

Forensic Alcohol and Other Drugs Treatment Service Delivery Model

Alcohol and Other Drugs Treatment and Services

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1 Executive Summary

There are a growing number of offenders managed in the community, and the profile of these offenders is increasing in complexity. Substance use and offending patterns have contributed to the complexities. These factors were the catalyst for designing a new Forensic Alcohol and Other Drugs (AOD) Service Delivery Model (the Model). Combined with this are a number of challenges for the AOD treatment system, including significant system change and the need for a more tailored approach to engagement, treatment and collaborative case management of offenders on court orders.

A truly collaborative partnership between the Department of Justice and Regulation (DJR), the Department of Health and Human Service (DHHS) and the AOD sector facilitated the establishment of the Model. The partnership allowed for equal consideration of outcomes of AOD service provision for offenders in treatment coupled with the community safety benefits gained from a revised service response.

There are six key themes in the Model that focus on screening and assessment, treatment approaches, collaborative practice, workforce development, governance and data systems. These have been identified through a review of existing service responses and draw heavily from previous reviews that identify the key elements needed for a tailored forensic AOD system. The Model has been developed through substantial engagement and consultation with the AOD and Community Correctional Services (CCS) sectors.

The Model is predicated on the establishment and implementation of new assessment and treatment approaches and culture and practice changes. This will result in AOD providers and CCS sites working more closely together to motivate and sustain an offender through their AOD treatment and to complete their orders.

There are a number of high level initiatives to be implemented over the coming years as follows:

- A new forensic screening and assessment tool that better identifies an individual's risk of substance related harm and the relationship to their risk of re-offending
- A new treatment typology that links the new assessment tool with a differentiated model of

treatment interventions based on a person's risks and needs

- The design and implementation of new group based criminogenic AOD programs over a number of years. The programs vary in length and intensity depending on risk of AOD harm and risk of re-offending
- A *Collaborative Practice Framework* that clearly articulates the joint focus of the AOD and CCS sectors to work together with clients on court orders with AOD assessment and treatment conditions
- A formalised governance and reporting structure that brings managers and executives together to review and respond to system demands and service design
- A comprehensive workforce capability building initiative to enhance the collaboration between the AOD and CCS sectors. This includes a supervision framework and professional development for the existing AOD workforce to build skills and expertise in working with complex forensic clients, particularly in group settings
- Enhancements to data collection and information sharing between AOD and CCS agencies, as well as informing the establishment of new information technology (IT) and client management systems for the future.

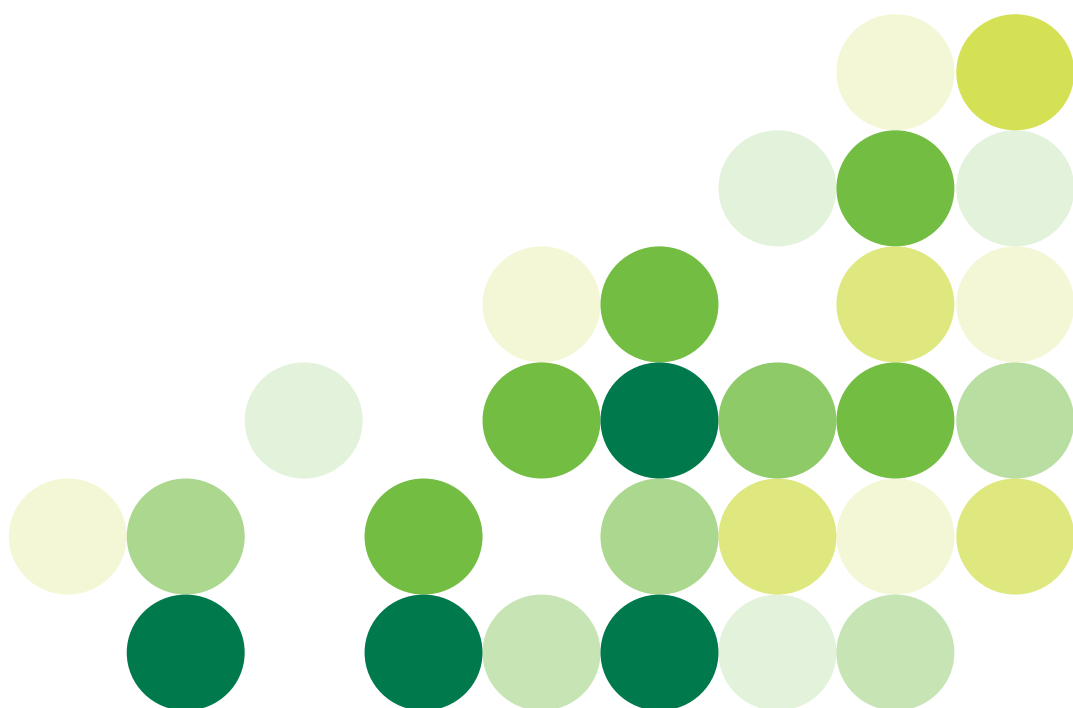
These initiatives will be phased over a number of years. The first phase focuses on the development, implementation and evaluation of new treatment interventions for forensic clients who are on Community Correction Orders (CCOs), CCO-Imprisonment orders and Parole. It is acknowledged that there are other forensic clients that are assessed by the Community Offender Assessment and Treatment Service (COATS) and receive AOD services under forensic brokerage funding. Phase two implementation of the Model will look at mechanisms to streamline referral pathways and the assessment and treatment options for these cohorts, which include clients on bail or diversion programs. The first phase focuses on the delivery of a number of new treatment programs for community based adult male offenders on court orders with an AOD assessment and treatment condition at designated trial sites. Throughout the first phase of implementation these programs will

be evaluated and and, in the later phases, tailored to suit the specific needs of various population groups including women, Aboriginal and Torres Strait Islander people, and young people in the criminal justice system.

Success in implementing the Model is reliant on new ways of working together and new treatment models that better address the complex relationship between a person's substance use and their offending behaviour. The focus on new and innovative treatment programs that work with a person to address their substance use and offending behaviours is expected to have benefits for the individual, their families and the broader community.

Key initiatives in support of the Model have already commenced. The first phase of trialling criminogenic AOD group programs has commenced. This phase will include a comprehensive program evaluation that will inform future service delivery and program design. A number of existing data collection and reporting mechanisms will be utilised to review progression of these initiatives.

The Model is founded on a set of core principles that bridge AOD treatment and offender case management. They have been developed in consultation with both sectors through a comprehensive consultation process. The principles focus on best practice in case management and treatment, and recognise the need for strong collaboration.

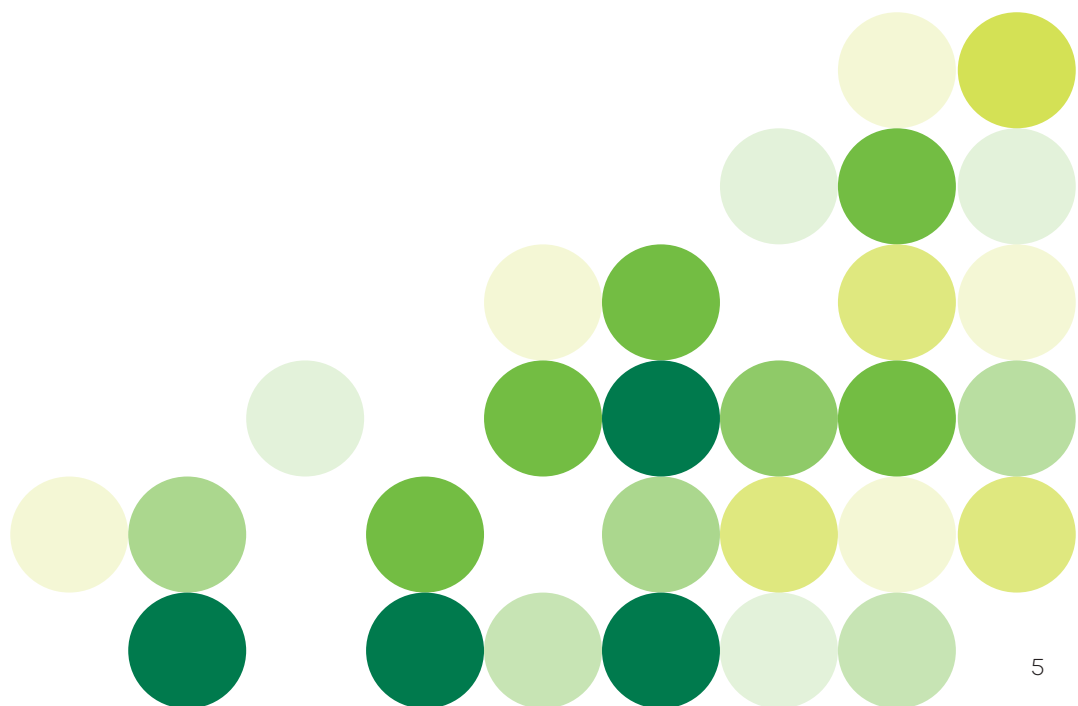


2 Document purpose

This document outlines the new Forensic AOD Service Delivery Model. This includes:

- a rationale for the development of the Model
- detailed actions for implementation of the six key themes.

The terms offender and client are used interchangeably throughout the document.



3 Rationale

3.1 AOD Treatment System Changes

The state funded AOD system and the CCS system have undergone substantial changes over the past three years.

The 2014 system reforms to the adult non-residential AOD service system established an activity based funding model for all adult non-residential providers. The new funding provided for a new payment structure for agencies, the Drug Treatment Activity Unit (DTAU). This payment approach differentiated standard and complex cases for counselling and non-residential withdrawal streams, and applied a further 15 per cent loading on the DTAU for non-residential services for forensic clients. In addition, forensic case load targets of 20 per cent (of all clients) was set across the sector and loading and targets were applied to all forensic clients, including offenders on CCO, CCO-Imprisonment order and parolees¹.

An independent review of the recommissioning process was conducted in 2015, which found that recommissioning made it difficult for vulnerable Victorians to navigate the system and access alcohol and drug treatment and support.

3.2 Community Correctional Services Changes

During 2016/2017, Corrections Victoria also undertook substantial reform to the management of offenders in the community. The reform included a substantial recruitment program, a new framework for case management to strengthen the application of evidence based practice, a focus on enhancing the workforce capability with new professional practice staff, and a focus on staff supervision, training and accountability.

In alignment with the noted increase in AOD referrals for service, there has also been significant growth in the number of offenders supervised by CCS. The number of offenders required to be managed by CCS has increased over recent years as a result of legislative reform and changes in sentencing practices, specifically:

- the abolition of suspended sentences (effective in the Magistrates' Court from 1 September 2014)
- the increased use of a combined sentence of imprisonment and a Community Correction Order (CCO).

Both the guideline judgement and the abolition of suspended sentences increased the number of CCOs imposed in Victorian adult courts, including a 36% increase in the Magistrates' Court (as a principle sentence). Coupled with this, a review by the Sentencing Advisory Council (2016) found that for offenders sentenced to a CCO with a term of imprisonment or a CCO as a principle sentence, the offenders were generally older, the conditions applied were more intensive and the orders were longer in duration². These sentencing changes have resulted in a growth in the number of offenders on supervised court orders. Between 30 June 2014 and 30 June 2017 the number of offenders managed on supervised court orders has increased by 67 per cent, from 6,386 to 10,651, with the majority of these offenders being managed on a Community Correction Order (CCO)³. With around three quarters of offenders on a supervised CCO subject to at least one drug or alcohol treatment condition, this increase in numbers has resulted in a significant increase in demand for service.

1 DHHS Alcohol and other Drugs Program Guidelines April 2017 – part 3 – Quality Reporting and Performance Management

2 Sentencing Advisory Council 2016, *Community Corrections Orders: Third Monitoring Report (Post-Guideline Judgement)* June 2016.

3 Current supervised court orders primarily include Community Correction Orders (CCOs) with at least one condition other than community work, as well as the Drug Treatment Order. Historically this category included Home Detention, Intensive Correction Orders, Community Based Orders and Combined Custody and Treatment Orders. Data available at <http://www.corrections.vic.gov.au/utility/publications+manuals+and+statistics/monthly+time+series+prisoner+and+offender+data>

3.3 Offender Profile Changes

In addition to the above noted changes, there has also been significant growth in the number of CCOs combined with imprisonment (CCO-Imprisonment order). Sentencing changes allowed for an extension to the term of imprisonment that can be combined with a CCO from three months to two years, before reducing to one year in March 2017.

Between 30 June 2015 and 30 June 2017 the number of offenders on a CCO-Imprisonment order has more than doubled.

