

COLLABORATIVE PRACTICE FRAMEWORK

Community Correctional Services,
Alcohol and other Drugs Sector and
the Community Offender Advice
and Treatment Service

Justice Health

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1. Introduction

On 20 July 2018 the Department of Health and Human Services (DHHS) and the Department of Justice and Community Safety (DJCS) released the Forensic Alcohol and other Drugs Treatment Service Delivery Model (the Model). The Model aims to enhance the forensic Alcohol and other Drugs (AOD) service response to offenders who are on court orders with AOD assessment and treatment conditions.

The Model was developed in response to a review of Community Correctional Services (CCS) in 2015. The review recommended organisational reform to meet the challenges of increasing demand, improve successful order completion and offender recidivism rates, and strengthen CCS to ensure it was responsive to changes in the criminal justice system.

As a result of the review and outcomes from the 2015 budget, CCS developed an intensive case management approach that was built upon best practice principles; shifting the focus from order and compliance management to offender management. Implementing this new approach has provided the opportunity to clarify the roles, responsibilities and expectations of AOD providers delivering assessment and treatment services to forensic AOD clients, and strengthen engagement between AOD providers and CCS practitioners.

The Model has been developed following a thorough examination of AOD services and significant consultation with CCS and the AOD sector. The partnership between the DJCS, DHHS and the AOD sector, has allowed for equal consideration of outcomes of AOD service provision for offenders in treatment, coupled with the community safety benefits gained from a revised service response.

The Forensic AOD Treatment Service Delivery Model Objectives

The primary aims of the Model are:

- to enhance the forensic AOD service response to offenders on court orders with AOD assessment and treatment conditions
- to improve the efficacy of AOD treatment.

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

- improve referral pathways and access for offenders to AOD services
- improve the delivery of specialist forensic AOD treatment to offenders. Appendix 1 details the treatment typology matrix
- enhance the capability of the AOD and CCS workforces to implement service enhancements
- develop enhanced and flexible treatment models for forensic clients
- embed governance over the delivery of services between CCS and AOD (centrally and locally)
- develop effective reporting and monitoring tools and data systems
- strengthen collaboration, co-ordination and accountability between AOD and CCS sectors.

Collaborative Practice Framework

To achieve the final objective to strengthen collaboration, the Collaborative Practice Framework (the Framework) has been developed to enhance and clarify collaborative practice between CCS, the AOD sector, and the Community Offender Advice and Treatment Service (COATS).

The stakeholders

CCS operates within a correctional framework and has the primary role of managing offenders according to legislative requirements. Using a client-centred case management model based on a thorough risk assessment, CCS works with individuals on community orders to access opportunities for treatment and rehabilitation, with the overarching principle of community safety.

COATS and AOD providers operate within a health framework where their primary role is to assess individual needs, make recommendations, and deliver treatment and support to contribute to positive health outcomes.

Purpose

The purpose of this Framework is to bolster a greater connection between these agencies and create a shared focus and understanding of what collaborative practice looks like for the forensic client with AOD treatment needs.

The collaborative care approach

Collaborative care is an evidence-based approach to service provision which integrates several services to facilitate positive outcomes. The approach can include care coordination, case management, treatment of presenting issues, and progress monitoring. In the context of delivering forensic AOD services, successful collaborative treatment describes a client-centred approach and shared responsibility between CCS, COATS and the AOD provider and the individual, to complete the treatment condition on their order.

The Framework relies upon the exercising of professional judgement by all parties in the assessment, treatment, and case management of offenders. As such, this document is not intended to be prescriptive, but rather to serve as a guide to support best practice case management across agencies engaged in the delivery and management of AOD treatment for offenders.

Terms offender and client

Within this document, the terms 'offender' and 'client' are used interchangeably, but are referring to those who have been sentenced to a community based disposition by a court or released onto a period of parole by the Adult Parole Board.

2. Guiding Principles of Forensic AOD Service Delivery

A Forensic AOD Clinical Advisory Group, has overseen the development and implementation of the Model including the Framework. The group's membership represents a genuine partnership in engaging with the AOD sector, DJCS and DHHS.

A set of joint principles for guiding forensic AOD service delivery were developed by the AOD and CCS sectors through a number of workshops, and further refined by the Forensic AOD Clinical Advisory Group. These principles do not replace the existing DHHS 'alcohol and other drug treatment principles' or those of CCS. The forensic AOD principles apply to the management and treatment of the shared cohort, and act as supplementary principles that articulate the particular forensic service delivery requirements.

