VICTORIAN ALCOHOL & DRUG ASSOCIATION

Forensic AOD treatment and service delivery: a discussion of issues

June 2016

VAADA Vision

A Victorian community in which the harms associated with alcohol and other drug use are reduced and wellbeing is promoted

VAADA Purpose

To provide leadership, advocacy and information within the AOD sector and across the broader community in relation to alcohol and other drugs

About VAADA

VAADA is a non-government peak organisation representing publicly funded Victorian AOD services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use across the Victorian community. VAADA's purpose is to ensure that the issues for people experiencing harms associated with substance use and the organisations who support them are well represented in policy, program development and public discussion.

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 and related services.

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

Acknowledgements

VAADA would like to thank those AOD services who contributed to the development of this Issues Paper by sharing their experiences of delivering forensic AOD services. VAADA hosted a sector wide forum in March 2016 with over 60 representatives of AOD services attending the event. VAADA also undertook a series of initial telephone based consultations with a number of agencies. We appreciate the time and effort of all those who contributed.

VAADA extends thanks also to Mishma Kumar, Masters of Social Policy student from the University of Melbourne for her contribution to this project and the early development of this paper.

Disclaimer

This report is not intended as a review or evaluation of the forensic service system. It is a snapshot of a number of issues facing AOD service providers in the delivery of forensic AOD services at a particular point in time. We recognise that a diversity of opinion and experience exists among AOD service providers, as well as the varying views and expectations of funders in the provision of forensic AOD treatment.

While the material presented in this report draws on the views of AOD agencies with whom VAADA consulted, the final recommendations in this report represent the views of VAADA.

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Introduction

This Paper is the result of a project undertaken by VAADA between February and May 2016. VAADA embarked on this work following a series of enquiries from AOD service providers about changes to forensic AOD service delivery post-recommissioning of AOD services in September 2014.

AOD service providers spoke of a complex and confusing system highlighting serious concerns around the changes to the forensic funding and significant additional administrative pressures associated with reporting requirements and data collection. In response, VAADA undertook a small number of preliminary consultations with AOD agencies to identify issues of shared concern. Early discussions pointed to potential systemic issues related to funding, workforce capacity and administrative burden.

VAADA then invited all Victorian AOD agencies to participate in a state wide Forensic Forum. The forum was held in early March 2016 and was attended by over 60 representatives of over 30 metropolitan and rural and regional AOD services. Attendees represented both non-residential and residential AOD services. An analysis of forum discussion was conducted to identify key themes and potential solutions. This process identified a number of consistent themes across services, despite diversity among service providers in terms of treatment types delivered, staffing profiles and size and location of the agency.

Aims and scope of the paper

This paper has two main aims. First, to document a number of current challenges for AOD services in the provision of forensic AOD treatment. The second aim is to present a series of recommendations to the Department of Health and Human Services (DHHS) in response to the challenges identified.

It is VAADA's intent that this paper will be a foundation for ongoing work between VAADA, ACSO-COATS, DHHS, Department of Justice (DoJ) and other criminal justice stakeholders, and importantly, AOD service providers, to continue to improve AOD service provision for forensic clients.

Recommendations

1. The Department of Health and Human Services (DHHS) establish and auspice a Forensic AOD Working Group with representation from a broad cross-section of AOD service providers, alongside ACSO-COATS, and VAADA to progress the issues and recommendations outlined in this paper. This working group should be established as a priority and serve as an ongoing mechanism to consider resolutions to a number of longstanding issues, including:
    - the varied aims and objectives of forensic AOD treatment;
    - the most suitable treatment interventions for this client cohort;
    - alignment of funding approaches and targets with evidence and data around demand;
    - building sustainability across the AOD workforce to meet growing demand for forensic AOD treatment options.

2. DHHS and ACSO-COATS commit to releasing a quarterly report, which at a minimum, details the profile of forensic AOD clients, including AOD use along with offending patterns, treatment referrals coming into the AOD service system, and completion rates. This would assist AOD services to have timely access to changing client demographic data and improve transparency about forensic client pathways through the AOD service system.

3. DHHS promptly release program guidelines for all treatment types, including Non-residential Withdrawal and Care & Recovery Coordination to enable improved treatment matching for forensic clients.

4. DHHS investigate the barriers identified around utilisation of Non-residential Withdrawal as a treatment type for forensic clients and determine mechanisms to address these issues. This work must be undertaken in consultation with AOD service providers and the Forensic AOD Working Group (recommendation 1). Any necessary revisions to the Non-residential Withdrawal guidelines should only be made following thorough consultation with non-residential withdrawal service providers.

5. DHHS clarify the role of Care and Recovery Coordination for forensic clients, particularly in relation to the role and functions of Community Corrections Officers.

Funding

6. DHHS, in consultation with the AOD sector, review the 20 per cent forensic target and if appropriate, move to a system with separate targets across each treatment type.

7. DHHS commit to a review of forensic funding including the 15 per cent forensic loading to ensure that it adequately and appropriately covers the catalogue of additional administrative tasks and ancillary costs associated with forensic service delivery such as accounting for DNAs, after-hours appointments, travel time associated with outreach,

report writing, and data entry across multiple platforms. Any review must involve input from AOD service providers and the results clearly communicated to the sector.

8. DHHS consider an increase in the DTAU pricing for rural and regional agencies in recognition of the additional costs of forensic AOD service delivery across these settings.

Workforce

9. DHHS clarify as a matter of urgency the current requirements associated with forensic accreditation so that AOD service providers can support staff accordingly. Any additional training and professional development requirements associated with the accreditation should be financially supported by DHHS, as part of a broader professional development strategy (see also recommendation 11).

10. DHHS explore mechanisms to utilise information technology and online mechanisms to enhance access to training and professional development opportunities for rural and regional services.

11. DHHS work with the AOD sector and VAADA to advance the development of an AOD workforce strategy that comprises a specific forensic component to enhance forensic competence and capacity across the sector. A workforce development strategy must be adequately and appropriately funded and consider:
    - Any minimum skill-set required of forensic AOD clinicians and how to build capacity across the system for regular and ongoing professional development opportunities
    - Pathways for career progression and the creation of advanced practitioner roles across the AOD sector which are adequately and appropriately remunerated
    - Enhancing access to appropriate forms of specialist forensic clinical supervision
    - Strategies to address ongoing recruitment and retention challenges
    - The role of peer networking and mentoring in developing the AOD workforce, including forensic skill sets
12. DHHS revise the funding formula to ensure adequate resources are available for clinical supervision.