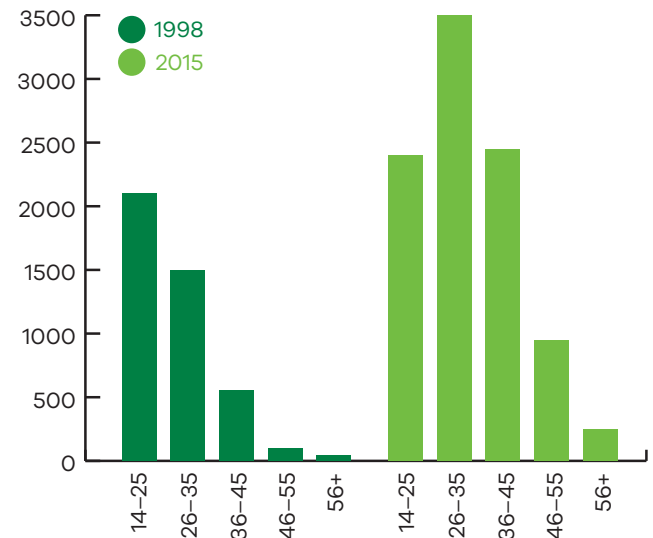
The increase in this type of sentence has created new challenges for the criminal justice system, particularly in relation to supporting the transitional needs of offenders and ensuring a seamless connection to community based programs post release, particularly from remand. The growth in CCO-Imprisonment orders and the need to enhance transitional support has implications on service access and treatment completion. Almost half of all offenders who receive a CCO-Imprisonment order are released onto the CCO component of their sentence after time served in remand. This means that many offenders' remand time is considered their term of imprisonment. Some remandees may be discharged from court onto their CCO.

3.4 Increasing complexity and demand

Offenders are often subject to a number of treatment and rehabilitation conditions on one order. The growing number of offenders with multiple conditions poses challenges in responding to increased complexity. Offenders with a drug or alcohol treatment condition can have this condition in combination with a mental health treatment and/or condition or a condition to participate in programs to reduce re-offending.

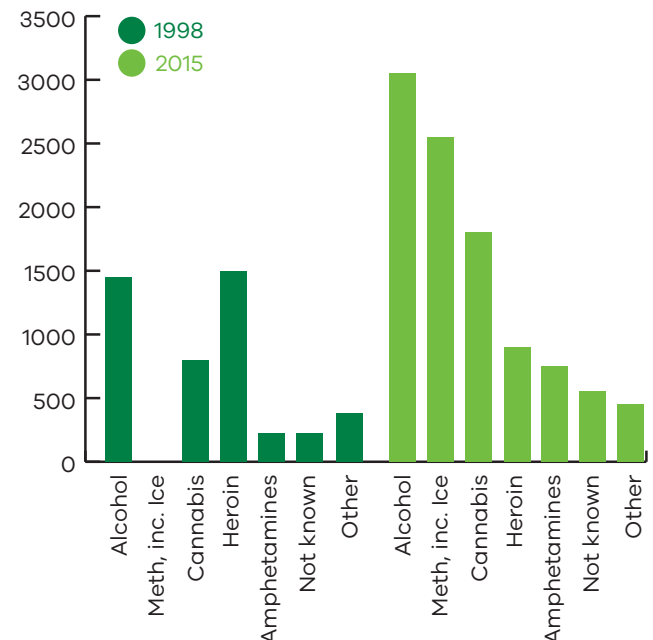
Analysis undertaken by the Australian Community Support Organisation (ACSO) in relation to the services provided by COATS program over the past 20 years has revealed that demand for forensic assessments and referral for treatment has continued to grow since 2014. Whilst some of the demographics of clients has remained stable there have been two areas of significant change; age of offender and primary drug of concern. Figure 1⁴ identifies that in 2015, youth contributed only 25 per cent of assessed COATS clients, whereas the older age groups (above 36 years) have doubled since 1998. This data is based on offenders that completed a COATS assessment and does not reflect the overall Corrections Victoria offender profile.

Figure 1: Age profile of offenders in 1998 and 2015 who completed a COATS assessment



As indicated in Figure 2⁵, significant changes in the consumption of heroin and methylamphetamine are noted. Heroin decreased from the most frequently reported drug of choice in 1998, to fourth in 2015, and methylamphetamine (including ice) was the second most reported drug of choice in 2015. The shifting drug consumption pattern toward methylamphetamine has created challenges in the treatment interventions required to support clients experiencing psychosis and/or methylamphetamine dependence.

Figure 2: Drug consumption patterns in 1998 and 2015 from offenders who completed a COATS assessment



3.5 Level of treatment completion

The majority of forensic clients accessing AOD treatment in community receive individual counselling. Outcome data for forensic AOD treatment completion during 2015–16 identifies that 45 per cent of offenders completed treatment⁶.

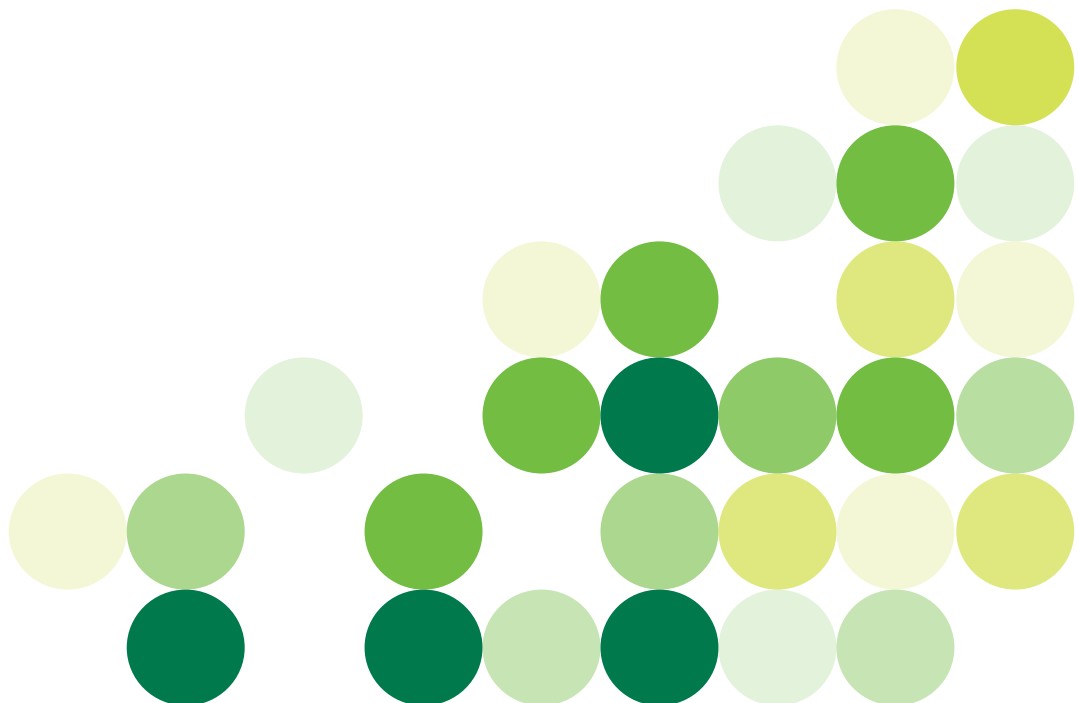
4 ACSO/COATS (2017) A Snapshot – 20 years of seamless transformation

5 Ibid

6 ACSO/COATS (2017) A Snapshot – 20 years of seamless transformation, <http://www.acso.org.au>

4 Development of the Service Delivery Model

The Model was developed with extensive consultation from the AOD and CCS sectors, including a number of workshops and forums. The Model's development was overseen by a joint DHHS/DJR Working Group and informed by a Forensic Clinical Advisory Group. The development of the Model is led by a project team located at Justice Health, DJR. Refer to [Appendix 1](#) for the governance structures and membership.



5 Aim and Objectives

5.1 Aim

The primary aim of the new Forensic AOD Service Delivery Model is to enhance the forensic AOD service response to offenders on court orders with AOD assessment and treatment conditions and improve the efficacy of AOD treatment.

5.2 Objectives

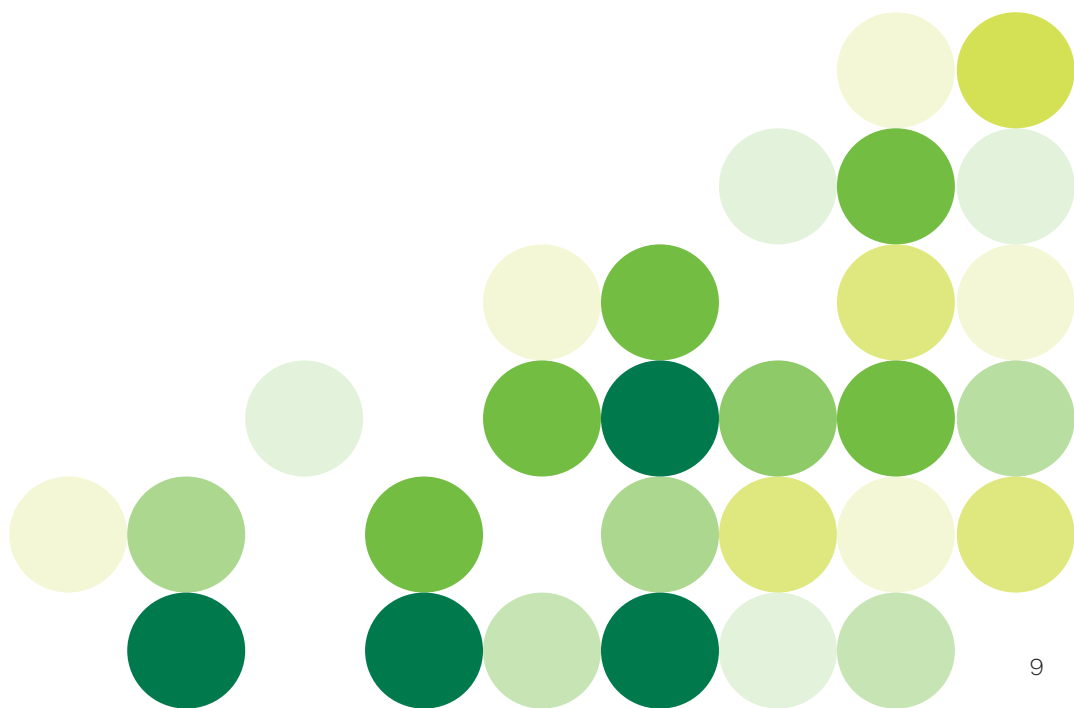
The following objectives have been developed to achieve the primary aim of the Model:

- ✓ Improve referral pathways and access for offenders to AOD services
- ✓ Improve the delivery of specialist forensic AOD treatment to offenders
- ✓ Strengthen collaboration, co-ordination and accountability between AOD and CCS sectors
- ✓ Enhance the capability of the AOD and CCS workforces to implement service enhancements
- ✓ Develop enhanced and flexible treatment models for forensic clients
- ✓ Embed governance over the delivery of services between CCS and AOD (centrally and locally)
- ✓ Develop effective reporting and monitoring tools and data systems.

5.3 Outcomes

Full implementation of the new Model is expected to result in the following outcomes:

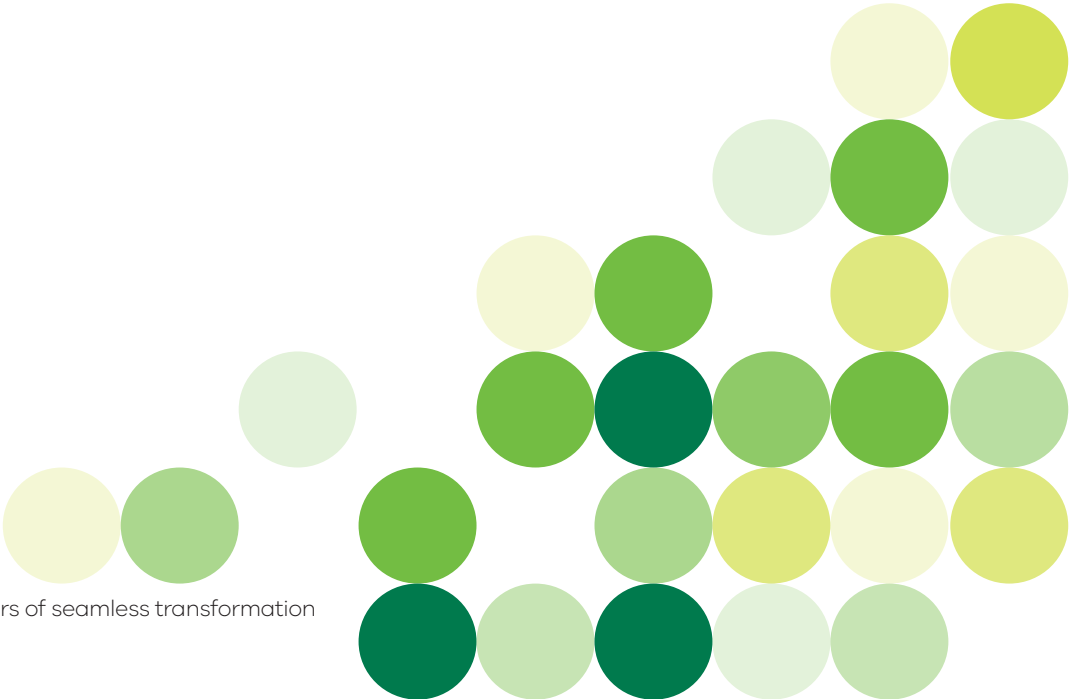
- Improved AOD treatment to offenders
- Increased treatment attendance and completion leading to successful order completion
- Reduction in waitlists for forensic clients
- Improve compliance by offenders to the conditions of their orders
- Improved treatment outcomes for offenders including harm reduction and better health and wellbeing
- Enhanced capability of AOD and CCS workforces to work collaboratively and provide case management and treatment that jointly respond to AOD and offending behaviour issues



6 Scope

The first phase of the Model is focused on clients on Community Correction orders (CCOs), Parolees and offenders with a combined Custody and Imprisonment order (CCO-Imprisonment order) that have court orders with AOD assessment and treatment conditions. This cohort represents about 65 per cent of all referrals for assessment and treatment by ACSO/COATS⁷.

