

Discussion Paper on the Forensic Drug Treatment System

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This Discussion Paper aims to create a shared understanding of the current forensic alcohol and drug treatment system, to address issues and to develop themes for the future in line with *'A New Blueprint for Alcohol and Other Drug Treatment Services 2009 – 2013'*.

**Closing date for written responses:
Friday 3 April 2009**

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Please supply the name and contact address of the respondent, the capacity in which they write and the organisation/drug treatment agency that they are associated with. A contact telephone number would also be appreciated should the Department wish to clarify any of the information provided.

Please note: The discussion paper provides questions to prompt a response; respondents are free to answer more broadly on forensic issues should they so wish.

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Contents

1. Introduction	1
1.1 Policy Context	1
1.2 Purpose of this Discussion Paper	2
1.3 Evolution of the Forensic Drug Treatment System	2
2. Key themes	5
2.1 Consumer Focus	5
2.2 Partnerships	6
2.3 Evidence-based practice	7
2.4 Continuous Quality Improvement	9
2.5 Workforce development	10
2.6 Clinical Governance	11
3. Summary of key points for Discussion which you may wish to address in your response	13
Consumer Focus	13
Partnerships	13
Evidence based practice	13
Continuous Quality Improvement	14
Workforce development	14
Clinical Governance	14
Attachments	15
Attachment 1	16
Attachment 2	21
Attachment 3	23
References	25

1. Introduction

1.1 Policy Context

This Discussion Paper on the forensic drug treatment system builds on the discussion paper titled, *Towards a New Blueprint for Alcohol And Other Drug Treatment Services (2007)*. Resulting from this paper is *A new blueprint for alcohol and other drug treatment services 2009-2013 - Client centred, service focussed* (the Blueprint).

The Blueprint strives to ensure Victorians with alcohol and other drug (AOD) issues have access to timely, effective and quality AOD treatment services and interventions to reduce the harms caused to individuals, families and communities. The Blueprint sets out the vision for AOD services and interventions:

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

Key actions of the Blueprint are grouped by the following priority areas:

- Clients
- Children and families
- Young people
- Prevention
- Improving access
- Excellence and quality

Under the Blueprint, the Mental Health and Drugs Division (MHD) has been tasked with “reviewing forensic programs to ensure an outcomes focus, exploring alternative models of funding, developing stronger continuity of care for clients and improving forensic workforce skills”

The objective of improved quality has also been defined in *Shaping the Future: The Victorian Alcohol and Drug Quality Framework (2007)* (Quality Framework), produced by the Mental Health and Drugs Operations Branch (MHDO) of the Department of Human Services (DHS). This document identifies six core standards:

- Consumer focus
- Partnerships
- Evidence-based Practice
- Continuous Quality Improvement
- Workforce development
- Corporate and Clinical Governance.¹

These policy documents are two recent examples of the context within which this Discussion Paper has been developed. Other broader policies such as *A Fairer Victoria*¹ have also provided a useful foundation upon which to build. The six core standards in the Quality Framework are used as a guide to discuss the key themes in this Discussion Paper.

1. Please note that for clarity the descriptors used in the Quality Framework have been replicated in this Discussion Paper.

1.2 Purpose of this Discussion Paper

This Discussion Paper aims to create a shared understanding of the current forensic alcohol and drug treatment system, to address issues and to develop themes for the future.

There has been a range of consultations, including the Blueprint consultative process, discussions with DHS representatives involved in the forensic treatment system and feedback provided via other DHS policy documents including the Quality Framework and service system reviews. These consultations have identified issues for further work.

This Discussion Paper considers ways of addressing these issues and enhancing the treatment outcomes for forensic clients by:

- Improving client information, access to treatment and feedback processes.
- Developing ways to share information and collaborate with our partners in the criminal justice system.
- Ensuring that forensic clients are provided with evidence-based treatment and are retained in treatment longer-term with the aim of achieving the cessation or reduction of AOD use.
- Improving the qualifications, skills and experience of AOD clinicians working with forensic clients.
- Examining the utilisation of forensic funding by AOD agencies and determining ways of ensuring the integrity of the forensic EOC purchased.
- Considering whether the current forensic funding model needs to be revised in order to achieve these aims.

Feedback from this Discussion Paper will help us develop a new framework for forensic AOD service delivery in Victoria. MHDO has posed questions under each theme and encourages written submissions in response to these questions.

1.3 Evolution of the Forensic Drug Treatment System

In March 1996, the then Premier's Drug Advisory Council (PDAC) published *Drugs and Our Community*. The report detailed the Council's investigation into illicit drug use in Victoria, and found that significant numbers of people who come into contact with the criminal justice system have histories of problematic drug use. Amongst a range of findings, the report recommended a substantial upgrading of services for people who come into contact with the criminal justice system and who have serious problems resulting from drug misuse.²

MHDO commenced funding the Community Offenders Advice and Treatment Service (COATS) in 1997 as a key component of *Turning the Tide*, an integrated strategy announced by the Victorian Government in June 1996 in response to recommendations made by the Premier's Drug Advisory Council.³ COATS is an independent service operated by the Australian Community Support Organisation (ACSO), a non-government community based agency that provides services to people who have had, or are at risk of having contact with the criminal justice system. The forensic drug treatment system was then enhanced by the Deed of Agreement between the Commonwealth and Victorian governments for the National Illicit Drug Strategy (NIDS) – Illicit Drug Diversion Initiative (IDDI). Originally signed in 2000 and extended until 2009, NIDS - IDDI provides the framework for diversion of illicit drug users from the criminal justice system into drug education or assessment and treatment. The NIDS - IDDI provides a Commonwealth budget to DHS for additional brokerage funding to COATS.

