

Towards a New Framework for Forensic Alcohol and Other Drug Treatment in Victoria

A report for the
Victorian Department of Health.

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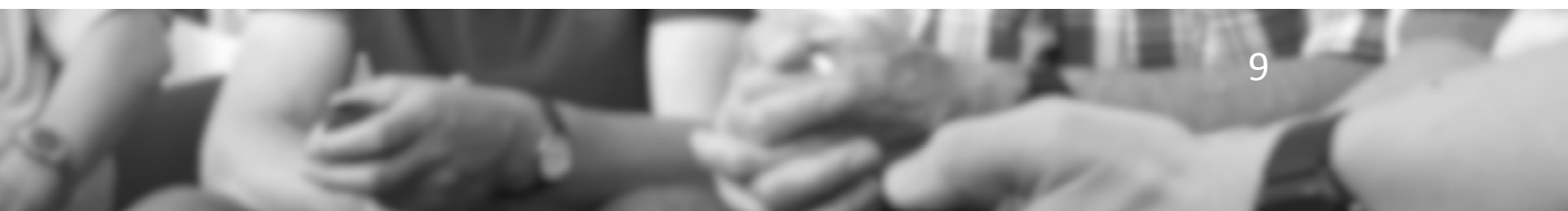
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Executive Summary

The forensic alcohol and other drug (AOD) system that currently operates in Victoria was initially established in 1998 to provide a more comprehensive and systematic system for delivering assessment and treatment services to forensic clients with alcohol and drug problems. Since then client flows have increased from a little over 2000 episodes per year to nearly 15,000 per year in 2010, and the characteristics of the client population have changed in important ways. However, the fundamental policy and service delivery framework remains essentially the same as when the system was originally established. This report has been commissioned to inform the development of a new framework for forensic AOD services around which health and justice agencies can continue to treat and support forensic clients with substance using and offending needs.

The Victorian Forensic AOD Population

Over the period since 1998 there has been a considerable shift in the profile of forensic clients. While the sex distribution of clients has remained stable (five out of six referrals are males), the age distribution has changed, with a greater proportion of clients in the 36-45 age group, mainly due to older persons who enter the system for the first time. More than one in three current referrals are identified as having alcohol-related issues – a 300% increase since 2000. Clients with heroin issues, who were the largest client group in 1998, now make up around one sixth of forensic clients. In addition, about one-sixth of clients are identified as being ‘poly-drug’ users.

These data also reveal increasing complexity in the needs of the population group in terms of not only AOD use but also offending behaviour. While half of clients received only one treatment episode in the seven-year window of observation, more than one in ten (11%) received five or more episodes suggesting either lower treatment responsiveness or higher treatment need for this latter group. It is

noteworthy that there were no significant differences between males and females in this pattern of recidivism. This indicates that recidivists need to be clearly identified as early as possible in order to ensure appropriate allocation of resources is made. Further examination of the link between AOD issues, offending behaviour and engagement in the criminal justice system is warranted.

The client population is also becoming increasingly anti-social. In 2000 only one-third of clients were classified as violent, however by 2010 this increased to more than 50%, suggesting that offenders with more established anti-social attitudes made up a much greater proportion of the total client pool than before. This may be related to the shift in primary drug, with alcohol becoming the most commonly reported primary drug of concern. Providing assessment, treatment and support services to these clients requires additional specialist skills that are more complex than those required to work with voluntary clients. Targeted assessment that is able to differentiate the lower-level offenders from more antisocial offenders is of paramount importance in determining the suitability and appropriateness of service type and setting.

The treatment types available in the Victorian forensic system are the same for offenders as for voluntary clients. Alcohol and Other Drug Assessment accounted for a quarter of all interventions and the most common treatment type purchased is Counselling, Consultancy and Continuing Care (CCCC). However, this treatment type has the lowest completion rate of all service types with less than half of all clients completing an episode of care, bringing into question its suitability for this population group. Of those who do complete CCCC treatment, the average number of sessions was just four. This level of service is unlikely to be adequate in meeting the needs of clients with complex AOD and offending needs.

More than half of Victorian prisoners reported that their offences were committed either to support their substance use, or under the influence of alcohol or drugs. The relationship between AOD use and offending is complex with five broad areas needing consideration. The first relates to the relationship between AOD use and offending, being different for male compared with female offenders, with the latter being more influenced by mental health issues. Second, simply possession of illicit drugs is an offence, resulting in recreational and occasional users entering the justice system, whereas possession of alcohol is not an offence under most conditions. A third point concerns offences relating to alcohol and amphetamine use tending to be committed when intoxicated, whereas those relating to heroin use tending to occur when the person is in withdrawal.

Fourth, the severity of AOD is highly variable in forensic populations, from occasional use (more likely to result in possession or nuisance offending) through to dependent use (crimes of acquisition). Furthermore in the period before their arrest, the client is likely to be at a lower level of treatment readiness than would clients in voluntary settings, and this makes a fifth point of difference.

An appropriate service model for forensic AOD clients must be able to address the key characteristics of this population, including the prevalence of mental health issues (especially in female clients), the complex interaction between alcohol and drug use and offending, the considerable variation in the severity of both AOD and offending, and the generally lower state of treatment readiness. A central issue in this report is therefore to identify how forensic service models need to differ from voluntary models if they are to successfully respond to these characteristics.

It seems unlikely that simply increasing access to voluntary-based treatment will provide an adequate response to these issues, preventing these individuals from reaching the point of offending. Many offenders at the time of their arrest were already in some form of treatment. For others, their substance use may only be loosely related or incidental to their criminal behaviour, and in many cases their offending careers preceding substance misuse. Finally, for some offenders, motivation to address their AOD issues does not arise until there is the presence of a justice-based incentive.

In order to assist with assessment and treatment planning, two typologies are proposed, one for illicit drugs, and one for alcohol-related offending. These typologies describe the relationship between substance use and offending, type of offending, key assessment issues and recommended treatment pathways and settings.

The illicit drug typology creates a six-type matrix, categorising problematic substance use into two broad areas – recreational/situation use, and dependent use. Offending behaviour is divided into three broad areas, minor (e.g. possession), moderate (acquisition offending), and major (violence against persons). Mapping these two dimensions against each other produces the six categories of drug-using offender. The alcohol-related offending typology has four broad categories, due in part to the different relationship between alcohol use and offending behaviour compared with illicit drugs.

Where AOD use is directly related to offending behaviour, there should be an integrated response to treating them, much akin to the way that AOD services and mental health are moving towards an integrated response for clients identified as 'dual diagnosis'. This general service approach should incorporate best practice elements of forensic program models such as the widely used Risk, Needs, Responsivity framework.

Whereas voluntary AOD treatment is based upon the principle of harm minimisation and works towards goals that the client identifies, in contrast forensic AOD treatment has a more targeted behaviour change objective, towards the reduction and/or cessation of drug use, which, can have an effect in reducing offending behaviour. Low motivation to change is not seen in the forensic system

as a barrier to treatment, rather motivational enhancement and working through resistance are key goals and an integral part of the treatment process.

In the voluntary sector, the form of intervention and the extent of a client's involvement will be primarily determined by the nature of the client's AOD problems and his or her willingness to undertake treatment. In contrast, criminal justice interventions are delivered within a framework governed by sentencing considerations such as the severity of the person's offence and his or her criminal history. A critical issue here is that the degree of intervention determined by the court is related to the severity of their offending, not the severity of their AOD use.

Forensic AOD Treatment

Despite the policy frameworks, a single definition of the aims and objectives of the Victorian system cannot match the values and priorities of all those who work across that system; be consistent across all phases of the system; or specifically address the individual needs of all of the clients who are serviced by the system. This kind of differentiated forensic AOD framework is to consider in more detail the *target population* for whom this service sector is intended as well as the needs of the justice system in which they have become involved. An effective forensic AOD treatment system requires that all key stakeholders have a mutual appreciation and a shared understanding (if not agreement) on the priorities of the forensic AOD sector and a firm commitment to the philosophy of that sector.

The National Institute on Drug Abuse (NIDA) has emphasised four critical areas of focus for forensic AOD treatment services and these represent a significant paradigm shift for some voluntary AOD services. Forensic AOD treatment should:

- address both substance use & offending behaviour;
- include assessment & integrated treatment for substance abuse, offending, personality and mental health;
- provide continuity of care into the community for offenders completing programs in prison; and
- ensure that forensic AOD workers and correctional staff work collaboratively and that treatment is coordinated across both systems.

Furthermore, counsellors working with forensic clients may need to place greater emphasis upon:

- motivation and enhancement of treatment readiness;
- early interventions for non-dependent users;
- addressing the antisocial attitudes and behaviours that are related to the substance use;
- recognition of the very different offending and misuse patterns from different drugs; and
- access to resources to ensure that they also able to meet the needs of female offenders.

Where there is little or no readiness to change and treatment outcomes do not involve abstinence or explicit reduction of AOD use, counsellors should nonetheless consider reduced offending related to AOD use.

A range of psycho-social interventions are recommended to form the treatment component of the forensic AOD system in Victoria, with the appropriate intervention being determined by a combination of AOD need, offending need, and treatment responsiveness. The eight recommended types are:

- Brief Intervention;
- Supportive Counselling;
- Therapeutic AOD Counselling;
- Forensic Therapeutic AOD Counselling;
- Non-Residential Rehabilitation;
- Residential Rehabilitation;
- Forensic Residential Rehabilitation, and
- Specialist Forensic Services.

Reliable screening ensures that clients are directed to the most appropriate treatment pathway in the minimum number of steps, with those with low treatment need being diverted out of the forensic AOD system and specialist resources only being allocated to those with complex needs. Screening in the forensic AOD system needs to identify four key points:

- (i) risk factors that require immediate attention;
- (ii) the presence of problematic AOD use;
- (iii) the level of risk of re-offending;
- (iv) the person's eligibility for treatment.

Screening and Assessment

Screening tools can provide a reliable and systematic basis for determining whether a person should be:

- (i) diverted out of the forensic AOD system due to low needs;
- (ii) referred to a community AOD agency for a general assessment;
- (iii) referred for a Specialist Forensic AOD Assessment;
- (iv) referred back to justice services.

Specialist Forensic AOD Assessment includes all the elements of a general AOD assessment but has an additional focus upon assessing the offending behaviour and attitudes and how these relate to the person's AOD use and their ability and responsiveness to treatment.

The assessment should have four functions:

- (i) to advise courts, corrections and the parole board;

- (ii) to provide guidance for treatment providers;
- (iii) to facilitate continuity of care;
- (iv) to provide a basis for treatment measures.

In order to achieve this, assessment needs to identify the particular typology that is most descriptive of the client, as this will provide information about the treatment needs and responsivity of the client, as well as the most appropriate referral pathway.

Factors to assess when establishing the relationship between AOD use and offending include: the age of onset for each, the substances used, the types of crimes committed, the circumstances in which substance use and offending occur, and level of intoxication / withdrawal at the time of the offence. The nature and seriousness of the offence is important. While, the majority of substance-using offenders have possession offences and many will have committed acquisition offences to support their substance use, nearly half will have committed violent offences. Violent offences or offences against other people are fundamentally different to property offences and indicate a higher risk of reoffending.

Forensic clients are likely to present with a range of additional needs. Many of these can be classified as criminogenic, as they have a direct impact upon the offending behaviour, and it is essential that these be considered in the assessment process, along with the impact upon the individual of the justice process itself. It is also essential to gauge both the client's level of motivation, and their ability to engage in and respond to treatment. Low motivation for change is common among forensic populations but should not be considered an obstacle to treatment given the availability of targeted motivational enhancement therapies.

Staffing and Treatment Setting

Four tiers of agency are recommended for the forensic AOD sector. Those with low needs would be diverted to community settings, whereas low offending/high AOD need clients are best seen in current voluntary agency settings. Moderate offending clients would benefit from the targeted environment of a Specialist Forensic AOD service, and highly antisocial offenders should remain within the criminal justice system for their treatment. There are currently no community based treatment options for this client group.

Minimum training requirements for staff in the forensic AOD sector require either a Certificate IV in Alcohol and other Drug Work, or a Health discipline tertiary qualification and four core AOD competencies. However, these minimum standards may fall short of that required to provide many of the services required in the forensic AOD sector. For example, there is no requirement that persons counselling forensic AOD clients have training in either forensic matters, or counselling and psychotherapeutic technique.

Support and clinical staff need appropriate training and supervision and there needs to be a match between staff skills and roles. Generic counsellors should have a basic orientation in AOD and forensic issues, and AOD Support workers need additional AOD and motivational interviewing training. AOD Therapeutic Counsellors would require additional counselling training, with Forensic AOD Therapeutic Counsellors requiring more comprehensive training around offending behaviour. All staff should be aware of the challenges of perceived power and control by the service provider on the part of some forensic clients. Clinical supervision around both AOD use and offender populations would be essential for all staff working with clients who are likely to have more established antisocial traits.

Investment needs to be made in the training programs producing the new AOD clinicians, to ensure that these programs contain adequate content to facilitate employment in this sector. In addition, a state-wide coordinated professional development program would encourage consistency across the sector, especially when delivered in a sustainable and regular manner, rather than in the form of ad hoc training.

Continuity of Care

Continuity of care is an important issue in terms of transfer of information between justice and AOD provider agencies. There is a risk that the client may see justice agencies as the 'bad guys', and AOD providers as the 'good guys'. It is recognised that there are limitations to confidentiality in forensic settings; however, these do not necessarily form a barrier to building a therapeutic relationship, especially when the limitations set out, and the information shared between justice and treatment providers is agreed in policy and transparently communicated with the client group.

A comprehensive framework is essential to ensure the smooth flow across assessment and treatment services in both justice and health settings. Referrals need to be accompanied by specific information, as requested by treatment providers and assessment and discharge information would be stored centrally on a database that would be updated with each admission.

Continuity of care along the system can also have some challenges and there are three areas where these are most pronounced. For example, current systems do not support the sharing of information from the pre to the post sentencing stage.

With regards to parolees, better targeted programs are required to address their unique needs, as well as improved mechanisms for the communication of information from their prison-based treatment. Furthermore, therapist style needs to be contiguous with prior treatment received. Prison-based staff should provide a full discharge report using the template for the Specialist Forensic AOD Assessment. Where this report is less than, for example, three months old at the time of parole, it could suffice in lieu of an additional assessment.

Finally, the transition from youth to adult services also has challenges. Not only may there be a change on the Justice agency monitoring the person's order, but also from the service provider as the young person becomes ineligible for continued youth services.

Reporting and Outcomes

Measurement and reporting of outcomes are often difficult for behavioural and psychological interventions, and especially in the case of substance-use disorders, due to the wide variety of problematic behaviours, the multiple underlying causes driving those behaviours, and the cyclical nature of the process of recovery. Nonetheless, delivery, experiences and outcomes need to be reported for any integrated health service, and the current system is neither valid nor reliable in the measure used for a variety of reasons.

Reporting in the Victorian forensic AOD system has to serve three core functions. The first function is on an individual client level: to facilitate good continuity of care with one clinician directly reporting the outcomes of their work and any other relevant information, onto the next. The second function focuses upon agency outcomes, discussed in the next paragraph, and the third function regards sector outcomes as a whole, looking at differences from a community-wide perspective.

With regards to the second function, agency outcomes, there are a further three areas to be considered, with the first reporting upon individual outcomes. AOD services typically deliver one or more of five outcome areas as a result of interventions. These are (1) a reduction of negative symptoms (e.g. by completing a withdrawal); (2) changes in knowledge as a result of the intervention (e.g. harm reduction information); (3) changes in attitude as a result of the intervention (e.g. motivational shift, desire for help); (4) changes in deliberate behaviours (e.g. increased exercise, or increased phone calls to peer supports when in distress); and (5) linkage with relevant support services. Furthermore, these can relate to the primary target of the intervention (in the forensic AOD sector this would be the person's drug use and factors directly related to it, as well as their drug-related offending behaviour), as well as secondary treatment outcomes (including criminogenic and non-criminogenic issues). Indicators of these can either be objective measures, which are preferred, or subjective reporting, which in most cases is considerably less reliable.

The second area under the area of agency outcome focuses upon throughput measures and this includes the number of significant treatment goals achieved (per funded position), program attendance and completion rates (number of contacts per completed significant treatment goals), accessibility (such as waiting times) and whether the program is servicing its target population.

The third area of agency outcomes involves key performance indicators used to determine the quality and integrity of the service provided, such as consumer

focused service, best practice interventions, good case work (e.g. assessments, case conferencing) and quality staff support. It is emphasised here that the paradigm of “best practice” may not be as suited to the AOD sector as a paradigm of “good practice” – enabling treatment to be truly reflective and responsive to the needs of the population group, and abilities of the sector and staff supporting them.

The third and final function of reporting relates to sector outcomes as a whole, to demonstrate whether policy is being effectively implemented at a population level. Two core areas of policy are (i) that services are effectively reducing AOD-related offending, and (ii) that offenders with AOD-related crimes are accessing the services.

Summary of Recommendations

Throughout the following chapters, a series of suggestions and recommendations for the future forensic AOD treatment system are made. They are summarised below, along with the strength of the recommendation from 1 – a suggestion that may enhance service delivery, through to 2, a recommendation that would definitely improve service delivery, through to 3, an essential feature of a forensic AOD services.

General

1 The current sector does not utilise typologies in the assessment of treatment planning; however, the proposed typologies may assist with the assessment and treatment planning of forensic AOD clients.

Recommendation level 3/3

1 Forensic AOD treatment must recognise the prevalence of alcohol related offending and the differences in the nature of the relationship between alcohol use and offending compared to illicit substance use.

Recommendation level 3/3

1 The forensic AOD client group can be more diverse than voluntary clients, and have highly variable treatment needs. Whilst some agencies currently recognise this to a limited degree, the forensic AOD system needs to formally

offer a range of treatment responses and pathways that can respond appropriately these diverse needs.

Recommendation Level: 3/3

1 The forensic AOD client group can be more diverse than voluntary clients, and have highly variable treatment needs. Whilst some agencies currently recognise this to a limited degree, the forensic AOD system needs to formally offer a range of treatment responses and pathways that can respond appropriately these diverse needs.

Recommendation Level: 3/3

1 The Risk, Needs, Responsivity principle is not currently utilised in the community-based forensic AOD system, but may provide a beneficial paradigm to guide treatment planning.

Recommendation level 2/3

Treatment Types

1 Only one current service describes specialist services for recidivist drink/drivers, but it is recommended that all recidivist drink/drug drivers undergo a thorough clinical assessment in addition to any attendance at Drink Drive programs.

Recommendation level 3/3

1 With the exception of DDAL, the current system does not offer alternative treatment focus for low-risk forensic AOD clients. These should primarily be secondary prevention strategies delivered through generic community organisations, such as linkage to pro-social peers and group, employment support and education.

Recommendation level 2/3

1 Residential withdrawal is indicated for the same types of presentation in forensic clients as voluntary clients, primarily low offending/high dependence, and, with careful monitoring, moderate offending/high dependence, and so should continue to be offered for forensic clients.

Recommendation level 2/3

1 Staff working in residential withdrawal settings need to be mindful of the impact that the secure locked environment may have upon clients with history of incarceration.

Recommendation level 2/3

1 The use of pharmacotherapy to assist in the creation of stable lifestyles without crime should be best targetted to those offenders whose substance abuse is primary (low antisocial/high dependence).

Recommendation level 2/3

1 Co-locating replacement pharmacotherapy services, especially dispensing, with forensic AOD counselling services or even justice services may be indicated as an approach to be considered and trialled in Victoria, with the dual possible benefit of both increasing likelihood that the offenders will remain on the pharmacotherapy, and that they will be more likely to attend the adjunctive counselling.

Recommendation level 2/3

1 The model for counselling should be changed to permit an adequate treatment dose of up to six months where indicated, within the same setting, and with the same clinician if therapeutically desirable.

Recommendation level 3/3

1 Forensic AOD counselling needs a greater emphasis upon enhancement of treatment readiness; early interventions for non-dependent users; understanding to work with antisocial attitudes and behaviours that are related to the substance use; recognition of the different offending and misuse patterns from different drugs; and specialist resources to ensure that the system is still able to meet the needs of female offenders.

Recommendation level 3/3

1 Current forensic agencies describe primary focus upon AOD use, however, when treatment outcomes do not involve abstinence or explicit reduction of AOD use, forensic AOD treatment in future should consider treatment outcomes that focus upon reducing AOD use-related offending.

Recommendation level 2/3

1 Those clients with low AOD and low offending profiles rather than being referred to AOD agencies as per current practices, may be better diverted into generic community health settings who provide a wider raft of counselling and support options.

Recommendation level 3/3

1 Eight psycho-social treatment types are recommended for the forensic AOD system

- 1) Brief intervention
- 2) Supportive Counselling/Outreach
- 3) Therapeutic AOD Counselling
- 4) Therapeutic Forensic AOD Counselling
- 5) Non-Residential Rehabilitation
- 6) Residential Rehabilitation
- 7) Forensic Residential Rehabilitation
- 8) Specialist forensic service

Recommendation level 3/3

1 There should be a new treatment of type of “brief intervention” focussing upon short-term goals such as harm reduction, linkage, or motivational enhancement for those who are resistant to engaging in, or unlikely to be responsive to treatment.

Recommendation level 3/3

1 Supportive Counselling as a service type would be indicated for low treatment readiness/responsive clients with significant needs, and focus upon motivational enhancement, harm reduction, general support and, where not provided by Justice or other service (e.g. courts without CREDIT or CISP), care coordination.

Recommendation level 3/3

1 The current service type of Therapeutic AOD Counselling should only be offered to those forensic clients showing problematic substance use, but low levels of antisocial behaviour

Recommendation level 3/3

1 Forensic Therapeutic AOD Counselling as a service type would be indicated for moderate to high readiness and responsive clients with significant AOD-related needs related to their offending, along with moderate levels of antisocial behaviour. Focus would be upon both the substance use and any associated offending behaviour.

Recommendation level 3/3

1 Non-residential rehabilitation currently is available through one voluntary service provider. It could be considered as a forensic treatment type if there are adequate numbers of eligible clients in a particular location.

Recommendation level 2/3

1 Current residential rehabilitation services should continue to be provided for moderate risk clients with high levels of treatment need.

Recommendation level 3/3

1 Forensic residential rehabilitation should be provided for higher risk clients, especially those on parole from prison and who may have received Therapeutic Community-based treatment during their incarceration (i.e. those attending Marngoneet).

Recommendation level 3/3

1 Offenders with high levels of antisocial behaviour should be treated within the forensic system, rather than the forensic AOD system.

Recommendation level 3/3

Assessment

1 Screening for forensic AOD treatment should be standardised and require minimal training and no clinical judgment to administer, due to the diversity of persons performing this function.

It should not just focus upon AOD use as per the current approach, rather it should also focus upon the degree of antisocial attitude and behaviour, as well as eligibility for treatment and other risks of priority.

Screening should determine whether a client is in need of specialist forensic AOD assessment, or general AOD assessment, or be diverted out of the forensic AOD or general AOD sectors.

Recommendation level 3/3

1 There is currently a forensic supplement to the Victorian Specialist AOD Assessment and this is adequate for low offending risk client. However for higher risk clients, a Specialist Forensic AOD Assessment should be developed that explores the degree of antisocial personality, along with the relationship between AOD use and offending.

Recommendation level 3/3

1 Both the standard AOD assessment, and the Specialist Forensic AOD Assessment, should have four functions: (i) advise courts, corrections and the parole board, (ii) provide guidance for treatment providers (iii) facilitate continuity of care, (iv) provide a basis for treatment measures. Assessors should be trained so that reports provide for all four functions.

Recommendation level 3/3

Workforce

1 There are no core skills required of a forensic workforce. All forensic counselling and assessment staff should be accredited in the areas described in this section.

Recommendation level 3/3

1 There is currently no body coordinating forensic training. A centralised Forensic AOD profession development program should be established to ensure access to appropriate training for the purposes of accreditation.

Recommendation level 3/3

1 It is recommended that no specific clinical skills be required for screening roles, however screening staff should be trained in the use of the screening tool.

Recommendation level 2/3

1 It is recommended that staff conducting SFAAs are accredited based upon not only their expertise in AOD treatment, but also in assessing the nature of offending behaviour and how it interacts with substance use; writing a report for courts and justice agencies; and the admission criteria for all AOD services.

Recommendation level 3/3

1 It is recommended that whilst there are many highly experienced forensic clinicians in Victoria, the system does not have senior forensic AOD roles. These should be created for the provision of supervision and mentoring of other forensic AOD therapeutic counsellors, and could take the form of a lead clinician.

Recommendation level 3/3

1 A tiered approach to employment within the forensic AOD sector with a clearly defined career path in the sector should be developed.

Recommendation level 3/3

1 Given the breadth and scope of substance misuse disorders in the Victorian community, it would be recommended that the Department of Health work with universities and training providers to introduce content into qualifications that reflect the needs of this client group.

Recommendation level 2/3

1 The Department of Health or a central agency should initiate a sustainable model of professional development for the Forensic AOD Sector, with adequate forensic supervision to consolidate the learning into practice, and cross training between justice and AOD service providers wherever possible.

Recommendation level 2/3

1 Supervision is essential for staff working with clients with established antisocial traits, and supervisors need to have expertise around both AOD use and working with offender populations however this is currently provided on ad hoc basis dependent upon agency resources. There could also be a panel of approved specifically-funded supervisors able to support staff in smaller or regional agencies.

Recommendation level 2/3

Service Providers

1 Currently forensic brokered treatment only goes to community AOD providers. However, four types of treatment setting are recommended for a forensic AOD system, and these are Community Health Services, Community AOD Agencies, Specialist Forensic AOD Service (all funded by health) and Specialist Forensic Service (remaining within Justice).

Recommendation level 3/3

1 It is recommended that low risk and low AOD needs clients are referred to Community Health Services rather than be retained in the AOD system.

Recommendation level 2/3

1 It is recommended that moderate to high AOD needs, but low offending needs clients are referred to the voluntary sector Community AOD Agencies, as per current arrangements.

Recommendation level 3/3

1 It is recommended that Specialist Forensic AOD Services are established to work with the moderate offending risk client group.

Recommendation level 3/3

1 Services for clients with high antisocial presentations should be delivered through Justice agencies.

Recommendation level 3/3

1 All agencies providing treatment to forensic clients should be accredited ensuring AOD qualifications, counselling training and forensic training of staff, as well as supervision and professional development.

Recommendation level 2/3.

1 A clearly defined referral path should be articulated based upon all potential referral entry points, and all possible treatment outcomes. This should also include clear articulation of referral information required, and assessment

responsibilities. Specific recommendations regarding all of these are included in this report.

Recommendation level 3/3

1 Although collaborative approaches do occur in some areas, there should be policies and procedures implemented by both health and justice to ensure that forensic AOD workers and correctional staff work collaboratively and treatment should be coordinated across both systems.

Recommendation level 3/3

1 Regular regional network meetings could be formalised discuss local issues and build links between providers and justice agencies.

Recommendation level 2/3

Process and Reporting

1 Transparent and articulated limits around confidentiality should be developed and used across all forensic AOD services with an information sheet describing confidentiality for service users.

Recommendation level 3/3

1 Processes should be established sector wide ensuring the two-way sharing of information needed by each service in order to fulfil its functions effectively and efficiently.

Recommendation level 2/3

1 Information sharing protocols should be expanded to ensure continuity of care along the justice pathway, ideally through a centralised referral service.

Recommendation level 3/3

1 Better targeted programs are required to address the unique needs of parolees, as well as improved mechanisms for the communication of information from their prison-based treatment. Furthermore, therapist style needs to be contiguous with prior treatment received.

Recommendation level 2/3

1 Prison-based staff should provide a full discharge report using the template for the Specialist Forensic AOD Assessment. Where this report is less than, for example, three months old at the time of parole, it could suffice in lieu of an additional assessment.

Recommendation level 3/3

1 The transition from Youth to Adult services should be reviewed ensuring a contiguous therapeutic style, and that information and experiences are shared.

Recommendation level 2/3

1 A comprehensive standardised discharge summary should be introduced and developed for use across the sector. These summaries should be incorporated into a centralised electronic record to facilitate continuity of care and where a variation to another form of treatment is indicated, that this summary also includes an updated Assessment and is provided to future assessors to ensure continuity of care.

Recommendation level 3/3

1 Rather than the current system of picking a significant treatment goal, that the measures of treatment outcome should be quantifiable and objective, focus upon AOD use, AOD-related offending behaviour, and other bio-psycho-social wellbeing (depending upon program focus). These outcome measures could include indicators of any of the five treatment outcome areas: (i) reduction in symptoms, (ii) improved knowledge, (iii) altered attitudes, (iv) deliberate behaviours, (v) and support & linkage. The measures under each of these headings should aim to be, achieved outcomes.

Recommendation level 2/3

1 Currently agencies report throughput in terms of number of episodes of care. However there are a range of problems associated with this measure of effort and efficiency, and future measures of agency throughput should include waiting lists, retention rates, typical number of contacts, and the population being targeted, as well as the category of significant treatment goal being reported.

Recommendation level 2/3

1 Quality of service delivery can also be reported above and beyond that required for Quality Accreditation. Examples of this could include a variety of good practice areas such as the occurrence of assertive referral, effective management of waitlists, case conferencing with other providers, review of clinical practice in line with latest developments, and quality of discharge reporting.

Recommendation level 2/3

Introduction

This report represents the final stage in the process for the continued development of alcohol and other drug (AOD) service delivery to forensic clients in Victoria, taking into consideration:

- Balance between Government and service provider expectations and accountabilities
- Available funding
- Evidence-based best practice for drug treatment provision to forensic clients utilising current research
- Other models of service delivery to forensic clients

It is recognised that any forensic AOD treatment must by necessity be integrated with the voluntary sector, however, this report deals specifically with the *forensic* AOD treatment sector in relation to key areas identified by the Department of Health (DH) in their 2009 discussion paper on the forensic AOD system. The areas identified by the DH were:

- Aims and objectives of the forensic system
- Different treatment types (including matching against different cohorts)
- Types of agencies best suited to deliver treatment services (government, NGOs, private, medical, community, hubs, local services, specialist, community health integrated)
- Roles and responsibilities, (e.g. for assessment, care plan coordination, treatment planning, etc.)
- The preferred workforce for the treatment type

- The process for shaping effective partnerships/collaborations
- Outcome and quality indicators
- Administrative procedures for measurement and payment of services
- The model of workforce training, supervision and professional development
- The clinical/diagnostic tools required

This report presents the views and findings derived from a wide range of sources, not all of which have been specified in the body of the text regarding the key components and features of a comprehensive and integrated forensic AOD treatment framework. Further details regarding sources are available in the draft report that set out the foundations for this report.

Sources

This report is based on comments, feedback and data obtained from the following sources:

- ACSO COATS data regarding patterns and trends of forensic AOD service delivery in Victoria
- ACSO COATS data regarding the profile of services users of forensic AOD services
- Submissions received to the 2009 Discussion Paper on the Forensic Drug Treatment System
- Review of policy documents relating to the forensic AOD sector
- Review and recommendations for the Victorian voluntary AOD sector
- Supplementary interviews with principal stakeholders
- Evaluations of forensic AOD programs
- Review of interstate and overseas models
- Review of the international literature around best practice in forensic AOD services
- Seven solution building-forums held across Victoria with AOD providers, government departmental representatives, and criminal justice agencies

Further details of the review methodology are provided in Appendix A - Methodology.

Aims and scope of this report

This report has two primary aims. First, to describe the current system for forensic AOD service delivery, and second, to provide recommendations for the development of a new framework of AOD service delivery to forensic clients, including the latest in best practice standards and principles. The material

presented includes advice from stakeholders, including practitioners and service providers, resulting in a range of recommendations for the forensic sector.

Exclusions

This project is not concerned with *evaluating* the Victorian AOD sector and no part of the methodology is intended to evaluate the services provided or the agencies or sectors providing them. Due to the specific needs of both youth and koori services, it was agreed that this report would exclude analysis of those sectors. Many non-custodial sentencing options that have comparatively small numbers were also excluded, including First Offender Court Intervention Service (FOCIS), Koori Court - Koori Alcohol and Drug Diversion Worker Program, Neighbourhood Justice Centre (NJC), Drug Court – Dandenong Magistrates' Court were also excluded.

In terms of type of offences, sex offending has not been included because of the specific and unique relationships between sex offending and substance use that are better addressed within specialist sex offender programs. Sex offenders are currently excluded from most diversion programs because of their specialist treatment needs.

Peer support is a funded support service, but not a treatment type and so is not discussed in this report. Likewise, although the DH funds supported accommodation specific to the forensic sector, it too has also been excluded, being primarily adjunctive in purpose.

A discussion of AOD treatment services funded through the Department of Justice (i.e. prison-based AOD treatment) was beyond the scope of this report, however the interface between AOD treatment services provided by Justice and Health is discussed.

Funding considerations

There is much debate between the sector and funders regarding the best way to fund a forensic AOD system, with many different strategies being used including pre-purchased positions by case load, pre-purchased positions by KPI, and fee-for-service. This project did not require cost analysis of existing or proposed service models, nor has there been review of the unit costings for different types of AOD treatment. This kind of analysis should take place at a later date once the future treatment types have been determined. However, concerns regarding the current model of funding and considerations for any future models, are noted below.

Assessment

Although all clients will receive a greater or lesser degree of assessment at the commencement of a new service type that is a standard part of any good therapeutic intervention, it is recognised that the preparation of an assessment

report requires time, not only in drafting the report, but also in following, collating and verifying information from third parties. As a result, although assessment itself need not be considered to be a separate treatment type as it is a part of good practice, where a report is required, this should be additionally funded.

Fee-for-service versus Pre-purchased treatment

It could be considered as unnecessarily complicating the administrative work of the AOD sector having two different models of funding for forensic and voluntary services. Furthermore, within the forensic system itself, there are fee-for-service and pre-purchased payment arrangements. It is recommended that, wherever possible, the funding models for voluntary and forensic AOD systems operate under the same framework, based upon the service types and outcomes recommended in this report. Any additional administrative and management issues relating to some forensic clients would need to be considered when setting targets.

Full and partial payment

Partial payment would no longer be a necessary consideration for the bulk of services in the proposed model of reporting and outcome measurement. However, in the case of agencies that require a fee-for-service payment due to lower or erratic throughput, then the formula for full or partial payment should be clearly articulated, considering both effort involved by the service provider and outcomes obtained.

Ancillary Costs

Funding models should take into account not just direct client consultation, but also time spent in secondary consultation, report writing, case conferencing, and supervision. Any funding model should also include relevant administrative support, management requirements, infrastructure, after hours loading, backfill, and other costs incurred by the agency.

Funding to reflect Tier of Service

Clients with a greater degree of complexity including antisocial traits require a more highly trained workforce, and as such, Specialist Forensic AOD Counsellors and Specialist Forensic AOD Assessors should be salaried commensurate with their level of experience, expertise and additional training.

Glossary of Terms

Throughout this report a variety of terms will be used and a description of each is available here to which the reader is encouraged to refer back. Presented first are those terms used to describe the current sector, followed by recommended treatment types, recommended agencies, and recommended staff.

Current Sector

ACSO COATS - Australian Community Support Organisation Community Offender Advice and Treatment Service. COATS is a state wide service funded through the DH to provide a comprehensive drug and alcohol assessment and broker services.

Antisocial Personality Disorder – a psychological clinical disorder of personality typified by pervasive pattern of disregard for and violation of the rights of others.

Antisocial Personality Traits – antisocial personality characteristics, attitudes or beliefs that may result in offending behaviour, but do not necessarily constitute a psychological disorder.

AOD – Alcohol and Other Drugs.

CCCCs – Counselling, Consultancy and Continuing Care – the name used to describe the funded treatment type of AOD counselling in community settings.

CCO – Community Corrections Officer.

CISP – Court Integrated Services Program. Court-based intensive pre-sentencing case management services.

CRDWU – Community Residential Drug Withdrawal Unit – residential facility for drug and alcohol withdrawal.

CREDIT / BAIL - Court Referral and Evaluation for Drug Intervention Treatment / Bail Support Program. Court based presentencing case management services.

Criminogenic – also called dynamic risk. Refers to the changing areas of functioning that contribute to a client’s likelihood of reoffending.

DDAL – Drug Diversion Appointment Line – takes referrals from Police for persons eligible for diversion programs at point of arrest.

DHS – Victorian Department of Human Services.

DH – Victorian Department of Health.

DoJ – Victorian Department of Justice.

Forensic Client – an individual who has been referred to forensically funded AOD assessment or programs. This person may have been convicted or pleaded guilty to offences. They may also have not plead guilty, not been charged, or simply at risk of offending behaviour.

Offender – an individual that has been convicted of an offence and is under a current order.

Recommended Treatment Types (See chapter 6 for greater explanation)

AOD Assessment – this is not a treatment type, rather an added component to any of the other treatment types when a forensic AOD assessment or reassessment report is provided to the Central Referral Service.

Specialist Forensic AOD Assessment (SFAA) – a specialist assessment that determines the relationship between substance abuse, offending behaviour and the extent of antisocial traits with a view to determining AOD and offending related Risk, Treatment Needs, and Treatment Responsivity. It may also include elements of Brief Intervention (described below) and would be conducted by an accredited clinician through a Specialist Forensic AOD Service or the Central Forensic AOD Assessment Service (see below).

1a) Brief Intervention (BI) – short targeted 1-3 session intervention (initial treatment type for most clients) which could be varied into one of the longer treatment types. May have AOD Assessment as an additional component.

2) Supportive Counselling/Outreach –focussing upon supportive counselling, enhancing motivation, case management, and referral. Primarily centre-based, but could be outreach, especially in regional areas.

3) Therapeutic AOD Counselling – primarily centre-based treatment focussing upon targeting behaviour change in relation to AOD use or other key life areas related to AOD use – can be individual, group, or family.

4) Therapeutic Forensic AOD Counselling – centre-based treatment (service provider or outplacement at Corrections) focussing upon targeting behaviour change in relation to AOD use, AOD-related offending behaviour, and other key life areas related to AOD use - can be individual, group, or family.

5) Day Program – centre-based structured activities including individual counselling, group counselling, diversional programs, recreational programs, and other interventions.

6) Non-Residential Rehabilitation – centre-based structured program running over several weeks covering a range of group and individual activities

7) Residential Rehabilitation – a residential structured program running over weeks or months that provides higher intensity treatment for clients with greater treatment need. May or may not also be a Therapeutic Community.

8) Forensic Residential Rehabilitation – a residential rehabilitation therapeutic community environment with a focus upon the development of pro-social behaviours and addressing offending behaviour.

Medical Interventions – medically supported withdrawal or replacement pharmacotherapy services.

Future Framework – Agencies (see chapter 8)

Community Health Services (CHS) - any public community health service that offers counselling.

Community AOD Agency (CAA) - a DH accredited community AOD provider.

Specialist Forensic AOD Service (SFAS) - a specialist team of forensic AOD clinicians who receive more targeted forensic AOD training and supervision.

Specialist Forensic Service (SFS) – this refers to services outside of the existing DH funded drug and alcohol sector, suitable for clients with highly antisocial presentations and typically provided by the Department of Justice.

CRS – Central Referral Service – this is a central body with state-wide responsibility for the allocation of referrals to the appropriate, monitoring service provision levels, maintaining records on all service users.

RAL – Referral and Assessment Line – this is a single telephone line with state-wide responsibility for the allocation of referrals including after hours that is linked to the *Central Referral Service*.

CFAAS – Central Forensic AOD Assessment Service – this is a central body with state-wide responsibility for the assessment of forensic AOD clients.

Future Framework - Individual Roles (see chapter 9)

AOD Support Worker – a suitably qualified worker providing supportive centre-based or outreach motivational counselling and case-management.

AOD Therapeutic Counsellor – a suitably qualified worker providing targeted behaviour change interventions focussing upon AOD use.

Forensic AOD Counsellor – a suitably qualified worker providing integrated targeted behaviour change interventions focussing upon AOD use and AOD-related offending behaviour.

Specialist Forensic AOD Assessor – a suitably qualified worker providing specialised forensic assessment of AOD use and offending behaviour.

1 The Current Sector

This chapter presents an overview and analysis of the current forensic AOD system in Victoria. The first section describes the sector, commencing with an overview of the policy and legislative framework governing the sector before outlining the pathways through the justice system and into forensic AOD treatment.

The second section utilises the ACSO COATS data to describe the shifting profile of forensic AOD clients, including demographic information, with the third part exploring the referral information, and providing some recidivism data, with a discussion of the key implications of these findings for any future model of forensic treatment.

1.1 Description of the Victorian Forensic AOD System

1.1.1 Legislative and Policy Basis

The current legislative and policy framework for the Victorian AOD system reflects developments across a range of policy areas including

alcohol and other drug services, illicit drug law enforcement, and sentencing. The policy context of forensic AOD initiatives is described

in detail in the Discussion Paper on the Forensic Drug Treatment System (Department of Health, 2009) and

related documents, therefore only a brief summary of these issues is provided here.

Health Policy

In 1996, the Premier's Drug Advisory Council published a paper entitled "Drugs and Our Community", which recommended an increase in service capacity for forensic AOD clients. In order to facilitate this process, the Community Offender Advice and Treatment Service (COATS) was established, with the goal of facilitating the additional services, including those funded as part of the Federal Turning the Tide initiative. At the time COATS was administered by the Victorian Offenders Support Agency (VOSA), subsequently renamed the Australian Community Support Organisation (ACSO).

Over the last fourteen years additional federal and state funding streams have been established for the provision of forensic AOD services resulting in a significant increase in the capacity of existing services, as well as in the number of clients being referred through COATS. As service options and client

numbers have grown the client population itself has also become more diverse, especially with regard to the needs of those clients and their stage in the criminal justice system. However, this incremental expansion of services and client population over time has resulted in an ad hoc approach to forensic AOD treatment without reference to an overarching treatment framework (Wundersitz, 2007).

The Department of Human Services policy document "A New Blueprint for Alcohol and Other Drug Treatment Services 2009-2013" required that the department not only implement strategies aimed at the broader AOD sector, but also recommended that the department "review forensic programs to ensure an outcomes focus, exploring alternative models of funding, developing stronger continuity of care for clients and improving forensic workforce skills".

Legislative Issues

Legislative issues regarding sentencing and other court orders under which courts can direct clients into programs are central to the policy base of the forensic AOD sector. Sentencing legislation (principally the Sentencing Act 1991) prescribes the orders available to

courts, the circumstances under which each order is appropriate, the requirements imposed on offenders placed under the order and the consequences of breach of the order. Sentencing orders for juvenile offenders are separately prescribed

in the Children, Youth and Families Act 2005.

In recent years there has been a proliferation of sentencing orders available to Victorian courts that include provision for referral to forensic AOD programs. These are discussed in detail below. Reform of sentencing orders continues, in part to rationalise the existing array of orders. A key recent area of reform has been in “high end” community orders with the proposed introduction of a new type of Order (as of June 2011, referred to as a Community Corrections Order). This Order will be directed at higher risk offenders and is intended to replace

Intensive Correction Orders (ICOs) and Combined Custody and Treatment Orders (CCTOs).

Police and courts also have access to a range of diversionary or pre-trial orders that may include referral for forensic AOD assessment or treatment. These are not sentencing orders and include those prescribed in Victoria Police Manual: policy and guidelines – Cautions, court procedural legislation (for example, the Criminal Justice Diversion Program is specified in the Magistrates’ Court Act 1989) or as part of courts’ operational policy (for example, the Court Integrated Services Program).

1.1.2 Pathway through the justice system

The figure below depicts a simplified model of the flow of clients through the justice system highlighting four key stages at which individuals may be referred into the forensic AOD system.

At the arrest stage, individuals may be either diverted out of the system with a caution (which may include a condition to attend an AOD assessment and treatment program), or formally charged with an offence.

Those who are formally charged may be either held on remand; receive bail (which may include an AOD treatment requirement); be referred onto a formal pre-trial program with AOD treatment components such as CREDIT or CISP (depending upon the court); or have the option of no conviction recorded through the successful completion of a treatment plan through the Criminal Justice Diversion program.

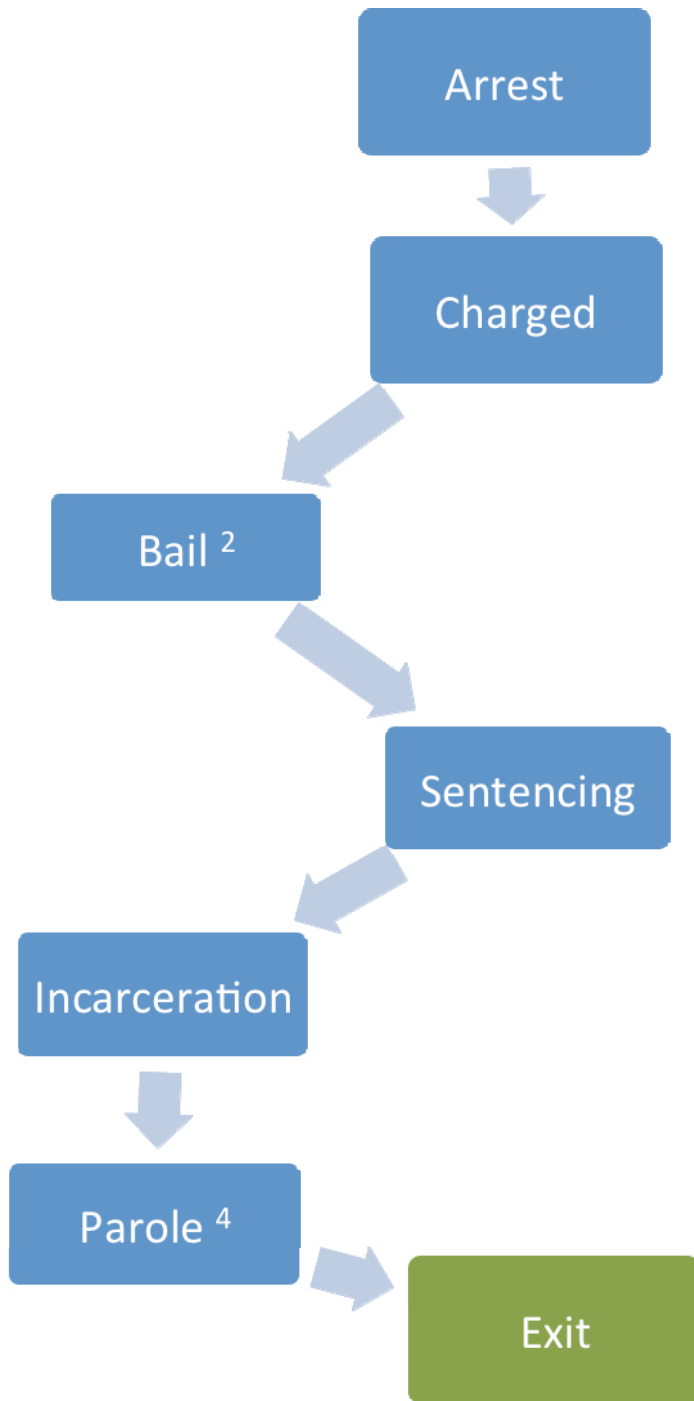


Figure 1: Pathways through the Justice System (simplified version) marking the four points of referral into the forensic AOD system (numbered 1-4).



Individuals found guilty of an offence may be sentenced to imprisonment and receive access to AOD treatment provided within the prison setting. Those released on parole may be directed to AOD treatment in the community. Those released after having completed their sentence may access voluntary AOD support through a post-release program called Step Out.

Other legal outcomes for offenders include community-based dispositions with an AOD treatment component, fines and other orders, or no conviction. A small number of offenders are sentenced to the Drug Court of Victoria with treatment ordered as part of their sentence; however this is only available to offenders in the catchment of the Dandenong Magistrates Court.

1.1.3 Justice Program Streams.

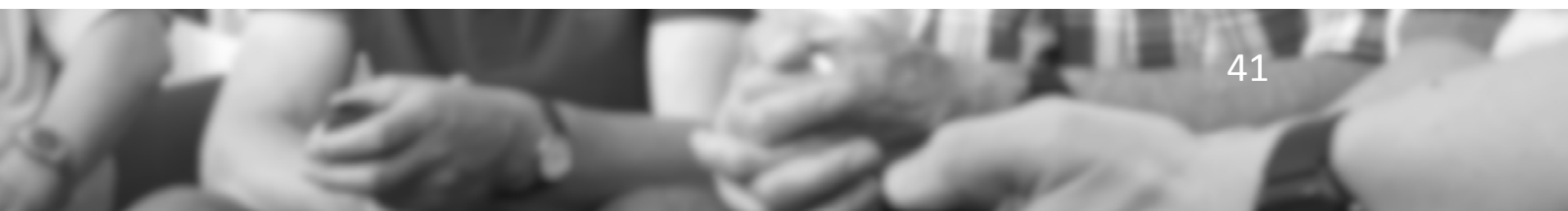
At each of the four AOD treatment entry points described above, there are a variety of program streams available. The following chart shows the type of programs that are available at the corresponding stage, along with details around who is responsible for screening for AOD issues and referring on, who conducts the assessment, what treatment types are available, and who is responsible for the case management of the client. It should

be noted that across the sector different programs are linked to different types of orders, however not all programs are available in all locations across the state, and as a result, the nomenclature used in the *Program/Order Type* column reflect the reporting categories that COATS currently use. Home Detention Orders are planned to be abolished by the Victorian government and so have not been included.

	Program / Order Type	Screening	AOD Assessment	Intervention/ Treatment Types	Case Manager
1) Arrest	Police Diversion Cannabis Caution	Police	None	Cautious with Cannabis	None
	Police Diversion Illicit Drug Caution	Police	AOD Agency	DDAL CCCCs	None
2) Bail	Rural Outreach Diversion	Police Magistrates Court	RODW	All*	RODW
	Diversion Plan-Criminal Justice Diversion	Magistrates Court	COATS	All*	None
	Bail with conditions-CREDIT/Bail Support	Magistrates Court	AOD Agency	All*	CREDIT worker
	Bail with conditions-CISP	Magistrates Court	AOD Agency	All*	CISP worker
3) Non-custodial	CBO	Corrections	COATS	All*	CCO
	CCTO	Corrections	COATS	All*	CCO
	DTO	Drug Court	COATS	All*	Drug Court Clinician
4) Post-Custodial	Parole	Corrections	COATS	All*	CCO

Table 1: Types of order, contacts and assessment at each of the four main diversion points into the AOD system.

*“All” treatments include CCCCs, CRDWU, Home-Based Withdrawal, Specialist Pharmacotherapy, Aboriginal Community Alcohol and Drug Worker, Outpatient Withdrawal, Rural Withdrawal, and Therapeutic Community.