Referral pathways, information sharing and meeting demand

13. DHHS, in consultation with AOD service providers, consider the development and funding of additional treatment options for the forensic client cohort, including group-based interventions to support people on wait-lists for residential services and as a mechanism to provide after-care or post-residential relapse prevention support.

14. A mechanism be developed and administered by ACSO-COATS to provide real-time information to all AOD service providers on those services and locations which are ‘on hold’ in order to assist agencies to meet demand within a catchment. This mechanism should be developed for the purposes of improving access and to meet demand, not as a performance management tool.

15. Referral forms from ACSO-COATS be amended to include contact details of Community Corrections Officers so that AOD clinicians have ready access to a contact person for consultation and information gathering purposes. Information around any potential risk issues should be made available earlier in the referral process.

16. Opportunities for cross-sectoral capacity building for Community Corrections Officers be explored to enhance their knowledge of AOD treatment services, modalities and approaches.

17. DHHS and ACSO-COATS investigate the multiple referral pathways into forensic AOD treatment and options to simplify the intake and assessment pathways for forensic clients.

Section One: The forensic Alcohol and other Drug (AOD) treatment system

Forensic AOD treatment is provided as part of the broader community based AOD system in Victoria. Forensic clients are described by DHHS as "…people who access alcohol and other drug treatment as a result of their contact with the criminal justice system."[1]

Forensic AOD service delivery occurs in the context of broader change to the Victorian AOD service system associated with recommissioning of adult non-residential AOD treatment services in 2014. Recommissioning saw the introduction of a new funding model, one which is activity-based, along with the consolidation of treatment types and centralised pathways for intake and assessment (Berends & Green 2016). It also saw services move into consortia arrangements across the state. Stage two of recommissioning which was planned by the previous government and would include youth and residential services, has not eventuated.

COATS is the state wide centralised intake, assessment and referral service for the majority of forensic clients into AOD treatment services in Victoria and was established to:

- Administer state and commonwealth funded treatment pathways for forensic clients;
- Provide support to agencies in managing forensic referrals and ensuring forensic clients get treatment as a priority and achieve outcomes that reduce drug and alcohol related offending;
- Provide financial and activity reporting to AOD agencies, the Department of Health and Justice services.[2]

The main referral points into forensic AOD treatment programs via COATS are from Corrections, courts and the adult parole board. Forensic clients may also enter AOD services via police diversionary programs; and at the point of bail, sentencing and parole. Referrals also arrive via Youth Justice and a number of specialist court programs such as Court Integrated Services Program (CISP), Assessment Referral Court List (ARC List), CREDIT Bail Support Program (CBSP) and other diversionary referrals.

However, the intake and assessment of forensic clients is not the sole responsibility of COATS. Intake and assessment is split between COATS and catchment based AOD Intake and Assessment providers. COATS undertake intake, assessment, treatment planning and referral where clients are referred via courts, corrections or parole. Whereas catchment based intake and assessment services are responsible for the intake and assessment of clients referred through diversion pathways as well as young people referred via Youth Justice and those who may have had contact with the courts without a specific order in place. AOD agencies have commented during the process of this project that these multiple entry points and referral pathways for forensic clients is confusing and unnecessarily complex.

1.1 Aims and objectives of forensic AOD treatment

According to DHHS, "Alcohol and other drug treatment for forensic clients is aimed at reducing the harms associated with alcohol and other drug misuse, including the related offending behaviour."[3] However, there has been considerable discussion over many years about the varied aims and objectives of forensic AOD treatment. For instance, the divergence of opinion among AOD and

[1] DHHS website see https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services.
[2] COATS Communique #2, n.d.see https://www.acso.org.au/files/8214/0849/4580/ACSO_COATS_Communique_2_-_20-8-14.pdf
[3] DHHS website see https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services.

criminal justice stakeholders about the principal goals and priorities of treatment for forensic populations was considered as part of the Forensic Drug Treatment Review commenced in 2009.[4] This issue was also canvassed in some detail in the Caraniche publication *Towards a New Framework for Forensic Alcohol and Other Drug Treatment in Victoria*.

While significant change has occurred since the publication of the Caraniche report in 2012 - most notably that associated with recommissioning of AOD services in 2014 - feedback from AOD service providers indicates that this issue remains unresolved with potential for ongoing tension between the goals, priorities and philosophies of AOD services and criminal justice stakeholders.

VAADA recognises that significant work was underway as part of the forensic review process to determine an agreed set of aims and objectives for forensic AOD treatment, or at a minimum, to establish a framework of 'mutual understanding' (Caraniche 2012) among those working across the forensic service system. For instance, it has long been recognised that reducing harm from AOD use and improving health and wellbeing may be the priority among AOD service providers, while addressing the offending behaviours may take precedence over other goals for criminal justice personnel. It is VAADA's view that a recommitment to this work is needed to progress a resolution for these varied and complex issues.

1.2 Profile of forensic clients & available treatment

The forensic AOD population has also changed significantly over the years. While the distinction between voluntary and forensic clients is not simple or straightforward, it is clear that forensic clients, like their voluntary counterparts, are not a homogenous group (Caraniche 2012). Forensic clients are diverse in their AOD use, offending behaviour, education, employment and housing histories, health and mental wellbeing and personality traits.

However, the research literature suggests there are various discrete populations within the broader forensic population and that forensic clients may have specialist needs that distinguish them from voluntary client populations in a number of important ways. Often referenced is the potentially lower levels of motivation for change or 'treatment readiness' among forensic populations.

ACSO recently published a guide for AOD agencies conducting forensic assessment with clients who have been referred by the courts and other diversion sources and an '*Optional Module 12: Forensic*' to be used alongside the state wide Comprehensive Assessment. The guide includes the MASCOT tool (Melbourne Attitudes to Substance, Change and Openness to Treatment Scale) as a measure of treatment readiness and recommends AOD clinicians apply this tool as part of the Comprehensive Assessment for forensic clients to determine an individual's level of motivation and appropriate treatment pathways.

