged the limitations of diagnosis focused approaches to complexity. Nevertheless, prior to my visit in 2011 few, if any, of my professional conversations included reference to Acquired Brain Injury (ABI). It was simply not on my radar.

However, during my Churchill Fellowship practitioners, policy makers and academics consistently raised the issue of people with Acquired Brain Injury (ABI) within the context of discussions on complex needs, particularly in the justice system. They emphasised the need to identify this frequently hidden disability and their attempts to develop appropriate referral pathways for this in the difficult context of co morbidity.

What is an Acquired Brain Injury?

The Department of Human Services and Health in Victoria (1994) has defined ABI as follows:

"Acquired Brain Injury (ABI) is an injury to the brain which results in deterioration in cognitive, physical, emotional or independent functioning. ABI can occur as a result of trauma, hypoxia (lack of oxygen to the brain), infection, tumour, substance abuse, degenerative neurological diseases or stroke. The impairments to cognitive abilities may be temporary or permanent and may cause partial or total disability or psychosocial maladjustment." (Corrections Victoria, 2011, p.4)

Traumatic brain injury (TBI) is the most common cause of acquired brain injury among the general population (Williams, 2012), although by no means its only cause.

The Child Brain Injury Trust identifies a range of changes and impairments that can result from brain injuries. These include:

- **Impairments to thinking abilities**: taking longer to process information; difficulties concentrating or focussing attention; forgetfulness (in particular regarding new information and recent events); following verbal instructions; organising and planning.
- **Emotional changes:** depression, anxiety, fearfulness, obsessiveness.
- **Problematic behaviours:** impulsiveness, immaturity, aggression and sexually inappropriate behaviour.
- **Physical changes:** doing things at a slower pace; tiredness and fatigue. (Child Brain Injury Trust)

However, one important feature of acquired brain injury is that often there are no physical signs of disability once the external injury (if there was one) has 'healed' and so it is a 'hidden' disability.

Complexity and ABI

The primary concern of this report is not how you respond to issues in isolation, but how they might interact to create complex presentations requiring different approaches.

There is growing evidence of brain injury within prisoner and other offender populations. It is important to highlight that many of those with an ABI do not go on to offend. However, potential consequences of ABI such as impulsivity, reactivity and aggression may predispose individuals to offending (Department of Justice, 2011).

A recent report on brain injury and its implications for criminal justice identifies 'compelling evidence' of a very high prevalence rate of traumatic brain injury in offenders in custody relative to the general population. It reports that while less than 10% of the general population has experienced a head injury, studies from around the world have typically shown that between 50-80% in offender populations have experienced a head injury (Williams, 2012). In addition, it reports that longitudinal studies have shown a link between traumatic brain injury and later offending, while putting this in the context that risk taking individuals may be more susceptible of both offending behaviour and behaviour that puts them at risk of injury.

As above, much of the research into prisoner populations has focused on the incidence of traumatic brain injury. This excludes other causes of acquired brain injury such as alcohol and substance abuse (and hypoxia through drug overdose) which are likely to be more common in prison populations, as with homeless populations, where there are known high levels of drug and alcohol use.

Research by the Victorian organisation Arbias and La Trobe University suggested that 42% of males and 33% of females in the Victorian Correctional (prison) system have evidence of an ABI following formal neuropsychological assessment (Arbias & La Trobe University, 2010). This compares to a reported prevalence of 2.2% in the general population in Australia (Australian Institute of Health and Welfare, 2007, cited in Department of Justice, 2010). Only a small proportion of these were identified as having a severe ABI (6% men; 7% women) or moderate ABI (39% men; 21% women) with the majority showing evidence of a mild ABI (55% men; 72% women). Notably, those prisoners who were not identified as having an ABI performed within the average range on neuropsychological tests indicating that the majority of prisoners have intact cognitive functions similar to the general population (Department of Justice, 2011).

The male and female prisoners produced different profiles of cognitive impairment with females presenting with more impairments in spatial abilities, complex attention and working memory, and males presenting with more widespread and generalised impairments in all areas, apart from basic processing speed and basic perceptual abilities. The researchers suggested that this was likely due to different profiles in the causes of ABI, with the women's profile resembling that due to substance related brain injury (particularly benzodiazepine) and the men's profile resembling that due to alcohol related brain injury and traumatic brain injury (Arbias and La Trobe University, 2010).

Recent research from the Disabilities Trust has also highlighted high levels of Traumatic Brain Injury among homeless populations in the UK, with 48% of the homeless participants reporting a history of traumatic brain injury compared to just 21% in the control group. The vast majority of these homeless participants (90%) reported that their first traumatic brain injury occurred prior to homelessness (The Disabilities Trust Foundation, 2012).