Payment for forensic AOD treatment occurs via the COATS brokerage program. COATS is funded to broker the purchase of AOD treatment services for forensic clients from accredited AOD treatment agencies. MHDO enters into a Service Agreement with COATS. The COATS Service Agreement sets out the total funding to be provided to COATS from the Victorian government and the Commonwealth government. The AOD treatment services purchased by COATS include Community Residential Drug Withdrawal; Rural Drug Withdrawal; Home-based Withdrawal; Outpatient Drug Withdrawal; Residential Rehabilitation; Specialist Pharmacotherapy Service; Counselling, Consultancy and Continuing Care (4C's service type); A & D Supported Accommodation; Youth Outreach; Koori Community Alcohol and Drug Worker; Koori Community Alcohol and Drug Resource Service; Youth Specific Residential Services; Rural Outreach Diversion Worker. These services must comply with the service requirements set out in the *Framework for Service Delivery*⁴ document.

In the last decade in Victoria, a comprehensive system of Commonwealth and State funded forensic programs has evolved to enable offenders to be diverted away from the criminal justice system into AOD services that provide drug assessment, education and treatment interventions. These interventions occur at different stages along the criminal justice continuum:

- By the Police – pre-arrest
- By the Courts or Magistrate – point of arrest/bail
- By the Courts or Magistrate – deferral of sentence
- By the Magistrate, Corrections Victoria or Youth Justice – sentencing options
- By the Parole Board – post-prison
- Release without condition – StepOUT program

A brief overview of the funded forensic programs is outlined at Attachment 1.

2. Key themes

2.1 Consumer Focus

Within the forensic system, consumer focus is critically important, particularly as a violation of the treatment program may have additional legal consequences for the client. In the forensic system there is less consumer choice. This means that clinicians have a duty to maximize the client's ability to make educated decisions about their AOD treatment and to provide informed consent. Clinicians must have sufficient experience and skill to ensure that clients understand the expectations of the Magistrates, courts, Corrections, Adult Parole Board and Youth Justice in relation to the client's treatment and the consequences of the client failing to engage in and comply with the AOD treatment. It is also part of the clinician's role to inform clients about the reporting and communication that occurs between the AOD service providers and the justice system regarding the client's progress in treatment. Clinicians have responsibility to provide clients with therapeutic interventions that focus on long-term, positive behaviour change including the reduction and cessation of drug use.

The forensic system should also strive to improve service flexibility and access to timely interventions. One way that the forensic system is improving access is by removing geographical barriers to accessing residential forensic AOD treatment. From 1 July 2007, in line with the funding agreement between the Commonwealth and Victorian Governments under the NIDS IDDI, rural and regional access to forensic residential treatment services has been opened up. All residential drug withdrawal and rehabilitation facilities are now statewide and have both a voluntary and a forensic treatment component. Forensic clients have also been given priority access to pre-purchased forensic treatment at residential facilities. A further approach to improve access and outcomes for consumers is for services to register as after-hours providers with COATS. Services need to implement strategies that promote and encourage after-hours appointments so that forensic clients can continue to be engaged in employment, education or training.

In the forensic system, the active participation of clients in decisions about their treatment is encouraged. Clients are informed about service options and encouraged to provide feedback and make complaints about the quality of services. AOD service providers strive to improve the mechanisms by which client input is gathered and also the extent to which this information is used in service development. Client feedback is often collected via a feedback questionnaire, a formal complaints procedure or via a suggestions box. This feedback should be used to inform regular program review and service improvement processes. AOD services also endeavour to engage a client's family and significant others in planning, implementation, delivery and evaluation of interventions and services.

You may like to consider the following questions when formulating your response to this discussion paper.

- How do you ensure timely access for forensic clients to your service?
- Has your service ever excluded forensic clients and why? What strategies do/could you use to ensure this exclusion is minimized?
- In what ways, does your service prepare forensic clients for treatment?
- Does your service encourage after-hours appointments for forensic clients?
- What strategies could be implemented to encourage agencies to provide after-hour appointments to forensic clients?

- What are your forensic client feedback and involvement processes? Is a client's family or significant others encouraged to participate in treatment and program review processes?
- Do you offer any follow up of forensic clients post-treatment?

2.2 Partnerships

Collaborative relationships with criminal justice agencies and other social services are critical to good treatment outcomes for forensic clients. The evidence also suggests that AOD treatment with forensic clients is strengthened where there is continuity of treatment and appropriate linkages and referrals.⁵

One of the key strengths of the forensic drug treatment system is the strong collaborative partnerships and networks that have developed between the AOD and criminal justice sectors in the last ten years.

Key partnerships exist between the AOD sector and the following departments and organisations:

- Australian Community Support Organisation (ACSO – the auspice agency) Community Offenders Advice and Treatment Service (COATS);
- Department of Justice (DOJ) – Court Services and Justice Policy;
- Community Correctional Services;
- Magistrates Courts; Koori Courts; Children's Court; Drug Court; Court Integrated Services Program (CISP) and the Neighbourhood Justice Centre (NJC);
- Adult and Youth Parole Boards;
- Court registrars and Criminal Justice Diversion Program (CJDP) coordinators;
- Victoria Police;
- Youth Justice and Community Care;
- Solicitors and barristers.

It is important that AOD clinicians and justice staff clearly understand each other's expectations.