This guide also presents a 'matrix' of treatment options for forensic clients based on various broad 'profiles' of client determined by 3 key factors: likely AOD dependence, level of treatment readiness and severity of offending.[5] Treatment in the forensic service system is administered via funding and service agreements between AOD lead providers and DHHS. The treatment available to forensic clients via AOD services is largely the same as that on offer to voluntary clients and includes

[4] The review commenced in 2009.

[5] The determination of an individual's likely AOD dependence is assisted by administration of the AOD screening tool alongside clinical judgement; treatment readiness is determined by administration of the MASCOT tool.
Early feedback from AOD service providers suggests there is limited capacity for utilisation of any of the Optional Modules, including the new forensic Optional Module 12, due to the time taken to complete assessments, secure secondary referral information, formulate treatment plans and present cases for clinical review.

counselling, non-residential withdrawal, Care & Recovery Coordination, community residential drug withdrawal, residential rehabilitation, specialist pharmacotherapy, non-residential day programs, youth outreach and youth residential services. A number of specialist forensic services also exist such as HiROADS counselling, the Kick Start Program, Forensic Koori Community Alcohol and Other Drug Workers and the Torque program.

Given the potential diversity within the forensic population, VAADA believes it is important that AOD agencies have access to timely data on client demographics and changing client profiles to assist with tailoring interventions and responses to this client group. Furthermore, feedback received as part of this project has pointed to the need to resolve a number of longstanding issues in the forensic space (see recommendations 1 and 2 below).

Recommendations:

1. The Department of Health and Human Services (DHHS) establish and auspice a Forensic AOD Working Group with representation from a broad cross-section of AOD service providers, alongside ACSO-COATS, and VAADA to progress the issues and recommendations outlined in this paper. The working group should be established as a priority and serve as an ongoing mechanism to consider resolutions to a number of longstanding issues, including:

- **the varied aims and objectives of forensic AOD treatment;**
- **the most suitable treatment interventions for this client cohort;**
- **alignment of funding approaches and targets with evidence and data around demand; and**
- **building sustainability across the AOD workforce and meet growing demand for forensic AOD treatment options.**

2. **DHHS and ACSO-COATS commit to releasing a quarterly report, which at a minimum, details the profile of forensic AOD clients, including AOD use along with offending patterns, treatment referrals coming into the AOD service system, and completion rates. This would assist AOD services to have timely access to changing client demographic data and improve transparency about client pathways through the forensic AOD service system.**

Section Two: Funding

Historically there have been divergent views amongst stakeholders about the best approach to funding forensic AOD treatment. All adult non-residential AOD services (both forensic and 'voluntary') are currently funded under an activity-based funding model whereby agencies receive funding based on the hnumber and type of services delivered via a new common unit of pricing known as a Drug Treatment Activity Unit (DTAU).

According to the DHHS *AOD Fact Sheet: Funding Model*, 'DTAUs allow relative products to be compared and adjusted across AOD activities that use different combinations of inputs".[6] The fact sheet goes on to state, "[t]he use of DTAUs allows for easy aggregation of information to account for the total cost of an individual client's journey, even where this involves use of multiple treatment streams. This in turn will be linked to transparent reporting of outcomes" (Department of Health 2014, p.1).[7]

2.1 Current features of forensic funding

Significant change to the way forensic services are funded and delivered occurred with the broader recommissioning of AOD services in2014. Forensic treatment became part of 'core business' for adult non-residential treatment services. All providers of these services have a 20 per cent target attached to this work. That is, all funded AOD services are now required to meet a minimum target of 20 per cent of their DTAU utilisation for treatment of forensic clients.[8] This arrangement is with the funded lead entity, therefore these targets must be achieved by all agencies within a consortia and across all treatment types before any individual agency can access additional fee-for-service payment. However, in some consortia, agreements have been made that specific agencies are responsible for forensic work across the whole of the consortium. In these instances, the combined consortium forensic target needs to be achieved, in addition to any individual agency's forensic retainer or pre-payment, before the consortium, or any individual agency within it, is eligible to receive any additional fee-for-service income.

A price loading of 15 per cent applies to forensic work "in recognition of the additional costs associated with service delivery to [the forensic] client group".[9] This loading is funded within an AOD agency's DTAU allocation, not as an additional payment.[10] A DHHS fact sheet on funding states "this essentially means that the price for each product is 15 per cent higher for a forensic client and that agencies will utilise a greater proportion of their DTAU allocation and therefore meet their annual service delivery DTAU targets faster".[11] However, as discussed in section 4 of this paper, the attainment of targets does not necessarily equate with meeting demand for forensic services. Instead, it has been suggested that the forensic target may impede the system's capacity to meet demand by placing an artificial 'cap' on capacity.

Although the work of forensic service delivery has been built into the broader system with the introduction of the 20 per cent DTAU allocation, the way in which services are paid for this work differs markedly. A key feature which distinguishes forensic funding from the broader funding is a

[6] Department of Health (2014) *AOD Fact Sheet: Funding Model.*
[7] One DTAU equates to $695.94 for voluntary clients.
[8] COATS Program - – Guide for Payment Claims *Adult Non-Residential Services (in Scope)* effective 1st January 2016
[9] Department of Health (2014) *AOD Fact Sheet: Funding Model.*
[10] COATS Program – Guide for Payment Claims *Adult Non-Residential Services (in Scope)* effective 1st January 2016
[11] Department of Health (2014) *AOD Fact Sheet: Funding Model*, p.2.

system of partial payments. This system splits payments for a course of treatment into quarters and prescribes a set number of sessions to meet a payment. This system is routinely reported by AOD providers as being burdensome, confusing and inconsistent and undermines clinical judgement. It does not align with the broader approach to funding across the sector.

Perhaps not surprisingly, one of the most significant concerns for AOD service providers was the current forensic funding approach. AOD agencies noted that difficulties in understanding and navigating the changed funding arrangements were compounded by limited communication from DHHS and ACSO-COATS around payment structure and general changes to the system post-recommissioning. Some agencies expressed concern also about receiving potentially three separate responses on any one issue or enquiry – central DHHS, regional DHHS and ACSO-COATS and varied information being provided in different catchments. Gaps in communication flow were also discussed in relation to having one lead agency in a consortia liaising with DHHS and the flow of that information to other consortia members. In relation to funding, these perceived communication challenges have exacerbated confusion and anxiety for service providers around tracking and meeting targets.