2.1 Principles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Continuity of care is essential.

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

3. Agency Descriptions

This document applies to the Department of Health and Human Services (DHHS), Community Correctional Services (CCS), Community Offender Advice and Treatment Service (COATS) and AOD providers for the delivery of services to clients throughout the provision of assessment, treatment, or support.

Department of Health and Human Services

Provides funding to AOD providers to work specifically with forensic clients.

DHHS is a Victorian Government department which funds public health organisations such as hospitals, aged care facilities, ambulance services and community service agencies. In addition, DHHS funds and delivers health, community and housing services in line with the government's vision for making Victoria a stronger, more caring and innovative state.

Community Correctional Services

Provides case management interventions to support offenders to successfully complete their community based dispositions.

Community Correctional Services is delivered by the Department of Justice and Community Safety (DJCS), being part of Corrections Victoria. It has responsibility for the supervision of adult offenders sentenced by the courts to serve community based dispositions, or who have been conditionally released from prison on parole. Offenders are supported to complete their orders through a holistic case management approach. Case management includes, but is not limited to, implementation of order conditions, such as AOD assessment, treatment and rehabilitation, to address criminogenic needs and responsivity factors related to offending behaviour.

Community Offender Advice and Treatment Service

Provides assessment and treatment service brokerage for offenders on community-based dispositions with an alcohol or other drug condition on their order.

COATS is a program funded by the DHHS to coordinate AOD services for community-based forensic clients. Operating within a brokerage model, COATS undertakes independent AOD assessments and purchases treatment services from community-based AOD treatment services across the State.

Alcohol and Other Drugs (AOD) Providers

Provide specialist AOD treatment services delivered via treatment streams that may include counselling, withdrawal, non-residential and residential rehabilitation.

AOD Providers deliver a range of therapeutic services to reduce harms associated with substance misuse, including offending behaviour related to AOD use.

Forensic AOD treatment is part of the broader AOD treatment system, and includes evidence-based treatment to reduce the harms caused by alcohol and other drugs, and promote recovery. Treatment includes residential care, group programs and individual counselling.

AOD treatment services seek to reduce harm using a recovery oriented approach, acknowledging that treatment and support should build on an individual's own resilience and resources and that each person's goals are individual and unique.

4. Key components of collaborative practice

Collaborative practice refers to agencies working together to improve outcomes for clients by coordinating and supporting the delivery of key services.

Extensive consultation was conducted with CCS, COATS and the forensic AOD sector to identify key issues and improve alignment with the practice framework of each agency including practice enhancement. The resulting Framework provides an agreed model for the management of forensic AOD clients. The Framework is predicated on collaborative information sharing across service agencies to support a mutual AOD treatment objective.

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

Expanded or new collaborative practices include:

- immediate reporting of events and associated service responses
- the sharing of all relevant information to minimise the risk and harm to the offender and the community
- immediate reporting requirements that applies across AOD and CCS throughout the AOD episode of treatment. Immediate reporting relies on the professional judgement of CCS practitioners and AOD providers to determine the timing and method of reporting that is most appropriate to meet the requirements
- managing and responding to risk. Risk has different meaning for both CCS and AOD providers. For CCS, risk means reducing the risk of re-offending and risk to the community, while for AOD providers it means risk of AOD harm and the likelihood of an event happening with potential harmful outcomes for the individual or others
- identification of trigger behaviours and escalating risk. This includes new procedures for managing the risk and obligations for participating in case conferencing, case management review meetings, risk and review meetings and compliance review hearings (CRH)
- consultation between agencies. Where issues are identified that relate to risk and that need

to be reported immediately, at a minimum, a consultation should occur between the AOD provider and CCS practitioner

- recognition of continuity of care for a forensic client that is shared by all service agencies across a course of AOD treatment. This is particularly important in the transition between services and/or between custody and community.

The following sections expand on each of these areas.

4.1 Immediate reporting

Information sharing between CCS and AOD providers is critical to treatment engagement and completion and order compliance. Immediate reporting of key events is outlined in this section. Immediate reporting relies on the professional judgement of CCS practitioners and AOD providers to determine the timing and method of reporting that is most appropriate to meet the requirements.