From an AOD treatment perspective this includes treatment that aims to produce a reduction and/or cessation of substance use and hopefully lead to a reduction in criminal activity if substance use was a driver for offending. From a justice perspective this may relate to the expectation that AOD treatment will result in a decrease in criminal activity.

AOD stakeholders have responsibility for informing and educating partners about success factors relating to treatment and the chronically relapsing nature of addiction. AOD stakeholders should also work to ensure that they maintain strong communication with justice personnel so that there is increased cooperation and collaboration on goal setting for forensic clients, responding to violations of an order or modifying the intensity of the treatment plan. Stakeholders in the criminal justice system are more likely to trust the clinical decisions of AOD treatment providers if collaborative relationships are enhanced.⁷

AOD stakeholder feedback suggests that Magistrates, Corrections and the Parole Board generally expect AOD clinicians to conduct regular treatment sessions with forensic clients over the period of their involvement with the justice system (e.g. the length of their order), which in turn assists in reducing offending behaviour. AOD stakeholders argue that it is difficult to achieve this expectation as it takes away the clinical nature of the interventions being delivered but also because agencies are paid the

same amount per EOC regardless of the number of sessions conducted (See Attachment Two: Current Funding Model). This suggests a tension between the funding model and the variability in length of time taken to achieve treatment goals.

You may like to consider the following questions when formulating your response to this discussion paper.

- In what ways could we ensure better collaboration, communication and teamwork between stakeholders (COATS, AOD clinicians, criminal justice personnel)?
- What information do you currently share with criminal justice personnel?
- Would you recommend facilitating staff exchanges, secondments or rotations between the AOD and criminal justice agencies? If yes, what arrangements would you propose?
- What strategies has your agency implemented to ensure continuity of treatment and appropriate linkages and referrals? What are your key referral destinations?
- How can we facilitate a better understanding of the AOD system by Magistrates, Corrections, the Adult Parole Board and other justice personnel?

2.3 Evidence-based practice

Australian statistics indicate that between 50% and 80% of offenders in Australian prisons are in prison for drug-related offences or were drug affected or dependent at the time of the offence.⁸ Evidence also shows that drug dependency increases criminal activity amongst criminal justice populations and that their criminal activity reduces as their drug dependency decreases.⁹

The research evidence for effective drug treatment has been shown to apply to all AOD clients regardless of offending status. The National Institute on Drug Abuse¹⁰ has published principles of effective treatment which have been widely endorsed. Of particular relevance to the forensic area are the principles that suggest:

- No single treatment is appropriate for all individuals.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counselling (individual and/or group) and other behavioural therapies are critical components of effective treatment for addiction.
- Treatment does not need to be voluntary to be effective. This means that entry into treatment via the criminal justice system can be as effective as voluntary treatment.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.
- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach¹¹

These principles are supported by rigorous studies conducted in Australia and internationally that provide findings for effective AOD treatment for both the general and forensic AOD sector. These studies found that longer-term engagement of clients in treatment was linked to more favourable client outcomes.¹² The appropriate length of time in treatment was found to vary according to an individual's

needs, but research indicates that significant improvements are often reached at three months in treatment.¹³ A review of the literature by Caraniche suggests that forensic clients with AOD issues benefit from an extended time in treatment (approximately one-year).¹⁴ Extended time in treatment is defined by the literature to include a variety of treatment types used in combination or succession. Also, individuals may require more than one treatment experience. Legally mandated retention in treatment has been found to be as beneficial as voluntary treatment, and those with mandated treatment often remain in treatment longer.¹⁵ The studies also indicate that AOD treatment leads to a decrease in criminal activity.¹⁶

There is considerable support in the AOD sector for flexible treatment approaches that provide interventions that are responsive to client needs and that work towards the cessation or reduction of drug use. However, a review of the COATS quantitative and qualitative data collected from treatment agencies demonstrates a majority of short-term information based interventions. Despite sector feedback that clients have become more complex, the average number of sessions conducted by Youth Outreach workers decreased from 41.7 sessions in 97/98 to 7.5 sessions in 05/06. The average number of sessions conducted by the 4C's service type decreased from 13.3 sessions in 98/99 to 4.7 in 05/06. This data appears to be at odds with the evidence that ongoing engagement of clients in treatment increases the likelihood of long-term, positive, behaviour change. The shorter average length of treatment may be related to the way that forensic EOC payments are structured as there is no financial incentive to engage forensic clients in longer-term treatment.

Finance

Stakeholders are committed to exploring ways of enhancing the treatment outcomes for forensic clients. This may include addressing the current model for compensating agencies for delivering AOD treatment to forensic clients. A new forensic funding model should provide AOD treatment agencies with more flexibility to retain forensic clients in treatment for longer periods when required. A proposed funding model should recognise that no one specific treatment is appropriate for all individuals and that an individual's AOD treatment must be continually assessed and varied to ensure that it is responsive to the individual's ongoing needs. A new forensic funding model should accommodate interventions of varying lengths and composition that are based on client need and the aim of longer-term behaviour change.

One of the areas of financial management relevant to this discussion paper relates to prepayments or 'fee for service' payments made by COATS to AOD treatment agencies for treating forensic clients. These payments are made to AOD agencies in addition to the amounts paid by DHS for meeting voluntary targets. This typically means that AOD agencies working with forensic clients employ additional staff or take on additional beds. Two issues have arisen. Some AOD agencies have not purchased extra capacity with the funding and expect generalist AOD clinicians to deliver forensic treatment in addition to their full voluntary client load. Also, some AOD agencies have been providing forensic clients with short forensic EOC and then transferring them to the voluntary system and recording them against the voluntary EOC target. Neither of these practices is supported. These practices compromise the forensic system and minimise the capacity to understand the true cost associated with the delivery of AOD treatment services.