Williams (2012) also reports evidence that mental health issues, developmental disorders (notably Attention Deficit Hyperactivity Disorder) and drug misuse may arise as a result of a traumatic brain injury. Conversely, both alcohol and substance abuse are risk factors for an ABI (Arbias & La Trobe Univeristy, 2010) while Attention Deficit Hyperactivity Disorder may put someone at greater risk of a traumatic brain injury due to inattention.

ABI in the criminal justice system: Key features of the Victorian approach

- **Leadership from government departments:** Corrections Victoria has shown strong leadership in commissioning research to provide indicative data on the prevalence of ABI within the Victorian Correctional System and to test the efficiency and veracity of a three-stage screening process for identifying ABI among prisoners (Arbias & La Trobe University, 2010). The validated tool takes roughly 30 minutes and can be administered by frontline justice staff such as prison officers who were trained to deliver the tool as part of the research. This screening tool looks at eight risk factors for ABI: alcohol use; drug use; assault; motor vehicle accident; amateur/professional boxing; suicide attempts; psychiatric conditions; and stroke. In response to identified need, the department also established the Corrections Victoria Acquired Brain Injury Program to improve outcomes for those with ABI in the justice system.
- **Moving beyond traumatic brain injury:** Notably, discussion in Victoria extends beyond traumatic brain injuries to include other causes of brain injury including alcohol and other substance related brain injury which are likely to be more prominent in offender and homeless populations where there are high levels of substance abuse. In addition, co-morbidity of a substance misuse dependency alongside an ABI gives an added dimension of complexity in client presentation and response. The not-for-profit organisation, Arbias, which specialises in alcohol and other substance related brain injury appear to have had a prominent role in raising awareness of other causes of brain injury in both Victoria and New South Wales.
- **Corrections Victoria ABI Program:** Corrections Victoria recruited an acquired brain injury clinician to improve support for prisoners and offenders with an ABI in the North West Metropolitan Region of Victoria. The clinician has a multi-functional role that includes consultation, capacity building, information, education, intervention planning - including the development of a treatment plan - and staff training including prison and community corrections (probation) officers (Famularo, 2011; also information from ACSO 6th Forensic Disabilities Conference).
- **Raised awareness of the issue among justice based initiatives:** Acquired Brain Injury appeared to be at the forefront of discussion during my visit to Victoria. Medical and justice professionals across a wide range of support services were both aware of the condition and its impact as well as referral routes for neuropsychological assessment, with many even having brokerage funds to secure these. This includes the police-based programme PACT, as well as the court-based responses CISP, the ARC List and the two drug courts. An evaluation of the CISP service reported that the prevalence clients with possible ABI was higher than anticipated in the demand estimates (Ross, 2009). They have a specialist ABI worker to respond to this group. The mental health court in Melbourne (the ARC List) also includes ABI as one possible condition for eligibility for the court.
- **Access to neuropsychological assessments:** In addition to MACNI, a number of the criminal justice services had brokerage funding with which they could access full neuropsychological assessments where necessary. This includes both CISP and the ARC List as well as the targeted Corrections Victoria ABI Program.

Alcohol Related Brain Injury Australian Services (Arbias Ltd)

During my Churchill Fellowship I was able to meet with John Eyre, Executive Manager of Arbias Ltd to talk about their clients, the impact of an ABI and the service that they provide. Arbias specialises in providing services for those with alcohol related and substance related brain injury. John Eyre reported that the majority of their clients are still actively using drugs or alcohol, have multiple other support needs and are in contact with the criminal justice system, mainly for low-level offending.

They provide a range of services including neuropsychological assessment, case management, specialist accommodation and social and recreational support. The assessment unit specialises in the

identification of alcohol or substance related brain injury and provides medico-legal assessments and assessment for case management purposes. As well as identification of the condition, assessments can provide detailed information about the manifestation of the condition so that practical strategies can be implemented in conjunction with case managers and family. The neuropsychologists also provide clinical supervision to the case managers.

Case managers provide holistic, person-centred support and undertake a range of activities in addition to the development of management strategies, including linking in with other services; coordination of services; facilitating case conferences; up-skilling other support workers in contact with the client; applying for funding; and providing emotional support and education for those who are newly-diagnosed and their families. The organisation prides itself in its dual issue specialism (ABI and drug and alcohol use) and offers staff specific training on this. In addition, staff are recruited from a range of different backgrounds, for example social care or housing. This was seen as particularly valuable by John Eyre, in particular he reported that those with backgrounds in occupational therapy had valuable problem-solving skills.