1.1.4 Justice Orders and Associated Programs

1) Arrest Diversion Programs/Cautioning

Arrest diversion programs aim to divert young or minor offenders, who admit guilt, from further criminal justice processing. Individuals are only able to receive a total of two cautions, in any combination of cannabis cautioning

or illicit drug diversion cautioning. Eligibility is restricted to drug use or possession offences, and if any other offence has been commissioned the person is excluded from pre-arrest diversionary programs.

Police Diversion – Cannabis Cautioning

Police can offer any person aged 18 years and over a caution if found in possession of cannabis leaf, stem or seeds weighing up to 50 grams, in instances where the person admits to the offence, consents to being cautioned, has not received more than one previous drug cautioning notice (including drug diversions), and has not been involved or detected in another offence at the time of apprehension, unless that

offence(s) could be dealt with by way of another caution or infringement notice.

The caution has no mandatory conditions however offenders have an opportunity to attend a voluntary education program, “Cautious with Cannabis”. This option is only available where the person admits guilt. It is the only forensic AOD program that is not brokered by ACSO COATS and is not mandatory.

Police Diversion - Illicit Drug Diversion Cautioning

The Illicit Drug Diversion Cautioning program provides the option of a caution for persons detained by the police for use and/or possession of small amounts of illicit drugs other than cannabis. The person must be over 10 years of age, be apprehended for the use/possession of a small (non-trafficable) amount of illicit drugs, admit to the offence, understand the requirements of the diversion and consent to participate, not have received more than one previous drug cautioning notice

(including cannabis cautions), and not be involved or detected in any other offence at the time of apprehension, unless that offence(s) can be dealt with by way of another caution or infringement notice. Those who receive a caution for illicit drugs are required to attend a drug treatment service for an assessment and appropriate treatment. Appointments with treatment providers are organised by police through the Drug Diversion

Appointment Line (DDAL), which is available 24 hours a day.

Unlike Cautious with Cannabis, this treatment type is mandatory and therefore is brokered by ACSO COATS. If the offender attends two

sessions no further legal action is taken. A person may continue in treatment and COATS will pay for a full Counselling (CCCCs) episode. This funding stream is seen as an opportunity to engage clients in ongoing 'voluntary' AOD treatment.

2) Bail

Rural Outreach Diversion Workers (RODW)

RODWs have been established in rural areas and provide a range of services including community linkage and assertive outreach support, rather than therapeutic counselling, typically at the bail or presentencing stage. RODWs are available to offenders in rural or regional areas

where neither CREDIT nor CISP pre-trial programs are available, and where the person has been apprehended for a non-drug related offence (and are therefore ineligible for Police Diversion) but has AOD-related issues.

CREDIT/Bail Support and CISP Programs

The Court Referral Evaluation and Drug Intervention Treatment (CREDIT) Bail Support Program commenced in 1998 and is available in many Magistrates Courts throughout the metropolitan area and in most large regional centres. At Melbourne, Sunshine and La Trobe an enhanced version of the CREDIT program has been available since 2006, as the Court Integrated Services Program (CISP). CISP is similar to CREDIT, however CISP employs a multidisciplinary team rather than a single support worker and participants have access to a wider range of support services.

These bail support programs are offered as part of bail proceedings to offenders with substance abuse issues. An accredited Court Drug Clinician or an accredited drug treatment agency assessor provides a drug assessment for a person eligible for bail who has an immediately presenting drug problem. Where appropriate, drug treatment is provided as a condition of the bail process. COATS arranges an initial assessment appointment with a drug treatment service provider and, based upon the assessment outcome, purchases the recommended drug treatment.

Criminal Justice Diversion Program (CJDP)

Offenders charged with minor offences and/or those with no serious prior criminal history may be eligible for Criminal Justice Diversion. Around 5,000 offenders are administered through the CJDP each year, but only about three per cent

are required to undertake any kind of AOD intervention. Offenders must admit guilt and the prosecution must agree to diversion, upon which offenders may access treatment or support programs through referral to COATS.

3) Sentencing Options – Non Custodial

Dispositions Served in the Community.

There are a variety of orders available to magistrates for community-based settings. These include Community-Based Orders (CBO) with Assessment and Treatment Conditions, and Intensive Corrections Orders (ICO), which are terms of imprisonment served in the community. In 2011 a new type of Order will be developed with the intention of replacing ICOs, although the current implementation status of these Orders remains undecided. All dispositions may have conditions attached that require an offender to attend for an AOD assessment and treatment. Around 6,000 persons per year receive an AOD intervention as part of a CBO or ICO, and this represents the vast majority of forensic AOD interventions delivered as part of a community-based

sentence. With the reforms and abolition of suspended sentences, this figure is anticipated to increase.

Suitability for community orders is determined by a court-based Community Corrections Service worker. Where assessment for AOD issues has been included or identified, the Community Corrections Officer supervising the order refers the client to COATS for a full assessment. Treatment is provided across a range of service types and delivered through accredited treatment providers. If clients require ongoing treatment (i.e. a second forensic treatment episode is indicated), then this typically requires reassessment by COATS, or a variation for a new episode if there is a change of provider or treatment type.

4) Custodial and Post-Prison Options

Released prisoners have two programs available to them. The first is Parole with assessment and treatment conditions as determined by the Adult Parole Board (APB).

COATS provides an assessment at the request of the APB with a treatment plan and purchases treatment for adult parolees.

The second is for offenders on straight release, having served their complete sentence, and is a voluntary program called Step Out. This program provides assessment in prison and, where appropriate, case management to people on release from prison. However, client take up of the Step Out program is low and forms a very minor part of the total forensic AOD program.

All AOD treatment provided in prisons is funded and managed

through the Department of Justice and therefore a review of these services is beyond the scope of this paper. Released prisoners participating in post-prison support programs like Link Out or the Women's Integrated Support Program, who are not on a parole order, can access Step Out through COATS provided they make their application prior to release.

1.2 Profile of Victorian Forensic AOD Clients

A responsive and effective forensic AOD system must seek to address the specific treatment needs of forensic clients, and in order to do that, an understanding of the changing profile of the current service users is required.

The material below has been drawn from the ACSO COATS client database. Demographic data was

provided for twelve years 1997/98 to 2009/10 with partial data for 2010/11, as well as some cross-tabulated demographic data for five years from 2005/06. In addition, all data for all referrals from 1998-2003 were followed up for the seven years post referral. Treatment type data was provided for two years, 2008/09 and 2009/10.

1.2.1 Aggregate Referrals to COATS

The number of forensic clients in the sector has significantly increased over the past 11 years. The aggregate number of COATS referrals has increased from just over 2,000 in 1997/98 to nearly 15,000 in 2009/10 (see Figure 2). This represents an annual increase of between five and twenty per cent each year, or an annual average increase of around ten per cent.

Referrals are increasing by approx. 10% per year.

This is a much faster rate of increase than the number of cases initiated in the Magistrates' Court of Victoria (around two per cent per year), and there is no indication that this growth will stabilise in the near

future. This suggests that most of the increase in COATS-funded activity is coming from either an increase in the proportion of criminal cases that are referred for treatment, and/or individual cases receiving a greater number of episodes of treatment per sentence.

Much of this increase could be coming from a greater proportion of criminal cases referred for

The specific causes of these increases are not clear but may include:

- An increasing willingness by police and courts to refer offenders for assessment;
- The growth in sentence and pre-sentence programs that provide a pathway into treatment; and
- The increasing use of pre- and post-sentencing treatment options

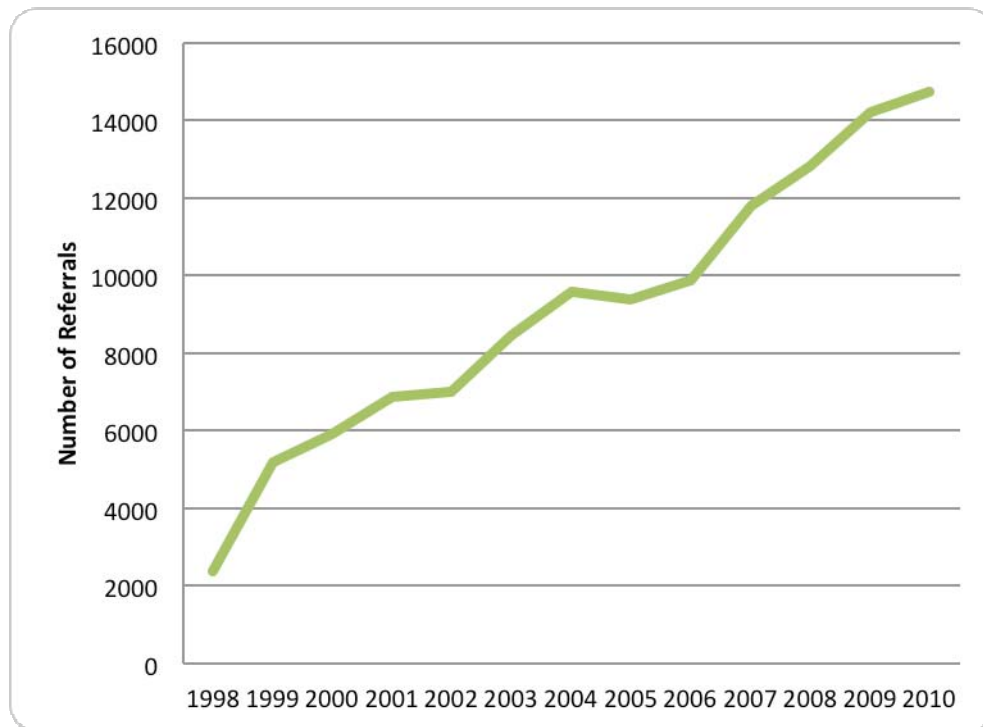


Figure 2: Total COATS referrals by year.

1.2.2 Client Demographics

Gender

In the period from July 2009 to July 2010 males accounted for approximately 84% of the clients serviced by ACSO COATS. This gender ratio has remained consistent over the past five years (83.9% to 84.6%).

84% of all referrals were male – a greater proportion than in the voluntary sector

These data do not mirror the ratio of males and females with substance use problems in the community, with stakeholders estimating that among clients in voluntary treatment, two-thirds of clients are male (ADIS data confirming exact numbers of

male versus female clients was not available). The greater proportion of males in forensic compared with voluntary programs probably reflects the much higher prevalence of offending in males. Around three-quarters of all persons proceeded against by police in Victoria are male (refer ABS Cat No. 4519.0) and the proportion of males is generally greater for more serious offences. A second possible contributing factors is that male offending could be more likely to be directly associated with alcohol or drug use, either as a precipitating factor (offences committed while intoxicated) or as a motivating factor (offences committed to gain access to funds to purchase drugs or alcohol).

Age

The number of forensic AOD clients from 2000 to 2010 in five age bands is provided in Figure 3 below. There has been a general increase in the average age of persons referred, with the highest rates of increase evident in clients aged 26 and above.

Although the *numbers* of clients in all age bands has increased, the *proportion* of forensic AOD clients within the 18-25 year old band has decreased from around 45% of the yearly total in 2000 and 2001 to around 30% in 2010. This trend has corresponded with an increase in the

proportion of 36-45 year olds, which has risen from approximately 12% of the total client population in 2000, to 22% in 2010. The proportion in the 45+ age band has also risen marginally over this time.

The 26 and over age group have increased disproportionately compared to the under 26s.

These trends may be in part reflective of an ageing general

population. The median age for Victorians in 1989 was 33 years and in 2009 had risen to 37. (www.abs.gov.au/ausstats/abs@.nsf/mf/3201.0). However, the apparent ageing of the COATS client population is more likely to be occurring because of either an increase in average age at entry (that is, over time clients tend to be older when they first come into contact with forensic AOD services) or because clients are retained for longer within the system.

once, where as multiple referrals were more common in the young adult groups, with a little over one-third of 18 to 35 year-olds presenting on multiple occasions.

The data suggest that the increased proportion of older clients is because they entered the system at an older age, rather than being retained for longer

In order to answer this, Figure 4 shows the breakdown for each of the age bands, and the proportion of clients who were on their first, second, third, fourth, or fifth referral over the seven years since their first contact. It can be seen that in the youngest and oldest age groups, four fifths of clients were referred only

This suggests that older COATS clients are present because they have entered the system at an older age rather than having been retained there for longer. However, this is a relatively crude analysis and ideally these data should be partitioned according to the nature of their COATS referral.

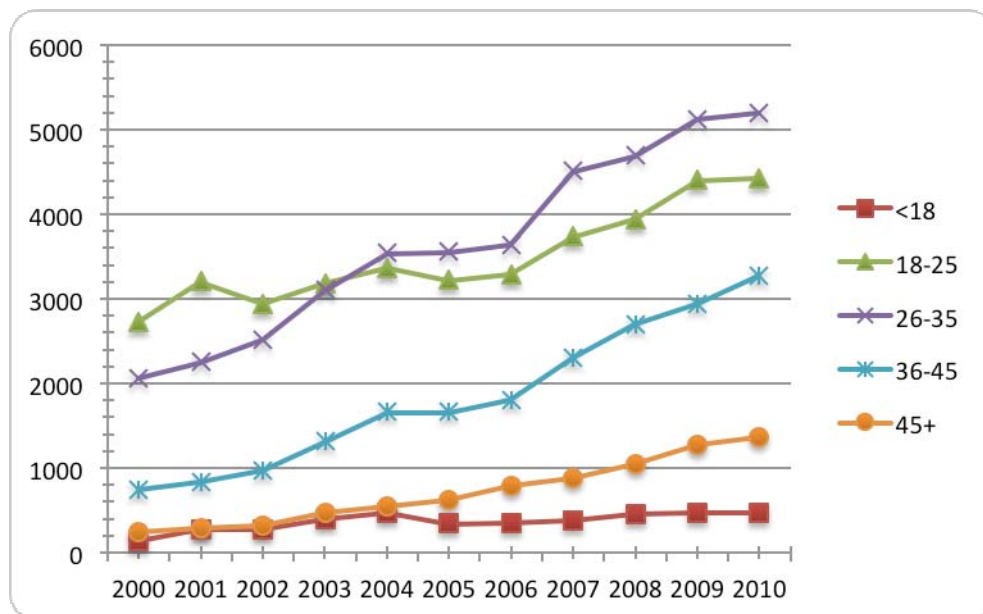


Figure 3: Number of clients in each age group from 2000 to 2010

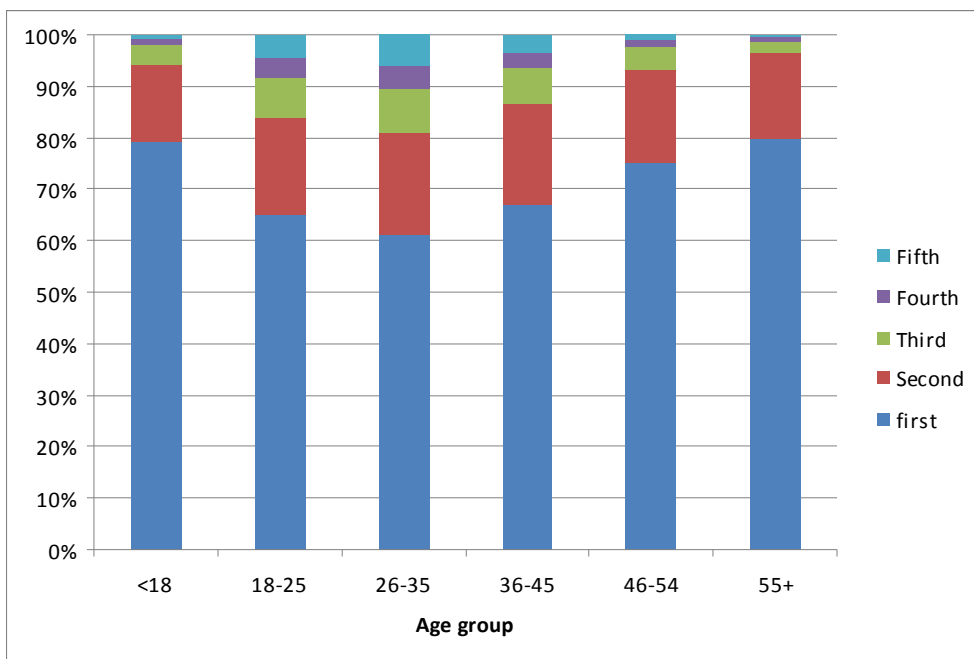


Figure 4: distribution of ages at first, second, third, fourth and fifth referral.

Place of Residence

Clients' place of residence was classified into Local Government Areas (LGA) using postcode data. As an index of the representation of COATS clients in each LGA, the total number of clients per LGA was divided by the LGA population total. The mean number of forensic AOD clients per one hundred thousand in the general population across all Victorian LGAs was 147.2 (standard deviation = 73.9). LGAs that sat more than one standard deviation above the mean (i.e. had a higher than average proportion of forensic AOD clients residing in that LGA)

included Golden Plains Shire, Greater Dandenong, Horsham, Latrobe and Mildura. LGAs that fell more than two standard deviations above the mean included Bass Coast, Central Goldfields, Bendigo and Swan Hill.

(Client postcodes were grouped to LGA using a Postcode to LGA look-up table. Where a postcode maps to more than one LGA the count for that postcode was split evenly between LGAs. This may produce high estimates for some rural LGAs).

Primary Drug of Choice

The largest number of referrals were for alcohol problems (4,600 in

2009/10, or around 36% of total referrals), followed by cannabis and

heroin referrals (each with 2,300 referrals or 18% of the total). 18% of all referrals were also tagged as 'poly-drug' users.

Treatment should recognise the different needs of forensic clients with primary alcohol misuse, compared with those with primary heroin use.

in particular. The increased representation of alcohol problems is a significant finding, because the relationship between alcohol use, risk of offending, and other harms is quite different to the relationship between heroin, risk of offending and other harms (discussed further in chapter 3), indicating a need for targeted interventions that are able to differentiate both population groups.

The drug types showing the highest rates of growth have been alcohol and 'other drug' referrals with there being no significant increase in the numbers of heroin users, suggesting that much of the increase in referrals into the system may be accounted for a broadening of the referral base in terms of primary drug, and alcohol

36% of all referrals are for alcohol related problems – the largest single group. 18% were poly-drug users and the number of heroin users referred has remained constant.

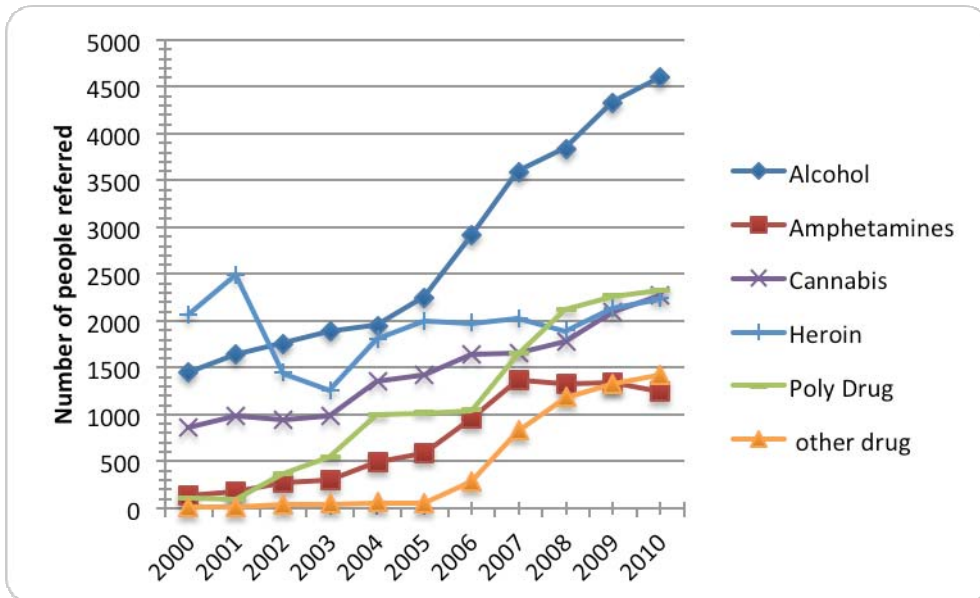


Figure 5: Number of clients by substance

Mental Health Status

In 2009/2010 between six and eight per cent of referrals to COATS specified that the client reported having a diagnosed psychiatric disorder. This proportion has remained generally stable over the period from 2000 to 2010, and there is no evidence to suggest an increase in the prevalence of psychiatric disorders in any of the four offence groups used to classify COATS cases.

This finding should be viewed with caution as the basis of identification of psychiatric disorders is unclear and it is possible that this is significantly underreported.

Mental health diagnosis remains stable at around 8% of referrals

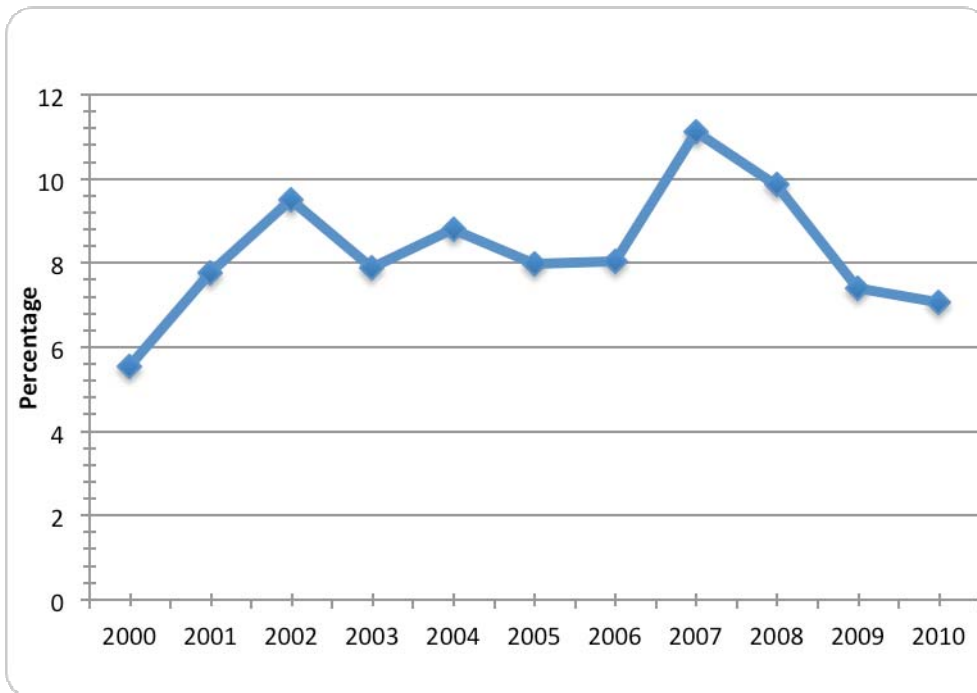


Figure 6: Percentage of clients with a diagnosed psychiatric disorder



1.3 Client Flow Through the COATS System

The next section looks at client flow through the COATS-brokered service system, from the perspective of referral numbers and treatment outcomes, rather than specific client characteristics.

1.3.1 By Referrals

Number of episodes

The COATS protocols specify that all offenders referred to COATS have two opportunities throughout the duration of an order to participate in an assessment and any recommended treatment. Each opportunity is defined as an Episode of Care.

An Episode of Care includes:

- COATS assessment
- Initial recommended treatment
- Any necessary treatment variations
- Receipt and processing, of Treatment Completion Advice (TCA) for all treatments recommended (including variations)

The above must be achieved before a further Episode of Care can be approved.

In order to approximate the broader recidivism of persons with alcohol and other drug related issues, all referrals to COATS between 1998 and 2003 were tracked for a period of seven years and the number of episodes of care made for each client during that period was recorded. The resulting data presented in figure 7 suggests that around 50% of clients are referred only once, one-fifth receive two episodes, and a little over 10% receive five or more episode.

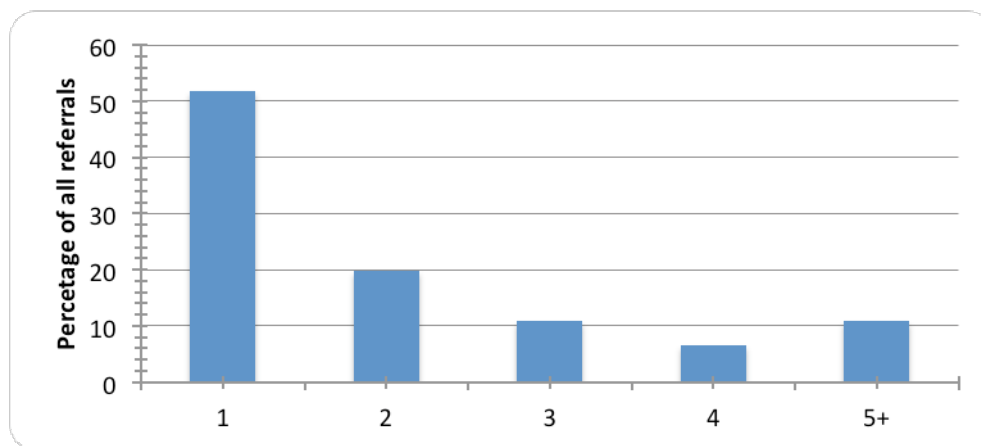


Figure 7: Percentage of total referrals x number of episodes during seven-year window.

This variation in the number of episodes per client reflects the diverse needs of the forensic AOD population. For some clients a single intervention may have been sufficient to address their substance-related offending, and therefore, were not referred again. However, it is also likely that a proportion of these clients did not require any AOD intervention and according to stakeholders there are often inappropriate referrals to the forensic AOD system of clients without AOD treatment needs.

The data also reveal that there are a small proportion of clients who, over the 7-year period, were referred to COATS multiple times, with some clients referred almost yearly.

Over a 7-year window, nearly half of all clients only had one treatment episode, whereas 11% had five or more, suggesting that this group may have more complex needs, or are more treatment resistant, and so resources should target both AOD use and offending.

It is clear that there are clients who

have either low treatment need, or are treatment responsive, as well as clients who are either more resistant to treatment, or have more complex treatment needs resulting in continued offending. This latter group need to be identified and resources targeted towards interventions that holistically address both their substance use and their offending behaviour.

A comparison of recidivism rates between the genders was conducted for the period between July 2005 and July 2010 (figure 8) and found that there was little variation in the average number of episodes based on gender.

The data suggest minimal differences in the recidivism rates for male and female clients in the forensic AOD system.

This suggests that, once a person has reached the point of being referred into the forensic AOD system, there may be no quantitative difference between males and females in terms of recidivism.

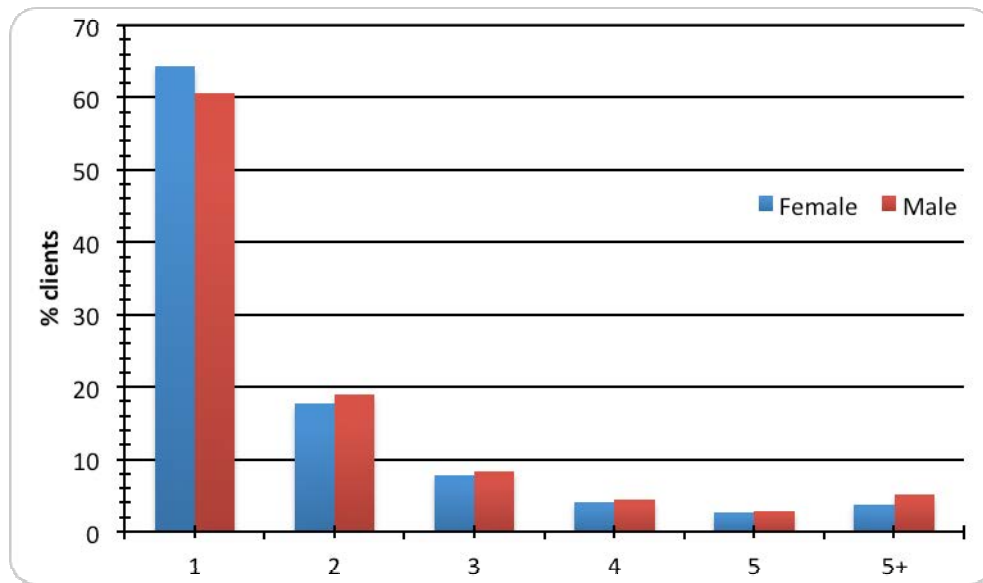


Figure 8: percentage of multiple referrals by gender for 2005 - 2010

To further understand these data, it is important to assess whether the duration of client retention in treatment (in terms of number of episodes of care, rather than duration of each episode) has changed over the past decade. Higher rates of re-referral might indicate a general increase in the severity of clients' AOD issues, or the failure of treatment interventions to have a long-term impact on the AOD problems in the client population. Figure 9 shows the proportion of clients who were referred one or more times in a seven-year window over six time periods. Note that this is a "moving window" description of the client population, i.e. the same client may appear as a single referral in successive observation periods, or

may appear as a single referral in one period, a double referral in the next, etc.

Rates of recidivism have remained consistent over the past 10 years.

These data show that generally the pattern of repeat referrals has remained reasonably stable, with around 50-54% of clients being referred once only, and around 9-12% being referred five or more times in any seven year period. This suggests that rates of recidivism in this population group has remained consistent over the past 10 years.

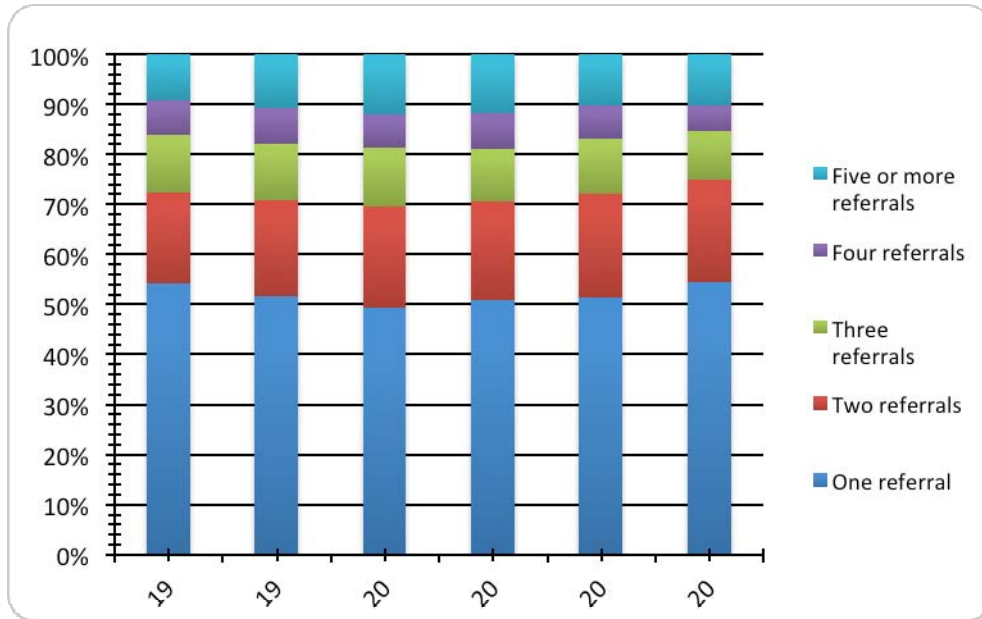


Figure 9: Proportion of clients referred one or more times in a seven year period

Client Order Types

There has been a steady increase in case flow across most order types. The number of ‘other diversion’ (DDAL, Koori Outreach, Rural Outreach, and Drug Diversion) and ‘other court’ (Criminal Justice Diversion Programs) referrals have increased at a more accelerated pace since the early 2000s. Note that while the absolute number of referred clients on Community Corrections Orders increased from 2000 to 2010, the increase in total referrals means that the proportion of COATS referrals from this source decreased from around 80% of all referrals in 1997/98 to around 40% in 2009/10. These data also suggest that the original model and system for supporting offenders with AOD issues may no longer reflect the

changed profile of current service users. Whilst adults on Community Corrections Orders remain the single largest group, the number of parolees, pre-sentence program clients (e.g. CISP and CREDIT bail) and diverted offenders are also increasing rapidly.

Whilst adults on Community Corrections Orders remain the single largest group, the number of parolees, pre-sentence (e.g. CISP and CREDIT bail) and diverted offenders are also increasing rapidly.

These groups have very different risks, needs and motivators, suggesting that a range of treatment

types and approaches need to be available within the forensic AOD system.

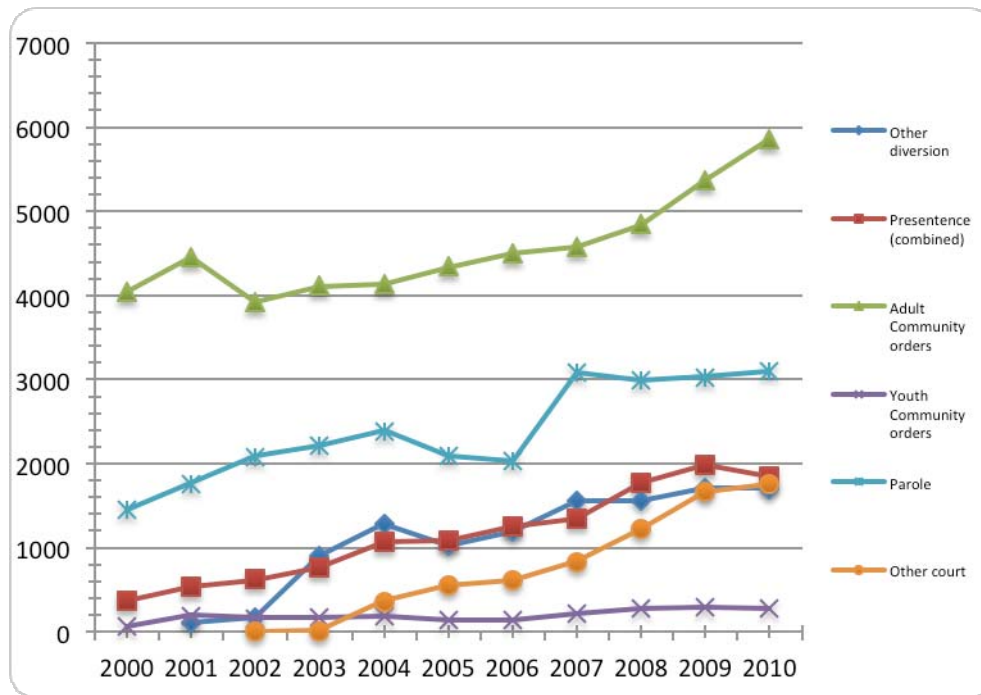


Figure 10: Number of clients by Order type

Offence Type

In the COATS database, referrals are classified by offence according to the offence category nominated by the referring CCOs. The offence categories classify offences quite crudely according to whether they were sexual/non sexual, violent/non violent and other. Violent offences among AOD clients is often regarded to be indicative of anti-social personality traits (discussed in greater detail in chapter 2), suggesting that this group have at least dual treatment needs, namely their AOD use, and their antisocial attitudes.

Non-sex offences account for around 95% of all referrals. Note that while the number of referrals categorised as non-violent/ non-sex offences has remained stable (at around 4,000 cases per year), the number of referrals for violent non-sex offences has grown (more than doubling between 2000 and 2010) and these now comprise the largest offence group.

There has been a small but steady increase in the number of clients who have committed violent sex offences and no change in the

number of non-violent sex offenders seen over this period.

The increase in referrals classified as violent may suggest that offenders with higher levels of antisocial personality traits are being referred into the AOD system.

These data indicate that there has been a shift in the profile of clients through the Victorian forensic AOD system over the past 10 years. Current data appears to indicate a higher proportion of violent substance-using offenders than when the system was originally set-up, and this may suggest that a

greater number of offenders with stronger antisocial traits are accessing forensic AOD treatment services.

The data do not show whether this shift is a reflection of a change in the AOD-using population in general, however, given the data in earlier graphs in this chapter, it is likely that a greater number of offenders with more significant levels of antisocial traits and behaviours are being diverted into the AOD system.

Given this drift in the profile of forensic AOD clients towards a more antisocial presentation than is typical of voluntary clients there is an increasing need for the forensic AOD sector to have the capacity to work with antisocial offenders.

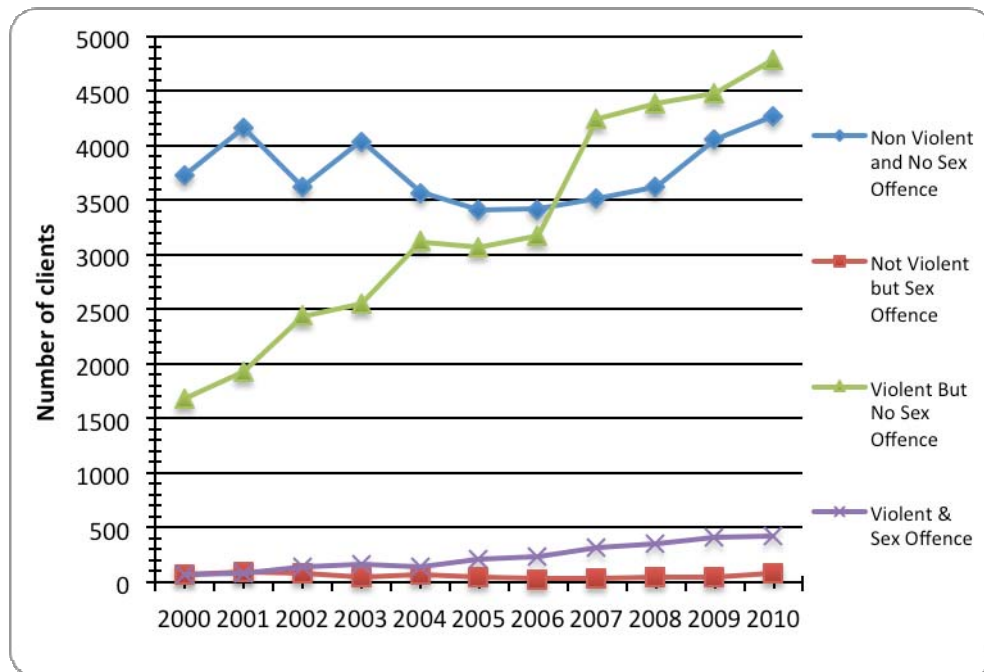
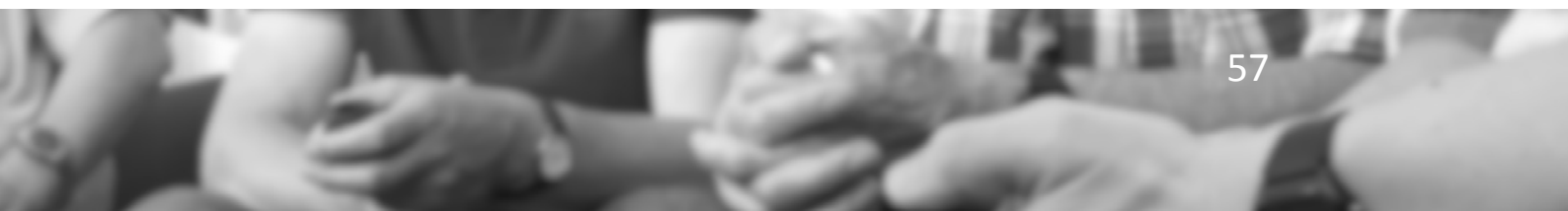


Figure 11: Numbers of referrals identified as violent or sex offender



1.3.2 Treatment Types

COATS records 28 different forms of intervention which were reduced to 11 core treatment types to aid in analysis. Completed treatment episodes are recorded via a Treatment Completion Advice (TCA) system. Alcohol and drug assessments, which are not a treatment type, account for 25% of all activity in terms of discrete interventions recorded. Of the remaining activity, the most commonly recorded treatment type is the CCCCs (Counselling, Consultancy and Continuing Care) program, making up nearly three-quarters of remaining episodes of

care, and one-tenth of referrals are for rural outreach drug worker episodes and community residential drug withdrawal.

It is important to note here that these data do not reflect all the treatment received by forensic clients, rather they only reflect treatment that is forensically funded. For example, specialist pharmacotherapy programs for complex clients are available under forensic funding, however forensic clients accessing community based pharmacotherapy programs through a GP would not be recorded in these data.

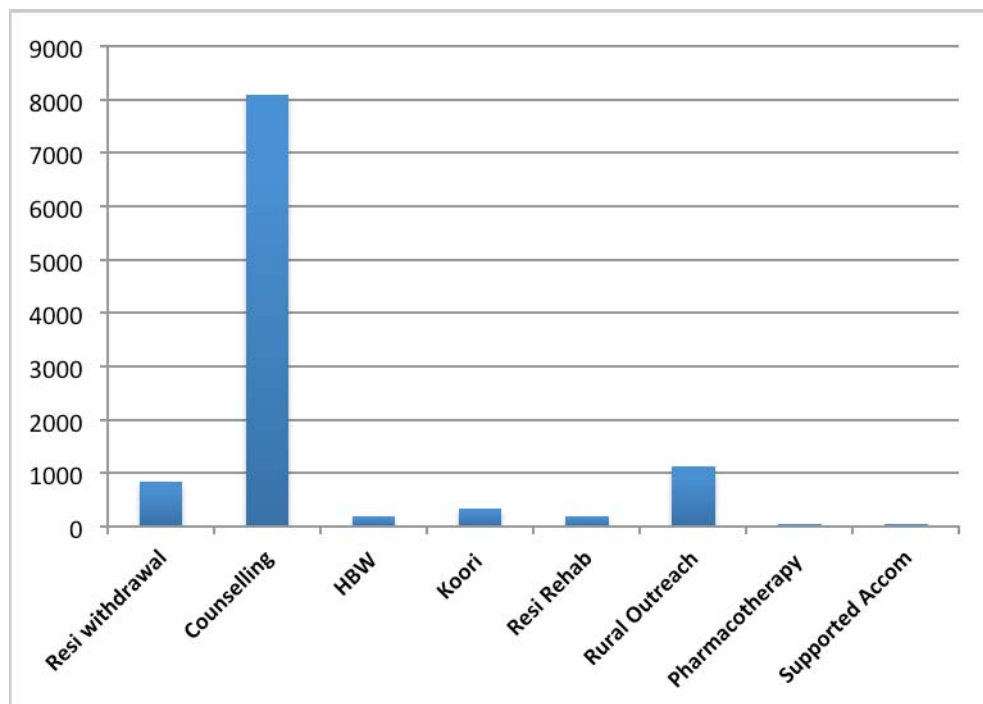


Figure 12: Percentage of referrals by treatment type for 2010

Treatment Outcomes

Treatment outcomes are recorded as either fully or partially completed, did not attend (DNA), or Treatment Completion Advice not received. Analysis of treatment completion rates for each type can be useful to determine this population group's level of responsivity to that treatment type. In 2010, across all interventions excluding assessments, 60% were completed, 18% partially completed, 10% did not attend and for 12% there was no data available. However, a significant proportion of these completed treatment episodes related to assessments - nearly 90% of assessment sessions were fully completed.

Looking at the data by treatment type, Diversion programs have the highest treatment completion rates with 70% of Rural Outreach Diversion recorded as fully completed and a further 18% recorded as partially completed. Non-attendance rates were highest for residential rehabilitation (26%), specialist pharmacotherapy (21%) and community residential drug withdrawal (16%). It is important to bear in mind that different treatment types have different treatment goals, precluding a comparison of one type over another in terms of efficacy.

The most frequently recommended treatment type, CCCCs counselling, had a relatively low completion rate of 40%. A further 32% partially completed, 12% did not attend and the TCA was not available for 16%. Of those referred for treatment and for whom a TCA was received, the

mean and median number of sessions attended was four.

Of those who do complete CCCC counselling, the average number of sessions was just four.

While the data to cross-match the duration of treatment and treatment type was not available, it is clear that only a small proportion of clients currently being referred for forensic AOD services are accessing treatment of sufficient duration to create any lasting behaviour change according to the NIDA 2009 principles discussed later in this report.

The most common treatment, counselling, had the lowest completion rate of all types with less than ½ of all clients completing, questioning its suitability for this population group.

This may suggest that the current model of CCCCs may not be appropriate for many forensic AOD clients and alternative treatment types may need to be considered, such as brief interventions developed with clear goals that can be achieved within one to three sessions.

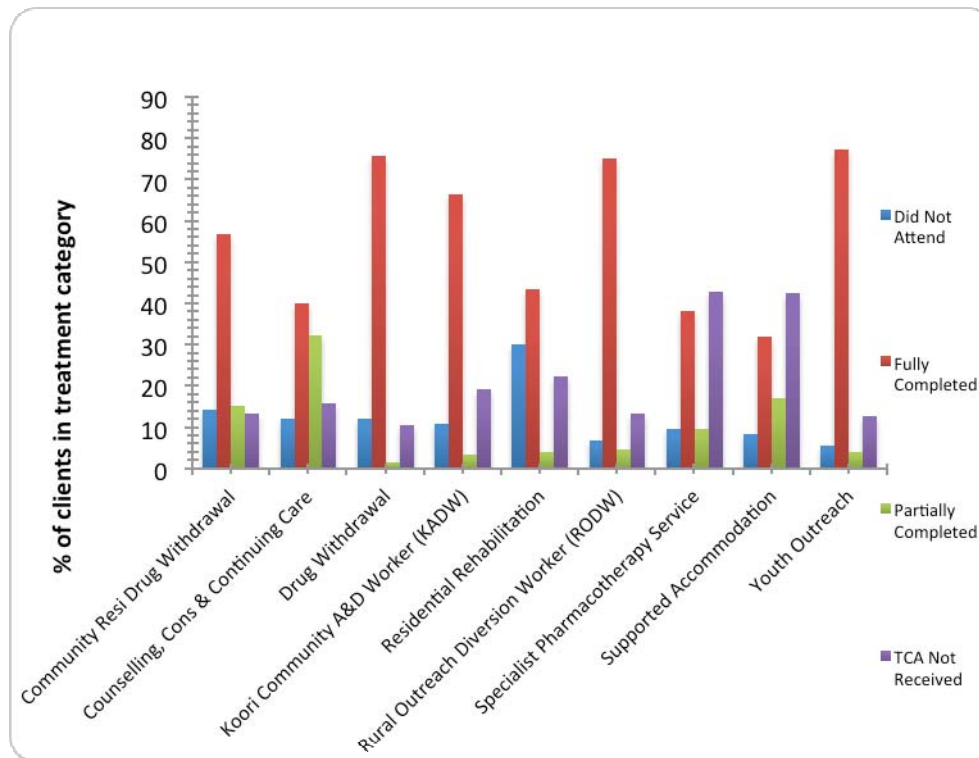


Figure 13: 2010 completion rates by treatment type

Summary

The forensic AOD system in Victoria has four main entry points that account for the bulk of referrals. These are at arrest, bail, post-sentencing community based dispositions, and post-release from prison.

The data from ACSO COATS show that the profile of the client group has changed significantly. Client volumes have increased from a little over 2,000 episodes per year to nearly 15,000. Although the gender balance has remained constant, it is still more skewed than the voluntary population, with 5/6 of referrals being male. The age distribution has moved considerably over the years, with a greater proportion of clients

in the 36-45 age group, much of which is due to older persons entering the system for the first time. More than one in three referrals was identified as having an alcohol-related issue – a more than 300% increase since 2000. In contrast, the number of referrals with heroin issues has remained stable, but due to the overall increase in the number of referrals across the board, they now form around one sixth of forensic clients. About one-sixth of clients were additionally identified as being ‘poly-drug’ users. This change in the substance-using profile of forensic clients has significant consequences for service providers, as the treatment needs of illicit offenders are often quite different

from those of alcohol-related offenders (more in chapter 2). The proportion of referrals with identified mental health issues has remained constant over the past decade, however this statistic should be interpreted with caution due to differing interpretations regarding diagnosed psychiatric disorders.

These data also reveal shifts in the dual needs nature of the population group in terms of not only AOD use but also offending behaviour. Half of clients received only one treatment episode in the seven-year window of observation, with 11% receiving five or more episodes suggesting much lower treatment responsivity or higher treatment need for this sub-group. Of note was the finding that there were no significant quantitative differences between the genders in terms of this pattern of recidivism. It is argued that recidivists need to be clearly identified as early as possible in order to ensure that appropriate allocations of resources are made. Further examination of the link between AOD issues, offending behaviour and engagement in the criminal justice system is warranted.

Of further note was the finding that in 2000 less than one-third of clients were classified as violent, however by 2010 this increased to more than half, suggesting that offenders with a greater degree of anti-social attitudes made up a much greater

proportion of the total client pool than before. This may be related to the shift in primary drug, with alcohol becoming the most commonly reported primary drug of concern. As will be discussed in the next chapter, approaches to counselling clients with these dual needs requires additional specialist skills that are more complex than those required to work with voluntary clients, and this also applies to assessment. Targeted assessment that is able to differentiate the lower-level offenders from more antisocial offenders is of paramount importance in determining the suitability and appropriateness of service type and setting.

The treatment types currently available in the Victorian system are the same for offenders as for voluntary clients and Alcohol and Other Drug Assessment accounted for a quarter of all interventions. The most common treatment type purchased is CCCC's counselling. However, this treatment type has the lowest completion rate of all service types with less than half of all clients completing an episode of care, raising questions about the suitability of the current delivery approaches for this sub-group. Of those who do complete CCCC counselling, the average number of sessions was just four; unlikely to be adequate in meeting the needs of complex dual needs clients.

2 Understanding the Forensic AOD Population

Not all persons who use alcohol and other drugs offend, and as such, there is a need to understand the relationship between offending and AOD use. Consideration of the research literature, and the experiences of Victorian AOD and criminal justice agencies, is required in order to understand and plan for the treatment and support needs of criminal justice populations. Interpreting this information appropriately requires that attention be paid to the Victorian context, and in particular, specific features of the Victorian system such as sentencing laws, imprisonment rates, multiple pre-sentence diversion options, in-prison AOD treatment programs, and the model for community forensic AOD treatment.

This chapter commences with an overview of the principles behind understanding offending behaviour, before exploring the relationship between AOD use and offending and an important distinction between alcohol and illicit drugs is drawn here. Several typologies for understanding substance-using offenders are presented from the literature, concluding with a new typology that may be of benefit to the Victorian context in order to better match treatment to the person.

2.1 Pathways into Offending Behaviour

A range of factors have been identified as contributing to the development of offending behaviour including social, individual and environmental factors.

Social, individual, and environmental factors can all contribute to the development of antisocial personality, attitudes

Social factors identified in the literature include poor attachment and bonding, poor parenting and low parental supervision, abuse and neglect, antisocial family systems, and antisocial peer groups. Individual factors include temperament, impulsivity, aggression, poor emotional self-regulation, academic failure, poor cognitive skills, and low self-esteem. Environmental factors include impoverished communities, social disadvantage, poverty, and inadequate welfare and support services (National Crime Prevention, 1999).

