



VICTORIAN ALCOHOL & DRUG ASSOCIATION

Draft Community Correction Services Drug Strategy

Submission to
Department of Justice
Discussion Paper

May 2006

VAADA is a peak organisation, which aims to reduce the harms associated with alcohol and other drug (AOD) use within the Victorian community. VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms associated with drug use.

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This section provides an overview of the formation of the Prison Reference Group (PRG), and its membership. The VAADA PRG was established to receive input from drug treatment providers and other organisations on the current evaluation of the Victorian Prison Drug Strategy (VPDS), Opioid Substitution Therapy Program (OSTP), and development of the Community Correctional Services (CCS) Drug Strategy.

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This section provides a brief overview of feedback received from the VAADA PRG on the evaluation of the VPDS. This information is relevant to the development of the CCS Strategy, as many issues identified within the prison context have a direct impact on community corrections – especially for those transitioning from one system to the other.

More detailed feedback will be provided to the Department of Justice at a later date, in response to the evaluation of the VPDS and OSTP.

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This section provides initial comment from the VAADA PRG on the development of the CCS Drug Strategy. The key issues and recommendations are discussed in 6 sections:

- Integration of Court, Prison and CCS Processes
- Transition through Drug Treatment Support
- Role and Aims of Key Stakeholder Agencies
- Communication and Understanding
- Complex Issues, Flexible Responses
- Treatment Options - What Works?

Executive Summary

As the peak body which aims to reduce the harms associated with alcohol and other drug (AOD) use within the Victorian community, VAADA welcomes the development of a draft strategy for community corrections, and the opportunity for input into the process.

It is VAADA's hope that the final CCS Strategy will contribute to reduced harm associated with AOD use amongst offender populations by focussing on their broader health and well-being needs in a way that evokes respect and dignity.

This paper contains a number of recommendations to the Department of Justice on the formulation of the draft Community Correctional Services Drug Strategy, which are summarised on pp.5-6.

VAADA established a Prisons Reference Group (PRG) in late March 2006 to consult with its members on the intersection between AOD issues and involvement in the criminal justice system.

The PRG's primary focus has been the Department of Justice (DoJ) evaluation of the Victorian Prison Drug Strategy (VPDS) and Opioid Substitution Therapy Program (OSTP), and development of a draft CCS Drug Strategy.

Through this consultation process, VAADA identified a number of issues in relation to the VPDS related to:

- differing focus and cultures of practice between drug treatment providers and Corrections Services, and across different prison sites;
- the complexity of client need;
- barriers to a more comprehensive and collaborative approaches between stakeholder agencies; and
- seamless and coordinated transition through various stages of drug treatment for offenders.

Key barriers identified by VAADA that impact on offender access to drug treatment services include:

- different prison and provider cultures;
- unplanned prisoner releases;
- primacy of drug issues;
- access to general health care;
- waiting lists for drug treatment;
- types of drug treatment offered;
- offenders' complex needs; and
- marginalised sub-groups within the offender population.

While these issues may not relate directly to all offenders engaged by Community Corrections (those who have not served a custodial sentence), they have a clear impact on prisoners released on community orders by the Adult Parole Board.

Consequently, VAADA is of the view that the CCS strategy must be closely aligned with the VPDS to ensure:

- offenders' smooth transition through various stages of drug treatment;
- collaborative and flexible approaches that recognise the complexity of offenders' lives and diversity of the offender population; and
- holistic responses to the alcohol and other drug and other needs of the offender population.

VAADA's recommendations regarding the development of a draft CCS Strategy are broadly grouped into six sections, discussed on pp.13-20. These include:

- Integration of Court, Prison and CCS Processes
- Transition through Drug Treatment Support
- Role and Aims of Key Stakeholder Agencies
- Communication and Understanding
- Complex Issues, Flexible Responses
- Treatment Options - What Works?

VAADA looks forward to the release of the draft document and will consult further with its membership upon its release.