2.2 Forensic targets and fee-for-service

AOD agencies report facing numerous barriers to meeting forensic targets. These barriers include: the combined treatment target of 20 per cent across all treatment types; partial and full payments; consortia membership and agency location. Of particular concern to agencies at the present time is the combined forensic target across treatment types, with agencies reporting it is considerably more difficult at the current time to meet targets for non-residential withdrawal and care and recovery coordination services in particular.

Agencies report the bulk of referrals come via ACSO-COATS for either 'standard' or 'complex' counselling services. There was some consensus that the 20 per cent forensic target for counselling may be relatively achievable given the bulk of referrals are for this treatment type. However, partial payments[12] complicate this scenario and there was considerable discussion about the complexities of managing demand for forensic AOD counselling services while also providing a responsive counselling service to the broader community. This issue is discussed in greater detail in Section 4 of the report.

2.2.1 Non-residential Withdrawal

A variety of explanations were put forward in relation to the difficulties of meeting Non-residential Withdrawal targets. In light of the absence of departmental guidelines on non-residential withdrawal, the Service Specification for the Delivery of Selected Alcohol and Drug Treatment Services in Victoria, is being utilised to guide eligibility and intervention. Each of the four treatment types are briefly visited in the service specifications which state that non-residential withdrawal is best suited to "low risk clients with an alcohol and/or drug dependence."[13] The specifications further recommend that clients accessing non-residential withdrawal have access to "a level of stability in their lives such as supportive friends or family, and stable housing"[14]

Many forum participants identified the low number of referrals received from ACSO-COATS as a significant barrier to reaching any target for this treatment type. Furthermore, agencies linked the relatively low number of referrals to a more fundamental question of whether non-residential withdrawal is too narrowly defined and interpreted via the current Service Specifications and

[12] For a copy of the of the current payment guidelines see www.acso.org.au

[13] Department of Health and Human Services (2014) *Service Specification for the Delivery of Selected Alcohol and Drug Treatment Services in Victoria*, p.17, paragraph 11

[14] Department of Health and Human Services (2014*) Service Specification for the Delivery of Selected Alcohol and Drug Treatment Services in Victoria*, p.18, paragraph 1

therefore excludes a proportion of clients who may benefit from a non-residential withdrawal intervention.

The current conceptualisation of non-residential withdrawal as outlined in the Service Specifications means that very few clients will meet this criteria. It has been suggested that guidelines for the delivery of non-residential withdrawal need to provide for a mode of delivery that is flexible and allows for clients with more complex needs and of higher risk who may require a step-up and step-down intervention. Such an intervention could be attached to a residential withdrawal admission (pre and/or post-withdrawal) or focused on stabilisation of substance use.

The challenges associated with client flow and low referral numbers into non-residential withdrawal exist across both voluntary and forensic populations, although this is difficult to adequately assess this in the absence of data on referral numbers.

It is hoped that the pending release of guidelines for non-residential withdrawal will provide more guidance on how this treatment type can be ustilised, allowing for a flexible model of non-residential withdrawal which forms part of a continuum of care and support for individual's seeking to reduce and/or cease their substance use. There was also a view among some service providers that a lack of understanding of the role of non-residential withdrawal more broadly among intake and assessment providers, justice referral sources and the broader community has contributed to a lower utilisation of this treatment type.

Agencies have recommended separate DTAU forensic target be introduced for non-residential withdrawal in recognition of the smaller proportion of forensic clients being referred into this treatment type (see recommendation 6)

2.2.2 Care & Recovery Coordination

It appears that agencies are similarly struggling to meet the forensic target for care and recovery coordination. Recommissioning saw the introduction of this treatment type in recognition that people with complex needs require additional support to facilitate their entry into, and pathway through treatment.

AOD agencies have continually raised concerns about the limited capacity of Care & Recovery Coordination to work with the most complex clients within the current model. This pertains to both voluntary and forensic AOD clients.[15] Agencies have recently reported pressure from other service systems, particularly mental health, to refer people requiring case management support to Care & Recovery Coordination. There appears to be a general misunderstanding of the role and function of Care & Recovery Coordination with it being viewed as a case management service rather than a care coordination service.

Agencies also reported low rates of referrals for care and recovery coordination from ACSO-COATS and felt this was at least in part, due to DHHS highlighting the service as a 'scarce resource'. Compounding this, agencies and ACSO-COATS reported confusion about the role of Care & Recovery Coordinators within the forensic system as many forensic clients work with a Corrections Officer who may be considered to provide a case management function, although does not have sufficient knowledge of AOD treatment to coordinate care and treatment pathways.

The sector requires clarity from the Department on the role and function of Care & Recovery Coordination for forensic clients (see recommendation 5).

[15] These issues have been canvassed in other VAADA publications. See for example, *VAADA Regional Voices Final Report*, available at: http://www.vaada.org.au/wp-content/uploads/2016/02/VAADA-Regional-Voices-Final-Report.pdf

2.3 Number of sessions and partial and full payments

Agencies raised significant concern about the payment structure and the number of sessions, as defined by the ACSO-COATS payment guidelines, required for a full payment across various treatment types.

According to the *COATS Program – Guide for Payment Claims*, to satisfy a full payment, complex clients are required to attend 12+ sessions, for complex counselling, and the 9+ sessions for non-residential withdrawal. Many agencies questioned the clinical validity of the number of sessions and sought clarity about the evidence upon which these guidelines were developed.

Agencies reported that the prescriptive nature of such guidelines diminished the vital role of clinical decision-making and judgement that is central to client-centered practice. Some agencies further reported that the number of sessions required to achieve a full payment across the treatment types were too many, and meaningful clinical outcomes could be achieved in fewer sessions in some instances. The flexibility within the broader funding model where a course of treatment includes an average number of contacts allows a clinician to work more intensively, and for longer periods, with those clients who require it while recognising that other clients will require fewer sessions.

Agencies reported considerable confusion about the basis upon which a system of partial payments remain for forensic clients while incorporating targets into the broader DTAU allocations for treatment types and services. This appears to undermine the broader approach to funding and the delivery of 'courses of treatment'.