The predisposition towards offending can develop over the lifetime. Some children will be born into antisocial families and socialised from an early age into offending behaviour. Others will suffer an accumulation of risk factors such as abuse and neglect that mean they do not transition to school well, do not

develop positive peer relationships and fail academically. Without intervention, this can translate into a sense of failure, a belief they do not belong and low self-esteem. Adolescents who do not feel a sense of attachment or connection to school and who have no experience of success are at risk of dropping out of school or attending sporadically. From here, the cycle of failure and social exclusion can become self-perpetuating. Such individuals may seek alternative places to belong and may find acceptance among peers who engage in and encourage antisocial and substance using behaviour.

For others, experimental or recreational drug use may rapidly escalate to dependence, and this may be their entry point to a range of offending peers and contexts. The extent to which an adolescent becomes involved and entrenched in drug use and offending at this stage will often depend on the level of pro-social family, friends and activities available to counterbalance this experimentation.

Over time, as an individual becomes more entrenched in a drug using and offending subculture they may become more removed from mainstream values and ideals. When offending behaviour brings them into contact with the police, the criminal justice response can further entrench them in an

offending/drug using lifestyle. As an alternative, diversionary programs can provide an opportunity to access treatment and support and rebuild a more pro-social lifestyle.

For others single acts of aggression when intoxicated (e.g. serious assault, manslaughter) can have devastating outcomes that require a significant criminal justice response usually involving imprisonment. This exposes the individual to prison culture in which daily living may require engaging in behaviours that are outside the realm of the individual's usual experience. Whether this leads to ongoing engagement in antisocial behaviour can depend on whether the individual is exposed to other harms whilst incarcerated e.g. drug use, blood borne viruses, violence and the extent of their pro-social support networks.

The response of the criminal justice system to substance-using offenders is often shaped by its views of the relationship between drug use and offending. Makkai and Payne (2005) outline three alternative models of drug related offending: the Enslavement model; the Criminal Career model, and the Escalation model, and other models will be discussed later in this chapter.

The Enslavement model, which is endorsed by many stakeholders in the Victorian sector, proposes that offending occurs when an individual becomes dependent on drugs and can no longer legitimately finance their drug use. This model reflects the commonly held belief that drug-using offenders offend to finance

their drug use and that the best way to address offending is to treat the substance use. Despite this widely accepted view, the Enslavement model is inconsistent with data showing that, for the majority of offenders, the development of offending precedes regular or problematic drug use (Dobinson and Poletti, 2001). This model is therefore only applicable to offenders whose offending behaviour developed after their substance use was established, whose offending is limited to drug and acquisitive offences and who do not demonstrate broader antisocial tendencies.

The Criminal Career model presents drug use and offending as separate elements of a broader criminal career or antisocial lifestyle, where the two behaviours proceed from common causes but are generally independent of each other. The Criminal Career model best applies to individuals who grew up in an environment that supports the development of antisocial tendencies and normalises offending behaviour. Such offenders often meet the criteria for antisocial personality disorder, their offending is the primary concern and the drug use can range from recreational to dependent.

For many offenders antisocial attitudes and behaviours preceded problematic drug use

The offending behaviour will most likely be generalist and may include

violence. For these individuals, drug and alcohol treatment will not alter offending unless complementary steps are taken to address the causes of their anti-social lifestyle.

The Escalation model also applies to individuals whose offending behaviour usually precedes their drug use, however, for these individuals, ongoing drug use and increasing dependency result in an escalation of the frequency or severity of offending behaviour. This model is supported by data that shows for many individuals irregular offending often precedes drug use, but that when drug use becomes regular, offending also becomes regular (Makkai & Payne, 2005). For these individuals, addressing drug use may reduce the severity or regularity of offending but is unlikely to end it all together.

Other models of drug-related offending focus on the pharmacological effects of the actual substances used, and, in particular, the state of intoxication or withdrawal of the person at the time of committing the offence. These models tend to find violence associated with intoxication in the case of alcohol use and amphetamine use (Makkai & Payne,

2005), acquisitive offences associated with withdrawal in the case of heroin use (UKDPC, 2008), and homicide most often associated with alcohol intoxication (Makkai & Payne, 2005).

Alcohol or amphetamine related offending tends to occur when intoxicated, whereas opiate-related offending tends to occur when in withdrawal.

Drug-dependent individuals, regardless of drug type, commit more property offences (Makkai & Payne, 2005) and poly-substance use is more likely to be associated with more entrenched offending.

It is clear that there is no single pathway into offending and that criminal behaviour is a complex interaction of individual, social, family, community, and situational factors. When offending is combined with substance use the picture is further complicated by the type of the substance used, the level of dependence and psychological factors such as personality, trauma and mental illness.

2.2 The Relationship between AOD use & Offending

In addition to understanding offending behaviour, there is also a need for forensic AOD treatment services to operate with an understanding of the complex relationship between substance abuse and offending (Hussain &

Cowie, 2005). American studies indicate that up to 80% of arrestees test positive for drug use and Australian studies indicate that between 50% and 80% of Australian prisoners are incarcerated for drug related offences or were under the

influence at the time of their arrest (McGregor & Makkai, 2001). In a report released in June 2007, 57% of Victorian prisoners reported that their offences were committed either to support their substance use or under the influence, and 38% of violent offences were reported to have been committed under the influence of alcohol (Corrections Victoria, 2008).

57% of Victorian prisoners reported that their offences were committed either to support their substance use, or under the influence.

These findings are further supported by research conducted by the Australian Institute of Criminology on the drug use patterns of arrestees (Drug Use Monitoring Australia, or DUMA) in six Australian jurisdictions from 2000 onwards. Arrestees at selected sites (one or two per jurisdiction) were interviewed about their drug use and drug market participation while in police custody, and urinalysis was used to confirm self-reported drug use. Victoria joined DUMA in 2006 and arrestees at Footscray provide the Victorian component of the research.

The key findings from DUMA are:

- Cannabis is the most commonly detected drug, with 48% of arrestees testing positive in 2008;
- 48% of arrestees in Footscray were linked with heroin use (although nationally, heroin use has been declining since 2000);
- Benzodiazepine use is also high in Footscray arrestees, with 40% testing positive;
- Two-thirds of males and all females who tested positive for drugs also reported heavy alcohol use in the 48 hours prior to arrest;
- Drug use was more prevalent for female arrestees than for males;
- Around 30% of Footscray arrestees report deriving income from shop-theft or other income generating crime.

For those admitting illicit drug use, 40% of males and 46% of females reported currently being in some form of treatment. In contrast, 31% of males and 21% of females reported never having been in treatment for their substance use. These data also bring into question claims relating to increased treatment opportunities in the community preventing escalation

into offending patterns of behaviour. It should be acknowledged that the patterns observed in the Footscray sample are probably not typical of Victoria in general, but are indicative of some of the key features of drug use and offending.

Whilst these findings are significant, it is important not to draw inappropriate conclusions. For

example, it would be incorrect to assume that, were the person's AOD use to be treated, they would not have committed those offences. While data such as this indicates a connection between AOD use and offending, there is no single causal relationship (McMurran, 1996; UKDPC, 2008). Some studies have shown a strong association between some drugs (heroin and crack cocaine) and acquisitive offending, however for many offenders substance use and offending are not causally related (UKDPC, 2008). The interaction between substance abuse and offending is complex and

needs to be specifically assessed for each individual (Taxman, Cropsey, Young & Wexler, 2007; Roberts, Contois, Willis, Worthington & Knight, 2007; Marlowe, Festinger, Lee, Dugosh, & Benasutti, 2006). Examples of the factors that need to be considered in attempting to determine the relationship include the individual's motivation to use substances and commit offences, drug type, the presence of antisocial personality traits and attitudes, co-occurring mental illness, antisocial peers, offence history and type of offence (CSAT, 2005).

Illicit Drugs Versus Alcohol

Another factor that warrants consideration when attempting to understand the interaction between antisocial traits, AOD use and offending is the different interaction of illicit drug use compared with alcohol use upon offending behaviour. Illicit drug possession is by definition an offence, however most illicit drug users do not come into contact with the criminal justice system until there has been an escalation in their drug-related offending.

when it is associated with behaviour that is illegal or it is being consumed in prohibited settings or by prohibited persons.

A second reason given by interviewees for differentiating AOD responses-based around substance type is related to the different relationship between the type of substance and the substance use status at the time of the offence. For instance, heroin users typically offend when in withdrawal and hence dependence is indicative of possible offending behaviour.

Illicit drug use is by definition an offence, whereas alcohol use and possession, for the most part, is not.

Heroin-related offences tend to occur when in withdrawal, whereas alcohol related offending tends to occur when intoxicated.

Alcohol by contrast is a legal substance and only becomes the focus of the criminal justice system

However crimes related to alcohol use tend to occur when the offender is intoxicated and in a state of disinhibition. In the latter case, it is the frequency of intoxication and the propensity towards antisocial behaviour when disinhibited, rather than dependence, that is indicative

of offending behaviour (UKDPC, 2008; Hegamin, Farabee, Lu, & Longshore, 2004). In light of these differences, the model for describing forensic clients illustrated in section 3.5 will be presented first with respect to illicit drugs and then repeated for alcohol use.

Degree of AOD Use and Offending

In conceptualising forensic AOD clients, although it may be simplifying the issue, it is useful to approximate their substance-using behaviour on a continuum from abstinence at one end, through occasional or situational use, regular intoxication, and finally to dependant use. When considering the degree of offending, it may also be useful to simplify the behaviour

on a continuum from offending that commences with illicit drug use and possession and the lowest point, on to nuisance offending, and then acquisitive crimes (property offences), with offences against other people (violent offences) at the higher end.

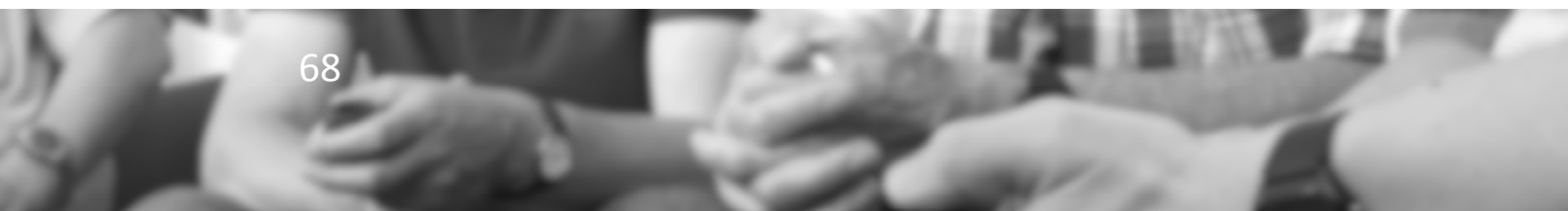
These two dimensions can be represented graphically, as per figure 14.



Figure 14: Proposed two dimensions against which forensic clients can be mapped to determine treatment need.

Some offenders, particularly those whose offending started at a young

age, will progress through the different offending categories over



time so that their repertoire of offending includes all types of offences, which may or may not be drug related. Others may offend over a long period of time, and their

rate of offending may escalate but they will only commit acquisitive offences. Offenders with stronger antisocial tendencies are more likely to escalate to violent offending.

2.3 Towards a typology for the Victorian Sector

Typologies can assist in treatment planning by illustrating the different treatment needs of subgroups within a population. Furthermore, such a model can help with the allocation of resources and also assist in the assessment process.

There is no agreed typology of substance-using offenders (UKDPC 2008). Models of offending described by Makkai and Payne(2005) at the beginning of this

chapter, a number of other typologies have been proposed. Typologies serve to illustrate the different relationships between substance use and offending, to identify treatment targets and barriers to treatment, and to match clients to appropriate treatment interventions.

McGregor and Makkai (2001) set out four potential relationships between substance use and offending:

1. Individuals who possess and use drugs on a small scale (e.g. for recreational purposes) but are not involved in criminal activities
2. People who are engaged in drug dealing, trafficking and manufacturing (and possibly violent offences arising from their commercial drug activity) but are not themselves users of drugs
3. Substance users who commit crimes to support their drug habit
4. Individuals who use drugs and commit crimes but their activities are not causally related

These four types can be mapped onto the 'offending behaviour x substance use' chart to give four approximate clusters, as follows:

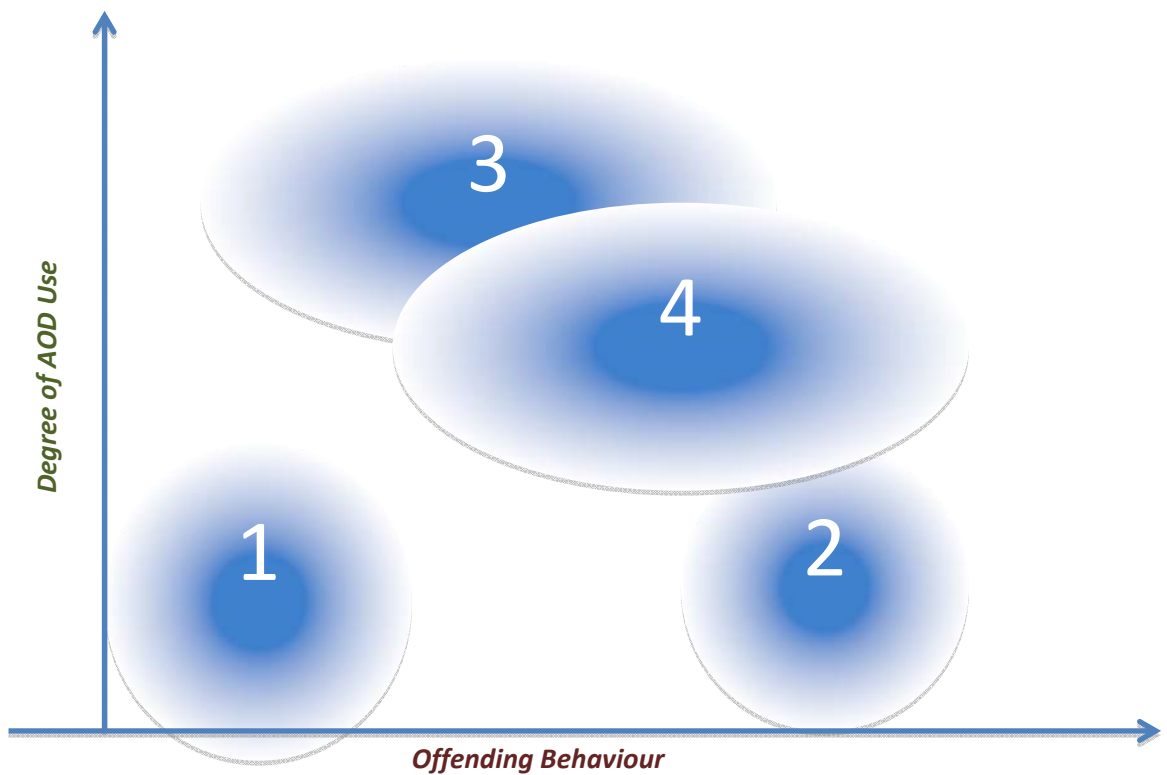


Figure 15: McGregor & Makkai's (2001) typologies mapped against the two dimensional model

The Virginia Addiction Training Centre (1995) also developed a typology that focuses on the different roles substance use plays in offending to give four categories of offender.

1. The early stage substance user - the recreational user who is not dependent, but may engage in antisocial behaviour as a result of disinhibition or impairment. This group is often associated with the offending behaviour of young people, but may include more serious offences such as culpable driving or assault.
2. The addict – the dependent user who is often the key focus of forensic AOD services. They engage in significant levels of petty crime to support their substance use and their daily lives have become narrowly focussed upon drug related activities.
3. The dually diagnosed substance user – they have co-occurring substance use and mental illness and are a highly variable group with variable treatment needs. Offending patterns are also variable and have

to be addressed in the context of the mental illness and substance use. An integrated approach to mental health and AOD needs is essential and the nature of the offending behaviour needs to be specifically assessed to determine if it needs to be directly addressed.

4. The criminogenic¹ substance user – this group are significantly antisocial and usually meets the criteria for a diagnosis of antisocial personality disorder (APD). Their substance use is often incidental to their offending and their histories usually show that the offending preceded their drug use. Their offending is diverse and often includes violent offences. They are difficult to engage in treatment and are most suited to structured prison-based residential programs.

The Virginia typologies are useful because they attempt to distinguish between dependent and non-dependent substance users, types of offence (i.e. violent vs. property offences), criminogenic (offending) vs. non-criminogenic users, and those with co-occurring mental illness, reflecting the diversity and complexity of substance using offenders.

The United Kingdom Drug Policy Commission (2008) review of the effectiveness of treatment programs for drug related offenders also called for the development of an evidence-based typology of drug-using offenders and proposed the following categories as a starting point for considering the relationship between drug use and crime. These are described below and mapped on Figure 16.

1. Recreational drug users – those who use cannabis and drugs such as ecstasy and cocaine but are not dependent on them and use is not related to their offending (other than use and possession).
2. Problematic recreational users – whose use of drugs may be getting out of control and, particularly in association with alcohol, may contribute to substance use disorders and minor offending.
3. Early stage dependent drug users – who are in the early stages of dependency and who are beginning to commit acquisitive crimes to fund their drug use.
4. Severely problematic drug users who have an established drug dependency and a history of extensive acquisitive offending to fund their habit as well as a range of other social problems.

¹ This is the label used by the Virginia Addiction Training Centre. A alternative label would be “Career Criminal substance User”

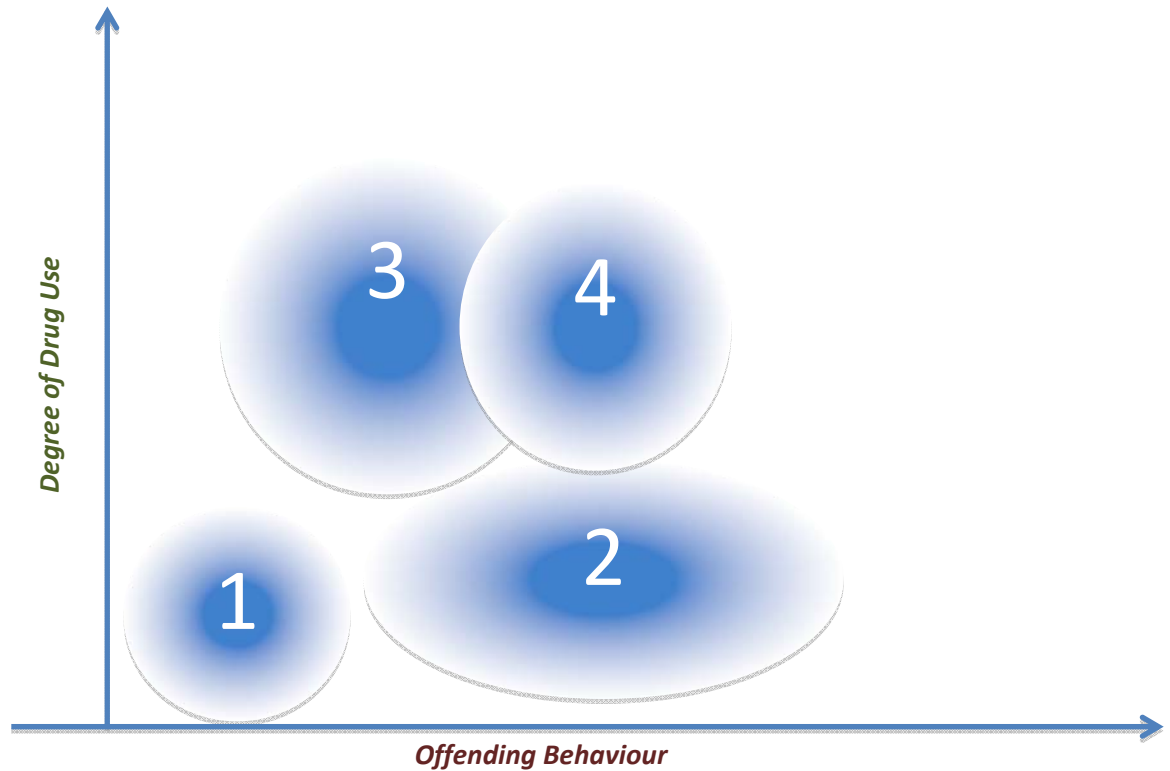


Figure 16: UKDPC’s (2008) typologies mapped to the two dimensional model

The UKDPC typologies were developed for identifying appropriate target groups for cautioning and only examined the relationship between substance use and acquisitive offending. As such, it could be argued that they are a reflection of the “Enslavement

Model” of offending. However, the UKDPC recognise that outside of acquisitive offenders are a far broader group of offenders, with a greater range of problems and more serious offending behaviour for whom reducing substance use is not likely to reduce offending.

The current sector does not utilise typologies in the assessment of treatment planning; however, the proposed typologies may assist with the assessment and treatment planning of forensic AOD clients.

Recommendation level 3/3

2.4 Illicit Drug Using Offenders – A Proposed Typology

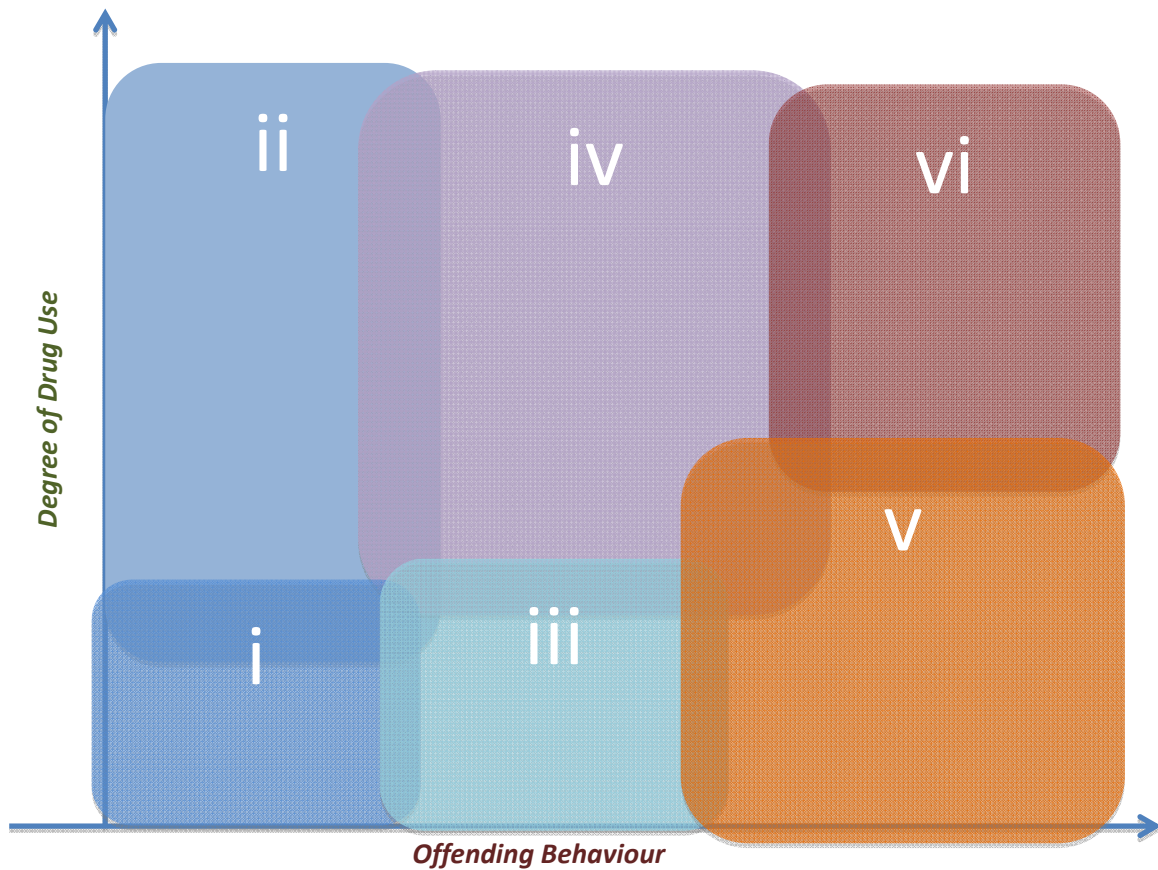
In order to assist with assessment and treatment planning, and drawing upon the review outlined above, the next section presents a typology for substance use that could be considered for use within the Victorian context. This typology will be discussed in terms of a range of substances in this section, and in

terms of alcohol in the next section. It is important to note that these suggested typologies are a product of the review of the literature. No study has yet been conducted to comprehensively map the phenomenology of alcohol and other drug-using offenders in Victoria.

2.4.1 A six category model

This typology is presented for illustrative purposes and describes substance-abusing clients in one of six categories across the two dimensions of degree substance use and offending behaviour, with an example of how that individual would typically come into contact with the criminal justice system. Some key assessment questions for differentiating the typologies and some preliminary suggestions around treatment outcomes are also described.

Depicting the typologies on a two-dimensional continuum gives a sense of where the types sit in relation to each other as well the overlap between them. The typologies are not designed to be exclusive or fixed categories, rather then intention is to provide an indicative framework for understanding some of the dynamics around the different relationships between substance use and offending. Future research will be required to verify the validity and relevance of each typology to the forensic AOD treatment system.



- i. **Low AOD – Low Offending** - minimal treatment needs – best in community settings
- ii. **Problematic AOD – Low Offending** – most similar to “voluntary’ clients
- iii. **Low AOD – Moderate Offending** – primarily offending focussed interventions
- iv. **Problematic AOD – Moderate Offending** – interventions that target these dual needs together
- v. & vi **High Offending** clients irrespective of AOD need best treated within Justice System.

Figure 17: Mapping six typologies against drug use and offending behaviour.

i) Low AOD /Minor Offending.

This category consists of recreational or situational use or intoxication. They are not drug dependent and do not engage in illegal behaviour to generate funds to procure drugs. The typical offence relates to possession of drugs such as heroin, amphetamines or cannabis for personal use and they are likely to be caught by chance or may commit a minor offence as a result of disinhibition (e.g. public nuisance offences).

Assessment would seek to ensure that there is no other offending behaviour,

or that there are no indicators that the person's drug use is becoming more serious. The literature suggests that most of these clients will recover with minimal intervention, and they are best diverted out of both the justice and the AOD treatment system. These offenders are generally appropriate for diversion from the criminal justice system and no (or only minimal) forensic AOD treatment is required.

ii) Dependent AOD /Minor Offending

This group is characterised dependent use of drugs, whilst remaining able to sustain use without resorting to significant criminal behaviour. These persons are often able to maintain employment to support their substance use or have alternate but legal sources of income. If this type of substance user is picked up by the justice system, it is likely to be for low level matters similar to the previous group, being possession or minor nuisance charges.

Assessment would examine the likelihood that they are able to continue

to sustain their drug use without progressing onto property or violent crime, as well as the usual factors related to drug use including treatment readiness. These clients are best diverted out of the justice system into the drug treatment system. Treatment should commence with education and harm minimisation but aim for longer-term engagement that addresses the issues underlying their sustained drug use.

iii) Low AOD /Moderate Offending

These persons are occasional or situational illicit drug users and their offending behaviour may not be related to their substance use, or where it is, it is likely to be a result of intoxication. They are likely to lead a lifestyle that involves consistent low level offending (e.g. shoplifting, car theft) and may be in the early stages of developing an entrenched offending lifestyle.

Thorough assessment of the relationship between their offending and level of intoxication is likely to find that their offending preceded their substance use and so intervention is usually best provided by the criminal justice system. Responses from the forensic AOD system if indicated would be low level and focus upon drug education and harm reduction.

iv) Dependent AOD / Moderate Offending

This category includes those with dependant drug use. Heroin users in this category are the stereotypical “addict” whose offending is primarily when in withdrawal, and who commit property crimes such as shop-theft or burglaries to support their use, which would decrease as their substance is addressed. Amphetamine users may also be offending to support their dependence, or as a result of disinhibition or other mood altering effects of sustained intoxication. Cannabis users in this category may be trafficking low quantities (often to support their own habit), or have offending behaviour totally unrelated to their substance use.

As well as the regular substance use issues, assessment would need to establish whether the drug use preceded their offending behaviour as well as it’s relationship to intoxication or withdrawal. Further considerations include their perception of their

offending behaviour, the existence of pro-social family and friends and whether they describe future plans for ‘pro-social’ self-supporting behaviours such as training or employment will help ascertain the degree of underlying antisocial attitudes.

This group may be appropriate for diversionary programs (provided they have not previously been offered these) but may have lengthy low-level criminal histories which mean that community orders are the most appropriate sanction. For clients with long-term dependence a similarly extended treatment relationship may be necessary. They are likely to require support by community AOD treatment services and case management services that help re-establish a non-offending lifestyle. The ability of the forensic AOD provider and case managing justice agency to work together is a critical element for positive outcomes with this client group.

v) Low AOD / Major Offending

This group are typified by a long history of offending behaviour and an entrenched offending lifestyle that is independent of their drug use. Typically they have grown up with significant criminal influence and commenced offending at any early age. They commit a wide variety of offence types but will be likely to enter the criminal justice system as a result of their violent offending. Violent offending is not limited to physical assault, but can include sexual assault, drug trafficking (as opposed to small scale dealing to support one’s own habit) and other

crimes against persons as well as property offences.

These clients may be screened into the forensic AOD assessment because drug use has been identified in their current or past history, but whatever their substance use, it is likely to be either incidental to their offending, or used to facilitate offending. They may exaggerate the extent of their drug problem in the hope of a lesser sentence (Dematteo et al 2006). These offenders can be highly resistant to treatment and are not usually suitable for community AOD treatment services.

Treatment should be focussed on their offending behaviour rather than their

substance abuse and should address antisocial attitudes, beliefs and peers.

vi) Dependent AOD / Major Offending

The final category involves similar characteristics to the previous group. Their antisocial behaviour is also primary, but their substance use is more significant and requires treatment alongside their offending behaviour. Like the earlier group, this group is likely to have a longstanding criminal history and their offending is not exclusively related to their substance use.

Assessment needs to carefully examine the severity of dependence, the relationship between substance use and offending and the level of violence. Research indicates that the best treatment outcomes for this group occur in long-term secure residential or therapeutic community treatment such

as prison-based therapeutic communities.

Clinical experience suggests that some antisocial individuals will cycle between these last two groups as their substance use moves in and out of their control, usually in conjunction with forced periods of abstinence due to imprisonment.

It is important to note the significant areas of overlap between the six typologies and the blurring of boundaries between them. At different point in time, forensic clients may move between types or may sit on the edge of two types making assessment of each individual, critical when planning appropriate responses.

2.5 Understanding Alcohol-Related offending

COATS currently process the same number of forensic clients for alcohol-related problems as for heroin and cannabis use combined. Therefore it is essential that the forensic AOD system is responsive to the different

relationship between alcohol use and offending, when compared to other drugs such as heroin.

For example, McMurran (2003) identified five potential relationships between alcohol use and offending:

- Alcohol is the cause of the crime (e.g. disinhibition or cognitive impairment)
- Alcohol use and crime are linked via another factor (e.g. antisocial personality)
- Alcohol use and crime may be in a conjunctive relationship connected by social or contextual factors (e.g. being in a pub with other drinkers)
- Crime may lead to drinking (e.g. celebrating an offence, assuage guilt after offending)
- The relationship may be spurious (e.g. the role of alcohol is exaggerated to excuse offending)

Therefore, with regards to a typology for alcohol use compared with other substances, there are two key differences that need to be considered. The first difference relates to alcohol

not being an illegal substance, although there are a variety of controls around who can purchase it, where it can be sold, and where it can be consumed. As a result, for adults, there are few

offences relating to the possession or use of alcohol, most simply being a matter of a direct fine rather than being referred into the forensic treatment system. Likewise, those for minor alcohol-related offenses such as disorderly behaviour are unlikely to be referred unless accompanied by a more serious offence. Therefore the graph plotting the client profile types in the forensic system commences further along the x-axis as can be seen when comparing figure 18 below, with figure 17. So there would be few if any clients in the 1st or 2nd type – low AOD/low offending and dependent AOD/low offending – being referred across.

A second difference is that alcohol is relatively inexpensive and highly accessible in comparison to hard drugs, so it is less likely that offenses will be committed to obtain or finance alcohol use (other than perhaps its direct theft). Furthermore, alcohol use may increase aggressive behaviour for a range of reasons, including the amplification of emotional states, reduction in anxiety, and/or disinhibition and increased reactivity, and, in longer term dependent persons, frontal cortex injury. As a result, those in the

moderate offending range in the typology above (types iii & iv) would more likely be referred because of disinhibited offences conducted when intoxicated, rather than acquisition offences when in withdrawal.

As a result of these factors, alcohol *dependence* does not necessarily lead to a lifestyle involving crime. Rather, it is alcohol *intoxication*, irrespective of whether there is dependence that seems to drive offending behaviour, which may range from nuisance offending, to drink drive offences, up to violent offences including family violence and serious assault. Addressing alcohol related violence is a particular focus for the current government in Victoria.

This suggests the need for a modified typology for clients for whom alcohol use has brought them in contact with the criminal justice system focussing upon four primary categories described below and illustrated in figure 18. It is important to note that there is a greater degree of overlap between the alcohol-related types, compared with the types presented in figure 17.

i) The Disinhibited Offender

For this group the offences took place when intoxicated. The criminal activity was not pre-planned but occurred as a result of disinhibition. Very low levels of offence such as drunk and disorderly or drinking in a public place are unlikely to result in referral for treatment. However, drink driving (where the person had no previous intention of driving drunk), through to becoming physically or verbally aggressive in response to events may be present in this group. These offenders usually demonstrate remorse as the behaviour

is quite out of character. This offender is unlikely to be dependent but may be in the early stages of developing an alcohol problem.

Assessment would need to consider the degree of offending behaviour when the client is sober, as well as explore for remorse for offences committed. This person could be appropriate for diversion programs with an alcohol treatment component (again, subject to the qualification that their offending is not frequent) but is unlikely to identify

with the offending and use patterns of illicit drug users so targeted interventions specific for this group may be best. Where the offending is non-violent and restricted to intoxicated

states, treatment could be well suited to being provided by community AOD services and primarily focus upon the alcohol use.

ii) The Alcohol Dependent Offender

This offender has longstanding alcohol abuse. The extent of their offending can depend upon the social supports and structures around them, and often involves drink driving – which may or may not be premeditated (e.g. drink driving that occurs in a ‘blackout’) as well as disinhibited offending. They may become progressively more antisocial as the alcohol damages their ability to lead a functioning lifestyle. Later stage alcoholics are at greater risk due to the likelihood of alcohol-related brain injury, losses of housing, relationships or other key assets, and moving into more criminogenic environments such as boarding houses.

Assessment should focus upon determining the severity of alcohol use and its harmful consequences, including the presence of alcohol related brain injury. Patterns of alcohol use and its impact on daily functioning should also be examined along with the nature of the offending behaviour. In particular the assessor should examine whether the type of offending has changed with increasing alcohol use and whether it is becoming more violent. Treatment for these clients should focus on the alcohol use and in the later stages they may also require extensive case management support if there is neurological impairment.

iii) The Aggressive/Violent Drinker

This offender may or may not be dependent, but becomes aggressive when intoxicated and may commit violent offences including street fights and family violence. There is some research to suggest that these offenders may have an underlying predisposition towards violence and use alcohol to facilitate their aggression (Pihl, Assad & Hoaken 2003). They may also overlap significantly with the other groups described.

Assessment needs to examine the nature of the offence, evidence of other forms of violence and other offending, (particularly violence when not intoxicated), to determine the extent to which the violent behaviour needs to be the focus of intervention. Where there is alcohol dependence, it also requires treatment but this should be in conjunction with an intervention targeting their violent behaviour.

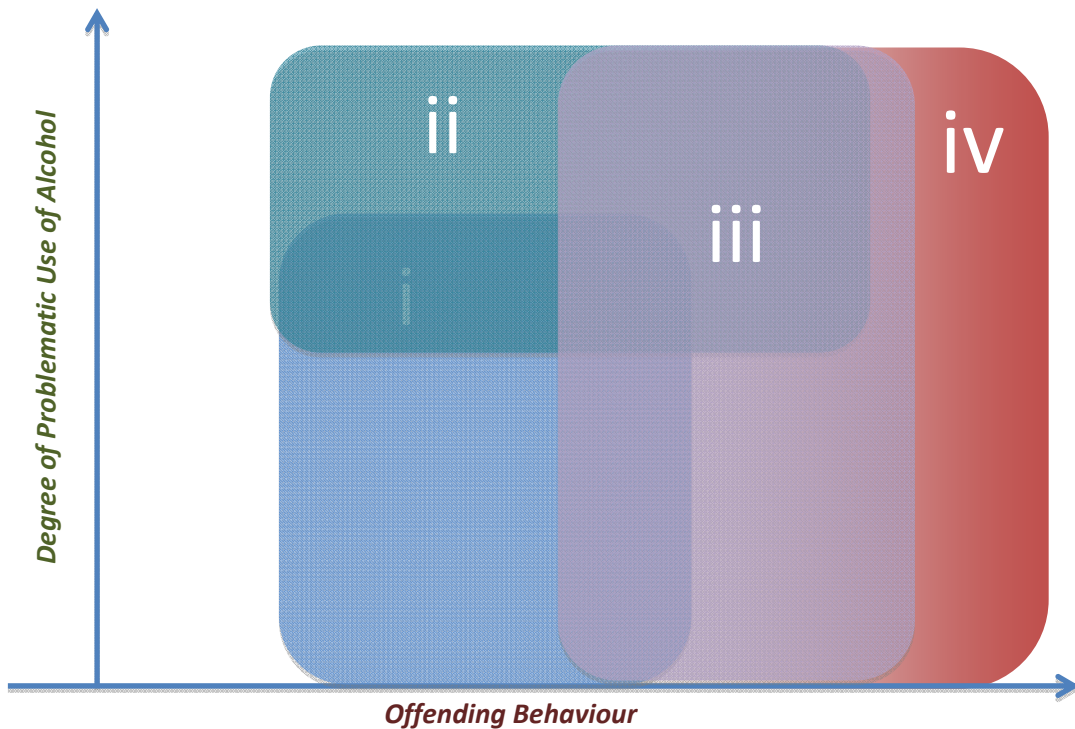
iv) The Antisocial Offender

This group has a long history of offending and an entrenched criminal lifestyle. They commit a range of offences and may or may not be alcohol dependent. Their offending is not caused by their alcohol use, but alcohol may be used to facilitate offending or may alter the nature of the offending (i.e. like the group above they may be more violent when intoxicated). Assessment needs to determine the degree of alcohol dependence, if any, however the appropriate treatment response is forensic in focus, with a

view to addressing their offending lifestyle as well as understanding any other motives for their alcohol use. Like the previous type, treatment should be provided by forensic clinicians, rather than generic or AOD clinicians.

Again, there is significant overlap between the four types, with assessment needing to distinguish whether there needs to be an integrated response to the alcohol use and offending behaviour particularly in the areas of overlap.

i. Disinhibited offender – offences typically under the influence of alcohol.

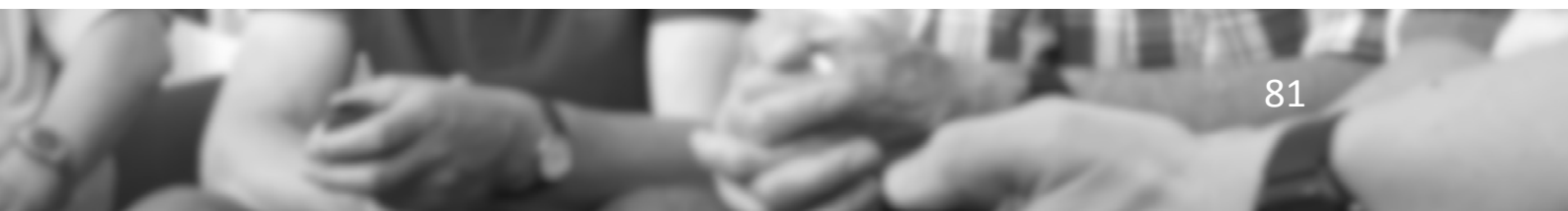


ii. Dependent offender – likely to become progressively more antisocial over time

iii. Aggressive/Violent Drinker – may or may not be dependent but becomes violent when intoxicated.

iv. Antisocial Offender – Offending not caused by alcohol use

Figure 18: A different typology for alcohol-related offending.



Forensic AOD treatment must recognise the prevalence of alcohol related offending and the differences in the nature of the relationship between alcohol use and offending compared to illicit substance use.

Recommendation level 3/3

Drink Driving

Drink drivers present a particular challenge to the criminal justice system because drink-driving offences may be committed by each type of alcohol-using person, therefore the key factors underlying this behaviour can be quite different.

Currently, drink drive programs are the primary response to drink driving, unless matters are escalated with the inclusion of other offences. Drink drive programs are primarily a mechanism for reinstating a driver's license and are delivered by accredited agencies. Their focus is upon psycho-education, and they operate under the assumption that this is sufficient to change the problematic behaviour.

Whilst this may work for a significant number of people (most likely the type 'i' disinhibited offender described above), they are not a clinical treatment program and do not examine the

relationship between the alcohol use and drink driving behaviour, nor do they treat either substance dependence or offending behaviour if the person were to fall into the type ii, iii, or iv categories. For example, there can be a range of reason for driving whilst intoxicated, such as a premeditated disregard for the law; lack of awareness of the risk/dismissal of the risks; or if it was a spontaneous decision made under the influence or in 'black out'. Clearly the response needed in each of these cases needs to be quite different.

Whilst drink drive programs themselves are outside the scope of this report, it is recommended that any future reviews of drink drive programs consider more thorough assessment, especially in the case of recidivist offenders, in order to adopt a more responsive approach to drink drive offences where problematic substance use or antisocial attitudes are significant contributing factors.

Only one current service describes specialist services for recidivist drink/drivers, but it is recommended that all recidivist drink/drug drivers undergo a thorough clinical assessment in addition to any attendance at Drink Drive programs.

Recommendation level 3/3

2.6 Female Forensic Clients

Gender is an important factor in understanding offending rates and patterns, as it is argued that the link between AOD use and offending is significantly different for men and women. Johnson (2004) found that women's pathways to offending were often shaped by their substance use and Forsythe and Adams (2009) identified a strong connection between offending, drug use and reported mental health problems (psychiatric admissions and Kessler K10 measures of psychological distress) in female arrestees.

In addition, they found that women are more likely than men to use prescription drugs, benzodiazepines and anti-depressants and to "self medicate". They proposed that services and programs for male offenders may not be appropriate for female offenders who are likely to require programs that specifically address mental health problems.

Programs for male offenders may not be appropriate for females, who are likely to require programs to address mental health problems.

Johnson (2004) also found that experiences of violence contributed to both mental health issues and substance abuse in women offenders, although research has not been able to establish a causal link between such experiences and offending behaviour (Drugs and Crime Prevention Committee, 2010).

Therefore, whilst the typologies described above apply across both genders, there are some specific considerations for women in the forensic AOD system that should be considered. Based on the Drug Use Monitoring in Australia (DUMA) data, collected over six years, Loxley and Adams (2009) noted the following key differences in the relationship between drugs, crime and offending for females.

Compared with their male counterparts, women offenders:

- are more likely to be dependent on illicit drugs
- are more likely to be poly-substance users
- are less likely to be dependent on alcohol
- their drug use was more likely to precede their offending
- started offending at a later age
- are more likely to attribute their offending to the substance use
- are more likely to have engaged in treatment
- are more likely to have mental health issues
- are more likely to have children

These findings were verified by the Drugs and Crime Prevention Committee in its 2010 inquiry into drug related offending and are supported by research conducted by Caraniche on Victorian prisoners which showed that females were twice as likely to report psychological problems and self-

harming behaviour, five times more likely to have had an eating disorder, and 3.8 times more likely to have been sexually abused in childhood. The Drugs and Crime Prevention Committee Report (2010) also noted that female offenders have a more complex range of problems that contribute to

offending and are more likely to have been unemployed, homeless, and in debt prior to sentencing. These factors are criminogenic needs and should be a key focus of assessment with female offenders and addressed as part of the treatment process. However, the report also noted that since 2002 there has been an increase in the number of women committing serious offences, in particular violent and trafficking offences and an increase in the average age of female prisoners.

Whilst the literature rightly has a focus on female offenders' experiences of violence and trauma, it remains important to examine the underlying criminogenic risk factors, such as antisocial personality. In a study by Caraniche on trauma, substance abuse and coping, 65% of women prisoners were found to have clinically significant drug use and trauma symptoms, 15% had significant substance use without trauma symptoms and 20% were assessed as having neither and being more "criminogenic" or antisocial (Thomas & Pollard, 2001).

2/3 women had clinically significant drug use and trauma symptoms.

Johnson (2004) found that extent of women's offending and the length of their criminal career was correlated with their degree of dependency. This suggests that the typologies outlined in chapter 2 may not neatly apply to women offenders and that female offenders will tend to belong to the high drug dependency categories. As with the men, careful assessment of the severity of substance dependence and its relationship to offending behaviour is the only way to prise apart these factors and identify the full range of criminogenic needs.

Whilst many of these issues sit outside the responsibilities of the forensic AOD sector, an awareness of the supports and resources in place to address them and which agency is carrying the case management responsibility for each individual woman, is critical to both the assessment and treatment process.

2.7 Treatment Needs – Balancing Substance Use and Offending Behaviour

The distinction between forensic and voluntary clients is not simple or clear cut. For example, most voluntary illicit drug using clients will also fall into one of the typologies described above (especially i, ii and iii), but they have not been caught up in the justice system. In general though, the more serious a person's offending behaviour, the greater the likelihood that they will become a forensic client. At the most serious end of the offending spectrum (groups v and vi) it seems unlikely that, without forensic involvement, they would ever have formed part of the

voluntary client group, rather they are only likely to attend treatment under external coercion.

More serious offenders may be less likely to present for voluntary treatment

In contrast, some forensic clients may exhibit only minor levels of AOD use and may not be dependent, something that is rare in voluntary AOD clients.

Those who present only minor levels of AOD use are rare in the voluntary system

As a result, the forensic population group is likely to be more variable in presentation and needs than the voluntary population on both the dimensions of severity of substance use (with lower levels being more prevalent), and severity of co-occurring antisocial traits (with higher levels being more prevalent).

As a result, the term ‘forensic’ needs to be used with significant caution when describing this population group as it wrongly implies that this population is homogenous. Rather, ‘forensic’ when used in the Victorian context is solely a systemic construct, referring in this context to persons who are currently in contact with the criminal justice system irrespective of their level of risk, need or treatment readiness/responsivity.

The term ‘forensic’ does not describe the needs of the population group

Forensic clients are a more diverse population group than voluntary clients not just in terms of severity of AOD use and offending behaviour, but also in terms of motivational readiness. Furthermore, they are not a homogeneous group; rather they show variations in personality, patterns of drug use, health status, offending, socialization, education, mental functioning, family support, and peer support.

Forensic clients are a more diverse population group than voluntary clients.

They range from the highly antisocial individuals with few links to mainstream society to more pro-social with optimal family and social support (Pearce & Holbrook, 2002).

The relationship between substance use and offending is not a simple linear relationship in which reducing substance use will automatically result in reduced offending. As the DUMA survey showed, 79% of females and 69% of males arrested in Footscray reported that they were either currently receiving or had previously received treatment for their substance use, suggesting that voluntary AOD treatment models may have little to no impact on a significant number of those in need.

Voluntary AOD treatment models may have little impact on many of those in this population group

It may be argued then, that specialist interventions and treatments that address both AOD use *and* offending are needed where there is a relationship between the two. A parallel can be drawn with the mental health system where there is the presence of AOD use and another mental disorder, commonly referred to as being dual diagnosis. Whether the two can be treated in isolation, sequentially, in parallel, or together, depends upon the relationship between the two for that individual client, and where a relationship is found, like with dual diagnosis, an integrated treatment response is recommended.

Whether AOD use and offending can be treated in isolation, sequentially, in parallel, or together, depends upon the individual client

Where there is a relationship, an integrated response to treating AOD use and offending behaviour delivered by specifically trained personnel. Whilst this is currently left to the discretion of individual agencies, it should be integrated into the service specifications.

Recommendation level 3/3

The forensic AOD client group can be more diverse than voluntary clients, and have highly variable treatment needs. Whilst some agencies currently recognise this to a limited degree, the forensic AOD system needs to formally offer a range of treatment responses and pathways that can respond appropriately these diverse needs.

Recommendation Level: 3/3

Treating Offending Behaviour

In the Victorian criminal justice system, treatment for offending behaviour, including substance abuse treatment, is provided in accordance with the Risk, Need, Responsivity Model developed by Bonta and Andrews (2007). The Risk Needs Responsivity Model (RNR) aims to reduce reoffending by providing a framework for determining which offenders should receive treatment, how intense treatment should be and what it should target.

The Risk principle states that treatment resources should be directed to those offenders at most risk of reoffending as these clients have the most to gain from treatment and return the greatest benefit to the community (Taxman, Thanner & Weisburd, 2006). High risk

offenders should be allocated to the most intense treatment regimes with low risk offenders allocated to less intense forms of treatment. Research demonstrates that allocation to appropriate levels of treatment is associated with higher rates of treatment completion and better treatment outcomes for offenders (Taxman, Thanner & Weisburd, 2006; Palmer, McGuire, Hatcher, Hounscome, Bilbly & Hollin, 2009). Further, placing low risk offenders in treatment designed for high risk offenders has been found to be detrimental to the client as it increases their level of engagement in the criminal justice system and exposes them to sanctions and consequences that potentially deepen their involvement rather than

stream them out of it (Taxman et al, 2007), which can increase reoffending (Andrews & Bonta, 1998).

The Need Principle states that treatment for offending behaviour should target the factors that underlie the offending behaviour. These are the known predictors of crime that can be changed through treatment such as antisocial attitudes, beliefs and behaviours, substance abuse, mental health issues, criminal associates, employment, education, relationship skills, leisure activities etc. (DeMatteo et al, 2010). These are different for each individual and thorough assessment of the precursors to offending are required to identify the most appropriate treatment needs.

The Responsivity Principle focuses on delivering the treatment in a way that

maximises the client's ability to engage and benefit from it. This means matching the treatment to certain characteristics of the offender (e.g., motivation, learning style and ability, and multicultural needs) (Ward & Maruna, 2007). There is a significant body of research that demonstrates the efficacy of the RNR approach to offender treatment. Andrews and Bonta (2010 cited in Dematteo, Hunt, Batastini, & LaDuke, 2010) report that delivering offender treatment in accordance with the RNR model results in 35% reduction in recidivism. Andrews and Bonta (2010) also found that fewer than 16% of the programs they reviewed adhered to the RNR model and linked assessment to treatment planning and program delivery.

The Risk, Needs, Responsivity principle is not currently utilised in the community-based forensic AOD system, but may provide a beneficial paradigm to guide treatment planning.