A funding model supported by some stakeholders would provide payment to AOD treatment agencies per session. This would mean that services would be paid a fixed cost per session for a particular service type. The maximum number of sessions would be capped at a certain level. Within this proposed model, AOD treatment agencies would still be required to develop an Individual Treatment Plan (ITP) with clients

and to work with clients towards the completion of an EOC. Based on this, AOD agencies would be paid for the amount of time the forensic client is retained in treatment. If forensic clients require further treatment beyond the capped amount of sessions, the clients could continue their treatment in a voluntary capacity. A mechanism would need to be developed to enable this to occur.

You may like to consider the following questions when formulating your response to this discussion paper

- How do you currently achieve quality clinical outcomes for forensic clients?
- Do you use a variety of tools and interventions to keep the client engaged with the agency? If so what are these interventions?
- The treatment aims for youth and adults involved in the criminal justice system are the same, but do we require different treatment approaches or models for youth and adult forensic clients?
- Do we require different treatment approaches or models for other cohorts e.g. mental health, Indigenous, Acquired Brain Injury etc? This may include purchasing more than one treatment intervention (therapeutic and case work/support) or a partnership approach with other services such as mental health or disability.
- What clinical ‘end point’ does your service aim to achieve and at what point does the service claim an EOC
 - in ADIS, and;
 - with COATS?
- What strategies could we implement to ensure that the AOD treatment sector is able to adequately respond to complex or violent offenders? Particularly group such as those with anti-social personality disorder and sex offenders.
- In what way could the forensic funding model be adjusted to ensure better therapeutic outcomes for clients?

2.4 Continuous Quality Improvement

AOD services need to develop systems of continuous quality improvement, including regular monitoring and evaluation of organisational structures, systems and practices.

The Quality Framework encompasses the following dimensions: effectiveness and capability, such as a competent workforce; safety through comprehensive risk management systems; appropriateness, including evidence-based interventions that are responsive to client needs; fairness including equity and access to services; acceptability and responsiveness, such as providing useful information and considering and implementing client feedback; accessibility and timeliness of treatment interventions; continuity of care across agencies and systems; sustainability requiring ongoing assessments of clinical practice; good management and efficiency. A commitment to quality also requires external quality assurance. The elements of continuous quality improvement are addressed separately under each theme of the Discussion Paper.

Questions

- Has your service undertaken a quality accreditation program?
- If so, what strategies were recommended and/or implemented to ensure continuous quality improvement in relation to treating forensic clients?

2.5 Workforce development

In line with the general AOD workforce strategy, the forensic AOD service system needs to promote a workforce that is competent, confident and has the capacity to identify, assess and respond to AOD issues in the forensic community. It also needs a sustainable workforce. There has been a range of discussions with the AOD sector about the appropriate experience and qualifications required of AOD clinicians working with forensic clients and whether the current accreditation requirements for assessing diversion clients are sufficient to ensure quality service delivery to forensic clients (See Attachment 3).

There has been consistent feedback that AOD clinicians in the forensic system require specialised training, skills and experience to provide improved services to forensic clients. AOD treatment for forensic clients has a dual aim. It must work towards reducing or ceasing AOD use as well as concentrating on the causal relationship between the client's substance use and their offending behaviour. The literature notes that forensic clients are likely to need 'more intense and supervised treatment'.¹⁷ Evidence suggests that forensic clients respond to specific styles of intervention including cognitive-behavioural therapy.¹⁸ Also, the empathy of a counsellor in some cases has also been found to be effective when delivering services to forensic clients.¹⁹ Issues such as anti-social attitudes and behaviour and emotional and impulse control may also need to be addressed. AOD treatment may also need to address relapse prevention and lifestyle modification issues.²⁰ This means that AOD clinicians need to be specifically trained in providing these interventions to forensic clients.

Stakeholders have consistently raised the issue of the additional responsibilities associated with treating forensic clients. Some of the procedures and responsibilities cited include writing progress reports for justice personnel, formal written exit reports, completing Treatment Completion Advice (TCA), forms identifying and recommending variations to the client's individual treatment plans and liaising with justice personnel about the forensic client's attendance and progress in treatment.

There is currently also debate about the most appropriate composition and structure of the forensic AOD workforce. The first line of argument is that all generalist AOD clinicians should continue to treat forensic clients, and as such receive additional training, education and clinical support in relation to effective clinical treatment for this population as well as training in the operation and procedures involved in the forensic drug treatment system. The alternative argument is that AOD agencies should identify specific forensic AOD clinicians to specialise in the treatment of forensic clients. This group of specialist forensic clinicians would be expected to provide direct treatment to forensic clients, as well as providing expertise and secondary consultation to the AOD treatment sector in relation to the assessment, care planning and treatment interventions and procedures involved in the forensic system. Forensic AOD clinicians would also be responsible for enhancing links and relationships between forensic and AOD services. Strategies to recruit, train and clinically supervise this specialist group of AOD clinicians would be required.

Since January 2007, a Forensic AOD Intervention Unit (Forensic Interventions Unit) has been trialled at the South East Alcohol and Drug Service (SEADS) through the NIDS IDDI one-off funding projects. The Forensic Interventions Unit involves a small group of highly qualified and experienced AOD clinicians developing and delivering a range of interventions aimed at behaviour change. The Unit does not provide case management as, in the main, this is the responsibility of Corrections, Youth Justice²¹ or the Courts. The Forensic Interventions Unit also provides services outside normal business hours, to assist diversion clients to continue any employment or educational responsibilities. In addition a secondary consultation role allows clinicians in other agencies opportunity to access advice on engagement, retention and treatment options for forensic clients.