The second phase of the Model will explore opportunities to further streamline forensic referral, assessment and treatment options for all other clients. This will require further engagement with Court Services Victoria, Victoria Police and Magistrates. Throughout the development of this project the opportunities and links between the AOD and mental health service systems has been considered. Currently there is a reform to the forensic mental health service system in development. Throughout phase two implementation of the Model, there will be close engagement with the Forensic Mental Health Implementation Plan to identify opportunities for alignment and to reduce the likelihood of duplications in referral and assessment.



⁷ ACSO (2017) A snapshot – 20 years of seamless transformation

7 Guiding Principles

The development of the new Forensic AOD Service Delivery Model is underpinned by a set of joint principles for the AOD and CCS sectors. These principles do not replace the existing DHHS 'Alcohol and other drug treatment principles' or those of CCS. The forensic AOD principles apply to the management and treatment of the shared cohort, and act as supplementary principles that articulate the particular forensic service delivery requirements. The principles have been developed in consultation with the AOD and CCS sectors.

- 1) Forensic AOD service delivery should be person-centred and holistic.

The forensic system should be holistic, person-centred, trauma-informed and take into consideration the needs and resources of the client's family. Building pro-social networks with families, case managers, significant others, self-help groups, faith communities and others can play an invaluable role in assisting individuals to achieve their goals.

- 2) Addressing problematic substance use should contribute to improving compliance with court orders.

Addressing an offender's problematic substance use, the associated behaviours and the interaction with offending should provide the best opportunity to reduce re-offending.

- 3) A collaborative and integrated forensic AOD service system is in the best interests of individuals in the service systems and for the community.

A forensic AOD service delivery system that is founded on strong collaboration, case planning and a joint understanding of roles across the AOD and CCS sectors will achieve the best results for the offender and the service systems. Critical to this is sharing of timely and appropriate information.

- 4) Court ordered conditions and interventions should be sequenced by CCS Case Managers to respond to an offender's health and wellbeing needs as well as the risk of re-offending.

Treatment responses and progression against CCO conditions should be sequenced to address the highest priority risk and needs of the offender. This will ensure the best opportunity for the offender to engage and participate in treatment.

- 5) The forensic AOD service system should be underpinned by a skilled and capable workforce.

Across the forensic AOD service system the workforces must have the appropriate skills, training, supervision, resources and professional development opportunities to engage and support complex offenders.

- 6) Mandatory AOD treatment should be as effective as voluntary treatment.

This principle recognises the mandated nature of treatment for forensic clients on orders. Whilst the motivation for treatment may be different to voluntary clients, entry into treatment via the criminal justice system can be as effective in minimising harm as voluntary treatment. The priority should be on motivation, engagement and matching to the client's 'stage of change'.

- 7) Access to AOD treatment for offenders should be accessible and equitable.

A client/offender should have access to the same quality level of case management, assessment and treatment regardless of their location or situation. The client's access to the physical location of services should also be considered.

- 8) A harm reduction approach is critical to reduce risk to the client, others and the broader community.

The focus must be on encouraging a client to safely reduce, manage or stop problematic substance use in order to address criminogenic factors.

- 9) Service responses should be founded on high quality and culturally competent approaches.

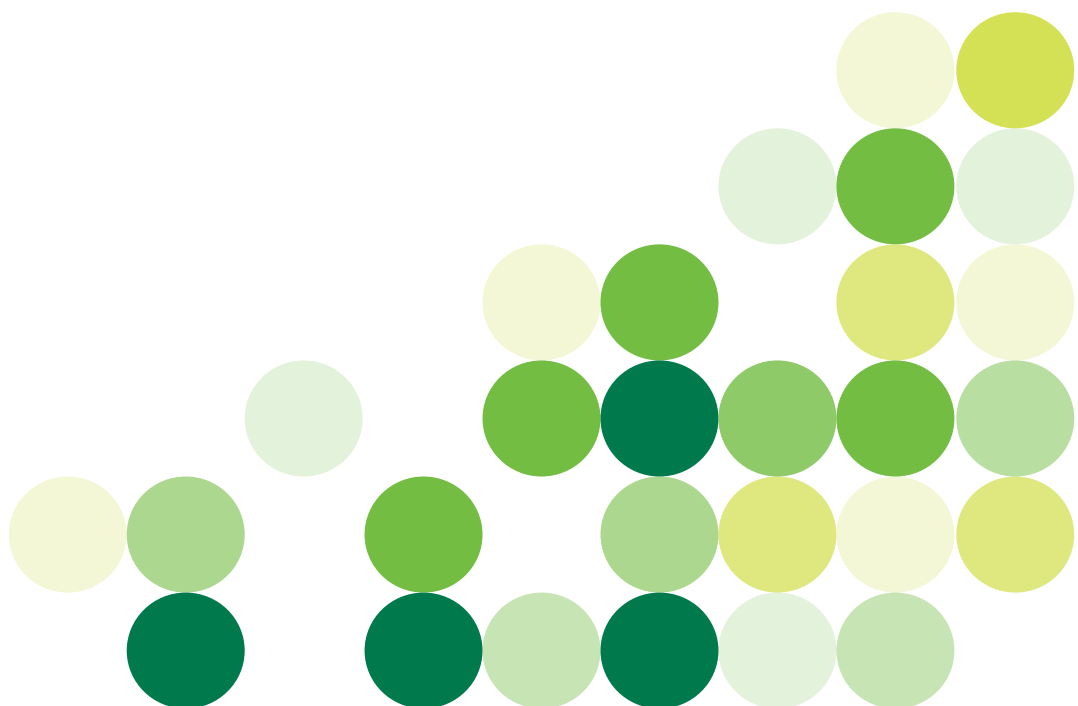
Case management and treatment interventions should be responsive to the needs of culturally diverse client groups.

- 10) Treatment interventions should be tailored to the needs and risks of the offender.

Evidence based treatment responses must be adaptable to account for risk of re-offending, motivation, level of substance use and diverse population groups. The focus should be on early engagement, motivation and self-efficacy, as well as including contingency management (risk management, crisis response and de-escalation of issues), and order compliance.

- 11) Continuity of care is essential.

The forensic AOD service system should focus particularly on those at greatest risk of relapse and re-offending. Critical is the effective transition from prison based AOD treatment to treatment in the community.

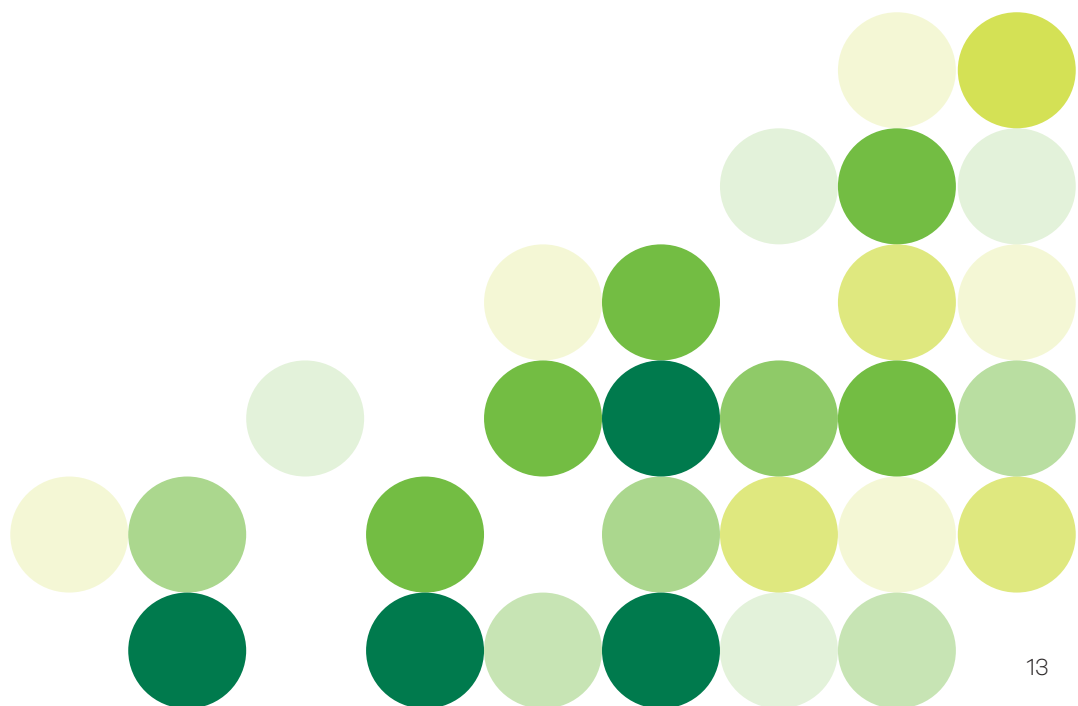


8 Service Delivery Model Themes

The Model is comprised of the following six themes:

- 1) Improving and streamlining referral and assessment functions
- 2) Developing and implementing effective AOD treatment and service design models
- 3) Enhancing and formalising case management, collaboration and information sharing
- 4) Embedding governance and accountability
- 5) Building workforce capability and capacity
- 6) Improving linkages between CCS and AOD information and IT systems.

Each of these themes will be discussed in more detail in the following sections.



9 Referral and Assessment

One of the key areas of focus in the development of the Forensic AOD Service Delivery Model has been the development of a specific screening and assessment tool that better captures the risk of substance related harm and the relationship to risk of re-offending.

ACSO/COATS have the sole responsibility of conducting forensic assessments for offenders subject to Community Correction orders (CCO); as well as assessing those on CCO-Imprisonment orders and Parole orders for AOD treatment needs, within Victorian prisons and the community.

There are numerous referral pathways into forensic AOD treatment which can often result in duplication of screening and assessment, with offenders repeating this process at least twice. In addition to duplication, various external reviews and stakeholder consultation have revealed that due to the varying needs and complexities of offenders, the existing AOD screening and assessment process may not be relevant to all offenders.

9.1 Key Objectives

- Improve the screening and assessment tools used with forensic clients
- Better identify the treatment needs of forensic clients based on risk of re-offending and risk of AOD harm
- Improve the information provided on assessment reports to treatment providers
- Provide a less intensive assessment process for offenders that are low risk of AOD harm
- Streamline referral pathways and reduce duplication of assessments.

9.1.1 Custody Referral Pathways

The referral pathways for forensic clients can be complex. Referrals for assessment can occur from a number of sources, particularly for offenders in custody. As part of the development of the new Model, an analysis was conducted on the referral and assessment pathways for offenders exiting a custody centre. The primary focus was on offenders on current parole or CCO-Imprisonment orders. The referral pathways for these two sentence types differ substantially, but the assessment for both is undertaken by ACSO/COATS, primarily within the prison.

Existing challenges relating to prisoner transitions can be summarised as follows:

- Duplication of referral to ACSO/COATS for parolees. This duplication occurs at the point of an application for parole and again at the point of parole suitability
- Insufficient referral information provided to ACSO/COATS. This is due to varying levels of access, and the number of data systems involved in prisoner transitions and referrals
- Release from custody prior to assessment. Offenders on remand may be released from custody on a CCO-Imprisonment order. As a result of time served in remand, the offender may be released directly from court. In these cases, ACSO are unable to assess the offender prior to release. ACSO will assess them in the community but this can create some delays
- Almost half of the offenders who receive a CCO-Imprisonment order are for prisoners on remand who have had their time spent in custody (remand) credited towards the imprisonment component of the order. Remandees have access to AOD health stream programs but not criminogenic AOD programs that require more formal assessment.