Recommendation level 2/3

Treating Substance Abuse

There is a significant body of research on substance abuse treatment with offenders, however the methodological limitations of much of the research make it difficult to draw clear conclusions about the effectiveness of treatment (Cochrane Review, 2009). The strongest research evidence comes from prison-based Therapeutic Community treatment programs with aftercare components such as Key Crest, Forever Free, New Vision (Office of Justice Programs, 2000; Cochrane Review, 2009). These programs are high intensity programs provided to high-risk offenders in segregated prison units. It is likely that one of the critical success factors for such treatment is the

long duration of treatment (usually 9 - 12 months) as evidence suggests that treatment effectiveness is directly related to the length of time in treatment (Anglin & Maugh 1992; Falkin, Wexler & Lipton, 1992; Pearce & Holbrook 2002).

Few studies have looked into the treatment needs of low to mid-level offenders and how best to treat these dual needs of substance use and antisocial behaviour, with much of the literature focussing upon those at the more antisocial end of the continuum (using prison-based populations). However, findings suggest that at the milder end of both the antisocial

spectrum and drug use, minimal intervention is needed. For example, according to Valuri, Indemauro and Ferrante (2002), drug related arrestees could be categorised into three distinct groups in relation to their offending: Group 1 no prior arrests, Group 2 prior arrests for drug offences, Group 3 prior arrests for at least one other non-drug offence.

After 10 years of monitoring it was found that the three groups had different rates of re-arrest with Group 3 having the highest chance of being re-arrested (77%), Group 2 having a 63% chance of re-arrest and half of the first time offenders going on to be rearrested. Half of the first time offenders were not re-arrested suggesting that they did not go on to develop an active criminal lifestyle. This matches the data from ACSO that suggested that two-thirds of all clients were only referred for one treatment episode during the seven years they were followed.

Valuri et al (2002) concluded that drug using offenders are not a homogeneous group and that treatment and sentencing options must consider prior offending history. Offenders with a prior history of arrest for a non-drug offence represent a more serious group

of offenders and should be the focus of treatment resources. Given that 50% of first time offenders do not reoffend extensive treatment is not indicated for this group. This view supported by Hughes and Ritter (2008) who caution that there is a risk of net widening with drug diversion programs, as people who would have had any ongoing or formal involvement with the forensic system may come into contact with it. These may then be at risk of net-deepening, whereby individuals that fail to comply even with minor diversionary orders, end up with increasing criminal matters against them as orders are imposed and then breached.

Low risk offenders who are not yet drug dependent should have secondary prevention strategies aimed at forestalling the progression from drug use to drug dependence, rather than drug treatment. Secondary prevention strategies could include; pro-social peers and activities, activity scheduling and recording, education and other activities that take the offender away from the drug using and criminal milieu. They should not include; time consuming reporting regimes, participation in groups with high risk offenders, intensive programs or 12 step programs. (Dematteo et al, 2006)

With the exception of DDAL, the current system does not offer alternative treatment focus for low-risk forensic AOD clients. These should primarily be secondary prevention strategies delivered through generic community organisations, such as linkage to pro-social peers and group, employment support and education.

Recommendation level 2/3

Summary

Although more than half of Victorian prisoners reported that their offences were committed either to support their substance use, or under the influence, the relationship between AOD use and offending is complex with five broad areas of needing consideration. The first relates to the relationship between AOD use and offending being different for male compared with female offenders, with the latter being more influenced by mental health issues.

Second, possession of illicit drugs is an offence, resulting in recreational and occasional users entering the justice system, whereas possession of alcohol is not an offence under most conditions. A third point concerns offences relating to alcohol and amphetamine use tending to be committed when intoxicated, whereas those relating to heroin use tending to occur when the person is in withdrawal. Fourth, the severity of AOD is highly variable in forensic populations, from occasional use (more likely to result in possession or nuisance offending) through to dependent use (crimes of acquisition). Furthermore, the client is likely to be a lower level of treatment readiness pre-arrest, than would those in voluntary settings, and this makes a fifth point of difference.

To conclude that greater availability of community-based treatment is the answer could be erroneous for several reasons: many offenders when arrested for illicit drug-related activity were already in treatment; their substance-use may only be loosely related or incidental to their criminal behaviour; their offending careers preceding substance misuse; and/or motivation to address the behaviour does not arise

until there is the presence of a justice-based incentive.

In order to assist with assessment and treatment planning, two typologies are proposed, one for illicit drugs, and one for alcohol-related offending. Users with primary illicit drug use other than these two could be approximated to the typology that best matches their presentation. These typologies describe the relationship between substance use and offending, type of offending, key assessment issues and recommended treatment pathways.

The illicit drug typology divides problematic substance use into two broad areas – recreational/situation use, and dependent use (low/high dependence respectively). Offending behaviour is also divided into three broad areas, minor (e.g. possession), moderate (acquisition offending such as shop-steal), and major (violence against persons). Mapping these two dimensions against each other produces six categories of drug using offender. The alcohol-related offending typology has four broad categories, due in part to the different relationship between alcohol use and offending behaviour compared with illicit drugs.

Where there is a relationship established between the AOD use and the offending behaviour, best practice would suggest that there should be an integrated response to treating them, much akin to the way that AOD services and mental health are moving towards an integrated response for clients identified as 'dual diagnosis'. Adopting the Risk, Needs, Responsivity model of developing and then targeting interventions may prove to be a useful paradigm for the voluntary sector.

3 Aims and Objectives of the system

Where chapter 3 looked at the needs of the individual clients in a forensic system, this chapter looks at the objectives of a system as a whole, discussing the policy requirements, followed by recommendations relating to how the sector should proceed.

3.1 Aims and Objectives of Forensic AOD treatment.

The forensic AOD sector in Victoria operates as a subcomponent of the general AOD sector. It accepts referrals from the criminal justice system (CJS) for a diverse range of clients with identified substance abuse problems and whose offending behaviour has brought them into contact with the criminal justice system (clients at risk of involvement with the CJS may also be referred through forensic AOD funding through “other diversion” category programs).

Consultations have identified several important differences in the objectives and priorities of the forensic AOD sector when compared with the general AOD sector, including:

- The goals of treatment, and in particular the priority given to the reduction in substance use as a goal;
- The way that motivation for, and participation in treatment is dealt with, and the role of treatment agencies in responding to poor motivation and lack of engagement;
- The prevention or reduction of offending, and the role of coercion in the pursuit of this goal.

3.1.1 General AOD service goals

The guiding framework for AOD service delivery in Victoria (Government of Victoria 1997) describes a range of treatment services with the objective of:

- Providing a range of services which aim to meet the treatment and support needs of people who have alcohol and drug use problems and their families and/ or carers, in a timely and effective way.
- Providing services appropriate to the specific needs of the individual client.
- Monitoring and coordinating the provision of services to clients to ensure continuity of care.
- Ensuring that service delivery is appropriately informed by and responsive to, review and evaluation of service delivery within the context of best practice developments.

More recently, the Victorian Department of Human Services Blueprint for Alcohol and other Drug Services (2008) updated this with the following vision for the sector:

“To prevent and reduce the harms to individuals, families and communities associated with alcohol and other drug misuse by providing appropriate, timely, high quality and integrated services that help people to address their substance use issues and participate fully in the social and economic life of the Victorian community” (page 9)

The Blueprint (2009) also incorporated the following client centred principles to guide the future development of the Victorian Alcohol and Other Drug service system:

“The alcohol and other drug treatment system should be client centred: Effective treatment recognises the things that are important to clients and utilises their family and cultural connections to support them in achieving lasting behaviour change and linking them with the other services and support they require.”

In line with this, Victorian AOD treatment services adopt a harm minimisation approach and work initially upon motivation and engagement of the client, drug education and harm reduction. For the most part, community alcohol and drug services do not give priority to or seek to achieve the specific goal of changing or ending substance-using behaviour unless this is a goal identified by the client.

In contrast, the aim of DH funded *forensic* AOD treatment, as stated in the Department of Human Services Guidelines and Business Rules, is to provide:

“therapeutic intervention directed towards modifying the behaviour of offenders in relation to their drug use. The primary goal for both adults and young persons is the reduction and/or cessation of drug use which, in turn can have a positive effect in lessening offending behaviour” (Department of Human Services 2008).

Therefore, it is clear that from a policy perspective, there are different expectations from voluntary funded AOD treatment, and forensically funded AOD treatment.

3.1.2 Forensic AOD service goals

The Criminal Justice System typically has a specific goal of reducing reoffending behaviour. Programs may be offence-specific (that is, they target the causes of specific offending behaviour such as sex offending or violent offending) or they may be offence-related. Offence related programs address individual, environmental or social factors that contribute to the frequency or severity of offending (for example, unemployment or inadequate family support). Alcohol and other drug treatment programs differ in that they have the potential to be both offence-specific and offence-related with a focus on the health impacts of drug use, or offending behaviours and drug use, or both. Sector interviews described how community based AOD programs have a greater focus on health issues, while prison based programs had a greater focus on offending behaviour.

Corrections Victoria is a key stakeholder in the Victorian forensic AOD system, particularly at the higher end of the drug and offending nexus. In 2007, 48%

of offenders under Community Correctional Services (CCS) supervision were being referred to AOD treatment services (Corrections Victoria, 2008). Corrections Victoria operates within a framework that aims to reduce recidivism and uses the key principles of offender rehabilitation (such as risk, needs and responsivity) to target treatment to factors that contribute to offending behaviour. Under this framework, drug and alcohol use is identified as a criminogenic risk factor and therefore, for some offenders, the provision of AOD treatment is viewed as a leading to reduced reoffending (Andrews, Bonta & Hoge, 1990; McMurrin, 1996; Hussain & Cowie, 2005; Dematteo et al, 2010).

Corrections Victoria has clearly articulated the aims and objectives of its engagement with substance using offenders in the Corrections Victoria Community Correctional Service Drug and Alcohol Strategic Plan (Department of Justice 2008).

This plan outlines four key goals for drug and alcohol interventions for offenders under its supervision. These are:

- 1. Harm Reduction** - To reduce health and safety risks to the community, staff, and offenders resulting from drug use.
- 2. Demand Reduction** - To reduce illegal drug use and harmful legal drug use.
- 3. Improved Treatment Outcomes** - To effectively manage treatment opportunities that assist offenders to establish healthy crime free lives by:
 - identifying the extent to which individual substance abuse is criminogenic;
 - providing treatment options which are informed by the link between substance abuse and offending behaviour;
 - providing a range of treatment options, which respond to differing levels of risk (of harm and re-offending) and need; and
 - providing treatment for ex-prisoners that builds upon that undertaken in prison.

4. Integrated and Coordinated Response -To improve communication and strengthen cooperation between CCS and other relevant agencies for enhanced treatment outcomes.

Of particular interest in this context is the goal of Improved Treatment Outcomes as Corrections Victoria does not have direct responsibility for delivering AOD treatment to the client. Rather, this is delivered by AOD service providers brokered through ACSO COATS. It is at this point that there is potential conflict between the different goals, philosophies and priorities of the AOD sector and the criminal justice system (Bull, 2005). As shown in the diagram below, the forensic AOD system sits at the nexus of the AOD sector and the Criminal Justice System. The AOD sector has a health focus and provides voluntary treatment to clients who should be active and willing participants in the treatment process. In line with its client-focused philosophy the sector works to support the client who is an active participant in the development of their own treatment goals, which may or may not include a reduction in substance use.

There is potential conflict between the different goals, philosophies and priorities of the AOD sector and the criminal justice system

The Victorian publicly-funded AOD sector is value neutral and does not impose goals or targets upon the client, but rather focuses upon assisting the client to achieve their own goals through maintaining a focus on engagement, support and reducing harm. In the voluntary AOD sector low motivation or resistance are often viewed as barriers to treatment.

In the voluntary AOD sector low motivation or resistance can sometimes be viewed as barriers to treatment.

Clients within the criminal justice system are mostly involuntary and coerced into treatment participation through incentives such as lesser sentences or threat of breaching an order and, for prisoners, reduced security ratings and release on parole. AOD treatment typically takes place in conjunction with other forms of supervision and intervention (e.g. unpaid community work) and the offender's engagement with treatment is viewed as one component of a more general obligation to satisfy the requirements of the courts and corrections agency. Low motivation and resistance is an expected feature of engagement with corrections (including any treatment requirement) and is worked with as part of the process of change rather than being seen as a barrier to treatment.

Low motivation in the criminal justice sector is not seen as a barrier to treatment, rather it is part of the process of change.

Another area of difference concerns how the nature and scope of treatment interventions are determined. In the voluntary sector, the form of intervention and the extent of a client's involvement will be primarily determined by the nature of the client's AOD problems and his or her willingness to undertake treatment. In contrast, criminal justice interventions are

delivered within a framework governed by sentencing considerations such as the severity of the person’s offence and his or her criminal history.

A key issue in this regard is that of proportionality: that is, the principle that the severity or intrusiveness of any intervention delivered under sentence should be proportionate to the seriousness of the offending for which the sentence was made. This can be especially problematic where individuals with serious AOD problems engage in repetitive but minor forms of offending, and vice versa whereby persons with minor AOD use receive more intensive sentences with treatment conditions because of the severe nature of their offence.

The alignment of justice response to severity of offence can cause problems where persons with significant AOD issues present with multiple minor charges (and vice versa).

However, measures would need to be in place to prevent ‘net-deepening’,

whereby a person given a minor condition or diversion for a minor offence fails to comply with that condition and can escalate through offences relating to breaching court orders.

A further consideration is that forensic AOD services are often delivered as part of a sentence or order that imposes a variety of requirements on the client such as abstinence, residence at a designated place, the performance of unpaid community work, and attendance at supervision meetings. Failure to comply with these other requirements may result in revocation of the whole order including termination of any treatment component. Thus, participation in forensic AOD treatment is often contingent upon compliance with requirements that have nothing to do with treatment engagement.

While the forensic AOD sector is embedded in the voluntary AOD sector, with services provided by the same agencies and workforce, there is a requirement to work in conjunction with the sometimes conflicting goals of the criminal justice system.

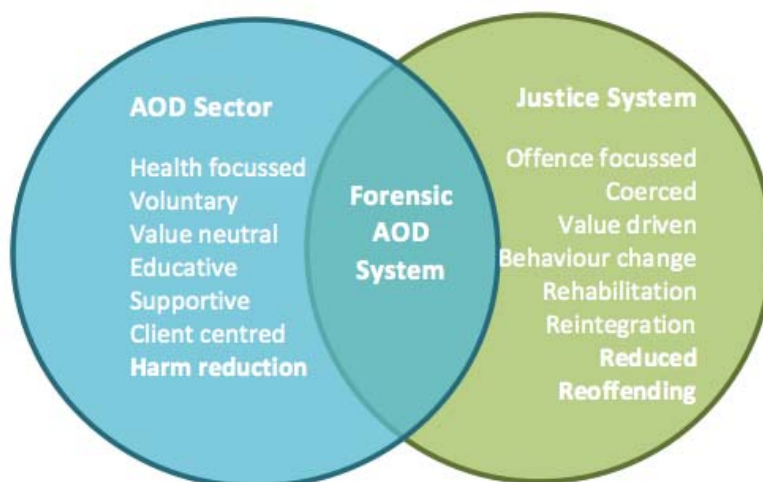


Figure 19: Goals / values of the AOD sector and the Criminal Justice System

Conflicting philosophies and goals between the two sectors are not unique to Victoria and have been described in other jurisdictions including the United States (Fletcher, Lehman, Wexler, Melnick, Young, Farrell, Henderson & Taxman, 2009; CSAT TIP 44, 2005; CSAT TIP 12, 1994) and the United Kingdom (UKDPC 2008). Stakeholder consultations conducted as part of this project also revealed significant differences in views on what the goals

of the forensic AOD sector should be. Analysis of Victorian stakeholder views found that a number of factors contribute to the differing perspectives on the role and purpose of the forensic AOD system, such as the individual's role within the system, which stage of the criminal justice continuum they are involved in, and their degree of involvement with clients. Stakeholder views are discussed in more detail in 4.3 below.

3.2 Forensic AOD Treatment in other Jurisdictions

The aims and objectives of forensic AOD treatment in other jurisdictions are similar to Victoria's, and for the purposes of this report, Western Australia, Queensland and the United Kingdom were chosen for consideration because they have well-articulated forensic AOD systems. These services aim to encourage offenders with substance related problems to: engage with treatment services, address their substance use, avoid more severe legal consequences and, reduce the likelihood of future offending.

These services aim to encourage offenders to: engage with treatment services, address their substance use, avoid more legal consequences and, reduce the likelihood of offending.

In general, objectives for initiatives targeted at the lower end of substance use and offending (i.e. diversion initiatives) focus primarily on the engagement of offenders in the AOD treatment system in order to reduce the health and social risks associated with problematic and illegal substance use, while initiatives at the more severe end of offending (i.e. community corrections and parole programs) aim to rehabilitate offenders and reduce recidivism by treating substance use issues as well as criminogenic needs.

The Drug and Alcohol Office of Western Australia, which is responsible for the provision of drug diversion programs, states that *"the main aim is to provide an opportunity for offenders with substance related issues to access compulsory treatment and address their drug use"* (Drug and Alcohol Office, Western Australian Comprehensive Drug Diversion Program, 2005).

The stated objectives include:

- Increasing the number of offenders with drug problems who are compelled to undergo treatment
- Ensuring that participation in the treatment condition forms a substantial intervention
- Explaining that non-compliance will result in automatic return to the courts for that offender.

Queensland Health oversees the provision of drug diversion programs in that state through the Queensland Illicit Drug Diversion Initiative. The stated aim of this initiative is to *“provide offenders with the opportunity to divert from the criminal justice system and enter into treatment to address their illicit drug or alcohol-related problems”* (Queensland Government, 2006). The objectives are to;

- Provide people with an incentive to address their drug use early and, in many cases, before incurring a criminal record
- Increase the number of illicit drug users accessing assessment, education and treatment, and
- Reduce the number of people being convicted before the courts for possession of small quantities of illicit drugs

The Department of the Attorney General oversees the Perth Drug Court, and as stated by Perth Drug Court Magistrate Dr King (Department of the Attorney General, Review of the Perth Drug Court, 2006) *“drug courts usually involve more serious offenders and a more intense program over a longer period than court diversion programs, with ongoing judicial case management, residential and/or community based treatment, urinalysis, the use of penalties, behavioural contracts and graduation ceremonies”*. Despite this more judicial stance, the stated objectives of the Drug Court Programs are not greatly different from those of the diversion programs in that they are aimed at encouraging offenders to engage with AOD treatment. The main objectives are to provide offenders with:

- An incentive to identify and treat their illicit drug use
- A face to face assessment
- Treatment matching with the most appropriate treatment agency
- An opportunity to address their drug use

The Queensland Drug Court is overseen by the Department of Justice and Attorney General and the objectives reflect the responsibility of the Justice Department towards community safety. According to the Department (Department of Justice and Attorney General, Queensland’s Court System Factsheet, 2007), the Drug Court aims to:

- Reduce drug dependency in the community and the drug dependency of eligible persons
- Reduce criminal activity associated with drug dependency
- Reduce pressure on the court, health and prison systems
- Promote the rehabilitation of eligible persons and their reintegration into the community

In both Western Australia and Queensland the provision of AOD treatment services to offenders in community corrections or on parole are the responsibility of the Department of Corrective Services and accordingly the aims of these programs have a greater focus on the reduction of recidivism and rehabilitation. For instance, the

Department of Corrective Services in Queensland states that the aim of AOD intervention programs is to *“assist offenders to confront their criminal behaviour, and develop pro social skills and techniques to control their behaviour and avoid situations that may lead to further offending”* (Queensland Corrective Services).

In the UK, forensic AOD services are delivered by community based treatment services and the National Probation Service through the National Offender Management Service (NOMS). Public Service Agreement 25 requires NOMS to “reduce the harm caused by alcohol and drugs” by ensuring that

The initiative, the Drug Interventions Program, therefore has a broad list of objectives, which are to:

- Reduce drug-related offending
- Reduce drug-related deaths
- Reduce drug-related ill-health
- Reduce the supply of illegal drugs

The UK model is probably closest to the Victorian model in that services are provided through community agencies rather than through corrections.

3.3 Stakeholder views

Even when there are clearly articulated system aims and objectives, it is common for stakeholders and workers on the ground to have differing views and opinions regarding the aims of treatment services. This was found to be the case in Victoria. Analysis of stakeholder views found that a number

of factors contribute to the differing perspectives on the role and purpose of the forensic AOD system, such as the individual’s role within the system, which stage of the criminal justice continuum they are involved in, and their degree of involvement with clients. These factors are outlined below.

3.3.1 Role within the system

As would be expected, interview responses varied with the profession of the interviewee and the role within the forensic system that they fulfil. Those with primarily a health and welfare focus were more inclined to express a view that improving the welfare and social situation of clients was a priority, and a prerequisite to AOD issues being addressed.

They held that this would subsequently result in a reduction or cessation in offending behaviour and that the offending behaviour itself did not need to be addressed. It should be noted that while this view is consistent with

the harm minimisation philosophy underpinning the voluntary AOD sector it is not supported by current best practice forensic AOD approaches for certain types of offenders (see chapter 5).

The primacy of harm reduction over reduction in re-offending was the position of the Victorian Association of Alcohol and other Drug Agencies (VAADA) in its response to the Victorian Government Discussion Paper on the Forensic Drug Treatment System which noted that *“there is confusion amongst AOD service providers with regard to the goals of forensic drug treatment and the*

primacy of objectives related to reducing harm, improving health outcomes and reducing re-offending" (VAADA, 2009). The VAADA submission states that reducing recidivism should not be the primary goal of forensic AOD treatment but that the primary focus should be on health related needs as negotiated between the clinician and the client.

Other respondents held the view that the purpose of a separate targeted forensic AOD funding stream should be to address AOD use that has not been picked up by the voluntary AOD sector (e.g. because the person may have low treatment readiness), *and* for whom there is a direct link between the AOD use and the person's offending behaviour. Furthermore, because these clients may have lower levels of treatment readiness, forensic AOD treatment should be integrated with motivational enhancement, provide responses to health and social needs, and address the risk that AOD related offending will lead to greater involvement with the justice system. These respondents tended to work within criminal justice settings, with more antisocial clients and pointed out that not all drug users resort to criminal

activities to sustain their substance use.

Those in health related roles tended to focus upon harm reduction and health promotion, whereas those in justice roles focussed more upon motivational enhancement and reducing criminogenic risk factors

Authors such as Bull (2005) note that these tensions have the potential to undermine diversion programs as different workers involved with the offender may not agree upon shared goals. It is therefore of central importance that there is a shared understanding of forensic drug treatment, especially given that this is a population group for whom consistency of response from the treating/supervising team is essential (Dick, Elkadi, Van den Bossche & Pollard, 2008). However, despite the different perspectives on appropriate treatment goals for forensic AOD treatment among those from the AOD and Criminal Justice sectors, there was recognition of the distinctive expertise of each.

3.3.2 Stage in the justice continuum

The second factor influencing opinions about the objectives of a forensic AOD system was the stage in the justice process where the interviewee was involved with offenders. As has been described in chapter 1, for the purpose of this report, these stages are broken into four areas: pre-trial, pre-sentencing, post-sentencing community orders, and parolees.

Those involved at pre-trial and cautioning stages emphasised that diversion out of the criminal justice system was the priority for their intervention. However, as Hughes and

Ritter (2008) point out the concept of diversion itself has multiple meanings, and it no longer is limited to the context of diverting clients out of the justice system itself (a view expressed at the pre-trial/cautioning level). Diversion also refers to the process of diverting offenders out of punitive responses and into therapeutic ones.

Those involved at pre-trial and cautioning emphasised diversion out of the justice system; those at the pre-sentence stage emphasised holistic interventions and helping clients to navigate the justice system; at post-sentence and parole the need to avoid breaching orders was a high priority.

Stakeholders involved with clients at the pre-sentence stage expressed a greater emphasis on holistic

3.3.3 Involvement with Clients

The third way that responses clustered was in terms of the degree and duration of involvement the respondent had with the client. Those who had longer periods of involvement, such as staff involved in the pre-sentence phases (up to four months) or in prison-based settings, emphasised a greater degree of social and/or behaviour change as being a primary focus. They described the complexities involved with recidivist offenders and chronic substance users, and how brief interventions alone were unlikely to produce long-term behaviour change amongst this group of the offenders.

On the other hand, those with shorter periods of involvement such as those

interventions, as well as assisting clients to navigate the, often complex, justice system. Those working at the post-sentence and parole phases emphasised the need to assist their clients to avoid the risk of breaching and to successfully complete orders as a high priority. Targeted AOD interventions matched to the client's readiness to change, were seen as the ideal treatment type by these stakeholders, as such interventions were more likely to result in successful completion of the treatment conditions on their order.

providing CCCCs with post-sentencing community-based offenders, prioritised goals around harm reduction, health education, and risk reduction in terms of health risk. In addition, for these stakeholders, a key objective was around introducing the offenders to the treatment services and giving them a positive experience of that sector, so that when they are ready to change, they may be more likely to seek help.

The longer the involvement with the client, the greater the emphasis upon behaviour change

3.3.4 Perception of Readiness to Change

Differences in priorities were also shared by those who perceived that the role and focus of forensic AOD treatment was greatly influenced by a client's readiness to change. Some interviewees reported that where there is low treatment readiness to change,

the focus needed to be upon developmental and social factors related to the client's AOD use, and in doing so, provide the client with a greater opportunity to grow towards treatment readiness and the idea of a lifestyle change.

On the other hand, for those clients presenting with high treatment readiness, a greater emphasis upon their substance-use was appropriate. It was felt that services should have the capacity to provide a greater depth of involvement for these clients to ensure that they receive the support that they need to attain their treatment goals.

In addition, interviewees described how a forensic AOD system has to reflect the reality that readiness to change and behaviour change itself are both cyclical processes.

A forensic AOD system has to reflect the reality that readiness to change and behaviour change itself are both cyclical processes

Therefore, instead of prioritising sustained behaviour change the focus should be upon supporting clients through the seemingly inevitable lapses and relapses and giving them positive treatment experiences to reduce the duration of these lapses. Stakeholders also described how young people in particular were regarded as less likely to be treatment ready, and therefore reduction in AOD use was unlikely to be a realistic outcome per se.

3.3.5 Severity of client's AOD use

Another factor influencing views about the focus of forensic AOD treatment related to the nature and severity of the offender's AOD use. Although stakeholders did not elaborate upon how this factor affected service objectives, the literature does discuss this matter.

For non-dependent drug users, a health-oriented approach may be taken, providing education, reliable information, brief motivational and behavioural counselling, and measures to facilitate social reintegration and reduce isolation and social exclusion (UNOCOC, 2010). However, in the case of drug-dependent individuals it may also involve more comprehensive social support and AOD targeted pharmacological and psychosocial treatment, and aftercare (UNOCOC, 2010).

A challenge around this area has been shown to be discrepancies and lack of consistency around the assessment of the severity of AOD use (Bull 2005, Dematteo 2010).

Problems can arise from inconsistent assessment around severity of AOD use.

Priorities vary significantly not only around the severity of substance use, but also around the type of drug being used, whether it was alcohol, cannabis, heroin or amphetamines with alcohol-related violence treated through a different funding pool, and drink-driver programs being under a separate operational area altogether.

3.3.6 Criminogenic Factors

The final way that responses varied was in terms of the degree of co-occurring antisocial traits that presented alongside the person's AOD use. This relationship has already been described in detail in chapter 1 with these dual needs clients often being enmeshed in a cycle of offending and that may be precede their AOD use and be inextricably linked and therefore not treatable out of context. Parallels can be seen with dual diagnosis presentations, such as clients with anxiety disorders and alcohol use, for which neither can be treated independently of the other.

As expected, offenders with higher levels of antisocial traits tend to find

themselves deeper in the forensic system, with interviewees from prison-based AOD services placing a greater emphasis upon treating the person as a dual needs presentation, targeting the offending behaviours that were bringing the client into that depth of involvement with the justice system, as well as their AOD use.

Prison based staff placed a greater emphasis upon treating both AOD and criminogenic factors

3.4 A Mutual Recognition

Despite the policy frameworks within which forensic AOD treatment exists, the feedback provided by the stakeholders interviewed for this report suggests that a single definition of the aims and objectives of the Victorian system cannot:

- (i) match the values and priorities of all those who work across that system (such as community treatment, community corrections, or prison based services),
- (ii) be consistent across all phases of the system, or
- (iii) specifically address the individual needs of all of the clients who are serviced by the system.

It is also clear that, despite significant overlap, the stakeholders of the forensic AOD system do not have the same objectives and priorities as the voluntary sector. These differences stem from variations in professional values, philosophies and task requirements and are deeply embedded and strongly held.

Resolution of these differences therefore cannot proceed from the imposition of a single framework of goals and priorities. Rather, they require a differentiated framework where the goals within each part of the system are acknowledged to be

appropriate to the issues present in that part of the system.

The key to the development of this kind

Resolution of these differences requires a differentiated framework where the goals are appropriate to the issues present in that part of the system

of differentiated forensic AOD framework is to consider in more detail the *target population* for whom this service sector is intended as well as the

needs of the justice system in which they have become involved. To be an effective forensic AOD treatment system requires that all key stakeholders have a mutual appreciation and a shared understanding (if not agreement) on the priorities of the forensic AOD sector and a firm commitment to the philosophy of that sector (Bull, 2005; OJP, 2000).

Both systems should work together to ensure that wherever possible individuals are diverted from the criminal justice system, and more specifically prison. By working together

collaboratively, lower risk offenders can be treated, supported and supervised and successfully complete order requirements in the community. However, it also needs to be recognised that some substance using offenders are more antisocial or criminogenic and, therefore, a greater focus on offending behaviour is required. Research shows that these offenders are actually more likely to comply with coerced treatment (CASA, 2003) and achieve better outcomes in structured prison based treatment programs (Wexler, 1997; CASA, 2003).

Summary

Whereas voluntary AOD treatment is based upon the paradigm of harm minimisation, working towards goals that the client identifies, forensic AOD treatment has a more targeted behaviour change objective, towards “the reduction and/or cessation of drug use, which, in turn, can have a positive effect in lessening offending behaviour”. Low motivation to change in the form of resistance is something that is accepted within the voluntary system, given that the client is responsible for choosing their treatment outcomes. However, the forensic system does not see low motivation as a barrier to treatment; rather motivational enhancement and working through resistance are key goals and an integral part of the treatment process.

In the voluntary sector, the form of intervention and the extent of a client’s involvement will be primarily determined by the nature of the client’s AOD problems and his or her willingness to undertake treatment. In contrast, criminal justice interventions are delivered within a framework governed by sentencing considerations such as the severity of the person’s offence and his or her criminal history. The

challenge here is that the degree of intervention determined by the court is related to the severity of their offending, not the severity of their AOD use.

Whilst there seems to be a clash in values and priorities between the voluntary and forensic AOD treatment sectors, this is by no means a uniquely Victorian experience, with Queensland, Western Australia and the UK all reporting that their systems had the objective of providing an incentive for offenders to address their substance-using behaviour. Objectives for initiatives targeted at the lower end of substance use and offending focus primarily on the engagement in the AOD treatment system in order to reduce the health and social risks, while initiatives at the more severe end of offending aim to rehabilitate offenders and reduce recidivism by treating substance use issues as well as criminogenic needs.

Factors that influenced opinions of what should be the focus of a forensic AOD system included the person’s role within the system (e.g. corrections, or case management); stage in the justice system (those involved at pre-trial and

cautioning emphasised diversion out of the justice system; those at the pre-sentence stage emphasised holistic interventions and helping clients to navigate the justice system; at post-sentence and parole the need to avoid breaching orders was a high priority); duration of involvement (the longer the involvement with the client, the greater the emphasis upon behaviour change); perceived readiness to change; severity of substance use; and the presence of other criminogenic factors.

Despite the policy frameworks, a single definition of the aims and objectives of the Victorian system cannot match the values and priorities of all those who

work across that system; be consistent across all phases of the system; or specifically address the individual needs of all of the clients who are serviced by the system. This kind of differentiated forensic AOD framework is to consider in more detail the *target population* for whom this service sector is intended as well as the needs of the justice system in which they have become involved. An effective forensic AOD treatment system requires that all key stakeholders have a mutual appreciation and a shared understanding (if not agreement) on the priorities of the forensic AOD sector and a firm commitment to the philosophy of that sector.

4 Treatment Types

This chapter begins by looking at the best practice principles that underpin forensic AOD treatment and draws attention to the ways that these differ from voluntary services.

Current forensic AOD treatment types are then discussed, divided into two groups. First, the medical interventions are presented, with a discussion of some of the considerations needed for the management forensic clients in these settings. This is followed by an overview of some key issues relating to psycho-social interventions in forensic settings, and eight core treatment types are described that could form the basis for a new forensic AOD system in Victoria.

4.1 Principles of Forensic AOD Treatment

The most commonly referred to principles for AOD treatment are the National Institute on Drug Abuse (NIDA) principles, first developed in 1999. The principles were revised in 2009 and are widely accepted as a sound evidence-base for AOD treatment. In 2006, NIDA adapted these principles for criminal justice or forensic populations. Whilst most of the criminal justice principles map closely onto the original principles,

but there are some important shifts in emphasis that recognise the importance of addressing offending behaviour and the context of treatment provision. Some of the general NIDA principles are listed appendix B, alongside the equivalent criminal justice principle providing a starting point for discussion and recommendations for future forensic AOD treatment in Victoria.

NIDA's general principles are as relevant to the forensic population as they are to the voluntary population and reflect the fact that substance abuse is a chronic relapsing condition that requires individualised and accessible treatment of sufficient duration to facilitate changes in behaviour.

However, in developing specific principles for criminal justice populations NIDA has emphasised four critical areas of focus for forensic AOD treatment that are consistent with the offender treatment literature.

1. Forensic AOD treatment should address both substance use & offending behaviour
2. Forensic AOD treatment should include assessment & integrated treatment for substance abuse, offending, personality and mental health
3. Offenders completing programs in prison need continuity of care into the community
4. Forensic AOD workers and correctional staff should work collaboratively and treatment should be coordinated across both systems

More recently, a set of clinical guidelines for providing AOD treatment to AOD clients with antisocial presentations was developed by Dick and colleagues (2008) on behalf of the Victorian Department of Human Services. Whilst these guidelines focus on a subset of the total forensic AOD population with a more criminogenic presentation (groups 5 & 6 in the typologies), they echo many of the NIDA principles and outline the following as "essential components" of forensic AOD treatment with antisocial clients.

- A focus on reducing substance abuse and offending behaviour
- Assessment of the functional basis of antisocial attitudes and behaviours
- Identification and addressing the interaction between substance use and offending
- A focus on the development of pro-social behaviours
- Assisting clients to develop self-management and emotional regulation skills
- Addressing antisocial attitudes and behaviours as barriers to employment and engagement with other services

As a result, it is clear from the literature that best practice in forensic settings varies significantly from best practice in voluntary settings, including all the principles of voluntary AOD treatment, but with the addition of features to reflect the different profile of this population group.

Forensic AOD should address both substance use and offending; it should include integrated assessment and treatment for substance abuse, offending, personality and mental health; there should be continuity of care from prisons to the community; and workers and correctional staff should work collaboratively and treatment should be coordinated across both systems and the process should be facilitated on a sector-wide basis.

Recommendation level 2/3

4.2 Forensic AOD Treatment Types in Victoria

The 1997 Victorian Framework for AOD Service Delivery describes a range of treatment types that are to be provided at a regional level, in addition to key services that operate at a state-wide level. These regionally-based services are:

- Residential Withdrawal.
- Home-Based Withdrawal.
- Outpatient Withdrawal.
- Rural Withdrawal Support.
- Specialist Methadone.
- Counselling, Consultancy and Continuing Care.
- Residential Rehabilitation.
- Supported Accommodation.
- Peer Support.

Three models of forensic AOD service provision were examined in the course of the preparation of this paper, two Australian models; Western Australia and Queensland, and one international model; the United Kingdom (UK). When the features of these programs are mapped to those of the current Victorian forensic AOD system, it is evident that the range of AOD treatment types available to forensic clients in Victoria is generally consistent with those provided to forensic clients in other parts of Australia and internationally. All programs

incorporate provision for individual and group counselling, residential rehabilitation, supported withdrawal, pharmacotherapy and case management / care coordination.

The following sections will look at these service types and discuss how they may best be developed in order to maximise their responsiveness for forensic clients and will be clustered into two broad categories: Medical interventions (Withdrawal, Replacement Pharmacotherapies) and Psychosocial Interventions (Behavioural Therapies and Residential Rehabilitation).

4.3 Medical Interventions

The first category of AOD treatment, the medically-focussed interventions, comprises Withdrawal and Replacement Pharmacotherapies.

4.3.1 Withdrawal

Medically-supported withdrawal can be provided either in a Community Residential Drug Withdrawal Unit or through Home-Based Withdrawal. Outpatient withdrawal is a treatment type available to services; however few forensic referrals are made, with 20 episodes in 2010 compared with 663 for

Community Residential Drug Withdrawal in the same period.

NIDA (2009) states that withdrawal alone is not a treatment and needs to be accompanied by other supports and behaviour change interventions to effect lasting change.

As withdrawal is a physiological process, forensic clients have no additional or specific physical needs and the literature does not describe any specific ways in which forensic clients differ from voluntary clients with regards to this treatment type. However, there are other factors that may require consideration when engaging forensic clients in withdrawal services, as outlined below.

As withdrawal is a physiological process, forensic clients have no additional physical needs compared with voluntary clients, however factors relating to management that should be considered

- Ex-prisoners are often reluctant to accept any form of institutionalised care and may refuse in-patient withdrawal. They may be more willing to consider home-based or outpatient withdrawal. This needs to be balanced with the client's likelihood of being compliant with treatment.
- The safety of workers providing home-based withdrawal services to clients is a primary consideration especially when providing services to highly antisocial clients with violent offending.
- Forensic clients may see withdrawal as a quick cure. Such clients need strong encouragement to engage in post-withdrawal support services and education about the risks of overdose post withdrawal. The same can be said for replacement pharmacotherapies.
- Highly antisocial (type vi) clients may not be suited to a setting where there are voluntary clients.
- Withdrawal can provide an important opportunity to assess further treatment needs and provide motivational interventions.
- For high dependence/low antisocial-type forensic clients who have been caught in the drug/crime cycle withdrawal provides a critical break in the cycle and an opportunity for the client to assess the impact of their offending behaviour. This may be accompanied by feelings of guilt, shame and depression that must be monitored post withdrawal.
- Forensic clients may have ongoing court matters which can add to their overall stress of recovery from addiction.

Residential withdrawal is indicated for the same types of presentation in forensic clients as voluntary clients, primarily low offending/high dependence, and, with careful monitoring, moderate offending/high dependence, and so should continue to be offered for forensic clients.

Recommendation level 2/3

Staff working in residential withdrawal settings need to be mindful of the impact that the secure locked environment may have upon clients with history of incarceration.

Recommendation level 2/3

4.3.2 Replacement Pharmacotherapies

A second treatment category is replacement pharmacotherapy, such as methadone or buprenorphine, and these are only indicated for clients dependent on opioids. NIDA (2006) states that pharmacotherapy is an important component of treatment for offenders due to the impact they have on offending behaviour related to the procurement of drugs, and that the most effective pharmacotherapy programs also include counselling. There are Department of Justice initiatives such as OSTP that aim to facilitate prisoners' start up on pharmacotherapies by paying for the medication dispensing fee for the first 30 days post-release (the cost of the medication is 100% covered by the government already). However, Turning Point (unpublished 2010) noted that the

current pharmacotherapy system in Victoria is under-funded and vulnerable due to a lack of prescribers and dispensers so this start up may not carry across into sustained behaviour change.

Similar to withdrawal, as a physiological treatment, there are no real differences in the use of pharmacotherapies with forensic clients.

Replacement pharmacotherapy is no different for forensic than for voluntary clients, however they may have additional needs regarding their management.

However, there are factors specific to forensic clients that require consideration as noted below:

- Research indicates that prisoners are at high risk of overdose in the first few weeks post release (Kariminia, Law, Butler, Levy, Corben, Kaldor, & Grant, 2007) and that methadone maintenance therapy initiated in prison reduces the risk of death by overdose (Dolan, Shearer, White, Zhou, Kaldor & Wodak, 2005).
- Stakeholders report that the provision of pharmacotherapy within the Victorian prison system is increasing, resulting in more forensic clients needing to access pharmacotherapy treatment upon release.
- An increase in the initiation of prisoners on pharmacotherapy means some offenders will be released from prison on pharmacotherapies having never previously accessed them in the community
- Forensic clients have high rates of self-initiated withdrawal from pharmacotherapy treatment (Zador, 2010).
- Poly drug users seeking pharmacotherapy treatment can be difficult to assess (Zador, 2010)
- Forensic clients, particularly those who have been in prison, may abuse pharmacotherapies, placing themselves at greater risk.
- Short stints on methadone (<1 month) in prison are associated with increased recidivism (Dolan, 2005) with some authors reporting antisocial clients are more likely to drop out of methadone treatment while others report that clients diagnosed with ASPD do as well in replacement pharmacotherapy treatment as other clients (Drake, Bartels, Teague, Noordsy & Clark, 1993).

The use of pharmacotherapy to assist in the creation of stable lifestyles without crime should be best targeted to those offenders whose substance abuse is primary (low antisocial/high dependence).

Recommendation level 2/3

Co-locating replacement pharmacotherapy services, especially dispensing, with forensic AOD counselling services or even justice services may be indicated as an approach to be considered and trialled in Victoria, with the dual possible benefit of both increasing likelihood that the offenders will remain on the pharmacotherapy, and that they will be more likely to attend the adjunctive counselling.

Recommendation level 2/3

4.4 Psychosocial / Behaviour Change Interventions – Current Practices

The second group of AOD services are the psychosocial and behaviour change interventions, and these mirror those available for voluntary clients based around the principal treatment type of Counselling, Consultancy, and Continuing Care (CCCC).

Psychosocial and behaviour change service types may have a care-

coordination focus (e.g. Rural Outreach), a therapeutic focus (e.g. Specialist Pharmacotherapy, Residential Rehab), or be a combination of these two (e.g. CCCC). However, there are five key factors that need to be considered when determining which of the psychosocial interventions should be included in a future forensic AOD framework.

4.4.1 Consistency of Care

The overwhelming majority of psychosocial interventions purchased are of the CCCC type (Counselling, Consultancy and Continuing Care designated to encompass all centre-based psychological one-on-one outpatient interventions (although group based interventions can be included as a part of a CCCC episode of care, they cannot be the sole format). CCCC has a range of accepted significant treatment goals (STGs) which, when one or more have been attained, constitute an Episode of Care (EoC). Although both the general

and the forensic AOD systems offer the CCCC treatment type, the STGs prescribed are the same and neither specifies in what form or modality the counselling should be delivered.

STGs are not differentiated for forensic treatment and there are no standards of intervention across services

Most agencies describe providing this treatment type in a one-on-one format for both forensic and voluntary clients, with the specific orientation being chosen by the counsellor, and typically

comprising supportive, motivational, and relapse prevention counselling however there is no standardisation of what is required to be covered within a treatment episode.

4.4.2 Completion Rates

The second factor is the very low completion rates for the CCCC treatment type in the forensic AOD sector - approximately half attend a full treatment episode, averaging 3.8 contacts. Whilst some of this may be accounted for by variations to other treatment types, it is clear that most offenders will only attend a small number of sessions.

Most offenders will only attend a few counselling sessions

Whilst the goal may be to engage forensic clients in treatment for an adequate period, the attendance data strongly suggest that it may be more reflective to split the current CCCC type into two with the inclusion of an additional treatment of type of brief intervention for those who are highly resistant to engaging in treatment. This may also provide transparency to both treatment providers and correctional workers on the nature, intensity and likely outcomes of the intervention. Treatment would not have to be limited to brief interventions, and could be varied if the client develops treatment readiness.

The model for counselling should be changed to permit an adequate treatment dose of up to six months where indicated, within the same setting, and with the same clinician if therapeutically desirable.

Recommendation level 3/3

4.4.3 Re-episoding

A third way that forensic CCCC differ from voluntary CCCC concerns the capacity for counsellors to provide multiple episodes of counselling (and therefore a higher treatment dose) to voluntary clients, but not to forensic clients. A second forensically-funded CCCC episode may be available later in the order (subject to reassessment by COATS), if the client presents with

additional treatment needs². This short-term focus for those higher dependence clients who are willing to engage in treatment, is contrary to the

² The Drug Court program operating out of Dandenong is the only program to purchase treatment based upon caseload and duration of care, rather than discrete Episodes of Care, and this is similar to the Western Australian and Queensland models, where assessment includes determining the duration of an intervention.

literature and the NIDA principles that link treatment effectiveness to duration and recommend that three months is the minimum treatment dose for this client group.

This short-term focus is contrary to the core principles that link treatment effectiveness to duration and recommend that three months is the minimum dose for the forensic client population.

forensically funded initial episode of care can work well for clients with low-level antisocial traits and behaviours who are being treated within voluntary sector settings, as additional 'voluntary' episodes of care can be generated. This single episode of care model may also work well for those who are likely to only attend a brief intervention due to low treatment need, readiness or responsiveness. However, this model is inadequate for a significant proportion of forensic clients, who have longer-term treatment needs.

This model of having a single

4.4.4 Client Profile

The review of the population group in chapter 2 described how forensic AOD clients are a more heterogeneous group than voluntary clients. These differences may include:

- lower levels of treatment readiness (people with substance use issues may be picked up by the forensic system and referred to treatment earlier in their substance-using careers than if they self-referred),
- progression of substance use (occasional and recreational users of drugs and alcohol may be referred because of possession or intoxication related offences, even though they may not be dependent substance users),
- a greater prevalence of dual-needs clients in the context of co-occurring antisocial traits and possible personality disorder,
- different types of relationship between offending patterns and alcohol compared with offending and heroin,
- an increased proportion of males.

It is clear therefore that the skill-set and toolkit of a forensic clinician may need to be broader than that required for working with voluntary clients, due to the broader variety of presentations in this population group.

Forensic AOD counselling needs a greater emphasis upon enhancement of treatment readiness; early interventions for non-dependent users; understanding to work with antisocial attitudes and behaviours that are related to the substance use; recognition of the different offending and misuse patterns from different drugs; and specialist resources to ensure that the system is still able to meet the needs of female offenders.

Recommendation level 3/3

4.4.5 Treatment Objectives

It is clear that it is neither practical nor productive to order abstinence; hence orders issued in Victorian courts usually require assessment, with treatment only where indicated. However, the criminal justice system is charged with reducing offending behaviour, and is reliant on the forensic AOD system to conduct assessments and provide treatment consistent with justice system goals, including reduced reoffending.

Reducing offending behaviour related to AOD use has long been an accepted and proscribed significant treatment goal for both voluntary and forensic AOD services. Therefore, the fourth consideration for forensic AOD services should be that although treatment outcomes may not involve abstinence or explicit reduction of AOD use, they should nonetheless consider reduced offending related to AOD use.

Current forensic agencies describe primary focus upon AOD use, however, when treatment outcomes do not involve abstinence or explicit reduction of AOD use, forensic AOD treatment in future should consider treatment outcomes that focus upon reducing AOD use-related offending.

Recommendation level 2/3

4.5 Recommended Psycho-Social Treatment Types for the Victorian Forensic AOD System

In addition to the medical interventions of withdrawal and replacement pharmacotherapy described above, a range of psycho-social treatment types could be considered as a part of an holistic forensic AOD system, from brief interventions through to long-term residential rehabilitation.

As already discussed in this report, those clients with low AOD and low offending profiles may not be in need of formal AOD interventions, as their behaviour may have been driven by

other issues or concerns. As a result, these clients could be diverted away from the AOD system, into more generic community health services who provide a wider range of options (e.g. financial counselling, vocational counselling, grief counselling) and may be better placed to address the person's primary need. This also reduces the risk of net-widening, whereby persons are brought into contact with the AOD system who may not have primary AOD issues.

Those clients with low AOD and low offending profiles rather than being referred to AOD agencies as per current practices, may be better diverted into generic community health settings who provide a wider raft of counselling and support options.

Recommendation level 3/3

However, for the remainder of the client population, eight treatment types are recommended. These are summarised below, with a more detailed description provided in appendix C.

Eight psycho-social treatment types are recommended for the forensic AOD system

- 1) Brief intervention
- 2) Supportive Counselling/Outreach
- 3) Therapeutic AOD Counselling
- 4) Therapeutic Forensic AOD Counselling
- 5) Non-Residential Rehabilitation
- 6) Residential Rehabilitation
- 7) Forensic Residential Rehabilitation
- 8) Specialist forensic service

Recommendation level 3/3

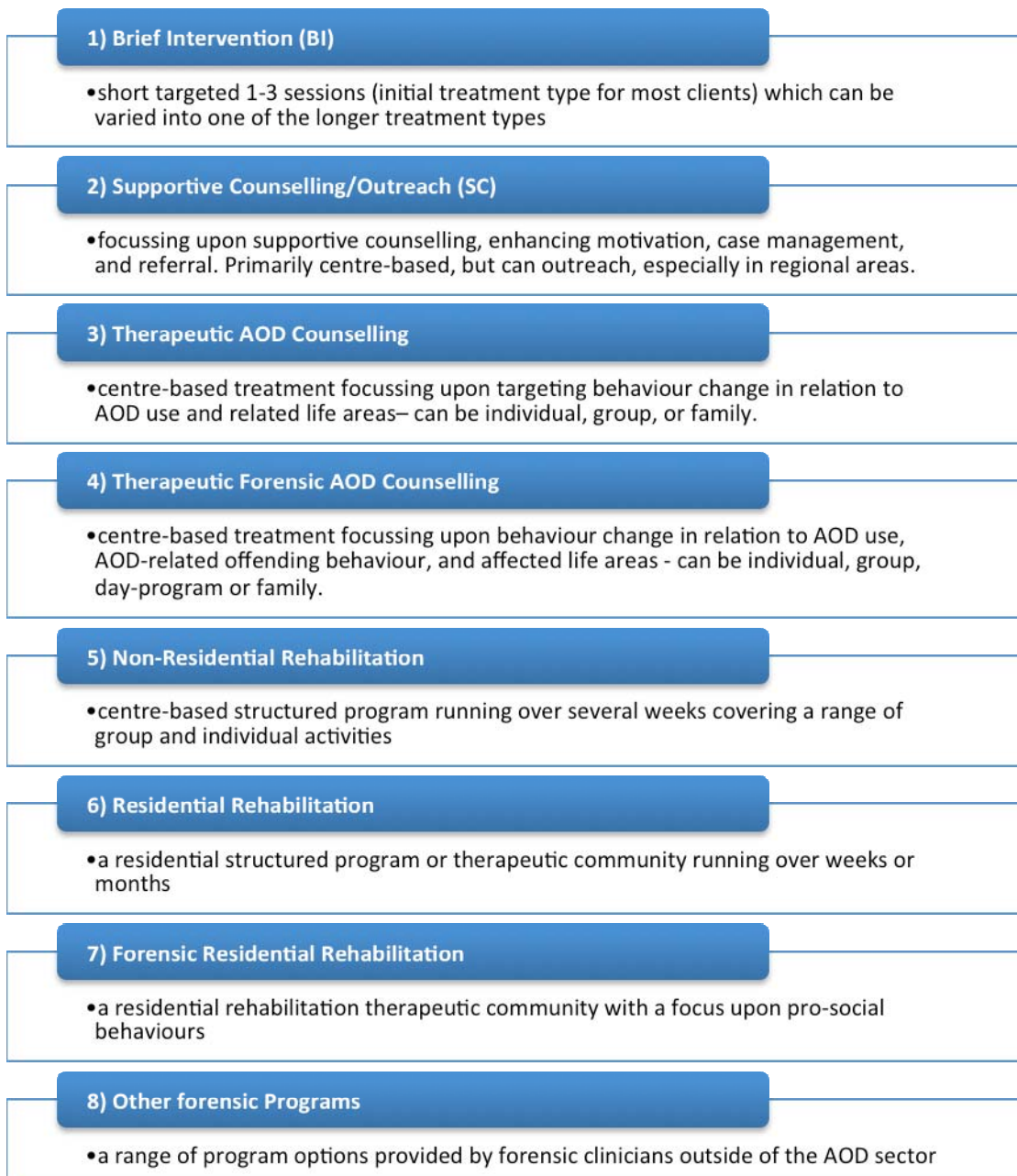


Figure 20: Eight proposed psycho-social treatment types.