You may like to consider the following questions when formulating your response to this discussion paper

- What should be the minimum qualifications, experience and skill of AOD clinicians treating forensic clients?
- What types of incentives (professional development or otherwise) could be implemented to recruit and retain senior clinicians in the forensic treatment system?
- Should a system of on-going professional development be implemented for AOD clinicians to maintain their accreditation as assessors and for other AOD clinicians to work with forensic clients? What should be the components of this system?
- What specialist education and training modules should be core components of on-going professional development in the forensic system (including modules on court reporting and other forensic processes)?
- Does your agency support leadership enhancement activities that promote the development of specialist knowledge and capacity in the forensic AOD sector?
- Should AOD clinicians working with forensic clients attend peer support networks?
- Does your agency have sound succession planning strategies in relation to forensic AOD clinicians?
- Should we ask AOD agencies to select clinicians who will primarily work with forensic clients?
- Should we develop specialist forensic interventions units to provide more intensive, treatment interventions to forensic clients?

2.6 Clinical Governance

Clinical governance frameworks typically focus on placing improved client outcomes at the forefront of clinical decision-making. Ongoing clinical reviews, incorporating the best possible data about the client, the intervention and the system, is an integral part of decision making within a clinical governance framework. A learning environment where staff are encouraged to critically review their practice is also important as are clearly articulated roles, responsibilities and lines of accountability.

Stakeholders have suggested that the development of comprehensive clinical governance frameworks around the forensic clinical work can be challenging but acknowledge that this is an important step towards improving the quality of services available to forensic clients. These structures need to be embedded across the AOD treatment system and should encompass forensic work.

You may like to consider the following questions when formulating your response to this discussion paper

- How can we improve the forensic system so that the integrity of the forensic EOC and treatment interventions are maintained?
- Has your agency implemented mechanisms to ensure that the following processes and procedures are embedded?
 - File maintenance, management and preparation of all relevant documentation for example, recording of file notes, progress reports and discharge summaries;

- Writing comprehensive and meaningful reports to the Magistrates, Corrections Victoria, Youth Justice and other justice personnel as well as other documentation such as Treatment Completion Advices (TCA) for COATS;
- Assessments and clinical treatment planning;
- Best clinical practice such as regular clinical supervision and clinical practice review; and
- Occupational health and safety policies and procedures.

3. Summary of key points for Discussion which you may wish to address in your response

Consumer Focus

- How do you ensure timely access for forensic clients to your service?
- Has your service ever excluded forensic clients and why? What strategies do/could you use to ensure this exclusion is minimized?
- In what ways, does your service prepare forensic clients for treatment?
- Does your service encourage after-hours appointments for forensic clients?
- What strategies could be implemented to encourage agencies to provide after-hour appointments to forensic clients?
- What are your forensic client feedback and involvement processes? Is a client's family or significant others encouraged to participate in treatment and program review processes?
- Do you offer any follow up of forensic clients post-treatment?

Partnerships

- In what ways could we ensure better collaboration, communication and teamwork between stakeholders (COATS, AOD clinicians, criminal justice personnel)?
- What information do you currently share with criminal justice personnel?
- Would you recommend facilitating staff exchanges, secondments or rotations between the AOD and criminal justice agencies? If yes, what arrangements would you propose?
- What strategies has your agency implemented to ensure continuity of treatment and appropriate linkages and referrals? What are your key referral destinations?
- How can we facilitate a better understanding of the AOD system by Magistrates, Corrections, the Adult Parole Board and other justice personnel?

Evidence based practice

- How do you currently achieve quality clinical outcomes for forensic clients?
- Do you use a variety of tools and interventions to keep the client engaged with the agency? If so what are these interventions?
- The treatment aims for youth and adults involved in the criminal justice system are the same, but do we require different treatment approaches or models for youth and adult forensic clients?
- Do we require different treatment approaches or models for other cohorts e.g. mental health, Indigenous, Acquired Brain Injury etc? This may include purchasing more than one treatment intervention (therapeutic and case work/support) or a partnership approach with other services such as mental health or disability.
- What clinical 'end point' does your service aim to achieve and at what point does the service claim an EOC
 - in ADIS, and;
 - with COATS?
- What strategies could we implement to ensure that the AOD treatment sector is able to adequately respond to complex or violent offenders? Particularly group such as those with anti-social personality disorder and sex offenders.
- In what way could the forensic funding model be adjusted to ensure better therapeutic outcomes for clients?

Continuous Quality Improvement

- Has your service undertaken a quality accreditation program?
- If so, what strategies were recommended and/or implemented to ensure continuous quality improvement in relation to treating forensic clients?

Workforce development

- What should be the minimum qualifications, experience and skill of AOD clinicians treating forensic clients?
- What types of incentives (professional development or otherwise) could be implemented to recruit and retain senior clinicians in the forensic treatment system?
- Should a system of on-going professional development be implemented for AOD clinicians to maintain their accreditation as assessors and for other AOD clinicians to work with forensic clients? What should be the components of this system?
- What specialist education and training modules should be core components of on-going professional development in the forensic system (including modules on court reporting and other forensic processes)?
- Does your agency support leadership enhancement activities that promote the development of specialist knowledge and capacity in the forensic AOD sector?
- Should AOD clinicians working with forensic clients attend peer support networks?
- Does your agency have sound succession planning strategies in relation to forensic AOD clinicians?
- Should we ask AOD agencies to select clinicians who will primarily work with forensic clients?
- Should we develop specialist forensic interventions units to provide more intensive, treatment interventions to forensic clients?