Immediate reporting events between AOD providers and CCS have been clearly identified and should be reported by whoever identifies the event. This includes:

- further offending
- significant AOD use and/or type of drug which has a relationship to offending behaviour and/or could potentially lead to de-stabilisation of an individual
- any AOD use for an individual with an active condition of abstinence
- new court orders issued to the offender
- contravention and/or incarceration of the offender
- any identified family violence concerns or events, including knowledge of any intervention order, or other family safety notices being issued and/or breached by the offender
- any instance of occupational violence or threat to the relevant treatment provider or CCS staff member by the offender
- death or hospitalisation of the offender
- attempted or confirmed overdose, whether prescribed or illicit substance by the offender.

Further details in Section 7 of this document.

4.1.1 Information sharing

Understanding information sharing and effective communication between AOD providers and CCS is essential to collaborative practice. Timely sharing of information enables effective engagement with fellow service providers to support the offender's participation and completion of treatment.

In line with legislative requirements and best practice, authorisation to share information between CCS, COATS and AOD providers is obtained from an individual prior to commencing referral, assessment and treatment.

The client's signed authority for inter-agency information exchange and sharing underpins the Framework.

Shared information may include, but is not limited to:

- information to inform AOD assessment needs and requirements
- treatment attendance, engagement and participation
- potential risks for the offender, agency staff or the community
- identification of strategies that will support the successful completion of treatment.

CCS assesses offenders for both the judiciary and the Adult Parole Board, making a recommendation as to their suitability to participate on a community based disposition and whether it should be a CCO or period of parole. Offenders are advised that information related to their risk and needs will be shared with relevant treatment and service providers. An Authority to Exchange Information is completed, specifying the information type and the nominated agencies to receive information. This can be completed in person via a signature or with verbal consent if the offender is in custody.

Consent to share specified information between COATS, CCS and AOD providers is obtained by COATS during the AOD assessment. This consent serves to support the exchange of all treatment-related information. Additionally, during induction with the AOD provider, clients are advised that information related to their attendance, participation and potential risk to themselves or the

community, will be shared with the CCS practitioner to support their progression throughout treatment.

4.2 Managing and responding to risk

Throughout this document, use of the term 'risk' refers to the risk of re-offending.

4.2.1 Risk of re-offending

Corrections Victoria assess all sentenced offenders to identify their risk of general re-offending. To measure risk, two tools are applied:

1. Level of Service Inventory – Revised: Screening Version (LSI-R:SV)
2. Level of Service/Risk Needs Responsivity (LS/RNR).

LSI-R: SV

- short screening test
- eight items focused on the risk of re-offending.

LS/RNR

- longer risk/need assessment tool
- assessment of offender attributes and situations relevant to decision making regarding the level of service requirements
- measures general and specific risk/need factors
- eight questions relate to AOD use providing a strong picture of AOD related needs.

4.2.2 Risk of AOD harm

Risk of AOD harm relates to the likelihood of an event happening with potential harmful outcomes for the individual or others.

As mentioned above, throughout this document, use of the term 'risk' refers to the risk of re-offending. This rating is often followed by the risk of AOD harm. For example: a risk rating of 'high/high' refers to an individual who has been rated as high risk of re-offending and a high risk of AOD harm.

Three categories of risk are considered:

- risk to self:
 - self-harm and suicide ideation
 - self-injury
 - self-neglect
 - health – including AOD misuse
 - quality of life.
- risk to others:
 - violence and aggression
 - reckless behaviour that endangers others.
- risk by others:
 - physical, sexual or emotional harm or abuse.

Clinical risk of harm is assessed and managed according to the level of risk.

Where the risk (potential or real) is illegal or involves illegal activity, AOD clinicians are required to report this information¹ to CCS.

4.3 Escalating behaviour

CCS has established procedures for managing escalating behaviour, to which AOD providers may be invited to participate, which can include:

- Risk review panels
- Compliance review hearings
- Case management review meetings
- CCS Compliance Framework
- Case conference/consultation.

4.3.1 Case conferences

Case conferencing can be beneficial to develop a multi-agency case management approach. This approach has been identified as an effective response to offenders who present with concerns relating to any of the following:

- poor compliance with the order or AOD treatment
- identified complex needs
- multiple treatment requirements/treatment providers engaged

- prisoners who are about to transition to the community (note this reflects CCO-Imprisonment orders and parole orders)
- difficulty engaging with CCS and other treatment providers
- AOD treatment variations
- entry into residential rehabilitation
- any concerns identified in the 'immediate reporting' section.

Where these issues are identified, at a minimum, a consultation should occur between the AOD provider and CCS practitioner, with a case conference to be determined following this discussion.