AOD agencies also reported significant difficulties in tracking their progress against targets with the Treatment Completion Advice (TCA) reports provided by ACSO-COATS and the system of partial payments.

AOD agencies seek clarification and communication from DHHS around pricing structure and the basis for current forensic funding approach, including the system of partial payments.

2.4 Non-attendance

VAADA's consultations highlighted particular concerns for rural and regional agencies in the delivery of forensic services. Rural agencies who participated in the forum expressed difficulty in meeting the 20 per cent forensic target, reporting an overall decrease in forensic referrals and a high number of clients who do not attend (DNA) sessions.

Some agencies argued that the number of DNAs may be higher in regional and rural areas. While it is understood that DHHS factored a DNA rate into the forensic loading; some rural and rural agencies argued that DNAs can account for approximately 50 per cent of all client referrals.

Rural and regional services highlighted the particular challenge this poses in relation to resourcing when clinicians spend significant travel time out-posting to various locations and clients do not attend appointments. Metropolitan services also noted travel time as an issue across service types that offer outreach as a mode of service delivery. AOD services proposed a review of the calculation of DNAs be undertaken and factored into the forensic loading, or that a direct DNA payment be re-introduced.

There was a general consensus among AOD service providers that a significant amount of clinician time can be invested in following up referral information; contacting the client to arrange an appointment and liaison with Corrections for a proportion of clients who never attend a treatment session (see recommendations 7 and 8).

2.5 The consortia model and interdependence of agencies

The formation of consortia in each of the 16 catchments was an outcome of recommissioning. Both the VAADA *Regional Voices Report* and *Aspex Independent Review of New Arrangements for the delivery of MHCSS and Drug Treatment Services* discussed the various implications of a consortia model in the delivery of treatment services across Victoria. In the forensic space, AOD agencies report that consortia arrangements limit capacity of individual agencies to meet their forensic targets and therefore access fee-for-service funding. Consortia were also discussed in relation to referral blockages and communication and information flow, as discussed in Section 4 of this paper.

Some agencies who are not providing non-residential withdrawal services or Care & Recovery Coordination noted frustration when other consortia members could not fulfil targets attached to those specific service types, which then impacts on their capacity to access fee-for-service funds in higher demand treatment types such as counselling. This again points to the need to review the 20 per cent target across all treatment types.

A number of AOD service providers remarked that the current funding approach is designed to prevent AOD service providers from accessing these funds beyond their DTAU allocation. As a result, AOD agencies experience the challenge in determining whether to contract staff to meet demand, without clear indications that a steady flow of funding will be available over time. This financial risk falls directly upon agencies.

2.6 The forensic 'loading', remuneration for 'non-direct' client work and ancillary costs

It is the view of many AOD service providers with whom VAADA consulted that current forensic funding does not take into account work that sits outside of direct client contact. This includes time spent by clinicians on tasks such as case notes and report writing (e.g. court reports and completion of TCAs); case meetings, case conferencing and clinical review processes; secondary consultations and ongoing contact with Corrections, Justice staff and other case managers.

Rural agencies in particular highlighted travel, especially outreach work and other 'non- direct' client contact work, such as administrative tasks, as mandatory activities that should be funded accordingly. Regional and rural clinicians often travel significant distances to provide outreach treatment to complex clients who face barriers to accessing services. Agencies argue that this mode of service delivery is necessary to be responsive to local need yet is increasingly difficult to offer in a meaningful way and directly impacts on the options and outcomes available for clients in regional and rural areas. To address this, agencies advocated for outreach work to be recognised in the forensic system as a funded treatment product or appropriately factored into forensic funding.

While the current 'pricing' for forensic clients includes a loading of 15%, AOD service providers report this loading is insufficient to fulfil administrative requirements, provide for after-hours appointments and outreach; account for those who do-not-attend appointments alongside providing for clinical supervision and training and professional development needs (see recommendation 9) .

Recommendations:

3. DHHS promptly release program guidelines for all treatment types, including Non-residential Withdrawal and Care & Recovery Coordination to enable improved treatment matching for both voluntary and forensic clients.

4. DHHS investigate the barriers identified around utilisation of Non-residential Withdrawal as a treatment type for forensic clients and determine mechanisms to address these issues. This work must be undertaken in consultation with AOD service providers and the Forensic AOD Working Group (see recommendation 1). Any necessary revisions to the Non-residential Withdrawal

guidelines should only be made following thorough consultation with Non-residential Withdrawal service providers.

5. DHHS clarify the role of Care and Recovery Coordination for forensic clients, particularly in relation to the role and functions of Community Corrections Officers.

6. DHHS, in consultation with the AOD sector, review the 20 per cent aggregated forensic target and if appropriate, move to a system with separate targets each treatment type.

7. DHHS commit to a review of forensic funding including the 15 per cent forensic loading to ensure that it adequately and appropriately covers the catalogue of additional administrative tasks and ancillary costs associated with forensic service delivery such as accounting for do-not-attends, after-hours appointments, travel time associated with outreach, report writing, and data entry across multiple platforms. Any review must involve input from AOD service providers and the results clearly communicated to the sector.

8. DHHS consider an increase in the DTAU pricing for rural and regional agencies in recognition of the additional costs of forensic AOD service delivery across these settings.

Section Three: The Forensic AOD workforce

VAADA believes we need urgent investment in the AOD workforce, this includes a focus on the needs of the workforce in relation to forensic service provision. Agencies called attention to the impact of recommissioning on the recruitment and retention of suitably qualified and experienced staff across the AOD sector as a whole. Retention of an experienced and qualified workforce has long been an issue in the AOD sector, however these challenges appear to have been exacerbated over recent years with agencies reporting the recruitment and retention of highly skilled and sufficiently experienced staff has been especially challenging since recommissioning. As a result, less experienced clinicians could be tasked with managing and providing treatment for highly complex clients with multiple needs and risks.

There is a growing body of evidence suggesting that recommissioning may have resulted in a structural shift in the composition of the AOD workforce. This issue was first revealed in anecdotal feedback from service providers throughout the recommissioning process and has subsequently been highlighted in VAADA's 2015 *Recommissioning Survey*, as well as VAADA's *Regional Voices* project and the Independent review of the MHCSS and AOD undertaken by Aspex Consulting in 2015. Aspex consulting noted that recommissioning brought with it some opportunities for agencies, particularly those whose scope of service delivery expanded, to "consolidate their workforce capacity and capability" (Aspex Consulting 2015, p.47), though it also found that recommissioning had a substantial impact on the AOD workforce.