However, challenges with this model include throughput and the provision of time-limited support for those with permanent disabilities and the organisation was increasing its focus towards developing exiting strategies (particularly in Arbias, NSW).

Arbias also provide training for other agencies and have produced materials to support professionals who may be working with a client with an ABI. As well as providing information about the condition and case studies, their publication *Looking Forward – Acquired Brain Injury* contains a range of strategies to support people with an ABI. Although ABIs manifest themselves differently in different people, strategies are based around the central principle of "compensation". The guide also includes strategies for managing poor concentration, managing memory problems, improving communication, managing anger, managing change and goal setting and individual planning (Arbias, 2011).

Compensation

1) Reducing demands on impaired cognitive skills
   - avoiding overloading people;
   - structuring the environment;
   - minimising change in the environment;
   - being available to the person with an ABI: generating ideas and alternatives, planning, prioritizing, re-focusing attention

2) Tapping a person's strengths and preserved skills.
   - using familiar language;
   - talking about the past when agitated or depressed while being aware of sensitivities;
   - prompts/cues and closed ended questions;
   - encouraging old interests and hobbies.

Arbias, 2011

Limitations to the Victorian approach

This is not to suggest that Victoria has yet achieved a gold standard in the support for ABI within the justice system although it has demonstrated significant work towards this goal.

Despite the work undertaken to develop and validate a screening tool, at the time of my visit in September 2011 there was still no systematic screening of prisoners in Victoria for Acquired Brain Injury

although identification and subsequent referral pathways for this group appeared to be a significant concern for those working on disabilities within Corrections Victoria. One expert who I met with during my trip also suggested that recognition of ABI within the juvenile justice system was less developed, however I did not meet with anyone from juvenile justice services to verify this.

Nevertheless, there are clear lessons for England and Wales in improving responses to this group.

ABI in the criminal justice system: the situation in England and Wales

Until recently, there has been low awareness of ABI among criminal justice policymakers, commissioners and practitioners in England and Wales; particularly in services for adult offenders. However, awareness does appear to be growing with a number of promising recent developments.

In January 2011, a range of organisations working in the fields of criminal justice, brain injury and research came together to form the Criminal Justice Acquired Brain Injury Interest Group (CJABIIG) to raise awareness of these issues. More recently, in October 2012, the Transition to Adulthood Alliance published a report on brain injury and its implications for criminal justice (Williams, 2012) which received media attention (BBC News, 19th October 2012; The Guardian, 19th October 2012).

Although prisoners in England and Wales are not systematically screened for an Acquired Brain Injury, the new Comprehensive Health Assessment Tool (CHAT) for young offenders being developed by the Youth Justice Board will include questions related to Acquired Brain Injury. Less progress nationally is apparent for adult offender populations, although the Disabilities Trust is piloting a specialist brain injury link worker role in an adult prison to undertake assessments and negotiate care pathways (Williams 2012; also information from the CJABIIG 2012 conference).

It is an important time to bring Acquired Brain Injury into criminal justice policy discussions which have hereto focused largely on mental health and learning disabilities. The government is currently committed to the roll-out of liaison and diversion services in police stations and courts by 2014 (provided that a business case can be made to the Treasury) and has committed £19.4 million to support this roll-out in 2012-13 (Hansard, 2012). It is hoped that such services will reduce reoffending, improve health outcomes and reduce criminal justice costs through the early identification of mental health problems and learning disabilities among offenders and the resulting diversion of such offenders out of or within the justice system to more appropriate disposals. It is a prime opportunity to identify acquired brain injury among those passing through the justice system and ensure more appropriate responses to these groups. However, there is a significant risk that Acquired Brain Injury will not be recognised as an important issue and thus excluded from these developments.

9

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Appendix A - Timetable of trip

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
September					23rd
AM					
PM					
Evening					Leave UK

September	26th	27th	28th	29th	30th
AM		**MACNI**: Anne Leonard, Marilyn Kraner & Indigo (10am - 1pm). 50 Lonsdale St, Melbourne Central Business District	**Melbourne Magistrates Court:** Jo Beckett (CISP& CREDIT) 9am; Viv Mortell (ARC) & Glenn Rutter. 233 William Street, Melbourne 3000	**Neighbourhood Justice Centre:** 9.30am - Cameron Wallace - overview of the NJC, client services and our therapeutic approach to justice delivery; 11.00am -Stuart McGown and Jay Jordens - talk about how CCS work at the NJC, court reviews and short sentence program; 12.00pm - Carolyn Dryden - chat about the recidivism project; 12.30pm - depart	**Australian and New Zealand Society of Criminology Conference**
PM		**Victoria Police Mental Health: 3pm** Eva Perez	**Melbourne Magistrates Court**		**Australian and New Zealand Society of Criminology Conference**
Evening					