4.4 Continuity of care

Continuity of care is shared across all AOD providers throughout the duration of AOD treatment. Key points of service transition that trigger collaborative communication and care include:

- transfer of CCS location
- placement into custody or transfer from custody to the community
- transfer into or exit from residential care
- completion of Order
- change of CCS practitioner or treatment provider
- clinical change in treatment plan
- offender death.

Further details in Section 7 outlines the key requirements of both CCS and AOD providers at key transition points.

1 *Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services, 2008, Department of Health WA. Implementing Best Practice Client Risk Assessment and Management in AOD Services, Dr Nathan Castle, Windara. Presentation for VAADA. 2016*

5. Embedding collaborative practice into daily practice

To embed collaborative practice, there needs to be a clarification of the operational expectations for each agency at key points of engagement across all stages during a course of AOD treatment.

Building a shared understanding and capability between agencies and CCS means they can work together more effectively and support each other in service delivery outcomes

Working collaboratively within an organisation requires role clarification, encouragement of team working, a focus on the importance of communication and trust in building relationships, and collaborative leadership. Section 7.5 details the roles and responsibilities for all parties.

When referring to processes and roles and responsibilities the Framework should also be read in conjunction with agency instructions, including CCS case management statements and practice guidelines, and AOD operational guidelines and practice instructions.

5.1 Shared goals and purpose

Recognition of continuity of care for a forensic client that is shared by all service agencies across a course of AOD treatment is particularly important in the transition between services and/or between custody and community.

Having shared goals and a commonly understood purpose provides a foundation on which activities, processes and governance can be developed and improve impact through collective strength. A shared goal and purpose approach includes:

Understanding of roles and responsibilities

Both CCS and AOD providers operate with a shared understanding of working towards better client outcomes. Developing a shared understanding of the roles and responsibilities for each sector is key to knowing what outcomes are sought by each party and, is critical to effective collaboration. Section 7.5 details the roles and responsibilities of CCS, COATS and AOD providers.

Shared understanding

There is a shared understanding of the nature of the problem or issue that the collaboration is intended to address. CCS and AOD providers demonstrate commitment to a common and agreed agenda and engage in mutually reinforcing activities that support the work of each organisation to reduce duplication.

Common language and understanding of key terms

It is important to acknowledge that the language used can differ across providers and sectors. Determining and clarifying the language used and its meaning is important to having a shared purpose. Key terms should be identified and shared as understanding evolves. Appendix 2 contains a glossary of common terms used between CCS and AOD providers.

Using a strengths-based approach

Effective collaborative practice recognises and harnesses the unique and particular contributions or strengths that each party brings. It draws on the knowledge, skills and experiences of all staff for the collective good and the interest of an offender/client.

6. Monitoring the Framework

The aim of the Framework is to enhance collaborative case management between agencies involved in the delivery of forensic AOD services. Underpinning this aim is the premise that working together more effectively and keeping the client at the centre of all interactions will increase the participation in and completion of orders for offenders with an AOD assessment and treatment condition on their order.

Implementation of the Framework will focus on embedding changes into practice at the local levels across the AOD and CCS sectors.

The Model has achieved this through the objective: *embedded governance over the delivery of services between CCS and AOD (centrally and locally).*

Monitoring the implementation of the operational requirements identified in the Framework will enable the identification of barriers and inform strategies to enhance the collaborative process.

Reporting mechanisms identified below will be utilised in this process.

Key practice elements of the Framework will be incorporated into existing:

- Practice Guidelines for CCS staff
- AOD Program Guidelines for AOD providers
- COATS, CCS and Drug Treatment Services Protocol.

6.1 Individual Case Management

Supported formalised arrangements between AOD providers and CCS practitioners on the day to day management of clients enhances the case management relationship.

As part of standard supervision, CCS Supervisors discuss particular cases with CCS practitioners and seek feedback on how collaborative practice approaches across AOD providers and CCS are progressing. Where a client has been on a waitlist for a period of time because of a client or CCS preference for a particular AOD service provider (if it is not withdrawal), then this should be resolved at the operational level.

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

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

6.2 Local Service Area Contract Management

CCS Regional General Managers, should meet regularly with catchment based forensic AOD providers and DHHS local managers. These meetings enable a formalised arrangement where AOD providers and DHHS local areas/CCS regions meet to address any local service issues and opportunities.