A number of opportunities have been identified to enhance the referral and transition process such as information sharing using client management systems, review and removal of duplicate processes and consideration of participation in prison based AOD treatment programs prior to release. Further information is provided later in this document. Corrections Victoria are also progressing with a number of initiatives to enhance the transition process for remandees and prisoners on CCO-Imprisonment orders.

9.1.2 New Forensic Screening and Assessment Tool

Throughout the consultation phase of the Model's development, the need for a specific forensic screening and assessment tool was identified. A new forensic tool has now been developed as a key initiative of the new Model.

The development of a new tool has been undertaken by the ACSO, with specialist input from Dr Astrid Birgden. The new tool will replace the previous Adult Screening and Assessment Tool and Optional Module 12: Forensic.

Based on consultation with CCS and AOD service providers, staff identified that the new tool and the resultant assessment report must include the following:

- The AOD treatment needs of the person
- The relationship between the person's substance use and their offending behaviour
- Factors influencing recovery
- The supports required to increase the likelihood of treatment attendance and completion.

The new assessment tool is designed to generate the data required to develop a report that addresses the above points. An assessment is not required for clients who have been assessed by CCS as low risk of general re-offending. These clients are referred directly to the 'Choices' offender AOD program.

Key elements of the new screening and assessment tool will provide for a more comprehensive assessment and treatment recommendation report and provide greater alignment with existing assessment tools used in forensic sectors, such as:

- Corrections Victoria are now providing more information on the person's offending history including the results of the assessment of their risk of re-offending using the Level of Service/Risk, Need, Responsivity (LS/RNR) tool
- The inclusion of Corrections Victoria's Treatment Readiness Questionnaire and Criminal Thinking assessment tools

- The use of the *'Alcohol, Smoking and Substance Involvement Screening Tool'* (ASSIST) screen. ASSIST is a World Health Organisation tool that will replace the existing screening tools (Alcohol Use Disorders Identification Test (AUDIT) and Drug Use Disorders Identification Test (DUDIT)) in the initial screen stage.

The new forensic screening and assessment tool does not require the calculation of a tier, instead it utilises a matrix of level of risk of re-offending (as determined by the LS/RNR results) and level of AOD related harm (as determined by the administration of the ASSIST) to determine treatment type/level. It will better identify the relationship between substance use and offending to create a more targeted assessment report and treatment plan to assist AOD providers. The screening and assessment tool is more automated than the previous tools which will allow the client to undertake the self-assessment using iPads onsite at ACSO, rather than paper based to be able to determine what level of assessment is needed, and with what psychometric tests.

The more automated assessment tools will allow for real time completion between ACSO assessor and the client so that more time can be spent on the assessment rather than in writing up the report.

Currently AOD providers can also undertake assessments with some forensic clients and refer to AOD treatment, as identified in the referral and assessment pathway chart at [Appendix 2](#). As part of phase two of the Service Delivery Model implementation, consideration will be given to streamlining the referral and assessment process for the broader cohort of forensic clients, such as offenders on the Court Integrated Support Program (CISP) and bail programs.

The tool will be used by COATS assessors with offenders who are referred by CCS, prisons and the courts. It will become operational with the release of the new COATS client management system, OSCA.

The tool has been tested by COATS with a selection of assessors and the tool will be rolled out with the release of ACSO's new client management system OSCA.

Post evaluation and review of the full rollout to COATS, there will be further consideration on whether state funded AOD providers that undertake screening and assessment for other forensic clients (court diversion, CREDIT/CISP and clients that self-refer for forensic treatment) will use this tool, or continue to undertake forensic assessments. Currently these providers use the existing Adult Screening and Assessment Tool.

10 Treatment Typology and Service Model

Whilst there are various treatment modalities available to offenders to address their AOD needs, there are limited treatment interventions that address criminogenic needs. The majority of clients on court orders with AOD assessment and treatment conditions are referred to standard counselling, predominantly delivered as individual-based sessions. External reviews and sector feedback suggest that this is not the most effective treatment dose for offenders.

10.1 Key Objectives

- Increase the criminogenic focus within AOD service provision
- Prioritise and target treatment to the most high risk and complex offenders
- Increase engagement and participation of clients on court orders with AOD assessment and treatment conditions in treatment
- Deliver more intensive, best practice treatment and services.

10.1.1 Why develop a new treatment typology?

As identified in early sections of this paper, the current treatment response for forensic clients has become standardised to individual counselling. Consultation with the AOD sector revealed the following reasons for this:

- Insufficient selection of program types available to forensic clients
- Waitlists for accessing other AOD treatment such as residential programs
- A treatment system that has focussed predominantly on counselling rather than group programs
- A workforce that requires additional training to work with forensic clients in more intensive interventions such as group programs.

Throughout the consultation process for developing the new Service Delivery Model it was consistently identified that the treatment response for complex

forensic clients should be different to voluntary clients. The need for a differentiated response was also identified in the 2011 and 2016⁸ reviews of the forensic AOD system.

The profile of the forensic AOD cohort differs from voluntary AOD clients. Offenders typically present with serious levels of offending and significant behavioural issues that require treatment intervention directed towards modifying behaviour to reduce re-offending whilst addressing AOD use.

Among the principles of practice developed by the National Institute on Drug Abuse (NIDA) for working with substance using offenders is a recognition that AOD treatment should not only be delivered in accordance with evidence based effective treatment but should also target factors associated with criminal behaviour, particularly attitudes and beliefs that contribute to offending⁹. To address these issues, forensic AOD treatment must incorporate two key issues:

- 1) Risk, Need, Responsivity (RNR) principles of effective correctional practice that address the criminogenic needs of offenders
- 2) Harm reduction principles associated with substance rehabilitation.

10.1.2 A focus on structured criminogenic programs

There is a substantial body of evidence indicating that rehabilitation programs that adhere to the principles of RNR reduce recidivism¹⁰. The RNR model of offender rehabilitation incorporates a set of empirically validated principles which provide direction for the assessment and treatment of offenders. These are:

Risk

The importance of the risk principle is well established in correctional settings. The risk principle of effective intervention indicates that the intensity of treatment dosage should match the risk level (probability of re-offending) of the individual

8 Caraniche *Towards a new framework for forensic alcohol and drug treatment in Victoria*, 2011 and VAADA *Forensic AOD Treatment and Service Delivery: A discussion paper*, 2016

9 <http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>

10 O'Brien, Sullivan & Daffern, 2016) Andrews & Bonta, 2010, Andrews, Bonta & Hoge, 1990

offender. In practice, the risk principle directs the delivery of more intensive treatment to higher risk offenders. In contrast, lower risk offenders should receive lower levels of treatment¹¹.

Need

The need principle identifies that there are two types of offender needs: criminogenic and non-criminogenic. Criminogenic needs are the behavioural needs that when changed, can result in changes in re-offending. For example, alcohol and drug use is a criminogenic need that when successfully addressed, may reduce re-offending behaviour. Anxiety and self-esteem are examples of non-criminogenic needs. Decreasing anxiety or increasing self-esteem is unlikely to change offending behaviour. Treatment that targets criminogenic needs is associated with reduced rates of re-offending¹².

Responsivity

The responsivity principle relates to factors that may impede participation and engagement in treatment. These factors include personality and cognitive behavioural characteristics that influence how responsive an offender is to different types of treatment and how that treatment is delivered.

Program Integrity

In addition to the above principles, the concept of program integrity is a critical factor to ensure treatment is effective¹³. The concept of program integrity is defined as the degree to which the delivery of an intervention adheres to the program model intended by the developer. Research has demonstrated that the closer an intervention adheres to the original design, the greater the degree of behavioural change. Consequently, ensuring that an intervention is delivered in the same way by every facilitator in every treatment location delivering the program is essential to preserving the behavioural change mechanisms that make the intervention effective in achieving the intended impacts and outcomes.

In summary, the RNR model identifies:

- who should be targeted for intervention
- the factors that should be addressed during treatment to reduce re-offending

- the best method for delivering treatment, and
- the importance of delivering treatment in a structured manner.

Research indicates that treatment delivered in accordance with the RNR framework result in reductions in recidivism¹⁴.

Structured group treatment

Group programs based on the RNR framework have traditionally been the treatment modality of choice in correctional settings. Corrections Victoria commonly use group based interventions for Offender Behaviour Programs as well as AOD programs within Victorian prisons. Virtually all published research that examines best practice in offender rehabilitation is derived from interventions delivered in a group therapy format. These studies consistently show that group therapy produces beneficial results across a range of problems¹⁵.

Prison based AOD treatment is delivered through a range of group based treatment programs aligned to criminogenic risk and AOD risk of harm. Individual treatment is available by exception to accommodate the needs of prisoners deemed unsuitable for groups or in response to crisis intervention. In contrast, forensic AOD treatment delivered to offenders within the community commonly takes the form of individual counselling, delivered over four to fifteen sessions.

Currently there are no consistently applied AOD group programs available specifically for offenders in non-prison settings, other than *Choices* for low risk offenders. Some agencies run group based programs either as stand-alone groups or as part of Therapeutic Day Programs and residential programs, but analysis has identified that these programs do not necessarily have specific forensic elements (other than the Torque and Catalyst programs delivered by Regen).

In order to address an identified gap in the provision of criminogenic programs for community based offenders, group based AOD programs will be developed, trialled and evaluated to determine the impact on health outcomes and re-offending risk.

11 Andrews, D.A., Bonta, J. & Hoge, R. (1990) Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behaviour*, 17, 19-52

12 Ibid

13 Gendreau P. & Goggin, C. (1996) Principles of effective correctional programming. *Forum on Correctional Research*, 8(3), 38-41

14 Andrews, D.A., Bonta, J. & Hoge, R. (1990) Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behaviour*, 17, 19-52

15 Fuhrman & Burlingame, 1994

10.1.3 Establishing more intensive approaches

The new treatment typology is predicated on the establishment of structured criminogenic programs based on the RNR principles. The programs are more intensive and longer in duration than the standard AOD interventions currently applied to forensic clients. The new programs have been designed to include care and recovery coordination, regular client contact and one-on-one support that is expected to see more clients attend, participate and complete treatment. This is supported by the evidence that indicates that better treatment outcomes will be achieved by completing programs¹⁶.

The new forensic structured group and individual AOD programs have been designed to enhance treatment outcomes that focus on reducing criminal thinking, and other psycho-emotional risk factors associated with offending behaviour. Evidence indicates that reducing criminogenic risk factors can lead to reduced recidivism¹⁷.

The primary focus is the establishment of structured group programs. Group treatment generally involves a greater, more intense dose of treatment than that delivered through individual counselling, and if the groups are run as part of AOD therapeutic communities, there is evidence of good outcomes¹⁸. Creating more intensive interventions that draw on group dynamics, particularly in relation to challenging criminal thinking and enhancing communication skills, will increase the therapeutic benefits for reducing the risks associated with substance use and re-offending.

The focus on group programs also provides additional benefits in ensuring that key treatment modules associated with reducing re-offending and the relationship between substance use and recidivism are addressed in an integrated manner during the program. The delivery of modularised content in a group setting allows for program integrity across sites and across clinicians. In contrast, individual treatment can be variable and is heavily dependent on the individual clinician to deliver best practice criminogenic based treatment in order to be effective in reducing drug related re-offending.

The structured group program content will also be developed into a manualised program that can be delivered by AOD Clinicians in a one-on-one format for those who are unsuitable to participate in group programs. The structured individual format ensures that offenders that require more intensive criminogenic programs, but are not suitable for

group environments, still receive the formal content structure over a prescribed period of individual sessions ensuring program integrity.

The new treatment typology matrix, and the establishment of structured group and individual programs has been developed with technical expertise provided by the Forensic AOD Clinical Advisory Group. The typology provides the recommended treatment programs required to address varying offender risk, need and complexity.

The proposed typology matrix can be reviewed at [Appendix 3](#). Structured programs will be trialled over the next two years. These programs will be externally evaluated and the outcomes will inform the treatment typology and what level of treatment is required for each of the typology segments.

The matrix also includes interventions currently provided across the spectrum of service delivery such as residential rehabilitation, residential withdrawal, specialist pharmacotherapy and other specialist services.