Summary of Recommendations

On the basis of consultations with its members through the Prison Reference Group, VAADA recommends that:

1. That the VPDS ensure drug treatment programs offered within the prison environment are consistent with those offered in the community.
2. That the CCS Strategy clearly articulate processes and lines of accountability that ensure smooth and consistent transition from prison-based drug treatment programs to those in the community.
3. That consideration be given to more comprehensive court-based assessment of offender circumstance and need.
4. That a more comprehensive court-based assessment process be adequately resourced.
5. That other factors impacting on re-offending risk, such as access to housing, education and training be taken into account by the Court when making community orders.
6. That the suitability of abstinence-based community orders be reviewed in terms of their efficacy and alignment with the principles of harm minimisation.
7. That the CCS Strategy consider how those with a previous history, or at risk of re-offending might be assisted to more readily access timely drug treatment when not on a community order.
8. That the CCS Strategy clearly articulate the aims, roles, and responsibilities of key partner agencies – especially CCS, COATS and forensic drug treatment services.
9. That the CCS Strategy incorporate guidelines and strategies for improved coordination between stakeholders.
10. That training be provided to all CCS staff on working with clients with alcohol and other drug support needs, and the nature of addiction.
11. That opportunities be explored for joint training initiatives between CCS, COATS and drug treatment service staff.
12. That the CCS Strategy explicitly recognise the complexity of offenders' lives and the interrelationship between offending behaviour, alcohol and other drug use, and a broad range of other risk factors, including but not limited to, housing, poor access to education, training and transport, income and poverty issues, and family and child protection concerns.
13. That the CCS Strategy firmly establish lead case management responsibility with Community Correctional Services.

14. That the CCS Strategy clearly articulate the role of drug treatment providers in relation to case management, and establish opportunities for their engagement and input into the development of individual management plans.
15. That drug treatment services be adequately funded to ensure staff involved with forensic clients are adequately inducted into the role.
16. That drug treatment services be adequately funded to ensure staff receive specialised forensic training, support and supervision on an on-going basis.
17. That further research be conducted into best practice models for treating forensic drug and alcohol clients, and most successful modes of treatment.
18. That current youth and rural outreach models be expanded to support metropolitan-based adult offenders on an as-needs basis.
19. That an expanded role for peer support workers be explored.
20. That drug screening be used as part of a broader treatment response that is flexible, that measures achievement on an individual basis, and that does not regard a positive result as an automatic breach of an order.
21. That any breach decision taken by CCS must be made in communication with the offenders' drug treatment provider.
22. That the current two-week pharmacotherapy subsidy for those exiting prison is insufficient, and that it be extended.

About VAADA

The Victorian Alcohol and Drug Association Inc. (VAADA) is a peak organisation, which aims to reduce the harms associated with alcohol and other drug (AOD) use within the Victorian community.

As the peak body for alcohol and other drug services in Victoria – a central role for VAADA is to advocate on behalf of its membership to achieve systemic change, social justice and to improve system responses to people experiencing the harms associated with substance use.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by alcohol and other drugs.

What does VAADA do?

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing the harms associated with alcohol and other drug use and the organisations that support them are well represented in policy and program development and public discussion

VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our member's identify
- Providing leadership on priority issues to pursue
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services (and related services)

Our history

VAADA became an incorporated association in 1981 and was created as a forum for agencies working in the field of alcohol and other drug issues, as well as those individuals interested in alleviating the harms caused by alcohol and other drugs. VAADA's role was to provide mutual support for its members as well as facilitating planning and development in the AOD field. It was also envisaged that VAADA would have an educative and information role for both its member agencies and the broader community.

Description of VAADA community / constituents

As a statewide peak organisation VAADA's community / constituency is broad. Its membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others (schools, counselling services, correctional/diversion services, legal services) as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services.

Member services of VAADA provide a range of services to people experiencing the harms associated with alcohol and other drug use – which include:

- Withdrawal – residential, home-based, outpatient and rural
- Substitute programs – methadone and buprenorphine
- Supported accommodation
- Residential rehabilitation
- Peer support
- Counseling, consultancy and continuing care
- Aboriginal services
- Day programs

VAADA Consultation Process

VAADA established a Prison Reference Group (PRG) in late March 2006 to consult with its members on the intersection between alcohol and other drug (AOD) issues and involvement in the criminal justice system. The group has met twice to date.

The PRG's primary focus has been the Department of Justice (DoJ) evaluation of the Victorian Prison Drug Strategy and Opioid Substitution Therapy Program, and development of a draft CCS Drug Strategy.