1) Brief Interventions with or without assessment

For many low risk/low need forensic AOD clients one or two sessions is a sufficient level of intervention, while for many higher need, but low responsivity clients, one or two sessions may be all that they will attend. As a result, the preliminary treatment type recommended would be a brief intervention with a focus upon

assessment, crisis management, engagement, harm reduction, motivational enhancement and linkage with the option to varying this treatment into ongoing counselling where clients develops a willingness to engage further. Behaviour change per se would not be an expectation of this treatment type. Those clients who

initially present with higher levels of treatment responsiveness could still commence with this treatment type and be varied into longer-term counselling.

A formal assessment (or reassessment) would only be indicated for those who have not had recent or prior involvement with the forensic AOD system, or have not recently been assessed elsewhere in the system, and the filing of an Assessment report should be recognised as additional work on the part of the provider.

This first tier of intervention does not have to be limited to individual work. Rather, it can also include psycho-educational session with, or for, the clients' families and significant others,

as well as group based psycho-educational work. It could be centre-based at an AOD service provider, or delivered outreaching to Correctional Offices or other locations to maximise engagement. For non-dependent and low-criminogenic types (e.g. possession of cannabis) this could be a group-based intervention, like the Cautious with Cannabis programs currently provided in Victoria.

Brief intervention would focus upon assessment, crisis management, engagement, harm reduction, motivational enhancement and linkage.

There should be a new treatment of type of "brief intervention" focussing upon short-term goals such as harm reduction, linkage, or motivational enhancement for those who are resistant to engaging in, or unlikely to be responsive to treatment.

Recommendation level 3/3

2) Supportive counselling and Care Coordination

Supportive Counselling with Care coordination is similar to current outreach treatment types and could be considered as an intervention for clients who show a degree of willingness to engage and have a greater level of need, especially in terms of psycho-social support, but who have been assessed during the Brief Intervention as having low responsivity to formal treatment.

This type would focus upon support, practical assistance, and motivational enhancement and some case management.

practical assistance, motivational enhancement, and some case management. It is particularly beneficial for more complex clients, for examples those with an acquired brain injury or cognitive impairment who would not be able to benefit as fully from a direct therapeutic counselling model. While case management improves service linkages there is no conclusive evidence that case management itself reduces drug use (Cochrane Review, 2009).

It is not a therapy per se, having a supportive role with a focus upon

Supportive counselling would be indicated where this function is not being met by other services

As this treatment type has more of a care coordination focus, it would be indicated where this function is not being met by other services, such as Community Corrections or Area Mental Health Service, and where the psychosocial problems clearly are related to the person's AOD use. The level of case management support currently

provided by the Justice Sector is highly variable, with some areas providing intensive case management (e.g. CISP), and other providing limited or no case management. Hence, the challenge for forensic AOD services is to recognise the case management role provided by the correctional system, be responsive to it and not to duplicate it.

Correctional case management and the use of legal coercion have been shown to improve treatment outcomes (ChanhataSilpa, MacKenzie, & Hickman, 2000) by increasing retention in treatment.

Supportive Counselling as a service type would be indicated for low treatment readiness/responsive clients with significant needs, and focus upon motivational enhancement, harm reduction, general support and, where not provided by Justice or other service (e.g. courts without CREDIT or CISP), care coordination.

Recommendation level 3/3

3) Therapeutic AOD Counselling

Therapeutic AOD counselling is appropriate for those with both treatment need and moderate to high levels of treatment responsivity (unlike the previous type, being for those with treatment needs, but lower levels of responsivity). As a result, this type of intervention would focus specifically upon behaviour change in substance-using behaviour and associated offending behaviours, through insight, skills training and other psychotherapeutic methods.

Therapeutic AOD counselling would focus upon both behaviour change in substance-use and associated offending

behaviour change focus, including risky behaviour, offending behaviour, vocational development and enhancement of social skills and networks. Further significant and related areas such as trauma may also be addressed where the service provider has adequate skills sets. Although CBT is widely regarded as being a strong candidate for this level of intervention, it is important to recognise that at least some of this preference can be accounted for because of CBT's compatibility with empirical research methods.

In addition to individual approaches, day programs and group programs are also an effective option, and various agencies in Victoria have developed a range of such adjunctive programs, such as short group-based programs of two to four sessions designed to match

Other AOD related harm areas would also be legitimate focal points of

forensic clients' stage of change, complementing the individual counselling that clients were receiving. Evaluation of some of these interventions has found that these programs were well received by some participants, especially those at earlier stages of change. In addition, further to

NIDA principles about minimal treatment doses, and in recognition of the complexity of many AOD clients, it is recommended that Therapeutic Counselling be able to be delivered over an extended period, typically covering multiple significant treatment goals.

The current service type of Therapeutic AOD Counselling should only be offered to those forensic clients showing problematic substance use, but low levels of antisocial behaviour

Recommendation level 3/3

4) Forensic Therapeutic AOD Counselling

It is well acknowledged that whilst for some clients there is a direct relationship between their substance use and offending. However, as with the relationship between mental illness and AOD use, for many clients there is not a simple cause and effect relationship, and the two cannot be treated sequentially or in parallel, rather an integrated therapeutic intervention is required. Forensic Therapeutic AOD Counselling, provided through forensic AOD services by specially trained dual-focus clinicians, addresses this need, and in accordance with the NIDA 2009 principles, has a dual focus on both substance abuse and offending behaviour.

Specially trained dual-focus clinicians would be able to address both AOD use and associated offending

As with the previous treatment type, this treatment type need not be limited to individual counselling, but can also include group-based, day program and family interventions and should have the capacity to be delivered over an extended period with multiple treatment goals.

Forensic Therapeutic AOD Counselling as a service type would be indicated for moderate to high readiness and responsive clients with significant AOD-related needs related to their offending, along with moderate levels of antisocial behaviour. Focus would be upon both the substance use and any associated offending behaviour.

Recommendation level 3/3

5) Non-residential Rehabilitation

Non-residential rehabilitation AOD programs can take a variety of forms and have already been piloted in Victoria, including a six-week structured non-residential program for those with primarily alcohol-related concerns.

These programs are more comprehensive than the ad hoc or weekly group models described in the previous treatment types, providing a full non-residential structured program for up to six weeks. Attendance at voluntary sector programs may be appropriate for some clients, as such a pro-social environment can be highly beneficial for forensic clients with moderate to low levels of antisocial traits, providing an opportunity to experience challenges and observe and practice pro-social skills as they happen-

Furthermore, unlike residential rehabilitation programs, community

rehabilitation programs allow clients to engage in treatment while maintaining their life roles and responsibilities, and target a different population group from residential programs. Family commitments, financial constraints and the need for familiar social supports are some of the reasons why residential rehabilitation may not be suitable for some AOD clients, and conversely, complexity of AOD use and severity of other psycho-social problems may result in community rehabilitation being unsuitable for many clients.

Community rehabilitation programs allowing clients to engage in treatment while maintaining their life roles and responsibilities

Non-residential rehabilitation currently is available through one voluntary service provider. It could be considered as a forensic treatment type if there are adequate numbers of eligible clients in a particular location.

Recommendation level 2/3

6) Residential Rehabilitation

Residential Rehabilitation is not limited to residential group-based treatment types, but also includes Therapeutic Community (TC) or Modified Therapeutic Community (MTC) programs. These interventions provide a safe and secure environment in which to address the issues underlying substance abuse. Not all Residential Rehabilitation programs can be described as providing TC or MTC treatment as the defining feature of a TC is that it uses the 'community as method' with a focus on re-socialisation through the development of relationships, group therapy, and individual counselling (NIDA, 2003).

A defining feature of a TC is that it uses the 'community as method' with a focus on re-socialisation through the development of relationships.

Therapeutic Community treatment works well with AOD-dependent offenders because it takes a whole-of-life approach and aims to re-socialise the individual through the intense relationships developed within the community. The maladaptive lifestyle of the entrenched drug using offender

includes antisocial attitudes and beliefs, irresponsibility, rule breaking, poor coping, lack of self-efficacy and rigid thinking style are directly challenged through everyday life in the community.

Rehabilitation for this group needs to be at least three months duration to be

effective, but possibly closer to 12 months (NIDA, 2009). MTCs are adapted in some way to meet the particular needs of a group or environment and usually provide a more structured treatment approach.

Current residential rehabilitation services should continue to be provided for moderate risk clients with high levels of treatment need.

Recommendation level 3/3

7) Forensic Residential Rehabilitation

Forensic residential rehabilitation is a service type that is not currently funded in the community in Victoria, although there are two prison-based residential rehabilitation programs.

There are AOD residential rehabilitation programs within two Victorian prisons, the Dame Phyllis Frost Centre (DPFC) and Marngoneet Correctional Centre. DPFC is a 10 bed residential drug program for women prisoners and Marngoneet is a 300 bed treatment prison that houses the Station Peak unit which runs as a 100 bed modified AOD Therapeutic Community. Funding for these prison based AOD programs is managed by Victorian Department of Justice and as such they are currently separate from the community forensic AOD services overseen by the Department of Health.

Prison TCs provide an effective starting point for rehabilitation, even for offenders with low levels of motivation, because the system applies a level of coercion to keep them in treatment long enough for the change process to commence. Once the change process has commenced and the internal motivation to change increases they can fully participate in the treatment

process and continue it post release.

Prison TCs provide an effective starting point for offenders with low levels of motivation, because there is a level of coercion to keep them in treatment long enough for the change process to commence

Given the research data demonstrating the importance of attaching a post release component to prison based TCs to maximise treatment outcomes and the research stating that forensic AOD treatment for high risk/needs offenders must have an explicit focus on offending behaviour, there is a strong argument to suggest that community based TCs that do not explicitly focus on offending behaviour cannot appropriately meet the needs of high risk/need offenders, although they are likely to be highly effective for lower criminogenic risk forensic clients.

There is no data on the outcomes of TC treatment for forensic compared to voluntary clients in a mixed TC setting. It is likely that the best outcomes for forensic clients exiting prison would be achieved with the establishment of a

specialist forensic AOD TC in the community that has direct links to existing prison based TCs.

It is likely that the best outcomes for forensic clients exiting prison would be achieved with a specialist forensic AOD TC in the community that has direct links to existing prison based TCs.

Whilst prison-based TC have the support of the system and imprisonment to engage highly resistant offenders, in order to be effective in engaging high risk / high need offenders in the earliest stages of change a forensic AOD TC in the community would require significant support from the courts, including attendance under direction and substantial penalties for non-compliance.

Forensic residential rehabilitation should be provided for higher risk clients, especially those on parole from prison and who may have received Therapeutic Community-based treatment during their incarceration (i.e. those attending Marngoneet).

Recommendation level 3/3

It should be noted that while TCs are effective forms of treatment for most serious offenders, they are not appropriate for psychopathic individuals because they do not learn from relationships in the same way as most people, and are likely to exploit and manipulate the vulnerability of other community members.

At the other extreme, research has also shown that placing low risk/need offenders in intensive residential treatment designed for high risk offenders can also be counter-productive as it further entrenches them in criminal subculture (Taxman et al, 2007). In either case, it is clear that thorough assessment of criminogenic risk, substance related treatment need and personality factors (ASPD vs. psychopathy) is critical to successful residential rehabilitation.

8) Other Forensic Counselling

As outlined in chapter 2 there may also be forensic clients referred into the forensic AOD treatment system who are recreational drug users with relatively low AOD treatment needs, but significant offending behaviour treatment needs. These clients are currently referred into the forensic AOD treatment system because of a lack of more appropriate treatment types

suited to addressing their offending. Whilst some low level AOD treatment is probably indicated for these clients, AOD treatment alone will not reduce their offending behaviour and should be offered as an adjunct to more focussed offending behaviour treatment.

Where offenders have low level AOD treatment needs that these are addressed as a component of these more focussed offending behaviour programs

Community Corrections already offers offending behaviour treatment programs such as sex offender programs, violence programs and cognitive skills programs and it is suggested that where offenders have

low level AOD treatment needs that these are addressed as a component of offending behaviour programs provided by Community Corrections. This will ensure that treatment is holistic and integrated with a clear focus on offending behaviour. A current example of this type of intervention is the Alcohol Driven Aggression Psycho-educational Treatment (ADAPT) Program that was specifically developed in response to the increasing number of men with convictions for violent behaviour under the influence of alcohol.

Offenders with high levels of antisocial behaviour should be treated within the forensic system, rather than the forensic AOD system.

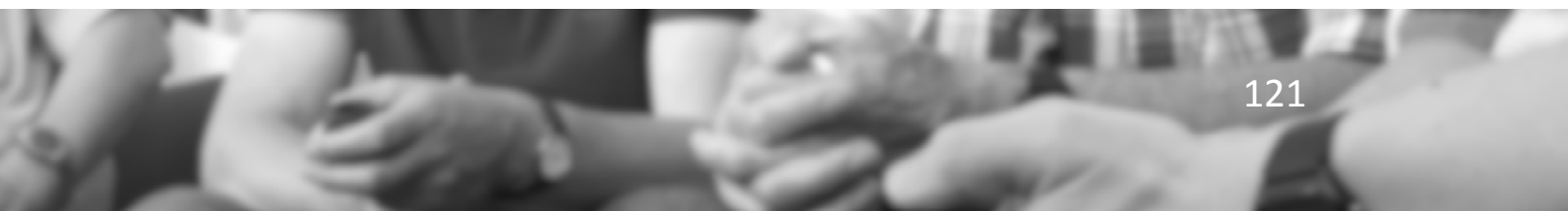
Recommendation level 3/3

Summary of treatment types

The figure below illustrates the relationship between the different treatment types described above and numbered 1 to 7, when mapped against client treatment need and treatment responsivity. For those clients identified as being low treatment responsivity, supportive counselling would be indicated. As treatment responsivity increases, the person may be eligible for

the other non-residential or residential services.

For clients identified as being low treatment responsivity, supportive counselling would be indicated, with therapeutic interventions indicated for those with higher responsivity.



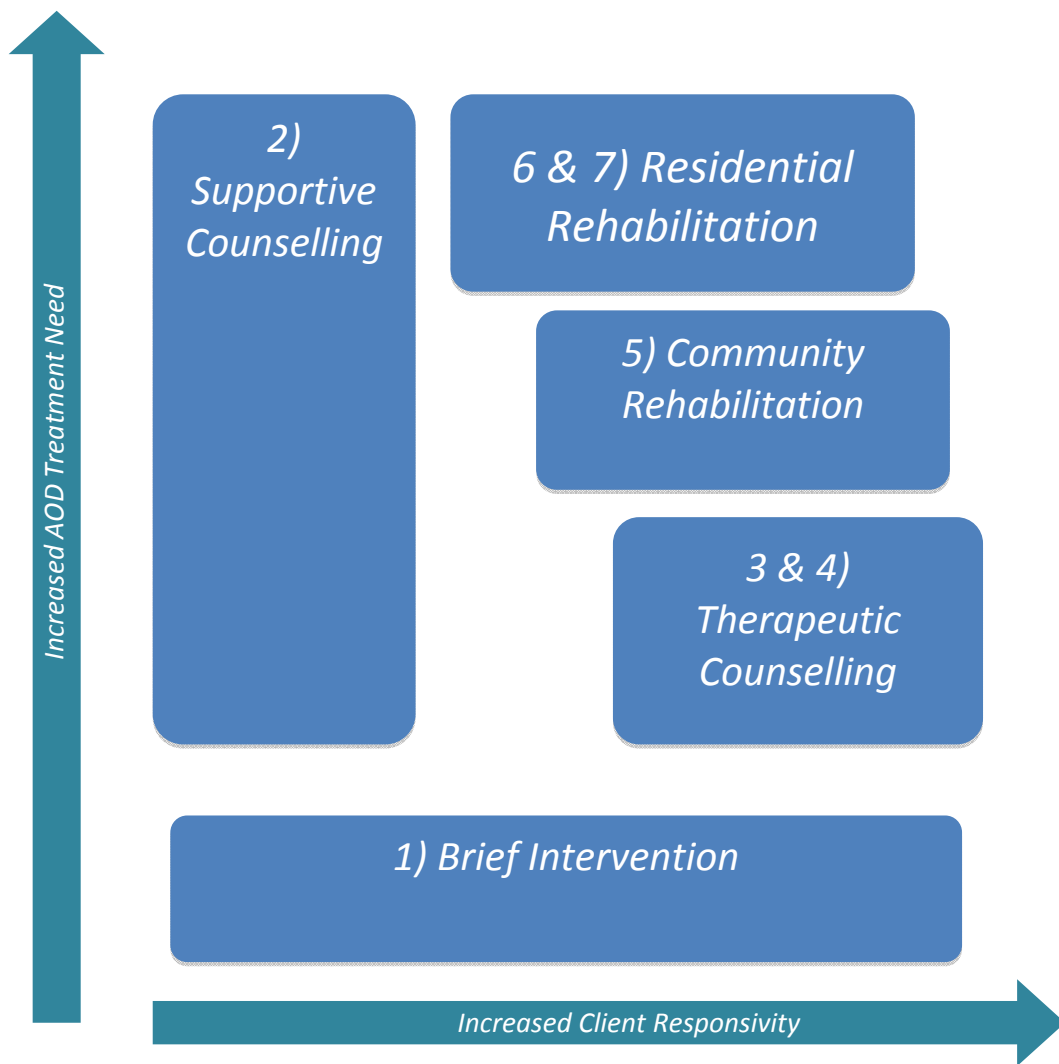


Figure 21: Mapping intervention against treatment need and client responsibility.

Summary

NIDA has emphasised four critical areas of focus for forensic AOD treatment that are consistent with the offender treatment literature. These are:

- Forensic AOD treatment should address both substance use & offending behaviour
- Forensic AOD treatment should include assessment & integrated treatment for substance abuse, offending, personality and mental health
- Offenders completing programs in prison need continuity of care into the community
- Forensic AOD workers and correctional staff should work collaboratively and treatment should be coordinated across both systems

These four principles represent a significant paradigm shift for some

voluntary AOD services, and different treatment types would require different

degrees of change. Whilst, in the case of medical interventions such as withdrawal or replacement pharmacotherapies, the intervention itself is not any different for forensic clients, there are issues around care and management that do differ.

Residential withdrawal is indicated for the same types of presentation in forensic clients as voluntary clients, primarily low offending/high dependence, and, with careful monitoring, moderate offending/high dependence.

The principle of using pharmacotherapy to create a stable lifestyle without crime will best apply to those offenders whose substance abuse is primary (low antisocial/high dependence). Co-locating replacement pharmacotherapy services, especially dispensing, with forensic AOD counselling services or even justice services may be indicated as an approach to be considered and trialled in Victoria, with the dual possible benefit of both increasing the likelihood that the offenders will remain on the pharmacotherapy, and that they will be more likely to attend the adjunctive counselling.

With regards to psycho-social interventions, those clients with low AOD and low offending profiles may be better diverted into generic community health settings who provide a wider range of counselling and support options. For the remainder, not only does the care and management need to broaden, but the treatment interventions may need to be adapted to be more suitable to a forensic population.

The low attendance rate for the current CCCC counselling suggests that clients presenting with treatment readiness may not receive an adequate therapeutic dose (NIDA recommends three months). Therefore, it is proposed that there be an additional treatment type, Brief Intervention, for those with low treatment readiness and an option for extending care up to recommended therapeutic doses.

Furthermore, counsellors working with forensic clients may need to place greater emphasis upon motivation and enhancement of treatment readiness; early interventions for non-dependent users; understanding to work with antisocial attitudes and behaviours that are related to the substance use; recognition of the different offending and misuse patterns from different drugs; and access to resources to ensure that they still able to meet the needs of female offenders. Where there is little or no readiness to change and treatment outcomes do not involve abstinence or explicit reduction of AOD use, they should nonetheless consider reduced offending related to AOD use.

In light of these issues, a range psycho-social interventions are recommended to form this aspect of the forensic AOD system in Victoria, with the appropriate intervention being determined by a combination of AOD need, offending need, and treatment responsivity. The eight recommended types are Brief Intervention, Supportive Counselling, Therapeutic AOD Counselling, Forensic Therapeutic AOD Counselling, Non-Residential Rehabilitation, Residential Rehabilitation, Forensic Residential Rehabilitation, and Specialist Forensic Services.

5 Screening and Assessment

This chapter commences by exploring some of the key principles that underpin effective and efficient screening and assessment of forensic AOD clients.

Key screening criteria are discussed initially, followed by a discussion around the purpose of a forensic AOD assessment and how to best assess forensic AOD clients, with a view to understanding the often complex relationship between their offending behaviour and their AOD use.

5.1 Principles of Screening and Assessment

For treatment to be both effective, and provide maximum impact within fixed resources, it is essential that proper screening and assessment are able to not only define the approximate typology of the client, but also determine their risks, needs, and responsiveness.

Reliable screening ensures that clients are directed to the most appropriate treatment pathway in the minimum number of steps, that clients with low treatment needs can be quickly

identified and diverted out of the forensic AOD treatment system, and that only those clients with significant treatment needs are referred on for a more thorough clinical forensic AOD assessment.

Reliable screening ensures that clients are directed to the most appropriate treatment pathway in the minimum number of steps

Mapping of the existing approaches to screening within the forensic AOD sector revealed considerable inconsistency in standards and approaches with no clear definition of problematic substance use. In some settings this has resulted in referrals for AOD treatment when there is no current treatment need. Magistrates may sometimes impose AOD assessment and treatment conditions on offenders who do not have significant AOD problems.

With regards to the current forensic AOD assessment process, there is very limited examination of offending behaviour, with assessors required to have no formal training in forensic assessment, and no standardised template to follow. Current forensic assessments tends to focus more upon

the offending history, and less upon extrapolating the relationship between substance abuse and offending behaviour.

The current assessment process involved very limited examination of offending behaviour and its relationship with AOD use.

Both the forensic and the AOD literature describe best practice interventions as consisting of distinct stages or activities. These include: screening, assessment, treatment planning, treatment provision and review/reassessment (CSAT, 2005). Screening and assessment are described below.

5.2 Screening

The screening process is usually quick, focussed and non-clinical and can be provided by a large range of personnel including: police, paramedics, court staff, prison officers, case-workers and community corrections staff (CSAT, 2005). Screening ensures that only those individuals with treatment needs are referred for more thorough assessment, enabling assessment and treatment resources to be directed to those with the greatest need.

Structured screening and assessment tools are more reliable and effective than clinical judgement alone.

The literature widely advocates the use of screening prior to an individual's first contact with forensic AOD treatment (Taxman et al, 2007; CSAT TIP 44, 2005). The incorporation of a sound model of

screening into standard practice is an important factor in ensuring early identification of risk factors for vulnerability, potential mental health problems and offending, and in reducing the cycle of admissions to the criminal justice system (Parsonage, 2009; Swan et al, 2008).

Research shows that structured screening and assessment tools are more reliable and effective than individual clinical judgement (CSAT, 2005). Screening aims to direct the right people to the right gateway for assessment. In the criminal justice system the screening can also be considered an "eligibility assessment" (CSAT, 2005) in that it asks "*is this person eligible for treatment?*" according to basic program rules or eligibility criteria. Hence, effective screening also requires clear eligibility or screen in and out criteria (Bull, 2005).

5.2.1 Stages of Screening

In forensic AOD treatment the first screening requirement explores for any risk factors that preclude current participation in treatment and require immediate attention. These may include, risk of self-harm/suicidality, mental health risks, significant health risks requiring immediate attention, housing crises etcetera. If such factors are present, they need to be addressed prior to further assessment for treatment.

The second screening requirement is to identify the presence of a clinically

significant substance-use disorder. Those with any evidence of a substance use disorder (not necessarily dependence) should be screened in and those without evidence of a substance use disorder should be screened out. This is important to prevent net widening whereby people enter the forensic treatment system without significant treatment need, as evidenced by Dematteo et al (2006) reporting that up to 30% of a sample of offenders referred to drug court programs did not have a clinically significant drug or alcohol problem.



Figure 22: Screening priorities

The third screening priority involves the offender's risk of reoffending. One of the fundamental principles of forensic treatment is the risk principle – which states that treatment resources should

be allocated in accordance with the offender's risk of reoffending (Bonta & Andrews, 2007). Higher risk offenders should be directed to intensive forensically-focused treatment based

upon a thorough assessment of their treatment needs, whereas low risk offenders should be directed to similar treatment services much akin to voluntary clients, and so they do not require a specialist forensic assessment, rather the standard AOD assessment at the service provider should suffice.

The fourth and final screening requirement is to look at specific

6.2.2 The Screening Tool

Screening needs to be systematic, standardised and straight-forward because of the diversity of staff that may be required to conduct screening, such as corrections officers, police, and court personnel.

Screening needs to be systematic, standardised and straight-forward because of the diversity of staff that conduct them.

Screening tools also require clear instructions so they can be administered using minimal clinical judgement. Staff need to understand how the screening process relates to the treatment pathway to ensure confidence in the process (Swan et al,

program/service eligibility factors, where these exist. These are usually not clinical factors but practical and immediately obvious factors such as: length of time available to complete the treatment program, gender, geography, language, age, and any exclusion criteria. If the individual does not meet the program requirements there is little point in referring for further assessment.

2008). Central to the usefulness and validity of any screening tool is the need for it to be specific to the local context, providing the depth and scope of information necessary for determining the presence of treatment need (although the specifics regarding treatment need would be determined during assessment).

The brief screen should be conducted at the entry points into the forensic AOD system, as well as by the telephone workers operating the DDAL referral line. Outcomes would be determined based upon risks identified in the screen, and details of these pathways are provided in the next chapter.

Table 2: Screening outcomes according to risk and levels of substance abuse.

Low	Low	Referral to Community Health
Low	Problematic	Referral for Generalist AOD Assessment
Moderate/High	Problematic	Referral for Specialist Forensic AOD Assessment
Moderate/High	Low	Referral back to Justice Services

Screening for forensic AOD treatment should be standardised and require minimal training and no clinical judgment to administer, due to the diversity of persons performing this function. It should not just focus upon AOD use as per the current approach, rather it should also focus upon the degree of antisocial attitude and behaviour, as well as eligibility for treatment and other risks of priority. Screening should determine whether a client is in need of specialist forensic AOD assessment, or general AOD assessment, or be diverted out of the forensic AOD or general AOD sectors.

Recommendation level 3/3

An example of a screening tool currently in use is the *Victorian Intervention Screening Assessment Tool (VISAT)* which was developed to assess a range of risk and needs factors, including AOD use and offending behaviour as well as other areas of relevance such as violent behaviour, housing and health. This simple tool can be completed incrementally, and generates risk/needs scores around each of the areas, enabling non-clinical staff to determine where further investigation is required.

The VISAT was developed specifically for Victorian context and is currently used to screen all offenders entering prison or Community Corrections and stakeholders from Corrections, Courts and the Adult Parole Board report high levels of confidence in its utility. It is not currently used for bail clients including CREDIT and CISP as well as caution stage clients, however given its prevalence within the criminal justice system, it makes sense to link the forensic AOD screening to the VISAT rather than implement a duplicate process.

The VISAT generates risk/needs scores around each of the areas, enabling non-clinical staff to determine where further investigation is required

and a shorter version of the tool will be available to provide immediate advice to the courts. This means from 2012 information about risk of reoffending and substance abuse treatment needs will be available in electronic format at the point of sentencing and able to guide initial decisions about referral for forensic AOD assessment.

The VISAT is currently undergoing redevelopment by Corrections Victoria

5.3 Clinical Assessment

The purpose of the clinical assessment is to look more thoroughly at all areas of treatment need and commence the process of treatment planning (Swan, Sciacchitano, Berends, 2008; Taxman et al, 2007). Therefore, those screened as having low AOD use and low offending risk could be screened out of the system and not require an AOD assessment as it is a resource-intensive activity and therefore it is recommended that it only be conducted on individuals with high treatment need.

requiring further investigation, one of two levels of assessment are recommended.

Referring back to table 2 again, a generalist AOD assessment could be conducted where there is low risk of offending and little evidence of antisocial traits, and a Specialist Forensic AOD Assessment could be offered where offending risk is higher and/or there is greater evidence of antisocial traits, in order to unravel the complex relationship described in the previous chapters.

Those with low AOD use / offending risk could be screened out of the system as AOD assessment is resource-intensive activity

Generalist AOD assessment could be conducted for those with low offending risk, and an SFAA could be conducted where offending risk is higher

However, where an issue is identified through the screening process as

There is currently a forensic supplement to the Victorian Specialist AOD Assessment and this is adequate for low offending risk client. However for higher risk clients, a Specialist Forensic AOD Assessment should be developed that explores the degree of antisocial personality, along with the relationship between AOD use and offending.

Recommendation level 3/3

The generalist AOD Assessment is similar to that conducted for voluntary

clients. The focus of the assessment is to understand the person's AOD use,



their readiness to change, and other general risk factors. Victoria has an AOD assessment tool, however all assessment processes and tools are currently under review. A Specialist Forensic AOD Assessment would have a greater forensic focus, includes all the

elements of a general AOD assessment but has an additional focus upon assessing the offending behaviour and attitudes and how these relate to the person's AOD use and their ability/responsivity to treatment.

Whether a generalist or specialist assessment is determined by the screening, the process should have four primary functions.

- 1) **Advice to Courts, Parole Board and Community Corrections** – the most appropriate treatment type, the most appropriate treatment provider and whether the client is currently ready for treatment. For medium and high offending risk clients the assessment would be used to provide clear advice back to the referring body on the relationship between substance use and offending. This enables clear conditions to be placed on orders that can be monitored by Community Corrections.
- 2) **Guidance for treatment providers** – the assessment report would need to document history and severity of the client's substance use as well as the offending behaviour. It would document the relationship between the substance use and offending behaviour, and outline a treatment plan with treatment goals. There would also be information about offending behaviour and antisocial attitudes for with moderate or higher risk of offending. As requested by providers, it would also note any engagement issues or risks, e.g. violence, sex offending, to ensure the safety of staff.
- 3) **Continuity of Care** – the assessment process brings continuity the assessment and treatment process by ensuring that assessment information is shared between corrections and AOD providers. All assessment data would ideally be held centrally by a Central Referral Service in a format that can build over time, also ensuring that the past assessment (and treatment) data creates a starting point for any new assessments and is integrated into the assessment report. This will assist with the creation of a continuous and seamless treatment experience for the client and avoid assessment fatigue.
- 4) **Pre and Post Measures** – the final function could be to provide a set of baseline measures that can be re-tested to show progress in treatment and demonstrate treatment effectiveness. The storage of all assessment data with the Central Referral Service will ensure a large data set is available for system-wide research and evaluation.

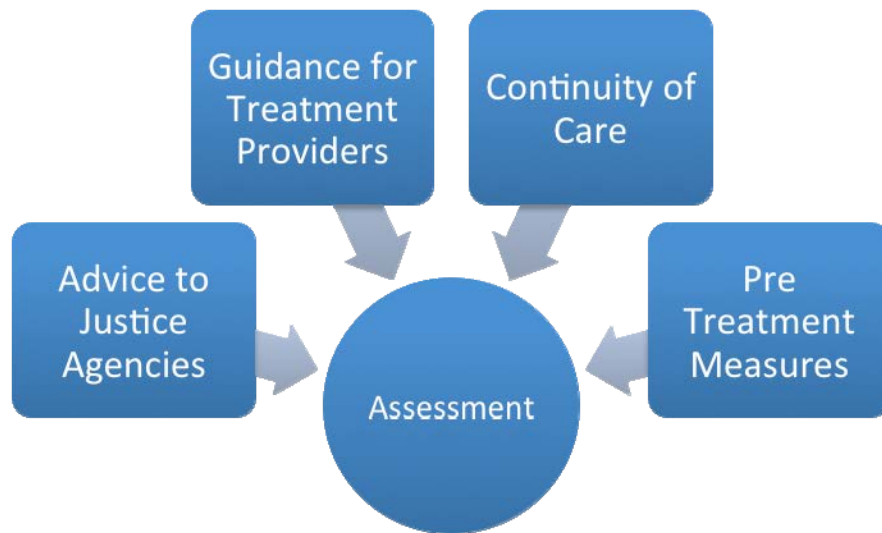


Figure 23: Four Functions of Forensic AOD Assessment

Both the standard AOD assessment, and the Specialist Forensic AOD Assessment, should have four functions: (i) advise courts, corrections and the parole board, (ii) provide guidance for treatment providers (iii) facilitate continuity of care, (iv) provide a basis for treatment measures. Assessors should be trained so that reports provide for all four functions.

Recommendation level 3/3

5.4 The SFAA Tool

The general AOD assessment could use a similar tool to the voluntary sector, with a report being provided based upon a standardised template. However, for the SFAA to fulfil all its functions, a new assessment template is required to ensure a consistent approach to forensic AOD assessment across the criminal justice system. This SFAA tool should be based upon a template that is

available in an electronic format and enables information to be readily shared, integrated, and updated.

Whilst it is beyond the scope of this report to develop the assessment tool, it is recommended that the SFAA tool should assess each of the following factors for the purposes of developing a treatment plan:

- Substance use
- Offending behaviour and antisocial traits
- Relationship between substance use and offending behaviour
- Mental Health Issues
- Physical Health Issues
- Psychosocial history
- Trauma
- Social situation
- Responsivity Issues
- Priority Risk Factors

The first three of these domains, and to a lesser degree, the last two domains, are particular to the forensic sector, and so the reasons for assessing them, the type of information that is required, how to interpret the information, and suggestions for potential measures are discussed in detail below.

5.4.1 Assessing Substance Use

Substance use is the primary reason for referral for assessment, hence it is the first focus of the SFAA. This aspect of the assessment is very similar to the standard approach to AOD assessment, however, clinicians need to be mindful around the reliability of self-report as the client may have reasons to exaggerate or minimise their substance use given the coerced nature of the referral.

Clinicians need to be mindful around the reliability of self-report as the client may exaggerate or minimise their substance use given the coerced nature of the referral

This being considered, the AOD assessment should focus on areas such as the type, nature, frequency, duration and patterns of alcohol use, drug use or poly-substance abuse. The focus is to determine the individual's experiences with substance abuse, their history and current using practices, previous attempts at change or abstinence and current levels of motivation to address their issues and commit to treatment (treatment readiness). It is also important to identify triggers, circumstances of vulnerability, lapses/relapses and risk of self-harm or overdose.

The usual elements of a clinical assessment also apply to assessing substance abuse thoroughly such as mental/physical health history, trauma, family structure and generational patterns, social supports and other pro-

social structures, co-dependent using relationships and previous experiences in treatment.

At the completion of this part of the assessment it should be reasonably clear whether the client is a recreational, situational, or dependent user, their pattern of substance use, the extent to which their substance use interferes with daily living, patterns of substance use and specific drug related risks and harms. This should provide a good indicator as to their treatment needs from an AOD perspective.

This is where this process differs in terms of breadth of the assessment. Whereas voluntary AOD assessment may be driven by the service type for which the client is being assessed (e.g. residential rehabilitation, counselling, pharmacotherapy or withdrawal), forensic sector AOD assessment needs to be more holistic in focus as it often brings together a broader treatment plan than voluntary assessment. As a result, the clinician needs considerable familiarity with the AOD treatment sector, with an understanding of not only the service types provided by their agency, but also of service types and eligibility criteria provided of other services.

Whereas voluntary sector assessments may be driven by the service type offered e.g. residential withdrawal, forensic assessments need to be more holistic in focus.

For example, different Community

Residential Drug Withdrawal Units vary in terms of the complexity of client that they are able to manage due to varying

levels of medical support available on site.

5.4.2 Assessing Offending

Under the proposed model, all offenders referred for the SFAA will have already been screened for risk of reoffending and will be in the medium or high categories, hence their need for a specialist rather than generalist assessment. At screening the risk of reoffending would be calculated using a formula based on static historical factors with little examination of the

actual offences. At assessment it is important to fully examine the offending behaviour and understand its function in the client’s life in order to assess its relationship to their substance use. This involves examining the nature and seriousness of the current offence, the client’s offending history and the presence of antisocial traits.

Current Offence

The assessment should include a detailed account of the current offence. A police report or court transcript may accompany the referral details, but it is also important to hear the offenders account and pay attention to the way they discuss it. Some offenders minimise, justify and blame others for their offences; others will take responsibility and demonstrate empathy for their victims. The timing of the offence, the events leading up to it and the effect of the substance use (e.g. when intoxicated or in withdrawal) on the offence should also be examined.

Violent offences and those against people are fundamentally different to property offences and indicate a higher risk.

Violent and impulsive offences are often indicative of an antisocial offender, more so when there is a history of violent crime (Douglas & Skeem, 2005). If the current offence is violent it is important to determine if the offender was intoxicated or withdrawing at the time of the offence.

If the current offence is violent it is important to determine if the offender was intoxicated or withdrawing at the time.

The nature and seriousness of the offence is also important. While, the majority of substance-using offenders have possession offences and many will have committed acquisition offences to support their substance use, nearly half will have committed violent offences. Violent offences or offences against other people are fundamentally different to property offences and indicate a higher risk of reoffending (CSAT, 2005).

so, specific details on what substances were used and when they were used are required. The client’s history of violence will provide important context for this examination. A long history of violence across a range of situations would suggest the primary focus of

treatment should be on their offending behaviour. Even when violence only occurs under the influence of substances, research suggests this is indicative of underlying violent tendencies that need to be treated rather than a simple consequence of substance use (Pihl et al, 2003).

Offending History

The client's offending history also provides important information when trying to assess the typology. First time offenders will generally be assessed as low risk, unless their offence was particularly violent or of a sexual nature. This means that nearly all offenders who are medium to high risk and referred for an assessment are likely to have prior offences.

Examination of the offending history should reveal whether the offending developed in response to the substance use, if the client was offending before they commenced using substances or if the behaviours developed concurrently. Research shows that the younger the age at which offending commenced and the longer the criminal history, the higher the risk of reoffending.

Early offending and juvenile justice history are indicators of antisocial personality traits and assessors should pay close attention to client's age at first offence as a predictor of treatment responsivity and likelihood of recidivism (CSAT, 2005).

The focus on the degree of violence is critical to determining whether the offender is best treated in the forensic AOD system or in a corrections-based offending behaviour treatment program, such as the Violence Intervention Program or the Alcohol Driven Aggression Psycho-educational Treatment (ADAPT) program.

The younger a client at their first offence, the lower the likelihood that they would complete their current adult forensic treatment episode.

Where a client's offending behaviour preceded their substance use clinicians should carefully assess for the presence of antisocial personality traits (The Forensic Psychology Research Group, 2003) or evidence of past conduct disorder.

An association between age at first offence and treatment responsivity was clearly demonstrated in the evaluation of the SEADS Forensic Interventions Unit (FIU) in Dandenong, Victoria which found that the younger a client was at their first offence, the lower the likelihood that they would complete their current adult forensic treatment episode (Caraniche, 2009). The SEADS FIU evaluation also found a significant relationship between number of past convictions and likelihood to complete treatment. 80% of those with two or fewer prior offences completed treatment, whereas this figure dropped to less than 50% for those with three or more prior offences.

Antisocial Personality Traits

The identification of antisocial traits provides valuable information with regard to the client's risk of reoffending, as well as their treatment needs and responsiveness. The general antisocial behaviour and attitudes of some clients presents a significant barrier to engagement and will determine whether a client is better suited to a forensic AOD service or a corrections-based forensic service. The crucial question for assessment is the extent to which these traits are present, ranging from not present at all, through to clinically diagnosable personality disorder (Dick et al, 2008).

A thorough review of the client's offence history, in conjunction with clinical observations of the client, will provide clinicians with a good indication of the presence of antisocial traits. Diagnosis of antisocial personality disorder, however, should be conducted using a standardised assessment tool that has been validated for use with offender populations, (Dick et al, 2008). A diagnosis can only be made by appropriately trained and qualified staff, and where a client attends with a

presentation which appears to fit the criteria of APD or psychopathy, referral for forensic assessment should be made. (Dick et al, 2008).

A thorough review of the client's offence history, along with clinical observations, will provide a good indication of antisocial traits / personality.

Other factors to consider when assessing clients for antisocial personality traits include any associations with offenders, including partners, peers and family members, co-occurring mental health issues, maladaptive responses to coping with environmental stressors and previous non compliance with treatment (CSAT, 2005; Dick et al, 2008). Clients who present with these risk factors are more likely to reoffend and are harder to rehabilitate both in terms of offending and substance use, either because they drop out or do not respond to treatment (CSAT, 2005).

5.4.3 The Relationship between Substance Use and Offending

The purpose of gathering information about substance use, offending (current and historical) and the degree of antisocial traits is to understand the relationship between them and use this to identify the client's typology and the most appropriate treatment option and setting.

The relationship between alcohol, drugs and crime is complex and varies for different individuals as well as across different drugs. For instance, the relationship might be causal whereby crimes are committed to support illicit drug use, or while under the influence of drugs or alcohol (or the two might be

unrelated). Where the relationship is causal, addressing the precipitating factor (typically substance use) may lead to a reduction of both behaviours. Where they are unrelated the extent to which either offending or substance use are the target of intervention will depend on the extent to which each of the behaviours is present at problematic levels (The Forensic Psychology Research Group, 2003). Other questions to consider include:

- Was the offender intoxicated at the time of the offence?
- Was the offender in withdrawal at the time of the offence?

- Did the offender plan the behaviour whilst sober, or was it decided when intoxicated/withdrawal?
- Does the individual offend when not intoxicated/withdrawal?

As described above, important factors to consider in assessing the nature of the relationship between substance use and offending are the age of onset for each, the types of substances used and types of crimes committed, the particular circumstances in which substance use and offending occur, the level of intoxication or withdrawal at the time of the offence, and the presence of risk factors that are common to each such as cognitive impairment, psychiatric disorders or a history of trauma or abuse.

Factors to assess the relationship between AOD use and offending include: the age of onset for each, the substances used, types of crimes committed, circumstances in which substance use and offending occur, and level of intoxication / withdrawal at the time of the offence.

Where an SFAA occurs at court prior to sentencing, the strength of the relationship between substance use and offending is critical for the sentencing process. If the relationship is clearly defined, a judge or magistrate may be more confident in imposing a sentence that mandates treatment and involves substantial penalties for failure to comply. If no relationship or only a weak relationship exists, there may be a greater focus on punitive sentencing responses.

5.4.4 Assessing for Client Type & Matching to Treatment

Chapter 2 identified six typologies of illicit-substance using offenders, based upon the extent of substance dependence and degree of entrenched offending behaviour. Substance use ranged from low to high dependence, while offending behaviour is described in terms of low (i.e. minor possession offences), moderate (i.e. acquisitive and other property offences) and high (i.e. violent) offending. These categories reflect points on a continuum of substance use and offending, and it is the relationship between the two that determines the particular client typology.

The overall purpose of assessment, therefore, is to identify the particular typology that is most descriptive of the client, as this will provide information about the treatment needs and responsivity of the client, as well as the most appropriate referral pathway.

The information collected through the SFAA aims to clarify the typology of the client and what types of treatments are most appropriate. The SFAA would rarely be conducted on low risk offenders, as these should be diverted out to a community-based treatment that matches their AOD treatment need. Low risk offenders with low or no

substance use will be referred directly out to a generic community health provider to work on any lifestyle issues

and problems, but not to an AOD service.

Table 3: Risk of Reoffending against level of dependence guiding referral pathways

Community Health Service <i>Lifestyle & Wellbeing</i>	Specialist Forensic Service <i>Offending Behaviour</i>	Specialist Forensic Service <i>Offending Behaviour</i>
Community AOD Service <i>AOD Treatment</i>	Forensic AOD Service <i>AOD & Offending</i>	Specialist Forensic Service <i>Offending & AOD</i>

5.4.5 Assessment of Other Treatment Needs

Like all clients in the AOD treatment system, forensic AOD clients need comprehensive and integrated service delivery. The SFAA cannot purely focus on substance issues and offending behaviour but must also look at these issues in the context of the whole person.

Forensic treatment considers needs as any factors that contribute to the individual’s offending behaviour. These are called criminogenic needs and include antisocial attitudes, criminal peers, substance abuse, anger, and poor problem solving skills (Taxman, Thanner & Weisburd, 2006) personality factors, cognitive appraisals about offending, arousal and self control, and psychopathology (Howells & Day, 1999).

Forensic treatment considers criminogenic needs - any factors that contribute to the offending behaviour.

However, in forensic AOD treatment needs should be more broadly defined and not limited to just those factors that reduce reoffending. Ward’s (2002) “Good Lives Model” provides a more appropriate framework for understanding forensic AOD treatment needs. Under the Good Lives Model, treatment aims to address the offender’s needs and reduce their risk of reoffending through the provision of treatment aimed at developing the skills and values to live a “good” or more functional and pro-social life and



increase well-being. A critical component of the SFAA is an assessment of the other lifestyle factors or skill areas that if developed and enhanced will increase the client's ability to live a more pro-social life.

Forensic AOD clients often have long histories of psychosocial problems that have contributed to substance use and criminal involvement, including interpersonal difficulties with families and intimate partners, emotional and psychological difficulties, trouble managing anger and stress, educational and vocational skills deficits and employment problems (CSAT, 2005). They may have co-occurring mental health issues, cognitive impairment or childhood experiences of trauma, abuse and neglect (Caraniche, 2009; The Forensic Psychology Research Group, 2003; Messina, Grella, Burdon & Prendergast, 2007).

Forensic AOD clients may be facing stressors related to their justice matters that may exacerbate their substance use.

Forensic AOD clients are also likely to be facing a number of current stressors related to their involvement with the criminal justice system that may exacerbate their substance use, such as pending court dates and the possibility of incarceration, or adjustment issues related to release from prison (CSAT, 2005). It is crucial to treatment outcomes that the assessment process is able to identify both short and long-term needs of clients. Attempts to address long term criminogenic needs may be unsuccessful if more immediate needs are not addressed first (Butzin, Saum & Scarpitti, 2002). Some offenders may need to learn basic

psychosocial skills such as emotional self-regulation, communication, and anger management prior to being able to engage appropriately with support services.

It is essential to assess both the client's level of motivation, and their ability to engage in and respond to treatment.

A further key focus of needs assessment is trauma. A history of trauma is common in offending populations, particularly among women and those with substance use problems. Trauma, PTSD and their potential contribution to both substance use and offending therefore need to be assessed, particularly in women. In a Victorian study of substance using female prisoners Pollard and Baker (2000) found that the women showed significant symptoms of PTSD and reported high levels of abuse, with 53% reporting physical abuse in childhood, 66% reporting neglect and 38% reporting sexual abuse.

The SFAA assessment must consider all of these needs and make recommendations about which are the priority for intervention or case management. Once the targets for case management have been identified, how they are to be provided can be negotiated. Some will be best provided through correctional case management (e.g. CISP), whilst others may be best provided through the forensic AOD system. The critical factor is that there is a process for identifying and sharing information about the clients' treatment needs and that there is an integrated approach to addressing them, regardless of who is providing case management. This is discussed further in chapter 6.

5.4.6 Assessing Treatment Responsivity

Responsivity is a fundamental principle of offender treatment because the client group is often poorly motivated and difficult to engage. Offender treatment frameworks recognise that significant effort needs to be put into working with forensic clients to increase their motivation if treatment is going to be effective. Hence, gauging both the client's level of motivation, and their

ability to engage in and respond to treatment, are essential features of assessment. Identifying the actions the client and the service provider can take to increase engagement and treatment retention are also important parts of the treatment planning and referral process. A comprehensive assessment and treatment plan is pointless if the client does not attend for treatment.

Motivation

Treatment readiness or motivation for change is a key responsivity factor that should be identified in the SFAA and considered during treatment planning and provision. For treatment to be effective it must be tailored or matched to the individual's level of readiness for change. Motivation is a dynamic factor that changes over time and needs to be monitored throughout the treatment process. Treatment readiness is influenced by a range of internal factors such as beliefs about treatment, past experience of treatment, treatment goals, and capacity for insight, as well as external factors such as coercion, and perceptions of the treatment setting and treatment staff (Casey, Day, Howells & Ward, 2007).

Low motivation for change is common among forensic populations but should not be considered an obstacle to treatment.

Whilst low motivation for change is common among forensic populations and may be used as a rationale for not providing AOD treatment, it should not be considered an obstacle to treatment given the availability of targeted motivational enhancement therapies. Research shows that mandatory or legally coerced treatment provides an important role in encouraging offenders to access and stay in treatment (NIDA, 2006) and various studies suggest that coerced treatment is associated with better outcomes including reduced recidivism (Hussain & Cowie, 2005; Anglin & Maugh, 1992; Falkin et al 1992; Pearce & Holbrook, 2002).

Ideally, clients who are assessed as having low treatment motivation are provided with motivational enhancement interventions as the starting point of treatment (NIDA, 2006).

Cultural Factors

The particular needs of clients with poor literacy and communication skills,

cognitive impairment and culturally and linguistically diverse (CALD)

backgrounds also need to be considered when determining treatment responsiveness.

Assessment processes need both to identify such needs, and at the same time be tailored to accommodate them if clients are to be responsive to assessment and subsequent treatment (CSAT, 2005).

Assessors must be aware of the importance of the client's cultural identity and their extent of acculturation in the dominant culture. It is important to recognise that institutional and individual

discrimination may exist in the criminal justice system and this may negatively affect the assessment process (CSAT, 2005). For this reason it is critical that culturally and linguistically competent staff are available to conduct assessments with clients.

It is important to recognise that discrimination may exist in the criminal justice system and this may negatively affect the assessment process.