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

6.3 Escalation Points

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

Operational ▶ Local Service Area

- an offender or offenders, particularly those assessed as high risk of re-offending, who are on a waiting list for a period of time. CCS Supervisors are to be informed during supervision sessions with CCS practitioners. General Managers are to be informed if unresolved
- identified communication gaps between AOD providers and CCS locations regarding case conferencing or engagement in review hearings.

Local Service Area ▶ Strategic Systems Level

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

Strategic Systems Level ▶ State-wide

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

7. Collaboration in practice

Central to the collaborative practice is the commitment to:

- engage with fellow treatment providers to support the offender's participation and completion of treatment
- share all relevant information to minimise risk and harm to the offender and the community.

The information provided below details the operational expectations for each treatment provider engaged in providing AOD services to forensic clients. Service provision has been described across four key stages:

- immediate reporting
- referral and assessment
- during treatment
- treatment completion.

7.1 Reporting of Significant Events

All parties are responsible for sharing information about significant issues at any point during the AOD course of treatment.

- reporting of all information related to significant issues (refer to the table below) relies on the professional judgement of CCS practitioners and AOD providers. Information sharing within 24 hours is a minimum expectation, with follow up to be scheduled
- identification of these issues can be obtained through formal court obtained information, disclosure during treatment or supervision, or through formal CCS sources
- identification of these issues can occur at any stage of case management, including during treatment, supervision or through any other agencies including Victoria Police
- information should be communicated via phone, and if no response, via email.

NOTE: Offenders on parole may have an abstinence condition on their parole order. As a consequence, **any AOD use must be** reported to CCS. Where possible, CCS and the AOD provider, and any other service providers involved, will work collaboratively to continue support for the offender in the community. This information and the offender's treatment plan may be communicated to the Adult Parole Board to provide a holistic view of treatment and dynamic risk management.

IMMEDIATE REPORTING

Significant Issue	Agency
Further offending	CCS
Significant AOD use where the type of drug has a relationship to offending behaviour and could potentially lead to de-stabilisation of the individual	CCS/AOD
Any AOD use where an abstinence condition is active	CCS/AOD
New court orders	CCS
Offender death/hospitalisation	CCS/AOD
Any instances of occupational violence or threats of violence	CCS/AOD
Any family violence concerns identified or events including knowledge of any intervention violence order or other family safety notices being issued and/or breached	CCS/AOD
Contravention and/or incarceration	CCS
Attempted or confirmed overdose, whether over the counter, prescribed or illicit substance	CCS/AOD

7.2 Referral and Assessment

WHEN	WHO	TO	HOW	SUBJECT	SHARE
Referral for AOD assessment	CCS	COATS	Phone/ email/ Client Management System (CMS) portal	Assessment request	<ul style="list-style-type: none"> • Authority to Exchange Information • offending history • LS/RNR Summary Report • Summary of Charges/ Sentencing Comments • order
Receipt of referral	COATS	CCS	Phone/email/ CMS portal	Assessment date	<ul style="list-style-type: none"> • date of assessment • location of assessment
Completion of assessment	COATS	CCS	Phone/email/ CMS portal	Assessment outcome	<ul style="list-style-type: none"> • Assessment Report • additional client information • treatment recommendations • referral for treatment letter • consent to share information
Referral for AOD treatment	COATS	AOD provider	Phone/email/ CMS portal	Referral/ treatment recommendations	<ul style="list-style-type: none"> • Assessment Report • additional client information • treatment recommendations • referral for treatment letter • consent to share information • Initial Treatment Plan
	CCS	AOD provider	Phone/email	Shared case management/ treatment plan	<ul style="list-style-type: none"> • frequency of supervision (CCS) • intervention goals • treatment programs related to the Order • potential risks and behaviours in regard to managing: <ul style="list-style-type: none"> – complex clients – intervention Orders – violence – ongoing AOD use • AOD treatment plan • frequency of sessions • death or incarceration

7.3 During Treatment

Communication and consultation between CCS and AOD providers throughout a forensic episode of care is an expectation. Key factors to be communicated include:

- changes in risk factors
- changes in criminogenic needs and responsivity factors
- further offending
- AOD use
- location transfer.