10.1.4 What are the key elements of the new treatment typology?

The treatment typology has been designed based on best available evidence and in conjunction with the new Forensic AOD Screening and Assessment tool. The following features have been considered to ensure alignment with the tool:

- New treatment interventions have been developed that focus on the relationship between risk of re-offending and risk of AOD harm
- The typology is applicable to medium and high risk offenders who are on a CCO, Parole or a CCO-Imprisonment order which is consistent with the RNR principles
- The forensic treatment typology provides a more structured referral pathway for a client. Through assessment, a client's risks and needs will be matched to the treatment typology to identify the most appropriate treatment
- Central to the new typology is a focus on structured group and individual programs which will be the primary treatment intervention for medium and high risk offenders with AOD conditions on their orders subject to evaluation.

¹⁶ Delnef, 2001

¹⁷ Andrews et al 1990

¹⁸ Amram & Benbenishty, 2014

10.1.5 Building an evidence base for forensic AOD structured programs

The first phase of implementation of the Model will focus on trialling each of the new structured interventions at four metropolitan sites.

These programs will be evaluated to understand the impact that the interventions have on outcomes for offenders as well as the AOD and CCS systems.

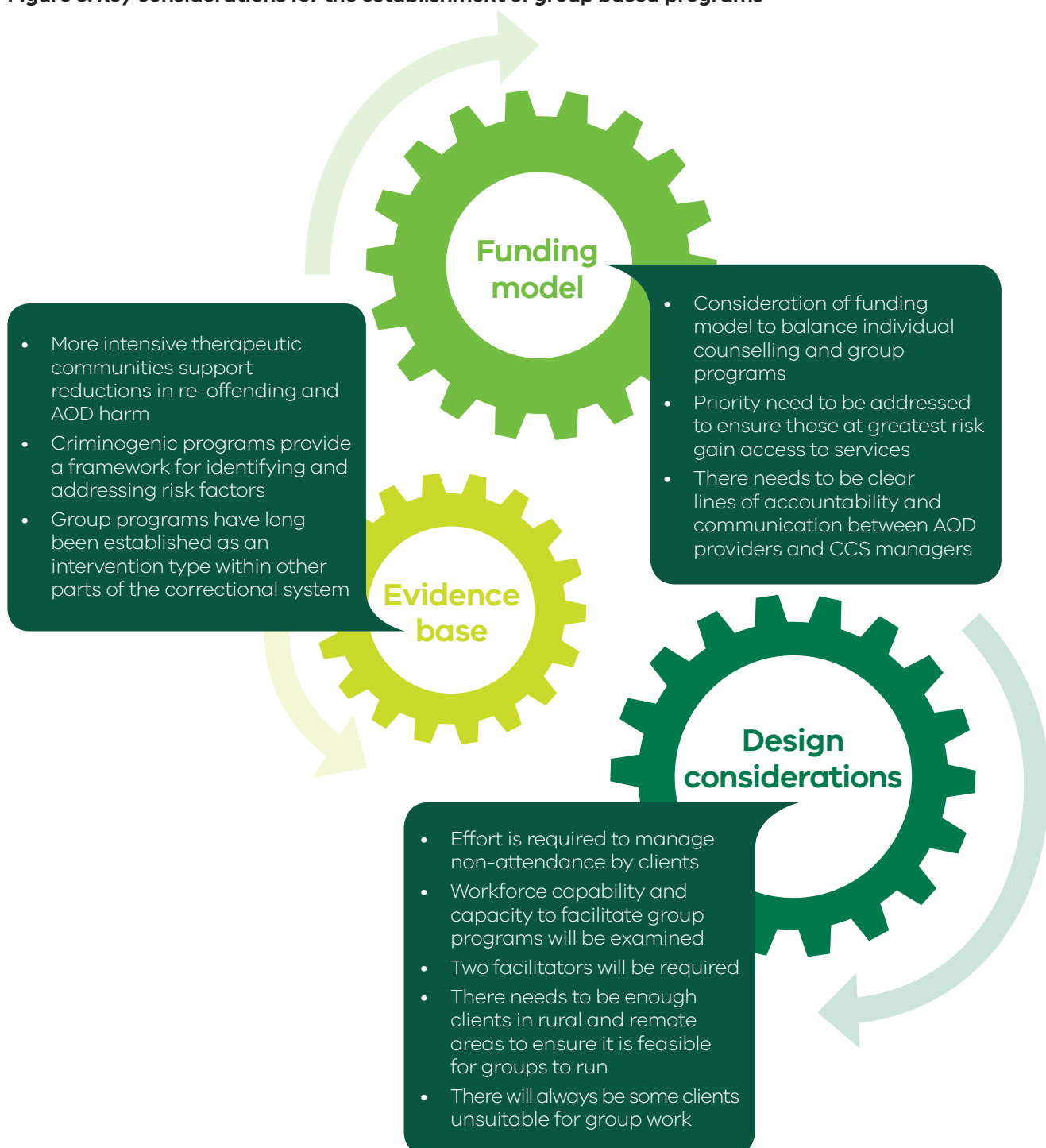
The evaluation will also include a review of the content and program design to ensure that treatment interventions best match criminogenic and AOD risks.

Full rollout of the typology will be informed by the outcomes of the external evaluation.

The first phase of design and delivery for forensic AOD structured programs is focused on males, who comprise the majority of the forensic AOD population. The next phase will include tailoring these programs, based on the evaluation outcomes, to the needs of women, young people and Aboriginal populations.

Figure 3, identifies the considerations applied to the establishment of the new treatment typology. Funding considerations for running intensive programs and the need for workforce capability uplift have been addressed with the establishment of the new AOD programs.

Figure 3: Key considerations for the establishment of group based programs



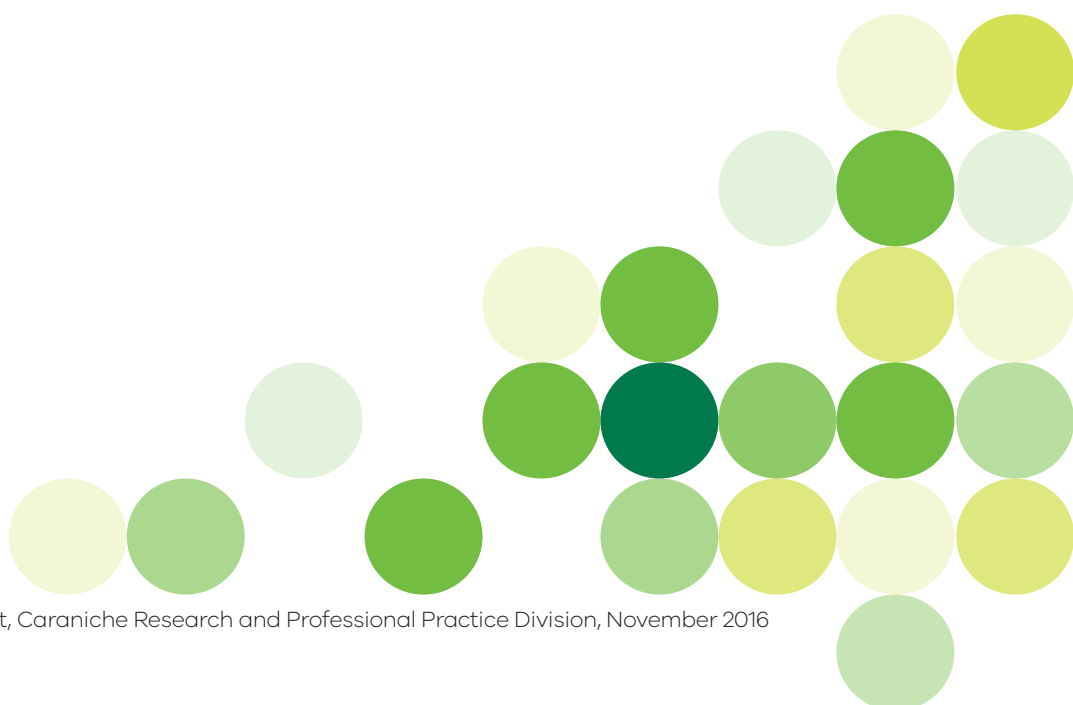
10.1.6 *KickStart* 42 hour group and 15 session structured individual programs

Phase one of the transition towards the new treatment typology commences with a targeted rollout of *Kickstart*, a 42 hour forensic AOD group program. *Kickstart* is an evidence-based group program drawn from the principles of Cognitive Behavioural Therapy (CBT) and Risk, Needs, Responsivity (RNR) for offender treatment. By intervening in offenders' thinking patterns, belief systems, and behaviours, *KickStart* aims to reduce offenders' substance use, improve their lifestyle choices and health, reduce criminogenic risks and improve order compliance¹⁹.

KickStart has commenced in Abbotsford and Broadmeadows with Caraniche delivering the program. Three more metropolitan sites in the west, south and east DHHS regions will commence in March 2018. All *KickStart* providers will also trial the structured individual version of the *KickStart* program with offenders that are found unsuitable for the group version of *KickStart*. The structured individual programs run for 15 sessions using the same content as the group program.

The structured programs will be provided to offenders on Community Correction orders (CCO), CCO-Imprisonment orders and Parole orders. Eligible offenders will be assessed as medium to high risk of re-offending by the LS/RNR tool used by Corrections Victoria, with moderate to high risk of AOD harm as determined by ACSO/COATS.

An evaluation will be conducted over the life of the *KickStart* project at specified locations.



¹⁹ Kickstart: Pilot Evaluation Report, Caraniche Research and Professional Practice Division, November 2016

11 Collaborative Case Management

The new case management focus adopted as part of the CCS reforms in January 2017 allows for CCS Case Managers to use professional judgement for sequencing the implementation of court ordered conditions for medium and high risk offenders on a CCO, CCO-Imprisonment order or parole. Offenders will be referred for assessment or services based on consideration of the priorities of treatment needed. Offenders with two or more treatment conditions (such as mental health assessment and/or treatment, alcohol and other drugs assessment and/or treatment or attending offender behavior programs) are now able to have referrals for treatment sequenced, with priority given to the most immediate treatment need prior to commencing their treatment program or service.

This new approach provides the opportunity to clarify the roles, responsibilities and expectations of agencies delivering assessment and treatment services to forensic AOD clients and to strengthen engagement between AOD providers and CCS Case Managers. Extensive consultation was conducted with CCS, COATS and the forensic AOD sector to identify key issues and to align practice with existing procedures. The resultant '*Collaborative Practice Framework*' (the Framework) provides an agreed model for the management of forensic AOD clients.

The Framework is predicated on collaborative information sharing, as authorised by the offenders' consent, across service agencies to support a mutual AOD treatment objective.

11.1 Key Objectives

- Establish and embed collaborative case management across AOD Clinicians and CCS Case Managers
- Support community safety through effective case management between AOD and CCS sectors
- Develop confidence and capability in joint case management and information sharing
- Create strong working alliances between CCS staff and AOD service provider staff
- Provide clarity around service expectations, roles, responsibilities and accountabilities
- Embed stronger accountabilities between agencies for client outcomes and court order and other compliance.

11.1.1 What are the key elements of the new collaborative approach?

The Framework details communication expectations and identifies when services should interact, the minimum information requirements to inform service delivery and issues requiring an effective collaborative response. Expanded or new collaborative practices include:

- ✓ Immediate reporting of events and associated service responses
- ✓ Managing and responding to risk
- ✓ Identification of trigger behaviours and escalating risk. This includes new procedures for managing the risk and obligations for participating in case conferencing, case management review conferences (CMRC), risk and review meeting and compliance review hearings (CRH)
- ✓ Recognition of continuity of care for a forensic client that is shared by all service agencies across a course of AOD treatment, particularly important in the transition between services and/or between custody and community
- ✓ Clarification of the operational expectations for each agency at key points of engagement across all stages during a course of AOD treatment.

The development of the Framework has been supported across the service sector by CCS staff and by AOD Accredited Forensic Clinical Supervisors, in addition to interdepartmental and multidisciplinary Service Delivery Model governance and advisory committees.

11.1.2 How will the framework be implemented?

Implementation of the framework will focus on embedding changes in practice at the local levels across the AOD and CCS sectors. The *Collaborative Practice Framework* resource was trialled in October 2017 across two designated sites; Loddon Mallee and Broadmeadows. The pilot ran for two months and brought together CCS staff and AOD providers to foster enhanced collaborative practice and information sharing. The outcomes of the trial were very positive, with an internal evaluation demonstrating substantial changes in collaborative practice and enhanced relationships between the sectors.

The Framework will be used to develop further joint training opportunities between CCS and the AOD sectors. A registered training organisation has been contracted to develop a collaborative practice workshop that will be co-facilitated with CCS Professional Practice Managers. The workshops will be phased in over the 2018–2019 period.

12 Governance, Accountability and Reporting

In order to successfully implement the new Forensic AOD Service Delivery Model it is critical to develop formalised governance and accountability structures across staff with responsibilities at the operational and senior leadership levels. Consideration has also been given to enhancing the communication and reporting between central departments and regions/local areas.