System Responsivity

System responsivity involves delivering treatment to the client in a way that maximises their ability to engage with and gain from it. It is about the system tailoring the treatment to the individual needs of the client and can range from internal factors such as learning style, motivation, language and cognitive capacity to external factors such as ease of access and convenience.

External system factors are likely to impact on client's responsivity to assessment and treatment. Child-care and other family responsibilities, employment responsibilities, lack of transport, unstable accommodation and

financial troubles can make attending appointments and accessing treatment difficult, even if motivation to attend is high. When such issues are identified during assessment, and treatment plans are developed to assist with or accommodate for factors that would otherwise be an obstacle to engagement, then responsivity to treatment and treatment outcomes are likely to be enhanced. Further, addressing external barriers to treatment engagement is of particular importance to mandated clients who may be further penalised for non-attendance.

5.5 Summary

Reliable screening ensures that clients are directed to the most appropriate treatment pathway in the minimum number of steps, with those with low treatment need being diverted out of the forensic AOD system and specialist resources only being allocated to those with complex needs. Screening in the forensic AOD system needs to identify four key points: (i) risk factors that

require immediate attention; (ii) the presence of problematic AOD use; (iii) the level of risk of re-offending, and (iv) the person's eligibility for treatment.

Screening tools can greatly enhance the reliability of the screening process, especially given the diverse array of persons who may be responsible for this task and an example of such a tool, already in use in the forensic system.

Screening would determine that the person should either (i) be diverted out of the forensic AOD system due to low needs, (ii) be referred to a community AOD agency for a general assessment, (iii) be referred for a Specialist Forensic AOD Assessment, or (iv) be referred back to justice services. Specialist Forensic AOD Assessment includes all the elements of a general AOD assessment but has an additional focus upon assessing the offending behaviour and attitudes and how these relate to the person's AOD use and their ability/responsivity to treatment.

The SFAA should have four functions: (i) to advise courts, corrections and the parole board, (ii) to provide guidance for treatment providers (iii) to facilitate continuity of care, (iv) to provide a basis for treatment measures. In order to achieve this, assessment needs to identify the particular typology that is most descriptive of the client, as this will provide information about the treatment needs and responsivity of the client, as well as the most appropriate referral pathway.

The AOD history should focus on areas such as the type, nature, frequency, duration and patterns of alcohol use, drug use or poly-substance abuse. The nature and seriousness of the offence should be described, as violent offences or offences against other people are fundamentally different to property offences and indicate a higher risk of reoffending. Offending history is also

relevant, with multiple prior offences being indicative of increased risk, and the younger the age of client at their first offence, the lower the likelihood that they would complete their current adult forensic treatment episode. A thorough review of the client's offence history, along with clinical observations, will provide a good indication of antisocial traits / personality. Factors to assess when establishing the relationship between AOD use and offending include: the age of onset for each, the substances used, the types of crimes committed, the circumstances in which substance use and offending occur, and the level of intoxication / withdrawal at the time of the offence.

Forensic clients, like all other clients, are likely to present with a range of additional needs. Many of these can be classified as criminogenic, as they have a direct impact upon the offending behaviour, and it is essential that these be considered in the assessment process, along with the impact upon the individual of the justice process itself. It is also essential to gauge both the client's level of motivation, and their ability to engage in and respond to treatment, and this underpins the assessment of responsivity. Low motivation for change is common among forensic populations but should not be considered an obstacle to treatment given the availability of targeted motivational enhancement therapies.

6 Workforce

This chapter provides an overview of the recommended workforce for each of these service types, including training and skills required, as well as a suggested career pathway to assist with skill retention in the sector. Supervision and professional development and workforce planning needs are also described.

6.1 Current Framework

Workforce requirements have been the source of much discussion in the AOD sector and this was one of the driving factors behind the introduction in Victoria of a minimum level of competency for workers in DH funded agencies (Victorian Government, 2004). For non-tertiary qualified workers who

are new to the sector, the minimum requirement is a Certificate IV in Alcohol and Other Drugs Work. Those entering with a health, social or behavioural science tertiary qualification require four core AOD competencies from the Cert IV.

These competencies are:

- CHCAOD402A - Work effectively in the AOD sector.
- CHCAOD406D - Work with clients who are intoxicated.
- CHCAOD408A - Assess needs of clients with AOD issues.
- CHCMH401A - Work effectively in the Mental Health sector.

This up-skilling brought some core skills to the voluntary AOD sector along with a greater degree of shared understanding and language around working with clients with AOD issues.

However, as with any type of minimum standards, there is a risk that they will be misconstrued as a recommended or ideal standard for the workforce.

There is a risk that a minimum required standard will be misconstrued as a recommended or ideal standard for the workforce

This is clearly not the intention in the AOD sector, given the heterogeneity of the services in Victoria and the diverse skill-sets required. For example, there is no requirement that persons counselling forensic AOD clients have training in either forensic matters, or counselling and psychotherapeutic technique.

There is no current requirement for forensic AOD counsellors to have training in either forensic issues, or counselling

Currently, the uniform standard across the sector only defines the basic shared skill-sets, and the core competencies do not go further to prescribe the particular skill-sets required for individual roles such as assessment workers, counselling staff, and residential withdrawal unit support staff. Rather, these criteria are left for each individual agency to determine, usually in line with its own resourcing strategy.

It is well recognised that the skills and attitudes of AOD clinicians are critical to effective treatment (Turning Point, 2010; Hubble, Duncan, & Miller, 1999; McNeill, Batchelor, Burnett, & Knox, 2005). AOD clinicians need appropriate training and supervision and there needs to be a match between staff skills and roles (Andrews et al, 1990; Miller & Rollnick, 1991; Forensic Psychology Research Group, 2003).

AOD clinicians need appropriate training and supervision and there needs to be a match between staff skills and roles

The pathways for workers into AOD counselling are diverse and range from peer roles or a past personal history of addiction, to certificate courses, to post graduate university degrees in a health or welfare discipline, with a significant proportion having no accredited qualifications (Roche & Pidd, 2010). Even those with tertiary health qualifications will often have had no specific training in AOD issues or AOD treatment. Regardless of qualifications, staff members need specific training in the interventions they are required to deliver (Forensic Psychology Research Group, 2003; Andrews et al, 1990; Hussain & Cowie, 2005).

6.2 Core skills for Forensic AOD Staff

Specific suggestions regarding the profile of Victoria's AOD workforce have already been described in the Turning Point review (2003), and it is not the intention of this report to repeat such a review.

However, as chapter 1 described, there are some issues that need to be considered when working with forensic populations, due to variations in the

profile between voluntary and forensic clients presenting at treatment. These differences can exist on a range of dimensions including treatment readiness and personality presentation.

The literature and interviews confirm this, and suggest a range of principles that can be considered to assist clinicians to improve their ability to provide the best outcomes in light of

some of the additional needs and challenges for forensic clients.

These include:

1. Understanding criminogenic personality traits, along with the differing degrees to which the person presents with antisocial traits and behaviours and how to adapt therapeutic approach and worker boundaries accordingly (Dick et al, 2008; CSAT TIP 44, 2005);
2. Recognition and understanding of the motivational states of mandated clients in relation to their alcohol and other drug use, and how to adapt engagement style (NIDA, 2006);
3. Recognising the relationship between the person's AOD use and their offending behaviour, particularly violent behaviour, and addressing it where appropriate (Taxman et al, 2007, NIDA 2006);
4. The interpersonal relating style of the person and how they react to perceived power and control (especially those who have personality styles high on measures of dominance).
5. Specific skills in working with alcohol related offending and the ways that different drugs can interact with offending behaviour (nearly half of the forensic AOD client group report primary problems with alcohol).
6. Establishing, despite the presence of AOD use and/or a criminal justice order, whether there is any substantial treatment need, or if a brief educational intervention would suffice (i.e. those clients who have low levels of AOD use that would not be 'treated' in the voluntary system) (DeMatteo et al, 2006; NIDA, 2006);
7. The capacity to provide brief interventions, with a clear focus on specific treatment goals, as an alternative to providing more traditional counselling interventions (Dick et al, 2008);
8. Understanding the specific impacts and possible trauma related to involvement in the justice system, including police and court experiences and the impact of incarceration (CSAT, 2005);
9. Additional capacity for screening for brain injury given this population's over representation in the forensic system (Schofield et al, 2006);
10. Understanding of the systems and processes that make up the forensic AOD system, including the intent behind sentencing, order requirements around reporting and treatment planning (CSAT, 1996; Bull, 2005);
11. Core skills around collaborative practice across different stakeholder requirements, both across and along the continuum of care (CSAT, 1995; 2005);
12. Confidentiality training and report writing, including privacy legislation, Health Records Act, consent forms and release of information, file notes, duty of care, mandatory reporting and reporting protocols (Hussain & Cowie, 2005).

There are no core skills required of a forensic workforce. All forensic counselling and assessment staff should be accredited in the areas described in this section.

Recommendation level 3/3

There is currently no body coordinating forensic training. A centralised Forensic AOD profession development program should be established to ensure access to appropriate training for the purposes of accreditation.

Recommendation level 3/3

6.3 Screening Roles

Because forensic clients can be screened to determine their eligibility and suitability for AOD treatment at various stages within the criminal justice system, screening is generally conducted by a wider range of professionals and agencies than formal assessment. This can include police, responsible for screening those charged with minor drug offences to determine their eligibility for cautioning and brief assessment and intervention programs,

Court Officers, Corrections Officers, and staff on the telephone intake.

The skill set required should be kept to the minimum given this highly diverse group, and so the determination of suitability for services should best be determined, as in the case of persons currently screened by Corrections Officers, by a standard tool and formula describing risk, rather than relying upon any particular clinical judgement.

It is recommended that no specific clinical skills be required for screening roles, however screening staff should be trained in the use of the screening tool.

Recommendation level 2/3

6.4 Assessment Staff

Currently, assessment by community providers in the Victorian forensic AOD sector for presentence or other diversion programs requires accreditation, a process that is overseen by the Department of Health. However, this process does not require any formal training in forensic treatment or assessment and is seen more as an extended voluntary assessment.

Low offending profile clients may still be appropriately assessed by the current assessors, however medium to high-risk offenders with more interrelated AOD use and offending behaviour, who are being referred for Specialist Forensic AOD Assessment (SFAA) require assessors with specialised expertise and training.

These include training around:

- tailoring a report to meet the needs of the purpose of the assessment (e.g. for treatment planning, or to guide the court),
- the areas the assessment examines (AOD use, offending Behaviour, and the often complex interaction between the two),
- and the breadth of the assessment (rather than assessing for a limited range of service types provided by that AOD service, forensic assessment needs to consider the full raft of available options across the sector).

It is recommended that staff conducting SFAAs are accredited based upon not only their expertise in AOD treatment, but also in assessing the nature of offending behaviour and how it interacts with substance use; writing a report for courts and justice agencies; and the admission criteria for all AOD services.

Recommendation level 3/3

6.5 Counselling and support roles

Chapter 4 described a variety of counselling, support and other therapeutic roles required within the AOD system in Victoria in centre-based (e.g. Supportive Counselling, Therapeutic AOD Counselling, Forensic AOD Counselling, Specialist Pharmacotherapies clinician), residential (e.g. CRDWU support worker, CRDWU nurse, Residential Rehab

counsellor), and outreach settings (e.g. Rural Outreach, Koori).

The specialist forensic workforce requirements of these treatment types are outlined below. Table 4 provides an example of a qualification and training schedule that could guide the accreditation of staff receiving forensic clients with more detail on each of the roles given below.

Table 4: Qualifications against Role

		-		-	-
	-		-		-
			-		-
			-		-
		-		-	-
	-		-		-

Formal Counselling Training refers to a recognised training course that has an emphasis upon counselling skills of certificate IV level or higher.

Motivational Interviewing Training refers to having attended a minimum of two days training that includes an understanding of readiness to change, along with strategies around how to work with people with low readiness to change.

AOD Training: a minimum certificate IV level of orientation work working with clients with alcohol and other drug issues.

Forensic Orientation: a minimum one-day workshop around assessing antisocial behaviour, the relationships between offending and AOD use, understanding the forensic system in Victoria, working with Justice bodies, and managing boundaries.

Formal Forensic Training: a minimum five days training including assessing antisocial behaviour, relationship between offending and AOD use, managing boundaries, report writing, and addressing AOD-related antisocial behaviours.

6.5.1 Community Counselling

Clients with low AOD use and low offending risk are best screened out of the forensic and AOD system into

community health settings where they can be offered generalist counselling



support, or specific counselling targeted to the client's needs.

These counsellors should have a basic understanding of AOD issues and be

6.5.2 AOD Support Workers

Mandated forensic clients are often not treatment ready, and often have a range of other social and health related problems. While it is recognised that the responsibility for case coordination for the majority of clients rests with the Justice services in Victoria, agencies are still likely to have referrals of non-treatment ready clients.

As a result, there may be circumstances where the relevant treatment response is provided by supportive counsellors taking more of a case coordination approach by assisting with linkage to

6.5.3 AOD Therapeutic Counselling

The basic skills for counselling and therapeutic interventions for forensic clients are similar to those seeking treatment voluntarily, particularly when working with forensic clients at the less severe end of the offending continuum. However, amongst the forensic client group, there may be a greater proportion with low readiness to change, a greater range of severity of substance use from recreational through to dependent, and a greater prevalence of antisocial traits and violent behaviour.

Therefore, clinicians with counselling-based relationships with their clients

6.5.4 Forensic AOD Therapeutic Counselling

Clinicians providing services to antisocial populations require targeted and specialised training (Dick et al, 2008). Developing a therapeutic relationship with clients with more entrenched antisocial personality traits

orientated to the forensic system, but their primary expertise and training would lie in other domains such as grief counselling, clinical counselling, or relationships counselling.

housing, health and other support services. These clinicians need to have not only a core understanding of AOD issues, but also additional skills relating to engaging with a population group that are likely to be more treatment resistant than voluntary clients.

Specific targeted training around motivational interviewing would be highly recommended as well as training around managing boundaries with clients who exhibit antisocial presentations.

need the same core counselling skills as those working with voluntary clients, and a strong appreciation for the need to utilise engagement and motivational skills, as well as the ability to adapt to work with those clients who present with non-dependent substance use (e.g. disinhibited offenders). An understanding and appreciation of the relationship between trauma, substance use and offending (CSAT TIP 44, 2005) and the compounding effect of the stress and/or trauma of being in the justice system should also be included (such as training around understanding the court experience and understanding the prison experience).

requires a range of additional skills above and beyond those used for regular AOD counselling, especially around setting and maintaining boundaries, assessment, group facilitation skills and targeted therapies.

Senior roles could also be created to provide supervision and mentoring.

The diversity of forensic AOD clients means a “one size fits all” workforce is inappropriate as some clients will be better served by a generic AOD or support services while others will require services provided by staff with specialist skills in working with antisocial personalities, violence and

offending behaviour. Therefore, the literature recommends specialisation in forensic AOD service delivery, particularly for clients who are more antisocial with greater criminogenic needs and the development of specialist teams can bring stronger team cohesion, better adherence to administration and reporting requirements, and more collaborative relationships with justice agencies.

It is recommended that whilst there are many highly experienced forensic clinicians in Victoria, the system does not have senior forensic AOD roles. These should be created for the provision of supervision and mentoring of other forensic AOD therapeutic counsellors, and could take the form of a lead clinician.

Recommendation level 3/3

6.5.5 Forensic Clinicians

Those clients with low levels of substance abuse but an increasing seriousness of offending should be identified at assessment and diverted out of the forensic AOD system to be treated forensic clinicians who are specially trained in addressing offending behaviour. For these clients substance use is generally secondary to their offending behaviour and the focus of

treatment should be primarily on offending. These clinicians require relevant tertiary qualifications and experience in CBT based treatment that addresses antisocial attitudes and beliefs, antisocial peers and networks, lack of emotional control and self-regulation, taking responsibility, and pro-social activities and relationships (Dick et al 2008).

6.5.6 Mapping the roles against substance use and offending behaviour

The figure below illustrates one possible profiling of a forensic AOD workforce against the client types. Both lower

AOD/low offending clients, and high offending clients are best treated outside of the forensic AOD sector.

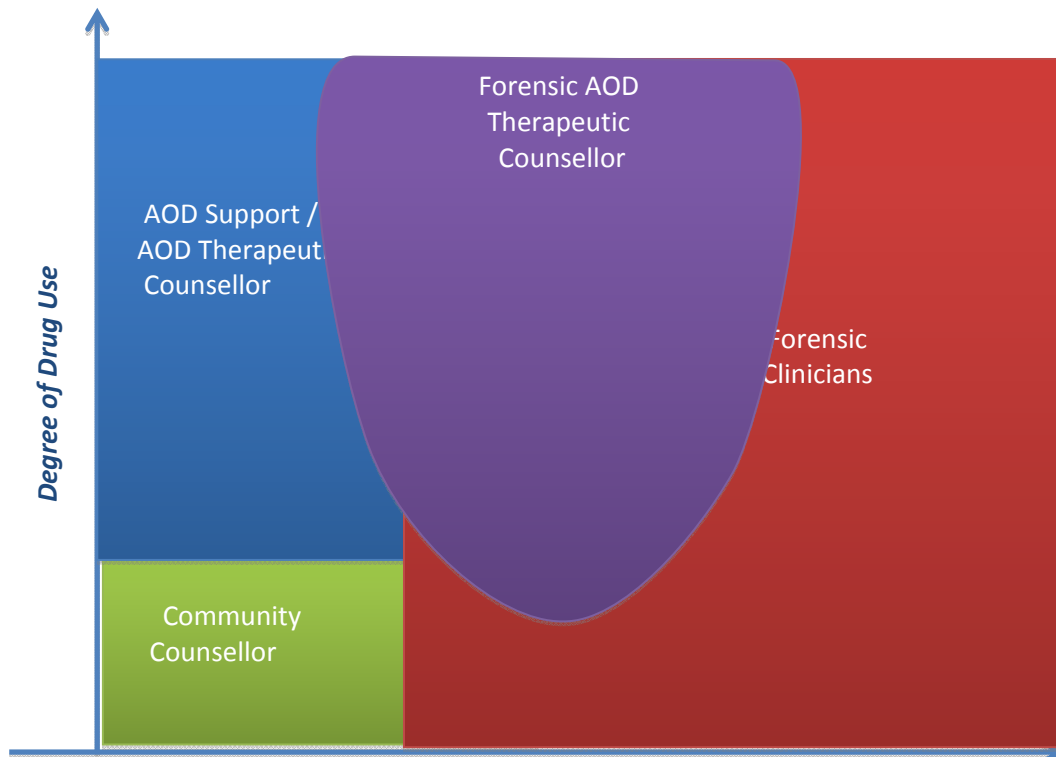


Figure 24: *Offending Behaviour*
Matching counsellor to client need

6.6 Other Supportive Roles

As well as the counselling roles, there are a range of other workers in the AOD sector who are likely to come into contact with forensic clients, and the following are recommendations about their relevant qualifications.

Residential setting staff would require similar training and understanding to those working with voluntary clients, however, they would need to be more aware of identifying behaviours indicative of possible antisocial traits, along with training around boundaries and managing clients with these traits in a residential setting, especially those with a past history of incarceration for

whom possible trauma or institutional behaviour may resurface.

Residential staff should be mindful of clients with past history of incarceration for whom trauma or institutional behaviour may resurface

Medical staff in pharmacotherapy settings, staff should be aware of how the client may react to the perceived power or control of the prescribing agency.

6.7 Specific Shared Skills

The table below suggests some possible needs across the forensic workforce that may vary depending upon the type of role that the person has with the clients. Skills such as understanding the relationship between AOD use and offending, working collaboratively with Corrections officers, maintaining boundaries, and understanding readiness to change are almost universally required across the workforce. Skills such as understanding the relationship between AOD use and offending is needed in counselling but less in withdrawal services. Other skills, such as understanding the forensic system or court-report writing, are more relevant to certain roles, such as assessors and counsellors.

A final point relates to the multidisciplinary nature of the sector. Not only are there staff with a health and welfare focus working with the client, but there are also staff coming from a justice-orientated framework with compliance management responsibilities as well as more general support roles. These differing approaches can mean there are conflicting views about best practice and treatment goals among the various staff working with any individual client. As a result, the skill sets also expand across to interpersonal skills relating to other agencies and organisations in the sector, and how to develop and maintain effective collaborative relationships.

Competency Area	Screening	Assessment	Supportive CCCC and Outreach	AOD Residential Support	Medical Interventions	AOD Therapeutic CCCC	Forensic AOD CCCC	Lead Forensic AOD Clinician‡
Assessing and understanding antisocial personalities	-	++	+	+	+	+	++	++
Assessing and understanding the relationship between AOD use and offending	-	++	+	-	+	++	++	++
Assessing and understanding readiness to change and the process of recovery (although this is a core skill across all AOD settings, in justice settings clients may be exposed to treatment at an earlier stage).	-	++	++	+	+	++	++	++
Addressing drug-related offending behaviour.	-	-	-	-	-	-	+	+
Understanding the objectives and admission criteria for AOD service types	-	++	-	-	-	-	-	+
Understanding the court/prison experience	-	++	-	+	-	+	+	+
Building collaborative relationships with stakeholders who have non-clinical/welfare roles and responsibilities.	-	+	++	+	+	+	++	++
Managing boundaries with antisocial personality clients and working with violent behaviours	+	++	+	++	+	+	++	++
Forensic report writing, privacy and record keeping	-	+	+	+	+	+	++	++
Understanding court and corrections processes, specifically relating to what information is needed and why	-	++	+	-	+	+	++	++

Table 5: Example skill-sets that may be required in differing AOD sector roles.

Key: - No formal training/experience + basic workshop ++ short course / formal study ‡ > 5 years experience

6.8 Clinician Roles and Creating a career path

There are significant concerns in the Victorian forensic AOD sector regarding the retention of staff. Given the limited amount of formal forensic training available before commencing in the sector, most training is provided on-the-job through a significant investment of time and supervision.

The lack of perceived career path in the sector, in particular the forensic AOD sector, was identified as a likely contributor to skills and talent moving into other areas where there is greater opportunity for professional development and advancement.

Lack of perceived career path contributes to skills leaving the sector.

A possible solution could involve the creation a tiered approach to employment within the forensic AOD sector, remunerated accordingly, starting with AOD support work level, moving up with additional training and formal learning into specialist forensic supervisory roles. Remuneration could be proportional to experience in the sector, the amount of training undertaken, and the degree of responsibility. The figure below shows one possible pathway.

A tiered approach to employment within the forensic AOD sector with a clearly defined career path in the sector should be developed.

Recommendation level 3/3



Figure 25: Example of a career path incorporating forensic AOD roles

6.9 Workforce Planning

The need for a strategic approach to AOD workforce development in Australia has been well described by Roche and Pidd (2010). The problems described by Roche and Pidd (2010) were echoed by many stakeholders and relate to the difficulties in recruiting and retaining appropriately skilled and trained staff, with the sector having a high rate of staff turnover, especially within justice roles. Existing qualifications themselves do not seem to be adequate. The Certificate IV in Alcohol and Other Drug Work has minimal focus upon therapeutic interventions, with no direct content informing clinicians on how to provide interventions to forensic clients or how to work within the criminal justice system.

Knowledge acquired in a workplace is likely to be agency-specific and not necessarily transferable to another agency

Furthermore, tertiary post-graduate degrees in Victoria do not typically include modules on drug and alcohol treatment or information relating to working with offenders and mandated clients. This results in graduates from programs being required to learn skills in course placements or on the job, with little consistency around the degree, depth and quality of training being received. Knowledge acquired in a workplace is likely to be agency-specific

and not necessarily transferable to another agency.

This is a problem shared with the Justice sector, who identified inadequacies with current tertiary training programs

that include minimal training on understanding and working with addictions even though a significant proportion of their client group are in the Justice system for substance-related matters.

Given the breadth and scope of substance misuse disorders in the Victorian community, it would be recommended that the Department of Health work with universities and training providers to introduce content into qualifications that reflect the needs of this client group.

Recommendation level 2/3

6.10 Ongoing professional development

It is recognised that, for the reasons already described, new staff in the forensic AOD sector are going to enter the workforce without many of the skills necessary for working effectively with the diverse array of clients in the forensic sector. The Department of Health has responded with a range of initiatives involving sector wide training programs, which have been developed through discrete projects such as the Forensic Workforce Training (Caraniche & YSAS).

This training content covered key areas identified in the literature such as:

- Working effectively with the Criminal Justice Service System
- Courts and court processes
- Preparing quality court reports
- Criminology and Criminal Behaviour
- Drug Diversion Programs
- Engaging mandated clients
- Cognitive Behavioural Therapy
- Motivational Interviewing
- Solution Focused Therapy

It also included three workshops:

- Working with clients with 'antisocial' presentations

- Working with clients who are Sex Offenders;
- Ideas for making AOD services more accessible for Forensic AOD clients from Aboriginal and Torres Strait Islander backgrounds;

The training was well received by the sector with over 260 workers attending one or more sessions (YSAS, 2007). However, this, along with the other initiatives, has been funded as finite projects. There are two challenges with this. First, staff turnover in the sector is high, so after a short time, the benefit of the training has become diluted as new clinicians enter the forensic workforce.

Ad hoc trainings are not ideal in the sector because of high staff turnover.

Second, in order for training to result in longer-term change in practices, it needs to be followed up by clinical supervision or some other activity enabling the theory taught to be translated into practice.

The absence of a sustainable training framework has resulted in some individual agencies developing their own ongoing professional development. Whilst this training can be excellent, it may result in different standards and approaches across different services.

Given the greater degree of inter-agency collaboration required for forensic clients there is a strong need for consistency in workforce training across the areas of assessment, professional practice, reporting and intervention.

The Department of Health or a central agency should initiate a sustainable model of professional development for the Forensic AOD Sector, with adequate forensic supervision to consolidate the learning into practice, and cross training between justice and AOD service providers wherever possible.

Recommendation level 2/3

The training needs of staff differ depending on the role they perform in the sector and their relevant expertise. Much of the training provided has focussed around basic core skills, however ongoing professional development opportunities funded and coordinated through a central channel should be considered to target those with differing levels of expertise. Rather than training up a workforce to be competent in basic Motivational Interviewing, this could be expanded to provide further opportunities to move from competence, through to expertise in Motivational Interviewing. The same can be applied across other core areas essential to the sector and these can

provide a pathway for skills development. Such a response could be coordinated by a central organisation funded to coordinate the development needs of the sector, not just those new to working in forensic AOD work.

To assist with this, a sector-wide ongoing orientation package could aim to reflect the specific needs of the sector, adapting previous packages developed for this role. This could incorporate cross-training to assist in the mutual and shared understanding across both AOD and justice workers. It could be developed centrally and delivered in a coordinated and ongoing manner, with the specific modules matching the needs of those staff.

These could include two tiers of content that is:

1. generic to the whole forensic AOD sector such as shared objectives, understanding different stakeholders' needs, and understanding the interactions between AOD use and offending; and,
2. specific to individual roles. Agency specific protocols and requirements should continue to be delivered as a part of agency in-house orientation as these are not necessarily applicable to the entire forensic AOD sector.

Clinicians new to the sector also need a structured and funded induction program including operational matters, a point highlighted in the confusion

experienced by many around current sector processes. These operational topics could also focus on how to build collaborative relationships with workers

in the justice system (who have different goals and priorities), and how to work effectively with the justice system.

Having a central body coordinate a state-wide forensic AOD professional development calendar could assist with sustainability and consistency, and the training should range from orientation

to clinical skills development to specialist worker training. The calendar should be organised 12 months in advance and published across the sector to enable agencies to plan their worker's attendance. All training should be provided by appropriately skilled and experienced staff, such as the state-wide Forensic AOD Supervisors.

6.11 Supervision

Clinical supervision is regarded as an ideal medium to build upon and reinforce skills and professional practice and is well supported as a key development activity (Turning Point unpublished 2010; Hussain & Cowie 2005; CSAT, 2009). Most agencies have supervision policies, some differentiating operational from clinical supervision, others integrating the two.

The style and format of supervision do not need to be any different in the forensic AOD sector than the voluntary sector. Rather, the key is to ensure the clinical supervision also provides guidance and a reflective space to include the specific challenges in this sector, and from within the framework and paradigms of this sector. This is all the more important for those clinicians working with forensic clients who may have more established antisocial traits, and for whom boundary setting and maintenance may be of a higher priority

supporting clinicians to respond appropriately when their 'buttons are pushed' or the relationship is manipulated.

This degree of specialist support where the supervisor has experience in both AOD treatment and working with offender populations, may be available in-house with larger agencies. However, for smaller agencies, it is less likely to be available in house and so specialised forensic external supervision may be useful. In either case, supervisors would be well supported by practice suggestions and guidelines for developing forensic AOD skills.

The administration of this external supervision could be through a panel arrangement, or using Specialist Forensic AOD Services to support their region's needs, or with a state-wide provider for the whole sector, to compliment the internal supervision already being provided.

Supervision is essential for staff working with clients with established antisocial traits, and supervisors need to have expertise around both AOD use and working with offender populations however this is currently provided on ad hoc basis dependent upon agency resources. There could also be a panel of approved specifically-funded supervisors able to support staff in smaller or regional agencies.

Recommendation level 2/3

Summary

There are currently minimum training requirements for staff in the forensic AOD sector, requiring either a Certificate IV and Alcohol and other Drug Work, or a Health discipline tertiary qualification and four core AOD competencies. However these minimum standards may fall short of that required to provide many of the services required in the forensic AOD sector, as for example, there is no requirement that persons counselling forensic AOD clients have training in either forensic matters, or counselling and psychotherapeutic technique.

Staff in screening roles would need minimal training, primarily focussing upon the screening tool itself. Those conducting Specialist Forensic AOD Assessments would need further training around in assessing the nature of offending behaviour and how it interacts with substance use; writing a report for courts and justice agencies; and the admission criteria for all AOD services.

Support and clinical staff need appropriate training and supervision and there needs to be a match between staff skills and roles. Generic counsellors should have a basic orientation in AOD and forensic issues, and AOD Support workers need additional AOD and motivational interviewing training. AOD Therapeutic Counsellors would require additional counselling training, with

Forensic AOD Therapeutic Counsellors requiring more comprehensive training around offending behaviour.

Residential staff should be mindful of clients with a past history of incarceration for whom possible trauma or institutional behaviour may resurface. Medical staff need, like all staff, to be aware of the challenges of perceived power and control by the service provider on the part of some forensic clients. Clinical supervision around both AOD use and offender populations would be essential for all staff working with clients who are likely to have more established antisocial traits.

A career path could be created in the system, with the inclusion of Senior forensic AOD roles for the provision of supervision to, and mentoring of other forensic AOD therapeutic counsellors, and could take the form of a lead clinician. However, investment needs to be made in the training programs producing the new AOD clinicians, to ensure that these programs contain adequate content to facilitate employment in this sector. In addition, a state-wide coordinated professional development program would encourage consistency across the sector, especially when delivered in a sustainable and regular manner, rather than in the form of ad hoc training.

7 Service Providers

This chapter describes the types of agency that may be best matched to the needs of clients, using the risk of offending / severity of substance use typology as a guide, and the role of community agencies, AOD services, forensic AOD providers and Justice-based services are discussed. Some preliminary suggestions regarding accreditation to provide services to forensic clients are also presented.

7.1 Matching Workforce and Service Provider

When considering the types of agencies best suited to delivering services to forensic AOD clients it is essential to return to the key principle underpinning

this report – that the forensic AOD client group is diverse, with wide-ranging treatment needs, and the setting needs to be responsive to this diversity.

7.2 Summary of Types of Agency

Figure 26 provides a diagram representing the different types of agency ideally suited to providing treatment to the full range of clients within the forensic AOD system, using the same dimensions of substance use and offending risk presented earlier in this document. The blue areas depict a primary focus on substance use hence responses should be provided in the

health and welfare sector, whilst the red areas depict a primary focus on offending behaviour hence responses should be based within the Criminal Justice Sector. As a result, four types of agency could be considered as being best suited to cover the needs of almost all presentations of forensic clients and these are described below.

Currently forensic brokered treatment only goes to community AOD providers. However, four types of treatment setting are recommended for a forensic AOD system, and these are Community Health Services, Community AOD Agencies, Specialist Forensic AOD Service (all funded by health) and Specialist Forensic Service (remaining within Justice).

Recommendation level 3/3

Community Health Services (CHS) refers to any public community health service that offers counselling, and would be suited for clients with low AOD needs and low offending risk, but who are likely to have other issues and support needs.

It is recommended that low risk and low AOD needs clients are referred to Community Health Services rather than be retained in the AOD system.

Recommendation level 2/3

Community AOD Agency (CAA) refers to the current model of Department of Health accredited community AOD providers, suitable for low offending / high AOD need clients. These agencies currently exist in the voluntary system, and receive most of the forensic AOD clients. It would be anticipated that, given the COATS data support the notion that most forensic clients fall into the low-moderate offending/high AOD need category, these agencies would still receive the bulk of referrals.

In regional/rural settings where demand doesn't permit a dedicated service, AOD counsellors would likely be part of the local Community Health Service, as per the current model.

It is recommended that moderate to high AOD needs, but low offending needs clients are referred to the voluntary sector Community AOD Agencies, as per current arrangements.

Recommendation level 3/3

Specialist Forensic AOD Service (SFAS) refers to community AOD providers or other services which have a specialist team of forensic AOD clinicians who receive more targeted forensic AOD training and supervision. This is a model that has been piloted and evaluated in Victoria and found to be beneficial on a number of grounds (Caraniche 2009).

It would be recommended that these are located the major metropolitan centres where there is a sufficient forensic population to warrant the service. These may be a standalone SFAS or they may be a specialist unit embedded in a larger AOD agency.

In regional/rural areas this would most likely be a single accredited Specialist Forensic AOD Counsellor, trained in both assessing and working with offending behaviour and addressing AOD use. However, a single worker model in a Community AOD agency in metropolitan areas is not the preferred arrangement due to the specific supervision and support needs of this role.

It is recommended that Specialist Forensic AOD Services are established to work with the moderate offending risk client group.

Recommendation level 3/3

Specialist Forensic Service (SFS) – this refers to services outside of the existing drug and alcohol sector, suitable for clients with high antisocial presentations and typically provided within the Department of Justice and its associated agencies.

Services for clients with high antisocial presentations should be delivered through Justice agencies.

Recommendation level 3/3

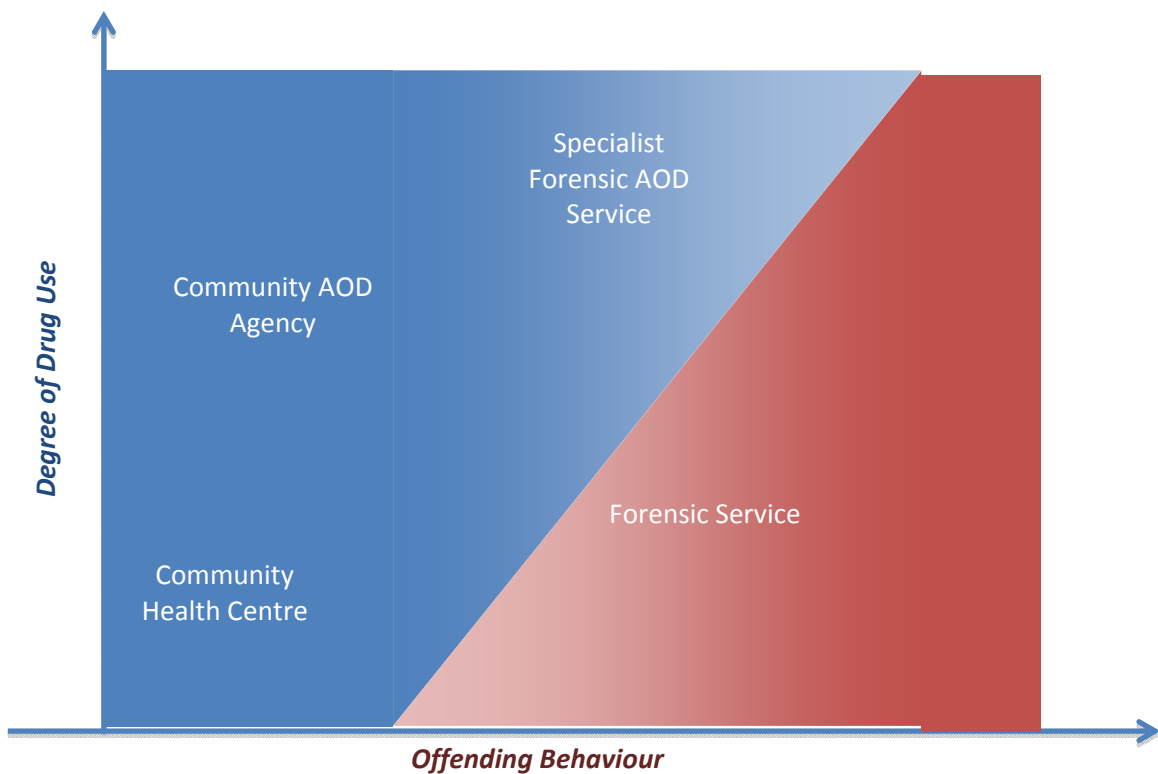


Figure 26: Matching service setting to degree of dependence and seriousness of offending

7.3 Agency Accreditation

All agencies receiving forensic referrals could be accredited to provide forensic

AOD treatment to ensure consistent levels of care as well as familiarity with

reporting requirements. Agencies could apply to be classified to as a particular type of provider (i.e. Forensically Accredited Community Health Service or Community AOD Agency, or SFAS,) and would have to meet the specific criteria for that classification.

The classification process could consider the following, depending upon the level of service being provided:

- AOD Qualifications of Staff

- Forensic Training of Staff
- Counselling Training of Staff
- Degree of forensic focus in supervision
- Plan around targeted ongoing professional development

The Agency accreditation process could be overseen by the Department of Health or alternatively outsourced to a state-wide service.

All agencies providing treatment to forensic clients should be accredited ensuring AOD qualifications, counselling training and forensic training of staff, as well as supervision and professional development.

Recommendation level 2/3.

7.4 Matching Service Provider to Level of Treatment Need

The following section specifically maps out the suggested treatment agency recommended for different client types according to the typology presented earlier in this report.

Low AOD /Low offending type

In line with the principle of diversion, clients who are not dependent on substances or who do not have significant offending should be diverted out of the forensic system to community health and welfare agencies, as the client's primary area of need are unlikely to be either their AOD use or their offending behaviour.

These services would have the capacity to address the primary needs of this client group, such as vocational support, grief, relationship or financial support. This would reduce the risk of further entrenching these clients in environments that may inadvertently reinforce and/or normalise substance-using or offending behaviours.

Dependent AOD/Low offending

For these clients whose primary problem is their substance abuse and whose offences are minor, treatment should be focussed on their substance use and provided by a community AOD agency. Because these clients differ little from typical voluntary AOD clients (aside from their treatment readiness), they would be best integrated with the

voluntary population and may benefit from mixing with peers who have higher levels of treatment readiness. Treatment may include medical interventions such as withdrawal services and pharmacotherapy but must also include AOD focussed behaviour-change strategies.

Low AOD / Moderate Offending

This group do not have a significant substance use problem and are not substance dependent. Rather, their treatment needs relate to their

offending behaviour and are best treated within the correctional environment with AOD competent clinicians.

Dependent AOD /Moderate Offending

These clients have significant substance abuse issues and need targeted AOD treatment ranging from withdrawal, pharmacotherapies and drug related behaviour change interventions. However, this group also has established offending behaviour and may present greater challenges for their management making them unsuitable for community AOD settings. Their

treatment should be provided by a Specialist Forensic AOD Service preventing the mixing of these clients in groups with voluntary clients. One of the longer-term aims of this treatment is to hopefully prepare the client for future engagement with Community AOD services once the offending behaviour has resolved.

Low AOD /High Offending

In this group the offending behaviour is a more significant problem than their AOD use and treatment should be provided within the correctional system with a strong focus on offending behaviour and reducing recidivism. This group will often include violent offenders, including family violence and traffickers and may also include sex offenders. There will also be a high proportion of non-dependent but problematic alcohol use in this group.

Corrections Victoria already has correctional programs to address alcohol related violence that are delivered within the Community Corrections setting; for example, the Alcohol Driven Aggression Psycho-educational Treatment program (ADAPT) delivered by clinicians with a strong understanding of offending principles and working with antisocial behaviours, as well as an understanding of AOD issues.

Dependent AOD /High Offending

This group has both serious offending and significant substance abuse problems. However, AOD issues should still be treated in the context of their offending behaviour because the offending behaviour in this group is unlikely to be secondary to their AOD use. These clients should be closely case managed and monitored by correctional agencies, but it is likely that they will also need access to specialist AOD treatment such as withdrawal and pharmacotherapy which should be addressed through very close collaboration between correctional agencies and Specialist Forensic AOD Services.

The treatment setting with the best demonstrated efficacy for this group is specialist residential AOD treatment that focuses on substance use and offending behaviour and provides access to treatment outside the mainstream prison environment. Despite best practice being the continuation of this treatment in specialist residential treatment units in prison to similar units in the community, there are currently no community-based, specialist, forensic units that meet the requirements for this client group. This is a significant gap in the current forensic AOD treatment system.

There are no specialist, forensic units that meet the requirements for this group

Summary

Four tiers of agency are recommended for the forensic AOD sector. Those with low needs would be diverted to community settings, whereas low offending/high AOD need clients are best seen in current voluntary agency settings. Moderate offending clients would benefit from the targeted

environment of a Specialist Forensic AOD service, and highly antisocial offenders should remain within the criminal justice system for their treatment. There are currently no community based treatment options for this client group.

8 Referral & Client Flow

This chapter explores a referral & client flow framework for the Victorian forensic AOD sector. Commencing with an overview of continuity principles, the chapter proceeds with a suggested pathway from each of the five primary referral sources, that incorporates screening, assessment and allocation to a service provider.

Transfer of information and mechanisms for information sharing are discussed in the context of collaborative care across the whole sector, with the chapter concluding by highlighting some concerns and key questions for three key transition points within the system.

8.1 Referral and Continuity of Care

In order for the key elements of screening, assessment and program delivery to work effectively across treatment and justice services, there has to be a comprehensive framework in place to facilitate efficient flow of clients and client information.

The processes supporting the Victorian forensic AOD system were designed for a client throughput of one seventh of 2010 levels, resulting in difficulties today around:

- multiple pathways required depending upon the type of program being referred to;
- multiple repetitive assessment processes resulting in assessment fatigue;
- inappropriate referrals where treatment has already been provided;
- problems regarding the sharing of information from one provider to the next;
- and unsatisfactory levels of communication between correctional services, assessment services and treatment services.

As a result, the processes need to be considerably updated to ensure that there is as seamless as possible a flow

of clients and transfer of information, and coordination of services, in order to

maximise both therapeutic and judicial outcomes.

8.2 Proposed Referral Pathway

As has been described in the previous chapter, referrals should be directed based upon the severity of AOD use (recreational/situation or dependent) and the degree of anti-sociality suggested by their past offending behaviour according to the principles of risk and need. A possible referral and treatment pathway is illustrated in the figure below, that draws together the four main entry points to the system, distinguishes screening from assessment and notes the key treatment types and settings based upon assessment of risk and need.

The entry points are noted in the green text boxes on the left, being screened either by the referring body or by a telephone worker on a Referral and Assessment Line. Where 'Moderate' to 'High' offending risk is identified, or where a screening is not possible (the 'misc' entry point in the diagram below), the client should be referred on for a Specialist Forensic AOD Assessment (orange) before being allocated to the appropriate service based upon client risk, need and responsivity factors.

Where 'Low' offending risk is identified, then referral would be made directly to a service provider for a Generalist AOD Assessment and appropriate treatment plan.

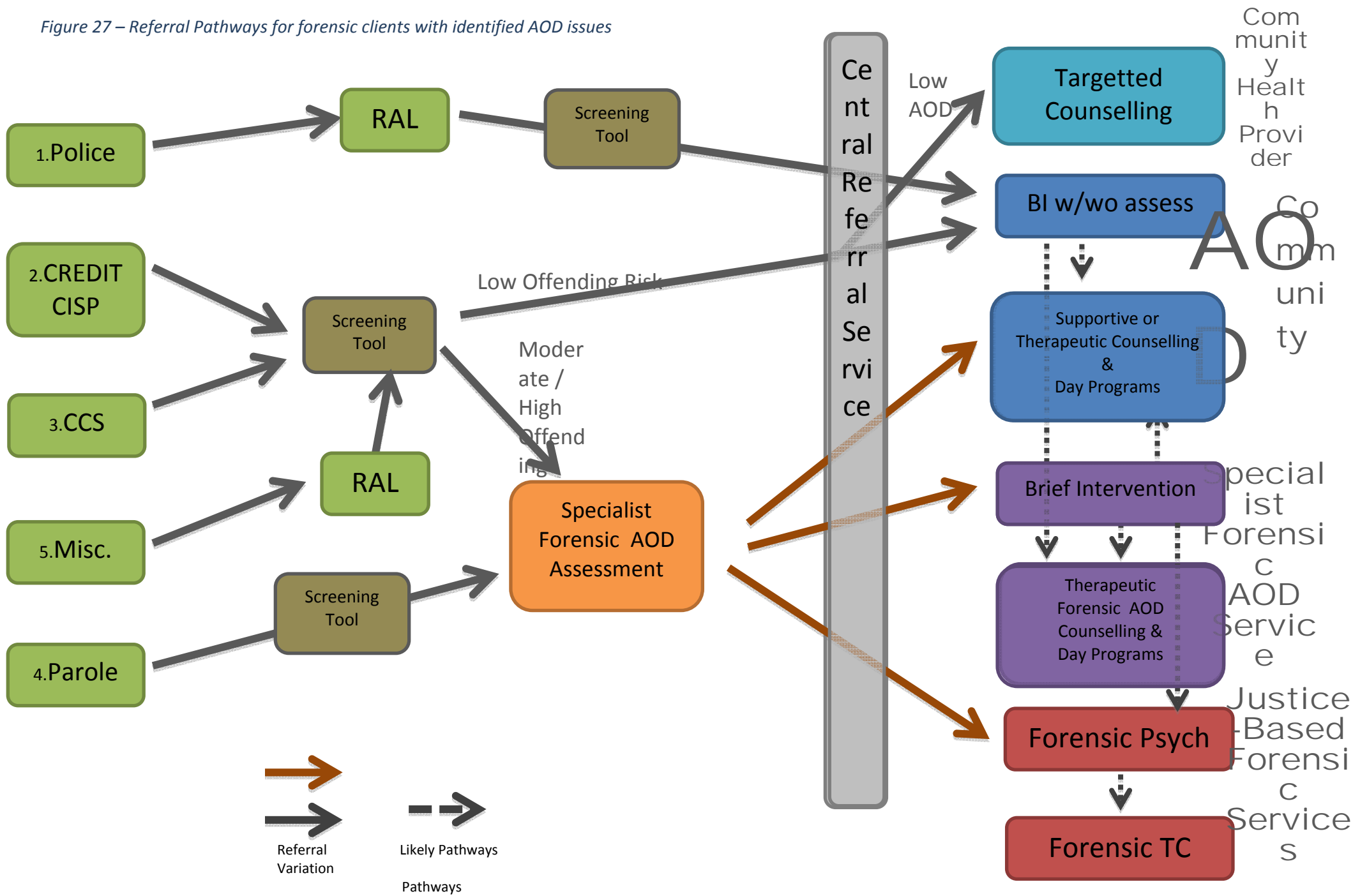
- The *Referral & Assessment Line* would be a first point of contact for referrals that have not come through a Correction or CREDIT/CISP worker or the parole board, and so provide a triage service.
- The purpose of the *Central Referral Service* is to allocate referrals to the appropriate tier of forensically accredited agency, as well as collating the relevant referral information, and monitoring and evaluating service delivery.
- The *Central Forensic AOD Assessment Service* would provide trained forensic AOD assessors state-wide. These assessors may be drawn from local providers, or from a central staff bank.

Note that the diagram only includes the more common community psychosocial services that are recommended for this population group. Medical interventions such as withdrawal and replacement pharmacotherapy, and residential and non-residential rehabilitation have not been included as these are typically "voluntary" services with forensic beds and referrals or variations to treatment can be made at any point.

Day programs have been included as they are a service type that can be integrated with counselling to complement the individual counselling and can be customised for more complex clients. Forensic residential rehabilitation has been included as although it is a service type that does not currently exist, there is nonetheless a targeted forensic AOD client group with such a need.

The description of the referral pathways names the justice-based agencies that interface with the proposed forensic AOD system. The different tiers of service provider are described in more detail in the previous. However, services and agencies within the forensic AOD system may have function and scope that varies from the current function and scope of services and agencies such as COATS and DDAL.

Figure 27 – Referral Pathways for forensic clients with identified AOD issues



1) Caution / Presentence

- Police telephone the *Referral Assessment Line (RAL)* of the *Central Referral Service (CRS)*.
- The *RAL* worker conducts required *screening* to confirm eligibility including low offending risk and low AOD use and forwards the assessment outcome to the *Central Referral Service (CRS)*
- *Central Referral Service (CRS)* refers onto community AOD provider.
- The AOD provider conducts their standard assessment and provides a *Brief Intervention (see chapter 5)*.
- The AOD provider returns a generalist *AOD Assessment* or Reassessment to the CRS.

It is encouraged that these clients be seen and treated alongside 'voluntary' clients, rather than in forensic AOD settings.

2) CREDIT/CISP &

3) Post Sentence

- CREDIT/CISP worker/CCO to complete the required *screening*.
- *Screening* and other required referral information (see below) forwarded to *Central Referral Service (CRS)* where screened AOD use and offending risk determines whether *CRS* refers for *Specialist Forensic AOD Assessment (SFAA)*
- If *SFAA* is indicated then
 - *SFAA* conducted by an accredited worker from a local AOD agency, or if not available, by *Central Forensic AOD Assessment Service*.
 - *SFAA* determines appropriate tier of service, treatment type and treatment setting.
 - Referral then passed on by *Central Referral Service* to appropriate local service provider (Community Health, Community AOD, Specialist Forensic AOD Service, Forensic Service)
 - Service provider opens *Brief Intervention* treatment type³
 - Service provider varies treatment type if indicated by client need and engagement
- If *SFAA* is **not** indicated then
 - Referral passed directly onto appropriate tier of service provider (usually *Community Health* or *Community AOD Service*)

³ Note that where the *SFAA* is conducted by a local service provider, and the assessment recommends that the same provider continues to see the client, then the *SFAA* would be directly varied into the appropriate treatment type, rather than into a *Brief Intervention*.

- Service provider opens *Brief Intervention* treatment type
- Service provider would conduct generalist *AOD Assessment* if none completed in previous six months and returns this to the *CRS*
- Service provider varies treatment type if indicated by client need and engagement

4) Parole

Metro & Regional

The Parole Board will request an SFAA for any prisoner they want assessed prior to a parole hearing.