WHEN	WHO	TO	HOW	SUBJECT	SHARE
Commence treatment	AOD provider	CCS	Phone/email/ CMS portal	Treatment notes	<ul style="list-style-type: none"> • treatment progress <ul style="list-style-type: none"> – attendance – participation • extensions or variations to treatment • disclosure of AOD use related to offences • intention to exit treatment
During treatment	CCS	AOD provider	Phone/email/ CMS portal	Supervision updates	<ul style="list-style-type: none"> • attendance/ participation • non-compliance • changes in risk factors • changes in criminogenic needs and responsivity factors • further offending • location transfer • change of CCS practitioners • case management/ treatment goals to align objectives • urinalysis • death or incarceration

NOTE: Where CCS reporting is required (for example, Court , Adult Parole Board) consultation with the AOD provider is required to enable information related to current/future treatment recommendations to be included within the report

WHEN	WHO	TO	HOW	SUBJECT	SHARE
Identification of triggers	CCS/ AOD provider		Face to face/ phone/ video conferencing	Consultation – medium risk offenders Case conference – for offenders with a high risk of re-offending	All information relevant to possible trigger issues: <ul style="list-style-type: none"> offender has multiple and complex needs engaged with multiple service providers number of changes to dynamic risk factors poor compliance/ missing consecutive appointments contravention refusal to engage treatment variations entry into/exit from residential rehab consideration of parole cancellation any other matter deemed necessary

NOTE: It is an expectation that concerns regarding escalation of potential risk will be discussed between CCS and AOD providers. Where consultation is deemed insufficient, participation of treatment providers in the management of non-compliance will be strongly encouraged.

At continued escalation of risk of re-offending	CCS	AOD provider	Face to face/video conferencing	Risk Review Panel (Court) Case Management Review Meeting (parole)	All information relevant to escalating risk (in other words case note)
At continued escalation of risk of re-offending	CCS	AOD provider Offender	Face to face	Compliance Review Hearing (Court) Submission of report to Adult Parole Board (parole)	All information relevant to escalating risk (in other words case note)

NOTE: Case conference outcomes are to be entered into the CMS. Where no change to treatment is determined, the treatment plan is to be continued.

Where changes to treatment or management are recommended, this information must be communicated to COATS to inform any funding changes and the treatment plan updated within the CMS to reflect the amendments.

7.4 Treatment Completion

Consultation between CCS and AOD providers is mandatory prior to exiting an offender from treatment.

WHEN	WHO	TO	HOW	SUBJECT	SHARE
At exit planning	Treatment Provider	CCS	Face to face/ phone/video conferencing	Treatment completion	<ul style="list-style-type: none"> effectiveness of treatment goals ongoing concerns future recommendations
Treatment completed	Treatment Provider	CCS	CMS portal/ email/phone	Treatment completion	<ul style="list-style-type: none"> treatment outcomes
		COATS	CMS portal/ email/phone	Treatment outcome advice	<ul style="list-style-type: none"> Treatment Completion Advice (TCA)
Treatment variation	Treatment Provider	COATS	CMS portal/ email/phone	Treatment variation	<ul style="list-style-type: none"> Varied Individual Treatment Plan as agreed with CCS
	ACSO	Treatment Provider	CMS portal/ email	Treatment variation	<ul style="list-style-type: none"> variation outcome

7.5 Roles and responsibilities

Community Correctional Services (CCS)

CCS case management staff are responsible for applying evidence-based case management practices to assist offenders to successfully complete their orders, within the overarching principle of community safety.

CCS operates within a risk and needs case management model, where CCS practitioners deliver interventions based on an offender's criminogenic needs and responsivity factors. Some of these interventions can include intensive case management, offending behaviour programs, psycho-education programs, case management workbooks, reintegration programs, case conferencing and other treatment services.

Treatment referral and assessment

When referring offenders to the AOD sector, CCS has responsibility for:

- facilitating referrals for AOD assessment by:
 - contacting the treatment provider for AOD program information to assist in the completion of the Parole Suitability Assessment for prisoners being considered for parole
 - contacting COATS to facilitate an assessment for prisoners being released on a CCO or parole
 - contacting COATS to facilitate an assessment for offenders with an AOD treatment condition serving a community based disposition.
- providing COATS with a signed copy of the Authority to Exchange Information
- providing the following information to COATS for the purpose of assessment:
 - sentencing comments.
- criminal history:
 - summary of charges
 - LS/RNR Summary Report
 - release date/Earliest Eligibility Date (for those offenders in prison)
 - court or parole order
 - previous treatment completion reports

- custody treatment or other AOD treatment report (if applicable)
- incidents in custody (if applicable)
- ensuring that the offender is aware of the COATS assessment appointment details.
- changes in information including, but not limited to, release dates, CCS location or prison location. These will be provided to COATS at the earliest opportunity.