Clinical Governance

- How can we improve the forensic system so that the integrity of the forensic EOC and treatment interventions are maintained?
- Has your agency implemented mechanisms to ensure that the following processes and procedures are embedded?
 - File maintenance, management and preparation of all relevant documentation for example, recording of file notes, progress reports and discharge summaries;
 - Writing comprehensive and meaningful reports to the Magistrates, Corrections Victoria, Youth Justice and other justice personnel as well as other documentation such as Treatment Completion Advices (TCA) for COATS;
 - Assessments and clinical treatment planning;
 - Best clinical practice such as regular clinical supervision and clinical practice review; and
 - Occupational health and safety policies and procedures.

Attachment 1

Pre-arrest Programs

Police Diversion – Cannabis Cautioning

The Cannabis Cautioning Program is available to adults found in possession of, or using dried cannabis leaf, stem or seeds weighing not more than 50 grams. A caution can be issued for a use and/or possess offence only. The person must admit to the offence and consent to the caution. They are provided with written material about the health and legal risks associated with cannabis use and given information about counselling through the Directline telephone service. A voluntary education program, “Cautious with Cannabis” is also offered.

Police Diversion - Illicit Drug Diversion Cautioning

The Illicit Drug Diversion Cautioning commenced as a pilot in the north-western suburbs on 1 September 1998. It has now been implemented throughout Victoria. It provides the option of a caution for persons detained by the police for use and/or possession of small amounts of illicit drugs. A condition of the caution is that the offender attends a drug treatment service for an assessment and appropriate treatment.

A 24-hour Drug Diversion Appointment Line (DDAL) is available for Police to organise appointments with the treatment provider. The AOD assessment and treatment services are provided by accredited drug treatment agencies, with additional per capita funding. COATS acts as a payment agency for the program. Persons under 21 may choose to attend a youth specific service. The caution is expiated by attendance at two appointments. A person can accumulate two pre-arrest drug cautions only. A subsequent offence for illicit drugs or cannabis will result in prosecution.

Other programs available at the pre-arrest stage

Rural Outreach Diversion Workers (RODW) have been established in rural areas. Their role is to provide a link between the community, schools, legal professionals, police, courts and the drug treatment service system. This program primarily targets young offenders (or persons in danger of becoming an offender) aged below 25 years. However, they are available to older offenders or possible offenders assessed as being appropriate for an outreach program. RODW is a flexible, early intervention program with a capacity for assertive outreach. A key component of this role is being out in the community building strong links with Police, Courts and other community organisations.

There are also a small number of locally developed arrest referral programs. These programs provide a variety of support and linkage services to persons detained by the Police and can facilitate entry to drug assessment and treatment through COATS.

Point of Arrest/Bail

Custodial Alcohol and Drug (CHAD) Nurses

CHAD nurses provide a health service to people held in Category A police cells who have a demonstrable drug problem and who require drug treatment/withdrawal or substitute pharmacotherapy services whilst they are in Category A police cells.

Alcohol and Drug Youth Consultant (ADY-C) Workers

As part of the Victorian Government Drug Initiative (VGDI) five Specialist Alcohol and Drug Youth Consultant positions were established. These workers provide secondary consultation and support for child protection clients and staff in “Out of Home Care” residential facilities and adolescent community placement. All workers are auspiced by existing Drug Treatment Agencies with experience in working with young people.

CREDIT Bail Support Program

The Court Referral Evaluation and Drug Intervention Treatment (CREDIT) Bail Support Program commenced as a nine-month pilot program in November 1998 in the Melbourne Magistrates Court. It is now available in many Magistrates Courts throughout the metropolitan area and in large regional centres. The CREDIT bail support program is offered to offenders with substance abuse issues as part of bail proceedings after initial arrest. An accredited Court Drug Clinician or an accredited drug treatment agency assessor provides a drug assessment for a person eligible for bail who has an immediately presenting drug problem. Where appropriate, drug treatment is provided as a condition of the bail process. COATS arranges the appointment with a drug treatment service and purchase drug treatment.

Criminal Justice Diversion Program (CJDP) and Salvation Army Chaplains

These general support programs for offenders are run from the Magistrates Court. Both programs are able to refer persons with drug issues to drug education, assessment and treatment via COATS.

Court Integrated Services Program (CISP)

This program provides short-term assistance for defendants with health and social needs before sentencing through individual case management support. CISP clients are provided with priority access to treatment and community support services. CISP is aimed at defendants at a moderate to high risk of re-offending with multiple and complex offence related needs. The defendants’ risk of re-offending and needs is established by using a screening and assessment tool developed specifically for a court-based population.

Neighbourhood Justice Centre (NJC)

The NJC, a three year pilot, has recently opened in Collingwood with a range of services co-located with the Court that offer services to victims, offenders, civil litigants and the local community. The Court is multijurisdictional but has only one Judicial officer, who hears all matters. A screening and assessment team at the Court refer clients who require alcohol and drug treatment via COATS to services primarily located within the City of Yarra.