- SFAA is conducted in prison by the an accredited prison-based clinician or Central Forensic AOD Assessment Service who may have outplacement workers at local AOD agencies
- External assessors required to contact in-prison AOD treatment providers to gather information about treatment accessed in prison.
- Assessment Report is provided to the Parole Board with recommendations for a treatment and service type.
- The Parole Board makes the final determination of what treatment conditions are to placed on the Parole Order.
- In accordance with Parole Board instructions the referral is then passed onto the *Central Referral Service* for allocation to the appropriate tier of service provider (Community Health, Community AOD, Specialist Forensic AOD Service, Forensic Service)
- Service provider opens *Brief Intervention* treatment type
- Service provider varies treatment type if indicated by client need and engagement

Currently, significant numbers of prisoners complete AOD treatment in prison that is not reviewed or considered during the assessment and planning process for parole. To overcome this, it is suggested that all prisoners who have attended programs designated by Justice Health as being Level 4 or Level 5 (i.e. criminogenic AOD treatment programs) will, with the approval of

Justice Health, have a discharge plan completed by the in prison AOD provider lodged with Central Referral Service that meets all the requirements of a Specialist Forensic AOD Assessment. The CRS will determine if there is sufficient information on the discharge form to take the place of an SFAA, otherwise CRS will request a full SFAA.

- Depending on the outcome of the Parole hearing, the CRS will refer the prisoner directly to the appropriate service provider.
- Service provider opens Brief Intervention treatment type

- Service provider varies treatment type if indicated by client need and engagement

5) Miscellaneous

- Referrer calls *Referral Assessment Line* of the *Central Referral Service*.
- The *RAL* worker would screen to confirm eligibility
- The *RAL* refers for Specialist *Forensic AOD Assessment (SFAA)*
 - *SFAA* conducted by an accredited worker at a local provider, or if not available, by *Central Forensic AOD Assessment Service*.
 - Referral then passed on by *Central Referral Service* to appropriate tier of service provider (Community Health, Community AOD, Specialist Forensic AOD Service, Forensic Service)
 - Service provider opens *Brief Intervention* treatment type
 - Service provider varies treatment type if indicated by client need and engagement

8.3 Referral Information Required

In order to facilitate appropriate assessment and treatment planning, a variety of information is required in addition to that provided by the client at the time of assessment.

In light of this, it is recommended that following are collated by the Central Referral Service to enable a referral to the service provider be completed.

8.3.1 Intake

There are several pieces of information identified as important to service providers. These include the following, depending upon the referral source.

1. Police – Diversion

From Police:

- Charge sheet
- Referral form

From *Referral and Assessment Line*:

- Relevant Screening Elements
- Previous assessment information from *Central Referral Service*

2. CREDIT/CISP

From CREDIT/CISP worker:

- Relevant Screening Elements
- Police Offence Summary
- Charge sheet if any
- Other orders currently applied
- If violent or sex offender - relationship between AOD use and violence/sex offending, as well as current risk to workers and other clients.
- Explanatory notes if client is low AOD use or high risk but still being referred through.

And *either*, from *Specialist Forensic AOD Assessment* if conducted:

- Forensic AOD Assessment (see chapter 4), which integrates previous assessment information already held by central brokerage service.

Or, if a direct referral to the provider, from *Central Referral Service* archives:

- Previous assessment information

3. Corrections – Post Sentence

From Corrections Officer:

- Relevant Screening Elements
- Police Offence Summary
- Current order
- Other orders currently applied
- If violent or sex offender - relationship between AOD use and violence/sex offending, as well as current risk to workers and other clients.
- Explanatory notes if client is low AOD use or high risk but still being referred through.

And *either*, from *Specialist Forensic AOD Assessment* if conducted:

- Forensic AOD Assessment (see chapter 5), which integrates previous assessment information already held by central brokerage service.

Or, if a direct referral to the provider, from *Central Referral Service* archives:

- Previous assessment information

4. Parole Board

From Parole Board

- Relevant Screening Elements
- Police Offence Summary if available
- Current order and parole conditions
- Other orders currently applied
- If violent or sex offender - relationship between AOD use and violence/sex offending, as well as current risk to workers and other clients.
- Explanatory notes if client is low AOD use or high risk but still being referred through.

And either, from *Specialist Forensic AOD Assessment* if conducted:

- Forensic AOD Assessment (see chapter 5), which integrates previous assessment information already held by central brokerage service.

or, if a direct referral to the provider, from *Central Referral Service* archives:

- Previous assessment information

5. Other Channels

This category does not have fixed referrers like the previous categories, and so the Referral and Assessment Line would collate part of the information passed onto the service providers.

From Referrer

- Police Offence Summary if available
- Current legal conditions
- Explanatory notes if client is low AOD use or high risk but still being referred through.
- If violent or sex offender - relationship between AOD use and violence/sex offending, as well as current risk to workers and other clients.

From Referral and Assessment Line:

- Relevant Screening Elements

And either, from *Specialist Forensic AOD Assessment* if conducted:

- Forensic AOD Assessment (see chapter 5), which integrates previous assessment information already held by central brokerage service.

Or, if a direct referral to the provider, from *Central Referral Service* archives:

- Previous assessment information

8.3.2 Assessment Report if Conducted By Service Provider

Where an assessment has not been conducted, the service provider may complete an assessment report in the required template to be lodged with the *Central Referral Service*, and integrated into the current client record (rather than appended as a

separate document). This would enable rapid access of full client history when referred back into the system. Performance indicators would need to account for the additional work involved in preparing such a report.

8.3.3 Discharge

Outcome from treatment would be lodged with the Central Referral Service. This would include update to all variable factors that are maintained by the Central Referral

Service, e.g. housing, AOD use, legal status. This could also include required reporting measures and also risk, engagement and responsivity to treatment.

A clearly defined referral path should be articulated based upon all potential referral entry points, and all possible treatment outcomes. This should also include clear articulation of referral information required, and assessment responsibilities. Specific recommendations regarding all of these are included in this report.

Recommendation level 3/3

8.4 Storage of Information

Continuity of Care should be a strong consideration when discussing the matter of storage of data, balanced at the same time against the privacy of the client. To facilitate continuous treatment it would be recommended that key information such as assessment, attendance, and

discharge information is stored centrally at the Central Referral Service. Progress notes should still be held by the treating agency.

Paper and fax-based systems seem to be universally identified across the Victorian system as being outdated, and there are many problems

described with current databases used for reporting agency outcomes (e.g. ADIS) which are not longer able to keep up with the demands from a growing sector. There is a preference for an electronic reporting system, that may be also be integrated in an internal electronic case record for the providers themselves.

This system could integrate new assessment data, rather than appending it to the current file. Such a system would then be able to generate an updated assessment and treatment history for all returning clients, reducing the risk of assessment fatigue. Furthermore, this system could incorporate treatment progress and discharge summaries, so although the specifics of treatment interventions may remain in the providers' own case

histories, fixed historical data and key issues and focus of treatment will be accessible to all future service providers.

This system could also register contacts and interventions automatically with the Central Referral Service, as well as generate throughput and outcome reports for the agencies' contract reporting, greatly reducing the administrative burden.

Central brokerage could use the Corrections' JAID numbers for all clients, with an adapted JAID number (e.g. beginning with X) for other diversion and DDAL clients without JAID numbers. This may reduce the risk of confusing clients or creating multiple files for the same client, especially with more common family names.

A central record database could be developed to store client assessment data, program utilisation data, and other relevant information required from one service type to the next.

Recommendation level 3/3

8.5 Collaborative Care

8.5.1 Clearly Identified Case Manager

The majority of forensic AOD clients will have a justice case manager who is responsible for coordinating and monitoring the client's care and facilitating their access to a range of resources including housing, employment, education and AOD treatment. The degree to which this is possible will depend upon factors

including the caseload of the Corrections Officer, and the needs and engagement of the client. Where case management is being provided by the criminal justice setting, the role of the AOD provider is to focus on AOD treatment provision and not to replicate the case management function. In the

evaluation report of the SEADS FIU a distinction was made between clinical case management provided by the AOD provider and comprehensive case management provided by Justice. Clinical case management is described as consisting of assessment, treatment planning, counselling, monitoring of clinical progress and feedback to the Comprehensive case manager (Justice).

In order for staff on the ground to understand their respective roles and the importance of collaboration in the overall treatment of the client, the principles of collaboration need to be endorsed at the highest levels

These included:

- Reducing recidivism should be the goal of the CJS and AOD treatment system
- Treatment must be policy driven
- AOD treatment staff and justice staff must function as a team
- Urinalysis should be used to monitor drug use
- Behavioural contracts should be used to specify expectations and sanctions
- Specialist justice case managers should oversee offenders in AOD treatment with specialist treatment staff who understand the CJS
- Sanction non compliant behaviour
- Reward positive behaviour
- Focus on quality not quantity. Higher quality targeted programs are more effective than applying generic programs to larger numbers of clients.

The implementation of Taxman's principles require a clear and shared understanding of the goals of forensic AOD treatment, consistent communication between workers of both systems and a willingness to work together for the best interest of both the individual client and the wider community. They need to be driven from a clear and shared policy

through the development of shared policies and frameworks that articulate the key roles, responsibilities and requirements of both systems in working together.

There is a difference between the clinical case management provided by an AOD provider and case management provided by Justice

Taxman (1998) developed a range of principles for a seamless system of treatment, supervision and transition within the criminal justice system.

framework so collaboration is not solely reliant on the professional practice habits of individual workers.

Collaborative practice should not be reliant on the practice habits of individual workers

8.5.2 Increased Communication and Sharing of Information

In the evaluation of the Forensic Interventions Unit pilot program SEADS, stakeholders reported significant increases in the quality of the relationships, communication and understanding between the Forensic Interventions workers and the correctional staff and reported that this led to improved outcomes for clients (Berry & Van den Bossche, 2008).

At the Marngoneet Therapeutic Community Prison, a model of care has also been developed where Prison Custodial Staff and program clinicians, provide a collaborative approach to all interactions with the prisoners. Rather than resulting in poorer engagement with the prisoners, staff report that this has had the effect of enabling greater opportunity for therapeutic change, as well as working to reduce risk of any colluding and reduce the “us and them” culture between custodial and therapeutic staff.

The client may see justice agencies as the ‘bad guys’, an approach that an AOD counsellor could easily and inadvertently reinforce.

Collaboration between service providers and community corrections is a feature of the Victorian forensic AOD system, however, it is not systemic and occurs on an ad hoc basis driven by individuals and local protocols. In some settings there may be a culture of avoiding information sharing that this could feed into pre-existing suspicion or disdain of authority by the clients. Collaboration between health and justice is an important tool in addressing antisocial traits, where the client may see justice agencies as the ‘bad guys’, an approach that an AOD counsellor could easily and inadvertently reinforce.

As a result, regular communication is central to building stronger and more collaborative relationships between the AOD providers and correctional agencies, and, from a therapeutic perspective, it is an essential ingredient in the overall treatment experience. Regular regional networking forums can provide a space for managing these and other challenges of working across two diverse areas.

Although collaborative approaches do occur in some areas, there should be policies and procedures implemented by both health and justice to ensure that forensic AOD workers and correctional staff work collaboratively and treatment should be coordinated across both systems.

Recommendation level 3/3

Regular regional network meetings could be formalised discuss local issues and build links between providers and justice agencies.

Recommendation level 2/3

AOD Providers to Corrections

AOD providers reported that the following information could be shared with the justice case manager on a regular basis:

- Focal area for counselling
- Treatment progress
- Treatment goals (including revisions)
- Changes to AOD treatment (e.g. commencing or terminating methadone)
- Changes of engagement with other services
- Referrals to other services
- Appointment attendance
- Date of next appointment
- Any key issues that might be relevant in providing support for the client and that other workers need to know about
- Any risks / triggers that have been identified regarding relapse and recidivism
- Change of AOD Counsellor

Treatment progress does not need to be in detail, nor breach confidentiality. Rather it is to a degree that would enable the corrections officer to assess the other needs and overall progress of the client against their order.

It is also important to note here that there are significant limitations to confidentiality in the forensic setting, however, as numerous agencies and services have attested – this is by no means a barrier to developing a strong therapeutic relationship.

The limitations to confidentiality in forensic settings, do not necessarily form a barrier to building a therapeutic relationship

Transparent and articulated limits around confidentiality should be developed and used across all forensic AOD services with an information sheet describing confidentiality for service users.

Recommendation level 3/3

Corrections to AOD Providers

Good collaborative care requires two-way communication, and so information shared by Corrections Officers with AOD providers should include notification of the following:

- Compliance with orders
- New offences and other court matters
- Breaches and action plans
- Urine Drug Screen results
- Any risks / triggers that have been identified regarding relapse and recidivism

- Any other risks
- Relevant information from other service providers
- Change of Justice case manager

A simple electronic form would be the ideal medium for this communication that, for example, could generate an email to be sent to the relevant party. This could be developed relatively easily as a web-based, or stand alone PC based application.

Processes should be established sector wide ensuring the two-way sharing of information needed by each service in order to fulfil its functions effectively and efficiently.

Recommendation level 2/3

8.6 Continuity of Care - Transition Points

As well as the matters of lateral continuity of care described above, there are also three transition points which have been identified where there is longitudinal interruption to

care: pre-sentencing to post-sentencing; imprisonment to post-imprisonment (including parole); and youth to adult systems. Each of these is discussed below.

8.6.1 Pre-Sentence to Post-Sentence

The original Victorian forensic system was set up with an emphasis upon post-sentence treatment. With the introduction of pre-sentence programs like CREDIT and CISP, as well as diversionary initiatives, a significant number of persons charged with offences now receive support and treatment while on bail and in the period before sentencing. This can include a full AOD assessment and associated treatment delivered by a community AOD treatment provider; however, current systems do not support the sharing of information from the pre to post sentencing stage to facilitate continuity of care.

Systems do not support the sharing of information from the pre to the post sentencing stage.

Information sharing protocols could be expanded to include Court-based workers, corrections officers, and all treatment and support workers, with, for example, a Central Referral Service would be the most appropriate body to coordinate and collate this information.

Information sharing protocols should be expanded to ensure continuity of care along the justice pathway, ideally through a centralised referral service.

Recommendation level 3/3

8.6.2 Imprisonment to Post-imprisonment (including Parole)

Offenders released on parole are likely to have accesses a range of AOD treatment services during their imprisonment. The Victorian Prison System has a well-established drug and alcohol treatment framework that balances the health and offending related needs. AOD treatment programs are categorised into five levels. Level 1 programs are broad-based education and peer support; level 2 programs have a

harm prevention health-focus. Both level 1 and 2 are brief interventions and are provided to all offenders regardless of whether they have a substance use problem. Level 3 programs range from 12 – 24 hours of intervention and target substance users and involve a brief assessment, and have a psycho-educational and health focus and aim to reduce substance abuse. Level 4 and 5 programs are criminogenic programs

and target both the substance abuse and offending behaviour. They are far more intensive ranging from 40 hours to 120+ hours in duration. There is also a Therapeutic Community model at Marnongneet Prison that has already been discussed in this report. These programs are highly structured, with tertiary qualified staff receiving forensically orientated supervision.

Prison-based programs are highly structured, with tertiary qualified staff receiving forensically orientated supervision

The literature clearly indicates the value of continuing prison-based treatment in the community (NIDA, 2003 & 2009; Pelissier, Jones & Cadigan 2007; Wexler & Sacks, 2000) and linking treatment before and after release.

Prison-based treatment needs to continue into the community where the specific needs of parolees must to be considered by providers

In the current system, all potential parolees with AOD needs identified by the Parole Board are re-assessed by an external agency before referral to community AOD services where treatment delivery is as per any forensic or, in most settings, voluntary clients. Three significant concerns lie here. First, there are a

host of risks for parolees, especially during the first few months post release. These form a range of treatment needs specific to this group, and for whom specialist responses are required by treatment providers.

The second concern is that this assessment is often limited to prisoner self-report with little no access to third-party experiences such as prison-based counselling staff who may have had months of group and individual counselling with the person. Further, this assessment is likely to be an unnecessary additional step if the person has recently engaged with level 4 or higher programs which may involve more than 100 hours of direct contact with forensic AOD clinicians.

Assessment can be inaccurate if based primarily upon self-report.

Third, a level of consistency in therapeutic approach is critical to treatment continuity. For example, clinical practices, and formality and boundaries around relationship building, varied considerably from prison-based services to community-based services. However, the therapist style and boundaries for parolees in the community need to be contiguous with the therapeutic environment that they have experienced in prison otherwise they have to negotiate a whole new way of relating to their workers, and progress made in their interpersonal style may be undone.

Therapist style needs to be contiguous in the transition from prison to community services.

Better targeted programs are required to address the unique needs of parolees, as well as improved mechanisms for the communication of information from their prison-based treatment. Furthermore, therapist style needs to be contiguous with prior treatment received.

Recommendation level 2/3

Prison-based staff should provide a full discharge report using the template for the Specialist Forensic AOD Assessment. Where this report is less than, for example, three months old at the time of parole, it could suffice in lieu of an additional assessment.

Recommendation level 3/3

8.6.3 Youth - Adult

The third point of disjuncture in the flow through the forensic AOD system related to clients progression from the youth into the adult system. There is minimal experience of formal handover with the client's new adult services counsellors. Although there is supposed to be a dual-track system for those between the ages of 18 to 21 where those who have prior relationships with youth services can remain up until

the age of 21, there is no transitional treatment type provided by services specifically designed for young adults.

Rather there was still only a choice between Youth Outreach, or Adult CCCC. Resolution of this issue is an action item in the Victorian Blueprint for Alcohol and Other Drug Services. Solutions regarding this problem should best be considered as a part of a review of the youth sector.

The transition from Youth to Adult services should be reviewed ensuring a contiguous therapeutic style, and that information and experiences are shared.

Recommendation level 2/3

Summary

A comprehensive framework is essential to ensure the smooth flow of information and clients across assessment and treatment services in both justice and health settings. The current system was designed for 1/7 of the throughput it experienced in 2010 and is inadequate to ensure continuity for a much larger number of referrals from a diverse range of sources. A new referral process has been suggested drawing from the four primary entry points into the forensic AOD system, being police at arrest, pre-sentencing, community dispositions, and parole. The pathway includes screening and assessment responsibilities, as well as potential destinations and pathways for variation of treatment. Referrals need to be accompanied by specific information, as requested by treatment providers, are listed alongside each pathway. Assessment and discharge information would be stored centrally on a database that would be updated with each admission.

Continuity of care is an important issue in terms of transfer of information between justice and AOD provider agencies. It is recognised that there are limitations to confidentiality in forensic settings; however, these do not necessarily

form a barrier to building a therapeutic relationship, especially when the limitations set out, and the information shared between justice and treatment providers is agreed in policy and transparently communicated with the client group.

Continuity of care along the system also has some challenges and there are three areas where these are most pronounced. For example, current systems do not support the sharing of information from the pre to the post sentencing stage.

With regards to parolees, better-targeted programs are required to address their unique needs, as well as improved mechanisms for the communication of information from their prison-based treatment. Further, treatment options and approaches need to be contiguous with prior treatment received. Prison-based staff should provide a full discharge report using the template for the Specialist Forensic AOD Assessment. Where this report is less than, for example, three months old at the time of parole, it could suffice in lieu of an additional assessment.

Finally, the transition from youth to adult services also has challenges.

Not only may there be a change on the Justice agency monitoring the person's order, but also from the

service provider as the young person becomes ineligible for continued youth services.

9 Outcome Reporting and evaluation

This chapter commences by describing the purpose of reporting in the forensic AOD system, along with some of the challenges involved. Three core functions that need to be reported are then described, from individual outcomes, through to agency outcomes and sector measures as a whole.

Agency outcomes are further divided into three areas, with illustrations and suggestions provided on what and how reporting should occur. The chapter concludes with a summary of other issues relating to the reporting and outcome measurement process.

9.1 Principles of Reporting

Effective reporting mechanisms are essential in any health or welfare service in order to demonstrate the viability and benefits of the service. The best reporting and evaluation mechanisms usually meet the criteria of being relevant, efficient, and valid.

Effective reporting and evaluation mechanisms usually meet the criteria of being relevant, efficient, and valid.

Relevant means that those collecting and processing the data see the purpose and reason behind this effort, especially when it is often detracting from 'client time'. Ideally, they would also see some clinical benefit or utility in the evaluation process and data. *Efficient* refers to the way that the reporting mechanisms are embedded as seamlessly as possible into current processes, with little or no duplicating of activity. *Valid* relates to the data being collected genuinely reflecting not only the breadth of service outcomes being reported, and also collecting factors such as agency effort.

Demonstrating and reporting outcomes in the AOD sector is a challenging issue for services because the majority of clients present with a complex range of issues rather than simple substance misuse or dependence. In addition, forensic clients usually have a range of criminogenic factors above and beyond their substance use that resulted in their entering the forensic system. Measurement and reporting of outcomes is often challenging for behavioural and psychological interventions,

especially in the case of substance-use disorders, due to the wide variety of problematic behaviours, the multiple underlying causes driving the behaviours, and the cyclical nature of the process of recovery.

Reporting for substance-use disorders can be challenging due to wide variety of problematic behaviours, multiple underlying causes and the cyclical nature of the process of recovery.

As a result, treatment outcomes are difficult to measure with validity and reliability, compared with interventions that focus upon the biological components of problematic substance use.

Despite these challenges, reporting on treatment delivery, experiences and outcomes is an essential function for any integrated health service. It is proposed that in the Victorian forensic AOD system, outcome measurement serves three core functions as illustrated in figure 27.

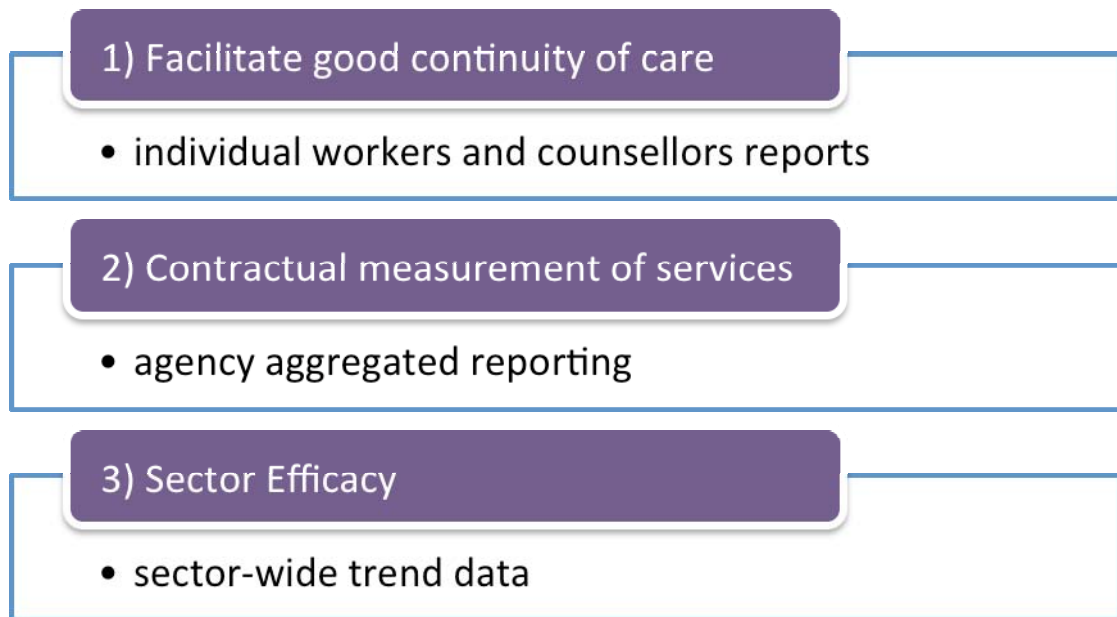


Figure 27: The three key areas for outcome reporting.

The first is to facilitate good continuity of care for the individual client, with one clinician directly reporting the outcomes of their work and any other relevant information, discussed further in section “9.2

Reporting to Facilitate Continuity of Care”. This enables treatment to be delivered on a continuous basis, with each service type building upon the work of previous services.

The second function for reporting relates to the contractual measurement of services by agencies. Good practice generally focuses upon three methods for determining successful treatment outcomes at the program or agency level illustrated in figure 28, being Aggregated Client Outcome

Measures, Throughput Measures, and Quality Measures. These are discussed in greater detail in section “9.3 Contractual Measurement of Services”.

The third and final function for reporting illustrated in figure 27 relates to the efficacy of the sector as a whole. These data include the aggregate outcomes from all AOD service providers, and can include crime data, recidivism data and other indicators relating to the efficacy of the forensic AOD system at a community level and these are discussed in section “9.6 Sector Outcomes”.

Together these elements provide a comprehensive picture of treatment outcomes on the individual, service, and sector levels.

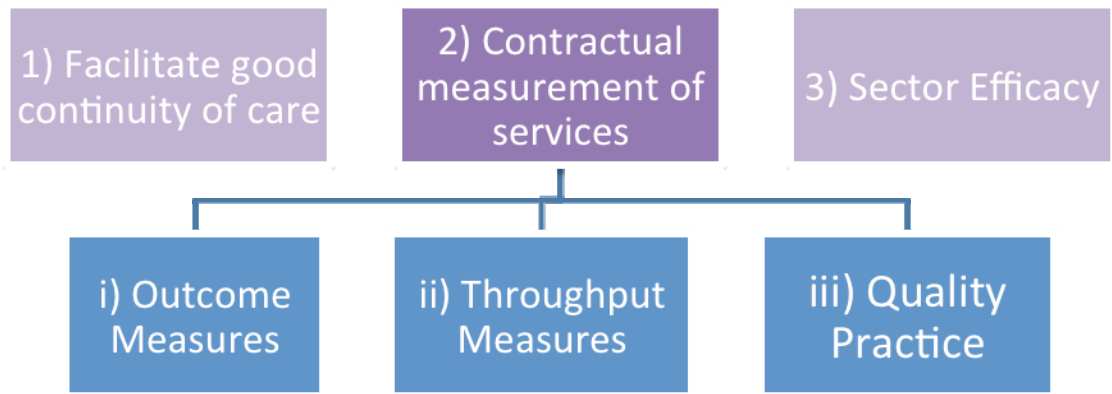


Figure 28: Three types of reporting for contract management purposes

9.2 Reporting to Facilitate Continuity of Care

Continuity of care is an essential ingredient for good service provision, and this applies at the individual worker level rather than at an agency or sector level. It involves an effective and efficient interface between treatment providers and case managers, both laterally across concurrent services, and longitudinally along the service system.

Continuity of care requires system-wide processes to maximise the level of communication from one stage to the next.

Lateral continuity of care has been discussed already in chapter 8, with particular emphasis upon continuous reporting between Community Corrections case managers and the AOD service provider.

Longitudinal reporting is also well identified as being critical to quality care, however, the Victorian system currently has no specific mechanisms facilitate this process, and there are several clear disjunctures (such as pre to post sentence and prison to parole). Therefore, continuity of care requires system-wide processes to maximise the level of communication from one stage to the next, especially when the client's transition is not immediate.



Figure 29: Reporting under the first function: “good continuity of care”

High quality discharge summaries are an invaluable tool for facilitating the transition process and are critical for the provision of quality, coordinated care. Without them, key information relating to client history, and to their ability to engage in treatment and treatment experiences, are lost at the closure of an episode of care and cannot be shared with future service providers.

High quality discharge summaries prevent key information relating to client history, ability to engage in treatment and treatment experiences, being lost at the closure of an episode of care.

To be of maximum benefit, a discharge summary would contain the following information, especially where there may be a gap between discharge from one service, and continuing onto the next:

- current order and conditions
- other services engaged including other AOD treatment
- referrals made and outcomes
- changes to AOD use and AOD use on discharge
- significant goals achieved during treatment
- risks around AOD use, offending, and other key life areas
- engagement and management in treatment issues
- where the person is likely to be referred onto another service and updated AOD Assessment or Specialist Forensic AOD Assessment depending upon client need.

However, without a mechanism for the storage and sharing of this information, they are of little use. Therefore, the use of a standard template that could be adopted sector-wide, so that the discharge summary can be integrated into,

rather than appended onto, the Central Referral Service’s client file, enabling this to be provided for all future assessments and treatment.

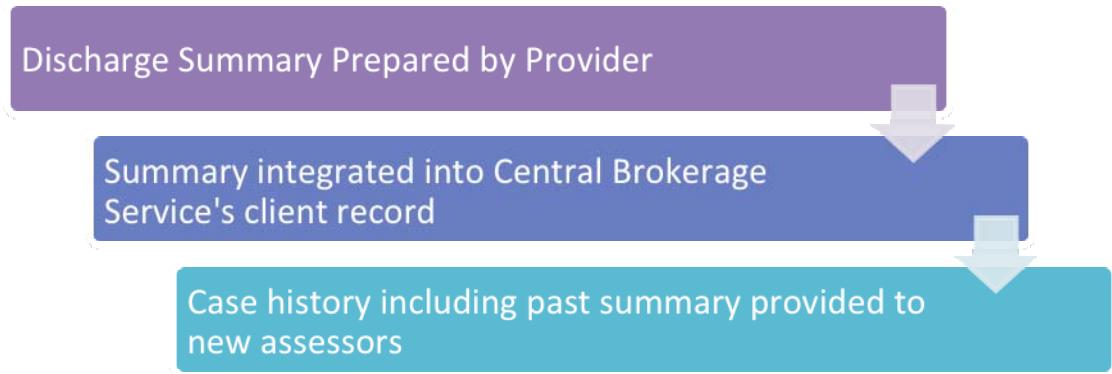


Figure 30: Example flow of discharge summary

A comprehensive standardised discharge summary should be introduced and developed for use across the sector. These summaries should be incorporated into a centralised electronic record to facilitate continuity of care and where a variation to another form of treatment is indicated, that this summary also includes an updated Assessment and is provided to future assessors to ensure continuity of care.

Recommendation level 3/3

9.3 Contractual Measurement of Services

The second domain of reporting illustrated in figure 28 relates to contractual reporting by agencies, and is divided into three areas: individual client outcomes, throughput measures, and quality practice, and each is discussed in turn below.

The first method collates the treatment outcomes of clients, providing an overall picture of whether the program has achieved its intended goals (e.g. reduced

offending and substance use) as well as client satisfaction with treatment. The second area explores throughput and the ability of the program or agency to engage clients in treatment and includes the number of significant treatment goals achieved (e.g. per funded position), program attendance and completion rates (number of contacts per completed significant treatment goals), accessibility (such as waiting times) and whether the

program is servicing its target population. The third area that can be measured includes indicators that determine the quality and integrity of the service provided, such as consumer-focussed service, best-practice interventions, good case work (e.g. assessments, case conferencing) and quality staff support.

Each of these outcome indicators are interrelated and many have been shown in various studies to predict

positive treatment outcomes for clients, both in the short and long term (Brochu, Cournoyer, Tremblay, Bergeron, Brunelle & Landry, 2001; Butzin, Saum & Scarpitti, 2002; Freeman, 2003; Knight, Hiller & Simpson, 1999; Sung, Belenko & Feng, 2001). In addition, ongoing analysis of treatment outcomes at all levels allows continued reflective practice, building a culture of development and improvement (Fitzpatrick, Chambers, Burns, Doll, Fazel, Jenkinson et al, 2010).

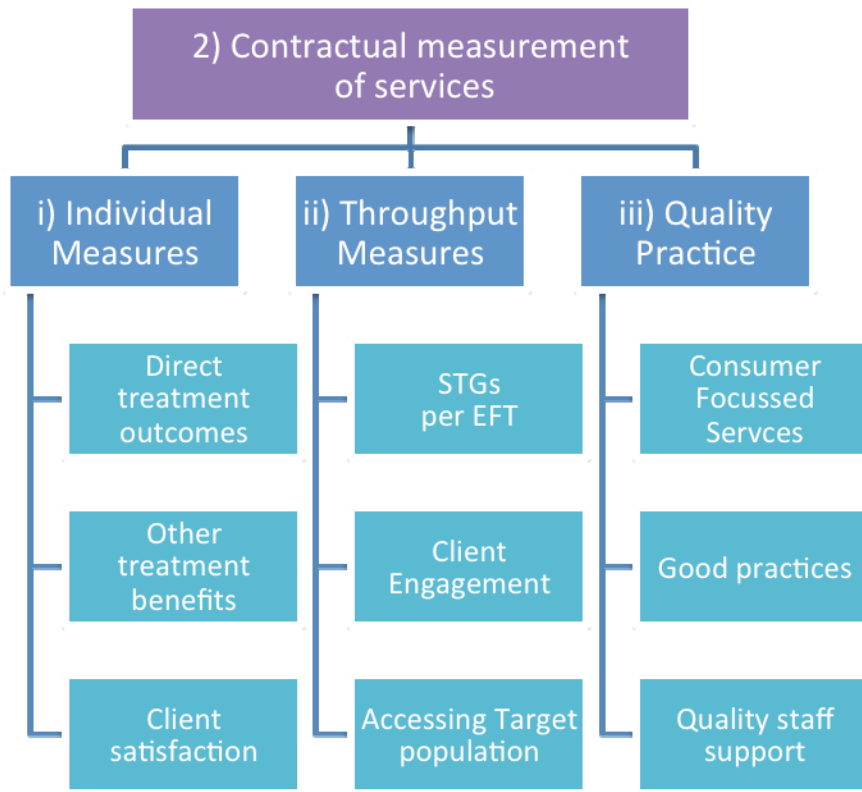


Figure 31: Reporting under the second function “Contractual measurement”



9.3.1 Individual Measures

The Department of Health in Victoria and Corrections Victoria both describe purchasing treatment services with the objective of long-term reduction or cessation of AOD use through behaviour change. This results in positive health benefits, and the reduction of AOD related harm to both the individual and the community (Department of Health Blueprint for the AOD sector, 2009; Community Correctional Services AOD Strategy, 2008).

These outcomes fall under the three headings, as illustrated in figure 31, of Direct Treatment Outcomes (those changes relating to the AOD use and offending behaviour); Other Treatment benefits (those beneficial changes in other life domains); and Client Satisfaction with services, discussed below.

Valid and reliable measures of these service objectives, based upon treatment outcomes for individual clients, need to be in place. In the current system, there is some question around the appropriateness and consistency of the measures used across the sector for forensic AOD clients. First, outcomes in the forensic sector are measured by the clinician selecting one or more 'significant treatment goals', from a list approved by the Department of Health. However, these goals were developed for the voluntary sector, and do not specifically recognise the different treatment priorities for forensic

versus voluntary clients.

Current Significant Treatment Goals were developed for the voluntary system and do not reflect the priorities of forensic AOD treatment.

Second, these outcome measures may not meet the conditions of being valid and reliable, as there are no requirements for objective or quantitative measures of change. As a result, the reporting system is primarily based upon clinician opinion rather than objective measures (described later in this chapter), which, in practice, is based upon client self-report, a measure in forensic AOD settings is not considered very reliable.

Current outcome measures are not necessarily objective, valid, or reliable and change is not recorded quantifiably.

Third, these goals are neither explicit nor quantifiable, so for example, the goal of 'reduced substance use' does not indicate by how much and so it does not differentiate minor from major degrees of change.

Fourth, there are no benchmarks regarding the degree of change expected, resulting in a high level of

variability in criteria of reporting from one worker to the next, and from one agency to the next. As a result, there is no capacity to audit treatment outcomes across the sector and compare performance from service to service.

There are no benchmarks against which workers and agencies can measure their clinical efficacy

It is clear that evaluation and reporting of outcomes in the AOD sector is fraught with challenges, due to the complex nature of substance use and addiction, and the cyclical process of recovery. However, the appropriate use of objective and/or quantitative measurement tools needs to be carefully considered.

AOD services aim to a range of significant treatment goals, and for the purpose of this chapter, they can be considered in one or more of five outcome areas. These are (1) a reduction of negative symptoms and

health risks (e.g. by completing a withdrawal), (2) changes in knowledge as a result of the intervention (e.g. harm reduction information), (3) changes in attitude as a result of the intervention (e.g. motivational shift, desire for help, change in justification of offending), and (4) changes in deliberate behaviours (e.g. increased exercise, or increased phone calls to peer supports when in distress) and (5) support and linkage with relevant services (e.g. addressing housing situation). These represent the individual outcome areas that need to be reported, and this is illustrated in the matrix in table 6 below. It is important to note that not all programs would target all five domains so such a matrix would be adapted to reflect the objectives of each program.

These five areas could be applied to the issue being targeted (such as the amount of AOD used, or risk-taking behaviour), and also to any additional areas of benefit (such as housing, or health).

Table 6: Example Program Outcomes Matrix

Caution needs to be considered before considering the tools for measuring these areas, as many were developed for assessment purposes and are not appropriate for use in evaluating outcomes. For example, instruments designed to measure motivation and treatment readiness such as the SOCRATES are not a valid when used as a pre and post measure because a decrease in scores could either indicate a lack of motivation to address problematic behaviours as a result of ineffective treatment, or a decrease in perceived treatment need as a result of successful treatment, depending upon the individual client.

Many assessment and screening tools are not valid as pre/post measures

However there are some tools available that may assist in this process, many of which are

discussed in the following sections looking at direct and other treatment outcomes. These are broken into objective and subjective measures of outcomes, with objective measures being preferred due to possible higher levels of reliability and validity.

Objective outcome measures are preferable where possible over subjective measures

Ultimately, future research needs to continue developing methods that yield more reliable and valid ways of predicting client change and/or success factors, as well as determining the usefulness of interventions that are targeted at underlying factors driving criminal behaviour.

Rather than the current system of picking a significant treatment goal, that the measures of treatment outcome should be quantifiable and objective, focus upon AOD use, AOD-related offending behaviour, and other bio-psycho-social wellbeing (depending upon program focus). These outcome measures could include indicators of any of the five treatment outcome areas: (i) reduction in symptoms, (ii) improved knowledge, (iii) altered attitudes, (iv) deliberate behaviours, (v) and support & linkage. The measures under each of these headings should aim to be, achieved outcomes.

Recommendation level 2/3

9.3.1 Direct treatment outcomes

For forensic AOD populations, three outcome areas are generally regarded as indicators of treatment effectiveness; reduced substance use, reduced offending, and reduced risks associated with those areas. However, goals relating to these areas need to be explicitly defined, quantifiable, verifiable, mutually agreed between funder and provider, and relevant to a range of key factors such as the service type, the service user's level of substance use, their treatment readiness, and their treatment responsiveness.

Methods for assessing outcomes in these areas can take two forms; subjective measures, such as self-report, and objective measures, such as physiological indicators (e.g.

breathalyser), police/court records and other service use data. The use of both subjective and objective measurement techniques for each of the three outcome areas, substance use, offending, and risk are discussed below, followed by a section looking at other benefits including improvements to bio-psycho-social well-being.

Three outcomes are generally regarded as indicators of treatment effectiveness; reduced substance use, reduced offending, and reduced risks associated with each.

Substance Use

The extent of a client's substance use can be measured in a variety of ways, including type of drug(s) used, the frequency and amount of use, and the severity of dependence. When quantifiably described at assessment (e.g. by using a substance use chart), they can be reassessed on discharge, with any decline serving as an indicator of treatment effectiveness.

Treatment effectiveness can also be gauged by measuring changes in the clients' attitudes towards substance use, and given that forensic clients often present to treatment with low motivation with regard to behaviour change, shifts in attitudes towards recognition of their problematic

behaviours (and need for treatment) may be a particularly useful indicator of treatment effectiveness for this population. This is especially true for brief interventions or where the client presents with low treatment readiness so actual behaviour change may be less likely.

Treatment effectiveness can also be gauged by measuring changes in the clients' attitudes towards substance use.

However, forensic clients may be required to abstain from substance use as a condition of their court

order or probation. Therefore, while actual use may decline or cease during the period of mandated

treatment, they may have little intention of remaining abstinent once treatment has been completed.

Subjective measures

Other states utilise a variety of assessment tools for use in their diversion programs such as QMERIT and QIADP and the ASSIST screening tool. The extent of substance use is measured at assessment and treatment completion, using self-report to indicate the amount and frequency of use in the previous month. Clients are also asked to indicate the substance of greatest concern. Severity of dependence for the primary drug of concern is assessed pre and post treatment using the Severity of Dependence Scale (SDS), which consists of five questions designed to measure dependence as defined by the DSM-IV. Assessment of risky behaviours requires clients to indicate drug injecting behaviours and overdoses in the previous three months.

The wide use of different screening tools as pre and post assessment measures indicates that there is a lack of valid and reliable standardised tools available that have been specifically developed for measuring post treatment improvements in substance use. However, what is essential is that the assessment tool used does include quantifiable measures to ensure that treatment effect may be determined.

The assessment tool must include quantifiable measures to determine treatment effect.

Objective measures

The use of Breathalysers and sampling Urine Drug Screens are the primary means for objective AOD reporting used in the Victorian forensic AOD system. However, for a range of reasons including cost, this approach is more commonly used for high-risk clients with serious substance dependencies, and with those in prison settings or for monitoring clients on bail. Treatment settings adopting urinalysis typically require clients to provide samples pre-treatment (e.g.

at time of arrest or charge), during treatment at various intervals or where clinically appropriate, and at treatment exit or program completion. In contrast, few community-based treatment settings have been found to use this method, with some even cautioning that adopting this approach can be problematic for establishing the therapeutic alliance with the client. This needs to be balanced against an assessment of the reliability of self-reported measure in forensic clients.

That said, the DUMA project showed that self reported drug use has a higher degree of reliability when validated against Urine Drug Screens.

Self reported drug use has a high degree of reliability when validated against Urine Drug Screens.

Other valid objective measures of changes to AOD use, and these can

Offending behaviours / attitudes

One of the primary aims of forensic AOD treatment is to reduce substance-related offending behaviour. The underlying principle behind this expectation is that the client's substance use and offending are often related, though the nature of this relationship is sometimes complex and varies from one client to another (this issue is discussed in more detail in chapter 2).

While a reduction in the likelihood of future offending is a desirable outcome for all forensic AOD treatment, the need for service providers to assess for changes in risk of re-offending post treatment does not apply across all levels of service delivery. For instance, clinicians providing brief diversionary interventions to low-level clients would have less need to assess for changes in offending attitudes and behaviour than those providing more intensive, longer-term

include blood tests or saliva samples. Physiological impacts of AOD use can also be measured such as body weight changes, or improvements in Liver Function Tests. Third party reports from family or significant others may also be included however they may have limited reliability and influenced by the nature of their relationship with the client.

interventions to high-offending risk clients, such as those on probation or community orders.

Those providing brief interventions to low-offending risk clients would have less need to assess for changes in offending attitudes

In addition, services may differ with regard to how they measure improvements in a client's offending or risk of offending, depending on the level of intervention and nature of the client population. However, measurement of offending may also be implied by the development of pro-social behaviours and attributes, such as stable relationships, employment or study, and other factors.

Subjective measures

Subjective measures of a client's offending include risk assessment, measures of criminal or antisocial attitudes and personality traits, and self-report of offending behaviour. A client's level of risk with regard to offending can be measured using standardised tools of antisocial behaviour and attitudes such as the Psychology Inventory of Criminal Thinking Styles (PICTS), the Texas Christian University Criminal Thinking Scale (TCU-CTS), the Anti-Social Activities Attitude Scale, the Criminal Sentiments Scale, and the State-Trait Anger Expression Inventory -2 (STAXI-2), Violence Risk

Scales (VRS), Novaco Anger Scale, and Hare's Psychopathy Checklist Revised (PCL-R). In addition, clinicians can assess for changes in criminogenic factors (factors known to increase risk of offending), such as associating with antisocial peers, unemployment and poor community integration.

Tools can measure antisocial attitudes and behaviour, or criminogenic risk factors.

Objective measures

Individual service providers delivering AOD treatment to clients may have little need for assessing reductions in client offending using objective measures such as rates of re-arrest, court appearances and incarceration, unless these incidents occur during the course of treatment. However, the observable presence of pro-social behaviours can be

helpful, and there are several scales, especially for within residential settings, such as the Blackburn & Glasgow's CIRCLE. Whilst these may still require subjective reporting by the observer, they are likely to be more objective in terms of the client. Measures of recidivism are better for evaluating outcomes across the sector as a whole.

9.3.2 Other Treatment Outcomes

Improvements in overall health and functioning are an important outcome indicator of treatment effectiveness. Pre-treatment health and well-being assessments of clients are part of standard practice

in many AOD agencies, and are equally as important for forensic clients as for voluntary clients. Poor mental and physical health, quality of life and social functioning are barriers to achieving positive

treatment outcomes and therefore assessment of bio-psycho-social functioning is both an important outcome indicator in its own right and a proxy indicator of the effectiveness of treatment in reducing substance use and offending.

Bio-psycho-social functioning is an important outcome indicator in its own right and as a proxy indicator of treatment efficacy.

Improvements in health and functioning can be measured using standardised instruments before and after treatment, or by assessing the effectiveness of any linkages made to health and support services during the course of treatment, or most simply by having ordinal rating questions for core life areas such as housing stability and satisfaction, social connectedness, and vocational status. Although these areas have been identified as relevant and important issues in the literature, these domains have not been consistently employed in forensic AOD outcomes research (Fitzpatrick et al, 2010).

Subjective measures

Various self-report measures are available and used in different jurisdictions. Different versions of the Short Form (SF) Health Survey are used in each state to assess for changes in health and social functioning (the SF-36 is used in Queensland and the SF-8 is used in Western Australia). The Kessler-10, which is a measure of psychosocial distress, the Depression, Anxiety and Stress Scale (DASS), and the Trauma

Symptom Inventory (TSI), are also used to measure treatment impacts. While most measures seek to quantify presence and reduction of problematic symptoms, other measures assess improvements in bio-psycho-social well-being, such as the World Health Organization Quality of Life Scale (WHO-QoL) which is available in a full and a brief version.

Objective measures

Data which may be useful as objective indicators of improvements in bio-psycho-social wellbeing could include: improvements in physical health, changes in employment or housing status, enrolment in education and

training, and engagement in aftercare support services. These, like many measures, need not necessarily be complex or lengthy; rather a simple question relating to housing status pre and post intervention may be adequate.

9.3.3 Client Satisfaction

The third heading under individual outcomes in Figure 31 relates to client satisfaction with the treatment. This principle is reflected in quality standard frameworks that require services to adopt a consumer focus and to incorporate client feedback into program review and development processes. However, client engagement and retention are also strong indicators of positive treatment outcomes and so the client's perception of the service can be a useful measure. Caution has to be taken when assessing client satisfaction in the AOD sector, as there may be a variety of reasons why a client may be dissatisfied with a service that have no bearing on the quality service itself (for example, a client being discharged from a residential setting for having used drugs).

Programs often provide the opportunity for client feedback, however not all programs proactively seek out satisfaction measures in reviewing and

evaluating services. Regular check in with clients' perspectives on the relevance and efficacy of the treatment process and program content, as well as their experience of case management, may enhance retention and improve treatment outcomes and these can be as simple as Miller's 4-point "Session Rating Scale". Treatment type-specific client satisfaction tools should be standardised and implemented across the forensic AOD system and assertively integrated into service delivery and discharge planning, rather than being solely used as a mechanism for those wishing to provide feedback.

Whereas most measures focus upon reduction of negative symptoms, other measures assess improvements in bio-psycho-social well-being

9.4 Throughput Measures

Referring back to figure 31, the second area for reporting in the sector concerns the activity that is involved in providing treatment, how many treatment episodes are provided, and whether that treatment is targeting the right population group in a way that is accessible. This provides the capacity for agencies to be able to report effort, not just outcomes, something particularly relevant when working

with populations with low treatment readiness as these clients may achieve fewer treatment goals and have lower completion rates. Consideration of throughput measures or Key Performance Indicators (KPIs) can be in the form of either minimum targets that must be attained (e.g. a minimum of 104 episodes of care per year). Alternatively they can be in terms of benchmarking data based upon

performance against the rest of the sector (e.g. 90% of clients should be assessed within two working days, or 80% of clients attending counselling need to have achieved a significant treatment goal).

Using either minimum throughput or sector benchmarking, there are three areas that throughput could be measured: Significant Treatment

Goals per EFT, Client Engagement, and accessing the Target Population.

Throughput measures can be represented by minimum targets or sector benchmarking.

9.4.1 Significant Treatment Goals per EFT

The first relates to the number of Significant Treatment Goals (STGs) being achieved per funded position. This is already in place in the current system and forms the primary measure of agency output.

Agency output is a lot broader than simply the number of STGs per position

However, in any future system the formula for this target in forensic AOD system should take into account:

- i. forensic client have higher levels of non-attendance,
- ii. many forensic clients require greater amounts of assertive follow-up, phone calls, case conferences and other client-related activities, and
- iii. counsellors should be able to claim different service types depending upon the engagement of the client,
- iv. fewer STGs should be required for therapeutic counselling compared with Supportive counselling given that behaviour change goals take considerably longer to attain than psycho-educational goals or linkage goals.

The nature of substance use itself means that there are a range of factors beyond the influence of the counsellor, and often beyond the influence of the client, that can have a significant impact upon treatment and the capacity to achieve behaviour change outcomes regardless of how well the person has engaged in services. As a result, there will always be a proportion of clients for whom STGs may not be obtainable in a particular episode of

care, either because of resistance to change, or because of external factors.

Resistance or external factors will always impact ability to achieve Significant Treatment Goals for some clients.

Given this a sector-based benchmark could be set requiring that, for

example, 80 - 90% of all episodes of care need to result in a significant treatment goal. This would enable agencies to legitimately register 'no

Significant Treatment Goal' attained in these cases and count them towards their Episode of Care targets.

9.4.2 Client Engagement

In addition to Significant Treatment Goals, the extent to which clients engage with treatment is consistently reported as one of the key indicators of treatment effectiveness (Brochu et al, 2001). Treatment engagement can be viewed both from an individual client perspective (i.e. the ability and desire of clients to engage in treatment, otherwise referred to as responsivity) as well as from a program perspective (i.e. the ability of the program to maintain clients in treatment by, for example, assertive follow-up) (Sung, Belenko & Feng, 2001).

The extent to which clients engage with treatment is a key indicator of effectiveness

For forensic AOD clients, the length of time spent in treatment and/or successful completion of a treatment program serve as consistent predictors of positive treatment outcomes and have been identified amongst offenders as important factors in reducing both substance use and criminal activity (Butzin, Saum & Scarpitti, 2002; Freeman, 2003; Knight, Hiller & Simpson, 1999;

UK Drug Interventions Programme: NAT models of care, 2006). An evaluation of the NSW MERIT Court Program (Passey, Bolitho, Scantleton, & Flaherty, 2007) indicated that those who completed the program were less likely to reoffend in the next three (half the typical rate) and 12 months (three quarters of the typical rate) than those who did not complete the program, and were also slower to reoffend (at 100 days 73% of completers had not reoffended compared to 50% of non completers). Further, a study of the NSW Drug Court Programme found that offenders who remained in treatment for a minimum of four months demonstrated significant improvements in health and wellbeing, and that improvements were maintained for up to 12 months for offenders who completed the treatment program (Freeman, 2003).