12.1 Key Objectives

- Embed shared accountability for offenders requiring AOD treatment across the AOD service providers, DHHS and DJR
- Strengthen the use of data and reporting to respond to forensic AOD service system challenges
- Ensure timely and effective implementation of new forensic AOD programs and policies
- Formalise risk management approaches between key stakeholders including identifying and responding to risk
- Enhance shared reporting and collaboration.

12.2 Governance and Accountability

12.2.1 What will the new governance look like in practice at the Operational level?

Individual Case Management

At the operational level there will be more formalised arrangements between AOD service providers and CCS Case Managers on the day to day management of clients. This has been supported through the rollout of the *Collaborative Practice Framework*. The new case management approach adopted by CCS will support this enhanced case management relationship. CCS Managers Professional Practice will work at CCS locations to embed the principles of collaboration in training, professional development and supervision frameworks. As part of standard supervision, CCS Supervisors will discuss particular cases with Case Managers and seek feedback on how collaborative practice approaches across AOD service providers and CCS are progressing. Where a client has been on a waitlist for a period of time because of client or CCS preference for a particular AOD service

provider (if it is not withdrawal) then these issues should be resolved at the operational level.

Senior Practitioners who are responsible for the case management of parolees and offenders on CCO-Imprisonment orders will engage with CCS General Managers and AOD providers regularly on any high risk clients. Case conferencing with AOD providers is recommended for all high risk offenders.

AOD service providers' engagement with CCS will also be enhanced and assessed through the rollout of the Framework. Enhancing confidence and practice in sharing relevant client information will be supported through joint training and workshops, and feedback from AOD service providers and CCS staff will be sought via staff surveys.

Local²⁰ Service Area Contract Management

DHHS local Managers will continue to work with AOD providers on any service level issues in relation to referrals, waitlists, on hold reports or issues with implementing new treatment programs (such as *KickStart* or *Choices*). Any systemic or funding issues should be reported via DHHS local Managers to DHHS local Directors for inclusion at the Executive bi-annual meetings.

CCS Regional General Managers, will meet regularly with catchment based forensic AOD providers and DHHS local Managers. The meetings will be set by DHHS catchment.

These meetings enable a formalised arrangement where AOD providers, DHHS local areas/CCS regions meet to address any local service issues and opportunities.

The focus will be at the local area level data. Specific cases will not be discussed here unless it is a high risk offender (and/or parolee) who has been on hold and it is not because of a preference for a particular service. Where case management of a client has escalated from case conferencing (between CCS and AOD provider) to CCS CRH, or where escalation of risk has been identified these cases will be discussed at these quarterly meetings (but not limited to them).

²⁰ Local is defined by the CCS or DHHS identified service area. For CC it is a region, for DHHS it is a catchment.

12.2.2 What will the new governance look like in practice at the Strategic level?

Where emerging system failures or blockages have been identified, or common themes of service delivery challenges extend beyond one region/catchment, these will be escalated to the state-wide level. Examples include policy or new program implementation challenges, data and reporting issues (with state wide data collection or client management systems) or implications of any new treatment funding.

The final level will be informed by the reporting and outcomes. DHHS, DJR and AOD Senior Executive will meet bi-annually to review emerging themes in relation to the implementation of the Service Delivery Model.

Any decisions on new funding models, revisions to existing service or treatment responses or identified workforce challenges will be addressed at this level (and informed by the advice of operational, tactical and strategic levels).

The discussions will be informed by a high level executive data from ACSO/COATS, CCS' Service Delivery Outcomes and DHHS data on the performance of the forensic AOD system (as a minimum).

Appendix 4 outlines the potential reporting and accountabilities between the operational and strategic, and regional and central departments.

12.2.3 Escalation Points

There are identified points across the operational, tactical, strategic and state-wide that have been identified. There will be other scenarios and opportunities for engagement across each level.

Operational ► Local Service Area

- An offender or offenders, particularly those assessed as high risk of re-offending who are on a waiting list for a period of time. CCS Supervisors to be informed during supervision sessions with Case Managers. General Managers to be informed if unresolved.
- Emerging waitlists at local agencies. DHHS local Managers to escalate issues with agencies on hold or substantial waitlists to DHHS local Directors and DHHS Central.
- As identified communication gaps between AOD service providers and CCS locations regarding case conferencing or engagement in review hearings.

Local Service Area ► Strategic Systems level

- Any systemic service issues should be reported via DHHS local Managers to DHHS local Directors for inclusion in the Strategic quarterly meetings once established
- Any reportable incidents involving forensic clients accessing AOD services will be escalated to the Strategic level.

Strategic Systems Level ► State-wide

- Where emerging system issues or blockages have been identified, or common themes of service delivery challenges extend beyond one region/catchment these should be escalated to executive representatives and reported to central office for resolution.

12.2.4 Outcomes and Reporting

A number of outcomes are anticipated through the effective implementation and monitoring of the new Service Delivery Model. In summary the following high level outcomes are expected:

- A strengthened, best practice and sustainable forensic model of treatment and services for offenders
- Increased offender treatment attendance and completion leading to successful order compliance through effective and timely AOD treatment and engagement
- Improved outcomes for offenders including reducing re-offending, harm reduction and better health and wellbeing
- Improved management and monitoring of service delivery through increased communication, reporting and accountability between AOD service providers and CCS in order to fulfil statutory and contractual obligations
- Enhanced capability of AOD service providers and CCS workforces to provide case management and treatment that jointly respond to AOD and offending behaviour issues and reduce re-offending.

There are a range of anticipated outcomes across the six key themes of the Service Delivery Model. Appendix 5 outlines these anticipated outcomes.

13 Workforce Development

A key component of the project is building capability and capacity within and across the varied workforces engaged in the management of AOD issues for offenders in the community.

13.1 Key Objectives

The focus on workforce underpins a number of the key themes within the Service Delivery Model and full implementation will require continued investment to enhance the capability and capacity of the AOD workforce, and a further skills uplift to the CCS Case Manager workforce.

The key objectives are:

- Establish and embed identified forensic skills and competencies with the AOD workforce
- Develop a formalised accreditation process for forensic workers that reflects the skills and experience required
- Develop confidence of forensic AOD Clinicians and CCS Case Managers in working with complexity, offending behaviours and AOD harm risk
- Establish and embed group facilitation skills within the AOD workforce
- Enhance the treatment response to clients through practice leadership and supervision approaches.

13.2 Community Correctional Services

The delivery of ongoing professional development is an existing core element of CCS practice and has been further enhanced with the establishment of Managers of Professional Practice (MPPs). MPPs are responsible for embedding evidence based case management practice across CCS to maximise practice effectiveness. This involves working directly with staff as well as establishing professional development opportunities and supporting the staff supervision framework. MPPs also have responsibility for engaging with local AOD providers to promote the case management approaches of CCS and to ensure effective communication and collaboration across the sectors.

Expert training is also delivered by an AOD service provider to case management staff within their first six months of employment. The focus of AOD training is to increase CCS staff capability and confidence in the effective management of offenders who are engaging in drug related activities whilst under community based supervision.

As part of building workforce capability and capacity, the project has engaged with the CCS Learning and Development Branch to provide advice on the alignment of specialist AOD information with the proposed Service Delivery Model. Identified areas for additional and expanded content are identified in the table 1.

Table 1: Amendments introduced to CCS Foundational training

Practice Area	Additional Content	Learning Outcomes
Collaborative practice	Identification of 'what and when' to share information between CCS and AOD service providers	Procedures as per <i>Collaborative Practice Framework</i> are understood
Forensic AOD treatment	Information about the foundations of forensic AOD treatment. Information on the new forensic group based programs.	Participants have a foundational understanding of the fundamentals of forensic AOD treatment. Participants are aware of the range of treatment options and the focus on group work.
Process and procedures	Offender treatment referrals	Referral pathways as per <i>Collaborative Practice Framework</i> are understood (refer to section 11.1.2).

13.3 Alcohol and Other Drugs Services

Within an environment of increasing in AOD service demand, client complexity and forensic referrals, the need to enhance the capability and capacity of AOD services is essential. Factoring in the workforce implications when designing the new Service Delivery Model has been a primary area for the governance groups overseeing the Model's development.

Consultation with the sector during the development of the Model identified that there were opportunities to strengthen the AOD workforce through opportunities and access to:

- Enhanced forensic supervision
- Leadership and change management programs and support
- Specialist training in working with forensic clients and client complexity
- Improving the collaboration between AOD and CCS sectors
- Aligning forensic accreditation with skills and experience.

13.3.1 Establishing a Competency Based Specialist Forensic Workforce

In order to assist with upskilling the AOD workforce, a job analysis has been conducted to identify the core competencies underpinning the effective performance of forensic AOD Clinicians. Using a high performance modelling approach, the qualifications, experience and knowledge required to perform a forensic AOD role under the existing accreditation scheme have been analysed. The identification of forensic core competencies will be used in the following ways:

- ✓ To consider a new Forensic AOD Accreditation process
- ✓ To build foundational training as well as more specialist forensic professional development for AOD workers
- ✓ To identify and develop a scope of practice for forensic clinicians, and embed a supervision process to support this practice
- ✓ To promote the use of the identified core competencies, attributes, knowledge and skills as part of attraction and recruitment strategies.

13.3.2 Alignment with DHHS AOD Workforce Strategy

A broader AOD Workforce Strategy is currently under development by DHHS. This strategy will focus on building the capability of the existing AOD workforce, as well as attracting more workers to the AOD sector. The focus will be on additional support

in training and upskilling of AOD workers at all levels; better and more accessible clinical supervision; and targeted recruitment and retention.

Both new and existing staff will be supported by new professional development and formal supervision approaches. The key requirements for a specialist forensic workforce to successfully implement the new Model are also being considered as part of this strategy.

13.3.3 Specialist Forensic Workforce Capability

A number of workforce initiatives will be developed to support the existing AOD workforce to work with complex forensic clients. Whilst working with complexity will be part of the foundational training and skills uplift of the broader DHHS AOD Workforce Strategy there will be specialist forensic development opportunities.

Phase one key workforce development initiatives in progress:

- Identifying forensic AOD foundational capabilities in development
- Forensic AOD training in structured programs (group and individual) commenced
- Generalist training in group facilitation skills enhanced
- Forensic supervision designed.

13.4 Joint AOD and CCS Workforce Training

A number of professional development and training opportunities will be developed to support the implementation of the Forensic AOD Service Delivery Model in the first phase of implementation. These will include joint training between CCS Case Managers, COATS Forensic Assessors and Forensic AOD Clinicians, which will support the implementation of the *Collaborative Practice Framework* referenced in section 12.

Initial joint training activities took place in October and November 2017 at the sites where the trial of the Framework was undertaken. The focus of joint training included information provision to support shared case management and build relationships across the AOD and CCS sectors.

Post the review and evaluation post trialling the Framework, a joint AOD and CCS training program has been commissioned. This training program is currently under development and will be rolled out through a registered training organisation. The training will commence in May 2018 and the training content draws heavily from the practical aspects of the new *Collaborative Practice Framework* resource.

14 Data and Information Technology

There are a multitude of data and IT systems utilised to manage offenders, particularly as they transition through the criminal justice system, including court services, custody and Community Correctional Services. There are opportunities to enhance links between systems to reduce duplication and administrative obstacles. These enhancements will further improve reporting and monitoring processes where possible.

There are a number of systems that can be drawn on to seek data on an individual that is managed in the corrections system, including information on their risk assessments, participation in treatment programs, transition and reintegration needs, case management and compliance.

14.1 Key Objectives

- Enhance information sharing between relevant agencies during offender referral, assessment and treatment
- Ensure AOD providers and CCS staff have access to timely client information to effectively manage risk and engagement
- Embed CCS requirements with the new ACSO/COATS client management systems
- Embed appropriate offender management and AOD order condition monitoring within new IT systems.

14.2 Transitions from Prison: Information Sharing

The Corrections Victoria Intervention Management System (CVIMS) is used by DJR providers for offender interventions within the prison and for community based Offending Behaviour Programs. In mid-2017 an AOD module was established for AOD service providers to record and maintain all AOD service and intervention records of prisoners.

A review of existing referral pathways between prison-based AOD program providers, transition and reintegration support programs and health programs identified a number of opportunities to enhance the information shared between providers and programs.

In the short term, improvements will be made to referral processes to ensure that ACSO/COATS

receive information on an offender's participation in prison based AOD programs. This will better inform the screening and assessment process for offenders with court orders that have an AOD assessment and treatment condition to undertake AOD treatment post release.

This will ensure that the assessment undertaken for a person transitioning to community based AOD treatment is completed with the relevant and required information to inform the treatment recommendations.