Deferral of Sentence

Deferred Sentencing (17 – 25 years)

Deferred Sentencing is targeted at persons aged between 17 and 25 who have a drug problem and have been found guilty of an offence. Sentencing is deferred for up to six months with a specific condition to attend drug treatment. COATS assessors undertake pre-sentence clinical drug assessments and a treatment plan is recommended to the court. Offenders then attend the prescribed drug treatment and a report on progress will be made to the court before sentencing. COATS purchases the treatment from approved drug treatment services.

Victorian Children's Court Clinic Drug Program

Two accredited specialist drug clinicians have been out-posted to the Children's Court to provide drug assessment and advice services to the Court and to purchase drug treatment through COATS, at a youth specific drug treatment agency, for young offenders.

Sentencing Options – Non Custodial

First Offender Court Intervention Service (FOCiS)

FOCiS provides drug education sessions for first offenders convicted of possessing a small quantity of illicit drugs (other than marijuana) who receive a bond with an undertaking to attend such education. This service, called FOCiS is provided by Moreland Hall and approved treatment agencies. It commenced on 11 June 1998, following the proclamation of this new sentencing option.

Victorian Accredited Driver Education Programs (VADEP) – Drink and Drug Driver Programs²

The VADEP - Drink Driver and Drug Driver Program are fee for service programs that are operated throughout Victoria by about 38 accredited VADEP drink and drug driver agencies. Many VADEP Drink Driver agencies operate as private businesses. VADEP Drug Driver agencies have to be an accredited Drink Driver Agency as well as being a funded Drug Treatment Agency. The Government does not subsidise these services in any way.

The VADEP - Drink Driver and Drug Driver Programs for most offenders consists of two clinical drug assessments, twelve months apart, plus an eight-hour drink driver or drug driver education program. Following successful completion of these components the drink driver assessor forwards a licence restoration report to the Magistrates' Court for the purpose of supporting the application of a client to have their driving licence restored.

Koori Court - Koori Alcohol and Drug Diversion Worker Program

Seven Koori Courts (Shepparton, Broadmeadows, Warrnambool, Mildura, Morwell, Bairnsdale and Children's Koori Court) have been established and an eighth Court is due to commence in June in Swan Hill. Under the Koori Diversion Initiative a Koori Diversion Worker attached to a mainstream agency, works with the Koori Court to provide linkages for offenders appearing before the Court to both the mainstream agency and to the Koori Co-operative.

2. This is part of the forensic drug treatment system but operates on a fee for service basis.

Community-Based Dispositions

Community-Based Order with Treatment Conditions (CBO) and Intensive Corrections Orders (ICO) are imposed by the Court at sentencing. These orders have conditions attached which may include referral for assessment and drug treatment. COATS conducts the assessment and negotiate a treatment plan. COATS then purchase the required drug treatment services from an accredited drug treatment agency. Corrections Victoria case manages the client.

Combined Custody and Treatment Order (CCTO)

The CCTO provides that a sentence of less than 12 months can be served partly in prison, receiving drug treatment, and partly in the community, attending a community-based drug treatment service. The assessment and administration of treatment rests with COATS (see above).

Youth Justice Orders

Youth Justice provides case management services to approximately 140 statutory clients subject to community-based orders. Youth Justice Orders are community-based orders to which a Children’s Court Magistrate can attach treatment conditions. The Youth Justice Unit has approximately 18 positions with community teams that provide case managed services for young people subject to probation, Youth Supervision or Youth Attendance Orders. These teams also supervise some young people subject to bail or deferral of sentence.

Drug Treatment Order (DTO) - Drug Court – Dandenong Magistrates’ Court

The Drug Treatment Order (DTO) is imposed on persons with a significant drug abuse issue found guilty of offences that carry a penalty of at least two years in prison. Prior to sentencing the offender is referred to the Drug Court for assessment and, if found suitable for the program, is sentenced to a two year DTO. There are three distinct phases to the program. The offender is assigned a Community Corrections Case Manager and a Drug Court Clinical Advisor monitors the drug treatment progress of the offender in community-based treatment and reports back to Court. The Drug Court Magistrate imposes sanctions on the individual for non-compliance with the conditions of the DTO. This may involve some time spent in prison. Alternatively, compliance and progress on the DTO is rewarded and praised. The DTO finishes after two years and only those who complete the third phase of the program “graduate”; others simply have their order cancelled.

Custodial

Corrections Victoria - Prison Treatment Services

Drug treatment programs in prisons include: drug awareness sessions for all prisoners on entry, drug education, relapse prevention, semi-intensive group therapy programs, intensive residential treatment programs, individual counselling, relapse preparation and peer support programs.

Office for Children, Youth Justice and Youth Services - Youth Justice Centres

Young people sentenced to Youth Residential Centres and Youth Training Centre (Custodial) Orders, as well as young people remanded to a Youth Justice Centre are placed in secure custody. Secure Youth Justice Centres are Malmsbury, Melbourne and Parkville. Drug treatment programs are provided by the Adolescent Forensic Health Service (AFHS) within the metropolitan centres. Malmsbury has an in-house drug treatment program.

Post-Prison Options

Parole with Drug Treatment Conditions

COATS provide assessment, treatment planning and purchase treatment for adult parolees. The Parole Custody Team provides case managed services for young people subject to Youth Residential or Youth Training Centre Orders. COATS purchases treatment from community based alcohol and drug treatment agencies for young people on parole – assessment and treatment planning for young people is arranged between the Adolescent Forensic Health Service (AFHS) and the drug treatment agency.