Moreover, agencies report that forensic clients are one of many diverse groups that staff are required to be skilled in working with including young people, Aboriginal people, those from culturally and linguistically diverse communities as well as people experiencing co-occurring issues such as mental health concerns, problem gambling, family violence and trauma.

3.1 Workforce composition and structure

There was some divergence of views among AOD service providers about the best composition of the AOD workforce in the delivery of forensic AOD services. Some providers have developed specialist forensic teams, while others have integrated the provision of forensic treatment within a team of clinicians working with both forensic and voluntary clients.

Some AOD service providers suggested that the core skills required to work with forensic clients are not unique and that both voluntary and forensic clients share more characteristics than not. Irrespective of whether forensic and voluntary clients differ in their profile, and in what particular ways, there were some providers who saw benefit in building clinical capacity across their workforce to work with *both* voluntary and forensic clients. They felt this provided opportunity for breadth in clinical experience; variety within an individual clinicians' caseload; greater collaboration and cross-fertilisation of skills and sharing of many of the particular administrative 'burdens' associated with forensic service provision.

On the other hand, some AOD agencies felt strongly that having a dedicated team of forensic workers had benefits and allowed clinicians 'choice' and 'specialisation' in the type of clinical work they deliver. Those who favoured this workforce composition suggested there are advantages to a model whereby clinicians are specialist in their work. This approach, they argued, allows for enhanced peer support, informal mentoring and skills development within teams and allows for focused clinical and task supervision that is specific to the needs of a forensic worker. Managers in these services contended that employing forensic clinicians allowed them to employ staff who are dedicated and passionate about working with forensic clients.

Some AOD service providers felt that their agencies' capacity to decide the composition of their forensic workforce was now more constrained than previously because of the funding model and

associated targets. These changes had removed the choice of agencies to create specialisation within their workforce where they wished to do so without carrying significant financial risk.

3.2 Accreditation, professional development and ongoing training

There is widespread confusion about the status of accreditation for AOD clinicians providing services to forensic clients, with providers requiring clarification from the Department about the current accreditation process and requirements. According to the ACSO-COATS website, all funded agencies providing assessment and treatment must nominate a clinical supervisor who will be accredited with DHHS. The DHHS 'Clinical Supervisor role statement', outlines the position description of the Clinical Supervisor as being:

- A person employed by a Department of Health funded alcohol and other drug treatment provider, who is responsible for overseeing clinical standards and governance in relation to forensic clients accessing alcohol and other drug treatment
- The Clinical Supervisor must have appropriate qualifications and experience to monitor , supervise and evaluate clinical staff providing treatment interventions to forensic clients
- The person must have an appropriate level of authority within the organisation to undertake the roles and functions of this position.

There has been no assertive effort from the Department to communicate the current requirements around accreditation and whether all AOD clinicians working with forensic clients are required to obtain accreditation, or if it is sufficient to have an accredited forensic supervisor within an agency overseeing the work of clinicians. It is VAADA's view that the Department must communicate the accreditation requirements to all AOD service providers as a matter of urgency and appropriately fund agencies to support staff to go through any required accreditation process (see recommendation 9)

Beyond the requirements of any formal accreditation process, there is a need for capacity to be built into the system to allow agencies to appropriately induct new AOD clinicians into working with forensic clients as well as providing for ongoing professional development and training opportunities to build a depth of clinical skill within the workforce.

VAADA notes the Department has funded Caraniche to provide a series of free two-day training workshops for AOD clinicians which covers topics such as: understanding substance use and offending; working with Corrections, confidentiality, and appropriate documentation; working with forensic clients, motivation, maintaining boundaries and treatment interfering behaviours; and dealing with aggression among other topics.

While such initiatives are welcome, agencies continue to report challenges in providing 'backfill' to release staff to attend training and limited opportunities for ongoing professional development to upskill staff and build clinical expertise in the delivery of forensic AOD treatment. Access to ongoing professional development beyond short-term initiatives is also necessary and important (see recommendations 10 and 11).

Further training of benefit to the workforce, but which is currently provided at a cost, includes topics such as advanced motivational interviewing and enhancement techniques, therapeutic interventions in working with forensic populations, advanced clinical supervision and working with anti-social presentations among others. Moreover, rural and regional agencies felt especially disadvantaged by much of the training on offer as it generally requires travel to Melbourne and these additional travel costs are not covered by available funding. Some rural and regional services saw value in exploring how technology could be better utilised to support staff to access training and professional development activities.

Agencies reported a 'funding gap' in relation to training and professional development and argued that the 15% forensic loading is insufficient to cover the costs of providing professional development opportunities for staff. They noted that most training on offer is undertaken at a cost to the agency, and on an ad-hoc basis, rather than being funded in a systematic way that supports the development of the workforce as a whole.

Agencies favoured an approach which looks broadly at workforce needs and provides for meaningful clinical skills development to ensure a baseline level of forensic competence across the AOD workforce, coupled with the opportunity to advance and develop clinical skill and open career pathways within the sector. As VAADA has noted previously,[16] there remain few opportunities for AOD workers to move into advanced and appropriately remunerated clinical roles, leading to skilled and experienced practitioners moving out of clinical work and into management positions in order to progress financially.

One mechanism to address this would be the introduction of advanced practitioner roles within the AOD sector. This could open clinical career pathways and build advanced clinical expertise across the sector. Such workers could provide supervision and support to less experienced staff. Investment in the establishment of these roles would be welcomed as an important and vital recognition of the importance of clinical pathways and career advancement for the AOD workforce (see recommendation 12).