14.3 Opportunities for Information Sharing and Monitoring Enhancements

The need for justice, health and welfare systems to have better integration on case management and the sharing of information in timely and efficient ways continues to gain momentum and importance. This is particularly the case for monitoring and tracking offender pathways through the health and justice systems, especially when there are multiple agencies and providers supplying services such as AOD, mental health and family violence interventions. Improving the approach to collecting data on individuals engaged in multiple systems, and sharing timely information, particularly in relation to risk assessment and risk management were key findings from the Royal Commission into Family Violence.

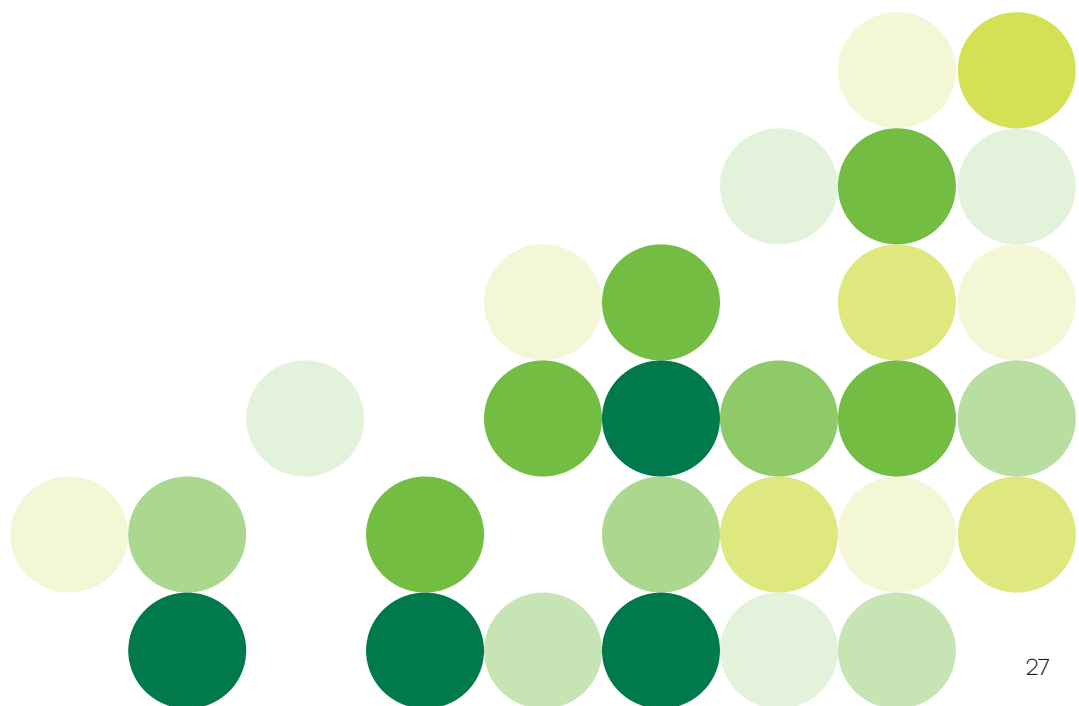
14.3.1 A New Forensic Client Management System

The client management system that provides information on an individual who is screened, assessed and/or treated as a mandated forensic client is Penelope, ACSO/COATS' client management system. This system is accessed by ACSO/COATS, CCS Case Managers and AOD Clinicians.

ACSO/COATS is currently developing a new client management system to supersede Penelope. The new system will resolve some of the design limitations of Penelope that have resulted in administrative burdens on users, and therefore a lack of effective utilisation of the system by CCS and AOD providers in collaborating on case management.

As part of the development of the new Service Delivery Model, particularly in relation to designing the *Collaborative Practice Framework*, the project team has actively engaged with ACSO/COATS to ensure that the new system, OSCA, has enhanced functionality allowing for more automated processes, reduced duplication and greater applicability for CCS and AOD providers.

OSCA is anticipated for release in 2018 and the project team continue to be part of the ongoing consultation process to ensure the greatest functionality managing clients. A review of access to OSCA will also be included, including consideration of prison based AOD providers accessing OSCA to assist with transitioning offenders to community AOD service providers.



15 Culture and Practice Change

At its foundation, the new Service Delivery Model is a practice and culture change initiative. Successful implementation of the Model requires new treatment approaches and new ways of working between the AOD service provider and CCS. These new practices have been established with early and fulsome engagement across AOD and CCS sectors, which has prepared the sectors for the changes to come. Full implementation of the Model will be incremental, with workforce support and resources dedicated to ensuring practice changes are embedded.

15.1 Communication and plan for change

A substantial communication and engagement approach has been adopted in the design and early phases of implementation of the Model. This engagement and consultation process informed the design of the Model and completed in collaboration across Corrections Victoria, DHHS and the AOD sector.

The comprehensive engagement plan has also prepared the workforces for the implementation of the Model.

16 Document information

Document details

Criteria	Details
Document title:	Forensic Alcohol and Other Drug Treatment Service Delivery Model
Document owner:	General Manager, Forensic AOD Treatment and Services, Justice Health

Document approval

This document received the following approval:

Name	Organisation
Executive Director	Justice Health, Department of Justice and Regulation
Assistant Director	Drug Policy and Reform, Community Based Health Policy & Programs Branch, Department of Health and Human Services
Deputy Secretary	Youth Justice, Department of Justice and Regulation
Deputy Secretary	Corrections, Department of Justice and Regulation
Deputy Secretary	Community Participation, Health and Wellbeing, Health & Wellbeing Division, Department of Health & Human Services

Appendix 1 Governance Arrangements for the Development of the Model

Governance

CCS Governance Committee

Development of an Alcohol and Other Drugs Treatment Model for Offenders – Joint DHHS/DJR Working Group

Executive Director, Justice Health (DOJ) (co-chair)
 Director, Prevention, Population, Primary and Community Health (DHHS) (co-chair)
 Senior Advisor, Drug Policy and Reform, Department of Health and Human Services
 Area Manager, Integration and Partnerships, Outer East and Manager, Alcohol and Drugs
 Manager, Delivery and Performance – Policy and Reform, Department of Health and Human Services
 General Manager, Forensic AOD Treatment and Services, Justice Health
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 Assistant Director, Community Correctional Services, Corrections Victoria
 Manager, Strategic Policy and Planning, Department of Justice and Regulation
 CCS General Manager, Community Correctional Services, Corrections Victoria
 Regional Director, West Metropolitan Region, Department of Justice and Regulation
 Assistant General Manager, Service Reform Unit
 Assistant Director, Drug Policy and Reform, Department of Health and Human Services
 Regional Manager, Health and AOD Services, Department of Health and Human Services
 Manager, Wulgunggo Ngalu Learning Place, Corrections Victoria
 General Manager, Offending Behaviour Programs, Department of Justice and Regulation

Justice Health Project Management Team

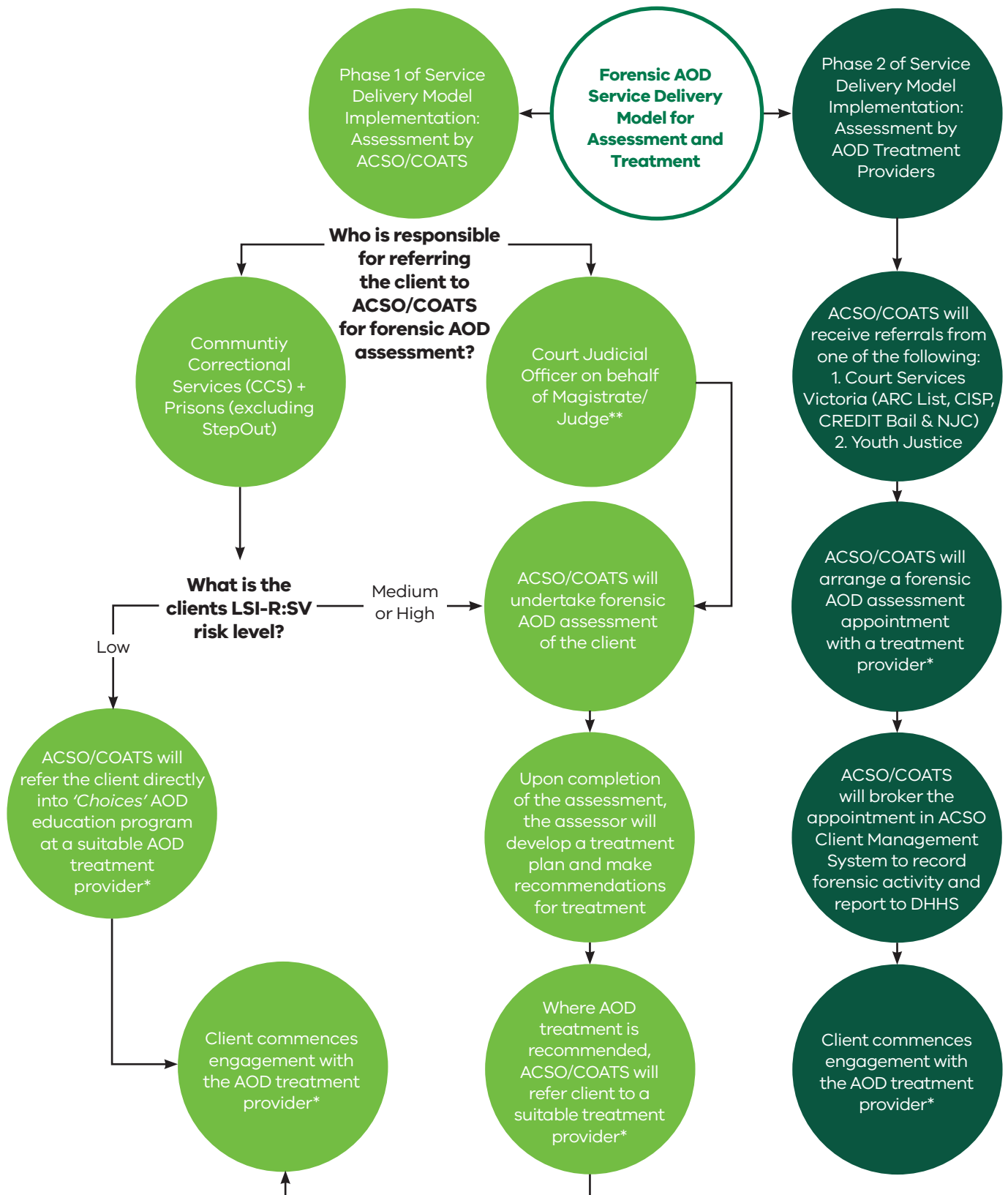
General Manager, Forensic AOD Treatment and Services
 Senior Project Officers, Justice Health
 Senior Project Officer, Justice Health
 Project Officer, Justice Health

Forensic AOD Clinical Advisory Group

Executive Director, Justice Health (DOJ) (co-chair)
 Director, Prevention, Population, Primary and Community Health (DHHS) (co-chair)
 CEO, Youth Support and Advocacy Service (YSAS)
 Senior Advisor, Drug Policy and Reform, DHHS
 CEO, Windana
 Associate Director, Turning Point
 CEO, Latrobe Community Health Services
 Manager, Delivery and Performance – Policy and Reform, DHHS
 General Manager, Forensic AOD Treatment and Services, Justice Health
 Director of Clinical Services, Uniting Care Regen
 CEO, Western Region Alcohol and Drug Centre (WRAD)
 Program Manager – AOD, Ngwala Wilumbong Ltd
 Managing Director and Psychologist, Caraniche
 CEO, Australian Community Support Organisation (ACSO)
 Assistant Director, Drug Policy and Reform, DHHS
 Team Leader, Monash Health Drug & Alcohol Services/SECADA
 CEO, Victorian Alcohol and Drug Association (VAADA)
 CEO, Odyssey House
 Service Development Officer, Territorial AOD Unit, Salvation Army

Appendix 2 Forensic Clients in Scope for Phase 1 of the Service Delivery Model Implementation

Figure 4: Phased implementation Model starting with CCOs (including CCO-Imprisonment orders), and parole clients



* ACSO/COATS will refer clients to AOD treatment providers that are contracted by DHHS to deliver forensic AOD assessment and treatment.

** Clients referred by the Judicial Officer will not be referred to the recommended treatment unit until they are sentenced to a CCO and referred to ACSO/COATS by CCS.