During Treatment

During AOD assessment and treatment, CCS has responsibility for:

- ensuring the rationale for a 'No Treatment' recommendation is noted on the CCS offender file
- monitoring the CMS for attendance at scheduled appointments
- ongoing monitoring of the Initial Treatment Plan developed by COATS
- referring an offender back to COATS for re-assessment if lapse or relapse occurs or if they do not demonstrate engagement and are exited from the program when still deemed in need of treatment
- notifying COATS of any changes to offender contact information or CCS practitioner details
- submitting a variation request to COATS if necessary due to relocation of the offender
- ensuring consultation with the treatment provider has occurred prior to a request for an extension in treatment
- regular communication with the treatment provider regarding:
 - level of participation and engagement
 - any risk escalation or problematic behaviours
 - urinalysis results
 - pertinent issues arising during CCS supervision throughout the continuation of AOD treatment.
- identifying and facilitating the need for a case conference or consultation with the treatment provider where there are multiple/complex needs, multiple service providers, changes in dynamic risk factors or as a response to non-compliance

- identifying escalation of risk and facilitating Risk Review Panel and Compliance Review Hearings to encourage compliance
- reporting to the treatment provider and COATS for re-referral or variation on key events, including:
 - further offending, whether alleged or confirmed
 - significant AOD use related to their offending
 - any AOD use, where an abstinence condition is in effect
 - family violence concerns or events including intervention violence order matters
 - new court orders
 - contravention or incarceration
 - preparing to close the CCS case.

Community Offender Advice and Treatment Service (COATS)

COATS is responsible for undertaking a comprehensive screening and assessment, developing an Initial Treatment Plan for offenders with an AOD condition on their court or parole order and for brokering and monitoring treatment services during the forensic 'Course of treatment'.

Treatment Referral and Assessment

During referral COATS has responsibility for:

- accepting referrals from CCS and prisons
- referring to the treatment typology matrix to determine treatment options.

Where offenders present with a low risk of re-offending and are sentenced to a CCO:

- referring low risk offenders, sentenced to a CCO, to the 'Choices' program
- monitoring the CMS portal for attendance
- reporting attendance to CCS
- rebooking appointments as required
- notifying CCS of program completion/non-attendance/exit.

Where CCO offenders present with a medium – high risk of re-offending or are subject to a period of parole:

- arranging an appointment for an AOD assessment:
 - PRISON** Contacting the prison location and arranging an assessment date within two working days of referral
 - COMMUNITY** Contacting the CCS practitioner and arranging an assessment within five working days of the CCS referral
 - COURT** Facilitating a RAPIDS assessment within two working days from the CCS referral.
- conducting a comprehensive assessment
- recommending 'No Treatment' if:
 - no current AOD issues are identified during assessment, taking into consideration a prisoner's extended period/s in custody
 - engagement with a non-DHHS service is confirmed.
- advising CCS of a 'No Treatment' decision and completion of Assessment Report with 'No treatment' recommendation.
- uploading the following information to the CMS portal:
 - assessment report, including screening outcome and treatment recommendations
 - Initial Treatment Plan
 - information not known at time of initial referral
 - letter of referral to the AOD provider
 - signed consent to share information.
- contacting the AOD provider and:
 - arranging brokerage to continue existing treatment services, or
 - purchasing treatment services for a new referral.
- arranging the first appointment.
- advising offender and CCS of their first treatment appointment.
- advising CCS of treatment referral via the CMS portal.

During Treatment

- facilitating variations and extensions in treatment services as required
- managing the CMS portal and facilitating access for CCS and the AOD provider.

AOD Providers

AOD providers are responsible for providing a range of treatment services to address the needs of individuals with current or historic substance use issues and assisting them to complete the treatment and rehabilitation condition on their order.

AOD providers responsible for delivering services to offenders in the community are required to hold forensic accreditation. This ensures that forensic AOD providers have the appropriate qualifications and experience to provide treatment interventions to forensic clients.

The following features have been considered to ensure alignment with the tool:

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

The treatment typology can be viewed in Appendix 1.

Treatment Referral and Assessment

After receiving a referral for treatment², AOD providers have responsibility for:

- undertaking specialist forensic AOD treatment as purchased by COATS and outlined in the Initial Treatment Plan
- providing scheduled treatment details to COATS within the CMS portal
- providing COATS with a scheduled first appointment date within five working days (Key Performance Indicator) of receiving the referral from COATS.