The VAADA PRG has been informed by the:

- *Victorian Prison Drug Strategy*;
- Victorian Prison Opioid Substitution Therapy Program, *Clinical and Operational Policy and Procedures*;
- Department of Justice, *Specifications for the delivery of an evaluation of the VPDS and OSTP*;
- Department of Justice, *CCS Drug Strategy Project Issues Paper*;
- Success Works, *CCS Drug Strategy Report on Client Interviews*;
- CCS Drug Strategy Stakeholder Forum presentations and notes; and
- Participants' expertise and practice experience.

Membership of the VAADA PRG was extended to organisations from within VAADA's broader membership and comprises representatives from:

- A range of community-based drug treatment services (including those servicing young people, Indigenous communities and those with dual diagnoses);
- Drug treatment providers operating within the prison population;
- Community legal services;
- Pharmacists;
- COATS; and
- User groups.

VAADA also participated in the DoJ CCS Drug Strategy stakeholder forum on the 4th April 2006.

The comments contained in this paper represent initial input on the development of a draft CCS Drug Strategy. VAADA looks forward to the release of the draft document and will consult further with its membership upon its release.

VPDS - Drug Treatment in Prisons

This section provides a brief overview of feedback received from the VAADA PRG on the evaluation of the VPDS. This information is relevant to the development of the CCS Strategy, as many issues identified within the prison context have a direct impact on community corrections – especially for those transitioning from one system to the other.

More detailed feedback will be provided to DoJ at a later date in response to the evaluation of the VPDS and OSTP.

VAADA will provide further details on the range of issues raised by the VAADA PRG in relation to prison drug treatment, as part of its response to the DoJ evaluation of the VPDS. A brief overview for the purposes of developing the draft CCS Strategy however, would seem appropriate.

The VAADA PRG has considered a range of issues in relation to access, availability and efficacy of drug treatment services within the prison population.

While these issues may not relate directly to all offenders engaged by Community Correctional Services (those who have not served a custodial sentence), they have a clear impact on prisoners released on a parole order by the Adult Parole Board.

Additionally there are a range of similarities in the issues identified in both the VPDS and the CCS strategies. These relate to:

- differing focus and cultures of practice between drug treatment providers and Corrections Services, and across different prison sites;
- the complexity of client need;
- barriers to a more comprehensive and collaborative approaches between stakeholder agencies; and
- seamless and coordinated transition through various stages of drug treatment for offenders.

Substantial concern was raised regarding the lack of appropriate transitional support for prisoners post-release and access to AOD treatment services while in custody. These issues have clear implications for prisoners released onto correction orders.

Barriers to accessing treatment within treatment and during transition back into the community included the following:

Prison Culture

Although improving, a broad prison culture of discrimination against the drug-using population results in a generalised lack of regard for health and well-being and drug-using prisoners being identified as 'management problems' by Correctional staff. Prison responses to drug use are seen to be weighed towards prison population management rather than effective and successful treatment outcomes.

Unplanned Releases

Unplanned releases were identified as a major issue of concern in ensuring continuity of treatment. The lack of coordination between the Courts and Correctional

Services results in convicted prisoners, or those in remand, appearing in court and being subsequently released, with no capacity to ensure contingency plans for continued treatment.

Primacy of Drug Issues

Many identified the relatively low priority that drug-related issues can take. In addition to the issues discussed above regarding general prison culture, AOD issues were seen to often be of lower importance to the individual, except in circumstances where a prisoner's substance use is likely to have a direct relationship to the success of any application for release.

For those prisoners recently released, dealing with the complexities of integrating back into the community, organising income, accommodation, employment, dealing with discrimination, or fulfilling the requirements of any order, may take priority over dealing with drug issues. In addition, the opportunity to "break out" and "enjoy freedom" may be seen to be of greater importance.

Accessing Healthcare

A broad range of issues were raised by the VAADA PRG in relation to access to healthcare for prisoners, including testing for blood borne viruses, access to test results and pre- and post-test counselling, inconsistent access to healthcare across prison sites, and disincentives to accessing required healthcare (for example fear of relocation).

Wait Lists

Wait lists for access to drug treatment programs were identified as a significant barrier for two groups of prisoners – those with short sentences, and those transferred between facilities. Prisoners in either situation are often unable to access drug treatment prior to the end of their sentence or release onto a community order.