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
October	3rd	4th	5th	6th	7th
AM	**PACT:** Meeting with Blanca, Clinician, PACT (9:30-17:30) including CANCELLED: Amy Leeks, MACNI (11am)	**Support Link:** 11-12.30pm Inspector Bernie Jackson, Local Area Commander Melbourne East & St Kilda Road Police Service Area. 226 Flinders Lane, Melbourne 3000.	*9-11.30am* - **Corrections Victoria Head Office** (central Melbourne) - Transition Services, Transitional Service for people with an ID/ABI; Sheree Drever, manager, Reintegration program Branch; and Disability policy with Peter Persson	**Prof Freiberg & Prof Bernadette McSherry:** Town Hall House, Level 5, 456 Kent Street, Sydney, 2001	**Marlborough Unit** at Port prison for men with an ID 9am -2pm, Laverton
PM	**PACT**: Elli Wellings & Inspector John Thexton, PACT	**Women's prison:** 2 to 4pm	**Jesuit Social Services:** 12:30-2:30pm, Brunswick (6km from central Melbourne) **ARBIAS**: 3pm - 5pm, also Brunswick	**Forensicare:** 3pm Dr Douglas Bell, Thomas Embling Hospital	**ACSO:** 3pm - 5pm, Western House in Footscray (nearby)
Evening				Magdalena Maguire, Researcher, Department of Justice	

Week 3	Monday	Tuesday	Wednesday	Thursday	Friday
October	10th	11th	12th	13th	14th
AM	**Dandenong Drugs Court:** 9.30am Lucille Thomas, Drug Court entrance, Langhorne Street, Dandenong; 10.00am - 11.30am - case conferences. 12pm-1.00pm lunch	**Forensic Disabilities Conference:** 8am Registration open; Conference 8:45am-7pm, Rendezvous Hotel Melbourne, 328 Flinders Street, Melbourne	**Forensic Disabilities Conference:** 8am Registration open; Conference 9am-5:30pm		CANCELLED: Superintendent David Donohue, Corporate Spokesperson - Mental Health, **NSW Police Force** at 9:30am at the Sydney Police Centre, Goulburn Street
PM	**Dandenong Drugs Court:** 1.00pm- 3.00 pm - Reviews - In which the participants attend Drug Court; 3.00 - 4.00pm - Chats to team members	**Forensic Disabilities Conference:** Close at 7pm http://www.conferenceworks.net.au/acso/page/Program	**Forensic Disabilities Conference:** 8am Registration open; Conference 9am-5:30pm		**Way2Home Assertive Outreach Health Team:** 2pm Amy Cason The O'Brien Centre St Vincents Hospital Darlinghurst NSW 2010
Evening		Dinner with Prof Bernadette McSherry and colleagues	Fly to Sydney		

Week 4	Monday	Tuesday	Wednesday	Thursday	Friday
October	17th	18th	19th	20th	21st
AM		**Parramatta Drug Court:** Karen Hay, 12 George Street PARRAMATTA	Visit to **MERIT**: Matt Jessimer & Rod Lander	**MSIC:** 8:30am-11am Sarah Hiley, 66 Darlinghurst Rd, Kings Cross **Kirketon Road Centre:** 11am Kings Cross	**Integrated Services Project & Community Justice Programme**: Caroline Dodson & Vince Ponzio: A/Director/Integrated Services Program Office of Senior Practitioner Ageing, Disability and Home Care Department of Human Services Level 4, 93 George Street, Parramatta NSW 2150
PM	**Homelessness Intervention Project: 1-3pm,** Maria Berry and Mat Flynn, Level 14, 97 – 99 Bathurst Street Sydney NSW 2000 **4pm Liz Giles,** Manager of Homelessness Unit, Town Hall House, Level 5, 456 Kent Street, Sydney, 2001	**2:30pm NSW Police:** Yasmin Hunter & Assistant Commissioner Denis Clifford (NSWPF Corporate Spokesperson for Vulnerable Communities); Parramatta	Visit to **MERIT**: Matt Jessimer & Rod Lander		**Integrated Services Project & Community Justice Programme**
Evening		Gina Andrews, Mental Health Policy Officer at NSW Police	Dinner with Dr Leanne Dowse, Prof Eileen Baldry and colleagues	Gina Andrews, Mental Health Policy Officer at NSW Police	