3.3 Clinical Supervision

As VAADA noted in a 2009 submission to the then Victorian Department of Health's Discussion Paper on the Forensic Drug Treatment System:

> "Clinical supervision, especially in the early years of practice, is widely accepted as being important for professional development to ensure optimal client outcomes (Bambling 2003). It is also acknowledged as an important key lifelong learning activity for many in the health care setting (McMahon 2006). The relevance of clinical supervision to workforce development and as a quality control/improvement measure is acknowledged by many sectors, including the AOD sector (NSW Health 2006; Kavanagh et al 2002)"[17]

Agencies reported that the current forensic loading does not adequately cover clinical supervision. This reduces an agency's capacity to sufficiently support workers, especially less experienced clinicians. Service providers suggested DHHS provide additional funding to boost AOD agencies' capacity to provide ongoing and regular clinical supervision to clinicians at all levels and in a variety of formats, including one-one, observational and in group based environments (see recommendation 12).

There was some discussion about potential mechanisms to enhance access to formal supervision as well as informal peer support among AOD clinicians by drawing on the breadth and depth of experience across services and within consortia, including opportunities for sharing resources to provide group-based supervision, rotations, the establishment of peer networks and mentoring processes. At the present time, a major barrier to implementation of such initiatives is resourcing or capacity to undertake such activities in meaningful way.

[16] See VAADA (2016) *Submission to the Development of Victorian Gender Equity Strategy*, VAADA, Melbourne.
[17] VAADA (2009) *VAADA Response to the Victorian Government's Discussion Paper on the Forensic Drug Treatment System*, VAADA, Melbourne.

3.4 Managing risk

Forensic clients are far from a homogenous group of service users. Like voluntary clients, forensic service users access AOD treatment with a range of needs, risks and motivations.

The issue of 'risk' was raised by forum participants in relation to the pressure to allocate an appointment to forensic clients within 48 hours upon receipt of a referral. Some agencies felt this time was insufficient to adequately assess risk, particularly in the absence of a comprehensive assessment. Clinicians then spent time gathering information and following up with Corrections Officers to gather the necessary information to form an initial assessment of risk and be able to allocate accordingly. Forum participants felt one simple solution to this would be providing the referring CCO's contact details on the referral form so clinicians could follow up with immediately to gain the necessary information prior to allocating an appointment time and clinician.

Issues of rurality was also discussed in relation to risk, both for the clinicians undertaking this complex and challenging work, and for the clients receiving forensic AOD treatment. Clinicians in these settings may work in isolation and across large catchment areas which raises a number of OH&S concerns. Forum participants reported that clinicians working in these settings were prone to stress, compassion fatigue, vicarious trauma and possible burnout as they are required to work with complex clients without adequate mechanisms in place to enable timely supervision. Rural agencies advocated for specific funding for the provision of clinical supervision in order to better support these staff.

As the issues outlined in this paper suggest, attention needs to be paid to a long-term workforce development plan across the AOD sector as a whole, including attention to the needs of clinicians providing forensic AOD treatment. This work should be undertaken jointly by DHHS in collaboration with the AOD sector.

Recommendations:

9. DHHS clarify as a matter of urgency the current requirements associated with forensic accreditation so that agencies understand the requirements and can support staff accordingly. Any additional training and professional development requirements associated with accreditation should be financially supported by DHHS, as part of a broader professional development strategy (see also recommendation 11).

10. DHHS explore options to utilise information technology and online mechanisms to enhance access to training and professional development opportunities for rural and regional services.

11. DHHS work with the AOD sector and VAADA to advance the development of an AOD workforce strategy that comprises a specific forensic component to enhance forensic competence and capacity across the sector. A workforce development strategy must be adequately and appropriately funded and consider:

- **Any minimum skill set required of forensic AOD clinicians and how to build capacity across the system for regular, ongoing professional development and opportunities.**
- **Pathways for career progression and the creation of advanced practitioner roles across the AOD sector which are adequately and appropriately remunerated**
- **Enhancing access to appropriate forms of specialist forensic clinical supervision**
- **Strategies to address ongoing recruitment and retention challenges**

- **The role of peer networking and mentoring in developing the AOD workforce, including forensic skill-sets**

12. DHHS revise the funding formula to ensure adequate resources are available for clinical supervision.

Section Four: Information sharing, managing demand and referral pathways

In addition to the funding and workforce issues discussed, AOD agencies reported challenges with managing demand and meeting significant administrative requirements associated with the delivery of forensic services. These factors, along with ensuring effective and efficient referral pathways exist to meet client need, are clearly barriers that impact negatively on the provision of holistic and integrated care.

4.1 Managing demand and delivering responsive services

System capacity issues and managing demand were highlighted by AOD service providers as a significant and ongoing challenge. A number of people report difficulties in responding to forensic demand while retaining a responsive and accessible service for the community at large.

In particular, agencies spoke of the difficulties of managing demand at a local level and needing to place referrals 'on hold' for a particular period, location or service type to assist with capacity issues. AOD service providers' expressed concern about the new requirement to consult with their regional DHHS office before placing referrals on hold. VAADA notes since the Forensic Forum in March, ACSO-COATS have advised that agencies will also be required to complete an 'on hold' form when they seek to place referrals on- hold. This form must be submitted to the regional office for approval.

This process, according to service providers, can increase the pressure to accept referrals beyond an agency's capacity and impact on their ability to manage caseloads and provide responsive and timely access to treatment for both forensic and voluntary clients. VAADA has received multiple reports of agencies being inundated with new referrals once referrals are taken 'off-hold' which quickly results in an agency halting referrals again.

Agencies argued that they should be able to make a decision about when and where to place a hold of referrals without consulting regional DHHS offices.

Agencies further advocated for a mechanism to be developed which can monitor capacity across the system and provide regular updates to treatment providers about capacity across treatment types within a catchment. This could assist with enhancing referral pathways, managing demand and client flow across a catchment.

Some agencies have suggested that the forensic funding model places on 'artifical cap' on capacity across the AOD sector .Indeed, it was suggested that the funding approach has created a significant structural barrier for AOD agencies in being able to build a viable forensic service that can grow and meet demand over the longer-term. There is also a need to investigate the broad treatment types available and whether they are most suitable for the forensic client cohort, or if additional treatment types are needed. Funding and targets must be aligned with evidence and data about which treatment types are best suited to the cohort as well as referrals from external sources, such as COATS, coming into the system. Some of this work could be led by the Forensic Working Group as suggested in recommendation 1.

For instance, in some areas of high demand, it has been suggested that group-based treatment options should be explored. Such options could be available to people who are on wait-lists for residential services or those who have exited residential services and require relapse prevention skills development. Such programs could be delivered over a relatively short time-frame of 4-6 weeks offering modules of relapse prevention and could assist in meeting current demand.