For prisoners with longer sentences, drug treatment does not always form an integrated part of their Individual Management Plan over the duration of their sentence. In many cases drug treatment is only accessed or made accessible in readiness for, or as a prerequisite for release.

Types of Drug Treatment/Support

A range of issues were raised in relation to the types of drug treatment offered within prisons.

Drug treatment is offered on a needs basis, across five drug treatment 'streams' of increasing intensity. While remand prisons do not provide the highest drug treatment streams, the VAADA PRG noted that across the remaining facilities, the five drug treatment streams are not uniformly implemented or accessible.

While changes have been made to the way in which incentives/sanctions are applied within the Drug Free Incentive Program, it was noted that the program still favours coercive responses to maintaining a drug free status over treatment-focussed approaches.

The efficacy of group-based sessions, which forms the majority of treatment offered in prisons, over one-on-one counselling was questioned.

So too was the capacity of drug treatment services to meet the needs of diverse prison populations within this context – particularly relating to those with complex needs, those with acquired brain injuries (ABI) or other intellectual disabilities, dual diagnoses, and those for whom English is a second language.

Linking prisoners planned for release to community-based drug treatment services was identified as a key referral difficulty, with few services conducting prison-based assessments.

The importance of establishing personal, face-to-face contact between the client and the drug treatment agency was highlighted as a key contributor to successful referral, which in the absence of prison visits by community-based treatment agencies is heavily compromised.

Marginalised Groups and Complex Need

In addition to the cultural attitudes to substance-using prisoners mentioned above, the lack of training and expertise in working with complex prisoners was also highlighted.

In particular issues of cultural sensitivity, and for those with ABI's and other disabilities were highlighted. This is of notable concern given the over-representation among prison populations of those with ABI's, mental health issues, and those from Indigenous and some CALD communities.

The increasing complexity of substance-using prisoners, especially those with dual diagnoses, raised serious questions the capacity of prison and community-based providers' capacity to provide adequate support.

Characteristics for Success

Questions arose within the VAADA PRG as to whether and how drug treatment successes are measured at various prison sites, and whether program delivery methods and cultures across prison site have been analysed for their comparative rates of success.

Within this context, the need for the VPDS to develop benchmarks for success was noted. Possible areas of investigation might include rates of successful referral, completion of treatment programs, impact on rates of re-offending, length of wait times and accessibility of services within prisons etc.

As previously mentioned, there are substantial intersections across the experience of prisoners seeking AOD treatment in the prison environment with those released or sentenced on community correction orders.

This paper will go on to detail some of these issues in more detail.

Community Corrections Strategy: Key Issues & Recommendations

This section provides initial comment from the VAADA PRG on the development of the CCS Drug Strategy. The key issues and recommendations are discussed in 6 sections:

Integration of Court, Prison and CCS Processes
Transition through Drug Treatment Support
Role and Aims of Key Participants
Communication and Understanding
Complex Issues, Flexible Responses
Treatment Options - What Works?

VAADA welcomes the development of a draft strategy for community corrections, and the opportunity for input into the process.

VAADA is of the view that the CCS strategy must be closely aligned with the VPDS, ensuring:

- offenders' smooth transition through various stages of AOD treatment;
- collaborative and flexible approaches that recognise the complexity of offenders' lives and diversity of the offender population; and
- holistic responses to the AOD and other needs of the offender population.

In order to achieve these aims, a number of issues raised by the VAADA PRG are discussed as follows:

Integration of Court, Prison and CCS Processes

VAADA PRG members cite the need for greater integration of court, prison and CCS processes to ensure more effective planning when courts are considering community based dispositions.

As discussed previously, this is especially the case in relation to current serving prisoners.

VAADA PRG members cite a lack of continuity of support and care when prisoners are released to the community or onto a community order. There is little capacity to plan for post-release AOD treatment, especially for those on unplanned releases. Neither is there the opportunity to ensure support is consistent with treatment received in prison.

A second issue relates to court-based assessments. Focus must be given to ensuring court-based assessments are conducted in sufficient detail as to ensure any order imposed is consistent with need and circumstance.

Many offenders presenting to court may do so with a complex array of criminogenic needs. Courts are restricted to making orders in relation to AOD and/or psychological need, without consideration to the other support needs of the individual, particularly their housing, employment or family support needs.