During Treatment

During the delivery of treatment, the AOD provider has responsibility for:

- timely liaison with CCS regarding:
 - attendance or non-attendance, via the CMS portal
 - level of engagement and participation.
- significant issues arising during treatment, including increases in risk factors and criminogenic needs.
- regular updates regarding the individual's attendance, ongoing appointments, and progress via the CMS portal
- identifying and collaborating with CCS to initiate case conferences and consultations as required
- reporting to CCS on key issues, including:
 - significant AOD use related to their offending
 - any AOD use, where an abstinence condition is in effect
 - any family violence concerns identified or events including knowledge of any intervention violence order or other family safety notices being issued and/or breached.
- discussing with CCS variations to the Individual Treatment Plan, including treatment extension
- requesting variations to the Individual Treatment Plan via the CMS
- liaising with CCS regarding the intent to exit from treatment, whether due to completion or non-participation, before terminating a treatment episode.

2 In the event that a nominated AOD treatment provider is at capacity, the offender will be placed on a waitlist. When there is a change in status, the treatment provider will advise COATS of the assessment date and enter the information into the CMS portal. In turn, COATS will advise CCS and the offender of the appointment date.

8. Document information

Document details

Criteria	Details
Document title:	Collaborative Practice Framework
Document owner:	AOD Treatment and Services, Justice Health

Document approval

This document requires the following approval:

Title	Organisation
Corrections Commissioner	Corrections Victoria
Executive Director, Justice Health	Justice Health
Assistant Director, Drug Policy and Reform	DHHS
Assistant Director - Community Correctional Services	CCS

Audience

The Framework has been developed to enhance and clarify collaborative practice between CCS, the AOD sector and COATS. The audience for this document is CCS sector, the AOD sector and COATS.

Appendix 1 Forensic AOD Treatment Typology

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

KEY NOTES

1. **Group Criminogenic Program:** Referred to as "KickStart" which was developed by Caraniche, this program is new to forensic AOD treatment. KickStart is delivered as a 42 hour group-based program to high risk offenders.
2. **Less Intensive Group Program:** KickStart is also delivered as a 24 hour group-based program to medium risk offenders.
3. **Structured Individual Programs:** The 15 hour and 8 hour programs incorporate the modules of the 42 hour and 24 hour group-based programs respectively. These programs are available to offenders found unsuitable for groups, as determined by the AOD provider

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

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

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

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

LEGEND

-  New treatment
-  Existing treatment

Appendix 2 Glossary

The Framework recognises that the use of language varies between the AOD providers and CCS. This glossary provides an example of some common terms, but it is by no means indicative of all the common terms used between CCS and AOD providers.

It is strongly suggested collaborating regularly with your local AOD providers and CCS locations to develop your own set of joint terms and glossary that is updated regularly.

Term	Description
Case Management	Identification of trigger behaviours and escalating risk. This includes procedures for managing the risk and obligations for participating in case conferencing, Case Management Review meetings, risk and review meeting and CRH.
CCS practitioner	Encompasses Court Practice staff, including CCS Case Managers, CCS Case Officers, Advanced Case Managers
Client	A person receiving AOD treatment
Offender	A person who is subject to a Community Based Disposition.
Risk	<p>CCS: Reducing the risk of re-offending and risk to the community.</p> <p>AOD: Risk of AOD harm and the likelihood of an event happening with potential harmful outcomes for the individual or others.</p>
Sequencing	<p>CCS: Court ordered conditions and interventions are sequenced by CCS practitioners to respond to an offender's health and wellbeing needs as well as the risk of re-offending.</p> <p>AOD: Treatment responses and progression against CCO conditions should be sequenced to address the highest priority risk and needs of the offender. This will ensure the best opportunity for the offender to engage and participate in treatment.</p>
Supervision	<p>CCS: Supervision of an offender on an order</p> <p>AOD: Clinical supervision is the actual doing of the work and how workers can extend themselves in relation to their practice.</p>

Appendix 3 Acronyms

Term	Description
ACSO	Australian Community Services Organisation
AOD	Alcohol and Other Drugs
CCO	Community Correction Order
CCS	Community Correctional Services
CMS	Client Management System
COATS	Community Offender Assessment and Treatment Services
CRH	Compliance Review Hearings
CV	Corrections Victoria
DHHS	Department of Health and Human Services
DJCS	Department of Justice and Community Safety
LSI	Level of Service Inventory
LS/RNR	Level of Service Inventory/Risk Needs Response
TCA	Treatment Completion Advice