StepOUT - Post-Prison Release Services

A post-prison service is provided for those leaving custody who are high risk or for whom a further period of counselling and support would consolidate the outcomes of treatment received in prison. The Intensive Post Prison Release Drug Treatment Service (known as StepOUT) was established in October 1997. The service is provided by Moreland Hall and provides assessment in prison, and, where appropriate, intensive counselling and case management to people on release from prison. This service has also been extended to young people leaving Youth Justice Centres.

Attachment 2

This attachment contains an outline of the current funding model for forensic drug treatment. It is intended to provide information for those that are new to the forensic drug treatment system.

Current Method of Funding

Payment by COATS for the provision of treatment by AOD treatment agencies to forensic clients is made at the unit cost for an Episode of Care (EOC) for the particular service type. The unit cost per EOC fixed by DHS for each service type is calculated by dividing the annual EOC target for the service type into the unit price for an Equivalent Full Time (EFT - clinician/bed/service) paid by DHS for that service type.

For example, if the annual EOC target for Counselling, Consultancy and Continuing Care (4C's service type) is 110 EOC per EFT and the unit price per EFT for 4C's is \$79,940.30, then COATS will pay the AOD treatment agency from whom the treatment EOC has been purchased \$726.73 per completed forensic EOC.

An EOC is defined as 'a completed course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant agreed treatment goals'.²² An EOC is only completed when the significant goals agreed with the client that make up the client's Individual Treatment Plan (ITP) have been achieved. The significant goals in the ITP must relate to the key service requirements of the purchased service type.²³ The achievement of significant goals is an outcome, not time-based, measure. Maintaining the integrity of the Episode of Care measure has been supported because it is a single, consistent means of measurement that simplifies reporting requirements for AOD treatment agencies and enables monitoring of purchased services.²⁴

COATS either pay the AOD Treatment Agency a combination of an up-front payment called a prepayment or a 'fee for service' amount. Prepayments or 'fee for service' payments made by COATS to AOD treatment agencies for treating forensic clients are paid in addition to the amounts paid by DHS for meeting voluntary targets. This means that AOD agencies treating forensic clients are expected to employ additional staff or take on additional beds, rather than requiring existing clinicians to deliver forensic EOC in addition to their full voluntary EOC target. Also, AOD treatment agencies cannot provide forensic clients with short forensic EOC and then transfer them to the voluntary system and record them against their voluntary EOC target.

COATS Payments

COATS pay the AOD treatment agency the full unit cost for the service type for a completed EOC. A pro-rata amount of the unit cost is paid for partially completed EOC and a non-attendance fee is payable for forensic clients who do not attend treatment. To be paid, the AOD treatment agency must forward a Treatment Completion Advice (TCA) to COATS, 14 days before the end of the COATS' Accounting Quarter. The TCA contains some clinical information, but also sets out the services provided to the forensic clients for payment.²⁵

Prepayment

Prepayments can be made in two ways, either through the agency service agreement with DHS or from COATS. A prepayment means that the AOD treatment agency has an upfront payment equivalent to the cost of providing a specified number of EOC for a particular service type. The AOD treatment agency is then obliged to prioritise forensic clients and to provide the relevant amount of EOC pre-purchased for the period of the prepayment.

When treatment for a forensic client is ordered, a Treatment Completion Advice (TCA) form is generated and sent to the appropriate agency. Once a client has been exited from treatment at the agency (for non-attendance, leaving against advice or completing treatment) details of client engagement are provided on the relevant TCA and forwarded to COATS. Upon receipt of this documentation, COATS will make a determination about the value of the payment based on the information provided on the TCA.

If at the conclusion of the prepayment period, the cost attributed to TCA's submitted by the AOD treatment agency exceeds the value of the prepayment, COATS will pay fee for service for any balance of treatment ordered and TCA's submitted.

The AOD treatment agency does not have to refund COATS where the total number of completed EOC is less than the value of the prepayment (unless the contract between COATS and the AOD treatment agency has terminated).

Fee for service

If payment is made on a fee for service basis, COATS will send the AOD treatment agency, payment for the services provided and an invoice in arrears. The invoice will set out the services provided according to the TCA received by COATS 14 days before the end of the accounting quarter, the program under which COATS is funded and the unit cost for each EOC provided.

Attachment 3

Accreditation Requirements

Currently, in the forensic system, AOD agencies need to be accredited to provide services to forensic clients. Accreditation is achieved by having a suitably qualified clinical supervisor who is responsible for overseeing the delivery of AOD treatment to forensic clients. AOD clinicians undertaking AOD assessments of forensic clients must also be accredited by DHS.²⁶

According to the current system, the Clinical Supervisor must have the following mandatory qualifications:

- An appropriate tertiary qualification (minimum level of diploma) in a health-related discipline. A specific qualification such as a Graduate Diploma in Addiction Medicine is seen as an advantage;
- Has attained the minimum educational standard for working within the alcohol and drug system e.g. Certificate IV in Alcohol and Drug Work or equivalent competencies; and
- Minimum of 24 months' full-time AOD work experience in a credible AOD treatment agency (not including a drink driver program).²⁷

To be accredited as a Clinical Assessor, a worker must have the following mandatory qualifications:

- An appropriate tertiary qualification (minimum level of diploma) in a health-related discipline. A specific qualification such as a Graduate Diploma in Addiction Medicine is seen as an advantage;
- has attained the minimum educational standard for working within the alcohol and drug system e.g. Certificate IV in Alcohol and Drug Work or equivalent competencies;
- Minimum of 12 months' full-time AOD work experience in a credible AOD treatment agency (not including a drink driver program);²⁸ and
- Counselling skills and experience in a recognised counselling course.

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