Insufficient assessment may also lead to offenders opting for community orders rather than prison, with limited motivation for change or completion.

While abstinence-based community orders are in the minority, VAADA PRG members question their place within a system underpinned by the principles of harm minimisation.

Recommendation 1: That the VPDS ensure drug treatment programs offered within the prison environment are consistent with those offered in the community.

Recommendation 2: That the CCS Strategy clearly articulate processes and lines of accountability that ensure smooth and consistent transition from prison-based drug treatment programs to those in the community.

Recommendation 3: That consideration be given to more comprehensive court-based assessment of offender circumstance and need.

Recommendation 4: That a more comprehensive court-based assessment process be adequately resourced.

Recommendation 5: That other factors impacting on re-offending risk, such as access to housing, education and training be taken into account by the court when making community orders.

Recommendation 6: That the suitability of abstinence-based community orders be reviewed in terms of their efficacy and alignment with the principles of harm minimisation.

Transition through Drug Treatment Support

As discussed previously, a number of concerns relating to smooth, consistent and informed transition through offender drug treatment programs were highlighted by the PRG.

This transition relates not only from prison to community corrections, but also through to continued community treatment at the completion of an order.

Having developed working relationships with clients on community corrections orders, drug treatment providers consider it core business to continue to provide ongoing support beyond the life of the order.

In order to provide an effective response (with some chance for success), treatment support needs to extend well beyond the two episodes of care allocated to forensic clients.

In the current system, ongoing support may not be offered until a point much later in time, without brokered referral through COATS, and is subject to the ordinary waiting times for any given service.

Given the increased focus on client drug treatment need and broader criminogenic need, in addition to CCS's key aim of preventing re-offending behaviour, the CCS

Strategy should consider how those with a prior history, or at risk of re-offending, can be assisted to access timely drug treatment.

Recommendation 7: That the CCS Strategy consider how those with a previous history, or at risk of re-offending might be assisted to more readily access timely drug treatment when not on a community order.

Role and Aims of Key Stakeholder Agencies

The primary purpose of CCS is to enhance community safety by:

- Effectively enforcing orders imposed by the courts and Adult Parole Board;
- Providing objective and timely advice to these authorities; and
- Providing and/or participating in appropriate pre-sentence and post-sentence rehabilitation initiatives.

The primary purpose of COATS is to make a difference in the lives of disenfranchised people.

Broadly speaking, the primary purpose of community-based AOD treatment services is to assist and support individuals (and/or their families) to reduce the harms associated with AOD use.

While the intended outcomes for each may be similar in terms of reduced re-offending, increased integration and connection, and enhanced community cohesion, the means by which these outcomes are achieved by each of the agencies is quite different. So too are the measures of success that might be applied by each agency.

Drug treatment providers cite a lack of appropriate training, skills development and support in their role as forensic treatment providers. Additionally, for many there is a lack of certainty regarding the relationship between their role, and that of CCS and COATS.

Key issues include confidentiality and privacy concerns, the nature of client information required by CCS (especially regarding relapse or non-attendance), and the need for clearly defined and coordinated case management responsibility that properly addresses complex client need.

Drug treatment providers report that while assessments undertaken by COATS and CCS provide valuable information regarding the breadth of criminogenic need, improvement is needed to ensure coordinated and comprehensive case management of these needs.

In many instances AOD treatment providers see themselves as de facto case managers, attempting to respond not only to links between offending behaviour and AOD use, but also the links between offending behaviour and other risk factors.

While the recently updated CCS, COATS and Drug Treatment Provider protocols may clarify these issues, the CCS Strategy itself must clearly articulate each agency's roles, responsibilities and aims, and provide guidance to improved coordination between stakeholders.

Recommendation 8: That the CCS Strategy clearly articulate the aims, roles, responsibilities of key partner agencies – especially CCS, COATS and forensic drug treatment services.

Recommendation 9: That the CCS Strategy incorporate guidelines and strategies for improved coordination between stakeholders.

Communication and Understanding

The issues discussed above highlight the need for an increased level of understanding between stakeholder agencies, clearer articulation of roles and responsibilities, and a shared common language, in order to facilitate better collaborative partnerships, and more cohesive, targeted support.