Recommendations:

13. DHHS, in consultation with AOD service providers, consider the development and funding of additional treatment options for the forensic client cohort, including group-based interventions to support people on wait-lists for residential services and as a mechanism to provide after-care or post-residential relapse prevention support.

14. A mechanism be developed and administered by ACSO-COATS to provide real-time information to all AOD providers on those services and locations which are 'on hold' in order to assist agencies to meet demand within a catchment. This mechanism should be developed for the purposes of improving access and to meet demand, not as a performance management tool.

4.2 Administration

Agencies also reported a significant 'administrative burden' attached to forensic service delivery, noting an increasing proportion of a clinician's time is now spent on administrative tasks in addition to direct client work.

Agencies report the administrative burden associated with AOD forensic treatment delivery has increased significantly for individual clinicians as well as management within AOD agencies. Some examples include data entry into multiple systems such as case files, agency data system and the Penelope portal; requirements of community corrections officers; ACSO reporting requirements and completion of TCAs in addition to internal data systems. Anecdotally, forum participants reported that administrative requirements can account for half of a clinician's daily responsibilities. Some have commented that for every hour of direct client work, there could be an additional half an hour of associated administrative tasks. Some agencies report disillusionment among staff created by the administrative burden that accompanies their daily clinical workload. While agencies recognise the importance of data collection and quality in record keeping, they advocate for the implementation of a more efficient and integrated data system, rather than multiple systems requiring multiple inputs.

Some agencies reported having to employ a dedicated administrative officer to enter data and reconcile financial and activity reporting. This cost was seen as unsustainable in the longer-term without addressing the shortfalls of the current funding model.

4.3 Information sharing and collaboration with the criminal justice system

Information sharing and communication between AOD agencies, ACSO-COATS, DHHS and various criminal justice stakeholders could be improved. Communication challenges and information gaps have been discussed in detail in previous reports on the recommissioning of services, including VAADA's *Regional* Voices and the *Aspex* review.

In the forensic setting, agencies would like to see ongoing and regular communication from both DHHS and ACSO-COATS about current forensic activity. Information on waiting times and referrals that are 'on hold' would help agencies to manage demand at a local level.

There were also a number of everyday examples of where communication and information processes could be improved. For instance, AOD agencies are responsible for sharing information about treatment goals and outcomes with a variety of criminal justice stakeholders including Corrections Officers, courts and other referrers. However agencies report a number of deficiencies in the information provided to them throughout the treatment process and prior to commencing AOD treatment with a forensic client. Small details such as having a contact details for Community Corrections Officers on a referral form was suggested as a useful mechanism to improve efficiency in following up on referrals. Similarly, residential withdrawal services reported receiving referrals for the admission of a forensic client but not being able to access the Comprehensive Assessment until an admission date has been set. In the absence of this information, staff at residential unit can spend a significant amount of time following up with the client and other professionals trying to 'piece together' a story and make an assessment of risk and appropriateness of a client for a residential setting. This is especially relevant for sex offenders and the application of the new Child Safe Standards introduced by the Victorian Government in response to the Betrayal of Trust Inquiry.

On a broader level, forum participants were concerned by the lack of awareness held by some criminal justice personnel regarding the AOD sector. It was acknowledged that while the justice staff did not require intricate knowledge of the service system, an understanding of different treatment types, referral pathways and entries into the system is required for justice workers to effectively facilitate a client's entry into AOD treatment.

Recommendations:

15. Referral forms from ACSO-COATS be amended to include contact details of Community Corrections Officers so that AOD clinicians have ready access to a contact person for consultation and information gathering purposes. Information around any potential risk issues should be made available earlier in the referral process.

16. Opportunities for cross-sectoral capacity building for Community Corrections Officers be explored to enhance their knowledge of AOD treatment services, modalities and approaches.

4.4 Referral pathways and blockages

Agencies continue to report that current referral pathways are convoluted and therefore difficult to navigate. As previously noted, ACSO-COATS continues to undertake the majority of intake and assessment services for AOD forensic clients, in particular those referred through Community Corrections, Courts, Prisons and the Adult Parole Board (APB). Catchment Based Intake and assessment services provide intake and assessment, as some brief interventions, for Youth Justice clients and those referred via specialist court programs (ARC, CISP, CREDIT) ; police diversion pathways such as Police Drug Diversion (DDAL), as well as clients meeting criteria for 'other diversion' (ACSO-COATS 2016). An annual target of 10 per cent of Drug Treatment Activity Unit (DTAU) funding for each intake and assessment provider has been allocated for forensic clients.

There are multiple pathways into forensic AOD treatment, as discussed in Section One, and this contributes to blockages and inefficiencies within the system. In some catchments, ACSO-COATS refer forensic clients directly to AOD agencies for the delivery of AOD treatment and in other catchments, forensic referrals come via consortia leads who then distribute referrals to consortia members. However, intake and assessment services also refer forensic clients to AOD treatment. This system is confusing for all stakeholders involved in delivering forensic services.

AOD agencies continue to report disruption of long established referral pathways which has created ongoing challenges. For instance, many agencies rely on a third party for adequate client flow in both the voluntary and forensic space. Some agencies report lower numbers of referrals in consortia

where a lead agency is also an Intake & Assessment provider, although this issue is not seen as specific to forensic referral pathways.

Recommendation:

17. DHHS and ACSO-COATS investigate the multiple referral pathways into forensic AOD treatment and options to simplify the intake and assessment pathways for forensic clients.

Final thoughts

Overall there is continuing confusion as to the diverse pathways that clients are referred in for forensic AOD treatment, and numerous examples where forensic matters are identified subsequent to the individual initiating treatment. The stakeholders consulted in this project communicated a need for clarity on the various referral pathways and consideration of which treatment types are considered most valuable for this cohort. The DTAU funding model does not account for the work undertaken and provides limited capacity for aftercare or post treatment support.

Integrated models of care, targeted at some of the most marginalised people in the community, require investment that matches demand. Further to this is the requirement for a collaborative approach to outcomes that meets both the AOD treatment goals and offending behaviour needs of the client. Without effective processes and strategies in place we will continue to deliver fragmented responses.

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