Appendix 3 Forensic AOD Treatment Typology

TREATMENT TYPOLOGY – FORENSIC ALCOHOL AND OTHER DRUGS TREATMENT							
		RISK OF RE-OFFENDING					
		LOW RISK		MEDIUM RISK		HIGH RISK	
		TREATMENT OPTION	DESCRIPTION	TREATMENT OPTIONS	DESCRIPTION	TREATMENT OPTIONS	DESCRIPTION
AOD RISK OF HARM	HIGH AOD HARM	CHOICES AOD Group Education Program	Single session, three-hour group program	Less Intensive Group Program ₂ Duration: 3 months	Group Work: 24 hours Individual Counselling Support: 1 session per month (per client) Clinical Coordination: Up to 7 hours (per program)	Group Criminogenic Program ₁ Duration: 3 months	Group Work: 42 hours Individual Counselling Support: 1 session per month (per client) Clinical Coordination: Up to 15 hours (per program) After care support (as required)
				OR		OR	
				Structured Individual Program ₃	1:1 Program: Up to 8 hours	Structured Individual Program ₃	1:1 Program: Up to 15 hours Clinical Coordination: Up to 15 hours (per client)
				OR		OR	
				Therapeutic Day Program Duration: 6 weeks	In accordance with current DHHS program delivery guidelines	Therapeutic Day Program Duration: 6 weeks	In accordance with current DHHS program delivery guidelines
		OR		OR		OR	
		Other treatment as required for Medium Risk x High AOD Harm: Residential Withdrawal Residential Rehabilitation Non-Residential Withdrawal Other Specialist Services (such as Pharmacotherapy, Neuropsychology Assessment) Individual Counselling*		Other treatment as required for High Risk x High AOD Harm: Residential Withdrawal Residential Rehabilitation Specialist Forensic Residential Facilities Other Specialist Services (such as Pharmacotherapy, Neuropsychology Assessment) Individual Counselling*			
AOD RISK OF HARM	MODERATE AOD HARM	CHOICES AOD Group Education Program	Single session, three-hour group program	Less Intensive Group Program ₂ Duration: 3 months	Group Work: 24 hours Individual Counselling Support: 1 session per month Clinical Coordination: Up to 7 hours (per program)	Group Criminogenic Program ₁ Duration: 3 months	Group Work: 42 hours Individual Counselling Support: 1 session per month (per client) Clinical Coordination: Up to 15 hours (per program) After care support (as required)
				OR		OR	
				Structured Individual Program ₃	1:1 Program: Up to 8 hours	Structured Individual Program ₃	1:1 Program: Up to 15 hours Clinical Coordination: Up to 15 hours (per client)
				OR		OR	
				Therapeutic Day Program Duration: 6 weeks	In accordance with current DHHS program delivery guidelines	Therapeutic Day Program Duration: 6 weeks	In accordance with current DHHS program delivery guidelines
		OR		OR		OR	
		Other treatment as required for Medium Risk x Moderate AOD Harm: Non-Residential Withdrawal Other Specialist Services (such as Pharmacotherapy, Neuropsychology Assessment) Individual Counselling*		Other treatment as required for High Risk x Moderate AOD Harm: Non-Residential Withdrawal Other Specialist Services (such as Pharmacotherapy, Neuropsychology Assessment) Individual Counselling*			
LOW AOD HARM		CHOICES AOD Group Education Program	Single session, three-hour group program	Brief Intervention ₄	Individual education support, advice and intervention: 3 hours	Brief Intervention ₄	Individual education support, advice and intervention: 3 hours

KEY NOTES

- 1. Group Criminogenic Program:** Referred to as “*KickStart*” which was developed by Caraniche, this program is new to forensic AOD treatment. *KickStart* will be trialled and reviewed over the course of 2017–2018 and 2018–2019, to determine its impact on offenders; and how it can be modified to a less intensive format, based on the outcomes achieved. There are four AOD service providers that will be trialling the *KickStart* group program.
- 2. Less Intensive Group Program:** The implementation and delivery of the *KickStart* program will guide the development of a less intensive group program for medium risk offenders. It is anticipated that this program will be implemented in 2017–2018 with one provider, before it is rolled out to the other *KickStart* providers in 2018–2019.
- 3. Structured Individual Programs:** The 15 hour and 8 hour programs will incorporate the modules of the 42 hour and 24 hour group-based programs respectively. These programs will need to be developed, and will be available to any offender found suitable for groups, but was unable to participate due to program occupancy, early exit, or unsuitable group fit. Eventually, offenders ineligible for groups (those that do not meet the eligibility criteria) will also be referred to these programs. In 2018–19 the four *KickStart* providers will also deliver the structured versions of the programs.



*Individual Counselling: It is possible that non-structured individual counselling may be required in exceptional circumstances.

- 4. Brief Intervention:** In the existing forensic AOD treatment model, offenders who are identified as low risk of AOD harm during the forensic assessment are not required to attend AOD treatment. The aim of “brief” intervention is to provide those medium to high risk offenders (with low AOD harm) with AOD education relating to the risks associated with AOD misuse; while they engage in appropriate criminogenic treatment to address their offending behaviour that may be unrelated to AOD use.

Bridging Support: Where offenders are awaiting treatment, bridging support may be provided by ACSO/COATS; or AOD service providers responsible for the delivery of group criminogenic programs.

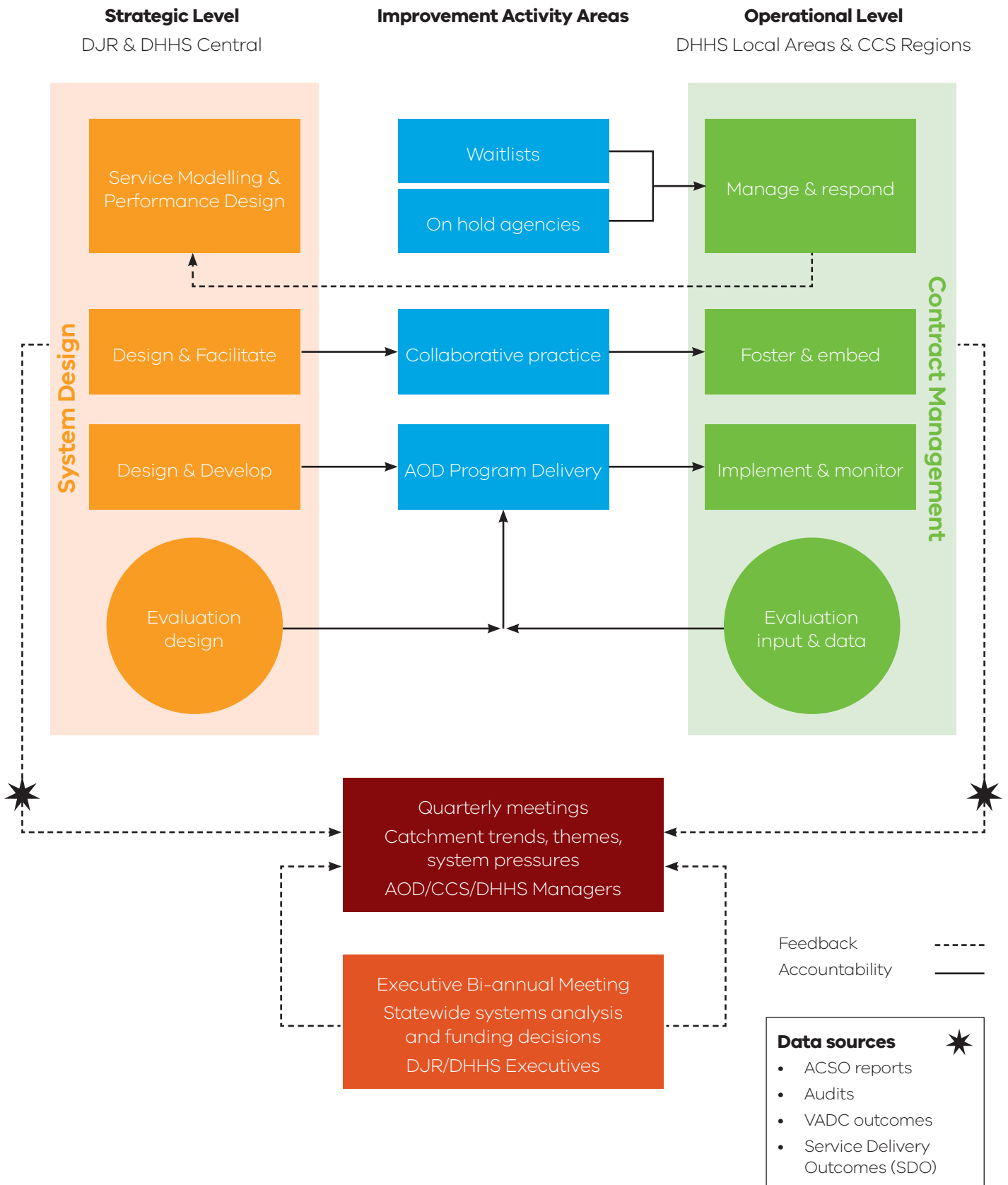
Mandatory Bridging Support: Mandatory bridging support will be provided to parolees who are assessed as high risk of AOD harm by ACSO/COATS. This cohort of parolees will be required to attend their bridging appointments.

LEGEND

-  New treatment
-  Existing treatment

Appendix 4 Proposed Governance Across Operational and Strategic Levels

Proposed Governance Model



Appendix 5 Forensic Service Delivery Anticipated Outcomes

The New Service Delivery Approach

Screening and Assessment
New screening and assessment tool will provide a more tailored assessment based on a client's risks, needs and responsiveness
Clients that do not require a full assessment can be screened out, creating less burden on the client and the service. Clients that do not need a full assessment will be provided with a brief intervention
The new screening and assessment tool uses ASSIST instead of the AUDIT/DUDIT tools which allows for a better risk assessment of an individual's current risk for substance harm
The new tool has been developed to assess AOD and re-offending risk and match this to a recommended treatment
AOD Treatment
The new treatment typology offers programs that will better respond to an individual's criminogenic factors and risk of harm from substance use. These programs will be the recommended course of treatment unless there are specific reasons why a client can't attend
The establishment of differentiated treatment interventions based on level of risk of re-offending as well as risk of AOD harm will better respond to motivation, engagement and treatment completion
Group based programs will provide a package of care that includes counselling, aftercare and care and recovery coordination where necessary to ensure clients stay engaged in treatment
The new treatment typology provides a process for prioritisation to ensure that clients with greatest risk of harm and/or offending are prioritised
The AOD programs are based on the evidence of 'what works' for offenders
The focus on group programs coupled with CCS case management approaches will focus on ensuring clients access treatment
The establishment of group programs allows for AOD Clinicians to work with a number of clients at a time
The new funding model applied for forensic group programs factors in the time and effort and skills required of AOD Clinicians to engage and motivate clients

Collaboration and Information Sharing

The new *Collaborative Practice Framework* clarifies information sharing requirements and processes, including obtained consent and authority to exchange information

The Framework clearly articulates what information is required and when, and clearly outlines who is to provide the information

The *Collaborative Practice Framework* specifies the client management system as the primary method for communicating assessment and treatment information, and details responsibility for updating client information and monitoring treatment status across the course of an offenders' treatment

Complex offenders requiring a collaborative response are clearly identified within the new *Collaborative Practice Framework*. The Framework identifies a range of strategies to support enhanced engagement between the services

The *Collaborative Practice Framework* includes service descriptions for each service type, articulating the role of the service providers in delivering supervision, assessment and treatment and detailing task responsibility across the course of treatment

Reportable events are identified within the *Collaborative Practice Framework*, including trigger behaviours by the offender and escalation points. A collaborative approach to manage potential risk is supported by the new service approach

Enhanced communication strategies are embedded strongly within the new *Collaborative Practice Framework*

Governance and Accountability

Formalised meetings will be established between CCS Regional Managers and DHHS Regional Managers to review and discuss regional level systems challenges and opportunities. The ACSO quarterly reports and monthly wait list reports will provide the relevant data for these meetings

CCS Professional Practice Managers will engage with AOD providers within their region on a regular basis to embed the collaborative case management processes

As part of the new Collaborative Case Management Framework, it is recommended that AOD providers are engaged at Compliance Review Hearings, particularly for clients who are high risk of re-offending and high risk AOD harm

The Service Delivery Model outlines a governance and communication process with trigger points for escalation and lines of accountability in responding to AOD treatment and court order compliance issues

ACSO monthly and quarterly data will be revised to provide good quality data to all stakeholders

Workforce Capability and Capacity

A joint training program will be established for AOD and CCS workforces to build collaborative case management and to outline the fundamentals of working with offenders with substance use problems

A new forensic AOD curricula will be developed that includes a focus on collaboration

A workforce strategy has been developed that includes a focus on recruitment and retention and a skills uplift for existing AOD workers

A comprehensive learning, development and supervision program will be established to support the rollout of the group programs

Data Systems and Information Technology

A new shared client management system is being developed by ACSO with substantial input from CCS and the JH AOD project team for streamlining and automating functions to increase user access and information sharing

Online referral pathways will be enhanced to ensure that relevant client information is included

Future versions of DHHS' Victorian Alcohol Drug Collection specifications will consider the inclusion of additional forensic data fields