Drug treatment providers recognise the value of strong working partnerships between themselves, COATS and CCS staff. A number of factors will facilitate a strengthened relationship, including:

- Open lines of communication;
- Clear roles and expectations;
- Clarity regarding the nature of client information CCS requires from drug treatment providers;
- Strong awareness among CCS staff about the nature of alcohol and other drug addiction and relapse; and
- Consistent but flexible approach from CCS staff.

Drug treatment providers cite the development of one-on-one relationships with CCS staff as being key to positive client outcomes, but acknowledge that these relationships can take time to develop.

Barriers to the development of effective collaborative relationships tend to revolve around inconsistent approaches by different CCS staff, a lack of flexibility, or lack of understanding about the nature of AOD addiction.

Some drug treatment providers report having to advocate for the needs of their clients on a regular basis, especially with newer CCS staff, and often in relation to relapse, difficulties engaging with clients and/or client non-attendance.

One legal service spoke in terms of community based orders being viewed by the courts as a rehabilitative/reparative measure for low-level offences. At times however, CCS staff are perceived to take a more punitive and inflexible approach to clients, setting them up to fail at the outset.

These experiences are backed up by many of the responses in the Success Works Report on Client Interviews, which highlights the 'level of distrust some clients feel for CCS workers and the importance of being treated like human beings'.¹

Recommendation 10: That training be provided to all CCS staff on working with clients with alcohol and other drug support needs, and the nature of addiction.

¹ Success Works (2006) CCS Drug Strategy, *Report on Client Interviews*

Recommendation 11: That opportunities be explored for joint training initiatives between CCS, COATS and drug treatment provider staff.

Complex Issues, Flexible Responses

Drug treatment providers advocate strongly for a CCS Strategy based on a recognition of:

- the enormous complexity of many offenders' lives;
- the close relationship between offending behaviour, AOD use, and other issues impacting on offenders' lives;
- offender experiences of discrimination, impact of poor access to affordable and stable accommodation, employment and training, family and child protection issues, and income stressors.

Drug treatment providers recognise that for many offenders, the initial period on a community order can be an extremely stressful time, which can itself lead to increased likelihood of re-offending, or increased use of alcohol and other drugs.

Client responses to the Success Works interviews, confirm these concerns. Clients spoke of the stress associated with having to meet multiple demands at a difficult period in their lives:

'What gets me off track are all the appointments! I'm getting breached by Centrelink because I've missed appointments with them because I've been too focussed on my order. I don't have a car or a license and it's hard to have to report all the time. I wish sometimes I could ring in – it would be far easier.'²

Within this context, offenders' capacity to focus on reducing their substance use can take a back seat to far more pressing issues. For many offenders, balancing more immediate demands such as their reporting requirements to CCS, fulfilling their community order, dealing with Centrelink, and any number of other appointments may take higher priority. Additionally these requirements must often be met with limited income and restricted mobility, creating additional stress.

The relative lack of primacy for AOD issues may be even more pronounced for those channelled into drug treatment as a condition of their order, in an attempt to avoid imprisonment.

These challenges signal the importance of coordinated and comprehensive case planning. This in turn is reliant on good communication between drug treatment providers, CCS workers, and other service providers, in order to assist integration into community life and reduced risk of re-offending.

Drug treatment providers have a valuable role to play in assisting CCS as the lead case management provider to develop effective, achievable individual management plans, and with COATS in reviewing requirements under individual treatment plans.

These challenges signal the need for realistic expectations about what the offender might reasonably achieve. To ensure the greatest chance of success the number of requirements in individual management plans must be achievable.

² *ibid.*

Recommendation 12: That the CCS Strategy explicitly recognise the complexity of offenders' lives and the interrelationship between offending behaviour, alcohol and other drug use, and a broad range of other risk factors, including but not limited to housing, poor access to education, training and transport, income and poverty issues, and family and child protection concerns.

Recommendation 13: That the CCS Strategy firmly establish lead case management responsibility with Community Correctional Services.

Recommendation 14: That the CCS Strategy clearly articulate the role of drug treatment providers in relation to case management, and establish opportunities for their engagement and input into the development of individual management plans.

Treatment Options - What Works?