Given that treatment attendance and retention is a valuable indicator of program effectiveness that could be recorded by service providers as part of their standard data reporting processes. This could be benchmarked against other comparable agencies providing the same treatment type.

9.4.3 Target Population

The final area of reporting for throughput measures could include indicators that measure whether the program is reaching and servicing its target population. For example, there are programs funded to target specific groups such as youth or indigenous Australians and it is essential that these services are reaching those for whom the service is intended.

Programs typically target population groups, or specific treatment needs, or a combination of the two.

Programs may also exist to target specific needs (as opposed to

population groups), such as residential rehabilitation for those for whom community based treatments have not been successful, or dual diagnosis services. Reporting could be encouraged to ensure that funding is indeed reaching the target groups, and to facilitate appropriate planning of resources across the sector by including specific information about that population group in terms of demographics, or assessed treatment need. Waiting times to access the services, provision or access to child-care and CALD accessibility may be considered as well to ensure their ability to support those intended, rather than just the majority.

Currently agencies report throughput in terms of number of episodes of care. However there are a range of problems associated with this measure of effort and efficiency, and future measures of agency throughput should include waiting lists, retention rates, typical number of contacts, and the population being targeted, as well as the category of significant treatment goal being reported.

Recommendation level 2/3

9.5 Quality Measures

Quality client care is an essential feature of any AOD service, and many core features are considered in

Quality Accreditation processes, some of which have been mentioned in the previous sections of this

chapter. However, quality accreditation itself usually focuses upon the existence and efficacy of quality assurance mechanisms considered at the time of audit, and does not necessarily include the continual reporting of quality measures. Whilst the issue of quality is generic to the whole AOD sector, and does not need to be adapted to the forensic AOD sector, nonetheless, issues relating to quality could be incorporated into any future model of forensic service delivery.

Individual agencies have no requirement to report on or provide evidence for how they maintain quality standards

Government departments and peak AOD organisations have laid out various standards for the delivery of AOD treatment programs, including those delivered specifically to forensic populations. At the national level the Australian Institute of Health and Welfare (AIHW, 2001) National Health Performance Framework provides nine performance indicators for AOD treatment services. These include effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuousness, capability and sustainability. Treatment programs delivered in each state and territory in Australia are also expected to adhere to

quality standards developed within, or approved by, the relevant government departments or recognised accrediting bodies. For example, the Shaping the Future – The Victorian Alcohol and Other Drug Quality Framework describes six standards which apply to different aspects of treatment provision, with STANDARD 3: Continuous Quality Improvement, requiring they have a quality accreditation program, monitoring of the regulatory and contractual requirements for funded drug treatment services, monitoring of client outcomes, performance monitoring, evaluations and reviews.

While these principles and quality standards are in place, the extent to which they are monitored is variable with no sector-wide standard or process, and quality reporting not occurring in most quality areas. Individual agencies are responsible for ensuring they adhere to best practice standards and principles of service provision, with no requirement to report on or provide evidence for how these standards are met other than at times of accreditation itself.

In light of this, several aspects of quality service delivery could be considered when reporting and recognising service providers' effort. These are described below, being: consumer-focussed services; best practice interventions; good clinical practices; and quality staff support.

9.5.1 Consumer Focussed Services

The Shaping the Future – The Victorian Alcohol and Other Drug Quality Framework (April 2008) requires in its first standard that agencies should adopt a **Consumer Focus**, incorporating a culture of “trust, respect, openness, equal opportunity, advocacy and support, responsiveness, shared ownership and accountability, dissemination, evaluation, new AOD service system frameworks, association of participating service use, client charter, agency feedback mechanisms”.

Active feedback mechanisms could be used by asking service consumers about their experiences.

Active reporting may not be required, however active feedback mechanisms could be employed akin to those typically used in evaluation processes, such as asking all, or sampled service consumers, about their experiences across the areas described in “Shaping the Future”, in recognition of the steps that many leading agencies make to ensuring that this underpins their practice.

9.5.2 Best Practice

The NIDA principles and literature highlight a range of key features that underpin quality client practice and these include: conducting quality assessments, collaborative work with other stakeholders, appropriate discharge and assertive referral planning, and practices that are responsive to client need. The existence of these factors provides some indication of the overall quality of the service provision.

Where service provision incorporates these broader activities there can be some confidence that the provider is operating with a broader awareness of client needs and a commitment to continuity of care beyond the current treatment episode. Whilst it is possible to account for the amount of time spent in these activities, it is difficult to report on these processes in a way that demonstrates their value to

the overall experience of the client. One way that it could be incorporated is for episodic client file audits to determine the frequency and quality of such activities. A file review could examine the completeness of the assessment, cross check treatment goals at assessment with the current treatment plan, look for evidence of achievement of treatment goals and verify the level of quality activities provided to support the treatment (e.g. case planning sessions, discharge forms, case conferences).

Episodic client file audits to determine the frequency of and quality of assessment, assertive follow up, collaborative work and discharge planning.

When looking at the specific interventions provided, it is important for services to have a sound basis in the literature, and therefore it is important that service providers are recognised for maintaining an understanding and articulation of what practices are being conducted at their service (e.g. what happens in a counselling session), a reflective view of their practices, and currency with the latest developments, guidelines and literature.

“Best Practice” is often used to describe the use of evidence-based interventions that have been empirically demonstrated to be effective. However there are several problems with this paradigm and caution should be used when applying best practice principles. First, although best practice is based upon empirical evidence, it does not limit itself to those interventions. This is because not all interventions can be demonstrated empirically due to the very large number of variables involved in AOD treatment, and that most psycho-social interventions do not follow a predetermined and

manualised process. Rather, they are adapted and modified each time they are used with a client to best match that client’s needs.

“Best Practice” should be applied to forensic AOD work, but with some points of caution.

Second, best practice should allow the intervention to be adapted to the unique cluster of needs of the target population group, and to the specific skills and attributes of the clinicians working with them. This is all the more important given that most research is conducted in foreign countries and cultures, using cohorts that may bear little resemblance to local populations.

Third, best practice should not be bound by the past, but should include the opportunity for innovation and creativity, and trying new ways to improve outcomes. This enables true reflective practice and permits the advancement of treatment and services.

9.5.3 Quality Staff Support

Frontline staff are at the core of the health and welfare sector as they provide the services to the clients. Support and development of frontline staff is therefore critical to the capacity to provide effective services. Many of the issues relating

to support and development have already been discussed in this document and will not be repeated here, however reporting though could include measures relating to these types of support and development.

Quality of service delivery can also be reported above and beyond that required for Quality Accreditation. Examples of this could include a variety of good practice areas such as the occurrence of assertive referral, effective management of waitlists, case conferencing with other providers, review of clinical practice in line with latest developments, and quality of discharge reporting.

Recommendation level 2/3

9.6 Sector Outcomes

In addition to individual outcomes and the agency outcomes illustrated in figure 28, there is a need to determine the effectiveness of the sector as a whole, with a view to assessing whether government policy is being implemented and the desired outcomes are being achieved on a population level. Rather than being drawn from agencies, the data reported here would be drawn from a variety of

sources such as Department of Health databases and Justice agencies.

In the current policy context two primary questions would need to be answered here (i) is there a reduction in substance-related offending and (ii) are all substance-using offenders who should be accessing services, being referred and retained.

Re-offending rates (Recidivism)

Reducing the re-offending rates of substance-using offenders was described in chapter 3 as being one of the primary harm reduction priorities of any forensic AOD sector. The importance of this is reflected in the use of recidivism rates as the most commonly reported indicator of treatment program success, both in academic research and program evaluation (Fitzpatrick et al, 2010; Knight, Hiller & Simpson, 1999). This focus on recidivism can be attributed

to the need for the criminal justice system to demonstrate that treatment services are a legitimate and effective response to drug and alcohol related offending, provided to protect the community from drug

related crime.

This focus on recidivism can be attributed in part to the need for the justice system to show that treatment services are a legitimate and effective response to AOD-related offending.

Recidivism data could be drawn from a variety of sources, such as, the Police Database (frequency of being arrested for substance-related crimes), or Court Databases (frequency of offences making it to the court), or the Central Referral Agency (reporting the number of re-referrals into the system). Privacy issues, as well as database content and functionality, are key restrictions around what data is available and can be accessed, hence for this report, the focus was upon the third data source: data held by ACSO COATS, who currently broker all forensic community AOD treatment.

Assuming access to the data is available, there remain several limitations to the use of recidivism data as an indicator of treatment effectiveness. First, data may be understated (e.g. the offence is not detected by police, the person is not charged, or does not appear in court) or overstated (the person is found not guilty in court but is included in re-arrest statistics). Second, information is obtained from a variety of sources using different methods, such as self-report, arrest or conviction databases and parole violations, and this leads to problems in comparing

outcome data across programs or research studies. Third, baseline rates of offending and variations in offence type are often not considered and therefore any changes in the frequency or severity of offences committed post treatment are overlooked.

There remain several limitations to the use of recidivism data as an indicator of treatment effectiveness

Despite these limitations, there is clear evidence demonstrating that forensic AOD treatment programs are effective in reducing recidivism. In the UK, for instance, nationally recorded acquisitive crime of the kind associated with drug users dropped by 20% from 2003 (when the Drug Intervention Program was introduced) to 2007 (Home Office, 2007). An evaluation of Western Australia's diversion programs found that, for each program, those who completed were less likely to have been re-arrested in the follow up timeframe (24 months), were slower to reoffend, and had lower re-arrest rates than were predicted by risk estimates (Crime Research Centre University of Western Australia, 2007). Evaluations of Queensland's Indigenous Alcohol Diversion Program (QIADP; Success Works, 2010) and the Queensland Drug Court (Makkai & Veraar, 2003) have also demonstrated a reduction in recidivism for offenders who complete treatment. For the Queensland Drug Court participants, rates of re-offending reduced

significantly, with few graduates reoffending in the follow up time frame (average of 441 non-incarcerated days), and where offending did occur, the average time to reoffending was longer than for matched comparison groups (Makkai & Veraar, 2003).

While there are no perfect methods for evaluating this outcome, several indicators can be used to gauge a sense of whether forensic AOD treatment is making an impact on the criminal justice system. These include reporting the number of

forensic clients who access treatment, as well as the number who complete treatment, and comparing sentencing outcomes, parole outcomes and recidivism rates for offenders who engage in treatment, compared with a matched group of offenders who do not engage in treatment. Where comparison groups are inappropriate or unavailable, risk estimates may be used. These indicators have been used by other jurisdictions, both in Australia and internationally.

Summary

Measurement and reporting of outcomes is often difficult for behavioural and psychological interventions, and especially in the case of substance-use disorders, due to the wide variety of problematic behaviours, the multiple underlying causes driving those behaviours, and the cyclical nature of the process of recovery. Nonetheless, delivery, experiences and outcomes need to be reported for any integrated health service, and the current outcome reporting systems produce data that is neither valid nor reliable.

Reporting in the Victorian forensic AOD system has to serve three core functions. The first function is on an individual client level: to facilitate good continuity of care with one clinician directly reporting the outcomes of their work and any other relevant information, onto the next.

The second function focuses upon agency outcomes. AOD services

typically deliver one more of five outcome areas as a result of interventions. These are (1) a reduction of negative symptoms (e.g. by completing a withdrawal), (2) changes in knowledge as a result of the intervention (e.g. harm reduction information), (3) changes in attitude as a result of the intervention (e.g. motivational shift, desire for help), and (4) changes in deliberate behaviours (e.g. increased exercise, or increased phone calls to peer supports when in distress) and (5) linkage with relevant support services. Furthermore, these can relate to the primary target of the intervention (in the forensic AOD sector this would be the person's drug use and factors directly related to it, as well as their drug-related offending behaviour), as well as secondary treatment outcomes (including criminogenic and non-criminogenic issues). Indicators of these can either be objective measures, which are preferred, or

subjective reporting, which may be less reliable but easier to obtain.

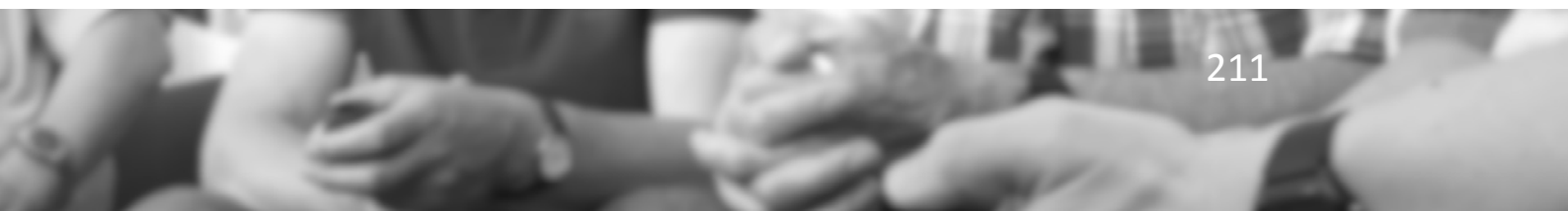
The second area of agency outcomes focuses upon throughput measures and this includes the number of significant treatment goals achieved (per funded position), program attendance and completion rates (number of contacts per completed significant treatment goals), accessibility (such as waiting times) and whether the program is servicing its target population.

The third area of agency outcomes involves key performance indicators used to determine the quality and integrity of the service provided, such as consumer focussed service, best practice interventions, good case work (e.g. assessments, case conferencing) and quality staff support. It is emphasised here that the paradigm of “best practice” should enabling treatment to be

truly reflective and responsive to the needs of the population group, and abilities of the sector and staff supporting them.

The third and final function of reporting relates to sector outcomes as a whole, to demonstrate whether policy is being effectively implemented at a population level. Two core areas of policy are (i) that services are effectively reducing AOD-related offending, and (ii) that offenders with AOD-related crimes are accessing the services.

When combined, these three functions of reporting would serve to increase client continuity of care, enable agencies to demonstrate not only their client outcomes, but also the quality and quantity of services provided, and show how policy and the sector are making a difference on the problem from a broader perspective.



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Appendix A – Methodology

This report was created over four stages. First, a background report was prepared with data drawn from a variety of sources and a thematic analysis was conducted to identify the key features and principles that were important to consider in the development of a comprehensive and integrated model for the forensic AOD treatment sector.

The background preliminary report was reviewed by stakeholders from Department of Health, VAADA, ACSO COATS, Corrections Victoria, Justice Health, Courts and Tribunals, Victoria Police, and two service providers. Feedback gained from these reviews was considered and added to the draft of this final report.

Concurrent with the above process, more than thirty questions raised in the preliminary report were taken to seven solution-building forums around the state. One forum was held for senior managers of key stakeholder agencies and focussed upon strategic matters, with the remaining six forums focussing upon managers and front-line staff and questions regarding service delivery, organisational and workforce matters, treatment outcome measurement and sector-wide research and evaluation. Two metropolitan forums (North-West, and South-East) and four regional forums (Camperdown, Swan Hill, Benalla and Traralgon) were held to capture any variations in viewpoints across the different geographic locations.

The final stage integrated the feedback from the reviews and the outcomes from the solution-building forums into a final report recommending a range of elements that could form the structure of a future forensic AOD sector in Victoria.

It is important to note that while most of this information was included in the preliminary report, much of the background research has been edited out for a more focussed final document.

1.1 Client Case Flows in the Current System

The forensic AOD system is complex and shows significant variability in its processes as a result of shifts in legislation, policy, operational practice and agency capacity. The description of client flow in the current system presented in this report was mapped from documents and data provided to the project team by ACSO COATS (presented in chapter 1), which included:

- The client flow over the past six years, by referral and funding source, into the forensic AOD treatment sector
- The flow into different service types for the past two years, along with completion rates for each of those service types
- Demographic data on forensic AOD service users over the past two years
- Data on the age of first contact with ACSO COATS for all clients referred since the 1st July 2005, and an analysis of trend data following the six year history of clients who had their first contact from 1998 to 2004

1.2 Characteristics of the Current Service System

The description of the current service system also drew on data from a variety of sources, including the feedback received in response to the Department of Health's March 2009 Discussion Paper on the Forensic Drug Treatment System, current policy statements, broader voluntary AOD sector reviews, and interviews with stakeholders. Interviews targeted (i) questions that were not, or were inadequately answered in the submissions to the discussion paper; and (ii) stakeholders that did not provide a response to the discussion paper.

Documents reviewed for this report included the following:

Policy:

- Towards a New Blueprint for Alcohol and Other Drug Treatment Services - A Discussion Paper. (Victorian Government, 2007)
- Victoria's Alcohol Action Plan 2008-2013 (Victorian Government, 2008)
- Victorian AOD Workforce Development Strategy (Victorian Government, 2004)
- Victoria's AOD Treatment Services - The Framework for Service Delivery (Victorian Government, 1997)
- Shaping the Future - The Victorian Alcohol and Other Drug Quality Framework (Victorian Government, 2008)
- Inquiry into the impact of drug related offending on female prison numbers (Drugs and Crime Prevention Committee, Parliament of Victoria, 2010)
- Community Correctional Services AOD Strategy 2008

Forensic AOD Treatment in Victoria and throughout Australia

- Discussion Paper on the Forensic Drug Treatment System (Department of Health, 2009)
- Forensic Drug Treatment System Principles for Services Delivery (Department of Health, 2009)

- Summary of Submissions to the forensic Drug Treatment Paper (Department of Health, 2009)
- VAADA's Response to the Victorian Government Discussion Paper on the Forensic Drug Treatment System (VAADA, 2009)
- A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia (Hughes, C., & Ritter, A., NDARC 2008)

Evaluations of Victorian Programs

- Evaluation of the Court Integrated Services Program (Ross, S., University of Melbourne, 2009)
- Forensic Interventions Unit - Literature Review and Recommendations for Ongoing Rollout (Berry, M., & Van Den Bossche, E., 2008)
- Evaluation of the Forensic Interventions Unit (Caraniche, 2009)

Interviews

Although most stakeholders had previously been invited to provide submissions regarding the forensic AOD sector in Victoria in response to the governmental Discussion Paper, supplementary interviews were conducted where additional information was required. These interviews were conducted with:

- The Board of VAADA
- ACSO COATS
Bernard Hanson - (Acting) Program Manager, Justice Services, ACSO
- Corrections Victoria
Jan Shuard - Deputy Commissioner, Community Correctional Service and Sex Offender Management Branch
Andrea Lynch - Director Community Correctional Services.
Michelle Wood - Project Director, Sentencing Reform Implementation
- Department of Justice
Michelle Gardner – Director Department of Justice Unit
- Magistrates Court
Simone Shields, Principal Registrar, Magistrates Court of Victoria
- CREDIT/CISP
Jo Beckett - Program Manager, Court Integrated Services Program & CREDIT/Bail Support Program
Glenn Rutter - Project Manager for the Assessment and Referral Court List,
Mark Longmuir - Project manager for CISP,
Peter Lamb - Manager, Complex Cases Programs, Programs and Strategy Branch, Courts and Tribunals Unit
- Department of Health
Belinda Maloney - Project Leader: AOD Service Operations DH
- AOD Prison Based Treatment
Frank Borg - Manager Prison Service, Caraniche
Samantha Beeken - Coordinator Station Peak, Marngoneet
- DHS Youth Justice
Shirley Freeman - Client Services Manager Melbourne Youth Justice.
Tina Gee - Snr Program Advisor, Program Dev. Unit, DHS Youth Justice

- The Adult Parole Board
David Provan – General Manager Adult Parole Board of Victoria
- Association of Participating Service Users
Regina Brindle – Manager
- Victoria Police
Michael Gorman - Acting Manager Drug & Alcohol Strategy Unit

Magistrates were unable to attend during the timeframes available.

1.3 Interstate and Overseas Models

The literature review looked beyond Victoria to other models in operation or being considered and trialled interstate and overseas. The most comprehensively described and accessible models were found in Western Australia, Queensland, and the United Kingdom and the documentation for these models were requested. None completely fulfilled all the requirements of the Victorian sector, however there were considerable areas of overlap with the needs of Victorian forensic AOD services.

1.4 Clinical Best Practice

A final source of data for the preliminary report was a literature review focussing upon the provision of AOD treatment services to forensic populations. This review examined best practice guidelines; evaluations of forensic AOD programs in places other than Victoria; and specific areas of practice in forensic AOD treatment delivery. In addition to the peer-reviewed articles listed in the references section, the following publications and reports were considered.

Best Practice Guidelines

- Clinical Treatment Guidelines: Forensic Drug Treatment Clients with Antisocial Presentations (Caraniche, 2009)
- Principles of Drug Addiction Treatment - Revised (NIDA, 2009)
- Principles of Drug Treatment for Criminal Justice Populations (NIDA, 2006)
- Defining Alcohol and Other Drug Treatment and Workforce (Turning Point, 2010)
- Background Papers Defining Alcohol and Other Drug Treatment and Workforce (Turning Point, 2010)
- Forensic Interventions Unit – Literature Review and Recommendations for Ongoing Roll Out (Berry & Van den Bossche, 2008)
- Corrections Victoria (2008) Community Correctional Services Alcohol and Drug Strategy 2008. Department of Justice, Melbourne, Australia.
- Alcohol and Other Drug Treatment within the Context of the Criminal Justice System: A Review of the Literature. Report for the Department of Human Services, Victoria. (Hussain & Cowie, 2005)
- Pathways - A Review of the Victorian Drug Treatment Services System (Ritter, A., Berends, L., Clemens, S., Devaney, M., Richards, J., Bowen K. and Tiffen, R. Turning Point, 2003. Unpublished Manuscript)

Evaluations of Other Services

Several evaluations and reviews of forensic AOD services were identified as having relevance upon this project and these included:

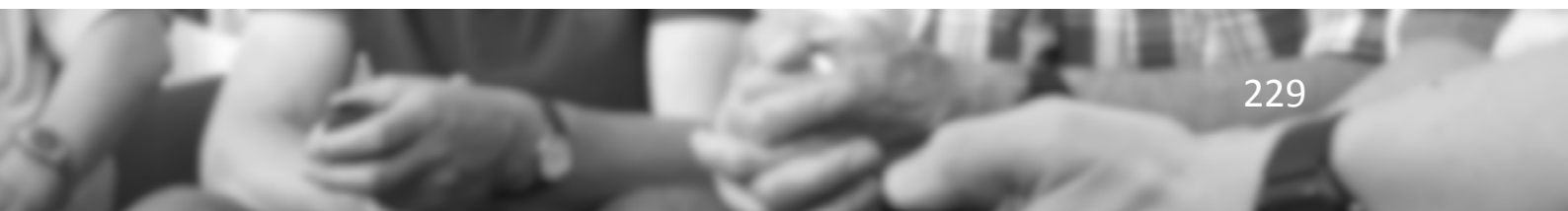
- Evaluation of the Forensic Interventions Unit (Caraniche, 2009)
- A Summary of Diversion Programs for Drug and Drug Related Offending in Australia (Hughes & Ritter, 2008)
- Court Diversion Program Evaluation. Turning Point and Health outcomes International (2004. Unpublished Manuscript)

Appendix B Comparison of the NIDA principles for voluntary and forensic clients.

2009 NIDA principle	2006 NIDA Principle for Criminal Justice Populations
No single treatment is appropriate for everyone	Tailoring treatment to meet the needs of the individual is an important part of effective drug abuse treatment in criminal justice populations..... drug treatment should address issues of motivation, problem solving, skill building for resisting drug use and criminal behaviour, building a pro social lifestyle, and healthy relationships.
Treatment needs to be readily available.	Recovery from addiction requires effective treatment, followed by management of the problem over time. Multiple episodes of treatment may be required.
Remaining in treatment for and adequate period of time (at least three months) is critical.	Treatment must be long enough to produce stable behavioural change. In treatment the drug abuser is taught to break old patterns of thinking and behaving and new skills for avoiding drug use and criminal behaviour.
Counselling – individual or group and other behavioural therapies are the most common forms of treatment.	Treatment for forensic client’s needs to address both substance use and offending behaviour including cognitive skills training to address criminal thinking, beliefs and attitudes.
Effective treatment attends to the multiple needs of the individual not just drug abuse.	Assessment is the first step of treatment – personality and other mental health problems are prevalent in offender populations.

<p>An individual's treatment and services plan must be assessed continually and modified to ensure it meets changing needs.</p>	
<p>Drug use during treatment must be monitored continuously as lapses during treatment do occur.</p>	<p>Drug use should be monitored throughout the treatment process as part of criminal justice supervision. Relapse should be used as a learning opportunity to understand drug use patterns and enhance treatment.</p>
<p>Treatment does not need to be voluntary to be effective</p>	<p>A balance of rewards and sanctions encourages pro-social behaviour and treatment participation.</p>
<p>Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies.</p>	<p>Medications are an important part of treatment for many drug abusing offenders.</p>
<p>Treatment programs should assess patients for blood borne viruses and provide risk reduction education.</p>	<p>Treatment planning for drug abusing offenders who are living or re-entering the community should include strategies to prevent and treat chronic medical conditions such as HIV and hepatitis.</p>
<p>Many drug addicted individuals also have other mental disorders</p>	<p>Offenders with co-occurring drug abuse and mental health problems require an integrated treatment approach</p>
<p>Medically assisted detoxification is only the first stage of treatment and by itself does little to change long term drug abuse.</p>	
	<p>Criminal justice supervision should incorporate treatment planning for drug abusing offenders and treatment providers should be aware of correctional supervision requirements. The Coordination of AOD treatment with correctional planning can encourage participation in treatment and can help treatment providers incorporate correctional requirements as treatment goals.....planning should incorporate the transition to community based treatment and links to post release services.</p>
	<p>Continuity of care is essential for drug abusers re-entering the community. Those who complete prison based treatment and continue with treatment in the community have the best outcomes.</p>





Appendix C - Datasheet for psycho-social AOD treatment types for the forensic AOD system

This appendix provides examples of how each treatment type could be defined in terms of the following headings:

- the type of agency eligible to provide it,
- the training for staff who deliver it,
- suggested modalities
- suggested significant treatment goals
- assessment components
- variation pathways
- exit/discharge pathways

It is recommended that the suggested significant treatment goals be reviewed by a working party as a part of any implementation process, however they should be quantifiable by nature. “Successful referral” when described in a significant treatment goal below is determined by whether an assessment appointment has been *attended* at the referred agency.

1. Brief Intervention (BI) – with or without assessment

Description

This would be the typical treatment type for clients who have not been assessed, or clients who have been assessed but identified as not treatment ready. The purpose is to focus upon harm reduction, referral, motivational enhancement and establishing a relationship with the service through a positive experience.

Agency Type

- Community AOD Agency
- Specialist Forensic AOD Service
- Central Assessment Service (only *with* assessment)

Staff training and supervision

AOD Counsellors

- Formal counselling qualification.
- Motivational interviewing training.
- AOD Training.
- Forensic orientation.

Supervision should be AOD in focus.

Modality

This must include at least

- one individual session with the client, and may include
- one session or more sessions with significant others, with or without the client
- one or more group sessions.

Significant Treatment Goals

Significant Treatment Goals may include:

- Successful referral into a residential program
- Successful referral into replacement pharmacotherapy or withdrawal service
- Successful referral into a specialist counselling or health service
- Reduced risk or harms associated with drug use
- Reduced drug related risk-taking behaviours
- Improved relationship with family/friends/community
- Linked successfully to employment, education, workforce training or the Centrelink job network
- Linked successfully to other meaningful regular activity
- Linked successfully to parenting support services
- Improved accommodation status
- Resolved presenting crisis situation (specify)

Assessment/reassessment report.

If the client has not been assessed then one is conducted by the agency at the request of the *Central Brokerage Service*.

A fee will also be payable if the client has not received an assessment or reassessment within the last six months and a reassessment report is returned to the *Central Brokerage Service*.

Variations

If during the open BI episode of care the client indicates readiness for change in one or more life areas, then a variation may be made to the following treatment types. In such a case the current episode is converted into the new episode type:

- Supportive Counselling
- Therapeutic AOD Counselling
- Therapeutic Forensic AOD Counselling

If an assessment/reassessment payment is to be charged, then the report must be filed and invoiced at the time of the variation and payment will be made at that time.

Exit and Referral

Clients may not be referred from a closed Community BI into CCCCs or Complex CCCCs, rather this should be a variation.

Referral to all other forensically funded treatment types permitted according to risk of reoffending and severity of dependence profile.

Referral to all other voluntary sector funded treatment types permitted according to risk of reoffending and severity of dependence profile.

2. Supportive Counselling

Differential description

This is the default treatment type for clients who present with minimal treatment readiness, but who have other case management needs that are not able to be met through a Justice-Based Case Manager (e.g. CCO or CISP worker). The focus would be to work on one or more of the identified significant treatment areas for this type primarily, around reducing harm relating to AOD use, as well as reducing offending.

Agency Type

Community AOD agency

Staff training and supervision

- Formal counselling qualification
- Motivational interviewing training
- AOD training
- Forensic orientation

Supervision should be AOD in focus.

Referral In

- By variation from Community BI
- From SFAS after specialist assessment where low offending risk indicated
- In exceptional circumstances, by referral from FIU BI

Modality

This must include at least

- two individual sessions with the client

and may include

- one session or more sessions with significant others, with or without the client
- one or more group sessions
- one or more day program sessions.

Significant Treatment Goals

Significant Treatment Goals may include:

- Reduced level of use of primary drug of concern
- Reduced level of poly-drug use
- Reduced harm in relation to AOD use
- Achieved positive changes in physical health status
- Reduced risk-taking behaviours
- Improved relationship with family/friends/community
- Improved social/communication skills
- Obtained employment
- Enrolled in education, workforce training
- Linked successfully to other meaningful regular activity
- Reduced offending
- Achieved compliance with legal requirements where was previously non-compliant
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated in this treatment type however supplementary treatment types may be indicated, such as withdrawal, specialist pharmacotherapy, or non-residential rehabilitation etc.

Exit and Referral

Referral to all other forensically-funded treatment types permitted including for a new Supportive AOD Counselling episode.

Referral to all other voluntary sector funded treatment types permitted.

3. Therapeutic AOD Counselling

Differential description

Clients who show treatment responsivity and treatment need would be varied into therapeutic AOD counselling. These clients would typically be low criminogenic in nature, with the offending behaviour usually a consequence of their AOD use. The primary objective of this treatment type would be behaviour change in relation to AOD use and associated harms, including health and offending.

Agency Type

Community AOD agency

Staff training and supervision

- Formal counselling qualification.
- Motivational interviewing training.
- AOD Training.
- Forensic orientation.

Supervision should be AOD and therapeutic behaviour change in focus.

Referral In

- By variation from Community BI
- From SFAS after specialist assessment where low offending risk indicated
- In exceptional circumstances, by referral from FIU BI

Modality

This must include at least

- four individual sessions with the client

and may include

- one session or more sessions with significant others, with or without the client
- one or more group sessions
- one or more day program sessions.

Significant Treatment Goals

Significant Treatment Goals may include:

- Achieved abstinence from drug of concern
- Significantly reduced level of use of primary drug of concern
- Significantly reduced level of poly-drug use
- Learnt relapse prevention strategies
- Achieved positive changes in physical health status
- Reduced risk-taking behaviours
- Improved relationship with family/friends/community
- Improved social/communication skills
- Obtained employment
- Enrolled in education, workforce training
- Linked successfully to other meaningful regular activity
- Reduced offending
- Achieved compliance with legal requirements where was previously non-compliant
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated in this treatment type. However supplementary treatment types may be indicated, such as withdrawal, specialist pharmacotherapy, or non-residential rehabilitation etc.

Exit and Referral

Referral to all other forensically-funded treatment types permitted including for a new Therapeutic AOD Counselling episode.

Referral to all other voluntary sector funded treatment types permitted.

4. Therapeutic Forensic AOD Counselling

Differential description

This would be a similar treatment type and modality to Therapeutic AOD Counselling described above, but targeting clients with more entrenched offending behaviours and antisocial attitudes and address the AOD use and offending in an integrated manner.

Agency Type

Forensic Interventions Unit with a dual diagnosis focussing upon AOD use and offending behaviour.

Staff training and supervision

- Formal counselling qualification
- Motivational interviewing training
- AOD training
- Formal forensic training.

Supervision should be both AOD and Forensic in focus.

Referral In

- By variation from Brief Intervention
- From SFAS after specialist assessment indicates a moderate offending risk

Modality

This must include at least

- four individual sessions with the client

and may include

- one session or more sessions with significant others, with or without the client
- one or more group sessions
- one or more day program sessions.

Significant Treatment Goals

Significant Treatment Goals may include:

- Achieved abstinence from drug of concern
- Significantly reduced level of use of primary drug of concern
- Significantly reduced level of poly-drug use
- Learnt relapse prevention strategies
- Achieved positive changes in physical health status
- Reduced risk-taking behaviours
- Improved relationship with family/friends/community
- Improved social/communication skills
- Obtained employment
- Enrolled in education, workforce training
- Linked successfully to other meaningful regular activity
- Reduced offending
- Achieved compliance with legal requirements where was previously non-compliant
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated in this treatment type. However supplementary treatment types may be indicated, such as withdrawal, specialist pharmacotherapy, or non-residential rehabilitation etc.

Exit and Referral

Referral to all other forensically-funded treatment types permitted including for a new forensic Therapeutic AOD Counselling episode.

Referral to all other voluntary sector funded treatment types permitted.

5. Non-Residential Rehab

Differential description

This treatment type would be indicated for lower criminogenic clients who present with moderate to high levels of treatment need and a moderate or high level of treatment readiness. The objective is to provide a more comprehensive response to the AOD needs of the client through a structured program over a period of weeks.

Agency Type

Community AOD agency

Staff training and supervision

- Formal counselling qualification.
- Motivational interviewing training.
- AOD training.
- Forensic orientation.

Supervision should be AOD and therapeutic behaviour change in focus.

Referral In

- By variation from Brief Intervention
- Upon completion of Therapeutic AOD Counselling
- Upon completion of Forensic Therapeutic AOD Counselling

Modality

This must include at least

- four individual sessions with the client
- minimum two weeks structured group programs of at least 20 contact hours per week covering a range of intervention styles and modalities.

Significant Treatment Goals

Significant Treatment Goals may include:

- Achieved abstinence from drug of concern
- Significantly reduced level of use of primary drug of concern
- Significantly reduced level of poly-drug use
- Learnt relapse prevention strategies
- Achieved positive changes in physical health status
- Reduced risk-taking behaviours
- Improved relationship with family/friends/community
- Improved social/communication skills
- Obtained employment
- Enrolled in education, workforce training
- Linked successfully to other meaningful regular activity
- Reduced offending
- Achieved compliance with legal requirements where was previously non-compliant
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated in this treatment type.

Exit and Referral

Referral to all other forensically-funded treatment types permitted.

Referral to all other voluntary sector funded treatment types permitted.

6. Residential Rehab

Differential description

An intensive residential program modelled upon the Therapeutic Community model of a minimum three months duration, suitable for clients with high treatment needs, and moderate levels of treatment responsivity.

Agency Type

Community AOD Provider

Staff training and supervision

- Formal counselling qualification.
- Motivational interviewing training.
- AOD training.
- Forensic Orientation.

Supervision should be both AOD in focus.

Referral In

- By variation from Brief Intervention
- Upon completion of Therapeutic AOD Counselling
- Upon completion of Forensic Therapeutic AOD Counselling

Modality

This must include at least

- 3 months residential
- A minimum of 20 contact hours per week covering a range of intervention styles and modalities
- Preference for Therapeutic Community model to encourage pro-social behaviours

Significant Treatment Goals

Significant Treatment Goals may include:

- Achieved abstinence from drug of concern
- Achieved positive changes in physical health status
- Improved relationship with family/friends/community
- Improved social/communication skills
- Enrolled in education, workforce training
- Measureable shift in anti-social attitudes
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated in this treatment type.

Exit and Referral

Referral to all other forensically-funded treatment types permitted.

Referral to all other voluntary sector funded treatment types permitted.

7. Forensic Residential Rehabilitation –

Note this service does not currently exist

Differential description

An intensive residential AOD treatment program for offenders with medium to high risk of reoffending and substance dependence that has an explicit focus on reducing substance use and reducing offending behaviour.

Agency Type

Specialist Forensic AOD Service/

Staff training and supervision

- Formal counselling qualification
- Motivational interviewing training
- AOD training
- Formal forensic training

Supervision should be both AOD and Forensic in focus.

Referral In

- Direct From AOD Assessment
- Direct From Specialist Forensic AOD Assessment
- By variation from any other service type
- From prison based residential treatment programs via SFAA

Modality

The treatment type should be delivered in a residential treatment setting consistent with the principles of a Therapeutic Community. It should provide a range of treatment options including psychotherapy groups, family therapy sessions, skills training groups, community groups, recreation and healthy living programs with provision for linked education and employment programs. Treatment should be of 3 – 12 months duration depending on treatment need with a minimum of 20 hours of treatment per week.

The community forensic residential rehabilitation service should be linked to prison based residential AOD treatment and enable seamless transition between in prison and post release treatment. High/medium risk and need offenders in the community identified through the SFAA should also be able to access the service.

Significant Treatment Goals

Significant Treatment Goals may include:

- Reduction in substance abuse
- Reduction in offending behaviour
- Achieved positive changes in physical health status
- Improved relationship with family/friends/community
- Improved social/communication skills
- Enrolled in education, workforce training
- Measureable shift in anti-social attitudes
- Improved management of problematic emotional states
- Reduced self-harming behaviours

Variations

Variations would not be indicated unless the treatment type was found inappropriate, in which case variation may be made to any other treatment type.

Exit and Referral

Referral to all other forensically-funded treatment types permitted.

Referral to all other voluntary sector funded treatment types permitted.

8. Forensic/Offending Behaviour Treatment

Differential description

Treatment provided to high risk offenders that targets offending behaviour and addresses criminogenic needs with the specific goal of reducing reoffending. This treatment is usually offered through Corrections Victoria.

Agency Type

- Corrections Victoria
- Specialist Forensic Provider operating through Corrections Victoria

Staff training and supervision

- Formal counselling qualification.
- Motivational interviewing training.
- AOD Training.
- Formal Forensic Training.

Supervision should be primarily Forensic in focus.

Referral In

- Direct From Specialist Forensic AOD Assessment
- By variation from any other service type

Modality

This treatment type should be specified in consultation with the Department of Justice (Corrections Victoria and Justice Health). It would most likely be a group based cognitive behavioural therapy program or a subcomponent of an offending behaviour change program. E.g. a unit on AOD offered within sex offending treatment program.

Significant Treatment Goals

- Are highly dependent on the criminogenic needs of the individual offender.
Reduced reoffending
- Reduced criminogenic needs such as;
 - Antisocial attitudes and beliefs
 - Antisocial peer networks
 - Reduced substance abuse

Variations

Variations would not be indicated unless the treatment type was found inappropriate, in which case variation may be made to any other treatment type.

Exit and Referral

Referral to all other forensically-funded treatment types permitted.

Referral to all other voluntary sector funded treatment types permitted.



Appendix D Embedded ongoing evaluation and quality improvement

In a complex system like the Victorian forensic AOD sector, evaluating the effects and impacts of changing models and frameworks to deliver services more efficiently and effectively is critical to policy and program development. What counts as evidence, however, is highly controversial, and major challenges centre on the issues of complexity of interactions, attribution and breadth of stakeholder perspective (Long, 2006).

A review by Long (2006, cited in Shaw, Greene & Melvin) highlighted four interconnecting themes within the literature on evaluation research in health services, that can be applied to the context of forensic AOD service delivery.

The first theme identified, and perhaps now the most widely adopted approach, is the 'what works' approach which provides a synthesis of evidence to pool the results, predominantly from RCTs (Randomised Controlled Trials) or acceptable alternative methods such as risk-matching. In academic and

research settings, RCTs have become one of the most widely accepted methods for evaluating program outcomes and/or treatment efficacy. It involves determining whether differences exist between treatment and comparison groups. Also, examining effect sizes can help determine whether the difference is of a magnitude to justify the investments being made in treatment. Overall, the intention is to identify what works best with the view of informing practice and policy decisions. However, given that that recovery from addiction is a cyclical process, RCTs are not a useful model as treatment is not standardised across all clients and relapse can be part of the recovery journey. In addition, RCT studies require that assignment to treatment is based on uncontrolled selection – that is, that persons are assigned to treatment and control groups independently of the nature and severity of their characteristics and AOD issues. This condition is almost impossible to satisfy in a forensic setting as it implies that some individuals who

do not warrant treatment will receive it, while it will be withheld from others who do have identified needs.

The second theme identified, which is an alternative representation of the 'what works' theme, is an 'empirical' perspective evaluation. The primary tendency is to evaluate a particular program, intervention or service by drawing comparisons against observable data and/or information from the help of measurement instruments. However, there is less concern for the 'theoretical' implications or theory underpinning the program(s), or enhancing the theory in a particular area so there is limited scope for original development and contribution to the sector. Some examples of this approach can include the use of subjective and objective measures (outlined earlier) in combination with other data such as criminal history and demographic descriptors.

The third area identified is a client / consumer focused model, in which the 'user' (client/consumer) is involved as a part of the evaluation and decision-making process. Earlier sections of chapter 7 highlighted that the extent to which clients engage in treatment forms an important indicator of treatment effectiveness (Brochu et al, 2001). Furthermore, the extent to which clients are satisfied with the treatment and service they are provided with is key to determining whether they will attend, comply with and engage in a treatment program. Therefore, it is of interest for evaluations in the context of forensic AOD service delivery to continue incorporating greater 'user' involvement into program reviews and development processes, to ensure exploration of the wider 'what works?' question, namely, 'what works', for whom, when, where and why, and from whose perspectives?

The fourth area involves evaluation for learning, where evaluation becomes a means not just to see what worked where, how and for whom, but more substantially to identify the learning arising from the implementation of new interventions or services. This can involve examining the key issues which inform policy and guide further program development, including problems in implementation, programmatic strengths and practices, and evaluation issues. A major learning identified in the forensic AOD literature and now widely acknowledged, is that AOD treatment for forensic clients is most effective when a collaborative justice approach exists (Hussain & Cowie, 2005). This involves elements of the court system, law enforcement system, and treatment system working together and understanding their respective attitudes and perspectives.

It is clear that evaluation in the forensic AOD sector(s) has a central role to play in assisting potential service users, practitioners and policy-makers to develop effective, cost-effective, efficient and acceptable models and mechanisms of forensic AOD service delivery. More importantly, there is a need for better integration and consistency of approach in forensic AOD evaluations, and also in applying a range of reliable and valid outcome indicators and measures. While there are numerous examples, none have been broad-scope evaluations.

In addition to the discussion around outcome measures, much of the feedback received in the process of the forensic review related to widespread concerns about the time it had taken to evaluate the system, with some interviewees commenting how they had been surprised that the system had gone so long without review. There have been no formal sector-wide quality-assurance activities, and quality improvement activities have been on an

ad hoc basis, rather than triggered by built-in quality mechanisms. This also highlights the need for broad-scope evaluations to draw on relevant research and various examples of evaluation frameworks and models used both nationally and internationally to develop 'built in' sector-wide quality mechanisms, but that are relevant to the context of the Australian forensic system(s).

However, establishing and implementing quality evaluation of such a large system can be challenging when taken as a single project. Simple experimental designs are not appropriate for evaluating such a large and complex system, and in principle these designs are unable to cope with the interactions and effects that a reform within a wider forensic AOD system comprises. Even where the evaluation focus is on narrowly defined outcomes like treatment success or reduction in drug use more complex designs like propensity matching are

required to allow the inherent variations between programs and their client populations to be taken into account. These approaches in turn require a detailed understanding of, and data on, client characteristics and their relationship to program outcomes. However, given that policy and funding changes often occur before an evaluation has been completed, or in the Victorian context, without the opportunity for the evaluation of existing services, an ongoing action-research evaluation model could be built into a future system providing a continuous quality improvement framework around which the sector and review can build its service delivery. At a research level, the action research approach can enable evaluations to be sufficiently flexible to adapt to develop an understanding of the changing context and support agencies' capacities as developing learning organisations.

Embedded research into client profile and sector needs

While there is a substantial body of research on forensic AOD issues and their relationship to service responses, much of this relates to US or UK contexts or criminal justice programs, or applies to client populations that are dynamic and undergoing significant change in some key features. As a result its relevance to contemporary

Australian and specifically Victorian populations and service responses is problematic. This section reviews the key issues that distinguish local client and service needs and sets out a research agenda designed to develop a better understanding of how to design and deliver forensic AOD responses.

These issues are:

- The distinctive nature of alcohol and other drug use in Australia and its impact on forensic AOD clients;
- The increasingly complex ethnic and cultural makeup of offender populations;
- Programmatic developments in the local criminal justice environment: in particular therapeutic jurisprudence, the concept of through-care and the engagement between government and non-government agencies in the delivery of forensic services;

Patterns of AOD use in offender populations

One of the important changes in offender populations in the last decade has been the development of a significant cohort of older (55 years or more) offenders. While most of the data relating to the ageing of offender populations is derived from studies of incarcerated populations (Turner & Trotter, 2010) it seems clear that the problem of ageing offenders is a general issue for criminal justice and the data presented in chapter 1 demonstrates that it is significant in the local context of forensic AOD programs. What is less clear is how the changes in offender demography are related to patterns of drug and alcohol use. It is known that drug and alcohol abuse rates are higher in elderly populations than in the past (Benshoff & Harrawood, 2003). However, the links between patterns of substance abuse and offender demography have not been studied, and it is unclear whether the growth in the number of ageing offenders is mainly a function of the ageing of the population, the result of systemic

factors (for example, lower rates of diversion and more punitive sentencing of offenders who have long criminal careers), or the product of an extended career of drug or alcohol abuse. Certainly, older offenders challenge the notion that one inevitably “grows out of” offending and substance abuse, and both criminal justice and treatment responses to them need to be framed by the expectation that integration into mainstream social and economic roles is not a likely outcome. Older offenders also present a range of distinctive clinical and support issues for criminal justice programs and AOD treatment interventions, including significant general and mental health problems (Dawes, 2009). However, again these issues have not been studied in any detail.

We can confidently expect that this group will continue to grow at a faster rate than offenders overall, if only because of population demography. Research is required into at least three issues relating to this group:

- the factors that bring older persons into the criminal justice process and in particular the relationship between long-term or late onset drug and alcohol abuse and criminal justice involvement;
- their treatment and support needs, with particular emphasis on the long-term management of older offenders; and
- the intersection between forensic AOD programs and general health and mental health interventions.

At the most basic level, research needs to track the involvement of older persons in the justice and AOD systems. However, the questions outlined above

require a more intensive study of the way that alcohol, drug, mental health and offending patterns develop over the life course.

Ethnic and cultural features of offender populations

To some extent, offender populations have always reflected the ethnic and cultural diversity in the general population, and a limited range of AOD programs and clinical interventions have been developed to meet the specific requirements of these culturally and linguistically diverse (CALD) groups. While it has been argued that access to programs for CALD offenders is generally inadequate, there are several areas where current responses appear to be particularly ineffective or otherwise significantly problematic.

A key problem in the Victorian context is the increasing number of offenders (in particular women offenders) of Vietnamese ethnicity. This group is significantly over-represented and appears to be growing rapidly (Drugs and Crime Prevention Committee, 2010). There remains considerable debate about the reasons for this growth. A variety of explanations have been proposed including the relatively young population structure of Vietnamese Australian communities, selective policing and rates of drug dependency in these communities (Beyer, 2003). While there is research being undertaken at Swinburne University on community policing strategies with Vietnamese Australians, there is little research that focuses on the relationship between drug use and offending, or the availability and effectiveness of AOD programs that target this group.

A second important issue for Victorian AOD programs is the changing nature of

Indigenous offender populations and their patterns of substance abuse. Historically, the primary AOD issue for indigenous offenders has been seen to be alcohol abuse and its relationship to violent offending (Mouzos, 2001), but more recent research has identified significant levels of cannabis and inhalant use in Indigenous offenders (Putt, Payne, & Milner, 2005). This research also reported “few discernible differences among Indigenous and non-Indigenous male police detainees in relation to their *recent* involvement in selling illicit drugs” (p.5). However, this research is based on two national studies - the Drug Use Careers of Offenders and Drug Use Monitoring Australia studies by the Australian Institute of Criminology). Victoria is not represented in the DUCO study and joined the DUMA study relatively recently, and it is unclear whether these results can be generalised to the Victorian context.

The primary research need in relation to both these issues is to strengthen the quality and scope of ethnicity and indigeneity information in criminal justice and AOD data collections in order to get a better understanding of the extent of representation of CALD and Indigenous groups. Beyond this, there is a need for more detailed study of the relationship between AOD issues, offending patterns and access to and the impact of existing clinical and justice programs on these groups.

Programmatic Developments

Victoria has been the site of a range of innovative criminal justice programs targeting AOD issues. These include widely-available and sophisticated post-

release programs (LinkOut and Women’s Integrated Support Program) and a range of diversionary and pre-trial assessment and support programs

(CREDIT, CISP), and a number of specialised court lists that can take into account AOD issues (Koori Court, Family Violence Courts, sex workers list). A consequence of these developments is that the operations of non-government agencies are increasingly closely integrated into justice and forensic AOD programs as direct service providers. Some of these developments have been

the subject of evaluation studies or clinical or program reviews (Alberti, King, Hales, & Swan, 2004; Ross, 2009; Wellings, 2004), but this research has provided little sense of the impact of these changes on the sector as a whole and key aspects of these developments remain under researched. Areas of critical concern include:

- The relationship between different programs. Individual offenders may have contact with a range of programs in the course of their forensic AOD career, but it is unclear how well interventions and case management delivered at different stages are integrated, how effectively information is shared, or how skills or support delivered at one stage bear on needs and capacities at a later stage.
- The relationship between government and non-government agencies. The effective delivery of forensic AOD programs requires a high level of cooperation between justice sector agencies (including judicial officers, court service staff, community corrections and police) and service delivery agencies, typically in the health and NGO sector. There are significant differences in the goals, professional philosophies, and work practices of these agencies.

The research needs in relation to these issues are mainly concerned with governance and integration. In relation to governance, a variety of inter-agency and inter-program arrangements have been established, often on the basis of pre-existing links or personal relationships. We need to know where these inter-agency and inter-program links are effective, how they are given effect in policy and practice, and what processes and activities help to develop or impede these relationships. Service integration also needs to be examined separately from the operations of distinct programs. We need to understand how individuals move between agencies and sectors, how

information, skills and capacities gained at one stage bear on their involvement at later stages, and how the interventions from multiple programs can be most effectively brought to bear on the diverse needs of offenders.

In particular we are interested in identifying what questions need to be answered to develop a better idea of the client group and their clinical needs, their treatment readiness and their ability to access treatment. We then need to identify the types of data that need to be collected on an ongoing basis and to embed appropriate research tools into the system that will enable consistent, useful and high quality evaluation of the sector.