There is broad acknowledgement that no single treatment modality works for all clients. Treatment must be:

- targeted;
- culturally appropriate;
- responsive;
- of sufficient intensity and duration; and
- focussed on the individual context of substance use as well as its relationship to offending behaviour or risk of re-offending.

Feedback from the DoJ stakeholder forums indicates successful treatment must focus on criminogenic need, and be structured and treatment focussed, rather than general support and counselling.

Two issues arise from this feedback. First is the implication that drug treatment providers are not sufficiently focussed on the relationship between offending behaviour and problematic drug use (tending to focus more on the latter). Second, is the issue of modes of treatment currently offered.

Drug treatment providers regard their treatment approach as one that addresses the attitudes, values, beliefs and behaviours (as well as other reasons) for problematic drug use, and its relationship to offending behaviour, and that this occurs as a matter of course.

Conversely, it has also been suggested that specialist AOD providers often treat forensic clients without adequate training and support, or awareness of their obligations in relation to CCS providers.

The second issue relates to treatment type. Evidence suggests support for offenders must be structured and treatment focussed, rather than general support and

counselling.³ The vast majority of forensic clients however, receive CCCC support with modest completion rates.⁴

Some drug treatment providers and clients question the achievements that can be made in four to six CCCC sessions, with many clients requiring much longer term support and treatment. Their experience is that many clients go on to relapse or re-offend after such short treatment.

Those treatments with the best completion success rates are the youth and rural outreach models, which are better equipped to respond to individual client need, facilitate access, and effectively engage.

Some drug treatment providers cite anecdotal evidence that outreach support provided to adult clients, often in conjunction with CCS, have had high rates of success.

These services suggest adult clients have as much need for outreach support as young people, given many of the barriers to participation and successful completion of their orders are identical (balancing numerous and complex tasks, lack of transport etc).

Other issues highlighted by the VAADA PRG include the place of group work, use of peers, drug testing, and access to pharmacotherapies.

Feedback from the DoJ stakeholder forums suggests that group-based treatments have a limited place, especially for young offenders.

The VAADA PRG indicate similar limits in working with older clients, citing barriers to engagement, concerns regarding confidentiality, and a desire to distance themselves from other offenders. These concerns are also present for clients entering and staying in residential facilities.

VAADA recommends further exploration of the role that peers can play in the treatment of some clients, provided they are appropriately recruited, trained and supported.

For some clients access to drug testing is regarded as a safety net that aids relapse prevention, while for others with a history of long-term and chronic use, or those on abstinence orders, testing requirements can set them up to fail.

VAADA recommends drug screening be used as part of a broader treatment response that is flexible, measures achievement on an individual basis, and does not regard a positive result as an automatic breach of an order.

Any such breach decision must be made in communication with the drug treatment provider.

Recent NHMRC research found prisoners and community-based offenders accessing pharmacotherapy treatment have a lower risk of re-offending.

³ Casey, S. (2006) *CCS Stakeholders Forum: What works – treatment for offenders with drug issues* (Forensic Psychology Research Group, Centre for Applied Psychological Research, University of South Australia)

⁴ Victorian Department of Justice (2006) *Community Correctional Service Drug Strategy Project – Issues Paper*

VAADA acknowledges the important role pharmacotherapies play in stabilising many of their clients, but have concerns about the current two-week restriction on subsidised access for those exiting prison. VAADA regards this time period as insufficient, and recommends that it be reviewed.

Recommendation 15: That drug treatment services be adequately funded to ensure staff involved with forensic clients are adequately inducted into the role.

Recommendation 16: That drug treatment services be adequately funded to ensure staff receive specialised forensic training, support and supervision on an on-going basis.

Recommendation 17: That further research be conducted into best practice models for treating forensic alcohol and other drug clients, and most successful modes of treatment.

Recommendation 18: That current youth and rural outreach models be expanded to support metropolitan-based adult offenders on an as-needs basis.

Recommendation 19: That an expanded role for peer support workers be explored.

Recommendation 20: That drug screening be used as part of a broader treatment response that is flexible, that measures achievement on an individual basis, and that does not regard a positive result as an automatic breach of an order.

Recommendation 21: That any breach decision taken by CCS must be made in communication with the offenders' drug treatment provider.

Recommendation 22: That the current two-week pharmacotherapy subsidy for those exiting prison is insufficient, and that it be extended.